The Patient Activation Measure: An emerging tool for patient self-management

Six PAM applications across the patient journey
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Executive summary

When a patient needs health care, we want their experience to be seamless. Our goal is to wrap services around them and keep them healthy for as long as possible. Unfortunately, few health systems can claim they do this consistently. Patients continue to stumble between disconnected providers causing patient confusion, service repetition and clinical deterioration.

Luckily, there is a scalable way forward that we can start almost immediately: Working with the patients themselves to turn them into experts in their own condition(s). The power of this approach is that the patient is the one constant in the care experience. If they have the knowledge, skills and confidence to manage their condition(s), those assets will stay with them in every scenario, across all sites of care and in every care interaction. This is what we call patient activation.

Clearly, this is easy to say but hard to do. It is essentially behaviour change and health care, with its emphasis on episodic, clinician-led care models, struggles to know where to start—let alone measure success.

This is why the Patient Activation Measure—or PAM—is so promising. It’s an emerging tool to help us measure how knowledgeable, willing and confident a patient is at managing their own condition(s). With that information we can tailor and focus our efforts. But like all tools, it’s not a “fix-all” to complicated problems, but rather an enabler of activation over time.

In this brief we’ll investigate two aspects of the tool:

1. How PAM is being used
2. The evidence of PAM’s efficacy

This is an assessment based on the current use of the tool in health care settings—a crash course in PAM and its various applications. Our goal is to ensure our members have the most detailed and impartial evidence base on where and when it works.

What is PAM?

The Patient Activation Measure (PAM) was developed by Insignia Health—a private health care company based in Oregon, United States—as a way to understand how motivated a patient is feeling and how capable they are at managing their clinical condition(s).

Think of it as a snap-shot of a patient’s knowledge, willingness and confidence to manage their condition(s). In other words, the PAM tells us “how activated the patient is right now.”

The PAM tool is a 13-item questionnaire that scores individuals along a 100-point scale and then segments them into one of the four activation levels shown below.¹

Over 450 published research studies have used PAM as a way to quantify and measure activation. Meta analyses from these studies show that PAM is an effective tool at measuring how capable a patient is in that moment at managing their condition(s) effectively.²

How is it used?

To date, PAM remains one of the most robustly and systematically evaluated tools² to measure how confident, willing and capable a patient is to manage their care. But taking the questionnaire does not activate the patient, nor is it accompanied by an activation plan for your care team to follow.

To turn the information from a score into action, health providers across the globe are experimenting with using the PAM tool in various ways with their patients.

The remainder of this brief will highlight both common and emerging ways that health care providers are using PAM with patients to build their knowledge, willingness and confidence to manage their conditions.

In cases where providers are curious about applications that lack evidence, we share alternative solutions we’ve found through our research. They will be noted as “alternatives in brief”.

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¹ Please see the Appendix for the PAM Questions.
² Here are 500+ research studies featuring the PAM survey as a key variable: https://www.insigniahealth.com/research/archive.

### PAM applications across the patient experience

Across a year of research, we’ve looked at health systems around the world to understand how providers are using the Patient Activation Measure (PAM) to achieve activation over time. This systematic review of both provider programmes and their effectiveness yields a number of real world examples. We found that PAM can be applied at various points in the patient journey. But not all applications have proven effective, nor are they all applied equally.

Below we use a simplified graphic of the patient journey to illustrate the various points where PAM is being used, trialled, or considered and for what purpose. We grade each application based on two metrics to determine how effective the PAM tool is to achieve each stated goal:

1. **The level of adoption**: How frequently the tool is used for that purpose
2. **The level of proof**: How consistent and high-quality the outcomes are for that purpose

We use traffic lights to signal our recommendation: green stands for “use with confidence,” amber for “use with caution,” and red for “avoid using.” For red ratings, we offer better alternatives from our research.

<table>
<thead>
<tr>
<th>Application</th>
<th>Purpose</th>
<th>Level of adoption</th>
<th>Level of proof</th>
<th>Advisory Board grade</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline activation assessment</strong></td>
<td>Determining how “activated” a patient is right now, prior to intervention, using the PAM tool</td>
<td>High adoption</td>
<td>Solid proof</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Patient selection and eligibility</strong></td>
<td>Enrolling patients into care models based on their PAM score</td>
<td>Low adoption</td>
<td>No proof</td>
<td>Red</td>
</tr>
<tr>
<td><strong>Clinician signalling and engagement</strong></td>
<td>Prompting clinicians to consider the activation of a patient in their care plan by showing them the PAM score</td>
<td>Some adoption</td>
<td>Some proof</td>
<td>Amber</td>
</tr>
<tr>
<td><strong>Care model tailoring</strong></td>
<td>Adjusting care models to meet each patient’s unique needs based on their PAM score</td>
<td>High adoption</td>
<td>Solid proof</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Patient graduation marker</strong></td>
<td>Signalling the patient is ready to graduate from a care model by reaching a predetermined PAM level</td>
<td>Low adoption</td>
<td>Some proof</td>
<td>Amber</td>
</tr>
<tr>
<td><strong>Intervention assessment</strong></td>
<td>Measuring the success of an intervention using PAM</td>
<td>High adoption</td>
<td>Solid proof</td>
<td>Green</td>
</tr>
</tbody>
</table>
Baseline activation assessment

Application in brief

One of the fundamental challenges with activating a patient—and as a result getting them to be the most active participant in their care—is that our clinical model is not designed to understand how close, or far away, a patient is from that goal.

At its core, the Patient Activation Measure (PAM) questionnaire is designed to assess how capable the patient is at actively self-managing their condition(s). A low score indicates that more effort, time and foundational work will be necessary to activate a patient. A higher score often indicates that person has the key knowledge and skills to move towards self-management faster.

Advisory Board Take:

Use the PAM measure as a way of measuring how motivated, willing and confident a patient is at a certain moment in time to manage their own condition.

Case in brief: PeaceHealth Medical Group

- PeaceHealth is a not-for-profit health care system with medical centres, hospitals and clinics located in Washington, Oregon and Alaska, United States
- The St. Joseph Patient Centred Medical Home is based in Oregon, United States
- Received a grant to pilot a patient-centred medical home, into which they incorporated the PAM tool

PeaceHealth’s approach to measuring baseline activation

The PeaceHealth Patient Centred Medical Home found that classifying patients by both baseline activation level—using the PAM tool—and by disease burden helped clinicians build the care model to meet the patient at their activation level.

For example, for a patient with a PAM level 1, PeaceHealth dedicates a high-skilled team member who focuses on prevention and skills development. While a PAM level 3 patient is cared for by the usual care team, as indicated in the table below.

In fact, understanding which patients are likely to require additional help enabled PeaceHealth to address both current and future challenges, such as potential readmissions.

By using PAM with patients who suffer from long-term diseases such as diabetes, PeaceHealth identified patients who are likely to struggle to engage with treatment, thereby enabling services to intervene earlier.

PeaceHealth’s care delivery segmentation by baseline PAM score

<table>
<thead>
<tr>
<th>PAM level</th>
<th>Low disease burden</th>
<th>High disease burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (3-4)</td>
<td>Electronic resources</td>
<td>Electronic resources and peer support</td>
</tr>
<tr>
<td></td>
<td>Usual care team</td>
<td>Usual care team</td>
</tr>
<tr>
<td></td>
<td>Focus on prevention</td>
<td>Focus on managing illness</td>
</tr>
<tr>
<td>Low (1-2)</td>
<td>High-skilled team members</td>
<td>High-skilled team members</td>
</tr>
<tr>
<td></td>
<td>Focus on prevention</td>
<td>More outreach</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus on developing skills to manage illness</td>
</tr>
</tbody>
</table>

Patient selection and eligibility

Alternative in brief
Population health models work best, and at scale, when we match the right patients with the right care models. To do that we try to build a set of rules or criteria to identify candidates. Time and again research shows that simple criteria are as effective as complex ones—and easier to rollout.

Across the year of research on this topic, many providers asked us whether PAM could be used as one of these criteria. They wanted to know whether they should select patients with high or low PAM scores. When we investigated PAM applications, we did not find any existing care models using the PAM as an eligibility metric. That is not to say it won’t work, rather that we can’t point to solid proof just yet.

Advisory Board Take:
Avoid relying solely on the PAM score to determine whether a patient would benefit from your care model. There is no evidence that it’s better, or worse, to work with patients at various PAM levels.

Metric selection should follow the goal of your care model. Generally speaking, most models are trying to identify patients for whom we can safely reduce the level of unplanned interactions with the health system. While a low PAM score might indicate a patient is at risk for several unplanned interactions, we’ve identified more frequently used metrics that are listed below.

Nine most common care model selection metrics

<table>
<thead>
<tr>
<th>Clinical status indicators</th>
<th>Patient demographics</th>
<th>Service utilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic illnesses</td>
<td>Age</td>
<td>Hospitalisation</td>
</tr>
<tr>
<td>Number of chronic conditions,</td>
<td>Several communities find</td>
<td>Number of hospital admissions</td>
</tr>
<tr>
<td>comorbid diagnoses within last</td>
<td>that advanced age is an</td>
<td>and/or readmissions in one year</td>
</tr>
<tr>
<td>1-2 years and how well they are</td>
<td>indicator of health risk</td>
<td>can indicate opportunity for better</td>
</tr>
<tr>
<td>being managed</td>
<td>and therefore target these individuals</td>
<td>management</td>
</tr>
<tr>
<td>Poly-pharmacy</td>
<td>Deprived community</td>
<td>ED visits</td>
</tr>
<tr>
<td>The number of prescriptions that</td>
<td>Historically underserved</td>
<td>Number of emergency room visits</td>
</tr>
<tr>
<td>the patient is taking at a single</td>
<td>or disadvantaged populations can benefit from more coordinated and targeted care</td>
<td>in one year</td>
</tr>
<tr>
<td>time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority condition</td>
<td>Social isolation</td>
<td>Number of “no shows”</td>
</tr>
<tr>
<td>Population health audits might</td>
<td>Living alone is often</td>
<td></td>
</tr>
<tr>
<td>identify one condition that</td>
<td>correlated with poor</td>
<td></td>
</tr>
<tr>
<td>accounts for outsized demand.</td>
<td>health status and lack of</td>
<td></td>
</tr>
<tr>
<td>Usually these are CHF(^2),</td>
<td>resources</td>
<td></td>
</tr>
<tr>
<td>COPD(^3) or diabetes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) This list was compiled via Advisory Board’s literature review and research interviews with key stakeholders. Source: Advisory Board, Mind the Gap: Managing the Rising Risk Patient Population, https://www.advisory.com/media/AdvisoryBoard/Research/PHA/Research-Study/2017/Mind-the-Gap-Managing-the-Rising-Risk-Patient-Population.pdf.
2) Congestive heart failure.
3) Chronic obstructive pulmonary disease.
Clinician signalling and engagement

Application in brief

PAM can provide a clear cut way to understand whether or not a patient is becoming more activated over time. But signalling progress is only part of the challenge. It’s not enough to monitor the PAM score, it also has to prompt some kind of action or change in care. That’s particularly important for doctors.

To date, our research has shown that various health care organisations are successfully capturing PAM scores and sharing them with clinicians in their patient records. What’s less evident is whether just presenting that score to a clinician prompts change in the care model design or delivery. More prescriptive guidance on what to do at each PAM level must accompany the PAM score in order to see sustained self-management from patients.

Advisory Board Take:

On its own, the PAM score will not prompt a shift in doctor behaviour. Pair the score with a recommended action for the clinician to take in response to the patient’s PAM level or change in that level.

Case in brief: COORDINARE

- COORDINARE is one of 13 Primary Health Networks (PHNs) in Australia
- Located in South Eastern NSW, it covers a population of 600,000
- First PHN in Australia to license PAM

COORDINARE’s doctor conversation starter

COORDINARE is using PAM to measure changes in patient activation, stratify services, and help clinicians tailor care to patient needs. It is also starting to use PAM to galvanise clinicians around population health management initiatives.

While still in its early stages, the theory is that a quantified metric, that is readily visible to clinicians, will signal and prompt clinical staff to consider both the ways they are describing and contextualising care for the patient, and also which services and interventions make sense for the patient at their current activation level.

Case in brief: North West London Collaboration of CCGs

- The North West London health and care partnership is made up of over 30 NHS1 and local authority organisations
- CCG2 collaboration composed of 8 commissioning groups across London, England, and covers over 2.2 million people
- Organisation manages PAM licenses, provided by NHS England, for all 8 of its boroughs1
- Designated NHS National Mentor for PAM

North West London’s PAM reporting

North West London collaboration of CCGs2 tracks PAM score changes for its patients and shares the PAM metric with executives and doctors alike to encourage the use of patient activation as a new metric, or “vital sign,” across clinical care.

The score is embedded in its Whole System Integrated Care (WSIC) dashboard, which provides patient activity summary for patient populations, including those with diabetes, asthma and COPD3. The hope is that the PAM metric will act as a signal of how “willing, confident and capable” the patient is, and can become an additional consideration in care plan design.

The WSIC dashboard for clinicians3

1) The National Health Services (NHS) in England purchased 1.2 million PAM licenses in 2016 for 90+ sites to equip hospitals with the tool to measure Patient Activation and tailor care for patients.
2) Clinical commissioning group.
3) Please see the Appendix for the original dashboard interface.
4) Long term conditions.
5) Chronic Obstructive Pulmonary Disease.

Care model tailoring

Application in brief

Providers often struggle to establish some level of routine when they’re building individualized care plans. Patients with the same conditions start from different places and progress at different rates, which make adjusting care models over time and across a cohort unruly.

PAM can help segment patients into nuanced groups that go beyond the traditional disease definitions, while also helping clinicians “meet the patient where they are.” This makes it easier for clinicians to adjust interventions for each cohort and adapt the content of self-care conversations between the patient and clinician appropriately.

Advisory Board Take:

Incorporate the PAM tool into patient care milestones and follow up with the patient and clinical team alike to tailor care goals to the patient’s changing activation level.

Case in brief: VA San Diego Healthcare System

- VA San Diego is a health system in California, United States
- System includes the flagship San Diego VA Medical Centre, six community outpatient clinics and is affiliated with UC San Diego School of Medicine
- Struggled to adapt care plans to differing needs of heart failure patients
- Developed PAM-based interventions to match Patient Activation, successfully reducing readmissions by one third

VA San Diego’s PAM-based care pathway design

VA San Diego used PAM levels to segment patients and structure care pathways for heart failure patients, designating interventions by activation level as shown below.

PAM level progression

<table>
<thead>
<tr>
<th>PAM Level 1</th>
<th>PAM Level 2</th>
<th>PAM Level 3</th>
<th>PAM Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Watch video on living with HF 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explore possible behaviours to try; help patient choose best fit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Remind how and when to contact GP or case manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explain BNP 4, review patient’s own levels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Discuss medications and purpose of each</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Link symptom improvement to behaviour (e.g., lower salt intake with less shortness of breath)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Help patient learn to adjust plans for behavioural change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identify “difficult times” for patient (e.g., holidays, eating out); establish a plan for each</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reinforce good behaviours, planning skills</td>
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</tbody>
</table>

A randomised study found that after six months, patients in VA San Diego’s PAM-based intervention group had 34.4% fewer patient readmissions (from 0.32 to 0.21 readmissions per patient), and their raw PAM scores increased 4.5 times compared to the usual care group (from 10.2 point change to 2.3 point change in mean PAM score).

Results of PAM-based intervention

![Mean PAM Score Chart](chart.png)

Progress to highest activation level with tailored interventions (level 4 vs. level 3 for usual care patients)

1. Department of Veterans Affairs (VA) San Diego Healthcare Systems.
2. Please see the Appendix for a more detailed chart of VA San Diego’s care pathways, which includes steps to achieve specific goals for each PAM level.
3. Heart failure.
4. Brain natriuretic peptide (BNP) is a measure that reflects severity of heart failure.
Alternative in brief

The ideal case for both the health system and the patient is for the patient to independently manage their care as much as safely possible. This is challenging because patients and their care management teams often grow attached. Equally, doctors can fear that the patient won’t be able to navigate every scenario they’ll experience without direct support.

Provider organisations have inquired whether the PAM tool can be used as a threshold marker to signal “the patient is ready to graduate to self-management.”

Though we have not yet observed providers using PAM in this capacity, below is an illustrative care pathway with a well-defined, PAM-based graduation definition for high-risk patients. A high PAM score would be considered one of many evaluation metrics for the graduation of a patient.

Advisory Board Take:

Use the PAM tool as an additional metric to determine whether a patient is ready to “graduate” from the care model. However, utilise PAM in this context with caution as we have not yet found evidence of its efficacy as a criteria of graduation on its own.

Case in brief: Treehill Hospital¹

- District general hospital based in the United States
- Built a care model with the goal of graduating patients to self-management
- Used a series of utilisation and self-reported metrics to establish the patient was ready to “graduate” from the programme

Treehill Hospital’s¹ illustrative care pathway with defined graduation

**Enrol**
- Identify high users of care
- Enrol in community-based or primary care programme

**Actively Manage**
- Routine home visits from care navigators
- High-risk clinic visits with multidisciplinary care team

**Graduate**
- Warm handoff to home GP for ongoing care
- Occasional care navigator check-ins as needed

To graduate, patients must:
1. Meet at least 50% of their care plan goals
2. Achieve PAM level 3 or 4
3. Reduce their hospital utilisation
4. Exhibit the ability to return to their GP
5. Show improved psychosocial risk scores

54% Drop in number of Treehill Hospital¹ admissions thanks to programme with clear graduation process


¹) Pseudonym.
Application #6

Intervention assessment

Application in brief
There are two related challenges when it comes to measuring the impact of activation work. Firstly, there is a delay between intervention and impact. So in the short term it can be difficult to know whether what we’re doing is working, which means we tend to abandon potentially successful efforts prematurely.

Secondly, the success of this activation work is built on avoiding care flashpoints or unplanned interactions with the health system. And unfortunately, it is incredibly difficult to measure when something “doesn’t occur.”

Given these two challenges, the PAM score is shown to be an effective proxy indicator for activation success and care avoidance. Observing an improvement in the PAM score would mean the patient is gaining a better understanding of their condition(s) and eventually getting better at self-management.

Advisory Board Take:
Use the PAM measure as a success metric at the individual and population level. It is a robustly proven indicator of reduced use, greater stability and better clinical outcomes.

Insignia Health’s evidence for PAM’s predictive power
Insignia Health is a private company headquartered in Oregon, United States that licenses and supports the implementation of PAM. They have reported that a single point increase in PAM score correlates to a 2% decrease in hospitalisation and 2% increase in medication adherence—which equates to 8% lower costs.

As such, because PAM is an effective tool at measuring how capable a patient is in managing their condition—both at baseline and over time—increases in PAM scores are a good way of indirectly measuring intervention success.

We have observed that the PAM score has been used to measure the following outcomes in order to assess intervention success:

1. Reduced demand
2. Improved biomedical outcome
3. Reduced cost
4. Increased patient satisfaction

We’ll only get better at measuring patient activation

Amidst continued health care challenges surrounding the management of the growing comorbid and complex patient population across disconnected care settings, patient activation is a compelling strategy to recruit patients to become part of their own care team. PAM has garnered support in the health care community as a useful tool to working towards that complicated, multifaceted and incremental objective.

In this brief, we have shown that PAM is most clearly effective when used to:

1. Understand how “activated” a patient is when they take the survey
2. Tailor care models to support an individual patient in their activation journey
3. Assess how effective the care model is in terms of correlated impact, such as readmissions.

Simultaneously, PAM has yet to show robust efficacy (although potential) for the following use cases:

4. Encouraging clinical staff to address activation
5. Standardising measurements of patient graduation and care success.

Finally, there is no proof that patients with a higher or lower PAM score do better or worse in specific care models. As a result we advise caution if considering:

6. Picking a patient for a care model based on their PAM score.

“As we’re developing a framework for commissioning and self-care, we’re using PAM as a tool for making care holistic and bringing the patient into the care conversation.”

Aran Porter
Self-Care Programme Lead
North West London CCG, UK

Since this is an ever-evolving terrain, the Global Forum research team will continue to monitor advancements and improvements related to the PAM metric. Cumulatively, we find that the design of the care model is more important that the metric itself. Consider the PAM as a tool to understand patients in a more holistic and robust way. That is the true power of this metric and where it continues to provide its users with solid returns.

Additional and Supporting Resources:

1. **Achieving care continuity:**
   - *Best practices for building a system that never discharges the patient*
   
   This study equips nurse leaders to address underlying, systemic issues that affect all transitions across the care continuum—and build a care delivery system that “never discharges” the patient.

2. **How to create patient-centred scripting in ongoing care management:**
   - *The care manager’s scripting pick list*

   Download this care management scripting pick list to learn how to better engage patients in two-way conversations about their care plan steps.
Appendix

Patient Activation Measure 13-question survey

1. When all is said and done, I am the person who is responsible for managing my health condition
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function
3. I am confident I can take actions that will help prevent or minimise some symptoms or problems associated with my health condition
4. I know what each of my prescribed medications does
5. I am confident I can tell when I need to go get medical care and when I can handle a health problem myself
6. I am confident I can tell my health care provider concerns I have even when he or she does not ask
7. I am confident I can follow through on medical treatments I need to do at home
8. I understand the nature and causes of my health condition(s)
9. I know the different medical treatment options available for my health condition
10. I have been able to maintain the lifestyle changes for my health that I have made
11. I know how to prevent further problems with my health condition
12. I am confident I can figure out solutions when new situations or problems arise with my health condition
13. I am confident I can maintain lifestyle changes like diet and exercise even during times of stress

VA San Diego’s PAM-based care pathways structure for HF patients


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Appendix

The North West London Collaboration of CCGs' WSIC Dashboard

Use the drop down menu below to choose your time period and hover over a bar to see more information.

View time period
- Last 2 years

Latest available data ranges from 28/02/2017 to 25/03/2017. Hover over the 'T' button below for more detail.

Patient Example
123 456 7890
Lives in care home

<table>
<thead>
<tr>
<th>Patient Example</th>
<th>Long term condition(s)</th>
<th>PAM Score &amp; Level</th>
<th>Key outcomes</th>
<th>Has GP care plan</th>
<th>Care plan up to date</th>
<th>Community care user</th>
<th>Mental health user</th>
<th>Social care user</th>
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<tbody>
<tr>
<td>123 456 7890</td>
<td>Asthma, COPD, Dementia, Diabetes, Hypertension</td>
<td>[Diagram showing PAM Score and Level]</td>
<td>Days not in hospital: 670 / 730</td>
<td>✔️</td>
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<td>Total spend: £115,203</td>
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<td>EFI: 0.47 (Severe Frailty)</td>
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<tr>
<th>Date</th>
<th>A&amp;E (SLAM)</th>
<th>Non-elective inpatient (..)</th>
<th>Outpatient (SLAM)</th>
<th>Community intervention</th>
<th>Primary care visit</th>
<th>Primary care prescribing</th>
<th>Primary care - outward ref.</th>
<th>Primary care - care plan</th>
<th>Primary care - flu vaccination</th>
<th>Outpatient - DNA (SUS)</th>
<th>Social Care</th>
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- 3 visit(s)
- 88 day(s)
- 1 appl(s)
- 31
- 51 event(s)
- 24
- 44 referral(s)
- 6
- 1
- 3

Care Type
- Emergency support
- Planned acute hospital care
- Planned outside acute hospital
- Potential warning signs