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(ARIC) cohort (adjusted hazard ratio [HR], 1.33; 95% CI, 1.01-1.74) and Geisinger Health System (adjusted HR, 1.12; 95% CI, 1.06-1.17). Excluding baseline estimated glomerular filtration rate from the adjusted model also demonstrated similar results in both cohorts (ARIC: adjusted HR, 1.50; 95% CI, 1.15-1.96; and Geisinger Health System: adjusted HR, 1.20; 95% CI, 1.15-1.26).

Thus, we believe that the conclusions of our study¹ remain unchanged. Poesen et al and Fusaro et al present plausible hypotheses of potential mechanisms that may explain the observed association between PPI use and CKD. We welcome further research investigating these hypotheses.

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Conflict of Interest Disclosures: None reported.

1. Lazarus B, Chen Y, Wilson FP, et al. Proton pump inhibitor use and the risk of chronic kidney disease. *JAMA Intern Med.* 2016;176(2):238-246.

Imaging More Wisely—Already At Work

To the Editor The American College of Radiology (ACR) has for decades worked to reduce unwarranted imaging and lower radiation dose. We wish to update the information in a recent editorial by Smith-Bindman and Bindman.¹

The reference cited on growth of computed tomography (CT) use includes data only through 2010. Since 2010, Medicare CT use is actually down overall in the outpatient, inpatient, and office settings.² Institute for Clinical Systems Improvement³ and Partners Healthcare⁴ studies have proven that appropriateness criteria-based clinical decision support (CDS) reduces imaging growth, radiation exposure, and costs.

The ACR Appropriateness Criteria are evidence-based, incorporating more than 6000 scientific references, most from nonradiology journals, and the criteria are also constantly updated. The ACR criteria for imaging in Acute Sinusitis⁵ care states that most of these patients do not need imaging. The 5 rating for CT would apply only if the imaging provider felt atypical factors compelled them to consider the exam.

The Protecting Access to Medicare Act that will require Medicare imaging providers to consult CDS systems now requires that most CT scans be performed on scanners that meet the MITA Smart Dose standard.⁶ The ACR Dose Index Registry enables dose optimization by allowing facilities to compare their dose levels with other facilities' and national benchmarks. The cost for registry participation is typically less than \$500 per scanner, and national average doses for each examination are publicly available.

The Image Wisely and Image Gently initiatives that predate Choosing Wisely by 2 and 5 years, respectively, have raised awareness and provided materials to help imaging providers optimize

dose; the ACR proudly participates in Choosing Wisely, whose recommendations closely follow ACR appropriateness criteria.

Physicians and patients need up-to-date information to optimize the discussion of imaging benefit vs risk. Policy makers need this information to work with imaging providers to create effective medical imaging policies.

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Conflict of Interest Disclosures: None reported.

1. Smith-Bindman R, Bindman AB. Imaging more wisely. *JAMA Intern Med.* 2016;176(2):168-170.
2. Harvey L. Neiman Health Policy Institute Neiman Almanac. CMS Physician/Supplier Procedure Summary Master File. <http://www.neimanhpi.org/almanac/series-select/#category-25>. Accessed January 5, 2016.
3. Institute for Clinical Systems Improvement. Decision Support for Ordering Appropriate High-Tech. Diagnostic Imaging Scans at the Point-of-Order. <http://cdn.medicexchange.com/images/whitepaper/icsi%20decision%20support%20white%20paper%202010.pdf>. Accessed January 5, 2016.
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5. American College of Radiology (ACR) Appropriateness Criteria. Sinusitis Disease. Updated 2012. <http://www.acr.org/-/media/ACR/Documents/AppCriteria/Diagnostic/SinusitisDisease.pdf>. Accessed January 5, 2016.
6. MITA Smart Initiative. MITA Smart Dose CT. <http://www.medicalimaging.org/policy-and-positions/mita-smart-dose>. Accessed January 5, 2016.

In Reply We are pleased that the American College of Radiology (ACR) "has worked for decades" to reduce unwarranted imaging and lower radiation dose, but given the substantial rise in unnecessary tests,^{1,2} and the dramatic variation in the radiation doses used in performing them even when patients are evaluated for the same clinical questions,^{3,4} it appears that the ACR's strategy is not working. Perhaps the problem would be even worse without the efforts of the ACR, but the current situation cannot be considered acceptable. An independent assessment of the ACR's appropriateness criteria determined that they had no effect on the use of imaging or the appropriateness of imaging when tested among more than 3900 imaging providers across 8 states.⁵ This finding is consistent with what has been found in many other aspects of clinical care. Voluntary guidelines are a weak lever to change physician practice behavior⁶ especially if the guidelines are not based on clear and convincing evidence⁷ or if they rely upon biased evidence or evidence perceived to be biased.⁸

We applaud the ACR's engagement with the issue of unnecessary imaging and excessive radiation doses, but if these efforts are to become more than window dressing they need to be aligned and refined by evidence, and their effects need to be assessed by independent researchers. As was reflected in the title of our editorial, we believe that existing evidence is not being used to ensure the wisest recommendations about when to use imaging.

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Conflict of Interest Disclosures: None reported.

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CORRECTION

Updated Supplement: In the Original Investigation titled "Effectiveness of Remote Patient Monitoring After Discharge of Hospitalized Patients With Heart Failure: The Better Effectiveness After Transition-Heart Failure (BEAT-HF) Randomized Clinical Trial," published online February 8, 2016, and also in the March 2016 issue of *JAMA Internal Medicine*,¹ an updated supplement has been added. This article was corrected online.

1. Ong MK, Romano PS, Edgington S, et al; Better Effectiveness After Transition-Heart Failure (BEAT-HF) Research Group. Effectiveness of remote patient monitoring after discharge of hospitalized patients with heart failure: the Better Effectiveness After Transition-Heart Failure (BEAT-HF) randomized clinical trial. *JAMA Intern Med*. 2016;176(3):310-318.

Errors Throughout the Text: In a Letter to the Editor by Ferric C. Fang titled "Toxin Immunoassays and *Clostridium difficile* Infection" published simultaneously online and in the March 1, 2016, print issue of *JAMA Internal Medicine*,¹ the term "immunoassay" was incorrectly used in place of "assay." This article was corrected online.

1. Fang FC. Toxin immunoassays and *Clostridium difficile* infection. *JAMA Intern Med*. 2016;176(3):412-413.