



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

**Monday, March 2, 2026 – 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: 998 0062 2109# 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.	<b>CALL TO ORDER/ROLL CALL</b>	Carol Somersille, MD Quality Committee Chair		<b>5:30 pm</b>
2.	<b>POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Carol Somersille, MD Quality Committee Chair	Information	<b>5:30 pm</b>
3.	<b>PUBLIC COMMUNICATION</b> a. Oral Comments <i>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.</i> b. Written Public Comments <i>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.</i>	Carol Somersille, MD Quality Committee Chair	Information	<b>5:30 pm</b>
4.	<b>CONSENT CALENDAR ITEMS</b> a. <a href="#">Approve Minutes of the Open Session of the Quality Committee Meeting (02/02/2026)</a> b. <a href="#">Receive FY 2026 Pacing Plan</a> c. <a href="#">Receive FY 2026 Committee Goals</a>	Carol Somersille, MD Quality Committee Chair	<b>Motion Required</b>	<b>5:30 – 5:35</b>
5.	<b>VERBAL COMMITTEE MEMBER EXPERTISE REPORT</b>	Jack Po, MD Quality Committee Member	Information	<b>5:35 – 5:45</b>
6.	<b><a href="#">PATIENT SAFETY STORY</a></b>	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Information	<b>5:45 – 5:50</b>

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
7.	<a href="#">PATIENT EXPERIENCE REPORT</a>	Ryan Lockwood, Vice President, Patient Experience	Information	5:50 – 6:10
8.	<a href="#">FY 2026 ENTERPRISE QUALITY DASHBOARD</a>	Shreyas Mallur, MD, Chief Quality Officer	Discussion	6:10 – 6:20
9.	<b>REVIEW FY 2027 COMMITTEE PLANNING ITEMS</b> a. <a href="#">Committee Dates</a> b. <a href="#">Committee Goals</a> c. <a href="#">Pacing Plan</a>	Carol Somersille, MD Quality Committee Chair  Shreyas Mallur, MD, Chief Quality Officer	Discussion	6:20 – 6:35
10.	<b>RECESS TO CLOSED SESSION</b>	Carol Somersille, MD Quality Committee Chair	<b>Motion Required</b>	6:35 – 6:36
11.	<b>ECH STRATEGY UPDATE</b> a. Review Progress of FY 2026 Organizational Quality Goal b. Preview of FY 2027 Organizational Quality Goal  <i>Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets</i>	Dan Woods, CEO  Shreyas Mallur, MD, Chief Quality Officer  Andreu Reall, VP, Strategy	Discussion	6:36 – 6:56
12.	<b>QUALITY COUNCIL MINUTES</b> a. Quality Council Minutes (02/04/2026) <i>Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance Committee</i>	Carol Somersille, MD Quality Committee Chair	Information	6:56 – 6:58
13.	<b>APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (02/02/2026)</b> <i>Report involving Gov't Code Section 54957.2 for Closed Session Minutes</i>	Carol Somersille, MD Quality Committee Chair	<b>Motion Required</b>	6:58 – 7:00
14.	<b>RECOMMEND FOR APPROVAL CREDENTIALING AND PRIVILEGES REPORT</b> <i>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</i>	Mark Adams, MD, Chief Medical Officer	<b>Motion Required</b>	7:00 – 7:05
15.	<b>VERBAL SERIOUS SAFETY EVENT REPORT</b> <i>Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee</i>	Shreyas Mallur, MD, Chief Quality Officer	Discussion	7:05 – 7:10
16.	<b>RECONVENE TO OPEN SESSION</b>	Carol Somersille, MD Quality Committee Chair	<b>Motion Required</b>	7:10 – 7:11
17.	<b>CLOSED SESSION REPORT OUT</b> To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	7:11 – 7:12
18.	<b>COMMITTEE ANNOUNCEMENTS</b> a. IHI Forum 2026	Carol Somersille, MD Quality Committee Chair	Information	7:12 – 7:15

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	<b>AGENDA ITEM</b>	<b>PRESENTED BY</b>	<b>ACTION</b>	<b>ESTIMATED TIMES</b>
<b>19.</b>	<b>ADJOURNMENT</b>	Carol Somersille, MD Quality Committee Chair	<b>Motion Required</b>	<b>7:15</b>

**Next Meetings:** May 4, 2026; June 1, 2026



**Minutes of the Open Session of the  
Quality, Patient Care, and Patient Experience Committee  
of the El Camino Health Board of Directors**

**Monday, February 2, 2026**

**El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040**

**Members Present**

**Carol Somersille, MD, Chair**  
**Krutica Sharma, MD, Vice Chair** *(joined at 5:38 p.m.)*  
**Pancho Chang**  
**Shahram Gholami, MD**  
**Erica Jiang**  
**Barbara Pelletreau**  
**Jack Po, MD** *(joined at 5:36 p.m.)*  
**Diane Schweitzer**  
**Steven Xanthopoulos, MD** *(joined at 5:31 p.m.)*  
**John Zoglin**

**Members Absent**

**None**

**ECHMN Staff Present**

**Alan Muster, MD,** President, ECHMN  
**Peter Goll, CAO,** ECHMN  
**Jaideep Iyengar, MD,** ECHMN  
**Kirstan Smith, BSN,** Director of Clinical Quality, ECHMN

**Staff Present**

**Mark Adams, MD, CMO**  
**Theresa Fuentes, CLO**  
**Shreyas Mallur, MD, CQO**  
**Tracey Lewis Taylor, COO**  
**Cheryl Reinking, DPN, RN CNO**  
**Deb Muro, CIO**  
**Lyn Garrett, Senior Director, Quality**  
**Tracy Fowler, Director, Governance Services\*\***  
**Gabriel Fernandez, Coordinator, Governance Services**

*\*\*via teleconference*

<b>Agenda Item</b>	<b>Comments/Discussion</b>	<b>Approvals/ Action</b>
<b>1. CALL TO ORDER/ ROLL CALL</b>	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at <b>5:30 p.m.</b> by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Committee members Po, Sharma, and Xanthopoulos were absent at the time of roll call.	<b>Call to order at 5:30 p.m.</b>
<b>2. CONSIDER APPROVAL FOR AB 2449 REQUESTS</b>	All Committee members participated in person. No consideration for AB 2449 was needed.	
<b>3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
<b>4. PUBLIC COMMUNICATION</b>	There were no comments from members of the public.	

<p><b>5. CONSENT CALENDAR</b></p>	<p>Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. No items were removed.</p> <p><b>Motion:</b> To approve consent calendar items.</p> <p><b>Movant:</b> Zoglin  <b>Second:</b> Schweitzer  <b>Ayes:</b> Somersille, Chang, Gholami, Jiang, Pelletreau, Schweitzer, Xanthopoulos, Zoglin  <b>Noes:</b> None  <b>Abstain:</b> None  <b>Absent:</b> Sharma, Po  <b>Recused:</b> None</p>	<p><b>Consent Calendar Approved, including Open Session minutes (12/01/2025) and receipt of FY2026 Pacing Plan and Committee Goals.</b></p>
<p><b>6. VERBAL COMMITTEE CHAIR'S REPORT ON CONFERENCE EDUCATION</b></p>	<p>Chair Somersille, Vice Chair Sharma, Mr. Chang, and Ms. Jiang provided verbal reports on their participation in the Institute for Healthcare Improvement (IHI) Forum. The discussion highlighted emerging perspectives on quality governance, the importance of aligning committee agendas to strategic quality priorities, and the value of board education in areas such as preventive care, risk-based surveillance, and high-reliability healthcare. Committee members also discussed evolving quality governance frameworks and the role of innovation and data in advancing patient outcomes.</p>	
<p><b>7. APPROVE COMMITTEE SURVEY RESULTS DRAFT ACTION PLAN</b></p>	<p>Chair Somersille presented the FY26 Committee Survey Results Draft Action Plan, outlining proposed actions to address committee effectiveness, meeting structure, and ongoing education priorities.</p> <p>Committee members discussed the importance of clear ownership of action items, appropriate use of pre-meeting questions to support effective discussion, and continued alignment of agenda content with strategic quality priorities.</p> <p><b>Motion:</b> To approve the FY26 Committee Survey Results Action Plan</p> <p><b>Movant:</b> Gholami  <b>Second:</b> Sharma  <b>Ayes:</b> Somersille, Chang, Gholami, Jiang, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin  <b>Noes:</b> None  <b>Abstain:</b> None  <b>Absent:</b> None  <b>Recused:</b> None</p>	

<p><b>8. PATIENT STORY</b></p>	<p>Ms. Reinking presented a patient story illustrating patient experience, quality outcomes, and opportunities for learning and improvement in clinical care.</p> <p>Committee members discussed the importance of transparency in sharing both positive and adverse patient experiences, including what occurred and the actions taken in response. Ms. Reinking noted that the Committee already rotates between patient stories and patient safety issues as part of its regular meeting cadence to support ongoing learning, accountability, and continuous improvement.</p> <p>Ms. Pelletreau shared that she values hearing both positive patient experiences and cases where opportunities for improvement were identified, noting that understanding what went wrong and how it was addressed is critical to strengthening patient safety and quality outcomes.</p>	
<p><b>9. ARTIFICIAL INTELLIGENCE REPORT</b></p>	<p>Ms. Muro presented the annual Artificial Intelligence (AI) Report, outlining current AI initiatives, organizational maturity, and opportunities to leverage AI to support quality, efficiency, and patient experience.</p> <p>Discussion focused on the growing role of AI across healthcare, including its potential to improve clinical workflows, address labor challenges, enhance patient engagement, and support data-driven decision-making. Committee members explored the organization’s position along the AI maturity curve and the importance of aligning investments with measurable value and outcomes.</p> <p>The Committee discussed considerations related to return on investment, data governance, privacy, and transparency in patient use of AI-supported tools. Members emphasized the need for strong oversight, clear accountability, and continued education on AI capabilities and risks.</p> <p>There was also discussion regarding strategic approaches to AI implementation, including balancing vendor solutions with the development of internal infrastructure and capabilities to ensure long-term flexibility, control, and alignment with clinical priorities. Committee members requested future updates on AI initiatives, outcomes, and governance considerations as implementation continues.</p>	<p><b>Action:</b> Staff to schedule a future agenda item to review Age-Friendly Health Systems initiatives and progress</p>
<p><b>10. Q2 FY26 STEEEP DASHBOARD REVIEW/ FY26</b></p>	<p>Dr. Mallur presented the Q2 FY26 STEEEP Dashboard and the FY26 Enterprise Quality Dashboard, highlighting organizational performance across safety, timeliness,</p>	

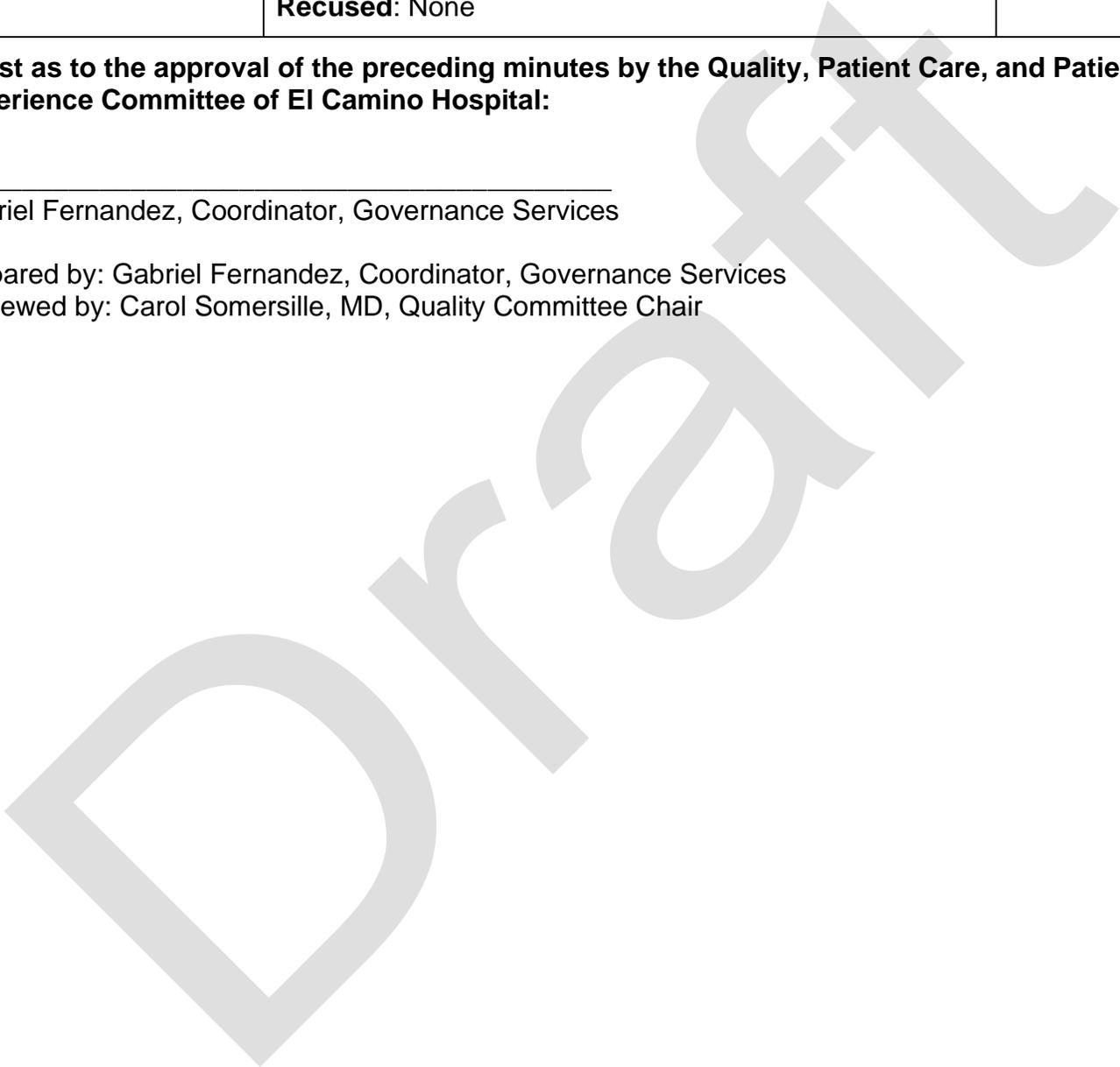
<p><b>ENTERPRISE QUALITY DASHBOARD</b></p>	<p>effectiveness, efficiency, equity, and patient-centered care measures.</p> <p>Discussion focused on trends in key quality metrics, areas of improvement, and ongoing initiatives to address performance gaps. Committee members asked clarifying questions regarding data attribution, benchmarking, and progress toward quality goals.</p>	
<p><b>11. EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT</b></p>	<p>Dr. Iyengar, Mr. Goll, and Ms. Smith presented the El Camino Health Medical Network (ECHMN) Quality Report, including final performance results, updates to attribution methodology, and the transition from traditional MIPS reporting to MIPS Value Pathways.</p> <p>The presenters reviewed progress across key preventive care and chronic disease quality measures, highlighting improvements in screening rates and quality performance over recent years. Discussion included the impact of updated patient attribution models on performance measurement and efforts to ensure consistent quality care across patient populations.</p> <p>Committee members discussed challenges related to data collection, chart abstraction, care gap identification, and integration of data across multiple electronic health record systems. The team shared ongoing work to improve real-time data access, establish benchmarking with affiliated physicians, and explore vendor solutions to support data aggregation and reporting.</p>	
<p><b>12. RECESS TO CLOSED SESSION</b></p>	<p><b>Motion:</b> To recess to closed session at 7:20 p.m.</p> <p><b>Movant:</b> Jiang <b>Second:</b> Po <b>Ayes:</b> Somersille, Chang, Gholami, Jiang, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin <b>Noes:</b> None <b>Abstain:</b> None <b>Absent:</b> None <b>Recused:</b> None</p>	<p><b><i>Recessed to Closed Session at 7:20 p.m.</i></b></p>
<p><b>13. AGENDA ITEM 19: CLOSED SESSION REPORT OUT</b></p>	<p>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 December 1, 2025, meeting.</p>	<p><b><i>Reconvened Open Session at 7:44 p.m.</i></b></p>
<p><b>14. AGENDA ITEM 20: COMMITTEE ANNOUNCEMENTS</b></p>	<p>Ms. Reinking announced that El Camino Health received its fifth consecutive ANCC Magnet designation, recognizing excellence in nursing practice and patient care. She noted that early preparation for the next re-designation cycle, anticipated in 2030, will begin in advance to support continued success.</p>	

<p><b>15. AGENDA ITEM 21: ADJOURNMENT</b></p>	<p><b>Motion:</b> To adjourn at 7:46 p.m.  <b>Movant:</b> Po  <b>Second:</b> Chang  <b>Ayes:</b> Somersille, Chang, Gholami, Jiang, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin  <b>Noes:</b> None  <b>Abstain:</b> None  <b>Absent:</b> None  <b>Recused:</b> None</p>	<p><b><i>Meeting Adjourned at 7:46 p.m.</i></b></p>
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**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





**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
<b>STANDING AGENDA ITEMS</b>												
Consent Calendar <sup>1</sup>			✓		✓	✓		✓	✓		✓	✓
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			✓		✓	✓		✓	✓		✓	✓
<b>SPECIAL AGENDA ITEMS – OTHER REPORTS</b>												
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						✓						
<b>COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR</b>												
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)



## 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: **safe, timely, effective, efficient, equitable, and person-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. <ul style="list-style-type: none"> <li>▪ Monthly Quality Dashboard</li> <li>▪ Quarterly Board Level Quality Dashboard</li> </ul>
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	<ul style="list-style-type: none"> <li>• Attend a minimum of 5 meetings in person.</li> <li>• Actively participate in discussions at each meeting.</li> <li>• Review of annual committee self-assessment results</li> </ul>
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%. <ul style="list-style-type: none"> <li>• Verbal/Written report of key learnings to the Quality Committee.</li> </ul>

**Chair:** Carol Somersille, MD

**Executive Sponsor:** Shreyas Mallur, MD, Chief Quality Officer



**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:** March 2, 2026  
**Subject:** Patient Safety Story

**Purpose:** To provide the Committee with a patient safety story demonstrating the use of HRO principles and subsequent system changes.

**Summary:**

1. **Situation:** Blood samples were taken in the OR, and the wrong patient labels were attached to the blood tubes and sent to the laboratory for processing.
2. **Authority:** To provide insight into a patient specimen identification error at El Camino Health and recognize the importance of using HRO and patient safety skills.
3. **Background:** The blood samples collected in the OR were labeled with chart labels from a patient who had been discharged, which were left in the current patient's chart.
4. **Assessment:** This incident represents a specimen ID labeling error with potential safety implications. The blood tubes with the wrong labels were delivered to the laboratory. As per usual laboratory procedures, the physician's orders were checked against the lab specimens sent to the lab, and a mismatch was identified using the HRO skills of qualify, verify, and validate (QVV). The laboratory team followed the appropriate escalation procedures, notified the OR, corrected the error, and completed an iSafe report for the OR manager to investigate.
5. **Outcomes:** Upon investigation, it was noted that the appropriate identification procedures were not followed to ensure the correct labels were placed on the specimens. In other departments, an automated labeling system is used, but not in the OR. However, with the implementation of the new Lab IS (Epic Beaker), an automated specimen labeling system will be in place on March 22, 2026.

**Suggested Committee Discussion Questions:**

1. What are the other HRO skills we have taught the staff?
2. What other safety elements will the new Beaker system advance?



## EL CAMINO HOSPITAL BOARD OF DIRECTORS COMMITTEE MEETING MEMO

**To:** Quality Committee of the Board of Directors, El Camino Health  
**From:** Ryan M. Lockwood, MBA, CPXP  
**Date:** March 2, 2026  
**Subject:** Patient Experience Update

**Purpose:** To provide the Committee with an update on Fiscal Year 2026 patient experience performance, survey methodology updates, and progress on key initiatives within the FY26 Patient Experience Plan.

**Summary:** This update includes:

- HCAHPS and OAS CAHPS surveying updates, including regulatory and reimbursement considerations
- FY26 performance results (July 2025 – January 2026), including national, state, and regional percentile rankings
- Progress updates on the FY26 Patient Experience Plan
- Areas of opportunity and performance variation across the system
- Comparison of FY26 targets against statistical significance thresholds

**Background:** Patient experience data remains federally regulated, publicly reported, payment-linked, methodologically standardized, and highly audited. Given its impact on federal reimbursement and public transparency, integrity and comparability of the data remain critical.

El Camino Health continues to standardize survey methodologies across inpatient, ambulatory, emergency, and medical network settings while exploring real-time feedback mechanisms to enhance service recovery and responsiveness.

**Assessment:** Through structured initiatives such as the Patient Experience Action Team (PEAT), standardized behavioral expectations, and enhanced feedback management workflows, El Camino Health has demonstrated measurable improvement in several performance domains.

Current FY26 percentile rankings include:

- HCAHPS: 87th National, 82nd California, 92nd Bay Area
- Medical Network: 46th National, 46th California, 40th Bay Area

Key areas of opportunity include internal variation reduction, discharge communication standardization, ED wait communication, and integration of QR-based real-time feedback systems.



## Patient Experience Update

*Ryan M. Lockwood, MBA, CPXP*

*March 2, 2026, Mountain View Hospital*

**“Setting the standard for the best  
healthcare experience in the Bay Area by  
delivering dependable clinical excellence  
in a caring, convenient way”**



# Patient Experience Update –

## Agenda

- Patient Experience Surveying Updates
- Fiscal Year 2026 Performance
- Update Fiscal Year 2026 Patient Experience Plan
- Fiscal Year 2026 Targets' Performance compared to Statistical Significance

# Patient Experience Surveying Updates

# Patient Experience Update – HCAHPS and OAS CAHPS Surveying Updates

- **Patient Experience surveying is unique as it is:**
  - Federally regulated
  - Publicly reported
  - Payment linked
  - Methodologically standardized
  - Highly audited
- **Flexibility is constrained because:**
  - Data directly affects federal reimbursement
  - Integrity of the program must withstand national comparison
  - CMS enforces strict anti-bias protections

# Patient Experience Update –

## Other Surveying Updates

- **Medical Network:**

- Standardizing survey methodology across all clinics
- Focused survey questions key drivers and friction points

- **ED and Outpatient Services:**

- Future State – real time feedback collection on friction points through QR technology
- Future State – utilization of other key performance indicators such as NPS and others

# Fiscal Year 2026 Performance

# Patient Experience Update –

## Fiscal Year 2026 Performance (July 2025 – January 2026)

	FY25 Top Box Percent Score*	FY25 Percentile Rank	FY26 Top Box Percent Score	FY26 Percentile Rank	Meeting Target
<b>Composite Performance</b>	<b>82.3%</b>	<b>-</b>	<b>83.4%</b>	<b>-</b>	
<b>Inpatient</b>	<b>81.5%</b>	<b>84th</b>	<b>82.7%</b>	<b>87th</b>	
<b>MCH</b>	<b>80.8%</b>	<b>82nd</b>	<b>86.2%</b>	<b>93rd</b>	
<b>ED</b>	<b>78.2%</b>	<b>72nd</b>	<b>79.2%</b>	<b>76th</b>	
<b>OP Surgery</b>	<b>88.5%</b>	<b>62nd</b>	<b>88.3%</b>	<b>60th</b>	
<b>OP Services</b>	<b>87.2%</b>	<b>57th</b>	<b>87.4%</b>	<b>53rd</b>	
<b>OP Oncology</b>	<b>90.7%</b>	<b>52nd</b>	<b>91.2%</b>	<b>50th</b>	
<b>Medical Network</b>	<b>82.1%</b>	<b>26th</b>	<b>86.2%</b>	<b>46th</b>	

### FY26 Percentile Ranks

#### HCAHPS

National – 87<sup>th</sup>  
 California – 82<sup>nd</sup>  
**Bay Area – 92<sup>nd</sup>**

#### Medical Network

National – 46<sup>th</sup>  
 California – 46<sup>th</sup>  
**Bay Area – 40<sup>th</sup>**

**\*Top Box Percent Score** reflects only the percentage of patients who select the highest possible rating (e.g., “Definitely Yes” for inpatient, “5 Stars” for Medical Network).

# Update Fiscal Year 2026 Patient Experience Plan

# FY26 Patient Experience Plan – Updates – What has led to our improvement



- **Patient Experience Action Team (PEAT)**
  - Standardized review cadence of composite, domain drivers, and variation across departments and clinics
- **Standardized Behavioral Expectations**
  - Consistent reinforcement of The Power of Three
  - Behavioral coaching rather than campaign-based tactics
- **Structured Feedback Management and Service Recovery**
  - Clear workflow for identifying service, staff, or safety concerns with closed loop communication
- **“It’s Not Easy Being Green” Recognition**
  - Monthly celebration departments and clinics for performing above their targets
- **Expanding Listening Strategy Beyond Surveys**
  - Real time inputs from grievances, rounding insights, and digital reviews
- **Increased Visibility of the Patient Experience Team**
  - Regular rounding in all departments and clinics
  - Direct observation and coaching to our evidence-based best practices



# FY26 Patient Experience Plan – Updates – Areas of opportunity

## Mountain View – Outpatient Surgery

- Standardize with clinical leadership our preprocedural education and discharge instruction process across both campuses to improve understandability and reliability (Los Gatos has developed a good process that is being deployed at Mountain View)
- Review key drivers monthly with clinical leaders and implement targeted leader accountability when performance deviates from target

## Reduce Internal Variation Throughout Healthcare System

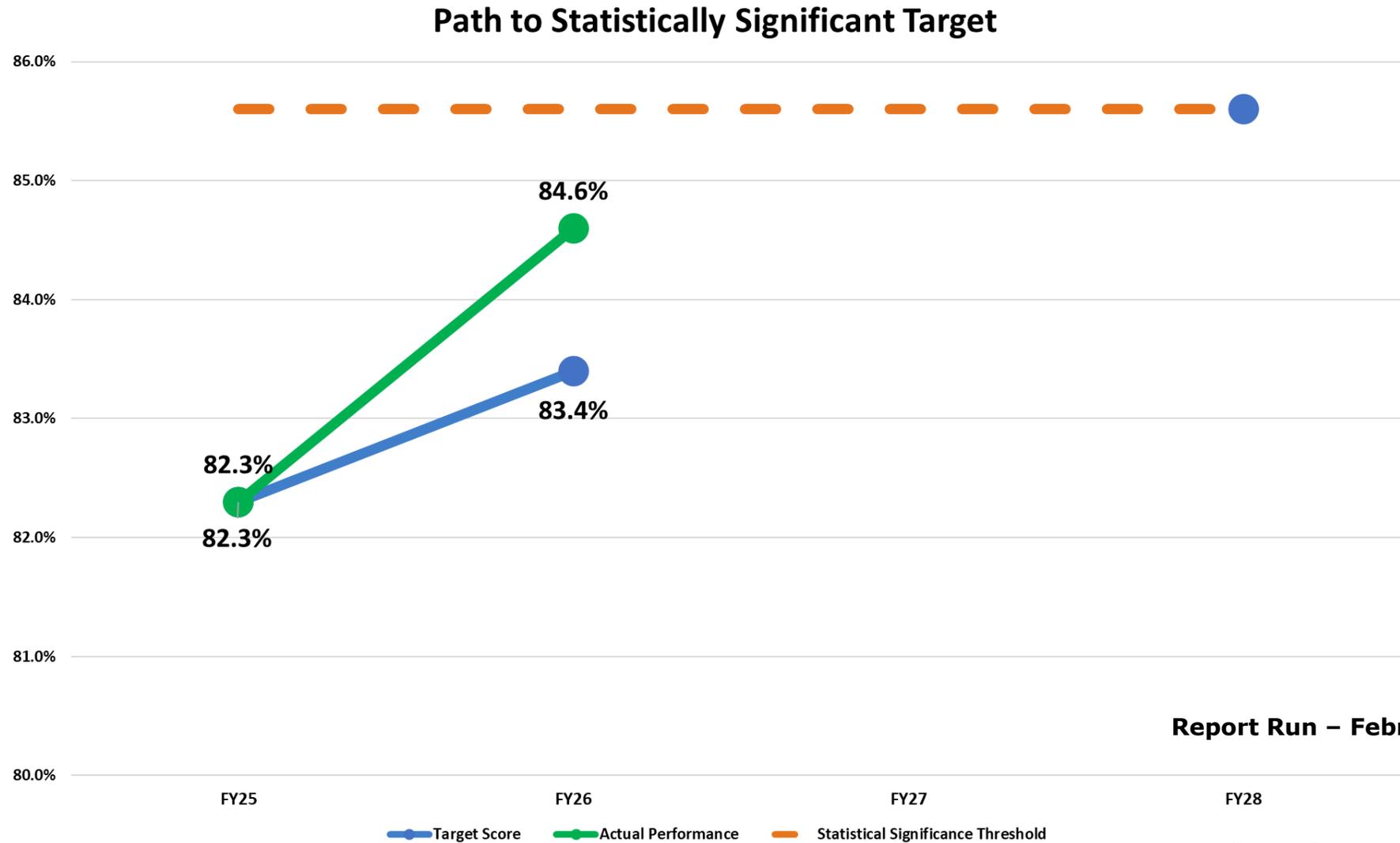
- Standardize core patient experience workflows, including leader rounding, service recovery, and discharge communication, across the enterprise
- Review variation monthly through PEAT with defined accountability pathways for clinical and operational leaders when performance falls outside established thresholds

## Real Time Feedback Integration

- Identified with clinical and operational leadership on recurring friction in ED wait communication, Outpatient Surgery discharge instructions and post care follow-up, and clinic access delays through grievances, rounding, and digital reviews
- Deploy QR based real time feedback in ED and Outpatient Services to capture in the moment concerns related to wait times, communication and discharge instructions
- Integrate real time inputs into monthly PEAT review to identify trends, variation by site, and equity gaps across language and demographic groups

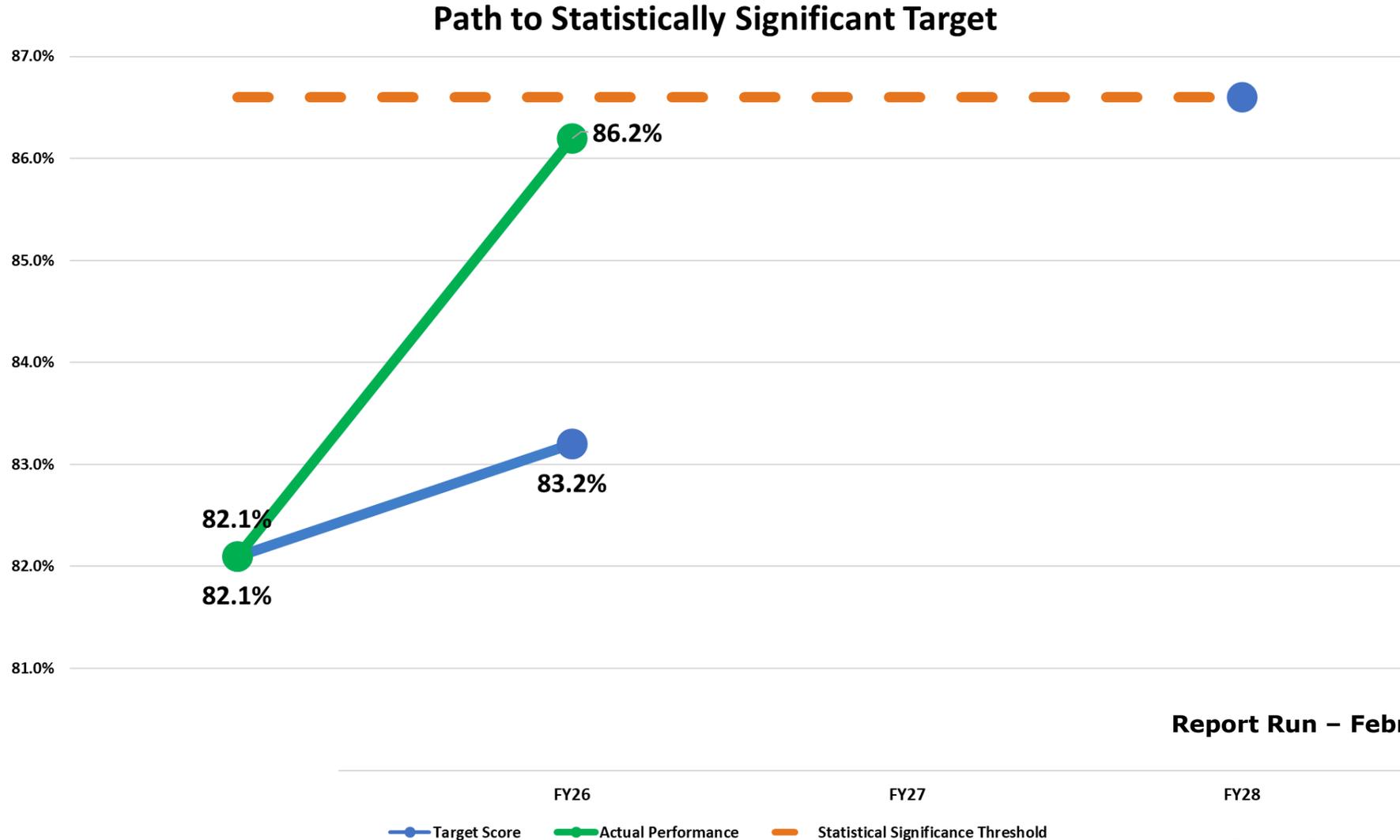
# **Fiscal Year 2026 Targets' Performance compared to Statistical Significance**

# FY26 El Camino Health's Targets – Composite Targets' Performance compared to Statistical Significance



Report Run – February 13, 2026

# FY26 El Camino Health's Targets – Medical Network Targets' Performance compared to Statistical Significance



Report Run – February 13, 2026

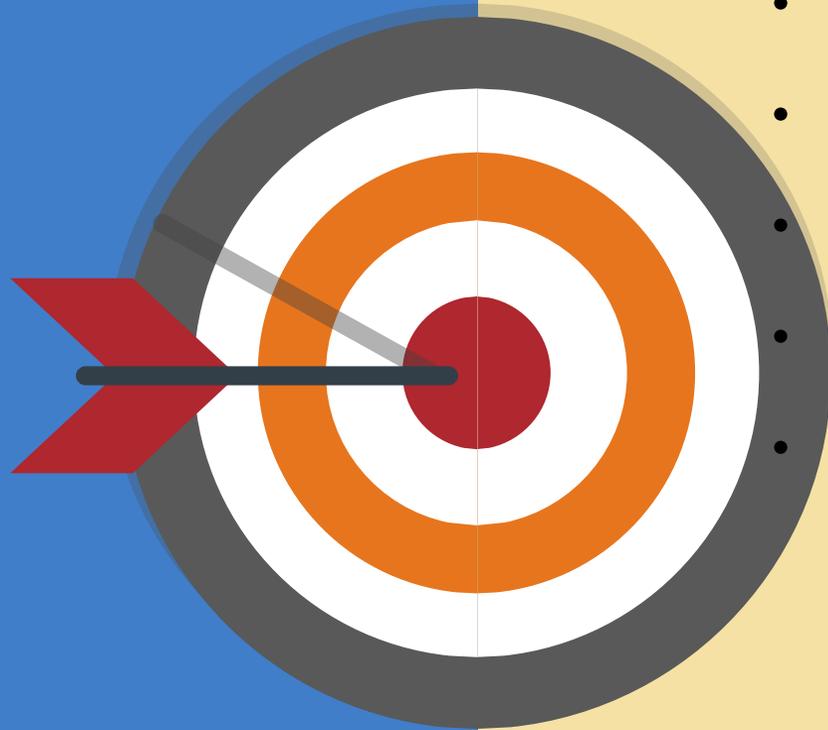
FY26 FY27 FY28  
—●— Target Score —●— Actual Performance — Statistical Significance Threshold

# Questions?

# Appendix

# Patient Experience Update

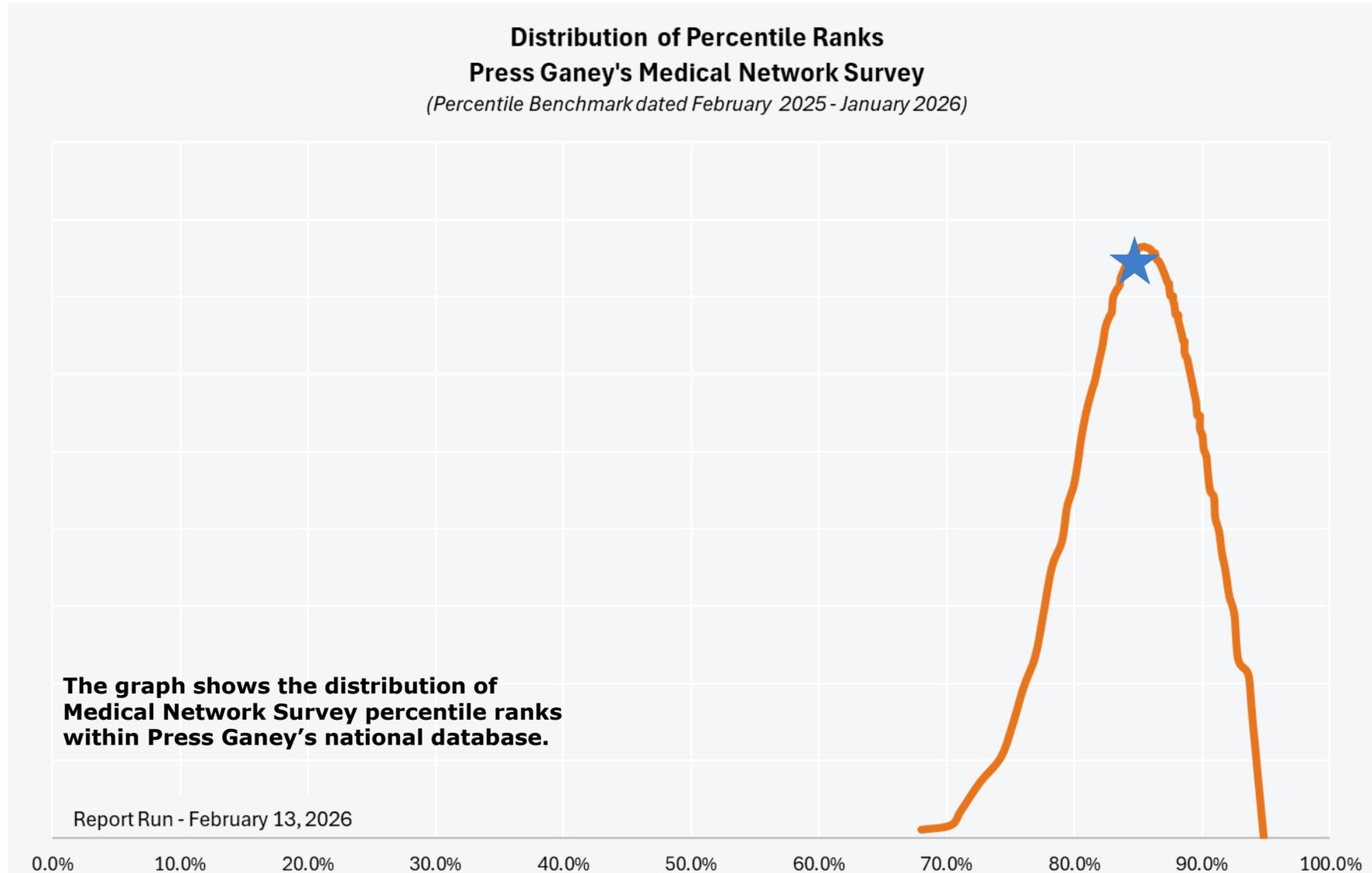
## Fiscal Year 2026 Patient Experience Focuses – Completed in Q4 FY26



- Creation of El Camino Health’s Patient Experience Playbook
- Reestablishing Patient and Family Advisory Groups
- Refresher of WeCare Service Recovery Training for all employees
- Creation of Comprehensive Patient Experience Reports
- Creation of Physician Partnership Program

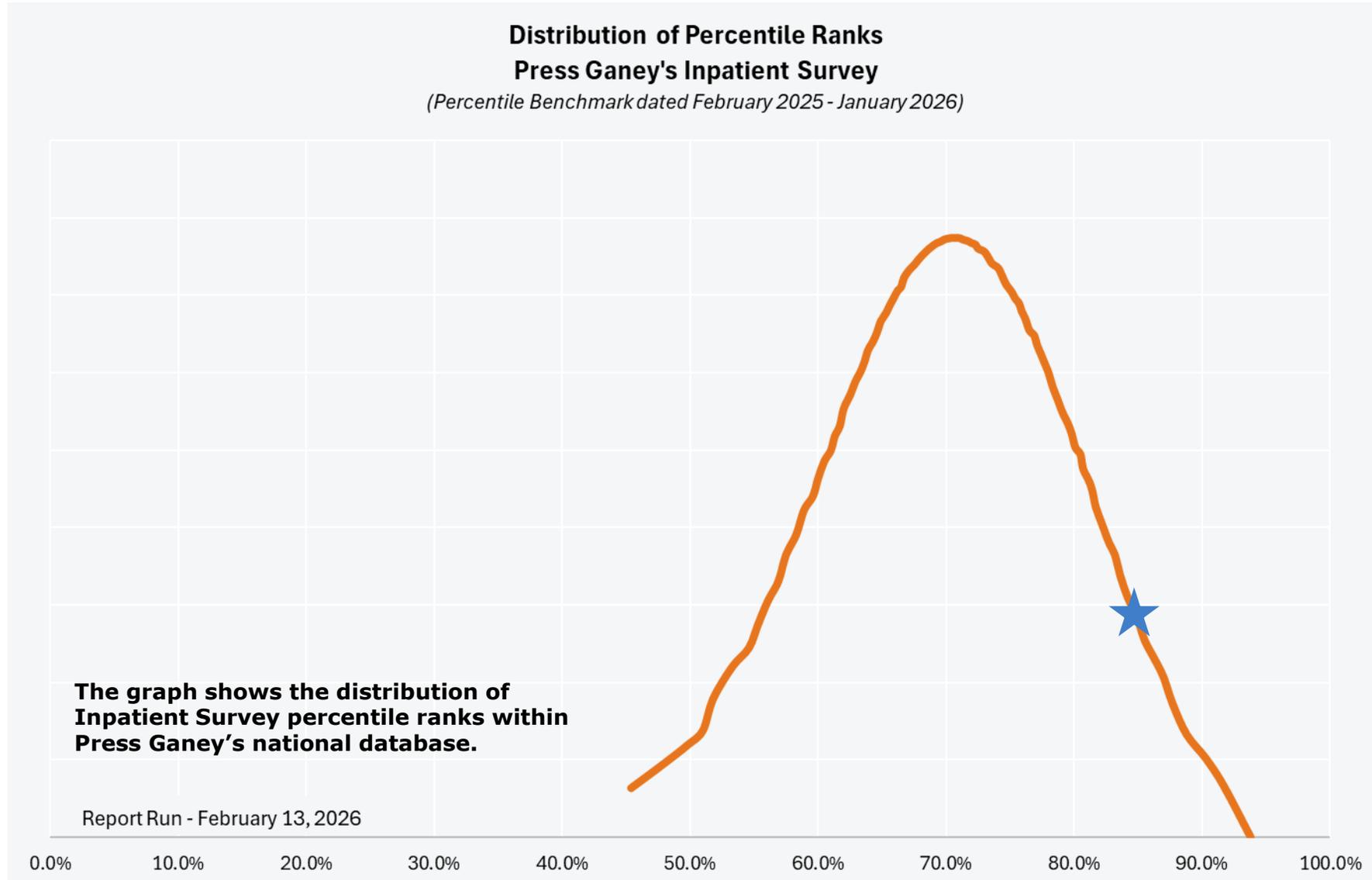
# Patient Experience Update

## Distribution of Percentile Ranks – Medical Network Survey



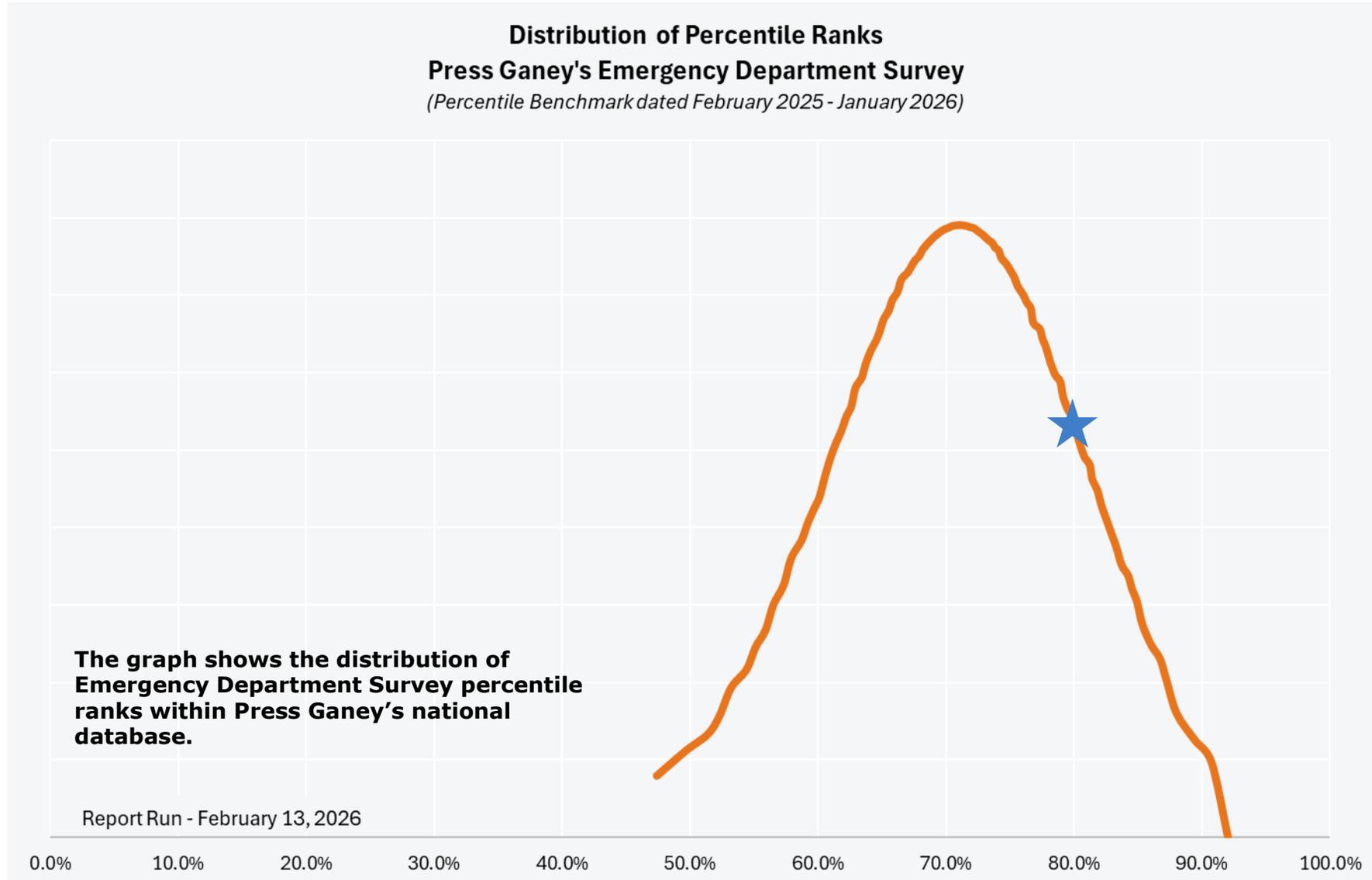
# Patient Experience Update

## Distribution of Percentile Ranks – Inpatient Survey



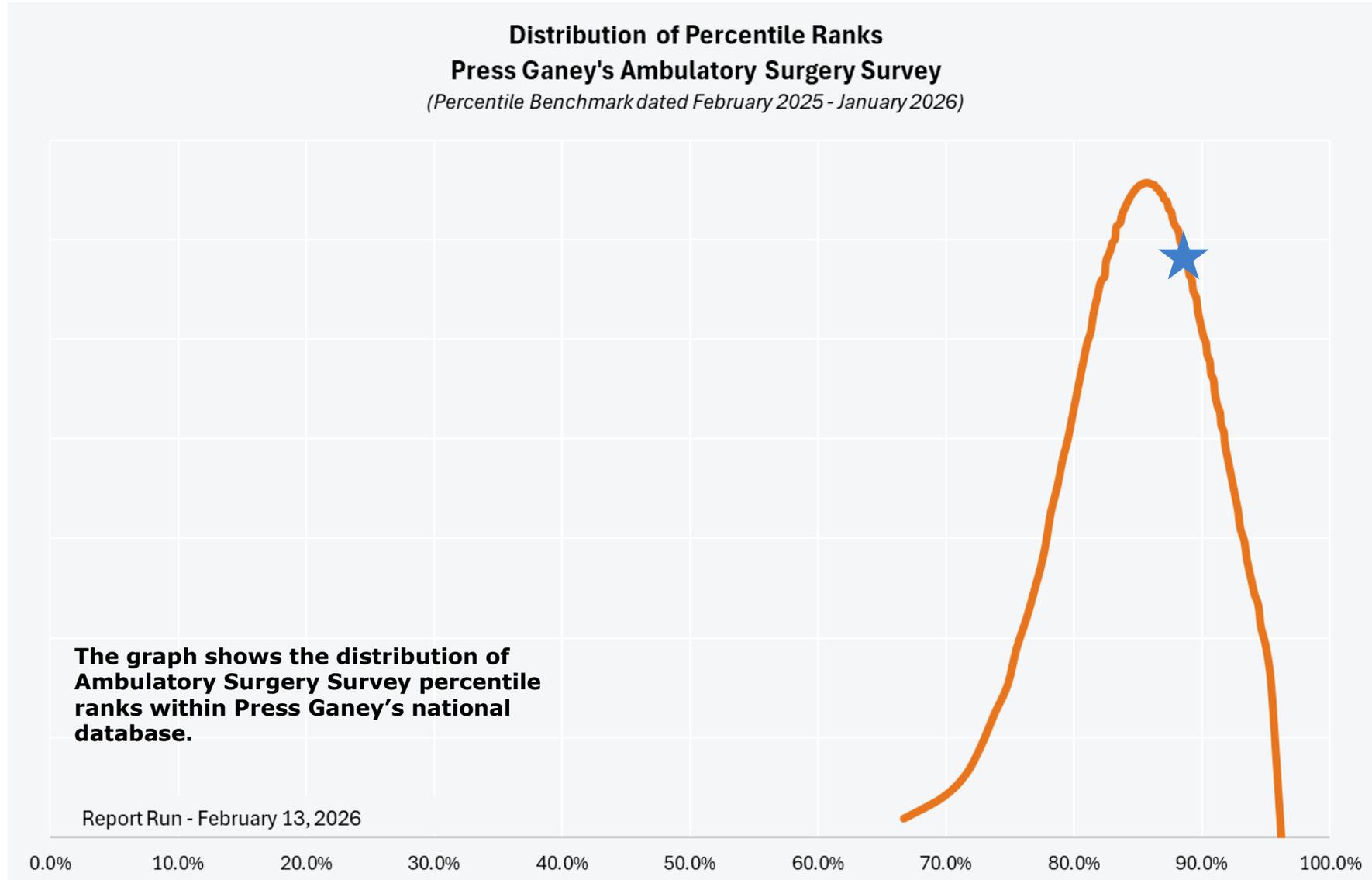
# Patient Experience Update

## Distribution of Percentile Ranks – Emergency Department Survey



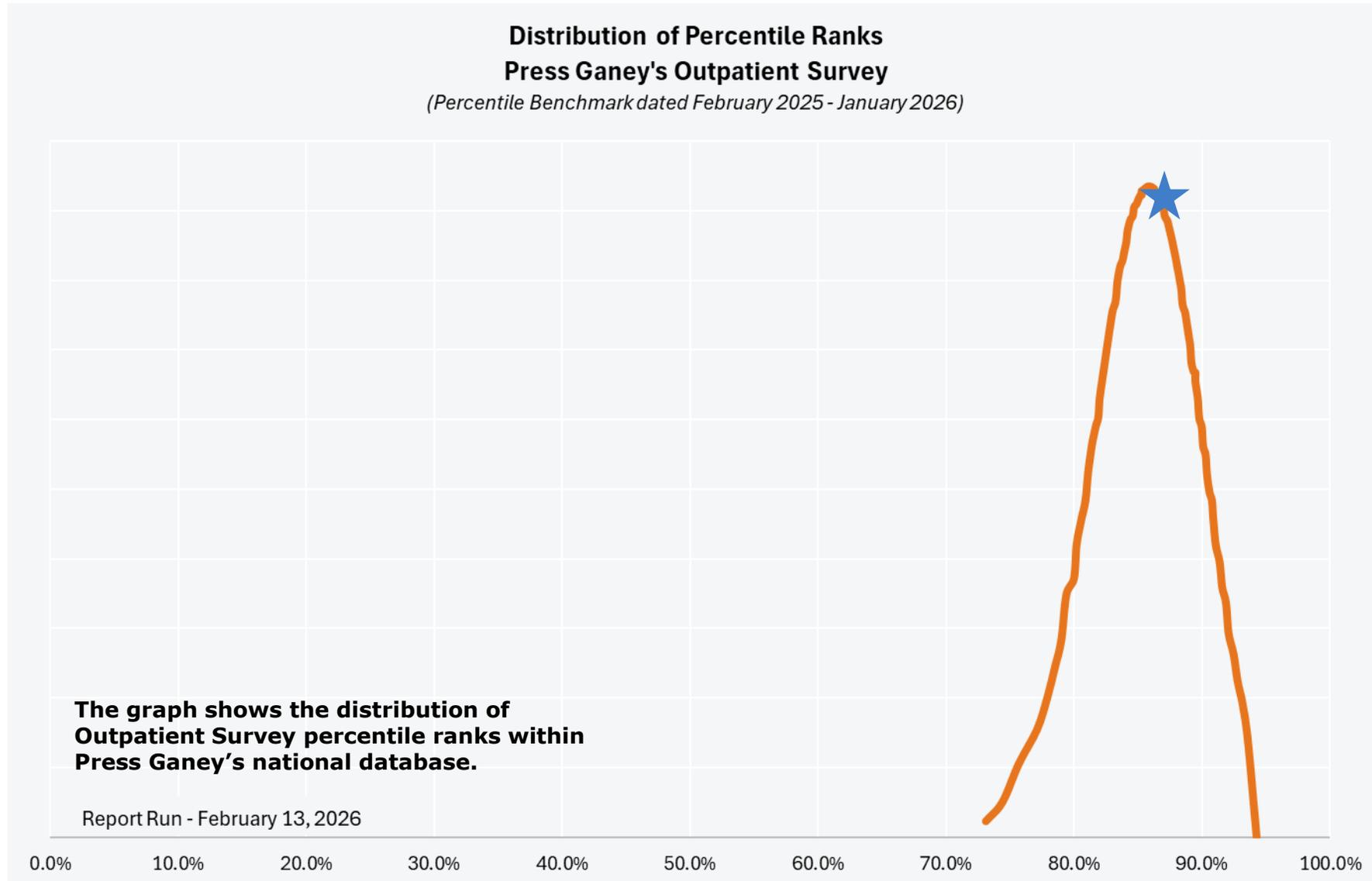
# Patient Experience Update

## Distribution of Percentile Ranks – Ambulatory Surgery Survey



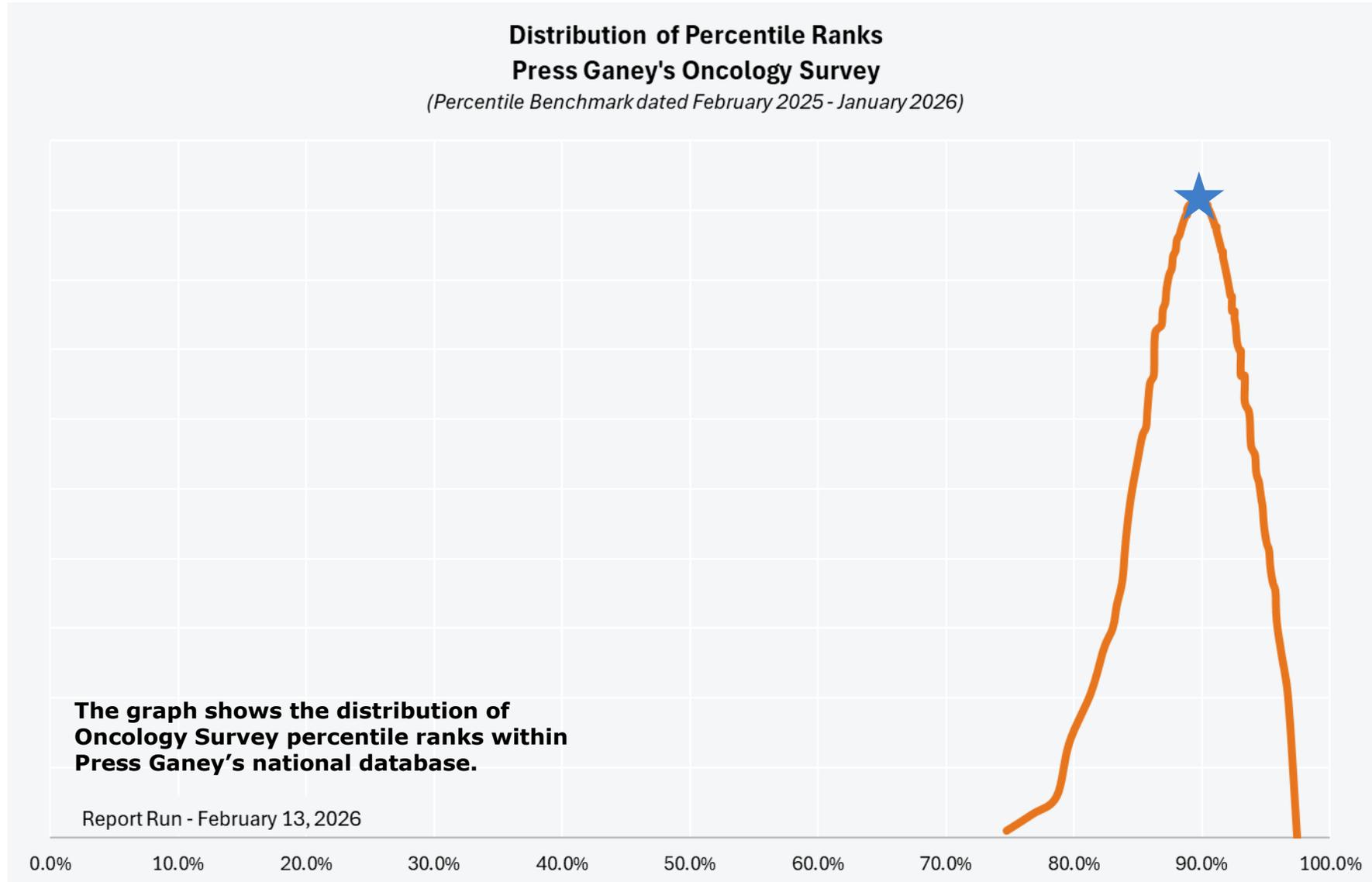
# Patient Experience Update

## Distribution of Percentile Ranks – Outpatient Survey



# Patient Experience Update

## Distribution of Percentile Ranks – Oncology Survey





**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:** March 2, 2026  
**Subject:** Enterprise Quality, Safety, and Experience Dashboard FY26 through January 2026

**Purpose:** To update the Quality, Patient Care, and Patient Experience Committee on quality, safety, and experience measure performance through **January 2026** (unless otherwise noted).

**Summary:**

The FY 26 Enterprise Quality, Safety, and Experience Dashboard is updated monthly and tracks eighteen quality measures.

**Hospital Acquired Conditions:**

1. **C. Difficile Infection:** There have been 5(0.71 cases per month) (Goal:  $\leq$  27 infections FY 2026 or less than 2.25 cases/month) Hospital Acquired C=Diff infections YTD 2026. Areas of focus to decrease C. Diff are four-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. Fourth, testing of C. Diff samples will follow CDC and IDSA guidelines. (Timeline for improvement: We are on track for this measure. We have measures described above in place which we believe will impact this rate. The benchmarked C Diff rate is per 10,000 patient days.)
2. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 2 (0.29 cases/month) CAUTI's cases year-to-date in FY2026, against a target of  $\leq$ 12 for the fiscal year. Prompt removal of urinary catheters, when clinically appropriate and consistent adherence to best practices for insertion and maintenance remain key focus areas. To minimize catheter duration, the frontline nursing managers and the infection prevention team review all patients with indwelling catheters in place for more than three days and collaborate with nursing and physician teams to confirm ongoing clinical indications and reinforce timely removal. (Timeline for improvement: While we are currently on track to meet the FY2026 goal, we continue to implement additional measures aimed at sustaining and further improving performance in the next fiscal year. Ongoing monitoring remains essential).
3. **Hospital Acquired Pressure Injury cases (HAPI):** There have been 2 cases (0.29) cases per month YTD against a target of  $\leq$  13 cases for the fiscal year. Hospital-acquired pressure injuries (HAPIs) at El Camino Health have been largely associated with medically complex, immobile patients (e.g., ICU, ventilated, or hemodynamically unstable) and prolonged device use (oxygen interfaces, lines, and tubing) where tissue perfusion and frequent repositioning are challenging. In response, ECH has reinforced prevention through standardized Braden risk assessments on admission and each shift, nurse-driven turning/repositioning protocols, use of pressure-redistribution surfaces and prophylactic foam dressings over bony prominences and under medical devices, and early wound-care nurse consultation for any skin changes. In addition, staff education, real-time safety huddles, and leadership review of each case (with root-cause analysis and unit feedback) have been implemented to ensure rapid learning and sustained reduction in HAPI occurrence. (Timeline for improvement: we are on track to meet target).

Enterprise Quality, Safety, and Experience Dashboard FY26 through January 2026  
March 2, 2026

4. **Central Line Associated Blood Stream Infection (CLABSI).** We have had 2 CLABSI YTD FY 2026 to a target of 5. CLABSIs at El Camino Health have occurred primarily in high-acuity patients requiring prolonged central access, including hemodialysis catheters, where frequent access and manipulation increase infection risk. In response, ECH has reinforced insertion and maintenance bundles with maximal sterile barrier precautions, chlorhexidine antisepsis, standardized checklists with nurse empowerment to stop any breach, and strict “scrub-the-hub” practices. We also perform daily line-necessity review with prompt removal of unnecessary lines, CHG bathing, staff competency validation, and multidisciplinary case review with unit feedback to sustain prevention. [\(Timeline for improvement: We are on track to meet target\)](#)
5. **Surgical Site Infection.** The number of surgical site infections for FY 26 (21) is unfavorable to target of  $\leq 34$  cases (2.83 cases/month). Process improvement has included implementing evidence based best practices shown to decrease SSIs: maintain Perioperative normothermia, timing and choice of preoperative antibiotics, clean closure tray utilization in the OR and glucose control in diabetics. Though the absolute number of SSIs are high, the rate of SSIs has remained stable since FY25. This remains a particularly challenging metric to improve given increasing case complexity and multiple patient- and procedure-related risk factors that are not entirely modifiable. However, we have implemented all evidence-based practices and are now closely monitoring targeted SSI-reduction measures for colon and biliary surgeries. [\(Timeline for improvement: Though the absolute number of SSIs are high, the rate of SSIs has remained stable since FY 25\).](#)
6. **Serious Safety Event Rate (SSER):** There have been 2 Serious Safety Events in FY26 (0.17/10,000 patient days) compared to a rate of 0.61/10,000 patient days in FY25. We have implemented High Reliability Organization (HRO) principles across the organization as well as standardized safety event reporting, daily safety huddles, leadership safety rounds, and structured root-cause analyses with action tracking, which has contributed to earlier identification of risk, stronger accountability, and a reduction in preventable harm. [\(Timeline for improvement: we are on track for meeting our SSER target\)](#)
7. **Hand Hygiene Combined Compliance rate:** Performance for Q2 FY2026 is **favorable (85.1 %)** to target of  $\geq 84\%$ . [\(Timeline for improvement: We are on track to meet this target\)](#)
8. **Hand Hygiene % of Departments Meeting Audit Compliance target:** Performance for FY 2026 YTD (100%) is **favorable (100%)** to target of 80% of units.
9. **Complications- Inpatient Hip & Knee Observed rate:** Performance through Q2 FY 2026 is **unfavorable (5.7%)** to target of  $\leq 4.3\%$ . 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 of Hip and Knee procedures are now outpatient and only the high acuity remain as inpatient. [\(Timeline for improvement: Q3 FY2026. We will continue to focus on reducing hip/knee SSIs in addition to engaging with surgeons to understand causes of complications\)](#)
10. **30 Day Readmission Observed Rate:** Performance YTD through January of 26 (10.7%) is **unfavorable to target ( $\leq 10.6\%$ )** 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

Enterprise Quality, Safety, and Experience Dashboard FY26 through January 2026  
March 2, 2026

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 close to our target and are confident we will continue to maintain our FY 25 trend)**

11. **Risk Adjusted Mortality Index.** Performance YTD FY26 (0.92) **is favorable to target (1.05).** Mortality index tracks, and for this time frame, is driven by sepsis mortality. 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. In addition, we are optimizing the expected mortality to accurately reflect the acuity of illness of our patients. **(Timeline for improvement: We are on track to meet this measure.)**
12. **Sepsis Mortality Index:** Performance through FY2026 is 1.14, **which is favorable to the target of 1.15.** Observed sepsis mortality is influenced by early goal-directed therapy, and El Camino Health continues to perform strongly on SEP-1 measures compared with national benchmarks. Ongoing efforts remain focused on reliable execution of SEP-1 components, including timely antibiotic administration and appropriate fluid and vasopressor management. In parallel, we are implementing a more robust approach to expected mortality management to better reflect patient severity of illness. These combined efforts have resulted in a downward trend in the sepsis mortality index. **(Timeline for improvement: We continue to see sustained improvement and are on track to meet this target.)**
13. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV). (Data through November 2025)** FY26 performance through November of 2025 (25.3%) **is unfavorable to target of 23.9%.** The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of FY2024. 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 been challenging for the organization as well as like hospitals in California. We will continue with our efforts to reduce this metric)**
14. **PC-05: Exclusive Breast Milk Feeding:** Performance for FY 2026 YTD for Enterprise is **favorable (80.7%)** to target of 74%. Performance for FY 2025 for LG is **favorable (88.4%)** to target of 84%. There has been an intense effort by the MCH department and to improve this measure over the last year. **(Timeline for improvement: We are on track to achieve this goal)**
15. **Median Time from ED Arrival to ED Departure (Enterprise).** Performance YTD FY26 (152 minutes) is **favorable to the target of < 159 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 meet this measure)**
16. **LTR Composite Score: FY26 Performance Highlights** (July 2025 through January 2026 performance): FY26 performance YTD of (84.6%) is favorable to target of 83.4%.

Enterprise Quality, Safety, and Experience Dashboard FY26 through January 2026  
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Fiscal Year 2026 year to date Likelihood to Recommend composite performance is 84.6 percent, exceeding the established target of 83.4 percent.

In addition to sustained favorable performance relative to target, leadership has transitioned the Patient Experience improvement model from localized unit optimization to enterprise level standardization and governance. The formation of the Patient Experience Action Team formalizes cross continuum oversight across acute, ambulatory, and medical network settings, with structured review of performance variation, key drivers, and defined escalation pathways.

This governance approach is designed to reduce unwarranted variability, strengthen behavioral reliability, and advance equitable outcomes across demographic groups. Progress will continue to be monitored through defined composite, percentile, and equity metrics and reported to the Committee as part of ongoing oversight.

**Attachments:**

1. Enterprise Quality Dashboard FY 26 through January 2026.



# FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Month to Board Quality Committee :  
Mar 2026 QC



Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average	
	Latest Month	FYTD					
<p><b>*Organizational Goal</b> Clostridium Difficile Infections (C-Diff) cases</p> <p>Latest Month : January 2026</p> <p></p>	0 cases	0.71 cases/mo	2.33 cases/mo	2.25 cases/mo		<p># of CDIFF Cases   Last 12 Months</p>	<p>FY26TD Total Cumulative CDIFF Cases</p>
<p><b>*Organizational Goal</b> Catheter Associated Urinary Tract Infection (CAUTI) cases</p> <p>Latest Month : January 2026</p> <p></p>	0 cases	0.29 cases/mo	1.17 cases/mo	1.08 cases/mo		<p># of CAUTI Cases   Last 12 Months</p>	<p>FY26TD Total Cumulative CAUTI Cases</p>
<p><b>*Organizational Goal</b> Hospital Acquired Pressure Injury (HAPI) cases</p> <p>Latest Month : January 2026</p> <p></p>	1 cases	0.29 cases/mo	1.25 cases/mo	1.08 cases/mo		<p># of HAPI Cases   Last 12 Months</p>	<p>FY26TD Total Cumulative HAPI Cases</p>



## FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Dashboard Managed by  
Quality Data Analyst : Jeffery Jair  
jeffery\_jair@elcaminohealth.org

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Measure	Definition Owner	Metric Definition	Data Source
<p><b>*Organizational Goal</b> Clostridium Difficile Infections (C-Diff) cases</p> 	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	Numerator: Infection control Dept. Denominator: EPIC Report
<p><b>*Organizational Goal</b> Catheter Associated Urinary Tract Infection (CAUTI) cases</p> 	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	Numerator: Infection control Dept. Denominator: EPIC Report
<p><b>*Organizational Goal</b> Hospital Acquired Pressure Injury (HAPI) cases</p> 	Ann Aquino	Stage 3 & 4 & Unstageable HAPIs	Epic Report (ECH Pressure Injuries - By Department (RWSQL) with manual chart reviews



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Jan 2026 (unless other specified)

Month to Board Quality Committee :  
Mar 2026 QC

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average	
	Latest Month	FYTD					
Central Line Associated Blood Stream Infection (CLABSI) cases  Latest Month : January 2026  ⓘ	0 cases	Total FY26 2 cases 0.29 cases/mo	Total FY25 4 cases 0.33 cases/mo	Total FY26 Target ≤ 5 cases 0.42 cases/mo	BETTER	# of CLABSI Cases   Last 12 Months 	FY26TD Total Cumulative CLABSI Cases 
Surgical Site Infections (SSI) cases  Latest Month : January 2026  ⓘ	1 cases	Total FY26 21 cases 3.00 cases/mo	Total FY25 38 cases 3.17 cases/mo	Total FY26 Target ≤ 34 cases 2.83 cases/mo	BETTER	# of SSI Cases   Last 12 Months 	FY26TD Total Cumulative SSI Cases 
Serious Safety Event Rate (SSER)  Latest Month : December 2025  ⓘ	0 events	0.17 (2/116279)	0.61 (13/214277)	n/a	BETTER	# of Events 	Rolling 12 Month Average Rate 



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jeffery\_jair@elcaminohealth.org

Measure	Definition Owner	Metric Definition	Data Source
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
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
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: Indu Adhikary



# FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Month to Board Quality Committee :  
Mar 2026 QC

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
<p><b>*Organizational Goal</b> Hand Hygiene Combined Compliance Rate</p> <p>Latest Month : January 2026</p> <p><i>i</i></p>	79.4% (6075/7647)	85.1% (56068/65861)	83.2% (171444/205958)	>=84% (1% improve of FY25)		<p>FYTD   Hand Hygiene Combined Rate</p>
<p>Hand Hygiene % of Departments Meeting Target</p> <p>Latest Month : January 2026</p> <p><i>i</i></p>	100.0% (25/25)	100.0% (175/175)	100.0% (300/300)	80% of units		<p>FYTD   Hand Hygiene % Department Meeting Target</p>
<p>Complications - Inpatient Hip &amp; Knee Observed Rate (within 90 days of procedure)</p> <p>Latest Month : January 2026</p> <p><i>i</i></p>	0.0% (0/10)	5.7% (3/53)	4.8% (6/126)	<= 4.3% (10% reduction of FY25)		<p>Rolling 12 Month Average Rate</p>

Quality Department | Note : updated as of February 12nd, 2026



## FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Dashboard Managed by  
Quality Data Analyst : Jeffery Jair  
jeffery\_jair@elcaminohealth.org

Measure	Definition Owner	Metric Definition	Data Source
<p><b>*Organizational Goal</b> Hand Hygiene Combined Compliance Rate</p> 	S. Mallur, MD / Lyn Garrett	% of yes Cleaning Before Entering or Exit	<p>Hand Hygiene Audit from Laudio Audit Tool</p> <p>Hand Hygiene Leapfrog Tableau Dashboard maintained by: Hsiao-Lan Shih</p>
<p>Hand Hygiene % of Departments Meeting Target</p> 	S. Mallur, MD / Lyn Garrett	Number of Unit done Audit according to their Target (Only Leapfrog units)	<p>Hand Hygiene Audit from Laudio Audit Tool</p> <p>Hand Hygiene Leapfrog Tableau Dashboard maintained by: Hsiao-Lan Shih</p>
<p>Complications - Inpatient Hip &amp; Knee Observed Rate <small>(within 90 days of procedure)</small></p> 	S. Mallur, MD	<p>Based on the Center for Medicare and Medicaid Services (CMS) Metric criteria, complications following an elective primary total hip arthroplasty (THA), total knee arthroplasty (TKA) procedure.</p> <p><b>Numerator</b> : 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.</p> <p><b>Denominator</b> : Eligible index admissions who have undergone a qualifying elective primary THA or TKA procedure.</p> <p>2.) Based upon Vizient Risk Model 2024 Community + AHRQ Version 2024</p> <p>3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Nonviable Neonate &amp; Normal Newborn)</p>	Vizient Clinical Database



# FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Month to Board Quality Committee :  
Mar 2026 QC

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
<b>30-Day Readmission Observed Rate</b> <small>Vizient Community Risk Model 2024</small>	11.5% (141/1224)	10.7% (745/6967)	10.6% (1539/14546)	<= 10.6% (maintain baseline)		
Latest Month : December 2025 ⓘ						
<b>Mortality Index Observed / Expected</b> <small>Vizient Community Risk Model 2024</small>	0.84 (2.13% / 2.56%)	0.92 (1.84% / 2.01%)	1.06 (1.85% / 1.74%)	<= 1.05 (1% reduction from baseline)		
Latest Month : January 2026 ⓘ						
<b>Sepsis Mortality Index Observed / Expected</b> <small>Vizient Community Risk Model 2024</small>	1.02 (11.57% / 11.36%)	1.14 (11.93% / 10.48%)	1.18 (10.63% / 8.97%)	<= 1.15 (2.5% reduction from baseline)		
Latest Month : January 2026 ⓘ						



## FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Dashboard Managed by  
Quality Data Analyst : Jeffery Jair  
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Measure	Definition Owner	Metric Definition	Data Source
<b>30-Day Readmission Observed Rate</b> <small>Vizient Community Risk Model 2024</small>  	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 2024 Community + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient (exclude Behavioral Health Service Line, Rehab, Nonviable Neonates, Normal Newborn, Pediatrics, Hospice). OB is included by default	Vizient Clinical Database  Readmission Tableau Dashboard maintained by: <b>Steven Sun</b>
<b>Mortality Index Observed / Expected</b> <small>Vizient Community Risk Model 2024</small>  	S. Mallur, MD	1) Based upon Vizient Risk Model 2024 Community for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient. (exclude Rehab, Nonviable Neonates & Hospice). Behavioral Health Service Line, Normal Newborn, Pediatrics & OB are included by default.  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
<b>Sepsis Mortality Index Observed / Expected</b> <small>Vizient Community Risk Model 2024</small>  	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



# FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Month to Board Quality Committee :  
Mar 2026 QC

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth  Latest Month : November 2025 ⓘ	MV : 29.3% (56 / 191)	MV : 26.6% (217 / 815)	MV : 27.6% (516 / 1870)	23.9% (FY26 ENT Target)		
	LG : 19.0% (4 / 21)	LG : 16.7% (20 / 120)	LG : 19.4% (62 / 320)			
	ENT : 28.3% (60 / 212)	ENT : 25.3% (237 / 935)	ENT : 26.4% (578 / 2190)			
PC-05 : Exclusive Breast Milk Feeding  Latest Month : November 2025 ⓘ	MV : 78.8% (260 / 330)	MV : 79.5% (1257 / 1581)	MV : 58.1% (1998 / 3437)	74.0% (FY26 ENT & MV Target)  84.0% (FY26 LG Target)		
	LG : 90.2% (37 / 41)	LG : 88.4% (214 / 242)	LG : 68.4% (428 / 626)			
	ENT : 80.1% (297 / 371)	ENT : 80.7% (1471 / 1823)	ENT : 59.7% (2426 / 4063)			
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)  Latest Month : January 2026 ⓘ	MV : 159 mins	MV : 165 mins	MV : 169 mins	FY26 Goals = MV ED = 178 min LG ED = 140 min ENT = 159 min		
	LG : 138 mins	LG : 139 mins	LG : 137 mins			
	ENT : 149 mins	ENT : 152 mins	ENT : 153 mins			



## FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Dashboard Managed by  
Quality Data Analyst : Jeffery Jair  
jeffery\_jair@elcaminohealth.org

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
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: <b>Hsiao-Lan Shih</b>



# FY26 Enterprise Quality, Safety and Experience Dashboard

Jan 2026 (unless other specified)

Month to Board Quality Committee :  
Mar 2026 QC

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				

LTR Composite Score  Latest Month : January 2026  	84.8	84.6	83.4	>= 83.4		



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Measure	Definition Owner	Metric Definition	Data Source
LTR Composite Score  	Ryan Lockwood	<p>The LTR Composite Score is a single, combined performance goal that reflects multiple metrics or data points - such as department-level patient experience scores - aggregated into one overall score for the fiscal year.</p> <p>It is calculated based on Likelihood to Recommend (LTR) performance from the previous fiscal year. Weighting is applied based on patient volume or priority areas to ensure a fair representation of each department's contribution.</p>	HCAHPS



**Quality Committee**  
**Proposed FY2027 Meeting Dates**

<b>RECOMMENDED QC DATES</b>	<b>CORRESPONDING HOSPITAL BOARD DATE</b>
<b>Monday, August 31, 2026</b>	Wednesday, September 16, 2026
<b>Monday, November 2, 2026</b>	Wednesday, November 18, 2026
<b>Monday, February 1, 2027</b>	Wednesday, February 10, 2027
<b>Monday, March 1, 2027</b>	Wednesday, March 10, 2027
<b>Monday, May 8, 2027</b>	Wednesday, May 12, 2027
<b>Monday, June 7, 2027</b>	Wednesday, June 16, 2027



**PROPOSED  
FY27 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: **safe, timely, effective, efficient, equitable, and person-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.	Q4FY26 review and update which measures to include on the FY27 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.	Q4FY26 review FY27 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars.	Performance measures on the Quality Dashboards. <ul style="list-style-type: none"> <li>▪ Monthly Quality Dashboard</li> <li>▪ Quarterly Board Level Quality Dashboard</li> </ul>
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY27.	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 2027	<ul style="list-style-type: none"> <li>• Attend a minimum of 5 meetings in person.</li> <li>• Actively participate in discussions at each meeting.</li> <li>• Review of annual committee self-assessment results</li> </ul>
5. Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics.	Fiscal Year 2027	Committee attendance rate at conference and/or session with a subject matter expert of at least 50%. <ul style="list-style-type: none"> <li>• Verbal/Written report of key learnings to the Quality Committee.</li> </ul>

**Chair:** Carol Somersille, MD

**Executive Sponsor:** Shreyas Mallur, MD, Chief Quality Officer



**PROPOSED FOR  
QC APPROVAL**

**Quality, Patient Care, and Patient Experience Committee  
DRAFT - FY27 Pacing Plan – Same number of meetings**

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
<b>STANDING AGENDA ITEMS</b>												
Consent Calendar <sup>1</sup>		✓			✓	✓		✓	✓		✓	✓
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		✓			✓	✓		✓	✓		✓	✓
<b>SPECIAL AGENDA ITEMS – OTHER REPORTS</b>												
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						✓						
<b>COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR</b>												
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)

**For review at March 2 QC Meeting**



**PROPOSED FOR  
QC APPROVAL**

**Quality, Patient Care, and Patient Experience Committee  
DRAFT FY27 Pacing Plan – December meeting removed**

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
<b>STANDING AGENDA ITEMS</b>												
Consent Calendar <sup>1</sup>		✓			✓			✓	✓		✓	✓
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		✓			✓			✓	✓		✓	✓
<b>SPECIAL AGENDA ITEMS – OTHER REPORTS</b>												
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					✓							
<b>COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR</b>												
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Propose Organization Goals									✓			
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Propose Pacing Plan									✓			
Recommend Pacing Plan											✓	
Review & Revise Charter									✓			
Recommend Charter											✓	

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**PROPOSED FOR  
QC APPROVAL**

**Quality, Patient Care, and Patient Experience Committee  
DRAFT FY27 Pacing Plan – February meeting removed**

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
<b>STANDING AGENDA ITEMS</b>												
Consent Calendar <sup>1</sup>		✓			✓	✓			✓		✓	✓
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		✓			✓	✓			✓		✓	✓
<b>SPECIAL AGENDA ITEMS – OTHER REPORTS</b>												
Quality & Safety Review of reportable events		✓			✓				✓		✓	
Quarterly Board Level Enterprise/ STEEEP Dashboard Review		✓			✓				✓		✓	
El Camino Health Medical Network Report		✓			✓				✓		✓	
Committee Self-Assessment Results Review						✓						
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Patient Experience Report		✓							✓			
Health Equity Report						✓						✓
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Refresh Quality/Experience Dashboard measures for FY26												✓
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<b>COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR</b>												
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Propose Pacing Plan									✓			
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Review & Revise Charter									✓			
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**For review at March 2 QC Meeting**