

## **Building Equity: Intervening Together for Health**

### **Request for Proposals**

Solicitation #: 2020.08.HIV.01.01

### **Issued by Public Health Solutions on behalf of the New York City Department of Health and Mental Hygiene**

**Issue Date: August 19, 2020**

The New York City Department of Health and Mental Hygiene (NYC DOHMH), Bureau of HIV (BHIV) is a recipient of funding for the Ending the HIV Epidemic (EHE): A Plan for America – Ryan White HIV/AIDS Program (RWHAP) Parts A and B as administered by the Health Resources and Services Administration (HRSA). Funds from this initiative are intended to provide resources to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in pre-determined jurisdictions across the nation. The EHE plan focuses on four strategies: Pillar One – *diagnose* all people with HIV as early as possible; Pillar Two – *treat* people with HIV rapidly and effectively to reach sustained viral suppression; Pillar Three – *prevent* new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs); and Pillar Four – *respond* quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.<sup>1</sup> With funds from this initiative, BHIV will focus on EHE Pillars Two and Four, treat and respond, by partnering with clinical agencies throughout NYC to implement effective strategies to reduce HIV transmission and improve HIV care outcomes.

BHIV has identified priority populations in order to prioritize the provision of tailored, equitable services to bridge gaps in health outcomes among populations that have historically been and are currently being left behind in our progress to ending the HIV epidemic in NYC. These populations include people with HIV (PWH) who identify as Black and/or Hispanic/Latino (H/L) and who identify as one of the following: cisgender women; transgender women; non-binary and/or genderqueer individuals; young people, ages 13-29; older adults, ages 50+; or cisgender, transgender, non-binary, and/or genderqueer men who have sex with men (MSM).

The impact of institutionalized racism, sexism, classism, homophobia, transphobia and other systems of oppression have contributed to imbalances and inequities along the HIV prevention, care, and treatment continuum.<sup>2</sup> To respond to these inequities, BHIV is launching a new program: Building Equity: Intervening Together for Health (BE InTo Health). Subrecipients will be selected to implement one (1) of the evidence-based interventions that will respond to the unique needs of one (1) priority population. Effective, evidence-based strategies exist that have been shown to improve health outcomes for those most vulnerable and critical in the fight to end the HIV epidemic. The evidence-based interventions proposed in this Request for Proposals (RFP) have been modified to respond to the unique needs of the NYC populations and include strategies that aim to improve engagement and re-engagement in care, initiation of immediate of antiretroviral treatment (iART), coordination of care, and ultimately, HIV outcomes among priority populations. The RFP included priority populations in the following two “Service Categories” based on the original design of the evidence-based interventions as well as the formative information collected from NYC stakeholders.

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<sup>1</sup> Azar, A. *Ending the HIV Epidemic: A Plan for America*. U.S. Department of Health & Human Services. February 5, 2019.

<sup>2</sup> Watkins-Hayes, C. (2014). Intersectionality and the sociology of HIV/AIDS: Past, present, and future research directions. *Annual Review of Sociology*, 40, 431-457.

The Service Categories are:

- Service Category 1: Black and/or Hispanic/Latina Women with HIV, including Black and/or Hispanic/Latina cisgender, transgender, non-binary and/or genderqueer women; and
- Service Category 4: Black and/or Hispanic/Latino Older People, ages 50+, with HIV.

The goals of the BE InTo Health program are to:

- Improve linkage to HIV medical care among the priority populations.
- Improve iART among the priority populations.
- Improve engagement and re-engagement in HIV care among the priority populations.
- Improve retention in HIV care among the priority populations.
- Improve VLS among the priority populations.
- Strengthen the capacity of HIV clinics to provide tailored services to priority populations.

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

The selected clinic, providing HIV primary care, will implement an evidence-based intervention (“project”) entitled: [\*Enhanced Patient Navigation for HIV-Positive Women of Color with HIV\*](#)<sup>3</sup>. This project was adapted from the HRSA Special Projects of National Significance (SPNS) Program, and has proven to improve linkage, engagement and/or re-engagement, and retention in care among Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women with HIV. Activities related to this project would include linking eligible clients to medical care; linkage to comprehensive sexual health care including STI and hepatitis C screening and care; providing iART (i.e., initiation of ART on the same-day or within 96 hours) for all eligible individuals<sup>4</sup> newly or previously diagnosed with HIV; using principles of motivational interviewing and trauma informed care to assess clients’ barriers to care and develop individualized care plans with the clients; conducting individual in-person and/or virtual structured sessions on health education topics (e.g., HIV transmission and life cycle of HIV, understanding lab values, disclosure and stigma, mental health, intimate partner violence); supporting clients in obtaining referrals for needed services (e.g., transportation, housing, etc.); offering accompaniment to internal and external appointments, and hosting group health education sessions. The intervention focuses on providing clients with enhanced services in addition to the clinic's existing case management standard of care in order to build clients’ patient trust; meet clients’ priorities first (i.e., putting the clients’ priorities ahead of service provider priorities); increase clients’ health literacy; and strengthen clients’ HIV knowledge, health beliefs, and self-efficacy in managing their care. In order to meet the needs of the priority population in this service category, the original intervention has been adapted to also include in-person and/or virtual group health education sessions to enhance social support for enrolled clients.

**Subaward(s)**

**Community Health Project, Inc.**

<sup>3</sup> Enhance Patient Navigation for HIV-Positive Women of Color. TargetHIV. <https://nextlevel.targethiv.org/deii/navigation>.

<sup>4</sup> Individuals eligible for iART include those with reactive point-of-care HIV test result, or confirmed HIV diagnosis, or suspected acute HIV infection, or known HIV infection; and no prior ART (i.e., treatment naive) or limited prior use of antiretroviral medications, and no medical conditions or opportunistic infections that require deferral of rapid ART initiation, including suspected cryptococcal or tuberculous meningitis. [https://www.hivguidelines.org/antiretroviral-therapy/when-to-start-plus-rapid-start/#tab\\_4](https://www.hivguidelines.org/antiretroviral-therapy/when-to-start-plus-rapid-start/#tab_4)

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

The selected clinic, providing HIV primary care, will implement an evidence-informed intervention (“project”) that has been adapted from University of California San Francisco’s Golden Compass Program. [The Golden Compass Program](#) is a multidisciplinary care coordination model that integrates care across several medical practices including, but not limited to, cardiovascular, neurological, and geriatric disciplines.<sup>5</sup> BHIV has adapted the *Golden Compass* Program model to fit the needs of Black and/or H/L OPWH living in NYC by adding a component of social and physical activities. The project will ensure multidisciplinary clinical and non-clinical needs are assessed and addressed. Activities of this project include utilizing trauma-informed or trauma-responsive approaches to: provide linkage to HIV medical care; linkage to comprehensive sexual health care including STI and hepatitis C screening and care; and iART (i.e., initiation of ART on the same-day or within 96 hours) for all eligible individuals<sup>29</sup> newly or previously diagnosed with HIV; conduct screening for common aging healthcare needs of Black and/or H/L OPWH; create individualized care plans for enrolled clients, including referrals to specialty care; offer care coordination and home visits; utilize telehealth to engage enrolled client; conduct multidisciplinary case conferencing; and facilitate in-person and/or virtual physical fitness classes (e.g. Zumba, yoga), in-person and/or virtual support groups, or other social events and activities. The recommended screenings for common aging health needs of Black and H/L OPWH include: [Montreal Cognitive Assessment](#) (MOCA), [Patient Health Questionnaire-9](#) (PHQ-9), [Katz Index in Activities of Daily Living](#) (ADLs), a medication review, and a fall assessment.

#### **Subaward(s)**

<p><b>Sunset Park Health Council, Inc.</b> <b>The New York and Presbyterian Hospital</b></p>
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<sup>5</sup> Greene, M. L., Tan, J. Y., Weiser, S. D., Christopoulos, K., Shiels, M., O’Hollaren, A., ... & Gandhi, M. (2018). Patient and provider perceptions of a comprehensive care program for HIV-positive adults over 50 years of age: The formation of the Golden Compass HIV and aging care program in San Francisco. *PLoS one*, 13(12).