LOS ANGELES COUNTY
COMMISSION ON HIV

AGING CAUCUS

VIRTUAL MEETING AGENDA

TUESDAY, AUGUST 2, 2022

1:00 PM – 3:00 PM

TO JOIN BY WEBEX, CLICK:

https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m2b6bf7de0033f275b1d4de30eaaa9e83

PASSWORD: AGING

TO JOIN BY PHONE: +213-306-3065 **MEETING #/ACCESS CODE:** 2594 723 8400

1.	Welcome & Introductions	1:00pm-1:10pm
2.	Co-Chairs' Report a. International AIDS Society Conference	1:10pm-1:25pm
3.	Division of HIV and STD Programs (DHSP) Report	1:25pm-1:40pm
4.	DISCUSSION: Revisit recommendations to include activities and strategies to address the needs of long-term survivors and individuals who acquired HIV perinatally	1:40pm-2:25pm
5.	Executive Director/Staff Report a. Social Media Update b. Comprehensive HIV Plan 2022-2026	2:25pm-2:35pm
6.	Next Steps and Agenda Development for Next Meeting	2:35pm-2:45pm
7.	Public Comments & Announcements	2:45pm-3:00pm
8.	Adjournment	3:00pm

LOS ANGELES COUNTY
COMMISSION ON HIV

AGING CAUCUS
July 5, 2022
Virtual Meeting Summary

In attendance:

Al Ballesteros (Co-Chair)	**Joe Green (Co-Chair)**	Allison Agwu, MD
Danielle Campbell	Mikhaela Cielo, MD	Viviana Criado
Carlene Davis	Kevin Donnelly	Michael Green (DHSP)
Helen	Lee Kochems	Pajazz Marie
Paul Nash	Katja Nelson	Pamela Ogata (DHSP)
Fran Sereseres	Ruben Vidales	Cheryl Barrit (COH Staff)
Catherine Lapointe (COH Staff)	Dawn McClendon (COH Staff)	Jose Rangel-Garibay (COH Staff)

CHP: Comprehensive HIV Plan
COH: Commission on HIV
DHSP: Division of HIV and STD Programs
DPH: Department *of Public Health*

Meeting packet is available at: https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/a3b13441-1cd1-46ac-966a-776d93b9a19c/Agenda-ATF_070522-Final-Rev.pdf

1. **Welcome & Introductions**
   Joe Green, Co-Chair, welcomed attendees and led introductions.

2. **Co-Chairs' Report**
   a. **Feedback to DHSP on Proposed Goals to Align the Ryan White Program with the California Master Plan on Aging**
      - Cheryl Barrit provided an overview of feedback from the Aging Caucus on the *Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging.* The document can be found in the meeting packet. Key feedback points are as follows:
        - Increase the provision of intergenerational housing rather than creating aging ghettos.
        - Add gerontology awareness training rather than geriatric only.
        - Foster interlinked service provision to meet the needs of intersectional clients.
        - Services should not be solely offered online.
        - Peer navigator systems could assist in upskilling people and providing them with employment to help others navigate health and social care as well as housing and benefits.

- Dr. Michael Green, DHSP expressed appreciation for the Aging Caucus' feedback on the document.
- Viviana Criado supported the document and expressed interest in reviewing the final product, as this work aligns with the Los Angeles Alliance for Community Health and Aging (LAACHA).
- C. Barrit will send the updated document to DHSP for review.
- Paul Nash stated that he is open to further explaining his feedback on the document.

3. **Division of HIV and STD Programs (DHSP) Report** – *No report provided.*

4. ***Special Guest Speakers and Community Discussion***
   Understanding Aging among Individuals who Acquired HIV Perinatally and Long-term Survivors under 50
   - At their June meeting, the Aging Caucus decided to hold a community discussion to better understand the needs of individuals who acquired HIV perinatally and long-term survivors under 50. Invited subject matter experts facilitated the discussion.

   Mikhaela Cielo, MD, Part D Representative, Commission on HIV, Assistant Professor of Clinical Pediatrics, University of Southern California Keck School of Medicine
   - Dr. Mikhaela Cielo related to Dr. Agwu's presentation. She stated that more support is needed for life skills to help perinatally infected individuals transition into adulthood. She also noted this population often feels forgotten and it is important to have support groups and mental health services.

   Community Members with Lived Experience
   - The group heard from two individuals who perinatally infected with HIV. The speakers shared their experiences and difficulties living with HIV.
   - Danielle Campbell noted the importance of including people who perinatally acquired HIV in discussions around aging.

   Allison Lorna Agwu, MD, Sc.M, Professor of Pediatrics John Hopkins School of Medicine https://www.hopkinsmedicine.org/profiles/details/allison-agwu
   - Dr. Allison Lorna Agwu, Professor, Pediatric and Adult Infectious Diseases; Director, Pediatric Adolescent HIV/AIDS Program and Accessing Care Early Clinic, Johns Hopkins School of Medicine, gave a presentation titled "Understanding Aging Among Individuals who Acquired HIV Perinatally and Long-term Survivors under 50." Main points from the presentation were as follows:

    - Among people who perinatally acquired HIV, 14% are under the age of 13; 47% are between the ages 13-24; 38% are between the ages 25-34; and 1% are 35 and older.
    - Among adolescents and young adults aged 13-24 living with HIV, male to male sexual contact accounts for 82% of cases among males and heterosexual contact accounts for 48% of cases among females.
    - Multimodal, combination strategies and approaches, improved engagement strategies, behavioral and community interventions, optimizing care models, and personalized medicine are recommended treatment options for youth.
    - It is important to think about the life course perspective for adolescents with HIV and addressing each stage in life.
    - 25%-60% of youth with HIV had mental health problems including depression, anxiety, and ADHD.
    - Among youth living with HIV, 24% reported either daily or almost daily tobacco use.
    - 40-52% of HIV-positive young adults are overweight or obese.
    - Long-term comorbidities associated with antiretroviral therapy (ART) include cardiovascular disease, malignancy, medication side effects, metabolic abnormalities, central nervous system issues, and longstanding inflammation.
    - Providers can help this population through education, counseling, and screening. They must also be aware of the unique comorbidities to optimize care and outcomes.
- Ruben Vidales commended Dr. Agwu on her presentation. He inquired about the effects of COVID-19 on youth living with HIV. Dr. Agwu responded that a few patients were hospitalized with COVID-19 due to immunosuppression; however, the social effects of the pandemic were more prominent. This includes job loss, economic devastation, and unstable housing. There were no long-term health effects as a result of COVID-19.
- Carlene Davis asked Dr. Agwu what her number one recommendation is to help youth living with HIV. Dr. Agwu recommended optimizing all aspects of health so that this group can live their lives to the fullest. C. Davis also asked if there are any differences in outcomes among transitional age/foster youth and other youth. Dr. Agwu stated there is not any recent research.
- Dr. Agwu can be reached by e-mail at ageorg10@jhmi.org.
- Kevin Donnelly asked Dr. Agwu what are some ways to help young adults who were born with HIV. She suggested supporting this group as they transition into adulthood, being aware of the uniqueness of their situation, and to be intentional about serving this population.

5. Next Steps and Agenda Development for Next Meeting

- The Aging Caucus will review their set of recommendations and incorporate feedback from the community discussion into the document.
- C. Barrit will send feedback on the *Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging* to DHSP.
- J. Green requested an update on the Commission's social media efforts.

6. **Public Comments & Announcements** – *There were no public comments or announcements.*

7. **Adjournment** – *The meeting adjourned at 2:23 PM.*

Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging

BACKGROUND: Currently more than 52% of people living with diagnosed HIV (PLWDH) in Los Angeles County are 50 years of age or older, and by 2030 more than 70% of PLWDH will be over the age of 49. As people age, they typically have more co-morbidities, take more medications, and are more vulnerable to side effects complicating the management of their HIV disease. PLWDH who are 50 years or older (50+) experience accelerated CD4 loss, decreased immune recovery, and are at an increased risk of acquiring serious non-AIDS illnesses. Long term health complications from HIV include poor mental health and bone, kidney, cardiovascular, and liver diseases.

This workplan aims to anticipate and address the physical, mental, social, and economic needs of PLWDH 50+ for good quality of life.

KEY SOURCE DOCUMENTS:
CA Master Plan on Aging document https://mpa.aging.ca.gov/

Goal One: Housing for All Stages and Ages

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
Increase coordination among housing agencies to include intergenerational housing options	Identify if/how housing for HIV positive seniors is prioritized	RWP housing providers, HOPWA, CoC			
Examine housing inventory to ensure that it provides safe and welcoming environments for seniors	Investigate if there is a list of housing regulations specifically for seniors				
Blend funding to support housing and rental assistance for seniors living with HIV	Identify all available housing assistance for seniors in LAC, note eligibility criteria, and assistance amount $				

Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
Identify services that can assist seniors in transitioning from different levels of residential support (i.e. independent living to assisted living) based on physical and cognitive needs	Research services provided by other LAC programs and cities				
Support training for housing service providers on needs of PLWH and LGBTQI persons to improve cultural competencies among staff	Research what training PAETC and other TA providers offer				
Foster mentorships between seniors and youth to improve understanding across generations of the HIV pandemic, its effects, and how seniors can be supported and honored within the community					

Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging

Goal Two: Health Reimagined

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
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	Research what training PAETC and other TA providers offer.				
Add Quality of Life (QOL) metrics to data collection variables to identify areas where changes in services and service access can lead to improved QOL among all people living with HIV	Identify validated QOL measures and discuss with Standards and Best Practices Committee				
Standardize age categories to identify priority populations for specialized services	Research age categories used in gerontology studies				
Review/update diagnostic screenings to include age-related conditions (i.e.	Compile list of diagnostic screenings and associated costs. Determine				

Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
screen for loneliness, ACEs, depression, anxiety, experiences of discrimination)	frequency of screenings and referral plan.				
Revise HIV Home Health and Support services to blend with existing services for PLWH over age X	1. Identify existing services (State OA, Cal-AIM expansion) 2. Convene internal DHSP HBCM workgroup				
Expand access to services that can prevent or slow age-related physical and mental declines					
Develop and maintain robust resource directories and train PLWH to access and use them	Identify existing resource directories				
Develop case management services that can monitor if care and support services are meeting the needs of seniors post-transition to Medi-Cal/Medicare	Standards and Best Practices will develop draft of service standards				

Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging

Goal Three: Inclusion and Equity, Not Isolation

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
Develop strong linkages to community social support programs for all PLWH, especially youth and seniors					
Acknowledge and support nontraditional family relationships that nurture well-being and social connection					COH recommends the Village model The Village Movement | Grantmakers in Aging (giaging.org). One of the core components of this model are volunteers. Volunteerism has declined over the past decade, especially in Los Angeles
Connect to ongoing education and learning programs to foster community engagement and physical activities that promote healthy living					
Improve all access, including digital access and understanding of digital programs	Research what training other LAC programs, PAETC, and other TA providers offer				
Develop linkages to community employment and volunteer training and opportunities	Collaborate with Job Corps and other agencies				
Foster mentorships between seniors and youth to improve understanding across generations					COH recommends that we remove HIV to address all life experiences

Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
of the HIV pandemic, its effects, and how seniors can be supported and honored within the community					
Add provider training that requires history of HIV, HIV politics and advocacy (this should be a mandatory Commission training as well)					
Develop transitional case management programs that help PLWH transition from RWP into Medicare, CalAIM, etc.	Standards and Best Practices will develop draft of service standards				This service should provide a single point of contact that seniors can reach out to for assistance
Foster strong community engagement and community planning that honor lived experiences of PLWH					

Goal Four: Caregiving That Works

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
Develop/support educational programs for service providers on sexual health for PLWH aged 50+ or (age X)	Research what training PAETC and other TA providers offer				These services should be provided online as well as in person. In person appointments may be the only social contact some seniors may have
Support educational and vocational training					

Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
programs that blend HIV medicine and social services with the broader needs of youth and an aging population of PLWH					
Seek out mental health specialists who can treat both HIV and age-related conditions					
Develop training programs for nontraditional families to support each other as they age with HIV					
Reduce the digital divide by promoting access to and understanding of digital and online services	Research what training other LAC programs, PAETC, and other TA providers offer				

Goal Five: Affording Aging

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
Support robust benefits enrollment, financial and retirement planning for PLWH					

Commented [PO1]: COH recommends a peer support model with a single point of contact

Alignment of Los Angeles County's Ryan White Program with the California Master Plan on Aging

Objective	Activity	Partners	Timeline	Performance Measure (Baseline/Target)	Notes
Expand access to emergency financial assistance and financial planning services to senior PLWH	Obtain and review data on what % of EFA clients are 50+				
Develop and maintain strong linkages with nutrition and housing programs to eliminate barriers to access, safe, and affordable housing and nutrition services					

Understanding Aging Among Individuals who Acquired HIV Perinatally and Long-term Survivors under 50

Allison Agwu, MD ScM, FAAP FIDSA
Professor, Pediatric and Adult Infectious Diseases
Director, Pediatric Adolescent HIV/AIDS Program and Accessing Care Early Clinic
Johns Hopkins School of Medicine, Baltimore, Maryland, USA
July 5, 2022

Disclosures

- Gilead scientific advisory board, site investigator under clinical research contract managed through JHU
- Merck scientific advisory board, consultant, site investigator under clinical research contract managed through JHU

Objectives

- Review the epidemiology of individuals with early-acquired HIV
- Describe risk factors for developing comorbidities over the life course
- Discuss opportunities to prevent comorbidities and optimize outcomes

PEDIATRICS
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Acquired Immunodeficiency Syndrome in Children: Report of the Centers Control National Surveillance, 1982 to 1985
Martha F. Rogers, Pauline A. Thomas, E. Thomas Starcher, Mary C. Noa, Timothy J. Bush and Harold W. Jaffe

"although they make up only 1% of AIDS patients, they have unique clinical, social, and public health problems that require special attention." Rogers

First known infant to be born with HIV

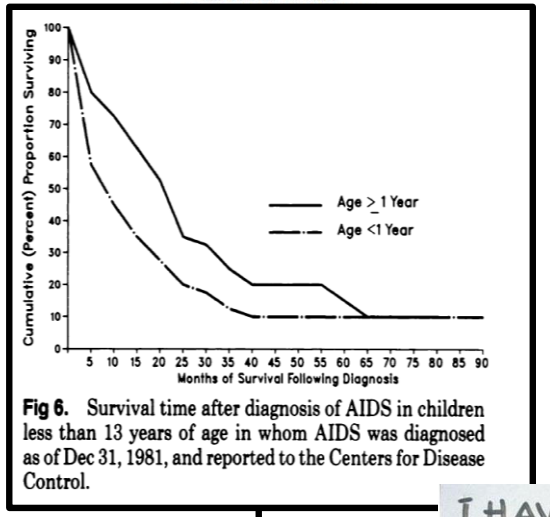
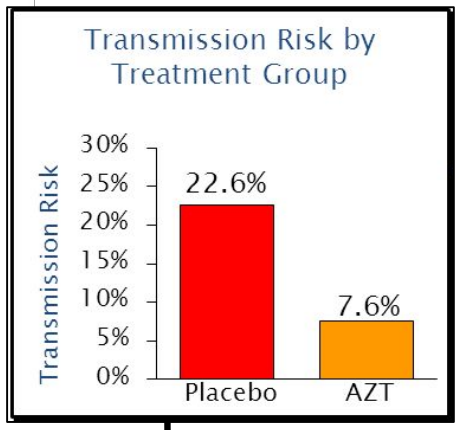
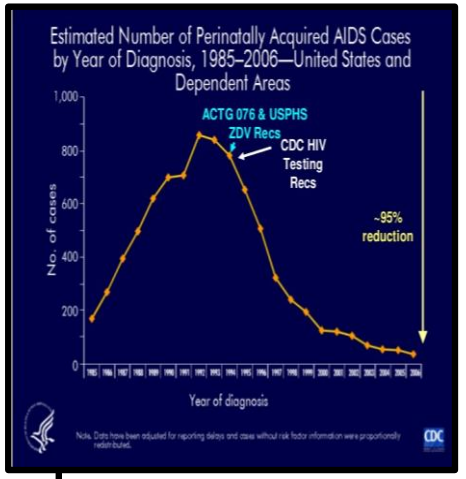
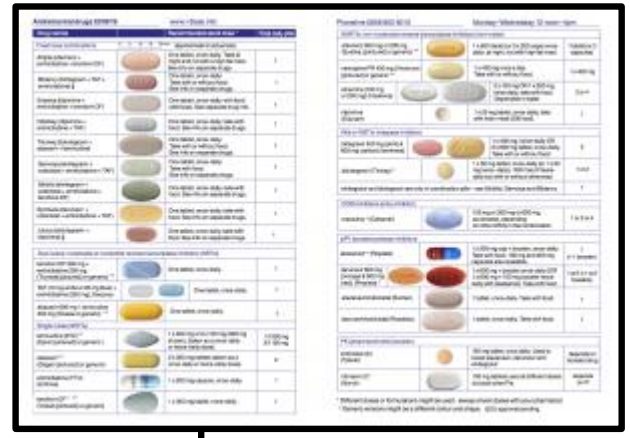
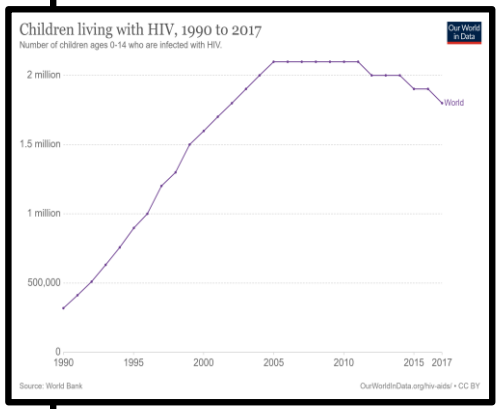


Fig 6. Survival time after diagnosis of AIDS in children less than 13 years of age in whom AIDS was diagnosed as of Dec 31, 1981, and reported to the Centers for Disease Control.









RARE CANCER SEEN IN 41 HOMOSEXUALS

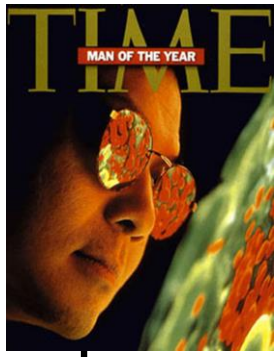
Outbreak Occurs Among Men in New York and California —8 Died Inside 2 Years

By LAWRENCE K. ALTMAN

Doctors in New York and California have diagnosed among homosexual men 41 cases of a rare and often rapidly fatal form of cancer. Eight of the victims died less than 24 months after the diagnosis was made.

The cause of the outbreak is unknown, and there is as yet no evidence of contagion. But the doctors who have made the

FDA approves 1st HIV ab test



FDA approves Nelfinavir for kids

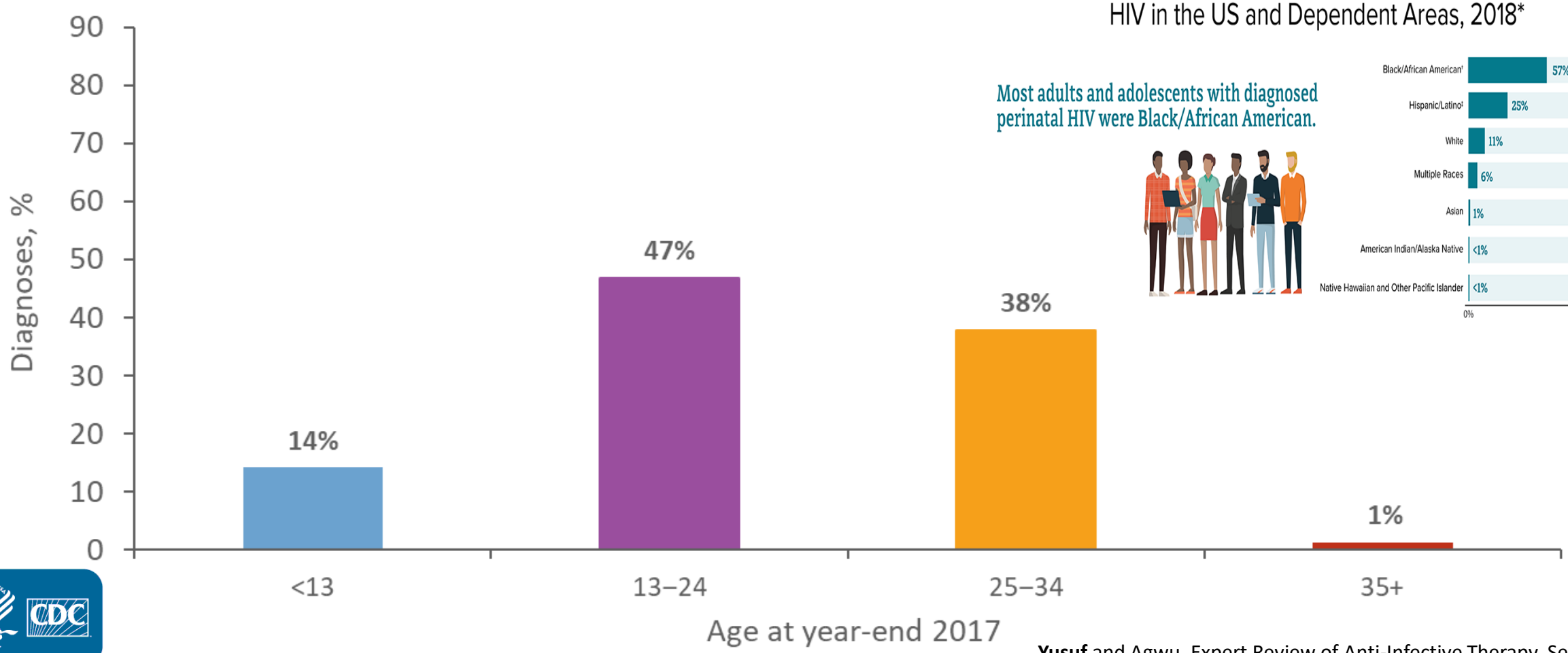
'Cured' HIV Baby is Infected, Doctors Find

South African child in HIV remission without drugs

1977 1980 1982 1985 1987 1988 1990 1994 1996 2003 2006 2013 2014 2015 2017 2020 2021

https://www.hiv.gov/sites/default/files/aidsgov-timeline.pdf; Rogers et al. 1987 (79): 1008-1014

Age Distribution of Persons Living with Diagnosed Perinatally Acquired HIV Infection, Year-end 2017—United States and 6 Dependent Areas (N = 11,924)



Yusuf and Agwu. Expert Review of Anti-Infective Therapy. Sep 2020

Many AYA born with HIV are thriving……

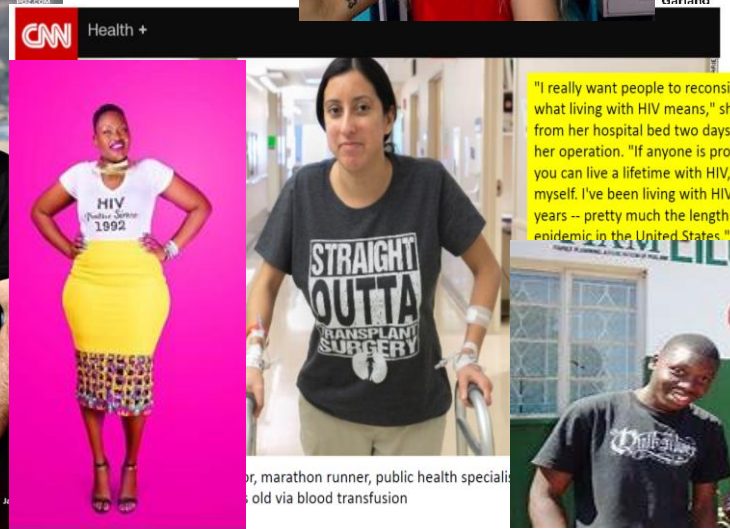
Health | Nation & World

First wave of babies born with HIV nearing 30

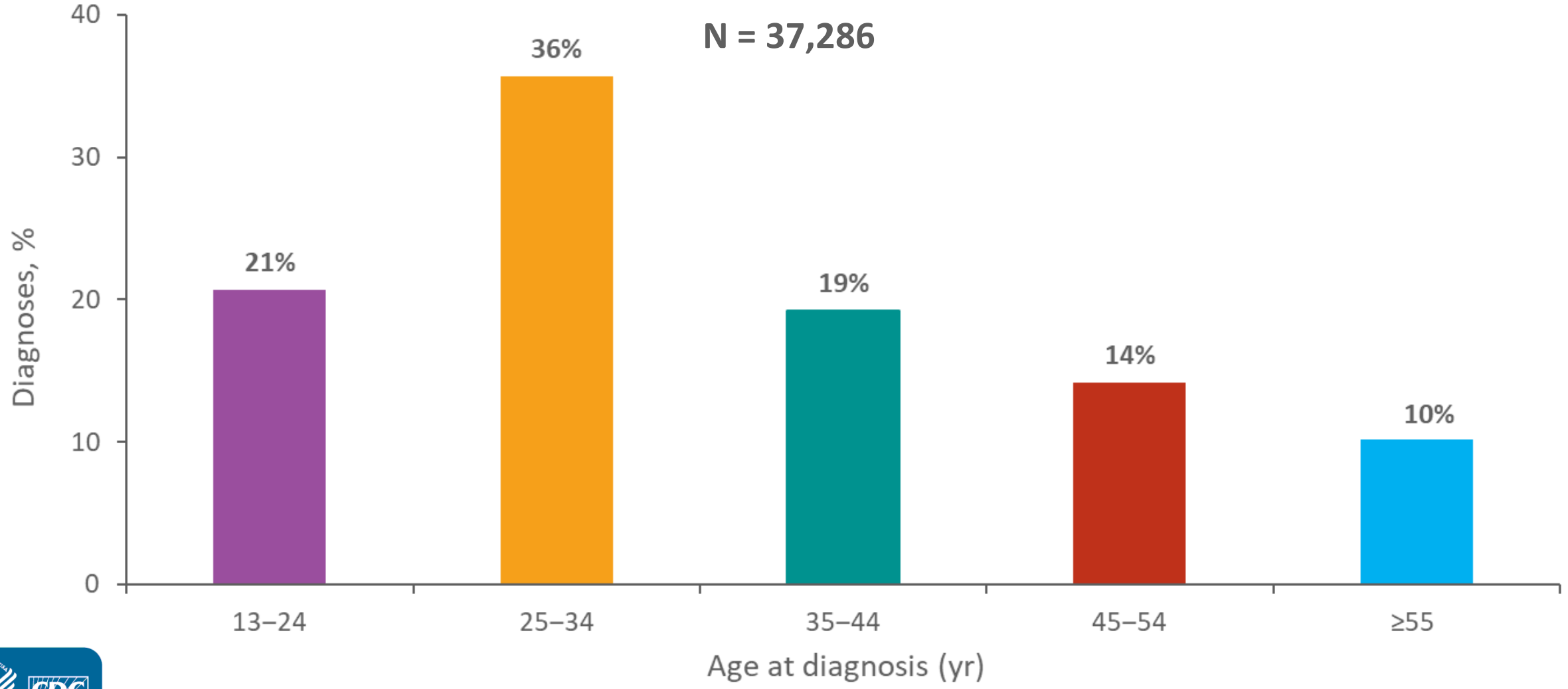
Originally published October 9, 2010 at 6:15 am | *Updated October 9, 2010 at 8:16 am*

Chaneil Scott, left, and Lafayette Sanders, of Philadelphia, were both infected with HIV at birth. Both of the… have died, too. Scott is a college sophomore; Sanders is a brand rep for a… More

…as said

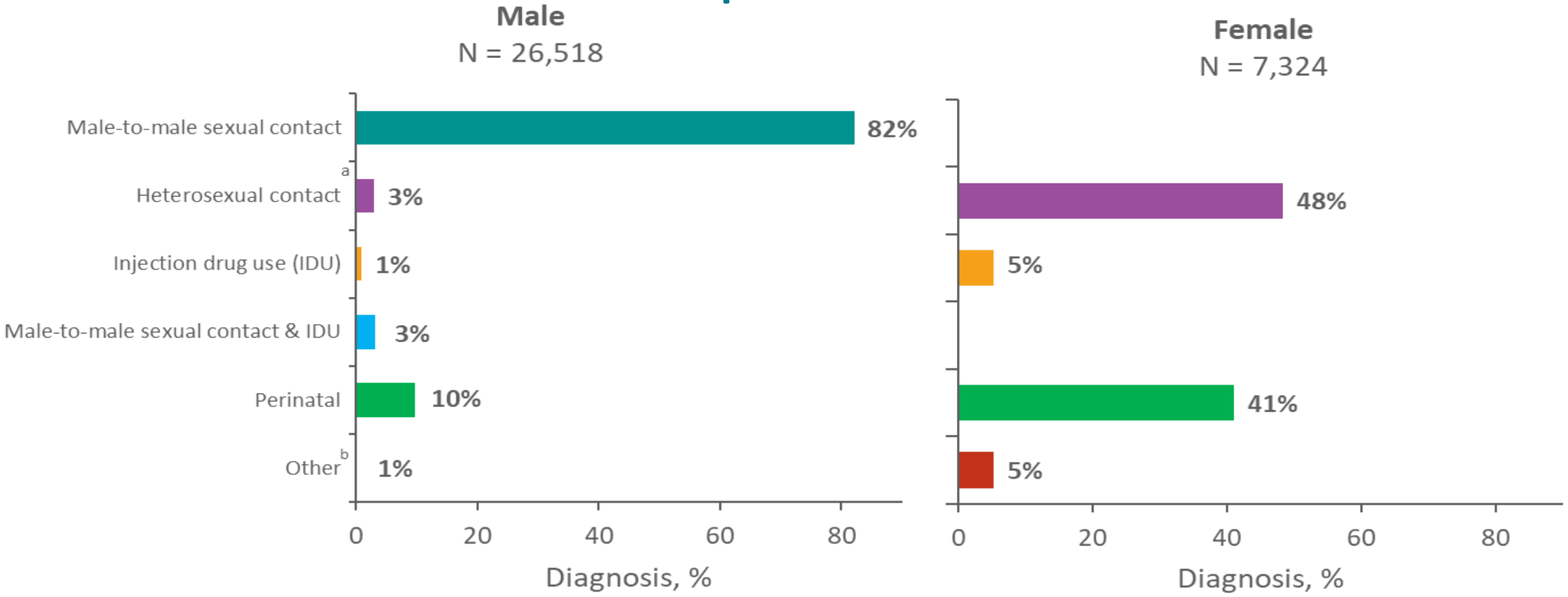


Diagnoses of HIV Infection among Adults and Adolescents by Age at Diagnosis, 2018—United States



Note. Data for the year 2018 are considered preliminary and based on 6 months reporting delay.

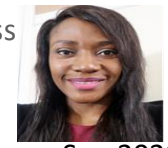
Adolescents and Young Adults Aged 13–24 Years Living with Diagnosed HIV Infection by Sex and Transmission Category, Year-end 2017—United States and 6 Dependent Areas



Note. Data have been statistically adjusted to account for missing transmission category. "Other" transmission category not displayed as it comprises 1% or less cases.

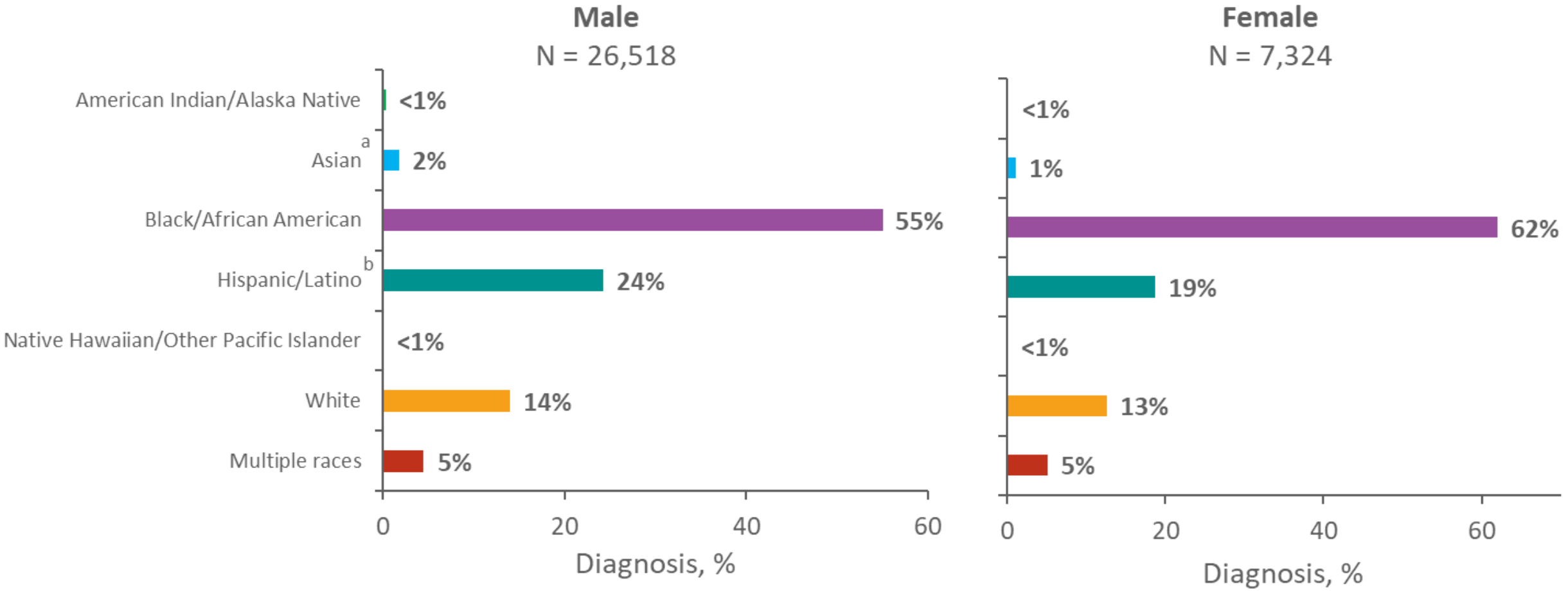
[a] Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

[b] Includes hemophilia, blood transfusion, and risk factor not reported or not identified.



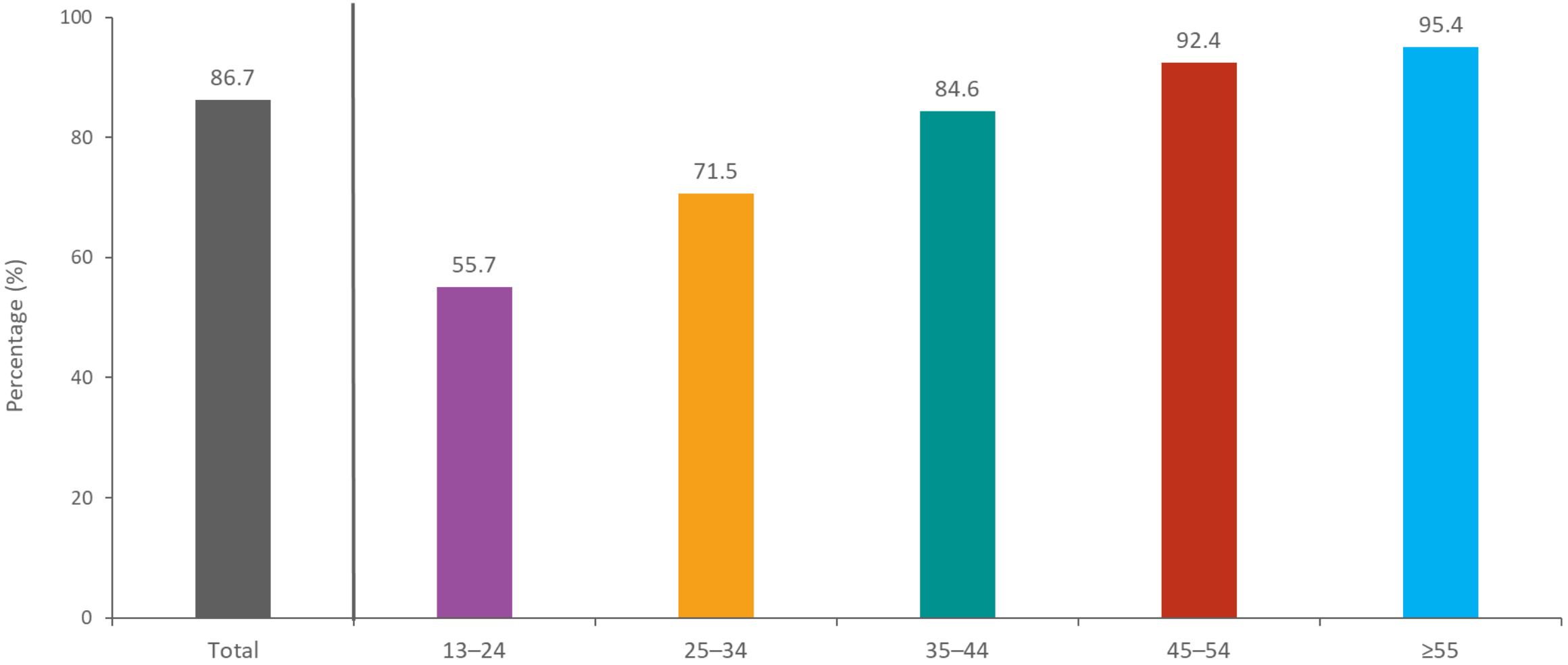
Yusuf & Agwu. Expert Review of Anti-Infective Therapy. Sep 2020

Adolescents and Young Adults Aged 13–24 Years Living with Diagnosed HIV Infection, by Sex and Race/Ethnicity, Year-end 2017—United States and 6 Dependent Areas



[a] Includes Asian/Pacific Islander legacy cases.
[b] Hispanics/Latinos can be of any race.

Diagnosed Infection among Persons Aged ≥13 Years Living with Diagnosed or Undiagnosed HIV Infection, by Age, 2019—United States



Note. Estimates were derived from a CD4 depletion model using HIV surveillance data. Estimates for the year 2019 are preliminary and based on deaths reported to CDC through December 2020.

Persons Living with Diagnosed or Undiagnosed HIV Infection
HIV Care Continuum Outcomes, by Age, 2018—United States

OPPORTUNITIES

Note. Receipt of medical care was defined as ≥1 test (CD4 or VL) in 2018. Retained in continuous medical care was defined as ≥2 tests (CD4 or VL) ≥3 months apart in 2018. Viral suppression was defined as <200 copies/mL on the most recent VL test in 2018.

Next for treatment for youth

- Multimodal, combination strategies & approaches
  - ART modified (stronger, longer, safer, simpler)
    - ART Resistance
  - Different delivery modes & strategies
  - Monoclonal ab
  - Vaccines
  - Latency reversing agents
  - Activated T cells
- Improved engagement strategies
- Behavioral and community interventions
- Optimizing care models
  - Alternative “venues” for care delivery
  - Increased use of technology
- Personalized medicine?

JOHNS HOPKINS MEDICINE

I>AV

I>AV

I am greater than my highs and lows.

T1D INTERNATIONAL

I>AV

Life course perspective for adolescents with HIV

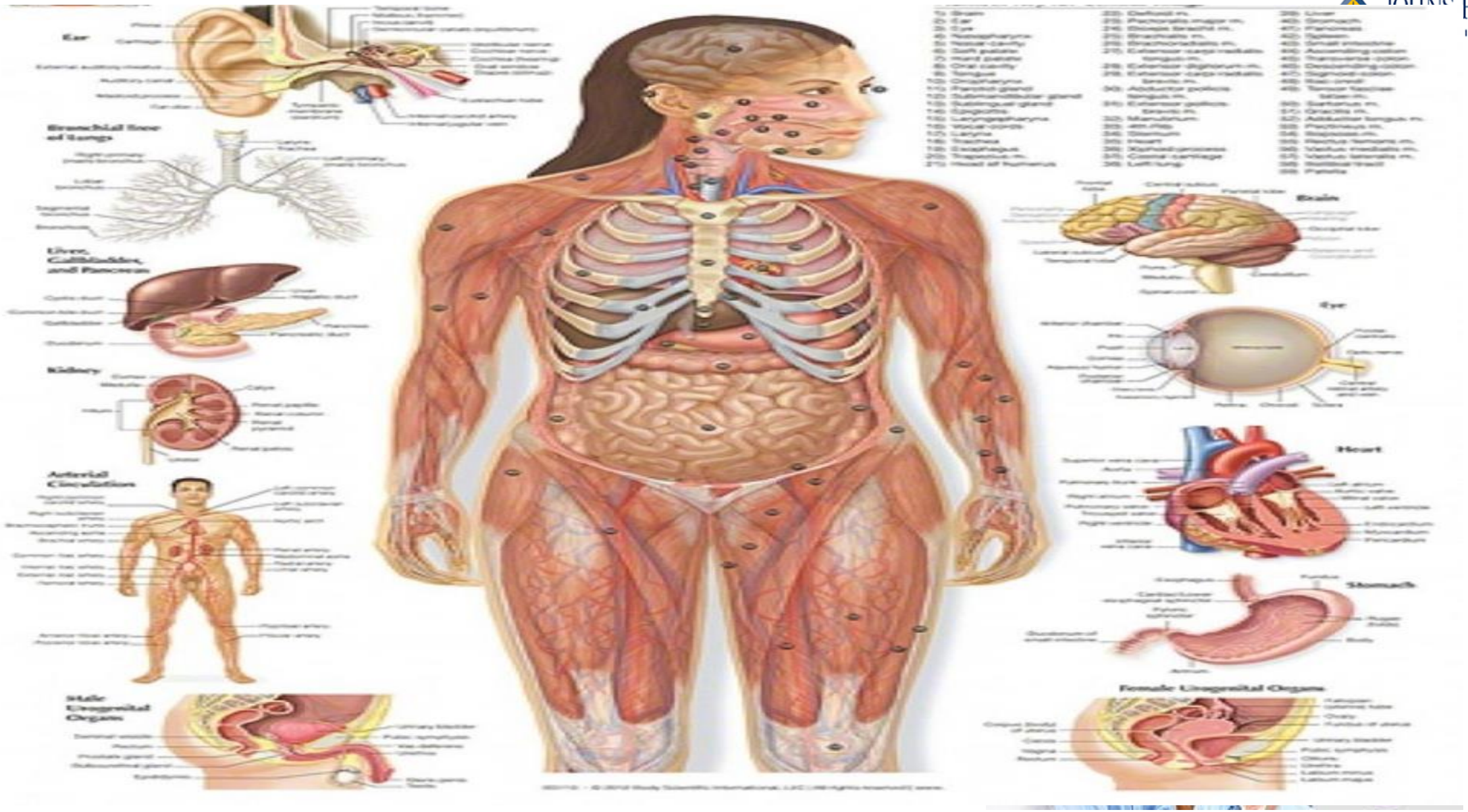
	2nd Decade 10-19 years	3rd Decade 20-29 years	4th Decade 30-39 years	5th Decade 40-49 years	≥6th Decade ≥50 years
					
Environmental/Psychosocial Factors					
Life events	School Trade School/College Employment Parent/guardian loss	Trade School/College Employment Partnerships Children Parent/guardian loss	Employment Partnerships Children Parent/guardian loss	Employment Partnerships Parent/guardian loss	Employment/Retirement Partnerships
Self-management	Parental/caregiver involvement wanes	Self-management			Self-management May need assistance
Disclosure	Disclosure (to self) Disclosure to others	Disclosure of status to partners, children, friends, others			
Stigma	Internal and external stigma				

Zinyemba TP et al. J Econ Surveys 2019; **Yusuf** and Agwu. Expert Review of Anti-Infective Therapy. Sep 2020

Life course perspective for adolescents with HIV

	2nd Decade 10-19 years	3rd Decade 20-29 years	4th Decade 30-39 years	5th Decade 40-49 years	≥6th Decade ≥50 years
					
Treatment and Treatment-related Factors					
Antiretroviral treatment	Simple regimens* Increased responsibility of ART	Simple regimen Increased complex regimens due to development of resistance Full responsiblilty of ART	Simple regimen Increased complex regimens due to development of resistance Full responsiblilty of ART		
Adherence	May wane with decreased parental/caregiver involvement, stigma and nondisclosure to peers	Adherence variable Increased risk of resistance			
Co-morbidities	OIs if nonadherent with immune compromise Non-AIDS comorbidities	Inflammation, accelerated ageing, increased risk of comorbidities	Inflammation, accelerated ageing, ↑ risk of comorbidities		
Care Delivery	Pediatric/Adolescent care; transition from pediatric to adolescent or adult care may occur	Transition to adult care	Adult Care		
Risk factors	Tobacco, substance use may commence, modifiable risk factors begin	Increased weight gain, engagement in modifiable risk factors			

Yusuf and Agwu 2021



How will adolescents with HIV infection be impacted?

Deeks SG 2013; Vance DE et al. Am J Nurs. 2010 March ; 110(3): 42–49; Chiappini E. etal. Aging. 2018.

JOHNS HOPKINS MEDICINE

Leading Cause of Death in the United States for Select Age Groups (2019)

Data Courtesy of CDC

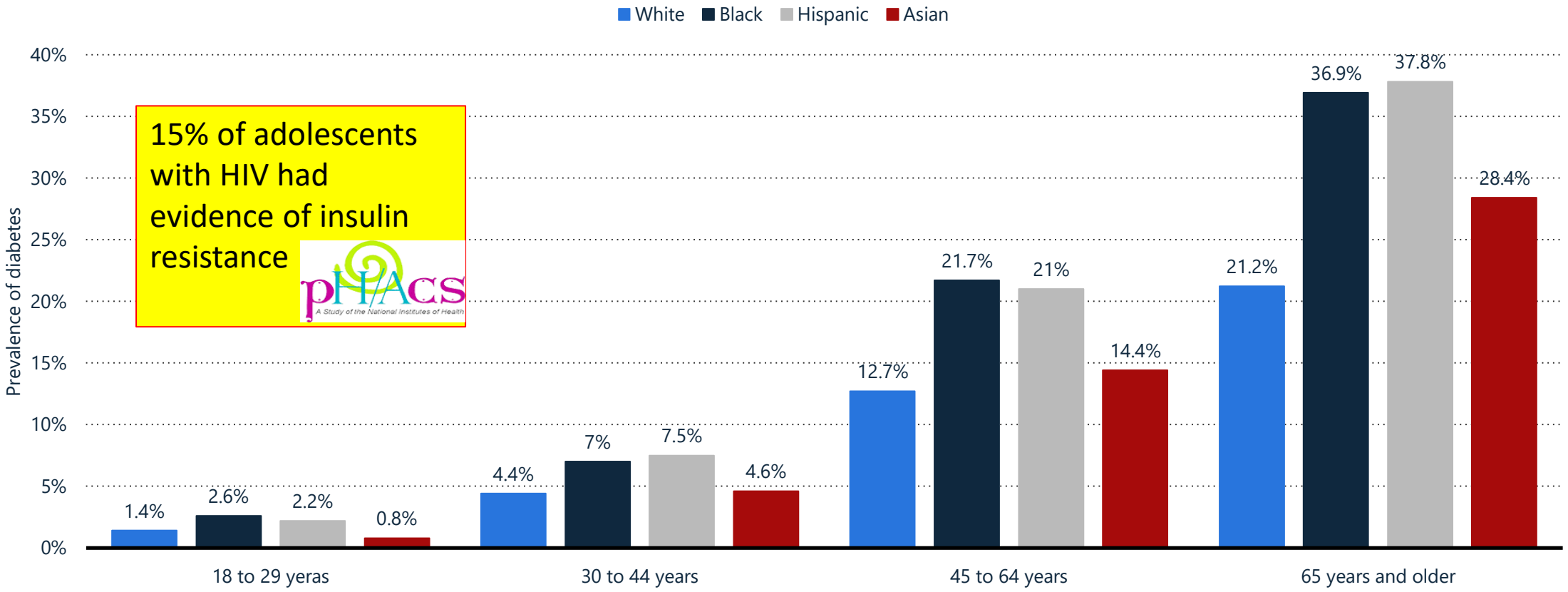
Rank	10-14	15-24	25-34	35-44	45-54	55-64	All Ages
1	Unintentional Injury 778	Unintentional Injury 11,755	Unintentional Injury 24,516	Unintentional Injury 24,070	Malignant Neoplasms 35,587	Malignant Neoplasms 111,765	Heart Disease 659,041
2	**Suicide 534**	**Suicide 5,954**	**Suicide 8,059**	Malignant Neoplasms 10,695	Heart Disease 31,138	Heart Disease 80,837	Malignant Neoplasms 599,601
3	Malignant Neoplasms 404	Homicide 4,774	Homicide 5,341	Heart Disease 10,499	Unintentional Injury 23,359	Unintentional Injury 24,892	Unintentional Injury 173,040
4	Homicide 191	Malignant Neoplasms 1,388	Malignant Neoplasms 3,577	**Suicide 7,525**	Liver Disease 8,098	CLRD 18,743	CLRD 156,979
5	Congenital Anomalies 189	Heart Disease 872	Heart Disease 3,495	Homicide 3,446	**Suicide 8,012**	Diabetes Mellitus 15,508	Cerebro-vascular 150,005
6	Heart Disease 87	Congenital Anomalies 390	Liver Disease 1,112	Liver Disease 3,417	Diabetes Mellitus 6,348	Liver Disease 14,385	Alzheimer's Disease 121,499
7	CLRD 81	Diabetes Mellitus 248	Diabetes Mellitus 887	Diabetes Mellitus 2,228	Cerebro-vascular 5,153	Cerebro-vascular 12,931	Diabetes Mellitus 87,647
8	Influenza & Pneumonia 71	Influenza & Pneumonia 175	Cerebro-vascular 585	Cerebro-vascular 1,741	CLRD 3,592	**Suicide 8,238**	Nephritis 51,565
9	Cerebro-vascular 48	CLRD 168	Complicated Pregnancy 532	Influenza & Pneumonia 951	Nephritis 2,269	Nephritis 5,857	Influenza & Pneumonia 49,783
10	Benign Neoplasms 35	Cerebro-vascular 158	HIV 486	Septicemia 812	Septicemia 2,176	Septicemia 5,672	**Suicide 47,511**

CLRD: Chronic Lower Respiratory Disease

Note: Suicide is not among the ten leading causes of death among children in the 0-9 year age group nor in adults in the age group 65 years and older.

CDC

Percentage of adults in the U.S. with diabetes as of 2016, by age and ethnicity



Note(s): United States; January 2 to December 30, 2016; 18 years and older; 177,192 respondents; Full or part time workers
Further information regarding this statistic can be found on page 8.
Source(s): Gallup (Gallup-Sharecare Well-Being Index); Sharecare; ID 790778

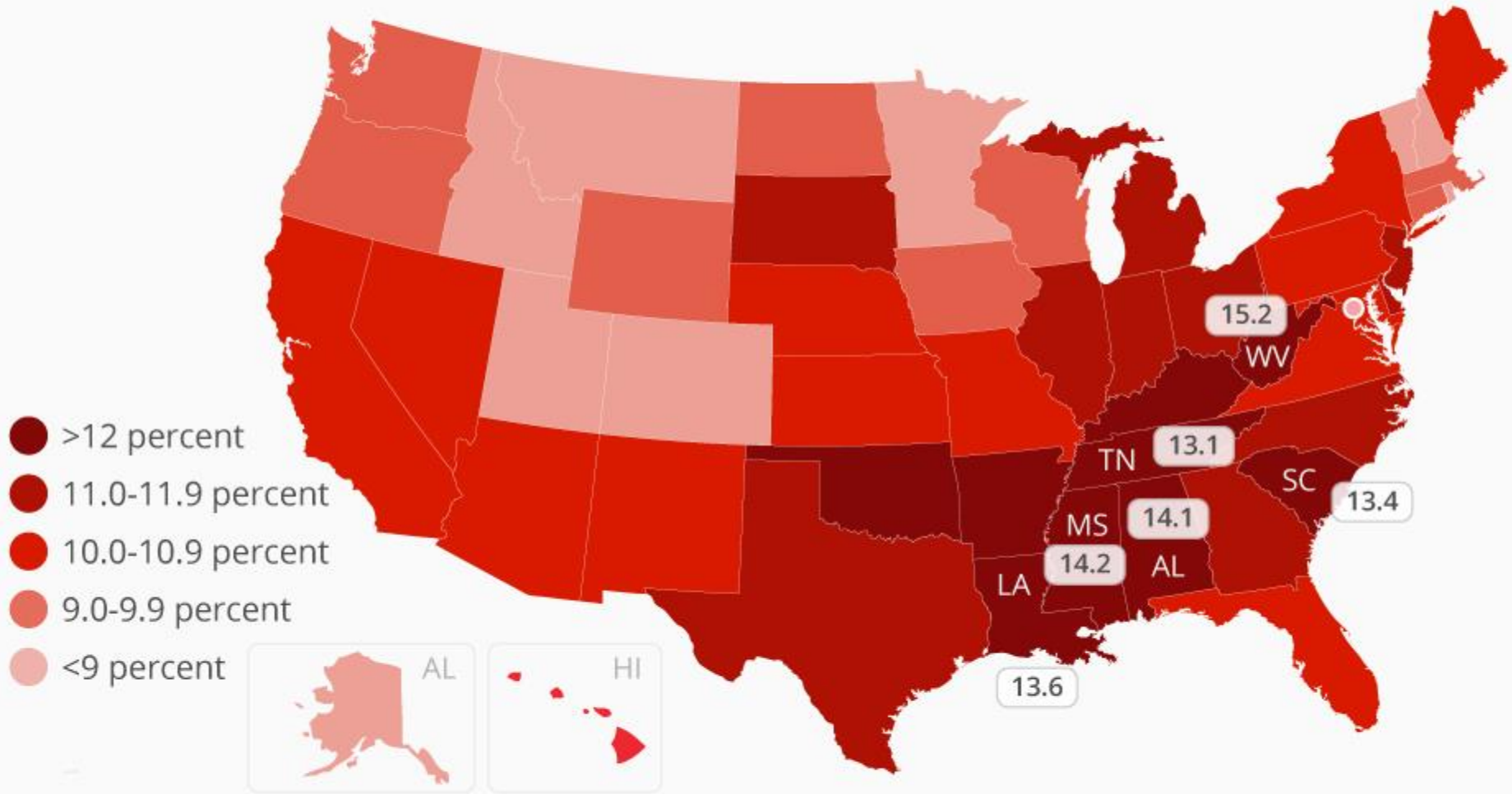
statista

Geffner ME. Horm Res Paediatr 2011; 76: 386-91

JOHNS HOPKINS MEDICINE

Where Diabetes is Most Prevalent in the U.S.

Percent of adults who have ever been told by a doctor that they have diabetes (2017*)



Includes pregnancy-related diabetes, percentages are weighted to reflect population characteristics (e.g. average age)
* latest on record

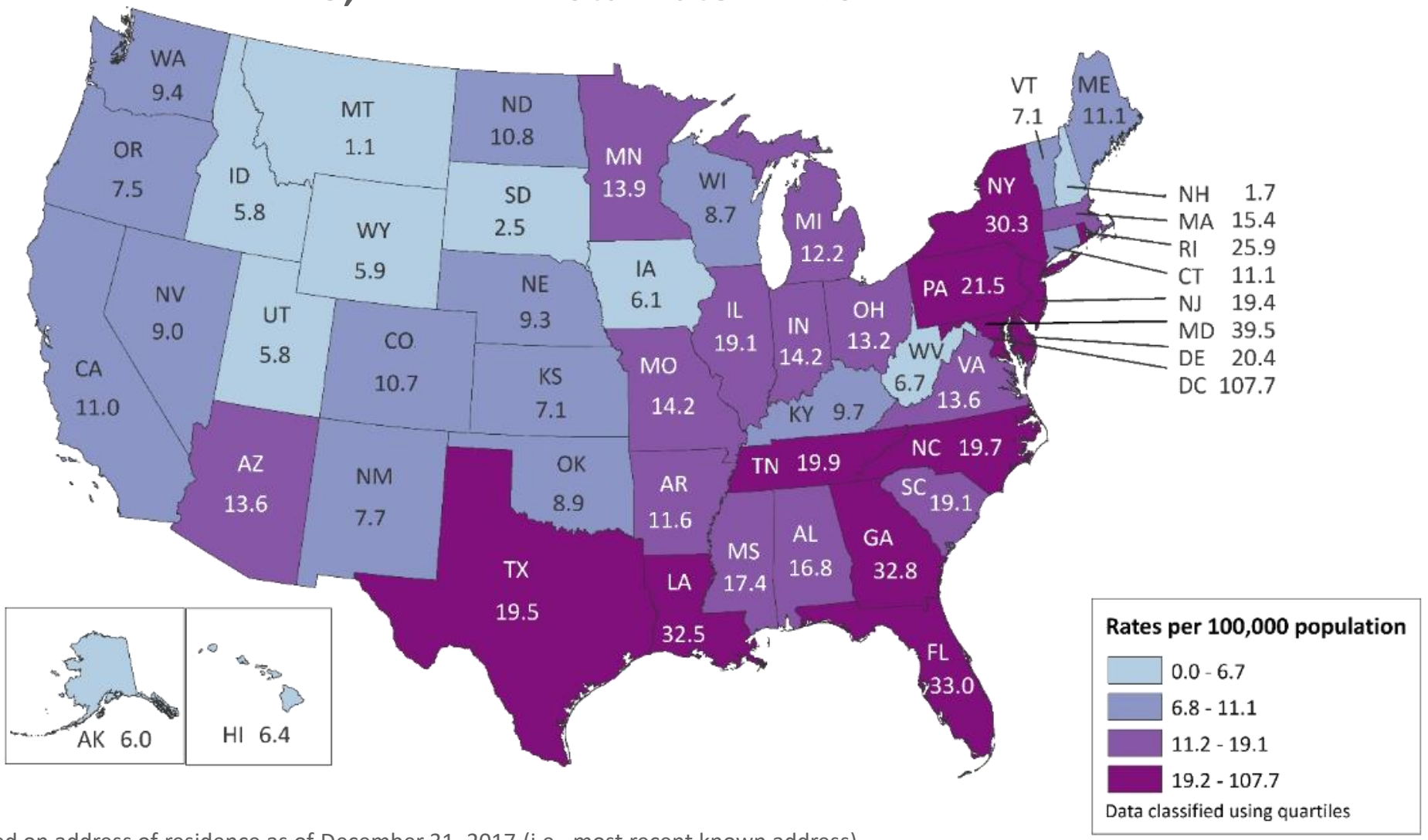
Sources: Kaiser Family Foundation, CDC

statista

Rates of Adolescents Aged 13–19 Years Living with Diagnosed HIV Infection

Year-end 2017—United States and 6 Dependent Areas

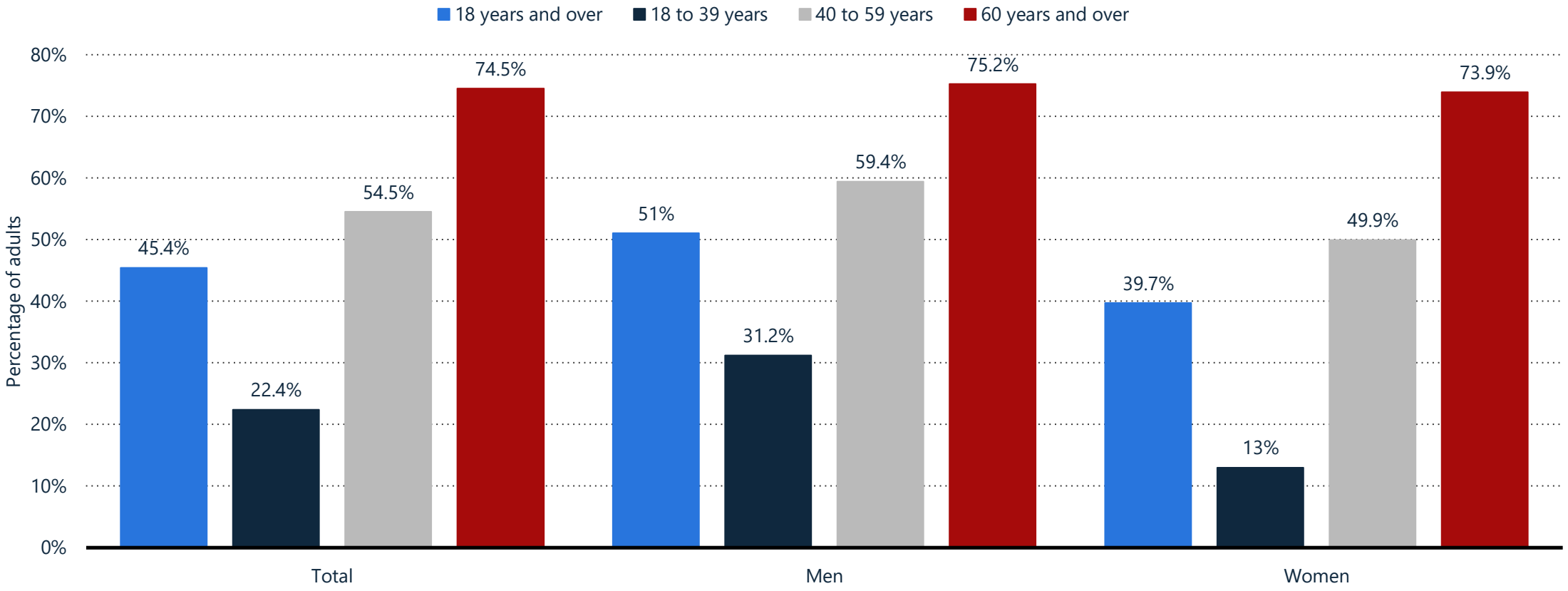
N = 5,222 **Total Rate = 17.6**



American Samoa	0.0
Guam	5.0
Northern Mariana Islands	0.0
Puerto Rico	14.6
Republic of Palau	0.0
U.S. Virgin Islands	34.3

Note. Data are based on address of residence as of December 31, 2017 (i.e., most recent known address).

Prevalence of hypertension among adults in the U.S. in 2017 and 2018, by age and gender

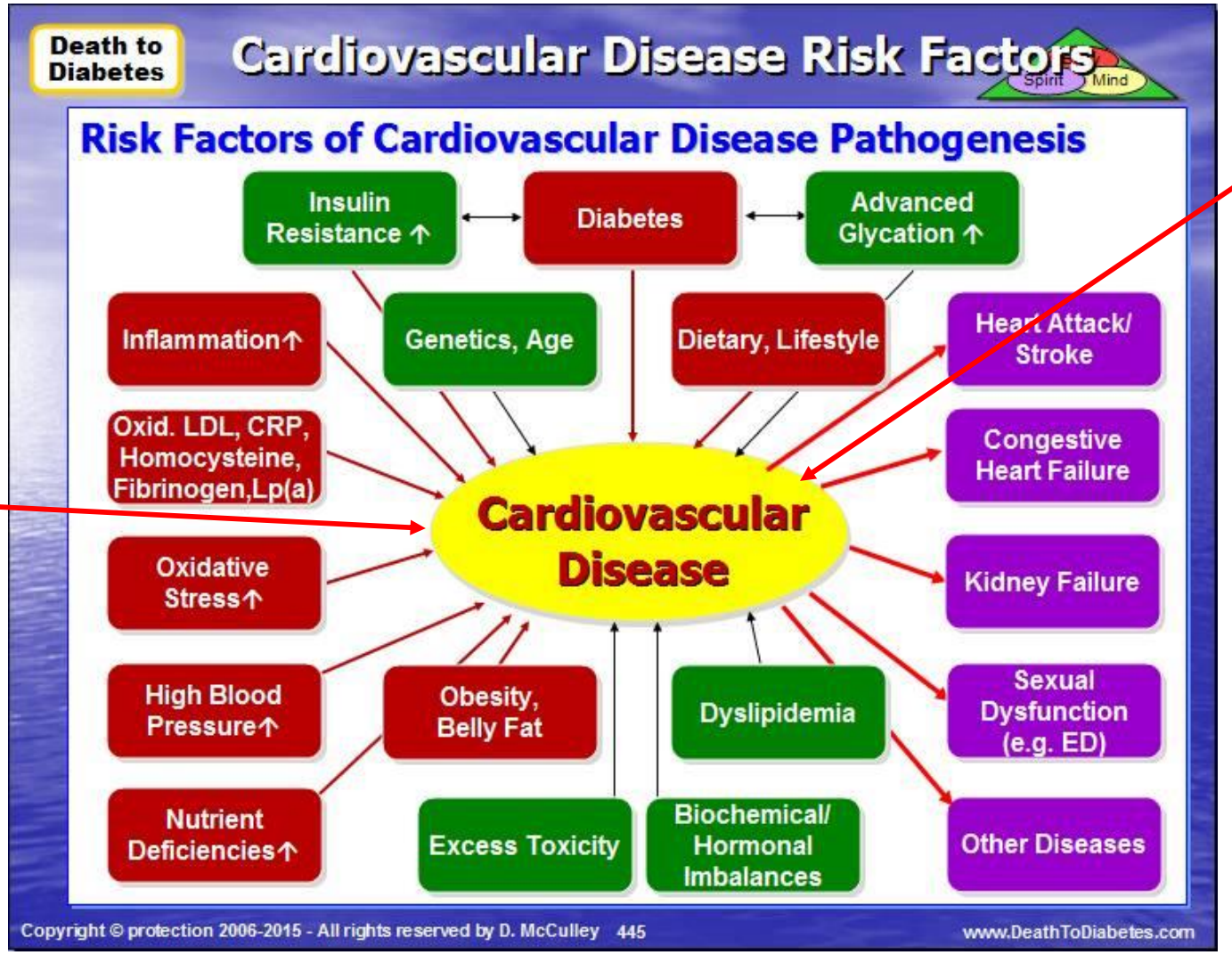


Adolescent boys (15-19%); adolescent girls (7-12%) Flynn JT et al. Pediatrics 2017
Among HIV+ youth ??20% Sainz et al PIDJ 2016

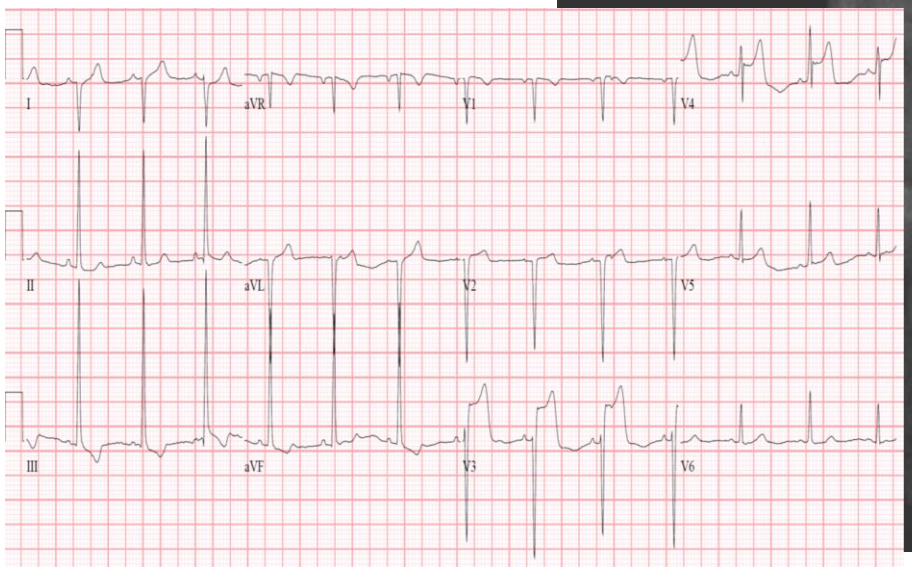
Note(s): United States; 2017 and 2018; 18 years and older
Further information regarding this statistic can be found on page 8.
Source(s): NCHS (National Health and Nutrition Examination Survey); CDC; ID 778065

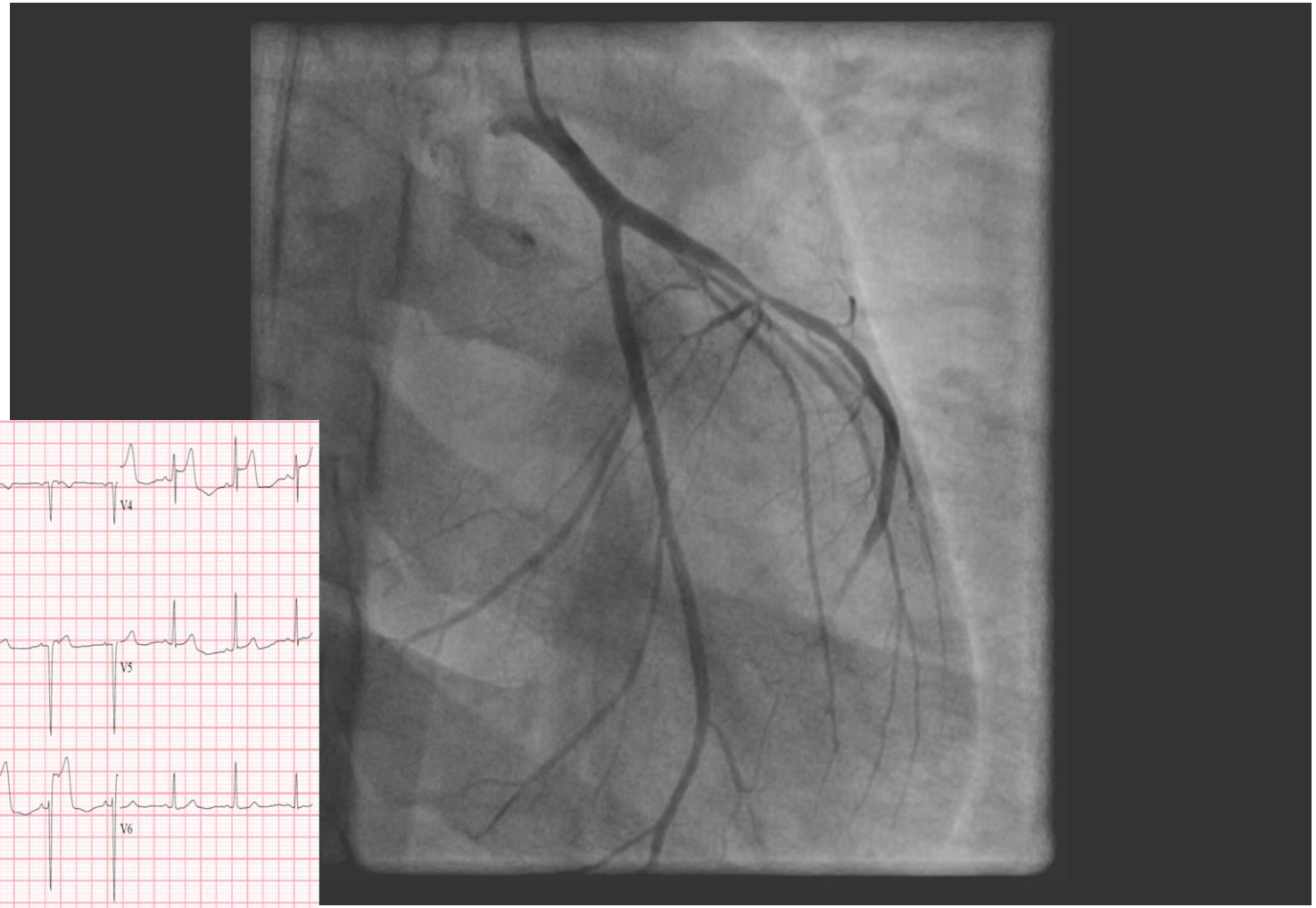
HIV

ART?


Death to Diabetes
Cardiovascular Disease Risk Factors
Spirit
Mind
Risk Factors of Cardiovascular Disease Pathogenesis
Insulin Resistance ↑
Diabetes
Advanced Glycation ↑
Inflammation↑
Genetics, Age
Dietary, Lifestyle
Heart Attack/ Stroke
Oxid. LDL, CRP, Homocysteine, Fibrinogen,Lp(a)
Congestive Heart Failure
Cardiovascular Disease
Oxidative Stress↑
Kidney Failure
High Blood Pressure↑
Obesity, Belly Fat
Dyslipidemia
Sexual Dysfunction (e.g. ED)
Nutrient Deficiencies↑
Excess Toxicity
Biochemical/ Hormonal Imbalances
Other Diseases
Copyright © protection 2006-2015 - All rights reserved by D. McCulley 445
www.DeathToDiabetes.com

23 year old with HIV and acute chest pain





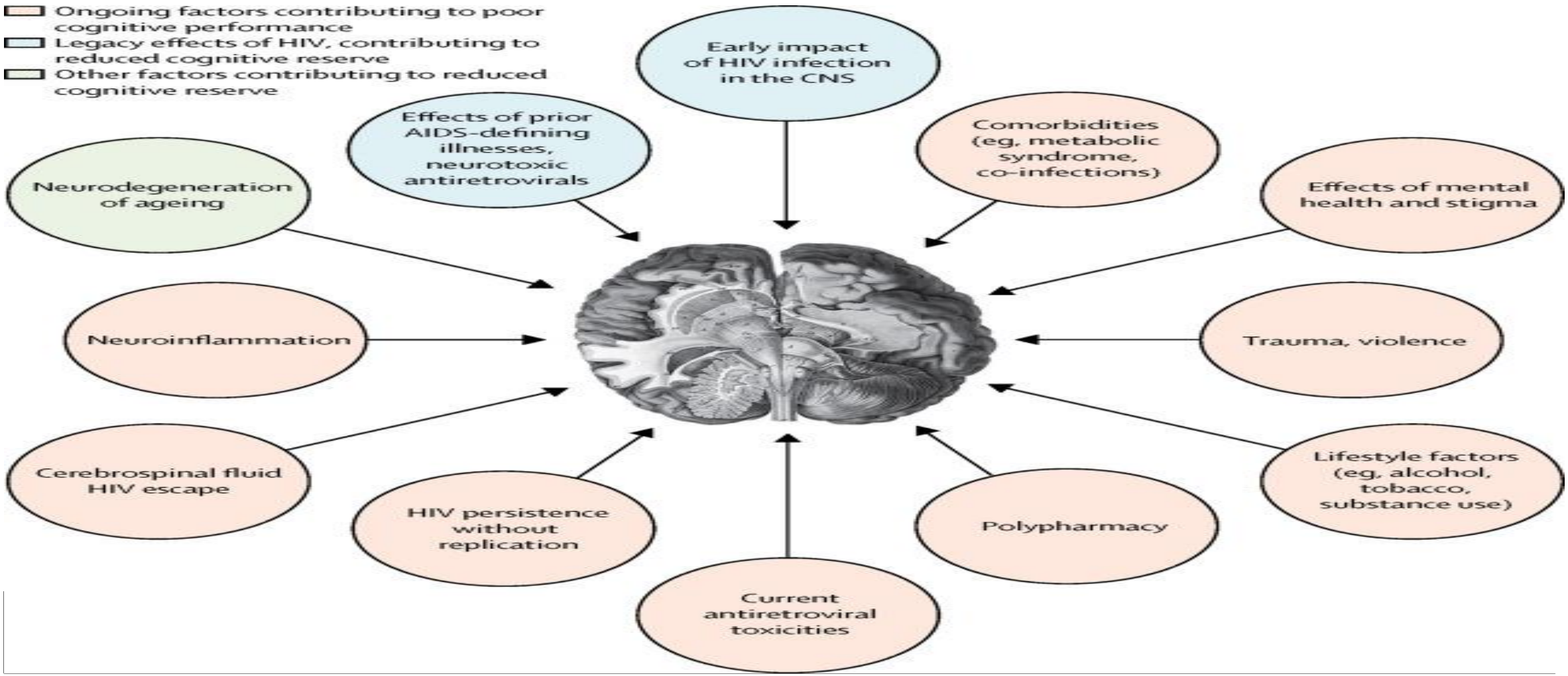
Griffith OFID 2018

CVD Data for Youth with HIV

- **Studies of children and youths in non-HIV disease states (diabetes, obesity) link arterial stiffness and thickness to hypertension & increased left ventricular mass**
- **Limited data on youth with perinatal infection**
  - Mixed results, study challenges
  - ↑ arterial thickness (carotid intimal medial thickness) in HIV+ vs. HIV-
  - ↑ arterial stiffness (pulse wave velocity) & ↓ flow-mediated dilatation in HIV+ vs. HIV-
  - ↑ inflammatory markers in HIV+ vs. HIV-→ associated with arterial thickness, stiffness, and flow-mediated dilatation
  - ↑ inflammatory markers despite longstanding virologic suppression
  - AYA with HIV have higher markers of cardiopulmonary dysfunction
    - Up to 28% show evidence of early cardiovascular dysfunction
    - Biomarkers of cardiomyocyte stress and injury (high sensitivity cardiac troponin-T [hs-cTnT] and N-terminal-pro-brain natriuretic peptide [NT-proBNP]) are elevated compared to uninfected adolescents after adjusting for adherence to ART,
    - Inflammation associated with poorer left ventricular function and increased stress in the ventricular walls

Miller TI, et al. HIV Med. 2012 13(5): 264-75; Sainz T et al Atherosclerosis 2014, Ross et al, Persaud D JAMA Peds 2014, Yusuf 2020

Mental health in adolescents born with HIV



Phillips Pediatrics 2016; Malee AIDS Care 2011; Scharko AIDS Care 2006; Earnshaw AIDS & Behavior 2018; Well Project; Winston A et al Lancet HIV 2020

Sexual and reproductive health for adults born with HIV

	2nd Decade 10-19 years	3rd Decade 20-29 years	4th Decade 30-39 years	5th Decade 40-49 years	≥6th Decade ≥50 years
					
Sexual and Reproductive Health					
Sex/reproductive	Sexual and gender identify evolving; Sexual activity often commences Risk reduction	Secondary Prevention Child bearing Risk reduction	Secondary Prevention Child bearing Risk reduction	Secondary Prevention Risk reduction	

Phillips Pediatrics 2016; Malee AIDS Care 2011; Scharko AIDS Care 2006; Earnshaw AIDS & Behavior 2018; Yusuf 2020

STI Rates among adolescents

Rates of chlamydia, gonorrhea, and primary & secondary syphilis ↑ for both sexes in 15–24 year olds

Chlamydia: highest among women 15–24 years; males 15–24 years ↑ 29% (2013–2017), while the rate in females ↑ 9%

Gonorrhea: males 15–24 years ↑ 52%, while the rate in females increased 24%

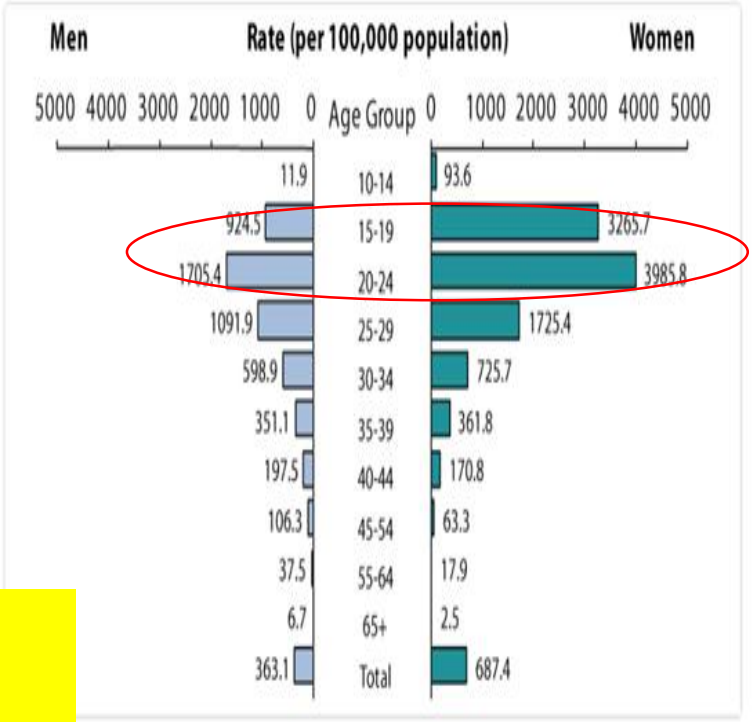
Reasons for increases include:

- ↑ incidence
- ↑ screening among young men
- ↑ extragenital screening

HIV positive adolescents:

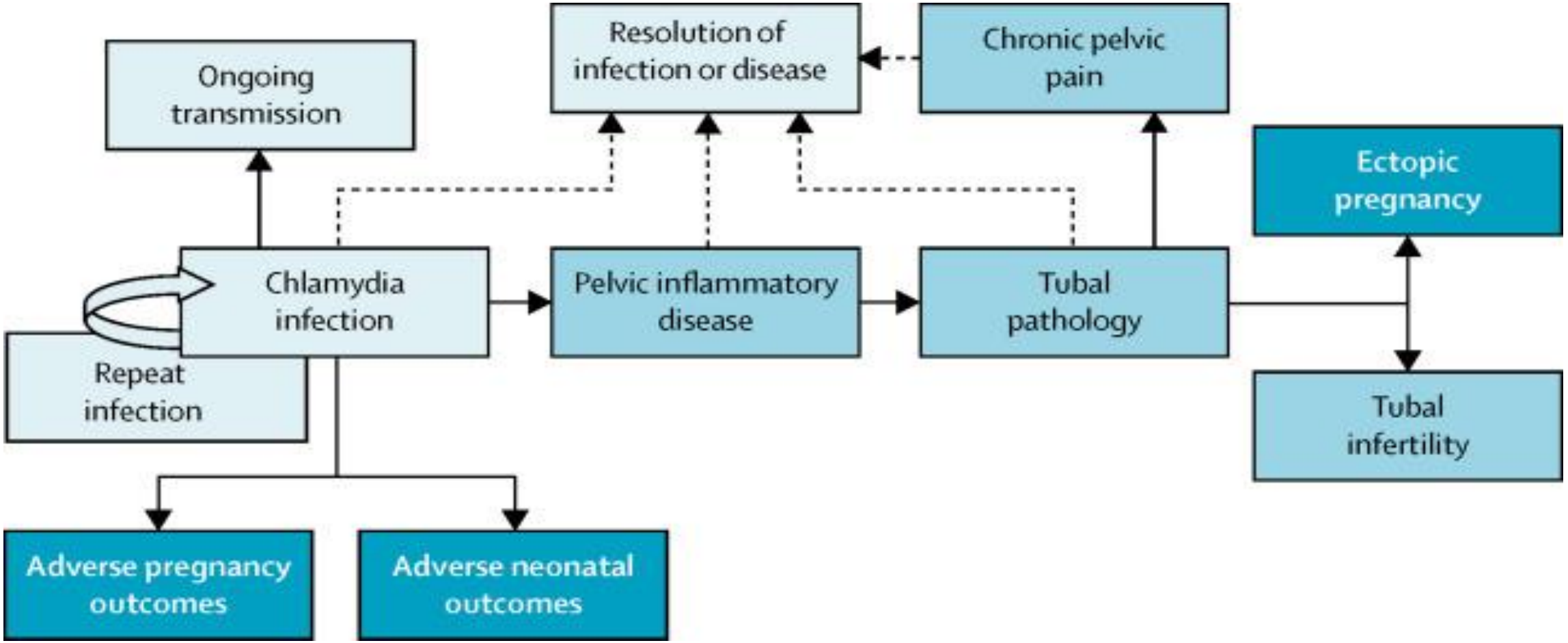
- Perinatally acquired: ↑ likelihood to use condoms (60% use condoms inconsistently); 30% have >1 concurrent partner
- Non-perinatally acquired: continued sexual activity, inconsistent condom use
- Pregnancy desires unchanged

Figure 5. Chlamydia – Rates of Reported Cases by Age Group and Sex, United States, 2017

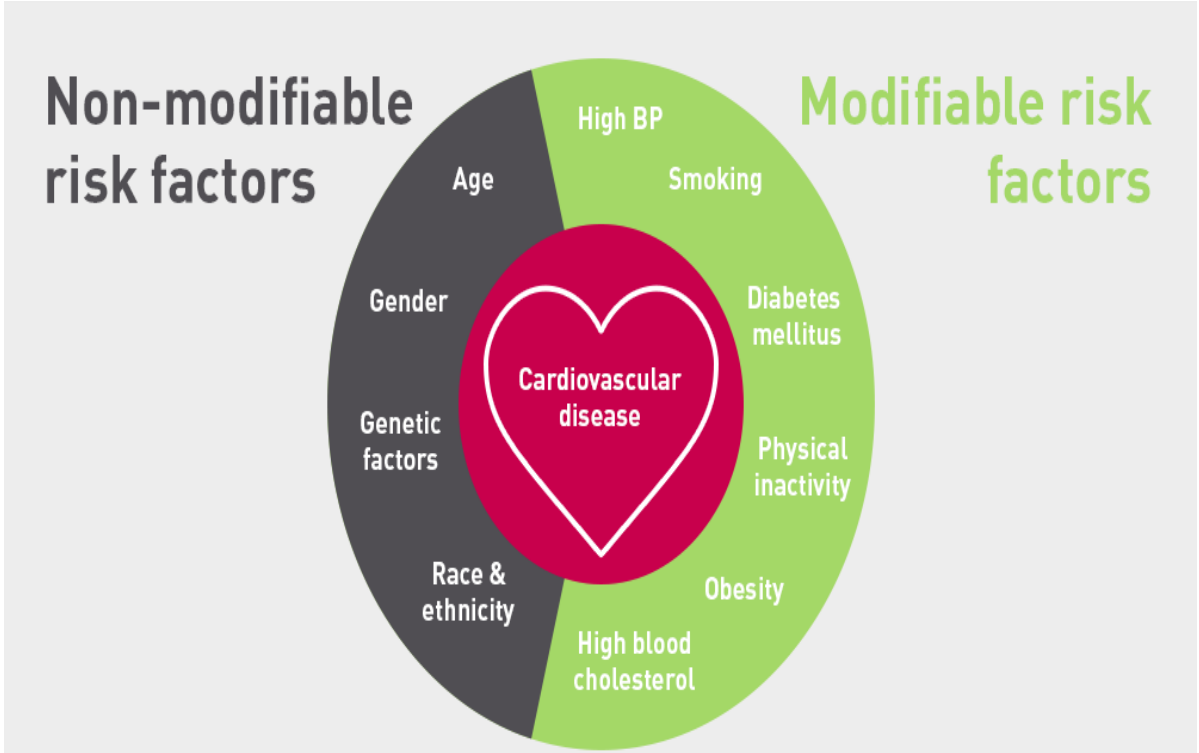


Judd et al PLoS One 2018; Ankunda Pan Afr Med 2016; Koenig JAIDS 2010; CDC

Comorbidities and Sequelae Resulting from STIs



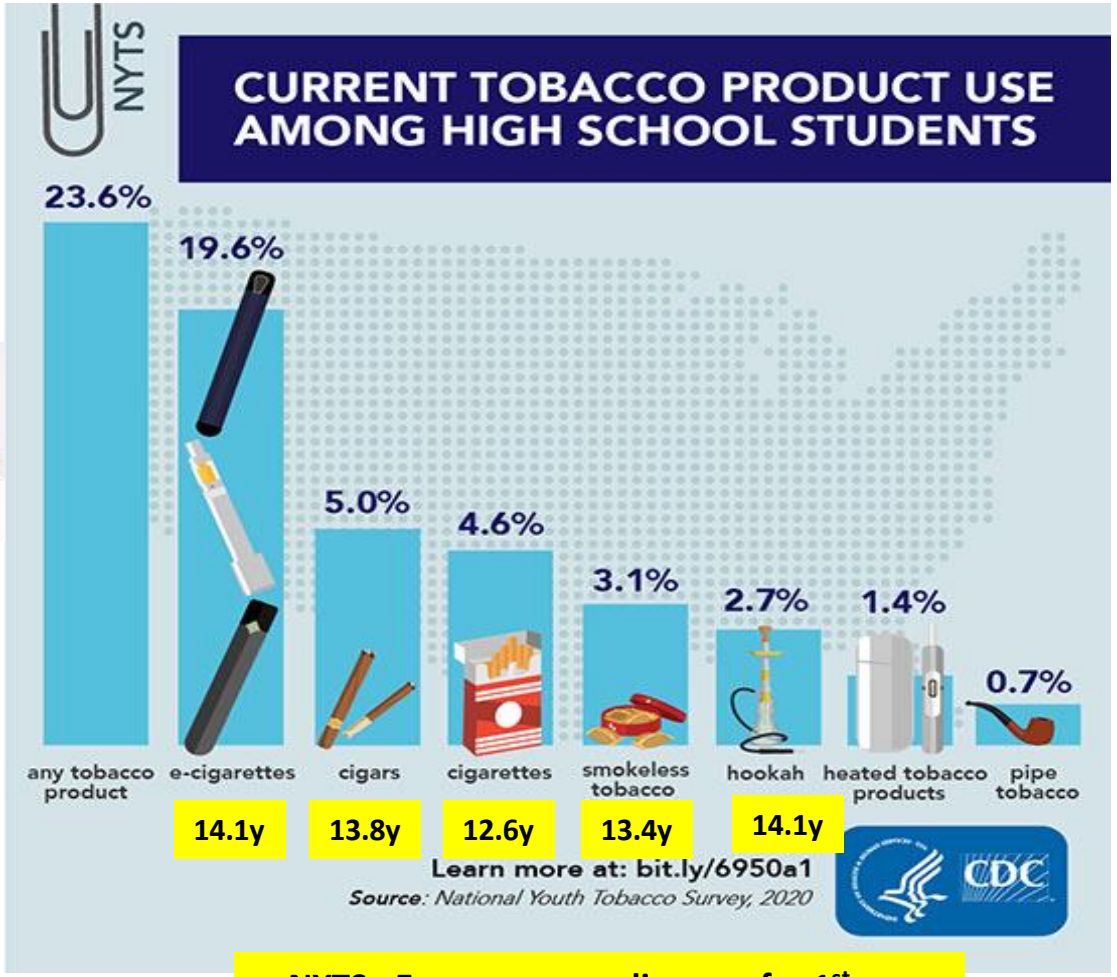
Unemo et al. Lancet ID 2017. 17(8): E235-79



Non-modifiable	Modifiable	Lifestyle	Social
• Age • Gender • Family history of CVD • Ethnicity • Genetic evidence • Previous history of CVD	• Blood pressure • Total cholesterol • HDL cholesterol • Smoking • Blood sugar/diabetes • BMI • Markers of chronic inflammation	• Smoking • Diet • Exercise • Stress	• Income • Social deprivation • Environment

Tobacco use among adolescents

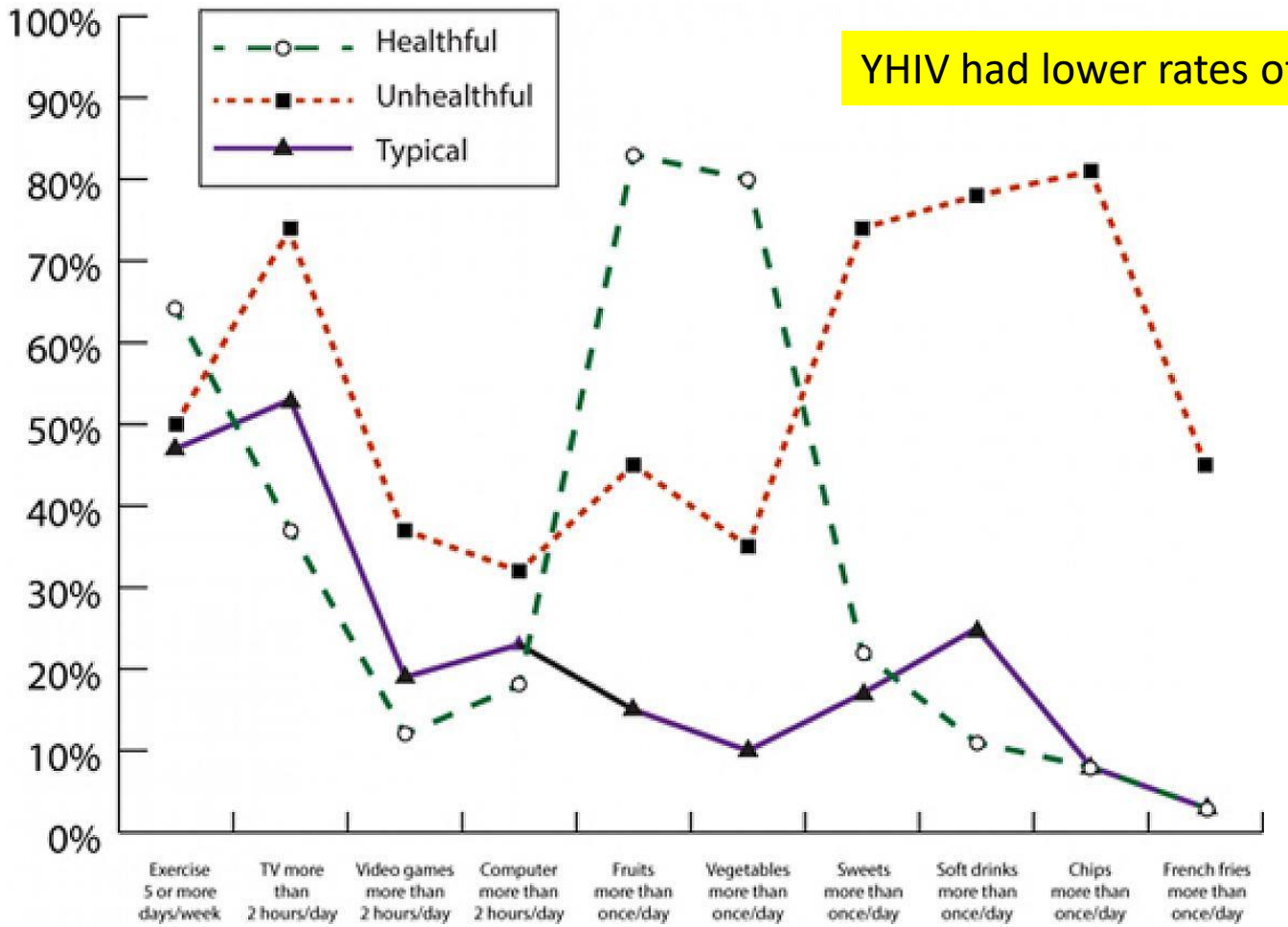
- 7% of middle schoolers and 23% of high schoolers report current use of a tobacco product
- Younger age at start associated with ↑ nicotine dependence
- Cigarillos use has markedly ↑ among adolescents
- YHIV: 24% daily/almost daily tob (ATN)
  - Associated with greater AIDS-related morbidity/mortality
  - Mixed association with viral load



NYTS: Ever-users, median age for 1st use

Nasim et al. Nicotine & Tobacco Research 2016; https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm, Sharapova BMJ 2018

Physical activity and lifestyle among adolescents

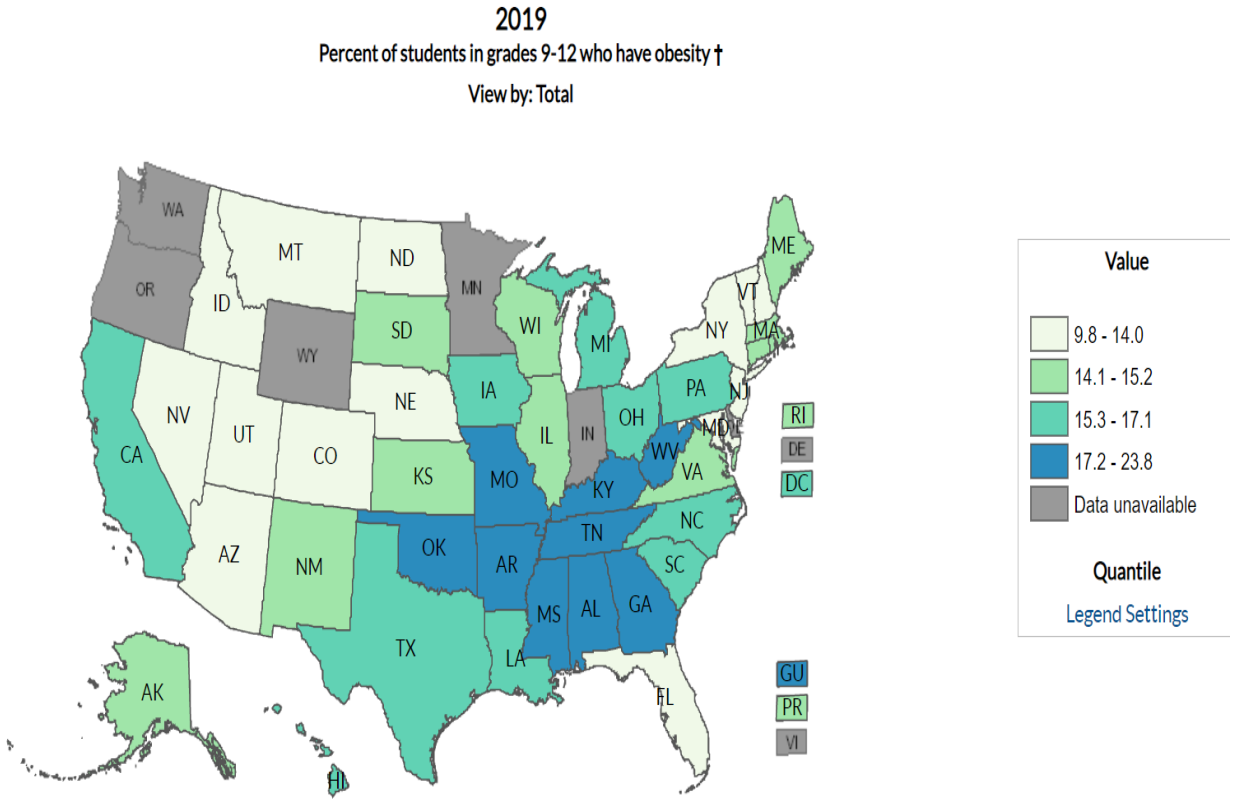


YHIV had lower rates of physical activity than HEU (PHACS)

https://www.nih.gov/news-events/news-releases/only-half-us-youth-meet-physical-activity-standards-nih-study-shows; Dirajilal-Fargo et al. JAIDS 2021

Obesity

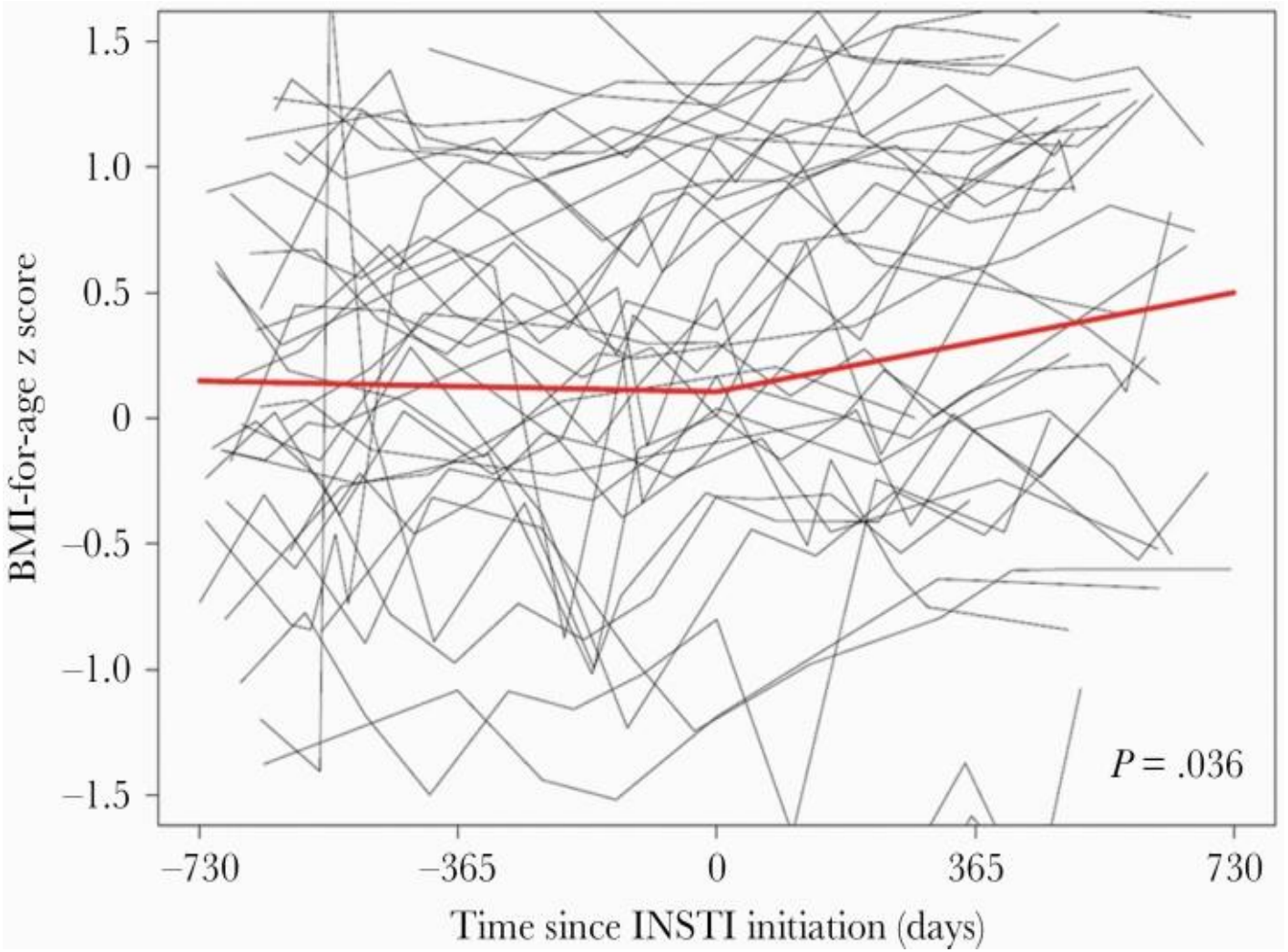
- 21% of 12-19 year olds are obese
  - Hispanic (26%)
  - non-Hispanic Black (24%)
  - non-Hispanic White (16%)
- 40-52% of HIV-positive youth overweight/obese



Obesity: ≥95th percentile BMI

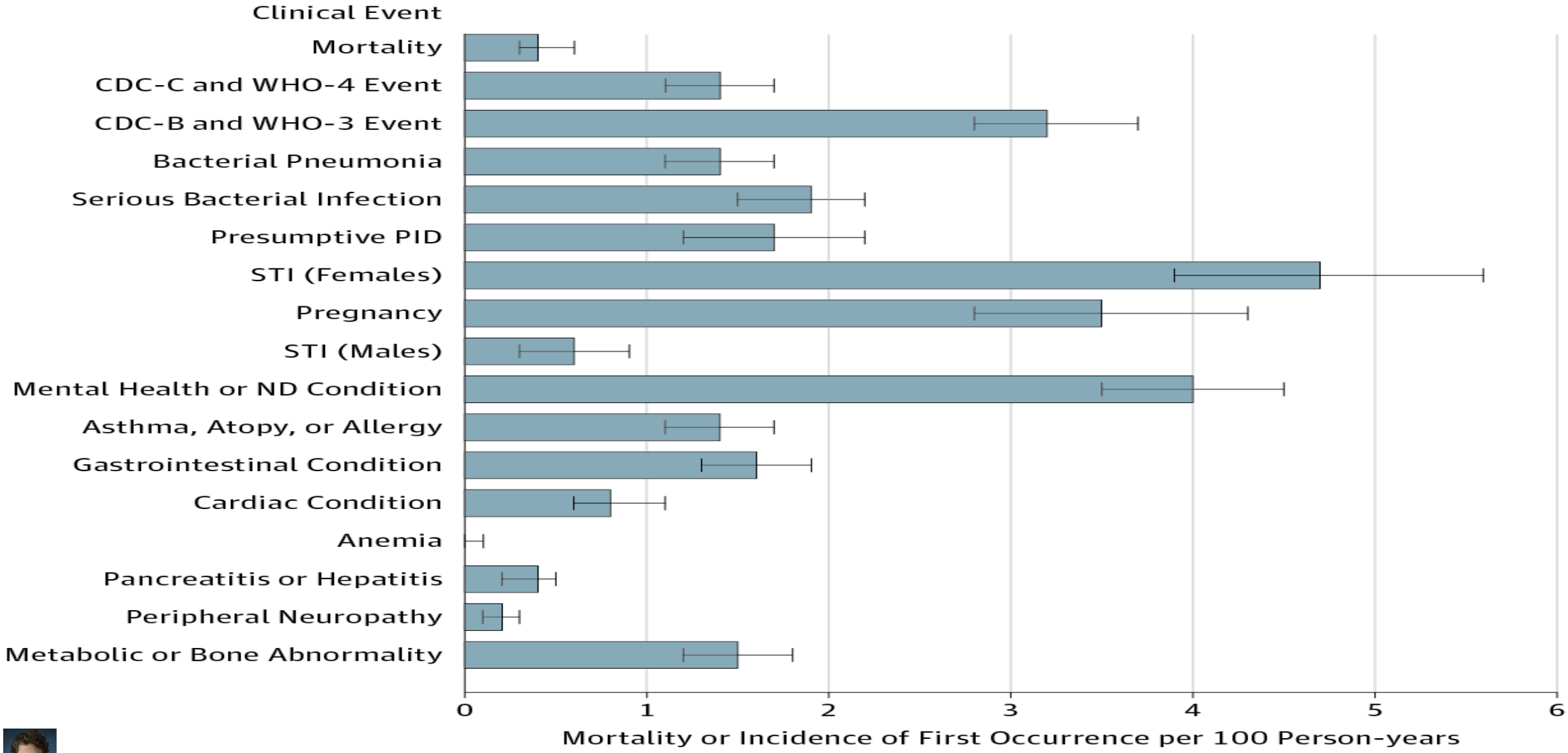
CDC, Youth Risk Behavior Survey 2019; Kruzich LA. J Acad of Nutri and Diet 2004; Mulligan K CID 2010

Weight again among adolescents with HIV



Li et al. JPIDS 2020; Koay et al OFID 2021

Long-term morbidity of HIV +/- ART



Griffith D et al. OFID 2017; Hazra R et al.; Izbudak, Agwu J Neurorad 2013;, **Venkataramani** 2012; Eckard et al Curr HIV/AIDS 2016; **Neilan** et al JAMA Peds 2017

What can you do?

- Take a good history
- Assess risk factors
  - Tobacco
  - Substances
  - Sex
  - Activities
  - Diet
  - Helmets, firearms
- Detailed family history
- Physical examination

Leading Cause of Death in the United States for Select Age Groups (2019)
Data Courtesy of CDC

Rank	10-14	15-24	25-34	35-44	45-54	55-64	All Ages
1	Unintentional Injury 778	Unintentional Injury 11,755	Unintentional Injury 24,516	Unintentional Injury 24,070	Malignant Neoplasms 35,587	Malignant Neoplasms 111,765	Heart Disease 659,041
2	**Suicide 534**	**Suicide 5,954**	**Suicide 8,059**	Malignant Neoplasms 10,695	Heart Disease 31,138	Heart Disease 80,837	Malignant Neoplasms 599,601
3	Malignant Neoplasms 404	Homicide 4,774	Homicide 5,341	Heart Disease 10,499	Unintentional Injury 23,359	Unintentional Injury 24,892	Unintentional Injury 173,040
4	Homicide 191	Malignant Neoplasms 1,388	Malignant Neoplasms 3,577	**Suicide 7,525**	Liver Disease 8,098	CLRD 18,743	CLRD 156,979
5	Congenital Anomalies 189	Heart Disease 872	Heart Disease 3,495	Homicide 3,446	**Suicide 8,012**	Diabetes Mellitus 15,508	Cerebro-vascular 150,005
6	Heart Disease 87	Congenital Anomalies 390	Liver Disease 1,112	Liver Disease 3,417	Diabetes Mellitus 6,348	Liver Disease 14,385	Alzheimer's Disease 121,499
7	CLRD 81	Diabetes Mellitus 248	Diabetes Mellitus 887	Diabetes Mellitus 2,228	Cerebro-vascular 5,153	Cerebro-vascular 12,931	Diabetes Mellitus 87,647
8	Influenza & Pneumonia 71	Influenza & Pneumonia 175	Cerebro-vascular 585	Cerebro-vascular 1,741	CLRD 3,592	**Suicide 8,238**	Nephritis 51,565
9	Cerebro-vascular 48	CLRD 168	Complicated Pregnancy 532	Influenza & Pneumonia 951	Nephritis 2,269	Nephritis 5,857	Influenza & Pneumonia 49,783
10	Benign Neoplasms 35	Cerebro-vascular 158	HIV 486	Septicemia 812	Septicemia 2,176	Septicemia 5,672	**Suicide 47,511**

CLRD: Chronic Lower Respiratory Disease

Note: Suicide is not among the ten leading causes of death among children in the 0-9 year age group nor in adults in the age group 65 years and older.

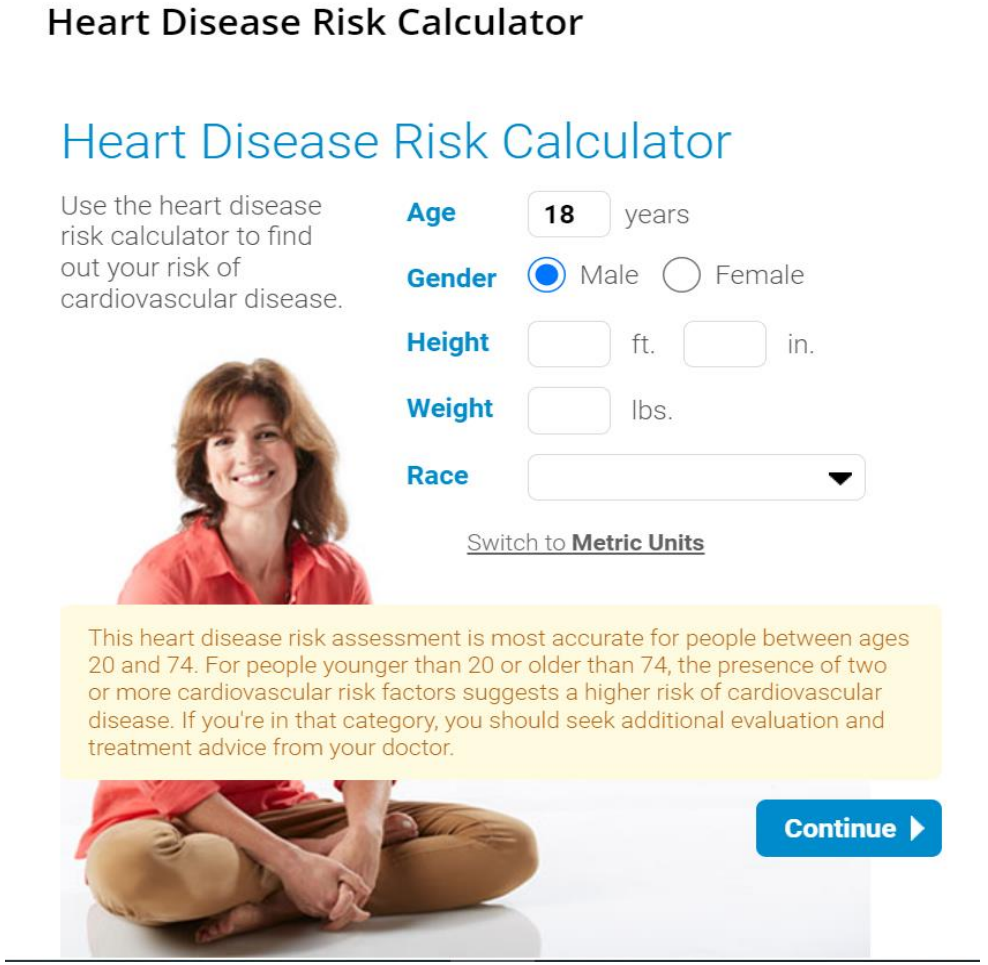
What can you do?

- **Education** (patient and staff)
- **Counseling**
  - Nutrition
  - Exercise
  - Smoking (cigarettes, vape, cigarillos, e-cigarettes))
  - Substance, ETOH use
  - Sex
  - Etc
- **Screening:** BP, lipids (fasting/non-fasting), glucose, weight

USPSTF

Risk calculators for adolescents?

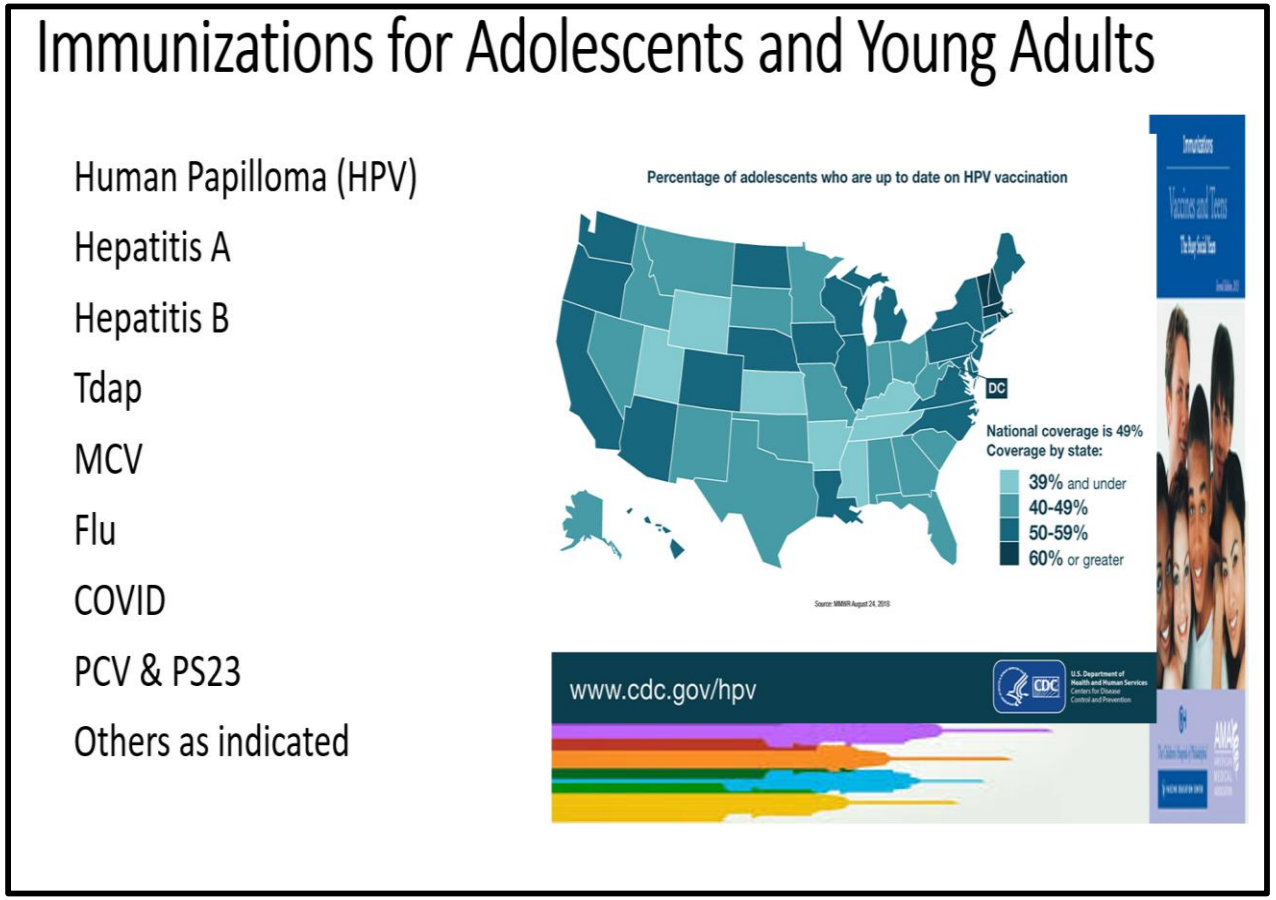
- ASCVD Heart Risk Calculator (age 40-79)
- If you know your lipids information and you are <60, the Framingham Heart Study General Cardiovascular Disease 30-Year Lipid-Based Risk Score Calculator is used. FOR AGES 30-79
- If you don't know your lipids information and you are <60, the Framingham Heart Study General Cardiovascular Disease 30-Year BMI-Based Risk Score Calculator is used. FOR AGES 30-79
- If you know your lipids information and you are ≥60 or older, the ACC/AHA Pooled Cohort Equations CV Risk Calculator is used.
- If you don't know your lipids information and you ≥ 60 or older, the Framingham Heart Study Cardiovascular Disease 10-Year BMI-Based Risk Score Calculator is used.



http://www.cvriskcalculator.com/; https://www.mayoclinichealthsystem.org/locations/menomonie/services-and-treatments/cardiology/heart-disease-risk-calculator

What can you do?

- **Actions:**
  - Smoking cessation
  - Lifestyle modification
  - Treatment
    - HTN (<130/80 goal) or <90th percentile
    - Hyperlipidemia: ?? (benefit for older youth with clear abnormal)
  - Weight loss
  - hyperlipidemia
  - Substance use treatment
  - STI counseling, screening, and treatment; family planning
  - Immunizations



USPSTF

Conclusion

- Adolescents with early-acquired HIV are surviving into adulthood
- Providers must be aware of their unique milieu and potential comorbidities to optimize care and outcomes
- Important to screen for and address comorbidities with prevention and early treatment

Acknowledgements

The Youth!!

ACE

Bartlett team

IPC/PAHAP

WICY team

JHU HIV Clinical Research team (IMPAACT, ATN, Cure, Tech2Check)

Center of Adolescent and Young Adult Health

Pediatric & Adult Infectious Diseases Divisions

Family & support network

Funding:

NIMHD
National Institute on Minority Health and Health Disparities

National Institute of Allergy and Infectious Diseases

Eunice Kennedy Shriver NICHD
National Institute of Child Health & Human Development

CENTER FOR AIDS RESEARCH
JOHNS HOPKINS UNIVERSITY

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

AGING TASK FORCE RECOMMENDATIONS
(Final 12/10/20)

Background: The Aging Task Force (ATF) was formed in February 2019 to address the broad health needs of those over 50 years living with HIV and long-term survivors. According the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

The ATF developed the following recommendations to the Commission on HIV, Division of HIV and STD Programs (DHSP) and other County and City partners to address the unique needs of this population. The term older adults refer to individuals who are age 50 and older.

**This is a living document and the recommendations will be refined as key papers such the State of California Master Plan on Aging and APLA's HIV and Aging Townhall Forums are finalized. **

Ongoing Research and Needs Assessment:

- Encourage the Division of HIV and STD Programs (DHSP) to collaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issues:
    - Conduct additional analysis to understand why approximately 27% of new diagnoses among persons aged 50-59 and 36% of new diagnoses among person aged 60 and older were late diagnoses (Stage 3 – AIDS) suggesting long-time infection. This may reflect a missed opportunity for earlier testing as it seems likely that persons aged 50 and older may engage in more regular health care than younger persons. (Data Source: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf)
    - Gather data on PLWH over 50 who are out of care or those who have dropped out of care to further understand barriers and service needs.
    - Conduct studies on the prevention and care needs of older adults.
    - Understand disparities in health outcomes within the 50+ population by key demographic data points such as race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status.

- Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.
- Conduct deeper analysis on mental health, depression, isolation, polypharmacy and other co-morbidities that impact the quality of life of older adults living with HIV.
- Conduct analysis of best practices on serving older adults in non-HIV settings and adapt key strategies for a comprehensive and integrated model of care the population. Examples of best practices to explore are National Association of Area Offices on Aging (https://www.n4a.org/bestpractices) and Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Growing Older: Providing Integrated Care for an Aging Population. HHS Publication No. (SMA) 16-4982. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.
- Request DHSP to develop a data collection and reporting plan with a timeline on an annual report to the community.

Workforce and Community Education and Awareness:

- Educate the Commission on HIV, Department of Public Health, HIV workforce and community at large on ageism, stigma, and build a common understanding of definitions of older adults, elders, aging process and long-term survivors.
- Address ageism on the Commission on HIV and the community at large through trainings and by convening panels composed of Ryan White and prevention services clients and subject experts.
- Openly discuss and examine as part and parcel of HIV planning and implementation, the impediments to HIV prevention and care among aging populations posed by the historically embedded discrimination and bigotry institutionalized in mainstream US culture and society, as well as embedded in subcultural (ethnic, racial, social, religious, etc.) cultures and institutions that often goes unacknowledged: that is the interconnected/overlapping linkages between ageism (or what is expressed in ageism) and societal heteronormativity/homophobia (internalized and cultural), sexism, misogyny, racism, xenophobia, ableism, and all forms of discrimination and bigotry targeting "The Other."
- Educate the HIV workforce on HIV and aging, including but not limited to how to work with the non-profit sector to link seniors to health, social services, and HIV prevention and treatment services.
- Train the HIV workforce on diseases of aging, such as cardiovascular disease and osteoporosis and dementia, and equip staff with the knowledge and skills to properly assess and treat conditions that impact older adults.
- Train older adults on how to adapt to the new realities of seeking care as they progress in the age spectrum. Train the HIV workforce on how to develop and deliver classes to older adults with respect, compassion, and patience.
- Expand opportunities for employment among those over 50 who are able and willing to work.
- Provide training on the use of technology in managing and navigating their care among older adults.

- Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.
- Collaborate with local resources and experts in providing implicit bias training to HIV service providers.

Expand HIV/STD Prevention and Care Services for Older Adults:

- Expand and develop service models that are tailored for the unique needs of PLWH over 50. Specifically, community members representing older adults living with HIV have identified ambulatory/outpatient medical, medical care coordination, and mental health as key services they need. Unify and coordinate care within a medical home and reduce referrals to specialty care, if appropriate.
- Integrate an annual patient medical records review by gerontologist for PLWH over 50 in the Medical Care Coordination and Ambulatory/Outpatient Medical programs. The annual medical records review should review care needs for mental health, polypharmacy, social support, mobility, and other markers of overall health and quality of life. Ensure that MCC teams monitor and assist patients affected by cognitive decline in navigating their care.
- Customize food/nutrition and physical activity and mobility services for the aging population. Remedial exercise and rehabilitation to maintain or regain muscle mass may be needed for some older adults to help them remain in care and virally suppressed.
- Enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.
- Expand supportive services, such as financial assistance, as incomes become more fixed in older age. As frailty increases with age, services should be customized by specific age groups.
- Address social isolation by supporting psychosocial and peer support groups designed for older adults. Leverage the work of agencies that already provide support groups for older adults and encourage the community to join or start a support group.
- Address technological support for older adults living with HIV as medical service modalities rely more and more electronic, virtual, and telehealth formats.
- Dedicate at least 15% of prevention funds to programming specifically tailored for individuals over 50. According to the California HIV Surveillance Report, persons over 50 accounted for 15% of all new infections. A similar trend is observed for Los Angeles County with about 13-14% of new HIV diagnoses occurring among persons aged 50 and older
- Address the lack of sexual health programs and social marketing efforts geared for older adults. Social marketing and educational campaigns on PrEP and Undetectable=Untransmittable (U=U) should include messages and images with older adults.

- Integrate programming for older adults in the use of Ending the HIV Epidemic funds in Los Angeles County. Schedule annual reports from the Division of HIV and STD Programs (DHSP) on how they are addressing HIV and aging.

General Recommendations:

- Collaborate with traditional senior services or physicians, or other providers who specialize in geriatrics and leverage their skills and expertise of those outside the HIV provider world.
- Ensure access to transportation and customize transportation services to the unique needs of older adults.
- Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV
- Direct DHSP to start working with agencies that serve older adults such as the Los Angeles County Workforce Development, Aging and Community Services, City of Los Angeles Department of Aging, and DPH Office of Senior Health to coordinate and leverage services.
- Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21; COH approved on 11/18/21)

STRATEGIES:

1. This framework seeks to facilitate medical wellness examinations and offers a flexible and adaptable guide to customizing care for ALL older adults with HIV. The suggested list of assessments may be used for younger PLWH, as deemed appropriate by the medical care team, especially in communities of color, experience aging-related issues earlier in life (before age 50) .

2. Leverage and build upon Medical Care Coordination Teams & Ambulatory Outpatient Medical Program.

3. Integrate a geriatrician in medical home teams.

4. Establish coordination process for specialty care.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (10.18.21)

Assessments and Screenings			
Mental Health	Hearing	HIV-specific Routine Tests	Immunizations
Neurocognitive Disorders/Cognitive Function	Osteoporosis/Bone Density	Cardiovascular Disease	Advance Care Planning
Functional Status	Cancers	Smoking-related Complications	
Frailty/Falls and Gait	Muscle Loss & Atrophy	Renal Disease	
Social Support & Levels of Interactions	Nutritional	Coinfections	
Vision	Housing Status	Hormone Deficiency	
Dental	Polypharmacy/Drug Interactions	Peripheral Neuropathologies	

From Golden Compass Program

From Aging Task Force/Commission on HIV

Screenings & Assessment Definitions

- HIV-specific Routine Tests
  - HIV RNA (Viral Load)
  - CD4 T-cell count
- Screening for Frailty
  - Unintentional weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, weak grip strength
- Screening for Cardiovascular Disease
  - Lipid Panel (Dyslipidemia)
  - Hemoglobin A1c (Diabetes Mellitus)
  - Blood Pressure (Hypertension)
  - Weight (Obesity)
- Screening for Smoking-related Complications
  - Lung Cancer - Low-Dose CT Chest
  - Pulmonary Function Testing, Spirometry (COPD)

Screening for Renal Disease

  - Complete Metabolic Panel
  - Urinalysis
  - Urine Microalbumin-Creatinine Ratio (Microalbuminuria)
  - Urine Protein-Creatinine Ratio (HIVAN)
- Screening for Coinfections
  - Injection Drug Use
  - Hepatitis Panel (Hepatitis A, B, C)
  - STI - Gonorrhea, Chlamydia, Syphilis

Screenings & Assessment Definitions (continued)

- Screening for Osteoporosis
  - Vitamin D Level
  - DXA Scan (dual-energy X-ray absorptiometry)
  - FRAX score (fracture risk assessment tool)
- Screening for Male and Female Hormone Deficiency
  - Menopause, decreased libido, erectile dysfunction, reduced bone mass (or low-trauma fractures), hot flashes, or sweats; testing should also be considered in persons with less specific symptoms, such as fatigue and depression.
- Screening for Mental Health Comorbidities
  - Depression – Patient Health Questionnaire (PHQ)
  - Anxiety – Generalized anxiety disorder (GAD), Panic Disorder, PTSD
  - Substance Use Disorder - Opioids, Alcohol, Stimulants (cocaine & methamphetamine), benzodiazepines
  - Referral to LCSW or MFT
  - Referral to Psychiatry
- Screening for Peripheral Neuropathologies
  - Vitamin B12
  - Referral to Neurology
  - Electrodiagnostic testing
- Screening for Sexual Health

Other Suggestions from ATF/COH Discussions

- Screen patients for comprehensive benefits analysis and financial security
- Assess patients if they need and have access to caregiving support and related services
- Assess service needs for occupational and physical therapy (OT/PT) and palliative care
- Review home-based case management service standards for alignment with OT and PT assessments
- Establish a coordinated referral process among DHSP-contracted and partner agencies
- Collaborate with the AIDS Education Training Centers to develop training for HIV specialist and geriatricians.

Los Angeles County Commission on HIV

Social Media Update

Current Platforms

Twitter: @HIVCommissionLA

- 279 Followers

Facebook: @HIVCommissionLA

- 683 Followers

Instagram: @hivcommla

- 206 Followers

Purpose of Social Media

- Announce meeting times
- Announce events happening within the HIV service network
- Spread awareness about the work of the Commission
- Increase engagement with the public

Commissioner Testimonials

Goal: Increase the Commission's social media engagement and outreach.

Purpose: Highlight our commissioners and help the public understand what the Commission on HIV does and who is behind the work.

Examples

LUCKIE ALEXANDER

Prevention Training Specialist, APLA Health & Executive Director, Invisible Men

Luckie serves as the Co-Chair of the Operations Committee and the Transgender Caucus.

WHY DID YOU JOIN THE COMMISSION ON HIV?

My reason for joining the Commission is two fold, first I wanted to be a representation of a community that is very under represented in the realm of HIV, the transmasculine community, and I want to find a way to keep one of my childhood best friends as healthy as possible. He was diagnosed when we were 18 and I have been in the work ever since.

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE?

I want people to know that transmasculine individuals are often left out of the conversation around HIV and are one of the populations the most at risk. More research needs to be done to ensure the transmasculine population is not the next wave of the epidemic.

Examples

Mallery Jenna Robinson

Commissioner

- Transgender and HIV Advocate and Healthcare Specialist for MJR
- CAB Coordinator for WeCanStopSTDsLA- CoachmanMoore and Associates
- Peer Facilitator for Plume
- Community and Social Media Manager for Trans Women Connected
- Associate Producer for Two Eyes Film
- Founder and Instructor Trans Excellence Academy and Transgender Empathy Trainings (T.E.T Talk)
- Podcaster for A Hateful Homicide

Why did you join the Commission on HIV?

> As an AfraCaribbean Transwoman living undetectably with HIV, I wanted to be a representation for my community and serve in a space where my identity would be validated.

Examples

GERALD GARTH

DIRECTOR OF DIVERSITY, EQUITY, AND INCLUSION, LOS ANGELES LGBT CENTER

CO-CHAIR, BLACK AFRICAN AMERICAN WORKGROUP; MEMBER, PUBLIC POLICY COMMITTEE

Q1

Why did you join the Commission on HIV?

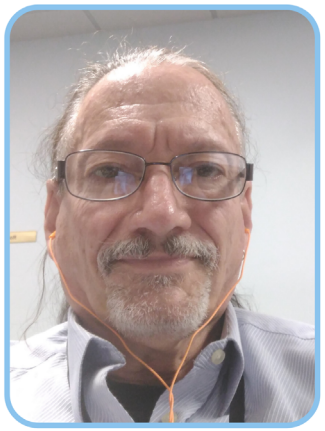
Black people continue to be disproportionately impacted by HIV, yet at the same time, are underrepresented in spaces of decision-making and influence. I am humbled that community trusts me to know that I will continue to bring all of us into the work. Being a part of the Commission allows me to prioritize and advocate for all of our intersections and identities.

Q2

Is there anything else you would like to share?

We all have a role in the wholeness and healing of our communities when it comes to HIV. Our responsibility is to define what that is and commit to bringing those skills and strengths unabashedly. One of my own quotes that guides me is “none of us have to do everything, if all of us do something.”

Examples



THOMAS GREEN

COMMISSIONER,
MEMBER OF STANDARDS AND
BEST PRACTICES COMMITTEE

Peer Support Specialist, Asian
Pacific AIDS Intervention Team

Why did you join the Commission on HIV?

I joined the Commission because I feel I have an unusual perspective on HIV. I am a long-term survivor having been diagnosed with HIV in Italy in 1991. I spent most of my adult life living and working abroad. Even though I missed much of the terror of the epidemic here in the USA, I experienced the loss of my best friends and more than one of my lovers to this terrible disease as well as more than a few employees. I accessed care through donations of medicines to one of the countries I was living in, Tanzania. Despite being HIV positive I have lived more than a special life having worked as a dancer, a resort hotel choreographer, a hotel owner and director on the island of Zanzibar. Ultimately I also survived the financial crisis of 2008, losing my business and money regaining my footing in the USA/Los Angeles as an older adult starting over. Navigating the resources here in Los Angeles I went from homelessness to having stability working with APAIT sharing my life with those affected by HIV, especially us long-term survivors. Part of this has been my advocacy through the Commission and events like AIDS WATCH and AIDS Action Week in Sacramento. I share my experiences to promote the Commission, advocacy for PLWH, and my clients here at APAIT.

Examples

Dr. Paul Nash

Commissioner, Member of Standards and Best Practices Committee and Aging Caucus

Associate Professor of Gerontology/Psychologist

Why did you join the Commission on HIV?

> Quite simply I want to make a difference. In academia it is very easy to become detached from the real world and conduct abstract research, but I want to do work that really matters. I am able to provide an evidence base for discussions and decisions on the Commission as well as direct future research to meet the needs of the public that we serve. It is important to engage in participatory research and for ownership to exist within the community to create real change. The mission of the Commission aligns with my own in making real world positive change and I want to do all I can to help realise this and improve the lives of people in our community and help in the fight against HIV.

Is there anything else you would like to share?

> I am an avid cyclist and enjoy combining my two passions, riding in the AIDS/Lifecycle event from SF to LA raising money and awareness to fight HIV and the stigma that still exists.

If you would like to be featured...

What I will need:

- Photo of yourself
- Occupation
- Role in the Commission
- Reason for joining the Commission
- Any additional information you would like to share

Contact

Please e-mail Catherine Lapointe at clapointe@lachiv.org

Thank you!