Baylor College of Medicine 12th Annual Quality Improvement and Patient Safety Conference

High Value Care: Patient Experience and Provider Experience

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12th Annual Quality Improvement and Patient Safety Conference

Baylor College of Medicine

Rayzor Lounge and Cullen Auditorium
1 Baylor Plaza
Houston, TX 77030

In collaboration with
Institute for Healthcare Improvement

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Oral Presentations

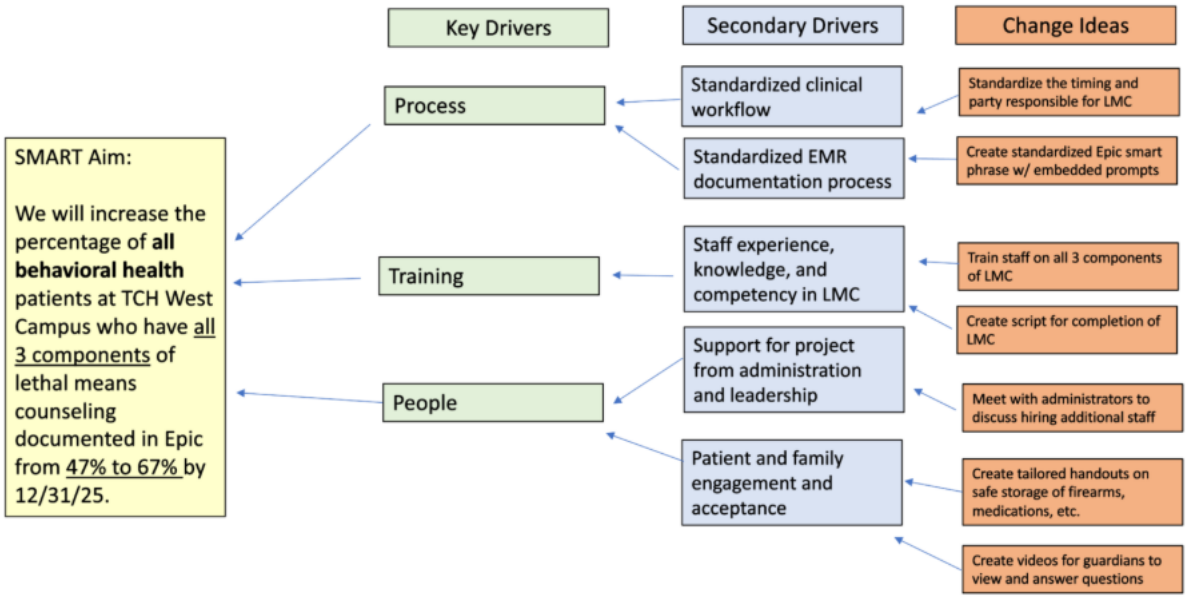
Abstract 1 – Improving Lethal Means Counseling for Pediatric Behavioral Health Admissions at Texas Children's Hospital West Campus

Megan Schmalz, Ritika Gupta, Vidya Menon, Alyssa Schlotman

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Aim Statement

We aimed to increase the percentage of behavioral health patients admitted at TCH West Campus who have all 3 components of LMC (i.e., identification of lethal means, a plan for mitigation, and resources) documented in the EMR from 47% to 67% by 12/31/25.



Background

Children with behavioral health conditions are frequently admitted to U.S. children's hospitals, and ongoing safety concerns often persist after discharge.

Prior studies have shown that lethal means counseling (LMC) and restriction are effective strategies to mitigate risk of self-inflicted injury and suicide after discharge.1,2 While most caregivers are open to such counseling3, it is performed inconsistently4 and must be appropriately documented in the electronic medical record (EMR) to verify its completion. Prior to this study, there was no standardized process for the performance and documentation of LMC at Texas Children's Hospital (TCH) West Campus. Our global aim was to improve LMC at TCH by standardizing the LMC process in collaboration with key stakeholders in the social work and psychiatry departments.

Methods

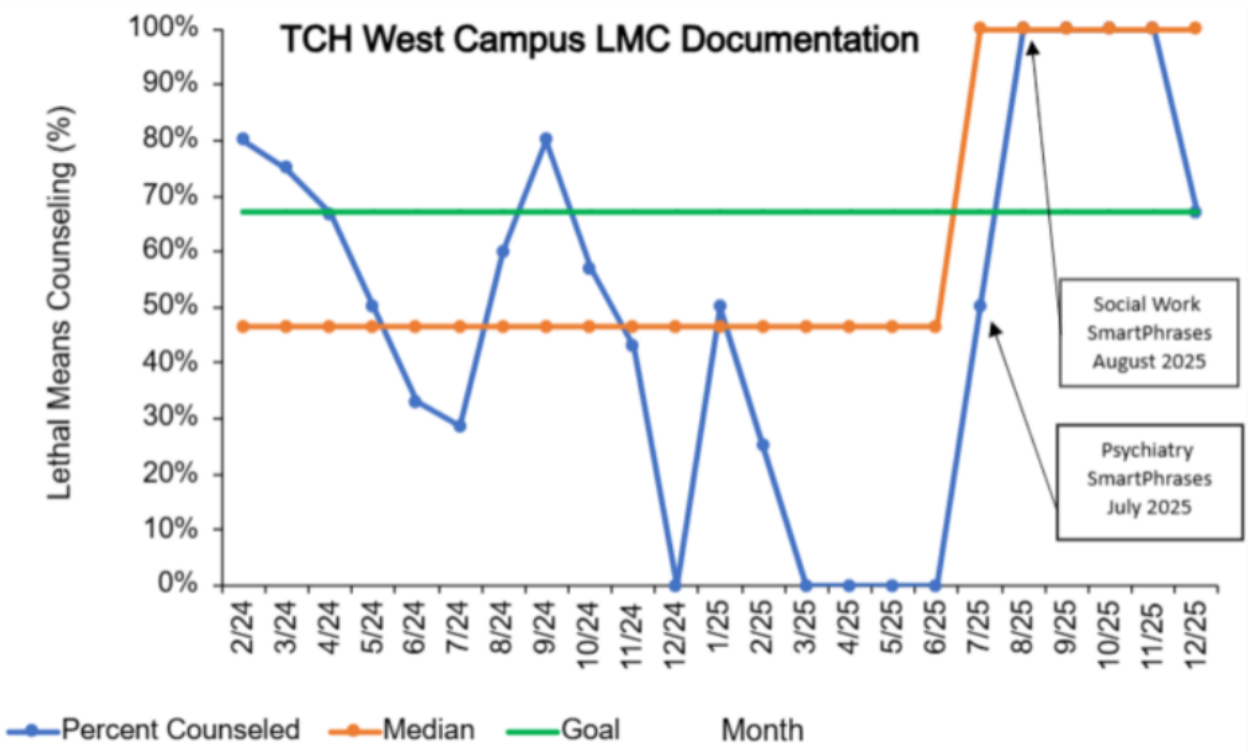
We created a process map, key driver diagram, and fishbone diagram to identify areas of variability and targets for improvement. We implemented two interventions to improve documentation of LMC:

1. Psychiatry documentation standardization, implemented July 2025
2. Social work documentation standardization, implemented August 2025

For both interventions, the provider note template was updated in the EMR to include all three components of LMC, prompting them to complete and document each step in the LMC process.

Results

After implementing these interventions, the median LMC documentation rate at TCH West Campus rose from a baseline of 47% to 100%, which has been sustained for 6 months.



Discussion

The engagement of key stakeholders and standardization of electronic workflows proved to be effective and sustainable for improving the LMC process for behavioral health patients admitted to TCH West Campus. The success of our interventions highlights the importance of understanding the workflow of interest, engaging key stakeholders early and often, and translating pre-existing processes into measurable and documented outcomes. Next steps should include tracking patient-centered outcomes of the LMC process, like readmission rates and patient/caregiver perception, to inform future quality improvement efforts.

Abstract 2 – Burnout Disparities between Neurodivergent and Neurotypical Healthcare Workers: Initial Findings from a Pilot Study

Lauren Robinson, Nicholas Balbin, Lisa Sublett, Lacey Schmidt, Cale Fellenstein, Kelly Slack

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Aim Statement

Within the first year of project initiation, quantify meaningful ND–NT differences in burnout, job demands, and perceived supports; identify ND-salient risk factors; and generate preliminary recommendations for intervention and work-design improvements.

Background

Burnout continues to threaten healthcare quality, safety, and workforce retention. Although neurodiversity is increasingly recognized, little is known about whether neurodivergent (ND) healthcare workers experience burnout differently from their neurotypical (NT) peers. Understanding these differences is critical for developing equitable organizational strategies. This pilot study examines ND–NT differences in burnout, workplace experiences, and associated outcomes. Initial quantitative findings are reported here.

Methods

This study is part of a larger sequential mixed-methods project. An initial qualitative phase informed survey development. The present abstract reports findings from the quantitative cross-sectional component administered to healthcare workers (N = 94). Participants self identified as neurotypical (62%), neurodivergent (31%), or prefer not to say/unsure; 70% were female; 37% were in training (student, intern, resident, or fellow). Validated measures included burnout (Maslach Burnout Scale), perceived organizational support, organizational constraints (Spector & Jex; supervisory barriers, inadequate training, lack of information, conflicting demands, inadequate help, and interruptions), and intention to quit. Independent-samples t-tests and regression analyses controlled for weekly paid work hours and training status

Results

ND healthcare workers reported significantly higher burnout than NT peers ($p = .008$) and higher intention to quit ($p < .001$). No significant ND–NT difference emerged in perceived organizational support. However, ND workers reported significantly greater organizational constraints, including supervisory barriers ($p < .001$), inadequate training ($p = .01$), lack of necessary information ($p < .001$), conflicting demands ($p = .04$), and inadequate help ($p = .02$). Interruptions did not differ between groups but were strongly associated with burnout for all participants ($\beta = .779$, $p < .001$). All effects remained significant after controlling for weekly work hours and training status.

Discussion

ND and NT healthcare workers experience burnout with both shared and distinct contributing factors. ND workers demonstrate higher burnout and greater intention to quit, underscoring the need for differentiated organizational responses. Interruptions emerged as the strongest predictor of burnout and represent a pervasive workflow stressor affecting all clinicians, making them an immediate system-level improvement target. ND-specific gaps, particularly in supervisory and structural constraints, highlight critical areas for targeted intervention.

Abstract 3 – Implementation of a Comprehensive Neuromuscular Hip Care Pathway at a Tertiary Referral Children's Hospital

McKenna Powers-Garcia, **Dorothy Beauvais**, Zina Smadi, Edward Wright, Sutapa Khatua, John Wall, Jr.

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Aim Statement

By December 2025, increase EMR-based hip surveillance enrollment for GMFCS III–V children with CP from 76% to 100%, improve MP documentation to at least 95%, reduce cumulative radiographs by 50%, and ensure that all complex cases are reviewed in the multidisciplinary neuromuscular hip conference prior to definitive surgical decision-making, through implementation of a standardized neuromuscular hip pathway embedded in routine clinical workflows.

Additional Objectives

- Link between surgical flow and outcomes and the hip surveillance system.
- Incorporate patient-reported outcomes into the hip surveillance dashboard.
- Review all complex cases captured through surveillance in the multidisciplinary conference.

Background

Children with cerebral palsy (CP) have a high risk of progressive hip subluxation and dislocation, particularly at higher Gross Motor Function Classification System (GMFCS) levels, and benefit from structured radiographic hip surveillance using migration percentage (MP) thresholds. Fragmented care, inconsistent surveillance practices, and variability in perioperative optimization contribute to delayed intervention, higher complication rates, and inefficient use of resources. In response, our institution developed a comprehensive neuromuscular hip care pathway integrating EMR-based surveillance, multidisciplinary review, standardized surgical workflows, and longitudinal outcome tracking.

Methods

A parental satisfaction survey was developed using validated pediatric anesthesia satisfaction tools and adapted for the congenital cardiac population. A QR code linking to the survey was placed in multiple perioperative locations. The primary process measure was survey completion rate, aligned with the project aim of assessing feasibility and workflow integration. Iterative Plan–Do–Study–Act (PDSA) cycles were used to improve survey uptake. Cycle 1 focused on passive nurse education via email and staff meeting announcements. Subsequent cycles implemented active interventions including just-intime staff education, QR code business cards, role modeling by anesthesia providers, enhanced visual prompts, and regular feedback on response rates to frontline staff.

Results

GMFCS III–V surveillance enrollment increased from 76% to 100%. All patients transitioned to single standardized AP pelvic views, reducing cumulative radiographs from 1,084 to 400. MP documentation improved from 43 (6.5%) to 389 (97.3%) cases, identifying 124 patients (31.9%) with MP > 30%. Timely surveillance rose from 449 (2021) to 686 (2024); delayed surveillance declined from 271 to 169. Since March 2024 multidisciplinary pathway launch, 153 patients (162 presentations) were reviewed: 135 approved for surgery (112 completed), 19 did not proceed, 27 denied after risk–benefit discussion

Discussion

The comprehensive neuromuscular hip care pathway improved surveillance adherence, documentation accuracy, imaging efficiency, and multidisciplinary surgical optimization. Embedding QI processes within EMR workflows reduced care fragmentation while enhancing high-risk patient identification. This scalable model supports sustainable, high- value neuromuscular hip care and health equity for medically complex pediatric populations.

Abstract 4- Telemetry Usage Reduction on 9T at Baylor St. Luke's Medical Center

Brad M. Roche, Ashley S. Vaughn, Victoria Brehm, Alison Heinen Taylor, Francis Jorge Dalimbang, Grafe Chua, Renz Bordan, Selina Zulfiqar, Janie Bila, Grant Roller

Affiliations: Baylor College of Medicine

Aim Statement

Our goal is to reduce the number of patients on 9T unit at BSLMC with expired telemetry orders by 30% between December 1, 2025, and May 30, 2026.

Our vision is to create a sustainable, interdisciplinary telemetry monitoring model minimizing unnecessary monitoring, preserves hospital resources, improves workflow, and promotes guideline-driven, patient-centered care.

Background

Telemetry is a high-cost intervention that increases nursing workload and can delay procedures and diagnostic studies. Inappropriate telemetry use reduces ED throughput and limits the hospital's ability to accept transfers. Previous efforts at BSLMC to reduce unnecessary telemetry use were either discontinued or didn't achieve sustained success. This project addresses that gap by ensuring monitored patients have active telemetry orders supported by appropriate clinical criteria.

Baseline data showed that 40% of patients on 9T unit remained on telemetry each morning with expired orders. We estimated this unnecessary monitoring added approximately $20,800 per quarter in patient care costs.

Methods

Before launch, project leaders held a Nursing Education Breakfast for 9T staff, followed by additional education via a PowerPoint presentation reviewing project goals, staff roles, and a physician call script to help nurses address expired telemetry orders.

A nursing escalation algorithm was developed based on BSLMC's existing escalation pathway. Posters outlining telemetry criteria and project goals were placed in key nursing areas. Nurses were instructed to contact physicians about expired telemetry orders at noon, after multidisciplinary rounds.

A later phase will include physician education to determine whether provider-focused interventions further reduce expired telemetry orders.

Results

With the nursing-focused intervention alone, the percentage of patients with expired telemetry orders each morning decreased from 38.48% to 27.12%, an absolute improvement of 11.36 percentage points. This change has been statistically significant to date.

Discussion

We found that some nurses interpreted "expired" telemetry orders as "discontinued" orders. Review of BSLMC telemetry policy clarified expired orders do not discontinue monitoring; rather, telemetry orders auto-expire. This was emphasized in follow-up education.

Pre-project nursing surveys showed hesitation in contacting physicians to request discontinuation when telemetry was no longer indicated. Follow-up education therefore reinforced telemetry criteria, the physician call script, and the escalation pathway.

Next steps include a physician-focused intervention, routine daily charge nurse review of telemetry order status, integration of telemetry review into rounds and handoffs, updated educational posters, and annual education for nurses and physicians. If successful, the project may be expanded hospital-wide.

Poster Presentations

Abstract 1 – Parental Views on Premedication and Satisfaction in Congenital Cardiac Anesthesia

Lisa Caplan, Mellissa Delcont

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 201

Aim Statement

The aim of this quality improvement project was to establish a baseline measure of parental satisfaction with the preoperative separation process for non-ICU congenital cardiac patients by implementing a QR-code–based survey into the perioperative workflow. The primary feasibility goal was to collect 100 completed parental surveys during the initial project phase.

Background

Children with congenital heart disease (CHD) experience substantial perioperative stress, and separation from parents prior to anesthesia induction is among the most distressing moments for families. Elevated parental anxiety during this transition has been associated with difficult inductions, postoperative behavioral changes, and decreased trust in the care team. Despite routine use of premedication, parental perceptions of the preoperative separation experience in the congenital cardiac anesthesia population remain largely unexplored. Establishing a baseline measure of parental satisfaction is a necessary first step toward advancing family-centered care for non-ICU congenital cardiac patients, a population that represents a significant portion of perioperative encounters yet is inconsistently evaluated.

Methods

A parental satisfaction survey was developed using validated pediatric anesthesia satisfaction tools and adapted for the congenital cardiac population. A QR code linking to the survey was placed in multiple perioperative locations. The primary process measure was survey completion rate, aligned with the

project aim of assessing feasibility and workflow integration. Iterative Plan–Do–Study–Act (PDSA) cycles were used to improve survey uptake. Cycle 1 focused on passive nurse education via email and staff meeting announcements. Subsequent cycles implemented active interventions including just-intime staff education, QR code business cards, role modeling by anesthesia providers, enhanced visual prompts, and regular feedback on response rates to frontline staff.

Results

No surveys were completed during the first 10 days, indicating that passive education alone was insufficient. Identified barriers included limited staff awareness, workflow variability, and lack of reinforcement. Following implementation of successive PDSA cycles, response rates improved from 17% in Cycle 1 to 33% in Cycle 2, 35% in Cycle 3, and 42% in Cycle 4, demonstrating increasing workflow reliability. At the time of analysis, 49 surveys had been completed toward the goal of 100. The cardiac catheterization lab accounted for the highest number of responses (n=30), reflecting anesthetic case distribution within the practice. Preliminary survey data demonstrate consistently high parental satisfaction with communication, preparation, and support during preoperative separation.

Discussion

This project demonstrates that active staff engagement and intentional workflow design are essential for successfully integrating parental experience measures into congenital cardiac anesthesia practice. Iterative, high-visibility interventions were necessary to improve survey feasibility and uptake. Early findings suggest current separation practices are positively perceived by families, while ongoing data collection will enable deeper thematic analysis and guide targeted, data-driven enhancements to family-centered perioperative care.

Abstract 2 – Reducing PICU Delirium by Re-Timing Routine X-Rays

Craig Pymento

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 202

Aim Statement

By retiming non-emergent CXRs from night shift to dayshift, we aimed to reduce the average monthly number of patients screening positive for delirium by 10% before the end of 2025.

Background

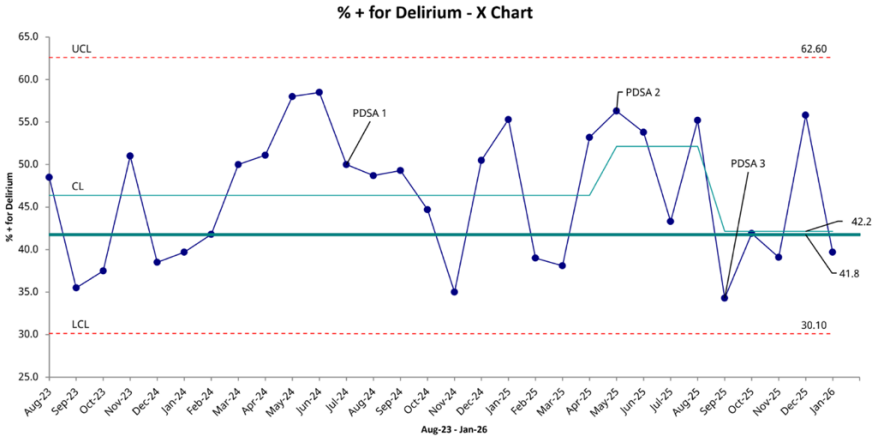
Delirium is a frequent condition in the PICU, associated with increases in length of stay and in-hospital mortality. Optimization of sleep hygiene is recommended for prevention. At Texas Children's Hospital – The Woodlands, routine early-morning chest X-rays (CXRs), were identified as a preventable source of nighttime disturbance.

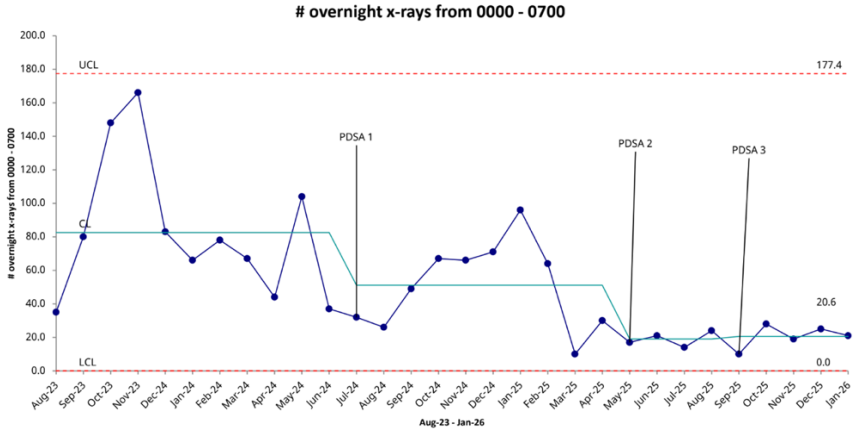
Methods

A multidisciplinary survey was conducted in April 2024 among nurses, respiratory therapists, critical care physicians, radiology staff, and patient families to assess perceptions of sleep disruption and workflow challenges. Guided by this feedback, the team implemented three PDSA cycles: (1) shifting non-emergent CXRs for non-ventilated patients to day shift (July 2024), (2) extending daytime-only imaging to all non-emergent CXRs (May 2025), and (3) refining criteria to allow nighttime imaging for patients who were both sedated and under neuromuscular blockade (September 2025). Outcome measures included the average monthly number of patients screening positive for delirium utilizing the Cornell Assessment for Pediatric Delirium (CAPD). Process measures included the timing and number of x-rays obtained overnight. The project was deemed exempt by the Institutional Review Board.

Results

Baseline review demonstrated that 4 a.m. was the most common time for portable X-ray acquisition. Survey results showed provider and family support for reducing nighttime disruptions and improving sleep hygiene. Retrospective chart review from August 2023 to January 2026 showed 8,306 encounters, 6,505 CAPD screenings, and 3,807 positive screens identified. The average monthly number of patients screening positive for delirium decreased from 46.4% to 42.2% across the three PDSA cycles, a 9% reduction. The average monthly number of x-ray studies obtained between midnight and 7 AM decreased from 82.5 to 20.6.





Discussion

Retiming non-emergent CXRs to daytime hours is feasible, sustainable, and supported by staff and families. Doing so can reduce the incidence of delirium within pediatric intensive care units.

Abstract 3 – Improving West Campus Emergency Center Throughput by Implementing a Split-Flow Pathway

Bryan Greenfield, Binita Patel

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 203

Aim Statement

Process improvement interventions will be implemented in the West Campus Emergency Center to decrease LWBS + LBTC rate (primary metric) and decrease Door to Doc (secondary).

Background

Inefficiencies and highly variable care delivery processes coupled with a mismatch between patient demand and available capacity in the WC emergency center has resulted in prolonged wait times and throughput delays, leading to high left without being seen/left before treatment complete (LWBS/LBTC) rates, safety concerns, and poor patient experience. The healthcare team is also impacted with moral distress, attrition, and burnout.

Methods

We created a split-flow pathway with expanded patient criteria beyond fast track in order to evaluate patients quickly, perform diagnostics, keep patients vertical, and determine disposition. This pathway required the formation of a new care team that included two nurses, a tech, a physician, and an APP.

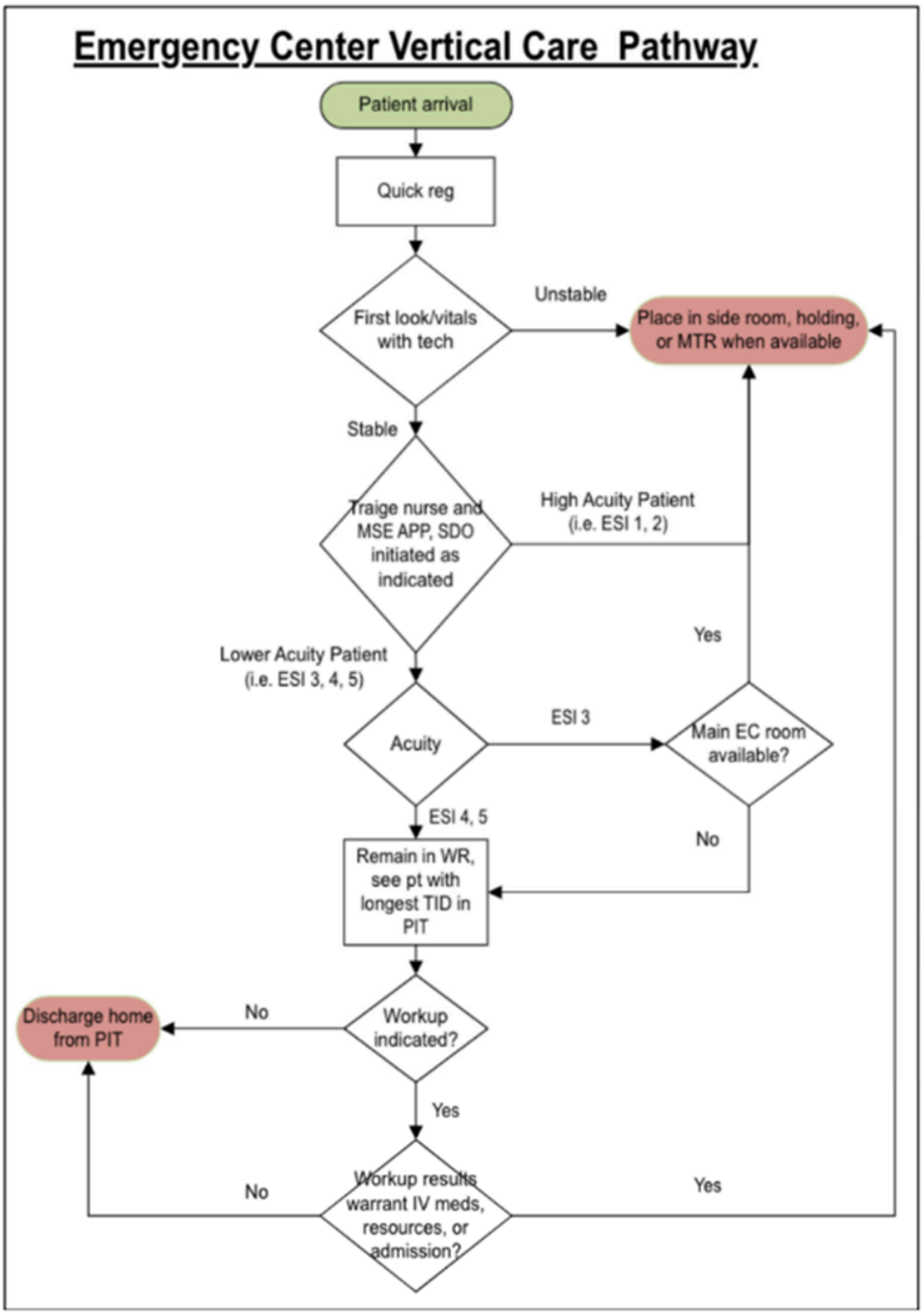


Figure 1. Patient flow algorithm to guide patient movement through the split-flow process.

Results

When comparing similar high-volume seasons (September through December) from 2024 and 2025, we decreased LWBS/LBTC from 16.9% to 5.9%. We also

decreased door to doc time from 135 to 79 minutes and time in department from 251 to 188 minutes. All of these metrics were significantly significant (p=0.000).

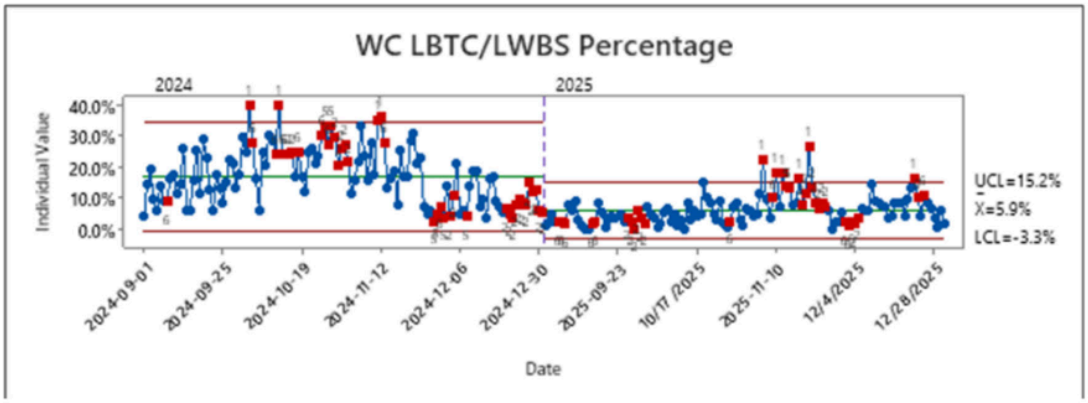


Figure 2. LBTC/LWBS improved from an average of 16.9% to 5.9% when comparing similar high-volume seasons before and after the implementation of the split flow pathway.

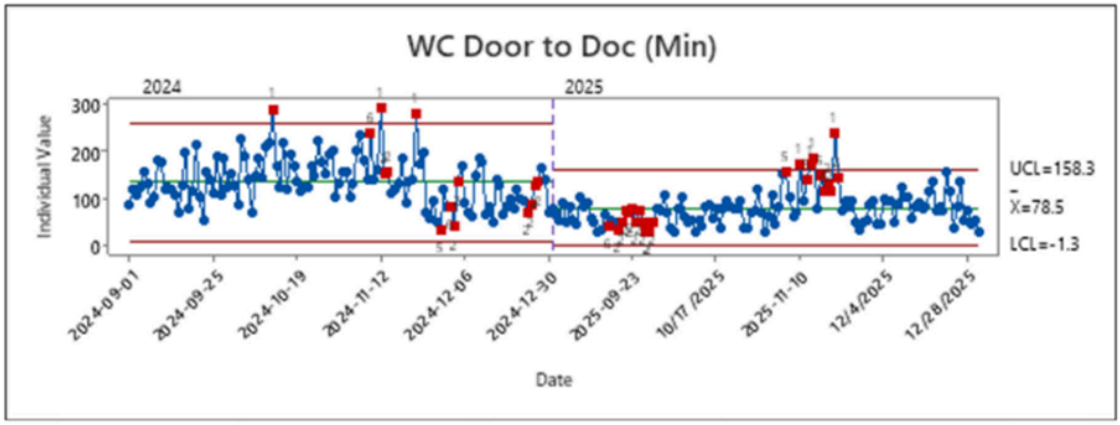


Figure 3. Door to doc time improved from an average of 135 to 79 minutes when comparing similar high-volume seasons before and after the implementation of the split flow pathway.

Discussion

The creation of a split-flow pathway in the EC allowed for more efficient care with a statistically significant improvement in LWBS/LBTC, door to doc time, and time in department. It is important to note that this care pathway required additional staff in order to implement and was not just a reallocation of EC resources.

Abstract 4 – Improving Bone Density Screening Rates in Patients at Risk for Falls Using Chart Screening and Protocol Orders

Lona Winnegan

Affiliations: Baylor College of Medicine, UT Health Houston

Poster Number 204

Aim Statement

The aim was for patients diagnosed with spine fractures and degenerative spine conditions to be screened for osteoporosis/osteopenia according to screening recommendation standards. The goals were to maintain a minimum 90% fall risk screening rate, increase bone density screening rate by 20%, and add an electronic health record (EHR) check for bone density screening.

Background

Spine fractures result in serious morbidity and mortality. The type of treatment options available for spine fractures and the timing of intervention is affected by the patient's bone density.

Methods

Using the DMAIC framework, implementation of technology controls created a hard stop in the EHR for electronic screening for bone density documentation. Enhanced provider communication provided a fall risk warning on the encounter signing screen with an alert to address the positive fall risk screening and a best practice advisory to address the missing bone density with DEXA order.

Results

The fall risk screening rate was maintained at 95% mean during the intervention. The bone density screening rate was increased by 117% from a mean of 12 prior to the interventions to a mean of 26 during the interventions.

Discussion

Improved bone density screening rates can guide treatment for those who would benefit from bone health optimization.

Abstract 5 - Improved Microalbuminuria Screening to Guide GLP-1 RA and SGLT2 Inhibitor Use for CKD prevention in Type 2 diabetes

Soham Datar, Rekha Afzalpurkar, Hammad Mahmood, Kamna Bansal, Preethi Nambi, Nidhi Mehrotra, Ambreen Mujahid, Afroze Ali, Jacqueline Hirth, Malvika Juneja, Roger Zoorob

Affiliations: Baylor College of Medicine, Harris Health System - Ben Taub Hospital

Poster Number 205

Aim Statement

Improve awareness in providers for critical importance of at least annual screening for microalbuminuria screening in diabetes and use of SGLT-2 I. GLP-1RA , ACE and ARBS for CKD prevention in diabetes.

Background

Type 2 Diabetes Mellitus (T2DM) affects 10.5% of the U.S. population, with 40% progressing to chronic kidney disease (CKD). Albuminuria is an early indicator and needs addition of GLP-1 agonists (GLP-1A), SGLT2 inhibitors (SGLT2-I). However, microalbuminuria screening is not universally done as indicated. Our system's EMR triggers microalbuminuria testing only on T2DM patients on ACE inhibitors or ARBs, missing screening in many patients. We conducted a pre-and-post study, identifying gaps, physician/system limitations, & followed this by education and studied impact of this QI.

Methods

A retrospective review of 299 T2DM charts provided demographics, CKD status , microalbuminuria, and medication profiles. 15 physicians were surveyed for awareness of ADA guidelines & barriers to microalbuminuria screening and data analyzed for knowledge gaps, inefficiency of clinical teams, and limitations in EMR utilization. Thereafter we launched a 2-tier education campaign on the ADA guidelines & proposed a workflow.

Results

In the retrospective study, 299 patient charts analyzed, 80 had CKD. Of 219 eligible for microalbuminuria testing, only 60% were screened. In this group of tested patients only 73% were on ACE-I/ARB, 43% on GLP-1A, 38% on SGLT2-I. The physician survey indicated that 85% had indistinct knowledge of ADA guidelines, & 20% utilized EMR regularly for microalbuminuria screening. The post-education analysis of 260 patients showed significant improvement in microalbuminuria testing and prescribing practices as follows. After educating 5 providers their 260 patients were followed for three months. Microalbuminuria was ordered according to ADA recommendations; GLP 1 RA and SGLT2 I were added according to ADA guidelines.

Out of 260; microalbuminuria was ordered for 90% patients VS 55% in retrospective group. There was 11% increase in Patients who were started on SGLT2 and 15% increase in patients started on GLP-1 RA post education.

Discussion

Microalbuminuria testing and early treatment is the cornerstone of CKD prevention. GLP1RA and SGLT2 I play a crucial role in CKD prevention in diabetes. Microalbuminuria screening; an inexpensive and easily available test is the first step in CKD detection and prevention. It is not done per ADA recommendations in all diabetes patients, so EMR optimization, physician education, and nursing support are essential in preventing CKD in the complex T2DM patients of safety net settings.

Abstract 6 - Improving Real-Time Morbidity Tracking in Pediatric Cardiac Surgery

Brooke Hortness, Jennifer Barr, Sarah Clunie

Affiliations: Texas Children's

Poster Number 206

Background

The Congenital Heart Surgery (CHS) team wanted a way to help track post-operative events at a more frequent cadence then currently presented. Historically, post operative events were presented in two different regularly scheduled conferences. Performance Rounds occurs at a two-week cadence capturing events falling within the first two weeks post op. Events falling after the first two weeks through discharge were reviewed during monthly morbidity and mortality (M&M) meetings the month following patient discharge. This project aimed to implement a real-time morbidity identification and reporting system to accelerate review and awareness.

Methods

Using Lean Six Sigma and the DMAIC framework, the CHS team mapped the existing process, identified areas of waste, and developed a streamlined workflow. The identification focused on 17 common morbidities based on The Society of Thoracic Surgeons (STS) guidelines. Key interventions included creating a standardized morbidity tracking form, implementing weekly reporting cycles, and validating data through the quality team. Events are identified through Advanced Practice Provider (APP) rounding, Intensive Care Unit (ICU) weekly quality meetings, and patient chart review. Baseline data was collected to establish current performance, and post-implementation data was analyzed to measure improvements and use for comparison. Metrics focused on reducing the time from event occurrence to report-out and maintaining event capture rates.

Results

Baseline analysis showed an average of 10.73 days from event to report-out. After initial process changes, this decreased to 9.79 days, and following a data

validation enhancement, the average dropped to 6.63 days. Median reporting time improved from 10 days to 7 days.

Discussion

Implementing a structured, real-time morbidity tracking system improved the timeliness of event reporting and maintained event capture. Sustaining these gains will require ongoing staff education, process monitoring, and integration of automation tools. Future improvement ideas include embedding the tracking system into the electronic health record, automating notifications, transferring data to the STS database, and creating a dashboard to further enhance visibility and efficiency.

Abstract 7- Food Insecurity Screening and Connection to Resources Through the Texas Children's Hospital Emergency Center

Karina Hofstee, Michael Alavi, Rachel George, Karina Hofstee, Kristen Timberlake, Mary Wisbon, Binita Patel, Nancy Correa, Elyse Portillo, Bryan Greenfield

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 207

Aim Statement

This study has a global aim to increase access to resources for patients who screen positive for FI. The primary aim is to increase the percentage of EC patients with food insecurity who receive resources from 0% to 30%.

Background

Food insecurity affects over 23% of households with children in Harris County, Texas, which is significantly above the national average of 14.3%1. FI serves as an independent predictor for adverse health outcomes including increased hospitalization, asthma, anemia, behavioral disorders, and cognitive delay, and disproportionally affects socially vulnerable populations2. The American Academy of Pediatrics (AAP) recommends pediatricians to both screen for FI and link families to resources, and the emergency center (EC) has previously been described as an opportune location to implement screening and assistance programs3,4. With over 170K EC encounters yearly at Texas Children's, we have an opportunity to reach a significant number of households facing food insecurity.

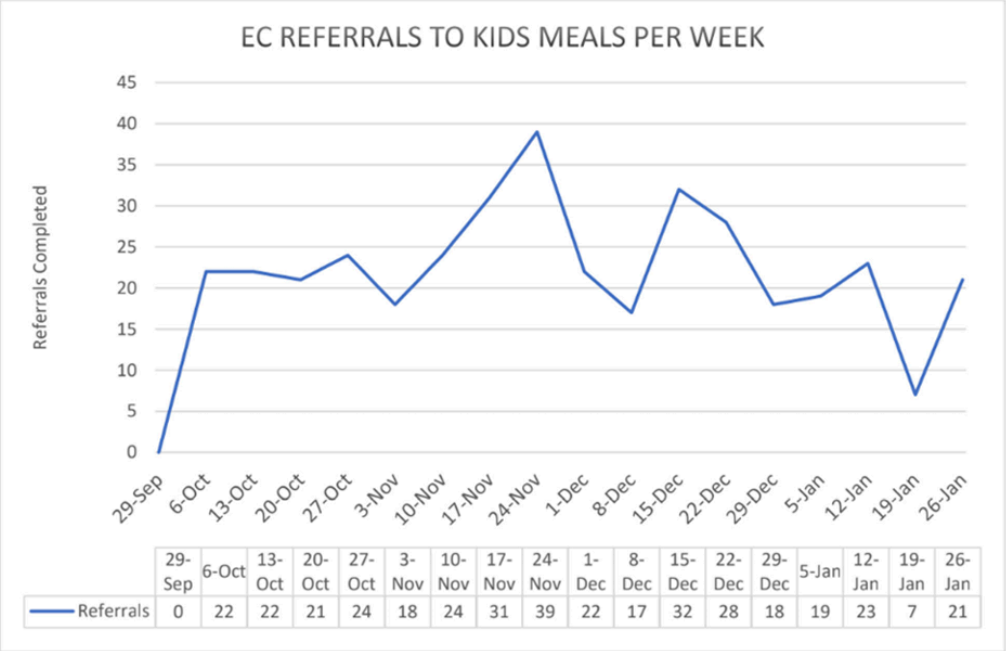
Methods

From October 1, 2025 - January 31, 2026, we screened patients age five and under who live in high-risk area codes at all of the TCH Houston-based ECs for FI via the Hunger Vital SignTM screen during the MyChart self-registration process5. Families were asked if they would like to be referred to a local meal delivery service, Kid's Meals, and consented to sharing their contact

information. Representatives from TCH subsequently referred interested families to Kid's Meals who reached out to eligible families directly.

Results

No standardized referral or screening for food insecurity was active in the EC prior to the initiation of this program. From October 1, 2025 - January 31, 2026, 388 patients screened positive, requested services, and were referred to Kids' Meals, which was an average of 3 referrals per day. Kid's Meals emailed or called 100% of the referrals received.



	29-Sep	6-Oct	13-Oct	20-Oct	27-Oct	3-Nov	10-Nov	17-Nov	24-Nov	1-Dec	8-Dec	15-Dec	22-Dec	29-Dec	5-Jan	12-Jan	19-Jan	26-Jan
Referrals	0	22	22	21	24	18	24	31	39	22	17	32	28	18	19	23	7	21

Figure 1: *Weekly referrals from the Texas Children's Hospital Houston area ECs to Kid's Meals during PDSA 1*

Discussion

The Pediatric EC can serve as an access point to community resources for households experiencing FI. The first PDSA cycle successfully created an automated process to screen and refer patients with FI without changing the EC clinical workflow. This cycle was limited by only screening those with access to MyChart, which is 33% of our encounters. Further cycles can either implement bedside screening or expand self-registration. Additionally, while the community partner attempted to contact 100% of the referrals, we do not have data on the percentage of families that ultimately received services.

Abstract 8 - Developmental of a Standardized Referral and ACTH Stimulation Testing Framework For Infants with Abnormal Congenital Adrenal Hyperplasia Newborn Screens

Sri Nikhita Chimatapu, Nella Aikaterini, Kelly Rhodes, Manal Tantoush, Sheila Gunn, Sarah Lyons

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 208

Aim Statement

To design an evidence-informed clinical framework to guide referral urgency and consideration of ACTH stimulation testing following abnormal CAH newborn screening, and to describe baseline evaluation patterns and diagnostic outcomes.

Background

Congenital adrenal hyperplasia (CAH) newborn screening (NBS) enables early identification of infants at risk for adrenal insufficiency; however, downstream referral pathways and biochemical evaluation strategies vary widely. In the absence of structured decision support, ACTH stimulation testing is frequently pursued in clinically stable infants with low-risk biochemical profiles, contributing to practice variability, invasive testing, and increased healthcare costs. This work was undertaken as part of an institutional quality improvement initiative aimed at improving the care of infants identified through CAH newborn screening.

Methods

We developed standardized, gestational age–based decision-support frameworks to guide referral urgency and consideration of ACTH stimulation testing following abnormal CAH newborn screening and initial serum 17-hydroxyprogesterone (17-OHP). Framework development was informed by retrospective review of baseline outpatient referrals of infants ≥37 weeks gestational age evaluated in pediatric endocrinology clinic between March 2023 and May 2025 to characterize evaluation pathways, diagnostic outcomes, and

institutional charges. Infants born at 37–39 weeks gestation were classified as near-term and incorporated into the preterm/near-term pathway (Figure 2), while infants ≥40 weeks followed the term pathway (Figure 1).

Results

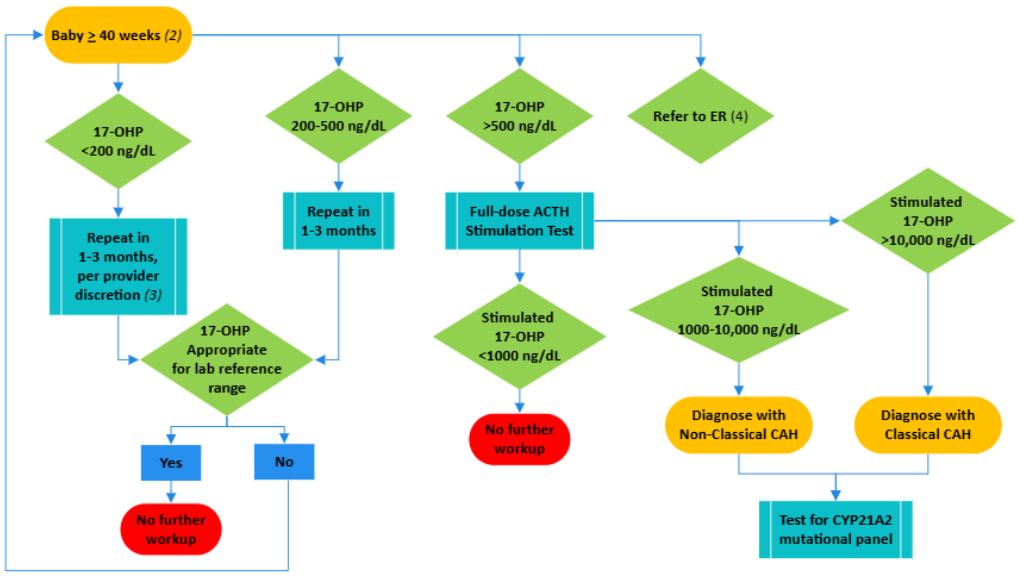
Baseline review identified 31 infants referred for abnormal CAH NBS. Initial 17-OHP levels ranged from 13 to 2910 ng/dL. Based on individual provider clinical decision-making, 13/31 infants (42%; baseline 17-OHP 52–2910 ng/dL) underwent ACTH stimulation testing. Nonclassical CAH was diagnosed in 4/31 infants (12.9%), while the remaining 9 infants who underwent stimulation testing had normal results. Eighteen of 31 infants (58%; baseline 17-OHP 13–579 ng/dL) were managed with serial biochemical monitoring without ACTH stimulation testing, and none were subsequently diagnosed with CAH. Institutional charge data demonstrated that a single ACTH stimulation testing episode generated approximately USD 4,000–4,200 per patient, reflecting cosyntropin administration, comprehensive adrenal steroid panels, electrolyte testing, and associated nursing and procedural resources. In contrast, repeat outpatient serum 17-OHP measurement alone generated charges of approximately USD 350.

Discussion

Baseline evaluation of infants referred for abnormal CAH newborn screening demonstrated substantial variability in ACTH stimulation testing utilization, low diagnostic yield for non-classical CAH, and marked cost differences between testing strategies. A standardized, risk-based framework has been designed to support targeted testing by improving selection of infants for resource-intensive evaluation while maintaining safety. The framework is finalized, with prospective implementation and evaluation planned to assess clinical outcomes and health-system impact.

Endocrine Workup for Abnormal NBS for CAH or 17-OHP

Full-Term Baby (Gestational Age ≥ 40 weeks) *(1,2)*



1. This algorithm is only applicable for babies who are not currently on steroids, or were not treated with systemic steroids before the date of the lab tests.
2. Age on date of the lab tests.
3. Very low risk for CAH.
*4. Refer to ER: if clinically unstable, **or** ambiguous genitalia, **or** with 17-OHP > 1000 ng/dL with/without abnormal electrolytes.*

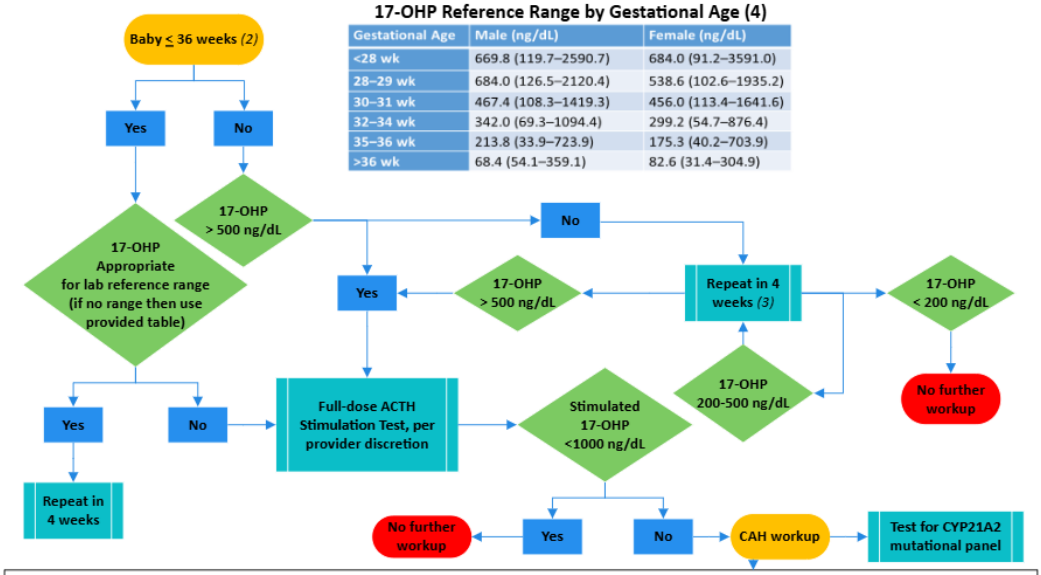
Last updated 01/26/2026

Endocrine Workup for Abnormal NBS for CAH or 17-OHP

Preterm/Near-Term Baby (Gestational Age < 40 weeks) *(1, 2)*

17-OHP Reference Range by Gestational Age (4)

Gestational Age	Male (ng/dL)	Female (ng/dL)
<28 wk	669.8 (119.7–2590.7)	684.0 (91.2–3591.0)
28–29 wk	684.0 (126.5–2120.4)	538.6 (102.6–1935.2)
30–31 wk	467.4 (108.3–1419.3)	456.0 (113.4–1641.6)
32–34 wk	342.0 (69.3–1094.4)	299.2 (54.7–876.4)
35–36 wk	213.8 (33.9–723.9)	175.3 (40.2–703.9)
>36 wk	68.4 (54.1–359.1)	82.6 (31.4–304.9)



1. This algorithm is only applicable for babies who are not currently on steroids, or were not treated with systemic steroids before the date of test.
2. Age on date of test.
3. Baby will be full-term after 4 weeks, refer to Endocrine Workup flowchart for Full-Term Baby.
4. References: J Clin Endocrinol Metab 92:2581-2589, 2007. Arch Dis Child Fetal Neonatal Ed 1999; 81:F175-F178

Last updated 01/26/2026

Abstract 9 – Spatial Analysis of Buprenorphine-Dispensing Pharmacies and Neighborhood Disparities in Harris County

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Affiliations: Baylor College of Medicine, Baylor St. Luke's Medical Center, CommonSpirit Health

Poster Number 209

Aim Statement

(1) Create a geographically precise, clinician-usable map of BUP-dispensing pharmacies in Harris County to support timely identification of treatment access points for patients with OUD.
(2) Assess and compare demographic and socioeconomic profiles of neighborhoods served by dispensing vs. non-dispensing pharmacies to identify disparities and guide targeted interventions.

Background

Buprenorphine (BUP) is a gold-standard treatment for opioid use disorder (OUD), yet only about 20% of patients receive evidence-based pharmacotherapy, with pharmacy-level barriers remaining a major obstacle. Prior studies show BUP availability as low as 37.1%, with substantial geographic variation. Harris County has persistently higher opioid-related mortality than the Texas state average, but no studies have mapped BUP-dispensing pharmacies or evaluated geographic disparities in access.

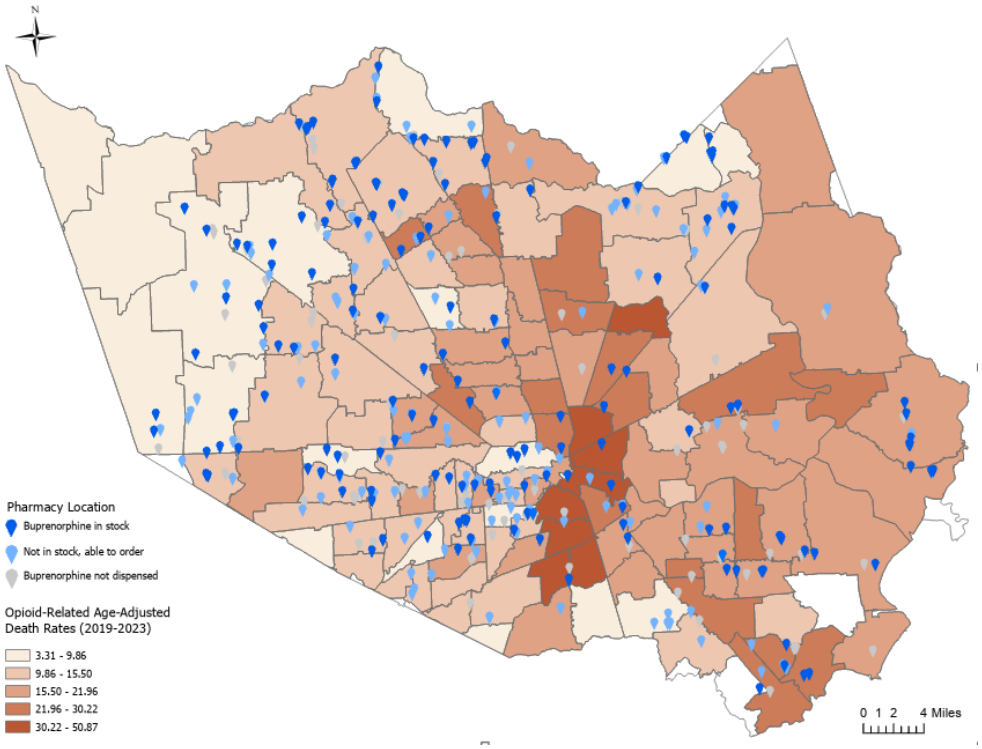
Methods

We identified chain and county system pharmacies in Harris County with active Texas State Board of Pharmacy licenses and conducted cross-sectional data collection from February to September 2025. Using publicly available prescription lines and a standardized script, we assessed whether each pharmacy stocked BUP. Locations were geocoded in ArcGIS Pro and overlaid with zip-code-level, age-adjusted opioid-related death rates (2019-2023). Mixed effects logistic regression estimated adjusted odds of BUP availability, with zip

code as a random intercept. Global Moran's I assessed spatial clustering of dispensing pharmacies.

Results

Of 475 eligible pharmacies, 378 (79.6%) provided information, and 164 (43.4%) reported having BUP in stock. The geocoded map (Fig. 1) revealed several high-mortality areas with few or no dispensing pharmacies. In the regression model, pharmacies located in neighborhoods with higher proportions of non-White residents had significantly lower odds of stocking BUP, independent of population density, education, income, and unemployment. Unadjusted Moran's I indicated modest spatial clustering (I = 0.02, p = 0.04), which was no longer significant after covariate adjustment (I = 0.00, p = 0.50).



Discussion

Less than half of Harris County pharmacies stocked BUP, and geographic mismatches between BUP availability and opioid-related mortality were evident. Pharmacies in neighborhoods with higher proportions of non-White residents were less likely to stock BUP—even after accounting for population density and other socioeconomic indicators— highlighting structural barriers that may reinforce disparities in OUD treatment access.

Abstract 10 – Improving Provider Listened Satisfaction Score

Thomas Porter, Huma Rahman

Affiliations: Baylor College of Medicine

Poster Number 210

Aim Statement

The goal of this project is to implement a process that will improve the patient satisfaction score for provider listened.

Background

Patients are surveyed about whether they felt their provider listened to them during their most recent clinic visit. The surveyor generates a score according to their answers.

Methods

1. On the day before clinic the provider designates all new patients on their schedule with a purple dot in the EMR. (Patients new to that provider). New patients are targeted because we know that all new patients will receive a survey.
2. On clinic day: Provider sees patient then exits room.
3. Before discharging the patient, the nursing staff enters room and asks the patient: " Do you feel that the provider listened to you today."
4. If the answer is yes, the nurse makes a statement: You may receive a survey we would appreciate if you gave us a high score.
5. Nurse informs provider of patient's comments who then moves on to next patient. (provider waits before seeing next patient)
6. If answer from step 3 is no, the nurse inquires what the patients' concerns are, then reports those concerns to the provider. The provider then goes back into the room to resolve the patient's concerns.

Results

This process was implemented at Strawberry Clinic in September 2025. The chart below shows the scores from September 2025 to January 2026 and contrasts them from the scores in the same months a year earlier.

Month/Year	Score		Month/Year	Score
Sept 2024	61.0		Sept 2025	70.3
Oct 2024	69.0		Oct 2025	75.3
Nov 2024	64.6		Nov 2025	75.0
Dec 2024	65.8		Dec 2025	71.4
Jan 2025	68.4		Jan 2026	72.3

Discussion

This process informally known as the Purple Dot project gives us real time information about if a patient feels their provider listened to them. New patients are designated in the EMR with a purple dot so the nursing staff will know which patients to focus on. If the patient states the provider did not listen then, the provider now can resolve any concerns the patient may have. The data in the chart above shows data from September 2025 to January 2026. There was a definite increase in the satisfaction scores compared to the previous year.

Abstract 11 – Implementation of an Evidence-Based PACU Monitoring Protocol for Surgical Outpatients with Obstructive Sleep Apnea at High-Volume Veterans Affairs Medical Center

Maisie Jackson, Edward Summey, Raegan Gately, Shahid Ali, Megan Atkinson

Affiliations: Michael E. DeBakey VA

Poster Number 211

Aim Statement

To implement an evidence-based postoperative monitoring protocol for surgical outpatients with OSA at MEDVAMC and reduce median PACU length of stay for patients receiving general anesthesia by at least 20% within six months, without increasing postoperative respiratory complications or unplanned admissions.

Background

Obstructive sleep apnea (OSA) affects approximately 22.6% of the global population and is highly prevalent among veterans. OSA increases the risk of postoperative respiratory complications, including hypoxemia and unplanned admission. Despite these risks, evidence guiding optimal postoperative monitoring duration remains limited. At the Michael E. DeBakey VA Medical Center (MEDVAMC), a high-volume tertiary care facility, a time-based PACU monitoring protocol for OSA patients was implemented a decade ago in the absence of national guidelines, requiring fixed recovery times of three hours after general anesthesia and 1.5 hours after monitored anesthesia care (MAC). While designed to enhance safety, this approach resulted in prolonged PACU stays and reduced throughput.

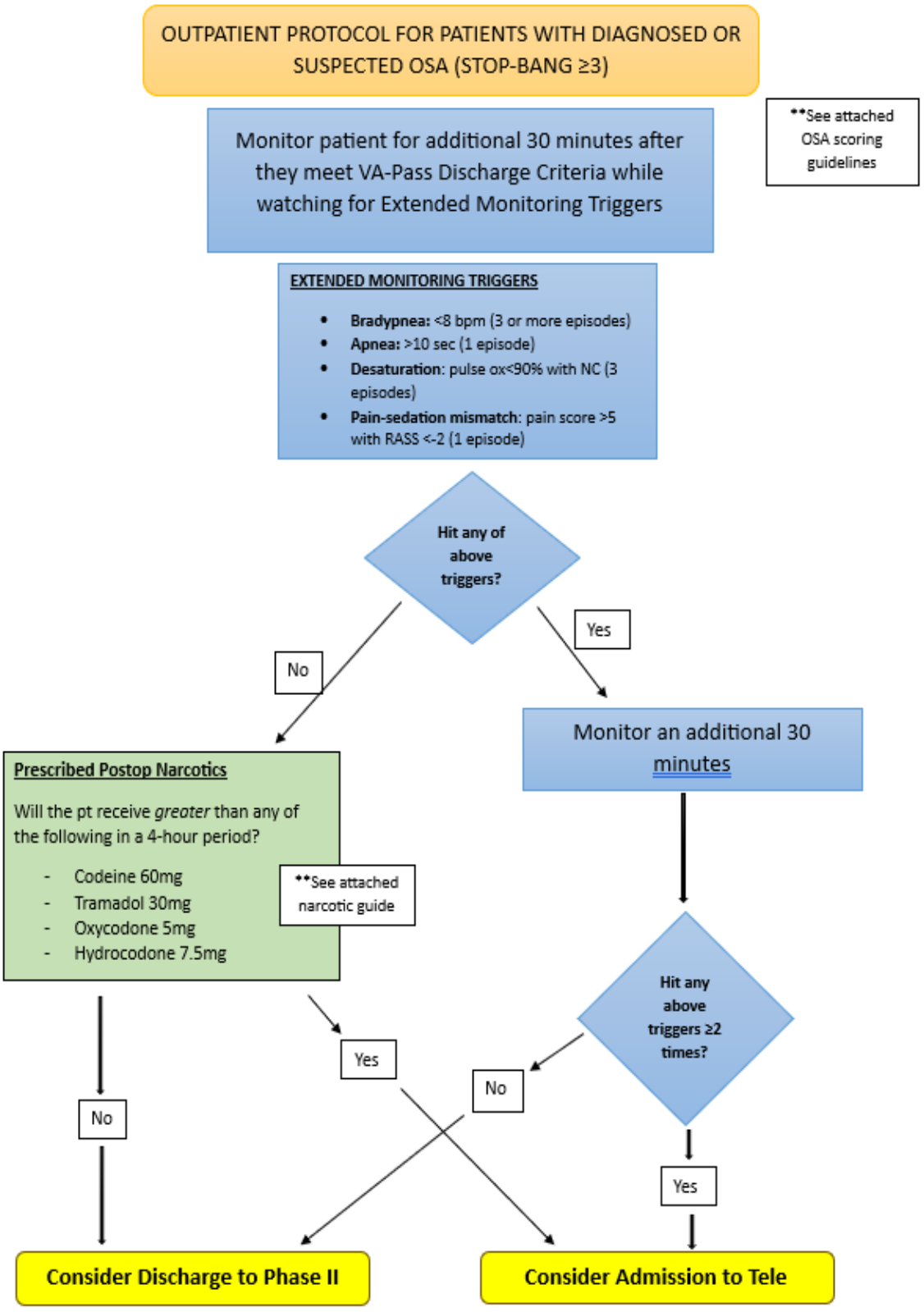
Methods

A new protocol based on the Mayo Clinic OSA discharge algorithm was developed, focusing on identification of “respiratory-specific events” associated with increased complication risk. See Figure 1 for protocol flowsheet. Documentation fields were added to the electronic medical record (Innovian) to facilitate standardized data capture. Six months after implementation, PACU

length-of-stay data were extracted for 647 OSA patients; after exclusion of documentation errors and extreme outliers, 617 post- implementation cases were analyzed and compared with 118 pre-implementation cases. Because distributions were non-normal, median recovery times were compared using a rank-sum test, stratified by anesthetic type

Results

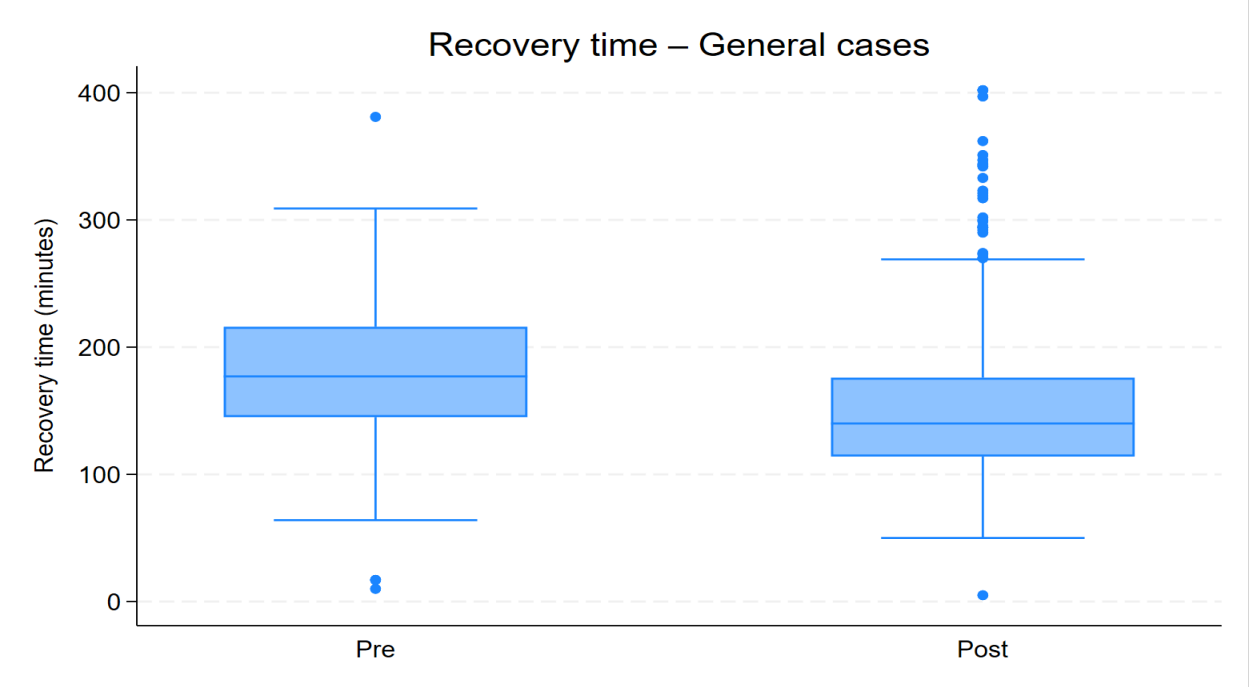
Among patients receiving general anesthesia, median PACU recovery time decreased significantly from 177 minutes pre-implementation to 140 minutes post-implementation ($p < 0.05$), a 37-minute reduction. No significant difference was observed for MAC cases (92 vs. 109 minutes; $p = 0.2$). See Figure 2 for results. Over six months, this reduction translated to approximately 308 cumulative hours of PACU time saved. Given that PACU time is estimated to cost between $2.50 and $13.00 per minute, this reduction corresponds to a savings of approximately $92 to $480 per patient. Ten patients required extended monitoring based on protocol criteria, and two were admitted for further care.


OUTPATIENT PROTOCOL FOR PATIENTS WITH DIAGNOSED OR SUSPECTED OSA (STOP-BANG ≥3)
**See attached OSA scoring guidelines
Monitor patient for additional 30 minutes after they meet VA-Pass Discharge Criteria while watching for Extended Monitoring Triggers
EXTENDED MONITORING TRIGGERS
Bradypnea: <8 bpm (3 or more episodes)
Apnea: >10 sec (1 episode)
Desaturation: pulse ox<90% with NC (3 episodes)
Pain-sedation mismatch: pain score >5 with RASS <-2 (1 episode)
Hit any of above triggers?
Yes
No
Monitor an additional 30 minutes
Prescribed Postop Narcotics
Will the pt receive greater than any of the following in a 4-hour period?
- Codeine 60mg
- Tramadol 30mg
- Oxycodone 5mg
- Hydrocodone 7.5mg
**See attached narcotic guide
Hit any above triggers ≥2 times?
Yes
No
No
Yes
Consider Discharge to Phase II
Consider Admission to Tele

Discussion

Implementation of an evidence-based OSA monitoring protocol significantly reduced PACU recovery time for general anesthesia patients while preserving patient safety. Ongoing collaboration with VASQIP will evaluate postoperative complication rates to confirm sustained safety and effectiveness.

Figure 2



Abstract 12 – Improving Identification of Patients at Risk for Obesity Hypoventilation Syndrome in a Veterans Affairs Sleep Fellows Clinic

Nicholas Shaffer, Victoria Wang, Makayla Cox, Joanna Lee, Candace Miyaki, Michelle Yun

Affiliations: Baylor College of Medicine, Texas Children's Hospital, Michael E. DeBakey VA

Poster Number 212

Aim Statement

Our primary aim was to increase the percentage of patients with BMI ≥ 35 kg/m2 who had documented review of a baseline serum bicarbonate (within 12 months) to ≥ 80% during the intervention period. Secondary aims included improving documentation consistency and identification of patients at risk for OHS.

Background

Obesity hypoventilation syndrome (OHS) is an underrecognized condition associated with increased morbidity and mortality if untreated. Serum bicarbonate is a widely available screening tool to identify patients at risk. In our clinic, screening and documentation in high-risk patients were inconsistent, suggesting a workflow reliability gap.

Methods

We implemented a BMI-triggered documentation section within the Veterans Affairs Sleep Fellows Clinic note template to prompt review and documentation of serum bicarbonate in at-risk patients. A BMI threshold of ≥ 35 kg/m2 targeted a population with increased OHS prevalence. The intervention was embedded into clinical workflows, allowing providers to review laboratory data and document reasoning without alerts.

Iterative refinement occurred through Plan-Do-Study-Act (PDSA) cycles over 6 weeks. We conducted a pre–post analysis comparing baseline data (July–

December 2025) to intervention data (January–February 2026). Data were obtained through Computerized Patient Record System chart review and tracked using a standardized tool.

Outcome measures included the percentage of patients with documented review of serum bicarbonate or appropriate ordering if unavailable. Process measures included use of the templated documentation section. Balancing measures included workflow efficiency and laboratory ordering.

Results

In the baseline cohort, 30.8% of encounters met BMI ≥ 35 criteria; among these, 94.5% had bicarbonate available, but only 7.1% had documented review.

During PDSA Cycle 1 (weeks 1–3), template introduction improved documentation to 75.5% (37/49), with 91.8% bicarbonate availability. Remaining gaps were mainly due to variation in provider interpretation and documentation.

During PDSA Cycle 2 (weeks 4–6), a refined template with explicit options and an email reminder improved documentation to 90.6% (29/32), with 93.8% availability. Laboratory ordering remained low, suggesting minimal increase in testing.

Discussion

The intervention exceeded the predefined target, demonstrating that embedding structured documentation into workflow improves reliability of OHS screening. Iterative refinement improved clarity and consistency. This was achieved without training, alerts, or disruptions, supporting feasibility in similar settings.

This project demonstrates that workflow-integrated documentation can improve screening reliability without increasing provider burden. This approach may enhance clinical decision-making by improving visibility of relevant laboratory data and reinforcing consistent, guideline-aligned evaluation. The approach is scalable and adaptable to other screening processes.

Abstract 13 – Early Implementation of a Survivorship Care Process in Rural Oncology Clinics: A Quality Improvement Initiative

Lilian Moraes de Vasconcelos, Isela Prado, Naima Rodriguez, Eugenie Pflieger, Elizabeth Kvale

Affiliations: Baylor College of Medicine

Poster Number 213

Aim Statement

The aim was to deliver structured SC to survivors reached during early implementation and assess feasibility of integration into routine clinic workflows.

Background

Rural cancer survivors face gaps in access to guideline-concordant survivorship care (SC), including preventive health counseling, symptom management, and coordination with primary care, increasing risk of unmanaged comorbidities and delayed complication detection. SC processes are inconsistently implemented in rural oncology settings due to multilevel barriers, including workflow constraints and challenges in operationalizing survivorship eligibility. In response, a structured SC process was introduced as a quality improvement (QI) initiative in a rural oncology clinic in Northeast Texas within a regional oncology network.

Methods

This QI initiative was conducted in rural oncology clinics serving survivors transitioning from active treatment. During early implementation, SC was delivered in person within clinic workflows. Interventions included staff training, establishment of workflows, nurse- led encounters, structured documentation, facilitated goal-setting aligned with survivorship guidelines, and delivery of survivorship care plans (SCP). Iterative refinements occurred through team feedback and observation. Local primary care providers (PCP) received targeted education to promote coordination with oncology teams.

Measures assessed feasibility and delivery. Because no systematic mechanism existed within the electronic health record to identify treatment completion, a reliable denominator of eligible survivors could not be established. Indicators included: (1) number of survivors receiving SC (with SCP delivery); (2) number of survivors establishing ≥1 preventive health goal and goal types; (3) number of treatment summaries delivered to PCPs; and (4) number of PCPs receiving training. Data were summarized descriptively. Ongoing qualitative evaluation examines contextual factors influencing implementation.

Results

To date, a total of 83 rural cancer survivors received in-person SC through implemented clinic workflows. Among survivors completing a survivorship encounter, 31 engaged in goal-setting, with some selecting more than one preventive health goal. Most common were physical activity (n = 19) and weight-related goals (n = 18); goal categories were not mutually exclusive. SC delivery and documentation were feasible within clinic workflows; however, population-level reach could not be quantified. Additionally, 19 local PCPs received academic detailing training on SC.

Discussion

Early implementation of a structured SC process in rural oncology clinics was feasible and enabled workflow testing and verification of system-level barriers to survivor identification. An evaluation is ongoing to guide refinement and future spread across rural oncology settings.

Abstract 14 – Standardizing Pediatric Blood Pressure Measurement Practices in the Ambulatory Setting to Accurately Identify Hypertension and Improve Service Utilization

Kelly Rhodes, Melissa Marshall, Aikaterini A. Nella, Ioanna D. Athanassaki, Sarah K. Lyons, Yuezhen L. Lin

Affiliations: Texas Children's Hospital

Poster Number 214

Aim Statement

Increase the rate of same-visit elevated BP rechecks from an average weekly rate of 11% to 30% in the pediatric Diabetes and Endocrine Clinic by December 31, 2025, through implementing evidence-based practices and standardizing the recheck process for elevated BP readings.

Background

Elevated blood pressure (BP) is frequently observed in pediatric ambulatory care settings. Distinguishing true hypertension from transient BP elevation related to appointment associated anxiety remains challenging. Variability in measurement technique and recheck practices increase the risk of misclassification, potentially leading to unnecessary parental concerns, inappropriate referrals, and/or avoidable diagnostic evaluations.

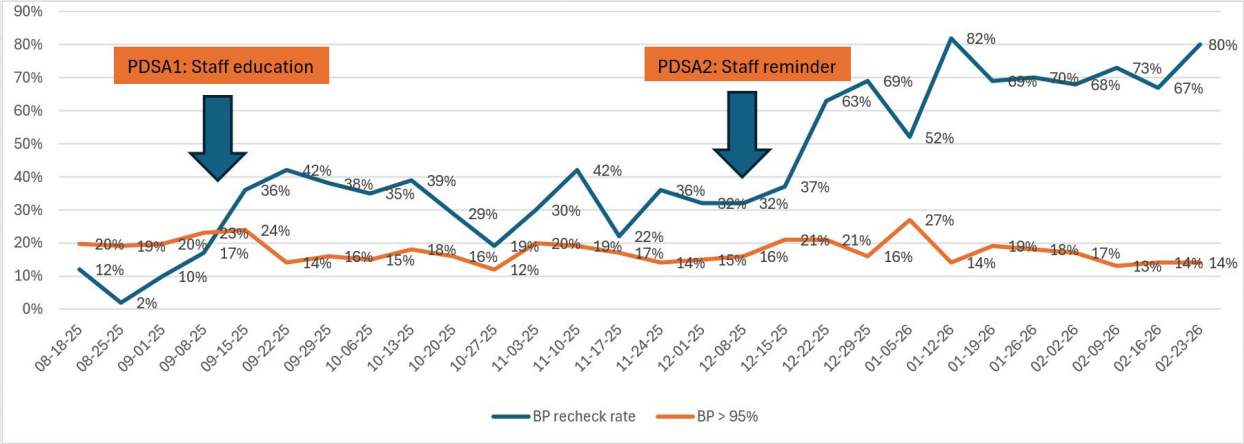
Methods

Prior to this Quality Improvement project, BP measurement techniques varied among clinic staff. A committee, comprised of the Nurse Educator and three clinic nurses, conducted a literature review and identified best practices. Plan-Do-Study-Act (PDSA) Cycle 1 included the development and implementation of a BP refresher course. All Medical Assistants and Registered Nurses completed the course. One key practice implemented was to automatically obtain a second BP reading when the initial reading was elevated, defined as greater than the 95th percentile for age, sex, and height, and flagged as an abnormal value in the electronic medical record.

Three months after course completion, the committee implemented PDSA Cycle 2, consisting of weekly reminders by the Nurse Manager to staff, reinforcing standardized BP measurement techniques to sustain practice change.

Results

Baseline data showed the average weekly recheck rate for elevated BPs was 11%. Following the refresher course, the average weekly recheck rate tripled. After implementing weekly reminders, the average weekly recheck rate rose to 56% by December 31, 2025, and from this goal date through Feb 23, 2026, rose even higher to 70%, indicating substantial improvement in adherence to best practices and a 6.4-fold increase from baseline. Concurrently, the proportion of elevated BP readings decreased from a weekly average of 21% pre-education to 17% from the goal date to Feb 23, 2025, reflecting a 19% relative reduction.



Discussion

Adopting evidence-based practices into standardized workflows, along with providing structured education and ongoing reinforcement, can enhance BP measurement practices in pediatric ambulatory care. By improving consistency in BP measurement practices and reducing the likelihood of misclassification, pediatric ambulatory clinics are better positioned to deliver high-quality, evidence-based care while minimizing unnecessary patient stress, referrals, and interventions. Further analysis is planned to evaluate the percentage of BP rechecks that resulted in normal readings.

Abstract 15 – Enhancing Obstetric Team Readiness for Maternal Cardiac Arrest Through Simulation-Based Defibrillator Education

Sarah Detlefs, Tara Barrick, Joseph Hagan, Michael Sparks, Brennan Lang

Affiliations: Baylor College of Medicine

Poster Number 215

Aim Statement

To evaluate whether a structured, simulation-based educational intervention improved obstetric staff proficiency in defibrillator use.

Background

Maternal cardiac arrest is a critical emergency requiring rapid recognition and coordinated response to optimize maternal and fetal survival. Despite widespread Basic Life Support (BLS) certification, institutional preparedness for cardiac arrest is inconsistent.

Methods

This was a repeated cross-sectional pre–post comparison of two cohorts from June 2023 to May 2025. The educational intervention included: (1) online defibrillator training; (2) hands-on skill stations covering defibrillator use and pad placement; and (3) team-based simulation emphasizing high quality CPR, coordinated pad placement, and safe shock delivery. Staff completed an objective BLS skills assessment prior to training (2023) and prior to annual education (2025). Skills were rated on a 5-point Likert scale and categorized as Proficient (scores 4–5) or Not Proficient (scores 1–3). Proportions were compared using Fisher's exact test.

Results

Among 272 staff evaluated (58 in 2023, 214 in 2025), no significant differences were observed in initial recognition and basic CPR measures (Table 1). Significant improvements occurred in defibrillator-specific skills: correct pad

placement increased from 37.9% to 77.1% ($p < 0.001$), clearing before shock increased from 74.1% to 92.5% ($p < 0.001$), and safe shock delivery increased from 81.0% to 93.9% ($p = 0.007$).

Table 1. Proportion Proficient in Basic Life Support Measures

Survey Item	Number (%) Proficient		P-value
	2023 (n=58)	2025 (n=214)	
Checks responsiveness	58 (100.0%)	203 (94.9%)	0.128
Activates emergency response system	56 (96.6%)	208 (97.2%)	0.800
Checks breathing	55 (94.8%)	191 (89.3%)	0.312
Checks pulse	53 (91.4%)	202 (94.4%)	0.372
Performs high quality chest compressions	57 (98.3%)	199 (93.0)	0.207
Gives 2 rescue breaths	54 (93.1%)	200 (93.5%)	1.00
Powers on defibrillator	33 (56.9%)	152 (71.0%)	0.056
Correctly attaches defibrillator pads	22 (37.9%)	165 (77.1%)	**<0.001**
Clears for analysis	44 (75.9%)	197 (92.1%)	**0.002**
Clears to safely deliver a shock	43 (74.1%)	198 (92.5%)	**<0.001**
Safely delivers a shock	47 (81.0%)	201 (93.9%)	**0.007**

Bold indicates significant difference.

Discussion

A structured educational intervention significantly improved staff readiness for maternal cardiac arrest and defibrillator use. Nonetheless, 22% of staff were unable to correctly place defibrillator pads and 29% were unable to proficiently turn on the defibrillator, possibly due to knowledge decay and the impact of staff turnover. These findings underscore the need for ongoing training to maintain competency in managing high-acuity, low-frequency events such as maternal cardiac arrest.

Abstract 16 - Evaluating Professionalism Matters: An Educational Initiative to Promote Professionalism in Academic Medicine

Aubrey Cui, Matthew Brandel, Ellen Friedman, Stacey Rose, Kelley Arredondo

Affiliations: Baylor College of Medicine

Poster Number 216

Aim Statement

To evaluate participant perceptions of the Professionalism Matters Grand Rounds sessions in promoting professionalism awareness and behavior across a 16-month period, with the goal of improving institutional professionalism.

Background

Professionalism is a foundational competency essential to patient safety, teamwork, and trust. Despite its importance, professionalism is difficult to cultivate and sustain within complex healthcare systems. Educational initiatives that promote reflection, ethical reasoning, and professional identity formation may strengthen professionalism; however, many lack systematic evaluation to inform continuous improvement. The Center for Professionalism at Baylor College of Medicine (BCM) developed Professionalism Matters as an interactive, educational session focused on practical strategies to enhance professionalism in academic medicine. This quality improvement project evaluated participant perceptions and intended practice changes to inform ongoing program refinement.

Methods

We conducted a descriptive quality improvement evaluation of Professionalism Matters Grand Rounds sessions at BCM in Houston, Texas, from January 2024 to April 2025. Participants included medical students, trainees, faculty, and staff who voluntarily attended professionalism presentations. A standardized post-session survey assessed participant characteristics, teaching effectiveness, content relevance, balance and objectivity, achievement of learning objectives, and perceived applicability to professional practice. Open-ended responses to

the prompt, “What is one practical lesson you plan to implement to promote professionalism?” were analyzed using thematic analysis to identify common themes. Quantitative responses were summarized using descriptive statistics.

Results

Participants reported high ratings of teaching effectiveness, relevance, and achievement of learning objectives. Among 264 open-ended responses describing intended practice changes, thematic analysis identified 10 themes. The most frequent theme was expressing gratitude to colleagues and patients (53/264; 20%), followed by improving communication quality through more mindful tone and respect (51/264; 19%). Additional themes included practicing self-reflection and accountability (46/264; 17%) and exercising empathy, compassion, and patience (45/264; 17%). Participants’ comments highlighted increased awareness of professionalism and intention to apply specific behaviors to improve workplace culture and interactions.

Discussion

This quality improvement evaluation demonstrates that a structured approach to professionalism education in an academic medical center was perceived as relevant, effective, and applicable to practice. Participants identified specific, actionable behaviors aligned with professional and patient-centered care. Systematic evaluation of professionalism programming can inform iterative improvement and support institutional efforts to strengthen professional culture, teamwork, and patient safety.

Abstract 17 - Multidimensional Quality Profiles of U.S. Dialysis Facilities: A Latent Profile Analysis

Jishu Zheng, Xiao Li, Jae Man Park

Affiliations: UT Health Houston

Poster Number 217

Aim Statement

This study aimed to identify latent dialysis facility performance profiles using multiple quality measure score indicators, evaluate whether profiles show meaningful separation on clinical outcomes, and assess whether ownership, network affiliation, and state context predict membership in the highest performing profile.

Background

Maintenance dialysis is a high-intensity, high-risk therapy requiring frequent weekly visits, making facility-level practices and care coordination critical determinants of preventable adverse events. Dialysis facility performance is typically summarized using single measures or aggregate scores, which may mask heterogeneity across quality domains and limit the ability to identify distinct performance patterns that could inform targeted quality improvement.

Methods

We conducted a cross-sectional latent profile analysis using Dialysis Facility Care Compare data from the Centers for Medicare & Medicaid Services, including 7,434 facilities. Latent profiles were estimated using nine standardized quality measure score indicators. Models with two to eight profiles were estimated using multistart optimization, and a four-profile solution was selected based on a prespecified parsimony rule requiring a minimum class proportion of 3 percent and adequate classification certainty. External validation used standardized readmission ratio, standardized transfusion ratio, and standardized hospitalization ratio measure scores and improvement ratios, summarized into a composite clinical quality index. Prediction of membership in the highest quality profile was evaluated using ridge logistic regression with ownership group, network affiliation, and state indicators.

Results

The highest quality profile included 1,987 facilities, representing 26.7 percent of the sample, and had the highest mean composite clinical quality index at 0.161. Classification certainty was high, with a mean maximum posterior probability of 0.903, and conditional independence assumptions were satisfied after domain aggregation, with a maximum within-profile absolute correlation of 0.378. Prediction of high-quality profile membership using ownership, network affiliation, and state achieved moderate discrimination, with a test-set Area Under the Curve of 0.683.

Discussion

Dialysis facilities exhibit distinct, multidimensional performance profiles that can support more targeted quality improvement by grouping facilities with similar cross-domain performance patterns and highlighting the role of organizational and geographic factors in shaping effective quality strategies.

Abstract 18 - Bridging the Evidence-Practice Gap Through a Weekly Evidence-Based Forum in Family Medicine

Kaveri Iyengar, **Savannah Sims**, Rekha Afzalpurkar, Juneja Malvika,

Affiliations: Baylor College of Medicine, Harris Health System - Ben Taub Hospital

Poster Number 218

Aim Statement

- Implement a feasible, low-resource model for integrating evidence-based medicine into routine outpatient family medicine practice.

- Apply a structured evidence-based medicine framework to formulate clinical questions, appraise evidence, and translate research findings into patient-centered care and enhance the learning of students and residents for EBM application for day-to-day clinical medicine practice.

- Identify strategies to embed brief, case-based EBM discussions within existing clinical workflows to promote lifelong learning and confidence building for all strong evidencebased practice for clinicians, residents and students.

Background

Family medicine clinicians, residents, and medical students must integrate rapidly evolving medical evidence into busy outpatient practice; however, time constraints and information overload often limit consistent application of evidence-based medicine (EBM) at the point of care. To address this challenge, we started the Weekly Evidence-Based Report (WEBR) as a brief, structured educational initiative to integrate EBM into routine clinical care within a medical school–based family medicine clinic serving a large, underserved population.

Methods

WEBR was launched in July 2025 as a recurring educational forum open to attending physicians, residents, and medical students. Sessions are concise, interactive, and casebased, emphasizing practical application of EBM across levels of training. Clinicians. residents, and students actively participate by

presenting cases, formulating focused clinical questions, and engaging in guided critical appraisal with faculty facilitation. The curriculum follows the EBM framework (ask, acquire, appraise, apply, assess) and aligns with the Evidence-Based Pyramid, prioritizing systematic reviews and randomized controlled trials. Topics include emerging public health issues, chronic disease management, diagnostic reasoning, preventive care, nutrition and exercise counseling, and responsible use of artificial intelligence in clinical decision-making.

Results

WEBR has addressed a wide range of clinically relevant topics, including infectious disease outbreaks, functional gastrointestinal disorders, complex diagnostic cases, oncology-related diagnoses, patient satisfaction strategies, and lifestyle-based prevention. Preliminary feedback from faculty, residents, and students suggests high satisfaction and perceived educational value, with participants reporting increased confidence in applying evidence-based medicine at the point of care and relevance to everyday clinical practice. A formal survey-based evaluation of learner and faculty outcomes is planned.

Discussion

WEBR is a feasible, low-resource, and scalable model that integrates faculty development with resident and student education. The model is readily adaptable to other family medicine clinics and residency programs and promotes a sustainable culture of evidenceb ased practice without requiring additional funding or protected time.

Abstract 19 - Peritoneal Dialysis at Ben Taub Hospital: Let's Make it the Option, Not the Exception

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Poster Number 219

Aim Statement

To increase the percentage of patients who receive documented education about peritoneal dialysis as a treatment option by 20% among patients initiated on dialysis at Ben Taub Hospital between January and May 2026.

Background

Peritoneal dialysis (PD) remains an underutilized option of treatment despite well-known clinical, quality of life, and cost advantages. Multiple reports have shown inadequate dialysis modalities education prior to dialysis initiation. Early and structured dialysis education is associated with PD initiation, better vascular access at hemodialysis starts, and lower mortality.

Current evidence supports a multidisciplinary approach to successfully increase PD utilization.

At Ben Taub Hospital, informal observations suggest that limited provider familiarity with PD, complex referral processes, and inconsistent documentation contributed to low PD uptake. Data from a 2024 quality improvement project indicated an increase in patients screening for PD from 28% to 76% and initiation rates from 3% to 20%, following the implementation of measures such as healthcare providers education, reminders, and patients counselling.

Methods

We conducted a retrospective review of all patients initiated on dialysis between January and June 2025. Collected variables included demographics, etiology of

kidney failure, documentation of PD counseling, patient's interest in PD, and dialysis modality initiated. In parallel, pre-intervention surveys were administered to nephrology providers to assess knowledge, comfort level, and training in PD, as well as their perceived barriers to PD use.

Using these findings, we implemented a Plan–Do–Study–Act (PDSA) cycle that included: (1) targeted educational sessions on PD for nephrology providers; (2) hands-on PD workshops for fellows focusing on prescription and complication management; (3) increased fellows' exposure through PD clinics and Quentin Mease rotations; (4) streamlined and standardized PD referral pathways; and (5) regular reminders emphasizing PD screening and documentation.

The primary outcome measured was the proportion of patients with documented PD education among those initiated on dialysis. Process measures included rates of PD referral, patient interest in PD, and PD initiation.

Results

Pre-intervention results: Among 77 patients initiated on dialysis, 59.7% males, 81.8 % Hispanics, PD counseling was documented in 43 patients (55.8%). Of the patients counseled, 23 expressed interests in PD; however, only 10 ultimately initiated PD. Attendance of the formal dialysis education program (Kidney SMART class) was low (20.8%). Provider surveys revealed higher comfort levels with hemodialysis compared to PD, as well as perceived barriers including lack of support, complexity of the referral process, and time required for education. Post-intervention data is currently being collected.

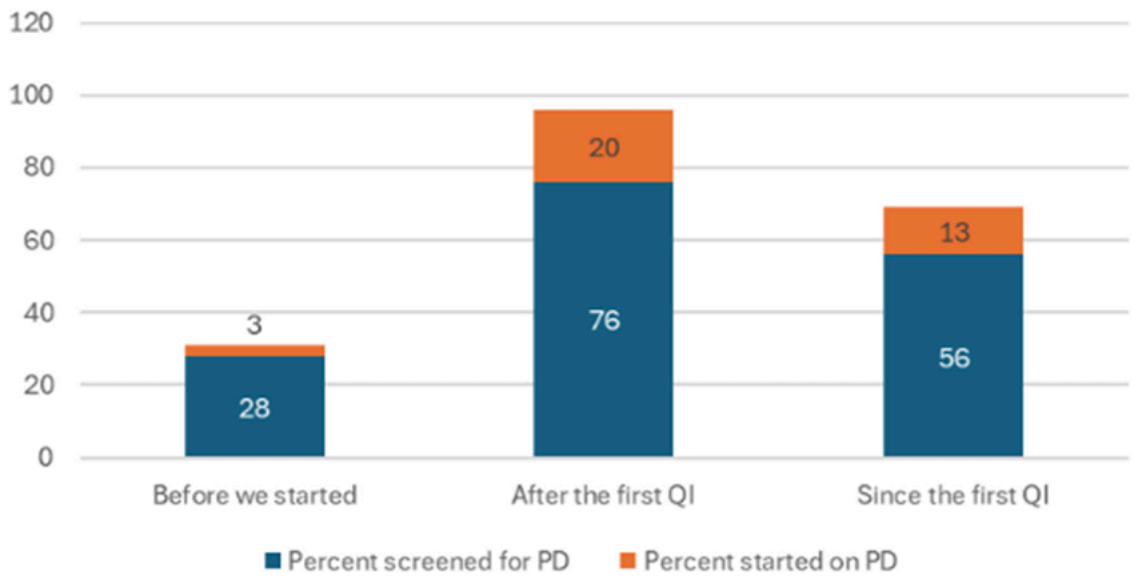


Figure 1: Percentage of Screened Patients and those initiated on PD

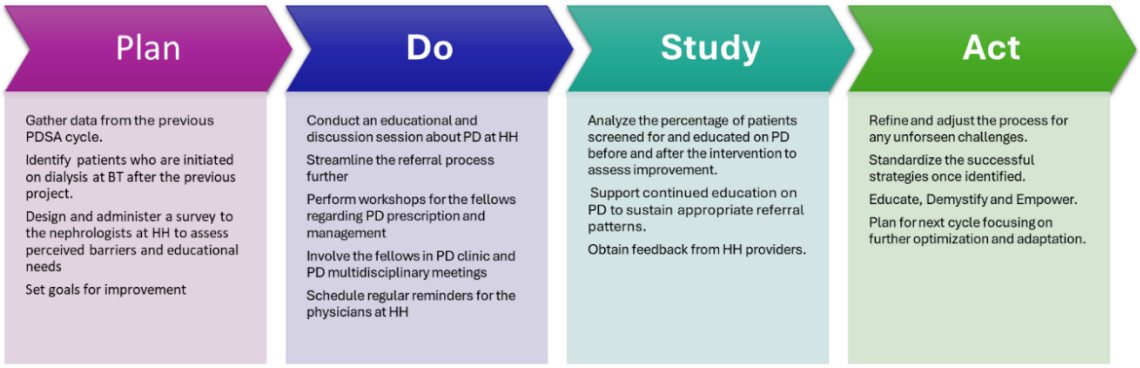


Figure 2: The PDSA Cycle

Discussion

PD underutilization at our hospital appears driven primarily by modifiable provider- and system-level barriers rather than lack of patients' interest. Structured education, increased provider's exposure, and simplified referral processes represent actionable targets for improvement. Ongoing PDSA cycles aim to achieve sustained increases in documented PD education and PD initiation.

Abstract 20 - Improving No-Show Rates in Outpatient Psychiatry Through Depression-Focused Intervention and Predictive Modeling

Afroz Shamim

Affiliations: Baylor College of Medicine, Harris Health System - Ben Taub Hospital

Poster Number 220

Aim Statement

Process measures

A: Improve no-show rates by 20% in 6 months by providing a memory card to 75% of patients with a PHQ-9 score over 10, attending a specialty Psychiatry clinic.

B: Develop a multilinear regression model for predicting no-show rates

Background

Outpatient Psychiatry in Harris Health System, a safety net establishment, caters to mental health needs of those with significant non-modifiable adverse social determinants of accessing healthcare. Historically, a no-show rate of 20%-50% has been reported, with specialty Psychiatry clinics experiencing the lowest no-show rates.

Relevance: Missed appointments are a source of distress for providers, cause economic loss for the healthcare system and interfere with patient care. Depression-related factors were addressed to help improve no show rates in Psychiatry clinics by providing a reminder of clinic contact numbers and a visual reminder to keep a thought journal.

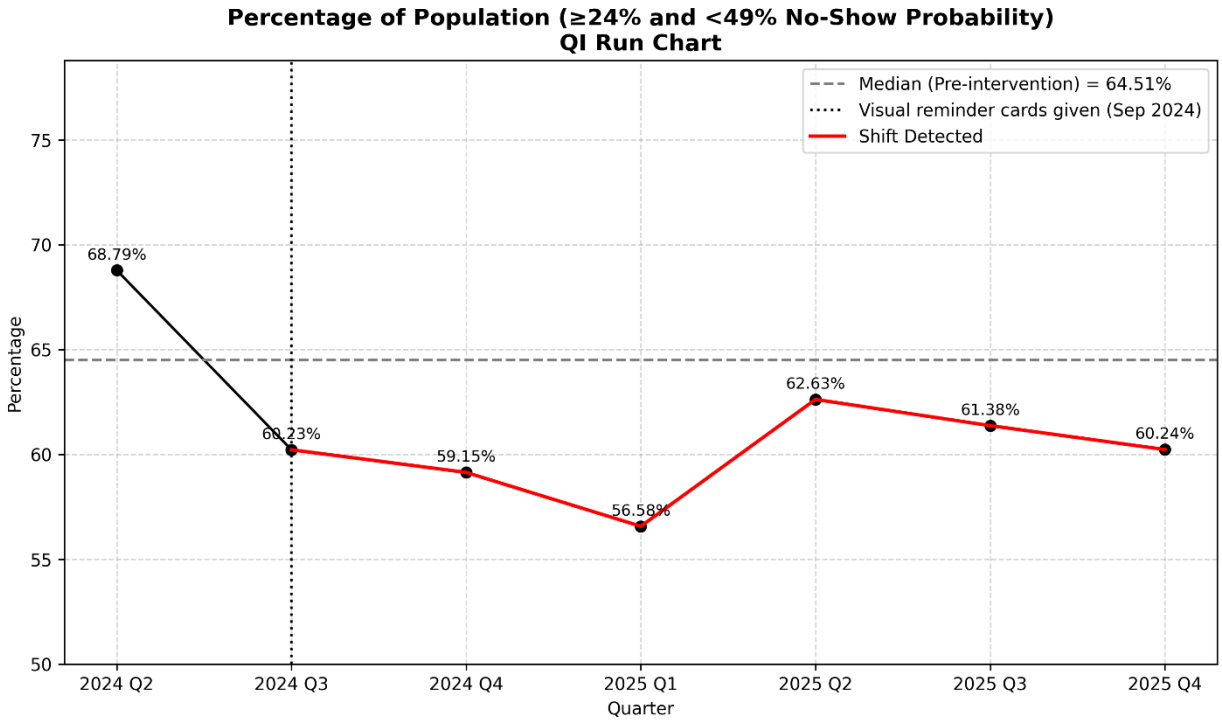
Methods

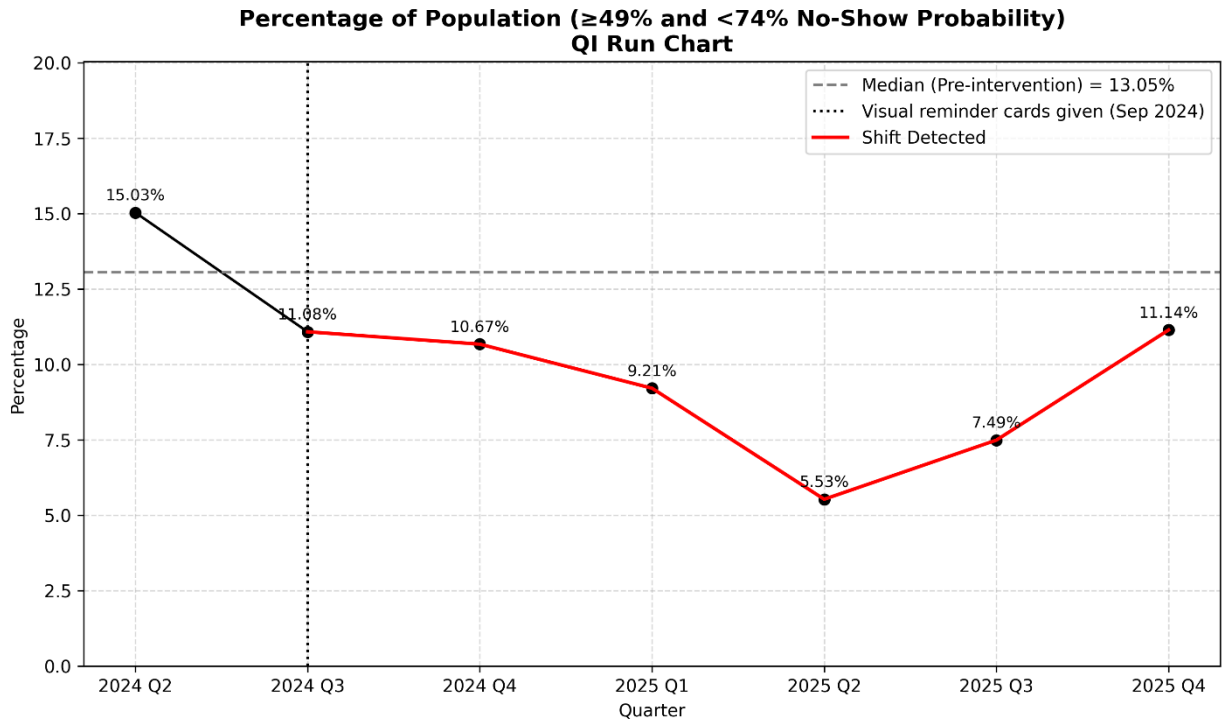
Social determinants and systemic factors were not considered for intervention. Based on a staff opinion poll about mental health symptoms, the severity of depression was identified as a potential risk factor for no-shows. In the first

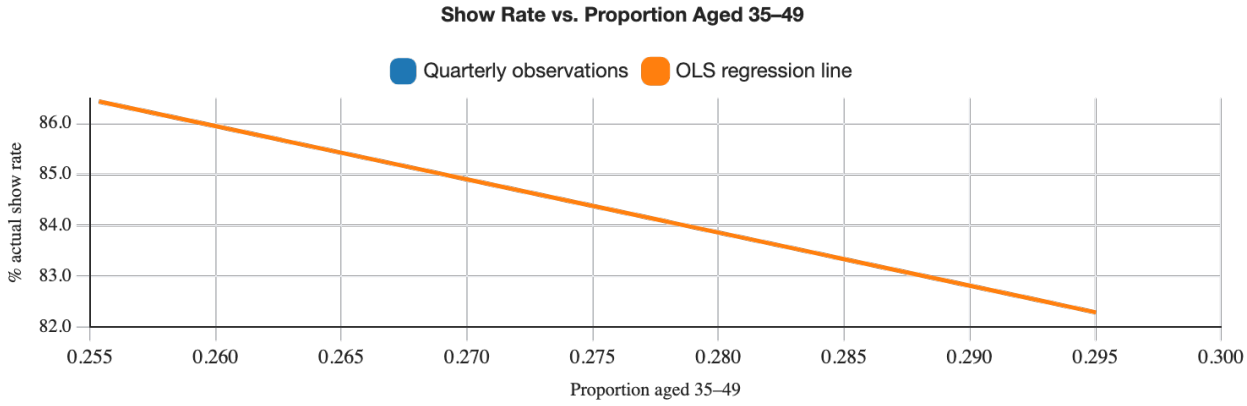
stage of the study, show rates from July 2024 through December 2024 were determined. This was followed by a 12-month period of providing a visual aid with a 30-second description aimed at depression treatment to all clinic attendees with a PHQ 9 score over 12. Run charts were used to visualize pre and post intervention show rates. Further, a multivariate analysis of quarterly no-shows was used to determine the correlation between patient demographics and no-show rates.

Results

1. Overall, 3880 visits were reviewed. The average no-show rate over the first 6 months was 15.1% which decreased to 14.4%. Although the change was only 4.6 %, a run chart of the proportion of patients with a prior no show-rate between 25-50% and between 50-75% showed a statistical trend towards decline.
2. The proportion of patients in the age group 35–49 showed a correlation coefficient of +0.84 (strong positive) with no-show rates. This and remaining results of the multivariate analysis were used to build a random forest model in an app that can help predict no-show rates.







Discussion

Further quantifying the role of severity of depression in determining show rates at a community clinic can help our (or any other future multivariate or AI based models) used to predict no-show rates in Psychiatry clinics, irrespective of social determinants of accessing care.

Abstract 21 - “Pulse Check”: Implementing a Decompression Huddle to Reduce Nursing Stress in a Pediatric Cardiac Progressive Care Unit

Michelle DeRusso, Brooke Hortness, William C. Sims, Christopher Sturrock

Affiliations: Baylor College of Medicine, Texas Children’s Hospital

Poster Number 221

Aim Statement

Global

• Increase the percentage of staff reporting reasonable job stress in the CPCU from 64% to 74% by the next annual survey.

Project Aim

• Complete a Pulse Check decompression huddle during 80% of CPCU shifts with at least 50% attendance among on-staff nurses and PCAs by December 5th. As a result, reduce the number of nurses staying past the designated clock-out time.

Background

Nursing stress and burnout remain major contributors to job dissatisfaction and turnover, particularly following the COVID-19 pandemic. Press Ganey survey results from the Cardiac Progressive Care Unit (CPCU) revealed high perceived stress and staffing concerns. Evidence suggests that structured team huddles can improve communication, morale, and psychological safety. We hypothesized that implementing a decompression “Pulse Check” huddle would strengthen team cohesion, reduce staff stress, and improve surrogate stress markers such as clock-out times.

Methods

A series of Plan-Do-Study-Act (PDSA) cycles guided development and implementation of the Pulse Check huddle. Baseline data were obtained through staff surveys (n=57), informal interviews, and Press Ganey results, highlighting

high stress and concerns related to staffing, recognition, and patient/family pressures. Process measures included percentage of completed huddles and attendance rates. Outcome measures included pre/post surveys, EPIC charting times, and Kronos clock-out patterns. Balancing measures assessed potential negative impacts, such as delays in task completion. Data were collected from September–December

Results

During PDSA cycles 3–4, huddles occurred during 51% and 48% of shifts, below the 80% goal. Participation varied by floor and shift, with some areas demonstrating greater consistency. Pre/post surveys showed a slight increase in perceived job stress reasonableness (3.64 to 3.3/5), likely influenced by concurrent unit acuity and staffing challenges. However, surrogate measures improved: perceived coworker support increased (3.95 to 4.25), and comfort reporting stressors to leadership improved (3.54 to 4.08). Clock-out patterns also shifted favorably, with nurses reporting “often/always staying late” decreasing from 49% to 23%.

Discussion

The Pulse Check huddle improved teamwork, communication, and perceived support despite inconsistent implementation. While global stress ratings did not improve, surrogate indicators showed meaningful gains in collaboration and workflow efficiency. This intervention shows promise as a sustainable strategy for mitigating nursing stress and will continue in the CPCU with planned refinements and potential spread to additional units.

Abstract 22 - Implementation of a Patient Educational Flyer to Improve At-Home Wound Dressing Compliance in the Ben Taub Osteomyelitis Wound Clinic

Eric Nguyen, Judy Amaya, Dora Glaser, Lorna Bautista, Adrienne Woods, Gladisel Valentin, Yuriko Fukuta

Affiliations: Baylor College of Medicine

Poster Number 222

Aim Statement

We aimed to increase documented at-home dressing compliance in BTOWC by at least 10 percentage points within 2 months.

Background

Patients with chronic wounds require strict adherence to prescribed at-home dressing changes to promote healing. Inconsistent adherence is associated with delayed healing and increased healthcare costs. Patients at BTOWC often face health literacy barriers and rely primarily on verbal wound care instruction. To address these barriers, we implemented a paper-based, standardized educational flyer embedded in the After Visit Summary (AVS) to improve dressing adherence and enhance clinic efficiency.

Methods

The intervention was a standardized, plain-language flyer (English and Spanish) reviewed each visit with visual step-by-step dressing instructions, rationale for adherence, resource information, and return precautions. To standardize documentation, a dressing compliance Epic SmartPhrase was introduced. The intervention was implemented in November 2025. For evaluation, we sampled 100 encounters each from October 2025 (pre-intervention) and January 2026 (post-intervention). Outcomes included documented dressing compliance (outcome measure), encounter time (balancing measure), and compliance documentation rates (process measure). End-user feedback was collected through surveys of BTOWC patients and therapists. Dressing compliance was

compared using chi-square analysis. Encounter time was compared using an independent two sample t-test.

Figure 1: Example page

Results

Dressing compliance was documented in 77 encounters during the pre-intervention period and 86 encounters during the post-intervention period. Encounter time was documented for all 200 encounters.

Documented dressing compliance improved from 75.3% (58/77) pre-intervention to 87.2% (75/86) post-intervention (p = 0.0506) (Figure 2).

Mean encounter time decreased from 36.6 minutes pre-intervention to 30.6 minutes postintervention (95% CI 2.5–9.4; p = 0.0008) (Figure 3). The therapists (n = 4) reported the flyer was helpful and easy to implement. Patient survey responses (n = 6) reported improved understanding of dressing instructions.

Figure 2: Dressing Compliance Pre vs Post (p = 0.0506)

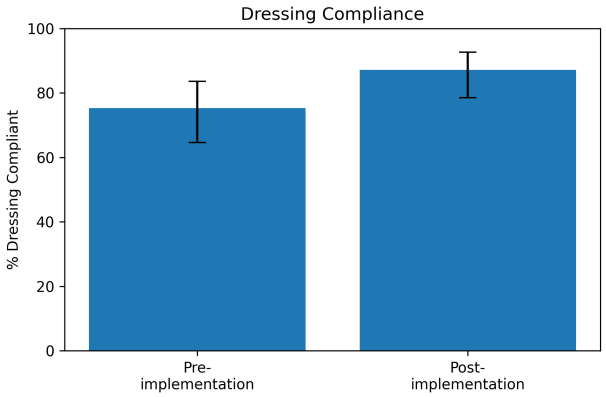
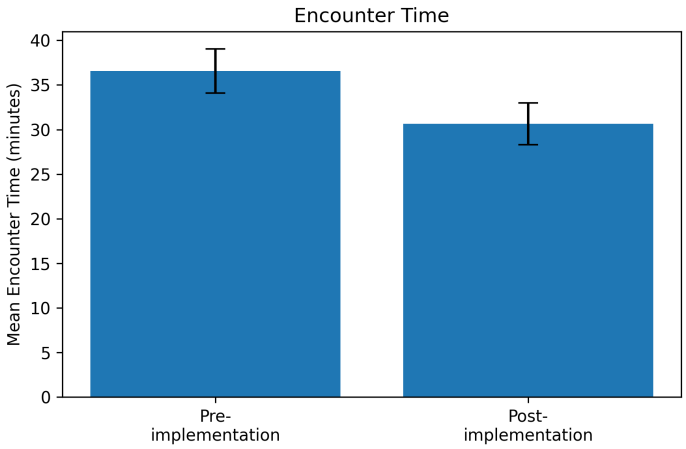


Figure 3: Encounter Time Pre vs Post (p = 0.0008)



Discussion

Implementation of a standardized educational flyer was associated with improved athome dressing compliance and a significant reduction in clinic encounter time. A second PDSA cycle will refine the intervention and assess sustainability and wound-healing outcomes.

Abstract 23 - Effect of Classical Music on Short-Term Blood Pressure Reduction in the Primary Care Setting

Isabel Valdez, Sydney Lavigne, Katherine Erdman

Affiliations: Baylor College of Medicine

Poster Number 223

Aim Statement

To improve the accuracy of blood pressure assessment by implementing a 6-minute classical music–guided rest period and evaluating its impact on repeat systolic and diastolic blood pressure readings among adult patients with elevated initial measurements at BMGIM McNair Clinic

Background

Hypertension (HTN) remains a leading modifiable risk factor for cardiovascular morbidity and mortality, affecting nearly half of United States (U.S.) adults. Despite widespread endorsement of both pharmacologic and non-pharmacologic interventions, many practices struggle to meet blood pressure (BP) control benchmarks. At Baylor Medicine General Internal Medicine (BMGIM) McNair Clinic, blood pressure control has plateaued at 67%, falling short of the 75.7% Quality Metric Target. Early research on classical music therapy suggests it could be a low-risk, cost-effective, non-pharmacological intervention for improving BP control in the clinical setting

Methods

This IRB approved (H-57645) quality improvement study was conducted over a four-week period. Participants were adults (≥ 18 years) with an initial triage BP ≥ 140/90 mmHg and without any self-reported hearing impairment. Participants were randomly assigned to sit in silence or listen to classical music for six minutes while repeat BP readings were recorded every two minutes. Descriptive statistics and t-tests were used to analyze group differences, and quality metric rates were reviewed to assess clinical impact.

Results

This IRB approved (H-57645) quality improvement study was conducted over a four-week period. Participants were adults (≥ 18 years) with an initial triage BP ≥ 140/90 mmHg and without any self-reported hearing impairment. Participants were randomly assigned to sit in silence or listen to classical music for six minutes while repeat BP readings were recorded every two minutes. Descriptive statistics and t-tests were used to analyze group differences, and quality metric rates were reviewed to assess clinical impact.

Discussion

Brief exposure to classical music during in-clinic BP measurements resulted in significant acute reductions in systolic BP compared to patients who sat in silence, with nonsignificant changes in diastolic pressure. These findings support the use of music as a simple, low-cost, and non-pharmacologic approach to reduce stress and improve BP readings during clinic visits. Further research with larger and more diverse samples is warranted to confirm and expand upon these results

Abstract 24 - Decreasing Discharge Turnaround Times

Marina Bishai, Veena Ramgopal, Laura Arreola Boehm, April Poncik

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 224

Aim Statement

This project aimed to reduce the average DTAT for patients hospitalized on the Pediatric Hospital Medicine (PHM) service, with respiratory diagnoses (Asthma, Pneumonia, Bronchiolitis) in WC Acute Care Units by 25% by June 30, 2025. The baseline DTAT for this group was 2.81 hours.

Background

Brief exposure to classical music during in-clinic BP measurements resulted in significant acute reductions in systolic BP compared to patients who sat in silence, with nonsignificant changes in diastolic pressure. These findings support the use of music as a simple, low-cost, and non-pharmacologic approach to reduce stress and improve BP readings during clinic visits. Further research with larger and more diverse samples is warranted to confirm and expand upon these results

Methods

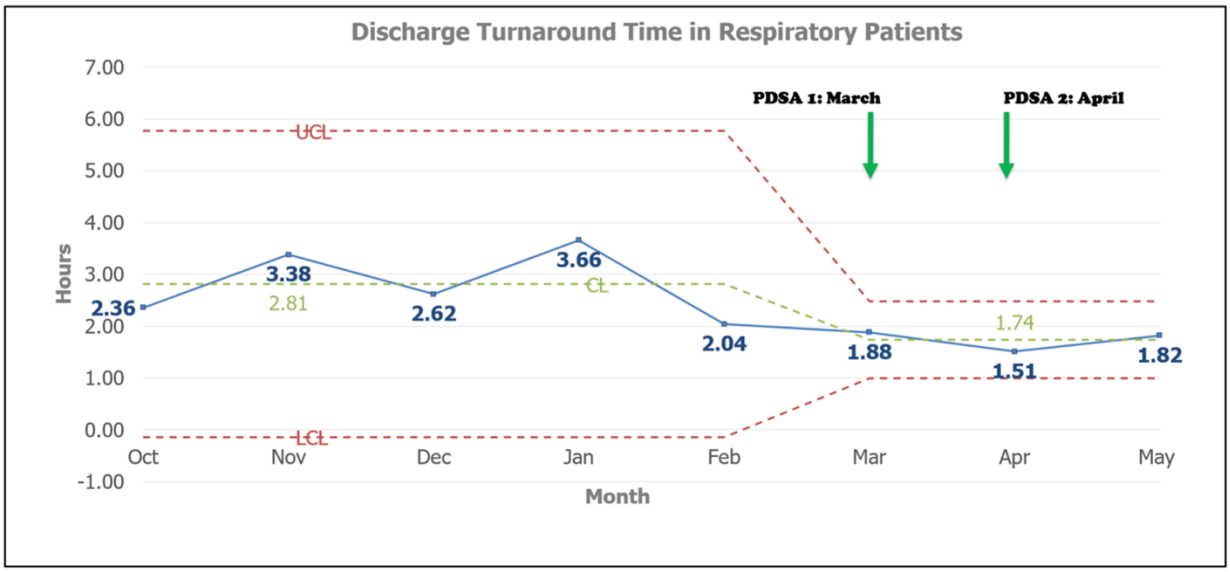
Using key driver and fishbone diagrams, we identified multiple factors contributing to discharge delays. In a survey of nurses and physicians, top barriers included transportation and use of conditional discharge orders. The first PDSA cycle provided targeted education to PHM physicians on the use of conditional discharge orders, focusing on documenting an expected discharge time. The second PDSA cycle focused on nursing education addressing common barriers such as lack of insurance, transportation issues, and discharge medications. Charge nurses added "Payor Status" to their Epic lists to identify uninsured patients. Bedside nurses completed "Discharge Preparedness Cards" to address barriers to transportation and discharge prescriptions. Primary outcome measures were DTAT, which is the time from expected discharge time to the patient leaving the unit, and the percentage of discharges completed in less than 2 hours. Documentation of expected discharge times was used as a

process measure. Readmission rates, patient satisfaction scores, and number of social work consults were used as balancing measures. Run charts and statistical process control charts were used for data analysis.

Results

Post-intervention, the average DTAT decreased to 1.74 hours—a 38% reduction, exceeding the project aim. We observed increased utilization of expected discharge times in orders, from 11% to 44% post-intervention. Discharges completed within 2 hours increased from 49% to 70%. Balancing measures, including social work consults, 30-day readmissions, and Press-Ganey scores, showed no significant changes.

Figure 1: Outcome Measures - DTAT



Discussion

This initiative successfully reduced DTAT for respiratory patients, demonstrating measurable improvement, sustainability and potential for system-wide spread. Ongoing feedback and collaboration with staff and leadership continue to support broader discharge process enhancements across the organization.

Abstract 25 - Reducing Delays in Management of Prolonged Seizures in the Epilepsy Monitoring Unit: A PDSA-Driven QI Initiative

Rane Schweta, Lu Lin

Affiliations: Baylor College of Medicine

Poster Number 225

Aim Statement

Decrease the time-to-treatment of prolonged seizures in EMU by 50% by June 2026.

Background

Prolonged seizures, require rapid treatment to prevent neurological injury and reduce morbidity. National guidelines necessitate benzodiazepine administration within 5 minutes of convulsive seizure onset. In the Epilepsy Monitoring Unit (EMU), where seizure induction is common, treatment delays of prolonged seizures are a preventable patient safety hazard. This Quality Improvement (QI) initiative aims to advance high-value care, patient safety and provider efficiency in Baylor St Luke's Medical Center (BSLMC) EMU.

Methods

Following IRB approval, we conducted a retrospective review of patients admitted to BSLMC EMU between January 2023–December 2024. Prolonged seizures were defined as seizures ≥5 minutes or recurrent seizures without return to baseline consciousness for ≥5 minutes.

Using a PDSA framework, the multidisciplinary team (physicians, nurses, EEG technologists, pharmacists) identified care gaps. Interventions implemented in June 2025 included seizure recognition and notification education sessions, a revised admission order-set with a rescue plan, and daily plan-verifying rounds. Post-intervention analysis was conducted between July–December 2025.

Primary outcome was time from seizure onset to intravenous (IV) lorazepam administration. Process measures included compliance with as-needed IV lorazepam orders at admission and time from order entry to administration.

Results

Pre-intervention analysis included 279 patients; 62 received IV lorazepam: 13 for prolonged seizures, 30 for brief seizures, 11 as bridging medication, 7 for non-seizure indications, and 1 during cortical mapping. Median administration time was 31 minutes overall and 29 minutes for prolonged seizures. 37% had as-needed orders on admission; others required new orders, with a 12-minute median order-to-administration time.

Post-intervention, 99 patients have been evaluated. Thirty-two patients received IV lorazepam, 2 for prolonged seizures, 5 as bridging medication, and the rest for brief seizures. The median administration time was 16 minutes overall and 23 minutes for prolonged seizures. As-needed IV lorazepam order was placed at admission in 93% of patients.

Pre- vs. Post-Intervention Data

	Pre-Intervention	**Post-Intervention**
IV lorazepam recipients	62	32
Patients with PRN lorazepam	37%	93%
Median IV lorazepam time (all)	31 minutes	16 minutes
Median IV lorazepam time (prolonged seizures)	29 minutes (N=13)	13 minutes (N=2)

Discussion

This QI project addressed operational delays in management of prolonged-seizures in EMU. Structured, team-based interventions significantly improved response time. Standardizing rescue protocols within electronic medical record (EMR) and staff education produced improvements in medication administration speed. Sustained monitoring and iterative PDSA cycles will guide further refinement and institutional spread.

Abstract 26 - A Quality Improvement Initiative to Improve Guideline-Concordant Metformin Use in Prediabetes

Eric F. Lee, Rekha Afzalpurkar, Eric T. Lee, Nadia Khera, Malvika Juneja

Affiliations: Baylor College of Medicine

Poster Number 226

Aim Statement

To improve adherence to ADA guideline–recommended metformin use in eligible patients with prediabetes through provider education and standardized clinical processes, with the goal of reducing insulin resistance and improving metabolic syndrome parameters.

Background

Metabolic syndrome is common among patients with prediabetes and significantly increases the risk of type 2 diabetes and cardiovascular disease. The American Diabetes Association (ADA) recommends metformin for diabetes prevention in selected high-risk adults with prediabetes; those with body mass index (BMI) ≥35 kg/m2, higher glycemic measures (fasting plasma glucose ≥110 mg/dL or HbA1c ≥6.0%), and individuals with a history of gestational diabetes. Despite these recommendations, metformin remains underutilized in primary care, particularly for metabolic risk reduction in underserved populations. Metabolic syndrome is defined by the presence of at least three of five cardiometabolic risk factors: increased waist circumference, elevated triglycerides, reduced HDL cholesterol, elevated blood pressure, and elevated fasting glucose. Insulin resistance is the unifying pathophysiology; therefore, addressing multiple components simultaneously may provide additive cardiovascular benefit. Metformin improves insulin resistance, weight, and glycemic parameters, making it a potentially valuable therapy in this population.

Methods

We conducted an ongoing quality improvement project in an underserved primary care clinic. An initial 6-month retrospective chart review identified patients with prediabetes (HbA1c 5.7–6.4%) who met ADA criteria for metformin but were not receiving therapy. Approximately 200 eligible patient charts were

reviewed. Providers were educated on ADA recommendations, and metformin was initiated during routine visits for patients who met criteria and consented to treatment. Standardized lifestyle counseling—including exercise guidance, nutrition referral, and waist circumference measurement—was incorporated into care workflows. The project is expanding clinic-wide, with planned enrollment of up to 500 patients. Outcomes being tracked include changes in fasting glucose, triglycerides, HDL cholesterol, blood pressure, waist circumference, weight, and BMI, as well as patientreported well-being and medication tolerance.

Results

Preliminary findings demonstrate improvement in multiple metabolic syndrome parameters, including reductions in fasting glucose, weight, BMI, and waist circumference, with favorable trends in blood pressure and lipid measures. Most patients reported improved well-being and tolerated metformin without significant adverse effects. Data collection is ongoing.

Discussion

This quality improvement initiative improved provider awareness and appropriate use of metformin for prediabetes per ADA recommendations. Early results suggest that timely metformin initiation, combined with lifestyle counseling, is associated with meaningful improvement in metabolic syndrome parameters and may serve as an effective cardiometabolic risk-reduction strategy in underserved primary care settings

Abstract 27 - Evaluating the Relationship between Adapt Survey Scores and Transition Success in a Pediatric Rheumatology Clinic

Jimin Kim, Kyla Blasingame, Karissa Chesky, Charles Lee, Alonzo Needum, Miriah Gillispie-Taylor, Tiphanie P. Vogel

Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 227

Aim Statement

To increase successful transition by identifying which ADAPT score components correspond with successful transition within the first 3 years of starting survey use.

Background

Young adults with chronic health conditions deserve an intentional transition from pediatric to adult care. We have standardized a process to prepare patients for transition from pediatric to adult rheumatology providers. Our pathway includes use of the validated Adolescent Assessment of Preparation for Transition (ADAPT) survey, delivered via EMR, to measure patients' self-reported transition readiness as well as determination of transition success based on a novel score.

Methods

We retrospectively reviewed a cohort of patients following transfer. We determined transition success, ascertained ADAPT completion rates, and calculated scores for ADAPT components for the latest survey completed. ADAPT responses were used to score 3 components—independent self-management (C1), knowledge of medications (C2), and planning for transfer (C3)—between 0 (low) and 100 (high). ADAPT components were unable to be scored (null) if patients did not meet inclusion for or did not answer every question of a component. Our novel transition success score requires 4 factors for successful transition: attendance at adult visits, medication refills with the adult provider, and the absence of rheumatology-related emergency department

visits in the first year after transfer. GraphPad Prism was used for statistical analysis (Mann-Whitney).

Results

Between 2022-2025, 94 patients were scored for transition success. Of these, 69/94 (73%) patients responded to at least one ADAPT survey. Only ADAPT results generated within 6 months of the final pediatric appointment (50/69, 72%) were included. The C1 median score was 75 (range 0-100), C2 was 100 (range 0-100), and C3 was 50 (range 0-75). Due to null assessments, C1 was scored 44/50 times, C2 31/50 times, and C3 only 13/50 times, and thus not further evaluated. Transition success was realized in 13/50 (26%) of patients. Patients who transitioned successfully had higher C1 scores than those who did not (C1 median of 100 versus 75, $p=0.0451$); C2 scores were not different ($p = 0.68$).

Discussion

We have developed a structured transition process that incorporates the ADAPT survey. Patients are encouraged, but not required, to take the ADAPT and self-assess their transition readiness. In this initial analysis, we found a significant association between independent self-management scores and transition success. Future work will investigate how to tailor our transition process so that provider-lead transition planning can improve patient self-management prior to transfer of care.

Abstract 28 - Pressure Injury Prevention in Neonates: A Focus on Continuous Electroencephalogram Monitoring

Haley Chambers, Myrna Garcia, Stacy Pedigo, Nana Funk, Neida Juarez, Leigh Ligas

Affiliations: Texas Children's Hospital

Poster Number 228

Aim Statement

Reduce cEEG-related HAPIs in NICU by 15%, from 2.1% to 1.8%, by 6/30/2024.

Background

Continuous electroencephalogram (cEEG) monitoring is a critical diagnostic tool used in neonatal intensive care units (NICU) to assess neurological function in newborns and premature infants. While essential, prolonged cEEG use—defined as lead placement for at least 24 hours—has been linked to hospital-acquired pressure injuries (HAPIs), posing a significant risk to patient safety.

Between January 2023 and January 2024, the NICU reported six cEEG-related HAPIs after a two-year period with zero incidents. Alarmingly, 50% of these injuries were classified as severe harm - Unstageable. This increase highlighted a need for targeted interventions to reduce pressure injuries associated with cEEG monitoring.

Methods

The project employed the Institute for Healthcare Improvement's Model for Improvement, focusing on understanding workflow processes through staff interviews and utilizing quality improvement tools such as fishbone and key driver diagrams. Outcome, process, and balancing measures were defined to assess the effectiveness of interventions and monitor unintended consequences.

Key changes included:

- Standardizing EEG lead assessments from a front-to-back to a back-to-front approach.
- Implementing a dual-person skin assessment protocol using QR code documentation
- (Neurophysiology Technician and bedside RN).
- Standardizing EEG lead removal procedures. • Using green skin markers to identify lead placement areas.
- Optimizing electronic health record documentation.
- Aligning policies and procedures with change in practice.

Results

The original aim was to reduce cEEG-related HAPIs by 15%, from 2.1% to 1.8%, by 6/30/2024. Outcome measures tracked the percentage of NICU patients with cEEG monitoring who developed pressure injuries, including severe harm cases. Process measures monitored compliance with dual assessments and documentation practices. Balancing measures ensured that interventions did not increase staff workload or disrupt care delivery. The original goal was exceeded with zero HAPIs by 6/30/24. One year later, 6/30/25, the HAPI rate dropped even further, with only one Stage 2 injury and the centerline decreasing from 0.021 to 0.003.

Discussion

This initiative reinforces a culture of safety and promotes evidence-based practices through multidisciplinary collaboration. By improving skin integrity and reducing recovery time, the project enhances overall care quality. Standardized protocols and improved communication between staff are expected to sustain long-term reductions in HAPIs and decrease length of stay for NICU patients.

Abstract 29 - The Power of a Ping: How Epic Chat Transformed Restraint Documentation Compliance

Jyothi Asokan, Jennifer Tran, Sini Mathew

Affiliations: Baylor College of Medicine, Harris Health System - Ben Taub Hospital

Poster Number 229

Aim Statement

The aim of this quality improvement initiative was to enhance physician compliance with non-violent restraint standards from a baseline of 49.1% in January 2025 to at least 90% by December 2025 by implementing a real time review process for physician documentation enhanced by standardized education, visual job aids, EMR-integrated prompts, and EPIC Chat communication.

Background

Physical restraints are a high-risk intervention requiring rigorous oversight precise documentation, and continuous monitoring to protect patients and staff. National data associate restraint use with higher in-hospital mortality, longer length of stay, and greater costs, while sentinel event reviews frequently implicate inadequate assessments, delayed monitoring, and protocol lapses as contributors to harm. At Ben Taub Hospital, our medically vulnerable, behaviorally complex population increase restraint utilization, and high-acuity workflows can lead to inconsistent documentation of restraint justification, physician face-to-face (F2F) evaluations, and timely reassessments. These gaps elevate risk for patient harm, regulatory non-compliance, and staff liability, underscoring the need for a structured, technology-enabled improvement strategy.

Methods

Quality Management established a multidisciplinary, real-time review process to monitor restraint activations and evaluate corresponding physician F2F notes for regulatory elements. When deficiencies were noted, immediate feedback was delivered via direct communication and targeted electronic outreach, including

streamlined EPIC chat messages to enable rapid provider response. To support sustainability, we delivered standardized provider education on restraint indications and regulatory requirements, developed visual job aids and EMR integrated prompts to guide note completion, and build tracking tools and dashboards to measure adherence to timelines and completeness.

Results

Documentation performance improved markedly following implementation. Compliance increased from 49.1% (January 2025) to 96% (January 2026). Rates of incomplete or delayed F2F assessments declined, and adherence to required elements improved across service lines, Clinicians reported greater clarity regarding expectation; EMR prompts, visual job aids, and EPIC chat outreach facilitated timely notification and correction of deficiencies, promoting more reliable documentation. Early internal audits demonstrated fewer restraint-related variances and reduced documentation-associated findings during readiness reviews, reflecting strengthened regulatory compliance and improved reliability of the restraint documentation process

Discussion

A real-time review process (reinforced by standardized education, visual job aids, EMRintegrated prompts, and EPIC Chat communication) was effective in improving the timeliness and completeness of physician F2F documentation for non-violent restraints. The intervention reduced variability, enhanced organizational compliance, and supported safer, more reliable restraint practices. Continued monitoring, ongoing education, and continuous optimization of EMR and EPIC Chat workflows are planned to sustain gains and further mitigate risk in high-acuity environments.

Abstract 30 - “Keeping Babies Warm”: A Quality Initiative to Decrease Rates of Hypothermia on Admission to the Newborn ICU in Premature Infants at Ben Taub Hospital

Lyca Intal, Selina Bowler, Mary Rouse, Gabriella Abouelkheir, Meghan Cusack, Harshkumar Patel, Kelli Phillips, Leilani Jovero, Daniela Dinu, Lisa Owens, Catherine Gannon, Joseph Garcia-Prats, Pablo Lohmann

Affiliations: Baylor College of Medicine

Poster Number 230

Aim Statement

To reduce the rate of hypothermia (<36.5C or 97.7F) in infants <36 weeks gestational age admitted to Ben Taub Hospital’s Level III NICU by 10% from a baseline of 25.3% by May 2026 through staff education and standardizing thermoregulation practices at deliveries and admission.

Background

Admission hypothermia, defined as temperature <36.5C (97.7F), is associated with increased morbidity and mortality in neonates. Premature infants are particularly vulnerable due to larger surface area-to-body mass ratio, reduced subcutaneous fat and immature thermal regulation. Hypothermia increases the risk of hypoxia, hypoglycemia, metabolic acidosis, intraventricular hemorrhage, sepsis, respiratory distress and death. Evidence-based strategies to prevent hypothermia include the use of pre-warmed radiant warmers, hats, blankets, plastic wraps and chemical warming mattresses for infants <32 weeks' gestation, keeping patient dry, transport incubators and maintaining delivery room ambient temperature (74-77F).

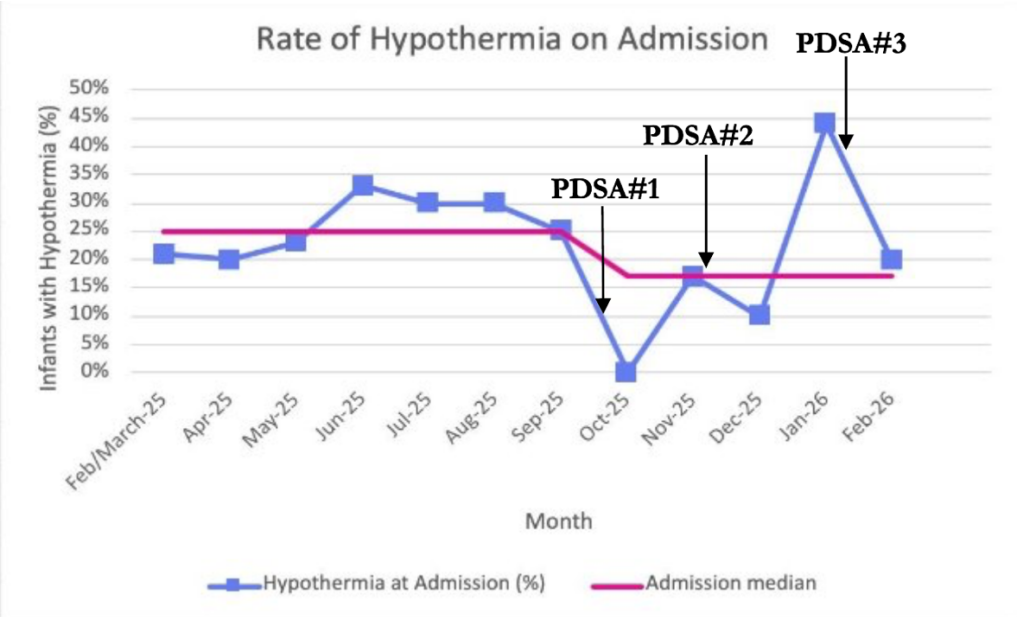
Methods

The quality improvement initiative was conducted at Ben Taub Hospital’s Level III NICU. A team of fellows, neonatologists, and nursing leadership identified contributing factors, and performed a fishbone analysis. A retrospective review established baseline hypothermia rate in infants <36 weeks admitted between February and September 2025. Three Plan-DoStudy-Act (PDSA) cycles were

performed over five months targeting key drivers: standardizing thermoregulation practices and staff education. Interventions included a delivery room thermoregulation checklist and weekly staff education sessions. The primary outcome measure was the rate of neonatal hypothermia on admission. This project was approved by BCM IRB.

Results

Baseline admission hypothermia rate was 25.3% (20/79). After completing three PDSA cycles (October 2025 to February 2026), the rate of hypothermia decreased to 17.1% (7/41). A similar rate of hyperthermia (>99.5F) was observed before, 2.5% (2/79), versus after the interventions, 2.4% (1/41). 83% (59/71) NICU staff members received education with 95.5% (42/44) compliance with weekly education sessions.



Discussion

Initial PDSA cycles established standardized thermoregulation protocols and delivery checklist where none previously existed, providing a vital framework for thermal regulation in the labor and delivery unit and NICU. Preliminary results identified operating room temperature as a key association with neonatal hypothermia, with 90% of hypothermic infants originating there. Future interventions will focus on interdisciplinary collaboration with OB/operating room leadership to address environmental factors to this setting and expanding staff education.

Abstract 31 - Two-Year Outcomes of a Focused Hypertension Clinic in a Medically Underserved Population

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Affiliations: Baylor College of Medicine, Harris Health System - Ben Taub Hospital

Poster Number 231

Aim Statement

To evaluate whether patients attending the weekly HTN clinic in 2025 demonstrated significant improvement in systolic and diastolic blood pressure within 6 months of enrollment, and to assess whether the magnitude of BP reduction and control rates were comparable to the 2024 cohort.

Background

Hypertension control rates remain suboptimal despite established treatment guidelines. Competing visit priorities and delayed medication intensification contribute to poor blood pressure (BP) control. In 2024, our clinic implemented a weekly single-issue hypertension (HTN) clinic dedicated to focused BP management. Initial evaluation demonstrated significant BP reduction and improved control rates. Ongoing assessment is needed to determine sustainability.

Methods

This retrospective quality improvement study included patients referred to a weekly Thursday afternoon HTN clinic managed by two primary care physicians. Eligible patients were aged 18–85 years, prescribed at least one antihypertensive medication, and had a most recent BP >140/90 mmHg. Pregnant patients and those receiving dialysis were excluded.

The 2024 cohort (n=37) was previously analyzed. The 2025 cohort consisted of patients newly referred during the 2025 calendar year (n=33).

The intervention consisted of focused visits dedicated to medication titration, adherence review, and lifestyle counseling.

Baseline BP was defined as the measurement at the first HTN clinic visit in the calendar year. Final BP was defined as the first outpatient BP recorded within 180 days after the last HTN clinic visit. Primary measures were mean change in systolic BP (SBP) and diastolic BP (DBP). A secondary measure was the proportion achieving BP <140/90 mmHg per HEDIS definition. Paired t-tests were used to assess change.

Results

In 2024 (n=37), mean SBP decreased from 154.4 to 138.9 mmHg (Δ = 15.5 mmHg, $p<0.001$). Mean DBP decreased from 94.4 to 87.4 mmHg (Δ = 7.0 mmHg, $p<0.001$). 56.8% achieved BP <140/90 mmHg.

In 2025 (n=33), mean SBP decreased from 146.7 to 135.9 mmHg (Δ = 10.8 mmHg; 95% CI 3.6–18.0; $p=0.004$). Mean DBP decreased from 80.0 to 76.1 mmHg (Δ = 4.1 mmHg; 95% CI −1.1 to 9.2; $p=0.12$). 48.5% achieved BP <140/90 mmHg.

Discussion

Patients attending the 2025 HTN clinic demonstrated significant SBP reduction consistent with 2024 findings, supporting reproducibility of the intervention. DBP reduction in 2025 was smaller and did not reach statistical significance, likely reflecting lower baseline DBP levels and reduced physiologic room for improvement. Control rates were similar across years. Focused hypertension visits may help improve BP control within routine primary care.

Abstract 32 - From Metrics to Meaning: Using HBIPS Measures to Drive Addiction Education and Quality Improvement

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Affiliations: Baylor College of Medicine, Harris Health System - Ben Taub Hospital

Poster Number 232

Aim Statement

To improve performance on HBIPS-SUB-2, HBIPS-SUB-2a, and HBIPS-TOB-3a while enhancing resident and staff education in alcohol use disorder screening, intervention, and referral.

Additional Objectives

A secondary goal was to improve tobacco screening and cessation treatment. Resident education was provided on FDA-approved treatments for tobacco use disorder.

Background

Hospital based inpatient psychiatry service (HBIPS) measures are widely used to assess inpatient psychiatric quality but are often treated as administrative tasks rather than integrated into clinical education. Structured approaches are needed to align HBIPS-driven quality improvement with training in substance use disorder (SUD) screening, brief intervention, and referral to treatment.

Methods

We implemented multimodal staff and resident training, revised EHR templates to prompt screening and discharge documentation, conducted chart reviews with feedback, and compared pre- and post-intervention HBIPS reports. Reports from 07/01/2023 to 12/31/2025 were analyzed with percent change in multiple HBIPS sub-categories calculated.

Results

HBIPS-SUB-2 and SUB-2a performance significantly improved, with increased documentation of screening, brief intervention, and referral to addiction treatment at discharge. Tobacco screening and treatment documentation also improved. The following percent change were found from 7/01/2023 to 12/31/2025: 312.87% for HBIPS-SUB-2, 113.30% for HBIPS-SUB-2a 34.13% for HBIPS-TOB-3a

Discussion

Integrating HBIPS measures into educational and documentation workflows improved regulatory compliance and addiction psychiatry training. This approach is replicable and may enhance patient outcomes and trainee competency.

Abstract 33 - Standardizing Postoperative Aortic Surgery Care through a Clinical Pathway to Reduce Length of Stay and Readmissions

Brittany Rhoades, Gilda Martinez, Marc Moon

Affiliations: Baylor College of Medicine

Poster Number 233

Aim Statement

The aim of this quality improvement project is to implement a standardized clinical pathway for postoperative aortic surgery patients to reduce average LOS by 2 days (from 14 to 12 days) and 30-day readmission rates to less than 10% within 6 months of pathway implementation.

Background

Individuals undergoing aortic dissection and aneurysm repair represent a highly complex surgical population that requires coordinated, multidisciplinary postoperative care. In a large academic medical center, postoperative management practices—such as timing of chest tube removal, pacing wire removal, wound vac discontinuation, and discharge planning—are guided by clinician expertise but may vary across providers. This variability presents an important opportunity to enhance consistency in care, strengthen nursing communication, and better align patient expectations with postoperative milestones. Institutional data demonstrate an average length of stay (LOS) of 14 days and 30-day readmission rates of up to 25% among patients undergoing aortic surgery, suggesting potential benefits of a standardized, nursing-driven postoperative clinical pathway designed to optimize recovery, improve care predictability, and support timely discharge.

Methods

This project utilizes a Plan–Do–Check–Act (PDCA) framework to design, implement, and evaluate a standardized inpatient aortic surgery pathway. Primary outcome measures include average LOS and 30-day readmission rates for patients undergoing aortic surgical interventions. Process measures include

pathway adherence and nursing knowledge of postoperative aortic care, assessed through staff surveys. Interventions include developing a multidisciplinary postoperative aortic pathway outlining standardized timelines for routine postoperative milestones and delivering targeted nursing education. These interventions are intentionally aligned to impact the selected measures by reducing care variability, improving interdisciplinary communication, and enhancing nurse-led patient education regarding the plan of care and anticipated discharge milestones.

Results

Outcomes will be evaluated by comparing LOS and readmission rates before and after pathway implementation. Secondary outcomes include improvements in nursing knowledge and patient satisfaction related to clarity of postoperative expectations.

Discussion

Standardizing postoperative aortic surgery care through a clinical pathway has the potential to improve consistency of care, reduce LOS and readmissions, enhance patient satisfaction, and generate substantial cost savings. This nurse-led intervention supports sustainable improvements in quality, efficiency, and patient-centered care for a high-risk surgical population.

Abstract 34 - Seeing the Whole Patient: A Unified Dashboard Advancing Stroke Safety

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Poster Number 234

Aim Statement

Develop and implement an automated, real-time Stroke Outcomes Dashboard that integrates ICD-10 stroke cohorts with patient safety harm events (falls, CAUTI, CLABSI, VAE) to improve visibility, accuracy, and timeliness of monitoring. The goal was to reduce manual data collection by at least 50% and enable earlier interventions for outcome trends.

Background

Following a DNV finding that the organization lacked systematic tracking of quality metrics for stroke patients, a major gap was identified: harm events—falls, CAUTI, CLABSI, and VAE—were occurring across multiple units, yet outcome data remained siloed and inaccessible in a unified, stroke-specific view. This fragmentation limited transparency, delayed quality review, and hindered targeted intervention. Addressing this need aligned with national priorities to reduce preventable harm in high-risk populations and the industry's shift toward automated, interdisciplinary analytic tools.

Methods

To address fragmented visibility into stroke patient harm events, our team developed an automated Stroke Outcomes Dashboard that consolidates fall, CAUTI, CLABSI, and VAE data for all ICD-10–identified stroke encounters. We began by mapping the data flow across existing reports, validating definitions, and aligning outcomes to national safety guidelines and internal quality priorities.

A data-driven approach guided each step: historical harm event trends, unit-level variability, and stroke-specific volumes informed which metrics to prioritize

and how to structure filters for usability. Collaboration with Clinical Informatics enabled automated extraction of ICD-10 stroke cohorts and integration with infection prevention and patient safety event sources.

Methods included detailed metric validation with Quality and Infection Prevention teams, weekly cross-walks with Epic reporting tools, and iterative user-acceptance testing with nursing and stroke program leaders. Metrics incorporated quantitative measures (event counts, event rates per 1,000 patient days, encounter-level outcomes) and qualitative insights from frontline staff on workflow gaps that influenced harm risk.

Results

The dashboard significantly improved visibility and timeliness of harm event monitoring. Manual data gathering time decreased by more than 75%, and completeness of outcome documentation improved. The stroke program achieved multiple months with a zero harm event rate among primary stroke diagnosis patients. Frontline staff reported clearer insights into trends and contributing factors, enhancing multidisciplinary discussions during safety rounds and leadership reviews.

Discussion

Transforming a previously fragmented process into a unified, automated tool strengthened accuracy, consistency, and responsiveness. Real-time, interactive visualizations improved interpretability and operational relevance for teams. Quantitatively, the dashboard reduced manual data gathering time by more than 75%.

Abstract 35 - Improving Continuous Glucose Monitor Utilization in Type 1 Diabetes Through Early Adoption in the Inpatient Setting

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Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 235

Aim Statement

Over 50% of patients with recently diagnosed T1D will use a CGM within 3 months of diagnosis by December 2021 from a baseline of 30% in 2019.

Background

Continuous glucose monitors (CGMs) are the standard of care for Type 1 diabetes (T1D), improving glycemic control, reducing hypoglycemia, sharing data with caregivers and providers to optimize care, and decreasing diabetes distress. Despite these benefits, significant barriers to use exist including cost, insurance coverage, provider hesitations and patient factors. Through early introduction to CGM at diagnosis, we worked to increase CGM use for patients with newly diagnosed T1D.

Methods

Patients with T1D managed by pediatric endocrinology at Texas Children's Hospital were identified through electronic medical record and QlikView dashboard. CGM utilization was tracked monthly and stratified by date of diagnosis, payor type, and race/ethnicity. Interventions were implemented through plan, do, study, act (PDSA) cycles, including 1) Partnering with CGM companies to provide 1 month of samples for all newly diagnosed diabetes patients; 2) Submitting CGM prescriptions prior to discharge; 3) Revising inpatient documentation to support CGM insurance authorization; 4) Adjusting diabetes education to include CGM setup, use, and data sharing (family members and clinic); 5) Standardizing actionable CGM alerts to avoid alarm fatigue. Balancing measures included survey of diabetes educators to assess post-discharge call burden and perceived caregiver anxiety.

Results

Our SMART goal was achieved and surpassed in 2021, with sustained increases thereafter. From 2019 to 2026, among recently diagnosed patients (<3 months from diagnosis), CGM use increased from 57% to 95% in privately insured patients and from 8% to 89% in publicly insured patients.

From 2019 to 2026, the absolute gap in CGM use between privately and publicly insured patients decreased from 49% to 6%. Within this same period, CGM utilization within race/ethnicity also improved, rising from 53%, 18%, and 22% in 2019 for Non-Hispanic White, Black and Hispanic patients, respectively, to 95%, 74% and 70% in 2026. Despite these improvements, racial and ethnic differences persisted independent of insurance status. Overall, CGM use among newly diagnosed patients has been sustained >80% since 2024.

Discussion

Through a multidisciplinary quality improvement initiative incorporating standardized CGM initiation, iterative PDSA cycles, and continuous process evaluation, we achieved sustained increases in CGM utilization in patients with new onset T1D. Insurance payor-related differences in use narrowed following implementation. Persistent racial/ethnic disparities independent of payor type suggest that additional equity-directed strategies are necessary to address barriers beyond coverage and workflow optimization.

Abstract 36 - Satisfaction of In-Service Nurse Education for Venous Thromboembolism Prevention

Nicholas Balbin, Matias Cattani, Jackson Dabagia, Teresa Lyons, Theodore Carlin, Connor Welsh, Atif Iqbal, Todd Rosengart

Affiliations: Baylor College of Medicine, Baylor St. Luke's Medical Center

Poster Number 236

Aim Statement

To evaluate the satisfaction of VTE prophylaxis education among nurses using a 5 star rating system, with scores of 4 or 5 stars being determined as satisfactory within the education period of the VTE prevention project at BSLMC.

Background

Venous Thromboembolism (VTE) is a serious but preventable complication of hospitalization through mechanical and chemical means of prophylaxis, and nurses can play a key role in their prevention. Although previous studies have shown subjectively high satisfaction with education towards VTE prophylaxis, nursing in-service education has generally shown variable satisfaction.

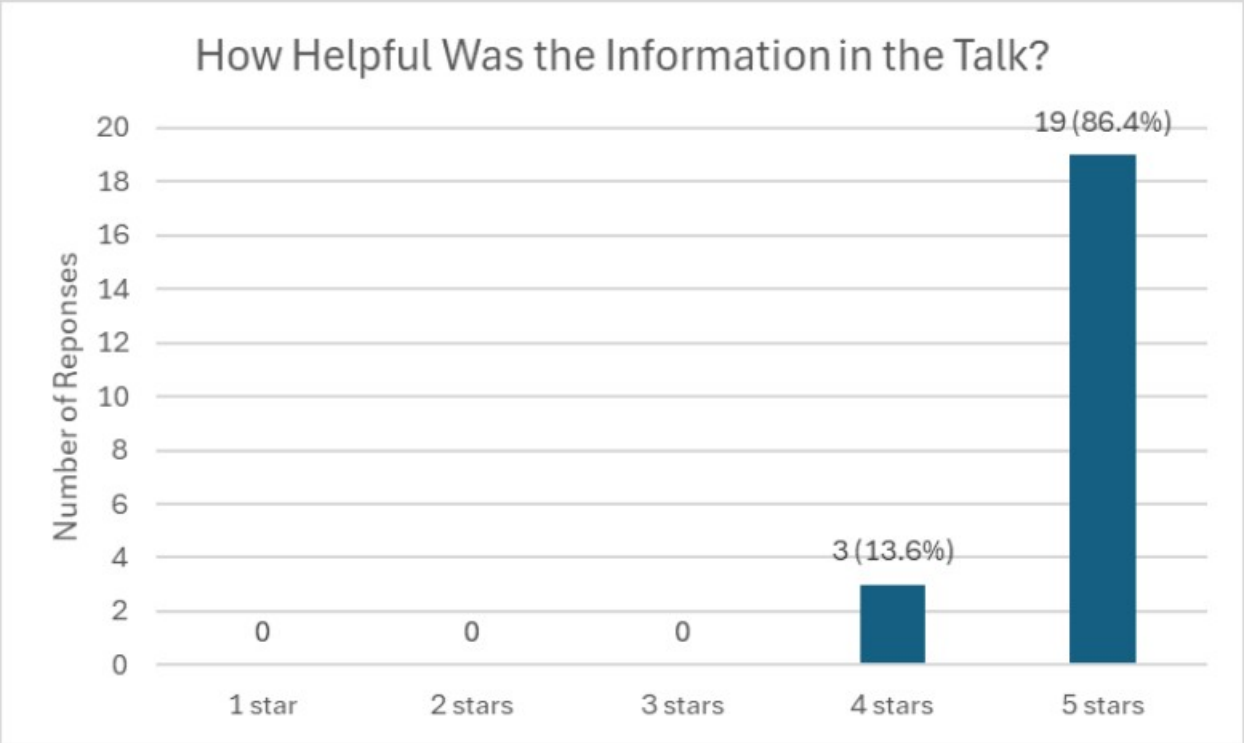
Methods

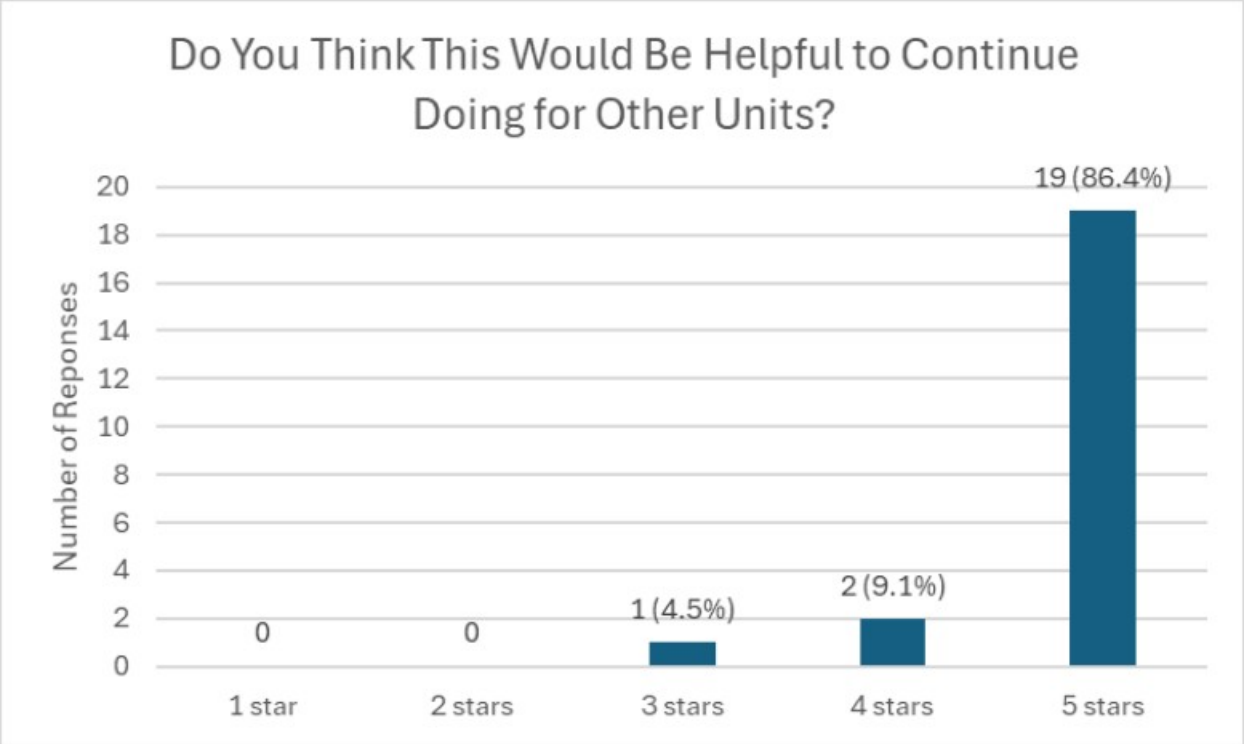
The in-service nursing education was part of an on-going VTE prevention project at Baylor St. Luke’s Medical Center. Units were surveyed on their optimal days and times to host an in-service education a week prior intervention. Education was performed by medical students and consisted of a short speech and Q&A with nurses, as well as posted educational fliers. A voluntary and anonymous survey was provided following each inservice education.

Results

In total, 22 survey responses from nursing staff indicated an overall positive response to our in-service education. Nineteen nurses rated the helpfulness of the information as 5 out of 5, while the remaining three rated it 4 out of 5. Similarly, 19 of the 23 nurses gave a 5/5 rating when asked whether this type of educational intervention should be implemented in other units. Eleven of the

respondents left free response comments which included suggestions about performing physician education and ensuring SCD's are readily available





Discussion

Based on nurse feedback, our in-service education was very well received and effective in communicating best practices to improve VTE rates. Nurses felt satisfied with the quality of the education, and responses indicated that the concise education protocol provided adequate explanation without negatively impacting their nursing responsibilities. Future research could benefit from larger scale and more heterogeneous administration with regard to unit types surveyed, as this project focused only on those units with the highest rates of VTE.

Abstract 37 - Next Chapter Adult Diabetes Care

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Affiliations: Baylor College of Medicine, Texas Children's Hospital

Poster Number 237

Aim Statement

Adolescents with diabetes face a critical period when transitioning from pediatric to adult care, as they take on more self-management responsibilities. Guidelines recommend a structured approach to this transition. This quality improvement project sought to develop a guided transition roadmap

Background

Adolescents with diabetes face a critical period when transitioning from pediatric to adult care, as they take on more self-management responsibilities. Guidelines recommend a structured approach to this transition. This quality improvement project sought to develop a guided transition roadmap

Methods

A multidisciplinary QI team implemented the following PDSA cycles:

1) November 2023: Implemented a transition policy with transition curriculum and EMR tools for providers/CDCES, including an EMR flowsheet with an anticipated transition date.

2) January 2024: Defined transition tasks for each member of the diabetes care team (i.e., provider, CDCES, social worker).

3) February 2024: Conducted a transition seminar for providers/staff to increase comfort with and knowledge of transition topics, including health insurance.

4) April 2024: Integrate key transition education topics into the EMR flowsheet.

5) May 2024: Updated a geographical-based list of local adult endocrinologists.

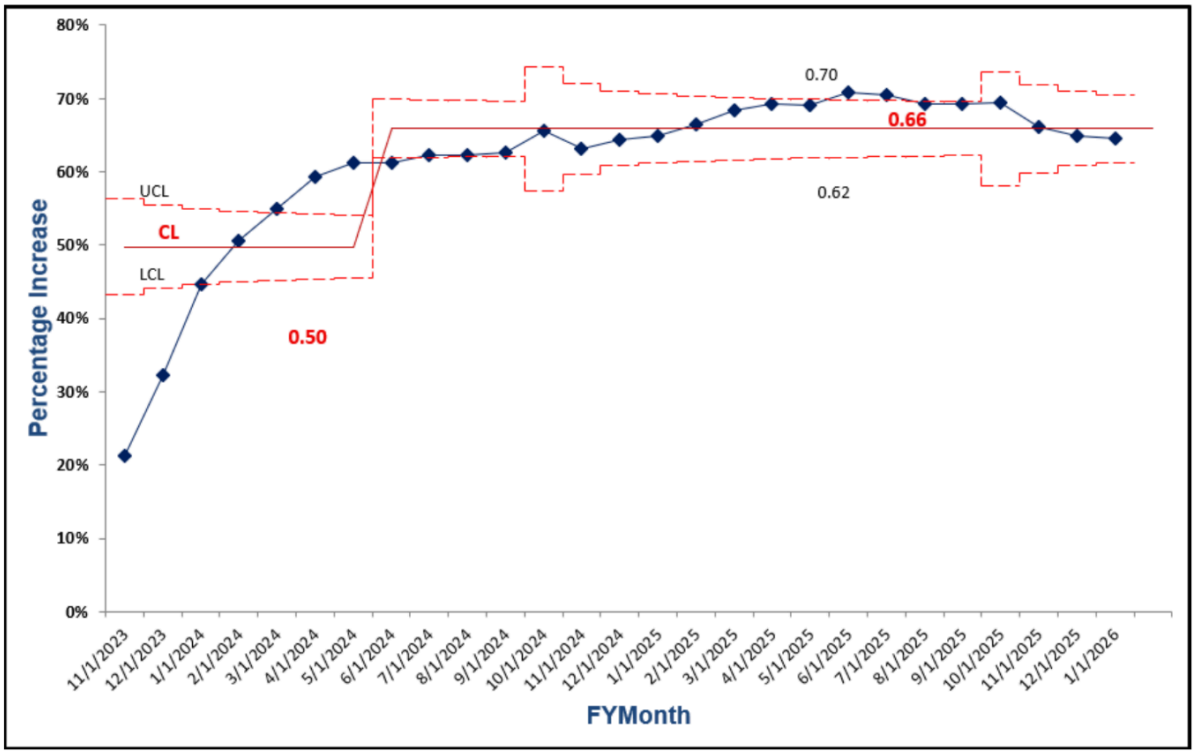
6) January 2025: Updated clinic passport to assign specific transition tasks to each care team member.

Results

The percentage of patients aged 16 and older with type 1 or 2 diabetes with a documented transition plan increased from a baseline of 21% to 70% by June 2025. A statistically significant centerline shift accompanied this improvement and has been sustained over the past six months, beyond the project period (Figure 1).

Figure 1

Percentage of documented transition plan for youth with type 1 and 2 diabetes



Discussion

A structured, team-driven transition roadmap markedly improved both preparation and documentation for emerging adults with diabetes. This approach is highly replicable – other care teams can use similar QI methods to implement tailored interventions in their own settings.

Abstract 38 - Eliminate SEP1 Fallout Through Nurse Education on Early Recognition of Signs and Symptoms of Severe Sepsis and Compliance with Time-Sensitive Interventions for Patients With Severe Sepsis and Septic Shock at Baylor St. Luke's Medical Center

Mortin Limenih, Nikhil Seth, Liza Arenas

Affiliations: Baylor St. Luke's Medical Center

Poster Number 238

Aim Statement

To improve SEP-1 bundle compliance through targeted nurse education focused on early recognition of severe sepsis and adherence to time-sensitive interventions. Objectives included increasing post-education nursing knowledge scores to ≥95% and improving compliance with key SEP-1 three-hour bundle components.

Background

Sepsis remains a leading cause of morbidity and mortality among hospitalized patients in the United States, affecting approximately 1.7 million adults annually and contributing to nearly 350,000 deaths or hospice discharges. Early recognition and rapid implementation of evidence-based interventions are critical to improving outcomes. The CMS SEP-1 bundle standardizes early management of severe sepsis and septic shock; however, consistent compliance remains challenging. At Baylor St. Luke's Medical Center (BSLMC), the 20 Tower unit cares for a predominantly immunocompromised population at high risk for severe sepsis. During FY 2024–2025, SEP-1 compliance remained below institutional benchmarks. Process review identified delays in sepsis recognition, delayed blood culture collection prior to antibiotics, incomplete bundle execution, and nursing knowledge gaps related to SEP-1 workflow and escalation.

Methods

A quasi-experimental pre-/post-education quality improvement project was conducted on the 20 Tower unit using the Define-Measure-Analyze-Improve-Control framework. Interventions included baseline knowledge assessment, targeted nurse education on SEP-1 workflows, and ongoing monitoring of bundle compliance and time-to- intervention metrics.

Results

Baseline data demonstrated low compliance with SEP-1 bundle components.

- Blood culture collection prior to antibiotic administration ranged from 4–15%
- Timely antibiotic administration ranged from 2–22% (Figure A2-1)

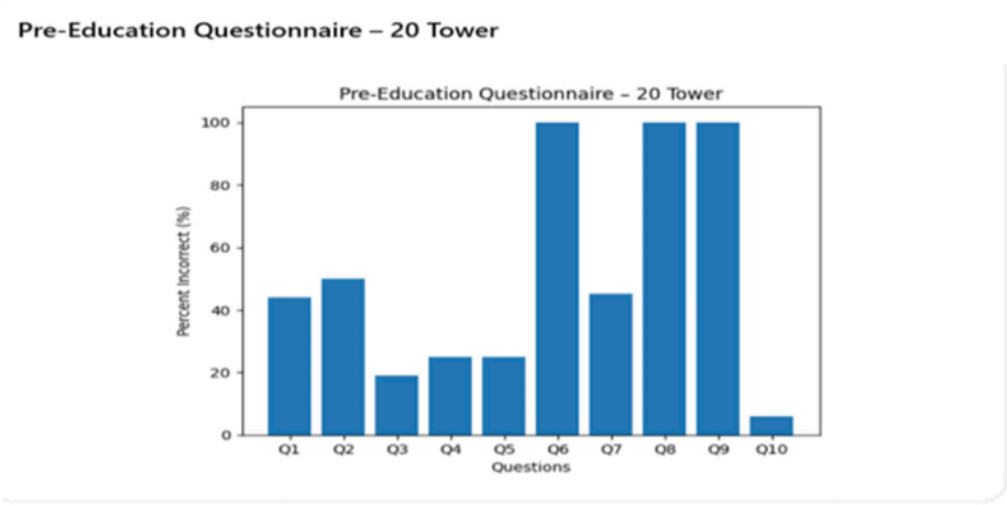
Knowledge assessments revealed substantial gaps, including:

- 44–50% incorrect responses regarding SIRS criteria
- Up to 100% incorrect responses related to organ dysfunction recognition (Figure A1)

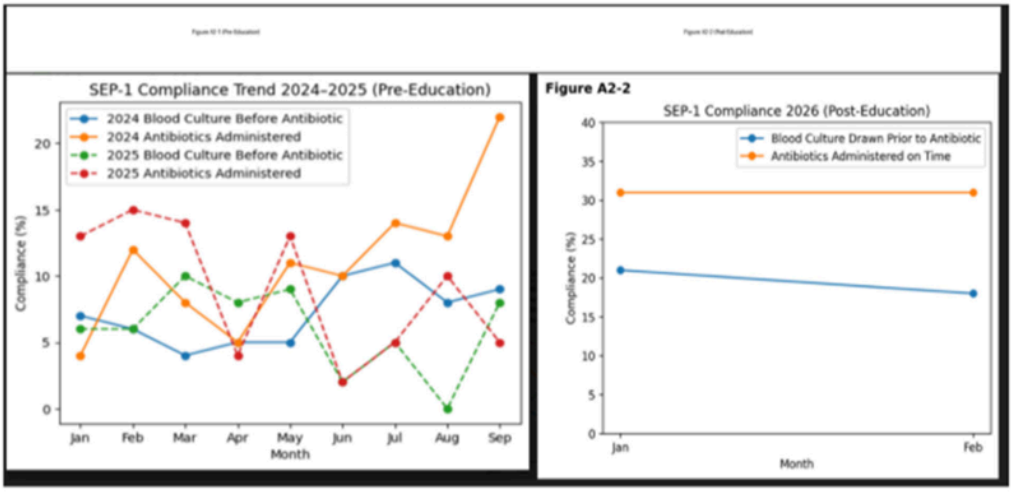
Early 2026 post-intervention data demonstrated modest improvement:

- Blood culture collection prior to antibiotics increased to 18–21%
- Timely antibiotic administration improved to approximately 30% (Figure A2-2)

Figure A1



Figures A2-1 **Figures A2-2**



Discussion

Targeted nurse education identified significant knowledge deficits and improved awareness of SEP-1 requirements. Early findings demonstrate modest process improvement; however, continued education, workflow optimization, and ongoing monitoring are needed to achieve sustained SEP-1 compliance and improved patient outcomes.

Abstract 39 - Improving Diagnostic Accuracy of Cesarean Surgical Site Infections Through Alignment with NHSN Criteria: A Quality Improvement Initiative

Alex Flaherty, Hendrick Lombaard

Affiliations: Texas Children's Hospital

Poster Number 239

Aim Statement

To evaluate cesarean surgical site infections for alignment with NHSN criteria and develop a diagnostic algorithm to support appropriate wound assessment and reduce misclassification.

Background

Cesarean surgical site infections (SSI) are closely monitored quality metrics defined using standardized criteria from the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Accurate classification is essential for reliable surveillance, appropriate antimicrobial use, and meaningful quality improvement efforts. At our institution, variability in wound assessment documentation and reliance on wound cultures as a diagnostic trigger raised concern for potential misclassification of postoperative infections.

Methods

A retrospective review of cesarean delivery cases classified as SSI from October 2024 through February 2026 was conducted. Cases were systematically evaluated using NHSN SSI definitions to determine whether documented infections met standardized criteria. Clinical documentation, wound characteristics, and culture utilization were reviewed to identify patterns contributing to potential misclassification. Findings informed development of a diagnostic decision-support algorithm, created in collaboration with physician leadership, to reinforce alignment with NHSN criteria and support consistent clinical assessment.

Results

Among cases initially classified as cesarean SSI, 19 (33%) did not meet NHSN criteria upon detailed review. Several cases involved positive wound cultures without accompanying clinical signs of infection or represented superficial colonization rather than true surgical site infection. Variability in wound documentation and use of cultures as a diagnostic driver were identified as key contributors to misclassification.

Discussion

Misclassification of cesarean SSI can lead to inaccurate surveillance reporting and unnecessary antibiotic exposure. Aligning clinical assessment with NHSN diagnostic criteria and reinforcing appropriate use of wound cultures may improve diagnostic consistency and support antimicrobial stewardship. Development of a diagnostic algorithm may provide clinicians with structured guidance for evaluating postoperative wounds and distinguishing colonization from infection, ultimately supporting more accurate SSI surveillance and targeted quality improvement efforts.