

Minutes

HEALTH EVIDENCE REVIEW COMMISSION
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
August 13, 2015

Members Present: Som Saha, MD, MPH, Chair; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC (teleconference-left early); Holly Jo Hodges, MD; Irene Croswell, RPh; Susan Williams, MD; Derrick Sorweide, DO.

Members Absent: Leda Garside, RN, MBA; Mark Gibson; Gerald Ahmann, MD, PhD.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Denise Taray, RN; Jason Gingerich; Daphne Peck.

Also Attending: Robyn Liu, MD, Adam Obley, MD, and Valerie King, MD, Center for Evidence-based Policy; Jesse Little, OHA Actuarial Services Unit; Kim R. Wentz, MD, MPH, and Laurie Theodorou, OHA Health Systems Division; Aiesha Moore, Aerocrine; Pam Keuneke, Providence; Joanne Rogovoy, March of Dimes; Kerry Kostman Bonilla, AstraZeneca; Bruce Croffy, FamilyCare; Ashlen Strong, Health Share; Courtney Johnston, COHO; Mellony Bernal, OHA Public Health Division; Jen Gilbert, Jonathan Modie, OHA Communications; Emily McLain, Nico Quintana, Basic Rights Oregon; Phillip L. Santa Maria, Avanir; Sharron Fuchs; Jeana Colabianchi, Pharm D, Sunovion; Maros Ferencik, SCCT; Teresa Everson, Will Nettleton, MD and Cristina Fuss, OHSU.

Call to Order

Som Saha, Chair of the Health Evidence Review Commission (HERC), called the meeting to order and role was called.

Minutes Approval

[Meeting Materials](#), page 4

MOTION: To approve the minutes of the 3/12/2015 meeting as presented. CARRIES 7-0.

Director's Report

Membership:

- Darren Coffman noted today is the first official meeting for recently confirmed Commissioner Dr. Derrick Sorweide. He is an osteopathic physician, a former family practice physician, is an Army Major, teaches at Western University of Health Sciences and is the current president of the Osteopathic Physicians & Surgeons of Oregon (OPSO).

MOTION: To seat Sorweide on the Health Technology Assessment Subcommittee. CARRIES: 7-0.

- Coffman noted the Governor’s office anticipates a Senate confirmation hearing in September to fill the vacant dental position.
- Recently, the EBGs CCO representative, Kattie Leuken, resigned.

Legislative update:

- Palliative Care and Quality of Life Interdisciplinary Advisory Council
 - Denise Taray will be lead staff
- Task Force on Researching the Medical and Public Health Properties of Cannabis
 - HERC Staff were initially tasked with staffing this group but found out this week staffing will come from elsewhere
- Report on diagnosis and treatment of Lyme disease
 - Ariel will be lead staff for this report to an interim legislative committee

Staff/organizational updates:

- Coffman introduced Dr. Kim Wentz, the new medical assistance program medical director. That organization has been renamed the “Health Systems Division.” HERC is now under Health Policy and Analytics Division, Clinical Services Improvement Unit. Jeanene Smith, CMO, is leaving state service.
- Coffman invited Val King to introduce Center for Evidence-based Policy staff. Adam Obley will take over Robyn Lui’s role, with Craig Mosbaek and Aasta Thielke acting as research assistants.

Coverage Guidance Topic: Planned out-of-hospital birth

[Meeting Materials](#), pages 26-197

No recommendation reached at the VbBS meeting held earlier in the day, therefore this topic was tabled until a future meeting.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes

[Meeting Materials](#), pages 198-271

Ariel Smits reported the VbBS met earlier in the day, August 13, 2015.

Gender dysphoria discussion:

Smits brought VbBS’s recommendations forward:

- Clarify which mental health provider appropriate for assessments/referrals
- Re-affirm no age limitations
- Do not specify provider type restrictions for gender dysphoria medication prescribing
- Issues tabled until the next meeting:
 - Changes to many surgery codes were tabled until a future meeting, including procedures for penile and testicular implants and chest surgery

Saha began the discussion by mentioning the onslaught of emails and phone calls staff received over a Fox news story in July. Most of them came from non-Oregon residents. What most struck Saha is that we did not receive a single negative feedback/comment from someone who has gone through this as a patient or a parent. Every testimony from a patient, parent or provider implored the Commission to stick with the original decision.

Smits stated the new recommendations are based on the [World Professional Association for Transgender Health](#) (WPATH) guidelines. Williams pointed out that these guidelines have extensive requirements related to gender dysphoria training and experience, rather than limits on a particular type of provider degree type. Westbrook shared some concern with the language in the meeting materials regarding mental health professions. Smits stated VbBS adopted WPATH guidelines which specifically outlines necessary training (e.g. clinical training in psychiatry, mental health counselling, nursing or family therapy with specific training in behavioral health and a minimum of master's level degree or equivalent in a clinical behavioral health field by an accredited institution with continuing education in gender dysphoria).

Saha broached the issue of medical age of consent. He stated there is confusion over "age of procedure," when and who should be able to get it. In the case of gender dysphoria, it is disadvantageous clinically to wait until secondary sex characteristics are fully developed. There is no good clinical rationale to require patients to be 18 years old. Further, having heard from providers, advocates and patients, it is rare when the parents are not involved. It is not feasible to make parental involvement mandatory since this is a stigmatized condition where sometimes patients become estranged from their family and their parents don't approve. That becomes an issue of discriminating against people who have basically been disowned by their parents. It is a false idea that a child could just walk in and say "do this to me." There is a long list of criteria to meet, primary care doctor approval, multiple mental health evaluations, surgeon approval – plenty of adults involved in the discussion. A child is never making this decision alone, ever.

In Oregon, the age of medical consent is 15. This commission does not have the authority to change this state law. Without parental consent, a 15 -17 year old can have brain surgery, breast augmentation, or terminate a pregnancy. This policy has far more safeguards to help ensure a child isn't reaching a wrong decision than in the case of other surgeries.

Westbrook felt, for pre-surgery criteria, we should be even more cautious with minors, encouraging the group to consider adding criteria for a doctoral level person to complete any testing, especially a psychosexual developmental piece. Smits countered there are addition referrals required (1 for chest/breast surgery, 2 for genital surgery) from a provider with master's level or higher credentials.

Wentz said there is a shortage of child mental health care providers. Further, she mentioned there are currently ten active OHP discrimination cases pending over lack of appropriate care for transgender individuals; five are mental health cases. Hodges added the providers may be available in the community but may not be currently contracted by CCOs. Smits said Kaiser Permanente wrote her, objecting to any deviation from WPATH since doing so would cause them to treat their Medicaid patients differently, and potentially discriminately, than their "commercial" population. Saha wondered if the world-wide guidelines agree on this level, is changing anything necessary? Wentz added, if you ask for more scrutiny *only* for transgender patients you are discriminating on the basis of gender and you cannot do this in implementation. Further, Hodges shared there was an abundance of compelling

testimony heard at VbBS to leave the 15-17 year-old coverage in place. Livingston said it may be in a patient's best interest to begin college as their identified gender.

Public comment:

Maura Roach, Basic Rights Oregon, urged the Commission to align with the world standard guidelines, WPATH, and to accept the VbBS recommendations.

Nico Quintana of Basic Rights Oregon testified that the lowest barriers possible for care should be adopted due to the marginalized nature of the transgender community, and their high risk of violence and suicide.

Census was reached to accept the VbBS proposal to modify the mental health evaluation sections to refer to the WPATH version 7 guidelines. The number of referrals required for chest/breast surgery was reduced from 2 to 1 to conform to WPATH guidelines, resulting in the following guideline.

GUIDELINE NOTE 127, GENDER DYSPHORIA

Line 413

Hormone treatment with GnRH analogues for delaying the onset of puberty and/or continued pubertal development is included on this line for gender questioning children and adolescents. This therapy should be initiated at the first physical changes of puberty, confirmed by pubertal levels of estradiol or testosterone, but no earlier than Tanner stages 2-3. Prior to initiation of puberty suppression therapy, adolescents must fulfill eligibility and readiness criteria and must have a comprehensive mental health evaluation. Ongoing psychological care is strongly encouraged for continued puberty suppression therapy.

Cross-sex hormone therapy is included on this line for treatment of adolescents and adults with gender dysphoria who meet appropriate eligibility and readiness criteria. To qualify for cross-sex hormone therapy, the patient must:

1. have persistent, well-documented gender dysphoria
2. have the capacity to make a fully informed decision and to give consent for treatment
3. have any significant medical or mental health concerns reasonably well controlled
4. have a comprehensive mental health evaluation provided in accordance with Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org).

Sex reassignment surgery is included for patients who are sufficiently physically fit and meet eligibility criteria. To qualify for surgery, the patient must:

1. have persistent, well documented gender dysphoria
2. have completed twelve months of continuous hormone therapy as appropriate to the member's gender goals unless hormones are not clinically indicated for the individual
3. have completed twelve months of living in a gender role that is congruent with their gender identity unless a medical and a mental health professional both determine that this requirement is not safe for the patient
4. have the capacity to make a fully informed decision and to give consent for treatment
5. have any significant medical or mental health concerns reasonably well controlled
6. for breast/chest surgeries, have one referral from a mental health professional provided in accordance with version 7 of the WPATH Standards of Care.

7. for genital surgeries, have two referrals from mental health professionals provided in accordance with the version 7 WPATH Standards of Care.

Electrolysis (CPT 17380) is only included on this line for surgical site electrolysis as part of pre-surgical preparation for chest or genital surgical procedures also included on this line. It is not included on this line for facial or other cosmetic procedures or as pre-surgical preparation for a procedure not included on this line.

Other VbBS report items:

Smits presented recommendations on other topics, but there was no discussion:

- Add certain procedure codes to the covered gender dysphoria line to better include all procedure codes for procedures previously approved for this line; remove 2 inappropriate codes from this line
- Make various straightforward coding changes
- Modify the left ventricular assist device guideline to allow destination therapy
- Modify the continuous blood glucose monitoring guideline to specify that recurrent hypoglycemia is defined as 3 or more events in the previous 6 months
- Adopt various straightforward guideline corrections

MOTION: To accept the VbBS recommendations on Prioritized List changes not related to coverage guidances, as stated. See the VbBS minutes of August 13, 2015 for a full description. Carries: 6-0. (Absent: Saboe; Abstained: 0)

Coverage Guidance Process Redesign

[Meeting Materials](#), pages 273-285

Jason Gingerich reminded the group they had granted permission to change the literature search process and GRADE table format at a previous meeting. He reviewed the staff's proposed changes to the coverage guidance process including: 1) additional research prior to releasing the initial draft of the guidance, and 2) a brief 7-day comment period focused on insuring that the literature search strategy returns the correct information to guide the HERC's decision. He also presented examples of the new GRADE tables which will provide more quantitative information about key outcomes. There was minimal discussion.

Coverage Guidance Topic 2-Year Review

[Meeting Materials](#), pages 286-302

Livingston led the discussion with help from Adam Obley, MD, of the Center for Evidence-based Policy. The new process now calls for the identification of Population, Intervention, Comparator, Outcomes (PICO) and Key Questions (KQ) for each topic, followed by posting for public comment for 7 days and a review of the literature search results at the September EbGS & HTAS meetings.

The Commission discussed the scope documents and made the changes shown in Appendix A.

- **Treatment of ADHD in Children (See Appendix A)**
- **Coronary Artery Calcium Scoring (See Appendix A)**

Public comment:

Maros Ferencik, MD, cardiologist and associate professor at OHSU, Board member of Society of Cardiovascular Computed Tomography. His stated conflict is that he is a practicing cardiologist who performs these tests and is a grant recipient for American Heart Associate to study coronary CTs. Dr. Ferencik said the current scope document partially mixes diagnostic uses with the test's preventive and prognostic value. He said the PICO should focus on the role of calcium scoring in predicting cardiovascular events and improving classification of the risk. Further, CACS should be compared to other tests or screening that lead to risk classification. She said that in certain cases adding a calcium score can help rule out further testing

- **Carotid Endarterectomy (See Appendix A)**
- **Coronary CT Angiography (See Appendix A)**

Public comment:

Cristina Fuss, MD is the section chief for cardiothoracic Imaging in the department of Diagnostic Radiology at OHSU. No conflicts declared. She said that studies have proven diagnostic accuracy and therefore the usefulness of this test is excellent. It does indeed prevent invasive tests in many cases and can help shorten the length of hospital stays. She said that in certain cases adding calcium score can help rule out further testing.

Maros Ferencik, MD spoke to urge the group to consider effects of radiation on the population. Also stressed the need to look at negative and positive effects of incidental findings.

At this point, with many more scope documents yet to review, Saha called a halt to reviewing the scope documents, as time for the topic had elapsed. He would like these discussions to take place at the subcommittee level in the future. Coffman and Gingerich added such a process change could result in a two-month delay. For this iteration, the scoping documents for all of the topics will be posted for public comment. The four reviewed at HERC today may then go on to a literature search, incorporating changes reflecting public comments as appropriate. The remainder will go to their originating subcommittee for additional discussion before proceeding with the literature search. After a literature search is conducted the subcommittee will review the results to see if revisiting the topic is warranted. Staff will work on a more stream-lined process for future topics.

Coverage Guidance Topic: Biomarker Tests of Cancer Tissue for Prognosis and Potential Response to Treatment

[Meeting Materials](#), pages 303-368

Dr. Robyn Liu, Center for Evidence-based Policy, reviewed the evidence resulting in the draft coverage guidance recommended by HTAS. Livingston reviewed the GRADE table and box language and the proposed changes to the Prioritized List recommended by VbBS. There was no discussion.

MOTION: To approve the proposed coverage guidance for Biomarker Tests of Cancer Tissue as recommended by HTAS. Carries 6-0.

MOTION: To approve the proposed guideline and coding changes for the Prioritized List as recommended by VbBS. Carries 6-0.

HERC APPROVED COVERAGE GUIDANCE

BIOMARKER TESTS OF CANCER TISSUE FOR PROGNOSIS AND POTENTIAL RESPONSE TO TREATMENT

Oncotype DX is recommended for coverage in early stage breast cancer when used to guide adjuvant chemotherapy treatment decisions for women who are lymph node negative (*strong recommendation*).

The following genetic tests of cancer tissue are recommended for coverage (*strong recommendation*):

- BRAF gene mutation testing for melanoma
- Epidermal growth factor receptor (EGFR) gene mutation testing for non-small-cell lung cancer
- KRAS gene mutation testing for colorectal cancer

The following genetic tests of cancer tissue are not recommended for coverage (*weak recommendation*):

- Mammaprint, ImmunoHistoChemistry 4 (IHC4), and Mammostrat for breast cancer
- Prolaris and Oncotype DX for prostate cancer
- BRAF, microsatellite instability (MSI), and Oncotype DX for colorectal cancer
- KRAS for lung cancer
- Urovysion for bladder cancer
- Oncotype DX for lymph node-positive breast cancer

The use of multiple molecular testing to select targeted cancer therapy is not recommended for coverage (*weak recommendation*).

Changes to the Prioritized List of Health Services:

1) Coding changes:

- a. Add S3854 (Gene expression profiling panel for use in the management of breast cancer treatment) to Line 195 (breast cancer).
 - i. Advise the Health Systems Division to remove S3854 from Ancillary Codes File
- b. Place 81275 (KRAS) on Line 161 (colon cancer)
 - i. Advise the Health Systems Division to remove 81275 from the Diagnostic File
- c. Place 81210 (BRAF) on Line 233 (malignant melanoma)
 - i. Advise the Health Systems Division to remove 81210 from Diagnostic File
- d. Add the following to the Services Recommended for Non-coverage Table (all represented by nonspecific CPT codes unless otherwise indicated)
 - Mammaprint
 - ImmunoHistoChemistry 4 (IHC4)

- Mammostrat
- Microsatellite instability (MSI)
- Urovysion
- Prolaris
- Multiple molecular testing (81504)

2) Adopt a new Guideline Note:

GUIDELINE NOTE 148, BIOMARKER TESTS OF CANCER TISSUE

Lines 161, 188, 195, 233, 266, 274, 333

The use of multiple molecular testing to select targeted cancer therapy (CPT 81504) is included on the Services recommended for non-coverage table.

For breast cancer, Oncotype Dx testing (CPT 81519, HCPCS S3854) is included on line 195 only for early state breast cancer when used to guide adjuvant chemotherapy treatment decisions for women who are lymph node negative. Oncotype Dx is not included on this line for lymph node-positive breast cancer. Mammprint, ImmunoHistoChemistry 4 (IHC4), and Mammostrat for breast cancer are included on the Services recommended for noncoverage table.

For melanoma, BRAF gene mutation testing (CPT 81210) is included on line 233.

For lung cancer, epidermal growth factor receptor (EGFR) gene mutation testing (CPT 81235) is included on line 266 only for non-small cell lung cancer. KRAS gene mutation testing (CPT 81275) is not included on this line.

For colorectal cancer, KRAS gene mutation testing (CPT 81275) is included on line 161. BRAF (CPT 81210) and Oncotype DX are not included on this line. Microsatellite instability (MSI) is included on the Services recommended for noncoverage table.

For bladder cancer, Urovysion testing is included on Services recommended for noncoverage table.

For prostate cancer, Oncotype DX is not included on line 333 and Prolaris is included on the Services recommended for noncoverage table.

The development of this guideline note was informed by a HERC coverage guidance. See [website](#).

Advisory Panels Update

Coffman said the three advisory panels to help VbBS with a variety of issues have been revitalized and will meet in September and October. Membership has been updated to ensure current CCO/DCO

representation on the Behavioral Health Advisory Panel, Oral Health Advisory Panel, and Genetics Advisory Panel.

Best Practices, Evidence-based Toolkits

Livingston said there is a need for a way for HERC to make a statement on effectiveness and appropriateness of services that do not fit within the current constructs of the Prioritized List. These would be strategies for population health management on topics such as obesity, chronic pain, and tobacco use for services not traditionally billed as medical services. The product might be a stand-alone document and/or could be embedded in the Prioritized List.

Saha agreed there is a need to break down barriers between medical care and public health in support of our biggest stake holder, the CCOs. Discussion centered on the scope of the new venture, whether a task force should be convened for each topic or if adopting another group's practices was desired. Staff will bring back options at the next meeting in October, possibly focused on tobacco cessation.

2016 Biennial Review

Livingston asked for permission to convene a task force on obesity management which would include a wide variety of providers including primary care, CCO representatives, and endocrinology. This will take a look at HTAS recommendations on surgical indications as well as a comprehensive look at non-surgical approaches.

MOTION to create a task force on obesity management. CARRIES: 6-0.

Next Steps

I was determined that the next VbBS/HERC meeting date needs to be moved to October 1st or 22nd. Staff will poll the members for availability by email and confirm the date and location as soon as able.

Adjournment

The meeting was adjourned at 4:30 pm.

Appendix A

PICO & Key Questions for Literature Search on Coverage Guidance Topics Last Reviewed in 2013

Treatment of ADHD in Children

Populations

Children 6 years of age or older diagnosed with ADHD, or
Children under 6 years of age deemed at-risk for ADHD

Interventions

Parent behavior training, teacher consultation, pharmacotherapy (methylphenidate, amphetamine salts, non-stimulant medications, atypical antipsychotics) other pharmacologic treatments, psychosocial and behavioral interventions

Comparators

Usual care, no intervention

Outcomes

Critical: Academic achievement, measures of social functioning

Important: Measures of impulsiveness, grade retention, growth restriction

Outcomes considered but not selected for GRADE table: Measures of inattention, overactivity, non-specific harms

Key Questions

KQ1: What is the effectiveness of pharmacologic, behavioral, and psychosocial interventions for children with ADHD?

1a. Does effectiveness vary based on patient characteristics?

KQ2: Is there comparative effectiveness evidence for interventions for children with ADHD?

KQ3: What is the effectiveness of interventions for children under 6 years of age deemed at-risk for ADHD?

KQ4: What is the evidence of harms associated with the interventions for ADHD in children?

Coronary Artery Calcium Scoring

Populations

Asymptomatic adults with coronary heart disease (CHD) risk, adults with acute chest pain with normal EKG and negative cardiac enzymes, adults with chronic stable chest pain

Intervention

Coronary artery calcium scoring (CACS)

Comparators

No further risk stratification, other forms of risk stratification (including serial monitoring (EKG, troponins), exercise EKG, stress echocardiography, stress myocardial perfusion scanning, coronary angiography, clinical risk prediction tools

Outcomes

Critical: All-cause mortality, major adverse cardiovascular events

Important: Incidental findings, avoidance of invasive procedure

Outcomes considered but not selected for GRADE table: Length of stay

Key Questions

KQ1: What is the comparative effectiveness of CACS in improving outcomes for asymptomatic patients with CHD risk or patients with chest pain (either acute chest pain with normal EKG and negative cardiac enzymes or chronic stable chest pain)?

KQ2: What is the cost-effectiveness of CACS?

KQ3: What are the harms of CACS?

Appendix A

PICO & Key Questions for Literature Search on Coverage Guidance Topics Last Reviewed in 2013

Coronary CT Angiography

Population

Adults with acute chest pain or chronic stable chest pain

Intervention

Coronary CT angiography (CTA)

Comparators

Usual care (including no additional testing, exercise EKG, stress echocardiography, stress myocardial perfusion scanning, coronary angiography; serial monitoring with EKG/troponin)

Outcomes

Critical: All-cause mortality, Major Adverse Cardiac Events (MACE)

Important: Contrast-induced nephropathy, avoidance of invasive procedures

Outcomes considered but not selected for GRADE table: radiation exposure; need for revascularization procedure

Key Questions

KQ1: What is the comparative effectiveness of coronary CTA for improving outcomes among adults with chest pain?

1a. Are there patient characteristics that modify the utility?

KQ2: What are the harms of coronary CTA (including incidental findings)?

KQ3: What are the comparative costs and/or cost-effectiveness of coronary CTA?

Coronary Endarterectomy

Populations

Adults with carotid stenosis with or without recent symptoms of cerebral ischemia

Intervention

Carotid endarterectomy

Comparators

Optimal medical therapy, carotid stenting

Outcomes

Critical: All-cause mortality, cerebrovascular accidents

Important: Transient ischemic attacks, development/progression of vascular dementia, quality of life

Outcomes considered but not selected for GRADE table: Need for reintervention

Key Questions

KQ1: What is the comparative effectiveness of carotid endarterectomy for treatment of symptomatic or asymptomatic carotid stenosis?

1a. What degree of carotid stenosis predicts clinical utility of carotid endarterectomy?

KQ2: What are the harms of carotid endarterectomy?

KQ3 Under what circumstances should carotid endarterectomy be covered for asymptomatic patients (i.e. when stenosis is found as an incidental finding?)

Coronary Artery Calcium Scoring

PICO & Key Questions for Updated Literature Search

Populations

Asymptomatic adults with coronary heart disease (CHD) risk, adults with acute chest pain with normal EKG and negative cardiac enzymes, adults with chronic stable chest pain

Intervention

Coronary artery calcium scoring (CACS)

Comparators

No further risk stratification, other forms of risk stratification (including serial monitoring (EKG, troponins), exercise EKG, stress echocardiography, stress myocardial perfusion scanning, coronary angiography, [clinical risk prediction tools](#))

Outcomes

Critical: All-cause mortality, major adverse cardiovascular events

Important: ~~Need for revascularization procedure; incidental~~ [Incidental findings, contrast induced nephropathy avoidance of invasive procedure](#)

Outcomes considered but not selected for GRADE table: Length of stay

Key Questions

KQ1: What is the comparative effectiveness of CACS in improving outcomes for asymptomatic patients with CHD risk or patients with chest pain (either acute chest pain with normal EKG and negative cardiac enzymes or chronic stable chest pain)?

KQ2: What is the cost-effectiveness of CACS?

KQ3: What are the harms of CACS?

Treatment of ADHD in Children

PICO & Key Questions for Updated Literature Search

Populations

Children 6 years of age or older diagnosed with ADHD, or

Children under 6 years of age deemed at-risk for ADHD

Interventions

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Comparators

Usual care, no intervention

Outcomes

Critical: Academic achievement, measures of social functioning

Important: Measures of, impulsiveness, and global functioning, grade retention, academic achievement, Growth growth restriction

Outcomes considered but not selected for GRADE table: Measures of inattention, overactivity, non-specific harms

Key Questions

KQ1: What is the effectiveness of pharmacologic, behavioral, and psychosocial interventions for children with ADHD?

1a. Does effectiveness vary based on patient characteristics?

KQ2: Is there comparative effectiveness evidence for interventions for children with ADHD?

KQ3: What is the effectiveness of interventions for children under 6 years of age deemed at-risk for ADHD?

KQ4: What is the evidence of harms associated with the interventions for ADHD in children?

Carotid Endarterectomy

PICO & Key Questions for Updated Literature Search

Populations

Adults with carotid stenosis with or without recent symptoms of cerebral ischemia

Intervention

Carotid endarterectomy

Comparators

Optimal medical therapy, carotid stenting

Outcomes

Critical: All-cause mortality, cerebrovascular accidents

Important: Transient ischemic attacks, development/progression of vascular dementia, quality of life

Outcomes considered but not selected for GRADE table: Need for reintervention (~~to be discussed by HERC~~)

Key Questions

KQ1: What is the comparative effectiveness of carotid endarterectomy for treatment of symptomatic or asymptomatic carotid stenosis?

- a. What degree of carotid stenosis predicts clinical utility of carotid endarterectomy?

KQ2: What are the harms of carotid endarterectomy?

KQ3 Under what circumstances should carotid endarterectomy be covered for asymptomatic patients (i.e. when stenosis is found as an incidental finding?)

Coronary CT Angiography

PICO & Key Questions for Updated Literature Search

Population

Adults with acute chest pain or chronic stable chest pain

Intervention

Coronary CT angiography (CTA)

Comparators

Usual care (including no additional testing, exercise EKG, stress echocardiography, stress myocardial perfusion scanning, coronary angiography; serial monitoring with EKG/troponin)

Outcomes

Critical: All-cause mortality, ~~myocardial infarction, stroke, Major Adverse Cardiac Events (MACE)~~

Important: ~~Diagnostic accuracy, costs/cost-effectiveness, Contrast-induced nephropathy, avoidance of invasive procedures~~

Outcomes considered but not selected for GRADE table: ~~avoidance of invasive testing~~; radiation exposure; need for revascularization procedure

Key Questions

KQ1: What is the comparative effectiveness of coronary CTA for improving outcomes among adults with chest pain?

1a. Are there patient characteristics that modify the utility?

KQ2: What are the harms of coronary CTA (including incidental findings)?

KQ3: What are the comparative costs and/or cost-effectiveness of coronary CTA?