



## Baptist Medical Center, North Little Rock, AR

### Introduction

In October 2015, the Centers of Medicare and Medicaid (CMS) and The Joint Commission (TJC) implemented guidelines to assist in care of Sepsis patients. Baptist Health North Little Rock had a Sepsis protocol in place that was not being effectively utilized. It was with the implementation of the Sepsis Core Measure that Sepsis compliance was noted to consistently run between 30-40 percent. Baptist as a system decided to implement a Sepsis Committee to work to improve on Sepsis care with Baptist North Little Rock hiring the first Sepsis Coordinator in February 2017.

### SMART Goal

By September 2017, Sepsis Bundle Compliance will be consistently greater than 50%.

### Measures

**Outcome Measure:** Number of patients meeting the Sepsis bundle compliance/Total number of patients with the diagnosis of Sepsis.

**Process Measure(s):** The Sepsis patient has the Sepsis Bundle completed per physician's orders.

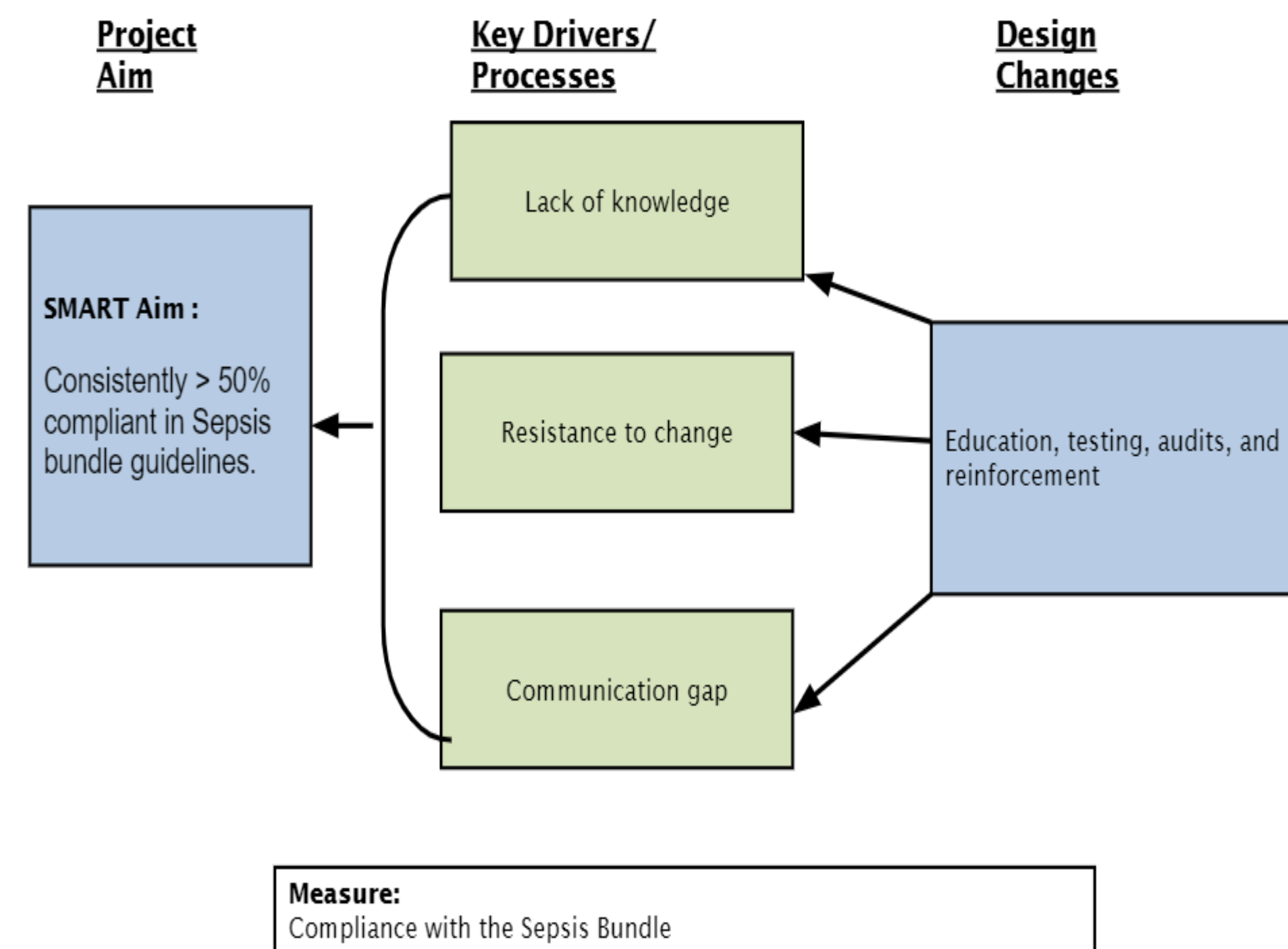
### Interventions

Using the Plan - Do - Study - Act (PDSA) method, a Multidisciplinary Sepsis Team was created to assist with Sepsis bundle compliance. The Sepsis Order Set was updated.. Education was provided for the physicians, nurses, phlebotomists, and lab employees with compliance discussed monthly with staff and leaders.

### Methods

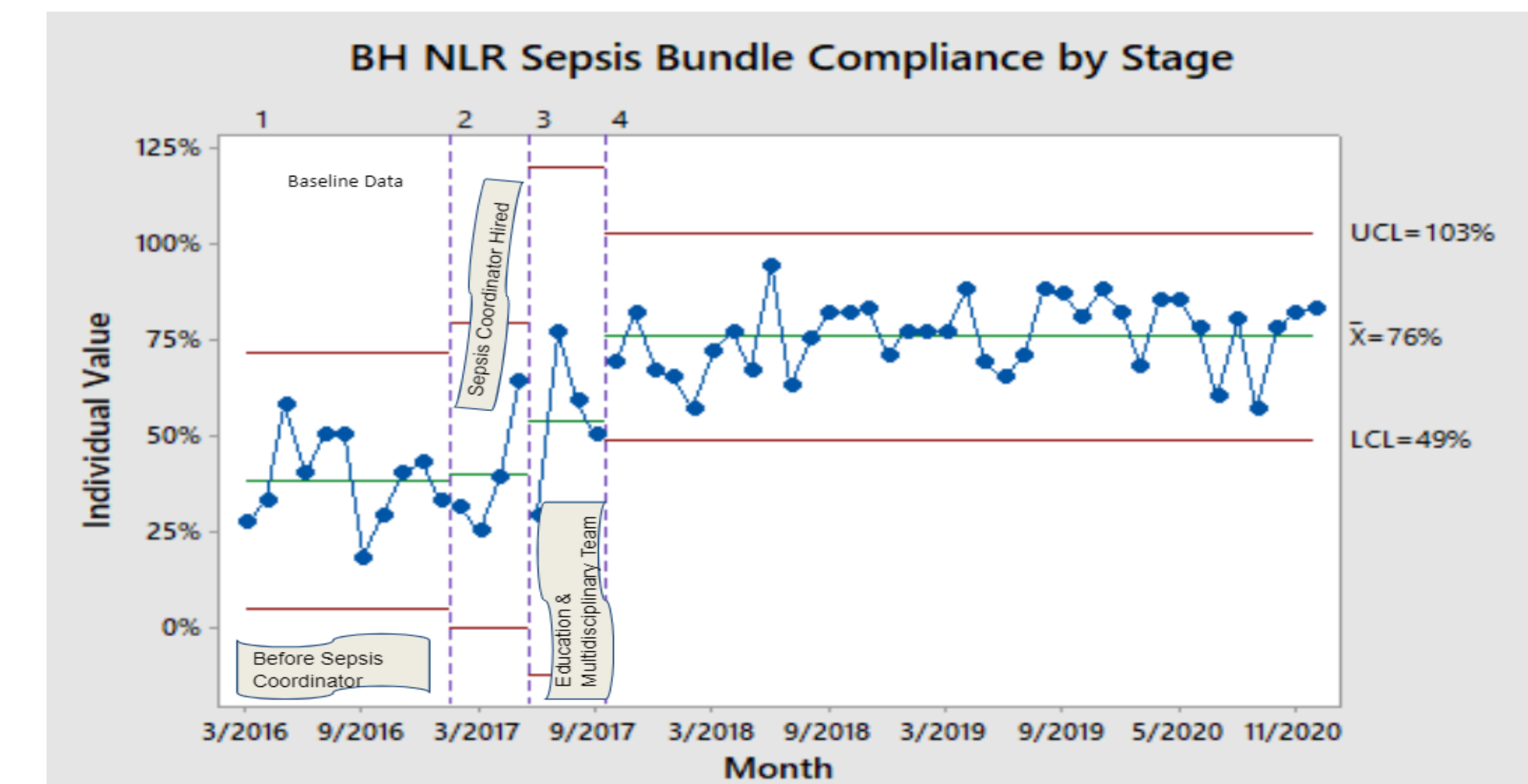
The PLAN-DO-STUDY-ACT (PDSA) method was used. As many as twenty-five charts were reviewed monthly to assess Sepsis bundle compliance and analyzed by the Sepsis Coordinator. A Sepsis Interdisciplinary Team was formed to work on improvement processes discovered from chart reviews. The Sepsis Order Set was updated, and the doctors and nurses were educated on Sepsis bundle guidelines with performance tracked monthly.

### Key Driver Diagram



### Outcomes

In September 2017, the organization was consistently above 50%. As a result, the goal was increased to 80% Sepsis bundle compliance. In February 2021, Baptist Health North Little Rock became the first to become Joint Commission Sepsis Certified in the State of Arkansas.



Baptist Health North Little Rock  
Joint Commission Sepsis Certified



### Barriers and Lessons Learned

Nurse and physician buy-in is crucial to the success of every improvement plan. A Multidisciplinary Team is an evidenced-based model that works to assist with improved patient outcomes.

### Next Steps

Our next steps include, continuous improvement with our Sepsis bundle compliance and initiation of community education regarding Sepsis. We will re-submit our data in one year to maintain our Joint Commission Sepsis Certification.

# Healthcare Disparity in the Assessment of Dementia in the Outpatient Setting

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Office of  
Interprofessional  
Education

## INTRODUCTION

Literature suggests racial implicit bias exists in patients' quality of care provided across healthcare. Most prevalence studies indicate that Blacks aged 65 years and above are twice as likely to have Alzheimer's or other dementias as their White counterparts (18.6% vs 10%).

Inappropriate methods of screening or differential screening could easily result in an over or under-estimation of the diagnosis of dementia. Both provider and patient bias or knowledge deficit could influence the rate of screening.

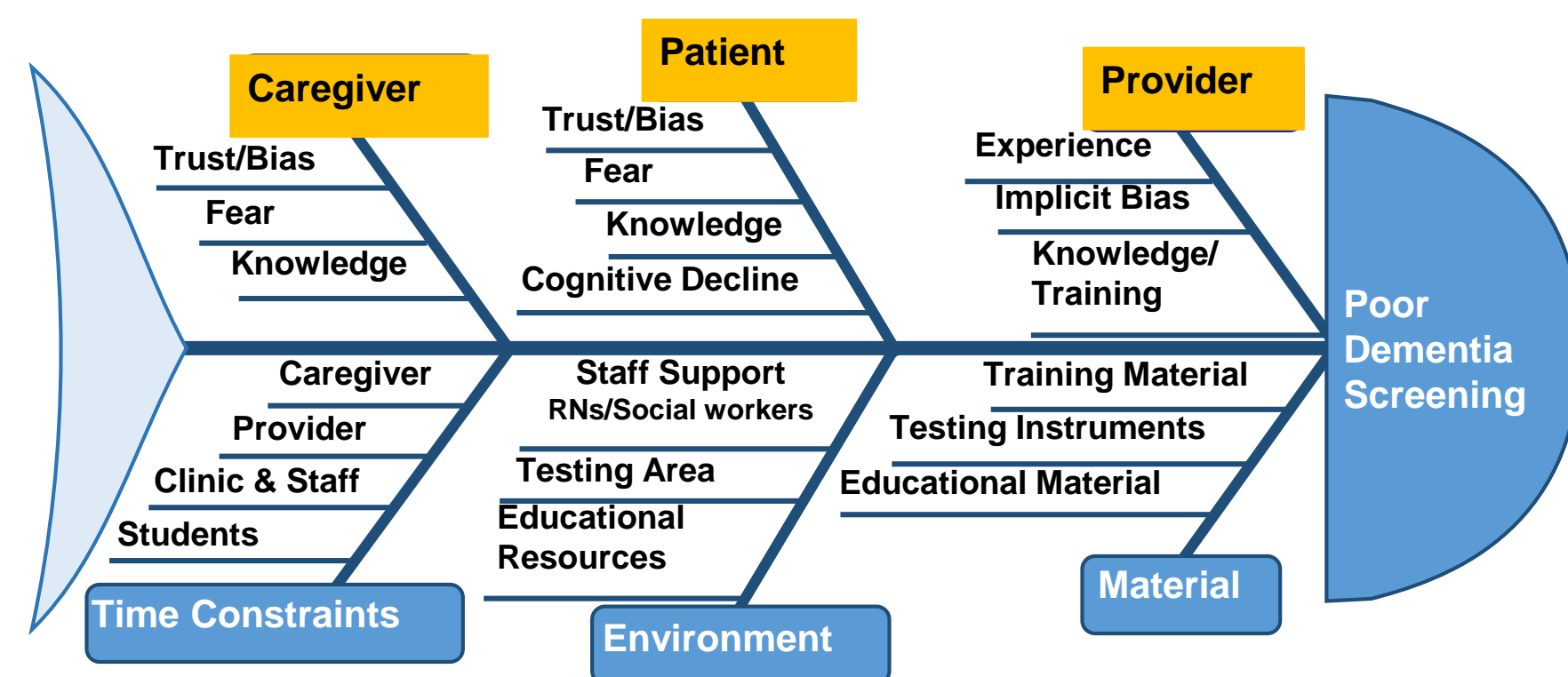
## SMART GOALS

To document racial disparity in the use of standardized screening methods for dementia at the Thomas and Lyon Longevity Clinic, UAMS and to implement interventions to improve screening for dementia and reduce racial disparity.

## MEASURES

**Outcome measures:** To improve the screening rate for dementia using standardized tools in Black patients comparable to that of White patients

**Process measures:** Education of healthcare providers in appropriate approach towards patients and screening. Education of patients and caregivers about dementia



**Figure 1:** Ishikawa diagram showing the potential factors that led to poor dementia screenings as well as disparities in screenings for geriatric patients. We focused on patient/caregiver and provider factors as interventions (brown).

## METHODS

Two Plan-Study-Do-Act (PDSA) cycles guided our methods. We sought patients' caregivers' perspectives of care they receive from the longevity clinic. We reviewed patients' records and identified disparity in dementia screening, with reduced screening of Blacks vs Whites. To improve consistency in cognitive impairment screening across races, healthcare providers participated in the following educational interventions: Geriatric Grand Rounds, a special talk and short video clips on the diagnosis and management of dementia. Additionally, providers received one on one instructions on dementia screening and diagnosis. Providers completed a survey to explore the challenges and barriers faced when providing care in the longevity clinic.

### PDSA 1

**PLAN:** Determine racial disparity in screening methods for Alzheimer's & related dementia at the Thomas and Lyon Longevity Clinic at UAMS

- ACT:**
- Geriatric Grand Rounds on "dementia"
  - "Communicating the dx of dementia in difficult situations" special talk
  - Short video clips on "How to approach dx of dementia" via email to providers
  - One-on-one instruction of providers on dementia screening, approach & reducing implicit bias

**DO:** Reviewed random selection of EMRs of n=78 patients > age 60 who had a dx of dementia in 2020. Evaluated documentation of appropriate standardized tests; MoCA, SLUMS, MMSE

**STUDY:** Initial review indicated that Black patients were screened for dementia at a lower rate compared to their White counterparts using standardized tests.

### PDSA 2

**PLAN:** Determine the impact interventions had on screening disparity for dementia: Continue

**ACT:** to engage providers in dementia presentations and case discussions. Continue to educate patients and caregivers about all aspects of dementia

**DO:** Review of EMR of n=72 patients with a diagnosis of dementia between Nov 2020 and March 2021.

**STUDY:** Review of EMR data showed improved screening rates for dementia in Black patients to levels comparable to White patients. Review of provider surveys suggest greater overall confidence in approaching screening for dementia and managing patients with dementia over the past 4 months. Patients/caregivers surveyed reflect they value & appreciate the care received from providers.

## BARRIERS AND LESSONS LEARNED

**Barriers:** Surveying the cognitively impaired patients and stressed caregivers. Time constraints in Memory clinic & providers unaware of implicit bias in diagnosis. Provider burn-out from emotional toll of taking care of memory patients

**Lessons:** Need for education for memory care & training in implicit bias needed for Providers. Incentive payments for patient and caregiver education and support group. Greater need for an inter-professional team approach for the Memory Clinic

## RESULTS

- Fifteen healthcare providers were surveyed and 150 patient records reviewed
- Dementia screening rates improved in both races post-educational intervention.
- In Whites the screening increased from 68.5% to almost 90%. In Blacks the screening rate improved significantly from 43.4% to 82.3% (Fig 2)
- 95% of providers were more comfortable seeing memory patients and all were more experienced conducting memory tests after 4 months (Fig. 3)
- Overall, the educational interventions worked and improved the clinic providers' self-efficacy in managing cognitively impaired patients and improved their skills in conducting memory tests. Patients and their caregivers value the care received from the Longevity Clinic and appreciate compassionate providers who take their time to listen to and address all patient and caregiver questions and concerns.

**The improved self efficacy of providers regarding screening for dementia as well as patients & caregivers regarding dementia knowledge improved the screening rates for dementia in Black patients to levels comparable to those of White patients in our clinic.**

Fig. 2

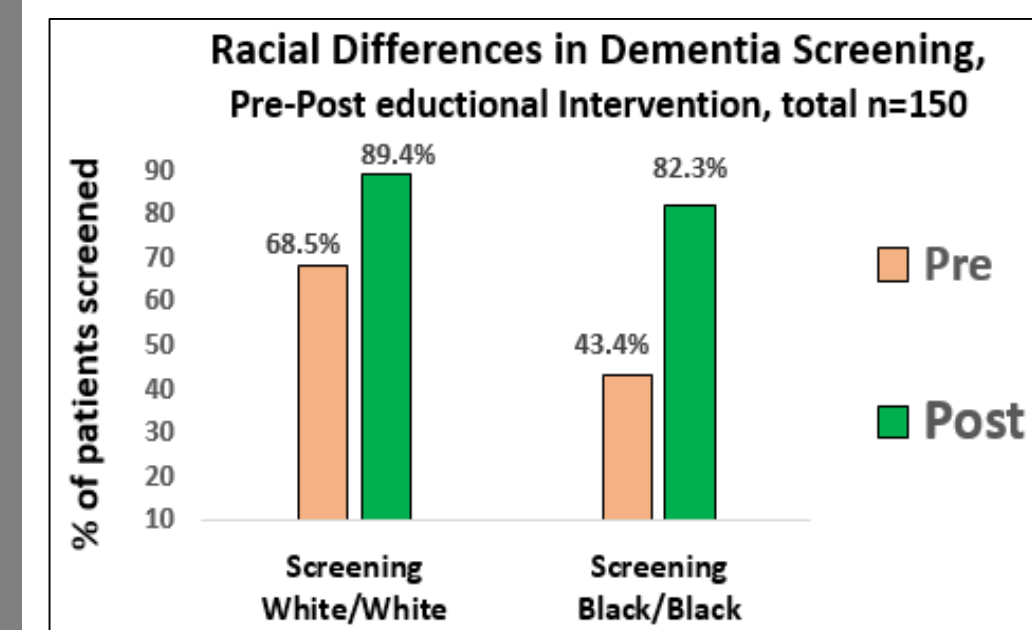
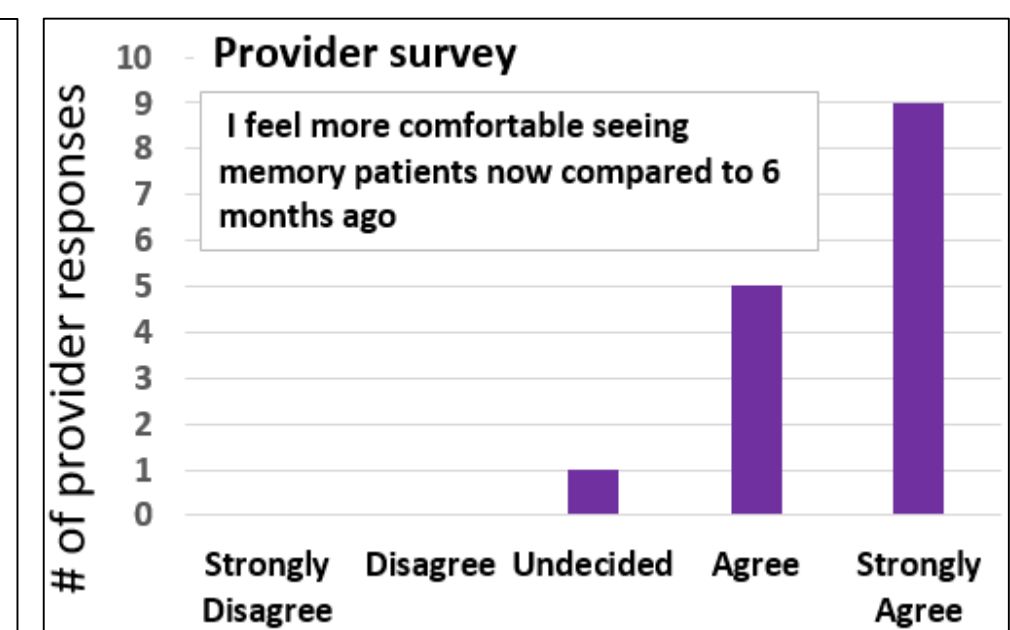


Fig. 3



## NEXT STEPS

- Managing patients with memory problems remains a challenge for most providers. Main challenges include the significant time commitment and lack of adequate training of providers and education of patients and caregivers about dementia.
- Education & training of providers using a variety of different convenient modalities & incorporation of presentations spaced throughout the year.
- Training to reduce implicit bias and improve cultural sensitivity of providers.
- Continue reviewing feedback from patients, caregivers and providers for continuous quality improvement,
- Funding for a robust patient and caregiver support group for Alzheimer's disease and dementia will also assist in enhancing understanding of memory disorders and improve screening rates. There is an opportunity to pursue avenues to bill for memory patients' care administered in the outpatient settings.
- An inter-professional team approach for the Memory Clinic with education of nurses, advanced care nurse providers, social workers and pharmacists and trainees (geriatric fellows) incorporating diversity, will further broaden the scope of care provided to patients & caregivers.

# Increasing monthly compliance rates for psychoactive medication informed consents – a regulatory QI initiative

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## Introduction

Informed consent (IC) is an agreement/permission accompanied by a full notice about the care, treatment, or service that is the subject of the consent - patients must be apprised of the nature, risks, and alternatives of a medical procedure or treatment before a physician or health care professional begins any such course. Per Texas' regulatory guideline -Texas Administrative Code, RULE §414.405- within psychiatric units, administration of psychoactive medications mandates patients to complete a psychoactive IC-form for each medication.

**PROBLEM:** UTHSCT's inpatient psych unit's monthly IC-form compliance rate is unsatisfactory, secondary to errors in obtaining and completing via paper forms; consequently, the monthly average of 19.4% correctly- completed IC-form. Such a low compliance rate poses a risk for infractions and fines by regulatory agencies – The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS).

## SMART Goal

**AIM:** To increase the monthly rate of correctly completed psychoactive IC-forms from a baseline of 19.4% to a goal of greater than 70% within three months in the 4-East inpatient behavioral unit.

## Measures

**Outcome Measure:** Monthly Correctly completed IC compliance rate per unit

**Process Measure(s):** Adherence and adoption of digitalized IC form

**Balancing Measure(s):** Training time of staff

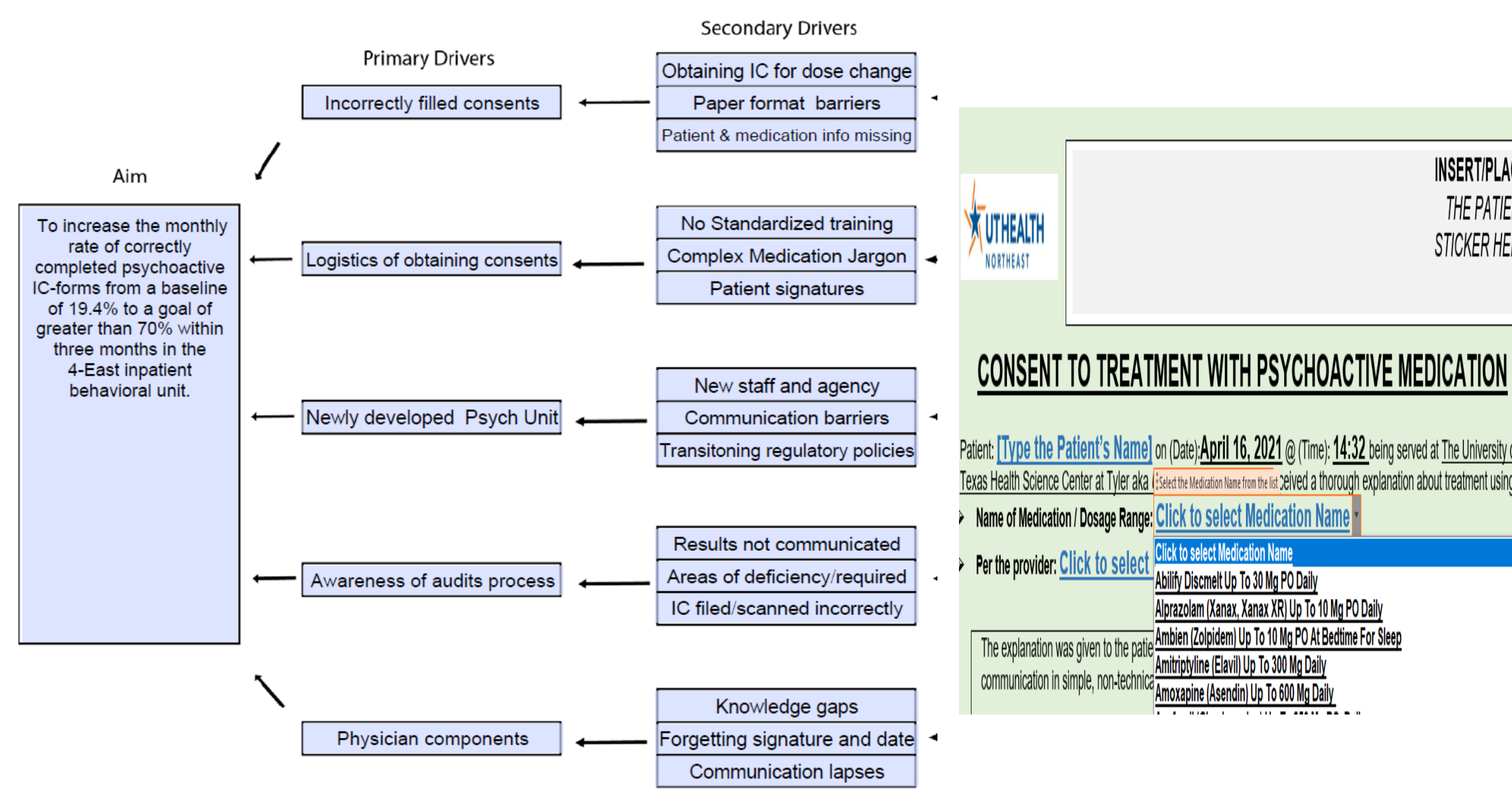
## Interventions

- Development of digital psychoactive consent form
- A collaborative behavioral health and quality team tasked with developing iterations of the form and approval from hospital regulatory committees .
- Training –video developed to train nursing staff on digital form utilization

## Methods

**METHODS:** Implement pilots and PDSA cycles for optimization and development of digital psychoactive IC-forms. Obtain and track data utilizing monthly compliance rates audits conducted by the quality department.

## Key Driver Diagram



	Check Mark
1) The nature of his/her mental and physical condition	✓
2) The expected beneficial effects on his/her condition as a result of treatment with the medication.	✓
3) The probable health and mental health consequences of not taking medication, including the occurrence, increase or recurrence of symptoms of mental illness.	✓
4) The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefits as the medication and why the physician rejects the alternative treatment.	✓
5) A description of the proposed course of treatment with the medication.	✓
6) The fact that side effects of varying degrees of severity are a risk of all medications	✓
7) The relevant side effects of the medication being prescribed, including: A. any side effects which are known to frequently occur in most individuals; B. any side effects to which the patient may be predisposed; and C. the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking antipsychotic medication, especially in large doses and/or over long periods of time.	✓
8) The need to advise staff immediately if any of these side effects occur.	✓
9) An instruction that the patient may withdraw consent at any time.	✓
10) An offer to answer any questions concerning treatment.	✓
11) A review of Patient's Rights Under the Consent to Treatment with Psychoactive Medication Rule	✓
12) A written summary of information regarding this medication was provided.	☐

I have received a thorough explanation of the psychoactive medication by means of:

ORAL EXPLANATION     VIDEO EXPLANATION     PRINTED MATERIAL     OTHER

Based on this explanation, I hereby consent to treatment with the specific psychoactive medication as indicated on the top of this consent form. I understand that I may withdraw this consent at any time.

Patient or Guardian (if patient has a Guardian, only the Guardian can give consent)    Date / Time

Patient refuses to sign, but gives verbal consent as witnessed below:

Witness    Date / Time    Witness    Date / Time

Primary Caregiver Supportive of Patient's Consent    Relationship to Patient    Date / Time

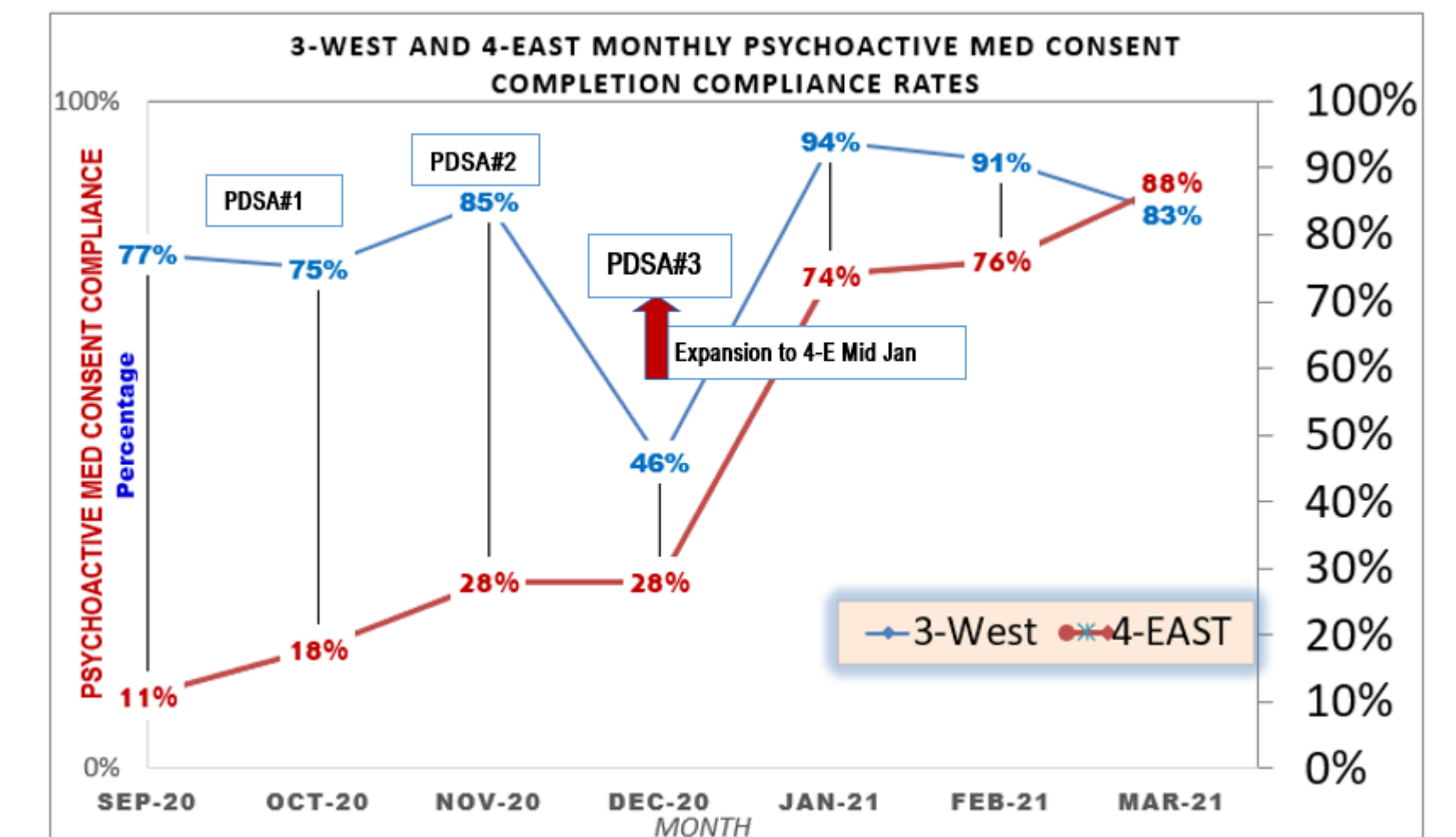
Physician, PA, RPH, RN, or LVN providing explanation    Date / Time

Signature of Treating Physician to confirm explanation given by PA, RPH, RN, or LVN    Date / Time

## Outcomes

**RESULTS:** Within three months of implementation, our QI increased the average monthly rate of correctly completed psychoactive IC-form from the 5-month average baseline rate of 19.4% to 79.3%, surpassing the goal set of >70%.

**CONCLUSION:** Our QI initiatives resulted in increased regulatory compliance via identifying and addressing the prior paper-format IC-form deficiencies with digital IC-form.



## Barriers and Lessons Learned

- Barriers of technological knowledge gaps among senior nursing staff; which was mitigated by step-by-step on-demand video guide for utilization of digitalization form
- Regulatory policies and deficiencies might only be shared from the administrative level and is not being effectively communicated to all staff; thus, ensuring more integration of quality department focus as it pertains to regulatory initiatives and areas for deficiency and improvement in care delivery with all staff members.

## Next Steps

- Continue to expand the QI initiative to all our units
- Ensure as part of the onboarding process for new nursing staff and physicians that training is offered on the utilization of digital forms
- Continue to monitor for compliance rates with higher benchmarks

# A Hospital-Wide Project to Improve Influenza Vaccinations in Children

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## Introduction

Children have the highest rates of influenza and play a strong role in transmitting flu to household members and other close contacts. Children under 5 are at increased risk of flu hospitalizations and complications. Flu vaccination reduces the risk of severe illness, hospitalization, and flu-related death in children.

## SMART Goal

Increase flu vaccination rates in patients 6 months and older seen at Arkansas Children's Hospital by 10% above the 2019-2020 season rate of 6.5 vaccines per 100 patient visits to 7.2 vaccines per 100 patient visits by March 2021.

## Measures

**Outcome Measure:** Percentage of patient visits in patients older than 6 month at ACH with flu vaccine administered

**Process Measures:** Vaccination status, EHR reminders, vaccine hesitancy, provider comfort

## Interventions

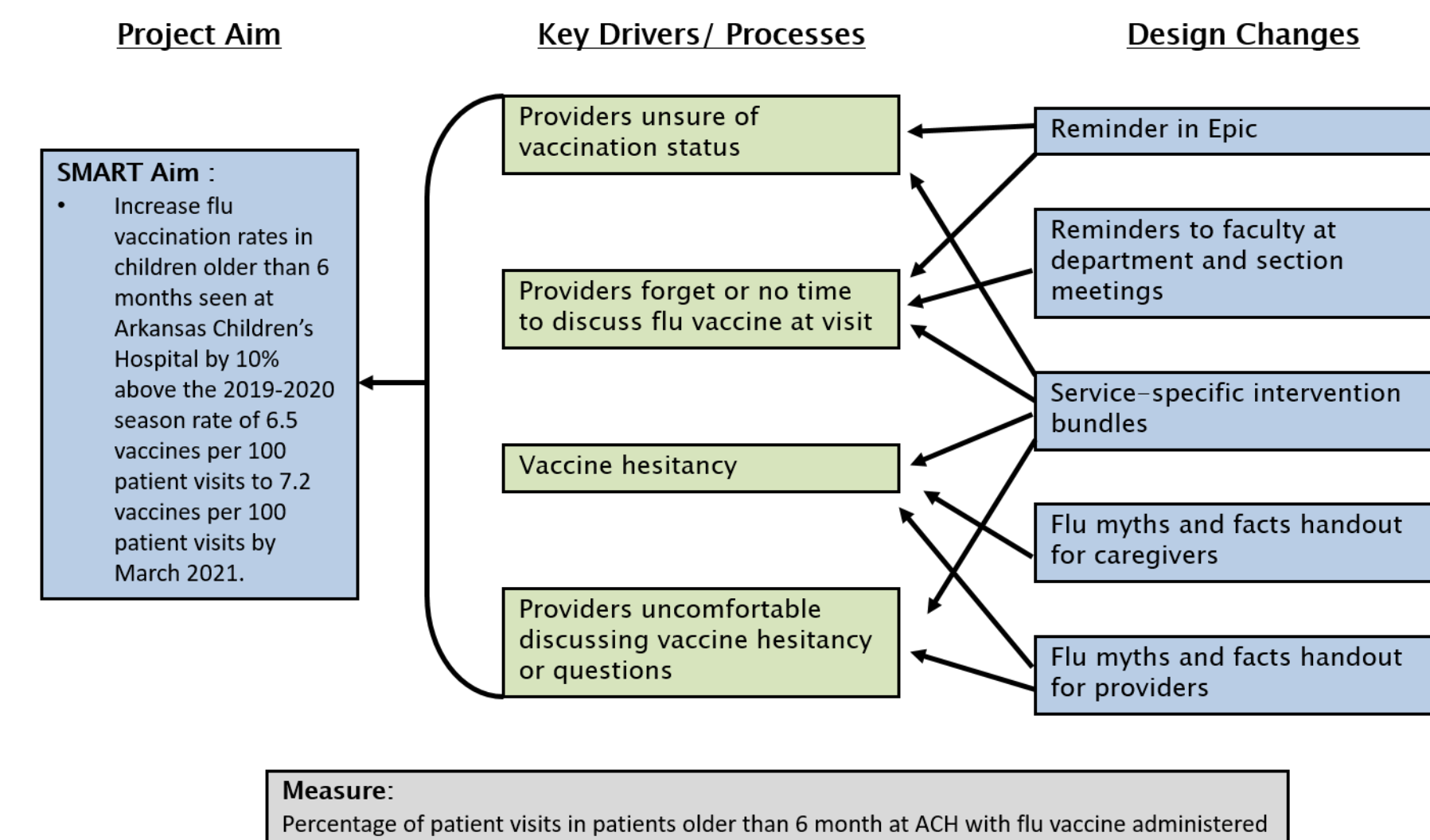
- Awareness Campaign
- Electronic Medical Record (EMR) changes
- Service-Specific Intervention Bundles
  - Decided upon by each service
  - Aimed at specific processes and key drivers affecting their patients

This project was approved for American Board of Pediatrics Maintenance of Certification Part 4 credit.

## Methods

- **Awareness Campaign:** Recruitment of 11 section champions to lead their sections in the project, information sheets on flu myths and facts, and monthly progress reports were delivered at department and section meetings
- **EMR changes:** Banner with flu vaccine status visible for all patients; SmartPhrase available for notes
- **Section-specific intervention bundles:** Examples include:
  - Hospital Medicine: Hard stop for flu vaccine status in history & physical template; intermittent contests for teaching teams; visible reminders for providers
  - General Pediatrics: Increased nurse-only vaccine visit slots; vaccine flu clinics and drive-through clinics; sibling flu vaccines
  - Nephrology: Vaccine tool to evaluate reasons for refusal
  - NICU: Focus on parental vaccines; special EMR documentation; vaccine tool to evaluate reasons for refusal
  - Hematology-Oncology: Order set; vaccine tool to evaluate reasons for refusal

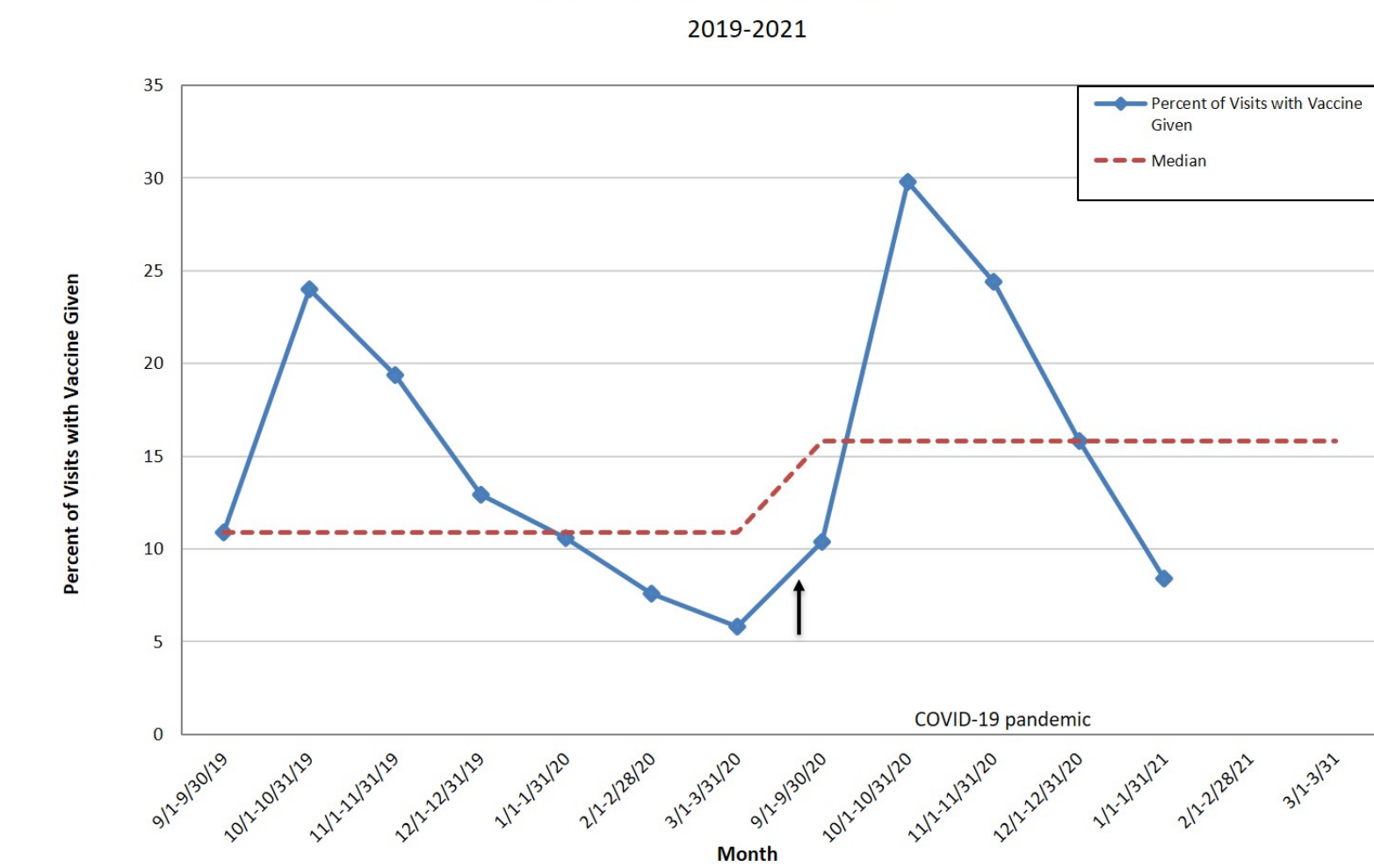
## Key Driver Diagram



## Outcomes

Influenza vaccination rates in children seen at Arkansas Children's Hospital increased by **35%** above the 2019-2020 season rate of 6.5 vaccines per 100 patient visits to a rate of 8.8 vaccines per 100 patient visits.

### ACH Flu Vaccines



## Barriers and Lessons Learned

This project demonstrated both the feasibility and challenges of a hospital-wide QI project incorporating many sections and practice areas (e.g., inpatients and outpatients, general and specialty clinics)

**Barriers:** delayed access to data –low influenza rates (likely due to masking and social distancing in response to the COVID-19 pandemic) and significantly decreased patient volume made this an atypical flu season.

## Next Steps

Preparation for 2021-22 flu season project to begin Summer 2021 with ongoing work to identify and obtain useful data points including weekly data to better identify variation. Data collected this year on reasons for refusal will inform new interventions for next season.