Mayers Memorial Hospital District

Quality Committee
Meeting Agenda
October 14, 2020 12:00 pm
Boardroom: Fall River Mills

Attendees

Laura Beyer, Board Secretary
Jeanne Utterback, Director
Louis Ward, CEO
Jack Hathaway, Director of Quality

1	**CALL MEETING TO ORDER**		Chair Laura Beyer			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – September 12, 2020		Attachment A	**Action Item**	2 min.
4	**REPORTS: QUALITY FACILITIES**					
	5.1	Pharmacy – Hospital	Keith Earnest	Attachment B	Report	5 min.
5	**REPORTS: QUALITY STAFF**					
	5.1	Worker's Comp Quarterly Report	Libby Mee	Attachment C	Report	5 min.
6	**REPORTS: QUALITY PATIENT SERVICES**					
	6.1	Telemedicine	Amanda Harris	Attachment D	Report	5 min.
	6.2	Cardiac Rehab	Trudi Burns	Attachment E	Report	5 min..
	6.3	Physical Therapy	Daryl Schneider	Attachment F	Report	5 min.
	6.4	Respiratory	David Ferrer	Attachment G	Report	5 min.
	6.5	Retail Pharmacy	Heidi Fletcher	Attachment H	Report	5 min.
	6.6	SNF Events/Survey	Candy Vculek	Attachment I	Report	5 min..
	6.7	Infection Control	Dawn Jacobson	Attachment J		
	6.8	Hospice Statistical Report	Mary Ranquist	Attachment K	Report	5 min.
7	**REPORTS: QUALITY FINANCES: NO REPORTS**				Report	5 min.
8	**DIRECTOR OF QUALITY**					
	8.1	Education, Prime, Quality/Performance Improvement, Hospice Quality	Jack Hathaway		Report	5 min.
9	**NEW BUSINESS**					
	9.1	Patient Activation Measure		Attachment L	Report	5 min.
10	**ADMINISTRATIVE REPORT**			Louis Ward	Report	10 min.
11	**OTHER INFORMATION/ANNOUNCEMENTS**				Information	5 min.

12	**MOVE INTO CLOSED SESSION**				
	12.1	**Government Code Section 54962: Medical Staff Credentials** <u>Staff Status Change to Inactive</u> 1. Kenneth Childers, CRNA 2. Darla Schmunk, NP 3. Thomas Peterson, NP 4. Kirk Lott, CRNA 5. Eric Stirling, MD 6. Chuck Colas, MD 7. Rebecca Dyson, MD 8. Peter Halt, MD 9. Michael Maloney, MD 10. Scott Bleazard, MD 11. Suzanne Aquino, MD 12. Hanna Bae, MD 13. Baharak Bagheri, MD 14. Daniel Baker, MD 15. John Boardman, MD 16. James Brull, DO 17. Annemarie Buady, MD 18. Dennis Burton, MD 19. Courtney Carter, DO 20. Lillian Cavin, MD 21. Charles Gould, MD 22. Todd Greenburg, MD 23. Jeff Grossman, MD 24. Kristen Grubb, MD 25. Morgan Haile, MD 26. James Haug, DO 27. Kyle Henneberry, MD 28. Miriam Hulkower, MD 29. Frederick A. Jones, MD 30. Perry Kaneirya, MD 31. Russell Kosik, MD 32. Bao Nguyn, MD 33. Austin Peters, DO 34. William Phillips, MD 35. Asti Pilika, MD 36. Teppe Popovich, MD 37. Peter Reuss, MD 38. Anjali Roy, MD 39. William Rusnack, MD 40. Shree Shah, MD 41. Frank Snyder, MD 42. Brent Tilseth, MD 43. Joseph Trudeau, MD 44. Charles Westin, MD 45. Aaron Wickley, MC 46. Anthony Willis, MD 47. Yuming Yin, MD <u>AHP Appointment</u> 1. Lewis Furber, JR, FNP <u>Medical Staff Reappointment</u> 1. David Panossian, MD – Pulmonary Care 2. Julia Mooney, MD – Pathology 3. Stephen McKenzie, MD – Family Medicine <u>Medical Staff Appointment</u> 1. Kelly Kynaston, DO – Infectious Disease 2. Mietsy Woodburn, MD – Neurology 3. Stephen Hofkin, MD – Radiology 4. Don Chin, MD - Radiology			

13	**RECONVENE OPEN SESSION** – Report closed session action		Information	
14	**ADJOURNMENT:** Next Regular Meeting – November 11, 2020			

Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Board, are available for public inspection at the office of the Clerk to the Board of Directors, 43563 Highway 299 East, Fall River Mills CA 96028. This document and other Board of Directors documents are available online at www.mayersmemorial.com.

Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Board of Directors
Quality Committee
Minutes
September 8, 2020 @ 1:00 PM
Fully Remote Zoom Meeting

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

1	**CALL MEETING TO ORDER:** Board Chair Laura Beyer called the meeting to order at 1:03 pm on the above date.			
	BOARD MEMBERS PRESENT:		**STAFF PRESENT:**	
	Laura Beyer, Secretary Jeanne Utterback, Director		Louis Ward, CEO Candy Vculek, CNO Keith Earnest, CCO Jack Hathaway, Director of Quality Dawn Jacobson, Infection Control Jessica DeCoito, Board Clerk	
	ABSENT:			
2	**CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**			
	None			
3	**APPROVAL OF MINUTES**			
	3.1	A motion/second carried; committee members accepted the minutes of August 11, 2020	***Utterback, Ward***	**Beyer – Y** **Utterback – Y**
4	**REPORTS: QUALITY FACILITIES: NO DEPARTMENT REPORTS**			
5	**DEPARTMENT REPORTS:**			
	5.1	**Outpatient Services:** Skin tears have been an issue and we are addressing those issues with training and adding in some additional staff. More rounding in patient rooms will occur too.		
	5.2	**Infection Control:** COVID testing every 4 weeks with employees involved in the SNF facilities. More manager involvement has been required to remind staff to go get their testing done. All nursing staff will continue to be tested for COVID. Reminders are needed for all staff needing the testing and maybe using the time clock system. Would like an update next month on changes made in the communication.		
	5.3	**Med Staff:** No additional questions.		
	5.4	**Acute Services:** We need to standardize the weights being entered. Should all be in Kilos.		
	5.5	**Outpatient Surgery:** Maintenance is ordering necessary parts for the hot water fix and will drop electrical outlets needed. A full fix will require this project to be an OSHPD Project and will require strategic planning.		
	5.6	**SNF Events/Survey:** Continuing to struggle with a CNA shortage and daily scheduling for the whole nursing staff. Scheduling responsibilities for the 6-week schedule stands with managers, and daily responsibilities stand with the Ward Clerk at station 1. Adding in non-clinical CNA positions to help the CNAs. 5 in the CNA class right now with a lot more interest in the October classes. Shasta College is looking at making the CNA Program a permanent class with MMHD.		

6	**REPORTS: QUALITY FINANCES: NO DEPARTMENT REPORTS**	
7	**REPORTS: QUALITY EDUCATION:** We should increase education on RL6 and general "How to" programs. Jennifer Levings is working on developing the "How To" programs for departments – focusing on the basics.	
8	**QUALITY PROGRAM REPORTING AND INITITATIVES**	
	8.1	**Quality/Performance Improvement:** Leaning our processes out so that everything is standardized for reporting and educational purposes. This will give us an opportunity to be more aware in the MMHD team.
	8.2	**Prime:** Most likely this will be the last iteration of Prime. QIP most likely be the next program. Annually we would get to report on our Best Measures and not locked into certain projects and metrics. The State would make QIP easy for us to fit in with exceptions.
	8.3	**Compliance Quarterly Report:** Currently working with Sheriff's Office – taking traction after many years after being started. Surveyor came in to prep us for upcoming survey and things looked great. IT is working very hard with an External Contractor to give us a look at what our security measures are and what we can do better.
	8.4	**CMS Core Measures Quarterly Report:** Has been on hold due to COVID which gave us an opportunity to work with Premier to help identify the things on Acute side that would be beneficial for us on STAR rating. Hopeful that our lean process will help us identify those reporting measures. HCAPS – this would be the area of concern, and if we can figure this out and get the work we do recognized, this would be great. But we need to identify the right interface with both groups.
	8.5	**5-Star Monitoring Quarterly Report:** Positions have been fixed in the system so we should see our STAR Rating doing very well. Survey goes out to all those discharged from Press Gainey & MMHD with a letter from CEO. Discussion on survey communication occurred with thoughts on phone calls, sending out a letter with discharge papers, etc.
9	**Old Business**	
	9.1	**Report Template:** some simple changes can be made but waiting on consensus from other department managers before a DRAFT template is created. A written report from Director of Quality is requested.
10	**ADMINISTRATIVE REPORT:** Cases continue to come in Shasta Co. Acute floor census has been very busy. We have had some PUIs – Patients Under Investigation for COVID on the floor. Testing is occurring for all patients coming into the Acute and SNF floors. Students, teachers and school staff are considered Tier 1 and we can get the test results back in 24 hrs. We continue to work with the School District on helping provide a safe environment for our students, teachers and staff. Power issues but Maintenance and Emergency Preparedness Director worked with PG&E to get a generator at both facilities to provide the full facility with power, in addition to our generator. Employee Meetings will be held on the 23rd and 28th in the parking lots with a prize wheel and goodies to give away. SNF van purchase is still in progress with negotiations. New Clinic Manager starts on Monday, September 14th. Burney Clinic construction is going well.	
11	**OTHER INFORMATION/ANNOUNCEMENTS**: NONE	
12	**ANNOUNCEMENT OF CLOSED SESSION:**	
	List of Credentials: **MEDICAL STAFF APPOINTMENT: Telemed Radiologists** 1. Joshua Albrektson, MD 2. Michael Allen, MD 3. Dennis Atkinson, MD 4. Steven Cohen, MD 5. Deborah Conway, MD 6. Theresa DeMarco, MD 7. Andre Duerinckx, MD 8. Scott Kerns, MD 9. Nancy Ho-Laumann, MD 10. Marwah Helmy, MD 11. Megan Hellfeld, MD 12. Robert Hansen, MD 13. Robert Filippone, DO 14. Jerome Klein, MD 15. Ernest Kinchen, MD 16. Jennifer Kim, MD 17. Shwan Kim, MD	

	18. Kingsley Orraca-Tetteh, MD 19. Sergey Shkurovich, MD 20. Brock McDaniel, MD 21. Eric Kraemer, MD 22. Kedar Kulkarni, MD 23. Stephanie Runyan, DO 24. Mark Reckson, MD 25. Farhad Sani, MD 26. Albert Ybasco, MD 27. Mohammad Rajebi, MD 28. Shaden Mohammad, MD 29. Stephen Oljeski, MD 30. Nanci Mercer, MD 31. Stephen Fox, MD 32. David Bissig, MD 33. Ivy Ngyuen, MD
13	**RECONVENE OPEN SESSION** - Approval of credentials were moved, seconded and carried.
14	**ADJOURNMENT: 2:29 pm** - Next Regular Meeting – October 14th, 2020

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	October 14, 2020
Department:	Hospital Pharmacy
Submitted By:	Keith Earnest, Pharm.D.

List up to three things that are going well in your department.

1. Pharmacy Sterile Compounding Inspection
2. Barrier Isolator issues resolved
3. Employee Flu Shot consents and program significantly revised.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

Improving the CII narcotic quarterly reconciliation process. The Board of Pharmacy inspector was very helpful in explaining what she wanted to see to meet the regulations. The reconciliation accounts for each CII narcotic. Basically reconciliation it is a process that everything signed out of perpetual narcotic inventory is verified from another source. For example, if 20 tablets are removed from inventory and added to NS1 Pyxis, the add is shown on the Pyxis report. An Excel spreadsheet was created to enter all the data. The point of the process is to detect diversion early and not at the biannual inventory. Not a lean process.

How does this impact on patients? Do you think this is acceptable?

No direct impact on patients. Regulatory compliance

How does this impact on staff? Do you think this is acceptable?

None

What progress has been made on these projects since the last quality committee meeting?

Draft policy was composed and we are trying it out at the end of the quarter (July-September).

Has anyone in particular been instrumental in helping to progress/improve the problem?

Tracy Geisler created the spreadsheet.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

It does not directly relate, but regulatory compliance may be part of outstanding facilities.

Have any new quality-related issues arisen? Briefly describe.

Reordering process from Skilled Nursing—currently a cumbersome manual process. This issue has come up at employee meetings and SNF DON and myself have been working on a solution through PointClickCare.

Are there any other issues to be discussed with the Committee?

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	Wednesday October 14, 2020
Department:	Worker's Comp
Submitted By:	Libby Mee – Director of Human Resources

List up to three things that are going well in your department.

- MMHD continues to have very low claim volume
- Addition of Dana Hauge, Employee Wellness Coordinator, to Employee Health team
- Implementation of Rural Health Clinic. Will help streamline Work Comp process for employee's that need additional care beyond a first aide claim

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

I will be supporting Dana Hauge as she provides individual wellness programs to staff including nutrition, fitness, ergonomics and safety. We will also be collaborating with our Work Comp Insurance provider, BETA, to implement the Employee Safety and Wellness Initiative. This initiative focuses on eight key loss prevention areas: Ergonomics, Fleet Safety and Mobile Ergonomics, Manual Material Handling, Opioid and Polypharmacy Prescribing, Return to Work, Safe Patient Handling and Mobility, Slip, Trip and Fall Prevention and Workplace Violence Prevention. This incentive base program also allows members to receive credits applicable to the following year contribution.

How does this impact on patients? Do you think this is acceptable?

YES - This initiative promotes safe and responsible behavior, reducing days away from work and turnover, so MMHD is an atmosphere that can provide the best patient care possible.

How does this impact on staff? Do you think this is acceptable?

YES - This initiative provides programs and resources to help MMHD provide a safe, injury and exposure free workplace.

What progress has been made on these projects since the last quality committee meeting?

Not Applicable as these programs are new and are actively being implemented.

Has anyone in particular been instrumental in helping to progress/improve the problem?

BETA support staff and programs.
Dana Hauge, with her current certifications and previous professional experience.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding Staff and Outstanding Finances

Have any new quality-related issues arisen? Briefly describe.

CA Legislature recently passed SB1159, which creates a Workers' Compensation presumption for employees who contract COVID-19. I am currently working with BETA on the provisions and implementation plan for complying with these new regulations.

Are there any other issues to be discussed with the Committee?

3rd Quarter Work Comp Claims:

- 2 First Aide Injuries with 1 day away from work.
- 1 Reportable Injury. Employee has returned to work.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	October 14, 2020
Department:	Telemedicine
Submitted By:	Amanda Harris

List up to three things that are going well in your department.

1) Rheumatology referrals have slightly increased.
2) The Take 4 Counseling program has resumed at the school sites.
3) The last two months have been the most productive outpatient months ever for Telemed (43 consults each month – excluding counseling program).

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

Not currently.

How does this impact on patients? Do you think this is acceptable?

Telemedicine provides specialty services to our patients and community that otherwise wouldn't be available locally. The level of care is one that they may not be able to achieve if they had to travel to Redding for services.

How does this impact on staff? Do you think this is acceptable?

We have used Telemedicine to better serve our SNF residents which helps make our staff's working environment more enjoyable. Some staff have used our Telemedicine services and I believe they were happy to connect with quality specialists in a way that was convenient for them. When the primary care clinic is open it will be very easy for our providers to refer to specialists for further treatment of our patients.

What progress has been made on these projects since the last quality committee meeting?

N/A

Has anyone in particular been instrumental in helping to progress/improve the problem?

N/A

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Telemedicine supports multiple goals but I think it relates most strongly to Outstanding Patient Services. Telemedicine helps provide our patients with high quality care locally so that they can be provided with services they would otherwise not have access to.

Have any new quality-related issues arisen? Briefly describe.

No, not to my knowledge.

Are there any other issues to be discussed with the Committee?

No, not to my knowledge.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	10/14/2020
Department:	Cardiac Rehab
Submitted By:	Trudi Burns RNBSN

List up to three things that are going well in your department.

Cleaning the equipment after each use.
Keeping a distance while exercising.
People that do not feel safe being here are encouraged to stay home and those that do feel safe are coming in and exercising. We use the side entrance to decrease the amount of people going through the hospital. Masks are in place upon entering Cardiac Rehab. We continue to encourage all people to stay home when not feeling well and they comply.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

Working on a way for the maintenance crew to routinely check our equipment so it stays in the best shape and is regularly oiled/adjusted as needed.

How does this impact on patients? Do you think this is acceptable?

I believe it will make the workout experience more safe and enjoyable. Yes

How does this impact on staff? Do you think this is acceptable?

The staff that works with the Cardiac Rehab department understands the value and safety of well-working equipment. Mayers' employees are unable to utilize the equipment like they have in the past due to COVID restrictions.

What progress has been made on these projects since the last quality committee meeting?

The last quality report was concerned with our broken Elliptical. That has since been fixed with new parts and is being used regularly.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Maintenance department

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding Patient Services

Have any new quality-related issues arisen? Briefly describe.

No

Are there any other issues to be discussed with the Committee?

Not at this time

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	October 14, 2020
Department:	Physical Therapy
Submitted By:	Daryl Ann Schneider, PT, DPT

List up to three things that are going well in your department.

1. Transitioned to use of disposable face rest cushion covers for our therapy tables to decrease use of linen following the fire at our laundry facility and to improve safety measures with COVID-19.
2. Set up a phone in room D of PT building and starting to utilize medical translation services.
3. Consistently maintained 3 therapists and did not require travelers, which reduced costs.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

Working on improving use of medical translation services. Previously we found it easiest to use bilingual employees to translate; however, this takes the employee from their job and we have found that it does not provide adequate medical translation for more accurate depiction to patient and we could not have as in-depth educational discussions with the patients. At this point we have identified The Interpretation Services Policy (https://mmhd.ellucid.com/documents/view/3793?product=policy) and have collaborated with our director (Keith Earnest) and IT Dept to get a phone placed in one of our treatment rooms and used the service two times thus far. The room still needs adjustment as no high-low or mat table is in that room and had some difficulty when patient would point to an area and say "here" but causes delay in translating.

How does this impact on patients? Do you think this is acceptable?

This will significantly improve communication with our limited or non-English speaking patients. Translating medical terms and being able to adequately describe anatomical structures, healing processes, movement patterns and diversifying patient sensations in order to determine tissues involved takes more extensive training in English or any other language and requires a higher skill level than our bilingual workers can provide; thus in turn providing improved patient care and holding ourselves to higher standards of care to reach a more culturally diversified patient population in our clinic.

How does this impact on staff? Do you think this is acceptable?

This is reducing our reliance on staff from admitting and finance that are bilingual and therefore not taking time from their other duties.

What progress has been made on these projects since the last quality committee meeting?

Since our last meeting we have identified this as a problem and limitations in our services. Previously none of our clinic rooms were equipped with phones to use this system and we have since gotten one treatment room equipped with a phone and have used it three times, two which were successful. The first time we logged in and requested Spanish language but did not know the Mayers account number, which was later identified in the policy and made for successful use twice.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Keith Earnest, in helping to give direction of finding the policy, followed by working with maintenance and IT in helping to setup the phone and then a return visit to get the phone authorized into our system.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding Patient Services

Have any new quality-related issues arisen? Briefly describe.

We have identified difficulty with the process of acquiring DME at time of discharge from inpatient/swing status. We would like to reduce requests to borrow PT equipment at discharge to limit liability. This is on our goal list for the year to work a flowsheet to acquire DME that staff can refer to.
Are there any other issues to be discussed with the Committee?
While currently using The Language Scientific Center (dialing TRAN) on our phone system, we are trying to look into if our system has an upgrade feature to utilize a video translation service or the possibility of using Stratus Video (https://www.stratusvideo.com/) in the future to improve patient experience.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	
Department:	Respiratory Therapy
Submitted By:	David A. Ferrer Sr. RRT

List up to three things that are going well in your department.

1. We are performing (PFT) Pulmonary function tests that we weren't when I got here
2. We purchased and are using a High-flow nasal cannula system
3. We purchased a 2nd bipap unit that was much needed, and was able to get a great deal on it

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

1. Am working on marketing our PFT lab to clinics, Doctor's offices, Fire departments, and Ranger stations.
2. We are delivering therapies in a more beneficial manner to our PT's. We have 2 metaneb systems that weren't being used when I got here.

No Lean project.

How does this impact on patients? Do you think this is acceptable?

1. We can service more patients in our surrounding areas and communities
2. PT's can receive Resp. therapy tx's that not only open airways, but help mobilize secretions
3. This is highly acceptable

How does this impact on staff? Do you think this is acceptable?

It doesn't due to we are trained to perform these tests. Yes, this is acceptable.

What progress has been made on these projects since the last quality committee meeting?

1. The PFT lab is open for business in which it wasn't before
2. We are using the equipment in a more productive manner

Has anyone in particular been instrumental in helping to progress/improve the problem?

Yes, I had outside reps come in for in-servicing

Which Strategic Goal does your quality issue BEST relate to (choose one)?

We would like to open a Pulmonary rehab clinic. We need the covid issue to go away so that we can get the necessary training.

Have any new quality-related issues arisen? Briefly describe.

Unable to open our Pulmonary rehab clinic.

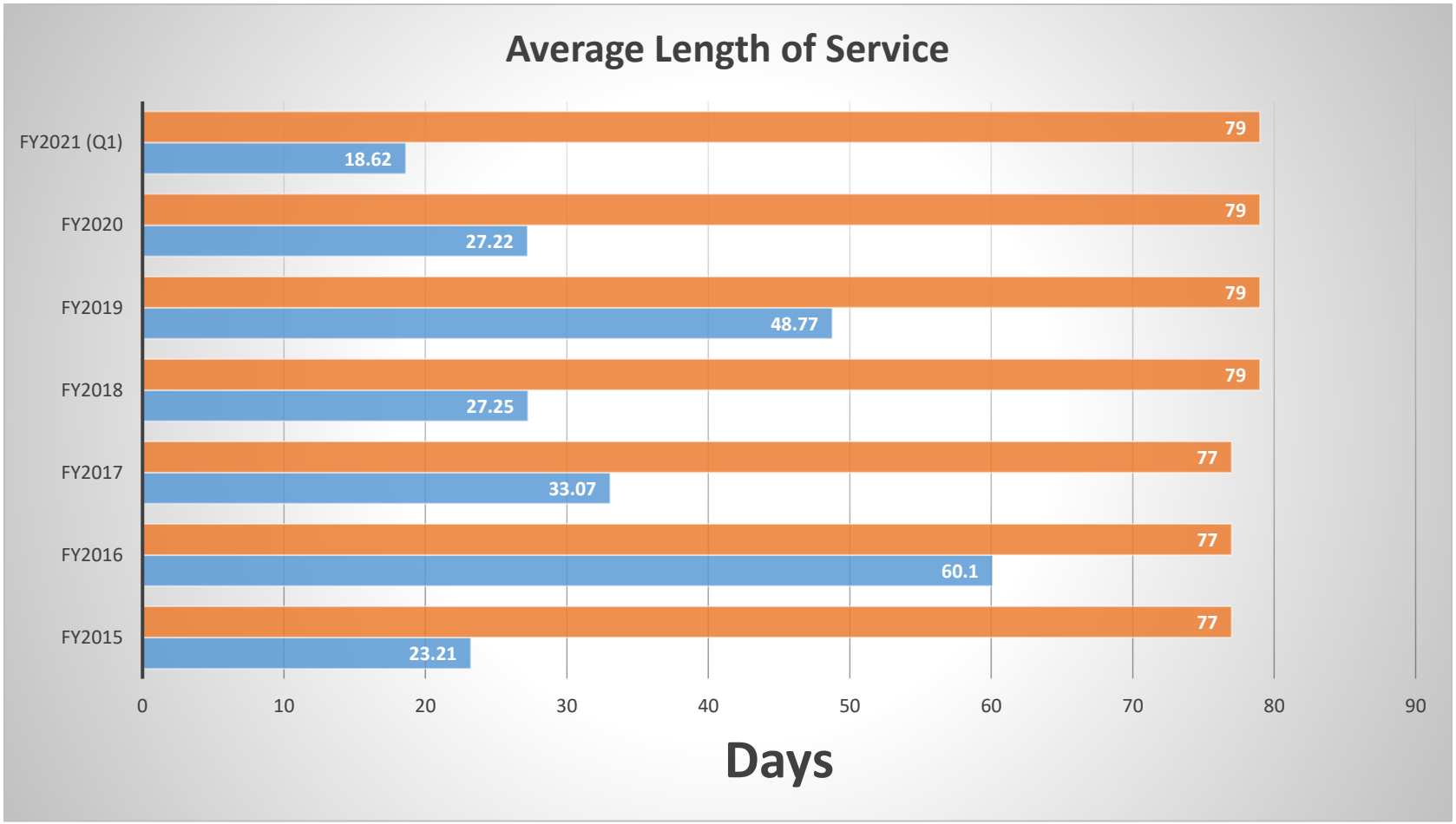
Are there any other issues to be discussed with the Committee?

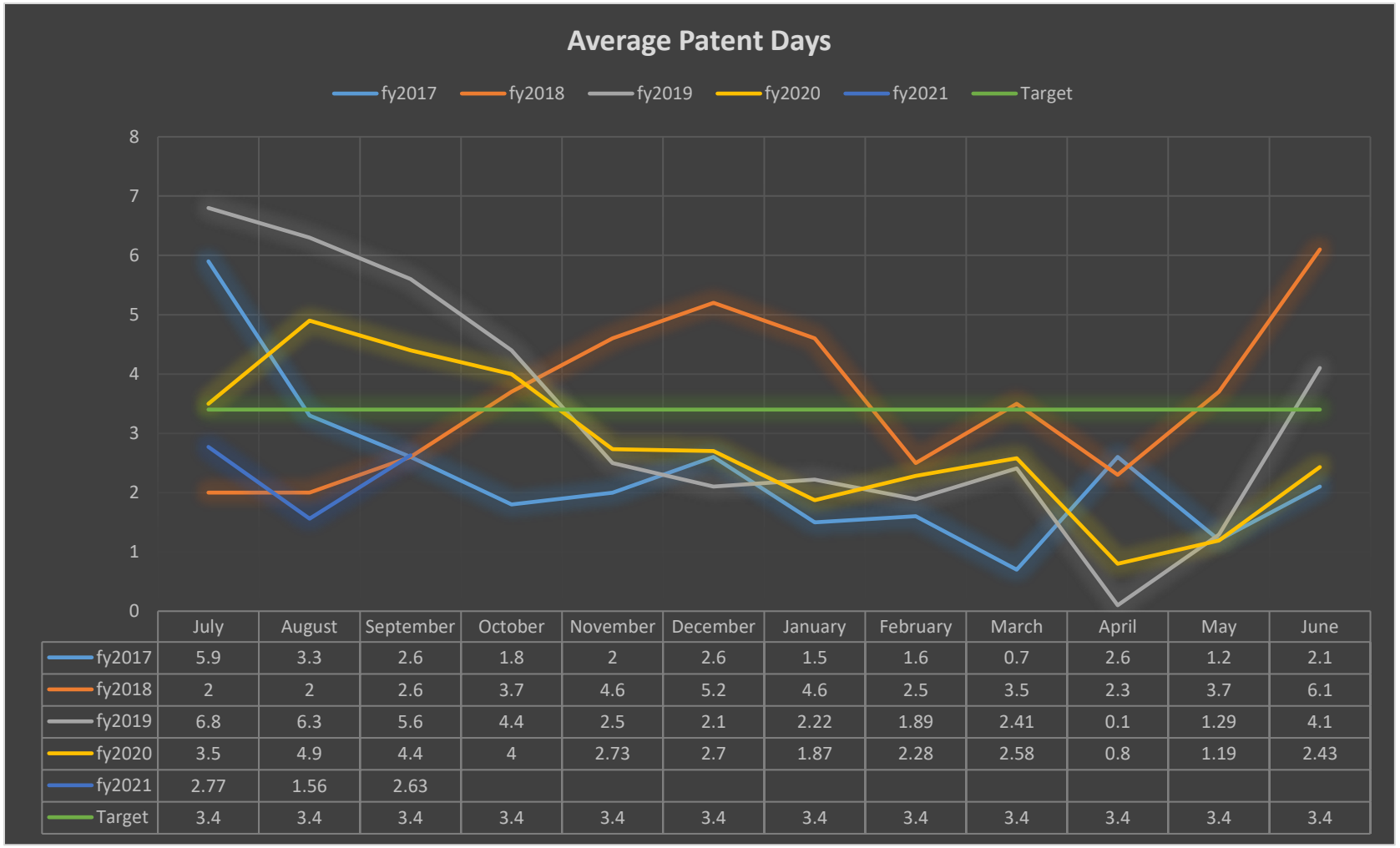
We have rented 3 ventilators, instead of purchasing, which saved the hospital a ton of money. We have sent one back due to lack of usage. This leaves us with three. I think we should send one more back. The rental fee on each unit is ***four-hundred dollars/month***.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	October 14, 2020
Department:	Retail Pharmacy
Submitted By:	Heidi Fletcher
List up to three things that are going well in your department.	
Our system of colored baskets to prioritize prescriptions is working well. Our prescription volume is increasing Our drive through has become a very popular feature with our pharmacy	
Do you have any current quality improvement projects/activities underway? Please provide a brief description. **Is this a LEAN project? Y/N**	
Inventory control in relation to 340b. The initial lag between dispensing a 340b rx & the replacement of the stock resulted in excess inventory. Excess inventory was returned to correct the problem. New process is to compare the report of what will be shipping the next day from the 340b order and remove from the current daily regular order. I try to also be mindful of what inventory is likely to be replaced via 340b as the prescriptions are being filled, and not reorder the stock, but rather allow it to come 340b.	
How does this impact on patients? Do you think this is acceptable?	
Transparent to pateints.	
How does this impact on staff? Do you think this is acceptable?	
This process is more work for the staff but in retail pharmacy, inventory control is the difference between being profitable or not.	
What progress has been made on these projects since the last quality committee meeting?	
Has anyone in particular been instrumental in helping to progress/improve the problem?	
Kristi Shultz was instrumental in returning inventory.	
Which Strategic Goal does your quality issue BEST relate to (choose one)?	
Have any new quality-related issues arisen? Briefly describe.	
An ongoing issue we eagerly need is faster internet!!! Evidently we are waiting on Frontier for the next phase of the upgrade. We need someone to keep a close eye on that process and do whatever necessary to expedite it if possible. We also need to be able to answer the phone and transfers calls from any of the 4 workstations. This is currently not possible from our mailing/extra station. It would also be really good if we could place a call on hold from any station, and it would be visible and answerable from any other work station. I would also like to make the mailing/extra station a fully functional work station with a scanner to scan rx hardcopies and a thermal Rx label printer	

Are there any other issues to be discussed with the Committee?


Average Length of Service
FY2021 (Q1)
FY2020
FY2019
FY2018
FY2017
FY2016
FY2015
79
18.62
79
27.22
79
48.77
79
27.25
77
33.07
77
60.1
77
23.21
0
10
20
30
40
50
60
70
80
90
Days



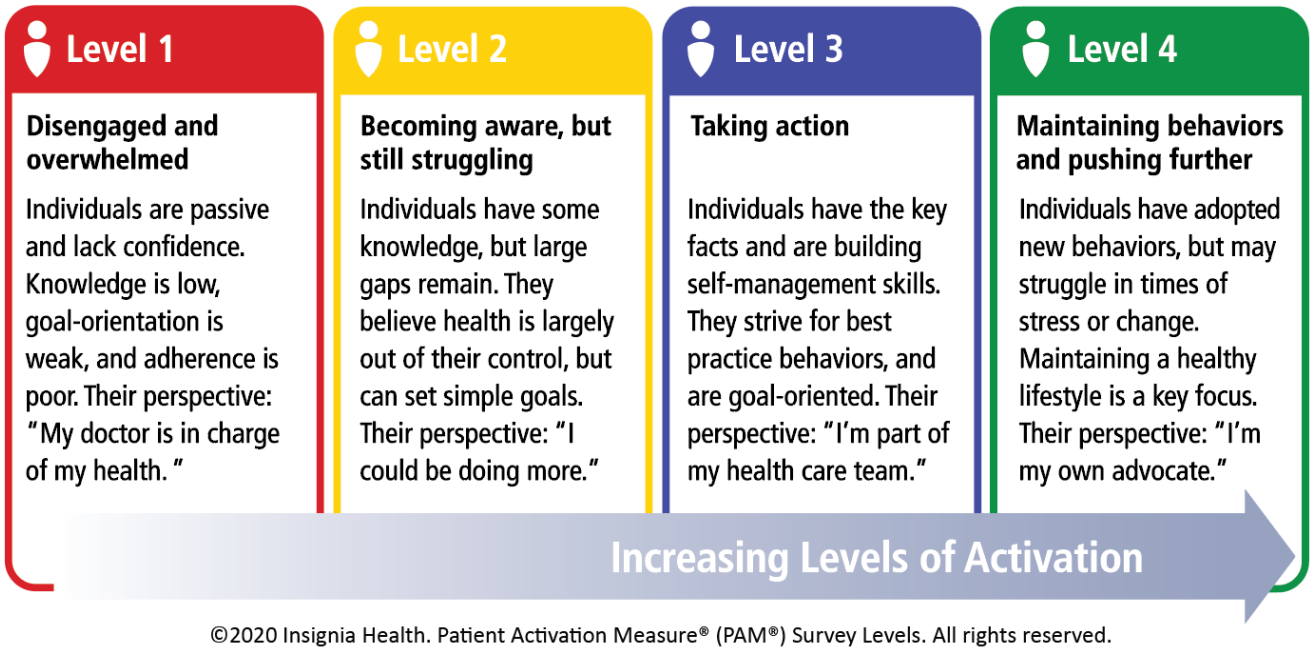
	July	August	September	October	November	December	January	February	March	April	May	June
fy2017	5.9	3.3	2.6	1.8	2	2.6	1.5	1.6	0.7	2.6	1.2	2.1
fy2018	2	2	2.6	3.7	4.6	5.2	4.6	2.5	3.5	2.3	3.7	6.1
fy2019	6.8	6.3	5.6	4.4	2.5	2.1	2.22	1.89	2.41	0.1	1.29	4.1
fy2020	3.5	4.9	4.4	4	2.73	2.7	1.87	2.28	2.58	0.8	1.19	2.43
fy2021	2.77	1.56	2.63									
Target	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4

PATIENT ACTIVATION MEASURE® (PAM®)

Increasing Activation Starts with Measurement

The Patient Activation Measure® (PAM®) is a 10- or 13-item survey that assesses a person's underlying knowledge, skills and confidence integral to managing his or her own health and healthcare.

PAM segments individuals into one of four activation levels along an empirically derived 100-point scale. Each level provides insight into an extensive array of health-related characteristics, including attitudes, motivators, and behaviors. Individuals in the lowest activation level do not yet understand the importance of their role in managing their own health, and have significant knowledge gaps and limited self-management skills. Individuals in the highest activation level are proactive with their health, have developed strong self-management skills, and are resilient in times of stress or change.



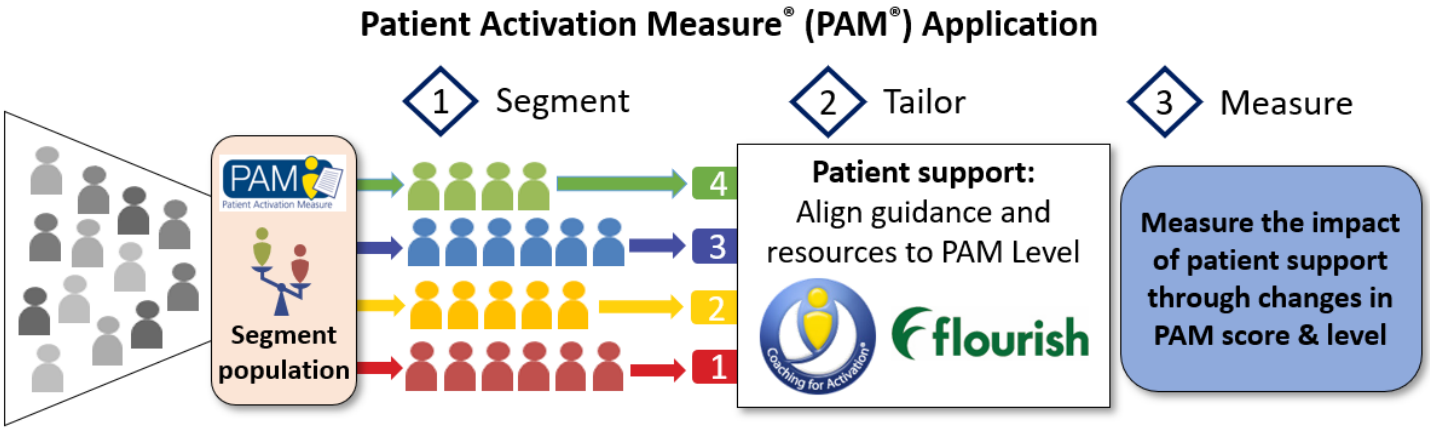
PAM is Backed by Extensive Research

The Patient Activation Measure survey is a unidimensional, interval level, Guttman-style question scale developed by Dr. Judith Hibbard, Dr. Bill Mahoney and colleagues at the University of Oregon. PAM was created and tested using Rasch analysis and classical test theory psychometric methods. Related versions include Caregiver PAM and Parent PAM, and over 35 validated translations.

To date, over 500 peer-reviewed published studies worldwide have documented the PAM survey's ability to measure activation and predict a broad range of health-related behaviors and outcomes. This foundation in research consistently demonstrates that individual self-management improves significantly as activation increases, and has led to endorsement of PAM as a performance measure by the National Quality Forum.

PAM® Applications

The Patient Activation Measure survey is reliable and valid for use with all patients, including those managing chronic conditions and engaged in disease prevention efforts. PAM is widely used today in population health management programs, disease and case management systems, wellness programs, medical home projects, care transitions, value-based programs, and much more. PAM is applied in three key manners:



1. **Improving segmentation and risk identification**. Traditional risk models rely upon past utilization and have been shown to miss over half of the individuals in the lower two activation levels. Research consistently shows that lower activation is an indicator for disease progression, like diabetes or depression, as well as increased ED visits, hospital admissions, and ambulatory care sensitive (ACS) utilization.

2. **Tailoring Support to PAM Level**. Hundreds of health-related characteristics have been mapped to PAM Levels, offering a wealth of insight into a person's self-management abilities. This insight guides patient support to establish goals and action steps that are realistic and achievable for each individual. An activation-based approach to coaching and education, whether provided by phone, in clinic, online or in-home, has been proven to deliver significantly improved outcomes. Insignia Health's coaching model (Coaching for Activation®) and consumer-facing Web-based program (Flourish®) make over a decade of activation research and experience actionable for health care organizations and the people they serve.

3. **Measuring Impact**. Even a single point change in PAM score is meaningful. By periodically re-administering the PAM survey, the impact of patient support strategies and programs can be understood well in advance of traditional outcome measures.

About Insignia Health

Insignia Health specializes in helping health systems, health plans, hospitals, care management services, and other organizations assess patient activation and develop strategies for helping individuals become more successful managers of their health and health care. Insignia Health applies its proprietary family of health activation assessments to measure each individual's self-management competencies. The Patient Activation Measure® and over 15 years of health activation research form the cornerstone of a complementary suite of solutions that help clinicians, coaches and population health providers improve health outcomes and lower costs. Insignia Health supports health activation efforts of over 250 health systems and organizations around the world.

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

Six PAM applications across the patient journey

RESEARCH REPORT

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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:

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.

Source: NHS England website, "Patient Activation" page.

Activation: From passive patient to active partner

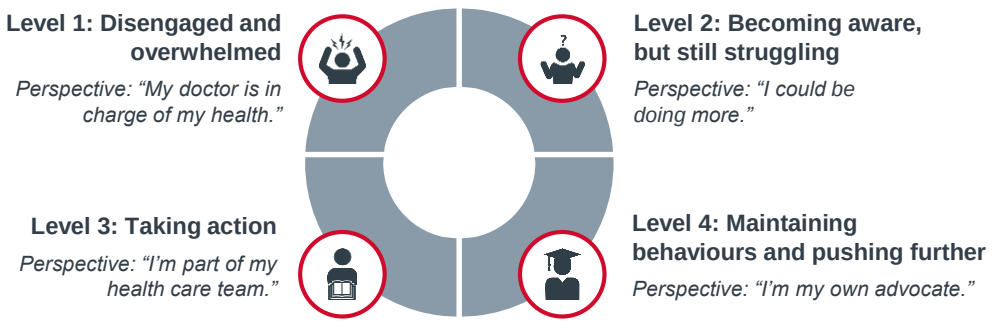
What is PAM?

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]

PAM's four activation levels



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 tools[2] 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".

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/

Source: Insignia Health, "Patient Activation Measure (PAM)," 2018, https://s3-us-west-2.amazonaws.com/insignia/PAM-Fact-Sheet-20180212.pdf; Insignia Health, Oregon, US; Global Forum for Health Care Innovators interviews and analysis.

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.

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

Baseline activation assessment

- ✓ **High adoption**
- ✓ **Solid proof**

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[1] is based in Oregon, United States
- Received a grant to pilot a patient-centred medical home[1], into which they incorporated the PAM tool

PeaceHealth's approach to measuring baseline activation

The PeaceHealth Patient Centred Medical Home[1] 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

PAM level	Low disease burden	High disease burden
High (3-4)	• Electronic resources • Usual care team • Focus on prevention	• Electronic resources and peer support • Usual care team • Focus on managing illness
Low (1-2)	• High-skilled team members • Focus on prevention	• High-skilled team members • More outreach • Focus on developing skills to manage illness

1) The patient centred medical home is a multi-disciplinary, primary care model designed to support the totality of patients' primary care needs. More information on medical homes is available on www.advisory.com.

Source: Blash et al, "PeaceHealth's Team Fillingame Uses Patient Activation Measure to Customize the Medical Home" (2011), https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/10.1%202011_05_PeaceHealth's_Team%20Fillingame_Uses_Patient_Activation_Measures_to_Customize_the_Medical_Home.pdf.

Patient selection and eligibility

- **Low adoption**
- **No proof**

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 a 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[1]

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

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/Advisory-com/Research/PHA/Research-Study/2017/Mind-the-Gap-Managing-the-Rising-Risk-Patient-Population.pdf.
2) Congestive heart failure.
3) Chronic obstructive pulmonary disease.

Source: "Proactively Identifying the High-Cost Population," *Health Care Transformation Task Force*, 1 July 2015, https://hcttf.org/wp-content/uploads/2018/01/WhitePaper-ProactivelyIdentifyingtheHighCostPopulation.pdf; Global Forum for Health Care Innovators interviews and analysis.

Clinician signalling and engagement

- **Some adoption**
- **Some proof**

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

COORINARE'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

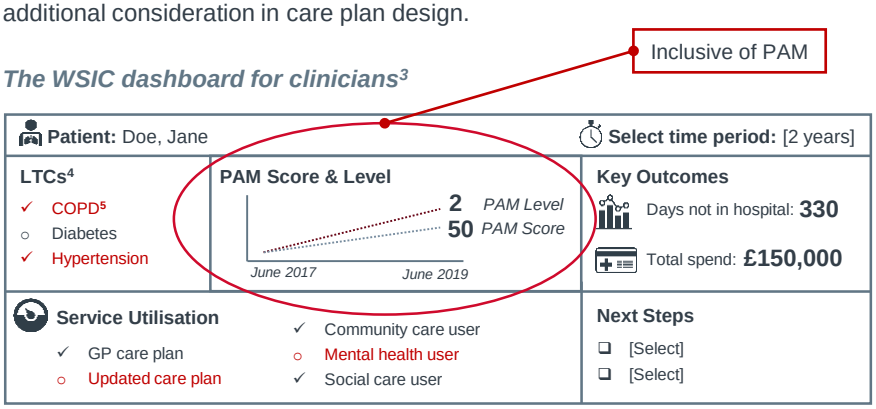
- The North West London health and care partnership is made up of over 30 NHS[1] and local authority organisations
- CCG[2] collaboration composed of 8 commissioning groups across London, England, and covers over 2.2 million people
- Organisation manages PAM licenses, provided by NHS England, for all 8 of its boroughs[1]
- Designated NHS National Mentor for PAM

North West London's PAM reporting

North West London collaboration of CCGs[2] 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 COPD[5]. 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 clinicians[3]



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.

Source: NHS England, "Patient Activation licenses", https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/licences/

Care model tailoring

✓ **High adoption**
✓ **Solid proof**

Application in brief

Providers often struggle to establish some level of routine when they're building individualised 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[1] 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

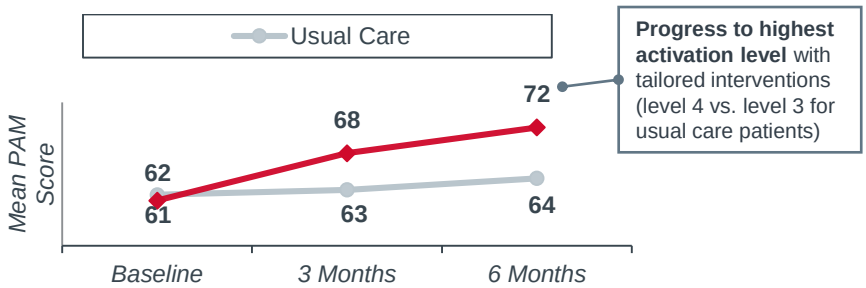
VA San Diego used PAM levels to segment patients and structure care pathways for heart failure patients, designating interventions by activation level as shown below.

PAM level progression[2]

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

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



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.

Source: Shively MJ, et al., "Effect of patient activation on self-management in patients with heart failure," *Journal of Cardiovascular Nursing*, 2013, 28: 20-34; https://www.ncbi.nlm.nih.gov/pubmed/22343209 .

Patient graduation marker

- **Low adoption**
- **Some proof**

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.

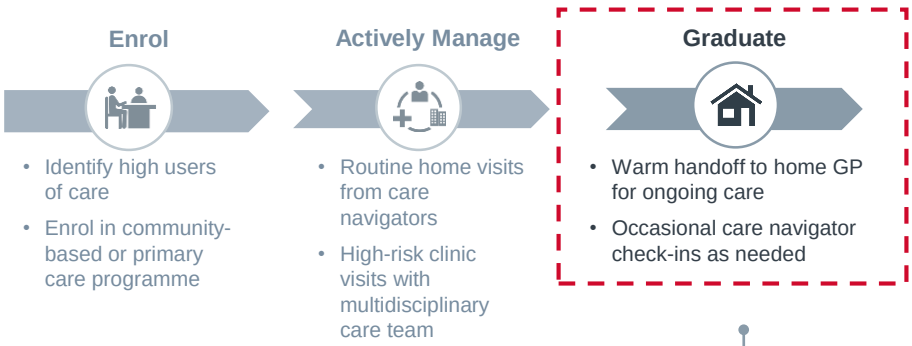
Advisory Board Take:

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 Hospital[1]

- 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's[1] illustrative care pathway with defined graduation



54%

Drop in number of Treehill Hospital[1] admissions thanks to programme with clear graduation process

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

Source: South Central Pennsylvania High Utilizer Collaborative, "Working with the Super-Utilizer Population: The Experience and Recommendations of Five Pennsylvania Programs," 2015, http://www.aligning4healthpa.org/pdf/High_Utilizer_report.pdf; "Care Connections," Lancaster General Health, http://www.lancastergeneralhealth.org/LGH/About-Lancaster-General-Health/Innovative-Care-Models/Care-Connections.aspx; Global Forum for Health Care Innovators interviews and analysis.

1) Pseudonym.

Intervention assessment

- ✓ **High adoption**
- ✓ **Solid proof**

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.

2%
Increase in medication adherence for each PAM point increase

2%
Decrease in hospitalisations for each PAM point increase

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 bio-medical outcome**
3. **Reduced cost**
4. **Increased patient satisfaction**

Source: Insignia Health, "Patient Activation Measure (PAM)," 2018, https://s3-us-west-2.amazonaws.com/insignia/PAM-Fact-Sheet-20180212.pdf; Insignia Health, Oregon, US; Global Forum for Health Care Innovators interviews and analysis.

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

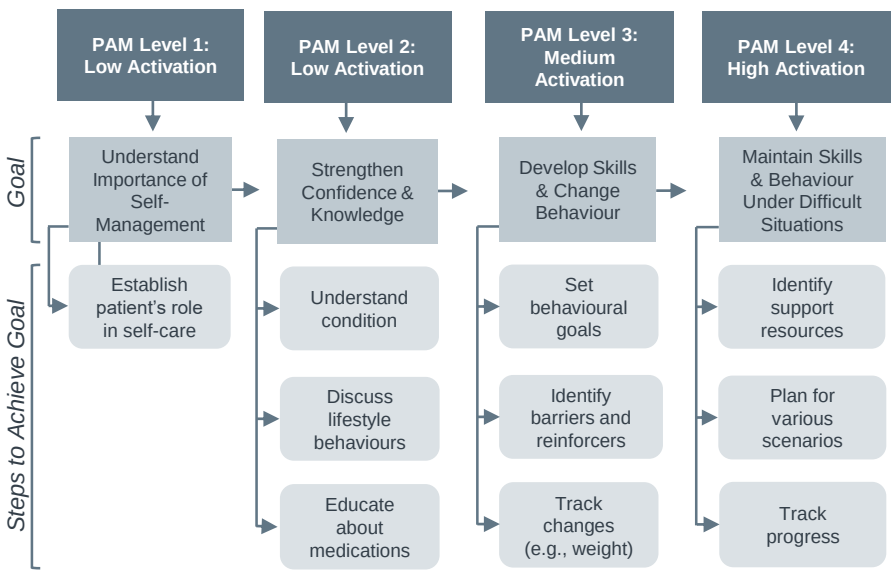
   Download this care management scripting pick list to learn how to better engage patients in two-way conversations about their care plan steps.

Appendix

Patient Activation Measure 13-question survey[1]

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



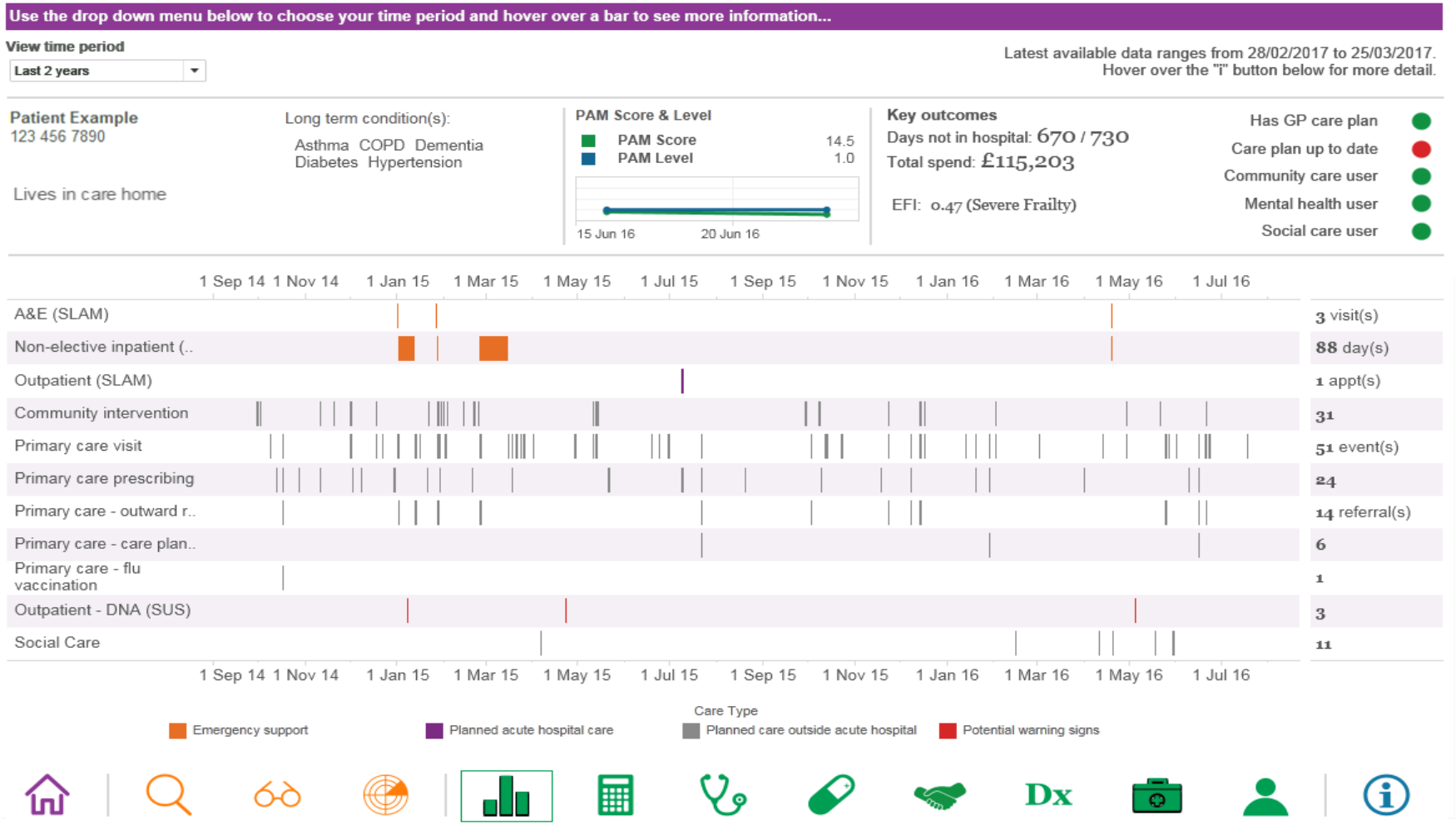
Source: Hibbard JH, et al., "Development and Testing of a Short Form of the Patient Activation Measure," *Health Research and Educational Trust*, 2005, 40: 1918-1930; Moljord IE, et al., "Psychometric properties of the Patient Activation Measure-13 among out-patients waiting for mental health treatment," *Patient Education and Counseling*, 98, no. 11 (2015):1410-1417), https://www.sciencedirect.com/science/article/pii/S0738399115002827; Insignia Health, Oregon, US; Global Forum for Health Care Innovators interviews and analysis.

Shively MJ, et al., "Effect of Patient Activation on self-management in patients with heart failure," *Journal of Cardiovascular Nursing*, 2013, 28: 20-34; Global Forum for Health Care Innovators interviews and analysis.

1) The 13 items have four possible responses ranging from strongly disagree to strongly agree, plus a 'not applicable' option.

Appendix

The North West London Collaboration of CCGs' WSIC Dashboard



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