

Five Things Physicians and Patients Should Question

1 **Don't place, or leave in place, urinary catheters for incontinence or convenience or monitoring of output for non-critically ill patients (acceptable indications: critical illness, obstruction, hospice, perioperatively for <2 days for urologic procedures; use weights instead to monitor diuresis).**

Catheter Associated Urinary Tract Infections (CAUTIs) are the most frequently occurring health care acquired infection (HAI). Use of urinary catheters for incontinence or convenience without proper indication or specified optimal duration of use increases the likelihood of infection and is commonly associated with greater morbidity, mortality and health care costs. Published guidelines suggest that hospitals and long-term care facilities should develop, maintain and promulgate policies and procedures for recommended catheter insertion indications, insertion and maintenance techniques, discontinuation strategies and replacement indications.

2 **Don't prescribe medications for stress ulcer prophylaxis to medical inpatients unless at high risk for GI complications.**

According to published guidelines, medications for stress ulcer prophylaxis are not recommended for adult patients in non-ICU settings. Histamine-2 receptor antagonists (H2RAs) and proton-pump inhibitors (PPIs), commonly used to treat stress ulcers, are associated with adverse drug events and increased medication costs, and commonly enhance susceptibility to community-acquired nosocomial pneumonia and Clostridium difficile. Adherence to therapeutic guidelines will aid health care providers in reducing treatment of patients without clinically important risk factors for gastrointestinal bleeding.

3 **Avoid transfusions of red blood cells for arbitrary hemoglobin or hematocrit thresholds and in the absence of symptoms of active coronary disease, heart failure or stroke.**

The AABB recommends adhering to a restrictive transfusion strategy (7 to 8 g/dL) in hospitalized, stable patients. The AABB suggests that transfusion decisions be influenced by symptoms as well as hemoglobin concentration. According to a National Institutes of Health Consensus Conference, no single criterion should be used as an indication for red cell component therapy. Instead, multiple factors related to the patient's clinical status and oxygen delivery should be considered.

4 **Don't order continuous telemetry monitoring outside of the ICU without using a protocol that governs continuation.**

Telemetric monitoring is of limited utility or measurable benefit in low risk cardiac chest pain patients with normal electrocardiogram. Published guidelines provide clear indications for the use of telemetric monitoring in patients which are contingent upon frequency, severity, duration and conditions under which the symptoms occur. Inappropriate use of telemetric monitoring is likely to increase cost of care and produce false positives potentially resulting in errors in patient management.

5 **Don't perform repetitive CBC and chemistry testing in the face of clinical and lab stability.**

Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing during short periods of time. Phlebotomy is highly associated with changes in hemoglobin and hematocrit levels for patients and can contribute to anemia. This anemia, in turn, may have significant consequences, especially for patients with cardiorespiratory diseases. Additionally, reducing the frequency of daily unnecessary phlebotomy can result in significant cost savings for hospitals.

How This List Was Created

The Society of Hospital Medicine (SHM) created a *Choosing Wisely*[®] subcommittee comprised of representatives of the Hospital Quality and Patient Safety committee and included diverse representation of academic, community and adult hospitalists. SHM committee members submitted 150 recommendations for consideration, which were discussed for frequency of occurrence, the uniqueness of the tests and treatments and whether the cost burden for a specific test or treatment proved to be significant, narrowing the list to 65 items. The *Choosing Wisely* subcommittee ranked these items and a survey was sent to all SHM members to arrive at 11 recommendations, of which the final five were determined utilizing the Delphi method. SHM's Board approved the final recommendations.

SHM's disclosure and conflict of interest policy can be found at www.hospitalmedicine.org/industry.

Sources

- Hooton TM, Bradley SF, Cardena DD, Colgan R, Geerlings SR, Rice JC, Saint S, Schaeffer AJ, Tambayh PA, Tenke P, Nicolle LE. Diagnosis, Prevention, and Treatment of Catheter-Associated Urinary Tract Infection in Adults: 2009 International Clinical Practice Guidelines from the Infectious Diseases Society of America *Clin Infect Dis* [Internet]. 2010 [cited 2012 Sep 4];50(5): 625-663.

Saint S, Meddings JA, Calfee D, Kowalski CP, Krien SL. Catheter-associated Urinary Tract Infection and the Medicare Rule Changes. *Ann Intern Med* [Internet]. 2009 Jun 16 [cited 2012 Sep 4];150(12): 877-884.

Centers for Medicare & Medicaid Services, Joint Commission. Standards for hospital care, surgical care improvement project (SCIP), SCIP-Inf-9; Performance Measure Name: Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero. 2013. 2013 Joint Commission National Hospital Inpatient Quality Measures Specification Manual, version 4.11.
- American Society of Health System Pharmacists. ASHP Therapeutic Guidelines on Stress Ulcer Prophylaxis ASHP therapeutic guidelines on stress ulcer prophylaxis: ASHP commission on therapeutics and approved by the ASHP Board of Directors on November 14, 1998. *Am J Health Syst Pharm* [Internet]. 1999 Feb 1 [cited 2012 Sep 4];56: 347-379.
- Carson JL, Grossman BJ, Kleinman S, Tinmouth AT, Marques MB, Fung MK, Holcomb JB, Illoh O, Kaplan LJ, Katz LM, Rao SV, Roback JD, Shander A, Tobian AA, Weinstein R, Swinton McLaughlin LG, Djulbegovic B; Clinical Transfusion Medicine Committee of the AABB. Red blood cell transfusion: A clinical practice guideline from the AABB. *Ann Intern Med* [Internet]. 2012 Jul 3 [cited 2012 Sep 4];157(1):49-58.

Consensus conference. Perioperative red blood cell transfusion. *JAMA*. 1988 Nov 11; 260(18):2700-3.

Advancing Transfusion and Cellular Therapies Worldwide. AABB name change. [Internet]. 2012 [Cited 2012 Oct 15]. Available from: www.aabb.org/about/who/Pages/namechange.aspx.
- Drew BJ, Califf RM, Funk M, Kaufman ES, Krucoff MW, Laks MW, Macfarlane PW, Sommargren C, Swiryn S, Van Hare GF. Practice standards for electrocardiographic monitoring in hospital settings: an American Heart Association scientific statement from the Councils on Cardiovascular Nursing, Clinical Cardiology, and Cardiovascular Disease in the Young; endorsed by the International Society of Computerized Electrocardiology and the American Association of Critical-Care Nurses. *Circ*. [Internet]. 2004 [cited 2012 Sep 4];110:2721-2746.

Crawford MH, Bernstein SJ, Deedwania PC, DiMarco JP, Ferrick KJ, Garson A Jr, Green LA, Greene HL, Silka MJ, Stone PH, Tracy CM, Gibbons RJ, Alpert JS, Eagle KA, Gardner TJ, Gregoratos G, Russell RO, Ryan TJ, Smith SC. ACC/AHA guidelines for ambulatory electrocardiography: Executive summary and recommendations a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the Guidelines for Ambulatory Electrocardiography) developed in collaboration with the North American Society for Pacing and Electrophysiology. *Circ* [Internet]. 1999 Aug 24 [cited 2012 Sep 4];100(8):886-93.

Snider A, Papaleo M, Beldner S, Park C, Katechis D, Galinkin D, Fein A. Is telemetry monitoring necessary in low-risk suspected acute chest pain syndromes? *Chest* [Internet]. 2002 Aug [cited 2012 Sep 4];122(2):517-523.

Henriques-Forsythe MN, Ivonye CC, Jamched U, Kamuguisha LKK, Onwuanyi AE. Is telemetry overused? Is it as helpful as thought? *Cleve Clin J Med* [Internet]. 2009 Jun [cited 2012 Sep 4];368-372.

Adams HP Jr, del Zoppo G, Alberts MJ, Bhatt DL, Brass L, Furlan A, Grubb RL, Higashida RT, Jauch EC, Kidwell C, Lyden PD, Morgenstern LB, Qureshi AI, Rosenwasser RH, Scott PA, Wijdicks EFM, American Heart Association, American Stroke Association Stroke Council, Clinical Cardiology Council. Guidelines for the early management of adults with ischemic stroke: a guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups: the American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists. *Stroke* [Internet]. 2007 May [cited 2012 Sep 4];38(5):1655-711.
- Salisbury AC, Reid KJ, Alexander KP, Masoudi FA, Lai SM, Chan PS, Bach RG, Wang TY, Spertus JA, Kosiborod M. Diagnostic blood loss from phlebotomy and hospital-acquired anemia during Acute Myocardial Infarction. *Arch Intern Med* [Internet]. 2011 Oct 10 [cited 2012 Sep 4];171(18):1646-1653.

Thavendiranathan P, Bagai A, Ebidia A, Detsky AS, Choudhry NK. Do blood tests cause anemia in hospitalized patients?: The effect of diagnostic phlebotomy on hemoglobin and hematocrit levels. *J Gen Intern Med* [Internet]. 2005 June [cited 2012 Sep 4];20(6):520-524.

Stuebing EA, Miner TJ. Surgical vampires and rising health care expenditure: reducing the cost of daily phlebotomy. *Arch Surg* [Internet]. 2011 May [cited 2012 Sep 4];146(5):524-7.

About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.

To learn more about the ABIM Foundation, visit www.abimfoundation.org.



About the Society of Hospital Medicine

Representing the fastest growing specialty in modern healthcare, the Society of Hospital Medicine (SHM) is the leading medical society for more than 34,000 hospitalists and their patients. SHM is dedicated

to promoting the highest quality care for all hospitalized patients and overall excellence in the practice of hospital medicine through quality improvement, education, advocacy and research. Over the past decade, studies have shown that hospitalists can contribute to decreased patient lengths of stay, reductions in hospital costs and readmission rates, and increased patient satisfaction.

For more information about SHM and hospital medicine, visit www.hospitalmedicine.org.



For more information or to see other lists of Five Things Physicians and Patients Should Question, visit www.choosingwisely.org.