Impact of Institutional Enteral Feeding Tube Policy on Medical Nutrition Utilization

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INTRODUCTION: Neurodegenerative diseases (ND) are a group of diseases affecting brain neurons. Patients with ND have difficulty self-feeding1. Enteral feeding tubes, including Percutaneous endoscopic gastrostomy (PEG) tubes are placed for patients at risk for severe malnourishment. There is extensive evidence showing PEG placement is associated with increased complications and provides no mortality or palliation benefit5. In 2017 NYU Winthrop Hospital implemented a policy where patients with ND require a palliative care consultation prior to enteric tube placement. This study was performed to determine if implementation of the hospital policy had a significant effect on the number of PEG tubes placed in patients with ND.

METHODS: All patients who received an enteral feeding tube were studied. The number and percentage of PEG tubes to total enteral tubes placed in patients with ND between the years 2017 (before hospital policy implementation) and 2018 (after hospital policy implementation) were compared. PEG placement percentages were compared between patients with ND who received Palliative Care (PC) consult and those who did not examine if there is a correlation between PC consult and decrease in PEG placement. Categorical data was compared via Fisher’s exact test. Binomial percentages were computed along with 95% exact confidence intervals. SAS 9.4 was used for all analyses.

RESULTS: In 2017, 70.5% (241/342) subjects had PEG tubes placed compared to 67.1% (177/264) in 2018 (P = 0.377) which represented no significant difference. There were 84 Patients who had ND and PEG placed. Among patients who had PEG placed, 20.6% (48/233) had neurodegenerative disease in 2017 compared to 20.5% (36/176) in 2018, P = 1.00 which represented no significant difference. There was a significant reduction in overall enteral feeding tube placement in patient who received PC consult compared to those who did not [56.6% vs. 89.0%, Odds Ratio (95% CI) = 0.160 (1.0–0.25), < 0.0001].

CONCLUSION: There was no statistical significance in the number tubes placed in patients with ND after the policy was implemented. These findings were due to incomplete compliance with or knowledge of the policy. There was a significant reduction in enteral tube placements in patients who received palliative care consults. Palliative care consultation appears to be an important component of the policy. We suggest discussions to broaden the scope of this policy to impact patients with other medical conditions who are the end of life.

Figure 1. Demographics of PDs – by gender (a) and by age (b).

[1273] Figure 1.
CONCLUSION: PDs and APDs, gender disparities exist in leadership roles in GI fellowship programs. Efforts should be made to bridge this gap.

A National Survey of Burnout Among Gastroenterology Fellows in the United States

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INTRODUCTION: In a national survey of practicing gastroenterologists, burnout was reported in nearly half of the respondents. However, the prevalence of burnout in gastroenterology (GI) fellows in the United States (US) is unknown. The aim of this study was to determine the burnout prevalence in GI fellows and examine respondent identified factors that were reported to exacerbate and mitigate burnout.

METHODS: A survey to assess prevalence and risk factors for burnout was sent by email to all GI fellows members of the American College of Gastroenterology (ACG). This survey was reviewed and approved by the subgroups of the ACG committees on Professionalism and Training, as well as the Board of Trustees. All US GI fellows currently enrolled in an Accreditation Council for Graduate Medical Education accredited GI fellowship program, as well-fourth-year subspecialty fellowships were eligible to participate. Burnout rate was assessed using a single item measure, consisting of 5 choices, that has been well-validated against the Maslach Burnout Inventory (MBI). In order to provide pilot data for further exploration, respondents were also asked to select factors/activities from a given list that exacerbate and mitigate burnout in their personal experience.

RESULTS: A total of 323 out of 1240 (26%) GI fellows responded to the survey. There were 276 females (85.6%), 46 males (14.4%), and 1 outlier of gender unknown. The age distribution was 117 (36.5%) first year, 34.1% second year, 32.9% third year and 5.4% subspecialty GI fellows in the cohort, and 107 were women (33.2%). Average age was 32.5 years (SD: ± 12.03). Burnout was reported by 42.7% (138/323) of GI fellows [Figure 1]. There was a trend towards significance for the difference in prevalence of burnout across gender (males (39.3%) vs females (49.5%), P = 0.08). Although there was a higher burnout rate for fellows with children < 18 years of age versus those without, the difference did not reach statistical significance (48% vs 44%, P = 0.21). There was no difference for fellows in different years of training. Factors identified by respondents that can exacerbate or mitigate burnout in their personal experience are summarized in Figures 2 and 3.

CONCLUSION: Nearly half of GI fellows report symptoms of burnout. Our pilot data examining exacerbating and mitigating factors can be used to design targeted interventions to help reduce burnout rates in GI fellows.

Implementation and Integration of GI Quality Improvement Consortium (GIQuIC) in a Large Tertiary Care Academic Health System: A Personalized Approach

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INTRODUCTION: Implementation of GI Quality Improvement Consortium (GIQuIC) in a large tertiary care system can be challenging. We successfully launched GIQuIC which in 14 total hospitals and endoscopy centers with 48/85 physicians trained in GIQuIC to date.

METHODS: Physicians apprehension regarding measuring quality as well as constraints with appropriate documentation in the EMR have historically made quality improvement challenging. An alternative method involves a physician champion who can relate to provider frustrations while maintaining educational goals and streamlining documentation. We took a specialized approach in training our physicians (Figure 1). Initial training conducted by the physician champion involved overview of GIQuIC benefits and expectations. At 12 weeks, further training on requirements including best practice guidelines and documentation was provided. Questions were reviewed with GIQuIC and endorversoftware companies with answers communicated to physicians. Side-by-side training with the data manager working individually with each physician was executed before, during, and after go live date. Tip sheets were given to physicians for quick reference (Figure 2).

RESULTS: Initial variability was noted in documentation, surveillance recommendations, bowel prep, risk assessment and oesum photo documentation. GIQuIC measure criteria and documentation tips were re-communicated to physicians by email, faculty meetings, and in person. Physician scorecards were developed and de-identified reports were reviewed at quarterly faculty meetings with individual correction plans implemented. Follow-up data showed better adherence to guidelines (Figure 3).