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

Monday, June 1, 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: 999 7094 2159 # 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 Committee member is participating in the meeting via teleconference.

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 pm**
2.	**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 Committee on any matter within the subject matter jurisdiction of the Committee 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 Committee 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 (05/04/2026) b. FY2026 Pacing Plan c. Progress Against FY2026 Committee Goals	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:30 – 5:35**
5.	**VERBAL COMMITTEE EXPERTISE REPORT**	Shahram Gholami, MD, Quality Committee Member	Information	**5:35 – 5:45**
6.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Information	**5:45 – 5:55**
7.	**HEALTH EQUITY REPORT**	Shreyas Mallur, MD, MBA, Chief Quality Officer	Discussion	**5:55 – 6:15**
8.	**FY2026 ENTERPRISE QUALITY DASHBOARD** a. Review Readmission Analysis	Shreyas Mallur, MD, MBA, Chief Quality Officer	Discussion	**6:15 – 6:25**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
9.	**REFRESH FY2027 STEEEP DASHBOARD MEASURES**	Shreyas Mallur, MD, MBA, Chief Quality Officer	Discussion	**6:25 – 6:40**
10.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**6:40 – 6:41**
11.	**QUALITY COUNCIL MINUTES** a. Quality Council Minutes (05/06/2026) *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Carol Somersille, MD Quality Committee Chair	Information	**6:41 – 6:46**
12.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (05/04/2026)** *Report involving Gov't Code Section 54957.2 for closed session minutes*	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**6:46 – 6:51**
13.	**REVIEW FY2027 ENTERPRISE QUALITY AND PATIENT EXPERIENCE-RELATED ANNUAL ORGANIZATIONAL PERFORMANCE INCENTIVE METRICS AND GOAL-SETTING METHODOLOGIES** *Health and Safety Code Section 32106(b) and Gov't Code Section 54957.6 for a report and discussion involving healthcare facility trade secrets, and a report and discussion on personnel matters*	Shreyas Mallur, MD, MBA, Chief Quality Officer	Discussion	**6:51 – 7:06**
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 reports regarding personnel performance of the Medical Staff*	Mark Adams, MD, Chief Medical Officer	**Motion Required**	**7:06 – 7:16**
15.	**VERBAL SERIOUS SAFETY EVENT REPORT** *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Shreyas Mallur, MD, MBA, Chief Quality Officer	Discussion	**7:16 – 7:21**
16.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:21 – 7:22**
17.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:22 – 7:23**
18.	**RECOMMEND FOR BOARD APPROVAL FY2027 ENTERPRISE QUALITY AND PATIENT EXPERIENCE-RELATED ANNUAL ORGANIZATIONAL PERFORMANCE INCENTIVE METRICS AND GOAL-SETTING METHODOLOGIES**	Shreyas Mallur, MD, MBA, Chief Quality Officer	**Motion Required**	**7:23 – 7:28**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
19.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:28 – 7:30**
20.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:30**

Next Meetings: August 31, 2026; November 2, 2026; February 1, 2027; March 1, 2027; May 3, 2027; June 7, 2027

Minutes of the Open Session of the
Quality, Patient Care, and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, May 4, 2026
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD, Chair
Krutica Sharma, MD, Vice Chair
Shahram Gholami, MD *(at 5:34 pm)*
Barbara Pelletreau
Jack Po, MD
Diane Schweitzer
Steven Xanthopoulos, MD
John Zoglin

Members Absent
Pancho Chang
Erica Jiang

***via teleconference*

Staff Present
Dan Woods, CEO
Mark Adams, MD, CMO
Shreyas Mallur, MD, CQO
Tracey Lewis Taylor, COO
Theresa Fuentes, CLO
Lyn Garrett, Senior Director, Quality
Ryan Lockwood, VP, Patient Experience
Alan Muster, MD, MBA, MHA, FCCP, President, ECHMN **
Jaideep Iyengar, MD, FAAOS
Peter Goll, Chief Administrative Officer, ECHMN **
Kirstan Smith, BSN, CPHQ, VP Quality Performance, ECHMN
Anne Yang, Executive Director, Governance Services
Gabriel Fernandez, Coordinator, Governance Services

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:30 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Committee members Chang, Gholami, and Jiang were absent at the time of roll call.	**Call to order at 5:30 p.m.**
2. 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.	
3. PUBLIC COMMUNICATION	There were no comments from members of the public.	
4. CONSENT CALENDAR	Chair Somersille asked whether any Committee member wished to pull an item from the consent calendar. Chair. Somersille requested further discussion on item c) Core Measures. Chair Somersille requested a discussion of the outpatient head CT or MRI scan measure, which was performing below the target. Staff provided context on the small patient population captured by the measure and noted that performance has been trending in a positive direction.	***Consent Calendar Approved***

Draft

Draft

<table>
<tr>
<td></td>
<td>Committee members provided feedback on the consistency of data presentation across the report and requested that staff standardize the format so that the same information is presented in a consistent manner for each measure, with color coding to indicate status.

Additional discussion continued regarding item d) Revised FY2026 Patient Safety Plan.

Dr. Mallur provided context for the revision, explaining that a new requirement for hospitals is to maintain a separate Patient Safety Plan with specific language addressing health equity and processes for responding to patient concerns about discrimination.

The Committee discussed the relationship between the California requirements and CMS and Joint Commission standards and was advised that this document will serve as the governing plan.

Motion: To approve the consent calendar.

Movant: Zoglin
Second: Sharma
Ayes: Somersille, Gholami, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin
Noes: None
Abstain: None
Absent: Chang, Jiang
Recused: None</td>
<td>Action: Management to standardize the Core Measures report format to consistently present the ECH goal, CMS benchmark, and current performance for each measure, with color coding to indicate performance status.</td>
</tr>
<tr>
<td>5. VERBAL COMMITTEE MEMBER EXPERTISE REPORT</td>
<td>Dr. Xanthopoulos provided the verbal Committee Expertise Report on recent advances in the field of anesthesia.

Dr. Xanthopoulos described the organization’s preoperative assessment team and the growing role of artificial intelligence in identifying higher-risk surgical patients. He noted opportunities and challenges in implementing AI tools within the existing electronic health record environment. He also highlighted advances in non-invasive monitoring technologies and other significant developments.

The Committee engaged in discussion regarding the clinical applications of the technologies described and the potential for further adoption at El Camino Health.</td>
<td></td>
</tr>
<tr>
<td>6. PATIENT SAFETY STORY</td>
<td>Mr. Lockwood presented the Patient Experience Story in keeping with the Committee’s request to focus these presentations on lessons learned.

Mr. Lockwood described patient frustration related to wait times and lack of information at the outpatient laboratory, and the improvements implemented in response.

Following the identification of these concerns, Mr. Lockwood shared that the laboratory implemented an appointment-scheduling system and processes to proactively communicate</td>
<td></td>
</tr>
</table>

	wait times to patients and that these changes resulted in measurable improvements in patient experience scores for the area.	
7. EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT	Dr. Muster, Dr. Iyengar, Mr. Goll, and Ms. Smith presented the ECHMN Quality Report for Calendar Year 2026. Ms. Smith provided an overview of the evolution of the ECHMN quality program over the past three years, highlighting significant growth in the number of measures tracked and the breadth of provider groups covered. Ms. Smith shared that the program spans across primary care, urgent care, pediatrics, and multiple specialty areas, and is aligned with the CMS quality framework. The Committee reviewed the current year's priority metrics and performance data through April 2026; the network was on track for most measures. Committee discussion focused on the approach to extending quality oversight to IPA physicians, including how data will be collected across practices not currently on the organization's electronic health record platform, the contractual framework for performance accountability, and the strategy for onboarding and engaging both new and existing network physicians. Additionally, the Committee inquired regarding the challenges of EMR adoption among smaller independent practices.	
8. Q3 FY2026 STEEEP DASHBOARD REVIEW / FY2026 ENTERPRISE QUALITY DASHBOARD	Dr. Mallur presented the Q3 FY2026 STEEEP Dashboard and Enterprise Quality Dashboard, summarizing organizational quality performance and highlighting key areas of progress and continued focus. Dr. Mallur described significant improvements in hospital-acquired infection rates achieved through a structured, frontline-driven initiative that applied evidence-based practices and lean methodology. The effort produced substantial reductions in both C. difficile and catheter-associated urinary tract infection rates compared to the prior fiscal year. Dr. Mallur also shared that hand hygiene compliance has improved considerably through a thorough observation and accountability program. Dr. Mallur highlighted improvement in imaging turnaround times following a change in the radiology provider group, noting that both the speed and quality of reads have improved. The Committee discussed the 30-day readmission rate, noting that while year-to-date performance remains close to target, the trend over recent months has been unfavorable. Dr. Mallur described ongoing readmission reduction initiatives and agreed	***Action**: Management to investigate the cause of the downward readmission trend and present a breakdown of readmission data by patient segment at the June 2026 meeting.* *Management to return to the Committee with a recommendation on the C-section rate target after internal review.*

	to investigate the recent trend and report back with a more detailed breakdown of the data. The Committee also discussed the C-section rate target, specifically whether it remains appropriate given the patient population. Dr. Mallur agreed to bring the question back to the relevant clinical team for review.	
9. RECOMMEND FY 2027 COMMITTEE PLANNING ITEMS	The Committee reviewed the proposed FY2027 Committee Planning items, including committee meeting dates, goals, and the pacing plan. No substantive discussion was raised regarding the dates or pacing plan. Discussion focused on Committee Goals 4 and 5, which address committee member education and conference attendance. Committee members emphasized the importance of ensuring goals are accompanied by clear metrics and a means of tracking progress, noting that goals without measurement are difficult to hold people accountable for. Various approaches to measurement were discussed, including tracking participation in conferences and educational sessions, as well as the value of the verbal expertise presentations already incorporated into committee meetings. The Committee reached consensus that these goals should be retained, that the goals section heading should be updated to reflect "Metrics and Monitoring," and that staff should provide a year-end written report on participation in conferences and educational sessions starting in FY2027. **Motion:** To approve the FY2027 Committee Planning items, including committee dates and goals, with the section heading revised to 'Metrics and Monitoring.' **Movant**: Po **Second**: Gholami **Ayes**: Somersille, Gholami, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos **Noes**: Zoglin **Abstain**: None **Absent:** Chang, Jiang **Recused**: None	***FY2027 Committee Planning Items Approved*** ***Action:*** *Staff to revise the goal section heading to 'Metrics and Monitoring.'* *Staff to provide an annual report on committee member participation in conferences and educational sessions at the close of each fiscal year beginning in FY2027.*

Draft

DRAFT

10. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 6:48 p.m. **Movant**: Sharma **Second**: Po **Ayes**: Somersille, Gholami, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang, Jiang **Recused**: None	***Recessed to Closed Session at 6:48 p.m.***
11. AGENDA ITEM 18: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee approved the Closed Session Minutes of the March 2, 2026, meeting and approved the recommendation for Board approval of the Credentialing and Privileges Report.	***Reconvened Open Session at 8:03 p.m.***
12. AGENDA ITEM 19: RECOMMEND FOR APPROVAL FY2027 ENTERPRISE QUALITY AND PATIENT EXPERIENCE-RELATED ANNUAL ORGANIZATIONAL PERFORMANCE INCENTIVE METRICS AND GOAL-SETTING METHODOLOGIES	Chair Somersille reported that the FY2027 Enterprise Quality and Patient Experience-Related Annual Organizational Performance Incentive Metrics and Goal-Setting Methodologies were reviewed during closed session. The item will be brought back to the Committee at the June 2026 meeting for further discussion and a motion.	***No Action Taken for Agenda Item 19***
13. AGENDA ITEM 18: COMMITTEE ANNOUNCEMENTS	There were no committee announcements.	
14. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 8:05 p.m. **Movant**: Po **Second**: Gholami **Ayes**: Somersille, Gholami, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang, Jiang **Recused**: None	***Meeting Adjourned at 8:05 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

Draft

APPROVED BY QC
06/02/2025

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

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]			✓		✓	✓		✓	✓		✓	✓
Verbal Committee Member Expertise Sharing or Chair's Report			✓		✓	✓		✓	✓		✓	✓
Patient Experience Story			✓		✓	✓		✓	✓		✓	✓
Serious Safety Event (as needed)			✓		✓	✓		✓	✓		✓	✓
Recommend Credentialing and Privileges Report			✓		✓	✓		✓	✓		✓	✓
Quality Council Minutes			✓		✓	✓		✓	✓		✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events			✓		✓			✓			✓	
Quarterly Board Level Enterprise/ STEEEP Dashboard Review			✓		✓			✓			✓	
El Camino Health Medical Network Report			✓		✓			✓			✓	
Committee Self-Assessment Results Review						✓						
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience Report			✓						✓			
Health Equity Report						✓						✓
Recommend Safety Report for the Environment of Care					✓							
PSI Report						✓						
Value-Based Purchasing Report			✓									
Recommend Quality Improvement & Patient Safety Plan (QIPS)			✓									
Refresh Quality/Experience Dashboard measures for FY27												✓
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)

06/19/2025

FY26 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

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

STAFF: Chief Quality Officer (Executive Sponsor)

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

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards are in alignment with the El Camino Hospital Board strategic plan.	Q4FY25 review and update which measures to include on the FY26 Quality Dashboards.	Quality and experience performance measures aligned with the STEEEP domains of; safe, timely, effective, efficient, equitable, and person-centered.
2. Monitor Quality, Patient Care, and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY25 review FY26 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars.	Performance measures on the Quality Dashboards. ▪ Monthly Quality Dashboard ▪ Quarterly Board Level Quality Dashboard
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY26.	Monitor the effectiveness of ECH activities to reduce healthcare disparities through review of the biannual "health equity report".
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee.	Fiscal Year 2026	• Attend a minimum of 5 meetings in person. • Actively participate in discussions at each meeting. • Review of annual committee self-assessment results
5. Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics.	Fiscal Year 2026	Committee attendance rate at conference and/or session with a subject matter expert of at least 50%. • Verbal/Written report of key learnings to the Quality Committee.

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

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING MEMO

To: ECH Quality, Patient Care, and Patient Experience Committee
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: June 1, 2026
Subject: Patient Safety Story

Purpose:

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

Summary:

1. Situation: A 71 y/o male patient entered the emergency department with a descending aortic aneurysm. These cases are infrequent for El Camino Health. Many efforts were made to provide proper care and treatment for this patient.

2. Authority: To provide the committee with information regarding a recent patient safety event at El Camino Health.

3. Background: The patient presented to the emergency department at the Mountain View campus with an aneurysm in the early hours of the morning. An ECH vascular surgeon, JL, responded and determined the patient needed a procedure to repair the aneurysm. The case would be done in the hybrid interventional services lab. The patient's vital signs were deteriorating, and the life-saving procedure needed to be done emergently.

4. Assessment: In planning for the emergent case, the surgeon determined that the stents from the vendor would need to be fitted precisely to the patient's anatomy as per the CT Angio that had already been performed. ECH does not carry this stent, nor does it come in all the sizes that might be necessary, given the patient's vessel measurements. The vendor was called and was able to bring all sizes onsite to ensure the correct size per the images on site. Having the images readily available from the vendor would have allowed much quicker access to the precisely right size for the patient.

5. Outcomes: The correct size stent was provided for the patient, and the procedure was completed, though a delay occurred waiting for the correct size stent to be delivered by the vendor. The patient recovered and was discharged. Upon review of the case, it was determined that PACS image sharing is available through the vendor's portal to avoid future delays. Creating this sharing capability will allow the vendor to quickly assess the anatomy from the images and select the correct-sized device for immediate delivery. This process has been completed with the vendor, and ECH is prepared for our next patient requiring this procedure.

Suggested Committee Discussion Questions:

1. What is the process if the procedure cannot be completed at ECH?

2. What is the process required for image sharing?

EL CAMINO HOSPITAL BOARD
QUALITY COMMITTEE MEETING COVER MEMO

To: ECH Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, MD, MBA, Chief Quality Officer
Date: June 1, 2026
Subject: Social Drivers of Health Screening and Assessment

Summary:

1. Background: The SDOH-1 (Social Determinants of Health Screening) CMS recommends that healthcare providers systematically screen patients for social determinants affecting health, such as housing instability, food insecurity, transportation barriers, financial instability and interpersonal safety. The SDOH-2 (Social Needs Action Plan) recommends providers to develop and implement action plans to address identified social needs, integrating these into patient care plans. Both requirements aim to improve health outcomes by addressing non-medical factors impacting patient health. Compliance involves regular data collection, documentation, and voluntary reporting to CMS to demonstrate efforts and outcomes in mitigating social health determinants. It also remains a mandatory requirement under California AB 1204 - Hospital Equity Measures Reporting Program as well as Leapfrog Hospital Safety Grade.

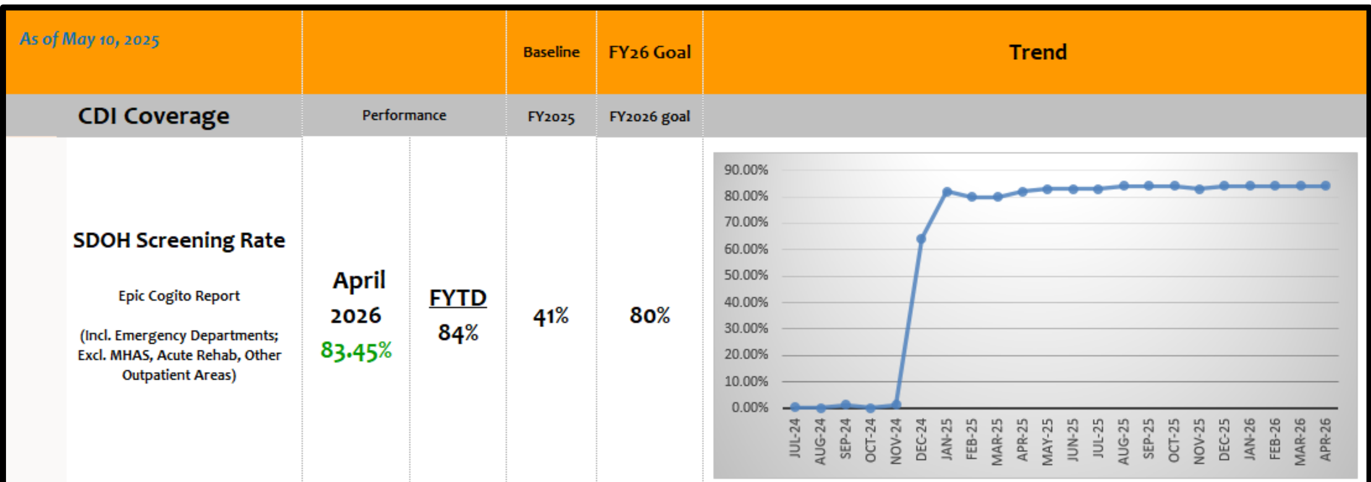
2. Assessment: By going live with SDOH on December 19, 2024, El Camino Health successfully implemented and attested on all the measures for the mandatory reporting period 01/01/2024 – 12/31/2024 and 01/01/2025 – 12/31/2025.

   The required elements of performance for SDOH-1 and SDOH-2 measures are:

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

3. Recommendation: The SDOH rates below are provided for discussion purposes. As SDOH went live in December 2024, there is no data to report for calendar year 2024. As demonstrated on the chart below, El Camino Health has successfully achieved a greater than 80% compliance rate for all months to date in calendar year 2025 and 2026, and as of May 2026, has achieved an overall rate since go-live of 84%. The goal for FY26 is to continue to achieve a greater than 80% rate.

Memo: Social Drivers of Health Screening and Assessment
June 1, 2026 | pg. 2



As of May 10, 2025			Baseline	FY26 Goal	Trend
CDI Coverage	Performance		FY2025	FY2026 goal	
SDOH Screening Rate Epic Cogito Report (Incl. Emergency Departments; Excl. MHAS, Acute Rehab, Other Outpatient Areas)	**April 2026** 83.45%	**FYTD** 84%	**41%**	**80%**	

EL CAMINO HOSPITAL BOARD
QUALITY COMMITTEE MEETING COVER MEMO

To: ECH Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, M.D, MBA, Chief Quality Officer, and Lyn Garrett, MHA, MS, CPHQ
Date: June 1, 2026
Subject: Enterprise Quality, Safety, and Experience Dashboard FY26 through April 2026

Purpose:

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

Summary:

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

Assessment:

Hospital Acquired Conditions:

1. **C. Difficile Infection:** There have been 7(0.70 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 4 (0.40 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 4 cases (0.40) 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).

4. **Central Line Associated Blood Stream Infection (CLABSI)**. We have had 3 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 (27) is favorable to target of </= 34 cases (2.70 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:** We are on track to meet this metric. However, we are continuing to monitor this closely).

6. **Serious Safety Event Rate (SSER):** There have been 3 Serious Safety Events in FY26 (0.15/10,000 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 YTD FY2026 is favorable (87.3 %) to target of 85%. (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 YTD FY 2026 is unfavorable at (4.4%), against a target of ≤ 4.3%. This measure is actively monitored given its role as a CMS metric influencing Value-Based Purchasing, Star ratings, and health system benchmarking. The elevated rate is largely attributable to a shift in surgical volume, as the majority of hip and knee procedures have migrated to the outpatient setting, leaving a higher-acuity, more complex patient population in the inpatient

cohort. Despite this, the measure has shown consistent improvement over recent quarters. Ongoing efforts include a continued focus on reducing hip and knee surgical site infections, along with structured engagement with surgeons to identify and address underlying causes of complications. (Timeline for improvement: This measure has been improving for the last two quarters and we expect this measure to be close to target by end of FY26)

10. **30 Day Readmission Observed Rate:** Performance YTD through January of 26 (11.1%) 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 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:** The readmission trend is rising and is of concern. We are doing a deep dive to understandd the causes by service line and by site of discharge.)

11. **Risk Adjusted Mortality Index.** Performance YTD FY26 (0.92) is favorable to target (0.88) against a target of </= 1.05. Mortality index tracks, and for this time frame, is driven by sepsis mortality. We will continue to monitor 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 1.10, 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 March of 2026 (26.5%) 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 (79.4%) to target of 74%. Performance for FY 2026 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 (151 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 (Likelihood to Recommend) Composite Score and Medical Network Performance: FY26 Performance Highlights (July 2025 through April 2026)**

    Fiscal Year 2026 year to date Likelihood to Recommend (LTR) Composite performance is 84.6%, exceeding the established target of 83.4%, with April 2026 performance at 84.0%. Performance continues to reflect sustained strength in patient experience across the enterprise and ongoing operational focus on reliability, standardization, and accountability.

    The El Camino Health Medical Network continues to demonstrate favorable momentum, achieving an FY26 year to date score of 85.9%, with April 2026 performance at 84.6%. Improvement efforts across clinics remain focused on standardizing patient experience practices, reducing operational variation, and strengthening communication and service consistency.

    To support sustained improvement and enterprise alignment, the Patient Experience Action Team (PEAT) continues to serve as the organization’s multidisciplinary governance structure for patient experience oversight across acute, ambulatory, and Medical Network settings. Current enterprise strategies remain focused on standardized behavioral expectations, leadership visibility and rounding, structured service recovery, expanded patient listening strategies, and recognition of high-performing departments and clinics.

El Camino Health
FY26 Enterprise Quality, Safety and Experience Dashboard
April 2026 (unless other specified)
Month to Board Quality Committee :
JUNE 2026 QC
page
1/6
Measure
FY26 Performance
Baseline FY25 Actual
FY26 Target
Trend
FYTD or Rolling 12 Month Average
Latest Month
FYTD
*Organizational Goal
Clostridium Difficile Infections (C-Diff) cases
Latest Month :
April 2026
1 cases
Total FY26
7 cases
0.70 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
# of Cases
FY26TD Total Cumulative CDIFF Cases
Target : <=27 cases
*Organizational Goal
Catheter Associated Urinary Tract Infection (CAUTI) cases
Latest Month :
April 2026
0 cases
Total FY26
4 cases
0.40 cases/mo
Total FY25
14 cases
1.17 cases/mo
Total FY26 Target
<= 13 cases
1.08 cases/mo
# of CAUTI Cases | Last 12 Months
FY26TD Total Cumulative CAUTI Cases
Target : <= 13 cases
*Organizational Goal
Hospital Acquired Pressure Injury (HAPI) cases
Latest Month :
April 2026
0 cases
Total FY26
4 cases
0.40 cases/mo
Total FY25
15 cases
1.25 cases/mo
Total FY26 Target
<= 13 cases
1.08 cases/mo
# of HAPI Cases | Last 12 Months
# of cases
FY26TD Total Cumulative HAPI Cases
Target : <= 13 cases
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26
Mar 26
Apr 26
May 26
Jun 26
Quality Department | Note : updated as of May 18th, 2026

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

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

page
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 May 18th, 2026

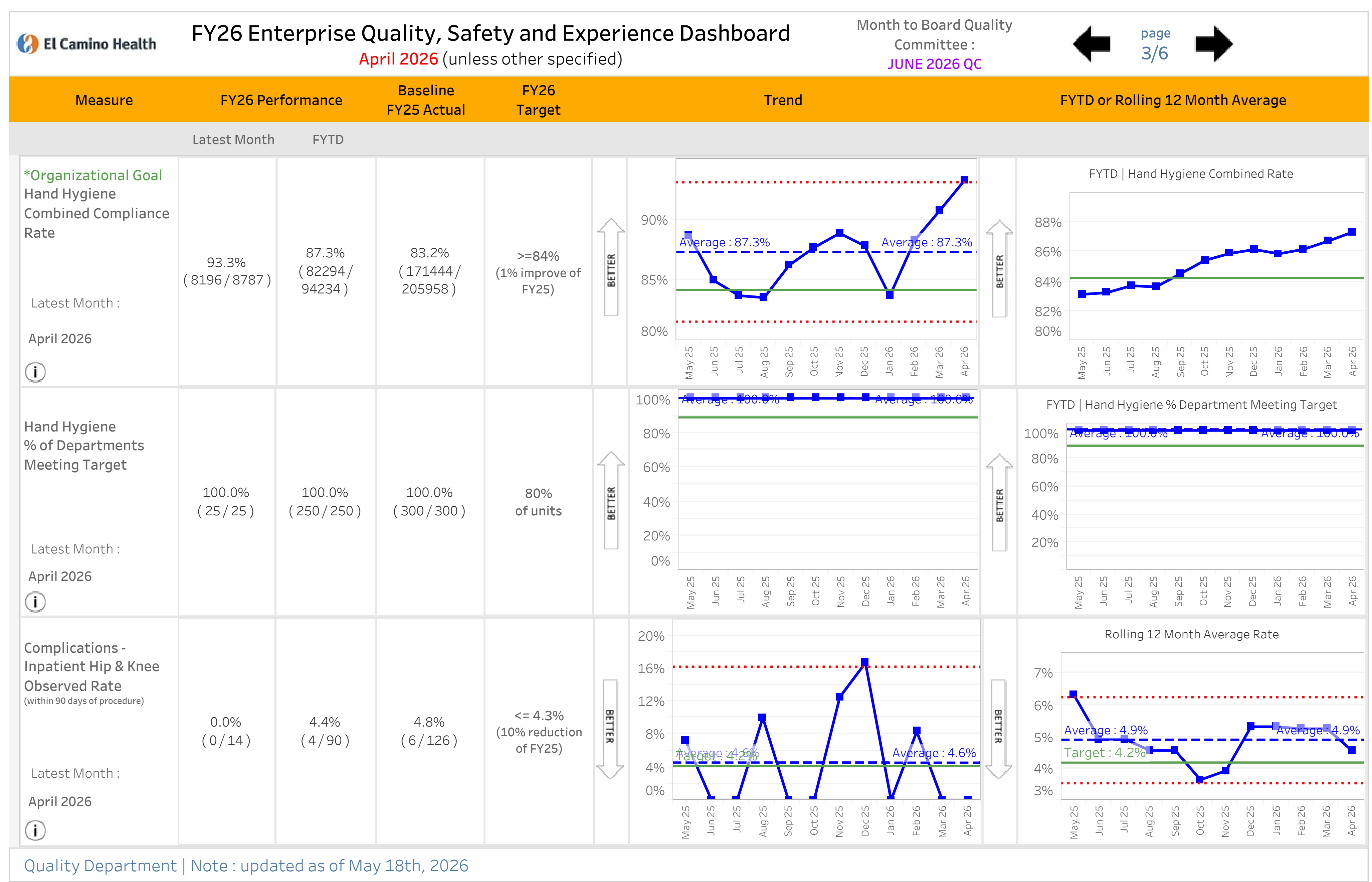
El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

Dashboard Managed by
Quality Data Analyst : **Jeffery Jair**
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**



El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

Month to Board Quality Committee : JUNE 2026 QC

page 3/6

Measure	FY26 Performance: Latest Month	FY26 Performance: FYTD	Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
*Organizational Goal Hand Hygiene Combined Compliance Rate Latest Month : April 2026	93.3% (8196 / 8787)	87.3% (82294 / 94234)	83.2% (171444 / 205958)	>=84% (1% improve of FY25)	BETTER ↑; Average : 87.3%	BETTER ↑; FYTD | Hand Hygiene Combined Rate
Hand Hygiene % of Departments Meeting Target Latest Month : April 2026	100.0% (25 / 25)	100.0% (250 / 250)	100.0% (300 / 300)	80% of units	BETTER ↑; Average : 100.0%	BETTER ↑; FYTD | Hand Hygiene % Department Meeting Target; Average : 100.0%
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure) Latest Month : April 2026	0.0% (0 / 14)	4.4% (4 / 90)	4.8% (6 / 126)	<= 4.3% (10% reduction of FY25)	BETTER ↓; Average : 4.6%; Target : 4.2%	BETTER ↓; Rolling 12 Month Average Rate; Average : 4.9%; Target : 4.2%

Quality Department | Note : updated as of May 18th, 2026

El Camino Health

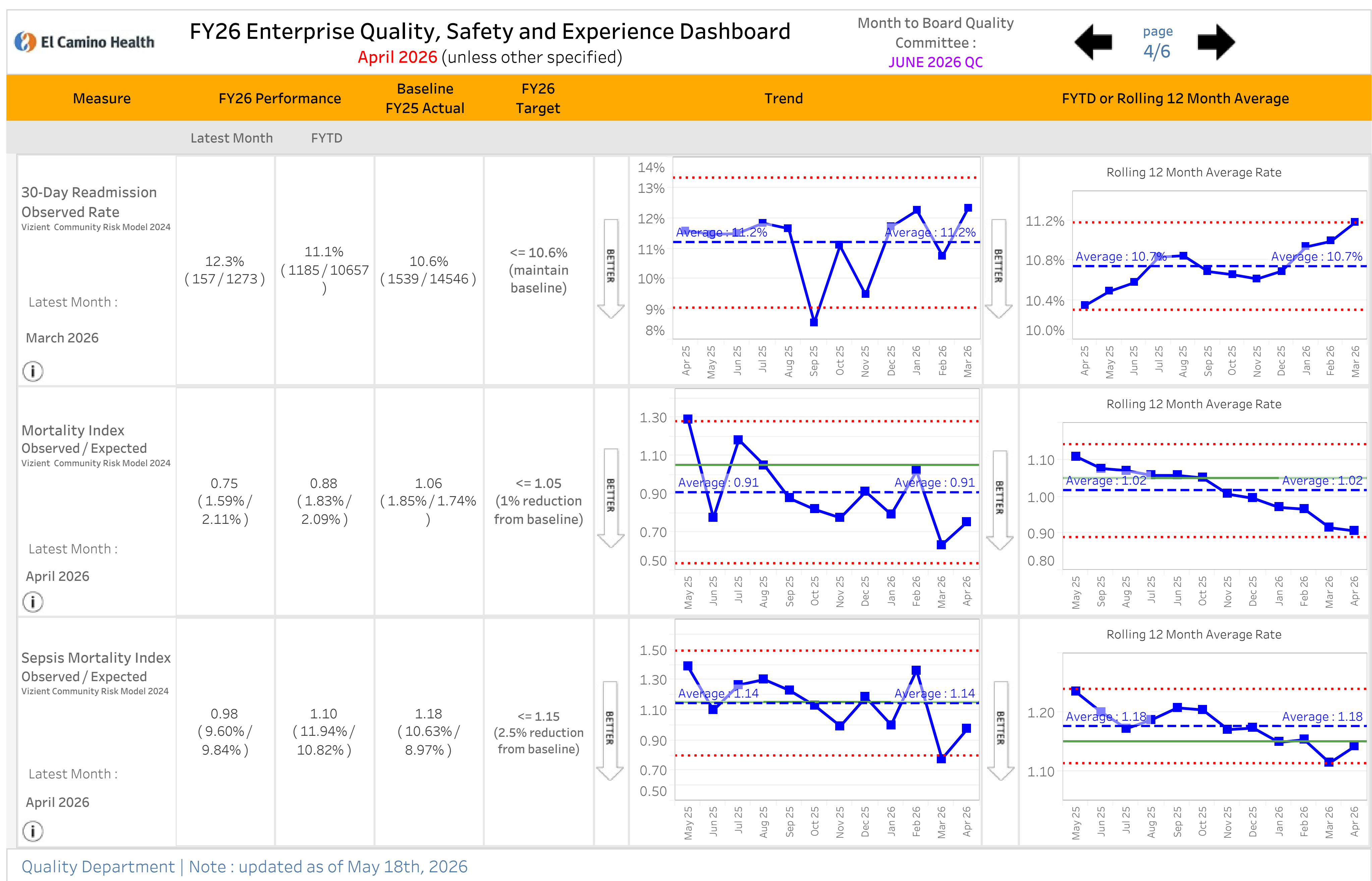
FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

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

page 3/6

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



FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

Month to Board Quality Committee : JUNE 2026 QC

page 4/6

Measure	FY26 Performance: Latest Month	FY26 Performance: FYTD	Baseline FY25 Actual	FY26 Target
30-Day Readmission Observed Rate (Vizient Community Risk Model 2024); Latest Month : March 2026	12.3% (157 / 1273)	11.1% (1185 / 10657)	10.6% (1539 / 14546)	<= 10.6% (maintain baseline)
Mortality Index Observed / Expected (Vizient Community Risk Model 2024); Latest Month : April 2026	0.75 (1.59% / 2.11%)	0.88 (1.83% / 2.09%)	1.06 (1.85% / 1.74%)	<= 1.05 (1% reduction from baseline)
Sepsis Mortality Index Observed / Expected (Vizient Community Risk Model 2024); Latest Month : April 2026	0.98 (9.60% / 9.84%)	1.10 (11.94% / 10.82%)	1.18 (10.63% / 8.97%)	<= 1.15 (2.5% reduction from baseline)

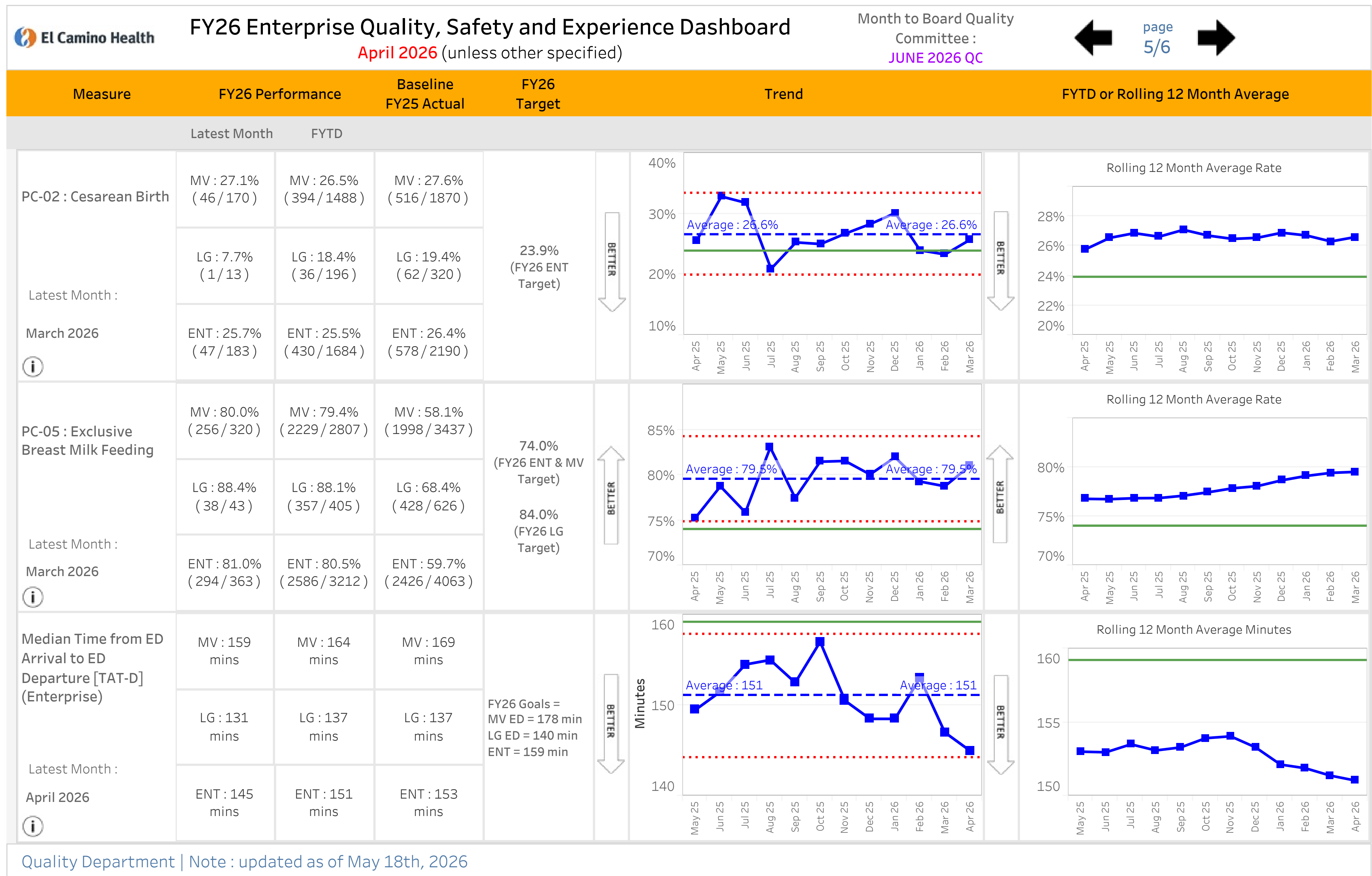
El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

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

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



El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

Month to Board Quality Committee : JUNE 2026 QC

page 5/6

Measure	FY26 Performance Latest Month	FY26 Performance FYTD	Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
PC-02 : Cesarean Birth Latest Month : March 2026	MV : 27.1% (46 / 170)	MV : 26.5% (394 / 1488)	MV : 27.6% (516 / 1870)	23.9% (FY26 ENT Target)		
	LG : 7.7% (1 / 13)	LG : 18.4% (36 / 196)	LG : 19.4% (62 / 320)			
	ENT : 25.7% (47 / 183)	ENT : 25.5% (430 / 1684)	ENT : 26.4% (578 / 2190)			
PC-05 : Exclusive Breast Milk Feeding Latest Month : March 2026	MV : 80.0% (256 / 320)	MV : 79.4% (2229 / 2807)	MV : 58.1% (1998 / 3437)	74.0% (FY26 ENT & MV Target) 84.0% (FY26 LG Target)		
	LG : 88.4% (38 / 43)	LG : 88.1% (357 / 405)	LG : 68.4% (428 / 626)			
	ENT : 81.0% (294 / 363)	ENT : 80.5% (2586 / 3212)	ENT : 59.7% (2426 / 4063)			
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : April 2026	MV : 159 mins	MV : 164 mins	MV : 169 mins	FY26 Goals = MV ED = 178 min LG ED = 140 min ENT = 159 min		
	LG : 131 mins	LG : 137 mins	LG : 137 mins			
	ENT : 145 mins	ENT : 151 mins	ENT : 153 mins			

El Camino Health

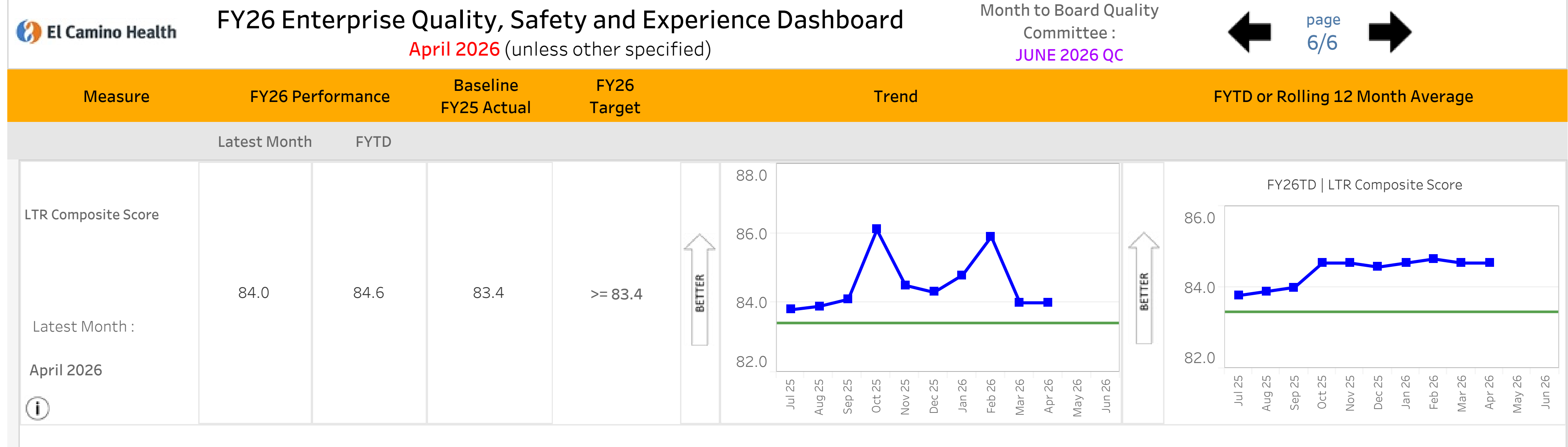
FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

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

page
5/6

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**

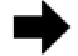


Quality Department | Note : updated as of May 18th, 2026

FY26 Enterprise Quality, Safety and Experience Dashboard

April 2026 (unless other specified)

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



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

EL CAMINO HOSPITAL BOARD
QUALITY COMMITTEE MEETING COVER MEMO

To: ECH Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, MD, MBA, Chief Quality Officer
Date: June 1, 2026
Subject: FY26 30-Day All-Cause Readmission Analysis Executive Summary

10.9%	14.8%	12.9%	15.4%
FY26 FYTD Rate	**Highest Service Line**	**Highest Payer**	**Highest Age Group**
vs. ≤10.6% target	Pulmonary/Critical Care	Medicare	Age >100 / 90s cohort

KEY FINDINGS

Overall Performance: The readmission rate has been trending higher in the last few months, a spike warranting a deep dive.

Discharge Disposition: Patients discharged to Skilled Nursing Facilities (SNF) carry the highest average readmission rate at 15.4%, followed by Home Health Care Services (14.1%) and Home Self Care (8.5%). These three categories collectively represent the highest-leverage intervention points, particularly given that 19–20% of readmissions from each group occur within the first 3 days of discharge.

Timing of Readmission: Across all three discharge dispositions, 37–40% of readmissions occur within 4–7 days of discharge. This window represents the highest-impact intervention zone — suggesting that enhanced post-discharge follow-up protocols, medication reconciliation, and early primary care or specialist touchpoints within the first week could prevent a significant proportion of returns.

Service Line Concentration: Pulmonary/Critical Care (14.8%), Oncology (13.8%), and General Medicine (13.1%) lead by readmission rate. General Medicine is by far the highest-volume service with 7,107 discharges, making even modest rate improvement there highly impactful systemwide. Cardiology (10.7%, 1,855 discharges) represents a high-volume, above-average-rate opportunity aligned with existing heart failure management programs.

Age Gradient: Readmission rates rise sharply with age — from 6.5% in patients under 30 to 15.4% in those over 100 years old. Patients aged 60–80 represent the highest absolute volume of readmissions given discharge counts of 2,262–3,105 per decade.

Payer & Insurance: Medicare carries the highest readmission rate at 12.9% (7,006 discharges), representing both the greatest volume and the largest CMS penalty exposure under the Hospital Readmissions Reduction Program (HRRP). Among specific plans, Aetna–Stanford Health Alliance (18.8%), Alignment Health Plan SR HMO Sutter (17.3%), and Valley Health Plan Medi-Cal MC (15.8%) demonstrate outlier rates warranting payer-specific care coordination review.

READMISSIONS AT A GLANCE — PRIORITY SEGMENTS

Segment	Rate	Volume	Notable Finding
Pulmonary/Critical Care	**14.8%**	123	Highest rate; COPD/respiratory cases drive returns
Oncology	**13.8%**	1,061	High rate + significant volume; chemo & post-surgical returns
General Medicine	**13.1%**	**7,107**	Highest volume by far — even 1% rate reduction = ~71 fewer readmissions/year
SNF Discharge Disposition	**15.4%**	224 avg/month	Highest by discharge type; SNF quality & communication gaps
Medicare	**12.9%**	**7,006**	HRRP penalty exposure; highest volume

Attachment: Readmission Analysis Data Presentation

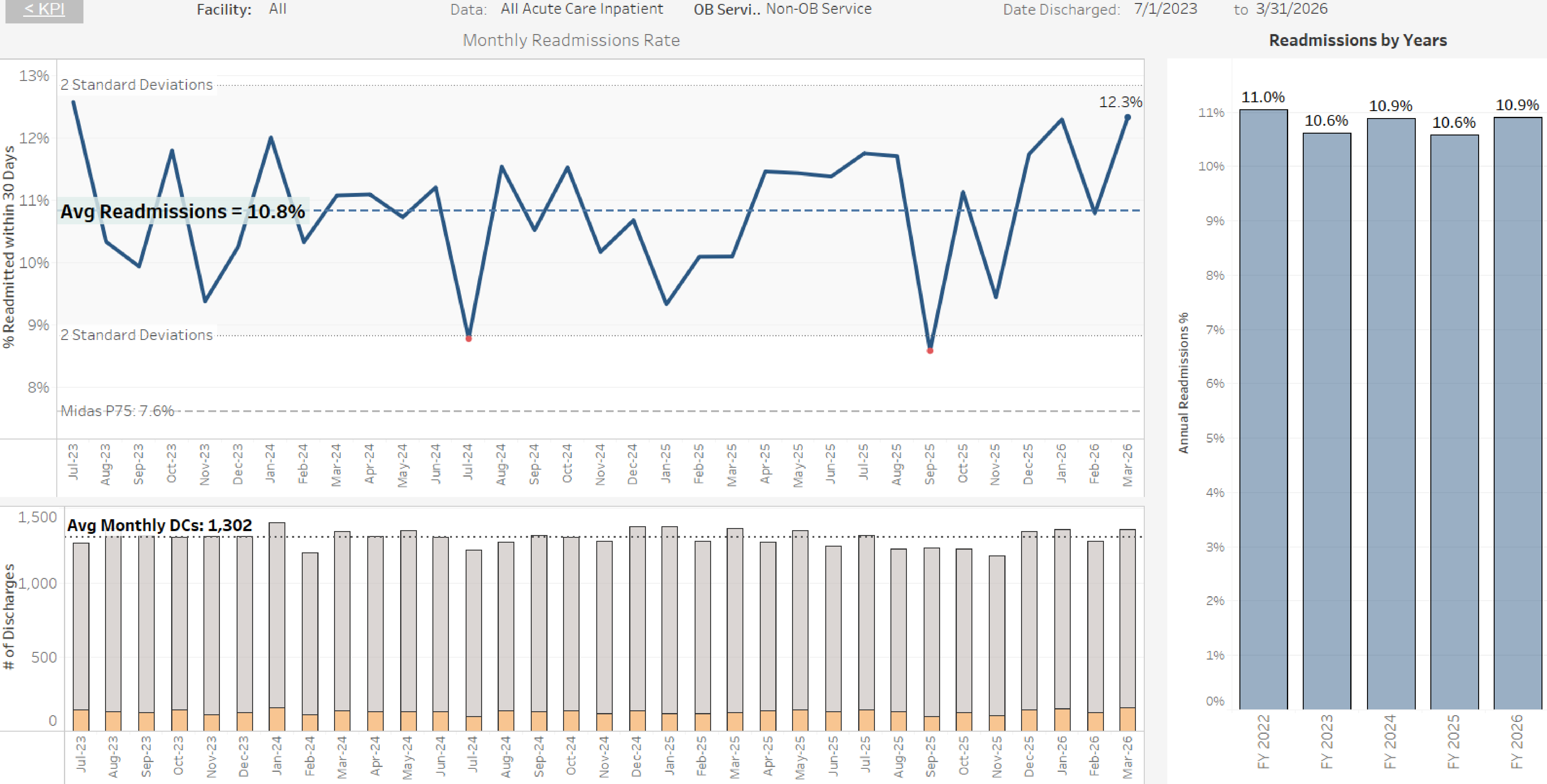
Readmission Analysis Data

Quality, Patient Care, and Patient Experience Committee

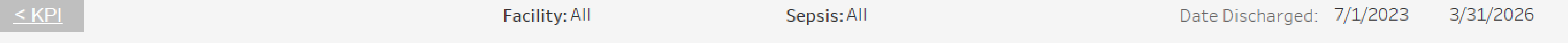
Shreyas Mallur, MD, MBA

June 1, 2026

30 Days All Cause Readmissions Overview



30 Days All Cause Readmissions by Discharge Dispositions



30 Day Readmissions by Discharge Dispositions

Days to Readmissions Distribution

El Camino Health

< KPI

Facility: All | Data: All Acute Care Inpatient | Sepsis: All | Date Discharged(Exclude Last 30 D.. 4/1/2025 to 3/31/2026

Distribution - Days to Readmissions

Days to Readmission: 0 to 3 Days | 4 to 7 Days | >=8 Days

Home Health Care Svc: 19.5% (day 3), 37.5% (day 7)

SNF: 13.1% (day 3), 32.1% (day 7)

Home Self Care: 19.2% (day 3), 40.0% (day 7)

Numbers of Days to Readmissions

Readmissions by Age Group (Rolling 12 months, April 2025 to March 2026)

30-Days Readmissions %

Age Group	30-Days Readmissions %
10	6.5%
20	6.5%
30	7.3%
40	10.6%
50	10.4%
60	11.7%
70	12.0%
80	11.0%
90	13.7%
>100 Y.O.	15.4%

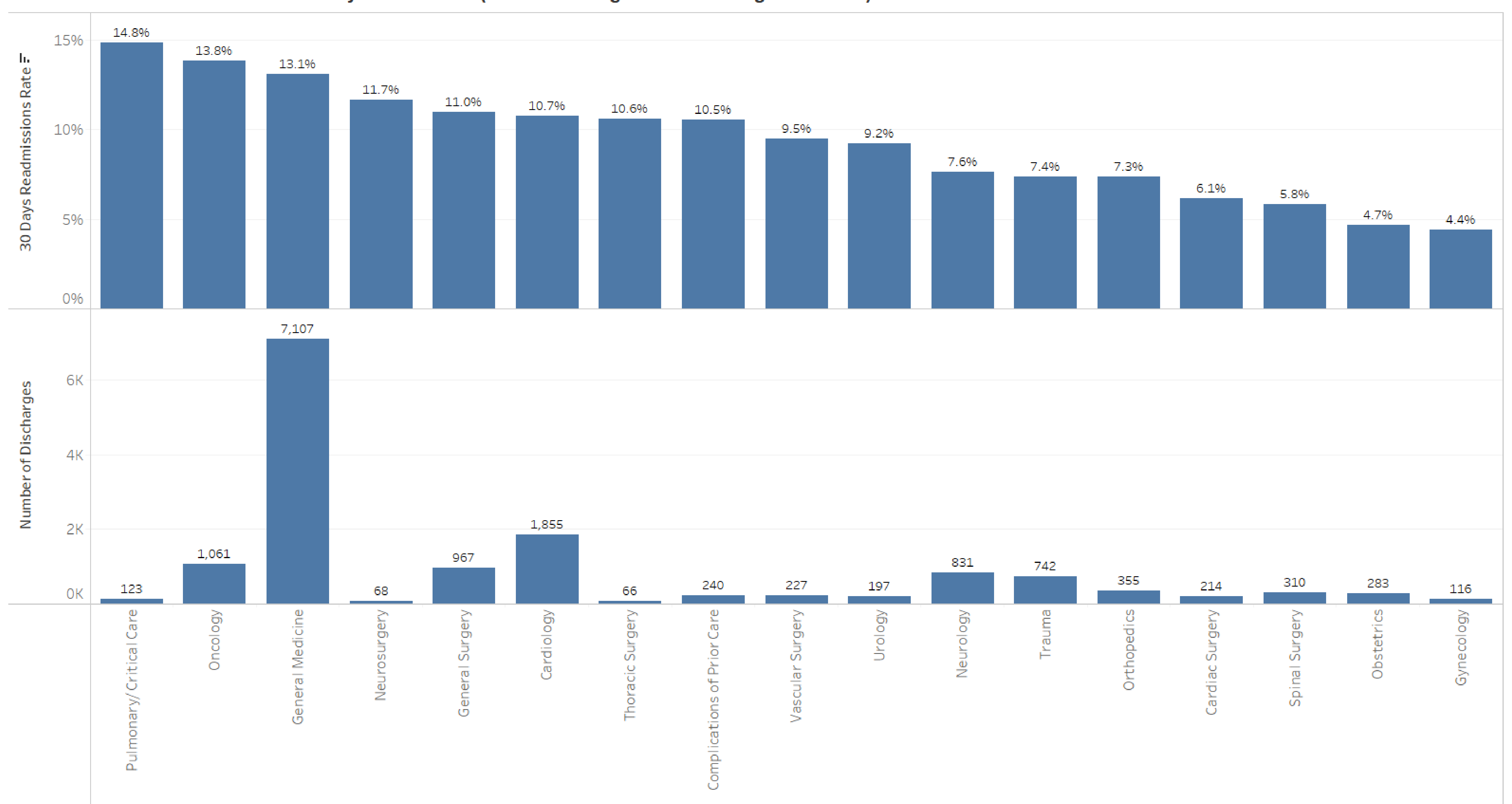
Discharge Count

Not Readmitted
Readmitted

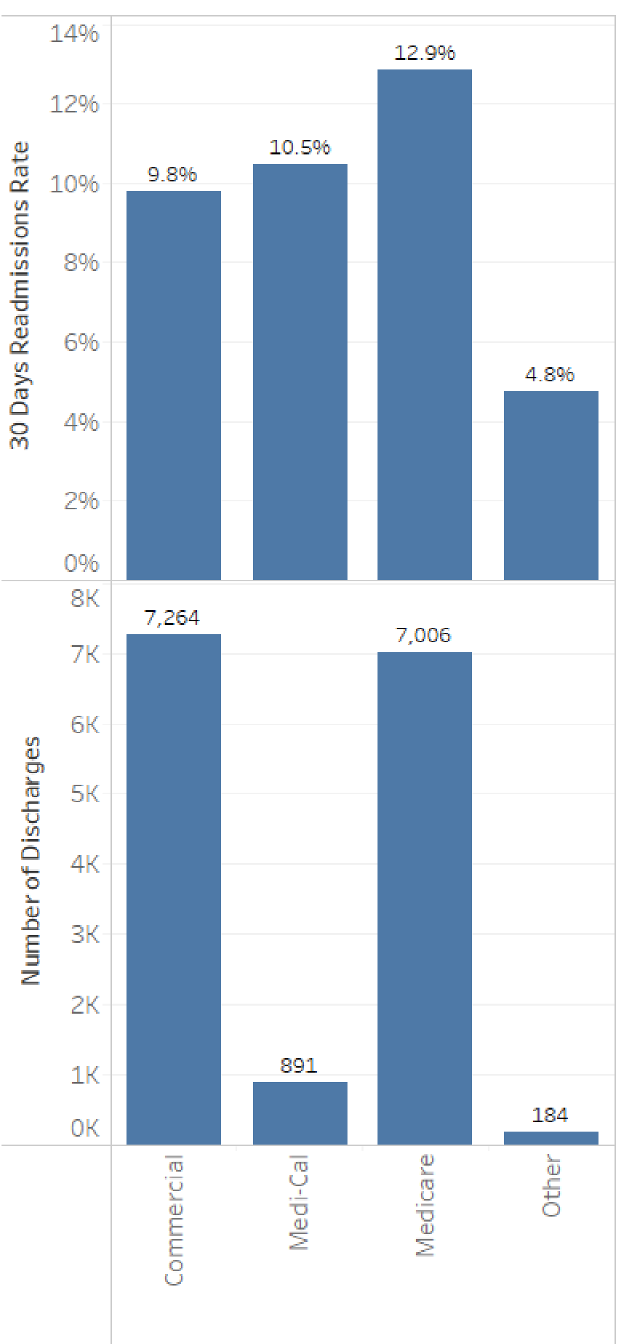
Age Group	Not Readmitted	Readmitted
0	202	
20	392	
30	862	
40	913	
50	1,361	
60	2,262	276
70	3,093	392
80	3,105	360
90	1,447	213

Age Group

ECH: All Cause Readmissions Rate by Service Line (>= 30 Discharges within rolling 12 months)



Readmissions by Insurance Payor



Readmissions by Insurance Plan (Medicare not shown)

30 Days Readmissions Rate

18%
16%
14%
12%
10%
8%
6%
4%
2%
0%

AETNA - STANFORD HEALTH ALLIANCE (18.8%)
MEDI-CAL MANAGED CARE GENERIC (16.9%)
ALIGNMENT HEALTH PLAN SR HMO SUTTER (17.3%)
VALLEY HEALTH PLAN MEDI-CAL MC (15.8%)
ALIGNMENT HEALTH PLAN SR BALANCE PPO (13.9%)
ANTHEM BLUE CROSS MEDI-CAL HMO OTHER (13.4%)
SCFHP MEDI-CAL HMO OTHER (13.2%)
SCFHP DUAL CONNECT SR HMO OTHER (11.7%)
SCAN HEALTH PLAN SR HMO ECHMN (11.0%)
UHC - MEDICARE ADVANTAGE PPO (10.5%)
ANTHEM BLUE CROSS PPO/EPO (8.9%)
BLUE SHIELD PPO (9.0%)
AETNA PPO EPO (7.9%)
ANTHEM BLUE CROSS PRUDENT BUYER (7.6%)
COVERED CA ANTHEM BLUE CROSS PPO/EPO (5.5%)
UHC SELECT PPO EPO (5.0%)
UHC CHOICE/CHOICE PLUS PPO (3.9%)
CIGNA PPO (4.0%)
(2.2%)
HEALTH PLAN OF SAN MATEO (0.0%)

0 50 100 150 200 250 300 350 400 450 500 550 600 650 700 750

EL CAMINO HOSPITAL BOARD
QUALITY COMMITTEE MEETING COVER MEMO

To: ECH Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, MD, MBA - Chief Quality Officer
Date: June 1, 2026
Subject: Proposed FY27 STEEEP Dashboard Refresh

Purpose: This memorandum requests the Quality Committee review and discuss three targeted changes to the FY2027 STEEEP Quality Dashboard. These changes are designed to sharpen our organizational focus, align measures with enterprise-wide strategic goals, and direct operational attention to areas where El Camino Health can most meaningfully improve patient outcomes and system efficiency.

SUMMARY OF PROPOSED CHANGES

Change	Measure Affected	STEEEP Domain	Action
1	**NTSV C-Section Rate**	Safe	**REMOVE** from FY2027 dashboard
2	**CMS SEP-1 Bundle Compliance**	Effective	**ADD** as a new FY2027 measure
3	**Length of Stay**	Efficient	**MODIFY** from O/E ratio to Observed LOS; target = prior year − 0.1 day

DETAILED RATIONALE

Change 1 — Remove: NTSV C-Section Rate (Safe Care Domain)

- The Nulliparous, Term, Singleton, Vertex (NTSV) C-section rate has historically served as a patient safety marker; however, it has increasingly proven difficult to move at the health-system level through quality improvement alone.
- Achieving meaningful reduction requires sustained change in obstetric practice culture, patient expectations, and physician decision-making — factors that are not reliably responsive to dashboard-level accountability mechanisms within a single fiscal year.
- Continued inclusion risks diverting Quality Committee attention and organizational resources toward a measure with limited near-term actionability. Removing it allows reallocation of focus to measures where improvement efforts have greater likelihood of measurable impact.
- The clinical program will continue to monitor NTSV C-section rates internally through the Perinatal Quality Improvement Committee and report to the Quality Committee as needed, ensuring appropriate oversight without formal dashboard inclusion.

Change 2 — Add: CMS SEP-1 Bundle Compliance (Effective Care Domain)

- Sepsis remains one of the leading causes of in-hospital mortality. For FY2027, reducing the Hospital Mortality O/E Index has been elevated to an enterprise organizational goal. SEP-1 bundle compliance is a direct, evidence-based lever to drive that outcome.
- The SEP-1 measure — Timely and Appropriate Management of Sepsis — is a CMS-mandated core measure. Board-level visibility creates accountability alignment between the Quality Committee's oversight function and the organization's most critical safety imperative for the fiscal year.
- Note: SEP-1 data has a reporting lag; CMS chart-abstracted data for FY2027 will be updated as results become available.
- Adding SEP-1 to the STEEEP dashboard ensures the Board has direct visibility into sepsis management performance alongside the Mortality O/E Index, enabling a complete picture of the organization's progress toward its enterprise mortality goal.

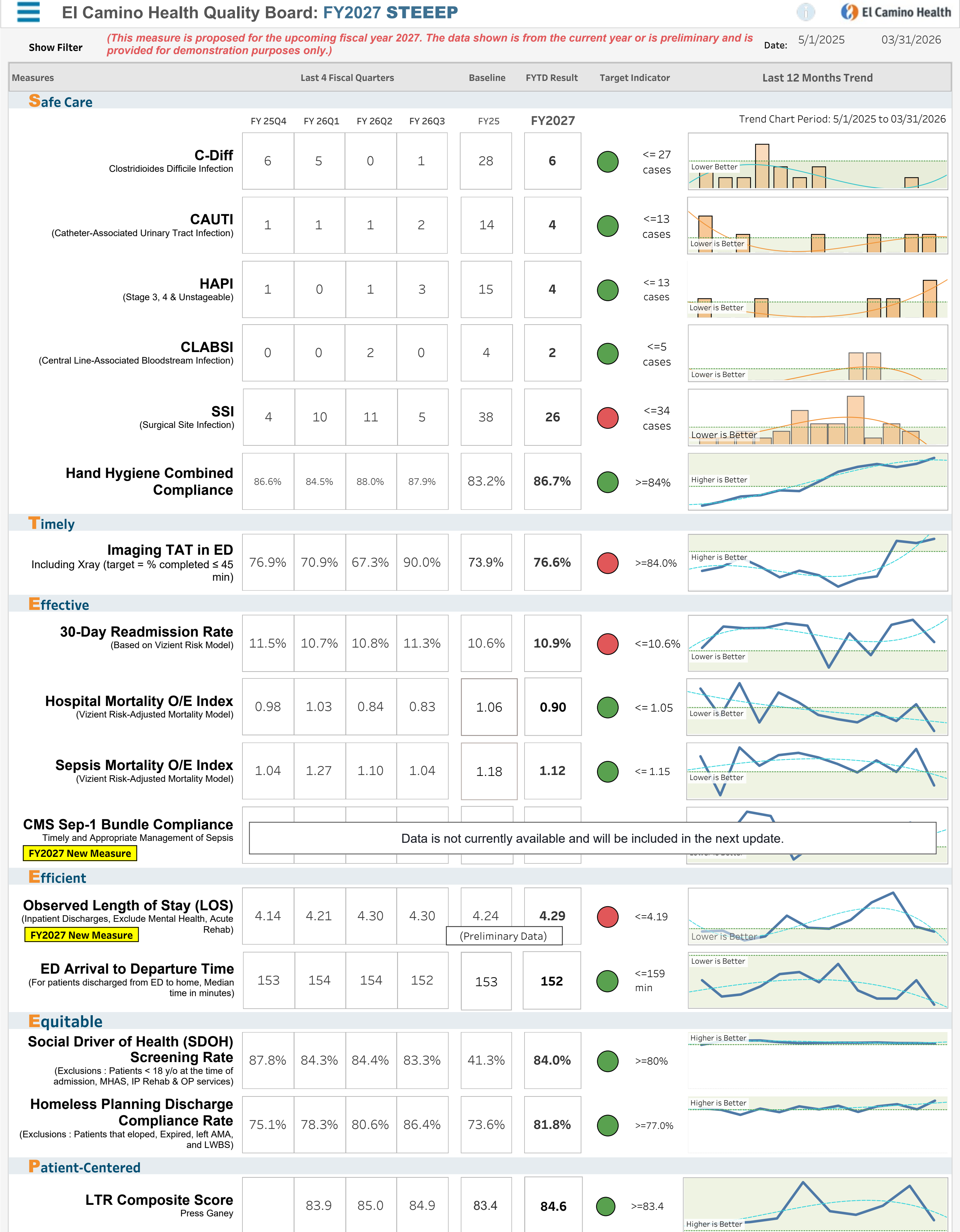
Change 3 — Modify: Length of Stay — O/E Ratio to Observed LOS (Efficient Care Domain)

- The current LOS measure tracks the Observed-to-Expected (O/E) ratio using Vizient risk-adjustment. While methodologically sound for external benchmarking, the O/E ratio is a relative metric that can mask real changes in patient throughput and does not directly translate into operational action for frontline teams.
- Shifting to Observed LOS (in days) provides a direct, tangible metric that case management, hospitalists, nursing, and care coordination teams can act on in real time. It aligns health system resources — bed management, discharge planning, and clinical workflows — toward reducing actual patient days rather than a modeled ratio.
- The Vizient O/E LOS ratio will continue to be reported internally to the Quality leadership team for benchmarking purposes, ensuring no loss of comparative intelligence while improving the actionability of the Board-level measure.

GOVERNANCE & OVERSIGHT

- These proposed changes were developed in alignment with El Camino Health's FY2027 organizational strategy and the STEEEP framework for quality measurement.
- Removal of NTSV C-section rate does not eliminate clinical monitoring; the Perinatal Quality Improvement Committee retains accountability for that metric.
- The Vizient O/E LOS ratio will be maintained as an internal operational benchmark reported to Quality leadership.
- These measures will appear on the FY2027 STEEEP Quality Board dashboard effective Q1 FY2027.

Attachment: Proposed FY27 STEEEP Dashboard



El Camino Health Quality Board: FY2027 STEEEP

El Camino Health

Show Filter

(This measure is proposed for the upcoming fiscal year 2027. The data shown is from the current year or is preliminary and is provided for demonstration purposes only.)

Date: 5/1/2025 03/31/2026

Trend Chart Period: 5/1/2025 to 03/31/2026

Measures	FY 25Q4	FY 26Q1	FY 26Q2	FY 26Q3	Baseline FY25	FYTD Result FY2027	Target Indicator	Target	Last 12 Months Trend
Safe Care									
C-Diff Clostridioides Difficile Infection	6	5	0	1	28	**6**	Green	<= 27 cases	Lower Better
CAUTI (Catheter-Associated Urinary Tract Infection)	1	1	1	2	14	**4**	Green	<=13 cases	Lower is Better
HAPI (Stage 3, 4 & Unstageable)	1	0	1	3	15	**4**	Green	<= 13 cases	Lower is Better
CLABSI (Central Line-Associated Bloodstream Infection)	0	0	2	0	4	**2**	Green	<=5 cases	Lower is Better
SSI (Surgical Site Infection)	4	10	11	5	38	**26**	Red	<=34 cases	Lower is Better
Hand Hygiene Combined Compliance	86.6%	84.5%	88.0%	87.9%	83.2%	**86.7%**	Green	>=84%	Higher is Better
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	76.9%	70.9%	67.3%	90.0%	73.9%	**76.6%**	Red	>=84.0%	Higher is Better
Effective									
30-Day Readmission Rate (Based on Vizient Risk Model)	11.5%	10.7%	10.8%	11.3%	10.6%	**10.9%**	Red	<=10.6%	Lower is Better
Hospital Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	0.98	1.03	0.84	0.83	1.06	**0.90**	Green	<= 1.05	Lower is Better
Sepsis Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.04	1.27	1.10	1.04	1.18	**1.12**	Green	<= 1.15	Lower is Better
CMS Sep-1 Bundle Compliance Timely and Appropriate Management of Sepsis **FY2027 New Measure**	Data is not currently available and will be included in the next update.								
Efficient									
Observed Length of Stay (LOS) (Inpatient Discharges, Exclude Mental Health, Acute Rehab) **FY2027 New Measure**	4.14	4.21	4.30	4.30	4.24 (Preliminary Data)	**4.29**	Red	<=4.19	Lower is Better
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	153	154	154	152	153	**152**	Green	<=159 min	Lower is Better
Equitable									
Social Driver of Health (SDOH) Screening Rate (Exclusions : Patients < 18 y/o at the time of admission, MHAS, IP Rehab & OP services)	87.8%	84.3%	84.4%	83.3%	41.3%	**84.0%**	Green	>=80%	Higher is Better
Homeless Planning Discharge Compliance Rate (Exclusions : Patients that eloped, Expired, left AMA, and LWBS)	75.1%	78.3%	80.6%	86.4%	73.6%	**81.8%**	Green	>=77.0%	Higher is Better
Patient-Centered									
LTR Composite Score Press Ganey		83.9	85.0	84.9	83.4	**84.6**	Green	>=83.4	Higher is Better

EL CAMINO HOSPITAL BOARD
QUALITY COMMITTEE MEETING COVER MEMO

To: ECH Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, M.D, MBA Chief Quality Officer
Date: June 1, 2026
Subject: Organizational Quality Incentive Goals – Methodology, Calibration, and Proposed Targets

Motion: Recommend Board approval of the proposed FY2027 Enterprise Quality and Patient Experience-Related Incentive Metrics and Goal-Setting Methodologies

FY2027 PROPOSED QUALITY GOALS

#	Goal / Measure	Plan Weight	FY26 Baseline	Threshold	Target (−2.5%)	Stretch (−5%)
1	**Risk-Adjusted Mortality Index (RAMI) — O/E Ratio Vizient Risk-Adjusted, AHRQ v2025**	**17%** of overall plan	TBD (YTD 0.99)	**Maintain FY26**	**>/= (−2.5%) Off baseline**	**>/= (−5%) Off baseline**
2	**Hospital-Acquired Pressure Injuries (HAPI) Stage II+ (NDNQI definition) — Monthly Average**	**17%** of overall plan	TBD	**Maintain FY26**	**>/=(−2.5%) → ~0.25 SD**	**>/=(−5%) → ~0.5 SD**
	Patient Experience	**Weighting**	**FY26 Baseline**	**Threshold**	**Target**	**Stretch**
1	**Likelihood to Recommend - Composite**		TBD	**FY26 × 0.98**	**Maintain FY26**	**FY26 × 1.02**