Admission 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, CHF, Cardiac Dysrhythmias, Renal Failure, Pneumonia, or Schizophrenia (see LACE tool and workflow)
2) Recent unplanned admission for new diagnosis for chronic medical condition such as COPD, DM, Asthma, CAD, CHF, Cardiac Dysrhythmias, Renal Failure, Pneumonia, or Schizophrenia.
3) Recent planned admission (example: scheduled surgery) with a complication / exacerbation of chronic medical condition such as COPD, DM, Asthma, CAD, CHF, Cardiac Dysrhythmias, Renal Failure, Pneumonia, Schizophrenia
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) Patient with a recent discharge from Acute Care having had a surgical procedure that increases risk of readmission, including:
    a. Lower Limb amputations
    b. Renal Surgeries
    c. AV Shunt placements for hemodialysis
    d. Complicated wounds (including burns or infected wounds)
    e. Open heart surgeries (including CABG and valve replacements)
    f. Organ Transplants
    g. Bowel resections with or without colostomies or ileostomies

6) 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)
7) 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
8) New Diagnosis of a chronic medical condition such as COPD, DM, Asthma, CAD, CHF, or Cardiac Dysrhythmias requiring education and support
9) Patients at risk for developing chronic medical conditions due to risk factors (example: obesity or hyperlipidemia)

RFGH Modified LACE Tool

Attribute	Value	Points	*Total @ ADM*	*Total @ DISC*
			L	L
Length of Stay (L)	1	**0**		
	1	**1**		
	2	**2**		
	3	**3**		
	4-6	**4**		
	7-13	**5**		
	≥ 14	**6**		
			A	A
Acute (emergent) Admit – (A)	Yes	**3**		
	Observation	**0**		
			C	C
Comorbidity (C) *cumulative to max of 6 points **Modified Charlson Comorbidity Index**		**0**		
	history of myocardial infarction peripheral vascular disease cerebrovascular disease diabetes without complications Peptic Ulcer Disease	**1**		
	congestive heart failure chronic obstructive pulmonary disease mild liver disease any tumor, cancer Leukemia Lymphoma DM with end organ damage Moderate to severe renal disease	**2**		
	dementia connective tissue disease	**3**		
	moderate to severe liver disease HIV infection	**4**		
	Metastatic cancer	**6**		
			E	E
Visits to the Emergency Room in the past 6 months – (E)	0	**0**		
	1	**1**		
	2	**2**		
	3	**3**		
	≥ 4	**4**		
	Total LACE Score ➔			

***Modified LACE Tool adapted from Chinese Hospital's Modified LACE tool.**
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Proposed Work Flow for LACE Trial

Patients with Diagnosis of CHF, COPD, CAD, Cancer, Diabetes, Asthma, or Renal Failure

1) MA Health Coach will review the Hospital Lists looking for all Patients discharged from EMMC or St Joseph Hospital
2) LACE Tool will be done by the MA Health Coach
   a. All patients scoring as a HIGH risk (score of 11 or greater) for readmission will have
      i. Automatic referral for CCT
      ii. Follow up phone call by RN
         - 3 calls then letter
      iii. Follow up appointment in the clinic within 2 to 3 days
   b. All patients scoring as a MODERATE risk (risk of 5 to 10) for readmission will have
      i. Automatic referral for Care Management OR CCT (based on need)
      ii. Follow up phone call by RN
         - 3 calls then letter
      iii. Follow up appointment in the clinic within 3 to 5 days
   c. All patients scoring as LOW risk (score of 0 to 4) for readmission will have
      i. Follow up call by MA Health Coach
         - 2 calls then letter
      ii. Follow up in the clinic within 5 to 7 days
      iii. Second follow up call by MA Health coach within 7 to 10 days as a check in (if patient agrees on first outreach call)

Follow up analysis will include:

Number of referrals generated for both CCT and Care Management

Readmission monitoring

Look at volume/numbers of visits and calls added to current workloads