Case Study Commentary:

Margaret Holmes-Rovner

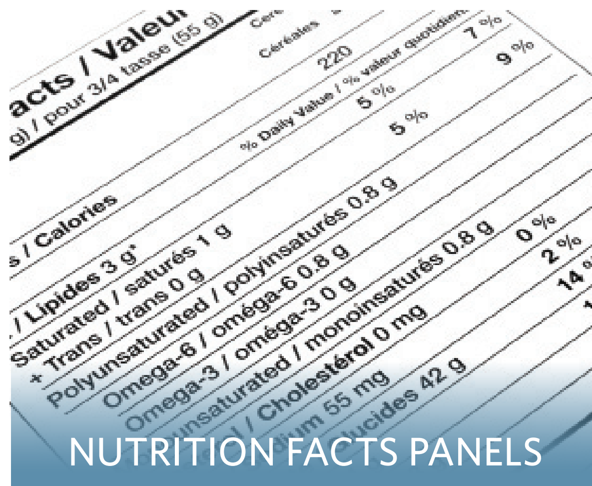
Getting Tools Used

Lessons for Health Care from Successful Consumer Decision Aids

U.S. News & World Report: AMERICA'S BEST COLLEGES

CONSUMER REPORTS: CAR BUYING GUIDE

eBay.com



NUTRITION FACTS PANELS

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Case Study Commentary

Margaret Holmes-Rovner, PhD

I. Analyst's Perspective

I am a sociologist and health services researcher. My research focuses on patient and physician decision making and communication. My early studies of physician decision making undertook both normative and descriptive studies focused on competing treatments for specific conditions and dilemmas like whether or not to take hormones in the menopause. The normative studies were decision analytic studies to determine the optimal solution for a variety of diseases. Since health professionals appeared to make suboptimal decisions in real time, my colleagues and I conducted descriptive studies to find their reasons for doing so. This interest in understanding how and why real people make the decisions they do, and how we collectively may serve ourselves better, continues to drive my interests in decision support tools.

Our early descriptive studies looked at physician decision making. Data came from structured clinical scenarios that used conjoint analysis to analyze decision patterns, as well as from qualitative studies reviewing actual decisions made using chart-stimulated recall techniques. We have been interested in cognitive and emotional explanations for both decision making and effective conversations about improving decisions—within their social and political context.

More recently, I have focused on patient decision making and on patients' traditional and expanding roles in decision making about their healthcare. My interest in developing, evaluating, and expanding use of decision support tools is aimed at moving the healthcare system toward optimal use of resources to maximize healthcare outcomes while respecting patients' and providers' values and expertise. I have worked on developing print and multimedia tools to show the effects, and side effects, of specific medical treatments patients and providers may be considering. Importantly, these tools include the option of continuing with the status quo. My interest in examining information tools from non-health sectors is to apply insights obtained there to the problem of getting healthcare decision support tools used in a complex social, political, and regulatory environment.

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II. Case Studies

U.S. News & World Report: America's Best Colleges

Objectives: U.S. News ranks colleges to raise the profile of the U.S. News publications and sell magazines.

Audience: The direct audience for "*America's Best Colleges*" is the people who purchase college educations (parents of college students, acting on behalf of the students). U.S. News is a publisher, and their audience is the people who buy or might buy their print and electronic publications.

Resources and Constraints: In 1983, the College Guide was based simply on a survey of college presidents, asked to rank their peer institutions. It required no great outlay of resources. Over the 25 years of its development, the college guide has developed methods of ranking colleges based on more objective data. However, the source of the data has always been the colleges themselves, augmented by publically available data. Various methods to ensure the quality of the self-report data are employed, and appear to be largely successful. Since the data are self-report, and some colleges boycott the data collection, there will always be gaps in their coverage. U.S. News equates reputation with academic quality, though recent additions of freshman retention rate, SAT score, high school class rank, acceptance rate, and average alumni giving rate are attributes that suggest academic quality, which will always be elusive.

Barriers and Facilitators: It appears that being the first in the field has been an important asset. U.S .News has become the college rating system to beat. As with all rating systems, credibility and trust are the basis for consumer use. U.S. News's attention to updating their method appears to be their main strategy to maintain the credibility of their annual rating. This approach undercuts reliability, and does not change the fact that this continues to be a reputation-based ranking. However, they continue to lead the field, in part because colleges use the rankings to market themselves. Thus, U.S. News will likely continue to enjoy media attention they do not have to purchase. A natural limit to widespread use of the college guide lies in the nature of the largely middle-class audience of families of high school seniors.

Design/Redesign and Reasons for Redesign: Better publically available data have allowed the rankings to become more data driven. They continue to rely primarily on their single ranking. Additional tables rank the colleges' performance on the other attributes.

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Electronic products are more in-depth, and appear to have been added to exploit the availability of the Internet.

Promotion and Dissemination: The college guide is inexpensive, allowing it to be a tiny purchase in the range of college expenses. It costs less than a college logo sweatshirt.

Impact: While the college guide was never meant to be a reform tool, it has provided increased transparency about aspects of college quality. The unintended impact of colleges enhancing their images to match the college guide criteria may have created expenses for higher education.

Consumer Reports (CR): Car Buying Guide

Objectives: The CR Car Buying Guide is published by Consumers Union (CU). CU is a consumer advocacy organization that aims to be an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to make purchases that are data driven regarding safety and value. Consumers Union employs lobbyists, grassroots organizers, and outreach specialists to work with 600,000 online activists to change legislation and the marketplace in favor of the consumer interest.

Audience: Consumers and producers of both goods and services.

Resources and Constraints: CU has $200 million in revenue. However, the organization has been growing since 1933, and there were many lean years. In order to make their ratings hold up, it has been critical that they were able to defend themselves against lawsuits when their car ratings were negative. Size and infrastructure have supported their mission, and the steadfast attention to the mission has kept them focused and determined. Revenue comes from report sales (92 percent) and individual contributions (7 percent).

Barriers and Facilitators: The credibility of CU is greatly enhanced by their consistent eschewing of support from any producer of goods they rate. While this has cost them money, it has maintained their credibility.

Design/Redesign and Reasons for Redesign: While the CR car guide remains independent in method and free of commercial influence, it could still become irrelevant to consumers. The CU move to address audiences of users (like parents of teenagers) and newly

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important car attributes (miles per gallon) is important. Critical is adaptation to the Internet. Here, they appear to be making their traditional print format interactive.

Promotion and Dissemination: CU's credibility rests on the organization's unbiased research. They appear to have disseminated this message successfully. They really have no competition with the rigorous testing methods they practice.

Testing, Evaluation: The strict attention to independence and rigor in testing cars by engineering criteria has been quite powerful. It is probably not an exaggeration to say that this has helped to convert cars from experience goods to search goods. Consumers can, and do, pick out cars by their attributes using the CU data and then search out the model with the cosmetic attributes and price they desire. This lets people search anywhere for their preferred car.

Impact: The car guide, in aiming to allow consumers to protect themselves, appears to have influenced manufacturers' attention to safety and frequency of repair of the cars they produce. The reform impact has been substantial according to most observers.

eBay

Objectives: Provide a platform for buyers and sellers to meet each other in cyberspace and buy and sell. Since the company is now publically traded, it must provide profits to shareholders.

Audience: General adult public; hobbyists and collectors among people who use the Internet.

Resources and Constraints: eBay, since it owns no goods itself, was able to start up with little capital. Its income is from fees and advertising, and PayPal fees. Since revenue is largely from fees, the system rests on having a large volume of exchanges. It appears to be growing, though market data are proprietary.

Barriers and Facilitators: Credibility and trust are key. Buyers and sellers must be confident that each will hold up the transactions. Fraud is, therefore, a serious concern. There appears to be controversy about fraud levels, but the main facilitator has been the measures taken to assure that sellers deliver and buyers pay. The problem appears to be within acceptable limits, and eBay is able to compensate people for transactions that are not satisfactorily completed.

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Design/Redesign and Reasons for Redesign: The original plan to provide a platform has been supplemented by development of the community of users. Information tools appear to be important, suggesting that, as in other tools, the ability to supply information about experience goods is a key to success.

Promotion and Dissemination: Largely word of mouth, depending on the "virtuous cycle" of satisfactory exchanges. Since most users appear to be bargain hunters, the downturn in the economy may not hurt eBay.

Testing, Evaluation: The evaluation component of eBay is critical to its credibility and people's confidence in it. Buyers and sellers are invited to rate each transaction, using a 5-point scale. One key to this process is that eBay prompts people to respond, meaning that they attempt to avoid the bias that usually occurs in such rating systems. Rather than a small number of very happy, or very disappointed consumers, eBay attempts to keep their evaluation reflective of their population of users.

Impact:: eBay is credited with helping to invent Web 2.0, using a platform (of buyers and sellers) to create online communities. Whether or not this is a commercial success, its potentially revolutionary power to engage consumers in rating goods and services has reform potential. The information tools help to keep this from being a collective sharing of ignorance.

Nutrition Facts Panel (NFP)

Objectives: The Nutrition Facts Panel (NFP or The Block) is the quintessential information tool. It is different from the other tools in the case studies in that it is not designed to rate a food as "best" or "best buy" or "least fattening."

The NFP was designed to assist adult consumers (and secondarily adolescents) in making wise food choices (following dietary guidelines), and it is fair to evaluate the impact on its objectives of shaping consumer eating habits, and ultimately to improve health and reduce chronic disease burden. Designing an information tool rather than a decision tool is an important strategy to consider in terms of the key variables for success of the decision tools. It contains important strengths as well as limitations.

The Food and Drug Administration (FDA) had as a major intent for the NFP the desire to counter inappropriate health claims that were being made for foods by manufacturers. The need for this reform was one perceived by the experts in Food Safety and Human Nutrition, and advocates, such as those in the Center for Science in the Public Interest (CSPI).

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Consumers were happy with the food they were eating, a situation that shares some characteristics with healthcare. The audience for the NFP is the general public. The challenge was to present complex information simply and uniformly, in a field in which there were no labels in 1993 and no agreement on exactly what were the most important attributes to communicate to the public. I should tell you that this case is probably the most controversial among our group of commentators. I think it is both brilliant in design and amazing in the degree of agreement reached quickly within the federal government, and the degree of compliance achieved in the food industry.

Audience: Food shoppers and their families; indirectly, food manufacturers.

Resources and Constraints: The federal mandate to produce uniform labeling across all processed foods required a potentially large budget. In addition to requiring that all food producers do the analysis required, and print labels on their containers, the FDA had to educate the public to use the tools.

Barriers and Facilitators: Leadership was key. Secretary Kessler built an authoritative information base from the ground up, created the broad political consensus, and then remained a tireless and effective champion of the process. Not just Secretary Kessler, but the first President Bush himself personally mediated an impasse at one point when scientists in two federal agencies were struggling with the basis for the daily values to report on the labels. The current public perception that the information is accurate and trustworthy rests on reality and is reinforced by the public education campaign that followed implementation. Getting industry to comply was an astonishingly successful task. It cost them money and it exposed formerly “hidden” high fat, high calorie, high sodium elements foods that tasted good and sold well.

This could not have been done without regulatory authority, and the promise of uniformity of implementation. This was vital to the success both with manufacturers and with consumers, and with health professionals and consumer advocates. Informed choice always depends on the ability of the decision maker to compare the competing options using the same parameters. All manufactured food has to comply for this tool to work. The ability to require compliance created a large resource contribution from industry, a large resource contribution from personnel in the federal agencies, and a relatively modest new appropriation. This was a large public/private virtual partnership created by clarity of purpose, and simplicity of design of the NFP itself.

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There is no competition for a different NFP. Competition within industry could be built on the information tool created that encouraged healthy eating, if that is the hallmark a manufacturer wanted to claim. That opportunity moved parts of industry in the direction hoped for by the creators of the NFP. For example, the recent addition of "trans" fats to the NFP virtually eliminated trans fats in manufactured foods. Standardization of the information tool exposed, or made transparent, the variability in the food in the packages. No one mandated what products manufacturers could sell. Variability continues to be appropriately great. This lack of regulation of what could be created, allowed creativity and innovation to thrive within the industry being regulated.

Tool design and functionality is an area of some controversy. The NFP has received design awards. It incorporates plain language. It is not as pretty as some would like, and the upgrades to the graphics have been few. The main area of functional concern is that some of the interpretations of numerical information are difficult for people who have lower literacy and numeracy skills. However, almost everyone can compare the amounts of nutrients in two cans of soup. They can also give a correct answer about how the amount of calories, fat, and carbohydrates relate to diet guidelines. They can also use the information to check rudimentary health claims. One key to success may be what is effectively a two-tiered information base: 1) The basic information is understandable across most of the adult US population. 2) More sophisticated judgments based on "% daily values" are usable only by a few. Research in risk communication and numeracy may ultimately offer some improvements in this area.

Placement of the NFP on the food labels, so that it is universally available at the time a food purchase is made, is a key to its frequency of use. Consistency of format and content is another key. People can learn to use the tool, either through their own initiative, through the mass media campaigns, through health educators, or other venues. Once they get it, they can count on it not to change drastically.

Design/Redesign has not been done often. That is the flip side of the regulatory basis for the tool. Apparently some changes are working their way through Congress, but they compete with the other challenges FDA is now facing.

Promotion and Dissemination: The education campaign was key to the success of the NFP reflected in over 60% of consumers saying they have looked at the tool. The education campaign has not been well supported in recent years, and the potential of Web 2.0 platforms to create experiences and online communities has not been well developed. That potential is an opportunity awaiting the next generation of innovators. It is an open question whether the

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perception of need will have to be created among the Web savvy who might pay attention to nutrition, or whether an educational campaign and a new set of tools can drive that process.

In addition to the public education campaign, a key to dissemination is the universality of the NFP. Any consumer who wants to check a calorie count or sodium content can count on doing so. This makes it possible for health educators and others to rely on the tool when teaching.

Testing, Evaluation: Research on interpretation of the NFP shows that consumers can interpret the main elements of calories, fat, sodium, etc, and use the labels to make some evidence-based choices. However, since no explanation is included, people who lack background knowledge need education to make judgments about decisions about types of fats, and other tasks.

Impact: The twin objectives of informing consumers and curbing manufacturers' health claims seem to have been met in a brief time window. However, for consumers, the NFP is not a decision tool. It is an information tool. The tool itself does not, in and of itself, help people make decisions. Research on interpretation of the NFP shows that consumers can interpret the main elements of calories, fat, sodium, etc, and use the labels to make some evidence-based choices. However, since no explanation is included, people who lack background knowledge need education to make judgments about decisions about types of fats, and other tasks.

III. Cross Case Analysis

Each of the tools selected is presently a prominent, and generally a widely accepted tool. One consistent finding is that each tool was the first to enter the arena in its area, and each has maintained its prominence and credibility. Examination of cases that began early and failed might show whether this is coincidence or a common element.

What was rated by the tool, and what was provided by the tool? Two of the tools rated goods (cars, foods), and two rated services (college educations, sellers/buyers). The tools themselves are all information tools, and some grade the quality of the good or service. All provided information in one place, not previously available to consumers about the good or the service. When provided with previously unavailable, reliable and generalizable information, consumers have new control over what could formerly only be known by experience. This is probably most true of cars. The attributes of these goods could be uniformly reported and reliably found in cars no matter where they were bought. Thus, having the tool makes choice meaningful in an entirely new way. It is potentially transformative.

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The tools varied in the extent to which they were uniformly applied across the fields they rated. The only one that was universal was the NFP, and it probably had the most reform potential, but not guaranteed impact. The NFP was designed to shape consumer food choice. It likely has shaped food selection. It could not, by itself, however, affect the amount of food consumed. That is, type of food chosen could not, itself, change risk factors for chronic disease. Reform potential is somewhat related to the issue of universality, but not entirely. It is likely that CR Annual Car Buying Guide had the biggest reform impact, because it affected manufacturers' behavior, which was shaped by a few high-profile instances of impact on consumer behavior. Sales of cars rated as unsafe fell dramatically. While deep price discounts disposed of cars, manufacturers apparently did not want to expose themselves to the risk of being branded unsafe.

Did the tool production and maintenance require a large and expensive infrastructure either to produce or maintain? Was this infrastructure related to the level of reform that followed? CR car guide and the NFP were clearly more expensive to start and maintain than either the U.S. News college guide or eBay. They also have had the most impact on consumer behavior, and the greatest reform potential. In both cases, this appears to be related to their independence from the good or service being rated, and their intention to produce reform.

Did the tool itself shape consumer behavior? Yes, in the cases of NFP and eBay. This appears to be due to the innovative nature of the tool itself. To use the tool, one has to do something unaccustomed. In the case of NFP, look at the label, put two goods side by side to choose between them, or develop an informal decision rule. For example, "I do not buy a canned vegetable with greater than 350 mg sodium." In the case of eBay, the creation of interactive communities of people, based on the search process, and the buying and selling process, stimulated not only eBay users to interact differently, but demonstrated the power of online communities.

IV. Commentary on application to healthcare

What do these four cases suggest about getting information and rating tools used effectively in healthcare? In all four cases, the basic information function that the tool serves comes from its ability to demystify, to go beneath a mysterious process, and supply reliable information that can guide a consumer to control the quality of the service received. This function is highly relevant to the two kinds of healthcare rating tools that are best developed: 1) public reporting of ratings of doctors and hospitals, and 2) patient decision aids based on comparative effectiveness ratings of treatment and prevention.

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In all four case studies, the price to consumers for the services is small. While the cost of developing the service may be high, the price for using it is low. This is likely important in healthcare, where there is no public perception that rating tools are needed. People like their own doctors, and they assume that most treatments and preventive screenings are necessary and valuable. The reform that lurks behind decision support tools and ratings of doctors and hospitals is the assumption that too many resources are being used. Consumers and patients, on the contrary, are getting along fine without any of these tools. The case for healthcare reform is simply that healthcare costs too much and does not produce optimal health. Two of the tools, CR car guide, and NFP food labels, have consumer protection and informed consumer choice as their mission.

What previously hidden information is provided by healthcare decision support tools? The new information is that not all healthcare contributes equally to the public's health, or the potential for a cure of an ill person. The new information would be designed to counter the public assumption that all healthcare is good quality, that more is necessarily better, and all interventions and preventive measures are necessary. This would require providing standard information that challenges public assumptions in the way the NFP food facts and the CU car guide has done. This reform may be accomplished in two ways:

- Target the consumer, and produce tools with universal access (the NFP example)
- Target the products, and go public with the gaps.

The public campaign to reduce errors has attempted to make a case similar to that of CU. The re-engineering of healthcare to improve quality is based on exposing the errors. However, choosing high-quality health plans, and choosing treatments that have the best chance of improving health and minimizing side effects appears to require a set of tools with universal access. What strategies do the cases suggest might be employed to produce such a set of tools? They include at least the following:

- Government could design the tool and require compliance (like NFP).
- Government could produce the tools with contracts and grants, as AHRQ is doing with patient decision aids.
- Government could produce rankings based on existing data supplemented by institutional responses (like U.S. News). Rankings would be much more controversial than the present ratings of hospitals by risk-adjusted mortality rates, as in the state of Pennsylvania.
- Information industries could produce rating tools and compete with each other for credibility.

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- Government can set standards for acceptable tools and encourage business to produce them.
- Industry can independently produce tools and let consumers use them if they will.

Comparative Effectiveness Reviews (CERs) have reform potential and are aimed at providing a metric by which to choose the most effective interventions. They are somewhat different from the cost-effectiveness analyses required in some countries to establish a threshold for healthcare system payment for a particular intervention. CERs compare viable alternatives for treatment of specific conditions. A major constraint for this movement is the potential number of CERs required to accomplish reform and their accessibility. The present movement to perform CERs focuses on both the analysis, and on producing patient decision aids that communicate the results to patients (and providers). While the present activity in the field is growing, both through private vendors, and through government agencies, the field is presently still in its infancy. What lessons can be learned from the present case studies? One is that the cost of the infrastructure is potentially very large. Some of the cost could be borne by industry, as was done with the information in the NFP Panel requiring new drugs and devices to provide CERs, in addition to the present investigational new drug (IND) application presently required. In addition to the financial burden this would add to the device and drug development process, the necessity to provide comparisons, rather than elements -- such as the nutrients in foods described in the NFP Panel -- makes direct production of CERs by producers unwieldy. CERs could be used in determining reimbursement by payers. This would require independent review, and would likely have to be done by a government or not-for-profit entity(s). It will undoubtedly be expensive to reach the level of comprehensiveness required. It also runs the risk of a backlash from consumers, unless it is cast within the patient choice framework. This approach is part of the patient decision aid approach. What do the case studies suggest would improve this process?

What would a CER and decision aid NFP for consumers look like?

It would be simple in design, contain only a few essential elements, and communicate well visually and graphically, with a limited number of positives and of negatives. To provide a basis for co-production by the private and public sectors, it would have to communicate essential elements that are reportable by the producer, something equivalent to nutrients. This expansion of the duty to explain risks and benefits during informed consent could be improved by attention to literacy and to reducing the amount of information on a label, an area of active investigation. What might minimal standard elements for a CER template look like? To alert patients/consumers that the treatment or preventive intervention is one in which different interventions have similar outcomes, treatment decision aids should be reserved for “patient

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choice problems," those in which cure rates are similar, but side effects vary. A simple "Fact Panel" could become a predictable document to assist health professionals in an informed consent discussion. It might look like this:

Treatment Choice Facts Panel for Condition X

	Treatment 1	Treatment 2	Treatment 3
Possible Benefits			
Average life extension over watchful waiting			
Relief of symptoms			
Possibility of cure			
Possible Harms			
Side effect 1			
Side effect 2			
Side effect 3			
Possible costs			
Out of pocket payment may be required (yes or no)			

This simple-looking Fact Panel contains important information that is rarely available to clinicians and patients when they are considering treatment choices. Particularly the first item, "average life extension over watchful waiting," is discoverable, but rarely part of the thinking of clinical researchers or clinicians. The failure to compare the outcomes of treatment to what would happen with no intervention leads to exaggerated claims about cures. This is most dramatic with screening. Thousands of women each year thank their lucky stars that they were "cured" of breast cancer discovered early, when the vast majority of the cures were false positive results of the mammography. Most patients and most clinicians are not eager to think about uncertainty, average mortality, or the chance that doing something may or may not lead to a cure or a longer life. They may, however, become more comfortable with these concepts if considering the relative payoffs of interventions becomes a routine and predictable part of clinical care. The Treatment Choice Facts Panel above might serve to make decision-making encounters easier for providers and patients/families. Making the information more explicit may suggest that the success or failure of an intervention is no one's fault, but is part of life.

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The infrastructure to create such a goal may take a few pointers from the Nutrition Facts Panel. The initial investment must be substantial, and an educational campaign is essential. In addition, it likely requires a joint undertaking of manufacturers and government, with a strong partnership with healthcare professional organizations. These organizations can be especially helpful in participating in and leading the educational campaign and lending credibility to the undertaking. The public needs to know they have doctors and nurses as their partners in shared decision-making. Training to accomplish shared decision making using facts in the Treatment Choice Panel would become a core part of clinical training.

What would a Healthcare Buyers Guide look like?

Rating systems for doctors, hospitals, and health plans exist, but do not appear to be widely used. Government, not-for-profit, and for-profit organizations are undertaking such efforts. What does the past success of the Consumers Union car Buyers Guide suggest will be important?

While doctors, nurses and health plans are not widgets that come off assembly lines, there are some strategic suggestions to be found in the CU car buying guide experience. One of the intended or unintended consequences of the CU approach to rating cars is that a major impact was on manufacturers, through the media and assumed consumer pressure. It should be noted that CU does not always rate every available make and model. Their impact is felt across the industry through a few high-level cases. It may be that carefully evaluating a few big-ticket interventions may produce ripples across the field. This could especially be true if procedures that are elective and cannot show a clear benefit, or exhibit high levels of regional variation are chosen. Choosing these types of procedures can create media attention and serve as an additional education effort. Clinicians do not want to be seen as doing unnecessary and invasive procedures that do not work. The decreasing rates of screening and biopsy for prostate cancer suggest that similar attention to other diseases may be effective. While there will be push back from health professionals, the incremental attention to such cases over the last several decades may have created fertile ground. These may provide consumers with examples that can greatly shift the paradigm and demonstrate that all healthcare may not improve health equally.

Two of the tools, eBay, and U.S. News, have increased sales as their mission, rather than reform of an industry that affects the health and safety of the nation. It may be helpful to look at these two sets of tools to better understand how participation in tool use can be encouraged within a lean business model. Cues to effective marketing can build on these success stories,

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while the actual production of decision tools would require an undertaking on the order those represented by the CU and NFP cases.

What would an eBay for finding providers look like?

Services that rate doctors are already becoming available on the Internet. However, they differ from eBay, in that they do not have a closed system to rate, as we find in eBay buyers and sellers. Perusal of many physician rating Web sites suggests that to date, they appear to have few patients rating the physicians and are expensive to join. Unless such a system could gain universal participation, it seems likely that it may remain small and have modest impact on the quality or cost of health-care. If providers felt they gained by participating in a rating system, and if the cost to consumers were low, such a service might gain a foothold. Clearly disease-specific communities of patients exist. However, these do not presently rest on information that has reform potential, and are not aimed at reform.

What would a Nation's Best Healthcare Organizations look like?

A first lesson learned from the criticisms of U.S. News is that the data must be sufficient, reliable and independently verifiable. Furthermore making numerical rankings, using statistically non-significant differences is a bad idea. One could, however, release a "Nation's Best Health Plans" list on the basis of data presently available. Healthcare Effectiveness Data and Information Set (HEDIS) ratings would not accomplish reductions in healthcare utilization, since they generally promote doing more, not doing less. The criteria for an effective patient-centered medical home (PCMH), on the other hand, promise reduction in healthcare costs together with improvement in coordination of care. Publication of the criteria for being on a list of Best Health Plans should emphasize quality and value, and may affect provider organizations' behavior. Present use of provider ratings suggests that people consult them only to check for "bad apples," not proactive shopping for providers. While people who are happy with their providers would likely not change, two other purposes might be accomplished. People who are selecting providers and plans de novo might use the ratings. More importantly, the providers themselves might change their behavior to meet the explicitly stated criteria.

Lessons learned from the U.S. News case study include exploiting gains in free publicity. Such an approach may decrease the cost of educational campaigns that must accompany release of the data on which patient choice tools are based. This is most likely if the reporting on health plans and providers across the nation is kept up to date. One can imagine a two- or three-tier system that would support the *drama* requirements of news reporting. The problem of

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cosmetic playing to the criteria is likely to be substantial. This already happens with hospitals that compete on the hotel aspects of their services.

In summary, Consumer Choice Tools hold reform potential in healthcare. They must have consumer protection at their core and must be driven by a mission to provide critical information at the time of decision making. They must be inexpensive for people to use. A universal access model, like the NFP, would be extremely helpful, but will require a large investment, perhaps over an extended period of time.

Publication of a book of cases of Comparative Effectiveness ratings in lay language and with good graphics, is an intriguing idea. It might take the form of an Annual Effectiveness Comparison for treatment and screening choices for very expensive, but marginally more effective intervention choices for commonly used procedures or treatments. This book, sitting in libraries and on the book shelves of 15 percent of healthcare consumers, and 80 percent of providers, might greatly increase the growing influence of such tools found on governmental and non-governmental Web sites. Both need to have simple formats for easy accessibility, bolstered by a public information campaign.

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