CURRICULUM VITAE

PAUL J. SHAREK, M.D., M.P.H.

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CURRENT POSITIONS

Professor, Department of Pediatrics (Hospital Medicine), Stanford University School of Medicine
Medical Director, Center for Quality and Clinical Effectiveness, Lucile Packard Children's Hospital
Chief Clinical Patient Safety Officer, Lucile Packard Children's Hospital

PERSONAL

Marital Status: Married
Children: Ryan (19 yo), Liam (16 yo)

EDUCATION

1981-1985	Pomona College, Claremont, California	B.A.	Mathematics
1984-1985	University College, Oxford University		Biology
1985-1989	College of Physicians and Surgeons, Columbia University	M.D.	Medicine
1989-1990	University of California, San Francisco	Intern	Pediatrics
1990-1992	University of California, San Francisco	Resident	Pediatrics
1992-1993	University of California, San Francisco	Chief Resident	Pediatrics
1995-1996	University of California, Berkeley	M.P.H.	Epidemiology
1996-1998	Stanford University	Postdoctoral Fellow	Health Care Outcomes & Quality Improvement

ACADEMIC POSITIONS

1992-1993	University of California, San Francisco San Francisco General Hospital	Chief Resident, Pediatrics
1993-1994	University of California, San Francisco	Assistant Clinical Professor, Pediatrics
1996-1998	Stanford University	Postdoctoral Fellow, Pediatrics
1996-2001	University of California, San Francisco	Assistant Clinical Professor, Pediatrics
1998-2005	Stanford University	Clinical Assistant Professor, Pediatrics
2005-2010	Stanford University	Assistant Professor, Pediatrics (MCL)
2010-2015	Stanford University	Associate Professor, Pediatrics (MCL)
2015-present	Stanford University	Professor, Pediatrics (MCL)
2007-present	Institute for Healthcare Improvement (IHI)	Faculty Member
2008-present	Stanford University Center for Health Policy (CHP) and Center for Primary Care and Outcomes Research (P-COR)	Associate Faculty Member
2014-present	University of Alabama Birmingham, School of Health Professions	Faculty Member Ad Hoc

LEADERSHIP ROLES

1998-2011	LPCH	Medical Director of Quality Management
2011-present	LPCH	Medical Director, Center for Quality and Clinical Effectiveness
2001-present	LPCH	Chief Clinical Patient Safety Officer
2007-present	CPQCC	Medical Director of Quality
2001-05	CHCA	Medical Director, Child Health Accountability Initiative
2013-present	CHA	Member, Quality Strategic Planning Committee (QI subctte)
2012-present	SPS	Founding member, Clinical Steering Committee
2012-present	SPS	Co-Chair, Research and Publications Committee

HONORS AND AWARDS (n=28)

1984-85	Exchange student, Oxford University, Oxford, England
1985	*Cum Laude*. Bachelors of Arts in Mathematics, Pomona College,
1991-1992	Housestaff Teacher of the Year Award, University of California, San Francisco
2002	Golden Coffee Cup Award (inaugural winner), for teaching excellence of the Stanford University Pediatrics Residents
2004	Faculty Honor Roll for Teaching Service. Awarded to 35 Stanford University School of Medicine faculty members for being "an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"
2005	First place award, Patient Safety Category (patient safety research design), for study: "Comparing the Utility of a Standard Pediatric Resuscitation Cart with a Pediatric Resuscitation Cart Based on the Broselow Tape: a Randomized, Controlled, Cross-Over Trial involving Simulated Resuscitation Scenarios". Fifth International Meeting for Medical Simulation conference, February 2005 Miami, FL.
2005	*Race for Results Award*, awarded by Child Health Corporation of America (CHCA) to 2 hospitals and the associated leaders (Paul Sharek, MD, MPH at LPCH) that produced the "most significant clinical, financial, and safety related improvements" among the 41 CHCA hospitals
2006, 07	R.O.S.E. (Recognition of Service Excellence) Award, Lucile Packard Children's Hospital (x2)
2006	Faculty Honor Roll for Teaching Service, with *Letter of Teaching Distinction*. Awarded to 8 Stanford University School of Medicine faculty members for being "an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"
2007	*Race for Results Award*, awarded by Child Health Corporation of America (CHCA) to the 2 hospitals and the associated leaders (Paul Sharek, MD, MPH at LPCH) that demonstrated the most "significant and sustained improvements in the delivery of safety, effective and efficient care" among the 41 CHCA hospitals
2007	*Champion of Family Centered Care Award*. Annual award from the Lucile Packard Children's Hospital Family Advisory Council, "in recognition for outstanding commitment to promoting family-centered care"
2007	Faculty Honor Roll for Teaching Service, with *Letter of Teaching Distinction*, Stanford University School of Medicine. Given to 10 Stanford University School of Medicine faculty members for "standing out as an exceptional teacher, based on

student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"

2008 Faculty Honor Roll for Teaching Service, Stanford University School of Medicine. Given to 35 Stanford University School of Medicine faculty members for "standing out as an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"

2008 Dr. JM Bowman Distinguished Lecture in Neonatal Research (3rd annual) selection, University of Manitoba, Winnipeg, Manitoba, Canada. Delivered September 25, 2008.

2009 Sydney Snyder Endowed Patient Safety Lecturer, Children's National Medical Center, Washington, DC. Delivered February 4, 2009

2010 Estrellita and Yousuf Karsh Visiting Professorship (3rd annual), Children's Hospital of Eastern Ontario (CHEO), Ottawa, Ontario, Canada. September 21-23, 2010

2010 Faculty Honor Roll for Teaching Service, Stanford University School of Medicine.

2011 Faculty Honor Roll for Teaching Service, Stanford University School of Medicine. Given to 41 Stanford University School of Medicine faculty members for "standing out as an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"

2011 David Wirtschafter Award, California Association of Neonatologists/American Academy of Pediatrics District IX (Section of Perinatal Pediatrics)/California Perinatal Quality Care Collaborative. Award "in recognition of outstanding achievement in Neonatal Intensive Care Unit quality improvement" across California

2012 Faculty Honor Roll for Teaching Service, Stanford University School of Medicine. Given to 37 Stanford University School of Medicine faculty members for "standing out as an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"

2012 Computerworld "Honors Laureate" awarded to LPCH (Longhurst, Pageler, Sharek) in recognition of "organizations and individuals who have used information technology to promote and advance public welfare, benefit society and change the world for the better"

2012 GBCHealth "Finalist", Business Action on Health Award (Application of Core Competence Category). Reflective of an exceptional program combining solid intervention design, a strong commitment to achieving results and a focus on long-term sustainability.

2013 Faculty Honor Roll for Teaching Service, Stanford University School of Medicine. Given to Stanford University School of Medicine faculty members who demonstrate "standing out as an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"

2013 Recognition for the Dedication to Safety, from the Ohio Children's Hospital Solutions for Patient Safety Collaborative. For "leadership, passion and commitment to the OCHSPS Steering Committee"

2013 **Inaugural Paul V. Miles Fellow in Quality Improvement, American Board of Pediatrics**. Award "honoring the passion for improving healthcare for children that Dr. Paul V. Miles (Senior Vice President for Maintenance of Certification) has exhibited throughout his career". Award bestowed on individual who has "dedicated themself to quality improvement and demonstrated accomplishments leading to better healthcare for children".

2015 Solutions for Patient Safety Research Award, for poster entitled: Trigger Detection of Opiate Related Adverse events across five years and thru children's hospitals: A description of findings St Louis, MO 10.2015

2016 Faculty Honor Roll for Teaching Service, Stanford University School of Medicine. Given to Stanford University School of Medicine faculty members who demonstrate "standing out as an exceptional teacher, based on student's ratings and comments on your individual teaching evaluations, your input to student performance evaluations, and your overall contribution to the running of the clerkship"

2016 First Quality Visiting Professor, Nationwide Children's Hospital, Columbus Ohio (10.2016)

PROFESSIONAL ACTIVITY

International

2007-2012 Founding Member, Pediatric International Patient Safety and Quality Collaborative (PIPSQC). Membership includes world's experts in pediatric patient safety from Australia, Great Britain, Canada, and the United States. Focus is on sharing best practices amongst international colleagues and establishing dissemination strategies of these pediatric patient safety and quality of care best practices throughout the world

Visiting Scholar/Professor (International)

June 2007 Visiting Scholar, Pediatric Quality and Patient Safety Hospital for Sick Kids, Toronto, Ontario, Canada

Oct 2009 Visiting Scholar, Great Ormond Street Hospital for Children, London, England

Sept 2010 Visiting Scholar Children's Hospital of Eastern Ontario. Ottawa, Ontario, Canada

June 2016 Visiting Speaker, Royal College of Physicians of Ireland, Dublin, Ireland

National

Institute for Healthcare Improvement (IHI). Boston, MA

2007-present Faculty Member, Institute for Healthcare Improvement (IHI). The IHI is the most influential quality and patient safety organization in the world

2007-2010 Co-Principal Investigator, Rx Foundation Harm Study: How Safe is a Hospital. Grant awardee was the Institute for Healthcare Improvement.

2007-2010 Member, Scientific Advisory Committee, charged with developing and implementing the measurement strategy for the IHI "5 million lives campaign"

American Academy of Pediatrics (AAP)

2006-2010 Project Advisory Committee member, "Safer Healthcare for Kids" initiative. Oversight committee establishing a formal and practical strategy for describing relevant pediatric patient safety issues and providing solutions for pediatricians. This strategy included establishing a section of the AAP website dedicated to pediatric

patient safety education, and a series of approximately 20 webcasts over a 3-year period.

National Institute for Children's Healthcare Quality (NICHQ)

2007 National Conference Steering Committee and Co-Chair; Chair of the Patient Safety Tract, Sixth Annual National Forum for Improving Children's Healthcare. San Francisco, CA (approximately 1000 attendees).

2007 Co-author, High Alert Medications "How to Guide", a pediatric-based supplement to the IHI 5 million lives campaign literature

2007 Member, Pediatric Affinity Group. Group dedicated to translating the adult patient-based recommendations of the *IHI's 5 million lives campaign* into pediatric-relevant recommendations

Child Health Corporation of America

2001-2005 Medical Director: Child Health Accountability Initiative (CHAI), a national 14-site children's hospital collaborative dedicated to improving the quality of health care for children using collaborative research and performance improvement techniques.

2005-present Advisor, Child Health Corporation of America (CHCA), on areas of pediatric patient safety and quality of care. CHCA (Now called Children's Healthcare Association) consists of (as of 2010) 200+ children's hospitals that focus on practical quality and safety interventions and diffusion of these interventions throughout pediatric organizations in the US. The most affective technique used at CHCA for these purposes is the IHI-style collaborative quality improvement model, which I helped integrate into CHCA quality and safety initiatives

2013-present Appointed by CHA (merged entity between CHCA and NACHRI) to Quality Improvement Subcommittee (of the Quality Strategic Plan) to provide strategic recommendations to CHA for their Quality and Patient Safety portfolio

Alliance for Pediatric Quality

2007-2010 Member, Alliance for Pediatric Quality (APQ). The APQ, formed jointly by leadership of the American Academy of Pediatrics, the American Board of Pediatrics, the National Association of Children's Hospitals and Related Institutions (NACHRI) and Child Health Corporation of America, was a small group of thought leaders in pediatric quality and patient safety focusing on establishing a unified vision for improving pediatric quality and patient safety outcomes.

Ohio Children's Hospitals Solutions for Patient Safety Initiative (OCHSPS now known as SPS):

2012-present Steering Committee Member, overseeing the strategic planning and tactical implementation of best practices to reduce Healthcare Acquired Conditions (HACs) and Serious Safety Events (SSEs) across the 110 sites (including 35 original sites) involved in the Collaborative. This Collaborative is the only Pediatric Healthcare Engagement Network (HEN) funded by CMS

2013-present Co-Chair, Research and Publications Committee of OCHSPS, constructing, guiding, and overseeing the approach to scientific and scholarship outputs

Visiting Professor/Scholar (National n=14)

March 2008	St Louis Children's Hospital, St Louis, MS: Visiting Scholar, Pediatric Quality and Patient Safety. Role included multiple presentations and meetings with senior administrative and medical leadership to provide guidance on quality/safety restructuring. Particular focus on Microsystems implementation, and the integration of simulation and rapid response teams to improve patient safety
May 2008	Morgan Stanley Children's Hospital at Columbia University, NY, NY. Visiting Scholar, Pediatric Quality and Patient Safety, and Invited Leader of Quality/Patient Safety Retreat. Role included multiple presentations and meetings with senior administrative and medical leadership to provide guidance on quality/safety restructuring
June 2008	Children's Hospital of Philadelphia, Philadelphia, PA Visiting Scholar, Pediatric Quality and Patient Safety. Role included multiple presentations and meetings with senior administrative and medical leadership to provide guidance on quality and patient safety improvements, with particular focus on integrating administration and medical staff leaders
Feb 2009	Children's National Medical Center, Washington, DC. Visiting Scholar. Role included multiple presentations and meetings with senior administrative and medical leadership to provide guidance on quality/safety restructuring. Particular focus on measurement strategies for patient safety, and construction of an effective peer review program.
October 2010	Children's Hospital of Los Angeles, Los Angeles, CA. Visiting Scholar. Role included multiple presentations and meetings with senior administrative and medical leadership to provide guidance on quality/safety restructuring.
October 2010	Children's Hospital Minneapolis. Minneapolis, MN. Visiting Scholar. Role included multiple presentations and meetings with senior administrative and medical leadership to provide guidance on quality/safety restructuring, integration of Quality Improvement and Performance Improvement, and to provide guidance to their new Medical Director of Quality Management.
October 2011	Amplatz Children's Hospital at University of Minnesota, Minneapolis, MN. Visiting Scholar. Role included multiple presentations and meetings with senior administrative and medical leadership to provide guidance on quality/safety.
March 2012	Children's Hospital of Colorado, Aurora, CO. Visiting Scholar. Role included multiple presentations and meetings with senior administrative and medical leadership, Information Technology and Family Advisory Leaders to provide guidance on quality/safety.
Sept 2012	St Louis Children's Hospital (SLCH), St Louis, MO. Visiting Professor. Specific request by SLCH Executive Leadership and Washington University School of Medicine Senior Faculty members to review quality of care and patient safety infrastructure, leadership, physician involvement, and quality/safety initiatives in order to provide summary recommendations to enhance the St Louis Children's Hospital Quality and Patient Safety Programs.
October 2012	Kapiolani Children's Hospital at University of Hawaii, Honolulu, HI. Visiting Scholar. Role included grand rounds presentations (x2), multiple presentations and meetings with senior administrative leaders, medical leadership, and residents to provide guidance on multiple aspects of quality/safety including integration of the family perspective/voice and effective integration of IT.

October 2013 American Board of Pediatrics, Chapel Hill, NC. Visiting Scholar. Role included discussing with the ABP Board of Directors next generation approaches to integrating Board Certified Pediatricians into effective quality improvement; discussing the application of quality improvement techniques to improve the ABP's certification testing tools; discussing opportunities for improvement in the maintenance of certification (MOC) process, and presenting basic quality improvement principles to all ABP staff

June 2014 St Louis Children's Hospital (SLCH), St Louis, MO. Visiting Professor. Invited by SLCH Executive Leadership and Washington University School of Medicine Senior Faculty members to work with the Board of Directors, Medical and Administrative leadership at St Louis Children's Hospital to construct the new Center for Quality and Patient Safety.

Nov 2015 St Jude Children's Hospital, Memphis, TN. Visiting Professor. Invited by St Jude Chief Patient Safety Office and Executive Leadership to work with Medical and Administrative leadership at St Jude to evaluate the present Quality and Patient Safety infrastructure and provide advice toward restructuring.

October 2016 Nationwide Children's Hospital, Columbus, OH. Invited by Chief Medical Officer and CEO to be their first quality improvement visiting professor

State

California Perinatal Quality of Care Collaborative (CPQCC). Palo Alto, CA

2002 Conference Planning Committee: California Perinatal Quality Care Collaborative Workshop: Successful Strategies for Implementing Neonatal Practice Improvements

2007-present Director of Quality for CPQCC and Chair of the Perinatal Quality Improvement Panel (PQIP). Provide thought leadership and oversight for quality of care initiatives created by CPQCC targeting large scale collaborative quality improvement for the 129 Neonatal Intensive Care Units in CPQCC. Establish strategic plan, redesign the organizational structure, create and implement a charter, and oversee 20-30 site IHI style collaborative quality improvement programs (such as infection reduction-2008, breast milk feeding improvements-2009, improving delivery room management-2011, and optimizing length of stay-2013) across the state

Local

Department of Quality Management, Lucile Packard Children's Hospital

Department of Pediatrics, Stanford University School of Medicine

1997-2006 Innovations in Patient Care Program (Co-developer, and selection committee member). This program (launched in 1997) awards yearly Packard Foundation-funded grants to LPCH staff/clinicians to support/test innovative interventions to improve patient care

1998-2006 Neonatal Intensive Care Unit 2000; 2002; 2005 (NIC/Q2000; NIC/Q2002; Your Ideal NICU) National Collaborative Quality Improvement Projects (Site Director for LPCH). These 50+site evidence-based quality improvement collaborative from the Vermont Oxford Neonatal Network aims to achieve measurable improvements in the quality and efficiency of NICU care, develop new tools and knowledge for the quality improvement process, and disseminate the improvement knowledge to the neonatology community.

2000-2002	Pain Management Committee at LPCH (Member). Committee to improve pain management in liver and renal transplant patients
2000-2002	Discharge Planning Committee at LPCH (Creator and Co-Chair)
2000-2003	Medical Director of Case Management. LPCH
2001-2002	Medical Center Quality Assurance Review Committee (LPCH representative). Committee charged with overhauling the peer review process at Stanford University Medical Center and LPCH
2001-2012	Care Improvement Committee (Founder and Chair thru 2008, member 2008-2012). Committee consisting of 1 physician representative from each service line at LPCH, charged with oversight of LPCH peer review.
2001-2012	General Pediatrics Service Peer Review Committee (Founder and Chair thru 2008, member 2008-2012). Committee charged with reviewing relevant peer review cases for the General Pediatrics Service at LPCH
2002-2006	Patient Progression Steering Committee (Member). An LPCH committee focused on optimizing patient throughput, improving the discharge planning process, and enhancing inpatient access to LPCH
2002-2010	LPCH Pharmacy and Therapeutics Committee (Member)
2002-2010	Order Set Committee (Founder and Chair). Multidisciplinary committee focusing on creation and implementation of approximately 500 order sets for clinical use at LPCH (inpatient and outpatient)
2004-2006	Clinical Transformation Project: Rapid Design committee -“care provision” (Member). This LPCH committee focused on providing MD input to design a prototype of the results review and order entry components of the Cerner Millennium electronic medical record.
2004-2006	Clinical Transformation Project: Biomedical and Medical Informatics committee. (Member). This physician-focused LPCH committee was responsible for advising leadership on IT decisions, during the Cerner Millennium electronic medical record implementation, to ensure alignment with the mission and vision of LPCH.
2004-2007	“Who is in Charge of the Ship” (WICOTS) Committee (Founder and Chair). Committee defined service-line accountability for all patients at LPCH, established physician and nursing roles related to patient care, defined a formal chain of command, and formalized standardized communication strategies all to ensure higher patient safety and quality of care
2005-2009	Information Technology Management Council (ITMC-Member). Committee reviewed all IT related project proposals at LPCH, and prioritizing technology selection and implementation.
2006-2009	Clinical Transformation Steering Committee (Member): This LPCH committee was charged with overseeing the entire clinical transformation process at LPCH including integration of CPOE and the Electronic Medical Record. Tasks included: Establish strategic direction for Clinical Transformation; Review and approve proposed Clinical Transformation initiatives; Review and approve Measures and Metrics; Provide organizational leadership, thought leadership, and strategic direction to the project; Overall Program monitoring and risk management
2008-2009	Care Provider Redesign Committee (Member). Committee charged with reviewing present roles of care providers in the present LPCH Care model, and redesigning each practitioners roles to support the Care Model Redesign underway at LPCH.

2008-2012	Laboratory Services Advisory Committee (Member). Committee charged with reviewing laboratory effectiveness and recommending/advising on approaches for improvement
2009-2012	Ambulatory Electronic Medical Record (EMR) Steering Committee (Member). Committee charged with oversight of the 3rd phase of the Cerner EMR role out at LPCH. Components of the Ambulatory phase included E-prescribing, medication reconciliation, and MD documentation
2000-present	Quality and Safety Leaders Forum (LPCH Site Director), Children's Hospital Association (previously Child Health Corporation of America or CHCA). CHA is presently a 200+ children's hospital organization, with a core of 43 free standing children's hospitals intensely focused on identifying, testing, and disseminating quality and safety best practices for hospitalized children. CHA is dedicated to improving the quality of health care for children using collaborative research and performance improvement techniques
2000-present	LPCH Quality Improvement Steering Committee "QIC" (Founder and Chair). LPCH committee charged with overseeing quality and safety strategy for LPCH, establishing quality and safety goals for LPCH, overseeing and tracking quality and safety outcomes, and reporting to the LPCH Board of Directors via the Quality, Service, and Safety Committee of the Board.
2000-present	LPCH Patient Safety Committee (Founder and Chair). Committee charged with establishing strategy for the LPCH patient safety program, identifying patient safety issues at LPCH, and implementing best practices to enhance patient safety at LPCH.
2000-present	LPCH Medical Board of Directors (known as "Medical Executive Committee" since 2008). Member
2002-present	Quality, Service, and Safety Committee (Co-Founder and Staff). The LPCH Board of Directors committee focusing on governance of quality, service and safety at LPCH.
2005-present	Patient Safety Oversight Committee (Creator and co-Chair with CEO). Executive level committee reviews all significant adverse events (harms) occurring at LPCH, determines and oversees reporting of such events to the CA. Department of Public Health and ensures an appropriate action plan is in place to correct system issues contributing to these events.
2005-present	Medication Management Steering Committee (Creator and Chair). Provides oversight and coordination to all medication related processes at LPCH, with particular focus on enhancing patient safety by system engineering and process redesign
2008-2014	Stanford University School of Medicine Quality and Safety Summit Planning Committee (Member). Committee charged with establishing the agenda for the annual Stanford University Medical Center Clinical Excellence Summit, identifying the theme, identifying relevant speakers, establishing goals, etc
2010-present	LPCH Microsystems ("Local Improvement Teams") strategy creation and launch (Creator and member). Built, staffed, funded, and deployed 9 local improvement teams (LITs) which are multidisciplinary committees accountable for quality/safety outcomes in their respective units. LITs form the backbone of structured problem solving at LPCH, and are tasked with creation of best practices (when none exist), local implementation of known best practices, and oversight of continuous quality

	improvement in their units. Units with LITs include: PICU, CVICU, NICU, 3-West, Bass Center, L and D, Post-partum, Perioperative areas, and Ambulatory areas
2010-present	Handoffs Executive Committee (Creator and Chair): multidisciplinary committee focused on constructing, implementing, measuring, and disseminating a standardized handoff process for all patients transitioning between units at LPCH. Examples of standardized structured handoffs include: OR to PICU, CVICU to 3-West (med-surg), and PICU to 1-North (Oncology unit).
2011-2015	Pain Satisfaction Executive Committee (Creator and Chair): Multidisciplinary committee charged with identifying, implementing, and disseminating a bundle of best practices to improve "Patient Satisfaction with Pain Control" as measured in the Press-Ganey patient satisfaction survey tool
2012-present	Solutions for Patient Safety LPCH Steering Committee (Founder and co-chair): Committee at LPCH overseeing the "Mission Zero" initiative (eliminating preventable harm at LPCH), including creation and oversight of all Healthcare Acquired Conditions (HACs) activities and strategic planning for deploying the 5 primary Culture of Safety domains (Error Prevention, Leadership Methods, Cause Analysis, Microsystems structure, and Safety Governance)
2012-present	CLABSI-CAUTI Steering Committee (Founder and co-chair); Steering committee overseeing the implementation of best practices across LPCH to eliminate Central Line Associated Blood Stream Infections (CLABSIs) and Catheter Associated Urinary Tract Infections (CAUTIs) across LPCH. This is one of the steering committees charge with eliminating "Healthcare Acquired Conditions (HACs)" across LPCH.
2013-present	Clinical Oversight Group ("COG"; member): oversight committee charged with ensuring decisions made for Epic EMR implementation are safe and appropriate from a clinician's perspective
2013-present	Packard Operations Committee (member): committee charged with reviewing all metrics relevant to operations at LPCH (quality, service, safety, financial, etc) and providing guidance/oversight to all initiatives focused on improving these operational metrics
2013-present	Stanford Clinical Effectiveness Training (CELT) Steering Committee (member): Committee charged with "facilitating the establishment of a comprehensive educational program that will drive a culture of continuous and sustained improvement of work process and clinical practices." The CELT program is a Stanford SOM initiative, including both Stanford Hospital and LPCH, and is being modeled after the Advanced Training Program (ATP) which offers an in-depth course for health care professionals who teach, implement, and investigate quality improvement efforts within the healthcare setting
2014-present	Heart Center QAPI committee (member): committee accountable for quality and safety outcomes across the LPCH Heart Center. Efforts include identification of critical relevant metrics, identification of improvement opportunities, prioritization of these opportunities, and tracking results of improvement efforts
2014-present	Dean's Committee on Safety Quality and Value (SQV). Dr Lloyd Minor (Dean of SOM) monthly meeting focused on identifying synergies between LPCH and Stanford hospital related to scholarship and educational offerings for quality, safety and value

2016-present Dean's Committee on Safety Quality and Value (SQV). "Clinical and Operations Committee" Co-Chair. Committee focused on integrating and merging the Stanford Healthcare and Stanford Children's Health approaches to clinical care and operations.

Department of Pediatrics, University of California, San Francisco

1991-1994 UCSF Pediatric Intern Selection Committee
1992-1993 Delivery of Pediatric Emergency Care Committee, SFGH
1992-1993 Pediatric Transport Policy Committee, San Francisco General Hospital
1993-1994 Medical Director of Primary Care, Department of Pediatrics, San Francisco General Hospital
1994 Preceptor, Introduction to Clinical Medicine for second year medical students
1998-1999 Mentor, University of Connecticut Medical School student, in clinical research
1998-1999 Medical Director of Pediatric Acute Care, Ambulatory Care Center San Francisco General Hospital Department of Pediatrics

San Francisco Health Plan (MediCaid managed care plan for San Francisco)

2001-2003 Member, Quality Improvement Steering Committee

Community Service

1994-1996 Pediatric Clinic, Family Addiction Center for Education and Treatment (co-Founder, Medical Director). Pediatric clinic providing primary care to children of adults attending methadone maintenance clinic in inner-city San Francisco
1997-1998 Bay View/Hunter's Point Asthma Task Force. Representatives from local government agencies and the community aiming to impact the high prevalence of asthma in children in this low socioeconomic status community of San Francisco.
1998-2007 Board of Directors, Asthma Resource Center. A not for profit organization dedicated to improving the quality of life for children with asthma in low socioeconomic areas of San Francisco
2008-2012 San Carlos Little League, Board of Directors.

SCHOLARLY PUBLICATIONS

(Published (63), In Press (3), submitted (2), in preparation (6))

Peer Reviewed Journal Articles (n=63)

1. 1986 Colbern D, **Sharek PJ**, Zimmerman E. The effect of home or novel environment on the passive avoidance by post-training ethanol. *Behavior and Neural Biology*. 1986;46:1-12
2. 2000 **Sharek PJ**, Bergman BA. Beclomethasone for asthma in children: effects on linear growth. *Cochrane Database Syst Rev*. 2000(2): CD001282. PMID: 10878177.
3. 2000 **Sharek PJ**, Bergman DA. The effect of inhaled steroids on the linear growth of children with asthma: A meta-analysis. *Pediatrics.* 2000;106:e8.
4. 2002 **Sharek PJ**, Benitz WE, Abel NJ, Freeburn MJ, Mayer ML, Bergman, DA. Effect of an evidence-based hand washing policy on hand washing rates and false-positive coagulase negative staphylococcus blood and cerebrospinal fluid culture rates in a level III NICU. *Journal of Perinatology.*2002;22:137-143

5. 2002 **Sharek PJ**, Mayer ML, Loewy L, Robinson TN, Shames RS, Umetsu DT, Bergman DA. Agreement between measures of asthma status: a prospective study to low income children with moderate to severe asthma *Pediatrics*. 2002;110:797-804
6. 2003 **Sharek PJ**, Baker R, Litman F, Kaempf J, Burch K, Schwarz E, Sun S, Payne NR. Evaluation and development of potentially better practices to prevent chronic lung disease and reduce lung injury in neonates. *Pediatrics.* 2003;111:e426-e431.
7. 2003 Kelly B, Rhine W, Baker R, Litman F, Kaempf JW, Schwarz E, Sun S**,** Payne NR, **Sharek PJ**. Implementing potentially better practices to reduce lung injury in neonates. *Pediatrics*. 2003;111:e432-e436.
8. 2004 Shames RS, **Sharek PJ**, Mayer M, Robinson TN, Hoyte EG, Gonzalez-Hensley F, Bergman DA, Umetsu DT. Effectiveness of a multi-component self management program in at-risk school age children with asthma. *Annals of Allergy, Asthma, & Immunology*. 2004;92:611-618
9. 2005 Agarwal S, Swanson S, Murphy A, **Sharek PJ**, Halamek LP. Comparing the utility of a standard pediatric resuscitation cart with a pediatric resuscitation cart based on the Broselow tape: A randomized, controlled, cross-over trial involving simulated resuscitation scenarios. *Pediatrics*. 2005;116:e326-e333
10. 2006 **Sharek PJ**, Wayman K, Lin, E, Strichartz D, Sentivany-Collins S, Good J, Esquivel C, Brown M, Cox K. Improved pain management in pediatric postoperative liver transplant patients using parental education and nonpharmacologic interventions. *Pediatric Transplantation*. 2006;10:172-177
11. 2006 **Sharek PJ**, Horbar JG, Mason W, Bisarya H, Thurm CW, Suresh G, Gray JE, Edwards WH, Goldmann D, Classen D. Adverse events in the neonatal intensive care unit: Development, testing, and findings of a NICU-focused trigger tool to identify harm in North American NICUs. *Pediatrics* 2006;118:1332-1340.
12. 2006 Dunbar AE, **Sharek PJ,** Mickas NA, Coker KL, Duncan J, McLendon D, Pagano C, Puthoff TD, Reynolds NL, Powers RJ, Johnston CC. Implementation and case study results of potentially better practices to improve pain management of the neonate. *Pediatrics*. 2006;118:87-94
13. 2006 **Sharek PJ**, Powers R, Koehn A, Anand KJS. Evaluation and development of potentially better practices to improve pain management of the neonate. *Pediatrics*. 2006;118:78-86
14. 2006 **Sharek PJ**, Classen D. The incidence of adverse events and medical error in pediatrics. *Pediatric Clinics of North America*. 2006;53:1067-1077.
15. 2007 Wayman K, Trotter S, **Sharek PJ**, Halamak L. Simulation-based medical error disclosure training for pediatric healthcare professionals. *Journal of Healthcare Quality*. 2007;29:12-19
16. 2007 **Sharek PJ**, Parast LM, Leong K, Coombs J, Earnest K, Sullivan J, Frankel LR, Roth SJ. Effect of a rapid response team on hospital-wide mortality and code rates outside the ICU in a children's hospital, *JAMA*. 2007;298:2267-2274
17. 2007 **Sharek PJ**, Mullican C, Lavanderos A, Palmer C, Snow V, Kmetik K, Antman M, Knutson D, Dembry, LM. Best practice implementation: lessons learned from 20 partnerships. *Joint Commission Journal on Quality and Patient Safety*. 2007;33(1):16-26
18. 2007 Bergman DA, **Sharek PJ**, Ekegren K, Thyne S, Mayer M, Saunders M. The use of telemedicine access to schools to facilitate expert assessment of children with asthma. *International Journal of Telemedicine and Applications*. 2008;2008:1-7

19. 2008 Agarwal S, Frankel L, Tourner S, McMillan A, **Sharek PJ**. Improving communication in the pediatric intensive care unit using daily goal sheets. *J Crit Care.* 2008;23:227-35
20. 2008 Takata G, Mason W, Takatoma C, Logsdon T**, Sharek PJ.** Development, testing, and findings of a pediatric-focused trigger tool to identify medication related harm in us children's hospitals. *Pediatrics*. 2008;121:e927-935
21. 2008 Fahrenkopf AM, Sectish TC, Barger L, **Sharek PJ**, Lewin D, Chiang VW, Wiedermann BL, Landrigan CP. Housestaff burnout and depression: Consequences for personal health, job satisfaction, and patient safety. *British Medical Journal.* 2008; 336(7642):488-91
22. 2008 Arimura J, Poole RL, Jeng M, Rhine W, **Sharek PJ**. Neonatal heparin overdose- a multidisciplinary team approach to medication error prevention. *J Pediatr Pharmacol Ther.* 2008;13:96-98.
23. 2008 Landrigan CP, Fahrenkopf AM, Lewin D, **Sharek PJ**, Barger LK, Eisner M, Edwards S, Chiang VW, Wiedermann BL, Sectish TC. Effects of the ACGME duty hour standards on sleep, work hours, and safety. *Pediatrics*. 2008;122:250-258
24. 2008 **Sharek PJ**, McClead RE, Taketomo C, Luria JW, Takata GS, Walti B, Tanski M, Carla N, Logsdon TR, Thurm C, Federico F. An intervention to decrease narcotic related adverse drug events in children's hospitals. *Pediatrics*. 2008;122:e861-866
25. 2008 Takata GS, Taketomo CK, Waite S, California Pediatric Patient Safety Collaborators (Billman G, Craig K, Feidner S, Fernandez MD, Kurtin P, Mason W, Minon M, Muraisi A, Sharek P*, Simmes D, Soto Z, Trotter S). Characteristics of medication errors and adverse drug events in hospitals participating in the California Pediatric Patient Safety Initiative. *Am J Health Syst Pharm.* 2008;65:2036-44. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Included patients and experiences from LPCH. Supervised the initiative at LPCH as LPCH site-director*
26. 2009 Goodnough LT, Viele M, Fontaine MJ, Jurado C, Stone N, Quach P, Chua L, Chin M, Scott R, Tokareva I, Tabb K, **Sharek PJ.** Implementation of a two specimen requirement for verification of ABO/Rh for blood transfusion. *Transfusion*. 2009;49:1321-827
27. 2010 Payne NR, Finkelstein M, Liu M, Kaempf J, **Sharek PJ***, Olsen S. NICU practices and outcomes associated with 9-years of quality improvement collaboratives**.** *Pediatrics* 2010;125:437-446. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Included patients and experiences from LPCH. Supervised the intervention of best practices at LPCH during the course of the study.*
28. 2010 Powers RJ, WIrtschafter D, Collaborators (**Sharek P***, Ahmad S, Bell R, Bollman DL, Botas C, Bliss MC, Chance K, Crockett M, Dalsey M, Durand DJ, Finer N, Fischer A, Gould J, Govindaswami B, Gregory K, Joe P, Korst L, Kurtin P, Main E, Mannino FL, Padilla-Robb G, Pettit J, Puri A, Ramstrom K, Rasmussen M, Rehan V, Rhine W, Simmons C, Shields L, Steinberg SJ, Topel RE, Vanotterloo L, Visveshwara N, Wozniak P) Prevention of Group B Streptococcus early-onset disease: a toolkit by the California Perinatal Quality Care Collaborative. *J Perinatol*. 2010.30(2):77-87. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Supervised the*

build and review of the manuscript as the Director of Quality for the California Perinatal Quality Care Collaborative.

29. 2010 Bernstein JA, Imler DL, **Sharek PJ***, Longhurst CA. Improved physician workflow after integration of sign-out notes into the electronic medical record. *Joint Commission Journal of Quality and Patient Safety.* 2010;36(2):72-78. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Supervised initiative in my role as Chief Clinical Patient Safety Officer at LPCH, charged with improving the reliability of handoffs at LPCH.*
30. 2010 Agarwal S, Classen D, Larsen G, Tofil LM, Hayes LW, Sullivan JE, Storgion SA, Coopes BJ, Craig V, Jaderlund C, Bisarya H, Parast P, **Sharek PJ**. Incidence of adverse events in pediatric intensive care units in the United States. *Pediatr Crit Care Med.* 2010;11(5): 568-578
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32. 2010 Landrigan CP, Parry GJ, Bones CB, Hackbarth AD, Goldmann DA, **Sharek PJ**. Temporal trends in rates of patient harm resulting from medical care. *N Engl J Med* 2010;363:2124-34.
33. 2010 Sectish TC, Starmer AJ, Landrigan CP, Sepctor ND, I-PASS study group (Bale JF, Bale JF, Berchelman K, Calaman S, Coffey M, Cole FS, Destino L, Gonzalez del Rey J, Kahana M, Keohane C, Landrigan CP, Lipsitz S, Loprieato J, Mahant S, Matlow A, McGregor R, O'Toole J, Patel S, Rosenbluth G, Rothschild J, Sectish TC, **Sharek P***, Spector ND, Srivastava R, Starmer AJ, Stevenson AT, West DC, White A, Wilson K, Yu CE, Balmer D, Schwartz A). Establishing a multisite education and research project requires leadership, expertise, collaborative, and an important aim. *Pediatrics.* 2010;126:619-22. **Participated in acquisition of data at LPCH. Participated in critical revision of the manuscript for important intellectual content. Provided administrative support of initiative in my role as Chief Clinical Patient Safety Officer at LPCH, charged with improving the reliability of handoffs at LPCH.*
34. 2011 **Sharek PJ**, Parry G, Goldmann D, Bones K, Hackbarth A, Resar R, Griffin FA, Rhoda D, Murphy C, Landrigan CP. Validation of a methodology to quantify harm over time to in-hospital patients. *Health Services Research.* 2011;46:654-78
35. 2011 Palma JP, **Sharek PJ***, Longhurst CA. Impact of electronic medical record integration of a handoff tool on sign out in a newborn intensive care unit. *Journal of Perinatology*. 2011;31:311-317. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Supervised initiative in my role as Chief Clinical Patient Safety Officer at LPCH, charged with improving the reliability of handoffs at LPCH*
36. 2011 Palma JP, **Sharek PJ***, Classen, DC, Longhurst CA Neonatal Informatics: Computerized physician order entry. *NeoReviews* 2011;12:393-396. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content.*
37. 2012 **Sharek PJ**. The emergence of the trigger tool as the premier measurement strategy for patient safety [Perspective]. AHRQ WebM&M. 2012 May 1;2012(5).pii:120. PMID 21105794 Available at: http://www.webmm.ahrq.gov/perspective.aspx?perspectiveID=120

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39. 2012 Shin AY, Longhurst C, **Sharek PJ**. Reducing mortality related to adverse events in children. *Pediatr Clin North Am*. 2012;59:1293-1306
40. 2012 Lee, H, Kurtin P, Wight N, Chance K, Cucinotta-Fobes T, Hanson-Timpson TA, Nisbet CC, Rhine WD, Risingsun K, Wood M, Danielsen BH, **Sharek PJ**. An intervention to increase breast milk usage in very low birth weight infants across California, *Pediatrics* 2012;130:e1679-87
41. 2013 Billett AL, Colletti RB, Mandel KE, Miller M, Muething SE, **Sharek PJ***, Lannon CM. Exemplar pediatric collaborative improvement networks: Achieving results. *Pediatrics*. 2013;131;S196-S203. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Included experiences from the California Perinatal Quality of Care Collaborative, a collection of 129 NICUs across California for which I am the Director of Quality for. Supervised all collaborative efforts that were reflected in the manuscript*
42. 2013 Carspecken CW, **Sharek PJ***, Longhurst C, Pageler NM. A clinical case of electronic health record drug alert fatigue and consequences for patient outcome. *Pediatrics*. 2013;131:e1970-3. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Provided clinical data relevant to the case study described*
43. 2013 Longhurst CA, Palma JP, Grisim LM, Chan M, Widen E, **Sharek PJ**. Evidence-based EMR implementation. *J Healthc Inf Manag*. 2013;27:79-83.
44. 2014 Pageler NM, Longhurst CL, Wood M, Cornfield DN, Suermondt J, **Sharek PJ***, Franzon D. An EMR-enhanced checklist plus unit-wide electronic dashboard is associated with decreased CABSIs. *Pediatrics*. 2014;133:e738–e746. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Supervised initiative in my role as Chief Clinical Patient Safety Officer at LPCH, charged with decreasing the frequency of adverse events (including CLABSIs) at LPCH. Provided administrative support of the intervention at LPCH. Contributed to acquisition of funding for this study.*
45. 2014 May LJ, Wood MS, Pageler NM, Longhurst CA, **Sharek PJ***, Zebrack CM. Electronic clinical decision support tools to optimize care of adults with congenital heart disease in a pediatric cardiovascular intensive care unit. *Pediatric Critical Care Medicine*. 2014 Jun;15(5):428-34. doi: 10.1097/PCC.0000000000000124. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Supervised initiative in my role as Medical Director for the LPCH Center for Quality and Clinical Effectiveness at LPCH, charged with improving the quality of care provided at LPCH.*
46. 2014 Profit J, **Sharek PJ***, Amspoker AB, Kowalkowski MA, Nisbet C, Thomas EJ, Chadwick W, Sexton JB. Burnout in the nicu setting and its correlates to safety culture. *BMJ Qual Saf 2014;***23**:806-813 Published Online First: 17 April 2014 doi:10.1136/bmjqs-2014-002831. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Enrolled study sites from the California Perinatal Quality of Care Collaborative, a collection of 129 NICUs across California for which I am the Director of Quality.*

Supervised enrollment of sites, dissemination of survey tools to all sites, coordinated collection of survey tools, and in general provided project management for this study in my role as Director of Quality.

47. 2014 Sexton JB, **Sharek PJ,** Thomas, EJ, Gould JB, Nisbet C, Amspoker A, Kowalkowski MA, Schwendimann R, Profit J. Neonatal Intensive Care Unit Patient Safety Climate is Associated with Leadership WalkRounds, Risk Reduction, and Burnout – A Cross-Sectional Study. *BMJ Qual Saf* 2014;**23**:814-822 Published Online First: 13 May 2014 doi:10.1136/bmjqs-2013-002042. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Enrolled study sites from the California Perinatal Quality of Care Collaborative, a collection of 129 NICUs across California for which I am the Director of Quality. Supervised enrollment of sites, dissemination of survey tools to all sites, coordinated collection of survey tools, and in general provided project management for this study in my role as Director of Quality.*

48. 2014 Bigham MT, Logsdon TR, Manicone PE, Landrigan CP, Hayes LW, Randall KH, Grover P, Collins SB, Ramirez DE, O'Guin CD, Williams CI, Warnick RJ, **Sharek PJ**. A quality improvement project to decrease handoff-related care failures in children's hospitals. *Pediatrics*. 2014;134:e572-9. DOI: 10.1542/peds.2013.1844

49. 2014 Stockwell DC, Bisarya H, Classen DC, Kirkendall ES, Lachman PI, Matlow AG, Tham E, Hyman D, Lehman SM, Searles E, Muething SE, **Sharek PJ.** Development of an electronic pediatric all-cause harm measurement tool using the modified delphi method. *Journal of Patient Safety.* Epub ahead of print: 08.26.14

50. 2014 Shin AY, Jin B, McCammond A, Axelrod D, Sutherland S, **Sharek PJ***, Roth SJ, Xuefeng BL. The Utility of Clinical Biomarkers to Predict Central Line Associated Bloodstream Infections following Congenital Heart Surgery. *Journal of Pediatric Infectious Diseases*. 2015;34:251-254. Epub ahead of print 09.23.14 DOI:10.1097/INF.0000000000000553. **Participated in study conception and design. Participated in critical revision of the manuscript for important intellectual content. Supervised initiative in my role as Chief Clinical Patient Safety Officer at LPCH, charged with decreasing the frequency of adverse events (including CLABSIs) at LPCH.*

51. 2014 Starmer AJ, Spector ND, Srivastava R, West DC, Rosenbluth G, Allen AD, Noble EL Tse LL, Dalal AK, Keohane CA, Lipsitz SR, Rothschild JM, Wien MF, Yoon CS, Zigmont KR, Wilson KM, O'Toole JK, Solan LG, Aylor M, Bismilla Z, Coffey M, Mahant S, Blankenburg RL, Destino LA Everhart JL, Patel SJ, Bale JF Jr.Spackman JB, Stevenson AT, Calaman S Cole FS, Balmer DF, Hepps JH, Lopreiato JO, Yu CE, Sectish TC Landrigan CP, for the I-PASS Study Group (includes **Sharek PJ**). Changes in medical errors after implementation of a handoff program. *N Engl J Med* 2014;371:1803-12. DOI: 10.1056/NEJMsa1405556. *Helped supervise handoffs initiative using the I-PASS structure in my role as Chair of the Handoffs Executive Committee and Chief Clinical Patient Safety Officer at LPCH. Provided mentorship and guidance to site principle investigators before and during study*

52. 2014 Lee HC, Powers RJ, Bennett MV, Finer NN, Halamek LP, Nisbet C, Crockett M, Chance K, Blackney D, von Kohler C, Kurtin P, **Sharek PJ**. Comparing quality

improvement methods for delivery room management. *Pediatrics*. 2014;134:e1378–e1386. (doi: 10.1542/peds. 2014-0863)

53. 2015 Caruso TJ, Marquez JL, Wu DS, Shaffer J, Balise RR, Groom M, Leong M, Mariano K, Honkanen A, **Sharek PJ.** Implementation of a Standardized Post Anesthetic Care Handoff Improves Outcomes and Efficiency. *Joint Commission Journal of Quality and Patient Safety*. 2015;41(1):35-42
54. 2015 Stockwell DC, Bisarya H, Classen DC, Kirkendall ES, Landrigan CP, Lemon V, Tham E, Hyman D, Lehman SM, Searles E, Hall M, Muething SE, Schuster MA, **Sharek PJ**. Measuring harm in pediatrics: Pediatric all-cause harm measurement tool pilot testing results. *Pediatrics.* 2015;135:1036-1042 (doi:10.1542/peds. 2014-2152)
55. 2015 Shin A, Zhongkai H, Bo J, Sangeeta L, Rosenthal D, Bradley E, **Sharek P**, Sutherland S, Cohen H, Roth S, Ling X. Exploring value in congenital heart disease. *Congenital Heart Disease.* 2015;10:e278-87
56. 2016 Algaze CA, Wood M, Pageler NM, **Sharek PJ**, Longhurst C, Shin AY. Reducing laboratory utilization in associated with improved cost without adversely affecting outcomes in a pediatric cardiovascular intensive care unit. *Pediatrics.* 2016;137(1):e20143019
57. 2016 Sheth S, McCarthy E, Kipps A, Roth S, **Sharek PJ**, Shin A. Implementation of a standardized multidisciplinary handover process between a pediatric cardiovascular intensive care unit and the medical-surgical unit improved patient safety, provider and family satisfaction. *Pediatrics. 2016;137:1-9. DOI:10.1542/peds.2016.0166*
58. 2016 Landrigan CP, Stockwell D, Toomey SL, Loren S, Tracy M, Jang J, Quinn J, Ashrafzadeh S, Wang M, **Sharek PJ**, Oarry G, Schuster MA. Performance Characteristics of the Global Asssessment of Pediatric Patient Safety (GAPPS) Trigger Tool. *Pediatrics. 2016:137:e20154076*
59. 2016 Stone S, Lee H, **Sharek PJ**. Factors associated with sustained improvement following a multicenter quality improvement collaborative. *Joint Commission Journal of Quality and Patient Safety.* 2016;42(7):309-19
60. 2016 Goel VV, Poole SF, Longhurst CA, Platchek TS, Pageler NM, **Sharek PJ**, Palma JP. Safety Analysis of Data Driven Heart and Respiratory Rate Parameters for Hospitalized Children. *Journal of Hospital Medicine*. Early release 07.15.16
61. 2016 Bennett SC, Mickas N, Finer N, Halamek LP, Nisbet CC, **Sharek PJ**. Effective implementation of delivery room checklists and communication standards in a multi-NICU collaborative. *Joint Commission Journal for Quality and Patient Safety.* 2016;42:369-76
62. 2016 Tawfik D, Sexton J, Kan P, **Sharek PJ**, Nisbet C, Rigdon J, Lee H, Profit J. Burnout in the neonatal intensive care unit and its relation to healthcare-associated infections. *Journal of Perinatology*. Epub ahead of print 11.17.16
63. 2016 Profit J, Lee H, **Sharek PJ,** Kan P, Nisbet CC, Thomas EJ, Etchegaray J, Sexton JB. Comparing NICU Teamwork and Safety Climate Across Two Commonly Used Survey Instruments. *BMJ Journal of Quality and Patient Safety*. 2016;25:954-61

Peer Reviewed Journal Articles: In Press (n=3)

1. 2016 Caruso T, Mokhtari T, Coughlan M, We D, Marquez J, Speth K, Duan M, Chen K, Freeman H, Giustini A, Tweedy M, S**harek PJ**. Pediatric postoperative pulse oximetry monitoring during transport to PACU reduces frequency of hypoxemia.

Joint Commission Journal of Quality and Patient Safety. Accepted June 2016, slotted for publication 02.2017

2. 2016 Marquez JL, Gipp MS, Kelleher S, **Sharek PJ**, Caruso TJ. Standardized Preoperative ICU to OR Handoff Increases Face-to-Face Communication and Satisfaction without Delaying Surgery. *International Journal of Quality Assurance.* Accepted 09.27.16
3. 2016 Lapcharoensap W, Bennett M, Powers R, Finer N, Halamek L, Gould J, **Sharek PJ**, Lee H. Effects of Delivery Room Quality Improvement On Premature Infant Outcomes. Accepted *Journal of Perinatology 11.14.16*

Peer Reviewed Journal Articles: Submitted (n=2)

1. 2015 Profit J, **Sharek PJ,** Bennett M, Kan P, Nisbet CC, Thomas EJ, Lee HC, Sexton JB. Correlations Between NICU Safety Culture and Quality of Care Delivered to Very Low Birth Weight Infants. *Archives of Disease in Childhood. Submitted 04.15.15*
2. 2016 Stockwell DC, Landrigan CP, Toomey SL, Loren S, Jang J, Quinn JA, Wang M, Wu M, **Sharek PJ**, Classen DC, Srivastava R, Parry G, GAPPS study group, Schuster MA. Trends in rates of adverse events in hospitalized pediatric patients 2007-2012. *New England Journal of Medicine*. Submitted 10.19.16

Peer Reviewed Journal Articles: In preparation (n=6)

1. 2016 Stockwell D, Landrigan CP, Schuster MA, Bisarya H, Classen DC, Hall M, **Sharek PJ.** Comparing hospital acquired conditions to harms using a pediatric trigger tool.
2. 2016 Bhat PN, Costello JM, Aiyagari R, **Sharek PJ,** Algaze C, Mazwi ML, Roth SJ, Shin AY. Diagnostic errors in pediatric cardiac intensive care.
3. 2016 Kipps A, Poole S, Slaney C, Feehan S, Longhurst C, **Sharek PJ**, Goel VV. Implementation of data-driven vital sign parameters to decrease acute care unit alarm burden. *Pediatrics*. Submitted 07.21.16, requested revisions 11.04.16
4. 2016 Caruso TJ, Wang E, Schwenk JT, Scheinker D, Yerverino C, Maheru M, **Sharek PJ**. A quality improvement initiative to optimize dosing of surgical antimicrobial prophylaxis. *Journal of Pediatric Anesthesia.* Submitted 11.08.16, revisions requested 12.08.16
5. 2017 Tawfik D, Phibbs C, Sexton JB, Pykan P, **Sharek PJ**, Nisbet C, Rigdon J, Trockel M, Profit J. Retrospective observational analysis of neonatal intensive care unit factors and provider burnout. *Pediatrics*. Accepted pending revisions 01.03.17
6. 2017 Lyren A, Brilli RJ, Zieker K, Marino M, Muething S, **Sharek PJ**. Children's Hospitals' Solutions for Patient Safety collaborative impact on Hospital acquired harm. *Pediatrics*. Submitted 10.21.16, Accepted pending revisions 12.12.16

Peer Reviewed articles: Invited submissions (n=1)

1. 2013 Patel SJ, Bergert LB, Longhurst CA, **Sharek PJ.** The Joint Commission's asthma care measures set: how does it measure up? National Quality Measures Clearinghouse, Expert Commentary. http://www.qualitymeasures.ahrq.gov/expert/expert-commentaries-index.aspx

Chapters (n=1)

1998 **Sharek PJ**, Bergman DA. Improving the Quality of Care in the Office Setting. Ambulatory Pediatric Care, third edition, 1998. Dershewitz, RA editor. Lippincott-Raven publishers, Philadelphia, PA

Letters to the Editor (n=6)

1. 2001 **Sharek PJ**, Bergman DA. Effect of inhaled corticosteroids on growth. Reply: Letter to the editor. *Pediatrics*. 2001;108:1234.
2. 2006 Longhurst C, **Sharek PJ**, Hahn J, Sullivan J, Classen D. Perceived increase in mortality after process and policy changes implemented with CPOE. *Pediatrics*. 2006;117:1450-51
3. 2008 **Sharek PJ**, Roth SJ. Cardiorespiratory Arrests and Rapid Response Teams in Pediatrics—Reply. *JAMA*. 2008;299:1424
4. 2008 Landrigan CP, Fahrenkopf AM, Lewin D, **Sharek PJ**, Barger LK, Eisner M, Edwards S, Chiang VW, Wiedermann BL, Sectish TC. Effects of the Accreditation Council for Graduate Medical Education Duty-Hour Limits on Sleep, Work Hours, and Safety: In Reply *Pediatrics*. 2008;122:1414-1415.
5. 2011 Landrigan CP, Goldmann DA, **Sharek PJ**. Temporal trends in rates of patient harm resulting from medical care. *N Engl J Med* 2011;364:685
6. 2011 **Sharek PJ**, Parast LM, Roth SJ. Rapid response team implementation in a children's hospital. The Pediatric Forum, *Arch Pediatr Adolesc Med*. 2011;165:1139

Journal reviewer

2012-present Reviewer, *Joint Commission Journal on Quality and Patient Safety*
2016-present Associate Editor, *Pediatric Quality and Safety*

Abstracts (n=63)

April 1999 **Sharek PJ**. Using quality improvement methods to improve nosocomial infection rates in a neonatal intensive care unit. Presented at the Vermont Oxford Network NICU 2000 quality improvement collaborative semi-annual meeting, Washington DC.

May 1999 **Sharek PJ**, Bergman DA. The effect of inhaled steroids on the linear growth of children with asthma; A meta-analysis. Presented at the Pediatric Academic Societies national meeting, San Francisco, CA

Sept 1999 **Sharek PJ**. Evidence of improved nosocomial infection rates after implementation of a handwashing policy. Presented at the Vermont Oxford Network NICU 2000 quality improvement collaborative semi-annual meeting, Chicago, IL

May 2000 **Sharek PJ**, Benitz WE, Abel NJ, Freeburn MJ, Bergman, DA. Improved nosocomial infection rates in a neonatal intensive care unit after initiation of an evidence-based hand washing program. Presented at the Pediatric Academic Societies national meeting, Boston, MA

Sept 2000 **Sharek PJ**. Vitamin A administration to improve Chronic Lung Disease at LPCH. Presented at the Vermont Oxford Network NICU 2000 quality improvement collaborative semi-annual meeting, Seattle, WA

Sept 2000 **Sharek PJ**. Gentle ventilation: Use of low tidal volume ventilation on premature infants at LPCH. Presented at the Vermont Oxford Network NICU 2000 quality improvement collaborative semi-annual meeting, Seattle, WA

April 2001 **Sharek PJ**. Decreasing adverse drug events from TPN administration at LPCH. Presented at the Vermont Oxford Network NICU 2000 quality improvement collaborative semi-annual meeting, Atlanta, GA

April 2001 **Sharek PJ**. Use of maximal barrier precautions with central line insertion at LPCH. Presented at the Vermont Oxford Network NICU 2000 quality improvement collaborative semi-annual meeting, Atlanta, GA

May 2001 **Sharek PJ**, Mayer ML, Bergman DA, Umetsu D, Shames RA. Correlations between measures of asthma status: A longitudinal study of low income inner city children. Presented at the Pediatric Academic Societies national meeting, Baltimore, MD

May 2001 **Sharek PJ**, Mayer ML, Bergman DA, Umetsu D, Shames RA. Comparison of Color Zones and Control Charts in Predicting Asthma Exacerbations in Children. Presented at the Pediatric Academic Societies national meeting, Baltimore, MD

May 2001 Bergman DA, Mayer ML, **Sharek PJ**, et al. An asthma disease management program: Results form a randomized clinical trial. Presented at the Pediatric Academic Societies national meeting, Baltimore, MD

October 2001 **Sharek PJ**. Decreasing adverse drug events from TPN administration at LPCH: An update. Presented at the Vermont Oxford Network NICU 2002 quality improvement collaborative semi-annual meeting, Burlington, VT

October 2001 **Sharek PJ**. Securing "strategic priority" Status for patient safety from LPCH governance and leadership. Presented at the Vermont Oxford Network NICU 2002 quality improvement collaborative semi-annual meeting, Burlington, VT

March 2002 Loring K, **Sharek PJ**, Bergman DA, Shames R, Mayer M, Umetsu D. Environmental exposure and sensitization to cockroach, dust mite, and cat allergen: Correlation with asthma symptoms in a population of disadvantaged, inner-city children in the San Francisco Bay Area. American Academy of Allergy, Asthma and Immunology annual meeting, NY, NY

April 2002 **Sharek PJ**. Improving patient safety. Decreasing adverse drug events from TPN administration at LPCH. Presented at the Vermont Oxford Network NICU 2002 quality improvement collaborative semi-annual meeting, New Orleans, LA

Sept 2002 Forte, J, Rhine W, **Sharek PJ,** et al. The use of sucrose analgesia to relieve procedural pain in neontaes. Presented at the Vermont Oxford Network NICU 2002 quality improvement collaborative semi-annual meeting, Chicago, IL

Sept 2002 **Sharek PJ,** Forte, J, Rhine W**,** et al. Involving families in establishing the safety agenda at LPCH. Presented at the Vermont Oxford Network NICU 2002 quality improvement collaborative semi-annual meeting, Chicago, IL

April 2003 Forte, J, Rhine W, **Sharek PJ,** et al**,** et al. Implementation of sucrose analgesia in the LPCH nurseries. Presented at the Vermont Oxford Network NICU 2000 quality improvement collaborative semi-annual meeting, San Diego, CA

April 2003 **Sharek, PJ**. Dizon R, Ikuta L, et al. Implementation of AHRQ and CDC barrier precaution best practices to prevent central line infections. Presented at the Vermont Oxford Network NICU 2002 quality improvement collaborative semi-annual meeting, San Diego, CA

Sept 2003 Forte, J, Almgren C, **Sharek, PJ**, et al. Implementation of sucrose analgesia in the Lucile Packard Children's Hospital nurseries. Presented at the Vermont Oxford

	Network NICU 2002 quality improvement collaborative semi-annual meeting, Montreal, Quebec, Canada
Sept 2003	Rhine, W, **Sharek, PJ**, Gilley, D, et al. Use of a human factors checklist to improve the safety around clinical alarms at Lucile Packard Children's Hospital. Presented at the Vermont Oxford Network NICU 2002 quality improvement collaborative semi-annual meeting, Montreal, Quebec, Canada
Oct 2003	**Sharek, PJ**, Frankel L, Parker, J, et al. Using AHRQ patient safety best practices: Intrahospital transport at Lucile Packard Children's Hospital. Presented at the semi-annual Child Health Accountability Initiative national meeting, San Diego, CA
Oct 2003	**Sharek, PJ**, Poole R, Trotter S. Using AHRQ patient safety best practices: Corollary orders at Lucile Packard Children's Hospital. Presented at the semi-annual Child Health Accountability Initiative national meeting, San Diego, CA
Oct 2003	**Sharek, PJ**, Dizon, R, Ikuta L, et al. Using AHRQ patient safety best practices to reduce central venous catherter associated infections at Lucile Packard Children's Hospital. Presented at the semi-annual Child Health Accountability Initiative national meeting, San Diego, CA
May 2004	Bergman DA, **Sharek PJ**, Ekegren K, Saunders M. The use of telemedicine access to schools to facilitate expert assessment of children with asthma. Presented at the Pediatric Academic Societies national meeting, San Francisco, CA
April 2005	Fitzgerald S, DeBattista A, **Sharek P**, Wayman K, Cerini L, Rhine W. Family involvement in the NICU at LPCH: Increasing staff awareness. Presented at the Vermont Oxford Network *Your Ideal NICU* quality improvement collaborative semi-annual meeting, Portland, OR
January 2006	Yaeger KA, Halamek LP, Wayman K, Trotter S, Wise L, Keller H, Ashland, **Sharek PJ**. Simulation-based parent-guided project to improve disclosure of unanticipated outcomes. Poster Presentation: Sixth Annual International Meeting on Medical Simulation, San Diego, CA
June 2006	Fahrenkopf AM, Sectish T, Barger L, **Sharek PJ**, Lewin D, Chiang VW, Weiderman B, Landrigan CP. Impact of the accreditation council for graduate medical education duty hour standards on resident sleep, education, and safety: A multicenter study. Oral Presentation: SLEEP 2006 20th Anniversary meeting of the Associated Professional Sleep Societies, LLC. Salt Lake City, UT.
Dec 2006	Rhine W, **Sharek PJ,** Armstrong L, Galazo D, Freeman H. Using Microsystems theory to improve quality and safety in the Lucile Packard Children's Hospital Neonatal Intensive Care Unit. Institute for Healthcare Improvement (IHI) National Forum 2006, Orlando, FL
June 2007	Staveski S, Childrey J, Leong K, **Sharek PJ**, Murphy D, Roth S. Optimizing patient safety through standardized provider handoffs. Fifth World Congress on Pediatric Critical Care, Geneva, Switzerland.
April 2008	Childrey J, Leong K, Murphy D, Roth S, **Sharek PJ**, Staveski S. Improving pediatric nurse practitioners' work efficiency and job satisfaction while optimizing patient outcomes during provider handoffs" National Association of Pediatric Nurse Practitioner's Annual Conference, 2008, Nashville, TN
October 2008	Staveski S, Bond J, Leong K, **Sharek PJ**, Murphy D, Roth S. Optimizing patient safety through standardized provider handoffs. Bay Area Research Day, 2008, San Francisco, CA.

Nov 2009 Butte A, Kogelnik A, Suermondt J, **Sharek PJ**; Longhurst C. Automated risk assessment for prediction of pediatric adverse events. American Medical Informatics Association (AMIA) Annual Forum 2009, San Francisco, CA

Nov 2009 Staveski S, Bond J, Leong K, **Sharek PJ**, Murphy D, Roth S. Optimizing patient safety through standardized provider handoffs. Lucile Packard Children's Hospital Nursing Research Symposium 2009, Palo Alto, CA.

May 2012 Profit, J, Sexton B, Amspoker AB, Kowalkowski M, **Sharek PJ**, Thomas E. Higher safety culture among neonatal intensive care units that participate in quality improvement collaboratives, abstract #752854, Pediatric Academic Societies' Annual Meeting 2012, Boston, MA

May 2012 Profit, J, Sexton B, Amspoker AB, Kowalkowski M, **Sharek PJ**, Thomas E . Prevalence of emotional exhaustion in a cohort of 21 neonatal intensive care units, abstract #752863, Pediatric Academic Societies' Annual Meeting, 2012, Boston, MA

Dec 2012 Shin AY, Algaze C, Wood M, Pageler N, Roth SJ, **Sharek P**, Longhurst C. Impact of clinical resource management: Optimizing laboratory utilization is associated with reduced cost and improved patient outcomes. Pediatric Cardiac Intensive Care Society 9th International Symposium, Miami, FL

Feb 2013 Caruso T, **Sharek, PJ**, Marquez J, Wu D, Wang E, Honkanen A. Development of a standardized OR to PACU handoff. Society of Pediatric Anesthesia meeting 2013, Las Vegas, NV

Feb 2014 Profit J, **Sharek PJ**, Thomas E, Gould JB, Nisbet C, Amspoker A,Kowalkowski M, Schwendimann R, Sexton B. Exposure to leadership walkrounds in neonatal intensive care units is associated with a better patient safety culture, and less caregiver burnout. Western Pediatric Academic Societies' Annual Meeting 2014, Monterey, CA

Feb 2014 Lee HC, Bennett M, **Sharek PJ**, Powers RJ. Collaborative vs individual quality improvement for delivery room neonatal management. Oral Presentation. Western Society for Pediatric Research Regional Meeting. Carmel, CA

Mar 2014 Caruso TJ, Duan M, Marquez J, We D, Makhatari T, Shaffer J, Groom M, Honkanen A, **Sharek PJ.** Implementation of a standardized post anesthetic care handoff improves outcomes and efficiency. Society of Pediatric Anesthesia meeting 2014, Fort Lauderdale, FL

Mar 2014 Gipp MS, **Sharek P**, Kellener S, Marquez JL, Caruso TJ. The development and implementation of a standardized multidisciplinary ICU to OR patient care handoff. Society of Pediatric Anesthesia meeting 2014, Fort Lauderdale, FL

April 2014 Goel VV, Poole SF, Platchek TS, Longhurst CA, **Sharek PJ**, Palma JP. Data drven approach to vital sign paramaters at Lucile Packard Children's Hospital. Stanford University School of Medicine 5th Annual Pediatric Research Retreat. Stanford, CA.

May 2014 Stone S, **Sharek PJ**, Lee H. Identification of factors critical to sustained improvement following a multicenter quality improvement collaborative. Pediatric Academic Societies meeting 2014. Vancouver, BC, Canada

May 2014 Lee HC, Bennett M, **Sharek PJ**, Powers RJ. Collaborative vs individual quality improvement for delivery room neonatal management. Pediatric Academic Societies meeting 2014. Vancouver, BC

July 2014 Stone S, **Sharek PJ**, Lee H. Identification of factors critical to sustained improvement following a multicenter quality improvement collaborative. Pediatric Hospital Medicine meeting 2014. Orlando, FL

August 2014 Goel VV, Poole SF, Platchek TS, Longhurst CA, **Sharek PJ**, Palma JP. Data driven approach to vital sign parameters at Lucile Packard Children's Hospital. American Medical Informatics Association (AMIA) National Symposium, Washington DC (Nov 2014) submission 08.06.14.

Dec 2014 Sacks L, Wright G, Shin A, **Sharek PJ**, Krawczeski C. Pre-arrival targeted education in the pediatric cardiovascular intensive care unit (CVICU): A model to improve situational awareness. 10th International Pediatric Cardiac Intensive Care Society (PCICS) Conference in Miami Beach, Florida 12.13.14

March 2015 Caruso T, Coughlin M, Mokhtari T, Wu D, **Sharek PJ**. Portable Post-Operative Pulse Oximetry Monitoring Reduces Incidence of Hypoxemia on PACU Arrival. 2015 Children's Hospital Association's Quality and Safety in Children's Health Conference, San Francisco CA.

March 2015 Giustini AJ, **Sharek PJ,** Loh LM, Olson J, Chen K, Caruso TJ. Designing for high reliability: A web based solution to reduce NPO violations. Society of Pediatric Anesthesia/American Academy of Pediatrics (SPA/AAP) Pediatric Anesthesia 2015 meeting. Phoenix, AZ. 03.13.15

March 2015 Elgin KH, Caruso T, **Sharek PJ**. A description of naloxone use in the perioperative setting at Stanford Children's Hospital. Society of Pediatric Anesthesia/American Academy of Pediatrics (SPA/AAP) Pediatric Anesthesia 2015 meeting. Phoenix, AZ. 03.14.15

April 2015 Algaze C, **Sharek PJ.** Building a clinical effectiveness program at LPCH. Establishing a prototype clinical pathway. Stanford University Department of Pediatrics Annual Research Retreat. 04.17.15

August 2015 Goel V, Poole S, Kipps A, Palma J, Platchek T, Longhurst C, **Sharek PJ**. Implementation of data driven heart rate and respiratory rate parameters on a pediatric acute care unit. International Medical Informatics Association "Medinfo" Conference, 15th World Congress on Health and Biomedical Informatics, San Paulo, Brazil. 08.19.15. IOS Press Ebooks http://www.ncbi.nlm.nih.gov/m/pubmed/26262220/ 08.20.15

October 2015 Thomas J. Caruso, MD, MEHP; Ling Loh, MPH; Hayden Schwenk, MD, MPH; Ellen Wang, MD; Jenny Shaffer, RN; Julie Cahn, MSN, RN; Kevin Chen, BS; Joh Olson, RN, MBA; **Paul J. Sharek, MD, MPH**. The development of a cardiovascular surgical site infection reduction bundle. Solutions for Patient Safety Meeting, October 2015, St Louis, MO

October 2015 Krisa Hoyle Elgin, David Stockwell, Valere Lemon, Darren Klugman, Eric Kirkendall, Philip Hagedorn, **Paul J. Sharek, MD, MPH**. Trigger Detection of Opiate Related Adverse Events Across Five Years and Three Children's Hospitals: A Description of Findings. Solutions for Patient Safety Meeting, October 2015, St Louis, MO

Dec 2015 Pardini-Kiely K, Mawer S, Elgin KH, **Sharek PJ.** Safety by Design: Creating the Prototype for Design Thinking for Patient Safety at Stanford and Lucile Packard Children's Hospital. Institute for Healthcare Improvement Annual Quality Forum, Dec 2015, Orlando, FL

Feb 2016 Bhat P, Costello J, Aiyagari R, **Sharek PJ**, Mazwi M, Roth S, Shin A. Harmful diagnostic errors occur frequently in Pediatric Cardiac Intensive Care: A multi-site

survey. Cardiology 2016: 19th Annual Update on Pediatrics and Congenital Cardiovascular Disease. February 2016, Orlando, FL.

April 2016 Connor E, Claure R, Wagner J, Wang E, Lusk B, Tweedy M, **Sharek PJ**, Caruso TJThe development and implementation of a pre-anesthesia diet to decrease fasting times and NPO violations. Western Society of Pediatric Anesthesiologists. April 2016, San Francisco CA. *Award winner- Best Project*

May 2016 Lee Henry C, Bennett Mihoko V, Nisbet Courtney , Gould Jeffrey B, Crockett Margaret, Crowe Ruth, Gwiazdowski Steven G, Keller Heather, Kurtin Paul, Kuzniewicz Michael, Mazzeo Ann Marie, Schulman Joe, **Sharek Paul J.** Collaborative Quality Improvement to Reduce NICU Length of Stay. Abstract presentation. *Pediatric Academic Societies (PAS) meeting.* May 2016, Baltimore, MD

May 2016 Kipps A, **Sharek PJ**, Slaney C, Feehan S, Goel V. Implementation of Data-Driven Vital Sign Parameters. *Western Society of Pediatric Cardiology meeting.* May 2016, Salt Lake City, UT

May 2016 Algaze CA**, Sharek PJ**, Nather C, Ramamoorthy C, Kamra K, Kipps A, Yarlagadda VV, Mafla M, Elgin K, Vashist T, Shin AY, Krawczeski CD. Standardizing the perioperative and postoperative care of Tetrology of Fallot. *Western Society of Pediatric Cardiology meeting.* May 2016, Salt Lake City, UT

Jan 2017 Rodriquez S, Wang EY, Terajewicz AG, Brockington D, Cunningham C, **Sharek PJ**, Marquez J, Caruso T,. A Novel Bed-Mounted Projection System is as Effective as Pharmacologic Modalities to Treat Pediatric Preoperative Anxiety. *Society for Technology in Anesthesia*. January 2017. San Diego, CA

Under Review (n=3)

March 2017 Feehan S, Sharek PJ, et al: MedsTime: Integrating Patients and Families in Medication Safety. CHA Quality Conference, March 2017, New Orleans, LA *(submitted)*

March 2017 Algaze CA, Sharek PJ, et al; Modular Pathways: Streamlining processes across patient populations to decrease variation. CHA Quality Conference, March 2017, New Orleans, LA *(submitted)*

March 2017 Algaze CA, Sharek PJ, et al; Target-Based Care: Targeting Clinical Outcomes in Real Time to Decrease Variability in Care. CHA Quality Conference, March 2017, New Orleans, LA *(submitted)*

PRESENTATIONS

Named Lectureships (n=4)

2008 Dr. JM Bowman Lecture in Neonatal Research, University of Manitoba, Winnipeg, Manitoba, Canada. *Moving Closer to High Reliability, Understanding and Improvement Patient Safety in the Neonatal Intensive Care Unit.* September 25, 2008

2009 Sydney Snyder, Endowed Patient Safety Lectureship, Children's National Medical Center, Washington, DC. *The Next Generation of Pediatric Patient Safety*. February 4, 2009

2010 Estrellita and Yousuf Karsh Lecture, Children's Hospital of Eastern Ontario (CHEO) and the University of Ottawa, Ottawa, Canada. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in Pediatrics.* September 22, 2010

2011 Julie Berg Memorial Lectureship, Amplatz Chidlren's Hospital, University of Minnesota, Minneapolis, MN. *Moving Closer to High Reliability: Partnering with Parents to Improve Patient Safety*. September 21, 2011

Keynote Speaker (n=7)

2002 Keynote speaker, National Association of Neonatal Nurses, Marco Island, FL: *Holy #@$%^&*! You Gave How Much Morphine? Medication Errors: Problems and Solutions.* April 28, 2002

2002 Keynote speaker, Child Health Corporation of America, Neonatal Intensive Care Management Meeting, Marco Island, FL. *Holy #@$%^&*! You Gave How Much Morphine? Medication Errors: Problems and Solutions.* April 29, 2002

2003 Keynote speaker, Perinatal Hot Topics Statewide Nurse Conference, Sacramento, CA. *Medication Errors.* February 25, 2003

2006 Keynote speaker. California Health Information Association (CHIA) annual meeting. Palm Springs, CA. *The Role of Health Information Management in Enhancing Patient Safety.* June 4, 2006

2008 Keynote speaker. Morgan Stanley Children's Hospital at Columbia University, New York, NY. Keynote presentation presented to 200+ attendees at the Columbia University annual leadership retreat on patient safety and quality of care. *Lucile Packard Children's Hospital's Most Excellent Adventure: Transitioning to High Reliability*. May 29, 2008

2009 Keynote. Health and Life Sciences Symposium, Hewlett Packard 2009, Phoenix, AZ. Keynote speaker. *The future of quality and safety in healthcare. Transitioning to high reliability.* March 3, 2009

2016 Keynote Speaker, Patient Safety and Quality Symposium 2016, "Hardwiring for High Reliability." Washington University, St Louis, MO. *Moving Towards High Reliability: Leveraging Health Information Technology to Improve Patient Safety*

Grand Rounds (n=31)

1995 University of California, San Francisco (UCSF), San Francisco General Hospital, San Francisco, CA. *Medical Experiences in a Refugee Camp in Southeast Asia.* June 7, 1995

1997 John Muir Medical Center, Walnut Creek, CA. *Improving the Quality of Care of Children in the Office Setting.* July 10, 1997

1997 University of California, San Francisco (UCSF), San Francisco General Hospital, San Francisco, CA. *Improving the Quality of Care for Children with Asthma.* November 25, 1997

1999 University of California, San Francisco (UCSF), San Francisco General Hospital, San Francisco, CA. *Bridging the Gap between Theory and Practice in Caring for Children with Asthma.* July 6, 1999

2000 University of California, San Francisco (UCSF), San Francisco General Hospital, San Francisco, CA. *You gave how much morphine? Medication Errors: Problems and Solutions.* August 22, 2000

2000 University of California at San Francisco (UCSF), San Francisco, CA. *Medication Errors.* November 16, 2000

2001 Lucile Packard Children's Hospital, Palo Alto, CA. *Medication Errors: What's All the Fuss About?* January 5, 2001

2001 Kaiser Permanente, San Francisco, CA. *Medication Errors.* February 22, 2001

2002 University of California, San Francisco (UCSF), San Francisco General Hospital, San Francisco, CA. *How the *&@#!*% Do I Begin to Improve Patient Safety? A Practical Approach Used at LPCH*. February 11, 2002

2007 Stanford University School of Medicine and Medical Center, Stanford CA. Department of Anesthesia. *Moving Closer to High Reliability: Improving Patient Safety in the Operating Room Using Reliability Science and Concepts of Organizational Psychology*. March 5, 2007

2007 University of California, San Francisco (UCSF), San Francisco General Hospital, San Francisco, CA. *Improving Pediatric Patient Safety Using High Reliability Science* May 29, 2007

2007 Hospital for Sick Kids, Toronto, Ontario, Canada. *Using High Reliability Concepts to Improve Pediatric Patient Safety.* June 6, 2007

2008 Children's Hospital of Philadelphia, Philadelphia, PA. *Lucile Packard Children's Hospital's Most Excellent Adventure: Transitioning to High Reliability*. May 30, 2008

2008 Oakland Children's Hospital, Oakland, CA. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in Pediatrics.* September 23, 2008

2009 University of California at Davis. Davis, CA. *Present and Future Approaches to Improving Pediatric Patient Safety*. April 17, 2009

2010 Children's Hospital of Eastern Ontario (CHEO) and University of Ottawa; Ottawa, Ontario, Canada. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in Pediatrics.* September 22, 2010

2010 Children's Hospital of Los Angeles, Los Angeles, CA. *What the heck is high reliability and what does it have to do with patient safety?* October 15, 2010

2010 Children's Hospital of Los Angeles, Los Angeles, CA. Grand Rounds (Nursing): *Patient Safety in Children: Challenges and Solutions Related to Medications.* October 15, 2010

2010 Children's Hospitals of Children's Hospitals and Clinics, Minnesota. Children's Hospital of St Paul campus. St Paul, MN. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in Pediatrics.* October 21, 2010

2011 California Pacific Medical Center, San Francisco, CA. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in Pediatrics*. June 17, 2011

2011 Montefiore Children's Hospital, Albert Einstein College of Medicine, New York, NY. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in Pediatrics.* October 12, 2011

2011 Stanford University School of Medicine, Department of Anesthesia Grand Rounds. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in Pediatrics*. November 7, 2011

2012 Colorado Children's Hospital, University of Colorado, Aurora, CO. *Advancing Quality and Patient Safety Using the Electronic Medical Record.* February 2, 2012

2012 University of Hawai'i, Kapiolani Children's Hospital, Honolulu, HI. *Moving Closer to High Reliability Part 1: Understanding and Improving Patient Safety in Pediatrics.* October 22, 2012

2012 University of Hawai'i, Kapiolani Children's Hospital, Honolulu, HI. *Moving Closer to High Reliability Part 2: Partnering with Parents to Improve Patient Safety in Pediatrics.* October 25, 2012

2013 Duke University, Durham, NC. Moving Towards High Reliability. *Leveraging the Electronic Medical Record to Improve Patient Safety.* October 8, 2013

2013 University of North Carolina, Chapel Hill, NC. *Leveraging the Electronic Medical Record to Improve Patient Safety.* October 10, 2013

2015 St Jude Children's Research Hospital. *The Journey to High Reliability: Understanding and Improving Patient Safety in Pediatrics*. December 3, 2015

2016 Nationwide Children's Hospital, Columbus, Ohio. "Forget the Airline Industry: How Do We Move Closer to High Reliability in *Healthcare.* October 25, 2016

2017 Lucile Packard Children's Hospital Stanford: TBD Feb 10, 2017

2017 New York University (NYU) Medical Center: TBD. March 7, 2017

Invited Speaker (n=91)

1999 Stanford University School of Business, Stanford, CA. Seminar, Quality Management in Health Care. *Tools for Continuous Quality Improvement: the Healthcare Providers Point of View.* April 9, 1999

2000 University of California San Francisco School of Medicine. Continuing Medical Education in Family and Community Medicine. Annual Review in Family Medicine. Controversies and Challenges in Primary Care, San Francisco, CA. *Pediatric Asthma.* March 31, 2000

2000 UCSF-Stanford Center for Research and Innovation in Patient Care Research Day 2000, San Francisco, CA. *Improved Coagulase Negative Staph Rates in a Large NICU after Implementation of an Evidence-Based Hand Washing Policy.* October 24, 2000

2000 National Association of Children's Hospitals and Related Institutions (NACHRI) Quality Improvement Workshop, San Francisco CA. *Improving Outcomes for Low-Birthweight Premature Infants.* December 5, 2000

2001 California Association for Healthcare Quality Symposium "Keys to Patient Safety", Palo Alto, CA. *How the *&@#!*% Do I Begin to Improve Patient Safety? A Practical Approach Used at Lucile Packard Children's Hospital.* October 5, 2001

2001 Vermont Oxford Neonatal Network 2nd Annual Quality Congress for Neonatology, Washington, D.C. *Improving the Safety of TPN Administration: A Practical Example from Lucile Packard Children's Hospital*. December 9, 2001

2002 Washington Township Hospital, Fremont CA. *Medication Errors: What's All the Fuss About?* January 25, 2002

2002 California Perinatal Quality Care Collaborative Workshop, Los Angeles, CA: Successful Strategies for Implementing Neonatal Practice Improvements. *Use of Quality Improvement Techniques to Prevent Nosocomial Infection in Nurseries.* March 1, 2002

2002 Child Health Accountability Initiative, semi-annual meeting. Kansas City, MO. *Integration of projects developed at the Child Health Accountability Initiatives into the general hospital workflow*. September 19, 2002

2003 Beyond Primary Colors: The Spectrum of Perinatal and Pediatric Nursing, Palo Alto, CA: *Patient Safety and Nursing Practice: Background to the Patient Safety Crisis in America*. February 22, 2003

2003 Child Health Accountability Initiative, semi-annual meeting. St. Louis, MO. *Multi-site Collaboration as a Strategy to Improve Medication Safety.* March 27, 2003

2003 Child Health Accountability Initiative, semi-annual meeting. St. Louis, MO. *Integration of the Pediatric Adverse Drug Event Trigger Tool into the Workflow.* March 28, 2003

2003 Child Health Accountability Initiative, semi-annual meeting. San Diego, CA. *Implementing Pediatric Patient Safety Practices: An update on the CHAI awarded Agency for Healthcare Research and Quality's Partnerships for Quality grant.* October 1, 2003

2004 Child Health Accountability Initiative: 5 year reunion conference, San Diego, CA. *Patient Safety and CHAI: Building the Foundation for the AHRQ Partnerships in Quality Grant Award*. January 12, 2004

2004 Center for Patient Safety in Neonatal Intensive Care meeting, Burlington, VT. *The Child Health Accountability Initiative (CHAI) and Pediatric Patient Safety: The IHI Trigger System*. February 9, 2004

2004 American Academy of Pediatrics (AAP) National Conference and Exhibition, San Francisco, CA. Seminar: *Making Health Care Safer for Children: Practical Strategies that Improve Quality and Reduce Malpractice*. October 12, 2004

2005 National Initiative for Children's Healthcare Quality (NICHQ), Fourth annual forum for improving children's health care, San Diego, CA. *Improvement by Collaboration.* March 1, 2005

2005 Child Health Corporation of America, Quality and Safety Conference 2005. Phoenix, AZ. *The Role of Physician Leaders in Patient Safety*. April 6, 2005

2005 Child Health Corporation of America, Quality and Safety Conference 2005. Phoenix, AZ. Race for Results Award presentation. *Adverse Drug Events: What Lucile Packard Children's Hospital did to Decrease them by 70%.* April 7, 2005

2005 Agency for Healthcare Research and Quality (AHRQ). Conference: Patient Safety and Health Information Technology: Making the Health Care System Safer through Implementation and Innovation. Washington DC. *"Patient Safety across Settings and Populations: Children's Care"* Panel. June 6, 2005

2005 California Patient Safety Consortium: Fourth Annual California Patient Safety Consortium Meeting. Stanford, CA. *Engaging Physicians in Quality and Patient Safety.* August 29, 2005

2005 Vermont Oxford Neonatal Network's Neonatal Intensive Care Quality Improvement Collaborative 2005 (NIC/Q2005) semi-annual meeting. Nashville, TN. *Development of a Neonatal Trigger Tool to Identify Adverse Events: Preliminary Results.* September 12, 2005

2005 Child Health Corporation of America, semi-annual national meeting. Chicago, IL. The Culture of Patient Safety at Children's Hospitals: *How We Stack Up Against the Big Boys and Girls (i.e. adults)*. September 13, 2005

2006 Ohio Children's Hospital Association's (OCHA) "Quality Summit", Columbus, Ohio. *Launching an Ohio-Based Children's Hospital Quality Collaborative*. I was the lone facilitator of the 6 Children's hospital members of OCHA's efforts to embark on a collaborative quality and patient safety improvement initiative. This 6

hour facilitation meeting was attended by the CEOs, Chief Medical Officers, and the Chief Nursing Officers of these 6 children's hospitals. June 16, 2006

2006 Child Health Corporation of America (CHCA). *"Improve today" Informational webcast series: Preventing Adverse Drug Events related to Opiates and Narcotics*. July 19, 2006

2006 National Initiative for Child Health Quality (NICHQ), Child Health Corporation of America (CHCA), American Academy of Pediatrics (AAP) and National Association of Children's Hospitals and Related Institutions (NACHRI): Getting to Zero: The Kids' Campaign, "Office Hours". *Adverse Drug Events.* July 26, 2006

2006 Agency for Healthcare Quality and Research (AHRQ).Partnerships for Quality annual meeting. Rockville, MD. *Improving Pediatric Patient Safety*. September 27, 2006

2006 National Association of Children's Hospitals and Related Institutions (NACHRI). National meeting, Boston MA. *Improving Communication in the Pediatric Intensive Care Unit Using Daily Goal Sheets.* October 8, 2006

2007 California Association of Neonatologists (CAN). Thirteenth Annual Conference. Current Topics and Controversies in Perinatal and Neonatal Medicine, Coronado Island, CA. *Moving Closer to High Reliability: Understanding and Improving Patient Safety in the NICU.* March 3, 2007

2007 National Initiative for Children's Healthcare Quality (NICHQ). Sixth Annual National Forum for Improving Children's Healthcare. San Francisco, CA. *Measuring Harm in Pediatrics-A Practical Primer on Trigger Tools. Pediatric Trigger Tools.* March 21, 2007

2007 Plenary session. Child Health Corporation of American. Annual meeting. Los Angeles, CA. *Sustained Reduction in Hospital-Wide Mortality Associated with Implementation of a Rapid Response Team in an Academic Children's Hospital.* April 25, 2007

2007 Hospital for Sick Kids, Toronto, Ontario, Canada. Third annual partners in pediatric patient safety symposium": Spreading the word. *Measuring and Improving Patient Safety.* June 7, 2007

2007 University of Toronto, Department of Neonatology. *Using quality improvement techniques to improve neonatal outcomes.* June 7, 2007

2007 University of Toronto Faculty of Medicine. First annual patient safety and quality academic day. *Patient Safety Culture: Obstacles and Enablers. Panel with James Conway, MS, ex-COO Dana-Farber Cancer Institute.* June 8, 2007

2007 University of Toronto Faculty of Medicine. First annual patient safety and quality academic day. *Advancing an academic approach to patient safety and quality improvement for clinicians. Panelist.* June 8, 2007

2007 Child Health Corporation of America. Quality and Safety Leaders Forum. Dallas, TX. *Integrating patients and families to improve pediatric patient safety.* October 23, 2007

2008 International Meeting on Simulation in Healthcare, 8th annual meeting, San Diego, CA. *Achieving sustainability: Aligning the mission of your simulation program with that of your hospital. The role of patient safety.* January 15, 2008

2008 Stanford University School of Medicine Deans Retreat (Panelist/Presenter): *Fostering the Highest Quality Patient Care.* Santa Cruz, CA. February 2008

2008 National Initiative for Children's Healthcare Quality (NICHQ). Seventh Annual National Forum for Improving Children's Healthcare. Miami, FL. *The Science of Measuring (and Preventing) Harm in Pediatrics: Pediatric Trigger Tools and Beyond.* March 18, 2008

2008 National Initiative for Children's Healthcare Quality (NICHQ). Seventh Annual National Forum for Improving Children's Healthcare. Miami, FL. *Transitioning to High Reliability: Operationalizing Simulation*. March 18, 2008

2008 St Louis Children's Hospital. St Louis, Missouri. *The Science of Measuring (and Preventing) Harm in Pediatrics: Pediatric Trigger Tools and Beyond*. May 13, 2008

2008 St Louis Children's Hospital. St Louis, Missouri. *Transitioning to High Reliability: Operationalizing Simulation.* May 13, 2008

2008 St Louis Children's Hospital. St Louis, Missouri. *"Run, Don't Walk". The Rapid Response Team Intervention at LPCH.* May 13, 2008

2008 St Louis Children's Hospital. St Louis, Missouri. *An Evidence-based Clinical Transformation: The Lucile Packard Children's Hospital Story.* May 13, 2008

2008 American Academy of Pediatrics Safer Healthcare for Kids Webnar Series. *Run, Don't Walk: Implementing a Rapid Response Team at an Academic Children's Hospital.* Presenter and Moderator, international webcast. June 05, 2008

2008 Institute for Healthcare Improvement, Twentieth Annual National Forum, Nashville, TN. *The North Carolina Patient Safety Study, 2002-2007. Is Hospital Care Getting Safer?* December 10, 2008

2008 Maryland Patient Safety Center, Expert Panel Meeting, Baltimore, MD. *Preventing Healthcare Associated Infections.* December 17, 2008

2008 Maryland Patient Safety Center, Expert Panel Meeting, Baltimore, MD. *Measuring and tracking the burden of harm in the Neonatal Intensive Care Unit- the NICU Trigger Tool.* December 17, 2008

2009 Stanford University Center on Health Policy/Center on Primary Care and Outcomes Research, "Research in Progress" Seminar. *The North Carolina Harm Study: Validating the IHI Global Trigger Tool (GTT) as a Potential National Harm Measure.* April 29, 2009

2009 Hospital for SickKids, Toronto, Ontario, Canada, 5th Annual Partners in Paediatric Patient Safety Symposium. *Are we making a difference in hospital mortality rates? The Lucile Packard Children's Hospital experience.* June 11, 2009

2009 Child Health Corporation of America. Quality and Safety Leaders Forum. Baltimore MD. *Are we making a difference in hospital mortality rates?* September 16, 2009

2009 Child Health Corporation of America. Quality and Safety Leaders Forum. Baltimore MD. *External data transparency at Lucile Packard Children's Hospital.* September 17, 2009

2009 Great Ormond Street Hospital for Children (GOSH). London, England. *Moving Closer to High Reliability: Understanding and Improving Medication Safety in Pediatrics.* October 12, 2009

2009 International Society for Quality in Healthcare (ISQua), 26th annual international conference on quality in healthcare, 2009. Dublin, Ireland. *Patient Safety in Children: Challenges and Solutions Related to Medications.* October 13, 2009

2010 Mid-Coastal California Perinatal Outreach Program (MCCPOP) 30th annual meeting. Perinatal potpourri: Reaching out a looking forward. Monterey, CA. *Patient Safety.* January 28. 2010

2010 Child Health Corporation of America. Quality and Safety Leaders Forum. Encore Presentations Webcast Series, 2009 Fall Forum Series. *Reporting Quality and Safety Data on Public Websites.* February 10. 2010

2010 National Initiative for Children's Healthcare Quality (NICHQ). National Forum 2010. Atlanta, GA. *Understanding the Challenges of Reducing Adverse Drug Events in Hospitalized Children.* March 9. 2010

2010 National Initiative for Children's Healthcare Quality (NICHQ). National Forum 2010. Atlanta, GA. *The Largest Dot: Are We Making a Difference in Hospital Mortality?* March 9. 2010

2010 Child Health Corporation of America. Quality and Safety Leaders Forum. Encore Presentations Webcast Series, 2009 Fall Forum Series. *Are We Making a Difference in Hospital Mortality?* March 10. 2010

2010 Children's Hospital of Eastern Ontario (CHEO) and University of Ottawa; Ottawa, Ontario, Canada. *Patient Safety in Children: Challenges and Solutions Related to Medications.* September 22, 2010

2010 Children's Hospital of Eastern Ontario (CHEO) and University of Ottawa; Ottawa, Ontario, Canada. *Quality Improvement and Safety in Health Care: Past, Present, and Future.* September 23, 2010

2010 Stanford University Clinical Excellence Research Center. Invited presentation to the Nordic School of Public Health (Sweden). *Transforming Healthcare Data into Better Healthcare: Using Data from Regional Outcomes Registries to Produce Better Healthcare.* October 5, 2010

2010 Children's Hospital of Los Angeles, Los Angeles, CA. *Adverse Event Prevention.* October 14, 2010

2010 Children's Hospitals and Clinics of Minnesota, Minneapolis Children's Hospital campus. *The Role of the Electronic Medical Record in Decreasing Mortality* October 21, 2010

2011 Northern California Pediatric Intensive Care Network Conference. "Extending Critical Care Practice Outside of the PICU". Oakland, CA. *Rapid Response Teams: Looking at Electronic Medical Record Indicators to Anticipate a Rapid Response Team call.* September 30, 2011

2011 American Board of Pediatrics, National Meeting on Collaborative Improvement Networks in Children's Healthcare. Alexandria, VA. *The California Perinatal Quality of Care Collaborative Approach to Collaboratively Improving the Quality of Care Across California.* November 11, 2011

2011 Institute for Healthcare Improvement (IHI) 23rd Annual National Forum on Quality Improvement in Healthcare. Orlando, FL. Minicourse *Making Health Care Safer for Children*. December 5, 2011

2011 Institute for Healthcare Improvement (IHI) 23rd Annual National Forum on Quality Improvement in Healthcare. Orlando, FL. Workshop (x2) *Patient Harm in the United States: How Much?* December 5, 2011

2012 California Association of Neonatologists (CAN) 18th annual conference. Cool Topics in Neonatology.CPQCC/CMQCC Pre-CAN Workshop 2012. *Developing a Change Package: Perils, Pitfalls, and Places to Look for Help*. March 3, 2012

2012 March of Dimes 12th Annual Conference for Healthcare Professionals. Irvine, CA. *California Perinatal Quality of Care Collaborative at Work: Improving Delivery Room Management Across the State of California.* March 6, 2012

2012 Child Health Association (CHA, formerly Child Health Corporation of America). Webnar. *"One Message One time": the LPCH OR to ICU handoff initiative.* April 3, 2012

2012 Frontiers in Pediatric Hospital Medicine, seventh annual symposium. San Francisco, CA. *Advancing Quality and Patient Safety using the Electronic Medical Record.* October 5, 2012

2012 Vermont Oxford Annual Meeting and Quality Congress, Chicago, IL. *100 percent Guarantee- Sustaining Your Gains by Pairing Your Microsystems with Lean* October 13, 2012

2012 Vermont Oxford Annual Meeting and Quality Congress, Chicago, IL. *Collaborative Quality Improvement Success Stories: The California Perinatal Quality of Care Collaborative Experience.* October 14, 2012

2013 American Board of Pediatrics, National Meeting #2 on Collaborative Improvement Networks in Children's Healthcare. Alexandria, VA. Participant/discussant on establishing a "Promoting and Sustaining Collaborative Networks" June 13, 2013

2013 National Association of Neonatal Nurses, 29th Annual Educational Conference, Innovations in Neonatal Care. Nashville, TN. *Cross the Chasm: Pairing Improvement Science and a "Lean" Management System to Continuously Improve.* October 3, 2013

2014 Children's Healthcare Association, Transforming Children's Health Care - Together: 2014 Implementing Quality Improvements in Children's Health Conference. Orlando, FL. *Reliably Measuring Pediatric Patient Safety-From Concept to Implementation.* March 11, 2014

2014 Children's Healthcare Association, Transforming Children's Health Care - Together: 2014 Implementing Quality Improvements in Children's Health Conference. Orlando, FL. *Zero is the Only Option: An Update on the Children's Hospitals' Solutions for Patient Safety (SPS) Network.* March 11, 2014

2014 St Louis Children's Hospital, Second Annual Clinical Informatics Symposium. Translating Improvements in Quality and Safety Using Health Care Informatics and Technology. *Moving Toward High Reliability: Leveraging the Electronic Medical Record to Improve Quality and Patient Safety.* St Louis, Mo. October 3, 2014

2014 Stanford University School of Medicine, Clinical Effectiveness Leadership Training (CELT). *The Journey to High Reliability: Understanding and Improvement Patient Safety*. October 18, 2014

2014 Children's Healthcare Association. Blueprints for Improvement. A Web Series for Children's Hospitals. *Reliably Measuring Pediatric Patient Safety-From Concept to Implementation.* November 19, 2014

2015 Solutions for Patient Safety. Leading Toward Zero Harm: The Next Level in the Role of the Board Conference. Atlanta, GA. *Understanding Safety Basics- Human Factors Engineering.* September 21, 2015

2015 Stanford University, Pediatric Resident Quality Improvement Concentration Conference. Palo Alto, CA. *Improvement Patient Safety in Pediatrics Part 1: Measurement Strategies and Epidemiology of Harm.* September 24, 2015

2015 Stanford University, Pediatric Resident Quality Improvement Concentration Conference. Palo Alto, CA. *Improvement Patient Safety in Pediatrics Part 2: Human Factors and Designing for High Reliability.* October 1, 2015

2015 (x2) Stanford University School of Medicine, Clinical Effectiveness Leadership Training (CELT). *The Journey to High Reliability: Understanding and Improvement Patient Safety*. May 7, 2015 and December 10, 2015

2016 Stanford University School of Medicine Leadership Retreat. Sausalito, CA. Panel *"The Science of Quality"*. February 19, 2016

2016 Breakout session. Patient Safety and Quality Symposium 2016, "Hardwiring for High Reliability." Washington University, St Louis, MO. *A Deeper Dive: Practical Health Information Technology Strategies to Support High Reliability*

2016 Royal College of the Physicians of Ireland (RCPI). Invited lecture. "Patient Safety – What's the big deal?" RCPI headquarters, Dublin, Ireland. June 29, 2016

2016 International Society for Quality in Healthcare (ISQua). Invited lecture (webnar). *The Journey to High Reliability: Understanding and Improving Patient Safety.* Nov 22, 2016

2017 University of California, San Diego. Informatics Department. *The Critical Role of Health Information Technology in Moving Toward High Reliability Healthcare.*

2017 University of California, San Diego. Graduate school of Bioinformatics. *The Critical Role of Health Information Technology in Improving Quality and Patient Safety*

MEETING PLANNING (n=10)

2007 National Initiative for Children's Healthcare Quality (NICHQ). Sixth Annual National Forum for Improving Children's Healthcare. San Francisco, CA. One-day Exploratorium: *Pediatric Patient Safety Knows no Boundaries: Lessons Learned from Around the Globe.* Role: organizer, chair, facilitator. March 19, 2007

2007 National Initiative for Children's Healthcare Quality (NICHQ). Sixth Annual National Forum for Improving Children's Healthcare. San Francisco, CA. Roles: forum steering committee/co-chair; chair of patient safety tract. March 20-21, 2007

2007 National Initiative for Children's Healthcare Quality (NICHQ) and National Association of Children's Hospitals and Related Institutions (NACHRI) "Cross over meeting" San Francisco, CA. *Don't Automate Junk: Overcoming the Pitfalls of Health Information Technology to Achieve the Quality and Safety Promise.* Role: organizer, chair, and facilitator. March 18, 2007

2008 CPQCC/CMQCC Pre-CAN Workshop 2008. California Association of Neonatologists 14th annual conference Current Topics and Controversies in Perinatal and Neonatal Medicine, Coronado Island, CA. *Nosocomial Infection Collaborative Learning Session #1*. Role: Course Director. February 29. 2008

2009 CPQCC/CMQCC Pre-CAN Workshop 2009. California Association of Neonatologists 15th annual conference Current Topics and Controversies in Perinatal and Neonatal Medicine, Coronado Island, CA. *Oxygen Saturation Monitoring and Breast Milk Feeding*. Role: Course Director. March 6, 2009

2010 CPQCC/CMQCC Pre-CAN Workshop 2010. California Association of Neonatologists 16th annual conference Current Topics and Controversies in Perinatal and Neonatal Medicine, Coronado Island, CA. *Best practices in selected neonatal/perinatal care and quality improvement.* Role: Course Director. March 5, 2010

2011 CPQCC/CMQCC Pre-CAN Workshop 2011. California Association of Neonatologists 17th annual conference Current Topics and Controversies in Perinatal and Neonatal Medicine, Coronado Island, CA. *Best practices in maternal-fetal and*

neonatal care and quality improvement-Delivery Room Management. Role: Course Director. March 3, 2011

2012 CPQCC/CMQCC Pre-CAN Workshop 2012. California Association of Neonatologists 18th annual conference. Cool Topics In Neonatology, Coronado Island, CA. *Getting Better at Getting Better*. Role: Course Director. March 3, 2012

2013 CPQCC/CMQCC Pre-CAN Workshop 2013. California Association of Neonatologists 19th annual conference. Cool Topics In Neonatology, Coronado Island, CA. Role: Course Director. March 1, 2013

2014 Site Visit, St Jude Children's Hospital visiting Lucile Packard Children's Hospital Center for Quality and Clinical Effectiveness. Physician, administrative, and quality improvement leaders from St Jude Children's Hospital spent 1 day at LPCH for the purposes of learning about our quality and patient safety infrastructure, models for improvement, integration of physicians into quality improvement work, leveraging of quality improvement efforts for scholarship/publications, leveraging the EMR to support quality and patient safety, etc. Role: Site Visit Planner and Chair

2016 Solutions for Patient Safety (SPS) California Regional Meeting (Role: Organizer/Facilitator). Convened the 10 children's hospitals in California that are participating in SPS for a 1 day meeting to "all teach all learn" regarding HAC reduction best practices, barriers to implementation, and discussions regarding launching a regular cadence of quality-focused meetings. Partners and participants included SPS, the California Children's Hospitals Association (CCHA), and the 10 CA children's hospitals involved in the national SPS collaborative.

GRANTS (n=17)

1996-2000 Co Principal Investigator (Principal Investigator David Bergman, MD, MPH, Stanford University School of Medicine), Asthma Initiative Grant, Packard Foundation. *An Asthma Intervention Using a Super-Nintendo Video Game*. This grant funded a randomized controlled clinical trial of the effectiveness of a disease management model on the outcomes of low socio-economic, inner-city children with asthma.

2001-2002 Principal Investigator, Pediatric Health Research Fund Grant, Stanford University. *Decreasing Adverse Drug Events Using a Novel Identification Tool: A Multi-centered Pilot Study*. Grant to integrate a validated computer-based tool that identifies children at risk for and/or who are harmed by adverse drug event

2001-2004 Co-Investigator (Principal Investigator, Louis Halamek, MD, Stanford University School of Medicine), AHRQ grant RFA-HS-01-008. Patient Safety Research Dissemination and Education. *Assessment of a Novel Pediatric Simulation Program.* Grant to study the clinical and safety outcomes resulting from a high-risk delivery simulation program in an academic children's hospital

2002-2004 Co-Investigator (Principal Investigator David Bergman, MD, MPH, Stanford University School of Medicine). The California Endowment grant. *An Asthma Telemedicine Project for Underserved Children in Bayview Hunter's Point (a disadvantaged minority population in San Francisco, CA)*. Grant to integrate and evaluate a research-proven asthma intervention into an inner-city school system using telemedicine.

2002-2004 Co-Investigator (PI: Glenn Takata, MD, MPH, University of Southern California School of Medicine) California Healthcare Foundation grant. *A Statewide Pediatric*

	Initiative to Improve Patient Safety. Grant to establish a collaborative of California Children's Hospitals to standardize nomenclature around pediatric patient safety and develop/integrate strategies to improve pediatric focused patient safety. Approx.
2002-2006	Principal Investigator, "AHRQ Partnerships for Quality" grant 1 U18 HS13698-01. *Implementing Pediatric Patient Safety Practices*. Grant to establish a formal partnership between the Child Health Accountability Initiative (CHAI) and the AHRQ to improve patient safety and pain management in children as well as effectively disseminate these advances.
2003-2004	Co-Principal Investigator (Principal Investigator Christopher Landrigan, MD, MPH, Harvard University School of Medicine), Pediatric Health Research Fund Grant, Stanford University. Effects of Duty Hour Standards on Patient Safety, Resident Sleep, Resident Safety, and Resident Self-Directed Learning.
2003-2004	Co-Investigator (Principal Investigator, Swati Agarwal, MD Stanford University School of Medicine), Innovations in Patient Care grant program, Lucile Packard Children's Hospital. "Comparing the Utility of a Pediatric Code Cart to a Braselow Code Cart.
2006-2007	Co-Investigator (Principal Investigator Swati Agarwal, MD Stanford University School of Medicine), Innovations in Patient Care grant program, Lucile Packard Children's Hospital. "Testing of a Trigger Tool to detect adverse events (AEs) and adverse drug events (ADEs) in the PICU: A multi-site trial."
2007-2009	Co-Principal Investigator (Principal Investigator, Christopher Landrigan, MD, MPH, Harvard University School of Medicine), Rx Foundation Harm Study: "How Safe is a Hospital". Grant housed at the Institute for Healthcare Improvement (IHI).
2007-2008	Co-Investigator (Principal Investigator Atul Butte, MD, PhD, Stanford University School of Medicine), Hewlett Packard Foundation. "Immunizing Against Harm".
2009-2011	Co-Principal Investigator (Principal Investigator, Andrew Shin, MD, Stanford University SOM Division of Pediatric Intensive Care). LPCH Innovations in Patient Care Grant Program. "The CVICU Dashboard".
2009-2011	Principal Investigator (Co-Principal Investigator, Scott Sutherland, MD, Stanford University SOM Division of Pediatric Nephrology). LPCH Innovations in Patient Care Grant Program. "Implementation of a Renal Transplant Trigger Tool to Identify and Prevent Transplant Related Harm".
2010-2013	Co-Principal Investigator (Principle Investigator, Chris Longhurst, MD, Stanford University School of Medicine), Hewlett Packard grant. "Introducing automated real-time patient-centered quality/safety dashboards in the EMR at LPCH".
2011	Co-PI (Principle Investigator Thomas Krummel, MD). Stanford-Coulter Grant. "Portable Respiratory Acoustic Monitoring Device".
2011-present	Co-Investigator (Principal Investigator Atul Butte, MD, PhD, Stanford University School of Medicine), Hewlett Packard Labs. Funds directed to multiple initiatives, including construction/testing of the Pediatric Global Trigger Tool.
2015	Co-PI (Principle Investigator, Dan Imler MD, Stanford University School of Medicine). Stanford Health Care Innovation Challenge Grant (Spectrum). "Implementing electronic clinical decision support to improve emergency care for children."

MENTORSHIP

Fellow/PhD Candidate Oversight (n=10)

2009-2011 **Scholarship Oversight Committee (SOC): Anand Rajani, MD,** Fellow, Department of Neonatal-Perinatal Medicine, Stanford University. Area of focus: simulation and patient safety

2010-2012 **Scholarship Oversight Committee (SOC): Jon Palma, MD,** Fellow, Department of Neonatal-Perinatal Medicine, Stanford University. Area of focus: neonatal informatics, and the role of informatics in quality and patient safety

2011-2013 **Research Advisor: Shreya Sheth, MD,** Fellow, Department of Pediatric Cardiology, Stanford University. Area of focus: 4th year of cardiology fellowship dedicated to Quality and Patient Safety. Special emphasis on handoffs and patient safety

2011-present **Scholarship Oversight Committee (SOC): Sohini Stone, MD.** Fellow, Department of Neonatal-Perinatal Medicine, Stanford University. Area of focus: Using simulation strategies in Labor and Delivery and translating business models to establish financial and clinical return on investment associated with this simulation training.

2012-present **Scholarship Oversight Committee (SOC): Nicole Yamada, MD.** Fellow, Department of Neonatal-Perinatal Medicine, Stanford University. Area of focus: The effect of standardized, effective communication on human performance in the delivery room setting.

2013 **Research Advisor: Tom Caruso, MD**. Pediatric Anesthesia fellow. Area of focus: creation and implementation of a standard handoff process from the ICU to OR settings using high reliability organization theory to support process and content

2013-present **Primary Research Advisor, Veena Goel, MD**. Pediatric Hospitalist Fellow and Informatics Fellow. Area of focus: utilizing "big data" to identify false positive Cardiovascular alarms, establish more sensitive and specific unit/population alarm parameters to minimize alarm fatigue, and to implement patient safety interventions to eliminate harm fatigue.

2013-2015 **Primary Research Advisor, Claudia Algaze**. 4th year fellow in Pediatric Cardiology, completed a 4th year of fellowship with an emphasis on quality improvement. Area of focus: Clinical Effectiveness in the Heart Center at LPCH

2013-present **Research Advisor, Kelly Randall**. PhD candidate in Healthcare Administration, University of Alabama, Birmingham. Thesis topic focused on determining the linkage between high reliability processes, healthcare acquired conditions (HACs) and Serious Safety Events (SSEs) across 80 US children's hospitals participating in the Ohio Children's Hospital Solutions for Patient Safety initiative

2015-present **Primary Research Advisor, Brett Palama**. Pediatric Hospitalist Fellow, focusing on the epidemiology of harm for complex care patients across the US. Research will include building a pediatric complex care "trigger tool" to identify harm, deploying this tool across multiple children's hospitals in the US, and using this information to create an intervention to decrease harm to this presumed high risk population.

Non-Fellow Mentees (n=11)

(Physician Leads of Local Improvement Teams, each with a formalized mentee relationship to Paul Sharek, MD, Medical Director of the Center for Quality and Clinical Effectiveness**)**

2012-2014 **Research and Operations Mentorship, Deborah Franzon, MD**. Dr. Franzon was the Physician Lead of the PICU Local Improvement Team (LIT). In this role, she worked with the RN co-chair, was accountable for the quality /safety outcomes for

her unit, oversaw local quality improvement initiatives, and when relevant translated significant quality improvement efforts into scholarship

2012-2015 **Research and Operations Mentorship, Kari McCallie, MD.** Dr. McCallie is the Physician Lead of the NICU Local Improvement Team (LIT). In this role, she works with the RN co-chair, is accountable for the quality /safety outcomes for her unit, oversees local quality improvement initiatives, and when relevant translates significant quality improvement efforts into scholarship

2012-present **Research and Operations Mentorship, Andrew Shin, MD.** Dr. Shin was the Physician Lead of the CVICU Local Improvement Team (LIT) through 2015, and is now (2015-present) the Physician Lead for Clinical Effectiveness in the LPCH Center for Quality and Clinical Effectiveness. In this role, he works with the Director of the CQCE division of Analytics and Clinical Effectivenss, is accountable for the strategic and tactical build of the new Clinical Effectiveness Program at LPCH

2012-present **Research and Operations Mentorship, Susan Crowe, MD.** Dr. Crowe is the Physician Lead of both the Labor and Delivery, and Maternity, Local Improvement Teams (LITs). In this role, she works with the RN co-chairs, is accountable for the quality /safety outcomes for these units, oversees local quality improvement initiatives, and when relevant translates significant quality improvement efforts into scholarship

2013-present **Research and Operations Mentorship, Alaina Kipps, MD.** Dr. Kipps is the Physician Lead of the 3-West unit (Heart Center med/surg unit) Local Improvement Team (LIT). In this role, she works with the RN co-chair, is accountable for the quality /safety outcomes for her unit, oversees local quality improvement initiatives, and when relevant translates significant quality improvement efforts into scholarship

2013-present **Research and Operations Mentorship, Krysta Schlis, MD.** Dr. Schlis is the Physician Lead of the 1-North unit (Hematology-Oncology, Bone Marrow Transplant) Local Improvement Team (LIT). In this role, she works with the RN co-chair, is accountable for the quality /safety outcomes for her unit, oversees local quality improvement initiatives, and when relevant translates significant quality improvement efforts into scholarship

2013-present **Research and Operations Mentorship, Tom Caruso, MD.** Dr. Caruso is the Physician Lead of the perioperative area Local Improvement Team (LIT). In this role, he works with the RN co-chair, is accountable for the quality /safety outcomes for his areas, oversees local quality improvement initiatives, and when relevant translates significant quality improvement efforts into scholarship

2014-present **Research and Operations Mentorship, Mahaela Damian, MD**. Dr. Damian is the Physician Lead of the PICU Local Improvement Team (LIT). In this role, she works with the RN co-chair, is accountable for the quality /safety outcomes for her unit, oversees local quality improvement initiatives, and when relevant translates significant quality improvement efforts into scholarship

2014-present **Research and Operations Mentorship, Hayley Gans, MD**. Dr. Gans is the Physician Lead of the Ambulatory Local Improvement Team (LIT). In this role, she works with the Clinic Manager co-chair, is accountable for the quality /safety outcomes for this area, oversees local quality improvement initiatives, and when relevant translates significant quality improvement efforts into scholarship

2016-present **Research and Operations Mentorship, Loren Sacks, MD.** Dr. Sacks is the new Physician Lead of the CVICU Local Improvement Team (LIT). In this role, he works

with the RN co-chair, is accountable for the quality /safety outcomes for his unit, oversees local quality improvement initiatives, and when relevant translates significant quality improvement efforts into scholarship

2016-present **Stanford Medicine Leadership Academy, Gerald Grant MD**. Dr Grant is the only pediatric awardee for Cohort #2 of the Stanford Medicine Leadership Academy. I function as the formal "mentor" to Dr Grant in this 18 month leadership program. Gerry's project is entitled "Quality and Safety in the Pediatric Neurosurgery Population" and is focused on "developing, validating, and incorporating disease-specific patient based instruments in the ambulatory setting to improve the quality of research and care of pediatric neurosurgery patients"

LICENSES AND CERTIFICATIONS

1990-present Medical License, California (#G070895)
1992-present Certified, American Board of Pediatrics (1992, 1999, 2006)
1999-present Fellow, American Academy of Pediatrics
2013 Pediatric Advanced Life Support (PALS), latest recertification 12.2015