LOS ANGELES COUNTY
COMMISSION ON HIV

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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.

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ADDENDUM TO AGING CAUCUS (Formerly Aging Task Force) RECOMMENDATIONS

Addressing the Needs of Individuals who Acquired HIV Perinatally and Long-term Survivors under 50

Final Approved by Aging Caucus 12/6/22; 01/26/23 Executive Committee; 2/7/23 COH

Background and Purpose: The Aging Task Force was formed in 2019 to address HIV and aging and completed a set of recommendations to enhance data collection, research, improve service delivery for HIV/STD prevention and care for older adults living with HIV, and increase community awareness and support for the unique and complex needs of PLWH over 50 years of age. In addition, the Aging Task Force developed the HIV and care framework to articulate key health screenings that would aid in providing comprehensive care for PLWH over 50.

In keeping with the Aging Caucus' commitment to treating the recommendations as a *living document*, the group has developed this addendum to recognize that the spectrum of disease and onset of health issues can occur at different ages, and to be inclusive of long-term survivors (LTS) under 50 years old and those who acquired HIV perinatally (may also be referred to as vertical transmission). These recommendations were derived from speaker presentations, scientific articles, and feedback from Commissioners and the community at large. Furthermore, the Aging Caucus recognizes that the themes of the original set of recommendations (ongoing research and assessment, workforce and community education and awareness, and expansion of HIV/STD prevention and care services) also apply to achieving optimal health for PLWH under 50 who are experiencing accelerated aging.

Cross-cutting recommendations

- Conduct targeted studies and data collection on how accelerated aging affects long-term survivors under 50 years of age
- Expand benefits counseling (from all program types, not just Ryan White funded) to include long-term planning and how to transition into Medicare
- Expand counseling services to include self-advocacy for care and treatment options
- Assessments for older PLWH may need to be discussed with the medical provider earlier in age/lifespan
- Consider using biomarker testing for long-term survivors under 50 to determine the rate and impact of accelerated aging.
- Work with providers to look for opportunities to address health inequities early in the lifespan.

Research and treatment for youth and individuals under 50 who identify as LTS

- Utilize multimodal and combination strategies and approaches to whole-person care and treatment
- Assess individual response to anti-retroviral treatment (ART) and monitor appropriate adjustment and modification in dosing and frequency.
- Assess and monitor ART resistance and make customized adjustments that address the individual needs of the patient.
- Use different delivery modes and strategies such as telehealth, dedicated teen clinics, women's clinics, technology, age-specific and intergenerational support groups, music, art, and multi-media communications.
- Support research on monoclonal antibody drug treatment for long-term survivors under 50
- Administer/offer vaccines for vaccine-preventable diseases as a part of comprehensive care across the lifespan
- Support research on the impact of latency-reversing agents for LTS and PLWH who acquired HIV perinatally. One of the main obstacles to curing HIV infection is that the virus can remain hidden and inactive (latent) inside certain cells of the immune system (such as CD4 cells) for months or even years. While HIV is in this latent state, the immune system cannot recognize the virus, and antiretroviral therapy (ART) has no effect on it. Latency-reversing agents reactivate latent HIV within CD4 cells, allowing ART and the body's immune system to attack the virus. Currently, latency-reversing agents are still under investigation and have not been approved by the Food and Drug Administration (FDA).
- Collaborate with LTS in identifying strategies for improved engagement and retention in care.
- Integrate behavioral and community interventions with clinical care
- Optimize care models by offering a diverse menu of wellness and preventive care services
- Support alternative venues for care delivery
- Expand the use of technology to deliver personalized care
- Research and clinical practice should examine the dynamic nature of epigenetic age, through examinations of differences in viral load over time, or how interventions leading to improved adherence impact epigenetic age[1].

Screening, Education and Counseling

- It is important to screen for and address comorbidities with prevention and early treatment.
- Take good health and wellness history and assess risk factors for:
    - Hypertension and cardiovascular disease
    - Diabetes
    - Mental health

[1] Epigenetic age is a biomarker of aging previously reported to be associated with age-related disease and all-cause mortality. Horvath S. DNA methylation age of human tissues and cell types. *Genome Biol*. 2013;14(10):R115-R115. doi:10.1186/gb-2013-14-10-r115

  - Sexually Transmitted Infections (STIs)
  - Physical activity
  - Obesity
  - Tobacco
  - Substance use
  - Sexual health
  - Daily and general life activities
  - Diet
  - Helmets
  - Firearms and exposure to violence and injury
- Include a detailed family history and family and social support systems in patient assessments and treatment plans
- Include physical examination in clinical visits
- Provide education for patients and staff in understanding the needs of LTS under 50. Providers must be aware of their unique milieu and potential comorbidities to optimize care and outcomes
- Offer counseling and health education on:
  - Nutrition
  - Exercise
  - Smoking (cigarettes, vaping, cigarillos, e-cigarettes)
  - Substance and alcohol use
  - Sex
  - Weight loss
  - Lifestyle modification
  - STI counseling, screening and treatment
  - Family planning
  - Immunizations
- Link LTS to services and support groups to reduce isolation and link LTS with other PLWH to build community and a sense of belonging and empowerment.