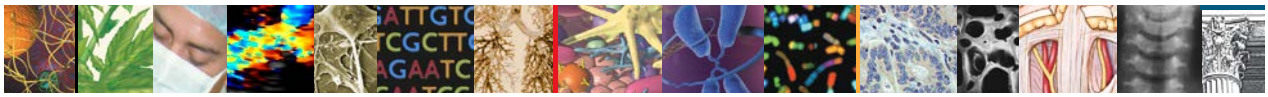

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

FEBRUARY 13, 2014

Choosing Wisely — The Politics and Economics of Labeling Low-Value Services

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With its Choosing Wisely campaign, the American Board of Internal Medicine (ABIM) Foundation boldly invited professional societies to own their role as "stewards of finite health care resources."[1]

Beginning in 2009, the National Physicians Alliance, funded by the ABIM Foundation, guided volunteers from three primary care specialties through the development of "Top Five" lists — specialty-specific enumerations of five achievable practice changes to improve patient health through better treatment choices, reduced risks and, where possible, reduced costs.[2] In April 2012, the effort was expanded and launched as the Choosing Wisely campaign, with lists from nine specialty societies and a patient-education component led by *Consumer Reports*. The vision was for societies to develop lists entitled "Five Things Physicians and Patients Should Question" to "spark discussion about the need — or lack thereof — for many frequently ordered tests and treatments."[1] In 2013, additional societies and consumer groups joined the effort; there are now more than 40 specialty-specific lists and more than 10 "consumer partners."[1]

The message, the messenger, and the method are key features of this stewardship initiative. The creators of the Choosing Wisely campaign have carefully crafted a recommendation for "conversation" emphasizing individual patients' needs as the top priority, preserving the preeminence of physician judgment, patient choice, and the therapeutic dyad. Doctors and their societies, not payers, develop the lists. As testimony to its careful design, the initiative does not appear to be generating concern about rationing or undermining the patient–doctor relationship, as past efforts to reduce health care overuse have tended to do.[3]

Participation in the program and the choice of items listed convey much about the societies and their members' inclination to embrace the stewardship challenge. On the surface, the creation of low-value–service lists suggests that physicians are willing to make recommendations to improve health care value even against their own financial interests. The services included on the lists, however, vary widely in terms of their potential impact on care and spending. The American Academy of Orthopaedic Surgeons, for example, named use of an over-the-counter sup-

Distribution of Services Targeted by "Choosing Wisely" Lists, According to Specialty Society.

plement as one of the top practices to question. It similarly listed two small durable-medical-equipment items and a rare, minor procedure (needle lavage for osteoarthritis of the knee). Strikingly, no major procedures — the source of orthopedic surgeons' revenue — appear on the list, though documented wide variation in elective knee replacement and arthroscopy among Medicare beneficiaries suggests that some surgeries might have been appropriate for inclusion.[4] Other societies' lists similarly include low-impact items.

Participating societies generally named other specialties' services as low-value. The graph shows the most common service types listed by the first 25 Choosing Wisely participants: 29% of listed items target radiology; 21%, cardiac testing; 21%, medications; 12%, laboratory tests or pathology; and 18%, other services. Cognitive specialists name very few of their own revenue-generating services. The notable exception is the Society of General Internal Medicine, whose list includes the annual physical, a common visit type for primary care physicians. Most procedurals, like the orthopedists, include few of their own operative services. The American Academy of Otolaryngology—Head and Neck Surgery, for example, lists three imaging tests and two uses of antibiotics but no procedures,

despite decades of literature on wide variation and overuse of tonsillectomy and tympanostomy-tube placement.[4] The American Gastroenterological Association stands out among proceduralist societies in listing specific uses of endoscopy as three of its "Top Five"; this list has potential to meaningfully reduce low-value care — and revenue for gastroenterologists.

Societies whose diagnostic work appears in the lists of other societies also list their own services as low-value, despite the potential effect on their revenue. The American College of Radiology names five imaging tests in its Choosing Wisely recommendations. The American Society for Clinical Pathology names five of its own laboratory services. Finally, while not significantly targeting its own interventional procedures, the American College of Cardiology includes noninvasive cardiac testing in four of its five items. The broad focus on these three specialties' services by others and by the relevant societies themselves may reflect the frequency of the services' use, the broad base of ordering physicians, and thus, partly as a function of volume, the magnitude of the potential for their overuse.

The ABIM Foundation's campaign was not intended to inform cost-containment efforts and quality measures, but the physician-endorsed low-value labels will probably be leveraged for these purposes. Payers may use lists to inform coverage, payment, and utilization-management decisions. We believe that if such efforts are designed and applied carefully, they should be embraced as a promising method for reducing use of low-value services. The lists would first have to be translated into measurable activities and valid quality indicators — a manageable but difficult task, because many services listed are, appropriately, finely nuanced and directed at precisely defined populations or clinical situations. Some Choosing Wisely items should also be incorporated into quality-measurement efforts such as the Centers for Medicare and Medicaid Services Physician Quality Reporting System and National Committee for Quality Assurance practice standards. Linking low-value–service use to financial incentives through these avenues should accelerate translation of the lists into practice change. Excessive links to incentives, however, risk deterring specialties from participating meaningfully in the program, so balance and caution are needed. Linking the lists to specialty-specific maintenance-of-certification activities such as practice audit and improvement tasks could also advance their dissemination and uptake at very low cost.

Public education will be essential to the success of the Choosing Wisely initiative; public reporting may be critical as well. Although the stated goal of this initiative is to "spark conversation," the importance of the effort derives from its potential to effectively reduce the use of the services listed. Such change will require revision of practice patterns and patient expectations that have been shaped and reinforced by habitual overuse of health care. What will it take to purge the "annual physical" from the American lexicon? What will convince patients with cardiac conditions that routine cardiac imaging is no longer needed and is in fact potentially harmful? Effective communication has been shown to be a key determinant of patient satisfaction and a deterrent to litigation, so the campaign's emphasis aligns with physicians' interests, but success will require skill and time.[1,5] The Choosing Wisely communication tools and consumer-education efforts are critical. Ideally, the public education campaign will be intense and sustained, so that the full burden of communication does not fall on limited patient–doctor conversations that are already strained by competing priorities. Public reporting at the physician-group, regional, or hospital level may accelerate practice change, reward physicians who avoid low-value services, and simultaneously inform patients about physicians' practice styles.

More numerous and more courageous lists should be developed, published, and heeded. Collaboration between payers and the ABIM Foundation could facilitate the creation of higher-impact lists by permitting initial scoring of suggested items. With as much precision as possible, payers could estimate the volume, quality impact, and cost of the services proposed for inclusion before they are codified in published lists. Scores for items on final lists could be made public. The individual insurance mandate, rising premiums, and increasing patient cost sharing, along with growing public discourse on health care's consumption of national resources, may sufficiently stimulate interest in such information and efforts aimed at meaningful practice reform.

Physicians' willingness to sincerely advance professionalism in medicine and to own their role

as stewards of limited health care resources will be revealed by physician-led efforts such as Choosing Wisely. General acceptance of this effort to date by physicians and the public is encouraging and probably reflects our enduring trust in physicians as healers and credible leaders of health care reform. This trust must not be squandered; rather, it should be leveraged to restore balance in our nation's health care investment.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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This article was published on January 22, 2014, at NEJM.org.

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DOI: 10.1056/NEJMp1314965

PCORI at 3 Years — Progress, Lessons, and Plans

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The Patient-Centered Outcomes Research Institute (PCORI), which recently marked its third anniversary, has established distinctive pathways for funding and conducting practical research and a solid foundation of funded studies. The PCORI board of governors has adopted three strategic goals to meet its mandate under the Affordable Care Act. These goals are to increase the quantity, quality, and timeliness of usable, trustworthy comparative research information; to accelerate the implementation and use of research evidence; and to exert influence on research funded by others to make it more patient-centered and useful. To address the first goal, PCORI funds comparative clinical effectiveness research (CER)[1,2] related to five national priorities: evaluating prevention, diagnosis, and treatment options; improving health systems; enhancing communication and dissemination of evidence; addressing disparities in health and health care; and improving CER methods and data infrastructure.

To ensure that funded research is useful and therefore more likely to be implemented, PCORI engages individuals and organizations representing patients, caregivers, clinicians, delivery systems, payers and purchasers, researchers, policymakers, and industry in generating research questions. Multistakeholder advisory panels help PCORI prioritize and refine suggested questions for targeted proposal solicitations.[3] We require funding applicants to involve patients and relevant stakeholders on their research teams throughout the study — helping to identify and refine research questions, choose comparators and outcomes, identify and recruit study populations, develop recruitment materials and survey instruments, and interpret and disseminate findings. Patients and other stakeholders, trained by PCORI in research review, make up 50% of the merit-review panels that evaluate applications — the idea being to keep the focus on relevant questions and lay a foundation for disseminating important findings.

Applications are scored on technical merit, including adherence to standards developed by PCORI's Methodology Committee; the relevant condition's burden on individuals and society; the relevance to patients of the proposed comparisons, study populations, and outcomes (patient-centeredness); the quality of patient and stakeholder engagement; and the likelihood that the results could change clinical or personal practice, improving outcomes. Patient-centeredness, engagement, and likelihood of