LOS ANGELES COUNTY
COMMISSION ON HIV

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Aging Task Force
Virtual Meeting

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Tuesday, April 5, 2022
1:00PM-3:00PM (PST)

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGING TASK FORCE (ATF)

VIRTUAL MEETING AGENDA

TUESDAY, April 5, 2022

1:00 PM – 3:00 PM

TO JOIN BY WEBEX:

https://tinyurl.com/bdh7urvz

PASSWORD: AGING

TO JOIN BY PHONE: +1-213-306-3065 **MEETING #/ACCESS CODE:** 2593 060 9423

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 and Staffing Updates

3. Co-Chairs' Report 1:15pm-1:45pm
   a. DISCUSSION: Preparing for Joint Meeting with Executive Committee
      a. Identify key asks and concerns
      b. Articulate population focus and justification
      c. Identify spokespersons

4. Review Proposed Changes/Updates to the Home-based Case Management Service Standards 1:45pm-2:30pm

5. Division of HIV and STD Programs (DHSP) Report 2:30pm-2:40pm
   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 (May meeting)
   b. Relevant Programmatic and Fiscal Updates

6. Next Steps and Agenda Development for Next Meeting 2:40pm-2:55pm

7. Public Comments & Announcements 2:55pm-3:00pm

8. Adjournment 3:00pm

LOS ANGELES COUNTY
COMMISSION ON HIV

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

In attendance:

Al Ballesteros (Co-Chair)	**Joseph Green (Co-Chair)**	Alasdair Burton
Kevin Donnelly	Bridget Gordon	Danny Gonzalez
Lee Kochems	Katja Nelson	Vivian Criado (DPH, Office of Women's Health)
Brian Risley	Jazmin Rojano	Brett Feldman (USC)
Paul Nash	Pamela Ogata (DHSP Staff)	Jose Rangel-Garibay (COH Staff)
Michael Green, PhD (DHSP Staff)	Cheryl Barrit (COH Staff)	

CHP: Comprehensive HIV Plan
COH: Commission on HIV
DHSP: Division of HIV and STD Programs
DPH: Department of Public Health

Meeting packet is available at https://tinyurl.com/4cznetrp

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

2. **Executive Director/Staff Report**
   a. **Comprehensive HIV Plan (CHP) 2022-2026**
      - C. Barrit reported that AJ King, CHP consultant, has met with various COH caucuses, taskforces, workgroups, and committees and has been collecting feedback what key issues to address in the plan. AJ King addressed the Aging Task Force (ATF) in February and received specific feedback on issues and possible strategies to address HIV and aging. He is currently in the process of analyzing and synthesizing data and feedback received from the COH and the community and writing the first section of the CHP. He will provide updates at the monthly COH meetings.

   b. **Operational Updates**
      - C. Barrit reported that the Executive Office of the Board of Supervisors have instructed Executive Directors of commissions to prepare for the return of in-person meetings in April 2022. The COH full meetings and standing committees will meet in-person while caucuses, workgroups, and task forces will meet virtually. A videoconferencing link will be made available for Commissioners and the public to join meetings.
      - C. Barrit asked for flexibility with the ongoing County Counsel review of the pertinent government meetings regulations such as AB 361 and the Brown Act

as the County navigates the loosening of public health orders to control the COVID pandemic, ongoing disease control response, and reconstitution of County meetings and business operations to in-person format.

c. Health 4 All Older Adults FAQs

- C. Barrit called the attendee's attention to page 6 of the meeting packet, a document created by Health4All Older Adults FAQs. The document seeks to provide partner organizations with information regarding the implementation of Health4All 50+ beginning May 2022. On July 28, 2021 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.

3. Co-Chairs' Remarks and Report

a. February 1, 2022 Meeting Summary Review --The ATF reviewed the February 1 meeting summary. No corrections were made.

b. February 24, 2022 Executive Committee Report

- J. Green and A. Ballesteros reported that they attended the February 24, 2022 Executive Committee meeting and asked the Committee to support the formation of the Aging Caucus. However, there was a change in the motion to include long-term survivors and individuals who acquired HIV perinatally in the scope of the proposed Aging Caucus.
- The group discussed returning to the Executive Committee at their March meeting to provide their feedback and vision for turning the task force into a Caucus for older adults living with HIV. The ATF discussed asking for a special follow-up meeting with the Executive Committee to discuss concerns about its forced recommendations to the group at the February Executive Committee. The Task Force was taken off guard when the Executive Committee, without any formal discussions with the Task Force, requested a broadening of the Task Force's mandate/work. The Task Force wishes to be inclusive of groups which fit into the mandate of the Aging Task Force. However, to accomplish this the Task Force needs to hear better the information or positions of the Executive Committee and others in order to incorporate or not that work. Several Aging Task Force members expressed discomfort with the way the Executive Committee made its recommendations which seemed more of a mandate to force an issue rather than a process calling for collaboration, education and/or discussion.

- Some ATF members indicated that the issue of including people who acquired HIV perinatally has been brought up to the ATF and the full COH and felt that it is important to include PLWH under 50.
- Some members noted that including PLWH under 50 years in the scope of the Aging Caucus would potentially be doing a disservice to long-term survivors. It was recommended that all COH groups address the needs of long-term survivors or start a separate group.
- Broadening the population focus of the group would end up diluting the work and effectiveness of the ATF.

➢ The ATF decided by consensus to remove the motion to form an Aging Caucus on the March 10 COH agenda and have a conversation with the Executive Committee first.

4. Street Medicine and HIV | Conversation with the University of Southern California

- Brett J. Feldman, MSPAS, PA-C, Director Division of Street Medicine Keck School of Medicine of USC, and Vice Chair Street Medicine Institute, delivered a presentation on Street Medicine and engaged in a dialogue with the ATF on types of outreach, care, and linkage to additional care and support for people living with HIV (PLWH) and older adults living on the streets.
- Refer to the packet link for presentation details. The following are a few highlights around the question (Q) and answer (A) portion:
    - Q: What is your success with linkage to care? A: There is poor linkage to primary care physicians and the linkage will continue to be poor as long as they are homeless, and that is why their street medicine team provides care on the streets.
    - Q: How do you provide care to PLWH? The USC street medicine program provides care to PLWH by partnering with the Rand Schrader Clinic. They are also working to form a full time HIV street medical team.
    - Q: Beyond wound care, what needs are you seeing among older adults? A: They see similar needs compared to older adult populations, however, the health conditions (chronic and acute; Alzheimer's disease, and diabetes for instance) are occurring much earlier in life for those who are homeless.
    - Q: How has COVID impacted street medicine? A: There has not been much impact due to COVID. Street medicine is good at managing disease outbreaks. The biggest challenge is wearing a mask, which hinders effective communication and the ability to make strong connections with the community.
    - Q: What happens when individuals have little or no insurance? What does it mean to have no insurance with this program? A: Insurance coverage is not an issue or requirement for using the USC street medicine program. No one is turned away or denied service.

- Q: Where does funding come from to support agencies that provide street medicine? A: Funding for the USC street medicine program comes from County contracts (largest source of funding for the USC street medicine program), private foundations, and the City of Los Angeles. The program is not fully reimbursed for its costs which is not sustainable in the long run.
- Q: How do you deal with (especially for older populations) the need for cancers/anal exams, colonoscopy, and pap smears? A: These types of screenings are one of the biggest challenges for street medicine. In cases like these, the street medicine team would bring the patient to a brick-and-mortar clinic. For colonoscopies, they partner with Illumination Foundation.
- Q: How do you deal with loss of medicines or medication compliance? A: The USC street medicine team dispenses medications a week or 2 weeks at a time.

- B. Feldman stated that one of the systematic barriers to street medicine is reimbursement. He noted that last year, the Governor vetoed AB 369 which would have directed the Department of Health Care Services (DHCS) to establish a Presumptive Eligibility Program for persons experiencing homelessness, authorize all off-premises services under Medi-Cal, remove care authorization and coordination strategies typically provided by Primary Care Physicians, and deduct capitation payments made to Medi-Cal Managed Care Plans if a person experiencing homelessness does not utilize services within 60 days of enrollment. This bill would have made street medicine programs a direct access provider, eliminating the needs for a primary care physician layer for authorization/referral. There are no plans to reintroduce AB 369 in 2022.

5. Review Proposed Changes to the Benefits Specialty Service Standards

- COH staff, Jose Rangel-Garibay, went over the proposed changes to the benefits specialty service standards to elicit feedback from the ATF. Refer to the packet for the document.
- Staff noted that standards from other jurisdictions are reviewed by the Standards and Best Practices Committee when updating documents for specific service categories. For benefits specialty, California and Los Angeles have more public benefits available compared to other jurisdictions.
- There was no feedback provided during the meeting, however, J. Rangel-Garibay encouraged ATF members to email comments or questions to him.

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

- Dr. M. Green noted that he did not have much to report but indicated that he will pull his staff together to prepare for a deeper dive and conversation on how DHSP can operationalize the ATF recommendations at the May ATF meeting.

7. **Next Steps/Agenda development for next meeting**
    - Pull motion to form Aging Caucus from the March 10 COH meeting agenda.
    - Return to the Executive Committee to express concerns about the Committee's decision to expand the population focus of the ATF.
    - Continue implementation of 2022 Workplan.

8. **Public Comments & Announcements**
    - There were no public comments made.

9. **Adjournment.** The meeting adjourned at approximately 2:44 PM.

LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV
AGING TASK FORCE 2022 WORKPLAN (REVISIONS 12.15.21; 1.10.22; 2.1.22; 3.28.22)

Task Force Name: Aging Task Force		**Co-Chairs: Al Ballesteros and Joe Green**		
Task Force Adoption Date: 2/1/22				
#	**TASK/ACTIVITY**	**DESCRIPTION**	**TARGET COMPLETION DATE**	**STATUS/NOTES/OTHER COMMITTEES INVOLVED**
1	Review and refine 2022 workplan		Ongoing	Initial draft presented to ATF 1/4/22.
2	Develop the Comprehensive HIV Plan 2022-2026	• All Committee and subgroup will contribute to shaping the CHP • Commission, committees and subgroup activities should aim to align with the CHP and support the EHE goals • Comprehensive HIV Plan 2022-2026 – integrating elements of ATF recommendations and care framework	**October 2022**	Per ATF request, staff sent recommendations, HIV and aging care framework, and HealthHIV planning council effectiveness assessment report to CHP consultant to begin review and analysis of integrating key elements into the CHP. Address prevention in older adults in CHP.
3	Present accomplishments, recommendations and structure of the ATF to Executive Committee	Executive Committee (January 2021) approved 1-year extension of the ATF until March 2022. The ATF discussed continuing the work as Caucus.	2/24/22	ATF discussed (Dec 2021) meeting to transition into a caucus. Presented accomplishments and recommendations to become a Caucus at 2/24/22 Executive Committee (EC) meeting. ATF wants to have joint meeting with EC to clarify focus of Caucus to 50+.
4	Ensure service standards are reflective of and address the needs of PLWH 50+	Provide feedback on service standards SBP will update for 2022 and future years	-Benefits specialty services (BSS) early 2022 - ATF reviewed on 3/1/22 -Home-based case management	SBP 2022 standards workplan and target completion dates are: benefits specialty services (BSS) (early 2022) Home-based case management (HBCM) TBD--SBP prioritized HBCM for 2022 based on recommendations from ATF and DHSP. 84% of HBCM clients are ages 50+ targeted review of the oral health service standards and developing guidance for

			(HBCM) late 2022 -Oral health dental implants June 2022 TCM	specialty dental providers related to dental implants (June 2022) Transitional case management – jails, youth, older PLWH transitioning out of Ryan White into Medicare (completion date to be determined by SBP)
5	Use ATF recommendations and care framework to inform Ryan White allocations	Infuse aging lens in the multi-year service ranking and funding allocations exercise conducted by PP&A	Ongoing @ PP&A meetings (3rd Tues of each month)	J. Green and A. Ballesteros, ATF Co-Chairs are on PP&A Committee and may help shepherd the allocations debate to include PLWH 50+. ATF members attend PP&A meetings to lend additional voices in support of the 50+ PLWH community.
6	Complete best practices project in collaboration with SBP	SBP is working with all Caucuses and workgroups/task forces to develop a compilation of best practices resources for special populations.	Started	
	Continue to work with DHSP to implement recommendations		Ongoing	Maintaining ongoing communication with Dr. Green and W. Garland to assess what is realistic for DHSP to implement.
	Continue to work with DHSP to implement HIV care framework for PLWH 50+		Ongoing	Per Dr. Green, DHSP to provide feedback on the framework and what is realistic for DHSP to implement at the 2/1/22 ATF meeting.
	Review HEDIS measures used by LA CARE Health Plan | Caring for older adults			Carried over from 2021 workplan. Al Ballesteros to contact LA CARE. Per A. Ballesteros, keep activity in the workplan to revisit/review at a later date.
	Review, track and revisit Master Plan on Aging		Ongoing	Carried over from 2021 workplan.
	Determine key priorities for implementation and possible integration to COH Committee work.		STARTED DISCUSSION COMPLETED 1/4/22. 2022	Carried over from 2021 workplan. Co-Chair, Al Ballesteros, asked COH staff to determine what is feasible to implement from

			Workplan revised to include standards review and SBP collaboration.	list of recommendations at COH meeting on 5/13/21. Standards and Best Practices Committee – integrating ATF recommendations and care framework in "Best Practices" document for special populations Planning, Priorities and Allocations Committee – using recommendations and care framework to inform multi-year priority setting decisions and program directives Comprehensive HIV Plan 2022-2026 – integrating elements of ATF recommendations and care framework Public Policy Committee – supporting policy initiatives and legislative bills that address HIV and aging
	Encourage the Division of HIV and STD Programs (DHSP) tocollaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issue: 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.	Collaborate with DHSP to provide data on HIV continuum and quality of life indicators by race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status. Addressing disparities within the 50+ population is in line with the DHSP EHE Plan Overarching Strategy: Ensure that Los Angeles County Ending the HIV Epidemic pillars of interventions address and eliminate health inequities, address and dismantle racial inequities that are at the root of HIV and related syndemics, focus on the communities most impacted by HIV, and adopts a client-centered, people first approach.	Ongoing STARTED & ONGOING	Carried over from 2021 workplan. Activity and description taken from the recommendations tracker and as discussed from 6/1/21 meeting. W. Garland presented MCC Performance At-a-Glance, 2013-2017 Patients 50 and Over at ATF meeting October 2021. Dr. Green reported at 1/4/22 meeting that DHSP is reviewing data to determine disparities within the 50+ PLWH population. Analysis will take time and report findings to ATF accordingly.

	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 issue: 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 Abuseand 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.	The Standards and Best Practices (SBP) Committee developed special guidelines for special populations (youth, women, and transgender) in 2007. The ATF may want to approach the SBP Committee to develop best practices/guidelines for 50+ PLWH. It is suggested that the ATF Co-Chair and ATF members bring up ideas and report back to the Executive Committee at their monthly meetings.	STARTED Activity is being integrated in priority #6	Carried over from 2021 workplan. Activity and description taken from the recommendations tracker and as discussed from 6/1/21 meeting. Standards and Best Practices Committee – integrating ATF recommendations and care framework in "Best Practices" document for special populations

HIV and Aging Champions – ATF members and committee assignments	
ATF MEMBER	**COMMITTEE ASSIGNMENT**
Joseph Green (ATF Co-Chair)	Planning, Priorities and Allocations
Al Ballesteros (ATF Co-Chair)	Planning, Priorities and Allocations
Kevin Donnelly	Planning, Priorities and Allocations
Katja Nelson	Public Policy, Standards and Best Practices, and Executive Committee
Lee Kochems	Public Policy, Standards and Best Practices, and Executive Committee
Alasdair Burton	Public Policy
Paul Nash	Standards and Best Practices

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AGING TASK FORCE RECOMMENDATIONS
(Final 12/10/20)

Background: The Aging Task Force (ATF) was formed in February 2019 to address the broad health needs of those over 50 years living with HIV and long-term survivors. According the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

The ATF developed the following recommendations to the Commission on HIV, Division of HIV and STD Programs (DHSP) and other County and City partners to address the unique needs of this population. The term older adults refer to individuals who are age 50 and older.

**This is a living document and the recommendations will be refined as key papers such the State of California Master Plan on Aging and APLA's HIV and Aging Townhall Forums are finalized. **

Ongoing Research and Needs Assessment:

- 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:
    - 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: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf)
    - 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.
    - Conduct studies on the prevention and care needs of older adults.
    - 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.

- Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.
- 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.
- 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 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.
- Request DHSP to develop a data collection and reporting plan with a timeline on an annual report to the community.

Workforce and Community Education and Awareness:

- 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.
- 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.
- 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."
- 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.
- 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.
- 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.
- Expand opportunities for employment among those over 50 who are able and willing to work.
- Provide training on the use of technology in managing and navigating their care among older adults.

- Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.
- Collaborate with local resources and experts in providing implicit bias training to HIV service providers.

Expand HIV/STD Prevention and Care Services for Older Adults:

- 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.
- 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 patients affected by cognitive decline in navigating their care.
- 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.
- 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.
- 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.
- 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.
- Address technological support for older adults living with HIV as medical service modalities rely more and more electronic, virtual, and telehealth formats.
- 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 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
- 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.

- 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.

General Recommendations:

- 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.
- Ensure access to transportation and customize transportation services to the unique needs of older adults.
- Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV
- 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.
- Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.

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.

Home-Based Case Management Services Standards of Care

DRAFT FOR REVIEW

4/5/2021

LOS ANGELES COUNTY
COMMISSION ON HIV

Home-Based Case Management Services
SERVICE STANDARDS

IMPORTANT: The service standards for Home-Based Case Management 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 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

Service Standards: Ryan White HIV/AIDS Programs

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 Home-Based Case Management Services standards to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality Home-Based Case Management 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, Women's Caucus, and the public-at-large.

SERVICE INTRODUCTION

Home-based case management services are client-centered case management and social work activities that focus on care for people living with HIV who are functionally impaired and require intensive home and/or community-based care. Services are conducted by qualified Registered Nurse (RN) case managers and master's degree-level social workers who facilitate optimal health outcomes for functionally impaired people living with HIV through advocacy, liaison, and collaboration.

Home-based case management services may include:

- Assessment
- Service planning
- Attendant care
- Homemaker services
- Medical case management
- Care coordination
- Psychosocial case management
- Mental health therapy

The goals of home-based case management for functionally impaired people living with HIV include:

- Assessing and facilitating in-home services
- Helping clients locate needed health care and supportive services
- Helping service providers coordinate care for clients
- Helping clients understand and manage their medical diagnoses, including comorbidities and other health-related diagnoses that impact HIV care treatment
- Educating clients on reducing risks for HIV infection
- Helping patients adhere to medical regimens and drug therapies
- Helping clients transition appropriately to self-management and care
- Providing appropriate, quality, cost-effective care

All service providers receiving funds to provide Home-based Case Management services are required to adhere to the following standards.

Table 2. HOME-BASED CASE MANAGEMENT SERVICE REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Home-based case management programs will outreach to potential patients and providers.	Outreach plan on file at provider agency.
Intake	Intake process will begin during first contact with client.	Intake tool, completed and in client file, to include (at minimum): • Documentation of HIV status • Proof of LA County residency • 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
Intake	Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and date by client on file and updated annually.
Intake	Consent for Services will be completed.	Signed and dated Consent in client file.
Intake	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
Assessment	Assessments will be completed within 30 days following intake. Updates to the assessment will be done on a continuous basis, but no less than once every60 days.	Assessment or update on file in client record to include: • Date • Signature and title of staff person • Comprehensive medical information (detailed above) • Client's educational needs related to treatment • Assessment of psychological adjustment and coping • Consultation (or documented attempts) with health care and related social service providers • Assessment of need for home-health care services A client's primary support person should also be assessed for ability to serve as client's primary caretaker.
Service Plan	Home-based case management service plans will be developed in conjunction with the patient.	Home-based cased management service plan on file in client record to include:

		• Name of client, RN case manager and social worker • Date/signature of RN case manager and/or social worker • Documentation that plan has been discussed with client • Client goals, outcomes, and dates of goal establishment • Steps to be taken to accomplish goals • Timeframe for goals • Number and type of client contacts • Recommendations on how to implement plan • Contingencies for anticipated problems or complications
Implementation and Evaluation of Service Plan	RN case managers and social workers will: • Provide referrals, advocacy and interventions based on the intake, assessment, and case management plan • Monitor changes in the client's condition • Update/revise the case management plan • Provider interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up • Advocate on behalf of clients • Empower clients to use independent living strategies • Help clients resolve barriers	Signed, dated progress notes on file to detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward plan goals • Barriers to plan and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent

	• Follow up on plan goals • Maintain ongoing contact based on need • Be involved during hospitalization or follow-up after discharge from the hospital • Follow up missed appointments by the end of the next business day • Ensuring that State guidelines regarding ongoing eligibility are followed	• RN case manager's or social worker's signature and title
Attendant Care	Attendant care will be provided under supervision of a licensed nurse, as necessary.	Record of attendant care on file in client chart.
Attendant Care	When possible, programs will subcontract with at least HCOs or HHCs.	Contracts on file at provider agency.
Homemaker Services	Homemaker services will be provided under the supervision of a licensed nurse, as necessary.	Record of homemaker services on file in client record.
Homemaker Services	Homemaker services will be monitored at least once every 60 days.	Record of monitoring on file in the client record.
Homemaker Services	When possible, programs will subcontract with at least HCOs or HHCs.	Contracts on file at provider agency.
HIV Prevention, Education and Counseling	RN case managers and social workers will provide prevention and risk management education and counseling to all clients, partners, and social affiliates.	Record of services on file in client medical record.
HIV Prevention, Education and Counseling	Case managers and social workers will: • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce sager behavior	Record of prevention services on file in client record.

	• Refer for substance abuse treatment • Facilitate partner notification, counseling, and testing • Identify and treat sexually transmitted disease	
HIV Prevention, Education and Counseling	When indicated, clients will be referred to appropriately credentialed/licensed professionals for prevention education and counseling.	Record of linked referral on file in client record.
HIV Prevention, Education and Counseling	Case managers and social workers will: • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce sager behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling, and testing • Identify and treat sexually transmitted diseases	Record or prevention services file in client record.
HIV Prevention, Education and Counseling	When indicated, clients will be referred to appropriately credentialed/licensed professionals for prevention education and counseling.	Record of linked referral on file in client record.
Referral and Coordination of Care	Home-based case management programs will maintain a comprehensive list of providers for full spectrum HIV-related services referrals.	Referral list on file at provider agency.
Referral and Coordination of Care	Home-based case management programs will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding detailing collaborations on file at provider agency.

Referral and Coordination of Care	Home-based case management programs will develop procedures and protocols for referrals.	Written procedures and protocols on file at provider agency that includes proves for tracking and monitoring referrals.
Case Conference	Case Conferences held by RN and social worker (at minimum) will review and revise services plans at least every 60 days. Client or representative feedback will be sought.	Documentation of case conferences on file in client record to include names and titles of those participating in the review and client or representative input.
Patient Retention	Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
Patient Retention	Programs will provide regular follow-up procedures to encourage and help maintain a client in home-based case management.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
Case Closure	Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client record
Case Closure	Home-based case management cases may be closed when the client: • Has achieved his or her home-based case management service plan goals • 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 • Uses the service improperly or has not	Case closure summary on file in client chart to include: • Date and signature of RN case manager and/or social worker • Date of case closure • Service plan status • Statue of primary health care and service utilization • Referrals provided • Reason for closure • Criteria for re-entry into services

	complied with the client services agreement • Has died	
Policies, Procedures and Protocols	Home-based case management programs will have written policies procedures and protocols, including eligibility criteria.	Policies, procedures, and protocols on file at provider agency.
Staffing Requirements and Qualifications	RNs providing home-based case management services will: • Hold a license in good standing form the California State Board of Registered Nursing • Have graduated from an accredited nursing program with a BSN or two-year nursing associate degree • Have two year's post-degree experience and one year's community or public health nursing experience • Practice within the scope defined in the California Business & Professional Code, Section 2725	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Staffing Requirements and Qualifications	Social workers providing home-based case management services will hold an MSW or related degree and practice according to State and Federal guidelines and the Social Work Code of ethics	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Staffing Requirements and Qualifications	RN case managers and social workers will attend an annual training/briefing on public/private benefits.	Documentation of attendance in employee files.
Staffing Requirements and Qualifications	Staff will maintain licenses by completing continuing education requirements of their respective professional boards.	Record of continuing education in employee files at provider agency.

DEFINITIONS AND DESCRIPTIONS

Assessment is a comprehensive evaluation of each client's physical, psychological, social, environmental, and financial status to determine the type and level of service needs. Assessments will be performed in accordance with guidelines set forth by the California Department of Public Health (CDPH) Case Management Program (CMP).
Attendant care includes the provision of non-medical personal care by a home health aide or nurse assistant certified by the CDPH. Services are provided under the direct supervision of a licensed nurse.
Home care organization (HCO) is an entity that provides attendant care and/or homemaker services only. HCOs are not licensed by the CDPH and are not subject to State-issued service standards or criteria.
Home health agency (HHA) is a public or private entity that provides skilled nursing and other therapeutic services to clients in their place of residence under a treatment plan prescribed by an attending physician. HHAs must be qualified and licensed by the CDPH as a home health agency.
Homemaker services include general household activities performed when the client is unable to manage home care for himself or herself at home. Services are provided under the direct supervision of a licensed nurse.
Registered Nurse (RN) case management services include the provision of comprehensive medical case management for people living with HIV who require intensive home and/or community-based services.
Service plan is a written document identifying a client's problems and needs, intended interventions, and expected results, including short- and long-range goals written in measurable terms.
Social work case management services include the provision of comprehensive social work case management services including, but not limited to, psychosocial, financial, housing, and related concerns for people living with HIV who require intensive home- and/or community-based services.
Social workers, as defined in this standard, are individuals who hold a master's degree in social work or related field from an accredited program.