Tools to Enhance Patient Engagement

Moderator: Judith Schaefer, MPH, MacColl Institute for Healthcare Innovation at Group Health

Speakers: Chris Delaney, MBA, Chief Executive, Insignia Health; Cathy Davenport, RN, BSN, Care Manager, Peace Health; Shannon Gilbert, MHA, Practice Leader Chronic Disease Management, Multicare Health System; Jim Weiss, MD, Primary Health Medical Group.
Change Concepts for Practice Transformation

1. Laying the Foundation
   - Engaged Leadership
   - Quality Improvement Strategy

2. Building Relationships
   - Empanelment
   - Continuous, Team-Based Relationships

3. Changing Care Delivery
   - Patient-Centered Interactions
   - Organized, Evidence-Based Care

4. Reducing Barriers to Care
   - Enhanced Access
   - Care Coordination
Leveraging the Patient Activation Measure®

to Increase Patient Engagement

Chris Delaney
Insignia Health

January 24, 2013
Patient self-management is key to achieving the Triple Aims

Most of the 33 CMS quality performance standards are dependent on patient self-management.
Why is Activation so Vital to a Medical Home program?

Because people are so different, the ability to measure activation is important:

- To know who needs more support
- To tailor the support and information patients need to be successful self-managers
- To evaluate efforts to increase activation
- To have a marker for quality care

Gloria B.
- T2 Diabetes. Blood glucose is high
- Hypertension. BP is near objective
- 2 ER visits in last 16 months
## Activation begins with measurement

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Agree</th>
<th>Agree Strongly</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>When all is said and done, I am the person who is responsible for taking care of my health</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>2</td>
<td>Taking an active role in my own health care is the most important thing that affects my health</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>3</td>
<td>I know what each of my prescribed medications do</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>4</td>
<td>I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>5</td>
<td>I am confident that I can tell a doctor concerns I have even when he or she does not ask.</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>6</td>
<td>I am confident that I can follow through on medical treatments I may need to do at home</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>7</td>
<td>I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>8</td>
<td>I know how to prevent problems with my health</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>9</td>
<td>I am confident I can figure out solutions when new problems arise with my health.</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
<tr>
<td>10</td>
<td>I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
</tr>
</tbody>
</table>

### Activation Level

- **Level 1**
- **Level 2**
- **Level 3**
- **Level 4**

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**Gloria**

**Manny**

**Ivey**

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Activation is Developmental

Four levels of activation along a 100-point continuum

**Level 1**
- **Disengaged and overwhelmed**
  - Individuals are passive and lack confidence.
  - Knowledge is low, goal-orientation is weak, and adherence is poor.
  - Their perspective: "My doctor is in charge of my health."

**Level 2**
- **Becoming aware, but still struggling**
  - Individuals have some knowledge, but large gaps remain.
  - They believe health is largely out of their control, but can set simple goals.
  - Their perspective: "I could be doing more."

**Level 3**
- **Taking action**
  - Individuals have the key facts and are building self-management skills.
  - They strive for best practice behaviors, and are goal-oriented.
  - Their perspective: "I'm part of my health care team."

**Level 4**
- **Maintaining behaviors and pushing further**
  - Individuals have adopted new behaviors, but may struggle in times of stress or change.
  - Maintaining a healthy lifestyle is a key focus.
  - Their perspective: "I'm my own advocate."

**Medicare/Medicaid Segmentation by level**

- **20-25% of the population**
- **25-35% of the population**
- **20-30% of the population**
- **15-20% of the population**

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Challenge to Healthcare Providers

- 45% to 60% of your patients are low-activated: they are insufficiently engaged in managing their own health and healthcare
- Low activation patients are at risk for poor outcomes and cost utilization. This is where opportunity resides

The MORE INVOLVED you are in your own health care, the BETTER HEALTH CARE you get...

<table>
<thead>
<tr>
<th>MORE INVOLVED Patient</th>
<th>LESS INVOLVED Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge</td>
<td>12.8%</td>
</tr>
<tr>
<td>Experienced a medical error</td>
<td>19.2%</td>
</tr>
<tr>
<td>Have poor care coordination between health care providers</td>
<td>12.6%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers</td>
<td>13.2%</td>
</tr>
<tr>
<td>Lose confidence in the health care system</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

Source: AARP & You, “Beyond 50.09” Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one key chronic condition. More Involved = Levels 1 & 2
Worldwide research validates PAM
Hallmarks of activation – affect, goal orientation and feeling overwhelmed
A PAM score is predictive of future utilization and outcomes

<table>
<thead>
<tr>
<th></th>
<th>% change for a 1 point change in PAM score</th>
<th>10 point gain impact 54 (L2) to 64 (L3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>1.7% decline</td>
<td>17% decrease likelihood of hospitalization</td>
</tr>
<tr>
<td>Good A1c control (HgA1c&lt;8%)</td>
<td>1.8% gain</td>
<td>18% greater likelihood of good glycemic control</td>
</tr>
<tr>
<td>A1c testing LDL-c testing</td>
<td>3.4% gain</td>
<td>34% improvement in testing</td>
</tr>
</tbody>
</table>

A PAM score guides the journey to best practice self-care

Source: Hibbard National Study, 2004
Engaging the low activated is key to the success of Medical Homes

Tailoring Support to activation levels can improve patient experience

Source: Center For Studying Health System Change 2007 Household Tracking Study
Differences between level 4 and other levels significant at p<.05
The value of PAM to Medical Homes
Integrating PAM into a Medical Home Program

1. Measure
   - Establish baseline
   - ID self-management competency

2. Segmentation
   - Allocate resources more effectively
   - Optimize interaction methods and mediums
   - Stratify basic intervention strategies
   - Can risk stratify

3. Tailored Support
   - ID appropriate starting points
   - Address realistic behavior goals
   - Tailor action steps, mediums, and frequency
   - Leverage individual PAM questions

4. Assessment
   - Re-measure activation (PAM)
   - Assess behavior change
   - Evaluate ROI
   - Optimize program as needed
A PAM score helps you tailor support to a patient’s ability

- Identify appropriate starting points
- Address realistic and achievable behavior goals
- Customize action steps, mediums, and frequency

**Level 1**
Increase in Knowledge, Initial Skills Development, Grow Confidence
Build Knowledge Base, Self-Awareness & Initial Confidence

**Level 2**
Skills Development, Pursue Guideline Behaviors
Improve health

**Level 3**
Achieve/Exceed Lifestyle Behavior Guidelines, Develop Techniques to Prevent Relapse
Increase self-management ability

**Level 4**
Reductions in unwarranted utilization of service
Tailored support builds self-management competencies
PAM & support tailored to levels can prove instrumental to success

PeaceHealth Medical Home Program

Number of Patient Visits to Urgent Care or ED

Source: PeaceHealth’s Team Filingame Uses Patient Activation Measure to Customize the Medical Home, Center for the Health Professions Research Brief, May 2011
Published Case Study Examples

- **PeaceHealth PCMH**: Tailored coaching improved 8 of 10 clinical measures: ED use declined by 46%, office appointments increased 24%

- **Regional Health Plan**: Tailored DM and Wellness coaching found a 35% reduction in HbA1c, 6% reduction in weight, cost savings of $21 PMPM

- **Medicaid Health Plan**: PAM-based coaching yielded an 836% ROI

- **Diabetes Patient Study**: Each single point gain in PAM score = 1.7% decreased likelihood of hospitalization

- **HIV Patient Study**: Each single point gain in PAM score = 3.2% improved medication adherence

- **Disease Management Group**: Coaching tailored to PAM levels reduced ER visits by 20% and hospital admits 33% over 6 months

- **Washington State ADSA**: Cost savings estimated at $253 per month per program enrollee.
What you can expect from PAM scores & PAM-based activation

- PAM scores are predictive of future utilization and cost
- Hospitalization & ER visits decline with increasing activation
- Disease self-management, such as medication-taking & self-monitoring, improves with increasing activation
- Use of preventive care services gains with higher activation
- Higher activation is linked to more productive encounters with healthcare providers (and more satisfied patients)

Manny G.
- Build knowledge base
- Understand the role he must play
- Carefully develop medication taking and self-monitoring skills

Gloria B.
- Close knowledge gaps
- Strengthen BG monitoring skills
- Help her to schedule and keep preventive care/screen appointments

Ivey M.
- Strive for 100% adherence to medications
- Improve nutrition skills and get more physical activity

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Thank you

Chris Delaney
cdelaney@insigniahealth.com
Using the Patient Activation Measure in the Clinical Setting

Cathy Davenport, RN, BSN
RN Care Manager
PeaceHealth Medical Group
Eugene, Oregon
Clinical Advantages to Using PAM

- Patient Centered Care is here to stay
- The PAM is one tool which enhances Patient Centered Care philosophy while improving health and wellbeing
- Indirectly, the PAM also enhances patient and team member satisfaction
Keys to Implementation

* Off site training and re-evaluation of training
* Administration support to use the tool and complete required training
* Availability of an identified “expert uses” for ongoing questions and concerns
* Establishment of policies regarding use with established review times
<table>
<thead>
<tr>
<th>Activation Level ↓</th>
<th>Coaching For Activation – Team Members Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Peer Support (Stanford Chronic Disease, Web sites)</td>
</tr>
<tr>
<td>3</td>
<td>Health Coach</td>
</tr>
<tr>
<td>2</td>
<td>Behavioral Health Contact</td>
</tr>
<tr>
<td>1</td>
<td>RN Care Mgr.</td>
</tr>
<tr>
<td>Acuity of care →</td>
<td>Low</td>
</tr>
<tr>
<td>Response</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>When all is said and done, I am the person who is responsible for managing my health condition.</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>Taking an active role in my own health care is the most important factor in determining my health and ability to function.</td>
<td>Strongly Disagree</td>
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<td>I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.</td>
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Real Time Practical Use

- When using the tool in real time it is not necessary to know the actual calculated score (Level and Score)
- Quickly visualize the patient responses on the PAM survey
- Use the first “to the left” response as a conversation starting point; this is also a great way to begin establishing rapport with a patient
Barriers to Implementation

* Lack of patient education about the PAM and its purpose
* Failure to educate and familiarize other key clinic members about the PAM process and benefits (the why of doing it)
* Awareness not all staff will be accepting of new clinic culture, processes, and increased responsibilities
Need to communicate to provider current PAM level at time of each clinic visit

The PAM is a one component in a major shift in clinic culture: critical to educate staff on the whys of the changes and support ongoing training and celebrate incorporation of learning into daily clinic work
Questions?
MultiCare Health System:
Health Coaching and PAM

Shannon Gilbert, MHA
Practice Leader – Chronic Disease Management
January 27, 2012
- Not-for-profit healthcare organization
- 5 hospitals
- Numerous outpatient specialty centers and primary and urgent care clinics throughout Pierce, South King, Thurston and Kitsap counties
- Employed medical group (MultiCare Medical Associates) with over 550 physicians and non-physician providers
- **Pilot Objectives**
  - Deploy innovative and lean care teams, workflows, and tools and technology at the MultiCare Gig Harbor primary care clinic
  - Triple AIM goals
    - *Highest national quality outcomes for chronic disease patients*
    - *High levels of patient engagement and satisfaction*
    - *Reduce cost*

- **Chronic Diseases** – Depression, Diabetes, Hypertension, and CHF

- **Care Coordination Team Model**
  - Clinical Care Coordinator
  - Pharmacist
  - Behavioral Health Specialist (LCSW)
  - Health Coach
• **PAM**
  - Began survey distribution June 2011
  - Over 1,500 PAMs distributed via MyChart and in clinic

• **Health Coach**
  - Started program in September 2011
  - Health Coach proactively reaches out to Level 1’s and 2’s
  - Allow Level 3’s and 4’s to opt into program if interested
  - Initial contact made via phone, at least one face-to-face visit scheduled, subsequent follow-up mainly via phone
Health Coach Background:
- MA for 29 years, 25 of those in a clinic setting
- Chronic Care Professional and Registered Health Coach (certification through Health Sciences Institute)
- Master Trainer for Living Well with Chronic Conditions Workshops

Goals:
- Tailor support based on patient engagement
- Help patients set goals and manage their own care
- Monitor patients’ ability to adhere to their plan
- Help patients overcome barriers to meeting health goals
- Provide evidence based, clinician-directed education materials
- 69 y-o gentleman, PAM activation Level 1
- Struggling to commit to diet change
- Health Coach met with patient over the course of a few months
- Patient had an ‘ah-ha’ moment that opened him up to trying again to change diet/eating habits & creating a doable action plan
- “The greatest thing is having someone to be accountable to, and someone who will listen to what is important to me.”
Currently in the beginning stages of data analysis

Goals:
- Increase in PAM score/level
  - Better clinical indicators
  - Reduction in hospitalization/ED use
  - Improved patient satisfaction
- Correlation between PAM score & treatment outcomes in depressed population
- Took many months to integrate PAM survey into EPIC EHR system
- A lot of IS support needed to ensure Lean workflows
- Difficult to get in contact with Level 1’s and 2’s
  - Direct referrals from PCP more likely to follow-up and actively participate
- Getting providers to integrate PAM conversation/health coach referral into patient visits has been challenging
Shannon Gilbert
Practice Leader – Chronic Disease Management
shannon.gilbert@ multicare.org
The Visit Summary: Provider Perspective

Jim Weiss, MD, Primary Health Medical Group
Why Do It?

• Become a hero!
• Patients love it, appreciate it, expect it
• Wrap up the visit
• Review plan and current medications with changes
• Fewer call backs!
How To Do It?

• Sticky notes!
• Staff reminders!
• Dope slaps!
Tips and Tricks

• Customize, where possible (bold, italics, underline)
• Be open to change
• Make a game of it
• Provider must not delegate to staff
Tools to Enhance Patient Engagement

Q & A
Project Funders

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Northwest Health Foundation
Partners HealthCare
The Boston Foundation
Blue Cross Blue Shield of Massachusetts Foundation
Blue Cross of Idaho Foundation For Health
Beth Israel Deaconess Medical Center
Tools to Enhance Patient Engagement

Please take our survey by clicking on the following link:

http://www.surveymonkey.com/s/L5GS2ZM