Introduction: Inflammatory bowel disease (IBD) is a chronic disease state with growing focus, due to its significant medical and economic health burden. Although targeted therapy against tumor necrosis factor (anti-TNF), interleukin receptors, and integrin receptors have established roles in ulcerative colitis and Crohn’s disease management, medication accessibility and literary contribute to medication non-adherence. Non-adherence to IBD therapy is associated with 62% higher costs for hospitalizations, along with increased disease mortality, relapse, loss of response, and antibody formation. IBD centers recognize the collaborative importance of a pharmacist’s role in medication optimization, patient adherence, and transitions of care.

Methods: From November 2017 - April 2018, patients discharged from the inpatient IBD Service received a post discharge follow-up (PDFU) call from a pharmacist within 72 hours. Concurrently, the pharmacist provided pharmacotherapy optimization and education during the 4 hour weekly clinic visits, followed by a call within 72 hours.

For all sites of care, the pharmacist performed a comprehensive evaluation for healthcare maintenance (including notable lab values, drug levels, and/or antibody levels), adherence to IBD medications, and drug interactions.

The primary outcome was 30-day readmissions. The secondary outcomes included the number and severity of drug-related problems (DRPs) identified, validated by two gastroenterologists.

Results: 132 patients were included in the study (63 inpatient; 69 clinic). The inpatient 30-day readmission rate for the study period was 14.3% versus 22.1% in 2016 (P=0.15). In comparison, the 30-day hospitalization rate for clinic patients remained relatively unchanged.

123 DRPs were identified from 132 patients, averaging 0.93 DRPs per patient. There were 87 DRPs from the inpatient setting and 36 DRPs identified in clinic. Of the DRPs, 60% of DRPs were prescriber-related and 40% were patient-related. 2% (2 cases) were considered life threatening and 61% of cases were significant DRPs; the remaining DRPs were low risk. Potential admissions were avoided in 6 patients (11%) by early detection of a drug-related error.

Conclusion: Results demonstrate the opportunities for a pharmacist to be involved in managing biologics and health maintenance therapy in the IBD patient population. There was an overall positive trend of a pharmacist role on IBD admission rates and decrease in medication related errors.

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PRACTICE PATTERNS OF PRIMARY CARE AND GASTROENTEROLOGY PHYSICIANS IN THE MANAGEMENT OF IRON DEFICIENCY ANEMIA IN INFLAMMATORY BOWEL DISEASE

Francis Wade, Florence-Damilola Oludalu, Gretchen Grosch, Melissa Chambers, Katie Schroeder

Introduction: Iron deficiency Anemia (IDA) is a common complication of inflamma-

tory bowel disease (IBD). High prevalence of IDA in IBD suggest suboptimal

diagnosis, surveillance and treatment. Oral iron is poorly tolerated, associated with wors-

ed disease activity, and often insufficient to reverse anemia in IBD patients. Intravenous (IV) iron is favored for treatment of IDA in IBD in most clinical scenarios

As first line IV iron guidelines recommend oral iron for IBD patients. Regardless of how to order IV iron; 61.5% of respondents, 7.7% were attendings; of PCP responders, 81.8% were residents, 18.2% were attendings. 15.4% GIs, 12.7% PCPs were very comfortable managing IBD patients with IDA; 76.0% GIs, 58.2% PCPs were somewhat comfortable; 7.7% GIs, 29.1% PCPs were not comfortable (p=0.275). 61.5% GIs, 25.5% PCPs always check iron studies when evaluating anemic IBD patients; 30.1% GIs, 21.8% PCPs check most of the time; 7.7% GIs, 34.5% PCPs sometimes check; 0% GIs, 12.7% PCPs rarely check; 0% Gls, 5.4% PCPs never check (p =0.05). In mild Crohn’s disease with severe anemia, 15.4% GIs, 41.8% PCPs would prescribe oral iron daily; 15.4% GIs, 12.7% PCPs would prescribe oral iron every other day; 69.2% GIs, 45.5% PCPs would prescribe IV iron (p=0.58). 0% GIs reported good knowledge of IV iron, 53.8% reported acceptable knowledge, and 46.1% reported poor knowledge. 7.7% GIs, 10.9% PCPs reported good knowledge of how to order IV iron; 53.8% Gls, 7.3% PCPs reported acceptable knowledge; 38.5% Gls, 81.8% PCPs reported poor knowledge (p=0.00215). 23.1% Gls, 61.8% PCPs thought PCPs were responsible for screening for IDA in IBD patients; 76.9% Gls, 36.4% PCPs thought GIs were responsible (p=0.0131).

Discussion: Both PCPs and GIs perceived responsibility to manage IDA in IBD patients and knowledge of IV iron. The study questionnaire was devel-
opred based on United States expert opinion consensus statements and European guidelines recommendations published in the Journal of Crohn’s and Colitis and Inflammatory Bowel Diseases.

Results: Of GI responders, 92.3% were fellows, 7.7% were attendings; of PCP responders, 81.8% were residents, 18.2% were attendings. 15.4% GIs, 12.7% PCPs were very comfortable managing IBD patients with IDA; 76.0% GIs, 58.2% PCPs were somewhat comfortable; 7.7% GIs, 29.1% PCPs were not comfortable (p=0.275). 61.5% GIs, 25.5% PCPs always check iron studies when evaluating anemic IBD patients; 30.1% GIs, 21.8% PCPs check most of the time; 7.7% GIs, 34.5% PCPs sometimes check; 0% GIs, 12.7% PCPs rarely check; 0% Gls, 5.4% PCPs never check (p =0.05). In mild Crohn’s disease with severe anemia, 15.4% GIs, 41.8% PCPs would prescribe oral iron daily; 15.4% GIs, 12.7% PCPs would prescribe oral iron every other day; 69.2% Gls, 45.5% PCPs would prescribe IV iron (p=0.58). 0% GIs reported good knowledge of IV iron, 53.8% reported acceptable knowledge, and 46.1% reported poor knowledge. 7.7% Gls, 10.9% PCPs reported good knowledge of how to order IV iron; 53.8% Gls, 7.3% PCPs reported acceptable knowledge; 38.5% Gls, 81.8% PCPs reported poor knowledge (p=0.00215). 23.1% Gls, 61.8% PCPs thought PCPs were responsible for screening for IDA in IBD patients; 76.9% Gls, 36.4% PCPs thought Gls were responsible (p=0.0131).

Discussion: Both PCPs and Gls perceived responsibility to manage IDA in IBD patients. PCPs were less likely than Gls to screen for IDA in anemic IBD patients or to order what they thought were adequate knowledge of clinical process to order IV iron. Future efforts to reinforce gastroenterologists’ role in the management of IDA in IBD and to bolster familiarity with IV iron and its indications might improve outcomes and quality of life for IBD patients.

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QUALITY OF CARE INITIATIVE IMPROVES OUTCOMES FOR PATIENTS WITH INFLAMMATORY BOWEL DISEASE (IBD) at High Risk

Gil Melmed, Brant Oliver, Jason Hou, Donald Lum, Donna Gerner, Damara Ciate, Megan Holhoff, Quin Turner, Jessica Caron, Samir Shah, Mark Mattar, Siddharth Singh, Alice Kennedy, Josh Deitch, Raluca Vrabie, Frances Ferraye, Helen Fasanya, Faiza Bhatti, Biny Abraham, John Valentine, Christina Ha, Alina Charabaty, David Hudesman, Sharon Dudley-Brown, Swapan Reddy, Amy Wang, Emmanuelle Williams, John Betteridge, Arthur Ostrov, Mark Metwally, Humberto Aguilar, Lia Kaufman, Mark Gerich, Caroline Hwang, David Rubin, Betty Kim, Erica Heagy, Rebecca Fausel, Frank Scott, Ann Flynn, Blaire Fenimore, Gaurav Sjal, Ziad Younes, Rebecca Fausel, Nirmal Kaur, Louis Pintilie, Harry Bray, Eugene Nelson, Kelly McCutcheon Adams, Caren Heller, Ridhima Oberai, Alanda Weaver, Corey Siegel

Introduction: There is significant variation in processes and outcomes of care for patients with inflammatory bowel disease (IBD), suggesting opportunities to im-
prove quality of care. Recent efforts to define quality measures for IBD have iden-
tified emergency room (ER) visits, hospitalizations, corticosteroid use, and opioid