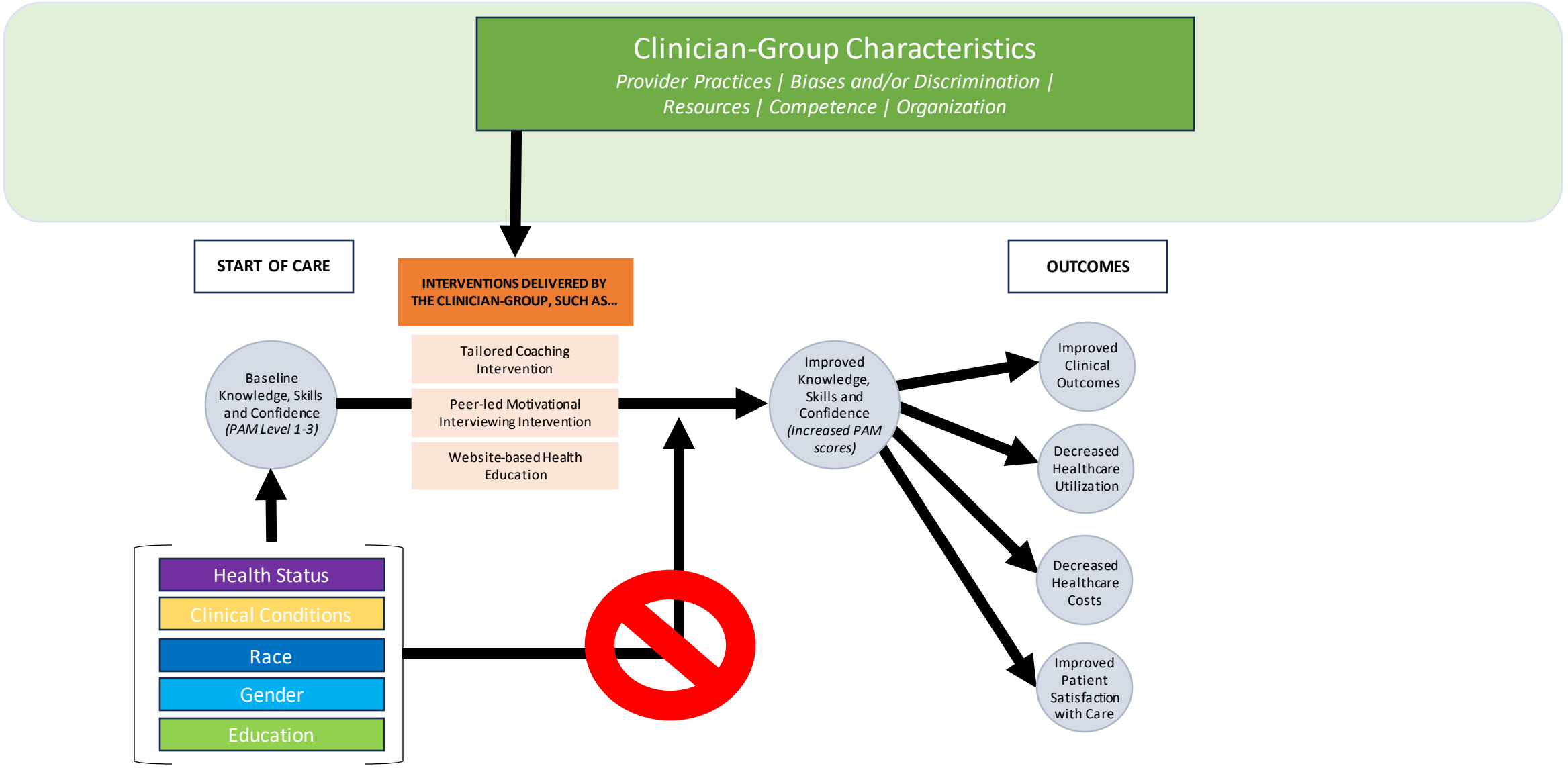
Figure 3. Conceptual Model for No Risk Adjustment



We have attached a conceptual model (Figure 3) that illustrates our rationale for not risk-adjusting the PAM-PM, that builds on our overall measure logic model.

Based on prior research, we know that certain clinical and/or socioeconomic status categories may impact baseline levels of patient activation; however, activation is not a static trait; in fact, once a patient's care team is aware of their PAM level, teams can intervene to improve patient activation. Through appropriate interventions, like tailored support, anyone (regardless of their starting PAM level) can become more activated and have better health outcomes. We anticipate variability in accountable entities' ability and skill in delivering those activation interventions, related to resources, intervention competence, potential biases/discrimination, and other organizational factors.

In all populations, regardless of demographic characteristics, when interventions are tailored to a specific patient's PAM level, we see that lower activated patients are able to achieve higher score changes. When AM is used in Medicaid, duals and uninsured populations, we still see a full range of PAM levels in each group. When resources are focused on the low activated patients within the group, we see increase in scores and meaningful reductions in utilization and costs. Said another way, while we see a full range of PAM scores across patient groups, and while there may be differences in baseline PAM scores, , what we find is that the ability to improve in PAM-assessed activation is not bound by demographic and health factors. Patients, when appropriately supported, can improve their PAM scores. The resulting changes in activation have been shown to lead to improved clinical outcomes, decreased healthcare utilization, decreased healthcare costs, and improved patient satisfaction with care through improved health behaviors, navigation, and communication.