

# IDAHO COMMUNITY HEALTH EMS (CHEMS) METRICS WORKGROUP

## Draft Measures<sup>1</sup>

Based on Discussion at February 25, 2016 Workgroup Meeting

### Experience

#### Health-Related Quality of Life

- Self report, measured pre and post CHEMS intervention
- More directly aligned with intervention
- Select cost-effective tool validated with “our” patient population (common denominator)
  - Look at CDC open source tool
  - Capture impact on home environment (also survey caregiver?)
- How to administer to maximize response rate? (In person?)
- Incorporate “confidence in managing own health” rating (1-10) - transcends demographics
- May require paramedic training on Motivational Interviewing
- Meets payer and patient goals

### Utilization

#### Reduction in More Expensive Visits/Interventions

- CP to gather data at time of visit, to potentially include:
  - Visit type/reason
  - Disposition
  - Outcome
- Carefully carve out CHEMS-related patients
- Focus is prevention of more expensive/“inappropriate” visit (e.g., go out with no transport)
- Looking for increase in PCP utilization, decrease in ED and inpatient
  - Tracking: payers can capture and mandated by SHIP
  - Consider whether CHEMS sometimes an alternative to or extension of PCP (or part of PCMH)
  - Consider as “off-site” PCP visits? – “PCP use” could include in clinic visit or CHEMS visit
- Right place, right time – always make it person-centric
- EMS visits are tracked universally
- Related to experience measure
- Qualify/identify calls where there is no other option (e.g. behavioral crisis)
- Dispatch (triage)
- May focus on “gap” group – lower ins, higher utilization
- Incorporate non-CHEMS agencies
- Can correlate with panel cost

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<sup>1</sup> Bolded headings indicate measure themes; underlined headings are proposed measures.

## **Cost**

### Cost Savings

- Combine with utilization measure – additional field to generate national average costs (will underestimate savings, but practical and a good start)
- Main cost driver is ED visit avoidance: all patient populations or high utilizer group only?

#### *Additional comments from the discussion:*

- Total cost of care/patient
  - Options: Payer derived or charges
  - May be able to determine with good relationships with providers
- High-utilizer expenditures (ED, PCP)
  - Rx costs may increase
  - Referring/contracted agencies to “dispatch” CHEMS
- Need a more robust data exchange between providers and agencies (certainly EMS)

## **Safety (An Aspect of Quality)**

### Percentage of Patients Connected with PCP

- Track pre and post CHEMS involvement
- Intent is to make PCP the “usual source of care”
- Link to impact on utilization measures (above)
- Include follow up with patient to assess whether connection/visit with PCP made
- Capture “no PCP available” – important data point; may prompt connection with virtual PCP

#### *Additional comments from the discussion:*

- Medication inventory - prescription drug
- Prevention of Adverse medication events (ADEs):
  - Components could include: screening, reconciliation and acquisition, remedy (schedule and dosage)
  - Ambulatory pharmacy
  - Some PCPs are undertrained, lack time
- Closing the communication gap back to PCPs

## **Stakeholders (General and EMS-Specific)**

### Partner Satisfaction Assessment

- Meeting needs
- Good care coordination
- Tie into talking points
- Could assess via stakeholder meetings, survey, or both

### CHEMS Employee satisfaction

## **Community (Preliminary Options)**

### Numbers of paramedics (ALS) across Idaho

- Indicator of system stability and overall capacity
- Volunteer versus paid - be sensitive to not inadvertently devaluing volunteer paramedics

### Community Engagement

draft