This can avoid unnecessary high-cost medical interventions, such as visits to the emergency department (ED), which often lead to excess use of steroids, narcotics, and radiographic imaging, all important measures of quality of IBD care.2 We sought to introduce an access/quality improvement program at a private gastroenterology practice with the goal of triaging and returning urgent calls from IBD patients in a timely manner and mitigate avoidable visits to the ED.

Methods: Gastroenterologists, nurses, and support staff at our private practice developed four criteria for “urgent” IBD calls: new, severe abdominal pain; new, severe anal pain; fever greater than 101 Fahrenheit; and refractory emesis. Patient calls that met any of these criteria were highlighted with a red flag and labelled as “IBD URGENT” by support staff in the electronic medical system. The primary gastroenterologist (or covering provider) then responded to these calls as soon as possible with a goal of responding within 4 hours. Subsequently, patients were advised to go to the ED for further emergent evaluation, given same/next day clinic visits, and/or given advice, such as medication changes, by the gastroenterologists.

Results: Over a 15-month period from June 2018 to August 2019, we received a total of 167 “IBD URGENT” calls (average 11 calls per month); of these, 92% (153 calls) received a response from a gastroenterologist within 4 hours. Abdominal pain, diarrhea, blood in the stools, and vomiting were the most common reasons for urgent calls. Only 10% (16 calls) of calls were patients with worrisome symptoms in which patients called more than once (2 calls), while 48% of urgent clinic visits (62 calls), and 58% resulted in advice/orders from the gastroenterologist such as laboratory testing, medication continuation/changes (97 calls); 12% (20 calls) resulted in both urgent clinic visits and advice (e.g., obtain laboratory testing and then present for office visit).

Conclusion: We piloted an urgent care hotline for IBD patients to receive rapid medical access at a private community gastroenterology practice. The majority of patients were successfully managed with outpatient medical care, including same/next day office visits and advice for laboratory testing/medication changes. Only a minority (10%) of calls resulted in ED visits. We plan to continue this project with the aim to return more than 90% of the urgent calls within 4 hours.


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27 UTILIZATION OF AN ELECTRONIC MEDICAL RECORD (EMR)-INTEGRATED DASHBOARD IMPROVES IDENTIFICATION AND TREATMENT OF IRON DEFICIENCY IN PEDIATRIC INFLAMMATORY BOWEL DISEASE

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Background: Anemia is frequently encountered in inflammatory bowel disease (IBD) with studies reporting an even greater prevalence among children (16–72%) than adults (4–67%) at any given time during disease course. Anemia is comorbid with a chronic iron deficiency (ID) and inflammation, and inflammation occurs in the majority of anemia cases. Studies have shown that gastroenterologists underestimate and undertreat these conditions. The majority of patients are successfully managed with outpatient medical care, including same/next day office visits and advice for laboratory testing/medication changes. Only a minority (10%) of calls resulted in ED visits. We plan to continue this project with the aim to return more than 90% of the urgent calls within 4 hours.

Results: In the pre-intervention period (July 2016-November 2017), 73.5% of our outpatient IBD population had a Hb ordered, with anemia prevalence of 36.3%. Only a minority of patients with anemia were being screened for ID (19.3%). Iron supplementation was prescribed in 38.1% of patients with documented anemia. Following the implementation of this QI initiative, rate of patients with biannual Hb testing completed increased to 80.1%, while prevalence of anemia decreased to 32.1%. Significant improvement was observed with screening and treatment rates increasing to 43.1% and 50.4%, respectively by July 2019 as shown in Figure 1-2. Notably, patients with moderate to severe anemia improved significantly from 48.7% to 62.1%.

Conclusion: ID and anemia are commonly underdiagnosed and undertreated in children with IBD. An evidence and expert based pathway combined with implementation of provider-based monthly reports using the EMR to support clinical decision may help increase screening and intervention and decrease rates of anemia prevalence.

https://www.chop.edu/clinical-pathway

Figure 1. Percentage of patients with anemia being screened for iron deficiency

Figure 2. Percentage of patients with anemia being treated with iron supplement (IV/Oral)

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VTE RISK WITH IBD PLUS ORAL CONTRACEPTIVES: ARE PATIENTS AWARE?

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Background: The risk of venous thromboembolism (VTE) is 1.5–3 fold higher in individuals with IBD compared to the general population. In addition, combination hormonal oral contraceptives (COCP) are associated with a 3–5 fold increase in VTE. However, there is limited data regarding VTE risk in women with IBD who are on OCPs. It is speculated that women with IBD who may be at increased risk for VTE occurrence are not consistently counselled about VTE risks. This study evaluated the rate of VTE counselling in reproductive aged women and those on oral contraceptives.

Methods: A retrospective medical record review of all IBD women seen at a university gastroenterology practice during a 5 year period was performed. Patients’ age, disease type, OCP use and VTE risk counseling were obtained. A database was created maintaining patient confidentiality. Analysis was conducted using Fisher’s Exact Test with significance set at p < 0.05. The study was approved by the university IRB.

Results: There were 209 female IBD patients with a mean age of 44 years (range 23–82). 153 had ulcerative colitis, 53 had Crohn’s disease and 3 had indeterminate IBD. Self-reported ethnicity included 93 White, 67 Black/African-American, 7 Asian, 1 Hawaiian, 19 other and 22 declined reporting their ethnicity. There were 146 women of reproductive age (<50 years) and 63 women ≥50 years. 7 women, all age <50, were counselled about potential VTE risk. There was no significant difference (p=0.105) in the rate of VTE counselling in women based upon age. In the 24 women of reproductive age who were on OCPs, one patient was counselled about increased VTE risk. There was no significant difference (p=1.00) in the rate at which women of reproductive age on OCPs (1 in 24, 4.2%) were counselled compared to women of reproductive age who were not on OCPs (6 in 122; 4.9%).

Discussion: Venous thromboembolism can result in significant morbidity and mortality. Individuals with IBD are at increased risk for VTEs. Women with IBD on oral contraceptives may be at greater risk for VTEs than other IBD patients. This study revealed that IBD women infrequently receive education about VTE risk. There was no significant difference in the rate of counselling in women based upon age. There was also no significant difference in the VTE counselling in women of reproductive age who were on OCPs compared to those who were not on OCPs. While this study is limited based upon single institutional design, retrospective evaluation and small sample size, it offers important information for further study and educational initiatives. Enhanced efforts to educate individuals about the risk for VTEs can improve IBD management and outcomes.