Identifying and Closing Gaps in Health Maintenance in IBD Patients: A Quality Improvement Project

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Introduction

It is a well-established fact that patients with chronic diseases such as inflammatory bowel disease do not receive preventative care at the same rate as the general population. Many reasons for this gap in providing care have been postulated, ranging from consumption of provider time by the chief disease to priority of patients being low to provider reimbursement issues to overall underinsurance of the chronically ill. With IBD having a steady rise in prevalence, Crohn’s disease alone has an annual economic impact in the United States exceeding $1.7 billion.

A large issue in the health care community is who should provide preventative services, the gastroenterologist or the primary care physician, and many IBD patients not having a PCP altogether complicates the comprehensive health management even further. Additionally, despite IBD being a worldwide chronic condition with increasing incidence, there is a near complete absence of tools in the literature to assist PCPs in delivering appropriate, evidence-based care – which is in contrast to other chronic conditions such as asthma, diabetes mellitus, and congestive heart failure. A low level of continuity of care among patients with IBD has been shown to directly correlate with higher likelihood of flares that require corticosteroid treatment, hospitalization, and surgical intervention, leading to overall increase burden to the healthcare system.

Aim/ Objectives

Identify patients in the outpatient fellow-run IBD clinic who have inflammatory bowel disease with a clear lack in care and offer intervention during clinic visit to tackle this disparity in preventative care with a goal of 90% completion rate.

Background

Studies have identified that patients with IBD are at increased risk for acquiring influenza infection relative to patients without IBD, particularly when patients are treated with immunosuppressive therapies. Furthermore, some patients with IBD who acquire influenza infection are more likely to experience hospitalization and co-infection with pneumonia. It is recommended that all patients with IBD undergo annual vaccination against influenza. Additionally, patients receiving immunosuppressive treatment should receive pneumococcal vaccination with both PCV13 and PPSV23 to maximize breadth of serotypes and ensure optimal protection against the most common and virulent strains.

Women at or over the age of 65, men at or over the age of 70, as well as any patient with IBD who has had steroid use for >3 months should have a DEXA scan once with subsequent screening based on results. Significant steroid therapy is defined oral corticosteroid therapy for >3 consecutive months in a dose >or= 7.5 mg/day or prednisone.

Smoking has been identified as a risk for development of Crohn’s disease with tobacco use being associated with disease progression, with development of arthritis, need for steroids or thiopurine therapy, and increased risk of structuring disease or perianal complications.

Secondary prevention methods are also in place to allow for early detection and prudent management of specific diseases, with clear guidelines surrounding skin cancer and colon cancer screening.

Patients with IBD (both UC and CD) should undergo screening for melanoma independent of the use of biologic therapy, as IBD has been associated with an increased risk of melanoma. In IBD patients on immunosuppression, particularly thiopurine (6-MP and azathioprine), there is strong data linking its use to non-melanoma skin cancer risk. Patients on immunomodulators (6-MP and Azathioprine) should undergo screening for non-melanoma skin cancer while on these agents, particularly if they are over the age of 50.

IBD patients have an increased risk of development of colorectal dysplasia and cancer and are also recommended to undergo colonoscopy starting 8-10 years after disease duration with subsequent interval based on results (as frequently as every 1-3 years). If primary sclerosing cholangitis is present along with colonic inflammation, annual colonoscopy starting at the time of diagnosis is the standard of care.

Methods

For each IBD clinic patient lacking in previously defined quality measures, provide actionable counseling (for smoking cessation), appropriate referrals (for primary care physician or dermatologist), and adequate orders for completion of certain measures (DEXA scan, colonoscopy, or vaccination against influenza virus and pneumococcal pneumonia). This is to be completed prior to patient leaving the clinic visit.

Metrics Measured

The American College of Gastroenterology came out with Guidelines on Preventative Care in IBD in 2017, with identification of specific measures to guide practitioners in providing appropriate preventative care to IBD patients.

Raw data collection through manual chart review of EMR in the following fields to identify baseline and periodically subsequent characteristics of current IBD clinic patient population:

- Presence of established primary care physician
- Tobacco use
- Prior evaluation of bone health with DEXA scan in appropriate population
- Influenza vaccination
- Pneumococcal vaccination in appropriate population
- Evaluation by dermatologist
- Up-to-date screening of colon with colonoscopy

Works Cited

1. ACADEMIA - Receipt of Preventative Health Services by IBD Patients Is Significantly Lower Than by Primary Care patients
2. ACADEMIA 2 – Communicating with Patients with IBD
3. JAMA – Association of Continuity of Care with Outcomes in US Veterans with IBD
4. WJG – Tools for Primary Care Management of IBD: Do they exist?
5. WJG Prevention in IBD – Preventative Health Measures in IBD
6. ACG Guidelines on Preventative Care in IBD 2017
7. IBD Prevention Recs – Prevention in IBD: An Updated Review of Guidelines 2020