CHCS Center for Health Care Strategies, Inc.

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Inclusion and Exclusion Criteria for Complex Care Programs: Survey of Approaches

IN BRIEF

Around the country, innovative health care organizations are developing programs to better coordinate care for people with complex medical, behavioral health, and social needs. As a first step, organizations need to consistently and efficiently identify individuals in their patient population who can benefit from enhanced care coordination and also determine when to "graduate" patients out of their programs. The Center for Health Care Strategies surveyed organizations involved in its ***Transforming Complex Care*** and ***Complex Care Innovation Lab*** initiatives to find out how they are identifying individuals for their respective complex care programs. Although this field is still emerging, the criteria used by these innovators can help inform other programs seeking to develop or refine eligibility criteria for complex care management programs.

Patients with complex needs often have multiple chronic health conditions and face significant social challenges that require a tailored care management approach. In response, health care organizations have developed intensive care coordination programs focused on addressing physical health, behavioral health and social needs. In developing these high-touch complex care programs, organizations must consider fundamental questions, including: (1) which individuals stand to benefit most from their services; (2) which specific groups of individuals with complex needs should *not* be included in the program; and (3) how long to keep individuals enrolled.

To understand how these complex care programs approach inclusion, exclusion, and graduation criteria, the Center for Health Care Strategies (CHCS) surveyed 10 sites involved in its *Transforming Complex Care* and *Complex Care Innovation Lab* initiatives. This technical assistance resource includes a summary of the survey results, as well as a discussion of common themes.

While research in the field of complex care has begun to examine how to effectively prioritize populations for care management interventions, further exploration is needed to identify the best criteria for program eligibility and graduation.[1,2] The following matrix (***see page 3***), developed from CHCS' survey of 10 complex care programs, provides organizations looking to refine or start complex care programs with examples of eligibility and graduation criteria from innovators in the field. While the science of understanding who to target for complex care interventions (and for how long) is still evolving, the experiences of the sites surveyed offer a valuable starting point for others looking to develop or refine their own approaches.

Inclusion Criteria

Many of the surveyed programs base eligibility at least in part on utilization of health care resources, often determined by emergency department (ED) visits or inpatient admissions. Several programs also link inclusion to interventions or services that they are equipped to provide, such as substance use disorder treatment or medication management services. Another approach to determining eligibility is the use of predictive modeling, which employs data-driven algorithms to identify individuals who are at risk for developing the types of conditions that a program is well-suited to address.

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Exclusion Criteria

Of the programs surveyed, those with exclusion criteria often focus on categories of individuals whose medical and social needs are not amenable to the types of care coordination interventions offered in the program, or those whose health conditions, utilization, or costs would likely not improve even if enrolled in the program. This often includes patients in hospice care, as an end-of-life patient's health status is not likely to be impacted by increased care coordination. For similar reasons, several of the surveyed programs exclude patients with an oncology diagnosis, as cancer care is specialized and potentially expensive regardless of the amount of external care coordination provided. Additionally, some of the programs exclude individuals whose health care costs are exclusively driven by a single acute event, such as pregnancy or a major trauma (e.g., a car accident).

Graduation Criteria

Approaches for transitioning individuals out of complex care coordination programs vary considerably across organizations, but three general strategies employed are: (1) a "step down" approach to reducing the intensity of services after a certain period of time or upon the achievement of identified goals; (2) a focus on fully graduating patients once health status is stabilized; and (3) provision of services in perpetuity. In making these determinations, most of the programs surveyed have graduation criteria based at least in part on the judgment of the care team, allowing clinicians some flexibility when applying program interventions.

Next Steps

Inclusion, exclusion, and graduation criteria for complex care programs are areas ripe for further investigation. Research that links alternative approaches to these criteria to patient outcomes would advance our collective understanding of how to most effectively target limited care management resources.

Sample Complex Care Program Eligibility Criteria: Survey Results

Organization	Inclusion Criteria	Exclusion Criteria	Graduation Criteria
AccessHealth Spartanburg Spartanburg, SC	■ One or more diagnosed chronic conditions; ■ Hospital utilization in the last 12 months; AND ■ Uninsured	■ Income higher than 150% of the federal poverty level (FPL);[3] OR ■ Non-Spartanburg County resident	■ Obtains insurance coverage; OR ■ Income rises above the threshold for the program (150% FPL)
Boston Health Care for the Homeless Program Boston, MA	■ Experiencing or have recently experienced homelessness; AND ■ Top 10% highest-cost Medicaid patients: • Six or more ED visits in the past six months; OR • Two or more inpatient admissions within the last six months	■ Primary diagnosis of mental illness; ■ Cognitive impairment; ■ Oncology diagnosis; ■ Complications of a progressive chronic disease with limited treatments (e.g., end-stage renal disease); ■ Dually eligible for Medicaid and Medicare; OR ■ Inpatient admissions specifically due to an acute problem	None
Camden Coalition of Healthcare Providers[4] Camden, NJ	■ Two inpatient admissions within last six months; AND ■ Two or more chronic conditions *(Patients are frequently recruited from the hospital bedside. Patients are further prioritized according to a set of additional factors.)*[5]	■ Oncology diagnosis; ■ Acute conditions without other complicating factors (e.g., trauma from an auto accident); ■ Living in a nursing home or assisted living facility; ■ Admission related to a surgical procedure for an acute problem; ■ Mental health diagnosis with no comorbidities; OR ■ Progressive disease with limited treatment	■ Determined to be ready by care team; AND ■ Possess long-term supports and able to self-manage care
Center for Health Care Services' Restoration Center Crisis Unit San Antonio, TX	■ At risk to themselves or others; ■ Brought in by law enforcement due to mental illness or addiction; ■ Severely mentally ill; ■ Substance use disorder; AND/OR ■ Experiencing homelessness (as defined by the U.S. Department of Housing and Urban Development, and the Substance Abuse and Mental Health Services Administration – housing insecure, open air, or car)[6]	Does not have a primary diagnosis of mental illness or addiction disorder	Determined to be stable enough to be referred to another community provider, and willing to be transferred
Los Angeles County's Care Connections Program Los Angeles, CA	■ Two acute care utilization equivalents[7] in the past year; ■ Diabetes with HbA1c >9 and co-occurring mental illness or substance use disorder; ■ One acute care utilization equivalent in the past year PLUS a history of any "high-risk" conditions;[8] OR ■ Two acute care utilization equivalents in the past year	Pose a physical threat to community health worker staff	■ Clinical judgment; AND ■ Warm handoff arranged with long-term care management program

Organization	Inclusion Criteria	Exclusion Criteria	Graduation Criteria
Maimonides Medical Center Brooklyn, NY	Super-Utilizer (SU) project: ■ Four or more inpatient visits in one year; OR ■ Four or more ED visits in one year Critical Time Intervention (CTI) project: ■ Behavioral health issues; AND/OR ■ Substance use disorder; AND ■ Three or more inpatient admissions in one year; OR ■ Three or fewer episodes of psychosis	Not insured by Medicaid	SU program: ■ Successfully connected to community-based care; OR ■ > 90 days post-discharge CTI program: ■ Enrolled for > 9 months
Mountain-Pacific Quality Health Billings, Helena, and Kalispell, MT	■ Two or more inpatient hospital admissions in six months; AND/OR ■ Two or more ED visits; AND • Chronic disease; AND/OR • Need for additional primary care	End of life/palliative care patient	■ Determined able to self-manage care; OR ■ > 90 days total enrollment[9]
Redwood Community Health Coalition's Partnership Health Plan Intensive Outpatient Case Management Program Petaluma, CA	■ Medi-Cal coverage through Partnership Health Plan; AND • One or more chronic medical conditions;[10] OR • Diagnosis of severe mental illness (major depression, bipolar disorder, or psychotic disorder); AND - One inpatient stay in the last 12 months; OR - Three or more ED visits in the last 12 months; OR - Chronic homelessness; AND - At least two separate insurance claims for the eligible condition	■ Diagnosed with chronic renal disease; ■ Uncooperativeness; ■ Poses a physical threat to staff, or is living in an unsafe environment; OR ■ Receives case management services through a separately funded program	■ Ineligible for enrollment in Partnership Health Plan's Medi-Cal plan for two or more consecutive months; ■ Becomes eligible for Medicare or other health insurance; ■ Care is "well-managed," defined as participating in another care management program; ■ Non-participation after 30 days; ■ Exhibits inappropriate or threatening behavior toward staff; ■ Living environment poses a safety or security risk to staff; ■ Incarcerated > 30 days; OR ■ Institutionalized > 30 days.
San Francisco Health Plan's Community Based Care Management Program San Francisco, CA	■ Two or more inpatient admissions in last 12 months; ■ One inpatient and five or more ED visits in last 12 months; OR ■ Six or more ED visits in last 12 months	■ In hospice care; ■ Utilization due to preplanned admissions, such as inpatient chemotherapy; ■ Utilization due to mental health if member is enrolled in intensive mental health case management; OR ■ Utilization due to pregnancy, if no complications	■ Achieves all care plan goals; OR ■ Non-participation (member is considered "lost to follow-up" after a six-week protocol is completed)
University of New Mexico ECHO Institute's Complex Care Program Albuquerque, NM	■ Age 18 or older; OR ■ Insured through Medicaid; ■ Two or more chronic conditions (which may or may not include mental health or substance use disorder); AND • One hospitalization in past six months AND one hospitalization in past 12 months; OR • Three ED visits in past six months	■ Utilization resulting from major trauma or childbirth ■ Insured through Medicare	None

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

ABOUT TRANSFORMING COMPLEX CARE

Transforming Complex Care is a multi-site demonstration aimed at refining and spreading effective care models that address the complex medical and social needs of high-need, high-cost patients. This national initiative, made possible with support from the Robert Wood Johnson Foundation and led by CHCS, is working with six organizations to enhance existing complex care programs within a diverse range of delivery system, payment, and geographic environments. For more information, visit **www.chcs.org/transforming-complex-care/**.

ABOUT THE COMPLEX CARE INNOVATION LAB

The *Complex Care Innovation Lab* is a national initiative made possible by Kaiser Permanente Community Health that brings together leading innovators in improving care for low-income individuals with complex medical and social needs. For more information, visit **www.chcs.org/innovation-lab/**.

ENDNOTES

[1] Hong, C.S.; Hwang, A.S.; and T.G. Ferris. (2015) *Finding a match: How successful complex care programs identify patients.* California Health Care Foundation. Available at: http://www.chcf.org/publications/2015/03/finding-match-complex-care.

[2] Hong, C.S.; Siegel, A.L.; and T.G. Ferris. (2014) *Caring for high-need, high-cost patients: What makes for a successful care management program?* The Commonwealth Fund. Available at: http://www.commonwealthfund.org/publications/issue-briefs/2014/aug/high-need-high-cost-patients.

[3] The Federal Poverty Level in 2018 is an annual income of $12,140 for an individual, scaling up to $42,380 for a family of 8: https://www.healthcare.gov/glossary/federal-poverty-level-FPL/.

[4] Standards attributed to Camden Health Care Coalition are for a model used since 2012, and now part of a randomized controlled trial.

[5] The Camden Coalition of Healthcare Providers considers the following additional factors on a case-by-case basis when deciding to include patients for within their care coordination program: (1) Polypharmacy; (2) difficulty accessing services examples, such as language barriers, history of non-compliance, low health literacy, etc.; (3) lack of social support at home or in the community; (4) homelessness; (5) mental health diagnosis.

[6] See United States Department of Housing and Urban Development. "Flowchart of HUD's Definition of Chronic Homelessness." Available at: https://www.hudexchange.info/resources/documents/Flowchart-of-HUDs-Definition-of-Chronic-Homelessness.pdf.

[7] LA County considers an "acute care utilization equivalent" to be: one admission OR two ED visits OR four urgent care visits OR one ED visit and two urgent care visits.

[8] Congestive heart failure; diabetes with HbA1c greater than nine; chronic obstructive pulmonary disease; asthma; coronary artery disease; PVD; cerebrovascular disease; uncontrolled hypertension with cardiac and/or renal complications; end-stage liver disease; end-stage kidney disease; dementia that is progressive with worsening function; failure to thrive; age greater than 90-years-old; depression with functional impairment; anxiety disorder with functional impairment/somatization; bipolar disorder with functional impairment; psychotic disorder; and/or substance use disorder.

[9] While MPQH has a set goal of 90 days enrollment, patients are not removed from the program until they demonstrate the ability to self-manage their care.

[10] IOPCM's chronic conditions are: asthma, chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, congestive heart failure, coronary artery disease, chronic liver disease, dementia, and substance use disorder; OR, hypertension AND: COPD, diabetes, coronary artery disease, or congestive heart failure; OR, asthma AND: diabetes, substance use disorder, depression, or obesity.