Positive Practice

NEWS AND EDUCATION FOR POSITIVE HEALTHCARE PROVIDERS Issue 20 Spring 2021

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Model of Care 2021 Provider Training

Although many of you took the Model of Care Training already via a PowerPoint Presentation, below is a written recap!

What's this Model of Care (MOC) and why do we have to have one?

1. Medicare Special Needs Plans (SNPs) were created by Congress in the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare managed care plan that focus on certain vulnerable groups of Medicare beneficiaries which includes care for seniors and persons with disabilities (SPD).
2. AHF PHP is a C-SNP (the "C" is for "chronic" condition) that focuses on the vulnerable group with HIV/AIDs.
3. The Social Security Act requires that every Special Needs Plan must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).
4. Therefore AHF PHP has a MOC!

What is the MOC?

The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees.

- The MOC is a written document. It must ensure the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

What must be in the written MOC?

- NCQA assesses MOCs from SNPS according to detailed scoring guidelines published by CMS.
- The MOC requirements comprise the following standards:
- MOC 1 - Description of the SNP Population.
- MOC 2 - Care Coordination.
- MOC 3 - SNP Provider Network.
- MOC 4 - Quality Measurement & Performance Improvement.
- AHF PHP received a score of 98.67% on its written SNP Model of Care Program from NCQA/CMS for 2021.

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"Model of Care Provider Training" continued.

- Every member in our Plans has at least one chronic condition HIV/AIDS.
- Staffing of the Plan and the Provider Network is based on the model of health service delivery described in the model of care.
- The model of health service delivery is a hybrid one which combines Chronic Care Disease Management and Population Health.
- QI produces an annual MOC Dashboard to measure our success with implementing the MOC for every member.

It's teamwork by all staff at every level.

All staff receive an electronic copy of the Model of Care every year. The MOC training is also assigned to be completed by all network providers in AHF University (HealthStream). A hard copy is also available.

MOC 1 - Description of the SNP Population

- Every member of AHF Plan has at lead one chronic condition: HIV/AIDS
- Other population descriptors can be seen in table below:

Plan	Homeless	Mental Health Dx	Alcohol/Drug Dependence	ER Visits	Hospitalizations
CA_PHC	8.48%	56.92%	49.11%	26.56%	16.52%
CA_PHP	4.99%	68.33%	51.77%	25.36%	21.16%
FL_PHP	1.86%	64.96%	39.05%	26.96%	23.18%
GA_PHP	5.88%	44.12%	35.29%	2.94%	5.88%
Grand Total	3.71%	64.37%	43.79%	26.42%	21.46%

Cultural, linguistic and special needs sensitivity training is conducted annually. AHF publishes a monthly newsletter called CHORD which addresses these issues in addition to newsletter articles.

MOC 2 - Care Coordination Overview

- Starts with identifying chronic disease status by using the Health Risk Assessment (HRA) by the RN Care Team Manager (RNCTM)
- Severity Level (SL) is calculated from HRA results (SL 1, 2 or 3 or Low, Medium, High)
  - Members assigned SL 3 (High) are placed under Complex Care Management
  - Members assigned SL 2 (Medium) are placed under Chronic Disease Management
  - Members assigned SL1 (Low) are placed in Population Health Management
- A Care Plan, which includes member goals, is established and shared
- Interdisciplinary Care Team Meetings are held to coordinate care & discuss best options for care and its delivery
- Ongoing support – working the care plan – teaching self management to member
- Annual re-evaluation of member

Severity Level Definitions

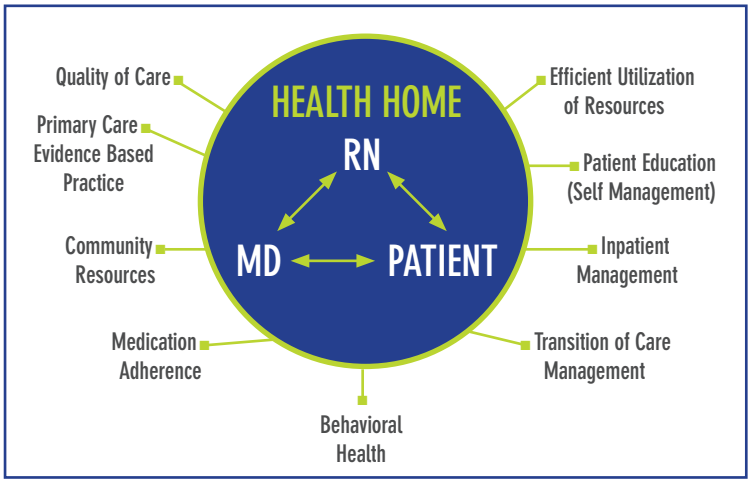
- Population Health Management (Low - SL 1) Addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions. (NCQA Resource Guide)
- Chronic Disease Management (Medium - SL 2) Ongoing care and support to assist individuals impacted by a chronic health condition with the medical care, knowledge, skills and resources they need to better manage on a day to day basis.
- Complex Care Management (High - SL 3) Designed for care of individuals with multiple chronic conditions, limited functioning and behavioral and social needs. Complex case management is a subset of case management aimed at members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.

Severity Determination Guidelines

Criteria	Severity Level 1 (Low) Population Health	Severity Level 2 (Medium) Disease Management	Severity Level 3 (High) Complex Care Management
HIV Viral Load	Undetectable Viral Load	Detectable Viral Load	Increased Viral Load
CD 4 count*	CD4 count >500	CD4 count <200-499	CD4 Count <200
Medication Adherence	ARV Adherence 95% or greater	ARV Adherence 85% or greater	ARV Adherence less than 85%
Hospitalization Acute Utilization	No hospitalizations within past 6 months	>1 hospitalization within last 6 months	>2 hospitalizations within the last 6 months
Emergency Department Utilization	No emergency department visits in the past 6 months	>1 emergency department visit in last 6 months	>3 emergency department visits in the last 6 months
Housing	Stable housing	Unstable or transitional housing	Transitional housing or homeless
Substance Abuse or Use/Addiction Disorder	No current abuse or active use / addiction disorders	Active abuse or use/ addiction disorder not in remission or relapse within last 3 months	Active substance use/ addiction disorder
Depression Screening PHQ9 Score	0-4	5-15	16 or greater
Mental Health Conditions (other)	May have diagnosis but no active complaints or concerns	Active diagnosis with questions or concerns	Active diagnosis with chief complaints
Uncontrolled Co- morbidities	3 or less	4 to 6	6 or more
Contact Frequency	Quarterly Outreach Annual HRA reassessment	Bi-Monthly (Q8 weeks) telephonic outreach Annual HRA reassessment	Monthly telephonic outreach Annual HRA Reassessment

Patient-centered Medical Health Home

A valuable concept that facilitates the achievement of Care Coordination and Population Health Management goals is the patient- centered medical health home (PCMH). The PCMH is a model of care that builds relationships between members and their care teams and streamlines care coordination. Please see illustration below.



MOC 3 - Provider Network Adequate + Specialized

1. • AHF Primary Care Physicians
   • Network Primary Care Physicians
   • Specialists
2. • Provider Contracts
   • Vision
   • Skilled Nursing Homes
   • Home Health
   • DME
   • Dental
   • Hospitals
   • Lab
   • Radiology
   • PT, OT & ST
   • Hospice

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Provider Network MOC Training

Code of Federal Regulations (42CFR §422.101(f)(2)(ii)) require SNPs to conduct MOC training for their network of providers.

- Training is provided initially and on an annual basis.
- Attendance at training must be documented.
- PHP uses a multidisciplinary team to implement the comprehensive training program.

MOC 4 - Quality Measurement & Performance Improvement Overview

Code of Federal Regulations (42 CFR §422.152(g)) require that all SNPs conduct a Quality Improvement Program (QIP) that measures the effectiveness of its MOC.

- The QI Plan outlines a coordinated and integrated system for organization-wide assessment and improvement. This is accomplished by:
  - Using comparative data to focus on areas of greatest opportunity for improvement.
  - Working collaboratively to develop or enhance mechanisms for patient safety oversight.
  - Working collaboratively to enhance the adverse events and peer review processes.
  - Dissemination of results across the organization.

Model of Care Dashboard

For the SNP members, their unique needs are considered as evidenced by the MOC Dashboard of measures.

Data Used to Evaluate if MOC Goals Met

PHP participates in both CMS required activities and internally developed activities that monitor quality of care and service. These measures are regularly reported out at least annually to the QMC, EOC, the Provider Meetings, ICT Meetings, and All Staff Meetings. The following outline summarizes the key components:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Health Outcome Survey (HOS)
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey
- Quality Improvement Project (QIP)
- Performance Improvement Project (PIP)
- Chronic Care Improvement Project (CCIP)
- Collection and reporting of Part C Reporting Elements (HPMS)
- Collection and Reporting of Part D Medication Therapy Management Data
- Grievance Aggregation and Category Stratification
- Initial Assessment and Reassessment Timeliness
- Star Ratings
- Internal Initiatives and Key Indicators

Questions? Please call or email Provider Relations at:

California: (888) 726-5411 capr@aidshealth.org,
Florida: (888) 456-4718 flpr@phcplans.org,
Georgia: (833) 267-6768 gapr@positivehealthcare.org.

Model of Care Dashboard 2020 - Based on 2019 Data (Sample Selection)

Measure	Measure Definition	Data Source	Benchmark	Timeframe	Goal Met	2020 Result 2019 Data	
Appropriate Use of Services for Chronic Conditions						CA	FL
% members with Viral Load Suppression <200mg	The percent of members with a viral load suppression <200mg	Data Warehouse	≥ 80%	Quarterly & YTD	Run chart presented quarterly at QMC	86%	83%
% members with at least 3 visits per year	The percent of members with at least 3 provider visits, 90 days apart or more, annually	Data Warehouse	≥ 80%	Quarterly & YTD	Run chart presented quarterly at QMC	93%	93.64%
ARV Adherence	Percent of member-years of enrolled beneficiaries 18 years or older with at least two fills of two unique products in the antiretroviral drug clss during the period measured	MedImpact	> 80%	Quarterly & YTD	Run chart presented quarterly at QMC	87%	86%
Percent of HIV patients not seen in first 6 months of MY	Percent of HIV patients who did not have a medical visit in the first 6 months of the measurement year	Data Warehouse	< 10%	Firts 6 mo's of measurement year	Run chart presented quarterly at QMC	74%	1%
Percent of HIV patients not seen in second 6 months period of MY	Percent of HIV patients who did not have a medical visit in the last 6 months of the measurement year	Data Warehouse	< 10%	Last 6 mo's of measurement year	Run chart presented quarterly at QMC	5%	5%

Initial Health Assessment (IHA) & Staying Healthy Assessment (SHA)

For all Medi-Cal managed care members within 120 days of enrollment, Primary Care Providers must perform an Initial Health Assessment (IHA), including a Staying Healthy Assessment (SHA), which is a California Department of Health Care Services (DHCS)-approved Individual Health Education Behavioral Assessment (IHEBA) tool. The IHA includes:

- Comprehensive history (which includes history of present illness, past medical history, social history and review of organ systems)
- Preventive services
- Comprehensive physical and mental status exam
- Diagnoses and plan of care
- Individual Health Education Behavioral Assessment (IHEBA) — also known as the Staying Healthy Assessment (SHA) — for each appropriate age group
    - Please note that the IHA is not complete without the SHA: DHCS provides links to SHA questionnaires by age group and language at: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx

Providers should document member outreach attempts and any member refusal to complete either an IHA or the SHA.

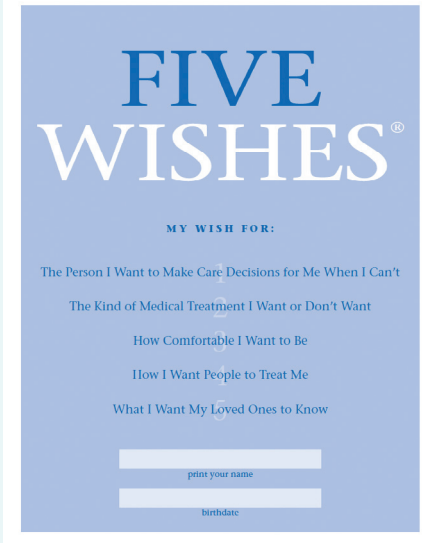
Advance Directive/Advance Care Planning Virtual Classes

AHF is offering monthly virtual "Five Wishes Workshops" so AHF patients can complete an advance health care directive, also known as living will. There are physician pay-for-performance indicators, as well as insurance plan indicators, measuring the number of patients with an advanced directive in their medical record. The measure is often referred to as "Advanced Care Planning". Currently, this measure requires annual documentation in the patient's medical record consisting of one of the following:

- The presence of an advance care plan in the medical record on or before December 31 of the measurement year.
- Documentation of an advance care planning discussion with the provider and the date when it was discussed. The documentation of discussion must be noted during the measurement year.
- Notation that the member previously executed an advance care plan. The notation must be dated on or before December 31 of the measurement year.

Please see schedule to the right and encourage your patients to make a reservation to attend one of the classes by calling Member Services. California plan enrollees call (800) 263-0067, Florida enrollees call (888) 456-4715, and Georgia enrollees call (833) 267-6768.

A $10 Gift card will be provided to those who attend and complete the process.



5 Wishes 2021
(last Friday of every month except November and December)

Date	Time	Date	Time
Mar 26	12:30 PST / 3:30 EST	Aug 27	12:30 PST / 3:30 EST
Apr 30	12:30 PST / 3:30 EST	Sep 24	12:30 PST / 3:30 EST
May 28	12:30 PST / 3:30 EST	Oct 29	12:30 PST / 3:30 EST
Jun 25	12:30 PST / 3:30 EST	Nov 19	12:30 PST / 3:30 EST
Jul 30	12:30 PST / 3:30 EST	Dec 17	12:30 PST / 3:30 EST

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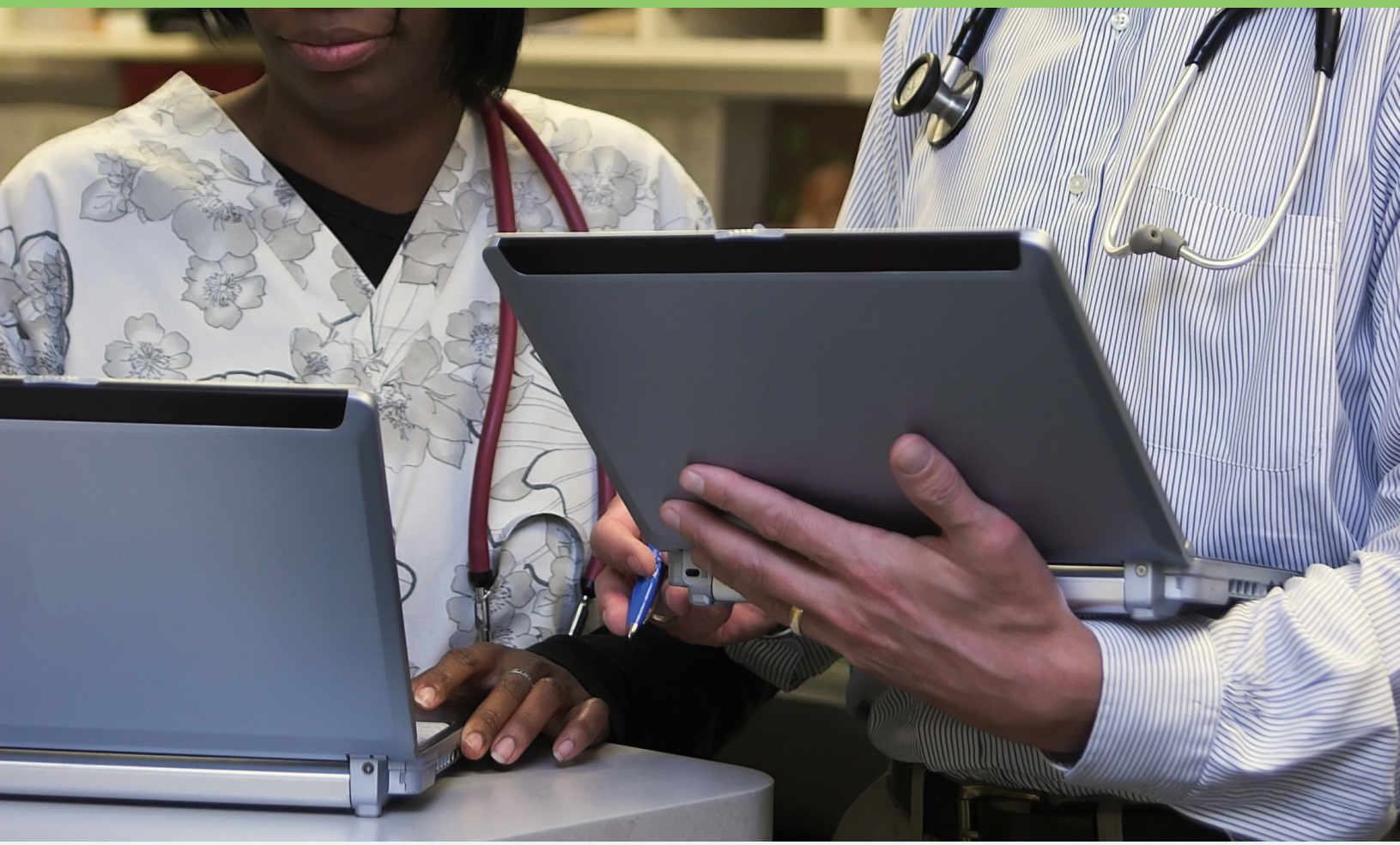
Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is a member-reported survey developed by the Centers for Medicare & Medicaid Services (CMS). Members respond to questions assessing their health and mental status. The HOS is administered annually to a random sample of Medicare Advantage (MA) beneficiaries. The same sample of respondents are surveyed again two years after the initial survey date. The HOS results contribute to a Plans Star Ratings. As one of our providers you are part of our Star Ratings and can help improve your scores. Some key HOS survey questions are listed in the table below along with tips to ensure patients feel well supported.

Measure	Sample Survey Questions to Patients	Tips for Success
Improving or maintaining physical health	• In general, how would you rate your health? • Does your health now limit you in these activities? o Moderate activities like vacuuming or bowling o Climbing several flights of stairs • During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? o Accomplished less than you would like o Were limited in the kind of work or other activities you were able to perform • During the past 4 weeks, how much did pain interfere with your normal work?	• Ask patients if they have pain, and if so, whether it's affecting their ability to complete physical activities they'd like to do in their daily lives. • Ask about goals the patients has that better pain management would allow them to achieve. • Then, identify ways to improve your patient's pain problem. • Determine if your patient could benefit from a consultation with a pain specialist, rheumatologist, or other specialist. • Consider physical therapy, cardiac, or pulmonary rehab when appropriate.
Improving or maintaining mental health	• During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems? o Accomplished less than you would like o Didn't do work or other activities as carefully as usual • How much of the time during the past 4 weeks: o Have you felt calm and peaceful? o Did you have a lot of energy? o Have you felt downhearted or blue? • During the past 4 weeks, how much of the time have your physical or emotional problems interfered with your social activities?	• Empathize with the patient. • Discuss options for therapy with a mental health provider when appropriate. • Offer ideas to improve mental health: o Take daily walks, o stay involved with family and friends, o own a pet, o complete puzzles or other games, o volunteer, o participate in a church, o go to senior community centers, and/or o help others solve a problem o try meditation, yoga or other relaxation techniques. • Consider a hearing test when appropriate as loss of hearing can feel isolating.

Attention: PHC California Providers Regarding Pharmacy Transition

The Department of Health Care Services (DHCS) is delaying the planned Go-Live date for Medi-Cal Rx Transition. This means that pharmacy claims will continue to be paid by PHC California. DHCS states they will provide further information in May. For more information, please visit: https://medi-calrx.dhcs.ca.gov/provider/



Review of HEDIS Measure: Transition of Care (TRC)

As CMS pushes forward the concept of a medical health home, the TRC measure was created to compel the provider office to acknowledge and follow-up hospitalizations of its patients. There are 4 sub-measures described as follows:

The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:

- Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

While the AHF PHP and PHC plans provide care management and will inform you of hospitalizations, you may find out about a hospitalization before the Plan does. Please document this notification. You can see there are severe time constraints to meet the measures. We also need your help with Medication Reconciliation post discharge.

We especially need your help with obtaining discharge information.

At a minimum, the discharge information must include all of the following:

- The practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge.

We will assist you with these measures but appreciate any documentation you can provide to help us.

How to Raise Your Risk Adjustment Scores

Based on presentation by Dr. Scott Howell, DO, Senior Medical Director of AHF PHP and published article:

Mandal AK, Tagomori GK, Felix RV, Howell SC. Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival. American Journal of Managed Care. 2017; 23(2): e41-e49.

[Initially published on January 10, 2017, as a Web Exclusive at: http://www.ajmc.com/journals/issue/2017/2017-vol23-n2/value-based-contracting- innovated-medicare-advantage-healthcare-delivery-and-improved-survival/P-1.

*Plan goal: **2.05** risk adjustment score for the very complicated HIV/AIDS PHP membership*

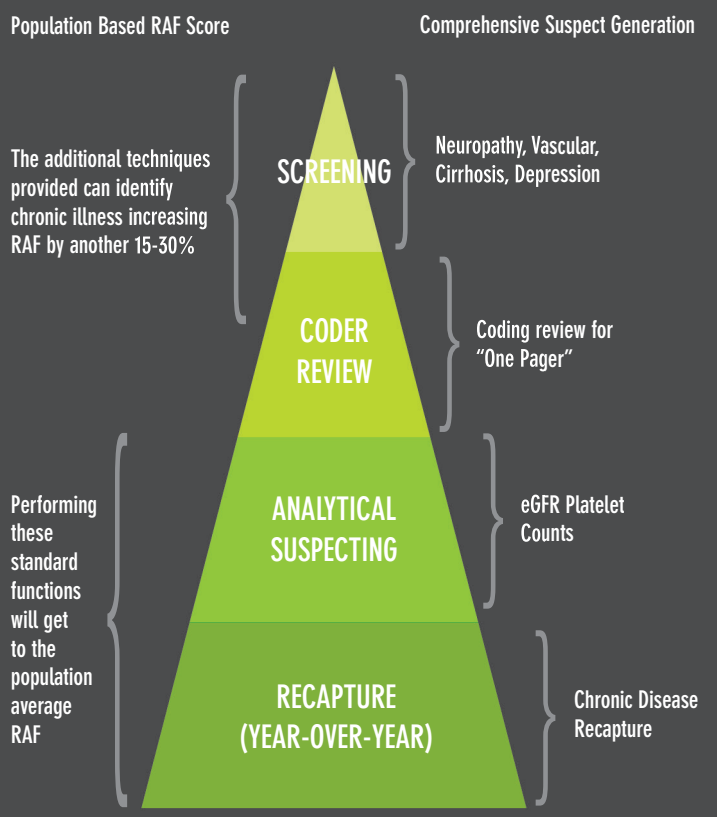
Tips for Risk Adjustment Approach to HIV

The graphic below illustrates how to get the best risk score possible.

Recapturing codes year after year will only yield the same or lower risk score.

To obtain the score that truly demonstrates the care needed by complicated patients, screen for disease progression especially to other body systems. Then, code results with most specific code as possible and use combination codes.

HIERARCHY OF SUSPECT GENERATION & INTERVENTION



Frequently Found Diagnosis and Codes in the HIV Patient

1. **Peripheral Neuropathy: Identify the Origin**
   You can use a simple monofilament testing strip to assist in your diagnosis of peripheral neuropathy.
   Neuropathy
   - HIV (G63)
   - Drug (G62.0)
   - Diabetes(E11.42)

2. **Use Quantaflo for PVD Identification I701 or I7020(x)**

3. **Consider using combination codes for diabetes complications**
   - Diabetic Neuropathy E11.40
     If a patient has diabetes and neuropathy there is an assumed causal ("complicated") relationship between the two conditions. The appropriate narrative would be diabetes with diabetic neuropathy.In this case only one code is required.
   - Diabetic CKD E11.22 [N18.-]
     If a patient has diabetes and CKD, the appropriate narrative would be diabetes with diabetic CKD. In this case you would need two codes to identify the stage of CKD. Example: E11.22, N18.- When more of the story needs to be identified a second code is required
   - Diabetic Vascular Disease E11.51
     If a patient has diabetes and PVD there is an assumed causal ("complicated") relationship between the two conditions. The appropriate narrative would be diabetes with diabetic angiopathy. In this case only one code is required.

4. **Renal Hyperparathyrodism E211**
   National Kidney Foundation recommends performing Phosphorus Calcium and PTH levels for all patients with eGFR < 45 ml/min (Stage 3b)

5. **Morbid Obesity E66.01**
   Defined as BMI > 35 with chronic disease required naming the specific disease (diabetes, hyptension, etc.)
   Any BMI over 40+ risk adjusts Z684(x)

6. **Protein Calorie Malnutrition E44(x)**
   - These six parameters are defined based on the amount of inflammation present mild (environmental/ socioeconomic), moderate (chronic disease) and severe (infection/trauma).
   - To formalize a national standard for protein calorie malnutrition in all clinical settings the following six parameters are evaluated with the requirement of two of the six for diagnostic criteria:
     - Insufficient Energy Intake (<75% energy requirements for > 1 month)
     - Diminished Functional Status (as measured by hand grip strength)
     - Weight Loss (5% 1 month; 7.5% in 3 months; 10% in 6 months 20% in 1 year)
     - Loss of Muscle Mass (mild or severe)
     - Loss of Subcutaneous Fat (mild or severe)
     - Localized of Generalized Fluid Collection (may sometime mask weight loss) (mild or severe
7. **Major Depression only Risk Adjust**
   Use PQ2/PQ9 annually
8. **Drug Dependency**
   Be careful with assigning dependency for opiates or benzo if they are prescribed for a specific reason of pain or anxiety or sleep. These would be the primary reason and would be considered long term users.....

INTERPRETING PHQ-9 SCORES

Diagnosis	Total Score	For Score	Action
Minimal depression	0 - 4	≤ 4	The score suggests the patient may not need depression treatment
Mild depression Moderate depression	5 - 9 10 - 14	5 - 14	Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression Severe depression	15 - 19 20 - 27	> 14	Warramts treatmenmt for depression, using antidepressant, psychotherapy and/or combination of treatment

9. **Please Understand the Underlying Pathology Prior to Documentation**
   - Senile Purpura
   - Secondary Hyperaldosteronism
   - Hypercoagulable State
   - Dementia
   - Drug Dependence/Substance Abuse Disorder for Opiates/Benzodiazepines
10. **Quality Scores**
    - Order all the diabetic tests
    - Referral for Eye Exam or Internal Scheduling
    - ColoGuard for 2021
    - Medication Adherence
    - Statins
    - Oral Diabetic Medications
    - Anti-hypertensives

Improve Provider Care Coordination – ALWAYS, EXCELLENT, 10

Each year, our members get a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). These surveys ask your patients (our members) to rate and evaluate their experiences with the best possible answer being Always, Excellent or 10!

The survey is comprised of several categories however; this tip sheet will focus on only one of those categories: Care Coordination. Care Coordination only scored below average for California however it was above average for Florida. It is important that the scores reflect the good care you are providing! For this category the questions asked of your patients are:

- **In the last 6 months:**
  - when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
  - when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
  - when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
  - how often did you and your personal doctor talk about all the prescription medicines you were taking?
  - did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
  - how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Please help us increase the score for California and sustain the good Florida results. Some improvement tips are:

- When you refer a patient to a specialist, ask the patient to bring you a copy the specialist report.
- Regularly talk to your patients about any specialists or other providers they have seen or need to see.
- Consider implementing a reminder in the medical record to request test results or follow-up reports. This will ensure appropriate follow-up for the patient.
- Set an expectation for the patient so they know when they will receive a follow-up call or test results.

Questions to ask your patient's:

- How did your appointment go with the specialist?
- Did he/she explain the treatment plan to you?
- Were you comfortable with the information and how it was explained?
- Did you receive your results on any testing that was done?
- Do you need another appointment or do you have a follow-up appointment already scheduled?
- Do you have any concerns with the treatment you received or will need going forward?

New HEDIS Measure: Kidney Health Evaluation for Patients With Diabetes (KED)

The National Kidney Foundation (NKF) partnered with the National Committee for Quality Assurance (NCQA) to create a new Kidney Health Evaluation Measure for Patients with Diabetes.

The new measure assesses the percentage of people aged 18 to 85 years with a diagnosis of diabetes who received both of the following during the measurement year on the same or different dates of service:

- At least one eGFR (Estimated Glomerular Filtration Rate Lab Test).
- At least one uACR identified by both a quantitative urine albumin test (and a urine creatinine test with service dates four or less days apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.

HIV Clinical Practice Guidelines Approved by AHF

The AHF Department of Medicine and the Managed Care Division Clinical, Quality and Utilization Staff participant in approving the practice guidelines the organization adopts. Clinical practice guidelines are adhered to in all aspects of work including but not limited to member newsletters, provider newsletter, member education, provider education, member engagement, etc., Highlighted in this issue are the DHHS Guidelines that provide best-evidence recommendations for ARV treatment of adolescents and adults (as well as pediatrics), opportunistic infection prevention and treatment, and perinatal care. For more detailed information please see: https://clinicalinfo.hiv.gov/en/guidelines

Model of Care Training Winners!!!

AHF Providers were challenged to complete their Model of Care Training by 2/28/2021 and win Above and Beyond Points and a Pizza Lunch for their Health Care Center. Congratulations to the following Health Care Center winners!

- ★ Downtown Fort Lauderdale
- ★ Homestead
- ★ Jacksonville
- ★ Liberty City
- ★ Oakland Park
- ★ Upland/Whittier/Riverside
- ★ Carl Bean
- ★ Long Beach

Congratulations!

CDC Recommended Adult Immunization Schedule 2021

The Infection Control and Prevention Committee under the leadership of Interim Director of Infectious Disease, Dr. Stuart Burstin, approved the following vaccines with the additional information for HIV patients. See table below.

Routine Vaccination in Patients with HIV

Vaccine	CD4-<200	CD4-≥200	Comment
Influenza			Quadravalent: HD, recombinant or adjuvanted ≥ 65 or CD-4≤200
Tdap			Every 10 years
Shingrix			Approved for all over 50, consider for all but reimbursement issue
HPV			3 doses through 26, 27-45 consider for high risk [insurance coverage]
PCV 12			Initial pneumococcal vaccine regardless of age
PPSV 23			*At least 8 weeks* after PCV 13 then every 5 years
HAV*			Routinely administered children 2007
HBV*			Three doses: Engerix, Recombivax, Twinrix {A&B} Two doses Heplisav-B
Men ACWY			Initial series revaccinate every 5 years risk > MSM
Men B			Consider if other indication
MWR			If born after 1957 and no immunity CD-44 > 200 six months
Covid-19			Variable by state: HIV may be considered immunocompromised

**Testing for anti HAV antibody and HbsAb*

Orange cell: if CD4 < 200 or age >65 use Quadravalent HD, recombinant or adjuvanted.

Green cells: no change from CDC recommendation

Blue cell: Shaded due to the different age of reimbursement, 50, but hopefully some insurance companies will start to reimburse at a lower age if CDC changes recommendations.

Yellow cells: Men B requires another indication, such as dormitory living or outbreaks.

Red cells: COVID in the different color for emphasis and the fact that the ACIP has not made any specific recommendations.

Vaccinations are critically important for people infected with HIV. HIV infected people should receive all routine vaccinations, such as TdaP, influenza and HPV; however they are at increased risk of other infections requiring additional vaccinations. All hepatitis viruses are problematic in people with HIV, and screening followed by vaccination or therapy is appropriate. Vaccination for pneumococcal pneumonia is recommended, if possible starting with conjugate vaccine followed at least eight weeks later polysaccharide vaccine. Meningitis remains a rare event but can be seen, especially in outbreaks in MSM. In the table above, recommended vaccines are listed and differences in the people who require special consideration are specified by color deviations from green and explained in the narrative.

The vaccines available for Covid-19 should be used in all people who can be vaccinated as soon as possible. There are limited data available for the response in people with low CD-4 count, but that is not a contraindication to vaccination, especially since there are some data that HIV infected people with CD-4 count < 200 may have a slightly worse prognosis.

Mask Up!

Do not wear your mask in the following ways -

Around your neck

On your forehead

On your Chin

Under your nose

Positive Practice

NEWS AND EDUCATION FOR POSITIVE HEALTHCARE PROVIDERS Issue 20 Spring 2021

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Eye Care Improvement at your Fingertips

RetinaVue700 Camera has been delivered to 10 AHF Healthcare Centers! Here are Provider FAQ's as the work flow process is perfected.

1) What is the RetinaVue 700 Camera?

a. The RetinaVue700 Camera is a handheld camera used specifically to take a picture of the retina in a primary care office.

2) How does the RetinaVue700 Camera process work in my office?

a. Staff has been designated at selected AHF Healthcare Centers to be trained and take the picture to complete the retinal eye exam screening during your routine appointment for your diabetic patients.
b.. The picture taken by the camera is submitted to website and read by an ophthalmologist.
c. Your patient's eyes will not need to be dilated.
d. It easy, quick and may save the eyesight of your diabetic patients, especially since this screening can be completed in one of the designate health care centers.
e. Patients will not have to make a different appointment and go to another provider.
f. If the retinal eye exam screening is positive, then you would refer the patient out to a specialist.
g. Please add CPT code 92228 on your claim when a retinal eye exam is performed during routine visit. If an E/M service is rendered along with the eye exam, use modifier 25.
h. If the patient only comes in for the eye exam, bill only 92228.

3) Which provider offices have the RetinaVue 700 Camera?

a. In California:

i. AHF Downtown	1400 S. Grand Ave. Ste. 801 Los Angeles, CA 90015 Phone: 213-741-9727
ii. AHF Hollywood	1300 N. Vermont Ave Ste. 407 Los Angeles, CA 90027 Phone: 323-662-0492
iii. AHF Valley	4940 Van Nuys Blvd. Ste. 200 Sherman Oaks, CA 91403 Phone: 818-380-2626
iv. AHF Westside	99 N. La Cienega Blvd. Ste. 200 Beverly Hills, CA 90211 Phone: 310-657-9353

b. In Florida:

i. AHF Fort Lauderdale	700 SE 3rd Ave. Ste. 301 Fort Lauderdale, FL 33316 Phone: 954-767-0887
ii. AHF Jacksonville	2 Shircliff Way DePaul Bldg. Ste. 900 Jacksonville, FL 32204 Phone: 904-381-9651
iii. AHF Kinder	3661 S. Miami Ave. Ste. 806 Miami, FL 33133 Phone: 786-497-4000
iv. AHF Northpoint	6405 N. Federal Hwy. Ste. 205 Fort Lauderdale, FL 33308 Phone: 954-772-2411
v. AHF Oakland Park	1164 E. Oakland Park Blvd. Oakland Park, FL 33334 Phone: 954-561-6900
vi. AHF South Beach	4308 Alton Rd. Ste. 950 Miami Beach, FL 33140 Phone: 305-538-1400

RetinaVue 700 Camera

continued on back

continued from front

4) Which patients may have the RetinaVue 700 Camera exam?

a. The RetinaVue 700 camera is for all diabetic patients needing their annual diabetic retinal eye exam. Even contact lens wearers and patients that have artificial lenses post cataract surgery may be examined.

5) Are there any Member incentives for the Retinal Eye Exam?

a. AHF offers a $20 incentive for completion of the diabetic retinal eye exam for PHP and PHC Plan members. Patients would have to check with their insurance if they are not members enrolled in the AHF PHP or PHC Plan.

6) How does a patient make an appointment for an eye exam?

a. It is as easy as a call to your local AHF Healthcare Center that has the RetinaVue Camera.
b. Workflow processes are currently being worked out to identify a diabetic patient during a routine visit so that the healthcare center can automatically offer the eye exam.

7) How long does the exam take?

a. The exam will take approximately 15-20 minutes, at the most, once in the eye exam area.
b. Sunglasses are being provided to each healthcare center with a camera so that the patient can put these on as soon as possible so that retina can enlarge. This may speed up the time it takes to complete a good picture.

8) Who is trained to use the RetinaVue 700 camera?

a. RN managers and medical assistants are the first being trained to use the camera.

9) What if I forget my password?

a. Request a password reset.
b. Enter your clinic
c. User Name in the field and then click Reset Password.
d. Once you receive an email notification with the password reset instructions, launch your web browser, navigate to the Customer Portal, and copy and paste the password into the password field.

10) Are there any contradictions to using the RetinaVue 700 camera?

a. It is safe for almost all patients. It can even be used on patients wearing contacts and post cataract surgeries.
b. However, if a patient has a history of seizures or epilepsy triggered by light flashes, please continue to refer them out.

11) Do we need a physician order for the exam?

a. Yes, the provider will write the order for the exam.
b. No prior authorization is needed for most plans since this is a preventative health screening.
c. AHF Plans – PHP & PHC DO NOT require a prior authorization.

12) Who do we reach out to for problems?

a. The RN Manager is your office administrator. If there are still questions, reach out to
Christine Uranaka, RN National Quality Auditor AHF
Christine.uranaka@aidshealth.org
954-594-0827

Helpful link:
https://www.hillrom.com/en/products/retinavue-700/