BACKGROUND: Inflammatory bowel disease (IBD) is a group of chronic inflammatory illnesses with a relapsing and remitting course often complicated by flares requiring hospital visits and/or surgeries. Numerous studies have outlined the role of a clinical pharmacist within IBD. The primary role of the clinical pharmacist in the published literature includes ensuring safe and effective use of biologics and immunomodulators through patient education and close monitoring of recommended laboratory tests. Further, the studies demonstrate the effectiveness of a clinical pharmacist in increasing adherence to medication therapy and in reducing the number of clinic visits. However, there has yet to be a study that ties such interventions to clinical or economic outcomes that demonstrate the potential long-term impact of a clinical pharmacist in IBD management. At Kaiser Permanente San Diego Medical Center, a pilot clinic was started in September 2018 where a clinical pharmacist was integrated within the IBD clinic. The primary role of the clinical pharmacist included patient education, baseline laboratory testing and vaccinations prior to initiating patients on biologics and immunomodulators, therapeutic drug monitoring and routine laboratory testing prior to refilling medications.

METHODS: The study is a descriptive, retrospective study conducted from October 1, 2018 to February 1, 2019. The study methods consisted of establishment of a Pharmacy & Therapeutics (P&T) approved protocol, which will define an approved workflow for the clinical pharmacist within the Gastroenterology clinic. Baseline and post-implementation data were collected for analysis. The purpose is to determine the role of a pharmacist in IBD management & can they make an impact on quality and cost of care. One full-time equivalent pharmacist’s interventions were classified and quantified during this time frame.

RESULTS: The pharmacist’s workflow begins with the IBD pharmacist receiving the referral from the gastroenterologist. IBD Pharmacist conducts full patient work up, including medication reconciliation to make interventions and contacts patients. IBD Pharmacist collaborates with gastroenterologist as needed to discuss complex treatment cases. Of 1,243 patient encounters reviewed, 1,090 interventions were classified. Classifications were the leading intervention for 12% of all interventions followed by Medication adherence 26%, therapeutic drug monitoring 10%, and new start education 9%.

CONCLUSION(S): Overall, pharmacists can potentially improve quality outcomes by increasing lab and medication adherence. Pharmacist-managed IBD service may result in more cost-effective use of medications. The IBD pilot clinic was well-received by our gastroenterologists and they have unanimously advocated for continuation of the service. Future studies using a control center to compare with our center with a clinical pharmacist within the workflow may provide more direct insight on quality of impact and cost of care.

PREVENTION AND TREATMENT OF OBESITY

P100

Using Data Aggregation to Determine Thematic Knowledge Transfer and Lasting Performance Change in Multiple Continuing Education Activities on IBD

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BACKGROUND: Often, implications of the effect of CME is difficult to determine due to reliance on single data points for post knowledge questions. Using aggregation methodology, we were able to combine the thematic assessments of 3 educational activities to determine the immediate and lasting effect of education on IBD practice.

METHODS: Surveys were designed based on learning objectives of 3 accredited CME activities on IBD. Activities were held at a regional CME conference and 2 webinars. Surveys were completed directly before and after the activities, as well as 3 months after activity completion. This 3-month follow-up sample was matched at the same time to a control sample of clinicians who did not participate in the education.

RESULTS: Based on the themes of the pre-post questions, we were able to aggregate the scores of the three activities and determine continuous change. Further, we used thematic aggregation methodology to aggregate the scores of the pre-post and 3-month surveys. The following scores were seen in recognizing key risk factors (p = 0.75) and clinical trial results (p = 0.71) while more modest effects were seen in establishing goals of treatment (g = 0.40) and selecting treatment (g = 0.59). Some of this modest effect seen in establishing goals can be attributed to a high baseline level of knowledge (a pre-score of 70.8%). However, looking at the scores of learners compared to a control group of similar clinicians that did not attend the education, robust effects can be seen even 30 days after the activity. Assessment of risk had an effect of 0.67 while establishing goals (g = 0.81) and treatment choice (g = 0.85) had even higher effects.

CONCLUSION(S): Aggregating the outcomes of multiple educational activities allows us to understand effect by theme, providing opportunities to inform key stakeholders of the value of educational interventions. Further it allows educators opportunities to understand the continuing need of the community that has not attended these activities, and focus future interventions on improving areas where they are needed most.

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Prevalence of Neoplasms and Their Relationship With the Treatment in Mexican Population With IBD in a Tertiary Care Hospital


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BACKGROUND: Inflammatory bowel disease (IBD) is described as a group of conditions which are associated to chronic inflammation of the gastrointestinal tract, is divided into Crohn’s disease (CD) and...