

RESOLUTION 19 - 2010

Subject: Comparative Effectiveness Research
Introduced by: Council on Health Care Access
Referred to: Quality and Clinical Outcomes

1 Whereas, Comparative Effectiveness Research is a tool which can be used to look at what are best
2 practices of care for improving treatment options for patients and for eliminating marginal medicine
3 waste; and
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5 Whereas, Our Comparative Effectiveness Research approach to value should consider quality over
6 cost; and
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8 Whereas, A value-based approach based on quality over cost will encourage our health care system to
9 give better quality cost effective care; and
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11 Whereas, Where marginal medicine is being used we should use Comparative Effective Research to
12 reduce waste and maintain cost effective quality; and
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14 Whereas, Comparative Effectiveness Research is a tool to slow growth in the ever increasing health
15 care costs while still maintaining high quality treatment options; and
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17 Whereas, Comparative Effectiveness Research will help give policy makers an evidentiary based
18 model and framework for making value decisions; therefore be it
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20 RESOLVED, Physicians must play an active part in the governing Comparative Effectiveness
21 Research entity to ensure that the effect does not disrupt the trust between a physician and her/his
22 patient; and be it further
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24 RESOLVED, That the Wisconsin Medical Society supports using Comparative Effectiveness
25 Research as a tool for determining what is the best evidentiary value-based approach based on quality
26 over cost; and be it further
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28 RESOLVED, That the Wisconsin Medical Society supports policy makers using Comparative
29 Effectiveness Research as long as the benefits from such use are not diverted to non-health care
30 funds, and that decisions on coverage are not based solely on cost.

Fiscal note: Within current budget, if the research tool exists and does not have to be developed
by Society.

Relevant Policies

Society: None

AMA:

H-460.909 Comparative Effectiveness Research

The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.

B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.

C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.

D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.

E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.

F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

H. Scope of Research. CER should include long term and short term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.

I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative. (CMS Rep. 5, I-08; Reaffirmed: Res. 203, I-09)