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Post-hospital stay therapies, interventions for chronic conditions, and even the simplest of preventive care regimens often rely heavily on member self-management. How can care and case managers influence action and help members make more proactive care decisions that ultimately improve health outcomes? We're sharing proven strategies in this white paper.

→ **Help Members Make More Proactive Care Decisions...
Through Engagement and Collaboration**

Help Members Make More Proactive Care Decisions... Through Engagement and Collaboration

The potential for improving self-care and achieving optimal results is tied to member engagement and collaboration across the care ecosystem. Engage members and their families, communities and care teams and encourage them to communicate with one another and take an active role in care management and decision-making.

What better way to net care that truly fits an individual's specific needs, preferences, goals and values than through active engagement and understanding of an individual's circumstances? And who better to provide that perspective than the members themselves and their trusted circle?

→ **Through Improved Health Literacy**

According to the National Library of Medicine, “personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. Examples of personal health literacy include understanding prescription drug instructions, understanding doctor’s directions and consent forms, and the ability to navigate the complex healthcare system.”ⁱⁱⁱ

Determine each individual's health literacy and fill in the gaps as needed.

One way to support good health literacy and informed decision-making is through the use of decision aids.

When members face medical decisions, they are often presented with multiple choices. Each option has benefits, side effects and costs associated with it. Good decisions can't be made without the right information. Unfortunately, "patients often are insufficiently involved in care decisions," reports the Institute of Medicine. And "fewer than half of patients receive clear information on the benefits and trade-offs of the treatments for their condition."^v

“Decision aids provide balanced information on diagnostic and treatment options, including risks and potential outcomes, and help patients consider what factors are most important to their decision. The goal is to help patients identify the diagnostic technology or treatment that best meets their needs, goals, and circumstances. Studies of such tools have found that they increase patients’ knowledge and understanding of benefits and risks and encourage them to participate in decisions.”^{vi}

Another way to support good health literacy is by encouraging members to tap into available programs and educational resources that will help them understand and manage their care, including patient and family councils for disease support.

Regardless of where health literacy starts, information sharing is key. Identifying the right intervention—from



medications to surgeries—requires members to know and understand their options, but also those who treat and guide the member to know and understand them as individuals.

When you can bridge the gap between ensuring members understand their choices while demonstrating that you understand how the member's life circumstances impact their decisions, it goes a long way toward helping members feel they've made a good decision. And comfort and clarity with a decision can encourage members to self-manage well through to the desired result.

Through Wellness Programs and Omnichannel Outreach

Whether it's sponsored by an individual's health plan, employer, or community, studies show wellness programs have the ability to improve health behaviors. Even seemingly small changes can have a statistically significant impact. For example,



"The New England Journal of Medicine reported that for every 1% drop in total cholesterol, the risk of having a heart attack dropped by 2 to 3%. For every one-point drop in elevated diastolic blood pressure, there is another 2 to 3% drop in heart disease risk."^{vii}

When possible, steer members toward available wellness programs. Likewise, develop digital wellness campaigns that share educational information, such as healthy eating tips and average timelines for beginning preventive care screenings.

With the right technology, you can even use campaigns with auto-workflows to automate outreach to target populations, as well as solutions that make it possible to not only integrate educational information, but track how members interact with that content.

And if you have the digital capabilities for both omnichannel outreach and inbound support, ensure members know the options available to them—from virtual visits, secure messaging, and self-scheduling, to ways they can access their personal health record (PHR), request prescription refills, pay their bills, and get customer service support. The more ways they can take control over their care, the greater the chance they'll use the opportunity to take proactive steps.

By Embracing Digital Care Management Technology

We chose the word embracing instead of use because this isn't just about accessing healthcare data and reporting. This is about leveraging all the digital tools at your disposal—omnichannel engagement, campaign outreach, digital scheduling, predictive analytics, clinical alerts, smart workflows, and more—to motivate and empower members and influence their behavior.

A good place to start is evaluating care management activities to determine where efforts and technology can be combined in meaningful ways.

For example, merge educational outreach with care management workflows. If you're focusing on reducing emergency department visits among a high-use population, set an alert to reiterate appropriate usage on your calls with those individuals. Follow that up with an educational campaign detailing when to visit an ER vs. when



to call the doctor. Collaborate with providers to reinforce the message during patient encounters. And keep family members and caregivers who are part of the member's trusted circle informed so they can support making appropriate, healthy and cost-effective decisions.

By Activating Self-Care Through Technology

Embracing technology also benefits members. As appropriate, encourage members to take advantage of technology-enabled self-care tools, such as:

- ✓ Mobile apps to record and track health information like diet, weight, exercise, blood pressure, etc.
- ✓ Secure texting to communicate with care providers and get their questions answered
- ✓ Remote patient monitoring tools to share essential information with care providers who can proactively intervene when necessary
- ✓ Apps that trigger texts with motivational or behavioral change support messages
- ✓ Weight loss or stress reduction programs that deliver videos by phone to encourage individuals to stick to their goals and mitigate the risk of worsening conditions

Through Effective Management of Care Transitions

Navigating the healthcare ecosystem can be challenging even for those within it, so you can imagine the perspective of members who are experiencing transitions of care, such as moving between different providers or care settings, or from a hospital setting to a skilled nursing facility.

Some members don't receive enough information to know what steps to take next, when they can resume normal activities, what side effects or complications they should be monitoring, and who they can turn to if they have questions. Some members receive too much information to process or more details than they can remember, especially at a time when they may still be reeling from a frightening experience or a new diagnosis.

The more complicated and confusing the journey, the greater the chance members will return to emergency departments, experience hospital readmissions and neglect to follow-up with primary care physicians.

There can be shared responsibilities when breakdowns in care transitions occur. Even the communication style of the person providing the information can be a factor. "Provider-patient communication about prognosis and preferences for care is critical in helping patients adequately prepare for and plan future care, and physicians' communication style may affect patients' satisfaction, trust, willingness to cooperate, and health status," notes the Agency for Healthcare Research and Quality (AHRQ).^{viii}

There can also be penalties for the organizations involved. For example, in 2013, approximately two-thirds of U.S. hospitals faced financial penalties from CMS because of excessively high 30-day readmission rates for acute myocardial infarction, heart failure, and pneumonia.^{ix}

To help improve care transitions, consider Coleman's Four Pillars of care transition activities. These include medication self-management, patient-centered health records, appropriate follow-up with primary care providers and/or specialists, and patient knowledge about "red flags" – signs that indicate worsening conditions or drug reactions and how to respond/report them.^x



Managing care transitions, both big and small, needs to be a primary focus for any care management program. These are moments that can serve as opportunities to engage and intervene with profound results.

Leverage metrics to identify and risk stratify populations, then align care management activities to the needs of those specific populations. For example:

- ✓ If you identify populations with modifiable (controllable) risks, you can develop risk-based approaches tailored to those individuals with the goal of minimizing their risk and helping them achieve better health.
- ✓ You can support high-risk or high-cost populations with more intensive care management and with care coordination, including coordination of specialty referrals, assistance with ancillary services, and referrals to and coordination with community services.^{xi}

✓ You can offer self-management support to at-risk and rising-risk populations. “Self-management support is particularly important for patients dealing with chronic diseases and those with emerging modifiable risks,” reports the AHRQ. “Understanding an individual’s readiness to change, or his or her activation level, can help care managers employ motivational interviewing to set goals, track progress towards these goals, and foster individuals’ self-management of their medical conditions.”^{xii}

For example, a Type 2 diabetic that isn't insulin dependent and has a controlled A1c of 5.8 does not need the same approach as one that is insulin dependent, rarely takes their medications, and is consistently getting A1c readings over 8.



"In the broadest terms, modifying risk includes improving health outcomes, positively influencing psychosocial concerns, as well as helping patients achieve goals that produce better health outcomes," reports the AHRQ. "Patient characteristics such as ethnicity, age, metabolic risk factors, smoking status, and chronic disease burden, as well as psychosocial issues, such as availability of caregiver support," help identify individuals and populations that might benefit from care management. "An understanding of these variables may be helpful in designing supports to assist patients in achieving their individual goals."^{xiii}

Managing multiple chronic illnesses can be difficult enough. But issues are compounded when you add barriers to care, such as lack of transportation, proper housing, insurance, good food, employment, safe living conditions, or access to proper healthcare to the mix. While these social determinants of health (SDoH) may be non-medical, they can drive up to 60% of health outcomes.^{xiv}

Care management technology that provides access to robust data and insights—including an actionable 360° picture of a member's health in near-real-time—and shares it across extended care teams is essential. It puts you in a much better position to influence whole-person care and individual needs. It allows you to see historical information and spot patterns, including breaks in a care plan caused by SDoH. By identifying those gaps, you gain insight into the non-medical issues that may be hindering an individual's success. And that insight can help you initiate conversations with members that can lead to meaningful interventions and meaningful results.

Findings from the Institute of Medicine^{xv} show patient-centered care and meaningful engagement have been correlated with:

- ✓ Better health outcomes
- ✓ Better use of resources
- ✓ Decreased costs
- ✓ Better economic outcomes
- ✓ Increased satisfaction with care
- ✓ Improved quality of life
- ✓ A patient's ability to undertake personal health maintenance
- ✓ Adherence to complex treatment regimens

- ✓ Reduced pain and discomfort
- ✓ Improvements in emotional health
- ✓ Faster recovery in physical health

- ✓ Fewer adverse events
- ✓ Increased employee retention
- ✓ Decreased operating costs
- ✓ Fewer malpractice claims
- ✓ Shorter lengths of stay
- ✓ Lower costs per case

It starts by rethinking the member's journey, not as a path an individual walks alone while navigating a fragmented, over-complicated healthcare system... but as a guided tour where you point members and their families in the right direction, informing and engaging them along the way toward better self-care and better outcomes.

Exceed your care management goals with Aerial™, a HITRUST CSF®-certified, SaaS solution from Medecision. Aerial seamlessly connects the healthcare ecosystem to powerful data and insights that drive meaningful consumer engagement while creating efficiencies to reduce costs and support effective care, case and utilization management.

Resources

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