LOS ANGELES COUNTY
COMMISSION ON HIV

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Aging Task Force
Virtual Meeting

Be a part of the HIV movement

Tuesday, March 1, 2022
1:00PM-3:00PM (PST)

Agenda and meeting materials will be posted on http://hiv.lacounty.gov/Meetings

TO JOIN BY COMPUTER:
https://tinyurl.com/2cxa6hfv

Meeting password: AGING

TO JOIN BY PHONE: +1-213-306-3065
Access Code/Event #: 2592 738 8902

For a brief tutorial on how to use WebEx, please check out this video: https://www.youtube.com/watch?v=iQSSJYcrgIk

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Apply to become a Commissioner at **http://tinyurl.com/HIVCommApplication**

For application assistance call (213) 738-2816.

LOS ANGELES COUNTY
COMMISSION ON HIV

AGING TASK FORCE (ATF)

VIRTUAL MEETING AGENDA

TUESDAY, March 1, 2022

1:00 PM – 3:00 PM

TO JOIN BY WEBEX:

https://tinyurl.com/2cxa6hfv

PASSWORD: AGING

TO JOIN BY PHONE: +1-213-306-3065 **MEETING #/ACCESS CODE:** 2592 738 8902

1. Welcome & Introductions 1:00pm-1:10pm

2. Executive Director/Staff Report 1:10pm-1:15pm
   a. Comprehensive HIV Plan 2022-2026 Updates
   b. Operational Updates
   c. Health 4 All Older Adults FAQs

3. Co-Chairs' Remarks and Report 1:15pm-1:20pm
   a. February 24, 2022 Executive Committee Report

4. Street Medicine and HIV | 1:20pm-1:50pm
   Conversation with the University of Southern California

5. Review proposed Changes to the 1:50pm-2:30pm
   Benefits Specialty Service Standards

6. Division of HIV and STD Programs (DHSP) Report 2:30pm-2:45pm
   a. Feedback on a presentation date for a discussion with DHSP leadership on what is realistic to implement in the proposed HIV and aging care framework

7. Public Comments & Announcements 2:45pm-2:55pm

8. Adjournment 3:00pm

LOS ANGELES COUNTY
COMMISSION ON HIV

AGING TASK FORCE (ATF)
February 1, 2022 Virtual Meeting Summary

In attendance:

Al Ballesteros (Co-Chair)	Jayda Arrington	Alasdair Burton
Kevin Donnelly	Bridget Gordon	Lee Kochems
Paul Nash	Katja Nelson	Octavio Vallejo
Brian Risley	Cheryl Barrit (COH Staff)	Catherine Lapointe (COH Staff)
Pamela Ogata (DHPS Staff)	Ilish Perez (DHSP Staff)	Jose Rangel-Garibay (COH Staff)
AJ King (CHP Consultant)		

CHP: Comprehensive HIV Plan
COH: Commission on HIV
DHSP: Division of HIV and STD Programs

1. **Welcome & Introductions**
   Al Ballesteros, Co-Chair, welcomed attendees and led introductions.

2. **Executive Director/Staff Report**
   a. **Comprehensive HIV Plan (CHP) 2022-2026**
      - AJ King, consultant for writing and managing the CHP, led a conversation with ATF participants on what they would like to see reflected in the CHP. He mentioned that the new National HIV/AIDS Strategy (NHAS) released by the White House on December 1, 2021 has a new focus on aging and a corresponding objective. He queried the group if there is interest in being consistent with the NHAS.
      - The group provided the following suggestions/ideas for the CHP:
      - It is important to put goals specific to HIV and aging in the plan. Many services are not targeted for people over 50 or those with physical limitations.
      - Geriatricians are not taught about sexual health and older adults, which impacts the delivery of comprehensive preventive and care services for those over 50 years.
      - Explore geriatrics and HIV as a workforce capacity issue.
      - Address unmet meets for PLWH and show differences/similarities by subpopulations
      - All groups are aging. Acknowledge accelerated and accentuated aging, social isolation and stigma.
      - Explore provider and consumer education. For example, educate consumers on what to anticipate as we get older; how to deal/work with practitioners; how to empower consumers to advocate for themselves.
      - Use the health disparities framework in addressing the needs of aging

community; there are disparities within the aging population. Improving health quality does not equate health equity.

- Create a sense of urgency to support the aging population in Los Angeles County. While PLWH over 50 years may have better viral suppression outcomes, they experience more mortality with late-stage cancer diagnosis and other co-morbidities. There is greater blurring of the lines between primary care and specialty care—how to do we provide services in this environment?
- Older adults also experience late diagnosis with HIV, prostate and anal cancer
- Include long-term survivors but acknowledge the differences between aging vs long-term survivors.
- There is room for improvement in the detect and prevention pillars for older adults. For example, there are no safe sex campaigns or messages focused on older adults.
- Include the 50+ PLWH as a one of the priority populations; LA is behind compared to other jurisdictions.

3. Co-Chairs' Remarks and Report

a. January 4, 2022 Meeting Summary Review & Approval --The ATF reviewed the January 4 meeting summary. No corrections were made.

b. Revised 2022 Workplan – The ATF reviewed the updated 2022 Workplan. No corrections were made.

4. Preparation for March 24 Executive Committee Meeting

- The ATF Co-Chairs will present the group's accomplishments, recommendations to turn the group into a caucus, and ongoing objectives to sustain the attention on HIV and aging. The group reviewed the draft presentation slides developed by staff. No changes were made.

5. Division of HIV and STD Programs (DHSP) Report

a. Feedback on a presentation date for a discussion with DHSP leadership on what is realistic to implement in the proposed HIV and aging care framework

- Pamela Ogata attended the meeting on behalf of DHSP and stated that she will work with Dr. Green to provide feedback on what is realistic for DHSP to implement in the proposed HIV and aging care framework. She reported that DHSP is conducting internal discussions about services for older adults (50+).
- A. Ballesteros noted that it is important to assess/review services now to be prepared for the coverage of individuals over 50 years in Medi-Cal beginning in May 1, 2022. People over 50 regardless of immigration status will become eligible for Medi-Cal. The County needs to address the use of Ryan White funds if Medi-Cal will not/cannot cover assessments and/or services specific to PLWH 50+ years. This change in Medi-Cal eligibility will free up Ryan White resources.

- P. Ogata replied that DHSP is currently looking into the transitioning of individuals over 50 years who would be eligible for Medi-Cal. A. Ballesteros recommended that DHSP look at specific populations like older PLWH women with children.

6. **Debrief of HIV, Aging and Stigma Annual Meeting Presentation by Dr. P. Nash**
   - Dr. Nash refreshed the group's memory about his presentation by summarizing key points:
     - Stigma has an impact on viral suppression
     - It is important to understand accelerated vs accentuated aging and work with the community/providers to respond accordingly based on the person's experience and unique situation.
     - Stigmas associated with HIV have consequences such as, reduced social networks; increased social isolation; decreased self-esteem, image & efficacy; decreased functioning (cognitive & physical); and decreased likelihood of status disclosure

7. **Next Steps/Agenda development for next meeting**
   - Reach out to USC's street medicine team to share information with the ATF on how many individuals with HIV they serve; where are they referring individuals from their outreach activities; what are the demographic characteristics of the clients with HIV they serve; what do they do when they find PLWH.
   - For a future activity, it may be better to have a panel on innovations around HIV care delivery.
   - Review proposed changes to the Benefits Specialty service standards.

8. **Public Comments & Announcements**
   - K. Donnelly commented that at his recent dental appointment, he heard a dental student use the term "Hi-5" as a euphemism for HIV. He thought that the intent is perhaps to reduce HIV-related stigma. Some attendees noted that they would have been offended by that incident as it only increases stigma.
   - Dr. Octavio Vallejo mentioned a research paper from the Health Resources and Services Administration (HRSA) about HIV and PLWH over 50 years. He will send the article to C. Barrit for dissemination to the ATF.
   - B. Risley announced a webinar APLA Health is co-hosting as part of the California Statewide HIV & Aging Educational Initiative on Feb. 16**.** The title of the webinar is Review of 2022 Benefits for Adults with HIV in California. This is the first of four quarterly series in 2022; upcoming topics will focus on housing, oral health, and substance use.

9. **Adjournment.** The meeting adjourned at approximately 2:20 PM.

Health4All Older Adults FAQ

This document seeks to provide partner organizations with information regarding the implementation of Health4All 50+ as of August 26th 2021. Please use this as a guide for creating materials for your community.

What is Health4All 50+?

On July 28, Governor Newsom signed into law the removal of immigration status as a barrier to Full-Scope Medi-Cal eligibility for Californians ages 50 and over. This means that ***low-income adults ages 50+, regardless of immigration status, will be eligible for comprehensive Medi-Cal health insurance coverage****, making California's health system more equitable and universal for all.*

When will undocumented immigrants ages 50+ be able to access Full-Scope Medi-Cal?

Implementation of Health4All 50+ is ***expected to happen in May 2022****. The Department of Health Care Services (DHCS) is preparing for implementation and their goal remains May 2022.*

How will eligible patients enroll into Full-Scope Medi-Cal?

Patients who enroll now in Restricted-Scope/Emergency Medi-Cal will automatically be transitioned to full Medi-Cal without further action*. Thus, enrolling in Restricted-Scope Medi-Cal as soon as possible will allow for a timely transition and is a good way for people to ensure they have access to Full-Scope care immediately in May 2022. DHCS is expected to mail notices to this population, and the DHCS website will also be updated with information about implementation in multiple languages.*

For folks not currently enrolled in Medi-Cal*, DHCS has a step-by-step guide on how to apply for Medi-Cal benefits, including links to the paper and online application.*

Find a local health center that can help you enroll in Medi-Cal: bit.ly/390NSYc

What services are included in Full-Scope Medi-Cal?

Full-Scope Medi-Cal has comprehensive health benefits including preventative care, dental, vision, and prescription drug coverage, among many others. A full list of services can be found here.

Will accessing Full-Scope Medi-Cal affect the "Public Charge" test?

Accessing Full-Scope Medi-Cal will not count toward the "Public Charge" test. *Using Medi-Cal will not negatively affect applications for green cards because the Medi-Cal expansion for older adults is state-funded, not federally funded, AND because the 2019 Public Charge Rule is no longer in effect.*

How does Health4All 50+ relate to the repeal of the Medi-Cal Assets test?

California will eliminate the Medi-Cal assets test, which limits seniors and people with disabilities to assets of no more than $2,000 for individuals and $3,000 for couples in order to access Medi-Cal, in July 2022. If an undocumented Californian over the age of 65 falls over this asset limit, they may not be able to benefit from Full-Scope Medi-Cal until July 2022.

Will the Full-Scope Medi-Cal coverage retroactively cover previous medical services and/or bills?

Applicants can request retroactive Medi-Cal coverage for up to three months prior to the month of application. For example: A newly-eligible individual who applies for Full-Scope coverage in the month of May 2022 can request coverage up to February 2022.

Why is Health4All implementation taking place in May 2022 and not the beginning of the year?

DHCS is undergoing system upgrades, and that date is the soonest DHCS would be ready to implement older adult expansion.

What is the eligibility criteria for this Medi-Cal expansion?

- *Age 50 or older (ages 25 and younger are already eligible)*
- *Household income under 138% of the Federal Poverty Level (FPL). For example, for a household of 4 people, this would be an annual household income of $36,570 (find information about income requirements here).*
- *Live in California*
- *Immigration status is NOT a criterion for eligibility. Undocumented individuals are eligible.*

Los Angeles County Commission on HI
Aging Task Force

Brett J. Feldman, MSPAS, PA-C

Director Division of Street Medicine KSOM of USC

Vice Chair Street Medicine Institute

March 1, 2022| WebEx, CA

Keck School of Medicine of USC
Street Medicine

Defining Street Medicine

- Direct delivery of healthcare to the rough sleeping population (unsheltered homeless)


LAC + USC
Keck School of
Medicine of USC
Street Medicine

Defining Street Medicine

- Direct delivery of healthcare to the rough sleeping population (unsheltered homeless)
- Care performed on the street


drive
osprey

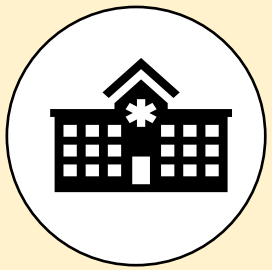
Defining Street Medicine

- Direct delivery of healthcare to the rough sleeping population (unsheltered homeless)
- Care performed on the street
- Done through walking rounds (motor cycles, horseback, kayak)

- “Go to the People”

Keck School of Medicine(KSOM) Street Medicine

Vision: all unsheltered homeless in LA have access to basic healthcare



Hospital-based consult service

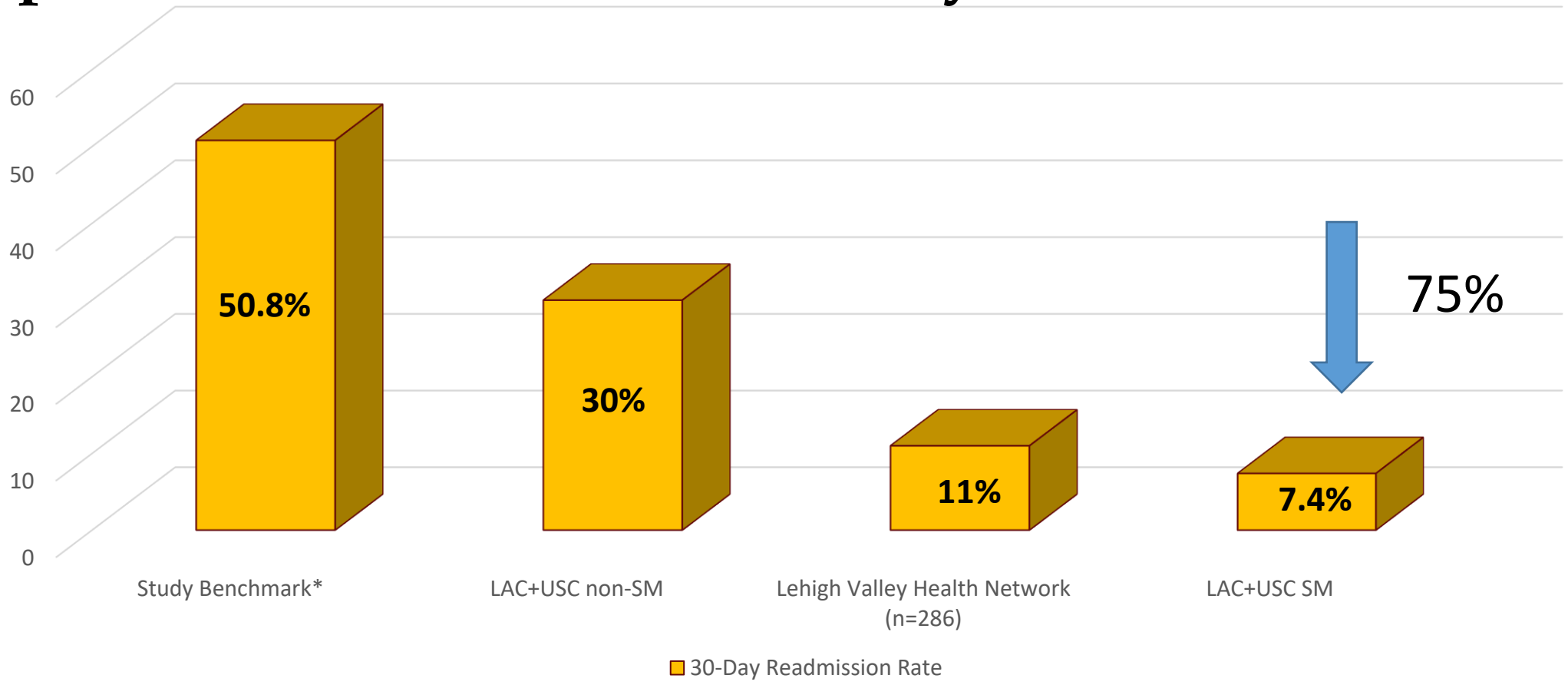
Street-based care

Workforce development

Education

Research

Impact of Street Medicine Primary Care on readmissions



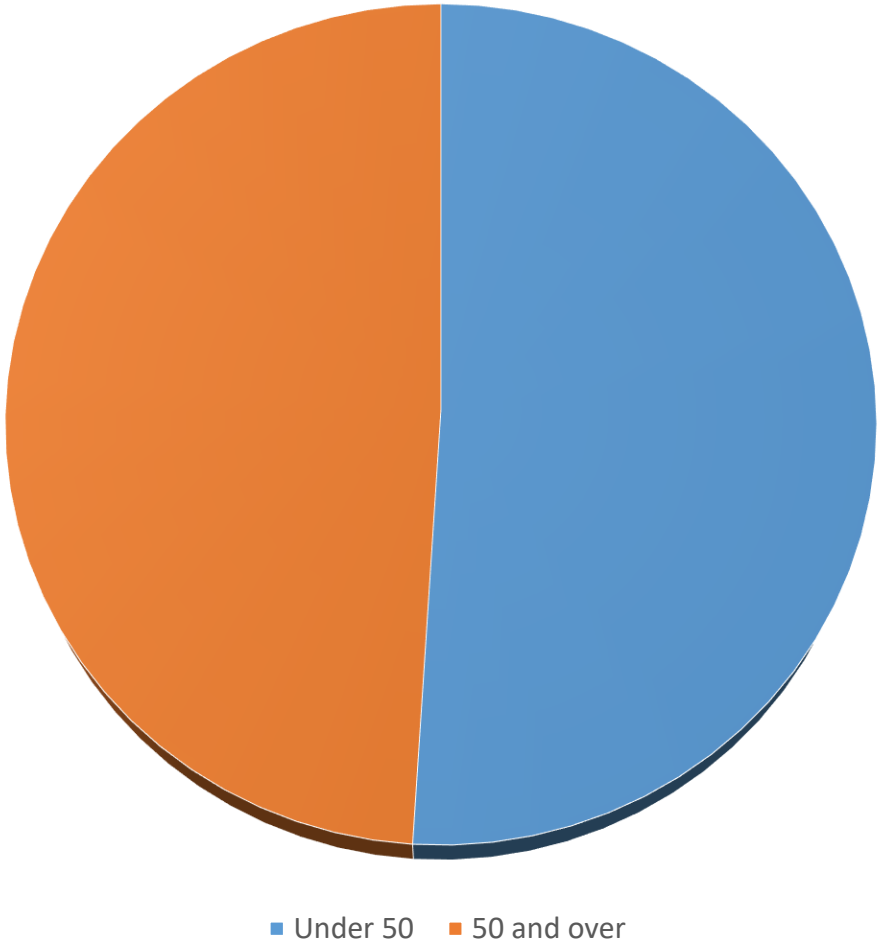
*Medical Care. 51(9):767–773, SEP 2013

Follow-up
8-27% Traditional
Vs.
73% Street Medicine

Insurance status	
Medi-Cal	172 (83.5)
MediCare	21 (10.2)
Uninsured	9 (4.4)
Not reported	4 (1.9)
Top admitting diagnosis	
Acute decompensated heart failure	40 (19.4)
Cellulitis requiring intravenous antibiotics	16 (6.8)
Pregnancy-related	11 (5.3)
Alcohol withdrawal	10 (4.9)
History of reported substance use	176 (85.4)
History of diagnosed mental health disorder	61 (29.6)
>3 medical co-morbidities	122 (59.2)
Length of time being unsheltered homeless	
<1 year	32 (15.5)
1-3 years	37 (18)
3-5 years	14 (6.8)
5-10 years	28 (13.6)
>10 years	51 (24.8)
Not reported	44 (21.4)

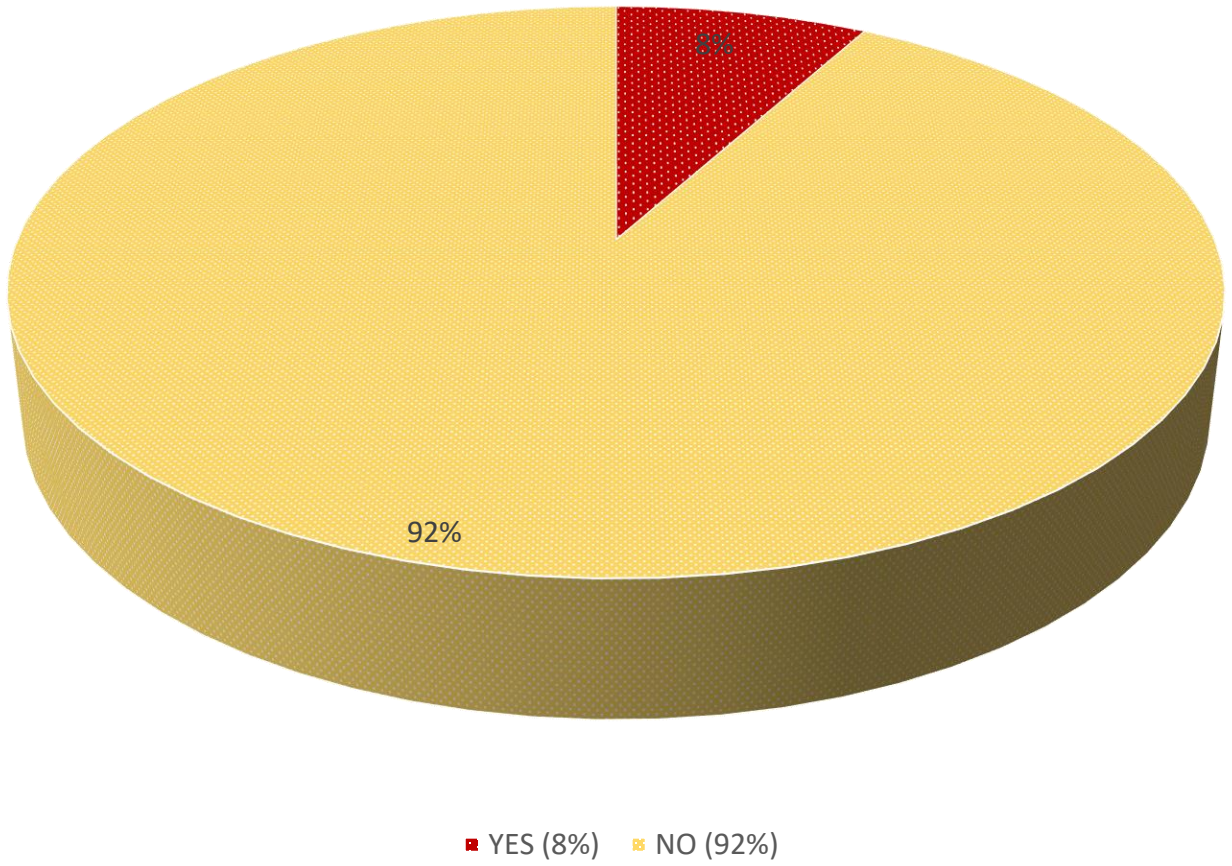
Feldman BJ, Kim JS, Mosqueda L,et al. From the hospital to the streets: Bringing care to the unsheltered homeless in Los Angeles. Healthc (Amst). 2021 May 27;9(3):100557. doi: 10.1016/j.hjdsi.2021.100557. Epub ahead of print. PMID: 34052622.

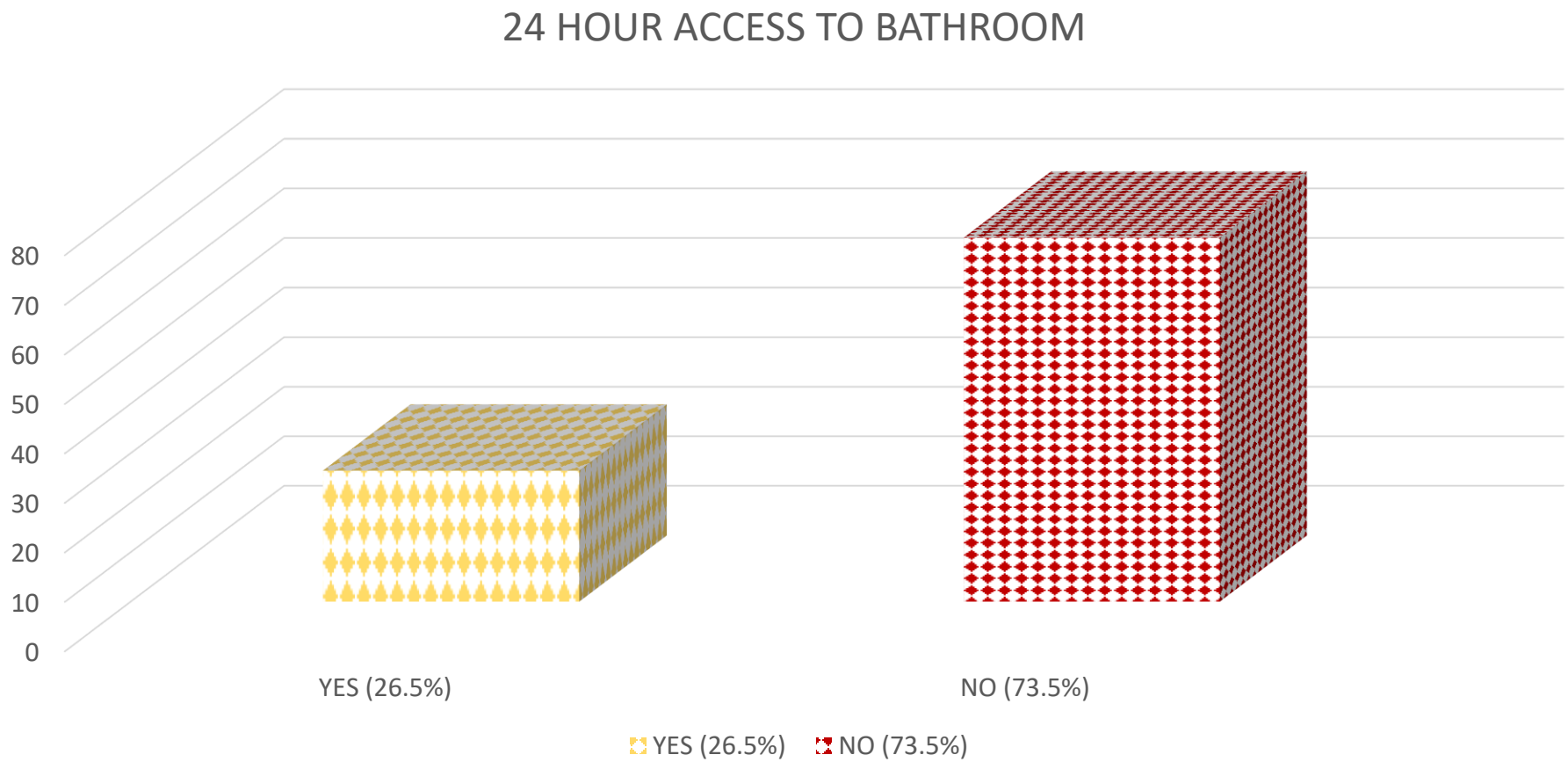
Aging Homeless Population

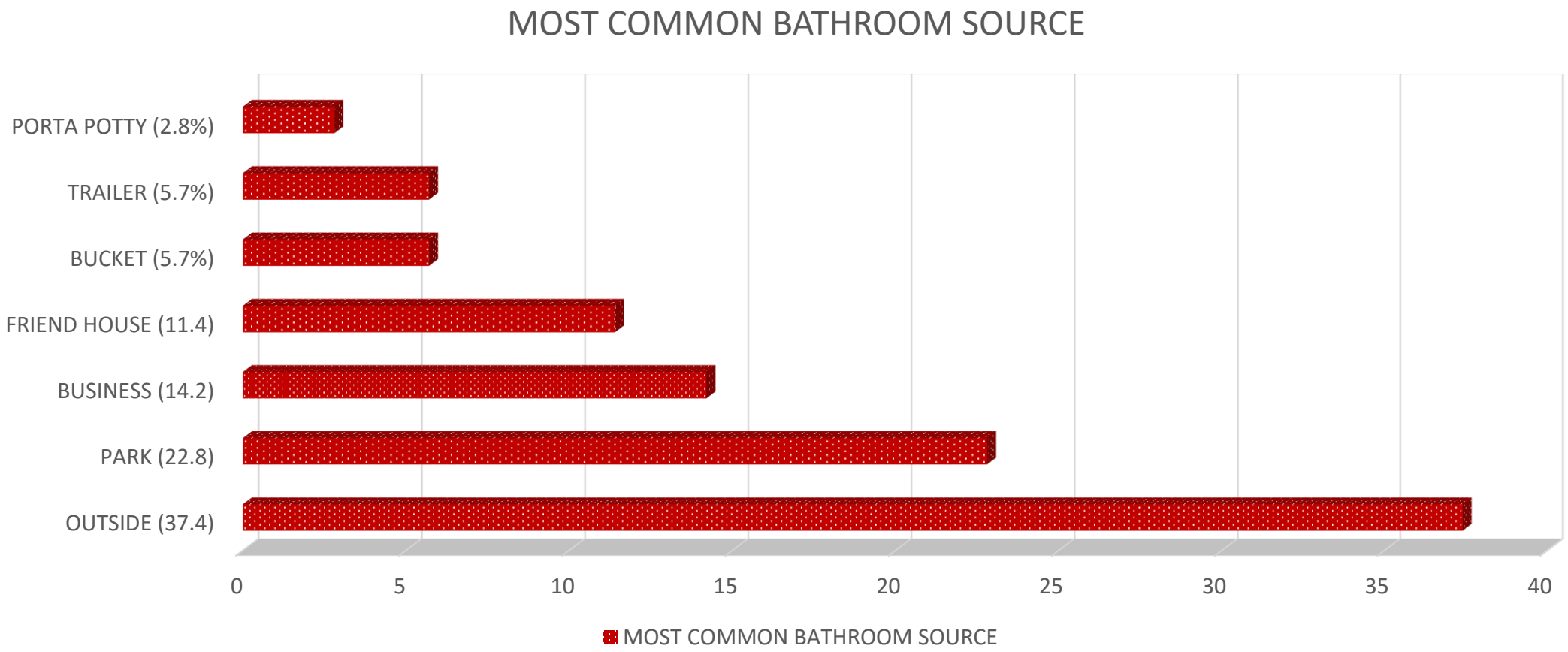


13% are >62 years old

OUTREACH OTHER THAN SM IN LAST 2 WEEKS




24 HOUR ACCESS TO BATHROOM
80
70
60
50
40
30
20
10
0
YES (26.5%)
NO (73.5%)
YES (26.5%)
NO (73.5%)


MOST COMMON BATHROOM SOURCE
PORTA POTTY (2.8%)
TRAILER (5.7%)
BUCKET (5.7%)
FRIEND HOUSE (11.4)
BUSINESS (14.2)
PARK (22.8)
OUTSIDE (37.4)
0
5
10
15
20
25
30
35
40
MOST COMMON BATHROOM SOURCE

Brett J. Feldman, MSPAS, PA-C

Brett.Feldman@med.usc.edu

Benefits Specialty Services Public Comments received as of 1/27/2022

Agency	Comment(s)	SBP Committee Course of Action
BSS Program Manager at JWCH Institute, Inc.	1. More training about various county benefits programs available for our clients would be helpful, along with most of the services that we are expected to provide. A lot of what we have learned has been through asking other enrollment workers or searching online. Cal Fresh was the only training in the last few years that we have received. There are no materials offered by DHSP or county programs to reference or learn from for programs such as Covered California or Social Security enrollment, amongst others. 2. Less required paperwork. During intake of new patients, they are expected to complete the clinic packet, the benefits packet (along with the assessment and Service Plan), and then also the NOLP Packet for enrollment into the food pantry. It would be helpful if a more condensed version of the BSS Packet is offered and will be less overwhelming for the clients especially during their initial visit. 3. Can workshops and outreach hours be counted towards the monthly Benefits hours/clients? This would be helpful to increase our service hours numbers and to meet that contract goal. Outreach is important for this position, but the hours aren't counted for some reason. If we are expected to bring in new people and outreach, then those hours should be counted and be credited for the work and time spent helping our clients. 4. Is there a specific form for Ryan White enrollment? I've been asked this before but the only enrollment into Ryan White that is provided is when we create and enter them into Case Watch along with the Benefits Packet. 5. If a client does not need Benefits, maybe there can be a single form they can sign stating that they were assessed and don't need any benefits. This would eliminate the client having to complete a Benefits Packet and Assessment for their charts when it is not needed.	

LOS ANGELES COUNTY
COMMISSION ON HIV

Service Standards for

BENEFITS SPECIALTY SERVICES

DRAFT FOR PUBLIC COMMENT

PUBLIC COMMENT PERIOD:
December 9, 2021—January 21, 2022

Email comments to HIVComm@lachiv.org

Service Standards Review
Guiding Questions for Public Comments

Service-Specific Questions

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD prevention services?

2. Are the standards reasonable and achievable for providers?

3. Will the services meet consumer needs? Are the proposed standards client-centered?

4. Is there anything missing from the standards related to HIV prevention and care?

5. Is there anything missing regarding accessing Benefits Specialty Services under Ryan White HIV/AIDS Program funding?

LOS ANGELES COUNTY COMMISSION ON HIV

BENEFITS SPECIALTY SERVICES
service standards

IMPORTANT: The service standards for Benefits Specialty Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

Ryan White HIV/AIDS Services: Determining Client Eligibility and Payor of Last Resort Program Clarification Notice (PCN) #21-02

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)

HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Benefits Specialty Services standards to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality Benefits Specialty Services when attending core medical and/or support services appointments and meetings. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Program (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, and the public-at-large.

BENEFITS SPECIALTY SERVICES (BSS): OVERVIEW

Benefits Specialty Services are client-centered activities that facilitate a client's access to public/private maintenance of health, social services, and disability benefits and programs. Benefits Specialty Services work to maximize public funding by helping clients identify all available health, social services, and disability benefits supported by funding streams in addition to Ryan White Part A funds. These services are designed to assist a client navigate care and social services systems outside of the service delivery network funded by the Ryan White Program, educate people living with HIV about public and private benefit programs, and aid in accessing and securing these benefits.

Benefits Specialty Services are unlicensed. All HIV Benefits Specialty Services will be provided in accordance with Commission on HIV guidelines and procedures, and local laws and regulations and will respect the inherent dignity of each person living with HIV they serve. In addition, BSS contractors must adhere to contractual requirements stipulated by DHSP.

Benefits Specialists will assist clients directly or through referral in obtaining the following (at minimum):

Table 1. BENEFIT SPECIALTY SERVICES LIST

Health Care	• AIDS Drug Assistance Program (ADAP)* • Patient Assistance Programs (Pharmaceutical Companies)
Insurance	• State Office of AIDS Health Insurance Premium Payment (OA-HIPP) • Covered California/Health Insurance Marketplace • Medicaid/Medi-Cal/MyHealthLA • Medicare • Medicare Buy-in Programs • Private Insurance
Food and Nutrition	• CalFresh • DHSP-funded nutrition programs (food banks or home delivery services)
Disability	• Social Security Disability Insurance (SSDI) • State Disability Insurance • In-Home Supportive Services (IHSS)
Unemployment/Financial Assistance	• Unemployment Insurance (UI) • Worker's Compensation • Ability to Pay Program (ATP) • Supplemental Security Income (SSI) • State Supplementary Payments (SSP) • Cal-WORKS (TANF) • General Relief/General Relief Opportunities to Work (GROW)
Housing	• Section 8, Housing Opportunities for People with AIDS (HOPWA) and other housing programs • Rent and Mortgage Relief programs
Other	• Women, Infants and Children (WIC) • Childcare • Entitlement programs • Other public/private benefits programs • DHSP-funded services

All contractors must meet the Universal Standards of Care in addition to the following Benefits Specialty Services service standards. Universal Standards of Care can be access at: http://hiv.lacounty.gov/Projects

Table 2. BENEFITS SPECIALTY SERVICES REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Benefits specialty programs will outreach to potential clients/families and providers.	Outreach plan on file at provider agency.
	Benefits specialty programs will collaborate with primary health care and supportive services providers.	Memoranda of Understanding on file at the provider agency.
Intake	The intake process will begin during first contact with client.	Intake tool in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency or Affidavit of Homelessness • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
	Consent for services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
	When indicated, the client will provide Disclosure of Duty Statement.	Signed and date Disclosure of Duty Statement in client file.

	Client will be informed of limitations of benefits specialty services through Disclaimer form.	Signed and date Disclaimer in client file.
Benefits Assessment	Benefits assessments will be completed during first appointment.	Benefits assessment in client chart on file to include: • Date of assessment • Signature and title of staff person • Completed Assessment/Information form • Functional barriers • Notation of relevant benefits and entitlements and record of forms provided • Benefits service plans
Benefits Management	Benefits management services will be provided to clients who are enrolled in benefits programs and require advocacy to maintain their benefits.	Benefits assessment on file in client chart to include: • Date • Signature and title of staff person • Notation of relevant benefits and presenting issues(s) • Benefits service plan to address identifies benefits issue(s)
Benefits Service Plan (BSPs)	BSPs will be developed in conjunction with the client at the completion of the benefits assessment.	BSP on file in client chart that includes: • Name, date and signature of client and case manager • Benefits/entitlements for which to be applied • Functional barriers status and next steps • Disposition for each benefit/entitlement and/or referral
Appeals Counseling and Facilitation	As necessary, specialists will assist clients with appeals counseling and facilitation. Cases that require further	Signed, date progress notes on file that detail (at minimum): • Brief description of counseling provided

	legal assistance will be referred to Ryan White Program-funded or other legal service provider.	• Time spent with, or on behalf of, the client • Legal referrals (as indicated)
	Specialists will attempt to follow up missed appointments within one business day.	Progress notes on file in client chart detailing follow-up attempt.
Client Retention	Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs will provider regular follow-up procedures to encourage and help maintain a client in benefits specialist services.	Documentation of attempts to contact tin signed, date progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
	Programs will develop and implement a client contact policy and procedure for homeless clients and those with no contact information.	Contact policy on file at provider agency. Program review and monitoring to conform.
Case Closure	Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client chart.
	Benefits cases may be closed when the client: • Successfully completes benefits and entitlement applications • Seeks legal representation for benefits • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term	Case closure summary on file in client chart to include: • Date and signature of benefits specialist • Date of case closure • Status of the BSP • Reasons for case closure

	• Uses the service improperly of has not complied with the client services agreement • Has died	
Staffing Development and Enhancement Activities	Benefits specialty programs will hire staff that have the ability to provide linguistically and culturally appropriate care to clients living with HIV. Staff meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role. Employment is an essential part of leading an independent, self-directed life for all people, including those living with HIV/AIDS. Agencies should develop policies that strive to hire people living with HIV in all facets of service delivery, whenever appropriate.	Hiring policy and staff resumes on file.
	All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
	Benefits specialists will complete DHSP's certification training within three months of being hired and become ADAP and Ryan White/OA-HIPP certified in six months.	Documentation of Certification completion maintained in employee file.
	Staff will complete benefits specialty recertification training annually and will seek other training opportunities as available.	Documentation of training maintained in employee files to include: • Date, time, and location of training • Title of training • Staff members attending • Training provider • Training outline • Meeting agenda and/or minutes

	Benefits specialists will practice according to generally accepted ethical standards.	Program review and monitoring to confirm.
	Benefits specialists will receive a minimum of four hours of supervision per month.	Record of supervision on file at provider agency.

APPENDIX A: DEFINITIONS AND DESCRIPTIONS

Benefits Assessment is a cooperative and interactive face-to-face interview process during which the client's knowledge about and access to public and private benefits are identified and evaluated.

Benefits Management refers to benefits specialty services provided to individuals who are enrolled in various health and disability programs. The goal of benefits management is to provider advocacy that helps the individual maintain his or her benefits.

Case Closure is a systematic process of disenrolling clients form active benefits specialty services.

Client Intake is a process that determines a person's eligibility for benefits specialty services.

Entitlement Program are benefits that require financial contribution into the program prior to collecting from the program (e.g., State Disability Insurance (SDI) and Social Security Disability Insurance (SSDI)).

Legal Representation defines a process through which a consumer is represented by an attorney, paralegal and/or licensed/certified insurance adjustor. (Please see Legal Assistance Standard of Care.)

Outreach promotes the availability of and access to benefits specialty services to potential clients and services providers.

Public Benefits describe all financial and medical assistance programs funded by governmental sources.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21; COH approved on 11/18/21)

STRATEGIES:

1. This framework seeks to facilitate medical wellness examinations and offers a flexible and adaptable guide to customizing care for ALL older adults with HIV. The suggested list of assessments may be used for younger PLWH, as deemed appropriate by the medical care team, especially in communities of color, experience aging-related issues earlier in life (before age 50) .

2. Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program.

3. Integrate a geriatrician in medical home teams.

4. Establish coordination process for specialty care.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21)

Assessments and Screenings			
Mental Health	Hearing	HIV-specific Routine Tests	Immunizations
Neurocognitive Disorders/Cognitive Function	Osteoporosis/Bone Density	Cardiovascular Disease	Advance Care Planning
Functional Status	Cancers	Smoking-related Complications	
Frailty/Falls and Gait	Muscle Loss & Atrophy	Renal Disease	
Social Support & Levels of Interactions	Nutritional	Coinfections	
Vision	Housing Status	Hormone Deficiency	
Dental	Polypharmacy/Drug Interactions	Peripheral Neuropathologies	

From Golden Compass Program

From Aging Task Force/Commission on HIV

Screenings & Assessment Definitions

- HIV-specific Routine Tests
  - HIV RNA (Viral Load)
  - CD4 T-cell count
- Screening for Frailty
  - Unintentional weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, weak grip strength
- Screening for Cardiovascular Disease
  - Lipid Panel (Dyslipidemia)
  - Hemoglobin A1c (Diabetes Mellitus)
  - Blood Pressure (Hypertension)
  - Weight (Obesity)
- Screening for Smoking-related Complications
  - Lung Cancer - Low-Dose CT Chest
  - Pulmonary Function Testing, Spirometry (COPD)

Screening for Renal Disease

  - Complete Metabolic Panel
  - Urinalysis
  - Urine Microalbumin-Creatinine Ratio (Microalbuminuria)
  - Urine Protein-Creatinine Ratio (HIVAN)
- Screening for Coinfections
  - Injection Drug Use
  - Hepatitis Panel (Hepatitis A, B, C)
  - STI - Gonorrhea, Chlamydia, Syphilis

Screenings & Assessment Definitions (continued)

- Screening for Osteoporosis
  - Vitamin D Level
  - DXA Scan (dual-energy X-ray absorptiometry)
  - FRAX score (fracture risk assessment tool)
- Screening for Male and Female Hormone Deficiency
  - Menopause, decreased libido, erectile dysfunction, reduced bone mass (or low-trauma fractures), hot flashes, or sweats; testing should also be considered in persons with less specific symptoms, such as fatigue and depression.
- Screening for Mental Health Comorbidities
  - Depression – Patient Health Questionnaire (PHQ)
  - Anxiety – Generalized anxiety disorder (GAD), Panic Disorder, PTSD
  - Substance Use Disorder - Opioids, Alcohol, Stimulants (cocaine & methamphetamine), benzodiazepines
  - Referral to LCSW or MFT
  - Referral to Psychiatry
- Screening for Peripheral Neuropathologies
  - Vitamin B12
  - Referral to Neurology
  - Electrodiagnostic testing
- Screening for Sexual Health

Other Suggestions from ATF/COH Discussions

- Screen patients for comprehensive benefits analysis and financial security
- Assess patients if they need and have access to caregiving support and related services
- Assess service needs for occupational and physical therapy (OT/PT) and palliative care
- Review home-based case management service standards for alignment with OT and PT assessments
- Establish a coordinated referral process among DHSP-contracted and partner agencies
- Collaborate with the AIDS Education Training Centers to develop training for HIV specialist and geriatricians.