Canadian Agency for Drugs and Technologies in Health

Health Technology Update

Issue 13 • March 2010

Health Technology Assessment HTA

A newsletter on new and emerging health care technologies in Canada

Scanning the Horizon

Informing Decision-Makers About Emerging Medical Technologies, Policies, Practices, and Research

Welcome to the thirteenth issue of *Health Technology Update*. The first newsletter of 2010 brings you more information about technologies that could significantly impact the health of patients and lead to high-quality, efficient, and sustainable health care in Canada.

Our feature article focuses on the growth of hospital-based health technology assessment across Canadian jurisdictions. Issue highlights include the role of the national drug review in the Yukon, and recommendations for self-monitoring of blood glucose using test strips. This issue also focuses on new and emerging health technologies in infection control and, as always, provides updates and links to recent Canadian health technology assessments, recommendations, and clinical practice guidelines.

We hope you find this issue informative and useful. If you would like to suggest a topic, please contact Andra Morrison at andram@cadth.ca. From all of us at CADTH, we wish you a healthy, peaceful, and prosperous 2010.

In this issue

We want your feedback… tell us what you think

Health Technology Update is a source of information for those involved in planning and providing health care in Canada. Did we hit the mark in our efforts to bring you information on medical technologies and issues in practice and policy? Has the information we've provided on HTA research been useful in helping to make decisions? Tell us what you think.

Send your comments to Andra Morrison at andram@cadth.ca.

In Memoriam: Dr. Jill M. Sanders

We regret to announce that Dr. Jill M. Sanders, President and CEO of the Canadian Agency for Drugs and Technologies in Health (CADTH), died peacefully in hospital on February 15th, 2010, following a six-month battle with cancer.

Dr. Sanders was appointed President and CEO in 1997. She led the transformation of CADTH from a small office into an agency with a national and international reputation for quality. CADTH now has a significant and growing impact on the quality and sustainability of health care in Canada.

Dr. Sanders' strength was an inspiration to everyone she met. Her vision for the organization continues because of the solid foundation she put into place.

In lieu of flowers, donations in memory of Dr. Sanders may be made to The Ottawa Hospital's Bone Marrow Transplant Unit. Please call (613) 761-4295 to make a contribution. You can also download a donation form and fax it to (613) 761-5014 or make a secure online donation.

HTA in Hospitals

The use of hospital-based health technology assessment (HTA) is growing in Canada. The desire for evidence-based decision-making and the need to sustain hospital budgets have created a demand for information on the efficacy, safety, costs, ethical, legal, and operational issues in the adoption of technologies. Hospital-based HTA, due to its proximity to the decision-maker and collaborative approach, has been shown to influence health policy and clinical practice.[1]

In Quebec, hospital-based HTA is well-established within the network of five university hospital centres, and is now expanding at other university institutes and affiliated university centres (Table 1). Cardiac and rehabilitation centres in Montreal and Quebec are establishing HTA units. An HTA unit also exists at l'Hôpital du Sacré-Coeur de Montréal. A group of five health and social services centres — which are multidisciplinary institutions operating local community service centres, residential and long-term care centres, and may include general and specialized hospital centres — have formed a consortium (Consortium pour l'évaluation des technologies et des modes d'intervention en santé et services sociaux or CETMISSS) to share resources to promote HTA, provide training to managers and health care professionals, and to undertake HTA projects on topics related to primary care.

The mandate of Quebec's university hospital HTA units are to conduct rigorous evaluations of medical devices, treatments, or delivery of health care services, and to develop policy recommendations relevant to their organizational context.[2,3] They are also involved in the training of researchers in evaluative methods, promoting a culture of evaluation, fostering networks, and disseminating knowledge. The units' scientific staff work in collaboration with the institutions' managers and health professionals throughout the evaluation process, from the selection and prioritization of topics, to collection and interpretation of evidence and the development of policy recommendations.[2,3] The HTA units are linked by various networks that encourage collaboration between researchers at the regional and provincial levels. For example, the CETMISSS is situated in the integrated university health network of the Université Laval and collaborates with the HTA unit of the Centre hospitalier universitaire de Québec (CHUQ). Leadership and support is also provided by the Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS). Funding to support HTA activities within Quebec's health care centres has been allocated from within existing institutional operational budgets, with no additional sources of funding.

The HTA units have had a substantial impact on local policy decisions. Between 2002 and 2007, the policy recommendations of 25 of 27 reports produced by the McGill University Health Centre (MUHC) technology assessment unit have been accepted and incorporated into

hospital policy.[4] Rejection or limited acceptance of 19 technologies resulted in an estimated savings of C$12.8 million, and adoption of six new technologies increased expenditures by C$1.0 million.[4] Operating costs for the technology assessment unit totalled $1.2 million over the five-year period.[4] The HTA unit at CHUQ reported high satisfaction with the technology assessment process among clinicians who requested an assessment or were involved in a working group.[5] The clinicians also reported that the evaluations made an impact on their practice. Sixty-nine per cent of recommendations from two reports were accepted resulting in annual cost savings of $460,000.[5] The MUHC HTA unit reported that the evaluations were completed within three to four months.[1] Success of the program was related to the timeliness, relevance to local decision-makers, and the formulation of policy that reflected the community's values.[1]

Alberta is in the process of enhancing the provincial program for technology assessment. The amalgamation of the province's nine health regions, mental health, cancer, addictions, and emergency medical services into one health care delivery entity, Alberta Health Services, has created an opportunity for an integrated approach encompassing the spectrum of care. In collaboration with Alberta Health and Wellness, Alberta Health Services is developing the Health Technology Assessment and Innovation (HTAI) program that will encourage the use of health technology assessments to make decisions at an operational level. The HTAI program will complement the provincial government's Alberta Health Technologies Decision Process, which evaluates and approves technologies that require provincial or national review.

The HTAI program's goals are to stimulate the uptake of innovative technologies with proven clinical and cost-effectiveness, explore opportunities to support access to technologies through evidence development, and discourage the use of obsolete or proven ineffective technologies. The program will evaluate technologies — excluding drugs and information systems — used in health promotion, disease prevention, screening, diagnosis, therapy, rehabilitation, and end-of-life care. The proposed process will include identification and prioritization of technologies, commissioning the production of assessments, incorporation of contextual conditions, development of recommendations, and submission to the Alberta Health Services' budgetary and decision-making process. The process will also include evaluating the impact of approved technologies and whether or not they achieved the results intended. The program will build on the existing expertise in HTA available in Alberta, including hospital-based units in Calgary and Edmonton, as well as the Institute of Health Economics, the University of Calgary, and the University

TABLE 1: Hospital-Based HTA Programs

Alberta
Health Technology Assessment and Innovation (HTAi) Program, Alberta Health Services
Ontario
London Health Sciences Centre
SickKids Hospital (http://pede.ccb.sickkids.ca/pede/task.jsp)
Quebec — University Hospital Centres
Centre hospitalier de l'Université de Montréal (CHUM) (http://www.chumtl.qc.ca/notre-equipe/directions/detmis.fr.html)
Centre hospitalier universitaire de Sherbrooke (CHUS) (http://www.chus.qc.ca/fr/general/gen_informationnelles.asp#etmis)
Centre hospitalier universitaire de Québec (CHUQ) (http://www.chuq.qc.ca/fr/evaluation/uetmis/evaluation_uetmis.htm)
Centre hospitalier universitaire Sainte-Justine (CHU Sainte-Justine) (http://www.chu-sainte-justine.org/Pro/micro-portails.aspx?AxeID=16)
McGill University Health Centre (MUHC) (http://www.mcgill.ca/tau/)
Quebec — Other Institutions With HTA Activities
Hôpital du Sacré-Coeur de Montréal (http://www.hscm.ca/evaluation-des-technologies-et-des-modes-dintervention-en-sante/index.html)
Montreal Heart Institute/Institut de Cardiologie de Montréal
Lindsay Rehabilitation Hospital /Institut de réadaptation Gingras-Lindsay-de-Montréal (http://www.hopital-lindsay.qc.ca/)
Institut de réadaptation en déficience physique de Québec
Consortium pour l'évaluation des technologies et des modes d'intervention en santé et services sociaux (CETMISSS)

of Alberta. Development and implementation of the HTAI Program is planned for 2010-2011.

Ontario has two groups undertaking hospital-based HTA — the High Impact Technology Evaluation Centre (HiTEC) at the London Health Sciences Centre and Technology Assessment at SickKids (TASK), a research institute-based unit at Toronto's Hospital for Sick Children (SickKids).[6] TASK is funded mainly by research grants, and conducts methodological research and economic evaluations in pediatrics, in addition to HTA. It undertakes HTA activities based on consultation with hospital administrators and clinicians.

At other institutions without a formal technology assessment unit, HTA is nonetheless incorporated into technology decisions. For example, Vancouver General Hospital is in the process of standardizing the equipment and products used in surgical services. Working in collaboration with surgeons and administrators, the hospital is developing a standardized process to reduce the number and variety of products purchased, and has incorporated evidence review into its decision-making. HTA is used to addressing budget pressures without sacrificing quality of care.

Reports produced by hospital-based HTA units are often available on their units' websites and some are indexed in the Centre for Reviews and Dissemination database (http://www.crd.york.ac.uk/crdweb/).

References

1. McGregor M, et al. *Int J Technol Assess Health Care* 2005; 21(2):263-267.
2. What is the Technology Assessment Unit? McGill Technology Assessment Unit, MUHC 2010. http://www.mcgill.ca/tau/objective/.
3. Mission. Centre hospitalier universitaire de Québec. http://www.chuq.qc.ca/fr/evaluation/uetmis/mission/.
4. Arnoldo J, et al. *Impact of TAU reports*. McGill Technology Assessment Unit, MUHC 2008. http://www.mcgill.ca/files/tau/FINAL_TAU_IMPACT_REPORT_FEB_2008.pdf.
5. Annual report 2008-2009. Centre hospitalier universitaire de Québec 2010. http://www.chuq.qc.ca/NR/rdonlyres/8EC83C28-401A-4BD5-9AF6-317B72E218F1/0/rapport_annuel_uetmis_2008_2009.pdf.
6. Battista RN, et al. *Int J Technol Assess Health Care*. 2009 Jul;25 Suppl 1:53-60.

CADTH's Common Drug Review in the Yukon

CADTH's Common Drug Review (CDR) provides clinical and pharmacoeconomic evaluations and recommendations that are used by formularies when making decisions to approve drugs.

Jurisdictional drug plans are not obliged to adhere to CDR's recommendations as local priorities, resources, and the precedence of previous formulary decisions must be considered. In reality, however, the participating public drug plans use CDR's recommendations to guide their decisions more than 90% of the time.[1]

In jurisdictions with small populations that have limited resources for expert committees to do drug evaluations, CDR's national process offers reassurance that jurisdictional coverage decisions are based on the same clinical and economic assessments. According to Dianne Tait, the Manager of Pharmaceutical and Extended Benefits Programs for the Yukon,

"The CDR process has helped to better align the provincial and territorial formularies."

In the Yukon, prior to the launch of CDR, the Yukon Formulary Working Group (YFWG) looked to the Saskatchewan Formulary when making drug coverage decisions. From 2003 on, the YFWG listing decisions have been made with consideration given to CDR recommendations. Tait also noted that it is beneficial to be able to direct Yukon physicians, pharmacists, and residents to the CADTH website to read CDR recommendations.

CDR was established in 2002 by federal and jurisdictional health ministries in an effort to avoid duplication of drug assessments, improve the quality and consistency of the review process, and to harmonize the pan-Canadian differences in drug coverage. Ever since its launch, CDR has received 197 drug submissions, 149 of which have received final recommendations and 21 of which are currently being reviewed.

Reference

1. Tierney M, et al. *CMAJ* 2008;178(4).

CADTH Recommendations on Self-Monitoring of Blood Glucose Using Test Strips

If CADTH's recent recommendations on self-monitoring of blood glucose (SMBG) using test strips became the practice in Canada, health outcomes for those living with diabetes would not be compromised, while over $150 million annually could be redirected to other priorities. This is important when considering the best way to support good health for people with diabetes and how best to use our finite health care resources.

So what does the evidence say? Recent research focusing on the use of test strips that measure blood glucose in people with diabetes has revealed — what may be to some — surprising results. The analysis included all applicable evidence to find out if and how often people with diabetes should be testing their blood glucose.

The findings indicate that, generally, most people with type 2 diabetes do not have to test as often as they do now. For example, most patients with type 2 diabetes not taking insulin and treated by diet and/or drugs taken orally do not require routine self-monitoring of their blood glucose.

However, the use of test strips among these patients is routine in Canada; it accounts for over 50% of the expenditure on test strips. Total spending in Canadian publicly and privately funded drug plans exceeds $330 million annually. In fact, in many public drug plans, the cost of test strips falls into the top five classes on which we spend the most.

In addition to the release of recommendations and intervention tools to support the optimal practice of SMBG, CADTH also published an article in the December 21, 2009 issue of the Canadian Medical Association Journal *CMAJ* entitled "Cost-Effectiveness of Self-Monitoring of Blood Glucose in Patients with Type 2 Diabetes Mellitus Managed Without Insulin."

For additional information on SMBG, please contact the CADTH Liaison Officer for your jurisdiction. To find out how, go to www.cadth.ca. Detailed reports and tools are available online at www.cadth.ca/smbg.

Providing Conditional Access to Technology

The terms "coverage with evidence development," "only in research," "pragmatic trials," "policy trials," "comparative effectiveness research," "field evaluation," and "real-time monitoring" have been used in various international contexts to describe the action of a health care administrator or steward to provide access to or funding of (i.e., conditionally approve) a technology only in the context of further evaluation. The term "access with evidence development" (AED) has been more recently proposed as an umbrella term for these evidence development approaches.[1]

Collecting further evidence has a strong theoretical basis, in that the value of collecting further evidence can be compared against the value of the opportunity costs from making incorrect decisions under uncertainty.[2] Similarly, reimbursement decisions could lead to reduced investigation and further data collection in the future, as both market access and third-party payer reimbursement are overcome by the organization who has commercialized the new technology, leaving fewer incentives to collect further evidence.[3] As such, the opportunity losses from adoption must be weighed against the opportunity losses from rejection and more research.

Based on a recently-held summit of leaders in technology management and evidence collection in Banff, Menon et al. have published a consensus statement of key principles for policy-makers and researchers who want to undertake this approach.[1] Among other things, the authors suggest that decision problems require clear articulation and that the governance of these activities "should not be in the hands of any party that would have a vested interest in any decision that might result from the particular AED."[1]

References

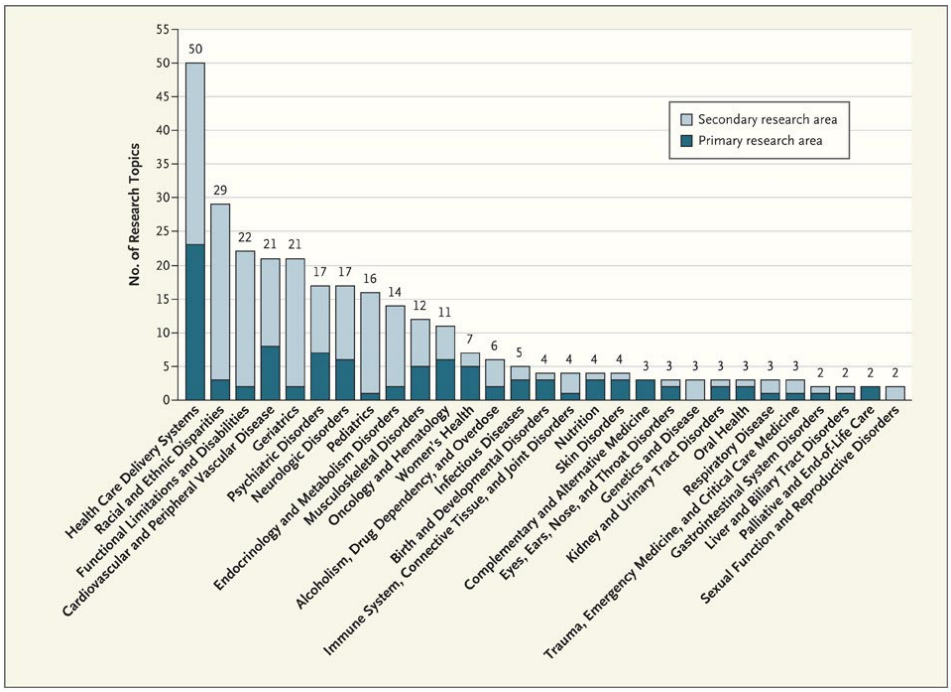
1. Menon D, et al. *Pharmacoeconomics* 2010; 28(2): 109-111.
2. Ades AE, et al. *Med Dec Making* 2004;24:207-27.
3. Philips et al. The Half-Life of Truth: What Are Appropriate Time Horizons for Research Decisions? *Med Decis Making*. 2008; 28: 287-299.

National Priorities for Research Topics in the United States

The US Institute of Medicine (IOM) was recently tasked with developing a list of 100 national health priority topics. The request came from the US Congress as part of a $1.1 billion funding initiative to improve the delivery of health care through comparative effectiveness research.

The report provided impartial recommendations, informed by extensive public engagement, on national priorities for research. The report also provided advice on how to spend the $400 million specifically allocated by Congress to invest in comparative effectiveness research.

FIGURE 1: Priority Topics



Source: Initial National Priorities for Comparative Effectiveness Research. US Institute of Medicine, 2009.

The 100 health priorities selected by the IOM were based on input from clinicians, policy-makers, the public, and others. Criteria were developed to assess the relevance of the topics suggested by stakeholders. The criteria included potential impact (based on prevalence of condition, burden of disease, variability in outcomes, and cost of care), potential to evaluate comparative effectiveness in diverse populations and patient subpopulations, uncertainty within the clinical and public health communities regarding management decisions, a need or gap addressed that was unlikely to be addressed through other funding mechanisms, and potential for multiplicative effect (e.g., lays foundation for future comparative effectiveness research or generates additional investment outside government).

The selected topics relate to a range of diseases, research methodologies, and care models. The priority list includes 29 research areas (see Figure 1) affecting a broad range of ages and population groups. Randomized controlled trials were recommended as the most appropriate method of generating evidence for 49 of the 100 research priorities. Observational research, literature reviews, and database registries were also recognized as potential study methods.

Emerging Technologies in Infection Control

A New Technology Promotes Hand Hygiene Accountability

Handwashing is believed to be the most effective method of reducing the spread of hospital-acquired infections. Yet many studies have shown poor hand hygiene compliance by health care workers.[1]

A new compliance monitoring device can detect whether or not hospital staff have followed handwashing protocols before making contact with patients. Sensors in the device verify that caregivers have washed their hands when entering a patient's room. If the caregivers have not used adequate hand hygiene, badges worn by them gently vibrate, reminding them to follow handwashing guidelines.

The technology, known as HyGreen, also collects and reports the frequency, time, and location of handwashing in a centralized database. This data alerts the hospital administration to staff compliance rates with hospital hand hygiene protocols.

Reference

1. Erasmus V, et al. *Infect Control Hosp Epidemiology* 2010;31(3).

Post-surgery Infection Control Techniques

A recent study suggests that pre-surgical preparation of a patient's skin with a chlorhexidine alcohol mixture is more effective at reducing post-surgical site infections than cleaning the skin with the standard preoperative surgical scrub.

In a multicenter randomized study involving 849 patients undergoing clean-contamination surgery, the chlorhexidine alcohol mixture was compared with povidone-iodine.

The study found that surgical site infections were more than 40% less common in the chlorhexidine group than in the povidone-iodine group.[1]

Another recent study looked at minimizing health-care acquired *Staphylocccus aureus* in patients identified as nasal carriers of the infectious agent. A group of 917 patients who had undergone surgery that was expected to keep them in hospital for a minimum of four days were randomized to treatment with nasal decolonization with mupirocin and chlorhexidine baths or a placebo procedure. Patients treated in the mupirocin/chlorhexidine group were 60% less likely to experience *Staphyloccus* infection than those given the placebo, and their average hospital stay was cut by two days.

References

1. Darouiche RO, et al. *NEJM* 2010;362:18-26.
2. Bode L, et al. *NEJM* 2010;362:9-17.

New Generation of Whole Room Decontamination Devices

A new generation of whole room decontamination (WRD) systems, developed for use in enclosed rooms, provides an effective strategy to control airborne and surface pathogens, including viruses, bacteria, and spores.

Developed as alternatives to conventional chemical surface and other cleaning methods, WRD reduces or eliminates the need for chemical cleaners and the toxic residu they leave. While conventional cleaning leaves many important surfaces untouched and relies on the diligence of cleaning staff, WRD ozone vapors penetrate all surfaces in a room (bed, walls, ceiling, etc.) and the air itself.

Older WRD technologies require significant staff training to operate the units. They also use vapours that require hours to dissipate before a room can be reused. A new WRD unit, developed by Meditrox, claims to kill 99.9% of hospital-acquired infections within an hour and does not require a high level of training to operate the system.

Reference

1. Meditrox receives positive toxicology opinion from BIBRA: http://www.steritrox.co.uk/Default.aspx?tabid=142.

Adenosine Triphosphate Monitoring System

A new hand-held swabbing system developed by 3M is being used in hospitals to determine if surfaces and equipment have been sufficiently cleaned. The device, Clean-Trace NG Luminometer, is used with adenosine triphosphate surface and water tests to determine the level of contamination in a sample. The presence of any level indicates the risk of microbial growth and the potential for the spread of infection.

The Clean-Trace NG Luminometer is intended to produce results within seconds and requires minimal skill to operate. The system is seen as an alternative to the current practice of visual assessment.

Reference

1. 3MClean-Trace NG Luminometer http://solutions.3m.com/wps/portal/3M/en_US/Microbiology/FoodSafety/product-information/product-catalog/?PC_7_RJH9U523003DC023S7P92O3O87_nid=994DWNJTD0beJ9C52DTHJWgl.

Research and Practice

These reports are available without cost at the websites below:

CADTH HTAs

📖 Clopidogrel versus Other Antiplatelet Agents in the Secondary Prevention of Vascular Events in Adults with Cerebrovascular Disease: Clinical and Cost-Effectiveness Analyses. CADTH, December 2009: http://www.cadth.ca/media/pdf/481_Clopidogrel_vs_Antiplatelet_Agents_tr_e.pdf

📖 Portable Monitoring Devices for Diagnosis of Obstructive Sleep Apnea at Home: Review of Accuracy, Cost-Effectiveness, Guidelines, and Coverage in Canada. CADTH, December 2009: http://www.cadth.ca/media/pdf/M0002_Portable_Monitoring_Devices_Obstructive_Sleep_Apnea_L3_e.pdf

HTAs from Other Organizations

📖 Sentinel Lymph Node Biopsy in Breast Cancer Treatment : Technical Aspects. AETMIS, 2009: http://www.aetmis.gouv.qc.ca/site/phpwcms_filestorage/2e5f616362f65d92be86e0bf742e9820.pdf

📖 Curative Treatment for Esophageal Cancer: Systematic Review of Neoadjuvant Therapy and Chemoradiotherapy Alone. AETMIS, 2009: http://www.aetmis.gouv.qc.ca/site/phpwcms_filestorage/16ada069623e528a0231f233ef1be99c.pdf

📖 Population-Based Smoking Cessation Strategies: A Summary of a Select Group of Evidence-Based Reviews. Ontario Medical Advisory Secretariat, Ministry of Health and Long-Term Care, 2010: http://www.health.gov.on.ca/english/providers/program/mas/tech/reviews/pdf/rev_smoking_20100114.pdf

📖 Airway Clearance Devices for Cystic Fibrosis: An Evidence-Based Analysis. Ontario Medical Advisory Secretariat, Ministry of Health and Long-Term Care, 2009: http://www.health.gov.on.ca/english/providers/program/mas/tech/reviews/pdf/rev_airway_20091201.pdf

📖 Ultraviolet Phototherapy Management of Moderate-to-Severe Psoriasis: An Evidence-Based Analysis. Ontario Medical Advisory Secretariat, Ministry of Health and Long-Term Care, 2009: http://www.health.gov.on.ca/english/providers/program/mas/tech/reviews/pdf/rev_uv_photo_20091201.pdf

New Canadian Practice Guidelines

📖 Extended-Release Medications for Children and Adolescents with Attention-Deficit Hyperactivity Disorder. Canadian Paediatric Society, November 2009: http://www.cps.ca/english/statements/CP/CP09-04.pdf

📖 Family-Based Treatment of Children and Adolescents with Anorexia Nervosa: Guidelines for the Community Physician. Canadian Paediatric Society, January 2010: http://www.cps.ca/english/statements/AM/AH10-01.pdf

📖 Gastroesophageal Reflux Disease — Clinical Approach in Adults. Guidelines & Protocols Advisory Committee. British Columbia Ministry of Health Services, December 2009: http://www.bcguidelines.ca/gpac/pdf/gastro.pdf

📖 Chronic Obstructive Pulmonary Disease (COPD): Guidelines & Protocols Advisory Committee. British Columbia Ministry of Health Services, December 2009: http://www.bcguidelines.ca/gpac/pdf/copd.pdf

📖 National Retinoblastoma Strategy Canadian Guidelines for Care. Canadian Ophthalmological Society, December 2009: http://article.pubs.nrc-cnrc.gc.ca/RPAS/rpv?hm=HInit&calyLang=eng&journal=cjo&volume=44&afpf=i09-194.pdf

📖 Osteoarthritis in Peripheral Joints — Diagnosis and Treatment. Guidelines & Protocols Advisory Committee. British Columbia Ministry of Health Services, December 2009: http://www.bcguidelines.ca/gpac/pdf/oa.pdf

📖 Cardiac Risk Assessment Before the Use of Stimulant Medications in Children and Youth. Canadian Paediatric Society, November 2009: http://www.cps.ca/English/statements/PP/CPS09-02.pdf

📖 2009 Canadian Cardiovascular Society/Canadian Guidelines for the Diagnosis and Treatment of Dyslipidemia and Prevention of Cardiovascular Disease in the Adult — 2009 Recommendations. *Canadian Journal of Cardiology*, October 2009: http://www.ccs.ca/download/consensus_conference/consensus_conference_archives/2009_Dyslipidemia-Guidelines.pdf

📖 A New Meningococcal Conjugate Vaccine: What Should Physicians Know and Do? Canadian Paediatric Society, October 2009: http://www.cps.ca/english/statements/ID/ID09-02.pdf

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