Hospital Quality Improvement Incentive

Operate the New Mexico Medicaid program in line with the state's quality goals by providing better care for individuals, better health for the population, and lower costs through improvement.

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 has been paid. For DY 4 the estimated amount to be paid is $8,825,544.

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

Measures

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.

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

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.

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

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

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

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

Domain 1 Measures

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.

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

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:

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

Alta Vista Regional Hospital

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	NO*
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	NO

Percentage of overall improvement 67%

(improved in 4 of the 6 eligible measures)

*Indicates only a slight decrease

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Artesia General Hospital

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	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 DY2 to DY3

Measures (Eligible measures only)	Showed improvement or met the minimum requirement
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	NO
Central Line Associated Blood Stream Infections (CLABSI)	YES
Ventilator Associated Events (VAE, VAP)	YES
Surgical Site Infections (SSI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
-OB vaginal laceration w/instrumentation	NO
-OB vaginal laceration w/o instrumentation	YES
All Cause Readmission	YES

Percentage of overall improvement 85%

(improved in 8 of the 10 measures)

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CHRISTUS St. Vincent Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	Showed improvement or met the minimum requirement
Adverse Drug Events (ADE)	NO
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Central Line Associated Blood Stream Infections (CLABSI)	YES
Ventilator Associated Events (VAE, VAP)	NO
Surgical Site Infections (SSI)	NO*
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
-OB vaginal laceration w/instrumentation	YES
-OB vaginal laceration w/o instrumentation	YES
All Cause Readmission	YES

Percentage of overall improvement 70%

(improved in 7 of the 10 measures)

*Indicates only a slight decrease

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Cibola General Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	YES

Percentage of overall improvement 100%

(improved in 6 of the 6 eligible measures)

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Dr. Dan C. Trigg Memorial Hospital

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
All Cause Readmission	YES

Percentage of overall improvement 100%

(improved in 5 of the 5 eligible measures, 1 exempt due to too small of a sample size)

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Eastern New Mexico Medical Center

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	Showed improvement or met the minimum requirement
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Central Line Associated Blood Stream Infections (CLABSI)	YES
Ventilator Associated Events (VAE, VAP)	YES
Surgical Site Infections (SSI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	NO*
Postoperative PE or DVT	YES
-OB vaginal laceration w/instrumentation	NO*
-OB vaginal laceration w/o instrumentation	YES
All Cause Readmission	NO*

Percentage of overall improvement 79%

(improved in 7.5 of the 10 measures, OB vaginal carries weight of .5 each)

*Indicates only a slight decrease

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PHS Espanola Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	NO
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	YES

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

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Gerald Champion Regional Medical Center

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	NO*
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	NO

Percentage of overall improvement 67%

(improved in 4 of the 6 eligible measures)

*Indicates only a slight decrease

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Gila Regional Medical Center

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	NO
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	NO*

Percentage of overall improvement 67%

(improved in 4 of the 6 eligible measures)

*Indicates only a slight decrease

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Guadalupe County Hospital

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
All Cause Readmission	YES

Percentage of overall improvement 100%

(improved in 5 of the 5 eligible measures, 1 exempt due to too small of a sample size)

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Holy Cross Hospital

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	NO
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	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 DY2 to DY3

Measures (Eligible measures only)	Showed improvement or met the minimum requirement
Adverse Drug Events (ADE)	NO*
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Central Line Associated Blood Stream Infections (CLABSI)	YES
Ventilator Associated Events (VAE, VAP)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	NO*
Postoperative PE or DVT	YES
-OB vaginal laceration w/instrumentation	YES
-OB vaginal laceration w/o instrumentation	YES
All Cause Readmission	YES

Percentage of overall improvement 80%

(improved in 8 of the 10 measures)

*Indicates only a slight decrease

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Lincoln County Medical Center

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	YES

Percentage of overall improvement 100%

(improved in 6 of the 6 eligible measures)

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Los Alamos Medical Center

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	NO
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	NO*
Postoperative PE or DVT	NO
All Cause Readmission	YES

Percentage of overall improvement 50%

(improved in 3 of the 6 eligible measures)

*Indicates only a slight decrease (within a one rate or estimated 10%)

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Lovelace Regional Hospital – Roswell

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	NO
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	YES

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

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Memorial Medical Center

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	Showed improvement or met the minimum requirement
Adverse Drug Events (ADE)	NO*
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Central Line Associated Blood Stream Infections (CLABSI)	NO*
Ventilator Associated Events (VAE, VAP)	YES
Surgical Site Infections (SSI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	NO*
Postoperative PE or DVT	YES
-OB vaginal laceration w/instrumentation	NO
-OB vaginal laceration w/o instrumentation	YES
All Cause Readmission	YES

Percentage of overall improvement 65%

(improved in 6.5 of the 10 measures, OB vaginal carries weight of .5 each)

*Indicates only a slight decrease

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Mimbres Memorial Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	NO*

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

*Indicates only a slight decrease

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Miners' Colfax Medical Center

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	NO*
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	YES

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

*Indicates only a slight decrease

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MountainView Regional Medical Center

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	Showed improvement or met the minimum requirement
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Central Line Associated Blood Stream Infections (CLABSI)	NO*
Ventilator Associated Events (VAE, VAP)	YES
Surgical Site Infections (SSI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
-OB vaginal laceration w/instrumentation	YES
-OB vaginal laceration w/o instrumentation	YES
All Cause Readmission	NO*

Percentage of overall improvement 80%

(improved in 8 of the 10 measures)

*Indicates only a slight decrease

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Nor - Lea General Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
All Cause Readmission	YES

Percentage of overall improvement 100%

(improved in 5 of the 5 eligible measures, 1 exempt due to too small of a sample size)

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Plains Regional Medical Center.

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	NO*
Central Line Associated Blood Stream Infections (CLABSI)	NO
Ventilator Associated Events (VAE, VAP)	YES
Surgical Site Infections (SSI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
-OB vaginal laceration w/instrumentation	NO
-OB vaginal laceration w/o instrumentation	YES
All Cause Readmission	YES

Percentage of overall improvement 75%

(improved in 7.5 of the 10 measures, OB vaginal carries weight of .5 each)

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Rehoboth McKinley Hospital

HQII Reporting results from DY2 to DY3

Measures **(Eligible measures only)**	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	NO*
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	NO

Percentage of overall improvement 67%

(improved in 4 of the 6 eligible measures)

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Roosevelt General Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	NO
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
All Cause Readmission	YES

Percentage of overall improvement 80%

(improved in 4 of the 5 eligible measures, 1 exempt due to too small of a sample size)

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San Juan Regional Medical Center

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	Showed improvement or met the minimum requirement
Adverse Drug Events (ADE)	NO*
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Central Line Associated Blood Stream Infections (CLABSI)	YES
Ventilator Associated Events (VAE, VAP)	NO*
Surgical Site Infections (SSI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
-OB vaginal laceration w/instrumentation	YES
-OB vaginal laceration w/o instrumentation	YES
All Cause Readmission	NO

Percentage of overall improvement 70%

(improved in 7 of the 10 measures)

*Indicates only a slight decrease

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Sierra Vista Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	NO
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Falls and Trauma	YES
All Cause Readmission	NO

Percentage of overall improvement 50%

(improved in 2 of the 4 eligible measures, 2 exempt due to too small of a sample size)

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Socorro General Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
Postoperative PE or DVT	YES
All Cause Readmission	YES

Percentage of overall improvement 100%

(improved in 6 of the 6 eligible measures)

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Union County General Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	**Showed improvement or met the minimum requirement**
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Pressure Ulcer Stage III & IV rate	YES
Falls and Trauma	YES
All Cause Readmission	YES

Percentage of overall improvement 100%

(improved in 5 of the 5 eligible measures, 1 exempt due to too small of a sample size)

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

University of New Mexico Hospital

HQII Reporting results from DY2 to DY3

Measures (Eligible measures only)	Showed improvement or met the minimum requirement
Adverse Drug Events (ADE)	YES
Catheter Associated Urinary Tract Infections (CAUTI)	YES
Central Line Associated Blood Stream Infections (CLABSI)	NO*
Ventilator Associated Events (VAE, VAP)	NO
Surgical Site Infections (SSI)	YES
Pressure Ulcer Stage III & IV rate	NO*
Falls and Trauma	YES
Postoperative PE or DVT	NO
-OB vaginal laceration w/instrumentation	YES
-OB vaginal laceration w/o instrumentation	NO
All Cause Readmission	NO*

Percentage of overall improvement 45%

(improved in 4.5 of the 10 measures, OB vaginal carries weight of .5 each

*Indicates only a slight decrease

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

Alta Vista Regional Hospital

Annual Report

Alta Vista Regional Hospital	
Hospital interventions:	The Foley catheter care protocol was revised to include retention protocol (did not include direction on how to prevent Foleys from being replaced). Patient's post-Foley removal may have retention difficulty and require bladder retraining. Ventilator Associated Pneumonia - The Ventilator-Associated Pneumonia (VAP) Bundle was re-evaluated, which had called for oral care but did not indicate every 2-hr. oral care or Chlorhexidine oral care every 12 hours. The Infection Prevention Committee voted to improve bundle using evidence based practice standard of care guidelines. There was poor compliance initially; it was determined that ease of gathering supplies aided in noncompliance. 24-hour oral care kits were introduced; after 3 mos., the process appears hardwired.
Hospital challenges:	The revised Foley protocol has not been completely hardwired and continues to be a work in progress.
Any mid-course corrections:	Intravenous (IV) site care was not being conducted regularly or consistently. Evaluation of IV products (peripheral and central lines) with multiple concerns re: IV start kit. The issue was reported up though products committee -> corporate level -> vendor. The product was pulled from shelves immediately. We trialed several products: built our own kit that met the needs of the patient population. Re-training was completed for line management and care. Since product change and re-education, we have had a reduction in non-compliance for line care and improved satisfaction from staff.
Successes:	Intravenous (IV) kits - we have had a reduction in non-compliance for line care and improved satisfaction from staff regarding ease of securement, cleaning and care. We improved oral care to decrease ventilator-associated events.

Artesia General Hospital

Annual Report

Artesia General Hospital	
Hospital interventions:	A new facility-wide quality program with performance measures and performance improvement cues (ActionCue by Prista Corporation) was implemented. Department Directors participated in selection of quality measures and are responsible for ensuring their data are entered, tracking performance, and creating action plans when goals are not met. The new system incorporates details from the event reporting portion of the program and creates reports of medication variances, patient Falls, Readmissions, and other patient safety indicators.
Hospital challenges:	Staff turn-over continues to be a challenge. Education and re-education is required to ensure that staff members who are responsible for the quality program in their settings are familiar with the system and quickly learn to participate in using the resulting data to review and improve processes.
Any mid-course corrections:	Initially, data from the new quality program were presented at the Quality Assurance/Performance Improvement (QA/PI) Committee. However, the amount of information and material increased to the point the meetings were too lengthy. Three quality councils were formed - Clinical Council (hospital clinical departments), Clinic Council (physician practices and clinics), and Non-Clinical Council. This allows participants with similar challenges to review data and brainstorm means of improving performance. Council results are then reported up to the QA/PI Committee with a focus on Action Plans.
Successes:	Using the new system, we have experienced increased compliance with timeliness of entering data and a growing understanding of the significance of the information. We celebrate successes as our Directors and others gain proficiency in creating and implementing action plans that result from their analysis of their data.
Any other information:	The Falls Prevention Team is restructuring to bring more direct patient care staff onboard. The Team has had good results but believes more can be accomplished with input from the new members. With the positive impact of Hospital Engagement Network 2.0, we have chosen to participate in Hospital Improvement Innovation Network.

Carlsbad Medical Center

Annual Report

Carlsbad Medical Center	
Hospital interventions:	Warfarin education being is done by pharmacy for patients discharged on warfarin. We schedule follow-up appointments for Heart Failure patients. We are engaging a Clinical Documentation specialist to notify Quality of any Hospital Acquired Conditions.
Hospital challenges:	There has been an increase in catheter-associated urinary tract infections (CAUTI), and Clostridium Difficile.
Any mid-course corrections:	Intensive Clostridium Difficile education included Environmental Services staff and physicians. There has been a focus on isolation for diarrhea, early testing and antimicrobial stewardship program. We provided annual training on Centers for Disease Control and Prevention (CDC) guidelines for Catheter-Associated Urinary Tract Infections prevention, and we report Central line and catheters on bedside shift reports.
Successes:	We maintained zero events for central line associated blood stream infections (CLABSI), pressure ulcer, iatrogenic pneumothorax, Post-operative hip fracture, post-operative venous thrombo-embolism, post-operative wound dehiscence, and surgical site infection - colon and hysterectomy.

CHRISTUS St. Vincent's Regional Medical Center

CHRISTUS St. Vincent Regional Medical Center	
Hospital interventions:	A number of initiatives that had begun last year continued. These included: Clostridium Difficile reduction efforts focused on increasing hand washing compliance, implementing best practice environmental cleaning practices including use of Ultraviolet light following terminal cleans, developing and implementing a nurse-initiated protocol for screening and testing for Clostridium Difficile during the first 48 hours after admission, and beginning a formal antibiotic stewardship committee. Central Line Associated Blood Stream Infections reduction efforts focused on increasing compliance with central line maintenance and reducing central line usage. Catheter-Associated Urinary Tract Infections reduction efforts focused on reducing the rate of catheter interruptions of collection systems and reducing catheter use. Surgical site infection reduction efforts focused on improving the rate of appropriate surgical antibiotic prophylaxis. There was continued focus of reducing early elective deliveries. Finally, efforts continued to increase the detection of adverse drug events causing harm through use of the IHI (Institute for Healthcare Improvement) global trigger tool.
Hospital challenges:	The hospital is recruiting for full-time infection prevention staff. Contractors and existing staff in the quality department are doing infection prevention work, but the hiring of full-time staff dedicated to this topic is a primary focus.
Any mid-course corrections:	The initial intervention aimed at reducing Catheter-Associated Urinary Tract Infections is focused on education regarding indications for indwelling catheter use. This proved marginally effective. A mid-course correction was switching out hospital equipment so that only catheters with urometer/temperature probes are stocked. This prevents the need for interrupting the system upon transfer to the Intensive Care Unit (ICU). In addition, non-indwelling catheters were stocked in the ICU.

CHRISTUS St. Vincent's Regional Medical Center

CHRISTUS St. Vincent Regional Medical Center continued	
Successes:	Clostridium Difficile reduction efforts resulted in: the rate of appropriate hand hygiene improved by 33% on average; the number of Clostridium Difficile infections has decreased; we hired a 0.8 full time equivalent (FTE) dedicated infectious disease pharmacist. Catheter-Associated Urinary Tract Infections reduction efforts resulted in: the rate of interrupted urinary catheter systems was reduced by almost half; there was a statistically significant decrease in indwelling catheter use by 10%. Central Line Associated Blood Stream Infections reduction efforts resulted in: a significant improvement in compliance with all central line maintenance best practices; there was a statistically significant decrease in indwelling catheter use by 17%. By end of year, it is anticipated there will be electronic order sets with appropriate surgical prophylaxis by surgery type, consistent with Infectious Disease Society of America (IDSA) recommendations. The rate of early elective deliveries was at 0%. There has been an increase in detection of adverse drug events causing harm through use of the Institute for Healthcare Improvement (IHI) trigger tool.
Any other information:	We experienced success in identifying adverse drug events that caused harm through using the IHI's Global Trigger Tool. This led to greater detection and reporting of adverse drug events which may appear to be an unwanted occurrence, but it is important to note that an increase in reported Adverse Drug Events (ADE) is nationally accepted within the medical community as a positive result of intervention. This does not mean more ADEs are occurring – rather, it means more are being detected and the hospital's culture supports and encourages reporting these events. Numerous well-accepted publications estimate that only about 10% of ADEs are reported, so an increase in the number of these events should not be construed as worsening performance.

Cibola General Hospital

Cibola General Hospital	
Hospital interventions:	We made changes in cleaning materials and how improvement can be made with Environmental Services (EVS) and competencies; hand washing compliance was reviewed and we shared ideas around improving compliance [i.e. changes to hand gel and locations, pictures of staff washing hands]. We implemented: • techniques from training received from HealthInsight on antimicrobial stewardship and physician involvement; • continued use of accelerated hydrogen peroxide use and working with EVS team on appropriate use/cleaning process; • annual competency and training for EVS staff, validation of cleaning practices through the use of glow pen application to high touch areas with real-time feedback to EVS staff: • education on ongoing monitoring of operating room (OR) staff on proper air flow, traffic control, and attire in OR environment: • continued evaluation of OR temperature, humidity, and airflow to verify operating parameters are within limits; • current sterilization and disinfection procedures in clinic and OR: developed and implemented preference card project to improve OR procedural efficiency and infection control: • A patient-focused project on pre-operative bathing instructions (using an antiseptic that we provide to them): painted the Post-Acute Care Unit: installed touchscreen TVs at patient's bedside. We continued with Fall Team and Fall Prevention Program; purchased gait belts for staff to start using to promote safe lifting techniques; all Directors and high performers are participating in a 12-month program focused on improving patient satisfaction scores called "HCAHPS Breakthrough Series" (Hospital Consumer Assessment of Healthcare Providers and Systems)
Hospital challenges:	The greatest challenges at CGH were with discharge planning--specifically implementation of the LACE tool (length of stay, acuity of admission, co-morbidities, Emergency Department visits within the last 6 months): properly addressing adverse drug reactions (ADRs)--specifically how to roll out the Paseo Opioid Sedation Scale (POSS): patient alarms: proper fire drill execution with CGH staff: and safety and security of CGH staff, particularly clinical staff (abuse by patients and potential harm from outsiders)

Cibola General Hospital

Cibola General Hospital **continued**	
Any mid-course corrections:	We conducted multiple community awareness projects to ensure that interventions became successes: for interventions that were LEAN ("Lena Six Sigma") project, LEAN methods were used to evaluate the success of the project and conduct mid-course corrections if the process or project needed further improvement
Successes:	We had an increase in the number of fall-free days after implementation of Fall Prevention Program: an increase in hand washing compliance among staff: a decrease in the number of contaminated blood cultures: no Catheter-Associated Urinary Tract Infections: and put "hard stop" and use of medical induction criteria in place which has virtually eliminated early elective deliveries.
Any other information:	We continued participation in the American Hospital Association (AHA)/Health Research & Educational Trust (HRET) Hospital Engagement Network (HEN): recipient of Excellence in Financial Strength award for National Rural Health Day: recipient of Most Wired award

Dr. Dan C. Trigg Memorial Hospital

Dr. Dan C. Trigg Memorial Hospital	
Hospital interventions:	An anticoagulation subcommittee was formed to oversee this process. We determine if INR>5 (International Normalized Ratio) is due to management, prescribing, monitoring decisions. We have a process in place to intervene. This has been implemented for all facilities. The Falls work is in process and focuses on implementation of NOWA model (No One Walks Alone). We are strengthening Hourly Rounding in facilities.
Hospital challenges:	We are analyzing the various data sources for similar measures and variation in results.
Any mid-course corrections:	We have ongoing quality improvements throughout Presbyterian Healthcare Services.
Successes:	A Medication Operation Safety Team was implemented in all facilities.
Any other information:	Work was not driven by occurrence but spread of standard work throughout Presbyterian Healthcare Services and establishing best practice.

Eastern New Mexico Medical Center

Eastern NM Medical Center	
Hospital interventions:	Sepsis: We educated physicians and staff on Guidelines; modified electronic record to use – MEDITECH has a toolkit that we can implement: Redraw of Lactic Acid if original >2: Catheter-Associated Urinary Tract Infections: we implemented a toolkit in MEDITECH that is in line with the Clinical Pathway recently implemented with policy and tools. ADE - (Adverse Drug Events) We reported a new measure beginning 2015 which showed baseline data. Specifically, Quality is focusing on the Narcan dose for Opioids.
Hospital challenges:	Two Safety Events occurred: Medication Reconciliation and Fall with Injury. Both have Performance Improvement Projects. Clostridium Difficile (C-diff) is a challenge to get the staff to send specimens per protocol; causing reportable rates to increase.
Any mid-course corrections:	Falls: During the first half of the year we had a significant decrease in Falls; however, not sustained. Two main factors: 1) lack of stable workforce – much fluctuation in staffing; 2) Purchase of new beds and bed alarms which led to a false sense of security by staff. The Risk Manager implemented a Safety Coach program which will monitor and educate staff on effective hourly rounding and help identify previously unknown risk factors for increased awareness on part of staff.
Successes:	Tobacco cessation: we provided education to prescribers and nursing staff to ensure education of the patient upon admission and discharge as well as medications while in-patient. Scores went from 40% to 90% compliance. Medication Administration Bar Code Compliance: We significantly improved to >98.5% average score. Behavioral Health Unit: we hired experienced leaders, on-site psychiatrist and nursing staff. We have seen significant improvement in the milieu on the unit as well as significant reduction in Code Strong and elimination of restraints. The attitude of the patients has significantly improved with the programming for the unit.
Any other information:	As soon as an error is identified and/or an area needing improvement: a drill down is completed followed by a Corrective Action Plan that is developed and implemented. Monthly data collection and reporting at the Quality Council occurs. This has provided detailed accountability and measurement of specific core problem rather than addressing the symptom of the issue. We implemented an Exclusivity Breast Feeding Initiative which included implementing Baby Friendly Initiative: educated physicians; identified resources in the community to support initiative; and established a relationship with La Leche League to be part of childbirth classes.

PHS Espanola Hospital

Espanola Hospital	
Hospital interventions:	An anticoagulation subcommittee was formed to oversee this process. We determine if INR>5 (International Normalized Ratio) is due to management, prescribing, monitoring decisions. We have a process in place to intervene. This has been implemented for all facilities. The Falls work is in process and focuses on implementation of NOWA model (No One Walks Alone). We are strengthening Hourly Rounding in facilities.
Hospital challenges:	We are analyzing the various data sources for similar measures and variation in results.
Any mid-course corrections:	We have ongoing quality improvements throughout Presbyterian Healthcare Services.
Successes:	A Medication Operation Safety Team was implemented in all facilities.
Any other information:	Work was not driven by occurrence but spread of standard work throughout Presbyterian Healthcare Services and establishing best practice.

Gerald Champion Regional Medical Center

Gerald Champion Regional Medical Center	
Hospital interventions:	We have maintained Zero early elective deliveries (EED). Warfarin monitoring was established through software improvements. The implementation of Fall prevention teams involved the bedside staff in solutions for the reduction of injuries sustained from Falls. We implemented Germ-Blast environmental cleaning system to combat hospital acquired infections.
Hospital challenges:	Hospital-Acquired Pressure Ulcer data is still manually abstracted from charts.
Any mid-course corrections:	Through chart audits for sepsis mortality, it was discovered that the charts with do-not-resuscitate DNR orders were not being coded as such which resulted in an artificially high risk adjusted mortality rate. The coding error was confirmed across multiple diagnoses. The error has been corrected going forward, and we expect to see a drastic reduction in Risk Adjusted Mortality rates.
Successes:	While overall Falls did not decrease in frequency, the injuries from Falls did as a result of involving staff in solutions.
Any other information:	Commercial hand washing compliance monitoring system has been purchased and is slated for implementation.

Gila Regional Medical Center

Gila Regional Medical Center	
Hospital interventions:	We focused work on Sepsis/Septic shock where we've seen improvement but continue to identify opportunities. The Catheter-Associated Urinary Tract Infections project wrapped up and we worked on hardwiring. Nursing focused programs surrounding the patient experience (Hospital Consumer Assessment of Healthcare Providers and Systems), care transitioning, and how to improve the level of noise within the hospital. We began work on Behavioral Health Unit (BHU) tobacco and substance measures as well as pain associated with IV and laboratory draws.
Hospital challenges:	Turnover in clinical staff is a continued issue as project hand-offs slow progress. Physician champions are occasionally difficult to come by, not because of lack of interest but due to scheduling conflicts and time. A new Electronic Medical Record has been in the works which has taken a lot of focus away from staff as we try to build a new system.
Any mid-course corrections:	We reviewed Behavioral Health Unit (BHU) measures with initial interpretation, made some changes and are re-focusing the staff on how to meet the goals.
Successes:	We finished the Catheter-Associated Urinary Tract Infections project and have implemented guidelines for physicians as well as nursing bundles to maintain our low rates.

Guadalupe County Hospital

Guadalupe County Hospital	
Hospital interventions:	This year GCH concentrated on discharge processes including the development of disease specific folders with a letter from the Administrator, education materials, discharge instructions, tracking forms (vital signs, meds, weight, etc.), and other hospital forms. GCH adopted a patient stay check list for observation and inpatients which include arrival time, code status, admission status, IV times and dates, care plan, Braden (skin breakdown) assessment, Hendricks (Fall risk) assessment, and other pertinent measures which must be addressed during each stay. Nurses must check off the item when completed, and the list must be completed by the end of the stay. We also implemented daily provider/nurse/pharmacist morning huddles similar to grand rounds in larger facilities. The team reviews patient records, status, plan of care and visits the patients as group. This facilitates the team process and continuity of care. GCH participates in the Medicare Hospital Rural Flexibility (FLEX) Improvement Program, and the New Mexico Rural Hospital Network Peer Group programs for improvement. We also participate in the HealthInsight data collection programs. We track data on readmission, Healthcare-associated Infections, Hypoglycemic Med Errors, Falls, Clostridium Difficile, Catheter-Associated Urinary Tract Infections, Central Line Associated Blood Stream Infections, Pressure Ulcers, ER re-visits within 72 hours, Venous Thromboembolism (VTE) Prophylaxis, Sepsis, Work days lost due to workplace violence. We report immunizations and syndromic data. We also report quality care measures to CART (Centers for Medicare and Medicaid Services Abstraction and Reporting Tool) and have attested successfully toMeaningful Use.
Hospital challenges:	GCH patient volumes are low, so it is difficult to adequately measure improvement. Therefore, we use days since last event (Falls, complaints, etc.). As in any other hospital, creating unique data and tracking the information through our electronic medical record (EMR) is often challenging. We have also had a rather high provider turnover so the training and education of providers continues to be challenging.
Any mid-course corrections:	We updated our electronic medical record (EMR) for better data extraction. We have also updated defaults on routes of medication administration. The discharge folders have been rolled out. We recently implement a terminal cleaning checklist for Clostridium Difficile patient rooms.
Successes:	We have still had no Catheter-Associated Urinary Tract Infections or Central Line Associated Blood Stream Infections, or other Hospital Acquired Infections. We have had no "never" events (no Falls with injury). Our patient experience scores have stayed around 90%.
Any other information:	We are planning an Infection Prevention training event on use of contact and isolation precautions for all clinical and housekeeping staff. We expanded our telemedicine support programs to include Critical Care and Pediatrics. We already had Tele-Neurology and Tele-Neurosurgery programs in place.

Holy Cross Hospital

Holy Cross Hospital	
Hospital interventions:	Holy Cross Taos continued to participate in the New Mexico Hospital Association Hospital Engagement Network over the course of the year. As the Hospital Engagement Network finished, Holy Cross had a relative improvement rate from 2014 baseline in adverse drug events, early elective deliveries, Central Line Associated Blood Stream Infections, Readmissions, Pressure Ulcers, Ventilator Associated Events, Venous Thromboembolisms and Surgical Site Infections - an improvement of 9 out of 11 topics. We revitalized our Internal Audit Team and revised the Audit schedule. The team includes members from across the hospital in every department from housekeeping and dietary to administration.
Hospital challenges:	We continue to struggle with Falls. We had been getting poor participation in the Fall Team. We moved the team meeting to be included in the Department meetings which had been well attended. We also enlisted the help of one of our hospitalists and one of our pharmacists. We have had great attendance since making those changes. Unfortunately, our Falls went up. Through the Hospital Engagement Network, we were able to conference with Jackie Conrad. She gave us great insight and tools to help with this problem. Since then we have instituted a post Fall huddle, including the patient if possible. We're investigating a different Fall score.
Any mid-course corrections:	Moving the Fall team meeting was a simple but extremely effective mid-course correction.
Successes:	We only had 2 cases of hospital-acquired Clostridium Difficile.

Lea Regional Hospital

Lea Regional Hospital	
Hospital interventions:	Our interventions: 1. Maintaining a multidisciplinary team meeting daily to review and discuss all patients - improved outcomes. 2. Use of best practices continues from conference calls to improve practices. 3. Participation in Hospital Engagement Network and benchmarked against other New Mexico facilities. 4. Change of practice and protocols based on evidence - best practice recommendations provided. 5. Updating and advancing ongoing performance improvement measures to match recommended standards. 6. Engaging the medical staff and Medical Staff leadership - enlisting Medical Staff champions to lead and educate peers accordingly. 7. As a Continuing Medical Education accredited facility, we enlist experts on staff to provide education to the Medical Staff regarding changes, best practices, etc. 7. Implementing electronic order sets based on best practices. 8. Re-established the Medical Staff peer review process, criteria for peer review relating to outliers or practice guidelines. 9. New Infection Control Practitioner with refocus on practices, education, etc. - this new Infection Control Preventionist (ICP) received and is receiving extensive education from certified peers, attending Association for Professionals in Infection Control and Epidemiology (APIC) meeting(s) and training(s). 10. Focused education for nursing staff - annual education/lab - established based on needs identified.
Hospital challenges:	1. We are still working to improve hourly rounding and bedside shift report - still a cultural change in process. 2. We focus bedside shift report to reduce healthcare acquired conditions and healthcare acquired infections - ongoing. 3. Electronic chart changes are pending approval for all facilities in network to make changes - working with work-arounds right now. 4. Regarding our patient population - we have increasing illicit drug use patients with significant needs, detox, increased Falls risk, danger to self and staff.

Lea Regional Hospital

Lea Regional Hospital continued	
Any mid-course corrections:	1. We identified practice problems with central line care on the skilled nursing facility (SNF) unit - education provided and no further issues - we continue to monitor. 2. We are re-establishing practices and new staff in Case Management to reduce Readmissions and 72 hour returns. Case Management is being used for effective disposition of care needs in the Emergency Dept. 3. Case Management and Quality Department are supporting coordination of care, follow up calls 2 weeks post discharge relating to Heart Failure patients to ensure proper follow up care being pursued as arranged at discharge to reduce the potential of readmission. 4. We are looking at potential for palliative care certification for Case Management staff. 5. We review any Readmissions relating to acute myocardial infarction (AMI), congestive heart failure (CHF), Pneumonia, Chronic Obstructive Pulmonary Disease, etc. to determine further trends, if standards of practice were met on previous admission, etc. 6. We re-established "Move the Dot" mortality reviews. 7. We re-review and re-educate Rapid Response Team role in facility (including re-education on Early Warning Scoring system). 8. We offered re-education regarding blood transfusion reactions, etc. 9. The Chief Nursing Officer reports physician compliance through Medical Staff Committees relating to electronic orders - improving activity/use ongoing.
Successes:	1. Readmissions were reduced - continue to focus on these. 2. Mortality and morbidity rates are improving - utilizing "Move the Dot". 3. We implemented nurse driven Foley catheter removal policy - re-education ongoing. 4. We continued use of central line checklist and training of hospitalist team members for ultrasound use with central line placement. 5. We engage Medical Directors and Physician Champion(s) regarding core measures, i.e. Sepsis, Chest Pain certification, etc.; 6. We established Performance Improvement teams; improvements were noted relating to Sepsis, Falls reduction, etc. 7. We continued focus on standard precautions, isolation standards, etc. - no issues with healthcare acquired infections, Central Line Associated Blood Stream Infections, Catheter-Associated Urinary Tract Infections, Methicillin-Resistant Staphylococcus Aureus (MRSA), etc. 8. We achieved above the national standards/rate in core measures -effectiveness of care.
Any other information:	1. The Hospital Engagement Network program matches our corporate practices and indicatives. 2. Participation in the Hospital Engagement Network opened up the ability for local networking and benchmarking comparison.

Lincoln County Medical Center

Lincoln County Medical Center	
Hospital interventions:	An anticoagulation subcommittee was formed to oversee this process. We determine if INR>5 (International Normalized Ratio) is due to management, prescribing, monitoring decisions. We have a process in place to intervene. This has been implemented for all facilities. The Falls work is in process and focuses on implementation of NOWA model (No One Walks Alone). We are strengthening Hourly Rounding in facilities.
Hospital challenges:	We are analyzing the various data sources for similar measures and variation in results.
Any mid-course corrections:	We have ongoing quality improvements throughout Presbyterian Healthcare Services.
Successes:	A Medication Operation Safety Team was implemented in all facilities.

Los Alamos Medical Center

Los Alamos Medical Center	
Hospital interventions:	LAMC is focused on three interventions: 1. Hospital Consumer Assessment of Healthcare Providers and Systems Action Plan- Focus on two initiatives for two months to hardwire process changes. First focus was Pain Control and Responsiveness to Call Lights. We participated in LifePoint Hospital Consumer Assessment of Healthcare Providers and Systems calls to identify best practices from other facilities & enlist resources/support as needed. We implemented rounding & communication by House Supervisors, Chief Nursing Officer, Director of Inpatient Nursing & Director of Quality. We updated Medical Staff and LAMC Advisory Board. For Pain Control- the key issues are communication about side effects of drug, asking frequent questions to patient about pain levels. For Response to Call Lights- the key issues are to answer within 3 rings, asking frequent questions to patients about nurse attentiveness to needs. Results update on two initiatives: LAMC is at 43% Top Box compared with LifePoint Top Box 48% for timely response to call button. LAMC is at 65% Top Box compared with LifePoint Top Box is 48% for pain control. 2. Case Management- we are aligning local initiatives with overall LifePoint goals: Interdisciplinary team meetings (IDT) daily huddles to incorporate discharge planning in place. We monitor length of stay, resource utilization, Readmissions, Hospital Acquired Pneumonia, Urinary Tract Infections (UTI), Hip Fractures, and Central Line Infections. We are training staff on best practices for daily case management functions. We identified a physician advisor for Utilization Management committee /the same physician is champion for LifePoint Sepsis Pilot Program. 3. Core Measures - We updated our Sepsis Protocol Policy to improve care of patients with sepsis diagnosis. A new Quality and Care Management Director started; we are working on resource utilization, length of stay, overall management of patient's stay with multi-disciplinary team: We re-engaged Reduce Emergency Department (ED) arrival to ED departure for ED admitted patients- supporting ED Physicians and Hospitalists to coordinate efforts to move patients to the appropriate level of care, including the decision to admit, transfer or discharge the patient.

Los Alamos Medical Center

Los Alamos Medical Center continued	
Hospital challenges:	We are challenged with engaging clinical and physician staff to be proactive with interactions with each other and patients to meet objectives of each initiative, and having individuals understand the importance of the impact that can be made in patient care by successfully meeting objectives. The new Quality/CM Director has successfully re-engaged a physician advisor for Quality and engaged an Emergency Department physician for Utilization Management Committee physician advisor.
Any mid-course corrections:	Mid-Course corrections have not been necessary but we constantly evaluate/monitor the interventions to ensure our plan is working. If changes are required, those are implemented immediately.
Successes:	Quarter over Quarter, we achieved a slight increase in Hospital Consumer Assessment of Healthcare Providers and Systems scores. Clinical & physician staff engagement has been good. Communication to Medical Staff leadership and LAMC Advisory Board has yielded positive feedback about efforts to improve patient care. Hospital Consumer Assessment of Healthcare Providers and Systems scores for Inpatient and Outpatient have experienced some declines; the new Quality Director is now Hospital Consumer Assessment of Healthcare Providers and Systems Champion and working on initiatives to improve scores through re-engaging directors and frontline staff.

Lovelace – Roswell Regional

Lovelace Roswell Regional	
Hospital interventions:	We've had a high focus on Falls, and patient/family engagement.
Hospital challenges:	Our paper record remains a challenge, with room for inconsistent documentation.
Any mid-course corrections:	We updated initial patient assessment for inpatients, and well as shift assessment to reduce variance in documentation. We introduced a disciplinary Algorithm for Falls, with a call tree to notify Administrator on Call and reassess patients.
Successes:	We've had compliance with Fall precautions by staff, and the call tree. In June, we had zero Falls. Labor & Delivery had 400 days with no Falls on unit.
Any other information:	We will Go Live with Electronic Health Record next year, which will help with charting, as well as data compilations.

Memorial Medical Center

Memorial Medical Center	
Hospital interventions:	We participated in LifePoint Hospital Engagement Network that includes multiple collaborative to reduce patient harms: • Sepsis - through multidisciplinary team approach, we created a sepsis screening tool, and implemented an overhead page "Sepsis Alert Team", sepsis badge buddies, and automation: reflex Lactateorder. • Falls with injury reduction - a multidisciplinary team developed Fall kits, installed Fall sensors, review high risk patients in daily briefs/debriefs, pharmacy Fall watch. • As part of "Quick Win," the Surgical Site Infection Collaborative has seen consistently low rate of Surgical Site Infections. • Interdisciplinary Rounds to reduce Readmissions and Partnerships with post-acute care providers through city-wide collaborative meeting at MMC. • Central Line Associated Blood Stream Infections - we partnered with vendor - focus on line care/maintenance, Chlorhexidine bathing, physician credentialing to include line insertionspecifics. • Clostridium Difficile reduction - The Infection Control and Prevention Committee is using the leading practices of fecal transplant, open biome and antimicrobial stewardship. We have an Emergency Department Pharmacist in the position of Antimicrobial Stewardship Pharmacist. We are trialing use of ultraviolet (UV) light to augment terminal cleaning. • Hospital Acquired Pneumonia - a multidisciplinary team addresses the issue from multiple angles including early mobility, toothbrush on meal tray. • Venous Thromboembolism - an interdisciplinary team reviews harms - developed scoring tool to be completed each shift or more often.
Hospital challenges:	Sepsis Alerts - we found some lack of psychological safety to call overhead with initial roll-out. Although Falls with HARMS have been minor injuries, we continue to have variability in Fall reduction rates house wide. Per National Healthcare Safety Network criteria, we had 3 Central Line Associated Blood Stream Infections, all related to care/maintenance (not related to insertion). Hospital Acquired Pneumonia rates are variable, as are Venous Thromboembolism rates.

Memorial Medical Center

Memorial Medical Center continued	
Any mid-course corrections:	We empowered bedside registered nurses and Family Practice residents to call overhead pages without fear of calling a "false alert", we empowered family medicine residents to take action and be supported in action taken (support from Medical Staff). Falls - the team is now alerting one another through increased attention of high Fall risk patients through use of a C-Tracker board. Central Line Associated Blood Stream Infections - we plan to begin Chlorhexidine bathing on inpatient oncology unit (trialed in Coronary Care Unit), replacing the Vascular Access Team Coordinator and re-building the team. Hospital Acquired Pneumonia - we are working with coding and provider education for documentation issues. Venous Thromboembolism - with newly rolled out scoring tool within Electronic Medical Record, we will have better tracking to help focus prevention efforts/improvements.
Successes:	Sepsis - our efforts have improved Sepsis Survival Rate for our patients. Falls - we have consistently reduced Falls in one unit (now using this unit as a role-model). We have low Surgical Site infections rates. The Readmission rate is below target year to date (YTD) (within LifePoint Hospital Engagement Network). YTD Clostridium Difficile rates well below target. Methicillin-resistant Staphylococcus Aureus - we use proactive automation, screen of all ICU admissions and surgical patients receiving implants and surgery planned for greater than 60 minutes. Hospital-Acquired Urinary Tract Infections/Catheter-Associated Urinary Tract Infections - we do daily needs assessment performed by Registered Nurse (nurse driven protocol to remove Foleys). Our rates have been consistently below target. We continue to see low Methicillin-Resistant Staphylococcus Aureus (MRSA) blood stream infections. We have improved Bedside Shift Report for all inpatient areas to the "Mastery Level" with ACE Unit placing second in LifePoint's Western Region BSSR Video Contest.
Any other information:	We continue to participate in the LifePoint Hospital Engagement Network, which offers benchmarking of data, best practices to improve, education on sustainability of quality improvements.

Mimbres Memorial Hospital

Mimbres Memorial Hospital	
Hospital interventions:	This year Mimbres Memorial Hospital has been focused in the improvement of hospital-wide Readmissions. We have analyzed our processes and have determined that we needed a more robust process for transitioning from inpatient to outpatient status. Case Management has led the inpatient coordination of patient tracking, education, and post-discharge follow-up.
Hospital challenges:	Challenges include having very few community resources, i.e., home health providers and few primary care providers in our community to help manage post-discharge care.
Any mid-course corrections:	We have identified an opportunity to coordinate care between our employed providers, our emergency room, and our in-patient services to help ensure that our patients receive the care they need. Once we have evaluated the effectiveness of this approach we will determine the value of trying to build similar coordination with independent providers in the community.
Successes:	Initial reduction in readmission showed that we were having some positive effect; analysis of subsequent Readmissions led to the idea of trying to coordinate care between our outpatient, Emergency Dept. and inpatient services.

Miner's Colfax Medical Center

Miners' Colfax Medical Center	
Hospital interventions:	The hospital has expanded the hospitalist program and strengthened the "bed-side" rounding model to include practitioner, pharmacy, nursing, case management, and therapies.
Hospital challenges:	The challenges have been to create consistent standard times for the rounding between the practitioners since there is a mix of independent and employed physicians.
Any mid-course corrections:	We established a 7:30 am rounding expectations for all participants to be available and engaged in rounding process.
Successes:	The hospital has experienced an increase in patient and caregiver satisfaction with the enhanced rounding. The patient and caregiver understanding of care plan along with educational and discharge needs have improved.
Any other information:	We continue to collaborate with the New Mexico Hospital Association improvement program to develop best practices around Healthcare Acquired Infections, Sepsis, and Fall prevention.

Mountain View Regional Medical Center

Mountain View Regional Medical Center	
Hospital interventions:	We progressed Foley removal post hip and knee replacement from day of surgery to earlier Post-Anesthesia Care Unit (PACU) removal, further eliminating use of Foley catheters. We provided ongoing training to phlebotomy staff to decrease blood culture contamination which attributes to Central Line Associated Blood Stream Infections. We see an increased use of Swab cap by surveillance and educating staff one-on-one in re: replacing after use. We performed ongoing training for use of Chlorhexidine bathing wipes reduce bacterial contamination, thus inhibiting growth of bacteria that could contaminate central lines. We implemented daily isolation precaution observations performed by the Infection Preventionist for all multi-drug resistant organism (MDRO) rooms. We implemented use of Sentri7 system to actively identify multi-drug resistant organism (MDRO) patients. We do an Event Analysis for each hospital acquired infection by Infection Preventionist and Departmental Director. We developed and created a nurse driven policy. Surgeons were educated on the purpose of a nurse driven policy for urinary catheter removal. We participate in New Mexico Hospital Engagement Network.
Hospital challenges:	We are challenged with Device Utilization; a hospital culture of increased line and catheter utilization is prevalent among providers. Approval of the nurse driven urinary catheter policy was a challenge. Staff turnover and expertise, and physician engagement is a challenge. We have multiple competing projects. We've had turnover of nursing staff and nursing leadership.
Any mid-course corrections:	Hand hygiene observation - we added the use of the i-scrub application for point of use hand hygiene observation reporting. We have increased focus on daily reviews of line utilization, reported up in hospital wide daily safety huddle in addition to departmental reviews. We implemented Adenosine Tri-Phosphate (ATP) monitoring post terminal room cleaning. We moved to oxycide sporicidal on all discharges to reduce Multi-Drug Resistant Organism Transmission.
Successes:	We have decreased Methicillin Resistant Staphylococcus Aureus. We have seen a decrease in Clostridium Difficile rate in the first 3 qtrs. There has been a reduction in hospital wide Central Line Associated Blood Stream Infections rates. We've observed Colorectal surgical site infection rates below expected rates. No total abdominal hysterectomy (TAH) infections. We had a reduction of Falls with injury.
Any other information:	We Developed an antibiotic stewardship program charter. We continued New Mexico Hospital Association Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation. We Collaborate with New Mexico Emergency Medical Systems Bureau for primary stroke center and chest pain center designation.

Nor - Lea General Hospital

Nor - Lea General Hospital	
Hospital interventions:	Electronic Medical Records was implemented in the Clinics and Clinical quality improvements were undertaken with 8 quality measures. Physician scorecards were implemented system wide for all providers.
Hospital challenges:	Our data accuracy with the electronic medical records (Electronic Medical Record) system is challenging. We worked on documentation and Electronic Medical Record issues. We have challenges with providers on scorecard data.
Any mid-course corrections:	We made changes in immunizations, and physician champions were used in quality initiatives.
Successes:	Large improvements were made in the family practice clinics with monitoring clinical quality and making improvements in several measures.

Plains Regional Medical Center

Plains Regional Medical Center	
Hospital interventions:	An anticoagulation subcommittee was formed to oversee this process. We determine if INR>5 (International Normalized Ratio) is due to management, prescribing, monitoring decisions. We have a process in place to intervene. This has been implemented for all facilities. The Falls work is in process and focuses on implementation of NOWA model (No One Walks Alone). We are strengthening Hourly Rounding in facilities.
Hospital challenges:	We are analyzing the various data sources for similar measures and variation in results.
Any mid-course corrections:	We have ongoing quality improvements throughout Presbyterian Healthcare Services.
Successes:	A Medication Operation Safety Team was implemented in all facilities.
Any other information:	Work was not driven by occurrence but spread of standard work throughout Presbyterian Healthcare Services and establishing best practice.

Rehoboth McKinley Hospital

Rehoboth McKinley Hospital	
Hospital interventions:	We continue to work on improving clinical documentation with relation to inpatient core measures (stroke, Emergency Department, Venous Thromboembolism, immunization, perinatal care and sepsis). With the implementation of the clinical documentation "T-System", the clinical documentation system in the Emergency Department, significant improvement has been noted in documentation in the Emergency Department resulting in preventing the need to remit justification to Press Ganey, our transmission vendor for Centers for Medicare and Medicaid Services, as to the reason our facility exceeded the 3% threshold for "unable to determine" responses. Justification statements were remitted for core measure data. No further notifications have been received since notifying our facility of Missing/Invalid Data >3%. The facility has established a Code Committee which reviews all codes within the hospital to identify areas of improvement with relation to documentation, process improvement and education/training opportunities. The hospital is working toward obtaining Stroke certification. The facility has re-established its Quality Program with a transition from a Quality Committee to a Quality Task Force Committee which includes an interdisciplinary group which includes nursing, ancillary and other key departments such as Utilization Review, Medical Staff and other appropriate departments.
Hospital challenges:	We transitioned the hospitalist program from Apogee Physicians to AlignMD for the purposes of having the same group providing hospitalist services to streamline patient care from the Emergency Department to the inpatient unit(s).
Any mid-course corrections:	We transitioned from Emergency Staffing Solutions to AlignMD due to quality of care concerns.
Successes:	We had a successful implementation of T-System clinical documentation system in the Emergency Department and implementation of Athena clinical documentation system in the clinics. This provided an ability for the facility to progress further with meeting Meaningful Use criteria. We successfully transitioned from Joint Commission to DNV hospital accreditation.
Any other information:	Based on the results of the accreditation survey, committees have been implemented to track and monitor various quality measures as well as contributed to refining policies and processes to improve the quality of care.

Roosevelt General Hospital

Roosevelt General Hospital	
Hospital interventions:	We worked within Hospital Engagement Network 2.0 to collect, aggregate and share measure data, using Health Research & Educational Trust Readmission toolkit to identify gaps, track and intervene when appropriate. We are working with local home health and hospice agencies to implement "Care Kits" when appropriate at discharge for transition of care. We use "Project Red" initiatives to improve discharge upon admission and beyond discharge with follow up calls.
Hospital challenges:	We are utilizing hospital electronic medical record to extract data into a reportable format, getting consistent physician involvement: we have challenges with entering data into multiple databases, and staff turnover (IT and Quality roles).
Successes:	We utilize Hospital Engagement Network 2.0 data collection for quality measure collection which enabled us to trend and monitor for interventions real time. Our Hospital re-admission rate is well below national benchmark. No Catheter-Associated Urinary Tract Infections, Central Line Associated Blood Stream Infections, Ventilator Associated Events or facility acquired Pressure Ulcers.
Any other information:	We have remained active in the New Mexico Hospital Association Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation. We will also continue our journey of continuous improvement with active engagement in Hospital Improvement Innovation Network project.

San Juan Regional Medical Center

San Juan Regional Medical Center	
Hospital interventions:	Catheter-Associated Urinary Tract Infections: we instituted an Assessment-Driven Urinary Catheter Removal Protocol (HOUDINI) for Foley catheter use in inpatients; nurse and provider education was included. Falls: (1) we reviewed best practices for Fall prevention and performed a gap analysis. One element that SJRMC did not have in place was the Post-Fall Huddle process for all areas. This was then implemented. (2) SJRMC determined this process was not performing house-wide analysis on Fall data. Pressure Ulcers: (1) we clarified responsibilities for initial assessment and identification of Pressure Ulcers; and (2) initiated a prevalence study process; (3) Collaborative Mobility best practices were implemented.
Hospital challenges:	Catheter-Associated Urinary Tract Infections 1) Consistency in practice is a challenge 2) determining data for monitoring practice adherence is a challenge. Falls (1) The post-Fall huddle was not occurring as designed for some departments. (2) It is a challenge to determine the level of data needed for analysis. Pressure Ulcers - Conducting the prevalence study is very resource-intensive.
Any mid-course corrections:	Catheter-Associated Urinary Tract Infections 1) we initiated review of data, 2) good use of protocol. Falls: An expectation was set that the post-Fall huddle was to be conducted using the standardized process for all areas of the organization to include all hospital and outpatient departments. The Huddle documentation sheet was revised. A team was created to monitor and analyze data for process improvement. Pressure Ulcers: Prevalence studies will be scheduled on a semi-annual basis and participants will be better prepped / educated to conduct the study. Also, we purchased additional products that will minimize the potential of equipment-related Pressure Ulcers.
Successes:	Catheter-Associated Urinary Tract Infections/Falls/Pressure Ulcers - it is too early to determine success.

Sierra Vista Hospital

Sierra Vista Hospital	
Hospital interventions:	We have seen improvement in hospital acquired infections and infection-related reporting, and are still reporting through National Healthcare Safety Network. We do monthly reporting at Organizational Performance Improvement (POI).
Hospital challenges:	We had our first survey by DNV hospital accreditation for deemed accreditation this past spring. The Quality Director is new, and is revising the Quality Program Plan.
Any mid-course corrections:	Post survey, we have been working on improvements to follow up on identified patient safety issues
Successes:	We have had no Catheter-Associated Urinary Tract Infections in the past 2 years. We hired new Infection Preventionist and Quality Coordinator - they are working on program for quality analysis. We had improved health care worker influenza vaccination compliance though mandatory vaccinations.

Socorro General Hospital

Socorro General Hospital	
Hospital interventions:	An anticoagulation subcommittee was formed to oversee this process. We determine if INR>5 (International Normalized Ratio) is due to management, prescribing, monitoring decisions. We have a process in place to intervene. This has been implemented for all facilities. The Falls work is in process and focuses on implementation of NOWA model (No One Walks Alone). We are strengthening Hourly Rounding in facilities.
Hospital challenges:	We are analyzing the various data sources for similar measures and variation in results.
Any mid-course corrections:	We have ongoing quality improvements throughout Presbyterian Healthcare Services.
Successes:	A Medication Operation Safety Team was implemented in all facilities.
Any other information:	Work was not driven by occurrence but spread of standard work throughout Presbyterian Healthcare Services and establishing best practice.

Union County General Hospital

Union County General Hospital	
Hospital interventions:	The education regarding medication administration was completed with identified nurses to include ongoing review of their practices. One identified nurse was required to complete an intravenous (IV) Therapy and Techniques Course for a more in-depth education process involving IV medications. A monthly report is now being reviewed to evaluate compliance with proper scanning of patient's identification bands and medications. Potassium and many other IV medications are now only available in pre-mixed bags.
Hospital challenges:	The Emergency Department has not implemented the electronic health record for medication administration, therefore obtaining an accurate number of total doses of medications given is an opportunity for improvement.
Any mid-course corrections:	The process for implementation of Omnicell (electronic medication administration program) has been started for the entire hospital.
Successes:	We continue to have zero Catheter-Associated Urinary Tract Infections. A protocol is being developed for Insulin intravenous drips.

University of New Mexico Hospital

UNM-University Hospital	
Hospital interventions:	The hospital continues Severe Patient Harm Event team meetings to address hospital acquired conditions. The hospital established an institution-wide mortality review system to identify challenges and opportunities for quality improvement. This system includes review of cases and monthly, multidisciplinary/multi-departmental meetings to address identified challenges and opportunities. We concluded the University Health Consortium Hospital Engagement Network to benchmark data with a commitment to participate in Hospital Improvement Innovation Network. We continue to participate in the Ambulatory Surgical Care National Surgical Quality Improvement Program (NSQIP)
Hospital challenges:	The hospital continues to have an increase in Hospital Acquired Conditions, including healthcare acquired infection. The hospital experienced an increase in Ventilator Associated Events (Ventilator-Associated Events, Ventilator-Associated, Condition, Infection-Related Ventilator Associated Complication, Ventilator Acquired Pneumonia) We continue to look at challenges related to the Mortality Index, including clinical documentation and issues identified in the recently established Mortality Review process. For the most recent fiscal year, our Mortality Index did have a downward trend.
Any mid-course corrections:	The hospital added two more Severe Patient Harm Event teams to review Hospital Acquired Conditions (Post Op Respiratory Failure, Deep Vein Thrombosis/Pulmonary Embolism, Falls, Iatrogenic Pneumothorax, Pressure Ulcers, Peri-Op Hemorrhage/Hematoma, Obstetrics with trauma, Catheter-Associated Urinary Tract Infections, Clostridium Difficile, Wound Dehiscence, Accidental puncture/laceration, Post-Op Sepsis, and Surgical Site infections).
Successes:	The hospital had a reduction in Catheter-Associated Urinary Tract Infections. The hospital has a downward trend in the Mortality Index. A Severe Patient Harm Event initiative has been established with a high level of engagement by multidisciplinary teams.

Thank you to the
New Mexico Hospital Association
for your continued support.

Human Services Department / Medical Assistance Division / Financial Management Bureau