



Case Study of SeniorMetrix Technology: *Targeting the Frail-Elderly Population*

SITUATION ANALYSIS

Health plans continue to struggle with effective sustainable interventions to manage the frail-elderly population, typically those patients with multiple chronic conditions, those using in-patient hospital care, and those who are in the last years of life. In fact, recent research from the Medicare Payment Advisory Commission states that 5 percent of the costliest beneficiaries consume 48 percent of health spending.

As part of a West Coast-based health plan, a physician group needed to address its Medicare Advantage population responsible for repeated hospitalizations and emergency room visits - in essence, those members yielding the highest health care costs. The client wanted solutions to reduce unnecessary hospital admissions through an on-site, personalized case management approach using SeniorMetrix core technology, tools and management systems. Specifically, the SeniorMetrix Onsite In-Home Case Management Program considers all of a member's needs, including social, with the In-Home Case Manager acting as a facilitator to implement a set of interventions to improve the overall health status and safety of the member. Collectively, the client and SeniorMetrix set goals to enroll at least 2.5 percent of the members in the plan and to reduce hospital admissions among its frail-elderly population.

THE SOLUTION

SeniorMetrix worked closely with the client to enhance our systems in collecting and measuring components of the clinical, medical, functional, nutritional, mental and social support information vital to assessing and managing these members. The small, but targeted, membership all had an admission history of three or more acute hospitalizations within 12 months. The average member age was 83.

SeniorMetrix and the client collaborated to develop and distribute informational materials to members to explain the program and give enrollment instructions. Primary Care Physicians were informed of the program's benefits and were supportive of its goals. Upon enrollment, members underwent a two-hour, on-site visit with the SeniorMetrix Case Manager, who then completed a comprehensive patient assessment. To provide a realistic infrastructure of needed care and services, a plan addressing the medical, functional, safety and social needs was developed and shared with both the client and the PCP. Care plan implementation needs were coordinated and executed, including home health services (rehabilitative therapy, wound care, caregiver training), medication compliance strategies, enrollment in disease management programs, advance directives, outpatient services (chemotherapy, wound care and physical therapy) and social services (transportation needs, meal preparation, adult day care interventions).

RESULTS

Within six months of implementation the program reached its enrollment goal of 35 to 40 members and experienced a 9 percent reduction in hospital admissions. The program also was extended for 2008. In addition:

- The program is on track to yield a 250 percent ROI
- 94 percent of the targeted qualified members enrolled in the plan
- The average duration of enrollment was 120 days
- The average number of encounters per patient was 10
- 56 percent of members now have advance directives
- 40 percent of enrollees were referred to an appropriate disease management program
- Through frequent social interventions, members now receive such services as LifeAlert devices, Meals on Wheels, caregiver resources, home safety assessments, socialization opportunities, and transportation to/from medical appointments and community events.

Most importantly, the patient-specific approach aligned more attainable expectations and created a stronger relationship between the physician and the member through personal visits, ongoing communications, and fundamental problem solving and services coordination.