Welcome!

Putting PAM and Coaching for Activation into Practice

October 8, 2014
Today’s Agenda

- *Quick* Patient Activation Measure Review
- What does PAM tell us
- Coaching for Activation (CfA)
- Vidant Case Studies
Which interaction looks better to you?
Why measure a person’s Activation?

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 measure performance and to have a marker for quality care
Activation cannot be predicted by demographics

PAM score works across conditions

Your patient is ready to improve if you meet him where he’s at
Behavior Maps & Health Activation Personas
PAM Relationship to Self-management Behaviors

PAM levels guide the journey to best practice self-management

<table>
<thead>
<tr>
<th>Diabetes Management Skills by Level</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Took medications as recommended</td>
<td>64%</td>
<td>70%</td>
<td>78%</td>
<td>84%</td>
</tr>
<tr>
<td>Checked blood sugar at least 1x/week</td>
<td>66%</td>
<td>75%</td>
<td>78%</td>
<td>83%</td>
</tr>
<tr>
<td>Identified good A1C reading correctly</td>
<td>37%</td>
<td>58%</td>
<td>72%</td>
<td>80%</td>
</tr>
<tr>
<td>Kept doctor's appointment</td>
<td>32%</td>
<td>40%</td>
<td>66%</td>
<td>79%</td>
</tr>
<tr>
<td>Eats 5 fruits or vegetables/day</td>
<td>8%</td>
<td>8%</td>
<td>15%</td>
<td>27%</td>
</tr>
<tr>
<td>Manages stress</td>
<td>8%</td>
<td>8%</td>
<td>12%</td>
<td>41%</td>
</tr>
<tr>
<td>Exercises regularly</td>
<td>2%</td>
<td>8%</td>
<td>22%</td>
<td>42%</td>
</tr>
</tbody>
</table>


Achieving best practice self-care is developmental
Patient experience with HCPs improves significantly with increasing activation

Source: Center For Studying Health System Change 2007 Household Tracking Study
Differences between level 4 and other levels significant at p<.05
Lower activated don’t feel in control

Percent Agree or Strongly Agree

Level 1  Level 2  Level 3  Level 4

100%

75%

50%

25%

0%

Even when I take care of myself, it’s easy to get sick
I would rather not think about my health
If I become sick, I have the power to make myself well again

Source: University of Oregon 2006, N=150
Patient perspective of YOU

![Bar chart showing experience with healthcare providers across different levels.](chart.png)

- **Level 1**: 48.3% for helping set goals to improve diet, 65.3% for helping set goals for exercise, 42.2% for teaching to self-monitor condition.
- **Level 2**: 78.6% for diet, 61.6% for exercise, 66.5% for self-monitoring.
- **Level 3**: 83.6% for diet, 73.6% for exercise, 80.9% for self-monitoring.
- **Level 4**: 100% for diet, 100% for exercise, 84.7% for self-monitoring.

Source: Center for Studying Health System Change 2007 Household Tracking Study. Differences between level 4 and other levels significant at p<.05.
Transitions - the low activated struggle with their medications

Source: QIO Care Transition Program, 2010-2011
Emotional drivers correspond well with levels of activation

Source: Knowledge Networks National Study 2008
Coaching for Activation guides patient coaching.

- Key areas of self-management
- Goals and Action Steps are tailored to activation level
- Resources reinforce coaching and can be easily printed or emailed
Condition & Symptoms - Level 1

Select Level: 1 2 3 4

- Goal: Work with the client to build awareness of problem symptoms, and what makes him/her feel better or worse. Symptoms might include fatigue or low energy, depression or anxiety, extreme thirst or excessive hunger

- Goal: Help the client understand his/her role in managing diabetes and the importance of their active involvement as part of their care team

- Goal: Help the client become familiar with the language of diabetes
Goals and action steps are tailored to a level of activation

**Level 1:** Knowledge, self-awareness and confidence is developed

- Goald: Become aware of portion sizes and start the journey to right sized eating
- Goald: Develop a solid understanding of how carbohydrates impact blood glucose and which carbs are okay, and which to avoid
- Goald: Become familiar with the Plate Method for diabetes and begin to put this approach to work
- Goald: Become aware of the good and bad foods that can impact diabetes management and the triggers that bring on poor eating habits
- Goald: Learn to use the food label and nutrition information to make better food choices at home or when eating out
- Goald: Start to grow confidence and control diabetes with a small-step change in diet and nutrition

**Level 3:** Guideline skills are pursued

- Goald: Develop a carb counting routine
- Goald: Improve food habits at home, from better grocery shopping to cooking smart
- Goald: Master use of the Glycemic Index to make good food choices
- Goald: Calories are key. Get to the right calorie intake based upon weight objectives
- Goald: Putting it all together. Engage in healthy diet and nutrition-related behaviors near, or at, guideline levels
- Goald: Celebrate. Do something good for yourself when improving eating habits
CareMaps™ provide high level coaching guidance

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
Demographics:
  Name (ficticious): Janice
  Age- 47
  Gender- Female

Problems/Medications
1. Hypothyroidism: synthroid (unstable and not to goal)
2. Noncompliance
3. Type 2 diabetes:
   Humalog 50/50  15U ac tid  **A1C 2008 to 2012 most often in the 8%s; 2013 to present >11-14%**
   **August 2014 11.7**
   Amaryl 4 mg daily
4. Hypertension: HCTZ 12.5 mg daily  **B/P often to goal, but occasional diastolic 80-100**
5. Dyslipidemia: Zocor  **Total cholesterol=239**
   Triglycerides=136
   HDL=38
   LDL= 174 (as high as 242)
6. Obesity:  **Wt 230-245# BMI 39**
Current Plan and Goals

• Purchase healthy items from shopping guide to pack in lunch for each day

• Check blood sugar before each meal (goal 100-150)

• Take humalog 15 units 50/50 before each meal

• Eat well balanced meal (1 meat type food, 1 portion starch/carbohydrate, 1 portion vegetable or fruit)
One size DOES NOT fit ALL!
Patient #1

PAM Level 1

- Does not feel in control
- Lacks basic health knowledge
- Poor self-awareness
- Poor Tx & medication adherence
- Few self-management skills developed
- Very passive
- Poor communication with providers
- Very low confidence
- Disengaged
- OVERWHELMED
PAM Level 1 Profile

PAM Level 1

- Does not feel in control
- **Lacks basic health knowledge**
- **Poor self-awareness**
- Poor Tx & medication adherence
- Few self-management skills developed
- Very passive
- Poor communication with providers
- Very low confidence
- Disengaged
- **OVERWHELMED**
Your Intervention with an Activation lens

PAM Level 1 Plan

Opportunities:

• What is on her mind? What resonated with the patient?

• Cardiac Risk...start here, but with an Activation-based focus
Your Intervention with an Activation lens

PAM Level 1 Plan (Choose 1 or 2)

• Build Basic Knowledge about her particular cardiac risk

• Develop knowledge about medications related to cardiac condition...connect non-adherence to increased risk

• Build knowledge about diet and cardiac risk...be specific about what a heart healthy diet is
  – Do not expect her to change her diet...start with goals built solely around knowledge

• Later, begin to connect cardiac risk and Diabetes Mellitus to get her thinking & talking about DM

Tactics at L1:

• Less is more

• Baby steps

• Show empathy

• Short term focus

• RED FLAG awareness
Demographics:

Name (fictitious): Thelma, 74
Gender: Female
9.11.14 visit: BS- 436, B/P 196-96

<table>
<thead>
<tr>
<th>Date</th>
<th>BS</th>
<th>A1C</th>
<th>Meds</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-13-14</td>
<td>256</td>
<td>11.8</td>
<td>Amaryl 4mg po q am</td>
<td>Non-compliant with med regimen</td>
</tr>
<tr>
<td>8-20</td>
<td>307</td>
<td></td>
<td>Lantus 24u q am</td>
<td>Does not remember to take Lantus more often</td>
</tr>
<tr>
<td>9-11</td>
<td>411</td>
<td></td>
<td>Adalat CC 30mg po qd</td>
<td>even though now takes in the am</td>
</tr>
<tr>
<td>9-12</td>
<td>283</td>
<td></td>
<td>Trazadone 50mg po q hs</td>
<td>Requires repetitive instruction of med</td>
</tr>
<tr>
<td>9-16</td>
<td>449</td>
<td></td>
<td>Novolog 8u sq tid with meals</td>
<td>changes</td>
</tr>
<tr>
<td>9-18</td>
<td>341</td>
<td></td>
<td></td>
<td>Verbalizes non-compliance with diet and med adherence</td>
</tr>
<tr>
<td>9-23</td>
<td>380</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient #2

PAM Level 1

- Does not feel in control
- Lacks basic health knowledge
- Poor self-awareness
- Poor Tx & medication adherence
- Few self-management skills developed
- Very passive
- Poor communication with providers
- Very low confidence
- Disengaged
- OVERWHELMED
PAM Level 1 Profile

PAM Level 1
- Does not feel in control
- Lacks basic health knowledge
- Poor self-awareness
- Poor Tx & medication adherence
- Few self-management skills developed
- Very passive
- Poor communication with providers
- Very low confidence
- Disengaged
- OVERWHELMED
**Your Intervention with an Activation lens**

### PAM Level 1 Plan

* *

* *

* *

* *

* *

### Opportunities:

- What is on her mind? What resonated with the patient?
PAM Level 1 Plan (Choose 1 or 2)

Tactics at L1:

- Less is more
- Baby steps
- Show empathy
- Short term focus
- RED FLAG awareness
PAM Level 2 Profile

- Passive in their care
- Struggle with medications
- Inconsistent self-management
- Poor communication with care givers
- Gaps in knowledge
- Low Confidence
- Very basic self-management skill set
- Unsure
Your Intervention with an Activation lens

PAM Level 2 Plan

Opportunities:

• Less is more
• Baby steps
• Show empathy
• Short term focus
• RED FLAG awareness
PAM Level 3 Profile

- Recognize responsibility for their health
- Taking action
- Have had some success
- Good interaction with providers
- Developing confidence
- Good goal orientation
- Good medication adherence
- Knowledgeable about their health
Your Intervention with an Activation lens

PAM Level 3 Plan

Opportunities:

• Build on past successes
• Baby steps still resonates
• Connect self-care to long term benefits
• Promote and encourage information seeking and sharing
• Strive for achieving self-care guidelines
PAM Level 4 Profile

- Self-aware
- Good self-managers
- Confident
- Realize importance of their role
- Strong medication adherence
- Strong goal orientation
- Aware of stress
- Interact well with healthcare providers
Your Intervention with an Activation lens

PAM Level 4 Discharge Plan

Opportunities:

• Focus on skills for relapse prevention
• Troubleshoot in advance of difficult/stressful times
• Create goals that challenge patient
• Promote social support and peer education
Increasing Activation. One size support does not fit all

More clinically significant skills are developed once a base of knowledge and confidence is established.
Progressing Along the Continuum

Yes, I did it!
I will do it
I can do it
I'll try to do it
How do I do it?
I want to do it
I can't do it
I won't do it

Which step have you reached today?
### Action steps are tailored to a level of activation

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss...</td>
<td>Discuss further...</td>
<td>Ensure strong understanding of...</td>
<td>Discuss stress</td>
</tr>
<tr>
<td>Encourage...</td>
<td>Continue together to...</td>
<td>Together discuss “complex” items...</td>
<td>Encourage maintenance of...</td>
</tr>
<tr>
<td>Do together...</td>
<td></td>
<td>Have the individual research...</td>
<td>Have individual research...</td>
</tr>
<tr>
<td>Promote awareness of...</td>
<td>Begin to track...</td>
<td>Consistently track...</td>
<td>Track and plan out...</td>
</tr>
<tr>
<td>Try a skill once or twice this week.</td>
<td>Try a skill 2-3x a week</td>
<td>Focus on guideline skills</td>
<td>Focus on guideline skills and pushing further</td>
</tr>
</tbody>
</table>
In a rigorous study, PAM demonstrated its ability to predict utilization and outcomes two years into the future.

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td></td>
<td>17% decreased likelihood of hospitalization</td>
</tr>
<tr>
<td>Good A1c control (HgA1c &lt; 8%)</td>
<td>1.8% gain</td>
</tr>
<tr>
<td></td>
<td>18% greater likelihood of good glycemic control</td>
</tr>
<tr>
<td>A1c testing</td>
<td>3.4% gain</td>
</tr>
<tr>
<td>LDL-c testing</td>
<td>34% improvement in testing</td>
</tr>
</tbody>
</table>

Patients will complete the PAM, and do so accurately. Proper administration is critical. Convey caring and not evaluation.

Help patients build competency and confidence, especially at the lower levels. Competency comes from confidence over time – it’s a journey.

Best practice/evidence-based self-care is achieved by those at L3 & L4.

Allocate more resources to the low activated (L1 & L2), while shifting from the most activated (L4).

L3 and L4 do not require intense support, but they do require appropriate support or they will ignore you.
Questions?
Thank you!

Insignia Health

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