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Breakout Session 1: Patient Selection Criteria

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Brief Report

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Abstract

This summary focuses on findings from the Patient Selection Breakout Session of the Alternate Care Facility (ACF) Symposium. Findings demonstrate that patient selection criteria were primarily shaped by community needs and operational constraints rather than clinical factors alone. Participants described using local population needs as a starting point to define ACF eligibility. Resource availability emerged as the dominant determinant of admission criteria, often superseding traditional clinical thresholds. External pressures from hospital systems frequently drove expansion of criteria to include higher-acuity patients requiring balancing of resources and capabilities. Successful selection criteria were characterized by iterative, multidisciplinary reviews incorporating frontline staff and strong interagency collaboration. Key challenges included clinician hesitancy to transfer patients to the ACF, limited external communication regarding capabilities, and persistent tension between flexible criteria and standardized guidance for dissemination. Additional barriers included staffing limitations, facility design constraints, and unanticipated logistical factors. External influences, including political decision-making, at times disrupted operational alignment with frontline realities. Patient selection represents a dynamic, resource-driven process requiring continuous reassessment. These findings support the need for flexible, resource-informed selection criteria, coordination with hospital partners, incorporation of frontline expertise into decision-making, and integration of discharge planning services to expand appropriate patient populations while maintaining quality care.

Introduction

The Patient Selection Criteria breakout session focused on participants' real-world experience with assessing and selecting appropriate patients to be managed at their alternate care facility (ACF). This included the development of guidelines for inclusion and exclusion of specific patient types and who was involved in this decision-making process. Participants were encouraged to discuss factors that influenced their patient selection criteria. The goal was to focus on what participants did, rather than proposing solutions and solving problems.

Facilitators used the following questions to prompt and guide participants:

- What were your approaches to patient selection for your ACF?
  - Include specific examples, inclusion/exclusion criteria, etc.
  - Who was making these decisions? Why were they the ones making those decisions?
- Describe some of the successes with your patient selection processes.
  - How did you sustain these?
- Describe some of the challenges with your patient selection processes.
  - How were these addressed?
- Do you have any best practice recommendations for ACF patient selection?

To encourage further detailed discussions, additional questions were available for facilitators. These questions could be asked if group discussions slowed during the 50 minutes and if time allowed. Some groups discussed some of these questions while others did not have time.

- Did your selection criteria change while the ACF was operational?
  - Why?
  - How was this managed?
- How did you determine the inclusion/exclusion criteria for your ACF?
  - What vital signs or clinical criteria should a patient meet before being accepted?
  - What patient acuity level or type was most appropriate for your site (stable med/surg, post-acute or recovering, behavioral health, etc.)?
- How were decisions made for patients whose clinical status fell between levels of care? (e.g., between ICU and med/surg criteria used at your facility)
- Were there patient cultural considerations that are worth planning for or being aware of?
  - Were there access and functional needs considerations that you wish you had considered or planned for?

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Theme 1: What Was Done

- **Community Needs Are a Starting Point for Selection Criteria**: Real-world exclusion criteria frequently involved social and logistical factors over clinical status. One ACF was forced to quickly expand its scope to manage patients presenting with housing instability and substance abuse problems, needs that were not initially included in formal medical criteria. Many participants cited community needs as a starting point used to determine patient selection criteria. This allowed ACFs to appropriately align with their mission with one participant noting that the "ACF needs to know its mission and select patients for it."
- **Resource Availability Drove Patient Selection**: Patient admission and selection criteria in ACFs were largely determined by available operational and logistical resources rather than clinical factors alone. Examples of these non-clinical elements that were considered include oxygen supply capacity, specialized staffing availability (i.e., addiction medicine specialists, wound care nurses, social work), and basic infrastructure limitations. These infrastructure considerations played a large role in selection criteria with the majority of symposium participants discussing bathroom location and number as a limiting factor leading to decisions that excluded patients with access and function needs.
- **Hospital Pressures Lead to Expanding Criteria**: The political and systemic necessity to "push patients higher" to increase hospital capacity resulted in admission criteria expanding to include increasingly higher acuity patients. One ACF noted an initial oxygen requirement of not greater than 2 L expanded up to 8 L to assist in offloading their local hospital partner. This introduced risk and required a balancing of staff and supply capabilities.
- **Exclusion Criteria Were Guided by Logistical Barriers**: These logistical barriers included such considerations as bathroom location and lighting. In one ACF, a simple "200-yard walk" to centralized restroom facilities excluded patients with reduced mobility or infectious disease concerns like *C. difficile*. Another ACF included a BMI cut-off for patients due to a lack of standard bariatric beds and equipment to appropriately care for these patients. Additional exclusion criteria used included behavior health needs, access and functional needs, ventilator requirements, and some comorbidities and primary diagnoses that may require labs and wrap-around services. Patients requiring multiple specialty consultations were also excluded due to the challenges of arranging necessary remote evaluations.

Theme 2: Success and Sustainment

- **Selection Criteria Were Frequently Reviewed and Revised**: Multiple participants noted success in adapting to the changes in community needs and hospital capacity through standing meetings to review and update their ACF selection criteria. These meetings included ACF leadership as well as frontline physicians and staff. At these meetings, patient cases were reviewed and systemic issues were identified and addressed, leading to more appropriate patient admissions. One ACF utilized disaster protocols that enabled various units of their ACF to turn on or off various criteria depending on what their ACF was responding to and what community needs they were serving.
- **Sustaining a Collaborative Interagency Approach to Patient Selection**: Patient selection and placement were more effective due to pre-existing inter-agency relationships and collaboration between hospital systems, local public health agencies, and government entities. This unified approach allowed for trust and sharing of resources which provided a more comprehensive assessment of community and patient needs.
- **Frontline Staff Were Included in Decision Making Process**: Participants noted success in developing and revising their selection criteria by including frontline physicians, advanced practice providers, nurses, therapists, and pharmacists in the decision-making process. One field director specifically asked for assurances and autonomy in the selection process to ensure their ACF was not forced to take patients that their facility was not equipped to appropriately care for.

Theme 3: Challenges and Mitigation Efforts

- **Optics of Sending Patients Out of a Hospital to Receive Care**: Participants noted hesitation to send patients to ACFs from hospital-based clinicians. Clinicians felt uncertain about the level and quality of care that their patients may receive if sent out of a hospital to the ACF. Participants also noted a lack of external communication to both partnering hospitals and community members regarding the capabilities of the ACF. Some participants noted success in mitigating this clinician hesitancy by proactively recruiting patients from hospitals and sending assessment groups from the ACF to the hospital. These groups would specifically assess patient appropriateness and readiness for transfer to the ACF and could answer clinician questions about the ACF's capabilities.
- **Noted Tension Between Flexibility and Standardization of Criteria**: A fundamental tension existed between the system-level need for flexible patient inclusion and exclusion criteria and the drive to standardize these criteria to assist in hospital-level dissemination and education. As discussed above, many ACFs note successful community support by flexing their patient selection criteria depending on the needs of their partner hospitals and communities. This flexibility leads to other challenges, including difficulty in widespread dissemination of these changes to hospital partners and hospital-based clinician education. Some participants also noted that when ACFs kept "hard criteria," these ACFs were viewed as not being willing to help their hospital partners. Some ACFs attempted to mitigate this by scheduling regular reviews of the selection criteria on a schedule that was known to their partners.
- **Accommodation of Specific Patient Populations**: Many participants noted that their ACFs found challenges with accommodating varying patient populations. Some instituted age cut-offs and would only accept patients over 18 due to challenges with changes in pediatric equipment, medications, and staff training and comfort. Other ACFs had to limit acceptance of patients with access and functional needs due to their facility's layout. Locations of bathrooms and showers played a role in this decision, especially if there were steps or narrow corridors leading to these areas. Additionally, participants noted the exclusion of some patients with mental and behavioral health needs due to facility layout and staffing numbers.
- **Need for Appropriate Decision Makers**: Clinical consensus decisions made by experts were sometimes overridden or altered by political leadership impacting admission criteria. As an example, staff were found learning about critical, unvetted changes to the ACF by "watching the news," forcing ACFs into reactive rather than proactive planning. At time, the patient

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criteria were set by the government, instead of involving frontline staff and hospital partners. This proved to be ineffective and did not allow the ACF to offload hospitals to the best of its ability. Symposium participants noted that there was significant benefit to working with the "wisdom in the room" or staff and providers actively working in the ACF when determining selection criteria.

- **Staffing as Primary Constraint on Patient Selection**: A significant limiting factor in ACF capacity was overwhelmingly staff including trained clinical and support personnel, rather than physical space. Staffing models frequently relied on nontraditional personnel pools, including temporary contract labor and providers with limited acute care experience (i.e., outpatient nurses and EMTs). These factors played a role in determining which patients could be accepted to the ACF, given the capacity and abilities of the available staff.
- **Unexpected Limiting Factors for Selection**: Many participants noted limitations to which patients could be accepted based on factors that were not anticipated during the ACF planning process. Some of these considerations noted include bathrooms, food service capabilities, cultural support availability, and lighting. Additionally, pharmacy stocks were noted to be a limitation especially when home medications and comorbidities of patients were considered. Infection control was also a significant limitation for both patient type and patient numbers depending on the ACF layout.

Theme 4: Potential Future Directions

- **Dynamic and Regularly Updated Admission Criteria**: Consider implementing a more dynamic, real-time patient admission/exclusion criteria update process. This should be tied to the ACF's current resource capacity (i.e., oxygen supply, staffing levels), community needs, and incorporate frontline staff input. To ensure clear communication with community and hospital partners, aim to provide these updates on a regular and known frequency to allow time for provider and staff education at hospitals.
- **Triage Patients to ACFs in Coordination with Hospitals**: Consider establishing a triage and referral system to match both clinical and social needs of the patient to the ACF in partnership with sending hospitals. Selection criteria and decisions related to this should not be made in isolation and need to incorporate all transferring partners.
- **Establish Advisory Board to Regularly Review Selection Criteria**: Ensure decision-making around selection criteria and operational scope of an ACF involves frontline clinicians to ensure real-world limitations at ACFs are being addressed. This advisory board should also include members from partner hospitals who send patients to the ACF.
- **Discharge Planning Support Can Broaden Selection Criteria**: When planning for the ACF, consider incorporating social work, substance abuse planning, and language support. These considerations can help broaden the appropriate population to receive care at the ACF depending on the community needs while ensuring accepted patient populations receive appropriate support during their admission.

Summary

Patient selection in ACFs is fundamentally constrained by community needs and operational capacity rather than clinical need alone. Symposium participants consistently reported that admission criteria were dictated by immediately available resources including oxygen supply, specialized staff, and basic infrastructure rather than purely clinical indications. This created highly fluid criteria that shifted regularly based on real-time assessments, with logistical barriers often excluding patients more strictly than their diagnoses would suggest. Participants highlighted the need to find the right resource for the right patient at the right time. This mission drove much of the selection criteria decisions. Future directions emphasize the importance of dynamic, resource-informed admission criteria, formalized coordination with hospital partners, inclusion of frontline expertise in governance structures, and integration of social and discharge planning services to expand appropriate patient populations while maintaining safe, effective care delivery.

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