Introduction

Dyslipidemia begins during development and in a clear risk factor for atherosclerosis and subsequent cardiovascular morbidity in adulthood.3,4 The early identification of dyslipidemia in childhood and adolescence is recommended by the National Heart, Lung, and Blood Institute (NHLBI) and American Academy of Pediatrics (AAP).1

Objective

To familiarize residents with current lipid screening and management guidelines and to improve lipid screening and adherence to guidelines among pediatric residents during continuity clinic didactics.

Methods

This study was approved by the institutional review board on 12/18/2019. It was conducted at the University of Texas Health San Antonio Pediatric Residency. Patients enrolled included residents from the QI team and its management as well as residents. Exclusion criteria were not met.

The Obesity Action Plan

The Obesity Action Plan (OAP) was hung up on a wall in the clinic and was also added to reference packets for residents. Every morning and afternoon during continuity clinic didactics, residents were introduced to the screening recommendations prior to the start of the next didactic.


While the percent of patients needing hyperlipidemia screening guidelines increased in the post-intervention period, the increase was not statistically significant. Furthermore, the increased percent of patients with hyperlipidemia who received follow-up was not shown to be significant. One significant limitation we encountered was the COVID-19 pandemic which decreased the number of patients seen in a five-year period.

Conclusions

Pre-Intervention: Well-child checks were assessed during the 4 weeks prior to the intervention week. Only children with BMI percentiles of 95% or greater were considered. Patients seen by members of the study were excluded.

Data collected:

demographic data (sex, age) • action documented for abnormal labs patient education received 

BMI %, if lipids and ALT were ordered 

Table I: Tallied sample test analysis performed between pre- and post-intervention periods.

Interpretation

We focused our study intervention on resident education. We concluded that the most significant barriers included physician lack of knowledge of hyperlipidemia screening guidelines did not apply. Such factors severely limited post-intervention data collection. Due to time constraints and limited data, a decision was made to include patients seen by the members of this QI study.

Nevertheless, the results do show that appropriate screening guidelines increased in the post-intervention period, the increase was not statistically significant. Whereas, the increased percent of patients with hyperlipidemia who received follow-up was not shown to be significant. One significant limitation we encountered was the COVID-19 pandemic which decreased the number of patients seen in a five-year period. Not only were appointments reduced and even canceled during the pandemic, but the patients that were being seen in clinic during the crisis were younger children to whom hyperlipidemia screening guidelines did not apply. Such factors severely limited post-intervention data collection. Due to time constraints and limited data, a decision was made to include patients seen by the members of this QI study.

References


Figure 2: Process Flows