AHF MCO of Florida, Inc. H3132
Chronic or Disabling HIV/AIDS Special Needs Plan

Model of Care Score: 87.50%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Positive Healthcare Partners Florida (PHP-FL) H3132 is a chronic condition special needs plan (C-SNP) that targets dual-eligible members with full Medicaid benefits who are living with HIV/AIDS disease in the Miami-Dade and Broward counties in Florida. Without access to appropriate primary medical care and adherence to antiretroviral therapy these members are likely to experience: significantly higher morbidity, e.g., from opportunistic infections such a Pneumocystis pneumonia and mycobacterial infections, opportunistic cancers such as Kaposi's sarcoma and lymphoma, HIV dementia, HIV wasting, cardiomyopathy and cardiac disease specifically related to HIV, increased complexities of managing other co-morbid medical conditions such as hypertension, diabetes, hyperlipidemia, pulmonary disease and significantly higher mortality rates. In addition, behavioral health issues, depression and the presence of multiple complex medical conditions, are also prevalent in this population.

Provider Network

PHP-FL provides a staff model along with a network of primary care physicians (PCPs) who specialize in internal medicine, family practice or infectious disease and who are classified as HIV/AIDS experts.

The SNP also contracts with: specialists who have experience treating HIV/AIDS patients, a behavioral health provider network, psychiatrists, psychologists, acute mental health facilities, physical and occupational therapists on an individual basis and PT/OT services in hospital settings, nurse practitioners, physician assistants, acute care facilities, ambulatory services in some geographic areas, urgent care facilities, long-term care and skilled nursing facilities, acute rehabilitation services, home health and hospice providers, a national lab vendor, a network of pharmacies and a dental network provider. PHP-FL healthcare centers also employ social workers and the SNP provides access to an after-hours nurse advice line and an on-call physician 24 hours a day.

Care Management and Coordination

PHP-FL uses a comprehensive self-developed tool to perform health risk assessments (HRAs) that incorporates features of "traditional" HRAs along with HIV/AIDS specific elements, including: member's medical history, history of HIV disease progression, HIV risk group and risk behaviors, sexual history and safer sex practices. The assessment also addresses co-morbid condition management, psychosocial evaluations, depression screening, SF-12 quality of life evaluation, HIV disease knowledge assessment, current medical treatment, comprehensive medication review, evaluation of activities of daily living (ADLs) and independent activities of daily living (IADLs). It further assesses family/significant other support systems, living conditions including risk for homelessness, home conditions, pets, travel to areas within the United States or internationally that may expose the patient to opportunistic pathogens, visual acuity history, hearing history and the use of prosthesis.

The registered nurse care team manager (RNCTM) conducts the HRA face-to-face or by phone within 90 days of enrollment and at least annually thereafter. The primary goal of the assessment is to determine the member's severity level so that care is consistent with the progression of disease. The information collected on the HRA is entered into an internally developed analytical database. This system analyzes the information and determines the member's acuity level based on an internally developed algorithm. The RN care manager subsequently reviews and validates the acuity determination.

The RN care manager develops the individualized plan of care (ICP) using findings from the HRA. The ICP includes problems, measurable goals to address each problem, interventions including specific services to assist the member in achieving the goals, medical treatment plans, and ancillary health care/community support agency input. The RNCTM reviews/revises the care plan in collaboration with the patient, PCP and other members of the care team if: there is a transition of care from one care setting to another, at the time of patient contact and on other occasions as needed.

Each member is assigned to an interdisciplinary care team (ICT). The ICT is led by a RNCTM and the PCP. Together, they comprise what PHP-CA refers to as the Core Team, which is designed to assist the patient to identify and articulate important aspects of care, assess knowledge of disease and progression, adherence with medications and care appointments and empower him/her to participate. The RN care manager facilitates weekly Core Team meetings to introduce the new patients, establish trust and model team participation.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at:
AHF MCO of Florida, Inc. H3132
http://positivehealthcare.net/florida/php/