An open letter to the home infusion provider, payer and business firm affiliate community…

by Nancy Kramer, RN, BSN, CRNI®

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Dear Colleagues,

There is one word in home infusion that has been touted to be the key to validation of our legislative agenda, the vital element in making our case for alternate-site cost effectiveness, the impetus for product development and refinement by our business firm affiliates, and the answer to our clinical decision-making challenges: **data**

That simple, four-letter word has proven over the years to be an extraordinarily tough nut for this industry to crack. On many occasions in the past and present, NHIA and a handful of companies and providers have attempted to meet this need for data in the industry, and fallen short of the far-reaching goals. Why? What makes data about home infusion therapy such a challenge? Competition, cost, and complexity are a few of the primary reasons.

Can Competition Live Next Door to Collaboration?

Competition drives individual providers to collect internal data that answers the question "why should a (circle all that apply) payer/patient/business firm choose to work with my home infusion company?" Competition can be good–it keeps prices in check, encourages innovations in quality and technology, and can drive improvements in goods and services.

But in the case of patient-centered data, competition and the resulting reluctance to share, can actually limit innovation and quality improvement. Internal comparisons are helpful, but how motivated is an individual provider to surpass its own benchmark? Who is to say a given provider's benchmark is the best we can do? Real change and field-wide innovations are stimulated when your measurements are held up to your neighbor's, and a national standard is established that all providers in the industry are striving to meet (and beat).

In this issue of INFUSION, Connie Sullivan, R.Ph., Infusion Director at Heartland I.V. Care, details some of the many challenges to providers in her article on clinical documentation (p. 27). As an accreditation surveyor, she's seen the span of emotions from "wow, we can really learn a lot if we just document and track this," to "that's far too difficult, takes too much time, and in today's environment doesn't affect my bottom line."

Despite being confronted with these realities, Sullivan is here to persuade us that it is worth the trouble to thoroughly capture information through clinical documentation. Furthermore, even in the absence of an industry standard at present, she shows us how her organization is using data from documentation to generate vital, new practices that address old problems–like reducing unexpected hospitalizations. Imagine what could be achieved within your organization and across the entire alternate-site infusion field if we all had access to (and actually utilized) a national normative database to benchmark against and innovate. ***Just imagine!***

Who Picks Up the Tab?

Who pays for an industry-wide data collection process? Adding cost to an already economically challenged health care system is a tough sell. What if the data we gathered could be used to validate clinical care decisions that actually led to a reduction in the cost of care? Could some of the data pay for itself and are providers willing to share that risk?

Consider this example: Most hospitals have moved to a saline-only flush for peripheral access devices[1] and some have expanded this initiative to centrally placed vascular access devices (VADs) capped with positive-pressure or neutral pressure injection devices.[2] Rationale for such a move includes reduction in the risk of heparin-induced thrombocytopenia, as well as cost-savings. Hospital-based outcomes research in those institutions has demonstrated a comparable number of VAD occlusions, regardless of the flush solution utilized.

Why haven't home infusion providers made a similar move to eliminate heparin flush from catheters? In part, because research conducted in the hospital on VAD patency isn't conclusive about all types of catheters in all settings.[2,3] The settings differ, catheter utilization and frequency differs, and level of caregiver flushing expertise differs. With all these differences, we clearly need our own data in the home setting that could influence practices surrounding heparin flush.

Also in this issue of INFUSION, Kelli Krutsinger, R.N., B.S.N., CRNI®, Nurse Manager at the University of Iowa Community HomeCare, Inc., reports her organization's successful process to reduce heparin exposure in all patients with a routinely flushed VAD by studying the effects of reduced heparin concentration in its flush solution (p. 21). This outcome didn't necessarily reduce the cost of care out of the gate, as 10 unit per mL heparin is roughly the same cost as 100 unit per mL heparin—however, it may have set the stage for a gradual elimination of heparin flush altogether, as additional data is gathered and risk factors are considered.

What impact could we have as an industry if we strategically collaborated on (and accelerated) such data gathering? One small infusion provider carefully selecting patients for consideration of heparin elimination, could take months to years before compiling enough data to produce practice-altering results. If many providers participated in this process simultaneously and shared results, the prospect for defining a home infusion-based standard of practice becomes very real—and very exciting! Alone, we may be limited, but together, the possibilities are wide open.

Oh, the Possibilities

What if the data we gathered was of value to business firms in our industry? Would they be willing to purchase data that assisted them in targeting products and services that would be of interest to home infusion providers? Demographic data about the patients we service, the geographical areas covered, the manner in which infusions are delivered, the type and nature of side effects reported, and a host of other points could contribute meaningfully to the development of tailored product portfolios.

Data representing costs of care provided by treatment diagnosis and therapy type would be of great benefit in our legislative efforts, as NHIA and our grassroots active members attempt to define for Congress and the Congressional Budget Office (CBO) the value proposition that is home infusion. Data is sketchy, but we're piecing together what we have in order to move our legislation through the process. And when the legislation is voted into law, we then enter a totally new data-phase.

OASIS, anyone (and I'm not referring to that place from which we can seek refuge after pouring our time and energy into passing the Medicare legislation)? Per the Center for Medicare and Medicaid Services (CMS) website, "The OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes and is … an integral part of the revised Conditions of Participation for Medicare-certified home health agencies (HHAs)".[4]

The OASIS program and data reporting has evolved over a 10-year period, and while many in the home care industry find significant value in the benchmarking of outcomes it provides, the added cost of implementation is undeniable. In a 2005 CMS-commissioned study to determine if OASIS data collection should be mandated for all private pay patients serviced by a certified HHA, the incremental cost of including private pay patients in OASIS was estimated to be $54.30 per patient admission.[5] In this same study, the private pay patient population was found to be too different from the Medicare patient population for comparison purposes within OASIS data sets. Consequently, the OASIS measures have not yet been mandated for private pay patients. The bottom line: regardless of the cost of data collection and analysis, Medicare requires validation of program fund allocation with data. OASIS provides that data for home care. As home infusion providers on the cusp of meaningful Medicare coverage, we must be proactively prepared to conduct our own measurement of the impact of the care we offer—and share such on-target approaches with our friends in government, lest the measurement values be decided for us.

The growing "pay for performance" trend, as evidenced by the October, 2008 CMS initiative to stop paying for certain hospital-acquired conditions, should cause all providers to pause and reflect on their ability to impact the complications of care provided. This concept of "value-based purchasing" places the emphasis on payers reimbursing for what providers do right, and not being held responsible for what providers do wrong. How will we define "right care" vs. "wrong care" in home infusion? As the Medicare benefit in our industry grows, so must our ability to justify compensation with positive outcomes data.[6] If we do not step-up and help constructively drive this measurement process, we will risk losing reimbursement and will also undoubtedly find such measurements thrust upon us—likely with much greater implementation and collection costs and challenges.

Solving the Complexity Challenge

If outcomes were easy to measure, we'd have a national standard for benchmarking and six solid years of data to work from, based on the earlier diligent efforts of provider members, NHIA staff, and business firm affiliates. In the real world we currently occupy, for a variety of reasons, we must return to the drawing board to develop a clear, shared vision of our data-destination. Today, our home infusion industry lacks:

- A clear mission surrounding the collection and utilization of industry data
- A consistent and unambiguous definition for the key data elements that are needed
- A sufficient, larger number of providers participating in shared data collection

programs to truly allow results to be extrapolated industry-wide
- The funds necessary to get a data-driven initiative off the ground
- A central, HIPPA-compliant repository for industry-wide data storage
- A process for mining, validating and publishing industry-wide data

The above "to-do list" is daunting–so, where do we begin? NHIA, over the course of 2009, is launching an industry-wide data measurement initiative and is interested in getting this endeavor off the ground by dialoguing with representatives from **all** key stakeholders. We need providers with ideas and the energy to put them forward. We need to hear from business firms who have data collection, analysis, and/or technology products in development or in active use, to tell us–or, better yet, to ***imagine with us***–what is possible. We need to understand from those experienced in benchmarking, the degree to which standardization is achievable, or even desirable–and to productively build off of whatever foundations may already exist. We need to understand the elements of data that are of interest to manufacturers. We need key stakeholders to work together for the common good of the industry and the patients we serve.

Accessible, industry-wide measurements and benchmarking are attainable, as are the thriving quality care and innovations they would generate–but we must chart this course for success together, as an entire field. **If you are interested in formally participating with NHIA in this new, critical data-initiative, please contact me at nancy.kramer@nhia.org**.

Without the profound commitment of all industry stakeholders, meaningful data advancements will not be possible–but with genuine collaboration, anything is possible! I urge you to get involved and join NHIA in imagining what we can achieve, together…

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