The Patient Empowerment Guidebook

Pathways to Advancing Patient Empowerment

HCPLAN
Health Care Payment Learning & Action Network

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Purpose

When individuals take an active role in their health, they are more likely to make informed decisions, follow through on care, and maintain healthy behaviors over time, ultimately leading to better care and better results.[1, 2] Yet many organizations lack clear, actionable guidance on how to design, implement, and scale patient empowerment strategies, slowing progress towards value-based care.

Patient empowerment rests on three interconnected principles: making care **affordable**, ensuring patients can **access** the services they need, and helping them **navigate** the health care system with confidence. Designed for a broad set of stakeholders — providers (including accountable care organizations (ACOs)), health plans, employers, and community-based organizations (CBOs) — this Guidebook highlights leading practices aligned to each pillar. These include redesigning financial incentives to improve affordability, expanding access to wellness activities, and delivering personalized reminders/nudges to strengthen navigation.

Defining Patient Empowerment

Patient empowerment goes beyond patient engagement, where the health system prompts patients to act. It enables patients to be primary drivers of their care with the right information, tools, and support.

[1] Hibbard, J. H., Greene, J., & Overton, V. (2013). Patients with lower activation associated with higher costs; delivery systems should know their patients' "scores." Health Affairs, 32(2), 216–222. https://doi.org/10.1377/hlthaff.2012.1064

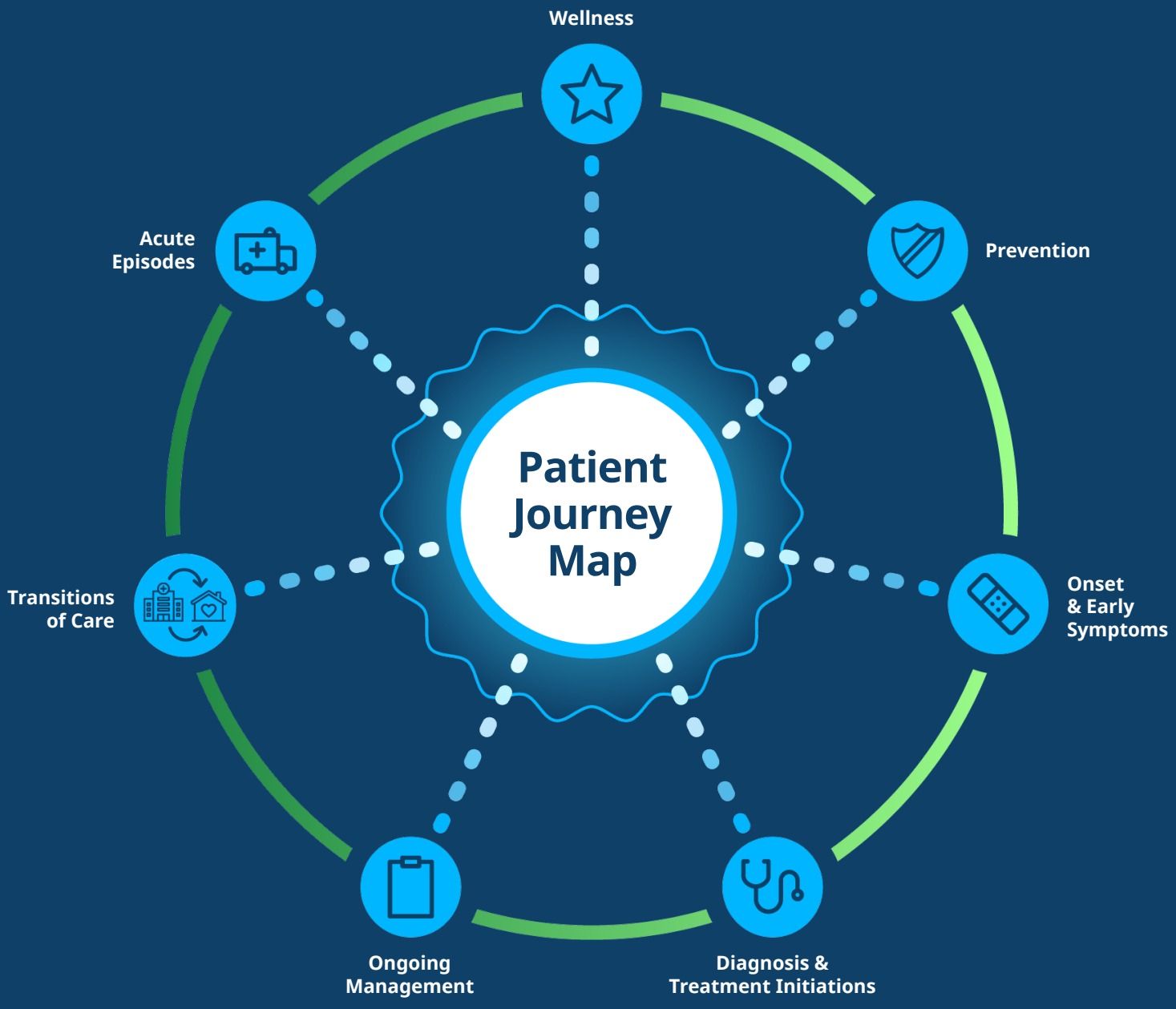
[2] Hibbard, J. H., Greene, J., Shi, Y., Mittler, J., & Scanlon, D. (2015). Taking the long view: How well do patient activation scores predict outcomes? Journal of Health Politics, Policy and Law, 40(6), 1274–1277. https://doi.org/10.1177/1077558715573871

Empowering Patients at Each Step in the Care Journey

Patients often face challenges throughout their care journey and may need support finding resources, understanding complex medical information, and/or navigating the care process.

The patient journey map* below reflects an ideal experience in which empowered patients have the information, support, confidence, and connections they need to make decisions, act, and stay engaged in ways that fit their goals, preferences, and daily lives.

Patient empowerment **should not rely on a one-size-fits-all model**. Patients may lead, share, or delegate decisions, including whether or not to follow recommendations, depending on their goals, readiness, health literacy, language, digital access, and support from trusted care partners. Empowerment can also occur through multiple channels, including text, apps, portals, or in-person support.



* Please note that these steps may not occur in chronological order, and not all patients may experience all of these phases.

Wellness

The patient has support to build and maintain healthy habits, understand basic health information, and establish connections with primary care and community resources to stay well. The patient feels confident managing their day-to-day health and know where to turn when questions or concerns arise.

Prevention

The patient understands how to lower health risks, stay up to date on preventive care, and take action on new concerns early. The patient is prepared and participates in screenings, monitoring, and other preventive steps that help maintain health or identify issues before they worsen.

Onset & Early Symptoms

The patient recognizes when something may be wrong, feels comfortable seeking help early, understands what to do next, and plans for the future. The patient can act on early signs — whether symptoms appear suddenly or gradually — before issues escalate.

Diagnosis & Treatment Initiations

The patient understands the diagnosis, treatment options, likely trade-offs, and immediate next steps. The patient also feels prepared to ask questions, express preferences, participate in decisions, and begin treatment with clarity and confidence.

Ongoing Management

The patient has the personalized care plan needed to stay engaged in managing a chronic condition over time, including through tertiary prevention strategies such as medication adherence support and rehabilitation that help maintain function and slow disease progression.

Transitions of Care

The patient experiences smooth transitions between care settings and understands what is changing, what to do next, and who to contact for help. This process feels coordinated rather than fragmented or repetitive.

Acute Episodes

In urgent situations, the patient knows what to do, where to go, and how to get help quickly. Even in stressful moments, the patient can take the next steps with confidence because guidance is clear and support is accessible.

Foundational Actions to Advance Patient Empowerment

The foundational actions below describe the fundamental structures needed to support patient empowerment across the health care ecosystem. Regardless of which strategies organizations use, these actions ***engage*** and reach patients, ***equip*** them to act, and ***integrate*** systems to reduce burden and improve follow-through.

Engage Patients as Owners in Their Care Journey

- Reach patients through trusted, ongoing, two-way communication so patients (and their chosen care partners) feel heard, respected, and accountable as true partners in care.
- Build trust and strong relationships by partnering with people who have lived experiences to co-design strategies that reflect patients' daily realities, preferences, and feedback — not just their clinical needs.
- Identify barriers (e.g., time, transportation, scheduling friction, caregiving burden) upfront and revisit them over time as circumstances change.

Equip Patients to Drive Their Own Health Outcomes

- Provide tailored tools and resources that build health literacy and self-management skills so patients can understand their options, ask questions, communicate their needs, and follow through on care.
- Support patients in expressing preferences, weighing trade-offs, and participating in shared decision-making in ways that fit their goals and readiness.
- Give patients complete, understandable, and personalized information and support so they can confidently take manageable next steps toward their health and wellness goals.

Integrate Systems to Reduce Burden and Improve Follow-Through

- Deliver coordinated support by aligning programs, incentives, and messaging across providers, health plans, family/care partners, and trusted community partners to support patient goals and needs (e.g., patients with complex needs and conditions).
- Enable appropriate data sharing to make it easier for patients to find and use resources, track progress, and connect to the right support at the right time, without needing to navigate multiple disconnected systems.
- Reduce repeated forms, conflicting outreach, and unnecessary handoffs so the process is seamless and feels more coordinated from the patient's perspective.

Key Stakeholder Roles in Advancing Patient Empowerment

Patient empowerment is a shared responsibility across the health care ecosystem. While each stakeholder contributes in different ways, meaningful progress depends on coordinated efforts that can make care more affordable, accessible, and easier to navigate. The stakeholders below play distinct but complementary roles in helping patients become active participants in their health and well-being.

Patients

Patients are at the center of patient empowerment. They bring their goals, preferences, lived experiences, and personal circumstances to decisions about their care. Family members, caregivers, and trusted support networks can help reinforce understanding, follow-through, and confidence when patients choose additional support.

Providers

Providers are often the most trusted source of health information and play a critical role in helping patients understand options, make informed decisions, and connect to the services and supports they need. Through trusted relationships and shared decision-making, providers help patients develop the knowledge and confidence to actively participate in their care.

Health Plans

Health plans can create the infrastructure, benefits, and supports that make empowerment possible at scale. By reducing barriers, coordinating services, leveraging data, and providing ongoing outreach and support, health plans help patients access resources and stay engaged throughout their care journey.

Employers

Employers can shape the environments, benefits, and workplace cultures that influence health behaviors. By making health resources accessible and supporting employee well-being, employers can help individuals engage in preventive care, wellness activities, and ongoing health management.

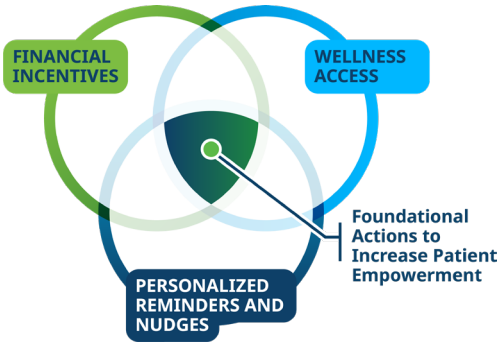
Community-Based Organizations

CBOs bring trusted local relationships, cultural understanding, and practical support that often extend beyond traditional health care settings. They help connect individuals to community resources, address barriers that affect health, and reinforce empowerment in ways that reflect people's daily lives and needs.

While their roles differ, these stakeholders are most effective when they work together to reduce burden, align support, and create a more coordinated experience that enables patients to take an active role in their health and well-being.

Levers To Support and Advance Patient Empowerment

Building on the foundational actions above, the three levers below outline specific strategies that can help stakeholders reduce barriers to care and advance patient empowerment strategies.



Lever One: Redesigning Financial Incentives

LEVER DESCRIPTION: Financial incentives — such as premium discounts, health savings account contributions, or branded debit cards — can make care more affordable by reducing out-of-pocket costs and increasing patients' trust and readiness to engage with sponsors of the incentives. While evidence regarding the return on investment for these incentives is emerging, there are leading practices that organizations implementing these types of interventions can use to streamline and improve their effectiveness.[3]

Example Actions To Redesign Financial Incentives

The actions below are based on what patients value: clear, easy-to-understand information, practical options that fit into everyday life, flexible rewards they can choose how to use, simple sign-up and redemption steps, and step-by-step navigation support so care feels manageable, not overwhelming.

The stakeholder icons indicate who may lead or support each action. See the Key Stakeholder Roles in Advancing Patient Empowerment section for additional context.

Legend: Patients | Providers | Health Plans | Employers | Community-Based Organizations

Simplify and Streamline Incentive Delivery and Participation

- Automatically enroll and notify eligible members into incentive programs and deliver rewards seamlessly (e.g., automatically loaded onto member cards)
- Provide rewards immediately after a patient completes a screening and clearly prompt via visual cues like QR-enabled steps (e.g., at medication pickup) to build momentum beyond the first action

[3] Michaud, T. L., Estabrooks, P. A., You, W., Ern, J., Scoggins, D., Gonzales, K., King, K. M., Dai, H., & Su, D. (2022). Effectiveness of incentives to improve the reach of Health Promotion programs - a systematic review and meta-analysis. https://doi.org/10.1016/j.ypmed.2022.107141.

Tailor and Personalize Incentives	• Offer a limited menu of incentive options based on individual needs (e.g., grocery cards, subsidized gym memberships) and patient data (e.g., age, health status, preferences) so patients choose what works for them without feeling overwhelmed
	• Use step-by-step or ongoing rewards through employer wellness programs (e.g., small rewards for incremental progress and a larger reward for completion in a step challenge)
Integrate Education and Support	• Pair each incentive with a brief, personalized tip sheet/educational handout and enable a "warm hand-off" to local supports that address the patient's barriers
	• Send coordinated, context-aware digital reminders with clear next steps and provide tracking so patients can view progress (e.g., milestones achieved, rewards, educational tips)

Redesigning Financial Incentives: Bright Spots

Explore real-world "bright spots" that show different ways financial incentives can increase patient empowerment.

Health Care LA, Independent Practice Association improved engagement for high-risk members experiencing homelessness or emergency department (ED) overuse by using a **"smart wallet"** approach. Patients earn rewards for completed **care actions** (e.g., bloodwork, primary care visits) with flexibility to use community-funded incentives plus encouragement messages or a privacy mode feature where incentives only come from care teams.

Over the reported period, **this resulted in a 35% reduction in total cost of care** for actively enrolled members and a **42% drop in total ED visits**. For patients, this means fewer health crises and hospital visits, and more consistent support to stay on track with everyday care.[4]

LDI Fellows at UPenn's **Center for Health Incentives and Behavioral Economics** helped about 1,000 heart patients (or people at high risk) walk more by pairing Fitbit step tracking with simple rewards. People received either a **game-like points system**, **money that they could lose** if they missed their daily goal, or **both**.

Over a year, the combined game-and-money approach worked best. It **added about 2,300 more steps per day** than the control group at 12 months, and most participants **(90%) stuck with the program**. For patients, small incentives and feedback can make healthy habits easier to maintain over time and support long-term improvements in heart health.[5]

[4] America's Physician Groups. (2023, October 13). Case Studies in Excellence 2023. https://www.apg.org/wp-content/uploads/2023/10/FINAL-Case-Studies-23-FINAL_10.13.2352.pdf

[5] Fanaroff, A. C., Patel, M. S., Chokshi, N., Coratti, S., Farraday, D., Norton, L., Rareshide, C., Zhu, J., Klaiman, T., Szymczak, J. E., Russell, L. B., Small, D. S., & Volpp, K. G. M. (2024). Effect of gamification, financial incentives, or both to increase physical activity among patients at high risk of cardiovascular events: The be active randomized controlled trial. Circulation, 149(21), 1639–1649. https://doi.org/10.1161/circulationaha.124.069531

Redesigning Financial Incentives: Change Management Tips

*To turn financial incentives into lasting behavior change, organizations need the right systems, trained staff, and shared goals to continue investing in patient empowerment.**

Set Aside Funding and Define Clear Outcomes

Set expectations that returns may take time — define the outcomes that incentives are intended to drive, establish leading and lagging indicators to track progress, plan funding before launch, and use measurement to identify friction points and make informed decisions about what to refine, continue, or scale.

Train Front Line for Consistent, Patient-Ready Support

Train and support patient-facing teams with clear, ready-at-hand resources (e.g., what the program is, who it's for, how and where to use the incentive, how to answer, "Why did I get this message?"). Align protocols and staff roles so every channel gives the same clear explanation, next steps, and ways to get additional help.

Enable Interoperable, User-Friendly Systems

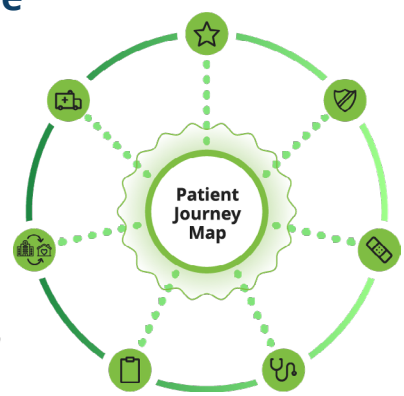
Build interoperable systems (or purchase existing vendor solutions) that use patient-shared data (e.g., reward preferences) to deliver incentives immediately, reduce sign-up and redemption steps, and show real-time updates ("we received X, you earned Y").

LOW INVESTMENT → HIGH INVESTMENT

* While these tips are intended to be broadly applicable, some may be more applicable to certain organization types, depending on their role in care delivery.

Redesigning Financial Incentives: Patient Profile

George is a 64-year-old truck driver managing Type 2 diabetes. He supplements his income by picking up extra shifts, but the long, irregular hours often leave him exhausted and time at home is filled helping his wife care for their grandkids. Juggling appointments, prescriptions, and healthy habits feels overwhelming, especially with so many competing demands.



*Explore below how the Patient Journey Map comes to life for George. The examples below illustrate how financial incentives and wraparound supports can reduce friction and help George build sustainable, healthy routines through SMART (Specific, Measurable, Achievable, Relevant, Time-Bound) goals.**

WELLNESS	• Book annual checkup and claim auto-loaded $25 reward for a healthier on-the-road meal
ONSET & EARLY SYMPTOMS	• Earn a starter incentive for completing seven days of blood sugar tracking and establishing a baseline • Document biggest barrier to care and ask for support options from providers • Call health plan and ask: "If cost is an issue, what are my options?" to help remove barriers to getting care when needed
DIAGNOSIS & TREATMENT INITIATION	• Earn an incentive for completing a diabetes education class and developing a personalized care plan to follow on the road • Confirm when and how to take medications to avoid missing doses due to confusion
ONGOING MANAGEMENT	• Take medications for seven consecutive days to claim "streak" rewards • Receive incentives for uploading blood sugar levels and engaging with personalized coaching or support programs to understand "what to do next"
TRANSITIONS OF CARE	• Receive a follow-up incentive for completing recommended post-discharge appointments and lab work to avoid readmission • Bring medication list and ask for it to be checked against care plan • Earn rewards for meeting with assigned navigator in-person or virtually based on what works, if feeling overwhelmed
ACUTE EPISODES	• Earn rewards for refilling medications, completing recovery-related care milestones, and/or completing a visit with your primary care or other provider for delivery support, if needed

* These are illustrative examples of steps that could be adopted gradually over time with support from health care providers, health plans, and others, not a checklist to be completed by all patients or all at once. Patients may choose which steps feel most relevant and manageable. This is not medical advice; please consult a licensed health care provider for a personalized treatment plan.

Lever Two: Increasing Access to Wellness Activities

LEVER DESCRIPTION: Increasing patients' access to wellness activities and building pathways to drive behavior change can help remove practical barriers (e.g., time, cost, inconvenience).[6] Over time, this may help many patients build and sustain healthy lifestyles (e.g., physical activity, healthy eating, and social engagement) and strengthen their self-management and confidence to take an active role in their health.[7]

Example Actions To Increase Access to Wellness Activities

The actions below are based on what patients value: options that fit real life (e.g., easy to start, pause, or rejoin as life changes), support from trusted people, and coordinated "one-stop" services aligned with their regular health care touchpoints.

The stakeholder icons indicate who may lead or support each action. See the Key Stakeholder Roles in Advancing Patient Empowerment section for additional context.

Legend: Patients | Providers | Health Plans | Employers | Community-Based Organizations

Offer Flexible, Person-Centered Participation Options

- Co-design programs with patients and offer flexible sign-up options that fit changing life circumstances and make it easy to pause and rejoin
- Where feasible, adopt flexible approaches that let people use their preferred activities or devices

- Provide short-term challenges and flexible wellness activities while allowing employees to join based on their changing availability and interest

[6] Yee, B., Mohan, N., McKenzie, F., & Jeffreys, M. (2024). What interventions work to reduce cost barriers to primary healthcare in high-income countries? A systematic review. International Journal of Environmental Research and Public Health, 21(8), 1029. https://doi.org/10.3390/ijerph21081029

[7] Knowles, M., Crowley, A. P., Vasan, A., & Kangovi, S. (2023). Community health worker integration with and effectiveness in health care and public health in the United States. Annual Review of Public Health, 44, 363–381. https://doi.org/10.1146/annurev-publhealth-071521-031648

Leverage Existing Technology and Long-Standing Relationships

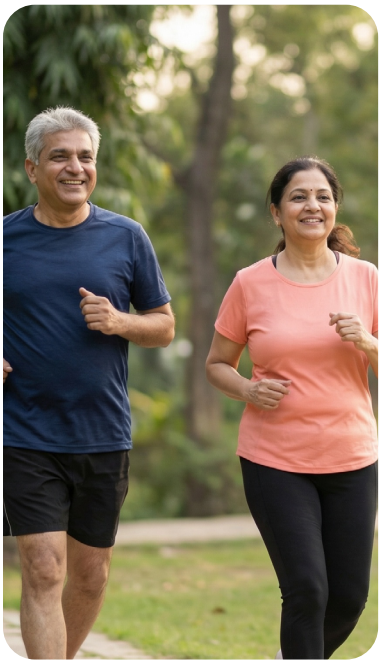
- Put community health workers (CHWs) and peer support at the center of outreach, problem-solving, and follow-through to build trust and long-term relationships in the community

- Add digital tools (e.g., apps, texting, chat, artificial intelligence (AI)) into existing care workflows to reinforce and tailor wellness messaging as needed, while recognizing they work best when paired with trusted, local relationships
- Provide digital literacy support and alternative access options to ensure patients who are less familiar with technology or who need additional guidance can still benefit from digital tools

Bundle Support Services and Build Sustained Engagement

- Work with Community Care Hubs to organize and coordinate bundled services (e.g., medical, nutrition, fitness, mental health) with regular, layered touchpoints (e.g., home visits, peer groups, virtual care) to keep people engaged and support outcomes

- Align benefits and programs by waiving copays for members who participate in bundled wellness initiatives to simplify their experience and reduce drop-off at common friction points



Increasing Access to Wellness Activities: Bright Spots

Explore real-world "bright spots" that show different ways to increase access to wellness activities and increase patient empowerment.

Valley Organized Physicians, an independent physician association, leveraged existing relationships (e.g., physician referrals) as well as clinical and claims data to identify patients with unmet social needs. **They then sent bilingual social workers** who knew the local community **to connect patients with trusted resources** (e.g., transportation, food, home services). The team followed up quickly and consistently to ensure barriers were truly resolved.

This resulted in **improved care continuity**, driving a **~20% reduction in hospitalizations**, a **~11% reduction in ED visits**, and a **~35% reduction in medical claim costs**.[8]

Blue Shield of California Promise Health Plan, in partnership with L.A. Care Health Plan, expands access to wellness activities by **offering flexible, person-centered participation options** through **14 Community Resource Centers** across Los Angeles County. By **bundling support services** and **building sustained engagement**, the centers provide health education, fitness classes, food and housing assistance, preventive screenings, and enrollment supports in a trusted, community-based setting.

In 2024, the Centers welcomed nearly **60,000 individuals** across **more than 361,000 visits**, helping patients connect to services that support prevention and follow-through on care.[9]

Increasing Access to Wellness Activities: Change Management Tips

*To turn better access to wellness activities into lasting behavior change, organizations should establish clear referral pathways to wellness programs, distribute work appropriately, and review how wellness tasks fit into daily operations.**

Review Wellness-Specific Workflows

Regularly track and improve the wellness workflow (screen → refer → schedule → confirm → close-the-loop) across provider and community partners. Standardize eligibility rules, documentation, and handoff data so referrals don't stall due to unclear supervision and billing.

Distribute Work Appropriately

Train or hire skill sets for managing programs (e.g., CHWs, navigators, benefits specialists) and set clear decision-making and escalation paths — so physicians don't become the default for everything.

Establish Direct Referral Pathways Between Clinicians and Program Providers

Use direct referral to trusted community organizations (e.g., local YMCAs or evidence-based programs) to simplify handoffs, boost patient adoption, and reduce drop-off. Clinicians are also more likely to refer patients if they have a vetted, reliable program to which they feel confident sending their patients.

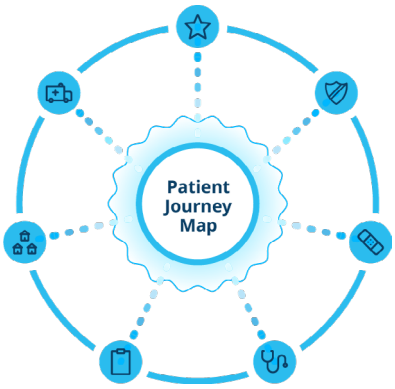
LOW INVESTMENT → HIGH INVESTMENT

[8] America's Physician Groups. (2024, November 7). Case Studies in Excellence 2024. https://www.apg.org/wp-content/uploads/2024/11/CSE-2024-FINAL-revised-11-7-24.pdf

[9] L.A. Care and Blue Shield of California Promise Health Plans Celebrate New Community Resource Center in West Los Angeles, Highlight Five-Year Partnership Milestone | L.A. Care Health Plan. (2024, April 26). https://lacare.org/news/news-releases/la-care-and-blue-shield-california-promise-health-plans-celebrate-new-community

* While these tips are intended to be broadly applicable, some may be more applicable to certain organization types, depending on their role in care delivery.

Increasing Access to Wellness Activities: Patient Profile



Tammy is a 65-year-old retired professional living in a rural community. She tries to stay active with book clubs, game nights, and local volunteering, but limited transportation options and occasional connectivity challenges can make it hard to participate consistently and leave her feeling isolated.

Additionally, she recently learned she has high blood pressure (BP), and while she is trying to follow her doctor's guidance, access to healthy food options near her home is limited. Even though she generally feels well, making changes to her eating habits and adding new health routines can feel challenging given these barriers.

*Explore how the Patient Journey Map comes to life for Tammy. The examples below illustrate how simple digital tools combined with trusted community and peer support can help Tammy build sustainable habits through small realistic SMART goals that protect her long-term health, without giving up the lifestyle she loves.**

WELLNESS	• Start two to four week flexible "Know Your Numbers" program to increase health literacy skills like checking and understanding key heart health measures like blood pressure, blood sugar, cholesterol, and body mass index • Set two habits with CHW and follow personalized dietary and walking plans
ONSET & EARLY SYMPTOMS	• Use phone-based or SMS check-ins to log BP readings and symptoms when app or portal access is unreliable • Complete two-minute symptom check surveys via SMS or phone call to identify triggers (e.g., certain foods) and adjust plan with care team and CHW
DIAGNOSIS & TREATMENT INITIATION	• Co-create a shared BP goal and medication plan with care team that reflects travel distance and visit frequency to combine in-person with virtual or phone follow-ups, when appropriate • Enroll in provider remote monitoring, if offered, and submit averages to get clear guidance on "what's next"
ONGOING MANAGEMENT	• Complete monthly BP check-ins via text, portal, or app • Use CHW and/or peer support for lifestyle coaching to increase adherence (e.g., refills, reminders) and problem-solve (e.g., feeling overwhelmed)
TRANSITIONS OF CARE	• After a specialist visit, use services provided through a Community Care Hub bundle to help coordinate transportation, referrals, or follow-up care to avoid gaps common in rural settings
ACUTE EPISODES	• For very high BP readings, follow the in-app escalation pathway (e.g., what to do now, when to call) and complete CHW follow-up and medication "reset" plan to reengage as soon as possible

* These are illustrative examples of steps that could be adopted gradually over time with support from health care providers, health plans, and others, not a checklist to be completed by all patients or all at once. This is not medical advice; please consult a licensed health care provider for a personalized treatment plan.

Lever Three: Delivering Personalized Reminders/Nudges

LEVER DESCRIPTION:
Personalized reminders/nudges, when delivered thoughtfully, give people helpful prompts at the right time and support patient navigation. Personalized reminders prompt a specific, single next step, while nudges go a step farther by making that specific action easier or more likely (e.g., gamification).[10,11] Technology and AI can help make this level of personalization more feasible at scale, but these tools are most effective when paired with clear next steps and human support when patients need help.

Example Actions To Deliver Personalized Reminders/Nudges

The actions below are based on what patients value: a personalized experience; pairing digital outreach with human support; and coordinated, short, and timely reminders to avoid alert fatigue and message overload.

The stakeholder icons indicate who may lead or support each action. See the Key Stakeholder Roles in Advancing Patient Empowerment section for additional context.

Legend: Patients | Providers | Health Plans | Employers | Community-Based Organizations

Combine Technology-Driven Personalization With Human Support

- Personalize beyond names by using messaging that fits the person's situation, lived experience, and/or preferences (e.g., newly diagnosed vs. chronic condition). Set small goals and tailor tone, timing, modality, and content to match readiness levels
- Connect reminders/nudges with human support (e.g., peer, care team, navigator support) when needed — especially if patients ask for help or stop responding

[10] Zhou, Z., Zhang, Y., Xu, J., & Zhang, N. (2025). Nudge-based interventions to improve medication adherence in adults with chronic diseases: A systematic review and meta-analysis of randomized controlled trials. Annals of Behavioral Medicine, 59(1), Article kaaf097. https://doi.org/10.1093/abm/kaaf097

[11] Ziyud, A., Al-Thelaya, K., & Schneider, J. (2026). Who, where, what, and how to nudge: A systematic review of co-designed digital nudges for behavioral interventions. Multimodal Technologies and Interaction, 10(4), 43. https://doi.org/10.3390/mti10040043

Engage Stakeholders in Co-Designing Programs and Messaging

- Co-design outreach with input from local providers, community organizations, and patients/family members; align messaging to fit local preferences and cultural norms

- Coordinate communications across organizations by using consistent wording, and when possible, one shared platform or single channel; keep reminders short and send them at key moments when people are making decisions

Integrate Bi-Directional Engagement and Feedback

- Use adaptive, two-way tools and technology that let patients reply to confirm they completed a step, ask for help, or pause reminders. Confirmation is best for one-off behaviors (e.g., mammograms), while follow-ups are more useful for ongoing behaviors (e.g., medication adherence)

- Pair digital reminders and nudges with enabling mechanisms (e.g., self-scheduling links, direct referrals, two-way response options) so outreach makes follow-through easier in the moment

Delivering Personalized Reminders/Nudges: Bright Spots

Explore real-world "bright spots" that show different ways personalized reminders/nudges can increase patient empowerment.

Hoag Clinic improved its call-center customer relationship management system so it works like a "personalized nudge engine". By combining technology-driven personalization with human support, the system surfaces **patient-specific context, provides real-time prompts** and **alerts**, and helps agents tailor conversations to each patients' needs. The approach also integrates bi-directional engagement by identifying care gaps, prompting next steps, and connecting patients to preventive services during routine interactions.

This resulted in **higher patient satisfaction, more appointment bookings, more Medicare Wellness visits, and fewer care gaps**. For patients, routine calls become timely, personalized support that helps them access needed care faster and follow-through on recommended services.[12]

Through its Clinical Transformation team, **Ascension advances patient empowerment through** a system-wide **digital nudge portfolio** that leverages technology and behavioral science to drive preventive care and population outcomes. On target to reach over 320,000 patients over the year, the **program uses automated SMS and email reminders** to engage patients at home and in the lead up to primary care visits, with the goal of addressing critical care gaps, including cancer screenings, chronic disease management, and vaccinations.

A randomized trial across 76 Ascension practices found that **care transformation nudges drove a 14% increase in quality gaps closed within 90 days** and **an 18% reduction in no-shows**. For patients, these timely touchpoints provide a clear path to proactive health management and continuous support.[13]

Delivering Personalized Reminders/Nudges: Change Management Tips

*To turn personalized reminders/nudges into lasting behavior change, organizations need to map the end-to-end journey, establish an iterative learning loop, and prioritize patients as partners.**

Culture Shifts for True Patient Partnership

Reinforce and reward staff behaviors that treat patients as equal partners in care (e.g., co-design care, act on feedback, design nudges/reminders to support patient goals, close the loop on patient priorities). Share clear evidence of time savings or outcomes to help address staff concerns around shared decision-making.

Evaluate Through an Iterative Learning Loop

Consider reminders and nudges as part of an iterative learning process by implementing them within an operational environment. Evaluate engagement, review key performance indicators, and assess areas of friction. Collect input from patients and stakeholders and make adjustments to the strategy over time.

Map the End-to-End Journey to Ensure Follow-Through

Map the end-to-end journey (nudge → scheduling → visit → follow through) and design each step to make the next action obvious and easy. Prioritize channels such as SMS, provide clear instructions, and reduce enrollment steps to reduce friction and improve completion.

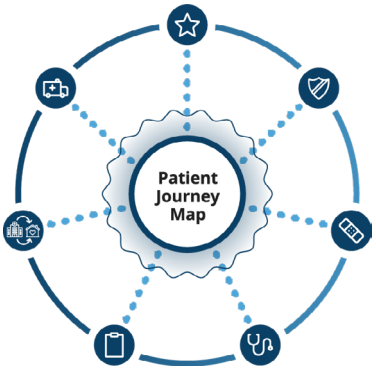
LOW INVESTMENT → HIGH INVESTMENT

[12] America's Physician Groups. (2024, November 7). Case Studies in Excellence 2024. https://www.apg.org/wp-content/uploads/2024/11/CSE-2024-FINAL-revised-11-7-24.pdf

[13] Source: Bright Spot shared by Josh Liao, MD, submitted through the Patient Empowerment Workgroup, June 2026

* While these tips are intended to be broadly applicable, some may be more applicable to certain organization types, depending on their role in care delivery.

Delivering Personalized Reminders/Nudges: Patient Profile



Robert is a 63-year-old retired technology attorney and a lifelong runner. He has been managing chronic musculoskeletal pain that requires regular physical therapy (PT) and at-home exercises. Recently, an unexpected life event — the sudden loss of his brother to a heart attack — left Robert grieving and disengaged, causing him to miss appointments and stop using his physical therapy app. Getting back on track will require flexible support, timely outreach, and encouragement from both his care team and family members to rebuild routines that feel manageable.

Explore how the Patient Journey Map comes to life for Robert. The examples below illustrate how personalized reminders and nudges can help Robert manage his musculoskeletal pain through small, realistic SMART goals.[*]

WELLNESS	• Set preferences in health plan app (e.g., language, tone, text vs. email), then follow the tailored weekly mobility plan • Encourage Robert to share his care plan and progress view with his wife and son or others in his support network so they can offer encouragement and check in during periods of low motivation
ONSET & EARLY SYMPTOMS	• If activity levels drop or reminders go unacknowledged for several weeks, the system prompts a care team or navigator check in to assess barriers (e.g., grief, schedule changes) and adjust the plan • If schedule is busy, reply "pause" or "later" to reduce notification overload during periods of stress, grief, and/or low motivation
DIAGNOSIS & TREATMENT INITIATION	• After missed PT sessions, receive a simplified re-entry plan (e.g., "one small step this week") and the option to restart with virtual or at home exercises rather than in person visits
ONGOING MANAGEMENT	• After each PT session, log mood, pain level, and physical activity to help tailor future nudges (e.g., gentler goals following setbacks, encouragement after gaps)
TRANSITIONS OF CARE	• After each handoff (PT/ortho/imaging), receive a single "next steps" message (medications, updated exercises, follow-up dates) and tap "I understand" or "I have a question" to prompt navigator support
ACUTE EPISODES	• After an unexpected intense flare-up settles, log what likely triggered it based on recent habit/routine changes, ensuring future nudges and supports are further personalized (e.g., "before long drives: try a 3-minute stretch")

[*] These are illustrative examples of steps that could be adopted gradually over time with support from health care providers, health plans, and others, not a checklist to be completed by all patients or all at once. This is not medical advice; please consult a licensed health care provider for a personalized treatment plan.

Scaling Patient Empowerment: CMS Innovation Models Support and Encourage Patient Empowerment

CMS is committed to advancing patient empowerment across the health care ecosystem through a diverse set of innovative payment and service models (e.g., Long-Term Enhanced ACO Design (LEAD), Advancing Chronic Care with Effective, Scalable Solutions (ACCESS), ACO REACH, Medicare Shared Savings Program (MSSP), and Medicare Diabetes Prevention Program (MDPP)).

These models aim **to test new ways for organizations to actively support patient empowerment in their health and well-being, using strategies such as:**

- Allowing ACOs to offer financial incentives, including gift cards, to eligible beneficiaries who complete qualifying activities tied to chronic disease management or preventive care.*
- Reducing or eliminating Medicare Part B cost-sharing for certain services, helping lower financial barriers to accessing needed care.
- Enabling $0-copay participation in MDPP, addressing a key barrier to engaging in that type of preventive intervention.
- Allowing non-monetary, in-kind support, such as MSSP's Patient Incentives Waiver, where ACOs may provide items like blood pressure cuffs or scales for patients with hypertension, prepaid transportation vouchers to appointments, or support of over-the-counter medications.

To learn more about how CMS is using value-based payment models to advance patient empowerment, please visit the CMS Innovation Models webpage.

* Note: The allowable types and amounts of financial incentives vary by ACO program and are subject to specific CMS guidance.

Addressing Policy and Regulatory Barriers

Policy and regulatory barriers can make it harder for patients to access information, navigate care, and stay engaged. They can also limit other stakeholders' (e.g., providers, payers, etc.) ability to have the data and flexibility needed to achieve patient empowerment. While many of the challenges listed below require system-level action, the strategies in the Guidebook can help organizations take practical steps now to empower patients.

Addressing Policy and Regulatory Barriers	Potential Future State
Data Silos and Health System Fragmentation Since clinical, health plan, pharmacy, and community data often sit in separate systems, patients and other stakeholders involved often struggle to access the data they need. This creates repeat outreach, broken handoffs across settings, a fragmented experience for patients and their caregivers, and often worse health outcomes. As AI becomes more common in health care, unequal access to information risks patients being left out of important decisions or unable to benefit from tools that can help them manage their care.	**Integrated Data Ecosystem and Coordinated Experience** Interoperable, privacy-protected data sharing that supports a whole-person view across settings. For patients, this means a more coordinated experience, better health outcomes, and access to their health information, beyond their patient portals, in formats that are usable and understandable.
Complex HIPAA-Driven Consent and Data-Sharing Processes HIPAA-driven consent and data-sharing permissions are often long, technical, and require multiple steps, which creates friction, reduces opt-in rates, and makes it difficult to personalize support and build trust.	**Low-Friction, Easy-to-Understand Consent Processes** Consent is redesigned into a simple, plain language process that clearly explains what is shared, how it benefits the patient, and how data is protected with options that reflect different technology savviness as well as health literacy levels and preferences.
Administrative and Billing Burdens for Community-Based Organizations CBOs play a critical role in helping address non-clinical barriers to patient empowerment. However, many face significant challenges (e.g., complex enrollment/registration requirements, credentialing) and lack the medical-billing infrastructure, specialized staff, or administrative capacity needed to manage these demands. Fragmented contracting and payment approaches often fail to cover the true cost of services, limiting participation and reducing access for patients.	**Scalable Community Support and Sustainable Models** CBOs have clearer reimbursable pathways, right-sized oversight, and simpler contracting and payment models that better reflect how services are delivered. This makes it easier to participate, sustains high-touch support, and frees providers to focus on clinical care. In some markets, umbrella hub organizations may help smaller CBOs manage billing and administrative functions; however, there is limited adoption to date.
Low Adoption of Policy and Program Changes Organizations often take time to translate new policy and program rules into their daily workflows. Many wait for proven use cases or "clear permission," which can slow the uptake of improvements that could benefit patients.	**Guided Implementation Leads To Faster Adoption of Changes** Policy changes are paired with clear implementation guidance, operational resources, and early-adopter examples so organizations can adopt changes faster and patient-facing improvements show up sooner in care.

Getting Started: Quick Tips & What To Do in the Next 30/60/90 Days

Quick Tips

- **Prioritize clarity and simplicity.** Programs work best when expectations are clear, information is easy to understand, and next steps are obvious.
- **Minimize burden on patients**. Reduce unnecessary steps that may increase the risk of drop-off by streamlining processes, coordinating across teams, and designing activities to fit into everyday life.
- **Ensure reliable support and follow-through**. Make it easy for patients to get help when questions or challenges get in the way, so they are not left navigating the system on their own.

In Next 30 Days Document Your Program Goals

- ☐ **Define the target population** and the **specific behavior, action, or outcome** you hope to improve (e.g., follow-up visits after discharge for patients with diabetes).
- ☐ **Identify where patients experience friction** across the Patient Journey.
  - *See:* Empowering Patients at Each Step in the Care Journey
- ☐ **Gather patient and caregiver perspectives** to better understand barriers, preferences, and support needs.
  - *See:* Foundational Actions: Engage Patients as Owners in their Care Journey
- ☐ **Establish a small set of leading and lagging indicators** to measure progress and success.

In 60 Days Design the Empowerment Strategy

- ☐ **Select the most appropriate lever(s) based on patient needs:**
  - Redesigning Financial Incentives
  - Increasing Access to Wellness Activities
  - Delivering Personalized Reminders/Nudges
  - Combination Approach
- ☐ **Apply the foundational actions throughout program design:**
  - Engage patients as owners in their care journey
  - Equip patients to drive their own health outcomes
  - Integrate systems to reduce burden and improve follow through
- ☐ Define stakeholder roles and responsibilities, including patients, providers, health plans, employers, community-based organizations.
  - *See:* Key Stakeholder Roles
- ☐ **Design workflows, partnerships, and support pathways** that make it easier for patients to take the next step.
  - *See:* **Change Management Tips** across all levers
- ☐ **Train frontline staff and partners** to consistently explain the program, answer questions, as well as connect patients to support.
  - *See:* **Change Management Tips** across all levers

In 90 Days and Beyond Pilot, Learn, and Scale

- ☐ **Launch a small pilot** with a defined population and timeframe.
  - *See:* Relevant **Lever** section and associated **Bright Spots**
- ☐ **Monitor engagement, friction points, and patient feedback** across the patient journey.
  - *See:* Empowering Patients at Each Step in the Care Journey
- ☐ **Review performance against leading and lagging indicators** to identify opportunities for improvement.
- ☐ **Refine the approach based on patient and stakeholder feedback,** adjusting workflows, messaging, incentives, or supports as needed.
  - *See:* Foundational Actions: *Engage Patients as Owners in their Care Journey*
- ☐ **Scale successful approaches** by expanding to additional populations, care settings, or partners while continuing to evaluate outcomes.
  - *See:* Scaling Patient Empowerment: CMS Innovation Models Support and Encourage Patient Empowerment

If you have any feedback or questions regarding the Patient Empowerment Guidebook, please contact hcplan@deloitte.com.

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