HUMAN SERVICES DEPARTMENT

HOSPITAL QUALITY IMPROVEMENT INCENTIVE (HQII)

INVESTING FOR TOMORROW, DELIVERING TODAY.

HUMAN SERVICES DEPARTMENT

MISSION

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

GOALS

We help NEW MEXICANS

1. Improve the value and range of services we provide to ensure that every qualified New Mexican receives timely and accurate benefits.

We communicate EFFECTIVELY

2. Create effective, transparent communication to enhance the public trust.

We make access EASIER

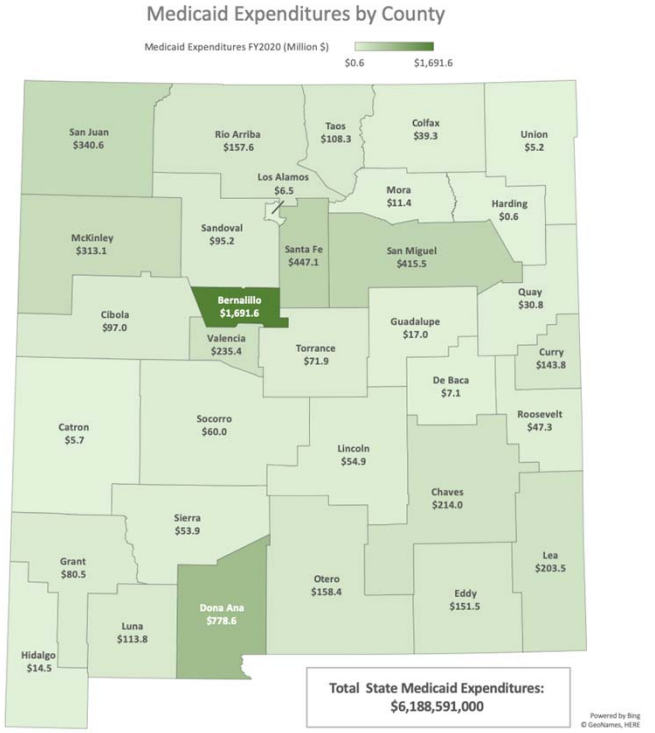
3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

We support EACH OTHER

4. Promote an environment of mutual respect, trust and open communication to grow and reach our professional goals.

GUIDING MEDICAID PRINCIPLES

- NM has the highest population percentage covered by Medicaid, which creates a greater NM HSD responsibility to our healthcare market and to fair payments.
- The overwhelming majority of federal CMS dollars must be spent on providing direct services to Medicaid beneficiaries.
- HSD aims to maximally leverage federal funds to improve the health of New Mexicans, while maintaining strict compliance with the law.



Source: NM Human Services Department Medical Assistance Division Estimates. Total State Medicaid Expenditure estimate includes expenditures from unknown counties not shown in map.

HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

The Hospital Quality Improvement Incentive (HQII) Program incentivizes hospital's efforts to ***meaningfully improve the health and quality of care of the Medicaid and uninsured individuals that they serve.***

Each hospital participating has submitted measures and have been paid for DY 2 of the HQII program in the amount of $2,824,462. In DY 3 the amount of $5,764,727 was paid. For DY 4 the amount paid was $8,825,544. In DY 5 $12,011,853 was paid. DY 6 paid the program providers $12,000,000 and the DY 7 payment was $11,000,993.

Click on hospital for reporting results	Met Participation Requirements
Alta Vista Regional Hospital	Yes
Artesia General Hospital	Yes
Carlsbad Medical Center	Yes
CHRISTUS St. Vincent Hospital	Yes
Cibola General Hospital	Yes
Dr. Dan C. Trigg Memorial Hospital	Yes
Eastern New Mexico Medical Center	Yes
Espanola Hospital	Yes
Gerald Champion Regional Medical Center	Yes
Gila Regional Medical Center	Yes
Guadalupe County Hospital	Yes
Holy Cross Hospital	Yes
Lea Regional Hospital	Yes
Lincoln County Medical Center	Yes
Los Alamos Medical Center	Yes
Lovelace Regional Hospital - Roswell	Yes
Memorial Medical Center	Yes
Mimbres Memorial Hospital	Yes
Miners' Colfax Medical Center	Yes
Mountain View Regional Medical Center	Yes
Nor - Lea General Hospital	Yes
Plains Regional Medical Center	Yes
Rehoboth McKinley Hospital	Yes
Roosevelt General Hospital	Yes
San Juan Regional Medical Center	Yes
Sierra Vista Hospital	Yes
Socorro General Hospital	Yes
Union County General Hospital	Yes
University of New Mexico Hospital	Yes

The HQII program is aligned with the goals of Centennial Care.

- To assure the right amount of care, at the right time, and in the most cost effective or "right" setting;
- To advance payment reform and assure that care is measured in terms of its quality and not merely quantity;
- To encourage greater personal responsibility of members and facilitate their active participation in their own health so they can become more efficient users of the health care system; and
- To streamline and modernize the program in preparation for the increase in membership that occurred with the expansion of Medicaid to previously ineligible low-income adults.

HQII is not intended to rate the performance of the hospital, nor used to compare against any other hospital. Measures requested of hospitals are specific to that hospital's capabilities and quality improvement intent. The information contained in the HQII program is used for the purpose of the HQII program.

Outcome Domain 1: Urgent Improvements in Care

The following are measures of safer care that align with the CMS Partnership for Patients initiative. ***For Facilities with less than 100 beds, only the six measures noted below are required and eligible.****

1. Adverse Drug Events*
2. Catheter-Associated Urinary Tract Infections (CAUTI)*
3. Central Line Associated Blood Stream Infections (CLABSI)
4. Injuries from Falls and Immobility*
5. Obstetrical Adverse Events
6. Pressure Ulcers*
7. Surgical Site Infections (SSIs) (NQF Measure 0753)
8. Venous Thromboembolism (VTE)*
9. Ventilator-Associated Events
10. All Cause (Preventable) Readmissions*

***Required measures for hospitals with <100 beds**

Outcome Domain 2: Population-Focused Improvements

These have been updated to the ICD 10

1. Diabetes Short-Term Complications Admissions Rate (PQI 01)
2. Diabetes Long-Term Complications Admission Rate (PQI 03)
3. COPD or Asthma in Older Adults Admission Rate (PQI 05)
4. Heart Failure Admission Rate (PQI08)
5. Bacterial Pneumonia Admission Rate (PQI 11)
6. Uncontrolled Diabetes Admission Rate (PQI14)
7. Asthma in Younger Adults Admission Rate (PQI 15)

1. ADVERSE DRUG EVENTS

DATA COLLECTION METHOD: Self-report: A, B or C

A. Hypoglycemia in Inpatients Receiving Insulin

Numerator – Hypoglycemia in inpatients receiving insulin or other hypoglycemic agents.

Denominator - inpatients receiving insulin or other hypoglycemic agents.

B. Adverse Drug Events due to Opioids

Numerator – number of inpatients treated with opioids who received naloxone.

Denominator - number of inpatients who received an opioid agent.

C. Excessive anticoagulation with Warfarin – Inpatients

Numerator – inpatients experiencing excessive anticoagulation with warfarin.

Denominator - inpatients receiving warfarin anticoagulation therapy.

Rate = Numerator / Denominator x 100

Specifications available at http://www.hret-hiin.org/data/hiin_eom_core_eval_and_add_req_topics.pdf

2. CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)

Numerator – total number of observed healthcare associated CAUTI among patients in inpatient locations.

Denominator - total number of indwelling urinary catheter days for each location under surveillance for CAUTI.

Rate = Numerator
Denominator x 1,000

Specifications available at:
http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf

3. CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTIONS (CLABSI)

Numerator – total number of observed healthcare associated CLABSI among patients in bedded inpatient locations.

Denominator - total number of central line days for each location under surveillance for CLABSI.

Rate = Numerator
Denominator x 1,000

Specifications available at:
http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf

4. INJURIES FROM FALLS AND IMMOBILITY/TRAUMA HAC 05 CMS

Numerator – total number of hospital acquired occurrences of fracture, dislocation, intracranial injury, crushing injury, burn and other injury (codes within the CC/MCC list).

Denominator - inpatient discharges.

Rate = Numerator
Denominator x 1,000

Specifications available at:

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf
or
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

5. OBSTETRICAL ADVERSE EVENTS

OB Trauma – Vaginal Delivery without Instrumentation PSI 19

Numerator – discharges among cases meeting the inclusion and exclusion rules for the denominator with any listed diagnostic codes for third and fourth degree obstetric trauma.

Denominator - vaginal deliveries identified by DRG or MS-DRG code.

OB Trauma – Vaginal Delivery with Instrumentation PSI 18 *if service is provided.

Numerator – discharges among cases meeting the inclusion and exclusion rules for the denominator with any listed diagnostic codes for third and fourth degree obstetric trauma.

Denominator - all vaginal delivery discharges with any procedure code for instrument-assisted delivery.

Rate = Numerator
Denominator x 1,000

Specifications available at:
https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V70/TechSpecs/PSI_18_Obstetric_Trauma_Rate-Vaginal_Delivery_With_Instrument.pdf

6. PRESSURE ULCERS STAGE III & IV RATE PSI 3

Numerator – discharges among cases meeting the inclusion and exclusion rules for the denominator with any secondary ICD-9-CM or ICD-10-CM diagnosis codes for pressure ulcer, and any secondary ICD-9-CM or ICD-10-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable).

Denominator – inpatient adult discharges.

Rate = Numerator
Denominator x 1,000

Specifications available at:
https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_03_Pressure_Ulcer_Rate.pdf

Note: update terminology, National Pressure Ulcer Advisory Panel has revised language to describe **"pressure injury"**

7. SURGICAL SITE INFECTIONS

Colon, abdominal hysterectomy, total knee replacement, or total hip replacements

Numerator – total number surgical site infections based on Center for Disease Control's (CDC) NHSN definition.

Denominator – all patients having any of the procedures included in the selected NHSN operative procedures category(s) as listed above.

Rate = Numerator / Denominator X 100

Specifications available at:
http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf

8. VENOUS THROMBOEMBOLISM (VTE) POST-OPERATIVE PSI 12

Numerator – Discharges among cases meeting the inclusion and exclusion rules for the denominator, with a secondary ICD-9-CM diagnosis code for deep vein thrombosis or a secondary ICD-9-CM diagnosis code for pulmonary embolism.

Denominator – all patients having any of the procedures included in the selected NHSN *operative procedures* category(s) For example "All surgical discharges age 18 and older defined by specific DRG's or Denominator MS-DRG's and a procedure code for an operating room procedure".

Rate = Numerator
Denominator X 1,000

Specifications available at:
https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_12_Perioperative_Pulmonary_Embolism_or_Deep_Vein_Thrombosis_Rate.pdf

9. VENTILATOR ASSOCIATED EVENTS

Ventilator-Associated Condition (VAC) & Infection-Related Ventilator-Associated Complication (IVAC)

Ventilator-Associated Condition (VAC)
Numerator – number of events that meet the criteria of VAC; including those that meet the criteria for infection-related ventilator-associated complication (IVAC) and possible/probable ventilator-associated pneumonia (VAP).

Infection-Related Ventilator Associated Complication (IVAC)
Numerator – number of events that meet the criteria of infection-related ventilator-associated condition (IVAC); including those that meet the criteria for possible/probable ventilator-associated pneumonia (VAP).

Denominator – (ventilator and patient days) for patients ≥ 18 years of age.

NOTE: VAE is currently not included in CMS Hospital Inpatient Quality Reporting.
Current NHSN recommendations for "appropriate public reporting" include

- *Overall VAE rate = rate of all events meeting at least the VAC definition*
- *"IVAC –plus" rate = rate of ALL events meeting at least the IVAC definition*

Specifications available at:
http://www.cdc.gov/nhsn/PDFs/pscManual/10-VAE_FINAL.pdf

10. ALL CAUSE PREVENTABLE READMISSIONS (NQF 1789)

Numerator - inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

Denominator – adult admissions to acute care facility (minus denominator exclusions).

Rate = Numerator
Denominator X 100

Specifications available at
http://www.hret-hiin.org/data/hiin_eom_core_eval_and_add_req_topics.pdf

DOMAIN 2 MEASURES

Outcome Domain 2: Population-focused Improvements
Please click on each measure to go to the respective website for more information

1. Diabetes Short-Term Complications Admissions Rate (PQI 01)
2. Diabetes Long-Term Complications Admission Rate (PQI 03)
3. COPD or Asthma in Older Adults Admission Rate (PQI 05)
4. Heart Failure Admission Rate (PQI08)
5. Bacterial Pneumonia Admission Rate (PQI 11)
6. Uncontrolled Diabetes Admission Rate (PQI14)
7. Asthma in Younger Adults Admission Rate (PQI 15)

All Domain 2 measures are supported by HIDD and can be found at:

https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx

ALTA VISTA REGIONAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	No
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 83%
(improved in 5 of the 6 eligible measures)

Annual Report – report of hospital's interventions, their challenges, mid-course corrections and successes

ARTESIA GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	No

Percentage of overall improvement 83%
(improved in 5 of the 6 eligible measures)

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CARLSBAD MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 100%
(improved in 8 of the 8 eligible measures)

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CHRISTUS ST. VINCENT HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 100%
(improved in 8 of the 8 eligible measures)

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CIBOLA GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	No
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 83%
(improved in 5 of the 6 eligible measures)

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DR. DAN C. TRIGG MEMORIAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	No
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	No
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 67%
(improved in 4 of the 6 eligible measures)

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EASTERN NM MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 100%
(improved in 8 of the 8 eligible measures)

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ESPAÑOLA HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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GERALD CHAMPION REGIONAL MEDICAL CENTER
HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	No
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 88%
(improved in 7 of the 8 eligible measures)

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GILA REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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GUADALUPE COUNTY HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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HOLY CROSS HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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LEA REGIONAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 100%
(improved in 8 of the 8 eligible measures)

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LINCOLN COUNTY MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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LOS ALAMOS MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	No
All Cause Readmission	No
Catheter Associated Urinary Tract Infections (CAUTI)	No
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 50%
(improved in 3 of the 6 eligible measures)

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LOVELACE ROSWELL REGIONAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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MEMORIAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	No
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 88%
(improved in 7 of the 8 eligible measures)

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MIMBRES MEMORIAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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MINERS' COLFAX MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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MOUNTAIN VIEW REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	No
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	No
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 75%
(improved in 6 of the 8 eligible measures)

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NOR-LEA GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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PLAINS REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	No
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 88%
(improved in 7 of the 8 eligible measures)

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REHOBOTH MCKINLEY HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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ROOSEVELT GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

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SAN JUAN MEDICAL CENTER

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 100%
(improved in 8 of the 8 eligible measures)

Annual Report – report of hospital's interventions, their challenges, mid-course corrections and successes

SIERRA VISTA HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	No
All Cause Readmission	No
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 67%
(improved in 4 of the 6 eligible measures)

Annual Report – report of hospital's interventions, their challenges, mid-course corrections and successes

SOCORRO GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

Annual Report – report of hospital's interventions, their challenges, mid-course corrections and successes

UNION COUNTY GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Falls and Trauma	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 6 of the 6 eligible measures)

Annual Report – report of hospital's interventions, their challenges, mid-course corrections and successes

UNIVERSITY OF NEW MEXICO HOSPITAL

HQII REPORTING RESULTS FROM DY6 TO DY7

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	N/A
-OB vaginal laceration w/o instrumentation	N/A
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	N/A

Percentage of overall improvement 100%
(improved in 8 of the 8 eligible measures)

Annual Report – report of hospital's interventions, their challenges, mid-course corrections and successes

ALTA VISTA REGIONAL HOSPITAL

Hospital interventions:	We focused on reducing infection rates for CAUTI's, in particular, efforts with Foley catheter utilization rates and bundle care. We achieved our goal by reducing our Foley utilization of inpatient areas by 7% and in our ICU by 10%. A reduction in surgical site infection rates was achieved after retraining and reeducation in wound care management with the focus on nutritional importance for wound healing in the area of colon resection and total hysterectomies. We put a strong focus on increasing employee annual influenza vaccination rates. We instituted mandatory masking policy for any declination regardless of reason. This improved overall compliance rates from 64% to 91%. Due to a small increase of central line utilization, we provided reeducation to frontline nursing staff on decision tree for appropriateness of central line devices and reevaluation of daily need. The device days for central lines stabilized and our facility maintained our CLABSI infection rate of 0.
Hospital challenges:	The lack of community opportunities, high quality school systems and labor opportunities results in high turnover rate. This creates increased training needs and limited resources to implement interventions and monitor outcomes consistently. From a data perspective, low denominator data results in no SIR data and a single infection then places our facility over the allowable infection rate. Recruiting or maintaining individuals with wound care experience to champion wound care protocols continues to be a challenge.
Any mid-course corrections:	Midyear, the infection preventionist instituted Purewick external catheters for females to assist in the reduction of indwelling foley usage.
Successes:	Our hospital had zero CLABSI's, VAE (Ventilator Associated Events) in all settings, including ICU and a large increase in influenza vaccination rates from the previous year. The infection preventionist is now actively involved with patient rounding, one-on-one education with frontline nursing staff, communication, and coordination with laboratory staff to ensure infection prevention practices were followed.

ARTESIA REGIONAL HOSPITAL

Hospital interventions:	1. In beginning of 2019, a Quality Improvement Committee (QIC) was organized. This was a multidisciplinary committee developed to meet monthly. This included developing a system to report performance improvement data to top leadership. 2. The hospital had policies and procedures on a shared drive, which led to changes/updates and duplicate polices without proper approvals. There was lack of consistency on policy and procedures. Beginning in 2019, the organization began a process to transition all policies and procedures from the shared drive into an automated policy application. This process was being shared by several individuals within the organization.
Hospital challenges:	1. The laissez-faire attitude that reporting meaningful data is a priority to drive improvement throughout the organization. 2. The transition process of uploading all policies and procedures into an automated application is most challenging. Another challenge is getting the policies on top leadership agendas for discussion and ensuring there was communication regarding availability of each policy. Another challenge is creating a process that does not create bottle necks for signature approvals has also been very challenging. 3. A turnover in leadership led to a lack of organized improvement efforts.

ARTESIA REGIONAL HOSPITAL (CONT.)

Any mid-course corrections:	1. In May 2019, we updated the Quality Improvement Committee agenda to be displayed in a PowerPoint presentation during the monthly meetings to encourage multidisciplinary discussions related to measures and actions to be taken. Each quality initiative was shown on its own individual slide with numbers to discuss. 2. The process for policy and procedures was transitioned over to the Quality Department for management, review, and consistency. 3. The Quality Department met with leadership from each area regarding data reporting.
Successes:	1. By year end, the PowerPoint presentation was enhanced into a slide deck of more meaningful aggregated data that then displayed an entire year's data. 2. By year end, all the policies and procedures were uploaded into the application and each has gone through the Medical Executive Committee and the hospital Board for approval. This increased the team's ability to provide safer care.
Any other information:	1. We are continuing to develop and improve a QMS Dashboard to present to top leadership. This is a work in progress to meet the needs of the organization, DNV, and CMS.

CARLSBAD MEDICAL CENTER

Hospital interventions:	Case management assumed the role of discharge planning on our Inpatient Rehab floor, which involved coordinating with nursing discharge education and follow-up. Challenges with our aging facility were addressed and improvements were undertaken. We revamped our environment of care and life safety team. A tour by hospital leadership identified areas that needed updates and remodeling. Our kitchen was remodeled; 9 patient rooms were scheduled for remodeling with completion in 2020. We updated our medical gas system and replaced pipes throughout the facility, some of which had resulted in downtime in our OR. We also added a new dietician to our staff, who is very engaged with the patients and staff.
Hospital challenges:	We had 4 patients with hospital onset C-diff infections in 2019, compared to 0 the year before. A chart review of those 4 patients did not reveal any trends or care deficiencies other than the patient being in a high-risk category. Our readmission rates, both Medicare and all-payer, increased in 2019 by 63% and 36% respectively, with a few patients having multiple admissions.
Any mid-course corrections:	All hospital curtains were replaced with disposable ones. Education was provided on risk factors for C-Diff and guidelines for testing. Handwashing was emphasized during staff trainings. The Case Management team changed their focus on readmissions by meeting with patients and families on admission and throughout the patient stay to assess for home needs and possible alternative placement. The case managers developed a closer relationship with outside care coordinators including insurance case managers to collaborate more effectively on patient needs at discharge. Our clinical documentation improvement specialist worked with our core measure abstractor on early identification of patients with sepsis allowing for improved concurrent review and staff education.
Successes:	Our catheter associated urinary tract infection rate improved by 100% in 2019 with 0 infections noted. We maintained 0 early elective deliveries, 0 stage 3+ pressure ulcers and 0 surgical site infections for both hysterectomies and colon surgeries. Our overall sepsis mortality rate improved from 9% to 6.9%. Our compliance with core measure sepsis bundle improved from 52.5% to 64%.
Any other information:	In 2019 we were able to recruit a urologist and an additional obstetrical provider.

CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER

Hospital interventions:	1. The objective of this quality initiative was to optimize the management of obstetric hemorrhage to reduce maternal morbidity and mortality. More than two women die every day in the USA from pregnancy-related causes. Obstetric hemorrhage has been identified as a treatable cause to prevent maternal mortality. Utilizing the Alliance for Innovation (AIM) on Maternal Health Safety Bundle, we have implemented the following processes to promote improved recognition, regulatory readiness, and response to obstetric hemorrhage: 1. Document on admission the maternal hemorrhage risk assessment 2. Improve quantitative blood loss assessments 3. Update hemorrhage cart for medication and equipment access 4. Hospital simulation lab training in Ob Hemorrhage for nursing staff and physicians 5. Clinical supervisor led response team for hemorrhage 6. Debriefs for staff and family after hemorrhage 7. Morbidity and Mortality Conference for the Ob/Gyn Department 8. Uterine artery embolization protocols to avoid cesarean hysterectomy

CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER (CONT.)

Hospital interventions: Cont	2. The goal of the antimicrobial stewardship project was to reduce inappropriate outpatient antibiotic prescribing by at least 20% for bronchitis and sinusitis from December 2019 through March 2020 compared to December 2018 through March 2019. To achieve this, a team of providers consisting of a pharmacy practice resident, infectious diseases pharmacists, an infectious diseases physician, and a family practice resident reviewed outpatient antibiotic prescribing for bronchitis and sinusitis for five primary care clinics and one urgent care clinic within CSV. Throughout much of 2019, members of this team went to each of the six clinics to educate providers on the most recent evidence-based prescribing recommendations. They also distributed an infectious disease pharmacist's contact information for immediate assistance in addressing clinical antimicrobial questions. Clinics were supplied with visual educational material. They were given a clinical decision support flowchart for the treatment of sinusitis and bronchitis, patient education handouts, and informative material to display on the walls of the clinic. In addition to the above, a method for retrospective audits and feedback was implemented. Every time a key antibiotic (identified as: amoxicillin/clavulanic acid, azithromycin, levofloxacin, cephalexin, doxycycline) was prescribed, a pharmacist was notified for review. The team then determined the appropriateness of the antibiotic and gave providers direct feedback during their monthly visits to the clinics.
Hospital challenges:	1. Our hospital challenges were the following: ownership of maternal hemorrhage risk assessments and documentation of blood loss; cost of new hemorrhage carts (we were able to repurpose old carts); staffing and coordinating simulation lab training; and provider buy-in to participate in post hemorrhage debriefs. 2. One of the biggest challenges to this study was provider buy-in. Some providers were very enthusiastic to improve antibiotic prescribing habits for improvement of patient care, while others were reluctant to make any changes to current practice. This difference in buy-in and provider behavior seemed to be clinic dependent and influenced by the established provider culture associated with the clinic.

CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	1. Our morbidity and mortality conference was postponed. We continue to explore the development of uterine artery embolization protocols.
Successes:	1. We now document maternal hemorrhage risk on more than 90% of our admitted patients. Our completion rate of blood loss assessments improved from 53% to 90%. All our OB nurses have undergone simulation lab training for OB hemorrhage. 2. The team was successful in achieving their goal for the project. A total of 400 patients (200 in the pre-intervention and 200 in the post-intervention period) were identified with a diagnosis of bronchitis or sinusitis and assessed for antibiotic appropriateness. Baseline data from the pre-interventional period showed that overall, 68% of all antibiotic use was inappropriate. Post-interventional data showed that overall, 43% of antibiotic use was inappropriate, resulting in a 37.5% percent decrease in inappropriate antibiotic use. ($p < 0.0001$).
Any other information:	1. Our efforts expand outside of CSV. We are part of the New Mexico AIM Hospital initiative through the University of New Mexico. We are also part of the Christus Health Perinatal Committee and are working at the system level to develop a Perinatal Dashboard to track data and to monitor progress toward our goals. 2. The project was immensely successful and demonstrated the positive changes that can be made with pharmacy's targeted interventions on quality improvement initiatives. Given this, CSV has decided to incorporate a Quality Pharmacist into the Quality Department. The goals of this position are to sustain the success of this project, in addition to making advancements in other similar initiatives.

CIBOLA GENERAL HOSPITAL

Hospital interventions:	Three key interventions that our hospital worked on in CY2019 were improving patient satisfaction and employee engagement, improving inpatient and employee influenza vaccination rates, and reducing inpatient falls. To improve patient satisfaction and employee engagement, our Executive and Leadership teams worked to deploy the hospital's 3-year strategic plan (co-developed by Studer) across all service lines. As a result, we were able to raise both or employee engagement and patient satisfaction survey scores. In CY2019, our hospital also focused on continuing to emphasize our inpatient and employee influenza vaccination initiatives. We increased our employee influenza vaccination rate from 60% to 90% for the 2019 flu season. Lastly, our hospital created a falls reduction team to address the increase in the number of patient falls. The team worked together to create a post-fall huddle sheet and update our hospital's falls policy so that it included department-specific information on fall precautions. Additionally, all clinical staff were educated at our hospital's annual clinical education event on properly using fall precautions and correctly identifying patients that are fall risks. As a result, we were able to reduce the number of inpatient falls in CY2019 compared to CY2018.
Hospital challenges:	Our hospital experienced a decrease in employee hand hygiene compliance and an increase in avoidable days. We also continued to struggle with inpatient falls. However, the inpatient falls that occurred were without trauma or serious injury.
Any mid-course corrections:	In CY2019, we had one anticoagulation-related ADE (Adverse Drug Event). A root cause analysis was conducted to ensure that no other anticoagulation related ADEs occurred. Over the course of two months, our hospital's Continuous Quality Committee (CQC) undertook a PDSA project focused on process improvement. Multiple changes were implemented, clinical staff were educated about the process changes and expectations regarding properly documenting and interpreting lab results, and it was decided that all ADEs would be sent up to P&T (Pharmacy and Therapeutics) Committee for review on a monthly basis.

CIBOLA GENERAL HOSPITAL (CONT.)

Successes:	In CY2019, all departments in our hospital worked diligently to implement new and improved initiatives focused on improving quality, safety, and patient satisfaction. Our major successes tied to the HQII initiative included reducing our within facility readmission rate to <3% on a monthly basis, achieving 0 harms related to post-operative DVTs, and achieving 0 harms related to hospital-acquired stage III and IV pressure ulcers. Other successes included undergoing a Focused Standards Assessment (FSA) by Joint Commission, submitting our electronic clinical quality measures (eCQM) to both CMS and Joint Commission, and implementing multiple safety initiatives focused on reducing workplace violence and increasing safety and security at our facility. Additionally, our hospital applied for the New Mexico Performance Excellence Adobe Award in which our work on falls reduction was highlighted.

DR. DAN C. TRIGG MEMORIAL HOSPITAL

Hospital interventions:	1. Dr. Dan C. Trigg Memorial Hospital (DCT) monitored the diabetic clinic patients for the elements of the D3 Bundle. The components of the bundle included A1C, B/P & LDL levels. Monthly reports were reviewed to identify patients needing support/education. Reports were routinely shared with the Providers to provide information on areas for improvement. 2. In 2018, Dr. Dan C. Trigg Memorial Hospital (DCT) had 5 patient falls or a rate of 9.328 per 1000 acute care patient days. As this was a significant increase from 2017, falls became a focus for patient safety. A falls committee was created to investigate all falls and potential contributing factors. Education to patients documented and other tools such as visual reminders and bed alarms. "Call before you fall" signs were placed on the ceiling where patients could visualize while in bed.
Hospital challenges:	1. Some of the challenges were getting the patients scheduled within the required time frames and compliance to all three of the components. 2. Signing the No One Walks Alone contract and reviewing the fall risk assessment with the patient was a process needing reinforcing but was achieved.
Any mid-course corrections:	1. Printed a list of patients requiring compliance of the bundle and used the list to schedule the visits when needed to maintain compliance. 2. Falls committee monthly meetings kept the topic on the forefront.
Successes:	1. January compliance began at 29.40% and 2019 compliance ended with 38.5%. 2. DCT was able to eliminate patient falls for the 2019 year.
Any other information:	1. The D3 Bundle was changed to D5 for 2020. 2. DCT went 418 days without a patient fall.

EASTERN NEW MEXICO MEDICAL CENTER

Hospital interventions:	In 2019, the hospital leadership group continued to focus on infection prevention. As a result, we only had one catheter associated infection, and one central line associated blood stream infection. We have decreased the number of C-Diff infections but have not reached our goal yet. We went the entire year without a fall with a serious injury. We also decreased our number of falls. Hospital readmissions continues to be a challenge.
Hospital challenges:	Readmissions continue to be a challenge for the hospital. In 2019, the senior leadership team initiated a PDSA project focused on scheduling follow-up care visits for all patients discharged with their preferred provider. An emphasis was placed on the continuation of hourly rounding and completing bedside shift report to ensure patient safety. Patients and families are included in this report, which allows them to ask questions active in the process of caring for them.
Any mid-course corrections:	Hand hygiene compliance monitoring needed to be adjusted in 2019. We used "secret shoppers" to assist in this initiative and monitor compliance.
Successes:	We decreased our fall rate and had no falls with fracture or serious injury in 2019. We strengthened our Safety Watch Program and did not have any falls with patients who were on the program.

ESPAÑOLA HOSPITAL

Hospital interventions:	PEH has worked diligently to try to minimize, if not eliminate, hospital onset, c-diff infections. Interventions included having a pharmacist trained for antibiotic stewardship, implementing cleaning with UV light following every discharge, a testing algorithm for providers, and education and signs for both staff and family members around the importance of handwashing and PPE.
Hospital challenges:	Insufficient UV lights to get rooms turned over efficiently. Involves multiple disciplines working together. Testing stewardship is challenging, depending upon how busy the unit is at the time.
Any mid-course corrections:	Purchased another UV light. Enlisted the use of an online testing guide for providers, reeducated nursing staff regarding the symptoms of clostridium difficile infection, the importance of testing stewardship. Engaged the lab in testing only appropriate specimens.
Successes:	No hospital-onset c-diff infections occurred between November 2019 and July 2020.
Any other information:	In July there were hospital-onset c-diff infections. Both patients were on medications that cause diarrhea, a therapeutic intervention, and did not meet testing criteria.

GERALD CHAMPION MEDICAL CENTER

Hospital interventions:	Falls and Trauma: Falls were closely monitored by having a weekly meeting with staff and leadership to review what steps in the process failed. Staff were involved in the meetings to ensure their concerns and challenges are being considered, along with seeking their ideas for improvement. Fall Risk posters were placed in patient rooms to educate patients and families on their risk. Pressure Ulcers: A wound care certified nurse was hired to provide close assessment and intervention for the pressure ulcer reduction program. A review of the hospital beds and mattresses was conducted. A team of staff participated in the NMHA state initiative on Pressure Ulcer reduction. Surgical Site Infections (SSI): A team of staff worked on three elements of the surgical process-Pre-op, Peri-op, Post-op. The team identified several variances in the process. Interventions included training for patients and staff on the pre-op shower process, kits were developed for patients with clear instructions. Inpatient staff were trained to ensure standard process is followed. Review of OR processes occurred to ensure standard cleaning and reduction of traffic in sterile environments, and also a UV light was introduced into the cleaning process for each room. The hospital also started prophylactically treating preop patients with Nosin, a cream in the nares to reduce staph infection (MRSA).
Hospital challenges:	Falls and Trauma: Alarm fatigue can occur when settings are not appropriate. Multiple Fall precaution interventions in place increase the chance of inconsistent compliance. Having staff attend post Fall meeting can be challenging with staff scheduling barriers. Pressure Ulcers: Having one clinical expert can be a challenge in trying to address all concerns timely. Documentation of wounds and treatment has been inconsistent within the EMR. Tracking mattresses and end of life criteria for each is a challenge as beds and mattresses are mobile. Surgical Site Infections (SSI): The multiple service lines patients come in to have surgery creates a challenge in providing consistency (i.e. Outpatient, Emergency, and Inpatient). Ensuring proper pre-op teaching and prep, intra-op standards and post-op care for patients of varying background creates challenges.

GERALD CHAMPION MEDICAL CENTER (CONT.)

Any mid-course corrections:	Falls and Trauma: We had changes in personnel which caused a short gap in processes as we on boarded the new leader. HAPU: No changes in interventions were initiated. SSI: No changes in interventions were initiated.
Successes:	Falls and Trauma: Fall rates for 2019 exceeded goal of 4.97 with 4.2 HAPU: We recruited a lead wound certified nurse to treat and support inpatients. SSI: 2019 SSI's were at 13 for the first 2 quarters and at 8 for the last 2 quarters. The reduction continues to trend in a positive direction into CY2020.
Any other information:	Falls and Trauma: A patient safety survey is being conducted facility-wide this year to provide staff feedback, which will be cascaded to directors and staff. Pressure Ulcers: Collaboration with NMHA has provided support and ideas for continued improvements. SSI: Significant improvements in reduction of SSI's is recognized in all areas of surgery (including orthopedic, OB GYN, etc.)

GILA REGIONAL MEDICAL CENTER

Hospital interventions:	1. Patient Falls Reduction: The goal for patient falls is always zero and worked continued in 2019 for this. Behavioral unit housing elderly/dementia patients with placement issues due to their behavior was a focus are to improve patient safety and reduce falls. 2. Ventilator associated events and Pressure Ulcers reduction through Early Mobility Program: Two projects (Heals to Meals and Culture of Mobility) were implemented in the Medical Surgical unit to educate patients and promote mobility. Early mobility provides multiple benefits in the reduction of hospital acquired conditions and falls while also reducing the patient's length of stay at the hospital. We focused on using appropriate equipment aids to reduce the likelihood of patient and staff injury. Staff were educated on the benefits of early mobility. Every patient got a gait belt in the room. Both patients and family became active participants in ambulation starting on the day of admission. Staff were educated on the use of all lift aides/equipment.
Hospital challenges:	1. Capturing detailed information surrounding the fall can be a challenge for staff. Behavioral unit staff are not accustomed to the older patient and age specific risks. Patient beds in that unit were safe for the patient with behavioral issues, which does not make them safe for the geriatric patient. 2. RN and nursing tech routines needed to adjust with refinement of time management skills. Education to the patients had to be frequent and sometimes a challenge. Culture change in the hospital among nursing staff that believed mobility is owned by PT and OT was a barrier.

GILA REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	1. We implemented comprehensive post-fall debrief hospital wide with the house supervisor or unit Director facilitating immediate review following the event. A blame- free debriefing with all staff on the shift and family members present, if applicable, was implemented. The debriefing tool was sent to Quality/Risk department for inclusion in data analysis. The policy for Fall Screening and Prevention in the behavioral setting was revised, and the screening criteria for fall risk was updated as well. There was a mitigation process developed for pressure relieving bed with bed exit alarms for the Geri-psych patient. 2. Heals to Meals/Culture of Mobility program required hardwiring of the process for all staff. The Physical Therapy department was a great help in developing a routine and rounding on staff daily as a reminder and to assist with getting patients up. Frequent follow-up with staff not meeting expectations and assessing for and removing the barriers occurred. Consistent communication was necessary for effective patient education.
Successes:	1. Post fall debriefs were done more often and with more detail to assist the Inpatient Services Director with course corrections throughout the year. 2. Collaboration with the Physical Therapy department was critical. This was a unit level initiative that Quality was not aware of until initially, so no data was measured related to this initiative. Unit Director did state compliance with expectations did improve so that all eligible patients were assisted up for meals and ambulated. Patients were noticed to be calling the nurses station stating it was time to get up for their meal after Day I on the unit.
Any other information:	1. There continues to be opportunity surrounding falls reduction. Tracking and analysis of data and best practice research is ongoing. 2. We did not have a VTE or Pressure Ulcer in 2019. hope The Heels to Meals and Culture of Mobility programs continue to keep patients active and support front line staff in ownership of patient mobility.

GUADALUPE COUNTY HOSPITAL

Hospital interventions:	In 2019, Guadalupe County Hospital set quality improvement measures and goals for all departments and for all CMS Conditions of Participation. Measures were monitored by hospital department heads and reported monthly at the hospital's Operational Performance Improvement Committee. The nursing department once again focused on patient discharge follow up calls to ensure patients understood their discharge orders, were able to follow them, including procuring prescriptions, and had followed up with the primary care providers. Follow up calls were completed on 90% of patients discharged from the hospital, which we believe reduced same cause readmissions to the hospital. Readmissions were within the national average. The nursing department also monitored hypoglycemic medication errors (of which there were none), and patient unassisted falls with and without serious injury. In 2019 there were 6 patient falls without serious injury. This will be tracked and compared in 2020. Interventions included proper identification and implementation of fall risk patients and processes, post fall huddles, and non-punitive reporting. The hospital also monitored CAUTIs, CLASBIs, and hospital acquired Pressure Ulcers, of which there were none reported in 2019. No other hospital acquired infections were reported in 2019.

GUADALUPE COUNTY HOSPITAL (CONT.)

Hospital challenges:	One of the greatest challenges we, and other small rural hospitals, face is our low volumes and the impact of just one error or negative outcome on our scores. However, our smallness and low volumes also facilitate our minimizing hospital acquired conditions and helps us focus on our patients as individuals, this is in part why we enjoy high patient experience and satisfaction scores. Another challenge is the lack of other health care providers or services in our community. We have no urgent care center, no home health agency, no nursing home, and no specialists. So, patients are less likely to get the continuing support they need, and more likely to return to the hospital or the emergency department for care. That is why we also measure return to the ED within 72 hours for same cause and have worked to keep this measure low (1-4% each month) by provided thorough care and robust ED discharge plans.
Any mid-course corrections:	At mid-year we usually drop measures which we achieved the goals and add new measures. New measures included troponin blood test turnaround times in the lab, and one of the measures that was dropped was lab draw waiting times.
Successes:	In early 2019 (for 2018) we achieved Top 20 Rural Community Hospitals by the National Rural Hospital Association. Our goal was to meet or exceed that status. In 2020, we were once again recognized as a Top 20 Rural Community Hospital. This recognition measures patient outcomes, quality measures, patient experience, market share, cost of care, and financial stability. More importantly we had zero hospital acquired infections or conditions and zero patient falls with serious injury. We will continue to work on ways to reduce readmissions and improve outcomes for all conditions.
Any other information:	In 2020, we have focused on Covid-19 response and infection prevention throughout the hospital, along with patient safety and total quality of care. To date, we have had zero staff Covid-19 infections or missed days of work due to Covid-19.

HOLY CROSS HOSPITAL

Hospital interventions:	1. CAUTI: The Medical Director of Infection Prevention met with the ED Medical staff. Statistics were shared with the team showing how their practices effected inpatient catheter days. The result was fewer catheters placed on patients who were admitted, decreased catheter days, and decreased CAUTIs. 2. HAPU: Our Pressure Ulcer rates remained low however proactively a refresher course was taught on proper skin assessment. The Wound Care nurses taught the course to our nursing team and assisted in developing a protocol for early intervention.
Hospital challenges:	1. Fall rates began to climb during the year. Nurse and quality leaders developed a falls team to assess, plan and implement actions. Rates dropped significantly after processes were addressed. 2. Inconsistent review of readmission causes was a challenge. The Case Management department added readmissions as one of their process improvement initiatives.
Any mid-course corrections:	1. We reestablished bedside reporting to engage patients and family in their care. 2. We increased communication with house shift coordinators on all high-risk fall patients.
Successes:	1. Continued vigilance in our infection prevention practices resulted in: a. Decreased Surgical Site Infections b. Decreased MRSA Blood Stream Infections c. Decreased Clostridium-difficile infections 2. The Antimicrobial Stewardship team after reviewing antibiotic use was able to remove fourteen antibiotics from the inpatient formulary.
Any other information:	Heightened awareness on quality and process improvement was achieved through Holy Cross Medical Centers LifeWings Quality and Safety program.

LEA REGIONAL HOSPITAL

Hospital interventions:	1. We improved communications and coordinated with nursing homes to accept patients to their facilities on weekends, which previously had not been occurring. We worked through appropriate processes so they could have procedures in place for weekend acceptance and ensured a smooth handoff. 2. Several EOC findings observed during 2019 survey, but only one related to infection prevention having to do with cracks in OR paint. Infection prevention is obviously very important to us and we have been successful in preventing HAI's and HAC's
Hospital challenges:	1. Many patients were not discharged in timely manner previously and had to be managed based on inconvenience in the calendar. The only challenge really was working through the original workflows to ensure proper handoff between facilities and have a seamless process. 2. Had to shut down OR's for multiple days at a time to ensure complete remediation and future prevention.
Any mid-course corrections:	1. All Positive after change was implemented and resulted in significant LOS drop. There were no corrections needed after initial improvement process completed. 2. Additional fixes needed to ensure complete remediation over time, but very minimal in relation to original fix.
Successes:	1. Overall LOS for entire facility was decreased on average for all patients by half a day from 3.5 days to under 3.0. This was a major win for the patients and for our facility. 2. 0 CLABSI in 2019, 0 CAUTI in 2019, 0 SSI in 2019, additional education for staff surrounding these EOC fixes have led to increased awareness and safety. EOC rounds have been augmented with additional teams on each EOC and Life Safety chapter.

LINCOLN COUNTY MEDICAL CENTER

Hospital interventions:	1. In early 2019, our patient flow from the Emergency Room (ER) to an inpatient unit within 30 minutes of bed assignment was as low as 18%. We formed a Throughput Committee and invited managers and staff from the involved departments to attend. We set a goal of 60% compliance by year end. Bedside hand-off from ER to ICU admissions was implemented. House Supervisors were charged with assisting with admissions during busy times and change of shift. EVS began to prioritize cleaning of patient rooms after discharge based on volumes and number of vacancies. Charge nurses were to identify patients for discharge and, also, designate at the beginning of the shift which nurse would receive the next admission. 2. In 2019, we again focused on patient falls as an improvement project. The organization implemented tele-video monitoring, and we purchased a monitoring unit to be able to have surveillance of our patients at high risk for falls. We also acquired more chair alarms.
Hospital challenges:	1. Documentation of time of room assignment was needed to track time from bed assignment to admission and sometimes this information was not documented by the ER staff. Our 4-bed ICU was often full and discharge orders were not done early in the day. 2. The nurses did not use chair alarms or initiate tele-video monitoring as much as they could have. During high volumes, we did not have enough tele-video units to monitor all patients at very high risk of falls.

LINCOLN COUNTY MEDICAL CENTER (CONT.)

Any mid-course corrections:	1. We worked with hospitalists to get discharge and transfer orders completed earlier in the shift so patients could be discharged earlier in the day. 2. The manager of ICU and Medical/Surgical units encouraged staff to have a lower threshold for initiating tele-video monitoring for patients at high risk of falls. Special attention was paid to those patients known to get out of bed without calling for assistance. The leader rounders monitored patients for chair alarm use.
Successes:	1. We struggled from May to August, but finally started to achieve some improvement in September. In December of 2019, we surpassed our goal of 60% compliance by admitting 66% of patients within 30 minutes of bed assignment. 2. We were able to reduce our fall rate to 1.4 per 1000 patient days in 2019 with goal of 1.9 falls per 1000 patient days. Our fall rate in 2018 was 2.059 per 1000 patient days.
Any other information:	1. We have been able to maintain over 60% compliance in 2020 through May. 2. We will be purchasing more tele-video monitors.

LOS ALAMOS MEDICAL CENTER

Hospital interventions:	LAMC focused on 3 areas in 2019 to reduce patient harms: 1. To maintain zero occurrences of central line associated blood stream infections, we reviewed our process to assure our practice is standardized across the facility. We participated in a collaborative with our parent company, LifePoint. We did a gap analysis which identified our focus – verifying that our practice follows standard of care. We then did real time verification and education with staff and providers. 2. Length of stay was another area we focused on because we were finding a correlation between harms and length of stay. We implemented a "what is this patient at risk for" guide and taught frontline staff how to use it and when. This guide was used during bedside shift report (BSSR) and our interdisciplinary team rounds (IDT). This resulted in a reduction of patient harms. 3. Blood Culture contamination rates were rising so we examined the root causes. We identified that there were many variations our collection techniques. A team was formed to standardize the process. All staff that would collect blood cultures were trained in this process. We then validated that staff were using this technique. After these techniques were standards, contaminations reduced.

LOS ALAMOS MEDICAL CENTER (CONT.)

Hospital challenges:	Because we are a small facility, we are often at core staffing which makes it hard to communicate well any initiatives or process improvements to assure all staff hear the message.
Any mid-course corrections:	At the end of the year we had a couple of episodes of C. diff which led to us looking at cleaning processes. This resulted in working with the environmental services department on cleaning techniques and verifying they were being used.
Successes:	We have been able to maintain our zero occurrence of central line associated blood stream infections. There was not any new patient with c-diff infections since the process change was implemented.

LOVELACE ROSWELL REGIONAL HOSPITAL

Hospital interventions:	1. We focused on infection control measures throughout the hospital. 2. We worked with a readmission team reduce hospital readmissions. 3. We focused on reducing inpatient hospital falls and hospital-acquired conditions through our Service Excellence Program.
Hospital challenges:	We had some leadership turnover with a transitional period of onboarding the new leaders. We did not initially have an employee to focus on staff education.
Any mid-course corrections:	Midyear, we hired a dedicated clinical educator. Through this, we have created a focus on staff education as well as a plan for ongoing education throughout the year.
Successes:	We reduced readmissions and have an ongoing process in place to prevent as many as possible. We have an EMR that we can run reports to identify patients that are high risk for readmission as well potential hospital acquired conditions during their inpatient stay. This allowed us to implement interventions very quickly during the inpatient stay. Every fall was investigated and evaluated for improvement needs. We implemented process improvement teams for various risks identified through quality outcomes.
Any other information:	HCHAPS were improved from 2018 to 2019. DNV accreditation was obtained in 2019, which was new to our facility.

MEMORIAL MEDICAL CENTER

Hospital interventions:	Reduction of Sepsis – Our collaborative approach with feedback from our frontline team led us to reintroduce information through posting correct antibiotic selections and sepsis bundle elements in the Emergency Department. We also began to have paramedics start fluids prior to patient arrival (RNs instructed to ensure this amount was verified with handoff). Lab began to respond to Sepsis Alerts to immediately draw required blood work. Our IT team added a Sepsis Protocol and improved our Physician orders within our electronic record system to "hardwire" processes. With this combination of initiatives in 2019 we have seen increased compliance for early identification and treatment of sepsis within the Emergency Department. Our Clinical Documentation (CDI) team members continue to make patient rounds with physicians. Through all these efforts and based on feedback from our team we now see the need to focus and improve processes within the ICU during the year of 2020. Pressure Injuries – In 2019 we began a 2 RN assessment of the patient's skin from head to toe on admission and at every shift change bedside report. Also, to teach and to best meet patient needs for prevention of pressure injuries our ICU team members volunteered to participated in "skin rounds" with our Wound Care nurse. Another focus within the ICU was to train 15 "Superusers" in proper use of their specialty beds and surfaces. This will allow for continual correct use of these beds for prevention of skin breakdown. To increase awareness and for learning we began taking pictures of pressure injuries as patients were admitted to the ICU. We switched products based on team feedback from wedges to pillows for patient positioning. We also switched from multiple skin care products to a single product that the team agreed worked best for our patients. Prevention of Falls with Injury – In 2019 we began a house wide focus to get patients out of bed for meals in the ICU and the Medical/Surgical departments. Our collaborative fall prevention team welcomed a physician champion who helped to lead providers to ensure diuretics were given at bedtime (not morning) and to lessen the use of narcotics (consider alternative methods for pain control). A fall risk contract was developed to increase patient and family member involvement for the prevention of falls. To quickly respond to patient needs we trialed moving our computers into the hallways instead of having all computers in a central location.

MEMORIAL MEDICAL CENTER (CONT.)

Hospital challenges:	Sepsis – Even with improved recognition and treatment within the Emergency Department we missed having appropriate labs drawn in time. MEWS tool for recognition of sepsis was not used consistently in medical/surgical areas and the ICU. Pressure Injuries – It was noted in the ICU that our patients who were positioned using wedges (new product) had increased pressure injuries. We had a great variety (large number) of products to treat/heal pressure injuries causing confusion and ineffective use of products. Falls with Injury – Patients fell most often when trying to get to the bathroom.
Any mid-course corrections:	Sepsis – Due to reasons beyond the control of the Emergency Department, the lab stopped responding to the overhead sepsis alerts. Through a team meeting and hiring/rearranging staffing this essential response was reinitiated. Team members in the Medical/Surgical areas were re-educated regarding the use of the MEWS tool. Their use of the MEWS is currently audited, and information is sent to the leadership for follow up with specific team members as needed. Within ICU the MEWS tool was found to be too difficult to accurately use for this critical population. A new Sepsis screening tool was developed (from the Sepsis Alliance). This is currently being trialed within the ICU.

MEMORIAL MEDICAL CENTER (CONT.)

Successes:	Sepsis - Our team within the Emergency Department (ED) has consistent early recognition and overhead paging for an improved team response within the ED. We have also seen improved Bundle Compliance (correct treatment) for our Sepsis patients in the ED. Pressure Injuries – Comparing 2018 to 2019 we have very few pressure injuries not found initially. Due to our 2 RN assessment on admission and with Bedside Shift Report these injuries are found and treated earlier. Falls with Injury is consistently at a low rate for 2018-2019.
Any other information:	Through our participation in the LifePoint National Quality Program (NQP) which offers benchmarking data, best practices for improvement and education we will continue to improve care for our patients.

MIMBRES MEMORIAL HOSPITAL

Hospital interventions:	1. Quality of Physician Chart Documentation 2. Troponin Turnaround Time
Hospital challenges:	1. Scores on hospital wide CMS focused mortalities had been above the State and National average through 2018 and worsening after the second quarter of 2018. Data analysis and chart audits we conducted on mortality charts beginning with the third quarter of 2018. It was identified through our mortality review process that the quality of physician chart documentation was not at a level of specificity that was clear enough for a coder to identify the level of risk, or likelihood, that the patient would not survive the admission. The result of this was that the "observed" mortalities did not meet the level of risk to be "expected" to not survive to discharge giving Observed/Expected (O/E) ratios >1.0 (should be =< 1.0). Review of the Physicians documentation process identified that most were using a dictation system and not much of what was being dictated was being related to specific diagnosis and complete lists comorbidities was not documented upon admission. Providers were re-educated in appropriate documentation and given tools and examples improve the severity of the patient's illness, as well as co-morbidities. A new dictation system with Computer Aided Provider Documentation (CAPD) was implemented in January 2019. This tool prompts providers to provide the appropriate level of detail of all co-morbidities to help ensure that the appropriate level of risk is assigned.

MIMBRES MEMORIAL HOSPITAL (CONT.)

Hospital challenges: Cont.	2. The ab was not meeting the <60-minute time requirement on troponin turnaround times, from order to result, for AMI and CP patients beginning in March 2019. Analysis of data found that the biggest variation of time occurred from the time the order was placed to the time the sample analysis began in the lab. Further analysis found that much of the variation occurred on the p.m. shift when there was only one lab technician and no phlebotomist on shift. Often the technician was in the lab analyzing samples and was not aware that samples had been dropped off in the front lab office. Another small contributing factor was determined to be the technician's prioritization of samples ordered as "STAT". It was also noted that there had been turnover in the Lab's night staff. In addition to the <60-minute overall turnaround time (Order to Result) a goal of 20 minutes or less from the time the order is entered to the time the sample anal sis begins (Order to Analyze). All lab staff was presented the results of the study as well as turnaround time goals for both measures. A timestamp was placed in the lab front office where orders were stamped by department staff when they dropped samples off. A doorbell was also placed in the front office and department staff rang the bell to call the technician. Sample and order were handed to the technician. All Lab Techs and phlebotomists were trained on appropriate prioritization of STAT samples. All training and changes were made at the end of May 2019. Monthly performance results, by technician, is presented at staff meetings and times not meeting the goals are evaluated by the Lab Director and involved staff to identify opportunities for improvement. Improvements in both goals were seen very quickly (by June) and both goals were met consistently throughout the following months.

MIMBRES MEMORIAL HOSPITAL (CONT.)

Any mid-course corrections:	1. Initial performance showed improvement but very soon, we saw an increase in O/E ratio. Data analysis found that a few physicians still had access to, and were using, the old dictation system. The old dictation system was removed, and their documentation improved as well. 2. Ongoing data analysis, chart audits and performance feedback to the physicians helped to keep scores on track.
Successes:	1. It was determined that education and the implementation of CAPD was effective. We saw a 200% relative improvement from January –December 2019. 2. Changes made were effective with 33% improvement in Order to Analyze and 17% improvement in Order to Result. A significant reduction in variation for both measures was also seen.

MINERS' COLFAX MEDICAL CENTER

Hospital interventions:	1. The clostridium difficile (c-diff) hospital rate was concerning and required a collaborative effort to coordinate services, positively affecting the patient experience. The following were intervention implemented to support improvement: • The provider, pharmacist, care manager and bedside care nurse participate in morning rounds, including antibiotic stewardship in the plan of care. • Communication regarding the culture results, type, timing, and discontinuance of antibiotics are discussed. • Discharge planning includes a follow-up phone call to assure the patient understands the medication plan. • Orientation and Education • Travel staff were included in nursing orientation, focusing on antibiotic stewardship. 2. The Catheter Associated Urinary Tract Infection (CAUTI) rates in the second quarter of 2018 required a review of process for the facility for 2019. The following were intervention implemented to support improvement: • Educational review for bedside care staff • Revise the data collection system to include bedside care staff via ActionCue to assure data was collected on all patients. • Timely follow-up by the Infection Preventionist to assure data collection was standardized. • Agency Staff included in nursing orientation, focusing on CAUTI. • Communication between departments with written documentation for discontinuance of catheter for shared patients

MINERS' COLFAX MEDICAL CENTER (CONT.)

Hospital challenges:	All cultured specimens are processed via an outside reference lab. This created the following challenges: • Turnaround time can be as long as 4 days. The lab module does not have antibiogram capability. • The outside reference lab can only provide an antibiogram twice a year. Staffing: • It is difficult to recruit permanent staff to a rural setting. • MCMC employs travel staff in the acute care setting. • 13 to 26- week contracts for travel nurses required a constant need for orientation and education. Small volume of catheters placed in patients: • One positive case can affect the entire organization. • The ActionCue worksheet is separate from the EMR systems, requiring the bedside care staff to open another system to enter the data.
Any mid-course corrections:	1. The infection preventionist and the laboratory director collaborated with the reference lab to decrease the turnaround time by 24 hours. The laboratory director checks the result portal 2-4 times per day to assure results are communicated. 2. Two EMR systems existed for the labor patient and the acute care patient without an interface to share data. • If a report ran on one system, it was under reporting the numbers for the entire organization. The ActionCue worksheet resolved the issue. • The data collection was manually reviewed for both systems to assure of correct data reporting.

MINERS' COLFAX MEDICAL CENTER (CONT.)

Successes:	1. The C-diff hospital scores improved. 4th quarter rates: 2017 – 2.326 2018 – 2.193 2019 – 0.00 2. The CAUTI rate improved at MCMC. 2018 – 2QTR: 9.132 2019 – 2QTR: 0.000
Any other information:	A permanent Quality Manager was employed in the fall of 2019.

MOUNTAINVIEW REGIONAL MEDICAL CENTER

Hospital interventions:	The major focus areas for MountainView Regional Medical Center in 2019 were Patient Safety Event Reduction, CAUTI Reduction, and Readmission Reduction. Patient Safety Event Reduction: The implementation of clinical huddle to review any potential patient safety events lead to vast improvements and reduction in events over prior year. The clinical huddle process helped us to find better ways for event identification while patients were in house allowing for real time interventions. Process improvement occurred with unit directors reviewing events and completing an RCA for gaps in care. CAUTI Reduction: A managing for daily improvement project was implemented in the Intensive Care Unit for reduction of CAUTI events. The MDI brought awareness to daily successes, challenges, and process improvement opportunities. Daily metrics monitored included device utilization and appropriateness of device. These metrics led to medical staff approved policy change and the implementation of a new external catheter device. Readmission Reduction: The readmission committee continued its efforts from 2018 into 2019. Discharge appointments were hardwired on the medical telemetry unit, so the focused improvement process was expanded to include the cardiac telemetry and surgical units. Additionally, an update to our bed monitoring system to include monitoring options for high risk score, discharge status, and discharge appointments were built and actively utilized by our case management team for communication with clinical and nursing teams. The initiative incorporating a dedicated discharge team to make appointments and coordinate post-acute care was continued in 2019.

MOUNTAINVIEW REGIONAL MEDICAL CENTER (CONT.)

Hospital challenges:	Patient Safety Event Reduction: Creating the clinical huddle pathway to become an effective process took many months of trial and error and help from our early adopters to become a trusted process. The initial struggle was to simply identify patients, then determine whether the event was hospital identified or hospital on-set. Once these two tasks were accomplished, process improvement projects were put into place to minimize harm events. CAUTI Reduction: Medical staff buy-in for appropriate use of indwelling catheters became the most important piece of policy and process change. Additionally, multimodal education was provided to providers on the appropriate collection of urine samples, appropriate interpretation of results, and documentation of CAUTI per CDC guidelines was conducted over a period of several months. For instance, a colony count of 50,000 is not indicative of an infection and might simply represent a colonization particularly in the setting of an asymptomatic individual. Readmission Reduction: Internal data showed that a portion of our readmissions were coming back from post-acute partner facilities. Detailed reviews of each of these readmissions were conducted to understand potentially avoidable readmissions and process improvements that could be implemented to help patients maintain status at the post-acute care facility.

MOUNTAINVIEW REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	Patient Safety Event Reduction: Mid-course initiatives came from a need to reward team for successes of process improvement. We began to discuss near miss events to help reinforce the success of effort and process changes. Kudos were celebrated not only at clinical huddle, but the daily safety huddle as well. CAUTI Reduction: Mid-course evaluation necessitated additional change to further reduce device utilization. Medical staff approved policies were implemented for appropriate use, nurse driven removal protocols, and device reduction, but more needed to be done. Our team engaged an external device company and trialed utilization on our Intensive Care Unit and found in the appropriate patients it became the preferred device. Readmission Reduction: A collaborative with our post-acute partners was created to help determine readmission reasons and work towards avoidable readmissions. An example of an issue identified was IV antibiotic administration and the scope of practice for the post-acute care facility. Rather than a patient returning for inpatient admission, a process for was created in collaboration with our outpatient infusion center for the IV antibiotic administration and return to the post-acute care facility.

MOUNTAINVIEW REGIONAL MEDICAL CENTER (CONT.)

Successes:	Patient Safety Event Reduction: Overall, Patient Safety Event Reduction from prior year was nearly 50%. Major categories had larger successes to include an 80% reduction in post-operative DVT/PE. The clinical huddle process was recognized by the New Mexico Hospital Association and awarded the Quest for Excellence for large hospital in 2019. CAUTI Reduction: The initiatives put in place to reduce devices, use devices appropriate, and remove devices sooner lead to a significant reduction in CAUTI events. The intensive care unit went 355 days without a CAUTI infection from process implementation in 2019. Readmission Reduction: Continued efforts and collaboration with post-acute partners has allowed for many avoidable readmissions and overall, all-payer reduction in readmissions by 50%. The Medicare O/E for 2019 was 1.0 down from 1.12 of prior year. 1Q2020 continues to show great trends at 0.80.

NOR-LEA GENERAL HOSPITAL

Hospital interventions:	1. Improve admission delays to the hospital from the emergency department by improving coordination between departments to streamline the admission process. 2. Improve emergency department throughput by streamlining processes and coordination between the physician, nursing, lab, radiology, and respiratory.
Hospital challenges:	1. Provider behavior changes and nursing elimination of unnecessary steps were the biggest challenges with this project. 2. Physician buy-in with goals was a challenge because the physicians felt they were too busy to get the patients out any sooner.
Any mid-course corrections:	1. Increased number of improvement team meetings and chart audit procedures were implemented mid-course to sustain improvements and identify challenges with changes implemented. 2. Regular meetings with all stake holders, bringing conversations back to the data and facts about delays were successful in moving improvements forward.
Successes:	1. Emergency Department arrival to admission to the nursing floor was reduced from 338 minutes to 262 minutes in 2019. NLHD had sustained those improvements into 2020 with an average admission time of 268 year to date. 2. Emergency Department overall throughput was reduced from 200 minutes to 153 minutes in 2019. NLHD had sustained improvements into 2020 even with the challenges around the nCOVID-19 pandemic.

PLAINS REGIONAL MEDICAL CENTER

Hospital interventions:	1. Plains Regional Medical Center (PRMC) focused improving patient's health related to Colon Cancer screening. 2018 saw 37.7% of patients between the ages of 50-75 complete either a colonoscopy or a FIT (fecal immunochemical test). In 2019, the target was increased to 38.4% with PRMC achieving a target of 40.5%. Monthly reports were reviewed to identify patients needing support/education and routinely shared with the Providers for intervention. 2. Plains Regional Medical Center (PRMC) set a target to reduce the surgical site infection rate below 1.0 for caesarean section procedures in 2019. Heightened awareness of sterile procedures and hand hygiene was taught to the new staff, which would be demonstrated with procedures through educational trainings and demonstrations. Infection control practitioner reviewed records and provided feedback to staff.
Hospital challenges:	1. Ensuring patients meeting the screen criteria received the appropriate testing. 2. Staff turnover in the Women's service line, those who assist with c-sections.
Any mid-course corrections:	1. New staffs were hired and completed orientation.
Successes:	1. In 2019 the target was 38.4% with PRMC achieving a target of 40.5%. The addition of another general surgeon and gastroenterologist to our multi-specialty clinic group also assisted in surpassing goal. 2. PRMC exceeded this target of 1.0 with a rate of 0.38 infections per 100 caesarean section procedures performed. One infection occurred with 262 c-sections performed.

REHOBOTH MCKINLEY HOSPITAL

Hospital interventions:	1. Recognizing that with early diagnosis and treatment, most septic patients make a full recovery, a multidisciplinary Sepsis Task Force was developed. With a focus on "The Sepsis Bundle" compliance for early identification and treatment, the Clinical IT Analyst developed standardized documentation that included Sepsis Assessments that tally the risk level of the patient, Physician orders sets, reflex Lactate laboratory tests. All staff attended mandatory education early recognition and the importance of Sepsis Codes. 2. A multidisciplinary team was developed to create a Quality Internal Audit Process. Auditors attended education, forms for the audit and corrective action plans were created. Corrective action tasks were created for to ensure follow up.
Hospital challenges:	1. If the providers did not use the Sepsis order set, a reflex lactate was not triggered. Maintaining buy-in, multiple priorities limiting attendance at the meetings and lack of manpower for data collection were additional difficulties. 2. The membership of the committee changed over time, but the demand of time was the largest challenge. It took time for the team to learn the new process of reporting and the building of action plans. We asked the committee members to dedicate a great deal of time to their already very busy schedules. Changing the audit to quarterly reduces the stress on the audit team.
Any mid-course corrections:	1. To correct the problem with using the order set for the reflex lactate, providers were reeducated on the correct process. Two departmental staff meetings increased awareness of the importance of early recognition and treatment. 2. We identified the need for adding members to the committee. These new members need education. We are evaluating how education will be rolled out. Instead of doing an audit every month, we will strive for one per quarter.
Successes:	1. Our Sepsis Bundle Compliance Rate increased from 11.76% Q3 2018 to 42.11% in Q4 2019. 2. Processes have been created to ensure, medications are given appropriately before, during or after dialysis.

ROOSEVELT GENERAL HOSPITAL

Hospital interventions:	With the introduction of a new quality leadership team at Roosevelt General Hospital (RGH), the overall arching theme of 2019 became "bringing awareness to metrics that are publicly reportable for those who can affect change". Core Measures—sepsis: After staff/provider interviews and reviewing data, it became obvious that intervention was necessary. The quality team met with the reporting data abstractor, to determine how and what data was being pulled and from where. We involved the Emergency Department (ED), lab, and providers to try to automate the process as much as possible. We set expectations regarding the process and documentation. Finally, we added sepsis process and documentation metrics to the ED quality dashboard; to assure improvement and sustainability, the metrics are reported monthly to the Quality Management Systems Oversight Committee (QMSOC). OP29—colonoscopy metrics: Education was provided to the surgeon and OR staff regarding the measure, as the metrics had not been met for three or more years. The provider was complying with the metric (post-op documentation for when the patient should schedule their next colonoscopy) in clinic notes, but not hospital post-op notes, as he was unaware of the differentiation to meet the measure. This metric was added to OR's quality dashboard; to assure improvement and sustainability, the metrics are monitored monthly and reported quarterly to QMSOC. Patient experience—The quality team started a Patient Experience Committee and began sharing Press Ganey survey information from executive leadership to the frontline staff. The quality team assisted with coaching to "ask for the survey" and for the staff to adapt to a culture of "Patient Experience" and "Patient Centered Care". Press Ganey metrics were added to each applicable department dashboard, are monitored monthly, and are reported during each department's scheduled reporting period at QMSOC.

ROOSEVELT GENERAL HOSPITAL (CONT.)

Hospital challenges:	Currently there are two major challenges at RGH: the electronic medical record (EMR) and the size/privacy for patients in the ED. Neither challenge is an "overnight fix", nor are they speedy implementations; both are accompanied by a heavy fiscal obligation. EMR: Our challenges with Paragon are not limited to but include the inability to provide real-time feedback for quality initiatives. The system is not user-friendly and requires chart-by-chart, hunt-to-find datamining; this is not only inefficient use of time for our directors, it is also incredibly frustrating. The Board of Directors along with our Executive Leadership Team approved the purchase of a new EMR. Our organization shopped, trialed, and decided upon a replacement that will begin implementation in 2020. ED: The challenges within our small, separated-by-curtain patient care space effects our compliance with HIPAA and patient experience among other things. In 2019, RGH developed and finalized plans to grow our organization's ED to include more patient rooms that are separated by traditional walls, a safe room for psychiatric patients, and a bariatric room.
Any mid-course corrections:	Again, with the introduction of a new quality leadership team, the overall arching theme of 2019 became "bringing awareness to metrics that are publicly reportable for those who can affect change". Fresh eyes were able to assess and prioritize the how we address Quality Assurance and Performance Improvement (QAPI) and Quality Management Plan. Data sharing/data transparency had been previously practiced, but not to the fullest extent. QMSOC was updated to assure all stakeholders were at the table. Department dashboards were updated to include meaningful metrics and put on a strict and regular reporting schedule. All departments with Press Ganey/Patient Experience data, began receiving the data on their dashboards and were encouraged to share this information with their staff. Data is now reported to all stakeholders from the Board of Directors through to the frontline staff; action plans are implemented and carried out to adjust undesirable metrics.
Successes:	We are very fortunate and had many successes in 2019. Some include, but are not limited to: improvement in our sepsis protocol (there is still opportunity here, but we are headed in the right direction), 100% compliance with OP29 metric (after staff education), gradual/steady improvement in patient satisfaction scores, a new EHR, and bigger/better ED. With all the successes and changes we have been able to celebrate in 2019, our employees are more engaged, knowledgeable, and satisfied.

SAN JUAN REGIONAL MEDICAL CENTER

Hospital interventions:	1. Hospital Acquired Pressure Injuries • Prevention of pressure injuries is instrumental in mitigating a wide range of undesired patient outcome and increased healthcare costs. In response, SJRMC redesigned current workflow and optimized EHR reporting processes, Braden Risk Score assessment tool, order triggers, and physician documentation prompting. In addition, SJRMC expanded its Wound Care team and unit, which helped to facilitate monthly Pressure Injury Prevalence studies and educational opportunities for Nursing staff. Processes for investigation, tracking and staff education were hardwired. 2. Fall Prevention • SJRMC's quality improvement goal for falls aimed to ensure the implementation of recent evidence-based best practices to eliminate falls. To address this improvement initiative, SJRMC implemented a No Pass Zone practice and policy, re1viewed and revised the post-fall huddle tool and process; reinforced protocol requirements and appropriate interventions with the full care team through standardized education, placed Gait belts in all patient rooms, and installed "Call, Don't Fall" ceiling tiles in selected patient rooms.
Hospital challenges:	1. Obtaining Provider buy in and compliance with documentation requirements remains a challenge. With the implementation of a new EHR system, increased proficiency in new EHR capabilities and proper utilization of the Braden risk score was needed among nursing staff. The goal of this initiative was to reduce SJRMC's CMS PSI 03 rate per 1,000 discharges to the benchmark of 0.00 from 0.1948 for the October 2015 to June 2017 reporting period. Unfortunately, SJRMC's rate increased to 0.9766 for the 2021 CMS PSI 03 reporting period July 2017 to June 2019. 2. Application of the Post Fall Huddle process and expectations varied among staff. The process was reviewed, revised, and implemented through staff education and included in departmental orientation for new employees. The goal of this initiative was to reduce SJRMC's 2020 CMS PSI 08 rate per 1,000 discharges to the benchmark of 0.00 from 0.1770 for the October 2015 to June 2017 reporting period. Unfortunately, SJRMC's rate increased to 0.3247 for the 2021 CMS PSI 08 reporting period July 2017 to June 2019.

SAN JUAN REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	1. During the project, the Wound Care Team recognized the need for standardized organization wide education for all nurses and developed a standard education package for current and new hire RNs. 2. "Call, Don't Fall" ceiling tiles were initially placed on the Medical Unit. Although patients were educated on fall prevention, the trial placement did not yield the intended results.
Successes:	1. As a result of the performance improvement project, physician documentation of pressure injuries has become more consistent. While this has this has contributed to the increase in pressure injury rate, it has also provided the organization valuable information and data to refine our improvement efforts in the prevention of pressure injuries. 2. Implementation of the No Pass Zone process and policy, in conjunction with purposeful rounding has proven to be beneficial. Fall prevention process improvements will continue into 2020.

SIERRA VISTA HOSPITAL

Hospital interventions:	In October 2018, our Organizational Performance Improvement Program was completely reorganized. We have worked diligently in 2019 to include all hospital departments in our OPI process. We were able to identify areas for improvement in patient care and safety. Identified issues included: 1. All Cause Readmissions – with constant low census, any readmission is a concern. 2. ADE: Hypoglycemics – This was an issue we did not realize we had until we started tracking it. 3. Hospital Acquired Condition: VTE Prophylaxis. Our compliance with ordering prophylaxis was challenging.
Hospital challenges:	1. Staff had become complacent with the hospital discharge appointments and follow-up calls. We had multiple staff changes and inconsistent training. 2. When we started tracking this measure, we found 3% of our patients were having low blood sugar episodes. However, between September and December, our rate jumped to 8%. 3. With rotating hospitalists and varying clinical opinions on best practice, compliance with ordering the VTE prophylaxis was very low.

SIERRA VISTA HOSPITAL (CONT.)

Any mid-course corrections:	1. Responsibility for the follow-up calls was shifted from the Unit Secretary to Case Management. This allowed the nurse responsible for discharge planning to ensure that everything planned was implemented. We made it mandatory for the Unit Secretary to make the follow-up appointment prior to the patient discharging; and document it in the patient record and for the nurse to include it on the discharge instructions. On weekends and holidays, the appointment was set up on the next working day, and call to notify the patient of the date and time. 2. Patients on home oral hypoglycemics who were being admitted were continued on them during the hospital stay, plus implementing sliding insulin scales. Providers and nurses were educated on the latest standards of care per ADA guidelines. We stopped allowing patients to dually use oral hypoglycemics and sliding insulin scale. When they admit with acute illness, we now stop their oral hypoglycemics, and only use the sliding insulin scales. As their condition resolves, they are restarted on their oral hypoglycemics. 3. All providers were educated on the latest AHA recommendations and supporting data for the use of VTE prophylaxis; then providers were held accountable thru their contract company. Nurses were educated to request prophylaxis orders. In June, we transitioned to a hospitalist model with permanent providers which provided more consistency and better compliance.
Successes:	1. We started the year with 67% compliance with making follow up appointments; and finished with 91% compliance. On the Follow Up Calls, we started the year with 47% compliance; and finished with 82%. Our average Readmission rate went from 5.3% in 2018 to 4% for 2019. 2. Early in 2019, we had a monthly spike to 8% of our patients who received hypoglycemics who had low blood sugar episodes. For the last 5 months of 2019, we have had 0%. We finished the year with an average rate of 2%. 3. Our average compliance rate in 2018 was 65%. For 2019, our average compliance had improved to 91%; with 100% compliance for the last 4 months of the year.
Any other information:	After the close of 2019, we noticed a significant difference between our internal Readmission Rate and that calculated by DOH. We feel this is due to readmissions to other facilities which we were not aware of. At the end of 2019, we began tracking readmissions to OBS and monitoring appropriateness of Discharges. The ER as begun to make follow up calls on all transfers. This will help us identify some of the admissions to other facilities.

SOCORRO GENERAL HOSPITAL

Hospital interventions:	1. In 2019 Socorro General Hospital continued its focus on fall prevention. This includes adhering to all the components of our Fall Prevention program No One Walks Alone (NOWA), which includes: the discussion of patients who are at risk for falls during daily huddles, Utilizing the No One Walks Along (NOWA) flow with each patient, encouraging patient participation with fall agreement, focus on hourly rounding, and using the patients white board during bedside shift report. Knowing that most of our falls occur in the Med/Surg unit, we increased our observance and response to fall alarms. The unit's leadership improved awareness through daily huddles, feedback, reviews of fall prevention documentation, and implemented a reward system. All patients admitted to Med/Surg and OB is assessed using the Fall Risk Assessment tool in EPIC. 2. The Hospital addressed Readmissions All Cause and instituted interventions to improve our performance. An important process change requires the Quality Manager to review every readmission with the unit manager or case manager to identify the reasons for readmissions. Thorough these meetings it was learned that our population would benefit from considering more Home Health services upon discharge. This was made a routine process step when evaluating a patient's discharge plan. Home Health visits addresses the patient's concerns/need and is proactively managed by their care in collaboration with their physician. This has resulted in a decrease in readmissions.

SOCORRO GENERAL HOSPITAL (CONT.)

Hospital challenges:	1. The patient population for Med/Surg ranges from newborn to hospices and include swing bed patients. The ageing populations has mobility, hearing and cognitive limitations. Swing bed patient are independent with their rehab therapy and have the right to move about within the hospital. 2. Attribution of Swing Bed program patient's readmissions to the hospital's inpatient reports. This results in a false perception of the Hospital's readmissions.
Any mid-course corrections:	1. Acquired more chair alarms and added signage on the ceiling to reminded patients to call before getting up. 2. Mid-year 2019 readmissions were at 9.26%. In August, leadership developed a plan with the SGH Hospitalists to carefully assess patients and admit patients for observation as appropriate. In addition, all readmission reports are carefully reviewed to assure proper readmission attribution to the correct program.
Successes:	1. The goal for 2019 falls per 1000 days was 1.9%, which is less than 3 falls with injury. Med/Surg unit in the hospital achieved 325 days without a fall during 2019. 2. The year-end Readmission All-Cause rate was reduced to 2.63% for 2019.
Any other information:	1. SGH Celebrated Med/Surg unit 300 days without a fall with cake and drinks for all staff. The Vice President of Quality and Regional Quality Director attended and congratulated leadership and staff. 2. SGH has a stable Hospitalist group who commit to giving our patients the best care possible.

UNION COUNTY GENERAL HOSPITAL

Hospital interventions:	1. Through the Antibiotic Stewardship Program, the providers are now reviewing antibiotic usage every 72 to determine continuance. The pharmacist is tracking the adherence. 2. During 2019 UCGH lost a fulltime physician but began recruiting efforts and were able to replace that position to cover ED and clinic. 3. For the entire 2019 year, Press Ganey were only able to obtain 12 inpatient satisfaction surveys for our hospital. Due to this low number we have changed our inpatient surveys to mail outs versus phone. 4. Because of losing a respiratory therapist we lost our sleep study program. After researching a few different companies, we were able to start that program back up for our community. 5. Our county has not had a Medicaid office in several years which is a huge disservice to our residents so UCGH had been working many angles to try to help with this and we were able to get a Medicaid Rep to start coming to the hospital from Raton and meeting with community members once week. The hospital is providing an office space for this and advertising to the public.
Hospital challenges:	The Sleep Study Program was put on hold but resumed in June. Inpatient and outpatient volumes had been reduced but we are now seeing an uptake.
Any mid-course corrections:	N/A
Successes:	1. Influenza Immunization for employees – 100% 2. Inpatient Immunization offered – 100%
Any other information:	

UNIVERSITY OF NEW MEXICO HOSPITAL

Hospital interventions:	• Multidisciplinary teams continue to meet regularly to reduce Severe Patient Harm Event (SPHEs) and Hospital Acquired Infections (HAIs). This year's highlights include a reduction in hospital acquired deep vein thrombosis and central line associated blood stream infections that is correlates with a decrease in central line utilization. • There is a continuation of the Implementation of a Program for Rounding on VTE Prophylaxis and Effective Infection Control (IMPROVE_IT) Project that has shown a consistent decrease in the preventable DVTs (Deep Vein Thrombosis), CLASBIs, and CAUTIs in the adult patients. This project is utilizing a real time dashboard to look at the unit level data.
Hospital challenges:	There has been an increase in Surgical Site Infections for abdominal hysterectomies.
Any mid-course corrections:	The surgery department is utilizing national benchmarking and reporting regarding abdominal hysterectomies. This data is being generated for each surgeon with individual case review.
Successes:	The hospital has downward trends, from the previous year, in: • Surgical Site Infections for C-sections by 40% • Surgical Site Infections for Colon Surgery by 39% • Central Line Associated Bloodstream Infections by 26% • Deep Vein Thrombosis by 14%

HUMAN SERVICES DEPARTMENT

THANK YOU

INVESTING FOR TOMORROW, DELIVERING TODAY.