Policy: **Evidence Based Health Information Evaluation / Technology Assessment**

Date of Implementation: **June 18, 2020**

Product: **All Products**

Related Policies:
- QM 33: Evidence Selection and Evaluation

American Specialty Health (ASH) has three lines of business that require evaluation of health-related information and evidence. This includes American Specialty Health – Specialty, American Specialty Health Management, and American Specialty Health – Fitness. For ASH products, programs, and services, the assessment of clinical evidence and other health-related information on a routine and timely basis is imperative. ASH evaluates, develops, updates, and maintains health information that reflect professionally recognized standards of practice, current scientific evidence, and consensus of appropriate experts. This policy describes the monitoring and evaluation of evidence for all ASH programs.

Internal Support

Staff clinicians, researchers, and other Subject Matter Experts (SME's) support ASH evidence evaluation processes. They are tasked with the following duties:

- Monitor and evaluate new/revised evidence in support of ASH programs to:
  - Identify changes to health information or updated evidence that impacts those ASH services that ASH manages or provides; including diagnostic procedures, therapeutic interventions, health and lifestyle behavior change, health assessments, and coaching programs;
  - Identify clinical trends and/or new areas of focus that may contribute to program enhancements; and
  - Identify new or emerging tests, procedures, or interventions and evaluate the best current evidence in order to develop policies or recommendations regarding the appropriate use of such tests, procedures, or interventions within the ASH programs; and
- Provide clinical policy recommendations, as applicable, to the appropriate committee(s) for final approval.

External Support

ASH may require the assistance of external clinical expert advisors to provide research, recommendations, or consensus opinion and/or develop or update health content or guidelines. To be contracted as an ASH clinical advisor, external experts must have extensive experience in the area in which they are requested to consult. Where applicable, external consultants should be board certified in their contracted area of expertise. This pool of external clinical experts is available to ASH on an ad hoc basis and may participate in an External Evidence Evaluation Committee (EEEC) as needed.

EVIDENCE EVALUATION PROCESS AND COMMITTEES

Evidence evaluation may be requested via approved company processes by any primary stakeholder including the ASH executive team or business units, internal or external subject matter experts (SMEs), clients, or practitioners or may be requested as a result of internal evidence monitoring activities. ASH has established a Research Leadership team comprised of the Chief Health Services Officer (CHSO), the Vice President, Health Services, Vice President, Health Affairs, Senior Director, Clinical Evidence Guidelines and Policy, Senior Director, Health Content Development, Senior Medical Director, Health Services, and other clinical staff. The Research Leadership team will determine when an Evidence Evaluation Committee meeting needs to be convened. The CHSO is responsible for budget and approvals with the Chief Executive Team (CET), who oversees and ensures appropriate organizational structure and resourcing for evidence evaluation. The CHSO ensures the structure of the committees and processes are based on the corporate principles that require separation of financial and clinical decision-making. CHSO will approve agendas for all committees that evaluate clinical evidence or influence guidelines or processes that affect ASH programs.

Purpose and Roles

The purpose of the evidence evaluation committees is to evaluate the best available evidence and provide interpretations and recommendations for application to ASH programs and products. The committees are formal decision-making bodies that maintain clinical independence and strive to ensure a balanced perspective when reviewing and interpreting the available evidence. The committees utilize formal processes to guide their work (e.g., modified Delphi and modified nominal group process). The processes to be used for all reviews will be determined in advance by the Research Leadership, agreed to by the committee, and documented as part of the final committee decisions.

The role of the committee is to provide expert clinical review and/or interpretation of the evidence utilizing the *Evidence Selection and Evaluation (QM 33 – ALL)* policy regarding:

- Accuracy, based on currently accepted evidence review principles;

- Consistency with professionally recognized standards of practice (PRSP);
- Relevance and applicability of the information/evidence to the ASH products and programs, clinical practitioners, and to health care consumers;
- Benefit to Risk profile related to Member/patient safety;

Committee Types

Evidence evaluation will be carried out by either an Internal Evidence Evaluation Committee (IEEC) or an External Evidence Evaluation Committee (EEEC) unless an ad hoc process of evidence review is approved by Research Leadership. These committees are Board chartered and operate according to ASH governance rules.

Evidence Evaluation Committees Resource Deployment:

Depending on the nature of the question and the impact of the process, the ASH evidence evaluation process will deploy the following guideline to determine which resources would be best utilized to answer the question at hand.

The ASH Research Leadership with any additional ASH Clinical Leadership as deemed necessary and appropriate by the CHSO, will be the final arbiter of how a question will be reviewed. These guidelines may be overridden if there are compelling reasons to change the process. In some situations, aspects or components of an evidence review topic may be handled by both the IEEC and the EEEC or an ad hoc review process.

Question / Evidence to be evaluated:	**External EEC**	**Internal EEC**
Development of the core body of evidence for new product	X	
Refinement of evidence that is currently in a Health Information Resource (HIR) or Clinical Practice Guidelines (CPG) or Coaching Guidelines (CG) or training material; impact on current product deployment or member health impact	X	X
Topic is debated (no consensus) by internal clinicians about direction of the evidence	X	
Conflicting evidence from third party credible sources		X
Evidence on the topic is clear, reasonably definitive, and supported by multiple third-party credible sources		X
Clarification on application of current evidence used in support of a product		X

Question / Evidence to be evaluated:	External EEC	Internal EEC
Evaluate new emerging, evolving, evidence to evaluate its relevancy and impact and need for external review (i.e., EEEC)		X

Preliminary Evidence Review and Summary

Prior to commencement of either the IEEC or EEEC review, an evidence review will be completed. As needed or assigned by CHSO, the evidence will be compiled into a narrative review of the literature which will include summary statements or conclusions. Either the IEEC or EEEC will review the evidence summary, any cited evidence (if requested), and may recommend other sources be considered during review and deliberation.

Internal Evidence Evaluation Committee

When appropriate and designated as the reviewing body for the topic under review, the IEEC meets to evaluate applicable literature along with summary documents prepared by ASH clinical and/or research staff to ensure consistency with professionally recognized standards of practice and current scientific evidence. The IEEC provides evidence surveillance, clinical review, and analysis of evidence related changes in the health care industry that may be applicable to ASH programs and supports ASH clinical policy annual review. If the IEEC cannot reach a conclusion, an EEEC may be convened.

The IEEC is comprised of internal clinical staff selected by the Board of Directors (BOD) or designee. The IEEC is chaired by the Executive Vice President and Chief Health Services Officer.

External Evidence Evaluation Committee

When appropriate and designated as the reviewing body for the topic under review, the EEEC meets to evaluate applicable literature along with summary documents prepared by ASH clinical and/or research staff to ensure consistency with professionally recognized standards of practice and current scientific evidence. The EEEC meets on an as needed basis to evaluate applicable literature along with summary documents prepared by ASH clinical and/or research staff to ensure consistency with professionally recognized standards of practice and current scientific evidence. Scheduled meetings are determined by the CHSO with input from clinical and research experts. The EEEC is comprised of experts in clinical epidemiology, health services research, health care policy, the basic sciences, clinical academia, and clinical practice, and/or health care practitioners (board certified where applicable) familiar with healthcare and the topics to be evaluated. The EEEC membership includes contracted clinical research experts and staff clinicians selected by the Board of Directors (BOD) or designee. Additionally, the EEEC's

chairperson or designee may invite, as necessary, independent experts to participate as discussants, voting members, or presenters of information on specific clinical information, diagnostic or therapeutic techniques or procedures. In support of the EEEC efforts, ASH may also use evidence-based workgroups to evaluate health information, techniques and procedures, develop consensus statements for ASH policy consideration, evaluate prior EEEC findings for updates and changes, and provide recommendations for new or currently existing ASH clinical content.

The chairperson, or designee, may elect to have the EEEC meet collectively as a committee, or specific review responsibilities may be performed by individuals to fulfill any review obligations.

STRUCTURED REVIEW PROCESS

A structured review of applicable and valid documented scientific evidence guides decisions made by the evidence evaluation committees. Where new or emerging evidence is considered applicable to ASH programs, a structured review of applicable and valid documented health care guidelines consistent with standards of care and scientific evidence (e.g., clinical studies) guides recommendations made by internal/external review processes, as well as when the EEEC or IEEC is required, as appropriate [see the *Evidence Selection and Evaluation (QM 33 – S)* policy for more information]. The Quality Oversight Committee (QOC), on behalf of the Board of Directors, maintains final approval responsibility for all policies and revisions based on EEEC or IEEC recommendations. The CHSO and/or designee have the authority for ad hoc approval of policy on behalf of the QOC to meet regulatory, accreditation, certification, or client requirements when time constraints for filings or other stakeholder expectations require rapid review and approval of policy. In the event that Policy Management senior staff identifies the need for a new policy revision outside of the routine review and approval process, the issue is escalated to the CHSO for approval and subsequent presentation to the QOC.

TYPES OF INFORMATION DEVELOPED FOR PROGRAMS:

I. CONDITION-SPECIFIC HEALTH INFORMATION

Condition-specific health information guidelines are considered applicable and valid if they are:

- Endorsed by the American Board of Medical Specialties applicable to the condition; and/or
- Endorsed by an applicable and reputable national health care association (e.g., American Heart Association, American Cancer Society); and/or

- Endorsed by a governmental health care organization (e.g., U.S. Preventive Services Task Force [USPSTF], Institute of Medicine [IOM], National Institutes of Health [NIH]); and/or
- Endorsed by a government-sponsored health research organization (e.g., Agency for Healthcare Research and Quality [AHRQ]); and
- Specific to the condition being addressed; and
- Publicly available; and
- Applicable to the general population with the stated condition.

II. BEHAVIOR-CENTRIC HEALTH COACHING INFORMATION

Behavior-centric health information guideline evidence must:

- Demonstrate credible scientific evidence; and
- Be clinically relevant; and
- Show positive outcomes in behavior modification; and
- Not require the practice of clinical psychology or psychiatry, thus, the behavior or behavior change education method is applicable to persons without a clinical license, registration, or certification; and
- Be amenable to a remote (e.g., telephonic) coaching health improvement program;
- Be focused on normal human behavior and does not address mental illness/ disorders (DSM-V conditions) and
- Be publicly available.

III. ESTABLISHING ASH CLINICAL PRACTICE GUIDELINES (CPGs) AND COACHING GUIDELINES (CGs)

The recommendations of ASH clinicians, researchers, and/or the IEEC or EEEC are considered by staff and clinical committees when developing applicable policy, guidelines, criteria, definitions, and processes. These criteria and processes also support the evaluation of practitioner performance within ASH specialty networks related to the use of specific diagnostic and therapeutic procedures during the credentialing and recredentialing processes, medical necessity review and quality case review, and monitoring of quality-related practitioner activity.

When reviewing policy edits for approval, clinical committees take into consideration the opinion of the clinicians, researchers, and/or the IEEC or EEEC, the information's effects on health outcome improvements, health risks, health benefits, professional standards, member safety, and applicability to ASH services.

ASH clinical committees, when reviewing a technology, diagnostic/procedure/therapeutic intervention, or coaching methodology for approval, take into consideration the relevant

effects on health outcome improvements, health risks, health benefits, professional standards, and potential for gold-standard substitution harm. This consideration includes, but is not limited to:

- Documented evidence of efficacy per the IEEC or EEEC review;
- Scientific plausibility/coherence per the IEEC or EEEC review;
- Documented evidence of a favorable benefit: risk profile per the IEEC or EEEC review;
- Documented evidence of sensitivity, specificity, and reproducibility, including the IEEC or EEEC review;
- Documentation of broadly accepted, scientifically supported expert opinion;
- Documented majority consensus support for appropriateness;
- Documented criteria for the appropriate use and member selection of the procedure;
- Procedure taught in the core curriculum of accredited clinical educational institutions;
- Procedure taught to competency and assessed for competency by National Board and/or licensing/regulatory body; and
- Federal regulatory approval of the technique or procedure as utilized by ASH practitioners, if applicable.

When developing, reviewing, and approving clinical policy, ASH peer-review committees consider whether the diagnostic or therapeutic technique/procedure or coaching methodology:

- Is established as clinically effective by:
  - Scientific information published in an acceptable peer-reviewed clinical science resource; and
  - The consensus opinion of the IEEC or EEEC when available;
- Is professionally recognized by:
  - Inclusion within the educational standards accepted by the majority of the professions' educational institutions,
  - Wide acceptance and use of the practice; and
  - Recommendations for use made by healthcare practitioners practicing in the relevant clinical area;
- Poses a health and safety risk; and
- Is plausible or implausible
  - A belief, theory, or mechanism of health and disease that can be explained within the existing framework of scientific methods, reasoning, and available knowledge is considered plausible;
  - A treatment intervention or diagnostic procedure that requires the existence of forces, mechanisms, or biological processes that are not known to exist within

the current framework of scientific methods, reasoning, and available knowledge is considered implausible.

When developing, reviewing, and approving preventive health services and wellness clinical policy, ASH peer-review committees consider the following:

- Patient Population – Persons presenting with a primary complaint who have been properly evaluated. For each service considered, this patient population may be further defined by age, gender, or clinical status.
- Opportunity for evaluation – Given the defined population and within the context of portal-of-entry practitioners, the degree to which accurate and actionable information can be practically obtained regarding the modifiable risk factor.
- Opportunity for intervention – Given the defined population and (i) within the context of portal-of-entry practitioners and (ii) given an appropriate evaluation of the modifiable risk factor, the degree to which the modifiable risk factor can be effectively improved, either directly and/or by referral to an appropriate resource.
- Potential Impact – Assuming appropriate evaluation and intervention, the degree to which improvement in the modifiable risk factor can improve health. This potential impact will be considered in three different clinical contexts:
    - Its impact on a presenting complaint;
    - Its impact on a specific chronic condition (e.g., diabetes); and
    - Its impact on general health and prevention. This includes prevention of health conditions and improvement or maintenance of functional capacity and quality of life.

Based upon the degree of potential impact, recommendations for best practice will be divided into one of the following categories:

- Necessary (should be done);
- Recommended (should be considered by the practitioner) and most likely performed unless there is a contraindication;
- Discretionary (up to the practitioner to determine);
- Unnecessary (not recommended); or
- Contraindicated (should not be done).

CPGs are posted publicly on the ASH website and available upon request.

CPG REVIEW AND NEW EVIDENCE

ASH peer review committees may determine that certain techniques or procedures are not established in current scientific literature as clinically effective or as having diagnostic utility. When making such a determination, the IEEC or EEEC may provide an opinion

regarding the status of that technique/procedure as Established, Not Established and/or Health and Safety Risk.

New evidence that has become available since the previous literature search and that meets the quality standards in the *Evidence Selection and Evaluation (QM 33 – HM)* is reviewed as part of the annual policy review process. When new evidence and/or newly published guidelines materially affect and/or alter the current CPG or other health-related content, the new evidence and/or newly published guidelines and ASH policy guidelines will be re-evaluated by clinical and/or research staff and/or the IEEC or EEEC, as applicable, in a timeframe applicable to the effect the new evidence and/or newly published guideline may have on the health and safety of members. If new evidence exists that supports the CPG and meets the quality standards of design as defined by the IEEC or EEEC, the evidence is submitted for clinical committee review for possible inclusion as a reference.

IMPACT ANALYSIS

Impact Level	Definition	Examples	Timeline
No Impact	Health information / new evidence does not suggest or require alteration of current programs, policies, procedures, and/or practices. Awareness of the change is informational and does not suggest the need for further action.	Changes in: • Percentage of obese Americans; • Percentage of Americans engaging in daily physical activity • A preventive health recommendation that has been discredited by leading scientific or clinical entities.	▪ Included in scheduled and routine updates (e.g., annual update). No change is made to scheduled and routine timelines for content editing.
Moderate Impact	Health information that may suggest or require changes to current programs, policies, procedures, and/or practices.	• Academy of Nutrition and Dietetics changes recommendations for number of	▪ Distributed to ASH clinical management within 20 business days in order to alert clinical staff

Impact Level	Definition	Examples	Timeline
	Awareness of this information may necessitate consumers to reconsider health choices but does not cause an immediate adverse risk to members.	servings of fruit per day; • American College of Sports Medicine (ACSM) changes recommendation for minutes of exercise per week. • American College of Physicians changes recommendations on measurement of hypertension. • American College of Chiropractic Radiology changes recommendations on use of radiological examinations.	and provide any applicable training. ▪ Identified in all guidelines and other materials impacted by the change within 60 days, ▪ finalized with appropriate language into all materials within 120 days and ▪ updated in online and print materials by the Consumer Health Information (CHI) team established processes including coordination with Information Technology (IT) and/or Marketing departments within 120 days; or a timeframe established by the CHSO, or designee.
High Impact	Health information that holds a significant potential for an immediate adverse risk to members; and is likely to necessitate	▪ A provider delivered service is identified to be a risk to patients or a previously experimental	▪ High impact health information changes are completed within 3 business days (e.g., member

Impact Level	Definition	Examples	Timeline
	changes to current programs, policies, procedures, and/or practices. Consumer awareness of this information requires prompt reconsideration of his/her health routine(s) and may require pro-active outreach from ASH to members who may have received outdated information.	intervention is definitively shown to be highly beneficial and medically necessary; ▪ Food and Drug Administration (FDA) changes warnings related to Nicotine Replacement Therapy; ▪ Dietary supplement product is implicated in hepatic toxicity; ▪ Wireless fitness device is recalled due to significant health risk.	notification, staff training, research, removal of product from distribution or stock, etc.), and ASH Legal Counsel may be notified as appropriate. ▪ High impact health information changes are: o Updated in guidelines and health content within 30 days, or a timeframe established by the CHSO, or designee. o Provided by Health Services to Marketing in the form of master document updates for print materials (as applicable) within 30 days, or a timeframe established by the CHSO, or designee. ▪ If the established timeframe parameters cannot be met, barriers to

Impact Level	Definition	Examples	Timeline
			completion must be documented and reasonable efforts for completion prioritized with reporting to Quality Committee with authority for oversight of the guideline.

If established timeframe parameters cannot be met, barriers to completion must be documented and reported to appropriate Quality Oversight Committee (QOC) with authority for oversight of the guideline/product, including a reasonable date for completion.

Reporting

High priority and moderate priority health information updates and progress on implementation are reported to the appropriate quality committee for each line of business (LOB): Quality Assurance Committee - Health Management (QAC-HM), Quality Assurance Committee – Fitness (QAC-Fitness), and Quality Improvement Committee (QIC). Low priority health information and information decided to not be of interest to American Specialty Health Management programs will also be reported to QAC-HM as informational. High priority health information updates and progress on implementation are also reported to the appropriate line of business QOC monthly until completed.

All health information updates, and progress are reported to the appropriate quality committee for each line of business, Quality Oversight Committee and the Board of Directors aggregately each quarter.

DISAGREEMENT BETWEEN CREDIBLE PROFESSIONAL ORGANIZATIONS BASED ON RESEARCH OUTCOME INTERPRETATION

Based on new available research and how various credible organizations interpret research outcomes, there may be disagreement between external expert organizations (e.g., American Medical Association, American Physical Therapy Association, US Preventive Services Task Force) regarding how evidence interpretation and guidelines should be written and put into practice. If and when disagreement among credible organizations

occurs, ASH will work with internal and, if needed, external experts to study the evidence and interpret the differences in the research as related to the ASH programs and to make a recommendation based on the research. Internal experts continue to closely follow the evolution of the evidence and adjust appropriately as more information becomes available. The appropriate parties will be notified based on the recommendations and decisions made

References

Eden, J., Levit, L., Berg, A., & Morton, S. (Eds.). Committee on Standards for Systematic Reviews of Comparative Effectiveness Research, Institutes of Medicine. (2011). Finding what works in health care: Standards for systematic reviews. Retrieved May 2, 2022, from http://www.nap.edu/catalog/13059.html

Graham, R., Mancher, M., Miller Wolman, D., Greenfield, S., & Steinberg, E. (Eds.). Committee on Standards for Developing Trustworthy Clinical Practice Guidelines, Institutes of Medicine. (2011). Clinical practice guidelines we can trust. Retrieved May 2, 2022, from http://www.nap.edu/catalog/13058.html