Hospital Quality Improvement Incentive

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

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

Each hospital participating has submitted measures and have been paid for DY 2 of the HQII program in the amount of $2,824,462. In DY 3 the amount of $5,764,727 has been paid. For DY 4 the estimated amount to be paid is $8,825,544.

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

Measures

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

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

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

Outcome Domain 1: Urgent Improvements in Care

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

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

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

Outcome Domain 2: Population-Focused Improvements

These have been updated to the ICD 10

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

1. Adverse Drug Events

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

A. Hypoglycemia in Inpatients Receiving Insulin

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

Denominator - inpatients receiving insulin or other hypoglycemic agents.

B. Adverse Drug Events due to Opioids

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

Denominator - number of inpatients who received an opioid agent.

C. Excessive anticoagulation with Warfarin – Inpatients

Numerator – inpatients experiencing excessive anticoagulation with warfarin.

Denominator - inpatients receiving warfarin anticoagulation therapy.

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

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

2. Catheter-Associated Urinary Tract Infections (CAUTI)

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

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

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

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

3. Central Line Associated Blood Stream Infections (CLABSI)

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

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

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

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

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

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

Denominator - inpatient discharges.

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

Specifications available at

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

5. Obstetrical Adverse Events

OB Trauma – Vaginal Delivery without Instrumentation PSI 19

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

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

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

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

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

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

Specifications available at
https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_18_Obstetric_Trauma_Rate%E2%80%93Vaginal_Delivery_With_Instrument.pdf

6. Pressure Ulcers Stage III & IV Rate PSI 3

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

Denominator – inpatient adult discharges.

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

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

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

7. Surgical Site Infections

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

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

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

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

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

8. Venous Thromboembolism (VTE) Post-operative PSI 12

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

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

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

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

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 DY3 to DY4

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

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

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Artesia General Hospital

HQII Reporting results from DY3 to DY4

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

Carlsbad Medical Center

HQII Reporting results from DY3 to DY4

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	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

CHRISTUS St. Vincent Hospital

HQII Reporting results from DY3 to DY4

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

HQII Reporting results from DY3 to DY4

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

Dr. Dan C. Trigg Memorial Hospital

HQII Reporting results from DY3 to DY4

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

Eastern New Mexico Medical Center

HQII Reporting results from DY3 to DY4

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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PHS Espanola Hospital

HQII Reporting results from DY3 to DY4

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

Gerald Champion Regional Medical Center

HQII Reporting results from DY3 to DY4

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

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

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

Gila Regional Medical Center

HQII Reporting results from DY3 to DY4

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

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

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

Guadalupe County Hospital

HQII Reporting results from DY3 to DY4

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 DY3 to DY4

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

Lea Regional Hospital

HQII Reporting results from DY3 to DY4

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

Lincoln County Medical Center

HQII Reporting results from DY3 to DY4

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

Los Alamos Medical Center

HQII Reporting results from DY3 to DY4

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

Lovelace Regional Hospital – Roswell

HQII Reporting results from DY3 to DY4

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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Memorial Medical Center

HQII Reporting results from DY3 to DY4

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	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)

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

Mimbres Memorial Hospital

HQII Reporting results from DY3 to DY4

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

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

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

Miners' Colfax Medical Center

HQII Reporting results from DY3 to DY4

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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MountainView Regional Medical Center

HQII Reporting results from DY3 to DY4

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)	No
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 73%

(improved in 8 of the 11 measures)

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

Nor - Lea General Hospital

HQII Reporting results from DY3 to DY4

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

Percentage of overall improvement 83%

(improved in 5 of the 6 eligible measures)

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

Plains Regional Medical Center.

HQII Reporting results from DY3 to DY4

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

Rehoboth McKinley Hospital

HQII Reporting results from DY3 to DY4

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

Roosevelt General Hospital

HQII Reporting results from DY3 to DY4

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 DY3 to DY4

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)	No
Ventilator Associated Events (VAE)	Yes

Percentage of overall improvement 91%

(improved in 10 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 DY3 to DY4

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 DY3 to DY4

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 DY3 to DY4

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 DY3 to DY4

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

Percentage of overall improvement 64%

(improved in 7 of the 11 measures)

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

Alta Vista Regional Hospital

Hospital interventions:	Our data collection and performance improvement plan were put in place to track all Narcan uses on patients receiving Opioids in an attempt to identify trends and alternate treatment options for pain control. Pharmacy and Nursing worked together on the performance improvement plan and the data is reported quarterly at Quality Improvement Council meetings. Reporting the number Foley catheters present, and their justification, on all inpatients was hardwired as a standing discussion topic at the morning multidisciplinary safety huddles.
Hospital challenges:	The high rate of contract nursing staff has been the biggest obstacle for our hospital. With the onboarding of contract nurses every 13 weeks, education and diligent concurrent reviews were crucial in achieving our goals.
Any mid-course corrections:	The Foley care protocol was revised in mid 2016 and our Infection Control department completed 100% of clinical education for all staff. In addition, Infection Control met with providers and shared the Foley education to all providers with admitting privileges.
Successes:	Contract nursing staffing has been reduced significantly in 2017 due to increased hiring efforts and recruitment. Our facility had zero catheter-associated urinary tract infections in 2016.

Artesia General Hospital

Hospital interventions:	Artesia began a Chest Pain initiative to reduce EKG times with the involvement of the cardiologists, and has continued to participate with the New Mexico Hospital Association on the Centers for Medicare and Medicaid Services (CMS) Hospital Improvement Innovation Network (HIIN). A new Event Report System was introduced, allowing Departments Directors to be more involved in owning and addressing quality improvement. They enter data monthly, track performance and develop individualized plans of correction for their departments. The hospital initiated an aggressive plan to identify those patients that are at risk of falling, with a specific identification color in their hospital gowns, stars and fall risk warning signs.
Hospital challenges:	Turn-over in key positions has been a major challenge. Training and retraining new staff occurs routinely. Education about QI/PI data and how it applies directly to reduction of patient harm is ongoing.
Any mid-course corrections:	The Quality/Assurance Performance Improvement meetings are conducted regularly, allowing leaders to review data and develop improvement plans when necessary. Hand washing continues as a priority to prevent the spread of infections. While the number of hospital-acquired Clostridium difficile infection was very small, the community has seen a large increase in numbers.
Successes:	With the implementation of the Sepsis Protocol, Artesia has improved the ability to identify and rapidly treat our patients. A Falls Protocol was implemented, with a decrease noted in falls. There were no falls with major injury, no pressure injuries, and no post-operative deep vein thrombosis or pulmonary embolisms. EKG times have been reduced. The preventable readmission rate has also decreased, indicating that discharge planning and community collaboration has been successful in keeping our patients from being readmitted with the same diagnosis.

Carlsbad Medical Center

Hospital interventions:	We reestablished the code blue committee, with all codes being evaluated according to Advanced Cardiac Life Support guidelines. We began a suicide assessment documentation audit, with the goal being to increase documentation of risk of suicide and appropriate interventions implemented according to the risk assessment. In addition, education was provided by specialists to staff regarding accurate assessment of suicide risk, interventions, and safe room checklist. We contracted with a company to provide trained sitters for patient with a high level of suicide risk. We embarked on an intensive education campaign for patients and their families related to family members assisting with patient mobility and audited compliance with education.
Hospital challenges:	We determined that there was a lack of knowledge regarding assessment of suicide risk, and documentation. We have struggled with compliance with the sepsis bundle. Our catheter associated urinary tract infection rate and C-Difficile infection rate did not improve from 2015.
Any mid-course corrections:	We established a multidisciplinary sepsis committee to determine our weaknesses and discuss interventions to improve. We began a process whereby the lab would automatically repeat lactate level for any lactate greater than 2 in 3 hours after the initial lactate.
Successes:	We maintained a zero rate for central line associate blood stream infections, colon surgical site infection, and several other hospital acquired condition and patient safety indicator events.

CHRISTUS St. Vincent's Regional Medical Center

Hospital interventions	1. C. difficile reduction (noted below are 4 of the main interventions). - A project led by a physician/nurse dyad through the hospital's CDPI (Clinician-directed Performance Improvement) department aimed at increasing appropriate hand hygiene. - Implementation of a nurse-initiated protocol for early assessment, screening, and testing of patients (within first 48 hours of admission) who were clinically suspicious for C. difficile. - Development of focused screening guidelines to ensure patients meet basic testing criteria given the high community load of asymptomatic C. difficile carriers. - Antibiotic stewardship efforts with a goal of reducing the rate of broad-spectrum antibiotics by 20%. 2. Catheter-Associated Urinary Tract Infection reduction in the Intensive Care Unit (noted below are 6 of the main interventions). - Nurse in-service. - "Line rounds" implemented that precede daily multi-disciplinary rounds. - Review of catheter use and indications incorporated into daily interdisciplinary Intensive Care Unit rounding sheet. - Data feedback to staff. - Condom catheter equipment updated. - Urometer bags house wide to prevent interruptions of Foley catheter systems. 3. Central Line Associated Blood Stream Infection reduction in the Intensive Care Unit (noted below are 5 of the main interventions). - Nurse in-service. - Standardized criteria for central line use in the Intensive Care Unit. - Standardized best practices for central line care and maintenance. - Data feedback to staff. - Review of line use and indications incorporated into daily interdisciplinary Intensive Care Unit rounding sheet.

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

Hospital challenges:	Despite improvements with central line maintenance and a reduction in central line days, by national definition, the hospital still had some infections. However, a drilldown was completed by two Infectious Disease physicians on all events that met National Healthcare Safety Network definition since 2014, and they determined that while the events met the definition, approximately 40% were likely not true Central Line Associated Blood Stream Infections and instead were probably due to contaminants. (see next statement about mid-course corrections)
Any mid-course corrections:	We worked closely with the Hospital Association toward the end of 2016 to line up education and training by Dr. Kellie, an Infectious Disease physician, on reducing blood culture contamination. This was scheduled to occur in 2017.
Successes:	1. We had large decrease in the number of C. difficile infections meeting hospital-onset definition by 2016 year's end. 2. There was a doubling in the rate of appropriate hand hygiene (pre-intervention mean was 41%, and post-intervention mean was 82%). 3. There was a drop in the percentage of total antibiotics that were broad-spectrum antibiotics from over 50% to around 30%. 4. We went nearly a full year (Jan - Oct 2016) without a Catheter-Associated Urinary Tract Infection in the Intensive Care Unit, and went January - September 2016 without a Catheter-Associated Urinary Tract Infection house-wide. 5. Our appropriate central line maintenance (composite score) increased 19%, along with a 17% reduction in central line use in the Intensive Care Unit.
Any other information:	An important note is that when there is a decrease in the denominator (e.g. line days, or Foley catheter 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:	The three key interventions that our Hospital worked on in 2016 were focused on infection control, safety, and quality. To improve infection control at our Hospital, the following initiatives were implemented: surgical site infection reduction, hand hygiene improvement, new hand sanitizer and hand hygiene product roll out, an employee influenza vaccine campaign, and an assessment of the infection control program by Marti Heinze at Gerald Champion Memorial Hospital. To address the issues surrounding safety at our facility, the following actions were taken: active shooter training for staff, department lockdown and one button lockdown with immediate police notification installed, panic buttons installed in all departments, service aide hired for high incident days, security cameras were upgraded, parking lot lighting was updated, and assessments of safety and security were conducted by OmniSure Consulting Group. To improve quality at our facility, the following initiatives were implemented: peer review improvement, development of a Continuous Quality Committee, quality dashboard updated, implemented Patient Satisfaction webinars, and an assessment of the quality program was conducted by Quorum Health Services.
Hospital challenges:	The major challenge for our Hospital in 2016 was falls. After reaching over a full year of fall-free days at our Hospital, the number of falls increased. However, there was only one fall with injury that occurred. An additional challenge is influenza vaccination for inpatients, particularly with process and compliance.
Any mid-course corrections:	To address the increase in falls occurring at our facility, the following mid-course corrections were done: staff were trained on how to properly set up and address bed alarms, beds were to be kept low to the floor for patients with an increased fall risk, two stretchers with alarms were purchased, education with staff about fall precaution protocols continued, staff were expected to use communication boards in patient rooms to inform them about patient ambulation needs, hourly patient rounding by staff continued, fall huddles were conducted after every fall that occurred, and trends for patterns of falls were continuously review at monthly Safety & Security meetings.

Cibola General Hospital (cont.)

Successes:	In 2016, all departments in our Hospital worked diligently to implement new and improve existing initiatives focused on improving patient care and health outcomes. Below are highlights of the improvement work undertaken by staff. **Cardiopulmonary:** We completed sleep study process improvement, Electrocardiogram times improved for chest pain patients (from order time to completion time), nursing staff were trained to assist in performing them, and provided a mobile phone to department to improve response time. **Community outreach**: We started a drive through flu pod, community needs assessment, quarterly mini health fairs, and an annual health fair. **Emergency Department:** We revised and improved lab culture reporting and development, implementation, and updates of clinical pathways for fever and obvious fractures. **LAB:** We have a process to reduce turnaround time of results **Nursing units:** We developed, implemented, and updated sepsis, venous thrombo-embolism, and hypoglycemia pathways and provided a mobile phone to department to improve response time. **Obstetrics:** We implemented baby friendly initiatives (including exclusive breastfeeding promotion), early elective delivery adherence (100%), and established categories for staff call back to improve response times for procedures. **Pharmacy:** We developed an antimicrobial stewardship program, a pharmaceutical waste disposal programs, and improved physician communication. **Radiology:** We implemented Magnetic Resonance Imaging services 5 days/week and started using Trophan for ultrasound probes.

Dr. Dan C. Trigg Memorial Hospital

Hospital interventions:	<u>Fall Prevention:</u> The NOWA model (No One Walks Alone) has been fully implemented. A fall assessment is performed every shift for every patient. Hourly rounding has been formalized with a rounding schedule. Falls or number of days since last fall is reported at daily safety huddle. <u>Adverse Drug Events:</u> At DCT, a pharmacist is not on site 24/7. There has been a process improvement project utilizing satellite pharmacist at a sister facility to review all mediation orders. This process has added an additional safety check prior to medication administration. The objective of this project was to reduce ADEs.
Hospital challenges:	<u>Fall Prevention:</u> Small hospitals struggle to account for low volumes. One occurrence can greatly impact the hospital's score <u>Adverse Drug Events:</u> The challenge is the throughput of orders to the automated system.
Any mid-course corrections:	None identified at this time
Successes:	Fall Prevention: Total quantity of falls for the facility have decreased by one. Adverse Drug Events: Decreased adverse drug events by 48% at DCT.

Eastern New Mexico Medical Center

Hospital interventions:	The hospital leaders worked diligently throughout 2016 on infection prevention, with results being no catheter-associated urinary tract infections, central line associated blood stream infections or deep vein thrombosis during the year.
Hospital challenges:	Falls with injury continue to be the challenge, most especially in the Medical/Surgical Unit. Patient and Family Education at the time of the Intake Assessment has been identified as one of the factors. The hospital is now looking at Alarm Fatigue as we review Falls data.
Any mid-course corrections:	Hospital compliance with providing the patient with the *Important Message from Medicare* was significantly below threshold. With the education of the various staff and emphasis on the importance of providing this notice to patients, the scores significantly increased over time to the point we achieved 100%. The monitoring of **sepsis** patients and subsequent drill down to the issues that inhibit timely and best practice was a challenge. Quality staff worked with the Directors of the Emergency Department and the Critical Care Unit as well the Clinical Informaticist to track and identify how to achieve best practices. We implemented the "repeat lactic acid" standard and educated Emergency physicians with great results. We are now working with the Clinical Informaticist to have this part of the electronic record on the Inpatient units. The Emergency Department has a different electronic record than the Inpatient units.
Successes:	The use of checklists throughout the hospital has proved very beneficial as evidenced by our Infection Data for catheter-associated urinary tract infections, central line associated blood stream infections and deep vein thrombosis. We successfully completed our Joint Commission Survey for our Laboratory. We successfully completed our Trauma Certification for a two-year certificate.

PHS Espanola Hospital

Hospital interventions:	Fall Prevention: The NOWA model (No One Walks Alone) has been fully implemented. Jackie Conrad, HIIN/HRET falls expert, provided a work shop where best practices were shared. A fall assessment was performed every shift for every patient. Hourly rounding was formalized with a rounding schedule. Additionally, a patient assessed as high-risk results in increased patient rounding. There was daily review of fall risk status during daily huddles. Adverse Drug Events: To decrease ADE's related to the use of opioids, the facility provided education to the clinical staff on non-pharmaceutical interventions. In addition, pharmacy staff has been included to monitor appropriateness of all controlled substance orders. ADE's were closely tracked, trended, and reviewed. This process aimed at preventing overdoses or other outcomes leading to an ADE.
Hospital challenges:	<u>Fall Prevention:</u> Patient compliance and adherence to procedures was a challenge. Another challenge was hardwiring the process with clinical staff. <u>Adverse Drug Events:</u> The area our hospital serves has a large population of substance abusers. This poses a challenge to treatment plans and pain control.

PHS Espanola Hospital (cont.)

Any mid-course corrections:	<u>Fall Prevention:</u> Corrections included: a. Review of the program with the patient/ family on admission. b. Fall prevention goal written on white board. c. Reviewed at bedside report. d. Ongoing manager and supervisor rounds occurred. Additionally, staff training at monthly meetings occurred.
Successes:	<u>Fall Prevention:</u> Patient fall rate reduced from 3.73 per 1000 patient days to 2.29 per 1000 patient days. <u>Adverse Drug Events:</u> Adverse Drug Events (ADE) related to opioids decreased from 6.63 per 1000 patient days to 1.36 per 1000 patient days.

Gerald Champion Regional Medical Center

Hospital interventions:	The hospital has had no early elective deliveries in this reporting period. This remains a focus of the hospital because of the risk to the baby associated with early deliveries. The hospital improved its ability to monitor complications from blood thinning medications through software improvements. A team of bedside staff in collaboration with physicians and hospital leadership was developed to look at the data gathered surrounding patient falls. They implemented many strategies to help reduce falls and injury from falls. There was a significant decrease in the number of falls in the last quarter of 2016. There was also an associated decrease in the number of injuries sustained from falls. This team continues to in their work. In an effort to combat Clostridium difficile (C-diff), an infection associated with antibiotic use, the hospital has contracted with a vendor that comes in on a monthly basis and performs a service as part of the environmental cleaning. This service helps to reduce the level of bacteria in our environment for this very difficult to kill organism. The data is still early but our Clostridium difficile infections appear to be trending down.
Hospital challenges:	Our community has a high level of community acquired Clostridium difficile
Any mid-course corrections:	Through chart audits for sepsis mortality it was discovered that the charts with Do not resuscitate (DNR) orders were not being coded as such which resulted in an artificially high risk adjusted mortality rate. The coding error was confirmed across multiple diagnosis. While the existing charts were not resubmitted with the codes, the error has been corrected going forward. We expect to see a drastic reduction in our Risk Adjusted Mortality rates going forward.
Successes:	The hospital has seen a decline in the number of falls in the last quarter of 2016. There were no early elective deliveries.

Gila Regional Medical Center

Hospital interventions:	We have worked with Sepsis diagnoses to ensure all our patients meet the measure, every time.
Hospital challenges:	Our largest challenge was changes in staffing and implementation of new information system
Any mid-course corrections:	Our communication within nursing staff and clearly defined definitions helped.
Successes:	We have improved on the Sepsis measure by 15% over the previous year, we still have room to improve.
Any other information:	Due to changes within the hospital and restructuring of staff and patient flow, we continue to evaluate how we can better serve our patients.

Guadalupe County Hospital

Hospital interventions:	In 2016 Guadalupe County Hospital continued improvements in discharge processes, including newly **scripted follow up calls** for all inpatient discharges. The call script includes topics such as activities of daily living, medication review, follow up appointments, and the need for social services and/or home care. The goal is to call patients within 72 hours of discharge. This is tracked on a monthly basis and reported to the Quality Performance Improvement Committee. A second initiative was **monitoring and providing workplace safety and violence training**. An active shooter training was held for all hospital staff over two sessions. A review of hospital safety measures was also conducted (areas of refuge, emergency notifications, and panic alarms). Furthermore, all nursing staff were certified in Mental Health First Aid to help diffuse potential dangerous situations and provide better care to patients. Other continuing process improvements include participation in Hospital Improvement Innovation Network (HIIN), 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:	One of the challenges the follow up calls is the fact that many of our inpatients are tourists or travelers and are difficult to contact or to provide adequate follow up support for. The challenge with safety and work place violence is the lack of behavioral health services in the rural areas, especially at night and on weekends. We are working with the New Mexico Hospital Association PARC (Preserving Access to Rural Care) committee in developing a tele-behavioral health network. We will also be meeting with the New Mexico Behavioral Health Institute to improve the patient evaluation and transfer processes from our facility to theirs.

Guadalupe County Hospital (cont.)

Any mid-course corrections:	There were no specific mid-course corrections. Also, processes that were implemented last year were continued this year and improved as needed.
Successes:	Our successes include a small reduction in avoidable hospital readmissions. However, because our volumes are so low, it is difficult to adequately quantify this. In terms of work place safety, we have had no incidents since our training (no violent interactions with patients). The nursing staff reported that the Mental Health First Aid training was very informative and provided several useful strategies for de-escalating situations before more serious interventions are required (law enforcement or security). Successes regarding continuing 2015 initiatives include the full implementation of the disease specific patient education folders, and ongoing daily patient stay check lists (and improved measures for compliance with daily tasks), continuing daily clinical staff huddles and morning patient rounding by all clinical staff. Electronic medical record systems continue to be customized to help improve patient care through clinical reminders and easier data extraction. Lastly, our Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS - patient experience) scores continue to hover around 90%.
Any other information:	As mentioned in the 2015 annual report, an infection prevention exercise was planned and held in 2016 to show maintenance staff and clinical staff the importance of isolation precautions and terminal cleaning of patient rooms. A presentation of the exercise results was made to the hospital infection prevention and safety committees, and to the hospital governing board.

Holy Cross Hospital

Hospital interventions:	In 2016 Holy Cross Hospital focused on decreasing the number of urinary catheter days. As part of the daily patient rounding, patients with urinary catheters in place were discussed with the care team. Adding this to rounding resulted in catheters being removed as soon as possible. We were able to drop our number of infections from 2015 to 2016. We also focused on Central Line days. At the daily patient rounds we include discussions related to Central Blood stream lines. We were successful in decreasing our number of central line associated blood stream infections.
Hospital challenges:	The hospital staff was challenged with making sure patients were placed in infection-prevention precautions when needed. Infection Preventionists started keeping a score card on nursing for appropriate precautions being placed. As a result, the patients were appropriately placed in precautions 100% of the time
Any mid-course corrections:	A positive Clostridium difficile result for an inpatient resulted in our Infection Preventionist calling our housekeeping staff each time. Staff were reminded to use the proper cleaning products and procedures. As a result, our Clostridium difficile rate remained low.
Successes:	In 2016, we only had two hospital onset Clostridium difficile cases with no spread to other patients or staff. Nursing is vigilant to place patient with cellulitis into appropriate precaution measures, thus keeping our methicillin-resistant staph aureus rates low.

Lea Regional Hospital

Hospital interventions:	1. We continue with our high reliability processes, i.e. Daily hospital-wide and department Safety Huddles – focusing on safety at all times. This also enables timely communication about any past, present, or anticipated safety issues. 2. We established and maintained a daily multidisciplinary meeting to review and discuss all patients to improve outcomes. 3. We used best practices from conference calls to improve practices. 4. We participated in the Centers for Medicare and Medicaid Hospital Engagement Network/Hospital Improvement Innovation Network and benchmarked against other NM facilities. 5. We remain 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. 6. 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. 7. Our Inpatient Dialysis program has been established and is ongoing to meet community needs and reduce patient transfers. 8. We continue to voluntarily participate in a Falls Collaborative with our parent Patient Safety Organization (PSO). 9. We've had a vigorous Infection Control program, noting no hospital-acquired infections for 2016. We continue to focus on Infection Control practices. 10. Our Chief Nursing Officer (CNO) and the Medical Director of the Emergency Department continue to focus on patient throughput, best practices, etc. 11. Our patients are vocalizing hourly rounding and bedside shift report as part of routine practices on our nursing units – this process is becoming hardwired. 12. We completed construction on our Medical/Surgical Unit involving patient safety champions (actual patients) on placement of items, i.e. signage, etc.

Lea Regional Hospital

Hospital challenges:	1. We are focusing on bedside report to reduce hospital-acquired conditions and maintain no hospital-acquired infections 2. We are working to reduce patient falls and patient falls with injuries by addressing patient and family education, and compliance 3. When our patient volumes surge we may have throughput issues in the Emergency Department. We are working closely with local EMS and with our trauma coordinator to ensure we work together to ensure timely throughput and care.
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. 2. We changed practices and protocols based on evidence based practice recommendations provided. 3. We updated and advanced ongoing performance improvement measures to match recommended standards

Lea Regional Hospital

Successes:	1. Our readmission rates have been reduced 2. Our Mortality and Morbidity rates have improved 3. We implemented a nurse-driven Foley catheter removal policy 4. We implemented a central line checklist and training of our hospitalist team members for ultrasound use with central line placement 5. We have noted improvements in the annual employee influenza vaccine rate from 2015 to 2016 and 2017 year to date. 6. We have reduced our Emergency Department "Left Without Treatment" rate from 2015 to 2016 to meet national benchmark 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 9. We improved our post-colonoscopy follow up documentation/ recommendations for patients regarding a follow up interval of at least 10 years 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. We have maintained over 90+% compliance with Sepsis core measures – improving patient outcomes (compared to national compliance rates around 45-55%)

Lea Regional Hospital

Any other information:	The Centers for Medicare and Medicaid Hospital Engagement Network/Hospital Improvement Innovation Network program matches our Corporate practices and initiative. Participation in the Centers for Medicare and Medicaid Hospital Engagement Network/Hospital Improvement Innovation Network opened up ability for local networking and benchmarking comparison. We have unit specific and hospital-wide Safety Huddles every day to maintain focus on patient safety, preventative measures, and streamlined communication. As a hospital/patient safety organization, we continue our focus on high reliability and safety, requiring all new employees and established employees to complete education ongoing regarding patient safety – we believe in: *S – Support the Team *A – Ask Questions *F – Focus on the Task *E – Effective Communication Every Time

Lincoln County Medical Center

Hospital interventions:	<u>Fall Prevention:</u> The NOWA model (No One Walks Alone) was implemented at Lincoln County Medical Center to prevent patient falls. Staff performed fall risk assessments every shift for every patient. Hourly rounding was formalized with a rounding schedule for nurses and techs. Audits were conducted to monitor compliance. Falls were reported at daily safety huddles. Time/Days since last fall was tracked and reported. NOWA compliance was audited and reported to the QAPI Committee. <u>Adverse Drug Events:</u> Adverse Drug Events was addressed by having a pharmacist at Lincoln County Medical Center review all "PRN" orders for same indication to prevent duplication and prevent overdoses.
Hospital challenges:	<u>Fall Prevention:</u> Achieving consistent compliance with implementation of all the elements of the NOWA bundle. <u>Adverse Drug Events:</u> "As needed" orders continued to be found for same indication.
Any mid-course corrections:	<u>Fall Prevention:</u> Staff re-education regarding compliance with NOWA bundle elements.

Lincoln County Medical Center (cont.)

Successes:	Fall Prevention: Fall rate decreased by 5%, which was just below the NDQI benchmark. Adverse Drug Events: Therapeutic duplication decreased markedly. Since the performance improvement project began, there was no reported patient harm related to therapeutic duplication at Lincoln County Medical Center.
Any other information:	Pharmacy receives a daily report where orders meeting criteria for duplication were identified.

Los Alamos Medical Center

Hospital interventions:	LAMC is focused on three areas for 2017 that align with our parent company's recommendation. 1. Maintaining a culture of no occurrence of central line associated blood stream infections. Because our population size for the hospital is small it is important to be focused on measure that will eradicate variance and ensure standardized care for every patient, every time. To that end we have performed an internal gap analysis utilizing tools from LifePoint and are current with that practice. We currently are free of central line associated blood stream infections for greater than 60 months. 2. Our second initiative for this year is to reduce Hospital acquired Clostridium-difficile. We are part of a company collaborative that helps guide our gap analysis and toolkit for this initiative. Mid-point in the year we have one occurrence. Our ongoing work will include greater hand wash surveillance, house-wide education for appropriate cleaning, isolation, and monitoring technique as well as education to lab for appropriate specimen acceptance. 3. Continuing an initiative from last year we will be again focusing closely on Patient Experience survey scores. Our overall scores have improved significantly. We would still like to see improvement on Nursing Communication scores as a specific area. Our work on that includes, more robust Bedside shift report, unit specific briefs and debriefs, greater use of our Learning boards and huddles.
Hospital challenges:	Challenges to our hospital include: hospitalist group that is not stable and dedicated to this hospital, continued emphasis on reduction of travelers and turnover in quality department from 2015-2017. Our hospitalist group is contracted and our vendor has worked diligently to acquire physicians who will be dedicated to this facility. We are just beginning to realize a group who may be consistent for LAMC. Our facility has also been able to effectively reduce some travelers in our key areas but we feel this is still a barrier to overall success in our quality initiatives and would like to be traveler-free by year end. The quality department will be fully staffed again by August of this year and we look forward to building on that foundation a group that is tenured experienced and dedicated to LAMC.

Los Alamos Medical Center (cont.)

Any mid-course corrections:	Mid-course corrections are positive in nature for us. As described above our quality department is stabilized and we are seeing stabilization in the hospitalist group
Successes:	Successes include, realignment of our committee organization chart and renaming of our quality oversight committee to more accurately reflect the work done. The new name is “Patient Safety and Clinical Quality Committee” It is co-chaired by our Chief Executive Officer and a physician quality champion signifying the executive support and the need for physician engagement in our quality efforts. The structure of the meeting is no longer a data “report out” but a robust discussion surrounding areas for improvement and groupthink on how to get there. We believe this will reap important rewards throughout 2017 and beyond.

Lovelace – Roswell Regional

Hospital interventions:	We addressed the need to implement a new process for identifying potential sepsis patients according to the Surviving sepsis campaign guidelines. We implemented a sepsis nurse initiated protocol to streamline the identification of potential sepsis patients. We educated our staff and providers on this protocol at implementation and re-educated as needed.
Hospital challenges:	Providers missed repeat lactate level for lactate greater than 2.0 mmol/L within the sepsis protocol. We worked with the Laboratory and the Information Technology departments to find a way to streamline the repeat order. We also had issues with initial provider participation in the protocol. Involving the providers and staff in a sepsis meeting helped to identify real time issues so they could be addressed quickly and the process could be improved.
Any mid-course corrections:	Our lab implemented an automatic four hour repeat lactate order to generate for any lactate level greater than 2.0 mmol/L. We also implemented a sepsis meeting inviting management, providers, and staff to participate and discuss ways to improve the protocol.
Successes:	Our facility had increased compliance with the with the surviving sepsis recommendations by implementing our sepsis protocol and streamlining the sepsis protocol process for better patient outcomes.
Any other information:	We have our Epic Electronic Health Record coming soon.

Memorial Medical Center

Hospital interventions:	We participate in multiple LifePoint Collaboratives = Quick Win Sepsis Collaborative - Through a collaborative approach with an emphasis on input from our Registered Nurses caring for patients at the bedside, we have revised and streamlined our Sepsis Screening Tool. We follow-up on overhead Sepsis Alert calls with a debrief to learn from our team how to continue to improve. We modified our computer system in the Emergency Department to alert providers of possible Sepsis patients as they arrive in triage. We have begun to trial a Modified Early Warning System (MEWS) screening tool to use instead of current screening tool to reduce false alerts and more quickly treat patients for multiple concerns. Falls with Injury Reduction -This is a multidisciplinary approach that includes a daily briefing and a debriefing of excessively high fall risk patients. We are using Bedside Shift Report, incorporating patient/family teaching to reduce falls, and "Know Before You Go" posters for patient rooms. Reduction of Venous Thromboembolism (VTE) - We have placed screening tools within the electronic record that require the physician to complete this screening for all admissions. A Registered Nurse screening tool was also modified within our electronic system to "prompt" the Registered Nurse to contact the provider for all moderate to high risk fall patients who are not currently on pharmacological prophylaxis.
Hospital challenges:	We have seen an inconsistent use of our Sepsis Order Sets and continue to have variable results for Sepsis. We continue to see some false positive and negative "sepsis" alerts, causing our team to not call the Sepsis Alert consistently. Falls - we have seen an overall reduction in all falls over the last 4 months, and will need more time to determine sustainability. Our Venous Thromboembolism rates remain variable but overall are seeing a downward trend.
Any mid-course corrections:	As previously mentioned, we are trialing the Modified Early Warning System to reduce Sepsis variability. We modified our Fall Reduction Kits so that there is more individualized use based on each patient's specific needs. We changed parameters in the Registered Nurse Venous Thromboembolism screening tool in order to put in a "hard stop" for prompting communication with the physician.

Memorial Medical Center (cont.)

Successes:	Sepsis - We continue to see overall improved Sepsis Survivability. Falls - We have exceeded our goal of less than 2 falls per month. Any falls have been minor injuries, such as bruises, redness or scratches. We have reduced Surgical Site infections. Our Readmission rate is better than our year-to-date target. Year-to-date, our clostridium difficile rates are reduced, and are well below our target. Our Methicillin-resistant Staphylococcus aureus infections are also reduced (below our target rates). We will continue to perform Bedside Shift Report at the Mastery Level in all units within the hospital.
Any other information:	We participate 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 Memorial Hospital has continued to evaluate and improve our processes regarding hospital-wide readmissions. The position of "Patient Navigator" has been added (January 2017) to the Case Management department with the main responsibility of improving patient access to needed services and improving communication between inpatient and outpatient services. The need was determined through ongoing process analysis and improvement activities through the second half of 2016.
Hospital challenges:	Challenges include having very few community resources, i.e., home health providers and few primary care providers in our community to help manage post-discharge care.
Any mid-course corrections:	The identification that many patients did not know which documents were being referred to when the Patient Navigator referenced "discharge instructions" led to MMH dedicating a labeled folder to discharge instructions.
Successes:	Since addition of the addition of the Patient Navigator, MMH has seen a 39% improvement in Hospital-wide readmissions (year over year).
Any other information:	MMH will be using funding obtained from a federal grant to evaluate opportunities to improve, or possibly establish, community resources to help provide needed support for high readmission populations.

Miner's Colfax Medical Center

Hospital interventions:	The hospital has continued to expand the discharge planning and care coordination through our hospitalist program. This includes multi-disciplinary "bed-side" rounding model which includes practitioner, pharmacy, nursing, case management, and associated therapy services. The hospital has also focused on fall prevention in collaboration with partners through the NM Hospital Association. The hospital also developed a focused clinic group to strengthen early recognition of sepsis and evidence based treatment protocols.
Hospital challenges:	The challenges have been to create consistent standard times for the rounding between the practitioners since there is a mix of independent and employed physicians. There is also a distance challenge for team members to collaborate on fall prevention interventions and participate in sepsis education.
Any midcourse corrections:	The hospital is working closely with providers, families, and caregivers to develop stronger communication tools for rounding and discharge planning. Nurse leaders will be working closely with NMHA on tele-mentoring and education for fall prevention and sepsis education.
Successes:	The hospital continues to experience increased patient and caregiver satisfaction with the enhanced bed-side rounding. The patient and caregiver understanding of care plan along with educational and discharge needs has improved. Quality metrics also demonstrate improved early detection and treatment for sepsis.
Any other information:	MCMC is committed to continue our collaboration with the NMHA improvement program designed to develop best practices around HAIs, Sepsis, and fall prevention.

Mountain View Regional Medical Center

Hospital interventions:	We performed ongoing education for Physicians and Staff in managing central lines and Swab cap use. Ongoing training was provided for proper cleaning and using sterile technique to decrease blood culture contamination for phlebotomists. An Event Analysis was performed on each Postoperative Pulmonary Embolism or Deep Vein Thrombosis by the Infection Preventionist and Department Director. The Clinical Informaticist met with Physicians to update order sets according to evidence based literature. We implemented a post-procedural screening assessment with the Care Plan for Deep Vein Thrombosis and offered ongoing training to Physicians and staff on new order sets along with updated guidelines. A review of Pressure Ulcer Stage III and IV by the Wound Care Director and Unit Director was completed. As a result, ongoing training has been provided to staff and patients along with ensuring documentation on skin assessments is completed correctly. A review was performed on each Fall incident along with monthly audits, which are completed and discussed at Staff meetings and Safety Huddles and brought to the Quality Improvement Committee meetings. We provided Directors/Managers and Staff with ongoing training on the importance of reporting.
Hospital challenges:	The process for pulmonary embolism/deep vein thrombosis management has been a challenge due to inconsistent documentation in Postoperative Risk Assessments for postoperative pulmonary embolism or deep vein thrombosis. Staff turnover and expertise, nursing leadership turnover, and physician engagement has contributed to our challenges, as well as multiple competing projects.

Mountain View Regional Medical Center (cont.)

Any mid-course corrections:	We developed daily reviews of line necessity and use of antimicrobial-impregnated central venous catheters. The Electronic Physician Documents were reviewed and will designate risk for pulmonary embolism or deep vein thrombosis. If the Physician does not provide prevention strategies then they have to state why. Orthopedic surgeries and the Intensive Care Unit added the use of Nozin nasal product for reduction of healthcare associated infections.
Successes:	We successfully decreased methicillin resistant staph aureus, c-difficile infections, and hospital wide central-line associated blood stream infections rates. We had no Colorectal Surgical Site Infections in 4th quarter. Our indwelling urinary catheters are removed in the post anesthesia care unit.
Any other information:	We have developed an antibiotic stewardship program. We also continued the Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospital in the state and nation. We also collaborate with NM Emergency Medical Services Bureau for primary stroke center and chest pain center designation.

Nor - Lea General Hospital

Hospital interventions:	1. Nor-Lea worked on a falls project to reduce inpatient falls. 2. Nor-Lea worked on improved use of deep vein thrombosis prevention measures on the inpatient unit.
Hospital challenges:	1. Nor-Lea moved to a new inpatient unit which addressed some old challenges related to falls, however the new challenges were unknown. 2. Nor-Lea had budget restraints to broad use of sequential compression devices.
Any midcourse corrections:	1. Nor-Lea did nursing education on low and high fall risk patient interventions. 2. Nor-Lea did nursing education on implementation of sequential compression devices use.
Successes:	1. Nor-Lea reduced falls in 2016 from 0.24% to 0%. The opportunities identified to maintain zero falls are to integrate nursing training with new staff members and ensure all fall risk interventions are used appropriately. 2. Nor-Lea improved deep vein thrombosis prophylaxis to 100%.

Plains Regional Medical Center

Hospital interventions:	<u>Fall Prevention:</u> The NOWA model (No One Walks Alone) was fully implemented. A fall assessment was performed every shift for every patient. Hourly rounding was formalized with a rounding schedule. Falls or number of days since last fall was reported at a daily safety huddle. <u>Behavioral Patient Management:</u> Ligature risk assessment completed with mitigation plans for providing care to suicidal/homicidal patients. New forms instituted for documentation of room safety checklist, and 1:1 sitter checklist was scanned into patient records.
Hospital challenges:	<u>Fall Prevention:</u> Small hospitals struggle to account for low volumes. One occurrence can greatly impact the hospital's rate. <u>Behavioral Patient Management:</u> Lack of behavioral health providers and/or facilities to accept patients for inpatient care.
Any midcourse corrections:	None identified.
Successes:	<u>Fall Prevention:</u> Total falls with injury decreased from 4 in previous year to 2 falls with injury. <u>Behavioral Patient Management:</u> 0 instances of patient self-inflicted harm reported.
Any other information:	Pharmacy receives a daily report where orders meeting criteria for duplication are identified.

Rehoboth McKinley Hospital

Hospital interventions:	Customer Service training was provided to all employees, which began in the latter part of 2016 to address complaints received from patients concerning customer service. We continue to modify processes identified in our 2016 accreditation surveys to improve compliance related to the Important Message from Medicare and the Detailed Notice of Discharge. Modifications were also made to our existing electronic health record to improve our Plans of Care, Advanced Directives and Medication Administration process. Efforts were started to consider moving our organization to one electronic health record. Software demonstrations were scheduled for a total of six different systems and various leaders and staff were asked to participate in the demonstrations and provide feedback. Resources continue to be allocated to education and training for our leaders in collaboration with Lovelace Medical Center in Albuquerque through their Leadership Development courses.
Hospital challenges:	Staffing challenges with nurses and providers persist. It is difficult to recruit and retain nurses and providers due to the rural area. We have been successful in decreasing agency staff however by increasing participation with local and regional nurse-focused job fairs. With a much more stable nursing team, the quality and nursing departments are focused on process improvement activities and outcomes.
Any mid-course corrections:	The Gallup Fire Department, EMS and flight transport companies have been invited to collaborate with the development and initiation of stroke protocols as RMCHCS increases focus on the interventions for stroke patients. This will lead to increased efforts toward Acute Stroke Accreditation with DNV-GL.
Successes:	The Charity Invitational event in September 2016 was the first step toward opening our new Wellness Center where the Physical Therapy department will relocate. The Wellness Center will not only benefit our patients but employees as well. Efforts began in mid-2016 to open an Urgent Care Center. A building previously used as a Clinic was renovated to accommodate the Urgent Care center. This was an effort to address the long wait times and overflow of the patients in the Emergency Department.

Roosevelt General Hospital

Hospital interventions:	Roosevelt General Hospital (RGH) worked with HEN 2.0 to report out and analyze various data measures. In order to improve patient care with regard to sepsis, the emergency department implemented a new screening tool for early identification of sepsis in ER patients. A 'Healthy Hands at Work' initiative was also introduced to improve hand hygiene compliance, with some focused education regarding the importance of hand hygiene in the prevention of infections such as *Clostridium difficile.* There was also emphasis in new employee orientation about worker safety by the RGH safety officer.
Hospital challenges:	The sepsis screening tool has not been integrated into the electronic health record, inconsistency in hand hygiene monitoring, and staff turnover in the CNO and Quality/Infection Control management positions.
Any mid-course corrections:	None
Successes:	No catheter-associated urinary tract infections, central line-associated bloodstream infections, or facility-acquired pressure ulcers occurred during calendar year 2016.

San Juan Regional Medical Center

Hospital interventions:	**Cather Associated Urinary Tract Infection:** 1). We instituted an Assessment-Driven Urinary Catheter Removal Protocol (HOUDINI) for Foley catheter use in inpatients that began late June 2016. 2). Electronic provider orders were developed which included urinary catheter with and without HOUDINI. 3). Our vendor completed an assessment on current practice and based on results, the recommendation was to change Foley kits. The new kit is easier to use and facilitates better aseptic technique. Education was provided to staff and implemented. 4). We monitor monthly and feedback is provided to front-line staff. **Central Line Associated Blood Stream Infection:** 1). Staff re-education on central line care and maintenance was completed for all staff with a distinct focus in the Intensive Care Unit setting. 2). We continue to use the central line checklist with each insertion. 3). When appropriate, we encourage a peripherally inserted central catheter line versus a central line placement which is less invasive and reduces potential infections. **FALLS:** 1). A standardized post-fall huddle form was developed to be used for all falls that occurred organization-wide. 2). An expectation was set for the post-fall huddle to be conducted using the standardized process/form for all areas including inpatient and outpatient departments. 3). A Fall Management Team was created to monitor and analyze data for process improvement. The team is assessing for any trends in the following areas: post-fall completion rate, fall rate for each area, compliance of best practice for assessment, interventions, and documentation, time of day, day of the week, and patient activity prior to fall.
Hospital challenges:	We have continued challenges with consistency in practice and determining data for monitoring practice adherence

San Juan Regional Medical Center (cont.)

Any mid-course corrections:	We reinforced expectations with departments not following the established process. We re-educated on patient identification and preventative measures, and continue to review data.
Successes:	The goal for 2016 was to decrease the total number of Foley-related urinary tract infections from prior year. The goal was met. The goal for 2016 was to decrease the total number of central line associated blood stream infections from prior year. The goal was met in both the intensive care setting and non-intensive care settings. We had good compliance with central line care. We have seen a slight decrease in the in-patient fall rate from the prior year.

Sierra Vista Hospital

Hospital interventions:	Sierra Vista Hospital appointed a new quality manager. The hospital changed to DNV for Centers for Medicare and Medicaid Services-deemed accreditation and had its first survey. There were new services opened to the community and new providers were added to the team. The hospital updated a policy on employee vaccination making it mandatory. The hospital participates in the Hospital Improvement Innovation Network. A bundle checklist is done for every central line insertions to monitor compliance with the standards of care. Surgical site infection tracking was implemented hospital wide to capture surgical site infections. The nursing department audits skin assessment documentation regularly to validate that initial, ongoing, and discharge assessment is done to reduce pressure ulcers. A multi-disciplinary huddle is conducted before the start of the morning shift to discuss and assess patients that are a risk for falls and implement actions for high-risk patients.
Hospital challenges:	The quality department is working on improving the organizational performance improvement plan. A contract service evaluation was placed to evaluate criteria and contracts of the vendors and services in the hospital. Any quality issue that is addressed utilizes a collaborative approach model for resolution. The utilization review committee in the hospital proactively meets on a regular basis. Daily rounds were implemented by the infection preventionist to support a decrease in usage of Foley catheters.

Sierra Vista Hospital (cont.)

Any mid-course corrections:	The quality department is working on improving the organizational performance improvement plan. A contract service evaluation was placed to evaluate criteria and contracts of the vendors and services in the hospital. Any quality issues were addressed using a performance improvement plan was a collaborative approach is done among appropriate staff for problem resolutions.
Successes:	The hospital successfully passed the survey with few nonconformities and no immediate jeopardy. The intensive care unit department, wound care department, and women's health are new programs that are now available in the community. The flu vaccination compliance among employees was 98%. With a strong infection control program in the hospital, SVH maintains a low rate for any type of hospital infections. The hospital has a low rate of falls because of the multidisciplinary team effort conducted every day to evaluate patient needs.

Socorro General Hospital

Hospital interventions:	<u>Fall Prevention:</u> The NOWA model (No One Walks Alone) was fully implemented. A fall assessment was performed every shift for every patient. Hourly rounding was formalized with a rounding schedule. Procedure developed where high fall risk patients received increased rounding. Fall risk status was reported during safety huddles. <u>Adverse Drug Events:</u> Implemented a process where all PRN orders with the same indication were reviewed by a pharmacist to prevent therapeutic duplication. The process was aimed at preventing overdoses or other outcomes leading to an ADE.
Hospital challenges:	<u>Fall Prevention:</u> At SGH, we have inpatients and Swing Bed patients. With the Swing Bed program, those patients have greater freedom and more opportunity to have a fall event. Low patient volume is a challenge, too, as one fall can greatly affect rates. <u>Adverse Drug Events:</u> TSGH Pharmacy is available 8 hours/7 days week, and the remote pharmacy at Kaseman Hospital assisted with processing SGH orders. The patients who are admitted to the Swing bed program offered some challenges with their previous drug addiction. There was still PRN orders with the same indication being ordered after education.

Socorro General Hospital (cont.)

Any mid-course corrections:	None identified.
Successes:	Fall Prevention: Hourly rounding showed to be the best intervention for fall prevention. Our aggregate total falls with injury was maintained to only 1 fall in the year. Adverse Drug Events: Socorro General Hospital achieved 0 rate of ADE.
Any other information:	None.

Union County General Hospital

Hospital interventions:	Omnicell, an automated pharmacy delivery system, has been live for approximately 6 months. There has been a decrease in medication errors and a significant decrease in nurses accessing the pharmacy after hours from approximately 200 times per month to 20 times. The Emergency Department is now using the electronic health record for medication administration with the installation of the system.
	Our patient satisfaction scores continue to vacillate. This is an area we will begin focusing on, along with employee and physician satisfaction surveys.
Hospital challenges:	N/A
Any mid-course corrections:	Tele-neurology has been implemented with the University of New Mexico. All nursing staff and Emergency Department providers received neurology education and training on the entire system. This will support improve emergency care delivery to our community
Successes:	The primary focus pertaining to patient satisfaction will begin with the patient discharge process.

University of New Mexico Hospital

Hospital interventions:	The hospital is participating in the Hospital Improvement Innovation Network (HIIN) aimed at improving patient outcomes. An antibiotic stewardship team was initiated to gather data and make quality improvement recommendations related to antibiotic administration based on those data. We initiated an institution-wide mortality review system to identify challenges and opportunities for quality improvement, continue to hold regular Severe Patient Harm Event Elimination (SPHEE) team meetings to address hospital acquired conditions and healthcare acquired infections. There are a total of 13 SPHEE teams: Post Op Respiratory Failure, Deep Vein Thrombosis/Pulmonary Embolism, Falls, Iatrogenic Pneumothorax, Pressure Ulcers, Peri-Op Hemorrhage/Hematoma, Obstetrics with trauma, Catheter-Associated Urinary Tract Infections, Clostridium Difficile, Wound Dehiscence, Accidental puncture/laceration, Post-Op Sepsis, and Surgical Site infections. We continue to participate in the Ambulatory Surgical Care National Surgical Quality Improvement Program (NSQIP).
Hospital challenges:	The hospital continues to have an increase in healthcare acquired infections including surgical site infections for both colorectal surgeries and abdominal hysterectomies, urinary tract infections secondary to catheter use, blood stream infections from central intravenous catheters, and infections caused by antibiotic resistant organisms.
Any mid-course corrections:	The surgical site infection (SSI) SPHEE team became an area of particular focus with implementation of best practices based on the latest research and data (“care bundles”). A new area identified for collection of data is adverse drug events secondary to opioid administration.
Successes:	Overall patient harm in the areas of focus of the SPHEE teams mentioned above was reduced 30%. There were downward trends for 2016 compared to the previous year in the following measures: patients’ falls (both with and without harm), stage 3+ pressure ulcers, iatrogenic pneumothorax, perioperative hemorrhage or hematoma, postoperative respiratory failure, postoperative wound dehiscence, accidental puncture or laceration, and Obstetric trauma with instrumentation and without instrumentation.

Thank You

New Mexico Human Services Department
Medical Assistance Division