LOS ANGELES COUNTY
COMMISSION ON HIV

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Aging Caucus
Virtual Meeting

Tuesday, June 4 2024
1:00pm-2:30pm (PST)

Older Americans Act Update

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

JOIN BY WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mc7f2a0b613a9beec5e1d24e612603250
Meeting number/Access Code: 2534 902 0564
Password: AGING
Join by phone
+1-213-306-3065 United States Toll (Los Angeles)

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 over 50 and long-term survivors.

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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VIRTUAL MEETING AGENDA
TUESDAY, JUNE 4, 2024
1:00 PM – 2:30 PM

JOIN BY WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mc7f2a0b613a9beec5e1d24e612603250
Meeting number: 2534 902 0564
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1	**Welcome & Introductions**	1:00pm-1:10pm
2	**Co-Chairs' Report** a. Collaboration with Women's Caucus b. Meeting schedule review	1:10pm-1:20pm
3	**HIV and Aging CROI 2024 Updates Part 2 (Dr. David Hardy)**	1:20pm-1:45pm
4	**Executive Director/Staff Report | Older Americans Act Updates**	1:45pm-2:00pm
5	**Division of HIV and STD Programs (DHSP) Report**	2:00pm-2:15pm
6	**Next Steps and Agenda Development for Next Meeting**	2:15pm-2:20pm
7	**Public Comments & Announcements**	2:20pm-2:25pm
8	**Adjournment**	2:25pm-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, April 2, 2024
MEETING PACKET: CLICK HERE.

Attendees: Kevin Donnelly (Co-Chair), Paul Nash (Co-Chair), Jamie Baker, Cheryl Barrit, Alasdair Burton, Viviana Criado, Joseph Green Dr. David Hardy, Lee Kochems, Lizette Martinez, Leonardo Martinez-Real, Katja Nelson, Pamela Ogata, and Paul Pinion.

Co-Chairs' Report

a. **Purpose of the Aging Caucus (AC)**
- Co-Chairs P. Nash and K. Donnelly called the meeting to order and welcomed attendees. The group was reminded of the purpose of the AC which is to call attention to the needs of older adults living with HIV and long-term survivors, advance their health through the provision of effective prevention and care services, and bring to light a more comprehensive approach to their care and services. Another key role of the AC is to monitor and ensure the implementation of the recommendations it developed.

Participants added the following desired roles for the AC:

- Integrate aging outside of HIV but also across all agencies and determine the roles and responsibilities of those agencies. There is a need for case management; what could non-medical case management services and components look like for older PLWH?
- Collaboration with the Aging Commission.
- Promote the existence of the Aging Caucus to the community at large.
- Dental issues with HIV, lack of meaningful employment and isolation are major concerns for older PLWH.
- Promote safe space and housing.
- Education and training with more focus on addressing loneliness, psychosocial well-being and depression, not just biomedical areas of aging. Loneliness among older PLWH is a direct link to losing people in personal circles due to HIV.
- Look at the intersections of aging and HIV (not as separate issues); address stigma and biases.

b. **February 6, 2023 Meeting Brief Recap** -- K. Donnelly provided a brief recap of the February 6 meeting and referred attendees to the meeting packet.

c. DHSP Workforce Summit and Conference Updates (Dr. Nash)

- Dr. Nash reported that he attended and presented at the DHSP Workforce Summit which was well attended and he was pleased that aging was given a spotlight in the conference. Other key topics discussed were homelessness, health literacy, and sex and older adults. He noted that some providers reported that they are considering providing older adult-specific health screenings. He observed that there are remaining age gaps in awareness and utilization of HIV testing.

- Dr. Nash reported that he conducted a symposium at the American Society of Aging. He encouraged attendees to review the change to the Older Americans Act to include people who identify as LGBTQ and PLWH over 50 in the definition of "populations of greatest need".

Meeting schedule—the AC agreed to keep the AC meetings as until June 4 (every other month) at which time, the group will re-assess meeting frequency.

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

- Jamie Baker provided a presentation on data collected by Being Alive regarding consumer needs on aging and HIV. While the sample size was 50, the data provide key insights on service needs.

- 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.

4. and Aging CROI 2024 Updates (Dr. David Hardy)

- Dr. David Hardy provided key highlights on selected studies on HIV and aging from CROI 2024. See packet for presentation materials. He highlighted the following studies:

- REPRIEVE: Mechanistic Substudy of Effects Pitavastatin on Plaque on People Living with HIV and Low-Moderate Cardiovascular Disease Risk -- the study found that participants with HIV infection who received pitavastatin had a lower risk of a major adverse cardiovascular event than those who received placebo over a median follow-up of 5.1 years.

- **In STI Switch**: Ingrase strand transfer inhibitors (INSTIs) have been associated with greater weight gain in women with HIV than men with HIV. The study found that switching to an INSTI-based regimen during late peri- and post menopause is associated with early accelerated increase in weight circumference and body mass index (BMI) when compared to women who did not switch. This suggests that menopausal status should be considered when switching to an INSTI.

- The AC requested that Dr. Hardy return to the next AC meeting to go over the study involving the pharmacokinetics of long-acting cabotegravir and rilpivirine in elderly patients.

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

- Pamela Ogata provided the DHSP Report. She shared that DHSP funds Being Alive's Buddy Program. There are currently 19 mentors and 25 mentees. DHSP is currently preparing a solicitation for the ambulatory outpatient and medical care coordination contracts. They are meeting with providers to get feedback to help shape the RFP and program design and requirements. There are no updates on housing services yet.

- P. Ogata suggested forming a workgroup with mental providers that specialize in aging and HIV to identify solutions and implement realistic programs.

IV. Executive Director/Staff Report

- C. Barrit mentioned the Commission's training schedule. Trainings are mandatory for Commissioners and all sessions are open to the public.

V. Next Steps and Agenda Development for Next Meeting

- Next Meeting: June 4, 2024 @ 1pm to 2:30pm to be held virtually via WebEx.
- CROI 2024 Updates Part 2.

Meeting was adjourned at 2:30pm.

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*

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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.

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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.

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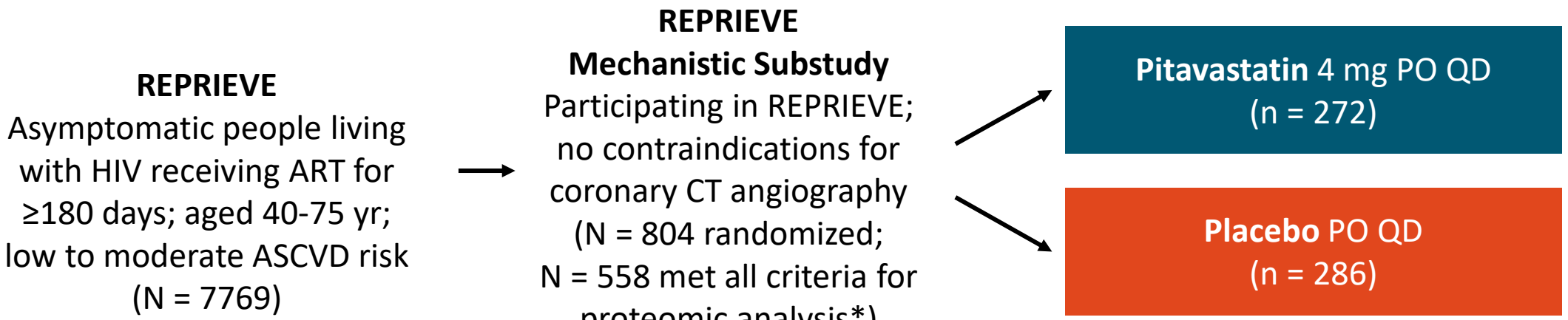
REPRIEVE Mechanistic Substudy: Study Design

- 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.

Kolossváry. CROI 2024. Abstr 151. Lu. JAMA Cardiol. 2024;[Epub].

Slide credit: clinicaloptions.com

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)

Kolossváry. CROI 2024. Abstr 151.

Slide credit: clinicaloptions.com

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**

Kolossváry. CROI 2024. Abstr 151.

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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

Kolossváry. CROI 2024. Abstr 151.

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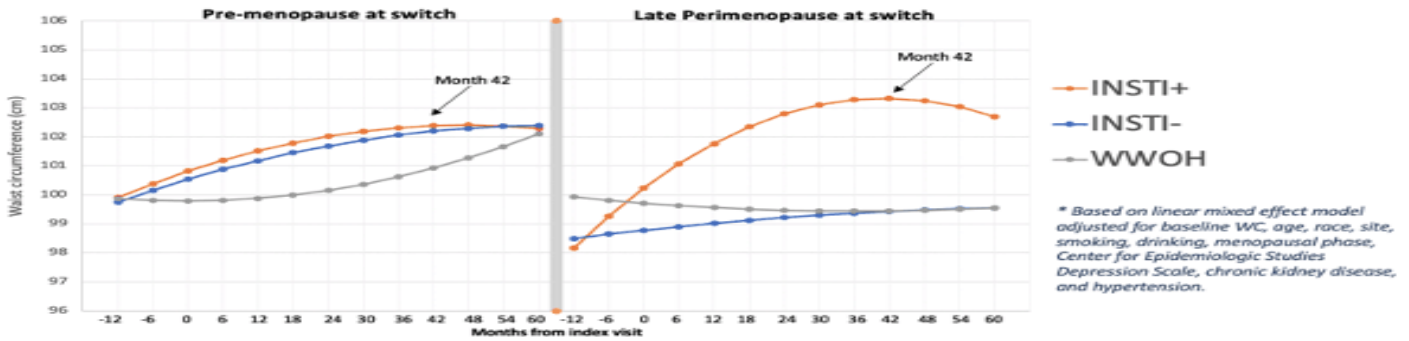
InSTI Switch During Menopause Is Associated With Accelerated Body Composition Change

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

Slide credit: clinicaloptions.com

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

Results

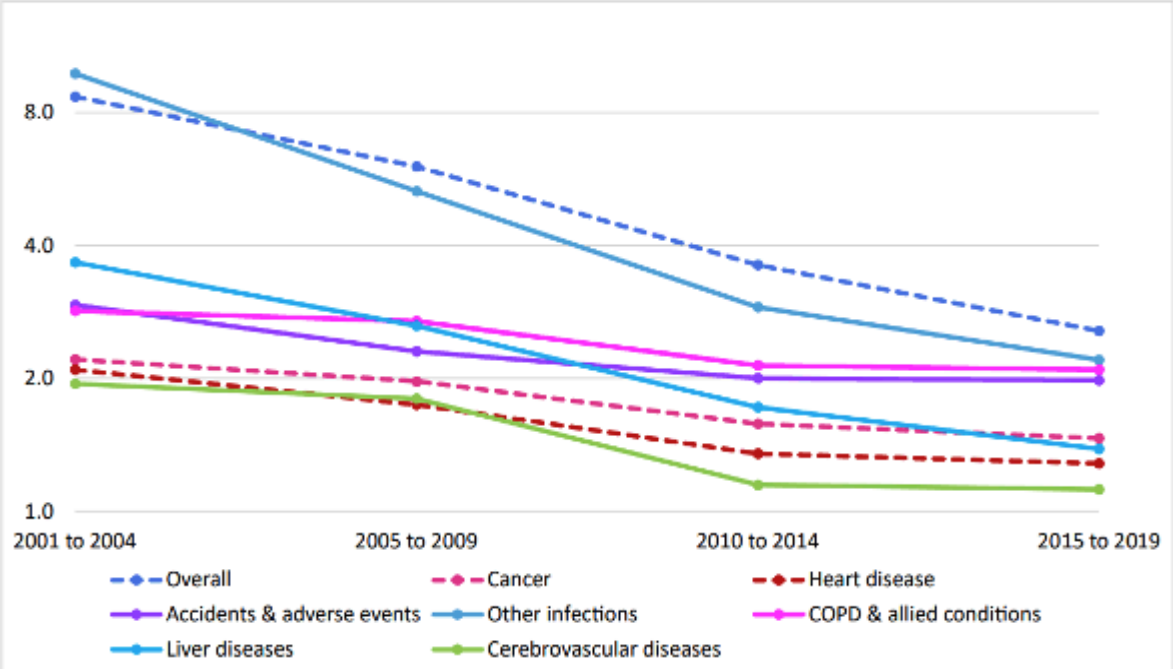
- There were 131,120 deaths among PWH over 5.3 million person-years of follow-up
- Among decedents: 72.2% were male, 61.5% were aged 40–59 years, 51.3% were non-Hispanic Black

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



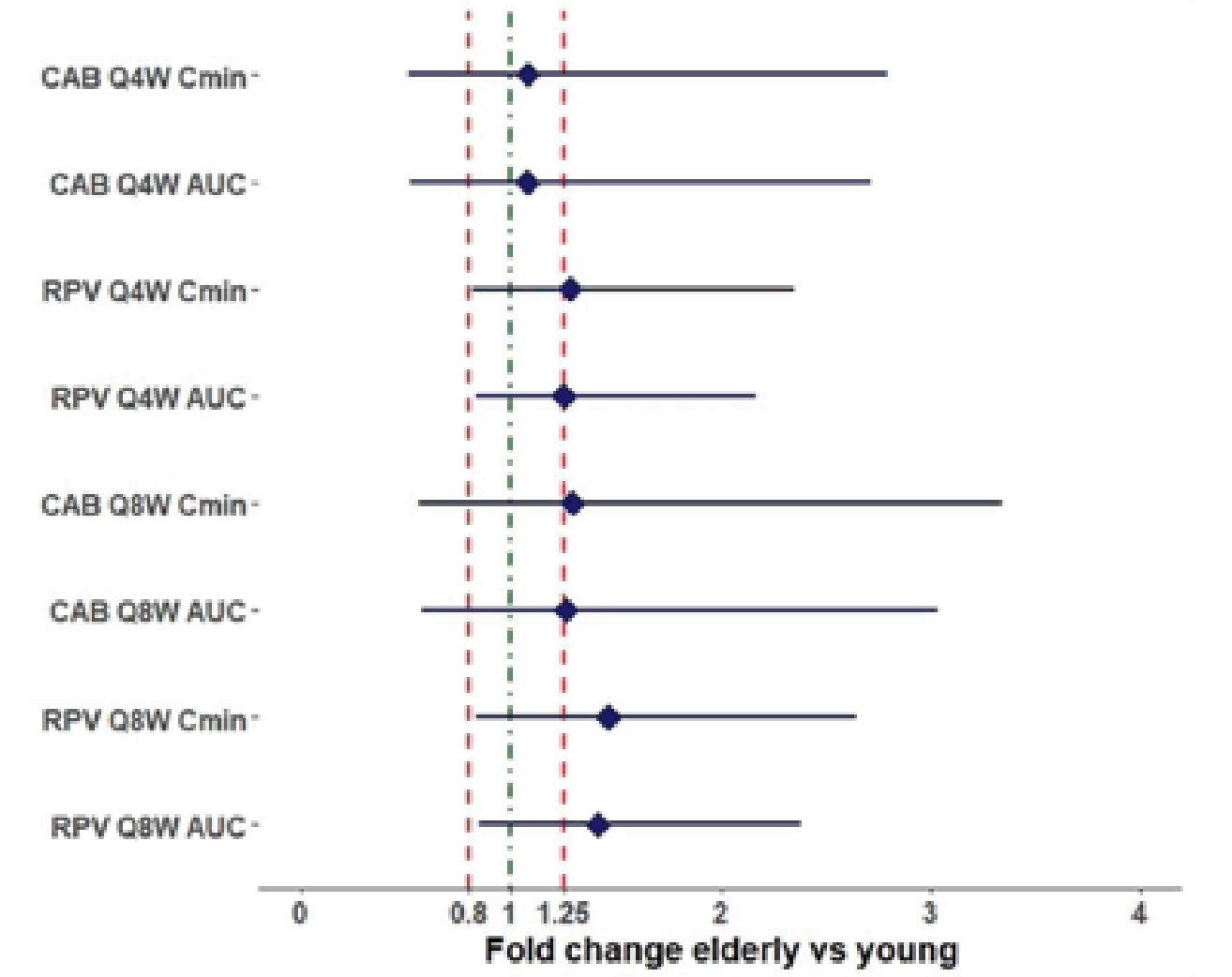
Key Findings

- 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).



OLDER AMERICANS ACT (OAA) UPDATES

(SOURCES: SAGE WEBINARS, CA DEPT. OF AGING, ADMINISTRATION FOR COMMUNITY LIVING)

Aging Caucus

June 3, 2024

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Its History: Signing It Into Law

- First signed in 1965 by President Johnson to establish community services for older people
- A part of his "Great Society Reforms"
- Established authority for grants to states for:
  - Community planning and social services
  - Research and development projects
  - Personnel training in the field of aging.

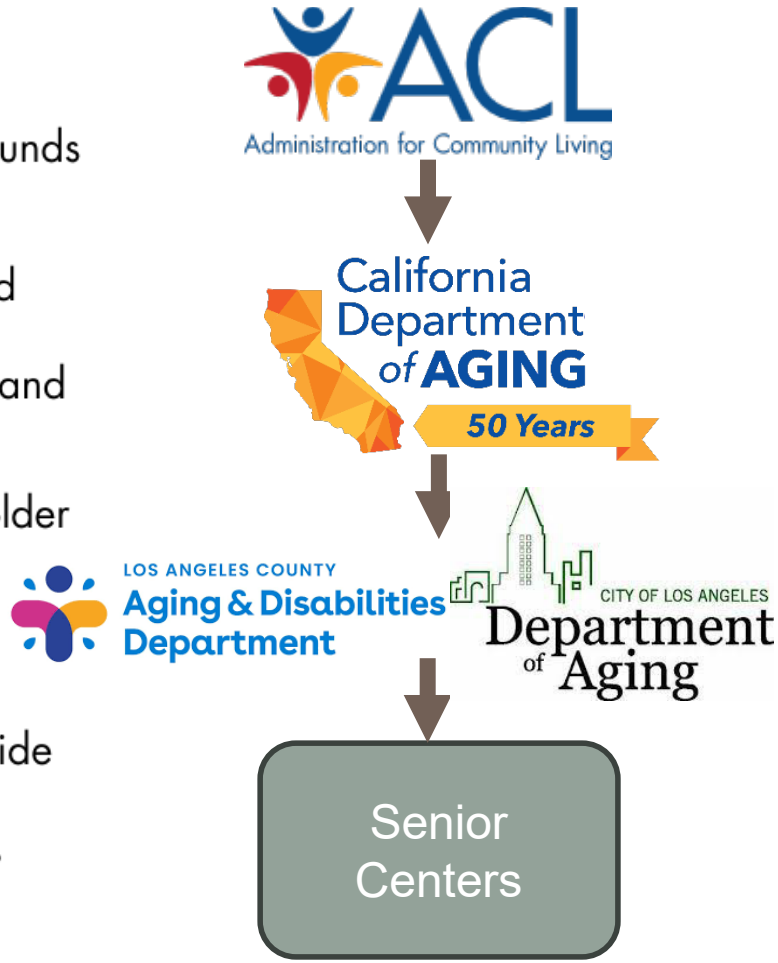
Infrastructure and Agencies Involved

- Our federal department of aging and disability.
- Funded through the Federal Budget and then distributes funds to states…

- Your state department on aging – but it may not be called that!!
- Funded through state legislature and the Federal budget and distributes funds to localities…

- Local base for home and community-based services for older people
- Can be a governmental organization or a nonprofit
- Distributes funds to local service providers

- Receives funds from their AAA and other sources to provide services to the community
- For example… A local senior center! A Meals-on-Wheels program! And other supportive services



How is it funded?

ACL is funded through the Federal Budget

- It then distributes funds to the State Units on Aging
  - The State Units are funded through that federal money, plus money from their state legislature
    - The State Unit then distributes funds to their AAAs (Which are both publicly (by the government) and privately (by foundations/individuals) funded)
      - The AAA then contracts out with service providers like Meals on Wheels and others

The OAA allows states to leverage additional funds, like state revenue, Medicaid, grants, and donations in support of their programs

Agencies Involved in City/County

The State is divided geographically into 33 Planning and Service Areas (PSAs). Within each PSA is an Area Agency on Aging (AAA) responsible for planning and administering services for seniors.

There are 2 AAAs in City and County of Los Angeles.

LOS ANGELES COUNTY
Aging & Disabilities Department

PSA 19
Total 2021-2025 PSA Allocation:
$18,904,507*

CITY OF LOS ANGELES
Department of Aging

PSA 25
Total 2021-2025 PSA Allocation:
$11,423,004*

OAA Title III Total for CA FY 2023" $157,457,510**

*Source: 2021-2025 CA State OAA Plan
**https://acl.gov/sites/default/files/about-acl/2023-10/Title%20III-2023.pdf

What does it actually DO?

- Support older people as they live at home with independence for as long as possible – to prevent people from entering unwanted and cost-prohibitive institutional care
- Updated every four years
- Majority of programs only accessible to people 60+

60+

Supports a wide array of services like…

Support for caregivers

Transportation and legal assistance

Elder abuse prevention

Benefits enrollment help

Meal programs and nutrition assistance

Job training

Community centers

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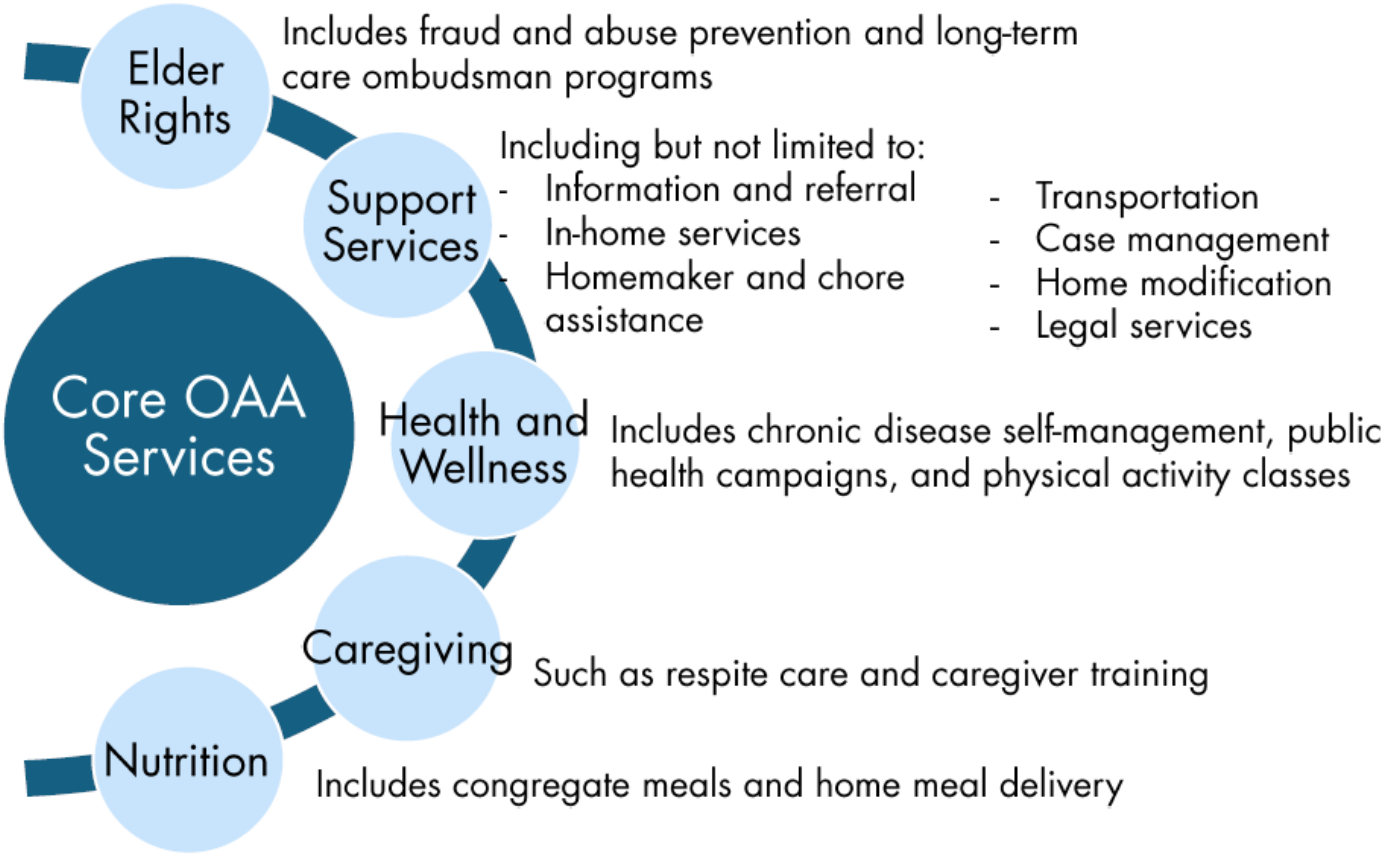
Core Services

All AAAs provide 5 core services under the OAA—but some do more!



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2020 Reauthorization

- Most recent reauthorization of the OAA in 2020 requires that state and local departments of aging (state units on aging and area agencies on aging)…
  - Engage in outreach to LGBT older adults
  - Collect information on their needs
  - And collect information on if they are meeting those needs

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Regulations vs Statutes

A **statute** is a law enacted by the state or federal legislature signed by the Governor (state) or the President of the United States (federal.

A regulation is a policy or procedure, implemented by the administrative agency.

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2024 Regulatory Update

- The most recent update to the Regulations that guide the implementation of the OAA updated the definition of Greatest Social Need to include LGBTQ+ older people and older people living with HIV
- The regulations are ACL's interpretation of the law
- As states implement the OAA they should look to ACL's interpretation
- Serving people who have the greatest economic and greatest social need is one of the basic tenets of the OAA

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2024 Reauthorization Priorities

- Defining LGBTQ+ older people and older people living with HIV as populations of greatest social need in statute
- Add HIV to Routine Health Screening list
- Include HIV in list of chronic diseases under Evidence-Based Health Promotion Programs
- Updated definition of family to include families of choice
- Include and require coordination with Ryan White Programs and/or HIV case management
- Update definition of "older individual" to 40 for PLWH
- Establish Office of Sexual Health
- Cultural Competency Training Requirement
- National Plan in consultation with HRSA
- LGBTQ+ and HIV Long-Term Care Bill of Rights in coordination with CMS
- And more

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PEOPLE LIVING WITH HIV AND OAA OPPORTUNITIES

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The issue

Major areas of concern for many older people living with HIV include food and housing insecurity and the management of finances and health care benefits.

The OAA program to help address it

Benefits enrollment centers that help people understand what public assistance they're eligible for, help them through enrolling, and more

Free and reduced meals at community centers and delivered to homebound elders

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The issue

Older people living with HIV are more likely to be socially isolated.

The OAA program to help address it

The OAA funds senior center programs like support groups, but not all senior centers have support groups specific for people living with HIV, who may not feel comfortable being public about living with HIV in certain spaces.

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The issue

Older people living with HIV have higher rates of frailty and falls.

The OAA program to help address it

The OAA helps prevent falls through home modification, and exercise programs.

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The Issue

Aging with HIV brings an increased risk of other health conditions, including cardiovascular disease, diabetes, renal disease, and cancer.

The OAA program to help address it

Chronic Disease Self-Management Education (CDSME) programs provide older adults and adults with disabilities with education and tools to help better manage chronic conditions such as diabetes, heart disease, arthritis, chronic pain, HIV, and depression.

- There are over 30 CDSME programs
- Most widely disseminated and available are the Self-Management Resource Center suite of programs

The Positive Self-Management Program (PSMP): Helps build confidence in ability to manage health, navigate medication adherence, and maintain active and fulfilling lives for people living with HIV

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State Plan on Aging

- Multi-year State blueprint for Older Americans Act services (§ 1321.27)
- Contains goals, objectives, strategies, outcomes/ performance measures
- Grounded in data
- Intrastate funding formula

- Details how greatest economic and social needs determined, defined.
- How advocacy & services provision targeted to greatest social need.
- Developed by State Unit on Aging consultation with:
  - Stakeholders
  - Area Agencies on Aging
  - ACL Regional Administrators

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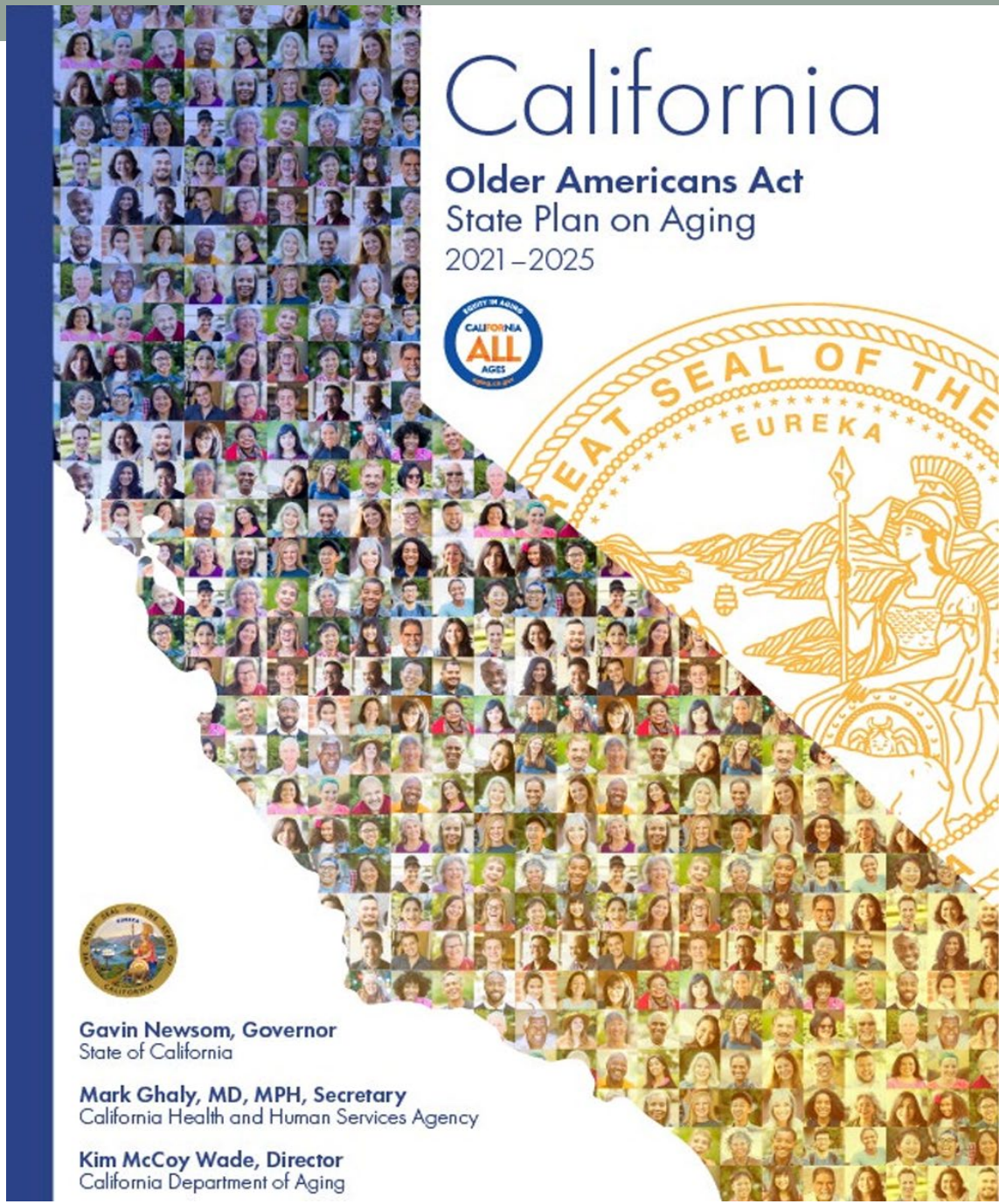
Plans, Plans, Everywhere

- CA OAA State Plan Due July 2025
- Area Plan on Aging (Due to the State May 1, 2024)
  - Similar to state plan but at the regional level
  - Covers distinct planning and service area
  - Submitted to and approved by the State Unit on Aging (CA Dept. of Aging)
  - May include both federal (OAA) and State requirements.
  - 4-year period for CA (can be 2, 3 or 4); *Area plan updates, as needed*
  - There may be individual area plan guidance from states
  - Must take into account stakeholders and advisory council input on those in greatest economic and social need, including PLWH.

https://aging.ca.gov/download.ashx?lE0rcNUV0zamRRK2e67GGw%3d%3d – State OAA Plan

….there is also the CA Department of Aging Strategic Plan and the Master Plan on Aging



No Income Requirements | But there is a "PREFERENCE"

While the OAA is concerned with the provision of services to all older persons, it requires assurance that preference is given to older individuals with greatest economic or social needs, with particular attention to low-income minority individuals. Under the OAA, the term "greatest economic need" means the need resulting from an income level at or below the poverty level established by the Office of Management and Budget. The term "greatest social need" means the need caused by non-economic factors that include physical and mental disabilities, language barriers, and cultural, social, or geographical isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks, or which threatens such individuals' capacity to live independently.

"Greatest economic need" "Greatest social need"

https://aging.ca.gov/download.ashx?lE0rcNUV0zamRRK2e67GGw%3d%3d

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance;

Poverty Guidelines for Older Americans Act and Older Californians Act Programs Updated: February 2024

OAA Title III Programs shall use the FPG for targeting and reporting purposes. These programs do not have income eligibility requirements for participation. The AAAs shall consider the needs of individuals at or below 100 percent of the FPG in targeting services. Services shall be targeted to those with the greatest social and economic need with particular attention to low-income minority individuals, as set forth in the California Code of Regulations (CCR), Title 22, Division 1.8, Chapter 3, Article 3, Section 7310.

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Additional Resources

- https://aging.ca.gov/Providers_and_Partners/Area_Agencies_on_Aging/Supportive_Services/Program_Narrative_and_Fact_Sheets/

- PSA 19 Los Angeles Pages 60-61Clients Served/Expenditures https://aging.ca.gov/download.ashx?lE0rcNUV0zYgMJ2eUjlfxA%3d%3d
- Justice in Aging- LAC Snapshot https://justiceinaging.org/wp-content/uploads/2023/03/Snapshot-of-Older-Adults-in-LA-County-Accessible-Outline.pdf

Recommendations

- Engage and partner with LA County Commission on Older Adults https://ad.lacounty.gov/commissions/laccoa/
  - Increase awareness and education through public comments/letters
    - Meet every first Monday of the month at 10:00 a.m.
- Participate in, synchronize, and leverage City and County AAA planning processes
- Engage and partner with LA City Aging and Disability Resource Connection (ADRC) Advisory Committee https://aging.lacity.gov/adrc-advisory-committee/
- Provide input in the State of CA OAA Plan (due 2025)

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- Thank you.
- Reflections and Comments.
- Discussion.
- Questions and Answers.

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2024 AGING CAUCUS WORKPLAN (REVISION DATES:4.17.24)

Created 02.09.24. Adopted 4.2.24

Task Force Adoption Date: 4.2.24

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)	4th Quarter 2024	
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.	July-October	
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?*	Ongoing	
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.	Ongoing	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).	Completed at AC meeting on 4/2/24.	
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.	September	
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.	Ongoing	Consider as topics for the annual conference

	• 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?*	Leverage LA Gay and Lesbian Center HIV and Aging Educational event on May 29	