Target patients with reducible demand

How to move from myth to reality:

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

Reality: Patients won’t want to leave our programme or look for local partners delivering similar workshops.

Example exclusion criteria: patients better suited to a shared care model (like those with limited resources for an extended period of time), or those who require unavoidable inpatient care (like those with active cancer treatment).

The AIM tool is a useful exclusion criteria guide to help with programme development.

Build bridges between clinical and non-clinical sectors

Myth: Intervening with our sickest, costliest patients is a failure in the care delivery system.

Reality: Medical care accounts for only about 10% of health utilisation and cost data are only a small part of what makes a patient ideal for care management.

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:

Myth: Patients are empowered to manage their health in the same frictionless way—meaning they’re accessible, convenient, and reliable.

Reality: Equipping patients with skills to navigate everyday life.

Equipment plays an important role in building a patient’s confidence in managing their own care.

How to move from myth to reality:

Myth: Self-management is a skills acquisition exercise.

Reality: Patients learn a number of skills to navigate various activation levels.

How to move from myth to reality:

Myth: Patients will benefit equally from programmes regardless of their non-clinical factors, such as physical environment and social circumstances. But don’t feel like you need to do it all yourself.

Reality: Focus on connecting your clinical work with existing non-clinical resources. This may include curating a list of local clinical and non-clinical supports.

Medical care accounts for only about 10% of health utilisation.