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Assessing Clinicians' Endorsement of Patient Activation in Health Management

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ABSTRACT

Chronic condition management requires strategies to mobilize patients as active partners in their health. Primary care providers (PCPs) play a unique role in influencing patient activation (PA). This practice-based study explored the impact of a PCP-PA–tailored training on clinician adoption of strategies to influence PA. Before training, clinicians completed the Clinician Support for Patient Activation Measure survey, assessing their beliefs in PA, with 55% endorsing the importance of patient knowledge/involvement. In contrast, 1-month after training, over 85% agreed they were confident in recognizing the level of PA, and 71% reported modifying their practice to impact PA. Gains were retained at 3 months posttraining.

Keywords: clinician-patient interactions, Clinician Support for Patient Activation Measure, patient activation, primary care providers

The management of chronic conditions in the United States requires new strategies to mobilize patients to be active partners in their health. As the nation moves from fee-for-service reimbursement to a pay-for-performance model, payment will be associated with improved patient outcomes, quality, and restrained cost, rather than quantity of services.[1,2] The concept of empowering patients to have ownership in the management of their health/diseases is not new, yet the struggle continues with ways to actually enhance patient activation (PA). There is 1 validated psychometric tool, which was developed by Hibbard et al in 2004,[3] known as the Patient Activation Measure (PAM). The PAM assesses patient knowledge, skill, and confidence for self-management and scores them into levels of 1 through 4 according to an assigned stage of activation.[3] The use of PAM scores becomes advantageous because a participant's score can serve as a guide for tailoring disease-specific interventions with cost savings.[3-8]

Prior research has shown that departures from traditional patient-clinician roles are positively correlated with higher PA, but success of this dynamic relies on clinician motivation for patient engagement and training.[9,10] Primary care providers (PCPs) have a crucial role in supporting PA, yet most do not receive training that incorporates motivational strategies for partnering with patients.[11] A new and reliable tool to assess and differentiate between clinicians who support PA is called the Clinician Support for Patient Activation Measure (CS-PAM).[12] Additionally, the literature on motivational interviewing (MI) shows the applicability and feasibility of its methods despite real-time limitations that PCPs encounter during face-to-face office visits.[13]

The purpose of this project was to develop, deliver, and evaluate a tailored PA educational teaching module for PCPs practicing in internal and family medicine. The teaching module was based on the strategies of MI best suited to a patient's PAM score. The primary objective was to promote behavior change in participants, which would in turn promote PA in their patients. A secondary objective was to assess if there were specific clinician characteristics that were correlated with a greater acceptance of PA.

METHODS

This project incorporated a preintervention CS-PAM and 1- and 3-month postintervention surveys of participating family or internal medicine PCPs (MDs, nurse practitioners, and physician assistants) from a

large Southern California multispecialty medical group serving patients at least 18 years or older with known diabetes mellitus type 2 and/or chronic obstructive pulmonary disease. The educational session was held in a conference room at the participants' place of work. Each 60-minute session included 3 to 8 participants. The session started with a short introduction to the methods of MI and PAM followed by group discussions of vignettes that included patients' diagnosis and PAM score. Discussion focused on specific skills and strategies clinicians could use to tailor interventions and health messages to a patient's level of activation.

Instruments

Demographic Survey. An online 7-question survey was administered to collect information on clinician variables that might influence PAM adoption, such as professional status, years in practice, specialty, age, sex, and ethnicity.[11,12]

CS-PAM. A preintervention online survey was administered to assess clinicians' PA readiness through the CS-PAM. The CS-PAM was adopted from the PAM, a psychometrically validated instrument that reflects a developmental model of activation of patients.[3,14] Evidence supports the construct validity of PAM, with scores of higher activation reporting better health ($r = .38$, $P < .001$) and lower rates of office visits, emergency room visits, and hospital nights ($r = .07$, $P < .01$).[3] CS-PAM used the same Rasch analysis as PAM and showed overall sound psychometric properties, with a Cronbach alpha of 0.86, person reliability of 0.80, infit and outfit scores within the acceptable range, and the 14 items calibrated between 34 and 68.[12] CS-PAM 13 is a shorter version of the original 14-item CS-PAM, showing similar psychometric properties as its parent.[12,14]

Clinicians' attitude toward PA was scored on a 5-point scale (1 = not important, 2 = somewhat important, 3 = important, 4 = extremely important, and 5 = not applicable), and a raw score was calculated by summing the responses. Items with no response or with a "not applicable" response were scored as "missing." A sum score was calculated with a potential range from 1 to 100, with higher scores indicating more positive beliefs about the importance of a patient's role in his or her health care and thus a more engaged clinician. The raw scores were converted into 3 activation levels; level 1 (scores $\leq$ 58.6) implies that a clinician believes a patient should follow medical advice, level 2 (scores between 58.6 and 69.9) indicates that a clinician believes that a patient can make independent judgments and actions related to the management of his or her health; and level 3 (scores $\geq$ 70.00) means the clinician believes that a patient can function as part of the care team and seek information independently.[15]

Postintervention Survey. A 10-question survey was administered at 1 and 3 months after training to assess the clinicians' understanding of PA and the level of adoption into their clinical practice. Expert reviewers and the PCPs who approved the educational training confirmed face validity. To provide additional information on 3 of the Likert scale questions, 3 open-ended questions were included. Conventional content analysis was used to identify themes in the open-ended responses.

RESULTS

Of the 42 PCPs invited to participate in the presurvey, 40 completed the demographics survey, for a response rate of 95%. In the final analysis, 9 questionnaires were further omitted: 3 because participants did not complete the training, and 6 because all scores on the 1-month postintervention survey were missing/skipped. Thirty-one participants completed the 1- and 3-month postintervention surveys. Thus, the final sample size of the study was 31, for a response rate of 73.8%, with 27 physicians, 3 nurse practitioners, and 1 physician assistant. Participant demographic characteristics remained unchanged when comparing the original 40 PCPs with the 31 participants who completed the postintervention surveys.

Of the 31 PCPs who completed the CS-PAM and the postintervention surveys, 14 scored below 61.90 (level 1 CS-PAM), 5 scored between 67.67 and 75.20 (level 2 CS-PAM), and 12 scored between 83.10 and 100.0 (level 3 CS-PAM). There was no statistically significant association found among PCPs' age, ethnicity, or professional preparation and CS-PAM