Patient Activation and Engagement for ACOs

Judith H. Hibbard, PhD
Institute for Policy Research and Innovation, University of Oregon

Ralph Prows, MD
The Regence Group

Richard Baron, MD
Centers for Medicare and Medicaid Services

Michael Trisolini, PhD, MBA
RTI International

We will start shortly after 3:30 PM EST

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Patient Engagement in Accountable Care Organizations

Judith H. Hibbard, DrPH
Institute for Policy Research and Innovation
University of Oregon
To Hold Down Costs and Retain Members, Accountable Care Organizations Will Need to Engage with Patients so that they:

- Make informed choices about providers
- Engage in effective self-management
- Collaborate with providers
- Are sufficiently satisfied to remain within the system
The Agenda

• What is patient engagement/activation?
• What do we know about those who are more and less activated/engaged?
• How does activation/engagement relate to costs and outcomes?
• How can Delivery systems activate patients?
Patient Activation  Definition

• Individual understands their role in the care process, and has the knowledge, skill, and confidence to carry it out.
There is great variation in patient activation/engagement in any population group

Measurement allows us:

- To know who needs more support
- To target the types of support and information patients and consumers need
- To evaluate efforts to increase activation
- To evaluate the quality of care
- To Build the evidence base
Patient Activation Measurement (PAM)  
Difficulty Structure of 13 Items

Measurement Properties
• Uni-dimensional
• Interval Level
• Guttman-Like Scale

Level 1: Does not yet believe they have active/important role
Level 2: Lack confidence and knowledge to take action
Level 3: Beginning to take action
Level 4: Maintaining behavior over time
### PAM 13 Question

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

* Related instruments: PAM 10, PAM 2, Clinician PAM
Activation is developmental

**Level 1**
Starting to take a role
Patients do not yet grasp that they must play an active role in their own health. They are disposed to being passive recipients of care.

**Level 2**
Building knowledge and confidence
Patients lack the basic health-related facts or have not connected these facts into larger understanding of their health or recommended health regimen.

**Level 3**
Taking action
Patients have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

**Level 4**
Maintaining behaviors
Patients have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

Source: J.Hibbard, University of Oregon
Emotion plays a profound role in patient activation

Source: KnowledgeNetworks National Study 2008
Activation Level is Predictive of Behaviors

Research consistently finds that those who are more activated are:

– Engaged in more **preventive behaviors**
– Engaged in more **healthy behaviors**
– Engaged in more **disease specific self-management behaviors**
– Engaged in more health **information seeking behaviors**
Level of activation is linked with each behavior

<table>
<thead>
<tr>
<th>Hypertension Self-care Behaviors</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take Rx as recommended</td>
<td>31</td>
<td>55</td>
<td>73</td>
<td>88</td>
</tr>
<tr>
<td>Know what BP should be</td>
<td>13</td>
<td>17</td>
<td>27</td>
<td>58</td>
</tr>
<tr>
<td>Monitor BP weekly</td>
<td>6</td>
<td>16</td>
<td>14</td>
<td>33</td>
</tr>
<tr>
<td>Keep BP diary</td>
<td>0</td>
<td>9</td>
<td>8</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: US National sample 2004
Behaviors by Level of Activation Among Diabetes Patients

Diabetes Self-care Behaviors

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Level 1 &amp; Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication as directed</td>
<td>57%</td>
<td>62%</td>
<td>62%</td>
</tr>
<tr>
<td>Test glucose 3/week</td>
<td>44%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Read food labels</td>
<td>53%</td>
<td>74%</td>
<td>74%</td>
</tr>
<tr>
<td>Check cracks in feet</td>
<td>33%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Read about side effects</td>
<td>28%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Keep glucose diary</td>
<td>33%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Manage stress</td>
<td>19%</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>Exercise</td>
<td>7%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Count carbs</td>
<td>12%</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Exercise</td>
<td>5%</td>
<td>31%</td>
<td>31%</td>
</tr>
<tr>
<td>Count carbs</td>
<td>1%</td>
<td>19%</td>
<td>19%</td>
</tr>
</tbody>
</table>

RWJ PeaceHealth Study 2006
Behaviors in Medical Encounter by Activation Level

- **Read about complications:**
  - Level 1: 36%
  - Level 2: 43%
  - Level 3: 52%
  - Level 4: 78%

- **Bring doctor a list of questions:**
  - Level 1: 29%
  - Level 2: 24%
  - Level 3: 45%
  - Level 4: 66%

- **Persistence in asking:**
  - Level 1: 8%
  - Level 2: 10%
  - Level 3: 22%
  - Level 4: 70%

- **Look up doctor’s qualifications:**
  - Level 1: 10%
  - Level 2: 6%
  - Level 3: 16%
  - Level 4: 52%
New Insights

- Use activation level to determine what are realistic “next steps” for individuals to take
- Many of the behaviors we are asking of people are only done by those in highest level of activation
- When we focus on the more complex and difficult behaviors— we discourage the least activated
- Start with behaviors more feasible for patients to take on, increases individual’s opportunity to experience success
When activation changes several behaviors change. Implications for how to start this process

- Estimated Marginal Means of Activation by Wave by Activation Growth Class
- Increased Growth Class
- Stable Growth Class

11 of 18 behaviors show significant improvement within the Increased Growth Class compared to the Stable Growth Class
Activation is important in any situation where the patient has a significant role to play

- If people don’t understand their role, they aren’t going to take action, they aren’t going to look for or take in new information
- If people don’t feel confident, they are less likely to be pro-active
- This appears to be true regardless of condition
Medication Adherence by Level of Activation for Different Conditions

Use of Medications By Level of Activation

<table>
<thead>
<tr>
<th>Condition</th>
<th>Level 1 &amp; Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>57</td>
<td>72</td>
<td>86</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>45</td>
<td>57</td>
<td>86</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>44</td>
<td>73</td>
<td>88</td>
</tr>
<tr>
<td>Hypertension</td>
<td>46</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

National Study 2004
Low activation signals problems (and opportunities)

<table>
<thead>
<tr>
<th>Problem</th>
<th>More Activated Patient</th>
<th>Less Activated Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge</td>
<td>12.8%</td>
<td>28%</td>
</tr>
<tr>
<td>Experienced a medical error</td>
<td>19.2%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Have poor care coordination between health care providers</td>
<td>12.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers</td>
<td>13.2%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Lose confidence in the health care system</td>
<td>15.1%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

Source: Adapted from AARP & You, "Beyond 50.09" Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one chronic condition. More Involved=Levels 3 & 4, Less Involved=Levels 1 & 2
Activation can predict utilization and health outcomes two years into the future for diabetics

<table>
<thead>
<tr>
<th></th>
<th>% change for a 1 point change in PAM Score</th>
<th>10 Point Gain in PAM Score 54 (L2) vs. 64(L3)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>1.7% decline</td>
<td>17% decreased likelihood of hospitalization</td>
<td>.03</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>
<td>.01</td>
</tr>
<tr>
<td>A1c testing</td>
<td>3.4% gain</td>
<td>34% greater likelihood of testing</td>
<td>.01</td>
</tr>
<tr>
<td>LDL-c testing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Carol Remmers. *The Relationship Between the Patient Activation Measure, Future Health Outcomes, and Health Care Utilization Among Patients with Diabetes*. Kaiser Care Management Institute, PhD Dissertation.

Multivariate analysis which controlled for age group, gender, race, comorbidities and number of diabetes-related prescriptions.
## Study Population in Large Delivery System

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Sample Size</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD)</td>
<td>15,984</td>
<td>50.2 (16.1)</td>
</tr>
<tr>
<td>Female (%)</td>
<td>15,984</td>
<td>52.1</td>
</tr>
<tr>
<td>Chronic Conditions, mean (SD)</td>
<td>15,984</td>
<td>1.0 (1.1)</td>
</tr>
<tr>
<td>Patient Activation, mean (SD)</td>
<td>15,984</td>
<td>66.7 (15.3)</td>
</tr>
</tbody>
</table>
Higher Activation Scores are Related to Better Outcomes (Regression Coefficients)

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Clinical Indicators in Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon Mammograms Pap Smears</td>
<td></td>
</tr>
<tr>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>.02***</td>
<td></td>
</tr>
<tr>
<td>.01**</td>
<td></td>
</tr>
<tr>
<td>Healthy Behaviors</td>
<td></td>
</tr>
<tr>
<td>Not Obese Not Smoking</td>
<td></td>
</tr>
<tr>
<td>.04***</td>
<td></td>
</tr>
<tr>
<td>.02***</td>
<td></td>
</tr>
<tr>
<td>Costly Utilization</td>
<td></td>
</tr>
<tr>
<td>Lower Hospital Lower ER</td>
<td></td>
</tr>
<tr>
<td>.00***</td>
<td></td>
</tr>
<tr>
<td>.01***</td>
<td></td>
</tr>
</tbody>
</table>

Controlling for age, income, gender, and chronic diseases
The predicted probabilities are based upon regression models that control for patient age, gender, zip code income, and number of chronic conditions. For ED use, the model also includes the percent of a clinic’s total patient costs that are Fairview costs.
Patient Activation & Total Costs

<table>
<thead>
<tr>
<th>Patient Activation Level</th>
<th>Raw Differences</th>
<th>Adjusted Difference in Median Cost*#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>(Reference)</td>
<td>(Reference)</td>
</tr>
<tr>
<td>Level 2</td>
<td>-$1,409*</td>
<td>-3.6%</td>
</tr>
<tr>
<td>Level 3</td>
<td>-$3,442***</td>
<td>-9.4%**</td>
</tr>
<tr>
<td>Level 4</td>
<td>-$5,101***</td>
<td>-10.5%**</td>
</tr>
</tbody>
</table>

* p < .05  ** p < .01  *** p < .001

* Adjusted differences were derived from a regression model using log-transformed total costs of Fairview care, controlling for demographics (age, gender, median income of patient’s zip code), Ingenix retrospective risk score, and percent of a clinic’s total patient costs that are Fairview costs.
Study Implications

• Findings highlight the importance of the patient role in outcomes and cost
• As provider payments become more closely linked with patient outcomes, understanding how to increase patient activation will become a priority for payers and providers.
Summary of Evidence: Higher Activated Patients:

- More likely to seek out and use information to make health care choices
- Engage in more healthy behaviors
- Have better care experiences, are more satisfied
- Have fewer care coordination problems
- Less likely to be hospitalized or use ED
- Less likely to be re-admitted to hospital
- More likely to have bio-metrics in normal range
- More likely to have overall lower costs
Increases in Activation are Possible

• If we want patients to take ownership we have to make them part of the process.
  • Listen, problem-solve, and collaborate
  • Help them gain the skills and confidence they need

• This represents a major paradigm shift
  – Moving away from simply “telling patients what to do.” Different than “compliance”--
  – There is a focus on developing confidence and skills, and not just the transfer of information.
Patients who get more support for self-management from their Doctors are more activated.

Source: Center For Studying Health System Change 2007 Household Tracking Study
Differences between level 4 and other levels significant at p<.05
Increasing Activation in Clinical Settings

- Tailored coaching
  - Including brief coaching in the clinical setting— with follow-up
- Segmentation approaches and differential allocation of resources
- Care transitions and reducing hospital re-admissions
- Wellness, disease management
Activation Model Requires a Patient Centered Approach

► Giving the patient’s agenda attention and priority
► Ask-- don’t tell
► The goal is to build capacity— not just compliance
► Listening, joint-problem solving, affirmation
Use PAM in Clinical setting in 4 Ways

► Assess activation level
► Tailor coaching and support to activation level
► Segment population and allocate resources (more efficient use of resources)
► Track progress
## TAILORING: Levels 1 and 2

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Approach to Patient Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Overwhelmed</td>
<td>• one focus at a time. Avoid a long list of goals/actions</td>
</tr>
<tr>
<td>- Weighted down by negative emotions</td>
<td>• Focus on what is important to the patient</td>
</tr>
<tr>
<td>- Lack confidence</td>
<td>• Reinforce the importance of their participation</td>
</tr>
<tr>
<td>- Poor problem solving skills</td>
<td>• Small steps with encouragement</td>
</tr>
<tr>
<td>- Lack basic health/condition knowledge</td>
<td>• Experiencing success builds confidence</td>
</tr>
<tr>
<td>- Poor self-awareness</td>
<td>• Loop back on behavioral goals</td>
</tr>
<tr>
<td>- Few self-management skills developed</td>
<td>• Develop problem solving skills—jointly problem solve</td>
</tr>
<tr>
<td>- Passive. Self-management is following Dr. orders</td>
<td></td>
</tr>
<tr>
<td>- May not grasp importance of their role</td>
<td></td>
</tr>
</tbody>
</table>
## TAILORING: Level 3

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Approach to Patient Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Takes some positive actions around health</td>
<td>• Use small step approach, but focus on ‘larger’ single step</td>
</tr>
<tr>
<td>• Feels more ready to take on challenges</td>
<td>• Focus on what Individual wants to focus on</td>
</tr>
<tr>
<td>• Still needs to build confidence and fill knowledge gaps</td>
<td>• Build on strengths</td>
</tr>
<tr>
<td></td>
<td>• Provide encouragement</td>
</tr>
<tr>
<td></td>
<td>• Loop back on behavioral goals</td>
</tr>
<tr>
<td></td>
<td>• Jointly problem solve around specific behaviors</td>
</tr>
</tbody>
</table>
TAILORING: Level 4

Characteristics

- Goal Oriented
- More self-aware
- Self-management skills developed
- Pro-active
- Good problem solving skills

Approach to Patient Support

- Focus on what is important to the patient
- Focus on maintaining behaviors and any lagging behaviors
- Still use small steps approach
- Experiencing success builds confidence
- Stretch goals
- Problem solving around relapse issues
- Build on strengths
Tailored Coaching Study

- Intervention group coached based on level of activation. Control group was “usual care” coaching (DM company)
- Examined changes in claims data, clinical indicators, and activation levels
- 6 month Intervention period.
Coaches allocated more talk time to lower activation participants when they had access to PAM scores.

<table>
<thead>
<tr>
<th>Coaching Call Talk Times</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Talk Time (minutes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>16</td>
<td>17</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>PAM Integrated into Coaching</td>
<td>18</td>
<td>17</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

Control group did not integrate PAM scores and related insights into the coaching process.

Source: National DM Firm. N=1030 intervention; N=501 in control group. Difference between the two groups is significant at the .05 level.
PAM tailored coaching resulted in a statistically significant greater gains in activation

N.=245 in intervention group; N=112 in control group. Only those with 3 PAM scores are included. Repeated measures shows that the gains in activation are significant in the intervention group and not significant for the control group (P<.001)
Tailored coaching can improve adherence and reduce costly utilization

Clinical Indicators*

**Medications:** intervention group increased adherence to recommended immunizations and drug regimens to a greater degree than the control group. This included getting influenza vaccine.

**Blood Pressure:** Intervention group had a significantly greater drop in diastolic as compared to control group.

**LDL:** Intervention group had a significantly greater reduction in LDL, as compared to the control group.

**A1c:** Both intervention and control showed improvements in A1c.

*Using repeated measures, and controlling for baseline measures

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Hibbard, J, Green, J, Tusler, M. Improving the Outcomes of Disease Management by Tailoring Care to the Patient’s Level of Activation. The American Journal of Managed Care, V.15, 6. June 2009
Tailoring had a positive impact on all patient outcomes

- Findings consistent across all outcome measures
- Results are compared to usual coaching
- Valuable Implementation lessons learned along the way
Engagement Means...

• Start where the patient is
• Encourage realistic steps—creating opportunities to experience success
• Build on strengths
• Use measurement to assess and to track progress
Patient Activation
Its Role in Accountable Health

Ralph Prows, MD
Chief Medical Officer
The Regence Group
Agenda

- Context
  - Role Definitions in an *Accountable Health System*
  - Support for delivery system redesign: medical home pilots
- The PeaceHealth/Regence/PAM Implementation
- Next Steps
Regence’s vision and end state

The Accountable Health System

- Alignment of the Delivery Systems, Health Plan and Members to achieve improved health, improved member experience, and lower costs

The Accountable Care Organization

- A clinically and financially integrated organization of providers (including primary care, specialist, ancillary, facilities, etc) working together toward the common goals set for their attributed/ assigned patient population
AHS Objectives & Stakeholder Roles

AHS objectives

1. Deliver products and services that drive value through provider-plan-member alignment

2. Implement payment and network strategies that improve quality and lower the cost trend

3. Actively engage consumers in their health and healthcare decisions

AHS Stakeholder Roles

- **Health Plan**: Being a catalyst for value across the entire ecosystem
- **Accountable Health System**: Actively engaged in their health and healthcare decisions
- **Providers**: Defining outcomes in terms of cost and quality
- **Consumers**: Defining outcomes in terms of cost and quality
Early experiments that informed the PeaceHealth initiative

- 2005: HIT Community Connectivity
- 2006: Boeing IOCP Pilots
- 2007: Pay-4-Condition
- 2008: Expanded Primary Care Home Demos
- 2009: Clinical Performance Improvement Pilots
- 2010: IOCP 2.0

Patient Satisfaction
Implementing PAM in the PeaceHealth Patient Centered Medical Home

- Part of medical home demonstrations 2006-2010
- Key structural features:
  - Family practice integrated care teams designed, funded, supported with data and technical assistance
  - Team-based care with a central role of nurse care managers
Implementing PAM in the PeaceHealth Patient Centered Medical Home

- Key Functional features:
  - Patient identification and stratification
    - Clinical: chronic complex diseases (CHF, DM, other)
    - Claims-based predictive scores
    - PAM Scores
  - PAM-Tailored personal care plans with goals
  - Intensity of staffing and interventions based on stratification scoring
Staffing

- Wellness Coach – behaviorist
- Health Coaches – MOA’s
- Nurse Care Manager – RN
- Nurse Practitioner
- MD’s

*All team members trained in Coaching for Activation*
## Segmentation and Staffing

### Acuity

<table>
<thead>
<tr>
<th>Activation Level</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RN</td>
<td>NP</td>
<td>MD + RN</td>
</tr>
<tr>
<td>2</td>
<td>WC</td>
<td>NP + RN + WC</td>
<td>MD + RN + WC</td>
</tr>
<tr>
<td>3</td>
<td>Health Coach</td>
<td>NP + Team</td>
<td>NP + RN + WC</td>
</tr>
<tr>
<td>4</td>
<td>Care Facilitator Peer Support</td>
<td>Health Coach + RN + WC</td>
<td>NP + Team</td>
</tr>
</tbody>
</table>
Stratification

- Patient stratification by score into Red, Yellow or Blue
- Matched stratification with staff skill levels
- Intake care planning assessment for all patients
- PAM Level 1 & 2 reassessed q. 6 weeks
  - All acuities received PAM-tailored intensified education, coaching
  - PAM served to provide consistent support from all team members
  - Red/Yellow also received intensified medical management (CHF, DM, etc.)
- PAM Level 4 discharged and reassessed q. 12 months
Challenges

- Staffing
  - Funding and ROI
  - Managing significant role shifts
    - Transition to shared decision making
    - Nurses shifting from 1:1 care giving assistance to population management, focusing on highest acuity patients
    - MOA’s shifting from clerical or 1:1 care giving assistance to coaching/education
  - Burnout
  - Training

- Scaling up
- Team play: re-tasking, schedule scrubbing, work sessions
- Patient segmentation and protocol development
- Tracking & reporting
- Health Plan interaction
Outcomes
(Team Fillingame)

- Improved clinical measures
  - Steady statistically significant improvement in 8/10 clinical measures
  - Improved adherence
- Reduced ER visits (54%)
- Improved patient experience scores (NRC Picker)
  - Willingness to recommend, access, etc.
- Improved staff experience
  - Exceeded 85% of the PH organization
- Improved PAM scores
  - 47% improved their scores
  - 25% improved > 10 points
- Received Practice Management Award for Practice Improvement from Society of Teachers of Family Practice
Next Steps

- PAM now deploying across all PeaceHealth Medical Group Practices and planned for Oregon CCO’s
- Patient Activation adopted for deployment across 2 million Regence members for care management and other engagement opportunities
- Fulfillment of AHS accountability
  - Upfront payment for care management
  - Incentive payments based on member engagement, clinical and cost performance
  - PAM integration will be a key metric for success
Thank You for Attending this Webinar