Caring for people aging with HIV (PAWH)
Building Equity: Intervening Together in Health

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2022

NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Disclosures

Presenters Peter Maugeri, Damaris Rodríguez, Johanna Hernández, and Mila González have no relevant financial interests to disclose.

Susan Olender receives grant and/or research support from Gilead Sciences (Tracking # ISR-17-10169).

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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Describe current challenges when caring for PAWH
2. Consider strategies to develop customized care intervention for older adults (50+)
3. Recognize common barriers to client engagement in wellness interventions including virtual and IT-based programming

The population with HIV will grow older and older

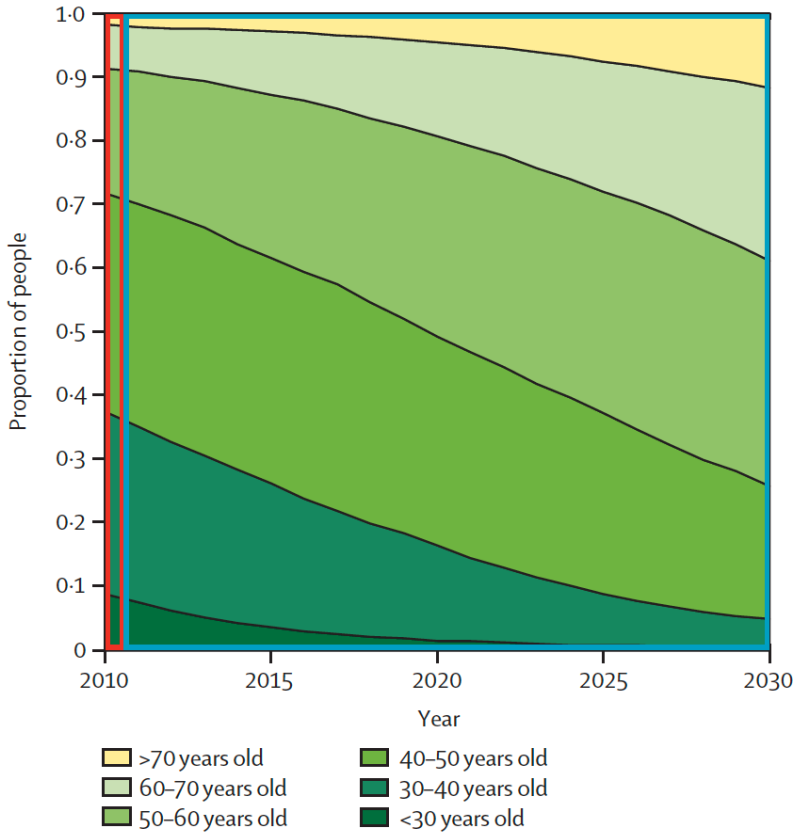


Figure 1. Smit et al. *Lancet ID* 2015.
http://dx.doi.org/10.1016/S1473-3099(15)00056-0

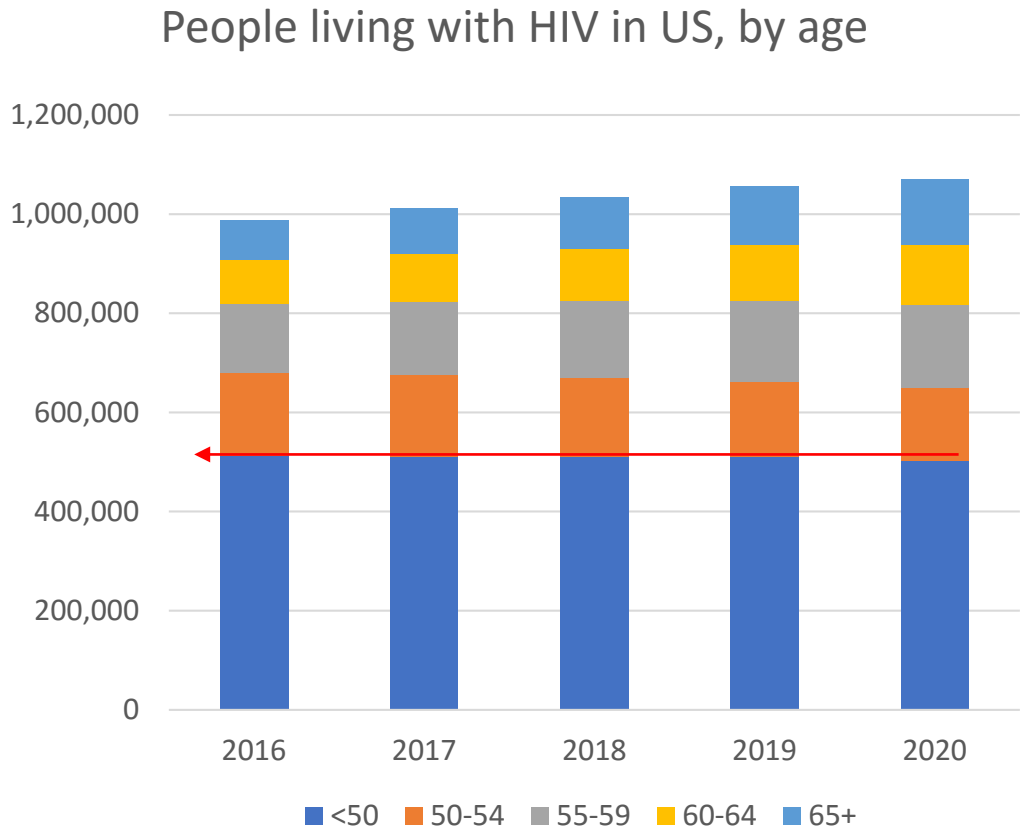
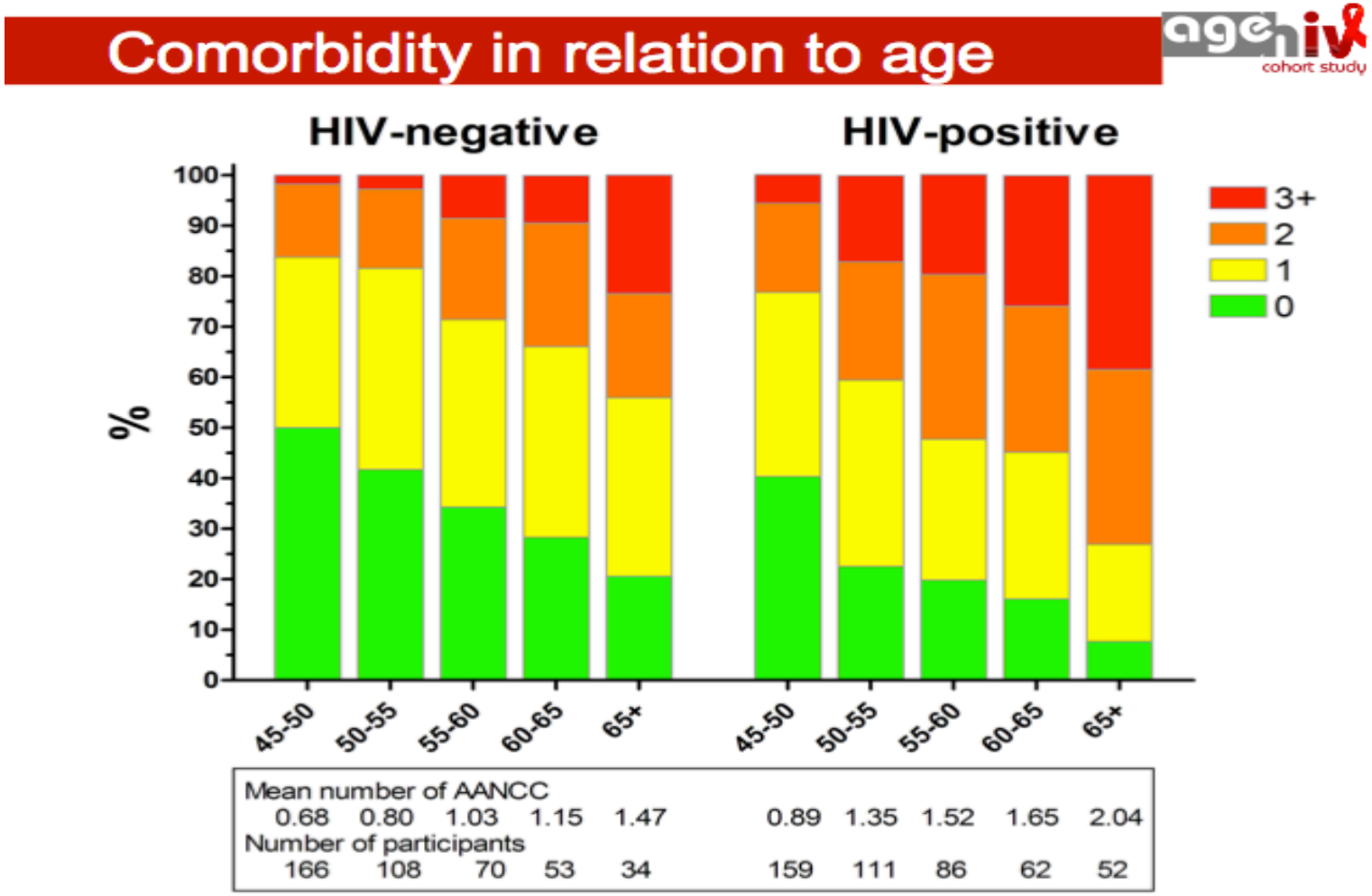


Figure 2. CDC. *HIV Surveillance Reports*.
http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

Credit: Dr. Genie Siegler CHP presentation 10/1/21.

Over half of HIV population in U.S. is 50+, and have more age-associated comorbidities



- Cardiovascular disease (HTN, MI)
- Peripheral arterial disease
- Impaired renal function

Figure 3. Schouten et al. *CID* 2014. https://doi.org/10.1093/cid/ciu701

Credit: Dr. Genie Siegler CHP presentation 10/1/21.

HIV is highly prevalent in older people throughout NYC

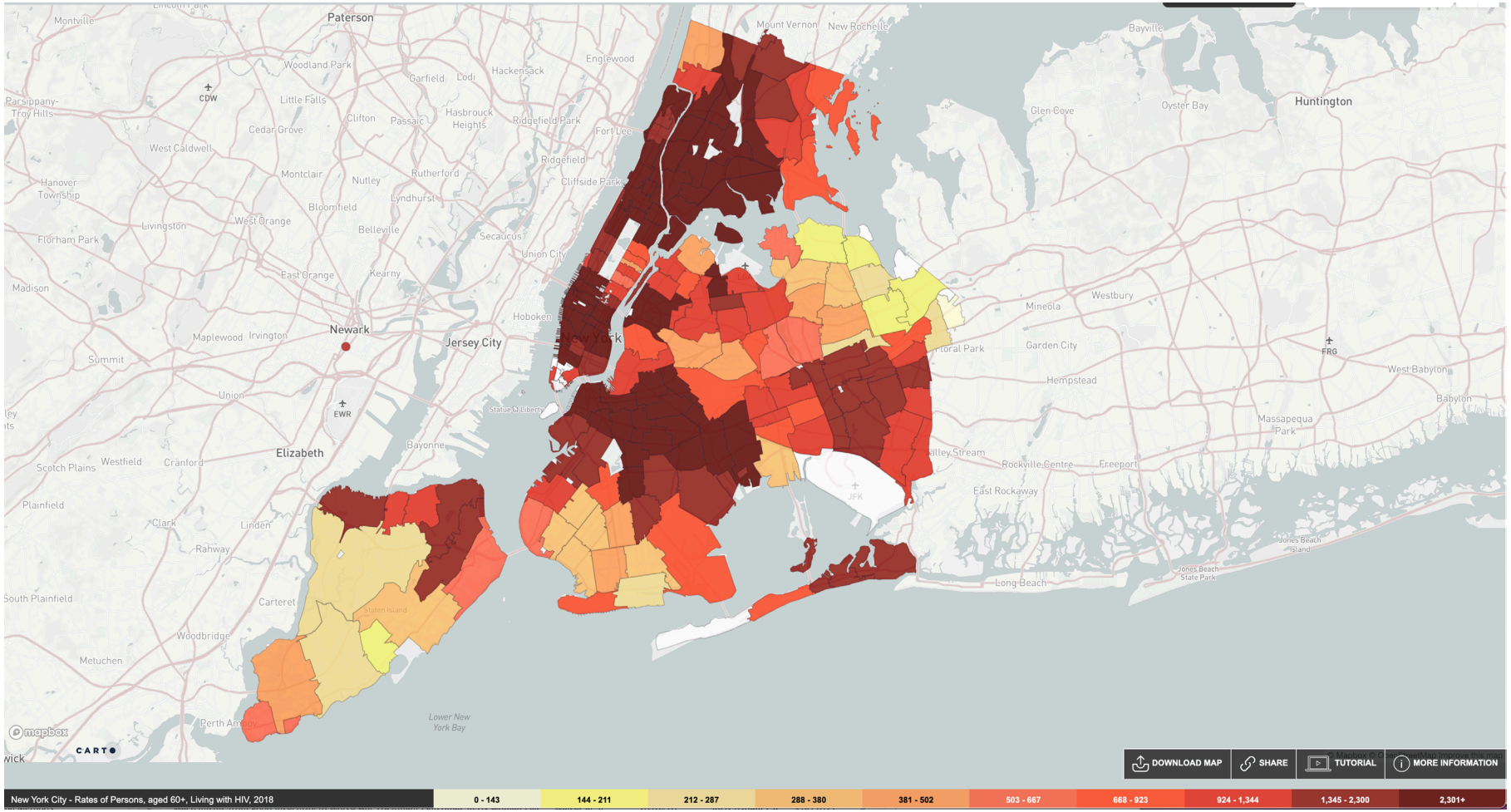


Figure 4. https://map.aidsvu.org/map

Credit: Dr. Genie Siegler CHP presentation 10/1/21.

Percentage of new HIV diagnoses with AIDS highest among 60+

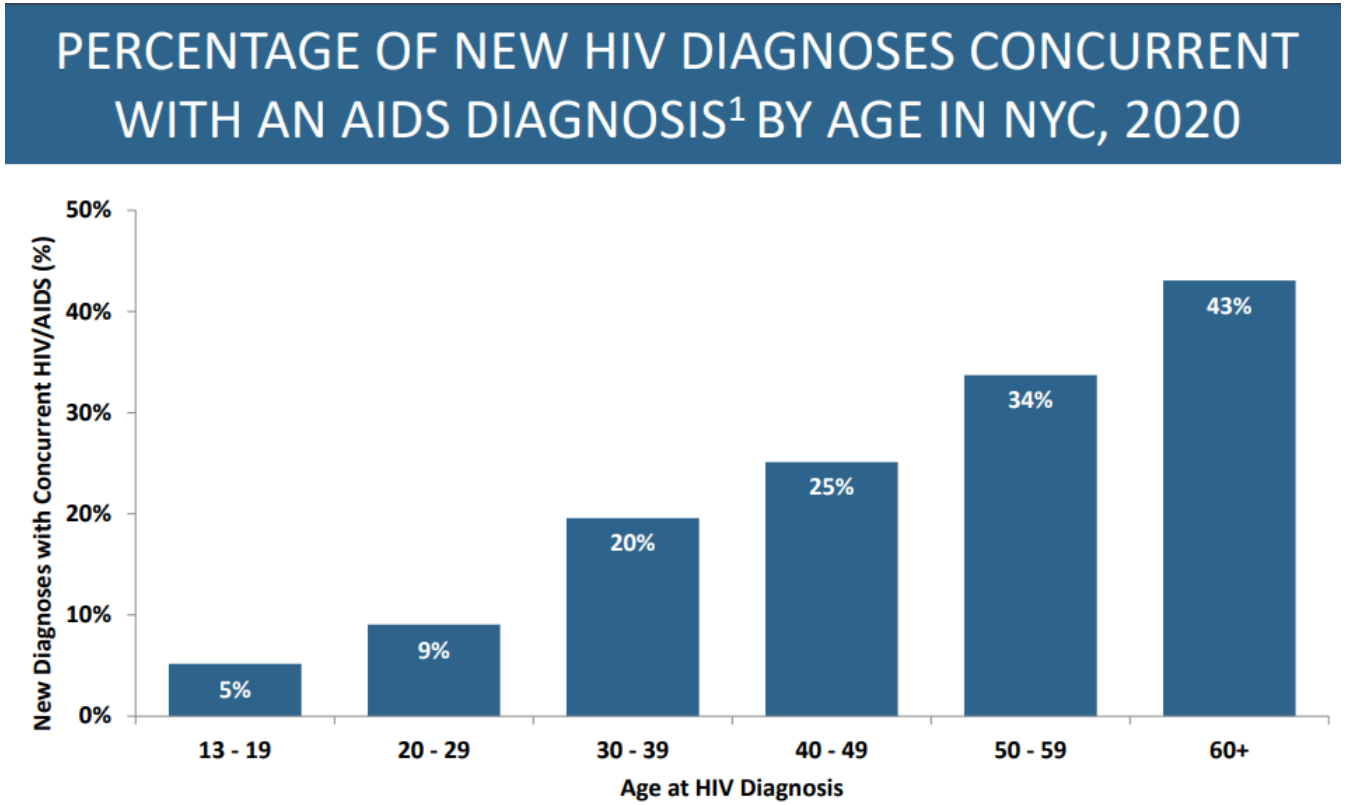
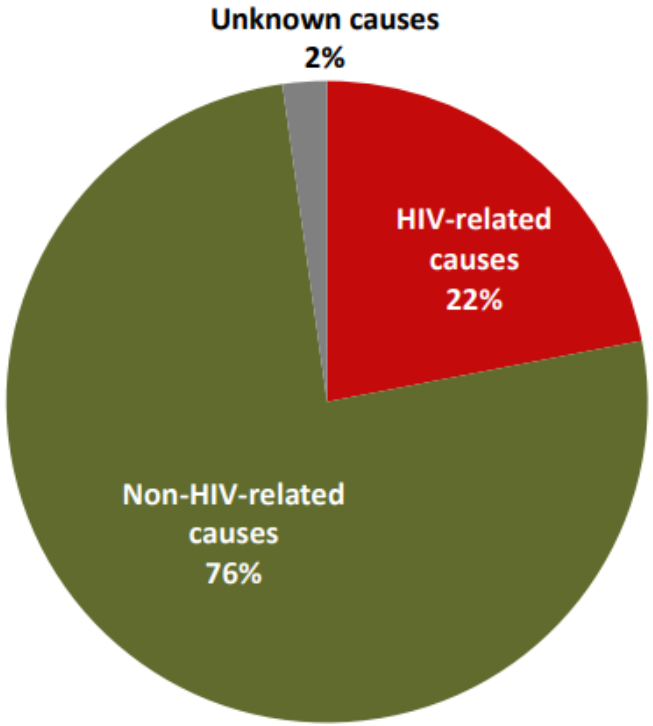


Figure 5. NYC Department of Health & Mental Hygiene. HIV Annual Report. 2020.

Credit: Dr. Genie Siegler CHP presentation 10/1/21.

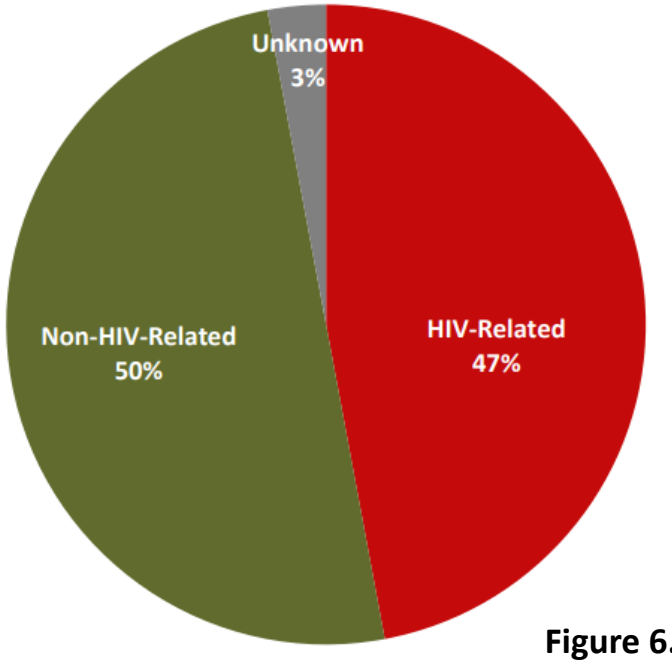
Causes of Death in PLWH in NYC

>50 years old



- 29% Cardiovascular
- 26% non-HIV malignancies

13-29 years old



- 33% accidents

Figure 6. NYC Department of Health & Mental Hygiene. HIV Annual Report. 2020.

Credit: Dr. Genie Siegler CHP presentation 10/1/21.

Caring for PAWH presents numerous challenges at the program level

- Large proportion of clients 50+
- Substantial early multimorbidity
- Older adults with late diagnoses
- Psychiatric disorders and substance use common
- Cumulative SDOH barriers to care engagement (syndemic)
- Individuals often relatively isolated, limited ‘social capital’
- Decreased capacity to utilize digital health services

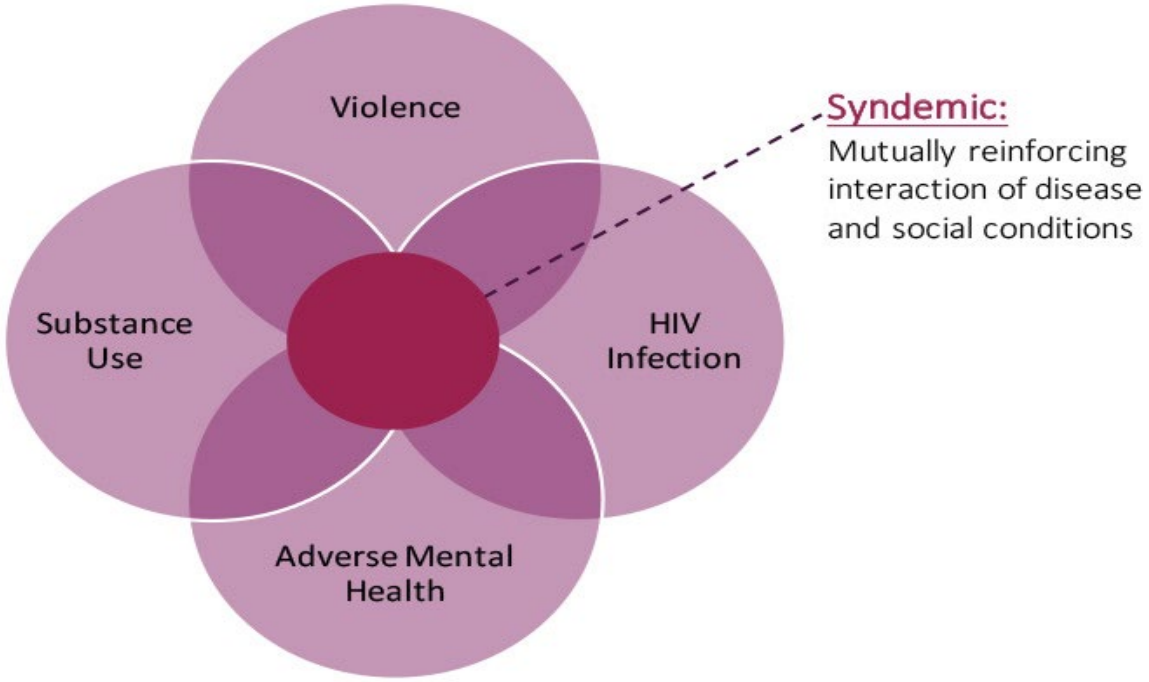


Figure 7 . STRIVE Research Lab University of California San Diego.

Credit: Dr. Genie Siegler CHP presentation 10/1/21.

Building Equity: Intervening Together for Health (BITH) Project

New-York Presbyterian Hospital/Comprehensive Health Program (CHP) Model of Care Delivery for PAWH

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

- In 2021, NYP/Columbia served **3,389 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 143 were new to CHP**
- Between 2015-2018, CHP underwent practice redesign to optimize HIV care delivery
  - **Team-based care**
  - Use of HIT for **data-driven panel management**
  - Enhancements to **care coordination**, **same day services (walk-in)**
  - Expanded capacity **for onsite behavioral health**

Figure 8. Upper Manhattan Map.

CHP Patient Demographics

- In 2020/21, 59% gender male, 32% female, and 1% trans experience
- High proportion of patients identify as Hispanic or Black (47% vs 46%)
- Among PAWH, 34% report Spanish as their preferred language
- Almost all patients are publically insured (Medicaid, Medicare, or dual) of which 9% have ADAP
- 5% of patients experienced some housing instability including homelessness
- High rates of severe mental illness and depression/anxiety

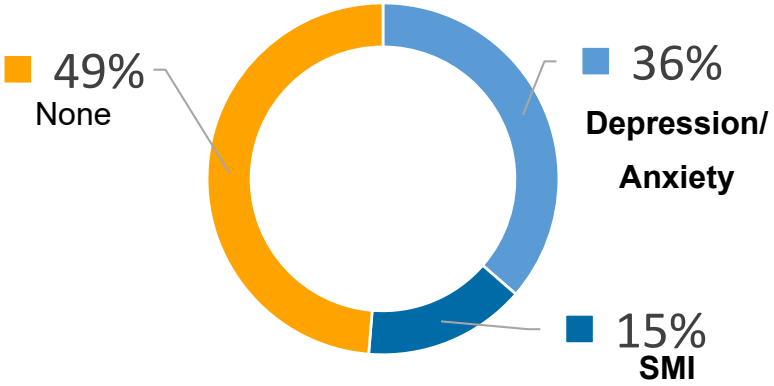


Figure 9. CHP mental health burden among patients living with HIV in 2020.

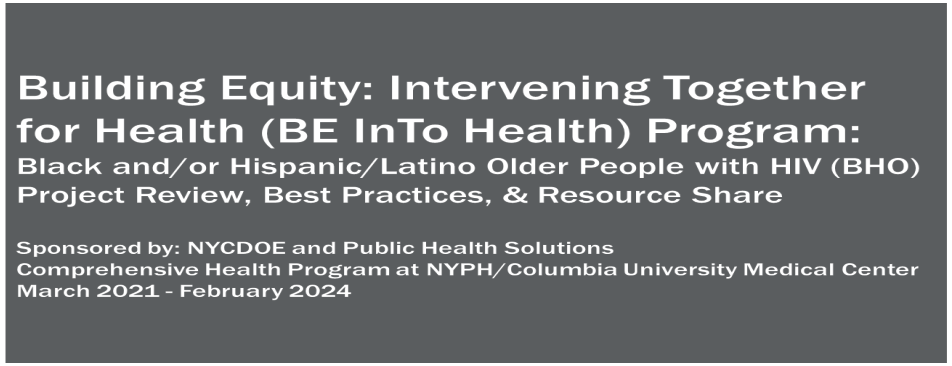
CHP PAWH Service Needs Before Project Implementation

- High rates of comorbidities including substance use and psychiatric disorders especially among virally unsuppressed
- Common musculoskeletal disorders affecting function and QoL including: osteoporosis, fractures, OA, DJD, deconditioning, chronic pain
- Pervasive polypharmacy
- Lack of full integration of care, specialty silos

CHP PAWH Service Needs Before Project Implementation

- 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

NYCDOH BE InTo Health Project RFP, 2020 (EHE)



3-Funded Sites:

- SUNY Downstate STAR Health Clinic (Tonya Taylor, PI)
- Sunset Park Health Council (Migdalia Vientos, PI)
- NewYork-Presbyterian Hospital CHP Clinic (Susan Olender, PI)

The objectives of the BE InTo Health BHO project are to:

1. Increase percentage of enrolled Black and/or Hispanic/Latino (H/L) OPWH linked to medical care;
2. Increase percentage of enrolled Black and/or H/L OPWH, newly and previously diagnosed, who are engaged in care;
3. Increase percentage of enrolled Black and/or H/L OPWH re-engaged in care;
4. Increase percentage of enrolled Black and/or H/L OPWH who are retained in care;
5. Increase percentage of enrolled Black and/or H/L OPWH who are virally suppressed;
6. Increase **screening of common aging-related healthcare needs** among enrolled Black and/or H/L OPWH;
7. Increase **successful referrals** to address enrolled Black and/or H/L OPWH-specific needs;
8. **Decrease rates of depressive symptoms** among enrolled Black and/or H/L OPWH;
9. **Increase in quality of life** among enrolled Black and/or H/L OPWH;
10. **Increase physical and social activities** among enrolled Black and/or H/L OPWH;
11. Increase capacity of clinic to improve HIV care continuum outcomes among enrolled Black and/or H/L OPWH.

UCSF Evidence-informed Model: The Golden Compass Program

Comprehensive care for people with HIV ages 50 years or older framed around the 4 points of a compass:

1. *Heart and Mind (Northern Point):* on-site cardiology, cognitive evaluations, and brain health classes
2. *Bones and Strength (Eastern Point):* focus on bone health, fitness, and physical function through exercise and on-site geriatric consultations
3. *Dental, Hearing, and Vision (Western Point):* ensure appropriate screens and linkage to dental, audiology, and optometric/ophthalmology services; and
4. *Networking and Navigation (South Point)* focus on social and community-building activities.

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7385829/

CHP BITH Project Target Population

Enroll at least 75 clients who identify as Black and/or Hispanic/Latino (ages 50 and older) and are:

- newly diagnosed with HIV, or
- previously diagnosed with HIV and determined to be out of care (i.e., lapse of at least nine months [six months if not virally suppressed] of no HIV medical care visit in a 12-month period), or
- previously diagnosed with HIV and not virally suppressed, or
- previously diagnosed with HIV

In 2021, 52% of CHP patients were 50 years or older

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58-year-old woman with history of CVA and dementia whose sister and daughter are in conflict over her care

75 year-old man undocumented and undomiciled without a phone

68-year-old man, paranoid, isolated, morbidly obese, CAD refusing cardiology, sometimes estranged from his family, conspiracy beliefs

70 year-old man with schizophrenia, recent diagnosis of HIV during admission for PCP, unstably housed, food insecure

86 year-old woman HTN, CVD, CHF, monocular vision, social isolation, with prolonged hospitalization for COVID, deconditioned

80-year-old woman with sciatica receiving steroid injections, develops weakness, falls, and found to have Cushing's syndrome

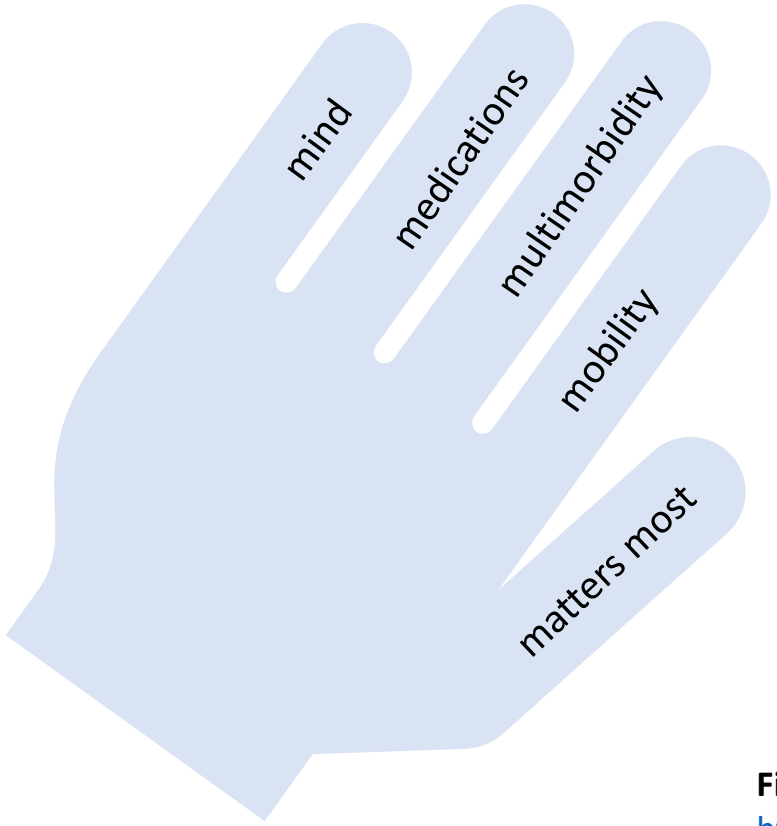
CHP's BITH Project Integrated Care Delivery Model for PAWH

Figure 10. CHP BITH Project Integrated Care Delivery Model for PAWH.

CHP BITH Project Enhancements

Figure 11. CHP BITH Project Enhancements for PAWH.

How might a geriatric approach help PAWH?



We concentrate on the 5 Ms

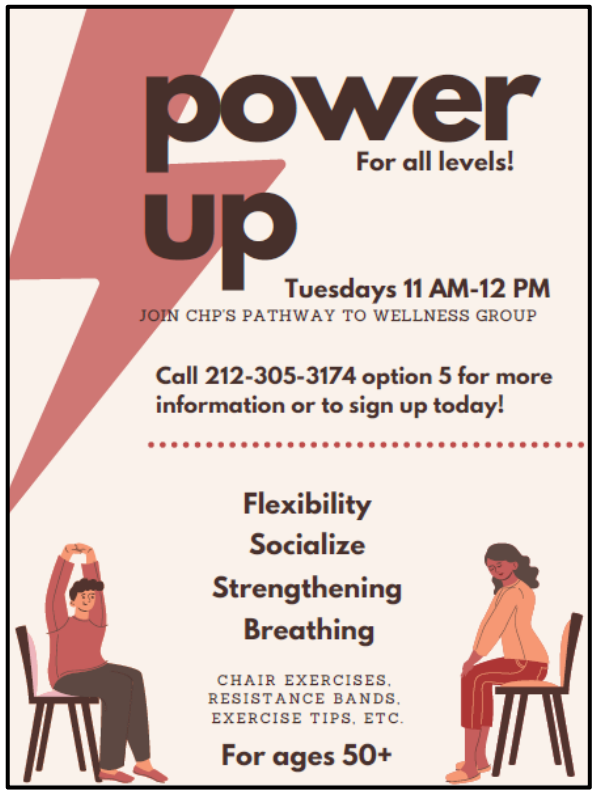
Figure 12. BGS Blog. *Geriatric 5Ms.* https://britishgeriatricssociety.wordpress.com/2017/10/13/the-geriatric-5ms-the-5-simple-words-every-geriatrician-needs-to-know-the-new-mantra/

Dr. Genie Siegler CHP presentation 10/1/21

Path to Enrollment into BITH Wellness Groups

- Any care team member can refer a client to BITH programming
- Black and Latino/Hispanic and 50+ years of age
- Completed universal care coordination assessment *covering 5Ms including medication reconciliation visit with a RN Care Manager*
- Care plan reflects client-centered goals around wellness
- Integration with Health Home Care Management services crucial to support scheduling/engagement in customized interventions

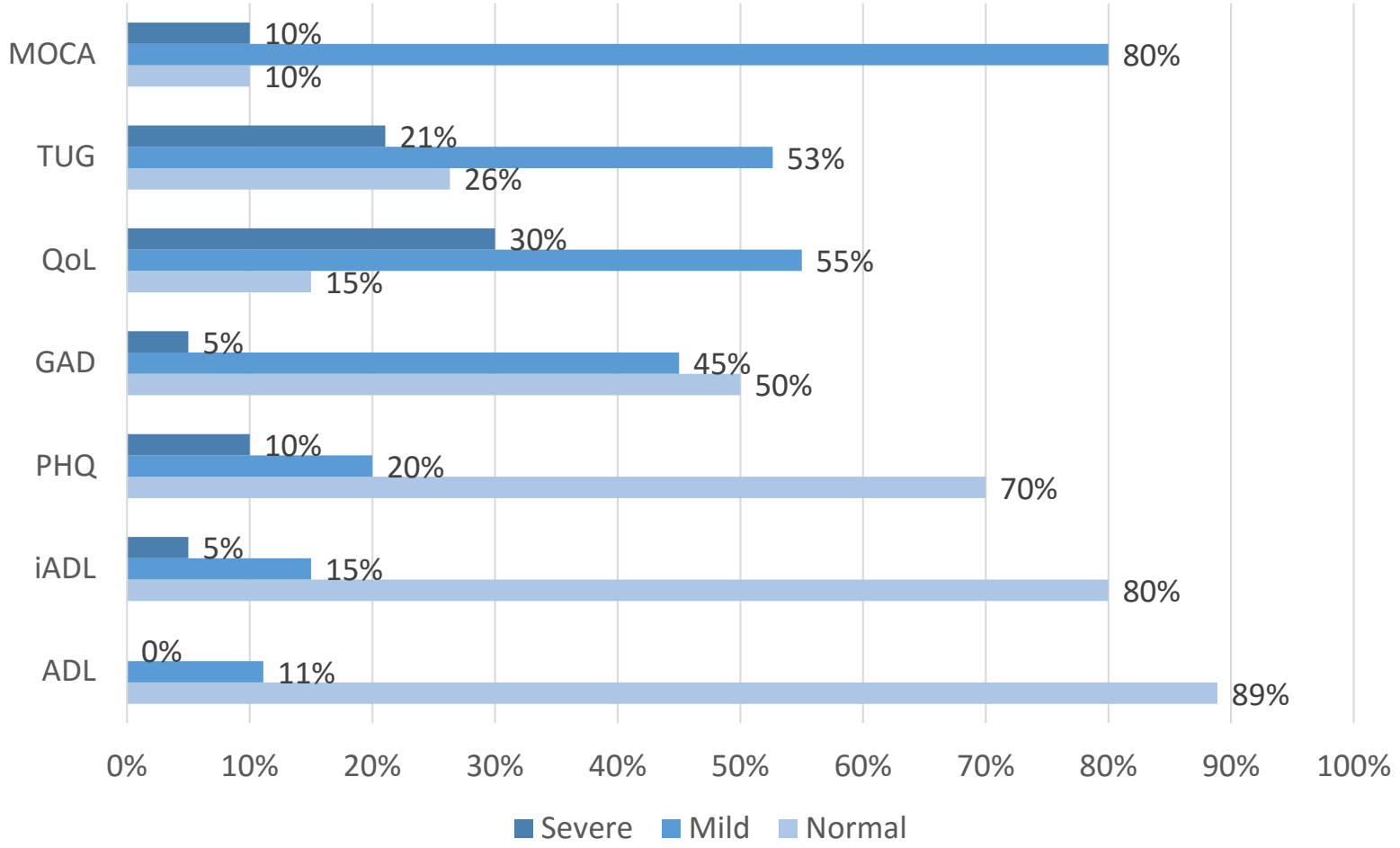
CHP's BITH Wellness Group Flyers



CHP BITH Project Years 1-2

Outcomes and Challenges with Implementation

Year 1-2 Baseline Geriatric Screeners, % by Severity (August 2021-Current)



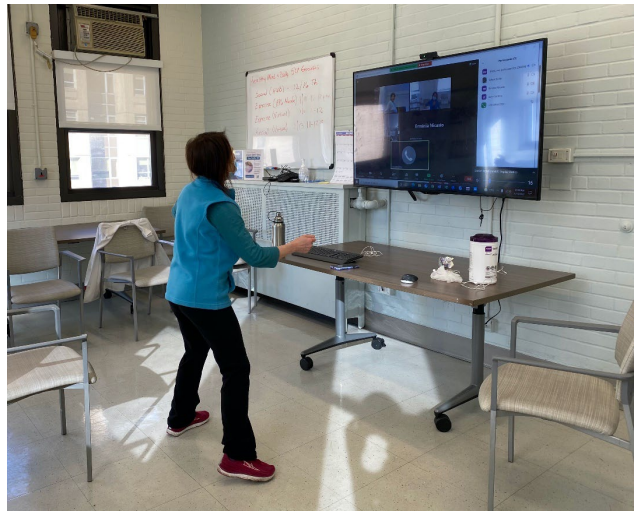
Demographics (BITH Participants)

Demographics	N 43
Current Age (median)	65
Mean Yrs w HIV	25
Gender (%)	-
Male	44%
Female	56%
Race (%)	-
Black	49%
Other	37%
White	12%
Declined	2%
Ethnicity (%)	-
Hispanic	60%
Non-Hispanic	35%
Declined	5%
Risk Factors	-
HC	65%
MSM	16%
MSM/IDU or HC/IDU	5%
Other	14%
VL < 200 (%)	95%
CD4	728
Active Tobacco	16%
Depression or Anxiety History	26%
SMI Diagnosis	30%

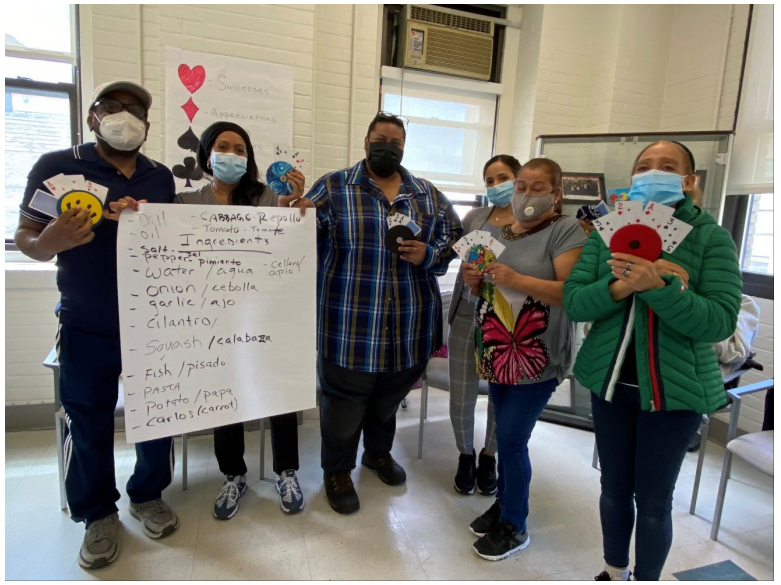
Screeners	Mean	Interpretation
ADL (N=18)	5.7	Independent
iADL (N=20)	7.1	Independent
PHQ (N=20)	4.1	Minimal Depression
GAD (N=20)	5.7	Mild Anxiety
QoL (N=20)	59.5	Health fair or poor
TUG (N=20)	20.1	At Risk for Falling
MOCA (N=20)	19.5	Mild Cognitive Impairment

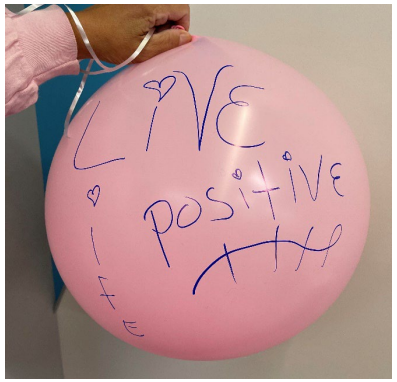
Vaccination Status	N=43
Pfizer 3-dose series	88%
Pfizer 2-dose series	2%
Moderna 3-dose series	7%
No vaccination	2%

CHP BITH Exercise Groups



CHP BITH Social Groups





Meet our Consumer Champions

Juana Rivera, 65 y.o. female
Attending Wellness Groups for 4 months

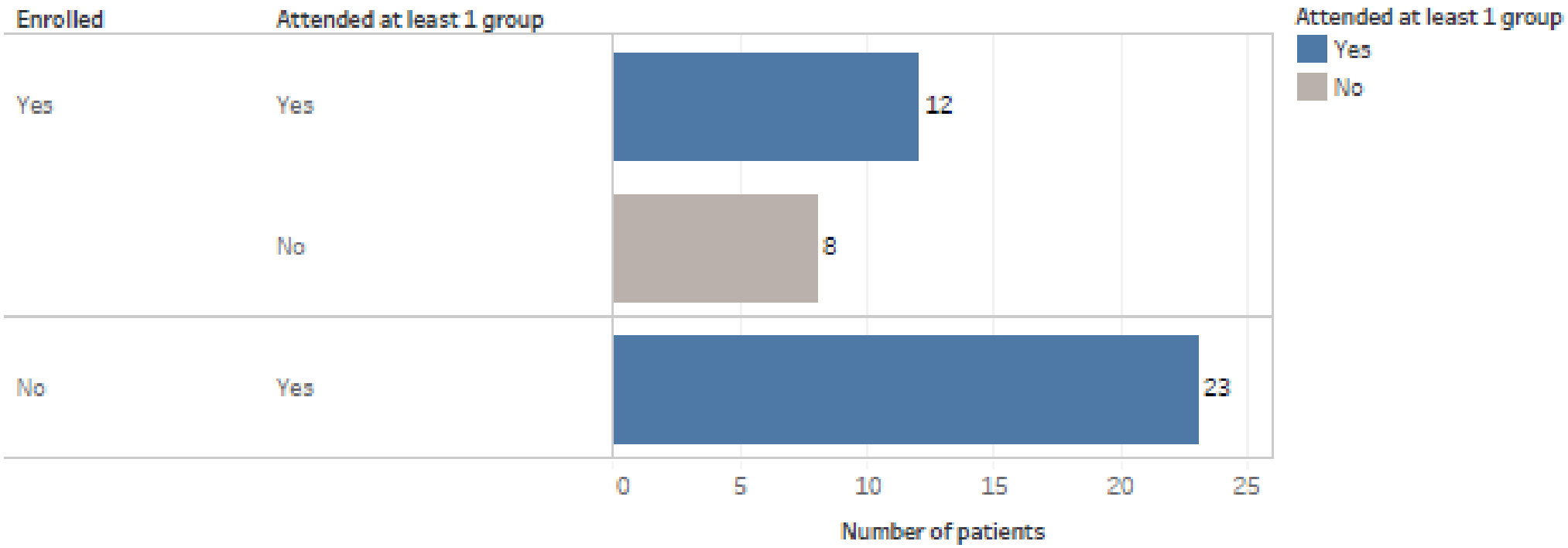
Yanet Tejeda, 55 y.o. female
Attending Wellness Groups for 10 months

Earl Stacy, 61 y.o. male
Attending Wellness Groups for 11 months

What are consumers telling us about our BITH groups?

See transcript on page 40

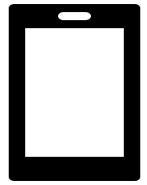
Enrollments versus Engagement (aka BITH Participants)



Client Engagement in Exercise and Social Groups

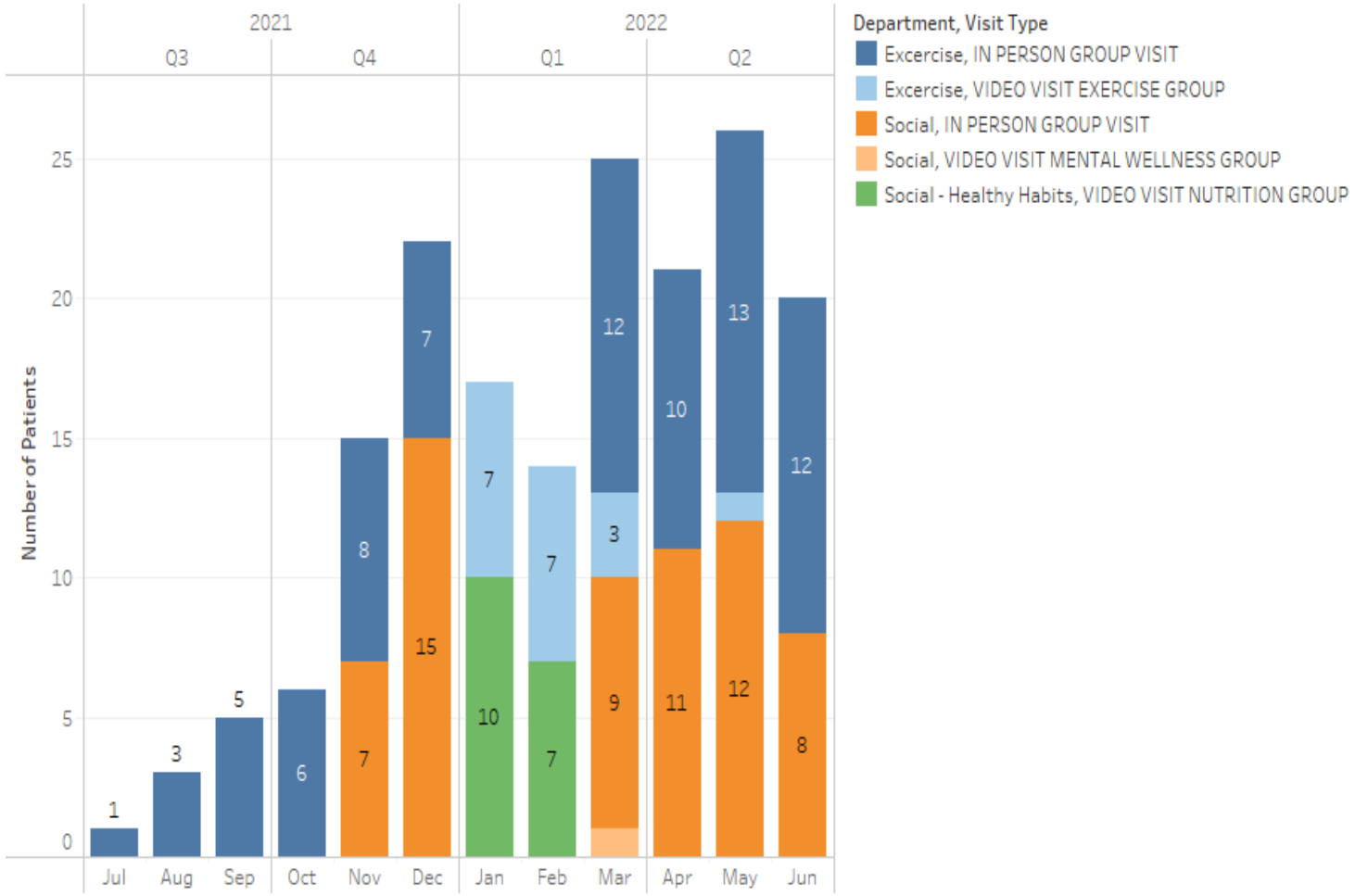
- 93 Group Sessions
  - 35 unique clients engaged

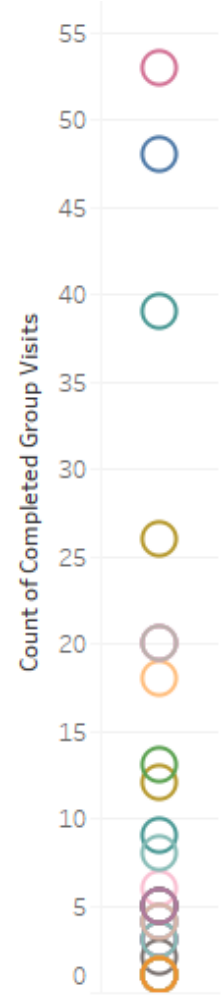
- 19 Telehealth only sessions
  - Average 2-3 participants



- 5 hybrid sessions
  - Average 1-2 participants joining via Telehealth

Number of Distinct BITH Group Participants Engaged per Month





Range Number of Groups Attended: 1-53

Median Number of Groups Attended: 4

BITH Participant Group Feedback Surveys

- Social group events feedback (N=13)

Most Liked Elements

- Exercise group events feedback (N=6)

Most Liked Elements

iPad/Hotspot Loaner Program Development Essentials

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- Organizational review and approval took longer than expected:
  - IT project approval (Oct-Nov 2021)
  - Legal approval of user agreement (Jan-Feb 2022)
- Reconfiguring of existing iPads (15) purchased through a prior grant not in use
- Purchasing of new iPads (85) and hotspots (10) was relatively easy through NYP approved vendor
- Trainings of care coordination staff (12) to be able to run virtual visit simulations with patients
- Since February, only 6 iPads and 2 hotspots have been loaned

Use of iPads and Virtual Groups: Lessons Learned

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Successes

- Client interest in Virtual Groups as an option especially if discussed with their PCP (need to update referral order)
- Exercise aids provided to clients to facilitate engagement virtually (yoga mats and exercise bands)
- Facilitator and co-facilitators are EPIC superusers who are able to support check-in and technical challenges during session
- Expanding use of iPads for storytelling projects and access to wellness resources (i.e. recipes, home exercises)

Challenges

- Validation and testing of Group Video Visits prior to launch
- IT patient iPad set up (October 2021-March 2022)
  - PMO process lengthy for patient iPad security controls which are limiting client access/ configuration to certain features (web surfing)
  - Legal review of consumer agreement for patient iPads
- Not all clients know how to use iPads – we provide onsite training through patient's care coordinators and incorporate technology in social group activities

Barriers & Facilitators

Predisposing	Reinforcing	Enabling
• Medical complexity and opportunity cost • Competing priorities for patients and providers	• Exhaustive screening requirements • Management governance structure • Supervision	• Staffing • Staffing vacancies • Labor peace agreements • Limited Space • Data systems to support reporting requirements and custom monitoring and evaluation plans

Acknowledgements

- **BITH Project Staff and Champions**
  - Peter Maugeri, MSW, Project Lead
  - Damaris Rodríguez, Care Coordinator
  - Johanna Hernández, MPH Care Coordinator
  - Joselyn Cabrera, MEd Program Lead
  - Marilu Zhan, Fitness Specialist
  - Audrey Perez, RN, Clinical Supervisor
  - Stacey Gladstone, RN, Clinical Supervisor
  - Kaile Eison, MD, Physical Medicine & Rehabilitation
  - Kiran Thakur, MD, Neurologist
  - Susan Olender, MD, MS, PI
- **CHP Practice Leadership**
  - Peter Gordon, MD, Medical Director
  - Maria Espinal, MPH, Practice Administrator
  - Iris Gutierrez, LCSW, Administrator and Manager for Behavioral Health
- **Quality/Data Team**
  - Sara Lewittes, Data coordinator
  - Kelley Lou, MPH, Data coordinator
  - James Beltran, Data coordinator
  - Mila González, MPH, Manager
- **BITH Participants**

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Transcript for video on page

Juana Rivera (in Spanish): I'm really grateful for my group peers because we have made beautiful friendships and we learn a lot of things.

Yanet Tejeda (in Spanish): "Bueno" I've liked the group a lot because I've improved quite a lot. it has given me the opportunity to meet a lot of people and we have made friendships and this way I've made it a habit to come to the exercise groups since I don't do them at home, and I've felt really good.

[Upbeat music and cheering].

Earl Stacy (in English): I love the social group—it's so much fun. I like the exercise very much. And the Tai Chi, when Mary Lou introduced the Tai Chi, I immediately volunteered to participate because I've seen it in Chinatown, but I never really understood it.

And now I have a better understanding of what it feels like to participate in something that was foreign to me.

So it's motivated me to be more physically active.

I like the resistance bands. I had never done them before, but I've seen them before, and now I even do them at home when I'm watching the news.

And I like participating in the groups with the people.

I learned to play dominoes, which I never knew how to play, but I always saw people playing it on the street. It's been a very interesting experience.

[In Spanish] And I practice my Spanish with my friends!

[Laughing and cheering as Earl continues] and I can do the twist!