CARE TRANSITION ACTIVATION INTERVENTIONS
PAM LEVEL 1 & 2

LOW ACTIVATED PATIENT PROFILE

- May not understand that they need to play a role in their own health
- Lacks basic knowledge about their condition
- May not understand treatment options or self-care expectations
- May not feel in charge of own health and healthcare
- Used to failure and lacking problem solving skills
- Feels very overwhelmed
- Experiences a lot of negative emotion that makes it hard to cope
- Low confidence in their ability to impact their health
- Difficulty following through on treatment regimens
- Has trouble connecting behavior to health
- 30%-40% Rx adherent; High rate of ER use/hospitalization

OVERARCHING COACHING GOALS

- Frequent contact, especially during first 2 weeks when readmission risk is highest
- Short term focus on symptoms and red flag awareness
- Focus on medication adherence
- Help patient overcome immediate barriers to a successful care transition
- Avoid overwhelming with too much information
- Baby steps with small achievable goals to improve confidence
- Increase self-awareness through self-monitoring; help them connect the dots between behavior and how they feel
- Show empathy by using positive messages

INTERVENTIONS

RED Flags

- Enable patient understanding of RED FLAGS by focusing on the *most important* signs that can lead to a readmit. Supply a simple step for the patient to carry out should he/she encounter a red flag. Avoid overwhelming the patient
  Action: Educate the patient about the red flags that apply to his/her condition. Keep it simple

  Action: Ask patient to explain his/her red flags.

  Action: Educate patient on how to respond to RED Flags. Create/provide a simple list outlining RED Flags and how to respond/who to call.

  Action: Highlight which RED flags require an ER visit or 911 call

INTERVENTIONS

Medications

- Work with patient to understand how prescribed meds work; emphasize those meds *most important* to preventing a readmission and how to take medications correctly
  Action: Identify and address any medication concerns including potential barriers to taking correctly

  Action: Together, fill out a medication chart that includes all prescribed meds & dosing directions

  Action: Decide with patients what reminder he/she will put in place to remember to take meds.

Physician Communication & Appointments

- Emphasize importance of patient keeping his/her follow-up appointments
  Action: Schedule the follow up appointment for the patient.

  Action: Make a reminder call the day prior to the patient's appointment

- Encourage patient to communicate with providers
  Action: Ask them to have a pad near them at home to write down questions for his/her next visit. Remind him/her to bring questions during reminder call

CARE TRANSITION ACTIVATION INTERVENTIONS
PAM LEVEL 3

LEVEL 3 PATIENT PROFILE

- May have understanding of basic condition facts and treatments
- Some experience and success in making behavioral changes
- Has confidence in the role they need to play
- Beginning to connect health to longer term goals
- Experiences mostly positive emotions related to their health
- Partners with healthcare providers
- Becoming a good self-manager, ex. 65-75% adherent to meds
- Much less likely than levels 1 & 2 to readmit within 30 days
- This level is the 'bridge' between low activation (L1/L2) and level 4

OVERARCHING COACHING GOALS

- Start to build on past experiences and successes to increase confidence and ability in handling all aspects of health condition
- Strive for achieving self-care guidelines
- Connect self-care to long-term benefits
- Leverage positive attitudes about a healthy lifestyle to bring about steps to improve healthy behaviors
- The "one small step" approach still resonates
- Promote and encourage health information seeking and sharing
- Continue with problem-solving and skill development
- Reinforce the success they've had while focusing on achieving new goals

INTERVENTIONS

RED Flags

- Close any gaps in RED flag understanding and response plans
  Action: Ask the individual to explain his/her RED flags, related signs, how to watch for these flags, and how to respond appropriately

Medications

- Pursue full adherence to prescribed medication(s)

  Action: Identify any remaining gaps and related causes (e.g. cost, side effects, 'don't need/feeling good', forgetting)

  Action: Educate regarding risks of stopping prescribed meds

  Action: Create a plan to overcome tough days/weeks and/or changes in schedule

Physician Communication & Appointments

- Encourage thorough communication with providers
  Action: Request patient keep running log of questions and bring questions to appointments

INTERVENTIONS

Condition Knowledge & Symptom Awareness

- Close any condition knowledge gaps such as causes, symptoms, and best practice self-management. Ask them to engage in self-care behaviors at/near guideline levels
  Action: Ask patient to explain what he/she should be doing to manage his/her health. Elicit gaps or opportunities to improve self-management

  Action: Compare patient's numbers to guideline numbers for BP, cholesterol, blood sugar, etc. Develop a plan to close any gaps

Diet & Nutrition (example goals & steps)

- Increase awareness of foods that can worsen patient's condition

  Action: Develop a plan to avoid/reduce unhealthy foods and to increase vegetable, fruit, fiber intake

  Action: Provide with a food journal template and have patient track diet for two weeks

Insignia Health

Care Transition Activation Interventions
PAM Level 4

Level 4 Patient Profile

- Has made many of the necessary behavior changes, but may have difficulty maintaining behaviors over time or during times of stress
- Significant opportunity remains to address lifestyle behaviors – nutrition, physical activity, coping with stress
- Able to regularly practice self-care behavior at guideline levels, particularly with nutrition, medications, and activity.
- Goal oriented with regard to health
- Experiences more positive emotions related to engaging in healthy behaviors

Overarching Coaching Goals

- Focus on skills for relapse prevention and learn to troubleshoot in advance of difficult times and events
- Close any gaps in self-care behavior
- Create "stretch" goals, typically emphasizing nutrition, activity, and stress management, to further improve health
- Monitor for relapse (e.g., behaviors and medication adherence) and work on skills to re-start healthy behaviors
- Promote social supports and peer-education to create a strong network of health advocates
- Reinforce the successes they've had, highlighting their strong self-management to date

Interventions

RED Flags

- Close any gaps in RED flag understanding and response plans
  Action: Ask the individual to explain his/her RED flags, related signs, how to watch for these flags, and how to respond appropriately

Medications

- Have a plan in place to maintain 100% medication compliance
  Action: Identify tendency and temptation to slack off Rx's when symptoms have improved

  Action: Identify ways to maintain a medication routine during times of change or stress. Advise patient to fill Rx in advance of travel

Condition Knowledge & Symptom Awareness

- Help patient maintain target numbers for condition(s), at or near guideline levels and look toward stretch goals
  Action: Track and monitor numbers, then make modifications in routines and habits when not aligned with guidelines

Interventions

Diet & Nutrition (example goals & steps)

- Work with patient to troubleshoot and plan for difficult situations, (eating in a restaurant or when travelling, eating in response to stress)
  Action: Tell patient to research restaurants ahead of time, pack healthy snacks
- Expect that dietary relapse (consuming too many calories, saturated fat, sodium/salt) can and will happen
  Action: Ask patient to develop to get back on track following relapse. Reiterate that a dietary lapse does not mean the patient gives up.

Physical Activity (example goals & steps)

- Encourage longer term goals
  Action: Provide a list of upcoming 5ks or other community athletic events. Encourage patient to improve time, duration, intensity or distance of existing activity
- Troubleshoot ways to overcome activity slumps
  Action: Suggest patient become a mentor or motivator for someone else
  Action: Advise patient to pack athletic clothes when away from home