In-Hospital HTA.

The McGill University Health Care Experience. 2001-2013 .

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Peter Chinneck asked me to share what I have learned about hospital HTAs from our McGill experience. Not a presentation but a list of points to remember. So this is what I will try to do.

MUHC is a consortium of 6 McGill affiliated hospitals

This one is the Royal Victoria. We started doing our own HTA's in 2001. Why? Because we must make decisions about new technologies. And preparation of the ***evidence*** requires expertise. And framing ***recommendations*** requires a ***local*** perspective. I will list 5 points that I hope may help others considering doing in-hospital HTA's.

1. **<u>Don't waste time on HTA's that have not been requested.</u>**

In general, advice not asked for is seldom taken.

Your most brilliant creation wont have the slightest influence on policy unless ***you have been asked*** to carry it out. So if it's your idea ***first sell it*** to your administrator to the point that she thinks it is hers

This is easy when you are situated in your own istitution . (You can sit down with the asker and shape the question).

Almost all our HTA's have been written in response to a request from our hospital.

The others although brilliant have been forgotten.

2. Credible recommendations require a credible jury.

Collection and synthesis of ***evidence*** is a scientific, objective activity that requires credible professionals.

But framing ***recommendations*** on the basis of the evidence (**what the institution should *do*?)** is a subjective, values based activity. (Life years saved vs headaches prevented?).

There are no "right answers" to such questions.

All you can ask for is that recommendations are made by people who are demonstrably ***fair*** and unbiased using a ***transparent*** process.

So your jury must be, and be seen to be, ***unbiased, credible,*** and ***respected*** by the ***community affected*** by the recommendations.

The ***"jury" or Policy Committee*** in our hospital consists of nurses, allied H-C workers, patients, administrators, doctors, ***chosen by their peers***.

Supplemented for each report by representatives of the ***discipline most affected.*** These provide subject expertise, and at the end, greatly influence acceptance

This not the traditional way in which policy decisions are made. (Administrator(s). Closed door.)

This permits bias. It also favours technology acquisition. (Lay Administrator vs MD Professional)

3. Be transparent. Make recommendations public.

Recommendations that are well supported by good evidence and clear reasoning can carry considerable weight. Hard for administration not to accept.

So our recommendations are not just handed over to the administration. They are made very public. (www.mcgill.ca/tau/), **(10,000 hits / month).**

Over the past 11 years we have completed 72 reports.

They are available in full on the web.

Hospital HTA

	Technology	Acquisition Recommended	Advice Accepted
2002	1) IV safety catheters	No	Yes
	2) Antiviral treatment of chronic Hep C	Yes	Yes
	3) Mitoxantrone for Multiple Sclerosis	Limited	Yes
	4) GPIIb/IIIa inhibitors for PCI	Limited	Yes
2003	5) L-M-W Heparin for DVT/PE	Yes	Yes
	6) Colorectal stents	Yes	Yes
	7) Video Capsule endoscopy system	No	Yes
	8) Risk of PRCA.? Use of Eprex	Yes	Yes
	9) Drotrecogin alfa (activated) in sepsis	Limited	Yes
	10) Drug eluting stents for PCI	Limited	Yes
	11) Implantable cardiac defibrillators	Limited	Yes
	12) Esophageal stents for dysphagia	Yes	Yes
2004	13) Biventricular pacing for heart failure	No	Yes
	14) Gliadel wafer for malignant glioma	Limited	Yes
	15) Gastric banding for morbid obesity	No	Yes
	16) Matrix coils for cerebral aneurysm	No	Yes
2005	17) Stem cells from unrelated donors	Yes	Yes
	18) Probiotics for C Difficile	No	Yes
	19) Expansion of VAC wound therapy	No	No
	20) Neuro monitoring in spinal surgery	Yes	Partly

Hospital HTA

	Technology	Acquisition Recommended	Advice Accepted
	21) Microdialysis after brain trauma	No	Yes
	22) Botox for refractory anal fissure	Limited	Yes
2006	23) Testing for HER2 +ve breast cancer	Yes	Yes
	24) Mitoxantrone for MS (update of 4)	Limited	Yes
	25) Needlestick safety devices (update of 1)	No	No
	26) Wait times, MUHC 1 (IMAGING,ORTHO,CATARACT,CARDIAC)	n/a	n/a
	27) Wait times, MUHC 2 (MEDICINE<SURGERY)	n/a	n/a
2007	28) Navitrack computer assist system	Limited	Yes
	29) Drotrecogin alfa in severe sepsis	Limited	Yes
	30) Pulsatile perfusion for renal transplant	Yes	Yes
	31) Wait times, MUHC 3 (FRACTURE MANAGEMENT)	n/a	n/a
2008	32) Wait times, MUHC 4 (DIAGNOSTIC IMAGING)	n/a	n/a
	33) Impact of TAU reports	n/a	n/a
	34) Coblation Tonsillectomy	No	Yes
2009	35) Gliadel Wafers (CARMUSTINE IMPLANTS)	No	Yes
	36) Opportunity Costs of new technologies	n/a	n/a
	37) Impella Pump for C-V Support	Yes	Yes
	38) DBS for Parkinson's Disease	Yes	Yes
	39) Radio-frequency ablation (RFA) for liver cancer	Yes	Yes
	40) A.A. Derm. Matrix, breast reconstruct.(Update 40)	Yes	Yes

Hospital HTA

	Technology	Acquisition Recommended	Advice Accepted
2009	41).Collatamp for post colo-rectal surg infections	Yes	Yes
	42).Matrix Coils for C-V aneurysms. (Update)	No	Yes
	43).Collatamp to prevent post-Cardiac infection	No	Yes
	44).Probiotics for C.Diff diarrhoea. (Update)	No	Yes
	45).Transcatheter aortic valve implant (TAVI)	Yes	Yes
	46).RFA for Barrett's oesophagus	Yes	Yes
2010	47).Ultrafiltration for heart failure.	Yes	Yes
	48).Negative Pressure Wound Therapy.	Yes	Yes
	49).Argon beam coagulation	Limited	Yes
	50).Aortic valve bypass for aortic stenosis	Yes	Yes
2011	51).X-ray/gamma ray irradiation of blood.	No	Yes
	52).Fiducial Markers for irradiation of Ca prostate	Yes	Yes
	53).VerifyNow to detect Clopidogrel resistance	No	Yes
	54).Probiotics for prevention of C Diff diarrhoea	No	Yes
	55).Drug eluting stents.Current indications.	NA	NA
	56).Subglottic drainage endotracheal tubes	Yes	Yes
	57).Binax Now for Diagnosis of Strep Pnumonia	No	Yes
2012	58).Drotrecogin Alfa in severe Sepsis(Update of 29)	Withdrawn	NA
	59).Acellular Dermal Matrix, Breast Reconstruct.	Limited	Yes

Hospital HTA Technology	Acquisition Reccomended	Advice Accepted
60). Videocapsule Endoscopy (Update of 7)	Yes	Yes
61). 532nm KTP Laser for vocal fold surgery	No	Yes
62). Pro-Calcitonin assay for antibiotic coverage	No	Yes
63). Intrabeam for Breast Cancer	No	Yes
2013 64). Rituximab in Neurologic Autoimmune Diseases	Limited	
65). Impact of TAU Reports	NA	NA
66). Islet Cell Transplantation		
67). Hybrid OR for CVT procedures. Analysis	NA	NA
68). Balloon Catheter Dilatation for Chronic Sinusitis	Limited	
69). Hyaluronic Acid Fat Graft Myringoplasty	Yes	
70). TAVI Update	Yes	
71). Sutureless Aortic Valve	Limited	
72). Renal Artery Denervation for Resistant Hypertension	Limited	

www.mcgill.ca/tau/

4.Systematically evaluate the impact of your reports

Whether HTAs are abysmal or brilliant, if they don't ***influence decisions*** they are a ***waste of time.***

We did our last impact evaluation in 2012.**[Rep No 65]**

Of 63 recommendations made between 2002-11

40% recommended acquisition.

60% recommend rejection or limited use.

71% were incorporated into hospital policy.

Importantly, the reason for lack of impact could be identified and corrected.

Average Budget saving, $1.14 million/yr.

But if you don't evaluate you will never know.

5. **In-hospital HTAs can adjust recommendations to the strength of the evidence**.

When the background evidence is imperfect we have a problem writing recommendations .

The common solution is to conclude that until better evidence is obtained no recommendation is possible.

The GRADE authors recommend that when the evidence is weak, we should make a “weak recommendation”. But weak recommendations are not very helpful to decision-makers.

Actually, there is no definable, hard border separating acceptable and unacceptable evidence. Subjective.

The ***graver the decision*** the ***stronger the evidence*** needed to support it.

When you are reporting from within an organisation , and the evidence is marginal, you can make qualified, less grave, recommendations.

Eg., When evidence favours a new technology but is too insubstantial to recommend ***permanent*** approval, one can recommend ***limited*** and/or ***temporary*** approval. (e.g.Use can be limited to an experimental setting, or a registry, with the object of acquiring the missing proof).

22 of the last 72 reports have recommended limited approval of this type.

In summary, when preparing in-Hospital HTA's:

Make sure your HTA has been ***requested***. If not it may be ignored.

That recommendations come from a **credible "jury".** *This will increase in their acceptance.*

Publish your reports . *This will add to their power.*

Evaluate the ***impact*** of your reports. *If they don't influence policy they are a waste of time.*

Consider giving ***limited/qualified*** approval when evidence is suggestive but imperfect. *This is a real advantage for the in-Hospital HTA.*

THANKYOU