New York State
Department of Health
Division of HIV and Hepatitis Health Care
Bureau of Community Support Services
And
Health Research Inc.

Request for Applications (RFA)
RFA #22-0011

People Aging with HIV (PAWH) Pilot – Suffolk County

Applicants may submit no more than one (1) application in response to this RFA.

KEY DATES

RFA Release Date:	**February 1, 2023**
Questions Due:	**February 15, 2023 by 4:00 PM ET**
Questions, Answers and Updates Posted: (on or about)	**March 1, 2023**
Applications Due:	**March 21, 2023 by 4:00 PM ET**

Contact Name & Address:
John Hartigan
HIV and Aging, Project Director
Bureau of Community Support Services
New York State Department of Health/AIDS Institute
Email: AIGPU@health.ny.gov

How to File an Application:

Applicants must submit one PDF version of the entire application (including Application Cover page, Application checklist, narrative and all attachments) to the following Bureau Mail Log (BML) AIGPU@health.ny.gov by the date listed in the Key Dates section above. The subject of the email line should reference PAWH RFA. Applications will only be accepted electronically to the Bureau Mail Log (BML) as stated above. Applications will not be accepted via fax, hard copy, courier, or hand delivery. Late applications will not be accepted.

Table of Contents

I. INTRODUCTION

The New York State Department of Health AIDS Institute (NYSDOH AI) and Health Research, Inc. (HRI) announce the availability of $400,000 annually in federal funding for four years to provide services to support the health of people living with diagnosed HIV over 50 years of age in the Suffolk-county region of Long Island.

A. Background/Intent

The intent of this funding is to support innovative program models that address barriers and needs of older adults living with HIV so that they can maintain optimal health, including but not limited to sustained viral suppression, improved management of co-morbidities, and improved emotional health and sense of social connectedness. When looking at the statewide data of people living with diagnosed HIV (PLWDH), those over 50 years of age were disproportionately underrepresented when looking at the age demographics of those enrolled in NYSDOH AI funded programs, which speaks to an increased need for outreach to this population. Innovative approaches are defined as models of care that are novel and not widely available across New York State (NYS). Funds will support providers that develop creative, collaborative approaches using the defined service categories to meet the unique needs of this population with a goal of reducing health disparities and health inequities.

PAWH are a priority population in the state's efforts to end AIDS as an epidemic. In 2019 these older adults comprised 56% of the entire HIV diagnosed population in NYS, a percentage that continues to rise. People with HIV now have a life expectancy near that of the general population due to the availability and use of HIV antiretroviral therapy and high rates of viral suppression among people 50 years and older.[1,2,3] Based on the Ryan White (RW) Unmet Need evaluation 9.5% of PLWDH in NYS are in care but not virally suppressed.

In addition, one (1) in every five (5) new HIV diagnoses in NYS occurs in these older adults.[4] Unfortunately, older adults who are newly diagnosed with HIV are more often likely to be concurrently diagnosed with AIDS and communities of color face the greatest disparities. Of those with late diagnosis, 47% are Black/African American, and 27% are Hispanic/Latino, even though Black/African American people make up 17.6% and Hispanic/Latino people make up 19.3% of New York's population. [5] The likelihood of receiving an AIDS diagnosis increases with age and may be indicative of inadequate testing efforts that prioritize older populations.[4]

At present, there is a lack of specialized services and supports which address the unique emerging care needs of a population aging with HIV, including long-term survivors.[6] Increasingly, providers of clinical care for people with HIV are spending less time managing HIV drug resistance and associated short-term antiretroviral (ART) toxicities and more time managing age-associated non-communicable chronic diseases (NCDs). This array of comorbidities is largely non-AIDS related [7,8,9,10] and includes chronic kidney disease [11,12,13], cardiovascular disease [14,15,16,17,18,19,20], malignancies

[21,22,23], liver disease and failure (HCV) [24,25,26], frailty [27,28,29], and mobility limitations.[30] There is also a high prevalence of chronic obstructive pulmonary disease in those living with HIV, even after an adjustment for tobacco consumption, which is also disproportionate as compared to the general population.[31]

Older adults with HIV experience a significantly higher rate of non-HIV related illnesses when compared to their peers who do not have HIV.[32,33,34] In HIV-infected people, due to the use of combination antiretroviral therapy (cART), life expectancy has increased. As a result, non-AIDS conditions which are age-associated have become more prevalent and appear earlier, resulting in accelerated aging in HIV patients. Likewise, in older adults with HIV, rates of depression and other behavioral health issues are often five times greater than observed in community samples.[35,36,37,38] High rates of depression are one of the primary indicators of non-adherence to HIV and other medications [39], leading to poor clinical outcomes.[40,41,42] People living with HIV infection are disproportionately burdened by trauma and the resultant negative health consequences. For the older adult with HIV the use of a Trauma Informed Care Model is essential.[43,44]

These older adults with HIV and their providers must engage in health care strategies that optimally address the challenges of multimorbidity, namely, the concurrent diagnosis of two or more comorbid conditions.[45,46] Multimorbidity complicates HIV care by increasing the burden of disease and increasing the likelihood of polypharmacy, the concurrent use of multiple medications by a patient to treat usually coexisting conditions, which may result in adverse drug interactions.[47,48,49] In addition, the cooccurrence of behavioral health issues is a common characteristic for this population. Many PAWH use alcohol, tobacco, and/or illicit drugs, further compromising their health and often leading to riskier sexual behaviors. [37,45,50,51] These behavioral health issues are exacerbated when older adults with HIV are socially ostracized and isolated (supra). Low social support [52,53,54] is related to poor care engagement and treatment adherence [55], which can translate into poor health care, including increased hospitalization, morbidity, and mortality.

Barriers to achieving viral suppression include ageism, HIV stigma, providers' lack of knowledge about HIV/AIDS, aging, multimorbidity, as well as pandemics and health emergencies that contribute to uncertainty, fear, and isolation.[56] Those PAWH and people of color not only face this isolation but increased stigma, lack of access to care, poverty, and racism.[57] The characteristics of the aging older adult HIV population need to embrace care delivery systems that emphasize integration and coordination.[58,59,60] Improving care for the older adult with HIV must address both providers' and patients' lack of knowledge about risk for comorbidities and how best to manage multimorbidity. These challenges can in part be addressed by implementing self-care models [61,62] and embracing geriatric care principles, especially since there is a serious shortage of geriatricians in the United States.[63,64]

This shift in the care for older adults with HIV can be facilitated by engagement and collaboration between organizations experienced in serving aging and diverse

populations such as AIDS service organizations, minority service organizations/minority health organizations, Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) entities, as well as faith-based and community-based organizations. Key partners who should be involved in carrying out implementation strategies include: Primary Care Providers /other health care and allied health providers (Nurse Practitioners, Physician Assistants, Registered Nurses, Licensed Clinical Social Workers, Licensed Master Social Workers), HIV treating and Infectious Disease physicians, aging service providers (e.g. Area Agencies on Aging), aging policy stakeholders (American Association of Retired Persons (AARP), the Administration for Community Living (ACL), SAGEUSA.org (Advocacy & Services for LGBT Elders), AIDS service organizations, LGBTQ organizations, Case/Care Management Organizations, sexually transmitted infection (STI) testing centers, as well as community-based and faith-based organizations serving at-risk older adults.

Multiple research studies find that older adults with HIV are challenged by increased levels of loneliness and social isolation. Fewer than 20% of PAWH have a partner or spouse and 70% live alone. The vast majority are Medicaid dependent and are not employed.[65] Their social support networks are inadequate to meet the twin challenges of aging and HIV.[51,52] Many remain connected to their religious congregations but have not disclosed their HIV status.[66] Many who are living with HIV have rejected, or felt rejected by, formal religious institutions and seek a sense of peace, comfort, or social support through a shared spirituality. Interventions or connections fostering resilience and strengths in HIV positive older adults may include spirituality which can have a positive impact on an individuals' sense of coherence, social support and wellbeing as measured by life satisfaction.[67,] Data suggests that low social support translates into increased hospitalization mortality in this population.[68] These findings highlight the need for tailored programs and services for this population as they lack the informal social care resources available to most other older adults.[69,70] This challenge places increased emphasis on the use of specialized case management services[71] that can facilitate connections to existing community support services for older adults.[72]

The shift in care must include efforts to address the fact that these older adults lack the social supports[73] that many have, namely partners, family members and social networks that provide emotional and day-to-day assistance with daily tasks as they age. Improving care for the older adult with HIV must address lack of knowledge about risk for comorbidities and how best to manage multimorbidity. Traditional non-HIV and HIV non aging specific social support networks are inadequate to meet the dual challenges of aging and HIV.

The health care of older adults should include the emerging use of technology, but often resistance to change or continual advances in technology, augmented by fear, lack of education, resources and guidance, create a barrier for PAWH's usage of these tools.[74] This might include the receipt of messages as reminders for appointments, refills, and reminders for taking medications as well as education and prevention tools.[75,76] Older Adults Technology Services/Senior Planet (OATS) technology and social media-based approaches are examples of effective older adult online learning and technology

education.[77] There are several published research articles describing benefits of technology, telehealth as well as mobile phone based, in terms of compliance; reminders; chronic disease management; and depression/loneliness /isolation. One well-studied and validated HIV-specific intervention is the use of the telephone to reduce depression in older adults with HIV.[78,79]

In June 2014, NYS announced a three-point plan to end the AIDS epidemic in NYS. [1] This plan provided a roadmap to significantly reduce HIV infections to a historic low by the end of 2020, with the goal of achieving the first ever decrease in HIV prevalence. The plan also aimed to improve the health of all HIV positive New Yorkers and was the first jurisdictional effort of its kind in the U.S. The three points highlighted in the plan are:

1) Identify persons with HIV who remain undiagnosed and get them linked to care;

2) Link and retain persons diagnosed with HIV in health care to maximize viral suppression; and

3) Increase access to Pre-Exposure Prophylaxis (PrEP) for persons who are HIV negative.

NYS has been laying the groundwork for ending the AIDS epidemic since the disease emerged in the early 1980s. NYS's response to the HIV/AIDS epidemic has involved the development of comprehensive service delivery systems that evolved over time in sync with the evolution of AIDS from a terminal illness to a manageable chronic disease. This strategy enabled the state to implement new technologies as they were introduced, including new treatments, new diagnostic tests and, more recently, PrEP. By building upon each individual success and relying on a strong administrative infrastructure, the state was able to roll out innovative programs quickly to achieve the greatest impact. Ending the epidemic in NYS is within reach, thanks to aggressive and systematic public health initiatives that have made it possible to drive down rates of new infections. The State's Ending the Epidemic (ETE) initiative was launched with visionary leadership and extensive stakeholder leadership and participation.

The RFA specifically addresses Blue Print (BP) #(s):

- BP4: Improve referral and engagement
- BP5: Continuously act to monitor and improve rates of viral suppression
- BP7: Use client-level data to identify and assist patients lost to care or not virally suppressed
- BP8: Enhance and streamline services to support the non-medical needs of all persons with HIV
- BP18: Health, housing and human rights for LGBT communities
- BP22: Access to care for residents of rural, suburban and other areas of the state
- BP23: Provide comprehensive sexual health education

[1] https://www.health.ny.gov/diseases/aids/ending_the_epidemic/index.htm

The ETE BP continues to guide all ETE efforts. The ETE Addendum Report is a written report that provides an overview of the past five years of New York State's ETE initiatives, as well as a summary of the community feedback sessions that were conducted in 2020 to assist in identifying areas of focus for ETE beyond 2020.

The ETE BP and the ETE Addendum report are available on the NYSDOH website at: www.health.ny.gov/endingtheepidemic

Other relevant resources are the National HIV/AIDS Strategy (NHAS) and the New York State Prevention Agenda. The National HIV/AIDS Strategy is a five-year plan that details principles, priorities, and actions to guide our collective national response to the HIV epidemic. Information on the National HIV/AIDS Strategy and updates to the strategy through 2025 can be found at: https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/. The New York State Prevention Agenda is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability and low socioeconomic groups, as well as other populations who experience them. The New York State Prevention Agenda can be found on the following website: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/.

B. Available Funding

Up to $400,000 annually in HRI funding is available for four (4) years to support programs funded through this RFA.

Funding will be allocated annually as stated in the chart below. Individual awards will not exceed $400,000.

NYSDOH Region	Annual Award Amount	Number of Awards
Long Island/Suffolk	$400,000	0-1

Applicants with offices located outside of the NYSDOH region of Suffolk County in Long Island may apply for the funding as long as the applicant can provide services in the Suffolk County region.

Applicants may submit no more than one (1) application in response to this RFA. If more than one (1) application is submitted in response to this RFA, the first application that is received will be reviewed and considered for funding. All other applications will be rejected.

- Awards will be made to the highest scoring applicant(s) in the region, up to the minimum number of awards indicated for that region.

- If there is an insufficient number of acceptable applications (scoring 70 or above) received, HRI/the NYSDOH AI reserves the right to fund an applicant scoring in the range of 60-69.

- If there is an insufficient number of fundable applications in the region, the maximum number of awards may not be met. HRI/NYSDOH/AI reserves the right to re-solicit any region where there are an insufficient number of fundable applications.

- HRI/the NYSDOH reserves the right to revise the award amounts as necessary due to changes in availability of funding.

Should additional funding become available, the NYSDOH AI and HRI may select an organization from the pool of applicants deemed not approved due to limited resources. If it is determined that the needed expertise/services are not available among these organizations, the NYSDOH AI and HRI reserve the right to establish additional competitive solicitations.

II. WHO MAY APPLY

A. Minimum Eligibility Requirements

All applicants must meet the following minimum eligibility requirements:

- Applicant must be a registered not-for-profit 501(c) (3) community-based organization or a New York State Department of Health licensed Article 28 facility;
- Applicant must have a minimum of at least three (3) years of experience providing services to PAWH; and
- Applicant must submit **Attachment 1: Statement of Assurances** signed by the Chief Executive Officer (CEO) or Designee to certify the organization meets all criteria listed on Attachment 1.

III. PROGRAM MODEL

A. Program Model Description

Applicants are encouraged to be creative and propose person-centered models of care based on the needs of the eligible priority population. The pilot programming should address barriers and needs of PAWH so that they can maintain optimal health, including but not limited to sustained viral suppression, improved management of co-morbidities, and improved perceptions of social connectedness. One intended outcome of this program is to identify new, innovative, and replicable approaches to reaching and serving PAWH. The NYSDOH AI recognizes that pilot projects are not always successful and that documenting what did not work is just as important as documenting what did work. (see **Attachment 2: Program Specific Clauses – NYSDOH AI** for a list

of unallowable costs).

Client eligibility
Eligible clients are people who meet RW eligibility criteria (see **Attachment 2: Program Specific Clauses – NYSDOH AI)** ages 50 and older, and who self-identify as having unmet physical, behavioral, and/or social health needs. Clients do not need to provide documented proof of these unmet needs in order to be eligible for services. As we know, HIV disproportionately affects people of color and those in the LGBTQ community, so applicants should assess the needs of the PAWH in their community and can propose prioritizing a subset of the PAWH population within their application.

Scope of services
Funded applicants may provide the following services. Applicants should select an array of services most appropriate for the needs of their clients. **Case Management is a required service for funded applications.**

(1) **Outreach**: Funded applicants should provide clearly defined outreach services to the priority population to raise awareness of the availability of services provided by funded program. Programs are encouraged to be creative in their use of outreach mechanisms to secure the participation of PAWH and especially identify new, PAWH who may benefit from the proposed services. One outcome is to increase the number of PAWH enrolled in NYSDOH AI funded programs who have previously not been served.

(2) **Non-Medical Case Management (NMCM) or Medical Case Management (MCM)**: Funded applicants will be required to provide case management, following standards developed by the NYSDOH AI. The case management program staff must demonstrate the capacity to coordinate care and health supports across a diverse and complex array of systems, given the increased risk for co-morbidities that PAWH face compared to younger PLWH. NMCM is provided in community settings and MCM is provided in medical settings.

Non-Medical Case Management activities and interventions include but are not limited to initial assessment of service needs; development of a comprehensive, individualized care plan; timely and coordinated access to medically appropriate level of health and support services and continuity of care; client specific advocacy and/or utilization of services; continuous client monitoring to assess the efficacy of the care plan; re-evaluation of the care plan at least annually; and ongoing assessment of the client's and other key family members needs and personal support systems.

Medical Case Management activities and interventions include but are not limited to initial assessment of service needs; development of a comprehensive, individualized care plan; re-evaluation of the care plan at least annually; ongoing assessment of the client's and other key family members needs and personal support systems; treatment adherence counseling to endure readiness and

adherence to complex HIV and other medical treatments; and client specific advocacy and/or utilization of services.

In addition, both case management models should incorporate referrals to services; negotiation for services; coaching and skills development; addressing personal, cultural, and systemic barriers to engagement in care; general education; navigation of healthcare systems; and appointment and ongoing support. Case management services pro-actively address the immediate and ongoing needs presented by the individual. There is a strong focus on linking, engaging, and re-engaging consumers to care and treatment, with an emphasis on frequent contact as a means of retaining the consumer in care, avoiding health-related crises, and achieving self-management.

Case management providers must establish and document active bi-directional linkages with providers of services including but not limited to primary medical care services; insurance based or other medical case management; if necessary, behavioral health (both mental health and substance abuse treatment) services; housing and entitlement services; nutrition services; transportation services; and legal services.

(3) **Health Education/Risk Reduction:** Age-appropriate sexual health education is necessary to address the unique needs of those aging. Health provider's ageism, older adults' reluctance to discuss sexuality, and their misconception of their HIV risk can all complicate an older adult's understanding of their risk and require a different approach to education. Education will also promote self-advocacy and ensure clients can manage multimorbidity, polypharmacy etc., and can confidentially and competently communicate with medical providers, adherence, behavioral health, etc.

(4) **Psychosocial Support:** Psychosocial support includes activities to increase social supports, such as groups and peer services. The use of Peer Navigators is required for funded applicants. The National HIV/AIDS Strategy for the United States, updated to 2025, states a culturally competent and skilled workforce is vital to developing a model of competent care which includes peer navigators. Peers are a valuable community resource lending credibility and cultural competence to a program. Peers can be particularly helpful with individuals who are sporadically engaged in or resistant to care, and they also provide an additional social support. Peers can assist with outreach, contacting and engaging consumers, accompany clients on clinical and supportive service appointments, assist with technology, provide encouragement as well as coaching elements, assist clients in self-advocacy and self-management, and assist with monitoring of progress. Peers can also assist a Health Educator during sessions but cannot be the main/sole facilitator. Peers provide a culturally competent approach to self-management that incorporates the sharing of similar experiences and strategies for success from an individual who has navigated similar systems.

(5) **Insurance navigation**: The NYSDOH AI currently funds programs to facilitate enrollment into comprehensive health insurance coverage. The intent of funding the "insurance navigation" service is NOT to duplicate the work of providers funded under the "Outreach and Enrollment to Increase Minority Enrollment in the AIDS Drug Assistance Program." Rather, the intent is to provide enhanced support for navigating specific reimbursement issues particularly for those enrolled in Medicare or both Medicaid and Medicare with multiple co-morbidities. This includes providing support to individuals transitioning into the Medicare program from Medicaid; ensuring continuity of care as not all medical providers accept Medicare as payor. Staff may assist individuals in identifying any potential gaps in coverage and/or care.

(6) **Cognitive, physical, and behavioral screening services**: Given the aging of the population, PAWH may have multiple health problems. Besides the complexity of managing multiple morbidities, other concurrent factors can impact medical, behavioral, and social health. Identification of conditions, both medical and those related to the psycho-social status or the environment, increase in importance for PAWH because they frequently coexist with and interfere with maintaining health-related quality of life. Performing age specific systematic assessments (e.g., frailty, cognitive function, elder abuse, depression) is relevant for health and well-being, since these factors may be overlooked or are under-identified due to time constraints in care settings and/or the lack of specific training. Screening by trained/licensed professionals or supervised by trained/licensed professionals is essential to identify PAWH who may need further comprehensive assessments and/or specific interventions. Incorporating virtual or in-person geriatric consultation and/or services is highly recommended.

(7) Additional services identified by the contractor that are consistent with the goals and eligible costs as stipulated in this RFA. For example, applicants may have innovative ideas that support the goals of this RFA but are not specifically mentioned above as fundable services; applicants are encouraged to propose such ideas in this RFA.

Minimum Required Staffing

All funded programs must adhere to the minimum staffing requirements, but staffing should meet the needs of the priority population in the applicant's community. A comprehensive holistic approach to care is critical. Funding for the positions under this initiative may **NOT** be blended with other initiatives or funding streams (the data/quality position is an exception).

(1) One or more 1.0 Full Time Equivalent (FTE) positions to provide the complement of services described above and in the provider's grant application.

The minimum qualifications for this position are:

- B.A. or B.S. with at least two (2) years of experience working in the field of HIV/AIDS or other chronic illness;

- Possess an understanding of community level work and the importance of collaborating and coordinating with other organizations;
- Effective communication and documentation skills;
- Cultural and linguistic competence for the population served; and
- Preferred qualification: BSN or RN level or other professional with two (2) years medical or geriatric experience.

(2) One or more Peer Navigator(s) to:
- Conduct outreach and engagement efforts to engage and retain consumers in care;
- Coach consumers in self-advocacy and self-management;
- Accompany consumers on clinical and supportive service appointments; and
- Assist Case Managers during some interventions.

The minimum qualifications for a Peer Navigator are:
- Ability to speak and write clearly;
- Be reflective of the communities/populations being served (bilingual, PAWH, African American, Latino, LGBTQ, former substance users, etc.); and
- Be knowledgeable about the region's services and familiar with navigating the systems of care.

(3) At least .5 FTE position to provide quality, data, and evaluation activities consistent with tracking outcomes as described in the next section and the application. Funding for this position under this initiative may be blended with other initiatives or funding streams.
The recommended qualifications for this position are:
- B.A. or B.S. with at least two (2) years of experience working in data/evaluation.

Outcomes
The intended outcomes of this initiative are to develop a set of best practices for engaging and providing high quality services to older PAWH, reduce racial and ethnic disparities, and demonstrate success in the following areas:

1. Increased connections to, and engagement of, PAWH who have not received NYSDOH AI funded services in the past five (5) years;
2. Increased rates of sustained HIV viral load suppression;
3. Improved ability to self-manage multiple co-morbid health conditions;
4. Improved perceptions of social connectedness;
5. Improved perceptions of sexual health;
6. Fewer identified unmet needs;
7. Identify new, innovative, and replicable approaches to reaching and serving PAWH over the age of 50; and

The best practices identified by applicants during this round of funding may be used to inform future potential funding solicitations.

Applicants may subcontract components of the scope of work. For those applicants that propose subcontracting, it is preferable to identify subcontracting agencies during the application process. Applicants that plan to subcontract are expected to state in the application the specific components of the scope of work to be performed through subcontracts. Applicants should note that the lead organization (contractor) will have overall responsibility for all contract activities, including those performed by subcontractors, and will be the primary contact for the NYSDOH AI/HRI. All subcontractors should be approved by the NYSDOH AI/HRI.

Demonstration of Cultural and Linguistic Competency

In order to effectively engage clients and provide high-quality services, a meaningful, trusting partnership should be developed between provider and client. Programs should be designed with an understanding of the differences that derive from language, culture, race/ethnicity, religion, age and developmental characteristics. Programs would benefit from using *The Guide to Providing Effective Communication and Language Assistance Services* within their organization. This Guide is grounded in the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (or the National CLAS Standards), which were developed by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) as a means to advance health equity, improve health care quality, and help eliminate health care disparities. Applicants should also review the topic of Structural Competency, which aims to develop a language and set of interventions to reduce health inequalities at the level of neighborhoods, institutions and policies. Organizations that address structural competency can be more attentive to social determinants of health in patients/clients, shift how clients are understood, and potentially increase empathy for marginalized clients.

Demonstration of a Commitment to Health Equity

Health Equity (HE) is the fair and just opportunity for everyone to achieve optimal holistic health and well-being regardless of social position or other social or structural determinants of health. This requires addressing avoidable inequalities (e.g., access to affordable and high-quality food, housing, education, health care/services, and safe environments), historical and contemporary injustices (e.g., economic injustice/poverty, racism, classism, ableism, sexism, homophobia, transphobia, xenophobia, and other forms of oppression, discrimination, and/or stigma) and valuing health differences equally. We also acknowledge the historical and structural underpinnings of race, racism, and genocide in the United States that perpetuate many of the racial inequities we see manifested today. Because health equity can never truly be achieved without racial equity, we work toward achieving both.

The NYSDOH AI works closely with its community partners to identify and respond to current needs. The needs are wide and varied, but they center on addressing social determinants, socioeconomic status, education, housing, transportation, employment,

cultural competence, access to healthcare services and discrimination.

The NYSDOH AI is committed to ensuring our funded programs and partners are equipped with the knowledge, skills, and expertise to adequately address health and social inequities. We are all accountable to pay attention to the intersections of race and health equity. We are committed to the implementation of new and tailored approaches to address the challenges faced by our Black/Brown, Indigenous, and People of Color (BIPOC) communities. In our mission to ensure that everyone has a fair chance to experience optimal health, we are employing the following health equity principles:

- Be Explicit
- Identify and Effectively Address Racism and Racial Implicit Biases.
- Adopt a "Health in all Policies" Approach.
- Create an Internal Organization-Wide Culture of Equity.
- Respect and Involve Communities in Health Equity Initiatives.
- Measure and Evaluate Progress in Reducing Health Disparities.

B. Requirements for the Program

All applicants selected for funding will be required to:

1. Adhere to Health Literacy Universal Precautions (AHRQ Health Literacy Universal Precautions Toolkit | Agency for Healthcare Research and Quality);
2. Serve a cross-section of clients who are representative of the overall (HIV and aging) population demographics within the selected community;
3. Participate in a collaborative process with the NYSDOH AI to assess program outcomes and provide monthly narrative reports describing the progress of the program with respect to: 1) implementation, 2) client recruitment, 3) significant accomplishments achieved, and 4) barriers encountered and plans to address noted problems;
4. Submit statistical reports on clients served, and other data using the NYSDOH AI Reporting System (AIRS). Successful applicants must demonstrate the capacity to collect and report all required data, both personnel and hardware-related using AIRS. AIRS is a data reporting system that is required by the NYSDOH AI to report client demographic information as well as program activities. The NYSDOH AI requires maintenance and reporting of unduplicated client level data, including demographics and service histories, in accordance with applicable federal and/or state reporting requirements. The NYSDOH AI provides and supports the AIRS software to enable providers to meet data submission requirements. Details on this software product may be obtained by accessing the following Internet address, www.airsny.org;
5. Participate in quality management activities as established by the NYSDOH AI. This includes, but not limited to, the collection and reporting of data for use in measuring performance and identifying quality improvement projects. Quality management activities require a quality management infrastructure, including commitment from agency leadership, development of a quality management plan

that incorporates the principles of a proven quality improvement framework, staff development and training, and a process that supports participation of staff from all levels and various disciplines, and consumer involvement; and

6. Address and assess the specific social and/or structural determinants of health. The unequal distribution of social and/or determinants can lead to disparities and ultimately inequities in health and health outcomes. Strategies should prioritize those populations that are most impacted, negatively, by social and structural determinants of health.

   Please see **Attachment 3** for **Health Equity Definitions and Examples** of social and structural determinants of health.

IV. ADMINISTRATIVE REQUIREMENTS

A. Issuing Agency

This RFA is issued by the New York State Department of Health AIDS Institute, Division of HIV and Hepatitis Health Care, Bureau of Community Support Services, and Health Research Inc. The Department and HRI are responsible for the requirements specified herein and for the evaluation of all applications.

B. Question and Answer Phase

All substantive questions must be submitted via email to:

AIGPU@health.ny.gov

To the degree possible, each inquiry should cite the RFA section and paragraph to which it refers. **Written questions will be accepted until the date posted on the cover of this RFA.**
Questions of a technical nature can also be addressed in writing at the email address listed above. **Questions are of a technical nature if they are limited to how to prepare your application (e.g., formatting) rather than relating to the substance of the application.**

All questions submitted should state "*PAWH RFA*" in the subject line.

This RFA has been posted on HRI's public website at:
http://www.healthresearch.org/funding-opportunities.

Questions and answers, as well as any updates and/or modifications, will also be posted on HRI's website. All such updates will be posted by the date identified on the cover sheet of this RFA.

Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the

submission of an application.

C. Letter of Intent

Letters of Intent are not a requirement of this RFA.

D. Applicant Conference

An Applicant Conference will not be held for this project.

E. How to File an Application

Applicants must submit one PDF version of the entire application (including Application Cover Page, Application checklist, narrative and all attachments) to AIGPU@health.ny.gov by 4:00 pm ET on the date posted on the cover page of this RFA. The subject of the email line should reference "PAWH RFA."

It is the applicant's responsibility to see that applications are emailed to AIGPU@health.ny.gov by 4:00 PM ET on the date specified. **Applications will only be accepted electronically to the Bureau Mail Log (BML) as stated on the cover page. Applications will not be accepted via fax, hard copy, courier, or hand delivery. Late applications will not be accepted.**

F. Department of Health's and HRI's Reserved Rights

The Department of Health and HRI reserve the right to:

1. Reject any or all applications received in response to this RFA.
2. Withdraw the RFA at any time, at the Department's or HRI's sole discretion.
3. Make an award under the RFA in whole or in part.
4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.
5. Seek clarifications and revisions of applications.
6. Use application information obtained through site visits, management interviews and the state's investigation of an applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFA.
7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.
8. Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RFA amendments.
9. Change any of the scheduled dates.
10. Waive any requirements that are not material.
11. Award more than one contract resulting from this RFA.
12. Conduct contract negotiations with the next responsible applicant, should the

Department be unsuccessful in negotiating with the selected applicant.
13. Utilize any and all ideas submitted with the applications received.
14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening.
15. Waive or modify minor irregularities in applications received after prior notification to the applicant.
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's application and/or to determine an offerer's compliance with the requirements of the RFA.
17. Negotiate with successful applicants within the scope of the RFA in the best interests of the State and HRI.
18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.
19. Award grants based on geographic or regional considerations to serve the best interests of the state and HRI.

G. Term of Contract

Any contract resulting from this RFA will be effective only upon approval by Health Research Inc. Refer to **Attachment 4: HRI General Terms and Conditions**. Contracts resulting from this RFA will be for 12-month terms. The anticipated start date of the contract is **September 1, 2023**. However, depending on the funding source, the initial contract term could be for a shorter time period. HRI awards may be renewed for up to three (3) additional annual contract periods through November 30, 2027, based on satisfactory performance and availability of funds. HRI reserves the right to revise the award amount as necessary due to changes in the availability of funding.

H. Payment & Reporting Requirements of Grant Awardees

1. Due to requirements of the federal funder, no advance payments will be allowed for HRI contracts resulting from this procurement.

2. The funded contractor will be expected to submit voucher claims and reports of expenditures in the manner that HRI requires. Required forms will be provided with the contract package.

All payments and reporting requirements will be detailed in Exhibit "C" of the final contract.

I. General Specifications

1. By signing **Attachment 5: Application Cover Page**, each applicant attests to its express authority to sign on behalf of the applicant.

2. Contractors will possess, at no cost to HRI, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by HRI and the Department during the Question and Answer Phase (Section IV.B.) must be clearly noted in Attachment 5 (Application Cover Page).

4. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

5. Provisions Upon Default

   a. The services to be performed by the Applicant shall be at all times subject to the direction and control of HRI and the Department as to all matters arising in connection with or relating to the contract resulting from this RFA.

   b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, HRI and the Department acting for and on behalf of the State, shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.

   c. If, in the judgment of the Department and HRI, the Applicant acts in such a way which is likely to or does impair or prejudice the interests of the State and HRI, the Department and HRI acting on behalf of the State, shall thereupon have the right to terminate any contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

6. Applicant must maintain an active registration in the System for Award Management (SAM) at SAM.gov, have no exclusions or delinquent federal debt.

V. COMPLETING THE APPLICATION

A. Application Format and Content

Please respond to each of the following statements and questions. Your responses comprise your application. ***Number/letter your narrative to correspond to each statement and question in the order presented below.*** Be specific and complete in your response. Indicate if the statement or question is not relevant to your agency or proposal. The value assigned to each section is an indication of the relative weight that will be given to that section when your application is scored.

An applicant checklist has been included to help ensure that submission requirements have been met. Applicants should review this attachment before and after writing the application. **In assembling your application, please follow the outline provided in Attachment 6: Application Checklist.**

Applications should not exceed **twelve** (12) double-spaced pages, (not including the budget, and all attachments) using a 12-pitch type font with one-inch margins on all sides. Pages should be numbered consecutively, including all attachments. The Application Cover Page (Attachment 5), Program Abstract, budget and budget justification, and all attachments are **not included** in the twelve (12) page limitation. Please submit only requested information in attachments and do not add attachments that are not requested. **Failure to follow these guidelines will result in a deduction of up to ten (10) points.** When responding to the statements and questions, be mindful that application reviewers may not be familiar with the agency and its services. Therefore, answers should be specific, succinct, and responsive to the statements and questions as outlined.

Application Format

1.	Program Abstract	Not Scored	
2.	Community and Agency Description	Maximum Score:	15 points
3.	Health Equity	Maximum Score:	15 points
4.	Program Design and Implementation	Maximum Score:	50 points
5.	Budget and Justification	Maximum Score:	20 points
			100 points

1. Program Abstract — Not Scored

Applicants should provide a program abstract with the following information:

1a) Describe the proposed program. Include what will be completed and how.
1b) What are the Project goals and objectives?
1c) Besides the people over 50 aging with HIV, what other sub-populations do you anticipate serving? Indicate the total number of unduplicated clients over 50 to be served and the estimated number for each sub-population.
1d) What types of outcomes does your organization expect to achieve? How will success be measured?

2. Community and Agency Description **Maximum 2 Pages**
Maximum Score: 15 points

2a) Describe why the applicant is qualified to implement the proposed program model (including the number of years the applicant has served PAWH). Include organizational description, leadership and staff providing both quantitative and qualitative evidence to address this question. Applicants are instructed to include their **Organizational Chart** as **Attachment 7.**

2b) Describe the other programs and agencies in the geographic area that are relevant to your proposed program model and how you will leverage these programs to maximize benefit to people aging with HIV in your community without supplanting other resources. Applicants are instructed to complete and include the **Services Linkages Chart** as **Attachment 8.**

2c) Describe any prior grants your organization has received that are relevant to this proposal. Include the results of the program and successes of those grants. OR, if your organization has not received funding from the NYSDOH AI, describe any similar types of programs that your organization has undertaken in the past, including the identified results of the program and the successes in achieving those results.

3. Health Equity **Maximum 1 Page**
Maximum Score: 15 Points

3a) Which SDOH(s) barriers will you address with the priority population served by this funding?

3b) Please provide the most current data that you have used to identify the SDOH barriers affecting the population served by the funding.

3c) Describe how you will monitor and evaluate the immediate impact of your efforts to address the SDOH(s). (i.e., if you have offered nutrition or housing services, for example, to a client and they have responded, has it improved their adherence with treatment?)

3d) What is your organization's policy around addressing SDOH(s)? What is the agency's capacity (staff knowledge, staff training, support for collaboration and evaluation) at addressing this?

3e) How does the organization's leadership reflect the population served?

4. Program Design and Implementation **Maximum 9 Pages**
Maximum Score: 50 points

4a) Describe the community or communities you will serve through this funding. Besides the PAWH population, include a description of any priority sub-

population; the geographic area to be served; the service location(s) within the proposed service area; and site accessibility for the priority population. Applicants are instructed to complete **Attachment 9: Sites, Days, and Hours of Operations chart.**

4b) Describe your overall program design. Include descriptions of specific strategies for implementing the program services to PAWH, including strategies related to outreach, case management, activities to increase social supports, insurance navigation, and cognitive and behavioral screening services. Describe any innovative strategies you will utilize to implement your program model and the rationale or evidence that has informed the strategy. Describe how PAWH will be involved in the design, implementation, and evaluation of program services. Describe how peers will be utilized by the program model, including how peers will be selected, trained and the types of peer services that will be provided. Describe the timeline for implementing your program. Applicants are instructed to complete and include the **Program Timeline** as **Attachment 10.**

4c) Describe key community partnerships required for successful implementation of the proposed program and how clients' access to and engagement in these services will be facilitated, coordinated, recorded, reported, and evaluated for outcomes.

4d) Provide an estimate of the number of clients your organization proposes to serve in your PAWH program. Include the number and demographic breakdown of clients you served for the past two (2) years. Include the number of new clients over the age of 50 your agency has recruited in the past two years.

4e) Describe your program's indicators for successfully achieving outcomes outlined in the RFA. Describe how you will track and measure the program indicators and apply a continuous quality improvement framework to ensure that indicators falling below targets are addressed and improved.

4f) If this program builds upon an existing model, indicate previous outcomes and any changes that were made to the model to improve outcomes and to accommodate PAWH. If this is a new service, include a rationale for why your organization expects this model will work. Include any evidence of pilot programs to demonstrate potential success.

4g) Describe how data will flow from point of service delivery to entry into AIRS. Include how your organization will collect, analyze, and report client level and programmatic data. If using an electronic health record (EHR), describe how data is extrapolated from this to AIRS and other tracking systems.

4h) Describe how the proposed staffing plan meets the minimum requirement and innovations described in the program model. Explain the modifications made that will enhance service delivery and improve program outcomes and provide the rationale. Provide a brief description of each position's roles and responsibilities,

along with job qualifications, educational background, licensures, and experience required for each position. Staff roles and responsibilities for AIRS activities (System administration, data entry, data quality control and NYSDOH AI reporting) should be included. If in-kind staff are included in the proposed program, they should be included in the staffing detail. Applicants are instructed to complete the **Agency Capacity and Staffing Information** form as **Attachment 11**.

4i) Describe the plan for initial and ongoing staff training and support. Describe the agencies health equity training plan, current and proposed.

4j) Describe how the organization will assess that the services provided are culturally competent and linguistically appropriate.

5. Budgets and Justifications **Total 20 Points**

Complete and submit a budget following these instructions:

5a) Applicants are instructed to prepare an annual budget based on the maximum award as listed in Section I.B. Available Funding. Complete all required Budget Pages. See **Attachment 12: HRI Expenditure Based Budget Summary**. Instructions for completing the budget forms are included as **Attachment 13: Instructions for Completion of Budget Forms for Solicitations**. All budget lines should be calculated using whole dollar amounts. All costs should be related to the proposed activities, as described in the application narrative, and should be justified in detail. All costs should be reasonable and cost-effective. Contracts established resulting from the RFA will be cost reimbursable.

5b) For staff listed in the Personal services (Salary and Fringe) section of the budget, include a breakdown of the total salary needs for staff. Indicate how the positions relate to program implementation. Applicants are instructed to include a justification for each of the requested FTE's and for the fringe benefits requested.

5c) For each item listed under Non-Personal services, describe how it is necessary for program implementation. Non-Personal services include: Supplies, Travel, Equipment, Space/Property, Telecommunications, Miscellaneous costs, Contractual and Operating Expenses.

5d) For the last three (3) years, does your organizations' Statement of Activities from your yearly audit show that revenues exceeded expenses or expenses exceeded revenue? If the expenses exceeded revenues, please describe both the cost reduction plan and the deficit reduction plan that will correct this. Please attach the **Statement of Activities** from your yearly audit for the last three (3) years as **Attachment 14**. The Statement of Activities must show total support and revenue and total expenditures.

5e) Applicants are required to submit a copy of the agency's most recent **Yearly Independent Audit** attached as **Attachment 15.**

5f) Applicants are required to submit a copy of their agency **Time and Effort policy** as **Attachment 16.**

5g) Describe the specific internal controls your agency uses to comply with the Federal Uniform Guidance (2 CFR 200).

5h) Funding requests must adhere to the following guidelines:

- An indirect cost rate of up to 10% of total modified direct costs can be requested. If your organization has a federally approved rate, an indirect cost rate of up to 20% of total direct costs can be requested. If your agency has a federally approved rate of less than 20%, the maximum indirect rate that can be requested is the federally approved rate.
- Funding may only be used to expand existing activities and create new activities pursuant to this RFA. Funds may **not** be used to supplant funds for currently existing staff and activities.
- Ineligible budget items will be removed from the budget prior to contracting. Ineligible items are those items determined by NYSDOH/HRI to be inadequately justified in relation to the proposed program or not fundable under existing federal guidance (Uniform Guidance). The budget amount requested will be reduced to reflect the removal of the ineligible items.

B. Freedom of Information Law

All applications may be disclosed or used by NYSDOH to the extent permitted by law. NYSDOH may disclose an application to any person for the purpose of assisting in evaluating the application or for any other lawful purpose. All applications will become State agency records, which will be available to the public in accordance with the Freedom of Information Law. **Any portion of the application that an applicant believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the application.** If NYSDOH agrees with the proprietary claim, the designated portion of the application will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

C. Application Review & Award Process

Applications meeting the eligibility requirements and guidelines set forth above will be reviewed and evaluated competitively by a panel convened by the NYSDOH AI using an objective rating system reflective of the required items specified for each component.

The NYSDOH AI anticipates that there may be more worthy applications than can be

funded with available resources. Please see Section I. B of the RFA for specific review and award information. Applications will be deemed to fall into one of three categories: 1) approved and funded, 2) not funded, due to limited resources, and 3) not approved. Not funded applications may be awarded should additional funds become available.

In cases in which two or more applicants for funding are judged on the basis of their written applications to be equal in quality, the applicant with the highest score for Section 3 (Health Equity) will receive the award.

Applications with minor issues (missing information that is not essential to timely review and would not impact review scores) MAY be processed, at the discretion of the State, but all issues need to be resolved prior to time of award. An application with unresolved issues at the time award recommendations are made will be determined to be non-responsive and will be disqualified.

NYSDOH AI and HRI reserve the right to revise the award amounts as necessary due to changes in the availability of funding. If changes in funding amounts are necessary for this initiative, funding will be modified and awarded in the same manner as outlined in the award process described above. NYSDOH AI and HRI reserve the right to review and rescind all subcontracts.

Once the awards have been made, applicants not funded may request a debriefing of their application. Please note the debriefing will be limited only to the strengths and weaknesses of the subject application and will not include any discussion of other applications. Requests must be received no later than fifteen (15) calendar days from date of award or non-award announcement.

In the event unsuccessful applicants wish to protest the award resulting from this RFA, applicants should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found on the OSC website at *http://www.osc.state.ny.us/agencies/guide/MyWebHelp*. (Section XI. 17.)

To request a debriefing, please send an email to AIGPU@health.ny.gov.
In the subject line, please write: *Debriefing request (PAWH).*

VI. REFERENCES

1. Autenrieth CS, Beck EJ, Stelzle D, Mallouris C, Mahy M, Ghys P. Global and regional trends of people living with HIV aged 50 and over: Estimates and projections for 2000-2020. PLoS One. 2018 Nov 29;13(11):e0207005. doi: 10.1371/journal.pone.0207005. PMID: 30496302; PMCID: PMC6264840.
2. Katz IT, Maughan-Brown B. Improved life expectancy of people living with HIV: who is left behind? Lancet HIV. 2017 Aug;4(8):e324-e326. doi: 10.1016/S2352-3018(17)30086-3. Epub 2017 May 10. PMID: 28501496; PMCID: PMC5828160.
3. Antiretroviral Therapy Cohort Collaboration. Survival of HIV-positive patients starting antiretroviral therapy between 1996 and 2013: a collaborative analysis of cohort studies. Lancet HIV. 2017 Aug;4(8):e349-e356. doi: 10.1016/S2352-3018(17)30066-8. Epub 2017 May 10. PMID: 28501495; PMCID: PMC5555438.

4. NYSDOH. New York State HIV/AIDS Annual Surveillance Report: For Cases Diagnosed Through 2013. In: http://www.health.ny.gov/diseases/aids/general/statistics/annual/2013/2013-12_annual_surveillance_report.pdf 2015.
5. United States Census Bureau, Quick Facts (New York). Population Estimates, July 1 2021 (Race and Hispanic Origin)
6. Slomka J, Lim JW, Gripshover B, Daly B. How Have Long-Term Survivors Coped With Living With HIV? J Assoc Nurses AIDS Care 2012
7. Lopez C, Masia M, Padilla S, Aquilino A, Bas C, Gutierrez F. [Deaths due to non-AIDS diseases among HIV infected patients: A 14-year study (1998-2011)]. Enferm Infecc Microbiol Clin 2015.
8. Zhang S, van Sighem A, Kesselring A, Gras L, Prins JM, Hassink E, et al. Risk of non-AIDS-defining events among HIV-infected patients not yet on antiretroviral therapy. HIV Med 2015,16:265- 272.
9. Zhang S, van Sighem A, Kesselring A, Gras L, Prins J, Hassink E, et al. Risk of non-AIDS-defining events among HIV-infected patients not yet on antiretroviral therapy. HIV Med 2015.
10. Zucchetto A, Suligoi B, De Paoli A, Pennazza S, Polesel J, Bruzzone S, et al. Excess mortality for non-AIDS-defining cancers among people with AIDS. Clin Infect Dis 2010,51:1099-1101.
11. Malkina A, Scherzer R, Shlipak MG, Bacchetti P, Tien PC, Grunfeld C, et al. The association of adiposity with kidney function decline among HIV-infected adults: findings from the Fat Redistribution and Metabolic Changes in HIV Infection (FRAM) study. HIV Med 2015,16:184-190.
12. Hsieh MH, Lu PL, Kuo MC, Lin WR, Lin CY, Lai CC, et al. Prevalence of and associated factors with chronic kidney disease in human immunodeficiency virus-infected patients in Taiwan. J Microbiol Immunol Infect 2015,48:256-262.
13. Adedeji TA, Adedeji NO, Adebisi SA, Idowu AA, Fawale MB, Jimoh KA. Prevalence and Pattern of Chronic Kidney Disease in Antiretroviral-Naive Patients with HIV/AIDS. J Int Assoc Provid AIDS Care 2015,14:434-440.
14. Ntobeko N, O'Dwyer E, Dorrell L, Wainwright E, Piechnik S, Clutton G, et al. HIV-1-Related Cardiovascular Disease Is Associated With Chronic Inflammation, Frequent Pericardial Effusions, and Probable Myocardial Edema. Circulation: Cardiovascular Imaging 2016,9:1.
15. Nou E, Lo J, Hadigan C, Grinspoon SK. Pathophysiology and management of cardiovascular disease in patients with HIV. The Lancet Diabetes & Endocrinology 2016.
16. Kaplan RC, Hanna DB, Kizer JR. Recent Insights Into Cardiovascular Disease (CVD) Risk Among HIV-Infected Adults. Curr HIV/AIDS Rep 2016,13:44-52
17. Feinstein MJ, Bahiru E, Achenbach C, Longenecker CT, Hsue P, So-Armah K, et al. Patterns of Cardiovascular Mortality for HIV-Infected Adults in the United States: 1999 to 2013. Am J Cardiol 2016,117:214-220.
18. Koethe JR, Grome H, Jenkins CA, Kalams SA, Sterling TR. The metabolic and cardiovascular consequences of obesity in persons with HIV on long-term antiretroviral therapy. AIDS 2015.
19. Ho JE, Scherzer R, Hecht FM, Maka K, Selby V, Martin JN, et al. The association of CD4+ T-cell counts and cardiovascular risk in treated HIV disease. AIDS 2012,26:1115-1120.
20. Freiberg M. The Association Between Alcohol Consumption and Prevalent Cardiovascular Diseases Among HIV-Infected and HIV-Uninfected Men. J Acquir Immune Defic Syndr 2010,53.
21. Zucchetto A, Virdone S, Taborelli M, Grande E, Camoni L, Pappagallo M, et al. Non-AIDS Defining Cancer Mortality: Emerging Patterns in the Late HAART Era. J Acquir Immune Defic Syndr 2016.
22. Yanik EL, Katki HA, Engels EA. Cancer Risk among the HIV-Infected Elderly in the United States. AIDS 2016.
23. Wise J. Older patients with HIV should be offered cancer screening, study recommends. BMJ 2015,351:h5262
24. Neukam K, Mira JA, Collado A, Rivero-Juárez A, Monje-Agudo P, Ruiz-Morales J, et al. Liver Toxicity of Current Antiretroviral Regimens in HIV-Infected Patients with Chronic Viral Hepatitis in a Real-Life Setting: The HEPAVIR SEG-HEP Cohort. PLoS ONE 2016,11:1-12.
25. Kim HN, Nance R, Van Rompaey S, Delaney JC, Crane HM, Cachay ER, et al. Poorly Controlled HIV Infection: An Independent Risk Factor for Liver Fibrosis. J Acquir Immune Defic Syndr 2016.
26. Swanson S, Ma Y, Scherzer R, Huhn G, French AL, Plankey MW, et al. Association of HIV, Hepatitis C Virus, and Liver Fibrosis Severity with the Enhanced Liver Fibrosis Score. J Infect Dis 2015.
27. Kooij KW, Wit FW, Schouten J, van der Valk M, Godfried MH, Stolte IG, et al. HIV infection is independently associated with frailty in middle-aged HIV type 1-infected individuals compared with similar but uninfected controls. AIDS 2016,30:241-250.

28. Gustafson DR, Shi Q, Thurn M, Holman S, Minkoff H, Cohen M, et al. Frailty and Constellations of Factors in Aging HIV-infected and Uninfected Women--The Women's Interagency HIV Study. J Frailty Aging 2016,5:43-48.
29. Watson S. HIV and frailty: Just another symptom? HIV Nursing 2015,15:38
30. Vearey J. HIV, Population Mobility, and the Post-Conflict Nexus: Unpacking Complexity. International Peacekeeping 2013,20:439-449.
31. Bigna J, Halaha Kenne A, Asangbeh S, and Siibetcheu A. Prevalence of chronic obstructive pulmonary disease in the global population with HIV. 2018 Feb; 6 (2): e193-e202.doi: 10.1016/S2214-109X(17)20451-5/ Epub2017 Dec16.
32. Salter MLaLAUBaGVFaMSHaKGD. HIV Infection, Immune Suppression, and Uncontrolled Viremia Are Associated with Increased Multimorbidity Among Aging Injection Drug Users. Clinical infectious diseases: an official publication of the Infectious Diseases Society of America 2011,53:1256--1264.
33. Justice A, Falutz J. Aging and HIV: an evolving understanding. Curr Opin HIV AIDS 2014,9:291- 293.
34. Gallant J, Gebo K, High K, Horberg M, Justice A. Advances in HIV treatment uncover a new issue: Aging. Aging Infectious Disease News 2014.
35. Lovejoy TI, Heckman TG, Sikkema KJ, Hansen NB, Kochman A. Changes in sexual behavior of HIV-infected older adults enrolled in a clinical trial of standalone group psychotherapies targeting depression. AIDS Behav 2015,19:1-8.
36. Lovejoy TI, Heckman TG. Depression Moderates Treatment Efficacy of an HIV SecondaryPrevention Intervention for HIV-Positive Late Middle-Age and Older Adults. Behav Med 2014,40:124-133.
37. Havlik RJ, Brennan M, Karpiak SE. Comorbidities and depression in older adults with HIV. Sex Health 2011,8:551-559.
38. Grov C, Golub SA, Parsons JT, Brennan M, Karpiak SE. Loneliness and HIV-related stigma explain depression among older HIV-positive adults. AIDS Care 2010,22:630-639.
39. Willie TC, Overstreet NM, Sullivan TP, Sikkema KJ, Hansen NB. Barriers to HIV Medication Adherence: Examining Distinct Anxiety and Depression Symptoms among Women Living with HIV Who Experienced Childhood Sexual Abuse. Behav Med 2016,42:120-127
40. White JR, Chang CC, So-Armah KA, Stewart JC, Gupta SK, Butt AA, et al. Depression and human immunodeficiency virus infection are risk factors for incident heart failure among veterans: Veterans Aging Cohort Study. Circulation 2015,132:1630-1638.
41. Primeau MM, Avellaneda V, Illa L, Musselman D, Jean GS. Treatment of Depression in Individuals Living with HIV/AIDS. Psychosomatics 2013.
42. Pence BW, Gaynes BN, Williams Q, Modi R, Adams J, Quinlivan EB, et al. Assessing the effect of Measurement-Based Care depression treatment on HIV medication adherence and health outcomes: Rationale and design of the SLAM DUNC Study. Contemporary Clinical Trials 2012,33:828-838.
43. Brezing C, Ferrara M, Freudenreich O. Review Articles: The Syndemic Illness of HIV and Trauma: Implications for a Trauma-Informed Model of Care. Psychosomatics 2015,56:107-118.
44. Willie TC, Overstreet NM, Peasant C, Kershaw T, Sikkema KJ, Hansen NB. Anxiety and Depressive Symptoms Among People Living with HIV and Childhood Sexual Abuse: The Role of Shame and Posttraumatic Growth. AIDS Behav 2016.
45. Karpiak S, Havlik R. HIV-Infected Older Adults Challenged by Multimorbidity but Not Accelerated Aging. In; 2015.
46. Guaraldi G, Brothers TD, Zona S, Stentarelli C, Carli F, Malagoli A, et al. A frailty index predicts survival and incident multimorbidity independent of markers of HIV disease severity. Aids 2015,29:1633-1641.
47. Holtzman C, Armon C, Tedaldi E, Chmiel JS, Buchacz K, Wood K, et al. Polypharmacy and risk of antiretroviral drug interactions among the aging HIV-infected population. Journal Of General Internal Medicine 2013,28:1302-1310.
48. Acquah R, Graham H, Winter A. Quantifying polypharmacy in a large HIV-infected cohort. HIV Med 2015,16:583-584.
49. Greene M, Steinman M, Nicolas K, Valcour V. Polypharmacy and Prescribing Quality in Older HIV-Infected Adults. JOURNAL OF THE AMERICAN GERIATRICS SOCIETY 2012,60:S103-S103.
50. Martin J, Volberding P. HIV and premature aging: A field still in its infancy. Ann Intern Med 2010,153:477-479.
51. Abrass C, Appelbaum J, Boyd C, Braithwaithe RS, Broudy C, Covinsky K, et al. Summary Report from the Human Immunodeficiency Virus and Aging Consensus Project: Treatment Strategies for

Clinicians Managing Older Individuals with the Human Immunodeficiency Virus. Journal of the American Geriatrics Society 2012,60:974-979.
52. Shippy RA, Karpiak SE. The aging HIV/AIDS population: fragile social networks. Aging Ment Health 2005,9:246-254.
53. Shippy RA, Karpiak SE. Perceptions of Support Among Older Adults With HIV. Research on Aging 2005,27:290-306.
54. Karpiak SE, Shippy RA, Cantor MH. ROAH: Research on Older Adults with HIV. In; 2006.
55. Rotzinger A, Locatelli I, Reymermier M, Amico S, Bugnon O, Cavassini M, et al. Association of disclosure of HIV status with medication adherence. Patient Educ Couns 2016,99:1413-1420.
56. Nguyen A. Davtyyan M. Taylor J. Christensen C. Planikey M. Karpiak S. Brown G. Living with HIV During the COVID-19 Pandemic: Impacts for Older Adults in Palm Springs, California. 2021 Aug;33(4):265-275.doi: 10.1521/aeap.2021.33.4.265.
57. JD Davids The Body: On National HIV/AIDS and Aging Awareness Day, Attention Turns to Growing Number of Elders with HIV, Sept. 18 2017 (statement by The National Minority AIDS Council)
58. Gallo JJ, Hwang S, Joo JH, Bogner HR, Morales KH, Bruce ML, et al. Multimorbidity, Depression, and Mortality in Primary Care: Randomized Clinical Trial of an Evidence-Based Depression Care Management Program on Mortality Risk. J Gen Intern Med 2016,31:380-386.
59. Held FP, Blyth F, Gnjidic D, Hirani V, Naganathan V, Waite LM, et al. Association Rules Analysis of Comorbidity and Multimorbidity: The Concord Health and Aging in Men Project. J Gerontol A Biol Sci Med Sci 2016,71:625-631.
60. Marengoni A, Angleman S, Melis R, Mangialasche F, Karp A, Garmen A, et al. Aging with multimorbidity: a systematic review of the literature. Ageing Res Rev 2011,10:430-439
61. Marie Modeste RR, Majeke SJ. Sources and types of information on self-care symptom management strategies for HIV and AIDS. Curationis 2014,37:E1-9.
62. McDonald K, Slavin S, Pitts MK, Elliott JH, HealthMap Project T. Chronic Disease SelfManagement by People With HIV. Qual Health Res 2016,26:863-870.
63. Hirth VA, Eleazer GP, Dever-Bumba M. A step toward solving the geriatrician shortage. Am J Med 2008,121:247-251.
64. Lester P. Dharmarajan T. Weinstein E. The looming geriatrician shortage: Ramifications and Solutions. J Aging Health 2020 Oct;32(9):1052-1062. doi: 10.1177/0898264319879325. Epub 2019 Oct 4
65. Brennan M, Karpiak S, Shippy R, Cantor M. Older Adults with HIV: An In-Depth Examination of an Emerging Population. Nova Science 2009.
66. Brennan M, Strauss SM, Karpiak SE. Religious Congregations and the Growing Needs of Older Adults with HIV. Journal of Religion, Spirituality & Aging 2010,22:307.
67. Emlet C. Harris L. Pierpaoli C, Furlotte C. "The Journey I Have Been Through": The Role of Religion and Spirituality in Aging Well Among HIV-Positive Older Adults. 2018 Mar;40(3):257-280. doi: 10.1177/0164027517697115. Epub 2017 Mar 6.Greysen SR, Horwitz LI, Covinsky KE, Gordon K, Ohl ME, Justice AC. Does Social Isolation Predict Hospitalization and Mortality Among HIV+ and Uninfected Older Veterans? Journal of the American Geriatrics Society 2013,61:1456-1463.
68. Nguyen A. Davtyyan M. Taylor J. Christensen C. Planikey M. Karpiak S. Brown G. Living With HIV During the COVID-19 Pandemic: Impacts for Older Adults in Palm Springs, California. 2021 Aug;33(4):265-275.doi: 10.1521/aeap.2021.33.4.265.
69. Brennan-Ing M, Seidel L, Larson B, Karpiak SE. Social care networks and older LGBT adults: challenges for the future. J Homosex 2014,61:21-52.
70. Brennan-Ing M, Seidel L, Karpiak S. Social networks and support among older gay and bisexual men: The impact of HIV. APA Society and Aging Series. 2014,In press.
71. Brennan-Ing M, Seidel L, Rodgers L, Ernst J, Wirth D, Tietz D, et al. The Impact of Comprehensive Case Management on HIV Client Outcomes. PLoS One 2016,11:e0148865.
72. Brennan-Ing M, Seidel L, London AS, Cahill S, Karpiak SE. Service utilization among older adults with HIV: the joint association of sexual identity and gender. J Homosex 2014,61:166-196.
73. Talbert-Slagle KM, Canavan ME, Rogan EM, Curry LA, Bradley EH. State variation in HIV/AIDS health outcomes: the effect of spending on social services and public health. AIDS 2016,30:657- 663.
74. Vaportzis E. Blausen M. Gow A. Older Adults Perceptions of Technology and Barriers to Interacting with Tablet Computers: A Focus Group Study. Font Psychol. 2017; 8:1687

75. Mugo PM, Wahome EW, Gichuru EN, Mwashigadi GM, Thiong'o AN, Prins HAB, et al. Effect of Text Message, Phone Call, and In-Person Appointment Reminders on Uptake of Repeat HIV Testing among Outpatients Screened for Acute HIV Infection in Kenya: A Randomized Controlled Trial. PLoS ONE 2016,11:1.
76. USGOV. President's Report on Independence, Technology, and Connection in Older Age. In; 2016.
77. DFTA. Seniors and the WEB. In: Department for the Aging (NYC); 2016.
78. 7. Heckman TG, Sutton M, Heckman BD, Anderson T, Bianco JA, Lovejoy TI. Common Factors and Depressive Symptom Relief Trajectories in Group Teletherapy for Persons Ageing with HIV. Clinical Psychology and Psychotherapy 2016.
79. Lin CH, Chiang SL, Heitkemper MM, Hung YJ, Lee MS, Tzeng WC, et al. Effects of telephone-based motivational interviewing in lifestyle modification program on reducing metabolic risks in middle-aged and older women with metabolic syndrome: A randomized controlled trial. Int J Nurs Stud 2016,60:12-23.

VII. ATTACHMENTS

Attachment 1: Statement of Assurances*
Attachment 2: Program Specific Clauses – NYSDOH AI**
Attachment 3: Health Equity Definitions and Examples**
Attachment 4: HRI General Terms and Conditions**
Attachment 5: Application Cover Page*
Attachment 6: Application Checklist*
Attachment 7: Organizational Chart*
Attachment 8: Service Linkages Chart*
Attachment 9: Sites, Days, and Hours of Operations chart*
Attachment 10: Program Timeline*
Attachment 11: Agency Capacity and Staffing Information*
Attachment 12: HRI Expenditure Based Budget Summary*
Attachment 13: Instructions for Completion of Budget Forms for Solicitations**
Attachment 14: Statement of Activities for past three (3) years*
Attachment 15: Yearly Independent Audit*
Attachment 16: Time and Effort Policy*

*These attachments are required and must be submitted with your application.

**These attachments are for applicant information only. These attachments do not need to be completed.