

REACH-IBD Newsletter

Spring 2024

Kelly's Korner



Kelly Cushing-Damm, MD, MSCI — University of Michigan

This year has kicked off with an incredible start! At the Crohn's & Colitis Congress in Las Vegas, REACH-IBD hosted an exceptional junior faculty event. Experts shared valuable insights on building multi-disciplinary IBD centers in various settings. For those who missed out, Dr. Qazi provides a comprehensive, high-level overview in this newsletter.

In this edition, we are also thrilled to showcase two outstanding REACH-IBD members, Drs. Jeff Berinstein and Adam Faye. Dr. Berinstein's groundbreaking research on optimal treatment for patients with acute severe ulcerative colitis is a testament to the impact mentorship has had on his journey. Meanwhile, Dr. Faye's work on treatment selection in geriatric IBD patients underscores the importance of shared decision-making. He also shares his experience with multi-disciplinary mentorship, which is extremely valuable for young physicians and investigators. I hope you enjoy these REACH-IBD member spotlights. We look forward to highlighting more of our members and their remarkable work in future newsletters.

Looking ahead, the REACH-IBD committee remains focused on education and networking for fellows and young faculty interested in IBD. We're eager to provide even more rewarding events and initiatives, so stay tuned!

REACH-IBD Recap: The Building Blocks of Developing a Multidisciplinary IBD Center

Taha “Sonny” Qazi, MD - Cleveland Clinic

Establishing an Inflammatory Bowel Disease (IBD) Center perplexes many junior faculty, who may lack a clear framework due to varying practice models and increasingly complex patient care. Three speakers addressed this common challenge in the always-topical REACH-IBD event at Crohn’s and Colitis Congress 2024.

According to Dr. Tauseef Ali, the medical executive director of the SSM Health’s Crohn’s and Colitis Center in Oklahoma City, the unpredictability of IBD means IBD care is, by definition, integrated. Integrated care models decrease health-related costs, surgeries, and comorbidities in IBD, but often come with higher direct costs, heavy time commitment, and potential for organizational conflict. Dr. Ali emphasized the need for close collaboration in a community IBD center like his.



Tauseef Ali, MD



Establish rapport with core members of the care team, such as IBD nurses, colorectal surgeons, dieticians, psychologists, and ostomy nurses

Lead through project management. A project plan that includes thorough research and cost-benefit analysis demonstrates value and overcomes barriers.

Dr. David Hudesman, co-director of the IBD Center at NYU Langone Health, focused on academic center creation, giving practical steps.

Track clinical volume, including endoscopy, infusions, office visits and surgery.

Understand extent of institutional support and seek out collaborators across the institution.

Perform a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis

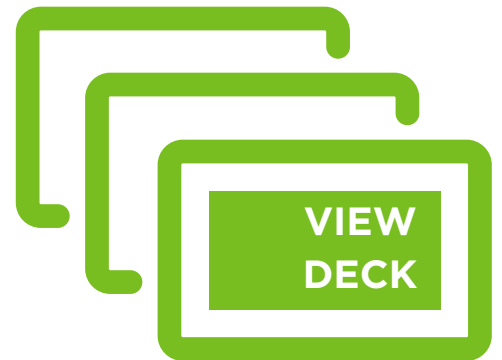
Create a business plan, complete with vision, goals, and financial targets, to facilitate growth.

David Hudesman, MD



Forming a pandemic-era academic IBD center presented unique obstacles for Dr. Jennifer Seminerio-Diehl, the director of the USF Health Inflammatory Bowel Disease Center. She highlighted the importance of identifying major stakeholders, a strong business plan, budget management, and demonstrating value. Resilience was also key, as was mentorship and a foundation for growth in education, research and clinical support.

In summary, a few themes emerged across practice models, such as using productivity metrics and a strong business plan to demonstrate value. Understanding the environment and culture of your institution is crucial, whether you're in a community center or large academic practice. Lastly, make multidisciplinary partnerships a priority. As Dr. Ali mentioned, "Integrated care is vitally important for the care of our IBD patients, and creating centers of care are important in decreasing cost and increasing the value of care."



Drs. Jennifer Seminerio-Diehl, David Hudesman, David Fudman, Tauseef Ali

Jeffrey Berinstein, MD, MSc

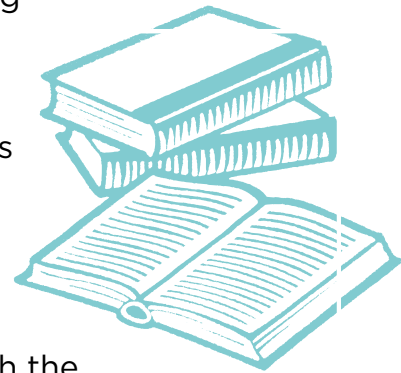
University of Michigan



Tell us more about your research focus.

My fascination with immunology dates back to my undergraduate and medical school years. IBD captured my interest when I discovered the prospect of using immunological insights to tailor therapies for reducing inflammation, improve symptoms, and enhance quality of life. Supporting young individuals through the tumultuous journey of managing a severe, life-altering condition is profoundly rewarding. My dedication to these patients shaped my research focus on personalized treatment strategies for acute severe ulcerative colitis (ASUC). ASUC demands a multidisciplinary approach, prompt inpatient treatment, high intensity and fast-acting

medications, and surgical intervention to address the severe inflammatory burden as well as the emotional toll of this disease. My aim is to move away from the current one-size-fits-all approach towards personalized care.




How did you become involved with the Crohn's & Colitis Foundation?

When I attended my first Crohn's and Colitis Congress as a fellow, I discovered exciting avenues to connect with peers and mentors through the Foundation. I am currently involved with the Foundation nationally through REACH-IBD and Congress and locally through the Michigan Chapter Healthcare Professional Engagement Committee. Dr. Peter Higgins, my mentor and the current chair of the Crohn's & Colitis Foundation National Scientific Advisory Committee, guided me towards active involvement, emphasizing the importance of engaging with organizations that provide both professional development and excellent patient resources.

“ MENTOR ADVICE

ENGAGE WITH ORGANIZATIONS THAT PROVIDE BOTH
PROFESSIONAL DEVELOPMENT AND PATIENT RESOURCES





How do you integrate newer IBD agents into your work with ASUC?

My research focuses on tailoring treatment strategies for acute severe ulcerative colitis, prioritizing individual patient needs and adjusting treatment dynamically based on clinical progression. I increasingly incorporate newer targeted small molecules like tofacitinib and upadacitinib, which have shown promise in reducing colectomy rates, particularly in patients who have failed tumor necrosis factor inhibitors. These mark a significant advance in our treatment arsenal for acute severe ulcerative colitis.

How has mentorship influenced your career trajectory?

Mentorship has been pivotal, shaping my growth as an IBD clinician and clinical researcher. Extraordinary mentors at every stage of my career have provided me with guidance and advocated for my advancement. They've opened doors by recommending me for speaking opportunities, leadership roles, and research collaborations. Dr. Peter Higgins is an ideal mentor; his influence has been instrumental in my personal and professional development.

Tell us about your IBD career plans.

My primary focus is to stay current on the latest developments in IBD care and research to provide optimal patient care. Additionally, I am committed to leading and implementing large multi-center, investigator-initiated clinical trials for ASUC using innovative clinical trial methodologies and novel machine learning and modeling techniques.

What do you do for fun?

Outside of my professional life, my world revolves around my two young sons, aged one and three. Most of my free time is spent keeping them out of trouble. However, when they go to sleep, I embrace my Canadian roots and play hockey a couple times per week.



Adam Faye, MD

NYU Langone



How did you end up focusing on geriatric care and IBD?

I grew up on Long Island, NY, and pursued my education at Harvard for college and Weill Cornell Medical College for my medical degree. After seven years at Columbia University Medical Center for internal medicine training, GI fellowship, and master's degree in patient-oriented research, I pursued an additional year of training in inflammatory bowel disease at Mount Sinai. Now, I serve as faculty in both the Departments of Medicine & Population Health at NYU.

My introduction to medicine began at a young age when my dad was hospitalized in the ICU for months with Guillain-Barre syndrome. During his hospital stay and prolonged recovery, I was struck by the team's dedication not only to my father's care, but also to supporting my mother, older brother, and me. Many relationships forged then continue today. This formative experience made me sensitive to the impact of IBD on patients and their families, fueling my desire to partner with them and provide the kind of longitudinal care that my family and I had.

Furthermore, my volunteer work as an Emergency Medical Technician in high school sparked a drive to improve quality of life for older adults. Throughout my training, I noticed a gap in data-driven approaches regarding geriatric care in IBD. Recognizing the complexities of geriatric care, the need for cross-disciplinary collaboration, and the impact that data-driven approaches can have on health outcomes, I've focused my research on bridging the fields of geriatrics and IBD to address this gap effectively.

Tell us more about your Foundation involvement.

I joined the Crohn's and Colitis Foundation very early in my GI training, eager to learn more and advocate for individuals with IBD. I became involved in a fellow's educational program led by Dr. Shannon Chang and Dr. Lisa Malter through the Greater NYC Chapter, eventually taking a leading role in organizing and facilitating IBD education for fellows.



Since then, my involvement with the Crohn's and Colitis Foundation has greatly expanded: I now serve on the **REACH-IBD Committee**, my local **Healthcare Professional Engagement Committee**, act as faculty moderator for the IBD fellow's Greater NYC course, participate in initiatives such as **IBD A to Z** at the **Crohn's and Colitis Congress**, and attend patient advocacy events.

Who are some of your key mentors?

Throughout my career, I have had so many wonderful mentors, ranging from various fields within and outside of medicine. During my residency and fellowship, Dr. Benjamin Lebwohl and Dr. Chin Hur helped hone my critical thinking and statistical skills, laying the foundation for my research. Their guidance led me to complete a Master's degree in patient-oriented research at the Mailman School of Public Health, where I began to design studies to advance clinical care in GI.

During IBD fellowship and beyond, Dr. Jean-Frederic Colombel's instrumental support and ideas have furthered our work to bridge geriatrics and IBD. As a faculty member at NYU, I am surrounded by an amazing cadre of diverse research mentors including Dr. Aasma Shaukat, Dr. John Dodson (cardiology-geriatrics), Dr. Joshua Chodosh (geriatrics), Dr. Mara McAdams Demarco (renal-geriatrics), as well as mentors within the IBD space: Dr. David Hudesman, Dr. Jordan Axelrad, Dr. Lisa Malter, and Dr. Shannon Chang, to name a few. This is just a small list of my multidisciplinary team of mentors who have significantly impacted my career thus far.

Did you know Crohn's & Colitis Foundation Professional Membership is free to fellows/trainees? Tell a friend!

Many Foundation chapters have a Healthcare Professional Engagement Committee (HPEC). Check with your local chapter director to find out if your chapter has one, what it does, and how to get involved

IBD A to Z is a Crohn's & Colitis Congress classic event:

An engaging, interactive case-based exploration for those new to IBD or looking to deepen their knowledge.

How do you integrate newer IBD agents into your approach with older patients?

I could probably spend 10 pages on this question, but will try to keep it brief! For me, therapy/treatment strategies boil down to **risks** and **benefits**:

Risks

Although newer agents like JAK inhibitors and S1P modulators carry risks, so do some older therapies like anti-TNF drugs. However, the risk of undertreated disease and ongoing inflammation often outweighs the risks associated with our medical and surgical interventions.

Much of the data showing higher risk of adverse outcomes from these therapies center around a comparison of older to younger adults, as opposed to older adults on these therapies vs. older adults not on these therapies. Recent data indicates ongoing disease itself poses the greatest risk to our patients (particularly older adults), and that effectively targeting inflammation is associated with a reduction in adverse events. Similar findings have also been observed in conditions such as heart failure, where individuals who are frail as a result of underlying heart failure derive the greatest benefit from treatment.

Recent data indicates ongoing disease itself poses the greatest risk to older patients

Thus, in patients with moderate-severe disease who are suspected to have ongoing physiologic decline and/or symptoms from their IBD, my general approach is to choose a treatment option (medical or surgical) that I think is most likely to reduce/target their ongoing inflammation.

[Since] effectively targeting inflammation is associated with a reduction in adverse events... my general approach is to choose a treatment option that I think is most likely to target ongoing inflammation.

Benefits

I always begin by asking patients what matters most to them. This guides treatment options/goals and enhances both quality of life and clinical outcomes. Among those with ongoing moderate-severe disease, I discuss risks associated with each medication (in the context of the 5M's), along with the risk of undertreated disease, within the context of the patient's priorities.

As with all care, the focus is on shared-decision making, and there is still considerable research to be done to help guide these decisions, but this is a working framework for approaching treatment in my older adults with IBD.

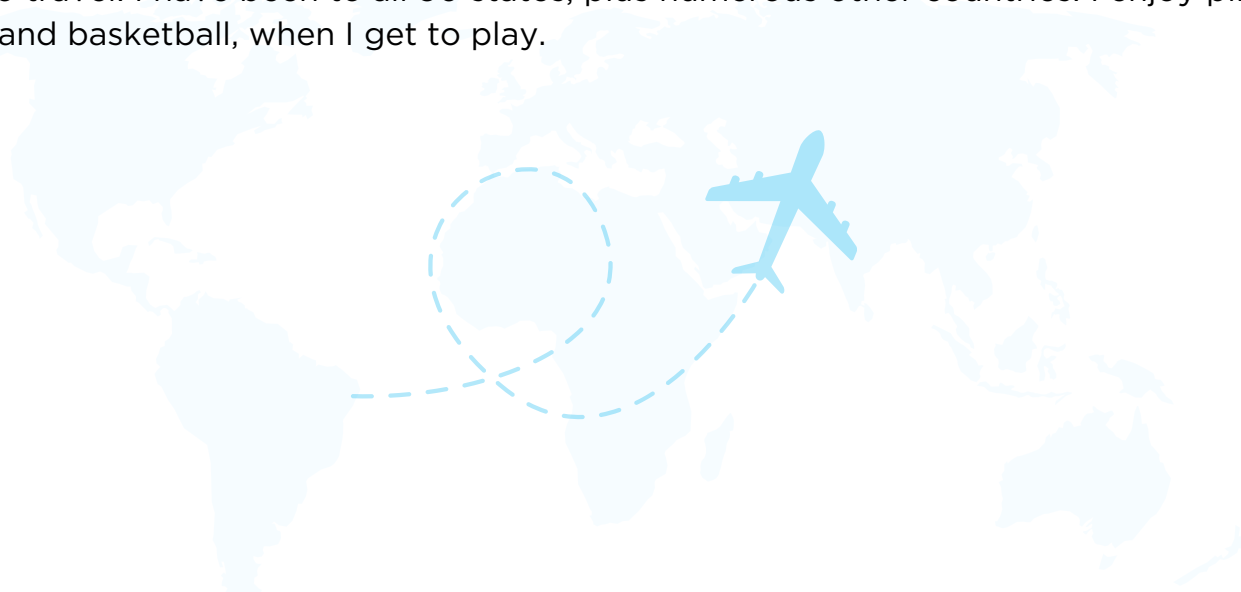


What does the future hold for you?

My overarching goal is to improve the care and quality of life for our patients with IBD. In that pursuit, I will continue to learn from my patients, colleagues, and mentors; I will continue to explore unanswered questions that can help guide clinical care; and I will continue to hone my leadership skills to support IBD trainees and advocate for patients, at a national and international level. I also look forward to bridging all subdivisions of GI with Geriatrics to advance the care for all older adults.

What are some of your hobbies?

I love spending time with family and friends -- especially our 3-year old daughter. I also love to travel: I have been to all 50 states, plus numerous other countries. I enjoy ping pong and basketball, when I get to play.



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JAK Inhibitors for Ulcerative Colitis

Conversations From the Clinic

A Free, Internet-Based Activity



FACULTY



Aline Charabaty, MD, AGAF, FACC

Assistant Professor of Medicine
Division of Gastroenterology and Hepatology
Clinical Director, IBD Center
Sibley Memorial Hospital
Johns Hopkins School of Medicine
Washington, DC

Participation by Dr Charabaty does not constitute or imply endorsement by the Johns Hopkins University or the Johns Hopkins Hospital and Health System.

TARGET AUDIENCE

This activity is intended for gastroenterologists, primary care physicians, physician assistants, nurses, and nurse practitioners.

LEARNING OBJECTIVES

Upon completion of this activity, participants will:

- Compare the risks and benefits associated with Janus kinase (JAK) inhibitors in different patient populations with ulcerative colitis (UC)
- Initiate JAK inhibitor therapy in appropriate patients with UC

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IPCE



This activity was planned by and for the healthcare team, and learners will receive 0.25 Interprofessional Continuing Education (IPCE) credit for learning and change.

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For Nurses

Awarded 0.25 contact hour(s) of nursing continuing professional development for RNs and APNs; 0.25 contact hours are in the area of pharmacology.

CLICK LINK TO ACCESS FREE ACTIVITY

www.medscape.org/case/colitis-2

Supported by an independent educational grant from AbbVie.

Developed through a collaboration between American Gastroenterological Association, Crohn's & Colitis Foundation, and Medscape.

