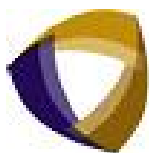


LSU School of Medicine

Quality Improvement  
and Patient Safety  
Forum

May 27, 2014



**LSU Health New Orleans**

*Enhancing Quality Improvement for Patients (EQIP) Program*

# Program

- 1:00 – 2:00 *Keynote*  
Fostering a Culture of Safety: More than Just  
'Kumbaya'  
*Niraj Sehgal, MD, MPH*  
*Associate Professor of Clinical Medicine &*  
*Associate Chair for Quality & Safety,*  
*Department of Medicine*  
*University of California, San Francisco*
- 2:00 – 2:15 Morbidity and Mortality: Using Quality  
Improvement to Assess Outcomes  
*Amy Young, MD and Stacey Holman, MD*  
*OB/GYN*
- 2:15 – 2:30 Delayed Autopsy Reporting: A Self-Study and  
Root Cause Analysis  
*Caroline Raasch Alquist, MD, PhD*  
*Resident, Pathology*
- 2:30 – 2:45 One (Metered) Breath at a Time: Use of Albuterol  
HFA Metered Dose Inhalers during Inpatient  
Asthma Exacerbations  
*Kevin Gipson, MD and Jimisha Patel, MD*  
*Residents, Pediatrics*
- 2:45 – 3:00 Changes in Patient Outcomes in Dedicated  
Internal Medicine Resident Diabetes Continuity  
Clinic  
*Rachel Coleman-Pierron, MD*  
*Resident, Internal Medicine*
- 3:00 – 4:30 *Poster Session (Lobby)*

# Posters

A Short Report on Laboratory Results: A Preliminary Look into Improving Efficiency

*Craig Billeaud, MD; Ryan Kline, MD; Jonathan Ma, MD*

*Anesthesiology*

Pediatric Emergent Situations

*Adam Broussard, MD*

*Anesthesiology*

A Quality Improvement Project: Cricothyrotomy Awareness at LSUHSC-New Orleans Department of Anesthesiology

*Greg Bordelon, MD; Amit Prabhakar, MD, MS; Jared Landry, MD*

*Anesthesiology*

Medication Error in the Operating Room

*Lynley Leithead, MD; Moises Sidransky, MD*

*Anesthesiology*

Central Line Associated Blood Stream Infections: What's the Big Picture?

*Trey Bates, MD; Frank Rosinia, MD; Brian McClure, MD*

*Tulane Anesthesiology*

The Interim LSU Hospital (ILH) Cardiac and Cardiovascular Mortality and Morbidity Committee: A Fundamental Resource to Improve the Quality of Inpatient Care

*Bashar Ababneh, MD; Prashanti Atluri, MD; Patrice Delafontaine, MD; Gary Sander, MD; Frank Smart, MD*  
*Cardiology*

Do You Want Insulin with That? An Observational Study of Carbohydrate-Controlled Diet of Hospitalized Patients in Bogalusa

*Steve Ogden, MD; Dianna Phan, MD; Nichole Guillory, MD*

*Family Medicine – Bogalusa*

Exploring Strategies to Improve Enrollment of Online Patient Healthcare Portals

*Mark Fujita, MD*

*Family Medicine – Kenner*

Using EHR for Metrics-Based Resident Performance Tracking and Quality Improvement

*Oliver Mollère, MD; Evan Atkinson, MD; April Burrows; Betty Lo-Blais, MD*

*Internal Medicine/Pediatrics*

Written Versus Electronic Documentation of Multiple Sclerosis Disability Measurements

*Wael Richeh, MD; Cornel Rogers, MD; Frank Torres Delgado, MD; Raisa Martinez, MD; Jesus Lovera, MD, MsPH; Amparo Gutierrez, MD, FAAN*

*Neurology*

Improving Neurosurgical Discharge Dispositions for Patients with Public Health Insurance Plans: A Prospective Quality Improvement Study for At-Risk Patients Using a Targeted Documentation Program

*M. Daniel Eggart, MD*

*Neurosurgery*

# Posters (contd.)

Enhancing Nursing Staff Education in LSU OBGYN clinic

*Ashley Hirsch, MD; Kira Clement, MD; Amanda Thomas, MD; Traci Iwamoto, MD; Amber Lambert, NP; Stacey Holman, MD*  
*OB/GYN*

Placental Protocol: Establishing a Systematic Review of Placental Pathology

*Latoya Clark, MD; Kellin Reynolds, MD; Andrew Jones, MD; Stacey Holman, MD; Asha Heard, MD; Randall Craver, MD*  
*OB/GYN*

Efficacy of a Post-Hoc Orthopaedic Review Protocol for Pediatric Injuries Seen in the Emergency Department: A Pilot Study

*Ahmed M. Thabet, MD; Prerana Patel, MD; Stephen Heinrich, MD*  
*Pediatric Orthopaedics*

Shaken Baby Syndrome: A Prospective Study Utilizing Media Intervention

*Nabila Malik, MD; Danielle Eggie, MD; Amy Prudhomme, MD; Jessica Patrick, MD; Kate Brown, MD*  
*Pediatrics*

Evaluation of a Patient Hand-Off Curriculum for Pediatric Residents

*Heidi Murphy, MD; Lauren Hernandez, MD; Michelle Steinhardt, MD; Julie Gallois, MD; Amanda Messer, MD; Chelsey Sandlin, MD*  
*Pediatrics*

Obesity Prevention Curriculum in Pediatrics Using the "5-2-1-0" Program

*Shreepal Shah, MD; Lauren Raney, MD; Paul Remedios, MD; Anas Khouri, MD; George Hescoock, MD*  
*Pediatrics*

The Better Plate Project

*Ricardo Gomez, MD; Eileen Baez, MD; Sarah Black, MD; Megan Murphy, MD; Katie Price, MD; Alison Rivera, MD*  
*Pediatric Endocrinology and Pediatrics*

The Utility of Peripheral Blood Cultures in Febrile Pediatric Oncology Patients

*Dana LeBlanc, MD; Nicholas Bartel; Cruz Velasco, PhD; Lolie Yu, MD*  
*Pediatric Hematology/Oncology*

Patient Satisfaction with Hurricane Plan Given to Hematology-Oncology Patients at Children's Hospital in New Orleans

*Chittalsinh Raulji, MD; Maria Velez, MD; Renee Gardner, MD*  
*Pediatric Hematology/Oncology*

Addressing Health Literacy Using a Patient Centered Teach-Back Loop to Promote Better Medication Adherence and Accurate Blood Glucose Self-Monitoring in Diabetic Patients

*Victoria Aucoin (L2), Morgan Walker (L2), Margaret Coleman (L2), Denise Capps (L2), Mary Coleman, MD, PhD; Angela McLean, MD*  
*New Orleans Healthcare Improvement (Student Interest Group)*

Establishing Student Involvement with CHNO Quality Improvement

*Spandana Induru (L2), Elise Milani (L2), and Abhita Reddy (L2)*  
*New Orleans Healthcare Improvement (Student Interest Group)*

# Abstracts

## Patient Empowerment Impact on Surgical Safety Checklist Compliance

*Elizabeth Wingo, MD, Ashwin Ananth, Seth Christian, MD, L Webber, Boriss Losso, MD, Marcia Henry, MD, and Frank Rosinia, MD*  
*Tulane Anesthesiology*

**Background:** The World Health Organization's (WHO) Surgical Safety Checklist (SSC) has been reported in reduced complication rates. However, its clinical efficacy is barred by various implementation hurdles. Conley D.M., et al., advised that the SSC is most effect when patients have been educated about SSC implementation. This study aims to present an intervention to increase operating room (OR) compliance with a modified SSC at Tulane Medical Center (TMC), by empowering patients through education, awareness, and involvement.

**Methods:** The study group included adult patients. Preoperatively, patients are educated on the SSC, and given Tulane SSC flyers and 5"x8" card, which is signed by a circulator nurse. The SSC is audited in the OR for compliance and compared to baseline compliance data. Postoperatively, patients will fill out a 5 item patient safety survey.

**Results:** 42 patients were studied, showing a greater compliance rate for Sign IN, Time OUT, and Sign OUT compliance; 63% to 80%, 52% to 73%, and 17% to 54% respectively. Only 35% of patients were aware of a SSC before surgery, and 100% saw the checklist as beneficial to their care.

**Discussion:** 100% compliance was not seen in any category, meriting room for improvement. Reasons for incomplete SSC performance included memory, time restraints, production pressure, and non-complaint physicians. The positive impact patient awareness and safety and observer-expectancy bias had on SSC compliance was noted despite any statistical significances.

**Conclusion:** Empowered patients may improve compliance with patient safety efforts, create a culture of safety, and improve the quality of care. Future efforts include implementing the Patient Empowerment Initiative throughout the OR at TMC.

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## Access to Same-Day Appointments

*Tai Nguyen, MD*

*Family Medicine - Kenner*

**Aim:** To identify the demand for same day appointments with a goal to reach 75% slots open at the start of day.

**Plan:** Measure numbers of appointment slots open for next day at 5 pm each day for 1 week beginning July 9, 2013, to July 15, 2013. Time was allowed to enact any changes necessary with goal to review data in future to see if the Aim was met.

At the onset of the study, the original decision was to maintain the 10am slot available for same day appointments, as is a requirement for Patient Centered Medical Home recognition by the National Committee for Quality Assurance (NCQA).

Evaluation of our clinic practices revealed inconsistencies regarding both the definition of same day appointments and the availability of same day appointments. While the 10 AM slot was deemed available for same day appointment, we found that many of those slots were filled prior to the start of that business day.

After conferring with staff, the decision was made to create an urgent care/same day appointment slot for 10AM and 3PM.

Upon review, we were able to maintain open slots for same day appointments above the goal of 75%.

### Limitations:

- Change in definition for same day appointments from only 10 AM slot to both the 10am and the 3pm slot.
- While this study did achieve the goal of maintaining open slots strictly for same day appointments, it was apparent that some same day appointments were added ad-hoc to other slots that were available upon arrival.

## Health Literacy in Primary Care

*Rachel Coleman-Pierron, MD; Amy Patel, MD; Angela McLean, MD*

### *Internal Medicine*

**Background:** Health literacy is defined as the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. In the United States, eighth grade is the average reading level. According to the 2003 National Adult Literacy Survey, forty four percent of New Orleans adults read at the lowest functional level compared to twenty five percent of the nation. Since health literacy scores are directly related to literacy scores, physicians must possess the skill of translating complex medical terminology to concepts that all can understand. Lower health literacy has been found in patients with one or more chronic diseases. Low literacy has been found to be an independent risk factor for increased mortality, lower satisfaction with care, lower quality of care, worse patient safety, and higher health care costs. Rapid Estimate of Adult Literacy in Medicine (REALM-R) is a word recognition test used to assess a patient's ability to read common medical words to aid medical professionals in identifying patients at risk for poor literacy skills. A score of 6 or less suggests a patient is at risk for poor health literacy. Our goal is to assess the health literacy in the LSU internal medicine resident primary care clinic in order to improve communication, confirm comprehension, and provide appropriate educational materials.

**Methods & Results:** Clinicians and staff at two academic clinical training sites, internal medicine resident continuity care clinic and faculty multi-disciplinary primary care clinic, completed a health literacy assessment tool from the Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit. This tool assessed baseline health literacy levels in four domains: spoken communications, written communications, self-management/empowerment and supportive systems. Eleven of forty nine elements on AHRQ's Deficiencies Health Literacy assessment tool were rated by 83% of the evaluating staff/clinicians as needing improvement. Health literacy was then identified as a focus for improvement. Seventy one patients were then screened in the LSU internal medicine resident primary care clinic using the REALM-R short form. Forty six percent of participants scored six or less, which indicates a high risk for poor health literacy.

**Discussion:** A large percentage of the sample was found to be at high risk for poor health literacy. We suspect that almost half of our clinic patients are at risk for poor health literacy. Poor health literacy likely leads to worse outcomes, lower patient satisfaction, worse patient safety, and higher health costs. Health literacy has been targeted over the past ten years as an area of much needed improvement since electronic health literacy has become more recognized with the easy access to online searching of chronic medical conditions. A six month pilot study performed at Durham Veterans Affairs Medical Center on patients with cardiovascular disease risk factors applied individualized calendars containing medication name, time of day, picture of medication, number of times daily consumed, dose of medication, and clinical indication. There were insignificant improvements in blood pressure, but results suggested intervention improved medication adherence. A randomized clinical trial of people living with HIV and limited health literacy used pictograph guided patient education and skills-building intervention versus general health improvement counseling (control) in Atlanta, Georgia from November 2008 to April 2012 in efforts to improve HIV treatment adherence in patients with marginal and lower literacy skills. Marginal health literacy participants benefited from pictograph guided and standard adherence counseling. Lower literacy participants demonstrated greater adherence than those in the pictograph-guided and standard adherence counseling. By recognizing poor health literacy in our clinics, we can implement policies in our internal medicine clinic to communicate clearly, confirm comprehension and provide appropriate educational materials. In the future, we hope analyze medication adherence, relevant labs, and vitals of patients with chronic medical conditions at baseline and after interventions such as pillboxes, watch alarms, calendars, and reminder notes in our LSU internal medicine resident primary care clinics.

## Therapeutic Hypothermia: Use of Cardiac Rhythm Changes and Return-of-Spontaneous-Circulation Time as Inclusion Criteria for Improved Protocol Outcomes

*Jorge Martinez, MD, JD, Brandon Roberts, MD, Sr. Holly Toca, RN  
Internal Medicine and Interim LSU Hospital*

**Background:** Therapeutic Hypothermia (TH) is the accepted standard for comatose patients with Return-of-Spontaneous-Circulation (ROSC) after CPR regardless of initial rhythm being shockable or non-shockable. Since TH is expensive and resource consuming, we sought to develop criteria to exclude those unlikely to benefit from TH.

**Methods:** Retrospective Chart Review of 107 consecutive adults undergoing TH from 3/1/2010-5/1/2014 yielded complete records for 99 patients in the Pre-hospital, ED and ICU assessment.

**Results:** 69 males and 38 females with 45 survivors (42%) and 62 deaths (58%). Presenting rhythm divided into shockable (Pulseless Ventricular Tachycardia, Ventricular Fibrillation, n=26) and non-shockable (Pulseless Electrical Activity, Asystole, n=73). ROSC <20 minutes in shockable rhythms had 21 patients with 15 survivors (71%) and those >20 minutes ROSC in shockable rhythms had 5 patients with 3 survivors (78%). ROSC <20 minutes in non-shockable rhythms had 54 patients with 18 survivors (33%). ROSC >20 minutes in non-shockable rhythms had 19 patients with 2 survivors (10%).

**Conclusion:** Patients undergoing TH with shockable rhythms even greater than >20 minutes ROSC had overall survival of 70%. In contrast, while patients with non-shockable rhythms, particularly after 20 minutes ROSC, had only 2 survivors (10%). Our data indicate patients with non-shockable rhythms and >20 minutes ROSC do not benefit from subsequent TH.

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## Effect of Prior Aspirin Therapy on Stroke Severity as Measured by NIH Stroke Scale and the Duration of Hospitalization

*Christopher Edwards, MD, Zhora Oganisyan, MD, Gelasio A. Baras Avila, MD, Saurabh Lalan, MD, Nirmala Tumarada, MD  
Neurology*

**Objectives:** The Joint Commission Clinical Guidelines recommends that long-term aspirin therapy should be prescribed at discharge for the secondary prevention of subsequent cardiovascular events in eligible patients who have had an acute myocardial infarction (MI). Similarly, many patients who have not suffered acute MI are prescribed daily aspirin therapy for other medical reasons, most often as an antiplatelet agent to reduce the risk of adverse cardiovascular and/or thromboembolic events. The current retrospective cohort study investigated whether there is an association between chronic aspirin therapy prior to admission for stroke and severity of sequelae (as measured by NIHSS), impact on duration of hospital stay or death from stroke.

**Methods & Results:** It is retrospective study where we analyzed the data collected from the EPIC EMR system on all patients in a 4-month period admitted to Interim LSU Public Hospital (ILH) for stroke. There are 104 patients that we worked on, more than 95% of those are genuine stroke activations with focal neurological deficits in ER. Out of these 104 patients, 44 patients were on ASA prior to the current episode and the remaining 60 were not on ASA. NIHSS were compared in all the patients at the time of admission, Outliers have been excluded from both the study and control groups as NIHSS scores only the new onset neurological deficits, but not the baseline deficits prior to the presentation.

Our data analysis showed that there is a significant difference ( $P < 0.05$ ) in the NIHSS in the study group vs control group. NIHSS for ASA users is  $2.667 \pm 2.420671$  (Mean  $\pm$  st dev), where as in ASA non users it is  $15.46154 \pm 10.86731$  (Mean  $\pm$  st dev).

But there is no significant difference in the length of hospital stay: ASA users  $75.19231$  (st dev  $\pm 27.92135$ ), whereas in ASA non users, it is  $122.2414 \pm 45.95623$ .

**Conclusions:** NIHSS is not a good indicator of the overall neurological status of an individual. In this current study we got a significant difference in NIHSS between the two groups as outliers were found due to small study group. But this won't work for large study groups. Hospital stay is not just decided by the neurological status of the patient but the overall general health condition of the patient. So hospital stay would not be a good indicator to measure the efficacy of ASA in the secondary prevention of thromboembolic events.

Use of Electronic Health Records May Improve Compliance with The Joint Commission Stroke Core Measures  
*Faraz Khursheed, MD, Frank Williams, MD, Frank Torres-Delgado, MD, Christopher Edwards, MD, Louis Cannizzaro, MD, Lionel Branch, MD, Toni Rougeou, RN*

### *Neurology*

Stroke core measures were introduced by the Joint Commission in collaboration with the American Heart Association (AHA)/American Stroke Association (ASA)/Brain Attack Coalition (BAC) for use by Disease-Specific Care (DSC)-certified primary stroke centers. These are evidence based patient care interventions shown provide best outcomes in setting of acute stroke.<sup>1</sup> The compliance with these core measures is recorded for Primary Stroke Center Certification and is shown to improve patient outcomes and soon will have financial implications. It is therefore imperative for any certified stroke center to ensure strict implementation of core measures. Since the introduction of EPIC at ILH (Interim Louisiana Hospital), we sought to introduce BPAs (best practice alerts), modification and addition in stroke admission and discharge order sets to remind healthcare providers of stroke core measures at different time points during patient's hospital stay. There have been several modifications in the stroke admissions and discharge order sets over last 12 months which have helped improve hospital performance with these core measure compliance as recorded by the stroke coordinator. The BPAs are currently developed to remind prescribers of some core measures at certain time points as the Joint Commission mandates. After these BPAs and other proposed changes are in effect, we plan to quantitatively analyze the compliance rates with the stroke core measures before and after EPIC using a randomized sample. It will be a first such direct demonstration of improved stroke core measures compliance at a teaching hospital that has adopted electronic medical records. (Reference: [http://www.jointcommission.org/core\\_measure\\_sets.aspx](http://www.jointcommission.org/core_measure_sets.aspx))

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### Determining the Appropriateness of a Referral: A Chart Review of First-Time Child Neurology Patients

*Rashmi Rajendra, MD; Daniella Miller, MD, MPH*

### *Child Neurology*

**Objective:** Nationally, the list for a new patient appointment with a child neurologist is reported to be between four to six months. Previous studies have noted that the high demand for an appointment in child neurology clinic is not only due to a shortage of child neurologists, but also due to a large amount of low acuity referrals that are being funneled through the system. The goal of our study is to evaluate new patients and the acuity of their referrals to our child neurology nurse practitioner's clinic and in two child neurology faculty member's clinics in a 4 month time span. We hope to identify the diagnoses most associated with referrals of low acuity. Once identifying the low acuity diagnoses, we may be able decrease the wait list of our patients by developing parameters for acceptance of new patients based on acuity and appropriateness. Additionally the identification of specific educational topics for referring physicians may be realized.

**Methods:** We acquired information through the scheduling system and dictation records of new patients seen in the child neurology nurse practitioner's clinic and in two child neurology faculty member's clinics. The data we collected included age, patient attendance to clinic, diagnosis based on dictation, whether a follow up appointment was made and whether any additional studies were scheduled. Based on these variables, a level of acuity of low, intermediate or high was assigned. Low acuity was categorized as patients who were not scheduled for follow up nor additional studies. Intermediate acuity included patients who had no follow up appointment scheduled but did require additional studies. High acuity included all patients who required follow up neurology appointments. From this, an "appropriate" referral was classified as any patient meeting criteria for intermediate or high acuity. Data is still in the process of being collected.

**Results:** In total, 543 patient encounters were included in the study. Of these, 113 encounters were classified as low acuity. Categorizing low acuity patients by diagnosis, the percentages are as follows: 27% developmental delay/behavioral (i.e. concern for autism), 14% tics/Tourette's syndrome, 16% chronic daily headache/migraine, 16% seizure (including provoked, prior diagnosis of epilepsy or concern for seizure without diagnosis of epilepsy,) 5% post-concussive syndrome, 6% movement disorders, 6% psychiatric etiology, <1% cerebral palsy, <1% syncope and 9% other.

**Conclusion:** The majority of patients of low acuity are diagnosed with developmental delay/behavioral issues. It may be important to re-route these patients to the proper resources upon identifying this concern as the initial reason for referral. Additionally, we must educate community physicians on the greater role that psychiatrists, psychologists and neuropsychologists play in the care of these patients as compared to the neurologist. Tics/Tourette's syndrome and chronic daily headache/migraines are other diagnoses that often require no neurological follow up or intervention and in theory can be managed by the primary care physician with adequate education.



## Local Management of Patients with Distal Symmetric Polyneuropathy as Compared to Published Standards

Victoria Mifsud, MD, Jenny Guerre, MD, Diana Crisan, MD

*Clinical Neurophysiology*

**Objective:** To assess whether the management of patients with Distal Symmetric Polyneuropathy (DSP) at the LSU Health St. Charles Clinic meets published quality standards.

**Background:** Standards for the management of patients with DSP published by the American Academy of Neurology (AAN) cover various aspects of management of the condition including key elements in history taking, electrodiagnostic and laboratory investigation, symptom management and the communication of the diagnosis and treatment options to the patient. Adherence to these standards is recommended to optimize overall management and we aim to assess this in our practice.

**Method:** We randomly selected for retrospective chart review 15 patients diagnosed with DSP from the LSU Health St. Charles Neuromuscular Clinics. 1) We looked at the points documented in the history especially whether patients were questioned about neuropathic symptoms including pain, sleep interruption by pain, falls, autonomic symptoms, alcohol consumption and family history. 2) We noted whether electrodiagnostic studies were performed. 3) We noted whether the laboratory investigative work up was complete. 4) We noted whether there was documentation of the communication of the diagnosis to the patients and whether treatment options had been discussed.

**Results:** Neuropathic symptoms and signs documented: 15 (100%). Questions asked about: Pain: 9(60%); Sleep interruption by pain: 0; Falls: 3 (20%); Autonomic Symptoms: 2 (30%); Alcohol Consumption: 11 (73%), but not using a validated screening tool; Family History: 3 (20%). Appropriate Electrodiagnostics: 15 (100%); Temperature documented: 0. Lab Tests: Glucose: 14 (93.3%); B12 +/- MMA: 14 (93%); SPEP: 13 (87%). Diagnosis & Treatment Options discussed with the patient: 15 (100%).

**Conclusions:** We do not fully meet the AAN Standards for management of DSP. To improve the capture of all key elements in the history, we propose introducing a patient questionnaire and a standardized peripheral neuropathy template which we can incorporate in our Electronic Health Record. The EMG machines have already been adjusted to ensure documentation of temperature in every electrodiagnostic study. Once these changes have been implemented we will reassess our performance and we are confident that we will see a positive impact on the results.

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## Neurosurgery for Dummies - Beginners Survival Manual

Silvia Gesheva, MD and Walid Radwan, MD

*Neurosurgery*

Residents from various subspecialties rotate on the LSU neurosurgical service at ILH and WJMC for exposure to general neurosurgery, neuro ICU and neurotrauma. To improve bedside teaching and resident education we are going to develop a mobile beginner's manual for management of neurosurgical patients. The format of this information can be printed or offered on a share drive, but we feel the best medium would be a smart phone application. This format would offer the most efficient delivery for resident and medical student education. We would initially make the application available to LSU residents and students, but it could potentially be offered nationally. The contents will include initial patient evaluation, common neurosurgical problems and management. We will also include common contact phone numbers, formulas, medications and hope to create standardized protocols. By standardizing this information and making it readily available we hope to offer expedited and accurate patient care. Our endpoints will include: final app design and implementation and resident feedback.

## Development of Standardized Method for Vaginal Prep in the Operating Room

*Stacey Holman, MD, Valerie Williams, MD, Amy Young, MD, Megan Bina, DO, Barry Hallner, MD, Lisa Peacock, MD*  
*OB/GYN*

**Goal:** To develop a standardized protocol for preparation of the vagina for all gynecologic procedures which require a vaginal prep.

**Tools/Resources:** Gynecology anatomy and surgical textbooks that illustrate and describe the preparation of vagina will be used as baseline knowledge for this procedure.

### Methods:

- \* Textbook and literature review was completed to determine common aspects of prep descriptions.
- \* Guidelines were developed by GYN surgeons to standardize each step of the prep process. Each step is described and illustrated with a photograph of that step using simulation models.
- \* Standard process will be approved and adopted by our department and disseminated in surgical teaching labs.

### Proposed outcomes:

- \* By standardizing prep of the vagina (as part of a larger research project to reduce surgical site infections), we hope to contribute to a decline in infection rates at ILH.
- \* Present for approval to the surgical quality committee and medical executive committee for adoption as the standard surgical prep process for all GYN procedures in the operating room at ILH.
- \* Develop educational tool for dissemination to all faculty and resident surgeons doing GYN cases.

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## Conchotome Muscle Biopsy: The Patient-Centered Alternative to Open Surgical Biopsy (project concept)

*Kenneth Van Dyke, MD; Randall Cravers, MD; Rohan Walvekar, MD; Lesley Ann Saketkoo, MD*  
*Rheumatology*

**Introduction:** A definitive diagnosis by muscle biopsy is essential for treatment and prognosis of neuromuscular diseases (NMD). Open surgical biopsies (OSB) are associated with high cost and complications (infections, hematomas, intra- / post-procedure pain, prolonged recovery with sutures, large scars, and missed diagnosis due to surgical delays). For 20 years, Karolinska Institute (KI), the premiere center for tissue-based NMD research, has used CMBT - a less invasive method that improves patient-centered outcomes and decreases overall cost while providing ample tissue for diagnosis and research - with a complication rate of <.01%. LSU is supported by KI and IMACS (<http://www.niehs.nih.gov/research/resources/imacs/>) to be the lead US institution to establish a CMBT operational template.

**Methods:** KI and IMACS supported proficiency training to LAS at KI. In concert with Children's Hospital (CH), patients with clinical NMD undergo CMBT -a sterile procedure by conchotome, a slender ENT instrument, descended into a <1 cm incision painlessly extracting muscle. Wound healing occurs via primary intention by steristrips only, requiring no post-procedural follow-up. The specimen is handed directly to pathology at CH. Prospective data over 1 year (>20 cases) on time to procedure, diagnosis, adequacy of specimen, healing time, complications, pain scales at time 0, 2 days,7 days and cost are compared to matched retrospective data on OSBs with pain med, patient complaints, nursing notes etc. used as surrogate for pain.

**Discussion:** Muscle biopsy is essential for diagnostic, prognostic and therapeutic accuracy. CMBT improves all patient-centered variables over surgical and instituting such provides substantial benefit to our patients.

## Screen Time Assessment in Continuity Clinics

JoNell Bolton, MD, Karen Kern, MD, Sarah Hickey-White, MD, Barbara Brunet, MD

Pediatrics

**Background:** In modern society, children are exposed to a large amount of technology. Most households have two or three TV sets in their home; thirty percent of preschoolers and seventy-five percent of adolescents have TV sets in their room. Studies have shown that early and excessive exposure to television results in decreased scores in reading recognition, reading comprehension, and memory. In response to the prevalence of technology use in children and the negative effects associated with its use, the American Academy of Pediatrics has made recommendations to help guide the use of technology. The policy was published in 1999 and reaffirmed in 2011. The American Academy of Pediatrics uses the term screen time to describe the use of TV, video games, and internet. The American Academy of Pediatrics discourages any use of screen time in children less than two years of age. For older children, total screen time should be limited to less than two hours per day of educational, non-violent programs, which should be supervised by parents or another responsible adult. They further recommend not allowing TVs in children's bedroom and encouraging alternative entertainment to screen time. In order to educate parents on screen time recommendations, it is recommended that pediatricians assess screen time at well visits.

**Methods:** Our group wanted to assess if residents were following the American Academy of Pediatrics recommendation to evaluate and counsel on screen time at well child visits. We initially performed a chart review to look for documentation of screen time assessment and discussion during well child visits. We chose to look at two year well child visits in three of our continuity clinics. We found that residents were not documenting screen time evaluation or counseling. These findings were presented to the residents in order to make them aware of this gap in care. During our presentation, the results of our chart review were presented as well as the American Academy of Pediatrics recommendations about screen time. This information was presented in a way to provide residents with the knowledge and motivation to counsel patients. In addition to discussing this topic with residents, our group placed check boxes at the bottom of the preprinted two year old well child physician note to encourage residents to document discussion about screen time. We have also provided a handout with the American Academy of Pediatrics recommendations that can be given to patients in order to facilitate this discussion. We are currently gathering the information through a second chart review to see if residents are now assessing screen time.

**Results:** Our initial chart review showed that of the two year old visits, zero percent of residents were documenting screen time counseling. Of note, sixteen percent of the charts reviewed had a documented development concern without any documentation of screen time assessment despite a known association of inappropriate screen time and developmental delay. We are now in the process of a second chart review to see if adding a check box to the well child physician note encourages screen time discussion. In our preliminary data, it appears that residents are now assessing screen time, however we need further information in order to make conclusions about the current percentage of residents now discussing screen time. We will complete our chart review next month at which time we hope to see a significant change in resident behavior.

**Conclusions:** It is important in the community pediatric continuity clinics to have screen time assessed and appropriate counseling given to patients. The American Academy of Pediatrics has made specific recommendations regarding screen time and states that general pediatricians should be knowledgeable about the effects of screen time and to share this information with patients. Our group reviewed physician documentation and found that residents were not discussing this topic at the two year old well child visit. Our goal was to educate the residents on the importance of screen time counseling for our patients in an effort to change their behavior. Our quality improvement presentation given to all the pediatric residents aimed to empower residents with the tools to offer appropriate counseling. In addition, the handout available in clinic was meant to facilitate screen time discussion with families. By adding check boxes to our well child forms, we provided a reminder to residents to discuss this topic and document their discussion. Preliminary results show that we have made a difference in resident behavior.

## 2<sup>nd</sup> Annual Quality Improvement Forum Program Overview

**At the conclusion of this activity, the learner should be better able to:**

- Identify and distinguish QI and Patient Safety methodologies and how different approaches can be suited to the particular healthcare needs of hospitals and clinics.
- Organize and conduct a collaborative QI project that maximizes local resources and healthcare professionals.
- Understand the importance of engaging in systematic quality improvement in order to improve patient safety.

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**The following faculty and planning committee members disclosed relationships with commercial interests:**

Name	Commercial Interest	Received/Role
Amparo Gutierrez, M.D.	Teva	Speaker honoraria
	Genzyme	Speaker honoraria
Maria Velez, M.D.	CSL Behring	Advisory committee
	Octopharma	Advisory committee
	NovoNordisk	Clinical trials

**The following faculty and planning committee members have reported they have no relevant financial relationships with commercial interests:**

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