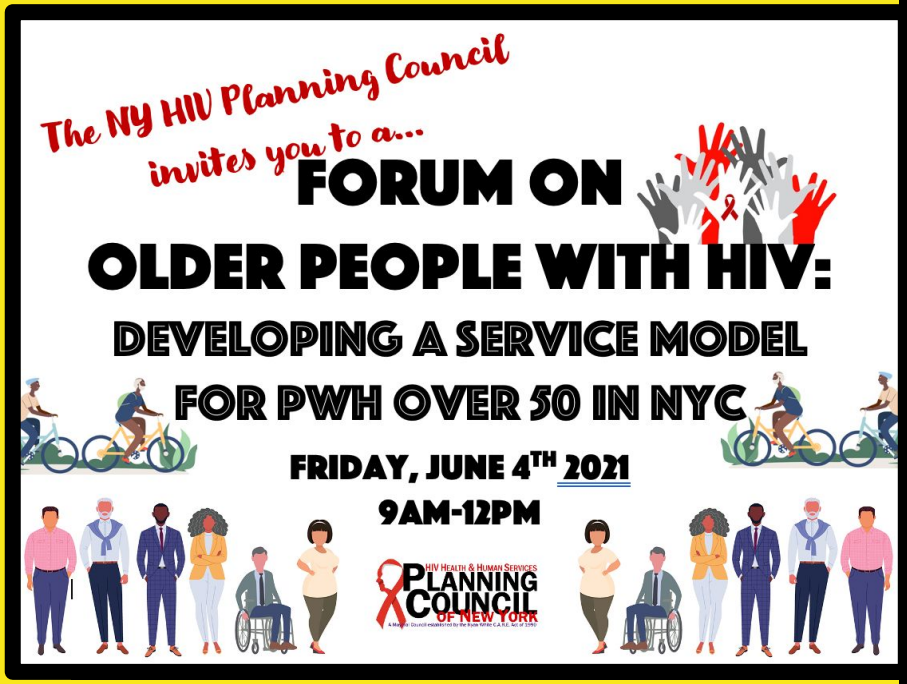


Welcome!

Click button for meeting reactions, nonverbal feedback, and Raise Hand

Reactions

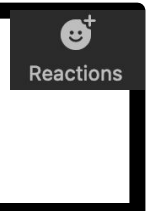
On phone:

*6 - Toggle mute/unmute

*9 - Raise hand

Agenda

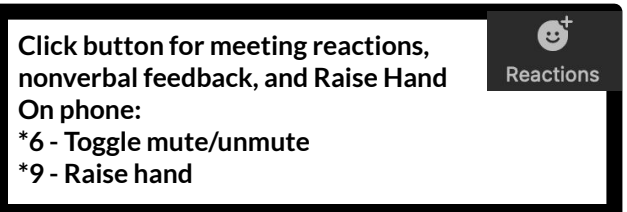
9:00a	Welcome
9:05a	Agenda & Housekeeping
9:10a	Moment of Silence
9:12a	Recognition of Long Term Survivors
9:15a	Panel
10:15a	Project PROSPER
10:40a	Service Model for Older People with HIV
11:00a	Breakout Rooms
11:30a	Reconvene & Review
11:50a	Next Steps



Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand

Housekeeping

Technical questions?
Direct message @Melanie
for help in the chat



1. Please keep yourself on mute! (*6 on the phone)
2. Click the happy face to access the raise hand emoticon (*9 on the phone)
3. Use chat or Swiftpolling.com #28111 to ask questions (Q&A) or give input
4. Please complete the anonymous polls throughout the forum. You can text answers to (202) 933-9005 or go to Swiftpolling.com #28111

POLL: Who is in the room?

Tell us about yourself!

Use your phone to scan the QR code

or

Text your vote to

(202) 933-9005

or

join at

Swiftpolling.com #28111

https://poll.excitem.com/s/presentation/poll?id=91467

Moment of Silence

Lisa Best, Co-chair of the Consumers Committee

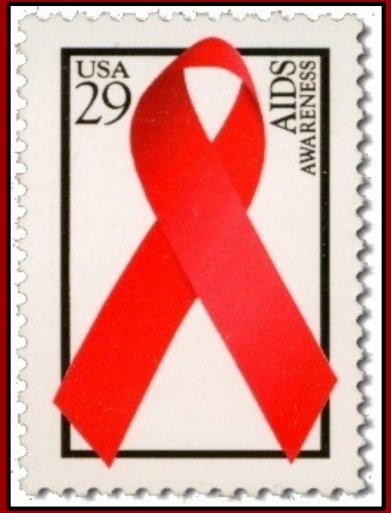
Recognition of Long-Term Survivors

David Martin, Consumer at Large

https://visualaids.org/

JUNE 5 HIV LONG-TERM SURVIVORS AWARENESS DAY

HLTSAD.ORG



JUNE 5 HIV LONG-TERM SURVIVORS AWARENESS DAY

HLTSAD.ORG

https://visualaids.org/

POLL:
LTS: Tell us
(briefly - 24 characters)
what getting older,
as a person with HIV,
means to you/your community.

(can enter multiple answers)

Use your phone to scan the

QR code

or

Text your vote to

(202) 933-9005

or

join at

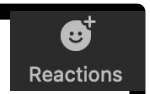
Swiftpolling.com #28111

https://poll.excitem.com/s/presentation/poll?id=91468

Panel

Timekeeper: Melanie

Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand



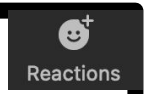
Featuring:

Jules Levin
Moisés Agosto-Rosario
Eugenia Siegler, MD
Anjali Sharma, MD

NATAP Presentation

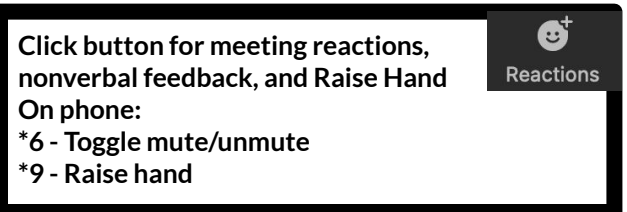
Jules Levin, Executive Director, NATAP

Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand



Care - Services - Research

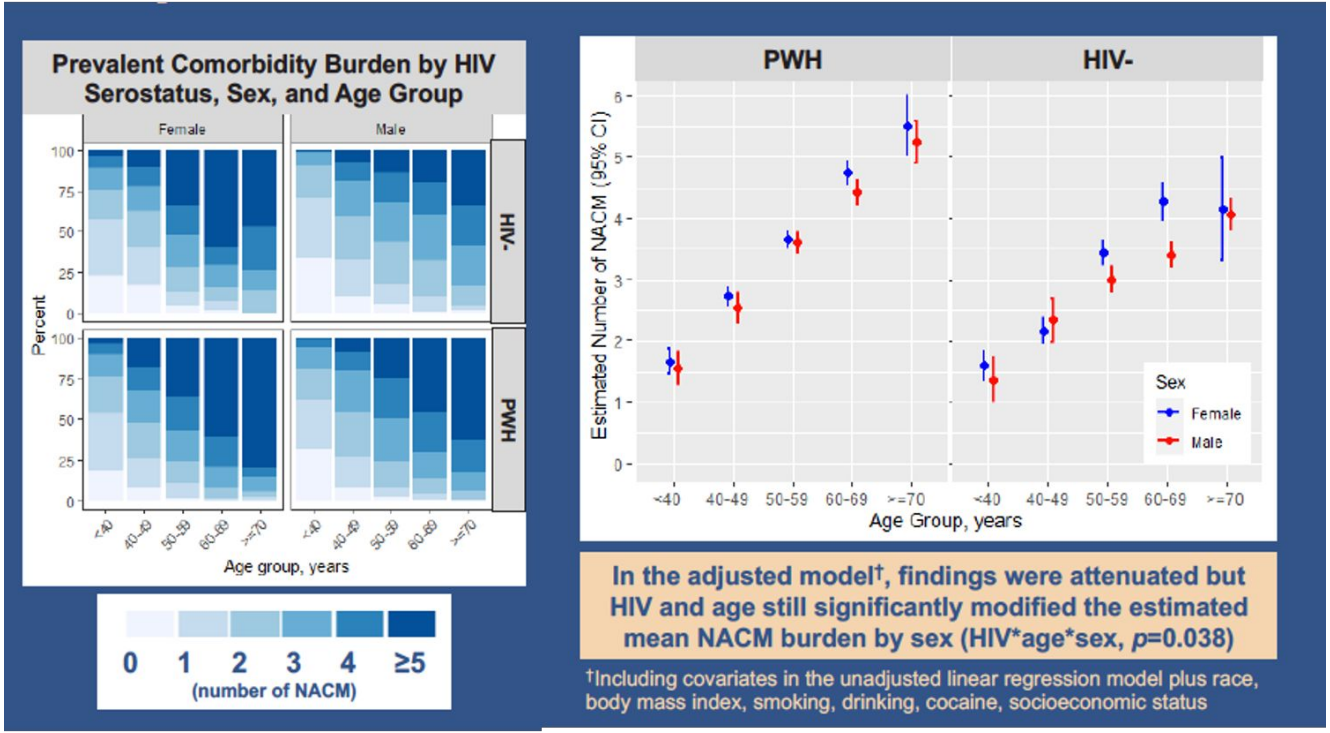
- **Home Care ?? Nursing facilities??**
- **”Aging Nurse Coordinator”** - Extended flexible doctor visits, **better coordinated communication** between PCP & specialist & PLWH: zoom visits with PLWH & PCP & specialist.
- **CONVENIENCE & EASE-** colocation of care/services, **convenient** referrals system
- Special attention to issues for **women**
- **Opioid prescription use & substance abuse**
- **EDUCATION for PCP/Doctor: stigma, ageism, sensitivity…and CBOs:** better have top specialists. Training for specialists, HIV PCP - Committee of Experts: Hsue, Brown, kidney etc. – stigma, sensitivity trainings for PCP ageism, racial, gender



Care - Services - Research (cont)

- Comprehensive **mental/Physical, CNS evaluation, frailty**: easy mental health access, aging stigma - **motor function, memory**
- **Physical Therapy, food education, convenient & sustainable exercise program**
- **1st Priority – the oldest & Most Impaired:**
  - **Most in need: >65 with physical & mental impairments limiting their ability to perform normal daily functioning like shopping/food prep., medical visits etc.**
- **NYC-wide Database of aging, comorbidities**
- **Standard of Care – Bone Dexa – Guidelines – Fatty Liver, NAFLD**

Multimorbidity Burden Related to HIV Status is Greater in Women than in Men – MACS/WIHS



NATAP NATIONAL AIDS TREATMENT ADVOCACY PROJECT

EDUCATING COMMUNITIES ABOUT HIV AND HEPATITIS

Webinar

Amazon Gift Card Raffle Prizes!

Women and HIV

JOIN US!! Topics will Include:

- HIV & Comorbidities Among Women
- HIV & Menopause
- Aging Considerations
- Health Disparities
- COVID-19 Pandemic
- ART Updates from Prevention to Treatment
- The Future is Bright

Contact Hours available to: Nurses, CASAC, CAADE, Addiction Professionals, and Social Workers! **Must log-in and view entire lecture to receive hrs.**

This nursing continuing professional development activity was approved by the North Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Hours are approved for 2.0 hrs.

Friday, June 25th, 2021

Log-in time: 12:30pm EST / Presentation ends at: 2:30pm EST

Webinar will consist of a 60min lecture followed by a 45min interactive Q & A/discussion

Speaker: Lauren Collins, M.D., M.Sc.

Assistant Professor of Medicine, Division of Infectious Diseases, Emory University School of Medicine & the Infectious Diseases Program, Grady Memorial Hospital

Click to Register for Women and HIV

Link to Register:

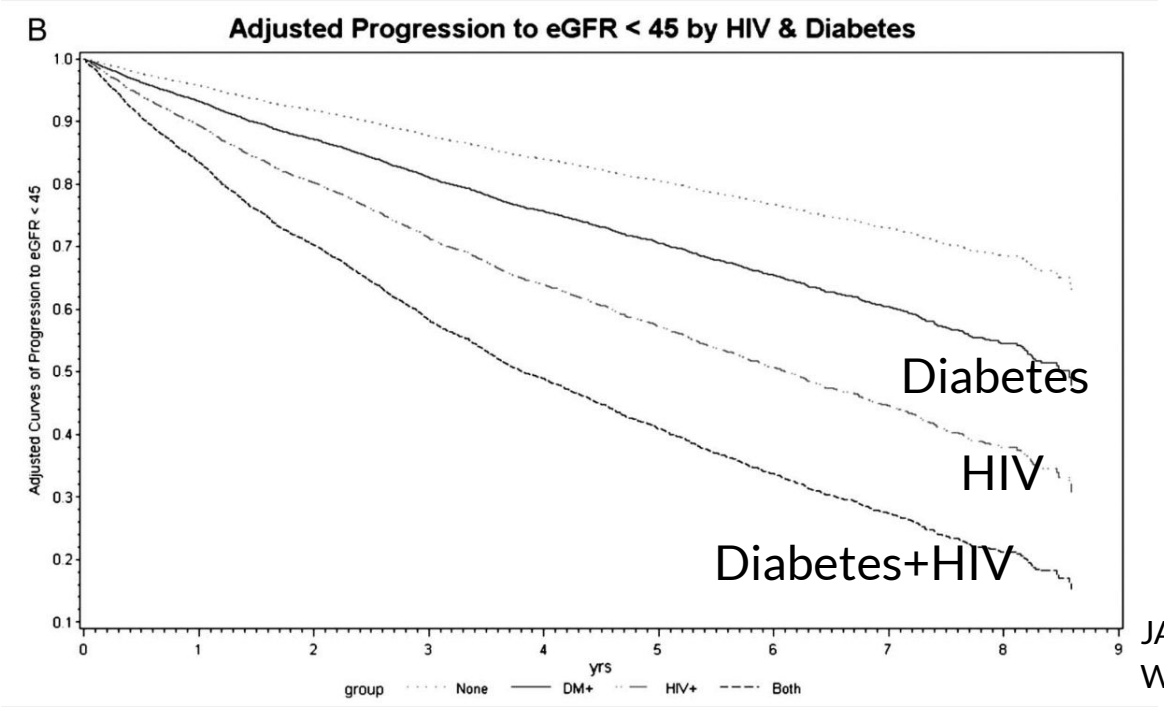
https://event.webcasts.com/starthere.jsp?ei=1421587&tp_key=c4e36d5af1

Kidney Disease in HIV

- As in the general population, **diabetes** [hazard ratio 1.7), and **hypertension** (hazard ratio 1.9) are **associated with increased ESRD** risk in **HIV-infected** adults.
- 31072 adults in the Veterans Aging Cohort Study(VACS) demonstrated com-pared with veterans without HIV or diabetes:
  - Relative rate of progression to eGFR less than 45ml/min/1.73m2 was increased in those **with HIV only** (hazard ratio **2.8**, 95% CI 2.5–3.15)
  - **Diabetes only** (hazard ratio **2.5**, 95% CI 2.2–2.8
  - **Concomitant HIV and diabetes** (hazard ratio **4.5**, 95% CI 3.9–5.2)[25&]
  - The conclusion that **HIV and diabetes may have an additive effect on CKD** risk is consistent with data from a mouse model of diabetic kidney disease, which demonstrates a more aggressive phenotypein mice expressing an HIV-1 transgene

4 times Greater Progression to CKD

Over a median follow-up of 5 years (interquartile range: 3–7 years), 7% of subjects progressed to eGFR <45 mL/min/1.73m^2, ranging from **<4% in those without HIV or DM** to **18% in those with both HIV and DM** (Table 1)



JAIDS 2012; Medapall, Wyatt.

Demographic and clinical patients characteristics

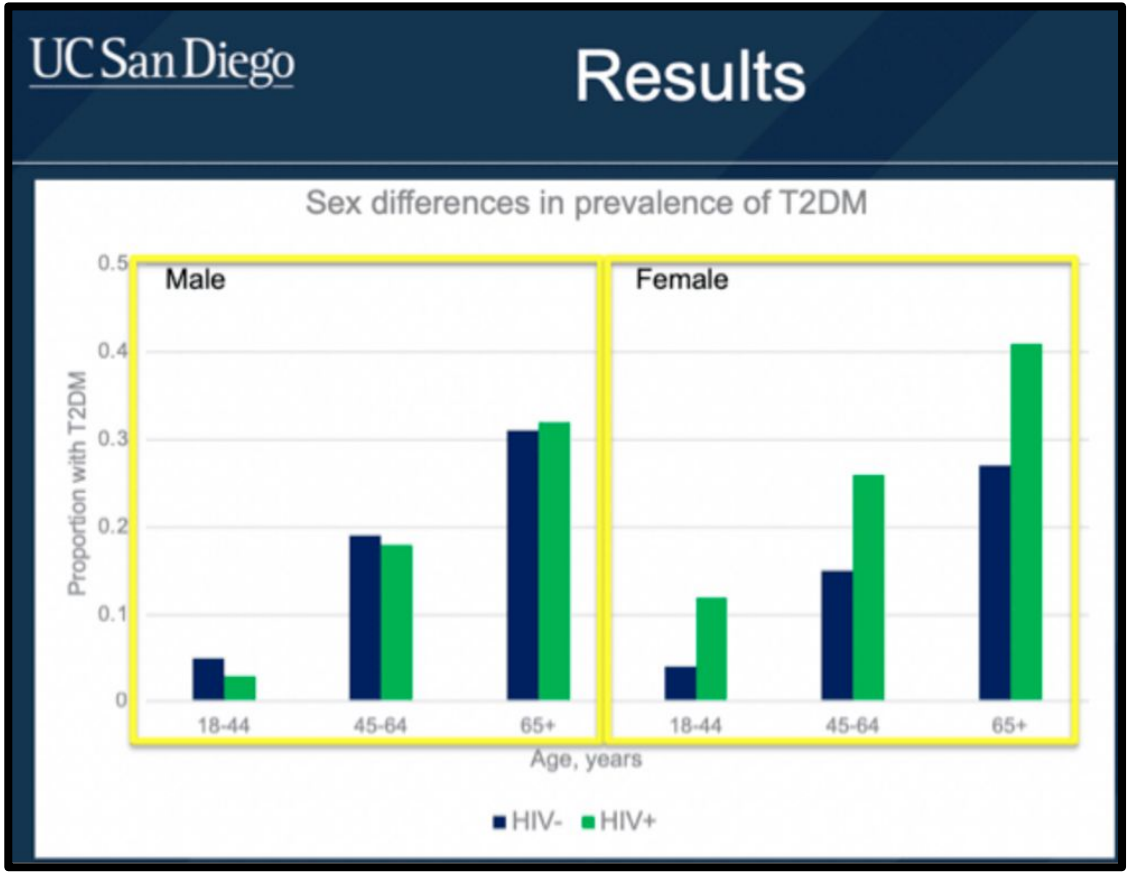
Variable	Total (n=492) Mean (SD)[n]	HIV- (n=200) Mean (SD)[n]	[<10 yy] (n=65) Mean (SD)[n]	[10-20yy] (n=144) Mean (SD)[n]	[>20yy] (n=83) Mean (SD)[n]	P-Value
Sex (F)	23.37% [115]	27.5% [55]	18.46% [12]	20.83% [30]	21.69% [18]	
Age	78.05 (2.82)[492]	78.34 (2.91)[200]	77.77 (2.26)[65]	77.96 (3.11)[144]	77.76 (2.41)[83]	0.241
BMI	26.37 (4.39)[408]	27.9 (4.42)[184]	26.09 (4.24)[50]	24.82 (3.86)[109]	24.92 (3.86)[65]	<0.001
Current smoker	12.53% [53]	8.89% [16]	13.21% [7]	16.24% [19]	15.07% [11]	0.251
Hypertension	291 (69.12%)	128 (64.97%)	38 (69.09%)	83 (76.85%)	40 (68.97%)	0.202
Type 2 Diabetes Mellitus	117 (28.4%)	49 (25%)	11 (20.37%)	33 (32.35%)	21 (36.84%)	0.132
Cardiovascular Disease	131 (32.59%)	72 (36.73%)	15 (29.41%)	26 (26.8%)	17 (30.36%)	0.337
Chronic Kidney Disease	71 (22.33%)	7 (7.29%)	13 (22.81%)	32 (30.48%)	19 (33.33%)	<0.001
Chronic Obstructive Pulmonary Disease	50 (12.56%)	31 (15.98%)	4 (8%)	7 (7.22%)	7 (12.73%)	0.133
Dislypedemia	203 (64.86%)	45 (46.88%)	27 (50%)	87 (82.86%)	43 (76.79%)	<0.001
Multimorbidity	208 (71.23%)	62 (65.26%)	28 (58.33%)	73 (77.66%)	43 (81.13%)	0.019
Polypharmacy	145 (39.19%)	70 (35%)	20 (51.28%)	30 (35.29%)	25 (55.56%)	0.024

Guaraldi. 2016
Comorbidities Workshop

Sex Differences in Prevalence of T2DM

Multi-health system electronic medical record database: 64 million persons

Among women over 65: 40% have diabetes in this study vs. 27% for women without HIV



Risk Factors for Kidney Disease: Diabetes & HIV

- Black race is a strong risk factor for CKD progression in HIV-infected individuals, resulting in a higher burden of advanced CKD and ESRD among HIV-infected blacks.
- Similar to the general population, aging of the HIV-positive population will result in an increase in the incidence of CKD. May be independent of race as shown in this mostly white European cohort & mostly Black US cohort.
- **Diabetes**, Cd4, viral load, baseline eGFR, **HCV, IDU**, cigarette smoking, **increasing age**, **hypertension**, heart disease, alcohol abuse. - Proteinuria ???

Risk Factors for Kidney Disease: Diabetes & HIV (cont)

Table 1. Increased incidence of chronic kidney disease in older adults with HIV: data from the USA and Europe

Reference	Country	Data source	*n*	Male	Black race	Age strata	Adjusted incidence rate ratio (95% CI)
Morlat *et al.* [29]	France	ANRS CO3 Aquitaine Cohort	4350	74%	<10%	<45 years	1 (referent)
						45–60 years	1.7 (1.2–2.6)
						>60 years	2.6 (1.6–4.1)
Lucas *et al.* [27]	United States	Johns Hopkins HIV Clinical Cohort	4259	68%	78%	<45 years	1 (referent)
						45–55 years	1.45 (1.01–2.09)
						>55 years	3.47 (2.07–5.81)

Both studies defined chronic kidney disease according to the current practice guidelines, as an estimated glomerular filtration rate (eGFR) less than 60 ml/min/1.73 m^2, confirmed on two measurements at least 3 months apart. The Modification of Diet in Renal Disease (MDRD) equation was used to estimate GFR.
CI, confidence interval.

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Safety	Early Childhood Education		Community Engagement	Provide Linguistic and Cultural Competency
Debt	Parks	Vocational Training		Discrimination	
Medical Bills	Playgrounds	Higher Education		Stress	Quality of Care
Support	Walkability				
	Zip Code/ Geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

Let's Get Screened

Condition	Tests	Frequency
Diabetes	Fasting Glucose Hgb A1C	Yearly
High Cholesterol	Lipid Panel	Yearly
High Blood Pressure	BP Measurement	At least yearly
Kidney Disease	Serum Creatinine Urine protein test	Every 6-12 months
Osteoporosis	DXA Scan	Age 50+

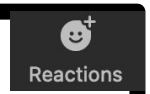
Let's Get Screened (cont)

Condition	Tests	Frequency
Ana/Cervical Cancer	Pap test	Yearly
Lung Cancer	CT (if smoker)	debated
Liver Cancer	Ultrasound (if HBV or HCV+)	Yearly
Breast Cancer	Mammogram	Yearly
Colon Cancer	Colonoscopy	Every 5 years
Prostate Cancer	PSA	Debated

Panel

Timekeeper: Melanie

Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand



Featuring:

Jules Levin

Moisés Agosto-Rosario

Eugenia Siegler, MD

Anjali Sharma, MD

Ending the HIV Epidemic Update: Project PROSPER (HRSA-20-078) Funding Allocated to Serve Black and/or Hispanic/Latino Older People with HIV

Erica D'Aquila
NYC Department of Health and Mental Hygiene
June 4, 2021

Project PROSPER's Building Equity: Intervening Together for Health Program (BE InTo Health)

BE InTo Health

Goal

Increase engagement and re-engagement in care and decrease racial/ethnic inequities in HIV outcomes among priority populations.

EHE Priority Populations

1. Black and/or Hispanic/Latina (H/L) women with HIV, including Black and/or H/L cisgender, transgender, non-binary and/or genderqueer women
2. Black and/or H/L transgender women with HIV, and those who identify as non-binary or genderqueer
3. Black and/or Hispanic/Latino (H/L) younger PWH (ages 13-29)
4. Black and/or H/L older PWH (ages 50 and older)
5. Black and/or H/L MSM with HIV, including Black and/or H/L cisgender, transgender, non-binary, and/or genderqueer MSM

Intervention

Five clinic and evidence-based interventions to respond to the specific needs of each priority population.

NYC Health

BHO Logic Model

Inputs	Activities	Outcomes
BE InTo Health Funding - Project Staff - Project Materials DOHMH Technical Assistance	**Project Start-up** - Hire Staff - Complete DOHMH-identified Trainings **Project Outreach and Recruitment** **Project Implementation** - Clients linked to HIV medical care - Clients provided immediate antiretroviral treatment - Clients provided annual STI and hepatitis C screening and treatment - Clients enrolled in project - Bi-annual screening and creation of care plans (e.g., MOCA, PHQ-9, ADL, a medication review, a fall assessment) - Monthly case management and coordination (e.g., medical and non-medical referrals, on-site or virtual client follow-up) - Monthly multidisciplinary case conferencing - Monthly client-centered physical and social activities	**Project Outcomes** - Increase in % of clients newly diagnosed engaged in care - Increase in % of clients previously diagnosed engaged in care - Increase in % of clients re-engaged in care - Increase in % of clients retained in care - Increase in % of clients achieving viral load suppression - Increase screening for OPWH-specific needs - Increase in successful referrals - Decrease in rates of depressive symptoms among clients - Increase quality of life among clients - Increase in % of clients who attend regular physical activities - Increase in % of clients who are socially active - Integration of multidisciplinary care coordination intervention for Black and/or

NYC Health

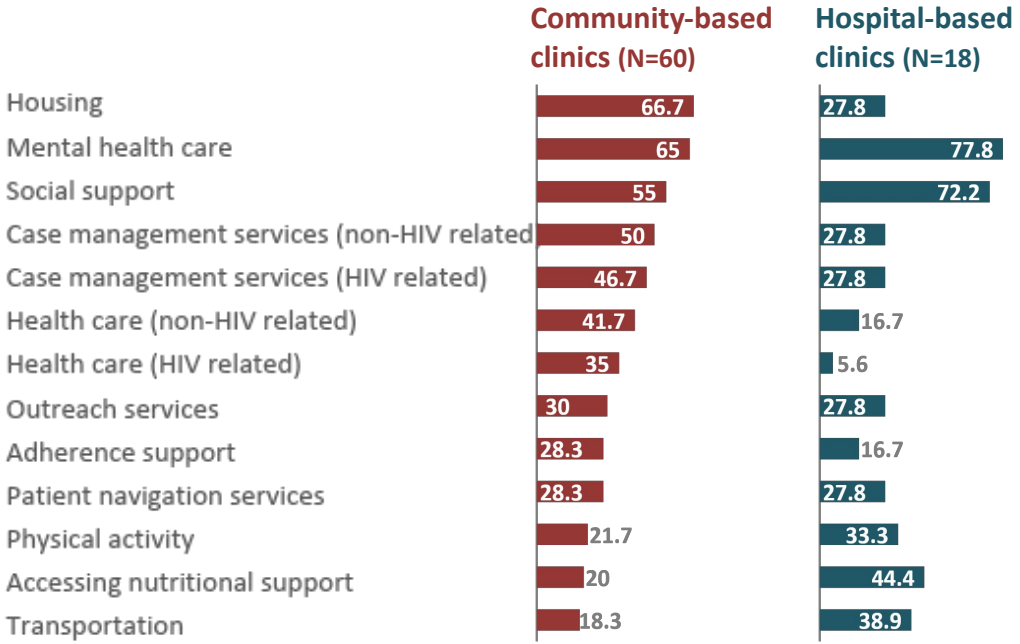
BHO Subrecipients

- To date, Project PROSPER funds two BE InTo HEALTH BHO awards, and a third award will begin this summer.

Funded Agency	Annual Funding	Projected Client Enrollment	Project Start Date
New York Presbyterian Hospital, Comprehensive Health Program	$375,000	75 clients	03/01/2021
Sunset Park Health Council, Inc., Sunset Terrace Family Health Center	$375,000	75 clients	03/01/2021
The Research Foundation for the State University of New York (SUNY), Downstate	$375,000	75 clients	08/01/2021

NYC Health

HIV Clinic Survey Responses on Unmet needs among OPWH: percent of total[1] by clinic type[2]



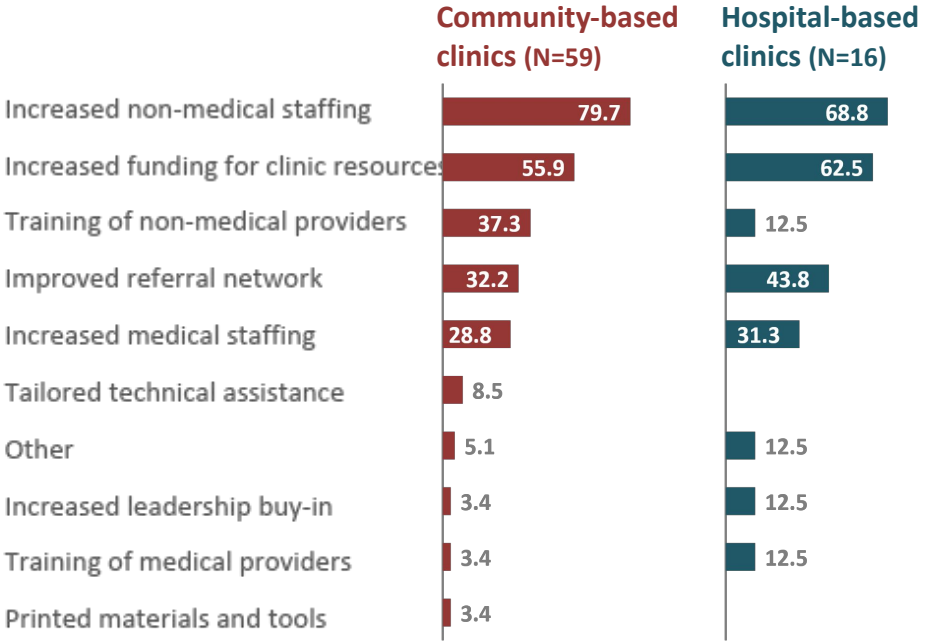
	Clinic type	
	Community-based n (%)	Hospital-based n (%)
Housing	40 (66.7)	5 (27.8)
Mental health care	39 (65.0)	14 (77.8)
Social support	33 (55.0)	13 (72.2)
Case management services (non-HIV related)	30 (50.0)	5 (27.8)
Case management services (HIV related)	28 (46.7)	5 (27.8)
Health care (non-HIV related)	25 (41.7)	3 (16.7)
Health care (HIV related)	21 (35.0)	1 (5.6)
Outreach services	18 (30.0)	5 (27.8)
Adherence support	17 (28.3)	3 (16.7)
Patient navigation services	17 (28.3)	5 (27.8)
Physical activity	13 (21.7)	6 (33.3)
Accessing nutritional support	12 (20.0)	8 (44.4)
Transportation	11 (18.3)	7 (38.9)

- Housing, mental health care, and social support were the most reported unmet needs of older people with HIV by clinics serving this population on at least weekly basis
- Differences existed in reported unmet needs among older people with HIV by clinic type (e.g., housing needs)

NYC Health

[1]Facilities that indicated that older people with HIV served at their clinic had no unmet needs (n=3) or unmet needs were unknown (n=6) are excluded from analyses; [2]Treatment facilities were excluded due to low counts

HIV Clinic Survey Responses on Resources for unmet needs among OPWH: percent of total[1] by clinic type[2]

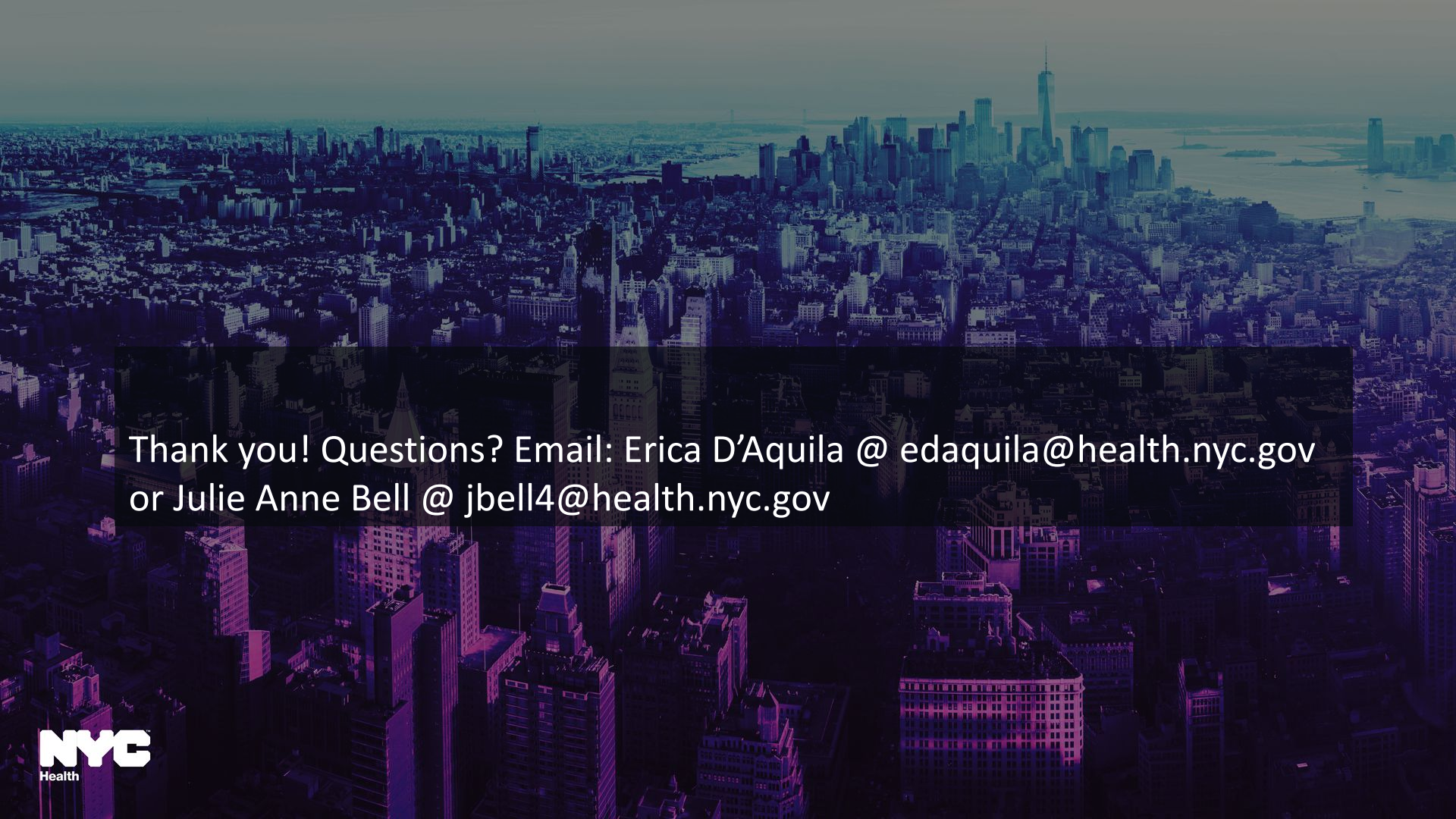


	Clinic type	
	Community-based	Hospital-based
	n (%)	n (%)
Increased non-medical staffing	47 (79.7)	11 (68.8)
Increased funding for clinic resources	33 (55.9)	10 (62.5)
Training of non-medical providers	22 (37.3)	2 (12.5)
Improved referral network	19 (32.2)	7 (43.8)
Increased medical staffing	17 (28.8)	5 (31.3)
Tailored technical assistance	5 (8.5)	0 (0.0)
Other	3 (5.1)	2 (12.5)
Increased leadership buy-in	2 (3.4)	2 (12.5)
Training of medical providers	2 (3.4)	2 (12.5)
Printed materials and tools	2 (3.4)	0 (0.0)

- Increased non-medical staffing and funding for clinic resources were the most reported resources needed to meet the unmet needs of older people with HIV by clinics serving this population on at least weekly basis

NYC Health

[1]Facilities that indicated resources needed to meet unmet needs of older people with HIV served at their clinic were unknown (n=3) are excluded from analyses; [2]Treatment facilities were excluded due to low counts


Thank you! Questions? Email: Erica D’Aquila @ edaquila@health.nyc.gov
or Julie Anne Bell @ jbell4@health.nyc.gov
NYC
Health

BE INTO HEALTH:

Centering Black and Hispanic/Latino Older People Living with HIV

Sunset Park Health Council
d.b.a. Family Health Centers at NYU Langone

Taylor Robinson & Migdalia Vientos

About Family Health Centers at NYU Langone

- FQHC network, established in 1967 (formerly known as Lutheran Family Health Centers)
- Affiliated with NYU Langone Health
- Primarily serves Sunset Park, Park Slope, and Flatbush neighborhoods of Brooklyn
- Ryan White program active since 1990, about 500 clients currently active in HIV care

Our HIV Program

- About half of clients are age 50+, a majority identify as Black and/or Hispanic/Latino
- We provide medical and nonmedical case management with RW Part C and Care Coordination Redesign (Part A) funding
- We emphasize a client-centered approach in all of our work

PRIOR TO BHO GRANT

- Consumer Advisory Board suggested additional social and educational programming
- An arts and crafts group formed (pre-Covid), which allowed clients to receive social support in an unstructured setting
- We hosted a Chronic Disease Self-Management workshop series in partnership with Jeff Natt at NYUSOM/Bellevue
- Lack of dedicated staff time and funding were challenges to ongoing implementation

BARRIERS TO CARE FOR OPWH

1. Stigma

OPWH may be uncomfortable disclosing sexual and substance use practices to providers, therefore aren't offered proper services

2. Cultural Sensitivity

Providers may make assumptions or use language that isn't culturally sensitive or relatable for OPWH

3. Representation

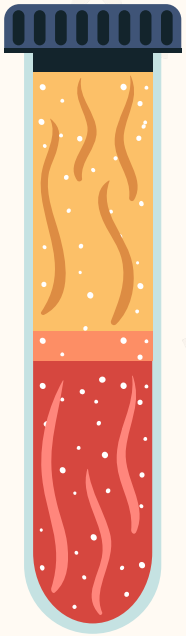
OPWH (especially cis women) did not find themselves represented in HIV-related education materials or advertisements

4. Immigration Status

OPWH who are undocumented encounter a higher prevalence of housing, food, financial, and medical care insecurities

BE InTo Health: Our Program

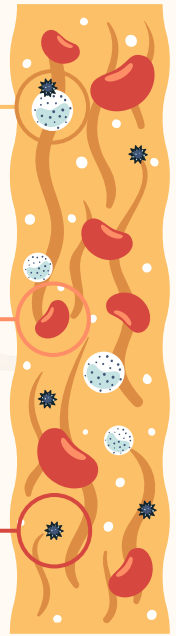
Eligibility



HIV POSITIVE

50 YEARS AND OLDER

BLACK AND/OR
HISPANIC/LATINO



PROGRAM GOALS

01 Improve linkage to HIV medical care among the OPWH.

02 Improve iART among the OPWH.

03 Improve engagement and re-engagement in HIV care among the OPWH.

04 Improve retention in HIV care among the OPWH.

05 Improve viral load suppression (VLS) among the OPWH.

06 Strengthen the capacity of HIV clinics to provide tailored services to OPWH.

BHO PROGRAM OFFERINGS

Wellness Screenings

- Cognitive Assessment (MoCA)
- Depression Screening (PHQ-9)
- Substance Misuse Screening (SBIRT)
- Fall Assessment
- Medication Review

Wellness Programming

- Health Education
- Support Groups
- Arts and Crafts
- Physical Fitness (Zumba, yoga, meditation)

BHO PROGRAM STRENGTHS

- Provides client-centered case management and social support
- Integrates wellness screenings into HIV care
- Offers flexibility to design programming that will meet the needs of the client population

This program fills a gap for individuals who do not require intensive medical case management but would benefit from additional social support.

RECOMMENDATIONS

1. Take the time to connect – program models must offer the flexibility to allow the creation of trusting relationships
2. Create a client-centered culture where all staff prioritize engaging with the client. “The most important thing is the client, not the form.”
3. Set targets and reporting requirements to support a flexible, client-centered approach; consider outcomes-based payments (ex: viral load suppression) to allow programs to be tailored to the communities they serve
4. Create literature that is relatable to the cultural norms of the populations being served

THANK YOU!

Taylor Robinson
taylor.robinson@nyulangone.org

Migdalia Vientos
migdalia.vientos@nyulangone.org

Developing a Service Model for People Living with HIV over 50 in NYC:

Comprehensive Health Program's Building Equity-Intervening Together for Health (BiTH) Program

Susan Olender, MD, MS

June 4, 2021

NY HIV Planning Council Meeting

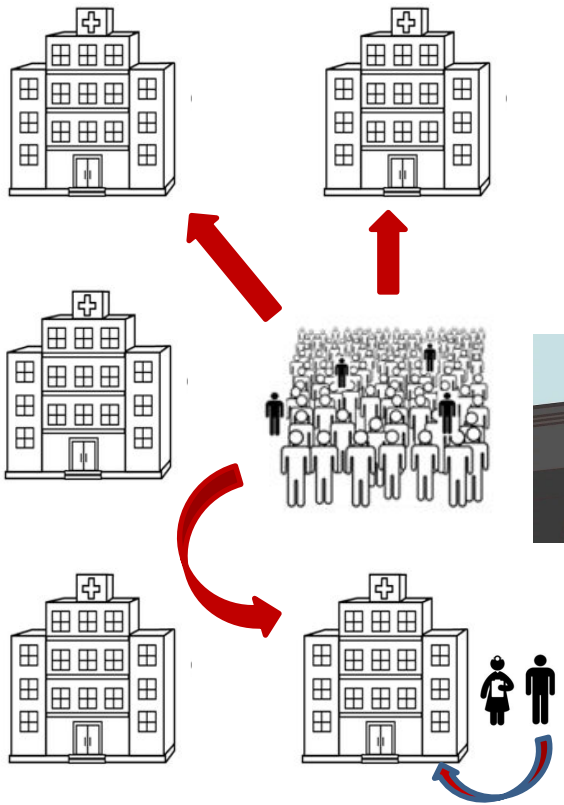
NewYork-Presbyterian
Columbia University Medical Center

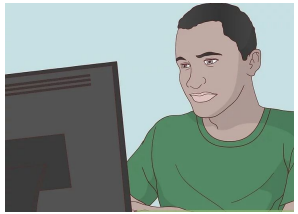
NewYork-Presbyterian Hospital's Comprehensive Health Program (CHP)

- In 2019, NYP/Columbia served **3,263 clients living with HIV** via inpatient, ED, and outpatient services
- The Comprehensive Health Program (CHP)–the Designated AIDS Center (DAC) within the Columbia campus—**served over 2,300 of these clients of which 257 were new to the program**.
- Between 2015-2018, CHP underwent practice redesign to optimize HIV care delivery
  - Team-based care
  - Use of data-driven alerts and panel management strategies
  - Enhancements to care coordination, same day services
  - Expanded capacity for behavioral health services

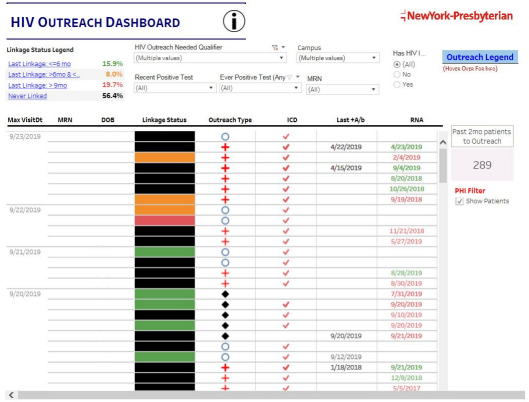
Figure 1. Upper Manhattan Map.

NYP/CHP Multi-Institutional Outreach Dashboards to Facilitate Linkage and Reengagement





Dashboard Pilot



NewYork-Presbyterian
The University Hospital of Columbia and Cornell

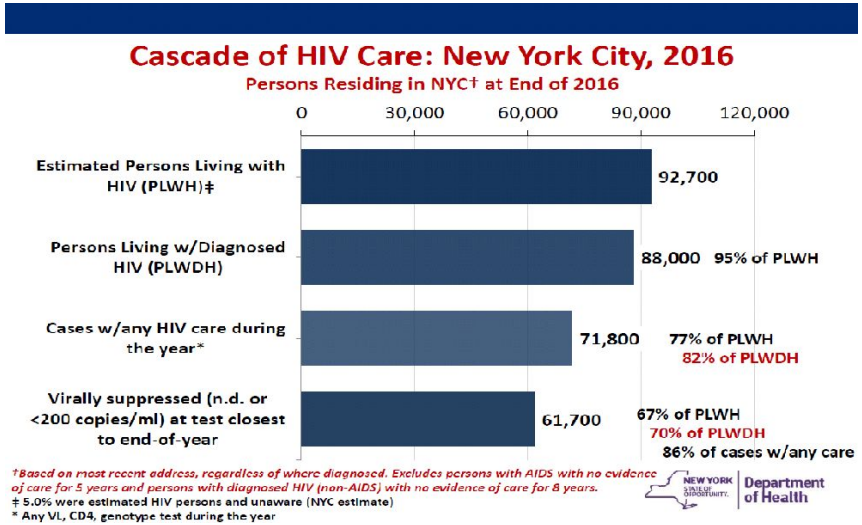
Comprehensive Health Program (CHP)

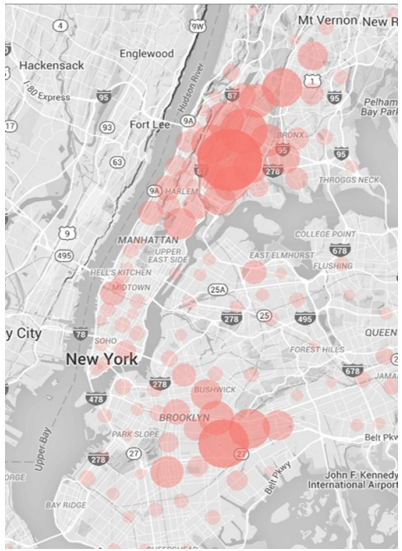
- Designated AIDS Center (DAC)
- HIV Center of Excellence
- PEP/PrEP Center of Excellence
- Level III Patient-Centered Medical Home (PCMH)
- Care Management Agency (CMA) under Medicaid's Health Home
- Academic medical center setting with full-time and part-time PCPs who provide outpatient & inpatient care (21 bed inpatient unit)
  - HIV MDs (4), ID MDs (14), HIV/ID Fellows (8), and NPs (6)
- Care team includes RNs (5), RN Care Managers (2), MAs (4), LCSW/LMSW (6), and care coordinators (10)
- Nutritionist (1)
- Psychiatry providers (3)

Table 1. Demographic characteristics of PLWH seen at CHP in 2019 (N=2328)

Characteristic	N (%)
Age	
50 years and older	1189 (51%)
Active Hepatitis C Co-Infection	
Yes	51 (2.2%)
No	2277 (97.8%)
Primary Risk Factor	
Men who have sex with men (MSM)	879 (37.0%)
MSM/Injection Drug Use (IDU)	74 (3.5%)
IDU	80 (3.6%)
Heterosexual Contact (HSC)	1108 (48.9%)
Perinatal Transmission	106 (4.8%)
Blood	28 (1.1%)
Unknown	53 (1.1%)
Sex	
Male	1533 (65.9%)
Female	795 (34.1%)
Race/Ethnicity	
Black/Hispanic/Multi-Race	1215 (52.2%)
White	174 (7.5%)
Other Race*	99 (4.3%)
Unknown	840 (36.1%)
Insurance	
Public/Grant	2181 (93.7%)
Private	113 (4.9%)
Uninsured	34 (1.4%)

CHP: Local Context





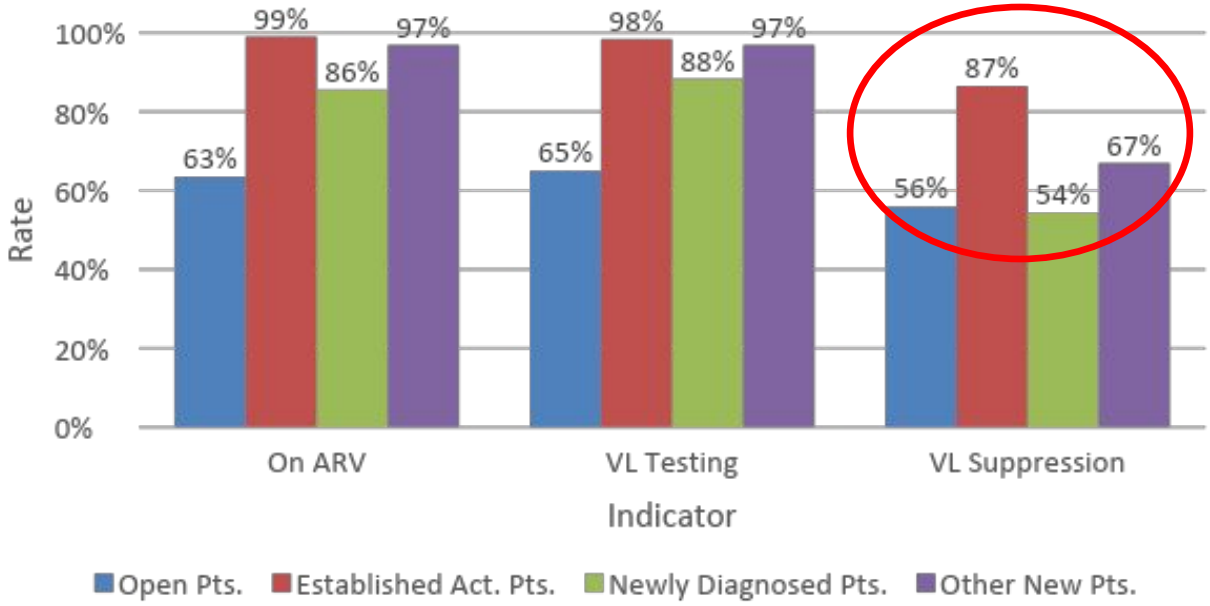
CHP Ryan White Care Coordination Program: 2010-2016

Table 1. Univariate analyses

Characteristic	No.	% VLS at 12m	P-value	% EIC at 12m	P-value
Total	**525**	**47.0**		**65.1**	
Newly diagnosed at enrollment	52	51.9	0.52	71.2	0.46
Virally suppressed at enrollment	87	75.9	< 0.05	74.7	< 0.05
Engaged in medical care	342	62.3	< 0.05	--	--
Virally suppressed at 12 months	247	--	-	86.2	< 0.05
Multiple enrollments	56	32.1	0.04	78.6	< 0.05
Unstable housing	73	41.1	0.35	57.5	< 0.05
Gender					
Male	313	46.5	0.97	65.8	0.72
Female	209	47.8		64.6	
Transgender	3	50		50	
Age at Enrollment (years)					
<=24	16	62.5	0.09	93.8	0.04
25-44	205	42.0		68.3	
45-64	257	47.1		60.7	
>= 65	47	63.8		66.0	
Race/Ethnicity					
Black/African American	271	49.1	0.09	62.7	0.93
Hispanic	210	46.7		69.0	
White, Asian, or Other	44	36.4		61.4	
Closure Reason					
Program graduation	71	80.3	< 0.05	93.0	< 0.05
Lost to follow-up	102	40.4		60.8	
Deceased	39	20.5		38.5	
Moved, relocated, or transferred	103	35.9		55.3	
Discharged due to other reasons	97	45.4		73.2	

Characteristic	No.	% VLS at 12m	P-value	% EIC at 12m	P-value
CD4 at Enrollment					
<200	116	49.1	< 0.05	64.7	< 0.05
200-349	53	64.2		86.8	
350-499	40	52.5		73.8	
>=500	57	43.9		73.7	
Unknown	258	42.6		57.4	
Medical Comorbidities					
Respiratory disease	193	45.6	0.6	65.8	0.81
Cardiovascular disease	222	48.6	0.53	65.8	0.8
Chronic kidney disease	67	44.8	0.68	70.1	0.35
Cirrhosis	47	42.6	0.52	57.4	0.25
Diabetes	85	50.6	0.48	61.2	0.4
Past or current Hepatitis C	108	34.3	< 0.05	56.5	< 0.05
Malignancy	109	49.5	0.56	71.6	0.1
Behavioral Comorbidities					
Cognitive impairment	41	65.9	< 0.05	68.3	0.15
Depression	177	50.3	0.29	70.1	0.09
Serious mental illness	210	51.4	0.1	73.3	< 0.05
Substance use	322	39.1	< 0.05	62.1	0.06
Tobacco Use	252	39.3	< 0.05	61.5	0.09
Chronic Condition Count					
0-2	204	51.5	0.14	66.2	0.65
3-5	250	44.4		64.8	
>5	71	43.7		63.4	

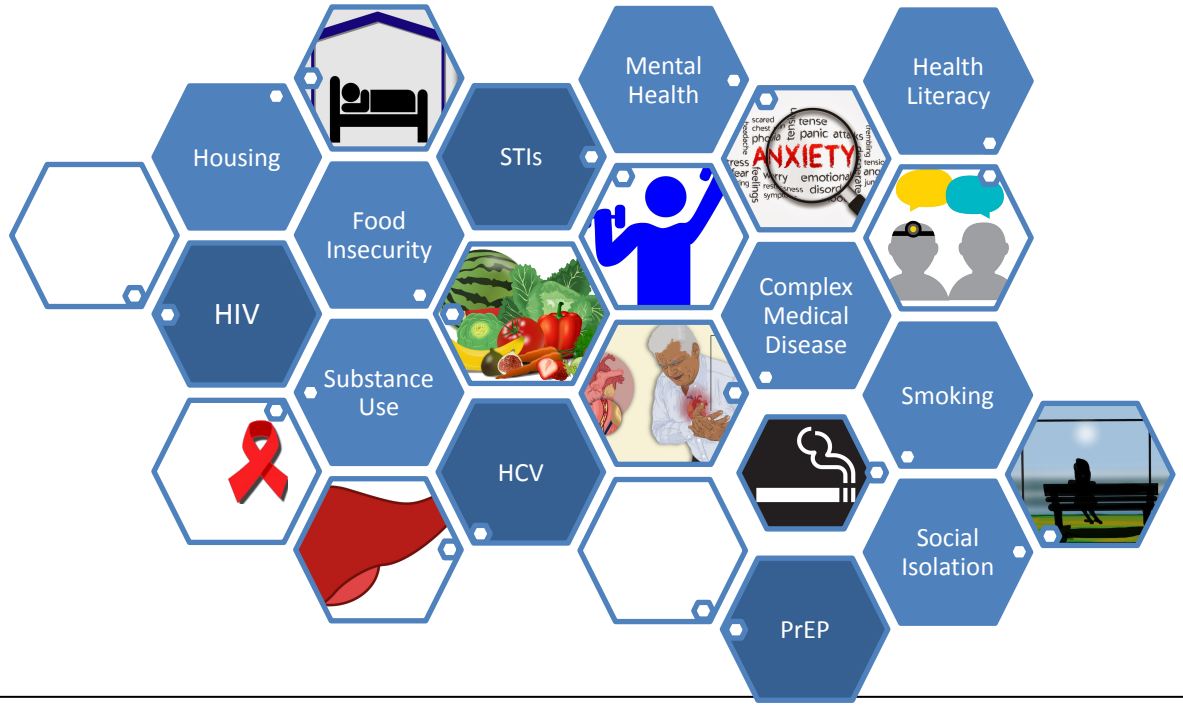
CHP HIV Care Cascade Indicators 2019



CHP Service Needs for OPLW in 2020

- ❑ Over 50% patients are 50 years or older
- ❑ High rates of polypharmacy and comorbidities including psychiatry disorders
- ❑ Lack of full integration of care, silos
- ❑ Patient access barriers for specialty care services
  - ✔ Delays in care (e.g., average wait >3 month for specialty appointments)
  - ✔ Limited capacity within specialty clinics serving Medicaid/ADAP patients
  - ✔ Complexity in confirming off site specialty appointments often resulting in high no show rates
- ❑ COVID-19
  - ✔ System level: service interruptions for specialty care
  - ✔ Patient level: social isolation, changes in physical activity (more sedentary), anxiety/stress and impact on nutrition and brain health

CHP Building Equity– Intervening Together for Health



BiTH at CHP: Client-level Intervention Components and Activities

- **In-depth screening and care coordination support**
  - Geriatric Screens
  - Complex Med Reconciliation
  - Care Planning
  - IT assessments to improve virtual access (iPads Loans, Home IT needs, Classes)
- **Group classes:**
  - "Wellness Club" -- 45 min classes conducted on a weekly basis over 2 time periods.
  - Brain health classes
  - IT Access Coaching

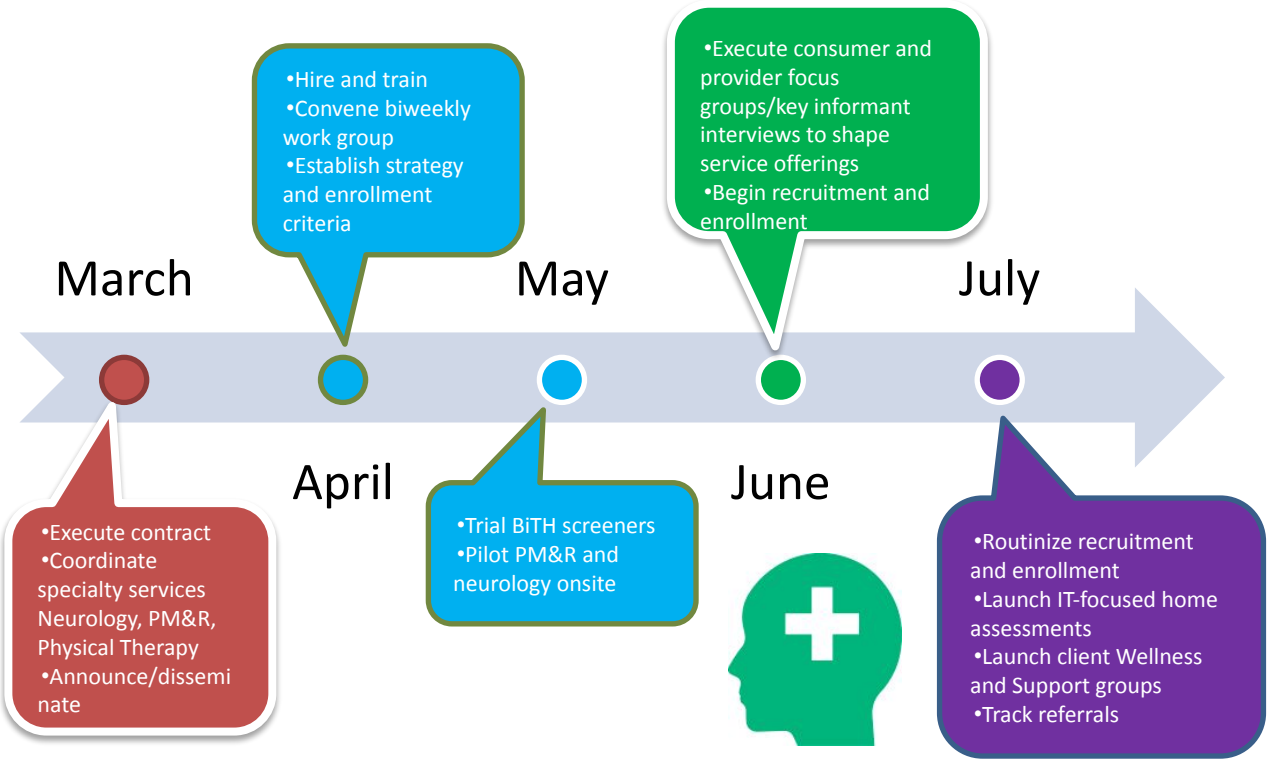
On-site Specialty Consultation:

- **Neurology clinic:**
  Referral based on patient need, a neurologist with HIV expertise conducted cardiology consultations
- **Physical Medicine and Rehabilitation consult:**
  Referral based on patient need, a physiatrist with HIV expertise held weekly consult clinic

BiTH at CHP - Staffing

- Project Director
- Quality Manager
- Project Manager
- Clinical Supervisor (RN Care Managers)
- Client Navigators (Care Coordinators)
- Care Coordination Teams
- Community Health Workers
- Physiatrist
- Physical Therapist Classes
- Neurologist

CHP BiTH Start-up Timeline 2021



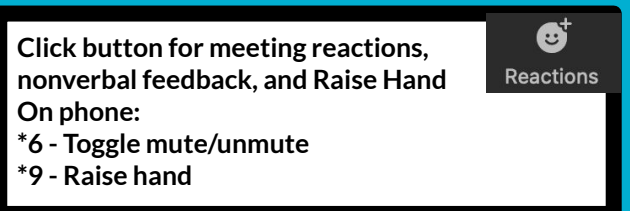
Evaluation Framework: RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) - mixed methods approach including qualitative and quantitative reflection

Focus Suggestions: Addressing the needs of OPWH

- Fitness access and training
- Virtual and onsite Behavioral Health Services
- Strategies to balance management of complex comorbidities and polypharmacy

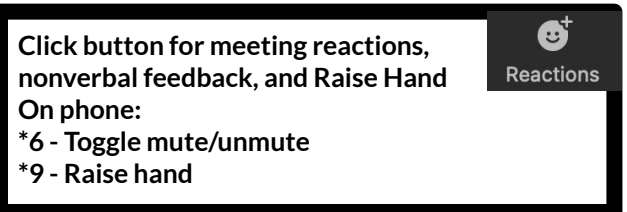
Developing a Service Model for Older People with HIV

Graham Harriman, Director,
NY Health & Human Services Planning Council



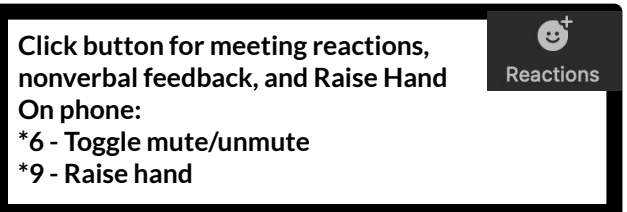
Why do We Need a Service Model for Older People with HIV?

- PWH over 50 represent a majority of the total PWH population (59% of PWH in NYC in 2019) and yet their unique intersectional needs are often underrecognized and unaddressed by HIV service organizations
- PWH over 50 have achieved the highest proportions of sustained viral suppression of any age group and yet care for their comorbid health conditions remains suboptimal
- PWH still have shorter life expectancies than those not living with HIV with two thirds of deaths among PWH due to non-HIV-related causes.



Why do We Need a Service Model for Older People with HIV? (cont)

- PWH have 16 fewer healthy years than uninfected adults, with diagnoses of common comorbidities beginning at age 34, and no improvement over time or with early ART initiation.
- Local focus group results underscore the need for improved resources for PWH over 50, including the need to develop services that address social isolation, increase coordination between programs, increase the benefits navigation, increase the availability of services offered in Spanish, address medical conditions of women with HIV over 50



Drafting a Service Model for Older PWH

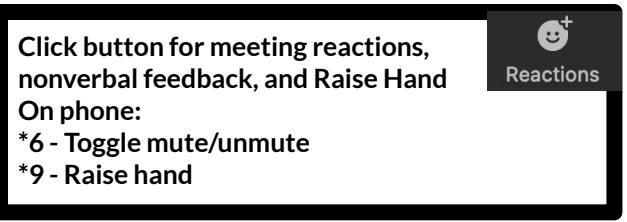
Outpatient Medical Care:

- Increase capacity to treat the complex needs of PWH over 50 mirroring aspects of the Golden Compass **model through use of clinical staff** (MD, RN, Pharmacist, Medical Assistant) **to provide health education**
- Geriatric, Psychiatric, and Cardiology consultation, and **referrals** to ongoing specialty care
- Resources provided by RWPA to **address gaps in current care** provided at clinical sites.
- Funded services should support improved self-advocacy/ self-management so that PWH over 50 **can talk to their medical providers about broader health concerns**

Drafting a Service Model for Older PWH (cont)

Referral for Healthcare and Supportive Services:

- **Increase the knowledge of resources** available to support PWH over 50 among RWPA funded providers
- Improve **referral tracking** to ensure PWH over 50 are engaged in needed services
- Adapt referral practices from the ARTAS model, i.e. the **development of referral partnerships**, communication/outreach/education, **navigation and transportation if needed**



Drafting a Service Model for Older PWH (cont)

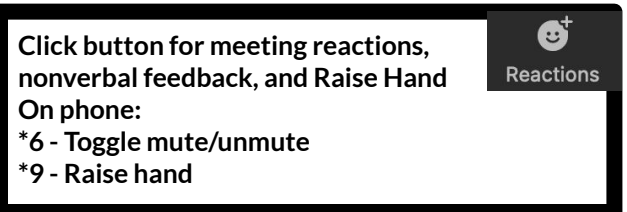
Prevention and Wellness:

- **Strengthen and expand PWH networks** and fund organizations that provide social support services for older people living with HIV
- Fund social support for exercise: **set up buddy systems,** making contracts with others to complete specified levels of physical activity, or **set up walking groups** and other groups to facilitate friendship and support
- **Fund navigation, structured health education** and practical and emotional peer support services to increase engagement in care and promote self-care
- Identify how to **leverage technology for social support** and connection and to overcome barriers that older people living with HIV face

Drafting a Service Model for Older PWH (cont)

Training

- **Increase training** of RWPA providers to ensure
  - They are able to **effectively support PWH over 50** through increased ability to **identify comorbidities**,
  - **Link** PWH over 50 to **needed resources,** and
  - Services are delivered **equitably**



Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand

Reactions

Goals of the Service Model

This program is designed to increase:

- The number of HIV clinics **providing screening/ assessment for comorbid conditions**
- **Clinical capacity** to provide services for common comorbidities for PWH over 50 through an **increase in knowledge and skills**
- **Attendance** of PWH over 50 at **specialist appointments for comorbidities**
- **Consumer social support** (peer delivered services, support groups, health education groups) activities
- Consumer **participation in at least one fitness and exercise class** over 12 months
- Client **perception of self-management skills** when surveyed

POLL: What services would help support you and the larger community's health?

What needs to change/improve/be enhanced?

(can enter multiple answers)

Use your phone to scan the

QR code

or

Text your vote to

(202) 933-9005

or

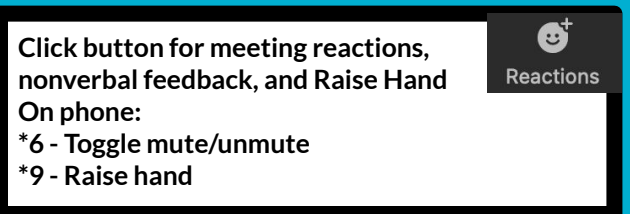
join at

Swiftpolling.com #28111

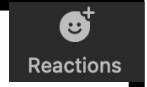
https://poll.excitem.com/s/presentation/poll?id=91469

Time for Testimony

Breakout Rooms –
please enter when the room pops up



Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand



Discussion Questions

Do you feel supported as a person aging with HIV?
Why or why not?
Does your provider engage you respectfully?
Are services patient-centered?
What services have you seen a need for?
Feel free to speak for the community and/or for yourself
What support do people need to get physical exercise?
What support do people need to get to appointments?

Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand

Reactions

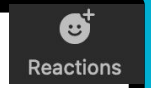
Discussion Questions (cont)

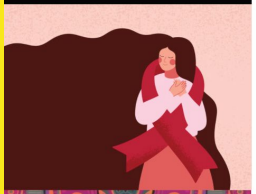
How can we support people who are dealing with substance use or mental health issues as they age?
How can services help PWH over 50 reduce loneliness and increase social support?
What are the barriers for people to access the services they need?
What would be the best place(s) for people to access support services?
How should faith based support be engaged?

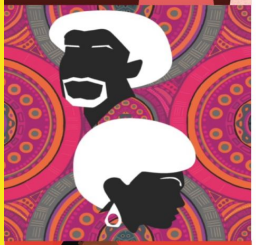
Review Highlights

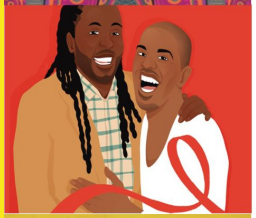
Report Back!

Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand









HIV Health & Human Services
PLANNING COUNCIL
OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

- Are you interested in improving the lives of people living with HIV (PLWH)?
- Do you want to enhance programs and services offered to PLWH?
- Do you want to be part of a group that advocates for the needs of PLWH?

Join the NY HIV Planning Council!

Attend one or more two-hour Council meetings per month and lift up your voice to improve services and ensure that we meet the needs of all PLWH.

Come join an active group of PLWH and become an agent for change!

For more information, visit our website at www.nyhiv.org or call Jose at 917.821.1500.

Nothing about us, without us!
Your Voice Matters!

Join Us!

Nyhiv.org for info on all meetings

Click button for meeting reactions, nonverbal feedback, and Raise Hand
On phone:
*6 - Toggle mute/unmute
*9 - Raise hand

Reactions