Partnership for Quality Measurement
Powered by Battelle

National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2024 Cycle Endorsement and Maintenance (E&M) Meeting Discussion Guide

PRIMARY PREVENTION COMMITTEE

July 26, 2024

Prepared by:
Battelle
505 King Avenue, Columbus, Ohio 43201

The analyses upon which this publication is based were performed under Contract Number 75FCMC23C0010, entitled, "National Consensus Development and Strategic Planning for Health Care Quality Measurement," sponsored by the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Table of Contents

List of Tables

List of Figures

Overview of Spring 2024 Measure for Committee Review

For this measure review cycle, one measure was submitted to the Primary Prevention committee for endorsement consideration (Table 1). The measure focused on Patient Activation Measure (PAM) Scores (Figure 1).

Table 1. Overview of Measures Under Endorsement Review

CBE Number	Measure Title	New/Maintenance	Developer/Steward
#2483	Gains in Patient Activation Measure (PAM) Scores at 12 Months	Maintenance	Insignia Health

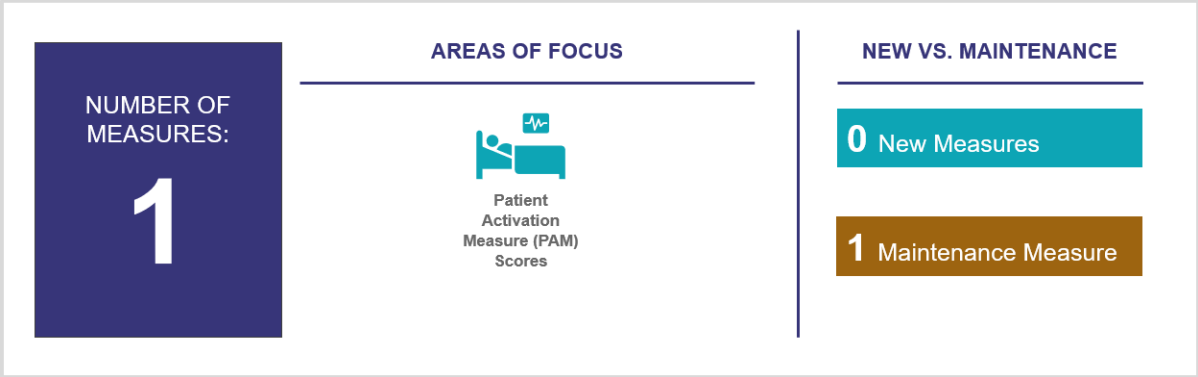

Figure 1. Spring 2024 Measures for Committee Review

Public Comment

Battelle accepts comments on measures under endorsement review through the Partnership for Quality Measurement (PQM) website and Public Comment Listening Sessions. For this evaluation cycle, the public comment period opened on May 16, 2024, and closed on June 14, 2024, and the Public Comment Listening Session was held on May 29, 2024.

Battelle received 10 public comments prior to the endorsement meeting. Nine comments expressed support for the measure, emphasizing the importance and impact of this measure from both a clinical and patient perspective. The remaining comment was a question regarding the measure's threshold at the individual patient level.

After the public comment period closed, developers/stewards had the opportunity to submit written responses to the public comments received. Summaries of the public comments and developer/steward responses are provided within the respective measure evaluation summaries of this discussion guide below.

Advisory Group Feedback

The Advisory Group was convened on June 3, 2024. Seven of 12 (58%) active Advisory Group members were in attendance to share feedback and ask questions regarding the measures

under endorsement review. Developers/stewards of the respective measures were also in attendance and provided responses to the Advisory Group discussions. After the meeting, developers/stewards had the opportunity to submit additional written responses to Advisory Group member feedback and questions.

Summaries of the Advisory Group member discussions and developer/steward responses are provided within the respective measure evaluation summaries of this discussion guide below.

To support the review of the public comments and Advisory Group summaries, the number of comments or individuals that shared similar comments, feedback, and/or questions is represented as “a few” (2-3 individuals), “several” (4-6 individuals), and “many” (more than 6 individuals).

Measure Under Endorsement Review

CBE 2483: Gains in Patient Activation Measure (PAM) Scores at 12 Months [Insignia Health]

Measure Description:

The measure is the percentage of patients who achieve a 3-point increase in their Patient Activation Measure® (PAM®) survey score within 12 months. The outcome measure demonstrates how a clinician group performed in providing best care to its patients by quantifying the proportion of patients who had at least a 3-point score change. The PAM surveys the knowledge, skill, and confidence necessary for self-management on a 0–100-point scale that can be broken down into 4 levels from low activation to high activation. The 13 (or 10) item survey has strong measurement properties and is predictive of most health behaviors, many clinical outcomes, and patient experience. PAM® scores are also predictive of health care costs, with lower scores predictive of higher costs.

Measure Status	
New or Maintenance: Maintenance	**Used in An Accountability Application?** Yes • Payment Program • Quality Improvement (Internal to the specific organization)
CBE Endorsement Status: Endorsed **Last Endorsement Review Cycle:** Spring 2016	**Proposed/Planned Use:** Merit-based Incentive Payment System (MIPS)

Measure Characteristics

Measure Type	Target Population(s)	Level of Analysis	Care Setting(s)
Patient-reported Outcome-Based Performance Measure (PRO-PM)	Eligible patients with at least two PAM scores no less than 6 months and not more than 12 months apart	Clinician: Group/Practice	Clinician Office/Clinic

Measure Overview
Rationale: The Patient Activation Measure® (PAM®) is a 10 or 13 item questionnaire that assesses an individual´s knowledge, skills and confidence for managing their health and health care. A positive change would mean the patient is gaining in their ability to manage their health. 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 medical diagnosis. The PAM is predictive of most health outcomes, including such diverse outcomes as how a patient fares after orthopedic surgery; remission of depression over time; the likelihood of hospital re-admission or

ambulatory care sensitive (ACS) utilization; the trajectory of a chronic disease over time; and even the likelihood of a new chronic disease diagnosis in the coming year. PAM scores are also predictive of health care costs, with lower scores predictive of higher costs.

The PAM is in use both in the US and internationally in research (including more than 850 peer-reviewed journal articles) as well as clinical settings. It has been translated into more than 30 languages. Because researchers all over the world use PAM, we have been able to validate the instrument with people of different racial and ethnic backgrounds, and with people from different socio-economic levels. The measure has been shown to be valid and reliable in different clinical settings and under different payment models.

Numerator:
The numerator includes eligible patients whose PAM score increased by at least 3 points in a 6-12 month period.

Denominator:
The denominator includes eligible patients with two PAM scores no less than 6 months and not more than 12 months apart who were seen for a qualifying visit at least once during the performance period.

Clinician groups would need to have two PAM scores on a minimum of 50 patients.

Exclusions:
Diagnosis of Dementia (ICD-10-CM): F01.5, F02.80, F02, F03.9, F10.27, F10.97, F13.97, F13.27, F18.17, F18.27, F19.97, F19.17, F19.27, G31.0

OR

Diagnosis of Huntington's disease (ICD-10-CM): G10

OR

Diagnosis of Cognitive Impairment or Alzheimer's disease (ICD-10-CM): A81.00, A81.09, G20.0, G30.0, G30.1, G30.9, G31.01, G31.84, G40.909, I67.850, R41.0

Measure is Risk-Adjusted and/or Stratified:
No risk adjustment or stratification

Logic Model

Summary:
The logic model highlights how improving patient activation (as measured with the PAM survey) can lead to improved health-related outcomes. A clinician group assesses patients' knowledge, skills, and confidence for self-management to identify patients (i.e. those with baseline PAM Levels 1-3) who may benefit from an intervention to improve their self-management skills (i.e. increased PAM score). Those interventions lead to improved health behaviors, navigation, and communication, which in turn lead to improved clinical outcomes, decreased healthcare utilization, decreased healthcare costs, and improved patient satisfaction with care. Patients with baseline PAM Level 4 scores (the highest level of activation) are less likely to benefit from intervention to improve their PAM scores and so are excluded.

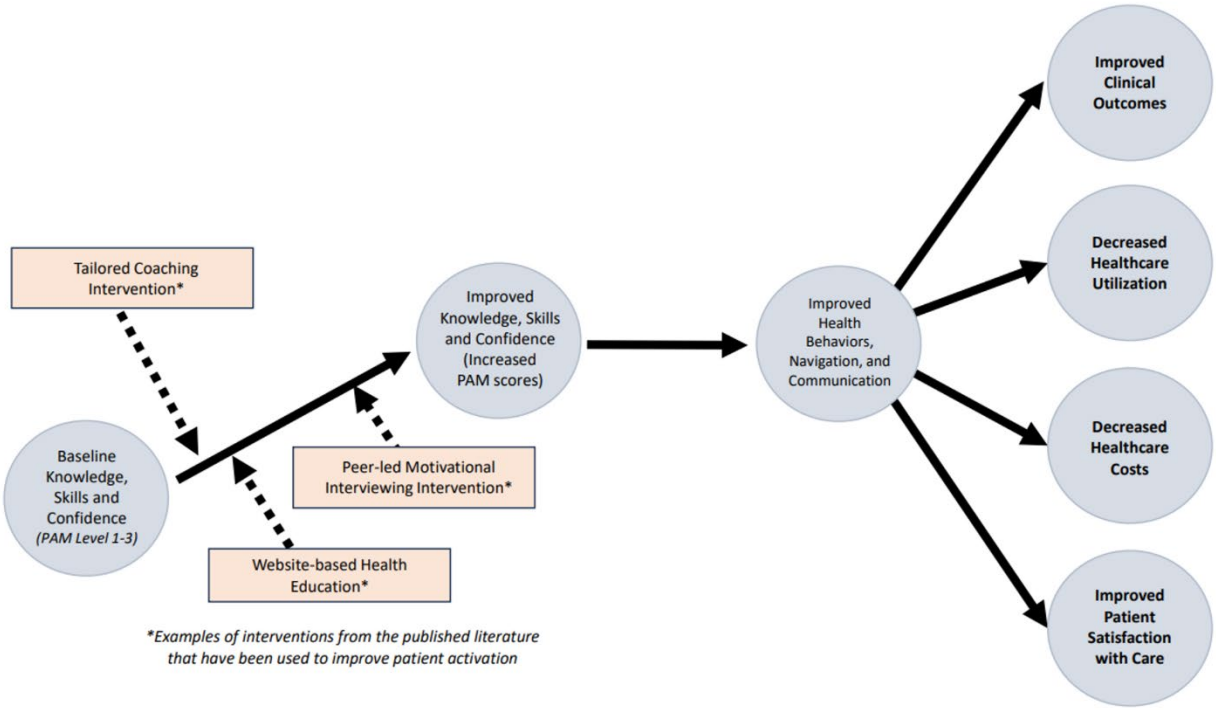

Figure 2. CBE #2483 Logic Model

Measure Evaluation Summary: CBE #2483

Importance
Staff Preliminary Rating: Met
• **Importance**: The developer cites several systematic reviews that have demonstrated an association between patient activation and material outcomes such as avoidable emergency department (ED) use and health-related quality of life. Overall, use of this measure informed decision-making for entities and individuals, and the measure has modest potential for improvement.

Feasibility
Staff Preliminary Rating: Met
• **Feasibility:** Data are collected using a relatively low burden survey instrument. Overall, the measure has been used for many years in multiple settings.

Reliability	
Staff Preliminary Rating: Met	
Testing Level:	Accountable Entity Level
Testing Method:	Reliability testing was conducted using **a beta-binomial approach.** The results reported across all three datasets have a mean reliability exceeding 0.8.
• **Reliability:** The measure is well-defined. Reliability was assessed at the entity level. Reliability statistics are above the established thresholds for all but a few entities.	

Validity	
Staff Preliminary Rating: Met	
Testing Level:	Accountable Entity Level
Testing Conducted:	Empirical validity testing was conducted to test the pathway defined in the logic model that increased PAM scores lead to improved health behaviors, navigation, and communication, which in turn leads to improved patient satisfaction with care. The developer tested the following hypothesis: As average measure performance improves at the accountable entity, average ratings of patient satisfaction with care at the accountable entity also improves. The developer conducted validity testing using **an Ordinary Least Squares (OLS) regression analysis,** and results reported a statistically significant positive association between the performance measure and patient satisfaction with

	coefficient effect size 1.13 (0.1->2.16) and p-value 0.03. The Pearson's correlation coefficient showed a similar statistically significant positive association between the PAM-PM measure and patient satisfaction of 0.43 with p-value 0.03.

- **Validity:** Overall, based on the strength of the body of clinical study evidence, the measure strongly demonstrates the association between the entity and the measure focus.

Equity	
Staff Preliminary Rating: Met	
Equity Considered:	Yes

- **Equity:** Overall, there does not appear to be detectible differences in performance scores across subgroups, and there does appear to be some reason to claim that increasing patient activation would reduce disparities.

Use & Usability	
Staff Preliminary Rating: Met	
Current or Planned Use:	Measure is currently used in the Merit-based Incentive Payment System (MIPS).

- **Use & Usability**: The developer references studies that demonstrate approaches to overcoming barriers to increasing patient activation in challenging populations (e.g., chronic conditions). The measure also is used in a structured quality improvement program.

Public Comment[1]

Number of Comments Received: 10

Full text of developer/steward responses can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
Nine comments expressed support for re-endorsement of this measure. Support from clinical and patient perspectives were represented through these comments.	Support	We thank you for this positive feedback.

[1] Comments, as submitted, can be found on the PQM website.

Comment Summary	Support Level	Summary of Developer Response
One individual raised a question related to the topic of the measure's threshold and what that looks like at the individual level.	N/A	Thank you for this important question. Because the PAM-PM is focused on patients' gains in activation, we do focus only on those patients who are at PAM Level 1, 2, or 3. Patients with the highest levels of activation (Level 4) are unlikely to improve at an individual level. Decisions on how these highly activated patients are treated in follow-up program years have typically been decided at the program level.

Advisory Group Feedback

Full text of developer/steward responses can be found on the PQM website.

Feedback/Questions	Summary of Developer Response
Bias Toward Healthier Patients: One committee member asked if the PAM scores are biased toward folks who are in better health than others.	The developer responded that the measure focus is on gains in scores over time, so if a patient population started at a lower baseline, the accountable entity's ability to improve over time is not impacted by those baseline scores. The developer used socioeconomic status (SES) as an example and noted that those with lower SES can still gain a 3-point score change, which is clinically and statistically meaningful. *Summary of Response Received after the Advisory Group Meeting:* None.
Patient Activation: One committee member requested clarification regarding the expectations for when a patient should be activated, as there may be certain situations when activation is not appropriate. For example, if someone has a sprained ankle, would they need to be activated?	The developer agreed that it may not be appropriate to assess patient activation using the PAM survey for every visit type. Developers have found that people in acute distress provide less reliable data, so they recommend using the survey for routine visits rather than for sick visits when the patient is experiencing discomfort. *Summary of Response Received after the Advisory Group Meeting:* The developer agreed that it may not be appropriate to assess patient activation using the PAM survey for every visit type. Developers have found that people in acute distress provide less reliable data, so they recommend using the survey for routine visits rather than for sick visits when the patient is experiencing acute distress. However, given the reality that some sick patients may be candidates for an activation intervention, the developer believes that providers and clinician-groups are in the best position to make this determination.

Response Bias: One committee member asked how response bias is handled; specifically, how may a patient's case affect how they respond to the survey?	The developer responded that the types of bias being discussed are handled at the program level. The re-administration rate that would be required for a specific program that might implement the PAM performance score would be the best potential safeguard for the types of bias being discussed. As measure developers, they will continue to monitor the potential impact of non-response on reliability and validity of the measure. *Summary of Response Received after the Advisory Group Meeting:* None.
Electronic Use of the Measure: A few committee members expressed interest/support of this measure expanding to electronic use. One committee member said that this would be an important adoption for wider use. Another member asked if the developer is pursuing licensing opportunities for various electronic health records (EHRs) systems so the measure could be more rapidly operationalized in routine clinical care.	The developers are working to help make the PAM performance measure more readily available in electronic health records. They are actively working with EHR systems to help facilitate broad adoption of the PAM performance measure to meet clinician and clinician groups where they are at. *Summary of Response Received after the Advisory Group Meeting:* None.
Proxies: One committee member asked whether the developer had any data on proxy use.	The PAM survey is a family of measures that include caregiver report, and patient report. This measure's focus is on a patient primary report. The development of a proxy measure may be considered down the line. *Summary of Responses Received after the Advisory Group Meeting:* The PAM survey is a family of measures that includes the Caregiver PAM, Parent PAM, and the Patient PAM. This measure—CBE #2483—focuses on the Patient PAM and is intended to specifically capture the patient's perspective. The development of a measure focused on the caregiver or parent may be considered in the future.
Target Population Age: One committee member asked why the age range drops down to 14.	Data suggest that the PAM survey does work with younger populations—specifically adolescents who are dealing with chronic illness and are moving into a phase where they must take on more responsibility. Individual programs may decide that it is not necessary to range down to 14—they may focus on 18+— but it is included for availability. *Summary of Response Received after the Advisory Group Meeting:* None.

Health Literacy: One committee member asked if research had been done on patients with lower health literacy and whether the patient would switch to one of the other translated versions of the measure.	The PAM survey was written at grade school reading level. Close to 50 linguistic translations of the PAM survey and its variants are available. It is a programmatic decision on how to best screen for and provide these translations. *Summary of Response Received after the Advisory Group Meeting:* None.

Key Discussion Points:

- **Bias:** The Advisory Group questioned whether the measure is biased toward healthier patients and how response bias is handled.
    - The developer responded, noting that the measure focus is on gains in scores over time, so if a patient population started at a lower baseline, the accountable entity's ability to improve over time is not impacted by those baseline scores. Regarding response bias, the developer noted that this is handled at the program level and improving re-administration rates would be the best potential safeguard.
- **Electronic Use of the Measure:** The Advisory Group expressed interest in having this measure used within electronic health record systems.
    - The developer noted that they are pursuing having this measure used within EHR systems.
- **Proxies:** The Advisory Group questioned whether there was any proxy use.
    - The developer noted that this measure is strictly for patient primary report and would consider a proxy measure in the future.
- **Target Population Age:** The Advisory Group questioned why the age range includes 14 and whether there was any information on health literacy and the use of the survey.
    - The developer noted that the PAM survey has been shown to work in adolescents. With respect to health literacy, the developer noted that the survey is at a grade school reading level, with close to 50 linguistic translations.