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Alimentary Tract

Quality of care indicators in inflammatory bowel disease in a tertiary referral center with open access and objective assessment policies

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ABSTRACT

Background: In the management of inflammatory bowel diseases, there is considerable variation in quality of care.
Aims: The aim of this study was to evaluate structural, access/process components and outcome quality indicators in our tertiary referral IBD center.
Methods: In the first phase, structural/process components were assessed, followed by the second phase of formal evaluation of access and management on a set of consecutive IBD patients with and without active disease (248CD/125UC patients, median age 35/39 years).
Results: Structural/process components of our IBD center met the international recommendations. At or around the time of diagnosis usual procedures were full colonoscopy in all patients, with ileocolonoscopy/gastroscopy/CT/MRI in 81.8/45.5/66.1/49.6% of CD patients. A total of 86.7% of CD patients had any follow-up imaging evaluation or endoscopy. The median waiting time for non-emergency endoscopy/CT/MRI was 16/14/22 days. During the observational period patients with flares (CD/UC:50.6/54.6%) were seen by specialist at the IBD clinic within a median of 1 day with same day laboratory assessment, abdominal US, CT scan/surgical consult and change in therapy if needed. Surgery and hospitalization rates were 20.1/1.4% and 17.3/3.2% of CD/UC patients.
Conclusion: Our results highlight that structural components and processes applied in our center are in line with international recommendations, including an open clinic concept and fast track access to specialist consultation, endoscopy and imaging.
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1. Introduction

Inflammatory bowel diseases (IBD) are chronic, progressive, disabling conditions affecting mainly young adults and having substantial impact on social functioning and quality of life. Together with rapidly increasing incidence rates they contribute to the high health-economic burden associated to the disease.

The management of IBD has become increasingly complex. Patient management including diagnostic tools, medical and surgical therapy, monitoring and follow-up strategy has changed significantly in the last decade with the advent of biological therapies. New treatment goals have been developed (STRIDE) [1] and became realistic. We moved away from symptomatic improvement to measuring more objective parameters including clinical, biochemical remission and endoscopic healing, leading ultimately to less complications and improved quality of life. To achieve this, we need multidisciplinary approach and optimized patient stratification, reassessment of monitoring and follow-up strategies and re-thinking of care pathways. Besides new treatment strategies and new diagnostic/assessment tools, timing became utmost impor-

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tant. All these are important components in establishing quality of care (QoC) in IBD [1–3].

However, there is considerable variation in the process of care for patients with IBD which may be associated with poor outcomes [3,4]. The IMPACT [5] patient survey of the European Crohn's and Colitis Organization (ECCO), conducted in 27 European countries and sampling responses from almost 5000 IBD patients, highlights a number of gaps in current clinical care. This indicates the need for identifying quality of care indicators (QIs) for IBD that could be used worldwide in specialized IBD and/or gastroenterology units to harmonize and increase the quality of care delivered to patients [5].

QIs may relate to the structure, process, and outcome parameters of care and could be used to develop standards by which the provided QoC can be assessed and measured [6,7]. Multiple QI sets were developed with expert interpretation of literature and multidisciplinary input in both Europe and North-America with the aim to present measurable basic aspects of quality of care that could be used for limiting variation and improving patient care. A set of 11 QIs for best-practice management of inflammatory bowel disease in Canada was reported in 2014. These focus on accurate diagnosis, timely management, disease monitoring, and prevention or treatment of complications [8]. In 2011, the American Gastroenterology Association (AGA) published a set of 10 clinical performance measures for the management of IBD, while a further QI set containing 10 process and 10 outcome parameters was developed by the Crohn's and Colitis Foundation of America (CCFA) [9,10]. The 'NICE—The National Institute for Health and Care Excellence, IBD Quality Standard' recommendation were also proposed in the UK in 2015 determining structure, process and outcome QIs on 4 key recommendation in IBD management [11]. In a Spanish consensus, Calvet et al. selected a core set of 56 QIs, including 12 structure, 20 process and 24 outcome parameters by conducting a web-based survey and including an expert panel of patient representatives (n = 4), nurses (n = 7), surgeons (n = 2) and physicians (n = 18) [12].

Complex evaluation of QoC provided by IBD centers or country profiles based on the above measures are still scarce. Even the most recent publications highlight significant gaps and need for improvement in the quality of care [13–15]. The aim of our present study was to evaluate structural, access/process components and outcome quality indicators based on the QI sets developed and published in literature to assess QoC in our tertiary referral IBD center.

2. Materials and methods

The present study was conducted at an academic tertiary referral IBD center of the Gastroenterology Unit at the 1st Department of Internal Medicine, Semmelweis University, Budapest.

In the first phase of the study, structural components (hospital characteristics and infrastructure, personnel and referral professionals, equipment, patient registers) of our IBD center were assessed. This was followed by the formal evaluation of process/access indicators in patient management (including monitoring disease activity and selecting treatment strategies, measures to prevent disease complications and drug adverse events, access to diagnostic tools and procedures, imaging, access to urgent outpatient consultation). Finally, we present selected access and outcome QI measures, such as time to accessing an IBD specialist in patients with flares, evaluation strategy of flares and time to therapeutic decision, hospitalization rates and surgery requirements, documented relapses in disease activity.

In the second phase we evaluated access, monitoring and outcome parameters in a set of consecutive IBD patients who presented as out- or in-patients at our IBD center up to 2016 July. Medical records of patients with and without active disease/flare were collected and comprehensively analyzed (n = 248 Crohn's disease (CD) patients/n = 125 ulcerative colitis (UC) patients, 52%/52% female, median age 35/39 years (y), IQR: 27–44 year and 33–50 year). Data regarding frequency of disease flares, access to IBD specialist physician and imaging procedures, hospitalization and surgery rates were collected between the period of 2014 January and 2016 July (n = 163 CD/n = 95 UC). Ileocolonic location, complicated disease behavior and perianal disease was present in 62.1%, 49.6% and 45.9% of CD patients. 72.1% of UC patients had extensive disease.

Statistical analysis: descriptive statistics, frequency distributions were calculated. Medians and interquartile ranges were calculated for continuous variables. Outcomes in patients with and without flares were compared by D-test of Chi^2 analysis, and logistic regression as appropriate. Statistical analysis was performed using the SPSS software v. 20.0 (Chicago, IL).

Table 1
Structural components at our IBD center.

Hospital characteristics
• Dedicated outpatient clinic
• Affiliated inpatient ward
• Endoscopy unit
• Outpatient infusion therapy unit
• Emergency department
Personnel and referral professionals
• 3 consultant gastroenterologists with IBD interest
• Histopathologist
• Consultant expert colorectal surgeons
• Consultant radiologist with IBD interest
• Access to dermatologist, rheumatologist, ophthalmologist
• Psychologist
• Dietician
• Stoma therapist
• Pharmacist experienced with IBD and biologic drugs
• Regular multidisciplinary and transition meetings are held[a]

IBD: inflammatory bowel diseases; MDT: multidisciplinary team.
[a] Patients can attend the MDT meeting if their case will be discussed.

2.1. Ethical considerations

The study complies with the principles of the Declaration of Helsinki (6th revision, 2008). The study protocol was approved by the Semmelweis University Regional and Institutional Committee of Science and Research Ethics [TUKEB] (No.: 142/2010).

3. Results

3.1. Evaluating structural components

Our IBD center includes an outpatient clinic, an affiliated inpatient ward with 10 hospital beds and an endoscopy unit. Further structural components of the center regarding personnel and access to referral specialists and other health care professionals as well are presented in Table 1. Our center cannot provide access to a specialized IBD nurse.

3.2. Process/access quality measures

Process quality indicators were also part of formal standard operational processes of IBD patient care at our center. Process and access quality measures related to our center are presented in Table 2.

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