Interdisciplinary Coordination for Successful G tube Placement

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Disclosures

I have no financial relationships to disclose

Objectives

- Identify the diverse health care disciplines involved in successful feeding tube placement.
- Discuss common difficulties in coordinating tube placement and after care.
- Emphasize the importance of having a process in place to ensure patient safety, promote quality of life, and avoid miscommunication

Nutrition for ALS

- Average life expectancy is 2-5 years from diagnosis
- Malnutrition is directly associated with reduced survival time.
- Increased survival with BMI 30-35
- Weight Maintenance
- Nutrition and hydration
- Social/cultural aspect of food
- Quality of Life

Barriers to Nutrition

- Difficulty chewing and dysphagia
- Hypermetabolism
- Constipation
- Depression
- FTD
- Taste Changes particularly later in disease
- Upper extremity weakness: limiting food preparation and self-feeding difficulty
- Food Insecurity
- Caregiver burden

Nutrition Interventions

- Calorie and protein dense food selection
- High Calorie High Protein beverages
- Texture modification
- Increased meal frequency
- Feeding assistance
- Assistance with food preparation
- Meals on Wheels
- Appetite stimulant
- **Feeding tube placement**

Multi-disciplinary Team

- Registered Dietitian is the nutrition champion but it takes a village…
- SLP
- PT/OT
- PharmD
- Neurologist
- RT
- RN
- Social Work
- ALSA Chapter Representatives

Outside the Multi-disciplinary ALS Team

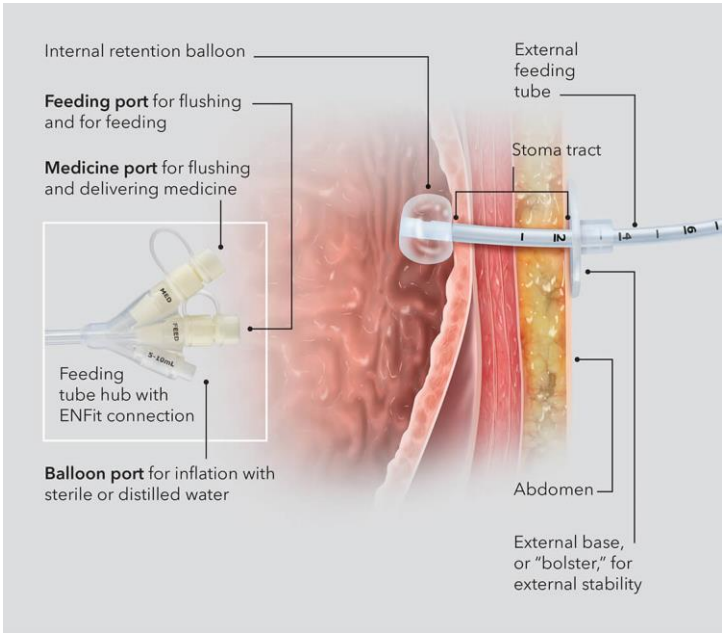
- Referrals/ Scheduling
- Pulmonary
  - Local to patient? Within healthcare system?
- Team placing tube
  - GI
  - IR
  - General Surgery
- Inpatient staff
- DME Company
- Insurance

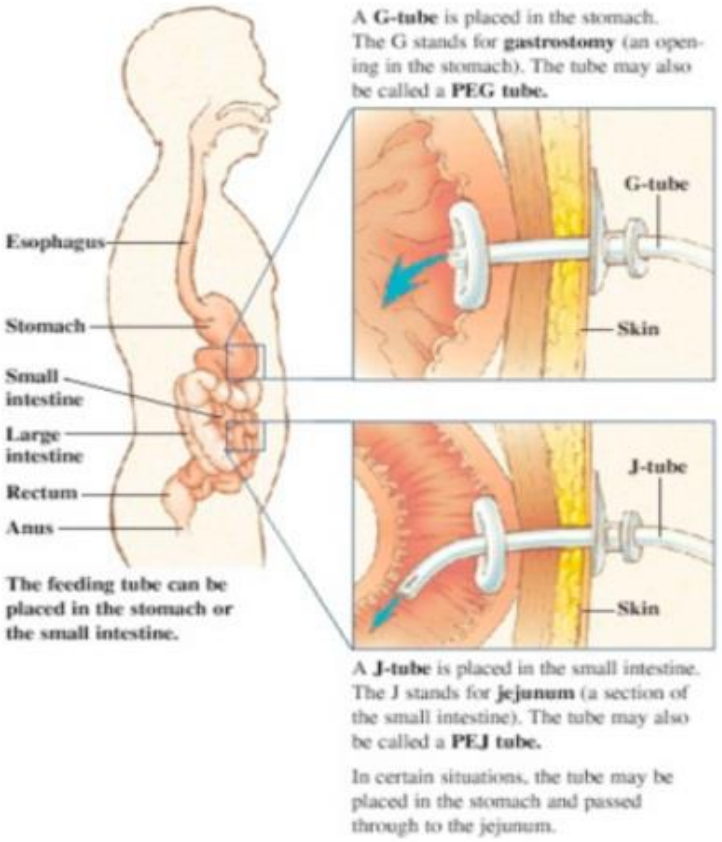
Patient

- The RD plays a key role in the feeding tube discussion
- Neurologist will have introduced the concept soon after diagnoses
- Indications for feeding tube placement are…
  - Weight loss and malnutrition
  - Dysphagia
  - Prolonged mealtimes
  - Tracheostomy
  - Quality of Life
  - Pulmonary function- threshold of FVC 50% has been used to indicate safety of tube placement but more recent literature supports safe placement with FVC < 50%.
  - European guidelines (2024) now recommend use of NIVV during G tube placement for those with compromised pulmonary function.

Patient Education in ALS clinic

- What does a tube look like?
- Percutaneous Endoscopic Gastrostomy
- Radiologically Inserted Gastrostomy
- Low profile tube e.g. Mic-key button





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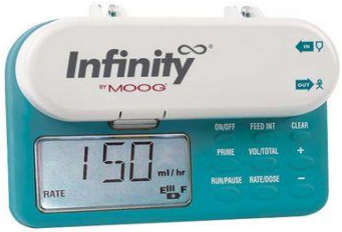
Patient Education in ALS clinic

- What could a day look like?
  - Feeding methods –
  - Syringe
  - Gravity
  - Pump
  - Oral diet + EN
  - Provide a plan for patient and family
  - Supporting printed information to guide decision making.
  - Pump feeding Education- DME?



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Patient Education in ALS clinic

- Common question – What do I pour through there?!
- Home blenderized feedings vs commercial formula
- Who is going to administer feedings –patient, caregiver (burden-gravity easier?)
- Inform patient of EN ordering process- formula through DME

  They should expect a call from the DME company.

  Who should they call if the patient is non-verbal?
- Explain insurance coverage
- Formula not covered? Oley, EN formula manufacturer patient assistance programs, donated formula.

- Who is the designated team member to educate and support the above?

Medicare Guidelines

- General documentation requirements for EN:
- Physician's written order or prescription
- Documentation to show permanence (not lifetime, > 90 days)
- Documentation to show disease or dysfunction "of the structures that normally permit food to reach or be absorbed from the small bowel and require tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status"
- Note: "sole source of nutrition" NOT mentioned
- A specialty formula is covered with adequate documentation of both the specific condition and the need for the formula (no longer required to trial a standard formula)
- A pump for patients fed via gastric tubes requires documentation to prove medical necessity i.e., gravity feeding is not satisfactory due to aspiration risk or intolerance (emesis, diarrhea, dumping syndrome) to a higher infusion rate/ intermittent feedings

Coordination of Care beyond ALS clinic

- GI/Surgery/Interventional Radiology referral- evaluation for procedure safety, placement window
  - Schedule and complete procedure
  - Post procedure follow up
- ALS RD assessment during ALS clinic visit or over the phone:
  - completes nutrition risk assessment –pt at refeeding risk? Recommend admission for electrolyte supplementation and slow introduction of feeding.
  - recommends/enters EN orders
- Who is entering and faxing orders? RD/RN/MA?
- Provide direct callback number- DME may have questions re: documentation or information on formula shortages (hopefully not!)
- Other RD involvement with orders- inpatient? GI clinic?
- Feeding tube placed at other facility – facility RD or ALS RD placing orders?

Coordination of Care in the ALS Clinic and Beyond

- Provide patient with a list of who to call and when.
- One triage number?
  - Follow up for feeding tube care – leaking tube, loose tube, cracked tube, pain at site, granulation tissue treatment
  - Low profile tube replacement at home or in GI clinic/IR clinic?
  - Issues with formula tolerance
- Guidelines for when to go to the ER
- Supply issues
- DME contact

What can be done to improve the process at your facility?

- Formally and systematically identify the key players and potential areas for breakdown in communication that can negatively impact patient safety and/or quality of life.
- Generate a formal process to ensure consistent care- this could be a simple checklist

- Quality Improvement Initiative- PDSA (Plan, Do, Study, Act) cycle
  - Collect and analyze data
  - Communicate results
  - Commit to ongoing evaluation (seeking patient and staff feedback) and improvement

What can be done to improve the process at your facility?

- Examples of process change at my facility
  - Change in staffing structure – RDs added in the GI clinic. Develop process to determine who is placing enteral nutrition orders
  - Noting that pts that opted to have PEG placed at outside facility did not have formula orders at time of PEG placement
  - DME unable to contact non-verbal patients via telephone- ALS RD including preferred contact person with orders.

  - Any other examples?

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