

NEW YORK STATE ENDING THE EPIDEMIC
Older Adults (50+) and HIV

Advisory Group Report
Older Adult Implementation Strategies (OAIS)
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Advisory Group

Core Advisory Group Members *

Facilitator - * Joseph Luniewicz, Deputy Executive Director for Programs, ACRIA

Abramson, Tobi, President, State Society on Aging of New York

Adams, Michael, Chief Executive Officer, Services and Advocacy for GLBT Elders (SAGE)

Akutagawa, Vaughn Taylor, Executive Director, Gay Men of African Descent (GMAD)

Albino, José, Executive Director, GRIOT Circle

* **Alvarez**, Maria, Executive Director, Statewide Senior Action Council

André, Randy, Senior Program Coordinator, St. Lawrence County Office for the Aging

Arneth, Diane, President, Community Health Action of Staten Island

* **Asen**, Leo, AARP New York State President

Barouh, Gail, PhD, President/CEO- Long Island Association for AIDS Care

Barry, John, Executive Director -Southern Tier AIDS Program (Ithaca)

* **Bashein** Benjamin, Executive Director, ACRIA

Bauer, David, Rabbi, Director of Social Justice Programming for Congregation Beit Simchat Torah

Beck, Jack, Correctional Association of New York State

* **Brennan-Ing**, Mark, Director for Research and Evaluation, ACRIA

Brick, Mari T., Associate Director, QTAC-NY/SUNY Center on Excellence in Aging & Community Wellness

Carpenter, Mae, Commissioner, Westchester County Department of Senior Programs and Services

Chacón, Guillermo, President, Latino Commission on AIDS

Cochran, John, Deputy Director Executive Division, New York State Office for the Aging (NYSOFA)

Cook, Anne Marie, Chief Executive Officer Life Span (Rochester)

Cortes, Tara, PhD, RN, FAAN, Health & Aging Policy Fellow, Executive Director, Hartford Institute for Geriatric Nursing & Professor, NYU College of Nursing

* **Cotroneo**, Richard, Director HIV Education and Training Programs, NYSDOH AIDS Institute

* **Daskalakis**, Demetre, Assistant Commissioner, New York City Department of Health and Mental Hygiene (NYCDOHMH)

Davila, José M., President & Chief Administrative Officer, BOOM! Health

DiDonato, Paul, former Executive Director of Funders Concerned About AIDS

Dionne, William, Executive Director, Carter Burden Center for the Aging

Drinane, Suleika Cabrera, Chief Executive Officer, Institute for the Puerto Rican/Hispanic Elderly, Inc.

Duke, Sharen I., Executive Director/Chief Executive Officer, AIDS Service Center New York City (ASCNYC)

* **Faria**, Lynn, Chief Officer for External Affairs, Services and Advocacy for GLBT Elders (SAGE)

Farid, Mujahid, Release Aging People in Prison

Ferretti, Lisa, Executive Director, SUNY Center on Excellence in Aging & Community Wellness

Fields, Virginia, President & Chief Executive Officer, National Black Leadership Commission

Finkel, Beth, State Director AARP

Francis, Lawrence, Community Member; FACES NY, Inc. Advocacy; NYSDOH CAC/ HAB member; Upper Manhattan Chairman, Ending the Epidemic

Gibson, Joel, Rev, Director, Faith-based Initiatives, Federation of Protestant Welfare Agencies (FPWA)

Halkitis, Perry, PhD - HIV/AIDS and Gay Men's Health Public Health Researcher, Psychologist

Haslanger, Kathryn, Chief Executive Officer, Jewish Association Serving the Aging (JASA)

Higgins, Matthew Crehan, Senior Director, Pride Center of Western New York (Buffalo)

Hill, Marjorie J. PhD, Chief Executive Officer, Joseph Addabbo Family Health Center

Hoak, Randal, Commissioner, Erie County Department of Senior Services

* **Jellinek**, Igal, Executive Director, LiveOn NY

Jones, Zachary, Senior Bishop, Unity Fellowship Church

Junjulas, Perry, Albany Damien Center

Kamber, Tom, Executive Director Older Adults Technology Services (OATS)

* **Karpiak**, Stephen, Senior Director for Research and Evaluation, ACRIA

Kilmnick, David, Chief Executive Officer, Long Island GLBT Services Network

* **King**, Charles, Executive Director, Housing Works

London, Andrew, Chair and Prof. Sociology Syracuse University

* **Lopez**, Michelle, Community Member

Louie, Kelsey, Chief Executive Officer, Gay Men's Health Crisis (GMHC)

Masten, James, PhD, Clinician

McClinton, Wendy, Chief Executive Officer, Black Veterans for Social Justice

Meyerhoefer, Victoria, Director, Nassau County Dept. of Human Services, Office for the Aging

* **Morne**, Johanne E., Director, NYSDOH AIDS Institute

* **Myers**, Gail, Deputy Director of Statewide Senior Action Council

O'Connell, Dan, Former Director, NYSDOH AIDS Institute

* **Purcell**, Erin, Program Analyst, New York State Office for the Aging (NYSOFA)

Ricard, Nilda, Program Director, Drop in Center & Health Services

* **Rindler**, Jeff, Director of Programs & Services, Hudson Valley LGBTQ Community Center

Rodriguez Therese R., Chief Executive Officer, Asian & Pacific Islander Coalition on HIV/AIDS (APICHA)

* **Rodriguez**, Marcus, Director of Institutional Relations, ACRIA

Rosenfield, Todd, Project Manager, New York State Division of Veterans Affairs

* **Ruttan, Julie**, NYSDOH AIDS Institute Office of Planning & Community Affairs

Ryan, Joan, Board Chair LiveOn NY

Sackman, Bobbie, Director of Public Policy, LiveOn NY

Shah, Krupa, MD, MPH, University of Rochester School of Medicine & Dentistry Division of Geriatrics & Aging, Department of Medicine

Smith, Kimberleigh, Senior Director for Community Health Planning and Policy, Callen-Lorde Community Health Center

Solomon Sebastian, Director of State Policy Legal Action Center (LAC), Co-Chair CoRA

Stone, MS, LMHC, Rev. Moonhawk River, RiverStone Consulting

Straus, Andrea, Executive Director, Hudson Valley Community Services (HVCS)

* **Swain, Carol-Ann**, Epidemiologist, NYSDOH AIDS Institute

* **Tapias, Karol**, Director of Training & Innovation, LiveOn NY

Testone, Glenda, Executive Director, Lesbian, Gay, Bisexual & Transgender Community Center

Thornton, Karen, Director of Member Services, Association on Aging in New York

Vladeck, Fredda, Director, Aging in Place Initiative

Ward, Jasan, Former Program Director, The MOCHA Center

Weber, Thomas, Director, Care Management Services, Services and Advocacy for GLBT Elders (SAGE)

Williams, Andrea, Program Director, ReConnect, Correctional Association of New York

* **Wilking, Stacey**, Special Assistant, Assistant Commissioner's Office Bureau of HIV/AIDS, New York City Department of Health and Mental Hygiene (NYCDOHMH)

Wirth, Doug, President/Chief Executive Officer Amida Care

Older Adult Implementation Strategies History

The **Ending the Epidemic Older Adults and HIV Statewide Advisory Group** was formed in response to meetings convened in the summer and fall of 2015 by **ACRIA**. The Advisory Group's mandate over the first six months of 2016 was to develop "guiding principles/implementation strategies" for working with Older Adults (50+) at risk and living with HIV in support of the **NYS Blueprint to End the AIDS Epidemic (Blueprint)**. The long term purpose was to make the blueprint specific to the needs of older adults and provide a statewide tool for advocacy through 2020 and beyond.

To be an inclusive statewide effort the Advisory Group reached out to AIDS, aging, faith-based, medical, community-based, and LGBT (lesbian, gay, bisexual, and transgender) providers, in addition to community members. The list of invitees grew to over 75 individuals and organizations. For the mandate to be accomplished in a six-month time period, organizations and individuals were asked to participate in one of two ways: To participate in the **Full Older Adults and HIV Statewide Advisory Group** and/or the **Core Older Adults and HIV Statewide Advisory Group**.

The **Full Advisory Group** required attendance in person or by phone at up to two meetings over the six months in Albany where members would review strategies and help develop our final recommendations. In addition some members were asked to work

on sub-committees of the **Core Advisory Group** to develop specific strategies in which they had expertise while others reviewed drafts or segments of this manuscript during the process of its development. The full group consisted of 77 individuals.

The **Core Advisory Group** required attendance *in-person* at six monthly meetings alternately in Albany and New York City between January and June 2016, and additional subcommittee work as needed in order to develop, draft and present the strategy recommendations to the **Full Advisory Group** and, upon endorsement, to the **New York State AIDS Advisory Council** for statewide adoption. The core group consisted of 21 individuals.

Meetings were held on January 22nd, February 17th, March 18th, April 18th, May 18th, and June 16th — with April and June held as **Full Advisory Group** meetings.

This report is meant as both a reference to the needs of older adults infected with and affected by HIV, and a guide for how to implement the Blueprint in a manner specific to this important and vulnerable population.

A note regarding the **evidence base** for suggested strategies: Information that is available in support of any of this report's recommendations are indicated by references or rationale provided in the text introducing each point's section.

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Introduction

New York State (NYS) made HIV/AIDS¹ history in 2014 by launching the Ending the Epidemic (ETE) initiative [2], the first of its kind in the United States. The goal is to reduce the number of new HIV infections to 750 by the end of 2020. That ETE target is

Almost half of all people diagnosed with HIV are over age 50

of high importance, but so too is ensuring that all at-risk populations are taken into account. The largest growing HIV infected population is adults age 50 and older. In 2013 these older adults comprised 50% (49.8%) of the entire HIV infected population in NYS. That percent will continue to rise [3]. In addition, 1 in every 6 new HIV diagnoses in NYS occurs in these older adults [3]. Unfortunately, older adults who are newly diagnosed with HIV are more often likely to be concurrently diagnosed with AIDS. The likelihood of receiving an AIDS diagnosis increases with age and may be indicative of inadequate testing efforts that target older populations [3].

The ETE Points

This report identifies how to best implement the three primary goals (ETE Points) that cut across all at-risk and infected populations [2]. They are:

1. *Identify persons with HIV who remain undiagnosed and link them to health care.*
2. *Link and retain persons diagnosed with HIV in care to maximize virus*

suppression so they remain healthy and prevent further transmission.

3. *Provide access to PrEP for high-risk persons to keep them HIV-negative.*

This report recommends strategies for implementing the NYS Blueprint for at-risk older adults and those 50 and older who are living with HIV. It provides detailed implementation strategies that, when executed by qualified trained individuals, will contribute toward achieving the ETE goal of ending the AIDS epidemic in NYS. By focusing on older adults, this report reflects the dominant paradigm of the ETE, namely, “health care as prevention.” These strategies recognize that there are specific factors related to HIV-infection risk in older adults. Similarly, this report addresses the characteristics of the older adult living with HIV that result in poor viral suppression and concomitant poor clinical outcomes. Add to this the emergence of Pre-Exposure Prophylaxis (PrEP) as a primary targeted HIV prevention intervention. This report details how PrEP is as viable and appropriate for older adults at-risk for HIV as it is for younger populations.

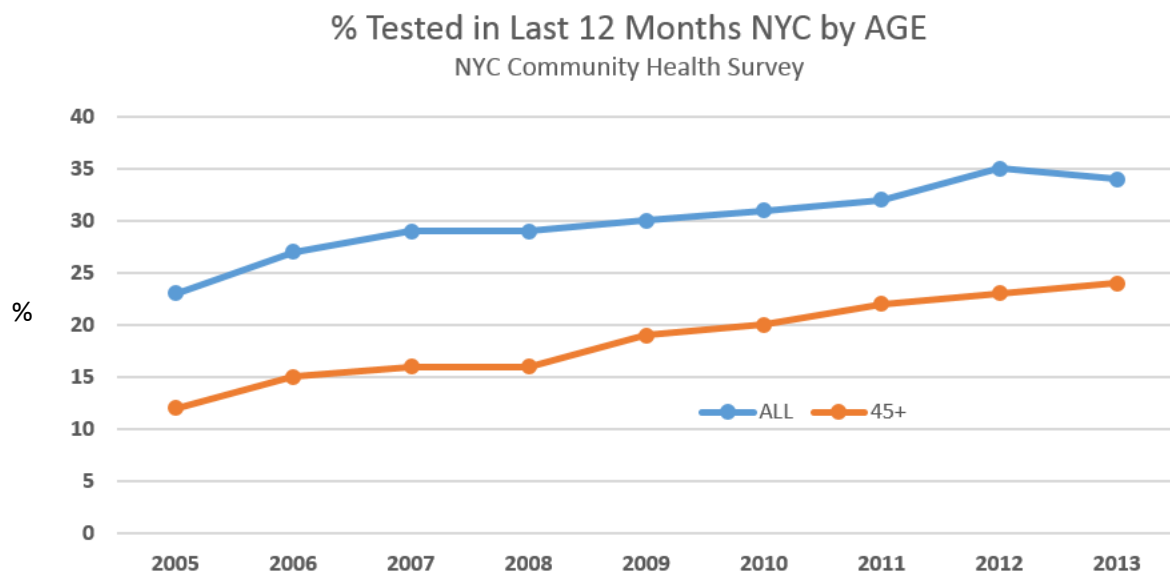
1 in every 6 new HIV diagnoses in NYS occurs in older adults.

Certain populations evidence greater disparities with regard to HIV infection and have been found to have disproportionate HIV incidence and prevalence. These include: 1) men who have sex with men (MSM), especially Blacks and

¹ AIDS stands for acquired immunodeficiency syndrome and is the final stage of HIV infection.

Latinos, of all age groups; 2) transgender and gender non-conforming individuals; 3) women of color; 4) injection drug users; and 5) sero-discordant couples (one partner is HIV-positive and the other is HIV-negative). It is important to note that demographic characteristics do not, in and of themselves, place individuals at-risk of HIV infection. It is not skin color, ethnicity, sexual or gender identities, or age that cause HIV infection. Rather this epidemic is fueled by a lack of

understanding by health and human services providers of the epidemic's impact on older adults as well as the contextual factors outlined in this report. They include poor health care, poverty, inequality, discrimination, mental health and substance abuse challenges [4]. This report highlights and addresses those factors which are embodied in the implementation strategies developed for the older adult population in New York State.

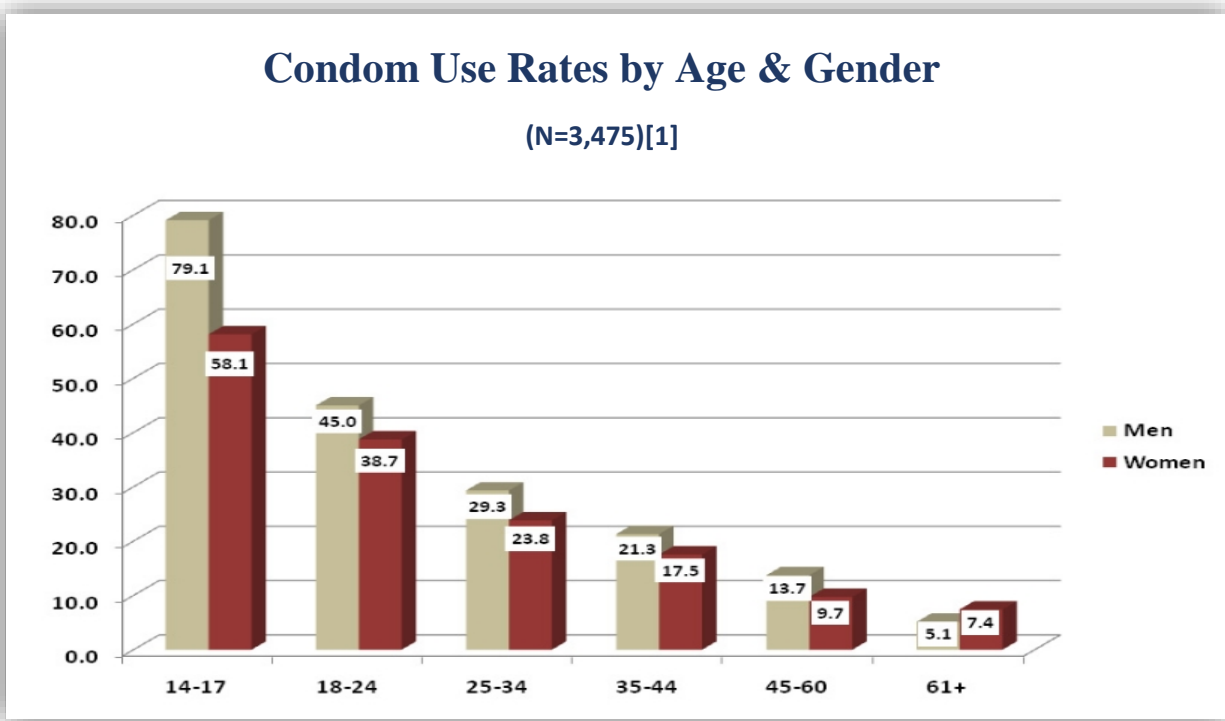


POINT1 - IDENTIFY PERSONS WITH HIV WHO REMAIN UNDIAGNOSED & LINK THEM TO HEALTH CARE

The 2015 Blueprint acknowledges that HIV infection, testing, and connection to care must be viewed in context. Addressing those contextual variables consistently is needed if the Blueprint is to achieve success. These contextual variables are often structural, thereby perpetuating disparities seen in HIV infection rates, concurrent HIV/AIDS diagnoses, and undetectable viral loads. An important contextual variable that is often overlooked is age, namely, the special circumstances people face as they grow older and are either infected or at-risk for HIV.

National data suggests that a lack of understanding of these circumstances has resulted in the testing prevalence for older adults remaining low (<5%) and decreases with age [5, 6]. The older you are the less

likely you are to have been tested even once for HIV. While national data show about one-third of 45-64 year olds have been tested for HIV, only 17% of 65-74 year olds and 8% of those 75 and older have been tested. Older adults continue to engage in activities that put them at-risk for HIV. Over 80% of older adult HIV infections result from sexual transmission. A large-scale national study found that more than half of adults age 65 to 74 were sexually active and over one-quarter were sexually active between the ages of 75 to 85 [7]. However, more than 90% of men over 50 did not use a condom when they last had sex with a date or casual partner, and 70% didn't do so when they had sex with a stranger. Among women over 50, a majority also report having sex without a condom [8]. Medical and non-medical providers, as well as older adults



themselves, do not perceive older adults as engaging in behaviors that increase their risk for HIV and other STIs [9, 10]. Only 38% of adults had discussed sex or sexual problems with a physician after the age of 50 [7]. Research indicates that physicians were not likely to be proactive in discussing sexual health with older adults. They prefer the patient raise the issue. This reflects a number of factors which include: limited knowledge of later-life sexuality issues; “inadequate” training; the perception that sexuality and intimacy were private topics and that raising them would cause offense [11-13]. Even staff in assisted living and

Medical providers avoid discussing sexual health with their patients.

long term care facilities acknowledge that sexual activity occurs with significant frequency [14].

The use of PrEP together with “treatment as prevention” and other prevention interventions (condoms and behavioral interventions) is considered to be an important path toward ending the AIDS epidemic [9, 10].

Older adults with HIV, in conjunction with their healthcare providers, can also serve as effective conduits for the uptake of PrEP among their HIV-negative partners who are at risk for HIV infection. They can convey the need to consider the use of PrEP. This significant degree of access should be leveraged by primary care providers, not only as a way to deliver the details of PrEP use, but also as an opportunity for the provider to engage the patient in often avoided discussion about sexual health issues.

The context of age is also apparent when assessing concurrent HIV/AIDS diagnoses. While 18% of newly diagnosed HIV infections occur in New York State (NYS) among those 50 and older, persons over 50 comprise nearly one-third of all new concurrent AIDS diagnoses, and more than half (55%) occur at ages 40 and older [3]. Each AIDS diagnoses indicates a failure to test, link to care or adhere to medication for HIV. These events call for the dedication of resources by the New York State Department of Health (NYSDOH) to serve at risk older adults. Testing efforts have historically failed to reach those who are age 40 and older as evidenced by the consistent, repeated surveillance reports which show that the likelihood of an AIDS diagnosis is highly correlated with age [15-21].

This failure to adequately test older adults for HIV is underlined by a recent report from the NYC Department of Health and Mental Hygiene which showed that preliminary results from an emergency department based serosurvey (survey that measures the presence of HIV antibodies in a given population) that was conducted in 2015 at Montefiore Medical Center in the Bronx, NY. More than 5,000 specimens were collected from patients in Montefiore’s emergency room over a two month period between March 8 and May 8, 2015. Overall, HIV prevalence among all surveyed patients was 5 percent, with the highest prevalence age group being 50 to 59 at 9.2 percent and the highest undiagnosed prevalence was 20% in those 70-79 [101].

Barriers to ETE implementation strategies targeting older adults include: ageism; HIV/AIDS stigma; lack of knowledge and underestimation of HIV and STI risks among older adults; lack of skill sets among care providers needed to engage older adults regards sexual health; misdiagnoses of

symptoms common to HIV infection and other illnesses; and lack of funding.

Ageism, fear and HIV stigma are barriers to testing for older adults.

Facilitation and implementation of this report's strategies include collaborations between aging, HIV, LGBT, faith-based and community-based organizations, as well as medical and non-medical care providers. Key collaborative partners include: primary care physicians (PCPs) /other health care and allied health providers (NPs, RNs), HIV treating and ID Physicians, aging service providers (e.g. Area Agencies on Aging or AAAs), aging policy stakeholders (American Association of Retired Persons (AARP), the Administration for Community Living (ACL), AIDS service organizations, LGBT organizations, testing centers, as well as community-based and faith-based organizations serving at-risk older adults.

The Centers for Disease Control and Prevention (CDC) calls for routine HIV testing among persons aged 13 to 64 years, with additional testing depending upon risk behaviors. In 2016, the New York State

Legislature passed a bill to remove the upper age limit on routine testing. With an aging HIV population and a growing NYS population of older adults 65 and older, removing the age limit for routine testing will help assure this vulnerable population receives testing, prevention information and critical linkage to HIV care. The CDC recommends routine HIV testing of every client presenting for services in geographic areas where HIV prevalence is high. Because older adults have particularly poor prognosis if they receive their diagnosis late in the course of HIV disease, any screening provided to younger adults should also be provided to older adults [19].

The reticence by providers and clients to engage in needed conversations about sexual health and other HIV risk requires a catalyst [22]. This can be achieved by providing materials (posters/flyers/brochures) which focus on older adult sexual health that are displayed in provider offices (e.g., waiting rooms, exam rooms), thereby creating an atmosphere conducive for conversions about HIV and STI testing [23-28].

BP1² Make routine HIV testing truly routine

1.1 Remove the recommended age limit on routine HIV testing.

1.2 Send a letter from the NYSDOH to all medical providers serving older adults stating the importance of HIV testing, prevention, and early treatment for this population, and their responsibility under existing NYS law to routinely test for HIV.

² BP = Blue Print Recommendation

1.3 Provide materials (posters/flyers/brochures) which focus on older adults' sexual health that are displayed in provider offices (e.g., waiting rooms, exam rooms), thereby creating an atmosphere conducive for conversations about HIV and STI testing.

1.4 Develop and implement training curricula on older adults and sexual health (including taking sexual histories, symptoms of acute HIV infection, talking about sex in the context of HIV, STI, and viral hepatitis, and HIV/STI testing) for both medical and non-medical providers which may include but not limited to:

- geriatricians
- internal medicine physicians
- senior service providers
- allied health workers
- HIV providers
- health home providers
- social workers
- case workers, case management team
- navigators and care coordinators
- geriatric case managers

See other Education Strategies on: sexual health at 2.5, and 23.1; acute infection at 3.1; HIV treatment at 5.2; self-management at 5.6; correctional at 9.1; PrEP/nPEP at 11.1; polypharmacy at 12.2; and transgender at 19.4.

BP2 Expand targeted testing

2.1 Tailor testing to at-risk older adults.

- Conduct testing targeted by smaller age range (example: target 50-64 year olds)
- Recognize and study the older adult/younger adult transmission axis to identify specific risk factors and develop targeted testing campaigns for these groups.
- Implement targeted outreach to all senior centers creating a wellness environment for health promotion addressing sexual health through the use of trained senior peers.
- Conduct targeted outreach through social media including online dating sites, Facebook, and advertising on Amazon/EBay.
- Look beyond senior centers by conducting outreach to older adults by trained outreach workers at diverse and targeted community locations, such as neighborhood taverns/bars, cultural organizations, barber and beauty shops, libraries, gyms, YMCA/YMHAs, faith-based organizations, bingo centers, gambling buses, nail parlors, sex toy parties, continuing education programs (e.g. SUNY and CUNY), senior housing, gated age-restricted communities, naturally occurring retirement communities (NORCS), and assisted living communities.

- Identify at risk older adults who lack a connection to health care and engage them at sites such as soup kitchens, food pantries and shelters.
- Address HIV testing in the context of chronic illness disease prevention and self-management, and sexual health.

See other Peer Strategies at 8.3; correctional at 9.3; PrEP/nPEP at 13.2; intergenerational at 21.1; and 30.1-3.

2.2 Promote opportunities for collaborations with AIDS Service Organizations and testing programs to offer on-site HIV/STI/Viral Hepatitis counseling and testing where older adults congregate including senior centers and other neighborhood sites (see 2.1).

2.3 Develop age appropriate surveys that can be used at venues where older adults congregate, including senior centers, to assess how older adults would best be informed/educated on sexual health and the need for HIV/STI/Viral Hepatitis testing.

2.4 Initiate collaborations with existing organizations whose membership or targeted populations include the broad spectrum of older adults in order to best update and disseminate existing health promotions documents.

2.5 When released, disseminate and train HIV and senior service non-medical providers on the use of the *Older Adults and Sexual Health: A Guide for Aging Services Providers* that was developed by ACRIA with support from the NYSDOH AIDS Institute and in collaboration with the NYS Office for the Aging (NYSOFA).

See other Education Strategies on: sexual health at 1.3, and 23.1; acute infection at 3.1; HIV treatment at 5.2; self-management at 5.6; correctional at 9.1; PrEP/nPEP at 11.1; polypharmacy at 12.2; and transgender at 19.4.

2.6 Provide Value Base Payment (VBP) incentives (as part of Delivery System Reform Incentive Payment or DSRIP) to medical providers (geriatric care in particular) to test older adults for HIV/STI/Viral Hepatitis.

See other DSRIP/VBP Strategies at 6.2 and 10.1-5.

2.7 Work with medical providers to couple HIV/STI/Viral Hepatitis testing and sexual health education with discussions of erectile dysfunction treatment/prescriptions.

BP3 Address acute HIV infection

3.1 Educate medical and non-medical HIV providers on the symptoms of acute HIV infection in the context of aging issues. Combine education on older adult acute HIV infection symptoms with STI training and Post-Exposure Prophylaxis (nPEP).

See other Education Strategies on: sexual health at 1.3, 2.5, and 23.1; HIV treatment at 5.2; self-management at 5.6; correctional at 9.1; PrEP/nPEP at 11.1; polypharmacy at 12.2; and transgender at 19.4.

BP4 Improve referral and engagement

4.1 Due to identified clinical needs for the aging HIV-positive population age 50 years and older, quality indicators in all healthcare and service provision areas should develop plans demonstrating effective care models that impact clinical outcomes. Those outcomes must include sustained connection to care (e.g. kept appointments) and specifically linkage from testing site to Primary Care.

POINT 2: LINK AND RETAIN PWH IN HEALTH CARE AND MAXIMIZE VIRAL LOAD SUPPRESSION

The 2nd Point of the Ending the Epidemic (ETE) initiative states “Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission”. The focused clinical outcome of this goal is viral suppression. If a person with HIV achieves viral suppression their infectivity is reduced to near zero. Achieving viral suppression underlines the need for the ETE initiative to account for factors that impact achieving this health outcome in the context of older adults. This report recognizes that older adults with HIV remain sexually active and some engage in high-risk sexual behaviors [10, 17, 29]. However, HIV infectivity approaches zero with sustained viral suppression. Sustaining viral suppression for older adults with HIV happens in the context of other comorbid conditions and health management issues.

At present, there is a dearth of specialized services and supports which address the unique emerging care needs of a population aging with HIV which includes long-term survivors [30]. Increasingly, providers of clinical care for people with HIV are spending less time managing HIV drug resistance and associated short-term anti-retroviral (ART) toxicities and more time managing age-associated non-communicable chronic diseases (NCDs). This array of comorbidities are largely non-AIDS related [31-34]. These include chronic kidney disease [35-37], cardiovascular disease [38-44], malignancies [45-47], liver disease and failure (HCV)[48-50], frailty [51-53] and mobility limitations [54].

Older adults with HIV, whose median age in 2013 was 57-58 years, experience a

significantly higher rate of non-HIV related illnesses when compared to their non-HIV infected peers [55-57]. In older adults with HIV, rates of depression and other behavioral health issues are often five times greater than observed in community samples [58-61]. High rates of depression are one of the primary indicators of non-adherence to HIV and other medications [62], leading to poor clinical outcomes [63-65]. For the older adult the use of a Trauma Informed Care Model is needed [66, 67].

High rates of depression are one of the primary indicators of non-adherence to HIV and other medications.

These older adults with HIV and their providers must engage health care strategies that optimally address the challenges of multimorbidity, namely, the concurrent diagnosis of 2 or more comorbid conditions [68, 69]. Multimorbidity complicates HIV care by increasing the burden of disease as well as increasing the likelihood of polypharmacy [70-73]. In addition, the co-occurrence of behavioral health issues is a common characteristic for this older population. As they age, many use alcohol, tobacco, and/or illicit drugs, further compromising their health and often leading to increased sexual risk behaviors [60, 68, 74, 75]. These behavioral health issues are exacerbated when older adults with HIV are socially ostracized and isolated (supra). This low social support [76-78] is related to poor care engagement and treatment adherence [79], which translates into increased hospitalization, morbidity, and health care

expenditures [60]. In these circumstances, sustaining viral suppression is tenuous.

Barriers to implementing this strategy include ageism, HIV stigma, providers' lack of knowledge about HIV/AIDS, aging, and multimorbidity. Many HIV providers lack knowledge of aging issues having delivered care that was *siloed* due to the younger age of their patient populations (understandably focusing on viral loads and CD4 counts). But the characteristics of the aging older adult HIV population emphasizes the need to embrace care delivery systems that are integrated and coordinated [80-82]. Improving care for the older adult with HIV must address both providers' and patients' lack of knowledge about risk for comorbidities and how best to manage multimorbidity. These challenges can in part be addressed by implementing self-care models [83, 84] and embracing geriatric care principles, especially since there is a serious shortage of geriatricians in the U.S. [85].

This shift in the care for older adults with HIV can be facilitated by engagement and collaboration between aging, AIDS service organizations, LGBT entities, as well as faith-based and community-based organizations. Key partners who should be involved in carrying out implementation strategies include: PCPs/other health care and allied health providers (NPs, PAs, RNs),

Improving care for the older adult with HIV must address lack of knowledge about risk for comorbidities and how best to manage multimorbidity.

HIV treating and ID physicians, aging service providers (e.g. AAAs), aging policy stakeholders (AARP, the Administration for

Community Living (ACL), AIDS service organizations, LGBT organizations, STI testing centers, as well as community-based and faith-based organizations serving at-risk older adults.

Multiple research studies find that older adults with HIV are challenged by the continued toxic effects of stigma as evidenced by multiple reports of increased levels of loneliness and social isolation.

Social support networks are inadequate to meet the dual challenges of aging and HIV.

Fewer than 20% have a partner or spouse and 70% live alone. The vast majority are Medicaid dependent and are not employed [86]. Their social support networks are inadequate to meet the twin challenges of aging and HIV [76, 77]. Many remain connected to their religious congregations but have not disclosed their HIV status [87]. Data suggests that low social support translates into increased hospitalization mortality in this population [88]. These findings highlight the need for tailored programs and services for this population as they lack the informal social care resources available to most other older adults [89, 90]. This challenge places increase emphasis on the use of case management services [91] who can facilitate connections to existing community support services for older adults [92].

The shift in care must include efforts to address the fact that these older adults lack the social supports [93] that most have – namely family members and social networks that provide emotional and day-to-day assistance with daily tasks as they age. The implementation of “buddy programs” is one example of this. These programs were prolific during the first decade of the

HIV/AIDS epidemic
(<http://www.gmhc.org/gmhc-services/other-services/buddy-program>).

The health care of older adults should include the emerging use of technology including expanded use of electronic health records. This might include the receipt of messages as reminders for appointments, refills and reminders for taking medications as well as education and prevention tools [94, 95]. Older Adults Technology Services/Senior Planet (OATS) technology and social media based approaches is an example of effective older adult online learning and technology education [96]. There are a number of published research

articles describing benefits of technology – telehealth as well as mobile phone based – in terms of compliance; reminders; chronic disease management; depression/loneliness /isolation.

One well-studied and validated HIV specific intervention is the use of the telephone to reduce depression in older adults with HIV [97, 98].

BP5 Continuously act to monitor and improve rates of viral suppression

5.1 Implement existing and develop additional specialized medical, social and wrap around services targeted to meet the needs of older adults with HIV in order to foster care engagement, treatment adherence and subsequent viral suppression. High rates of non-HIV related multimorbidity require engagement in care and treatment that addresses these other conditions in order to facilitate optimal clinical outcomes for this population.

5.2 Develop Older Adults specific training for medical and non-medical providers to foster care engagement and treatment adherence, using a health literacy approach and including:

- Cross training of HIV medical providers on aging issues and aging medical providers on HIV/AIDS.
- Cross training of HIV non-medical providers (counselors, case managers, care coordinators, navigators, outreach workers, educators, and administrators) on aging issues and aging non-medical providers (counselors, case managers, care coordinators, navigators, outreach workers, educators, and administrators) on HIV/AIDS.
- Recommend training for Health Home medical and non-medical providers (specifically case managers, care coordinators and patient navigators) on HIV and aging issues.
- Training for Natural Occurring Retirement Communities (NORCs) & housing providers on HIV, stigmas, LGBT and drug use issues in the context of an aging population.

- Recommend training for New York City Ryan White Funded Care Coordination Programs care coordinators and patient navigators on HIV and Aging issues.
- Training of institutional, residential and long-term care staff and consumers/residents on HIV and aging prevention, treatment and care issues.

See other Education Strategies on: sexual health at 1.3, 2.5, and 23.1; acute infection at 3.1; self-management at 5.6; correctional at 9.1; PrEP/nPEP at 11.1; polypharmacy at 12.2; and transgender at 19.4.

5.3 Build bridges/linkages to HIV and aging community based services for older adults including:

- Promote collaborations with AIDS Service Organizations and testing programs to offer onsite HIV/STI/Viral Hepatitis counseling and testing at senior centers and other venues frequented by older adults increasing points of entry into the system to address sexual health issues.
- Allow HIV positive individuals who are aged 50-59 years to access services at senior centers as a standard of care.
- Encourage Aging Provider assessment of HIV status at senior centers.
- Train Aging Provider staff on HIV confidentiality law and HIPPA compliance.
- Recommend making available onsite case management by properly trained staff at senior centers to address chronic illness as a linkage to addressing sexual health.

5.4 Utilize technology-based services to improve HIV care outcomes.

- Use of smartphone based medication and appointment reminders to improve HIV-related medical care compliance, treatment adherence and viral suppression
- Increase online learning opportunities for HIV Care
- Increase education for older adults on how to use technology-based systems (mobile phones, computers, tablets, software).
- Utilize telehealth models of care for individual and group HIV care support.

See other Technology Strategies on: distance/rural at OAIS-22.1 and OAIS-22.2.

5.5 Conduct Research on Older Adults and HIV (ROAH) needs assessment on a sample of older adults living with HIV in NYS with an oversampling in rural areas, in order to create a foundation of data to develop targeted interventions and health care specific to their needs.

See other Data and Needs Assessment Strategies on: data collection at 7.1, 7.2, and 29.1; and SEPs at 15.2.

5.6 Develop co-morbidities self-management training program for older adults with HIV.

- Train non-medical providers in training program implementation.

- Recognize the impact of comorbidities on adherence.

5.7 Develop and implement mental health interventions for identifying and addressing depression and loneliness/social isolation.

- Training in depression screening tools for HIV providers (medical and non-medical providers).
- Training in loneliness/social isolation screening tools for HIV providers (medical and non-medical providers).
- Training on Evidence-Based Interventions presently available on mental health issues for older adults.
- Develop HIV mental health resource manual – specific attention to depression and loneliness/social isolation services.
- Disseminate referral lists/resource manual for mental health assessments/services. Development of interventions for older adults with HIV addressing depression, loneliness, and social isolation.

5.8 Develop and implement mental health interventions for identifying and addressing trauma-related issues such as AIDS Survivor Syndrome and PTSD with long term survivors.

- Develop and implement screening tools and train both aging and HIV providers in its use.

5.9 Develop a new model based on the existing Trauma Informed Care Model specific to working with older adults and older adults with HIV.

5.10 Create Tool Kit for behavioral health providers for coping and living with HIV over fifty highlighting mental health, depression, and social isolation issues.

5.11 Develop support services for caregivers of older adults living with HIV including:

- Support groups
- Education on HIV and aging

BP6 Incentivize provider performance

6.1 Establish a list of patient incentives (patient activation techniques) that could be used for older adults and disseminate to providers including:

- Entitlement help, opportunities for socialization, cash, transportation (Metro Card, Uber/Taxi fare), gift cards, phone cards.
- Incentivize non-HIV illness treatment adherence (in addition to engagement in medical care, retention in care, and viral suppression).

6.2 Provide incentives to providers for working more effectively with older adults including:

- Incentivize NYS AAA's data collection of: HIV Status, sexual orientation, gender identity (2-part question).

- Incentivize agency engagement, retention and viral suppression success with older adult population
- Incentivize addressing other co-morbidities in addition to HIV and adherence to non-HIV treatments in dealing with multi-morbidity
- Incentivize addressing depression, social isolation, and anxiety through screening and assessment with older adults
- Utilize Value-Based Payments to incentivize physicians/geriatricians to test older adults for HIV.

See other DSRIP/VBP Strategies at 2.6 and 10.1-5.

BP7 Use client-level data to identify and assist patients lost to care or not virally suppressed

See other Data and Needs Assessment Strategies on: ROAH at 5.5, SEPs at 15.2, and 50+ at 29.1.

7.1 Recommend that **aging network** data collection questions include: HIV Status, Sexual Orientation, Gender Identity (2-part question).

- Department for the Aging's (DFTA) Senior Tracking, Analysis and Reporting System (STAR) system and NYSOFA's Compass - Comprehensive Assessment for Aging Network Community-Based Long Care Services be modified to collect data on care engagement and clinical indicators for older adults with HIV.
- Train older adult service providers and senior center staff in how to collect sensitive data which will help identify HIV-positive adults who have been lost to care.

7.2 Collect data specific to older adults including the following:

- Non-HIV co-morbidities and chronic conditions
- Age grouped data sets of 50-54, 55-59, 60-64, 65-69, 70+
- Focus groups based on risk behavior, culture/world-view

BP8 Enhance & streamline services to support the non-medical needs of all persons with HIV

8.1 To achieve and maintain viral suppression, an older adult with HIV needs a myriad of non-medical resources. Persons with HIV who lack jobs, housing, financial resources, adequate insurance, behavioral well-being, and/or personal support systems are less likely to achieve optimal health outcomes as they age.

8.2 All programs working with older adults living with HIV need to address nutrition, physical activity/exercise, mental health, and substance use (including tobacco and alcohol use) as part of the standard of care.

See other Peer Strategies at 2.1; correctional at 9.3; PrEP/nPEP at 13.2; intergenerational at 21.1; and 30.1-3.

8.3 Properly trained persons with HIV should be employed as peer navigators who can help others to engage entitlement and community support systems. These peer navigators can also offer personal understanding and encouragement to overcome stigma and discrimination that may undermine care engagement and treatment adherence.

- Expand access to employment and employment services, as well as stipend based work, for people living with HIV to improve health, clinical outcomes, financial, and psychological well-being.

8.4 Adequate nutrition assistance improves health outcomes and enhances treatment adherence in people living with HIV.

8.5 Provide a stipend or reimbursement for travel this allows people the opportunity to access medical care without sacrificing other essential needs such as paying rent, utilities and other items for personal care.

BP9 Provide enhanced services for patients within correctional and other institutions and specific programming for patients returning home from corrections or other institutional settings.

9.1 Train correctional staff in older adults and HIV issues and potential physical and cognitive challenges due to the interplay of HIV, incarceration and aging for incarcerated individual and previously incarcerated individuals.

- Medical and non-medical providers such as probation and parole who work with incarcerated populations should also receive such training.

See other Education Strategies on: sexual health at 1.3, 2.5, and 23.1; acute infection at 3.1; HIV treatment at 5.2; self-management at 5.6; PrEP/nPEP at 11.1; polypharmacy at 12.2; and transgender at 19.4.

9.2 Develop discharge planning models and assessment specific to the needs of older incarcerated adults with HIV.

- Connect correctional institutions to the Care Coordination Program (CCP) in NYC for help with adherence and the assessment of potential physical and cognitive impairment issues for older adults that may impact adherence.
- Train CCPs in the needs of and assessment tools for older adults coming out of incarceration and detention settings.

- Hospital-based medical provider training on the needs of and the assessment tools for older adults with HIV who are formerly incarcerated.
- Connect both staff and consumers with appropriate age-related resources including assessment and self-assessment tools.

9.3 Increase the training and engagement of older peer educators in correctional facilities (and in the community)

See other Peer Strategies at 2.1 and 8.3; PrEP/nPEP at 13.2; intergenerational at 21.1; and 30.1-3.

BP10 Maximize opportunities through the Delivery System Reform Incentive Payment (DSRIP) process to support programs to achieve goals related to linkage, self and viral suppression.

See other DSRIP/VBP Strategies at 2.6 and 6.2.

10.1 Develop Quality Indicators and incorporate them into DSRIP evaluation that are specific to older adults with HIV and use a bio-psycho-social frame (ex: include social isolation, depression, multimorbidity management).

10.2 Encourage older adults to use Medicare sexual health benefits such as HIV and HCV testing.

10.3 Develop bundled services addressing older adults and HIV social determinants of health.

10.4 Encourage aging, faith-based, and HIV provider consortiums to provide older adult specific services to PPSs (Performing Provider System) and ACOs (Accountable Care Organizations).

10.5 Provide technical assistance, training and capacity building to HIV-ACOs so that they can more effectively meet the specific needs of older adults living with HIV.

POINT 3: PROVIDE ACCESS TO PREP FOR HIGH-RISK PERSONS TO KEEP THEM HIV-NEGATIVE.

At present PrEP and nPEP are not regularly offered to older adults and, as with condoms and HIV testing, these discussions occur less frequently among older adults [9, 10, 99]. There are five reasons to offer PrEP and nPEP to older adults.

Condom use decreases with age.

1. Half of men aged 40 years and older have erectile dysfunction, making condom use problematic to protect against HIV.
2. Research finds few older men or women use condoms. Condom use decreases with age.
3. Medical and human service providers are not discussing sexual health with the majority of their older patients leaving at-risk patients undiscovered [7].
4. Older women may have difficulty negotiating condom use with partners (implications of them being gay, Injection Drug Users or IDUs), which may create situations of domestic/elder abuse. PrEP allows older women to be empowered about their sexual health.
5. HIV testing rates among adults over 50 are very low, encouraging PrEP will increase HIV testing rates in this group since such testing is part of the prescription protocol.

BP11 Undertake a statewide education campaign on PrEP and nPEP

- 11.1** Connect high-risk negative older adults to HIV prevention including PrEP and nPEP through targeted messaging, testing, and assessment of risk. Promote education of non-medical providers on the application of PrEP and nPEP to older adults
- Educated high-risk negative adults through conventional (newspapers, radio, TV, etc.) and social (Twitter, Facebook, etc.) media.
 - Educate medical and non-medical providers on PrEP and nPEP prescription protocols and the importance of making these available to adults 50 and older.
 - Develop focus and advisory groups of older adults (infected and high-risk non-infected) to provide strategies for increasing PrEP and nPEP uptake with key seniors to inform education and outreach efforts.
 - Ensure that older adults are represented in social messaging campaigns and that all models are realistic and represent at-risk older adults from age 50 through the 7th and 8th decades of life.
 - Provide community-based organizations with the opportunity for funding to create social messaging campaigns.

See other Education Strategies on: sexual health at 1.3, 2.5, and 23.1; acute infection at 3.1; HIV treatment at 5.2; self-management at 5.6; correctional at 9.1; polypharmacy at 12.2; and transgender at 19.4.

BP12 Include a variety of statewide programs for distribution and increased access to PrEP and nPEP.

See other Education Strategies on: sexual health at 1.3, 2.5, and 23.1; acute infection at 3.1; HIV treatment at 5.2; self-management at 5.6; correctional at 9.1; PrEP/nPEP at 11.1; and transgender at 19.4.

- 12.1** Incorporate PrEP/nPEP education and counseling into existing older adults services and develop older adult specific services where needed.
- Develop PrEP/nPEP Connect hotline to address issues specific to older adults.
 - Include discussions about PrEP/nPEP in general conversations about healthy aging and other health conditions.
 - Have true opt-out HIV testing and discuss PrEP/nPEP as part of older adult risk reduction.
 - Address the link between substance use and HIV risk among older adults with regard to PrEP and nPEP utilization in training, education, and outreach efforts.
- 12.2** Educate medical providers and consumers on polypharmacy issues for age-related and HIV-related comorbidities (i.e., potential drug interactions with PrEP/nPEP)

BP13 Create a coordinated statewide mechanism for persons to access PrEP and nPEP and prevention- focused care

- 13.1** Create PrEP/nPEP Connect hotline at HIV testing sites and train staff on issues specific to older adults.
- 13.2** Provide PrEP/nPEP Navigators with access to information and referrals for older adults.
- Create an older adult peer group of PrEP/nPEP users.

See other Peer Strategies at 2.1 and 8.3; correctional at 9.3; intergenerational at 21.1; and 30.1-3.

BP14 Develop mechanisms to determine PrEP and nPEP usage and adherence statewide

- 14.1** Create a provider follow-up checklist on usage, adherence, and social/behavioral issues around PrEP and nPEP.

4. RECOMMENDATIONS TO DECREASE NEW INFECTIONS AND DISEASE PROGRESSION.

BP15 Increase momentum in promoting the health of people who use drugs.

15.1 Recommend NYSOFA, NYSDOH AIDS Institute, and the NYS Office of Alcohol and Substance Abuse Services (OASAS) perform a joint review of program capacity to promote healthy aging among older adults who are substance users.

15.2 Review Syringe Exchange Program (SEP) data to clarify program utilization by older adults.

See other Data and Needs Assessment Strategies on: ROAH at 5.5, and data collection at 7.1, 7.2, and 29.1.

15.3 Develop guidelines for screening and intervention on tobacco and alcohol use specific to older adults with HIV.

- Adapt existing screening tools such as the Alcohol Use Disorders Identification Test or AUDIT for alcohol use.
- Develop brief interventions specific to older adults with HIV using a harm reduction approach to reduction/cessation of alcohol and tobacco use.
- Provide incentives for tobacco cessation for older adults with HIV along with access to tobacco cessation medications.

BP16 Ensure access to stable housing

16.1 Educate HIV providers about housing benefits provided to seniors Senior Housing, Senior Citizen Rent Increase Exemption/Disability Rent Increase Exemption (SCRIE/DRIE).

- Provide housing for transgender older adults at-risk for or living with HIV

See other LGBT Strategies on: government agency liaisons 18.1, and transgender health at 19.1-4.

BP17 Reducing new HIV incidence among homeless youth through stable housing and supportive services.

Not Applicable

BP18 Health, housing, and human rights for LGBT communities.

18.1 Create an LGBT and aging liaison at all government agencies.

See other LGBT Strategies on: housing at 16.1, and transgender health at 19.1-4.

BP19 Institute an integrated comprehensive approach to transgender health care and human rights.

See other LGBT Strategies on: housing at 16.1, and government agency liaisons 18.1.

19.1 Utilize U.S. Department of Health and Human Services (HHS) or National Center for Transgender Equality (NCTE) gender identity 2-part question for aging and HIV/AIDS organizations.

- Train staff on its use and importance of accurately assessing gender identity.

19.2 Develop and disseminate information/publications on potential drug interactions for transgender and gender non-conforming (TGNC) older adults with regard to hormone therapies, ARTs and PrEP/nPEP, and medications for common aging-related comorbidities.

19.3 Provide culturally sensitive long-term care in transgender friendly facilities.

- Train staff in long term care facilities in TGNC friendly health care practices – effective care engagement.

19.4 Develop and disseminate training on working with TGNC older adults.

- Train medical and non-medical provider staff.
- Train staff in aging organizations, faith-based organizations, and CBOs.

See other Education Strategies on: sexual health at 1.3, 2.5, and 23.1; acute infection at 3.1; HIV treatment at 5.2; self-management at 5.6; correctional at 9.1; PrEP/nPEP at 11.1; and polypharmacy at 12.2.

BP20 Expanded Medicaid coverage for sexual and drug-related health services to targeted populations.

Possible strategies pending further study.

BP21 Establish mechanisms for an HIV peer workforce.

21.1 Recommend the NYSDOH AIDS Institute explore the creation of a learning and training collaborative on successful models of intergenerational programs, specifically to support opportunities for older adults to mentor younger adults on a variety of

issues including HIV prevention and HIV self- management for people living with HIV.

See other Peer Strategies at 2.1 and 8.3; correctional at 9.3; PrEP/nPEP at 13.2; and 30.1-3.

BP22 Access to care for residents of rural, suburban and other areas of the state.

22.1 Use of tele-health and other technologies in innovative care coordination models to improve rates of adherence.

- Technology-focused: Telemedicine projects for both urban and rural areas
- Use of text messaging and Health Insurance Portability and Accountability Act (HIPAA) compliant mobile applications for medication and appointment reminders
- Patient portals through electronic health records or other innovations

See other Technology Strategies on: tele-health at 5.4, and distance/rural at 22.2.

22.2 Increase access to online chronic disease self-management education (CDSME) programming and other innovative support models i.e. telephonic support around depression

See other Technology Strategies on: tele-health at 5.4, and distance/rural at 22.1.

22.3 Develop home-based interventions for depression specific to older adults with HIV that would be applicable to those lacking access to behavioral health care providers including those living in rural areas.

BP23 Promote comprehensive sexual health education.

23.1 Provide older adult sexual health training and education for medical and non-medical providers in HIV and aging service sectors.

See other Education Strategies on: sexual health at 1.3, and 2.5; acute infection at 3.1; HIV treatment at 5.2; self-management at 5.6; correctional at 9.1; PrEP/nPEP at 11.1; polypharmacy at 12.2; and transgender at 19.4.

BP24 Remove disincentives related to possession of condoms.

24.1 HIV Stops with me campaign already features a representative sample of older adults. Ensure this continues.

BP25 Treatment as prevention information and anti-stigma media campaign.

25.1 Implement social marketing (social media and print media) campaign addressing stigma in older adults around HIV and ageism.

- Provide funding opportunities for community based organizations to apply for funding.

BP26 Provide HCV testing to persons with HIV and remove restrictions to HCV treatment access based on financial considerations for individuals co-infected with HIV and HCV.

Possible strategies pending further study.

BP27 Implement the Compassionate Care Act³ in a way most likely to improve HIV viral suppression.

Possible strategies pending further study.

BP28 Equitable funding where resources follow the statistics of the epidemic.

28.1 Target funding for older adults with HIV and at-risk for HIV as the largest growing HIV positive population.

BP29 Expand and enhance the use of data to track and report progress.

See other Data and Needs Assessment Strategies on: ROAH at 5.5, data collection at 7.1, 7.2, and SEPs at 15.2.

29.1 Collect data on age 50 and older population infected with or at risk for HIV.

BP30 Increase access to opportunities for employment and employment/vocational services.

³ New York's Compassionate Care Act, sponsored by Assembly Health Committee Chair Richard Gottfried and Sen. Diane Savino, was approved by the New York Assembly and Senate on June 20 and was signed by Gov. Andrew Cuomo on July 5, 2014. The new law will protect certain seriously ill patients who use marijuana pursuant to their doctors' advice from civil and criminal penalties.

See other Peer Strategies at 2.1 and 8.3; correctional at 9.3; PrEP/nPEP at 13.2; and intergenerational at 21.1.

- 30.1** Develop a series of documents to clarify implications of returning to work on government benefits, in particular Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs.
- 30.2** Educate older adults with HIV and their providers about the positive health impact and value of meaningful engagement in occupation, including work, volunteer opportunities, mentoring and other venues to share skills and wisdom to facilitate expression of generativity.
- 30.3** Adapt existing High Impact Prevention Evidence-based peer interventions such as Community PROMISE for older adult target populations.

Older Adults Living with HIV in New York State (Excluding NYC) by County of Residence

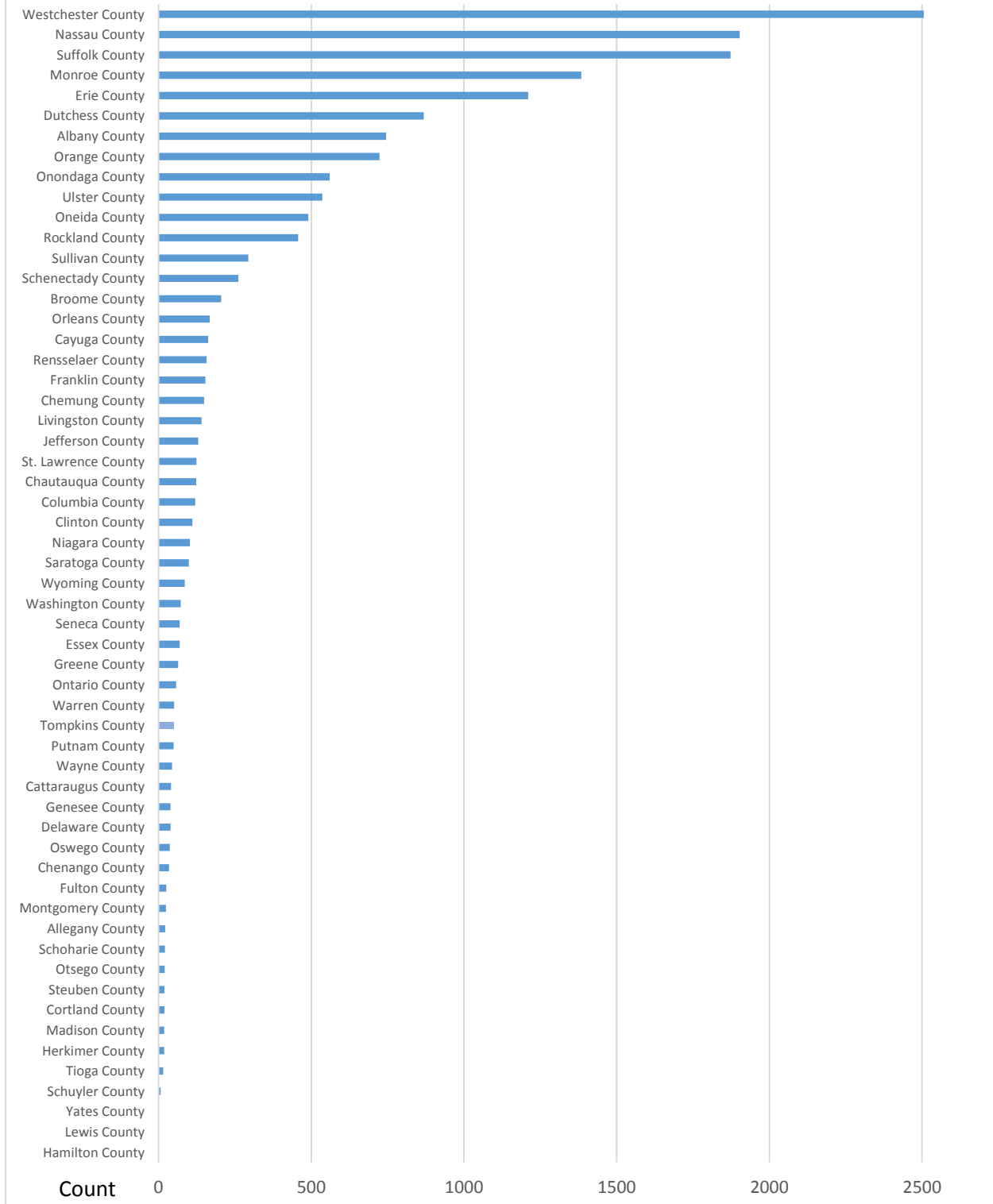


Figure 1 Based on CDC Data from AIDS-VU[100]

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