AGENDA
SPECIAL MEETING OF THE
EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS

Wednesday, August 13, 2025 – 5:00 pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 2

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: 923 4610 2834#. No participant code. Just press #.

To watch the meeting, please visit:

ECHD Meeting Link

Please note that the livestream 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.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	George Ting, M.D., Board Chair	Information	**5:00**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	George Ting, M.D., Board Chair	Information	**5:00**
3.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons desiring 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 District Board of Directors at 2500 Grant Road, 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 to the agenda.*	George Ting, M.D., Board Chair		**5:00**
4.	**DISTRICT BOARD CHAIR ELECTION**	George Ting, M.D., Board Chair	**Motion Required**	**5:00 – 5:25**
5.	**ADJOURNMENT**	George Ting, M.D., Board Chair	**Motion Required**	**5:25 pm**

Upcoming Meetings:; October 14, 2025; February 10, 2026; March 10, 2026; May 19, 2026; June 23, 2026

A copy of the agenda for the Special Board 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.

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: George Ting, MD, Board Chair
Date: August 13, 2025
Subject: Board Officer Elections

Recommendation(s):

To elect _____ as ECHD Board Chair for a term of two years effective July 1, 2025.

Summary:

1. Situation: The current Board Officer terms expire on June 30, 2025. The election for Board Chair was not completed at the June ECHD meeting.

2. Authority: Pursuant to Article III, Section 4 of the El Camino Healthcare District Bylaws, before July 1st of every odd-numbered year, the District Board shall elect officers from District Directors then in office by majority vote.

3. Background: It has been the Board's practice over the last several years to elect its Board Officers through nominations from the floor at the meeting when the election is held or declaring their interest in serving in advance of the meeting. Director George O. Ting and Director John Zoglin have both declared interest in serving as Board Chair.

4. Outcomes: Board Chair for FY26 and FY27 elected.

List of Attachments:

1. FY25 District Board Officers Nomination and Election Procedure
2. Statement of George Ting, MD
3. Concept Paper – Physician Culture and Competency in a Community Hospital
4. Statement of John Zoglin

DISTRICT BOARD OFFICERS
NOMINATION AND ELECTION PROCEDURE

Any current director of the El Camino Healthcare District Board is eligible to serve as a District Board Officer. The new District Board Officer terms begin July 1, 2025. El Camino Healthcare District Board Officer elections shall be held in June of odd-numbered years.

District Board Chair, Vice-Chair and Secretary/Treasurer:

1. Interested Directors will declare their interest in serving as an officer to the District Board Chair and CEO by close of business on June 6, 2025. Interested Directors will prepare a one-page Position Statement that summarizes the candidate's interest and relevant experience as it relates to the applicable position.

2. Position Statements will be distributed to Board members along with other District Board materials in advance of the June 17, 2025 meeting and will be made available to the public and posted on the El Camino Hospital website when the District Board materials are issued to the Board.

3. At the June 17, 2025 District Board meeting, additional interested Directors may announce their candidacy or nominations may be taken from the floor. Upon review and discussion of the candidates, the Board will vote in public session. The current Chair will facilitate the discussion and voting process.

4. The Board will elect each officer in accordance with the following procedure at a meeting where a quorum is present. The preliminary balloting can be eliminated when there is only one candidate for an officer position.

    a. Preliminary Balloting

        i. Each Board member shall vote for a candidate via electronic or paper ballot submission simultaneously to a neutral party who will announce the vote cast by each Director.
        ii. In the event a majority of votes cast is not achieved, the vote will be announced for each candidate, and the candidate receiving the lowest number of votes will be dropped from the next ballot.
        iii. This procedure will continue until one candidate receives a majority of the votes cast.
        iv. In the event a tie vote occurs (e.g., 2-2 or 1-2-2), interested Directors may be asked additional questions by District Board members, and the balloting procedure will continue until one candidate achieves a majority of votes cast.

    b. Motion

        i. Following the preliminary balloting, the Board shall consider a motion to elect the candidate who has received the majority of the votes in his/her favor.
        ii. If a motion pursuant to Section 7(b)(i) is not adopted by a majority of the Board members present at the meeting when a quorum is present, the Board shall continue to consider motions until a Board officer is elected.

George O. Ting M.D. Statement for Chair of District Board of Directors (DBOD) 2025-2027

I am running for DBOD Chair again because I feel I have unfinished business, so for now, continuity trumps the good arguments to share and rotate the role. At this point you are familiar with my leadership's good and bad points: I try to find the right balance between good timekeeping during our meetings, yet allow for full discussions when productive; to maintain decorum and professionalism in meetings, but having fun and humor together helps team spirit; to remember my role and responsibility to each of you and your ideas, and make sure we follow up and keep building on the ideas that have some traction, whether it is population health, or potential benefits of leveraging District real estate.

I think we made some important strides together in the past two years:

- At the top of the list, we have continued and improved our Community Benefit Program, with better DB presence at many of the grant site visits. The review and approval process has been successfully streamlined.
- We are committed to enhancing our relationship with the community. Our first newsletter was not our best work. I am grateful to Administration for their increased attention and resources that will allow us to do better. The next newsletter will be better, and I think some of the Administrative support stems from the DB speaking more clearly with one voice.
- Part of this has been due to working better as a team. We still have work to do, but our individual and group work has made a difference. I sense we value the progress we have been making together. In a word (or so), we have developed a better culture for the DB.
- We have had interesting discussions needing further deliberation on matters such as the DB's persistent interest in our real estate holdings.
- We are developing an identity beyond simply being good stewards of our community benefit funds. We have articulated a higher purpose for the DBOD, and until we find the right catch-phrase, "making our community the healthiest in the nation" says it for now. It has driven us to matters of population health, and tackling prediabetes as a starter, which is something we must monitor carefully for its risk/benefit ratio.

What I would like to see, if I have your support:

- The first is continue what we have been doing: Team building, enhancing community relationships, maintaining and improving our current CB programs, being very deliberate about the benefits and risks of new programs such as population health. But there is more.
- I believe our new-found DB purpose statement is important in a number of ways, because it is somewhat different from the purpose of ECH. ECH's operating goal, is to succeed in "the business of healthcare" as well as to "be good by doing good". As Lincoln is purported to have said to his ardent progressive congressman, knowing which direction the north star is does not tell you of the swamps and pitfalls along the way. The business of healthcare always crosses through many dangerous songs of Sirens, as the United Healthcare is one example out of many. The DB purpose is said equally well by "best healthcare in the country" or always "making the patient the primary customer": both allude to quality of healthcare being more important than the business. If ECH is successful as we all hope, there will be many times that the DB will need to be the guiding light to do things the right way: the El Camino Healthcare way.
- In my mind, that is the identity of the DB, which has been somewhat adrift since the remarkable and unselfish decision by prior DBs when they decided to share governance power with appointed HB

members, thereby diluting much of its own identity. This new identity to be a guiding light is necessary for the DB to do great things, and we can start now.

- As I have said *ad nauseum* during Board meetings, the quality of our network physicians (outpatient) is not where we want it to be. In the spirit of better quality as equally important as being successful, I have poked this governance nose into the management tent (somewhat) to put forth a novel plan to improve the competencies of those physicians. I have written a white paper describing how ECHMN can do better, recognizing that is not something a Board member should do, but in this case, I believe needs to be done. I therefore present it as a proposal for management (and the medical staff) to consider, and to reject, modify, or implement as they see fit, and for me to get my hands out of this after presenting it.

- After reading this (attached) the DB can decide if they think it is appropriate to give a thumbs up simply as indication of support. I hope that having that imprimatur will promote acceptance by the ultimate decision makers which are Administration and the Medical Staff Organization.

- Furthermore our efforts to clarify a District real estate strategy has led to the intriguing thought that there may be ways to expand the District balance sheet (more revenue) without adversely affecting ECH's balance sheet. This could increase the options for us to advance community health, either through the current CBP, or allow us to try other avenues.

- Another issue that has been raised but needs more discussion, is the matter of ECH BOD size and composition. Should the ECH BOD remain an even number that does not include the CEO? Although that is a matter for the ECH BOD to ultimately decide, the appointment of non-elected Board members is one of the most important DBOD functions.

I end with an apology for being long-winded. As Lincoln is also purported to have said: "Once I get going I'm too lazy to stop when I should" With this I nonetheless end up asking for your support.

George Ting

Memo to El Camino Healthcare District Board of Directors

Fellow District Board members:

I am submitting this Concept Paper for us to review, as part of the District Board's purpose of "Making our community the healthiest in California" (Dan said "in the world" at the recent Sunnyvale Community dinner, but a less ambitious claim may lend it more credence). My hope is that adding the imprimatur of the ECDB will encourage its acceptance by Administration and the Medical Staff Organization.

I started this paper over a year ago to further elevate ECH's reputation and standing by closing the physician quality gap between ECH and academic medical centers (AMCs). However, improving the ECHMN became more urgent with the difficulty filling its medical president position and stubborn physician quality metrics. The conclusions from the research for my first goal serendipitously is a way to achieve the second: that the methods to close the ECH-AMCs gap would the same as those needed to improve ECHMN as a medical group. That led to this concept paper which I hope will receive enough support from Administration and the Medical Staff Organization to consider piloting a novel project to address some of the ECHMN concerns we have had over the past few years. I acknowledge it is unusual for a Board member to make a concrete proposal rather than broadly advocating for a goal and allow management to figure out the best way to accomplish it.

This paper addresses an important issue for which Administration has not developed a clear strategy in spite of the urgings of the Hospital Board to address it: physician quality and competency. This is distinct from organizational quality which the Board Quality Committee focuses on through its STEEEP approach. I explain this difference in greater detail in the paper.

In recognition of, and respect for the distinct roles of governance and management, I ask the Board to see this as simply a suggestion for management and the medical staff to consider, and to modify and implement if it chooses to, rather than some prescriptive directive. As some of the comments may be less clear for non-clinicians, I have added examples in an appendix to illustrate concepts; the granularity of details is to clarify, not specify.

The essence of the concept is to use those methodologies proven to work in AMCs, and apply them to develop the culture and practice patterns of a high performing physician group. It will be left to management to modify, further define, structure and implement as it sees fit.

George O Ting

In the modern view, boards bear direct responsibility for the hospital's mission to provide quality care. This responsibility cannot be delegated to the medical staff or executive-level administrative and clinical leadership because it is at the very core of the board's fiduciary responsibility.

The Joint Commission Journal on Quality and Patient Safety, 34:4, 2008.

PHYSICIAN QUALITY AND CULTURE AT EL CAMINO HEALTH (ECH)

Ensuring the quality of clinical care is a responsibility shared by hospital administrations and physicians, both governed by the Board of Directors. The hospital administration manages the institutional aspects such as infrastructure, staffing, safety, infection control, regulatory requirements, coordination of services, and patient experiences while the Medical Staff Organization (MSO) oversees physician competencies in diagnoses, treatment and communication. Board quality reports primarily focus on what is under administrative control and leaves medical staff competency issues to the MSO credentialling process and report.

- ECH's existing board quality program has an organization-centered approach defined by the STEEEP processes. Matters of physician clinical competency are delegated to the Medical Staff Organization which reports to the board only through the credentialing and privileging report. It is telling that in board quality discussions more attention is spent on common hospital catheter-related urinary tract infections than in understanding its standardized hospital mortality rate which is the most important metric of hospital and physician quality of care. Efforts to improve ECH mortality rates would require in depth analysis of the complex practice patterns of many interacting physicians, something that is not possible in ECH's current quality assessment system. This underscores the difficulty of gauging physician competency as there are no widely-accepted objective ways to measure it. What is difficult to measure is difficult to monitor or change, and this problem will only become bigger as ECHMN expands further.

- Hospital quality rankings are routinely published, but physicians are harder to rate except by patient review or peer opinion; both are imperfect but used in the absence of better tools. The best method may still be to ask how well someone likes their own doctor. In any discussion of physician quality, however, physician competency must first be clearly defined.

- A good physician is often described as a good listener, thoughtful communicator, empathetic, respectful, and having a good bedside manner. These usually form the basis of physician reviews by their patients. However, every physician knows colleagues with these traits that do not provide high-quality medical care. Patients can be in a safe, well run, and highly regarded hospital such as ECH yet still be uncertain if their particular doctor has good clinical judgment, will make the best clinical decisions based on current evidence-based guidelines (EBGs), or perform complex procedures and treatments according to best practices, as these are not monitored by the quality programs of the hospital or board.

- It is useful then to examine academic medical centers (AMCs) since their primary mission is to produce competent physicians, whether for clinical practice, teaching or research. They have well-established and time-tested methods for teaching, monitoring and guiding physicians.

Academic Medical Center Methods

All AMCs have three essential components in their teaching programs.

1. LEARNING FACTS AND TECHNIQUES. This is the simple part, learning fundamental facts didactically, and procedures and skills through demonstrations and practice. Developing a culture of continuous learning is important as advancements in knowledge and theories demand ongoing critical re-evaluations.

2. LEARNING WHAT TO DO. After accumulating knowledge, the most important competency is learning when and how to apply it in any given situation, as well as the judgment and skill to do it well. When a patient presents with symptoms, it is vital to know what questions need to be asked, and what things need to be done or not done. Over time, clinical judgment is developed through discussions and deliberation.
3. HAVING THE RIGHT ENVIRONMENT AND CULTURE. Sustaining a level of competence over a lifetime depends on working in a culture of learning and accountability. In every AMC, the department chief has the crucial role of maintaining this culture, setting high expectations, and holding physicians accountable for what they do.

As a result of these three elements, a good doctor can be defined as one who:

1. has learned what is needed,
2. has good clinical judgment, makes good decisions on what needs to be done and can do it well,
3. will maintain learning and reliable performance over the long-term.

Other attributes are nice, but the *sine qua non* of a competent physician is knowing what to do and taking those actions at the right time.

Post Training

When a physician enters private practice, there is an abrupt transition from the academic to a non-AMC setting where efficiency and production are prioritized. There are far fewer educational activities and discussions. There is much less oversight or review of one's practice patterns, as each physician is the attending physician. For a young physician, the challenge is to keep learning and maintaining a consistent level of performance for decades. Towards this, the environment and culture are critical factors, and notably, those of a hospital are very different from those of an outpatient practice.

- Hospitals have rigorous quality metrics and programs due to the acute nature of more serious conditions, extensive written policies and procedures, regulatory oversight, and in addition, there is the constant interaction and scrutiny by colleagues, nurses and other professionals. A new physician starting in a hospital culture has an easier time continuing to learn and practice at a high level. ECH has a culture supporting high quality hospital care that has been developed over decades through its proximity to a world class AMC and the high expectations of colleagues and a well-informed community.

- A physician joining an outpatient practice such as ECHMN experiences a culture that is vastly different from that of an AMC. Outpatient practices have less robust quality programs due to the lower acuity of care, less aggressive treatment options, and limited review and regulatory oversight. Physicians work more independently, and this contributes to much wider variations in practice patterns. Most communication is focused on administrative details and the business of healthcare. Without a strong culture prioritizing learning and quality care, tasks and schedules define the culture.

- El Camino Hospital has developed an excellent reputation up to this point. A relevant question is why has this become a problem now? Much of the credit goes to previous nursing leadership which emphasized the importance of compassionate personalized care which is readily apparent. Good doctors from good medical schools chose to practice here and developed the hospital's culture of excellence. Over time outpatient physicians felt confident referring their patients for inpatient specialty care. By and large the ECH reputation reflected the great care from the nurses and inpatient physicians rather than the outpatient referring base.

- Now as ECH includes the outpatient network, the quality of primary care is in the spotlight, and therein lies a problem. Managing outpatient care is difficult at best, especially for a hospital-centric organization

with little experience managing primary care. Six years into our medical network operations, much good work has been done with operations and growth, but the Board must look at ways it can promote outpatient physician competency.

- Ironically, good primary care, which can make the biggest differences in long-term health, is in the department with the greatest practice variation, especially among more senior physicians. Its breadth of responsibilities is the widest in medicine, with ever-increasing new screening and prevention options, and better and more complex outpatient therapies for chronic conditions. Yet its functions are also the most difficult to standardize or measure since linking physician competency to long-term outcomes is impractical, as consequential lifestyle choices fall outside physician control. Implementation of EBGs may benefit primary care the most, not because their care is the most complex, but because it is the broadest, covering every specialty, has the most moving parts and thus is the most improved by regimentation.

- In medicine it is one thing to know what should be done; it is another to do it consistently. No one monitors a physician's every action, and no physician is perfect. The sense of responsibility and duty to always do the right thing is deeply influenced by the expectations of the team's culture. It is insidiously demoralizing when primary care activities are not done well yet there are no consequences. It is detrimental to the organization and quality inevitably declines. Some degree of accountability with constructive feedback for errant actions is necessary to maintain a true culture of excellence.

If the best measure of a competent physician is knowing what to do, there are very limited options to improve competency once out of training. One option is to monitor or test for the required knowledge and if considered deficient, then have the information reviewed. The second option is to continually have formal review and discussion of necessary information among colleagues so all are equally informed, then select the EBGs together to standardize clinical practice. This in fact is what is done at AMCs, where competency is achieved through review, discussions, understanding and developing consensus, not through testing or grading.

CONSIDERATIONS FOR ECH

The concepts in this paper are offered to ECH Administration and the Medical Staff Organization (MSO) and to the ECHMN to consider whether to develop such a Physician Quality and Culture.

ECHMN is a recent assemblage of several subgroups that are not yet well integrated nor share a common culture, and none has a physician quality program. Despite many years, its primary metric, the net promoter score, remains below expectations. The hope that one strong medical president will single-handedly transform ECHMN is not realistic and has risks that can be minimized. ECHMN needs a robust physician quality program now as well as a capable medical president. This proposed PQP would be a durable framework through which physician competency can be defined, and which will evolve as medical standards of care progress. This will be an ambitious endeavor as there are no non-AMC systems known to be formally using such an approach and may best be started as a pilot project, and based on the following principles:

- The adaptation of established AMC processes to be the foundation of a Physician Quality and Culture program,
  - Regular education with colleagues to establish communal evidence-based guidelines to decrease unwarranted practice variation,
  - Create and foster a deep culture competency, learning, collegiality and constructive accountability.

- The traditional role of the division chief in an AMC be filled by the ECH medical directors of service lines, or outpatient medical directors of their respective divisions.
- In order to be accepted by physicians, all medical aspects must be led by clinically active physicians with strong administrative support

It is neither difficult nor complex and uses methods all physicians are familiar with from their training, but will require developing new ways to collaborate among the physicians, management and the board. Being part of a high performing medical group counters physician burnout and improves professional satisfaction. The most far-reaching benefit is directly in line with our mission: the best possible long-term health outcomes for our patients, but much more immediate will be better patient experiences and patient satisfaction with El Camino Health.

The concepts presented above may not be intuitively clear to non-clinicians. An appendix is attached to make the concepts more concrete. The details are strictly to promote understanding, and not to be a recipe or directions on how management may choose to proceed. Acceptance and implementation of the principles and operational procedures will be entirely in the hands of Administration and appropriate physicians. For inpatients, they will be all members of the MSO; for outpatients the members of ECHMN.

APPENDIX: Examples for clarification only

To repeat the critical success factors:

1. This must be led by clinically active physicians
    a. Respected leaders organizing and developing all the guidelines with their colleagues will make the program their own, have credible analyses and have acceptable and appropriate accountability.
2. Proper compensation or mandate for departmental physicians to attend meetings.
    a. The carrot is likely to be more effective, and promote more enthusiasm
3. Have adequate administrative support.
    a. Physicians will know what needs to be done, but those in active practice will not be able to record, implement or track results. They will need administrative help to analyze findings and support follow-up actions.

EXAMPLES OF ONE INPATIENT AND ONE OUTPATIENT DIVISION

This proposal can be piloted in two pivotal departments, one primarily in the hospital, and one primarily in the outpatient clinic.

- For inpatient care, management of chronic obstructive pulmonary disease (COPD) has been recommended to be the pilot project. It is one of the CMS 30-day all-cause, risk-adjusted mortality measures required of all acute care hospitals and contributes 22% to CMS Overall Star Ratings, and one in which we have most difficulty.
    - The pulmonary medical director (MDD) will distill the current published EBGs from organizations such as the American Thoracic Society (ATS), American Lung Association (ALA), American College of Chest Physicians (AACP), Society of Critical Care Medicine (SCCM), and Critical Care Societies Collaborative (CCSC), then have periodic meetings with all inpatient and ECHMN outpatient pulmonologist and intensivists to review and tailor the guidelines for use throughout ECH and be used through EPIC.

        - In the future, improving our COPD mortality index will be possible as we can analyze whether it is the EBGs that need to be strengthened, or if it is a matter of inadequate physician adherence to the EBGs.
    - In this division, how to monitor physician adherence to the EBGs and whether or how to give feedback will be left to the division.

- For outpatient care, standardization of primary care activities could be the pilot project. The primary care physician (PCP) is usually the public's first encounter with ECH, is crucial for overall long-term patient health outcomes and would derive the most benefit from standardization of practice patterns. If done well, this PQP will improve patient outcomes, satisfaction and retention. Mastery of the PCP roles and responsibilities can be the key to elevating perceptions of ECHMN.
    - The primary care MDD will:
        - distill the recommended guidelines from major primary care organizations such as the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), Primary Care Associations (PCAs) and the North American Primary Care Research Group (NAPCRG) for ECH use.
        - have periodic meetings with all ECHMN primary care physicians to review these guidelines and develop the consensus guidelines to be used by every PCP through EPIC.

    - There are two major components to primary care: Screening and Prevention, and Treatment of Chronic Conditions.
        - For screening and prevention, EBGs will specify which procedures, such as vaccinations, are appropriate for which age and risk group, as well as frequency and how to follow up on results. Adherence can be tracked through EPIC.
        - For the very important treatments of chronic conditions, EBGs will specify roles and responsibilities between PCPs and specialists, establish optimal targets for treatment outcomes, and thresholds for referrals if targets are not met.
            - Treatment targets will be guided by best evidence and usually be more aggressive than what is reported to CMS (through HEDIS, or Healthcare Effectiveness Data and Information Set, which represents minimum rather than optimum standards).
                - Achieving optimal standards where possible can result in significantly better long-term outcomes.
            - Coordination of care for discharged patients with certain diagnoses should be included in the EBGs for inpatient and outpatient care. As an example, when the patient with AMI is discharged from the hospital, there will be specific instructions on when the patient needs to be seen in the clinic, whether by the PCP or the outpatient cardiologist first, and how to modify and continue the guidelines started in the hospital.

    - In this division, physician adherence to the EBG should be monitored. Monitoring adherence to the EBG will standardize the care and promote a specific culture which focuses on long-term outcomes. How feedback to physicians will be done will be left to the division.

Dear Esteemed Members of the El Camino Healthcare District Board,

I am writing to you today to convey my interest in taking on the role of ECHD Chair for the upcoming term, commencing on 7/1/25. My candidacy may be considered attractive along two parameters – temporal and experiential.

Traditionally, most locally elected boards, without a publicly elected leader eg Mayor or Chair, choose to rotate their top leadership position among members. Such an approach reflects a commitment to shared governance which contributes to ensuring diverse leadership perspectives and priorities. I have served on the ECHD board for a decade while stepping back to allow others to serve as Chair.

As chair of ECHD board I led our efforts to modernize our governance structure that has allowed us to provide quality governance and oversight of El Camino Health as it has trebled its revenue (since I joined as an ECHD board member) and significantly increased the quality of care delivered to our community. I also contributed to improving administrative details that support meeting transparency and efficiency, such as adding expected time-frames for agenda items.

Having served for 18+ years I possess a depth of institutional knowledge and leadership experience that is well-suited to this position. My past roles have equipped me with a keen understanding of our mission, the challenges we face, and the strategies that drive us forward. I am confident that my experience can provide both the practical background and strategic vision necessary to navigate the future of the El Camino Healthcare District.

Thank you for considering my application.

Sincerely,

John Zoglin
Director