LOS ANGELES COUNTY
COMMISSION ON HIV

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AGING TASK FORCE

VIRTUAL MEETING AGENDA

Tuesday, May 4, 2021 | 1:00pm-3:00pm

JOIN VIA WEBEX ON YOUR COMPUTER:
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1) Welcome, Introductions, April Meeting Recap 1:00pm-1:10pm

2) Executive Director Report 1:10pm-1:30pm
   - Commission Updates
   - Co-Chair Support

3) 2021 Work Plan/Priorities 1:30pm-1:55pm

4) Discussion: 1:55pm-2:45pm

   - Discussion of DHSP Response to the ATF Recommendations and Determine Next Steps
   - Discussion on Creating a Comprehensive, Client-Led, Client-Centered HIV Care for PLWH over 50 Years in Los Angeles County
     a. Identify critical assessments
     b. Identify key or core desired clinical outcomes
     c. Identify key or core quality of life outcomes

5) Next Steps/Agenda development for next meeting 2:45pm-2:50pm

6) Announcements 2:50pm-3:00pm

7) Adjournment 3:00pm

LOS ANGELES COUNTY
COMMISSION ON HIV

AGING TASK FORCE

April 6, 2021 Virtual Meeting Summary

In attendance:

Al Ballesteros (Co-Chair)	Laurie Arnoff	Alasdair Burton
Michael Green	Lee Kochems	Jules Levin
Mark McGrath	Paul Nash	Katja Nelson
Maria Scott	Abdul-Malik Ogunlade (Intern)	Cheryl Barrit (COH Staff)
	Dawn McClendon (COH Staff)	Sonja Wright (COH Staff)

1. **Welcome & Introductions**
   - Al Ballesteros, Co-Chair and Cheryl Barrit, Executive Director, welcomed attendees and led introductions.
2. **April Meeting Recap**
   - Ms. Barrit referred the attendees to the meeting summary in the packet. She highlighted the main areas as follows: (1) review CPT codes in order to begin the conversation regarding looking at specific types of assessments that can be integrated into the Ryan White care system; (2) review HEDIS measures that are used for LA Care; and (3) revisiting the different modules of care for people living with HIV (PLWH) 50 years and older, including the examples from the Golden Compass program in San Francisco, Owens Clinic, etc. The models will be reviewed and assessed within the Aging Task Force (ATF) first, before deciding which models to present to the full body. Note: the materials related to the models are in the packet.
   - Ms. Barrit outlined what staff was asked to do : (1) research CPT codes for geriatric care and (2) literature reviews/summary along with other models of geriatric care for PLWH, etc., all of which are in the packet. She added that most of the information is pertaining to the Golden Compass; however, there are summaries regarding the Owens Clinic, Program for All-Inclusive Care for the Elderly (PACE), Desert AIDS Project, University of Colorado, and the University of Alabama.
3. **Executive Director's Report**
   - Ms. Barrit reminded commissioners of the importance of responding to the HealthHIV planning council survey; she indicated that 12 more responses were needed in order for the survey to yield significant and meaningful data for the outcome's assessment. If a 90% response rate is reached, HealthHIV will issue $20 gift certificates to all commissioners as a token of their appreciation.
4. **2021 Work Plan/Priorities**
   - The work plan was updated to combine related tasks in specific models around HIV care for older adults (i.e., staff revised the work plan to reflect what was discussed in previous meetings). For the remainder of the year, the ATF is hoping to address what it is listed on the plan and refine/revise as we go along. The ATF will review the Department of HIV and STD Programs (DHSP) feedback and analysis on the ATF

recommendations, different models of care, Dr. Tony Mill's presentation, and review CPT codes for geriatric care. Note: the geriatric codes are included in the packet on page 22. There are additional CPT codes prepared by Wendy Garland (DHSP) that are used in the medical outpatient program. These codes can provide an initial point of discussion for what codes are useful in individuals 50 and older and 50 and below. Ms. Garland will also review the usage of these specific CPT codes in the medical outpatient program for 65 years and older to see what kind of data it will yield. Note: the initial codes Ms. Barrit requested to have reviewed did not appear in the initial analysis for what is being used in the current medical outpatient program. The ATF will continue to work on HEDIS measures and get feedback/support from LA Care. The Master Plan on Aging will be revisited. With respect to Implicit Bias and Training, staff reached out to SCAN who will host a training on ageism, *Trading Ages*, on May 6th, 2021.

5. **Discussion:**
   - Co-Chair Al Ballesteros reiterated Mr. Mark McGrath's sentiments. Rather than just looking at CPT codes, the ATF should look at quality programs for aging; inclusive of depression screening, mental health assessments, bone density screening, colonoscopy after age 50 and 40 years of age in high risk people.
   - Mr. McGrath added it is not necessary to have all the geriatric CPT codes and to place more focus on streamlining the four CPT codes for general assessments (ex: the Golden Compass uses cognitive, bone, and mental health screenings; these are the core functions of this program).
   - Mr. Ballesteros inquired if the aforementioned CPT codes are funded by the Ryan White Ambulatory Outpatient Medical (AOM) system, as this would be distinctly different versus other populations.
   - Mr. Jules Levin completed a Request for Proposal (RFP) in New York to implement a program similar to the Golden compass. It included some of the items mentioned above, in addition to recommendations for age and gender. He noted that over the past few years he has had multiple discussions with the Health Resources and Services Administration (HRSA) who contend that it is up to local hospitals to decide whether they will implement programs like the Golden Compass. Also, there is no dedicated funding for these types of programs; the funds are sourced through outside grants.
     - Ms. Barrit will research the New York RFP and take an additional look at the Golden Compass to streamline the focus.
   - Mr. Lee Kochems reminded everyone that aging populations of different races and ethnicities might have different needs that the ATF should keep in mind.
   - Dr. Michael Green (DHSP) recommended that the ATF should review the Medical Specialty Programs and not the AOM as a doctor would make a referral for a colonoscopy, for example, through the Medical Specialty Program since colonoscopy is not a part of the AOM; this also pertains to bone density screening.

DHSP Feedback – Dr. Green

- Table format: DHSP put together a table detailing the recommendations set forth by the ATF. There is a column for who is responsible for trying to implement or collect additional data, as well as a column for status updates/responses. Dr. Green noted that it is a draft document with anticipation that it will become a living document as additional recommendations are received from the task force and responses, recommendations, and ideas from DHSP continue to evolve; as such, the response column will change reflecting the additional information (i.e., data, new studies, etc.). Note: wherever recommendations set forth by the ATF were unclear, DHSP noted that under the "status" section on the table. In addition, if there is specific information that DHSP is asking for to help clarify the recommendations, DHSP has highlighted that under this section as well. If there are requests outside of DHSP's purview, it is also noted.

Ongoing Research and Needs Assessment

1.) Encourage DHSP to collaborate with universities…

Dr. Green indicated this is already being done but not specifically through the lens of HIV and aging. He stated the articles DHSP received, most notably the Golden Compass, was extremely eye opening and created many questions in terms of how they should be providing services and what they should be doing for at least half of the population they serve under Ryan White services. He added that whatever types of relationships they can establish with other providers and academic institutions that are already involved in this work they will, versus trying to reinvent the wheel.

1a.) Conduct additional analysis…

This can be done through literature reviews and reporting back of key findings. DHSP's existing data is not thorough, and it depends on the primary focus of the ATF. Dr. Green inquired, is it to look at creating optimal programs of care for ages 50 and older *or* is ATF looking to see what is being provided now. Dr. Green noted that for the purposes of developing the fee for service rate, DHSP should revisit filtering for different populations and creating separate fee structures for separate standards of care to put into contracts as right now they are universal and not specific to one population.

1b.) Gathering data on PLWH over 50…

Ms. Wendy Garland has already started this process and they have faced challenges with locating and identifying the out of care population. In total, DHSP does not see any disparities in PLWH 50 years and older versus populations who are under the age of 50, in their care system. This is specific to looking at viral suppression and retention of care rates and based solely on these two items; the system is doing a reasonably good job in serving people 50+.

Items c through g- general discussion as follows:

- Mr. McGrath pointed out that for the population of 50 and older, the ATF needs to think outside of viral suppression and look at what is missing → the overall quality of life.
- Mr. Ballesteros expressed that other jurisdictions have realized their system is set up for younger and healthier populations, which might stem from not expecting the older population to have reached their senior years living with HIV. He recommended that the ATF should review the actual costs in an "ideal situation " of optimal care considering people 50 and over make up much of this population.
- Mr. Alasdair Burton inquired if DHSP could start collecting data on comorbidities experienced by this population in addition to the core components and present the data to HRSA as a way

engaging and bringing them out of silence on this topic.

- Dr. Paul Nash stressed that aging-related clinical outcomes should be considered due to HIV's effect on accelerated and accentuated aging → aging + HIV-related outcomes.
    - Dr. Green will have Ms. Garland reach out to him regarding his expertise and access to data on this topic.

Workforce and Community Awareness

2.) **Educate the COH, DPH, and HIV workforce and community at large…**
This needs to happen at the community level and is beyond the scope of DHSP as a single entity; however, DHSP will assist in any way they can.

3.) **Address ageism on the Commission…**
COH issue.

4.) **Openly discuss and examine as part and parcel of HIV planning and implementation…**
This is beyond DHSP's scope; however, they need to be included in the conversation due to the impact of their funding.

5.) **Educate the HIV workforce on HIV and aging…**
DHSP needs more clarification and specifics.

6.) **Train HIV workforce on diseases of aging…**
DHSP needs more specifics.

7.) **Train older adults on how to adapt to the new realities of seeking care…**
Dr. Green thought this was a good idea but requested guidance and suggestions for how DHSP would go about doing this. *How would DHSP operationalize this?* As a response to Mr. Burton's suggestion for teaching the population to become their own advocates in the discussion of item 7, Dr. Green informed the task force that DHSP has attempted in previous solicitations and program designs to include programs that would increase health literacy among younger populations who might be trying to enter care for the first time, however they have not looked addressing this for older populations. He acknowledged that DHSP has not done a good job at notifying individuals of the type of services available under Ryan White care.

- Ms. Barrit offered to add an additional column to the feedback table highlighting COH activities that might fit within the recommendations/status (ex: Standards and Best Practices (SBP) upcoming trainings). This approach will provide clarity for all the parts that might not be clear when viewing the table.
- Ms. Barrit will also extract the items that were not clear for DHSP and present them back to the group for further clarification and ideas, including ways to operationalize the recommendations. Note: if it becomes apparent that the recommendations are beyond the purview of DHSP and the COH, the ATF will discuss what to do next.

- Ms. Katja Nelson asked the ATF to review the following items in the packet:
    - Publication from the California Department of Aging as it highlights all the different proposals for investments regarding the governor's budget for the aging program.
    - PowerPoint - Equity and Aging Advisory Committee: they have an Impact Committee whose focus is to relaunch the Master Plan's work. The last meeting was held April 21st and consisted of discussing Mater Plan updates. The Equity Group flagged six initiatives, numbers 75-80, in the Master Plan, that they will be working on.

- Ms. Barrit concluded the ATF meeting by directing the group to the report from the Oregon Health Authority on Aging, HIV, and Long-term Survivors, plus the slides on Medical Monitoring (MMP) data which is used to assess survivors.

6. **Determine Next Meeting Dates and Times**
   - The Aging Task Force will meet on the first Tuesday of the month from 1pm – 3pm. The next meeting will be held on May 4, 2021, 1pm-3pm.
7. **Next Steps/Agenda Development**
   - The group will continue to review the feedback from DHSP at their May meeting; some areas are beyond the scope of DHSP.
   - Include local data in the Part A application to demonstrate the unique needs of the PWLHA over 50 years
   - Look at the aging population beyond viral suppression and retention to care measures. Look at quality of life and other co-morbidities; services must be client led and client centered
   - Collaborate with Standards and Best Practices Committee to help shape service standards
   - Policy oriented strategies were also discussed as a possible collaboration with the Public Policy Committee
   - Will continue looking at care models such as the Golden Compass program to understand specific assessments, service modalities, and funding streams used to develop a similar program in Los Angeles County
   - Ms. Barrit will continue reaching out to the non-respondents regarding the care models
8. **Announcements:** None.
9. **Adjournment:** meeting adjourned at 1:46 pm.

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May 6, 2021: 11 a.m. to 1 p.m.
Click on the link to join via Zoom:

https://scanhealthplan.zoom.us/j/95115168945?pwd=QnMxRzZrNTM3NjNZOEppKzRkdTcrdz09

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LOS ANGELES COUNTY COMMISSION ON HIV

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LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV 2021
AGING TASK FORCE WORKPLAN (Updated 3.16.21)

Task Force Name: Aging Task Force	**Co-Chairs: Al Ballesteros**
Task Force Adoption Date: 3/2/21_updated 4.26.21	
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021. **Prioritization Criteria:** Select activities that 1) represent the core functions of the COH and Committee; 2) advance the goals of the Comprehensive HIV Plan and Los Angeles County HIV/AIDS Strategy; and 3) align with COH staff and member capacities and time commitment.	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Determine and continue to refine next steps for recommendations.	Final recommendations completed 12.20.10.	Ongoing	Recommendations presented at November & December 2020 Executive Committee and December 2020 & January 2021 full Commission meetings. COH approved 1 year extension of the ATF until March 2022.
2	Review and refine 2021 workplan		Ongoing	Workplan revised/updated on 3/16/21,4.26.21.
3	Secure DHSP feedback / analysis on Aging Task Force recommendations.		~~April~~	~~Dr. Green provided DHSP feedback at April's ATF meeting.~~
	Study models of HIV care for older adults then determine speakers / programs to highlight at a full COH meeting. Include a panel of speakers, especially consumers who are not connected to care.	Invite Dr. Tony Mills to ATF meeting; Golden Compass, Owen's Clinic, University of Colorado, University of Alabama, AltaMed PACE Program, etc.	April-May	ATF will review models of care first to determine which presenters/program to feature at a full COH meeting
4	Review CPT codes of geriatric care. Review health screenings/risk assessments for older adults and discuss how they may be integrated in Ryan White services		April-May	~~CPT codes introduced at April's ATF meeting.~~
5	Review HEDIS measures used by LA CARE Health Plan | Caring for older adults		April-May	Al to contact LA CARE
6	Review, track and revisit Master Plan on Aging		Ongoing	

7	Conduct ageism training for the community.	Raise awareness about implicit bias with specific focus on ageism.	May 6 11am to 1 pm	Partner with SCAN to co-host Trading Ages training.

Los Angeles County Department of Public Health
Division of HIV and STD Programs

Commission on HIV –**Aging Task Force Recommendations** to COH, DHSP, and other County and City Partners, FINAL 12/10/2020
DHSP Response: 4/05/2021

Recommendations	Who	Status/Notes
General Recommendations		
1. Collaborate with traditional senior services or physicians, or other providers who specialize in geriatrics and leverage their skills and expertise of those outside the HIV provider world.		• Not clear who this is directed to and where this expertise should be directed • Request that COH engage geriatric physicians/specialists in COH work and potentially present at upcoming COH meeting? • Collaborate with APLA Aging efforts?
2. Ensure access to transportation and customize transportation services to the unique needs of older adults.		• Beyond DHSP • CHHS Master Plan on Aging • Review Transportation contracts to ensure alignment with community need (this also came up during YCAB EHE Events as a priority)
3. Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV	CCS	• Benefits Specialists are expected to be versed in all services, programs and referrals for all of their clients. We can ensure this is happening during program reviews.
4. Direct DHSP to start working with agencies that serve older adults such as the Los Angeles County Workforce Development, Aging and Community Services, City of Los Angeles Department of Aging, and DPH Office of Senior Health to coordinate and leverage services.		• Need more information on the goals and expectations of these collaborations and how the commission is already working with these agencies.
5. Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.		• COH purview

Recommendation	Who	Status/Notes
Ongoing Research and Needs Assessment		
1. Encourage the Division of HIV and STD Programs (DHSP) to collaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issues:		
a. Conduct additional analysis to understand why approximately 27% of new diagnoses among persons aged 50-59 and 36% of new diagnoses among person aged 60 and older were late diagnoses (Stage 3 – AIDS) suggesting long-time infection. This may reflect a missed opportunity for earlier testing as it seems likely that persons aged 50 and older may engage in more regular health care than younger persons. (Data Source: 2019 Annual HIV Surveillance Report))		• This may be able to be addressed through a literature review and report back of key findings by DHSP. • Compare LAC with other jurisdictions, CA and US to see if unique to LAC • Could this be addressed through efforts to increase routine testing as older people are probably more likely to be in care for non-HIV related health conditions?
b. Gather data on PLWH over 50 who are out of care or those who have dropped out of care to further understand barriers and service needs.		• Locating and identifying the out of care population has been a challenge in the past. DHSP can review data from the Linkage and Re-Engagement Program (LRP) to identify barriers to care and service needs of PLWH over 50 who are out of care.
c. Conduct studies on the prevention and care needs of older adults.		• A literature review would probably be able to inform this • Perhaps the commission should partner with academic institutions for this
d. Understand disparities in health outcomes within the 50+ population by key demographic data points such as race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status.		• First step is to determine whether there are disparities and where they are • A literature review would help to inform as relates to those living with HIV • CHHS Master Plan on Aging

e. Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.		• Recommend to start with a literature review -not sure we have adequate data to address.
f. Conduct deeper analysis on mental health, depression, isolation, polypharmacy and other co-morbidities that impact the quality of life of older adults living with HIV.		• Recommend starting with a literature review
g. Conduct analysis of best practices on serving older adults in non-HIV settings and adapt key strategies for a comprehensive and integrated model of care for the population. Examples of best practices to explore are National Association of Area Offices on Aging (https://www.n4a.org/bestpractices) and Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Growing Older: Providing Integrated Care for an Aging Population. HHS Publication No. (SMA) 16-4982. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.		• This seems beyond scope of what we can do and has likely already been done and may be included in one of the listed docs. Perhaps SBP can create or adopt standards for this population. • This may overlap with broader recommendations in and the scope of the CHHS Master Plan on Aging as it may extend to all aging populations. • Recommend SBP work with Aging Task Force to develop best practices for working with PLWH aged 50 and older
h. Request DHSP to develop a data collection and reporting plan with a timeline on an annual report to the community.		• Could we include additional age groups – as appropriate to reports already generated?
Recommendation	**Who**	**Status/Notes**
Workforce and Community Awareness		
2. Educate the Commission on HIV, Department of Public Health, HIV workforce and community at large on ageism, stigma, and build a common understanding of definitions of older adults, elders, aging process and long-term survivors of HIV.		• Beyond DHSP • Within COH's purview? • Would CBA providers be able to provide these trainings?

3. Address ageism on the Commission on HIV and the community at large through trainings and by convening panels composed of Ryan White and prevention services clients and subject experts.		• COH
4. Openly discuss and examine as part and parcel of HIV planning and implementation, the impediments to HIV prevention and care among aging populations posed by the historically embedded discrimination and bigotry institutionalized in mainstream US culture and society, as well as embedded in subcultural (ethnic, racial, social, religious, etc.) cultures and institutions that often goes unacknowledged: that is the interconnected/overlapping linkages between ageism (or what is expressed in ageism) and societal heteronormativity/homophobia (internalized and cultural), sexism, misogyny, racism, xenophobia, ableism, and all forms of discrimination and bigotry targeting "The Other."		• Beyond DHSP
5. Educate the HIV workforce on HIV and aging, including but not limited to how to work with the non-profit sector to link seniors to health, social services, and HIV prevention and treatment services.		• Need more information/clarification
6. Train the HIV workforce on diseases of aging, such as cardiovascular disease and osteoporosis and dementia, and equip staff with the knowledge and skills to properly assess and treat conditions that impact older adults.		• Not sure this is DHSP? Could COH work with RWP/HRSA on workforce development or the AETCs? • Collaborate with DPH Office of Aging and invite representative to present at COH meeting?
7. Train older adults on how to adapt to the new realities of seeking care as they progress in the age spectrum. Train the HIV workforce on how to develop and deliver classes to older adults with respect, compassion, and patience.		• Mixing directives; first item seems beyond scope of DHSP. Second item maybe fits with item 6 above?

8. Expand opportunities for employment among those over 50 who are able and willing to work.		• Beyond DHSP • CHHS Master Plan on Aging
9. Provide training on the use of technology in managing and navigating their care among older adults.		• Could this be part of the $ we provide to agencies to strengthen telehealth services?
10. Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.		• Related to items #6 and #7?
11. Collaborate with local resources and experts in providing implicit bias training to HIV service providers.		• I believe this is probably already a resource we provide in our trainings to contracted providers • Share implicit bias/medical mistrust training being developed with Black/AA Task Force.
Expand HIV/STD Prevention and Care Services for Older Adults		
12. Expand and develop service models that are tailored for the unique needs of PLWH over 50. Specifically, community members representing older adults living with HIV have identified ambulatory/outpatient medical, medical care coordination, and mental health as key services they need. Unify and coordinate care within a medical home and reduce referrals to specialty care, if appropriate.		• MCC provides this already - maybe add a component to the training/service guidelines for working with specific pops that includes aging population? Major recommendations for an aging population include addressing the 4 Ms: medication, mentation, mobility, and what matters to the patient. There are many screening tools available. Maybe add to discussions around MCC and AOM service standards. • For some of the items in this section it seems like a landscape analysis of services for 50 plus clients is needed – just within the RWP.
13. Integrate an annual patient medical records review by gerontologist for PLWH over 50 in the Medical Care Coordination and Ambulatory/Outpatient Medical programs. The annual medical records review should review care needs for mental health, polypharmacy, social support, mobility, and other markers of overall health and quality of life. Ensure that MCC teams monitor and assist		• Not sure this is feasible with probably about 4,000 AOM clients and more than that in MCC receiving services. Could any of this be added to chart abstractions during contract monitoring? • MCC teams already are directed to conduct cognitive assessments for client aged 50 and older and assess IADLs and ADLs with each assessment.

patients affected by cognitive decline in navigating their care.		
14. Customize food/nutrition and physical activity and mobility services for the aging population. Remedial exercise and rehabilitation to maintain or regain muscle mass may be needed for some older adults to help them remain in care and virally suppressed.		• This is really geriatric medicine
15. Enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.		• Wouldn't this be covered through current FFS model?
16. Expand supportive services, such as financial assistance, as incomes become more fixed in older age. As frailty increases with age, services should be customized by specific age groups.		• CHHS Master Plan on Aging
17. Address social isolation by supporting psychosocial and peer support groups designed for older adults. Leverage the work of agencies that already provide support groups for older adults and encourage the community to join or start a support group.		• Could this be part of psychosocial services RFP whenever that happens? • CHHS Master Plan on Aging
18. Address technological support for older adults living with HIV as medical service modalities rely more and more on electronic, virtual, and telehealth formats.		• Overlap with #9? Not sure what they are asking for here; this kind of training would be a great project for the commission to undertake
19. Dedicate at least 15% of prevention funds to programming specifically tailored for individuals over 50. According to the California HIV Surveillance Report, persons over 50		• Need to verify in our data but not sure how to respond

accounted for 15% of all new infections. A similar trend is observed for Los Angeles County with about 13-14% of new HIV diagnoses occurring among persons aged 50 and older		
20. Address the lack of sexual health programs and social marketing efforts geared for older adults. Social marketing and educational campaigns on PrEP and Undetectable=Untransmittable (U=U) should include messages and images with older adults.		• This may be a more effective strategy than #19 to reach older population
21. Integrate programming for older adults in the use of Ending the HIV Epidemic funds in Los Angeles County. Schedule annual reports from the Division of HIV and STD Programs (DHSP) on how they are addressing HIV and aging.		• We have tried to shift away from a population focused approach to an outcomes approach where we are targeting services to those populations who are not in care and not virally suppressed and that generally does not represent the aging population.

Geriatric Assessment for People with HIV

Meredith Greene, MD
Assistant Professor of Medicine, Geriatrics
University of California San Francisco
San Francisco, CA

Dr Greene has received grant support paid to their institution from Gilead Sciences, Inc. (Updated 03/08/21)

Planner/Reviewer Financial Disclosures:
Planner/Reviewer 1 has no relevant financial affiliations to disclose. (03/16/21)
Planner/Reviewer 2 has no relevant financial affiliations to disclose. (03/01/21)
Planner/Reviewer 3 has no relevant financial affiliations to disclose. (03/16/21)

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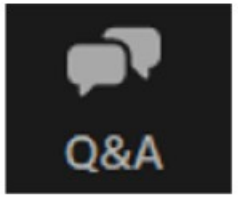
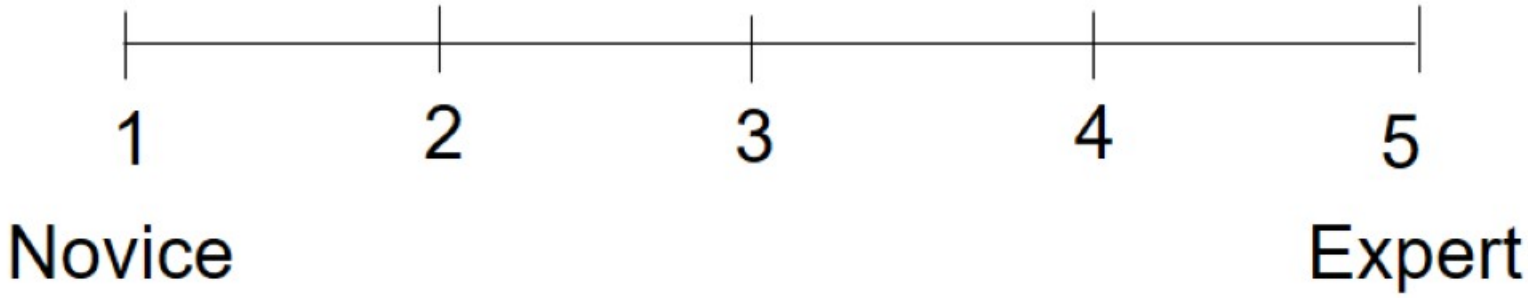


Poll 1

Please rate your level of experience in the medical management of HIV infection. (1 = Novice, 5 = Expert)



Geriatric Assessment for People with HIV

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Planner/Reviewer 1 has no relevant financial affiliations to disclose. (03/16/21)
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Planner/Reviewer 3 has no relevant financial affiliations to disclose. (03/16/21)

Learning Objectives

Upon completion of this webinar, learners will be able to:

- **List common geriatric conditions in people with HIV**
- **Describe assessment tools used to identify geriatric conditions**
- **Describe practical approaches to integrating geriatric assessment in clinical practice**

Learning Objectives & IAS-USA 2020 guidelines

- List common geriatric conditions in people with HIV
- Describe assessment tools used to identify geriatric conditions
- Describe practical approaches to integrating geriatric assessment in clinical practice

Box 6. Recommendations for Polypharmacy, Frailty, and Cognitive Function Screening for Older People With HIV

- Close and sustained attention to polypharmacy is recommended in the management of older people with HIV (evidence rating: AIII)
- Assessment of mobility and frailty is recommended for patients aged 50 years or older using a frailty assessment that is validated in all persons with HIV (evidence rating: BIa); the frequency of frailty assessment is guided by the baseline assessment and should be more frequent (every 1-2 years) in patients who are frail or before becoming frail, and less frequent (up to 5 yearly) in patients who are robust (evidence rating: BIII)
- In patients who are frail or prefrail, management of polypharmacy, referral for complete geriatric assessment, exercise and physical therapy, and nutrition advice is recommended (evidence rating: AIII)
- Routine assessment of cognitive function every other year using a validated instrument is recommended for people with HIV who are older than 60 years (evidence rating: BIII)

JAMA 2020

Pretest Question #1

A 63 y/o cisgender male with HIV, hypertension, COPD, diabetes, osteoarthritis, and chronic kidney disease admits he is struggling to take all of his medications. He currently takes 7 medications in addition to his antiretroviral medications (DTG/ABC/3TC). Which of the following is the best initial step to address polypharmacy?

1. Switch his ART regimen for another with fewer drug-drug interactions
2. Identify potentially inappropriate medications
3. Provide counselling on ART adherence
4. His medications cannot be reduced given his comorbidities

Pretest Question #2

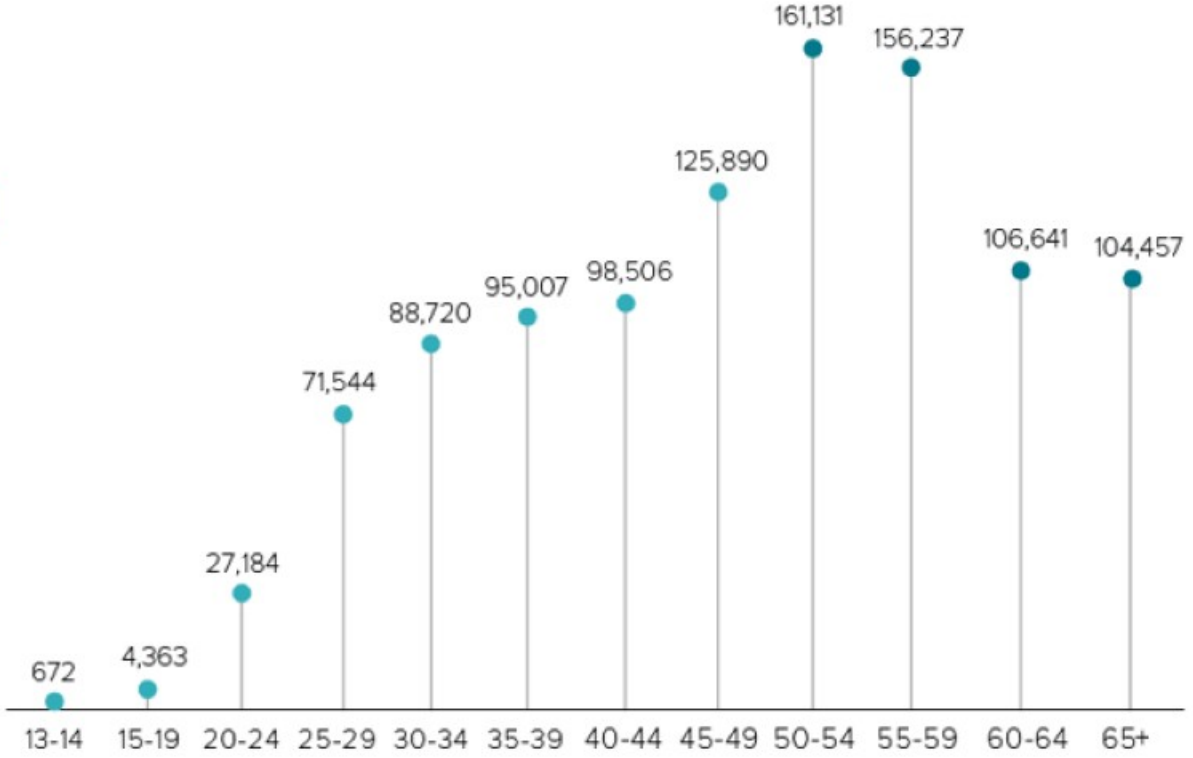
A 75 y/o cisgender female with HIV, hypertension, diabetes, and peripheral neuropathy is asked routine falls screening questions at her primary care appointment using the CDC STEADI tool. She denies having any falls or feeling unsteady, but is worried about falling. What is the next best step?

1. Nothing else is needed, reassess in 1 year
2. Evaluate her gait
3. Provide education on fall prevention

Why Geriatric Assessment is Important: The Numbers

Over half of people with diagnosed HIV were aged 50 and older.

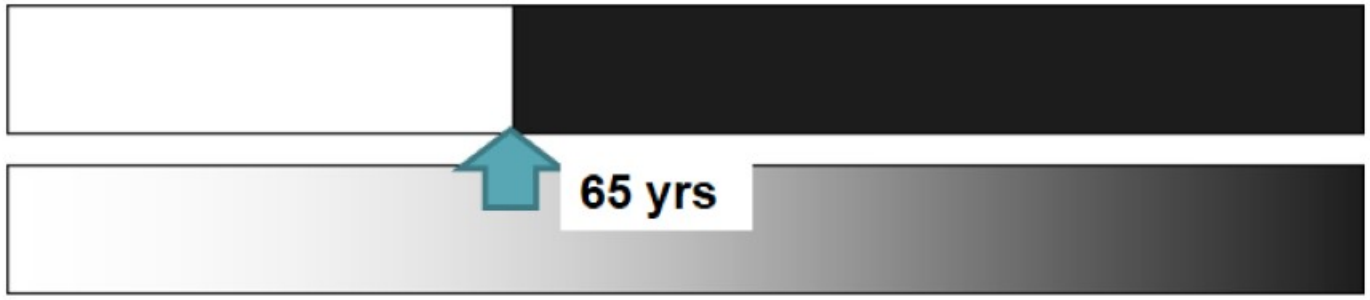
Adults and Adolescents with Diagnosed HIV in the US and Dependent Areas by Age, 2018



Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2018 (updated). *HIV Surveillance Report* 2020;31.

Why Age 50?

- Co-morbid & geriatric conditions occur at relatively younger ages HIV+
- Immunosenescence, biological theories of aging “Inflammaging”



More heterogeneity exists among older adults than other age groups!

Physiologic changes with Aging

Aging is not a disease!

- **Decreased GFR**
- **Decreased lean body mass**

Affect pharmacokinetics

- Decreased bone density
- Decreased cardiac output & increased myocardial and arterial stiffness
- Decreased vision and hearing

Why do we need a different approach for Older Adults?

- Diseases often present atypically:
  - May not have the “usual” signs and symptoms
- Less reserve—small insults can cause significant problems
- Ockham’s razor: one unifying diagnosis may not apply

What is Comprehensive Geriatric Assessment?

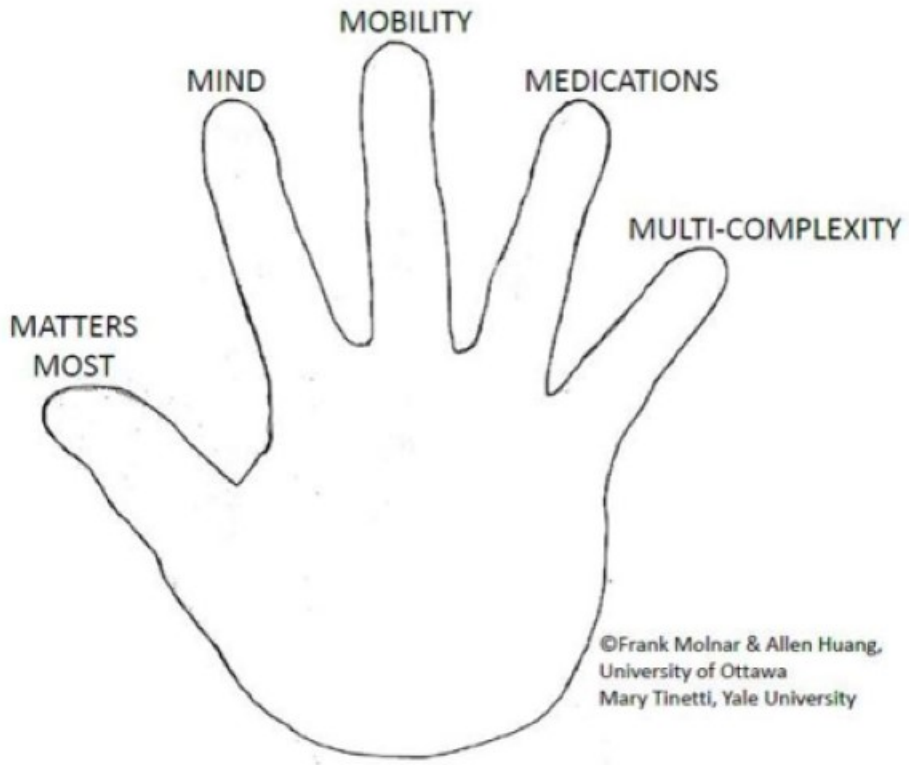
"multidisciplinary evaluation in which the multiple problems of older persons are uncovered… need for services assessed, and a coordinated care plan developed to focus interventions"

- Team: MD, NP, SW, pharmacist, PT/OT
- Different models but 3 key steps:
    1. Screen/target
    2. Assessment/develop recommendations
    3. Implementation

National Institute of Health Consensus Development Conference Statement. *Geriatric Assessment Methods for Clinical Decision-making.* Washington, DC: U.S. Department of Health and Human Services; 1987:6(13).

5Ms: Focus of Geriatrics

- Matters Most
- Mind
- Mobility
- Medications
- Multi-complexity



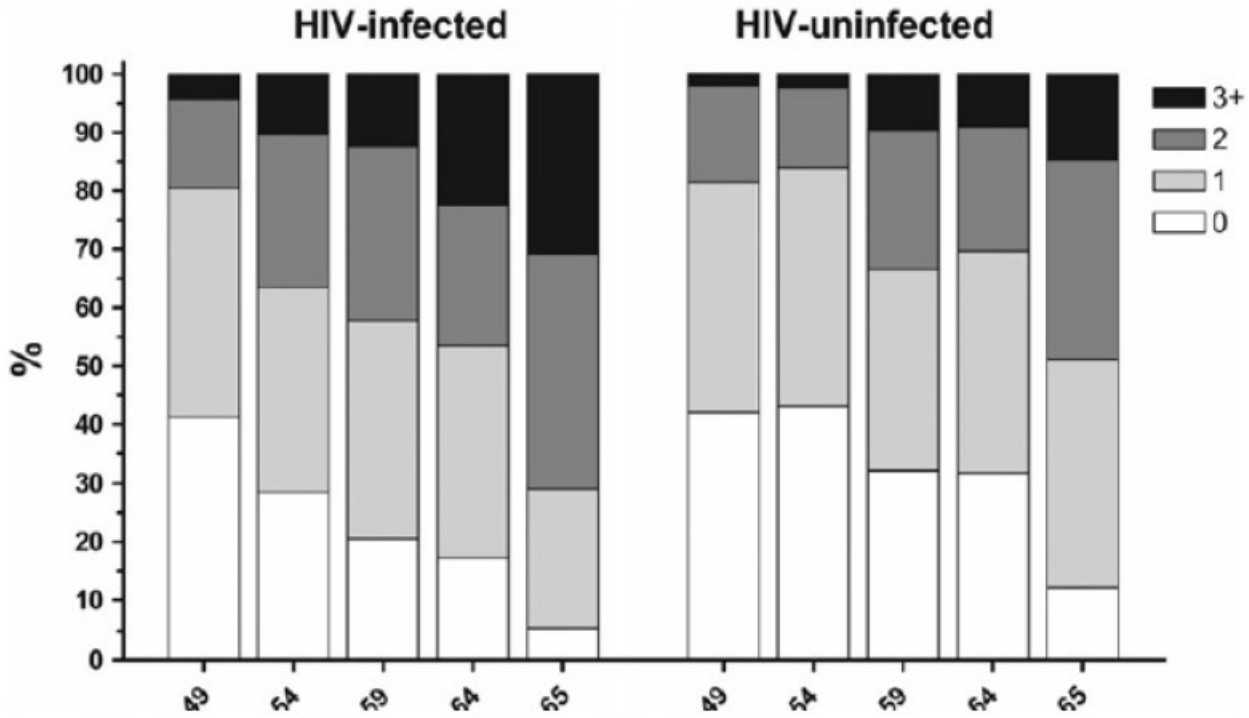
Molnar *Can Fam Physician* 2019; Erlandson *Infect Dis Clin North Am* 2019

Multi-complexity: Relevance to HIV and geriatrics

Multi-morbidity & polypharmacy

Geriatric Syndromes

Complex biopsychosocial situations



Multimorbidity Higher in PWH

Conditions included: CAD, HTN, PAD, CVD,COPD, DM, Renal Dz, Non-AIDS CA, Osteoporosis

Schouten *CID 2014*

Multimorbidity Requires a Different Approach

Time	Medications	Other Rx	All Day	Periodic
7 AM	Ipratropium MDI Alendronate 70mg weekly	Check feet Sit upright 30 min. Check blood sugar	Joint protection Energy conservation Exercise (non-weight bearing if severe foot disease, weight bearing for osteoporosis) Muscle strengthening exercises, Aerobic Exercise ROM exercises Avoid environmental exposures that might exacerbate COPD Wear appropriate footwear Albuterol MDI prn Limit Alcohol Maintain normal body weight	Pneumonia vaccine, Yearly influenza vaccine All provider visits:Evaluate Self-monitoring blood glucose, foot exam and BP Quarterly HbA1c, biannual LFTs Yearly creatinine, electrolytes, microalbuminuria, cholesterol Referrals: Pulmonary rehabilitation Physical Therapy DEXA scan every 2 years Yearly eye exam Medical nutrition therapy Patient Education: High-risk foot conditions, foot care, foot wear Osteoarthritis COPD medication and delivery system training Diabetes Mellitus
8 AM	Eat Breakfast HCTZ 12.5 mg Lisinopril 40mg Glyburide 10 mg ECASA 81 mg Metformin 850mg Naproxen 250mg Omeprazole 20mg Calcium + Vit D 500mg	2.4gm Na, 90mm K, Adequate Mg, ↓ cholesterol & saturated fat, medical nutrition therapy for diabetes, DASH		
12 PM	Eat Lunch Ipratropium MDI Calcium+ Vit D 500 mg	Diet as above		
5 PM	Eat Dinner	Diet as above		
7 PM	Ipratropium MDI Metformin 850mg Naproxen 250mg Calcium 500mg Lovastatin 40mg			
11 PM	Ipratropium MDI			

Boyd, JAMA 2005;294:716-724

Multimorbidity Requires a Different Approach

5 Domains for a Patient Centered Approach Multimorbidity:

1. Patient Preferences
2. Interpret the Evidence
3. Consider Prognosis
4. Treatment Complexity & Feasibility
5. Optimizing Therapies and Care Plan

J Am Geriatr Soc 2012; Boyd *J Am Geriatr Soc* 2019

Consider Prognosis

- Many interventions have immediate risks and delayed benefits
  - -Cancer screening (5-10yrs to benefit)
  - - Intensive glycemic control (8yrs to benefit)
  - -Total knee replacement (months of disability)

- For patients with limited life expectancy, these interventions subject patients to risk with little chance of benefit

Polypharmacy & Prescribing Issues

- Polypharmacy higher in PLWH, especially age >50
- May affect adherence to ART & non-ART meds
- Drug-drug interactions with ART
- Associations with falls, symptoms in PLWH

Halloren *Antivir Ther* 2019, Siefried *AIDS* 2018, Ware *AIDS Pt Care STDS* 2018, Kim *AIDS Care* 2018

Case: Routine Follow-up visit

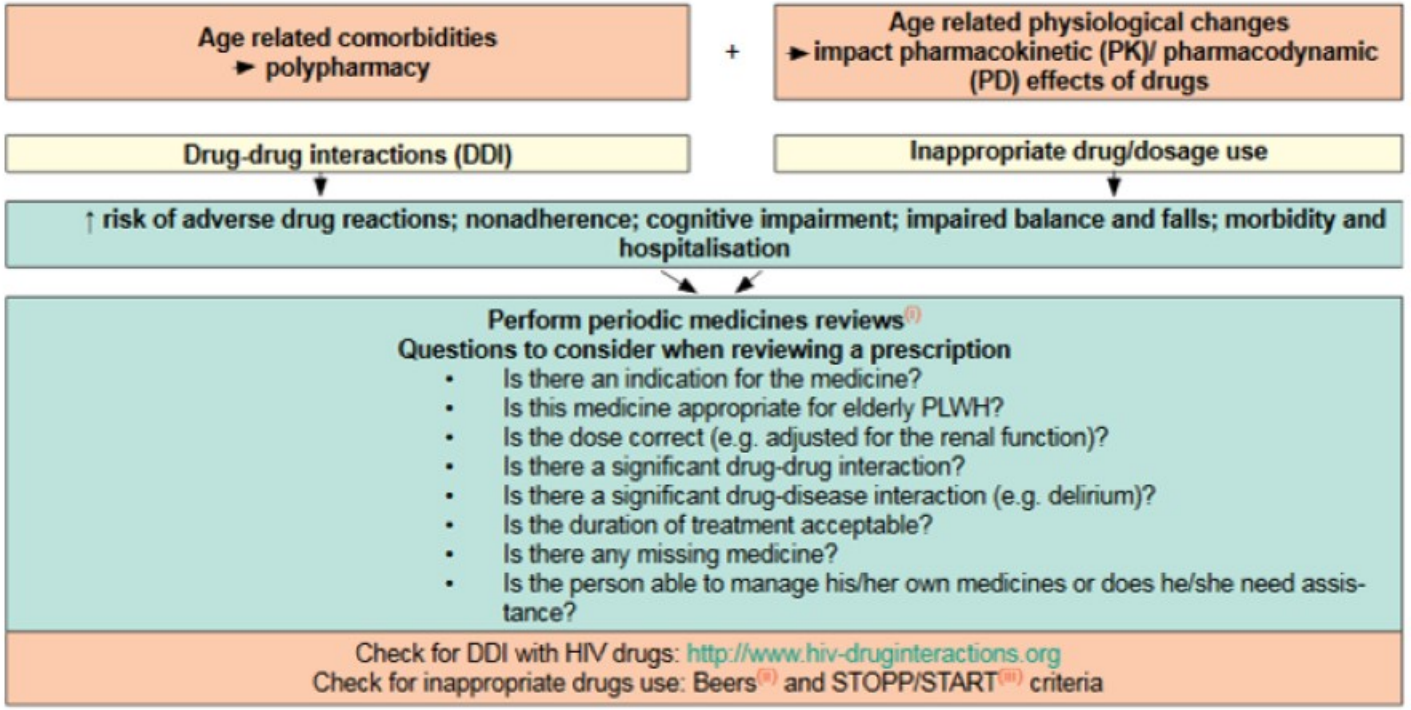
- 68 y/o male, HIV long term survivor
- CD4: 600 cells/mm3, viral load <40 copies/mL
- PMH: hypertension, hyperlipidemia, peripheral neuropathy, Type 2 diabetes, benign prostatic hypertrophy, renal insufficiency (CrCl 45), insomnia
- Exam: Afebrile, P 76, BP 130/70, 98% RA
- "So many pills…"

Medications	
DTG/ABC/3TC qd	Metformin 500 mg bid
Atorvastatin 40 mg qhs	Zolpidem 10 mg qhs prn
Lisinopril 20 mg qd	Tamsulosin 0.8 mg
Gabapentin 300 mg tid	Finasteride 5 mg qd
Amlodipine 5 mg qd	

Approach to Polypharmacy

1. Is there an indication for each medication?
2. Is the dose appropriate for age, liver and rena function?
3. Could any of the patient's symptoms be related to medications?
4. Are there drug-drug interactions?
5. Are there any potentially inappropriate medications?
6. Are there other medication concerns? (cost, adherence, complexity regimen)

Scott *JAMA Intern Med.* 2015



2020 EACS guidelines

Potentially Inappropriate Medications

AGS Beer's Criteria

START/STOPP criteria

O'Mahony *Age and Ageing* 2015;
J Amer Geri Soc 2019

Selected Top 10 Drug Classes To Avoid in Elderly PLWH

Drug class	Problems/alternatives
First generation antihistamines e.g., clemastine, diphenhydramine, doxylamine, hydroxyzine	Strong anticholinergic properties, risk of impaired cognition, delirium, falls, peripheral anticholinergic adverse reactions (dry mouth, constipation, blurred vision, urinary retention). Alternatives: cetirizine, desloratadine, loratadine
Tricyclic antidepressants e.g., amitryptiline, clomipramine, doxepin, imipramine, trimipramine	Strong anticholinergic properties, risk of impaired cognition, delirium, falls, peripheral anticholinergic adverse reactions (dry mouth, constipation, blurred vision, urinary retention). Alternatives: citalopram, escitalopram, mirtazapine, venlafaxine
Benzodiazepines Long and short acting benzodiazepines e.g., clonazepam, diazepam, midazolam Non-benzodiazepines hypnotics e.g., zolpidem, zopiclone	Elderly are more sensitive to their effect, risk of falls, fractures, delirium, cognitive impairment, drug dependency. Use with caution, at the lowest dose and for a short duration. Alternatives: non-pharmacological treatment of sleep disturbance/sleep hygiene.
Atypical antipsychotics e.g., clozapine, olanzapine, quetiapine	Anticholinergic adverse reactions, increased risk of stroke and mortality (all antipsychotics). Alternatives: aripiprazole, ziprasidone
Urological spasmolytic agents e.g., oxybutynin, solifenacin, tolterodine	Strong anticholinergic properties, risk of impaired cognition, delirium, falls, peripheral anticholinergic adverse reactions (dry mouth, constipation, blurred vision, urinary retention). Alternatives: non-pharmacological treatment (pelvic floor exercises).
Stimulant laxatives e.g., senna, bisacodyl	Long-term use may cause bowel dysfunction. Alternatives: fibres, hydration, osmotic laxatives
NSAIDs e.g., diclofenac, indomethacin, ketorolac, naproxen	Avoid regular, long-term use of NSAIDs due to risk of gastrointestinal bleeding, renal failure, worsening of heart failure. Alternatives: paracetamol, weak opioids
Digoxin Dosage > 0.125 mg/day	Avoid doses higher than 0.125 mg/day due to risk of toxicity. Alternatives for atrial fibrillation: beta-blockers
Long acting sulfonylureas e.g., glyburide, chlorpropamide	Can cause severe prolonged hypoglycemia. Alternatives: metformin or other antidiabetic classes
Cold medications Most of these products contain antihistamines (e.g., diphenhydramine) and decongestants (e.g., phenylephrine, pseudoephedrine)	First generation antihistamines can cause central and peripheral anticholinergic adverse reactions as described above. Oral decongestants can increase blood pressure. Avoid

Table: 2020 EACS guidelines

Simple interventions effective at reducing PIMS

Cluster RCT pharmacies in Quebec

- Randomized to usual care or given brochure

At 6 months:

- 27% stopped benzo compared with 5% in control group
- 11% had dose reduction

Tannenbaum JAMA Intern Med 2014 (EMPOWER trial)

Approach to Polypharmacy

Confirm all medications including OTC, herbal, also alcohol & other substance use

1. Is there an indication for each medication?

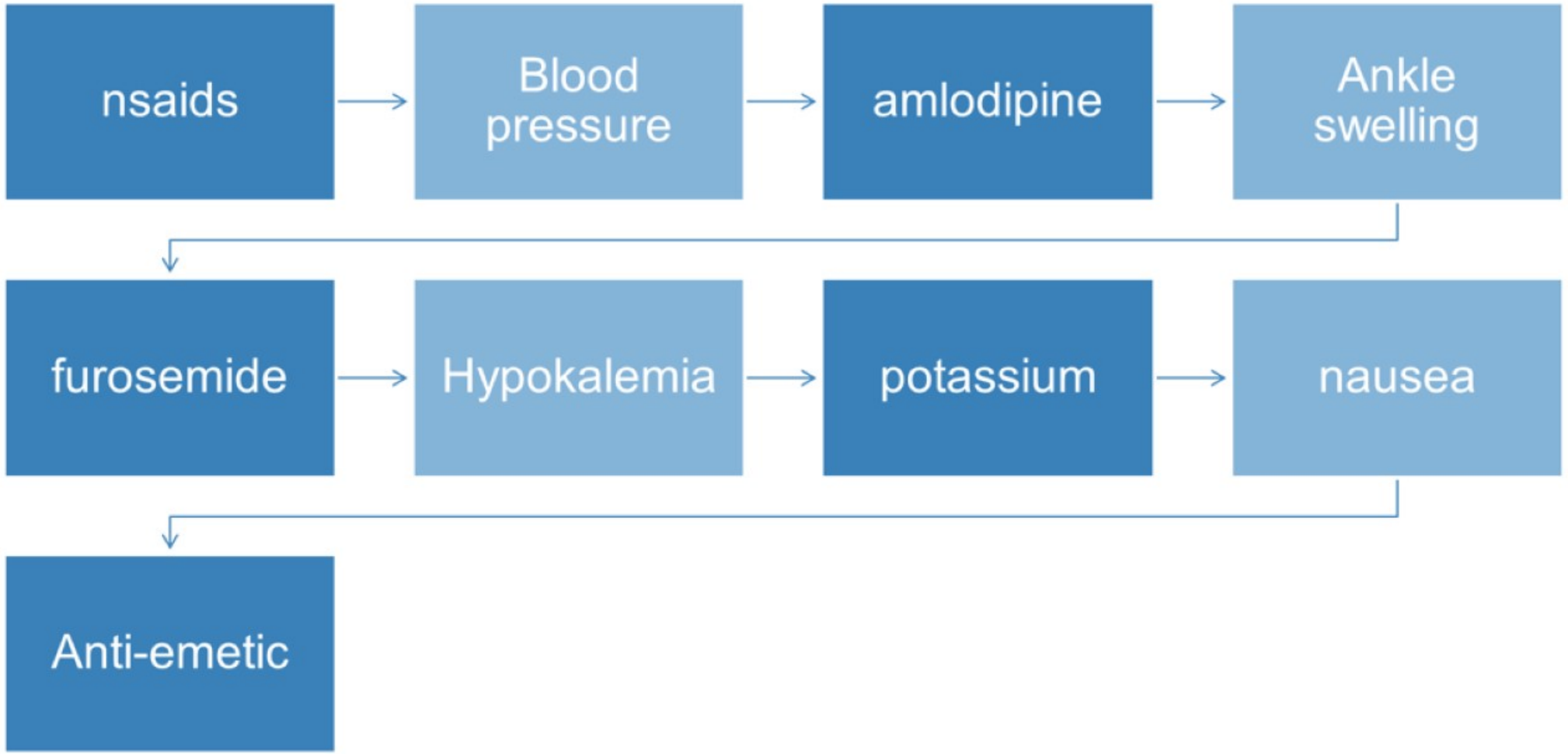
2. Is the dose appropriate for age, liver and renal function?

3. Could any of the patient's symptoms be related to medications?

Medication list and PMH

- Takes 4 vitamins, also prn naproxen
- DTG/ABC/3TC
- Atorvastatin, lisinopril, amlodipine, gabapentin, zolpidem, metformin, tamsulosin, finasteride
- PMH: neuropathy, htn, hyperlipidemia, diabetes, insomnia, BPH, renal insufficiency (CrCl 45)

Prescribing Cascade occurs often!



Approach to Polypharmacy

4. Are there drug-drug interactions?

5. Are there any potentially inappropriate medications?

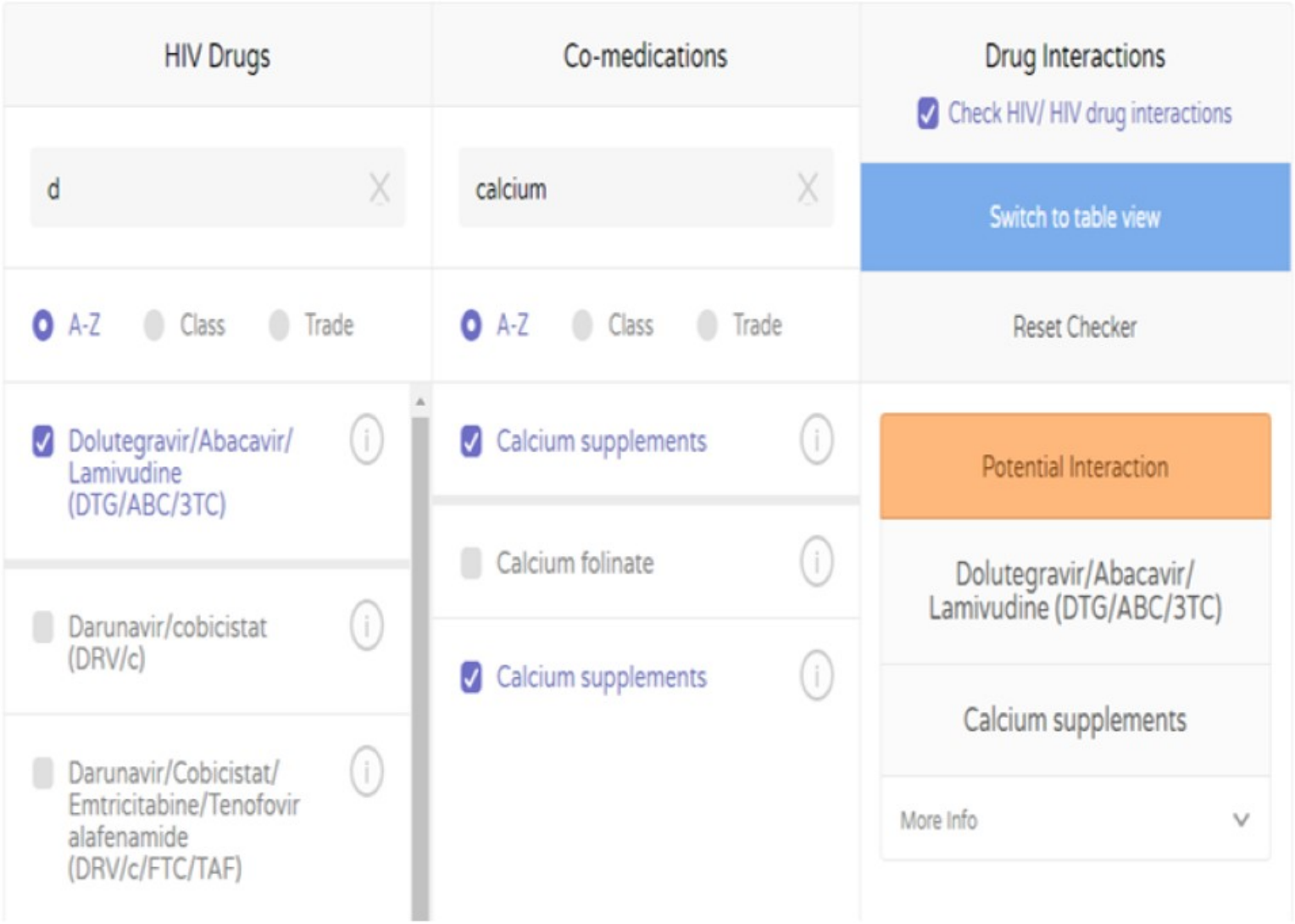
6. Are there other medication concerns? *(cost, adherence, complexity regimen)*

Medication list and PMH

- Takes 4 vitamins, also prn naproxen
- DTG/ABC/3TC
- Atorvastatin, lisinopril, amlodipine, gabapentin, zolpidem, metformin, tamsulosin, finasteride
- PMH: neuropathy, htn, hyperlipidemia, diabetes, insomnia, BPH, renal insufficiency (CrCl 45)

Drug-Drug Interactions

- Watch for ritonavir and cobicistat!
- Have to consider inhaled and intranasal steroids
- Vitamins & supplements



https://www.hiv-druginteractions.org/

Deprescribing Research and Clinical Resources

Deprescribing.org

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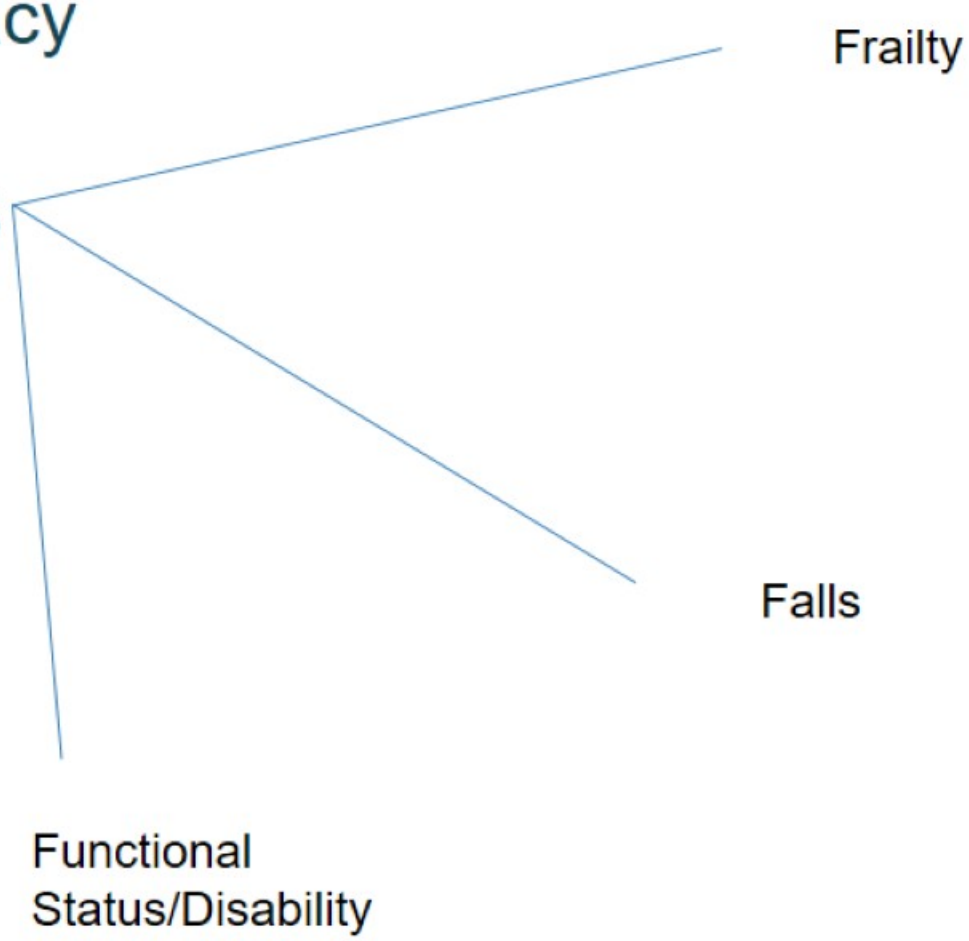
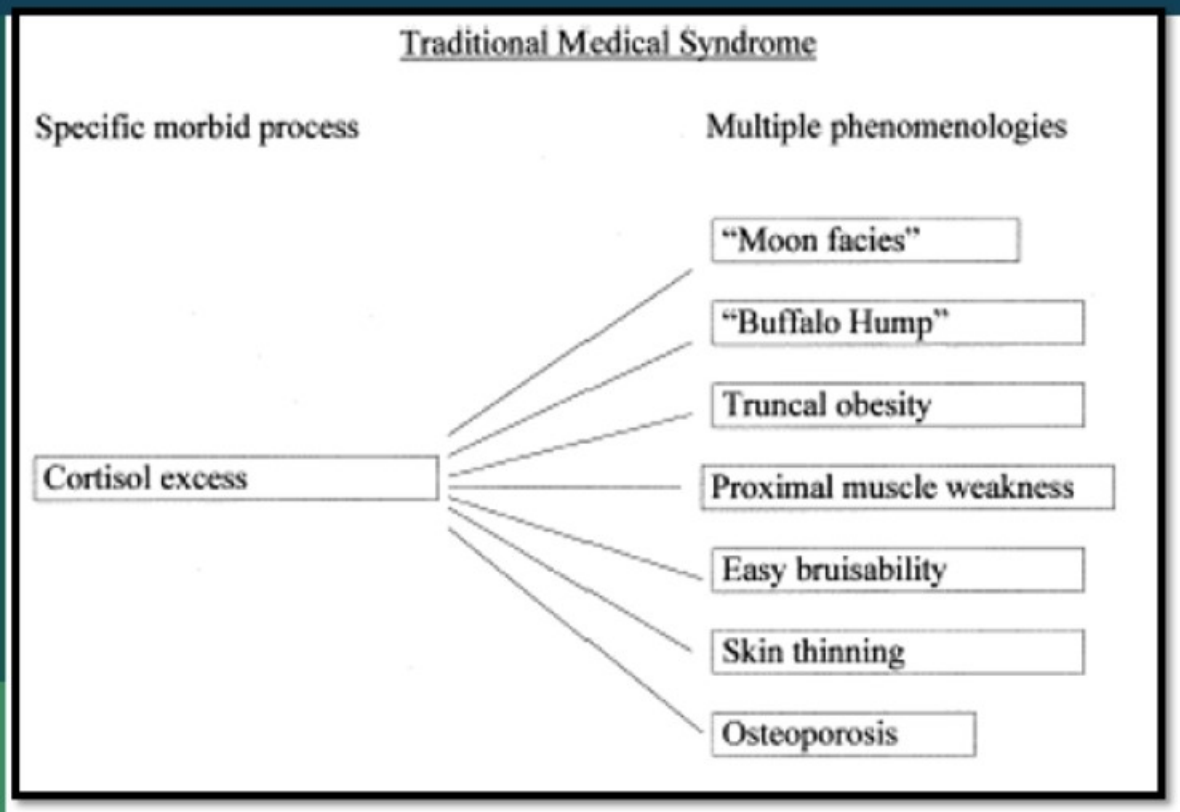
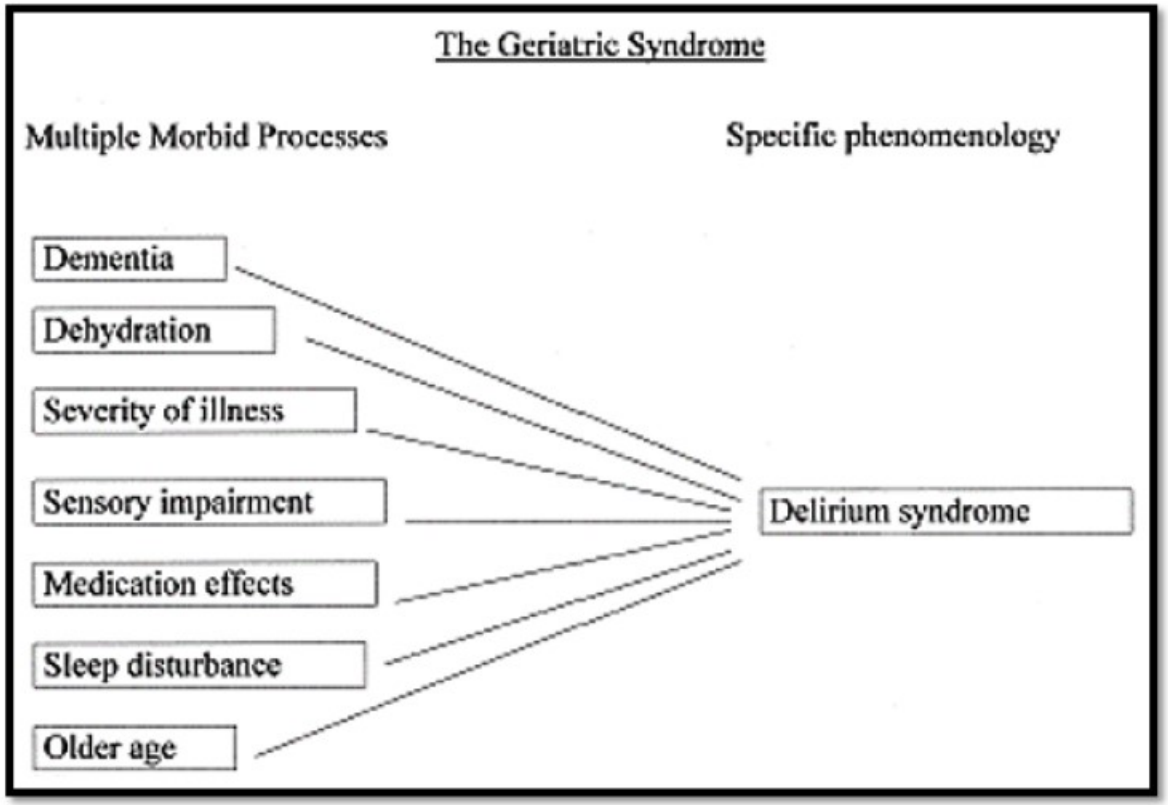


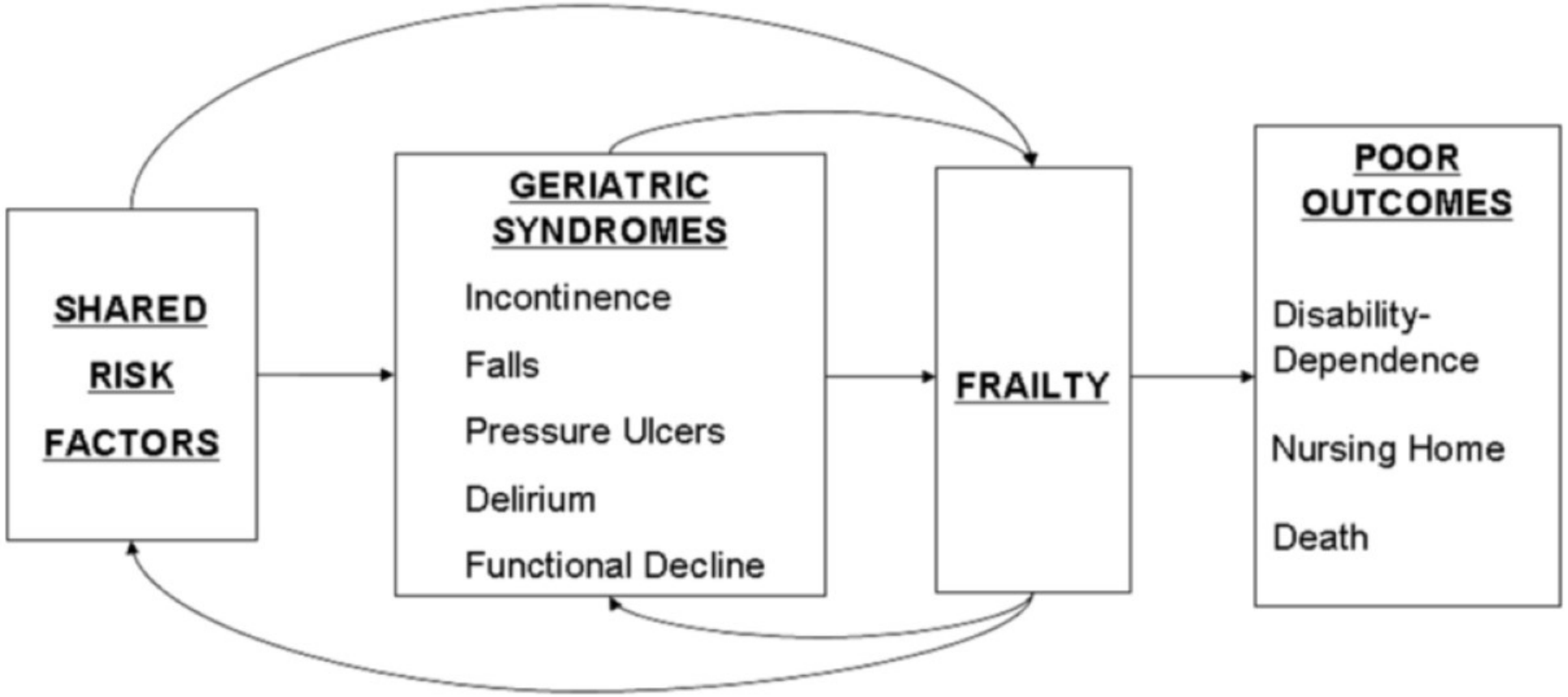
What is a Geriatric Syndrome?





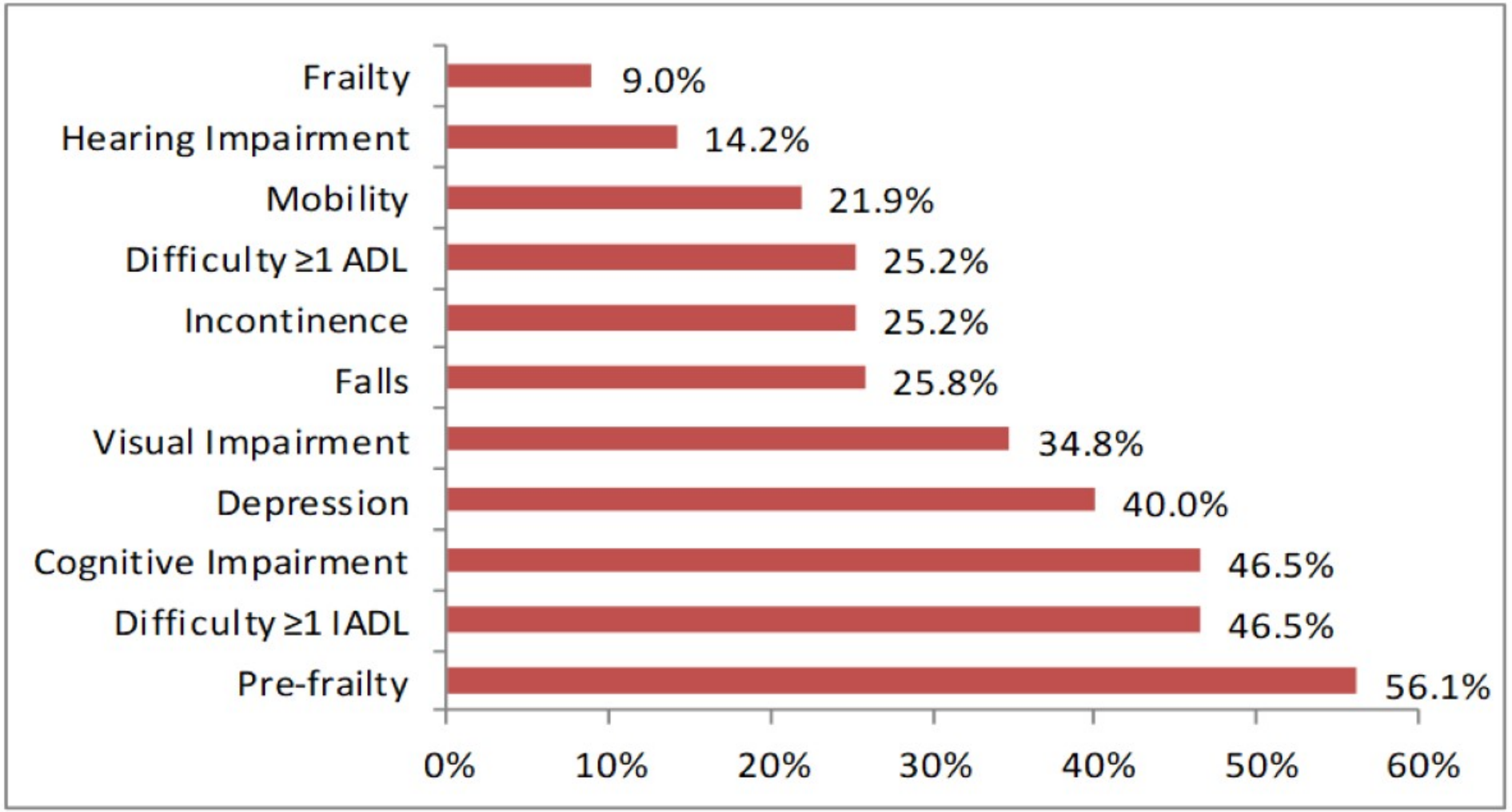
Flacker *J Amer Geriatr Soc* 2003

What is a Geriatric Syndrome?



Inouye *J Am Geriatr Soc* 2007

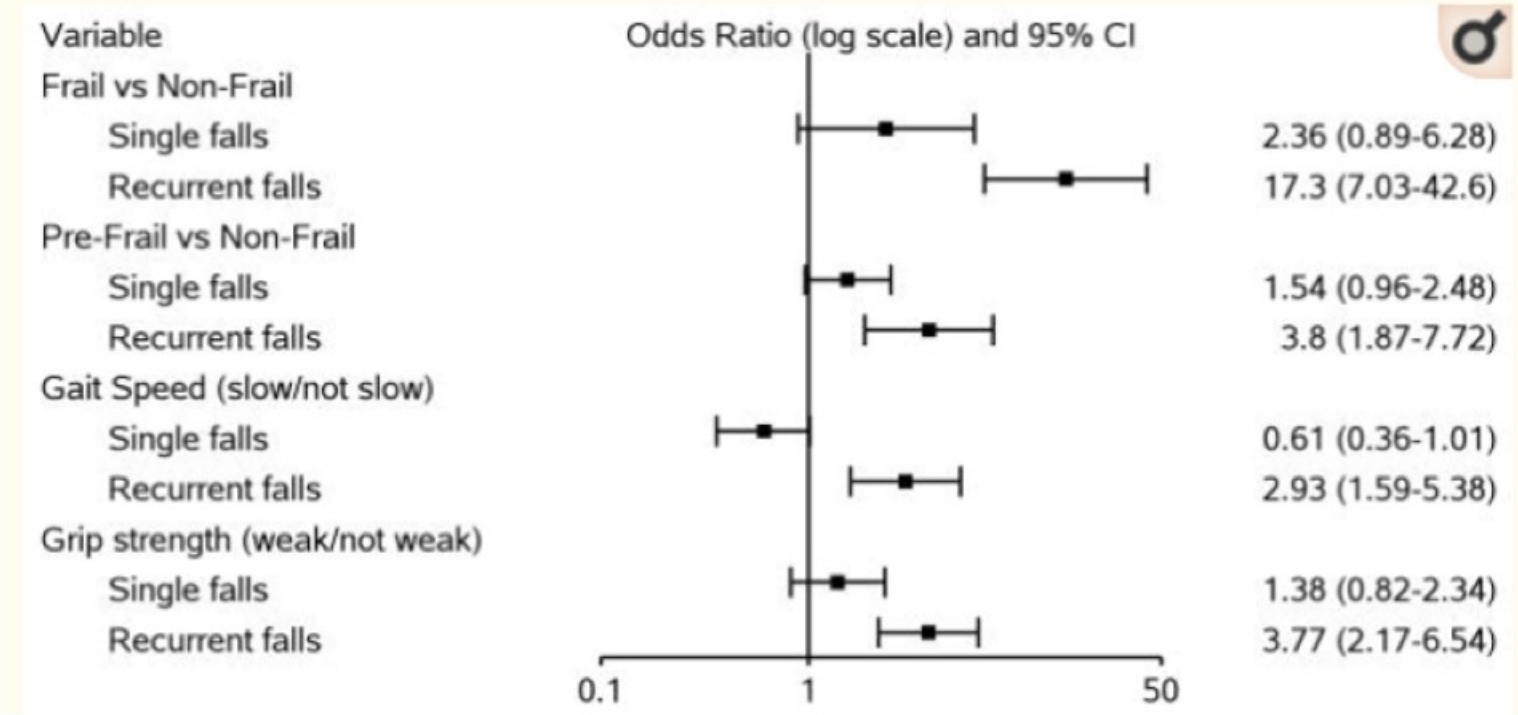
Geriatric Syndromes In PWH



Greene *JAIDS* 2015

Geriatric Syndromes travel together in PWH

Frailty is associated with falls



Tassiopoulos AIDS 2017 Sharma A, *JAIDS* 2021, Hosaka K *J Am Geriatr Soc* 2019

Frailty

Antivir Ther. 2018;23(2):101-104. doi: 10.3851/IMP3211.

Frailty: is thy name.....universal? Evolving challenges of managing effectively treated older people living with HIV

Julian Falutz [1]

Edmonton Frail Scale

Fried Frailty Phenotype

SOF index

Frailty Index

Tilberg Frailty Indicator

Frail Scale

Brief Frailty Index

Bouillon K *BMC Geriatr* 2013

Fried Frailty Phenotype- most studied in PWH

Fried Frailty Phenotype	
Shrinking	Weight loss
Exhaustion	Self-report items CES-D
Weakness	Grip strength
Slowness	Gait Speed
Low Physical Activity	Minnesota Leisure Time Scale

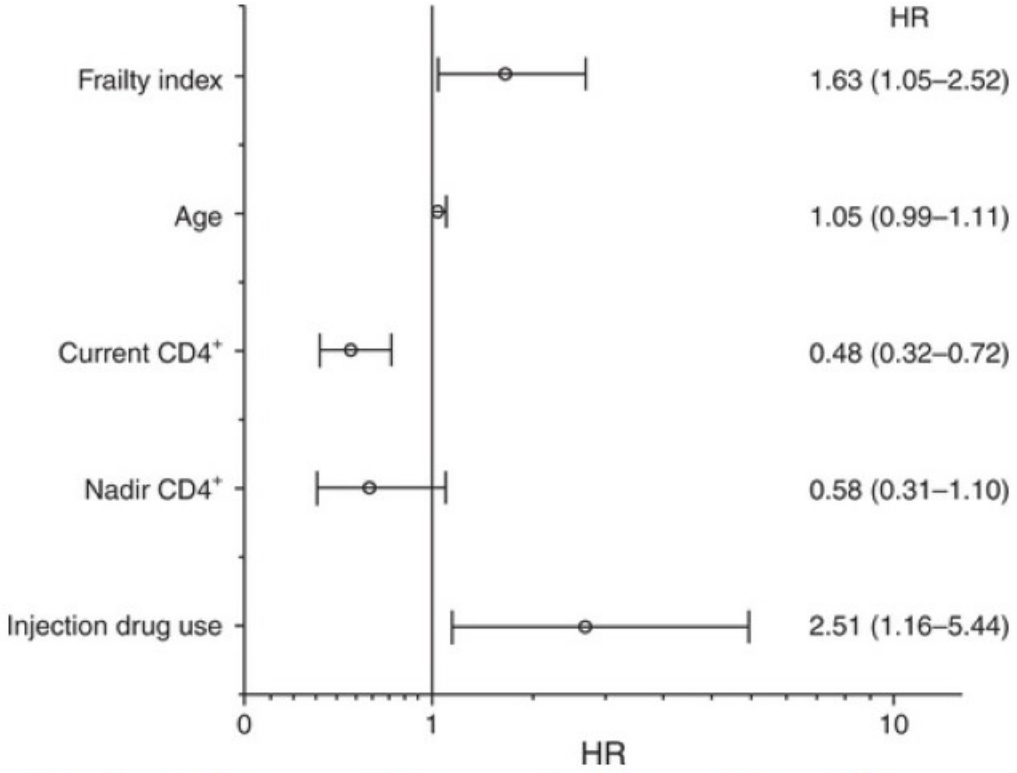
3/5 criteria =frail
1-2/5 criteria = pre-frail

- Studies in MACS, WIHS, VACS, ALIVE, AGEhIV cohorts
  - Earlier occurrence of frailty in HIV+
  - Many but not all increased in HIV+
    - Frailty increases with low CD4 count, viremia
- Associated with inflammatory markers, visceral adiposity
- Associated with hospitalization & mortality

Fried *J Gerontol Med Sci* 2001; Desquilbet *J Gerontol Med Sci* 2007; Terzian *J Womens Health* 2009; Piggott *PLoS One* 2013; Akgun *JAIDS* 2014; Verheij J *Infect Dis* 2020; Hawkins AIDS 2018

Frailty Index (Cumulative Deficit Model)

Frailty Index
Cumulative burden of health deficits
30-75 components
Index summary score between 0-1; 0.25 cut-off frail



Frailty Index predicts survival in multivariable model

Rockwood *J Gerontol A Biol Sci Med Sci* 2007; Guaraldi G *AIDS* 2015

Frailty = Vulnerability

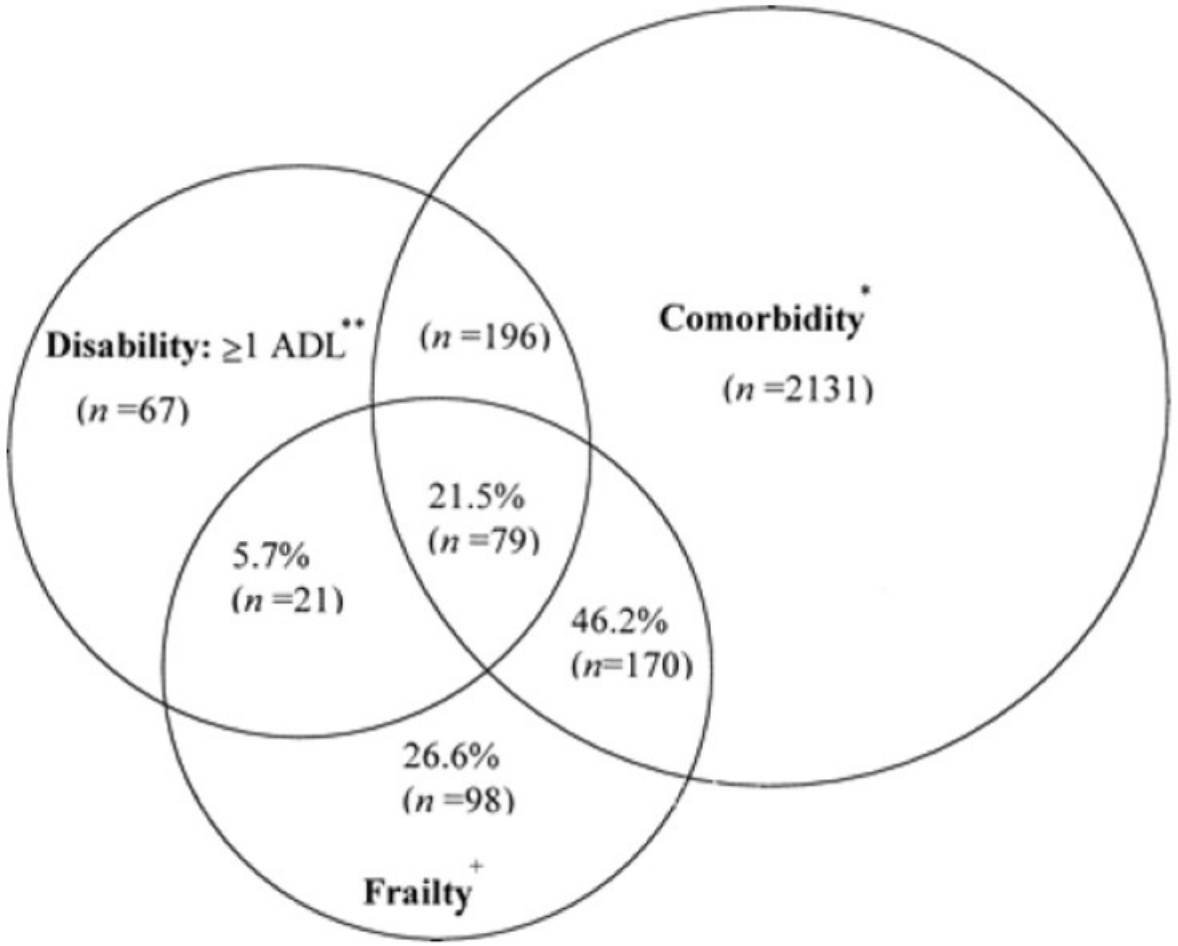
- All measurements trying to capture degree of vulnerability
- Frailty important research tool; and prognostic tool
  - Can be difficult to implement clinically
  - Gait speed alone? Grip strength?
- VACS index has also been proposed as frailty tool
  - Fewer variables, often routine labs
  - VACS 2.0, VACS +

VACS Index

Component	Level	Points
Age	<50	0
	50 to 64	12
	≥ 65	27
CD4	≥ 500	0
	350 to 499	6
	200 to 349	6
	100 to 199	10
	50 to 99	28
	< 50	29
HIV-1 RNA	< 500	0
	500 to $1x10^5$	7
	≥ $1x10^5$	14
Hemoglobin	≥ 14	0
	12 to 13.9	10
	10 to 11.9	22
	< 10	38
FIB-4	< 1.45	0
	1.45 to 3.25	6
	> 3.25	25
eGFR	≥ 60	0
	45 to 59.9	6
	30 to 44.9	8
	< 30	26
Hepatitis C		5

Falutz *Antivir Ther* 2018; Yeoh HL *Antivir Ther* 2018; Justice AC, Tate *J AIDS Res Hum Retroviruses* 2019; Umbleja *J Infect Dis* 2020

Frailty and Disability Distinct but Overlap



Fried *J Gerontol A Biol Sci Med Sci*, 2004

Functional status: self report disability

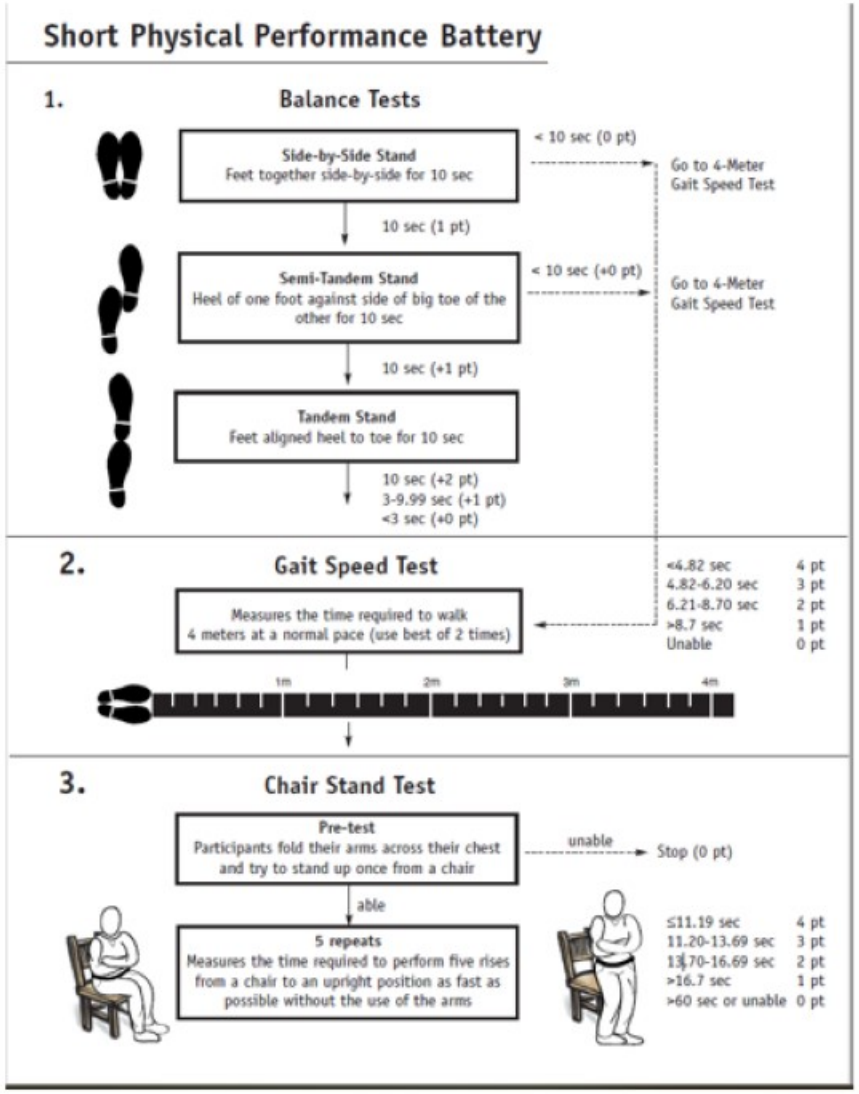
Activities of Daily Living (ADLs)

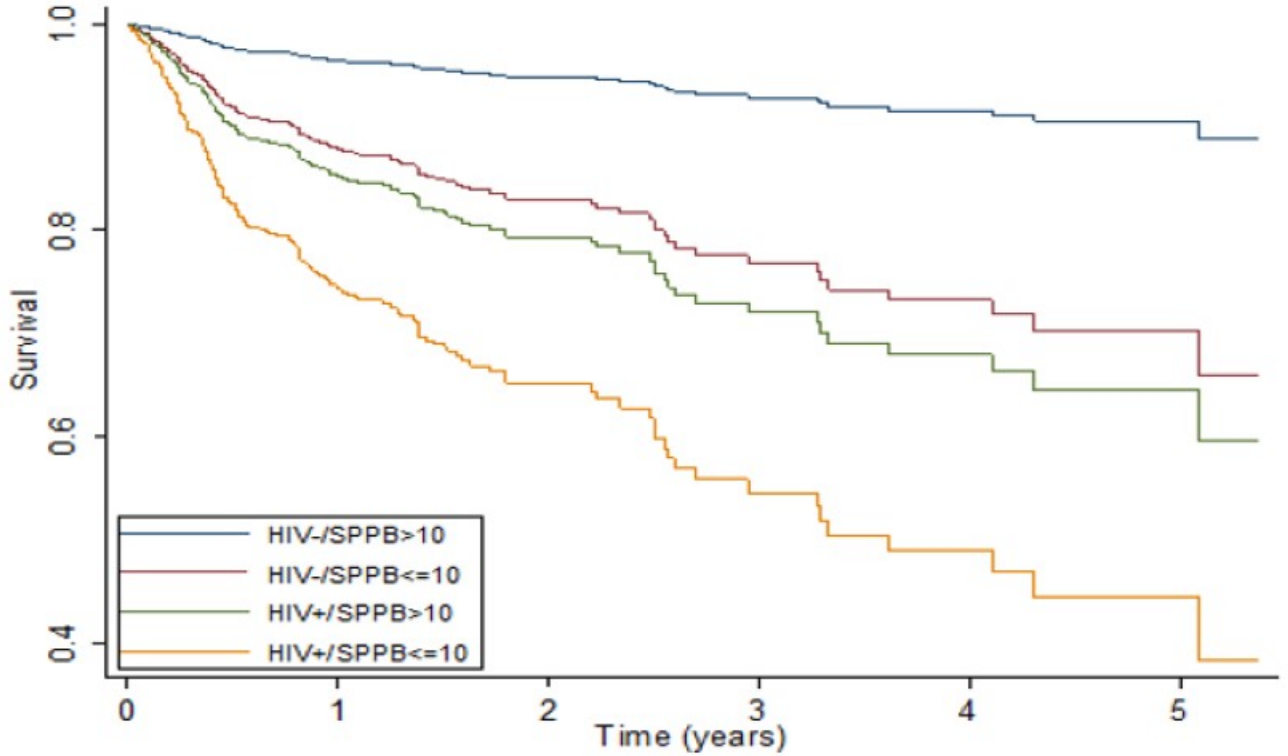
- Bathing
- Dressing
- Toileting
- Transferring
- Feeding

Instrumental Activities of Daily Living (IADLs)

- Telephone
- Transportation
- Housekeeping
- Meal preparation
- Medications
- Finances
- Shopping
- Laundry

Short Physical Performance Battery





*Adjusted for gender, race/ethnicity, age, comorbidities

Greene *AIDS* 2014

Functional Limitations & Disability

Other examples functional limitation assessments:

- Timed Up and Go (TUG)
- Chair stands
- Gait speed
- Functional reach test

Many also useful for falls

How you ask about disability matters:

- Normalize
- Ask as a 2-part question:
  - "difficulty with" task first
  - If "difficulty" then ask if need help from someone else

Back to the Case: Geriatric Syndromes

68 y/o with well controlled HIV, multimorbidity & polypharmacy

Assessment Domain/Tool	Result
Frailty	**Fried: pre-frail**
Function	**ADL: independent with all** **IADL: difficulty with managing medications, housekeeping**
Cognition/MOCA	28/30

Fall risk screen: (CDC STEADI)

-Have you fallen in the past year? No

-Do you feel unsteady when standing or walking? Yes

-Do you worry about falling? No

Why Falls?

IN 2018

1 in 4 older adults reported falling—this equals about 36 million falls.

Falls can threaten the health and independence of older adults.

More than **8 million**
falls required medical attention or limited activity for at least a day.

More than **32,000**
older adults died from falls—that's 88 older adults every day.

www.cdc.gov/steadi

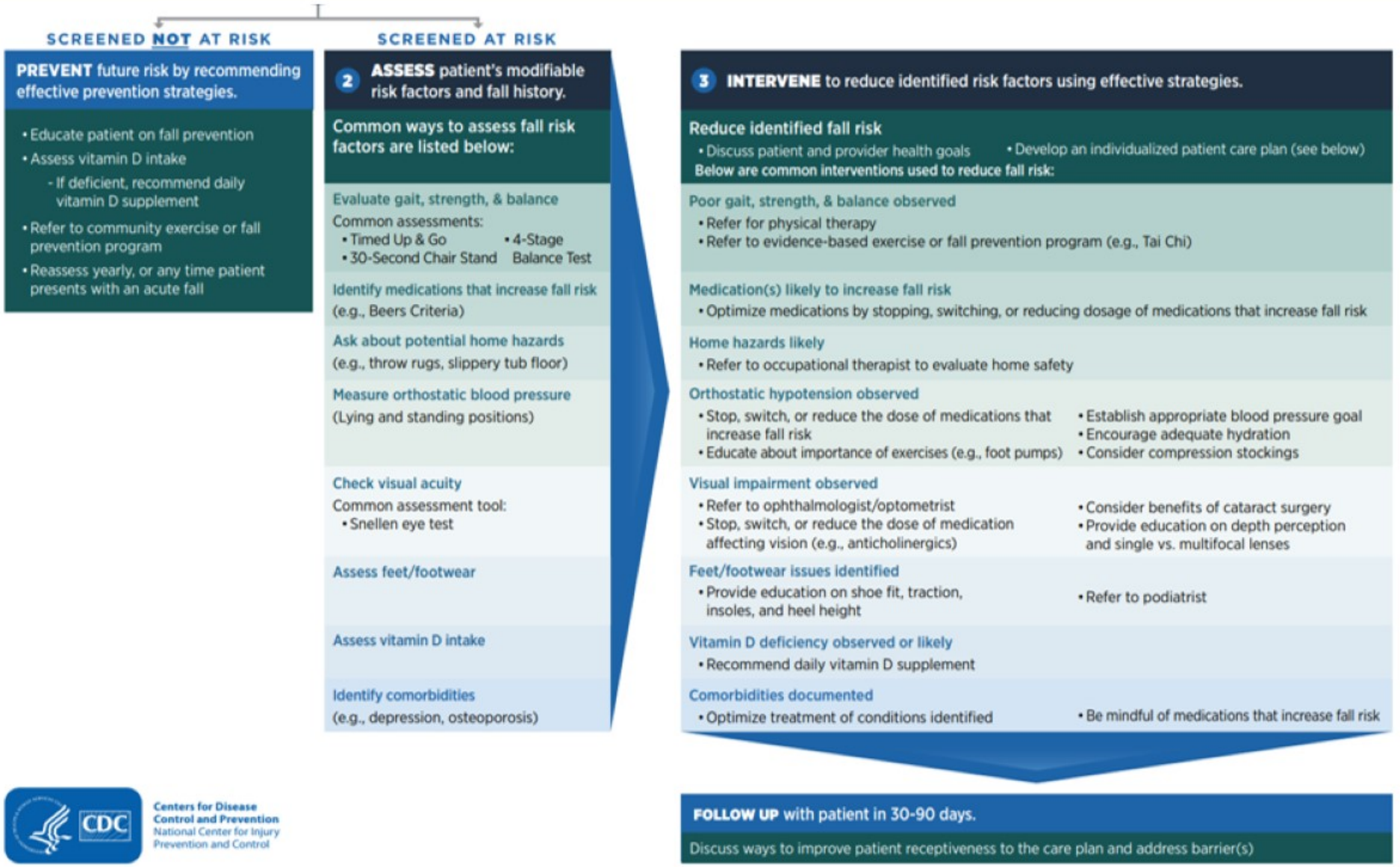
Falls in PWH

- Falls similar in HIV+ and HIV-
- Alcohol & substance use, medications, neuropathy, cognitive impairment, frailty associated with falls

Cohort	Mean age (years)	Any Fall	Recurrent Falls
HAILO	51	18%	7%
Colorado	52	30%	18%
MACS/WIHS	51	24%	13%
MACS-BOSS	61	41%	20%
WIHS	48	41%	25%
San Francisco	57	26%	--

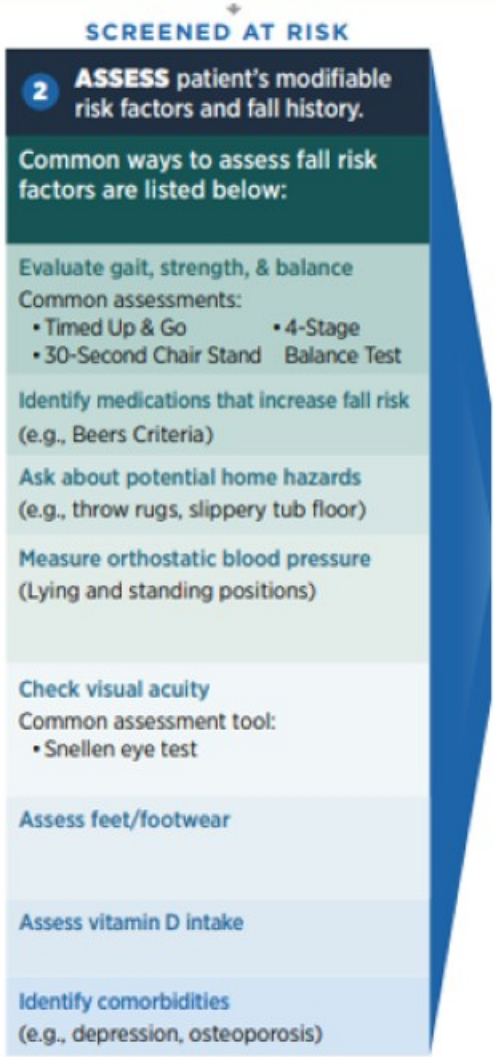
Tolentino *JAIDS* 2021; Womack *JAIDS* 2019; Tassiopoulos K *AIDS* 2017; Erlandson *HIV Med* 2016; Erlandson *JAIDS* 2012; Sharma *Antivir Ther* 2019; Sharma *Antivir Ther* 2018; Greene *JAIDS* 2015 Slide courtesy Kristine Erlandson

CDC STEADI fall algorithm



Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Case: Positive Screen



- Feels unsteady: gets dizzy when gets out of chair (lisinopril, amlodipine, tamsulosin, zolpidem)
- Reports decrease visual acuity (or do Snellen)
- No home hazards
- Has not had DXA to assess osteoporosis

Exam:

- Orthostatics: 130/70 (lying) to 110/68 (standing)
- Decreased sensation feet, wearing supportive shoes
- Difficulty with tandem stand

Develop a Comprehensive Plan

3 INTERVENE to reduce identified risk factors using effective strategies.

Reduce identified fall risk

- Discuss patient and provider health goals
- Develop an individualized patient care plan (see below)

Below are common interventions used to reduce fall risk:

Poor gait, strength, & balance observed

- Refer for physical therapy
- Refer to evidence-based exercise or fall prevention program (e.g., Tai Chi)

Medication(s) likely to increase fall risk

- Optimize medications by stopping, switching, or reducing dosage of medications that increase fall risk

Home hazards likely

- Refer to occupational therapist to evaluate home safety

Orthostatic hypotension observed

- Stop, switch, or reduce the dose of medications that increase fall risk
- Educate about importance of exercises (e.g., foot pumps)
- Establish appropriate blood pressure goal
- Encourage adequate hydration
- Consider compression stockings

Visual impairment observed

- Refer to ophthalmologist/optometrist
- Stop, switch, or reduce the dose of medication affecting vision (e.g., anticholinergics)
- Consider benefits of cataract surgery
- Provide education on depth perception and single vs. multifocal lenses

Feet/footwear issues identified

- Provide education on shoe fit, traction, insoles, and heel height
- Refer to podiatrist

Vitamin D deficiency observed or likely

- Recommend daily vitamin D supplement

Comorbidities documented

- Optimize treatment of conditions identified
- Be mindful of medications that increase fall risk

FOLLOW UP with patient in 30-90 days.

Discuss ways to improve patient receptiveness to the care plan and address barrier(s)

- Stop amlodipine and monitor blood pressure; tamsulosin at night
- Discuss alternatives to zolpidem
- Referral to Physical therapy and/or exercises to support balance
- Referral to ophthalmologist

Case

Polypharmacy:

- Stopped naproxen and amlodipine, blood pressure ok
- Considering zolpidem taper

IADL difficulty:

- Able to get IHSS once a week to help cleaning
- Adherence packaging

Fall risk:

- Dizziness resolved after adjusting bp meds and timing of tamsulosin
- Went to ophthalmology (got new glasses)
- Had DXA with normal results

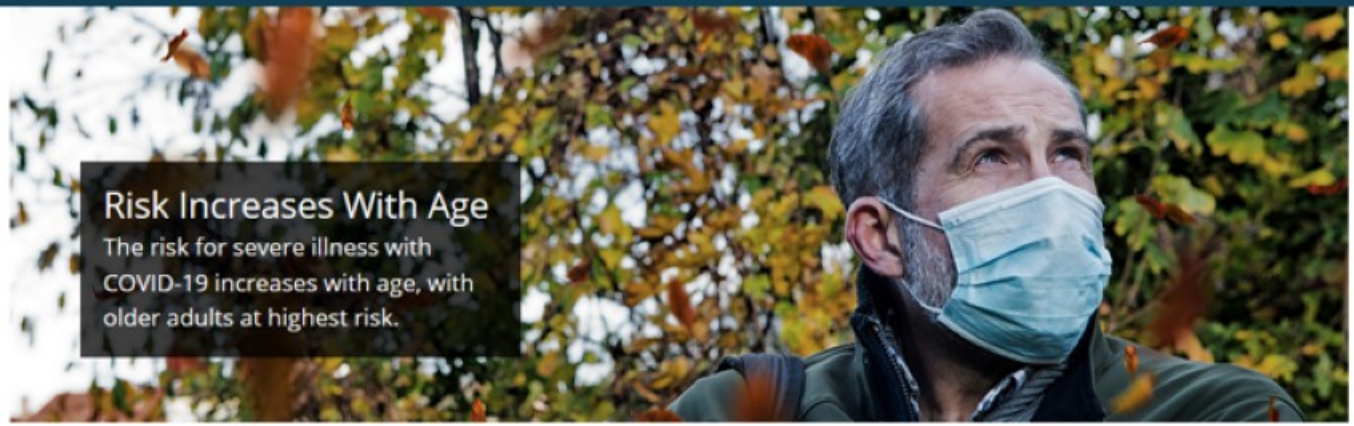
Key Take Home Points: Geriatric Syndromes

- You have to ask about geriatric conditions- older adults may not volunteer
- Frailty and other geriatric syndromes = vulnerability
  - Tools used in research and clinical practice may differ
  - Help give sense of overall health/prognosis to guide treatment plans
- Addressing polypharmacy & exercise (non-pharmacologic interventions) can address multiple concerns

Even more important since COVID-19

Geriatric Assessment During Covid

Other consequences COVID:



- Increased isolation
- Increase in mental health concerns & substance use
- Decreased physical activity (fear leaving home)
- Difficulty keeping caregivers

Many lead to decline in cognitive and physical function and falls

Geriatric Assessment During COVID

- Telehealth is here to stay
- Self-report of falls, function can be asked on phone
- Can still observe gait, getting up out of chair
- Advantages to video visits in home:
  - See parts of environment
  - Med review!!!
  - Improve access limited mobility

UCSF Geriatrics Workforce Enhancement Program Presents:

Caring for Older Adults During COVID-19: Assessment and Management via Telehealth

https://bit.ly/UCSFGWEP_TELEHEALTH

How will I be able to do This?

- What are your local resources?
  - Telehealth options with geriatrics?
- Which areas (like in 5Ms) are you already addressing?
  - Pick one to start;
- What is your staffing and availability to help with doing assessments?
  - And follow-up after screening/assessment
  - Team approach but can break into visits or telehealth sessions

Educational Resources: Where to Learn More

- IAS-USA online resources
- AETCs
- HRSA Bureau of Health Workforce: Geriatric Workforce Enhancement Program (GWEP)
  - 48 programs across the US
  - Northern California: Optimizing Aging Collaborative

Summary

- Multimorbidity and polypharmacy common in older PWH & require unique approach
  - 6 step approach to polypharmacy; reducing potentially inappropriate meds (PIMS) can be good place to start
- Geriatric Syndromes are multifactorial syndromes that predict mortality & identify vulnerability
  - Frailty: Fried frailty Phenotype used most in HIV
  - Functional Status/Disability –self-report and other measures
  - Falls: CDC Steadi screening questions & resources

- Many parts of geriatric assessment can be adapted to telehealth

Posttest Question #1

A 63 y/o cisgender male with HIV, hypertension, COPD, diabetes, osteoarthritis, and chronic kidney disease admits he is struggling to take all of his medications. He currently takes 7 medications in addition to his antiretroviral medications (DTG/ABC/3TC). Which of the following is the best initial step to address polypharmacy?

1. Switch his ART regimen for another with fewer drug-drug interactions
2. Identify potentially inappropriate medications
3. Provide counselling on ART adherence
4. His medications cannot be reduced given his comorbidities

Posttest Question #2

A 75 y/o cisgender female with HIV, hypertension, diabetes, and peripheral neuropathy is asked routine falls screening questions at her primary care appointment using the CDC STEADI tool. She denies having any falls or feeling unsteady, but is worried about falling. What is the next best step?

1. Nothing else is needed, reassess in 1 year
2. Evaluate her gait
3. Provide education on fall prevention

Question-and-Answer Session

Submit questions using the Q&A button.

END THE EPIDEMICS

Californians Mobilizing to End HIV, STIs, Viral Hepatitis & Overdose

HIV & Aging Demonstration Projects

$5 Million General Fund One-Time Over Three Years

Summary

In order to improve the health and wellbeing of older adults living with HIV in California, the End the Epidemics coalition urges the legislature to allocate $5 million general fund one-time over 3 years to establish up to 5 demonstration projects that address the clinical and non-clinical needs of people with HIV over 50. The demonstration projects would be modeled after the Golden Compass Program, a highly successful program for people with HIV over 50 at the Ward 86 outpatient HIV clinic at San Francisco General Hospital. The Golden Compass Program is an innovative geriatric-HIV program that provides multidisciplinary medical care along with comprehensive support services. A valuable model for other providers throughout California, it is important to further develop and evaluate this program and others like it.

While the proposed demonstration projects would be modeled after the Golden Compass Program, the specific program components may be adapted to address the unique needs of older people with HIV in California. Proposals would be evaluated based on need in the geographic area, populations served, competency of the entity applying and program design. Priority would be given to applicants that demonstrate expertise and competency in working with populations most impacted by HIV in California, particularly Black and Latinx communities. The demonstration projects would include an evaluation component and a plan for disseminating lessons learned in order to strengthen ongoing programs. The demonstration projects would be administered by the California Department of Public Health, Office of AIDS in consultation with the California Department of Aging.

Background

With recent advancements in HIV treatment, people living with HIV are living longer and older people with HIV are increasingly dominating the epidemic. Over 50 percent of people living with HIV in California are now aged 50 years or older.[1] A recent report from the Conference on Retroviruses and Opportunistic Infections (CROI) estimates that by 2030 over 25 percent of people with HIV in the U.S. will be over the age of 65.[2] Unfortunately, our current health and social service systems are ill-equipped to address the unique needs of this population.

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[1] Office of AIDS. California HIV Surveillance Report – 2018. Available at: https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/California_HIV_Surveillance_Report2018.pdf.

[2] Kasaie P et al. Multimorbidity in people with HIV using ART in the US: projections to 2030. Conference on Retroviruses and Opportunistic Infections, abstract 102, 2021. Available at: https://www.aidsmap.com/news/mar-2021/2030-quarter-people-taking-hiv-treatment-us-will-be-over-65-and-most-will-have.

A 2020 report by SAGE's HIV and Aging Policy Action Coalition identified several unique challenges and barriers to services experienced by older people with HIV.[3] Older people with HIV are more likely than their HIV-negative counterparts to have multiple comorbidities including certain cancers, cardiovascular disease, lung disease, HIV-associated neurocognitive disorders, fractures and hepatitis C. Older people with HIV are also more likely to experience behavioral health challenges, including depression, anxiety and substance use disorders. Research indicates that older people with HIV have rates of depression up to five times higher than their HIV-negative peers. Additionally, older people with HIV continue to encounter discrimination and alarming levels of stigma, which may be compounded by other stigmatized parts of their identities, including age, race/ethnicity, sexual orientation and/or gender identity. The combined burden of HIV, comorbidities, and geriatric conditions among older people with HIV has resulted in widespread recognition that more holistic models of care are needed to adequately meet the needs of this rapidly growing population.

HIV service providers in California are beginning to develop services to address the unique needs of older people with HIV, but there are too few programs, and those that exist are inadequately funded. Only one program, the Golden Compass Program at the Ward 86 outpatient HIV clinic at San Francisco General Hospital, currently addresses HIV and aging comprehensively. The Golden Compass Program is a geriatric-HIV program designed to address key health-related challenges experienced by older people with HIV and consists of consultative geriatrics and cardiology clinics located within the HIV clinic and participatory group classes for patients.

The Golden Compass Program launched in January 2017 involving a team of doctors (medical director, cardiologist, geriatrician), a registered nurse, a pharmacist, a program coordinator and a medical assistant.[4] The program was conceptualized as a comprehensive care program for people with HIV over 50, framed around the 4 points of a compass: (1) Heart and Mind (Northern Point) includes cardiology, cognitive evaluations, and brain health classes; (2) Bones and Strength (Eastern Point) focuses on bone health, fitness, and physical function, through exercise classes and geriatric consultation; (3) Dental, Hearing, and Vision (Western Point) ensures appropriate screenings and linkage to dental, audiology, and optometric/ophthalmology services; and (4) Networking and Navigation (Southern Point) focuses on social and community-building activities.

An initial evaluation of the Golden Compass Program found a high degree of satisfaction with all program components, often ≥90% among both patients and providers.[5] According to the authors, "Our findings have important implications for further research and policy directions in geriatric-HIV medicine. Our effectiveness findings, such as satisfaction with and acceptability of services, not only fill a knowledge gap regarding geriatric-HIV programs but also provide early evidence for policy makers to support development and funding of these programs."

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[3] SAGE. Emerging Issues in HIV and Aging. Available at: https://www.sageusa.org/wp-content/uploads/2020/07/emerging-issues-in-hiv-and-aging-may-2020.pdf.

[4] Greene, M., Myers, J., Tan, J. Y., Blat, C., O'Hollaren, A., Quintanilla, F., ... & Gandhi, M. (2020). The Golden Compass Program: Overview of the Initial Implementation of a Comprehensive Program for Older Adults Living with HIV. Journal of the International Association of Providers of AIDS Care (JIAPAC), 19, 2325958220935267. Available at: https://journals.sagepub.com/doi/full/10.1177/2325958220935267.

[5] Ibid.

In 2020, the New York City Department of Health and Mental Hygiene (DOHMH) launched a similar program: Building Equity: Intervening Together for Health.[6] This program will select up to five contractors to implement evidence-based interventions that will respond to the unique needs of priority populations in New York City, including Black and Latinx people with HIV over 50. According to DOHMH, "Health outcomes among Black and Latinx older people with HIV could be improved and protected through screening, addressing, and referring for common conditions and unmet needs associated with aging; multidisciplinary care coordination; social and physical activities; and frequent communication with HIV care teams."

DOHMH will select one clinic providing HIV primary care to implement an evidence-informed intervention that has been adapted from the Golden Compass Program. DOHMH has adapted the Golden Compass Program model to fit the needs of Black and Latinx older people with HIV living in New York City by adding a component of social and physical activities. The project will ensure multidisciplinary clinical and non-clinical needs are assessed and addressed.

Similarly, the proposed demonstration projects in California would be modeled after the Golden Compass Program. However, the specific program components may be adapted to address the unique needs of older people with HIV in California. For example, participants in the Golden Compass program noted that there was a greater need for behavioral health and substance use services. Additional program components may also include housing support services, benefits counseling, case management, and provider training, among others.

The proposed demonstration projects are consistent with California's recently launched Master Plan for Aging, which maintains a strong commitment to equity and addressing the needs of California's most vulnerable communities. As we approach the 40th anniversary of the first CDC report of 5 gay men contracting HIV in Los Angeles on June 5, the demonstration projects would be a fitting tribute to all Californians now living with HIV – including many long-term survivors – as well as those who have been lost to the epidemic.

[6] Public Health Solutions on behalf of New York City Department of Health and Mental Hygiene Bureau of HIV. Building Equity: Intervening Together for Health (BE InTo Health). Available at: https://natap.org/2020/HIV/BITH-RFPv2-REVISED-09.14.2020.pdf.

Request for Proposals

Public Health Solutions
On behalf of
New York City Department of Health and Mental Hygiene
Bureau of HIV

Building Equity:
Intervening Together for Health
(BE InTo Health)

Solicitation #: 2020.08.HIV.01~~.01~~02
REVISED 09/14/2020

Table of Contents

***Important Note*: For a copy of this Request for Proposals, please go to:**
https://www.healthsolutions.org/get-funding/request-for-proposals/

Basic Information

<table>
<tr><td>RFP Release Date</td><td>08/19/2020 (REVISED 09/14/2020)</td></tr>
<tr><td>Proposal Due Date</td><td>~~09/22/2020~~ 10/13/2020, 3pm ET</td></tr>
<tr><td>Pre-Proposal Conference Webinar</td><td>08/31/2020, 10am-1pm ET
Attendance at the Pre-Proposal Conference Webinar is not mandatory; however, those organizations interested in submitting a proposal are strongly urged to attend. If you plan to attend the Pre-Proposal Conference Webinar, please register via the webinar link:
https://webinar.ringcentral.com/webinar/register/WN_Sv-k9dvMRyWv2gmfLHHGCA
If you have not attended a RingCentral webinar, we encourage you to download and launch the RingCentral application a few minutes in advance of the call. Simply click on the link in the calendar invitation and follow the instructions to launch.</td></tr>
<tr><td>Anticipated Contract Term</td><td>~~02/01/2021~~ 03/01/2021 – 2/29/2024
Contracts will be awarded for a term of ~~one (1) month and~~ three (3) years; with the option of one renewal for up to three years.
New York City Department of Health and Mental Hygiene (DOHMH) reserves the right, prior to contract award, to determine the length of the initial contract term and each option to renew, if any.</td></tr>
<tr><td>RFP Contact</td><td>Mayna Gipson, Public Health Solutions, BITHRFP@healthsolutions.org</td></tr>
<tr><td>Anticipated Funding and Payment Structure</td><td>Total Anticipated Funding Amount: ~~$6,500,000~~$4,875,000 for ~~four (4)~~three (3) years, $1,625,000 per year.
However, DOHMH reserves the right to increase/decrease the total funding amount depending on funding availability.
DOHMH anticipates a milestone based reimbursement in the first six (6) months of the program. Thereafter and for the remainder of the contract, reimbursement ~~to~~ will occur ~~monthly,~~ upon submission of required reports as proof of achieved service benchmarks. The anticipated funding breakdown is as follows:
<table>
<tr><th>Service Category</th><th>Number of Awards</th><th>Annual Amount</th></tr>
<tr><td>Black and/or Hispanic/Latina Women with HIV, including Black and/or Hispanic/Latina cisgender, transgender, non-binary and/or genderqueer women</td><td>1</td><td>$300,000</td></tr>
<tr><td>Black and/or Hispanic/Latina Transgender Women with HIV, and those who identify as non-binary or genderqueer</td><td>1</td><td>$325,000</td></tr>
<tr><td>Black and/or Hispanic/Latino Younger People with HIV (ages 13-29)</td><td>1</td><td>$325,000</td></tr>
</table></td></tr>
</table>

		Black and/or Hispanic/Latino Older People with HIV (ages 50 and older)	1	$375,000
		Black and/or Hispanic/Latino Men who have Sex with Men with HIV, including Black and/or Hispanic/Latino cisgender, transgender, non-binary, and/or genderqueer MSM	1	$300,000
		Total	**5**	**$1,625,000**
Minimum Contractor Requirements	• Operate a static clinic in the Bronx, Brooklyn, Manhattan, or Queens • Provide clinical HIV care and treatment			
Required Documents	Proposers **must submit** the following documents: • Workplan Template (Attachment A) • Staffing Plan Template (Attachment B) • Clinic Demographics Table (Attachment C) *(can only submit via a link to the form in the CAMS Contracting Portal)* • Structured Proposal Form (Attachment D) • Organizational Chart (Attachment E, *no template provided*) • Twelve (12) Month Line-item Budget (Attachment F) • Two (2) Written Letters of Recommendation (Attachment G & H, *no template provided*) • Proof of Accreditation/Designation Instructions (Attachment I, *no template provided*) • Letter of Support from Non-profit Legal Organization *(Service Category 2 only, if no experience providing legal support)* (Attachment J, *no template provided*) • Board of Directors' Statement Template (Attachment K) • Current Board of Directors List (Attachment L, *no template provided*) *(can elect to share with PHS from the organization's Document Vault in the NYC HHS Accelerator)* • Most Recent Audited Annual Financial Statement (Attachment M, *no template provided*) *(can elect to share with PHS from the organization's Document Vault in the NYC HHS Accelerator)*			
Questions Regarding this RFP	• Questions regarding this RFP must be submitted via email to the RFP Contact at **BITHRFP@healthsolutions.org** • Questions Deadline Date: **09/01/2020, 12pm ET** • Responses to questions from the Pre-Proposal Conference Webinar, as well as questions submitted to the RFP email by the Questions Deadline Date, may be addressed in a supplement to the RFP. • The Supplement will also include the presentation slides from the Pre-Proposal Conference Webinar, and both will be posted on Public Health Solutions' website, **https://www.healthsolutions.org/get-funding/request-for-proposals/**			

Notice of Intent to Respond	• The Notice of Intent to Respond form (Attachment K) is not mandatory; however, proposers interested in responding to this RFP are strongly urged to submit the form by the due date so that Public Health Solutions may be better able to plan for the proposal evaluation process. Any information related to this RFP will be emailed to the individual(s) designated as the Proposal Contact Person. The form should be submitted via email no later than ~~09/15/2020~~ 10/06/2020 to **BITHRFP@healthsolutions.org**

Proposal Submission Instructions

Submit Proposal to CAMS Contracting Portal

All of the documents listed in the Required Documents section in Basic Information (see page 3) must be submitted to the CAMS Contracting Portal on Public Health Solutions' (PHS) website at ***https://mer.healthsolutions.org*** by the proposal due date and time. Individual documents can be uploaded, completed via link to form (Attachment C), and/or elected to be shared via HHS Accelerator (current Board of Directors List and/or most recent Annual Financial Statement). Required submission method for each will be indicated in the portal. *You do NOT need to submit a hard-copy or submit via email. Use of the Contracting Portal is REQUIRED. Proposals sent by hard copy or email will NOT be considered as submitted.*

The CAMS Contracting Portal ***https://mer.healthsolutions.org*** is used by current PHS contractors to report expenditure (eMER) and/or narrative (ePNR) data. The same Contracting Portal will be used for uploading proposals for this RFP. In order to use the Contracting Portal to upload a proposal, you must have a current login.

- If you have been named on a Contractor Contact Verification Form (CCVF) as an official contact for an existing contract with PHS CAMS, then you already have a login on the CAMS Contracting Portal. If you do not know what your login is, please email ***RFPloginrequest@healthsolutions.org***
- If you have not been named on a CCVF as an official contact for an existing contract, then a new login will need to be created for you. Please email ***RFPloginrequest@healthsolutions.org*** to request a login.
- All login request emails should include the following:
    - First and last name of the proposal submitter
    - Email address of proposal submitter
    - Job Title of proposal submitter
    - Full legal name of the applicant organization
    - EIN of applicant organization
    - RFP title should be in the subject line of the email

Note that only one individual may initiate and submit the proposal for an organization per RFP.

Please be aware that uploading a proposal will involve multiple files for various representing different required proposal documents. Please allow sufficient time to check that you have included all necessary digital file attachments. *Please ensure that you have a working login and familiarize yourself with the CAMS Contracting Portal's Proposal Upload area, at least one week before the proposal submission deadline.*

Note that proposals received after the deadline may be disqualified from funding consideration.

It is the responsibility of the submitting organization to ensure delivery of the proposal to Public Health Solutions via the CAMS Contracting Portal by the submission deadline. A confirmation of receipt of the required submission (via upload) will be sent by email. Note that the email confirmation is confirming the delivery and receipt of the proposal submission and is ***not*** *a confirmation that the proposal submission is complete or responsive.*

For all other communication (e.g., to submit questions, to submit notice of intent, etc.), please email the RFP contact at BITHRFP@healthsolutions.org

Section 1 – Program Background

The mission of the New York City Department of Health and Mental Hygiene (DOHMH) is to protect and promote the health of all New York City (NYC) residents. Central to this mission is addressing health inequities due to racism, sexism, homophobia, transphobia, and poverty in order to achieve racial equity and social justice. The efforts of the DOHMH's Bureau of HIV (BHIV) is also centered on racial equity and social justice in its mission to end HIV transmission, promote the health of all New Yorkers with or vulnerable to HIV, reduce HIV-related inequities, and combat stigma.

During the 2019 State of the Union address, the Trump administration announced the new "Ending the HIV Epidemic: A Plan for America." This is a ten-year initiative, beginning in Fiscal Year 2020, to achieve the important goal of reducing new HIV infections to less than 3,000 per year by 2030. BHIV is a recipient of funding for the Ending the HIV Epidemic (EHE): A Plan for America – Ryan White HIV/AIDS Program (RWHAP) Parts A and B as administered by the Health Resources and Services Administration (HRSA). Funds from this initiative are intended to provide resources to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in pre-determined jurisdictions across the nation. The EHE plan focuses on four strategies: Pillar One – *diagnose* all people with HIV as early as possible; Pillar Two – *treat* people with HIV rapidly and effectively to reach sustained viral suppression; Pillar Three – *prevent* new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs); and Pillar Four – *respond* quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.[1] With funds from this initiative, BHIV will focus on EHE Pillars Two and Four, treat and respond, by partnering with clinical agencies throughout NYC to implement effective strategies to reduce HIV transmission and improve HIV care outcomes.

BHIV supports clinical and non-clinical community and hospital medical organizations throughout New York City (NYC) to meet the needs of the 127,287 people with HIV (PWH) and those vulnerable to contracting HIV[2]. Efforts to reduce transmission have resulted in steady declines in new HIV diagnoses. In 2018, 1,917 new HIV diagnoses were reported in NYC, an 11.1% decrease from 2017.[3] Mortality rates have also experienced significant declines. HIV-related deaths among PWH declined by 83% between 2003 and 2017, as more sophisticated care and treatment strategies were implemented.[4] Despite successful efforts to improve HIV outcomes, inequities persist among racial/ethnic, sexual, and gender identities. As such, BHIV has identified priority populations in order to prioritize the provision of tailored, equitable services to bridge gaps in health outcomes among populations that have historically been and are currently being left behind in our progress to ending the HIV epidemic in NYC. These populations include people with HIV (PWH) who identify as Black and/or Hispanic/Latino (H/L) and who identify as one of the following: cisgender women; transgender women; non-binary and/or genderqueer individuals; young people, ages 13-29; older adults, ages 50+; or cisgender, transgender, non-binary, and/or genderqueer men who have sex with men (MSM).

The impact of institutionalized racism, sexism, classism, homophobia, transphobia and other systems of oppression have contributed to imbalances and inequities along the HIV prevention, care, and treatment

[1] Azar, A. *Ending the HIV Epidemic: A Plan for America.* U.S. Department of Health & Human Services. February 5, 2019.
[2] HIV Epidemiology Program. *HIV Surveillance Annual Report, 2018.* New York City Department of Health and Mental Hygiene.
[3] Ibid.
[4] Ibid.

continuum.[5] To respond to these inequities, BHIV is launching a new program: Building Equity: Intervening Together for Health (BE InTo Health). This program will select up to five (5) contractors to implement one (1) of five (5) evidence-based interventions that will respond to the unique needs of one (1) priority population. Effective, evidence-based strategies exist that have been shown to improve health outcomes for those most vulnerable and critical in the fight to end the HIV epidemic. The evidence-based interventions proposed in this Request for Proposals (RFP) have been modified to respond to the unique needs of the NYC populations and include strategies that aim to improve engagement and re-engagement in care, initiation of immediate of antiretroviral treatment (iART), coordination of care, and ultimately, HIV outcomes among priority populations. This RFP has grouped the priority populations into five "Service Categories" based on the original design of the evidence-based interventions as well as the formative information collected from NYC stakeholders.

The Service Categories are as follows:

- Service Category 1: Black and/or Hispanic/Latina Women with HIV, including Black and/or Hispanic/Latina cisgender, transgender, non-binary and/or genderqueer women;
- Service Category 2: Black and/or Hispanic/Latina Transgender Women with HIV, and those who identify as non-binary or genderqueer;
- Service Category 3: Black and/or Hispanic/Latino Young People, ages 13-29, with HIV;
- Service Category 4: Black and/or Hispanic/Latino Older People, ages 50+, with HIV; and
- Service Category 5: Black and/or Hispanic/Latino Men who have Sex with Men with HIV, including Black and/or Hispanic/Latino cisgender, transgender, non-binary, and/or genderqueer MSM

A. Priority Population Needs

The priority populations identified above have unique needs that the evidence-based interventions ("projects") described in this RFP seek to meet.

Black and/or Hispanic/Latina (H/L) Women with HIV, including Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women

Black and H/L women are disproportionately affected by the HIV epidemic in the United States (U.S.), accounting for 75% of new HIV diagnoses among women in 2018.[6] In NYC, in the same year, Black and H/L women made up 25% of the total population of PWH in the city with Black women accounting for 16%.[7] In 2018, Black and H/L women also accounted for approximately 90% of new HIV diagnoses among women in NYC – with Black women experiencing a diagnosis rate 3.2 times higher than H/L women and 11 times higher than White, Asian Pacific Islander and multiracial women in 2018.[8] Of those diagnosed and living with HIV, Black and H/L women often experience worse health outcomes related to the continuum of care with lower rates of engagement and retention in care and viral load suppression (VLS) in comparison to White women.[9] The disproportionate impact of social determinants of health, including poverty, low health literacy, reduced access to high quality HIV services, stigma among healthcare providers, and racism and other systems of oppression create and exacerbate HIV care continuum health inequities

[5] Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *Annual Review of Sociology*, *40*, 431-457.

[6] Centers for Disease Control. *HIV Surveillance Report, 2018 (Preliminary)*; vol. 30. Published November 2019. Accessed March 10,2020.

[7] HIV Epidemiology Program.

[8] HIV Epidemiology Program. *HIV Surveillance Annual Report, 2018.* New York City Department of Health and Mental Hygiene.

[9] Geter, A., et al. (2018). Trends of racial and ethnic disparities in virologic suppression among women in the HIV Outpatient Study, USA, 2010-2015. *PloS one*, *13*(1).

among Black and H/L women, such as engagement and retention in care, treatment and VLS.[10] [11] Interventions to improve outcomes along the HIV care continuum for Black and/or H/L women should include activities that enhance health literacy and self-efficacy in managing their own care; and increase access to social support and supportive services (e.g., child care, access to testing for sexually transmitted infections [STIs], etc.).

Black and/or Hispanic/Latina (H/L) Transgender Women with HIV and those who identify as non-binary or genderqueer

Transgender people are one of few groups in 2018 that experienced an increase in new HIV diagnoses in NYC. Between 2014 and 2018 in NYC, 97% of transgender people newly diagnosed with HIV were transgender women, and 90% of transgender women newly diagnosed were Black or H/L.[12] HIV-related outcomes in NYC have been worse for transgender women compared to transgender men; they are less likely to have timely linkage to care after diagnosis and are less likely to achieve VLS after three (3) months of diagnosis. Transgender people were found to have lower rates of VLS (78%) when compared to cisgender men (87%) and women (85%), and transgender women were found to have lower rates of sustained VLS even when established in HIV medical care (48%).[13] Due to persistent stigma and multifaceted needs, transgender people face significant inequities in HIV-related care as well as other barriers that effect their well-being. A 2015 national survey among transgender people in the U.S. found that almost a quarter of respondents reported that they did not seek health care when needed for fear of mistreatment based on their gender identity.[14] In addition to inequities in healthcare, transgender people also reported that they experienced higher rates of poverty, resulting in high rates of housing instability or homeless and food insecurity.[15] In this same survey, more than half of respondents reported experiencing harassment or mistreatment when interacting with law enforcement, and one out of ten transgender women reported interacting with law enforcement that assumed they were a sex worker.[16] Together, these realities can result in poorer HIV care and treatment outcomes for transgender women. Interventions to improve outcomes along the HIV care continuum for transgender women should include activities that build social support; enhance health literacy, client autonomy, and client-provider relationships; increase access to job and housing resources; reduce stigma; and provide access to supportive services, including legal support to protect clients' human, civil, and immigration rights.

Black and/or Hispanic/Latino (H/L) Young People with HIV (YPWH)

Across the U.S., YPWH, ages 13-29, experience disproportionate rates of new HIV infections and have the poorest HIV care continuum outcomes in relation to all other age groups, including lower rates of linkage to care, retention in care, and VLS.[17] In 2018, of the approximately 7,900 YPWH (ages 13-29) living in NYC, 67% had a suppressed viral load.[18] In addition, in 2018, sustained VLS among YPWH established in HIV medical care in NYC was also lower than all other age groups.[19] New HIV infections disproportionately

[10] Geter Fugerson, A., Sutton, M. Y., & Hubbard McCree, D. (2019). Social and Structural Determinants of HIV Treatment and Care Among Hispanic Women and Latinas Living with HIV Infection in the United States: A Qualitative Review: 2008-2018. *Health equity*, *3*(1), 581–587. https://doi.org/10.1089/heq.2019.0039

[11] Geter, A., Sutton, M. Y., & Hubbard McCree, D. (2018). Social and structural determinants of HIV treatment and care among black women living with HIV infection: a systematic review: 2005–2016. *AIDS care*, *30*(4), 409-416.

[12] HIV Epidemiology Program. *HIV Among People Identified as Transgender in New York City, 2014-2018.* https://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-in-transgender-persons.pdf. Published December 2019.

[13] HIV Epidemiology Program. *HIV Surveillance Annual Report, 2017.* New York City Department of Health and Mental Hygiene.

[14] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

[15] Ibid.

[16] Ibid.

[17] Centers for Disease Control. *HIV Surveillance – Adolescents and Young Adults*. Presentation. Accessed March 20,2020.

[18] HIV Epidemiology Program

[19] HIV Epidemiology Program. *HIV Surveillance Annual Report, 2018.* New York City Department of Health and Mental Hygiene.

affect young Black and H/L MSM in NYC. In 2018, there were more new HIV diagnoses among young Black men than any other race/ethnicity followed by young H/L men. The number of new HIV diagnoses among men ages 13 to 29 years with MSM exposure was consistently higher than other transmission categories during 2014-2018. [20] Among young women in NYC, in 2018, there higher rates of new HIV diagnoses among young Black women than any other race/ethnicity followed by young H/L women. [21] Enhancing engagement with Black and/or H/L YPWH is key to improving HIV health outcomes among this population. Black and/or H/L YPWH experience challenges such as low health seeking behaviors, unstable housing and frequent housing transition, stigma, and discomfort with providers. These barriers impact linkage, engagement, and retention in care among Black and/or H/L YPWH, which ultimately results in poor HIV health outcomes. [22] Interventions seeking to improve engagement and retention in care, medication adherence, and VLS among Black and/or H/L YPWH should facilitate frequent and appropriate interactions with Black and/or H/L YPWH and their care team and include activities to improve social support networks among Black and/or H/L YPWH and increase access to supportive services.

Black and Hispanic/Latino (H/L) Older People with HIV (OPWH)

As advancements in treatment and care have enabled PWH to live healthier and longer lives, OPWH (ages 50 years and above) are a growing demographic of PWH across the U.S. This is no more evident than in NYC, where OPWH accounted for 58% of the total population of PWH in 2018.[23] In NYC, OPWH achieved the highest rates of viral suppression compared to younger subgroups; however, racial and ethnic disparities among new diagnoses and concurrent AIDS diagnoses among OPWH must be addressed. In 2018, among all people 50 years and above, Black people had higher rates of HIV diagnoses than any other race or ethnicity. The proportion of concurrent HIV/AIDS diagnoses was also higher among Black people (35%) and H/L people (31%) ages 50 years and above than among White people (29%) and Asian Pacific Island people (23%).[24] Furthermore, death rates among Native American, Multiracial and Black PWH ages 50 years and above were higher than rates for PWH 50 years and above of other race and ethnicities. [25] Aging with HIV comes with unique challenges. While OPWH tend to have better HIV care outcomes when compared to other age groups, they must deal with the effects of aging, including comorbidities, polypharmacy, social isolation, and depression.[26] Consequently, care can become increasingly specialized and fragmented for OPWH, and the need for greater care coordination and management is critical to ensure comprehensive healthcare is received. Reductions in social supports, mobility, and other forms of physical and cognitive function; and increasing isolation, due to the loss of friends and partners can also impact morbidity, mortality, and the utilization of services among OPWH, which in turn can jeopardize HIV-related outcomes.[27] Health outcomes among Black and/or H/L OPWH could be improved and protected through screening, addressing, and referring for common conditions and unmet needs associated with aging; multidisciplinary care coordination; social and physical activities; and frequent communication with HIV care teams.

[20] HIV Epidemiology Program. *HIV Surveillance Annual Report, 2018.* New York City Department of Health and Mental Hygiene.
[21] HIV Epidemiology Program. *HIV Surveillance Annual Report, 2018.* New York City Department of Health and Mental Hygiene.
[22] Philbin, M. M., Tanner, A. E., DuVal, A., Ellen, J. M., Xu, J., Kapogiannis, B., ... & Adolescent Trials Network for HIV/AIDS Interventions. (2014). Factors affecting linkage to care and engagement in care for newly diagnosed HIV-positive adolescents within fifteen adolescent medicine clinics in the United States. *AIDS and Behavior*, *18*(8), 1501-1510.
[23] HIV Epidemiology Program.
[24] HIV Epidemiology Program.
[25] HIV Epidemiology Program.
[26] Greene, M., Covinsky, K. E., et al. (2015). Geriatric syndromes in older HIV-infected adults. *Journal of acquired immune deficiency syndromes (1999)*, *69*(2), 161.
[27] Ibid.

Black and/or Hispanic/Latino (H/L) Men who have Sex with Men (MSM) with HIV, including Black and/or (H/L) cisgender, transgender, non-binary, and/or genderqueer MSM

Black and H/L MSM are disproportionately affected by the HIV epidemic in the U.S.[28] In 2018, Black and H/L MSM living in NYC accounted for nearly 30% of the total population of PWH.[29] These populations also experience higher rates of new HIV diagnoses in comparison to other groups. Black men were diagnosed at rates five (5) times higher than rates among White, Asian Pacific Islander and Native American men; and H/L men were diagnosed at rates over three (3) times higher.[30] The impact of racism, stigma, discrimination, unemployment, poverty, unstable housing, and distrust in the medical system and providers create challenges for Black and/or H/L MSM with HIV and their HIV providers to address poor health outcomes along the HIV care continuum. [31] In order to overcome challenges to care among Black and/or H/L MSM with HIV, interventions should include activities that increase communication with HIV care providers, strengthen the role of social supports in HIV care, and develop tailored care plans to address the comprehensive needs of Black and H/L MSM with HIV.

B. Service Category Descriptions

BE InTo Health is designed for clinical agencies that provide HIV primary care and treatment to priority populations that operate out of a static clinic in the Bronx, Queens, Manhattan, or Brooklyn. DOHMH seeks contractors that have experience providing HIV care and treatment services and aim to expand the capacity of their agency to provide services to members of the identified priority populations. This is a new funding opportunity and does not replace any current BHIV funding opportunities. The selected contractors must provide HIV primary care and submit proof of **one** (1) of the following accreditations:

1. Article 28 (https://www.health.ny.gov/facilities/hospital/regulations/)
2. AIDS Clinical Trials Unit (https://www.niaid.nih.gov/research/aids-clinical-trials-group)
3. Federal Qualified Health Center (FQHC) (https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html)
4. FQHC-Look Alike (https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc-look-alikes/index.html)
5. New York State Patient-Centered Medical Homes (https://www.health.ny.gov/technology/nys_pcmh/ ~~https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/~~)
6. Joint Commission Accreditation (https://www.jointcommission.org/en/accreditation-and-certification/)
7. Designated AIDS Center (https://profiles.health.ny.gov/hospital/designated_center/AIDS+Center)

The goals of the BE InTo Health program are to:

- **Improve linkage to HIV medical care among the priority populations.**
- **Improve iART among the priority populations.**
- **Improve engagement and re-engagement in HIV care among the priority populations.**
- **Improve retention in HIV care among the priority populations.**

[28] Centers for Disease Control. *HIV Surveillance Report, 2018 (Preliminary)*; vol. 30. Published November 2019. Accessed March 10,2020.
[29] HIV Epidemiology Program.
[30] HIV Epidemiology Program. *HIV Surveillance Annual Report, 2018.* New York City Department of Health and Mental Hygiene.
[31] Remien, R. H., Bauman, L. J., Mantell, J., Tsoi, B., Lopez-Rios, J., Chhabra, R., ... & Cutler, B. (2015). Barriers and facilitators to engagement of vulnerable populations in HIV primary care in New York City. *Journal of acquired immune deficiency syndromes (1999)*, *69*(0 1), S16.

- **Improve VLS among the priority populations.**
- **Strengthen the capacity of HIV clinics to provide tailored services to priority populations.**

Based on formative work, including literature reviews and discussions with key stakeholders in clinical and community agencies throughout NYC, BHIV has identified five (5) evidence-based interventions ("projects") that are tailored to improve outcomes along the HIV care continuum for each identified priority population. Each evidence-based intervention is detailed in the following "Service Category Descriptions" for the relevant priority population ("Service Category").

Service Category 1: Black and/or Hispanic/Latina (H/L) Women with HIV, including Black and/or (H/L) cisgender, transgender, non-binary and/or genderqueer women

DOHMH is seeking one (1) clinic providing HIV primary care to implement an evidence-based intervention ("project") entitled: *Enhanced Patient Navigation for HIV-Positive Women of Color with HIV*[32]. This project was adapted from the HRSA Special Projects of National Significance (SPNS) Program, and has proven to improve linkage, engagement and/or re-engagement, and retention in care among Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women with HIV. Activities related to this project would include linking eligible clients to medical care; linkage to comprehensive sexual health care including STI and hepatitis C screening and care; providing iART (i.e., initiation of ART on the same-day or within 96 hours) for all eligible individuals[33] newly or previously diagnosed with HIV; using principles of motivational interviewing and trauma informed care to assess clients' barriers to care and develop individualized care plans with the clients; conducting individual in-person and/or virtual structured sessions on health education topics (e.g., HIV transmission and life cycle of HIV, understanding lab values, disclosure and stigma, mental health, intimate partner violence); supporting clients in obtaining referrals for needed services (e.g., transportation, housing, etc.); offering accompaniment to internal and external appointments, and hosting group health education sessions. The intervention focuses on providing clients with enhanced services in addition to the clinic's existing case management standard of care in order to build clients' patient trust; meet clients' priorities first (i.e., putting the clients' priorities ahead of service provider priorities); increase clients' health literacy; and strengthen clients' HIV knowledge, health beliefs, and self-efficacy in managing their care. In order to meet the needs of the priority population in this service category, the original intervention has been adapted to also include in-person and/or virtual group health education sessions to enhance social support for enrolled clients.

Table 1. Service Category 1: Black and/or H/L Women with HIV, including cisgender, transgender, non-binary and/or genderqueer women Project Model

Resources	Activities	Outcomes
BE InTo Health Funding - Project Staff - Project Materials **DOHMH Technical Assistance** - Project/contract management support - Implementation support	**Project Start-up** - Hire Staff - Complete DOHMH-identified trainings **Project Outreach and Recruitment** **Project Implementation** - Clients linked to HIV medical care	**Project Indicators** - Number of clients linked to HIV medical care - Number of clients receiving iART - Number of clients screened for STIs and hepatitis C - Number of clients recruited - Number of clients enrolled

[32] Enhance Patient Navigation for HIV-Positive Women of Color. TargetHIV. https://nextlevel.targethiv.org/deii/navigators.

[33] Individuals eligible for iART include those with reactive point-of-care HIV test result, or confirmed HIV diagnosis, or suspected acute HIV infection, or known HIV infection; and no prior ART (i.e., treatment naive) or limited prior use of antiretroviral medications, and no medical conditions or opportunistic infections that require deferral of rapid ART initiation, including suspected cryptococcal or tuberculous meningitis. https://www.hivguidelines.org/antiretroviral-therapy/when-to-start-plus-rapid-start/#tab_4

- Protocol guidance - Reporting guidance - Health Education Curriculum guidance - Required Trainings - Continuous Quality Improvement - Project monitoring support from TA Specialists	- Clients provided iART - Clients provided annual STI and hepatitis C screening - Clients enrolled in project - Creation of individualized care plans - Weekly/Bi-weekly individual structured sessions on health education topics - Weekly/Bi-weekly check-ins to provide enhanced client navigation (e.g., appointment scheduling, transportation assistance, scheduling referral appointments, accompaniment to referral and support services, assistance completing paperwork, etc.) - Review/update care plan every three months - Monthly group health educational sessions - Assessment of individualized care plans every six months and transition to standard of care case management (when appropriate) - Monthly case conferencing among project staff to review care plans and needs of enrolled clients - Specific evaluation activities to measure achievement of project outcomes **Project Quality Management Activities** - Staff Development and Support - Ongoing monitoring, evaluation and TA participation	- Number of individualized care plans - Number of individual structured sessions on health education topics - Number and type of referrals made to support services - Number and type of referrals to support services completed - Number of group health education sessions conducted - Number of clients completing group health education sessions - Number of clients who are transitioned into standard of care patient navigation **Project Outcomes** - Increase in % of clients newly diagnosed engaged in care - Increase in % of clients previously diagnosed engaged in care - Increase in % of clients re-engaged in care - Increase in % of clients retained in care - Increase in % of clients achieving VLS - Increase in % of clients adherent to HIV medication - Increase in % of clients' HIV knowledge, health beliefs, and self-efficacy in managing their own care - Integration of project into clinic

Project Objectives

The objectives of this project are as follows:

1. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women with HIV linked to medical care;
2. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women, newly and previously diagnosed, who are engaged in care (having more than two HIV medical care visits in a 12-month period);
3. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women who are re-engaged in care (having two or more HIV medical care visits after a lapse of at least nine [9] months [or six months if not virally suppressed] with no HIV medical care visit in a 12-month period);
4. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women who are retained in care (at least two [2] medical care visits at least three [3] months apart in a 12-month period);
5. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women who are virally suppressed (<200 copies/ml viral load in a 12-month period);
6. Increase in knowledge of HIV, health beliefs, and self-efficacy in managing their own care among enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women with HIV;

7. Increase capacity of clinic to improve HIV care continuum outcomes among Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women with HIV.

Service Category 2: Black and/or Hispanic/Latina (H/L) Transgender Women with HIV, and those who identify as non-binary or genderqueer

DOHMH is seeking one (1) clinic providing HIV primary care to implement an evidence-based intervention ("project") entitled: *Transgender Women Engagement and Entry to Care Project (T.W.E.E.T.)* [34]. This project was developed through the HRSA SPNS Program and has proven to increase linkage, engagement, and retention in care among Black and/or H/L transgender women with HIV through the provision of peer-led health education sessions aimed at improving health literacy and linkage to HIV medical care as well as support services, with an emphasis on legal assistance. Activities of this project include utilizing trauma-informed or trauma-responsive approaches to conduct outreach in non-traditional venues; link clients to HIV medical care; provide comprehensive sexual health care including STI and hepatitis C screening and care; provide iART (i.e., initiation of ART on the same-day or within 96 hours) for all eligible individuals[29] newly or previously diagnosed with HIV; host in-person and/or virtual group health educational sessions; maintain and promote robust referral network to link clients to support services (e.g., legal assistance, housing, and food and nutrition services).

Table 2. Service Category 2: Black and/or H/L Transgender Women with HIV, and those who identify as non-binary or genderqueer Project Model

Resources	Activities	Outputs
BE InTo Health Funding - Project Staff - Project Materials **DOHMH Technical Assistance** - Project/Contract Management Support - Implementation Support - Protocols Guidance - Reporting Guidance - Curriculum Guidance - Required Trainings - Continuous Quality Improvement - Project Monitoring Support from TA Specialists	**Project Start-up** - Hire Staff - Complete DOHMH-identified trainings **Project Outreach and Recruitment** - Outreach in non-traditional settings (e.g., nightclubs) - Clients referred to group health educational sessions - Clients enrolled after attending two educational sessions **Project Implementation** - Clients linked to HIV medical care - Clients provided iART - Clients provided annual STI and hepatitis C screening - Clients enrolled in project - Weekly group health educational sessions - Train Peer Leaders - Peer Leaders assist with outreach and facilitate health education sessions - Monthly needs assessments conducted, and appropriate referrals made to legal support and other support services (e.g., food and nutrition, mental health, housing, etc.) based on identified needs - Specific evaluation activities to measure achievement of project outcomes	**Project Indicators** - Number of clients linked to HIV medical care - Number of clients receiving iART - Number of clients screened for STIs and hepatitis C - Number of clients recruited - Number of clients enrolled - Number of needs assessment conducted - Number and type of referrals made to non-legal support services - Number and type of referrals to non-legal support services completed - Number of and type of legal support service referrals made - Number and type of legal support referrals completed - Number of Peer Leaders trained - Number of Peer-led educational sessions conducted - Number of clients completing group health education sessions **Project Outcomes** - Increase in % of clients newly diagnosed engaged in care - Increase in % of clients previously diagnosed engaged in care - Increase in % of clients re-engaged in care - Increase in % of clients retained in care

[34] Transgender Women Engagement and Entry To (T.W.E.E.T.) Care Project. TargetHIV. https://targethiv.org/sites/default/files/supporting-files/SPNS_CHN-TWEETCare_2018.pdf

	Quality Management Activities - Staff development and support - Ongoing monitoring, evaluation and TA participation	- Increase in % of clients achieving VLS - Increase in % of clients' knowledge of HIV, health beliefs, and self-efficacy in managing their own care - Decrease in % of clients' with unmet need for legal assistance and support services - Integration of project model into clinic

Project Objectives

The objectives of this project are as follows:

1. Increase percentage of enrolled Black and/or H/L transgender women and those who identify as non-binary or genderqueer with HIV linked to medical care;
2. Increase percentage of enrolled Black and/or H/L transgender women and those who identify as non-binary or genderqueer, newly and previously diagnosed, engaged in HIV care (having two or more HIV medical care visits in a 12-month period);
3. Increase percentage of enrolled Black and/or H/L transgender women and those who identify as non-binary or genderqueer re-engaged in care (having two or more HIV medical care visits after a lapse of at least nine [9] months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period);
4. Increase percentage of enrolled Black and/or H/L transgender women and those who identify as non-binary or genderqueer retained in care (at least two HIV medical care visits at least three [3] months apart in a 12-month period);
5. Increase percentage of enrolled Black and/or H/L transgender women and those who identify as non-binary or genderqueer engaged in care who are virally suppressed (<200 copies/ml viral load in a 12-month period);
6. Increase knowledge of HIV, health beliefs, and self-efficacy to manage their own care among enrolled Black and/or H/L transgender women and those who identify as non-binary or genderqueer;
7. Decrease percentage of clients with unmet needs for legal access to legal assistance and supportive services among enrolled Black and/or H/L transgender women and those who identify as non-binary or genderqueer
8. Increase capacity of clinic to improve HIV care continuum outcomes among Black and/or H/L transgender women with HIV and those who identify as non-binary or genderqueer.

Service Category 3: Black and/or Hispanic/Latino (H/L) Younger People with HIV (YPWH)

DOHMH is seeking one (1) clinic providing HIV primary care to implement an evidence-based intervention ("project") entitled: *E-VOLUTION* [35]. This project was developed through the HRSA SPNS Program and has proven to increase VLS, medical visits kept, and communication between case management among Black and/or H/L YPWH (i.e., younger people ages 13-29). The project entails utilizing trauma-informed or trauma-responsive approaches to provide linkage to HIV medical care; linkage to comprehensive sexual health care including STI and hepatitis C screening and care; and iART (i.e., initiation of ART on the same-day or within 96 hours) for all eligible individuals[29] newly or previously diagnosed with HIV; develop and implement a two-way text messaging system (e.g., CareSignal) that includes regular communication between case management and Black and/or H/L YPWH clients; deliver tailored case management services, and psychosocial support; and conduct multidisciplinary case conferencing with the clinic care team to review and address the needs of Black and/or H/L YPWH. The two-way text messaging system (to

[35] E-VOLUTION. TargetHIV. https://targethiv.org/sites/default/files/supporting-files/spns-smi-evolution-manual-508.pdf.

be procured by the awardee) should provide daily medication reminders, weekly mood check-ins, appointment reminders, and monthly social service needs assessments. The E-VOLUTION project has been adapted for the NYC population to include in-person and/or virtual psychosocial support activities such as individual psychosocial support (counseling) and group psychosocial sessions.

Table 3. Service Category 3: Black and/or H/L YPWH Project Model

Inputs	Activities	Outcomes
BE InTo Health Funding - Project Staff - Project Materials **DOHMH Technical Assistance** - Project/Contract Management Support - Implementation Support - Protocols Guidance - Reporting Guidance - Curriculum Guidance - Required Trainings - Continuous Quality Improvement - Project Monitoring Support from Technical Assistance Specialists	**Project Start-up** - Hire Staff - Complete DOHMH-identified trainings **Project Outreach and Recruitment** **Project Implementation** - Clients linked to HIV medical care - Clients provided iART - Clients provided annual STI and hepatitis C screening - Client enrolled in project - Safety Appraisal - Automated and Live Two-Way Text Messaging (e.g., daily med reminder; bi-weekly mood check; appt. reminders; housing/needs check) - Monthly multidisciplinary case conferencing - Monthly individual Psychosocial Support Sessions - Monthly group psychosocial support Sessions - Specific evaluation activities to measure achievement of project outcomes **Quality Management Activities** - Staff Development and Support - Ongoing Monitoring, Evaluation and TA Participation	**Project Indicators** - Number of clients linked to HIV medical care - Number of clients receiving iART - Number of clients screened for STIs and hepatitis C - Number of clients recruited - Number of clients enrolled - Number and type of alerts received from automated texting - Number of HIV appointments kept - Number and type of referrals made to support services - Number and type of referrals to support services completed - Number of individual psychosocial support sessions conducted - Number of group psychosocial support sessions conducted - Number of clients attending group psychosocial support sessions **Project Outcomes** - Increase in % of clients newly diagnosed engaged in care - Increase in % of clients previously diagnosed engaged in care - Increase in % of clients re-engaged in care - Increase in % of clients retained in care - Increase in % of clients achieving VLS - Increase in kept medical appointments - Improved communication between Black and/or H/L YPWH and medical case management - Decrease in % of clients with unmet needs for support services - Integration of engagement and retention intervention for Black and H/L YPWH into clinic

Project Objectives

The objectives of this project are as follows:

1. Increase percentage of enrolled Black and/or H/L YPWH linked to medical care;
2. Increase percentage of enrolled Black and/or H/L YPWH, newly and previously diagnosed, who are engaged in care (having two or more HIV medical care visits in a 12-month period);

3. Increase percentage of enrolled Black and/or H/L YPWH re-engaged in care (having two or more HIV medical care visits after a lapse of at least nine [9] months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period);
4. Increase percentage of enrolled Black and/or H/L YPWH who are retained in care (two HIV medical care visits at least three [3] months apart in a 12-month period)
5. Increase percentage of enrolled Black and/or H/L YPWH who are virally suppressed (<200 copies/ml viral load in a 12-month period);
6. Increase in kept medical appointments among enrolled Black and/or H/L YPWH;
7. Improved communication with case management among enrolled Black and/or H/L YPWH;
8. Decrease percentage of enrolled Black and/or H/L YPWH with unmet needs for support services;
9. Increase capacity of clinic to improve HIV care continuum outcomes among Black and/or H/L YPWH.

Service Category 4: Black and/or Hispanic/Latino (H/L) Older People with HIV (OPWH)

DOHMH is seeking one (1) clinic providing HIV primary care to implement an evidence-informed intervention ("project") that has been adapted from University of California San Francisco's Golden Compass Program. *The Golden Compass* Program is a multidisciplinary care coordination model that integrates care across several medical practices including, but not limited to, cardiovascular, neurological, and geriatric disciplines.[36] BHIV has adapted the *Golden Compass* Program model to fit the needs of Black and/or H/L OPWH living in NYC by adding a component of social and physical activities. The project will ensure multidisciplinary clinical and non-clinical needs are assessed and addressed. Activities of this project include utilizing trauma-informed or trauma-responsive approaches to: provide linkage to HIV medical care; linkage to comprehensive sexual health care including STI and hepatitis C screening and care; and iART (i.e., initiation of ART on the same-day or within 96 hours) for all eligible individuals[29] newly or previously diagnosed with HIV; conduct screening for common aging healthcare needs of Black and/or H/L OPWH; create individualized care plans for enrolled clients, including referrals to specialty care; offer care coordination and home visits; utilize telehealth to engage enrolled client; conduct multidisciplinary case conferencing; and facilitate in-person and/or virtual physical fitness classes (e.g. Zumba, yoga), in-person and/or virtual support groups, or other social events and activities. The recommended screenings for common aging health needs of Black and H/L OPWH include: Montreal Cognitive Assessment (MOCA), Patient Health Questionnaire-9 (PHQ-9), Katz Index in Activities of Daily Living (ADLs), a medication review, and a fall assessment.

Table 4. Service Category 4: Black and/or H/L OPWH Project Model

Inputs	Activities	Outcomes
BE InTo Health Funding - Project Staff - Project Materials **DOHMH Technical Assistance** - Project/Contract Management Support - Implementation Support - Protocols Guidance - Reporting Guidance	**Project Start-up** - Hire Staff - Complete DOHMH-identified Trainings **Project Outreach and Recruitment** **Project Implementation** - Clients linked to HIV medical care - Clients provided iART	**Project Indicators** - Number of clients linked to HIV medical care - Number of clients receiving iART - Number of clients screened for STIs and hepatitis C - Number of clients recruited - Number of clients enrolled - Number and type of screening tools completed - Number of care plans completed - Number of telehealth visits completed

[36] Greene, M. L., Tan, J. Y., Weiser, S. D., Christopoulos, K., Shiels, M., O'Hollaren, A., ... & Gandhi, M. (2018). Patient and provider perceptions of a comprehensive care program for HIV-positive adults over 50 years of age: The formation of the Golden Compass HIV and aging care program in San Francisco. *PloS one*, *13*(12).

- Curriculum Guidance - Required Trainings - Continuous Quality Improvement - Project Monitoring Support from TA Specialists	- Clients provided annual STI and hepatitis C screening - Clients enrolled in project - Bi-annual screening and creation of care plans (e.g., MOCA, PHQ-9, ADL, a medication review, a fall assessment) - Monthly case management and coordination (e.g., medical and non-medical referrals, on-site or virtual client follow-up) - Monthly multidisciplinary case conferencing - Monthly client-centered physical and social activities - Specific evaluation activities to measure achievement of project outcomes **Quality Management Activities** - Staff Development and Support - Ongoing Monitoring, Evaluation and TA Participation	- Number of home visits completed - Number and type of referrals made - Number and type of referrals completed - Number of case conferences conducted - Number of physical activities performed - Number of clients attending physical activities - Number of social activities conducted - Number of clients attending social activities **Project Outcomes** - Increase in % of clients newly diagnosed engaged in care - Increase in % of clients previously diagnosed engaged in care - Increase in % of clients re-engaged in care - Increase in % of clients retained in care - Increase in % of clients achieving VLS - Increase screening for OPWH-specific needs - Increase in successful referrals - Decrease in rates of depressive symptoms among clients (measured on a validated depression scale) - Increase quality of life among clients (measured on a validated quality of life scale) - Increase in % of clients who attend regular physical activities - Increase in % of clients who are socially active - Integration of multidisciplinary care coordination intervention for Black and/or H/L OPWH

Project Objectives

The objectives of this project are as follows:

1. Increase percentage of enrolled Black and/or H/L OPWH linked to medical care;
2. Increase percentage of enrolled Black and/or H/L OPWH, newly and previously diagnosed, who are engaged in care (having two or more HIV medical care visits in a 12-month period);
3. Increase percentage of enrolled Black and/or H/L OPWH re-engaged in care (having two or more HIV medical care visits after a lapse of at least nine [9] months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period);
4. Increase percentage of enrolled Black and/or H/L OPWH who are retained in care (two HIV medical visits at least three [3] months in a calendar year)
5. Increase percentage of enrolled Black and/or H/L OPWH who are virally suppressed (<200 copies/ml viral load in a 12-month period);
6. Increase screening of common aging-related healthcare needs among enrolled Black and/or H/L OPWH;
7. Increase successful referrals to address enrolled Black and/or H/L OPWH-specific needs;
8. Decrease rates of depressive symptoms (measured on a validated depression scale) among enrolled Black and/or H/L OPWH;
9. Increase in quality of life (measured on a validated quality of life scale) among enrolled Black and/or H/L OPWH;
10. Increase physical and social activities among enrolled Black and/or H/L OPWH;

11. Increase capacity of clinic to improve HIV care continuum outcomes among enrolled Black and/or H/L OPWH.

Service Category 5: Black and/or Hispanic/Latino (H/L) Men who have Sex with Men (MSM) with HIV, including Black and/or (H/L) cisgender, transgender, non-binary, and/or genderqueer

DOHMH is seeking one (1) clinic providing HIV primary care to implement an evidence-informed intervention adapted from the *Project nGage* intervention ("project"). This project is a social network support project that harnesses naturally existing supportive relationships among Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM with HIV to improve a client's HIV health outcomes.[37] This project has been proven to significantly improve retention in care and medication adherence among eligible clients with HIV. The project entails utilizing trauma-informed or trauma-responsive approaches to map a client's social network (i.e., a social worker makes a social network diagram) to assess the optimal social network member for participation in the project as a "Support Confidant" (SC). Then, the identified SC and client work with a social worker to identify the client's challenges to care and develop a care and support plan to overcome the identified challenges. Throughout the project, the SC and client are engaged by a social worker to ensure the success of the care and support plan. This project has been adapted for Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM with HIV living in NYC with the inclusion of in-person and/or virtual psychosocial support groups. In addition, other project activities include linkage to HIV medical care; linkage to comprehensive sexual health care including STI and hepatitis C screening and care; iART (i.e., initiation of ART on the same-day or within 96 hours) for all eligible individuals[29] newly or previously diagnosed with HIV, case management, and in-person and/or virtual individual and group psychosocial support group sessions.

Table 5. Service Category 5: Black and/or H/L MSM with HIV, including cisgender, transgender, non-binary, and/or genderqueer Project Model

Inputs	Activities	Outputs
BE InTo Health Funding - Project Staff - Project Materials **DOHMH Technical Assistance** - Project/Contract Management Support - Implementation Support - Protocols Guidance - Reporting Guidance - Curriculum Guidance - Required Trainings - Continuous Quality Improvement - Project Monitoring Support from TA Specialists	**Project Start-up** - Hire Staff - Complete DOHMH-identified trainings **Project Outreach and Recruitment** **Project Implementation** - Clients linked to HIV medical care - Clients provided iART - Clients provided annual STI and hepatitis C screening - Clients enrolled in project - Complete social network diagram/sociogram - Enroll selected Support Confidants - Conduct 90-minute orientation meeting with client and Support Confidant - Develop care and support plans	**Project Indicators** - Number of clients linked to HIV medical care - Number of clients receiving iART - Number of clients screened for STIs and hepatitis C - Number of clients recruited - Number of clients enrolled - Number of social network diagrams/sociograms completed - Number of Support Confidants enrolled - Number of 90-minute orientation meetings held - Number of care and support plans made - Number of follow-up calls completed - Number of case management sessions - Number and type of referrals made - Number and type of referrals completed - Client-reported ART adherence - Number of individual psychosocial support sessions conducted

[37] Bouris, A., Voisin, D., Pilloton, M., Flatt, N., Eavou, R., Hampton, K., ... & Schneider, J. A. (2013). Project nGage: Network supported HIV care engagement for younger black men who have sex with men and transgender persons. *Journal of AIDS & clinical research*, *4*.

	- Monthly case management sessions to assess needs and make referrals for supportive services - Conduct phone calls to check-in on care and support plans - Individual psychosocial support sessions - Psychosocial support group sessions - Specific evaluation activities to measure achievement of project outcomes **Quality Management Activities** - Staff development and support - Ongoing monitoring, evaluation and TA participation	- Number of group psychosocial support sessions conducted - Number of attendees at group psychosocial support sessions **Project Outcomes** - Increase in % of clients newly diagnosed engaged in care - Increase in % of clients previously diagnosed engaged in care - Increase in % of clients re-engaged in care - Increase in % of clients retained in care - Increase in % of clients achieving VLS - Increase in % of clients adherent to HIV medication - Decrease in rates of stigma among clients (measured on a validated stigma scale) - Increase in rates of received social support - Integration of project into clinic

Project Objectives

The objectives of this project are as follows:

1. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM linked to medical care;
2. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM, newly and previously diagnosed, who are engaged in care (having two or more HIV medical care visits in a 12-month period);
3. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM re-engaged in care (having two or more HIV medical care visits after a lapse of at least nine [9] months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period);
4. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM who are retained in care (two HIV medical care visits at least three [3] months apart in a 12-month period)
5. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM who are virally suppressed (<200 copies/ml viral load in a 12-month period);
6. Increase percentage of enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM who are adherent to their HIV medication;
7. Decrease in rates of stigma among enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM (measured on a validated stigma scale);
8. Increase in rates of received social support among enrolled Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM;
9. Increase capacity of clinic to improve HIV care continuum outcomes among Black and/or H/L cisgender, transgender, non-binary and/or genderqueer MSM with HIV.

C. DOHMH Technical Assistance (TA)

DOHMH's BHIV's Clinical Operations and Technical Assistance (COTA) program will provide regular TA to awarded contractors. TA includes ongoing project and contract management and support, and the provision of quality improvement project assistance. COTA will provide tailored TA to awarded contractors that may include mentoring, consultation, practical demonstration, skills building, information sharing, capacity building, and resource development. Upon award, COTA will convene weekly conference calls

with awarded contractors. As the project matures, these calls will transition to a monthly basis. In addition, COTA will conduct quarterly site visits to awarded contractors. COTA will also offer support to each awarded contractor to develop their staff training plan. COTA will provide oversight to ensure all awarded contractors are meeting contract deliverables on-time and spending down awarded funds appropriately and timely. COTA will also provide on-going monitoring of all required reporting from awarded contractors to ensure comprehensive evaluations of the projects can be conducted.

COVID-19 Statement: *Due to the ongoing COVID 19 pandemic, to ensure safety of all program staff and enrolled clients, proposals can include the use of tele-health or other virtual activities in place of in-person activities. Proposers that include virtual activities must include sufficient detail on the platforms, equipment, and technologies to be used to implement tele-health or virtual activities.*

Section 2 – Project Expectations and Proposal Instructions

DOHMH intends to fund five (5) clinical agencies providing HIV primary care. *One application per proposer can be submitted per service category, for a maximum of two service categories per proposer. Only one (1) service category will be awarded per proposer. (e.g. an organization may want to apply for two services categories. The agency can apply for up to two service categories; however, they will only be awarded for one service category and will receive only one award.*

Proposers that operate more than one static clinic may only operate the proposed program out of one of their sites – not multiple clinics.

A. Service Category Experience (25 points)

1. Project Expectations:

The Contractor should:

- **i.** Currently serve a HIV caseload that is comprised of a high proportion of PWH from the priority population of the service category they are applying for. Has experience meeting the needs of clients from the priority population of the service category they are applying for. *Priority will be given to the five proposers per service category who currently serve the highest HIV client caseload that is comprised of PWH from the priority population of the service category they are applying for compared to other proposals.*
- **ii.** Currently serve PWH who face systemic barriers and challenges to achieve VLS. Has experience providing services to intervene on systemic barriers and challenges to improve VLS. *The five proposers with the lowest proportions of clients with achieved VLS (i.e., <200 copies/ml) compared to other proposals will be given priority.*
- **iii.** Currently serve a HIV caseload that is comprised of PWH who reside in NYC zip codes with the highest levels of food insecurity and poverty and lowest levels of education. *Priority will be given to the five proposers per service category that currently serve a higher number of PWH from NYC zip codes with the highest levels of food insecurity and poverty and the lowest levels of education, compared to other proposals.* These zip codes are listed in Table 6 below.
- **iv.** Currently serve PWH clients who face challenges in paying for services and are ineligible for public health insurance (i.e., Medicaid). *The five proposers per service category with higher levels of uncompensated care (i.e., health care or services provided by hospitals or health care providers that do not get reimbursed) at the static clinic location where services will be provided, compared to other proposals will be given priority.*
- **v.** Currently experiencing low provider to client ratios. *The five proposers per service category with lower provider to client ratios compared to other proposals will be given priority.*

Table 6. NYC Zip Codes and Neighborhood with the Highest Levels of Food Insecurity and Poverty and Lowest Levels of Education

Zip Code	Neighborhood	Borough
10002	Lower East Side	Manhattan
10029	East Harlem	Manhattan
10032	Inwood and Washington Heights	Manhattan
10034	Inwood and Washington Heights	Manhattan
10035	East Harlem	Manhattan
10039	Central Harlem	Manhattan
10451	High Bridge and Morrisania	Bronx
10452	High Bridge and Morrisania	Bronx
10453	Central Bronx	Bronx
10454	Hunts Point and Mott Haven	Bronx
10455	Hunts Point and Mott Haven	Bronx
10456	Hunts Point and Mott Haven	Bronx
10457	Central Bronx	Bronx
10458	Bronx Park and Fordham	Bronx
10459	Hunts Point and Mott Haven	Bronx
10460	Central Bronx	Bronx
10467	Bronx Park and Fordham	Bronx
10468	Bronx Park and Fordham	Bronx
10472	Southeast Bronx	Bronx
10474	Hunts Point and Mott Haven	Bronx
11206	Bushwick and Williamsburg	Brooklyn
11207	East New York and New Lots	Brooklyn
11212	Central Brooklyn	Brooklyn
11213	Central Brooklyn	Brooklyn
11219	Borough Park	Brooklyn
11220	Sunset Park	Brooklyn
11221	Bushwick and Williamsburg	Brooklyn
11224	Southern Brooklyn	Brooklyn
11233	Central Brooklyn	Brooklyn
11237	Bushwick and Williamsburg	Brooklyn
11368	West Queens	Queens
11691	Rockaways	Queens

2. Proposal Instructions:

- **i.** Complete the relevant section of the Structured Proposal Form Structured Proposal Form (See Attachment D).
- **ii.** Complete the Clinic Demographics Table (See Attachment C).
- **iii.** Attach proof of one (1) of the following accreditations/designations (See Attachment I):
    1. Article 28 Clinic
    2. AIDS Clinical Trials Unit
    3. Federal Qualified Health Center (FQHC)
    4. FQHC-Look Alike
    5. New York State Patient-Centered Medical Homes
    6. Joint Commission Accreditation
    7. Designated AIDS Center

3. **Evaluation:**

   i. The *Service Category Experience* section is worth 25 points. Five (5) of the 25 points available in this section will be assigned to proposers that meet priority preferences indicated above: currently serve the highest HIV client caseload that is comprised of PWH from the priority population of the service category; have the lowest proportions of clients with achieved VLS; currently serve a higher number of PWH from NYC zip codes with the highest levels of food insecurity and poverty and the lowest levels of education; have higher levels of uncompensated care (total amount billed and not reimbursed for patients without private insurance); and have lower provider to client ratios. This section will be evaluated based on the extent to which the proposer demonstrates relevant experience based on the criteria listed in this section.

B. Project Design and Requirements (30 points)

1. **Project Expectations:**

   The Contractor should:

   i. Deliver all services in alignment with the Culturally and Linguistically Appropriate Services standards, considering low health literacy and ensuring services and materials are available in Spanish (required) and other languages as needed;
   ii. Submit quarterly outreach and client recruitment plans and reports for the purposes of monitoring and provision of technical assistance, as needed;
   iii. Ensure that the proposed activities will meet the objectives of the chosen Service Category;
   iv. Provide linkage to HIV medical care (attending a HIV medical visit including CD4/VL testing within 30 days of HIV diagnosis) and iART for eligible individuals newly and previously diagnosed with HIV;
   v. Provide comprehensive sexual health care, including STI and hepatitis C screening and care for PWH clients, in alignment with clinical best practices.
   vi. In addition, specific requirements for each Service Category are outlined in Table 7:

Table 7. Specific Requirements for each Service Category

Service Category	Specific Requirements
Service Category 1: Black and/or Hispanic/Latina Women with HIV, including Black and/or Hispanic/Latina cisgender, transgender, non-binary and/or genderqueer women	In Service Category 1, the Contractor will: 1. Enroll at least 50 clients who identify as Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women (ages 18 and older) and are: a. newly diagnosed with HIV, or b. previously diagnosed with HIV and determined to be out of care (i.e., lapse of at least nine months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period), or c. previously diagnosed with HIV and not virally suppressed, or d. diagnosed with HIV and identified by project staff as experiencing psychosocial barriers or challenges (e.g.

	food insecurity, housing difficulty, substance use, mental illness, intimate partner violence, etc.). 2. Use principles of motivational interviewing and trauma informed care to assess clients' barriers to care and develop individualized care plans with the clients. 3. Conduct weekly/biweekly individual structured sessions on health education topics. 4. Conduct weekly/biweekly check-ins to provide enhanced client navigation, including appointment scheduling, transportation assistance, accompaniment to referral and support services, assistance completing paperwork, health education, and coaching. 5. Develop and submit the evidence informed, group health education curriculum for review and approval by DOHMH. Review and approvals will be conducted by NYC DOHMH COTA team. 6. Conduct at least monthly group health education sessions with clients covering HIV basics, communicating with providers, reviewing lab results, stigma and disclosure, HIV and substance use, and mental health. 7. Review/update individualized care plans every three months. 8. Assess completion of individualized care plans with clients at least every six months. 9. Detail a plan to transition clients who meet the goals of their care plan to standard of care client navigation. 10. Hold at least monthly multidisciplinary case conferencing among project staff to ensure client's needs are met.
Service Category 2: Black and/or Hispanic/Latina Transgender Women with HIV, and those who identify as non-binary or genderqueer	In Service Category 2, the contractor will: 1. Enroll at least 30 clients who identify as Black and/or H/L transgender women and those who identify as non-binary or genderqueer (ages 18 and older) and are: a. newly diagnosed with HIV, or b. previously diagnosed with HIV and determined to be out of care (i.e., lapse of at least nine months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period), or c. previously diagnosed with HIV and not virally suppressed, or d. diagnosed with HIV and identified by project staff as experiencing psychosocial barriers or challenges (e.g. food insecurity, housing difficulty, substance use, mental illness, intimate partner violence, etc.). 2. Include location of outreach and recruitment activities in quarterly recruitment reporting, to ensure outreach is conducted in non-traditional venues, such as nightclubs.

	3. Develop and submit peer-led health education curriculum for review and approval by DOHMH annually. 4. At least monthly, conduct peer-led health education sessions on the topics of HIV/AIDS and STIs, sexual health, transitioning, wellness, and mental health, and assess change in clients' knowledge as a result of participation in the peer-led health education sessions. 5. Train peer-leaders to facilitate group health education sessions. 6. Use principles of motivational interviewing and trauma informed care to conduct monthly needs assessments with all enrolled clients and provide referrals to supportive services (e.g. gender affirming hormone therapy and surgeries, substance use, domestic violence, housing, mental health, etc.). 7. Partner with a non-profit legal organization (or connect to legal services available onsite) and develop a protocol to connect clients to legal support services. **Proposers applying for this Service Category must submit at least one (1) letter of support from a non-profit legal organization or narrative describing the agency's experience connecting clients to legal support services. The letter of support and the narrative should detail provision of legal support services to clients who identify as transgender women and those who identify as non-binary or genderqueer.**
Service Category 3: Black and/or H/L YPWH (ages 13-29)	In Service Category 3, the Contractor will: 1. Enroll at least 75 clients who identify as Black and/or H/L (ages 13-29) and are: a. newly diagnosed with HIV; or b. previously diagnosed with HIV and are determined out of care (i.e., lapse of at least nine months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period); or c. previously diagnosed with HIV and are not virally suppressed, or d. diagnosed with HIV and are having trouble remaining adherent to their treatment plan. 2. Complete a safety screening (i.e., an assessment to ensure that candidate understands and can evaluate his personal safety if someone finds messages on their phone or surveys on the computer) and a consent form for clients' participation. 3. Implement a two-way text messaging system to collect condition-specific data from enrolled clients. a. Upon award, the contractor will work with DOHMH to select a two-way messaging system and enter into a Business Associate Agreement with the chosen system.

	b. Upon award, the contractor will develop and implement a Medical Case Management Text Messaging Policy to ensure privacy protection. c. The two-way text messaging system must: i. automate text messages and provide real-time alerts to the Client Navigator team, in addition to live messaging capabilities; ii. provides daily medication reminders, weekly mood check-ins, appointment reminders, and monthly social service needs assessment, and iii. alert Client Navigators of missed medication doses, worsening mood, missed medical appointments and concerns about housing/ bills, and the Client Navigators must follow-up with client to provide support and close alert. In addition, the Client Navigators must send a minimum of one text message per month to check on the client. 4. Use principles of motivational interviewing and trauma informed care to conduct monthly individual psychosocial sessions between social worker and enrolled YPWH. 5. Create annual psychosocial support group curriculum that is tailored to YPWH. 6. Submit support group curriculum to DOHMH. 7. Conduct monthly psychosocial support groups. 8. Facilitate at least monthly case conferences, to review the individualized care plans of participating clients. Preference will be given to proposals that include multidisciplinary care conferences, as reflected in the workplan and proposed project.
Service Category 4: Black and/or H/L OPWH (ages 50+)	In Service Category 4, the Contractor will: 1. Enroll at least 75 clients who identify as Black and/or H/L (ages 50 and older) and are: a. newly diagnosed with HIV, or b. previously diagnosed with HIV and determined to be out of care (i.e., lapse of at least nine months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period), or c. previously diagnosed with HIV and not virally suppressed, or ~~c.~~d. previously diagnosed with HIV. 2. Use principles of motivational interviewing and trauma informed care to implement biannual screenings for cognition impairment, depression, activities of daily life, falls, and medication review (i.e., MOCA, PHQ-9, ADLs, Falls).

	3. Assess screening results and create individualized care plans to meet clients' needs. 4. Provide monthly case management to clients, including appointment reminder calls, transport support, coordinating referrals based on enhanced care plans. 5. Facilitate at least monthly case conferences, to review the individualized care plans of participating clients. Preference will be given to proposals that include multidisciplinary care conferences, as reflected in the workplan and proposed project. 6. Create, maintain, and promote a referral network to address OPWH-specific needs. 7. Conduct physical and social activities based on interests of clients at least monthly (e.g., yoga, fitness sessions, Zumba, art classes, movie showings). Physical and social activities are intended to be provided for clients by the contracted agency. Referrals are not adequate.
Service Category 5: Black and/or Hispanic/Latino Men who have Sex with Men with HIV, including Black and/or Hispanic/Latino cisgender, transgender, non-binary, and/or genderqueer MSM	In Service Category 5, the Contractor will: 1. Enroll at least 75 clients who identify as Black and/or H/L cisgender, transgender, non-binary and/or genderqueer men (ages 18 and older), who report having sex with men, and are: a. newly diagnosed with HIV, or b. previously diagnosed with HIV and determined to be out of care (i.e., lapse of at least nine months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period), or c. previously diagnosed with HIV and not virally suppressed. 2. Use principles of motivational interviewing and trauma informed care to conduct intake meetings with all clients to introduce them to the project; and monthly needs assessments, including mental health, housing, food security, and employment, make referrals to meet clients' needs. 3. Map each participating client's social network (i.e., make a social network diagram) to assess the optimal network member for participation in the project as a Support Confidant (SC). 4. Conduct a 90-min joint session with client and SC to create an individualized care and support plan. a. This client-centered, 90-minute session consists of individual and joint components between the client and the SC who is identified by the client. In the first 20 minutes of the session, the social worker discusses the importance of HIV care and social support with the SC and client. The next component consists of a 40-minute one-on-one discussion between the social worker and the SC focused on identifying the client's challenges to

	retention in care and ART adherence and finding appropriate solutions. For the final 20 minutes of the session, the social worker and SC will meet with the client to create a tailored "care and support plan." 5. Following the completion of the 90-minute session, the social worker delivers four (4) telephone boosters to the client on a monthly basis. The booster sessions focus on the implementation of the care and support plan as well as the emotional quality of the SC and index relationship. 6. Coordinate and facilitate at least monthly support groups for clients and their SC. 7. Monthly individual psychosocial sessions with a social worker for enrolled clients. 8. Monthly group psychosocial sessions led by social worker.

vii. Participate in at least monthly TA and quality improvement activities to enhance capacity of staff.

2. Proposal Instructions:

i. Complete the relevant section of the Structured Proposal Form – Attachment D.

ii. Complete the Workplan Template (See Attachment A), detailing the first 12-months of the project.

3. Evaluation:

i. The *Project Design and Requirements* section is worth 30 points. This section will be evaluated based on the clarity, comprehensiveness and relevance of the proposed approach to meet the unique needs of the priority population described in the chosen Service Category and the extent to which the proposer demonstrates successful relevant experience based on the criteria listed in this section.

C. Organizational Structure and Staffing Plan (20 points)

1. Project Expectations:

Organizational Structure

The Contractor should:

i. Demonstrate the organizational, programmatic, managerial and financial capability to perform the services described in this RFP.

ii. Demonstrate that the proposed program aligns with the organization's history, mission and services.

iii. Outline a plan to assume operation of the proposed program within three (3) months, incorporating this program seamlessly into the organization's existing programs and services.

Staffing Plan

The Contractor should:

i. Develop and implement a staffing plan to ensure oversight of all required services in the program's model, as well as perform necessary data management and fiscal and program reporting functions. The staffing plan will include a description of how the proposer will address vacancies with a comprehensive contingency plan and active recruitment.

ii. Implement recruitment and retention plans to prioritize staffing that is representative of the priority population being to be served.

iii. Ensure staff members follow culturally and linguistically appropriate standards to serve their clients and have relevant knowledge and skills. Contractors should have the capacity to provide services in the languages preferred by the clients they serve.

iv. Ensure the NYC LGBTQ Health Care Bill of Rights is upheld by all project staff, including clinical and nonclinical partners.

v. Service Categories 1, 2, 3, and 5 must include at least one clinical staff member (e.g., medical doctor, nurse, etc.) at a minimum of 10 percent level of effort on the proposed budget to ensure clinical collaboration and guidance for all staff providing direct client services. Service Category 4 must include at least one clinical staff member at 100 percent level of effort to ensure clinical supervision and participation in direct client services. Recommended staffing for each Service Category is outlined in Table 8.

Table 8. Recommended Staffing Plans for each Service Category

Service Category 1: Black and/or Hispanic/Latina Women with HIV, including Black and/or Hispanic/Latina cisgender, transgender, non-binary and/or genderqueer women		
Staff Position (number recommended)	**Recommended Credentials**	**Level of Effort**
Project Manager (1): leads oversight of workplan; conducts financial planning and reporting; completes reporting to DOHMH and HRSA; provides supervision of Client Navigators; generates list of out of care clients; develops recruitment strategy; develops educational curriculum; liaises with HIV clinical team leadership; supports staff capacity building and training	Master of Public Health (MPH), Master Social Worker (MSW), or equivalent with at least two years of patient navigation experience; or Bachelor of Arts (BA)/Bachelors of Science (BS) with at least five years of experience of patient navigation experience, and at least two years of experience managing services for LGBTQIA+ people with HIV	100%
Clinical Supervisor (1): collaborates with Project Manager and Client Navigators; provides oversight of client care plans; participates in multidisciplinary case conferencing	Medical Degree and/or Master of Science in Nursing (MSN) degree or equivalent; at least 2 years of experience caring for LGBTQIA+ people with HIV	10%
Client Navigators (2): implement recruitment strategy; conduct outreach; enroll clients; conduct regular communication with clients; lead group educational sessions; provide referral and linkage support to clients	High school degree or equivalent, demonstrated experience or certification as a health educator, demonstrated experience providing	100% each

	HIV health education, and/or peer with relevant lived experience	
Service Category 2: Black and/or Hispanic/Latina Transgender Women with HIV, and those who identify as non-binary or genderqueer		
Staff Position (number recommended)	**Recommended Credentials**	**Level of Effort**
Project Manager (1): leads oversight of workplan; conducts financial planning and reporting; completes reporting to DOHMH and HRSA; provides supervision of Client Navigators; generates list of out of care clients; develops recruitment strategy; develops educational curriculum; supports staff capacity building and training; liaises with HIV clinical team leadership; prepares letters for work authorization and courts; coordinates legal support with appropriate agencies	MPH, MSW, or equivalent, with at least two years of patient navigation experience or BA/BS with at least five years of experience of patient navigation experience, and at least two years of experience managing services for LGBTQIA+ people with HIV	100%
Clinical Supervisor (1): collaborates with Project Manager and Client Navigator; provides oversight of client care plans; participates in multidisciplinary case conferencing	Medical Degree and/or MSN degree or equivalent; at least two years of experience caring for LGBTQIA+ people with HIV	10%
Client Navigator (2): implements recruitment strategy; conducts outreach; enrolls clients; conducts regular communication with clients; provides referral and linkage support to clients; assists with gaining access to insurance and social services (e.g., housing, food, employment, etc.); develops service plans for each participant	BA/BS or equivalent; at least 2 years of patient navigation experience for LGBTQIA+ people with HIV, and/or peer with relevant lived experience	100% each
Peer Education Leader (1): facilitates group educational sessions; provides coaching sessions to peer leaders; organizes events to enhance retention; develops marketing for weekly sessions; updates social media for project workshops and events	Peer with relevant lived experience and high-school diploma or equivalent; or two years of experience facilitating adult educational groups, and experience providing services to LGBTQIA+ people with HIV	100%
Service Category 3: Black and/or H/L YPWH		
Staff Position (number recommended)	**Recommended Credentials**	**Level of Effort**
Project Manager (1): leads oversight of workplan; conducts financial planning and reporting; completes reporting to DOHMH	MPH, MSW, or equivalent, with at least two years of patient navigation experience or BA/BS with at least	100%

and HRSA; provides supervision of Navigators; generates list of out of care clients; develops recruitment strategy; liaises with HIV clinical team leadership; supports staff capacity building and training; secures and manages vendor of two-way messaging system.	five years of experience of patient navigation experience, AND at least two years of experience managing services for LGBTQIA+ people with HIV	
Clinical Supervisor (1): collaborates with Project Manager and Client Navigator; provides oversight of client care plans; participates in multidisciplinary case conferencing	Medical Degree and/or MSN degree or equivalent; at least two years of experience caring for LGBTQIA+ people with HIV	10%
Client Navigators (2): implement recruitment strategy; conducts outreach; enrolls and consents clients; monitors text-way messaging system alerts; sends messages to enrolled clients and responds messages from clients; provides referral and linkage support to clients	BA/BS or equivalent; with at least 2 years of patient navigation experience; and/or peer with relevant lived experience	100% each
Social Worker (1): assist with promotional and recruitment efforts; support reporting to DOHMH; conducts individual counseling; develop curriculum for group sessions, promotes group sessions, and facilitates groups sessions.	Licensed Master Social Worker (LMSW) or equivalent; experience working with YPWH	100%
Service Category 4: Black and/or H/L OPWH		
Staff Position (number recommended)	**Recommended Credentials**	**Level of Effort**
Project Manager (1): leads oversight of workplan; conducts financial planning and reporting; completes reporting to DOHMH and HRSA; provides supervision of Client Navigators; generates list of out of care clients; develops recruitment strategy; liaises with HIV clinical team leadership; supports staff capacity building and training; cultivates and maintains robust referral network for clinical and non-clinical services; coordinates and promotes social and physical activities/events	MPH, MSW, or equivalent, with at least two years of patient navigation experience or BA/BS with at least five years of experience of patient navigation experience, AND at least two years of experience managing services for LGBTQIA+ people with HIV	100%
Clinical Supervisor (1): conducts screening; convenes multidisciplinary case conferences to generate care plan based on screening; creates care plan with assistance from Client	MSN or equivalent; experience with care coordination and coordination of supportive services	100%

Navigators; assists with physical and social activities for clients		
Client Navigators (2): implements recruitment strategy; conducts outreach; conducts regular communication with clients; provides referral and linkage support to clients; assists with coordination of social and physical activities/events	BA/BS or equivalent; with at least two years of care coordination experience	100% each
Service Category 5: Black and/or Hispanic/Latino Men who have Sex with Men with HIV, including Black and/or Hispanic/Latino cisgender, transgender, non-binary, and/or genderqueer MSM		
Staff Position (number recommended)	**Recommended Credentials**	**Level of Effort**
Project Manager (1): leads oversight of workplan; conducts financial planning and reporting; completes reporting to DOHMH and HRSA; provides supervision of Client Navigator; generates list of out of care clients; develops recruitment strategy; liaises with HIV clinical team leadership; supports staff capacity building and training; cultivates and maintains robust referral network for clinical and non-clinical services	MPH, MSW, or equivalent, with at least two years of patient navigation experience or BA/BS with at least five years of experience of patient navigation experience, AND at least two years of experience managing services for LGBTQIA+ people with HIV	100%
Clinical Supervisor (1): collaborates with Project Manager and Client Navigator; provides oversight of client care plans; participates in routine case conferencing	Medical Degree and/or MSN degree or equivalent; at least two years of experience caring for LGBTQIA+ people with HIV	10%
Social Worker (1): assist with promotional and recruitment efforts; support reporting to DOHMH; lead initial contact with client and support confidants; lead scheduling and facilitation of appointments with clients and support confidants; lead creation of care and support plans; lead communication and follow-up with clients and support confidants; conducts individual and group psychosocial sessions	LMSW or equivalent; experience working with Black and/or H/L MSM	100%
Client Navigator (2): implements recruitment strategy; conducts outreach; conducts regular communication with clients and support confidantes; provides referral and linkage support to clients	BA/BS or equivalent; with at least two years of care coordination experience	100%

iv. Develop an annual training and support plan for all staff. BHIV Clinical Operations and Technical Assistance Program (COTA) will provide training and technical

assistance to contracted agencies to build the capacity of project staff to successfully implement a service category intervention. Staff funded through this RFP will be required to participate in all DOHMH calls and meetings, activities related to the transfer of knowledge and skills, DOHMH-sponsored trainings offered by DOHMH's Training and Technical Assistance Program (TTAP), and routine project monitoring and quality improvement activities. Waiver of any training requirements will be based on documented prior training or expertise, as determined by DOHMH.

2. Proposal Instructions:

i. Complete the relevant section of the Structured Proposal Form – Attachment D.

ii. Complete Staffing Plan Table (Attachment B).

iii. Proposers are instructed to attach the following:

1. Organization Chart that demonstrates where the proposed project will fit into the proposer's organization.

3. Evaluation:

i. The *Organizational Structure and Staffing Plan* section is worth 20 points. This section will be evaluated based on the proposed staffing plan and staff qualifications/experience based on the criteria listed in this section.

D. <u>Project Monitoring and Evaluation, Data Management, and Reporting (20 points)</u>

1. Project Expectations:

The Contractor would be responsible for adhering to requirements subject to federal, city, and state funders.

The Contractor should:

i. Comply with all applicable confidentiality and privacy laws, including federal, New York State and New York City laws in order to protect client privacy.

1. Contractors should have a detailed plan to ensure client privacy and confidentiality (including data quality and security) that is compliant with New York State public health law as well as the federal Health Insurance Portability and Accountability Act (HIPAA). The plan must specify data quality and security protections. All organizations providing HIV-related care are subject to New York State public health law (http://codes.lp.findlaw.com/nycode/PBH/27-F). All organizations providing clinical care are also subject to HIPAA (http://www.hhs.gov/ocr/privacy/).

ii. Implement protocols to collect, analyze, and report out all client-level and project data, ensure quality assurance, interpret reports, and perform project evaluations and continuous quality improvement.

1. Comply with all DOHMH and HRSA data reporting requirements.
2. Collect project monitoring data to measure all project indicators and outcomes (See project specific logic models in Tables 1 – Table 5). Final outcomes will be finalized by DOHMH after contract execution.
3. DOHMH will require the submission of data through a web-based data system, Electronic System for HIV/AIDS Reporting and Evaluation

(eSHARE). DOHMH and/or PHS will provide training and technical assistance on the use of eSHARE and submission of reports. Funded organizations will also be required to submit data to HRSA each year.

4. Complete an annual narrative report describing successes and challenges of project implementation, including integration of project services into existing clinic workflows and impact of training on staff capacity.

2. Proposal Instructions:

i. Complete the relevant section of the Structured Proposal Form – Attachment D.

ii. Include monitoring and evaluation activities in the submitted Workplan – Attachment A.

3. Evaluation:

i. The Project Monitoring and Evaluation, Data Management, and Reporting section is worth 20 points. This section will be evaluated based on the quality of the proposer's approach to budget management based on the criteria listed in this section.

E. Budget Management (5 points)

The anticipated maximum annual available funding is $1,625,000 for all contracts. DOHMH anticipates making up to five (5) awards. Additional awards may be made in the future, dependent upon additional funding. Maximum anticipated funding is listed in the Basic Information section of this RFP. Contractors will only be reimbursed for actual services provided up to the anticipated maximum available funding per service category.

Services provided under this RFP will use a hybrid reimbursement model that combines a milestone-based payment mechanism during the first six (6) months of the program and a cost-based reimbursement mechanism for the remainder of the contract.

In year one, 50% of the awarded amount will be paid at a fixed rate upon the completion of the following milestones in months 1-6: 10% when all staff are hired, 20% when the program workplan is approved by DOHMH, 2% for each of five (5) monthly TA meetings attended, and 1% for each of ten (10) DOHMH sponsored trainings completed by project staff. The expectation is that the program is fully up and running and delivering client services by month three (3). In months 7-12 of the first year, 50% of the program operating costs will be reimbursed upon submission of vouchers showing actual program costs. Additionally, 8.3% (1/12 of the approved budget) will be available as an advance upon contract execution (year one [1] only) to facilitate rapid program start-up. These funds will be recouped over the remainder of the year.

In years two and three, all the program operating costs will be reimbursed upon submission of vouchers showing actual program costs.

Budget Breakdowns for each Service Category are in Tables 9-13 below.

Table 9. Budget breakdown for Service Category 1: Black and/or H/L Women with HIV, including Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women

Project Year		Reimbursement Method

	Annual Award	Milestone-based	Cost-based
Year One	**$300,000**	All staff hired = $30,000	Monthly reimbursement based on actual costs reported against approved monthly budget
		DOHMH-approved workplan = $60,000	
		TA Meetings = $30,000 ($6,000 each)	
		DOHMH-sponsored trainings = $30,000 ($3,000 each)	
		$150,000 (months 1-6)	**$150,000 (months 7-12)**
Year Two	**$300,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$300,000
Year Three	**$300,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$300,000

Table 10. Budget breakdown for Service Category 2: Black and/or H/L Transgender Women with HIV, and those who identify as non-binary or genderqueer

Project Year	Annual Award	Reimbursement Method	
		Milestone-based	**Cost-based**
Year One	**$325,000**	All staff hired = $32,500	Monthly reimbursement based on actual costs reported against approved monthly budget
		DOHMH-approved workplan = $65,000	
		TA Meetings = $32,500 ($6,500 each)	
		DOHMH-sponsored trainings = $32,500 ($3,250 each)	
		$162,500 (months 1-6)	**$162,500 (months 7-12)**
Year Two	**$325,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$325,000
Year Three	**$325,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$325,000

Table 11. Budget breakdown for Service Category 3: Black and/or H/L YPWH

Project Year	Annual Award	Reimbursement Method	
		Milestone-based	**Cost-based**
Year One	**$325,000**	All staff hired = $32,500	Monthly reimbursement based on actual costs reported against approved monthly budget
		DOHMH-approved workplan = $65,000	
		TA Meetings = $32,500 ($6,500 each)	
		DOHMH-sponsored trainings = $32,500 ($3,250 each)	
		$162,500 (months 1-6)	**$162,500 (months 7-12)**
Year Two	**$325,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$325,000
Year Three	**$325,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$325,000

Table 12. Budget breakdown for Service Category 4: Black and/or H/L OPWH

Project Year	Annual Award	Reimbursement Method	
		Milestone-based	**Cost-based**
Year One	**$375,000**	All staff hired = $37,500	Monthly reimbursement based on actual costs reported against approved monthly budget
		DOHMH-approved workplan = $75,000	
		TA Meetings = $37,500 ($7,500 each)	
		DOHMH-sponsored trainings = $37,500 ($3,750 each)	
		$187,500 (months 1-6)	**$187,500 (months 7-12)**
Year Two	**$375,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$375,000
Year Three	**$375,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$375,000

Table 13. Budget breakdown for Service Category 5: Black and/or H/L Men who have Sex with Men with HIV, including Black and/or H/L cisgender, transgender, non-binary, and/or genderqueer MSM

Project Year	Annual Award	Reimbursement Method	
		Milestone-based	**Cost-based**
Year One	**$300,000**	All staff hired = $30,000	Monthly reimbursement based on actual costs reported against approved monthly budget
		DOHMH-approved workplan = $60,000	
		TA Meetings = $30,000 ($6,000 each)	
		DOHMH-sponsored trainings = $30,000 ($3,000 each)	
		$150,000 (months 1-6)	**$150,000 (months 7-12)**
Year Two	**$300,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$300,000
Year Three	**$300,000**		**Cost-based**
			Monthly reimbursement based on actual costs reported against approved monthly budget
			$300,000

1. **Project Expectations**
   The Contractor will:
   - i. **Develop and implement a budget that is consistent with the provision of services indicated in the chosen Service Category.** The project would operate a budget based on the anticipated available funding stated above and demonstrate the capacity to establish and manage appropriate operating budgets.
   - ii. **Develop** ~~an annual budget for the first year of operation~~12-month program budget (03/01/2021 – 02/28/2022)**.** The budget must include:
     1. Competitive salaries for staff identified in the chosen Service Category, that correspond to the individual's experience, and qualifications for provided family support services. Salaries or wages should comply with the New York City Living Wage laws.
     2. Project materials needed to complete the stated activities (e.g., laptops for staff, software licenses, etc.)
     3. A maximum rate of 10% applied to any indirect costs.
   - iii. **Adhere to all federal, state and local funding reporting requirements.**

2. **Proposal Instructions**
   - i. Complete the relevant section of the Structured Proposal Form – Attachment D.
   - ii. Submit a line-item budget for the first year of the project – Attachment F.

3. **Evaluation**

i. The *Budget Management* section is worth 5 points. This section will be evaluated based the quality of the proposer's approach to budget management based on the criteria listed in this section.

Section 3 – List of Attachments

All attachments for this RFP can be download from Public Health Solutions' website: **https://www.healthsolutions.org/get-funding/request-for-proposals/** . ~~An asterisk (*) indicates that there is no attachment template to download but is a required document that must be provided and submitted by the applicant.~~

Attachment A: Workplan Template

Attachment B: Staffing Plan Template

*Attachment C: Clinic Demographics Table (REVISED – see link to form in CAMS Contracting Portal)

Attachment D: Structured Proposal Form (REVISED)

Attachment E: Organizational Chart *(no template provided)*

Attachment F: Twelve (12) Month Line-item Budget

Attachment G & H: Two (2) Written Letters of Recommendation *(no template provided)*

Attachment I: Proof of Accreditation/Designation Instructions

Attachment J: Letter of Support from Non-profit Legal Organization *(Service Category 2 only, if no experience providing legal support) (no template provided)*

Attachment K: Board of Directors' Statement Template

**Attachment L: Current Board of Directors List *(no template provided)*

**Attachment M: Most Recent Audited Annual Financial Statement *(no template provided)*

Attachment N: Notice of Intent to Respond Form

Attachment O: Insurance Requirements

Attachment P: Sharing Documents to Public Health Solutions in the Document Vault

*- submit via link to form in CAMS Contracting Portal

** - can be shared with PHS from your organization's Document Vault in the NYC HHS Accelerator

Section 4 – Basis for Contract Award and Procedures

A. Proposal Evaluation

All proposals received by PHS, on behalf of DOHMH, will be reviewed to determine whether they are responsive or non-responsive to the requirements of this RFP. Proposals that are determined by PHS and DOHMH to be non-responsive will be rejected. The DOHMH evaluation committee will review and rate each responsive proposal. The proposals will be ranked in order of highest to lowest technical score. PHS and DOHMH reserves the right to conduct site visits and/or interviews and/or to request that proposers make presentations and/or demonstrations, as PHS and DOHMH deems applicable and appropriate. Although discussions may be conducted with proposers submitting acceptable proposals, PHS and DOHMH reserves the right to award contracts on the basis of initial proposals received, without discussions; therefore, the proposer's initial proposal should contain its best programmatic and price terms.

B. Contract Award

Contracts will be awarded to the responsible proposers whose proposal(s) is determined to be the most advantageous to the City, taking into consideration the price and such other factors which are set forth in this RFP. Awards will be made to the highest rated vendors whose proposals are technically viable. However:

- DOHMH reserves the right not to make awards in one or more service categories depending on availability of funding or need.
- DOHMH reserves the right to make more than one award per service category.
- DOHMH reserves the right, prior to contract award, to determine the length of the initial contract term and each option to renew, if any.
- DOHMH reserves the right, prior to contract execution and during the term of the contract, to change the reimbursement rate per client, program service size, program type, and/or model depending on the needs of the system.

Final award decisions will be made by DOHMH. At the discretion of the DOHMH, final awards may be less than requested in order to distribute funds among awardees and ensure adequate distribution of services throughout NYC.

Final award decisions may also consider past contract performance (if applicant has current contract(s) or had contracts within the last two years with PHS) or reference/background checks for applicants without any prior or recent contracting relationship with PHS.

Final contract execution is contingent upon successful completion of contract negotiations; vendor background check; and demonstration of all required insurance coverage and all other requirements of and approvals by DOHMH, PHS, the City of New York, the State of New York and the U.S. government, as applicable.

LOS ANGELES COUNTY COMMISSION ON HIV | GOLDEN COMPASS PROGRAM INQUIRY RESPONSES

1. What types of assessments and screenings are conducted?

   - depression screening
   - cognitive assessment
   - functional status assessment
   - falls and gait assessment
   - social support assessment
   - vision screening
   - dental screening
   - hearing screening

2. What specific CPT codes are used by the program? All of our medical visits (providers and nursing) use B20 (HIV). Behavioral health captures units of service in hours, but no CPT code.

3. What percentage of the program's funding is supported by Ryan White dollars? I have to defer to Meredith Greene to estimate this.

4. What is the cost of the program per patient? I have to defer to Meredith Greene to estimate this.

5. Finally, would you be willing or have time to join one of the Commission meetings (we have been holding them virtually) to talk about the Golden Compass project? The full body meets on the second Thursday of each month and we typically carve out presentations between 11am to 12noon. We are flexible with the date and time to accommodate your schedule. Meredith Greene is out of the office currently, but may have more to add upon her return, in addition to discussing her participation in a Commission meeting

CLINICAL CARE OPTIONS®
HIV

HIV and Aging: The Golden Compass Program

Supported by an educational grant from Gilead Sciences, Inc.;
Merck Sharp & Dohme Corp.; and ViiV Healthcare.

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Monica Gandhi, MD, MPH, has no relevant conflicts of interest to report.

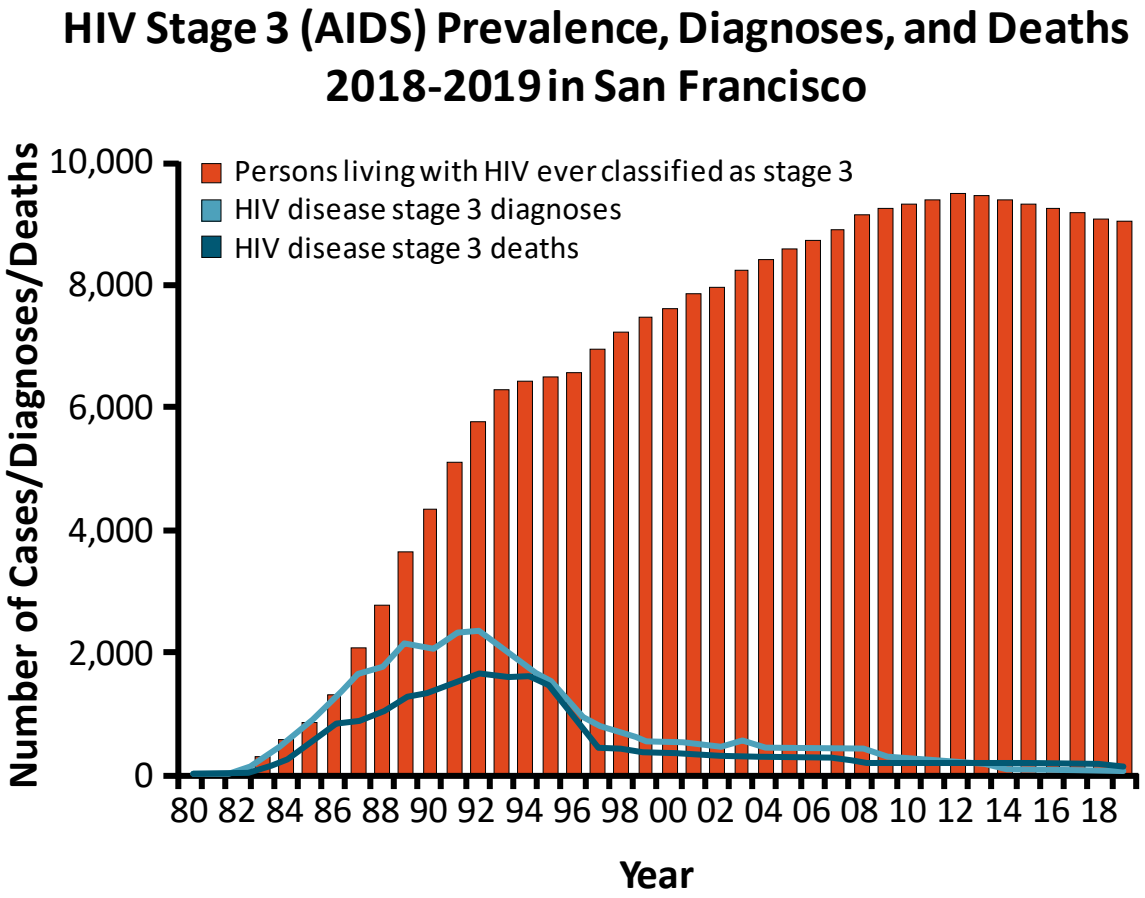
Patient Case: Background

- 72-yr-old man with HIV since 1988, on stable regimen of BIC/TAF/FTC with good adherence
- Comorbidities: mild CAD, HTN, and hyperlipidemia
- Social history: lives alone, and particularly lonely during COVID-19 pandemic

Parameters at Current Presentation	Value
CD4+ cell count, cells/mm^3	828
HIV-1 RNA, copies/mL	<40
HIV-1 genotype	M184V, K103N, in past
BMI	27
CBC	Normal
Metabolic panel	Normal
HBV and HCV status	Negative
HLA-B*5701	Negative
Comedications	A statin, ASA, Atenolol

Slide credit: clinicaloptions.com

Epidemiology of HIV in San Francisco



- Overall, HIV disease stage 3 diagnoses and deaths have declined with advent of highly effective ART
- Majority of persons newly diagnosed with HIV between 2010 and 2019 were MSM
- 30-39 years old age group accounts for highest proportion of new diagnoses

San Francisco Department of Public Health. 2020. https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2019_Indigo_20200929_Web_fixed.pdf.

Slide credit: clinicaloptions.com

Population Living With HIV is Aging

- In San Francisco in 2015, 59% of PWH in San Francisco ≥ 50 yrs of age
  - By 2019, percentage of PWH in this age group had increased to 69%
- Largest proportional shift in age group observed among 60-69 yr olds

Age, yrs n (%)	2015 (n = 16,017)	2019 (n = 15,908)
0-12	3 (< 1)	0 (0)
13-17	5 (< 1)	3 (< 1)
18-24	140 (1)	78 (< 1)
25-29	476 (3)	301 (2)
30-39	1868 (12)	1707 (11)
40-49	3951 (25)	2880 (18)
50-59	5826 (36)	5706 (36)
60-69	3068 (19)	3967 (25)
70+	680 (4)	1266 (8)

San Francisco Department of Public Health. 2020. https://www.sfdph.org/dph/files/reports/RptsHIVAIDS/AnnualReport2019_Indigo_20200929_Web_fixed.pdf.

Slide credit: clinicaloptions.com

Primary Care Guidance for PWH

- With continuous care engagement and uninterrupted access to ART, life expectancy for PWH approaches that of persons without HIV
- ~ 50% of the global population with HIV is now > 50 yrs of age[1]
  - Managing comorbidities an important aspect of HIV care
  - **~ 20% of newly-diagnosed PWH are > 50 yrs of age[2]**
- Stigma-free, culturally-appropriate, patient-centered treatment is essential to maximize care engagement and viral suppression
- Routine screening recommendations include mental health and metabolic assessments for common comorbidities in all aging persons:
  - Hypertension, hyperlipidemia, diabetes and glucose intolerance, decreased bone mineral density, substance use and depression

Thompson. Clin Infect Diseases. 2020;[Epub]. 2. https://www.cdc.gov/hiv/group/age/olderamericans/index.html.

Golden Compass: Birth of a Comprehensive Care Program for Older PWH

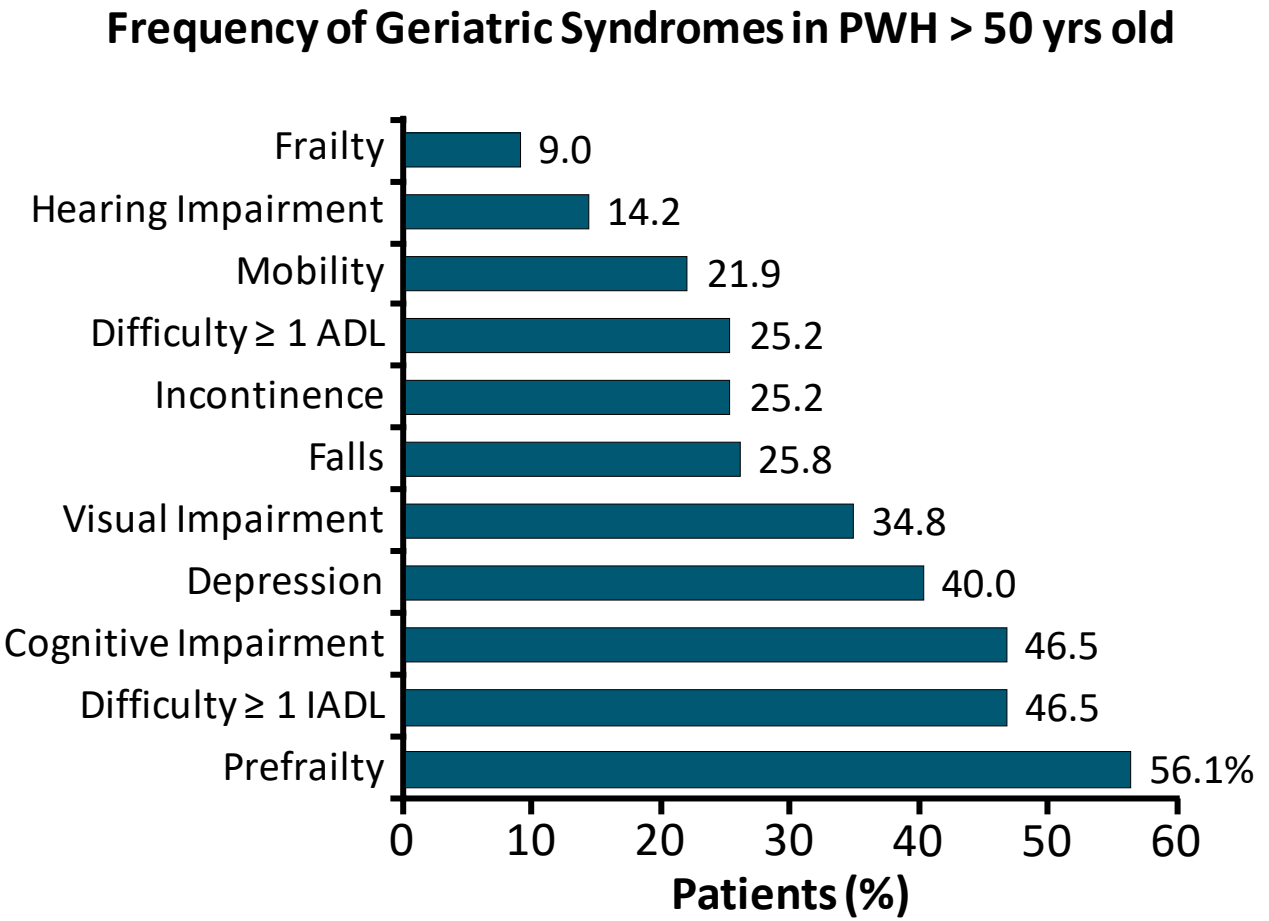
- Launched 2017 in San Francisco for PWH ≥ 50 yrs of age
- Developmental phases:
  - Community needs assessment
  - Literature review
  - Silver Project 2012-2014 (pilot program)
  - Patient and provider focus groups

Personal communication, Monica Gandhi. https://www.positivelyaware.com/articles/kicking-ass.

Slide credit: clinicaloptions.com

Characteristics of Older PWH in San Francisco

- Multivariate analysis of geriatric syndromes in 155 PWH in the SCOPE trial, aged ≥ 50 yrs old
  - Participants on ART with undetectable viral load for ≥ 3 yrs
  - 145 (94%) male; 98 (63.2%) white race
  - Median age: 57 yrs (IQR: 54-62); median time infected: 21 yrs (range 4-32)
  - Median CD4+ cell count: 537 (IQR: 398-752)

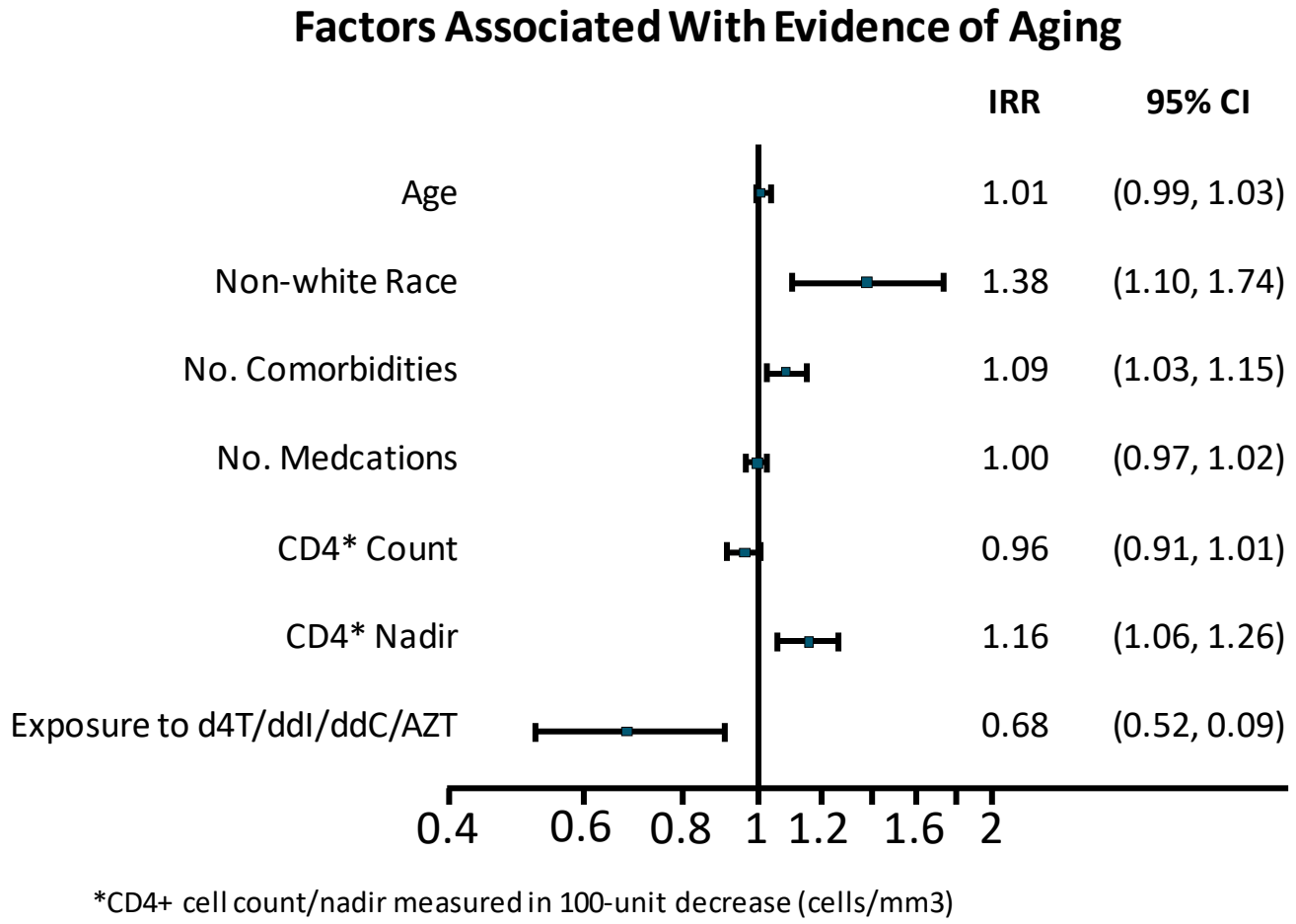


Greene. JAIDS. 2015;69:161.

Slide credit: clinicaloptions.com

Geriatric Syndromes in Older PWH in San Francisco

- Similar to other studies, authors noted evidence of clinical aging in PWH younger than the typical (≥ 65 yrs) geriatric population
- Lower CD4+ cell count nadir, greater number of comorbidities, and non-white race, associated with a greater number of geriatric syndromes



Greene. JAIDS. 2015;69:161.

Slide credit: clinicaloptions.com

Formation of Golden Compass: Focus Group Priorities

- Conducted surveys of key stakeholders, including patients and clinic staff from Ward 86
- Participants from pilot program, *Silver Project,* asked **which health assessments were most useful/important**

Ranked Most Important by Patients (n = 35)	Frequency n (%)	Ranked Most Useful by Providers (n = 10)	Frequency n (%)
Depression	22 (69)	Falls	9 (90)
Falls	17 (53)	Memory	8 (80)
HIV medication adherence	17 (53)	Depression	6 (60)
Social support	17 (53)	Functional status	6 (60)
Memory	16 (50)	Loneliness	5 (50)
Anxiety	13 (41)	HIV medication adherence	5 (50)
Functional status	13 (41)	Social support	5 (50)
Gait speed	10 (31)	Gait speed	4 (40)
Loneliness	9 (28)	Chair stands	3 (30)
Chair stands	9 (28)	Substance use	3 (30)
Substance use	7 (22)	Anxiety	2 (20)
PTSD	6 (19)	PTSD	1 (10)
Abuse	6 (19)	Abuse	0 (0)

Greene. PLoS One. 2018;13:e0208486.

Slide credit: clinicaloptions.com

Golden Compass Focus Groups: Emergent Themes

- **Knowledge of HIV and Aging Topics**
  - Providers need a deeper knowledge base to care for older PWH
  - Patients desire to understand more about HIV and aging issues
- **Social isolation and loneliness**
  - Need for regularly held social gatherings and events
  - Need for improved social support networks
- **Health-related needs of older PWH**
  - Neurocognitive screening
  - Falls and frailty assessments
  - Care navigation and case management
  - Access to ancillary services such as dental, vision, and hearing
  - Addressing impacts of mental illness and marginal housing

Greene. PLoS One. 2018;13:e0208486.

Slide credit: clinicaloptions.com

Golden Compass Program: Four Points of Care

Northern Point: Heart and Mind

HIV cardiologist on-site, brain health classes, cognitive evaluations and resources

Western Point: Dental, Hearing, Vision

Ensure age-appropriate screening; link to low-cost eyeglasses, hearing aids, and dental services

Eastern Point: Bones and Strength

Fall and balance evaluations, polypharmacy assessments, exercise classes, DEXA machine, provider/staff education by geriatrician

Southern Point: Network and Navigation

Partnerships with community agencies, social support groups, social work services, advanced care planning

Greene. J Int Assoc Provid AIDS Care. 2020;19:1.

Slide credit: clinicaloptions.com

Golden Compass Program: Implementation

Characteristic	Patients (N = 198)
Age in yr, mean (SD)	62 (7.6)
Race, n (%) ▪ White ▪ Black ▪ Asian ▪ American Indian/ Alaska Native ▪ Other	 78 (39) 43 (22) 14 (7) 10 (5) 33 (17)
Hispanic/Latino ethnicity, n (%)	31 (17)
Male sex, n (%)	178 (89)
CD4+ cell count, cells/mm^3, median (IQR)	514 (368-734)
Undetectable HIV-1 RNA (< 40 copies/mL), n (%)	171 (91)

- From Jan 2017 to June 2018, 198 adults ≥ 50 yrs of age participated
  - Estimated reach: 17% of older PWH in Ward 86
- **Friday Afternoon Geriatric HIV Clinic**
  - Medical assistant screenings: MoCA and mood symptoms, vision, hearing, and dental
  - Clinical pharmacist consult
  - Geriatrician consult

Greene. J Int Assoc Provid AIDS Care. 2020;19:1.

Slide credit: clinicaloptions.com

Golden Compass Program: Patient Feedback

Patient Data	% Reporting Satisfied/Very Satisfied or Agree/Strongly Agree
Satisfaction: Care overall	97/77
Satisfaction: Geriatrics clinic	100/75
Acceptability: Geriatrics clinic	93/75
Satisfaction: Cardiology clinic	100/88
Acceptability: Cardiology clinic	100/63
Satisfaction: Brain Health classes	93/80
Acceptability: Brain Health classes	100/88
Satisfaction: Wellness Club	100/76
Acceptability: Wellness Club	100/88

Greene. J Int Assoc Provid AIDS Care. 2020;19:1.

Slide credit: clinicaloptions.com

Go Online for More CCO Education on HIV and Aging!

Clinical Case Vlogs on individual patient cases, each highlighting challenges rendered by a select comorbidity or set of commodities in an older patient with HIV

ClinicalThought commentaries written by expert faculty on key issues relevant to optimal care of aging patients with HIV

Question and answer Webinars in which faculty answer your questions on caring for aging patients with HIV

clinicaloptions.com/hiv

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