



**IDAHO COMMUNITY HEALTH EMS (CHEMS)
 MEASURES DESIGN STAKEHOLDER WORKGROUP**

Measures and Data Elements

MEASURE 1: Health Related Quality of Life

Data Elements/Questions

Patients would answer the following questions at or around their last anticipated community paramedic (CP) visit:

- 1) Thinking back to *before* the start of your Community Paramedic visits, please rate your level of confidence in managing your own health.

Very low	Low	Moderate	High	Very high
1	2	3	4	5

- 2) Thinking about how you feel *today*, please rate your level of confidence in managing your own health.

Very low	Low	Moderate	High	Very high
1	2	3	4	5

- 3) How would you describe your overall health *before* the start of your Community Paramedic visits.

Very poor	Poor	Moderate	Good	Excellent
1	2	3	4	5

- 4) How would you describe your overall health *today*?

Very poor	Poor	Moderate	Good	Excellent
1	2	3	4	5

- 5) Thinking back to *before* the start of your Community Paramedic visits, how much did your health negatively impact your daily activities?

Not at all	A little bit	Somewhat	Quite a bit	Very much
1	2	3	4	5

- 6) How much does your health negatively impact your daily activities *today*?

Not at all	A little bit	Somewhat	Quite a bit	Very much
1	2	3	4	5

Notes/Considerations

- 1) Given workgroup discussions about balancing simplicity and valid measurement methods, the retrospective self-report approach is recommended.
- 2) This measure could be administered by the Community Paramedic at the last anticipated visit, or via a follow up confidential phone survey conducted by someone perceived as neutral to the patient. If the former, the CP could provide the survey (electronically or hard copy), and give the patient privacy to complete it confidentially. Completion during a visit would likely maximize the response rate.
- 3) The measure calculation would involve comparing before and after program average scores.

MEASURE 2: Reduction in Emergency Department (ED) Visits

Data Elements/Questions

Community paramedics would ask patients to report the *number of ED visits*:

- 1) Twelve months prior to starting community paramedic visits, and
- 2) During their participation in the community paramedic program.

Notes/Considerations

- 1) ED visits would be defined as any visit to an ED, regardless of the mode of transport to the ED and whether or not the patient was admitted to the hospital.
- 2) The number of ED visits prior to CP involvement would be *proportionally compared* to the number during CP involvement. While longer-term follow up may be ideal, this is a simple way to begin quantifying differences in ED visits before and during CP program involvement.
- 3) For long-term, or chronic, CHEMS patients, consider capturing ED visit frequency on various schedules (e.g., 30 days, 60 days, 6 months?). In doing this, keep in mind convenience for the practitioner (to facilitate good data collection practices) and meaningful time periods that also support good comparison with “non-chronic” patients.
- 4) In the future, it may be advisable to link this measure to hospital or payer records.
- 5) In the future, perhaps track others types of unplanned, “emergency-type” visits (e.g., urgent care or immediate visits to the primary care clinic).

MEASURE 3: Expenditure Savings

Data Elements/Questions

The calculations used in Measure 2 would be linked to an accepted national average ED visit expenditure to demonstrate an initial estimate of financial savings.

Notes/Considerations

- 1) It is recommended the Medicaid national average expenditure figure be used.
- 2) It is acknowledged that these calculations will significantly underestimate actual costs, but will provide a starting place for capturing this aspect of CHEMS impact.

- 3) SHIP data analytics personnel would be tasked with programming this function to allow for automatic calculation based on Measure 2.

MEASURE 4: Patient Connection with Primary Care Physician (PCP)

Data Elements/Questions

Community paramedics would ask patients at the beginning of their work together whether or not they have an established relationship with a PCP. If not, the CP would ask why (e.g., due to not knowing who available, insurance issues, none available in the community, other?). For those not connected, the CP would continue following up with the patient throughout the CP program to facilitate PCP connection, and track the outcome at the end of the CP program. For “no” PCP, the CP would capture cases where no PCP is available in the area, or if the patient connected with another type of provider or clinic.

Notes/Considerations

- 1) This measure is based on the assumptions that:
 - a. Many patients are not connected to PCPs prior to their participation in the CP program, and
 - b. PCP connection is a best practice in improving patient health outcomes (i.e., a foundation of the SHIP).
- 2) “Established relationship” may mean having a currently practicing PCP identified and having visited the PCP in the last year.
- 3) A new PCP “connection” may be defined as the CP facilitating selection of an appropriate local PCP (e.g., one who accepts the patient’s insurance, if any), making a first appointment, and the patient attending that first appointment.

MEASURE 5: Reduction in Medication Discrepancies

Data Elements/Questions

CPs will do a medication inventory at each visit with the patient, noting the number of “issues” or discrepancies at each visit. Issues will also be communicated back to PCPs.

Notes/Considerations

- 1) “Medication discrepancies” or “issues” will need to be very carefully defined to ensure alignment across all CPs.
- 2) This measure is based on the assumptions that medication discrepancies are very common and have a significant impact on patient health.