Policy and Procedure No: CM 130.2	**Revision No: 2**
Division: Care Management	
Department: Care Management	
Title: PHP Chronic Care Management Program	
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Reviewed/Revised by: Karen Haughey	**Review/Revision Date: 12/5/2025**
Approving Committee: Utilization Management Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To define and operationalize the PHP Model of Care: Chronic Care Program, as it applies to all care management programs within.

Policy:

This policy reflects the PHP Model of Care, which describes a comprehensive Chronic Care Program, promoting the principles of coordinated care management to address the continuing care needs of all Members. The Chronic Care Program incorporates a philosophy of building relationships among Members, caregivers, health care providers, the PHP Utilization Management (UM)/Care Management (CM) Care Teams, Interdisciplinary Care Teams (ICT), and the community to promote Members' self-management of their conditions and health care. The Registered Nurse Care Team Manager (RNCTM) serves a centralized role in facilitating seamless care coordination for the Members.

Procedure:

<u>Interdisciplinary Care Team (ICT)</u>

1. CM services are delivered to Members using an ICT model.
    a. The ICT is a multidisciplinary team assigned to a specific Health Home/PCP.
    b. The ICT is composed of a core team and a support team.
    c. Each member of the ICT has a specific role and responsibilities in the care management of Members.
    d. Members are assigned to a Registered Nurse Care Team Manager (RNCTM and automatically by the electronic CM system software based on the Member's Health Care Center (HCC).
    e. Members may change RNCTM upon request. Reassignment is made by the Associate Director of Care Coordination or their designee.
2. The ICT meets on a regular basis.
    a. The RNCTM leads the ICT clinical review discussion.

b. Health Risk Assessments (HRA) and/or Individual Care Plans (ICP) are presented for review and discussion during the conferences.

c. Member ICPs are presented during the conferences and all ICT members have an opportunity to provide input into the ICP.

d. Health Plan Members may attend ICT conferences when their HRA and/or ICP are being discussed. Member input and attendance is encouraged.

e. Records and results of conference discussions are recorded in Members' electronic CM record.

f. Minutes of the conferences are maintained and stored on the K-drive.

3. PHP assigned RNCTMs establish professional working relationships with the participating network PCMH/PCPs.

    a. The ICT assigned to a network PCP to provide support and coordination of services as outlined in the Model of Care.

    b. Onsite clinic reviews and ICTs are scheduled and conducted by the RNCTM and/or Care Coordination Team at the PCPs who are network-based providers.

See Standard Operating Procedures: Interdisciplinary Care Team (ICT) and Patient Centered Medical Home (PCMH) Interdisciplinary Team Conference Working with PCMH/Primary Care Physicians (PCP) outside the AHF System.

<u>Health Risk Assessments and Risk Stratification</u>

1. Member Services assigns each new member a PCP based on the Members' choice or in the absence of a Member choice, a Plan designated assignment based on the Members home address. Members may change their PCP selection at any time.

2. New Member information is uploaded by the IT Department into the electronic CM system, which assigns each new member to an ICT based on the member's PCP

    a. The National Director or their designee has the option to reassign Members to a different ICT, if appropriate.

    b. The ICT is notified when a new member has been assigned to the team.

3. All new Members receive a New Member Welcome Call.

    a. The purpose of the call is to:

        i. Introduce the Chronic Care Program.

        ii. Obtain and confirm accurate demographic information.

        iii. Schedule an Initial HRA with the RNCTM or Care Team to gather HRA data.

iv. Ensure a PCP appointment and orient the Member to the Health Plan's benefits and services. Prior to the assessment, the Member's medical record is reviewed in the electronic medical record, when available, or at a participating network PCP's office where possible. If the RNCTM is unable to contact the Member by phone, he/she/they attempts to make face-to-face contact with the Member at PCP's office or face-to-face home visit.

v. If RNCTM is unable to contact Member by making three (3) separate attempts within a thirty (30) day period, an Unable to Contact letter is sent.

i. For unassessed members the contact attempts/letter process will resume the following month and forward until contact is established and an initial HRA is completed.

4. Comprehensive HRAs are conducted for all new Members.

a. For members convenience, HRAs both initial and annual are also mailed in a self-addressed stamped envelope for completion. Returned and completed HRA data is entered into the Care Management software system, and clinically reviewed and finalized by the RNCTM. The RNCTM with the member will develop an individual care plan (ICP) based on the information gathered from the HRA so that achievable goals are outlined and understood.

b. The RNCTM is responsible for conducting the assessment within ninety (90) days of the new Member's enrollment.

c. Initial severity levels are automatically generated by the electronic CM system based on the assessment.

d. The RNCTM has the authority to change the severity level, if appropriate, based on clinical observation and his/her/their knowledge of the Member's status. Reasons for changing the severity level from the algorithm determination is documented in the electronic Case Management (CM) record by the RNCTM.

5. Appropriate level of tasks will be delegated to appropriate ICT staff by the RNCTM. Comprehensive HRAs are conducted for all Members on an annual basis.

a. Annual HRAs are conducted face-to-face whenever possible and within three-hundred and sixty-four (364) days of the Member's last assessment.

b. The ICT identifies Members for whom an annual HRA is due by monitoring the electronic CM system reports on a monthly basis.

c. The annual HRA includes: the completion of HRA forms, updates on the Member medical history from the PCP, a comprehensive medication review, and a review of documentation ICP in the Member's electronic CM record.

d. HRA findings are recorded in the electronic CM record. If a change in severity is identified in an HRA the RNCTM adjusts the severity scoring and documents the reasons why in a Session Note.

6. Comprehensive reassessments are conducted for Members who experience a change in level of care (LOC) or clinical condition or at least within three-hundred and sixty-four (364) days of initial assessment.

    a. The RNCTM conducts a reassessment whenever there is transition in the Member's location of care (LOC) (e.g., an admission to a hospital or SNF, discharge to a SNF or home health, etc., or a material change in the Member's clinical condition).

    b. The transition of care (TOC) reassessment includes: the comprehensive medication reconciliation review, completion of survey questions appropriate to the Member's transition and/or change in condition, and updates on the Member medical history from the PCP.

    c. If a change in severity is identified in a reassessment the RNCTM adjusts the severity scoring and documents the reasons why in a Session Note.

See Standard Operating Procedures: New Member Enrollment into Chronic Care Program; New Member Welcome Call, Telephonic Outreach Protocol, Initial Health Risk Assessment and Severity Risk Stratification, Annual and Interim Health Risk Assessments and Changes to Risk Stratification and Home Visit Safety.

Invidivual Care Plans

1. ICPs are developed for all new Members.

    a. The RNCTM is responsible for developing the ICP within ninety (90) days of the new Member's enrollment HRA. After the ICP has been developed with input from the member, the PCP, the ICT, and, as appropriate, the Member's family/significant other(s)/caregiver. The RNCTM obtains verbal acceptance of the final ICP from the Member and documents the acceptance in the electronic CM system.

2. ICPs are subsequently updated in the electronic CM system. ICPs are revised as Members achieve their goals, when the Member's health status or level of care changes, and/or when new issues present themselves.

    a. The RNCTM follows the TOC process whenever there is a transition change in the Member's LOC.

    b. ICPs are updated in accordance with interventions and goals or upon reassessment. After the ICP has been updated with input from the Member, the PCP, the ICT, and, as appropriate, the Member's family/significant other(s)/caregiver, the RNCTM obtains verbal acceptance of the final care plan from the Member. A copy of the updated CP is maintained in the electronic CM system.

3. ICPs are monitored by the ICT for tasks and interventions for follow-up activity due dates.

    a. The RNCTM and/or an ICT member conducts the follow-up activities, as necessary and assesses progress toward goals.

    b. Results of the follow-up activities are documented in the Members ICP and Session Notes. The next appropriate follow-up activity is determined, documented, and

scheduled in the ICP.

See Standard Operating Procedures: Initial Care Plan Development; Care Plan Revisions and Individual Care Plan Follow-Up (Contacts).

Care Management Medical Social Worker, Community Health Worker(s) and Support Systems

1. ICT Members make referrals to the Care Management Medical Social Worker (MSW) to review Social Determinants of Health (SDOH) and other referral reasons such as: coordination of community services, documented problems, need for referral to support systems, and/or behavioral health issues.

    a. Referrals may be made through the electronic health system, telephonically, by fax, secure email or the task functionality in the electronic CM system.

    b. All referrals to the Care Management MSW are documented in the Member's electronic CM record.

    c. The Member is notified when a referral to the Care Management MSW has been made.

2. The Care Management MSW reviews the documentation and ICP in the Member's electronic CM record and contacts the Member face-to-face or by telephone to conduct the assessment, discuss a plan of action, and obtains the Member's agreement with the plan of action.

    a. The Care Management MSW works with the ICT to initiate appropriate services to meet the Member's needs.

    b. Results of the Care Management MSW contact is documented in the Member's electronic CM record and discussed with the ICT via the RNCTM.

3. Referrals to behavioral health providers and/or community providers such as: Housing Opportunities for Persons with AIDS (HOPWA), AIDS service organizations (ASO), Medicaid Waiver programs, group therapy, adult day care, addiction support groups, etc., are facilitated by the Care Management MSW.

    a. The Care Management MSW coordinates services for unmet needs and documents in the electronic CM record.

    b. The Member is provided with necessary information by the MSW. Outcomes of the support service are documented in the Member's electronic CM record.

4. The Community Health Worker works in collaboration with the Care Coordination team to establish a strong support system for members including but not limited to – accompanying members to appointments, locating members for outreach, SDOH issues within the scope of the CHW, hospital and SNF visits.

See Standard Operating Procedures: Referrals to Care Management Medical Social Worker, Care Management Medical Social Worker Assessment and Referrals to Support Systems.

Performance Measurement and Monitoring

1. PHP measures and monitors performance of the Chronic Care Program.

    a. In collaboration with the Director of Care Management, the Medical Director, and the National Director of Quality, is responsible for establishing performance measures and goals, as well as collecting and analyzing performance data to support ongoing quality improvement.

    b. The results of the analysis are presented quarterly to the Utilization Management Committee (UMC), the Quality Improvement and Health Equity Committee (QIHEC), and the Executive Oversight Committee (EOC) of the Board of Directors.

    c. Care Management leadership and staff are responsible for implementing improvement activities based on performance measurement results and ongoing monitoring and evaluation.

See Standard Operating Procedures: Chronic Care Program Performance Measurement and Monitoring.

Definitions:

1. Individual Care Plan (ICP): Documented information about the Member that fosters communication, collaboration and continuity of care across all care settings. It is tailored to each Member and includes current health status information, current problems, nursing interventions, medication regimen, Member's goals, and other information important to the medical and psychosocial management of the Member.

2. Care Management (CM): A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet Member's and family significate other(s)/care giver's comprehensive health needs, through communication and available resources to promote quality cost effective outcomes.

3. Chronic Care Program (CCP): PHP's care management program is a vehicle through which PHP creates and builds a partnership between physicians, Members, and their families/significate other(s)/caregivers through team conferences and Member conferences. The team's activities under the direction of the RNCTM are to assist in the development of comprehensive treatment plans and provide information on the Member's home environment and the psychosocial aspects of care. Improving the quality of life for Members positively impacts Member satisfaction with the organization. Better managing utilization of services has a positive impact on financial resources.

4. Patient Centered Medical Home (PCMH): The Patient Centered Medical Home is where the PCP, RNCTM, member and his/her/their family/significant other(s)/care givers are in a care partnership. This partnership impacts the quality of care for Members by providing a team approach to care. The ICT incorporates evidence-based practice into Member care interventions and coordinates medical and/or community resources in order to initiate the plan of care.

5. Interdisciplinary Care Team (ICT): A team of health care professionals, licensed and/or non-licensed staff, as well as the Member and his/her/their family/significant other(s)/caregiver(s) who work in a coordinated fashion towards a common goal for the Member. The ICT are dedicated to the ongoing and integrated care of the Member. The PCP is responsible for the medical plan of care and participation in the ICT. The RNCTM is responsible for managing the

Plan component of the team. Each team is assigned to a specific PCMH/PCP office. RNCTMs are assisted by the LVN/LPN Care Partners and non-licensed Care Coordinators. The Care Management MSW is an additional resource for the Members as well as the teams. The MSW participates in Member assessments and referrals for community resources as needed. The Health Plan Pharmacists supports the ICT through consultation, review of medication management, and continuing pharmaceutical/medical education for staff. The CHW provides insight gained from one on one contact and relationship building with members based on their needs.

Monitoring:

This policy and procedure is reviewed, updated and approved, as necessary, and at least annually by the Utilization Management Committee (UMC).

References:

1. Case Management Society of America, 2023. https://cmsa.org/

2. PHP UM Program Description

3. PHP Model of Care