



**IDAHO COMMUNITY HEALTH EMS (CHEMS)
METRICS WORKGROUP**

Meeting Report
Friday, January 22, 2016

Idaho CHEMS Website:

<http://ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx>

Please access the above website for all materials provided in Workgroup packets and other key information.

Meeting Goals:

- 1) Establish a common foundation for Idaho CHEMS and corresponding measures development (Measures Design Workgroup and guests in attendance)
- 2) Identify preliminary CHEMS measures (Measures Design Workgroup - afternoon session)

Welcome, Introductions, and Meeting Overview

Elke Shaw-Tulloch, Administrator
Division of Public Health
Idaho Department of Health and Welfare

Monica Revoczi, Facilitator

Elke welcomed participants and provided an overview of the CHEMS Project. Attendees introduced themselves, and Monica reviewed the meeting purpose and agenda.

Project Background and Local Perspectives

Mary Sheridan, Bureau Chief
Bureau of Rural Health and Primary Care

Wayne Denny, Bureau Chief
Bureau of EMS and Preparedness

Mark Babson, Community Paramedic
Ada County Paramedics

Mary provided an overview of how CHEMS fits within the context of the Statewide Health Innovation Plan. Accompanying materials can be found in participant packets and in the attached slides.

Wayne provided context for CHEMS within the Idaho EMS community.

Mark shared Ada County Paramedics' experience in integrating CHEMS into its operations. Guest speakers, Dave Reynolds (Moscow Fire and EMS) and Rob Veilleux (Teton Valley Ambulance), shared their experience with CHEMS in rural areas of Idaho.

CHEMS Implementation and Measurement – A National Perspective

Matt Zavadsky, Public Affairs Director
MedStar Mobile Healthcare

Matt, a national expert on CHEMS implementation and measurement, shared his vast experience and knowledge and answered workgroup questions. His bio and slides were included in the workgroup participant materials.

CHEMS Goals and Measurement Development Principles

Monica Revoczi

To prepare workgroup participants for brainstorming potential measures for CHEMS, Monica asked the group to identify the many **stakeholders related to CHEMS**. Stakeholders are defined as “Anyone who *is affected by or influences* the success/impact of Idaho CHEMS.” The workgroup generated the following list:

- Patient Centered Medical Home (PCMH)
- Center for Medicare & Medicaid Innovation (CMMI)
- Statewide Healthcare Innovation Plan (SHIP)
- Area Agency on Aging (AAA)
- Healthcare providers
- Critical Access Hospitals (CAHs)
- Hospital systems
- Home health agencies
- Hospice agencies
- Schools
- Emergency department physicians
- Skilled Nursing Facilities (SNFs)
- Medicaid, Indigent/Catastrophic (CAT) funds
- Patients
- Families
- Caregivers
- Emergency Medical Services (EMS) agencies
- Educational institutions (research)
- Urgent care locations
- Social service agencies
- Faith-based organizations
- Regulators
- Legislators
- Child Protective Services (CPS)
- Adult Protective Services (APS)
- Outpatient clinics (e.g., dialysis, surgery)
- Professional organizations
- Area Health Education Center
- Payers
- Assisted living facilities
- Local health departments
- Veterans Administration (VA)
- Local government
- Dispatch centers
- Regional Health Collaboratives
- Idaho Healthcare Coalition
- Detention centers
- Law enforcement
- Public transportation
- Certified family homes
- Telehealth systems
- Trauma registry
- Time Sensitive Emergencies (TSE)
- Alliance/health partners
- EMS Bureau
- Crisis hotlines
- Shelters
- Behavioral health
- Licensure boards/EMS Physicians' Commission
- Local business
- Pharmacies
- 211 Careline

Effective measure development requires **goals**, or “**points of alignment**,” to provide focus. The following points of alignment were identified (asterisked items were prioritized for this meeting):

- *The Triple Aim
- *SHIP measures
- *PCMH/Medical Neighborhood
- Value-based reimbursement (purchasing, etc.)
- Meeting community needs, including those specific to rural areas
- The four CMMI priority measures
- Clinical quality measures
- EMS system sustainability
 - Stability of volunteer-based rural EMS agencies
 - Workforce educational opportunities
- The global burden of disease – World Health Organization (WHO)
(<http://vizhub.healthdata.org/gbd-compare/>)

Monica provided an overview of measure development principles, including a reminder that everything can be measured with the right methodology.

Initial Measures Development:

“What do We Need to Measure to Demonstrate the Value of CHEMS?”

Workgroup participants completed the following steps to identify initial CHEMS measures:

1. Individual brainstorm to answer the question: “What do we need to know to understand the value of CHEMS?”
3. Prioritization of individual brainstorm by marking top three most important items (indicated by asterisks)
4. Discussion of individual items with a partner and clarifying, as needed
5. Posting items on the wall

The group sorted and categorized the items by theme, culminating in the following (two tables):

Experience	Utilization	Cost
<ul style="list-style-type: none"> -*Are patients becoming more active in their health care? (PCP use/preventative care) -*Improved patient quality of life - * Patient quality of life - *What is the overall value to each patient? - * Rural patient satisfaction - *Does it improve patient’s mental well-being? - *Quality of life/patient abilities/confidence in self-management - * Patient self-management skills - * Patient metrics: increased patient confidence in managing own health - * Patient perception of their health pre & post program participation - Patient health improvement (Quality of life; fewer ER visits; less pain) - * Patient health goals identified and met (patient engagement) - * Are patients satisfied with care they received – in a CHEMS setting? -Satisfaction -*Patient satisfaction - Patient needs - Patient quality of care - Lower patient suffering (anxiety, physical, etc.) - * Lower stress for caregiver and patient (or raise quality of life) - *Post program, patient improves in self-reliance - * Post program improvements in condition - Raise support for patient and caregivers - Increase connection to community resources for patients - * Health status change – did the change improve the patient’s health status? (based on stakeholder audience) 	<ul style="list-style-type: none"> - * Reduce unnecessary use of medical system - * ED return rate - * Number of EMS (911) calls a year - * Number of ED admissions / year - *Hospitalization rate - * ER utilization - * Hospital ED visits - *Prevented hospitalizations for a certain subset population (diabetic, COPD, asthma, etc.) - * Reduce ER utilization for high frequency ER users - * Who are the frequent users of the EMS systems that aren’t life-threatening calls? * Avoidable emergency care without hospitalization - * Unplanned 30-day hospital readmissions - * How often are services delayed for true emergencies because crews are on non-serious, non-life-threatening calls - * PCP use - Length of stay - All-cause re-admittance - * Reduction of ED visits that do not result in hospitalization - Lower unplanned 30d hospital readmissions - Lower ED visits - ED visit - Readmission rates for specific medical problems - All cause hospital admissions - Successful connection of patients to PCP (appointment within 7 days) - Primary care provider use - *Focus on costs: fewer ED visits, fewer EMS runs, increase delivered care - Ambulance transport savings/ utilization 	<ul style="list-style-type: none"> - * Cost per patient per year - * Total expenditure savings, including: unplanned acute care utilization, PCP visits, usage of ambulance transport - *Monetary (cost savings) of the CHEMS program - * Total cost of care - * Cost savings -*Reduction of healthcare costs for the highest utilizers - * Hospital readmission (savings) - * Expenditure savings – lower expenditure from the changed delivery (based on stakeholder audience) - * Cost savings - * Impact of CHEMS on healthcare expenditures (Medicaid, Medicare, CAT fund, private insurance uncompensated care) - * The hook – show cost savings to stakeholders and health cost breakdown of healthcare neighborhood - Cost of providing CHEMS in rural areas (travel time, mileage, number of versus patients seen) - * Reduction of costs - * Cost savings/value added - * Value of waste - * Does it save money? - * Total cost of care - * Reduction of cost loss to EMS agencies and hospitals - *Expenditures - * Can critical access hospitals support CHEMS with their payment model? - * Total expenditure - * How much will it cost to provide EMS services on call? - * Financial impact based on expenditures - * Total cost of care - * Hospital ED visits (savings) - * Reduce cost to the consumer - How much will it save the community? - All-cause hospital admissions

Stakeholder - General	Stakeholder - EMS	Safety	Community	Medical Neighborhood
<ul style="list-style-type: none"> - * Engage local community stakeholders - * Involve payers - * Communication gap analysis - * Tangible measures - * Shared expectations from local to state to national level? - * Meet required metrics (national, state, SHIP, etc.) - * Process measure and outcome measures - * Process measures - * Who will pioneer payment for EMT-level CHEMs in rural Idaho? - * Will CAHs be harmed financially if CHEMS reduces ER and admissions? (Heavy fee for service today) - Need to know how to motivate increased collaboration between payers and providers - Could/should PCMHs employ CHEMS providers, especially in rural areas? 	<ul style="list-style-type: none"> - * CHEMS engagement/job satisfaction - * Financial stability (and sustainability) - * Will it provide a way to upgrade EMS levels? - * How are EMS providers educated to take on the role of participating in CHEMs? (Does it follow national curriculum?) - * Role expansion of career segway - * What will it cost an agency to start? - * Education of service providers/ agencies (for buy-in) - * EMS scope of practice (current vs. desired) - history of "9-1-1 Response" only - What's needed to start a CHEMS program? - Financial projections for the CHEMS agency 	<ul style="list-style-type: none"> - * Medication inventory - * Increased number of medication inventories (cross-referenced with Beers criteria for medical patients) - dementia or delirium? - * Patient safety (adverse outcomes) - Impact on immunization rates - Medication inventories reducing ADEs; outcome: decrease hospitalizations, decrease readmissions - Decrease medication discrepancies 	<ul style="list-style-type: none"> - * How does the CHEMS program benefit overall livability of that community? - * Economic impact of CHEMS in rural communities - * Agency-defined metric based on individual community needs - * Does it improve population health? - Increase community awareness 	<ul style="list-style-type: none"> - Community resource referral - Impact on access to services: medical, dental, behavioral health, social) - Successful referrals for mental health / substance abuse

Observations and Reflections on Initial Measures Development

- Centers for Medicare & Medicaid Services (CMS) is liberal in definition of population health
- Distill items related to program development
- Heavy focus on cost and utilization
- Select measure we can really impact (select strategically; focus on gaps/needs)
- Total cost: how to bridge communication gap between providers and payers
 - Utilization management
 - Put on shared risk contract
- Include non-economic measure(s)
- Consider data availability/collection (especially in rural areas)
- Without sustainability, it fails
- Consider win-win measures (e.g., lowering cost of uninsured) - start having these conversations
- Consider access question (outpatient)
- “Data menu” approach
 - Create win-win with mutually agreed upon and beneficial measures
 - Possible to gather enough consistent data to “prove” CHEMS value?

Project Communication and Input - Needs and Strategies

The purpose of the Communication and Input Plan is to maximize project success through stakeholder understanding, involvement, and support. The workgroup selected several key stakeholders and began identifying respective communication and input needs.

Stakeholder Group	Communication	Input
Critical Access Hospitals	<ul style="list-style-type: none"> – Understanding of CHEMS and its value 	<ul style="list-style-type: none"> – Specialties, needs, what's important – Look at previously conducted assessment in relation to measures
Home Health and Hospice Agencies	<ul style="list-style-type: none"> – Education/understanding of CHEMS and its value 	<ul style="list-style-type: none"> – Their gaps, needs, opportunities for collaboration
Care Coordination Communities	<ul style="list-style-type: none"> – Education, impact of getting most appropriate level of care 	<ul style="list-style-type: none"> – Needs, gaps
Hospitals	<ul style="list-style-type: none"> – Connect with smaller agencies to get buy-in about planned efforts; share others', regional solutions" (e.g., lower readmissions) 	
Area Agency on Aging	<ul style="list-style-type: none"> – Education: resource for their target population 	
PCMH	<ul style="list-style-type: none"> – Work with SHIP staff/PCMH contractors 	
County Commissioners	<ul style="list-style-type: none"> – Talking points/education (value) 	
Legislators	<ul style="list-style-type: none"> – Inform on how CHEMS supports healthy rural communities 	

Wrap Up

Next Steps/Action Items

- 1) The planning team will develop draft talking points and provide them to the workgroup subteam for feedback prior to the next workgroup meeting.
(Subteam: Mike Mikitish, Christine Packer, Dr. Davis, Linda Lowe, Petra Thorseth, Robert Veilleux, Dave Reynolds)
- 2) The next workgroup meeting will be February 25, 2016 in Boise.

Meeting Evaluation

Worked Well	Improve for Next Time
<ul style="list-style-type: none">→ Measures brainstorming exercise→ Matt's presentation and having guests in the morning	<ul style="list-style-type: none">→ Start the meeting at 8:00 a.m.