What's Down the Road?

Reflecting Upon Hospital-Based Lessons-Learned to Enhance Alternate-Site Performance Improvement Approaches and Industry-Wide Benchmarking

By Jeannie Counce

There is no question that when it comes to health care reform, a great number of issues remain undecided. But that doesn't mean that health care delivery will be static. There are too many compelling reasons to continually improve upon the practice of treating patients.

Taking the patient's best interest to heart, individual clinicians and organizations strive to provide quality care and satisfy customers. This alone is enough motivation for many to examine their processes and outcomes looking for ways to improve. Yet there are clear business incentives as well. By tracking and analyzing certain data points, an organization can lower its costs of delivering care, reduce risk, and establish itself as a strong competitor in its marketplace.

While some form of quality management is a "given" to many alternate-site infusion providers, including those who are accredited, the process remains voluntary and relatively inconsistent. There is no standardized set of metrics or national benchmarks, and no consistent method of connecting performance with remuneration.

Considering the health care environment of rapid change, it's difficult to imagine that the status quo will remain for long. When we take the long view on health care delivery—and look around at other sectors—we must imagine a future where quality will be defined and measured across our industry, and could eventually be tied to reimbursement levels.

For Example

Consider developments in the acute care sector over the past dozen years. The eye-opening 1999 Institutes of Medicine (IOM) report, *To Err is Human*, made the direct connection between inconsistent practices and unnecessarily poor clinical outcomes—as well as enormous, needless overspending. The staggering annual estimates of 98,000 lost lives and $17 billion in additional costs to the health care system it referenced caught the attention of many Americans, and certainly many policymakers.[1]

As a direct result, many hospitals began to focus their individual quality assurance efforts on the areas identified by the IOM as ripe for improvement. But attention had been permanently shifted to the quality chasm, and hospitals began to experience growing pressure from a variety of external forces as well.

Representing private consumers, the nation's largest corporations and other purchasers of health care benefits, the Leapfrog Group, created a system of "rewarding" hospitals that implemented proven quality and safety practices with the

business of its members. Leapfrog's buying power—and effect on quality patient care—has grown exponentially since it was founded in 2000. The consortium now represents public and private employers who provide benefits to more than 37 million Americans in all 50 states. In 2008, Leapfrog estimated that if all hospitals implemented just the first three of its four recommended quality and safety practices, called "leaps," more than 57,000 lives could be saved, more than three million medication errors could be avoided, and up to $12.0 billion could be saved each year.[2]

On the public side, as the largest purchaser of health care services in the country, the federal government's Medicare program was also intensely interested in improving the performance of America's hospitals and began to use a combination of techniques to encourage change. Over the course of eight years the Centers for Medicare & Medicaid Services (CMS) has advanced regulations that define certain quality indicators; encouraged—and then required—hospital reporting; and developed evidence-based best practices.

The process has been gradual, and for the first several years, generally used a "carrot" approach for early adopters. In 2003, CMS introduced a public-private collaboration, known as the Hospital Quality Alliance, to improve quality. Two years later, it created the Hospital Compare website, which makes quality-of-care information available to the public.

A few years ago, the agency turned a corner by introducing a "stick approach." Starting in 2007, hospitals that did not submit quality data received a two-percent reduction in their payment update. In its first year, nearly 95-percent of hospitals successfully participated in what many now call "pay for reporting." And, as of October 2008, CMS ceased reimbursing hospitals for additional costs related to certain preventable hospital-acquired conditions (HACs), including health care-associated infection (HAI). The rule was expanded the following year to affect other providers, such as dialysis centers and outpatient services.

Now, with the release of proposed regulations for value-based purchasing (VBP), CMS has blended the "carrot and stick" in an approach that requires hospitals to report performance data which will then be used to calculate reimbursement levels. The agency plans to use seven clinical "process of care measures" as well as eight "patient experience of care" measures (from the Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS] survey) as a basis for "value-based incentive payments" to hospitals. Payments will be adjusted to reflect achievement or improvement on the quality measures. The new reimbursement schedule is expected to go into effect for fiscal year 2013 based on data collected between July 1, 2011 and March 31, 2012.

In announcing the program, CMS recognized its "long-standing effort to forge a closer link between Medicare's payment systems and improvement in health care quality." The agency asserted that the transition to VBP "is intended to transform Medicare from a passive payer of claims based on volume of care to an active purchaser of care based on the quality of services its beneficiaries receive." It also noted that it intends to continue to "tie payments to how effectively hospitals deliver quality care for patients" by offering incentives for implementing electronic health records, and making payment adjustments based on rates of hospital-acquired conditions and readmissions.

Canary in the Coal Mine

A provider's bottom line is clearly impacted when connections start to be made between performance and pay. "VBP is already affecting hospitals," says Kathryn Hayes-Hallowell, CPHQ, FACHE, Vice President of Quality and Regulatory Affairs for New England Life Care. Prior to joining the alternate-site infusion provider community, Hayes-Hallowell drove clinical improvements within acute care organizations as a Regional Vice President of Performance Improvement with VHA, Inc., a health care alliance serving more than 1,400 not-for-profit hospitals.

"For a while it was good enough to be in the top quartile (25-percent)," she explains of hospitals whose performance scores would earn full reimbursement. "Now, as the process has matured, you need to be in the top decile (10-percent). That means that one or two patients can make or break your payment structure." According to Hayes-Hallowell, the remaining 90 percent of hospitals stand to lose one-percent of their DRG (diagnosis related group) payments.

"That's a scary thought," she exclaims, noting that as Medicare goes, so go commercial insurance companies. "The private payers are all prepared to hook their wagons to this. Hospitals are looking to the future and beginning to right-size in order to survive the coming changes."

The value-based model did not necessarily take hospitals by surprise, but their experience should be instructive to other health care sectors. Critical access hospitals (CAHs) have paid particularly close attention, notes Hayes-Hallowell. With lower patient volume and unique, inherent reporting challenges, CAHs were not

offered the same financial incentives for publically reporting quality data and later, when requirements for acute care hospitals kicked in, were given longer implementation timelines.

Despite the comparative lack of pressure—and strained resources—many CAHs began reporting quality measures anyway. In fact, by the close of 2007, nearly 70 percent of CAHs had reported on at least one measure to Hospital Compare—a 30-percent increase from 2004.[3] In addition, many of these facilities are working together through state and multi-state reporting and benchmarking programs with the hope of developing a common set of "rural relevant" hospital quality measures.

"While the larger facilities were undergoing change, the CAHs were watching and learning along the way," observes Hayes-Hallowell. "They saw what worked and what didn't work. They would model their efforts on that, but on a smaller scale."

Their reasoning was solid, she adds. "Change relative to pay-for-performance was a ground swell. It's not just limited to acute care, and it's not going away."

Reading the Tea Leaves

When Medicare started this reimbursement sea change with acute care hospitals, it was "beginning with the elephant in the room," according to Hayes-Hallowell. Upstream are the CAHs, which will soon follow. "It would just intuitively stand to reason that home care would have the same scrutiny," she reasons. In fact, Medicare-certified home health care agencies are already required to report quality measures under the OASIS (Outcome and Assessment Information Set) program.

Home care may become an even larger focus as hospitals trend toward lower admission rates. VBP could be a first step toward bundled payments, in which Medicare would administer a single payment for all services from ambulance to discharge. That kind of methodology would create an incentive to treat less-acute patients, including those with potentially avoidable and chronic conditions, in the outpatient setting.

"We've been flying under the radar so far," observes Danette Frauenholtz, R.N., Executive Director of University of Iowa Community HomeCare, noting that home infusion is a small portion of health care spending relative to hospitals. "Getting paid for good outcomes and not for bad is a great concept in theory," she continues, "but will Medicare be able to make it work? Some of the assumptions that they made when building the competitive bidding program make you wonder."

To Frauenholtz and other providers taking part in NHIA's Industry-Wide Data Initiative (see the Editor's Note on page 20), this is one of the many compelling reason for the alternate-site infusion field to come together to define quality metrics that accurately represent the care they deliver.

"If we don't control it, if we're not proactive, someone will do it for us," says Brian Simonds, M.B.A., R.R.T., Director of Baystate Home Infusion and Respiratory Services in Springfield, Massachusetts. "It's always been the right thing to do for patient safety, but it's also becoming a business imperative," says Simonds, who earlier in his career served as the Director of Quality Management for a community hospital.

Phase I of NHIA's Data Initiative, which collected basic demographic information from 283 infusion compounding pharmacy sites across the country, was a step in the right direction, according to Leo LaFranco, M.B.A., Director of Process Improvement & Analysis at Walgreens in Buffalo Grove, Illinois. "Now that we have a better understanding of the industry, we need to work together to gather outcomes data that will allow us to demonstrate our industry's value proposition," he says. "With it we can educate payers, referrals sources, and patients," he explains.

Challenges and Benefits of Industry-Wide Quality Improvement Efforts in Alternate-Site Infusion

Challenges	Benefits
◗ Differing home infusion pharmacy business models ◗ Information capture across continuum of care ◗ Defining measures that accurately reflect care delivered ◗ Benchmarks that draw apples-to-apples comparisons ◗ Fear of sharing data ◗ Fear of not comparing well to benchmark ◗ Requires resources (staff time, IT capabilities) ◗ Participation that is representative and statistically significant ◗ Using data to identify and share best practices	◗ National field-specific benchmarks for comparison ◗ Establishment of industry-wide best practices ◗ Improved patient safety ◗ Improved clinical outcomes ◗ Better risk management ◗ Differentiation among competitors ◗ Industry-wide collaboration on best practices ◗ Enhanced credibility for field ◗ Industry-defined measures ◗ On-target learning process ◗ Collaboration among professionals ◗ Data-driven strategic planning and growth ◗ Proactively prepare for likely value-based purchasing approaches within our industry

"Data can be a way of differentiating yourself in the market," adds Simonds, noting that benchmarking is an effective tool for comparison. "Being able to show where you are on the scale is powerful information for payers." Having a national database of patient outcomes and an industry-wide drive toward benchmarking and performance improvement would be a huge benefit to us all, adds Simonds, "including NHIA's efforts to gain a full Medicare benefit for home infusion therapy."

"You can learn from data," asserts Grace Sierchio-Fletcher, M.S.N., C.R.N.I.®, CPHQ, Director of Quality Assurance and Regulatory Compliance for Vital Care, Inc., in Meridian, Mississippi. "We can enhance patient safety, improve performance, manage risk, and support reimbursement."

Devil in the Details

While all of the aforementioned providers strongly support steps toward industry-wide data collection, they caution that when it comes to clinical metrics, the devil is in the details.

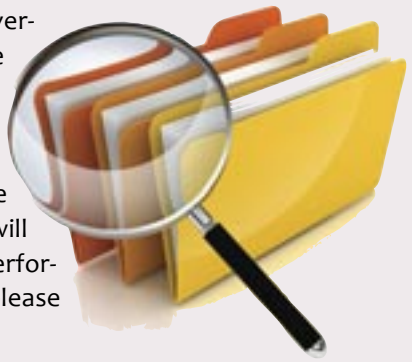
No one wants to be penalized for issues that are beyond their control. "For example," explains Frauenholtz, "the likelihood of a patient developing a bloodstream infection is higher for patients who are neutropenic." Without a clear understanding of what's behind the data, providers that treat a high percentage of TPN or oncology patients, who are often neutropenic, could appear to be performing poorly. "Will I get dinged for having that patient population?" she wonders.

Catheter infections are another potentially troubling metric, according to Seirchio-Fletcher, because it's difficult to pinpoint their origin as patients move across the continuum of care. On the other hand, the significant expense and patient safety issues related to catheter infections make them a prime target for genuine performance improvement activities. "The challenge is coming up with metrics that are directly affected by what we do as providers," she reasons.

And what about capturing data on what happens to patients once they go off service? "I see reports on adverse drug reaction rates that I think are far lower than they should be," notes Sierchio-Fletcher, who analyses data for nearly 100 Vital Care franchises. "I suspect it's because these providers are having an issue with data capture. It's not their fault, but it's not representative of what's really happening."

Under-reported data can lead to the misperception that no problem exists when, in fact, it might. But "false positives" can also appear when data is disproportionately reported among providers. Frauenholtz points to hospital readmissions, which should be a reliable indicator of home infusion provider performance. "As part of a larger health care system, we have access to the hospital's computer system and can easily track our patients," she explains. But when her organization participated in a national benchmarking program with stand-alone operations that didn't have the same level of tracking, "it ended up making us look bad," she recalls.

Editor's Note: NHIA just released the aggregate data report for Phase I of its Provider Survey (available to providers who participated in the survey). Thanks to overwhelming participation—40 percent of NHIA member locations—the report provides a first-of-its-kind snapshot of the industry that includes data points such as patients served, therapies administered, staffing, revenues and more. Capturing and benchmarking basic demographic information is only the first step. The NHIA Industry-Wide Data Initiative Steering Committee and associated Work Group remains active—and will soon begin exploring ways to move into clinical benchmarking and performance improvement. For more information about this vital initiative, please visit **www.nhia.org/data** or e-mail **nancy.kramer@nhia.org**.



How metrics are defined across the continuum can also present problems. "We look at medication errors by prescriptions filled, but the hospitals look at patient days," explains Simonds, whose home infusion organization is part of a hospital-based system. "Our board wants to know why we are not consistent." We need parameters that make sense for our industry, he continues. "That will allow us to accurately measure the value of the care we provide to patients."

Metrics within the industry would need to be standardized as well, which is not insignificant given the various business models and organizational affiliations present in alternate-site infusion today. Even amid the productive data captured via Phase I of NHIA's Data Initiative, this reality produced areas for further clarification where providers' systems for counting patients and days on service differed, Simonds recalls. "Moving forward, we must have common definitions—consistency is key."

Metrics should be fair and consistent, but they should also be meaningful. They should be scalable and significant enough to bring everyone to the table, asserts Sierchio-Fletcher. "There's a difference between avoiding negative outcomes and improving performance," adds Frauenholtz. "If we are not performing well, I want to know about it so we can do better."

From Point A to Point B

In addition to choosing representative metrics and fleshing out definitions, there are some logistical hurdles involved. "For people to feel comfortable participating, the data has to be confidential and shared only in aggregate form," observes Simonds. In other industries this is accomplished through a protected collaborative arrangement, such as a patient safety organization, or a neutral third party.

To make participation worthwhile, the data pool would need to cover a wide spectrum of providers—small and large with various organizational structures—thus making the results robust enough to draw meaningful comparisons. "It's important for providers of different sizes and from different parts of the industry to participate," observes Sierchio-Fletcher. "Otherwise we're not getting a representative picture of what's going on."

This is critical not only for performance improvement, but for education as well. Industry-wide data can objectively demonstrate some of the things that providers see anecdotally—like the neutropenic patients Frauenholtz mentioned. "We need to come up with our own field-specific data to educate payers, so they can understand these differences and know what to expect," she says.

Data can serve several educational functions, adds Walgreens' LaFranco. "In addition to payers, we can use outcomes data to work with physicians who are discharging their patients into our care and even with the prospective patients themselves regarding the care they need."

But if participation is key, it should not be too large a burden. To date, a lack of standardization across the industry has made data reporting tricky. "I know how much time we put into pulling information for the first phase of NHIA's Data Initiative," says Bill Lomis, R.Ph., Pharmacy Manager at Baystate. "It was worth it, and I'm encouraged that the effort put forth by NHIA is a good first step. Eventually, though, we have to be able to track outcomes electronically—there's no time to manually pull data."

Once a system is established clinical outcomes data can begin to support best practices and, ultimately, lead to better patient care. As part of the University Health System Consortium, Frauenholtz says her sister hospital often collaborates with other members on areas of improvement. "If they are not performing well on a cer-

tain parameter, they can contact another hospital that is and ask about their practices."

"The robustness of performance improvement is measuring, but also building information into your practices," concludes Simonds. "We're collecting data because it allows us to set goals to perform better." Given the vital lessons already learned from the hospital-based side of the continuum of care, it appears strategically prudent for alternate-site providers to actively collaborate as a field to advance the aggregate collection of standardized data. Whether it be to proactively prepare for a value-based purchasing approach to reimbursement or to generate field-specific best practices or to foster greater innovations in the field, industries that thrive are generally industries driven by data.

References

1. National Institutes of Health (IOM). *To Err is Human: Building a Safer Health System*. November 1999. National Academy Press.
2. Lwin A and Shepard D. Estimating Lives and Dollars Saved from Universal Adoption of the Leapfrog Safety and Quality Standards: 2008 Update. September 2008. Leapfrog Group. Available at http://www.leapfroggroup.org/media/file/Lives_Saved_Leapfrog_Report_2008-Final_%282%29.pdf.
3. Flex Monitoring Team. Critical Access Hospital Year 5 Hospital Compare Participation and Quality Measure Results. Briefing Paper No. 26. March 2010. Available at http://flexmonitoring.org/documents/BriefingPaper26-HospitalCompare5.pdf.

Jeannie Counce is INFUSION's Editor-in-Chief. She can be reached at jeannie.counce@nhia.org or 406-522-7222.