LACK OF PREVENTATIVE CARE IN IBD PATIENTS

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INTRODUCTION | BACKGROUND
• Despite being at higher risk for developing many preventable diseases, patients with IBD do not receive preventative care at same rate as general population
• American College of Gastroenterology’s 2017 Guidelines on Preventative Care in IBD identified specific measures to guide appropriate preventative care in IBD
• However, this care gap continues
• Barriers include determining who should provide the preventative services such as vaccinations, cancer screenings, smoking cessation:
  - The gastroenterologist? The primary care physician?

AIM | PURPOSE
• Identify patients with IBD in our outpatient IBD clinic with a clear lack in preventative care
• Offer preventative interventions during clinic visit to tackle disparity gap: Goal 90% completion rate in 1 yr

METHODS & METRICS

METHODS
• For each IBD clinic patient lacking in previously defined quality measures:
  - Provide actionable counseling (for smoking cessation)
  - Appropriate referrals to primary care physician (PCP), dermatologist, etc.
  - Adequate orders for completion of certain measures (DEXA scan, colonoscopy, vaccination against influenza virus and pneumococcal pneumonia
  - Complete prior to patient leaving the clinic visit
• Utilize metrics to identify successes and gaps in preventative care
• Initiate new PDSA cycle as needed

METRICS
• Raw data collection through manual EHR chart review
  - Identify baseline and update with status of current IBD clinic patient population
  - Preventative care metrics include: Established PCP, tobacco use, DEXA when appropriate, vaccinations (eg, influenza, pneumococcal), dermatologist evaluation, up to date with colonoscopy
  - Plot IBD clinic data longitudinally x preventative target

RESULTS
• No significant improvement in percentage of patients receiving preventative care
• No significant rise in referrals placed during fellow-run IBD clinic
• No improvement in established primary care physician
• Anecdotally, above findings seem to be secondary to patients declining certain care, however no tool implemented to date to evaluate exact reason

DISCUSSION

KEY FINDINGS
• Workflow Inefficiencies → challenge GI physicians/staff ability to provide preventative care

LIMITATIONS:
• Single residency clinic
• Inefficiencies in data abstraction from EHR
• Limited engagement of all GI physicians (faculty and fellows)

NEXT STEPS AND SUSTAINABILITY:
• Refine workflow for efficiencies for clinic staff and physicians
• Utilize EHR new tools to enhance data abstraction; Provide regular data/progress updates
• Make prevention initiative a program wide project with individual accountabilities