

Congestive Heart Failure



SDMS

CHRONIC HEART FAILURE MANAGEMENT PROGRAM

The SDMS Chronic Heart Failure Program is a targeted, customized disease management program that will help you save costs while improving outcomes.

- Accurately identify and index patients by level of need
- Support patient self-management skills
- Increase communication with and support of primary care physician
- Improve medication and treatment compliance
- Encourage appropriate utilization of medical services
- Monitor outcomes to measure program success

For health care organizations that must manage risk within a specific population, this approach has resulted in:

- Decreased medical utilization and overall cost of care
- Reduced practice variation within the provider network
- Improved patient satisfaction and quality of life

Meeting Industry Standards

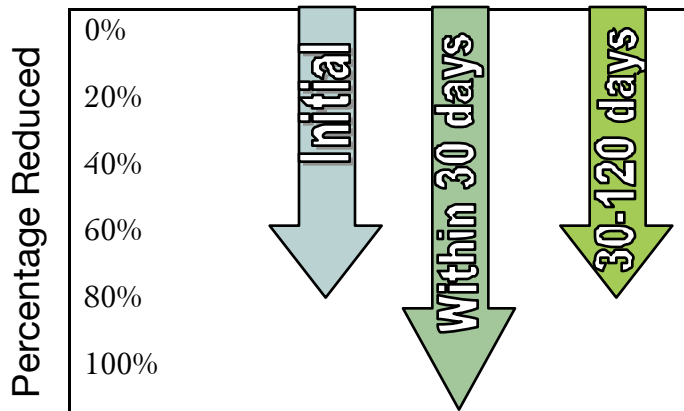
The SDMS disease management program helps health care organizations satisfy NCQA and other quality improvement standards. Specifically, health care organizations will be able to show that are to actively working to improve the health status of their chronically ill members, as required by HEDIS and HCFA. Demonstrable quality improvements also enhance member recruitment and retention, as well as attracting commercial business.

Did you know?

Congestive heart failure is the single most costly health care problem in America today. Over 3 million people in the US are afflicted with the illness; over 400,000 new cases are reported annually.

At a time when hospital admissions are declining, a significant amount of CHF care continues to be provided in acute care settings. Direct medical costs attributed to CHF are an estimated \$10.3 million per year. Experts believe medically supervised interventions aimed at limiting damage from heart disease are widely under-used in spite of their proven benefits.

Admissions and Readmissions



Proven Outcomes

Published outcomes on the effectiveness of our comprehensive CHF disease management program instituted for NYLCARE HMO revealed remarkable results within one year. Quarterly hospital admission and readmission rates declined

85% and 83% respectively. Length of stay and emergency room utilization also decreased significantly. Patient-reported quality-of-life was up by 44%. The health plan saved over \$5 million in hospital costs related to CHF.

INTEGRATION AND INFORMATION SERVICES

Pulling Information out of Data

The essential first step in assuring a disease management program's success, **SDMS's Data Integration** services identify and index members with CHF to reveal potential for management and cost savings. To further stratify patients by severity of need, The **SDMS Need Stratification Survey** applies a proprietary algorithm to combine both claims and patient reported data, such as behavior, symptoms and quality of life. **Utilization and Expenditure Monitoring and Tracking** reports evaluate the effectiveness of the program.

INTERVENTION SERVICES

Putting Information Into Action

CHF is a disease which experts believe can be successfully managed by interventions that extend support beyond the hospital and doctor's office. SDMS CHF Intervention Services are focused to promote compliance,

enhance patient knowledge and ensure early detection of symptoms. The program is customized to the individual needs of the health care organization, providing an appropriate mix of provider and patient directed interventions.

Home Health

Upon hospital discharge, a patient in the SDMS CHF program will receive a home visit by a program-trained nurse who conducts a thorough assessment of the patient's condition and reviews instructions and educational materials with the patient and/or caregiver. The health assessment and nurse's recommendations are forwarded to the appropriate SDMS case manager.

Monitoring

SDMS Telemonitoring nurses call patients every week to reinforce the treatment and medication regimen, survey the patient's health condition, and most importantly, to alert their physician to signs of exacerbation of illness, comorbidities/sequelae conditions, or dangerous drug reactions.

Patient Education

Patients and/or their caregivers receive a series of educational mailings to reinforce CHF management skills. These pieces, developed by specialists in patient care and education offer facts and guidance on nutrition, the importance of medication compliance, exercise and other helpful tips.

Provider Education

Physicians receive periodic visits from program representatives to discuss the goals of the CHF program, treatment guidelines, formulary recommendations and appropriate clinical studies that support guideline rationale. Adherence to the program is further reinforced with educational mailings.

SDMS: THE IDEAL STRATEGIC PARTNER

The SDMS CHF program shows that the promise can for improved clinical, financial and humanistic outcomes be fulfilled. Our medical and technological sophistication, our understanding of the issues surrounding CHF and chronic disease, and our proven track record make us an ideal strategic partner.

