El Camino Health

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.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
3.	**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**
4.	**CONSENT CALENDAR ITEMS** a. Approve Minutes of the Open Session of the Quality Committee Meeting (02/02/2026) b. Receive FY 2026 Pacing Plan c. Receive FY 2026 Committee Goals	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:30 – 5:35**
5.	**VERBAL COMMITTEE MEMBER EXPERTISE REPORT** *Appended with slides*	Jack Po, MD Quality Committee Member	Information	**5:35 – 5:45**
6.	**PATIENT SAFETY STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Information	**5:45 – 5:50**

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

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

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

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, 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*

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 Po, Sharma, and Xanthopoulos were absent at the time of roll call.	**Call to order at 5:30 p.m.**
2. **CONSIDER APPROVAL FOR AB 2449 REQUESTS**	All Committee members participated in person. No consideration for AB 2449 was needed.	
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.	

Open Minutes: Quality, Patient Care and Patient Experience Committee   *DRAFT*
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5.	CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. No items were removed.	***Consent Calendar Approved,*** *including Open Session minutes (12/01/2025) and receipt of FY2026 Pacing Plan and Committee Goals.*
		Motion: To approve consent calendar items.	
		Movant: Zoglin **Second**: Schweitzer **Ayes**: Somersille, Chang, Gholami, Jiang, Pelletreau, Schweitzer, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent**: Sharma, Po **Recused**: None	
6.	VERBAL COMMITTEE CHAIR'S REPORT ON CONFERENCE EDUCATION	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.	
7.	APPROVE COMMITTEE SURVEY RESULTS DRAFT ACTION PLAN	Chair Somersille presented the FY26 Committee Survey Results Draft Action Plan, outlining proposed actions to address committee effectiveness, meeting structure, and ongoing education priorities.	
		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.	
		Motion: To approve the FY26 Committee Survey Results Action Plan	
		Movant: Gholami **Second**: Sharma **Ayes**: Somersille, Chang, Gholami, Jiang, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** None **Recused**: None	

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| 8. **PATIENT STORY**	Ms. Reinking presented a patient story illustrating patient experience, quality outcomes, and opportunities for learning and improvement in clinical care.	
	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.	
	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.	
9. **ARTIFICIAL INTELLIGENCE REPORT**	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.	***Action:*** *Staff to schedule a future agenda item to review Age-Friendly Health Systems initiatives and progress*
	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.	
	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.	
	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.	
10. **Q2 FY26 STEEEP DASHBOARD REVIEW/ FY26**	Dr. Mallur presented the Q2 FY26 STEEEP Dashboard and the FY26 Enterprise Quality Dashboard, highlighting organizational performance across safety, timeliness,	

ENTERPRISE QUALITY DASHBOARD	effectiveness, efficiency, equity, and patient-centered care measures. 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.	
11. EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT	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. 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. 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.	
12. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 7:20 p.m. **Movant**: Jiang **Second**: Po **Ayes**: Somersille, Chang, Gholami, Jiang, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** None **Recused**: None	*Recessed to Closed Session at 7:20 p.m.*
13. AGENDA ITEM 19: 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 December 1, 2025, meeting.	*Reconvened Open Session at 7:44 p.m.*
14. AGENDA ITEM 20: COMMITTEE ANNOUNCEMENTS	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.	

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

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

_____
Gabriel Fernandez, Coordinator, Governance Services

Prepared by: Gabriel Fernandez, Coordinator, Governance Services
Reviewed by: Carol Somersille, MD, Quality Committee Chair

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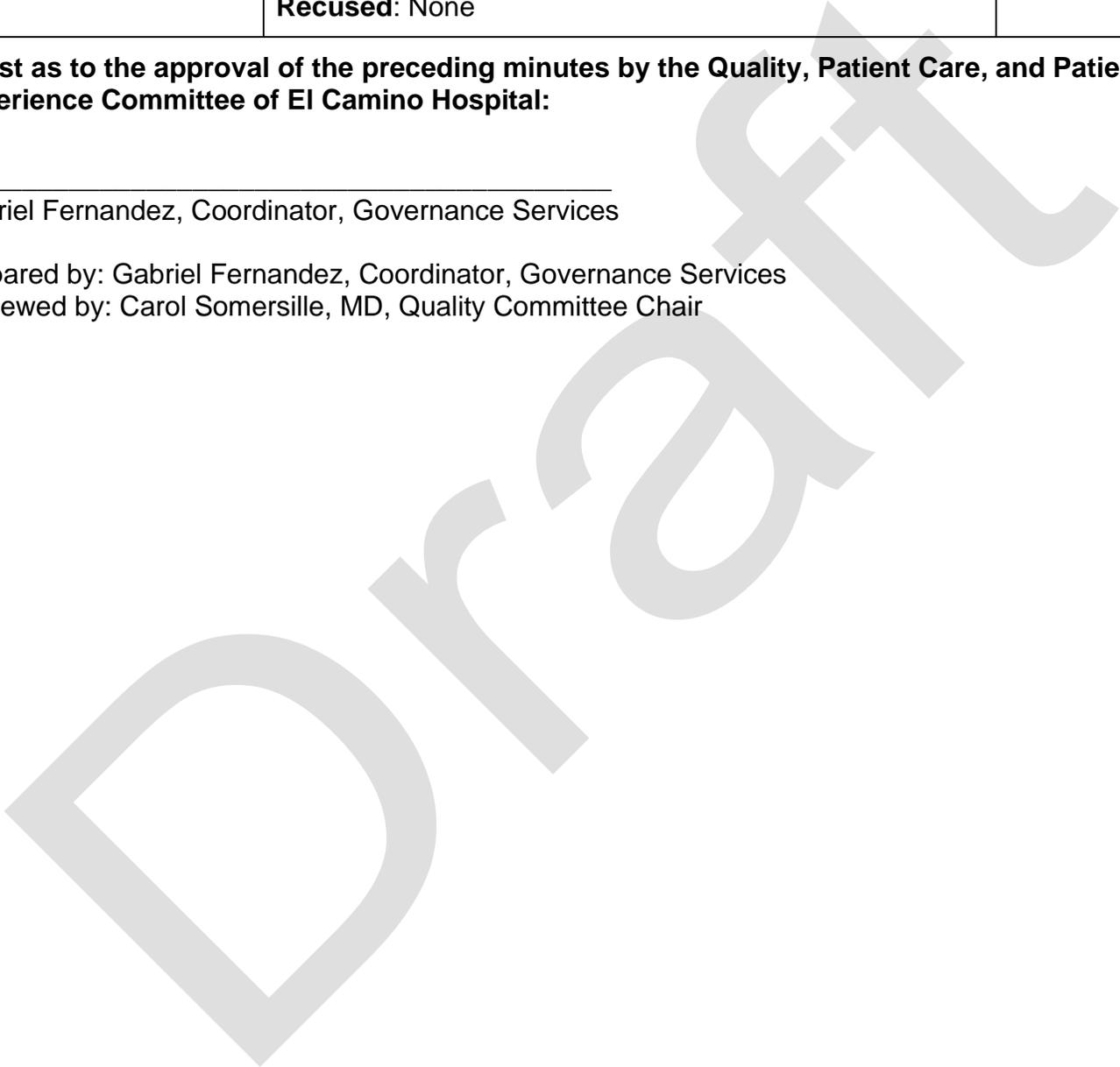
Quality, Patient Care, and Patient Experience Committee
FY26 Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar¹			✓		✓	✓		✓	✓		✓	✓
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

AI in Healthcare

Quality, Patient Care, and Patient Experience Committee

Ming Jack Po, MD, PhD
March 2nd, 2026

Conflict of Interest Disclosure

- Executive Role: Founder and CEO, AnsibleHealth
- Industry Collaborations: AnsibleHealth formally collaborates with Anthropic on AI development and deployment.
- Presentation Scope: This presentation is strictly educational. While examples (such as the Sentinel system) draw from real-world deployments at AnsibleHealth, the discussion is vendor-neutral and focuses on the broad capabilities, clinical impacts, and future potential of Agentic AI in healthcare.

2

The Baseline - From Chatbots (ChatGPT 3.5) to Clinical Proof

- The Benchmark (Feb 2023): First study evaluating ChatGPT on the United States Medical Licensing Examination (USMLE).

- General-domain LLM (ChatGPT 3.5) could perform at or near the ~60% passing threshold across all three USMLE Step exams without any specialized medical training


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The Benchmark Explosion (USMLE Scores Over Time)

Date	AI Model / Platform	USMLE Accuracy	The Milestone
Feb 2023	**ChatGPT 3.5** *(AnsibleHealth)*	**~60.0%**	The first general AI to approach the passing threshold.
Mar 2023	**Med-PaLM** *(Google)*	**67.6%**	The first medical-specific AI to officially pass.
May 2023	**Med-PaLM 2** *(Google)*	**86.5%**	Achieved "expert" test-taker level in months.
Late 2023	**OpenEvidence**	**>90.0%**	RAG systems push accuracy into the 90s.
Aug 2025	**OpenEvidence**	**100.0%**	The first AI system to claim a perfect score.

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4

The "Super-Power" Era — Ambient Documentation

- **The Problem**: "Pajama Time." Clinicians spend 2 hours on documentation for every 1 hour of care.

- **The Solution**: AI "Perfect Listeners" that capture 100% of the patient encounter in the background.

- **The Result**: Notes structured and finalized in minutes.

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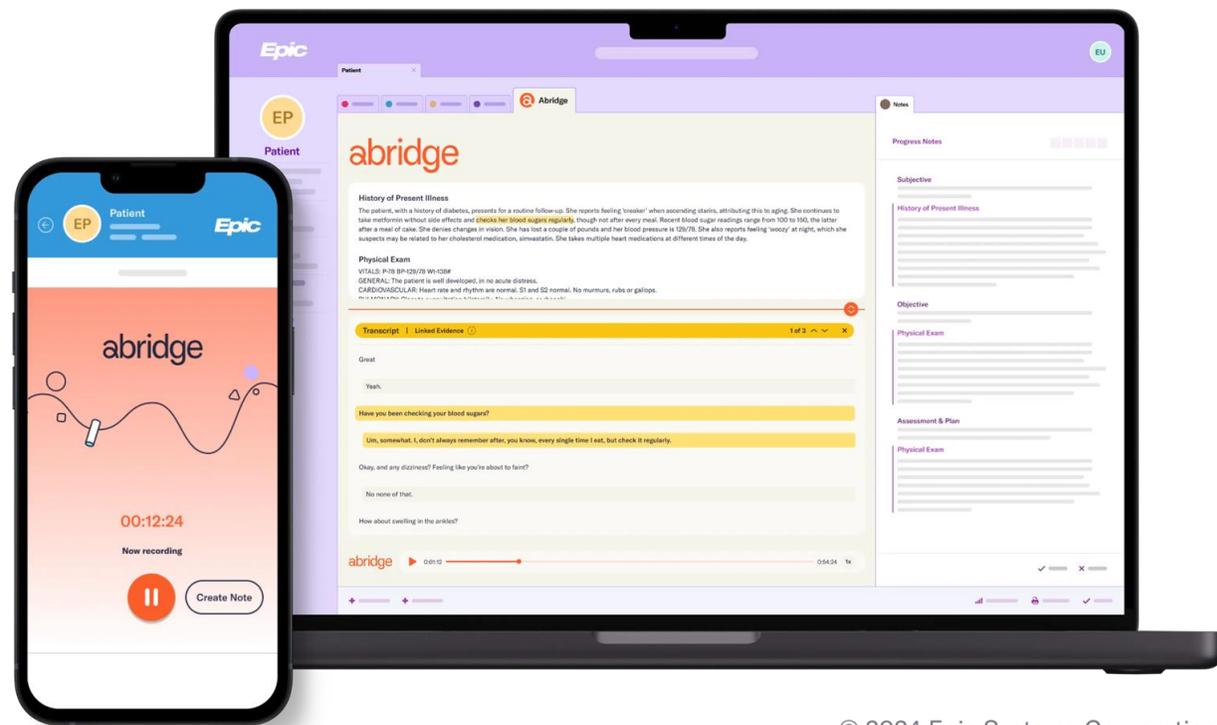
"Search" Power — Structured Data Retrieval (GraphQL)

- **The Problem**: Doctors spend hours "hunting and pecking" through 50+ tabs in the EHR to find a single lab trend or a specific note.

- **The Solution**: Using GraphQL to query the EHR directly.

- **How it works**: Instead of a human clicking through menus, the system asks the EHR: "Give me the last 3 HbA1c results and the most recent Cardiology note for Patient X."

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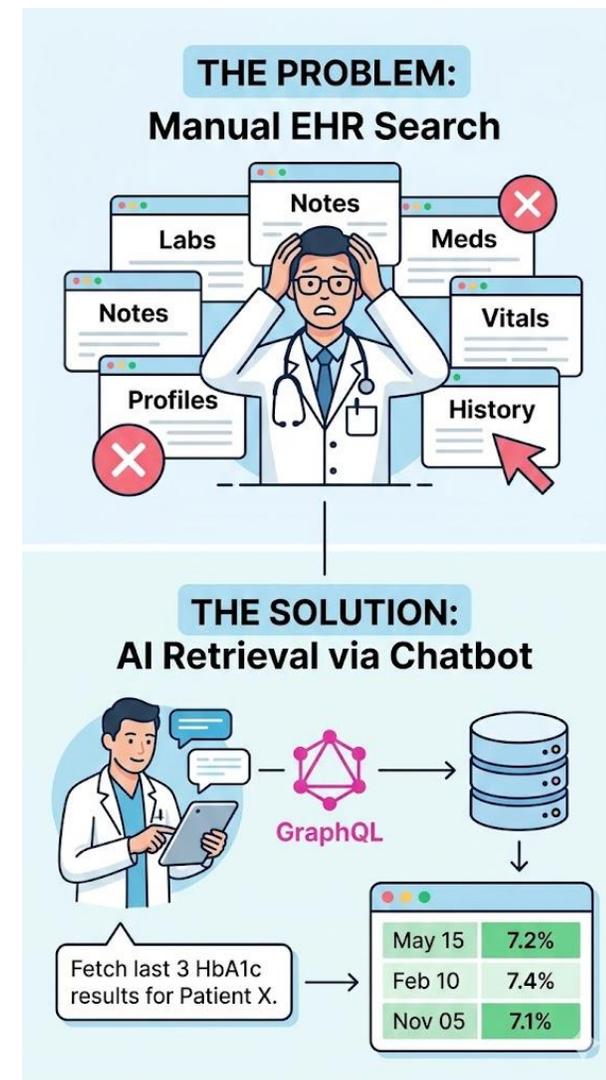
Synthesis Power — Medical Record Summarization (Part 1)

Clinical Summary [Patient], a 73-year-old female with a complex medical history including Alzheimer's dementia, type 2 diabetes, hypertension, and a history of cerebrovascular events, has experienced multiple hospitalizations in recent months. Her most recent admission from 09/14/2024 to 09/19/2024 was for headache, lightheadedness, and dizziness, following a suspected transient ischemic attack (TIA) in July 2024. Imaging studies, including a CT scan on 09/15/2024, showed no acute intracranial abnormalities but revealed chronic ischemic changes and a chronic left cerebellar infarct. An echocardiogram on 09/18/2024 demonstrated a low normal left ventricular ejection fraction of 50-55% with mild left ventricular hypertrophy.

[Patient]'s diabetes is poorly controlled, with an HbA1c of 9.2% as of 07/12/2024, despite a complex medication regimen including multiple types of insulin. Her care is further complicated by cognitive decline, which has significantly impacted her ability to manage her health independently. She now requires 24-hour home health aide services and assistance from her daughter, [Caregiver], who serves as her power of attorney. [Patient]'s functional status has been declining, with recent falls and difficulty with activities of daily living. She experiences occasional dizziness and vertigo with position changes, contributing to her fall risk. However, recent physical therapy has shown some improvement, with her Timed Up and Go (TUG) test improving from 140 seconds to 30 seconds.

Current priorities include optimizing diabetes management, addressing fall risk, monitoring cognitive decline, and managing cardiovascular risk factors. [Patient] requires close follow-up with her primary care physician, neurology for her dementia, and endocrinology for diabetes management. Her care plan should focus on medication reconciliation, fall prevention strategies, and support for activities of daily living to maintain her independence as much as possible while ensuring her safety. Recent challenges in reaching the patient or caregiver for follow-up visits highlight the need for improved care coordination and communication strategies.

Surgical History • Mediastinoscopy with biopsies (1973) • Soft tissue biopsy of neck/chest (1973) • Retinal photocoagulation (2004-2008) • Colonoscopy with biopsy (11/14/2013) • Laparoscopic appendectomy (08/05/2016)

ED Visits and Admission History • 09/14/2024 - 09/19/2024: Admitted for headache, lightheadedness, and dizziness. Primary diagnosis: Headache. Additional diagnoses: Stroke, Diabetes mellitus, Arthritis, Hypertension, History of CVA. Discharged with home health care. • 07/10/2024 - 07/16/2024: Admitted for suspected TIA with symptoms of lethargy, generalized weakness, and history of slurred speech and facial droop (resolved). CT head, CTA head and neck were normal. MRI brain ruled out acute stroke. Discharged to skilled nursing facility. • 05/08/2023 - 05/14/2023 (approximate): Admitted for syncope and fall with head trauma. Diagnosed with UTI. CT head and C-spine showed no acute findings. Echocardiogram showed EF 55%. Discharged to skilled nursing facility. • 04/22/2023: ED visit for lightheadedness, dizziness, and fall. Diagnosed with headache, head injury, and medication non-adherence. CT head showed no acute abnormalities. Discharged home. • 04/10/2023: ED visit for hypoglycemia (glucose 44 mg/dL) and lightheadedness. Treated with IV dextrose. Discharged home.

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7

Synthesis Power — Medical Record Summarization (Part 2)

The Input: 1,400+ unstructured HIE documents (Carequality, CommonWell).

The Output: A 12-section "Golden Record" generated in <5 minutes.

Complexity Synthesis: Captures a 50-year surgical history (1973–2024) alongside recent acute events.

Administrative Impact: Converts ~60 minutes of manual chart "hunting and pecking" into a 30-second read.

Family Medical History • Mother: Alcoholic hepatitis • Maternal Grandmother: Diabetes • Maternal Aunt: Diabetes • Brother: Diabetes • Sister: Multiple Sclerosis • Son: Diabetes

Social History [Patient] lives alone in her home but requires 24/7 home health aide support due to her declining functional status and cognitive impairment. Her daughter, [Caregiver], who is her power of attorney, visits regularly and is actively involved in her care. The patient is considered homebound due to the taxing effort required to leave home, needing assistance from another person and assistive devices for mobility.

Home health aides assist with personal care including bathing and dressing, as well as household tasks such as food shopping, meal preparation, and laundry. The patient receives meals through [Service] waiver service and has a medical alert system in place.

[Patient] is eligible for home modifications through waiver services, including a wheelchair lift and walk-in shower/tub. She also qualifies for ambulance transportation to medical appointments through these services.

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Deploying Synthesis into Live Workflows

ED Triage: Delivers 10-year longitudinal context the moment a patient registers.

- Eliminates "flying blind" in emergency settings; highlights acute contraindications before the physician enters the room.

IPA Quality Control (Cross-EHR Normalization): Acts as a universal translator for Independent Physician Associations.

- Instantly surfaces hidden care gaps, missed diagnoses, and medication conflicts.

Automated Case Reviews & Audits: Compresses retrospective chart audits and utilization management.

- Reduces hours of manual chart review per patient into a 5-minute verification.

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9

The Agentic Leap — Tool Calling & Voice AI

The "Read-Only" Ceiling

- **Past:** LLMs only summarize static text prompts.
- **Limitation:** Isolated from live, real-world systems.

The Agentic Shift (Tool Calling)

- AI dynamically calls external APIs and databases.
- Feeds real-time system responses back into its own instructions to decide the next action.

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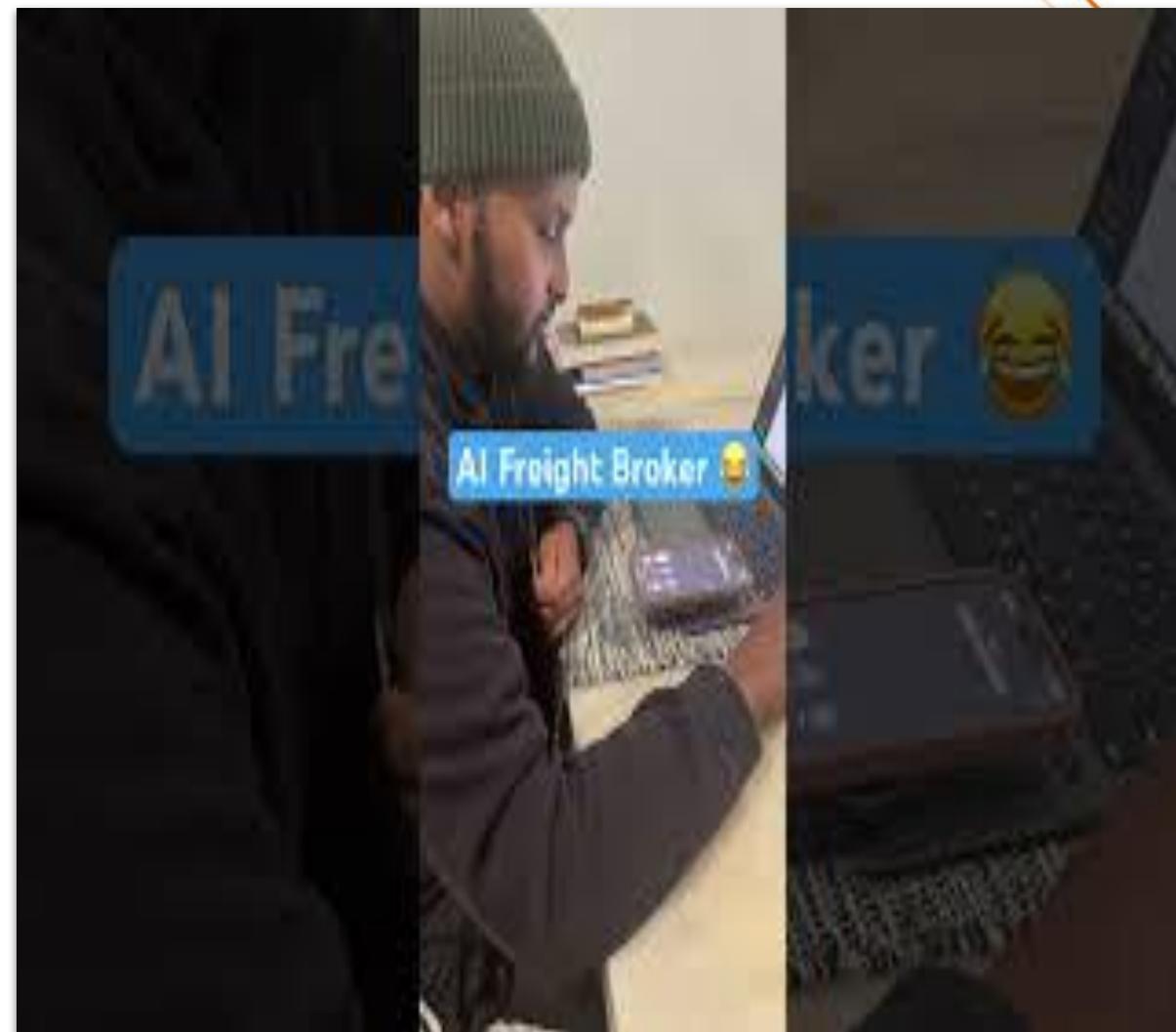
Use of Agents in Healthcare - Remote Patient Monitoring Triage

Dynamic Data Gathering (Tool Calling):

- Sentinel is equipped with 21 structured clinical tools via Model Context Protocol (MCP).
- When a patient event occurs, the AI dynamically queries live data sources— pulling HIE summaries, recent encounters, vital histories, and active conditions— building its own context in real-time.

Multi-Step Reasoning & Autonomous Action

- Executes a variable-length clinical reasoning workflow for every single patient event.
- After gathering the data itself, it assigns a precise severity level and autonomously routes the required clinical follow-up action.

F **Weight 98.35 kg** · Weight · Protocol-Exceeding Fluid Accumulation

Patient: CHF patient · NP-documented fluid management plan · Active respiratory infection

30-DAY VITAL TRENDS

3 INDEPENDENT REVIEWERS — MONITOR MONITOR MONITOR

HUMAN MAJORITY: MONITOR — MONITOR (unanimous)

AGENT CLASSIFICATION: URGENT — URGENT — 13 tool calls · $0.22 · 85s

AGENT REASONING

The patient is a 67-year-old male with HFrEF (reduced EF), ICD/pacemaker, COPD, T2DM, hypertension, obesity, and PAD. He has had 4 inpatient admissions in the past 6 months, including a January 8, 2026 admission for acute decompensated HF and COPD exacerbation (admission weight 220 lbs, discharge weight 199 lbs after aggressive diuresis). His NP explicitly set a fluid management plan on 1/29/2026: maintain weight near 199 lbs, and if weight increases ≥3 lbs over 2 days, contact PCP/cardiologist for furosemide dose adjustment. Today's weight of 216.8 lbs represents: (1) +17.8 lbs above dry weight target of 199 lbs; (2) +8.8 lbs gain in just 5 days since 2/13; (3) approaching his last acute decompensation admission weight of 220 lbs. The weight trajectory shows progressive fluid accumulation despite being on daily furosemide. The patient is also now acutely ill with an upper respiratory infection ('real bad cold' with fatigue, unable to exercise), which can trigger HF decompensation in this population. His BP readings from 2/10-2/11 show uncontrolled hypertension (165-179 systolic), which further stresses the heart. This combination — massive weight gain above dry weight, rapid 5-day trajectory, active URI, uncontrolled hypertension, history of recurrent decompensation requiring 4 hospitalizations, and documented 'unstable fluid status' — constitutes a clear same-day clinical urgency. The care plan's action threshold has been exceeded by nearly 6x (8.8 lbs gained vs. 3 lb trigger). Diuretic dose adjustment or escalation is needed today to prevent a fifth hospitalization.

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Questions?

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: 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?

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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.

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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

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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

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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 indictors such as NPS and others

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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
Composite Performance	**82.3%**	-	**83.4%**	-	⬆
Inpatient	**81.5%**	**84th**	**82.7%**	**87th**	⬆
MCH	**80.8%**	**82nd**	**86.2%**	**93rd**	⬆
ED	**78.2%**	**72nd**	**79.2%**	**76th**	⬆
OP Surgery	**88.5%**	**62nd**	**88.3%**	**60th**	⬇
OP Services	**87.2%**	**57th**	**87.4%**	**53rd**	⬆
OP Oncology	**90.7%**	**52nd**	**91.2%**	**50th**	⬆
Medical Network	**82.1%**	**26th**	**86.2%**	**46th**	⬆

FY26 Percentile Ranks

HCAHPS
National – 87th
California – 82nd
Bay Area – 92nd

Medical Network
National – 46th
California – 46th
Bay Area – 40th

*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).

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Report Run – February 13, 2026

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

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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

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Fiscal Year 2026 Targets' Performance compared to Statistical Significance

12

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

Path to Statistically Significant Target

Report Run – February 13, 2026

Target Score   Actual Performance   Statistical Significance Threshold

13
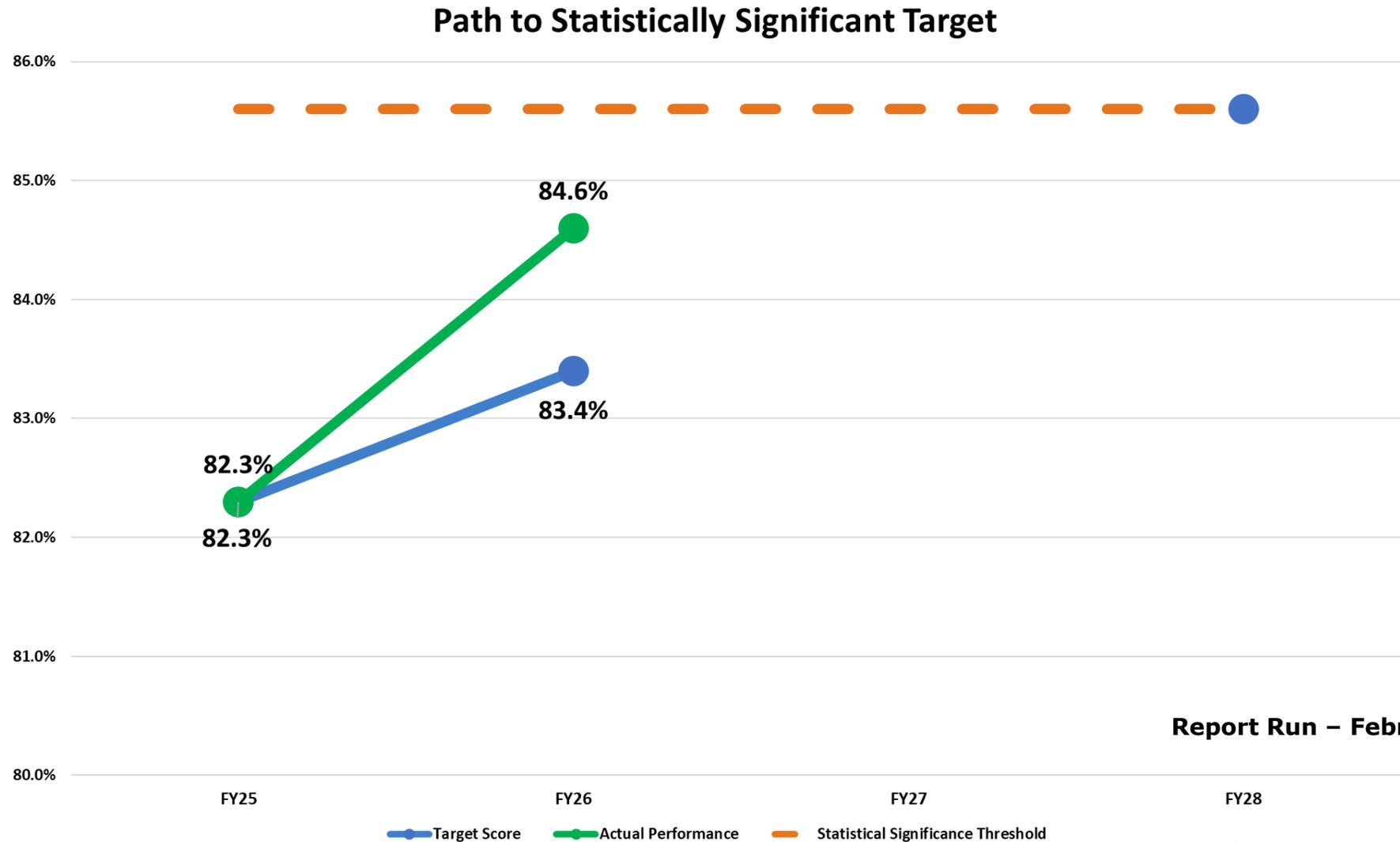
FY26 El Camino Health's Targets –
Medical Network Targets' Performance compared to Statistical Significance
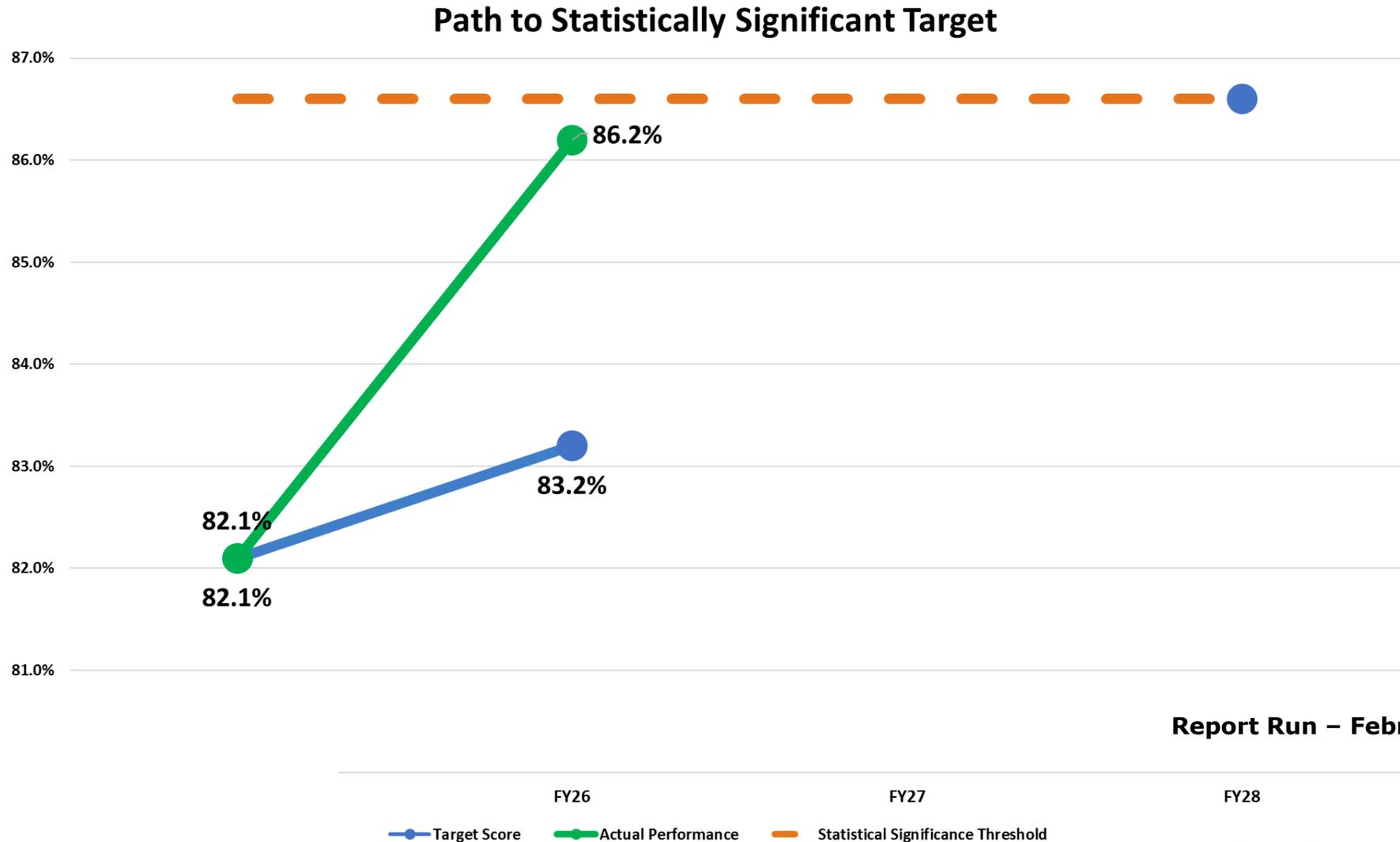
Path to Statistically Significant Target

Report Run – February 13, 2026

14

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Questions?

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Appendix

El Camino Health

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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

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Patient Experience Update
Distribution of Percentile Ranks – Medical Network Survey

Distribution of Percentile Ranks
Press Ganey's Medical Network Survey
(Percentile Benchmark dated February 2025 - January 2026)

The graph shows the distribution of Medical Network Survey percentile ranks within Press Ganey's national database.

Report Run - February 13, 2026

18
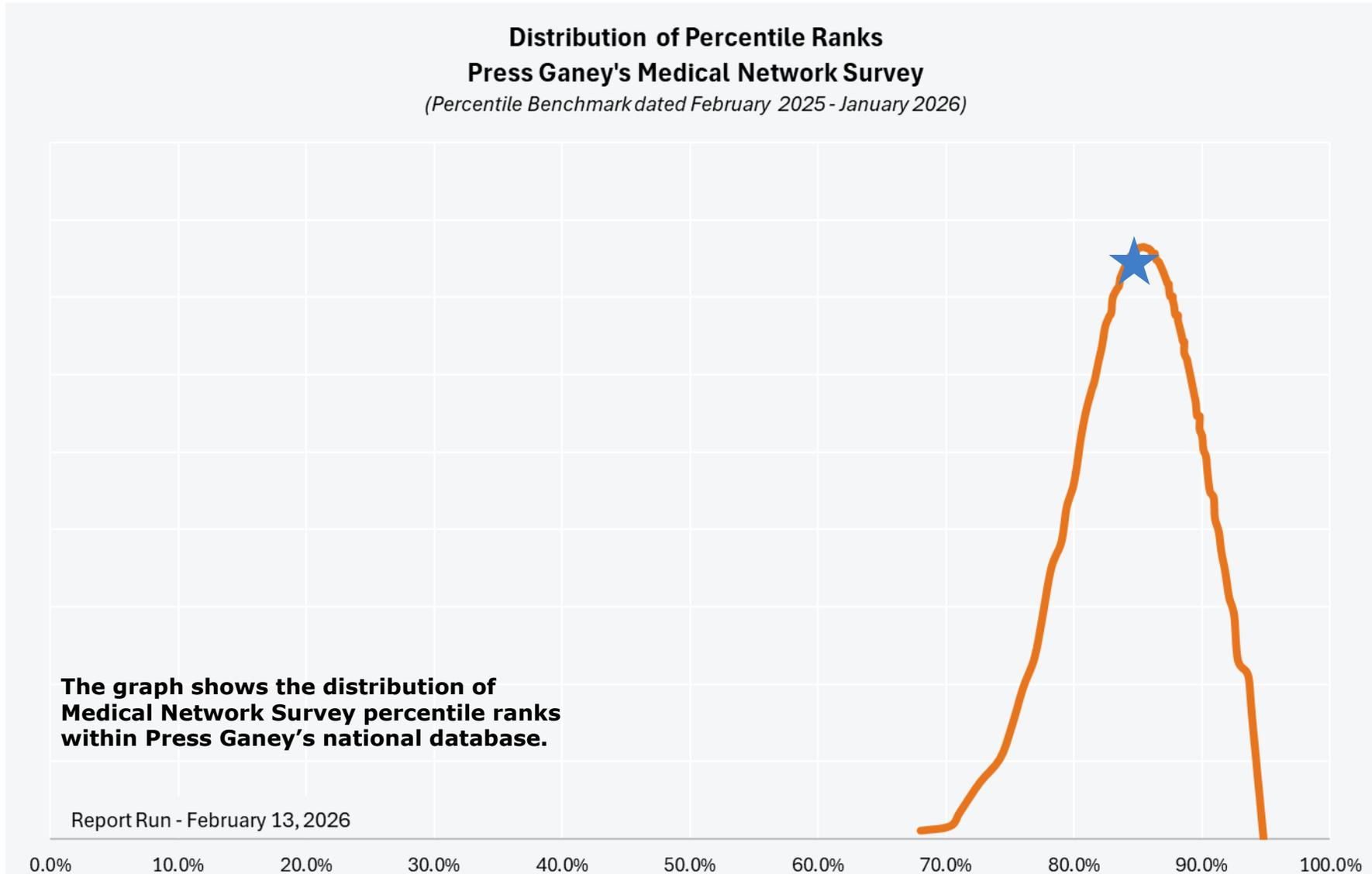
Patient Experience Update
Distribution of Percentile Ranks – Inpatient Survey

Distribution of Percentile Ranks
Press Ganey's Inpatient Survey
(Percentile Benchmark dated February 2025 - January 2026)

The graph shows the distribution of Inpatient Survey percentile ranks within Press Ganey's national database.

Report Run - February 13, 2026

19
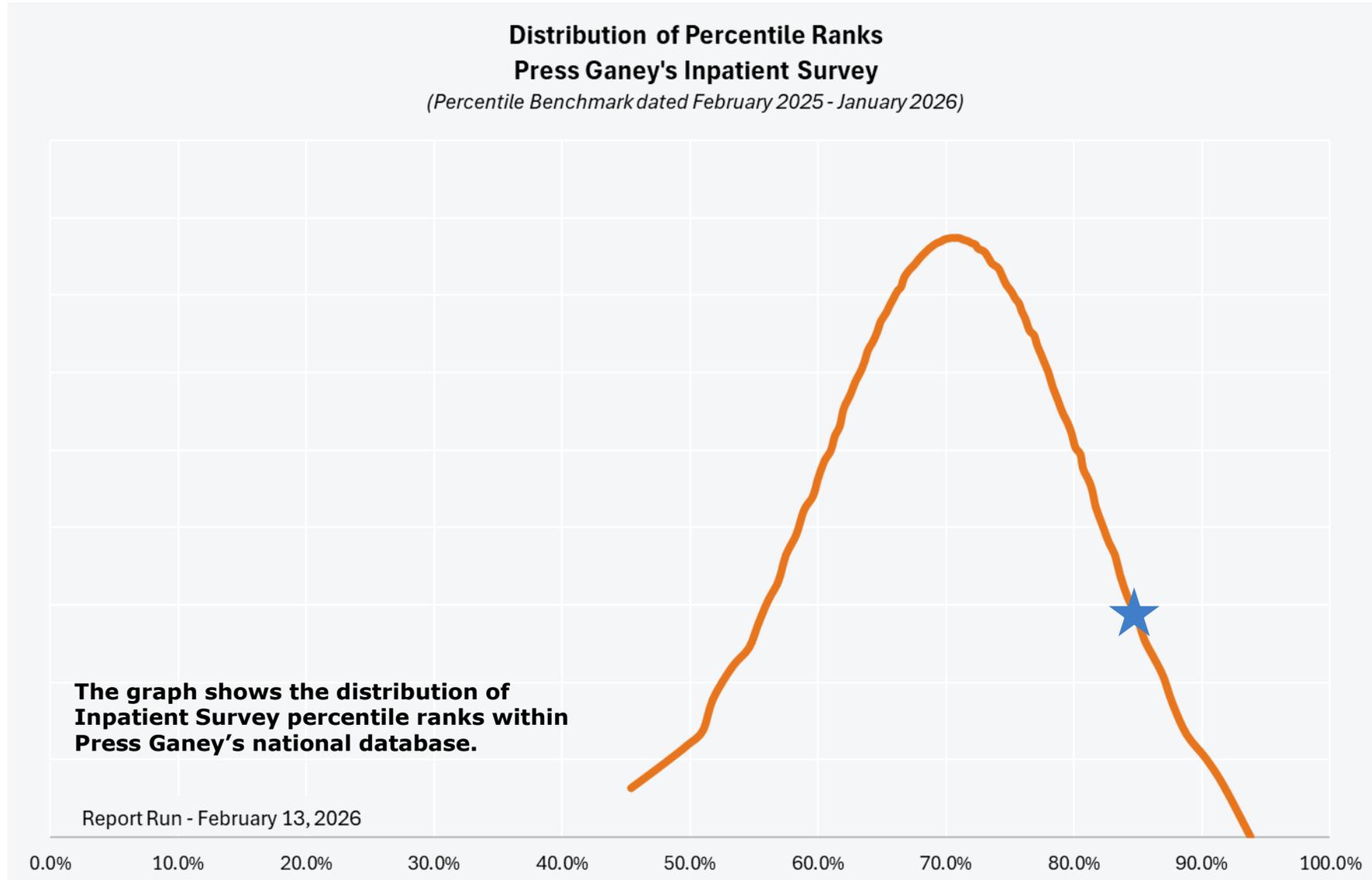
Patient Experience Update
Distribution of Percentile Ranks – Emergency Department Survey

Distribution of Percentile Ranks
Press Ganey's Emergency Department Survey
(Percentile Benchmark dated February 2025 - January 2026)

The graph shows the distribution of Emergency Department Survey percentile ranks within Press Ganey's national database.

Report Run - February 13, 2026

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%

20
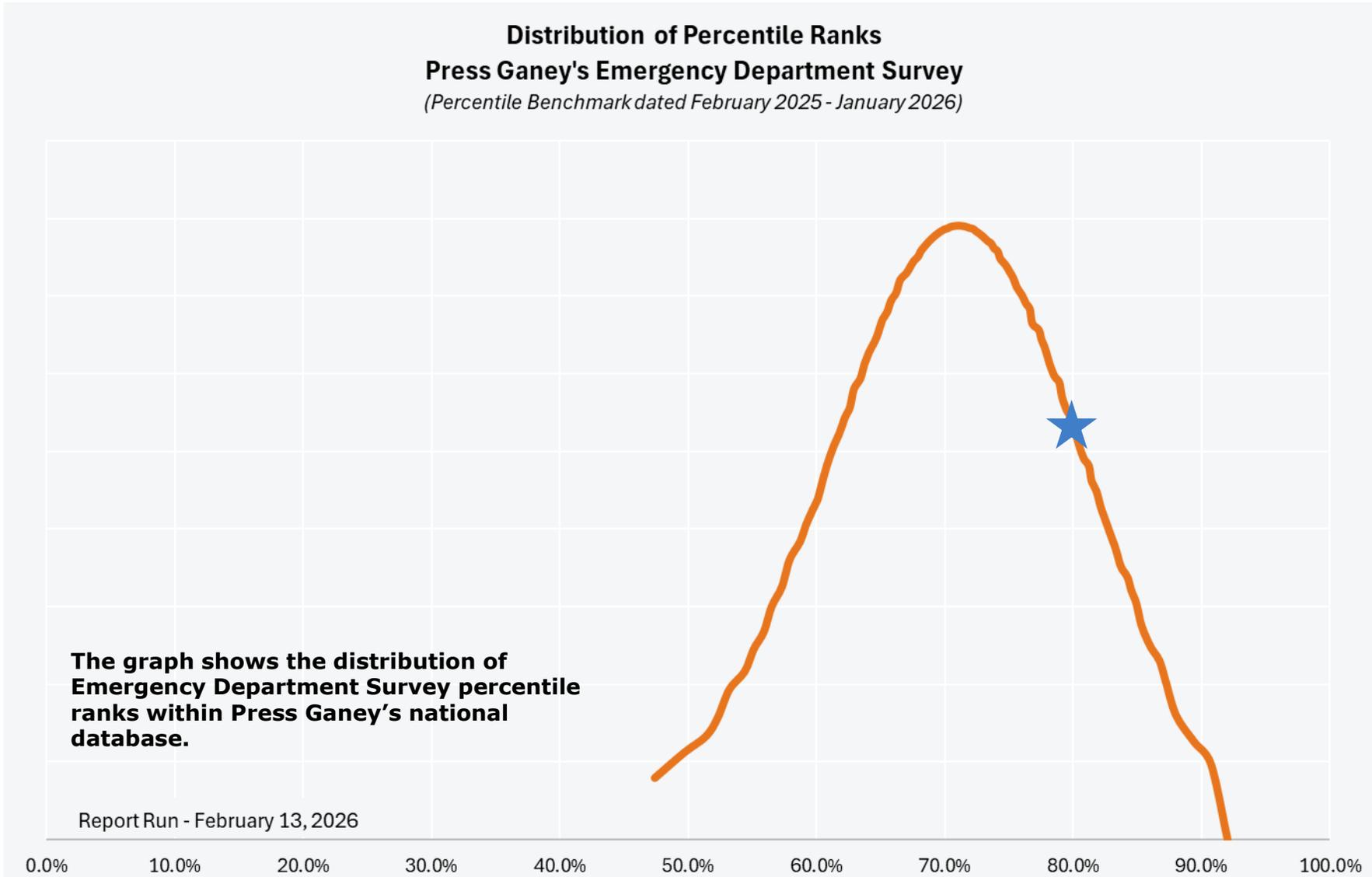
Patient Experience Update
Distribution of Percentile Ranks – Ambulatory Surgery Survey

Distribution of Percentile Ranks
Press Ganey's Ambulatory Surgery Survey
(Percentile Benchmark dated February 2025 - January 2026)

The graph shows the distribution of Ambulatory Surgery Survey percentile ranks within Press Ganey's national database.

Report Run - February 13, 2026

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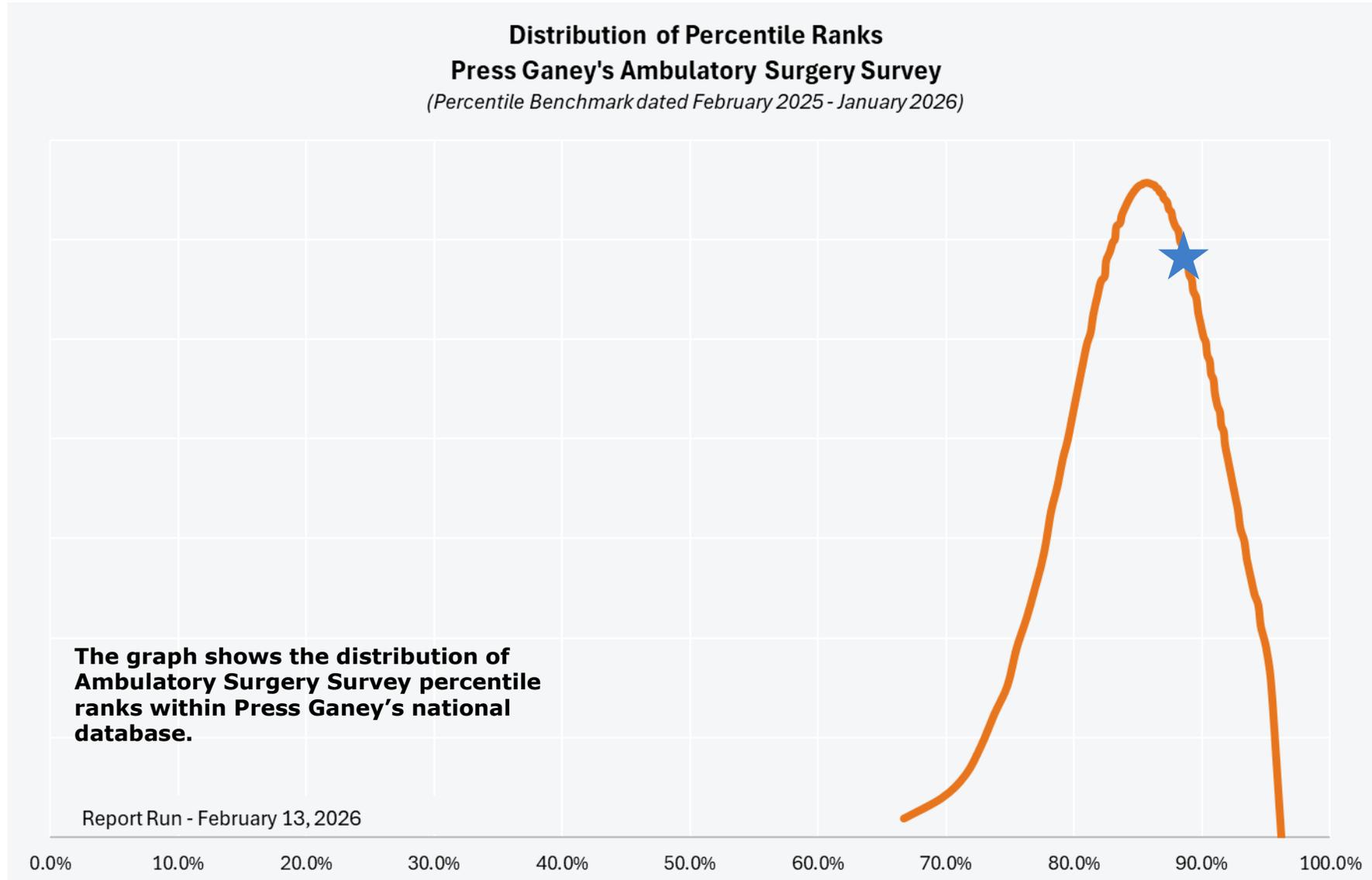
Patient Experience Update
Distribution of Percentile Ranks – Outpatient Survey

Distribution of Percentile Ranks
Press Ganey's Outpatient Survey
(Percentile Benchmark dated February 2025 - January 2026)

The graph shows the distribution of Outpatient Survey percentile ranks within Press Ganey's national database.

Report Run - February 13, 2026

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%

22
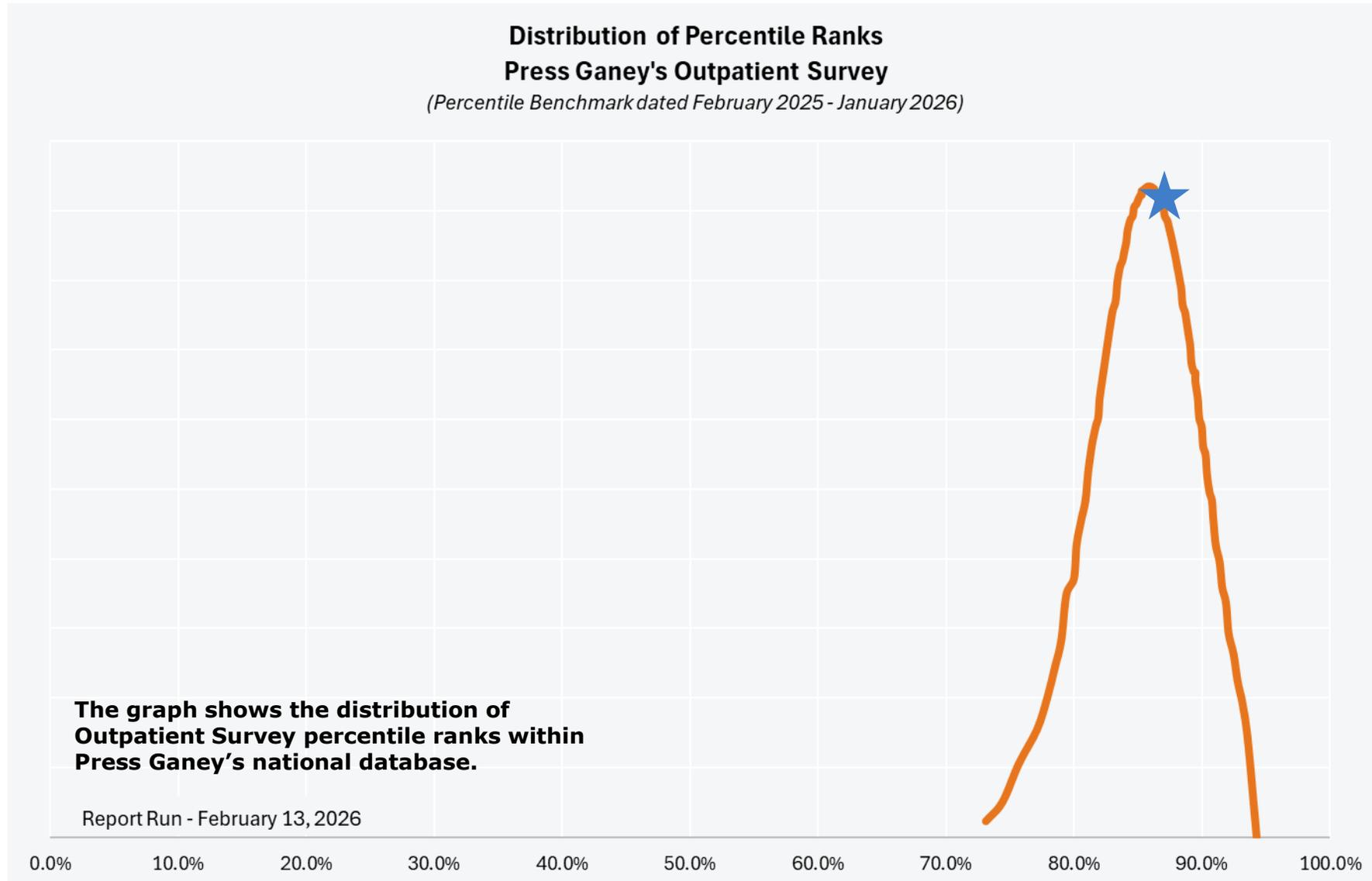
Patient Experience Update
Distribution of Percentile Ranks – Oncology Survey

Distribution of Percentile Ranks
Press Ganey's Oncology Survey
(Percentile Benchmark dated February 2025 - January 2026)

The graph shows the distribution of Oncology Survey percentile ranks within Press Ganey's national database.

Report Run - February 13, 2026

| 0.0% | 10.0% | 20.0% | 30.0% | 40.0% | 50.0% | 60.0% | 70.0% | 80.0% | 90.0% | 100.0% |

23
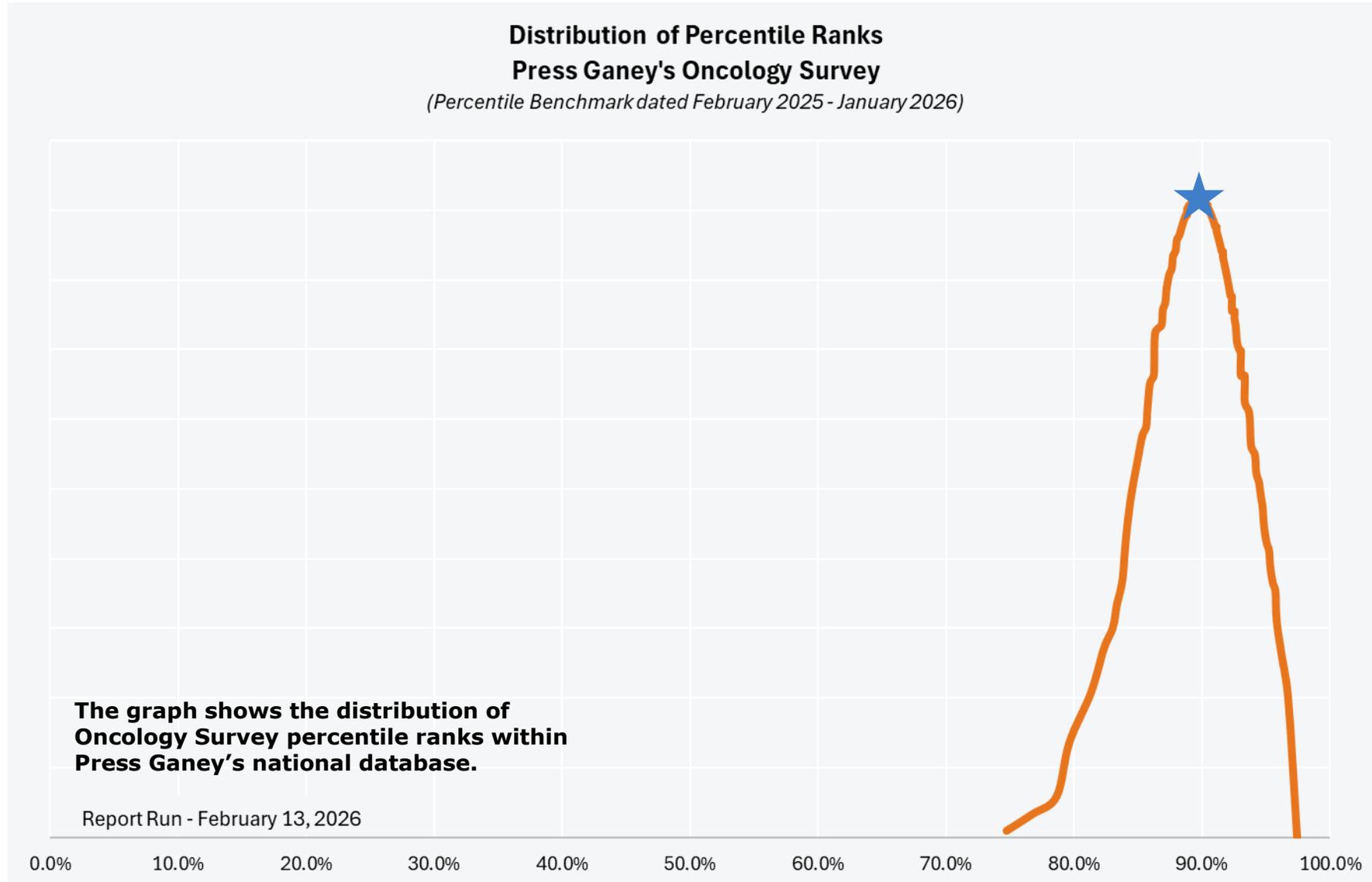
El Camino Health

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

To: Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, M.D, Chief Quality Officer, and Lyn Garrett, MHA, MS, CPHQ
Date: 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: </= 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 ≤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 ≤ 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 </= 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 >= 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 ≤ 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 (</=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
March 2, 2026

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.

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard
Jan 2026 (unless other specified)

Month to Board Quality Committee : **Mar 2026 QC**

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

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*Organizational Goal
Clostridium Difficile Infections (C-Diff) cases

Latest Month :
January 2026
ⓘ

- Latest Month: 0 cases
- **Total FY26** 5 cases — 0.71 cases/mo
- **Total FY25** 28 cases — 2.33 cases/mo
- **Total FY26 Target** <= 27 cases — 2.25 cases/mo

BETTER ↓

# of CDIFF Cases | Last 12 Months

BETTER ↓

FY26TD Total Cumulative CDIFF Cases
Target : <=27 cases

---

*Organizational Goal
Catheter Associated Urinary Tract Infection (CAUTI) cases

Latest Month :
January 2026
ⓘ

- Latest Month: 0 cases
- **Total FY26** 2 cases — 0.29 cases/mo
- **Total FY25** 14 cases — 1.17 cases/mo
- **Total FY26 Target** <= 13 cases — 1.08 cases/mo

BETTER ↓

# of CAUTI Cases | Last 12 Months

BETTER ↓

FY26TD Total Cumulative CAUTI Cases
Target : <= 13 cases

---

*Organizational Goal
Hospital Acquired Pressure Injury (HAPI) cases

Latest Month :
January 2026
ⓘ

- Latest Month: 1 cases
- **Total FY26** 2 cases — 0.29 cases/mo
- **Total FY25** 14 cases — 1.25 cases/mo
- **Total FY26 Target** <= 13 cases — 1.08 cases/mo

BETTER ↓

# of HAPI Cases | Last 12 Months

BETTER ↓

FY26TD Total Cumulative HAPI Cases
Target : <= 13 cases

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

	FY26 Enterprise Quality, Safety and Experience Dashboard	Dashboard Managed by	page
El Camino Health	Jan 2026 (unless other specified)	Quality Data Analyst : **Jeffery Jair** jeffery_jair@elcaminohealth.org	1/6 →

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

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

FY26 Enterprise Quality, Safety and Experience Dashboard
Jan 2026 (unless other specified)

El Camino Health

Month to Board Quality Committee :
Mar 2026 QC

page **2/6**

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
Target : <= 5 cases   Target : <= 5 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
Target : <= 34 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
Average : 0.42   Average : 0.42

Rolling 12 Month Average Rate

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

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard
Jan 2026 (unless other specified)

Dashboard Managed by
Quality Data Analyst : **Jeffery Jair**
jeffery_jair@elcaminohealth.org

page
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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**

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

FY26 Enterprise Quality, Safety and Experience Dashboard
Jan 2026 (unless other specified)

El Camino Health

Month to Board Quality Committee :
Mar 2026 QC

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Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal Hand Hygiene Combined Compliance Rate Latest Month : January 2026	79.4% (6075 / 7647)	85.1% (56068 / 65861)	83.2% (171444 / 205958)	>=84% (1% improve of FY25)	BETTER — Average : 84.5% / Average : 84.5%	FYTD | Hand Hygiene Combined Rate
Hand Hygiene % of Departments Meeting Target Latest Month : January 2026	100.0% (25 / 25)	100.0% (175 / 175)	100.0% (300 / 300)	80% of units	BETTER — Average : 100.0% / Average : 100.0%	FYTD | Hand Hygiene % Department Meeting Target
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure) Latest Month : January 2026	0.0% (0 / 10)	5.7% (3 / 53)	4.8% (6 / 126)	<= 4.3% (10% reduction of FY25)	BETTER — Average : 5.3% / Target : 4.0% / Average : 5.3%	Rolling 12 Month Average Rate — Average : 5.0% / Target : 4.0% / Average : 5.0%

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

El Camino Health

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
*Organizational Goal Hand Hygiene Combined Compliance Rate	S. Mallur, MD / Lyn Garrett	% of yes Cleaning Before Entering or Exit	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: **Hsiao-Lan Shih**
Hand Hygiene % of Departments Meeting Target	S. Mallur, MD / Lyn Garrett	Number of Unit done Audit according to their Target (Only Leapfrog units)	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: **Hsiao-Lan Shih**
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure)	S. Mallur, MD	Based on the Center for Medicare and Medicaid Services (CMS) Metric criteria, complications following an elective primary total hip arthoplasty (THA), total knee arthoplasty (TKA) procedure. Numerator : Distinct count of patients having complications / Total Cases. Patients with complications are counted in the numerator only once, regardless of the number or type of complication. Denominator : Eligible index admissions who have undergone a qualifying elective primary THA or TKA procedure. 2.) Based upon Vizient Risk Model 2024 Community + AHRQ Version 2024 3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Nonviable Neonate & Normal Newborn)	Vizient Clinical Database

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

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard
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Month to Board Quality Committee : **Mar 2026 QC**

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Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
30-Day Readmission Observed Rate Vizient Community Risk Model 2024 Latest Month : December 2025	11.5% (141 / 1224)	10.7% (745 / 6967)	10.6% (1539 / 14546)	<= 10.6% (maintain baseline)	BETTER	Rolling 12 Month Average Rate Average : 10.5%
Mortality Index Observed / Expected Vizient Community Risk Model 2024 Latest Month : January 2026	0.84 (2.13% / 2.56%)	0.92 (1.84% / 2.01%)	1.06 (1.85% / 1.74%)	<= 1.05 (1% reduction from baseline)	BETTER	Rolling 12 Month Average Rate Average : 1.06
Sepsis Mortality Index Observed / Expected Vizient Community Risk Model 2024 Latest Month : January 2026	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)	BETTER	Rolling 12 Month Average Rate Average : 1.21

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

El Camino Health	**FY26 Enterprise Quality, Safety and Experience Dashboard** Jan 2026 (unless other specified)	Dashboard Managed by Quality Data Analyst : **Jeffery Jair** jeffery_jair@elcaminohealth.org	← page 4/6 →

Measure	Definition Owner	Metric Definition	Data Source
30-Day Readmission Observed Rate Vizient Community Risk Model 2024	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: **Steven Sun**
Mortality Index Observed / Expected Vizient Community Risk Model 2024	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
Sepsis Mortality Index Observed / Expected Vizient Community Risk Model 2024	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

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

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard
Jan 2026 (unless other specified)

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

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

FY26 Enterprise Quality, Safety and Experience Dashboard
Jan 2026 (unless other specified)

El Camino Health

Dashboard Managed by
Quality Data Analyst : **Jeffery Jair**
jeffery_jair@elcaminohealth.org

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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: **Hsiao-Lan Shih**

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

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard
Jan 2026 (unless other specified)

Month to Board Quality
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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		

FY26TD | LTR Composite Score

El Camino Health

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
LTR Composite Score	Ryan Lockwood	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. It is calculated based on Likelihood to Recommend (LTR) performance from the previous fiscal year. Weighting is applied based on patient volume or prioerity areas to ensure a fair representation of each department's contribution.	HCAHPS

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

El Camino Health

Quality Committee
Proposed FY2027 Meeting Dates

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

El Camino Health

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: **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.	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. ▪ Monthly Quality Dashboard ▪ Quarterly Board Level Quality Dashboard
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	• 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 2027	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

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
STANDING AGENDA ITEMS												
Consent Calendar¹		✓			✓	✓		✓	✓		✓	✓
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)

For review at March 2 QC Meeting

El Camino Health

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
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

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
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)

For review at March 2 QC Meeting