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POLICY FORUM
Limiting Low-Value Care by "Choosing Wisely"
William L. Schpero, MPH

The Dartmouth Atlas of Health Care has long documented widespread variations in use of effective care. In its 2003 landmark study on the quality of health care in the United States, the RAND Corporation found that just over half of Americans received recommended preventive care, acute care, and care for chronic conditions [1].

Needed attention is now being paid to use of ineffective—or low-value—care, a form of overtreatment. While definitions vary, "low-value care" most often refers to medical services, including tests and procedures, that should not be performed given their potential for harm or the existence of comparably effective and often less expensive alternatives. Spending on overtreatment amounted to between $158 and $226 billion in 2011 and is estimated to be one of the biggest contributors to waste in the US health care system, second only to administrative complexity [2]. Reducing the use of low-value care is particularly appealing given the opportunity it represents to both lower costs and increase quality. Before low-value care can be reduced, however, it must be identified and described.

In 2008, the National Quality Forum convened 28 national health care organizations, including advocates for physicians, consumers, and businesses, to form the National Priorities Partnership, which was charged with developing a strategy to achieve a "high-performing, high-value healthcare system" [3]. The National Priorities Partnership identified the following nine broad areas of wasteful or inappropriate care: (1) inappropriate medication use, (2) unnecessary laboratory tests, (3) unwarranted maternity care interventions, (4) unwarranted diagnostic procedures, (5) inappropriate nonpalliative services at the end of life, (6) unwarranted surgical procedures, (7) unnecessary consultations, (8) preventable emergency department visits and hospitalizations, and (9) potentially harmful preventive services with no benefits [3].

In 2009, the American Board of Internal Medicine (ABIM) Foundation gave a grant to the National Physicians Alliance to develop lists to help primary physicians "be good stewards of resources" [4]. Howard Brody, envisioning a more substantial role for physicians in identifying opportunities to reduce low-value care, proposed in the *New England Journal of Medicine* in 2010 that all specialty societies generate "top five" lists that "would consist of five diagnostic tests or treatments that are very commonly ordered by members of that specialty, that are among the most expensive services provided, and that have been shown by the currently available evidence not

to provide any meaningful benefit to at least some major categories of patients for whom they are commonly ordered" [5].

Brody's proposal laid the groundwork for the ABIM Foundation's Choosing Wisely campaign, which was announced in March 2011. Nine specialty societies released the first Choosing Wisely lists in April 2012 [6], and, as of December 2013, 44 societies had contributed to the campaign [7]. The ABIM Foundation frames the Choosing Wisely lists as an opportunity to "spur conversation about what is appropriate and necessary treatment" [7]. Several efforts are under way to disseminate the lists to both physicians and patients; notably, the ABIM Foundation has partnered with a number of consumer groups, including AARP and *Consumer Reports*. The ABIM Foundation is explicit in stipulating that the Choosing Wisely guidelines "should not be used to establish coverage decisions or exclusions" [7].

The Choosing Wisely campaign is now perhaps the highest-profile effort to identify opportunities to reduce use of low-value care in the United States. In exploring the practical utility of the Choosing Wisely campaign—and its ethical implications—it is necessary to further examine how the Choosing Wisely lists were developed, what they include, and how they may be used.

How Were the Choosing Wisely Lists Developed?

Each specialty society's Choosing Wisely list includes a short description, with references, of how the items on the list were identified. Most societies relied on a workgroup or committee composed of a diverse array of clinical and administrative stakeholders who reviewed relevant evidence in the literature and made recommendations to the society's executive committee. All societies also included reference to their respective disclosure and conflict of interest policies.

The societies differed, however, in the following: (1) the criteria used to identify items (e.g., clinical evidence of efficacy and harm, cost, potential for improvement, potential for overuse, potential for misuse, potential for harm, prevalence of utilization), and (2) whether the society consulted additional experts, its broader membership, or other societies to refine items.

Publicly available documentation on the campaign suggests that the methodologies varied particularly with respect to involvement of experts on evidence evaluation, the use of external review, and the involvement of nonphysicians, including patient representatives. Though the Guideline Panel Review working group indicates that lacking any of these elements is a "red flag" in clinical guideline generation [8], holding the Choosing Wisely campaign to such standards may be too stringent; the ABIM Foundation frames the campaign's lists as opportunities for conversation, rather than explicit guidelines for clinical practice.

What Do the Choosing Wisely Lists Include?

Choosing Wisely lists are populated principally by recommendations on imaging and cardiac-related testing, although recommendations on procedures, medication usage,

and laboratory testing are also common. The tests and procedures included in the campaign are notable for significant variation in how commonly they are used, their cost, and the extent to which they directly affect the revenue streams of the specialty society that submitted them (rather than the revenue streams of a different specialty). While several societies include high-yield items that are both commonly used and relatively expensive, not all do. The inclusion of low-cost, uncommon tests and procedures may limit the efficacy of the campaign in reducing unnecessary resource use.

How May the Choosing Wisely Lists Be Used?

The Choosing Wisely campaign is intended primarily to create educational opportunities for physicians and patients. The campaign's recommendations also have obvious relevance to performance measurement for quality improvement. Payers are likely to consider the recommendations when developing coverage parameters, quality-contingent payment systems, and value-based benefits. Yet, given their clinical nuance, not all of the recommendations can be readily measured using claims data, which suggests at least some of them are best operationalized solely at the physician practice level for quality improvement and will have little utility for payers [9].

The Choosing Wisely campaign, as a physician-led initiative, represents an important step in identifying and reducing waste in health care while avoiding the "rationing" label that has been put on other efforts led by nonphysician stakeholders [10]. Although there is considerable variation in the methodologies used to develop the lists included in the campaign, and not all of the list items are likely to significantly reduce utilization of low-value care, it is a good starting point from which to begin a conversation about unnecessary care and policy interventions to curtail it.

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William L. Schpero, MPH, is a health policy fellow at The Dartmouth Institute for Health Policy and Clinical Practice at Dartmouth College in Lebanon, New Hampshire. His research focuses on measuring variation in health care utilization and spending, quantifying use of low-value care, and evaluating the effects of accountable care organization implementation.

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