**Ryan White Part A Directive for Aging Persons with HIV (PWH)**
**(Approved by the HIV Planning Council on October 28, 2021)**

# Directive for Aging PWH

## Rationale for Creating this Directive

**Research Evidence:** 1) PWH over 50 represent a majority of the total PWH population (59% of PWH in New York City (NYC) in 2019)[i] and yet their unique intersectional needs are often underrecognized and unaddressed by HIV service organizations; 2) PWH over 50 have achieved the highest proportions of sustained viral suppression of any age group [ii] and yet care for their comorbid health conditions remains suboptimal; and 3) PWH still have shorter life expectancies[iii] than those not living with HIV with two thirds of deaths among PWH due to non-HIV-related causes.[iv] PWH have 16 fewer healthy years than uninfected adults, with diagnoses of common comorbidities beginning at age 34, and no improvement over time or with early ART initiation.[v] Perinatally infected PWH also have unique challenges in regard to HIV and aging.[vi] Greater attention to comorbidity prevention for PWH is warranted. Multimorbidity is expected to grow over the next 10 years, researchers are calling for new HIV Care Models that address prevention and treatment of comorbidities of Aging PWH.[vii,viii] Local focus group results underscore the need for improved resources for Aging PWH, including the need to develop services that address social isolation, increase coordination between programs, increase the benefits of navigation, increase the availability of services offered in Spanish, and address medical conditions of women with HIV over 50.[ix] Given the finding from these focus groups the intent of this directive is to ensure the provision of services in additional languages of clients served.

**Lived Experience Evidence:** This directive was initiated at the request of and developed by the Consumers Committee, PWH with lived experience of the issues to be addressed. They identified the following barriers:

1) **Aging PWH Have More Engagement in System and Higher Data Burden**

Rationale: A need exists to reduce the amount and duplication of data burden. There is an overwhelming amount of required documentation and supplemental paperwork put upon Aging PWH who seek services. It has become more challenging to manage and for them to respond, and relief is needed.

2) **Income/Entitlements for Aging PWH Fluctuate Causing Interrupted Access to Care**

Rationale: A need to promptly update patient records. Communications between agencies, billing departments, and insurance carriers need to be prompt to ensure uninterrupted access to and coverage of healthcare. Delays updating records cause clients to be ineligible for and denied services, and/or increase wait time. Specific attention should be paid to the needs of Tri County Residents in this regard.

3) **Need for Mental Health Practitioners Who Are Culturally the Same as Clients**

Rationale: It is critical to address the needs of those disproportionately infected and affected by HIV. It is important that PWH seeking counseling have more choice of seeing and having dialogue with providers who are culturally the same. With greater inequities in certain populations, having providers that reflect the communities served is a critical factor in Ending the Epidemic.

4) **Oral Health Care is Suboptimal and Lacks Crucial Coverage**

Rationale: Oral health has an essential role in maintaining good health, diet and nutrition, and structurally functional teeth. Unfortunately, HIV has a declining effect on PWH's oral health. In general, dental services are

suboptimal and costly, and often result in preventable tooth removal and dentures instead of implants that would complement and keep permanent teeth.

5) **Implementation Practices May not Adapt nor be Flexible**

Rationale: Adopt various integration and assessment methods. Increased engagement goals should not rely on existing implementation practices. Service delivery protocols should be regularly reassessed, updated, and developed to have more agile responses to population needs. Providers should be able to address quickly and easily to what is happening with specific clients and their individual issues.

6) **Increased Relationship Building with PWH Needed for Providers**

Rationale: Providers should prioritize their relationship with clients and develop partnerships that build on open and honest communication. They need to invest more time and care toward listening to their concerns, and willingly explain details of test results, trends, and disclose the full range of options when available.

7) **PWH Should Have the Option to Select the Gender of Their Providers**

Rationale: Patients may not feel comfortable discussing concerns affecting their anatomy and sexual activity with differently gendered providers. PWH are usually excluded during provider selection and accommodate those designated to avoid being stereotyped as temperamental or difficult.

8) **Resilience of Aging PWH and Overlooked Need for Independence and Decision Making**

Rationale: Providers often do not include their clients in making decisions about their care. Protocols are dictated and medications prescribed without consideration for their ability to be adherent. They feel unheard, vulnerable, and fear divulging habits and behaviors, and engage in self-diagnosis and alternative treatments.

9) **Maintain Consistency with Scheduled Appointments**

Rationale: Canceling and rescheduling appointments often has adverse effects. It can appear inconsiderate, uncaring, and disrespectful to not keep appointments. It is often done close to an upcoming appointment date and causes more delays, sometimes weeks or months, before being able to see the provider.

**Terminology:** Throughout this directive, we use the term “aging” to recognize that the spectrum of disease and onset of health issues can occur at different ages, and to be inclusive of long-term survivors who were perinatally infected. “PWH over 50” is used when it mirrors the data cited.

**Format:** The directive mirrors the format of the Implementation Research Logic Model (IRLM), a logic model designed to improve the uptake of research evidence into routine healthcare and public health practice. See this website, for more information on the IRLM.

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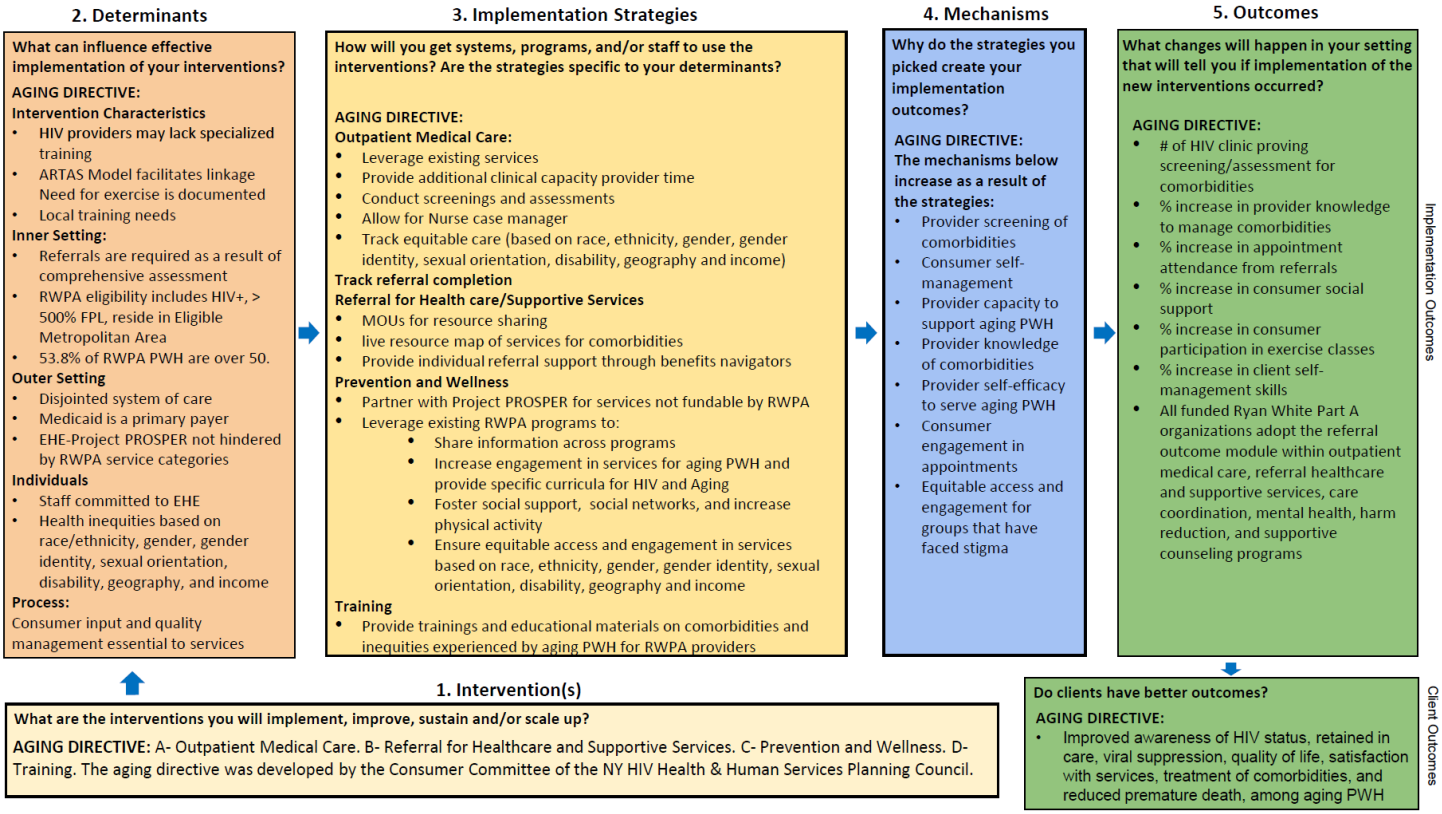
Snapshot view of directive:




Full directive:

# 1. INVERVENTIONS

This directive seeks to increase screening to support early detection and treatment for comorbidities (CVD, osteoporosis, social support, mental health, etc.) among aging PWH through 4 intervention activities:

A. **Outpatient Medical Care:** Increase capacity of Outpatient Medical Care to treat the complex needs of Aging PWH. Intervention to mirror aspects of Golden Compass model[x] through use of clinical staff (MD, RN, Pharmacist, Medical Assistant) to provide health education, Geriatric, Psychiatric, and Cardiology consultation, and referral to ongoing specialty care in line with HHS Guidance.[xi] Funded services should be supported to improve health education and self-advocacy/self-management so that Aging PWH can talk to their medical providers about broader health concerns.
B. **Referral for Healthcare and Supportive Services:** Increase the knowledge of resources available to support Aging PWH among RWPA funded providers. Utilize referral tracking to ensure Aging PWH are engaged in needed services. Utilize an adaptation of effective referral practices from the Anti-retroviral treatment and access to services (ARTAS) model, [xii] including development of referral partnerships (resource sharing agreements, linkage agreements), verification of insurance coverage, communication/outreach/education and training on availability of referral service, provide navigation and transportation if needed, provide program supervision to navigation staff.
C. **Prevention and Wellness** There is a need to "Strengthen and expand PLHIV networks and increase funding for community-based organizations that provide social support services for older people living

with HIV."[xiii] Services will provide social support for exercise by setting up a buddy system, making contracts with others to complete specified levels of physical activity, or setting up walking groups or other groups to provide friendship and support.[xiv] [xv] Program will provide peer support using navigation, structured health education (including wellness information and exercise, diet/nutrition, communication with a provider, and common comorbidities) and practical and emotional peer support services (support groups and/or buddy programs) to increase engagement in care and promote self-care.[xvi] Identify ways to leverage technology for social support and connection and to overcome barriers that older people living with HIV face in using technology. [xvii]

D. **Training** Increase training of RWPA providers to ensure they are able to effectively support Aging PWH through increased ability to identify comorbidities, link Aging PWH to needed resources, and increase ability to effectively serve Aging PWH given the intersectional identities experienced by this population. [xviii]

# 2. DETERMINANTS

*What factors can influence effective implementation? What contextual factors could influence implementation at the structural, interpersonal, and individual levels?*

**Intervention Characteristics -**

**A. Outpatient Medical Care**

- Hospitals, clinics, community-based organizations, correctional health, and some public health programs can serve as service sites, but they need resources to address the needs of Aging PWH.[xix]
- RWPA sites can adapt best practices from the Project PROSPER-funded Be InTo Health, Older People Living with HIV program[xx] adapted from the Golden Compass model.

**B. Referral for Healthcare and Support Services**

- The ARTAS model is an evidence-based intervention supported by the CDC since 2005 that can be utilized by NYC RWPA.

**C. Prevention and Wellness**

- Exercise and social support are well documented needs among Aging PWH, but exercise has not been commonly offered in Ryan White Programs.[xxi] Social support services are commonly provided in such RWPA services as Harm Reduction, Mental Health, Supportive Counseling, and Health Education/Risk Reduction.

**D. Training**

- New trainings are being developed to reflect the available science on Aging PWH. We can leverage non-RWPA resources (AETC, city, and Project PROSPER funded training). Trainings need to include assessing readiness and identifying barriers to coordinating integrated service delivery for Aging PWH.

**Inner Setting:** The characteristics of the HIV Care and Treatment Program (CTP)/NYC Department of Health & Mental Hygiene (DOHMH) & RWPA-funded organizations:

- The RWPA Program requires referrals for services through a comprehensive assessment completed at intake and every 6 months thereafter and as needed and identified by clients.

- RWPA fills in the gaps in Medicaid services by providing support & coordination, i.e. navigation and services not paid by Medicaid or another payer
- The RWPA Program eligibility – Aging PWH with incomes up to 500% of the federal poverty level (FPL) who reside in the eligible metropolitan area (EMA).
- In the NY EMA RWPA program, over 53.8% of actively served PWH are over 50.[xxii]
- CTP provides quality management and technical assistance to funded programs to improve client services and support fidelity to models of care.
- RWPA-funded and HRSA-defined service categories address gaps in the service system to stabilize clients and support anti-retroviral treatment (ART) adherence. Service categories are limited by legislative definitions. The Planning Council has allocated funding to the NY EMA portfolio of services which currently consists of a wide array of medical and non-medical case management support: housing, food/nutrition, mental health, harm reduction, health education/risk reduction, emergency financial assistance, oral health, legal, supportive counseling, and medical transportation (in Tri County only). Not all HRSA defined service categories are funded in the NY EMA.
- NYC DOHMH is funded for the HRSA 078 EHE-Project PROSPER which supports PWH over 50. The current Project PROSPER-funded Be InTo Health, Older People Living with HIV program is adapted from the Golden Compass model from San Francisco.[xxiii] Services are currently limited to three programs, two in Brooklyn and one in upper Manhattan.
- The disjointed and multiple funded system of care creates a challenge in coordinating care and support for Aging PWH. Care must be integrated. [xxiv] [xxv]

**Outer Setting:**

- Income inequality is a defining characteristic of the prevalence and disproportionate impact of HIV in the EMA.
- Medicaid is the primary payer for medical services. RWPA fills in the gaps in Medicaid services by providing support & coordination, e.g., navigation and services not paid by Medicaid or another payer.
- Medicaid is the primary payer for HIV services; data sharing between payers and between service sites has multiple barriers (e.g., data accessibility, timeliness of data), which impedes population health.
- Data sharing impedes coordination of care.
- The NYC DOHMH Training and Technical Assistance Program (T-TAP), HIV Clinical Operations and Technical Assistance Program (COTA) supports programs with up to date, interactive trainings.

**Characteristics of Implementers:**

<u>DOHMH and contracted RWPA program staff</u>:

- DOHMH and RWPA program staff are committed to the new federal Ending the HIV Epidemic (EHE) Plan and the NYS Ending the Epidemic (EtE) Plan.
- Geriatric expertise is uncommon among providers in HIV organizations.[xxvi] [xxvii]
- Need additional skills in anti-stigma, intersectionality, and trauma-informed approaches.[xxviii]

<u>Aging PWH have the following identified needs</u>:

- Persistent health inequities exist related to race/ethnicity, gender, gender identity, sexual orientation, disability, geography, and income.[xxix]
- Higher rates of social isolation.[xxx]
- Food and nutrition services.[xxxi]
- Increased rates of osteoporosis, chronic liver disease, and in particular cardiovascular disease.[xxxii]
- Increased risk of cardiovascular disease, mental health, lack of social support, substance use, smoking, HCV, HPV, osteoporosis, and chronic inflammation.[xxxiii]
- Health disparities also widen with aging as more disabilities and chronic illnesses accumulate.[xxxiv]
- In addition to multiple comorbidities (multimorbidity), Aging PWH are at risk for geriatric (henceforth termed aging-related) syndromes, such as frailty, falls, and cognitive and functional impairment.[xxxv]
- Aging-related syndromes can be seen before Aging PWH are chronologically elderly.[xxxvi]
- Clinical management requires preparing patients to be educated and supported in regard to healthy aging (as a way of trying to forestall or prevent these syndromes) as well as assessment and care of those who have aging-related syndromes.[xxxvii]
- COVID-19 has diverted many resources/staff and exacerbates existing inequities.
- Lack of housing access and the presence of housing discrimination is pervasive.

**Process:**

- Community planning processes: Planning Council, HIV Planning Group (HPG), consumer advisory boards (CABs), ad-hoc listening sessions, town halls, focus groups (consumers and planning body members not employed by HIV service agencies are not paid for planning work).
- Annual dissemination of HIV data for planning: HIV surveillance, Ryan White programmatic data, population-based surveys (Medical Monitoring Project (MMP), National HIV Behavioral Study (NHBS), Sexual Health Study (SHS), Community Health Advisory and Information Network (CHAIN)).
- Quality management supported by the HIV Care and Treatment Program (CTP) and at RWPA-funded organizations supports program implementation and continuous quality improvement.
- Informal and formal mechanisms for client input within HIV organizations (e.g., patient satisfaction surveys, support groups, etc.).
- All Ryan White Programs must ensure each client is aware of the agencies' grievance process and must include contacting the Recipient if the grievance does not reach a resolution. This can serve as an important tool for reporting stigma and human rights abuses.

# 3. IMPLEMENTATION STRATEGIES

*How will you get systems, programs, staff, and/or clients to use the interventions?*

**Required Activities:** <u>All services must be equitably provided, as per the Council's Framing Directive, to all Aging PWH. This shall be monitored and will be an ongoing subject of technical assistance.</u>

A. **<u>Planning and Quality Management Strategies for Clinical Services, Outpatient Medical Care[xxxviii]:</u>**

- Obtain formal commitments to coordinate care that leverage existing resources (current RWPA programs, Ryan White Part B, C, and D programs, Medicaid funded services and other resources at program sites).
- Provide additional capacity and clinical time to pay for extended visits to conduct comprehensive screenings/assessments to identify needed geriatric and healthcare-based services and support, [xxxix] [xl] outlined by the NYS HIV Clinical Guidelines.[xli]
- Conduct screenings and assessments for HCV, HPV, osteoporosis, mental health, cognition, social support, exercise, nutrition, oral health, sexual health, transgender health, medical issues specific to women (mammograms, etc.), cancer screening, substance use, smoking, cardiovascular disease (CVD) and any other issues included in HHS guidance for Aging PWH.
- Allow for a Nurse Case Manager or other qualified provider to coordinate the medical and behavioral health needs of those with multiple comorbidities, with referrals to case management for benefits and entitlement programs and programs that may be of assistance to partners and families of PWH.
- Provide education and support for advance directives.
- Track referral completion. Utilize Continuous Quality Improvement (CQI) tools to ensure equitable access and engagement in services based on race/ethnicity, gender identity, sexual orientation, disability, geography, and income.
- Deliver capacity building and technical expertise that promotes increased capacity and equitable access, regarding race/ethnicity, gender identity, sexual orientation, disability, geography and income, to geriatric and healthcare services for funded providers.

B. **Planning and Quality Management Strategies for Referral for Health Care/Supportive Services**[xlii]**:**

- Develop Memoranda of Understandings (MOUs) to establish resource sharing agreements, with language in regard to expedited access to appointments, as appropriate, among specialty medical and support service providers addressing comorbidities for Aging PWH (e.g., HCV, HPV, osteoporosis, mental health[xliii], assessment for suicidal ideation, cognition, social support, sexual health, transgender health, medical issues specific to women (mammograms, etc.), cancer screening, substance use, smoking, CVD) to leverage existing resources and increase engagement in services.
- Develop or support RWPA provider access to a live resource map to identify resources to lower risk and provide support for the management of CVD, chronic inflammation, osteoporosis, mental health, social support, exercise, nutrition, smoking cessation, and substance use when not available through primary care, resource map should include services provided outside of RWPA, such as NYC Department for the Aging (DFTA) resources, local Geriatricians, Health and Wellness Programs, Diet/Nutrition, Exercise, other resources that support client self-management, etc.) for Aging PWH. Resource map should be non-stigmatizing, easily accessible, provider developed and updated in real time.
- Provide individual referral support through trained certified benefits navigators, including education on insurance such as appropriate plans for Medicare, Medicaid, and other insurance to address a client's needs. Track referral completion and insurance

verification, including confirming the referral connection happened, and any follow-up needed. Use CQI to ensure equitable access and engagement in services.

C. **Prevention and Wellness**:

- Develop a system for referrals and linkages with DOHMH's Project PROSPER and Be InTo Health to conduct physical and social activities based on interests of clients at least monthly (e.g., yoga, fitness sessions, Zumba, art classes, movie showings).
- Leverage existing RWPA programs to increase engagement in services for Aging PWH.
- Modify and/or enhance RWPA supportive counseling, food and nutrition services, psychosocial support, health education and risk reduction programs to support prevention and wellness in their current service provision to Aging PWH.
    - Tailor social groups that foster community and social connections to address the needs of Aging PWH in RWPA supportive counseling/psychosocial support, harm reduction, and mental health programs. Allow for exercise groups (virtual or face to face, including yoga, neighborhood-based walking groups, or other exercise activities that may be popular with Aging PWH). Support faith-based organizations in the provision of social support services, including pastoral counseling as outlined in the Supportive Counseling directive.
    - Require the development of services that enhance social support networks among clients in Supportive Counseling, Psychosocial support, Food and Nutrition programs providing congregate meals, Mental Health, and Harm Reduction Programs through such tools as peer networks or use of technology for virtual communication/connection (including training for the use of such technology). Provide education and support to family members (as defined by the client) so that they too can be sensitive to the needs of Aging PWH.
    - Maximize the employment and support of peers[xliv] in supportive counseling, psychosocial support, food, and nutrition programs providing congregate meals, mental health, and harm reduction programs to support Aging PWH.
    - Develop specific curricula for Aging PWH in Health Education and Risk Reduction programs, the curricula should include such issues as physical exercise (including low cost/accessible physical exercise options), common comorbidities, wellness/prevention, sexual health, and any other common issues affecting Aging PWH including those in the HHS guidance for Aging PWH.
    - Define and develop the referral process for services that provide and/or increase access to disease prevention and wellness activities that address the needs of Aging PWH. Use CQI methods to ensure equitable access and engagement in services.
    - Include resources in health education/health promotion sessions in care coordination, harm reduction, mental health, and psychosocial support with such topics as; diet/nutrition, exercise, and fitness, sexual health, smoking cessation, harm reduction, social support and engagement, stress management, communicating with medical providers, technological support for virtual visits and services and any other issues included in the HHS guidance on HIV and Aging, as appropriate.
    - Ensure Food and Nutrition Providers maximize the potential of congregate meals as a means of reducing social isolation. Update provision of food so that it reflects the nutritional and dietary needs of Aging PWH.

- Utilize shared intakes or technology to allow information to be shared across programs as allowable by law.

D. **Training**:

- Identify/develop and deliver a dynamic, in-depth, comprehensive training on co-morbidities associated with aging, the disparate impact of co-morbidities on PWH, and how to moderate these impacts through prevention, wellness, and medical care.
- Develop effective educational materials to support providers and PWH's understanding of the impact of aging and the intersectional needs of Aging PWH from communities most impacted by the HIV epidemic.
- Educational materials shall be updated as needed based on the HHS guidance for HIV and Aging.

# 4. MECHANISMS

*Why do the implementation strategies you picked work to affect your implementation outcomes? Mechanisms are how we expect the strategies in the previous column will lead to the outcomes in the next column; e.g., increases in provider knowledge and willingness to utilize interventions, improved shared decision-making processes between PWH and providers, reduction in staff burnout and turnover.*

1. Increase provider screening of comorbidities associated with Aging PWH (including HCV, HPV, osteoporosis, mental health, oral health, cognition, social support, exercise, nutrition, sexual health, transgender health, medical issues specific to women (mammograms, etc.), cancer screening, substance use, smoking, CVD). (Intervention A)
2. Increase consumer self-management that support behavior changes (exercise, increased social support, engagement in specialty care, self-advocacy with medical providers) that prevent the onset of comorbidities among Aging PWH. (Interventions A, B, C, D)
3. Increase provider capacity to support Aging PWH in needed services through increase in provider knowledge of comorbidities of Aging PWH. (Interventions A, D)
4. Increase in self-efficacy rating regarding provider ability to serve Aging PWH. (Interventions A, C, D)
5. Improve consumer engagement in first-time appointments (and continued follow-up) for services that manage comorbidities for Aging PWH to reduce morbidity and mortality associated with these conditions.
6. Increase equitable access and engagement in services based on race/ethnicity, gender identity, sexual orientation, disability, geography, and income.

# 5. OUTCOMES

## Implementation Outcomes

*What changes happen as a result of the strategies you used? How would you know your implementation strategies were successful?*

These outcomes will be reported to the Planning Council on an annual basis post implementation.

# of HIV clinics providing screening/assessment for comorbid conditions. (Intervention A)
% increase in provider knowledge of common comorbidities for Aging PWH as evaluated through pretest-posttest surveys administered to training participants. (Intervention A)
% increase in appointment attendance for Aging PWH with comorbidities over 12 months (attendance at one appointment resulting from referral). (Interventions A, B, C)
% increase in consumer social support (peer delivered services, support groups, health education groups) activities over 12 months. (Intervention C)
% increase in consumer participation in fitness and exercise classes over 12 months. (Intervention C)
% increase in client perception of self-management skills when surveyed. (Intervention C)
100% adoption of referral outcome module among RWPA Outpatient Medical Care, Referral healthcare and supportive services, Care Coordination, Mental Health, Harm Reduction, and Supportive Counseling providers. (Interventions A, B, C, D)

## Clinical/Client Outcomes

*How are clients affected?*

- Increase in PWH over 50 aware of their status, retained in care, and virally suppressed. (Intervention A)
- Increase in PWH over 50 quality of life and satisfaction with HIV services. (Interventions A, B, C)
- Increase in treatment of comorbidities for PWH over 50. (Interventions A, B, C)
- Improve health outcomes for PWH over 50. (Interventions A, B, C)
- Reduction in premature death among those served. (Interventions A, B, C)

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[iv] Ibid. p.13
[v] Marcus. J. 2020.

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[xi] https://www.hivguidelines.org/hiv-care/aging-guidance/

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[xv] Community Preventive Services Taskforce. Behavioral and Social Approaches to Increase Physical Activity: Social Support Interventions in Community Settings. https://www.thecommunityguide.org/sites/default/files/assets/PA-Behavioral-Community-Support.pdf

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[xix] https://globalhealth.duke.edu/news/people-hiv-are-growing-old-and-were-not-ready-it

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[xxxiv] Ibid.
[xxxv] Singh HK, Del Carmen T, Freeman R, Glesby MJ, Siegler EL. From One Syndrome to Many: Incorporating Geriatric Consultation Into HIV Care. Clin Infect Dis. 2017 Aug 1;65(3):501-506. doi: 10.1093/cid/cix311. PMID: 28387803.
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[xxxviii] HRSA Ryan White Part A Monitoring standards definition: defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with HHS guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Allowable services include: Diagnostic testing, Early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing of medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services). Accessed at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
[xxxix] Siegler. E. Older People with HIV and Long-Term Survivors: Models of Care Presentation to the Consumer Committee of the NY HIV Health and Human Services Planning Council. April 20, 2021.
[xl] Sharma, A. "Evolving Care Needs of Older Women Living with HIV" Presentation to the Consumer Committee of the NY HIV Health and Human Services Planning Council. April 20, 2021
[xli] https://www.hivguidelines.org/hiv-care/aging-guidance/#tab_0
[xlii] HRSA Ryan White Part A Monitoring Standards definition: Services that direct a client to a service in person or through telephone, written, or other types of communication, including the management of such services where they are not provided as part of private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services . Services may include benefits/entitlement counseling and referrals to assist eligible clients in obtaining access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services. Referrals may be made: within the Non-medical Case Management system by professional case managers, informally through community health workers or support staff, or as part of an outreach program. Accessed at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
[xliii] Mental Health is defined by the World Health Organization as Mental health is an integral and essential component of health. The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. Accessed at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
[xliv] A "peer" is defined as someone living with HIV, AIDS, Hepatitis C (HCV), and/or has experience accessing Harm Reduction services. New York State AIDS Institute Peer Worker Course Catalog. March 2019. Accesssed at: PeerCertificationCourseCatalogue.pdf (hivtrainingny.org)