

MINUTES

Health Technology Assessment Subcommittee

Clackamas Community College
Wilsonville Training Center, Rooms 111-112
29353 SW Town Center Loop E
Wilsonville, Oregon 97070
February 18, 2016
1:00-4:00pm

Members Present: Som Saha, MD, MPH (Chair Pro Tempore); Chris Labhart; Gerald Ahmann (by phone), MD; Leda Garside, RN, MBA; Mark Bradshaw, MD.

Members Absent: Jim MacKay, MD, Derrick Sorweide, DO.

Staff Present: Darren Coffman; Cat Livingston, MD, MPH; Jason Gingerich.

Also Attending: Adam Obley, MD, Val King MD, MPH & Craig Mosbaek (OHSU Center for Evidence-based Policy), Joanie Cosgrove (MedTronic), Linli Pao.

1. CALL TO ORDER

Saha called the meeting to order at 1:10 p.m.

2. MINUTES REVIEW

Minutes from the December 10, 2015 meeting were reviewed and approved 5-0.

3. STAFF REPORT

Coffman provided information on various items:

- Tim Keenen has resigned from the committee as his clinical schedule does not allow participation on Thursdays. He has recommended a recently-retired osteopathic physician to replace him.
- The rescanning report on Vertebroplasty, Kyphoplasty and Sacroplasty was taken directly to HERC after an email to members, and no update is currently planned on this topic.
- The topic of Viscosupplementation for Osteoarthritis of the Knee had been recommended for a new review after the 2014 monitoring process after a new report became available. The report recently became available but staff review indicated that the report is unlikely to change the current recommendation for noncoverage. A more comprehensive rescanning report will occur later this year as a part of the regular monitoring process.
- The April HTAS meeting was cancelled in order to give staff time to prepare for the Obesity Task Force meetings happening this spring.
- Staff has developed a plan for cancer genetics topics, which is a rapidly-evolving field. The HERC will follow guidelines from the National Comprehensive Cancer Care Network (NCCN) where

they make a clear recommendation. Where the recommendation is not clear, the HERC will consider taking up the topic. This will help make best use of HERC resources in keeping up-to-date with this evolving field. Bradshaw suggested that the subcommittee consider mental health-related genetics topics as well. Coffman said that the EbGS is looking at genetic testing related to antidepressant selection.

4. COVERAGE GUIDANCE: Metabolic and Bariatric Surgery

Obley reviewed public comment on Metabolic and Bariatric Surgery, which consisted of a single comment offering “applause.” Livingston noted that CCO medical directors have raised concerns about costs. Coffman said that after the coverage guidance is approved any changes will be implemented in January, 2018 as a part of the biennial review so that costs can be incorporated into rates.

Dr. Bruce Wolfe, appointed expert for this topic, spoke in favor of fewer barriers to access for patients desiring this surgery. He noted that, for instance, smoking rates are usually about 20 percent at intake in this population, then 0 percent at surgery due to the requirements, then they rise to 20 percent again at followup. Adequate pre-operative weight loss is hard to define. Labhart noted that tobacco cessation is a big priority for CCOs this year due to metrics. After brief discussion the subcommittee referred the draft coverage guidance to HERC, without making any changes by a vote of 5-0.

DRAFT HERC Coverage Guidance

Coverage of metabolic and bariatric surgery (including Roux-en-Y gastric bypass, gastric banding, and sleeve gastrectomy) is recommended for:

- Adult obese patients (BMI \geq 35) with
 - Type 2 diabetes (*strong recommendation*) OR
 - at least two of the following other serious obesity-related comorbidities: hypertension, coronary heart disease, mechanical arthropathy in major weight bearing joint, sleep apnea (*weak recommendation*)
- Adult obese patients (BMI \geq 40) (*strong recommendation*)

Metabolic and bariatric surgery is recommended for coverage in these populations only when provided in a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (*weak recommendation*).

Metabolic and bariatric surgery is not recommended for coverage in:

- Patients with BMI <35, or 35-40 without the defined comorbid conditions above (*weak recommendation*)

Children and adolescents (*weak recommendation*)

5. SCOPE STATEMENTS FOR COVERAGE GUIDANCES

Genetic Testing of Thyroid Nodules. Obley reviewed the scope statement. Saha asked about harms

from testing be mentioned as an outcome, but not in key questions. Obley said the harm would be from neck dissections and thyroidectomies which did not reduce mortality. He said the harms could show up in mortality or be reported as harms, and could be covered under key question 3 (b) as a change in outcomes or management plans. No changes were made.

Noninvasive Testing for Liver Fibrosis in Chronic Hepatitis C Patients. Obley reviewed the draft scope statement. Saha expressed concern that with the outcomes as written even a bad test could receive favorable results if the information produced by the test didn't have good value. Obley said that from what he has seen so far, these noninvasive tests are better at the higher stages of liver fibrosis. He suggested adding hepatitis-related morbidity and progression. The subcommittee also made testing-related adverse events an important (not critical) outcome and re-ordered the listed outcomes. Bradshaw expressed concern that providers might do this test too frequently in an effort to qualify a patient for treatment. The subcommittee also discussed removing quality of life as an outcome but left it in.

Prostatic Urethral Lifts The subcommittee discussed the fact that there was only one critical outcome. After discussion, Saha said that even if an outcome may not be a major public health issue, it could be a critical outcome in terms of making the decision on a particular service. After discussion, the subcommittee changed the outcomes, adding procedural complications, long-term harms and making urinary incontinence and erectile dysfunction examples of harms).

Sacral Nerve Stimulation for Non-obstructive Urinary Retention Obley reviewed the draft scope statement. There was brief discussion but no changes were made to the statement.

Ultrasound-Enhanced Catheter Directed Thrombolysis for Deep Vein Thrombosis (DVT) Saha questioned whether pulmonary embolism should be moved to a critical outcome. Some are very serious, some aren't. The subcommittee changed the outcome to symptomatic pulmonary. Saha asked how often thrombolysis is used. Obley said at least at OHSU he doesn't believe the procedure is performed locally for pulmonary embolism, but it is being done for DVT, albeit not the catheter-directed, ultrasound-enhanced approach studied here.

Ultrasound-Enhanced Catheter Directed Thrombolysis for Pulmonary Embolism (PE) The subcommittee corrected an error in key question 2(d), changing the outcome to presence of DVT (not PE), and elevated recurrent pulmonary embolism to a critical outcome.

The subcommittee voted 5-0 to refer the scope statements for these 4 topics to HERC, as amended.

6. TOPIC SCORING/PRIORITIZATION

Livingston reviewed the topic scoring sheet and explained that the first 8 rows are added, then the meaningful coverage guidance row is a multiplier. She also explained that some of the scoring sheet has been revised to better capture the key concepts.

For Ultrasound-Enhanced Catheter-Directed Thrombolysis for DVT, the subcommittee discussed prevalence. The population who might need this procedure is extremely small, but for those patients the

disease burden would be high. The subcommittee discussed lowering the prevalence score to 0 and raising the disease burden to 3. This would result in the same score so no changes were made.

Saha asked whether the group should consider a report on all catheter-directed thrombolysis. Due to the DRG billing methodology, plans may never even make a decision on this service. Based on the low score, the subcommittee decided to recommend HERC not consider this topic, and made the same recommendation for the Ultrasound-Enhanced Catheter-Directed Thrombolysis for PE. This recommendation was approved by a vote of 5-0.

The subcommittee then reviewed the scoring for the remaining topics. All the other topics scored much higher. Gingerich said that the Continuous Glucose Monitoring and Sleep Apnea Diagnosis in Adults are rescan topics, which the subcommittee discussed previously.

Discussion turned to the multiplier row on the scoring sheet. Saha expressed concern that there could be good topics which might be eliminated due to lack of implementation levers. Gingerich gave the example of transitional care for patients with heart failure, which is an important topic that is difficult for plans to address with coverage policy. There was an extensive discussion about the changing nature of implementability given the changing structure of CCOs. Saha proposed that this scoring system should only be applied to clinical topics and not to other topics that a plan may use extra funds for, services which occur outside the typical clinical encounter. The group proposed developing a new product and/or process for multisector interventions. They discussed that the review of evidence of clinical and non-clinical interventions ought to happen simultaneously, as there would be a benefit to addressing a topic from multiple angles. Final recommendations could include a coverage guidance for clinical interventions and evidence-based strategies for non-clinical recommendations.

5. ADJOURNMENT

The meeting was adjourned at 3:20 pm. The next meeting is scheduled for April 21, 2016 from 1:00-4:00pm in Room 111-112 of the Wilsonville Training Center of Clackamas Community College.