Graduate high-risk patients to self-management

Ground your care management strategy in self-management from the start

A small subset of patients disproportionately drive health care utilisation. But programmes that target this population are usually resource-intensive and difficult to scale. The solution? Design a high-risk patient programme that ultimately 'graduates' patients to self-management. You'll be able to help more patients, and they'll gain more ownership of their health.

Use this four-phased approach to embed graduation in your care management programme and help your patients become stewards of their own care.

Phase 1: Identification—select patients who will benefit from a self-management programme

Phase 2: Active management—remove non-clinical barriers to self-management

Phase 3: Graduation—transition patients out of programme

Phase 4: Post-graduation—establish infrastructure to support continued self-management

PHASE 1: IDENTIFICATION

Target patients with reducible demand

Myth: Intervening with our sickest, costliest patients is the best opportunity to reduce demand and costs.

Reality: Utilisation and cost data are only a small part of what makes a patient ideal for care management.

How to move from myth to reality:

Target patients who are most likely to succeed in a programme aimed at self-management.

Start with **inclusion** criteria (like cost, utilisation, or number of chronic conditions), and overlay **exclusion** criteria to narrow the list to patients who are most likely to reduce demand.

Example exclusion criteria: patients better suited to a specialised treatment programme (like HIV patients), or those who require unavoidable inpatient care (like active cancer treatment).

Tailor care to each patient's activation level

Myth: All high-risk patients need the same care.

Reality: Every patient comes to you at a unique point in their self-management journey.

How to move from myth to reality:

Even patients with similar conditions and backgrounds can have very different 'activation' levels based on their knowledge, skills, and confidence in managing their own care.

Use the Patient Activation Measure to consistently assess each patient's starting point and build a care plan to meet each patient where they are at enrollment.

Develop standardised care pathways for each activation level to build patients' self-management abilities over time.

PHASE 2: ACTIVE MANAGEMENT

Equip patients with skills to navigate everyday life

Myth: If we tell patients plenty of information about their conditions, they'll know how to manage their health.

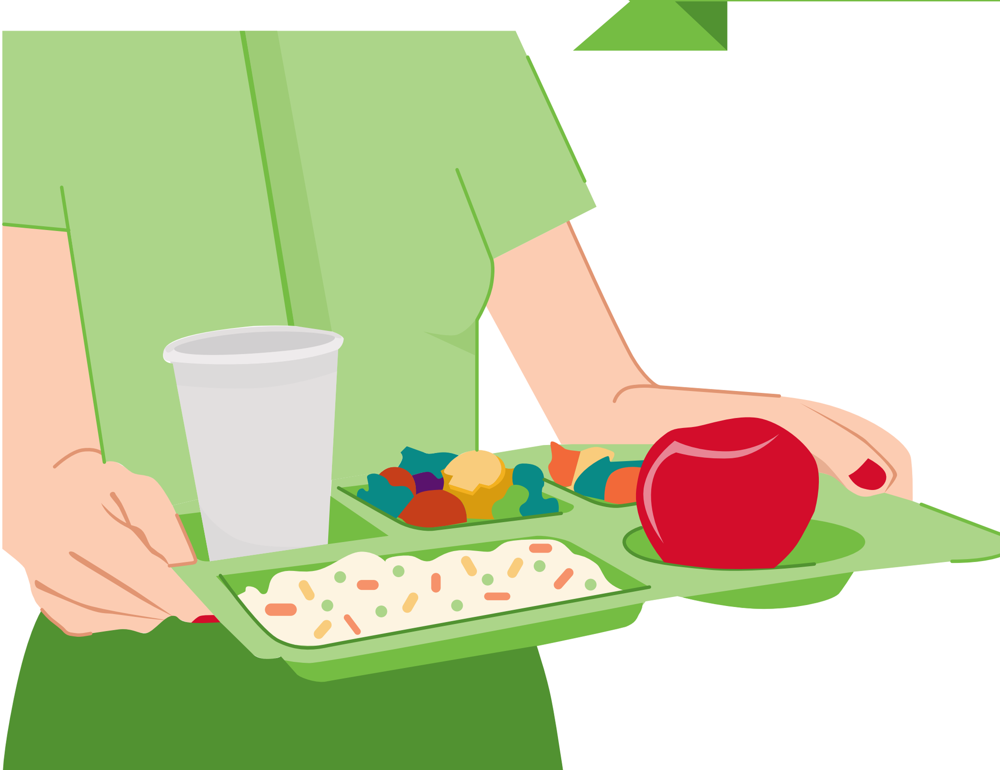
Reality: Outside the walls of health care facilities, patients encounter many obstacles self-management. Clinical knowledge alone isn't enough to navigate these challenges.

How to move from myth to reality:

Equip patients with a few core skills to navigate various obstacles—exemplary models focus on action planning, decision-making, and problem-solving.

Consider licensing the Self-Management Resource Center's (SMRC) six-week skills development curriculum or look for local partners delivering similar workshops.

Build bridges between clinical and non-clinical sectors



Myth: The right clinical care is all patients need to succeed.

Reality: Medical care accounts for only about 10% of health outcomes.

How to move from myth to reality:

To enable self-management, it's crucial to address non-clinical factors, such as physical environment and social circumstances. But don't feel like you need to do it all yourself.

Focus on connecting your clinical work with existing non-clinical supports. This may include curating a network of community partners, hiring staff to facilitate patient connections, or paying for non-clinical services.

PHASE 3: GRADUATION

Establish clear criteria to assess readiness to graduate

Myth: Patients won't want to leave our programme because they're reluctant to lose support.

Reality: Patients value independence and spending time away from health care facilities, as long as they feel prepared.

How to move from myth to reality:

Establish clear criteria to assess readiness, so graduation is based on individual progress rather than a fixed timeline.

Be sure to set the graduation expectation with patients and providers from the start. Celebrate graduation as a milestone of success once it's reached.

PHASE 4: POST-GRADUATION

Invest in virtual tools to scale self-management

Myth: If we graduate patients they'll just backslide into old habits.

Reality: While behaviour change is difficult to maintain, often people just need a little extra support.

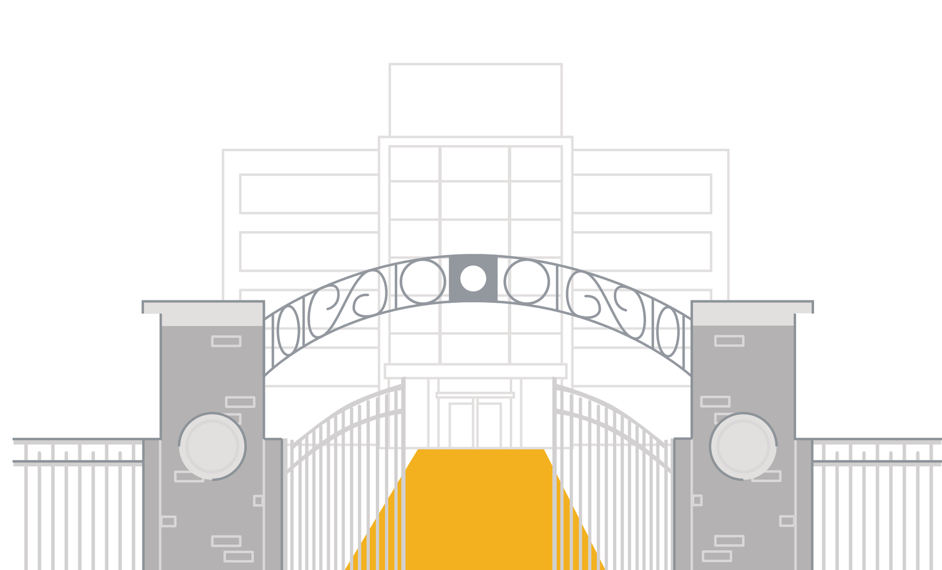
How to move from myth to reality:

Use virtual resources to extend support to all graduated patients in a scalable way.

Think about what your patients need to stay graduated and whether a virtual tool can fill that gap. Do patients need quick answers when unexpected questions arise? A tool to self-monitor health status? Something else?

Look for virtual tools that fill this need in a frictionless way—meaning they're accessible, convenient, and reliable.

Create a safety net for self-managing patients who escalate



Myth: Graduation means these patients won't need us again in the future.

Reality: Uncontrollable factors can knock even the most successful self-managers off course.

How to move from myth to reality:

Acknowledge and prepare for this reality by establishing fail-safe systems to 'catch' patients when they fall.

Set up a mechanism to quickly flag patient readmissions, and train staff on a standard protocol to reach out to patients and identify the root causes for readmission in a timely manner. To address these root causes, link into community partners.

When patients escalate, avoid the temptation of hanging onto them for too long. Establish a process to transition them back to self-management.

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