

Winner APPD 2019 Trainee Research Award

IMPROVING SCREENING LAB COMPLIANCE IN AN URBAN PEDIATRIC PRACTICE

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Background Screening laboratory evaluations are important components of pediatric primary care. Current AAP guidelines recommend hemoglobin and lead screening at 12 months as well as lipid screening between 9-11 years. Health disparities, including variable access to transportation, contribute to failure to complete recommended screening labs at an underserved urban pediatric clinic. Following urban clinic relocation from site 1 to site 2 and subsequent loss of on-site phlebotomy, the average lab completion rate declined significantly. Aim Statement Our primary aim is to increase the rate of screening lab completions in our urban pediatric population to 75% by December 2018. Interventions A multidisciplinary team completed a Quality Improvement study to evaluate barriers to completing screening labs. Standardized phone calls to families with incomplete labs were made and fishbone diagrams were created to categorize barriers. A process map was created to understand the steps required to complete screening labs. Interventions included: reminder phone calls, standardized instructions placed into After Visit Summary (directions to the lab location, lab hours and public transportation routes to the lab), initiation of access to onsite phlebotomy, and training of on site clinic staff in phlebotomy. Measures Outcome measures were the percent of patients with completed screening labs. Process measures included percentage of patients without complete labs who received follow-up phone calls. Balancing measures were allocation and cost of staff resources. Plan Do Study Act (PDSA) methodology was used to implement and test interventions. Statistical process control charts were used to analyze the impact of interventions.

Results 473 charts were reviewed.

Average screening lab completion at Site 1 was 79% with decline to baseline of 21% with move to clinic Site 2. Lab completion rates increased to mean of 42% with initial interventions in action period. Lab completion increased to 90% with special cause improvement after on site staff phlebotomy training. Cost analysis data pending. Conclusions and Next Steps Significant increase was noted in lab completion upon the addition of on-site lab phlebotomy at site 2. Initial interventions did not lead to increased compliance rates further highlighting the importance of accessibility in an urban population. Urban underserved clinics may consider addition of on-site phlebotomy to continue to close the gaps in health disparity.

