HUMAN SERVICES DEPARTMENT

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

Domain 1 Measures

3. Central Line Associated Blood Stream Infections (CLABSI)

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

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

Rate = Numerator
Denominator x 1,000

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

4. Injuries from Falls and Immobility/Trauma HAC 05 CMS

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

Denominator - inpatient discharges.

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

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

Domain 1 Measures

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".

Rate = Numerator / Denominator X 1,000

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

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.

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

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 DY4 to DY5

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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Artesia General Hospital

HQII Reporting results from DY4 to DY5

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 DY4 to DY5

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 measures)

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CHRISTUS St. Vincent Hospital

HQII Reporting results from DY4 to DY5

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)	No

Percentage of overall improvement 91%

(improved in 10 of the 11 measures)

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Cibola General Hospital

HQII Reporting results from DY4 to DY5

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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Dr. Dan C. Trigg Memorial Hospital

HQII Reporting results from DY4 to DY5

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 New Mexico Medical Center

HQII Reporting results from DY4 to DY5

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 measures)

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PHS Espanola Hospital

HQII Reporting results from DY4 to DY5

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 DY4 to DY5

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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Gila Regional Medical Center

HQII Reporting results from DY4 to DY5

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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Guadalupe County Hospital

HQII Reporting results from DY4 to DY5

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

Percentage of overall improvement 100%

(improved in 6 of the 6 eligible measures)

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Holy Cross Hospital

HQII Reporting results from DY4 to DY5

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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Lea Regional Hospital

HQII Reporting results from DY4 to DY5

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 measures)

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Lincoln County Medical Center

HQII Reporting results from DY4 to DY5

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

Percentage of overall improvement 100%

(improved in 6 of the 6 eligible measures)

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Los Alamos Medical Center

HQII Reporting results from DY4 to DY5

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 Regional Hospital – Roswell

HQII Reporting results from DY4 to DY5

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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Memorial Medical Center

HQII Reporting results from DY4 to DY5

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

Percentage of overall improvement 82%

(improved in 9 of the 11 measures)

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

Mimbres Memorial Hospital

HQII Reporting results from DY4 to DY5

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

Percentage of overall improvement 100%

(improved in 6 of the 6 eligible measures)

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Miners' Colfax Medical Center

HQII Reporting results from DY4 to DY5

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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MountainView Regional Medical Center

HQII Reporting results from DY4 to DY5

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	No
Pressure Ulcer Stage III & IV rate	No
Surgical Site Infections (SSI)	Yes
Ventilator Associated Events (VAE)	Yes

Percentage of overall improvement 82%

(improved in 9 of the 11 measures)

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Nor - Lea General Hospital

HQII Reporting results from DY4 to DY5

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 DY4 to DY5

Measures **(Eligible measures only)**	**Showed Improvement or Met the Minimum Requirement**
Adverse Drug Events (ADE)	Yes
All Cause Readmission	Yes
Catheter Associated Urinary Tract Infections (CAUTI)	Yes
Central Line Associated Blood Stream Infections (CLABSI)	No
Falls and Trauma	Yes
-OB vaginal laceration w/instrumentation	Yes
-OB vaginal laceration w/o instrumentation	Yes
Postoperative PE or DVT	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 measures)

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Rehoboth McKinley Hospital

HQII Reporting results from DY4 to DY5

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 DY4 to DY5

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

San Juan Regional Medical Center

HQII Reporting results from DY4 to DY5

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 measures)

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

Sierra Vista Hospital

HQII Reporting results from DY4 to DY5

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 DY4 to DY5

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

Percentage of overall improvement 100%

(improved in 6 of the 6 eligible measures)

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

Union County General Hospital

HQII Reporting results from DY4 to DY5

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 DY4 to DY5

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

Percentage of overall improvement 55%

(improved in 6 of the 11 measures)

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

Alta Vista Regional Hospital

Hospital interventions:	A Falls Collaboration team was assembled, and a revaluation of our falls program was completed. We recognized the need for additional interventions to care for the high fall risk patient population. This included adding yellow gowns and yellow non-slip footwear for our high fall risk population. Additionally, the hospital has focused on reducing hospital readmissions. Case Management adjusted the team members attending morning interdisciplinary team meetings to include all ancillary departments. Meetings regarding safe discharge and prevention of readmissions now include physicians, nursing staff, physical therapy, respiratory therapy, Laboratory, Emergency Services, Clinical Education and Quality Coordinator.
Hospital challenges:	Our ICP resigned her position and a replacement was not on-boarded until October. Our newly hired CNO started in January 2017 and resigned her position July 2017. Gaps in our leadership team slightly hindered the accountability piece with front line staff.
Any mid-course corrections:	Following another fall in August, falls team reconvened and additional strategies were implemented. They included department bedside reconciliation of the Morse Fall risk screening during bedside shift reporting, for continuum of care and the team recognized the need for a patient sitter pool and hired 8 PRN patient sitters.
Successes:	With the addition of interventions and new strategies from our Falls collaboration team, no falls with injury occurred for the remainder of the year. With the addition of care team members participating in Interdisciplinary meetings, all cause readmissions have decreased.

Artesia General Hospital

Hospital interventions:	Project 1: While auditing for sepsis core measures it was noted that trends were identified for missing the repeat lactic acid for the measure bundle requirements. Qtr. 3 2017 had results with 5 late or missing 2nd Lactic acid results. This was discussed with the ER providers and a plan for a process was developed. A reflex order for a repeat lactic within in 3 hours for Lactic acid results equal to or above 2.0. In addition, lab techs are to call the ER and notify the provider of verbal results above 2.0 as well as electronic reporting. This process was put in place with help from the Lab director on 10/19/2017. Project 2: Infection control based, during the mock survey done in 2017, it was noted that instruments (such as hemostats, clamps and forceps) that were coming from the clinics and ER to be sterilized were in closed position during the pre-clean process. It was also noted that there was no consistency in the type of enzymatic cleaning process or how the instruments were transported to the sterile processing department (SPD).
Hospital challenges:	The main challenge was handoff communication to ensure sepsis protocol is being followed. This is in relation to ER to med-surg handoffs. Not only was it challenging to make sure the receiving unit knew about the sepsis protocol, but even more so was to make sure the receiving unit knew the treatment stage of the sepsis protocol.

Artesia General Hospital (cont.)

Any mid-course corrections:	Project 1: The director of ER developed a policy and paper hand-off sheet on 10/26/2017 for use of a SEPSIS check-off to ensure report was given to the doctors and nurses when the patient was transferred to inpatient status. This process was developed to a.) Have a systematic process in place for bundle completion; b.) Help incoming doctors and nurses know what stage of the treatment patient was currently in and what steps were needed next. Project 2: The sterile instrument process in the clinics and the ER are to follow the same standardized process, proper cleaning and transportation process. The policy (IP 914.21 Clinics and ER-Transportation, cleaning and Disinfecting Surgical Instruments) was developed and all effected staff received training.
Successes:	Project 1: Improved the measure outcomes starting Qtr. 4 2017; with measure results having only 1 missed or late repeat Lactic acid result that was dated prior to the change in process. Project 2: To ensure this process is maintained the infection prevention nurse will check for compliance quarterly during Environment of Care (EOC) rounds and re-educate staff as needed.

Carlsbad Medical Center

Hospital interventions:	We provided education from physical therapists to nursing regarding safe lifting and patient handling and proper use of equipment. Gait belts were made readily available. The second initiative involved adopting a different approach to pressure injury assessment, including preventions measures and treatment. New wound care physician and wound care team for staging of injuries.
Hospital challenges:	Our fall rate was over benchmark with some patients falling multiple times. We reinforced importance of hourly rounding, use of interventions appropriate for fall risk score, and use of sitters as needed. Readmissions increased in 2017
Any mid-course corrections:	Case managers began discharge instructions with patients and making patient follow up appointments with their primary care providers.
Successes:	Our CLABSI rate remained at 0. Our CAUTI rate improved to 0 as did our SSI rate. We went from having 6 Hospital onset C-Diff infections in 2016 to 2 in 2017. Our core measure compliance with sepsis bundle score improved from 38.2% in 2016 to 43.6% in 2017.

CHRISTUS St. Vincent's Regional Medical Center

Hospital interventions	1. C. difficile reduction (noted below are 3 interventions, though not inclusive of all interventions). - Worked closely with lab to follow testing guidelines so there is no repeat testing if a patient has had a prior negative result in the past 7 days or a prior positive result in the past 21 days. Exceptions may be made on a case by case basis when there is a prior negative result within the past 7 days, after consultation with the ordering provider and dependent upon the patient's clinical presentation. - Continued use of focused screening guidelines to ensure patients meet basic testing criteria given the high community load of asymptomatic C. difficile carriers. - During the hospital's 2017 Patient Safety Fair, there was a booth dedicated to infection prevention, specifically, isolation and hand washing. Attendance at the fair was mandatory for all clinical staff, and education was provided at each booth. - Antibiotic stewardship efforts continued from the prior year. There was also a booth at the 2017 Patient Safety Fair on antibiotic stewardship. 2. CLABSI reduction in the ICU (noted below are 5 of the main interventions). - Standardized criteria for central line use in the ICU with a focus on reducing the use of central lines. - Standardized best practices for central line care and maintenance. - Data feedback to staff. - Review of line use and indications incorporated into daily interdisciplinary ICU rounding sheet. - There was a central line and peripheral line maintenance booth at the hospital's 2017 Patient Safety Fair at which clinicians received training.
Hospital challenges:	Despite improvements with central line maintenance and a reduction in central line days, some events still met NHSN's CLABSI definition in early 2017. However, a drilldown was completed by two Infectious Disease physicians on all events that met NHSN's definition since 2014, and they determined that while the events met NHSN's definition, approximately 40% were likely not true CLABSIs and instead were probably due to contaminants. (see next statement about mid-course corrections)

CHRISTUS St. Vincent's Regional Medical Center (cont.)

Any mid-course corrections:	CSV brought in Dr. Kellie, a NM infectious disease expert, to provide education on proper blood culture collection technique and best practices in March 2017. The training was mandatory for ED techs and for phlebotomists.
Successes:	1. Immediately following Dr. Kellie's training there was a decrease in the blood culture contamination rate, both for blood cultures drawn in the ED and house-wide. This success was maintained for much of 2017, with rates exceeding the goal of being below 3% for seven of the remaining months in 2017. Additionally, the house-wide rate was below 2% for five of those months. 2. Following Dr. Kellie's training and with the other interventions noted above to reduce CLABSI events, there was a six month stretch without a CLABSI house-wide. 3. In 2017 central line use in the ICU consistently performed better than goal, meaning there were fewer central lines days per ICU day. 4. In 2017, CSV was awarded a Certificate for Excellence in Quality Improvement for 'Reducing Hospital-onset C. difficile through a Multi-faceted Approach' from HealthInsight, the NM Quality Improvement Organization. 5. There was a decrease in the percentage of total antibiotics used that were broad-spectrum antibiotics from over 50% to around 30%. This decrease had occurred by the end of 2016 and was sustained throughout 2017.
Any other information:	An important note is that when there is a decrease in the denominator (e.g. central line days), any single event can result in the appearance of there being a higher rate by virtue of the denominator being smaller.

Cibola General Hospital

Hospital interventions:	Three key interventions that our Hospital worked on in 2017 were improving patient satisfaction (1) and inpatient influenza vaccination rates (2) and reducing falls (3). To improve patient satisfaction, our Leadership team participated in a monthly webinar program that focused on improving the 10 CMS domains of patient satisfaction. The Leadership team would attend these sessions on a monthly basis and were asked to implement one of the suggestions/best practices shared with our group by the patient satisfaction improvement experts. With the help of our Studer coach, we also included patient satisfaction/HCAHPS language into our patient rounds. Additionally, based on feedback from our department directors and patients we decided to shorten the length of the patient satisfaction surveys that our vendor sends out with the goal of increasing our Hospital's survey response rate. Our Hospital also implemented an inpatient influenza vaccine project aimed at improving vaccination rates. We developed a multidisciplinary team that included individuals from IT, nursing, infection control, and quality. The team streamlined the way flu shots were ordered, administered, and charted. We also designated 4 o'clock to be flu shot hour at our Hospital. As a result of these initiatives, we had a 150% improvement in our flu vaccination rate compared to the previous year's flu season. 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.
Hospital challenges:	The major challenges that our Hospital faced in CY2017 included a decrease in hand hygiene compliance and an increase in surgical site infections. We also continued to struggle with falls.

Cibola General Hospital (cont.)

Any mid-course corrections:	Our Hospital saw a decline in physician compliance with our antimicrobial stewardship program in July 2017. This led to the creation of a multidisciplinary team made of our infection control nurse, pharmacist, and microbiologist that would meet on a daily basis and follow up with physicians in order to address any issues around appropriate prescribing of antibiotics. Additionally, the team created pocket antibiotic reference cards for physicians to use and also worked with Project ECHO in efforts to improve physician compliance. To address the increase in surgical site infections at our Hospital, we worked to improve equipment sterilization processes in our ED, OB, MedSurg, ICU, and Outpatient Clinic departments. We also contracted with a new laundry service company.
Successes:	In 2017, all departments in our Hospital worked diligently to implement new and improve existing initiatives focused on improving patient care, safety, and health outcomes. Our major successes for 2017 include being successfully reaccredited by TJC, implementing our electronic clinical quality measures (eCQM) program, updating our patient restraint protocol for all areas of the hospital, and receiving supplemental FLEX funding to implement numerous projects focused on improving population health in our community. Additionally, our Hospital applied for and was awarded the New Mexico Performance Excellence Adobe Award.

Dr. Dan C. Trigg Memorial Hospital

Hospital interventions:	DCT identified the specific process steps as suggested by the Clinical Outcomes Action Plan Team (COARPT). The process steps were audited focusing on compliance and staff knowledge. A type of Rapid Project Planning and action plan process comprised of monthly meetings to insure compliance with the CAUTI process steps. The audit results are reported to the Clinical Outcomes Action Plan Team (COARPT) meeting on a monthly basis. Social worker has been closely working with inpatients and preparing them for discharge to decrease the readmission rate. She attended a Swing Bed Summit to obtain knowledge to better serve the swing patient population of DCT.
Hospital challenges:	No challenges identified at this time. Being a CAH with low inpatient volumes one readmission greatly impacts the percentage.
Any mid-course corrections:	Infection Preventionist meet with unit managers after rounding to provide feedback and collaborate with staff education related to documentation on continued need for Foley and care.
Successes:	Standardized process for data collection and validation. No readmissions at DCT in 2017.

Eastern New Mexico Medical Center

Hospital interventions:	The hospital leaders continued to focus work in 2017 on infection prevention, with the year end results of no catheter-associated urinary tract infections and favorable results with central line associated blood stream infections. Falls and Readmissions remained in the forefront of the initiatives addressed.
Hospital challenges:	Readmissions continue to be a challenge for the hospital. In 2017 the Director of Case Management initiated community meetings with area Nursing Homes, Hospice Care, SNF's, and Home Health companies to open the lines of communication and to improve communications a crossed the continuum. An emphasis was placed on case management completing an admission readmission risk assessment which by the end of the year compliance improved considerably.
Any mid-course corrections:	Falls with injury continued to be a challenge, most especially in the Medical/Surgical Unit. Re-education of staff was a focus to reinforce interventions of prevention. Continued attention to Hourly Rounding, encouraging the patient to utilize the call bell, and reinforcing the "NO Pass Zone" initiative of prevention methods, resulted in the decrease in the number of falls on the Medical/Surgical Unit in the second half of the year by greater than fifty percent.
Successes:	The use of checklists throughout the hospital has proved very beneficial as evidenced by our Infection Data for catheter-associated urinary tract infections and central line associated blood stream infections. We successfully completed our Triennial HAP Joint Commission Survey

PHS Espanola Hospital

Hospital interventions:	Process steps to decrease and/or eliminate the risk of hospital acquired C diff infections have been identified and selected. In addition to the NHSN surveillance requirement, we have developed a robust process monitoring project to insure compliance with the C. Diff prevention process steps. The Infection Preventionist performs an ongoing audit of orders for D. Diff specimens sent and their appropriateness. In addition, knowledge of the process is evaluated by engaging the front line in C. diff prevention and reviewing all housekeeping logs for aspects of the protocol. Results and findings are reported to the Clinical Outcomes Action Plan Team (COARPT) meeting on a monthly basis. Total opportunities for improvement in following the early sepsis treatment protocol from 3/2017 – 3/2018 were 73. The top 4 elements missed were obtaining the initial lactate, administering antibiotics within 3 hours, fluid resuscitation, and obtaining the second lactate. These 4 elements totaled 49 opportunities for improvement. An interdisciplinary PI group was convened and continues to meet monthly. Every opportunity for improvement is reviewed, and feedback is given to the appropriate provider/ staff member. Other interventions included multiple changes to the order sets to provide automated solutions, (ex, auto calculation of fluid bolus amount), remapping of lab orders, and a handoff tool to improve communication between ED and inpatient unit nursing staff.

PHS Espanola Hospital (cont.)

Hospital challenges:	A challenge that was identified was the turnover of housekeeping and clinical staff. Additionally, it took a significant amount of time for the UV light to be replaced. A challenge identified was the length of time required to implement changes to the order sets, generally 3-4 months for each change.
Any mid-course corrections:	Between 12/17 and 1/18 we had 4 hospital acquired C. Diff infections diagnosed. Each event was reviewed in detail by a multidisciplinary group, and education was conducted with the clinical staff, the laboratory staff, and the housekeeping staff. Additionally, our UV light malfunctioned, and needed to be replaced. As each solution was implemented and resulted in success, the next most problematic aspect of the protocol was addressed.
Successes:	No Hospital acquired C. Diff infections have been diagnosed since January 2018, more than 150 days. Since Nov 2017, there have been no fallouts with initial lactate being drawn, so the focus shifted to fallouts with the fluid bolus. The last fluid bolus fallout was in January 2018, and the last antibiotic fallout was in April 2018.
Any other information:	14 Fallouts in following the sepsis protocol in the first 6 months of 2018, compared with 28 in the last 6 months of 2017. Work is now underway to improve compliance with obtaining the second lactate.

Gerald Champion Regional Medical Center

Hospital interventions:	**CAUTI** Substantial reduction was observed utilizing a focused approach on the maintenance bundle that included positioning, manipulating, and continuation of a sterile system. Interventions implemented were nurse driven protocol for Foley removal, assessment via ultrasound, and including the need for Foley continuation discussion during grand rounds. **Falls with Injuries** Interventions included a survey to identify staff perceptions and level of knowledge, staff education, quick reference cards showing available interventions (bed alarms, floor mats, etc.), and dedicated staff positions were created to maintain constant observation of video monitors utilized for high risk patients. The mobility team reviewed assessment tools, created patient education brochures, developed high risk fall kits (yellow socks, arm band, and door magnet), and revised post-fall huddle forms. **Surgical Site Infections (SSI)** To reduce the incidence of post-surgical site infections, a gap analysis was completed. Staff education was initiated to reduce variations in pre-surgical skin antiseptic techniques. An OR Educator was assigned to the OR who reviewed the processes and utilized evidence-based practices to guide the initiatives.

Gerald Champion Regional Medical Center (cont.)

Hospital challenges:	**CAUTI** Physician acceptance of the nurse-driven protocol. Ensuring Foley continuation discussions during grand rounds. **Falls with Injury** The team discovered that one size does not fit all when it comes to fall prevention. Various interventions utilized successfully in one unit (Medical), did not work in another part of the hospital (Behavioral Medicine). **SSI** Surgical techniques vary by practitioner.
Any mid-course corrections:	**CAUTI** Changed catheters and kits to the utilization of antimicrobial catheters and a kit that provided “Sure Step” which is one tray with steps of procedures numbered versus two trays that were found to be problematic with maintaining sterile field. **Falls with Injuries** Unit specific fall prevention guidelines and tools were formulated and initiated by the Mobility Team. **SSI** None
Successes:	**CAUTI** We demonstrated a decrease in CAUTI’s from 4.58% to 1.2% by the end of 2017. **Falls with Injuries** Able to demonstrate a reduction from 7.3% to 2.9% by the end of 2017. **SSI** Surgical site infections decreased from 6 infections during the first two quarters to 3 during quarters 3 and 4 of 2017.

Gila Regional Medical Center

Hospital interventions:	Identified the need for a robust care transitions program to ease the patient from a hospital in-patient setting back to home care to help reduce readmission rates. Applied best practices within the behavioral health setting in regards to tobacco and alcohol substance abuse and worked with the community behavioral centers for follow-up care as appropriate.
Hospital challenges:	Turnover in clinical staff and administration slowed progress, some processes were dropped, and new processes developed creating unnecessary overlap. Removing departmental silos was a struggle as top-tier oversight was focused elsewhere.
Any mid-course corrections:	Learning how to capitalize on our EMR's functionality after implementation assisted the processes by reducing dependency on paper forms and allowing the facility to track real-time data.
Successes:	Marked increase in our BHU tobacco and alcohol interventions as indicated in the core measures. Continued downward trend for readmissions with increased patient satisfaction as they are in more frequent contact with our transitions team.
Any other information:	Identified the need for a robust care transitions program to ease the patient from a hospital in-patient setting back to home care to help reduce readmission rates. Applied best practices within the behavioral health setting in regards to tobacco and alcohol substance abuse and worked with the community behavioral centers for follow-up care as appropriate.

Guadalupe County Hospital

Hospital interventions:	During CY 2017, Guadalupe County Hospital improved the post-discharge follow up phone call process and is now consistently contacting 90-100% of discharged patients within 7 days. The original goal was 72-hour time frame, but sometimes it was difficult to make contact with patients on the first attempt. Patients are questioned regarding home care, daily living activities, prescription adherence, follow up appointments, and the potential need for social support services. This is still tracked and reported to the Operational Performance Improvement committee on a monthly basis. Two other initiatives include prevention of unassisted patient falls and monitoring medication-induced hypoglycemic events. A new process was implemented for post fall huddles conducted by a multidisciplinary team (nurses, techs, safety officers, administration). This includes a root cause analysis and performance improvement plan (Plan, Do, Study, Act process). As of yet, there have been zero medication induced hypoglycemic events. The hospital continues to participate in the Hospital Improvement Innovation Network (HIIN), the National Hospital Safety Network (NHSN), Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS - patient experience), Medicare Rural Hospital Flexibility Program (FLEX) improvement programs, and New Mexico Rural Hospital Network peer groups and quality improvement initiatives.
Hospital challenges:	Challenges still include reaching patients who live outside the community or the state, or who have wrong listed phone numbers. However, a new system was put into place to verify phone numbers, or to delete inactive numbers, forcing staff to request new numbers at the time of future service. The lack of behavioral health providers (prescribers in particular) is still a challenge. There are ample counselors but no providers that can prescribe or monitor prescriptions. The NM Hospital Association continue to work toward developing a statewide tele-behavioral health program to alleviate this problem in rural or remote areas of the state. The last challenge is workforce shortages. While our nurses are young, and we are not experiencing shortages caused by retirements, we are unable to recruit additional nurses needed to expand specialty programs. Physician recruitment is also a challenge in rural areas, and we are no exception.

Guadalupe County Hospital (cont.)

Any mid-course corrections:	One mid-course correction was assigning the follow up calls to one person and giving her specific paid time to complete it. We also recently purchased a cloud-based app (Prista ActionCue) which will help us monitor any patient or hospital safety event and will also monitor all our performance improvement projects and measures. Our Performance Improvement process consists of at least 2-3 measures per department for all departments (clinical, support, and administrative). This totals approximately 50 measures which we track, discuss at the monthly Operational Performance Improvement committee meeting, and report to the hospital's governing board on a monthly basis. This app will promote consistency, accountability, and ease of reporting. It will go live in July 2018
Successes:	We have experienced a continued decline in readmissions within 30 days for all cause to our own facility. Our patient experience scores continue to be the highest in the state. Our CMS clinical quality scores have seen improvement. We are now better at capturing vaccinations in the patient EMR. We had a very successful CMS/NM DOH Site survey in August 2017. Morning rounding and staff huddles continue to be successful, and popular with both staff and patients.
Any other information:	In 2017 GCH installed and implemented the EDie (emergency department information exchange) in our ED. Our staff can now identify patients who may be violating their prescription contracts, who are frequent visitors of other EDs, or who may have been violent or difficult in other EDs. This allows our staff to be better prepared and to provide a higher quality of care, in a safer environment.

Holy Cross Hospital

Hospital interventions:	In 2017 Holy Cross participated in the Readmissions reduction initiative, “Take a Dive, Interview 5”. Even though our readmission rates remained low, we wanted to be proactive and decided to take a closer look at readmissions and interview patients. There were no significant discoveries as a result of the interviews however our Case Management team will continue to closely analyze data as a preventative measure. A new Hospital Quality and Safety program was initiated in 2017. The program requires all departments clinical and nonclinical to select improvement goals to reduce risk and improve outcomes.
Hospital challenges:	Device utilization, specifically urinary catheters, continues to remain high. We have identified high use of catheters in patents admitted from the emergency room. Protocol for catheter use in the Emergency Department needs to be reviewed and modified. Accurate data collection form new EMR.
Any mid-course corrections:	The leader of our Falls Prevention team stepped down and as a result the team struggled for several months. In the third quarter of 2017 a new nurse leader was in place who reinstituted team meetings and review of post fall reports. The team has since taken additional steps to prevent falls.
Successes:	In the third quarter ED and Lab lowered blood culture contamination rates by instituting a new collection kit. Annual CLABSI and CAUTI rates were below the previous year. C. difficile infections were significantly lower than the previous year.
Any other information:	Completed and analyzed the use of vancomycin in 90 patients. Developed recommendations for change in practice and current orthopedic order sets to promote effective antibiotic use for surgical prophylaxis.

Lea Regional Hospital

Hospital interventions:	1. We have maintained a daily multidisciplinary meeting to review and discuss all patients to improve outcomes. 2. We used best practices from conference calls to improve practices. 3. We participated in the Centers for Medicare and Medicaid Hospital Engagement Network/Hospital Improvement Innovation Network and benchmarked against other NM facilities. 4. We have remained certified and recertified in Chest Pain and Stroke Care. We are also maintaining Heart Failure Certification. We are meeting Chest Pain, Stroke, and Heart Failure national standards of care/practice. We have received the Gold Plus Award from the American Heart Association/American Stroke Association for our stroke care - this is the highest award to receive for quality care and meeting "Get with the Guidelines". We continue to focus on physician use of best practice orders sets ensuring consistent, quality care. 5. We established an Interventional Cardiology Program to meet community needs, reduce transfers, and improve time from a patient's cardiac event to intervention – meeting a percutaneous coronary intervention (PCI) 90-minute goal. 6. Our Inpatient Dialysis program has been established and is ongoing to meet community needs and reduce patient transfers. 7. Extensive community education regarding stroke symptoms and treatment has facilitated at 13% increase in patients presenting with a stroke or stroke-like symptoms; we have seen improvements in timeliness of TPA administration and interventions for thrombectomy - "time is brain". 8. We have established practices and protocols for sepsis care, ensuring 95% or greater compliance with the national sepsis interventions/measures for over one year (exceeding the national and state compliance rates of 45%-55% overall). 9. Our Chief Nursing Officer (CNO) and the Medical Director of the Emergency Department continue to focus on patient throughput, best practices, etc.

Lea Regional Hospital (cont.)

Hospital challenges:	1. We continue to work to improve hourly rounding and bedside report – it is still a cultural change process. 2. We are focusing on bedside report to maintain no hospital-acquired infections 3. We are working to reduce patient falls and patient falls with injuries by addressing patient and family education, and compliance 4. Readmissions (all cause) remains a focus; we are working collaboratively with our providers, community resources, Case Management and the patients to ensure discharge follow-up appointments are scheduled prior to patient discharge and the patient has a transportation, etc., as well as other resources for medications, etc.
Any mid-course corrections:	1. We re-established our hospital Performance Improvement to reduce patient falls and eliminate falls with injuries – we have best practices in place regarding fall mats, identification of fall risks, patient education, etc.; we have seen a significant reduction in falls with injuries from prior years. 2. We are focusing on bedside report to maintain no hospital-acquired infections 3. We are working to reduce patient falls and patient falls with injuries by addressing patient and family education, and compliance

Lea Regional Hospital (cont.)

Successes:	1. Our sepsis core measures compliance continues to remain at 95% or greater compliance for well over a year; this far exceeds national and state average compliance of 45% to 50%. 2. Our Mortality and Morbidity rates have improved 3. We implemented and have maintained a nurse-driven Foley catheter removal policy and practice resulting in ZERO CAUTIs. 4. We implemented a central line checklist and training of our hospitalist team members for ultrasound use with central line placement - resulting in ZERO CLABSIs. 5. We have noted 100% compliance for the last several years in patient influenza and pneumococcal vaccinations compliance. 6. We have reduced our Emergency Department "Left Without Treatment" rate from 2015 to 2016 to meet national benchmark as well as maintaining at or below the benchmark for 2017. 7. We have continued use of our Safe Surgery Checklist use to prevent wrong-site surgery 8. We improved our post-colonoscopy follow up documentation/recommendation provided for patients with a history of adenomatous polyps - maintaining 100% compliance. 9. We improved our post-colonoscopy follow up documentation/recommendations for patients regarding a follow up interval of at least 10 years - maintaining 100% compliance. 10. We maintain a high level of Core Measures/Quality of Care indicators – the national standards of practice reported through The Joint Commission are at 99.80%; we are designated as a Key Quality Performer through The Joint Commission
Any other information:	We have unit specific and hospital-wide Safety Huddles every day to maintain focus on patient safety, preventative measures, and streamlined communication.

Lincoln County Medical Center

Hospital interventions:	1.	LCMC has implemented a type of Rapid Project Planning and action plan process comprised of monthly meetings to insure compliance with the CAUTI process steps. Process steps to decrease and/or eliminate the risk of a catheter-associated urinary tract infection (CAUTI) were identified and selected. The Infection Preventionist perform a detailed audit of Foleys present on the units at specific time intervals. Audit results are reported to the Clinical Outcomes Action Plan Team (COARPT) meeting on a monthly basis.
	2.	A review of medical records revealed that many diabetic patients were receiving the a.m. sliding scale Novolog a full hour before their breakfast arrived - leaving patients at risk of hypoglycemia between the time they received their injections and the arrival of their meals. The electronic medical record automatically times the insulin for 0700, but breakfast is scheduled at 0800. The interventions were to provide training to nursing staff to give the injections just prior to the meal (or to "chase" the meals with insulin) and to have pharmacy manually change the breakfast sliding scale time to 0745.
Hospital challenges:	1.	A challenge identified is the inclusion in the EPIC Foley order to include device justification and embed nursing CAUTI protocol into Foley Management order. The device justification would provide needed information for the RN to evaluate and follow when considering whether to discontinue or continue the Foley per policy.
	2.	The challenge was for pharmacy to remember to change the am dosing time.
Any mid-course corrections:	1.	The following corrections were implemented: 1. Increase the frequency of audits, rounding and data collection pending on compliance. 2. Infection Preventionist meets with unit managers after rounding to provide feedback and collaborate with staff education (performance and documentation).
	2.	Lead pharmacist reminded staff to change the times. Quality manager audited charts.
Successes:	1.	Overall compliance with the process steps increased to above our goal of 90%. One metric has improved to 100%.
	2.	Audit showed that 92% of breakfast sliding scale times were manually changed to 0745 and 100% of patients receiving the sliding scale insulin dose received it after 0800.

Los Alamos Medical Center

Hospital interventions:	LAMC's focus areas for 2017 were centered on prevention of harms. 1. Our first initiative is to reduce OB harms- shoulder dystocia's, post-partum hemorrhage, etc., therefore, we looked at our data, procedures, spoke with staff and providers and developed a plan of improvement. We did some process changes, staffing changes, drills and education to all staff and providers. Since December we have only had 2 as of July. We will continue to look at this for 2018. 2. Our second focus is to reduce Hospital Acquired Pneumonia. We again worked with staff and providers to try to answer why this is happening. We have put into place several procedures, Up and Out Early initiative, use of Incentive Spirometers, education for staff, and increased the awareness to be looking for potential problems at the daily Interdepartmental Team rounds. It is early in the process, but we have seen a decrease since April. We will continue to focus on this for 2018. 3. Our third focus is a LifePoint initiative to reduce harms related to ligature risks in the Behavioral Health population. As part of this collaborative we used a gap analysis and toolkit to improve our patient care areas. Hospital wide education, department specific risk assessments and protocols have been put into place to assure patient safety. A room in the Emergency Department was redesigned as a safe room/multi-purpose treatment room, should the patient need this. We will continue to monitor this project for 2018.
Hospital challenges:	We continue to work on decreasing the amount of Agency staff as this has been identified as one of the difficulties of getting initiatives hardwired. We have a dedicated Hospitalist group now and this has helped the consistency in the in-patient department. We now have a Quality department fully staffed and are working to develop this program to best address patient care and safety. We have had a change in leadership and Department Directors and look forward to building that team dynamic amongst the leadership.

Los Alamos Medical Center (cont.)

Any mid-course corrections:	The building of the Quality team with tenured staff. Changes in leadership. Consistent Hospitalist group. Identifying Hospital Acquired Pneumonia harms and putting an action plan in place.
Successes:	Getting a consistent Hospitalist group that is engaged with our initiatives. One of them is the physician champion for the Patient Safety and Clinical Quality Committee. Identifying the need to restructure the Quality Committee (PSCQ) to make it more of a group that discusses opportunities for improvement and how to make them happen.

Lovelace – Roswell Regional

Hospital interventions:	1. We implemented a new EMR with EPIC in August. There was much planning and education surrounding this launch. We reviewed many of our processes and some had to be modified for the EPIC flow. 2. We are closely monitoring readmissions with a readmission reduction team. 3. We launched a pre-op program through our Physical Therapy dept. 4. We launched an antibiotic stewardship program.
Hospital challenges:	The new EMR brought the challenge of all staff having to learn to work in a new system. With the EPIC launch, we lost the ability to have an automated second lactate order. Staff had to be re-educated to the EPIC process for sepsis. Best Practice Advisory pop-up fatigue has been a challenge for the staff.
Any mid-course corrections:	We did re-education on some of the Epic documentation pieces with nursing. We put in much time and effort working with our staff and Epic team to get additional flow sheets added as well as necessary corrections for their work flow.

Lovelace – Roswell Regional (cont.)

Successes:	1. Having an electronic medical record has been a huge asset. We can audit charts in real time much more efficiently. We can run reports that assist the directors in monitoring compliance. The providers are placing their own orders in the medical record, decreasing the number of telephone orders. 2. Readmission 3. Our PT Pre-op program has been successful in educating patients before having hip or knee surgery. This is still in the early stages, but we have had good outcomes thus far. 4. The antibiotic stewardship program has been an asset working hand in hand with providers to ensure appropriate antibiotic coverage and eliminating excess use.
Any other information:	1. We implemented a new EMR with EPIC in August. There was much planning and education surrounding this launch. We reviewed many of our processes and some had to be modified for the EPIC flow. 2. We are closely monitoring readmissions with a readmission reduction team. 3. We launched a pre-op program through our Physical Therapy dept. 4. We launched an antibiotic stewardship program.

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 trialed a new screening tool known as the Modified Early Warning System (MEWS). Our purpose for this trial was to reduce false alerts and more quickly treat patients for multiple concerns. Trial use was successful in our inpatient units and the MEWS screening tool was added to our Emergency Department electronic medical record. With physician support we have begun to overhead page Sepsis Alerts from the Emergency Department (originally pages were only from inpatient areas). Falls with Injury Reduction - Multidisciplinary approach that includes daily briefing, debriefing of excessively high fall risk patients. Bedside Shift Report incorporating patient/family teaching to reduce falls, "Know Before you Go" posters for patient rooms began in 2016 and continued through 2017. Have added new technology that alerts team members when a patient is trying to get out of bed. Improved availability of all equipment used to prevent falls and injury from falls. Prevention of Hospital Acquired Pneumonia – Team focus on consistent oral care through the addition of this on our patient's electronic medication administration record (EMAR). Added a dysphagia assessment to nurses' documentation. This assessment triggers a Speech Therapy consult. Improved use of Incentive Spirometer for all patients. Through a collaborative effort involving nursing, respiratory therapy and physical therapy we have improved Early Mobility for ICU patients.

Memorial Medical Center (cont.)

Hospital challenges:	Sepsis - Although we have seen improvement, we continue to have inconsistent use of Sepsis Order sets. Fewer Sepsis Alerts called overhead at night, with inconsistent team response. Falls – The majority of the equipment (portable) that alarms when the patient attempts to get out of bed ended up missing after first few months of use. Pneumonia – Assessment for dysphagia (difficulty swallowing) was not adequate with no automatic order for Speech Therapy consult. Incentive spirometry supply was not always available. With the change to a different oral care kit the team lost prompts for "oral care every 4 hours". Beds in ICU did not allow for sitting the ventilated patient up at the best angle (part of early mobility).
Any mid-course corrections:	Sepsis – Inconsistent team response to overhead Sepsis Alerts has improved through meeting with night shift consistently to educate and promote team response. Sepsis Response cards and Clinician Sepsis Aide cards developed, distributed and posted to support team efforts. Falls – Acquired replacement for lost/stolen equipment. Continued to support team to have enough supplies in all areas through regular checks of inventory. Pneumonia – As mentioned previously, a dysphagia assessment with automatic order was developed within the medical record. Also noted that documentation was not adequate – did not allow for documentation of patient effort or frequency. Revised electronic documentation to add prompts and drop-down menus to better document incentive spirometry use. Incentive spirometry supply levels were increased on each unit. Oral Care added to EMAR as a prompt to complete oral care every 2 hours (improved from every 4 hours). New ICU beds were obtained that allow patient to sit up immediately post-op (while still on a ventilator).

Memorial Medical Center (cont.)

Successes:	Sepsis - Reduction in Sepsis Harms over last quarter 2017. Falls with Injury – 35% reduction in the number of falls with injury from 2016-2017. Hospital Acquired Pneumonia – 45% reduction in the number of Hospital Acquired Pneumonia cases.
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:	Mimbres Hospital focused on improving hospital-wide readmissions. Mimbres Hospital also worked on decreasing the time from decision to admit to time of admission.
Hospital challenges:	Our biggest challenge was getting the physicians to follow the process and commit to the standardization that was needed to make the initiative successful.
Any mid-course corrections:	We had to change the way we educated our physicians to the process and adequately engage them for both interventions. We originally had had our data abstractor attempt to do some of the physician education, but that was not successful. Therefore, we decided to engage a physician leader to be a champion in the process. Once the ED Medical Director was included in the training and monitoring of the results the time began to consistently decrease.
Successes:	We saw a 44% improvement in hospital-wide readmission by the end of Q3 2017. We also have reduced our mean time from over 100 minutes to below 82 minutes.
Any other information:	The process was evaluated, and it was determined that a full- time employee would be employed as a Patient Navigator. The position helped ensure that the patient was able to schedule and attend follow-up appointments with their PCP. The position also helped to improve communication between the patient's inpatient and outpatient providers.

Miner's Colfax Medical Center

Hospital interventions:	Development of a Quality Steering Committee with Board Scorecard to measure categories in better health, patient experience, workforce development, and community Need. The second initiative was a hospital-wide "We're Listening Campaign." Promotion of our surveys to be completed so we can collect better data on what our patients are needing
Hospital challenges:	Some of the challenges we faced were changes in senior leadership and also low survey response.
Any midcourse corrections:	We will add financial health in subsequent score cards And kick off with a "Quality Rocks Program" engaging all hospital staff to remind our patients that we care, and we are listening.
Successes:	We noted an increase in patient satisfaction and increase in workforce development. Slow progress on increasing survey response. Development of "The Scoop" a global email with positive feedback received for staff to share.
Any other information:	Development of a Quality Steering Committee with Board Scorecard to measure categories in better health, patient experience, workforce development, and community Need. The second initiative was a hospital-wide "We're Listening Campaign." Promotion of our surveys to be completed so we can collect better data on what our patients are needing

Mountain View Regional Medical Center

Hospital interventions:	We conduct monthly audits of hypoglycemic incidents secondary to administration of an anti-hyperglycemic agent. Each incident is reviewed by a quality coordinator for trends, one on one education is provided as needed, and data reviewed by the pharmacy director at the Quality Improvement Committee Meeting. Steripath was introduced as a mechanism to reduce and identify blood culture contamination and has reduced false positives of CLABSI and reduced inappropriate antibiotic usage. A pressure ulcer committee was established to review patient at high risk of pressure ulcer development. Department directors look at daily Braden scores and ensure skin bundles are implemented and timely wound care consultations are obtained. C. diff rates were address in conjunction with the Antimicrobial stewardship committee and infectious disease doctor. Antibiotic timeouts at 72 hours to reduce incidents of antibiotic induced C. Diff. Decision trees, order sets, and clinical pathways were established and implemented to ensure appropriate testing, and reduction of high-risk antibiotic usage. Sepsis coordinator updated order-sets and implemented code sepsis to have a multidisciplinary response for identification, treatment, and management of sepsis patients and utilization of the sepsis bundle. The infection Preventionist reviews all potential infection and conducts a root cause analysis in conjunction with the department director to identify trends and analysis. Device utilization is reviewed daily and discussed at facility wide safety huddles, individual bedside nurses, and providers.
Hospital challenges:	Challenges arose in consistency of the EMR and implemented change orders for the sepsis bundle. The nation-wide antibiotic shortages lead to great challenges in accurately tracking 72-hour time outs and finding alternative therapies. Staff and leadership turnover lead to inconsistent training and is an ongoing challenge for us.

Mountain View Regional Medical Center (cont.)

Any mid-course corrections:	Revision of the sepsis bundle and order-sets was completed and allowed for appropriate orders with single activation easing compliance with the sepsis bundle. Procalcitonin testing was implemented to identify viral versus bacterial infections and reduce antibiotic usage. A revised C. Diff order tool and schematic was introduced to ensure appropriate testing was completed.
Successes:	We successfully decreased C diff rates, incidents of VAP, and CLABSI rate, and maintained zero MRSA Bacteremia events. Overall reduction in deaths secondary to sepsis and severe sepsis.
Any other information:	We developed a readmission reduction committee and readmissions will continue to be a priority focus area. We also implemented a fall reduction program and continue to see successes. We will continue to utilize the Hospital Engagement Network to implement best practices and decrease hospital acquired conditions, improve data collection methods and event analysis, make sustainable improvements, and benchmark with other hospitals in the state and nation. We also collaborate with NM Emergency Medical Service Bureau for Primary Stroke Center, Chest Pain Center, and Level 3 Trauma Center designations.

Nor - Lea General Hospital

Hospital interventions:	1.	Increase Pneumococcal Vaccination to reduce the incidence of admissions for older adults with community acquired pneumonia in the clinics to reduce admission in the hospital.
	2.	Implementation of the accountable care organization (ACO) pilot project to case manage and implement preventative annual wellness visits with the Medicare patients to reduce overall cost of care by reducing admissions and ER visits.
Hospital challenges:	1.	Capturing vaccination history from patients seen in the clinics due to the NMSIS system not interfaced with the clinics EMR system.
	2.	Implementation of the ACO was a system wide project and the annual wellness visits process and the time the exams take was for the providers and staff.
Any midcourse corrections:	1.	Training staff to chart prep and pull immunization history from NMSIS.
	2.	Annual wellness visits were being done by one provider and that changed to all providers in the system and allowing the ACO nurse to do the initial questionnaire for the provider to reduce the time in the visit.
Successes:	1.	Improvement of data collection around immunization status as well as improvement in pneumococcal vaccination rates in adults over 65 from a 12-month average of 41.8% in December of 2015 to a 12-month average of 62.5% in December of 2016 and a sustainment of those results through 2017.
	2.	Improvement of annual wellness visits from 0 in 2015 to 2.4% in 2016 and building on those processes increased to 15.3% in 2017.

Plains Regional Medical Center

Hospital interventions:	PRMC reviewed the CAUTI bundle at the end of 2016 with the staff. In 2017 the process steps to decrease and/or eliminate the risk of a catheter-associated urinary tract infection (CAUTI) were identified and selected. A type of Rapid Project Planning and action plan process comprised of focused monthly meetings/sessions to insure compliance with the CAUTI process steps. The Infection Preventionist performs a detailed audit of Foleys present on the units at specific time intervals. Results and findings are reported to the Clinical Outcomes Action Plan Team (COARPT) meeting on a monthly basis. The Infection Control Epic module was instituted to assist the facility monitor Foleys. Education to providers to include ADE protocol, order set usage and Pharmacy oversight of dosin
Hospital challenges:	At PRMC the challenge identified was documentation reflecting continued need of the Foley. Providers used the order set following protocol but the Pharmacy oversight while improved has yet to reach 95% or better.
Any midcourse corrections:	PRMC Infection Preventionist attended interdiciplinary daily huddles where patient specific information related to Foley is discussed: Does the patient need the Foley, can the Foley be discharged, any precautions needed.
Successes:	Overall compliance with the process steps has increased to above our goal of 90%. One metric has improved to 100%. Improvement from 60% to 80% with Pharmacy oversight of dosing.

Rehoboth McKinley Hospital

Hospital interventions:	The Emergency Room's Left Without Being Seen rate was high indicating we were not providing care to all patients seeking emergency room services. Several interventions have been implemented including being mindful of the importance of the project and continuously analyzing each incident, providing monthly data to providers and targeting the number as part of the daily Safety Huddle. Other key initiatives were skipping triage and bringing patients straight back to available rooms and initiating bedside registration allowing patients to be roomed more efficiently. Nursing bedside reporting was initiated towards the end of 2017. Several safety events and our patient satisfaction scores indicated communication between nurses and between nurses and patients needed to be improved. Nursing leadership spent several weeks leading and coaching the nursing staff into a successful and productive bedside rounding routine. This process has been hardwired and happens at each change of shift routinely. An Urgent Care was opened to provide community members requiring less acute care than the ER a more time and cost-efficient resource. The Urgent care is open during the ER's busiest times creating an outlet for less acute patients to receive care and freeing up the ER providers to focus on those patients requiring an emergent level of care and resources.
Hospital challenges:	Two initiatives this year targeted a high-risk area of patient safety and quality, the Left Without Being Seen rate (LWAB). The LWAB Performance Improvement Project and opening the Urgent Care has impacted through-put and the LWAB rate, but it continues to be a challenge that the hospital will remain to focus on as a key safety and quality Initiative.

Rehoboth McKinley Hospital (cont.)

Any mid-course corrections:	Several bad outcomes were experienced from tele-radiologist misreads on pediatric ER patients. The process was changed, and only Board-Certified pediatric neurologists read all neurologic pediatric CT scans.
Successes:	We received Acute Stroke Accreditation with DNV-GL. Prior to accreditation, 80% of Stroke patients were sent to a higher level of care and currently we keep close to 80% of patients for treatment at RMCH. The burden of being transferred to Albuquerque is immense for patients and families. This service has a huge impact on patient outcomes and financial and emotional burden on patients and families. The Left Without Being Seen rate was 7.8% in Jan 2017 to 5.2% in December of 2017. If current trends continue, the ER will provide care to 3,000 more patients seeking ER care in 2018.

Roosevelt General Hospital

Hospital interventions:	*Roosevelt General Hospital (RGH) worked with HIIN to report out and analyze various data measures. In order to improve patient care for falls, RGH improved its Fall Prevention policy. This policy, using EMR, implemented The John Hopkins Fall Risk Assessment Tool for new admissions, addressing bedside interventions such as placing the patient in a yellow “fall” gown and initiating a bed alarm, as well as creating an order for a Physical Therapy evaluation. The policy also provided for instructions for documentation after a patient’s fall called the Post Fall Huddle. This huddle is to involve multidisciplinary staff, who would investigate subjective and objective data, prior fall risk score, and implement new interventions for patient safety. *With regards to readmissions, RGH has hired on a full time Utilization Review/Case Manager in 2016, who implemented a change in process for 2017, by educating physicians on appropriate admissions and to provide patients a Care Transition Plan, focusing on follow-up appointments and patient understanding of their discharge instructions. *Another initiative RGH was involved in is our Appropriate Catheter Utilization Program. A committee was formed who researches best practice in indwelling catheter removal and investigates appropriate catheter insertion usage. An Indwelling Catheter Report form was also created and attached to every indwelling catheter insertion kit, that requires the nurse to indicate insertion reason, as well as date and time of insertion and removal.

Roosevelt General Hospital (cont.)

Hospital challenges:	* The Fall Prevention policy challenge had been staff inconsistency with having adequate staff members present in the Post Fall Huddle. There is ongoing education of new staff and supporting departments (i.e.: respiratory, pharmacy, and maintenance depts.) about their importance in patient's ambulatory safety. *With an effective but overworked Utilization Review/Case Management department RGH realized we need to hire on additional help. In December 2017, we hired on a full time Discharge Planner, who focuses on patient education and placement after discharge. *Challenges with the Appropriate Catheter Utilization Program are more founded in our Emergency Department (ED) where we have contracted physicians coming in going frequently. In 2018 we are trying to hire full time ED physicians who would be more familiar with policy.
Any mid-course corrections:	We hired more staff to support the Utilization Review department in discharge planning.
Successes:	*Falls reporting and documentation has improved from 2016 to 2017. 2017's post fall huddle compliance was at 64.28%. *Appropriate catheter use was a new measure being tracked in 2017, and after the implementation of the project we saw the average compliance go from 74.3% in quarter 3 of 2017 to 77.4% in quarter 1 of 2018. *There were no Healthcare Acquired Infections for 2017.

San Juan Regional Medical Center

Hospital interventions:	All Cause Readmissions: 1) Monthly readmission data revealed that 5-8 patients were re-admitted within 24 hours of discharged. A team composed of individuals from Nursing, Quality and Case Management began meeting mid-2017 to review 24-hour readmissions and identify any trends and propose corresponding actions. 2) Began working with HealthInsight and HIIN to develop a Readmission Symposium hosted by a national expert to be held early in 2018. Hospitals and health care organizations throughout the Four Corners were to be invited. Adverse Drug Events due to Opioids: 1) The policy and standard order sets were revised to provide instruction for the administration of pain medications in response to the patients' report of pain level. 2) Revised PCA standard order set to include the desired goal by using the Richmond Agitation Sedation Scale and instructions on when to decrease the volume. 3) Revised the Pain Management policy to include the recommended Institute for Safe Medication Practices Guidelines for PCA Monitoring by Centers for Medicare & Medicaid Services - Conditions of Participation. 3) Education conducted with providers and nursing staff. Surgical Site Infections: 1) Surgeons worked collectively to develop a standardized elective colon protocol based on current best practices. Formalized in this protocol were: Nose-to-Toes bathing protocol; use of the Alexis wound protector, glove and gown changes prior to closing, and introducing a new sterile instrument tray for closure, and a renewed focus on oxygenation and normothermia; 2) Antibiotic selection was standardized for use of Mefoxin and Ciprofloxacin preceding the surgery; 3) Developed a comprehensive pre-anesthesia patient education program tailored to optimize the patient status prior to surgery. The program includes an easily-understandable education booklet, and a surgery prep kit containing all items needed to prepare for the procedure, and for use immediately following the procedure

San Juan Regional Medical Center (cont.)

Hospital challenges:	The inability to identify trends in disease processes or reasons for re-admission. Consistency in practice as providers still have an option for generic pain versus mild, moderate, or severe when entering instructions for as needed pain medications. Obtaining surgeon agreement on elements of the bundle that should be incorporated into hospital processes, as individual practices would sometimes require dramatic change.
Any mid-course corrections:	The one-day readmission team is ongoing and will continue analysis of individual cases. Continue to audit for compliance and trends. Identified metrics to follow on an ongoing basis and making changes based on results.
Successes:	Focus will continue in 2018 with the goal to decrease All-Cause Readmissions. The goal was to decrease unplanned use of Narcan. The goal was met. Significant decrease in Colon Surgical Site Infection rates were achieved.

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 in 2016 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 also 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:	In 2017 SGH instituted the Epic Infection Control module which provides the Infection Preventionist the ability to monitor Foleys. In addition, the Infection Preventionist/Quality Manager performs monthly audits focusing on Foleys present on the units. Results and findings are reported to the Clinical Outcomes Action Plan Team (COARPT) meeting on a monthly basis. SGH instituted a process whereby all patients admitted with diarrhea are assessed for C-Diff. If the patient meets criteria for testing, a request C-Diff lab is ordered.
Hospital challenges:	A challenge identified for SGH is the low volume of cases. One event significantly affects our scores. Many of our Swing beds admitted at SGH, have had previous C-Dif. A challenge is the quick identification of these patients.
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:	Overall compliance with the process steps has increased to above our goal of 90%. One metric has improved to 100%. Achieved great than 180 without hospital onset C-diff.

Union County General Hospital

Hospital interventions:	An Antibiotic Stewardship Program has been implemented. The Pharmacist reviews all antibiotics and compares the utilization with the culture and sensitivity. If any discrepancies arise the Providers are changing the antibiotic to the appropriate medication 100% of the time.
Hospital challenges:	There were little challenges with the antibiotic stewardship as noted above with 100% compliance with changing orders as communication and collaboration amongst pharmacy and physicians was successful A separate challenge has been with patient satisfaction. Patient satisfaction scores continue to remain below target.
Any mid-course corrections:	A customer service company has been retained to begin providing trainings with the staff. Satisfaction of the staff and providers are also any area UCGH would like to focus on by starting with satisfaction surveys given to the employees and providers.
Successes:	1. Union County General Hospital was able to hire two fulltime providers and engage them in antibiotic stewardship. 2. UCGH continues to maintain a Level 4 trauma certification. 3. With the utilization of IV insulin drips, UCGH has had zero hypoglycemic episodes.
Any other information:	The primary focus pertaining to patient satisfaction will begin with the patient admission process.

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). The hospital is participating in the HRET Hospital Improvement Innovation Network (HIIN). The hospital is starting an opioid use stewardship team which will work closely with the Quality Outcomes people who are tracking opioid adverse drug events. The hospital continues to participate in several Vizient collaboratives designed to improve quality and safety outcomes, and in the National Surgical Care National Surgical Quality Improvement Program (NSQIP).
Hospital challenges:	The hospital has not made significant inroads into decreasing the number of C. difficile infections.
Any mid-course corrections:	The hospital is revising action plans for reducing C difficile infections including expanding environmental and antibiotic stewardship interventions. The Hospital was collecting data related to surgical bundle compliance for adult general surgeries and found compliance was good; shifted focus to surgeon-dependent variables and identified some areas for improvement.
Successes:	The hospital has downward trends in central line associated blood stream infections (CLABSI) and catheter associated urinary tract infections (CAUTI) as well as utilization rates for both central lines and urine catheters, peri-operative deep venous thrombosis/pulmonary embolisms (DVT/PE), post-op hemorrhage and hematomas, post-op respiratory failure, surgical site infections and workplace violence.

Thank You

New Mexico Human Services Department
Medical Assistance Division