In our current complex, rapidly evolving healthcare world important decisions are being and will be made about a bewildering number of clinical treatments and services by a bewildering number of people, including patients, physicians, other healthcare providers, patient advocates, policy makers, and insurers. Access to care, resources available, and individual clinical care decisions all need to be made in this complex world. To best accomplish this, evidence-based medicine and best practice must be considered all the while considering patients’ values and needs. Accomplishing this is no easy task. Newer methods, such as comparative effectiveness research (CER), are being developed and put into operation to assist in this task. As with any new method affecting how we treat patients, it engenders anxiety and suspicion, which can be allayed by explanation and a better understanding of what the method is. Physician involvement and input are an important and necessary component for understanding and acceptance.

An integral part of the Patient Protection Accountable Care Act (PPACA), comparative effectiveness research is a method designed to improve healthcare quality and reduce healthcare costs by identifying and disseminating evidence-based researched-information on the effectiveness of various modalities of care. This generally means comparing two or more methods of care or services.

According to the Comparative Effectiveness Public Advisory Council (CEPAC), it is a “regional body whose goal is to provide objective, independent guidance on the application of medical evidence to clinical practice and payer policy decisions across New England. Supported by a federal grant from the Agency for Healthcare Research and Quality (AHRQ), and with backing from a consortium of New England state health policy leaders, CEPAC holds public meetings to consider evidence reviews of medical tests and treatments and provide judgments regarding how the evidence can best be used across New England to improve the quality and value of health care services. CEPAC consists of practicing physicians with experience in evaluating and using evidence in the practice of healthcare, as well as patient/public members with experience in health policy, patient advocacy and public health.”

The coordination and direction of CEPAC is done by the Institute for Clinical and Economic Review (ICER), an academic CER investigative group based at the Massachusetts General Hospital’s Institute for Technology Assessment. ICER has an Advisory Board consisting of multiple stakeholders from throughout New England to assist in the process and act as a sounding board to ensure a meaningful, actionable agenda. Matthew Katz, MS, Executive Vice President/CEO of the CSMS is one of the four Connecticut members. As mentioned funding for CEPAC comes from the AHRQ.

Operationally, CEPAC, the Council, is a group of 19 individuals from the six New England states with expertise in healthcare: clinicians, academicians, payers, patient advocates and policy makers. It meets in a public forum involving open discussion by members with input from clinical experts and the public. Meetings are held in each New England state on a rotational basis. Connecticut is represented by four members: Claudia Gruss, MD, gastroenterologist from Fairfield, Ellen Andrews, PhD, Connecticut Health Policy Project, Robert Aseltine, PhD, University of Connecticut Health Care Center, and Michael Deren, MD, thoracic surgeon, New London. The first meeting was held on June 11, 2011 at the Harvard University Medical School and reviewed treatment of atrial fibrillation, including medical therapy and catheter and surgical ablation. The second meeting was held on December 9, 2011 at the Brown University School of Medicine and reviewed nonpharmacological interventions.
for treatment-resistant depression. Results of these discussions are available to the public at www.icer-review.org. They are not always clear-cut and at times point to areas where more research is necessary to make more concrete decisions. But it is a start.

The Council represents a public voice, open, honest and transparent, into what treatments appear best or most effective especially when the evidence may have elements of uncertainty or when services appear equal or when there is no clear advantage to one treatment or another. When evaluating comparative effectiveness research developed by any group, whether it be governmental, academic or other type, strong, educated, informed, up-to-date, deliberative public input by all stakeholders including physicians, other clinicians, patients, payers and public policy makers is vitally important if not a sine qua non. CEPAC is New England’s response to this public input. It is in its formative period and will be improving with each meeting.

CEPAC has no authority whatsoever to make treatment, payment or coverage decisions, nor can it deny care or limit care. It is a New England public voice, with patient and physician input, that has the potential to bring sense to the growing anxiety about the use of evidence-based medicine and best practices in the arena of comparative effectiveness. As comparative effectiveness research can involve value judgments, patients and physicians fear that such research could be misapplied or misused to limit or ration care. CEPAC, whose goal is to have credible information available for physicians to make informed treatment decisions, is one method to guard against such misuse and allay physician anxiety and suspicion, while providing creditable scientific review and evidence as to what are more effective or less effective treatment options.
CEPAC is a new, pace-setting endeavor, never before employed, with the purpose of providing objective, independent guidance on various aspects of comparative effectiveness research in a public New England forum. It is believed to be a first such program in the country. Background on its formation, function and operation are presented in this month’s From the Editor's Desk, p.241.

In order to explore this endeavor more fully, Connecticut Medicine convened a virtual roundtable discussion with three Connecticut members of CEPAC, Claudia Gruss, MD, Fairfield, Connecticut Gastroenterologist and CEPAC Vice Chair, Ellen Andrews, PhD, Executive Director of the Connecticut Health Policy Project, Robert Aseltine, Jr., PhD, Professor, Division of Behavioral Sciences and Community Health and Director of the Institute for Public Health Research at the University of Connecticut Health Center, and the CEPAC chair, Richard Lopez, MD, Chief Physician Executive for Atrius Health, an internist and Clinical Instructor at Harvard Medical School.

The primary purpose of this Roundtable was to explore and better understand the process, benefits, strengths and weaknesses of CEPAC as well as its impact on Connecticut patients and physicians. To this end, a series of nine questions were posed electronically to each of the four members. The answers were then circulated among the other members with follow up questions for further responses. The questions and their answers were then summarized by Connecticut Medicine and are presented here.

1. What should be the priority of comparative effectiveness research (CER)?

Priorities generally agreed upon by the panel included:

One: getting the best treatment for patient according to his/her needs, 
two: conduct and review research to determine clinical decision making, and 
three: to provide the latest-up-to-date, trustworthy research on different approaches to managing and treating disease. The physician, Dr. Gruss, MD, emphasized “providing objective information … so that every one … can make informed decisions,” whereas Professor Aseltine, PhD, prioritized the “conduct [of] high quality primary research and reviews of extant research to inform clinical practice and clinical decision making.” Our patient advocate Ellen Andrews, PhD, felt it important to have the latest, best, credible, independent and salient information available.”

2. What are the ideal results of CER efforts?

Results suggested by the Roundtable panel were generally consistent: One: every patient and physician having all the necessary information needed to find the best treatment option tailored to his/her specific need, 
two: having better outcomes at lower costs, 
three: having the community evaluate the relative benefits of new and traditional therapies, and 
four: having an understanding of the state and relative value of the evidence for treatment options.

3. How can products of CER best be disseminated to relevant stakeholder groups?

Here panel members again had uniformity of thought and felt essentially every available method should be used and that it was the responsibility of every stakeholder to participate in understanding the data and then using it.

4. What have you gained from being a member of CEPAC?

All appreciated the experience but in general pointed out:

One: awareness of the scarcity of good CER available for making clinical decisions, 
two: awareness that our present medical system makes data acquisition for good CER difficult, 
three: the knowledge, viewpoint and profession
of other stakeholders influenced their perspectives and decisions, but it was through this varied experience and expertise that further knowledge was gained and better informed decisions were made.

5. Thinking of the current and future products of CEPAC, how would you like to see them implemented? What changes do you hope they make?

There is the hope that the results of CEPAC become a tool for patients, physicians and other providers to use extensively in shared-decision making. This means that CEPAC results would change the way patients and physicians jointly make treatment decisions. Specifically Dr. Richard Lopez, chair of CEPAC “hope[d] that all the various stakeholders—physicians, patients, payers, policymakers—will rely on CEPAC’s independent judgments of evidence to inform medical policies and decision-making for the topics covered by CEPAC ... and that clinical societies and hospital leaders will take these recommendations seriously and become partners in the generation of critical evidence on clinical effectiveness so that we can continue to improve the quality and value of the care we provide our patients.”

6. In your experience, how is CER being implemented and adopted by physicians and other providers?

Generally, panelists with clinical experience expressed the use of evidence-based practice and the use of clinical guidelines. There seemed to be a lack of using CER, not so much from stakeholder resistance as from lack of information. Specifically, the clinician felt “our present tort-based medical liability system makes it more difficult for physicians to promote care based on CER results to their patients” and the patient advocate was concerned “providers are busier than ever-getting on their radar screen is a bigger challenge than ever.” It is clear from the comments that distribution of the decisions tied to the process needed to be mapped out in a way that gives clinicians the necessary information and support structure to implement changes in treatment protocols and modalities of patient care.

7. How can patients, physicians and providers become more engaged with CER?

Having readily accessible, reliable knowledge from large medical registries developed by specialty societies, using trusted messengers who are independent, credible sources accepted by all parties was thought to be particularly important by nearly all panelists. The model with trusted messengers will have to be further developed if widespread implementation of CER in New England is to be achieved by practicing clinicians.

8. How can the implementation process be improved to make the products of CER more useful for patients and providers?

A common theme in the panelists’ responses was that developers and evaluators of CER must clearly explain the decision making process and then educate the public and profession about a complex issue directly, simply and with transparency. Richard Lopez, MD from Atrius Health and Harvard Medical School indicated that “involving physicians, especially primary care physicians and patients in the process of generating CER will naturally lead to improved use of CER products.”

9. What are the current challenges impacting the timely use of CER?

Similar responses to this question included:
One: misinformation, two: lack of awareness, three: wariness about the potential to reduce needed care and 4. the limited scope of the scientific literature to date. All were seen as an important obstacles, but ones which should not divert attention from the beneficial aspects of the project. Here the background of the individual panelists brought added perspectives with the clinician Dr. Gruss concern that “we must all keep in mind any medical decision that incorporates CER must be individualized to the needs and desires of each patient.” The academician. Dr. Aseltine, thought the answer to this question might be “gleaned from research on the mechanisms through which these results are currently disseminated.” Dr. Andrews, as patient advocate, expected “there to be counter-productive misinformation directed at vulnerable patients by special interests in response to nonrecommended treatments,” although she not seen any yet.

In summary, our roundtable panel came from different backgrounds, with different educations and professions, yet worked together to enrich the process evaluating comparative effectiveness research and the CEPAC. As CEPAC members, all labored collaboratively and transparently in the public arena to make a better work product that will benefit and bring about positive change in our healthcare system in Connecticut, regionally and hopefully nationally as more information about the CEPAC process is learned by practicing clinicians and the healthcare community at large.
As we enter the brave new world of healthcare reform, there will be changes, both good and bad. Comparative effectiveness research, whether thought bad or good is one such change. It is a complex concept and not a simple tool as some suggest. Patients and physicians, payers and public policy makers will have to dedicate time and effort to understand its uses, abuses and limitations. In the process they will shape its implementation or lack thereof. It requires we become more responsible for the care we deliver and the care we ourselves receive. It requires a change in thinking and in culture.

The Comparative Effectiveness Public Advisory Council represents a public voice on what works best in health care. It is a mechanism where all parties can convene, discuss and build, using a transparent and trusting vehicle, the best patient care possible. It represents all parties involved in our health care delivery system and strives to assist all in gaining a much better understanding of the critical issues of quality and cost of medical care.

I would like to express my appreciation to Claudia Gruss, MD, Ellen Andrews, PhD, Robert Aseltine, PhD and Robert Lopez, MD for their thoughts and work involved in responding to the questions and to Matthew Katz, MS for suggesting the idea of a round table and his input on the final draft.

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Editor