Increasing Patient Activation to Improve Health Outcomes

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Agenda

• What is Patient Activation? How is it measured?
  – What is the Evidence that it is linked with outcomes: Behaviors; Health; Utilization, Costs?
  – Key insights from research
  – What are the implications for population health management?
  – How are health care delivery systems using measurement of activation to slow the progression of illness, improve the outcomes of care, and control costs?
What is Activation?

An activated consumer:

• Has the knowledge, skill and confidence to take on the role of managing their health and health care

• Full range of activation in any population group

• Demographics tend to account for 5% to 6% of PAM score variation
Over a Decade of Research Shows that the Patient Activation Measure (PAM) Is a Good Predictor of:

- Most health behaviors
- Many clinical outcomes
- Health trajectories
- Overall costs

- These findings hold true after controlling for demographics and health status
- Results are found across populations and within condition specific groups
### Activation Measure Items

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

Level 1
Overwhelmed & disengaged
10-20%

Level 2
Becoming aware, but still struggling
10-20%

Level 3
Taking action
25-30%

Level 4
Maintaining behaviors
20-25%

0-100 point scale
Activation and Behavior

Hypertension Self-Care Behavior

- Take Rx as recommended
  - Level 1: 31%
  - Level 2: 55%
  - Level 3: 73%
  - Level 4: 88%

- Know what BP should be
  - Level 1: 13%
  - Level 2: 17%
  - Level 3: 27%
  - Level 4: 58%

- Monitor BP weekly
  - Level 1: 6%
  - Level 2: 16%
  - Level 3: 14%
  - Level 4: 33%

- Keep BP diary
  - Level 1: 0%
  - Level 2: 9%
  - Level 3: 8%
  - Level 4: 21%

Source: US National sample 2004
Insights

- Activation underlies most health behaviors
- 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
Impacts of Being Engaged are Enduring: PAM in 2010 Predicts Outcomes 2 Years Later: Odds Ratios

Models included controls for age, sex, number of chronic conditions, income, and percent of care that was received in-network. Level 1 is reverence group. * Significantly different from PAM Level 1 at p<0.05  Health Affairs Mar 2015
Patient Role & Outcomes

- Study Findings indicate the importance of the patient role in outcomes and cost
- As payments become more closely linked with patient outcomes, understanding how to increase patient activation will become a priority
Managing Risks and Costs in a Patient Population

Fairview-- a Pioneer ACO,   \( N = 98,142 \)
PAM scores from 2011, predicting outcomes in 2012, 2013, and 2014
Illness Progression: a diagnosis of new chronic disease 1 to 3 years later
ACS ED, and hospital. Preventable utilization

*Published in HSR Aug 2016*
Odds Ratios from Logistic Regression Analysis Predicting a New Chronic Condition 1 Year Later By Baseline PAM Level

Adjusted for age, gender, income tercile, and presence of chronic conditions at baseline

Differences significant at the .01 level
ACS ED and Hospital Utilization

Does PAM level predict this type of costly utilization that could have been prevented?
First time PAM has been examined in relationship to ACS utilization
Odds of ACS Hospital Use by PAM Level – 1 Year Later

Multivariate analysis controlled for age, gender, income, risk and depression
Why would less activated patients have more avoidable hospitalizations and ED visits?

• Less likely to recognize “red flags”
• More likely to ignore symptoms
• Less likely to know what to do to handle symptoms
Implications

• This utilization represents “waste.” Utilization that could be prevented.

• This isn’t just happening in the high risk population—where much of the efforts are focused.

• Focusing on less activated patients—represents an opportunity to reduce this type of costly and wasteful utilization.
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.
Innovative Delivery Systems

- PAM score is a Vital Sign
- Tailored coaching/support
- Using both a behavioral lens and a clinical lens to manage patient populations
- More efficient use of resources: target those who need more help
- Used as an intermediate outcome of care measure
- Used as a way to assess provider performance
FIGURE 1. MODEL OF PHM FOR PRIMARY CARE

1. Low Disease Burden
   High Activation
   Focus on healthy behaviors. Provide -online tools and community supports

2. High Disease Burden
   High Activation
   Partner with patients to improve/maintain disease control. Usual clinical input. Provide on-line tools and community supports

3. Low Disease Burden
   Low Activation
   Focus on increasing activation, slowing risk and improving behaviors. Coaching support from trained MA

4. High Disease Burden
   Low Activation
   Focus on developing self-management skills. Coaching support from trained MA to augment conventional clinical support. Coaching to prepare for clinical visit coaching after visit
Meeting Patients Where they are:

• Improve patient experience
• Increase the likelihood the patient will do their part in the care process
• Improve efficiencies—more targeted use of resources
• Improve outcomes and reduce costs