

streamline the decision-making process for new medical technologies and balance quick turnaround with rigorous evidence standards. The program is also being developed in collaboration with UW Medicine's Value Analysis team, an evidence-based purchasing team and MedApproved, a new centralized software program for medical purchasing at UW Medicine.

RESULTS:

Smart Innovation has been reviewing technologies during its first year and has received encouraging results. For example, by adopting a new liver ablation technology, UW Medicine has estimated improved patient outcomes by reducing the number of procedures and adverse events; as well as saving approximately USD 8,000 per patient. Additionally, The Smart Innovation program has achieved projected cost avoidance from deciding not to adopt uncertain or investigational technologies. For example, by not adopting a new bladder cancer screen, our models indicate UW Medicine will avoid spending USD 1.5 million per year.

CONCLUSIONS:

Smart Innovation is proving to be an effective program for reviewing and making critical healthcare policy decisions that is showing significant fiscal and patient improvements for UW Medicine. As the program continues to grow and become embedded into UW Medicine, its impacts will become even more valuable and system-wide.

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OP102 Multiple Criteria Decision Analysis In The Field Of Hospital-Based Health Technology Assessment

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INTRODUCTION:

One of the main tools for Hospital-Based Health Technology Assessment (HB HTA) is the preparation of a mini-health technology assessment (HTA) report. Despite the high value of the results of mini-HTA reports for hospital decision-makers, the classical mini-HTA

report does not allow a direct comparison of several health technologies among themselves.

METHODS:

Based on the analysis of international experience of using the principles of multiple-criteria decision analysis (MCDA) in the field of HB HTA, we created and approved our own managerial decision-making model which includes five standardized multiple criteria. The value (weight) of each criterion was defined as the arithmetic mean obtained as a result of interviewing hospital decision-makers and an HTA expert group.

RESULTS:

Five standardized multiple criteria were included in the structure of our mini-HTA report. These criteria presented the main results of assessment of the viability of implementing new health technologies (HTs) in hospital practice and contain the following: i) Novelty/innovation; ii) Comparative clinical effectiveness and safety; iii) Relevance (demand); iv) Economic effectiveness; and, v) Payback period. We conducted the modeling of various options of HTA results by using multiple criteria, which allowed us to determine the threshold values of the evaluated HTs corresponding to their priority for implementation: i) High priority - HTs are recommended for implementation; ii) Medium priority - HTs can be recommended only if there are sufficient financial resources in hospital; and, iii) Low priority - HTs may be recommended only if there are strong reasons for their need.

CONCLUSIONS:

Integration of the principles of MCDA in the structure of mini-HTA reports gives the opportunity to i) make comparative assessments of implementing new health technologies based on standardized criteria; ii) determine the priority for implementation of newly evaluated health technologies; iii) avoid the influence of subjective factors on the managerial decision-making in hospitals.

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OP104 Moving Forward Hospital-Based Health Technology Assessment: Public Procurement Of Innovation

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