The New England Comparative Effectiveness Public Advisory Council (CEPAC) ORIENTATION MANUAL 2012

Institute for Clinical and Economic Review
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Welcome

Mission and Purpose

Initially funded by a three-year grant from the federal Agency for Healthcare Research and Quality (AHRQ), and backed by a consortium of New England state policy makers, the mission of the New England Comparative Effectiveness Public Advisory Council (CEPAC) is to provide objective, independent guidance on how information from AHRQ evidence reviews can best be used across New England to improve the quality and value of health care services. Managed by the Institute for Clinical and Economic Review (ICER), based at the Massachusetts General Hospital’s Institute for Technology Assessment, CEPAC is tasked with aiding in the dissemination of federally-produced comparative effectiveness information. The mission is to produce actionable information to aid regional policymakers in the medical policy decision-making process.

Objective and Scope of Activities

CEPAC will review timely comparative effectiveness research; comment on its relevance for the six New England states; and aid in the dissemination of the information to policymakers and decision-makers throughout New England. The deliberations and decisions of CEPAC will be conducted in a public forum to ensure transparency and accountability to all stakeholders throughout the process.

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Congratulations

Welcome to the New England Comparative Effectiveness Public Advisory Council (CEPAC). Evidence from clinical studies are critical to judgments that patients, clinicians, and health care insurers must make about treatment choices and coverage policies. But often that evidence is complicated and hard to interpret. Who will weigh what the implications of the research findings are for individual patients, for clinicians, and for the entire health care system? Will physicians and the public have a voice in this process?

In New England, the answer is “yes.” CEPAC brings together expert clinicians and public representatives from all six New England states to debate how best to interpret and apply medical evidence to practice and policy. Through CEPAC, we hope to serve as a national model for how the public can become more engaged in grappling with the difficult issues raised by the intersection of innovation, evidence, and sustainability.

The caliber and stature of the members of this group is a testament to the importance of engagement from clinicians and the public in today’s health care system. Your unique experience and perspective is fundamental to CEPAC’s success. Thank you for being part of the solution.

Steven D. Pearson
President
Institute for Clinical and Economic Review

New England Comparative Effectiveness Public Advisory Council
Meeting Guide

CEPAC convenes twice a year in locations across New England to review and deliberate on supplementary comparative effectiveness reports completed and presented by ICER. This guide provides an overview of the meeting participants, agenda, and voting.

Meeting Participants

**CEPAC Voting Members:** Voting members of the council consist of practicing clinicians, methodologists, and patient/public members appointed by the Institute for Clinical and Economic Review (ICER). Meetings are moderated by the Chair of CEPAC, or in his or her absence, the Vice Chair or other CEPAC member selected by ICER.

**CEPAC Ex-Officio Members:** Two (2) ex-officio members are appointed by ICER to offer the perspective of private and public payers. Ex-officio members will participate fully in discussions and deliberations, but do not vote.

**ICER Staff:** Staff from ICER participates in each meeting by presenting supplementary comparative effectiveness reports based on comparative effectiveness reviews from the Agency for Healthcare Research and Quality (AHRQ) and answering any questions from the council.

**Roundtable panelists:** ICER will invite key stakeholders to participate in the roundtable discussion following the voting. Stakeholders seated at the roundtable may represent the payer, patient, and the clinical communities, and will be selected on the basis of their expertise in the relevant subject matter and by recommendations from the CEPAC Advisory Board and relevant professional societies.

**Public:** Members of the public are invited to attend every CEPAC meeting and are given the opportunity to make public comments, according to the guidelines detailed in the Public Comment Guide. Advance registration is required by all attendees.

Typical Agenda

**Meeting Convened and Introduction:** The Chair calls the meeting to order and conducts any regular business and council members, ex-officio members and other meeting participants introduce themselves. [*Approximately 15 minutes]*

**Adaptation Presentation:** ICER staff presents the supplementary comparative effectiveness review to the AHRQ report [*Approximately 30 minutes]*

**Q&A with ICER Staff:** CEPAC members pose questions regarding the supplementary report to ICER staff and the Chair facilitates discussion. [*Approximately 30 minutes]*

**Public Comment:** Members of the public comment on the adaptation. [*Limited to 5 minutes per person and 30 minutes total]*

*Lunch [30 minutes]*

**Deliberation on Questions:** CEPAC discusses the questions surrounding the supplementary report. Votes on each question will be taken and recorded. [*Approximately 1 hour]*
**Roundtable Discussion:** CEPAC discusses and debates the implications of the votes with relevant stakeholder groups, highlighting key avenues for implementation of the evidence. *Approximately 1.5 hours*

**Voting**

Each public meeting of CEPAC involves deliberation and voting on key questions related to the supplementary AHRQ report being presented by ICER. Members of CEPAC discuss issues regarding the application of the available evidence to guide clinical decision-making and payer policies. The key questions are developed by ICER with significant input from members of the CEPAC Advisory Board to ensure that the questions are framed to address the issues most important in applying the evidence to practice and medical policy decisions.

**Categories of Questions**

Discussion and voting will highlight the following issues:

1. The evidence on risks and benefits to determine the *comparative* clinical effectiveness of management options for specific patient populations. In judging comparative clinical effectiveness, there are two interrelated questions: the relative magnitude of differences in risks and benefits; and the relative confidence that the body of evidence can provide in the accuracy of estimates of risks and benefits. Considering these two issues together is required in order to make a judgment of whether the evidence is “adequate” to demonstrate that one intervention is as good as or better than another.
2. Issues related to individual patient preferences and values, provider training, volume, or other factors that should be considered in judging the evidence on clinical effectiveness and value.
3. Weighing the evidence on cost-effectiveness and projected budgetary impact to determine the comparative value of various management options for key patient populations.
4. Comments or recommendations related to broader considerations of public health, equity, disparities, and access.

**Sample Questions**

**Comparative clinical effectiveness**

Given a health care “intervention A” for “patients with condition X,” we will compare its clinical effectiveness for these patients to that of a “comparator B” by voting on the following question:

*Is the evidence on risks and benefits “adequate” to demonstrate that “intervention A” is as good or better for “patients with condition X” than “comparator B”?

**Comparative value**

When a majority of CEPAC votes that the evidence is adequate to demonstrate that an intervention produces patient outcomes as good as or better than a comparator, the Council will also be asked to vote on whether the intervention represents a “high,” “reasonable,” or “low” value. The value “perspective” that CEPAC will be asked to assume is that of a state Medicaid program that must make resource decisions within a fixed budget for care. While information about hypothetical budget tradeoffs will be provided, CEPAC will not be given prescribed boundaries or thresholds for budget impact or incremental cost-effectiveness ratios to guide its judgment of high, reasonable, or low value.

*At the reimbursement rates assumed in this analysis, does the evidence suggest that the comparative value of Intervention X compared to Intervention Y is: 1) high value; 2) comparable value; or 3) low value for the following patient populations:*

- Population X (e.g. younger, healthy)?
- Population Y (e.g. older, multiple comorbidities)?
Meeting Preparation

Literature:
The topics of CEPAC meetings are selected from recently completed AHRQ comparative effectiveness reviews. ICER prepares a summary of key AHRQ review findings and also completes additional analyses to provide further context and to tailor the information for the deliberation and voting by CEPAC on the overall comparative clinical effectiveness and value of different health care interventions. ICER’s supplementary report as well as full PDF copies of the original AHRQ review and executive summary will be sent to CEPAC members in advance of the meeting and posted publicly. Before each meeting, ICER will organize a call/webinar with clinical experts to discuss their perspectives on the AHRQ review and on the various management options for the condition being reviewed. These discussions are held before the in-person meeting to ensure that CEPAC members enter the meeting with an understanding of the important clinical issues.

Training Calls and Webinars:
ICER offers optional training calls/webinars for CEPAC members on economic analysis, the basics of systematic review methodology, and medical policymaking for those CEPAC members who desire additional training.

Resources:
In addition to training calls/webinars, ICER will provide a list of online comparative effectiveness research (CER) training courses designed to help consumer advocates and decision makers better understand the fundamentals of CER.
FAQ

Will I be reimbursed for serving on CEPAC?
All voting members of CEPAC receive honoraria of $500 for their participation in each CEPAC meeting. Additionally, travel expenses for attending CEPAC meetings will be reimbursed for all members.

My term will expire this year. Can I re-apply to serve on next year’s council?
No council member shall serve more than two consecutive three-year terms. After a one-year absence, former council members are eligible to serve on CEPAC again. Excluding ex-officio members, CEPAC will consist of between 16-18 members each year.

How are meeting topics selected?
All CEPAC meeting topics are drawn from recently or soon-to-be completed comparative effectiveness reviews from the Agency for Healthcare Research and Quality (AHRQ). ICER works closely with the CEPAC Advisory Board to evaluate potential topics for review, basing its ultimate decision on the following criteria:

1. Topics of increasing significance to the public by virtue of prevalence, severity, and cost
2. Substantial opportunity to improve health outcomes by applying best evidence
3. Wide variation in utilization with substantial uncertainty over appropriate use
4. Variation in coverage policies across New England
5. Potentially overused or underused tests and treatments with significant public health or health system impact, especially when less expensive alternative options are available
6. Emerging treatments with potentially large eligible patient populations, especially when less expensive alternatives are available
7. Topics for which the AHRQ review suggests actionable results, presenting an opportunity to spur positive changes in existing clinical practice patterns

I am a patient/public representative, and am unfamiliar with the topics being discussed at CEPAC meetings. How can I be most helpful to this group?
Members of CEPAC approach meetings with a variety of experiences and perspectives. No member is chosen on the basis of his or her expertise in any particular topic, but rather on his or her ability to assess and provide judgment on comparative evidence.

For some members of the patient/public representative group, it can be challenging to feel like they are participating in meetings at the same level as a clinician or methodologist with more experience specific to the topics of CEPAC meetings. However, patient and public representatives are of equal importance to CEPAC and bring an invaluable perspective of patient experience to CEPAC meetings. Patient/public representatives have crucial expertise in translating health care quality information to patients and the general public and ensuring that the output of CEPAC meetings remains relevant to these communities.

In order to help members feel more prepared for CEPAC meetings, council members are provided with a list of training resources and calls designed to help members become more acquainted with the fundamentals of cost-effectiveness analysis and comparative-effectiveness research.

ICER staff is also available to answer any questions or concerns (sjreed@icer-review.org).

What does my vote mean?
When a council member votes during a CEPAC meeting, he or she is voting on the comparative effectiveness, and when applicable, the comparative value, of various management options for key patient populations. Votes are based on each council member’s judgment of the evidence provided to him or her as part of the meeting. Votes should reflect each council member’s perspective and not that of his or her employer.
Council members will not vote on specific questions related to broader considerations of provider training, volume, outcomes, health system impact, etc., but will be given the opportunity to bring up important issues for consideration and provide their rationale and justifications for each vote, which will be provided as part of the final meeting report.

CEPAC votes and comments during the roundtable do not serve as formal recommendations for specific policies. Rather, CEPAC votes contribute to the existing evidence base by providing judgments from an independent body and serve as leverage for the implementation of comparative effectiveness research in policy and practice throughout New England.

How are the votes and deliberations of CEPAC used?
CEPAC votes and deliberation are used to inform subsequent implementation of the evidence with the goal of promoting evidence-based policies. After CEPAC votes, the council will engage with key stakeholder groups, including clinical experts, patient/public representatives, and public and private payers in a roundtable discussion to answer questions related to possible applications of the evidence, based on CEPAC’s deliberation and final votes.

The final meeting report will include a meeting summary that captures CEPAC’s votes, deliberation of the evidence, key questions and concerns from council members relating to the evidence and its application in future or current policies, and fundamental points made during the roundtable discussion. This summary will form the basis for the key suggestions and recommendations that come out of the meeting, and that ICER will use when working with the CEPAC Advisory Board to help develop specific medical or coverage policies, such as tiered co-payments, prior authorization, etc. CEPAC votes and deliberation are not designed to lead to prescriptive recommendations, but rather to add to the existing evidence base within a given treatment category and help support dissemination efforts across New England.

For example, the Medicare contractor for most of New England, NHIC Corp, cited the CEPAC meeting and votes on nonpharmacologic interventions for treatment-resistant depression as part of its justification for reversing its non-coverage policy for repetitive transcranial magnetic stimulation (rTMS) for patients with resistant depression.

How are CEPAC members chosen?
Members of CEPAC are chosen based on their training and experience in evidence-based medicine and relevant fields, including clinical epidemiology; health economics; health services research; public health; biostatistics; medical quality management; health system planning and evaluation; cost-effectiveness analysis; decision sciences; healthcare access; and bioethics.

In order to serve on CEPAC, nominees must be a clinician, methodologist, or patient/public representative (such as patient advocates or health policy experts) working in a New England state. At least two members must represent each New England state.

Two representatives will be selected to serve as ex-officio payer representatives.

CEPAC members should also represent diversity on many levels, including diversity of thought, belief, race, ethnicity, geographic location, gender and culture.
Council Members

2012 Iteration

Richard Lopez, MD
(Chair)
Atrius Health

Claudia Gruss, MD, FACP, FACG, CNSP
(Vice Chair)
Arbor Medical Group, LLC

Ellen Andrews, PhD
Connecticut Health Policy Project

Robert H. Aseltine, Jr., PhD
University of Connecticut

R. William Corwin, MD
Miriam Hospital

D. Joshua Cutler, MD
MaineHealth
Maine Heart Center

Charles B. Eaton, MD, MS
Brown University
Memorial Hospital

Teresa Fama, MD, MS
Central Vermont Medical Center

Austin Frakt, PhD
Boston University
HCFE, VA Boston HCS

Felix Hernandez, MD, MMM
Eastern Maine Medical Center

Christopher Jones, PhD, MSc
University of Vermont Medical School

William Cyrus Jordan, MD, MPH
University of Vermont Medical School
Vermont Medical Society's Foundation for Research and Education

Joseph Kozachek, MD
(Ex-officio)
Aetna

Lori Nerbonne, RN, BSN
NH Patient Voices

Sandhya Rao, MD
Massachusetts General Hospital

Roger Snow, MD
(Ex-officio)
Commonwealth of Massachusetts, Office of Medicaid

Keith Stahl, MD, FACP
Family Health and Wellness Center at Bedford, NH

Mitchell Stein, MBA
Consumers for Affordable Health Care

William Taylor, MD
Harvard Medical School
Ellen Andrews, PhD
(Two-Year Term)
Ellen Andrews has been Executive Director of the Connecticut Health Policy Project (www.cthealthpolicy.org) from its inception in 1999. The Project is a non-partisan, non-profit organization working to improve affordable, quality health care for every Connecticut resident. The Project publishes regular policymaker issue briefs, conducts research on Connecticut health policy needs, hosts issue briefings at the Capitol and webinars with health care experts, coordinates a multi-state Health Policy Steering Committee for the Council of State Governments/Eastern Region, publishes Connecticut Health Notes, a bi-weekly electronic newsletter of timely health care issues in Connecticut, and the Connecticut Health Notes blog with updates on state health policy (www.cthealthblog.org). The Project also hosts the Consumer Health Action Network (www.cthealthconsumer.org), providing a statewide toll-free helpline assisting any Connecticut consumer with difficulty obtaining needed health care services or coverage. Ms. Andrews serves on over a dozen regional, state and local health policy committees, councils and boards. Ms. Andrews’ prior experience includes positions as Connecticut state legislative staff on health policy, non-profit health care advocacy, prenatal educator at a New Haven community health center, and academic teaching and research. She holds a PhD in Human Genetics from Yale University where she is on the faculty in the School of Nursing.

Robert H. Aseltine, Jr., PhD
(Three-Year Term)
Robert H. Aseltine, Jr., PhD is Professor in the Division of Behavioral Sciences and Community Health at the University of Connecticut Health Center, Deputy Director of the Center for Public Health and Health Policy and Director of the Institute for Public Health Research at the University of Connecticut. He is also the founding Director of the Connecticut Health Information Network, a federated network linking disparate health and human services databases maintained by Connecticut’s state agencies. Dr. Aseltine is a medical sociologist whose diverse research interests include adolescent mental health and social development, community-based risk prevention, and the development of innovative public health and medical information systems. He has expertise in quantitative research methods and statistics, particularly in designing large-scale population surveys and program evaluations. Over the past 20 years Dr. Aseltine has lead a number of studies investigating mental health and substance abuse funded by the National Institute of Mental Health, the National Institute for Alcohol Abuse and Alcoholism, the Substance Abuse and Mental Health Services Administration, the William T. Grant Foundation, and the Connecticut Health Foundation. Dr. Aseltine received his BA from Wesleyan University and his PhD from the University of Michigan.

R. William Corwin, MD
(Three-Year Term)
Dr. Corwin is currently working as the Senior Vice President of Medical Affairs and Chief Medical Officer at the Miriam Hospital in Providence Rhode Island. He returned to this clinical/administrative role in December, 2007 after four years at Harvard Pilgrim Healthcare where he was the Medical Director for Medical Management and Clinical Policy for Harvard Pilgrim Health Care (the insurer). Prior to returning to HPHC, he managed a start up Hospitalist program for three years with a 60 physician group in Rhode Island. Dr. Corwin was born, raised, and educated in Ohio, graduating from Heidelberg College and The Ohio State University College of Medicine in 1973. His Internal Medicine and Pulmonary Training occurred at Rhode Island Hospital (Brown University Program) and included two years of Infectious Diseases at Emory University. He tried academics for a short six year period of time (at the University of Massachusetts Medical Center) at which time he realized that research at the basic science level was not his forte and abandoned it for a staff model pulmonary practice in Rhode Island at Rhode Island Group Health (RIGHA). In the late 80’s and early 90’s his career morphed into a management and administrative role as Rhode Island Group Health Association merged with Harvard Community Health Plan (staff and group model delivery system) which merged with Pilgrim Health Care (IPA model delivery system) to form Harvard Pilgrim Health Care. In 1999 HPHC closed its Rhode Island delivery system. In 2000 he briefly left the HPHC organization to return to full time practice as the Director of a Hospitalist program before rejoining HPHC in 2003. He continues to work as a Hospitalist at The Miriam Hospital on as needed basis.
D. Joshua Cutler, MD  
*(One-Year Term)*  
Dr. Cutler is a Medical Director in MaineHealth’s Clinical Integration section and Executive Director of the Maine Heart Center. He practiced clinical and interventional cardiology in Washington, D.C. and in Portland, Maine, until 2007, leaving to participate in the Baldacci administration’s Dirigo health reform programs. He was a member of the administration’s Commission to Study Maine’s Community Hospitals and the Advisory Council on Health Systems Development, responsible for development of the State Health Plan. From 2007 – 2010 Cutler was Director of the Dirigo Health Agency’s Maine Quality Forum, which reports on and promotes health care quality and safety. At MaineHealth and its member organization the Maine Heart Center, his work concentrates on accountable care organization development and readiness. He practices clinical cardiology in the VA Maine Healthcare System. He has held prior medical faculty positions at the University of Oregon, Georgetown University, and the University of Vermont.

Charles B. Eaton, MD, MS  
*(Two-Year Term)*  
Charles Eaton, MD, MS is Professor in the Department of Family Medicine and Epidemiology at the Alpert Medical School of Brown University. He also directs the Center for Primary Care and Prevention and the Heart Disease Prevention Center at Memorial Hospital of Rhode Island. Dr. Eaton has been continuously funded for the past 20 years as principal investigator on a variety of epidemiologic, translational research and clinical trials related to chronic diseases, cardiovascular risk factor reduction and quality improvement in primary care practice. He has published over 100 peer reviewed articles related to chronic disease epidemiology, primary and secondary prevention, quality improvement, e-health and evidence-based medicine. He is presently principal investigator of the NHLBI funded Women’s Health Initiative, NIAMS funded Osteoarthritis Initiative, NIDDK funded Tailored Lifestyle Intervention in Obese Adults within Primary Care Practice, and the AHRQ funded eHealth BP Control Program. Dr Eaton’s 30 years of clinical experience and background in primary care, twenty year experience in epidemiology and quality improvement and 10 year experience in e-health and its application to a patient centered medical home provide an important perspective for CEPAC’s proceedings.

Teresa Fama, MD, MS  
*(One-Year Term)*  
Dr. Teresa Fama is a practicing rheumatologist at Central Vermont Medical Center in Berlin, Vermont. She was appointed recently to the Advisory Committee of the Green Mountain Care Board, whose mission is to establish a single payer health care system in Vermont. Prior to completing her medical training, Dr. Fama was a health policy analyst and consultant in Washington, DC. She worked in private consulting at Abt Associates and Lewin/ICF, for the Prospective Payment Assessment Commission, and most recently as Deputy Director of The Robert Wood Johnson Foundation’s “Chronic Care Initiatives in HMOs” program. Dr. Fama completed her medical training at the University of Vermont including residency and fellowship training at Fletcher Allen Health Care in Burlington, Vermont. She completed undergraduate and graduate work at the University of Rochester in Rochester, New York with a BA in Political Science and MS in Public Policy Analysis.

Austin Frakt, Ph.D.  
*(One-Year Term)*  
Dr. Frakt is a health economist and assistant professor with the Boston University (BU) School of Medicine and the BU School of Public Health. His research interests include the interaction between economics and health care policy, with a focus on patient choice, insurer decision-making and their relations to health and market outcomes. Dr. Frakt has conducted research studies funded by the Robert Wood Johnson Foundation, the Department of Veterans Affairs, and the Agency for Healthcare Research and Quality. His work has been published in *Health Affairs, Journal of Health Politics, Policy and Law, Health Economics,* and most recently the *New England Journal of Medicine* and the *Milbank Quarterly.* In addition to peer-reviewed literature, Dr. Frakt writes for and manages the popular economics and health policy blog *The Incidental Economist.* Dr. Frakt received his Ph.D. from the Massachusetts Institute of Technology in statistical and applied mathematics. He also received a master’s degree from MIT, and his bachelor’s degree from Cornell University in Applied and Engineering Physics.
Claudia B. Gruss, MD, FACP, FACP, CNSP (Vice Chair)
(Two-Year Term)
Dr. Claudia Gruss is a gastroenterologist and internist and a partner in a multispeciality private practice group in Connecticut. She has an undergraduate degree and medical degree from Brown University. She did her internal medical residency and gastroenterology fellowship at Rhode Island Hospital in Providence, Rhode Island. She is board-certified in both internal medicine and gastroenterology and is a certified nutrition support clinician. She is a Fellow of the American College of Gastroenterology and a Fellow of the American College of Physicians. In her practice, she is responsible for the managed care and government quality improvement incentive programs. She also is a clinical educator for the Yale-affiliated gastroenterology fellowship program at Norwalk Hospital. Her other hospital administrative functions include Chair of the Gastro-intestinal Patient Care Evaluation Committee and Chair of the Nutrition and Diet Committee. Her roles in organized medicine include Chair of the Connecticut State Medical Society Quality of Care Committee and Vice President of the Connecticut State Medical Society. She is an alternate to the AMA Physician Consortium for Performance Improvement.

Felix Hernandez, MD, MMM
(Two-Year Term)
Felix Hernandez, MD, MMM is a cardiothoracic surgeon and Chief of Surgery at Eastern Maine Medical Center. He is a graduate of Fairfield University and the University of Connecticut School of Medicine. He completed his residency in General Surgery at Wayne State University and did his Cardiothoracic Residency at the Medical College of Wisconsin. He received his Masters in Medical Management from the Heinz School of Policy and Management at Carnegie Mellon University. He is an Assistant Clinical Professor of Surgery at the University of Vermont School of Medicine and the University of New England School of Osteopathic Medicine. He is a founding member of the Northern New England Cardiovascular Study Group and has been involved in outcomes research in cardiovascular medicine and surgery with that group for over 20 years.

Christopher Jones, PhD
(One-Year Term)
A native of Gilford, New Hampshire, Christopher Jones brings unique expertise to CEPAC. As assistant professor of surgery at the University of Vermont (UVM) College of Medicine, his present research focus is on using health information technology combined with incentives to attain cost-effective and cost-beneficial treatments for chronic disease. Dr. Jones also directs the Global Health Economics Unit in the UVM Center for Clinical and Translational Science, and teaches Health Economics in the UVM School of Business Administration. Educated at the University of Michigan (B.Sc. ’99) and University of Oxford (M.Sc. ’00; D.Phil. ’06), Dr. Jones worked for 5 years collaborating with the National Institute for Health and Clinical Excellence (NICE) in London where he served as health economist for the Royal Institute of Psychiatrists’ National Guideline Development Group on six U.K. mental health initiatives. From this experience he gained considerable familiarity with voucher-based incentive programs for treating substance misuse and changing health-related behaviors. Mental health treatments were the center of his work, but not his perimeter. His doctoral dissertation was the first to evaluate the cost-effectiveness of in vitro fertilization (IVF) at the population level, the presentation of which led to national policy changes. Prior to joining UVM in 2011, Dr. Jones worked in international finance and in industry, most recently as director of global health economics for a publicly traded pharmaceutical firm specializing in rare diseases.

William Cyrus Jordan, MD, MPH
(Three-Year Term)
Dr. Jordan is the Director of the Vermont Medical Society’s Foundation for Research and Education, a public-benefit corporation that promotes public good through research, education and quality improvement in the field of health. Dr. Jordan’s principal initial goals are to: 1) design solutions and recruit resources that solve problems identified by Vermont’s rural health care practitioners and their communities; and 2) promote value and science driven health care by facilitating the availability of premier analytic and evaluative resources to public policy decision makers at both the state and local levels. Dr. Jordan assumed his position at the Foundation after serving as the Medical Director of the Vermont Program for Quality in Health Care, Inc. for 17 years. Dr. Jordan is a graduate of Dartmouth College and the University Of Connecticut School Of Medicine. He completed both a residency in family medicine at the University of Vermont and a pediatric residency at Boston University. He received his Masters in Public Health from Harvard University. Prior to his career in quality measurement and improvement, Dr. Jordan practiced family medicine and pediatrics in inner city Boston and rural Vermont. Dr. Jordan served as chair of the board of directors of the Vermont Information Technology Leaders, Vermont’s HITECH Regional Extension Center from 2007-2009. He
currently serves on the board of the Vermont Manufacturing Extension Center, a federal and state partnership to promote production and service efficiencies in both the private and public sectors including state government, education and health care. He is on the faculty of the Department of Pediatrics at the University of Vermont College of Medicine and is a member of the University’s Center for Clinical and Translational Sciences.

Joseph Kozachek, MD (ex-officio)
(One-Year Term)
Dr. Kozachek is a graduate of CMDNJ-Rutgers Medical School and completed his residency in Internal Medicine at Hartford Hospital in Hartford, Connecticut. He practiced emergency medicine for 17 years in Connecticut and was Director of two emergency departments. He has served on multiple hospital committees and worked extensively with the EMS community, implementing paramedic coverage in Northeastern Connecticut. He was appointed to the State of Connecticut Trauma Committee and chaired the Prehospital Care subcommittee. He served on the Board of Directors and as the President of the Connecticut College of Emergency Physicians. He joined Aetna in 2001 in the Northeast Patient Management department. In 2006, he joined the Aetna Clinical Claims review unit, working extensively with claims and coding policy. In 2008, he joined Aetna Better Health-Connecticut, as the Senior Medical Director responsible for implementing a new unit and plan in the Medicaid Business unit. In 2009, he assumed the role of Chief Medical Officer for Aetna Better Health, CT. He returned to the Northeast Regional Care management area of Aetna in September of 2010 as the Senior Medical Director for New England. Dr. Kozachek has participated in multiple committees within and external to Aetna including working with the Aetna Clinical Policy Committee for over 10 years.

Richard Lopez, MD (Chair)
(One-Year Term)
Dr. Richard Lopez, a physician at Harvard Vanguard Medical Associates, was appointed Chief Medical Officer of Atrius Health in January 2009. In this position, Dr. Lopez works collaboratively with the Chief Medical Officers and Chief Executive Officers of the five Atrius Health medical groups across a wide range of clinical and quality initiatives. Specifically, Dr. Lopez’s focus includes clinical program and regional project development, clinical aspects of payer/provider contracting, clinical informatics, medical management, and safety and quality, as well as collaborating to develop quality standards and the outcome reporting measures and clinical dashboards that support the medical groups in meeting those standards. More than a 25-year veteran of Harvard Vanguard, Dr. Lopez has made many significant contributions to the organization and was recently the recipient of Harvard Vanguard’s Lifetime Achievement Award. Dr. Lopez received his medical degree from Boston University School of Medicine and completed his residency and internship at St. Elizabeth’s Hospital. Dr. Lopez received his Bachelor of Arts degree from Boston University and is a clinical instructor at Harvard Medical School. As a board certified internist, Dr. Lopez has practiced primary care internal medicine at Harvard Vanguard’s Medford practice since 1982. Dr. Lopez serves on several committees including the Performance Measurement Expert Panel of the Massachusetts Healthcare Quality and Cost Council and is a member of the Massachusetts Medical Society Committee on Quality of Medical Practice. In addition, Dr. Lopez is also on the Board of the Massachusetts Coalition for the Prevention of Medical Errors, chairs the New England Comparative Effectiveness Public Advisory Council (CEPAC) and was appointed to the Statewide Advisory Committee on Standard Quality Measure Sets.

Lori Nerbonne, RN, BSN
(Two-Year Term)
Lori began her work in patient safety in 2005 with her sister Kelly Grasso after their mother’s death in 2004 from hospital-acquired conditions and medical errors. In 2010, she co-founded NH Patient Voices (www.nhpatientvoices.org). She is a member of the NH Healthcare Associated Infection Advisory Committee, works collaboratively with Consumers Union Safe Patient Project as an advocate at the state and national level and has served on patient safety committees at the CDC and DHHS Office of Healthcare Quality. She has submitted proposals for and testified in support of several state patient safety laws, three of which have passed since 2006. Prior to her advocacy work, she was a maternal-child health nurse and educator in hospital and community health settings for sixteen years.

Sandhya Rao, MD
(Three-Year Term)
Sandhya Rao, MD, is an internist at Women’s Health Associates at Mass General and the Associate Medical Director for Quality Improvement at the Massachusetts General Physicians Organization (MGPO) where she coordinates pay-for-performance
initiatives and other quality improvement and incentive projects. She previously served as the team leader for Partners HealthCare High Performance Medicine Team 5, where she was instrumental in developing the Partners Clinical Process Improvement Leadership Program. Before becoming a physician, she worked as a business analyst in the New York office of McKinsey and Company, focusing on health care and finance engagements. She has also held internships at the American Public Health Association, the Center on Budget and Policy Priorities, and the Office of Senator Jack Reed. Rao earned a bachelor’s degree in community health from Brown University, where she graduated magna cum laude. She attended the New York University School of Medicine, and did her residency in internal medicine at Brigham and Women’s Hospital in partnership with Harvard Vanguard Medical Associates.

Keith A. Stahl, MD, FACP
(One-Year Term)
A community-based internist for nearly 20 years, Dr. Stahl is the Medical Director for 10 hospital-owned Primary Care Practices in New Hampshire. Dr. Stahl is a full-time primary care internist and Adjunct Professor at Dartmouth Medical School. After completing his Internal Medicine residency at Cleveland Metropolitan General Hospital, Dr. Stahl joined the U.S. Air Force. After receiving his commission as a Captain, he served as a Staff Internist for the 380TH Medical Group and received the Air Force Commendation Medal for developing a comprehensive Diabetic Education Clinic. Since joining the staff at Catholic Medical Center in Manchester, NH, Dr. Stahl has served in a number of medical staff roles including Chief of Internal Medicine, Chairman of Credentials, and Medical Staff President, and has had hospital-appointed positions including Physician Advisor for Medical Management and currently serves on the hospital Board of Directors, Corporate Compliance Committee and Quality Management Committee.

Roger L. Snow, MD, MPH (ex-officio)
(One-Year Term)
Deputy Medical Director, Office of Medicaid, Commonwealth of Massachusetts.

Mitchell Stein, MBA
(Two-Year Term)
Mitchell Stein is the Policy Director of Consumers for Affordable Health Care where he is responsible for directing the policy agenda of the organization. His work includes conducting health policy research and writing reports for advocacy efforts as well as presenting at public forums, including state legislature, press conferences, and other venues. Prior to this role, Mitchell served as a member of the Board of Directors for CAHC as well as doing health care policy consulting work for CAHC and the Maine Council of Churches. In 2007 Mitchell moved to Maine to work as the Director of Program Coordination for Health Dialog in Portland. Before that he worked in New York for Mercer Human Resource Consulting, Inc. in various roles including as their Global Intranet Director, as the Marketing Manager for the US Health Care Practice and as Director of the National Survey of Employer-sponsored Health Plans. He has extensively studied the Affordable Care Act and researched its implementation in and impact on Maine. He also has extensive background working with various aspects of the health care environment including insurance benefits designs. Mitchell lives in Cumberland Foreside, Maine with his wife Martha and dog Sheba. He holds both a BA and MBA from the University of Chicago.

William Taylor, MD
(Three-Year Term)
Dr. William Taylor is Associate Professor of Population Medicine and Associate Professor of Medicine at Harvard Medical School (HMS). He directs the Brigham and Women’s Hospital’s (BWH’s) residency program in primary care and population medicine affiliated with Harvard Vanguard Medical Associates and the Department of Population Medicine at HMS and Harvard Pilgrim Health Care Institute. Dr. Taylor has practiced and taught primary care for more than three decades in the hospital-based practice at Beth Israel Deaconess Medical Center (BIDMC). He serves as associate master of one of HMS’s academic societies. Dr. Taylor earned his B.A. from Yale, and his M.D. from the University of Pennsylvania. He completed his residency in internal medicine and primary care at Boston City Hospital. He has held multiple roles in medical education at HMS, BIDMC, and BWH. Dr. Taylor served on the Internal Medicine Certifying Examination Writing Committee of the American Board of Internal Medicine. He was a Kellogg National Fellow, a Rabkin Fellow in Medical Education at BIDMC, and an associate editor of Journal Watch. He earned the “Humanism in Medicine” award from HMS and served as Harvard’s LCME faculty fellow for medical school accreditation. Dr. Taylor has written about medical education, clinical epidemiology, medical interviewing, decision
analysis, cost-effectiveness analysis, tuberculosis prevention, cancer screening, cholesterol reduction, and the periodic health examination. He is a fellow of the American College of Physicians and the American College of Preventive Medicine.
The New England Comparative Effectiveness Public Advisory Council (CEPAC)

Improving the application of evidence to guide policy and practice:

Initially funded by a three-year grant from the federal Agency for Healthcare Research and Quality (AHRQ), and backed by a consortium of New England state policy makers, the goal of CEPAC is to provide objective, independent guidance on how information from AHRQ evidence reviews can best be used across New England to improve the quality and value of health care services. ICER manages CEPAC, and relies on a multi-stakeholder Advisory Board to inform the CEPAC process and provide guidance on how the CEPAC output can be the most useful for stakeholder groups.

The CEPAC Advisory Board:

The CEPAC Advisory Board is selected by ICER and comprised of private and public payers, state agencies, and patient and consumer advocates across New England. The Advisory Board advises ICER on topic selection, council nominations, CEPAC meeting structure, as well as implementation avenues for CEPAC meeting results.

Current Members:

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<th>Regional Public Payer</th>
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<tr>
<td><strong>Craig Haug, MD</strong></td>
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<td><strong>Matthew Katz</strong></td>
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<td><strong>Joseph Kozachek, MD</strong></td>
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<td><strong>Jean Rexford</strong></td>
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<td><strong>Vance Brown, MD</strong></td>
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<td><strong>Andy Cook, MD</strong></td>
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<td><strong>Kevin Flanagan, MD</strong></td>
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<tr>
<td><strong>Secretary JudyAnn Bigby, MD</strong></td>
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<td><strong>John Fallon, MD</strong></td>
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<td><strong>Kimberly Haddad</strong></td>
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<td><strong>Richard LoFleur, MD</strong></td>
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New England Comparative Effectiveness Public Advisory Council
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<tr>
<td><strong>Rhode Island</strong></td>
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<tr>
<td><strong>Amy Schwartz, MPH</strong></td>
<td>University of New Hampshire</td>
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<tr>
<td><strong>Charles Eaton, MD</strong></td>
<td>Brown University Center for Primary Care</td>
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<tr>
<td><strong>Deidre Gifford, MD</strong></td>
<td>Rhode Island Chronic Care Sustainability Initiative</td>
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<td><strong>Bill McQuade, D.Sc., MPH</strong></td>
<td>State of Rhode Island, Department of Human Services/Center for Child and Family Health</td>
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<tr>
<td><strong>Elena Nicolella</strong></td>
<td>Rhode Island Department of Human Services, Office of Medicaid</td>
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<td><strong>Lieutenant Governor Elizabeth H. Roberts</strong></td>
<td>State of Rhode Island</td>
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<td><strong>Vermont</strong></td>
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<td><strong>Michael Farber, MD</strong></td>
<td>State of Vermont, Office of Medicaid</td>
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Comprised of key stakeholders (including private and public payers, state agencies, patient and consumer advocates, and clinical society representatives) in each New England state, the CEPAC Advisory Board advises ICER on topic selection, nominations, and avenues for implementation of the final CEPAC product.

ICER manages the operations of CEPAC and produces a final report for deliberation at each CEPAC meeting. ICER reports supplement recently completed AHRQ Evidence Reviews to include a) research updates; b) region-specific data; and c) economic analyses.

Comprised of clinicians, methodologists, and patient/public representatives from across New England, CEPAC convenes twice annually to deliberate and vote on evidence, and discuss implications of findings for future policy decisions and clinical practice.
Charter and Bylaws

Objective and Scope of Activities
CEPAC reviews timely comparative effectiveness research; comments on its relevance for the six New England states; and aids in the dissemination of the information to policymakers and decision-makers throughout New England. The deliberations and decisions of the CEPAC are conducted in a public forum to ensure transparency and accountability to all stakeholders throughout the process. For a more complete explanation of the voting of CEPAC, please see the document “Questions to Generate CEPAC Product.”

Description of Duties
Members of CEPAC are responsible for reviewing the supplementary reports produced by ICER based on federally-produced comparative effectiveness information. To that end, it is expected that Council members attend public meetings in person and be well-prepared for the meetings. In addition, Council members recognize that CEPAC must operate in an open and public manner and members must evaluate all evidence presented before making a judgment. Further, CEPAC members are agents for the dissemination of the final products of the Council throughout their states and professional networks.

Council Members
Council members deliberate in public and vote on judgments of evidence while producing comments on the best approach to apply the evidence in practice and policy.

Composition: The composition of the Council shall consist of practicing clinicians or methodologists (MDs, DOs, NPs, PhDs, etc.) and patient/public members (such as patient advocates or health policy experts.). The target ratio for composition will be approximately two-thirds clinicians, one-third patient and public representatives.

In addition, CEPAC will consist of two (2) ex-officio, non-voting members representing the healthcare payer perspective: one from a private health plan, and one from a public institution, such as a state Medicaid department. Ex-officio members should have knowledge of how evidence is used in medical policymaking.

It is expected that members of CEPAC will have knowledge of and experience with evidence-based medicine, including training and experience in fields such as clinical epidemiology; health economics; health services research; public health; biostatistics; medical quality management; publish health system planning and evaluation; cost-effectiveness analysis; decision sciences; access to healthcare; and bioethics. Through CEPAC’s membership, it is also expected that diversity on many levels will be represented: diversity of thought, belief, race, ethnicity, geographic location, gender and culture.

Eligibility and Selection: Members of CEPAC represent clinicians, methodologists, public/patient members, and two ex-officio payer representatives, from all six New England states tasked with reviewing adapted comparative effectiveness information from ICER. CEPAC members have experience in evidence-based medicine and bring that perspective to deliberations. All CEPAC members are selected by ICER from the pool of applicants that submit nominations through www.icer-review.org during the annual nomination period.

CEPAC members, excluding ex-officio members, cannot work for any of the New England state agencies or regional private payers. CEPAC members, excluding ex-officio members, are expected to be free from financial conflicts of interest, and all members will be required to disclose financial ties to any private healthcare organization. While issues of financial influence will be handled on a case-by-case basis, as a guideline, CEPAC members, excluding ex-officio members, may not have substantial financial interests in the healthcare industry, defined as more than $10,000 in healthcare company stock or more than $5,000 in honoraria or consultancies during the previous year from healthcare manufacturers or insurers.
Membership and Terms: The first slate of Council members was appointed for a term of one year. The second slate of Council members will be allocated terms as follows:
- Six (6) for a three-year term
- Six (6) for a two-year term
- Six (6) for a one-year term

Following the second session, Council members will fill vacant slots and serve for a three-year term. No Council member shall serve more than two consecutive three-year terms. After a one year absence, former Council members are eligible to serve on CEPAC again. Excluding ex-officio members, CEPAC will consist of between 16-18 members each year.

Officers: A Chair and Vice Chair of CEPAC will be appointed by ICER. The Chair, and in her or his absence, the Vice Chair, will have responsibility for conducting the public meetings, including deliberation, voting, and fielding public comments.

Reimbursement: CEPAC members, not including ex-officio members, are eligible for an honorarium for each meeting attended of $500. In addition, members traveling more than 100 miles to attend meetings will be reimbursed for travel.

Meetings and Public Comments
CEPAC welcomes comments from the public and participation from the public in meetings. For a more complete description of the opportunities and timelines for submitting public comments and what to expect at a CEPAC meeting, please see the “Meeting and Public Comment Guide.”

Frequency, time, location: CEPAC holds, on average, two (2) public meetings each calendar year on different comparative effectiveness topics, to be determined. All CEPAC meetings are open to the public, but advance registration is required by all attendees.

Notice: Notice of the meetings are posted to CEPAC’s website (cepac.icer-review.org) at least two (2) months in advance of the meeting.

Quorum: The presence of at least one voting member from each state AND at least 50 percent plus one of the total Council membership should represent a quorum to conduct the Council’s business.

Recusal: Any Council member with a potential influence on judgment, including but not limited to, a personal experience with a particular technology or condition; a financial arrangement with industry; or a political consideration, shall recuse themselves from voting at a CEPAC meeting. Their presence will count towards establishing a quorum, but they will not be able to vote.

Voting: Each meeting culminates in a series of votes on the comparative clinical effectiveness and comparative value of the adaptation being discussed, as well as on issues concerning patient characteristics, health systems issues, health disparities and applications of evidence in medical policymaking. A simple majority suffices to designate the decisions of the Council.

Publication: Agenda and summary from each public CEPAC meeting reflecting the final votes and any pertinent dissension is posted to the CEPAC website approximately one month following the meeting (cepac.icer-review.org).

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Introduction
ICER accepts public comments on both the draft and final supplementary reports. The main vehicles for submitting comments are detailed below.

Written Comments: Written comments are encouraged from the public at three points:
1. When the adaptation topic is selected, a notice is posted to the CEPAC website (cepac.icer-review.org) at least four (4) months prior to the meeting and members of the public are invited at that time to submit written comments to ICER via the website.
2. Two (2) months prior to the meeting, ICER announces the date, location and time of the public meeting. At that time, ICER also posts questions for deliberation by CEPAC on the adapted review and invites public comments on those questions.
3. When the evidence review adaptation is complete, a draft is posted to the CEPAC website (cepac.icer-review.org) at least three weeks prior to the meeting date and the public is invited to submit written comments via the website that will be included in all materials given to Council members prior to the meeting. Written comments are due 10 days prior to the meeting.
4. After the meeting, additional comments are accepted via the website up to two (2) weeks after the date of the meeting.
5. Approximately one month after the meeting, ICER posts the meeting and voting summary. Public comments on the summary will be accepted for one week after posting.

Oral Comments at CEPAC Meetings: Each CEPAC meeting includes time (up to 45 minutes) for comments from the public. Those wishing to speak at the meeting must contact ICER via the CEPAC website (cepac.icer-review.org) one week prior to the meeting and provide the name, title and organization of the speaker and a brief paragraph summarizing the expected comments. Each commenter will be limited to five minutes and there is no guarantee that each registered individual will have time to comment. A sign-up sheet will also be available for 30 minutes prior to the start of the meeting for those who did not previously register with ICER to request a three minute speaking spot. Because time is limited and there is no guarantee that all those wishing to comment will have the opportunity, ICER encourages everyone to submit written comments via the process outlined above.
About ICER

Mission
ICER's mission is to lead innovation in comparative effectiveness research through methods that integrate considerations of clinical benefit and economic value. Through a unique collaboration with patients, clinicians, manufacturers, insurers and other healthcare stakeholders, ICER develops tools to support patient decisions and medical policy that share the goal of achieving maximum value for every healthcare dollar.

Governance, Policy, and Procedures

Distinctive Features

Support

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