NHIA Industry-Wide Data Initiative

2012 Data Definitions Survey Questionnaire PDF

Questionnaire

INTRODUCTION:

Thank you for your interest in the NHIA Industry-Wide Data Initiative, and your commitment to advancing our industry through the sharing and benchmarking of meaningful data. This Data Definitions Survey represents the next step in our multi-phase data effort that holds great promise for all stakeholders involved in the alternate-site infusion industry. Following a strong response from NHIA members to the 2010 NHIA Provider Survey, our analysis of the survey results revealed a critical need for standardized definitions for key data elements. In order to effectively utilize shared data to benchmark provider performance, and to demonstrate the value of alternate-site infusion therapy to those who pay for our services, we must first ensure a valid and statistically significant pool of data.

Our goal in conducting this Data Definitions Survey is to establish those standardized definitions our industry can rally around, adopt, and advance in future Provider Surveys. NHIA is interested in your feedback regarding those definitions, as well as the way in which you collect and process specific points of data in your organization. Standardizing definitions across the industry is just the first step - automating the collection of that standardized data is the next crucial step, and before we can move forward with automated data collection tools we need to better understand how NHIA member organizations are utilizing their software systems to collect and store these key elements of data.

Just as it takes a multi-disciplinary team to provide home infusion services, it will take the perspectives of several members of your leadership team to validate the Standardized Definitions our Data Initiative Work Group volunteers have proposed in this survey, and to respond to how that data is currently processed, stored and retrieved by your company. We recommend that you and your team review this survey in its entirety before you begin, in order to assign sections to specific individuals and discuss your responses before entering the data into the survey. The _Survey Questionnaire PDF_, a copy of the entire survey, is available at the NHIA Data Initiative website for sharing with your team in advance.

Whether you contributed your data in the 2010 Provider Survey, or you are taking an active role in the NHIA Industry-Wide Data Initiative for the first time by completing this Data Definitions Survey, NHIA thanks you for your participation in this ongoing and critical endeavor!

ABOUT THIS SURVEY:

Moving from page to page in the survey tool:

- Throughout this survey, you will be asked to answer a variety of questions using different types of responses. For each question, please select the response that best describes your answer then click the **NEXT PAGE/SAVE ANSWERS** button.
- Most questions are required, which means if you leave them blank, the survey will direct you back so you can respond. Open-ended questions that ask for comments are generally not required; however, any additional information you choose to share via this survey is much appreciated.
- At any point in the survey, you may back up using the **PREVIOUS PAGE/BACK** button at the bottom of each screen (starting on the second page) and change your prior responses. Simply re-enter your responses from the point at which you resume the survey. **Do not use the back button in your internet browser tool bar - it will not work in the survey, and will cause an error.**
- If you are interrupted or need to suspend the survey and complete it at a later time, click the **FINISH LATER** button at the bottom of any screen. When you log on to complete the survey later, your earlier responses will be saved and you may resume the survey from the point at which you stopped.
- Once you complete the survey and click the **SUBMIT** button after the last question, your answers will be submitted and you will no longer be able to access the survey or change your answers.

How long will it take to complete the survey?

Based on feedback from providers who tested the survey functionality, estimated time for data entry is approximately 30 minutes. **This assumes that you and your team have previewed the survey by downloading the _Survey Questionnaire PDF_ and have prepared your responses before sitting down to enter responses into the survey itself.**

How will the results be reported?

NHIA will only report results from this survey in an aggregate form. No specific provider data will be identifiable in any report that is generated from this data. Upon clicking the **SUBMIT** button after the last question, an email will be automatically generated and sent to the address your provided in the beginning of this survey. Your individual survey

responses will be attached in that email for your records and to be saved for future reference.

1)
SURVEY CONFIDENTIALITY:

NHIA is committed to handling all data received via this survey in a private and secure manner, and intends to utilize results in aggregate form only to improve/enhance the questionnaire design of the 2013 NHIA Provider Survey, and to inform the next steps in our NHIA Industry-Wide Data Initiative. All survey responses and raw data will be password restricted and accessible only by those NHIA staff members directly involved in data analysis, specifically Kristen Santaromita, Associate Director of Research & Education and Nancy Kramer, Vice President, Clinical Affairs.

I have reviewed the NHIA Industry-Wide Data Initiative Confidentiality Statement and understand that if I have any questions regarding the content of this questionnaire I can call Kristen Santaromita at 703-838-2661.

- ○ Yes
- ○ No

2) Please enter information for the key contact at your company who would be available to answer any follow-up questions should additional information or clarification be needed.

Name: [_____]
Company: [_____]
Address: [_____]
[_____]
City: [_____]
State: [-- Choose one --]
Zip: [_____]
Phone: [_____]
E-mail: [_____]

3)
HOME INFUSION THERAPY (HIT) SOFTWARE UTILIZATION:

As we learned in our first 2010 NHIA Provider Survey, the more data we can collect using automated processes and system-generated information, the more valid and reliable that data will be for benchmarking purposes across our industry. We are interested in better understanding the software program(s) that your company currently uses, as we consider your responses to our proposed definitions in this survey and our ability to collect that data in an automated process.

Currently, what pharmacy software program(s) does your company use for billing/reimbursement, pharmacy, inventory, DME, and shipping etc? Please indicate all of the software programs that apply, and if you use more than one, please indicate the functionality for which each system is used. *(Select all that apply.)*

	Billing/ Reimbursement	Prescription/ Inventory	DME	Shipping/ Deliveries	Nursing Visit Documentation	Our company does not use this software
Apothesoft	☐	☐	☐	☐	☐	☐
Ascend (Mediware)	☐	☐	☐	☐	☐	☐

CPR+ (Definitive Homecare Solutions)	☐	☐	☐	☐	☐	☐
iEmphsys	☐	☐	☐	☐	☐	☐
Fastrack	☐	☐	☐	☐	☐	☐
HomecareNet (Healthcare Automation/Mediware)	☐	☐	☐	☐	☐	☐
Organization Developed/Owned	☐	☐	☐	☐	☐	☐
Mestamed	☐	☐	☐	☐	☐	☐
PDX	☐	☐	☐	☐	☐	☐
Rx30	☐	☐	☐	☐	☐	☐
QS/1	☐	☐	☐	☐	☐	☐

4) Because some providers may be in the midst of a software conversion, please indicate which pharmacy software program(s) your company anticipates using by the end of 2012. *(Select all that apply.)*

	Billing/ Reimbursement	Prescription/ Inventory	DME	Shipping/ Deliveries	Nursing Visit Documentation	Our company does not intend to use/purchase this software
Apothesoft	☐	☐	☐	☐	☐	☐
Ascend (Mediware)	☐	☐	☐	☐	☐	☐
CPR+ (Definitive Homecare Solutions)	☐	☐	☐	☐	☐	☐
iEmphsys	☐	☐	☐	☐	☐	☐
Fastrack	☐	☐	☐	☐	☐	☐
HomecareNet (Healthcare Automation/Mediware)	☐	☐	☐	☐	☐	☐
Organization Developed/Owned	☐	☐	☐	☐	☐	☐
Mestamed	☐	☐	☐	☐	☐	☐
PDX	☐	☐	☐	☐	☐	☐
Rx30	☐	☐	☐	☐	☐	☐
QS/1	☐	☐	☐	☐	☐	☐

5) **PROPOSED DEFINITIONS FOR DEMOGRAPHIC METRICS**

The Demographics data provided in the 2010 NHIA Provider Survey shed light on the number of patients treated by NHIA members, as well as the ages of those patients, the types of therapies administered, and the primary payers involved. The questions in this section of the survey seek to clarify these critical data definitions, as well as the degree to which providers can utilize their information systems to generate reports of the requested data.

UNIQUE PATIENT:

Anecdotally through member feedback and quantitatively as a result of analysis from the 2010 NHIA provider survey, we know that NHIA members count unique patients using different parameters or rationale. The more we are able to standardize this counting methodology, the more accurate this important data element will be.

As we learned from the 2010 Provider survey, unique patient counts differed from provider to provider in the following ways:

- Counted by therapy administered (one patient counted for each therapy administered in a calendar year)
- Counted by individual patient (one patient counted one time in a calendar year)

- Counted again when returning to service after hospitalization (possibly multiple times in the same calendar year)

In order to standardize how unique patients are counted in this industry, the NHIA Industry-Wide Data Initiative Work Group is proposing the following definition. After reading this definition, please answer the questions that follow:

Proposed Definition: *Unique Patient* A unique patient is a single patient identified by a unique medical record number that is assigned on initial admission and which follows the patient through any future re-admissions.

Rule # 1: If a company assigns a patient a new medical record number on each re-admission, a different unique patient identifier should be used (such as the Social Security number).

_____

Does your company use a single medical record number that follows the patient through every encounter/admission?

- ○ Yes
- ○ No

6) Can your company report on the unique number of patients served in a calendar year in accordance with the proposed definition noted above?

- ○ Yes
- ○ No

7) If no, please indicate which element of the proposed definition that your company could not apply when reporting unique patients: *(Select all that apply.)*

- ☐ We assign a new medical record number each time a patient is admitted, so the same patient could have multiple MR numbers.
- ☐ Our unique patient reporting counts unique MR numbers each month, so a patient who received service in every month of the calendar year would actually be counted 12 times in our unique patient census.
- ☐ We count a patient as new or unique each time they are re-admitted to service in the calendar year.

8) **THERAPY DAYS/LENGTH OF STAY:**

The total number of days a patient is on service is the alternate-site infusion industry's equivalent to a patient's length of stay. This includes the days a patient actively receives therapy, in addition to days a patient is inactive or on-hold but not yet discharged from service.

Therapy Days or patient length of stay is a key denominator for many of the measures and indicators our field can use for internal benchmarking. This critical information can also assist the industry in defining the value proposition of alternate-site infusion therapy, both to private payers and referral sources, as well as government payers and legislators in our quest for a comprehensive home infusion Medicare benefit.

Calculating how many days each patient is treated is difficult due to the lack of standardized definitions for patient "status". For instance, some providers count only those days the patient actually received infusion therapy, and others count every day the patient is on "service", whether they actively received therapy or not. Understanding how providers count therapy days will help us determine how best to capture this data in our 2013 Provider Survey.

Further adding to the complexity of this data element, we understand that multiple companies with the same information system, may apply different rules for what data is collected by that system and how it is used.

_____

Does your company assign a status to patients who are on service but *not* receiving therapy/treatment for reasons other than hospitalization? For example, a patient whose chemotherapy is delayed by doctor's order pending improvement in lab results. *(Select only one.)*

- ○ Yes, we change the patient's status to on-hold
- ○ Yes, we change the patient's status to inactive

    ○ No, the patient's status does not change

9) Does your company assign a status to patients who are on service but have been hospitalized? *(Select only one.)*

    ○ Yes, we change the patient's status to on-hold

    ○ Yes, we change the patient's status to inactive

    ○ Yes, we automatically discharge patients when they are hospitalized.

    ○ No, the patient's status does not change

10) **AUTOMATING THERAPY DAYS COUNTING:**

In order to automate data collection regarding therapy days, the NHIA Data Initiative Work Group discussed use of S-codes (per diem codes) to determine billed dates of service. However during this discussion, we learned that providers bill per diems using different methodologies. Some are based on contracts, others are based on the extent of care and services provided. Our goal with the next few survey questions is to better understand the variability in billed per diem days as we consider automated data collection options for arriving at total therapy days. After reading through each specific per diem scenario, please indicate the calendar days for which your company would bill a daily per diem based on the typical patient receiving the therapy shown.

Understanding that contracted terms may differ between payers, please select all of the days on which your company would bill a per diem for the therapy for a typical patient. For instance: Would you bill a per diem for the 14th, 15th, and 16th anticipating clinical monitoring and other skilled pharmacy services the day before and the day following a monthly IVIG dose? Or would you only bill a per diem on the day the IVIG was administered (the 15th)?

Per Diem Example 1: Patient receives IVIG Q 4 Weeks indefinitely, through a peripheral IV catheter that is placed for the administration only and removed when completed.

IVIG Q 4 Weeks

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15 Therapy Administered	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

	Check each day for which your organization would typically bill an IVIG per diem	Check each day for which your organization would count this patient as "On-Service" (as an active patient receiving service)
Our company doesn't administer IVIG to any patients. (Check either	☐	☐

column and move on to the next per diem example.)		
Day 1	☐	☐
Day 2	☐	☐
Day 3	☐	☐
Day 4	☐	☐
Day 5	☐	☐
Day 6	☐	☐
Day 7	☐	☐
Day 8	☐	☐
Day 9	☐	☐
Day 10	☐	☐
Day 11	☐	☐
Day 12	☐	☐
Day 13	☐	☐
Day 14	☐	☐
Day 15	☐	☐
Day 16	☐	☐
Day 17	☐	☐
Day 18	☐	☐
Day 19	☐	☐
Day 20	☐	☐
Day 21	☐	☐
Day 22	☐	☐
Day 23	☐	☐
Day 24	☐	☐
Day 25	☐	☐
Day 26	☐	☐
Day 27	☐	☐
Day 28	☐	☐
Day 29	☐	☐
Day 30	☐	☐

11) **Per Diem Example 2:** Patient self-administers SCIG once every week for 1-2 hours, indefinitely.

SCIG Q Week

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
3	4 *Therapy Administered*	5	6	7	8	9
10	11 *Therapy Administered*	12	13	14	15	16
17	18 *Therapy Administered*	19	20	21	22	23
24	25 *Therapy Administered*	26	27	28	29	30

	Check each day for which your organization would typically bill an SCIG per diem	Check each day for which your organization would count this patient as "On-Service" (as an active patient receiving service)
Our company doesn't administer SCIG to any patients. (Check either column and move on to the next per diem example.)	☐	☐
Day 1	☐	☐
Day 2	☐	☐
Day 3	☐	☐
Day 4	☐	☐
Day 5	☐	☐
Day 6	☐	☐
Day 7	☐	☐
Day 8	☐	☐
Day 9	☐	☐
Day 10	☐	☐
Day 11	☐	☐
Day 12	☐	☐
Day 13	☐	☐
Day 14	☐	☐
Day 15	☐	☐
Day 16	☐	☐
Day 17	☐	☐
Day 18	☐	☐
Day 19	☐	☐
Day 20	☐	☐
Day 21	☐	☐

Day 22	☐	☐
Day 23	☐	☐
Day 24	☐	☐
Day 25	☐	☐
Day 26	☐	☐
Day 27	☐	☐
Day 28	☐	☐
Day 29	☐	☐
Day 30	☐	☐

12) **Per Diem Example 3:** Patient is receiving a fluoruracil (5FU) infusion for 96 hours continuously via a tunneled catheter, every four weeks for six months. When not infusing 5FU, the patient receives catheter care maintenance.

5FU 96hrs Q4 Weeks

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
3	4 Therapy Administered	5 Therapy Administered	6 Therapy Administered	7 Therapy Administered	8 Therapy Administered	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

	Check each day for which your organization would typically bill a chemotherapy per diem	Check each day for which your organization would typically bill a catheter care per diem	Check each day for which your organization would count this patient as "On-Service" (as an active patient receiving service)
Our company doesn't administer 5FU to any patients. (Check either column and move on to the next per diem example.)	☐	☐	☐
Day 1	☐	☐	☐
Day 2	☐	☐	☐
Day 3	☐	☐	☐
Day 4	☐	☐	☐
Day 5	☐	☐	☐
Day 6	☐	☐	☐

Day 7	☐	☐	☐
Day 8	☐	☐	☐
Day 9	☐	☐	☐
Day 10	☐	☐	☐
Day 11	☐	☐	☐
Day 12	☐	☐	☐
Day 13	☐	☐	☐
Day 14	☐	☐	☐
Day 15	☐	☐	☐
Day 16	☐	☐	☐
Day 17	☐	☐	☐
Day 18	☐	☐	☐
Day 19	☐	☐	☐
Day 20	☐	☐	☐
Day 21	☐	☐	☐
Day 22	☐	☐	☐
Day 23	☐	☐	☐
Day 24	☐	☐	☐
Day 25	☐	☐	☐
Day 26	☐	☐	☐
Day 27	☐	☐	☐
Day 28	☐	☐	☐
Day 29	☐	☐	☐
Day 30	☐	☐	☐

13) **Per Diem Example 4:** Patient is receiving vancomycin IV every 36 hours for 6 weeks. No additional flush is administered between doses through the patients PICC line.

Vancomycin Dose Every 36 Hrs

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1 Therapy Administered 7 am	2 Therapy Administered 7 pm
3	4 Therapy Administered 7 am	5 Therapy Administered 7 pm	6	7 Therapy Administered 7 am	8 Therapy Administered 7 pm	9
10 Therapy Administered 7 am	11 Therapy Administered 7 pm	12	13 Therapy Administered 7 am	14 Therapy Administered 7 pm	15	16 Therapy Administered 7 am
17 Therapy Administered 7 pm	18	19 Therapy Administered 7 am	20 Therapy Administered 7 pm	21	22 Therapy Administered 7 am	23 Therapy Administered 7 pm
24	25 Therapy Administered 7 am	26 Therapy Administered 7 pm	27	28 Therapy Administered 7 am	29 Therapy Administered 7 pm	30

Check each day for which	Check each day for which	Check each day for which

	your organization would typically bill an anti-infective therapy per diem	your organization would typically bill a catheter care per diem	your organization would count this patient as "On-Service" (as an active patient receiving service)
Our company doesn't administer vancomycin to any patients. (Check either column and move on to the next survey question.)	☐	☐	☐
Day 1	☐	☐	☐
Day 2	☐	☐	☐
Day 3	☐	☐	☐
Day 4	☐	☐	☐
Day 5	☐	☐	☐
Day 6	☐	☐	☐
Day 7	☐	☐	☐
Day 8	☐	☐	☐
Day 9	☐	☐	☐
Day 10	☐	☐	☐
Day 11	☐	☐	☐
Day 12	☐	☐	☐
Day 13	☐	☐	☐
Day 14	☐	☐	☐
Day 15	☐	☐	☐
Day 16	☐	☐	☐
Day 17	☐	☐	☐
Day 18	☐	☐	☐
Day 19	☐	☐	☐
Day 20	☐	☐	☐
Day 21	☐	☐	☐
Day 22	☐	☐	☐
Day 23	☐	☐	☐
Day 24	☐	☐	☐
Day 25	☐	☐	☐
Day 26	☐	☐	☐
Day 27	☐	☐	☐
Day 28	☐	☐	☐
Day 29	☐	☐	☐
Day 30	☐	☐	☐

14) **COUNTING NUMBER OF THERAPIES PROVIDED BY PATIENT AGE:**

Many unique patients receive more than one therapy at the same time. We learned in our 2010 Provider Survey that methodologies for counting these therapies varied widely among providers, necessitating a common definition and counting methodology across the industry.

Proposed Rules: *Counting Number of Therapies by Patient Age*

1. Count every admission for the same patient as a new therapy, i.e. a course of antibiotics in January and a course in June for the same patient should count twice in the anti-infectives category.

2. Count multiple prescriptions within the same therapeutic category for the same patient; i.e. An order for ceftriaxone plus vancomycin for one patient should be counted as two therapies in the anti-infective category.

3. If a patient spans two age groups during the course of the year, count the patient in the lower age group only, do not count the therapy twice (in two age groups).

Example: A patient receiving TPN therapy throughout the year, a course of antibiotics in January and August, and catheter maintenance for two weeks while TPN was on hold, would be counted once in the TPN category, twice in the anti-infective category, and once in the catheter maintenance category.

Does your company agree with the proposed rules/example above?

○ Yes

○ No

15) If your company disagrees with any of these proposed rules, please explain why.

16) Is your company's reporting system able to provide therapy data by patient age in accordance with the proposed rules above?

○ Yes

○ No

17) If your company's reporting system is unable to provide therapy data by patient age in accordance with the proposed rules above, please explain why.

18) **DEFINING AND COUNTING PRESCRIPTIONS:**

We learned in the 2010 NHIA Provider Survey, that methodologies for counting Compounded Prescriptions (Rx), varied widely. In some cases, information systems differed in how they capture this data, or how they distinguished a "compounded" Rx from a "non-compounded" Rx. In other cases, providers themselves differed in what they defined as "compounded" vs "non-compounded".

For instance, some providers counted a seven-day supply of Total Parenteral Nutrition (TPN) as seven compounded items, while others consider this just one compounded prescription. Likewise, some providers counted every heparin or saline flush as a dispensed (non-compounded) item, while others counted the entire lot that was dispensed under the same prescription as just one non-compounded prescription.

Further clarification of what constitutes a compounded vs. non-compounded prescription is needed with future surveys to ensure consistent, comparable data, and is proposed in the following definition:

Proposed Definition: *Dispensed Prescription* A single prescription, regardless of how many items or units are included in that prescription, is counted one time when dispensed. For example, a prescription for seven days of once-daily heparin flush solution would count as one prescription, not 7 different prescriptions.

○ Our company agrees with this definition

○ Our company disagrees with this definition

19) If your company disagrees with this definition, please explain why.

20) Can your company generate a report of the total number of prescriptions dispensed according to this definition?

  ○ Yes
  ○ No

21) If your company cannot generate a report of the total number of prescriptions dispensed according to the proposed definition, please explain why.

  [   ]

22) **Proposed Definition:** *Compounded Prescriptions* This definition has two parts, clarifying the degree to which an ISO 5 environment impacts the definition of a compounded prescription.

  PART A: A compounded prescription refers to a single dispense of a prescription for any sterile preparation that required handling in an ISO 5 environment.

  ○ Our company agrees with this statement
  ○ Our company disagrees with this statement

23) If your company disagrees with this statement, please explain why.

  [   ]

24) **PART B:** A vial of medication that was labeled outside of an ISO 5 environment and required no manipulation on the part of the pharmacy is *NOT* a compounded item.

  ○ Our company agrees with this statement
  ○ Our company disagrees with this statement

25) If your company disagrees with this statement, please explain why.

  [   ]

26) Can your company's information system generate a report of the number of prescriptions that were compounded vs. non-compounded according to the above two-part definition?

  ○ Yes
  ○ No

27) **PREVIOUS SITE OF PATIENT CARE:**

  NHIA contends that one of the many benefits of home infusion therapy is the avoidance of hospitalizations when patients can begin HIT in their home rather than in the hospital. We are interested in learning about where your new patient referrals were diagnosed and/or started care, in order to determine the degree to which hospital avoidance is already occurring.

  Please indicate which data your company could provide regarding the number of patients who started service with your company from the following sites of previous care. If YES, please indicate whether the data source is an information system-driven report (IS) or manually produced (MAN).

  Can your company produce data regarding the number of new patient referrals who . . .

	Yes	No	Information system driven report	Manual reporting	Not applicable

Are discharged from a hospital to receive HIT?	☐	☐	☐	☐	☐
Are discharged from a long term care setting to receive HIT?	☐	☐	☐	☐	☐
Received first dose/start of therapy in an outpatient center (not your Ambulatory Infusion Suite/Center [AIS/AIC]) before transitioning to HIT?	☐	☐	☐	☐	☐
Received first dose/start of therapy in a physician's office before transitioning to HIT?	☐	☐	☐	☐	☐
Received first dose/start of therapy in your company's AIS/AIC before transitioning to HIT?	☐	☐	☐	☐	☐
Started HIT as a first-dose, without receiving the medication initially in an inpatient admission or outpatient treatment facility?	☐	☐	☐	☐	☐

28) **PROPOSED DEFINITIONS FOR FINANCIAL METRICS AND OPERATIONAL BENCHMARKS**

Financial and operational benchmarks not only provide valuable aggregate data about the size and scope of our industry as a whole, but also offer individual providers an important opportunity to benchmark their own performance against this aggregate. Successful benchmarking requires that first we ensure all providers are reporting their data following the same rules and standardized definitions.

Together, NHIA and its provider members can define our value as we develop data-driven industry-wide definitions for financial metrics and operational benchmarks, all of which can help members differentiate their business when communicating with referral sources, advocating for fair reimbursement from payers during contract negotiations, and improving their bottom line.

_____

Proposed Definition: _Net Infusion Revenue_ Refers to the gross revenue* minus the contractual allowance** and discounts*** for infusion services only (includes all drugs, supplies, equipment and professional services required to deliver infusion therapy).

*Gross Revenue - Gross revenue is defined as the sum of the list price for all items and services received by the patient.

**Contractual Allowance - The difference between the contracted rate with an insurance company and the gross revenue billed is referred to as a contractual allowance,

*** Discounts - The difference between list price for all items and services and the amount billed to the payer/patient on claims, due to managed care or other agreements to discount price.

○ Our company agrees with this definition

○ Our company does not agree with this definition

29) If your company disagrees with this definition, please explain why.

[   ]

30) Is your company reporting system capable of providing this data in accordance with the proposed definition above?

○ Yes

○ No

31) If your company reporting system is unable to provide data Net Infusion Revenue, please explain why.

[   ]

32) Is your company willing to provide this data in an upcoming NHIA survey?

○ Yes

○ No

33) If your company is not willing to provide data Net Infusion Revenue, please explain why.

[   ]

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34) **Proposed Definition: _Bad Debt Expense as a % of Net Revenue_** Bad debt expense as a percentage of net revenue is calculated by taking bad debt expense for a specified period of time divided by net revenue from the same period of time (multiplied by 100 to convert to a percent).

○ Our company agrees with this definition

○ Our company does not agree with this definition

35) If your company disagrees with this statement, please explain why.

[   ]

36) Is your company reporting system capable of providing this data in accordance with the proposed definition above?

○ Yes

○ No

37) If your company reporting system is unable to provide data for Bad Debt as a % of Net Revenue, please explain why.

[   ]

38) Is your company willing to provide this data in an upcoming NHIA survey?

○ Yes

○ No

39) If your company is not willing to provide data for Bad Debt as a % of Net Revenue, please explain why.

[   ]

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40) **Proposed Definition: _Days Sales Outstanding (DSO)_** - DSO is calculated by taking the infusion service accounts receivable (AR) balance divided by average daily net revenue over the most recent three month period.

Example:

Net Revenue

January = $100,000; 31 days

February = $120,000; 29 days

March = $130,000; 31 days

Total = $350,000; 91 days

Accounts Receivable (Infusion Services ONLY) as of March 31st = $275,000

3 Month Average Daily Net Revenue = $350,000 net revenue/91 days = $3,846 revenue per day

DSO = AR/Average Daily Net Revenue

DSO = $275,000/$3,846 = 71.5 days

Does your company agree with the definition and calculation above?

○ Yes
○ No

41) If your company disagrees with this definition, please explain why.

[   ]

42) Can your company reporting system provide this data in accordance with the proposed definition above?

○ Yes
○ No

43) If your company reporting system cannot provide this data in accordance with the proposed definition above, please explain why.

[   ]

44) Is your company willing to provide this data in an upcoming NHIA survey?

○ Yes
○ No

45) If your company is not willing to provide data, please explain why.

[   ]

46) **Proposed Definition:** *Charity Care Provided as a Percent of Net Revenue*

This calculation takes the total amount of AR written off in a specified time period, for provision of indigent care, divided by the total net revenue earned in the same time period.

Does your company agree with the definition above?

○ Yes
○ No

47) If your company disagrees with this definition, please explain why.

[   ]

48) Is your company willing to provide this data in an upcoming NHIA survey?

○ Yes
○ No

49) If your company is not willing to provide data, please explain why.

[   ]

50) Can your company reporting system provide this data in accordance with the proposed definition above?

   ○ Yes
   ○ No

51) If your company reporting system is unable to provide this data in accordance with the proposed definition above, please explain why.

[   ]

52) **Proposed Definition: *Cost per RN Visit***

This calculation accumulates all field RN costs in a specified time period, and divides by the number of RN visits made in the same time period. Depending on staffing compensation models and company policy for use of vehicles, the costs included in this calculation may vary. These costs do not include overhead allocation.

At a minimum, the following costs should be included (if applicable):

   - RN wages, taxes, and benefits
   - Mileage associated with RN visits
   - Expenses associated with company vehicles such as auto repairs, maintenance, gasoline
   - Depreciation on vehicles
   - Payments made to agencies for nursing visits (only if contracted visits are included in denominator)

Does your company agree with the definition above?

   ○ Yes
   ○ No

53) If your company disagrees with this statement, please explain why.

[   ]

54) Is your company willing to provide this data in an upcoming NHIA survey?

   ○ Yes
   ○ No

55) If your company is not willing to provide data, please explain why.

[   ]

56) Can your company reporting system provide this data in accordance with the proposed definition above?

   ○ Yes
   ○ No

57) If your company reporting system is unable to provide this data in accordance with the proposed definition above, please explain why.

[   ]

58) **Proposed Definition: *Pharmacy Cost per Rx Dispensed***

This calculation is based on the following:

- Pharmacy salaries and benefits
- # of prescriptions dispensed

Divide total pharmacy costs by the number of prescriptions dispensed over the reporting period. These costs do not include overhead allocation.

Does your company agree with the definition above?

○ Yes

○ No

59) If your company disagrees with this statement, please explain why.

60) Is your company willing to provide this data in an upcoming NHIA survey?

○ Yes

○ No

61) If your company is not willing to provide this data, please explain why.

62) Can your company reporting system provide this data in accordance with the proposed definition above?

○ Yes

○ No

63) If your company reporting system cannot provide this data in accordance with the proposed definition above, please explain why.

64) **DOCUMENTING UNSCHEDULED DELIVERIES**

In the 2010 NHIA Provider Survey, providers (n=110) indicated that on average 80% of deliveries were scheduled, 11% were unscheduled deliveries made after hours and 9% were unscheduled deliveries during normal business hours.

Proposed Definition: *Unscheduled Deliveries*

An unscheduled delivery is any delivery that had to be added to the daily delivery schedule after drivers/couriers or other modes of delivery had already been deployed for that day. In general, unscheduled deliveries add cost to the system and should be avoided when possible.

Proposed Rule #1: Unscheduled deliveries can be made during normal business hours or after hours.

Proposed Rule #2: A new start of care is not considered an unscheduled delivery.

Does your company agree with the definition and rules above?

○ Yes

○ No

65) If your company disagrees with this statement, please explain why.

66) Can your company report the total number of unscheduled deliveries in a calendar year?

   ○ Yes
   ○ No

67) If your company reporting system cannot provide this data in accordance with the proposed definition above, please explain why.

   [   ]

68) Can your company further report on the number of unscheduled deliveries with regard to the following reason codes and whether the delivery was avoidable/unavoidable and resolved after hours/during normal business hours? (*Select all that apply.*)

	Our company can report on whether a delivery as Avoidable/ Unavoidable for these reason codes:	Our company can report on whether a delivery was made After hour/During Normal Business Hours for these reason codes:	Our company does not track this reason code
Back order - drug/supply shortage	☐	☐	☐
Delivery/shipping error	☐	☐	☐
Drug/formula order change	☐	☐	☐
Intake Nurse error	☐	☐	☐
Nursing agency error	☐	☐	☐
Patient error	☐	☐	☐
Patient request	☐	☐	☐
Pharmacy error	☐	☐	☐
Product failure	☐	☐	☐
Product/item selection error	☐	☐	☐
Pump preventative maintenance	☐	☐	☐
Supply order change	☐	☐	☐

69) Our company uses other reason codes for unscheduled/unavoidable deliveries *(Please list.)*

   [   ]

70) **REFERRALS NOT ACCEPTED ON TO SERVICE/"NO-GOES"**

   NHIA would like to quantify the number of potential Medicare beneficiaries who are forced to receive infusion therapy in institutional or other undesirable settings due to the lack of a comprehensive Medicare benefit. To that end, we are seeking information regarding the way in which your organization collects data for those referrals you are not able to treat or accept onto service (No-Goes").

   Does your company document the total number of referrals received, regardless of whether each referral translates into a patient admitted on your service?

○ Our company can only report the number of patients referred who are on or have received service.

○ Our company can report both the number of referred patients who are on or have received services as well as the number of patients referred but not treated for various reasons i.e. no-goes.

71) Does your company document the reason codes for referral "no-goes"?

　　　○ Yes

　　　○ No

72) If no, please explain why.

　　　[   ]

73) If yes, please check all of the reason codes below that your company currently tracks for "no-goes". (Select all that apply.)

　　　☐ No Commercial Insurance benefit

　　　☐ No Medicare benefit

　　　☐ Inadequate Commercial Insurance benefit, patient unable/unwilling to cover the difference

　　　☐ Inadequate Medicare benefit, patient unable/unwilling to cover the difference

　　　☐ Drug not appropriate for home administration

　　　☐ Patient home environment unsuitable for HIT

　　　☐ Patient/care giver unable/unwilling to manage HIT

　　　☐ Our company does not document the reason for "no-goes"

　　　☐ Other

74) If other, please provide a listing.

　　　[   ]

75) **PROPOSED DEFINITIONS FOR OUTCOMES METRICS**

NHIA is evaluating clinical outcomes measures that will provide benchmarking opportunities for members, and that could contribute to defining the value of alternate-site infusion services.

The need for consistently defined, collected and reported clinical outcomes data is an essential component to the establishment of evidence-based best practices in the alternate-site infusion industry. The extent to which providers are already collecting and measuring a wide range of clinical outcomes data is encouraging, and lends itself to the next step: adoption of uniform definitions to drive consistent and comparable data collection.

If industry-wide patient outcomes could be defined, collected and published, providers could utilize this data to improve their clinical decision-making, define best practices and ultimately improve the quality of care they provide.

Which Clinical Outcomes Should We Measure?

NHIA Data Initiative Work Group Members shared their clinical outcomes "lists" for the 2010 NHIA Provider Survey and we asked survey respondents which of the listed outcomes they currently tracked. Responses ranged from a high of 98% of providers who collected data about Adverse Drug Reactions, to a low of 58% of providers who collect data about referral source satisfaction, with a wide range of measures and data collection in between.

Understanding what outcomes data providers are already collecting was just the first step - our next steps will be to determine standardized definitions for some of the key measures we should adopt as an industry. In the evolving pay-for-performance (P4P) health care delivery paradigm that is currently impacting acute care providers, ideal industry-wide outcomes would measure the value of care provided, including cost-effectiveness and clinical quality.

The Outcomes Subgroup of the NHIA Data Initiative Work Group considered how other sectors of health care

(e.g. acute care, long term care) are evaluating outcomes and quality, and arrived at the following set of measures as a starting point for our industry to define and adopt:

- Interruptions in Service
  - Unscheduled Hospitalizations
  - Emergency Room Visits
- Adverse Drug Reactions
- Adverse Catheter Events
- Status on Discharge
- Patient Satisfaction

Your company's perspectives on each of these measures will contribute to the eventual development of industry-wide definitions and measures that can be adopted and then reported on.

Unscheduled Hospitalizations:

In the 2010 NHIA Provider Survey, 87% of responding pharmacy sites (n=283) reported that they track unscheduled hospitalizations. As the low-cost site of care, alternate-site infusion providers strive to maintain patients at home with their prescribed infusion therapy, avoiding costly hospitalizations and re-hospitalizations to the degree possible. Data regarding rates of unscheduled hospitalizations could assist the alternate-site infusion industry in demonstrating our value proposition to payers, particularly if we are able to designate any unscheduled hospitalization as either being related to, or not related to, the infusion therapy being provided or the condition being treated.

Proposed Definition: *Unscheduled Hospitalization* Applies when an active patient requires an unplanned stay of more than 23 hours in an acute care facility for any reason.

- ☐ Our company agrees with this definition
- ☐ Our company does not agree with this definition

76) If your company disagrees with proposed definition for "Unscheduled Hospitalization", please explain why.

[   ]

77) Is your company reporting system capable of providing this data in accordance with the definition above?

- ○ Yes
- ○ No

78) If your company is unable to provide this data in accordance with the definition above, please explain why.

[   ]

79) Is your company willing to provide this data in an upcoming NHIA survey?

- ○ Yes
- ○ No

80) If your company is unwilling to provide this data in accordance with the definition above, please explain why.

[   ]

81) **Proposed Definition:** *RELATED Unscheduled Hospitalization* A hospitalization to treat a condition or event associated directly with the IV medication, IV catheter or the condition being treated with IV therapy.

Proposed Definition: *UNRELATED Unscheduled Hospitalization* A hospitalization to treat a condition or event NOT associated with the IV medication, IV catheter or the condition being treated with IV therapy.

Examples of *Related* Unscheduled Hospitalizations:

1) A patient is admitted to the hospital unexpectedly due to onset of a fever of unknown origin and signs of an infected catheter site.

2) A physician admits a patient currently receiving IV antibiotics for observation due to worsening of cellulitis.

3) A patient experiences a sudden negative shift in renal function after receiving four days of IV Vancomycin.

<u>Examples of *Unrelated* Unscheduled Hospitalization:</u>

1) A patient is in a car accident and is admitted to the hospital for treatment of new injuries.

2) A patient currently receiving home IV antibiotics for a foot wound is admitted to the hospital for symptom management related to congestive heart failure

Our company agrees with the definitions of *related* and *unrelated* as they pertain to categorizing unscheduled hospitalizations.

    ○ Yes

    ○ No

82) If your company disagrees with these statements, please explain why.

83) Is your company reporting system capable of providing this data in accordance with the definition above?

    ○ Yes

    ○ No

84) If your company is unable to provide this data in accordance with the definition above, please explain why.

85) Is your company willing to provide this data in an upcoming NHIA survey?

    ○ Yes

    ○ No

86) If your company is unwilling to provide this data in accordance with the definition above, please explain why.

87) Please indicate which, if any, of the below reason codes that your company uses when tracking RELATED unscheduled hospitalizations. (Select all that apply.)

    ☐ Adverse IV drug reaction/event

    ☐ Catheter infection

    ☐ Catheter event, other than infection

    ☐ Worsening of condition being treated with IV therapy/disease progression

    ☐ Infection (other than catheter related)

    ☐ Non-adherence

    ☐ Change in home environment/lack of support

    ☐ Other

88) Please list other reason codes, not listed above, that your company uses to track *Related* unscheduled hospitalizations.

[   ]

89) Understanding that some hospitalizations occur without the HIT provider being aware, please ***estimate*** how many hospitalizations you believe your tracking/reporting process captures for every 10 unscheduled hospitalizations that actually occur.

For instance, if you are confident that your tracking system is robust and even includes hospitalizations that you learn about after-the-fact, then you may estimate that you capture as many as 9 or 9.5 out of every 10 unscheduled hospitalizations. If, on the other hand, you feel certain that most after-the-fact hospitalizations are ***not*** making their way into your tracking system, you may estimate that you capture only 6 out of every 10 unscheduled hospitalizations that actually occur among your patients.

Please estimate a number.

[   ]

90) **Emergency Room Visits**

Proposed Definition: *Emergency Room Visit* Any visit to an acute care facility for immediate treatment resulting in a stay of less than 23 hours, that occurred in an active patient for any reason.

- ○ Our company agrees with this definition
- ○ Our company does not agree with this definition

91) If your company disagrees with this definition, please explain why.

[   ]

92) Is your company reporting system capable of providing this data in accordance with the definition above?

- ○ Yes
- ○ No

93) If your company is unable to provide this data in accordance with the definition above, please explain why.

[   ]

94) Is your company willing to provide this data in an upcoming NHIA survey?

- ○ Yes
- ○ No

95) If your company is unwilling to provide this data in accordance with the definition above, please explain why.

[   ]

96) **Proposed Definition: *RELATED Emergency Room Visit*** An emergency room visit to treat a condition or event associated directly with the IV medication, IV catheter or the condition being treated with IV therapy.

Proposed Definition*: UNRELATED Emergency Room Visit* An emergency room visit to treat a condition or event NOT associated with the IV medication, IV catheter or the condition being treated with IV therapy.

Examples of *Related* Emergency Room Visits:

1) A patient visits the emergency room for evaluation of redness at the catheter site, and is sent home within 3 hours after receiving a catheter dressing change.

2) A physician instructs a patient receiving IV antibiotics to report to the emergency room for evaluation of worsening of cellulitis. The patient's wound is assessed and the patient is released within 4 hours.

Examples of *Unrelated* Emergency Room Visits:

1) A patient is in a car accident and is sent to the emergency room for evaluation and treatment of new injuries, but is released within 6 hours.

2) A patient currently receiving home IV antibiotics for a foot wound reports voluntarily to the emergency room due to worsening shortness of breath. The patient is evaluated and instructed to change the dose of an oral medication and sent home within 12 hours.

_____

Our company agrees with the definitions of *related* and *unrelated* as they pertain to categorizing emergency room visits.

   ○ Yes
   ○ No

97) If your company disagrees with this statement, please explain why.

   [   ]

98) Is your company reporting system capable of providing this data in accordance with the definition above?

   ○ Yes
   ○ No

99) If your company is unable to provide this data in accordance with the definition above, please explain why.

   [   ]

100) Is your company willing to provide this data in an upcoming NHIA survey?

   ○ Yes
   ○ No

101) If your company is unwilling to provide this data in accordance with the definition above, please explain why.

   [   ]

102) Please indicate which, if any, of the below reason codes that your company uses when tracking RELATED emergency room visits. (Select all that apply.)

   ☐ Adverse IV drug reaction/event
   ☐ Catheter infection
   ☐ Catheter event, other than infection
   ☐ Worsening of condition being treated with IV therapy/disease progression
   ☐ Infection (other than catheter related)
   ☐ Non-adherence
   ☐ Change in home environment/lack of support
   ☐ Other

103) Please list other reason codes, not listed above, that your company uses to track *Related* emergency room visits.

   [   ]

104) Understanding that some emergency room visits occur without the HIT provider being aware, please estimate how many emergency room visits you believe your tracking/reporting process captures for every 10 unscheduled emergency room visits that actually occur.

For instance, if you are confident that your tracking system is robust and even includes emergency room visits that you learn about after-the-fact, then you may estimate that you capture as many as 9 or 9.5 out of every 10 unscheduled emergency room visits. If, on the other hand, you feel certain that most after-the-fact emergency room visits are not making their way into your tracking system, you may estimate that you capture only 6 out of every 10 unscheduled emergency room visits that actually occur among your patients.

Please estimate a number.

[   ]

---

105) **ADVERSE DRUG REACTIONS (ADRs)**

In the 2010 NHIA Provider Survey, 98% of responding pharmacy sites (n=283) reported documentation of adverse drug reactions. Before the HIT industry can begin to benchmark individual results, we must first establish a universal definition and classification system for reporting ADRs.

NHIA proposes using this ADR definition developed by the World Health Organization:

"A response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for modification of physiological function." (WHO Technical Report 498, 1972)

WHO has also developed a classification system to describe ADR severity that is the current standard in clinical trials:

Serious: Any adverse event occurring that results in any of the following outcomes: Death, a life-threatening adverse event, requires inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant disability/incapacity, or a congenital anomaly/birth defect.

Severe: An experience that requires therapeutic intervention. If hospitalization is required for treatment it becomes a serious adverse event.

Moderate: An experience that is alleviated with simple therapeutic treatments.

Mild: An experience that is usually transient and requires no special treatment or intervention.

Does your company agree with NHIA's adoption of the ADR definition and classification of severity developed by the World Health Organization?

　○ Yes
　○ No

106) Can your company reporting system provide the number of adverse drug reactions for a calendar year?

　○ Yes
　○ No

107) If your company reporting system cannot provide the number of adverse drug reactions in a calendar year, please explain why.

[   ]

108) Can your company reporting system further categorize the number of adverse drug reactions in a calendar year according to each category of severity in the WHO's classification system?

　○ Yes
　○ No

109) If your company reporting system cannot further categorize the number of adverse drug reactions in a calendar year according to each category of severity in the WHO's classification system, please explain why.

[   ]

110) Is your company willing to provide the number of adverse drug reactions in a calendar year in an upcoming NHIA survey?

- ○ Yes
- ○ No

111) If your company is unwilling to provide the number of adverse drug reactions in a calendar year in an upcoming NHIA survey, please explain why.

[   ]

112) Does your organization document clinical interventions performed in response to an ADR?

- ○ Yes
- ○ No

113) If yes, which of the below categories do you use to track interventions made in response to an ADR? (Select all that apply.)

- ☐ Provided teaching/education
- ☐ Dose held
- ☐ Dose/frequency changed
- ☐ New medication administered (i.e. diphenhydramine for rash, etc)
- ☐ Discontinued IV medication
- ☐ Unscheduled RN visit performed
- ☐ Hospitalized
- ☐ Emergency Room Visit
- ☐ Labs drawn
- ☐ Equipment replaced
- ☐ FDA notification
- ☐ Other

114) Our company uses other categories (please list below).

[   ]

115) Which of the following outcomes of a suspected ADR does your company record? *(Select all that apply.)*

- ☐ IV services continued with changes
- ☐ IV services continued without changes
- ☐ Discharged from IV services
- ☐ Hospitalized
- ☐ Catheter patency restored (for catheters)
- ☐ Death
- ☐ Other
- ☐ Our company does not record the outcome using any of the above categories.

116) Our company uses other categories when documenting the outcome of a suspected ADR (please list below).

[   ]

117) **<u>ADVERSE CATHETER EVENT</u>**

In the 2010 NHIA Provider Survey, 97% of providers indicated they are tracking catheter infections; 80% are

tracking catheter occlusions; 72% are tracking catheter phlebitis and 71% are tracking catheter dislodgement.

Yet, only 66% are counting and reporting catheter dwell time in the # of days. CDC guidelines recommend reporting of catheter complications per 1000 catheter days in order to create a consistent denominator across all sites of health care, and to account for complications that occur over time.

Proposed Definition: *Catheter-Related Blood Stream Infection(CR-BSI)*

Suspected CR-BSI

- Patient has an IV catheter in place for at least 48 hours, and is exhibiting one or more clinical signs of infection (fever, chills, hypotension), and has no apparent source for the BSI except the catheter.

Confirmed CR-BSI

- At least one positive peripheral blood culture.
- If available, simultaneous quantitative blood culture from the catheter and a peripheral site with a >5:1 ratio of catheter to peripheral (e.g. the catheter sample grows at least 5 times the number of organisms compared to the peripheral sample).
- If available, differential time to positivity of >2 hours catheter to peripheral blood culture (catheter culture appeared "positive" at least two hours before peripheral blood showed growth of the same organism).

Does your company agree with the definition above?

- ○ Yes
- ○ No

118) If your company disagrees with this definition, please explain why.

[   ]

119) Can your company reporting system provide this data in accordance with the proposed definition above?

- ○ Yes
- ○ No

120) If your company reporting system cannot provide this data in accordance with the proposed definition above, please explain why.

[   ]

121) Is your company willing to provide this data in an upcoming NHIA survey?

- ○ Yes
- ○ No

122) If your company is not willing to provide this data, please explain why.

[   ]

123) Can you report the number of *adverse catheter events* according to catheter type? *(Select all that apply.)*

	Dislodgement	Occlusion	Phlebitis	Infection	Damage/Breakage	Not Applicable
Central Venous Catheter (CVC), Tunneled	☐	☐	☐	☐	☐	☐

Central Venous Catheter (CVC), Non-Tunneled	☐	☐	☐	☐	☐	☐
Implanted Port	☐	☐	☐	☐	☐	☐
Intraspinal	☐	☐	☐	☐	☐	☐
Peripheral (PIV)	☐	☐	☐	☐	☐	☐
PICC/Midline	☐	☐	☐	☐	☐	☐

124) Does your company document any other adverse catheter event?

[   ]

125) Does your company track **_suspected_** CR-BSI?

     ○ Yes

     ○ No

126) If yes, does your company have a protocol in place for confirming suspected CR-BSI?

[   ]

127) Does your company currently track **_confirmed_** CR-BSI?

     ○ Yes

     ○ No

128) If yes, does your company track the following parameters?

	Yes	No
Causative organism	○	○
Time to positivity (see definition above)	○	○
Quantitative culture results (numberof organisms in the sample)	○	○

129) Can your company report _total catheter dwell days_ by catheter type? *(Select Yes or No.)*

	Yes	No	Not Applicable
Central Venous Catheter (CVC), Tunneled	○	○	○
Central Venous Catheter (CVC), Non-Tunneled	○	○	○
Implanted Port	○	○	○
Intraspinal	○	○	○
Peripheral (PIV)	○	○	○
PICC/Midline	○	○	○

130) **Calculating the Rate of Catheter Complications per 1000 Catheter Days:**

In March there were 3 CR-BSIs and 491 central-line days.

The calculation for the CR-BSI rate is the number of infections in March, divided by the number of central line days in March and multiplied by 1000

3/491 x 1000 = 6.1

The rate is interpreted as 6.1 CR-BSIs per 1000 catheter days in March

If your company tracks total catheter dwell days, do you calculate catheter complication rates (such as CR-BSI) per 1000 catheter days (as shown in the example calculation above)?

○ Yes
○ No

131) **PATIENT STATUS UPON DISCHARGE**

Does your company document patient status upon discharge?

○ Yes
○ No

132) **Proposed Definition:** ***Therapy Complete at Discharge*** Applies to any patient who administered all prescribed doses at the time of discharge.

Proposed Rules:

Rule # 1 Patients count as having completed therapy even if there were interruptions for adverse events, hospitalizations or catheter events.

Rule # 2 The designation "Therapy Complete" does not factor in progress toward specific therapy goals or continuation of oral antibiotics after cessation of IV treatment.

○ Our company agrees with this definition/rules
○ Our company does not agree with this definition/rules

133) If your company disagrees with the proposed definition and rules for "Therapy Complete at Discharge", please explain why.

[   ]

134) Is your company reporting system capable of providing this data in accordance with the definition above?

○ Yes
○ No

135) If your company is unable to provide this data in accordance with the definition above, please explain why.

[   ]

136) Is your company willing to provide this data in an upcoming NHIA survey?

○ Yes
○ No

137) If your company is unwilling to provide this data in accordance with the definition above, please explain why.

[   ]

138) In addition to Therapy Complete, which of the following discharge status categories does your company use? (Select all that apply.)

☐ Death - expected
☐ Death - unexpected
☐ Hospitalized
☐ Transfer to alternate site/level of care (hospice, SNF, HHA/VNA)
☐ Insurance change
☐ Lack of adherence

☐ Adverse drug reaction

☐ Change in home environment/lack of caregiver

☐ Loss of IV access

☐ Other

139) Please list other discharge status codes used at your company.

[   ]

140) **PATIENT SATISFACTION SURVEY MEASURES**

For the past two years, health care reform has brought a number of models of health care delivery forward for evaluation, all trying to achieve the triple aim: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. A critical voice in the success or failure of these new health care delivery models is that of the patient -- how satisfied is the patient with the level of care they have received? This voice is so critical, that measurement and reporting of patient satisfaction has been deemed a mandatory requirement for all Accountable Care Organizations (ACOs), one of the most visible new models being explored under health care reform.

Patient satisfaction as one measure of provider quality has existed in the alternate-site infusion industry for many years, driven in part by accreditation standards and also by the value derived from regularly assessing your company's customer service from the customer's perspective. The Data Initiative Outcomes Subgroup compared their respective organization's Patient Satisfaction Survey tools to determine the level of commonality that already existed among this small group of industry providers. The results were surprising: 15 satisfaction questions were identified that had commonality among the majority of the providers.

Building from this commonality, the Outcomes Subgroup has proposed the following list of standardized patient satisfaction survey questions. Please refer to your company's most recent patient satisfaction survey as you respond to the next series of questions. Indicate with the degree to which your company incorporates the proposed patient satisfaction survey questions below into your current survey.

Proposed Satisfaction Survey Measures:

	No: Our company does not ask this question on our current survey.	Nearly: Our company asks a similar but slightly different question on our current survey.	Yes: Our company currently asks this question, or a similarly worded question with the same meaning, as part of our patient satisfaction survey.
The equipment provided/delivered was clean and in good working order.	○	○	○
The equipment and supplies provided were adequate to meet my home infusion needs.	○	○	○
The medications, equipment and supplies were delivered on time.	○	○	○
Rate your interactions with the following personnel (delivery, nurses, billing, pharmacists) and whether each was	○	○	○

courteous and helpful.			
Instruction was adequate for whom to call if you had a problem.	○	○	○
The response received to calls for assistance after regular business hours was satisfactory.	○	○	○
The services provided met your needs and expectations.	○	○	○
You were informed of the possible side effects of the medication you received.	○	○	○
The instructions were adequate to teach you or your caregiver how to give the intravenous (IV) medications.	○	○	○
The nurses were knowledgeable regarding your infusion therapy.	○	○	○
The nurses were on time.	○	○	○
The explanation of your financial responsibilities was adequate.	○	○	○
You were included in decisions regarding the planning of your care.	○	○	○
You were satisfied with the overall experience of receiving IV therapy at home.	○	○	○
You would recommend our service to your family and friends.	○	○	○

141) Please list the scale used by your organization for patient satisfaction surveys.

<u>Example:</u>

1 to 5 Likert scale, in which 5= Strongly Disagree; 4= Disagree; 3= Neutral; 2= Agree; and 1= Strongly

Agree.

Dear [Q2a],

Thank you for completing the NHIA 2012 Data Definitions Survey. Your survey responses have been sent to you as a separate email. If you do not receive this email, please check your spam filters and junk email folder. Please print and save your survey answers for future reference. If you have any additional comments that were not addressed in this survey, please forward those to my email address below.

Respectfully,

Kristen Santaromita

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