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

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

"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

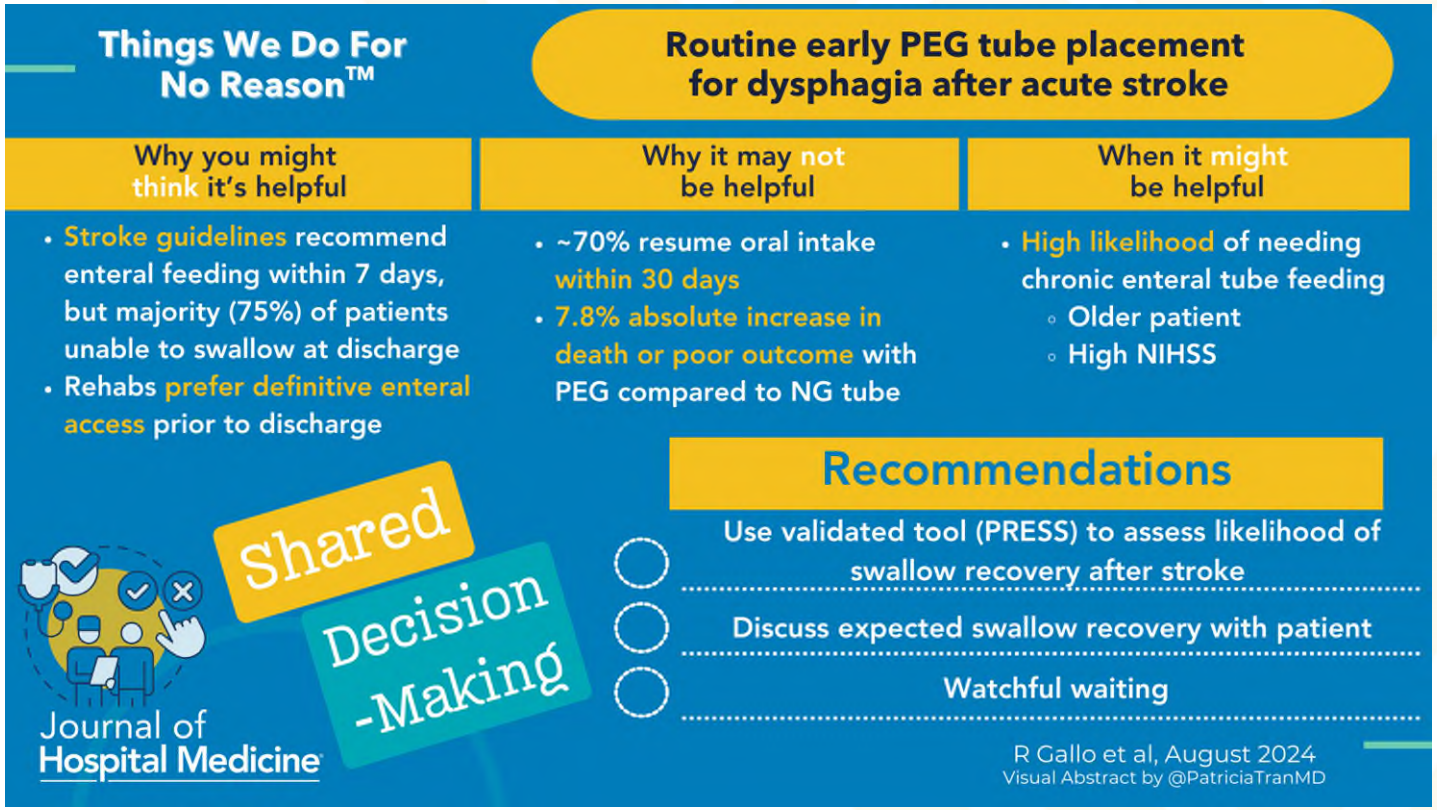
Society of Hospital Medicine – Journal of Hospital Medicine

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

CHOOSING WISELY®: THINGS WE DO FOR NO REASON™

- 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

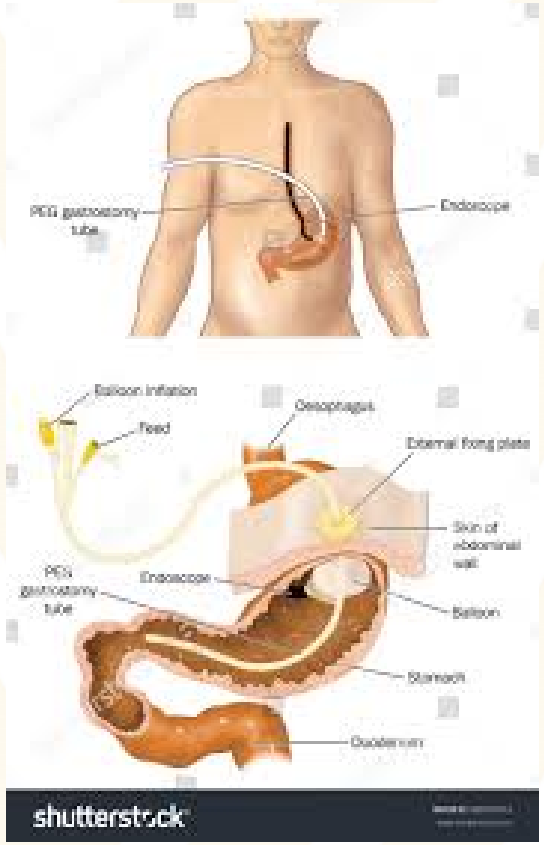


Routine early PEG placement for dysphagia after acute stroke

- 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



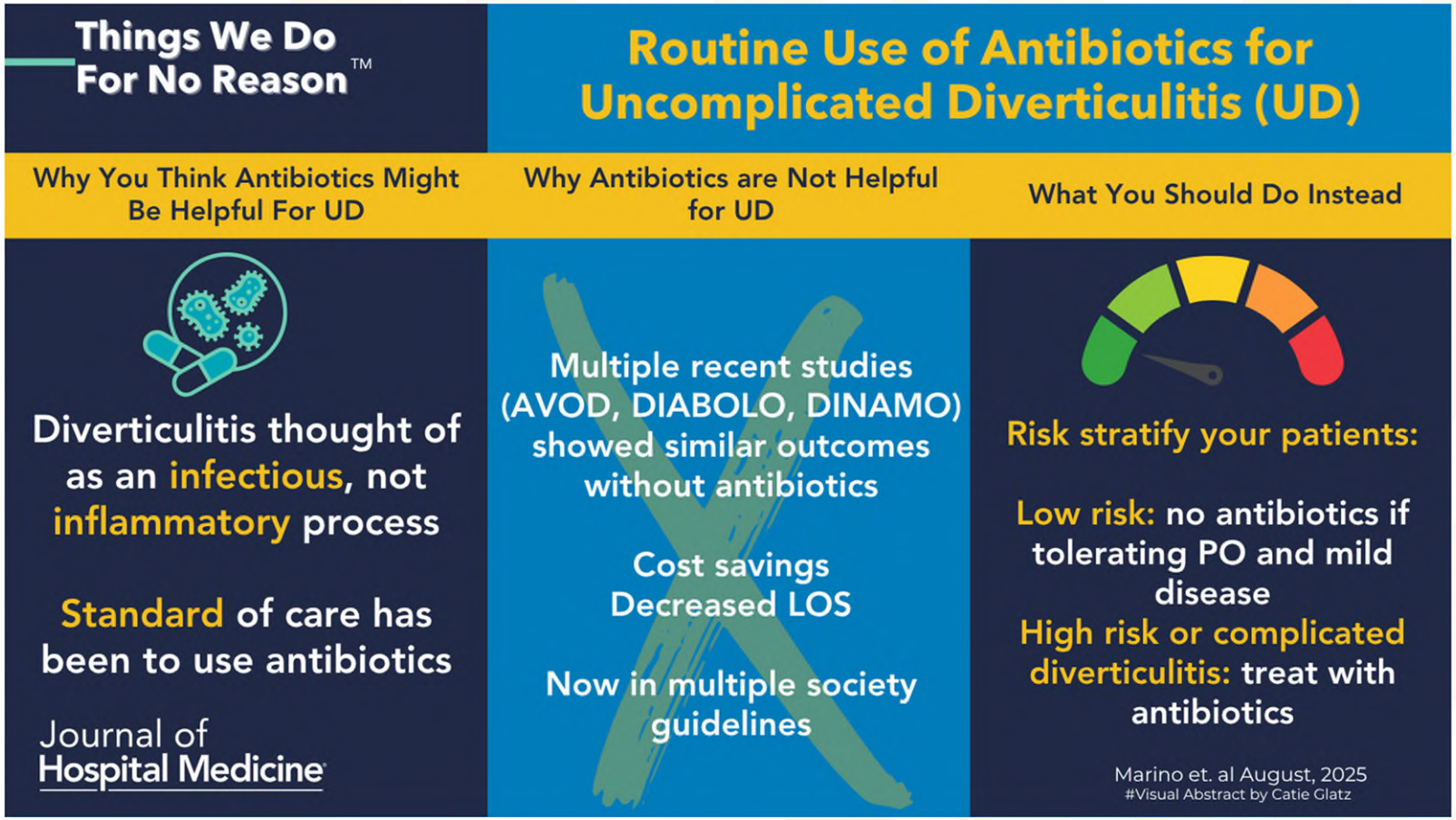
Routine early PEG placement for dysphagia after acute stroke

- 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

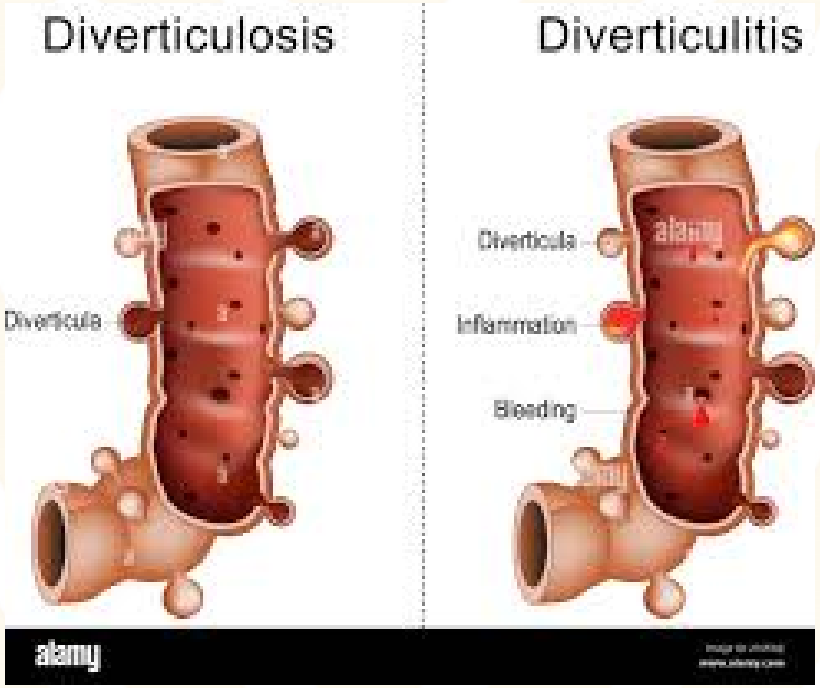
- Recommendations
  - Validated clinical prediction tool
    - PRESS (Predictive Swallowing Score)
  - Shared decision making
  - Watchful waiting if appropriate based on discharge planning
  - Speech/Swallow rehab

Routine use of Antibiotics for Uncomplicated Diverticulitis (UD)



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

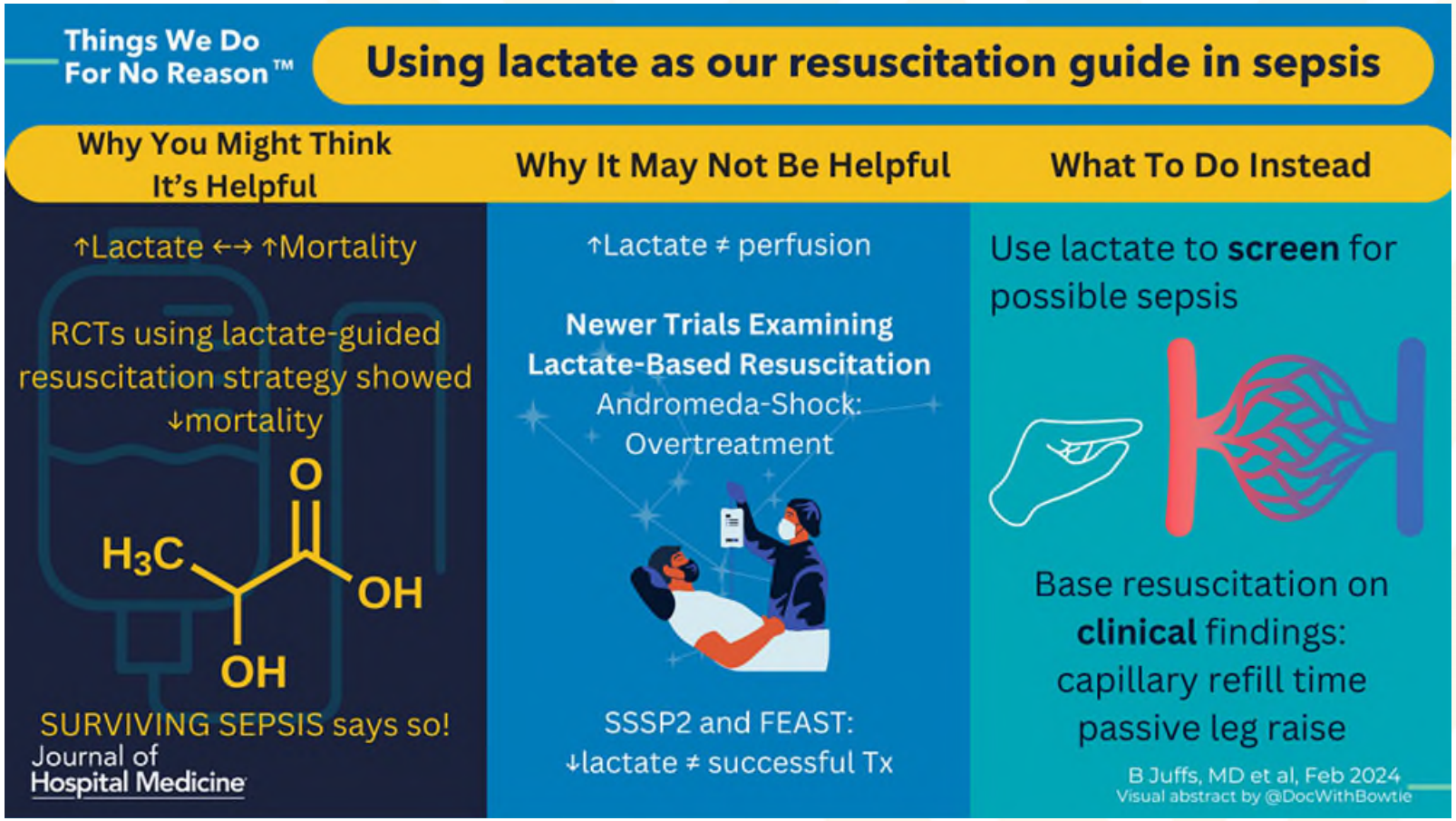
Routine use of Antibiotics for Uncomplicated Diverticulitis (UD)

- 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



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*

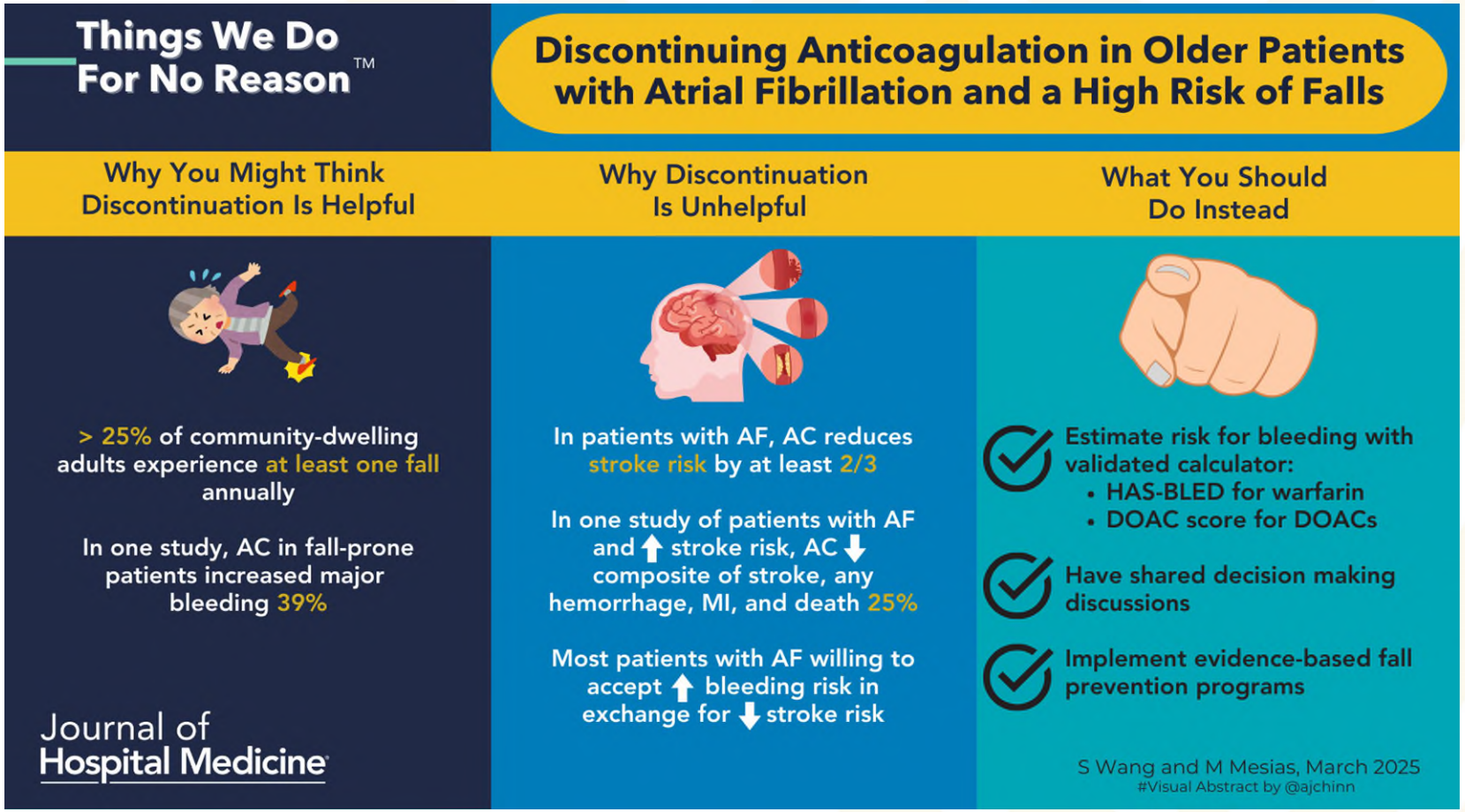
Using lactate as our resuscitation guide in sepsis

- 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



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_2DS_2-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"

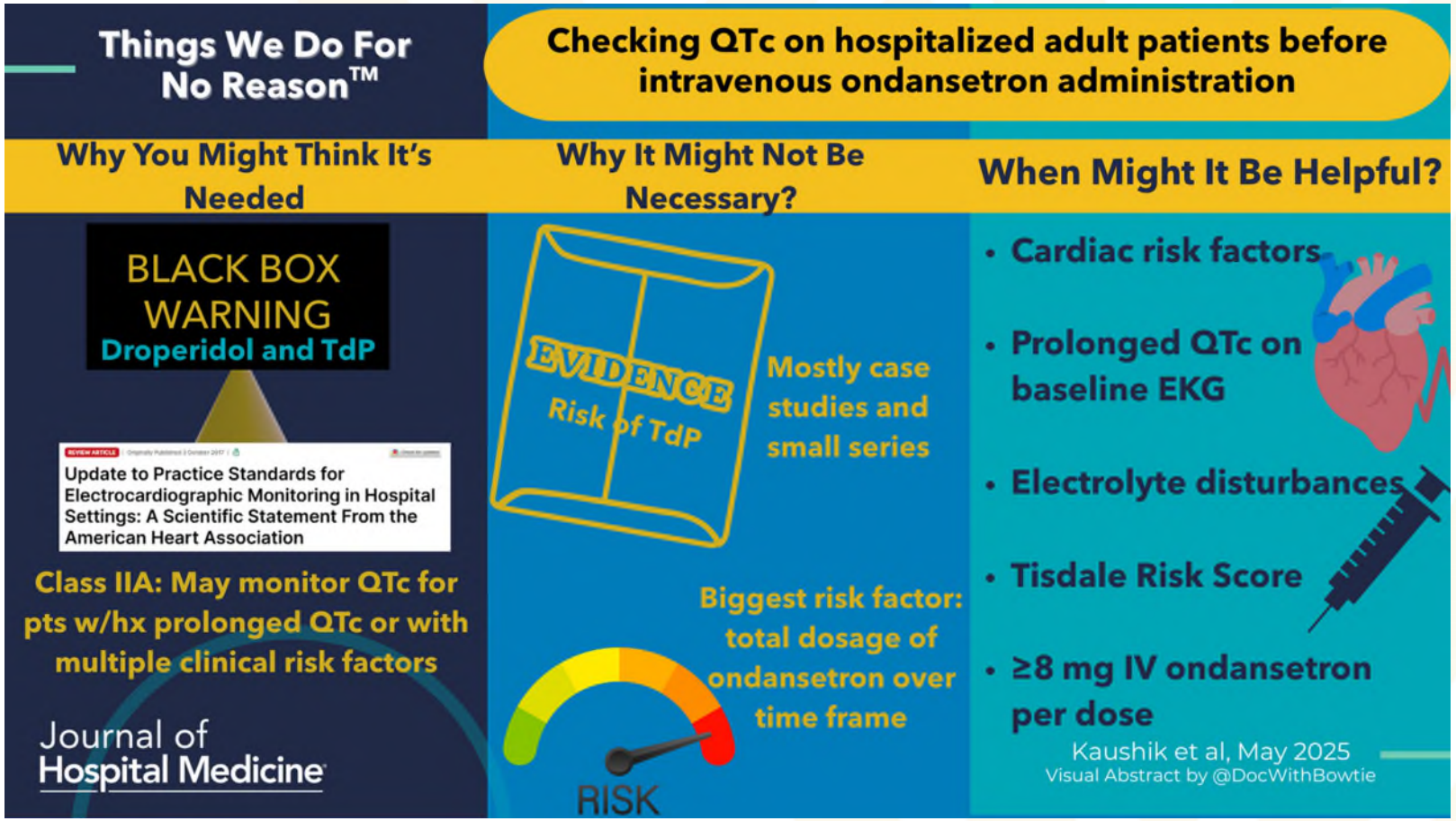
Discontinuing Anticoagulation in Older Adults with Atrial Fibrillation and a high risk for falls

- 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.



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 arrythmias 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*. 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, ibutolide, 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

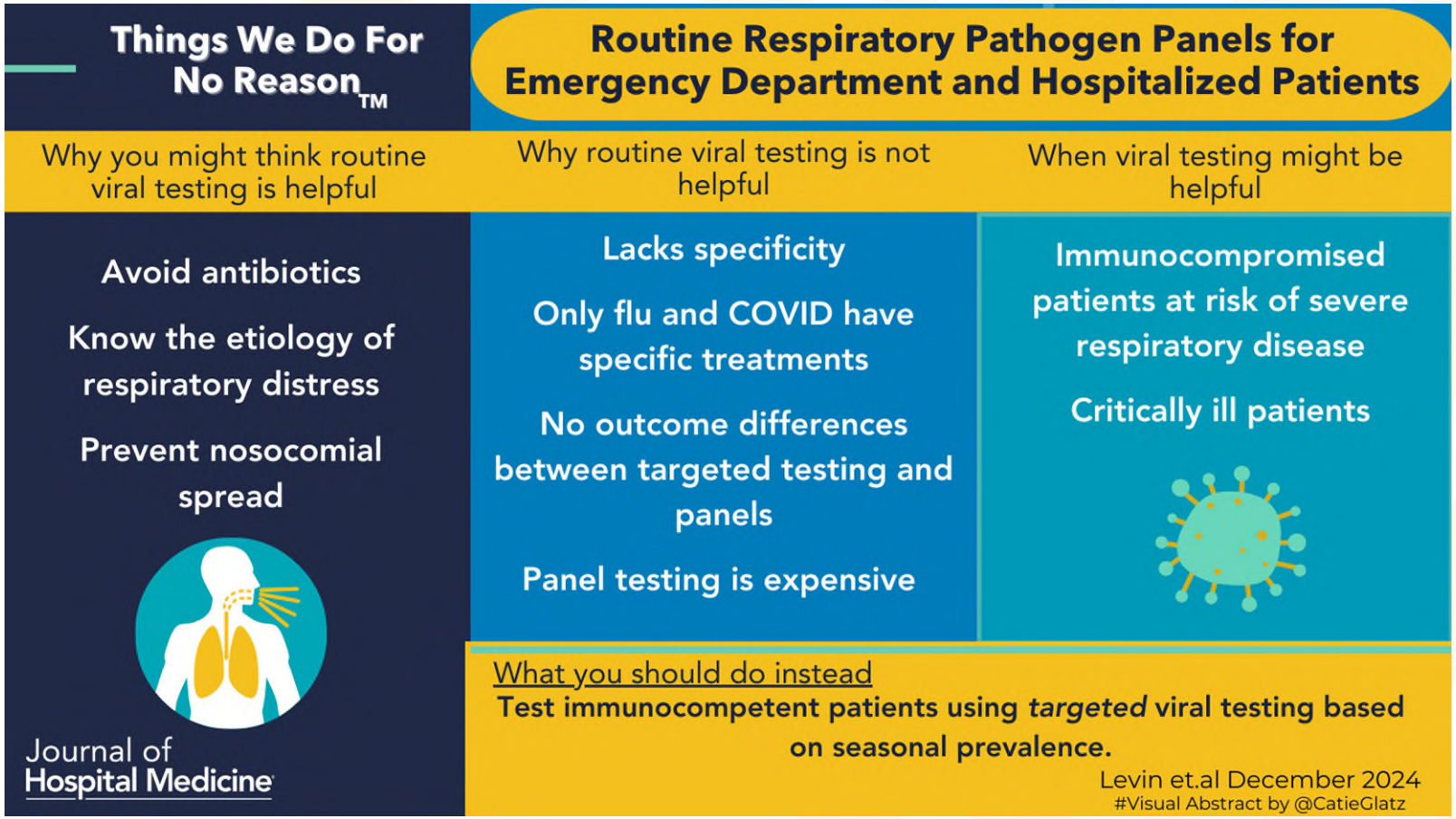
Note: Predictors of QT prolongation >500 ms in hospitalized patients per Tisdale Score. Score of ≤6 is low risk, 7–10 is moderate risk, and ≥11 or greater is considered high risk for QT prolongation.

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



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[a]
Xpert Flu Assay[1, 21]	Influenza A and B	$25–50
Xpert Xpress CoV-2/Flu/RSV plus[22]	SARS-CoV-2 Influenza A and B RSV	$40–60
FilmArray Respiratory Virus Panel[1, 22, 23]	Influenza A and B Coronavirus Human metapneumovirus Parainfluenza virus 1–4 RSV Rhinovirus Enterovirus *Bordetella pertussis* *Chlamydophilia pneumoniae* *Mycoplasma pneumoniae* 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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