HUMAN SERVICES DEPARTMENT

HOSPITAL QUALITY IMPROVEMENT INCENTIVE (HQII)

INVESTING FOR TOMORROW, DELIVERING TODAY.

BEFORE WE START...

On behalf of all colleagues at the Human Services Department, we humbly acknowledge we are on the unceded ancestral lands of the original peoples of the Apache, Diné and Pueblo past, present, and future.

With gratitude we pay our respects to the land, the people and the communities that contribute to what today is known as the State of New Mexico.

Evening drive through Corrales, NM in October 2021.
By HSD Employee, Marisa Vigil

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

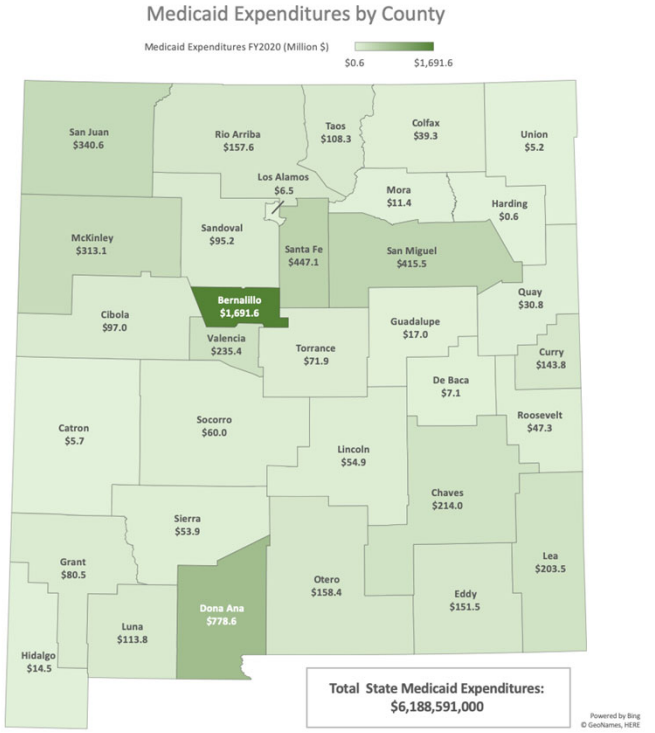
3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

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. The DY 6 payment was $12,000,000, DY 7 payment was $11,000,993, and DY 8 was $12,000,000.

	Click on hospital for reporting results	Met Participation Requirements
1	Alta Vista Regional Hospital	Yes
2	Artesia General Hospital	Yes
3	Carlsbad Medical Center	Yes
4	CHRISTUS St. Vincent Hospital	Yes
5	Cibola General Hospital	Yes
6	Dr. Dan C. Trigg Memorial Hospital	Yes
7	Eastern New Mexico Medical Center	Yes
8	Espanola Hospital	Yes
9	Gerald Champion Regional Medical Center	Yes
10	Gila Regional Medical Center	Yes
11	Guadalupe County Hospital	Yes
12	Holy Cross Hospital	Yes
13	Lea Regional Hospital	Yes
14	Lincoln County Medical Center	Yes
15	Los Alamos Medical Center	Yes
16	Lovelace Regional Hospital - Roswell	Yes
17	Memorial Medical Center	Yes
18	Mimbres Memorial Hospital	Yes
19	Miners' Colfax Medical Center	Yes
20	Mountain View Regional Medical Center	Yes
21	Nor - Lea General Hospital	Yes
22	Plains Regional Medical Center	Yes
23	Rehoboth McKinley Hospital	Yes
24	Roosevelt General Hospital	Yes
25	San Juan Regional Medical Center	Yes
26	Sierra Vista Hospital	Yes
27	Socorro General Hospital	Yes
28	Union County General Hospital	Yes
29	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.****

<100 Beds (6 measures)

1. All Cause (Preventable) Readmissions*
2. Adverse Drug Events*
3. Catheter-Associated Urinary Tract Infections (CAUTI)*
4. Injuries from Falls and Immobility*
5. Pressure Ulcers*
6. Venous Thromboembolism (VTE)*

>100 beds (11 measures)

7. Central Line Associated Blood Stream Infections (CLABSI)
8. Obstetrical Adverse Events with Instruments
9. Obstetrical Adverse Events without Instruments
10. Surgical Site Infections (SSIs) (NQF Measure 0753)
11. Ventilator-Associated Events

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.

$$\text{Rate} = \frac{\text{Numerator}}{\text{Denominator}} \times 100$$

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 in dwelling 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.

$$\text{Rate} = \frac{\text{Numerator}}{\text{Denominator}} \times 1{,}000$$

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

1. ALTA VISTA REGIONAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
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 83%
(improved in 5 of the 6 eligible measures)

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

2. ARTESIA GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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)

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

3. CARLSBAD MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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	No
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)

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

4. CHRISTUS ST. VINCENT HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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
Central Line Associated Blood Stream Infections (CLABSI)	No
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	No
-OB vaginal laceration w/o instrumentation	Yes
Postoperative PE or DVT	No
Pressure Ulcer Stage III & IV rate	No
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	No

Percentage of overall improvement 45%
(improved in 5 of the 11 eligible measures)

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

5. CIBOLA GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	N/A
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 5 of the 5 eligible measures)

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

6. DR. DAN C. TRIGG MEMORIAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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	N/A
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 80%
(improved in 4 of the 5 eligible measures)

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

7. EASTERN NM MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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	Yes
-OB vaginal laceration w/o instrumentation	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	Yes

Percentage of overall improvement 91%
(improved in 10 of the 11 eligible measures)

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

8. ESPAÑOLA HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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	No
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

9. GERALD CHAMPION REGIONAL MEDICAL CENTER
HQII REPORTING RESULTS FROM DY7 TO DY8

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	No
Pressure Ulcer Stage III & IV rate	No

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

10. GILA REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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

11. GUADALUPE COUNTY HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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

Percentage of overall improvement 80%
(improved in 4 of the 5 eligible measures)

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

12. HOLY CROSS HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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

13. LEA REGIONAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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

14. LINCOLN COUNTY MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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	No
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

15. LOS ALAMOS MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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)

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

16. LOVELACE ROSWELL REGIONAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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	No
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

17. MEMORIAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	No
-OB vaginal laceration w/o instrumentation	Yes
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	No
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	No

Percentage of overall improvement 64%
(improved in 7 of the 11 eligible measures)

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

18. MIMBRES MEMORIAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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

19. MINERS' COLFAX MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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	N/A
Pressure Ulcer Stage III & IV rate	N/A

Percentage of overall improvement 100%
(improved in 4 of the 4 eligible measures)

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

20. MOUNTAIN VIEW REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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)	No
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	Yes
-OB vaginal laceration w/o instrumentation	Yes
Postoperative PE or DVT	No
Pressure Ulcer Stage III & IV rate	No
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	No

Percentage of overall improvement 64%
(improved in 7 of the 11 eligible measures)

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

21. NOR-LEA GENERAL HOSPITAL
HQII REPORTING RESULTS FROM DY7 TO DY8

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	N/A
Pressure Ulcer Stage III & IV rate	Yes

Percentage of overall improvement 100%
(improved in 5 of the 5 eligible measures)

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

22. PLAINS REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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)	No
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	No
-OB vaginal laceration w/o instrumentation	No
Postoperative PE or DVT	No
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	Yes

Percentage of overall improvement 55%
(improved in 6 of the 11 eligible measures)

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

23. REHOBOTH MCKINLEY HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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

24. ROOSEVELT GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
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 83%
(improved in 5 of the 6 eligible measures)

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

25. SAN JUAN MEDICAL CENTER

HQII REPORTING RESULTS FROM DY7 TO DY8

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
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	No
-OB vaginal laceration w/o instrumentation	No
Postoperative PE or DVT	Yes
Pressure Ulcer Stage III & IV rate	No
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	No

Percentage of overall improvement 55%
(improved in 6 of the 11 eligible measures)

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

26. SIERRA VISTA HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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	N/A
Pressure Ulcer Stage III & IV rate	N/A

Percentage of overall improvement 75%
(improved in 3 of the 4 eligible measures)

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

27. SOCORRO GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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 100%
(improved in 4 of the 6 eligible measures)

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

28. UNION COUNTY GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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

Percentage of overall improvement 100%
(improved in 4 of the 4 eligible measures)

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

29. UNIVERSITY OF NEW MEXICO HOSPITAL

HQII REPORTING RESULTS FROM DY7 TO DY8

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
Central Line Associated Blood Stream Infections (CLABSI)	No
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	Yes
-OB vaginal laceration w/o instrumentation	No
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 60%
(improved in 6 of the 10 eligible measures)

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

1. ALTA VISTA REGIONAL HOSPITAL

Hospital interventions:	Hospital preparedness for COVID-19, patient safety, and healthcare provider safety were key interventions during 2020. Continuous improvement throughout the COVID-19 pandemic occurred to improve our gaps in managing COVID-19 patients, including infection control preparation, staffing, space, and supplies. Also, assuring clear and organized communication to all staff, maintaining a COVID-19 internal site with changes and updates related to care practices, infection prevention, impact supplies etc. was critical to those efforts. Some of the training and interventions included: • Basic improvement training for all staff • Inclusion of patient and family in the COVID-19 patient's care. • PPE usage • COVID-19 Testing strategies and testing turnaround times. • Bed management for COVID-19 patients including safely cohorting and providing appropriate air exchange. • A system of screening, testing, and reporting COVID-19 symptoms among staff, patients, and visitors. • Process improvement for transferring patients with COVID-19. • Management of postmortem care of the deceased COVID patient. • Refocusing on assuring proper cleaning, sanitation and disinfection are occurring at all levels of care. • Protocols for universal masking and the 3 types of masks, cloth, surgical and N-95 when and where they may be used. • Reducing Face-to-face encounters while maintaining safety and standards of care. • Ventilator care of the COVID-19 patient. • Community education about prevention of COVID19 including radio broadcasting and educational material. • Mass Community Vaccination clinics- as part of an alignment to protect our community and staff in collaboration with New Mexico Department of health and San Miguel County Emergency Management Division. • Focus on psychological Safety of Healthcare workers at Alta Vista Regional Hospital.

1. ALTA VISTA REGIONAL HOSPITAL (CONT.)

Hospital challenges:	• Aging Community population • Large population in poverty. Healthcare services and providers within the community are limited. • Large Hispanic population with multiple comorbidities. • Extreme difficulty in staff recruitment and retention. • Fatigue and exhaustion of healthcare workers. Like many healthcare workers world, our staff have experienced anxiety, fear and stress from the burden and uncertainty brough about by the pandemic. One of our focuses is around the wellbeing and health of our providers. Working towards a better process to assure ample time for breaks, decompression, and regeneration. Focus on assuring ample supplies of appropriate PPE and training are available to ease fears about caring for patients while placing themselves at risk. Continuance of Safety huddles and safety events like investigations and root cause analyses to assure appropriate emergency response to the pandemic. Focusing on staff well-being will in turn assist them in being able to provide the best care for their patients, while maintaining their own safety.
Any mid-course corrections:	Constant evaluation and improvement of infection prevention practices, PPE usage and patient management around COVID-19.
Successes:	Strong buy in from frontline healthcare providers to institute continuously changing COVID-19 practices for the safety and treatment of our patient population and healthcare personnel. Vaccination rate of 80% amongst Healthcare providers working within our facility. No hospital Acquired COVID-19 cases have been attributed to date. Improvement of hospital personnel becoming ill with COVID-19. No COVID-19 cases amongst healthcare personnel attributed to exposure. Reduction of staff exposures and staff COVID-19 cases.

2. ARTESIA REGIONAL HOSPITAL

Hospital interventions:	1. During the beginning of the Covid-19 pandemic Artesia General Hospital (AGH) began actively looking at solutions to help keep AGH patients, family members and employees safe. We closed all entry points into the facility except for the Emergency Room (ER) entrance; badge access is required to enter the facility through other doors. Signage was placed at all entry points directing everyone to the Emergency Room entrance for registration for the ER, or outpatient procedures. There is a security guard at the ER door that will help direct patients and family where to go for registration. We also implemented an employee drive through testing area on a section of our ambulance bay area for employees that have been exposed to Covid-19 to be tested utilizing all the infection control precautions. 2. A performance improvement (PI) project was implemented in May to increase the accuracy of the ER Log data for eCQM reporting. Prior to implementation, the ER Log data was often missing or incorrect, and there was no process to capture the Decision to Admit (DTA) time in the electronic health record (EHR), resulting in correction rates of 50-65% in-order-to capture and report eCQM data. ER nursing staff was educated on where to find and document the physician's DTA time. Working with medical records and clinical IT, disposition codes that pertain only to the ER Log were updated so they matched the discharge code for the ER visit and encounter. A "cheat sheet" education document was created and posted for the ER nursing staff to reference what discharge code should be used depending on where the patient was headed from the ER.

2. ARTESIA REGIONAL HOSPITAL (CONT.)

Hospital challenges:	1. One challenge was the flow of foot traffic in the facility and redesigning the flow of traffic facility to avoid cross-contamination. We created temporary barriers in the high-risk Medical/Surgical unit and were able to convert that entire area into a true negative pressure unit by re-engineering the air handler. We also constructed vestibules or antechambers prior to entering the Med/Surg unit on both the entry and exit of that area. This included the ability to allow medicine pass-throughs in the wall between the inpatient pharmacy and the Med/Surg unit so that pharmacy staff would not have to walk into the Med/Surg unit and risk the possibility of exposure. Another challenge was that we had all the patients and/or family members coming into the building via one entry point, but we were allowing individuals into the building to a registration desk without having a Covid pre-screen prior to entering the building. The screening was not taking place until the registration process, which could potentially allow for contamination. The weather also became a challenge for the laboratory team testing employees outside on the on the ambulance bay drive. 2. By June, the DTA time was being captured accurately, which revealed a discrepancy in Discharge time for patients admitted to the Med-Surg floor from the ER. ER Log data flows from many different areas of the EHR; changes from not only the ER staff, but also registration affect the ER Log data. Further, when the EHR system is down or internet connection drops, data may not be captured on the ER Log even when entered in the correct place.

2. ARTESIA REGIONAL HOSPITAL (CONT.)

Any mid-course corrections:	1. As the cold weather moved in, our facility's project manager recommended that we create an exam room outside the emergency bay area using an existing decontamination chamber and a temporary modular wall system from the STARC systems. It has negative pressure air, heating, and lights. It continues to serve the infection control needs of the facility and keeps our testing team out of the elements. We corrected our screening processes by setting up a table at the only patient entrance into the facility to pre-screen into the building. Our clinical educator trained the screening staff on how to use a non-contact infrared thermometer and implemented a few screening questions to be asked prior to entering the facility. We also placed hand gel at the screening table to ensure that individuals sanitize their hands upon entering the building. 2. Working with the ER director, Clinical IT educator, and Supervisor of registration, we determined the Discharge time is flowing from location maintenance, and not from the nursing documentation as originally thought. To remedy, our plan is to have the ER nurse communicate with registration clerks what the discharge time should be when they call to have the patient moved to the Med-Surg floor. Due to turnover in the registration supervisor position, this process has not been fully implemented, but meetings are scheduled to discuss with the new supervisor so they can support the initiative.
Successes:	Successes include: a. No reported Covid-19 cases of patient-to-patient transfer since March 2020. b. Turned our Med/Surg unit into a true negative pressure unit by re-engineering the air handler. c. Redesigned the flow of how individuals enter and exit the facility. d. Implemented a drive-up Covid-19 testing area for potentially exposed hospital staff. 2. Other Successes include: a. Improved accuracy of the DTA time, with reduction of the correction rate from 50-67% down to an average of 33%. b. Reduction in unusable data (e.g., unable to determine) for the Decision-to-Depart eCQM measure. c. Reduced corrections to ER Log Disposition and/or Discharge codes.

3. CARLSBAD MEDICAL CENTER

Hospital interventions:	We completed a renovation of Med/Surg wing which is also used currently as our COVID unit. We also remodeled our rehab patient rooms and were able to complete upgrades on facility chillers and refurbished both facility boilers. Making these facility enhancements allowed us to safety care for the surge of patients throughout the pandemic and meet the communities needs
Hospital challenges:	COVID-19 was our biggest challenge in 2020 as we experienced an influx of critically ill patients. In 2020, we had one central line associated blood stream infection, our first since 2011, in a critically ill patient with COVID. This patient was hospitalized for over a month. Positive COVID staff impeded patient admissions and sometimes made it difficult to meet the demand of caring for an influx of patients.
Any mid-course corrections:	We expanded the admissions of COVID patients from four to fourteen. We engaged PRN nursing and CNA staff for support to increase admission volumes.
Successes:	Our readmissions decreased from 6.8% in 2019 to 5.3% in 2020. Our compliance with the Sepsis bundle (SEP-1) increased from 64% in 2019 to 72% in 2020. Our PSI (patient safety indicator) index improved from 1.19 in 2019 to 0.81 in 2020. We maintained 0% for PC-01 Early elective delivery and celebrated a 50% decrease in primary C-Section in nulliparous women. (PC-02).
Any other information:	We were able to employ three new nurse practitioners to assist our clinic offices.

4. CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER

Hospital interventions:	1) Hypertensive disorders of pregnancy constitute one of the leading causes of maternal and perinatal mortality worldwide. Sixteen percent of maternal deaths can be attributed to hypertensive disorders in the United States. A team of healthcare professionals improved the process of caring for women with hypertensive emergencies in the labor and delivery unit at CSV. The most notable interventions were the following: Physician and nurse education regarding up-to-date protocols for treatment for severe preeclampsia. • Created order sets for medication protocols to treat severe preeclampsia. • Developed online and hard copy resources of the medication protocols for anti-hypertensive medication administration. • Created a nurse-initiated protocol for starting therapy, if unable to reach the covering or on-call physician within the 30-to-60-minute window. • Simulation training for nurses and physicians for treatment of hypertensive emergency. • Trained emergency room staff regarding medication order sets for patients presenting with severe preeclampsia in the post-partum period. • Implemented a debrief process after high-risk obstetric emergency cases to promote ongoing education, communication, and to identify opportunities for system improvement.

4. CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER (CONTINUED)

Hospital interventions Continued:	2) This seventeen-month long project, completing in 2020, was to address the unmet needs of patients at CSV with opioid use disorder (OUD) with medication-assisted treatment (MAT). Patients hospitalized with OUD may have extremely uncomfortable withdrawal symptoms. They also have reduction in opioid tolerance while hospitalized, making accidental overdose and death on hospital discharge a significant concern. Additionally, continuous outpatient intravenous opioid use places the patient at high risk of bacterial and viral infections. The mainstay of treatment for patients with OUD is with buprenorphine. At the beginning of this quality improvement initiative, providers were required to have an X-Waver to prescribe buprenorphine. This limited the number of providers that were able to treat OUD. Additionally, prescribing naloxone, a lifesaving opioid reversal medication, was not a standard practice upon hospital discharge for patients with OUD. Hospital interventions were the following: • Creation of a buprenorphine consultation service. • Support physicians new to prescribing buprenorphine. • Improve the transition of care, from inpatient to outpatient, by arranging close follow up with providers who can continue to monitor the patient on buprenorphine. • Ensure that hospitalized patients can receive substance abuse education and determination of eligibility for treatment services for detox on discharge and prescription for naloxone on discharge.

4. CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER (CONTINUED)

Hospital challenges:	1) The electronic medical record gave the team some challenges, and they are still working to get the "hypertensive order sets" to link to the "order algorithm" in the medication review tab. The newly developed policy and procedures are not yet available on the Vitranet for staff access. 2) In order for physicians to obtain a Drug Enforcement Administration (DEA) approved X-Waiver they needed to take a course and apply. These additional steps were a barrier to providers. In addition, physicians, having not been trained in residency to prescribe buprenorphine, were reluctant to learn this new skill later in their career. Of note, the U.S. Department of Health and Human Services has removed the X-waiver requirement for physicians, expanding their ability to utilize medication-assisted treatment (MAT) for patients recovering from OUD.
Any mid-course corrections:	New data suggests that utilization of the nifedipine protocol results in more rapid control of blood pressure.
Successes:	1) For patients with a diagnosis of severe preeclampsia defined as two blood pressures ≥160 systolic and/or ≥ 110 diastolic, within a 15-minute interval, there was a trend in improved number of patients that received appropriate antihypertensive medications within 60 minutes of blood pressure check. For patients cared for by an obstetrician, that number went from 55% to 83%, and for patients cared for by a non-obstetrician, that number went from 33% to 62% (large value is better). It is of note, the incidence of no medications given (lower is better) fell from 18% to 0% for obstetricians, and 43% to 0% for non-obstetricians, with statistical significance p=0.003. 2) In the pre-intervention portion of this study, on average, only 0.13 patients received buprenorphine per month for treatment of OUD. After the interventions, this rose to 2.6 patients per month. This is a ~1900% increase. In addition, there was a trend toward reduced hospital readmissions for patients with OUD. This fell from 36% to 26%. Additionally, there was a modest reduction in length of stay for patients with OUD, from 2.5 days to 2 days. We also increased prescriptions of naloxone (treatment of opioid overdose) for patients with OUD from 0.5 prescriptions/month to 2.6 prescriptions/month.

4. CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER (CONTINUED)

Any other information:	1)The team is planning ongoing emergency room provider education and to continue their debriefing process. 2)Now that an X-waiver is no longer needed to prescribe buprenorphine, we anticipate that more providers will begin prescribing this medication.

5. CIBOLA GENERAL HOSPITAL

Hospital interventions:	Key interventions that our hospital worked on in CY2020 were improving employee engagement, improving patient satisfaction, preventing hospital-acquired COVID-19 and other infections, reducing post-partum hemorrhage, reducing readmissions, and reducing patient falls. To improve employee engagement, our CNOs surveyed nursing staff to learn what workflows needed improvement and updated processes accordingly. Orientation processes were also updated, and all hospital new hires had check-in meetings with department leaders every other week for the first 90 days of their tenure at Cibola General Hospital (CGH). Additionally, amidst the pandemic, we had COVID safe engagement and celebration events for our staff including one-on-one new hire check-ins with the HR director, grab and go boxed lunches, multiple catered lunches, and a traveling Executive Team breakfast cart that rotated through different departments of our hospital every month. To improve patient satisfaction scores, our Executive Team worked with directors to hardwire focus on patient satisfaction scores. The Quality director started sharing monthly patient satisfaction performance data with all Hospital staff. Directors in charge of departments where patient satisfaction data is collected were charged with implanting at least one patient satisfaction initiative that would help raise their departmental patient satisfaction scores. Additionally, one of our hospital board members who has been in customer service for many years came to our Hospital to do an in-service with our Leadership team on customer service. With the onset of the pandemic in March 2020, our hospital initiated our Incident Command System which is currently still in place. Our Incident Command team meets daily after our morning safety huddle to have discussions about resources, safety, and operations in-order-to ensure that our hospital is responding appropriately to the pandemic. Our hospital also committed to achieving 0 harms from hospital acquired COVID-19 parallel to our commitment to achieving 0 hospital-acquired infections. We achieved the goal of no hospital acquired COVID-19 for patients. We also implemented a COVID-19 vaccination campaign, led by our Infection Control nurse, where we were able to successfully vaccinate 75% of our hospital staff (clinical and non-clinical). The remaining 25% of staff who declined have the option to still get vaccinated if they choose to do so. Additionally, we have been able to vaccinate first responders, home health care workers, and individuals who met the DOH's eligibility criteria for vaccination. We have administered 1500+ vaccinates over the past month a half.

5. CIBOLA GENERAL HOSPITAL (CONT.)

Hospital interventions Cont:	Our hospital continued work from CY2019 on reducing inpatient falls. We continued conducting post-fall huddles and implementation of our updated falls policy containing department-specific information on fall precautions. CGH also continued to improve our existing antimicrobial stewardship program by implementing daily discussions about antibiotic appropriateness at 10AM inpatient treatment team meetings and by updating our monitoring and tracking of antibiotic therapy so that it includes provider-specific information, and information on whether pharmacist recommendations about antibiotics were taken. Additionally, our pharmacists successfully completed the Antimicrobial Stewardship Certification training program that was sponsored by NMHA.
Hospital challenges:	Inpatient falls increased at our facility in CY2020. However, none of these falls resulted in patient injury or trauma. Our Hospital continued to implement post-fall huddles for patient falls that occurred in every unit of our hospital (inpatient and outpatient). Because of the pandemic, we were not able to have our annual clinical education event where we perform competencies and reeducate our staff on properly using fall precautions and correctly identifying patients that are fall risks.
Any mid-course corrections:	Our hospital had 0 anticoagulation related ADEs in CY2020. After our 1 event in CY2019, we implemented a process improvement project that resulted in parameters for critical lab values being updated, clinical staff being re-educated about the importance of questioning and reporting abnormal lab results that significantly deviate from previous lab results and sent all ADEs to our P&T Committee for review monthly. This process continues to be followed.
Successes:	In CY2020, all departments in our Hospital worked diligently to update processes and implement new initiatives to improve quality, safety, and satisfaction. Our major successes tied to the HQII initiative included reducing our within-facility readmission rate to <3% monthly, achieving 0 harms related to post-operative DVTs, achieving 0 harms related to anticoagulation-related ADEs, and achieving 0 harms related to hospital-acquired stage III and IV pressure ulcers. Other successes included completing a Financial Operational Assessment (FOA) that was supported by the Federal Office of Rural Health Policy, submitting four electronic clinical quality measures (eCQM) to both CMS and TJC for CY2020, and implementing multiple safety initiatives focused on reducing workplace violence and increasing safety and security at our facility. Additionally, our Hospital applied fora New Mexico Performance Excellence Award in which our work on post-partum hemorrhage reduction was highlighted.

6. DR. DAN C. TRIGG MEMORIAL HOSPITAL

Hospital interventions:	1) Dr. Dan C. Trigg Memorial Hospital (DCT) decided to monitor D5 instead D3 bundles in 2020. The D5 scores for the patients at DCT started at 12.7% in January. Due to the dedicated work of Dr. Willis and his team at the DCT PMG saw a gradual improvement in D5 scores. The team met in February 2020 and created an action plan utilizing the PDSA (Plan, Do, Study, Act) process improvement model. The plan consisted of addressing five main activities: 1. Clinicians to utilize "address topic" in the Electronic Medical Record when utilizing health maintenance. 2. Clinicians to utilize all ancillary services to support meeting our D5 bundle metric: a. Clinical Pharmacist b. Certified Diabetes Educator c. Care Managers d. Sub-specialty clinicians 3. Medical Assistants to follow standard work to ensure all orders are being prepared for their next visit with their PCP. a. Review cheat sheet order and update correct referral order numbers. 4. Care management to work towards the goal of 100 out reaches each month per care manager. 5. Care management designated a nurse visit clinic day each week to assist with outreach. 2) Dr. Dan C. Trigg Memorial Hospital (DCT) monitored readmissions into the hospital for those patients over the age of 64 within 30 days. In 2019 DCT ended the year with 5 readmits or 6.67%, in 2020 a target of 5% or less was set for readmissions for the patients over the age of 64 within 30 days. Daily Huddles, to include leadership, were put in place to identify patient needs to assure maximum patient optimization to reduce the risk of a readmission.

6. DR. DAN C. TRIGG MEMORIAL HOSPITAL (CONT.)

Hospital challenges:	1) Inability to see patients due to pandemic. 2) Being a Critical Access Hospital with low inpatient census one readmission can have a major impact on the metric. With the pandemic, the admission volumes were lower than budgeted
Any mid-course corrections:	1) Utilizing telemedicine visits to these D5 patients with Dr. Patel Trujillo, Endocrinology. 2) None
Successes:	1) The focus and teamwork resulted in a steady improvement of 13.1% in their D5 scores from June 2020 until Jan 2021 ending the year with a performance score of 20%, surpassing the organizational goal of 12.10%. 2) Surpassed the year-end target with a readmission rate of 2%.

7. EASTERN NEW MEXICO MEDICAL CENTER

Hospital interventions:	In 2020, the hospital leadership group has continued to work on infection prevention. As with many other facilities, COVID 19 has been a major focus. A dedicated COVID Unit was developed and opened. It has been a huge area of learning for all staff. As of February 15, 2021, the unit remains open. We have also continued to work to decrease falls with injuries and again had a year without a fall with serious injury. We have seen a decrease in the number of readmissions, but however we are not at a level that we are comfortable with and will continue to work to decrease the number of readmissions.
Hospital challenges:	We are struggling with the number of contract labor staff that are needed to meet the patient volume demands. As a result of the use of an increased number of contract labor staff, our HCAHPS scores have been negatively impacted and we are working to raise these scores. To address the issue with the HCAHPS scores, nurse leader rounding and leader rounding have been reimplemented, orientation has been reevaluated, and bedside shift report and hourly rounding by nursing staff. Every patient is seen at least daily by a leader in the hospital to validate care.
Any mid-course corrections:	Bedside shift report was reevaluated and re-initiated in the hospital. As a part of this process, nursing leaders are auditing staff while bedside shift report is in process. Coaching is provided when weaknesses in the process are identified. We have found these practices have a significant impact for both clinical care and perception of the care provided at ENMMC.

7. EASTERN NEW MEXICO MEDICAL CENTER (CONT.)

Successes:	We opened the COVID unit and were able to staff the unit over time. By having a dedicated COVID unit, we have been able to meet and follow the CDC recommendations and to provide the appropriate level of care for these patients while keeping the community and our staff safer. Although we did not decrease the overall number of falls, we continue to have zero falls with serious injury.
Any other information:	To summarize 2020 was a challenging year. There were global, national, and state level interventions in dealing with a pandemic while ensuring that "routine" hospital activities continued as appropriate. It was truly a tale of two hospitals and commends the efforts of our local healthcare providers in meeting the challenges. Now as we closed 2020, we have largely incorporated COVID practices into our normal daily operations and will be again refocusing on improvement activities to move ENMMC forward with better care and quality for South East New Mexico.

8. ESPAÑOLA HOSPITAL

Hospital interventions:	We have seen a reduction in the number of inpatient falls over the past 3 years. In 2019, there were 14, and we set a target to reduce that number to 12 or less for 2020. Although every fall is followed by a post fall huddle, we also had a falls committee that met monthly to review every fall and look for opportunities for improvement. We implemented a "We Walk With You Campaign," which was more patient focused than No One Walks Alone (NOWA), our previous strategy. Bed alarms were placed for all high- risk patients, which were virtually all patients. On admission, patients were educated and signed a contract of understanding. Colorful signs were strategically placed as reminders, and we enlisted tele-sitters for those patients who were confused or otherwise deemed to be significantly at risk.
Hospital challenges:	The main challenge in 2020 was the infection control implications of COVID, which caused delays in entering patient rooms to meet their needs in our usual timely manner.
Any mid-course corrections:	We made a targeted effort to ensure all tele-sitters were always in use to optimize prevention strategies. In mid-year, an admitted patient who suffered a fall in the ED started to count against the inpatient unit from which the patient was discharged, thereby increasing the overall falls rate for inpatients.
Successes:	In 2020, there were 11 falls for ICU and the medical surgical unit combined.
Any other information:	We saw a significant increase in number of falls in the ED, so in 2021, we will focus energies on this population.

9. GERALD CHAMPION MEDICAL CENTER

Hospital interventions:	Falls and Trauma: Falls continue to be a focus with us. A thorough review of our Fall interventions led to following our evidence and removing Care View, a camera program with a monitor tech. The system was not found to reduce the number of falls and we saw an increase in falls. The camera system and then staff notification caused a delay in getting help to the bedside. We have weekly post fall huddles with the staff and the Safety Officer to determine failures in our processes. Fall reductions have been noted. CLABSI and CAUTI: EMR documentation of lines has not been adequate. We hired additional Informatics nurses to train nursing staff on proper documentation to better track lines and drive interventions. We will continue to work on these initiatives. Pressure Ulcer: Our experienced Certified Wound Care Nurse resigned. The hospital hired two nurses who are currently going through training and certification. We will be growing this service line as staff complete training. SSI: Our infection preventionist left the organization and our replacement is in the learning curve intensified by Covid-19. All SSIs are presented to the Surgery Committee and reviewed for corrective actions.
Hospital challenges:	Falls and Trauma: Visitor restrictions due to Covid reduced families coming to help sit with confused patients. CLABSI and CAUTI: Staff turnover and increased use of agency nurses reduced compliance with documentation and process knowledge. Pressure Ulcer: Turnover and training of new staff cause delays in improvement processes. SSI: Turnover and training of new OR staff along with new Infection preventionist cause setbacks. Staffing shortages in the OR have resulted in onboarding of International nurses which includes more extensive onboarding processes. Had an uptick in SSI in December 2020. Investigation conducted without conclusive cause. A review of processes has been conducted.

9. GERALD CHAMPION MEDICAL CENTER (CONT.)

Any mid-course corrections:	Falls and Trauma: Weekly post-fall huddles have been moved in location and times to increase staff attendance. CLABSI and CAUTI: No changes at this point. Pressure Ulcer: Increased from one Wound RN to two in December to improve staffing consistencies and coverage. SSI: Repeat of OR training with staff turnover and International Nurse onboarding.
Successes:	Falls and Trauma: Falls have continued to decrease on the inpatient units. CLABSI and CAUTI: None at this time. CAUTI rates are continuing improvement at 0.903 vs 0.559 prior year, CLABSI rates are much improved this year at 0.0 vs 1.702 from prior year. Pressure Ulcer: Second Wound RN started in Dec. 2020-working on certification by March 2021. SSI: Overall SSI's are down from prior year. 2019 rate 0.0 & 2020 0.0 rate continue to see reduced rates.

10. GILA REGIONAL MEDICAL CENTER

Hospital interventions:	1. Readmission reduction 2. Adverse Drug Event (ADE) reduction related to ADE-Opioid and ADE-Anticoagulation
Hospital challenges:	1. Our Inpatient psych/Behavioral Health Unit (BHU) was a big contributor to our Readmission rates. This was difficult as these patients often lack the support and social systems that drive problem solving and self-directed help and rely on the hospital for treatment. We were also challenged with staff shortages in our case management team as well as a turnover in case management leadership. The great turn-over caused our care transitions program to fall to the wayside. We also have had new leadership in our medical staff Services department. 2. We have difficulty with documentation of anesthesia medications that contribute to our ADE Opioid reversal measure. Our anesthesia staff still use paper charting rather than electronic MAR – which makes it difficult to collect data. RN staffing shortages have caused nurses to be stretched thinner. Nurses need more education, refinement of time management and help with efficiencies. Pharmacy needs more oversight and better reporting of our ADE's for increased accountability and performance improvement.

10. GILA REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	Implemented new case Management Leadership who is also Leadership of our outpatient clinics. Focus has been on getting Case Management Team educated first and then will begin to focus reimplementing the Care Transitions Program in collaboration with Outpatient clinics and quick follow up appointments. Unfortunately, our Inpatient Psych/ Behavioral Health Unit closed in May (for other unrelated reasons), but this closure will contribute to a decrease in Inpatient readmissions to BHU. Quality staff is now working closely with our Medical Staff Services department to provide a more data-driven, robust Ongoing-Physician-Practice-Evaluation (OPPE) and Focused-Physician-Practice-Evaluation (FPPE) for improved provider monitoring and accountability related to readmissions. We did not have any ADE's related to anticoagulation since 2018 – however, we had one ADE incident in 2020 where patient was still given anticoagulation (Warfarin) per order even though the INR was elevated above 5. This was a newer nurse that just needed and received education. As we worked to create a better ADE Opioid report, we found that our report still requires manual validation of each chart. This is understandable and is being done to prevent errors in reporting.
Successes:	Case Management staff is educated, and leadership is already working towards re-implementing Care Transitions program. We currently have providers being monitored for what we are defining as 'excessive' re-visits. We were able to create an electronic report that captures nursing's documentation of the use of Narcan within 60 minutes of a Schedule2 medication. It does require some manual validation, but it has been successful. We also have new Pharmacy Director that is helping us better define "Medication Errors" versus "Adverse Drug Events" for better reporting to our stakeholders.
Any other information:	1. There continues to be opportunity surrounding readmissions. We currently have providers being monitored for what we are defining as 'excessive' re-visits.

11. GUADALUPE COUNTY HOSPITAL

Hospital interventions:	In January 2020, Guadalupe County Hospital once again 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 continued monitoring patient follow up calls and readmissions within 30 days. Follow up calls continue to have a positive effect on reducing readmissions. Patient condition specific discharge folders also improved home care, reducing readmissions. Patient falls with or without injury showed substantial improvement. In 2019 there were 6 patient falls without serious injury. In 2020, this was reduced by 50% to 3 patient falls without serious injury. Interventions included proper identification of high-risk patients, and implementation of fall prevention measures, post fall huddles, and non-punitive reporting. The hospital also continued to monitor CAUTIs, CLASBIs, and hospital acquired Pressure Ulcers, of which there were none reported in 2020. No other Hospital Acquired Infections or Conditions were reported in 2020. Hospital employee seasonal flu vaccine rate topped out at 80%, but COVID employee vaccine rates were much higher. (See mid-course corrections).
Hospital challenges:	As always, our low census is a challenge as a single incident can affect our rates substantially, either for hospital acquired conditions, falls or readmissions. But this goes both ways (up or down). COVID-19 presented substantial challenges as well, as some of our planned process improvements were postponed due to staff overload and limited time for training and implementation. This will be pursued in 2021

11. GUADALUPE COUNTY HOSPITAL (CONT.)

Any mid-course corrections:	In April, the hospital began planning for the installation of an automated medication dispensing unit in the med/surg unit. However, once COVID began to severely impact the hospital and staff (nursing and pharmacy), with testing, admissions, long inpatient stays of highly acute patients, and later, vaccinations, this was placed on hold. In December, hospital began COVID staff vaccinations. The hospital vaccination rate is currently 94%. The hospital is also the only vaccinator in our county available to the public. COVID also put infection prevention measures into high gear, with daily temp checks, handwashing stations and monitoring, N95 fit testing, symptom monitoring, and strict enforcement of face mask and eye protection throughout the hospital, and installation of sneeze guards and shields at the front desk and pharmacy. Thanks to safety measures put into place, only 1 employee has thus far tested positive for COVID.
Successes:	The successes include a reduction in falls by 50%, reduced readmissions, a high COVID vaccination rate (94%), and a very low COVID positivity rate (one employee).
Any other information:	Quality and operational performance improvement are central to everything we do at GCH. We encourage continuous training and education for all staff (clinical and administrative). In 2021, we will be focusing on patient and family engagement, and on care coordination outside our walls and outside our community. Our pharmacist is also participating in an Antibiotic Stewardship program to ensure that we continue to treat patients in need of antibiotics as conservatively and carefully as possible.

12. HOLY CROSS HOSPITAL

Hospital interventions:	1. Quality and operational performance improvement are central to everything we do at GCH. We encourage continuous training and education for all staff (clinical and administrative). In 2021, we will be focusing on patient and family engagement, and on care coordination outside our walls and outside our community. Our pharmacist is also participating in an Antibiotic Stewardship program to ensure that we continue to treat patients in need of antibiotics as conservatively and carefully as possible.
Hospital challenges:	COVID-19 has increased ventilator usage in the Intensive Care Unit and the incidence of mental health care being needed in the Emergency Department. With these two metrics increasing, so has the use of restraints. The need for increased nursing staff has brought in several new travelers experiencing a learning curve with our Electronic Medical Records. Compliance with restraint documentation has decreased due to these factors. A team comprised of the Chief Nursing Officer, The Vice President of Quality, The Inpatient Services Director, and the Emergency Department Director is working on a Plan-Do-Check-Act Cycle to address this issue. COVID-19 has increased ventilator usage and days-stay; this has increased our foley catheter utilization rate significantly. The issue is being brought up at all medical staff meetings and has been brought to the Chief Nursing Officer and Inpatient Services Director to address at this time.

12. HOLY CROSS HOSPITAL (CONT.)

Any mid-course corrections:	1) The COVID-19 response by the hospital saw great successes. Holy Cross was able to maintain appropriate personal protective equipment for all staff. Prompt planning allowed for proper oxygenation equipment to be obtained and for the training of our team. We were ultimately resulting in better outcomes for our patients. The medical staff's involvement proved fruitful in both medical staff and nursing buy-in to newly established policies to respond to the pandemic. Additionally, the hospital established an off-site testing center for the community and quickly set up robust Point of Dispensing sites that have vaccinated over 2000 community members in categories 1a and 1b. 2) The falls team's actions have resulted in a continued low rate of falls, despite the increase in patient census and acuity. Falls numbers remain low in the fall and winter of 2020.
Successes:	1) The COVID-19 response by the hospital saw great successes. Holy Cross was able to maintain appropriate personal protective equipment for all staff. Prompt planning allowed for proper oxygenation equipment to be obtained and for the training of our team. We were ultimately resulting in better outcomes for our patients. The medical staff's involvement proved fruitful in both medical staff and nursing buy-in to newly established policies to respond to the pandemic. Additionally, the hospital established an off-site testing center for the community and quickly set up robust Point of Dispensing sites that have vaccinated over 2000 community members in categories 1a and 1b. 2) The falls team's actions have resulted in a continued low rate of falls, despite the increase in patient census and acuity. Falls numbers remain low in the fall and winter of 2020.

13. LEA REGIONAL HOSPITAL

Hospital interventions:	1.We implemented processes which would reduce the number of falls for patients admitted to the Medical Surgical/Pediatric Unit particularly falls with injuries. The Medical Surgical Peds Director worked with Nursing Administration and Unit staff to order equipment and establish clinical rounding on patients at high risk for falls. 2.Reductions in readmissions continues to be a focus for the hospital. Case Management has worked with post hospital providers to assure there is continuity of care following the patient's discharge
Hospital challenges:	1. Patients who are normally independent and unaccustomed to requesting assistance attempting to get out of bed by themselves when there has been a major change in their physical status either due to a procedure or illness. Education and reinforcement for patients regarding calling for assistance when they need to get up from the chair or bed. 2.Patient refusing post hospital care when it recommended. Nursing Facilities not accepting patients due to weekends or restrictions.
Any mid-course corrections:	1.Continuous reinforcement of fall risk reduction strategies and monitoring for hourly clinical patient rounding, including hand-off and bed alarms checks. Assure patients who continue to be non-compliant are placed on a safety watch. 2.Continuing to work with nursing facilities and post hospital provider for appropriate and timely admissions.
Successes:	1.Reduction of inpatient falls in the 3rd and 4th quarters of 2020 to 4 falls with none sustaining injuries. All employees are educated to watch patients to assure patient remain safe and assist and report immediately to the patient's nurse. 2.All cause readmission rate has been reduced to 5% in the final quarter 2020.
Any other information:	1.Fall reduction strategies will continue for 2021 with risk identification and preventative actions being the focus. 2.Readmission continues to be a focus with high-risk diagnoses so we will continue to work with post-hospitalization providers for appropriate referrals and continuity of care plans for the vulnerable population.

14. LINCOLN COUNTY MEDICAL CENTER

Hospital interventions:	1) In 2020, we continued to focus on patient flow from the Emergency Room to inpatient units within 30 minutes of bed assignment. With concerns regarding the pandemic and potential surges, we wanted to ensure that patient flow through our Emergency Room was as efficient as possible. While we did quite well during the first five months of 2020, our compliance fell as we experienced surges with COVID positive patients. We strengthened key processes which included tracking each admission, Emergency Room nurses giving bedside report to Intensive Care staff, House Supervisors assisting with admissions during busy times, and Environmental Services prioritizing cleaning of patient rooms after patient discharge. 2) In 2020, we continued to focus on patient falls. With concerns regarding potential patient surges with the pandemic and the move to a new and bigger facility, we were concerned that our fall rate would rise. Staff continued to implement our Fall Prevention Protocol. Patients were scored for risk of fall every shift, and those at high risk were placed in rooms near the nurses' station. A "Call Don't Fall" sign was placed on the ceiling over each bed, and number of days since previous fall were tracked in the departments. Front-line staff continued to do hourly rounding, and managers from all the clinical departments were assigned patient rooms for daily rounding. We had Fall Committee meetings intermittently throughout the year. We continued with the "No Pass Zone."

14. LINCOLN COUNTY MEDICAL CENTER (CONT.)

Hospital challenges:	1)We experienced surges in COVID positive patients during the summer and again in the late fall, resulting in reduced compliance to moving patients from the Emergency Room to inpatient units within 30 minutes of bed assignment. We also had more staff unable to work due to illnesses, and at times our Intensive Care Unit was over capacity. COVID patients required more hands-on nursing care and nurses got tied up in patient rooms for extended periods of time unable to accept a new patient from the Emergency Room in a timely manner. Also, since patients were being cohorted and this required even more time in patient rooms by nursing to address the needs for both patients before exiting the room. COVID positive patients had longer lengths of stay, limiting bed availability, and room cleaning after discharge of COVID positive patients took more time delaying some admissions. 2)We experienced surges in COVID positive patients in early summer and in late fall. Because of the pandemic, we had to eliminate patient visitation throughout this time. Unfortunately, this resulted in patients being alone for much of their stay and may have contributed to the increase in patient falls that we experienced. We also had staffing issues that limited the number of available sitters for patients at high risk of falls. We continued to have tele-video monitoring capability for only one patient because we were unable to order new monitors at this time.
Any mid-course corrections:	1)When compliance with timely admissions dropped, we focused on the causes that resulted in reduced compliance. As part of the resolution traveler nurses were brought in to help care for patients, and house supervisors were also assigned to care for patients when needed. More beds were made available. The tent to separate COVID hallway from “clean” hallway was reconfigured as needed to accommodate the needs of the current patients. 2)When the rate of falls increased, we focused on the causes. We found that most patient falls were related to use of the restroom. We changed the scripting for hourly rounding from “Do you need to use the restroom” to “I’m here to help you to the restroom.” We also purchased baby monitors to help with monitoring of patients at higher risk of falls. Traveler nurses were brought in to assist with staffing shortages, and house supervisors were required to take a patient load during the busiest times. Staff received additional training in the fall prevention protocol.

14. LINCOLN COUNTY MEDICAL CENTER (CONT.)

Successes:	1) The compliance rate dropped as low as 46% in November and was in the 50% - 59% range for five of the months in the 3rd and 4th quarters. However, we met our goal of 60% for the year with an overall compliance rate of 61% of patients admitted within 30 minutes of bed assignment. 2) Unfortunately, we experienced an increase in inpatient falls well above our goal and ended the year with 3.758 falls per 1000 acute care patient days compared to 1.404 falls per 1000 acute care patient days in 2019. However, our Intensive Care Unit had a stretch of 216 days with no falls during 2020 and our Medical/Surgical unit went 117 days with no falls
Any other information:	1) The availability of beds, increased patient acuities, and number of staff needed to care for our patients were the main issues affecting our compliance.

15. LOS ALAMOS MEDICAL CENTER

Hospital interventions:	1. Los Alamos Medical Center is focused on the reduction of patient preventable harms such as, Hospital Acquired Pneumonia (HAP), Hospital Acquired Urinary Tract Infection (HAUTI), and Surgical Site Infections (SSI). Tactics that we have implemented to address these harms include: • Interdisciplinary harms chart review team created for review of all in-patient charts. Team consists of Physicians, Nurses, Directors, Members of the Executive Team and Clinical Informatics. • Opened new position (CDI) to review coding documentation and query Physicians. • Leadership Rounding on all ER and In-Patients initiated to ensure quality patient care provided and to assist patients and their families with any concerns that they may have. 2. Los Alamos Medical Center continues to have low obstetrical (OB) volume due to lack of a full-time OB/GYN Provider. Our low volume has the potential to impact the competency and skills of the nursing staff, especially in the case of high-risk presentations. Los Alamos Medical Center is mitigating these risks by: • Hiring a full-time OB/GYN Provider • Following a comprehensive OB education and ongoing competency plan. • Completing high-risk drills for situations such as post-partum hemorrhage (PPH), shoulder dystocia and stat c-section on a Covid-19 patient. • Development of competencies and additional skills checks.

15. LOS ALAMOS MEDICAL CENTER (CONT.)

Hospital challenges:	The Covid-19 Pandemic has created quite a few challenges for Los Alamos Medical Center, including reduction of leader rounding on in-patients and delaying the start of the new CDI position. Chart reviews continue a weekly basis remotely.
Any mid-course corrections:	Mid-course corrections due to covid-19 include: Remote meetings Modified leader rounder plan (on non-covid patients) Nursing/physician drills on Covid surgeries and codes. Patient/Family Communication Initiative due to No Visitor Policy
Successes:	1. In 2020, since implementing the interdisciplinary harms chart review team and the leadership rounding on patients, Los Alamos Medical Center had an 80% decrease on all preventable patient harms in 2020, compared to 2019.

16. LOVELACE ROSWELL REGIONAL HOSPITAL

Hospital interventions:	1. Rapid and frequent changes were implemented as the pandemic progressed to our area. 2. PPE conservation measures were put in place. 3. Increased infection control measures were put in place. 4. Readmission reduction efforts were reviewed, and new additions implemented.
Hospital challenges:	1. The constant changes with the pandemic were challenging for our facility. Staff quarantines due to sickness and taking COVID positive patients in our small facility were two specific challenges. 2. We had clinical leadership turnover in key departments.
Any mid-course corrections:	1. We added a daily clinical staffing call to facilitate coverage for any units needing additional staff and to cover the door screener position. 2. Many changes occurred during the pandemic. There were revisions of infection control guidelines, PPE conservation measures, universal masking implemented, visitation guidelines and restrictions, controlled access to the building, screening of every person entering the building, and COVID testing for all inpatients and surgical patients as testing became available.
Successes:	1. An exterior building placed to manage ED patient volumes with adequate equipment and supplies. 2. Conversion of a unit to negative pressure so we could accommodate the increasing volume of COVID positive patients presenting to the ED. Increased equipment and supplies obtained to manage the unit. 3. Conversion of a negative pressure room on the Labor and Delivery unit. 4. Conversion of 4 ICU beds and 4 Med/Surg beds to negative pressure. 5. Staff cross-trained to assist in other units.

17. 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. Along with this we began to better track fluids started by EMTs, hardwired use of the Sepsis Bundle through revisions to Meditech (provider orders). Our Clinical Documentation (CDI) team members continue to make patient rounds with physicians (specifically in the ICU). In addition to continuing these practices, the ICU Sepsis Screening tool (after a trial and revisions) went into effect in August 2020. This screening tool allows for the special circumstances these ICU patients face due to the severity of their illness. To continue to hardwire the process for the code sepsis alerts there is follow-up to the response team encouraging and educating after each sepsis alert. This has increased multidisciplinary attendance for sepsis alerts. This same multidisciplinary team has updated the Sepsis Alert policy to better fit our team and most importantly our patient's needs. Pressure Injuries – A 2 RN assessment of the patient's skin from head to toe on admission and at every shift change bedside report continues. To increase awareness and for learning we continue taking pictures of pressure injuries as patients were admitted to the ICU. Now pictures are also taken for wounds that develop or worsen so that these can be further discussed concurrently and as learning opportunities during unit meetings. Our wound care nurse (WOCN) has recommended a Leaf System-Repositioning Aid that will signal when a patient should be repositioned. Investment into a Wound Vision Thermal Imaging System has also been proposed for future use (may be cost prohibitive).

17. MEMORIAL MEDICAL CENTER (CONT.)

Hospital challenges:	Sepsis – Even with improved recognition and treatment within the Emergency Department, ICU and Medical Surgical floors we have seen an increase in the number Sepsis patients. Many of these patients are COVID-19 patients. Pressure Injuries – With our increase in critical care patients (majority are COVID-19), we have seen an increased number of pressure injuries especially related to prone positioning and critical care equipment.
Any mid-course corrections:	Sepsis – The increased number of Sepsis cases associated with COVID-19 are being tracked/reviewed concurrently to further learn how to treat COVID-19 Septic patients. Pressure Injuries – Team has learned to differentiate wounds caused by the COVID disease/dying process. The team is also attempting very slight position changes with patients who must remain in a prone position with careful attention to location of equipment that is required for these critical patients.
Successes:	Sepsis – Our ICU team has used the new Sepsis Screening Tool specific to the ICU to correctly overhead page the Sepsis Alerts. This allowed for improvement of diagnosis and treatment for several patients who without this new tool may have had Sepsis go unrecognized for an increased amount of time. Pressure Injuries – We have seen many more Pressure Injuries recognized and treated on admission than in previous years due to continued consistent assessment on admission and at the time of Bedside Shift Report.
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.

18. MIMBRES MEMORIAL HOSPITAL

Hospital interventions:	1) Hospital-wide Readmissions 2) Admitting Provider HCAHPS Improvement
Hospital challenges:	1) Hospital-wide Readmissions began showing greater variation and failed to meet the Observed/Expected (O/E) Ratio of =<1 at the end of Q3 2019 and continued through the beginning of Q1 2020. PLAN: The improvement team mapped the process from patient intake and admission on through discharge and post-discharge follow-ups. It was identified that the Patient Navigator, who was responsible for managing many of the steps in the patients flow, including arranging post-discharge PCP follow-ups and ensuring patients had access to prescribed medications and rides to appointments, had taken on another position in the facility at half time. While there were other caregivers and mechanisms in place to ensure that the post-discharge processes continued, communication was not very clear as to when they needed to be used and resulted in some patients being missed. DO: The team redesigned the post-discharge portion of the process by adding a decision point for the Patient Navigator (PN). If the PN was unable to reach the patient or was unable to take on the post-discharge duties due to working in another area, she would notify her Director who assigned another trained caregiver or perform the tasks herself. Discussion of post-discharge cases was also added to the agenda of the daily Case Management department meeting. These changes were implemented on April 10, 2020. STUDY: Initial review of the changes showed that they were effective, and the number of missed post-discharge patient contacts dropped rapidly. The O/E ratio began meeting its goal by June 2020.

18. MIMBRES MEMORIAL HOSPITAL (CONT.)

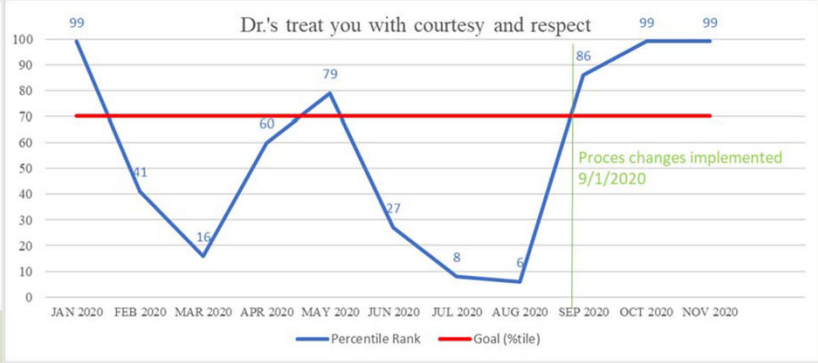
Hospital challenges: Cont.	2) Provider HCAHPS performance on two physician focused measures, Dr.'s Treat You with Courtesy and Respect and Dr.'s Listen Carefully to You, were not meeting the established Top Box percentile rank goal of 70%. PLAN: Analysis of data found great variation in scoring between providers and even with many of the same providers performance month to month. This high level of variation was indicative of a process that was not "hard wired" or, that many of the providers were unclear on the goals or requirements. Data had been shared at the quarterly General Medical Staff meetings, but data had been shared in aggregate, not by individual provider and when asked about the organizations' goals for their HCAHPS performance and none of the providers were able to recall them. DO: A letter from the CEO was sent to each admitting provider. The letter communicated our action plan for improvement and included the three items below: 1. Set Our Expectations- We expect every admitting/attending provider to meet our goalof 70th Top Box percentile. Our patients and their family/visitors should leave feeling that you have treated them with courtesy and respect, and that you have listened to their concerns. You should make every effort to ensure that they understand what you have discussed with them and that they have input into any decision that you make. 2. Provide a Guideline to Help Meet the Goal- Attached you will find a tool with twelve steps to help guide your interactions with patients/family/visitors. You should learn these steps and make an active effort to practice them. 3. Publish HCAHPS Results- Results will be posted monthly in the Med/Surg dictation room and physicians' lounge. Results will have about a two-month lag. September results (posted in November) will be considered the "starting point". Individual performance should improve monthly or be maintained if already at 100th. In addition to the three action items, the letter made clear that providers not showing improvements within the first six months would be addressed by the Medical Executive Committee. STUDY: Improvements in both measures were seen very quickly and both goals were met consistently throughout the following months of the fourth quarter.

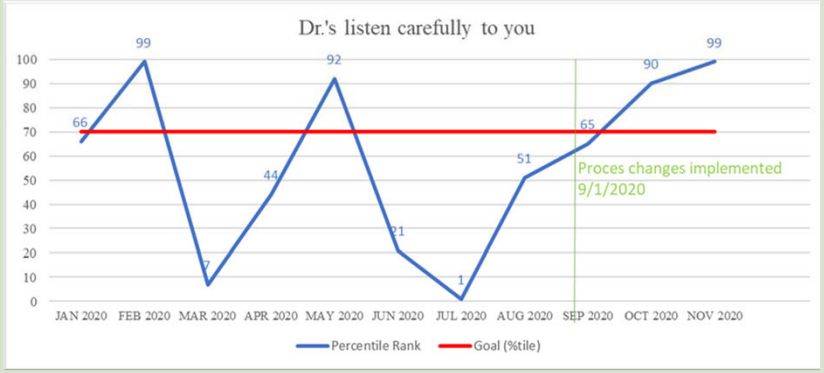
18. MIMBRES MEMORIAL HOSPITAL (CONT.)

Any mid-course corrections:	1) Several post-discharge patient contacts were missed, leading to re-training of all involved staff in the changes and the requirements of the new process section. 2) It was found that there were not enough data points to provide reports monthly. The decision was made to monitor the performance monthly and provide quarterly results to the providers.
Successes:	1) ACT: Ongoing monitoring showed a 47.9% improvement (reduction in O/E ratio) from the 8 months post-implementation over the 8 months baseline. Monitoring of the process is ongoing and any incidents are evaluated and addressed immediately. 2) ACT: Changes made were effective with 50.72% improvement in Dr.'s Treat You with Courtesy and Respect and 37.84% improvement in Dr.'s Listen Carefully to You. Monitoring will be ongoing. Issues will be addressed with the individual.

18. MIMBRES MEMORIAL HOSPITAL (CONT.)

Any other information:





19. MINERS' COLFAX MEDICAL CENTER

Hospital interventions:	1) Hospital Fall Prevention No matter how good the fall prevention program is in concept, if it is not used by the staff it will not be successful. We took the following steps: • Assessment of needs • Set goals. • Begin preparing for change. • Examine best practices. • The Nurse Leadership Team worked with the clinical staff to implement the prevention practices at the frontline care level. 2) Surviving Sepsis Campaign Bundles are the core of the sepsis improvement efforts by simplifying the complex process of the care of patient with severe sepsis. The Sepsis Campaign Hour-1 Bundle of Care consist of: • Initial blood lactate level • Blood cultures prior to antibiotics • Antibiotics administered timely. • Crystalloid for fluid challenge • Vasopressors for hypotension Weekly meetings to review sepsis charts from inpatient and Emergency department to collect data for each subset of the measure occurred. Attendees are Chief Nursing Officer, Infection Preventionist, Quality Manager, Care Manager, Emergency Department Manager and Acute Care Manager. We acted on findings and shared with appropriate physician committees

19. MINERS' COLFAX MEDICAL CENTER (CONT.)

Hospital challenges:	Hospital Fall Prevention 1. Limited resources compounded by pandemic conditions and contract staffing challenges the delivery of consistent evaluations for patient falls. 2. Constant turnover creates the need for education and re-education of clinical staff. 3. Inconsistent hand off communication between caregivers. 4. Acting and communicating the results of the chart audits to create effective change in the delivery of patient care services. Surviving Sepsis Campaign Bundles 1. Limited resources compounded by pandemic conditions and contract staffing challenges the delivery of consistent evaluations for sepsis. 2. Constant turnover creates the need for education and re-education of nurses, physicians, and lab personnel. 3. Inconsistent hand off communication between caregivers and providers from emergency department to the inpatient setting. 4. Need for permanent leader in the emergency department. 5. Acting and communicating the results of the chart audits to create effective change in the delivery of patient care services.
Any mid-course corrections:	None

19. MINERS' COLFAX MEDICAL CENTER (CONT.)

Successes:	1. NONE
Any other information:	Hospital Fall Prevention 2019 Fall Count: 6 2019 Fall Rate (HIIN): 0.69 (Patient Fall Injury/Patient Days) 2020 Fall Count: 10 2020 Fall Rate (HIIN): 2.55 (Patient Fall Injury/Patient Days) Surviving Sepsis Campaign Bundles • Initial blood lactate level ○ Q4 50% • Blood cultures prior to antibiotics ○ Q4 100% • Antibiotics administered timely ○ Q4 25% • Crystalloid for fluid challenge ○ Q4 75% • Vasopressors for hypotension ○ Q4 No data

20. MOUNTAINVIEW REGIONAL MEDICAL CENTER

Hospital interventions:	The major focus areas for MountainView Regional Medical Center in 2020 were Patient Safety Event Reduction, Heart Failure Mortality Reduction, and CLABSI Reduction. Patient Safety Event Reduction: The implementation of clinical huddle was a very successful initiative to ensure knowledge of events in real time and allowance of immediate intervention. Process improvement occurred with unit directors reviewing events and completing RCAs for gaps in care. The sustainability of the process was important for ongoing success. Continuing improvement with a reduction after nearly a 50% reduction in events from prior year was a lofty goal. Heart Failure Mortality Reduction: Mortality reviews are conducted within 7 days of the date of death. It was important to understand if the deaths were expected or if best practices were followed. The first steps in the focused approach were to ensure evidence-based admission order-sets were current and implemented. Then during the mortality review process, the utilization of the order set for each heart failure mortality was audited. CLABSI Reduction: A multipronged process was utilized to approach this reduction initiative. A focused team was brought together to understand current practices. The focus team identified areas of opportunity and the action items identified were policy review, skills review for placement and care of lines, duration of lines, and appropriate use. In the first quarter of 2020 a team from Becton Dickinson was brought on site to help with a prevalence study, to examine practice patterns, and product evaluations.

20. MOUNTAINVIEW REGIONAL MEDICAL CENTER (CONT.)

Hospital challenges:	Patient Safety Event Reduction: The areas identified as greatest need were Post-Operative Sepsis (PSI 13) and Pressure Injury (PSI 3). The obvious challenge for 2020 that impacted our ability to affect change was related to COVID 19. We made many changes to our delivery of care model, to include a reduction in surgery, increase in high acuity patients, substantial increase in high acuity patient volume, and longer lengths of stay. All of which are causal agents for Post-Operative Sepsis and Pressure Injury. Heart Failure Mortality Reduction: The order-sets in the Electronic Medical Record were reviewed against the latest evidence for any required updates. They were then presented to the Hospitalist Medical Director and Chief of Medicine for approval and implementation. Education was provided to the admitting physicians and resident teams for utilization. CLABSI Reduction: A significant increase in line utilization was seen with the treatment of COVID 19, as many patients were septic and requiring vasopressor support for hemodynamic stability. Many of these lines were placed emergently and in locations that are at higher risk of developing an infection such as the groin and neck. Efforts were thwarted to remove lines as many were determined to meet appropriate use criteria and necessary. When possible, emergent lines were replaced with a PICC line to a site at a reduced risk of infection.

20. MOUNTAINVIEW REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	Patient Safety Event Reduction: As engineering controls were implemented to support the safety of staff members, many meetings, including clinical huddle were put on hiatus. A mid-year evaluation of necessary meetings was conducted and as meetings were determined to be mission critical, they were added back to the schedule in a virtual or hybrid model. Heart Failure Mortality Reduction: Patients who presented to the hospital for care were at a much higher acuity level than in previous years and further advanced in their disease process requiring higher level s of care and more interventions. This was an unintended impact of COVID 19. We also noted a trend of patients being admitted with suspicion for COVID 19 and the COVID 19 specific order set was consistently chosen over the Heart Failure Order set, which was not clinically incorrect. CLABSI Reduction: Mid-course evaluation for this initiative was related to evaluation of line utilization and appropriate utilization with ongoing monitoring.

20. MOUNTAINVIEW REGIONAL MEDICAL CENTER (CONT.)

Successes:	Patient Safety Event Reduction: Overall, Patient Safety Event Reduction from prior year was 30%, in such a turbulent year, that is a reduction of great success. Major reductions were noted in Post-Operative Sepsis. It was evaluated whether this was a direct correlation to surgery reduction, and it was determined that a lower denominator made fewer events impactful but was not the sole source of reduction in events as our case mix index was over 2 for most of the year. Successes were related to early identification of sepsis and aggressive resuscitation. Heart Failure Mortality Reduction: Ongoing efforts are needed in this focus area. In 2020 the overall mortality rate was 15% higher than prior year. 27% of the overall mortalities were attributed to COVID 19. The case count for heart failure attributed mortalities remained flat over prior year. CLABSI Reduction: 2020 Q4 proved to be quite challenging for this initiative. We saw our greatest number of line days in the history of the hospital during our COVID 19 peak. Crisis capacity and care strategies were implemented and an increase in subsequent infection rates was noted. This initiative will be carried over to 2021.
Any other information:	Unprecedented care strategies and capacities were undertaken with alternate care sites and aggressive utilization of clinical teams. Our care system was on the brink of being overwhelmed at the time in which we experience our highest rates of complication events. COVID 19 continues to impact our delivery method and we are continuing to implement new strategies to adapt and provide the highest quality and safe care.

21. NOR-LEA GENERAL HOSPITAL

Hospital interventions:	•Improve the safety of NLHD healthcare workers and patients in a global pandemic. Improve the availability of PPE, reduce non-patient visitors, and standardize PPE use and cleaning and sanitizing processes to eliminate cross-contamination between COVID positive patients and non-COVID patients and staff. Developed a process for making cloth face coverings with a filter to protect staff during nonpatient interactions to reduce staff to staff exposures. Developed new standardized cleaning and sanitization processes for environmental services for all types of cleaning required in a hospital environment for both the inpatient and ambulatory care areas. Implemented Biomist sanitizing spray mist in areas of rapid turn-around is necessary. Local community partners donated PPE for the hospital's immediate needs and worked with vendors outside of normal supply chains to build up supply of PPE. Insytu virtual observation drill of a COVID patient in the ED and moved to the inpatient unit allowed NLHD to receive feedback to improve safety of staff by highlighting areas for improvement. Standardized donning and doffing of PPE to eliminate confusion of the order of donning and doffing instructions from the CDC with the PPE that NLHD had in stock. •Improve the identification of COVID positive patients in the community to reduce the spread of nCOVID-19. Put in public call center to answer questions and allow public to get tested when symptoms developed during the early pandemic. •Improve coordination of care and patient engagement in their healthcare through the implement EPIC EHR and use of the patient healthcare MyChart App. throughout NLHD.
Hospital challenges:	•Global shortages of PPE caused supply chain issues with maintaining adequate levels of PPE. Used partnerships with local business donated PPE and used vendors outside of the normal supply chain to fulfill immediate needs. CDC instructions for donning and doffing PPE caused contamination of staff, used best practices and published donning and doffing instructions specific to the PPE in-house. Also, published PPE reuse instructions for N95s from best practices from ICU nurses to prevent contamination. Lack of sanitizing equipment to turnover beds quickly in between patients. Worked with local partners to find solution for cleaning and sanitizing and borrowed a best practice from EMS whose equipment is difficult to sanitize and they used Biomist. •Lack of testing equipment and supplies. Lack of testing personnel to adequately staff the testing sites. Closed services to move staff to testing locations as necessary, worked with local healthcare partners for volunteers into testing sites, and put mobile drive through testing sites in place to improve access and reduce exposure for staff and patients. •EPIC system would not allow small hospitals to implement the EPIC system. Affiliation and relationship with CMC in Lubbock allowed NLHD to use the Community Connect Providence benefit for EPIC clients to implement the software system.

21. NOR-LEA GENERAL HOSPITAL (CONT.)

Any mid-course corrections:	•Evaluated and prevented inferior PPE products from patient care units from donated PPE. Coordinated and established communication with community, staff, and leaders to give regular updates that summarize all the updates from the CDC, NMDOH, WHO, and various professional sources. •Coordinated with local DOH office on testing times and locations to allow for expanded testing times. •Coordinated training times to comply with nCOVID-19 restrictions and allow staff to get properly trained and ready for implementation.
Successes:	•Evaluated and prevented inferior PPE products from patient care units from donated PPE. Coordinated and established communication with community, staff, and leaders to give regular updates that summarize all the updates from the CDC, NMDOH, WHO, and various professional sources. •Coordinated with local DOH office on testing times and locations to allow for expanded testing times. •Coordinated training times to comply with nCOVID-19 restrictions and allow staff to get properly trained and ready for implementation.

22. PLAINS REGIONAL MEDICAL CENTER

Hospital interventions:	1)Plains Regional Medical Center ended 2019 with a C. Diff infection rate of 5.4 per 10,000 inpatient census days. PRMC set a target to reduce the incidence of C. Diff infections to 3.35 or below per 10,000 inpatient census days for 2020. As an intervention our entire leadership team made it a point to be informed of C-Diff cases and aware of progress towards meeting our year-end target. The Infection Control Practitioner included Housekeeping along with Nursing departments to collaborate in mitigating any risks which could result in further cases. 2)In 2019 Plains Regional Medical Center (PRMC) had 26 patient falls or a rate of 2.5 per 1000 acute care patient days, 6 with injury. Falls became a focus for patient safety and an interdisciplinary falls team was developed. The fall team met monthly investigating the falls and possible contributing factors. The 2020 target of 2.30 per 1000 acute care patient days was set.
Hospital challenges:	1)Due to the pandemic, our inpatient census days were lower than anticipated. 2)Due to the pandemic and the decrease in acute care patient days would make this target more difficult to achieve.
Any mid-course corrections:	1. 1) In August we had 3 occurrences of C. Diff infections. A thorough investigation of the infections was completed and deep cleaning of the unit where the cases occurred was performed utilizing the UV light. Education was provided to the nursing and EVS staff by the Infection Control Practitioner.
Successes:	1) After the cases in August, PRMC did not experience any further incidents of C. Diff for the 2020 year. The C. Diff Infections per 10,000 inpatient census days rate for December 2020 was at 3.0 meeting the goal for the month. 2) Year-end target was surpassed with a rate of 2.11 per 1000 acute care patient days

23. REHOBOTH MCKINLEY HOSPITAL

Hospital interventions:	The clinical benefit of intravenous (IV) alteplase in acute ischemic stroke is time dependent. In 2019, Rehoboth McKinley Christian Health Care Services (RMCHCS) met the 60-minute benchmark 42.9% of the time. The stroke team examined each step in the stroke protocol and noted that the longest period that could be improved was the "Order to tele-stroke connection." In November of 2019, the process was changed, and the tele-stroke order was placed as part of the initial stroke orders instead of waiting for the radiology results and then determining if a neurology consult was necessary. This early order prompts the nurses to establish the tele-link while the patient is in radiology and gives time to troubleshoot any problems with the link before the CT results were back and the tele-link was necessary. When the COVID-19 pandemic hit McKinley County in March, hospital goals and priorities changed, and Rehoboth McKinley County Health Care Services went from testing a few people per week to over 100 people per day within a few weeks. Testing strategies quickly evolved and we were early adopters of an open testing strategy (test anyone regardless of symptoms) as our positivity rates soared. The testing also required education on isolation. Because COVID was a novel disease state with new data emerging daily coupled with public misinformation we created a process for reinforcement of isolation education. Patients received isolation education when tested and then again when called with results. This follow up education was key as we found misunderstandings and helped troubleshoot difficulties with isolation to help prevent the continued spread of COVID.
Hospital challenges:	Placing the neurology tele order as the initial set of orders was an easy intervention, but it took education and feedback with the nursing team to finally reach the "Order to tele-stroke connection" 25-minute benchmark 100% of the time. It was difficult to update our testing strategy and education and ensure staff were knowledgeable of the latest testing guidelines and isolation instructions to provide a consistent message to our patients. Information from the CDC changed almost on a daily a basis early in the pandemic and manpower was limited due to the size of our organization coupled with McKinley County was listed as having the highest rate of COVID per capita, twice by the New York times.

23. REHOBOTH MCKINLEY HOSPITAL

Any mid-course corrections:	There were no course corrections, the intervention continued to show improvement with education and feedback. Initially staff volunteers were utilized to decide if individuals met testing criteria and educating patients creating inconsistencies in understanding the latest testing and education information. With information from the CDC and the New Mexico Department of Health changing, sometimes several times per day, and the community experiencing many "firsts" in needing to test for COVID it was decided to establish one provider to help standardize the testing process and patient education.
Successes:	The "order to tele-stroke connection" in less than 25 minutes adherence was 11% for quarter 3 of 2019. During quarter 4, the intervention was created, and adherence increased to 82% by the end of quarter 1, 2020 and reached 100% in quarter 3 of 2020. Receiving alteplase within in 60-minute of arrival increased from 42.9% compliance in 2019 to 100% in 2020. RMCHCS tested, notified, and educated 17,696 patients in 2020. The early adoption of open testing (no criteria) and educating patients twice on isolation (when tested and when called with results) helped flatten the curve in McKinley County. The number of tests has decreased, and we have successfully incorporated a process for COVID testing and education that has been absorbed by our Urgent Care.

24. ROOSEVELT GENERAL HOSPITAL

Hospital interventions:	CHF/COPD Re-admits – Roosevelt General Hospital's (RGH) readmission rate for Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) patients is higher than the national average. With that knowledge, Quality gathered a multidisciplinary team and began planning our approach. The team decided to begin educating these specific patient populations upon admit. They would receive folders of educational material and exercises that the Case Manager would provide and frequent during their stay. The educational materials would contain information regarding their disease processes and information on what warning signs should prompt them to make an appointment with their primary care provider—all in the hopes to avoid hospitalizations for these patients. Patient Experience – in 2019 the Quality department started a Patient Experience Committee and began sharing Press Ganey survey questions/results from the Board of Directors to the frontline staff. In 2020, we hired an Education Coordinator who would also charge patient experience. Our Education Coordinator has begun attending staff meetings and further educating all employees. Metrics regarding patient experience have been added to the Education Coordinator's Quality dashboard and will be reported to the Quality Management System Oversight Committee on a quarterly basis.

24. ROOSEVELT GENERAL HOSPITAL (CONT.)

Hospital challenges:	Currently there are two major challenges (beyond COVID) at RGH: the electronic medical record (EMR) and the size/privacy for patients in the Emergency Department (ED). Both were named as challenges for 2019—the difference is that for 2020, the challenges in addition to operating with an inefficient EMR and insufficiently sized ED, we are experiencing the pains of progress. EMR: Building a new EMR to suit the needs of any hospital is a tremendous undertaking. Building a new EMR in the middle of a pandemic, during an ED construction project, quality grant project, and implementation of a new document warehousing system is purely chaotic. The staff at RGH will truly appreciate their ordinary level of busy as soon as these major projects are complete. ED: during the construction of the new ED, the construction crew has taken occupancy of a significant amount of our already limited parking. Where the staff are frustrated, they also have the final product in sight; we are fortunate to have employees who can see the big picture and know that this new ED will benefit our community greatly. With the implementation of our new EMR (going-live 1 March 2021) and the opening of our newly expanded ED (opening late March 2021), we have an opportunity to readdress throughput issues that we have been experiencing for years due to the limitation of our current EMR. We are making plans now to have these processes mapped out and ready to implement upon go-live.
Any mid-course corrections:	PASS: Through investigation during a Root Cause Analysis (RCA), which was performed due to an unexpected event in the Operating Room (OR), it was found that patients of a certain provider were not being cleared through our established Pre-Anesthesia Surgical Screening (PASS) program. This program extensively researches our patients' medical history and performs further testing to assure that patients are safe to undergo anesthesia. Quality put out an urgent memo to the RGH Surgical Services Department and all Surgical Services Providers, notifying them that effective immediately, 100% of patients who are to undergo anesthesia are to go through the PASS program. This has become a metric that is now being tracked on the Surgical Services quality dashboard and on the provider scorecards.
Successes:	A major success for RGH in 2020 was our response to COVID-19. Early in the pandemic, we developed an interdisciplinary team, turned "Pandemic Response Team", and set a response plan in motion. We were overprepared and had to scale back our response, which allowed us to have the foresight of how our plan would work for what was to come. Where we have been very fortunate in not having had a surge of positive cases until around August of 2020, we have also been very fortunate to not have to work beyond our capacity. From early response to now providing vaccines, the employees of RGH truly came together as a team to fight this public health disaster head-on.

25. SAN JUAN REGIONAL MEDICAL CENTER

Hospital interventions:	Hospital Acquired Pressure Injuries Prevention of pressure injuries is instrumental in mitigating a wide range of undesired patient outcomes and increased healthcare costs. In response, SJRMC has 1) convened Hospital Acquired Pressure Injury (HAPI) committee to meet weekly to investigate all pressure injuries 2) utilized a dedicated provider to assist in appropriate assessment and documentation of pressure injuries, and 3) continued education efforts to new and existing staff. Falls and Trauma SJRMC's quality improvement goal for falls aimed to ensure the implementation of recent evidence-based best practices to eliminate falls, with or without trauma. In 2021, SJRMC employed many of the same improvement initiatives instituted in 2020, such as 1) No Pass Zone practice and policy, 2) utilization of the post-fall huddle tool and process, and 3) staff education.
Hospital challenges:	Hospital Acquired Pressure Injuries • Level of patient acuity, prone positioning, and respiratory requirements. • SJRMC had 5 PSI-3(s) during calendar year 2020, resulting in a rate of 0.68, above the HQII Demonstration Year 7 target of 0.53. Falls and Trauma • Application of the fall risk assessment and Post Fall Huddle process and expectations continue to vary among staff. • Level of patient acuity and COVID safe practices required to respond quickly to patient call lights and toileting needs.

25. SAN JUAN REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	Hospital Acquired Pressure Injuries Utilization of alternative care team members to assist nursing in patient mobilization during COVID-19 peak periods. Implementation of prevention measures for prone patients. Falls and Trauma Utilization of alternative care team members to assist nursing in patient mobilization during COVID-19 peak periods
Successes:	Hospital Acquired Pressure Injuries Hospital acquired pressure injuries will remain a high priority area of focus in 2021. Falls and Trauma San Juan Regional Medical Center's HQII Falls and Trauma measure rate for calendar year 2020 has reduced to 0.00. Fall prevention process improvements will continue in 2021.

26. SIERRA VISTA HOSPITAL

Hospital interventions:	We identified two major areas of concern at Sierra Vista Hospital 1. Pneumonia: Blood Cultures before Antibiotics 2. Readmissions Code 44s: Inpatient to Observation Conversions
Hospital challenges:	Pneumonia: With contracted travel hospitalists and nursing staff, consistency was an issue. Readmissions: Any readmission is a problem with low census levels. However, we noticed that we were also getting a high percentage of Observation patients returning too.

26. SIERRA VISTA HOSPITAL (CONT.)

Any mid-course corrections:	Pneumonia: We had poor consistency trying to work with the providers. We decided to have this a nursing responsibility – to not hang antibiotics until blood cultures are done. It has continued to be an issue, so we are adding Core Measure Compliance to our Provider Report Cards. This has worked in the past with performance issues. Past compliance rates were 54% in FY-19, and 75% in FY-20. Our goal is to achieve 90% compliance by the end of FY-21. Readmissions: This is a significant concern for our facility. With an average monthly census of 22-26 inpatients, we also average 2 readmissions per month. To help reduce readmissions, we implemented follow-up calls after discharge. However, compliance with this was an issue (62% in FY-19 and 65% in FY-20). In October 2020, we moved this duty to Case Management. Compliance has since improved to 84%. We also provided Discharge Planning training to all our Case Managers to ensure we are discharging them with everything they need after discharge. The Case Managers inquire during the follow-up call to ensure that all discharge plans were completed or implemented. (Example: home health initiated, O2 or other home equipment arrived, and Rx's were picked up.) In addition to Inpatient Readmissions, we noticed 1-3 Observation readmissions each month. In the past, we only did follow-up calls to our Inpatients. We plan to expand this to our Observation patients as well to reduce their readmissions. We also suspected that some providers tended to discharge patients more quickly than others. We have begun to track this and plan to include Readmissions on our Provider Report Cards.
Successes:	We were having frequent Code 44s (Inpatient to Observation Conversions); 1-3 per month. We began to require an MCG (Milliman Care Guidelines) review prior to all admissions to check appropriateness of the admission; then required a Case Management consult for appropriate level of care. Since July of 2020, we have not had a single Code 44.
Any other	Overall, our Inpatient quality measures have been excellent. Our last hospital acquired VTE was November of 2019.

NC0

Slide 102

NC0 fix font

Nicole Comeaux, 2022-06-03T20:38:58.514

27. SOCORRO GENERAL HOSPITAL

Hospital interventions:	1) D5 Diabetic Bundle: 2019/2020 focus for Socorro General Medical Group was D5 Bundle. All staff completed visit planning before the visit and used Health Maintenance as a guide to pen orders for labs to provider when scrubbing schedules and during rooming. Abstract results into chart as needed. Part-time Care Manager assisting remotely. 2) Reduction in Restraints: In 2020 Socorro General Hospital (SGH) focused on reducing the use of restraints. The project included two aims, reduce the number of restraints, and improve documentation. SGH leadership considered the use of restraints to be high risk and low volume. SGH population includes patients with mental health/substance abuse issues and elderly patients who frequently exhibit disorientation and violent behavior. Restraints are used to ensure the immediate physical safety of patients, staff members, or others. To accomplish this SGH implemented the following: 1. Assign only trained sitters to every patient who may have required restraints as an alternative prior to initiating restraints. 2. Accurate and detailed documentation of periodic physical assessment, monitoring and outcome. Due to the low volume, perform a mock restraint exercise to evaluate the interventions above
Hospital challenges:	1) Covid-19 pandemic caused decreased compliance with patients due to fear of exposure. Priorities were changed to safety: PPE (personal protective equipment) and minimize potential exposures. 2 primary care providers resigned. Remote care manager resigned. Posted positions and filled care manager position in September. Minimal training available until Covid-19 restrictions are lifted. 2) Due to COVID priorities the Hospital was unable to perform the mock restraint exercise.

27. SOCORRO GENERAL HOSPITAL (CONT.)

NC0

Any mid-course corrections:	1) Transition to Covid-19 safe practices: Alternate Care Site implemented using tent in parking lot to maintain on-site access to care for all patients. Priorities were changed to safety: PPE and minimize potential exposures. Tricore lab draw site was placed outside and screener placed in sub-waiting area to identify Person under investigation, (PUI), and decrease any exposures after re-opening in-house visits for non PUIs. One provider working remotely assisted with all in-basket orders and questions from Diabetic patients, as well as referrals to specialties as needed to expedite care for patients who lost their primary care provider from resignations. Continuity of care managed in this way. 2) During the 1st quarter 2020 one patient required restraints. Review of documentation revealed gaps. Staff were retrained on proper documentation of restraints.
Successes:	1) Set the standard for safe access to continued care throughout the peak of pandemic. Telemedicine implemented to continue care as well. Staff continue to screen all on site visits for D5 criteria needs. Care Manager calling patients and pending orders to assist with compliance. Plans for 2021 to implement Food-RX program which will give free prescriptions for healthy food at local farmers market. Volunteered as a pilot site for SDOH (Social Determinants of Health) to identify patients who may need more resources. Audits and trainings to provide high risk patients documented in EPIC. Community Health Worker is point of contact for these programs, as well as assisting Diabetic patients in getting medication and referrals as needed. 2) No other patients required restraints in 2020. As a result of the 1st Quarter event a Restraint Reference Binder was created as a guide for the management of patients who may require the use of restraints.
Any other information:	1) D5 Bundle Components: BP<140/90, Hemoglobin- A1C<8, LDL<100 or statin on med list, Microalbumin test or ACE/ARB on med list, and Eye Exam or eye exam claim. Year-end target for 2019: 47.2%. Actual: 50.1%. Year-end target for 2020: 27.20%. Actual: 20.0%. 2) The Restraint Reference Binder was deemed leading practice by Regulatory consultants and was shared throughout the enterprise.

Slide 104

NC0 fix font

Nicole Comeaux, 2022-06-03T20:39:10.749

28. UNION COUNTY GENERAL HOSPITAL

Hospital interventions:	1. The lead Pharmacist is enrolled in an Antimicrobial Certificate Program. 2. Lab and Pharmacy are in the midst of implementation of antibiogram to guide an empiric antibiotic selection and to detect bacterial resistance patterns. 3. Continuing to monitor IV to PO antibiotic conversions and antibiotic selection. 4. Proactive at increased infection control practices when COVID pandemic started.
Hospital challenges:	1. Medicaid Office still on hold due to COVID. 2. Sleep study program had started back in June but placed back on hold in September due to COVID. Plans to resume in March. 3. Inpatient and outpatient numbers still reduced. 4. Press Ganey scores still below target. This is possibly due to no visitation throughout most of the year. Visitation restrictions have been lifted to one visitor per 24 hours from 10-3.
Any mid-course corrections:	NA
Successes:	1. RHC opened in September in Des Moines. 2. Influenza Immunizations for employees at 100%. 3. Influenza Immunizations for patients at 100%. 4. COVID vaccinations among hospital employees at 89%. 5. COVID vaccination clinics being offered for community.
Any other information:	1. The lead Pharmacist is enrolled in an Antimicrobial Certificate Program. 2. Lab and Pharmacy are in the midst of implementation of antibiogram to guide an empiric antibiotic selection and to detect bacterial resistance patterns. 3. Continuing to monitor IV to PO antibiotic conversions and antibiotic selection. 4. Proactive at increased infection control practices when COVID pandemic started.

NC0

Slide 105

NC0 fix font

Nicole Comeaux, 2022-06-03T20:39:22.687

29. 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). • UNMH is continuing our work on Hospital Acquired VTEs with a recently formed workgroup that will review individual cases. This is an extension of the Program for Rounding on VTE Prophylaxis and Effective Infection Control (IMPROVE_IT) Project that has shown a consistent decrease in the preventable DVTs, CLASBIs and CAUTIs in the adult patients. • The hospital is continuing mortality data review with a focus on sepsis and PSO-04: Death Rate Among Surgical Inpatients with Serious Treatable Conditions. • Initiation of preoperative surgical frailty scoring.
Hospital challenges:	• The rate of pressure ulcers remains unchanged between 2019 and 2020. • The patient volume and acuity due to the COVID pandemic has led to numerous challenges with standard nursing practices.
Any mid-course corrections:	Creation and implementation of enhanced organizational structure to align resources and drive performance improvement toward desired outcomes (in process).
Successes:	The hospital has downward trends, from the previous year in: • Surgical Site Infections for C Sections. • Surgical Site Infections for Colon Surgery. • Surgical Site Infections for Abdominal Hysterectomies. • Post-Operative Deep Vein Thrombosis. • Mortality Index

HUMAN SERVICES DEPARTMENT

THANK YOU

INVESTING FOR TOMORROW, DELIVERING TODAY.