HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
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Hospital Quality Improvement Incentive Annual Report
Demonstration Year 2

Hospital	Description of Report	***STC's NM 1115 Waiver states on pages 51-52, "Annual reporting template. The state will develop a standard annual reporting template for all HQII hospitals that includes information about hospital interventions, their challenges, mid- course corrections and successes, along with a data strategy for aggregating reporting from hospitals into reports that can be used for oversight by CMS and shared learning among all hospitals."*** *The information presented below represents the unmodified DY2 feedback from the 29 Safety Net Care hospitals participating in the HQII program.*
Alta Vista Regional Hospital	Hospital interventions:	Implemented remote order entry for Pharmacy to decrease ADEs by using a pharmacist in a sister hospital. This allows patients to receive medication more quickly and decreases risk of errors because order is reviewed by pharmacist prior to administration.
	Hospital challenges:	Had no pharmacist in the hospital during off hours, which compromised ability for pharmacist to review all non-emergent orders prior to med being released for administration to patient.
	Any mid-course corrections:	Starting to report computerized physician order entry in electronic medical record to help with errors. Implemented nurse driven Foley catheter removal protocol starting in 2015 to decrease risk of CAUTIs.
	Successes:	NO CAUTIs since 2015.
	Any other information:	N/A
Artesia General Hospital	Hospital interventions:	Throughout most of 2014, Artesia General diligently worked on improving all core measures, and understanding all their data sources. The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
	Hospital challenges:	Use of agency nursing compromised the ability to keep everyone educated and engaged. Artesia created a discharge checklist for nursing, which helped improve compliance on the nursing side. Artesia had one particularly unengaged physician. Artesia acknowledged probable chronic underreporting of medication errors and adverse drug reactions - some reports are received by Pharmacy, some via the electronic medication delivery system. This creates a challenge in accurate reporting of ADEs.
	Any mid-course corrections:	Based on the HIDD data pull, Artesia took a leading role in the state to validate HIDD data, participating in NMHA HIDD data Integrity and Data Consistency webinars, and has implemented measures to review all HIDD data prior to submission.
	Successes:	On the inpatient side, Artesia demonstrated tremendous success on all indicators. Artesia General Hospital was less successful with immunizations in 2014. Numbers for surgeries are generally low, but recently acquired a robotic arm for surgery.

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	Any other information:	Proud of their HCAHPs 4-star rating. Have been working to identify present on admission pressure ulcers, which showed issues with accurate coding of HIDD data, and need for education.
Carlsbad Medical Center	Hospital interventions:	Initiation of HAC event tool that includes drill down analyses of each event and check of best practices. Continued staff education on HAC. Educated physicians on accidental puncture. Case Management began analyzing readmission. Education to staff regarding importance of reporting ADE.
	Hospital challenges:	Lack of staff reporting ADE.
	Any mid-course corrections:	Implemented Coder notification to quality prior to final bill of any HAC.
	Successes:	Participated in HEN 1.0 with NMHA, was one of the highest performing hospitals in the state for rate of improvement in decreasing hospital acquired conditions.
	Any other information:	N/A
CHRISTUS St. Vincent Hospital	Hospital interventions:	In 2014, an OB consultant spent time with hospital staff and the Chief of Women's Services from another NM hospital visited with St. Vincent physicians to discuss best practices in obstetrics. In 2014, a nurse-initiated protocol was introduced for early Foley catheter removal and the physician order set was modified so Foley catheters would automatically be discontinued on the first day post procedure. These helped contribute to a reduction in CAUTIs. Infection prevention remained a focus and an area for improvement into 2015, and during the summer of 2015, a new department called Clinician-directed Performance Improvement (CDPI) launched. Following the world-renowned model for performance improvement in place at Intermountain Healthcare, this department pairs physicians and nurses together to work on improvement projects. In 2015, many of the CDPI projects focused on infection prevention and saw gains in reduction of CAUTIs, CLABSIs and SSIs.
	Hospital challenges:	ADE reporting increased, which is seen as a positive step (see below for the IHI Trigger tool), but to lay persons, it may seem that errors have increased, which is not necessarily true.
	Any mid-course corrections:	N/A
	Successes:	Had great success with decreasing 3rd and 4th degree lacerations for obstetric patients.

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	Any other information:	Additionally, a CDPI project focused on improving adverse drug event detection using the Institute for Healthcare Improvement's Global Trigger Tool, and this led to greater detection and reporting of adverse drug events (it is important to note that an increase in reported ADEs is nationally accepted within the medical community as a positive result of intervention – it does not mean more ADEs are occurring – rather, it means more are being detected and the hospital's culture supports and encourages reporting of these events. Numerous well-accepted publications estimate that only about 10% of ADEs are reported, so an increase in the number of these events should not be construed as worsening performance). The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
Cibola General Hospital	Hospital interventions:	C-Diff – Made recent changes in cleaning materials and how improvement can be made with EVS and competencies. Handwashing compliance reviewed and shared ideas around improving compliance [i.e. changes to hand gel and locations, pictures of staff washing hands]. Include a focus on ancillary services. Received training from HealthInsight on antimicrobial stewardship and physician involvement. SSI data – "Good saves with SSI." Changes include accelerated hydrogen peroxide use and working with EVS team on appropriate use/cleaning process. Development of annual competency and training for environmental services (EVS) staff. (not implemented yet); Validation of cleaning practices through the use of glow pen application to high touch areas with real-time feedback to EVS staff. (not implemented yet); Education for operating room (OR) staff on proper air flow, traffic control, and attire in OR environment. (done); Evaluation of OR temperature, humidity, and airflow to verify operating parameters are within limits. (ongoing); Education and training of OR and clinic staff on current sterilization and disinfection procedures.
	Hospital challenges:	For Falls, greatest opportunity being addressed in ED. Use of treatment chairs that are lower and easier for patients instead of beds, when appropriate. Falls protocols include use of ER Techs when needed for extra observations, armbands, door magnets, both side rails up on bed, discussion of fall risk during bedside report, supervisor huddles and hourly rounding and placing fall risk patients in ED in curtained areas for greater observation. Core measure data in 2014 suggested physicians were unaware of compliance rates with VTE measures - developed order sets for VTE prophylaxis, and implemented risk scoring to admission data base.
	Any mid-course corrections:	Received a Stroudwater Rural Grant, to improve transitions of care and reduce inpatient readmissions; improvement include making post-acute appointment for patient before discharge, after hours calls. Implemented LACE readmission assessment tool for Case Management (Length of stay, Acuity of admission, Co-morbidities, Emergency Dept. visits within the last 6 months).

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	Successes:	HCAHPS – 4 Star rating on Hospital Compare; EED – put hard stop in place and use of medical inductions criteria which has virtually eliminated this. Cibola was successful in decreasing CAUTIs, and has had none over the past couple years. The hospital has decreased the Foley catheter device utilization rate using "WTF – "Why the Foley?" Improvement seen by changing the wash basins before Foley care. Now it's a matter of reinforcing the practice. Airflow problems in OR addressed. OR director reports higher compliance rate among nursing staff with attire recommendations.
	Any other information:	The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
*** Dr. Dan C. Trigg Memorial Hospital**	Hospital interventions:	MOST (Medication Operations Safety Teams) in process of being implemented. Bar Code Scanning for automated dispensing has been implemented in all facilities. This is in addition to Bar Code Scanning of the patient, adding a layer of protection in the medication administration process. Facility level implementation of critical processes for prevention of readmissions. Use of LACE scoring, implementation of Discharge Call Back, and Readmission Questionnaire upon readmission.
	Hospital challenges:	Analyzing the various data sources for similar measures and variation in results. Participating in Data Integrity webinars through NMHA to more effectively understand specifications and variances.
	Any mid-course corrections:	Ongoing quality improvements throughout Presbyterian Healthcare.
	Successes:	Implementation of standard Foley catheter management, to include insertion and general Foley care, ordering and culturing practices. Education conducted at the facility level.
	Any other information:	All quality improvement activities were spread of standard work throughout Presbyterian Healthcare services and establishing best practice, and not based on occurrences or adverse events.
Eastern NM Medical Center	Hospital interventions:	Infection stand-point, ENMMC started hand hygiene compliance in 2014 [first started collecting data]. This data analysis led to mid-course corrections in 2015.
	Hospital challenges:	Big turnover in quality and risk in 2015. Quality identified med variances weren't being scored for severity. During scoring training and education, the hospital identified opportunities to improve the med administration process around the 5-rights.
	Any mid-course corrections:	Started secret shopper around hand hygiene compliance in hospital and in clinics to improve data validity.
	Successes:	Falls were happening frequently during end of 2014, beginning of 2015. 2015 focus on falls as a symptom of poor communication process. Started observing rounding process to make improvements. Falls went down by half immediately.
	Any other information:	Central line checklist implemented in 2015. CLABSI rates dropped after implementation of checklist.

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*** Espanola Hospital**	Hospital interventions:	MOST (Medication Operations Safety Teams) in process of being implemented. Bar Code Scanning for automated dispensing has been implemented in all facilities. This is in addition to Bar Code Scanning of the patient, adding a layer of protection in the medication administration process. Facility level implementation of critical processes for prevention of readmissions. Use of LACE scoring, implementation of Discharge Call Back, and Readmission Questionnaire upon readmission.
	Hospital challenges:	Analyzing the various data sources for similar measures and variation in results. Participating in Data Integrity webinars through NMHA to more effectively understand specifications and variance.
	Any mid-course corrections:	Ongoing quality improvements throughout Presbyterian Healthcare.
	Successes:	Implementation of standard Foley catheter management, to include insertion and general Foley care, ordering and culturing practices. Education conducted at the facility level.
	Any other information:	All quality improvement activities were spread of standard work throughout Presbyterian Healthcare services and establishing best practice, and not based on occurrences or adverse events.
Gerald Champion Regional Medical Center	Hospital interventions:	Maintaining zero EEDs, collecting opioid ADE data and are working on including warfarin. Video monitoring system was put in place to observe patients with a camera at nurses' station. Worked on device utilization (Foley catheters, central lines, ventilators).
	Hospital challenges:	Capturing the VTEs, their EMR does not capture the indicators well enough to capture this measure. Physician engagement. Two measures we are having a hard time obtaining are Pressure Ulcer (stage 2 and beyond) and DVT.
	Any mid-course corrections:	Sepsis workaround with the rapid response, evaluated process and training.
	Successes:	Use of MedMined to identify and report healthcare-associated infections. Use of special mats to reduce falls.
	Any other information:	The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation. The hospital started looking to collect additional data on sepsis and c-diff.
Gila Regional Medical Center	Hospital interventions:	Have been working on CAUTI and Sepsis improvement - have seen improvements in both; worked on accidental punctures and laceration documentation after receiving Medicare penalty. Patient communication board in patient rooms [pain management, allergies]. HAIs, started working on CAUTI-free in GRMC project. ACT training to deal with patient care [HCAHPS]. Clinic alarm fatigue to keep hospital environment quiet. Care Transitions.

	Hospital challenges:	The biggest challenge has been availability of physician champions. Physicians are engaged, but have limited availability for meetings (scheduling very challenging). Turnover in clinical staff.
	Any mid-course corrections:	Did mid-course correction with sepsis. Proactively reviewed cases of sepsis, implemented changes in practice, and then reviewed cases post-intervention.
	Successes:	Sepsis (see above). The hospital discovered that coders were capturing false positive data on punctures, and did some process work for coding data for accidental punctures to make sure documentation was correct. Issue has been resolved.
	Any other information:	N/A
Guadalupe County Hospital	Hospital interventions:	Guadalupe worked on Falls in 2015. Revision of the Policy and Procedure and the fall risk assessment on admission was done. One of the revisions was to include short stay and observation patients. Revision done on the fall risk assessment and enforced the post-fall huddle expectation.
	Hospital challenges:	Got staff to complete a post-fall huddle when there is a fall. Sometimes the information was incomplete. This required us to have to go back to make sure the post-fall information was captured. Since we hard-wired post-fall huddles and risk assessment tools we have not had a fall since Jan 2016 [without or without injury].
	Any mid-course corrections:	Carried over safety measures for adverse drug events and med errors. EMR default setting were not correct. Provider has to indicate route and the default setting was not what is should be. Fixing default.
	Successes:	CAUTIs, none at facility for several years. Same with CLABSIs; we are not placing central lines.
	Any other information:	N/A
Holy Cross Hospital	Hospital interventions:	In 2014 we recognized an opportunity to reduce CAUTIs; worked on a Nurse-driven protocol for urinary catheters were implemented. Holy Cross worked on EED by revising and enforcing policy to not allow non-medically indicated early elective deliveries.
	Hospital challenges:	Internal audits were not being done. Holy Cross had a lot of turnover, CNO and CQO retired during late 2015
	Any mid-course corrections:	Joined the HEN 2.0 to focus on process improvements. Used Harm Across the Board to track improvements and opportunities.
	Successes:	SSI - a year ago we traced an infection back to central sterilization. We improved educating of staff and improved the documentation of sub-sterile process, resulting in subsequent 0 non-conformities. A Root Cause Analysis determined the biological and the chem indicator evidenced that there was not a contamination however the staff didn't report the anomaly of the integrating indicator. Policy change, education and training were implemented. The process was audited for 1 year with no non-conformities.

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	Any other information:	During 2015 we were having inconsistent PI and board quality meetings. We planned to improve this process and by beginning of 2015, we started having these meetings monthly. The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
Lea Regional Hospital	Hospital interventions:	1. Established and maintained a multidisciplinary meeting daily to review and discuss all patients – improved outcomes. 2. Used best practices from conference calls to improve practices. 3. Participation in HEN network and benchmarked against other NM facilities. 4. Changed practices and protocols based on evidence - best practice recommendations provided. 5. Updated and advanced ongoing performance improvement measures to match recommended standards.
	Hospital challenges:	1. Still working to improve hourly rounding and bedside report – still a cultural change process. 2. Focusing bedside report to reduce HACs and HAIs - ongoing. 3. Electronic chart changes – pending approval for all facilities in network to make changes – working with work-arounds right now.
	Any mid-course corrections:	1. Identified practice problems with central line care on SNF unit – education provided and no further issues. 2. Established case manager for the ER to reduce readmissions and 72 hour returns. a. Case manager also being used for effective disposition of patient care needs in the ER.
	Successes:	1. Readmission rates reduced. 2. Mortality and Morbidity rates improved. 3. Implemented nurse driven Foley Cath removal policy. 4. Implemented central line checklist and training of Hospitalist team members for ultrasound use with central line placement.
	Any other information:	1. HEN program matches our Corporate practices and initiative. 2. Participation in HEN opened up ability for local networking and benchmarking comparison.

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*** Lincoln County Medical Center**	Hospital interventions:	MOST (Medication Operations Safety Teams) in process of being implemented. Bar Code Scanning for automated dispensing has been implemented in all facilities. This is in addition to Bar Code Scanning of the patient, adding a layer of protection in the medication administration process. Facility level implementation of critical processes for prevention of readmissions. Use of LACE scoring, implementation of Discharge Call Back, and Readmission Questionnaire upon readmission.
	Hospital challenges:	Analyzing the various data sources for similar measures and variation in results. Participating in Data Integrity webinars through NMHA to more effectively understand specifications and variance.
	Any mid-course corrections:	Ongoing quality improvements throughout Presbyterian Healthcare.
	Successes:	Implementation of standard Foley catheter management, to include insertion and general Foley care, ordering and culturing practices. Education conducted at the facility level.
	Any other information:	All quality improvement activities were spread of standard work throughout Presbyterian Healthcare services and establishing best practice, and not based on occurrences or adverse events.
Los Alamos Medical Center	Hospital interventions:	LAMC is focused on three interventions: 1. HCAHPS Action Plan - Focus on two initiatives for two months to hardwire process changes. First focus are Pain Control and Responsiveness to Call Lights. Participation in LifePoint HCAHPS calls to identify best practices from other facilities & enlist resources/support as needed. Rounding & communication by House Supervisors, CNO, Director of Inpatient Nursing & Director of Quality. Updates to Medical Staff and LAMC Advisory Board. For Pain Control - key issues are communication about side effects of drug, asking frequent questions to patient about pain levels. For Response to Call Lights- key issues are to answer within 3 rings, asking frequent questions to patients about nurse attentiveness to needs. 2. Case Management - Aligning local initiatives with overall LifePoint goals; Adopting best practices for interdisciplinary team meetings, daily huddles, discharge planning; Monitor length of stay, resource utilization, readmissions, hospital acquired pneumonia, UTI, Hip Fractures, Central Line Infections: Training, education for staff on best practices for daily case management functions. 3. Core Measures - Monitor Sepsis diagnosis on patients- resource utilization, length of stay, overall management of patient's stay with multi-disciplinary team; Reduce ED arrival to ED departure for ED admitted patients - focus with ED Physicians and Hospitalists for coordinated effort to move patient to appropriate level of care, including the decision to admit, transfer or discharge the patient.
	Hospital challenges:	Engaging clinical and physician staff to be proactive with interactions between each other and patients to meet the objectives of each initiative. Having individuals understand the importance of the impact that can be made in patient care by successfully meeting objectives.

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	Any mid-course corrections:	Mid-Course corrections have not been necessary but we constantly evaluate/monitor the interventions to ensure our plan is working. If changes are required, those are implemented immediately.
	Successes:	Quarter over Quarter achieved slight increase in HCAHPS scores. Clinical & physician staff engagement has been good. Communication to Medical Staff leadership and LAMC Advisory Board has yielded positive feedback about efforts to improve patient care.
	Any other information:	N/A
Memorial Medical Center	Hospital interventions:	Participated in LifePoint collaborative to decrease CAUTIs, implemented nurse-driven protocol to decrease Foley at 2 days.
	Hospital challenges:	Have had challenges with coding; hospital started looking at "harms" prior to final coding to improve accuracy.
	Any mid-course corrections:	Instituted standardized bundle for hospital acquired pneumonia, starting to see results.
	Successes:	Patient Management Team started using LACE Tool for discharge planning, and started inter-disciplinary rounding prior to discharge to improve preventable re-admission rates.
	Any other information:	Continue to participate in the LifePoint HEN, which offers benchmarking of data, best practices to improve, education on sustainability of quality improvements.
Mimbres Memorial Hospital	Hospital interventions:	Mimbres participated in a corporate falls collaborative in 2013; no falls in 2014.
	Hospital challenges:	N/A
	Any mid-course corrections:	N/A
	Successes:	Early Elective Delivery - the hospital had been working on the changes to early delivery prior to their involvement in the HEN Project. Mimbres reported that the HEN “hard stop” early elective delivery policy initiative was helpful to them since experiencing some resistance from a provider to the change. Given the sustained emphasis on this policy change, that provider has opted to leave the hospital.
	Any other information:	The staff works collaboratively with each other, their corporate network, and with the NM HEN 1.0 project to make and sustain improvements.
Miners' Colfax Medical Center	Hospital interventions:	Hospitalist Group was changed based on poor communication and patient dissatisfaction, hired 2 physician assistants and employed ED docs - now have dedicated ED docs.
	Hospital challenges:	Challenges with being a rural hospital getting nursing staff, PAs and physicians.

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	Any mid-course corrections:	Started rounding (case manager, pharmacist, and patient's nurse) with hospitalist 2015.
	Successes:	Rounding and improved communication have decreased preventable readmission rate.
	Any other information:	OB manager did a PI project on decreasing early elective deliveries, which has been very successful in decreasing EEDs. The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
Mountain View Regional Medical Center	Hospital interventions:	Started Monitoring IP hypoglycemic and INR rates, spent time reviewing data, such as CAUTIs due to candida species colonization, and on vented patients with antibiotics: initiated HAC reduction meetings. Monitor all stages of pressure ulcer from abrasions to unstageable - dropped to almost none. Participation in NM HEN. Participation in CDI regional collaborative.
	Hospital challenges:	Bedside shift reporting not fully rolled out, Staff engagement around disclosing safety issues, Staff turnover and expertise, and Physician engagement. Multiple competing projects. Turnover of nursing staff and nursing leadership.
	Any mid-course corrections:	Initiated Device utilization reports used for CAUTIs, CLABSIs and Vents because catheter days were not where they should be. Started doing Event analysis for each SSI, CLABSI and CAUTI. CLABSI/CAUTI remained zero for Q2 of 2015. Central line device utilization was reduced in ICU and MS. C-diff rates remained low over the first three quarters 2015.
	Successes:	Decreased CLABSI in 2014, continued to hardwire competencies around blood draws. Started a Safety Committee that attends morning huddles, supported by CEO, CFO, CNO, and COO.
	Any other information:	Techs trained on reportable events. Rapid response team in place. Opportunities addressed with nursing assessment and critical thinking skills. The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
Nor - Lea General Hospital	Hospital interventions:	In 2014, Nor-Lea focused on Core Measures, especially: falls, pneumonia, VTE, ED stroke, and chest pain. Update many of the emergency codes and a code trigger. Transitioned to a new Electronic Medical Record (EMR); integrating quality measures into the new system took some effort.
	Hospital challenges:	One Dept. Manager wasn't sufficiently engaged; the Nor-Lea Quality Department created some focused interventions which proved quite fruitful.
	Any mid-course corrections:	N/A
	Successes:	Improved on all core measures and the momentum continues today.

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	Any other information:	The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
*** Plains Regional Medical Center**	Hospital interventions:	MOST (Medication Operations Safety Teams) in process of being implemented. Bar Code Scanning for automated dispensing has been implemented in all facilities. This is in addition to Bar Code Scanning of the patient, adding a layer of protection in the medication administration process. Facility level implementation of critical processes for prevention of readmissions. Use of LACE scoring, implementation of Discharge Call Back, and Readmission Questionnaire upon readmission.
	Hospital challenges:	Analyzing the various data sources for similar measures and variation in results. Participating in Data Integrity webinars through NMHA to more effectively understand specifications and variance.
	Any mid-course corrections:	Ongoing quality improvements throughout Presbyterian Healthcare.
	Successes:	Implementation of standard Foley catheter management, to include insertion and general Foley care, ordering and culturing practices. Education conducted at the facility level.
	Any other information:	All quality improvement activities were spread of standard work throughout Presbyterian Healthcare services and establishing best practice, and not based on occurrences or adverse events.
Rehoboth McKinley Hospital	Hospital interventions:	Current Quality director hired August 2015. According to available records, predecessors worked heavily on inpatient core measures (CHF, Pneumonia, immunizations, VTE, stroke, surgical care improvement project, and early elective deliveries). For outpatient measures, it included AMI, chest pain, and pain management. Other elements included Falls, Medication Errors, Restraint Compliance, Transfusion Reactions, Appropriateness of Transfusions, Lab Values, Critical Radiology Results, Pressure Ulcers, Moderate Sedation, Medication Reconciliation, Code Blue Responses, Pre- Post-Operative Discrepancies, Serious Safety Events, and Procedures Placing Patients at Risk.
	Hospital challenges:	According to records, developing systems for appropriate documentation was a big challenge.
	Any mid-course corrections:	Provided education to providers and nurses on-site. Rehoboth McKinley implemented a variety of patient safety initiatives such as: Falls, Medication Errors, Restraint Compliance, Transfusion Reactions, Appropriateness of Transfusions, Lab Values, Critical Radiology Results, Pressure Ulcers, Moderate Sedation, Medication Reconciliation, Code Blue Responses, Pre- Post-Operative Discrepancies, Serious Safety Events and Procedures Placing Patients at Risk. These safety elements have been tracked and monitored since 2011. Our department directors continue to track and monitor safety elements as they relate to their areas. Process changes are made to prevent or decrease the likelihood of error or harm to the patient. This is accomplished with revision of policies, revision of forms and providing education to all appropriate staff and providers followed by monitoring to ensure compliance.

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	Successes:	Rehoboth had only 1 reportable infection in 2014, and haven't had any reportable infections since that time, reflecting Rehoboth's ability to eliminate reportable infections.
	Any other information:	Rehoboth developed and implemented a CAUTI bundle in 2014, which the hospital believes contributed to their success. The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
Roosevelt General Hospital	Hospital interventions:	During HEN 1.0, kept track of potential harms per discharge, able to track and make interventions when necessary. For example, readmissions: tested follow-up calls within 48 hrs., involved home health and hospice early in the hospital stay, and used the HRET Readmissions toolkit to identify gaps in best practice.
	Hospital challenges:	Staff challenges with data entry, challenge to get teams "to the table," and getting the physicians involved.
	Any mid-course corrections:	N/A
	Successes:	Patient falls have improved; hospital re-admissions are well under the national average. No CAUTIs, CLABSIs, and no facility-acquired pressure ulcers. ADE data challenges continue due to manual data extraction and software limitations for lab and pharmacy.
	Any other information:	Have remained active in the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
Lovelace Roswell Regional	Hospital interventions:	Revamped Falls program, participated in HEN Falls collaborative as well as other HEN initiatives to benchmark with other hospitals and get "best practice" ideas.
	Hospital challenges:	Unable to collect ADE data due to software limitations; have to collect manually
	Any mid-course corrections:	Based on gap in knowing when patients got surgical site infections, rolled out physician letters to better track surgical site infections.
	Successes:	Biggest success is Falls program, decreased Falls based on program.
	Any other information:	Planning to implement EHR to Epic, currently using paper charting.
San Juan Regional Medical Center	Hospital interventions:	Initiatives: the most important included: sepsis (with a goal of following best practices, including antibiotic administration), decreasing spread of multi-drug resistant organisms (MRSA and c-diff), decreasing of CAUTIs (nurse driven protocol), decreasing CLABSI, decreasing VTE, decreasing cesarean delivery SSIs (by improving turn-around and standardization of OR suite cleaning), improving health employee immunization rate for TDAP and Hep B, and finalizing Legionella prevention plan related to construction and water.
	Hospital challenges:	Provider and staff buy-in, as they already juggle myriad priorities. Another challenge is sustaining gains.

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	Any mid-course corrections:	N/A
	Successes:	Decrease in hospital-acquired C-diff, CLABSI, CAUTI, and decrease in ventilator-related pneumonias.
	Any other information:	The hospital joined the NMHA Hospital Engagement Network to work on best practices to decrease hospital acquired conditions, improve data collection and analysis, sustain improvements, and benchmark with other hospitals in the state and nation.
Sierra Vista Hospital	Hospital interventions:	Started to report to NHSN, as a critical access hospital, previously had not been required to report. This has improved data collection, reporting and assessment of priorities.
	Hospital challenges:	As a small CAH hospital, denominator is very low, and harm is very low. Rate may not be valid due to small "n." Have had turnover in leadership positions, so challenging to keep organizational history. Continue to work on all-cause readmissions within 30 days.
	Any mid-course corrections:	Participated in the NMHA HIDD Data Integrity webinars to improve accuracy of coding. Measured total harm per discharge in 2014, and met goal of less than 0.1 total harms per discharge by reviewing number of opportunities for harm and highest risk for Sierra Vista.
	Successes:	Improved accuracy in HAI data collection, specifically tracking any SSI infections in post-op clinics. Focused on identifying high risk patients for falls to prevent them. During Hospital Engagement Network were successful in reducing CAUTIs, Pressure Ulcers and VTEs.
	Any other information:	Was part of the HEN 1.0 and able to use many of the best practice initiatives in the hospital.
*** Socorro General Hospital**	Hospital interventions:	MOST (Medication Operations Safety Teams) in process of being implemented. Bar Code Scanning for automated dispensing has been implemented in all facilities. This is in addition to Bar Code Scanning of the patient, adding a layer of protection in the medication administration process. Facility level implementation of critical processes for prevention of readmissions. Use of LACE scoring, implementation of Discharge Call Back, and Readmission Questionnaire upon readmission.
	Hospital challenges:	Analyzing the various data sources for similar measures and variation in results. Participating in Data Integrity webinars through NMHA to more effectively understand specifications and variance.
	Any mid-course corrections:	Ongoing quality improvements throughout Presbyterian Healthcare.
	Successes:	Implementation of standard Foley catheter management, to include insertion and general Foley care, ordering and culturing practices. Education conducted at the facility level.
	Any other information:	All quality improvement activities were spread of standard work throughout Presbyterian Healthcare services and establishing best practice, and not based on occurrences or adverse events.

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Union County General Hospital	Hospital interventions:	Initiatives have been: Med/Surg - pre/post-surgical anesthesia care, patient education for new use of nebulizer/inhaler, RT assessment for at home oxygen, HCAHPs, meal accuracy relative to diet order; Emergency Dept. - patients in ED greater than 4 hours, ED returns in under 72 hours; and Laboratory - blood transfusion reactions, blood cultures without skin contamination, critical value reporting to providers.
	Hospital challenges:	Union County is a small critical access hospital with a very small inpatient census (less than 1 IP per day). IP data has a very small denominator, which makes identification of priorities challenging.
	Any mid-course corrections:	N/A
	Successes:	The laboratory-focused interventions improved significantly, despite turnover issues.
	Any other information:	N/A
UNM - University Hospital	Hospital interventions:	Starting Severe Patient Harm Events to address hospital acquired conditions, e.g., falls, pressure ulcers, post-operative DVTs. Mortality review of each patient death by UHC medical service line. Joined the UHC HEN to benchmark data and become proficient on best practices Initiate bundle to decrease CLABSI rates. Joined ASC National Surgical Quality Improvement Program to benchmark surgical data nationally.
	Hospital challenges:	Increase in Hospital Acquired Conditions, including HAI. Increase in Mortality I/O index.
	Any mid-course corrections:	Developed teams w/ physician lead to review Hospital Acquired Conditions, mortality and continuation of working on CLABSI bundles and CAUTI nurse driven protocols.
	Successes:	Decrease in HACS by 30%. Reduction of CLABSI in the Adult ICUs.

* All facilities owned or managed by Presbyterian Healthcare Services were participative in the quality improvement activities which include: spread of standard work throughout Presbyterian Healthcare services and establishing best practice, and not based on occurrences or adverse events.

Acronym dictionary is below

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

Hospital Quality Improvement Incentive Annual Report
Demonstration Year 2

ACRONYM Dictionary

ADE	adverse drug events
AMI	acute myocardial infarction
ASC	Ambulatory Surgery Center
CAUTI	catheter-associated urinary tract infection
C-Diff/CDI	clostridium difficile infection
CHF	congestive heart failure
CLABSI	central-line associated blood stream infection
CNO, CEO, CQO, CFO, COO	Chief Nursing/Executive/ Quality/Finance/Operations Officer
DVT	deep vein thrombosis
EED	Early Elective Deliveries
EMR/HER	electronic medical record; electronic health record
EVS	Environmental Services (Housekeeping)
HAC	hospital/healthcare associated/acquired condition
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HEN	Hospital Engagement Network

HIDD	Hospital Inpatient Discharge Data
IHI	Institute for Healthcare Improvement
INR	international normalized ratio (measures bleeding time)
IP	inpatient
LACE	Length of Stay, Acuity of Admission, Co-morbidities, Emergency Dept. visits within the last 6 mos.
NMHA	New Mexico Hospital Association
PA	physician assistant
PI	performance improvement
PNE	pneumonia
RT	respiratory therapy
SSI	surgical site infection
VAP	ventilator acquired pneumonia
VTE	venous thromboembolism