SeniorMetrix Technology and Solution:
Calibrating the Continuum of Care

SITUATION ANALYSIS

As our population ages, health plans with large senior enrollments are seeing their post-acute care costs rapidly increase every year. From 2003 to 2005, skilled nursing facility (SNF) costs alone rose nearly 26 percent. This increased need by older Americans for health care combined with a limited number of nursing home beds and a national shortage of nurses and therapists create an equation in which costs can only continue to climb. To further add to the gravity of the situation, the hospital length of stay in many communities is being impacted due to a lack of available SNF beds. Ironically, it is proven that at least 20 percent of patients sent to SNFs would get the same results if they were discharged to the community and received home health therapy instead.

Some health plan officials are realizing the seriousness of this reality. In 2005, a West Coast non-profit health care system was looking for ways to reduce SNF admissions for its higher functioning patients, while ensuring they received similar, if not improved, progress using home health services. The client set a goal of reducing SNF admissions of higher functioning patients to 23 percent.

THE SOLUTION

Working with the health plan client, the data of SeniorMetrix showed that six (6) of their contracted hospitals were admitting higher functioning patients to SNFs with higher percentages, often as high as 35 percent. As compared with the national average SNF admission rate of less than 18 percent to the most efficient rate being 7 percent.

By utilizing its technology, SeniorMetrix was able to work with the client in identifying those individuals who would do just as well at home, and make that information available to patients, families and hospital discharge planners. As a result, SeniorMetrix implemented the Outcome Management Program, which empowered care givers within 24 hours of hospital admission with evidence-based, severity-adjusted data needed to help them make the most informed decisions regarding their patients and families.

RESULTS

Within one year of instituting the SeniorMetrix's Outcome Management Program, SNF admissions for higher functioning patients was reduced to 19 percent, exceeding the health care plan's initial reduction goal of 23 percent. Results of this collaboration also included a change in referral patterns, as well as ongoing patient monitoring of at-home progress to ensure that health plan members continued to achieve positive outcomes in the comfort of their own homes. The use of SeniorMetrix data proved that higher functioning patients make similar gains with home health therapy or with therapy in a SNF setting. **SeniorMetrix has also shown that this practice does not increase acute care re-admission rates.**