H5852 AIDS Healthcare Foundation
Chronic or Disabling Condition (HIV/AIDS) Special Needs Plan

Model of Care Score: 98.33%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Positive Healthcare Partners California (PHP-CA) is a chronic care special needs plan (C-SNP) targeting qualified Medicare beneficiaries, i.e., those with Part A, Part B and Part D eligibility and/or full benefit dual-eligible Medicare and Medicaid beneficiaries who have a diagnosis of HIV/AIDS disease and reside in the Los Angeles County (LAC), California. There are 80,115 persons living with HIV/AIDS (PLWHA) in LAC. The incidence of members with HIV/AIDS is 772 per 100,000 for males and 98 per 100,000 for females. An estimated 60% of PLWHA, or 48,069 persons, in LAC are not receiving primary medical care and are most affected due to lack of access to health care and non-utilization of essential services are related to poorer health outcomes, especially among people of color.

Provider Network

PHP-CA provides specialized HIV chronic disease management focusing on care management, consumer empowerment, self-management, home safety, safer sexual practices, and prevention for positives (HIV), and transitions of care. The provider network consists of primary care physicians (PCP), nurse practitioners and physician assistants, specialists such as cardiology, oncology, endocrinology, ophthalmology, neurology and dermatology, acute care facilities for inpatient and ambulatory care, long-term care, skilled nursing facilities, free standing acute rehabilitation hospitals, acute psychologist, ancillary and support services such as lab, pharmacists, physical, occupational and speech therapist, dental services, social workers, mental health and behavioral health, home health and hospice care and 24-hour nurse advice line.

Care Management and Coordination

The health risk assessment tool (HRA) is completed within 90 days of enrollment and at least annually thereafter and upon significant change in the member's health status. The assessment is conducted telephonically but a home visit assessment may be performed if needed. The RN Care Team Manager (RNCTM) obtains additional input into the HRA from the member's HIV PCP. The HRA collects demographic data, employment, living environment, social services, ancillary health services, and benefits, mental health and life habits information, current therapy and/or medications, exercise, diet and nutrition, and activities of daily living, medical history, AIDS case definition categories (asymptomatic, symptomatic, AIDS indicator condition), ARV therapy history by drug category, investigational drug history, pain history, sexually transmitted diseases,

prosthesis and/or implanted devices and laboratory results. This initial information informs the care planning process and the development of the individualized care plan (ICP) and is shared with the interdisciplinary care team (ICT).

The ICT consists of the member or caregiver, the member's HIV PCP and the RNCTM. Other ICT members are added based upon the individual needs and could be a pharmacist, behavioral health professional, license practical nurse, care coordinators, medical social worker, utilization management nurse. The ICT meets on a routine monthly basis, with a concerted effort to meet on a personal, face to face basis, but when circumstances dictate, conference calls are made with web support whenever possible. The ICT conducts a comprehensive review of health trends of patients and overall clinical performance (based on the measurable goals).The ICT tracks and trends aggregate data collected from the HRA, medical record review and the medical and pharmacy claims system to identify opportunities to add specialized benefits, services or more refined interventions.

As previously stated, the RNCTM analyzes the HRA and collaborates with the ICT and PCP to create an ICP which is tailored to the member's needs and preferences. The ICP contains essential components such as identification of the problem/concern, goals or objectives that are specific, measureable, achievable/accurate, realistic and within a timeframe; a process called SMART). In addition, they perform specific interventions to achieve goals, tracking progress of the goals and continual evaluation to determine if goals are still achievable, and strategize to follow-up on those goals. The ICP will act as a roadmap, directing the improvement of the member's health status and quality of life. A copy of the ICP is available to the member, their caregiver/support system if appropriate, the ICT and PCP.

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: http://positivehealthcare.net/california/php/