Penobscot

Admission & Discharge Criteria for Care Management

Admission Criteria:

1) Recent admission to Acute Care due to exacerbation or worsening of existing chronic medical condition such as COPD, DM, Asthma, CAD or CHF
2) Recent unplanned admission for new diagnosis for chronic medical condition such as COPD, DM, Asthma, CAD or CHF
3) Recent planned admission (example: scheduled surgery) with a complication / exacerbation of chronic medical condition such as COPD, DM, Asthma, CAD or CHF
4) Patients with recent discharge from Acute Care setting and considered to be high risk for readmission based on medical conditions, complications in the hospital, or psychosocial challenges/ risks
5) ED visits (less than 3 in 3 months or less than 5 in 6 months) visits for chronic medical conditions that are not well controlled
    a. More than 3 in 3 months and more than 5 in 6 months would necessitate a referral to Community Care Team (CCT)
6) Existing chronic medical condition with metrics outside of goal range (example: DM with HgbA1C of 8.0) which places the patient at higher risk for admission
7) New Diagnosis of a chronic medical condition such as COPD, DM, Asthma, CAD, or CHF requiring education and support
8) Patients at risk for developing chronic medical conditions due to risk factors (example: obesity or hyperlipidemia)

Discharge Criteria

1) Hospitalizations decrease
    a. No hospitalizations over a 6 month period
    b. Reduced number of hospitalizations over a 6 month period as compared to 6 months prior to Care Management
2) No Readmissions to acute care within 90 days of discharge
3) Patient goals
    a. Patient goals have been met
    b. Patient has demonstrated positive progress toward reaching goals
    c. Primary goals have been achieved, now working on secondary goals
4) Chronic Disease Metrics
    a. Have been reached
    b. Patient has shown positive progress toward goal metric
    c. Metrics have stayed stable with no decline in 6 months
5) Patient Education
    a. Patient is able to articulate goals related to condition
    b. Patient is demonstrating positive steps toward meeting treatment goals
    c. Patient understands and is able to articulate when and who to call for exacerbation of symptoms or questions/ concerns
6) Patient/ Care Management Decision
    a. Patient wishes to stop participating with Care management
    b. Patient is not actively participating with self management goal setting and action planning; Patient continues to not engage with Care Manager on improving health behaviors

i. NOTE: This only happens after a discussion with PCP and the decision is made as a team, and discussion with the patient prior to the actual discharge from Care Management