

TABLE 12

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Appropriate Statin Prescribing Based on Current Guidelines: A Retrospective Review at a Community Clinic

Ankit Singh

Appropriate Statin Prescribing Based on Current Guidelines: A Retrospective Review at a Community Clinic

Ankit Singh, MD; Sariu Bisiriyu, MD; Khalid Haji-Kusow, MD; Chandra Cherukuri, MD



Family Medicine, Hennepin Healthcare, Minneapolis, MN

Background:

- Cardiovascular disease (CVD) is the leading cause of death in the U.S.
- The 2022 USPSTF Grade B recommendation advises low to moderate dose statins for adults aged 40–75 who:
 - Have ≥ 1 cardiovascular risk factor (e.g., HTN, DM, smoking, dyslipidemia)
 - Have a $\geq 10\%$ 10-year ASCVD risk
- While the benefits of statin therapy are well-supported, real-world adherence in primary care remains uncertain.

Methods

Design: Retrospective chart review (Epic EMR)

Setting: Whittier Clinic

Timeframe: 1/1/2022 - 1/1/2025

Inclusion Criteria:

- Age 40–75
- ≥ 1 CVD risk factor (HTN, DM, Dyslipidemia, Current smoker)
- ASCVD risk $\geq 10\%$

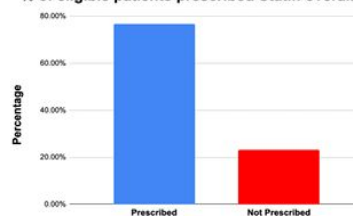
Data Collected:

- Demographics [Age 40-75, race(Hispanic vs Non-Hispanic)]
- Medical history (HTN, DM, Dyslipidemia, Current smoker)
- 10-year ASCVD risk $\geq 10\%$
- Prescribed Statins based on USPSFT Grade B Statin therapy guideline

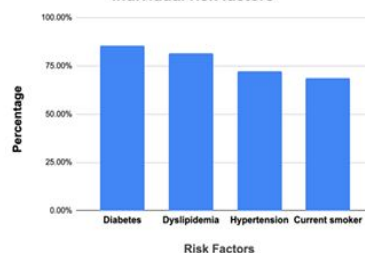
Results

Sample size: N = 2,295 total eligible patients for Statin therapy based on USPSTF Grade B recommendation.

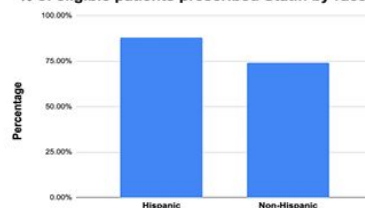
% of eligible patients prescribed Statin overall



% of eligible patients prescribed Statin by individual risk factors



% of eligible patients prescribed Statin by race



Discussion:

- From 2002 to 2013, among patients eligible for Statin use for primary prevention, only 41.8% were using Statins nationwide. Hispanic ethnicity was associated with lower odds of using statins.
- At Whittier Clinic between 1/1/2022 and 1/1/2025, overall 76.8% of eligible patients were prescribed statins per USPSTF Grade B guidelines, significantly higher than the national prescribing trend.
 - However, 23.2% eligible patients were not prescribed Statins, highlighting opportunities for improvement—particularly among Hypertensive patients and current smokers.
 - Potential barriers include: provider hesitancy, patient education, absence of automated ASCVD risk flags in Epic, and conscious efforts from providers to prescribe Statins based on guidelines.
 - Surprisingly 87.8% (more than double the overall national prescribing trend) of Hispanic patients eligible for Statin therapy were prescribed Statins compared to 74.26% of Non-Hispanic patients.

Conclusion/Future Directions:

These findings suggest that although majority of patients eligible for Statin therapy based on USPSTF “B” recommendation at Whittier clinic are receiving Statin therapy, system-level interventions may enhance adherence to the USPSTF Statin therapy recommendation. Incorporating automated ASCVD risk flags into Electronic Medical Records (EMR), increasing provider awareness, patient education and conscious efforts from providers could further improve adherence to USPSTF recommendations and enhance primary prevention of cardiovascular disease.

References:

- Salami, Joseph A., et al. "National Trends in Statin Use and Expenditures in the US Adult Population From 2002 to 2013: Insights From the Medical Expenditure Panel Survey." *Journal of the American Heart Association*, vol. 7, no. 10, 2018, e008398, <https://doi.org/10.1161/JAHA.117.008398>.
- USPSTF. *Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: 2022 Recommendation*.
- ACC/AHA ASCVD Risk Estimator Plus.



Febrile Seizure Clinical Guideline Development

Suanur Alp, Anja Touma ,
Samantha Vullo / Makaia Frober

Febrile Seizure Clinical Guideline Development

Nadia Maccabee-Ryaboy MD, Kate Allen, MD

Suanur Alp M.D., Anja Touma M.D., Samantha Vullo M.D., Makaia Frober M.D.

Introduction

- Clinical guidelines serve a wide variety of purposes including:
 - standardizing care
 - improving patient outcomes
 - reducing unnecessary interventions
 - increasing efficiency
 - ensuring equitable care amongst patients
 - increasing provider confidence
- Febrile seizures affect 2% to 12% of children and are a very common presenting complaint in our pediatric emergency room
- Large variability in the management
 - imaging?
 - labs?
 - neurology consult?
 - counseling families
 - admit or discharge?
 - future prevention

AIM STATEMENT

The goal of our quality improvement project was to create and publish a clinical guideline for the diagnosis and management of clinically stable children between 6 months - 6 years old presenting with febrile seizures in order to **increase resident comfort** in managing these patients by **20%**.

Methods

Pre-Intervention Data Collection

- We started by surveying the resident's current comfort without any existing guideline in place.
 - google survey distributed to current pediatric and medicine/pediatric residents during our weekly education sessions
- "On a scale of 1-10 how comfortable are you managing and evaluating children with suspected febrile seizure?"
 - PGY 1 - 5.5 out of 10
 - PGY 2 - 7.1 out of 10
- "On a scale of 1-10 how confident are you knowing if a child who presented to the emergency department with a suspected febrile seizure can discharge to home or if they need to be admitted?"
 - PGY 1 - 5.3 out of 10
 - PGY 2 - 6.9 out of 10
- On a scale of 1-10 how confident are you in knowing which children who present with febrile seizures necessitate brain imaging and which do not?
 - PGY 1 - 4.9 out of 10
 - PGY 2 - 7.5 out of 10

Intervention:

1. Create Clinical Guideline
 - Comprehensive literature review
 - Consulted pediatric hospitalist, neurologist, emergency medicine and outpatient providers
1. Publishing, distributing and making our Clinical Guideline openly accessible so all providers are able to access and utilize when managing patients presenting with febrile seizures (in process)

Outcomes

To assess outcomes, we plan to reassess resident comfort when caring for pediatric patients presenting with febrile seizures after one year of the guidelines being published and accessible, likely through redistribution of the same survey we used to collect pre intervention data.



Geriatric Boarding Approaches in the ED

Kevin Cao, Oscar Monterrosa

Geriatric Boarding Approaches in the ED

Background:

Improving boarding in the emergency department (ED) for geriatric patients can have significant effects with more efficient patient care, patient safety, and satisfaction. By implementing key strategies such as geriatric screening tools to identify high risk patients, polypharmacy, abuse, and higher levels of care coordination, providers can expedite often complex and lengthy aspects of care. Key strategies including more ED-focused delirium precautions, enhanced pre-hospital communications, and earlier frailty screenings for patients requiring functional status evaluations are crucial to shorter hospital stays and preventable readmissions.

Prolonged boarding in the ED can lead to adverse outcomes such as increased in-hospital mortality, higher rates of adverse events (e.g., falls, infections), and longer hospital stays.[2-3] For instance, a study published in JAMA Internal Medicine found that older patients who spent the night in the ED had a higher in-hospital mortality rate and increased risk of adverse events compared to those admitted to a ward before midnight.[2] Furthermore, the guidelines emphasize the importance of a multidisciplinary approach to improve care for older adults in the ED. This includes specialized staffing, appropriate transitions of care, and the use of geriatric-specific protocols and equipment.[1] Effective screening and early intervention can help prevent functional decline, delirium, and other complications, ultimately improving patient outcomes and reducing healthcare resource utilization.[4]

CLINICAL FRAILITY SCALE

1	VERY FRAGILE	People who are almost entirely dependent on others for their basic functioning and are at a very high risk for death.
2	MODERATELY FRAGILE	People who, for an acute illness, require a significant amount of help with their basic functioning.
3	MILDLY FRAGILE	People who are somewhat independent but still require some help with their basic functioning.
4	MODERATELY ROBUST	People who are mostly independent but still require some help with their basic functioning.
5	VERY ROBUST	People who are almost entirely independent and are at a very low risk for death.

DELIRIUM RISK ASSESSMENT TOOL

- AGE ≥ 75 y.o.
- DEMENTIA
- HEARING IMPAIRMENT
- PSYCHOSOCIAL/DRUGS/OTHER RISK

3+ HIGH RISK OF DELIRIUM

Geriatric Boarding Process Flowchart:

- POST-ADMISSION:** Patient arrives at the ED. Initial assessment by the ED team.
- 6 HOUR BOARDING:** Patient is boarded in the ED. A 6-hour boarding order is set. The patient is monitored by the ED team.
- DELIRIUM PRECAUTIONS:** Delirium precautions are implemented, including fall risk assessment, collateral information, and closed loop communication with the home environment.
- TRANSITION OF CARE:** The patient is transitioned to the appropriate care setting (e.g., ward, SNF, AL).

QI metrics:

- Geriatrician provider follow up rates in the next 2 months post ED/hospital follow up
- Linkage with social services
- Readmission rates
- Transition of care and care environments
- Hospital Length of Stay

Intervention:

EMR order set for boarding geriatric patients:
EMR order set triggered after >6 hours in the ED
Prompts provider/nursing staff to assess:

- Clinical Frailty Scale
- Delirium Risk Assessment Tool
- Options for interventions including: day-night light attenuation, noise and stimuli reduction, geriatric appropriate medication options, and functional assessments from different therapies including PT OT and SLP

Initial ED workup for geriatric patient


6 Hour: Boarding Order set

Delirium precautions, fall risk assessment, collateral information and closed loop communication with home environment

Prehospital communication (AL, SNF, SAR)

Bed availability and boarding

PT OT SLP
Social work coordination
Early intervention dispo planning



Improving Pediatric Rapid Response Teams: Initial Data Tracking and Perception Survey

Paige Malwitz

Improving Pediatric Rapid Response Teams: Initial Data Tracking and Perception Survey

Paige Malwitz, BS; Cash Pence, BS; Alyssa Mondelli, MS; Bonnie Bentson, MD; Ali Marquez, MD, MSTR; Billy Sveen, MD, MA

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Prospective Tracking of Rapid Responses (RR)

- RRT identify early clinical deterioration and escalate patient care
- RR were tracked over 2 months to determine:
 - Number of initial RR, repeat RR, and transfers to ICU after RR
 - RR within 12 hours of admission or ICU transfer
 - Number of clinical deterioration events (CDE) and emergency transfers (ET)

	February	March	Mean
Initial RR	17	14	15.5
Repeat RR	5 (30%)	2 (14%)	3.5 (23%)
Transfer to ICU	9 (53%)	7 (50%)	8.0 (52%)
Recent Admission	4 (24%)	4 (29%)	4.0 (13%)
Recent ICU Transfer	0 (0%)	0 (0%)	0.0 (0%)
CDE	4 (44%)	6 (86%)	5.0 (63%)
ET	0 (0%)	0 (0%)	0.0 (0%)

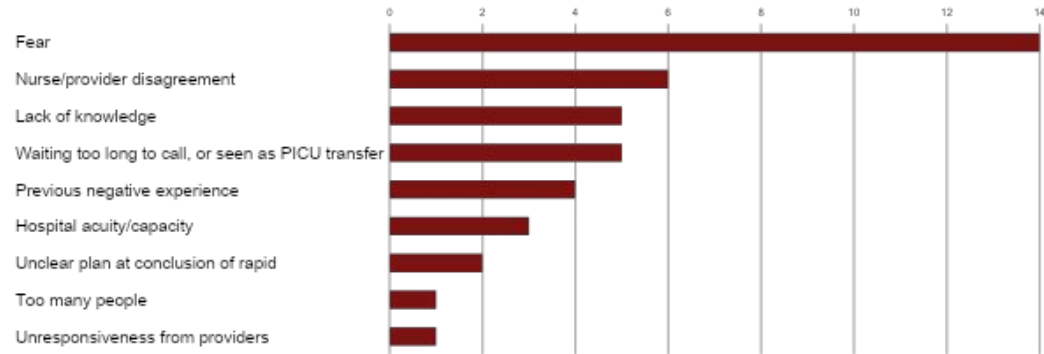
Determining Preventability of Pediatric Arrests

- Some pediatric cardiac arrests requiring CPR occur outside of ICU
- Cases from 2021-2024 that occurred outside ICU were identified and reviewed for preventability, signs of deterioration 15 minutes prior to arrest
- 5 cases occurred over 4 years
 - 2 of 5 (40%) cases were determined to be possibly preventable, rate of 0.5 cases per year
 - 4 of 5 (80%) had a primary cardiac diagnosis

Rapid Response Facilitators and Barriers Survey

- There are many different roles involved in RRT
- RNs, physicians, and RTs were surveyed to understand staff opinions on RR process
- Works well: fast response, number of people, information
- Needs improvement: communication, staff arriving at different times, unclear roles

Barriers to RR



Conclusion

- 63% CDE and 0% ET suggest appropriate escalation of care of a high acuity population during respiratory season
- 0.5 RRT-preventable arrests outside the ICU per year suggests appropriate RRT use
- Improving communication and reducing fear were common survey themes
- This baseline data will aid in quality improvement as changes to the RRT process are made in the future