Contact Information

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Physician Organization Name: IHA
Practice Name: IHA Primary Care
How many physicians in practice: 109
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): 35 Care Managers RN and SW

Executive Summary

- The Patient Activation Measure (PAM) is an evidence-based tool for measuring a patient's level of engagement (activation) in their healthcare. PAM levels 1-4 correspond to scores between 0-100. It is designed to assess an individual's knowledge, skill and confidence for self-management.
- PAM allows us to predict which patients will have higher avoidable health care utilization and be more likely to develop a chronic disease.
    - PAM level 1 patients are 62% more likely to have an avoidable hospitalization compared to level 4 patients.
    - PAM level 1 patients are 51% more likely to develop a new chronic condition in the next 2 years when compared to a level 4 patient.
- Care managing patients with lower PAM levels ensures that we are working with patients that are high utilizers of health care services and demonstrate a response to care management interventions. Traditional risk stratification tools only identify high risk utilizers and not patients engaged in improving their health outcomes.
- IHA Care Management has seen a significant increase in PAM scores in our level 1 and 2 patients, averaging a 12.4-point improvement. Per Insignia, there is a cost savings correlated to every 1-point improvement in PAM score when a patient's score increases at least 3 points (clinically significant change).
    - Level 1= $225.52
    - Level 2=$145.50
    - Level 3=$28
    - Level 4= $8
- If IHA were to experience the same results as Insignia Health based on cost savings and PAM score change the potential savings realized in the first year could be around $700,000.
- IHA is seeing an improvement in all Quality clinical indicators (A1c, Blood Pressure, LDL/HDL, BMI) especially in our less activated patients.
- Utilization of PAM also allows us to advance our PCMH initiatives as it involves patient self-management.

Category of Submission: Care Management Workflow

Title of Submission: IHA_IHAPrimaryCare_BestPractice_CareManagementWorkflow_2019

When did the intervention start and end?

The PAM/CFA program at IHA was launched in April of 2018. The program is an ongoing intervention

Goal of the Program/Intervention:

The goal of the intervention is to utilize Insignia Health's Patient Activation Measure (PAM) to identify IHA's patient activation levels and to engage with those less activated at their level of activation to make the most effective impact on their health. Understanding which patients are most likely to respond to care management interventions is a key factor of appropriate allocation of resources.

Who developed the program/intervention, and how?

IHA has traditionally done well with risk stratifying patients based on their medical risks, however, we have learned that in order to improve appropriate utilization, we need to also assess a patient's engagement level as well as social risks. The PAM tool was chosen as a patient engagement tool because of its simplicity, strong evidence base, and low relative cost. The Care Team leadership developed this intervention in order to improve patient engagement in their health. We have now seen other advantages of using the tool including panel management. Panel Management is a key Care Management workflow.

Description of the Program/Intervention:

At the time of enrollment into the Care Management program, all patients are asked to complete a PAM survey. The initial PAM survey is considered the patients baseline measure. The care manager uses the PAM level as a guide to provide tailored support based upon a person's self-management ability. This coaching guidance is easily obtained from Insignia's Coaching for Activation website. Tailoring the level of education and goal setting to match a patient's activation level based on their chronic condition leads to improving patient engagement.

Patients are managed by their care manager following a standard schedule protocol based on their PAM level. During these calls, the care manager uses motivational interviewing skills to assess the patients progress in achieving goals, making changes, identifying barriers that the patient may be experiencing. Subsequent PAM surveys are completed every three months while enrolled in care management and at the time of closure. We can run reports for patients that have had more than 1 survey completed to see if we are affecting (impacting) patient engagement based on changes in PAM scores. It has been determined by Insignia Health that a score change of 3 points is significant enough improve adherence, participation in health and utilization.

Once a patient is scored, they are then categorized into one of 4 levels, 1 being the least activated and 4 being the most activated. At IHA our goal is to focus on level 1 and 2 patients, our least activated patients. If a patient is a level 3 or 4, we set short term goals with them, understanding that they are already activated and will reach out if they encounter barriers.

How were patients identified for the program/intervention?

In order to be care management appropriate, patients must meet certain inclusion criteria. They must have had a recent discharge from the hospital with a high-risk score of 1-3 as determined by our internal PRISM risk algorithm or referred by the primary care physician for multiple co-morbidities, social determinants of health and or a combination of these things. In addition, care managers use payer reports that identify risk/complex patients.

How was success measured? Please delineate whether metrics were process-based or outcome-based

Measures of success for the PAM program were broken into three categories:

Program measures are process-based and include:

- # of patient contacts
- Average days on panel
- # of active patients on CM panels by PAM level

Clinical Measures are outcome-based and include:

- Improved clinical indicators for A1c, BP, LDL/HDL, BMI
- Change in PAM score (baseline compared to most recent PAM score) – looking for a 3pt increase in PAM score indicating clinically significant change

Utilization measures are outcome-based and include:

- ER and hospital visit utilization

What were the program results? Include qualitative data/graphs

Table 1 in the appendix shows program and utilization results for our patients who were newly enrolled in care management as of April 12, 2018.

- 40% of these patients are less activated and received an average of 2 to 3 times more contact per period of enrollment than those more activated.

- Our less activated patients spend more time, on average, on the CM's panel than those that are higher activated as shown in the "Avg. Days on Panel" measure. This meets another goal of reducing the panel size in our higher activated patients.
- A significant change was seen in baseline to most recent PAM scores for all PAM levels, but most significantly in our PAM 1 & 2 patients, averaging a 12.4-point improvement. A 3-point improvement is considered clinically statistically significant.
- Expected savings, as determined by Insignia, for each 1-point improvement includes: $225.52 for level 1, $145.50 for level 2, $28 for level 3, $8 for level 4 (Insignia, 2019).
- A drop in ER utilization and hospital utilization was realized in all PAM levels.

Table 2 in the appendix displays our clinical indicators, where we are seeing an improvement in most of our measures (A1c, BP, LDL/HDL, BMI).

- Our A1c measures, as an example, have improved in each PAM level, most significantly in our lowest activated patients.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?

We identified the need for more robust education around the use of the CFA (coaching for activation) tool so we developed training to support and enhance the training that was provided by Insignia; this included monthly meetings to discuss barriers and best practices. In addition to this, we also developed standard outreach guidelines for the care managers to follow; this provided a consistent schedule for the care managers to call to ensure that patients were receiving appropriate calls or PAM level. For patients in our transitions of care, congestive heart failure, heart failure or programs we already had standard guidelines and so those took precedence over the outreach protocols for PAM.

To assist our leadership team, we developed a dashboard to effectively identify patient activation by care manager and practice level. This is currently being utilized to assist in managing the management of panels by reinforcing meaningful targeted management within the level 1 and 2 populations with quick management strategies for the level 3 and 4.

What are you proudest of regarding this submission? Why does this work matter?

By utilizing PAM, we are now able to stratify our patients not only by utilization and chronic conditions but also by personal activation. We can focus on our less activated patients and provide more frequent personalized care management interventions and provide education/goal setting that meets patients where they are in their journey to a healthier lifestyle. Our data is showing us that these patients are becoming more activated and are making changes that reflect a statistically significant change in clinical indicators which leads to a healthier population.

Understanding our patient's activation also allows us to be more deliberate in who we manage, and this has provided us an opportunity to expand our care management program to touch more patients. When we provide short focused interventions on our level 3 and 4 patients it provides opportunity to have a higher volume of level 1 and 2 patients on our panels, allowing us to focus on the right patient population, the patients that need care management the most.

How will your organization use the funds if your submission wins?

If we were to be awarded the funds for this submission, we would use the funds to cover the cost of licensing fees for the PAM program in order to expand the use of the tool to other populations: specialty care, nutrition and pharmacy programs. Several of these other programs are currently utilizing self-management and motivational interviewing to provide services to their patients and we feel having a PAM score would only enhance our ability to work with them on setting goals and ensuring the right patients are on their panels as well. IHA would also use the funds to conduct further data analyses to determine our cost avoidance. And finally, we would expand staffing in our practices with higher population of PAM level 1 and 2. This population typically is more successfully managed with more frequent touches to give them smaller more targeted information over time.

APPENDIX

	Count	1. Patient Contacts	2. Avg Days on Panel	3. Change in PAM	4. Change # ER	5. Change in Utilization
PAM 1	121	9.88	175.35	34%	-0.2	-0.2
PAM 2	375	9.19	156.55	21%	-0.3	-0.5
PAM 3	555	7.48	135.49	11%	-0.7	-0.6
PAM 4	235	6.30	120.54	0.5%	-0.8	-0.7

Table 1. Program and Utilization Measures

	Count	6. A1c Pt Change	7. BP SYS pt Change	8. BP DYS pt Change	9. HDL pt Change	10. LDL pt Change	11. Weight pt Change	12. BMI pt Change
PAM 1	121	-0.77	0.40	-0.96	1.21	-5.37	-4.57	-1.37
PAM 2	375	-0.40	-0.76	0.03	1.90	-5.96	-7.21	-1.23
PAM 3	555	-0.26	-0.22	-0.97	-0.48	-1.43	-3.56	-0.56
PAM 4	235	-0.50	-0.14	-0.09	0.57	-17.98	-1.70	-0.29

Table 2. Clinical Indicator Measures

References:

Insignia. (2019, May 8). *Coaching for Activation*. Retrieved from Insignia Health: https://www.insigniahealth.com/products/cfa