MAYERS MEMORIAL
HEALTHCARE DISTRICT

Quality Committee
Meeting Agenda
March 25, 2026 @ 9:30 am
Mayers Memorial Healthcare District
Fall River Boardroom
43563 Hwy 299 E
Fall River Mills, CA 96028

In observance of the Americans with Disabilities Act, please notify us at 530-336-5511, Ext 1130 at least 48 hours in advance of the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations. The District will make every attempt to accommodate your request.

Attendees
Les Cufaude, Chair, Board Member
James Ferguson, Board Member
Ryan Harris, CEO
Libby Mee, CPO
Jack Hathaway, Director of Quality
Lisa Neal, Board Clerk

					Approx. Time Allotted
1	**CALL MEETING TO ORDER**	Chair: Les Cufaude			
	This meeting will be conducted in accordance with Robert's Rules of Order and the Bylaws of Mayers Memorial Healthcare District.				
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**				
	Persons wishing to address the Board are requested to fill out a "Request Form" prior to the beginning of the meeting (forms are available from the Clerk of the Board (M-W), 43563 Highway 299 East, Fall River Mills, or in the Board Room). If you have documents to present to the Board of Directors for review, please provide a minimum of 9 copies. When the President announces the public comment period, requestors will be called upon one at a time. Please stand and give your name and comments. Each speaker is allocated five minutes to speak. Comments should be limited to matters within the jurisdiction of the Board. Pursuant to the Brown Act (Govt. Code section 54950 et seq.), action or Board discussion cannot be taken on open time matters other than to receive the comments and, if deemed necessary, to refer the subject matter to the appropriate department for follow-up and/or to schedule the matter on a subsequent Board Agenda.				
3	**APPROVAL OF MINUTES**				
	3.1 Quality Board Committee Meeting – February 25, 2026		**Attachment A**	**Action Item**	2 min.
4	**DIRECTOR OF QUALITY REPORT**	Jack Hathaway	**Attachment B**	Report	5 min.
5	**OTHER INFORMATION/ANNOUNCEMENTS**			Information	2 min.

Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Board, are available for public inspection at the office of the Clerk to the Board of Directors, 43563 Highway 299 East, Fall River Mills, CA 96028. This document and other Board of Directors documents are available online at www.mayersmemorial.com.

6 MOVE INTO CLOSED SESSION

6.1 Hearing (Health and Safety Code §32155) – Medical Staff Credentials **Action Item** 5 min.

MEDICAL STAFF REAPPOINTMENT

1. Tikoes Blankenberg, MD – Pathology
2. Ashley Delaney, DO – Emergency Med.
3. Shelleen Denno, MD – Internal Med.
4. Dale Syverson, MD - Surgery

AHP REAPPOINTMENT

1. Lewis Furber, Jr, NP – Family Medicine (Pit River)

AHP APPOINTMENT

1. Vanessa Ulibas, LPCC (T2U)

8 RECONVENE OPEN SESSION:

9 ADJOURNMENT: Next Quality Board Committee Meeting – April 29, 2026

Posted: 03.19.26

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Quality Committee
Minutes
February 25, 2026 @ 9:30 am
Mayers Memorial Healthcare District
Burney Annex Boardroom
20647 Commerce Way
Burney, CA 96013

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations, and action taken.

1 **CALL MEETING TO ORDER:** Les Cufaude called the Quality Board Committee meeting to order at 9:31 am on February 25, 2026, in accordance with Robert's Rules of Order, which govern the conduct of the meeting.

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Les Cufaude, Committee Chair, Director	Ryan Harris, CEO
Jim Ferguson, Director	Jack Hathaway, Director of Quality
	Libby Mee, Chief People Officer
	Dana Hauge, Safety Officer
ABSENT:	Alex Johnson, Facilities Manager
Theresa Overton, Chief Nursing Officer	Sharon Lyons, Director of Nursing – Skilling Nursing Facility
Keith Earnest, Chief Clinical Officer	Lisa Neal, Board Clerk

2 **CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**
No public comment.

3 **APPROVAL OF THE MINUTES: January 28, 2026**

3.1	Regular Quality Committee Meeting – January 28, 2026 A motion to accept the minutes with changes of the January 28, 2026, meeting was made, seconded, and approved.	**Ferguson / Cufaude**	**Approved by All**

4 **DIRECTOR OF QUALITY:** Report submitted by Jack Hathaway.
Cerner Optimization is progressing well. A workgroup meeting is scheduled for early March to discuss workflows, beginning with ED and moving into the Clinic and Outpatient Medical Services. As part of the Cerner Learning Journeys, YouTube videos are being developed for Mayer's educational initiatives. There is ongoing collaboration with Cerner to address unresolved issues within the modules. Opportunity identified to improve communication with an end-of-the-month summary of improvements to be shared with all staff. An ongoing staff training plan, including Learning Journeys, will be implemented and set up with the Staff Educator once volume is determined.

Jack reported two complaints that he is addressing: one from a nurse and one from billing.

Improvements to the Med Error graphs: establishing baseline data on medication errors by researching and understanding daily medication pass volumes. The national baseline for skilled nursing is less than 5%. Include medication administered and errors with the relevant percentile. Add an explanation for the graphs.

HCAHPS Focus
Ryan will work with the Quality team to select 5 HCAHPS measures to focus on for improved outcomes (e.g., Communication with Nurses and Discharge Information), and report quarterly to the board. The Service Excellence Council (SEC) will also focus on the same five. Libby will bring the Service Excellence report for further insight. Once the target for an identified measure is met, another will be chosen. Jack suggests focusing on measures identified by CMS as having higher-than-normal discharge readmission rates.

5	**MMHD ACHC SAFETY RISK ASSESSMENT REVIEW:** Dana Hauge, Director of Safety and Security, presented a risk assessment. ACHC strongly encourages the Board of Directors to remain informed and engaged in ongoing risk assessment reviews, emphasizing the importance of maintaining a comprehensive understanding of organizational risks. Dana is focused on further refining and strengthening the details of these assessments. The risk assessments will be presented to the Quality Committee on a quarterly basis, in addition to inclusion in the annual report. Dana also provided a high-level overview of the 2025 risk assessment. Discussion included the placement of eyewash stations, with an ACHC recommendation that each department have access to a station; installation was determined by the types of chemicals used. There is a formal process for installing eyewash stations as a proactive measure to enhance safety systems. Annual safety reviews will be conducted on a staggered schedule throughout the year, based on the assessment findings. The scope of the safety assessment review was discussed, including Interim Life Safety Measures (ILSM/IPR), line isolation monitors, Alternative Life Safety Measures (ALSM), sprinkler systems, and clinical risk areas. Emphasis was placed on staff education to ensure awareness of safety concerns and protocols. Patient rights related to swing bed services were identified as needing additional focus. A motion to accept the 2025 risk assessment, as presented, was made, seconded, and approved.	**Cufaude / Ferguson**	**Approved by All**
6	**OTHER INFORMATION/ANNOUNCEMENTS:** The chairperson will bring forward, for the full board's discussion, inclusion in the bylaws for voting rights for committees (e.g., for the CEO and the Director of Quality) in the absence of a committee member. Voice AI has been implemented in the Clinic for the providers, and workflows are in continuous improvement.		
7	**MOVE INTO CLOSED SESSION** The Board Committee moved to closed session at 10:40 a.m. The Board Committee adjourned the closed session at 10:40 a.m.		
8	**RECONVENE OPEN SESSION** The Board Committee reconvened in open session at 10:40 a.m. No discussion or action was taken in the closed session.		
9	**ADJOURNMENT:** The committee chair declared the meeting adjourned at 10:41 a.m. Next Meeting is March 25, 2026		

Board Quality Report March 2026

Patient Experience

As requested – we have looked at the measures available in our PressGaney (PressGaney is the company who administers our HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) and makes the data available to us) of all the measures that are available to us we have found the opportunity to align with some work that will be going on this year in the hospital around discharge planning and continuity of care for those who are discharged from our acute floor back into the community.

PI Review

We can review current findings in Teams during the meeting.

ACHC

The submissions we made to ACHC for the feedback that they gave us on our Interim Progress Report (IPR) were accepted and have been closed. I am waiting to hear if the whole IPR was closed or just the facilities portions that were signed off by ACHC at the beginning of March. I believe that it was the whole IPR – I am just waiting on confirmation of that.

Risk (RL6) Review

See following pages for graphs – I moved them for a better view of the data.

State

I am not aware of any state visits this month.

Complaints

I have received a few (3) complaints that I am currently working on, it is worth noting that none of the complaints that I am currently working on have anything to do with quality of care or standards of care. All the current complaints have to do with the cost of receiving care in the Emergency Department, as opposed to with a PCP in the clinic setting.

Medication Error Audit

Most current data attached – we did discover a few things that are relevant to this discussion while on our call with our Richter consultants.

First, the security roles and clinical set up for our PCC system will require extensive work – as mentioned before – all the roles will have to be rebuilt and some of the clinical build will have to be rebuilt so that the system stops working against itself.

Second, when properly configured, the system will be able to track some of the medication data (number of medications administered monthly) on a widget on the dashboard landing page – and the

vast majority of the quality work that SNF leadership has been engaged in will be able to be captured and monitored electronically in the system rather than outside.

Third, we were able to pull a preliminary number of medications administered monthly. The number of documented medications that the system captured at this time is 26,645 documented medications passed in the month of February. We audited two residents on the list, and we know that the number of medications captured in this 26,645 is not perfectly accurate, however, it is a starting place for the conversation on how many medications we pass every month. Given that we know that number to be not totally accurate, we can cut it to 10,000 to have a reasonable conversation around the 5% number we have selected based on CDPH surveys we have had in the past where this medication error issue has come up.

Based on the 10,000 number (which I selected because of the ease for the math conversation and because it is less than half of 26,645) we can see that a 5% error rate based on 10,000 meds passed monthly would be 500. 500 is far too many medication errors to allow and based on our current numbers reported it is far too easy to meet as a goal. Moving to a 1% error rate would allow for 100 med errors a month based on our 10,000 number, again based on the data that we have been looking at, is still too high for us. In the meeting we had around all of this while we were exploring what errors were reported and how we were managing them we talked about establishing 0.5% as our error rate – which is still above the 0.19% performance rate that we have for February 2026 – but it is the reasonable starting place that the team has selected to begin this tracking phase of the process.

Over the next few months, as we monitor this work and the data – that will become more accurate as we fix the systems that we are working in so we can find ways to support the work, we will have to come to another target error rate. I am sure that we will not get back above the 50 errors a month mark.

I think that we should celebrate the work that the SNF team has done to get us to this point, and as we hone in on what our number of medications passed monthly rate is more specifically we will continue to adjust our targets and expectations as necessary to ensure that we are continuing to perform at our best for the residents we serve.

QIP – DHCS

Currently we are looking like we are positioned well for QIP – we are expecting to get all our Managed Care Plan (MCP) data from Partnership so that we can begin our internal audit process to prepare for our external audit that we expect to take place between now and August.

Cerner

Work on optimization continues. We have held the ED event and the Clinic event, to see what our current workflows look like, and compare them, where appropriate to the Cerner Model Experience. There are two departments that we have discovered that have no Cerner Model Experience to draw from Physical Therapy (PT) in the outpatient setting, and Cardiac Rehab. While PT has found a way to document in the patient chart for acute and swing patients, there is nothing that exists in the Cerner Model Experience for their outpatient work. I am still exploring what can be found for Cardiac Rehab – it is mentioned a few times in reference materials that are on the Cerner Model Experience – but I have not been able to find actual workflows like I have for Acute, Swing, ED, Clinic and so on. So, I am keeping my eye on that and seeing if there are other places I can find those departments mentioned in Cerner

materials to determine if we can reverse engineer our way back to functional workflows for those departments that we can then standardize for our folks.

Quality Workflows and reporting requirements

It has been fun transitioning under new leadership – I am lucky enough to have now worked under the CNO, CEO, and now the CPO, allowing me to see various aspects of the roles that my executive plays. It is also a fantastic refresher for me as I get to acquaint my new executive with my role, as I have done it in the district, and the different constraints that I do have in terms of required reporting and things of that nature.

To that end, our CPO asked that I put together a list, and calendar of dates that fall into those reporting requirements and the time that is put forward in those reporting tasks. Fortunately, some of the reporting requirements are nationwide, such as those found in MBQIP (Medicare Beneficiary Quality Improvement Project) I have attached that reporting calendar for you to see. I no longer report the HCP/IMM-3 measure or the Antibiotic Stewardship measures as they are managed by the Infection Preventionist – I handed those roles over when the CCO took IP under their line.

The rest of the measures on the list I chart audit monthly and report quarterly. EDTC (Emergency Department Transfer Communications) is reported out to our State Flex Program. OP-18 (Median time from ED arrival to ED departure for discharged ED patients) and OP-22 (Patients left without being seen), Safe Use of Opioids and the Hybrid measures HWR (Hospital Wide Readmissions) are reported through our Cerner workflows, I cart audit, and validate those measures for our Cerner regulatory team and they report them to HOQR (Hospital Outpatient Quality Reporting). That is what falls into the MBQIP bucket.

These measures, OP-18 and OP-22 are a part of the HOP-ED measures (HOP stands for Hospital Outpatient) along with those 2 measures we also report HOP-29 that looks at the percentage of patients between the ages of 50 to 75 who receive a screening colonoscopy and have a recommended follow-up interval of at least 10 years documented in their record and HOP-Stroke that looks at the timely completion and interpretation of head CT or MRI scans for patients with acute ischemic or hemorrhagic stroke. The Sepsis Management Bundle Measure is a part of the HIQR (Hospital Inpatient Quality Reporting) is the last measure that I audit and submit through our Cerner workflows. This measure calculates the proportion of Medicare beneficiaries with severe sepsis or septic shock who received all the elements of the management bundle, that includes timing between when the patient presents to the time that we have completed the care tasks associated with the sepsis management bundle such as, measuring an initial lactate level, drawing blood cultures prior to administering antibiotics and things of that nature.

All this, of course, is a Cerner workflow that is newer to me, as we did not report anything in 2023 as we had the Cerner implementation as a valid reporting exemption for that 2023 year. The Cerner Regulatory team reported for us while training me in 2024, so this past 2025 year was the first year that I did the reporting on my own. There were some adventures in that hand off – but I think we made it through.

This MBQIP and Cerner work process captures reporting for PI (Promoting Interoperability) and for MIPS (Merit-based Incentive Payment System) although to be completely transparent, I am not as familiar with MIPS as it has been rolled into PI in some ways, and I am still trying to figure out what parts of each individual program are still active and what parts have been combined into a single reporting program.

As far as I know and have been trained in our Cerner workflows – we are reporting what we are meant to through the Cerner workflows that we have in place now, and then Cerner submits all of the reported data to CMS, and I have to validate that through the QPP (Quality Payment Program) portal annually.

I will be finishing the Q1 26 abstractions and review at the end of this month, and if you like I can bring Q1 data for all the measures available in our Cerner Lights on reporting portal to the April meeting.

I also manage the PBJ (Payroll Based Journal) report that captures all the staff who work in the Skilled Nursing facility every quarter. The PBJ is due to CMS 45 calendar days after the end of each calendar quarter. This process has been optimized a few times since it became mine and currently has a relatively functional workflow. Although, we have identified opportunities for improvement in that we are missing some data from some travelers – so we are currently working through this process again to ensure that we capture all of the staffing data required to give us a complete picture of who is working where for how long each day – so it can be captured in a full and complete PBJ report.

As we have been working with various consultants that we have been lucky enough to have, there have been a few things that I am trying to shore up for SNF and CAH quality to ensure that we meet the requirements for QAPI (Quality Assurance and Performance Improvement) in our District. Both the SNF and CAH have specific rules around how we manage QAPI and its specific focus. SNF has the most direct requirements in CMS F tag 868 the people who are required to attend the SNF quality meeting are spelled out – this tag has evolved through the Phases 1, 2 and 3 work that CMS has put forward simplifying the tags and language that surveyors use to enforce Conditions of Participation. I am happy that this F868 tag now has language around designees who are allowed to attend the meetings in place of the Administrator of the SNF or the Medical Director – now the language allows for the following - Medical Director or his or her designee, at least three (3) other members of the facility's staff, at least one of whom must be the administrator, owner, a board member, or other individual in a leadership role and the infection preventionist. F 868 A necessary change as the language in earlier versions was more restrictive.

On the SNF and CAH side we are now having monthly meetings to memorialize the QAPI efforts in the scope of each area, and then we can report that out to Board Quality here to ensure that there is vision of the efforts that we are undertaking in those areas of the hospital. While this has existed in the past in one form or another, we have had the opportunity to revisit and right-size the work for our district and now we are on track again for compliance.

The CAH side of this is governed by ACHC standards and this helps ensure that we are maintaining compliance with the ACHC standards between survey cycles. I am working with our CAH team to reestablish our necessary QAPI work on the CAH side and ensure that we are ready for our full cycle review in March of 2027.

Conclusion

I am grateful for the opportunity to engage with staff and leadership for our quality endeavors here in the district. The Cerner work has showcased the fact that all the folks here are honestly putting in effort to serve those that come to us for care. Their frustrations are understandable, as the workflows that we were left with are at times not what is available for reference in the Cerner Model Experience, the ease and ability the staff has shown in adjusting to mirror the Model Experience is a testament to their resolve to continue to evolve to care for our patients.

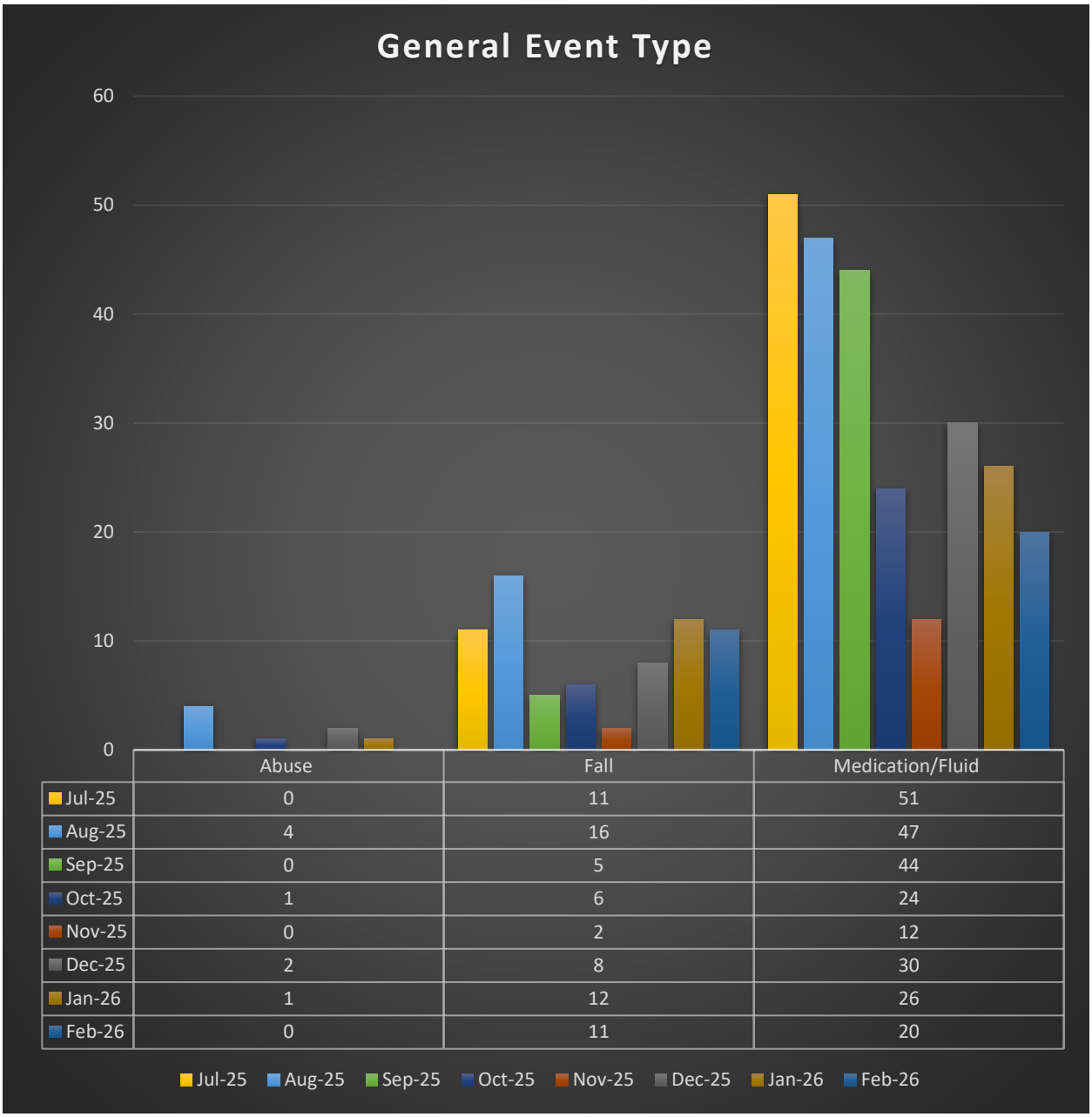
There is a lot of work to be done to get us to a fully functional workflow experience in Cerner, the team that I have now working with me, I believe will be able to get the work done, but there are some real projects that are ahead of us in terms of reconciling workflow and charges and data capture but it seems as though that everyone is enjoying the work as much as I am – so at least we are eating this elephant with a smile.

ACHC work is also going to be a building process – there are gaps in most departments – including quality – but this is work we are familiar with and is enjoyable as well, so as we continue to get this all buttoned up there will be more to report to you with our rebuilt and reinvigorated ACHC processes.

All and all – quality is moving along for the District, and I am happy to be a part of it.

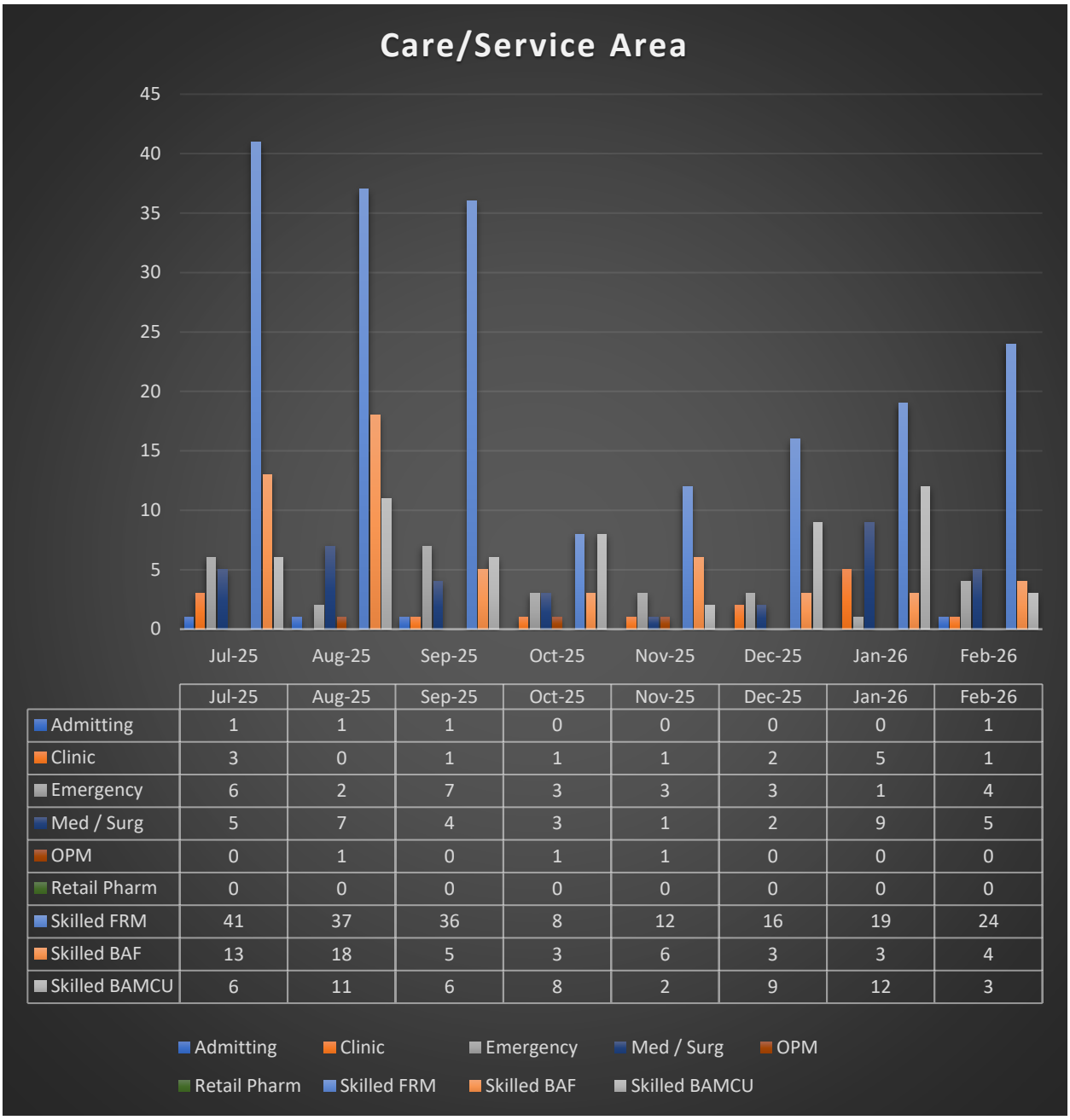
Respectfully submitted,

Jack Hathaway – Director of Quality



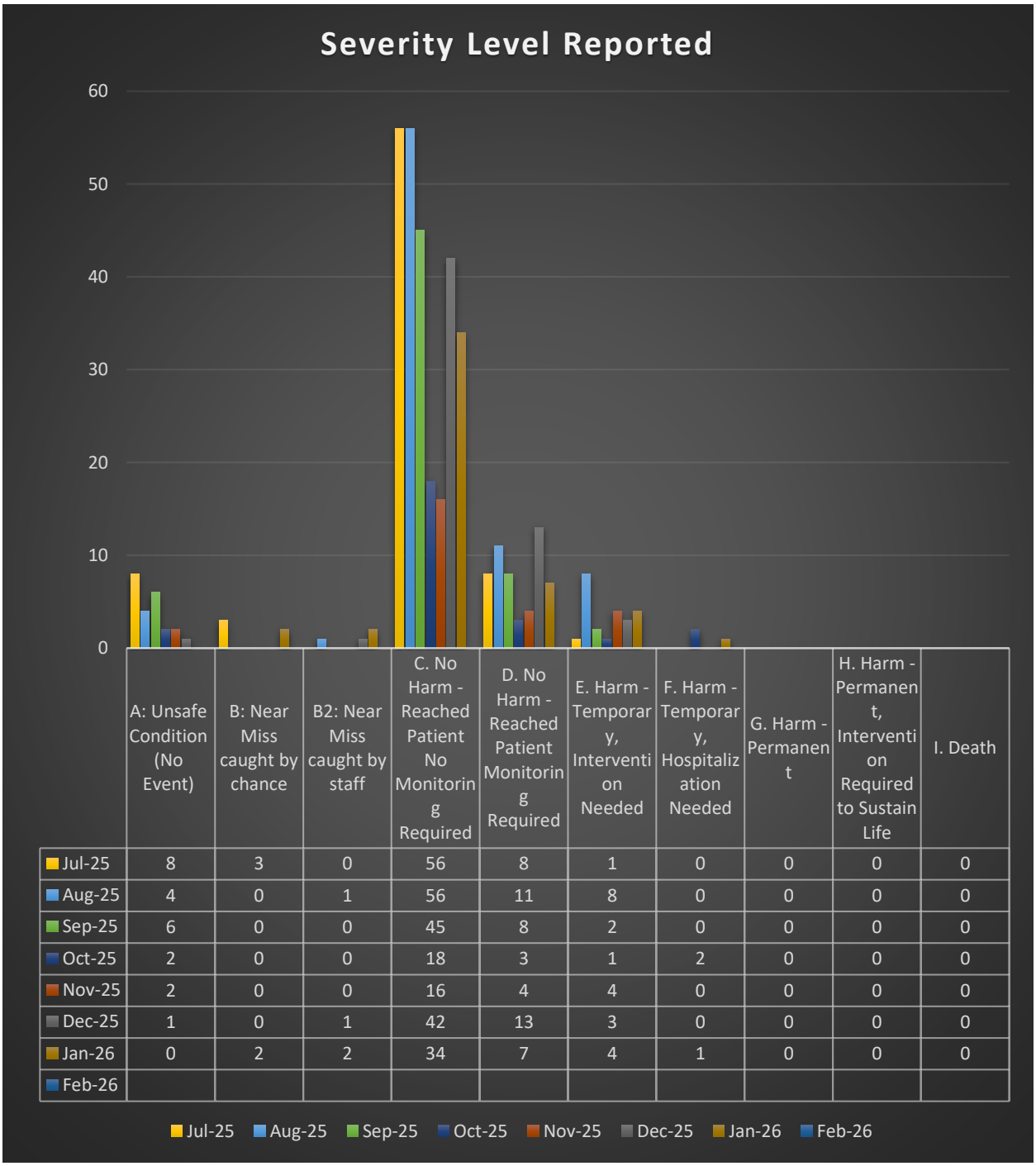
	Abuse	Fall	Medication/Fluid
Jul-25	0	11	51
Aug-25	4	16	47
Sep-25	0	5	44
Oct-25	1	6	24
Nov-25	0	2	12
Dec-25	2	8	30
Jan-26	1	12	26
Feb-26	0	11	20

This graph shows the Falls, Abuse, and Medication Errors reported across the district. We had decided to focus on Abuse, Falls and Medication Errors as they were our focus in terms of risk and harm. However, we could expand this to show all the events across the district again, if we feel that we have grown past this specific focus.



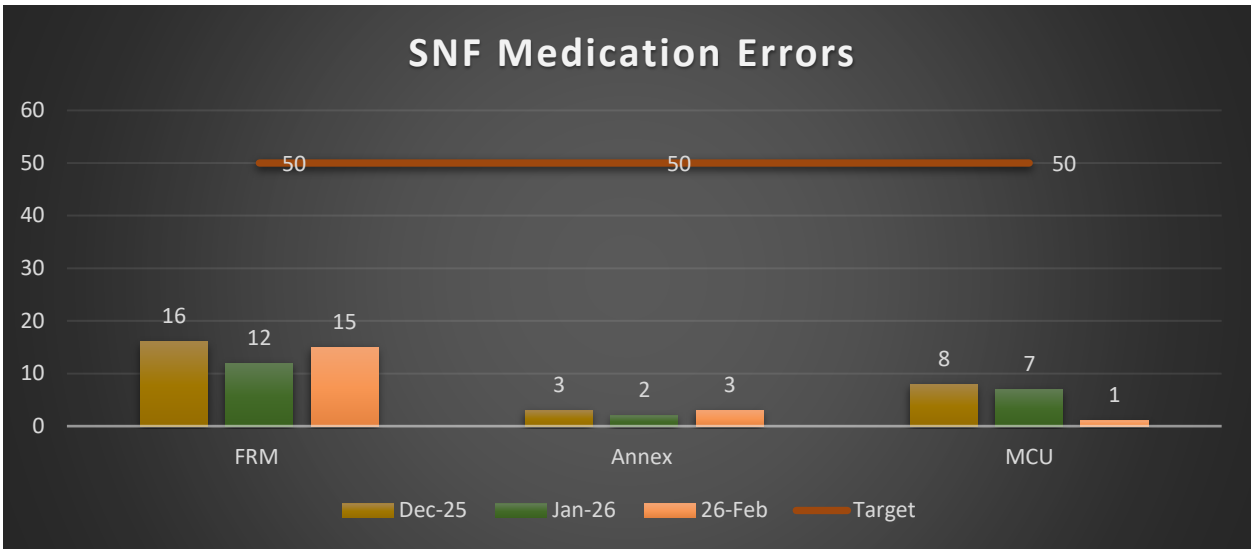
	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Admitting	1	1	1	0	0	0	0	1
Clinic	3	0	1	1	1	2	5	1
Emergency	6	2	7	3	3	3	1	4
Med / Surg	5	7	4	3	1	2	9	5
OPM	0	1	0	1	1	0	0	0
Retail Pharm	0	0	0	0	0	0	0	0
Skilled FRM	41	37	36	8	12	16	19	24
Skilled BAF	13	18	5	3	6	3	3	4
Skilled BAMCU	6	11	6	8	2	9	12	3

This graph shows the number to total reports made to RL6 (our electronic reporting system) across the district by care or service area.

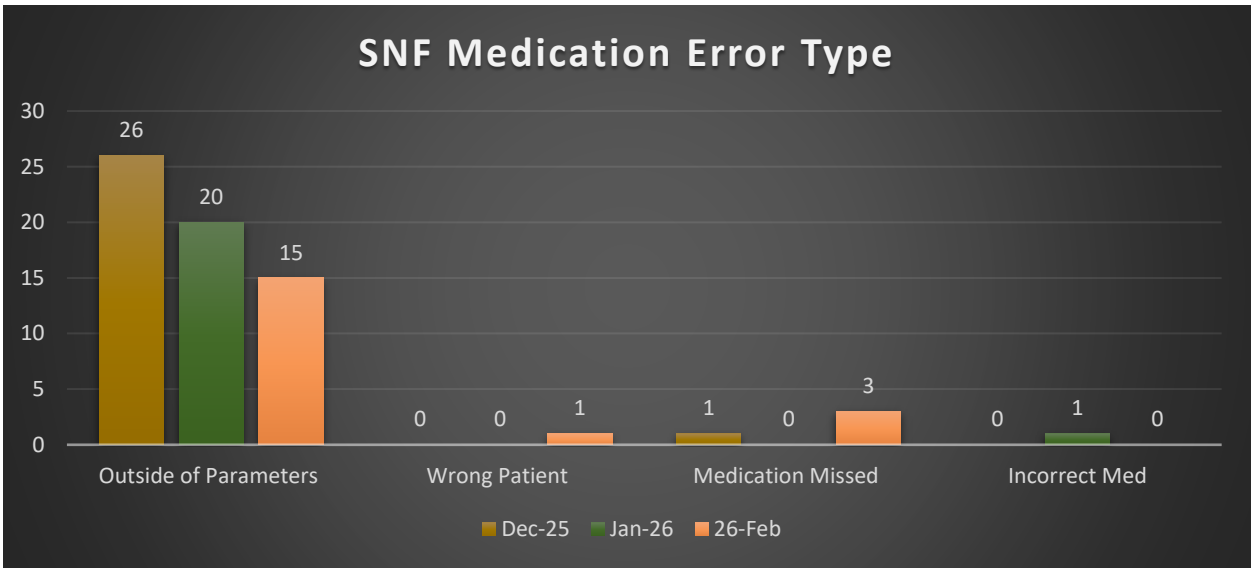


	A: Unsafe Condition (No Event)	B: Near Miss caught by chance	B2: Near Miss caught by staff	C. No Harm - Reached Patient No Monitoring Required	D. No Harm - Reached Patient Monitoring Required	E. Harm - Temporary, Intervention Needed	F. Harm - Temporary, Hospitalization Needed	G. Harm - Permanent	H. Harm - Permanent, Intervention Required to Sustain Life	I. Death
Jul-25	8	3	0	56	8	1	0	0	0	0
Aug-25	4	0	1	56	11	8	0	0	0	0
Sep-25	6	0	0	45	8	2	0	0	0	0
Oct-25	2	0	0	18	3	1	2	0	0	0
Nov-25	2	0	0	16	4	4	0	0	0	0
Dec-25	1	0	1	42	13	3	0	0	0	0
Jan-26	0	2	2	34	7	4	1	0	0	0
Feb-26										

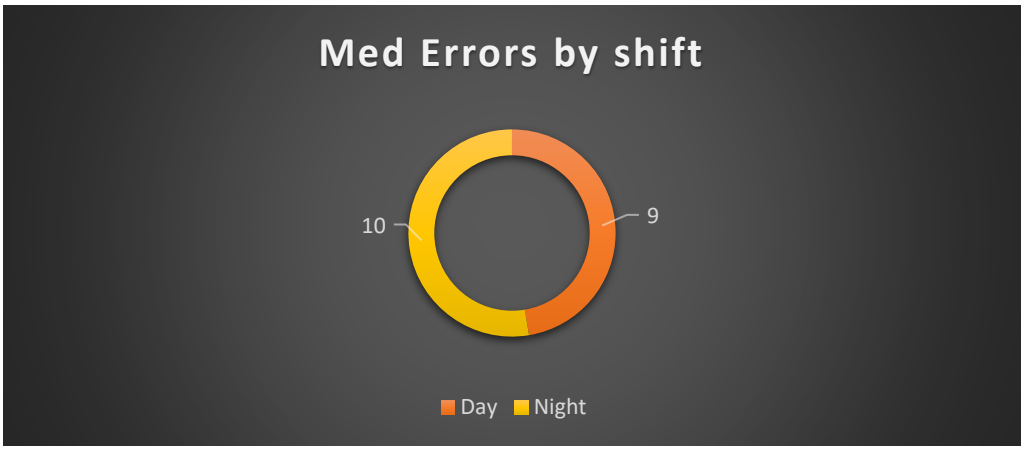
This graph shows the severity level reported for each of the events that were captured in RL6 across the district.



This graph shows the number of medical errors reported in SNF December 2025 through February 2026 for trending purposes, with the addition of the Target bar representing a 0.5% medication error threshold based on the 10,000 medications passed monthly number we are using until we can get a very solid number from Point Click Care (The SNF Electronic Health Record) after we correct the security roles and clinical build issues identified by our Richter consultants.



This graph shows the type of error that was reported in SNF for the corresponding medical errors captured for our December 2025 through February 2026 timeframe.



This graph shows the number of errors per shift for February 2026.

Dashboard Name: My Focus Items Summary | System Name: Mayers Memorial Hospital - System | System ID: 33270 | Facility Name: Mayers Memorial Hospital | Facility ID: 33270 | Service Line: Inpatient | Metric: Top Box Score | Date Type: Received Date | Time Frame: Last Quarter | Peer Group: All PG Database | Mode Adjustments: Applied | eSurvey Adjustment: Applied | CMS Reportable Responses: Not Applied | Skip Logic: Not Applied | Current Benchmarking Period: 10/01/2025 - 12/31/2025 | Fiscal Start Month: 01 | Download Date & Time: Mar 18, 2026 6:42 pm EDT

FILTER BY All sections selected

● High Point ● Low Point

Survey Items (SECTION/DOMAIN)	Survey Type	n	Top Box Score: Current (Q4 2025)	Top Box Score: Previous (Q3 2025)	Goal	Change	Percentile Rank	Score Trendline
GLOBAL ITEMS Rate hospital 0-10	CAHPS	12	66.54%	61.26%	—	5.28%	32	Compare Trending
GLOBAL ITEMS Recommend the hospital	CAHPS	11	72.80%	61.72%	—	11.08%	54	Compare Trending
RESPONSE OF HOSP STAFF Received help as soon as needed	CAHPS	11	82.27%	46.36%	—	35.91%	98	Compare Trending
COMM W/ DOCTORS Doctors listen carefully to you	CAHPS	11	81.16%	75.26%	—	5.90%	72	Compare Trending
COMM W/ DOCTORS Doctors expl in way you understand	CAHPS	11	90.25%	59.88%	—	30.38%	98	Compare Trending
DISCHARGE INFORMATION Domain: Discharge Information	CAHPS	11	81.95%	84.89%	—	-2.94%	13	Compare Trending
DISCHARGE INFORMATION Staff talk about help when you left	CAHPS	11	81.95%	77.20%	—	4.75%	27	Compare Trending
DISCHARGE INFORMATION Info re symptoms/prob to look for	CAHPS	11	81.95%	92.58%	—	-10.63%	8	Compare Trending
CARE COORDINATION Staff informed about your care	CAHPS	11	90.87%	61.45%	—	29.43%	99	Compare Trending
CARE COORDINATION Staff worked together for you	CAHPS	12	83.29%	76.83%	—	6.46%	83	Compare Trending
CARE COORDINATION Staff helped with care plan	CAHPS	11	72.68%	69.14%	—	3.54%	48	Compare Trending

Q3 2024 Q4 2024 Q1 2025 Q2 2025 Q3 2025 Q4 2025

† Custom Question ^ Focus Question

At or Above Goal <5 Points Below Goal >5 Points Below Goal No Goal

My Focus Items Summary

Rate hospital 0-10 — **Global Items**

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n	13	7	16	16	13	12
Top Box Score	84.62%	71.43%	68.73%	87.37%	61.26%	66.54%
Percentile Rank	92nd	49th	47th	96th	16th	32nd

Recommend the hospital — **Global Items**

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n	13	7	16	16	13	11
Top Box Score	76.92%	28.57%	62.51%	93.84%	61.72%	72.80%
Percentile Rank	72nd	1st	24th	99th	18th	54th

Received help as soon as needed — **Response of Hosp Staff**

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n			7	10	11	11
Top Box Score	N/A	N/A	57.14%	80.50%	46.36%	82.27%
Percentile Rank	N/A	N/A	42nd	96th	5th	98th

Doctors listen carefully to you — **Comm w/ Doctors**

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n	13	7	16	15	13	11
Top Box Score	69.23%	57.14%	74.89%	85.83%	75.26%	81.16%
Percentile Rank	8th	1st	32nd	90th	32nd	72nd

Doctors expl in way you understand — Comm w/ Doctors

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n	13	6	16	16	13	11
Top Box Score	53.85%	66.67%	74.89%	80.46%	59.88%	90.25%
Percentile Rank	1st	8th	50th	80th	1st	98th

Domain: Discharge Information — Discharge Information

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n	12	7	16	14	13	11
Top Box Score	91.67%	71.43%	83.98%	89.44%	84.89%	81.95%
Percentile Rank	91st	1st	28th	76th	33rd	13th

Staff talk about help when you left — Discharge Information

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n	12	7	16	14	13	11
Top Box Score	91.67%	71.43%	81.27%	85.86%	77.20%	81.95%
Percentile Rank	91st	1st	27th	57th	9th	27th

Info re symptoms/prob to look for — Discharge Information

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n	12	7	15	14	13	11
Top Box Score	91.67%	71.43%	86.69%	93.01%	92.58%	81.95%
Percentile Rank	81st	1st	36th	87th	84th	8th

Staff informed about your care — Care Coordination

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n			10	15	13	11
Top Box Score	N/A	N/A	49.99%	79.95%	61.45%	90.87%
Percentile Rank	N/A	N/A	1st	91st	12th	99th

Staff worked together for you — Care Coordination

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n			10	15	13	12
Top Box Score	N/A	N/A	69.99%	93.29%	76.83%	83.29%
Percentile Rank	N/A	N/A	20th	98th	49th	83rd

Staff helped with care plan — Care Coordination

Time Period	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
n			10	15	13	11
Top Box Score	N/A	N/A	69.99%	86.62%	69.14%	72.68%
Percentile Rank	N/A	N/A	37th	96th	27th	48th