LOS ANGELES COUNTY
COMMISSION ON HIV

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Aging Caucus

Virtual Meeting

Tuesday, April 2, 2024
1:00pm-2:30pm (PST)

Discussion | Service access and navigation issues faced by older adults living with HIV | Provider Insights from Being Alive LA | Jamie Baker, Executive Director

HIV and Aging Updates from CROI 2024 | Dr. David Hardy, Scientific and Medical Consultant, USC Rand Schrader Clinic

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https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m842b83bcb8b92cc3fc43c901ad145f50

Meeting number/Access Code: 2533 785 7231
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Join by phone
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The Aging Caucus is committed to addressing aging across the lifespan. We welcome your ideas and feedback. If you are unable to attend the meeting, you may still share your thoughts by emailing them to hivcomm@lachiv.org.

Click HERE for information on the Aging Caucus' Recommendations and Care Framework for PLWH

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

VIRTUAL MEETING AGENDA
TUESDAY, APRIL 2, 2024
1:00 PM – 2:30 PM

JOIN BY WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m842b83bcb8b92cc3fc43c901ad145f50
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1	**Welcome & Introductions**	1:00pm-1:10pm
2	**Co-Chairs' Report** a. Purpose of the Aging Caucus b. February 6, 2023 Meeting Brief Recap (refer to meeting summary in packet) c. DHSP Workforce Summit and Conference Updates (Dr. Nash).	1:10pm-1:20pm
3	**Discussion:** Service access and navigation issues faced by older adults living with HIV | Provider Insights from Being Alive LA | Jamie Baker, Executive Director	1:20pm-1:45pm
4	**HIV and Aging CROI 2024 Updates** (Dr. David Hardy)	1:45pm-2:00pm
5	**Division of HIV and STD Programs (DHSP) Report** a. Status/Actions Taken to Implement Aging Caucus Recommendations b. Internal Workgroups Status Report or Efforts to Better Address HIV and Aging c. Other updates and feedback on how the Aging Caucus can best support DHSP in addressing HIV and Aging	2:00pm-2:15pm
5	Executive Director/Staff Report	2:15pm-2:20pm
6	Next Steps and Agenda Development for Next Meeting	2:20pm-2:25pm
7	Public Comments & Announcements	2:25pm-2:30pm

8	Adjournment	2:30pm

2024 Meeting Schedule (Subject to Change**)**
All meetings are virtual from 1pm to 2:30pm unless changed by the Aging Caucus.
February 6, 2024
April 2, 2024
June 4, 2024
August 6, 2024
October 1, 2024
December 3, 2024

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AGING CAUCUS VIRTUAL MEETING SUMMARY
TUESDAY, FEBRUARY 6, 2024

Attendees: Kevin Donnelly (Co-Chair), Paul Nash (Co-Chair), Alasdair Burton, Lee Kochems, Katja Nelson, Viviana Criado (DPH Office of Women's Health/Los Angeles Alliance for Community Health and Aging), Crisel Santos (AltaMed PACE Program). Commission on HIV staff: Cheryl Barrit and Lizette Martinez.

Co-Chairs' Report

- Aging Caucus (AC) Co-Chairs Kevin Donnelly and Dr. Paul Nash, called the meeting to order at 1:06pm, welcomed participants, and introductions were made.
- K. Donnelly went over the purpose of the AC and highlights of the December 5, 2023 meeting. The purpose of the AC is to address the health needs of those over 50 years living with HIV and long-term survivors and to implement recommendations it developed in 2020. Several ideas were developed for key activities for 2024, including but not limited to, bringing attention to social isolation faced by older people living with HIV, housing and internal partnerships with Commission committees and caucuses. It was suggested that Dr. Nash provide a presentation to the full Commission on the topic of social isolation and resources needed to mitigate the impact of social isolation on the quality of older adults living with HIV.
- The AC stated the importance of aligning and doubling up its efforts for impact and results.
- New attendee, Crisel Santos, Marketing Coordinator for AltaMed's Program for All Inclusive Care for the Elderly (PACE), shared information on the PACE program as another opportunity and resource to address the needs of older adults living with HIV. The Program of All-Inclusive Care for the Elderly, or PACE, was established by Medicare to help independent seniors with complex medical needs. The program helps participants avoid nursing homes and instead, receive the care and services necessary to help them stay safe, comfortable, and healthy living in their own home.
- PACE offers care coordination, transportation, social services, and meals, all in a positive, comfortable environment. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department of Health Care Services, and be able to live safely in their home or community at the time of enrollment. AltaMed currently has 11 PACE Centers and is expanding more in alternative care settings.
- Additional information about the PACE Program is available at https://www.dhcs.ca.gov/provgovpart/Pages/PACE.aspx.

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

- No DHSP staff was in attendance to provide a report. The AC will follow-up via email on the following items:
    a. Status/Actions Taken to Implement Aging Caucus Recommendations
    b. Internal Workgroups Status Report or Efforts to Better Address HIV and Aging
    c. Other updates and feedback on how the Aging Caucus can best support DHSP in addressing HIV and Aging
- Some AC members recommended inquiring about a status update from DHSP at the full Commission meeting on February 8, 2024. AC members expressed the importance of holding DHSP accountable for continuing to engage with the AC and collaborating with the AC to tackle the recommendations developed by the group in 2020 and continue to address HIV and aging. The AC was particularly interested in the status of activities related to workforce capacity since it appeared there was momentum around that goal.
- Dr. Nash shared that DHSP did reach to USC to determine if a training program using a learning management system (LMS) was feasible with a $10,00 program budget. However, due to the complexity of developing tailored curriculum using and LMS platform, USC determined that the allocated project budget of $10,000 was not feasible or realistic.

III. 2024 Workplan/Key Activities Development (Discussion)

The group discussed developing its 2024 workplan.

- Add transitional case management, benefits specialty and navigation to the service standards review. Collaborate with the Standards and Best Practices Committee on updating these service standards to address HIV and aging.
- Regarding reports from DHSP, add specific questions to DHSP to better guide the discussions towards action and impact.
- Add an "outcomes/resolution" column to document success (or improvement needed) for each workplan activity.
- Add to the Planning, Priorities and Allocations (PP&A) Committee agenda an agenda item highlighting recommendations from all Caucuses to help inform the planning, priority setting and resource allocations process.
- Add the REPRIEVE study on activity related to tracking research efforts. Find out more about HIV and aging specific studies from CROI (Conference on Retroviruses and Opportunistic Infections). Consider a presentation on the REPRIEVE study. Dr. Nash noted that the American Society on Aging will be held in March and he will staff and will share key research highlights from the conference.
- Collaborative educational events – reach out to APLA and the M. McFadden from the LA LGBT Center if they are doing and aging events as potential collaborative efforts with the Commission/Aging Caucus. Pursue co-hosting sexual health educational events with the Department of Aging and Disability in small, intimate settings. Keep the momentum on the successful sexual health event held in 2023 and find a partner to co-host/co-plan the event.
- Working with SAPC, DMH – rethink how to integrate the essence of this activity under the 4 internal DHSP workgroups. Invite representatives from SAPC and DMH to come to the AC and identify best practices they are utilizing to address substance use and mental health in older adults.

- Add conversations on the impact of CalAIM on healthcare for older adults.
- ID cards – refine to get status update on upgrades to CaseWatch, solving administrative barriers to accessing RWP services – strive for a seamless RWP care system.

IV. Executive Director/Staff Report

- C. Barrit mentioned the full Commission meeting on February 8, 2024. The Bylaws Review Task Force will present a summary of proposed key changes to the Commission's bylaws. The 2023 Annual Report will be in the packet and must be submitted to the Board by February 29, 2024.

V. Next Steps and Agenda Development for Next Meeting

- Next Meeting: April 2, 2024 @ 1pm to 2:30pm to be held virtually via WebEx.
- Discussion item on service access and navigation issues faced by older adults living with HIV.

Meeting was adjourned at 2:30pm.

LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV
2024 AGING CAUCUS WORKPLAN (REVISION DATES:)

Created 02.09.24

Task Force Adoption Date:

Co-Chairs: Kevin Donnelly & Paul Nash

#	TASK/ACTIVITY	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED—Document outcomes and resolution
1	Review and refine workplan, as needed	Ongoing	
2	Ensure service standards are reflective of and address the needs of PLWH 50+ • Work with the Standards and Best Practices Committee to update/develop Transitional Case Management for older PLWH transitioning out of Ryan White into Medicare; benefits specialty and service navigation; and home-based case management service standards (completion date to be determined by SBP)		
3	Use Aging Caucus recommendations and care framework to inform Ryan White allocations. • Infuse aging lens in the multi-year service ranking and funding allocations exercise conducted by PP&A • Discuss impact of CalAIM on healthcare for older adults.		
4	Continue to work with DHSP to implement recommendations and HIV care framework for PLWH 50+ • Maintain ongoing communication with DHSP on shifting community needs and staff workload and priorities. Find the proper balance and accountability to maintain collective commitment to addressing the needs of older adults living with HIV. • *Are MCC and AOM programs conducting the assessments and screenings recommended by the group (see 2020 report). What capacity building needs/issues need to be addressed to move MCC/AOM programs to perform the recommended screenings?*		
5	Participate in internal DHSP HIV and Aging workgroups and monitor progress in implementing identified 4 priorities. 1. Examine housing inventory to ensure that it provides safe and welcoming environments for seniors. 2. Add gerontology training to Ambulatory Outpatient Medical, Oral Health, Medical Care Coordination and Mental Health services providers to improve awareness and understanding of age-related inequities in care and treatment. 3. Acknowledge and support nontraditional family relationships that nurture well-being and social connection.		Elicit ongoing feedback from DHSP on the status of the 4 workgroups. *What is the status of the gerontology trainings?* *Update from DHSP (Dr. Green; email 2/7/24: "Our priorities right now are looking at migration away from our RWP medical care because of California's Medi-*

	4. Seek out mental health specialists who can treat both HIV and age-related conditions.		*Cal expansion, working with providers to see if/how they intend to continue providing MCC services if RWP isn't paying for medical care, and developing new case management/social support models that should address many of the issues that have been identified by this and other groups. As discussed previously, the mentoring program is in full swing, but evaluation is still some months away."*
6	Monitor, learn and understand HIV and aging-specific evidence-based research activities to improve HIV/STD prevention and care programs for PLWH 50+ and long-term survivors (LTS). • Learn more about the REPRIEVE study and invite a representative from the research team to present to the Caucus. • Find out more about HIV and aging specific studies from CROI (Conference on Retroviruses and Opportunistic Infections). Dr. Nash to present on key highlights from the American Society on Aging (to be held in March).		
7	Plan and implement a special panel/speaker for in commemoration of National HIV/AIDS and Aging Awareness Day. Presentations/educational sessions may occur outside of COH or Aging Caucus meetings. • Leverage success from the 2023 Sexual Health and Older Adults Educational Event for Providers. Co-host and co-plan with interested partners. • Partner with the Department of Aging and Disabilities to explore conducting sexual health educational event in small settings in one of their senior centers. • Collaborate with the Women's Caucus on lifting the needs of older women living with HIV. • Presentation at the full Commission on social isolation and aging.		
8	Monitor issues related to mental health, substance use, homelessness for the aging population and to hear periodic updates from DHSP, DMH, SAPC, and other organizations; invite other commissions as well.		

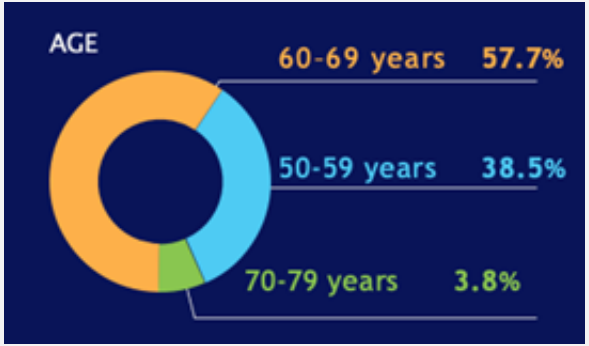
	• Invite representatives from SAPC and DMH to come to the AC and identify best practices they are utilizing to address substance use and mental health in older adults.		
9	Facilitate solutions-oriented listening sessions among older adults living with HIV on service access barriers and navigation issues they experience. *It is difficult to track information and the different staff/case managers when one gets older. Case managers should be linking and enrolling clients to all Ryan White and non-Ryan White services. Could there by only 1 case manager for all services?* *Is there a way to manage all the case managers since not all case managers carry the same expertise and knowledge across all areas and services. How can case managers share information and coordinate services?*		

HIV/AIDS & AGING:
SURVEY RESULTS AND NEXT STEPS

BEING ALIVE!

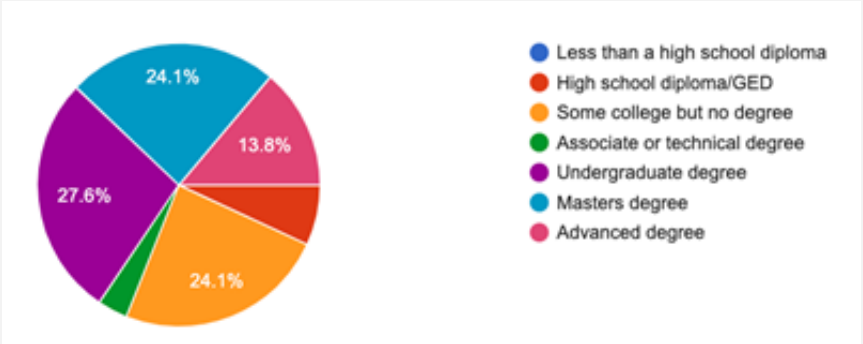
DEMOGRAPHICS

RACE AND ETHNICITY
Black: **3.4%**
Hispanic/Latino: **13.8%**
White: **58.6%**
Asian: **10.3%**
Native American/Indigenous/Alaska Native: **6.9%**
Multiracial or Biracial: **6.9%**

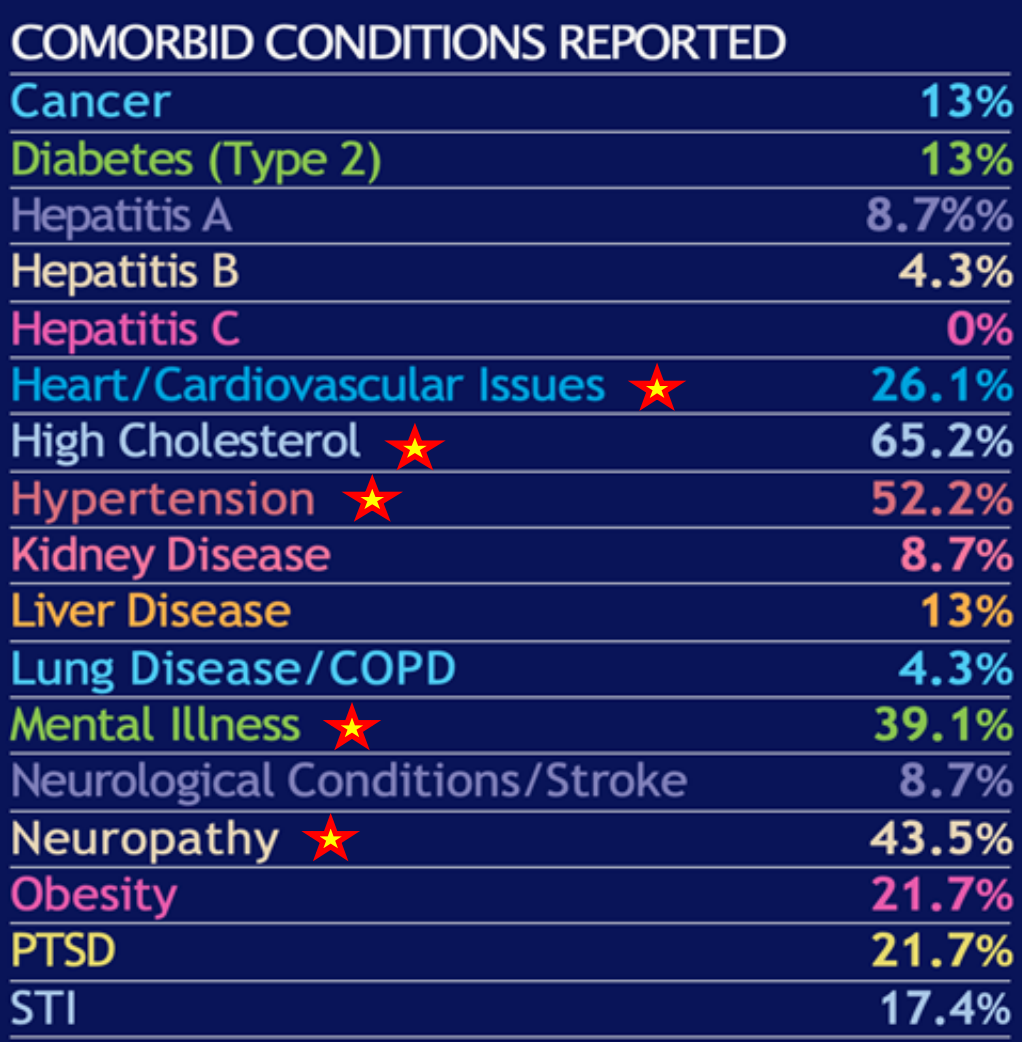


SEXUAL ORIENTATION
Gay/Lesbian: **93.1%**
Bisexual: **3.4%**
Heterosexual: **3.4%**

SEX AT BIRTH



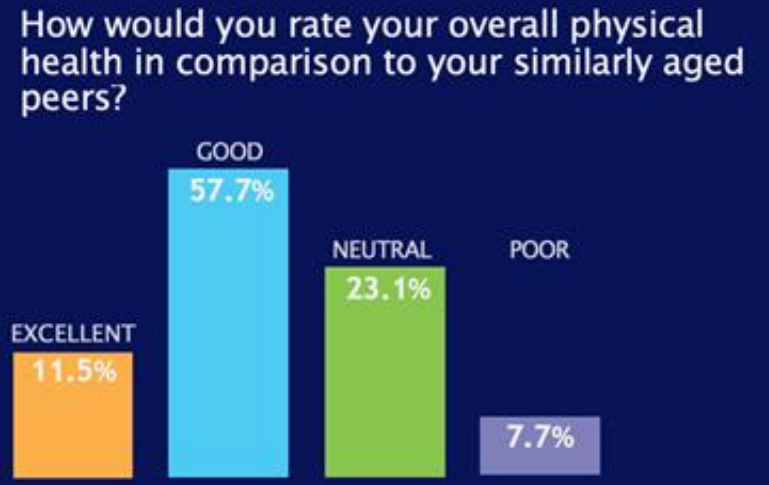
GENDER IDENTITY
Cisgender man: **89.3%**
Cisgender woman: **3.6%**
Queer/Non-binary: **7.1%**

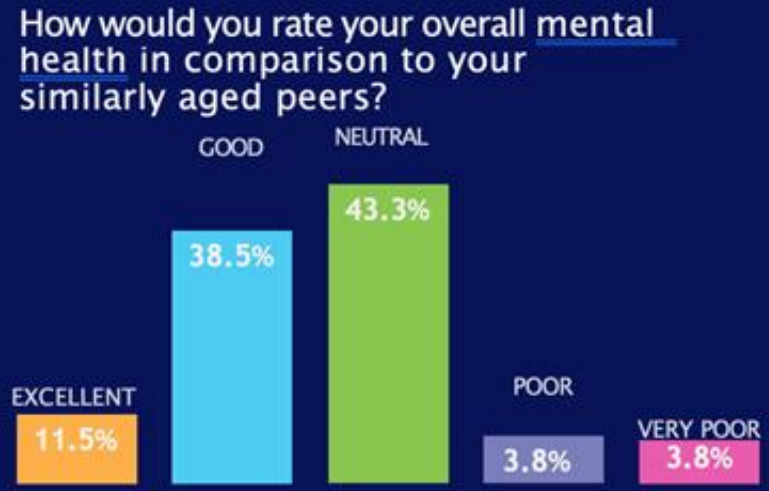


Double the Burden: People with HIV Face Increased Multimorbidity Risks as They Age

The burden of managing two or more comorbidities—also known as multimorbidities—is more common among people with HIV.

Cohort studies of OPWH have shown that the number of comorbidities increase with age, and at a higher rate than older adults without HIV.



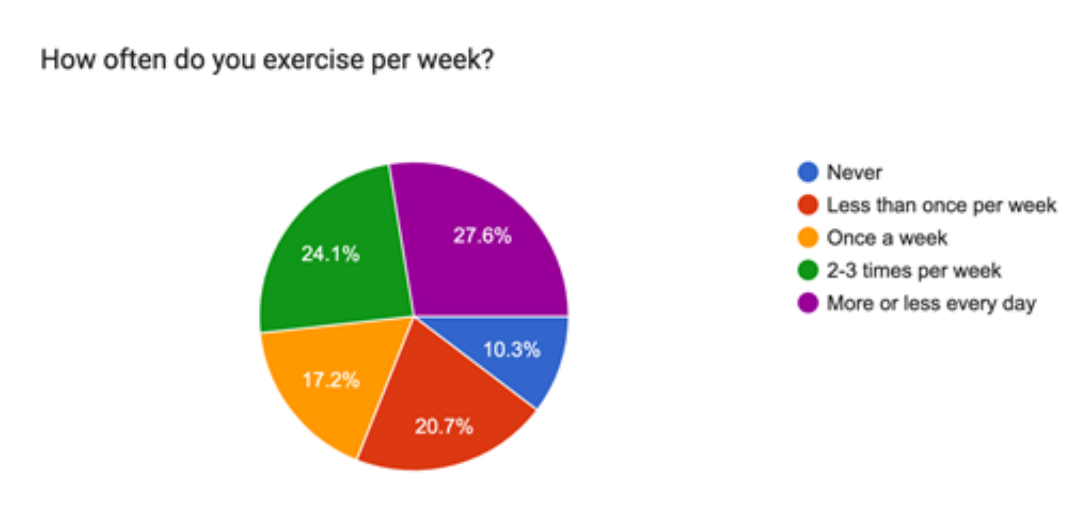


69% of respondents rated their overall physical health as either good or excellent.

However, 88% respondents reported living with at least two comorbidities. The most common being high cholesterol, hypertension, mental illness, and neuropathy.

Respondents expressed concern about how they would manage comorbidities as they aged, noting it as a top priority facing their cohort.

Physical Activity



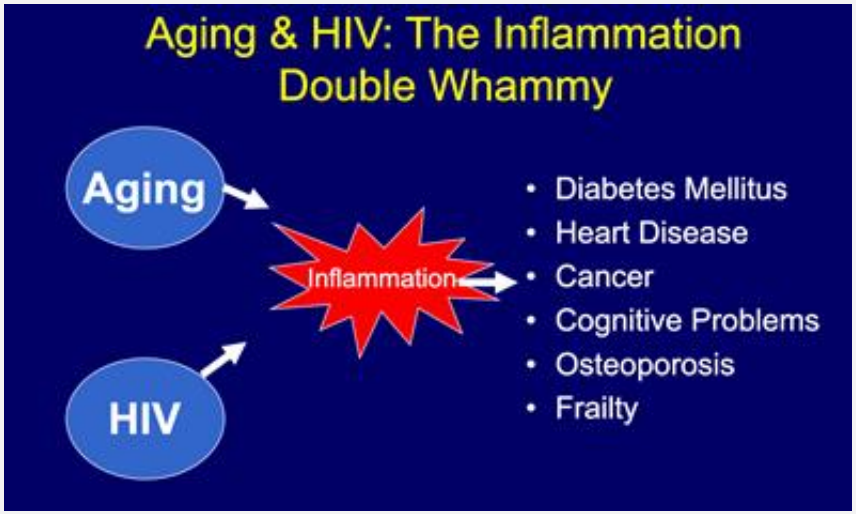
Broad distribution of physical activity among respondents with majority not currently meeting recommendations.

The CDC currently recommends that older adults/adults with chronic health conditions or disabilities who are able should:

Get at least 150 minutes (for example, 30 minutes 5 days a week) of moderate-intensity aerobic physical activity a week

Get at least 2 days a week of muscle-strengthening activities that include all major muscle groups.

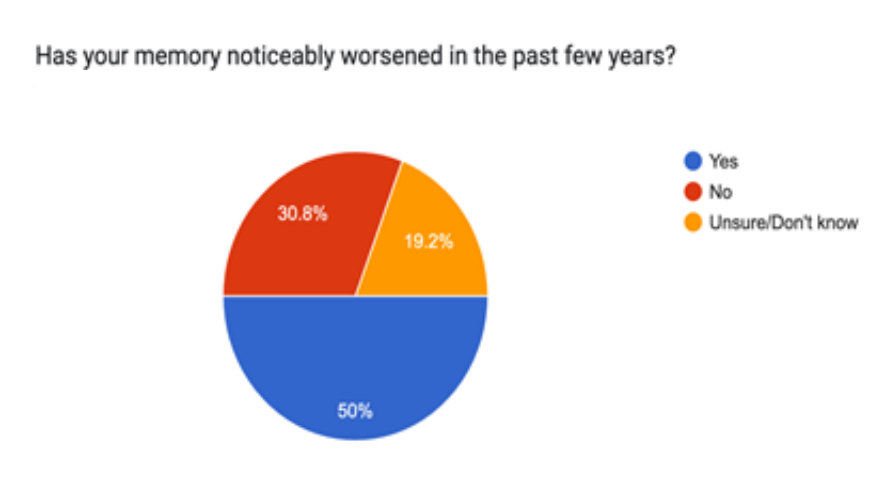
Aging with HIV



Unveiling the Mystery of Aging: Chronic Inflammation and Physiological Aging Leave a Mark on OPWH

The full impact of aging with HIV is still being explored as it involves a complex interplay of several factors. There is evidence that PWH are more likely to experience accelerated and accentuated aging related to physiological aging and chronic inflammation of the immune system. While we see immunosenescence in elderly populations with other non HIV-related chronic disease, it's often present in all PWH, even in the context of well-controlled HIV. (https://healthhiv.org/stateof/agingwithhiv/)

Memory Concerns

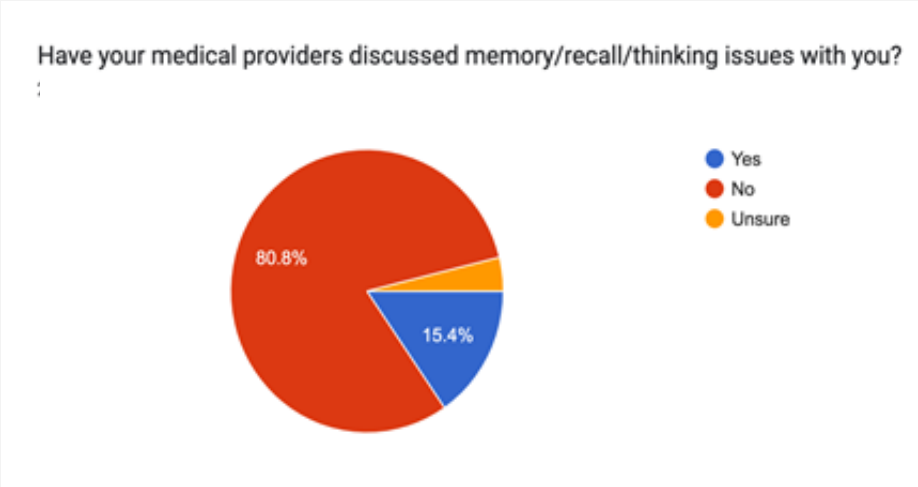


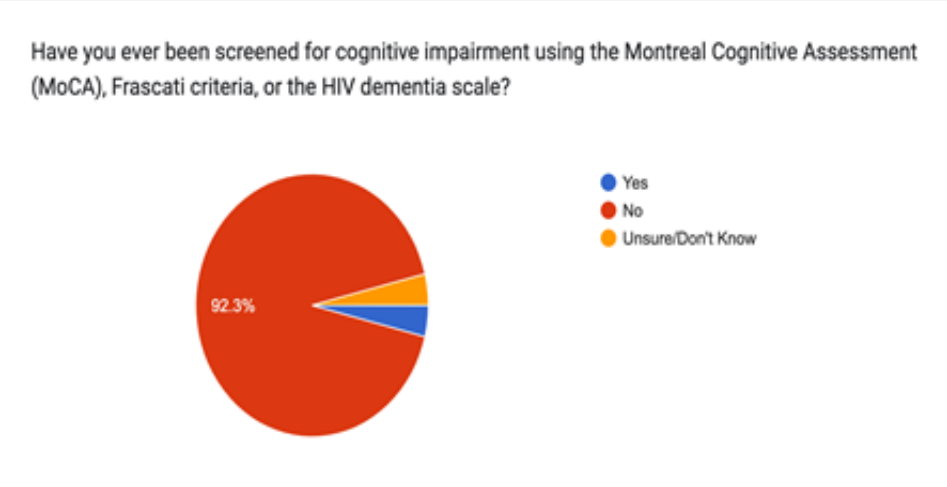
Although no robust treatment options exist for cognitive impairment and little evidence supports that early detection will improve the patient's outcome, early detection of cognitive impairment can allow both patients and family members to start planning while the patient is still capable of making informed decisions.

The health care team should conduct cognitive assessment screening *if individuals complain of memory impairment or other symptoms* or *if family members identify lapses in memory*. Furthermore, the health care team should assess the medications provided to people with HIV to identify and remediate any drug interactions that may cause cognitive impairment.

(https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-new-elements.pdf)

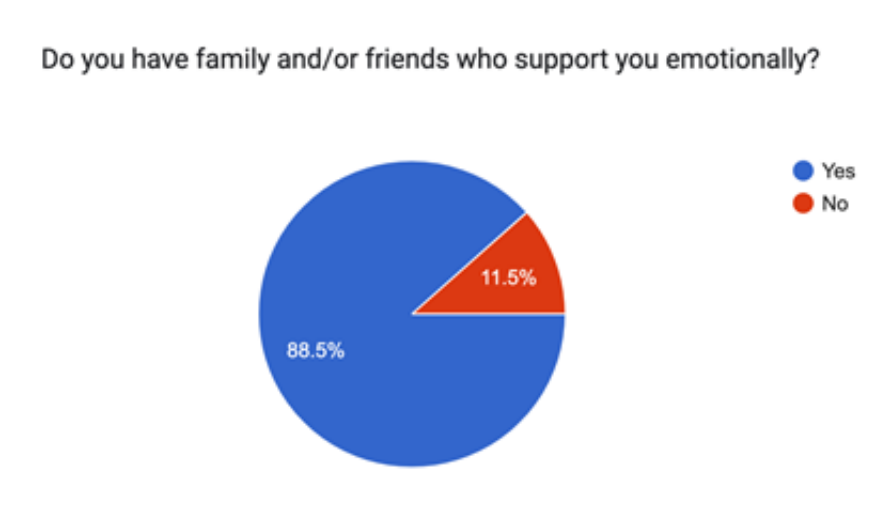
COGNITIVE SCREENING

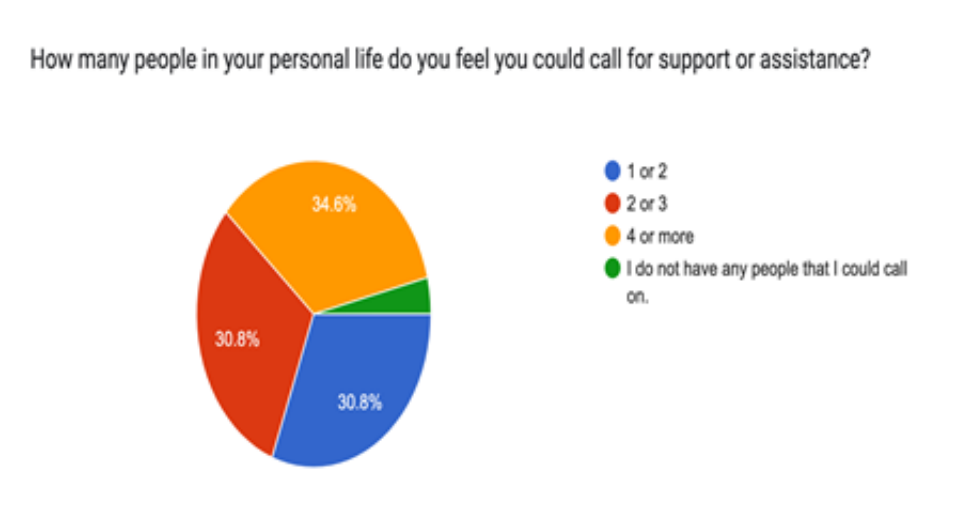




A large majority of respondents have not had their health care provider discuss memory or have been screened for any cognitive impairment.

SOCIAL SUPPORT

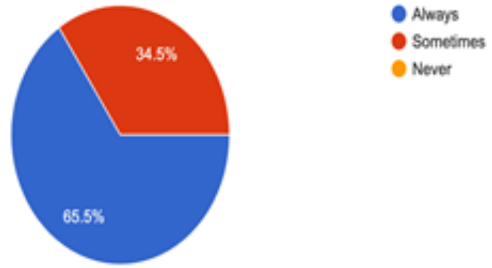




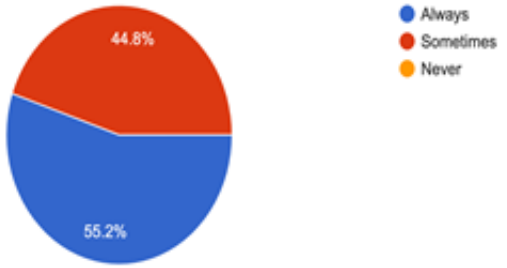
Social isolation may become more acute among people aging with HIV, particularly those who have experienced the loss of close friends to HIV throughout the past four decades or those who have limited family support.

HEALTHCARE PROVIDERS

I feel that my provider gives me enough time to address my concerns and questions

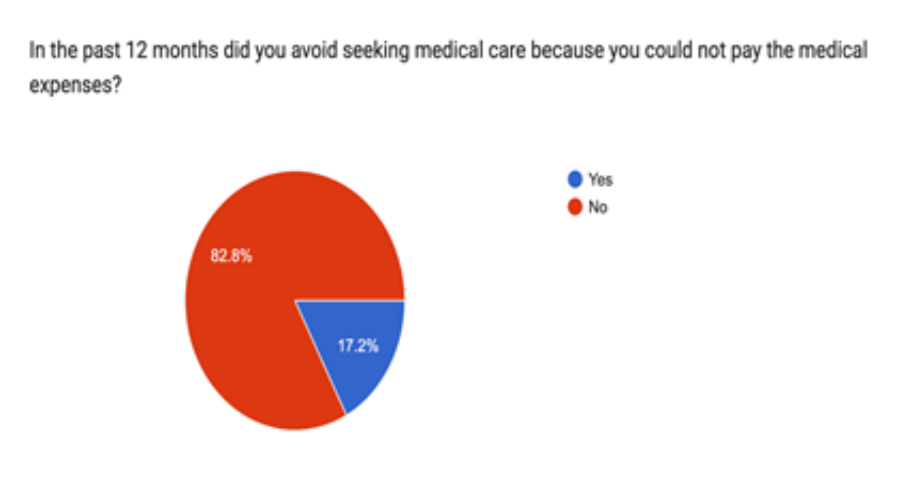


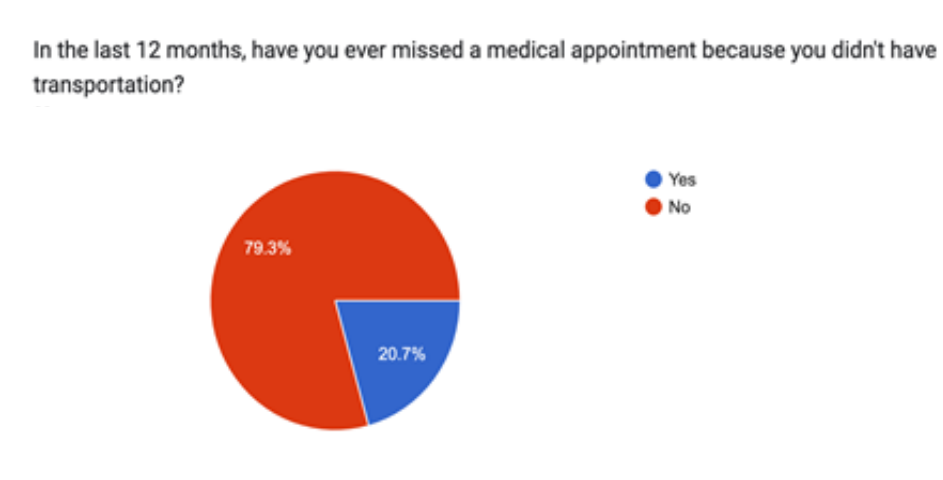
I feel that my provider gives me enough time to discuss other things of importance, beyond my HIV care.



Healthcare providers proficient at addressing patient concerns but there is still room for improvement. There was a very low incidence of stigma reported.

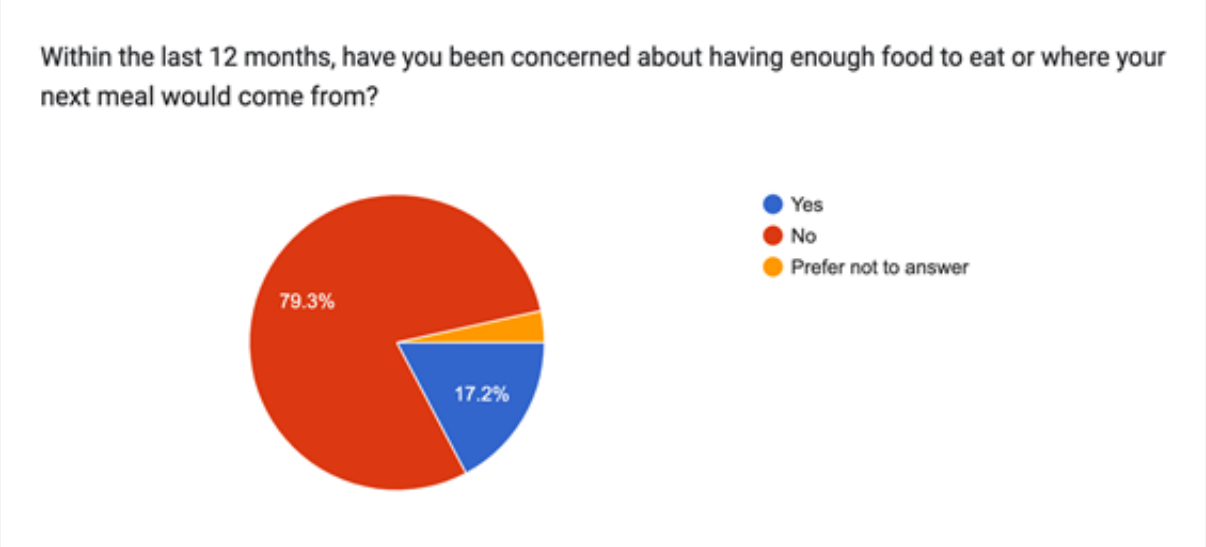
ACCESS TO CARE





Clearly, there are some barriers to accessing care in terms of affordability and transportation.
NOTE: Upon reflection, respondants most likely only considered medical care, not dental. There seems to be a high need for better access to dental care.

FOOD ACCESS



Access to healthy and affordable foods, a key social determinant of health, is a struggle among this population that needs clear solution in order to combat.

Hearing from the Community

When we asked the question “In your opinion, what is the most pressing need for improvement in HIV care for people over 50?” here are some of the responses we got.

- Related **comorbidities** like heart disease, liver disease, HPV related cancers
- Assistance for **food** for people who earn more than $1500 in social security and below $2500
- More time with prescriber to address other health concerns
- Lingering **social stigma**
- **Prevention** and early diagnosis
- Medication **side effect management**
- Keeping Federal Funding (Ryan White, etc.) fully funded
- Accelerated ageing and understanding what that will mean for long term survivors or HIV.
- **Education** on aging with HIV
- More access to **exercise** and **preventive health activities**
- **Mental health** and housing
- Social connections
- Health Care and Mental Health
- Doctors that are knowledgeable about all of the hiv meds, vaccines, and medical drug interactions
- Cognitive health, transportation, social
- Financial stability
- Memory issues

Being Alive

Some Findings:

- 96.6% of respondents are virally suppressed.
- 75.9% of respondents have been living with HIV for 15+ years.
- Only 3% of respondents are actively smoking/using electronic nicotine delivery systems

CONCLUSION

Despite high rates of viral suppression and engagement in care, respondents agreed that more advocacy efforts are needed to address the needs of people aging with HIV. This reflects the increasingly complex reality of providing comprehensive care to OPWH. While medical providers are often adept at addressing HIV, there remains a significant need for enhanced training and medical education that prepares providers to develop interventions that address, not only the many comorbid conditions associated with aging with HIV, but also the pervasive and intersecting systemic barriers that face OPWH, including housing/food instability, gaps in social support and insurance coverage, and stigma.

The following implications represent crucial sites for future research, advocacy, and policy interventions to improve quality of life for people aging with HIV:

- Building a competent workforce of HIV gerontologists is crucial to address the multifaceted issues confronting PLWH as they grow older.
- Implementing cognitive screening measures so that families of OPWH can plan for the future
- Addressing social determinants of health is fundamental to improve health outcomes as health extends beyond the clinic setting.
- Listening to the needs of community members and continuing to educate about HIV & aging so that this population can be informed and empowered to take charge of their health.

Finally, To Quote My Mom:

"Getting old is the sh*ts."

-Mary Helen

HIV and Aging
CROI 2024 – Denver

W. David Hardy, MD
Adjunct Professor of Medicine
Keck School of Medicine of USC
L.A. County Commission on HIV

https://www.natap.org/2024/CROI/croi_104.htm

REPRIEVE: Mechanistic Substudy of Effects of Pitavastatin on Plaque in People Living With HIV and Low-Moderate Cardiovascular Disease Risk

CCO Independent Conference Coverage*

of the *CROI 2024 Annual Meeting, March 3-6, 2024*

*CCO is an independent medical education company that provides state-of-the-art medical information to healthcare professionals through conference coverage and other educational programs.

Provided by Clinical Care Options, LLC

This activity is supported through independent educational grants from Gilead Sciences, Inc.; Merck & Co., Inc., Rahway, NJ, USA; and ViiV Healthcare.

powered by cea

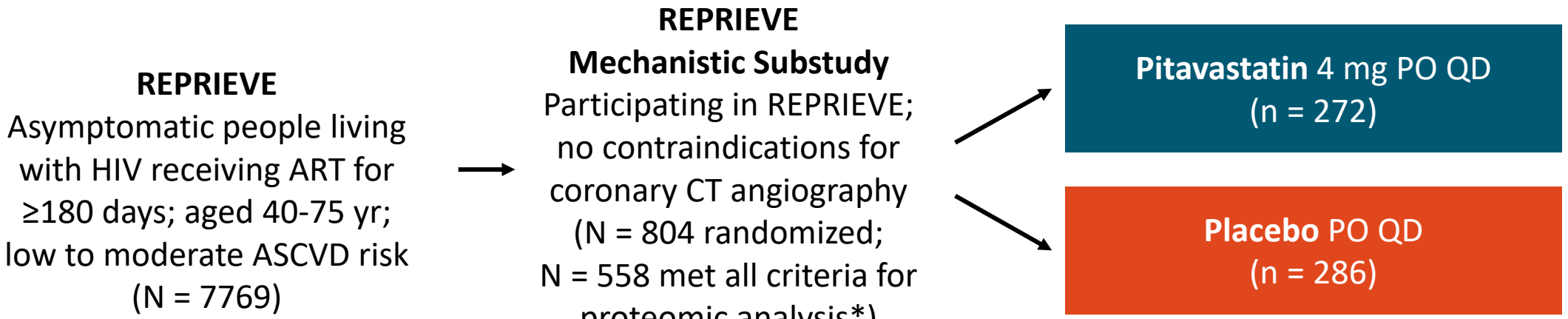
REPRIEVE Mechanistic Substudy: Background

- People living with HIV are twice as likely to develop cardiovascular disease as those without HIV[1]
  - Mechanisms may relate both to established traditional risks and to residual immune activation and inflammation[2]
- Research Question: Pitavastatin, a moderate-intensity statin may lower LDL-Cholesterol and decrease immune activation and inflammation; No drug-drug interactions with ART[3]
- In phase III REPRIEVE trial of people living with HIV and low-moderate CVD risk, pitavastatin significantly decreased incidence of heart attacks and strokes by 35% vs placebo after median of 5.1 yr[2]
  - In mechanistic substudy, pitavastatin decreased Non-Calcified Plaque volume and inflammatory markers with no significant association between LDL and Non-calcified Plaque volume[4]
- Current report presents expanded findings from REPRIEVE mechanistic substudy on pathways of effects of pitavastatin on plaque[5]
  - Included analysis of proteins such as PCOLCE (procollagen C-endopeptidase enhancer 1): rate-limiting enzyme participating in collagen deposition within interstitial tissues, expressed by fibroblasts

1. Shah. Circulation. 2018;138:1100. 2. Grinspoon. NEJM. 2023;389:687. 3. Grinspoon. Am Heart J. 2019;212:23.
4. Lu. JAMA Cardiol. 2024;[Epub]. 5. Kolossváry. CROI 2024. Abstr 151.

REPRIEVE Mechanistic Substudy: Study Design

- Planned mechanistic substudy of multicenter, randomized, double-blind phase III trial



All participants received information on heart-healthy lifestyle, smoking cessation, and diet.

- **Primary objective of mechanistic substudy:** investigate mechanistic pathways of effects of pitavastatin on plaque
  - Assessments performed at baseline and 2-yr follow-up: coronary CT for NCP volume; Olink Target 96 panels for cardiovascular, cardiometabolic, and immuno-oncologic proteomic markers

*Had 2 proteomic measurements, initiated tx on time, first sample collected before starting tx, second sample collected within 18-36 mo of first sample, and took tx until second measurement.

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REPRIEVE Mechanistic Substudy: Baseline Characteristics

Characteristic	Overall (N = 558)	Placebo (n = 286)	Pitavastatin (n = 272)
Mean age, yr (SD)	51 (6)	51 (6)	51 (6)
Male natal sex, n (%)	455 (82)	233 (81)	222 (82)
Race, n (%)			
▪ Asian	5 (1)	4 (1)	1 (0.3)
▪ Black/AA	206 (37)	106 (37)	100 (37)
▪ White	293 (53)	154 (54)	139 (51)
▪ Other	54 (10)	22 (8)	32 (11.7)
Mean BMI, kg/m^2 (SD)	27.3 (4.4)	27.3 (4.3)	27.3 (4.5)
Median ASCVD risk score, % (SD)	5.0 (3.1)	4.9 (2.9)	5.0 (3.2)
Median, mg/dL (SD)			
▪ Total cholesterol	186 (36)	186 (37)	185 (35)
▪ LDL-C	108 (30)	108 (31)	108 (29)
▪ Non–HDL-C	134 (35)	134 (36)	134 (34)
▪ Triglycerides	133 (74)	133 (77)	132 (72)

Characteristic	Overall (N = 558)	Placebo (n = 286)	Pitavastatin (n = 272)
Mean total ART use, yr (SD)	12 (7)	12 (6)	12 (7)
Nadir CD4+ cell count (cells/mm^3), n (%)			
▪ <50	116 (21)	58 (21)	58 (22)
▪ 50-199	168 (31)	92 (32)	76 (28)
▪ 200-349	155 (28)	78 (28)	77 (29)
▪ ≥350	106 (20)	52 (19)	54 (21)
HIV-1 RNA (copies/mL), n (%)			
▪ < LLQ	482 (88)	245 (88)	237 (88)
▪ LLQ to <400	54 (10)	29 (10)	25 (9)
▪ ≥400	14 (2)	6 (2)	8 (3)

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REPRIEVE Mechanistic Substudy: Changes in LDL–Cholesterol vs Noncalcified Plaque Volume

- Among people living with HIV treated with pitavastatin, **LDL-Cholesterol levels significantly changed** by -32.7% (95% CI: -38.3% to -27.1%; *P* <.001) over 2 yr
  - LDL-C levels stable over 2 yr in those treated with placebo
- Changes in LDL-Cholesterol were **not significantly associated with changes in Noncalcified Plaque Volume** over 2 yr
  - Change in NCP volume for each 10-mg/dL change in LDL-C: 1.5% (95% CI: -1.2% to 4.2%; *P* = .26)

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REPRIEVE Mechanistic Substudy: Changes in Proteins vs Noncalcified Plaque Volume

Modeled Change in NCP Volume per Doubling in Protein Expression	Univariable Regression		Multivariable Regression	
	% (95% CI)	*P* Value	% (95% CI)	*P* Value
LDL	1.5 (-1.2 to 4.3)	.26	-0.1 (-3.0 to 2.9)	.95
ANGPTL3	-19.8 (-34.0 to -2.6)	.026	2.3 (-20.3 to 31.3)	.86
MBL2	-18.7 (-31.5 to -3.5)	.018	-11.0 (-26.9 to 8.4)	.25
MIC-A/B	-11.1 (-36.2 to 23.7)	0.48	--	--
NRP1	-30.0 (-53.0 to 4.3)	.08	--	--
PCOLCE	-31.9 (-42.9 to -18.7)	<.001	-31.2 (-45.3 to -13.4)	.002
TFPI	1.5 (-22.6 to 33.0)	.91	--	--
TRAIL	-8.9 (-32.7 to 23.3)	.54	--	--

- Univariable regression modeling identified 3 differentially expressed proteins significantly associated with changes in NCP volume (ANGPTL3, MBL2, PCOLCE)
- **In a multivariable regression model, only PCOLCE was significantly associated with decrease in Non-Calcified Plaque volume**

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REPRIEVE Mechanistic Substudy: Investigators' Conclusions

- In this analysis of the mechanistic substudy of the phase III REPRIEVE trial in people living with HIV and low-moderate CVD risk, the plaque-stabilizing effects of pitavastatin were predominantly mediated by PCOLCE
- LDL change was **not** related to changes in NCP volume
- Investigators proposed that pitavastatin increases PCOLCE expression → increases fibrillar collagen types I-III in matrix → increases deposition, aggregation of calcium in matrix
- Impact of statin on collagen formation to stabilize **Non-calcified Plaque** may be an important mechanism for further study to reduce CAD in people living with HIV

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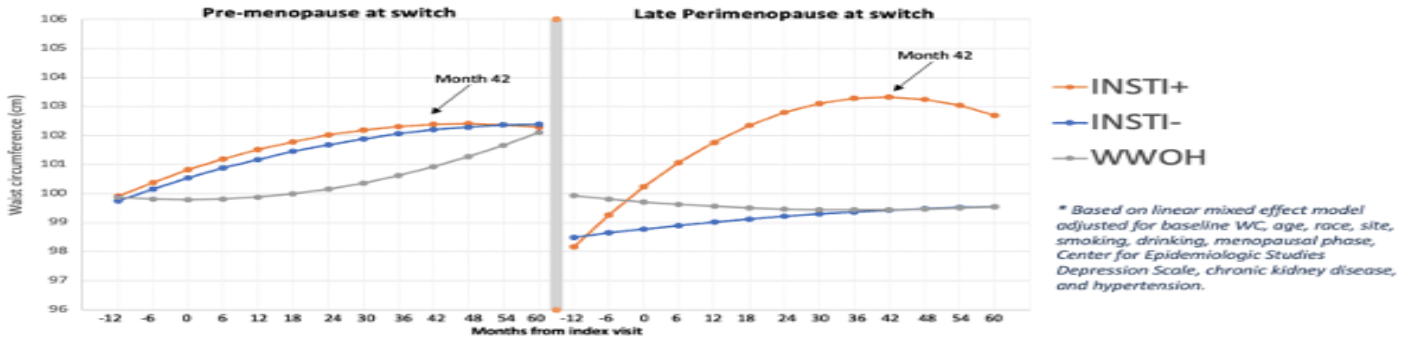
InSTI Switch During Menopause Is Associated With Accelerated Body Composition Change

Conclusions

- Switching to an INSTI-containing regimen during premenopause was not associated with accelerated gains in waist circumference or BMI
- Switching to an INSTI-containing regimen during perimenopause and menopause was associated with early accelerated increases in waist circumference and BMI
- Our findings suggest that menopausal phase contributes to the reported body composition changes after switching to an INSTI-containing regimen.
- Future directions: Evaluation of cardiometabolic disease parameters across the menopausal transition with and without switching to an INSTI

Waist circumference trajectories by menopausal phase



** Based on linear mixed effect model adjusted for baseline WC, age, race, site, smoking, drinking, menopausal phase, Center for Epidemiologic Studies Depression Scale, chronic kidney disease, and hypertension.*

	Pre-menopause		Late Perimenopause	
	Δcm/6 month (95% CI)	P-value	Δcm/6 month (95% CI)	P-value
INSTI+*time interaction	0.06 (-0.27, 0.38)	0.73	**0.96 (0.45, 1.46)**	**<.001**
INSTI+*time^2			**-0.07 (-0.13, -0.003)**	**0.04**
INSTI-*time	0.08 (-0.11, 0.28)	0.40	0.14 (-0.06, 0.33)	0.16

CROI 2024

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Leading Causes of Death Among People With HIV in the US, 2001–2019

Results

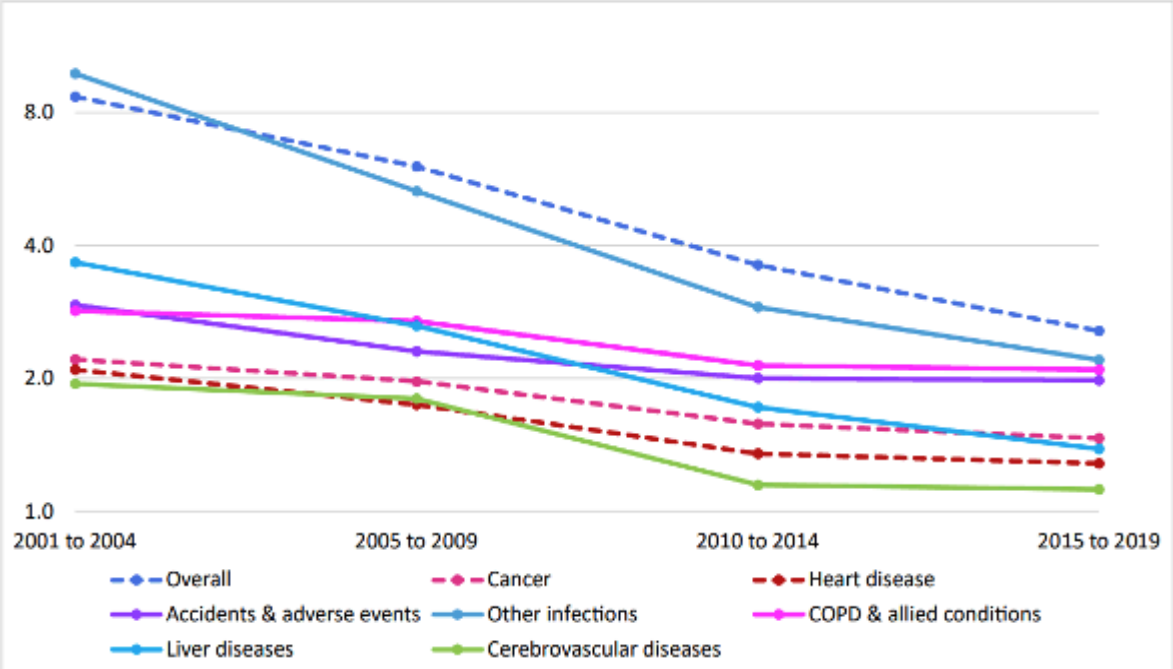
- There were 131,120 deaths among PWH over 5.3 million person-years of follow-up
- Among decedents: 72.2% were male, 61.5% were aged 40–59 years, 51.3% were non-Hispanic Black

Leading causes of death	No. of deaths*	% of deaths
HIV	67,458	51.4
Cancer	11,897	9.1
Heart disease	9,985	7.6
Accidents & adverse effects	5,831	4.4
Other infections**	4,974	3.8
COPD & allied conditions	1,863	1.4
Liver diseases	1,777	1.4
Cerebrovascular diseases	1,696	1.3

* Additionally, suicide & diabetes (1.2% each), kidney diseases & homicide (1.1% each), other causes (8.8%) & unknown causes (6.2%)
** Includes infections other than HIV, such as influenza, pneumonia, sepsis, etc.

Data

SMRs overall and for leading causes of death among PWH, by calendar period



Key Findings

- The leading causes of death were HIV (51.4% of deaths), cancer (9.1% of deaths) and heart disease (7.6% of deaths)
- PWH had more than 4 times higher risk of death (SMR: 4.44) compared to the general US population during 2001–2019
- SMRs steadily decreased with more recent calendar periods (8.7 during 2001–2004 vs. 2.6 during 2015–2019)

Pharmacokinetics of Long-Acting Cabotegravir and Rilpivirine in Elderly Using PBPK Modelling

Elderly people with HIV have higher exposure of ***LA cabotegravir and rilpivirine*** and therefore are *at* ***lower risk for suboptimal drug concentrations*** at the end of the dosing interval.

Figure 2: Fold change in exposure in elderly relative to young for LA cabotegravir and rilpivirine administered monthly (Q4W) or every other month (Q8W).