

Oregon Health & Science University

# OHSU GME Health Systems Science Symposium

May 2026

# Table of Contents

1 Screening in Community Outreach Programs .....	3
2 Contemporary Outcomes and Practice Patterns Following Direct Current Cardioversion Among Patients with Percutaneous Left Atrial Appendage Occlusion Devices .....	4
3 The Cortiven Decision: Demonstrating Cognitive Biases via a Collaborative Decision-Making Module .....	5
4 Developing A Novel AI/LLM-Based Approach for Classification of Patient Referrals to Care Management .....	6
5 Inpatient Penicillin Allergy De-Labeling: A Quality Improvement Study.....	7
6 Inpatient Penicillin Allergy De-Labeling: A Quality Improvement Study.....	8
7 Closing the Gap: Preliminary Results of a Multilingual Breastfeeding Support Intervention for Spanish-Speaking NICU Families .....	9
8 Improving the patient experience with intrauterine device (IUD) placement through an educational initiative.....	11
9 Results of Standardized Note Templates to Reflect Departmental Performance and Reimbursement.....	12
10 Improving Postpartum Depression Screening Rate at a Rural Health Center in Oregon. 13	
11 Axial Spondyloarthritis: Moving Beyond Cytokine Based Therapies to Cellular Targets . 14	
12 A Quality Improvement Initiative to Improve Contraception and Pregnancy Planning in Women with Rheumatic Diseases on Teratogenic Medications.....	15
13 Improving Patient Portal Engagement: Identifying Barriers to MyChart Use in a Clinic Patient Population.....	16
14 Community-Engaged Advocacy Project: Rural and Hispanic Disparities in Cancer Prevention .....	17
15 Improving Hypertensive Measurement and Treatment in the Portland VA Health System .....	19
16 Reducing the Carbon Footprint of the Endoscopy Suite: A Multimodal Quality Improvement Initiative.....	20
17 Balance Deficits are Present Across Mild Traumatic Brain Injury Symptom Subtypes ...	21
18 Portland VA Inpatient GDMT Algorithm .....	22
19 Repeat Intra-operative Urethral Preparation to Decrease Post-op UTIs .....	23

20 Ending Rural Addiction Care Disparity ..... 24

21 Lead Screening in Patients with Gunshot Wounds ..... 25

22 Opportunistic, Patient-Centered Gynecologic Care at the Time of Bariatric Surgery: A Single-Institution Experience ..... 26

23 Implementation of Validated Patient-Reported Outcomes in the OHSU Allergy & Immunology Clinic ..... 27

24 GI Mucormycosis and Total Colectomy in a Young Adult with T-cell acute lymphoblastic leukemia (T-ALL) ..... 28

25 Implementing an Inpatient Heart Failure Management Algorithm at the Portland VA Medical Center: a Quality Improvement Project Works-in-Progress ..... 29

26 Exploring provider perspectives around child protective services reporting for obstetric patients who use substances..... 30

# 1 Screening in Community Outreach Programs

Zhengchun Lu 1, Rabeka Ali 1, Rhiannon Gall 1, Erandi Velazquez-Miranda 1, Chengyun Tang 1, Marcela Riveros Angel 1, Vanderlene L Kung 1, Guang Fan 1

Affiliation

1From the Department of Pathology & Laboratory Medicine, Oregon Health & Science University, Portland, Oregon. Fellows

**Context:** On May 14, 2024, the US Food and Drug Administration (FDA) approved self-collected vaginal samples for human papillomavirus (HPV) testing, expanding cervical cancer screening access.

**Objective:** To evaluate the feasibility and acceptability of HPV self-collection through community outreach programs targeting underscreened populations in Oregon.

**Design:** From October 2024 to June 2025, women aged 25 to 65 years were recruited through local organizations. Following instruction by pathologists, participants completed self-collection by using Copan swabs, which were transferred to ThinPrep media for high-risk HPV testing using the Cobas 8800 system. Postcollection surveys assessed user experience.

**Results:** Among 156 participants (mean age, 47.1 years), 87 (55.8%) identified as Hispanic and 69 (44.2%) as non-Hispanic. Racial groups included Hispanic White (87; 55.8%), Asian (33; 21.1%), Black (16; 10.3%), non-Hispanic White (14; 9.0%), Pacific Islander (2; 1.3%), and nondisclosed (4; 2.5%). All tests were valid; 10 participants (6.4%) were HPV-positive, including 1 with HPV-18 and 9 with non-16/18 types. Follow-up cytology showed 1 case of atypical squamous cells of undetermined significance and 2 negative results; the remainder are pending follow-up. Of 129 survey respondents, 8 (6.2%) had received the HPV vaccine. Overall, 117 (90.7%) found the self-collection kit easy to use, 114 (88.4%) would recommend it, and 91 (70.6%) were likely to choose self-collection over clinician-collected samples for future testing. Common feedback included convenience, comfort, and privacy.

**Conclusions:** HPV self-collection is a practical, user-friendly, and accessible screening option. Pathologist-led outreach may help close screening gaps. This study represents the first academic center-led implementation of FDA-approved self-collection in US community settings."

## 2 Contemporary Outcomes and Practice Patterns Following Direct Current Cardioversion Among Patients with Percutaneous Left Atrial Appendage Occlusion Devices

William B. Earle, MD; Nathan Watson, MD; Caroline Wang-Crocker, MD; Aubrey Dawson, MD; Carla Boyle; Peter Jessel, MD; Francis Phan, MD; Charles Henrikson, MD; Saket Sanghai, MD  
Fellows

**Background:** Patients with atrial fibrillation requiring direct current cardioversion (DCCV) have increased thromboembolic risk, so current guidelines recommend left atrial imaging within 48 hours or uninterrupted oral anticoagulation (OAC) for  $\geq 3$  weeks, followed by 4 weeks of OAC. In those with left atrial appendage occlusion (LAAO), the optimal periprocedural DCCV management is unknown. This uncertainty can result in care delays.

**Objective:** To describe current management strategies and associated outcomes of patients with LAAO requiring DCCV at OHSU to inform the creation of a standardized institutional management guideline.

**Methods:** An institutional LAAO registry was queried to identify those with LAAO placed between January 2016 and June 2025. Retrospective chart review was performed to identify those who underwent a non-emergent DCCV after LAAO. Outcomes were stratified based upon periprocedural management strategy.

**Results:** Among 358 patients with LAAO, 41 patients underwent a total of 77 DCCVs (mean age 71 years, 41% male, 93% white race, median (IQR) CHA<sub>2</sub>DS<sub>2</sub>VASc 4 (3-5), HAS-BLED 1 (1-2)). Among DCCVs, 33.8% received preprocedural OAC, 55.9% received preprocedural imaging of the LAA to exclude thrombus, and 23.4% did not receive guideline-concordant management, which occurred more commonly in the emergency room (ER) (66.6%) vs inpatient (10%) or outpatient setting (23.5%). TIA/stroke and bleeding complications were low and similar regardless of guideline adherence; however, rates of 1-year readmissions appeared higher among those who underwent pre-DCCV imaging or anticoagulation (52.1% vs 25.0%).

**Conclusion:** DCCV is common among patients with prior LAAO, yet management patterns varied widely. Despite one quarter of DCCVs performed without OAC or pre-procedural imaging, stroke and major bleeding events were rare. These findings support the need for unified guidelines to standardize DCCV management in this population"

### 3 The Cortiven Decision: Demonstrating Cognitive Biases via a Collaborative Decision-Making Module

Mason Paas, MD; Matthew Diveronica, MD; Anne Smeraglio, MD; Nilan Schnure, MD; Max Rusek, MD  
Fellows

#### Learning Objectives

1. Identify and define common cognitive biases in clinical decision-making.
2. Recognize and manage the influence of cognitive biases during a clinical case.

**Purpose:** Cognitive biases significantly influence physician decision-making, yet GME instruction often relies on didactic lectures that are less effective for teaching real-time cognitive strategies. We developed a collaborative, interactive, case-based activity modeled after the Carter Racing Problem to enhance our cognitive bias curriculum. Grounded in Constructivist Learning Theory, the activity engages learners in problem solving rather than passive information receipt.

**Setting:** This activity occurred within our longitudinal Teaching Improvement Science (TIS) curriculum. Participants were internal medicine interns in cohorts of 8–9, each session led by a faculty facilitator and lasting two hours.

**Description:** Interns worked through a fictional ICU case involving rapidly progressive interstitial lung disease in which an attending proposes off-label use of a new medication, Cortiven. Although institutional data suggests dramatic improvements, rare adverse outcomes are severe. Interns were tasked with determining whether to administer Cortiven. The case subtly incorporated authority bias, anchoring, framing effect, endowment effect, and confirmation bias. After reaching a decision, facilitators revealed the embedded biases and led a discussion defining each bias, exploring how they affected decision-making during the case and in clinical practice. Learners reflected on their reasoning processes and discussed tools to mitigate cognitive bias, including checklists, evidence aggregators, and differential diagnosis generators.

**Evaluation:** Post-session Likert surveys assessed relevance, organization, complexity, interactivity, and overall quality. A Mann Whitney U test comparing 2024 didactic-only sessions with the 2025 case-based format showed significant improvement (mean 4.4 to 4.8,  $p=0.05$ ;  $n=33$  and 27). Qualitative feedback reflected fewer suggestions for improvement and greater appreciation of interactivity.

**Discussion:** This constructivist, case-based approach improved learner engagement and satisfaction. Adapting the Carter Racing framework to a clinical scenario effectively illustrated cognitive biases and strengthened educational outcomes.

## **4 Developing A Novel AI/LLM-Based Approach for Classification of Patient Referrals to Care Management**

Kevin Zhang, MD  
Fellow

OHSU Care Management receives patient referrals from a wide variety of clinical departments and service lines (primary care, emergency department, inpatient, etc.). Currently, employees must manually open, screen and read each referral to determine how to best categorize it and route the referral to the most appropriate case worker or department. This is a laborious and time-consuming process. In this paper, we demonstrate and evaluate the development of an artificial intelligence/large-language model (AI/LLM)-based natural language processing (NLP) referral classification pipeline using a zero-shot prompting, using a BERT-based model as a baseline.

## 5 Inpatient Penicillin Allergy De-Labeling: A Quality Improvement Study

Emily Fan, MD, Pei-Hsuan Li, DO, Quinn Nelson, MD, Alyssa Fujiwara, MD, Pooja Patel, MD, Genevieve Benedetti, MD, and Anne Smeraglio, MD  
Residents

While 10% of patients report an allergy to a penicillin class medication, less than 1% have a true IgE-mediated allergic response. Mislabeling leads to increased healthcare costs due to prolonged length of hospitalization, more exposure to broad spectrum antibiotics, and higher rates of infections from resistant organisms. More than 90% of penicillin allergies can be safely de-labeled with allergy testing but only 1% of patients with a penicillin allergy receive allergy evaluation. We collected baseline statistics and interviewed pharmacy and infectious disease stakeholders to understand current institution specific practices in order to develop a new protocol for inpatient de-labeling of penicillin allergies.

We found that 8.1% (570/7074) of the unique patients admitted to our hospital from May 7, 2024 to May 7, 2025 had a documented penicillin allergy. Based on interview data, inpatient allergy de-labeling is rarely pursued due to lack of an established protocol, limited provider knowledge about de-labeling, and insufficient pharmacy personnel. We created a team-based design with pharmacy, allergy, infectious disease and internal medicine to implement a penicillin allergy de-labeling protocol that will rely on a nationally available algorithm to confirm the allergy, de-label the allergy, or refer to outpatient allergy clinic for consideration of oral graded challenge with amoxicillin. Our investigation shows the VA has a near-standard rate of penicillin allergy, yet no inpatient de-labeling protocol exists despite nationally available models. Through our protocol, we aim to de-label more patients both inpatient and outpatient via referral to our allergists.

## 6 Inpatient Penicillin Allergy De-Labeling: A Quality Improvement Study

Emily Fan, MD, Pei-Hsuan Li, DO, Quinn Nelson, MD, Alyssa Fujiwara, MD, Pooja Patel, MD, Genevieve Benedetti, MD, and Anne Smeraglio, MD  
Residents

While 10% of patients report an allergy to a penicillin class medication, less than 1% have a true IgE-mediated allergic response. Mislabeling leads to increased healthcare costs due to prolonged length of hospitalization, more exposure to broad spectrum antibiotics, and higher rates of infections from resistant organisms. More than 90% of penicillin allergies can be safely de-labeled with allergy testing but only 1% of patients with a penicillin allergy receive allergy evaluation. We collected baseline statistics and interviewed pharmacy and infectious disease stakeholders to understand current institution specific practices in order to develop a new protocol for inpatient de-labeling of penicillin allergies.

We found that 8.1% (570/7074) of the unique patients admitted to our hospital from May 7, 2024 to May 7, 2025 had a documented penicillin allergy. Based on interview data, inpatient allergy de-labeling is rarely pursued due to lack of an established protocol, limited provider knowledge about de-labeling, and insufficient pharmacy personnel. We created a team-based design with pharmacy, allergy, infectious disease and internal medicine to implement a penicillin allergy de-labeling protocol that will rely on a nationally available algorithm to confirm the allergy, de-label the allergy, or refer to outpatient allergy clinic for consideration of oral graded challenge with amoxicillin. Our investigation shows the VA has a near-standard rate of penicillin allergy, yet no inpatient de-labeling protocol exists despite nationally available models. Through our protocol, we aim to de-label more patients both inpatient and outpatient via referral to our allergists.

## **7 Closing the Gap: Preliminary Results of a Multilingual Breastfeeding Support Intervention for Spanish-Speaking NICU Families**

Emily Chi, MD; Jamie B. Warren, MD, MPH; Maggie Jerome, PhD, RD, CNSC, LD; Susan Hwang, MD, PhD, MPH/MSPH, Devlynne Sasha Ondusko; MD  
Fellows

### **Background:**

Families with preferred languages other than English experience persistent disparities in breastmilk usage in the Neonatal Intensive Care Unit (NICU) despite the known benefits in preventing adverse outcomes and promoting positive neurodevelopment. The disparities are due to language discordance, cultural differences in lactation norms, and inconsistent access to tailored education and interpreter-supported care. Although multilingual lactation initiatives have improved outcomes in large urban NICUs, scalable, family-centered models remain limited. We sought to identify modifiable barriers and implement a culturally attuned peer-group breastfeeding education intervention.

### **Methods:**

This quality improvement initiative was conducted in a level IV NICU. Guided by a Spanish-speaking Family Advisory Board, we developed a multidisciplinary peer-group model consisting of 60-minute biweekly hybrid (in-person and virtual) sessions with interpreter support, co-led by International Board-Certified Lactation Consultants, doulas, dietitians, and Women Infant and Children peer counselors. Sessions emphasized practical pumping instruction, milk supply optimization, peer discussion, and individualized questions and answers. Iterative Plan Do Study Act cycles guided implementation and refinement.

### **Results:**

Preliminary data from four hybrid sessions involving eleven Spanish-speaking families indicates positive participant response. All families described the sessions as helpful and culturally affirming, reported a stronger sense of community, and noted greater openness in discussing pumping challenges. Facilitator feedback highlighted practical benefits, including ensuring access to pumping supplies, improved coordination of postpartum obstetric visits, and earlier lactation nurse follow-up aligned with family preference, indicating successful integration into NICU workflows.

### **Conclusions/Next Steps:**

A co-designed multilingual peer-group education model is feasible, well accepted, and sustainable within NICU care. Next steps include evaluating changes in breastmilk initiation and continuation rates compared with historical controls, refining workflow integration through

additional Plan Do Study Act cycles, and exploring expansion to prenatal settings. This model provides a scalable, promising framework for advancing breastfeeding equity in NICU populations.

## **8 Improving the patient experience with intrauterine device (IUD) placement through an educational initiative**

Emily Purzycki, Lucy Ward, MS, Lisa Bayer, MD MPH  
Medical Students

### **Introduction:**

Intrauterine device (IUD) placement is often a painful, anxiety provoking procedure with increasing negative perceptions despite multiple pain control methods. Providing anticipatory guidance can improve patient satisfaction and decrease anxiety and pain. This quality improvement project aimed to understand how providing written education prior to IUD placement affects the patient experience.

### **Methods:**

We developed a written patient education handout using a modified Delphi method and standardized, patient-reviewed to ensure readability. Patients presenting to a single institution's gynecology clinic for an IUD were surveyed about their experience pre and post utilization of the education handout standardly sent through the electronic medical record system patient portal. Additional balancing measures were collected through chart review. Descriptive statistics were used to compare groups.

### **Results:**

Both groups (30 pre-intervention, 33 post-intervention) reported high pre-procedure understanding of the IUD placement and pain management options. Of those who completed the post-procedure survey (53% pre-intervention, 30% post-intervention), 100% reported acceptable pain management and high levels of satisfaction. Per chart review, 16% of post-intervention patients engaged with the clinic before the visit to discuss pain management compared to 5% before the intervention ( $p=.086$ ). There were no differences in pain management pre- or post-intervention except for increased use of ketorolac in the post-intervention group (20% vs 4%,  $p=.01$ ).

### **Conclusion:**

Comparison of pre- and post-intervention data was limited due to low response rates and high levels of pre-procedural understanding among participants. However, using the patient handout resulted in a non-statistically significant increase in pre-procedural engagement and an increase in ketorolac use. This suggests that patients are more actively engaged in their pain management plan when using the educational patient handout, resulting in increased analgesic utilization.

## 9 Results of Standardized Note Templates to Reflect Departmental Performance and Reimbursement

Daye Park, MD

Jyoti Chouhan, DO, PharmD, MBA, FACS

Residents

Inpatient documentation serves many purposes including coding and reimbursement. At academic centers, residents are often responsible for the majority of inpatient documentation, though they receive minimal training on how documentation impacts coding and billing. This may lead to under-capturing of patient complexity and decreased reimbursements. We hypothesized that standardizing all types of inpatient notes, with an emphasis on capturing common urology-related diagnoses, would more accurately reflect patient complexity as represented by an increase in co-morbidity/complication (CC) and major comorbidity/complication (MCC) captures. The templates were instituted in June 2024. We reviewed data from academic years 2024-2025 and 2025-2026. As an example, for the bladder cancer diagnosis-related group (DRG) family (DRGs 653-655), we saw a decrease in encounters without a CC or MCC (16.4% to 8.5%) and an increase in encounters with an MCC, representing the highest complexity within that DRG (16% to 38%). For this DRG family, we billed an additional \$239,694 compared to a similarly sized hospital cohort. In conclusion, standardizing inpatient notes is an effective tool to guide comprehensive inpatient documentation and optimize reimbursement.

## 10 Improving Postpartum Depression Screening Rate at a Rural Health Center in Oregon

Mako Wakabayashi, MD, Tiantian White, MD, Brendan Kelley, MD, Rita Swartzwelder, MD, Dakota Lundstrom, MD, Lila Hawkinson, MD, Rachel Craven, MD, Brandon Carey, MD, Rebekah Schiefer, LCSW, Ryan Norton, DO, Emma Brooks, MD, Joe Skariah, DO  
Residents

**Background:** Maternal mental illness is the leading cause of maternal death in the US. Approximately 20% of women are screened for Postpartum depression (PPD) during the 12-month postpartum period. The American Academy of Pediatrics recommends screening for PPD at 1,2,4, and 6 month Well Child Checks. This project aimed to optimize PPD screening and intervention at OHSU Family Medicine Scappoose Clinic.

**Methods:** Epic tools were used to identify patients who are 0-12 months old and have Primary Care Providers (PCPs) at the clinic. Mothers' charts were accessed from each baby's delivery encounter. Mothers who didn't deliver at OHSU and whose PCPs aren't at the clinic were excluded. Babies not initially established at the clinic were excluded until they were established. The percentages of babies and mothers with EPDS scores in their charts were calculated for baseline data and after each intervention. Then patients' charts with EPDS score  $\geq 10$  were identified and were looked for interventions given.

**Results:** 15%, 3%, 1%, 1%, 1%, 0% of the babies who met criteria for this study at ages of <3weeks, 3-7weeks, 7weeks-3months, 3-6 months, 6months-1year had EPDS scores during each period. 46%, 43%, 11%, 2%, 0% of the mothers at each period had EPDS scores respectively. 3 PDSA cycles with interventions including implementing a clinic workflow, stapling EPDS with ASQs, and posting flyers in the clinic improved the screening rates in babies to 31%, 10%, 41%, 44%, 53% and those in mothers to 55%, 43%, 15%, 8%, 5%, respectively. 81% of patients with EPDS  $\geq 10$  were given interventions (e.g. medication, counseling, resources, self-action plan).

**Conclusions:** Family medicine clinics are potential intervention sites to improve screening and intervention for PPD, which could be achieved by structured workflows and reminders. We are developing local resource packets to share with patients with/at risk of PPD as a next step.

## 11 Axial Spondyloarthritis: Moving Beyond Cytokine Based Therapies to Cellular Targets

Surbhi Patel, MD; Rahul Patel, MD; Mohamad Bittar, MD; Atul Deodhar, MD  
Residents

**Background:** Rheumatology as a specialty is moving past cytokine inhibitors which have dominated the therapeutic landscape since the turn of the century, with novel cell-targeting therapies emerging to treat immune-mediated multi-system inflammatory diseases such as systemic lupus, systemic sclerosis, small vessel vasculitides, and inflammatory myositis. As of now, axial spondyloarthritis (axSpA) therapeutics has been limited to either inhibitors of TNF and IL-17, or blocking intracellular signaling of cytokines through Janus Kinase inhibitors.

**Methods:** We searched the MEDLINE, OVID and clinicaltrials.gov database to conduct a systematic review using the PRISMA guidelines. Searches were conducted on October 14 and 15, 2025. The existing adult and pediatric literature were reviewed from the time of inception of the database until October 14, 2025. The American College of Rheumatology (ACR) annual meeting abstract database and European Alliance of Associations of Rheumatology (EULAR) annual meeting abstract database were searched for abstracts from 2023 onwards to manually identify any studies that met our inclusion criteria.

**Results:** Four studies were identified and summarized.

**Conclusion:** Emerging therapeutics are shifting focus from cytokine-based therapeutics to T cell targeting agents. There is potential for selective CD8<sup>+</sup> T cell targets, and we highlight the proof of concept of using a monoclonal antibody against TRBV9<sup>+</sup> CD8<sup>+</sup> T cells from one published case study and one randomized placebo-controlled trial. There are several strategies for targeting pathogenic CD8<sup>+</sup> T cells in axSpA patients such as using an antibody to V9 antigen on the beta chain of the T cell receptor, using a bispecific antibody that binds to CD3<sup>+</sup> T cells and TRBV9<sup>+</sup> T cells, and targeting integrins that CD8<sup>+</sup> T cells express. There are currently no published studies on the use of CAR-T for treatment of axSpA. New therapeutic modalities and targets using CAR-T or shifting from cytokine targets to pathogenic T cell targets, to treat axSpA are currently ongoing. With further investigation and insights into multifactorial pathogenesis of axSpA, new treatment targets can be elucidated.

## **12 A Quality Improvement Initiative to Improve Contraception and Pregnancy Planning in Women with Rheumatic Diseases on Teratogenic Medications**

Madeleine Gertz, DO, Peter Liu, MD, Alex Belzer, MD, Nilan Schnure, MD, Anne Smeraglio, MD, Pascale Schwab, MD  
Residents

The American College of Rheumatology recommends routinely discussing and documenting contraception and pregnancy plans when prescribing teratogenic medications to women of childbearing potential (1). We aimed to assess documentation practices through interviews and chart review and use quality improvement methods to increase documentation.

We interviewed OHSU rheumatologists to create a process map of prescribing practices. We then reviewed charts of 80 female patients aged 18-50 with pregnancy potential who were prescribed methotrexate, mycophenolate mofetil, leflunomide, tofacitinib, or upadacitinib in rheumatology clinic from 2020-2024. Data collected included documentation of pregnancy intention, contraception type, documentation location, and classification of contraception. Qualitative and quantitative findings informed a root cause analysis presented at OHSU Rheumatology Grand Rounds, followed by a provider survey on preferred interventions.

Interviews revealed contraception and sexual activity are currently collected using paper forms at new and follow-up visits, then uploaded as PDFs into the media tab. These forms are unavailable for video or telephone visits and do not address pregnancy intention. Providers described variable practices for incorporating information from these forms into their notes. Chart review found pregnancy intention documented in 20% of patients (16/80), no contraception documented in 16% (13/80), and among those using contraception 20% (9/44) were using methods classified as less effective. Root cause analysis identified paper forms, variable documentation practices, documentation burden, limited dot phrase uptake, and lack of processes for virtual or phone visits as key contributors. In a provider survey, 93% of providers (15/16) ranked training MAs to collect pregnancy intention and contraception information during rooming and auto-populate it into note templates as their top two interventions.

Documentation of contraception and pregnancy planning remains inconsistent for patients prescribed teratogenic medications. Our quality improvement work supports a standardized process addressing sexual activity, contraception type, and pregnancy intention across all visit types while minimizing provider burden.

## 13 Improving Patient Portal Engagement: Identifying Barriers to MyChart Use in a Clinic Patient Population

Marlene Cervantes Gonzalez, DO MPH  
Resident

**Background:** Patient portals such as MyChart are designed to improve communication, access to health information, and overall patient engagement. Despite this, many patients do not use these tools. Understanding why patients do not use MyChart is important for improving access and optimizing care. The aim of this quality improvement project was to identify barriers to MyChart use and explore how factors such as language and comfort with technology may impact usage in a clinic patient population.

**Methods:** A cross-sectional survey of 150 patients was conducted in a clinic setting. Data collected included MyChart use, preferred language, technology comfort level, and perceived barriers to using MyChart. For multi-select barrier questions, only patients who provided at least one response were included in the analysis to avoid misclassifying missing data. Chi-square testing was used to evaluate associations, and an odds ratio was calculated to assess the strength of the relationship between reported barriers and MyChart use.

**Results:** Of 150 participants, 129 (86%) reported using MyChart and 21 (14%) were non-users. Patients reporting at least one barrier were significantly less likely to use MyChart compared to those who reported no barriers (57% vs <1% non-use;  $\chi^2$  p < 0.001), with an odds ratio of approximately 152. Commonly reported barriers included difficulty navigating the platform, login challenges, and lack of knowledge on how to use MyChart. Due to the small number of non-English-speaking participants, differences in MyChart use by language could not be reliably assessed. Lower comfort with technology was also associated with decreased MyChart use.

**Conclusions:** Barriers to MyChart use appear to play a major role in patient engagement. While language could not be fully evaluated, digital literacy and usability challenges are likely key contributors. Addressing these barriers through patient education and system-level improvements may help increase MyChart use in the clinic setting.

## 14 Community-Engaged Advocacy Project: Rural and Hispanic Disparities in Cancer Prevention

Julia Hamilton, M.D., Karissa Courtney, M.S.  
Residents

**Background:** Cancer has been the leading cause of mortality in Oregon since 2003, with pronounced disparities across rural populations and Hispanic communities.<sup>1</sup> Rural Oregonians experience higher cancer mortality than urban residents (165 vs. 145 per 100,000), driven by geographic isolation, limited healthcare access, and environmental exposures.<sup>1,2</sup> In Umatilla, Oregon, the community is concerned nitrate pollution in the water supply may be causing cancer. Many of those exposed to this pollution in Umatilla are Hispanic farm-workers. Hispanic populations face disproportionate burdens, including a twofold higher incidence of gastric cancer and lower colorectal cancer screening rates compared to non-Hispanic Whites.<sup>3,4</sup> These disparities highlight the need for community-engaged cancer-prevention interventions.

**Methods:** Across both projects, work was grounded in partnerships between community organizations and the Knight Cancer Institute. For the Oregon Rural Action collaboration, ongoing listening sessions and relationship-building informed a community-prioritized research agenda around nitrate-contaminated drinking water. Community stakeholders were engaged throughout study design to ensure alignment with local concerns, data sources, and interpretation. For the Unidos Bridging Community project, we collaborated with KCI Community Outreach & Engagement and a Community Cancer Specialist. Together, partners co-developed a community health fair model to deliver accessible education and facilitate connections to screening resources.

**Results:** The Oregon Rural Action partnership led to a co-created research agenda on environmental cancer risk, which secured EPA funding to support continued investigation of nitrate exposure and gastric cancer. The Unidos initiative contributed to a community-centered health fair that delivered culturally tailored cancer education and resources. Engagement with community members generated actionable feedback, including interest in more interactive educational tools and expanded on-site screening services.

**Conclusions and Next Steps:** These projects highlight that sustained community engagement, supported by institutions like the Knight Cancer Institute, is essential but requires navigating challenges such as differing priorities, resource constraints, and cultural or language barriers. Key lessons include the importance of long-term relationship-building, early and ongoing communication, and creating systems that support collaboration beyond individual contributors. Integrating community expertise—such as through roles like Cancer Control Specialists—

strengthens relevance and impact. Moving forward, efforts will focus on expanding cancer screening services at future Unidos health fairs and continuing implementation of the Oregon Rural Action research agenda through EPA-funded work. There are also opportunities to involve trainees in these established community–academic partnerships to support sustainability and growth.

## 15 Improving Hypertensive Measurement and Treatment in the Portland VA Health System

Jett Murray DO, Kevin Martz DO, Ria Sur MD, Leo Lester MD, Devan Kansagara MD, Max Rusek MD

**Introduction:** Hypertension (HTN) is a key modifiable risk factor for numerous chronic diseases, including chronic kidney disease, stroke, heart failure, and myocardial infarction. Only 62.8% of Portland VA resident clinic patients meet blood pressure (BP) goals of <140/90 mmHg, well below the national VA average of 76.4%. Root causes for this care gap are not clear.

Additionally, evidence supports the prognostic superiority of home BP over office BP for major adverse cardiovascular events, yet no standard process exists for home BP documentation when office BPs are persistently elevated.

**Aim:** To improve metric compliance (BP <140/90 mmHg) by 25% over 6 months

**Data Collection and Analysis:** Panel management review of 49 patients over two months categorized reasons for HTN metric fall-out, including documentation gaps, pending follow-up, lost to follow-up, and medical exceptions. Semi-structured interviews performed with clinical staff to identify key drivers of metric underperformance and informed a PDSA cycle targeting standardized BP workflows across clinical staff.

**Results:** The two most common reasons for fall-out—home BPs within goal but undocumented (32.7%) and HTN already being addressed with follow-up pending (28.6%)—accounted for over 60% of cases. Only ~10% of patients required new clinical action, suggesting documentation and workflow gaps, not clinical inaction, drive apparent non-compliance. Lack of repeating office BPs, no standardized workflow for collection of home BP logs, and over-reliance on clinical LPN/NCM staff were identified as modifiable factors via stakeholder interviews.

**Discussion:** VA's resident clinic's HTN metric underperformance reflects a systems problem more than a clinical one. Standardizing repeat BP checks, distributing a modified home BP log, and integrating the ShareMyHealth app are scalable interventions aligned with VA/DoD 2020 guidelines. Next steps include submitting the revised BP log for institutional approval, implementing PDSA Cycle 1 to systemize LPN and PCP roles in BP monitoring, and tracking monthly metric data. Barriers include staff time constraints, CPRS complexity, and asynchronous medication titration.

## 16 Reducing the Carbon Footprint of the Endoscopy Suite: A Multimodal Quality Improvement Initiative

Julia Hamilton, MD, Sophie Goldman, MD (co-first authors), Eddy Leung, MD, Seth Crockett, MD  
Residents

**Background:** Healthcare contributes 4.6% of global greenhouse gas emissions, with endoscopy suites being the third largest producer of medical waste among hospital departments.[1][2] Each procedure generates approximately 3 kg of waste, with 20-35% potentially recyclable but often misclassified as regulated medical waste (RMW).[2][3] Improper segregation increases environmental impact and disposal costs through unnecessary incineration.[4][5] Recent interventions combining staff education with structured waste protocols achieved 24% reductions in RMW and 33% reductions in emissions.[5] We aimed to reduce our endoscopy suite's carbon footprint through targeted educational and structural interventions.

**Methods:** We conducted a quality improvement initiative using Plan-Do-Study-Act methodology. Baseline assessment included literature review, root cause analysis, and stakeholder engagement. Pre-intervention surveys assessed knowledge and practices. Key drivers identified were limited knowledge and suboptimal bin placement. Interventions include targeted training with visual aids and waste bin reconfiguration. Outcome measures include proportion of correctly segregated waste and post-intervention survey changes.

**Results:** Forty-eight staff completed baseline surveys. While 79% strongly agreed proper sorting is important and 75% agreed they know how to segregate waste correctly, only 69% correctly identified appropriate disposal categories for common endoscopy materials. Baseline observational data collection suggest 64% of RMW is misclassified. Interventions are underway and post-intervention outcomes are pending.

**Conclusions:** Baseline findings demonstrate a gap between perceived importance and practical knowledge of sustainable waste practices. Ongoing evaluation will assess impact of training and waste bin reconfiguration on segregation accuracy and staff knowledge. Our hope is to reduce endoscopy's environmental impact through these targeted educational and structural interventions.

## 17 Balance Deficits are Present Across Mild Traumatic Brain Injury Symptom Subtypes

Jae W. Lee, MD; Jennifer L. Brodsky, MD; Siting Chen, MD; Trevor Gohl, Jason Hernandez, MD; James C. Chesnutt, MD; Robert J. Peterka, MD; Peter Fino, MD; Laurie King, MD  
Fellows

**Objective:** To determine whether balance deficits are present across mild traumatic brain injury (mTBI) symptom subtypes. We hypothesized that deficits would occur regardless of primary or number of subtypes.

**Design:** Cross-sectional study

**Setting:** Academic medical centers

**Participants:** A sample of 247 participants: 189 individuals with subacute mTBI (154F; age  $35.8 \pm 11.1$ ;  $43.2 \pm 20.7$  days post-injury) and 58 healthy controls (35F; age  $36.9 \pm 12.7$ ). The Neurobehavioral Symptom Inventory identified four subtypes (affective, cognitive, somatic/sensory, vestibular) using a mean subtype score  $\geq 25$ . Participants were categorized by primary subtype (including none and mixed) and total number of subtypes.

**Main Outcome Measures:** Central Sensorimotor Integration (CSMI) testing quantified balance control via sensory weights, time delay (TD), stiffness (KP), and damping (KD) using sway responses to pseudorandom sagittal plane stimuli under four conditions: surface tilt eyes closed (SS/EC), surface tilt eyes open (SS/EO), visual tilt eyes open (VS/EO), and combined surface and visual tilt (SS+VS/EO).

**Results:** Individuals with mTBI demonstrated greater sway across all conditions versus controls ( $p < 0.001$ ;  $d = 0.44 - 0.73$ ). TD was significantly increased across all conditions ( $p < 0.05$ ;  $d = 0.45 - 1.48$ ). Stiffness was reduced in all but SS/EC ( $p < 0.01$ ;  $d = 0.52 - 0.91$ ), while damping was lower in SS/EO and VS/EO ( $p < 0.05$ ;  $d = 0.30 - 0.69$ ). Sensory weighting differed in all but SS+VS/EO ( $p < 0.05$ ;  $d = 0.33 - 0.46$ ). Balance deficits were present regardless of primary or total subtypes. All subtypes, including those without a defined subtype, showed increased TD versus controls ( $d = 0.27 - 1.69$ ), with TD demonstrating the largest effect sizes overall.

**Conclusion:** Balance deficits persist across all mTBI symptom subtypes, independent of subtype classification or symptom burden. TD appears to be the most sensitive marker and should be assessed and targeted during subacute mTBI rehabilitation.

## 18 Portland VA Inpatient GDMT Algorithm

Raphael Abramov, Benjamin Yang, Connor Vinyard, Elizabeth Helmke, Aubrey Dawson, Mason Paas  
Residents

**Background:** Guideline Directed Medical Therapy (GDMT) has improved morbidity and mortality in heart failure with reduced ejection fraction (HFrEF), evolving from single agent ACE inhibitor therapy in the 1980s to current four pillar therapy including RAAS inhibitors, beta blockers, mineralocorticoid receptor antagonists (MRAs), and SGLT2 inhibitors. Increasing evidence supports early simultaneous rather than sequential initiation of these medications. At the Portland VA Medical Center (PVAMC), GDMT utilization is close to national averages but remains below expected levels for certain pillars based on patient eligibility. Inpatient hospitalization presents a key opportunity for initiation, yet no standardized protocol currently exists locally.

**Methods:** We developed a standardized inpatient GDMT initiation algorithm tailored to PVAMC workflows. Our algorithm prioritizes early initiation of RAAS inhibitors and SGLT2 inhibitors, followed by MRAs and beta blockers as clinically appropriate. The algorithm is informed by current guidelines and major clinical trials and refined through multidisciplinary stakeholder engagement, including cardiology, pharmacy, hospital medicine, and nursing leadership. Baseline data collection characterized GDMT use among hospitalized HFrEF patients, including the number of therapies prescribed on admission and discharge. Additional interventions include a structured documentation template and targeted resident education.

**Results:** Baseline data demonstrated gaps in GDMT use despite patient eligibility, particularly for ARNI and MRAs. Resident feedback surveys identified key barriers, including time constraints during admissions, variability in attending practice patterns, and uncertainty regarding safe inpatient initiation. Our algorithm has been developed and refined with stakeholder input, and implementation is underway with ongoing data collection.

**Conclusions:** This project establishes a feasible and standardized approach to inpatient GDMT initiation at PVAMC. Ongoing evaluation will compare pre and post implementation prescribing patterns with a goal of exceeding national benchmarks by 2-3% within one year. Future work will focus on refinement through Plan-Do-Study-Act cycles, multidisciplinary engagement, and assessment of sustainability and clinical outcomes.

## 19 Repeat Intra-operative Urethral Preparation to Decrease Post-op UTIs

Aleksei Dingel (MD) Kate Renkosiak (MD), Lucy Ward (M.S.), Helena Reising (MD) Emily Modlin (B.s), Mable Orser (B.s), Sara Cichowski (MD)  
Residents

**Objective:** Urinary tract infections (UTIs) are the most common post-surgical healthcare-associated infection. Reported incidence of UTI following urogynecologic procedures range from 20-28% and may result in significant morbidity. No standardized approach for post-operative UTI risk reduction exists. Povidone-iodine (Betadine) urethral preparation has shown efficacy in reducing postoperative UTI rates in men (22% to 7%) and in patients performing clean intermittent catheterization. This study evaluated whether implementing a standardized intraoperative repeat urethral Betadine preparation prior to urethral instrumentation during urogynecologic surgery reduced the incidence of postoperative UTIs within 30 days.

**Methods:** This quality improvement study was conducted at OHSU. Intraoperatively, prior to any urethral instrumentation, a repeat urethral antiseptic preparation was performed using Betadine consisting of a single anterior-to-posterior swipe across the urethral meatus. The number of urethral instrumentations and antiseptic preparations were documented in the operative report. Patients were monitored for symptoms of UTI's. Symptomatic patients underwent urinalysis and urine culture.

**Results:** Of the 471 surgeries screened, 350 met inclusion criteria with the pre-intervention and post-intervention cohorts including 232 and 118 patients, respectively. Postop UTI rate in the post-intervention group whose procedure was adherent to the intervention was 8.6% compared to 10.3% in the pre-intervention group, a non-statistically significant difference ( $p$ -value = 0.769). 78.8% of post-intervention procedures were compliant to the change. The prevalence of post-op UTI rates for major abdominal, major vaginal, and minor procedures were 8.8%, 16.7% and 7.3%, respectively.

**Conclusions:** In this single-center study, per-protocol analysis showed repeat intraoperative urethral antiseptic preparation did not significantly reduce the incidence of postoperative UTI following urogynecology procedures. Interpretation of these findings may be limited by several factors, including a lower baseline rate of postoperative UTI in the pre-intervention cohort (10.3%) compared to reported national rates (20–28%). Additional limitations include limited sample size.

## 20 Ending Rural Addiction Care Disparity

Michelle Pies, DO and supporting faculty, Meg Devoe, MD  
Fellows

**Background:** Addiction is a chronic, life-long condition that requires treatment. Substance use disorders contribute to >100,000 deaths and over 7 million emergency department visits every year, in the United States alone. Compounding the situation further, rural communities are disproportionately underserved with a higher number of at-risk populations, and they are less likely to have access to life-saving medications, such as buprenorphine. Numerous studies have proven the benefits of medication assisted treatment (MAT) and yet, less than half of the rural counties in the United States have a buprenorphine prescriber. In an effort to change these disparities, this study sought to increase addiction care access by increasing rural primary care clinicians' (PCP) comfort with MAT.

**Methods:** An initial survey was created to assess PCPs' self-reported comfort with MAT prescribing and perception of addiction care barriers within the rural communities of Oregon including Silverton, Mount Angel, Woodburn and Molalla. The survey was distributed to five clinics and included all of their 22 PCPs in the region. All survey responders remained anonymous to increase the likelihood of candid results. The initial survey received 15 responses (68%). Based on these results, a one-hour educational presentation was created and delivered in-person to cover humanistic barrier reduction strategies, pharmacology, selection and dosing of MAT. After completion of the presentation, each PCP in attendance was asked to complete an anonymous follow up survey to reassess self-reported comfort in prescribing MAT. The post-education survey received 13 responses (59%).

**Results:** After attending a single one-hour presentation, PCPs in the rural Oregon communities of Silverton, Mount Angel, Woodburn and Molalla, reported an average of over 30% increased comfort in MAT prescribing and intention to continue or begin prescribing MAT.

**Conclusions/Next steps:** This study finds education beneficial in the expansion of rural addiction care access. Therefore, it is reasonable to conclude, rural addiction care disparities could be reduced with further or perhaps, annual addiction support through education opportunities. Moving forward, the study plans to continue interventions for inpatient and emergency department teams. To end the rural addiction care disparities and truly create a continuum of care, we must acknowledge addiction is one of the many life-long, chronic conditions clinicians provide whole-person, human-centric care for, every day. Addiction cannot be limited to the metropolitan population.

## 21 Lead Screening in Patients with Gunshot Wounds

Kristin Potter, MD; Colleen Cowdery, MD; Myra Khushbakht, MD  
Residents

**Background:** Over 120,000 people per year in the United States experience traumatic injury from gunshot wounds (GSWs), of which over 25% will be hospitalized. As many as 38% of patients with retained fragments experience blood lead levels (BLLs)  $>10 \mu\text{g/dL}$  in the months following their injury, and they make up nearly 5% of all exposures with BLL  $>80 \mu\text{g/dL}$ . To date, no unifying recommendations exist for screening patients with retained fragments, leading to a population in which lead toxicity may go undetected. Furthermore, underserved communities are disproportionately affected by gun violence, raising concern for increased susceptibility to lead toxicity in this at-risk population.

**Methods/Proposal:** We recommend patients with GSWs resulting in retained fragments undergo screening with a BLL prior to discharge. Those with high-risk retained fragments (intra-articular, intra-osseous, or vascular or CSF spaces), should undergo screening every 3 months for the first year. Lower-risk patients should be screened at 1-3 months and 6-12 months. Thereafter, patients and providers can share decision-making regarding future monitoring. Those with high-risk retained fragments, rising BLLs, or symptoms of lead toxicity should seek screening at least annually.

Phase 1: Create and implement BLL screening within the trauma lab order set.

Phase 2: Engage the Oregon Poison Center to validate screening guidelines.

Phase 3: Coordinate with social work to design educational resources and discharge instructions.

Phase 4: Collaborate with the Gun Violence Prevention Team of Multnomah County to expand into the community and additional care centers.

**Future Considerations:** Following a period of successful implementation, we hope to expand our impact into other hospitals, including the other level I trauma center in the state. This study may also generate a population that the Oregon Poison Center wishes to track for outcomes and treatment purposes.

## 22 Opportunistic, Patient-Centered Gynecologic Care at the Time of Bariatric Surgery: A Single-Institution Experience

Fiona Stefanik, MD, Camille Le Gardeur de Tilly, MD, Andrea Stroud, MD, MS  
Residents

**Background:** Obesity significantly impacts reproductive health and access to gynecologic care, contributing to higher rates of endometrial cancer, polycystic ovary syndrome, and infertility. Weight loss following bariatric surgery improves fertility and can reverse endometrial hyperplasia. However, pregnancy within 12–24 months post-bariatric surgery carries substantial maternal and fetal risk, making family planning an essential component of preoperative care. Traditional care delivery fragments bariatric and reproductive services, creating missed opportunities for coordinated intervention.

**Innovation:** We developed and implemented a collaborative bariatric–gynecology care pathway that embeds reproductive health services into the perioperative bariatric workflow. This model leverages a single anesthetic event to deliver high-value gynecologic care (e.g., intrauterine device placement, opportunistic salpingectomy), integrates preoperative contraceptive counseling, and introduces bariatric surgery as a checkpoint for preventive gynecologic screening.

**Methods:** We conducted a retrospective review of patients undergoing bariatric surgery with concurrent gynecologic procedures at Oregon Health & Science University between March 2024 and September 2025. Collected data included demographics, procedural characteristics, operative time, complications, and pathology results.

**Results:** Fifteen patients (median age 35; 73% BMI  $\geq 45$  kg/m<sup>2</sup>) underwent combined bariatric and gynecologic procedures. Bariatric procedures included 7 Sleeve gastrectomy (50%), 4 Roux-en-Y gastric bypass (26%), and 4 Single anastomosis duodenal ileal bypass (26%). Gynecologic procedures included 2 sterilizations (13%), 2 hysteroscopic polypectomies (13%), 3 Pap smears (20%), and 12 IUD insertions (80%). Median additional procedural time for IUD placement was 13 minutes. No early postoperative complications occurred. Endometrial sampling (n=10) identified obesity-associated abnormalities in 50% of patients.

**Conclusions:** This integrated care model demonstrates a safe, efficient, and scalable innovation that enhances access to contraceptive needs during a high-risk fertility window, reduces procedural burden, and supports cancer prevention strategies without increasing operative risk. Embedding gynecologic interventions into bariatric surgical workflows represents a forward-thinking strategy to improve health system performance and patient-centered outcomes.

## **23 Implementation of Validated Patient-Reported Outcomes in the OHSU Allergy & Immunology Clinic**

Nithya Koka, MD  
Fellow

**Background:** Chronic urticaria (CU) is defined as recurrent hives (with or without angioedema) lasting > 6 weeks. Symptoms can be highly fluctuating day to day, with major effects on sleep, work, and quality of life. Currently, the OHSU Allergy & Immunology Clinic does not utilize an objective, standardized tool to monitor disease activity in patients with chronic conditions, such as CU and asthma. With new therapies emerging, implementation of validated patient-reported outcome measures could help providers monitor disease and guide treatment.

**Aim:** The aim of this project is to increase utilization of the Urticaria Control Test (UCT) score for patients > 12 years of age with chronic urticaria in the OHSU Allergy & Immunology Clinic. This study was extended to include the Asthma Control Test (ACT) score for patients with asthma.

**Methods:** Clinic stakeholders (Attendings, fellows, RNs, MAs) were interviewed to develop the most efficient method for distributing and documenting UCT/ACT scores during patient visits with least disturbance to clinic workflow. Medical assistants (MAs) were asked to inquire if a patient was being seen for “asthma” or “chronic hives” during the rooming process. MAs provide the patient with the appropriate questionnaire to complete while waiting for the provider. Patient responses are entered by the MA into their respective flowsheets built into Epic, and the provider can then pull this data into their clinic note using their respective dot phrase. Utilization of these flowsheets will be tracked every 2 weeks using Slicer Dicer.

**Next Steps:** The goal of this project is to utilize UCT/ACT scores for majority (>50%) of patients followed for CU or asthma in the OHSU Allergy & Immunology Clinic. Use of validated patient-reported outcome measures like the UCT and ACT improve objective assessment, treatment decisions, and longitudinal monitoring for patients with chronic conditions.

## 24 GI Mucormycosis and Total Colectomy in a Young Adult with T-cell acute lymphoblastic leukemia (T-ALL)

Ria Sur, Julia Hamilton, Melissa Hershman  
Residents

**Background:** GI mucormycosis is a rare, often fatal angioinvasive fungal infection in immunocompromised patients. Mortality approaches 85% due to delayed diagnosis and rapid progression to ischemia, perforation, and hemorrhage. We report a case of extensive GI mucormycosis caused by *Rhizopus microsporus* in a patient with T-ALL requiring total colectomy.

**Case Presentation:** A previously healthy young man was diagnosed with Ph-negative T-ALL after evaluation for a malignant pleural effusion. He was started on the CALGB 10403 protocol (prednisone, vincristine, daunorubicin, pegasparginase), with prophylactic valacyclovir, levofloxacin, micafungin, and sulfamethoxazole/trimethoprim. Admission imaging revealed cecal and distal colitis with negative CMV labs. Weeks later, he developed abdominal pain and constipation. CT confirmed pancolitis and large-volume ascites. Despite piperacillin-tazobactam for neutrophilic peritonitis on paracentesis, his condition worsened. Colonoscopy revealed terminal ileal necrosis, prompting right hemicolectomy with ileostomy. Pathology demonstrated angioinvasive fungal hyphae confirmed by PCR as *Rhizopus microsporus*. Liposomal amphotericin B was initiated, with micafungin replaced by isavuconazole based on susceptibilities. Postoperatively, he experienced persistent pancolitis, high-volume ascites, and pleural effusions. Despite interval colonoscopy biopsies being negative for fungal organisms, a second bowel perforation occurred, necessitating total colectomy with Hartmann's procedure. He stabilized on dual antifungal therapy and broad-spectrum antibiotics and was discharged on oral posaconazole.

**Conclusion:** This case highlights the diagnostic challenges of GI mucormycosis, which presents with nonspecific symptoms and is often missed by standard fungal assays ( $\beta$ -D-glucan, galactomannan). Even with PCR confirmation and targeted therapy, mucor's angioinvasive and myoinvasive properties can cause persistent bowel injury leading to transmural necrosis and perforation. Early biopsy, prompt antifungal therapy, and aggressive surgical management — including total colectomy when indicated — are essential to improving outcomes.

## **25 Implementing an Inpatient Heart Failure Management Algorithm at the Portland VA Medical Center: a Quality Improvement Project Works-in-Progress**

McLaughlin, Matthew; Grant, Emily; Kwon, Hyoshin, do Couto e Silva, Alex; Kuehn, Sydney; Pass, Mason; Puckett, Carrie  
Residents

**Background:** Acute decompensated heart failure (ADHF) is one of the most prevalent admission diagnoses at the Portland VA Medical Center (PVAMC) and represents significant morbidity, mortality, and healthcare costs nationwide. Unfortunately, the average ADHF length of stay (LOS) for admissions at the PVAMC was 2-3 days longer than the national average from 2018-2023. We suspect one reason for this shortcoming our teams' failure to aggressively diurese patients in the first 48 hours of admission. Previous studies have associated standardized clinical pathway interventions for ADHF management with reduced LOS and improved guideline-directed medical therapy adherence. We aim to improve the time to maximum IV diuretic dose and number of diuretic doses in the first 48 hours of admission at the PVAMC through implementation of an ADHF management algorithm.

**Methods:** Referencing published algorithms, we developed an ADHF management algorithm that guides diuretic dosing, titration, adjuvant diuretics, and discharge considers. We tailored the algorithm to the institutional practices of the PVAMC. The algorithm will be distributed to all resident general medicine team rooms. Then, we will survey residents every three weeks on their use of and satisfaction with the algorithm. Before and three months after implementation of the algorithm, we will collect data on patient demographics, diuretic type, dosing, and frequency, time to first diuretic dose after admission, and use of adjuvant therapies. Statistical analyses will include post-hoc t-tests and Chi-square tests with a p-value threshold of  $<0.05$  for significance.

**Results:** Our project is a works-in-progress and has not yet been implemented.

**Conclusions/Next steps:** Next steps include seeking approval of our algorithm from the pharmacy committee, deployment of the algorithm, data collection, and seeking feedback from residents, nurses, pharmacists, and attending physicians. Future directions could include long-term algorithm implementation and analysis on impact of average ADHF LOS at the PVAMC.

## **26 Exploring provider perspectives around child protective services reporting for obstetric patients who use substances**

Erin Nacev MD MPH, Kelly Shriver MD MDiv, Kristin Prewitt MD MPH, Amy Hermes MD, Honora Englander MD, Eleasa Sokolski MD MPH  
Fellows

Child protective services (CPS) reporting in the postpartum period is a complex and high-stakes process, particularly in cases involving substance use. Clinicians across disciplines may experience uncertainty, moral distress, and concern about inconsistency or bias in reporting decisions. Existing literature suggests that lack of role clarity and fragmented communication can contribute to variability in reporting practices and clinician distress. Multidisciplinary approaches have been proposed as a strategy to promote shared understanding and consistency in CPS reporting; however, limited data exist describing clinicians' current experiences, perceptions, and needs prior to implementation of such interventions. There is a gap in understanding how clinicians currently experience CPS reporting processes in postpartum obstetric care and what challenges they perceive in existing workflows. This formative qualitative study aims to address this gap and generate data to inform the design of future interventions. To this end, we conducted semi-structured interviews with multidisciplinary inpatient and outpatient staff, including providers, social workers, nurses, and peers. Preliminary data will be reported in this abstract.