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June 18, 2010

The Honorable Kathleen Sebelius
Secretary Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: MCC Strategic Framework

Dear Secretary Sebelius:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I respectfully offer the following comments for your consideration in response to the Request for Information on the Interagency Workgroup on Multiple Chronic Conditions draft strategic framework issued May 19, 2010, in the *Federal Register*.

DMAA: The Care Continuum Alliance represents organizations providing services along the continuum of care to more than 160 million Americans through wellness, chronic care management and complex case management. DMAA: The Care Continuum Alliance members include wellness, disease management and population health management (PHM) organizations; health plans; labor unions; employer organizations; pharmaceutical manufacturers; pharmacy benefit managers; health information technology innovators and device manufacturers; physician groups; hospitals and hospital systems; academics; and others. These diverse organizations share DMAA: The Care Continuum Alliance's vision of aligning all stakeholders toward improving the health of populations through collaborative whole person, whole population management. Our members seek to improve health care quality and contain health care costs by providing targeted interventions and services to individuals who are well, at-risk or managing one or more chronic conditions.

DMAA: The Care Continuum Alliance has defined a population health management program as one that strives to address health needs at all points along the continuum of health and well-being through participation of, engagement with and targeted interventions for the population. Population health management programs are designed to address the health needs of specific and targeted populations, while providing services to the individual patient.

We share the Department's vision and the framework's goals of managing and improving the care and health outcomes for those with multiple chronic conditions. Our members are engaged in numerous programs and initiatives utilizing the strategies outlined in the goals and objectives of the framework. We are especially encouraged by the Strategic Framework's commitment to building partnerships with all interested stakeholders to achieve the stated goals for individuals with multiple chronic conditions.

We appreciate the opportunity to provide these general comments on each of the goals outlined in the framework. In the attached addendums, we have referenced applicable peer-reviewed literature under specific framework strategies that we believe will be helpful to the Interagency Working Group as it develops the foundation for the paradigm shift to a population health management approach for individuals with multiple chronic conditions.

Broadly, the Strategic Framework asserts that "the delivery of community health and health care services generally continues to be centered around individual chronic disease silos." In reality, population health management programs recognize the role and complexity presented by comorbid conditions, such as depression, obesity and many others. Chronic condition management in the United States and globally has progressed beyond "single disease state" management. Evidence from numerous state-of-the-art programs delivered in private insurance, Medicare Advantage and state Medicaid programs supports this.[1]

Further, DMAA: The Care Continuum Alliance believes that HHS, in finalizing and implementing the Strategic Framework, should explore and test a variety of strategies that address the "whole person." Tremendous opportunities for people with multiple chronic conditions exist in population health management, care coordination and disease management programs. Ensuring program flexibility and support for a variety of intervention models tailored to meet the needs of specific populations is the most likely pathway to success, as there is no "magic bullet" for all populations. However, research also demonstrates the success of existing disease management programs in addressing comorbid conditions (i.e., multiple chronic conditions).[2],[3]

Goal 1 – Provide better tools and information to health care and social service workers who deliver care to individuals with MCC

The Strategic Framework appropriately notes the clinical heterogeneity of MCC populations. DMAA: The Care Continuum Alliance believes the same is true for programs that address MCC populations: No one program is replicable or appropriate for all populations. We urge HHS to retain this vision and the recognition that flexibility in program design, implementation and evaluation are necessary components for successful management of MCC populations.

Program evaluation, through the use of performance measures, can reveal best practices in the delivery of care for patients with MCC. DMAA: The Care Continuum Alliance has developed a core set of measures for the evaluation of population health management, disease management and health and wellness programs.[4] These guidelines are specifically designed to address the presence of MCC. These measures, which are annually updated and expanded, include medical costs, health care utilization, health risks/behaviors, quality of life, health status, productivity, psychosocial drivers, program satisfaction and process/operations measures. In addition, DMAA: The Care Continuum Alliance has developed quality measures of health status and participant satisfaction for the evaluation of population health management programs.

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[1] DMAA: The Care Continuum Alliance. Quality Improvement Cast Studies Registry. http://www.dmaa.org/Quality/QICSR_case_studies_list.asp

[2] Chen RA et al. The Case for Disease Management in Chronic Kidney Disease. Disease Management. 2006; 9(2): 86-92.

[3] Hibbard JH, Greene J, Tusler M. Improving the Outcomes of Disease Management by Tailoring Care to the Patient's Level of Activation. American Journal of Managed Care. 2009; 15(6): 353-360.

[4] DMAA: The Care Continuum Alliance. Outcomes Guidelines Report. Vol. 4. DMAA: Washington, DC. 2009.

In the area of medication adherence, DMAA: The Care Continuum Alliance has convened industry experts to develop guidelines and measures, published most recently in *DMAA Outcomes Guidelines Report, Volume 4*. These guidelines/measures 1) assist providers to better understand their patients' adherence to prescribed medications and 2) help to reduce patient risk associated with poly-pharmacy.

Goal 2 – Maximize the use of proven self-care management and other services by individuals with MCC

Challenges remain for motivating, engaging and empowering individuals and caregivers to become better stewards of their own health, but meaningful progress is apparent. Patient education and self-management can be directly linked to improvements in both clinical and financial outcomes. Additionally, self-management education programs can bring together patients with a variety of chronic conditions to learn and share techniques for better self management. Several examples of successful programs that incorporate patient education and self-management strategies are provided in Addendum A.

We support the framework's call for tools to improve patient knowledge to reduce chronic disease progression. In a 2007 *Health Affairs* article, O'Connor et al. discussed industry progress involving patients in preference-sensitive treatment decisions and called for national policies advocating for informed patient choice as the standard of practice.[5] Decision support is about helping individuals and caregivers better understand their conditions, ask their physicians the right questions and make more informed medical decisions. A growing body of research shows that both patients and providers benefit when patients are well-informed and play an active and significant role in deciding how they are going to treat or manage their health conditions. This, in turn, leads to improved health outcomes, lower costs and high patient satisfaction.

In addition, transitions of care for vulnerable populations, especially those with multiple chronic conditions, has been identified as an ideal opportunity to achieve the increased quality, improved health outcomes and efficiency that reform demands of the health care system, while reducing avoidable hospital admissions. Population health management has played a vital role by successfully managing transitions from acute care to home for many patients. Working with hospitals, providers and ancillary care organizations, population health management will lessen avoidable morbidity associated with transitions across different sites and levels of care by leveraging its experience employing the most advanced technology.

Goal 3 – Foster health care and public health system changes to improve the health of individuals with MCC

We agree with the Strategic Framework's assertion that the current fee-for-service model offers few incentives for appropriate care coordination. As such, we support efforts to implement alternative payment methodologies and reimbursement models that support longitudinal care coordination, as well as additional health care professionals, such as nurse practitioners, case managers and others who support the care of MCC populations. Many providers desire to transform their practice infrastructure, workflows, information technology and partnerships to better meet the diverse needs and desires of various populations in the pursuit of improved health. This has led to innovative collaborations among health care providers who recognize

[5] O'Connor AM et al. Toward the 'Tipping Point': Decision Aids and Informed Patient Choice. Health Affairs. 2007; 26(3): 716-725.

that, while physicians must lead these efforts, they can benefit from a team-based approach both within and beyond their practice walls to provide health support to their patients. As new models, such as patient-centered medical homes and accountable care organizations, evolve to focus more attention on outcomes of care, population health management will continue to influence these collaborative models due to its expertise and experience in key areas of service delivery and outcomes improvement. Our industry expertise has particular value in the coordination of care for those with multiple chronic conditions who receive care from multiple providers. Strong care coordination that ensures a seamless flow of information between providers on a timely basis can help minimize avoidable hospital admissions and lead to a more patient-centered experience for a population.

Population health management strategies and the push to "wire" the U.S. health care system are oriented toward the same goals: creating a patient-centric approach to health and health care that empowers patients to better manage their health and transitioning the health care system from a model that is episodic, fragmented and reactive to one that is continuous, coordinated and preventive. It is widely recognized that HIT will continue to dramatically change the landscape of health care delivery and is a central component of the population health management model. DMAA: The Care Continuum Alliance seeks to ensure that all stakeholders in the health care continuum are aligned toward optimizing the health of populations. We advocate the achievement of such alignment through the effective use of health information technologies and modalities. Systematic improvements in management of information are crucial to improving the quality of health care for patients with chronic conditions and decreasing the cost of their care.

DMAA: The Care Continuum Alliance is well-positioned as a key stakeholder in HHS efforts moving forward to address patients with multiple chronic conditions. Specifically, our population health management framework model found on page 15 of the *DMAA Outcomes Guidelines Report, Volume 4* (attached as Addendum C) outlines the process flow associated with a population health management program and includes these components: health risk assessment, risk stratification, enrollment/engagement strategies, components of tailored and personalized interventions, communication/intervention modalities, and program outcomes. These HIT components are essential for care models addressing the needs of a population across the care continuum, especially for those with multiple chronic conditions.

Population health management's use of various HIT methods – electronic medical records, Web-based care management, behavioral therapy, provider alerts, Internet-based decision support – has improved care delivery through greater efficiency, improved quality and increased accessibility to care for conditions that are more difficult to treat.[6] Additionally, patient identification for targeted health improvement interventions can be facilitated through the use of electronic medical records and predictive modeling.[7]

Goal 4 – Facilitate research to fill knowledge gap about individuals with MCC

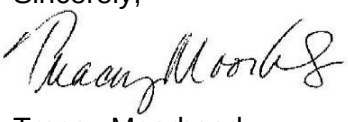
DMAA: The Care Continuum Alliance realizes the importance of expanding the evidence in the literature to support new models of care for patients and populations with multiple chronic conditions. Through a partnership with the RAND Corporation, we have launched an initiative to

[6] Goldzweig CL, Towfigh A, Maglione M, Shekelle PG. Costs and Benefits of Health Information Technology: New Trends from the Literature. Health Affairs. Web Exclusive. 27 January 2009: w282-w293.
[7] Pakhomov S et al. Electronic medical records for clinical research: application to the identification of heart failure. American Journal of Managed Care. 2007 Jun;13(6 Part 1):281-8.

add to this important body of evidence. The Population Health Management Industry Data Aggregation Initiative is a long-term initiative with a goal of building a robust, sustainable repository of data from organizations providing programs along the entire health continuum, from wellness to palliative care. The data repository will allow the industry to investigate both methodological-related questions, as well as programmatic questions. We would be honored to partner with HHS and other Federal agencies to utilize this important resource to facilitate new and insightful research on the management of MCC populations.

We appreciate the opportunity to submit these comments for your consideration. DMAA: The Care Continuum Alliance shares the draft framework's goals and looks forward to working with and being a resource to the Interagency Working Group as it fulfills its mission.

Sincerely,



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