Person- and Family Centered Care: Off-Cycle Review, 2015

DRAFT REPORT FOR COMMENT

December 14, 2015

NATIONAL QUALITY FORUM

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Contents

Person- and Family-Centered Care: Off-Cycle Review

DRAFT REPORT

Executive Summary

This is the third in a series of reports describing NQF's 2014-2016 measure evaluation project for person- and family-centered care measures. The background and description of the project and review of NQF's person- and family-centered care portfolio are available on NQF's project webpage. NQF is undertaking this project in multiple phases. Phase 1 examined experience with care measures; Phase 2 examined functional status measures and this current off-cycle project focused on patient activation. The background and description of the project, review of NQF's person- and family-centered care (PFCC) portfolio, and the results of the Phase 1 and Phase 2 evaluations are available on NQF's project webpage.

For this project, the Standing Committee evaluated one newly-submitted measure against NQF's standard evaluation criteria. In addition, during Phase 2 of the project, two measures received conditional endorsement and required finalization of a risk-adjustment methodology. These two measures with their finalized risk-adjustment strategies were reviewed by the Committee to determine if the conditional status could be removed. The Committee recommended the one new measure be endorsed and that the conditional endorsement be removed for two measures. The measures are as follows:

Recommend for Endorsement

- 2483: Gains in Patient Activation (PAM) Scores at 12 Months (Insignia Health)

Recommend for Endorsement/Conditions Removed

- 2643: Average change in functional status following lumbar spine fusion surgery (MNCM)
- 2653: Average change in functional status following total knee replacement surgery (MNCM)

Brief summaries of the measures reviewed in this off-cycle review are included in the body of the report; a detailed summary of the Committee's discussion and ratings of the criteria for the new measure (#2483: Gains in Patient Activation (PAM) at 12 Months) is in Appendix A.

Person- and Family-Centered Care Off-Cycle Review Measure Evaluation

On November 13, 2015, the Person- and Family Centered-Care Standing Committee evaluated one new measure and conducted an expedited annual review of two measures with conditional endorsement against NQF's standard evaluation criteria. To facilitate the evaluation, NQF staff conducted a preliminary review of the measures against the evaluation subcriteria prior to consideration by the entire Standing Committee. The Committee's discussion and ratings of the criteria are included in Appendix A.

Table 1. Person- and Family-Centered Care Measure Evaluation Summary

	Conditional Endorsement Review	New Measures	Total
Measures under consideration	2	1	3
Measures recommended for endorsement	2	1	3
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures where consensus is not yet reached	0	0	0
Measures not recommended for endorsement	0	0	0
Reasons for not recommending	N/A	N/A	N/A

Comments Received

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments prior to the evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from October 21- November 05, 2015 for measure 2483: Gains in Patient Activation (PAM) Scores at 12 Months. No comments were received during this comment period.

Overarching Issues

During the Standing Committee's discussion of the measures in this and the previous phases, several overarching issues emerged that were factored into the Committee's ratings and recommendations.

Endorsement of Measures versus Tools

As experienced in previous phases of work, many PFCC and Patient Reported Outcome- Performance Measures (PRO-PMs) are derived from assessment tools or surveys, and this is true of the new measure

under consideration, which is based on data from the Patient Activation Measure (PAM). Developers frequently provide robust testing data and a strong rationale for the use of the tool or instrument, but may struggle with data to meet the Scientific Acceptability criteria for the actual PRO-PM. This challenge continued to be a theme in this off-cycle review and NQF staff worked closely with both the developer and the Standing Committee to ensure the appropriate data was provided for the critical evaluation of the measure. Even though staff provided significant technical assistance to the Insignia team to ensure the NQF Measure Information Form was properly completed, the Committee still requested further clarification of the actual measure under review versus the focus on the tool. Ultimately, the developer was able to supply the appropriate studies to support the criteria as applicable to the PRO-PM.

Consideration for Proprietary Measures

The Standing Committee expressed concerns about the proprietary nature of the Patient Activation Measure (PAM) and associated algorithms. Dr. Helen Burstin clarified that approximately seven years ago, the NQF Board decided that there should be a corridor to allow measures to come in that have an associated fee; the Board determined that that associated fee would be something that committees should discuss and factor into the feasibility assessment. The developers did provide both scoring and pricing as required by NQF.

Summary of Measure Evaluation

The following brief summary of the measure evaluation highlights the major issues that were considered by the Committee. Details of the Committee's discussion and ratings of the criteria for the measure are in included in Appendix A.

2483: Gains in Patient Activation (PAM) Scores at 12 Months (Insignia Health): Recommended

Description: The Patient Activation Measure® (PAM®) is a 10 or 13 item questionnaire that assesses an individual´s knowledge, skill and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale. There are 4 levels of activation, from low (1) to high (4). The measure is not disease specific, but has been successfully used with a wide variety of chronic conditions, as well as with people with no conditions. The performance score would be the change in score from the baseline measurement to follow-up measurement, or the change in activation score over time for the eligible patients associated with the accountable unit. The outcome of interest is the patient's ability to self-manage.; **Measure Type**: Patient Reported Outcome; **Level of Analysis**: Clinician : Group/Practice, Clinician : Team; **Setting of Care**: Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Outpatient Rehabilitation, Pharmacy; **Data Source**: Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Patient Reported Data/Survey

As indicated above, one of the primary challenges this Committee faced was understanding the construct and translation of the PRO-PM and supporting evidence as opposed to the PAM instrument. Additionally, as a PRO-PM, the Committee evaluated both the performance measure testing and the data element testing against the NQF criteria; the Committee requested clarification of the evidence supporting the PRO-PM and specifically sought additional information on testing of the metric in the adolescent population (ages 15 – 17 years). Clarification was required on the actual PRO-PM under consideration, which was described as a measure that looks at the summary score change for the aggregate of eligible patients. Feasibility of implementation of the measure was an additional area of discussion for the Committee. The PAM is proprietary, with a cost for use of the tool and algorithm for scoring. As such, the Committee was advised to take this under consideration in evaluating the feasibility and usability criterions. The Committee voted on the measure via online survey tool and recommended the measure for endorsement.

Recommend for Endorsement/Conditions Removed

2643: Average change in functional status following lumbar spine fusion surgery (MNCM)

Description: For patients age 18 and older undergoing lumbar spine fusion surgery, the average change from pre-operative functional status to one year (nine to fifteen months) post-operative functional status using the Oswestry Disability Index (ODI version 2.1a) patient reported outcome tool; **Level of Analysis**: Clinician: Group/Practice; **Care Setting**: Ambulatory Care: Clinician Office/Clinic; **Data Source**: Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Patient Reported Data/Survey

2653: Average change in functional status following total knee replacement surgery (MNCM)

Description: Average change in functional status following total knee replacement surgery; **Level of Analysis**: Clinician: Group/Practice; **Care Setting**: Ambulatory Care: Clinician Office/Clinic; **Data Source**: Electronic Clinical Data: Electronic Health Record, Paper Medical Records, Patient Reported Data/Survey

Measures 2643 and 2653 were reviewed and recommended by the Standing Committee during their second phase of work (2015). During the Committee deliberations, it was noted that, although the measures were fully tested and use within Minnesota had begun, the risk adjustment methodology had not been finalized. In the original submission, Minnesota Community Measurement (MNCM) provided a rationale for the lack of finalized methodology, a timeline for full collection of data, and potential strategies they were considering. During the endorsement and ratification process, NQF placed a condition on the endorsement of the measures requiring that risk adjustment be finalized and evaluated by the Committee within one year of endorsement. MNCM was able to finalize risk adjustment in October, 2015 and presented their findings to the Committee at the November 13, 2015 webinar. The developer introduced the measures and provided the following information related to risk adjustment:

- The two measures for risk adjustment review are:
    - 2643, average change in functional status following a lumbar spine fusion surgery, which is a patient reported outcome based measure using the Oxford Knee Support tool. The measure assesses the change between patients' preoperative and

postoperative function at one year, which is defined as 9 to 15 months postoperatively; and
    - 2653, average change in functional status following total knee replacement surgery, another patient reported outcome measure, which uses the Oswestry Disability Index (ODI) tool.
- Although these procedurally-based measures reflect different patient populations, they are very similar in measure construct and rely on patient reported outcome tools to measure functional status. The patient functional status is accessible preoperatively and one year after the procedure. The absolute change between pre-op and post-op functional status score is calculated and then averaged to computer practice level, average change and functional status. MNCM publicly reports data that is risk adjusted using an actual to expected methodology, which allows the unadjusted rate to be preserved and displayed but also displays unexpected result for comparison.
- The developer indicated they utilize a Risk Adjustment Committee Methodology and Process, which includes a measure development advisory workgroup. The standard demographic variables used in the MNCM methodology include: gender, age, zip code, race/ethnicity, country of origin, primary language and insurance product as a proxy for socioeconomic status.
- The workgroup recommended the following variables for total knee replacement: the initial preoperative functional status as measured by Oxford knee, BMI, comorbidity of diabetes and tobacco status.
- The workgroup recommended the following variables for lumbar spine fusion surgery: the initial preoperative functional status as measured by the ODI, BMI, the clinical condition or reason for procedure, the history of prior back surgery and tobacco status.
- For total knee replacement, variables that were tested and failed to meet the significant test included: age, tobacco status, gender, and diabetes. For lumbar spine fusion surgery, the variables that failed to meet the F-Test were age, tobacco status, gender, history of prior back surgery and clinical condition reason for procedure.
- Next, variables for both measures were tested in the risk adjustment model including insurance product, initial preoperative functional status and BMI. There was a strong association with an F-Test P value of less than 0.3. The preoperative functional status was the only variable found to demonstrate a strong consistent empirical association with the outcome being measured for both measures under review.

The Committee asked some clarifying questions to ensure they understood the mechanics of both the risk adjustment strategy as well as final variables included in the model.

- A Committee member requested clarification about regression means and issues when starting with extreme values. It was noted that the inclusion of patients with very low functional statuses could impact the regression mean. In this scenario, the attribution back to quality is hypothesis-driven. The concern raised is that the measure will get some movement for those extreme values back to the norm, at the low-end and at the high-end there would be a smaller opportunity for improvement with respect to quality and surgery.

- A concern about the inclusion of pain status in a broader functional status assessment was also raised. A Committee member inquired about the approach to including pain as opposed to functional status. It was noted there is evidence that trying to address back pain is one of the drivers for surgery. The developer indicated components of both of the tools for functional status include a heavy focus on pain and patient tolerance in terms of different activities of function and their relation to pain. In addition, there are separate measures of back pain and leg pain that are calculated based on a 1 to 10 pain scale.

Upon analysis of testing data (2314 total knee replacement records, 880 spinal surgery records), MNCM finalized a statistical risk model using one risk factor: patients with poorer functional status prior to surgery have greater potential for a larger magnitude of absolute change in functional status than do patients with better initial functional status. As a result, any attempt to isolate the provider's contribution to the outcome of interest as measured by the absolute average change in functional status must take this into account. MNCM publicly reporting of data that is risk adjusted uses an "Actual to Expected" methodology, which allows the unadjusted rate to be preserved and displayed but instead also displays an "expected result" for fair comparison.

After discussion and consideration of the information provided by MNCM, the Committee voted to support full endorsement of the measures and to remove the conditions for the annual update.

Appendix A: Details of Measure Evaluation

Measures Recommended

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

2483 Gains in Patient Activation (PAM) Scores at 12 Months

Submission | Specifications

Description: The Patient Activation Measure® (PAM®) is a 10 or 13 item questionnaire that assesses an individual´s knowledge, skill and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale. There are 4 levels of activation, from low (1) to high (4). The measure is not disease specific, but has been successfully used with a wide variety of chronic conditions, as well as with people with no conditions. The performance score would be the change in score from the baseline measurement to follow-up measurement, or the change in activation score over time for the eligible patients associated with the accountable unit.

The outcome of interest is the patient's ability to self-manage. High quality care should result in gains in ability to self-manage for most chronic disease patients. The outcome measured is a change in activation over time. The change score would indicate a change in the patient´s knowledge, skills, and confidence for self-management. A positive change would mean the patient is gaining in their ability to manage their health.

A "passing" score for eligible patients would be to show an average net 3-point PAM score increase in a 6-12 month period. An "excellent" score for eligible patients would be to show an average net 6-point PAM score increase in a 6-12 month period.

Numerator Statement: The numerator is the summary score change for the aggregate of eligible patients in that unit (e.g., patients in a primary care provider´s panel, or in a clinic). The change score would be calculated from a baseline score and then a second score taken within 12 months of the baseline score (but not less than 6 months). The change score is the difference between the baseline and the second score in a 12-month period. The aggregate score would be the total score for the eligible patient population. The total aggregate score could be a positive or a negative number. A "passing" score for eligible patients would be to show an average net 3-point PAM score increase in a 6-12 month period. An "excellent" score would be for eligible patients to show an average of a 6-point PAM score increase in a 6-12 month period.

Denominator Statement: All patients can be included in the denominator, except children under the age of 14 and adults with a diagnosis of dementia or cognitive impairments (based on ICD codes). Also excluded would be patients who do not have two PAM scores. Finally, we exclude all patients who are at level 4 at baseline (as they are unlikely to gain in activation over time). To be considered for evaluation, an accountable unit would need to have two PAM scores per patient (taken no less than 6 months and not more than 12 months apart) on at least 50% of their eligible patients who had two visits during that time period.

Exclusions: All patients who are at PAM level 4 at baseline, as their scores are unlikely to increase, and children under 14 and any adults who have a diagnostic code indicating dementia or cognitive impairment.

ICD Codes include:

90.0 SENILE DEMENTIA UNCOMPLICATED

290.10 PRESENILE DEMENTIA UNCOMPLICATED

290.11 PRESENILE DEMENTIA WITH DELIRIUM

290.12 PRESENILE DEMENTIA WITH DELUSIONAL FEATURES

331.83 MILD COGNITIVE IMPAIRMENT

2483 Gains in Patient Activation (PAM) Scores at 12 Months

Adjustment/Stratification:

Level of Analysis: Clinician : Group/Practice, Clinician : Team

Setting of Care: Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Outpatient Rehabilitation, Pharmacy

Type of Measure: PRO

Data Source: Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Patient Reported Data/Survey

Measure Steward: Insignia Health

STANDING COMMITTEE MEETING [11/13/2015]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap

1a. Evidence: **Y=13 N=0** 1b. Gap: **H=6; M=4; L=2; I=1**

<u>Rationale</u>:

- The developer indicated the PAM measures an individual's knowledge, skill, and confidence, and their ability to manage their health and their health care. The rationale is that the PAM score is predictive of health behavior, clinical outcome, many measures of utilization or costly utilization, and overall cost. The underlying assumption is that high-quality care includes interventions such as coaching and support intended to increase patients' activation (ability to manage their disease), and that patients receiving such care should be gaining in their ability to self-manage over time. This is what the change in the PAM score would demonstrate.
- The proposed measure is based on examination of data from several sources. The numerator of the measure is the aggregate change in PAM score for a defined population, and the change over a 12- month period but not less than a 6-month period. The denominator is the patients in that facility or that panel who have at least two visits during that time period.
- Clarification of the timing of administration was requested and the developer indicated that for the measure, people need two scores in order to see a change. The measure requires measurement at two points in time; that could be over a year but not shorter than six months.
- The Committee had questions about the nature of the score, and the developer responded that an improvement of three points on a 1-100 scale for passing the measure, and that an improvement of six points is considered excellent. During their reviews, they have seen that a three-point change is related to changes and behavior. In addition, three points is also a reasonable improvement in terms of setting a bar for how many clinicians would pass. A very high level of performance would be needed to reach a change of six points, which is why it considered excellent.
- There was a request for specific literature supporting that a change in three points or six points is good and leads to better outcomes. The developers indicated the citations were provided in their submission, but they will further highlight them for committee consideration.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-4**; **M-6**; **L-1**; **I-2** 2b. Validity: **H-1**; **M-8**; **L-2**; **I-2**

<u>Rationale</u>:

2483 Gains in Patient Activation (PAM) Scores at 12 Months

- The Committee agreed there was good data that were presented on individual item reliability as well as test-retest reliability. The original PAM articles provided in the submission indicated very high internal consistency reliability.
- It was noted there were no reliability or validity data presented for children, specifically for adolescents over the age of 14 who are included in the measure denominator. The Committee member questioned what was known about meaningfulness of activation for this age group specifically, since the items are cognitively difficult and may mean something very different for a child whose parent or caregiver tends to take primary responsibility for managing their health condition. The developer team indicated that quite a few data taken in over the years have had children (ages 12 and above) with decent samples sizes but not in the published literature. They have also asked a number of clients to offer an opinion on its applicability to adolescents and whether a 14 or 15 or 16-year-old will respond as adults do. At the aggregate level, the developer stated the answer was yes. They thus believe the age range is suitable, and indicated a willingness to pull some of that data together for Committee review.

3. Feasibility: H-5; M-5; L-3; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee inquired as to what parts of the measure are proprietary: is the questionnaire itself proprietary, is the scoring proprietary, or is all of the above proprietary? The developer indicated all of the above are proprietary. The surveys and all the PAM versions are owned by the university and state of Oregon, and the algorithm is also proprietary. On occasion clients are permitted to have the algorithm to integrate into their systems, particularly into EMRs.
- The Committee was advised to review the licensing and other requirements for use of the survey as available on the Committee SharePoint site, and to consider cost and lack of transparence into their feasibility assessment vote.
- A member requested clarification on measure collection and who is actually responsible for contacting the patient or administrating the questionnaire, especially for the second round of surveys. The developer explained that the follow up PAM can mailed to a patient's home, administered via telephone, or via regular patient interaction in the course of a year.

4. Use and Usability: H-6; M-4; L-3; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- It was noted that the PAM tool seems to be easy to use, due to short length and the fact that it can be administered via a variety of modalities. It was noted that little was known about use in the adolescent age group.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-11**; **N-2**

- Some Committee members noted concerns with the proprietary nature of the PAM, as well as a wish to see more data and more of the calculation algorithm in order to more fully understand the linkage between the measure and feasible processes of care.

2483 Gains in Patient Activation (PAM) Scores at 12 Months
6. Public and Member Comment •
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

Appendix B: Person- and Family-Centered Care Portfolio—Use in Federal Programs

The measure evaluated in this cycle of the project is not currently used in federal quality improvement programs.

Appendix C: Project Standing Committee and NQF Staff

STANDING COMMITTEE

Lee Partridge (Co-Chair)
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Appendix D: Measure Specifications

	2483 Gains in Patient Activation (PAM) Scores at 12 Months
Status	Public and Member Commenting
Steward	Insignia Health
Description	The Patient Activation Measure® (PAM®) is a 10 or 13 item questionnaire that assesses an individual´s knowledge, skill and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale. There are 4 levels of activation, from low (1) to high (4). The measure is not disease specific, but has been successfully used with a wide variety of chronic conditions, as well as with people with no conditions. The performance score would be the change in score from the baseline measurement to follow-up measurement, or the change in activation score over time for the eligible patients associated with the accountable unit. The outcome of interest is the patient's ability to self-manage. High quality care should result in gains in ability to self-manage for most chronic disease patients. The outcome measured is a change in activation over time. The change score would indicate a change in the patient´s knowledge, skills, and confidence for self-management. A positive change would mean the patient is gaining in their ability to manage their health. A "passing" score for eligible patients would be to show an average net 3-point PAM score increase in a 6-12 month period. An "excellent" score for eligible patients would be to show an average net 6-point PAM score increase in a 6-12 month period.
Type	PRO
Data Source	Electronic Clinical Data : Electronic Health Record, Healthcare Provider Survey, Patient Reported Data/Survey PAM data have been successfully collected on the web through an online portal, over the phone, in-person (self-administered and interviewer-administered). A controlled trial showed no mode effects between web and phone administration (Greene, et al 2008). More than 120 organizations are administering PAM today over the phone, by paper, by Interactive Voice Response and online portal. See also: Greene J, Speizer H, Wiital W. "Telephone and Web: Mixed Mode Challenge." Health Services Research 43:1, 2008. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2323139/ Available in attached appendix at A.1
Level	Clinician : Group/Practice, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Dialysis Facility, Home Health, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Outpatient Rehabilitation, Pharmacy
Numerator Statement	The numerator is the summary score change for the aggregate of eligible patients in that unit (e.g., patients in a primary care provider´s panel, or in a clinic). The change score would be calculated from a baseline score and then a second score taken within 12 months of the baseline score (but not less than 6 months). The change score is the difference between the baseline and the second score in a 12-month period. The aggregate score would be the total

	2483 Gains in Patient Activation (PAM) Scores at 12 Months
	score for the eligible patient population. The total aggregate score could be a positive or a negative number. A "passing" score for eligible patients would be to show an average net 3-point PAM score increase in a 6-12 month period. An "excellent" score would be for eligible patients to show an average of a 6-point PAM score increase in a 6-12 month period.
Numerator Details	All patients are eligible to be included in the numerator, except children under the age of 14 and adults with dementia, or serious cognitive impairments. There is no need to risk adjust, as any patient, regardless of where they are starting, can make progress over time. In fact research shows that those who score in the lower levels of PAM are more likely to increase with appropriate interventions.
Denominator Statement	All patients can be included in the denominator, except children under the age of 14 and adults with a diagnosis of dementia or cognitive impairments (based on ICD codes). Also excluded would be patients who do not have two PAM scores. Finally, we exclude all patients who are at level 4 at baseline (as they are unlikely to gain in activation over time). To be considered for evaluation, an accountable unit would need to have two PAM scores per patient (taken no less than 6 months and not more than 12 months apart) on at least 50% of their eligible patients who had two visits during that time period.
Denominator Details	The denominator is the number of patients in the accountable unit (e.g., primary care provider panel, or clinic) that had two PAM scores during a 12-month period, taken no less than 6 months and not more than 12 months apart.
Exclusions	All patients who are at PAM level 4 at baseline, as their scores are unlikely to increase, and children under 14 and any adults who have a diagnostic code indicating dementia or cognitive impairment. ICD Codes include: 90.0 SENILE DEMENTIA UNCOMPLICATED 290.10 PRESENILE DEMENTIA UNCOMPLICATED 290.11 PRESENILE DEMENTIA WITH DELIRIUM 290.12 PRESENILE DEMENTIA WITH DELUSIONAL FEATURES 331.83 MILD COGNITIVE IMPAIRMENT
Exclusion details	Children under 14 and adult patients who have significant cognitive impairment should not be included in the measure. Those patients who did not have two visits during the year, and those patients who did not have two PAM scores during the year, would be excluded from the denominator. Accountable units should also exclude patients in the highest level of activation (level 4) if they are at level 4 in the baseline period. Patients at level 4 are less likely to gain in activation over time.
Risk Adjustment	No risk adjustment or risk stratification Rasch Analysis was used to develop the Patient Activation Measure. The analysis linking PAM with outcomes is based on multivariate (logistic and OLS regression) models that control for demographics and illness severity. These models are used to show the validity of the measure. The multivariate models are not necessary for using the PAM for a performance measure. Some of the research examines the link between PAM and outcomes for specific sub-populations, including disadvantaged populations.

	2483 Gains in Patient Activation (PAM) Scores at 12 Months
	For reference, see: Hibbard JH and Cunningham P. "How Engaged Are Consumers in Their Health and Health Care, and Why Does it Matter?" Center for Studying Health Systems Change Research Brief October 2008. http://www.hschange.com/CONTENT/1019/ Hibbard JH, Greene J, Overton V. "Patients With Lower Activation Associated With Higher Costs; Delivery Systems Should Know Their Patients' Scores." Health Affairs Feb. 2013. http://www.ncbi.nlm.nih.gov/pubmed/23381513 Hibbard JH, Greene J. "What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs." Health Affairs Feb. 2013. http://www.ncbi.nlm.nih.gov/pubmed/23381511
Stratification	N/A
Type Score	Continuous variable, e.g. average better quality = higher score
Algorithm	Difference between an aggregate baseline PAM score of eligible patients and the follow-up aggregate PAM score of eligible patients (not longer than 12 months after baseline or less than 6 months). PASSING: would be an average change score of 3 or more points. EXCELLENT: would be an average change score of 6 or more points. NO SPECIAL INTERVENTION: USUAL CARE Out of 295 primary care clinicians in a large integrated system, 62% would pass (their patients had on average 3 or more points increase). Patients in this system, were getting usual care. There was no special intervention to increase activation. Mean PAM Change Points for Patients by PCP CATEGORY Freq. Percent Cum%. ----------+---------- -25 thru 0 | 54 18.31 18.31 1 thru 2 | 59 20.00 38.31 3 or more | 182 61.69 100.00 ----------+---------- Total | 295 100.00 In the same delivery system we looked at how many clinics would get a passing grade. Out of 62 clinics (average of 3-4 PCPs) 66% would get a passing score (average PAM score change of 3 points or higher). TARGETED INTERVENTION TO INCREASE ACTIVATION In a separate analysis of 33 Insignia Health clients, where they were using a targeted intervention to increase activation, and included 19,882 patients, the findings were as follows: 33 clients of Insignia Health provided data on 19,882 patients who had at least 2 PAM scores. Across this diverse group of clients (e.g. state Medicaid, integrated delivery systems,

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	behavioral health, VA Clinics, etc), all were using the same targeted intervention to increase activation. Excluding patients who were at PAM level 4 at baseline, the average change score across all these programs was a positive 6.4 points (equivalent to our proposed EXCELLENT score). All of these 33 of these systems would have a passing or excellent score. References for point change criteria: Fowles J, Terry P, Xi M, Hibbard JH, Bloom CT, Harvey L. "Measuring self-management of patients' and employees' health: Further validation of the Patient Activation Measure (PAM) based on its relation to employee characteristics." Patient Education and Counseling Vol. 77 No.2:116-122. 2009. http://www.ncbi.nlm.nih.gov/pubmed/19356881 Hibbard, JH, Mahoney E, Stock R, Tusler M. "Do Increases in Patient Activation Result in Improved Self-management Behaviors?" Health Services Research 2007; 42(4). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955271/ No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: There are no competing measures.

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