

Improving Acute Discharge Results

In recent years, hospitals, health plans and government agencies have placed more focus on improving transitions of care for the aged and disabled. For Medicare populations, twenty percent of all hospital discharges will be readmitted to the hospital within 30 days and ninety percent of those readmissions are unplanned. Forty percent of all Medicare patients discharged from a hospital will receive postacute care in a specialty hospital, skilled nursing facility or home health agency. Research has shown that over one third of people receiving postacute care would have achieved the same outcome if they had gone to a lower level of care.

SeniorMetrix partnered with a west coast health plan and major medical center to address the challenges of appropriately discharging frail patients. One Med-Surg floor of the hospital was experiencing a readmission rate of over 40% for those Medicare members transferred to SNF. In addition, over half of those sent to SNF had almost no rehabilitation potential and no skilled need.

A study was developed that utilized SeniorMetrix' Outcome Prediction Tool (OPT). This tool utilizes a standardized functional assessment coupled with hundreds of thousands of patient records to establish an appropriate level of care and risk for readmission on a discharge by discharge basis.

The Medical Center staff was trained in the use of the tool and they screened all Medicare member admissions for a three month pilot period. Patients in the pilot group were similar to patients discharged prior to the pilot in terms of functional status, diagnosis and co-morbidities. 124 Medicare Members were transferred to SNF's from the entire hospital during the pilot and 30 (24%) of those were from the pilot unit.

The results of the study were:

- Patients that were discharged to SNF had their acute hospital stay shortened by 1.67 days
- The average functional status of patients transferred to SNF from the Acute Hospital was 21% higher
- SNF transfers showed 25% great functional improvement during their SNF stay
- The number of very low function scoring patients transferred to SNF was decreased by over 50%

Use of SeniorMetrix OPT for Acute Discharge Planning Decision Support

	Baseline Period – 180 days (N=54)	Study period - 90 days (N=30)
Acute Average Length of Stay	6.74	5.07
SNF Average Length of Stay	18.3	22.2
SNF Admit FIM ¹	43.4	52.3
SNF Discharge FIM ¹	56	67.9
SNF FIM Gain ¹	12.5	15.5
SNF Med Complexity ²	3.87	3.43
1 or more Groupers ³	18 (33.3%)	17 (57%)
SNF admits <40 FIM	30 (55.5%)	7 (23.3%)

¹Functional Independence Measure

²Med Complexity is a measure of co-morbidity (0-5 scale, higher value = more co-morbidity)

³A Grouper is one of several conditions that influence readmission and postacute utilization

The study demonstrated that use of the SeniorMetrix OPT tool was very effective at identifying appropriate cases for SNF discharge. The information provided by the OPT identifies the appropriate postacute site early in the hospital stay which also has a positive impact on acute ALOS. In addition, the number of very low functioning patients that were not appropriate for SNF care was reduced dramatically. The majority of these cases were transferred to a facility for custodial care.

The results of the pilot far exceeded expectations in terms of the scope of the improvement and the short amount of time needed to see change.

At the conclusion of the pilot, the Medical Center and Health Plan decided to expand the program to the entire hospital.