Tools and Strategies for Measuring Patient Activation

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Patient Activation Measure (PAM) Tool

How one Beacon Community is measuring patient activation to improve care coordination
Overview

- Why PAM?
  - Is this our missing piece...
  - The Patient Activation Measure assesses an individual’s knowledge, skills and confidence – essential self management competencies that underlie behaviors
  - ONC suggestion due to our focus on care management

- Why our Beacon?
  - Care transitions efforts (acute stay and ED)
  - Panel management in provider practices (diabetes, COPD)
  - Face-to-face care management model (home visits, practice visits)
  - Challenging patient population (Medicaid, complex co-morbid)

- Our approach
  - Leverage CCNC
  - Partner with our local Beacon stakeholders
  - Demonstrate patient improvement AND care manager role validation for sustainability
• Who (clinical)
  ◦ Community Care of North Carolina - care managers
  ◦ Beacon - Embedded care managers – all payers
  ◦ Beacon - Embedded social workers – all payers
  ◦ Beacon - Virtual home monitoring project – diabetes focus

• Who (patients)
  ◦ Medicaid
  ◦ Medicare and other commercially insured
  ◦ Diabetics with documented HGB A1c > 9.0
  ◦ COPD
  ◦ Other complex patients identified in the ED or provider practice
Approach

- **When**
  - As close to the first interaction between the clinician and patient as possible
  - Repeated tool administration every 6-8 weeks and at conclusion of relationship

- **Where**
  - In provider practices
  - In the patient’s home
  - In the hospital
  - Over the phone
What we have heard so far anecdotally:

- A few of the patient’s greater than 85 y/o have difficulty understanding questions or in some cases cannot hear the questions when presented verbally – have considered the “Caregiver PAM”.

- Some apprehension on the part of the clinicians that the language used in the tool includes words they would not normally use in their conversations with patients (i.e. Southern dialect nuances).

- Also some apprehension around minimum literacy necessary for patient’s to understand the intent of the tool and the questions themselves. We have seen a handful of tools with all of the “3’s” circled.

- NOTE: We have reached out to Insignia and other PAM users to learn from their experiences.
Response breakdown – 1st month, 50 initial surveys

Findings to date
Findings to date

Activation Score breakdown

Percentages

24
16
8

Low 1  Med 1  High 1  Low 2  Med 2  High 2  Low 3  Med 3  High 3  Low 4  Med 4  High 4

Activation Scores

Level 1  Level 2  Level 3  Level 4
Coaching for Activation

**Clients at Level 1:** Individual becomes self-aware of own behaviors and symptoms. Focus coaching on the relationship between symptoms and behaviors, building self-confidence and awareness. The individual should choose the area(s) they want to work on.

**Clients at Level 2:** Individual develops the knowledge, skills and confidence needed to master new self-management competencies. Coaching should focus on helping the individual learn to monitor symptoms, behaviors and adverse triggers - and adjust accordingly. Focus on taking small steps.

**Clients at Level 3:** Individuals initiate new health promoting behavior(s) and work to further refine techniques to monitor and adjust. Coaching should focus on providing encouragement, noticing successes, and problem solving.

**Clients at Level 4:** Individual strives to maintain desired health-related behaviors over time and learn to anticipate difficult situations that will arise. Coaching should focus on the issues that make it hard to stick to correct behaviors and to help the individual trouble-shoot.
Coaching for Activation

Diet & Nutrition - Level 2

Goal: Develop understanding of the Glycemic Index and how it can help make better food choices

Goal: Begin to self-monitor consumption of high glycemic index, high fat/calorie foods, and combinations that include high fat and high glycemic index foods

Possible Action Steps
- Encourage the use of cell phone pictures to document one day's food intake. Together, identify the glycemic index number of each food
  - What foods tasted salty? Was salt added right before eating?
  - What foods were high in fat and/or calories?
- Take camera phone pictures of all snacks eaten in a 24 hour period. Together, identify the glycemic index number of each snack food
  - What snacks tasted salty?
  - What snacks were high in fat and/or calories?
- Introduce the concept of food combinations that include both high fat and high glycemic index foods
Next steps

- Collect, compile and report data monthly
- Collect observational/anecdotal findings from CMs
- Interested in subsequent tool administration results
  - Will scores simply improve with increased exposure to a care manager?
  - Will scores improve with intentioned coaching activities and motivational interviewing techniques?
- Demonstrating success and spreading beyond Beacon by time and geography
Engaging consumers: Txt4Health & PAM

Crescent City Beacon Community
June 2012
Txt4health Overview

- Provide **targeted outreach** to (at-risk and undiagnosed) adults through mobile devices
- Reduce burden of diabetes in adult populations through risk awareness, education, and behavior change
- Link individuals to care and community resources
Txt4health Program

- Interactive, personalized 14 week text-based program that:
  - Assesses a participant’s risk for developing diabetes
  - Connects individuals to the best resources to help them improve health (e.g. health & wellness programs)
  - Sets goals and tracks weight and activity levels
  - Sends tailored educational and motivational messages to encourage healthy diet and increased exercise based on risk level
Need for Txt4health

- Louisiana has the highest diabetes mortality rate in the U.S. (35.5/100,000 persons)

- **One out of every 10** adults in Louisiana has been diagnosed with type 2 diabetes, including **one out of every four** people aged 65 and over (CDC, BRFSS, 2009)

- **60%** of adult residents in New Orleans have at least one risk factor for type 2 diabetes (CDC, BRFSS, 2009)

- In 2007, total cost of diabetes for people in Louisiana was **$2.4B**
Social Marketing

Formative Research
- Focus groups, KIIs (consumers, providers, community influencers)

Strategic Planning
- Consumer Advisory Board (13 public/private organizations)
- Public/Private Partnerships (e.g., BCBSLA, Walmart, Novo Nordisk)

Implementation
- Campaign launch event
- PSAs (tv, radio, print, outdoor)
- Community events
- Social/digital media (Facebook, Twitter)
- Earned media (TV & radio interviews)
- Campaign website (CCBC, T4H)
- 1-800-hotline, gnocommunity.org
Evaluating consumer engagement

- Txt4Health offers consumer-level service for a population level approach
- Txt4Health provides opportunity for consumer engagement in their health and health care
- Selected PAM* to understand consumer-level and population-level motivation and engagement
  - PAM designed to assess an individual’s knowledge, skill and confidence in managing their health and healthcare
  - Cost associated with PAM, quarterly reports to Insignia on # participants

*Copyrighted tool
PAM and Txt4Health

- Two main objectives for measuring PAM
  - **Objective 1:** Understand at the population level community members engagement in self-management of health.
    - What are the populations-level segmentation in GNO?
  - **Objective 2:** Examine levels of consumer engagement and PAM among Txt4Health participants
    - Do those with higher PAM scores set and complete goals?
    - What is the association of PAM and levels of satisfaction with the program?
Using PAM at the population-level

- **Target population**: Residents of the 4 Parish areas of Orleans, St. Bernard and Plaquemines (N=627)
- **Design**: Cross-sectional RDD telephone (n=400) and online panel (n=227) survey
- **Measures**: PAM, knowledge of diabetes, health and healthy choices, demographics
- **PAM Hypothesis**:  
  - The variation in activation levels will reflect the variations of U.S. population levels by race/ethnicity, age and insurance coverage.
  - The higher the engagement in self-management the higher the likelihood of making healthy choices
Using PAM at the consumer-level

- **Target Population**: Participants in the Txt4Health program who consent
- **Design**: Web-based survey
- **Measures**: PAM, knowledge of diabetes, health and healthy choices, program satisfaction, demographics
- **PAM hypothesis**:
  - There will be less variation in the program sample.
  - The higher the engagement, the higher the likelihood of setting goals.
  - All things being equal, the higher the motivation to manage their own health the greater the likelihood of completing the txt4health program.
Next Steps

• Roll out of Txt4Health program continues till March 2013
• Implementation of evaluation plan
  • Population-level survey to be conducted July 2012
  • Consumer-level program satisfaction conducted August 2012 and January 2013
• Preliminary results by Fall, 2012
Community Activation
Engaging At-Risk and Underserved Populations

Hawai‘i Island Beacon Community
Hawaiʻi County Statistics Compared to State:

• Population: 185,000
• 34% are Native Hawaiian
• 14% are 65+ years old
• Lowest per capita income
• Lowest median income
• Highest percent unemployed
• Highest level of poverty <200%
• 15% are uninsured
• Lowest ratio of physicians:population
• Higher rates of smoking
• Higher rates of obesity
• Higher death rates from heart disease, stroke and cancer

Instead of pointing out the problems we ask:

"How can our community assemble its strengths into new combinations, new structures of opportunity, new sources of income and control, and new possibilities?“

[Asset-Based Community Development]
HEAL PROJECTS

**North Kohala District**
- Get Fit Hawaii
- Eat Think Grow: Nutritional Education for School Garden Teachers on Hawaii Island
- Environmental Tobacco Smoke Office-Based Strategies for Prevention and Intervention

**South Kohala District**
- Mothers on the Move (MOM)

**North Kona District**
- Mothers on the Move (MOM)

**Hamakua District**
- Huli Ka Lima Ilalo

**North Hilo District**
- The HHDC Health Abundance Project

**South Hilo District**
- Volunteer Counseling and Health Screenings
- Marshallese Mobile Screening Clinic
- Big Island Babes Junior Roller Derby
- Mahi a Ai - Cultivate Health and Wellness
- Mahi a Ai - Rainbow Project
- Keeping Keiki Kicking
- Hana Ka Lima

**Puna District**
- Healthy Families Healthy Children
  - Ka Ohana Mala‘ai

**Ka‘u District**
- Na‘alehu Elementary School
  - Building a Garden and Doing Physical Activities to Improve Healthy Eating and Physical Fitness
Primary Objective

• Reduce disparities for Native Hawaiians and other populations at risk
  – Developed our own survey tool to measure attitude, knowledge and behavior changes activated through unique grass roots HEAL community initiatives.
  – Want to understand what works for our local communities.
  – Pre- and Post-Test questionnaire.
  – Measures changes in physical activity level, fruit and vegetable consumption, and tobacco use.
  – Questions tailored to individual project focus.
Prediction

• More activated patients show measurable changes in:
  – attitude about health
  – knowledge about making healthy choices
  – demonstrating healthy behaviors

• Activation is higher when trusted formal and/or informal community leaders deliver messages and model engagement behaviors in a culturally appropriate way.
Healthy People 2020

• GOAL
  – Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.

• OBJECTIVE
  – NWS 14: Increase contribution of fruits to the diets of the population age 2 years and older
  – NWS 15: Increase the variety and contribution of vegetables to the diets of the population age 2 years and older

• COMMUNITY INTERVENTION/ENGAGEMENT
Initial Results
Pre- and Post-Survey

Average Consumption of Fruit Servings per Day

- Huli Ka Lima Ilalo - Pre
- Huli Ka Lima Ilalo - Post

Average Consumption of Fruit Servings per Day

- Mahi A Ali - Pre
- Mahi A Ali - Post
Initial Results

**Average Consumption of Vegetable Servings per Day**

- **Huli Ka Lima Ilalo - Pre**
- **Huli Ka Lima Ilalo - Post**

**Average Consumption of Vegetable Servings per Day**

- **Mahi A Ai - Pre**
- **Mahi A Ai - Post**
Outcome

• Honor and build on community interests, priorities and assets

• Identify and leverage existing community based relationships and partnerships

• Identify support needed to maximize and maintain community participation

• Document and communicate the link between community engagement strategies and **improved population health outcomes**
Remote Patient Monitoring Program
Congestive Heart Failure

*December 2010 - August 2011*

Jason Broad
Director, Lean Six Sigma
CHF - Remote Patient Monitoring

Overview

Goals:

- Reduce unnecessary admissions (and readmissions)
- Keep patients well-managed at home
- Teach/empower patients to take care of their heart failure

Target Population:

- ≥ 60 years old
- Medi-Cal
- Medi-Cal with HMO
- CMS/Self-pay
- Medicare (FFS)
- High utilizers of the ED
- Patients with history of readmissions
CHF - Remote Patient Monitoring

Overview

Intervention:

- Assessment in hospital by program coordinator (recruitment / enrollment)
- Home visit at start of program to admit patient
- 90 days of remote patient monitoring using telehealth scale
- As needed phone calls to/from program coordinator and/or vendor’s remote monitoring nurses
- Home visit at end of program to graduate patient
CHF - Remote Patient Monitoring

Results

Enrollment statistics

Age range of patients 26 - 92

Dis-enrolled: 15
Surgery, SNF, Request,
Death, Left town, Worsening CHF, Hospice

Graduated: 65

Total Patients: 80*

*Reached enrollment goal of 80 patients
Last patient admitted to program 8/19/11
### 30-Day Readmissions:
Results for patients enrolled for at least 30 days (Sharp’s Baseline: @ 20%)

<table>
<thead>
<tr>
<th>Status</th>
<th>Readmits/ Total Pts</th>
<th>30-Day Readmit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dis-enrolled*</td>
<td>3 / 15</td>
<td>20%</td>
</tr>
<tr>
<td>Graduated</td>
<td>5 / 65</td>
<td>7.8%</td>
</tr>
<tr>
<td>Overall</td>
<td>8 / 80</td>
<td>10%</td>
</tr>
</tbody>
</table>

* Disenrollment reasons: Surgery, admit to SNF, moved out of region, worsening CHF, patient/family request, death, admit to hospice

Comparison to baseline indicates that the intervention is working and that patient selection is accurate, however, success of program will come from comparing enrolled patients to a natural control group comprised of similar patients who did not enroll in program.
CHF - Remote Patient Monitoring
Patient Activation

Objective:

• Establish baseline related to patients’ needs
• Evaluate effectiveness of the education/coaching program intervention

Tool Selection Criteria:

• Evidence based
• Easy for patients to use, self administered
• Available, low or no cost
• Available in multiple languages (primarily Spanish)
• Helped target patient specific needs
• Can be used to assess patient’s growth in program
CHF - Remote Patient Monitoring

Patient Activation

Tool Selected:

Self Care Heart Failure Index (SCHFI)

Use in Program:

- Baseline (pre-intervention): Administered to patients by program coordinator in hospital upon acceptance or in home during 1st home visit
- Re-measure (post-intervention): Admin to patients by program coordinator in home during discharge home visit.
98% of patients scored above the target of 70% on the maintenance domain of the SCHFI survey after completing the program.
## QUALITY OF LIFE OUTCOMES

Self-Care Heart Failure Index  
N=63 [patients who (a) completed 90-day program and (b) completed discharge surveys]

<table>
<thead>
<tr>
<th></th>
<th>Pre score</th>
<th>Post score</th>
<th>PRE % activated</th>
<th>POST % activated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maintenance Score</strong></td>
<td>50.25 (19.58)</td>
<td>88.77 (9.62)</td>
<td>2%</td>
<td>98%</td>
</tr>
<tr>
<td><strong>Management Score</strong></td>
<td>13 (12.26)</td>
<td>68.75 (23.23)</td>
<td>3%</td>
<td>97%</td>
</tr>
<tr>
<td>(scored only if symptomatic, N listed)</td>
<td>N=61</td>
<td>N=4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Confidence Score</strong></td>
<td>54.79 (27.59)</td>
<td>92.41 (11.27)</td>
<td>19%</td>
<td>92%</td>
</tr>
</tbody>
</table>
CHF - Remote Patient Monitoring

Patient Activation

Lessons Learned:

• Challenge balancing good survey administration protocols with the program’s demographic
• Patients have a false sense of confidence in their self-management
• Initially pursued as a measurement tool, but became a way of understanding each patient’s specific needs

Role in Future Programs:

• Incorporating ‘Patient Activation’ strategies and measurement in programs where outcomes are reliant on patient behavior/compliance, particularly new/enhanced post-acute and transitional care programs
Questions?

Consumer eHealth Affinity Group