

By Christopher J. O'Connor

Package Deal

Can quality and savings be one in the same?



Quality patient care and strong bottom lines have long been mutually exclusive healthcare pursuits, but national health reform and the drive toward industry best practices have merged quality and savings into a unified goal. All healthcare executives should agree that linking cost savings and quality patient care is essential to a successful organization, and that all hospital initiatives must strive to achieve both.

The proliferation of high-value products in acute care hospitals has created cost-saving opportunities – and the need for initiatives such as product assessments/consolidation and inventory reduction – in operating rooms, interventional radiology, cardiac catheter labs, electrophysiology labs, and other departments. To be successful, such projects must have strong C-suite support and must improve patient care.

While reducing supply utilization and expenses should be approached from the perspective of reducing supply costs, it should also be viewed as just the first cost-side component of the cost-quality equation. The best supply chain systems have robust management reporting infrastructures that utilize performance metrics to analyze purchasing trends such as pricing variation, contract terms and conditions, inventory, and supply overuse. Focusing on the clinical areas of high-cost and/or high-volume will facilitate the identification of not just cost opportunities, but also opportunities to address an essential cost-quality building block: quality care. And that's best accomplished through comparative effectiveness research.

Improving outcomes

Anyone who followed the national health reform debate is familiar with the term comparative effectiveness research

(CER), but what does it actually mean? In the simplest terms, CER is used to identify the relative strengths and weaknesses of various medical interventions with the goal of giving clinicians and patients valid information to make cost-effective decisions that will improve healthcare outcomes. Examples of successful CER include evidence summaries from the Agency for Healthcare Research and Quality on conditions such as prostate cancer and osteoporosis, and the National Institutes of Health's diabetes prevention trial that demonstrated that lifestyle change was superior to metformin and placebo in preventing the onset of Type 2 diabetes.

Thanks to astonishing achievements in biomedical science, clinicians and patients often have abundant choices when making decisions about diagnosis, treatment and prevention, but it remains a challenge identifying which therapeutic choice works best for whom, when, and under what circumstances. And that's CER's ultimate goal: helping clinicians get the right

product at the right price to the right patient at the right time.

The American Recovery and Reinvestment Act provided \$1.1 billion for comparative effectiveness research and established the Federal Coordinating Council for Comparative Effectiveness Research (the Council) to foster optimum coordination of CER conducted or supported by Federal departments and agencies. These critically important resources will enable us to pursue CER to a degree never before possible.

To be sure, CER's benefits will not be attained overnight. Like all areas of health reform, there is work to be done. But I'm convinced that when CER studies are completed, and the results reported, we'll not only have additional tools to transform our healthcare system, but also tangible proof of the validity and attainability of the cost-quality relationship. **JHC**

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