

Table 2: Results of NLP and ICD Codes Used to Identify Dysphagia Indications for Index and Repeat EGDs in the US Veteran Population (2010-2014).

	NLP (n)	ICD (n)	Difference between NLP and ICD (n, %)
Index EGDs with Dysphagia Indication (2010-2012)	19,295	17,021	2,274 (+11.8%)
Repeat EGDs Performed in Patients who had Index EGD for Dysphagia (2010-2014)	9,251	7,548	1,703 (+18.4%)
Repeat EGDs with Dysphagia Indication	4,802	3,365	1,437 (+29.9%)
Repeat EGDs without Dysphagia Indication	4,449	4,183	266 (+6%)

Tu1003

CAN WE TRUST THE DATA AT GASTROENTEROLOGY CONFERENCES? LESSONS LEARNED ACROSS THE POND

Raj Shah, Jamie Varghese, Mahathi Indaram, Samia Asif, Cody Braun, Usman Hasnie, Ahmed Elbermawy, Annapoorna Singh, Mir Fahad Faisal, Joseph D. Feuerstein

Introduction: Abstracts at conferences serve as an important avenue to inform physicians. We aimed to determine rate of and factors for successful publication of hepatology abstracts by February 2017 presented at the 2010 American conferences (USA) including Digestive Diseases Week (DDW), American Association for the study of Liver Disease (AASLD), and American College of Gastroenterology (ACG) and compare these to European conferences (EUR) including United European Gastroenterology (UEG) and European Association for the Study of Liver (EASL). Method: We reviewed the online 2010 AASLD, DDW, ACG, UEG, and EASL abstracts using the search term "Liver." We used validated methodology to determine successful publication and abstracted gender of authors and study design. We assessed whether studies that were published as manuscripts had different conclusions, results or number of study participants compared to the original abstracts. Results: A total of 3079 abstracts were reviewed with 308 (10.0%) were from DDW, 1815 (59.0%) were from AASLD, 91 abstracts (0.03%) were from ACG, 16.7% (515/3079) from EASL, and 11.4% (350/3079) from UEG. 35.9% (795/2214) of USA abstracts and 28.3% (245/865) of EUR abstracts were published by February 2017. Publication rate by location and gender were 31.5% for EUR female first authors, 30.0% for USA female first authors, 27.0% for EUR male first authors, and 35.3% for USA male first authors. Of the published EUR abstracts, 10.2% (25/245) were basic sciences, 27.4% (67/245) were retrospective, 34.7% (85/245) were prospective, and 10.6% (26/245) were randomized control trials. Of the published USA abstracts, 49.4% (393/795) were basic science studies, 30.8% (245/795) were prospective studies, 20.6% (164/795) were retrospective, and 10.9% (87/795) were randomized control trials. When compared to their manuscripts, 15/245 (6.1%) of EUR abstracts had a change in sample size or intervention, 1/245 (0.4%) in results, 3/245 (1.2%) in conclusion. Of the USA manuscripts, 36.2% (288/795) had a different sample size or change in intervention, 20.1% (160/795) results, and 14.1% (112/795) conclusions compared to the original abstract. Discussion: There is a low abstract to manuscript publication rate from both EUR and USA abstracts over a 7 year period in the hepatology field. There is higher prevalence of USA basic science publication compared to EUR. USA manuscripts had a higher prevalence of discrepancies compared to their original abstracts when compared to EUR manuscripts. This suggests that more data presented at the USA abstract stage may be incomplete and it may be premature to use this data for systematic reviews or secondary analyses. Further analysis is necessary to determine the etiology of this difference between the EUR and USA conference abstracts.

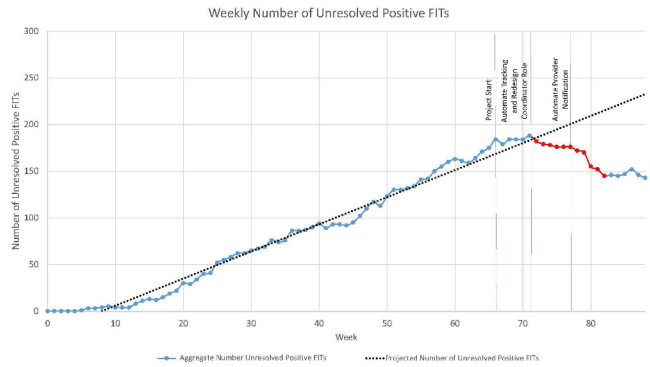
Tu1004

AUTOMATION AND PROCESS REDESIGN TO DECREASE UNRESOLVED POSITIVE FIT RESULTS

Bilal Ahmad, Sara Levy, Meena A. Prasad, Shanthi Srinivasan, Anne Tomolo, Stephan Goebel

Introduction: Fecal immunochemical testing (FIT) is a two-step process to screen for colon cancer. After a positive FIT, a colonoscopy is required to rule out colon cancer. The use of FIT has increased access to colorectal cancer (CRC) screening, but in many reports has resulted in decreased screening completion rates. With the implementation of FIT as the primary CRC screening modality at our center, we have observed an upward trend of positive FITs without appropriate follow-up. Methods: A multidisciplinary project team was created with representation from the Primary Care and Gastroenterology departments at our center. Quality improvement tools including process mapping, stakeholder interviews, and Pareto charts were used to understand reasons for positive FITs without appropriate follow-up. Interventions were implemented in sequential Plan-Do-Study-Act cycles. The primary measure was the aggregate number of unresolved FIT cases per week. Unresolved FITs were defined as positive FITs without documentation of follow-up colonoscopy, exception to testing, or patient refusal. Statistical Process Control methodology was used for data analysis. We aimed to halt the upward trend of unresolved cases. Results: Between January 2016 and April 2017, the Atlanta VA had a total of 674 positive FITs with 184 (27.3%) unresolved FIT cases. Despite the presence of a screening coordinator nurse, unresolved FITs were increasing at an average of 3 cases per week. The most common reasons for unresolved FITs included failed colonoscopy scheduling, incomplete records from outside referrals, and missed colonoscopy appointments accounting for 25.0%, 23.8%, and 19.0% of unresolved FITs, respectively. To address common reasons for unresolved FITs, we first developed a weekly tracking report of unresolved FITs using clinical data from the VA Corporate Data Warehouse. We redefined the screening coordinator's role to involve direct patient outreach. The coordinator used the newly developed weekly tracking report to assist patients with colonoscopy scheduling, counseling, and outside record completion. We then developed an automated tool to notify ordering providers of abnormal FIT results. These monthly alerts prompted providers to order a colonoscopy, document outside colonoscopy results, or complete patient refusal documentation. Once implemented, the number of unresolved FITs decreased to 143 cases compared to 232 cases projected without intervention. A

statistically significant downward trend ( $p < 0.05$ ) of unresolved FITs was noted after implementation of our interventions (Fig 1). Conclusion: Improved tracking, direct patient outreach, and automated provider alerts led to increased scheduling, completion, and documented refusal of colonoscopies for patients with unresolved FITs.



Tu1005

WILLINGNESS TO STOP PROTON PUMP INHIBITORS IN PATIENTS WITH GASTROESOPHAGEAL REFLUX DISEASE: RESULTS OF A PATIENT SURVEY

Jennifer K. Kennedy, Sameer Saini, Jacob E. Kurlander

Introduction: Increasing evidence has linked long-term proton pump inhibitor (PPI) use to multiple adverse effects (AEs), including chronic kidney disease, bone fracture, and enteric infection. These concerns have motivated efforts to minimize unnecessary long-term PPI use, such as the Choosing Wisely Campaign. Aims: To assess patients' willingness to stop or reduce PPIs using different deprescribing strategies. Methods: We administered an online survey in July 2017 to adults taking PPIs for gastroesophageal reflux disease (GERD), as identified by a commercial survey firm. We assessed participants' willingness to stop PPIs under varying conditions, including type of provider recommending stopping (primary care provider vs. gastroenterologist vs. pharmacist), and different deprescribing strategies (tapering PPI vs. substituting H2 blocker vs. providing reassurance about ability to resume PPI if needed). For analysis, responses to questions about willingness to stop PPI were dichotomized as somewhat/very unwilling vs. somewhat/very willing. Chi-square analysis was used to compare responses across conditions. Results: Among 755 survey participants, mean age was 49 years (SD 16), 71% were female, and 91% were Caucasian. A majority (62%) used PPIs at least daily. There was a significant difference in participants' willingness to stop PPIs based on the provider recommending discontinuation, with 77% willing to stop PPIs if recommended by a gastroenterologist vs. 71% if recommended by a PCP and 59% if recommended by a pharmacist ( $X^2=61.1, p < 0.001$ ). Rates of willingness to stop PPIs increased with adjunctive deprescribing strategies. While 71% were willing to stop a PPI in general, this number increased to 83% if they could stop by tapering the PPI dose, 82% if they could stop with the option to resume a PPI if needed, and 79% if they could stop by switching to a H2 blocker ( $X^2=38.8, p < 0.001$ ). Conclusion: Our results provide practical guidance for health systems and individual physicians attempting to deprescribe unnecessary PPIs for patients with GERD. Most patients are willing to stop PPIs if recommended by a gastroenterologist or primary care physician. However, patients are less willing to follow a recommendation to stop from a pharmacist, a group that would otherwise be well positioned to contribute to large scale deprescribing efforts. Patients are more willing to stop if given the option of adjunctive deprescribing strategies, such as a PPI taper, H2 blocker substitution, or reassurance about the possibility of resuming PPI if needed.

Tu1006

IMPROVEMENT IN COLONOSCOPY QUALITY METRICS IN CLINICAL PRACTICE FROM 2000 TO 2014

Simon Mathews, Jennifer L. Holub, David A. Lieberman

Background: Quality and safety are essential components of providing excellent care to patients in all settings including endoscopy. The landscape and literature on quality with respect to colonoscopy in particular have grown and matured greatly over the last 15 years. Guidelines since 2002 have promoted measurement of quality metrics in practice. We aimed to determine whether quality has improved over time in patients undergoing screening colonoscopy during the periods 2000-2004; 2005-2009; 2010-2014. Methods: Colonoscopy data were collected prospectively at 84 gastrointestinal practice sites from 2000 to 2014, using an endoscopic report generator, from 390,741 average-risk adults who underwent colorectal cancer screening. Demographic characteristics included age; sex; race/ethnicity; and ASA class were obtained. Primary outcomes included: bowel prep quality (percent good/excellent) and polyp detection rate. Results: Demographic differences among time cohorts are detailed in Table 1, with statistically significant differences noted in age, sex, race/ethnicity, and ASA class. Differences in quality measures are summarized in Table 2. Notably, there were statistically significant improvements in both bowel prep quality and polyp detection rate over time across all age and sex stratifications. Conclusion: Quality measures in screening colonoscopy have improved over distinct periods of time over a 15-year period, which may reflect the publication and dissemination of recommendations for quality metrics.