LOS ANGELES COUNTY
COMMISSION ON HIV

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AGING TASK FORCE Virtual Meeting

Tuesday, July 6, 2021

1:00PM -2:30PM (PST)

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AGING TASK FORCE
VIRTUAL MEETING AGENDA

Tuesday, July 6, 2021 | 1:00pm-2:30pm

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1) Welcome, Introductions, June Meeting Recap 1:00pm-1:10pm

2) Executive Director Report 1:10pm-1:20pm
   - Commission Updates
   - 2021 Work Plan/Priorities
   - Golden Compass Update | Funding Inquiry
   - Women Living with HIV & Aging: Virtual Lunch & Learn Special Presentation—Partnership Opportunity with Women's Caucus (July 19 @ 2pm-4pm)

3) Presentation: Senior Services, Los Angeles LGBT Center, Michael McFadden, Associate Director of Programs 1:20pm-1:30pm

4) Division of HIV and STD Programs (DHSP) Report 1:30pm-1:40pm

5) Discussion: Continued from June Meeting 1:40pm-2:20pm
   a. What does a comprehensive care for 50+ PLWHA look like for Los Angeles County?
      i. Review framework for HIV care for PLWH 50+
      ii. Define next steps for presenting framework to Executive Committee

6) Next Steps/Agenda development for next meeting 2:20pm-2:25pm

7) Announcements 2:25pm-2:30pm

8) Adjournment 2:30pm

LOS ANGELES COUNTY
COMMISSION ON HIV

AGING TASK FORCE

May 4, 2021 Virtual Meeting Summary

In attendance:

Al Ballesteros (Co-Chair)	Luis Argueta	Jayshawnda Arrington
Alasdair Burton	Kevin Donnelly	Wendy Garland
Bridget Gordon	Joseph Green	Michael Green
Lee Kochems	Michael McFadden	Mark McGrath
Paul Nash	Katja Nelson	Jose Ortiz
Brian Risley	Maria Scott	Cheryl Barrit (COH Staff)
		Sonja Wright (COH Staff)

1. **Welcome & Introductions**
   - Al Ballesteros, Co-Chair and Cheryl Barrit, Executive Director, welcomed attendees and led introductions.
2. **April Meeting Recap**
   - Dr. Michael Green (Division of HIV and STD Programs, DHSP) walked the Aging Task Force (ATF) through a portion of the DHSP response to the set of recommendations that the group completed. There are a few items left to review for feedback. The ATF will begin to focus on narrowing down the approach to the CPT codes and focusing on what ideal or optimal geriatric care for people living with HIV (PLWH) looks like, the type of assessments, and the key service modalities that should be included in the model. The ATF will continue to cite the Golden Compass program as one of the key model programs to reference.

     - Co-Chair Al Ballesteros reiterated the previous conversation of not getting caught in the weeds with too much data but focusing on common types of language for the senior population living with HIV such as: (1) increased mental health assessments (ex: cognitive assessments), (2) specific physical assessments (ex: bone density scans), and (3) utilizing best practices focused on seniors.

     - C. Barrit pointed out that the aforementioned is included in the current ATF packet on page 120 for this meeting's discussion. She also reached out to Drs. Monica Gandhi and Meredith Green and their team regarding the types of assessments under the Golden Compass. They are (1) depression screening, (2) cognitive assessment, (3) functional status assessment, (4) social support assessment, (5) vision screening, (6) dental screening, and (7) hearing screenings. There are no specific CPT codes, HIV behavioral health units are captured in service hours.

       Note: you may access the materials by clicking the following link: http://hiv.lacounty.gov/LinkClick.aspx?fileticket=4Ek7fvmVzMw%3d&portalid=22

- One of the main highlights from last month's discussion was the importance of looking at the ambulatory/outpatient medical contracts or their funding in terms of the assessments used for older adults living with HIV, as it appears that the rates for outpatient care consists of a blanket approach for everyone. The ATF wanted to look at whether this is indeed the case and if so, how are other things dealt with in regular assessments for older adults within outpatient Ryan White contracts.

- Incorporate discussion number 5 items on the summary into action items. C. Barrit will revise the work plan to incorporate the items or create another document for action items.

3. Discussion:

Creating a Comprehensive, Client-Led, Client-Centered HIV Care for PLWH over 50 Years in Los Angeles County (LACO)

Wendy Garland (DHSP) provided a summary of what she and Dr. Paul Nash identified as unmet psychosocial needs for aging populations:

- Data triangulation: it was agreed to start with comparing data they have from the Research on Aging and HIV (ROAH) project and from the medical care coordination (MCC) assessment to look at indicators related to housing status and stability, disability/functional status (IADL/ADLs), mental health, social support, medical complexity, and geriatric health. W. Garland will also look at MMP to see if there is any useful data there as well as reviewing the sociodemographic data in AOM to characterize clients under 50, 50-64 and 65+, as we know each of these cohorts likely differ. Next, consult the literature to fill any gaps or address any inconsistencies between the data sources.
- Landscape analysis: use this information to identify key services and resources for the aging population with HIV to conduct a landscape analysis in order to determine to what extent DHSP-funded agencies are implementing these services, if they are the barriers and facilitators and if they are not, the feasibility and interest to do so. This could be conducted using an online survey with other similar service explorations. The resulting information could be useful to DHSP and COH as we consider what services for the aging population should look like.
- Psychosocial Screener: based on this information, DHSP would identify 3-5 of the most relevant psychosocial domains and construct a screening tool that can be completed as part of a routine AOM visit. DHSP would initially pilot this in 1-2 agencies to determine the feasibility but could then expand to all AOM sites. Providers could access the online survey using a QR code and it would be submitted electronically. The survey could be used for all populations to help understand differences in the identified domains by age and other patient characteristics. DHSP would like to determine whether providers could be reimbursed for this activity through some health/psychosocial screener CPT code.

The plan is to start with item one. P. Nash has already shared the ROAH report for another site with W. Garland. W. Garland will work with staff to help with the DHSP data described above.

DHSP Response to the ATF Recommendations and Determination of Next Steps

- 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…

Dr. Green stated the MCC already provides this although it does not mean that they cannot go back and conduct trainings. The RC has it in the screener tools but there is not a separate screener specifically for this population. The recommendation was made to do what the ATF is already doing in terms of conducting a landscape analysis of services for patients who are age 50 and over to get a sense of quality of life measures. Question: It was asked if the MCC deals with more acute patients

as there have been previous discussions regarding the possibility of using or revising the tool for all patients 50+ to ensure that valuable information is not lost and to address particular issues this population might have. Dr. Green stated their data for older patients had pretty good numbers but that does not highlight their quality of life issues. The MCC data is integrated in the annual patient medical records review by gerontologist. He agreed that it is a good idea but does not know how that would be operationalized with the number of patients they. He also cautioned that because Ryan White resources are being used, the specialty care provided has to be related to HIV and while it is understood that people who are 50+ or who are long term survivors have HIV-related health issues that need to be measured and addressed, in order to be able to implement this within the Ryan White contact would require more investigation.

- **Customize food/nutrition and physical activity and mobility services for the aging population…**

Dr. Green stated this is specific to geriatric medicine and not to PLWH. If it becomes apparent that there are issues interfering with treatment adherence, then Ryan White resources can be used to address this, but he is unsure to what extent. Dr. Green noted that it would be hard to separate conditions of aging and HIV, especially in persons who have been living with HIV for long periods of time. He also reminded the ATF of the recommendation he made at the last meeting for the Standards and Best Practices (SBP) Committee to start working on standards of care for this population. This would help with looking at ways to integrate the new standards into the services that DHSP supports.

  - Dr. Green will review the actual language for screenings written in the contracts as he does not recall the actual language and whether all the screenings recommended are in the contracts.

- **Enhance the payment structure for services rendered for older adults living with HIV…**

There is no fee for service. It is the same for all patients and is not adjusted for any type of acuity or demographic measures.

- **Expand supportive services, such as financial assistance, as incomes become more fixed…**

There is no emergency financial assistance but there are other kinds of financial assistance (ex: help with utility payments, temporary housing payments, etc.). Question: has resources ever been allocated to exercise programs or physical rehabilitation services. It was suggested that the ATF looks at the service category to see if it warrants further investigation and if there is a need for resources, especially considering the COVID lockdown which limited opportunities for exercise. Dr. Green is open to suggestions on how to address this if there is the need. It was pointed out that it is data driven and might be a branch of the social determinants of health. There is a physical therapy component of the Golden Compass and similar programs which might be able to cover exercise that the ATF can center future conversations around and look for ways to replicate.

  - Look at the service category at the next meeting.
  - Dr. Green suggested reviewing the feedback for the entire document and making new recommendations and/or changes and then using it as a living document to track the way we go through the discussions.

- **Dedicate at least 15% of prevention funds to programming specifically tailored for individuals over 50…**

  It was expressed by the ATF they feel it is within DHSP's purview as those diagnosed with HIV over the age of 50 are late stage disease diagnosis and there is no reason why this should be the case. The ATF feels that this is not a special population issue but more of a pan population issue that has worse effects on people of color as they age. The ATF asked for clarification of the

response "need to verify the data". As a reminder, ATF stated that the data came from DHSP's surveillance report and from the California Office of AIDS. Dr. Green was inquiring if there was additional data that was needed as the conversation may have evolved since the initial data was sent to the COH. It was recommended to refer this to the Prevention, Planning and Allocations (PP&A) Committee. It was stated that #20 dovetails into this so there is no need for a separate discussion.

- **Address technological support for older adults…**
  This overlaps with #9 and falls in the domain of the COH, not DHSP.

    - It was decided that the ATF would review the document again and based on the responses from DHSP decide what the ATF is asking for and be clearer and more targeted on the requests, clarifying what is priority, and short-term versus long-term needs.

<u>Concerns expressed by the ATF:</u>

- The time delay between the initial data request where the ATF wanted to look at race disparities for 50+ PLWH in Los Angeles County (LACO) as well as the turnaround for the feedback on the document the task force reviewed today is unacceptable.
- It was expressed that the ATF is well aware of DHSP being busy and having their hands full due to the pandemic, so the concerns are not meant to be disrespectful, however ATF has been asking for data and feedback for quite some time. The general consensus was if they do not have the internal resources to respond to what is requested than the ATF needs to make a formal request that they get the necessary internal resources, such as permanent staffing, because the task force is having good attendance and spending their time in meetings but it is going in circles with recommendations from DHSP to send requests to different committees. The ATF asked a long time ago for directions in terms of understanding the contracts for older adults. There was a request for data in order to look at the aging populations who have fallen out of care and the discussion of prevention.
- It was reiterated that the task force understands that DHSP is busy but adamantly pointed out that there is money that rolls over in futures that can currently be used to hire staff to help complete the work the ATF is requesting. It is evident that there are resources to hire permanent help instead of money being allowed to rollover and the ATF is disappointed that this is occurring and disappointed at the slow rate of response.
- The specific data request asked for two years ago was an analysis of the populations that are falling out of care and not adhering to medical visits as it is suspected that there is a good percentage of older populations and people of color that fall into this category. It was stated that DHSP pulled a switch on the task force and presented data that they wanted to show. *How can the task force speak intelligently about this without access to the data that DHSP has?*
- The ATF as a whole felt that their time is not being respected and they are "just one of those task forces that has to be dealt with and the county should be able to chew gum and walk at the same time". They felt that over the past years there has been different types of hinderances and this year it happens to be COVID but the ATF feels responsible for helping the community and it is imperative that they stay adamant and consistent with their requests submitted to DHSP. The ATF also felt that DHSP's responses were inadequate and lacking in depth and detail.

Revised document recommendations:

- **Collaborate with traditional senior services or other providers who specialize in geriatrics and leverage the skills and expertise of those outside the HIV-provider world.** The first part of the recommendations are general recommendations that are broader in nature and does not fall into the other categories. DHSP's response says they are unsure who or where this expertise should be directed to. They requested that COH engage geriatric physicians/specialists in COH work and present at upcoming meeting? The task force felt that the question is suggesting that the COH should have geriatric seat. They felt it was a good idea but already have a Subject Matter Expert (SME) by way of Dr. Paul Nash. C. Barrit explained that if DHSP is suggesting an actual seat there would have to be change in bylaws and the process of working with the operations on implementation; there are 51 seats on the Commission and some of them are intended to cover different areas of expertise. If the ATF would like a specific bylaw change, it will take a larger discussion. C. Barrit also pointed out that there is also the opportunity to use recruitment efforts so that those voices and expertise are on the table without having to change the policy or procedures that are currently in place. The Commission also currently has parity based on age in the 50+ category. The ATF can also benefit from collaborating with other agencies that provide senior services, tap information from their SME, and overall networking.

    - The task force requested Dr. Gunzenhauser to attend one of the ATF meetings as perhaps they are talking to the wrong staff.

- **Ensure access to transportation and customize transportation service to the unique needs of older adults.** In what way can the ATF request that DHSP match the needs of PLWH that are dependent on Ryan White as it is an insult that their response indicates that this is beyond DHSP. This response was seen by many as disrespectful and one person indicated as someone with lived experiences, reading and listening to this made them feel that they are not being heard and decisions are being made on their behalf without their input. They also felt slighted in that most of what is done is not designed with women in mind and there is a lack of data that captures women.

    - It was the consensus of the task force that they dispute the response as not accurate as the Ryan White care system has a variety of programs that fund transportation across different populations, therefore the ATF asks that DHSP takes a deeper dive into reviewing this.

      It was pointed out that many of the recommendations are being punted back as if the strategy is to have the ATF running around in circles trying to figure out what DHSP is doing and so far, that tactic is working. The task force also made mention of item #5 which talks about the mental health needs of the populations and the recommendation made by DHSP for them to read the literature review. The pushback here is that DHSP should read the literature reviews as they are the ones funding these items.

    - Brian Risley will send DHSP the peer review spreadsheet again.

This is public information which includes articles about the Golden Compass which remains the most frequently cited program for HIV and geriatric care.

- **Benefits specialists should be well versed in Medicare eligibility services…**
  The intent of the benefit specialist program is to have staff available who are trained and knowledgeable of the various programs that individuals can qualify for including Medi-Cal and Ryan White. The question is how do you access the benefits specialist for care, would it be by virtue of making an appointment with that person?
    - The ATF would like information regarding who replaced Jacques Chambers and Julie Cross. Who is the current point person?
- **Direct DHSP to start working with agencies that serve older adults…**
  The consensus was this is too vague. The question became: Is there a way for DHSP to contract with other agencies that have these services, thus folding them into HIV?
- **Ensure robust and meaningful input from older adults living with HIV…**
  The consensus was this is straightforward and does not warrant any changes.
- **Ongoing research and needs assessment section**
  The ATF felt that DHSP is doing this correctly, except for the data requests for late diagnosis.
- **Gather data on PLWH over 50 who are out of care…**
  DHSP says that locating and identifying the out of care population has been a challenge in the past as such they can review data from the Linkage and Re-Engagement Program (LRP) to identify barriers to care and service needs of PLWH who are out of care.
    - Ask for the review from the LRP program; this can be by way of a presentation to the task force in the future.

      The ATF inquired if DHSP can hire experts to do a meta-analysis regarding underserved populations, people of color, etc., specifically addressing how much money is being spent to accomplish certain items. It was the consensus of the ATF to collaborate with universities to complete the meta-analysis which addresses the needs of the underserved while embarrassing DHSP in the process as they will continue to ignore the ATF if no action is taken. There was also a recommendation made to ask the Board of Supervisors (BOS) for assistance in carving out a portion of the Ryan White funding to be able to get the meta-analysis and other data requests done.

- **Conduct studies on the prevention and care needs of older adults.** Current data indicates that 15% of cell markers are coming in with late stage HIV. The task force is not sure why DHSP is telling the ATF to do a literature review or perform their own research. DHSP is supposed to be providing this data and keeping track by way of surveillance. The task force does not like DHSP's overall feedback.
    - Inform DHSP to do the literature reviews and report the findings to the ATF.
    - The ATF will continue where they stopped on the recommendations at the next meeting.
    - Staff will email the ATF a Word version of the document with a given deadline, that allows the ATF to type in their reactions to the DHSP responses. Staff will consolidate the feedback into one document to include in the packet materials at next meeting.

4. Determine Next Meeting Dates and Times

- The Aging Task Force will meet on the first Tuesday of the month from 1pm – 3pm. The next meeting will be held on June 1, 2021, 1pm-3pm.

5. **Next Steps/Agenda Development**

- Look at comprehensive care for 50+ PLWHA in Los Angeles County

- Golden Compass Program: Slides Presentation and Inquiry Responses
- New York RFP
- DHSP feedback - Revisit
    - DHSP response tracker

6. **Announcements:** None.
7. **Adjournment:** meeting adjourned at 1:46 pm.

AGING TASK FORCE

JUNE 1, 2021 Virtual Meeting Summary

In attendance:

Jayshawnda Arrington	**Al Ballesteros (Co-Chair)**	Alasdair Burton
Geneviéve Clavreul	Kevin Donnelly	Wendy Garland
Bridget Gordon	Lee Kochems	Catherine Lapointe
Eduardo Martinez	Paul Nash	Jose Ortiz
Maria Scott	Octavio Vallejo	Cheryl Barrit (COH Staff)

1. **Welcome, Introductions, May Meeting Recap**
    - Al Ballesteros, Co-Chair, and Cheryl Barrit, Executive Director, welcomed attendees and led introductions.
    - Cheryl Barrit provided a recap of May's meeting as follows:
        - The Aging Task Force (ATF) went through the feedback from the Division of STD and HIV Programs (DHSP) on the set of recommendations that the ATF provided and developed.
        - The ATF shifted their approach on how to deal with Current Procedural Terminology (CPT) codes. They will focus on key components and assessments on geriactic care and how they relate to Ryan White services.
        - The ATF discussed coordination on data analysis.
2. **Executive Director's Report**
    - Cheryl Barrit provided updates on Commission activities as follows:
        - Jose Garibay, new staff member, was introduced. He will serve as the lead staff for the Standards and Best Practices Committee.
        - Commissioners have selected members to serve as liaisons to the DHSP Ending the Epidemic (EHE) Steering Committee. Bridget Gordon will serve

as the main liaison, supported by Kevin Stalter, Katja Nelson, and Felipe Findley.
    - The next DHSP Steering Committee will be June 25th from 1-3 PM.

3. **Ending the Epidemic (EHE) Steering Committee**
    - Al Ballesteros asked how recommendations from the ATF will get into the Ending the Epidemic (EHE) work plan.
    - Alasdair Burton supported having a liaison between the ATF and EHE Steering Committee.
    - Octavio Vallejo recommended that the most substantial impact on allocation of funding would come from Standards of Care and Best Practices.
    - Kevin Donnelly commented that grants to the Commission are greater than funding from EHE.
4. **2021 Work Plan Updates**
    - Dr. Green continued going over DHSP's response to the recommendations on 5/4/21. ATF members were asked to provide further clarification where needed.
    - Golden Compass Program information was provided by staff on 5/4/21.
    - ATF members shifted focus on key assessments that are used in general geriatric care that may help form a customized model of care for 50+ PLWH at the April meeting.
    - Commissioners completed SCAN Trading Ages age sensitivity training on 5/6/21.
    - Cheryl Barrit added a new Task/Activity to the work plan: Determine key priorities for implementation and possible integration for COH Committee work. Co-Chair, Al Ballesteros, asked COH staff to determine what is feasible to implement from list of recommendations at COH meeting on 5/13/21.
5. **Discussion**
    - Cheryl Barrit gave an overview of the Golden Compass Program as follows:
        - Assessments and screenings conducted include:
            - Depression screening
            - Cognitive assessment
            - Functional status assessment
            - Falls and gait assessment
            - Social Support assessment
            - Vision screening
            - Dental screening
            - Hearing screening
        - The program uses B20 (HIV). Behavioral health captures units of service in hours, but no CPT code.

    - Cheryl Barrit was advised to reach out to Meredith Greene to estimate what percentage of the program's funding is supported by Ryan White dollars. She has not received a response yet.
- Dr. Monica Gandhi and Dr. Meredith Greene were asked to join a future full body Commission meeting and accepted.
- Alasdair Burton commented that an assessment of the levels of social interaction between older individuals and the outside world would be helpful to determine how COVID-19/isolation has influenced this population. Paul Nash supported this.
- Bridget Gordon commented that housing should be added to the assessments and screenings conducted.
- Al Ballesteros recommended conducting bone density screenings, cancer screenings, and nutritional assessments.
- Octavio Vallejo recommended polypharmacy services to monitor drug interactions. He also stated that there needs to be a clearer definition of HIV care and primary care for PLWH.
- Paul Nash recommended the importance of having a geriatrician monitor the drugs older adults are being prescribed.
- The Aging Task Force decided to add the following screenings and assessments:
    - Bone density screenings
    - Various cancer screenings
    - Muscle loss and atrophy screenings
    - Nutritional assessments
- Cheryl Barrit shared slides from Dr. Monica Gandhi's presentation on Primary Care guidelines for PLWH and emphasized the following points:
    - With continuous care engagement and uninterrupted access to ART, life expectancy for PLWH approaches that of persons without HIV.
    - Managing comorbidities is an important aspect of HIV care.
    - Stigma-free, culturally appropriate, patient-centered treatment is essential to maximize care engagement and viral suppression.
    - Golden Compass Emergent Themes:
        - Knowledge of HIV and Aging Topics
        - Social Isolation and loneliness
        - Health-related needs of older PLWH
    - Formation of Golden Compass: Focus Group Priorities
        - Top three issues ranked most important by patients: depression, falls, and HIV medication adherence

        - Top three issues ranked most important by providers: falls, memory, and depression
    - Golden Compass Program: Four Points of Care:
        - Heart and Mind
        - Bones and Strength
        - Network and Navigation
        - Dental, Hearing, Vision
    - MoCA: Montreal Cognitive Assessment

6. **Aging Task Force Recommendations to COH, DHSP, and other County and City Partners**
    - Cheryl Barrit presented the following COH staff suggestions:
        - Work with all Co-Chairs to foster input from 50+ PLWH and include a healthy aging lense in discussions. It is suggested that the ATF Co-Chair and ATF members bring up ideas and report back to the Executive Committee at their monthly meetings.
        - Collaborate with DHSP to provide data on HIV continuum and quality of life indicators by race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status. Addressing disparities within the 50+ population is in line with the DHSP EHE Plan Overarching Strategy: Ensure that Los Angeles County Ending the HIV Epidemic pillars of interventions address and eliminate health inequities, address and dismantle racial inequities that are at the root of HIV and related syndemics, focus on the communities most impacted by HIV, and adopts a client-centered, people first approach.
        - The Standards and Best Practices (SBP) Committee developed special guidelines for special populations (youth, women, and transgender) in 2007. The ATF may want to approach the SBP Committee to develop best practices/guidelines for 50+ PLWH. It is suggested that the ATF Co-Chair and ATF members bring up ideas and report back to the Executive Committee at their monthly meetings.
        - ATF may develop a framework for a model of Ryan White care for 50+ PLWH in Los Angeles County, using the Golden Compass and HIV Policy Project paper as guides. It is suggested that this framework be completed before March 2022 and presented in the Executive Committee for support.

7. **Next Steps/Agenda Development for Next Meeting**
    1) Cheryl Barrit will develop a separate document that lists the ATF's ideas for health assessments and screenings.

2) Wendy Garland and Cheryl Barrit will follow up on medical care coordination items.
3) Cheryl Barrit will get more information on Golden Compass funding.
4) The ATF will try to get physician input for the next meeting.

8. **Adjournment:** meeting adjourned at 2:27 PM.

LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV 2021
AGING TASK FORCE WORKPLAN (Updated 3.16.21; 4.26.21; 5.22.21; 6.18.21)

Task Force Name: Aging Task Force	**Co-Chairs: Al Ballesteros**
Task Force Adoption Date: 3/2/21_updated 4.26.21; 5.22.21	
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021. **Prioritization Criteria:** Select activities that 1) represent the core functions of the COH and Committee; 2) advance the goals of the Comprehensive HIV Plan and Los Angeles County HIV/AIDS Strategy; and 3) align with COH staff and member capacities and time commitment.	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Determine and continue to refine next steps for recommendations.	Final recommendations completed 12.20.10.	Ongoing	Recommendations presented at November & December 2020 Executive Committee and December 2020 & January 2021 full Commission meetings. COH approved 1-year extension of the ATF until March 2022.
2	Review and refine 2021 workplan		Ongoing	Workplan revised/updated on 3/16/21,4.26.21, 5/22.21, 6/18/21
3	Secure DHSP feedback / analysis on Aging Task Force recommendations.	Dr. Green continued going over DHSP's response to the recommendations on 5/4/21. ATF members were asked to provide clarification where needed.	~~April~~	~~Dr. Green provided DHSP feedback at April's ATF meeting.~~
4	Study models of HIV care for older adults then determine speakers / programs to highlight at a full COH meeting. Include a panel of speakers, especially consumers who are not connected to care. This task is to lead to the development of a framework for a pilot program that would leverage existing Medical Care Coordination (MCC) teams to integrate service components tailored to respond to the needs of the aging clients.	Invite Dr. Tony Mills to ATF meeting; Golden Compass, Owen's Clinic, University of Colorado, University of Alabama, AltaMed PACE Program, etc.	April-May	ATF will review models of care first to determine which presenters/program to feature at a full COH meeting. Golden Compass Program information provided by staff on 5.4.21.
5	Review CPT codes of geriatric care. Review health screenings/risk assessments for older adults and discuss how they may be integrated in Ryan White services		April-May	~~CPT codes introduced at April's ATF meeting.~~ ATF members shifted focus on key assessments that are used in general geriatric

				care that may help form a customized model of care for 50+ PLWH at the April meeting.
6	Review HEDIS measures used by LA CARE Health Plan | Caring for older adults		April-May	Al Ballesteros to contact LA CARE
7	Review, track and revisit Master Plan on Aging		Ongoing	
8	Conduct ageism training for the community.	Raise awareness about implicit bias with specific focus on ageism.	May 6 11am to 1 pm Ongoing	~~Partner with SCAN to co-host Trading Ages training.~~ Completed SCAN Trading Ages training on 5/6/21. Determine future training sessions with ATF members.
9	Determine key priorities for implementation and possible integration to COH Committee work.			Co-Chair, Al Ballesteros, asked COH staff to determine what is feasible to implement from list of recommendations at COH meeting on 5/13/21.
10	Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and otherhealth services	Work with all Co-Chairs to foster input from 50+ PLWH and include a healthy aging lens in discussions. It is suggested that the ATF Co-Chair and ATF members bring up ideas and report back to the Executive Committee at their monthly meetings.	Ongoing	Activity and description taken from the recommendations tracker and as discussed from 6/1/21 meeting.
11	Encourage the Division of HIV and STD Programs (DHSP) tocollaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issue: Understand disparities in health outcomes within the 50+ population by key demographic data points such as	Collaborate with DHSP to provide data on HIV continuum and quality of life indicators by race/ethnicity, gender, geographic area, sexual orientation, and socioeconomic status. Addressing disparities within the 50+ population is in line with the DHSP EHE Plan Overarching Strategy: Ensure that Los Angeles County Ending the HIV Epidemic pillars of interventions	Ongoing	Activity and description taken from the recommendations tracker and as discussed from 6/1/21 meeting.

	race/ethnicity, gender, geographic area, sexual orientation,and socioeconomic status.	address and eliminate health inequities, address and dismantle racial inequities that are at the root of HIV and related syndemics, focus on the communities most impacted by HIV, and adopts a client-centered, people first approach.		
12	Encourage the Division of HIV and STD Programs (DHSP) tocollaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issue: 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 for the population. Examples of best practices to explore are National Association of Area Offices on Aging (https://www.n4a.org/bestpractices) and Substance Abuseand 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.	The Standards and Best Practices (SBP) Committee developed special guidelines for special populations (youth, women, and transgender) in 2007. The ATF may want to approach the SBP Committee to develop best practices/guidelines for 50+ PLWH. It is suggested that the ATF Co-Chair and ATF members bring up ideas and report back to the Executive Committee at their monthly meetings.		Activity and description taken from the recommendations tracker and as discussed from 6/1/21 meeting.

Los Angeles County Department of Public Health
Division of HIV and STD Programs

Commission on HIV –**Aging Task Force Recommendations** to COH, DHSP, and other County and City Partners, FINAL 12/10/2020
DHSP Response: 4/05/2021 (Updated with ATF Reactions and COH Staff Suggestions for Priority Action Items. Rows highlighted in yellow are suggested priorities for ATF to tackle at their meetings)

Recommendations	Who	Status/Notes
General Recommendations		
1. 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.		• Not clear who this is directed to and where this expertise should be directed • Request that COH engage geriatric physicians/specialists in COH work and potentially present at upcoming COH meeting? • Collaborate with APLA Aging efforts? • The point here is that there is an existing and universe of agencies providing senior specific services outside of the HIV bubble. DHSP would benefit from such collaboration since it serves a majority aging population. Within 5 years over 70% of persons living with HIV in LA County with be over 50. Rather than getting lost in the text of this point, DHSP should demonstrate who it plans to work with existing senior services outside the field of HIV.
2. Ensure access to transportation and customize transportation services to the unique needs of older adults.		• Beyond DHSP • CHHS Master Plan on Aging • Review Transportation contracts to ensure alignment with community need (this also came up during YCAB EHE Events as a priority) • The DHSP reply in nonsensical. There are existing Federal monies for transportation services. This issue is particularly acute in rural areas of Los Angeles County and in addition, it is completely feasible to provide transportation services to persons with daily activity impairments.
3. Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV	CCS	• Benefits Specialists are expected to be versed in all services, programs and referrals for all of their clients. We can ensure this is happening during program reviews. • It is nice to hear that DHSP is engaged in this activity. We would like to know the details, and review protocols, to ensure the activities satisfactory.

4. 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.		• Need more information on the goals and expectations of these collaborations and how the commission is already working with these agencies. • The goal is to tap into existing resources for clients provided by other government agencies. The point of this text is inter-governmental collaboration. DHSPs reply makes us wonder if they are taking this matter seriously. DHSP should respond to how they are going to improve the health of the aging population such collaboration. DHSP should draft goals, strategies and activities.
5. Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.		• COH purview • DHSP should communicate its plan for community engagement from an aging population living with HIV. We feel the demographic trends that shows an aging "tsunami" are troubling. If members of the taskforce feels this is an issue, then it is valid. DHSP should reply with their plan to increase community engagement. • COH staff suggestion: Work with all Co-Chairs to foster input from 50+ PLWH and include a healthy aging lens in discussions. It is suggested that the ATF Co-Chair and ATF members bring up ideas and report back to the Executive Committee at their monthly meetings.

Recommendation	Who	Status/Notes
Ongoing Research and Needs Assessment		
1. 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:		• Many thanks to Wendy Garland for listening to the taskforce and acting on this point. At times, we get the impression from listening to DHSP representatives that they are not engaged in this issue. We find it troubling since issues of aging affect women, persons of color, and transgendered persons the most. Additionally through the lens of demography, it is clear that the aging cohort growing rapidly. It is troubling that DHSP in not familiar with the peer review literature on this topic.
a. 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: 2019 Annual HIV Surveillance Report))		• This may be able to be addressed through a literature review and report back of key findings by DHSP. • Compare LAC with other jurisdictions, CA and US to see if unique to LAC • Could this be addressed through efforts to increase routine testing as older people are probably more likely to be in care for non-HIV related health conditions? • DHSP should reply with their plan to address disparities that are clearly apparent in their published surveillance data.
b. 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.		• Locating and identifying the out of care population has been a challenge in the past. DHSP can review data from the Linkage and Re-Engagement Program (LRP) to identify barriers to care and service needs of PLWH over 50 who are out of care. • I find it troubling that DHSP has no understanding of the size of the out of care population. This does not seem to be the case with other jurisdictions such as King County, Washington; NY City; San Francisco. This goes beyond an aging issue. DHSP should present it's out of care measurements and any general understanding of the out of care population, to include but not limited to age discrepancies.

c. Conduct studies on the prevention and care needs of older adults.		• A literature review would probably be able to inform this • Perhaps the commission should partner with academic institutions for this • DHSP should demonstrated its plan for persons aging with HIV. The answer seems to indicate that its new on their radar.
d. 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.		• First step is to determine whether there are disparities and where they are • A literature review would help to inform as relates to those living with HIV • CHHS Master Plan on Aging • I feel we have come full circle "circumlocution." Our original data request was to identify disparities. I question whether or not we are speaking to the right personnel. • COH staff suggestion: Collaborate with DHSP to provide data on HIV continuum and quality of life indicators by race/ethnicity, gender, geographic area, sexual orientation,and socioeconomic status. Addressing disparities within the 50+ population is in line with the DHSP EHE Plan Overarching Strategy: Ensure that Los Angeles County Ending the HIV Epidemic pillars of interventions address and eliminate health inequities, address and dismantle racial inequities that are at the root of HIV and related syndemics, focus on the communities most impacted by HIV, and adopts a client-centered, people first approach.

e. Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.		• Recommend to start with a literature review -not sure we have adequate data to address.
f. 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.		• Recommend starting with a literature review
g. 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 for 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.		• This seems beyond scope of what we can do and has likely already been done and may be included in one of the listed docs. Perhaps SBP can create or adopt standards for this population. • This may overlap with broader recommendations in and the scope of the CHHS Master Plan on Aging as it may extend to all aging populations. • Recommend SBP work with Aging Task Force to develop best practices for working with PLWH aged 50 and older • DHSP should come up with a model of care for an aging population. • COH staff suggestion: The Standards and Best Practices (SBP) Committee developed special guidelines for special populations (youth, women, and transgender) in 2007. The ATF may want to approach the SBP Committee to develop best practices/guidelines for 50+ PLWH. It is suggested that the ATF Co-Chair and ATF members bring up ideas and report back to the Executive Committee at their monthly meetings.
h. Request DHSP to develop a data collection and reporting plan with a timeline on an annual report to the community.		• Could we include additional age groups – as appropriate to reports already generated?
Recommendation	**Who**	**Status/Notes**
Workforce and Community Awareness		
2. 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 of HIV.		• Beyond DHSP • Within COH's purview? • Would CBA providers be able to provide these trainings? • Again, maybe we are speaking to the wrong staff. I suggest direct contact with Gunzenhauser, I also recommend the taskforce begin drafting communications to the board of supervisors.

3. 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.		• COH • COH staff suggestion: Work with SBP on convening subject matter experts to help inform the development of best practices for 50+ PLWH
4. 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."		• Beyond DHSP
5. 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.		• Need more information/clarification • DHSP should work with benefits specialists to understand the full range of services for 50+ in the County and refer clients to services they need.
6. 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 the HIV workforce on how to develop and deliver classes toolder adults with respect, compassion, and patience. (Moved up from #7 below).		• Not sure this is DHSP? Could COH work with RWP/HRSA on workforce development or the AETCs? • Collaborate with DPH Office of Aging and invite representative to present at COH meeting?
7. Train older adults on how to adapt to the new realities of seeking care as they progress in the age spectrum.		• Mixing directives; first item seems beyond scope of DHSP. Second item maybe fits with item 6 above? (Moved up to #6).

8. Expand opportunities for employment among those over 50 who are able and willing to work.		• Beyond DHSP • CHHS Master Plan on Aging
9. Provide training on the use of technology in managing and navigating their care among older adults. Address technological support for older adults living withHIV as medical service modalities rely more and more on electronic, virtual, and telehealth formats. (Moved up from #18)		• Could this be part of the $ we provide to agencies to strengthentelehealth services?
10. Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.		• Related to items #6 and #7?
11. Collaborate with local resources and experts in providing implicit bias training to HIV service providers.		• I believe this is probably already a resource we provide in ourtrainings to contracted providers • Share implicit bias/medical mistrust training being developed withBlack/AA Task Force.
Expand HIV/STD Prevention and Care Services for Older Adults		
12. 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.	**SUGGESTED ATF PRIORITY**	• MCC provides this already - maybe add a component to the training/service guidelines for working with specific pops that includes aging population? Major recommendations for an aging population include addressing the 4 Ms: medication, mentation, mobility, and what matters to the patient. There are many screeningtools available. Maybe add to discussions around MCC and AOM service standards. • For some of the items in this section it seems like a landscape analysis of services for 50 plus clients is needed – just within theRWP. • COH staff suggestion: ATF may develop a framework for a model of Ryan White care for 50+ PLWH in Los Angeles County, using the Golden Compass and HIV Policy Project paper as guides. It is suggested that this framework be completed before March 2022 and presented to the Executive Committee for support.

13. 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		• Not sure this is feasible with probably about 4,000 AOM clients andmore than that in MCC receiving services. Could any of this be added to chart abstractions during contract monitoring? • MCC teams already are directed to conduct cognitive assessmentsfor client aged 50 and older and assess IADLs and ADLs with each assessment.

patients affected by cognitive decline in navigating their care.		
14. 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.		• This is really geriatric medicine • No this is routine HIV care for persons aging. See lit review Mark McGrath provided.
15. 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.		• Wouldn't this be covered through current FFS model?
16. 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.		• CHHS Master Plan on Aging • The master plan on aging does not relieve DHSP from tailoring services, programs, etc., Once again we must note the oncoming demographic shift towards an aging population
17. 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.		• Could this be part of psychosocial services RFP whenever that happens? • CHHS Master Plan on Aging • The peer review literature (see review supplied to DHSP) notes poor outcomes that can be supported by prevention services. DHSP should ensure that all future contracts account for aging risk factors elucidated in the peer review corpus.
18. ~~Address technological support for older adults living with HIV as medical service modalities rely more and more on electronic, virtual, and telehealth formats~~. Moved to #9		• Overlap with #9? Not sure what they are asking for here; this kind of training would be a great project for the commission to undertake Moved to 9 • Those of us who are familiar with the peer review research and subsequent focus group and medical discussion are familiar with the technological gap experienced by people aging with HIV. We request DHSP propose solutions.

19. 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		• Need to verify in our data but not sure how to respond • It seems the DHSP personnel we are speaking to are not familiar with the epi data presented in County and state surveillance reports. We request that the County communicable disease officer (Gunzenhauser) or an appropriate epi trained staff member address this issue.

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		
20. 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.		• This may be a more effective strategy than #19 to reach older population
21. 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.		• We have tried to shift away from a population focused approach to an outcomes approach where we are targeting services to those populations who are not in care and not virally suppressed and that generally does not represent the aging population.

Aging Task Force | Framework for HIV Care for PLHWA 50+ (6.18.21)