providers. We continued bi-weekly chart audits for appropriate referrals being placed for 12 months.

Results As of August 2020, we were able to meet our goal at 42% with 1,813 referrals placed for DSME. Of these, 1,086 patients completed their education sessions (figure 1).

Conclusions Quality improvement tools and methodologies can be successfully utilized to improve care for diabetes in clinical settings. We were able to create a process that has maintained success, even during the uncertain times of COVID-19. The processes created and put in place were sustainable and have allowed the staff to continue placing referrals during telehealth visits and patients completing DSME virtually.

19 DECREASING NEONATAL JAUNDICE READMISSION RATES THROUGH IMPLEMENTATION OF A JAUNDICE MANAGEMENT GUIDE

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Background Baylor Scott and White Medical Center at Waxahachie (BSWMCW), a level 1 neonatal designated facility, had rising neonatal jaundice readmission rates for two fiscal years (1.7% - 2.6%). Based off literature review, this was above the average rate for hospitals with similar populations (0.5% - 2.0%). Neonatal jaundice readmissions have several effects on families and the neonate related to increased costs, stress on bonding, and increased risk for hospital acquired infections.

Objectives By June 30, 2019, BSWMCW will reduce the rolling neonatal jaundice readmission rate from 2.6% (July 1, 2017-June 30, 2018) to less than 1% (July 1, 2018 - June 30, 2019).

Methods A multidisciplinary committee met to identify why excessive neonatal jaundice readmissions occurred. Issues identified were inconsistent practices in starting and stopping phototherapy, timing of discharge, and timing of newborn follow up in infants with jaundice (figure 1). The team prioritized management of jaundice through recognizing plan of care modifications during the initial hospitalization which would impact newborn readmission rates. Initially, clear guidelines were created on when to start or stop phototherapy, including discharge criteria, followed by implementation of new supplementation guidelines. Donor milk was offered as an alternative to formula supplementation. In order to adhere to supplementation guidelines, standardized newborn weights at 24 hours of life was added. Finally, jaundice lab testing was required through BSWMCW inpatient lab prior to admission rather

Brainstormed Issues	< Why It Happens	< Why It Happens	< Why It Happens
Neonatal Jaundice Readmission	<Inadequate Breastfeeding	<Excessive weight loss not identified <Mothers and nursing staff resistant to formula supplementation	<Infant weighed nightly versus hours of age <Concerned will adversely affect breastfeeding
	<Inconsistent Jaundice management practices	<Timing of discharge <Timing of start/stop of phototherapy treatment <Timing of newborn follow up post discharge	<Variable baseline practices of Neonatal Nurse Practitioners rotating to facility due to lack of standardized published guidelines
		<Inconsistent lab values between different facilities	<Different analytic instruments <Testing less accurate for severe jaundice

Abstract 19 Figure 1

Decreasing Neonatal Jaundice Readmission Rates Through Implementation Of A Jaundice Management Guide	
JAUNDICE MANAGEMENT GUIDE	
Indications to Start Phototherapy for Inpatients	
1. Serum Bilirubin $\geq$ treatment threshold based on hours of life, risk factors and Gestational Age at birth 2. Consider phototherapy with serum bilirubin below treatment threshold IF infant otherwise expected to discharge in the next 12 hrs AND one of the following criteria are met: <ul style="list-style-type: none"> Serum bilirubin $\leq$ 1 mg/dl below treatment threshold and infant with no risk factors on Bhutani phototherapy nomogram (i.e. $\geq$ 38 wks, DAT negative) Serum bilirubin $\leq$ 2 mg/dl below treatment threshold and infant is medium- or high-risk based on Bhutani phototherapy nomogram (i.e. $<$ 38 wks and/or DAT+) Serum bilirubin $\leq$ 2 mg/dl below treatment threshold AND bilirubin rate of rise $>$ 0.2 mg/dl/hour 	
How to Provide Phototherapy	
Bilirubin Level	Treatment
Below treatment threshold	o Bilirubin blanket
At threshold	o bilirubin blanket +/- overhead light, depending on rate of rise, risk factors, target day of discharge, etc.
Above treatment threshold	o Bilirubin blanket and at least one overhead light
Bilirubin within 3-4 mg/dl of threshold for exchange transfusion	o Bilirubin blanket and at least two overhead lights
Bilirubin $\geq$ 3 of treatment	o 3 total lights needed (i.e. blanket and double bank overhead) and/or infant needing IVF and/or any concerns for poor parental compliance with treatment: treatment should occur physically in intermediate care nursery)
*Outpatient phototherapy can be considered ONLY if no risk factors are present (i.e. full term, no ABO set-up, etc.), feeding is going well and family is reliable with good access to care	
Stopping Phototherapy	
Estimated Gestational Age $\geq$ 38 weeks at birth	o Serum bilirubin $\geq$ 3 mg/dl below treatment threshold for current hours of life
Estimated Gestational Age $<$ 38 weeks at birth	o Serum bilirubin $\geq$ 4 mg/dl below treatment threshold for current hours of life
➤ Schedule follow-up within 24 hrs if bilirubin is high intermediate risk and continuing to rise and/or if infant has persistent feeding difficulties (i.e. excessive weight loss, not latching well, etc.) associated with jaundice; otherwise follow-up should be scheduled within 48 hours.	
Determining Readiness for Discharge	
1. Recheck bilirubin 6-8 hrs after stopping phototherapy <ul style="list-style-type: none"> Bilirubin should rebound $<$ 2 mg/dl from previous bilirubin and remain at least 3 mg/dl below treatment threshold for current hours of life 2. Consider holding discharge and/or starting phototherapy IF: <ul style="list-style-type: none"> Bilirubin is high risk OR Bilirubin is high intermediate risk with rate of rise $>$ 0.2 mg/dl/hr., particularly if infant is medium or high risk on Bhutani curve. 	
Indications to Supplement Breastfeeding Infants with High Intermediate or High Risk Bilirubin	
One or more of the Following: <ul style="list-style-type: none"> weight loss $>$ 75% for age on NEWT calculator (newbornweight.org) and/or $\geq$ 7% at 24h poor skin turgor, dry mucous membranes, sunken fontanelle or other clinical signs of dehydration decreased output (fewer voids/stools than number of days old) hypernatremia (Na $>$ 145) hypoglycemia (BS $<$ 50) 	

Abstract 19 Figure 2

Abstract 19 Figure 3

than accepting lab values from other facilities which were often found to be different (figure 2).

Results Overall, the rolling percentage of neonatal jaundice readmissions for BSWMCW decreased from 2.6% to 0.8%, meeting the goal of less than 1%. This was sustained through fiscal year 2019 (figure 3).

Conclusions Neonatal Jaundice readmission rates can be affected through standardizing jaundice management protocols. In changing the timing of neonatal weights, this improved neonatal care, even for those without jaundice.

20 OPTIMIZING INPATIENT SITUATION AWARENESS TO RECOGNIZE AND MITIGATE CLINICAL DETERIORATION IN HOSPITALIZED CHILDREN

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Background Interventions to improve care team situation awareness (SA) are associated with reduced rates of unrecognized clinical deterioration in hospitalized children. Recent safety events at our institution revealed common etiologic themes, including 1) inadequate SA for patients demonstrating signs of deterioration, and 2) lack of a shared mental model due to inadequate psychological safety and communication.

Objectives We aimed to decrease emergency transfers (ETs) to the intensive care unit (ICU) by 50% over 10 months.

Methods An interprofessional team of physicians, nurses, respiratory therapists, and families convened to apply innovation to the original SA model for clinical deterioration by addressing emerging corruptors to SA, communication inadequacies, and evolving technology in our inpatient system. Key drivers included establishing a shared mental model, psychologically safe escalation, and efficient and effective SA tools (figure 1). Novel interventions including the intentional inclusion of families and diverse care team roles in huddles, a mental model checklist, door signage, and an electronic health record SA navigator were evaluated via a time series analysis. Sequential inpatient-wide testing of the SA model allowed for iteration and consensus building across care teams and families via qualitative data collection and review. The primary outcome measure was ETs, defined as any ICU transfer where the patient

Abstract 20 Figure 1 Key driver diagram for the SA Model for clinical deterioration

Abstract 20 Figure 2 Outcome measure: emergency transfers. Statistical process control U-chart of the rate of emergency transfers per 10,000 patient days. Established rules for shewhart control were utilized to determine if observed changes were due to special causes variation

Abstract 20 Figure 3 Process measures. Statistical process control P-charts: A) Percent of patients designated as watchers at least one hour prior to medical response team or code activation. B) Percent of watcher patients who have an SA note filed within two hours of watcher status initiation. C) Percent of watcher patients who have objective medical response team activation criteria. Established rules for Shewhart control charts were utilized to determine if observed changes were due to special cause variation