HUMAN SERVICES DEPARTMENT

HEALTH QUALITY IMPROVEMENT INCENTIVE (HQII)

INVESTING FOR TOMORROW, DELIVERING TODAY.

HUMAN SERVICES DEPARTMENT

MISSION

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

GOALS

We help NEW MEXICANS

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

We communicate EFFECTIVELY

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

We make access EASIER

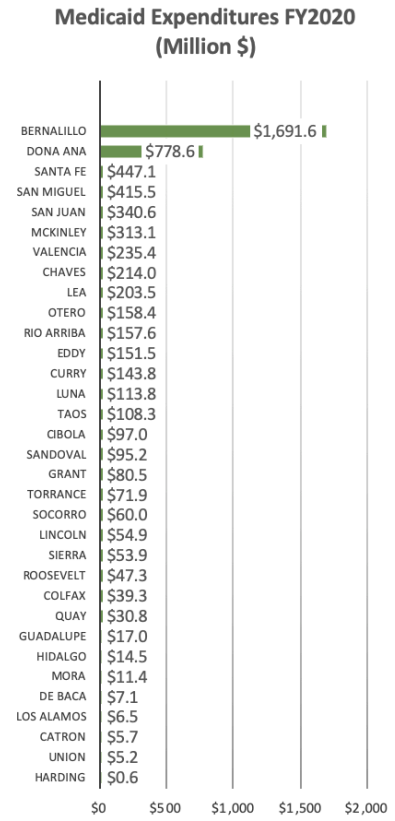
3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

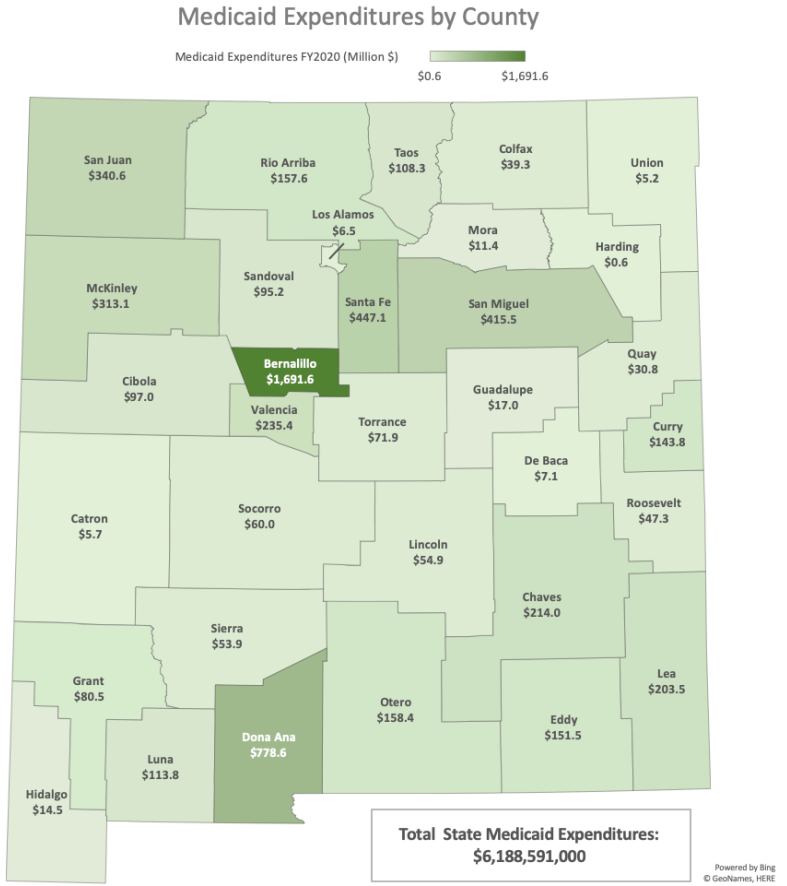
We support EACH OTHER

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

GUIDING MEDICAID PRINCIPLES

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





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

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

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

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

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

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

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

Outcome Domain 1: Urgent Improvements in Care

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

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

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

Outcome Domain 2: Population-Focused Improvements

These have been updated to the ICD 10

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

1. ADVERSE DRUG EVENTS

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

A. Hypoglycemia in Inpatients Receiving Insulin

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

Denominator - inpatients receiving insulin or other hypoglycemic agents.

B. Adverse Drug Events due to Opioids

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

Denominator - number of inpatients who received an opioid agent.

C. Excessive anticoagulation with Warfarin – Inpatients

Numerator – inpatients experiencing excessive anticoagulation with warfarin.

Denominator - inpatients receiving warfarin anticoagulation therapy.

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

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 indwelling urinary catheter days for each location under surveillance for CAUTI.

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

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.

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

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://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_18_Obstetric_Trauma_Rate%E2%80%93Vaginal_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.

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

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".

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

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

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

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

DOMAIN 2 MEASURES

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

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

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

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

ALTA VISTA REGIONAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

ARTESIA GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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CARLSBAD MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	No
-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)

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CHRISTUS ST. VINCENT HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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	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)

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CIBOLA GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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	No
Pressure Ulcer Stage III & IV rate	Yes

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

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DR. DAN C. TRIGG MEMORIAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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EASTERN NM MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

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
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	Yes
Pressure Ulcer Stage III & IV rate	Yes
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	Yes

Percentage of overall improvement 73%
(improved in 7 of the 11 eligible measures)

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ESPAÑOLA HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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GERALD CHAMPION REGIONAL MEDICAL CENTER
HQII REPORTING RESULTS FROM DY5 TO DY6

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	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 100%
(improved in 11 of the 11 eligible measures)

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GILA REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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GUADALUPE COUNTY HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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)

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HOLY CROSS HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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LEA REGIONAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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)

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LINCOLN COUNTY MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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LOS ALAMOS MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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LOVELACE ROSWELL REGIONAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

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)

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MEMORIAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	Yes
-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)	Yes

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

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MIMBRES MEMORIAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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)

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MINERS' COLFAX MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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MOUNTAIN VIEW REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	Yes
-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)	Yes

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

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NOR-LEA GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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PLAINS REGIONAL MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

Measures (Eligible measures only)	Showed Improvement or Met the Minimum Requirement
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	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 100%
(improved in 11 of the 11 eligible measures)

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REHOBOTH MCKINLEY HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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ROOSEVELT GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

SAN JUAN MEDICAL CENTER

HQII REPORTING RESULTS FROM DY5 TO DY6

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

Percentage of overall improvement 82%
(improved in 9 of the 11 eligible measures)

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

SIERRA VISTA HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

SOCORRO GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

UNION COUNTY GENERAL HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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

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

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

UNIVERSITY OF NEW MEXICO HOSPITAL

HQII REPORTING RESULTS FROM DY5 TO DY6

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
Central Line Associated Blood Stream Infections (CLABSI)	Yes
Falls and Trauma	No
-OB vaginal laceration w/instrumentation	Yes
-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)	Yes

Percentage of overall improvement 73%
(improved in 8 of the 11 eligible measures)

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

ALTA VISTA REGIONAL HOSPITAL

Hospital interventions:	ICP returned in August of 2018 fulltime and immediately implemented patient daily rounding with Physicians for collaboration of care regarding Foley Catheter utilization. ICP also reviewed nurse driven Foley Catheter protocol and provided one on one education to nursing staff. Foley Catheter Utilization improved by 10% in all settings and improved by 33% in ICU areas. Opioid Safety improved by 67% in the reporting period. Through data stratification and discussions in the Pharmacy and Therapeutics Committee, one recommendation from the committee to assist in decreasing the use of hydromorphone on the inpatient nursing floors was to stock and make available lower doses to use in pain management. Nursing then began a Performance Improvement project that involved auditing patient charts to ensure proper pain assessment and reassessments were being done and pain was being addressed accordingly.
Hospital challenges:	Overall Sepsis mortality is the measure where Alta Vista has the worst performance. After performing Mortality reviews and investigations, it was noted that hospital providers could have improved on the conversations had with family members regarding Comfort and or Palliative care. Our hospital does have a Case Manager available for coordination of family meetings; however, we do not have any social workers on staff.
Any mid-course corrections:	Pharmacy and Therapeutics committee added the topic of "Non-Pharmacological" interventions to the Quarterly Agenda to assist with safely managing pain in our patients. The Joint Commission standard regarding Opioid Stewardship provided evidence-based practice regarding Non-Pharmacological interventions for pain and new performance indicators were put forth.
Successes:	Our Hospital had zero CAUTI's in all settings, including ICU. Success includes ICP active involvement with patient rounding, one on one education with frontline nursing staff, communication and coordination with laboratory staff to ensure urine cultures are collected timely.

ARTESIA REGIONAL HOSPITAL

Hospital interventions:	1. Improve patient satisfaction in the Med/Surg unit by facilitating communication and patient feedback prior to discharge. 2. Developed Annual Skills Fair to train staff.
Hospital challenges:	1. Lack of training and limited resources to implement intervention and monitor outcomes.
Any mid-course corrections:	1. Reassignment of staff members in the Case Management Department to survey Med/Surg unit in a daily basis and request patient feedback. 2. A Clinical Educator position was added to work closely with CNO resulting in the implementation of Annual Skills Fair.
Successes:	1. Prompt resolution to patient's complaints and decrease in the number of grievances generated. 2. Improved knowledge and skills of staff directly translated into the development of a Suicide Prevention Program, with patients being evaluated in the ED by a Social Worker. The skills gained during the Annual Skills Fair allowed for prompt identification of suicide risks and increased patient satisfaction as well.
Any other information:	1. Review of PI projects was completed – Sepsis Measures were reassessed and there was no need for corrective action.

CARLSBAD MEDICAL CENTER

Hospital interventions:	We initiated contact with ECO-Lab for our infection prevention/terminal cleaning in the OR program. We began a new program of pharmacy educating patients on their medications. We started having multidisciplinary Sepsis team meetings. We began a new program of infection prevention education for our patients. We initiated a process for patient education using discharge folders.
Hospital challenges:	The aging physical plant with resulting maintenance issues was a big challenge for us. Our ability to hire and retain new employees has also been a unique challenge to our region due to the oil and gas production industry. This has resulted in severe housing shortages and diminished labor resources. We started our Swing Bed program in 2018. HCAHPS continue to be a huge challenge for us. We struggled with our wound care program in many areas including ensuring pictures of wounds were taken and documentation was comprehensive.
Any mid-course corrections:	We modified our wound care program to include a certified wound care nurse. New wound care policies were written and education for the staff was rolled out. We became more proactive in obtaining specialty beds, and prophylactic wound care supplies.
Successes:	We maintained zero surgical site infections for Abdominal hysterectomies and Colon surgeries. We maintained zero central line associated blood stream infections and stage III / IV pressure ulcers. Year after year we have maintained a rate of 0.00 for early elective delivery. We reduced readmissions from 9.33% in 2017 to 5.72% in 2018, nearly a 39% reduction. Our sepsis bundle compliance score improved from 39% in 2017 to 52.5% in 2018.
Any other information:	We were able to recruit a pulmonologist and pain management physician to join our staff.

CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER

Hospital interventions:	Decreasing use of central lines: Development of standardized indications for intensive care unit central lines with posting on performance improvement nurse clipboards at each room; Discussion of duration and need for central lines built into rounding checklist and daily multidisciplinary intensive care unit rounds; Education and data feedback Increasing use of line insertion best practices: Creation of a centralized line insertion checklist; Creation of expectation that line insertion checklist is completed by a second nurse observer in real time, to encourage active monitoring; Discussion of line insertion techniques at provider meetings; Confidential data feedback to individual providers on CLABSI rates for lines they inserted Increasing use of line maintenance best practices Development of a bundle of nine best practices for the daily nursing care of central lines (e.g. dressing changes, use of Curos caps on unused ports, etc.) with posting on performance improvement nurse clipboards at each room; Implementation of daily "line rounds" before interdisciplinary intensive care unit rounds to audit use of best practices and indications for central lines, and to provide an opportunity for bedside education; Education and data feedback Decreasing blood culture contamination: This part of the project was led by the quality department, laboratory, and emergency department, with data analysis and reporting support from CDPI. As above, an audit suggested that 1/3 of our reported CLABSIs may have been contamination. 1) Didactic education for technicians and phlebotomists 2) Hands on training for technicians and phlebotomists 3) Prioritization of issue on emergency department technical council 4) Regular data feedback

CHRISTUS ST. VINCENT REGIONAL MEDICAL CENTER (CONT.)

Hospital challenges:	Sustainable of providing protected time for physicians and nurse to carry out performance improvement work.
Any mid-course corrections:	Transition of electronic medical record from Cerner to EPIC required re-working documentation and order sets.
Successes:	Central line days in intensive care unit were reduced from 85% to 72% and hospital wide from 53% to 40%. Central line associated bloodstream infections (CLABSI) in the intensive care unit were reduced from 4 cases to zero cases and hospital wide from 5 cases to 1 case. Blood culture contamination rates were reduced from 3.52% hospital wide in 2017 to 1.97% in 2018.
Any other information:	Submitted for the NMHA Quest for Excellence Award.

CIBOLA GENERAL HOSPITAL

Hospital interventions:	Three key interventions that our Hospital worked on in CY2018 were improving patient satisfaction, improving inpatient influenza and pneumonia vaccination rates, and reducing falls. To improve patient satisfaction, our Executive and Leadership teams worked with our Hospital's Studer coach to develop a 3-year strategic plan aimed at improving employee engagement and patient satisfaction scores across all service lines at our Hospital. Our Hospital implemented an inpatient influenza vaccine project in CY2017. In CY2018, we aimed at hardwiring our improvement initiatives from the previous year. Lastly, our Hospital created a falls reduction team to address the increase in the number of falls that we were seeing. The team worked together to create an updated post-fall huddle sheet and updated our Hospital's falls policy so that it included department-specific information on fall precautions. Additionally, all clinical staff were educated on properly using fall precautions and correctly identifying patients that are fall risks at our Hospital's annual clinical education event.
Hospital challenges:	The major challenges that our Hospital faced in CY2018 included a decrease in hand hygiene compliance and an increase in avoidable days. We also continued to struggle with falls.
Any mid-course corrections:	In the middle of CY2018, our Hospital saw an increase in the number of CAUTIs. In response to going from 0 CAUTIs for a significant period to 4 CAUTIs over the course of 2 months, our Hospital's Continuous Quality Committee (CQC) undertook a PDSA project focused on Foley hygiene. Multiple changes were implements, clinical staff were educated about the process changes and expectations regarding properly documenting Foley care, and it was decided that all patient charts with CAUTIs would be sent up to ER/MS/ICU Committee for review on a monthly basis.
Successes:	In CY2018, all departments in our Hospital worked diligently to implement new and improve existing initiatives focused on improving quality, safety, and satisfaction. Our major successes tied to the HQII initiative included reducing our within facility readmission rate to <3% on a monthly basis, achieving 0 harms related to ADEs (anti-coagulation), and achieving 0 harms related to hospital-acquired stage III and IV pressure ulcers. Other successes included undergoing a Focused Standards Assessment (FSA) by TJC, implementing our electronic clinical quality measures (eCQM) program, and implementing multiple safety initiatives focused on reducing workplace violence and increasing safety and security at our facility. Additionally, our Hospital applied for the New Mexico Performance Excellence Adobe Award in which our work on falls reduction was highlighted.

DR. DAN C. TRIGG MEMORIAL HOSPITAL

Hospital interventions:	From 2017 to 2018 DCT had an increase in patient falls. In 2017 there were 2 falls and in 2018 there were 5. A Fall Committee was created in 4th quarter 2018 to address the occurrence of patient falls campus wide. Clinical staff were educated on documentation tools, safety devices available for use, hourly rounding process, safety sweeps, and fall debrief requirements. During the 1st quarter of 2018 a review of 2017 year-end compliance with the 3-hour Sepsis bundle was noted to be at 40%. With heighten public awareness of deaths related to sepsis the organization decided to evaluate adherence to the 3-hour sepsis bundle components and processes. It was found that the staff had created a workaround to avoid the Best Practice Alert (BPA) from initiating, allowing them to complete their triage. Physicians and clinical staff were instructed on the appropriate screening for Sepsis within EPIC and expectation of acknowledging the BPAs.
Hospital challenges:	Due to the low denominator one event is devasting to the overall performance. The challenge was to change the mindset of the staff, as initiating the BPA's created additional steps to complete the triage assessment resulting in a workaround of bypassing the BPA.

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

Any mid-course corrections:	Daily huddles discussing when last fall occurred, posting in staff area
Successes:	It has been over 260 days since we have had a patient fall at DCT.
Any other information:	A 6-month audit was performed to evaluate appropriate screening by staff to allow BPA initiation. The audit revealed 100% compliance.

EASTERN NEW MEXICO MEDICAL CENTER

Hospital interventions:	The hospital leaders continued to focus work in 2018 on infection prevention, with the year end results of one catheter-associated urinary tract infection, no surgical site infections and favorable results with central line associated blood stream infections. Patient falls decreased and there were no falls with serious injury, however Readmissions remained in the forefront of the initiatives addressed.
Hospital challenges:	Readmissions continue to be a challenge for the hospital. In 2018 the senior leadership team initiated a PDSA project focused on scheduling follow-up care visits for all patients discharged, with their proffered provider. An emphasis was placed on the continuation of hourly rounding focused on the 3 P's and completing bedside shift report for patient safety.
Any mid-course corrections:	Re-education of staff was a focus to reinforce interventions for prevention of infection related to handwashing. Continued attention for including patients and family members in the bedside shift report and handoff, allowed the staff to focus on patient safety and encourage improved communications.
Successes:	The use of Bedside Shift Report throughout the hospital has proved very beneficial as evidenced by our Infection Data for catheter-associated urinary tract infections, central line associated blood stream infections remaining low and our fall rates continuing to decrease. We successfully completed our Biennial Laboratory Joint Commission Survey.

ESPAÑOLA HOSPITAL

Hospital interventions:	In an effort to further reduce our in hospital fall rate, we implemented several process steps to augment the No One Walks Alone Program (NOWA). In addition to bed alarms we introduced chair alarms during the 2nd Quarter of 2018 on all patients who are at risk for falls, and the alarm rings through our nurse call system. In addition, we dedicated an inpatient physical therapist who sees patients when consulted and works with the nursing staff to develop the safest plan of care for ambulation progression. In addition, we have capability of telemonitoring 3 patients who are at risk for falls and have implemented an every 4-hour safety sweep. Although we have not had any recent CLABSI's, we remain acutely aware of the need to be diligent. To this end, we targeted initiatives that were focused on reducing line days. The need for every central line is evaluated critically with team discussion. We have a large population of patients who have challenging access issues, and in the past these patients have had PICC or other central lines placed. During 3rd Quarter 2018 we developed a class to educate staff on how to place ultrasound guided IV's. It was open to any staff member with interest on a voluntary basis. Line days are tracked by the Infection Preventionist and reported quarterly to the IC and Quality committees.
Hospital challenges:	A challenge has been the turnover of nursing and assistive personnel on the units, as well as intermittent short staffing. This has required reinforcement of education and policies repeatedly in order to ensure compliance. We have been unable to provide the number of classes necessary to accommodate all staff who have expressed interest, as we have not had an educator for the past year.

ESPAÑOLA HOSPITAL (CONT.)

Any mid-course corrections:	After participating in an enterprise wide falls summit, we realized that NOWA is not as inclusive of the patient as would be desirable. We changed our language to We Walk with You, thereby engaging patients to a higher degree. We also found that the chair alarm monitors were falling off the walls, and enlisted maintenance to determine a better solution, which was accomplished.
Successes:	Our days since last fall increased to as many as 74 "days since last fall" this year, as compared to 54 days in 2018. Also, families have become increasingly aware of the need to call for help, and not remove the bed/ chair alarms without staff assistance. Additionally, we have been able to avoid any significant harm with an increase of staff assisted or witnessed falls. We have reduced our central line days from over 200 days per quarter to less than 100 days per quarter over the past year. We believe this is due in part to the ultrasound guided IV training and increased ability to place peripheral lines.

GERALD CHAMPION MEDICAL CENTER

Hospital interventions:	CLABSI: Monthly rounds include validation of bundle compliance for central lines. Omissions or variances provide an opportunity for immediate feedback to staff. Compliance is tracked and reported to the Patient Safety/Infection Prevention Committee. FALLS: Injurious falls continue to decline with targeted focus on hourly rounding, use of prevention techniques/devices, and staggered placement of staff in hallways near patient rooms. The mobility team has implemented projects aimed at increasing patient strength and balance. A facility-wide survey for Patient Safety Culture was conducted and information is being cascaded to Leadership. CAUTI: Monthly rounding (prevalence parties) are opportunities for ongoing, real-time audits. Validation of bundle component compliance is conducted. Feedback is given to staff immediately upon identification of a variance or omission. HAPU: Developed a skin integrity team to look at early intervention and documentation. Utilized automated triggers from the electronic medical record's Braden assessment to initiate care plan entries. The organization recruited and hired a wound care certified nurse to establish a formulized inpatient program. The organization was able to combine the interior and outpatient programs. SSIs: Standardized skin prep was initiated in the operating room according to the CDC and American College of Surgeons recommendations for using alcohol-containing preparations. Templates were developed for the electronic medical record that only included the recommended antibiotic selections appropriate to the surgical procedure being performed.

GERALD CHAMPION MEDICAL CENTER (CONT.)

Hospital challenges:	CLABSI: Due to a change in vendor ownership, availability of the disinfecting caps that had been used for the last few years were no longer available. After an event, extensive efforts were made to locate a distributor for the product that had been effective in the past. FALLS: Analysis of data related to falls over a significant period indicate that the primary factor is toileting. Most frequent falls occur on non-acute wards (Behavioral Medicine and Inpatient Rehab). CAUTI: High utilization of indwelling catheters continues to be an area of challenge, especially in the ICU. HAPU: Recruiting qualified individual to lead wound care program. Nursing turnover requires ongoing training on skin care and pressure injury prevention.
Any mid-course corrections:	CLABSI: No corrections were implemented, but the additional of daily grand rounds provided an opportunity for interdisciplinary discussion of line removal. FALLS: Units had staff positioned in areas closest to the patient rooms with the use of portable workstations. CAUTI: No changes in interventions were initiated. HAPU: Skin care products were evaluated and standardized throughout the organization. Staff received education on new products.

GERALD CHAMPION MEDICAL CENTER (CONT.)

Successes:	CLABSI: Following the event that triggered a focused effort for return of the product that had served the organization so well, no further incidence of CLABSI was identified. FALLS: Unit directors have taken ownership and initiated interventions related to toileting (hourly rounding, placement of staff at staggered locations for quicker response and closer observation. Third consecutive year of reduced rates of Falls with injury. CAUTI: The incidence of CAUTI was sustained at below 1.0/1000 catheter days. There were no CAUTI events for the last 9 months of 2018. HAPU: New addition of dedicated inpatient skin care program was developed and initiated.
Any other information:	CLABSI: Increased rates in blood culture contamination has been identified. Training sessions have been conducted to validate technique and source of specimen. FALLS: Ongoing attention is being given to maintaining or increasing the patient's strength, balance, and mobility. A Patient Safety survey was conducted facility-wide and that information is being cascaded to directors and individual patient care units. CAUTI: Collaboration with other facilities has provided ideas for possible reduction of line days in 2019. HAPU: New mattresses were purchased for all patient care units and new therapeutic beds for the intensive care unit.

GILA REGIONAL MEDICAL CENTER

Hospital interventions:	1. Clostridium Difficile rates were addressed through review of requirements and all real or potential C-diff events. New Infection Preventionist entered role. Education provided to staff on identification and proper specimen collection. Hospital status corrected on NHSH site to more appropriately reflect hospital. 2. All-Cause Readmissions were addressed through the development and training of a Transitions Nurse position. Discharge phone calls also implemented. Created collaborative relationships with community support resources for smoother transitions.
Hospital challenges:	1. Staff and Provider education confusion on appropriate specimen collection and timing. Education also on correctly and accurately documenting in the patient record. Addressed through additional education focusing on the challenges identified. 2. Staffing challenges within the Case Management Department for Transitions and phone calls. This was addressed by seeking other staff positions who could be taught process (within scope). Behavioral related re-admissions remain a challenge to be addressed.
Any mid-course corrections:	1. Remedial education when a real or potential c-diff case is identified that focuses on the failure point. 2. Nursing Assistants were trained to make the discharge phone calls and forward any concerns to the appropriate person to address (RN, or Case Management staff). Added local Pharmacies to the collaborative relationships.
Successes:	1. Significant reduction in hospital onset clostridium difficile. Last half of 2017 saw 5 cases reported, first half of 2018 had 4 cases reported. Second half of 2018 with 2 cases reported. 2. Limited reduction in non-behavioral health related re-admissions. Goal was to reduce by 50% to a rate of 3% or less. Normal variation is noted in data, no real trends identified.
Any other information:	Much work remains in the area of readmissions. Additional staffing challenges have impacted the Transitions program, with discharge phone calls not being completed for a short period of time. This is impacting the readmissions. Phone calls have been partially reinstated recently, being completed by Quality Data Abstractors until Case Management positions can be filled.

GUADALUPE COUNTY HOSPITAL

Hospital interventions:	One of the interventions Guadalupe County Hospital employed was the adoption and implementation of the Prista ActionCue quality and risk management reporting and tracking application. With it we are able to see all quality scores and incidents across the hospital, in every single department. This allows us to have a strong visual overview of the hospital's quality trends and makes it easier to report on a monthly basis to the governing board so they can have a good grasp of our quality initiatives and our quality scores, as well as any reported incidents. Another intervention included continued participation in the NM Rural Hospital Network's peer groups which allows our hospital to learn from other hospitals, including best practices, and to share resources such as specialized training. The hospital also enhanced its practice of following up with all discharged patients to ensure that they were comfortable post-discharge, and both understood their stay and care plans, and were able to follow up with their primary care providers and also able to procure any and all prescriptions. The goal is to call 100% of discharged patients within 7 days of discharge.
Hospital challenges:	Guadalupe County Hospital has enjoyed high quality scores and low to zero infection rates. However, because our volumes are so low, it's often difficult to track trends over any of period of time. The ActionCue application allows us to do so in a more thorough and meaningful way, and thus we are able to address problems long before they are reported by Hospital Compare or any other data collection and reporting entity.
Any mid-course corrections:	Midcourse corrections always include changing measures to track and fix problems or challenges. Once something shows sustained improvement; we chose something else to measure so that we continuously improve, in a broader manner.

GUADALUPE COUNTY HOSPITAL (CONT.)

Successes:	One success was the recognition of our hospital by the National Rural Health Association for high quality scores and financial stability. Guadalupe County Hospital was recognized as one of the top twenty rural community hospitals (non-CAH) in the nation, and in fact tied for #6. The award is not nearly as meaningful as the clinical quality we have been able to sustain over a long time in spite of the fact that we are one of the smallest hospitals in the state. The hospital was also recognized for high patient experience scores. Our goal is not only to sustain those scores but to beat them.
Any other information:	The SNCP HQII has been integral in providing us funds to subscribe to the ActionCue quality and risk management application.

HOLY CROSS HOSPITAL

Hospital interventions:	1. Quality: To improve Anticoag safety Pharmacy has put in place the following: Patients that are being therapeutically anticoagulated are entered into a program that requires the pharmacist's daily review of the patient's status including ordering and review of monitoring labs and dose adjustments made based upon lab work or a patients renal status. A daily anticoagulation progress note is entered into the patient's medical record accessible for review by all care providers. All inpatient pharmacists are now practicing in the outpatient clinic, so the majority of patients admitted to the hospital on anticoagulation are well known to the staff. The outpatient record of the patient's care is readily available and known to the pharmacist providing continuity of care. Additionally, the hospital operates an outpatient anticoagulation clinic that provides a seamless transition of patients being discharged from or admitted to the hospital. 2. Patient Safety: Immunization of employees during Flu season required the Infection Prevention Department to change strategies. Hospital Emergency Response Team conducted a Point of Dispensing exercise, immunizing 40% of all healthcare personnel in a single day. Weekly follow-up with leaders noting who in their areas were unimmunized was a key step. Leaders in turn encouraged staff to receive the Flu shot or sign a declination. The end result was 95% immunization rate of all personnel.
Hospital challenges:	1. We continue to struggle with EMR data. Reports are incomplete and cannot be validated. Manual data collection remains the most reliable method for many measures. 2. Staff turnover, frontline and leadership, has made it challenging to stay on track with initiatives. Travelers and Interim leaders along with senior leaders picking up extra duties have helped to keep us on course.

HOLY CROSS HOSPITAL (CONT.)

Any mid-course corrections:	1. Quality: In 2018 Holy Cross organized an interdisciplinary committee to determine what delays were occurring that prevented timely admission of patients from the Emergency Department. The team collected data and reviewed the top issues. As a result, a new process was implemented.
Successes:	1. Hospital Acquired conditions remained low. One reported CAUTI, zero CLABSI, and zero SSI for Hysterectomy and Colon. 2. Urinary catheter utilization rate improved from 19% to 12%. 3. Pressure Ulcer rate remained at zero. 4. Achieved 100% for CT results for acute stroke patients interpreted within 45 minutes of arrival.

LEA REGIONAL HOSPITAL

Hospital interventions:	1. We have established a process of notification, review/analysis, physician query, and final determination process relating to hospital acquired conditions (HAC) and hospital acquired infections (HAI) to ensure that there is a group of expert review and physician involvement prior to determination of a HAC or HAI. 2. We have maintained a daily multidisciplinary meeting to review and discuss all patients to improve outcomes. 3. We are in constant review and research of best practices for implementation. 4. We continue to participate in Centers for Medicare/Medicaid Hospital Engagement Network/Hospital Improvement Innovation Network and benchmark against other NM facilities. 5. We have remained accredited/certified Chest Pain Centers and Primary Stroke Certified. We remain the only hospital in NM certified in Heart Failure. 6. We have maintained our interventional cardiology program to meet community needs, reduce transfers and improve time from patient's cardiac event to intervention – meeting PCI in less than 90 minutes. 7. Our inpatient dialysis program remains in place to meet community needs and reduce patient transfers. 8. Extensive community education outreach program for stroke education – "time is brain", as well as Senior Circle monthly education free to the community relating to a variety of healthcare topics, i.e. influenza prevention and vaccination, etc. 9. Focused review, data/tracking, interventions, education, etc. relating to worker safety. 10. Daily mortality/morbidity review. 11. Daily departmental and hospital-wide Safety Huddles with recognition of safety catches, best practices, interventions, etc.

LEA REGIONAL HOSPITAL (CONT.)

Hospital challenges:	1. Readmissions - established a process of ongoing review utilizing a toolkit/review form to identify any trends or issues through the Case Management process. Weekly team meetings to discuss further and address through various processes including the peer review process. We are working collaboratively with all providers to address discharge, follow-up processes, etc. 2. Bedside Shift Report – revamping the process to ensure consistent engagement of the patient and patient's family. 3. Reduction of patient falls focus ongoing – continue with falls safety program and address/focus on patient fall risks relating to detoxing patients, etc. 4. Increased number of pediatric or adolescent mental health and chemically dependent patients requiring services at a mental health or treatment facility requiring transfer from the Emergency Department.
Any mid-course corrections:	1. Re-establishing our front-line staff Safety Coach program – these are front line leaders (the go to person) to help other staff with questions, recognize successes, etc. 2. Re-establishment of weekly HAC/HAI meeting for early identification/review/intervention of any potential HAC or HAI. 3. Readmission toolkit and review to identify any trends or issues through the Case Management process. 4. Establishment of Senior Leadership daily rounds for safety, as well as patient and staff engagement/ satisfaction. 5. Establishment and trialing of a "Dr. Bhert" program – Behavioral Health Emergency Response Team, relating to mental health and/or chemically dependent patients – a proactive approach to treatment to prevent escalation of behaviors and to prevent any patient outbursts, needs to physical restraints, etc.

LEA REGIONAL HOSPITAL (CONT.)

Successes:	No CAUTI, CLABSI, or Ventilator Acquired infections/hospital acquired infections 2017-year to date. 2. 100% compliance relating to influenza and pneumococcal vaccination for our patients. 3. Surgery checklist in place preventing wrong site surgery. 4. SurgiCount process in place to prevention sponge or foreign body retention post-surgery – improvement in the surgical count process resulting in years of no retained sponges, etc. 5. Recognized by Get with Guidelines/American Stroke Association as a Gold Plus Award winner. 6. Sepsis best practices remain 95-100% compliant hospital wide for last couple of years – well above the national compliance percentage of 45-55%. 7. Daily mortality/morbidity review to identify any peer review needs, etc. 8. Continue emergent c-section call to cut in 30 minutes or less. 9. Continued 100% appropriate use of restraints as needed but a noted decrease in restraint use accordingly. 10.Best practices and recognition by TJC surveyor on kitchen cleanliness, practices, dish machine logs, etc. 11. Best practices and recognition by TJC surveyor regarding quality program, medical staff credentialing, and performance improvement.

LINCOLN COUNTY MEDICAL CENTER

Hospital interventions:	LCMC implemented an initiative to reduce readmissions for patients age 65 and older. Our readmission rate for this population was 6.5% at year-end 2017 with a goal of 5.2%. After meeting with our medical director, hospitalist, Chief Hospital Executive, Chief Nurse Executive, Case Management, Quality and Emergency Medical Services (EMS) staff, we implemented a plan to interview readmitted patients to gain knowledge or their perceptions of reasons for readmission. Case management scheduled follow up appointments with patients' providers prior to discharge and we arranged a process for EMS visits post-discharge. In 2017, LCMC had 21 patient falls resulting in a fall rate of 3.59 per 1000 patient days. Our goal was no more than 2.64 falls per 1000 patient days. The Falls Committee developed an improvement plan in 2018 which included staff education, focused hourly rounding by front-line staff and daily patient rounding by managers to audit use of elements of our fall prevention protocol. Compliance with the different elements of the protocol ranged from 45% for activation of bed alarm to 81% for use of designated fall-risk gowns. Each fall required a fall debrief by front-line staff on the unit to determine why it occurred followed by a separate analysis conducted by the department manager to determine root cause of the fall.
Hospital challenges:	While patients were offered post-discharge EMS home visits, many patients refused. Some patients refused some of the elements of the fall prevention protocol, particularly activation of their bed alarm. We also had shortages of designated fall gowns and other fall risk visual reminders.

LINCOLN COUNTY MEDICAL CENTER (CONT.)

Any mid-course corrections:	We participated in an HRET HIIN Multi-Patient Visit (MVP) cohort to learn new tactics. As a result, we learned to focus more holistically on patient issues, obstacles - medical and non-medical - that were drivers of utilization. We also presented EMS home visits to patients as part of the routine services we provided for discharged patients and not as an extra service. We began to have our social worker meet with patients in the Emergency Room to arrange for appropriate care outside of the hospital; thereby preventing unnecessary readmissions. Managers followed up with patients to explain the importance of complying with our fall prevention protocol to convince patients to comply. We purchased more fall gowns and added other visual reminders to accommodate our population of fall-risk patients. We began to include house supervisors in the rounding at nights and on weekends. We also tracked and posted compliance results and counted number of days since the last fall, celebrating at specific intervals. We implemented a "No Pass Zone" on the Medical/Surgical unit requiring any employee walking by to respond to call lights in that hallway.
Successes:	We exceeded our readmission rate goal of 5.2% for patients 65 and over with a readmission rate of 1.6% at year-end 2018. At year-end 2018, our compliance with the elements of the fall prevention protocol ranged from 88 to 98%. We exceeded our goal of 2.64 falls per 1000 patient days by achieving a fall rate of 2.059 per 1000 patient days with 10 patient falls. We had a 168-day stretch with no falls.
Any other information:	We learned that our fall prevention protocol was effective in reducing falls when all elements of the protocol were implemented. Compliance improved with continuous auditing of the protocol elements. We learned that psychosocial and family dynamic issues were the biggest drivers of readmissions for this vulnerable population in our community. By assessing patients in a more holistic manner, we were able to connect patients with the most appropriate services post-discharge and reduce our readmission rate.

LOS ALAMOS MEDICAL CENTER

Hospital interventions:	1. Los Alamos Medical Center (LAMC) is currently experiencing a lower than usual obstetrical (OB) volume of cases. This has the potential to impact the competency and skill of nursing staff, and especially in the case of high-risk presentations. To mitigate the risks associated with this, the following comprehensive OB education and ongoing competency plan was developed: • High risk drills, for situations such as Post-Partum Hemorrhage (PPH), shoulder dystocia, etc. • Development of revised PPH process (in process) • All RN's to study for Neonatal Orientation and Education Program (NOEP) (Multiple modules & ongoing) • All RN's to study for Perinatal Orientation and Education Program (POEP) (Multiple modules & ongoing) • Development of competencies and additional skills checks • Involvement of OB staff in the program development 2. Reduction in patent preventable harms, as based on billing claims, is another focus of LAMC. Such harms as Hospital Acquired Pneumonia (HAP), Hospital Acquired Urinary Tract Infection (HAUTI) and surgical site infection, for example. Tactics to address such harms include: • Proactive rather than reactive process • Weekly "Harms" meetings with executive team and other multidisciplinary members • Focus with staff on "Leading (proactive) measures" rather than "Lagging (reactive) measures" to care for patients • Mentoring and coaching staff to include focus on potential harms during the admission process and bedside shift report (BSSR). 3. Behavioral health and the safety of these patients continued as a major focus. In particular, the care of the suicidal patient was a significant focus. Tactics to address the safe care for this patient population included: • Revision of policy and process • Education of 200% RN's • Implementation of an evidenced based suicide scoring scale (Columbia Suicide Scale)

LOS ALAMOS MEDICAL CENTER (CONT.)

Hospital challenges:	Attracting qualified staff to Los Alamos continues to be a challenge. Although the reliance on agency/traveler nursing staff has been significantly decreased in the last 12 months, attracting experienced labor & delivery nurses and surgical services nurses remains a significant challenge. Volume is increasing from a surgical perspective, due to the successful onboarding of two new surgeons (and the potential for additional surgeons). An additional challenge is hiring a qualified and experienced director to lead the surgical services department.
Any mid-course corrections:	n/a
Successes:	1. Behavioral Health Suicide process established at LAMC is now being used as the company wide model. 2. 40% reduction in preventable patient harms in 1 year 3. 69% reduction in HAP, year over year 4. 100% reduction in surgical site infection, year over year 5. 100% reduction in HAUTI, year over year

LOVELACE ROSWELL REGIONAL HOSPITAL

Hospital interventions:	1. We focused on Infection Control measures throughout the hospital. 2. We worked with a readmission team reduce readmissions. 3. We focused on patient privacy in the ED. 4. We worked on reducing HAC.
Hospital challenges:	• Many of our readmissions are the same patients that we offer services to but refuse them with their initial admission. • We have difficulty with limited space in our ER, so we had to change the process for triage and patient flow. We opened an additional area for ED patients to remain so that patient flow could be efficiently managed.
Any mid-course corrections:	• We had to review the triage process due to patient flow issues. • We rearranged equipment to accommodate the changes. • We revised our readmission reduction plan based on review of the items we thought would help reduce readmissions.
Successes:	• We have an EMR that we can run reports to identify patients that are high risk for readmission as well potential HACs real time. • We worked closely with case management to reduce readmissions. • We improved patient safety in-regards-to infection control by working closely with our EVS team, providing further training, and validation. • PHI and Patient privacy were protected in the ED.

MEMORIAL MEDICAL CENTER

Hospital interventions:	Reduction of Sepsis - Through a collaborative approach with emphasis on input from our RNs caring for patients at the bedside, we began the use of a screening tool known as the Modified Early Warning System (MEWS) in 2017. Use of this assessment tool and subsequent sepsis alerts increased in 2018. Our Clinical Documentation (CDI) began to round with physicians in ICU providing support and education as needed. We improved our handoff process for patients transferred from the Emergency Department to inpatient units. An interdisciplinary team (including physicians) revised electronic order sets for easier use. We have focused on the Sepsis Bundle compliance for early identification and treatment in 2018. Pressure Injuries – Our Wound Care team revised procedures to include notification of providers for skin issues noted throughout the patient's stay. We revised the electronic health record to automatically notify the Wound Ostomy RN for consults based on skin assessment score and to allow RN to describe injury but not to stage injury. Researched and educated team on wound care products to prevent breakdown. We also purchased new ICU beds with the ability for improved mobilization and with an improved surface. We had equal numbers of pressure injuries when comparing 2017 to 2018 data. Prevention of Hospital Acquired Pneumonia - As noted in our 2017 Annual Report we began a team focus on consistent oral care through the addition of this on our patient's electronic medication administration record (EMAR). We also added a dysphagia assessment to nurses' documentation that will trigger a Speech Therapy consult. To educate our patients and to emphasize the importance of Incentive Spirometer use for all patients in 2018 we incorporated Incentive Spirometer "Teach Back" during Bedside Shift Report at a minimum. Through a collaborative effort involving nursing, respiratory therapy and physical therapy we have improved Early Mobility for ICU patients. We have been assisting our patients to be out of bed at a minimum for their meals.

MEMORIAL MEDICAL CENTER (CONT.)

Hospital challenges:	Sepsis – Although we continue to see improvement, we sometimes fail to identify and treat early. There is some continued resistance to call sepsis alerts and incomplete implementation of the Sepsis Bundle (diagnostics and treatment). Pressure Injuries – New equipment (ICU Beds) not used correctly (team members were not resetting weight with new patients), so pressure distribution was not always correct. Pressure injuries caused by BIPAP masks. Hospital Acquired Pneumonia – Patient Care Tech shortage made getting all patients out of bed for meals difficult.
Any mid-course corrections:	Sepsis – Alarm fatigue was noted with overhead pages, so the team was not as responsive and began to call fewer alerts. To improve this process and compliance with Sepsis Alerts we switched to Pulsara (text message system of notification). Due to orders not carried out completely when patients transferred from the Emergency Department, we revised our handoff communication and developed an ED RN continuation order (to allow for receiving RN to see original order). Pressure Injuries – Increased number of pressure injuries in ICU with the use of new beds required retraining RNs to set new weight parameters with each patient for improved distribution of pressure on the bed's surface (calculates pressure distribution based on patient weight). Pressure injuries noted with BIPAP use – educated regarding correct mask size and use of foam cushions with masks. Hospital Acquired Pneumonia – Began to have RNs get patients out of bed with Bedside Shift Report.

MEMORIAL MEDICAL CENTER (CONT.)

Successes:	Sepsis - 44% reduction comparing 2017 to 2018 data. Hospital Acquired Pneumonia – 25% reduction comparing 2017 to 2018 data.
Any other information:	Memorial Medical Center participates in the LifePoint National Quality Program, which offers benchmarking of data, best practices for improvement, education and sustainability of quality improvements.

MIMBRES MEMORIAL HOSPITAL

Hospital interventions:	Hospital-wide Fall Reduction & Hospital-wide readmissions.
Hospital challenges:	1. Our Skilled Nursing Facility was closed to admissions for the first 8 months of 2018 2. Case Management department was staff was reduced by 33% due to an employee transferring to another department causing the Patient Navigator to cover as a case manager
Any mid-course corrections:	n/a
Successes:	Establishing a post-fall huddle where staff and department leadership meet immediately after a fall to evaluate the cause and identify solutions to prevent it from happening again was very successful. Sharing the cause and preventative measure at the daily safety huddle helped to spread the information. This helped to take us from a rate of 1.79 (per 1000 Pt days) to .23 (per 1000 Pt days), a 307% improvement. Once the three challenges were resolved by the end of November, we started seeing a decrease in readmissions. We ended the year with a 4th quarter improvement of 12% over the previous quarters.

MINERS' COLFAX MEDICAL CENTER

Hospital interventions:	1. The clostridium difficile rate at MCMC was greater than the National Patient Safety Goal rate of 7.3%. Antibiotic stewardship was a requirement to bring this rate to a lower level for patient safety. 2. In 2017, MCMC experienced a flu outbreak among staffs and with the patient / resident population. The compliance rate for vaccination was less than 65%. A mandatory flu vaccination policy for the staffs was implemented because of the previous year. A consistent approach was needed to address illness associated with influenza and the return of the employee to work.
Hospital challenges:	1. The Infection Preventionist reviewed positive culture results from the inpatient population and reported to the pharmacist for appropriate antibiotic utilization. The pharmacist reviewed the antibiotic in use and made recommendations to the care providers. Nursing staff received education regarding timely administration and adherence to orders for discontinuation. 2. The Infection Preventionist implemented a mobile vaccine administration service, bringing the vaccine to the workstation during the day and night shifts. Approximately 75% of the workforce received vaccines in less than a week. Not every employee was enthusiastic about vaccination.

MINERS' COLFAX MEDICAL CENTER (CONT.)

Any mid-course corrections:	1. An outside reference lab processes all culture specimens. The turnaround time was greater than three days. Improvement opportunities addressed and implemented. 2. Vaccine Captains assigned to each unit assured consistency of the program. Counseling provided to those staffs that were reluctant to vaccination. Three staffs declined the vaccine and wore masks for the entire flu season. This required masks to be placed at each entrance to the building. Education was ongoing for personal protective equipment and monitoring of hand hygiene compliance. Ongoing education and Department of Health bulletins were shared with staffs to keep the awareness at the forefront of care.
Successes:	1. Utilizing a multidisciplinary approach, the rate dropped from 10.42% in 2017 to 7% in 2018. 2. The compliance rate improved from <65% to 98.2%. The absenteeism related to influenza was less than 20% compared to >60% the previous year. There were no documented cases of staff exposing patients/ residents to the flu during the 2018 season.
Any other information:	1. The Infection Preventionist, Pharmacist and Chief of Staff were supportive, communicative and responsible to assure the program moved in a positive direction. 2. The administrative team at MCMC was instrumental in the success of this program. The consistency in the approach to dealing with sick staff and sick patients improved the quality of care provided. The patients / residents and staff were afforded a better healthcare environment.

MOUNTAINVIEW REGIONAL MEDICAL CENTER

Hospital interventions:	The Major focus areas for MountainView Regional Medical Center in 2018 were C-Diff reduction, improved mortality review process, and readmission reduction. C-Diff Reduction: A subcommittee involving members from the infection prevention committee, the laboratory leadership, nursing leadership, and administration met to understand reduction efforts and change initiatives. It is noted that greater than 60% of all C-Diff cases are community acquired and per NHSN definitions if identified after hospital day 3, the incident is considered hospital acquired. Many process and protocols were put into place to ensure appropriate testing guidelines, timeframes, lab rejection process, and a two-step laboratory testing methodology to determine if the identified C-Diff is an active infectious process or a colonization of the bacteria. Mortality Review Process: The mortality review process was hardwired in 2018. A new process was initiated in 4Q17. The process includes a 24-hour review of each mortality for a determination of an expected mortality or an outcome requiring further review. A full review of the mortality is conducted within 7 days. If it is determined that the mortality is an outcome that requires further review, the case is either referred for peer review based on medical staff criteria or referred to the Morbidity and Mortality Committee (M&M). Our M&M is a multidisciplinary education-based committee which is held each month by our resident physicians in conjunction with the attending physician for each case. Readmission Reduction: The readmissions committee took on several initiatives in 2018 to reduce 30-day readmissions. Studies indicate the top reasons patients are readmitted within 30 days are lack of follow up appointment, medication barriers, and education barriers. Internal trends were identified, and new patient education materials were developed for the major disease processes, Heart Failure, COPD, Pneumonia, and Stroke. The education materials not only include disease process education, but common medication usage, dietary education, indication on when to call the doctor versus coming to the Emergency Room, appointment trackers, and home indicators. Additionally, a focused process improvement approach was initiated on the medical telemetry floor to ensure discharge follow up appointments for each patient are made prior to discharge.

MOUNTAINVIEW REGIONAL MEDICAL CENTER (CONT.)

Hospital challenges:	C-Diff Reduction: After completion of laboratory correlation process for validation of the two-step testing methodology, extensive education went to the Medical staff for interpretation of the new results. This was a long process to ensure all providers understood how to interpret the diagnostics and the appropriate intervention based on active infection versus colonization. Mortality Review Process: Physician notification and engagement in M&M was challenging and required new thought processes for communication. Readmission Reduction: The medical telemetry unit, on average, has 70 discharges per week. The volume of discharges and follow up calls required by the nursing team lead to barriers. A pilot was conducted to incorporate a dedicated discharge team to make the appointments and coordinate post-acute care and was successful in completing discharge appointments.
Any mid-course corrections:	C-Diff Reduction: Mid-course reduction was needed for nursing staff to follow the appropriate testing time frame guidelines, ensuring that patients who present with signs and symptoms of C-Diff are testing promptly to ensure community acquired infections are not inappropriately categorized as hospital acquired. Mortality Review Process: Mid-course initiatives included obtaining 1 contact hour of CME credits for licensed personnel. This added incentive increased participation. Additionally, the communication to attending physicians was changed to text versus email only. An anonymous mass texting app is utilized to notify each attending physician that a case in which they were involved with the care has been selected for M&M, and a reminder of the date and time. The protected details of the case are then sent to the physician via secure email. Readmission Reduction: Accuracy of the face sheet was identified as a mid-course barrier and focused education was completed with the registration team. Patient's contact information and CURRENT Primary Care Provider are verified at the time of discharge and updated as needed. This has increased compliance with discharge appointments.

MOUNTAINVIEW REGIONAL MEDICAL CENTER (CONT.)

Successes:	C-Diff Reduction: With the processes and protocols in place and the addition of the two-step laboratory testing methodology to truly determine hospital acquired infections, the C-Diff reported rate has decreased by 95%. Mortality Review Process: Each mortality is fully reviewed within 7 days greater than 90% of the time, well above goal. The M&M committee participation has increased by 25%, with the greatest increase in participation by the attending physicians at nearly 75% with the addition of CME and multimodal communication platforms. Readmission Reduction: Discharge appointment compliance on the medical telemetry unit is about 75%, during the pilot of a dedicated discharge team compliance surpassed 90%. An overall reduction of readmissions has been noted and the Medicare O/E at 1.02.

NOR-LEA GENERAL HOSPITAL

Hospital interventions:	1. Improve coordination of care with the accountable care organization nurse case manager, the outpatient community health workers, primary care clinic nurses, and the inpatient case manager and social worker to track the patient's needs and gaps and intervene to reduce readmissions. 2. Improve data collection of readmissions to all facilities.
Hospital challenges:	1. Electronic medical records systems in the hospital, clinics, and outpatient areas continue to be the number one challenge with all improvement efforts. The improvement of the accuracy and availability of clinical data to make real time decisions for patient care was identified as a challenge. 2. Staffing in the case management department with turnover of the nurse case manager and social worker were also identified as challenges during the year.
Any mid-course corrections:	1. Senior leadership is working with Covenant and EPIC Connect to partner to bring an EMR that could manage the scope of services, number of patients, and provider needs for quality reporting tracking, and case management. 2. Hired a new case manager and social worker to manage coordination of care with home health, DME, providers, and outpatient providers.
Successes:	1. Reduction of Readmission rates from 3% in 2016 to 2% in 2018 in the current data systems available. 2. Identified an electronic medical record system that will allow all clinicians in all NLHD facilities to have access to the patient chart with a one patient-one chart system.
Any other information:	1. A new electronic medical record partner, EPIC Connect, has come onsite and evaluated our needs and we may have a contract by the end of 2020.

PLAINS REGIONAL MEDICAL CENTER

Hospital interventions:	The Falls Committee was formalized during the 4th quarter of 2018 to continue to reduce the fall rate at PRMC. A process change was introduced to further reduce the risk of falls: Safety Sweeps. The Safety Sweeps started with each patient encounter. This includes a visual sweep of the room to identify any potential fall hazards using Scripting to discuss with the patient. In addition, a patient agreement is to be reviewed and signed by the patient, developing a collaborative approach in fall reduction. The inpatient units have begun to display, in staff areas, a “days since last fall" bulletin. Through the Clinical Outcome Team committee, a system wide program was developed during the last quarter of 2018 called "4 Eyes On", requiring two staff members to complete a patient's skin assessment together and document the assessment. The purpose of this process change is to identify community pressure ulcers, early recognition and treatment and prevention of new pressure ulcers to include accurate EPIC documentation and reporting.
Hospital challenges:	New staff in all departments pose challenge as they need to be educated on processes and expectations. New equipment staff need to learn. With visual assessment being completed by two staff an increase in observations of pressure ulcers was noted. This is an anticipated outcome by the heighten attention to recognition and reporting.

PLAINS REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	Units discuss daily at morning safety huddles, bringing it to the front-line staff. Days since last fall posted on the units, for visual ques.
Successes:	Reduction of patient falls by 10 from 2017 (32) to 2018 (22). Implemented celebrations for milestones (30-day, 60-day, 90 day and every 3 months after 90 days) days without a fall.

REHOBOTH MCKINLEY HOSPITAL

Hospital interventions:	Due to a medication error, Rehoboth McKinley Christian Health Care Services (RMCHCS) examined our pediatric medication administration process. The Pharmacy, Nursing, Providers, with the support of the Quality Department worked on improving the process to ensure safe pediatric medication administration. Changes were implemented that required providers to order pediatric medications as a weight-based dose in addition to a total dose, creating a double check. Pharmacy was required to call and clarify any order that did not have weight -based dosing. Pediatric medications were added to the High Alert Medication List requiring two-RN independent verification and nursing provided education and competency quizzes on pediatric medication dosing. In early 2018 a Pertussis Outbreak occurred in Gallup and Zuni New Mexico and soon after the announcement, we had patients admitted to our hospital that were positive for pertussis and within days, our own employees. The Infection Preventionist, Chief Quality Officer and the Chief of Pediatrics quickly created an action plan. Pertussis precautions were created starting with teaching Admissions staff to provide masks for anyone with respiratory symptoms; an employee and patient exposure plan was quickly developed; posters raising awareness of symptoms and ordering tests was posted in all provider areas; ordering, treatment and patient education was updated and standardized in the electronic ordering system; and education was sent to all staff. The most important intervention was a pertussis walk-in clinic that saw over 50 patients to educate, diagnose, treat and vaccinate.

REHOBOTH MCKINLEY HOSPITAL (CONT.)

Hospital challenges:	Standardizing a process, such as pediatric medication administration, is difficult due to the emergency room, hospital, clinics and operating room all using different medication ordering systems. This requires multiple processes to achieve the same outcome. Another challenge with being a small, rural hospital is that pharmacy is not always on site requiring a different process for days and overnight. The ideal is creating a standard process, but with so many variables; it is a much longer process to see improvement. Our out of state hospitalists were not as aware as our local providers that we were in the middle of a Pertussis outbreak. The nursing staff was aware of our efforts and challenged the hospitalists to test quickly and isolate any patients with symptoms similar to pertussis. The nursing staff's efforts were very successful after a case was diagnosed due the nurse's persistence in "Test, Treat and Isolate", our campaign motto.
Any mid-course corrections:	The two-RN verification was difficult to hardwire because the Electronic Medical Record could flag certain medications to require two-RN verification, however many medications are used for both adults and pediatrics. This led to fallouts in our process. The Nursing IT analyst created a Pediatric medication order dictionary that would require the two RN verification process to be documented, increasing compliance.
Successes:	We have not had another pediatric medication error since implementing these processes. The pertussis outbreak was minimized with our involvement in the community wide effort to diagnosis early and treat and to vaccinate.

ROOSEVELT GENERAL HOSPITAL

Hospital interventions:	Sepsis: Our facility was struggling to consistently meet sepsis guidelines and recommendations for the management of early-identified sepsis in our ED patients. We implemented a nurse-initiated protocol in triage and worked with providers to develop ongoing orders once criteria triggers were met. Our plan was to build in the EHR as an order set with follow up lactate and antibiotics. CAUTI/ Foley Utilization: We recognized that our CAUTI rate is very low, but we are continuing to see a high use of Foley catheters in our ED. We wanted to focus on appropriateness of insertion and overall utilization within our facility to ensure our CAUTI rate does not increase. IP and nursing worked with physician team to evaluate educate and implement new actions to ensure every catheter-met criterion for insertion. Every insertion is audited for compliance and early discontinuation.
Hospital challenges:	Difficulty making changes to our EHR system, which hinders electronic standardized processes. We could not create our protocols within the EHR or create hard stop limits on these two metrics due to limited EHR and analytics support. We had to revert to paper algorithms or referenced protocols for the pathway and encourage follow up with CPOE orders.
Any mid-course corrections:	Sepsis: Education to our providers and nursing staff to ensure understanding and use of criteria/ protocol. ED medical director had one on one meetings with the providers that were identified as not meeting criteria or not ordering antibiotics within the 3-hour time window. Audits of every chart coded with sepsis diagnosis for review and trending of care initiated. CAUTI/ Foley Utilization: Ongoing education from IP nurse at staff meetings and with the hospitalist group. Data is reported to the quality management committee monthly for support. Evaluation of a paper algorithm is still underway.
Successes:	Sepsis: Our ED providers are meeting and delivering upon our early sepsis-screening tool and recommendations for further orders with 100% compliance the last few months. CAUTI/ Foley Utilization: The use of educational pamphlets for the patients/families on Foley care, indications, and cleanliness helped encourage our patients to ask questions and advocate for early discontinuation. We also trialed several different products and worked with the facility Products Committee to find an alternative to Foley placement for our male patients (condom petal). We noted improved use of utilization across the organization and our CAUTI rate remains at zero.

SAN JUAN REGIONAL MEDICAL CENTER

Hospital interventions:	Malnutrition Screening Process Identifying, diagnosing, and treating malnutrition for hospitalized patients as quickly as possible is instrumental in avoiding or mitigating a wide range of undesired patient outcomes and increased healthcare costs. Malnutrition is present in at least on third of all hospital patients. In FY2016, < 2% of SJRMC adult patients were identified and coded for malnutrition. In response, SJRMC redesigned current workflow, adopted best practice malnutrition screening tool, developed an Oral Nutrition Supplement Standard Order Set, revised the Nutrition Screening Assessment policy, and developed education materials for staff and providers. Chest Pain Patient Observation Length of Stay In late September 2018, the length of stay (LOS) for chest pain observation patients was identified as a major challenge to the organization. SJRMC's base line data from March to August 2018 revealed the median length of stay consistently exceeded 16 hours for chest pain observation patients at 23.8 hours. To address these challenges, the following solutions were developed and implemented: Chest Pain Observation Patient Admission Order Set, Chest Pain Observation Pathway, Visual Management Tool to facilitate identification, prioritization, and status of chest pain observation patients, Nursing and Case Management Daily Huddle to facilitate care, and Chest Pain Observation process education to all stakeholders.
Hospital challenges:	There was limited capacity for Registered Dietitian to consult on all patients. Consistency in practice by providers to request Inpatient Clinical Nutrition consults when appropriate and routinely review nutrition notes and recommendations. Process deficiencies directly related to chest pain observation length of stay were an absence of a protocol-driven pathway, indistinct identification of Chest Pain observation patients, and inadequate or absent communication and coordination between care givers.

SAN JUAN REGIONAL MEDICAL CENTER (CONT.)

Any mid-course corrections:	Registered Dieticians continue to audit for compliance and trends. Staff collaboration with providers to ensure buy-in. Obtaining provider agreement and buy-in on elements of the Chest Pain Observation Pathway and Chest Pain Observation Patient Admission Order set.
Successes:	The percent of patients coded with malnutrition during the pilot and rollout period doubled. During the months of May and June 2018, the rate increased to 4.8%, moving from 2% to 4%, which surpassed the national average of 3.2%. Oral Nutrition Supplements ordered and distributed by increased by 55%, and Registered Dietitian consults increased from 72 to 325. Chest Pain Patient Observation length of stay has reduced by 58% from 23.8 hours to 14 hours since improvement initiatives were implemented November 2018.

SIERRA VISTA HOSPITAL

Hospital interventions:	Sierra Vista Hospital has undergone several changes during the past year: multiple CEO's and multiple position changes within the facility, including three changes in Quality Manager. Despite this, we have been able to maintain most of our programs and data tracking. Catheter Utilization was 14.29 for FY-16 and improved to 10.58 for FY-17. Our CLABSI rate has continued to be -0- for both FY-16 and FY-17. We attribute this to a culture that uses Foleys as a last resort and a strong infection control program. Diapers and Attends are weighed for I&Os instead of using Foleys
Hospital challenges:	With our low censuses, any adverse event causes our rates to rise significantly. Our Patient Falls has increased from 4.36 in FY-16 to 6.56 in FY-17. Both are significantly higher than the state and national rates. The FY-17 rate is due to 8 falls, out of 1471 patient days. However, we have been tracking All Falls. We are going to change and track Falls with Injuries in order to report more appropriately. We have also implemented Hourly Rounding and Bedside Reporting. Our Hospital Readmission, All Causes, for FY-16 was 2.36, and for FY-17 was 2.91. Both years are below the state and national rates. However, for FY-17, it is misleading. Our rate for the first half was 0.46, and the rate for the second half increased to 5.35. This was a significant increase for our censuses. We have been making discharge follow-up calls a few days after discharge. We are going to add a second follow-up call about 30 days after discharge. We also have a program thru our EMS that enables crewmembers to make home visits on high risk patients. We hope this will improve compliance with medications and physician appointments in our high-risk patients.

SIERRA VISTA HOSPITAL (CONT.)

Any mid-course corrections:	Since Quorum took over management of our facility in November, we have been working hard on bringing the facility back into compliance in several areas and getting us ready for survey. We have had a couple of mock surveys and found several issues that have been corrected or are in the process of improving. With the changes in Quality Manager, we have had issues with tracking and reporting in some areas. Hopefully this will improve.
Successes:	Our rate for Stage II Pressure Ulcers was 0.79 for FY-16 and -0- for FY-17. We attribute this improvement to the use of Alternating Pressure Mattresses for high risk patients. We use the Braden Scale to assess the patient's risk for skin breakdown on every admission. Skin assessments are done a minimum of twice a day by our nurses. Our Patient Care Techs also assess for skin changes during every cleaning and diaper change. We provide rapid intervention of any skin change.
Any other information:	In updating the HIIN reporting website, it was discovered that we are not reporting in the Sepsis department. We will begin tracking and reporting the Hospital Acquired Sepsis Mortality Rate immediately. We have recently begun working on the Value Based Programs. We are currently negotiating with the insurance companies for necessary contract changes. We have chosen some of the options to implement new processes to improve patient outcomes.

SOCORRO GENERAL HOSPITAL

Hospital interventions:	Socorro General Hospital (SGH) follows the Presbyterian Policy and Procedure "Fall and Injury Prevention". SGH Nursing staff followed the "No One Walks Alone" (NOWA) process. Interventions include, and is based on patients assessment: Admission folders containing Fall Risk Education; Fall Assessment screening; Fall Risk Bracelet; Fall Risk Care plan in the EMR; Laminated No One Walks Alone education material; Slip Free socks; Bed alarm; Chair alarm; Gait Belt; Call light; Telephone and NOWA Audits . There is also a procedure and interventions for the pediatric population. The staff has been trained and educated to tailor to the needs of the patient, whether it may be in an Inpatient Bed or Swing Bed. During the 2nd quarter of 2018 communication regarding falls was enhanced by the posting of "days since last fall" where staff are able to see daily reports. Staff reinforced to the patient the importance of calling for assistance when trying get out of bed. This has been effective in creating a heighten sense of awareness. In addition, staff perform daily Safety Sweeps which assesses the room for fall risks during hourly rounding, and more frequent as appropriate. RN new hire onboarding include attending nursing orientation and also unit competency -based orientation while working on the unit. Nursing staff also have the Epic "Fall Risk Documentation Resource Guide" which contains the link to the policy and incorporates evidenced based practice into the Individualized Care Plan. There is a daily Interdisciplinary Team Meeting to discuss patients plan of care. CLABSI Reduction: In 2018 the use of a disinfectant line tip protectors was implemented to further minimize the risk of infection. This was a multidisciplinary effort which required coordination, just in time education, and communication with all the process participants. In addition, in May 2018 a new central venous catheter dressing kit was implemented. Changes to the kit include a CVC dressing change Step-by-Step Guidance Card, a SANI-Cloth Germicidal Disposable Bleach Wipe, removal of the alcohol wipe package and replacement with two Chloraprep One-Step swab-sticks. The Guidance Card provided nursing a checklist to prevent misses in steps. Education was provided during the 2nd Quarter of 2018. Recognizing that one CLABSI is one to many, the objective was to improve practice by adding improved supplies and reinforce consistent practice in order to sustain current success. In 2018, Socorro General Hospital (SGH) had 468-line days with no CLABSI's reported. RN Staff completed the 2018 annual Central Line Associated Blood Stream Infection (CLABSI) computer-based training in the Presbyterian Annual Clinical Education Regulatory Requirement (PACERR) bundle. There is a daily Interdisciplinary Team Meeting to discuss patients plan of care.

SOCORRO GENERAL HOSPITAL (CONT.)

Hospital challenges:	The Swing bed patients are independent, and some refuse the bed alarms. Swing Bed patients who are admitted for 6 weeks of antibiotics treatment are more ambulatory with access to go outside. This poses a challenge to the SGH staff to constantly reeducate the patient on the care of their central line dressing.
Any mid-course corrections:	Increase the frequency of audits and rounding by the Infection Preventionist and Quality manager to assure compliance with the process steps. Education to providers and staff on appropriateness of ordering and specimen collection.
Successes:	There was 317 days since the last fall and the Med/Surg staff's next milestone is to reach no falls for 365 days. With the addition of new supplies, standard dressing change kit and Curios caps, along with consistent practice, SGH has been able to avoid a CLABSI for 596-line days total.
Any other information:	The policy was updated in which dressing changes were synchronized to one day a week. RN staff completed the annual CLABSI computer-based training in the PACERR bundle. Clinical Practice Leads are in the process of observing and documenting competency for dressing change on each RN on the Med/Surg unit via a manikin and a competency performance checklist. The Purchasing Department now restocks the central line insertion kit. The SGH patient population for Med/Surg range from newborn to geriatric. They also care for patients in hospice, swing bed status and outpatients. The policy was reviewed and updated based on new evidenced based practice such as a "We Walk with You" procedure, review of fall screen risk assessments, new teach back tool and new audit tool. The Socorro Inpatient Charge, the MS Clinical Practice Lead and Clinical Professional Development Specialist participated in the Presbyterian Fall Summit and participated in the organizational Falls Meetings to share best practice.

UNION COUNTY GENERAL HOSPITAL

Hospital interventions:	1. The Antibiotic Stewardship Program has started tracking the IV to PO conversion rate prior to discharge. The Pharmacist will consult with the Provider if this has not been done. Training was giving to the providers and nursing staff. 2. Customer service trainings were conducted by an outside company. All staff, including providers were required to attend. 3. Patient satisfaction is a top priority at UCGH. We have developed patient satisfaction surveys that are given to patients for feedback on their services.
Hospital challenges:	1. The customer service trainings were completed in April and to this date there has been no increase in inpatient scores. 2. UCGH was not able to retain one of our full-time physicians.
Any mid-course corrections:	n/a
Successes:	1. Recruitment of a full-time physician and a full-time nurse practitioner. 2. Our clinic was converted into a rural health clinic. 3. Continue to maintain a Level 4 trauma designation.

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). Highlights include a 46% decrease in Perioperative DVTs/PEs and a 40% decrease in post-operative sepsis cases. • There was a hospital-wide rollout for the Implementation of a Program for Rounding on VTE Prophylaxis and Effective Infection Control (IMPROVE_IT) Project that has shown a consistent decrease in the preventable DVTs, CLASBIs and CAUTIs in the adult patients. The pilot started in 4 inpatient units and is now in all the adult units, including the ICUs. • The Pediatric Inpatient Units are gathering data to begin a Failure Mode Event Analysis, for DVT prevention. • The hospital is participating in the HRET Hospital Improvement Innovation Network (HIIN) until March 2020 • The hospital continues to participate in several Vizient collaborative designed to improve quality. One focus has been the Transforming Clinical Practice Initiative (TCPi). This is an outpatient project that is looking at reducing cost, increasing access to care and chronic disease follow-up..
Hospital challenges:	• The hospital has seen an increase in the number of C. difficile infections in the inpatient units.
Any mid-course corrections:	• The hospital has revised the action plans for reducing C difficile infections including electronic handwashing monitoring on the inpatient units, changes to Environmental Services protocols and optimizing the Electronic Medical Records to assist providers in ordering cultures appropriately.
Successes:	The hospital has downward trends, from the previous year, in: • Central line associated blood stream infections (CLABSI) by 36%. • Catheter associated urinary tract infections (CAUTI) by 32%. • Perioperative deep venous thrombosis/pulmonary embolisms (DVT/PE). • Falls with injuries by 31%. • All Cause Readmissions by 8.5%.

HUMAN SERVICES DEPARTMENT

THANK YOU

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