

## 2025 AzHHA Quality Awards

### Runner up summaries

**Havasu Regional Medical Center** launched an initiative to improve nursing retention and workforce stability in a rural hospital setting. Faced with a high RN turnover rate of 31.25% in 2022, the hospital formed a multidisciplinary task force and implemented a Plan-Do-Study-Act (PDSA) approach focused on communication, recognition, and professional development. Key strategies included daily huddles, monthly emails, mentorship programs, cross-training, and career ladder pilots, which led to a reduction in turnover to 15.17% by 2025. Staff satisfaction improved by 15–20%, with 85% reporting feeling more valued and 70% of RNs engaging in development activities. The initiative fostered a culture of transparency, growth, and team cohesion, demonstrating sustained improvements in retention and engagement.

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**Valley View Medical Center** addressed critical nursing shortages by revamping recruitment and retention strategies, including partnerships with local colleges and the introduction of nurse externships and residency programs. Leadership focused on culture, daily staffing huddles, and engagement to drive performance and sustainability. These efforts led to increased nurse recruitment, a decrease in turnover rates from 20.1% in 2023 to 6.9% in 2025, and a stronger, more empowered workforce

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**Valley View Medical Center** implemented a comprehensive fall prevention program using PDSA cycles, multidisciplinary teamwork, and evidence-based interventions such as bedside shift reports, hourly rounding, and real-time post-fall huddles. The initiative resulted in a 52% decrease in patient falls from 2023 to 2024 and significant cost savings. Continuous education, policy updates, and a culture of shared responsibility were key to sustaining improvements in patient safety.

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**Valley View Medical Center** established a Patient and Family Advisory Committee (PFAC) to incorporate the voice of the patient into quality improvement and patient experience initiatives. The PFAC, guided by AHA blueprints and organizational values, provides feedback on projects and helps align care with patient needs. Early results include diverse membership, input on patient materials, and strengthened community engagement in care delivery.

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**Valley View Medical Center** implemented bedside shift reporting (BSSR) as a standard practice to improve patient safety, communication, and satisfaction. The process included staff education, audits, and patient/family involvement, resulting in increased compliance and a reduction in falls and injuries. VVMC will sustain success through continuous auditing, ownership, and a culture of excellence and accountability.

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Leader rounding at **Valley View Medical Center** was standardized using the PDSA cycle and Press Ganey iRound surveys to enhance patient experience, staff engagement, and care quality. Consistent leader

presence and accountability improved patient satisfaction scores and real-time feedback collection. The initiative emphasized communication, follow-up, and a patient-centered culture as drivers of high reliability and better outcomes.

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**Valley View Medical Center** created a clothing closet to address social determinants of health, providing clean, comfortable clothing to patients in need, especially those experiencing homelessness. The project involved community donations, inventory management, and staff/volunteer engagement, with over 350 lbs of clothing distributed by May 2025. The initiative improved patient dignity, discharge readiness, and community connection, with ongoing drives ensuring sustainability.

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**Valley View Medical Center** launched a targeted initiative to reduce healthcare-acquired *C. difficile* infections, using PDSA cycles, root cause analysis, and evidence-based practices. After a single infection in early 2024 led to reputational and financial penalties, the team implemented stricter specimen collection, staff education, and verification protocols. The result was zero *C. diff* infections for the remainder of the year, demonstrating the impact of culture, accountability, and continuous improvement.

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**Valley View Medical Center's** REACH Program for Nursing Professional Development focuses on recruitment, education, advancement, culture, and honors to support nurses at every career stage. Initiatives include mentorship, clinical ladders, tuition reimbursement, and leadership development, fostering a culture of lifelong learning and engagement. The program has led to increased retention, professional growth, and a supportive environment for both new and experienced nurses.

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**Valleywise Health's** Ambulatory Hypertension Task Force implemented standardized blood pressure recheck protocols and EMR alerts to improve hypertension management across FQHC clinics. Data analysis revealed variability in recheck rates, prompting targeted site visits and protocol reinforcement. By April 2025, several departments achieved over 85% compliance, correlating with improved CMS quality scores and better patient outcomes.

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**Valleywise Health** developed a Cold-Water Immersion (CWI) protocol for treating acute heat stroke, rapidly lowering core body temperature to reduce mortality and improve neurologic outcomes. The multidisciplinary program, expanded to pre-hospital settings, demonstrated increased inclusion rates, faster cooling, and improved survival and neurologic function. Continuous feedback and annual training have made CWI a sustainable, low-cost, and equitable intervention for vulnerable populations.

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**Valleywise Health** piloted standardized emergency management rounds at off-site locations using Lean and PDCA cycles, addressing disparities in preparedness, supplies, and staff training. The initiative

improved readiness scores, staff confidence, and clarity of roles during emergencies. Sustainability is ensured through digital tools, annual training, and integration into accreditation processes.

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**Valleywise Health**'s Ambulatory Diabetes Task Force enhanced diabetes care by implementing a protocol for timely HbA1c testing and developing granular missed opportunity reports. The initiative led to improved compliance, more actionable patient care, and declining rates of missed testing across clinics. Regular data review and targeted re-education sustain process improvements and better CMS quality scores.

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**Valleywise Health** formed a multidisciplinary committee to improve restraint order compliance and reduce the use of 4-point locked restraints. Education, audits, and a 90-day pilot led to policy changes, using default orders when appropriate and increasing compliance from 15% to over 95%. The initiative enhanced patient safety, reduced restraint episodes, and promoted the least restrictive environment for care.

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**Valleywise Health** improved the turnaround time for Seclusion & Restraint (S&R) forms sent to the Regional Behavioral Health Authority by implementing tracking tools, daily reminders, and staff training. Compliance increased, with late forms dropping to zero, ensuring regulatory adherence and timely documentation. Results will be sustained using ongoing education and quality improvement principles.

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**Sage Memorial Hospital**'s Swing Bed Program optimized admissions for skilled nursing and rehabilitation, reducing transfer times and increasing admissions by 430% from 2022 to 2024. The program used PDSA cycles, interdepartmental coordination, and partnerships with regional facilities to keep patients closer to home. Continuous evaluation, compliance, and workflow adjustments have improved patient outcomes and financial efficiency.

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**Sage Memorial Hospital** successfully transitioned to a new state-of-the-art facility using an incident command structure, detailed planning, and mock drills to ensure continuity of care and safety. The move involved tiered department transitions, EMS coordination, and real-time problem-solving for challenges like medication transfer and patient transport. Lessons learned include the importance of standardized processes, communication, and contingency planning for future hospital moves.

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**Sage Memorial Hospital**'s Purchased/Referred Care (PRC) department underwent a complete system redesign using Lean Six Sigma, process mapping, and cultural integration to address inefficiencies and backlogs. Staffing increased by 117%, workflows were standardized, and patient/provider education was enhanced, resulting in reduced referral and claims backlogs and improved patient satisfaction. The program's sustainability is supported by ongoing training, team building, and plans to expand services like non-emergent medical transport.

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**Onvida Health** redesigned its ICU New Grad Residency Program using Lean methodologies, structured education, and mentorship to address high vacancy rates and low staff engagement. The 24-month program, based on AACN recommendations and Benner's Novice to Expert model, included bedside training, ECCO modules, and regular evaluations. Results included a drop in ICU vacancy from 68% to 3%, increased engagement, and nearly \$2.9 million in cost savings by reducing agency nurse reliance.

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**Onvida Health** standardized diabetes education in its Transitional Care Clinic using the PDCA methodology and the ADCES7 self-care model, addressing a lack of formalized resources for patients. The nurse-led DSMES program achieved a 23% average reduction in HgA1c among participants, with a 46% program completion rate in 2024. Challenges included patient engagement and data tracking, but the program improved health outcomes and empowered patients to manage their diabetes effectively.

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**Northwest Medical Center** developed a Clinical Nurse Leader (CNL) Development Program to address rising turnover and gaps in leadership skills, using the PDSA cycle and AONL competencies. The program included education, self-assessment, and role-playing, resulting in significant improvements in CNL knowledge and confidence. All new CNLs will be required to attend, and the program is designed for replication and ongoing adaptation to meet evolving needs.

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**Northwest Medical Center** improved opioid use disorder (OUD) treatment for pregnant inpatients by educating nurses and increasing use of the Clinical Opiate Withdrawal Scale (COWS) and electronic order sets. Pharmacy-led training and rounding enhanced nurse confidence and reduced patients leaving against medical advice. Post-education surveys showed a 52.5% improvement in knowledge and comfort with OUD care.

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**Havasu Regional Medical Center** launched a preoperative education class for total joint replacement patients to reduce anxiety, improve preparedness, and lower readmissions. The class includes procedure education, caregiver support, facility tours, and resources for durable medical equipment. Since implementation, readmissions and emergency visits have significantly decreased, with 100% of patients receiving education in early 2025.

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**Havasu Regional Medical Center** reduced its Nulliparous, Term, Singleton, Vertex (NTSV) cesarean rate from 27% to 21% by implementing AWHONN guidelines and empowering nurses to advocate during labor. A multidisciplinary team conducted root cause analysis and standardized labor management practices. Sustainability is supported through EMR integration, ongoing staff education, and patient outreach.

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**Benson Hospital**'s Rural Health Navigator program improved post-discharge care by coordinating follow-ups, addressing social determinants of health, and reducing emergency department readmissions. The initiative used PDSA cycles and driver diagrams to streamline care transitions and enhance patient engagement. Strategic alignment with organizational goals led to measurable improvements in access, quality, and cost containment.

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**Cornerstone Specialty Hospital** embedded High Reliability Organization (HRO) principles into daily operations to reduce patient falls, achieving zero falls with major injury in 2024. Daily huddles, fall bundle audits, and cross-disciplinary collaboration fostered a culture of safety and proactive care. Staff empowerment and real-time feedback were key to sustaining improvements and enhancing patient outcomes.

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**Southern Arizona VA Health Care System** implemented a nurse-driven initiative to reduce catheter-associated urinary tract infections (CAUTIs) through education, Standard Operating Procedures, and interdisciplinary collaboration. Real-time monitoring and nonpunitive reporting improved compliance and fostered a culture of safety. Infection rates dropped significantly, with strong leadership support driving sustainability.

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**Southern Arizona VA Health Care System** reduced central line-associated bloodstream infections (CLABSIs) by empowering nurses, standardizing protocols, and enhancing patient and family education. A dedicated vascular access team and real-time monitoring supported continuous improvement. Infection rates declined, and staff engagement increased through training and recognition programs.

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**Summit Healthcare** launched a Patient Care Navigator program to address healthcare disparities in Navajo County, focusing on care coordination and financial advocacy. The program improved access, reduced missed appointments, and enhanced health outcomes for underserved populations. Strategic staffing, EMR integration, and data-driven management ensured sustainability and scalability.

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