Patient Activation: *Rethinking Non-Compliance*

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Key Objectives

1. Find out why a “non-compliant” patient might really be an “inactivated” patient
2. Learn how “activated” patients with knowledge, skills, & confidence to manage their health and health care can positively impact quality outcomes, cost, utilization, & patient experience
3. Gain skills and tools your care team can use to increase your patients’ activation level for improved hypertension control
4. Find out how to tailor your interventions to a patient’s activation level for optimal efficiency and effectiveness of resources

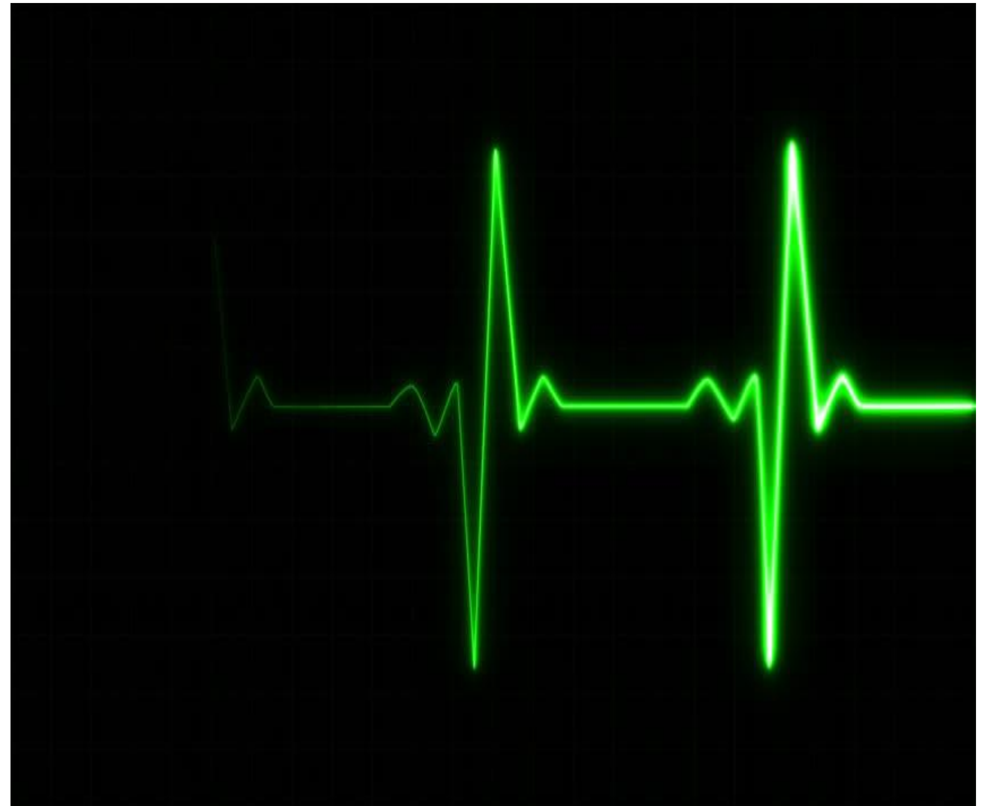
Time for Reflection

Think about a time when you felt out of control of a situation or lacked the confidence to accomplish a task…

How did you feel? Who/what did you turn to for support?

PULSE:
What do you know about Patient Activation?

- Who knows what "patient activation" is?
- Does anyone assess patients' level of "activation" in your practice?
- Who is familiar with the Patient Activation Measurement (PAM) tool?



What is Patient Activation?

Definition:

Patient activation describes the level of a “patient’s knowledge, skills, ability, and willingness to manage his or her own health and care.”

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Measuring Patient Activation

Less Reliable

More Reliable

Check patient's understanding

- *Communication Strategies:* Ask Tell Ask, Closing the Loop

Measure patient's level of confidence

- *Communication Strategies:*
  - Health Confidence Measure - how confident are you that you can control and manage most of your health problems?
  - Motivational interviewing

Measure patient's level of engagement across multiple domains

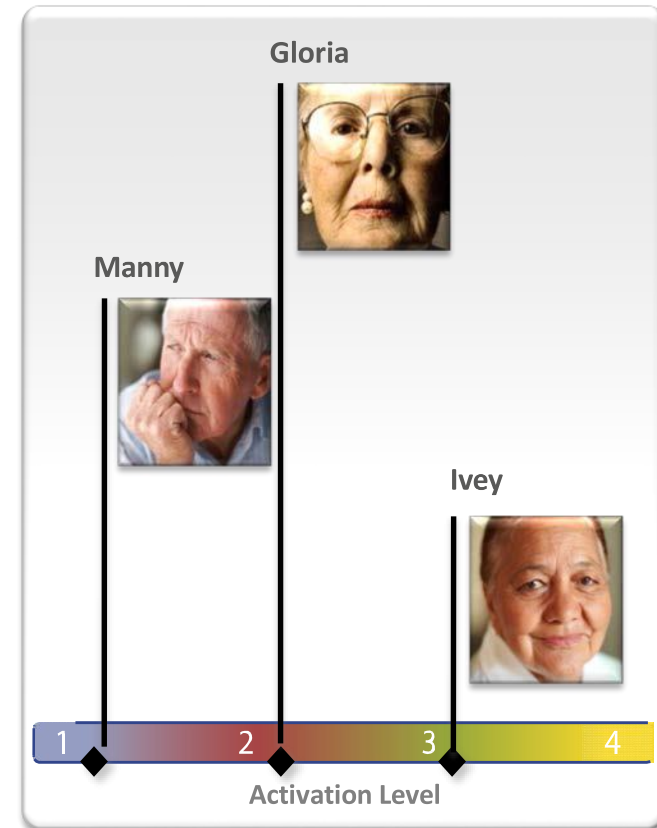
- Altarum Consumer Engagement (ACE) Measure: 12-item survey which assesses 3 domains of health engagement: *Commitment, Informed Choice, Navigation (validated tool)*

Measure patient's level of engagement across multiple domains linked to outcomes

- Patient Activation Measure (PAM)

Patient Activation Measure (PAM)

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



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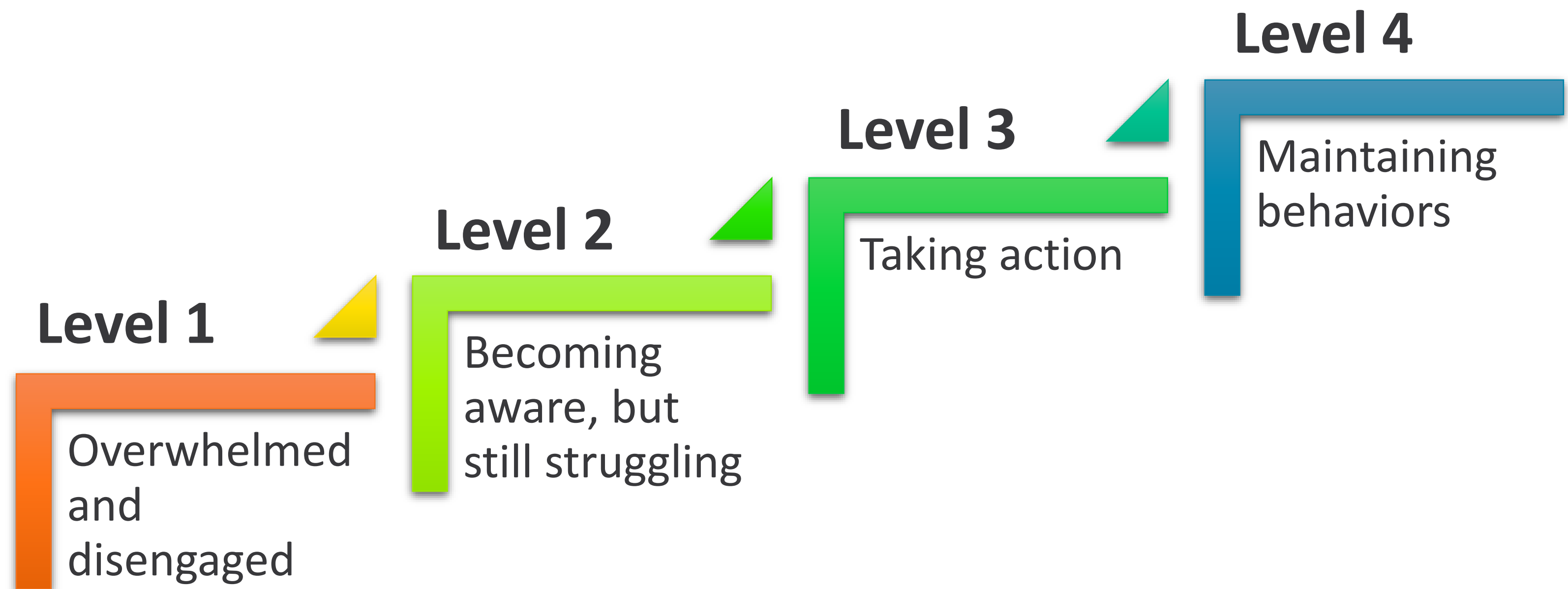
Patient Activation Levels (PAM)



- Patients can ebb and flow from one level to another
- Interventions should cater to specific PAM levels in order to meet the patient "where they are"

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Over a Decade of Research Shows that the PAM Is a Good Predictor of:

- Most health behaviors
- Many clinical outcomes
- Health trajectories
- Overall costs
- Unnecessary costly utilization
- These findings hold true after controlling for demographics and health status
- Results are found across populations and within condition specific groups

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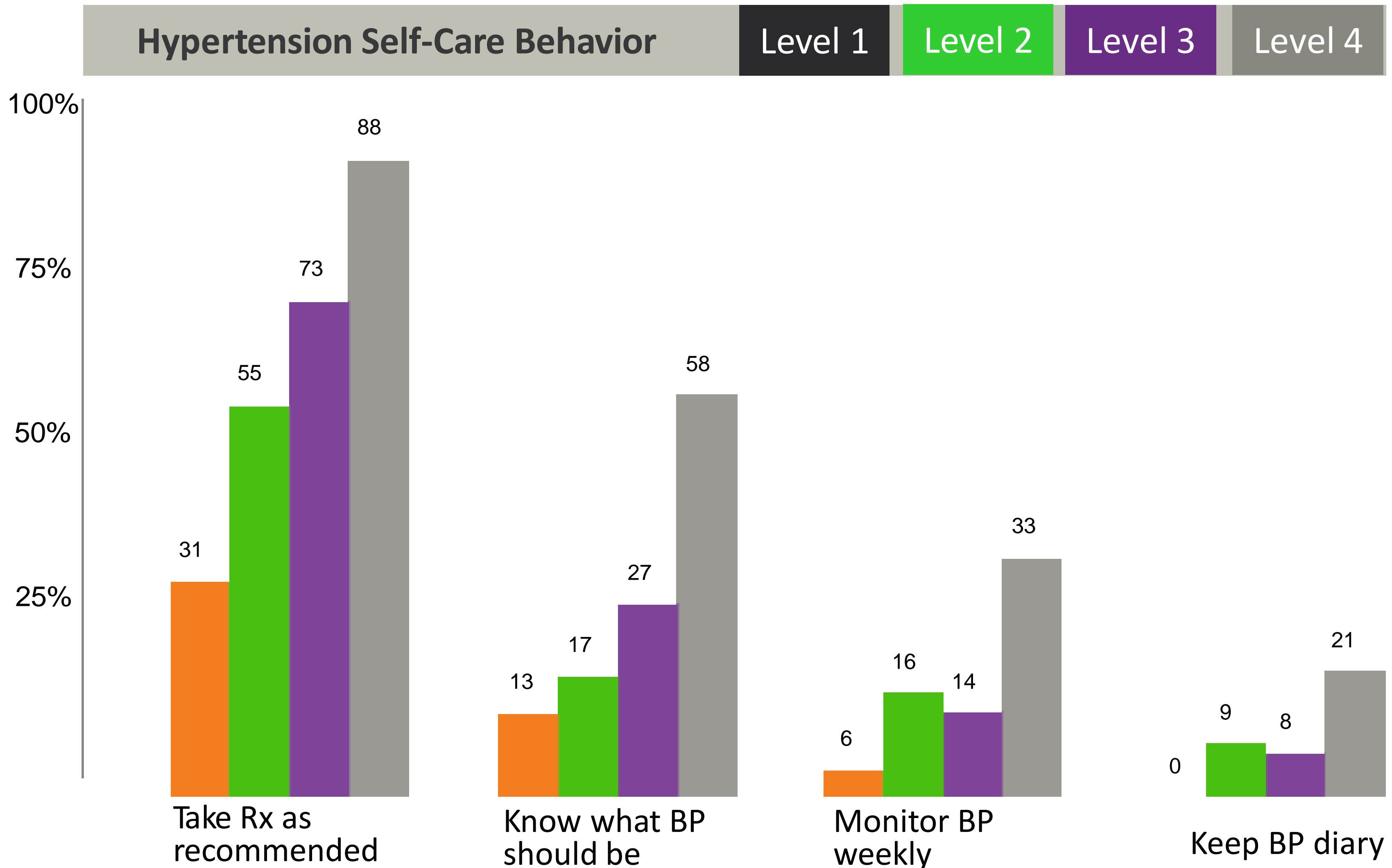
Activation and Behavior



Source: US National sample 2004

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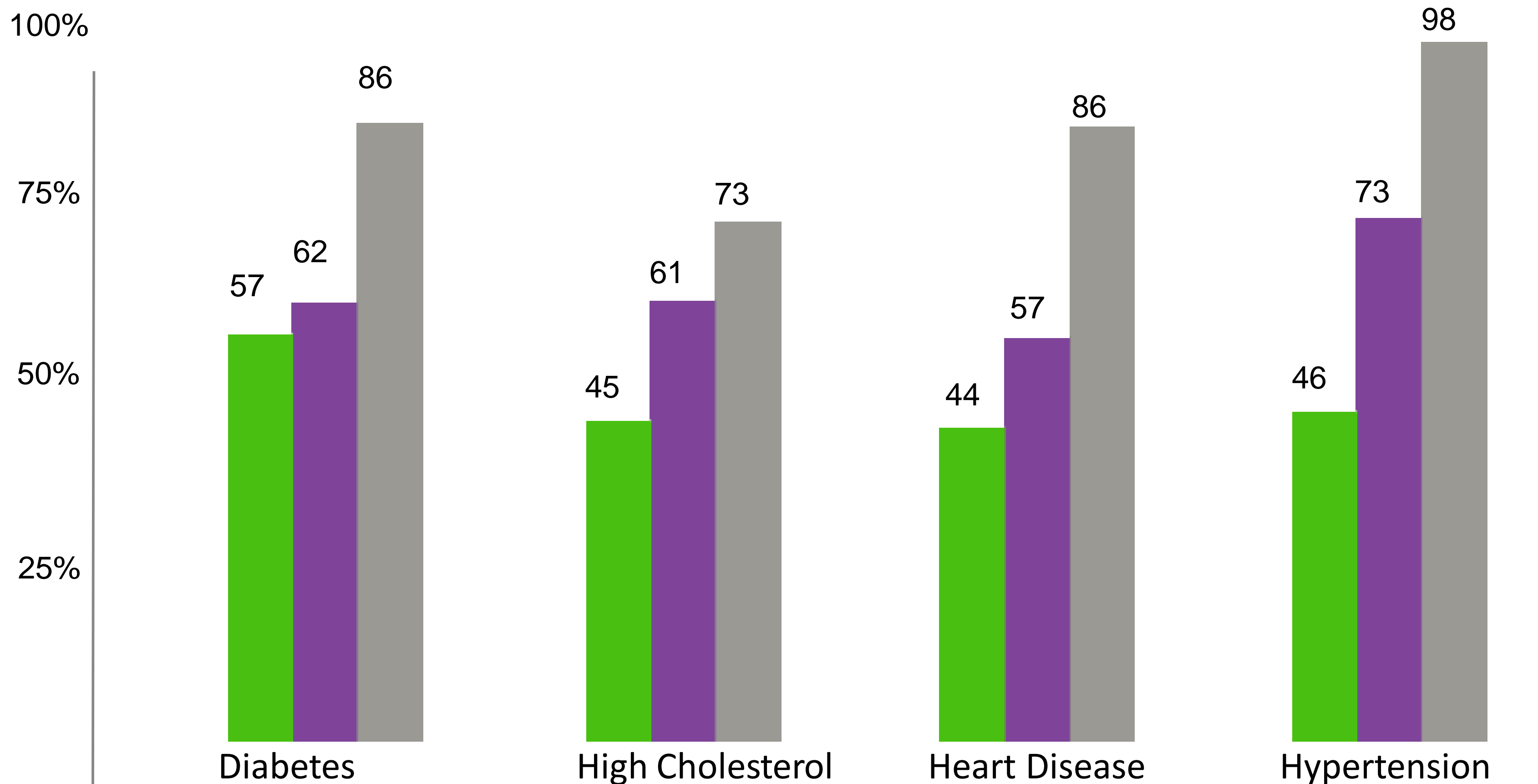
Activation is not disease specific:
Medication Adherence and patient activation level



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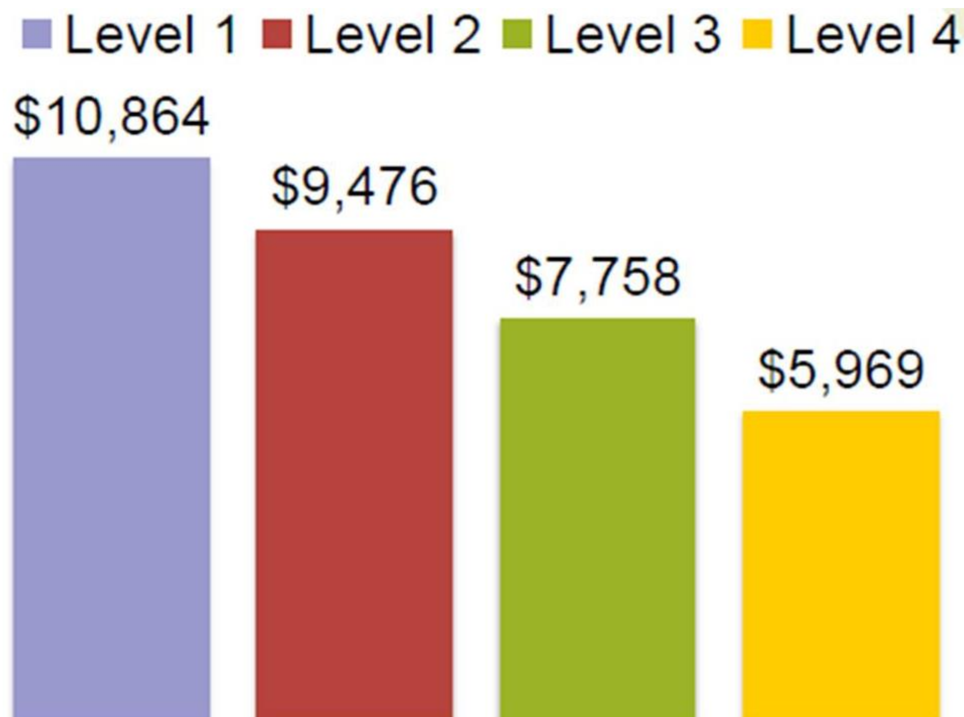
PAM Predictive Power – Medical Cost

Patients in the lower two PAM levels are at significantly greater risk for cost utilization—cost differential of almost half.



Hibbard, J. Greene, J., Overton, V. Patients With Lower Activation Associated With Higher Costs; Delivery Systems Should Know Their Patients' 'Scores'. *Health Affairs*, February 2014

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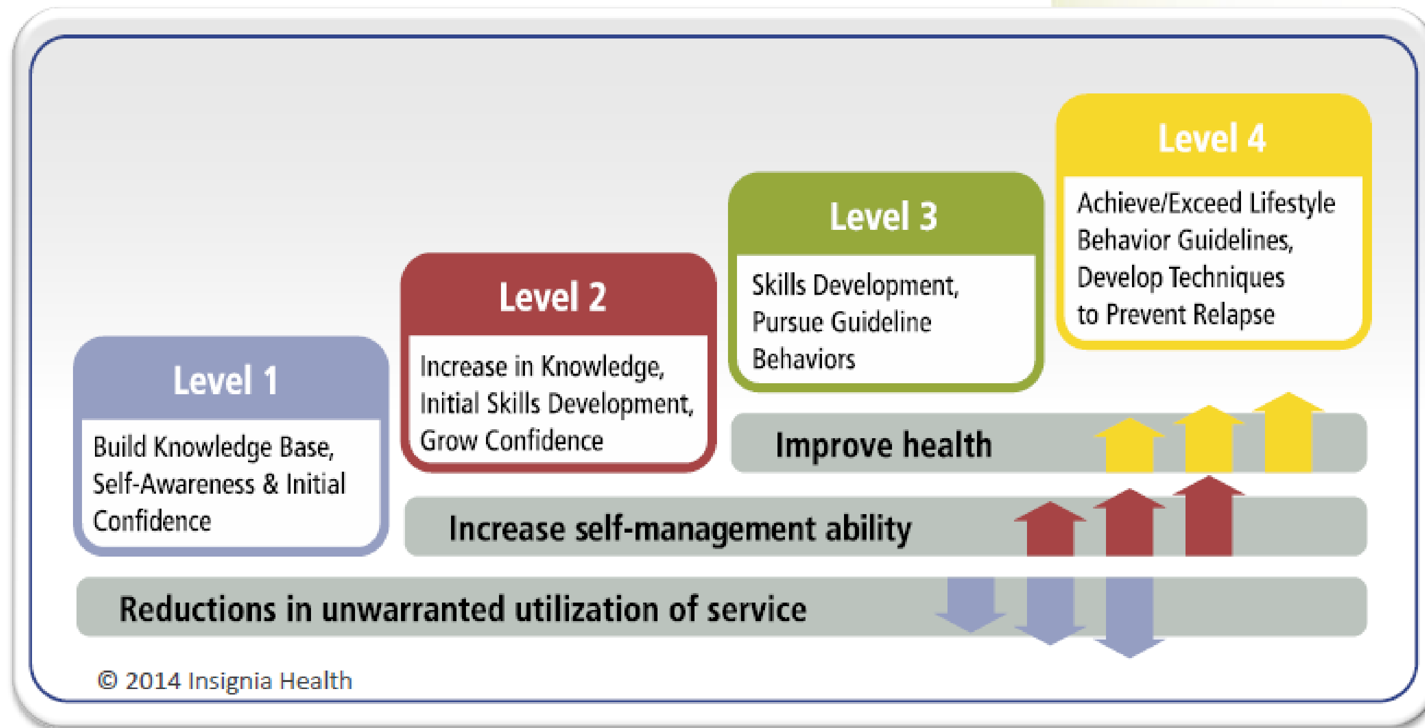
How Can a Care Team Use Patient Activation?

Tailor Support to Activation Level



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Use as a Measure of Risk

- Redefine risk measurement– to include the risk that the patient will not do their part in the care process
- Lower activated patients are more likely to develop chronic disease and allow their illness to progress faster
- Use in conjunction with clinical risk to empanel and manage patient populations.

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Team Based Care: Use Activation Levels to Allocate Resources

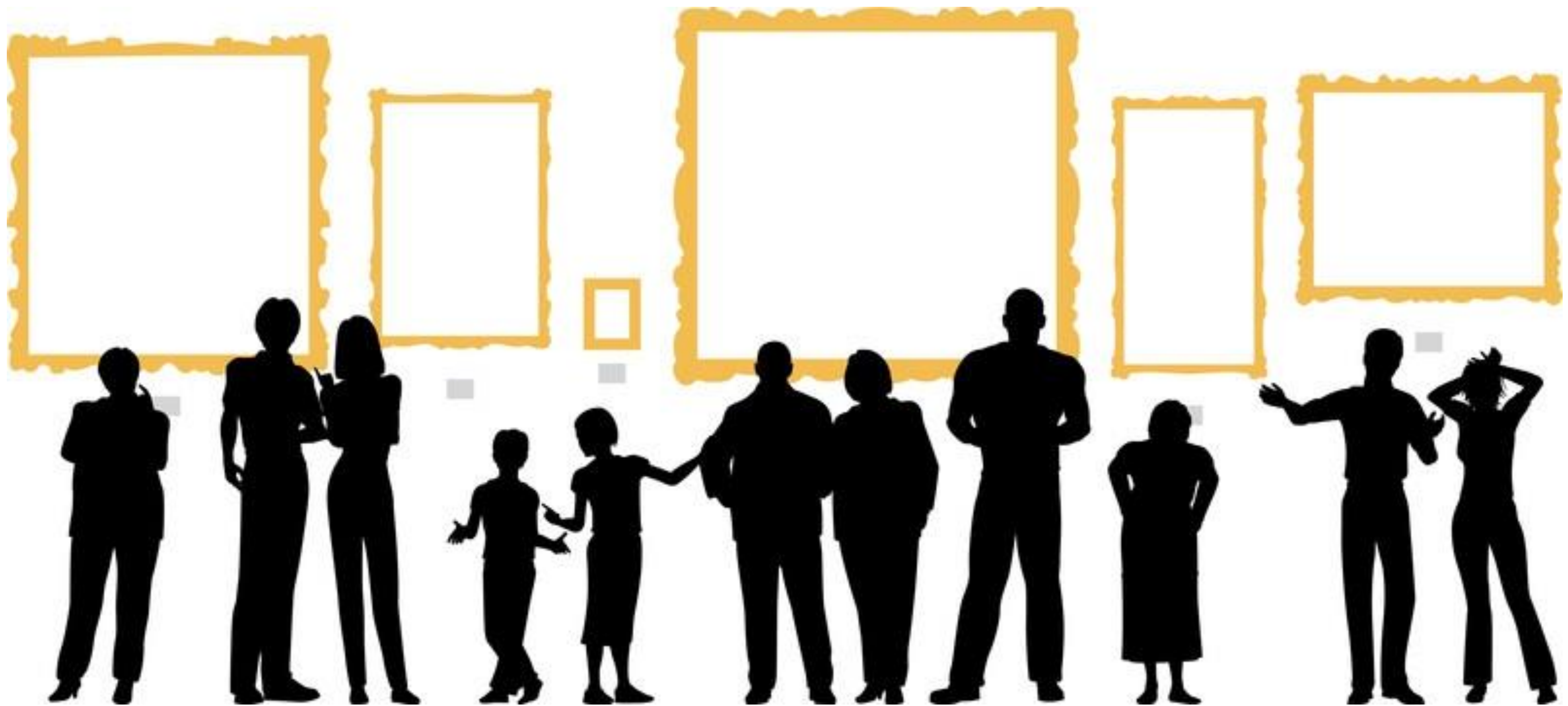
Activation Level	Acuity: LOW	Acuity: MEDIUM	Acuity: HIGH
1	RN	NP	MD + RN
2	WC	NP+ RN + WC	MD + RN + WC
3	Health Coach	NP + Team	NP + RN + WC
4	Care Facilitator Peer Support	Health Coach + RN + WC	NP + Team

Source: *PeaceHealth's Team Flingame Uses Patient Activation Measure to Customize the Medical Home*, Center for the Health Professions Research Brief, May 2011

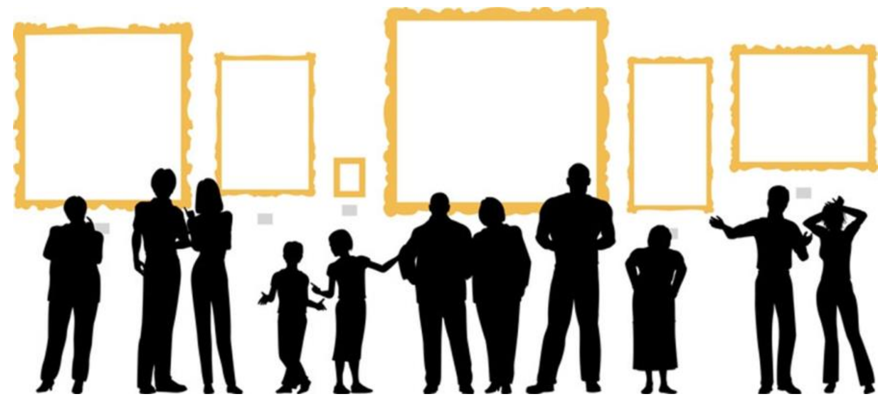
Innovative Delivery Systems are Using Patient Activation

- PAM score as a vital sign
- Tailored coaching / support (extra help for less activated patients)
  - Person-mediated support vs. Electronic-mediated support
- Intermediate outcome of care measure
- A way to assess provider performance

Gallery Walk (25 min)



Gallery Walk



Instructions:

- Take your Gallery Walk form out to take notes
- Pair up with a person you have not met.
- Introduce yourselves.
- Find a poster with a statement and stand in front of it.

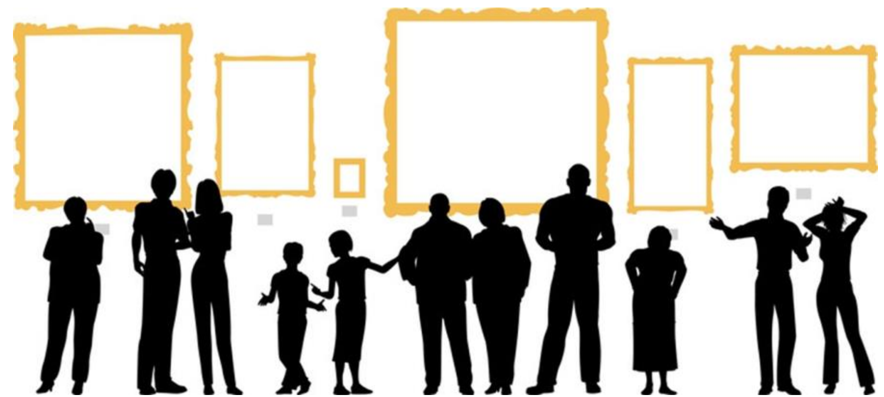
No more than 2 pairs at each poster.

You will have 3 minutes for each round!

You will be given a patient description in each round.

Discuss and take notes on your thoughts with your partner.

Gallery Walk – Round 1



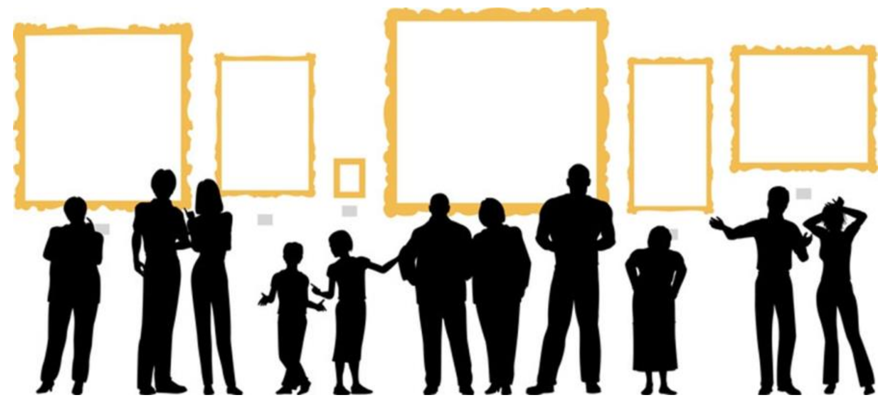
Patient Description:

This patient has **hypertension**, and they have rated this statement, **“Strongly Disagree.”**

Talk with your partner about:

- What implications do you think this has on this patient’s health?
- How might a care team use this information in their interventions?

Gallery Walk – Round 2



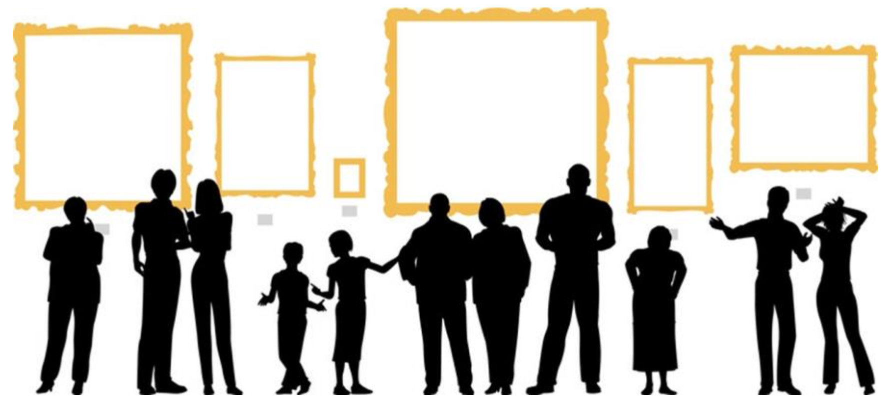
Patient Description:

This patient has **diabetes**, and they have rated this statement, **"Strongly Agree."**

Talk with your partner about:

- What implications do you think this has on this patient's health?
- How might a care team use this information in their interventions?

Gallery Walk – Round 3



Patient Description:

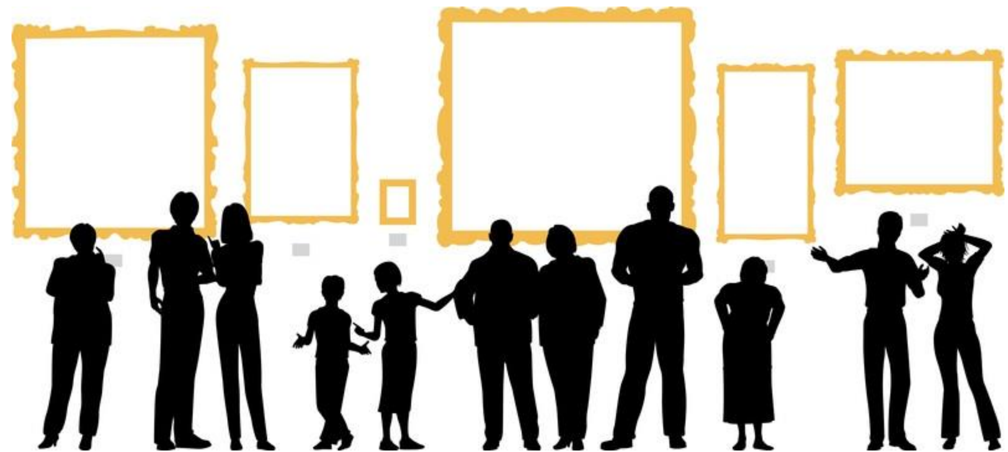
This patient has **hypertension**, and they have rated this statement, **"Disagree."**

Talk with your partner about:

- What implications do you think this has on this patient's health?
- How might a care team use this information in their interventions?

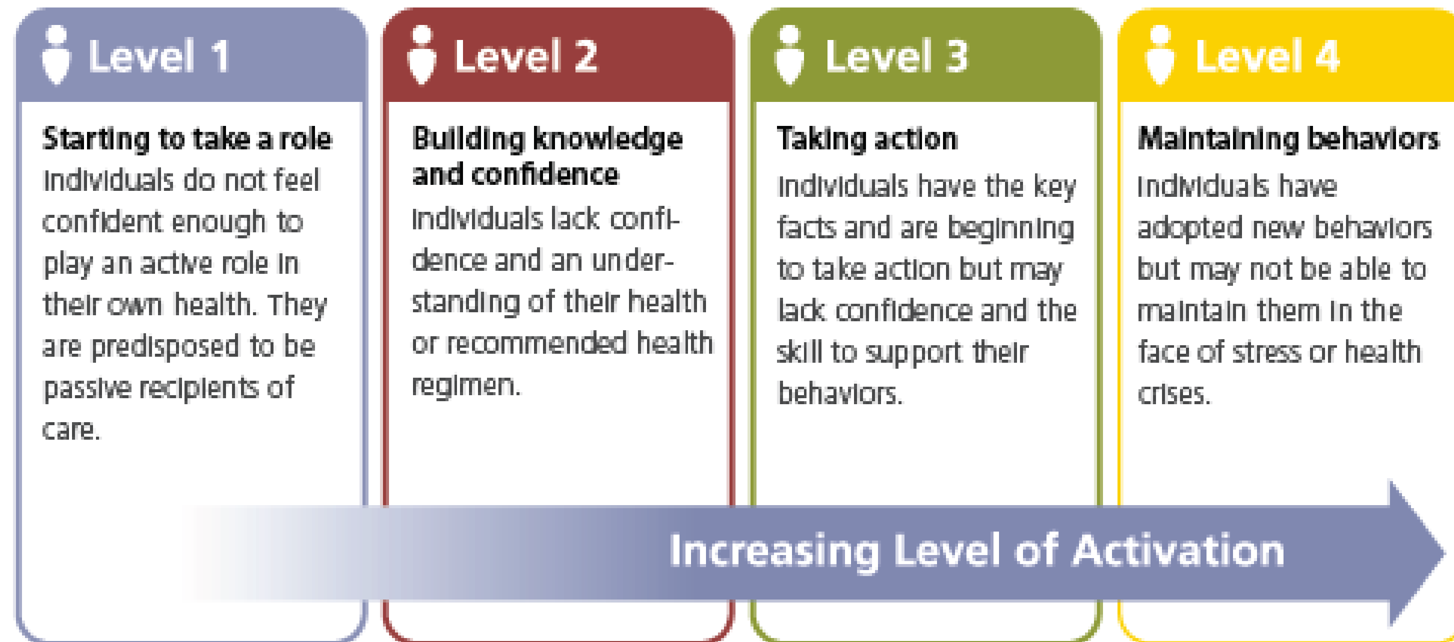
Gallery Walk
Debrief

- What insights did you have?
- Did you struggle with any of these?



Putting it into Practice

HANDOUT:
Activation Level—What the Patient Brings



Source: Judith Hibbard (OHSU) and Insignia Health

Stanford Coordinated Care:
Case Studies

By yourself, read the case studies and answer the following questions (5 min):

1. What is the patient's PAM score based on comments?
2. Through the lens of the patient's PAM score, what interventions would you propose for the patient?
3. Who in the care team would present/conduct the interventions?

Stanford Coordinated Care:
Case Studies

At your table, discuss your answers (10 min):

1. What is the patient's PAM score based on comments?
2. Through the lens of the patient's PAM score, what interventions would you propose for the patient?
3. Who in the care team would present/conduct the interventions?

SCC Case Study 1

- Supply Distribution, loves to surf, 59 year old male
  - Hypertension
  - Uncontrolled Type II DM with complications (foo ulcers, macular edema, retinopathy)
  - Colon CA
  - Stress
  - Orthopedic problems

Patient Comments

- I don't remember to take my medications.
- I get too overwhelmed.
- I didn't have my insulin needles. I needed a refill so I haven't been checking my sugars and my glucose meter isn't working.
- I have an all or nothing personality.
- I am a failure.
- What is an A1C again?
- What is diabetes again?
- What happens to my body if I keep forgetting to take my diabetic and hypertension medication?
- My wife says I should stop eating sugar or else it will kill me.

SCC Case Study 2

- Scheduler, Loves boxer, 49 year old female
  - Hypertension
  - Type II DM
  - Hyperlipidemia
  - Obesity
  - Hx of CVA
  - Sleep apnea
  - Orthopedic problems

Patient Comments

- I see how everything in my body is connected.
- I know I have to manage all of my conditions so I don't have another stroke.
- I keep imagining my perfect body.
- Now that I am taking my medications and exercising I feel like I am alive again.
- I am going to keep up doing what I am doing because I feel so good and want to live for myself and my sons.

How Did SCC Proceed?

1. What is the patient's PAM score based on comments?
2. Through the lens of the patient's PAM score, what interventions would you propose for the patient?
3. Who in the care team would present/conduct the interventions?

Case 1: Interventions

- Physician
  - Re-educates patient on disease "from scratch"
  - Refers to CDE for education and classes
- Care Coordinator
  - Practices MI to focus on small goals to improve health
  - Does glucometer teaching in office and sends in new supplies
  - Helps patient download app to share blood sugars with team
  - Makes sure patient gets diabetic eye exam and follows up with podiatry
  - Reminds patient of scheduled visits
  - Checks in regularly with patient
    - ❖ Foot check
    - ❖ Medication adherence
  - Offers continual support and compassion to encourage self-management skills

Case 2: Interventions

- Physician
  - Recommends visit with CDE and patient follows through
- Care Coordinator
  - Practices MI to focus on goals to improve health
- Patient
  - Solicits goals/action plans herself and is confident she can follow through
  - Commits to regularly checking BP and blood sugars and reporting progress to her team
  - Follows up in cardiology, sleep medicine, and ortho routinely without reminders

Questions