

SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, FEBRUARY 26, 2025

5:00 pm Regular Session

Held in Person:

SVH Administrative Conference Room

To Participate Via Zoom Videoconferencing, use the link below:

<https://sonomavalleyhospital-org.zoom.us/j/99901004530?from=addon>

Meeting ID: 999 0100 4530

One tap mobile

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AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the Board Clerk, Whitney Reese, at wreese@sonomavalleyhospital.org , at least 48 hours prior to the meeting.		
<p>MISSION STATEMENT <i>The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.</i></p>		
<p>1. CALL TO ORDER/ANNOUNCEMENTS</p>	<p><i>Daniel Kittleson, DDS</i></p>	
<p>2. PUBLIC COMMENT SECTION <i>At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.</i></p>	<p><i>Daniel Kittleson, DDS</i></p>	
<p>3. CONSENT CALENDAR</p> <ul style="list-style-type: none"> Minutes 02.22.25 	<p><i>Daniel Kittleson, DDS</i></p>	<p>Action</p>
<p>4. INFECTION PREVENTION AND CONTROL QA/PI</p>	<p><i>Stephanie Montecino, LN, CIC</i></p>	<p>Inform</p>
<p>5. 2025 SVHCD QUALITY WORK PLAN</p>	<p><i>Daniel Kittleson, DDS</i></p>	<p>Inform</p>
<p>6. QUALITY INDICATOR PERFORMANCE & PLAN</p>	<p><i>Louise Wyatt, RN JD</i></p>	<p>Inform</p>
<p>7. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report</p>	<p><i>Daniel Kittleson, DDS</i></p>	<p>Action</p>
<p>8. ADJOURN</p>	<p><i>Daniel Kittleson, DDS</i></p>	



**SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE**

Wednesday, January 22, 2025, 5:00 PM

MINUTES

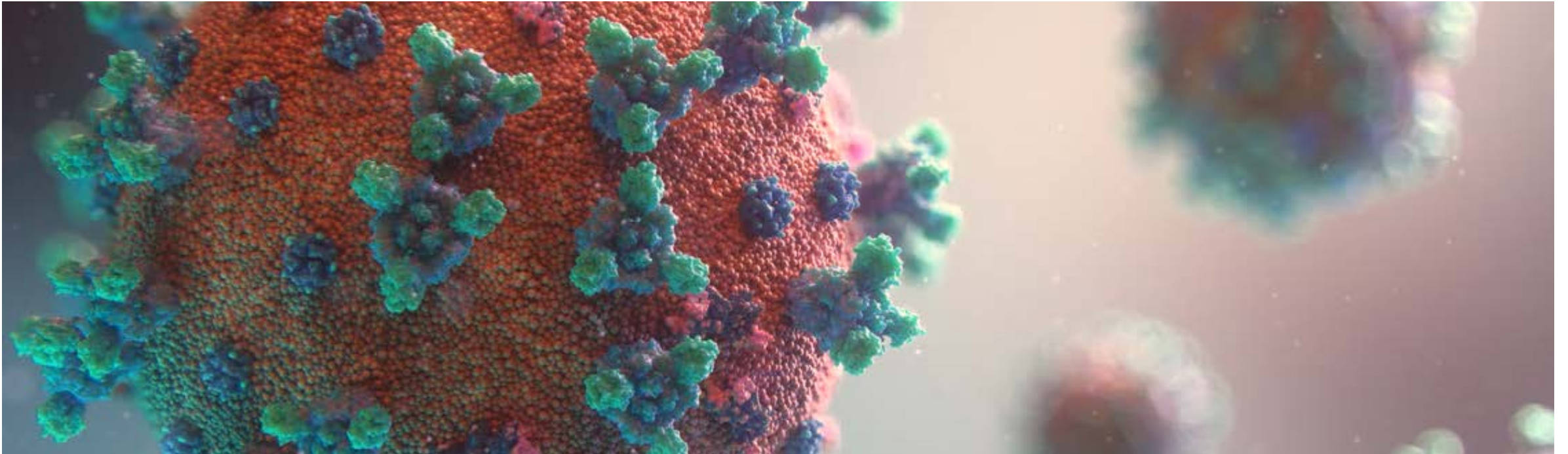
Via Zoom Teleconference

Members Present Daniel Kittleson, DDS Wendy Lee Myatt Carl Speizer, MD Howard Eisenstark, MD Michael Mainardi, MD Carol Snyder Susan Kornblatt Idell Kathy Beebe, RN PhD Paul Amara, MD, FACOG, via zoom	Excused/Not Present	Public/Staff – Via Zoom Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Whitney Reese, Board Clerk John Hennelly, CEO Louise Wyatt, Director of Quality Kelli Cornell, RN, Director of Perioperative Services Leslie Petersen, ED SVH Foundation
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AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	<i>Daniel Kittleson, DDS</i>	
	Kittleson called meeting to order at 5:00 pm.	
2. PUBLIC COMMENT SECTION	<i>Daniel Kittleson, DDS</i>	
	No public comments	
3. CONSENT CALENDAR Minutes 01.22.25	<i>Daniel Kittleson, DDS</i>	ACTION
	<i>Motion to approve by Kornblatt Idell, 2nd by Eisenstark. All in favor.</i>	
4. SURGICAL SERVICES QA/PI	<i>Kelli Cornell, RN, Director of Perioperative Services</i>	INFORM
Cornell presented the Perioperative Services Board Quality Report for February 2025: highlights, key developments, and performance metrics. The department, staffed with 43 FTEs, oversees surgical scheduling, pre- and post-operative care, outpatient infusion, the operating room, and sterile processing. In 2024, surgical volume totaled 1,828 procedures, slightly below the previous year's 2,048. Efficiency metrics, including		

<p>turnover times, exceeded national benchmarks, averaging 11-16 minutes. Key personnel changes included Dr. Walter's arrival and Dr. Kidd's departure. The ROSA orthopedic robot launched in January 2025, with five successful total joint replacements in its first month. 2025 will focus on growth, with at least two new surgeons, expanded plastic surgery and ENT services, and ongoing quality and compliance tracking. A new eye microscope was purchased today.</p>		
<p>5. QUALITY INDICATOR PERFORMANCE & PLAN</p>	<p><i>Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO</i></p>	<p>INFORM</p>
<p>Winkler presented the January 2025 quality data. HCAHPS Patient Satisfaction: Inpatient Ambulatory Surgery for Q4 2024: Strong performance in both ambulatory surgery and inpatient care, often exceeding state and national benchmarks. Ambulatory surgery excels in discharge processes (99.29%), care provider communication (91.44%), and facility/personal treatment (96.53%), surpassing both State CA and All PG Database averages. Inpatient care performs well, particularly in hospital rating, response of hospital staff (81.59% vs. 64.78% PG), and discharge information (92.11% vs. 86.93% PG). Overall, SVH maintains high standards in patient experience, with exceptional scores in staff respect, facility cleanliness, and discharge support.</p>		
<p>6. POLICIES AND PROCEDURES</p>	<p><i>Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, SVH CNO</i></p>	<p>INFORM</p>
	<ul style="list-style-type: none"> • New: Protocol to Reduce Ambulance Patient Offload Times 	<p>QC discussed and made recommendations. Edits will be made prior to recommending to Board of Directors.</p>
<p>7. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report</p>	<p><i>Daniel Kittleson, DDS</i></p>	<p>ACTION</p>
	<p><i>Motion to recommend to Board of Directors for approval by Speizer, 2nd by Mainardi. All in favor.</i></p>	
<p>8. ADJOURN</p>	<p><i>Daniel Kittleson, DDS</i></p>	
	<p>Meeting adjourned at 6:13 pm</p>	

INFECTION PREVENTION AND CONTROL (IPC)
SONOMA VALLEY HOSPITAL
BOARD QUALITY 2025



TODAY'S DISCUSSION

1

WHAT DOES AN
INFECTION
PREVENTIONIST
DO...EMPOWER
AND REPORT..

2

INFECTION
PREVENTION
KEY CONCEPTS
AND TOOLS..

3

LOOKBACK AND
COMPARISON:
YEAR IN
REVIEW..

4

CURRENT AND
ONGOING:
OBJECTIVES FOR
2025..

A CLOSER LOOK: INFECTION CONTROL NURSE



What Is an Infection Control Nurse?

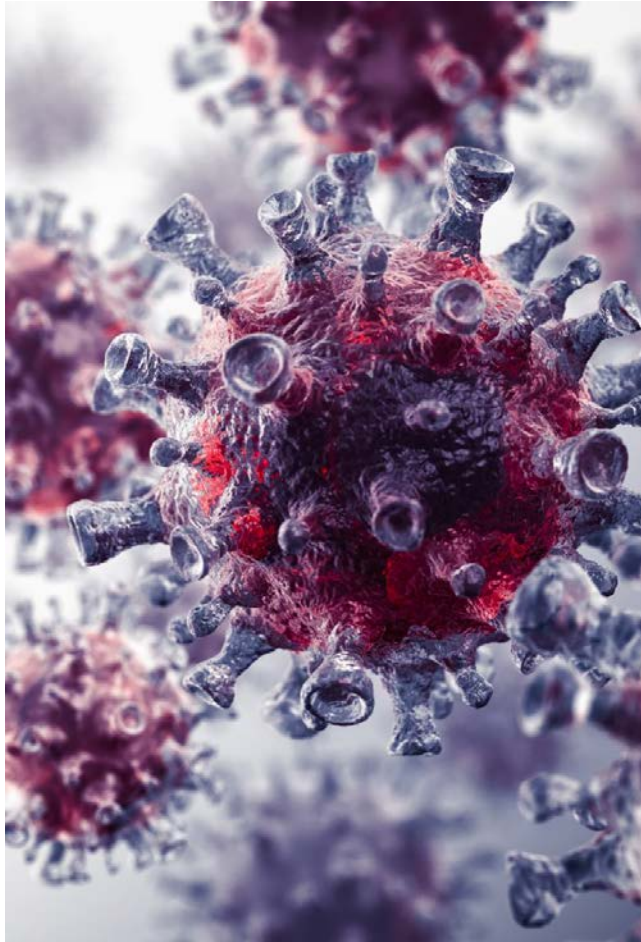
A Look at This
Specialized Role

THE INFECTION
PREVENTIONIST
EMPOWERS ALL STAFF...
BY
PROVIDING
EDUCATION, TRAINING,
RECOMMENDATIONS
AND MORE

AS WELL AS,

TRACK EPIDEMIOLOGICAL
TRENDS IN BOTH THE
HOSPITAL AND IN THE
COMMUNITY





WHAT ELSE DOES THE INFECTION PREVENTIONIST DO?

- The Infection Prevention Nurse: Monitors, tracks and Reports Infections.
- Completes all Required Local, County and State Public Reporting to the California Department of Public Health (CDPH) and regulatory bodies.
- Provides Daily Surveillance of applicable pathogens to local authorities and Task Force Updates, with communication and distribution of information
- Completes Daily Auditing and patient rounds on all Bundle Practices Such as CLABSI, CAUTI, SSI, CDI, MRSA and MSSA, Hand Hygiene Practices, etc. Develop and coordinate hospital policies and practices.
- Monitors Construction Projects for patient's and employee's wellbeing.
- Vaccinates and Tracks all Immunizations for all the employees of SVH

INFECTION PREVENTION KEY CONCEPTS AND TOOLS

1. Prevent Health-Care Associated Infections

TOOL KITS ACTIVITIES: CLABSI, CAUTI, CDI, SSI, MRSA, MSSA

2. Surveillance, tracking and reporting

STERILE FIELDS and ASEPTIC TECHNIQUES

3. Antibiotic Stewardship and Use

ENVIRONMENTAL CLEANING AND WASTE MANAGEMENT CONTAINMENT

4. Injection Safety

ANTIBIOGRAM AND ANTIBIOTIC USAGE; EMPIRICAL DATA USAGE

5. Sterilizing Practices

MDRO

6. Proper handling and storage of equipment for Operating Room

CONSTRUCTION and (ICRA) Infection Control Risk Assessment Air and Dust Containment in Acute Care Hospital Environment

2024 : YEAR IN
REVIEW: LAST
YEAR WE....

Sonoma Valley Hospital Finished Construction Projects and Launched the State-of-the-Art C-T Scanner

Sonoma Valley Hospital finished construction and opened the New 3Tesla MRI Scanner

Finished Construction on the Diagnostic Suites Center

Decreased all Hospital Acquired Infections in all category

Vaccinated 96% of all SVH employees with the Influenza Vaccine and uploaded data to Governing sites

CT IMAGING SUITES WERE COMPLETED IN 2024

- There were zero Hospital Acquired Infections due to the construction projects and their completion in 2024



MRI CONSTRUCTION COMPLETION 2024

- In 2024 MRI Suites and Imaging departments were finished and had zero Hospital acquired infections related to the construction projects.



QUALITY METRICS FOR HOSPITAL ACQUIRED INFECTIONS: COMPARISONS DATA FOR ALL NHSN REPORTING

All HAIs for year 2023-2024

- 3-Clostridium difficile Infection (CDI) Hospital Acquired Infections (HAI)
- 1-Catheter Associated Urinary Tract Infection (CAUTI) HAI
- 1-Central Line Associated Blood Stream Infection (CLABSI) HAI
- 1 Surgical Site Infection HAI
- 0 MRSA Infections HAI
- 0 HAI MSSA Infections HAI

All HAI's for year 2024-2025

- 2-Clostridium difficile Infection (CDI) Hospital Acquired Infections (HAI)
- 0-Catheter Associated Urinary Tract Infection (CAUTI) HAI
- 0-Central Line Associated Blood Stream Infection (CLABSI) HAI
- 0 Surgical Site Infection HAI
- 0 MRSA Infections HAI
- 0 HAI MSSA Infections HAI

IPC INITIATIVES:

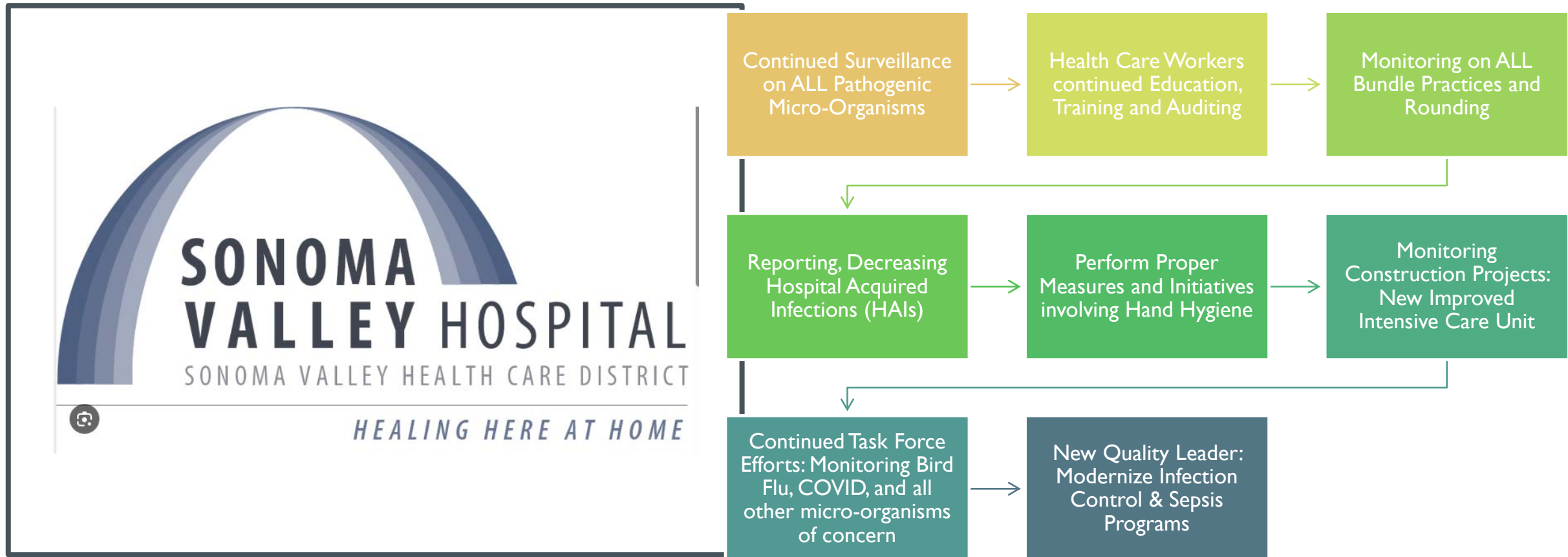
Hand Hygiene Auditing Initiative has shown an increased Achieved goal the target was for 96% and we achieved 98% hitting and surpassing targeted goals.

Hospital Acquired Infections in all categories were lower than the average in the year 2024

BREAKDOWN IN PERCENTAGE FOR 2024

Impact factor	Measurement	Target	Achieved
Hand Hygiene Auditing	Percentage (%)	96%	98%
CDI HAI	Average	<3	2
CAUTI HAI	Average	1	0
CLABSI HAI	Average	1	0
Surgical Site Infection	Average	1	0

CURRENT AND ONGOING: OBJECTIVES FOR 2025.



THANK YOU,

QUESTIONS?

- Stephanie Montecino,
- Infection Preventionist Nurse
- Sonoma Valley Hospital



SVHCD Quality Committee Work Plan 2025





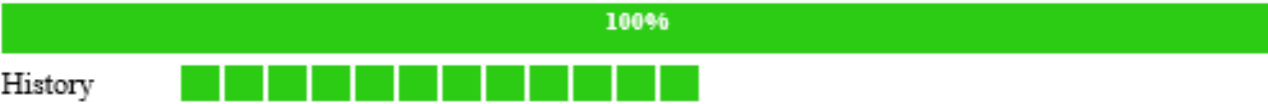











<p>JANUARY 1/22</p> <ul style="list-style-type: none"> • ED QA/PI - Marylou Ehret • Patient Care Services Dashboard 4th Qtr (2024) • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i> 	<p>FEBRUARY 2/26</p> <ul style="list-style-type: none"> • Surgical Servies QA/PI - Kelli Cornell • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i> 	<p>MARCH 3/26</p> <ul style="list-style-type: none"> • Infection Prevention Annual Risk Assessment / Plan - Stephanie Montecino • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i> 	<p>APRIL 4/23</p> <ul style="list-style-type: none"> • Lab QA/P – Alfred Lugo • Patient Care Services Dashboard 1st Qtr (2025) • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i>
<p>MAY 5/28</p> <ul style="list-style-type: none"> • Annual Quality Department Review - new Director of Quality • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i> 	<p>JUNE 6/25</p> <ul style="list-style-type: none"> • ED QA/PI - Marylou Ehret • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i> 	<p>JULY 7/23</p> <p>No meeting</p>	<p>AUGUST 8/27</p> <ul style="list-style-type: none"> • Inpatient Services QA/PI - Jane Taylor • Patient Care Services Dashboard 2nd Qtr (2025) • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i>
<p>SEPTEMBER 9/24</p> <ul style="list-style-type: none"> • Imaging QA/PI – Troy Ashford • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i> 	<p>OCTOBER 10/22</p> <ul style="list-style-type: none"> • PT/OT QA/PI - Chris Gallo • Patient Care Services Dashboard 3rd Qtr (2025) • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i> 	<p>NOVEMBER</p> <p>No meeting</p>	<p>DECEMBER 12/03</p> <ul style="list-style-type: none"> • Pharmacy QA/PI - Chris Kutza • <i>Quality Indicator Performance and Plan</i> • <i>Policies and Procedures</i> • <i>Credentialing</i>

Quality Indicator Performance & Plan

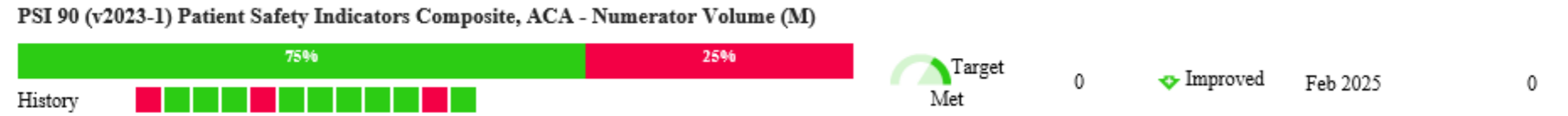
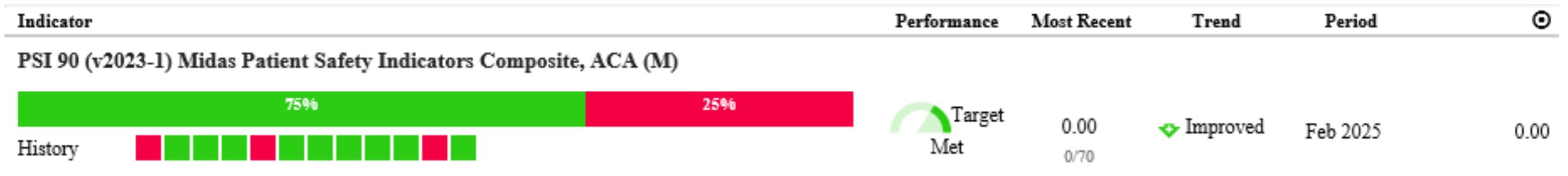
March 26, 2025

Data For February 2025

Mortality

Indicator	Performance	Most Recent	Trend	Period	📍
Acute Care Mortality Rate (M) 	 Target Met	4.1% 3/74	↕ Improved	Feb 2025	5.0%
COPD Mortality Rate [M] 	 Target Met	0.0% 0/5	— No Change	Feb 2025	8.5%
Congestive Heart Failure Mortality Rate [M] 	 Target Met	0.0% 0/2	— No Change	Feb 2025	11.5%
Pneumonia Mortality Rate [M] 	 Breaches Alarm	22.2% 2/9	↗ Deteriorated	Feb 2025	15.6%
Ischemic Stroke Mortality Rate [M] 	 Target Met	0.0% 0/3	— No Change	Feb 2025	13.8%
Hemorrhagic Stroke - Mortality Rate (M) 	 Target Undefined	n/a		Feb 2025	0.0%
Sepsis, Severe - Mortality Rate (M) 	 Target Met	0.0% 0/1	↕ Improved	Feb 2025	25.0%
Septic Shock - Mortality Rate (M) 	 Target Met	20.0% 1/5	↕ Improved	Feb 2025	25.0%

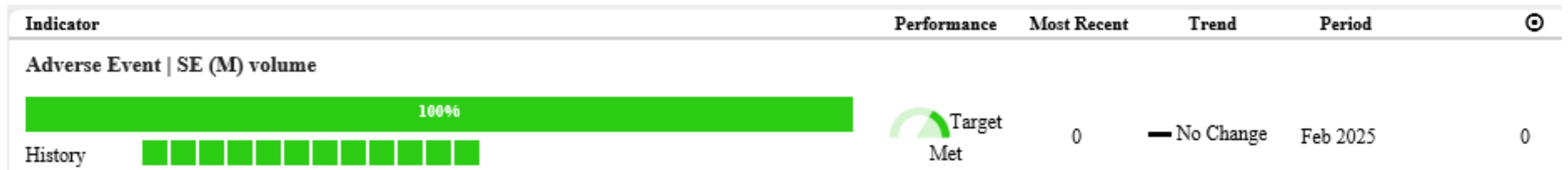
AHRQ Patient Safety Indicators



- Zero PSI 90 events in February

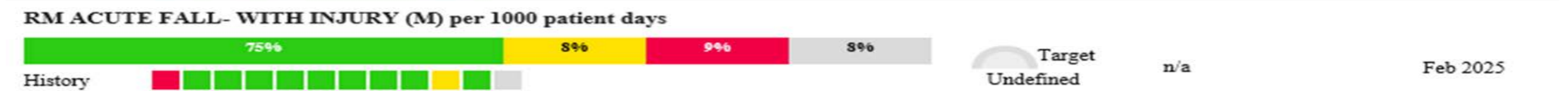
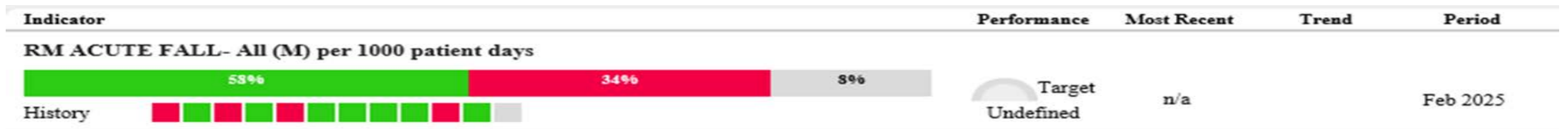
CMS Patient Safety & Adverse Events Composite is a summary of varying patient safety events across multiple indicators, monitors performance over time, and facilitates comparative reporting and quality improvement. (<https://www.cms.gov/priorities/innovation/files/fact-sheet/bpciadvanced-fs-psi90.pdf>)

Adverse Events Reporting









- No adverse events (Severe/Sentinel events; Not PSI90 events)

Falls



- Fall rates below target.

Significant Medication Errors: High Risk Meds and Administration Errors

Indicator	Performance	Most Recent	Trend	Period		
Rx-ADEs-High Risk Med Errors Per 10,000 Doses (M)	 History 	 Target Met	0.00 0/10897	— No Change	Feb 2025	1.13
Rx-Administration Errors Per 10,000 Doses Dispensed	 History 	 Target Met	0.92 1/10897	▲ Deteriorated	Feb 2025	1.00









- No High-Risk Medication Errors
- Administration Error Rate below target

Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	Target	
IC-Surveillance HAI-C.DIFF Inpatient infections per 10k pt days [M]	 History	Target Met	0.000	No Change	Feb 2025	1.000
IC-Surveillance HAI-CAUTI Inpatient infections per 10k patient days [M]	 History	Target Met	0	No Change	Feb 2025	1
IC-Surveillance HAI-CLABSI Inpatient infections per 10k patient days [M]	 History	Target Met	0	No Change	Feb 2025	1
IC-Surveillance HAI-MRSA Inpatient infections per 10k patient days [M]	 History	Target Met	0	No Change	Feb 2025	1
IC-Surveillance HAI-SSI infections per 10k pt days [M]	 History	Target Met	0	No Change	Feb 2025	1
QA-02 Hand Hygiene Practices Monitored [M]	 History	Target Met	92% 46/50	Deteriorated	Feb 2025	90%

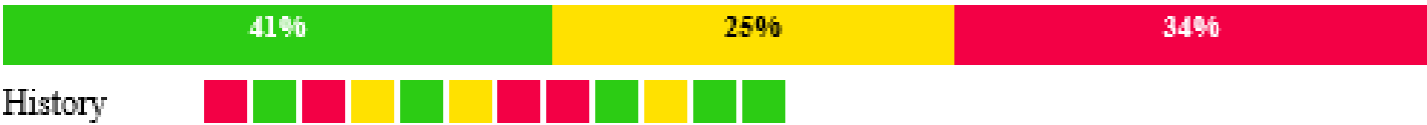








- No HAI, hand hygiene at target goal

Blood Products: Transfusions

Indicator	Performance	Most Recent	Trend	Period	
Lab Transfusion Effectiveness (M)	 History 	Target Met 100.0% 3/3	No Change	Jan 2025	100.0%
Lab Transfusion Reaction (M)	 History 	Target Met 0.0% 0/12	No Change	Jan 2025	0.0%
Lab Transfusion Effectiveness (M)	 History 	Target Met 100.0% 6/6	No Change	Feb 2025	100.0%
Lab Transfusion Reaction (M)	 History 	Target Undefined n/a 0/0		Feb 2025	0.0%

- Transfusions effective; no transfusion reactions

Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	🎯
Blood Cultures -Contamination Rate RN (M) 	 Target Met	1.3% 2/150	 Improved	Feb 2025	3.0%
Blood Cultures -Contamination Rate LAB (M) 	 Target Met	0.0% 0/55	 No Change	Feb 2025	3.0%
Blood Cultures -Total Contamination Rate (M) 	 Target Met	1.0% 2/209	 Improved	Feb 2025	3.0%









- Total of 2 contaminated out of 209 samples
 (n.b. the RN rate only reflects RNs in the ED)

CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period	🕒	
CDSTK-03 Median- Code Stroke Called [M] elapsed time (mins)	100%	Target Met	8	🔻 Deteriorated	Feb 2025	10
History						
CDSTK-04 Median- Door to Phys Eval [M] minutes	100%	Target Met	2	🔻 Deteriorated	Feb 2025	10
History						
CDSTK-05 Median- Door to CT Scanner [M] elapsed time (minutes)	100%	Target Met	8	🔻 Deteriorated	Feb 2025	25
History						
CDSTK-06 Median- Neuro Consult Contacted [M] minutes	100%	Target Met	16	🔻 Deteriorated	Feb 2025	30
History						
CDSTK-07 Median- CT Read by Radiology [M] minutes	100%	Target Met	33	🔻 Deteriorated	Feb 2025	45
History						
CDSTK-08 Median- Lab Results Posted [M] minutes	100%	Target Met	24	🔻 Deteriorated	Feb 2025	45
History						
CDSTK-10 Median- Door to EKG Complete [M] minutes	100%	Target Met	28	🔻 Deteriorated	Feb 2025	60
History						
CDSTK-11 Median-Door to tPA Decision [M] minutes	100%	Target Met	34	🔻 Deteriorated	Feb 2025	60
History						
CDSTK-12 Median-Door to tPA [M] minutes	25%	Target Undefined	n/a		Feb 2025	60
History						

All stroke metrics met for the month of February

Utilization Management

Indicator	Performance	Most Recent	Trend	Period	🕒	
MS-DRG Case Mix Index (CMI) [M]		Breaches Alarm	1.33	🔴 Deteriorated	Feb 2025	1.55
MS-DRG Case Mix Index (CMI) MEDICARE [M]		Bet. Target & Alarm	1.46	🟢 Improved	Feb 2025	1.55
1 Day Stay Rate Medi-Cal [M]		Target Met	0.00% 0/13	— No Change	Feb 2025	2.61%
1 Day Stay Rate-Medicare [M]		Target Met	0.00% 0/59	— No Change	Feb 2025	8.10%
Acute Care Risk-adjusted Average Length of Stay, O/E Ratio [M]		Target Met	0.99 282/285.13	🔴 Deteriorated	Feb 2025	0.99
Inpatients Risk-adjusted Average Length of Stay, O/E Ratio [M]		Target Met	0.98 283/287.91	🔴 Deteriorated	Feb 2025	0.99
Medicare Risk-adjusted Average Length of Stay, O/E Ratio [M]		Target Met	0.95 159/167.13	🔴 Deteriorated	Feb 2025	0.99
Acute Care - Geometric Mean Length of Stay [M]		Bet. Target & Alarm	2.95 38.3224/13	🟢 Improved	Feb 2025	2.75

Case mix index is below target. Medicare adjusted LOS is appropriate, GMLOS (raw data for all patients) improved slightly.

Readmissions

Indicator	Performance	Most Recent	Trend	Period	🕒
30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)	Target Met	3.23% 2/62	📈 Improved	Feb 2025	15.30%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)	Breaches Alarm	20.0% 1/5	📉 Deteriorated	Feb 2025	19.5%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	Target Met	0.0% 0/1	— No Change	Feb 2025	21.6%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	Target Met	0.0% 0/2	— No Change	Feb 2025	4.0%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	Target Met	0.0% 0/6	📈 Improved	Feb 2025	16.6%
Sepsis, Severe - % Readmit within 30 Days (M)	Target Met	0.0% 0/1	— No Change	Feb 2025	12.0%
Septic Shock - % Readmit within 30 Days (M)	Target Met	0.0% 0/2	— No Change	Feb 2025	13.3%

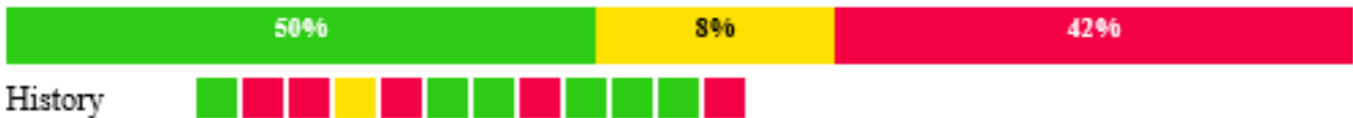








- Readmission rates below target threshold

CMS Core Measures

Indicator	Performance	Most Recent	Trend	Period	Target
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M) History	 Target Met	100.0% 5/5	 No Change	Feb 2025	88.0%
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M) History	 Target Met	121.00	 Improved	Feb 2025	132.00
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M) History	 Target Met	0.4% 3/791	 Improved	Feb 2025	2.0%
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M) History	 Target Met	100.0% 1/1	 No Change	Feb 2025	80.0%

Core Measures target thresholds met in all categories

CMS Core Measures: Sepsis

Indicator	Performance	Most Recent	Trend	Period	
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M) 	 Breaches Alarm	60.0% 3/5	 Deteriorated	Feb 2025	81.0%
SEPa - Severe Sepsis 3 Hour Bundle (M) 	 Breaches Alarm	83.3% 5/6	 Deteriorated	Feb 2025	94.0%
SEpb - Severe Sepsis 6 Hour Bundle (M) 	 Target Met	100.0% 4/4	 No Change	Feb 2025	100.0%

- *Sepsis metrics met*

CIHQ Corrective Action Plan Monthly Compliance Condition Level Findings: Continuous Observation of High Risk of Self Harm Patients

Full bundle compliance from Jan 2024

- 4 pts in Feb.
- 1 missed MD order
- Average LOS: 10 hours
- Age Range: 15- 64





HCAHPS Patient Satisfaction: Inpatient Ambulatory Surgery Reported Quarterly

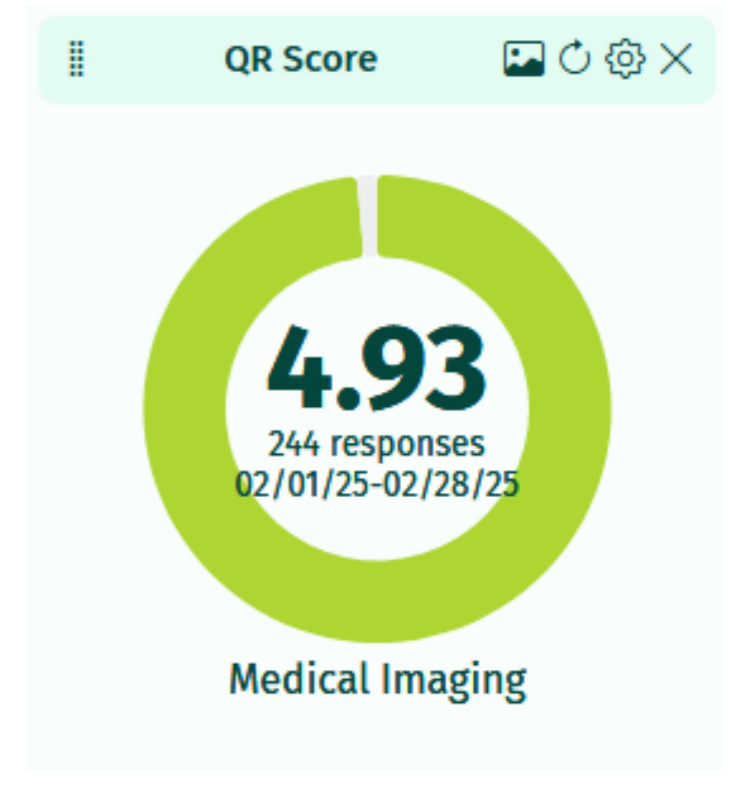
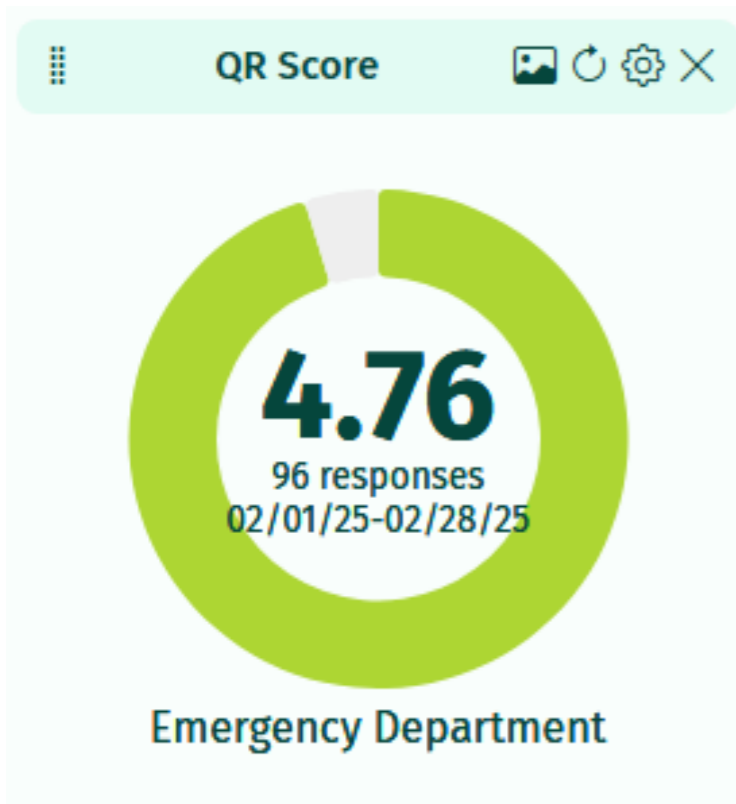
(Please refer to August report for Q2, November report for Q3 and February report for Q4)

Q Reviews: Rate My Hospital February 2025

Emergency
Department

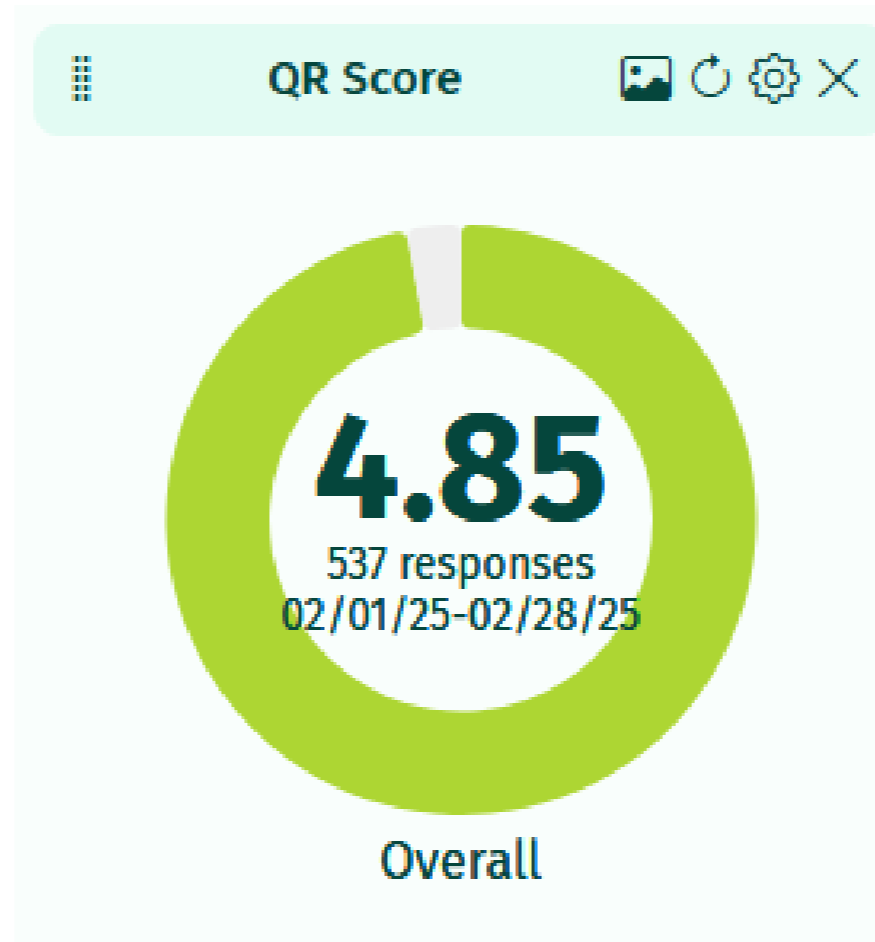
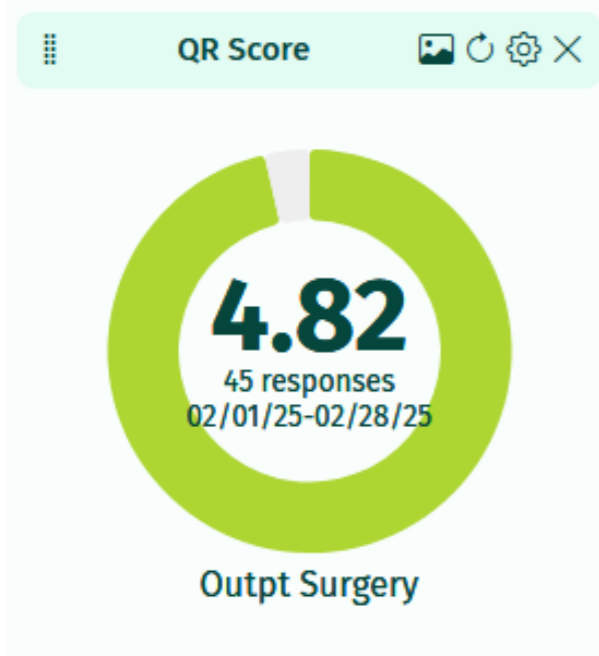
Outpatient Physical
Therapy

Medical
Imaging



Q Reviews: Rate My Hospital February 2025

Outpatient Surgery



Inpatient Care

