PAM®-based Coaching for Activation® (CFA) has consistently demonstrated significant improvements in health outcomes and decreases in healthcare utilization in both pre-post and control-intervention cohort evaluations. The insights shared below demonstrate the impact of tailoring support to PAM activation levels, when used by both clinicians and non-clinical coaches, and across different types of support: by phone, in clinic, and in home.

Phone-Based Programs

An Examination of the Relationship Between Care Management with Coaching for Activation and Patient Outcomes, American Journal of Managed Care, February 2017.

Published paper

Program Design

Population: Individuals managing long term conditions, most over the age of 50.

Two coach cohorts were created to assess the impact of PAM-based Coaching for Activation (CFA). The intervention cohort utilized CFA to guide support following administration the PAM survey, while the control cohort did not use PAM or CFA to guide support. All coaches were trained in Motivational Interviewing (MI).

Results

Relative to respondents in the CFA care management intervention group (CFA CM), respondents in the usual care management group (Usual CM) experienced 18% more A&E visits, 98% more hospital admissions, 18% lower adherence to medications, a higher glycated hemoglobin level, and higher systolic blood pressure.

Findings show that coaching interventions based on activation level helped care managers engage in more effective interactions that strengthen a patient’s role in managing his or her healthcare.
Program Design

Mobile Integrated Healthcare (MIH) is a novel, patient-centered approach to population management. One or more members of a multi-professional clinical team was assigned to support patients age 65+ on a scheduled or unscheduled basis. The selection of the site of care for scheduled interventions was driven by patient choice and, most often occurred in the patient’s home coupled with phone support.

Members who participated in the program were risk-stratified using the Patient Activation Measure (PAM) survey to guide intensity of MIH program intervention activity. Coaching for Activation helped to guide support through weekly phone calls and in home encounters for individuals lower in activation.

Results

All measured trends demonstrated favorable results for patients participating in the program and reached statistical significance when compared against a matched cohort and risk adjusted.

- ED/A&E utilization: 21% decrease and a 19% decrease in emergency department cost. (The control cohort increased by 3%.)
- Inpatient utilization: 40% decrease and a 37% decrease in inpatient cost. (The control cohort was flat.)
- PAM Score change: 3.4 average point change across the intervention population. Change based upon baseline activation level as follows: Level 1: 7.4, Level 2: 1.1, Level 3: flat.
Horsham & Mid Sussex CCG Health Coaching Service
Kings Fund Event Presentation 2017

Program Design
- Coaching program supporting patients with long term conditions
- Utilize motivational interviewing techniques
- Tailor approach to PAM levels

Results
- Baseline PAM score average of 53.6 increased to 63.2 at program discharge
- Risk for admission score declined 9%, from 54.6% at program start to 45.9% at discharge. 40% of the cohort achieved a reduced risk of admission of more than 20%.
- Unplanned admissions dropped by 25% for the intervention group as compared to a 33% rise for the control group.

PAM Based Disease Management Coaching Study

Program Design
A quasi-experimental pre-post design was used, with an intervention group coached with a PAM-based tailored approach and a control group coached in the usual way. Coaches in both cohorts were proficient in Motivational Interviewing. Coaching was delivered by phone over six months.

Results
The tailoring of coaching to a patient’s activation level improved both the outcomes and the efficiency of the disease management program.
- PAM score change average of 4.6 points for the intervention cohort compared to 1.4 points for the control cohort. Patients low in activation account for the gains in activation (chart to the right)
- PAM-based coaching resulted in a 33% decline in hospital admissions and a 22% decline in emergency/A&E visits.
- PAM coaching cohort had greater improvement in their biometrics and adherence to recommended immunization and drug regimens.
Clinic-Based Programs
Empowering Patients in the Blackpool Trust/Fylde Coast Vanguard Extensive Care Service  Conference presentation

Program Design
- One comprehensive service to meet all of their needs
- 2+ LTCs, frail, elderly and at high risk for emergency admission
- Coaching support provided in clinic
- Meets with wellbeing support worker on regular basis
- Culture shift to embrace patient activation and person-centered care enabled success

Results
- 9.9 PAM score increase across the study population
- 14% decrease in elective admissions and a 18% decrease in non-elective admissions
- 14% decrease in A&E attendances

PeaceHealth’s Team Fillingame Uses Patient Activation Measure to Customize the Medical Home
Link to published study  Insignia case study

Program Design
PeaceHealth Medical Group in Eugene, Oregon, developed a patient-centered medical home program to support clinic patients. Key aspects of this effort included:
- Tailoring and coordinating patient care to fit a patient’s PAM level of activation and health acuity.
- Using PAM-based Coaching for Activation to align goal setting to a patient’s level of activation.
- Revising staff roles and adding a part-time mental health worker to better address patients’ social, behavioral and medical needs.
- Cross-training medical office assistants to play a key role in providing health coaching, protocol-based supervised phone triage, and pre-visit planning.

Results
- A 48% decrease at 12 months and sustained at 18 months in the number of patient visits to the emergency department/A&E or urgent care.
- Steady improvement in the proportion of hypertensive patients with controlled blood pressure from a baseline of 56% in January 2009 to 77% of patients in January of 2011 as well as improvement in LDL and A1C measures for diabetic patients.
Partnership Health Plan Intensive Outpatient Care Program  
Conference presentation

Partnership Health Plan of California (PHC) is a non-profit community based health care organization that contracts with the State of California to provide care to over 525,000 Medi-Cal members. This intensive outpatient care management (IOCM) program operated in 10 Federally Qualified Health Centers (FQHC) and several smaller practices in rural areas.

**Program Design**
- Care coordinators, health educators, LCSWs and RNs provided support within the clinic sites, by phone, and through a combination of in person and by phone.
- Patients were identified for support based upon criteria identifying high risk for hospitalization.
- PAM and Coaching for Activation were used to guide support.

**Results**
- Hospital admissions were 37% lower for patients care managed, while days in the hospital were 76% lower.
- Mean PAM score increased by 11 points over six months within the largest clinic. Most patients moved to a higher activation level.

South Denver Care Transition Program  
Conference Presentation

**Program Design**
PAM-based Coaching for Activation guided patient support within a skilled nursing facility with the goal to improve care transitions and reduce 30-day readmissions.

**Results**
- Mean PAM score increased by 5.9 points.
- All program participants set goals with 97.5% of goals being achieved.
- 30-day readmissions dropped by 48%, from 9.5% to 5.9%.
Home-Based Programs

Home Health Group UK  
Home Group presentation (Kings Fund Event)

The Home Group is one of the UK’s largest providers of high quality housing and integrated housing, health and social care. The Home Group houses over 116,000 people a year in around 55,000 homes.

Program Design

This program provided a floating health support service in two housing centers using non-clinical staff. One housing center utilized PAM and Coaching for Activation (CFA), while the other center served as a control.

Results

- Quality of Life assessment scores increased by 45%
- 32% improvement in the Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
- PAM scores increased significantly across levels in the intervention group with little change in the control group.

<table>
<thead>
<tr>
<th>Control Group</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
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<tbody>
<tr>
<td>PAM Trend (Score) Initial PAM Level</td>
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<tr>
<td>Mean PAM Score</td>
<td>44.5</td>
<td>51.7</td>
<td>62.7</td>
<td>79.5</td>
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<tr>
<td>New Mean PAM Score</td>
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<td>53.5</td>
<td>63.2</td>
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<td>Score Point Change</td>
<td>0.94</td>
<td>1.8</td>
<td>0.44</td>
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<tr>
<td>% Improved</td>
<td>21.43%</td>
<td>16.67%</td>
<td>21.43%</td>
<td>2.47%</td>
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</table>

<table>
<thead>
<tr>
<th>Intervention Group using PAM and CFA</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAM Trend (Score) Initial PAM Level</td>
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<td></td>
<td></td>
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<tr>
<td>Original Mean PAM Score</td>
<td>40.5</td>
<td>51.1</td>
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<td>65.2</td>
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<td>83.8</td>
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<td>Score Point Change</td>
<td>16.5</td>
<td>14.1</td>
<td>11.2</td>
<td>6.6</td>
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<tr>
<td>% Improved</td>
<td>98.77%</td>
<td>97.83%</td>
<td>96.23%</td>
<td>75.0%</td>
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</table>

Meals on Wheels Community Health Navigator Program  
Conference presentation

Community Health Navigators (CHN), comprised of both paid and volunteer students and retirees, were trained to provide support in home to county lower income, age 65+ residents with multiple chronic conditions considered at high risk of hospitalization.

Program Design

- Fourteen graduate level students and retirees were trained to be CHNs.
- Clients are in the program for 6 months and supported with weekly calls and monthly in home visits.
- PAM and CFA guided interactions.

Results

- 24% decline in hospitalizations or A&E visits for 6 months following the intervention. 81% of clients showed positive changes self-reported health status.