Home Based Services Program Description

Home care services are covered services in most CareFirst benefit plans. Use of these services is often random and almost never coordinated. Often, home care services are used for recovery from acute conditions and, because of limits on the number of visits or the degree of cost-sharing in the benefit plans, services are not used for the longer term maintenance of patients with chronic diseases.

With the creation of the Home-Based Services Program (HBS), CareFirst has launched an enhanced, purposeful use of HBS for those patients in Complex Case Management (CCM) or Chronic Care Coordination (CCC) Care Plans with the highest risk of hospital readmission or frequent ER visits. This new HBS Program offers these Members support at home that is more extensive, more carefully directed and more targeted at longer term complex cases. It also is more inclusive of a range of services including psycho-social and behavioral health services that are necessary to stabilize patients at home and to ensure their enhanced compliance with prescribed medications and other treatment protocols.

In 2013, CareFirst will develop CCM or CCC plans for over 30,000 patients that have been carefully selected as having a high likelihood for breakdown if their care is not coordinated. A substantial subset of these patients is likely to benefit from care coordination at home. The HBS Program draws referrals from Local Care Coordinators (LCC) and Complex Case Managers (CCM). Only Members who are in an active CCM or CCC Care Plan are eligible for an advanced HBS plan provided under the HBS Program.

CareFirst is presently seeking regulatory approval to waive cost-sharing and visit limits for patients in the HBS Program so long as the patients involved comply and cooperate with their treating providers and the terms of their care plans. This provides a special, elevated benefit to Members who meet criteria for the HBS Program.

Due to the focus on multi-chronic patients, home-based services are often provided on a sustained basis over a considerable period of time – often many months – and are, therefore, not episodic in nature. Member consent is required in order for each HBS service to be rendered. A PCP, NP or Specialist order is needed as well since the HBS will proceed under their guidance.

Five Home Based Services Program Goals:

There are five specific, practical goals of the HBS Program as follows:

- Reduce preventable re-admissions
- Reduce ER visits
- Reduce Member non-compliance/misunderstanding of prescriptions
- Reduce the cycle of breakdown, depression, confusion in the home.
Remove barriers to multiple services in the home by better assuring they are delivered in a coordinated way in the context of a holistic understanding of the Member’s needs

**Guidelines for Selection of Members for Home Based Services**

The selection guidelines for Member referral to the HBS program are intended to identify those Members who, were it not for coordinated HBS, would likely be admitted, readmitted, or inclined to use ER/hospital inpatient services. The selection criteria used to identify candidates for HBS from among those in active CCM or CCC Care Plans are as follows:

- Lace Score >10
- Hospital stay >30 days
- High Drug volatility score (8 to 10 on a 10 point scale)
- More than three ER visits within the previous six months
- Two unplanned admissions for the same condition within six months
- Multiple providers involved in care and treatment simultaneously
- Multiple chronic diseases
- Poly-Pharmacy and history and Medication compliance issues
- Psycho-Social Issues that threaten recovery or compliance with the care plan or medications

**Selected Home Care Agencies and Process for Referral to Them**

As the foundation for the HBS Program, CareFirst has identified and contracted with a select group of Home Health Agencies to carry out services in the HBS program based on a systemic review of the capabilities of these agencies on such factors as geographic adequacy, quality and cost performance as well as managerial and technical sophistication. Two agencies in each of the twenty PCMH regions have been identified.

The Home Based Services Program begins with a referral from a CCM or LCC who has already developed a Care Plan for an individual Member. The referral request is made through the CareFirst Service Request Hub in the iCentric system which then directs the request to the appropriate Home Based Services agency covering the geographic area in which the Member lives.
The HBS Program requires that a Home Care Coordinator (HCC) from the referred-to agency must conduct a comprehensive assessment of the Member and the situation in their home within 24 to 48 hours of referral. Based on this assessment, the HCC makes recommendations to the LCC or CCM who referred the case. All relevant facts and aspects of the comprehensive assessment must be entered by the HCC into the HBS section of the MHR of the Member in the iCentric system.

After discussion between the HCC and/or the referring LCC or CCM, the LCC or CCM solidifies a home-based services plan which must be approved by the patient’s PCP or other treating provider (specialist). This plan is incorporated into the larger care plan that already exists for the Member and is documented in the Home-Based Services section of the Care Plan Template in the online iCentric Member Health Record. The LCC or CCM maintains oversight of the implementation of the care plan – including the HBS portion – and stays in close touch with the HCC responsible for the HBS portion of the plan.

Components of Home Based Services Plan

There are three key components of the Home-Based Services plan: initial assessment, subsequent assessment, and frequent monitoring. Each Home-Based Services plan developed by an HCC as a result of a request by an LCC or CCM must include and start with a comprehensive assessment which must cover the elements listed below:

Environment and Psychosocial Assessment

- Family/care giver support and education
- Advanced Directives
- Home Safety issues
- Functional Limitations and Nutrition

Clinical Assessment

- Vital signs
- Pain Assessment
- Risk Factors
- Behavioral Health Assessment
- Allergies
- Screenings and Immunizations
Community/Resource Needs/Community Based Services

- Financial Situation
- Community Program support-Community Based Services Programs
- Enhanced Monitoring
- Custodial needs
- Transportation

Medications and Assessment

- Complete review and reconciliation

Services Needed

- Equipment required
- Skilled services
- Social work services
- Home health aides
- Behavioral health

Overall Situation Analysis

- Conclusions and key observations
- Basis for recommended course of action for Member

Thus, the Comprehensive Home Assessment entails an analysis of the overall home situation and recommends a clear action plan that is documented in the iCentric Home-Based Service portion of the Care Plan template that is applicable to the patient.
Process Guidelines

a. The Home-Based Services Member must be referred to the Home-Based Services Program by a Case Manager (CCM) or Local Care Coordinator (LCC)

b. The referral must be sent to the selected agency in the region where the Member lives via a Service Request through the CareFirst iCentric system

c. The home health agency must acknowledge and accept or deny the Service Request within 24 hours from receipt of Service Request. If denied, specific justifiable reasons must be presented and documented in the iCentric system.

d. The home health agency must contact the Member, schedule a visit and complete a comprehensive assessment within 48 hours from receipt of the referral.

e. The home health agency must document the Comprehensive Assessment in the iCentric HBS Template within 24 to 48 hours after completion of the assessment by entering their findings, observations and analysis into the iCentric Portal: All sections listed above must be completed. The HCC must document ongoing activities in the Home-Based Services Plan and/or the Encounter Notes section of the HBS portion of the iCentric system.

f. Discussion must occur between the LCC/CCM and HCC before the HBS plan is finalized and the agency must obtain approval from LCC/ CCM before proceeding with services pursuant to the Plan.

g. The home health agency must communicate, at a minimum of once a week, with the referring CCM or LCC and document all follow-up in iCentric.

h. The home health agency must frequently monitor and carry out services for the Member in accordance with the Home-Based Services plan.

i. The home health agency must establish periodic checkpoints for subsequent assessments to ensure new issues are being identified and managed.

Overall patient satisfaction is measured by an independent survey arranged by CareFirst and overall program satisfaction with the home health agency’s services is measured by the CCM or LCC that made the referral.

As each HBS plan proceeds for each Member, the goal is to reach the highest possible functioning level for the Member and to achieve a “graduation date” for the Member that when achieved, will free them from the need for continuing home-based services to the maximum extent possible. Such a date must be agreed to by the referring LCC or CCM who is responsible to obtain PCP/NP or specialist consent. With a completed, agreed upon plan, the home health agency can bill in accordance with the Master
Ancillary Provider Participation Agreements and the details described in this Home-Based Services Program Description.

If an HBS agency is non-compliant with these standards and processes, CareFirst will initiate a multi-step plan to help the agency return to compliance. First, CareFirst will investigate and provide verbal clarification of the requirements. If the agency continues to be non-compliant, CareFirst will provide a formal written action plan to them. Finally, the agency will be terminated from the HBS program if warranted.