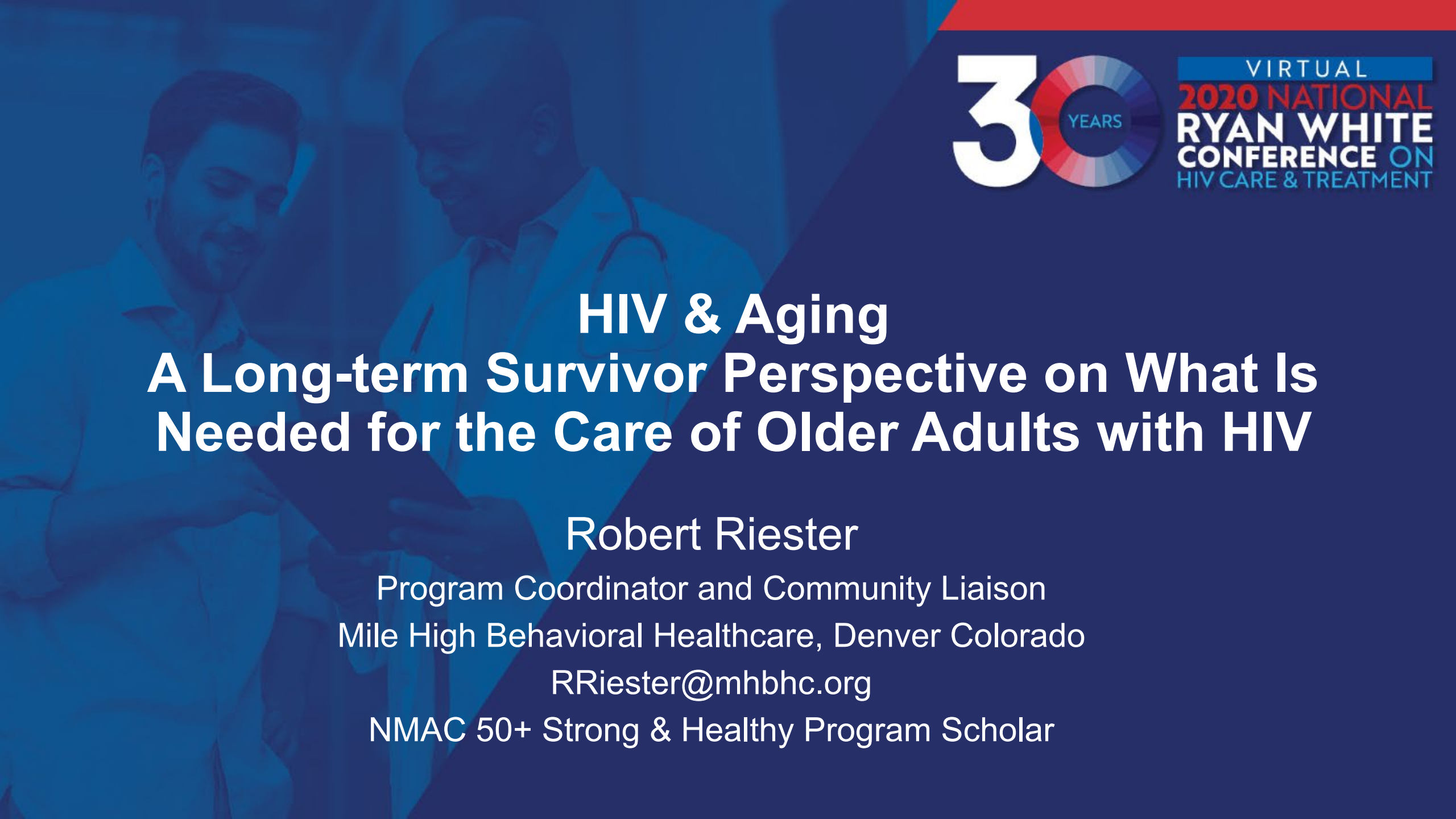

VIRTUAL
2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

30 YEARS

HIV & Aging
A Long-term Survivor Perspective on What Is Needed for the Care of Older Adults with HIV

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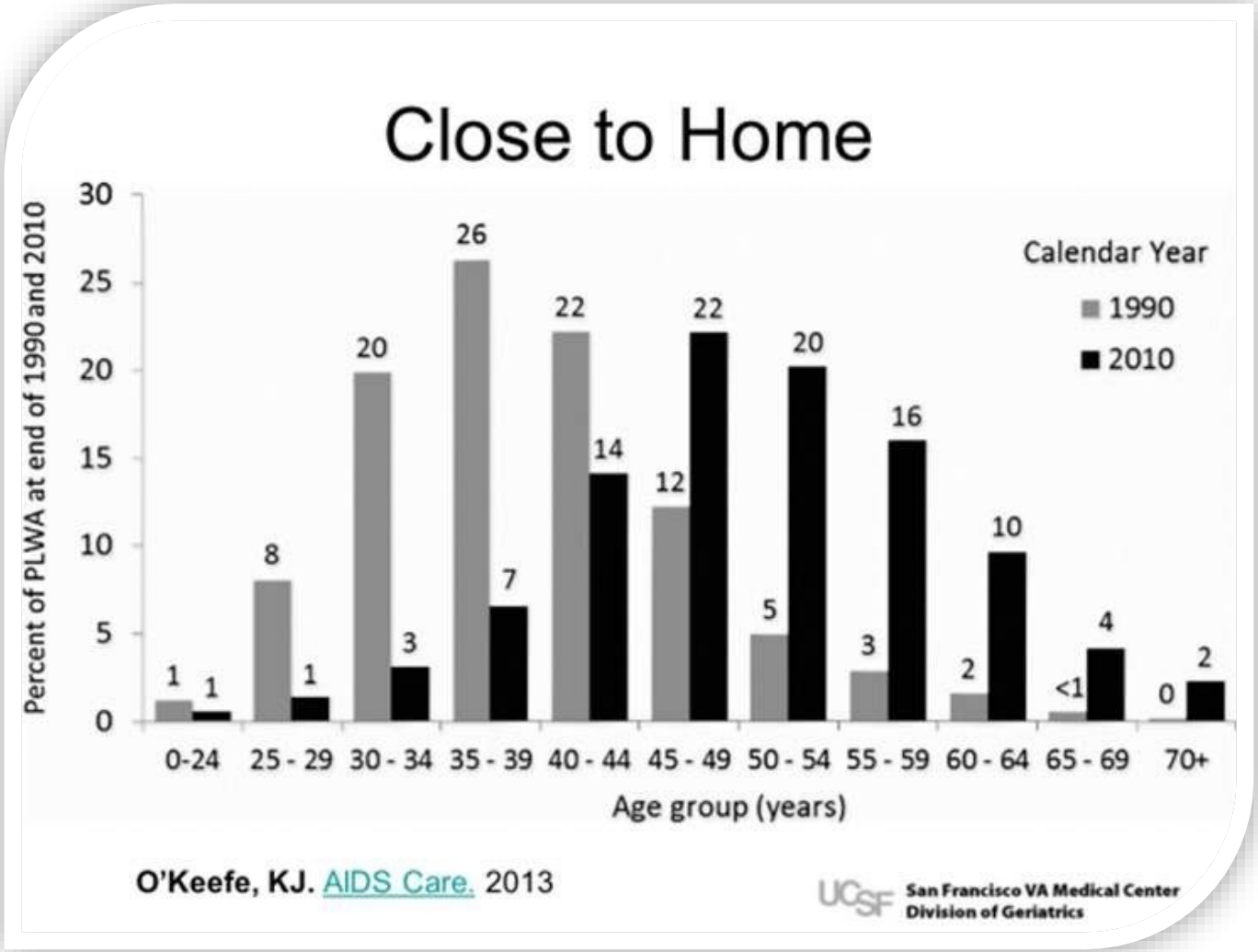
NMAC 50+ Strong & Healthy Program Scholar

Where We Were Back Then

- July 3, 1981 – Rare Cancer seen in 41 Homosexuals is the headline of a New York Times article, and the term Gay Cancer is born.
- Sept. 24, 1982 – With the cause still unknown, It would now be called AIDS by the CDC, because it was less stigmatizing than Gay Related Immune Deficiency, or Gay Cancer.
- Sept. 23, 1984 – HHS Secretary announces the discovery of the HTLV-III virus by Dr. Robert Gallo, which is believed to be cause of AIDS. (Now known as HIV-1)
- March 2, 1985 – The FDA approves the first commercial ELISA antibody test. There is still no treatment, but earnest prevention is now possible.
- July 25, 1985 – Actor Rock Hudson announces he has AIDS. This would be a turning point in public perception of the epidemic.
- Sept. 17, 1985 – The term AIDS is mentioned publically for the first time, by President Ronald Reagan.
- October 1986 – HRSA's AIDS Service Demonstration Grants program begins with $15.4 million available to the cities of New York, San Francisco, Los Angeles and Miami.
- March 19, 1987 – The antiretroviral drug AZT is approved by the FDA for treatment against HIV.

Source – HIV.gov, A Timeline of HIV and AIDS

Percent of PLWA 1990/2010 in San Francisco



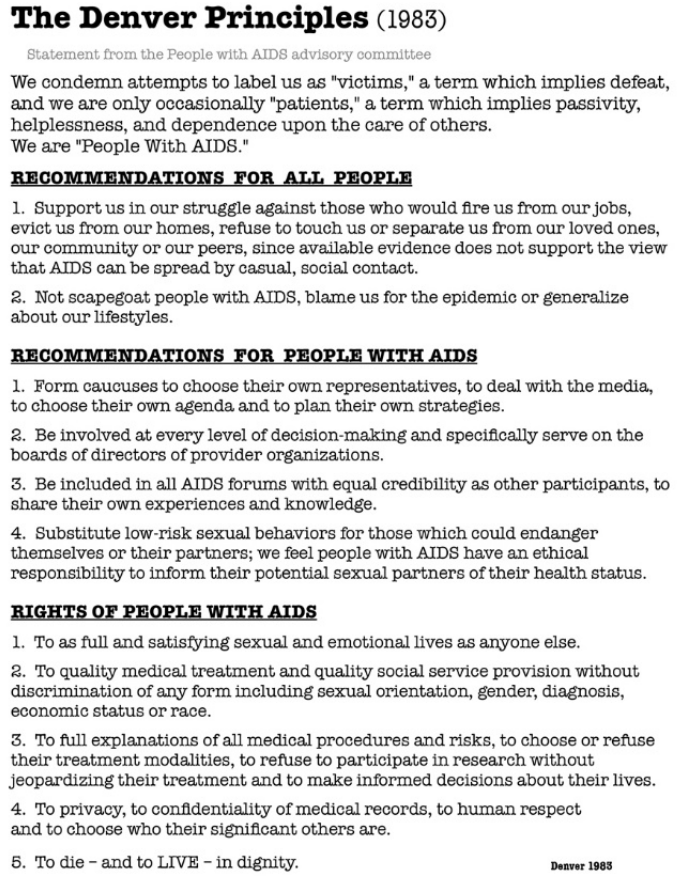
Carry On Baggage

- Do I need to think about retirement now? – Mobility
- How do we process what we have been through? – Mentation (Mind)
- I still feel like crap, WTF? – Medication
- After everything else, now there's COVID! – Multi-Complexity
- Destination change. – Modifiable
- Quality of life. – Matters Most

- The Denver Principles apply now more than ever. – Learn about them.

What Time is It?

- It's time to recall.
  - **The HIV/AIDS timeline** - HIV.gov
  - **The Denver Principles**
- It's time to act.
  - **Hire the Experts in the Field -** PLWHA 50+ Peer Advocates and Case Managers
- It's time to change.
  - **Existing** Ryan White Service Categories
  - **Additional** Ryan White Service Categories
  - **Standards of Care (SOC)** for Ryan White Service Categories
  - **Measures** for the SOC of Ryan White Service Categories
  - **Guidance** from HRSA regarding older adults living with HIV/AIDS
  - **Align Data** with other RW Parts and entities (CDC)
    - Using 5 year increments beginning with Age 50
  - **Barriers to Care** need to be lessened or eliminated
    - Especially for Psychosocial Services, needed now more than ever
  - **COVID-19** enhances the need for the Ryan White Care Act
    - **Support Services are increasingly becoming Core Services**



The Denver Principles (1983)

Statement from the People with AIDS advisory committee

We condemn attempts to label us as "victims," a term which implies defeat, and we are only occasionally "patients," a term which implies passivity, helplessness, and dependence upon the care of others.
We are "People With AIDS."

RECOMMENDATIONS FOR ALL PEOPLE

1. Support us in our struggle against those who would fire us from our jobs, evict us from our homes, refuse to touch us or separate us from our loved ones, our community or our peers, since available evidence does not support the view that AIDS can be spread by casual, social contact.

2. Not scapegoat people with AIDS, blame us for the epidemic or generalize about our lifestyles.

RECOMMENDATIONS FOR PEOPLE WITH AIDS

1. Form caucuses to choose their own representatives, to deal with the media, to choose their own agenda and to plan their own strategies.

2. Be involved at every level of decision-making and specifically serve on the boards of directors of provider organizations.

3. Be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge.

4. Substitute low-risk sexual behaviors for those which could endanger themselves or their partners; we feel people with AIDS have an ethical responsibility to inform their potential sexual partners of their health status.

RIGHTS OF PEOPLE WITH AIDS

1. To as full and satisfying sexual and emotional lives as anyone else.

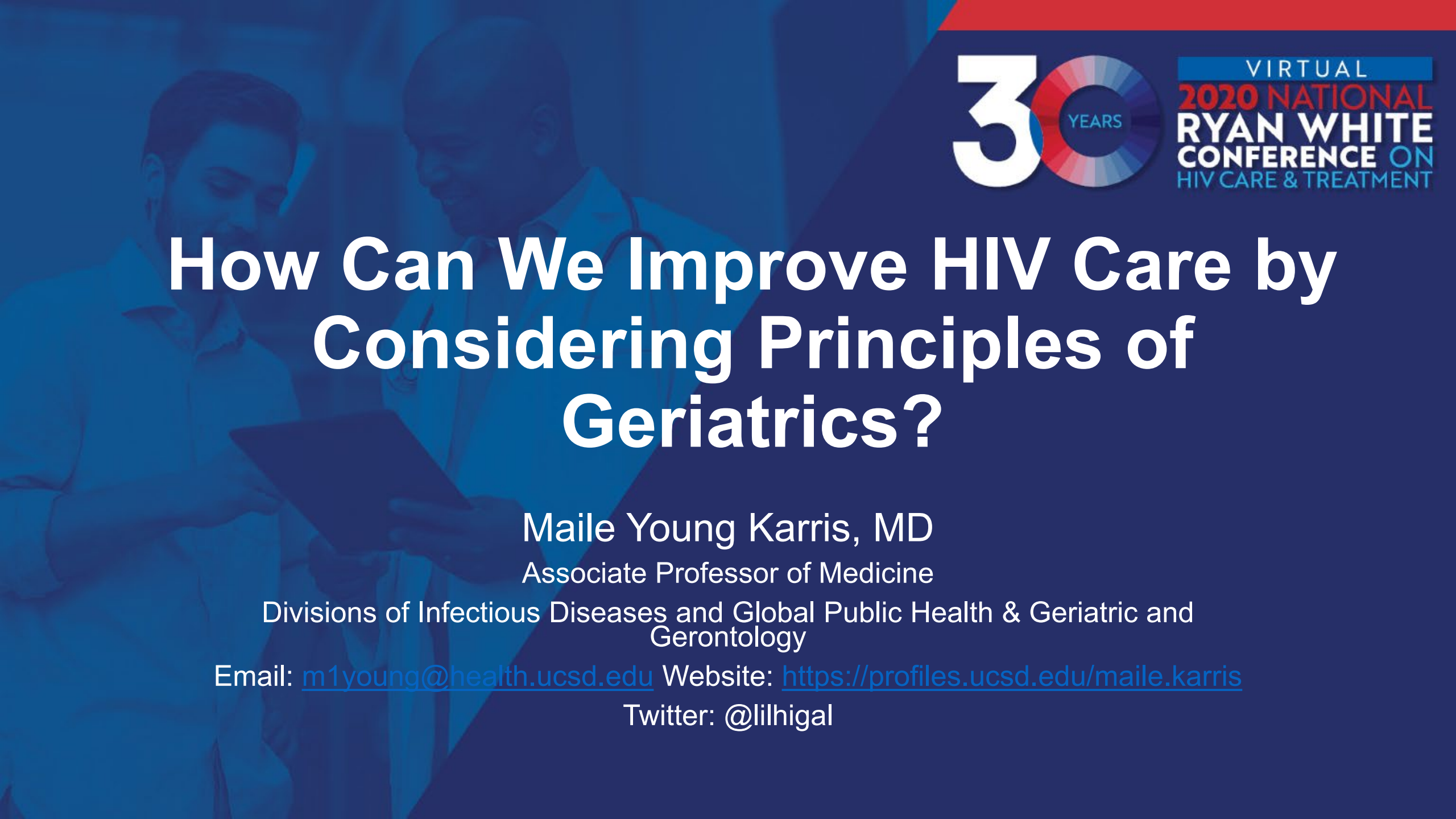
2. To quality medical treatment and quality social service provision without discrimination of any form including sexual orientation, gender, diagnosis, economic status or race.

3. To full explanations of all medical procedures and risks, to choose or refuse their treatment modalities, to refuse to participate in research without jeopardizing their treatment and to make informed decisions about their lives.

4. To privacy, to confidentiality of medical records, to human respect and to choose who their significant others are.

5. To die – and to LIVE – in dignity.

Denver 1983



How Can We Improve HIV Care by Considering Principles of Geriatrics?

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HIV and Geriatric Medicine

HIV Medicine

- HIV and other co-morbidities
- Medication review (ART)
- Problem list
- Mental Health
- Social circumstances
- Environment
- Multidisciplinary

ART adherence, barriers to care

Geriatric Medicine

- Co-morbidities in context of severity
- Medication review (age-appropriate)
- Problem list
- Nutrition
- Mental Health, cognition
- Function
- Social circumstances
- Environment
- Multidisciplinary

Safety
Independence

Welsh, Gordon and Gladman Int J Clin Pract 2014, Singh et al CID 2017

Embracing Geriatric Concepts (The Ms)

- Matters Most
- Mind
- Mobility
- Medications

4M

- Multi-complexity/Multi-morbidity

5M

- Modifiable

6M

Tinetti, Huang and Molnar JAGS 2017, Erlandson and Karris Infectious disease clinics of North America, 2019

Matters Most

- Understand personal health goals and care preferences
- Align care according to those preferences
- NOT just end of life care
  - Multi-morbidity management prioritization
  - Risk/benefit discussions

Mind = Cognitive Function

- Identify and manage dementia
  - Inquire about safety
- Optimize cognition
  - Diagnose and treat mood disorders
  - Explore mediators/moderators: social prescriptions, support groups, substance use
  - Maintain mental activity

Mobility = Physical Function

- Maintain ability to walk
  - Exercise prescriptions
- Preventing falls
  - Home safety evaluations
  - Balance training
  - Polypharmacy

https://go4life.nia.nih.gov/walking-clubs/walking-club-benefits/

Medications

- Aging changes pharmacokinetics and pharmacodynamics
  - Increased harm to benefit ratio
- Only prescribe necessary medications (Beer's Criteria)
  - Avoid medications that may alter mind or mobility
- **De-prescribe**
- Identify and stop prescription cascades

Multi-complexity

- Manage a variety of health conditions
  - Highest priority screening and treatment
  - Consistent with Matters Most
- Within the context of social and living conditions
  - Safety
  - Social isolation
  - Access to transportation

Magnified during COVID-19

Modifiable

- 50 is still young--- lets focus on prevention
- Prioritize factors that impact multiple systems
  - Physical activity
  - Nutrition
  - Substance use
  - Connection
  - Stress

Implementing into Practice

- Medicare annual wellness exam
- Return to every 3 month visit with specific aging focus
- Systematically introduce aspects of 6Ms or the comprehensive geriatric assessment (i.e. functional assessment, advanced care planning)
- Encourage and support ancillary staff to pursue training (social worker training in geriatrics)
- Consider incorporating Geriatricians into HIV clinic

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How Can we Incorporate the Geriatricians?

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What HIV/Aging Clinical Programs Currently Exist?

International Brighton	Vera	Geriatrician in HIV clinic, team meets/reviews monthly
Montreal	Falutz	Geriatrician in HIV clinic, CGA for 60+, referrals as needed
Chelsea	Boffito	Separate multidisciplinary clinic, pharmacist, NP, trainee (50+)
Madrid	Brañas	In HIV clinic, 50+, CGA on all, geriatrician does yearly follow-up, more often if needed
San Fran	Greene	Geriatrician in HIV clinic, pharmacist, additional services
NYC	Siegler	Geriatrician in HIV clinic, geriatrician follow longitudinally, additional services
Grant Recipients Chicago*	CORE Center	60+, activities developed/endorsed by clients, ”Aging Ambassadors”
Baltimore*	Schmalzle	Gerontology input for screenings, medication review, cognitive function
DC*	MedStar	Care coordination, navigation services, peer support, education
NYC*	Sharma	Attempting to adapt a CGA to older PWH within an HIV clinic
San Diego*	Ramers/Rojas	Home-base care for older adults with HIV (building on their mobile program)– barriers
Boston	Fitch/Triant	Not able to keep program running
Penn	Krain	ID/geriatrics trained clinician interested but logistically not possible
Baltimore VA	Oursler	VA-based, multi-disciplinary geriatric evaluation clinic; clinical lead moved institutions

Siegler 2018 J Int AIDS Soc; *Gilead HIV Age Positively Grantees

CGA= comprehensive geriatric assessment

Positive Aging in Colorado

- Simple approach of ensuring access to a geriatrician
  - Referred to Senior's Clinic (same building, different floor)
  - Unable to embed a geriatrician in the ID clinic due to billing
  - Advertisements in clinic and pharmacy, recruitment emails to all providers, pharmacists and students reached out to ~ 200 patients that were 50+ to let them know about the program.
- Few referrals and many 'no-shows'
  - Only 11 patients completed at least 1 seniors clinic visit over 18 months

Positive Aging in Colorado

Geriatric Conditions	N= 11
Fallen in the prior year	6
Vision loss	10
Hearing loss	6
Urinary incontinence	6
Cognitive impairment	2

- Mean number of medications = 17.7 (range 10-33)
  - At least 4 had high-risk medications
  - Recommended stopping higher risk medications with limited success

- *Topics commonly addressed*: screenings (osteoporosis, cognition, falls, hearing), advanced directives, driving safety
- If recommendations were not completed:
  - Patient felt overwhelmed, didn't want to see multiple providers, never scheduled follow-up assessments (DXA), or didn't want to stop the high-risk medications

What Worked or Went Well?

- Providers with complicated older patients appreciated the input
- Geriatrician very willing and interested in seeing patients with HIV
- Identified new medical issues, able to remedy some
- Additional screenings addressed
- Some very complicated patients continued care in the geriatric clinic
- Many patients completed or at least began to address advanced directives
- Simple, no additional funding or grant support needed

What Were Our Barriers To Success?

- Very little uptake from providers and patients
  - May not have appreciate added benefit of geriatric perspective
  - Patients didn’t see themselves as ‘old’
- Unable to have geriatrician in the HIV clinic
  - Providers forgot (or didn’t see the added benefit)
  - No direct, face-to-face communication
  - Patients didn’t want to schedule in or go to a new clinic
- No additional support
  - Coordination of care is as important as the initial geriatrics input
  - Lack the added benefit of team input

Mass General Hospital

- 2 physicians and nurse practitioner (NP)
- NP *volunteered* time twice/month to complete 1 hour visit for comorbidity risk assessment & recommendations for mental health, cognition, falls, nutrition/exercise, eye/dental
- Pros:
  - Patients appreciated the duration of visits and education provided
  - Providers appreciated screening & addressing other issues
  - Interest from geriatrics to incorporate a geriatrician
- Cons:
  - Burden of appointments may have contributed to high rate of no-shows
  - Provider engagement/referrals challenging
  - Financial support not yet available
  - Currently on hold

Source: Katie Fitch, NP

UPenn Medicine

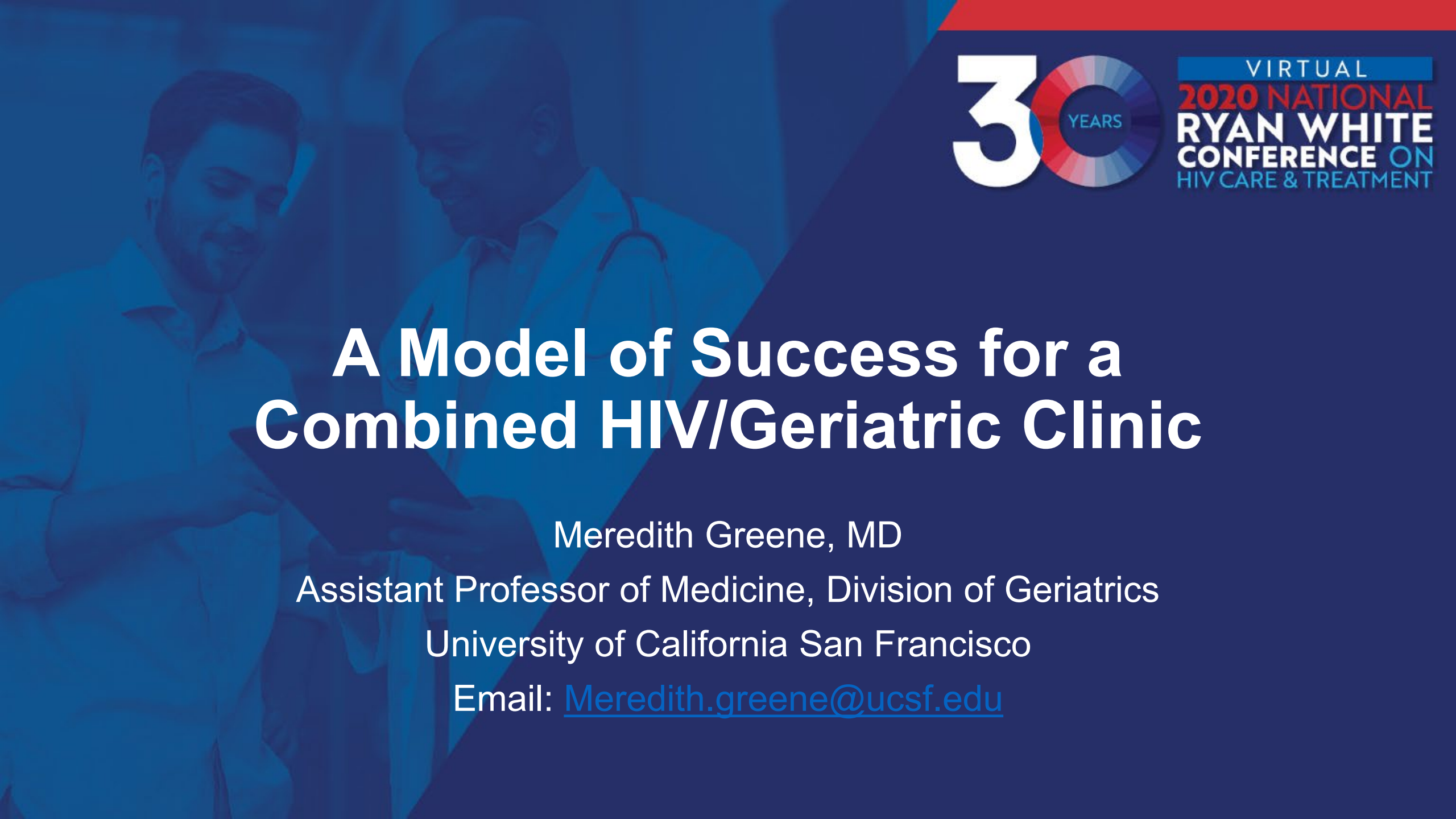
- Double-boarded ID/Geriatrics trained physician eager (but unable) to establish an HIV/geriatric clinic
- Barriers:
  - Geographically spread out hospital system, patients don't want to travel
  - Financial & personnel support: ID can't bill for geriatric visits, can't see non-Medicare patients in geriatrics clinic
  - Ownership issues: who coordinates referrals, do complicated patients transition to geriatrician for primary care with HIV referral
  - Many "younger" HIV patients don't want to go to a geriatric clinic
  - Need for grant support to start and keep a clinic running

Source: Alysa Krain, MD

THRIVE Clinic (Baltimore)

- Grant-funded program to bring gerontology focus into HIV clinic
- Multi-disciplinary team (ID, gerontology graduate students, NP, pharmacist, social workers)
- Solicited provider and patient feedback first
- Patients self-refer, receive $25 grocery gift card for completing
- MD/NP do chart review for screenings, pharmacist does med review, grad students complete mental and cognitive screening + questionnaires: summary is provided to PCP to follow-up on recommendations
- Positive feedback from patients; providers appreciate the time & information
- Recruiting, billing, community resources, and sustainability after grant support are concerns

Source: Dr. Sarah Schmalzle



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A Model of Success for a Combined HIV/Geriatric Clinic

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Development of HIV-Geriatric Program

- 1)Literature review
- 2) Demonstration/pilot program (Silver Project)
- 3) Surveys and focus groups with patients and providers -- - stakeholder engagement

Themes from Focus Groups

- Four overarching themes:
  1) Knowledge of HIV and aging topics
  2) Health/aging needs for Older HIV+ adults
  3) Importance of Social Networks
  4) Need for integrated services
     -consultative services
- Program name: theme of navigation healthcare systems; “golden years” acceptable term for aging

Greene M, PLOS One 2018

Golden Compass Program

Helping PLWH Navigate their Golden Years

NORTHERN POINT:
Heart and Mind
Components: Cardiology clinic on-site, brain health and memory classes, cognitive assessment testing

WESTERN POINT:
Dental, Hearing and Vision
Components: Medical assistant navigation to these three services

EASTERN POINT:
Bones and Strength
Components: Frailty and fall assessments, chair exercise classes, DEXA machine on-site (coming)

SOUTHERN POINT:
Network and Navigation
Components: Social support groups, link with community programs, peer navigators and helpers

One story

- 62 y/o Latino male, long term survivor
  - Geriatrics clinic: dizzy; bp/prostate meds adjusted & dizziness resolved
  - Grieving loss family member; isolated : connected to volunteer who still meets with him weekly
  - Highly engaged in all classes

GOLDEN COMPASS PROGRAM Ward 86

Reflecting on improvements in both physical and mental health: *"I'm in a good place compared to how I was before I started in the program."*

Initial Evaluation (2017-2018)

- RE-AIM framework
  - Reach: 200 older adults
    - Providers noted difficulty getting patients to see "aging specialist"
  - Effectiveness: >90% patients and providers satisfied with services;
    Medications, mobility, cognition were valued
  - Adoption: 85% providers referred ≥ 1 patient to geriatrics clinic
  - Implementation: largely as intended; co-location services important

Lessons Learned

- Framing still a challenge– addressing ageism
- Role of consultant geriatrician- Co-management, consults only
  -coordination of care
- Should (or can) everyone over 50 with HIV be seen?

Lessons Learned

- Outcome evaluation –especially for consultative models
- Funding mechanisms; finding sustainable, long term funding
  - Ryan White funds can be used to support subspecialists and staffing (and services)

Teaching the "Ms"

- HRSA Bureau of Health Workforce: Geriatric Workforce Enhancement Program (GWEP)
  - 48 programs across the US
- Northern California: Optimizing Aging Collaborative
  - Teaching "4Ms" to include HIV clinic staff and community partners

Age-Friendly Health Systems
Committed to Care Excellence for Older Adults

The **Optimizing Aging Collaborative at UCSF** is empowering San Francisco to meet the needs facing older adults.

Conclusions

- Older adults have unique needs that are not being met by the classic HIV paradigm
- COVID-19 stress on our medical system highlights vulnerable essential needs (and creative solutions, such as telehealth)
- Support services are increasingly becoming core services
- 6 M's provide a way of incorporating geriatric issues within the HIV paradigm
- Consider innovative ways that we can engage Geriatric consultations, structure care and enhance partnerships with *sustainable funding solutions*