Frequently Asked Questions

What is the care continuum?

The care continuum represents comprehensive, coordinated and integrated health services that improve the quality and value of care across all states of health and care settings.

Why are we changing our name?

With its new name, the Care Continuum Alliance completes a phased process started in 2007 to develop a brand that represents *all* stakeholders in population health improvement, as well as all its more than 200 organizational and individual members. Established in 1999 as the Disease Management Association of America, the association, like the industry it represents, has evolved to include all segments of the care continuum, including wellness and workplace health promotion, prevention, behavioral health, chronic care management, technology-enabled care, complex care management and end-of-life care.

What is population health improvement?

Generally, population health improvement promotes health and lowers the risk of illness at the group, or *population*, level, as contrasted with episodic care of individuals. A population can be the employees of a company, a physician group patient panel, hospital system post-discharge patients, community health clinic users or millions of health plan enrollees – there is no one-size population, and approaches to care can vary with each.

The population health improvement model, as defined by the Care Continuum Alliance, comprises three core components: the leadership and central care delivery roles of the primary care physician; the critical importance of patient activation, involvement and personal responsibility; and the patient focus and expanded capacity of care coordination provided by population health programs. Together, these roles raise quality and satisfaction, mitigate health care work force shortages and improve health care access and affordability.

What do Care Continuum Alliance members do?

Care Continuum Alliance members design, develop and implement programs to improve the health of populations – a manufacturer's work force, for example. They do this across the continuum of care, assessing health risks among the population to stratify individuals for appropriate interventions. This process might find that many members of the population have little or no health risk and can maintain good health through a wellness program. Others might fall into a moderate risk category and require health coaching or other risk management interventions. Still others might be at high risk or chronically ill and in need of disease or case management support.

Intervention techniques are as varied as the populations served and generally are delivered by licensed health care professionals. Often, they include technological innovations, such as Web-based health coaching, remote biometric monitoring and mobile device support. Interventions can be disease-specific – focusing on diabetes, for example – or can coordinate care for multiple conditions. But services often are for people with no existing conditions and are designed to ensure their continued good health through lifestyle education and support; this is the ideal and the goal of population health improvement.

What are the benefits of what we do?

Wellness, prevention and other strategies along the care continuum improve the quality and value of health care for all program participants. A well-designed, evidence-based population health management program can avert or delay the onset of a chronic condition, move at-risk individuals to low-risk categories, reduce hospital use, increase productivity and improve or maintain quality of life, among other benefits.

Care Continuum Alliance members also provide valuable care coordination services, helping individuals navigate the sometimes overwhelming maze of providers, social services and other support mechanisms necessary to successfully improve or maintain health status. Our members also aid transitions between care settings – from an inpatient hospital stay to home care, for example.

What does the research show about the benefits of wellness, prevention and care management?

Well-designed, peer-reviewed studies in recent years have added to a growing body of evidence in support of wellness and care management interventions. Two recent examples:

- A January 2010 article in the journal *Health Affairs* concluded that "wider adoption of such programs could prove beneficial for budgets and productivity as well as health outcomes" and that medical costs fall by about $3.27 for every dollar spent on workplace wellness programs and that absenteeism costs fall by about $2.73 for every dollar spent.

- A June 2010 *American Journal of Managed Care* study of TRICARE, the federal health plan for military members and their dependents, found that chronic disease management programs "more than pay for themselves, in addition to improving patient health and quality of life."

How do population health management and the continuum of care differ from traditional ideas about chronic disease management?

Disease management often is wrongly portrayed as limited in scope to a single disease state and consisting of cursory interventions, such as periodic telephone counseling. In reality, Care Continuum Alliance members deliver a rich and expanding menu of services to meet the needs of the whole person, as well as the entire population. These services span the full continuum of health, focus on assessing and avoiding health risks, engage individuals with a broad array of traditional and new technologies and demonstrate outcomes through evidence-based, consensus measures.

Care Continuum Alliance members promote and support proactive, accountable, patient-centric care in a collaborative, physician-guided delivery system. They work to develop and engage informed, activated patients over time to reduce illness and improve long-term health. Our members believe that managing health requires the active, integrated involvement of *all* health care professionals, coordinated with individuals and their caregivers and families.

How does population health improvement fit into the future of the health care delivery system?

More than 70 percent of the $2.2 trillion in annual health care spending nationally is related to chronic disease, and the costs of lost productivity and diminished quality of life are greater still. These are unsustainable economic and personal health costs. Health care reform recognizes this and has made wellness and prevention core goals for a reformed delivery system. Employers and other purchasers of health care services also understand the value of health promotion practices. Employers continue to adopt workplace wellness programs at a brisk pace, their support driven by demonstrated benefits in improved employee health and productivity and reduced health benefits costs.

Population health improvement and the work of Care Continuum Alliance members will have a central place in this continuing shift toward a true health care – rather than sick care – system. Learn more at www.carecontinuum.org.