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Establishing an Inflammatory Bowel Disease Practice in an Accountable World

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Roadmap to the FUTURE of PRACTICE

Care of patients with inflammatory bowel disease (IBD) is an important and impactful part of a gastroenterologist's practice. There is increasing pressure on us from payors, purchasers of health care, and patients to be sure we do well for populations of patients in addition to individuals. The concept of "population management" is foreign to a traditional consulting physician, but that will change. Since we might be the principle physician for many young patients with IBD, we owe it to our patients to provide preventive care and resources for their general health. In this month's article, a renowned IBD researcher, Dr Sunanda Kane, helps us understand how we might construct our IBD practices.

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Inflammatory bowel disease (IBD) has become an increasingly complex and dynamic field within gastroenterology. As recently as the early 1990s, all we had in our treatment armamentarium were mesalamine agents, steroids, and thiopurines to treat ulcerative colitis (UC) and Crohn's disease (CD). It was a frustrating situation for both patient and physician, which was compounded by the lack of evidence-based guidelines for routine or usual clinical care. After the initial introduction of biologic infusion therapy, it took some time for them to become integrated into community practice because of their novel mechanism of action. Now with the availability of 4 biologics approved by the Food and Drug Administration, multiple steroid preparations, improved surgical techniques, and the increasing importance of tailoring treatment by using personalized medicine and pharmacogenomics, it has become ever more challenging to decide what treatment plan is best for any given patient.

As health care reform continues to alter how we practice, the increasing complexity of individual patient care now is coupled with emerging demands to monitor our health outcomes for populations of patients, all while reducing overall cost. These 3 facets of care constitute the "Triple Aim" and suggest the challenges we face as we work with accountable care organizations and other integrated delivery networks in our respective regions.[1]

How should community gastroenterologists establish a high-quality clinical IBD practice and develop tools needed to manage a large population of IBD patients and to demonstrate value by using currently available performance measures? Jedel et al[2] have already discussed the mind-body-spirit for IBD in an earlier article in this Practice Management section, so we will focus on more practical aspects of care issues and suggest changes that need to meet challenges in the "Road Ahead" for gastroenterologists.

Approximately 1.4 million persons in the United States and 2.2 million persons in Europe have these diseases. Previously noted racial and ethnic differences appear to be disappearing, making the pool of patients even larger and the original stereotypes of an IBD patient obsolete. Variation in presentation and disease course suggests that environmental factors significantly modify the expression of CD and UC, which further excludes the ability to completely homogenize an IBD practice.

Why is it important to consider the practical aspects of clinical care for IBD patients? In a recent study looking at health care utilization for IBD, there were an estimated 1.1 million annual IBD-related visits (95% confidence interval, 0.9–1.4 million) during the period 1994–1996 that increased to 1.8 million visits (95% confidence interval, 1.4–2.2 million) during 2003–2005.[3] This trend relates to several factors, including the increasing annual incidence and prevalence of both UC and CD. The stark reality is that although a patient with IBD can be labor-intensive and emotionally demanding, IBD patients need our expertise and health care systems to recognize that when a gastroenterologist manages their population of IBD patients, they have the best chance to achieve high-value health outcomes. During an episode of IBD care, multiple providers and specialty resources are required including gastroenterology, radiology, endoscopy, laboratory services, and surgery. Most IBD patients have disease courses that are beyond the capability of non-gastroenterologists, so this population of patients fits naturally into a gastroenterology patient-centered medical neighborhood where we provide "Principal Care" as defined by the

Resources for Practical Application
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Abbreviations used in this paper: AGA, American Gastroenterological Association; BTE, Bridges to Excellence; CCFA, Crohn's and Colitis Foundation of America; CD, Crohn's disease; CSL, clinical service line; DHRP, Digestive Health Recognition Program; IBD, inflammatory bowel disease; PQRS, Physician Quality Reporting System; RN, Registered Nurse; UC, ulcerative colitis.

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American College of Physicians in their white paper on medical homes.[4] During their lifetime IBD patients consume a significant amount of health care resources, so it is helpful to establish clinical decision support tools that are based on existing national guidelines, develop information systems to monitor IBD care over time, and to participate in quality measurement and improvement programs becomes valuable for forward thinking practices. Links to current U.S. IBD guidelines and quality improvement programs are provided as additional online resources at http://cghjournal.org/content/practice_management.

Having suggested the need for a gastroenterologist to manage IBD patients, are there data to support this claim? There are good longitudinal data to suggest that health outcomes are better when a specialist, compared with a general practitioner, provides care for IBD patients. The 5-year risk of first surgery has decreased from 30% to 18% during a time period when specialists have increasingly managed IBD patients (before 1996 compared with 2008).[5] The adjusted hazard ratios for first surgery in patients dropped 43% during that time period. A higher prevalence of visits to a gastroenterologist within the first year of diagnosis was associated with a reduced need for surgery (hazard ratio, 0.83; 95% confidence interval, 0.71–0.98) and contributed to differences in surgery rates among patients over time. Use of immunomodulators within the first year of diagnosis was higher in later years as well. Thus, data suggest that specialist care within 1 year of diagnosis might improve overall outcomes in CD, and referral to a gastroenterologist within a year of diagnosis has been suggested as a quality measure.

"If you build it, they will come"; patients with IBD are looking for physicians and practices that demonstrate they are equipped to handle their needs. Many medium and large gastrointestinal practices are now building clinical service lines (CSLs) focused on IBD care. These CSLs include several physicians dedicated to IBD care, nurse practitioners or physician assistants specializing in IBD care, dedicated clinics and communication processes, educational programs, close connections with patient groups such as the Crohn's and Colitis Foundation of America (CCFA), linkages to national outcome registries, and robust clinical trials. Larger gastrointestinal groups are beginning to monitor population-level metrics and resource use in anticipation of CSL carve-outs as a component of risk contracts. Because many patients with IBD do not have a primary care physician, gastroenterologists are developing teams of physicians and physician extenders to provide preventative services, thus laying the foundation for specialty-care medical homes as described for patients with other types of chronic conditions.[6]

Important Components to an Inflammatory Bowel Disease Practice

If you are going to take care of IBD patients, it may help to spend a little time with some colleagues who take care of a reasonable number of patients with a variance of disease activity (Table 1). Visiting professorships are available through the CCFA as well as preceptorships that can be arranged with different teaching institutions that have IBD centers. In addition, there must be the commitment to staying up-to-date with the changes in patient care and to participate in performance measurement such as the newly created Digestive Health Recognition Program (DHRP) of the American Gastroenterological Association (AGA) that has a module devoted to IBD care (https://agarecognition.org/default.aspx). DHRP is closely linked to the IBD measure group that is part of the Physician Quality Reporting System (PQRS) that is part of Medicare's Value-base Payment Modifier program.[7,8]

Table 1. Helpful Aspects of a Practice for IBD Patients

Have several providers within the group specialize in seeing these patients
Establish standard protocols for the office for patient care so cross-coverage is easier
Health care extender who can care for the established practice
Have a nurse or other personnel dedicated to phone triage, paperwork, and scheduling for patients with IBD
Allow for flexibility in schedules for emergencies
Use already developed tools and materials to help educate patients
Within your practice environment, cultivate colleagues in other aspects of care who are consistent and reliable for help to manage IBD patients

Staying clinically up-to-date can be accomplished in several ways.

(1) Establishing and maintaining a good relationship with a tertiary center.

(2) Participating in continuing medical education programs either in person or online focused on IBD (http://www.gastro.org/practice/practice-resource-library/immunology-microbiology-ibd).

(3) Being aware of the latest published guidelines.

(4) Joining the CCFA at the local level.

(5) Participating in Practice Improvement Modules or Maintenance of Certification programs currently available.

(6) Joining performance measurement programs or outcome registries such as the Digestive Health Outcome Registry of the AGA (http://www.gastro.org/practice/digestive-health-outcomes-registry) or the Improve Care Now registry of the North American Society of Pediatric Gastroenterology, Hepatology and Nutrition.

(7) Participating in PQRS, which will soon have performance measures for both adult and pediatric gastroenterologists who care for IBD patients.

Establishing algorithms for care of common IBD-related problems can facilitate high-quality and consistent care. These might include an algorithm to manage patients who develop acute symptoms of pain or diarrhea, a protocol for immediate treatment of an acute flare, diagnosis and treatment regimens for *Clostridium difficile*, and a phone triage system can aid in standardizing care of patients regardless of who sees them in the office. The AGA is working to develop clinical decision support tools to help clinicians in community practice build these care components. Society published guidelines also serve to help to summarize the most recent research but can be outdated within a few months of publication. Another helpful tool is a "cheat sheet" available from the IBD Support Foundation (http://www.ibdsf.com). It is meant for clinicians as well as patients to help outline possible etiologies for gastrointestinal symptoms and drive diagnostic and treatment decisions.