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# Survey Results & Analysis

for

## National Home Infusion Association

Account: 14766

Thursday, February 25, 2010 4:42:24 PM

Vista™ Survey System

# Questionnaire

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/ SAVE** button.

At any point in the survey, you may back up using the **BACK** button (starting on the second page) and change your prior responses. Simply re-enter your responses from the point at which you resume the survey.

If you would like to suspend the survey and complete it at a later time, click **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 saved and you will no longer be able to access the survey or to change your answers.

## DEMOGRAPHICS

- 1) I have reviewed the [2010 NHIA Provider Survey 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.

☐ I agree

- 2) Please enter your address below:

Branch/Site "Doing Business As" Name:   
Address:   
  
City:   
State:   
Zip:   
First Name:   
Last Name:   
Phone:   
DEA Number:

To prevent duplicate entries of survey information from the same licensed pharmacy, NHIA is asking each provider to supply their DEA number as a unique identifier. NHIA will only use the DEA number to identify duplicate survey entries for the same physical pharmacy location. In this capacity, the DEA number serves as a data validation device, and will not be used in any other way.

- 3) Once you have completed the questionnaire, a summary of your survey responses will be sent to the valid email address provided below. PLEASE NOTE: *The emailed summary will be the only opportunity for you to save your survey responses for future reference.* You will want to print and save this information for future benchmarking against the aggregate results once a final report becomes available.

E-mail:

- 4) Is your home infusion site/branch location:

- ☐ Part of a national chain (a presence in all the time zones of the contiguous 48 states)  
☐ Part of a regional company (more than one service area but not national)  
☐ Local operation (one service area)

*Go to question 5a if question 4 is Part of a national chain (a presence in all the time zones of the contiguous 48 states) or Part of a regional company (more than one service area but not national)*

*Go to question 6 if question 4 is Local operation (one service area)*

- 5) Company headquarters office:

Company name:   
City:   
State:

- 6) Is this company a dues paying member of The National Home Infusion Association?

- ☐ Yes  
☐ No  
☐ Not sure

7) Is your home infusion site/branch location:

(Select all that apply.)

- ☐ Affiliated with a home health agency or Visiting Nurse Association  
☐ Affiliated with a durable medical equipment entity  
☐ Affiliated with a hospital  
☐ Not affiliated, operating independently

8) How many years has your site/branch location offered home infusion services:

- ☐ Less than 1 year  
☐ 2-5 years  
☐ 6-10 years  
☐ 11-15 years  
☐ More than 15 years

9) How does your branch/site location count "unique" patients to arrive at an annual patient census (total number of patients who received treatment from your organization in the calendar year)?

(Select all that apply.)

- ☐ We count each patient only one time, even if the patient is receiving more than one therapy. For instance, a patient receiving Parenteral Nutrition (PN) and an antibiotic would be counted *once* in the total patient census.  
☐ We count each patient as a new, unique patient for each therapy they receive. For instance, a patient receiving Parenteral Nutrition (PN) and an antibiotic would be counted *twice* in the total patient census.  
☐ We count each patient as a new, unique patient when the patient has been hospitalized and returns to our home infusion service. For instance, a Parenteral Nutrition (PN) patient who is hospitalized and returns home to continue PN therapy *is counted as a new, unique patient in the total patient census*.  
☐ We do not count each patient as a new, unique patient when the patient has been hospitalized and returns to our home infusion service. For instance, a Parenteral Nutrition (PN) patient who is hospitalized and returns home to continue PN therapy *is not counted again in the total patient census*.

10) In calendar year 2008, how many unique\* patients did your site/branch location service with home infusion, specialty pharmacy\* and/or enteral nutrition?

\* **Specialty Pharmacy** - generally includes high-cost biological therapies (such as monoclonal antibodies, immune globulin G, or Factor replacement therapy) prescribed for chronic conditions such as rheumatoid arthritis, multiple sclerosis, cancer, auto-immune disorders, bleeding disorders and primary immune deficiency.

11) At your branch/site, what is the cut-off age for pediatric patients?

- ☐ 14  
☐ 18  
☐ Other

If Other, please specify:

There are two questions in our survey that are more complex and will require a bit more time and focus to complete—this is the first one. Despite such complexity, we want to stress that the information this data will provide is of the utmost importance to meeting the goals of the survey. We encourage you to take the time needed to find the information and fully respond to these questions. Your contribution of data about the number of patients treated by therapy type and age will help our industry make the legislative case for providing the underserved elderly patient population with increased access to home infusion—a Medicare benefit. You will directly impact this outcome with the data you provide!

12) For each therapy category, please indicate the number of patients in each group that received services from your site/branch location in calendar year 2008.

Pediatric (up to age of	Adults (age 15/19 - 55)	Adults (age 55-65)	Older Adults (age 65 and
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	14/18)			above)
Anti-Infectives	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Catheter Care Maintenance	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chemotherapy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Enteral Nutrition	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hydration Therapy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pain Management	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Specialty Pharmacy*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total Parental Nutrition	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

13) In the matrix above, our branch/site location's data reflects

- ☐ Patients' primary therapy only  
☐ Patients with multiple therapies are counted in each therapy category they are receiving

\* **Specialty Pharmacy** - generally includes high-cost biological therapies (such as monoclonal antibodies, immune globulin G, or Factor replacement therapy) prescribed for chronic conditions such as rheumatoid arthritis, multiple sclerosis, cancer, auto-immune disorders, bleeding disorders and primary immune deficiency.

14) Do you have a pharmacy clean room on site?

- ☐ Yes  
☐ No

Go to question 15 if question 14 is Yes

Go to question 16 if question 14 is No

15) Number of prescriptions that required compounding in calendar year 2008:

#

16) Total number of prescriptions\* dispensed during calendar year 2008:

#

\* Please include drugs only as some states do not require a prescription for supplies.

17) What percent of your infusion patients receive their services/deliveries in the following care settings?

	Percent %
Ambulatory Infusion Suite/Center*	<input type="text"/>
Assisted living facility	<input type="text"/>
Care started in AIS/AIC and moved to the home	<input type="text"/>
Custodial care center	<input type="text"/>
Group home	<input type="text"/>
Home	<input type="text"/>
Hospice	<input type="text"/>
Skilled nursing facility	<input type="text"/>
Other	<input type="text"/>
Total (please round all numbers to the nearest whole number, total must equal 100%):	<input type="text"/>

18) These figures are

- ☐ Derived from data driven results from internal reports and/or information systems  
☐ Best estimates only

\* **Ambulatory Infusion Suite (AIS)/ Ambulatory Infusion Center (AIC)** - a clinic that can be associated with a hospital, physicians office, or home infusion pharmacy, or that is free-standing, in which patients receive infusion therapies that may not be administered in the home due to care giver support, clinical or financial reasons.

Your total does not equal 100%. Please correct your input.

19) What accreditation provider are you currently accredited by?

- ☐ Accreditation Commission for Health Care (ACHC)  
☐ Community Health Accreditation Program (CHAP)  
☐ The Compliance Team  
☐ Healthcare Quality Association on Accreditation (HQAA)  
☐ The Joint Commission (JCAHO)  
☐ We are not currently accredited  
☐ Other

If Other, please specify:

20) Are you considering a change in your accreditation provider before your next renewal period?

- ☐ Yes  
☐ No

If yes, why?

21) What Group Purchasing Organization (GPO) do you currently utilize? *(If more than one, please indicate your primary GPO.)*

- ☐ Innovatix  
☐ Managed Health Care Associates  
☐ PROVISTA  
☐ Other

If Other, please specify:

## FINANCIALS

22) Please indicate your site/branch location's total net revenue\* for calendar year 2008.

\$

**\* TOTAL REVENUE** - is the revenue from all lines of business, including home infusion, Respiratory Therapy (RT), Durable Medical Equipment (DME), and home health care.

23) Please indicate your site/branch location's total net revenue for *home infusion services only*, in calendar year 2008.

\$

Remember the earlier reference about two questions in the survey that were more complex? You have just reached the second and final one. Again, we are acknowledging this complexity up-front because we believe the information this data will provide is of vital importance to meeting the goals of this survey. We encourage you to take the time needed to find the information and fully respond to these questions. Your contribution of data about the extent to which patient therapies are currently reimbursed in the home by payor-type will help our industry make the legislative case for providing the underserved elderly patient population with increased access to home infusion via a complete Medicare benefit. You can directly impact this outcome with the data you provide!

24) For calendar year 2008, what is your site/branch location's net revenue (in dollars) by therapy, for each of the payor/payment sources listed?

	Part A	Part B	Part D	Medicaid	Managed Medicare	VA/ TRICARE	Commercial Insurance/ HMO/ PPO	Self-Pay	Other
Anti-Infectives/Antibiotics	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Catheter Care Maintenance	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chemotherapy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Enteral Nutrition	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hydration Therapy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pain Management	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Specialty Pharmacy*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total Parental Nutrition	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other

25) In the matrix above, our branch/site location's data reflects

- ☐ Patients' primary therapy only
- ☐ Patients with multiple therapies are counted in each therapy category they are receiving

\* **Specialty Pharmacy** - generally includes high-cost biological therapies (such as monoclonal antibodies, immune globulin G, or Factor replacement therapy) prescribed for chronic conditions such as rheumatoid arthritis, multiple sclerosis, cancer, auto-immune disorders, bleeding disorders and primary immune deficiency.

## HUMAN RESOURCES

26) In calendar year 2008, what percentage of your infusion patients (including enteral) received nursing services from:

	Percent %
Registered Nurses (RNs) on your staff	<input type="text"/>
Subcontracted Home Health Agencies* (HHA's)	<input type="text"/>
HHA's providing and billing for all nursing care	<input type="text"/>
Visits to an Ambulatory Infusion Suite/Center	<input type="text"/>
None- patients are independent in self-care	<input type="text"/>
TOTAL (please round all numbers to the nearest whole number, total must equal 100%)	<input type="text"/>

27) These figures are

- ☐ Derived from data driven results from internal reports and/or information systems
- ☐ Best estimates only

\* **Subcontracted Home Health Agency (HHA)** - Home infusion provider establishes a contractual arrangement with one or more HHA to provide home infusion nursing services for a pre-set fee. The home infusion provider is responsible for billing the insurer for reimbursement of nursing services.

Your total does not equal 100%. Please correct your input.

28) How many FTEs do you employ at your site/branch location for the following position types?

	FTEs
Accounting/Bookkeeping	<input type="text"/>
Billing & Collections	<input type="text"/>
Clerical	<input type="text"/>
Dispatch	<input type="text"/>
Delivery Driver	<input type="text"/>
Information Systems	<input type="text"/>
Service & Repair	<input type="text"/>
Re/hab Technician	<input type="text"/>
Warehouse	<input type="text"/>
Registered Nurse	<input type="text"/>
Licensed Practical Nurse	<input type="text"/>
Nurse Manager	<input type="text"/>
Registered Respiratory Therapist	<input type="text"/>
Certified Respiratory Therapist	<input type="text"/>
Respiratory Care Practitioner	<input type="text"/>
Respiratory Technician	<input type="text"/>
Pharmacist	<input type="text"/>
Pharmacy Manager	<input type="text"/>
Pharmacy Technician	<input type="text"/>
Registered Dietitian	<input type="text"/>
Licensed Social Worker	<input type="text"/>

To calculate **Full Time Equivalents (FTEs)** divide the total number of hours paid each week by 40. Example: 2 full time and 6 part time employees were paid for a total of 140 hours.  $140/40 = 3.5$  FTEs.

## OPERATIONS

29) Average number of deliveries to patients per month in calendar year 2008.

#

30) What percentage of your average monthly deliveries are:

	Percent %
Scheduled	<input type="text"/>
Unscheduled during normal business hours	<input type="text"/>
Unscheduled after hours	<input type="text"/>
TOTAL (please round all numbers to the nearest whole number, total must equal 100%)	<input type="text"/>

For the purposes of this survey, please consider new patients as scheduled deliveries.

31) What percentage of our deliveries are made by

	Percent %
Employed delivery staff	<input type="text"/>
UPS/Fed X or other carrier	<input type="text"/>
Local Courier	<input type="text"/>
TOTAL (please round all numbers to the nearest whole number, total must equal 100%)	<input type="text"/>

32) Figures for the previous two questions are

- ☐ Derived from data driven results from internal reports and/or information systems  
☐ Best estimates only

33) Average cost per delivery.

\$

**\* Average Cost Per Delivery** - is calculated by totaling all dollars spent on deliveries in calendar year 2008, and dividing that figure by the total number of deliveries that were made in the same period. For example, when calculating cost per delivery for your delivery FTEs please include salary, benefits, vehicle depreciation, overhead, etc. for an accurate reflection of delivery costs.

34) When shipping via common carrier, which is your preferred delivery service?

- ☐ UPS  
☐ FedEx  
☐ US Postal Service  
☐ Other

If Other, please specify:

Your total does not equal 100%. Please correct your input.

35) What pharmacy software program does your branch/site use? (Select all that apply.)

- ☐ Apothesoft  
☐ Ascend –Hann's On (Mediware)  
☐ CPR +  
☐ FastTrack  
☐ HomecareNet (Healthcare Automation/Mediware)  
☐ In-House Proprietary System  
☐ PDX  
☐ QS/1  
☐ Other

If Other, please specify:

36) Do you have a web site for your home infusion business?

- ☐ Yes

☐ No

Go to question 37 if question 36 is Yes

Go to question 38 if question 36 is No

37) What services do you offer on your website? (Select all that apply.)

- ☐ Patient re-orders  
☐ Process referrals  
☐ Patient education  
☐ Staff education

38) Which of the following describes your medical record processing best?

- ☐ All electronic  
☐ Hybrid - Mostly electronic, some paper  
☐ Hybrid - Mostly paper, some electronic.  
☐ All paper

39) In an average month, what percentage of your total pumps are

Rented?   
Owned?

Please include all pumps used to deliver medication or enteral therapy.

40) Do you have a software system to track your pumps?

- ☐ Yes  
☐ No

Please include all pumps used to deliver medication or enteral therapy.

Go to question 41 if question 40 is Yes

Go to question 42 if question 40 is No

41) What is the name of the software system that your site/branch uses to track pumps?

42) How many of each type of infusion pumps (including enteral) do you have in your fleet:

43) **AMBULATORY PUMPS**

	#
Abbott Aim +	<input type="text"/>
BodyGuard 323	<input type="text"/>
CADD Micro 5900	<input type="text"/>
CADD 5400, 5700, 5800	<input type="text"/>
CADD Prizm	<input type="text"/>
CADD Legacy	<input type="text"/>
Curlin 4000 CMS	<input type="text"/>
Hospira GemStar	<input type="text"/>
Other	<input type="text"/>

44) **STATIONARY (Pole-Mounted) PUMPS:**

	#
Abbott Plum	<input type="text"/>
	<input type="text"/>



Alaris/Cardinal Imed - Gemini		
Alaris/Cardinal Ivac		
BBraun Vista Basic		
Baxter 6201		
Baxter Colleague		
Sigma 6000, 8000		

45) **SYRINGE PUMPS:**

	#
Abbott 4100 PCA+ 2	
B Braun McGraw BD 360	
Bard/Baxter 150XL/300XL Mini Infuser	
Baxter AS40A	
Baxter AS50	
Excelsior	
Graseby MS16A	
Graseby MS26	
Medex Medfusion	
Repromed Freedom 60	

46) **ENTERAL PUMPS:**

	#
Kangaroo 224	
Kangaroo 324	
Kangaroo Joey	
Kangaroo PET	
Ross Companion	
Ross Flexiflo Companion	
Ross Patrol	
Zevex Enteralite	
Zevex Infinity	

47) Which of the following clinical outcomes do you currently track? (*Select all that apply.*)

- ☐ Unscheduled Hospitalizations
- ☐ Completed therapy as prescribed
- ☐ Catheter dwell time (# of days)
- ☐ Catheter infections
- ☐ Catheter occlusions
- ☐ Catheter dislodgement
- ☐ Catheter phlebitis
- ☐ Pump failure requiring removal o replacement
- ☐ Medication error; at the pharmacy
- ☐ Medication error; at patient's home
- ☐ Medication error; due to pump programming
- ☐ Adverse drug reactions
- ☐ Referral source satisfaction
- ☐ Type of access device
- ☐ Completed therapy as prescribed

## 48) If NHIA were to provide more detailed benchmarking opportunities in subsequent surveys, what other metrics would be most meaningful to your site/branch location?

**STOP. PLEASE READ.**

**This is the last question. clicking "submit" below will end your survey and you will no longer be able to access your survey to**

[add/ edit your responses. If you need to make any changes to previous answers, please select "Back" to edit or "Finish Later" to exit the survey temporarily and come back at a later point.\)](#)

Dear [Q2g],

Thank you for completing the 2010 NHI A Provider 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 comparison/ benchmarking with the aggregate results once a final report becomes available.

Respectfully,

Kristen Santaromita

Associate Director, Education & Research

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703-838-2661