

# High Value Care

“Things We Do for No Reason”  
2025 West Virginia ACP Meeting

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## Disclosures

- None

# Objectives

- Understand the Impact of the “Big Beautiful Bill Act”
  - Why this is this is relevant to “High Value Care”
- Discuss Major topics in Society of Hospital Medicine’s “Things we do for No Reason” 2024-2025
- Specifically examine something we in West Virginia may “do for now reason”
- Think of the above in terms of both clinical reasoning and impact on value-based care.

# An Act to Provide for Reconciliation Pursuant to **Title II** of H. Con. Res. 14

- “Big Beautiful Bill Act”
- Impact on West Virginia
  - Economy
  - **Health Care**
  - Taxes



“The cuts to Medicaid and the ACA will have devastating and dramatic impacts on health coverage, care, and costs for American families, and in many ways especially in West Virginia. The cuts will not just mean that tens of thousands of West Virginia residents lose coverage, but federal cuts will force state budgets into crisis, forcing states to drastically scale back services, leading to closures of rural hospitals and community clinics,”

# Big Beautiful Bill Impact

- Largest cut to Medicaid in History
  - \$ 859 Billion from Medicaid
- Removes \$349 billion from Marketplace coverage
  - Small business impact
- Forces \$500 billion in mandatory cuts to Medicare by triggering Federal spending laws.
- How does that impact our patients?
  - Eliminating coverage
  - Increasing premiums
  - Closing Hospitals

# Why is this important to understand?

- Ask yourself how you practice medicine? What percentage of your decision making revolves around the cost accrued to the patient?

# Some numbers to consider

- 27-29% of WV population is enrolled in Medicaid
  - 522,000 patients
- 16.7% of WV population has an income below the poverty level
  - \$21,150 for 2 people
  - One of the highest in the nation
- 21% of WV population is 65 years or older
  - 368,989
  - Average annual income of a senior in WV is \$33,901

# Society of Hospital Medicine – Journal of Hospital Medicine

- Choosing Wisely: Things We Do For No Reason
- Reviewed all from April 2024-August 2025

Journal of  
Hospital Medicine

shm.  
Society of Hospital Medicine

# ***CHOOSING WISELY*<sup>®</sup>: THINGS WE DO FOR NO REASON<sup>™</sup>**

- Routine early PEG placement for dysphagia and stroke
- Indiscriminate use of Behavioral Alerts
- Discontinuing Beta Blockers in patients who use Cocaine
- Deferring bisphosphonate initiation to outpatient setting after fragility hip fracture.
- Opioid infusions as initial therapy for symptoms at the end of life.
- Obtaining an ECG for Managing Mild Hyperkalemia in Hospitalized Adults.
- Dose Adjusting Apixiban in Acute Kidney Injury
- Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients
- Routine use of Antibiotics for Uncomplicated Diverticulitis (UD)
- Avoiding Naltrexone for Alcohol Use Disorder in Liver Disease
- Routine use of “denies” and other stigmatizing language in medical documentation.
- Checking QTc on hospitalized adult patients before intravenous ondansetron administration.
- Discontinuing Anticoagulation in Older Adults with Atrial Fibrillation and a high risk for falls
- *S. pneumoniae* and *legionella* urine antigen testing
- Prescribing cefdinir for treatment of common infections
- Pharmacological sleep aids (PSAs) for hospitalized patients with acute insomnia
- Using lactate as our resuscitation guide in sepsis

# Routine early PEG placement for dysphagia after acute stroke

Things We Do For No Reason™		
Routine early PEG tube placement for dysphagia after acute stroke		
Why you might think it's helpful	Why it may not be helpful	When it might be helpful
<ul style="list-style-type: none"><li>• <b>Stroke guidelines</b> recommend enteral feeding within 7 days, but majority (75%) of patients unable to swallow at discharge</li><li>• Reabs <b>prefer definitive enteral access</b> prior to discharge</li></ul>	<ul style="list-style-type: none"><li>• ~70% resume oral intake <b>within 30 days</b></li><li>• <b>7.8% absolute increase in death or poor outcome</b> with PEG compared to NG tube</li></ul>	<ul style="list-style-type: none"><li>• <b>High likelihood</b> of needing chronic enteral tube feeding<ul style="list-style-type: none"><li>◦ Older patient</li><li>◦ High NIHSS</li></ul></li></ul>

### Recommendations

- Use validated tool (PRESS) to assess likelihood of swallow recovery after stroke
- Discuss expected swallow recovery with patient
- Watchful waiting

Journal of Hospital Medicine

shared Decision-Making

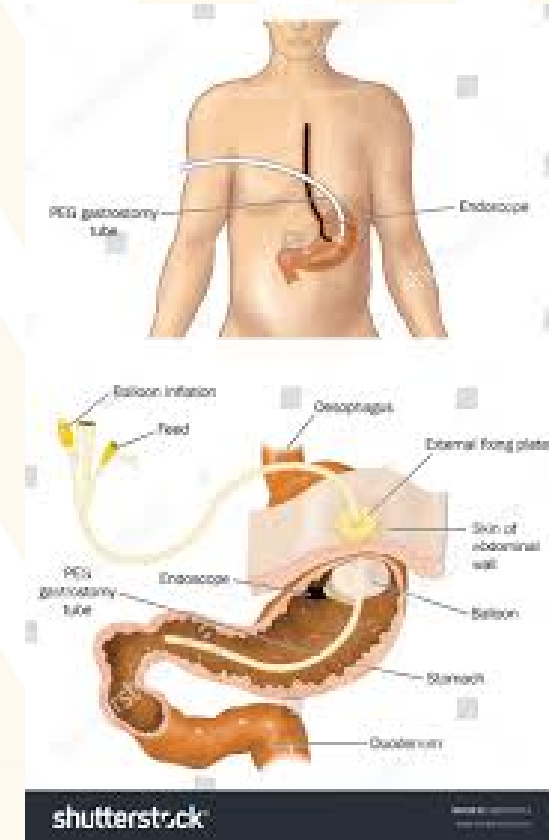
R Gallo et al, August 2024  
Visual Abstract by @PatriciaTranMD

# Routine early PEG placement for dysphagia after acute stroke

- Dysphagia after stroke is common
- About 25% of patients resume oral intake without complication before discharge
- In majority of cases PEG tube is usually placed within 7 days
  - 53%
  - More frequently in older patients

# Routine early PEG placement for dysphagia after acute stroke

- Why do we think this is a good idea?
  - 2019 American Heart Association Guidelines
    - Enteral Feeding within 7 days
- Why do we do this?
  - Guidelines vs “the system”
    - Skilled Nursing, Acute Rehab, LTACH




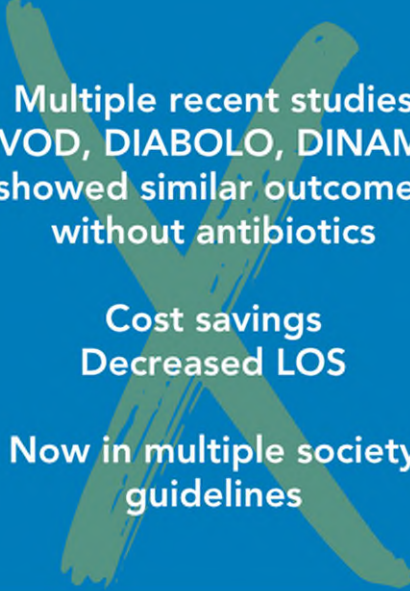

# Routine early PEG placement for dysphagia after acute stroke

- Why shouldn't we do this?
  - Approximately 70% of patients resume oral intake by 30 days
  - NG tube benefits
  - Anticoagulation
- PEG vs NG
  - Limited amount of data/evidence
- When should we use PEG?
  - Large stroke
  - Older patients with large stroke

# Routine early PEG placement for dysphagia after acute stroke

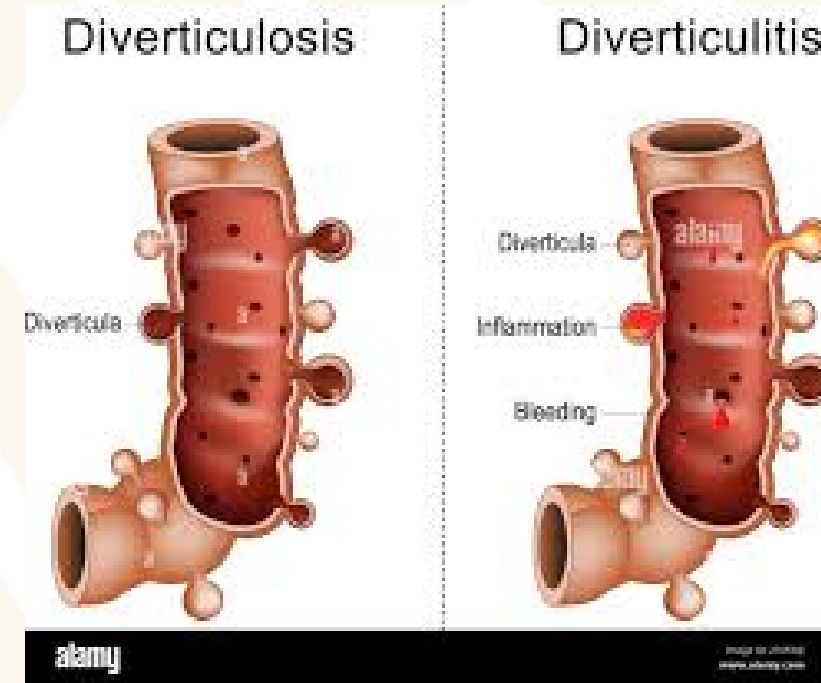
- Recommendations
  - Validated clinical prediction tool
    - PRESS (Predictive Swallowing Score)
  - Shared decision making
  - Watchful waiting if appropriate based on discharge planning
  - Speech/Swallow rehab

# Routine use of Antibiotics for Uncomplicated Diverticulitis (UD)

<b>Things We Do For No Reason™</b>	<b>Routine Use of Antibiotics for Uncomplicated Diverticulitis (UD)</b>	
Why You Think Antibiotics Might Be Helpful For UD	Why Antibiotics are Not Helpful for UD	What You Should Do Instead
 <p>Diverticulitis thought of as an <b>infectious</b>, not <b>inflammatory</b> process</p> <p><b>Standard</b> of care has been to use antibiotics</p> <p>Journal of Hospital Medicine</p>	 <p>Multiple recent studies (AVOD, DIABOLO, DINAMO) showed similar outcomes without antibiotics</p> <p>Cost savings Decreased LOS</p> <p>Now in multiple society guidelines</p>	 <p><b>Risk stratify your patients:</b></p> <p><b>Low risk:</b> no antibiotics if tolerating PO and mild disease</p> <p><b>High risk or complicated diverticulitis:</b> treat with antibiotics</p> <p>Marino et. al August, 2025 #Visual Abstract by Catie Glatz</p>

# Routine use of Antibiotics for Uncomplicated Diverticulitis (UD)

- Diverticulitis accounts for over 400,000 ED visits and 200,000 hospital admissions annually
  - Estimated cost of \$3.2 billion
- Uncomplicated vs Complicated
  - 88% vs 12 %



# Routine use of Antibiotics for Uncomplicated Diverticulitis (UD)

- Why do we (did we) use antibiotics so much?
  - Traditional definition / theory
  - Society guidelines from 1990s-2000s
  - Clinical trials
    - Failed to demonstrate benefit, but failed to demonstrate harm
  - Guidelines are vague
    - “severe”
  - Intervention bias, patient expectations
    - British and Canadian studies

# Routine use of Antibiotics for Uncomplicated Diverticulitis (UD)

- So why shouldn't we routinely use antibiotics for UD?
  - Inflammation rather than infection
  - AVOD trial (2012)
  - DIABOLO RCT (2016)
  - DINAMO RCT (2015-2021)
    - 42%-82% cost savings
  - AGA provided updated guidelines in 2021
    - Criteria based antibiotic use
    - ACP, SAGES, WSES, EAES followed and echoed above



# Routine use of Antibiotics for Uncomplicated Diverticulitis (UD)

- Recommendations
  - Give antibiotics to complicated diverticulitis and severe cases
    - Refractory symptoms
    - Sepsis
    - Vomiting
    - Drastically elevated CRP, WBC
  - Give antibiotics to high-risk patients
    - Frailty, immunocompromise, co morbidities
  - Hospital Protocols

# Using lactate as our resuscitation guide in sepsis

Things We Do For No Reason™

## Using lactate as our resuscitation guide in sepsis

Why You Might Think It's Helpful	Why It May Not Be Helpful	What To Do Instead
<p>↑Lactate ↔ ↑Mortality</p> <p>RCTs using lactate-guided resuscitation strategy showed ↓mortality</p> <chem>CC(O)C(=O)O</chem> <p>SURVIVING SEPSIS says so! Journal of Hospital Medicine</p>	<p>↑Lactate ≠ perfusion</p> <p>Newer Trials Examining Lactate-Based Resuscitation</p> <p>Andromeda-Shock: Overtreatment</p>  <p>SSSP2 and FEAST: ↓lactate ≠ successful Tx</p>	<p>Use lactate to <b>screen</b> for possible sepsis</p>  <p>Base resuscitation on <b>clinical</b> findings: capillary refill time passive leg raise</p> <p>B Juffs, MD et al, Feb 2024 Visual abstract by @DocWithBowtie</p>

# Using lactate as our resuscitation guide in sepsis

- Lactate elevation is strongly associated with mortality in sepsis
- Why do we think we should use lactate to guide resuscitation?
  - RCTs have shown lactate-guided strategy decrease mortality
  - Lactate lab is relatively inexpensive and noninvasive monitoring technique
  - *Surviving Sepsis Campaign*

# Using lactate as our resuscitation guide in sepsis




- Why is using lactate NOT helpful?
  - Examination of the physiology
  - Andromeda-Shock trial
    - Overtreatment using lactate as sole marker
    - Excess IVF given in lactate arm
  - SSSP2 trial (FEAST trial – pediatrics)
    - Decrease in lactate did not correlate with successful treatment outcome
    - Higher mortality in lactate/high resuscitation group

# Using lactate as our resuscitation guide in sepsis

- Recommendations
  - Use lactate as an aid in risk stratification early in clinical course
  - Do not use lactate in isolation
  - Consider CRT (capillary refill time)



# Discontinuing Anticoagulation in Older Adults with Atrial Fibrillation and a high risk for falls

<b>Things We Do For No Reason™</b>	<b>Discontinuing Anticoagulation in Older Patients with Atrial Fibrillation and a High Risk of Falls</b>	
Why You Might Think Discontinuation Is Helpful	Why Discontinuation Is Unhelpful	What You Should Do Instead
 <p>&gt; 25% of community-dwelling adults experience at least one fall annually</p> <p>In one study, AC in fall-prone patients increased major bleeding 39%</p> <p>Journal of Hospital Medicine®</p>	 <p>In patients with AF, AC reduces stroke risk by at least 2/3</p> <p>In one study of patients with AF and ↑ stroke risk, AC ↓ composite of stroke, any hemorrhage, MI, and death 25%</p> <p>Most patients with AF willing to accept ↑ bleeding risk in exchange for ↓ stroke risk</p>	 <ul style="list-style-type: none"><li>Estimate risk for bleeding with validated calculator:<ul style="list-style-type: none"><li>HAS-BLED for warfarin</li><li>DOAC score for DOACs</li></ul></li><li>Have shared decision making discussions</li><li>Implement evidence-based fall prevention programs</li></ul> <p>S Wang and M Mesias, March 2025 #Visual Abstract by @ajchinn</p>

# Discontinuing Anticoagulation in Older Adults with Atrial Fibrillation and a high risk for falls



By 2040, the population in the US over the age of 65 will be 80 million



Patients over the age of 65 fall, a lot; AND the get Atrial Fibrillation, a lot



Currently we use CHA<sub>2</sub>DS<sub>2</sub>-VASc to risk assess and determine need for anticoagulation



10% of falls account for 2.8 million emergency room visits and 800,000 hospitalizations



Falls are the primary cause of traumatic intracranial bleeding

High Mortality Rate – 15%

# Discontinuing Anticoagulation in Older Adults with Atrial Fibrillation and a high risk for falls

- Why do we think this is a good idea?
  - Falls contribute greatly to morbidity, mortality, and disability in older adults
  - Anticoagulation in fall prone patients increases bleeding risk by 39%
  - Intracranial Hemorrhage
    - High fall risk patients = 4.1 times more often than low risk fall patients
    - National Trauma Data Standard registry
      - 180% higher risk of death in patients who fell while on Anticoagulation
  - DOAC concerns

# Discontinuing Anticoagulation in Older Adults with Atrial Fibrillation and a high risk for falls

- So why SHOULDN'T we stop Anticoagulation (AC) in these patients?
  - Stroke Prevention, Stroke Prevention, Stroke Prevention
  - If on or not on AC, outcomes similar in ICH or TBI injuries
    - Large retrospective study showed no correlation between overall mortality
  - Net benefit of AC
  - We as physicians assume patients want to withhold AC
  - Quantitative models have suggested that a patient would need to fall 295 times per year for the risk of ICH to outweigh the benefit of stroke prevention. Others have estimated 35-40 falls / year.
  - European Society of Cardiology Guidelines
    - “a history of falls is not an independent predictor of bleeding on an oral anticoagulant”

# Discontinuing Anticoagulation in Older Adults with Atrial Fibrillation and a high risk for falls

- So, should we never stop AC when concerned for falls?
  - Higher bleeding risk from other comorbidities
  - Use HAS-BLED and ORBIT tools to characterize individual bleeding risk
    - DOACs Score
  - Should consider stopping in severe frailty and end of life / goals of care discussion scenarios


# Discontinuing Anticoagulation in Older Adults with Atrial Fibrillation and a high risk for falls

- Recommendations

- Do not routinely discontinue AC based on fall risk alone in older patients with Atrial Fibrillation
- Shared Decision Making
- Decrease fall risk



# Checking QTc on hospitalized adult patients before intravenous ondansetron administration.

Things We Do For No Reason™	Checking QTc on hospitalized adult patients before intravenous ondansetron administration	
Why You Might Think It's Needed	Why It Might Not Be Necessary?	When Might It Be Helpful?
<p><b>BLACK BOX WARNING</b> Droperidol and TdP</p> <p><small>REVIEW ARTICLE   Originally Published 3 October 2017</small></p> <p>Update to Practice Standards for Electrocardiographic Monitoring in Hospital Settings: A Scientific Statement From the American Heart Association</p> <p><b>Class IIA: May monitor QTc for pts w/hx prolonged QTc or with multiple clinical risk factors</b></p> <p>Journal of Hospital Medicine</p>	<p><b>EVIDENCE</b> Risk of TdP</p> <p>Mostly case studies and small series</p> <p><b>Biggest risk factor: total dosage of ondansetron over time frame</b></p> 	<ul style="list-style-type: none"><li>• Cardiac risk factors</li><li>• Prolonged QTc on baseline EKG</li><li>• Electrolyte disturbances</li><li>• Tisdale Risk Score</li><li>• ≥8 mg IV ondansetron per dose</li></ul> <p>Kaushik et al, May 2025 Visual Abstract by @DocWithBowtie</p>

# Checking QTc on hospitalized adult patients before intravenous ondansetron administration.

- Many medications affect the QT interval
- Excessive prolongation of QTc can theoretically lead to torsades de pointes
- Ondansetron (Zofran) is prescribed a lot
  - Blocks rectifying potassium channels – early depolarization



# Checking QTc on hospitalized adult patients before intravenous ondansetron administration.

- Why do we routinely check ECGs before Zofran administration?
  - 2001 FDA “Black Box Warning”
    - Droperidol
  - 2011 FDA issued a safety communication related to ondansetron
    - No recommendation about monitoring
  - Assumption that baseline long QTc puts patients in high-risk category for significant arrhythmias related to prolongation
  - Small studies showed that a significant amount of hospitalized patients did have long QTc
  - American Heart Association published guidelines in 2017 for monitoring of QT interval
    - “The AHA provides a class IIA recommendation that, before antiemetic use, providers may reasonably decide to monitor the QTc for patients with a history of prolonged QTc or with multiple clinical risk factors”

# Checking QTc on hospitalized adult patients before intravenous ondansetron administration.

- Why is this not necessary?
  - Actual rate of baseline prolonged QT is quite low
  - Most guidelines come from small, case studies without robust evidence
  - QT prolongation after IV ondansetron self-resolves rapidly
    - Evidence
      - Charbit et al. Prolongation of QTc interval after postoperative nausea and vomiting treatment by droperidol or ondansetron. *Anesthesiology* 2005
      - Khan et al. QT interval prolongation in hospitalized patients on cardiology wards: a prospective observational study. *Eur J Clin Pharmacol* 2017
      - FDA. *Drug Safety Communication: New Information Regarding QT Prolongation with Ondansetron (Zofran)* [fda.gov](http://fda.gov). Federal Drug Agency; 2012

# Checking QTc on hospitalized adult patients before intravenous ondansetron administration.

- Guess how many cases in the medical literature of ondansetron related torsades de pointes??

2

# Checking QTc on hospitalized adult patients before intravenous ondansetron administration.

Drug class	Examples
Antiarrhythmic	Amiodarone, disopyramide, dofetilide, ibutilide, sotalol
Antibiotic	Azithromycin, ciprofloxacin, erythromycin, levofloxacin, moxifloxacin
Antidepressant	Citalopram, escitalopram
Antiemetic	Droperidol, ondansetron
Antifungal	Fluconazole
Antipsychotic	Haloperidol, chlorpromazine
Opiate	Methadone

# Checking QTc on hospitalized adult patients before intravenous ondansetron administration.

Tisdale risk score for QT prolongation

Independent predictors	Points
Age 68 years	1
Female	1
Loop diuretic use	1
Potassium 3.5 mEq/L	1
Admission QTc 450 ms	2
Admission reason	
Acute myocardial infarction	2
Sepsis	3
Heart failure	3
Number of QTc prolonging drugs	
None	0
1 QTc-prolonging drug	3
2 QTc prolong drugs	6



*Note:* Predictors of QT prolongation >500 ms in hospitalized patients per Tisdale Score. Score of  $\leq 6$  is low risk, 7–10 is moderate risk, and  $\geq 11$  or greater is considered high risk for QT prolongation.

# Checking QTc on hospitalized adult patients before intravenous ondansetron administration.

- Recommendations
  - Use risk calculator if multiple medications / risk factors present
  - Do not obtain a baseline ECG in low risk group
  - Do not perform serial ECGs when giving IV ondansetron
- Guess how much an ECG costs?

**\$50 – 100 (minimum)**

# Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients

<b>Things We Do For No Reason™</b>	<b>Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients</b>	
Why you might think routine viral testing is helpful	Why routine viral testing is not helpful	When viral testing might be helpful
<p>Avoid antibiotics</p> <p>Know the etiology of respiratory distress</p> <p>Prevent nosocomial spread</p>  <p>Journal of Hospital Medicine</p>	<p>Lacks specificity</p> <p>Only flu and COVID have specific treatments</p> <p>No outcome differences between targeted testing and panels</p> <p>Panel testing is expensive</p>	<p>Immunocompromised patients at risk of severe respiratory disease</p> <p>Critically ill patients</p> 
<p><u>What you should do instead</u></p> <p>Test immunocompetent patients using <i>targeted</i> viral testing based on seasonal prevalence.</p> <p>Levin et.al December 2024 #Visual Abstract by @CatieGlatz</p>		

# Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients

- 40 FDA approved nucleic acid tests for respiratory pathogens
  - Can detect multiple viruses and some atypical bacteria
  - Good to “know what it is”
  - Expensive
    - 25-200\$
- Why do we routinely do this?
  - Acute Respiratory Illness accounts for 10% of ED visits
  - Relatively high sensitivity
  - Can reduce antibiotic use
  - Could reduce chest x-rays
  - Isolation protocols for inpatients

# Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients

- Why we should rethink the routine use of these panels?
  - Lack of specificity
  - For immunocompetent hosts, treatment is available and useful for
    - Influenza and COVID-19
  - Multiple studies demonstrate no difference in clinically relevant outcomes between these panels and targeted testing
    - Including Antibiotics and hospital days
  - Targeted testing is cheaper and faster

# Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients

- Evidence

- Byington et al. (BIG-LoVE) study (2015)
  - Lacks Specificity
- Brendish et al. and Kuitunen et al (2017 *Lancet* and 2023 *Open Forum Infect Dis*)
  - Did not reduce antibiotic usage
- Tran et al. 2017 *J Gen Intern Med*
  - Isolation practices that lengthen stay and hospital costs

# Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients

- EXPENSIVE

FDA approved test	Viruses tested	Cost per test sample <sup>a</sup>
Xpert Flu Assay <sup>1, 21</sup>	Influenza A and B	\$25–50
Xpert Xpress CoV-2/Flu/RSV plus <sup>22</sup>	SARS-CoV-2 Influenza A and B RSV	\$40–60
FilmArray Respiratory Virus Panel <sup>1, 22, 23</sup>	Influenza A and B Coronavirus Human metapneumovirus Parainfluenza virus 1–4 RSV Rhinovirus Enterovirus <i>Bordetella pertussis</i> <i>Chlamydophila pneumoniae</i> <i>Mycoplasma pneumoniae</i> SARS-CoV-2	\$100–200

# Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients

- Recommendations
  - Do NOT routinely order the respiratory panels
  - Target testing that will change management

# Routine Respiratory Pathogen Panels for Emergency Department and Hospitalized Patients

- Here in WV at WVU Ruby
  - 60,893 Biofire orders in last 2 years
    - \$100 X 61,000 = 6.1 million dollars
- Does Medicare and Medicaid cover these tests?
  - Will they cover them going forward?

# Summary

- Health care is expensive, and upcoming changes are going to make it even more expensive for patients in our state
- Be good stewards of health care services and follow the evidence

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