Case Study of SeniorMetrix Technology:
Providing the Data for the Right Care at the Right Time in the Right Setting

SITUATION ANALYSIS

The goal of today's healthcare industry is to provide the right amount of care, at the optimal time, in the least restrictive setting, utilizing the full care continuum. Medical or rehabilitation care can be provided in a variety of settings; it is not limited to a single setting.

Historically, post-acute rehabilitation for the senior population has been provided primarily in the institutional setting, specifically the Skilled Nursing Facility (SNF). Discharge functional goals (such as walking, transfers and activities of daily living) for patients in the SNF were typically established for a level which was more appropriately achieved in the community setting, such as home health or outpatient therapy. This practice of creating unrealistic goals at the SNF extended the institutional stay often resulting in secondary complications such as infections, depression, pressure sores and other medical problems. In addition, this practice inhibited the patient's ability to advance to the next level of functionality, as the SNF patient often becomes an all too passive recipient of caregiver assistance.

SeniorMetrix provides health plans with a constantly expanding database of some 400,000 actual patient records for use in discharge planning decision making. With the use of the SeniorMetrix tools in the hospital, SNF and home health settings, a large nonprofit health plan recently achieved its goals of providing members with the optimal level of service. Simultaneously, clinical goals and patient outcomes were achieved in the most appropriate, yet least restrictive setting, allowing patients to advance to the next level of functionality in the most efficient manner.

THE SOLUTION

In hospitals, the SeniorMetrix Acute OPT (Outcomes Prediction Tool) provides hospital discharge planners with the necessary and objective data to best assess the most appropriate discharge site (community with home health services or SNF) and predict functional capability at discharge. In addition, the length of stay (LOS) and level of caregiver assistance are predicted, allowing the discharge planner to establish realistic expectations with the patient and family while in the hospital. The patient's transition from one care setting to the next is less stressful and better coordinated thus re-admissions to acute are not impacted.

Similarly, in SNFs, the SeniorMetrix SNF OPT provides the rehabilitation team with data-based information for the SNF stay. Immediately after the initial evaluation, the team is able to predict length of stay, discharge functionality, caregiver and rehabilitation needs, and the most appropriate discharge site immediately after initial evaluation. Care planning for the patient is initiated immediately instead of the "wait-and-see" practices of the past. More appropriate referrals to home health, custodial or community settings are possible, providing the patient with optimal care in the most suitable locale.

RESULTS

- After implementation of the SeniorMetrix Acute OPT, a 10 percent greater possibility of returning home following hospital discharge was evident (see graph below).
- An objective database of clinical outcomes was established for integration into acute hospital discharge placement decisions as well as SNF and home health concurrent reviews.
- Clinical decisions were dramatically enhanced using individual patients' admission and historical functional information with the predictive capabilities of the SeniorMetrix tools. This key data significantly improved the clinical decision-making process and capabilities of the care team. Members are now referred for post-acute services more objectively and, most importantly, the patient experiences an enhanced quality of life.