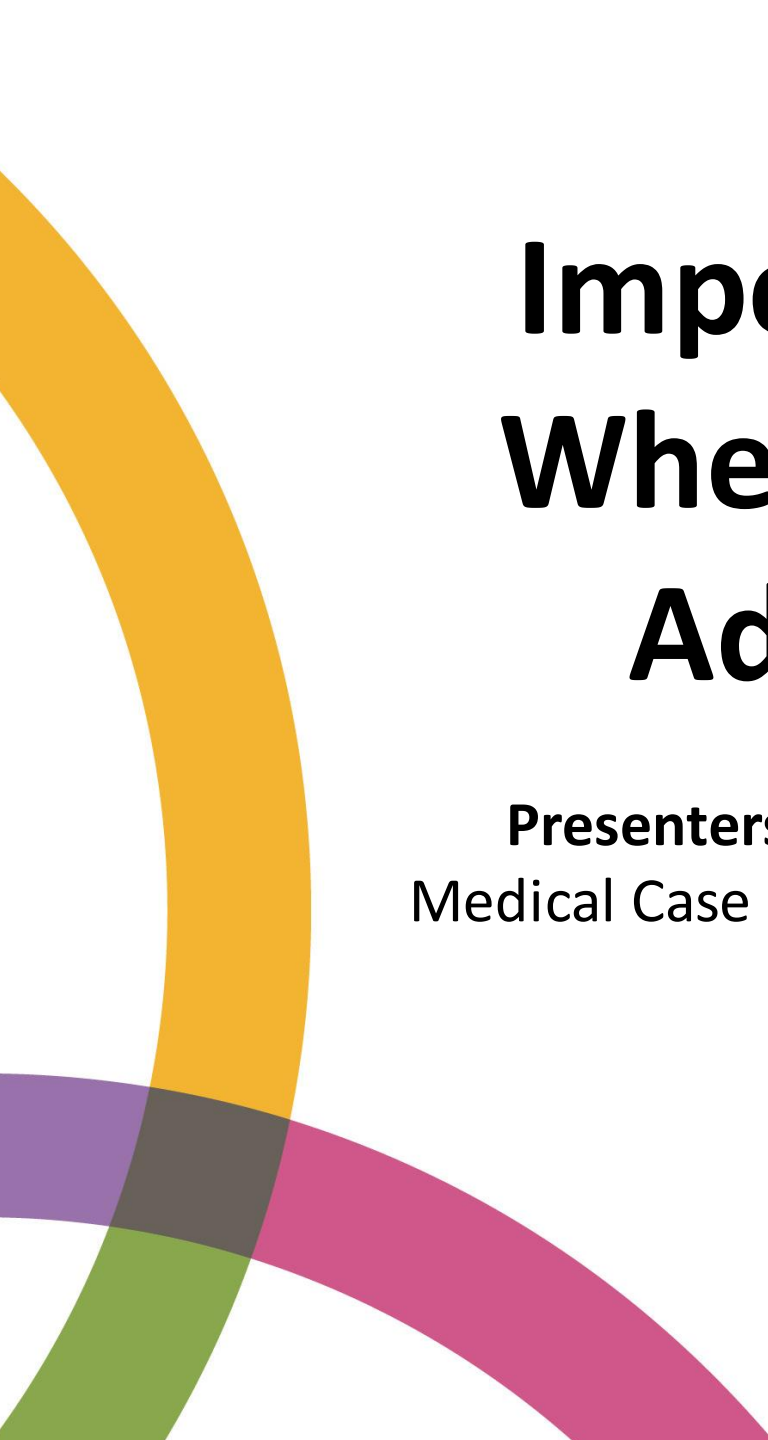




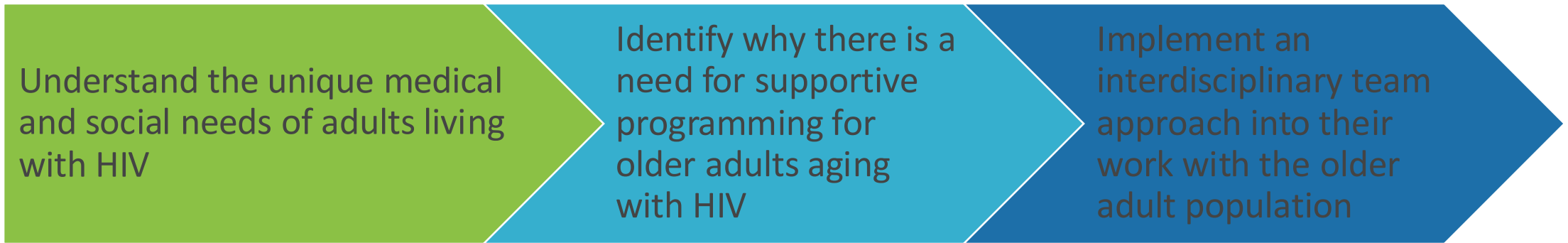
Important Considerations When Working with Older Adults Aging with HIV

Presenters: Zoe Gaby-Smith, MSW and Jennifer Gough, RN
Medical Case Manager and Nurse for the PAWH Program at Trillium
Health Inc.

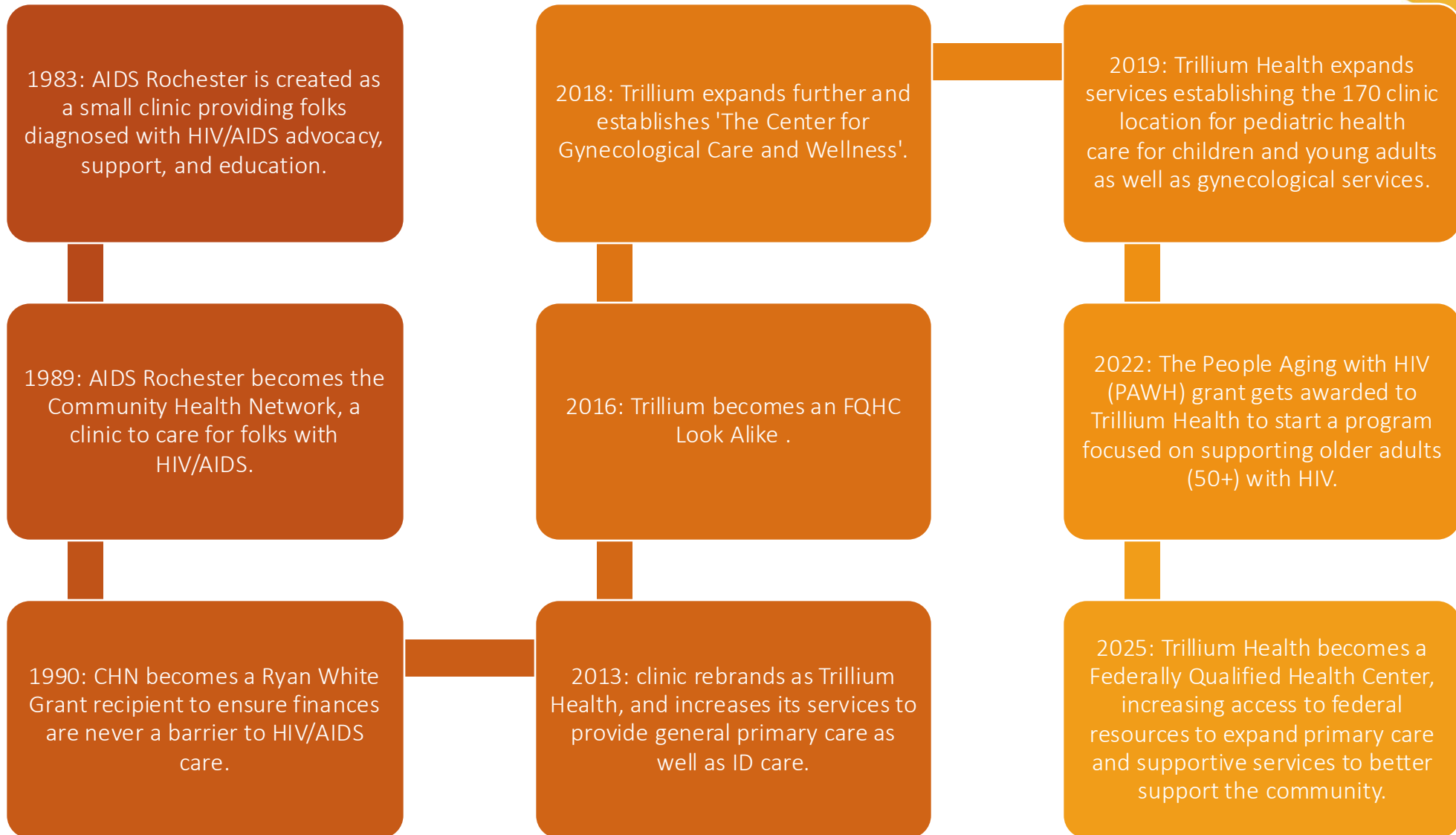
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Key Objectives

At the end of this presentation, participants will be able to....



Trillium Health



Why are we talking about Aging with HIV?

- Over 50% of individuals living with HIV in America are now over the age of 50.
- As of the end of 2024, 56% of individuals with HIV in New York State alone were over 50.
- Studies have shown that HIV can cause individuals to medically age faster than individuals without HIV.
- HIV can cause adults to have a greater risk of health-related issues, regardless of viral-load suppression, such as:
 - Multiple comorbidities
 - Polypharmacy
 - Depression
 - Frailty
 - Cognitive decline
- Research has also suggested older adults living with HIV can have increased psychosocial needs, which can impact overall health and wellbeing.

Historical and Social Impact on Long-Term Survivors

- The stigma that came out of the AIDS crisis has had a lasting effect on many long-term survivors.
- General stigma around HIV can intersect with stigma surrounding age, sexuality, etc.
- Stigma around diagnosis, sexual orientation, substance use, etc. can exacerbate mental health challenges, and can become a barrier to adults seeking appropriate care.
- The NYS DOH found that in 2021 only 15% of long-term survivors with HIV have a partner or a spouse, and 70% of older adults with HIV are living alone.
- The NYS DOH also found that only 50% of long-term survivors living with HIV have friends who know about their diagnosis.
- Social support (family/friends/community) can be integral to navigating all aspects of the aging process. When these supports are not in-place, it can make this process increasingly more difficult to navigate.

Creation of the PAWH/ARCH Grant

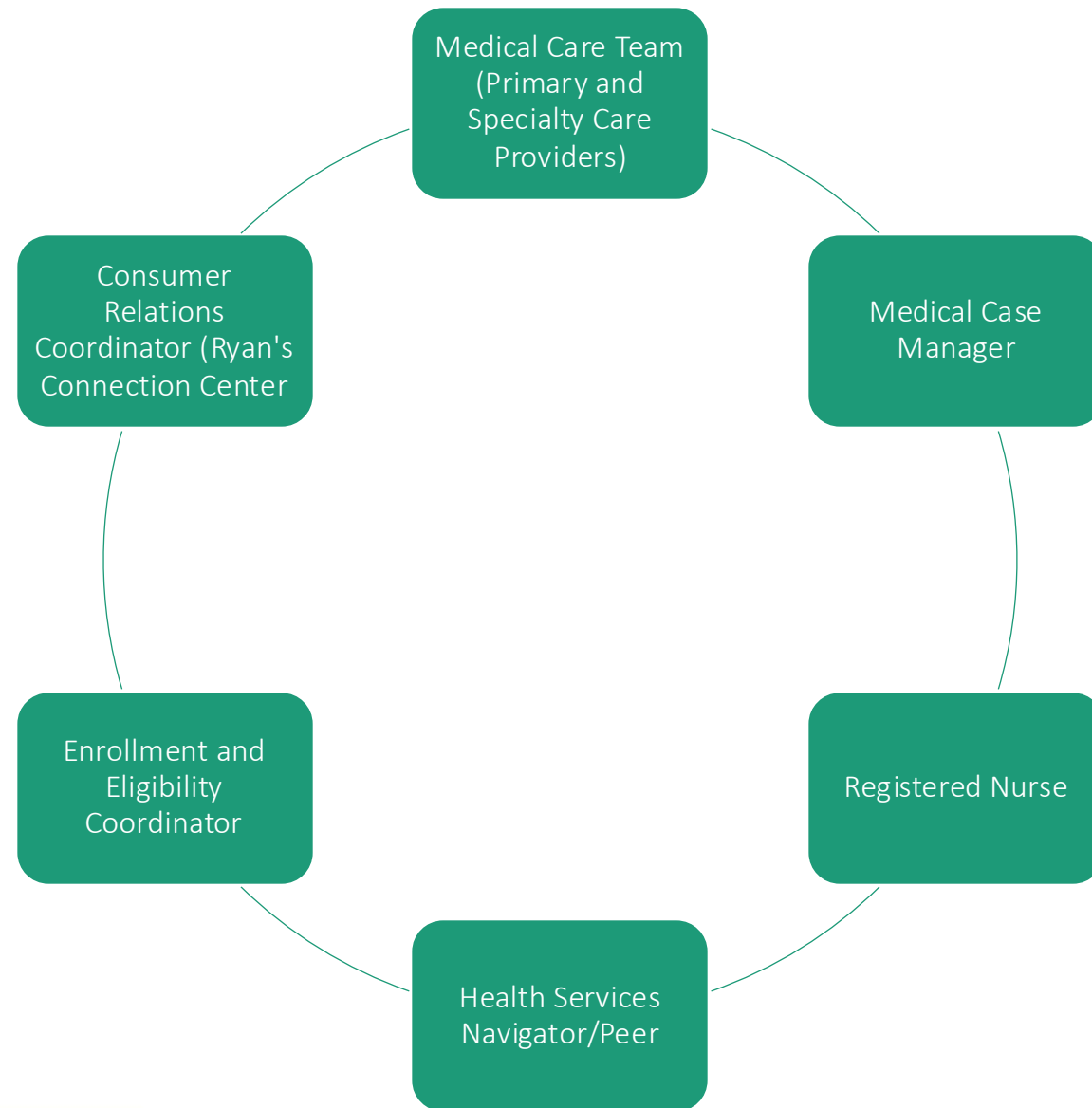
- In 2022, The New York State Department of Health AIDS Institute announced the start of a new grant-funded pilot program designed to address the unique needs of older adults aging with HIV. This program was named the PAWH (People Aging with HIV) program, and was designed to run for five years.
- PAWH provides funding for an interdisciplinary support team including: case management; health education; psychosocial support services; insurance navigation; cognitive, physical, and behavioral screening services; and peer support.
- The PAWH grant was developed to fund 10 sites across New York State in providing tailored healthcare and supportive services to this community.
- **Evergreen Health, local to Buffalo, is also one of the NYS locations participating in the PAWH pilot program!**



The Development of the ARCH Program at Trillium Health

- After soliciting consumer feedback on the title of this program, the PAWH program at Trillium was renamed to ARCH: Age Related Changes with HIV.
- The team, comprised of: Enrollment and Eligibility Specialist (insurance navigator), Registered Nurse, geriatric medical case manager(s), and a Health Services Navigator(s)(peer), collaborate with the provider on all aspects of a client's medical and social health needs.
- Using this multidisciplinary approach the ARCH team works together with the client in the driver's seat to help them navigate the various complexities of aging.

Interdisciplinary Team:



Case Study 1

The Importance of an Interdisciplinary Approach

- An older adult client with a physical disability presented to clinic for their routine appointment with their primary provider.
- The ARCH Case Manager (CM) and ARCH Health Services Navigator (HSN) greeted client in the waiting room, and escorted them to the exam room. HSN stayed with client for support while Medical Assistant (MA) reviewed vitals in preparation for provider to see client.
- MA approached ARCH CM and ARCH RN to inform them that client's blood pressure was concerningly high. ARCH RN reviewed and communicated this information to clients provider (ID and PCP), while CM went in to discuss this with client.
- Through an open and judgement free discussion client reported to CM and HSN that they have not been taking their blood pressure medication because it increases their need to urinate throughout the night. As they live alone, they have no one to help them get to the restroom outside of their home health aide's hours.

Case Study 1 Continued...

- Team jointly communicated concern that client was putting their health at risk due to not having the ADL care they need at home.
- ARCH CM and ARCH RN developed a plan with client to assist them in appealing their insurance company's denial for their hours to be increased.
- While ARCH CM reviewed insurance paperwork and appeal process with client, ARCH RN updated the provider. ARCH RN informed provider of the insurance appeal process and what medical documentation will be needed in order to submit appeal.
- Provider met with client and their ARCH care team. Provider was in agreement that client needed increased home health aide hours to maximize their safety at home.
- ARCH RN helped provider organize necessary documentation, and client left this appointment with clarity and everything necessary for an appeal.

Case Study 2

Stigma and Mental Health

- During a routine infectious disease appointment, an older adult patient opened up to provider about their anxiety regarding their upcoming gallbladder removal surgery.
- Patient reported that their HIV diagnosis has caused tension between them and their adult children, and they do not feel comfortable asking their family for help.
- Concerned for client's lack of social and medical support, provider urgently referred this client to the ARCH program for case management and nursing support.
- The Enrollment and Eligibility Coordinator (EEC) met with client while client was on-site to discuss client's needs and start the ARCH intake/initial assessment process.
- Given the patient's complex psychosocial needs, and immense anxiety regarding the procedure, coordinator alerted the ARCH HSN (peer), so they could meet with patient to provide support and reassurance.
- HSN was able to meet with EEC and patient during this appointment. HSN determined that patient may benefit from HSN/peer support and invited patient to attend the Long-Term Survivors (LTS) Group in Ryan's Connection Center for group programming.
- Patient attended LTS group and reported feeling much less anxious and stressed compared to when they first came in to see their doctor earlier in the day.
- The following day the Enrollment Coordinator informed ARCH CM and ARCH RN that they were referring a new client to ARCH for nursing/medical case management support.

Case Study 2 Continued

- ARCH team met with client in the clinic to discuss their current needs and how team can best support them. HSN, who client has built rapport with, was also present for increased psychosocial support.
- Client shared their anxieties around their upcoming procedure with the ARCH team. Client shared concern with Medicaid transportation not presenting as scheduled and that they will have anyone to help them at home, as they feel tension with their identified support system when asking for help, causing avoidance in doing so.
- The ARCH and medical team collaborated with client on a plan for their surgery, and reassured client that they will be there every step of the way to support.
- ARCH CM coordinated reliable transportation to transport client to surgery. ARCH RN met with client following surgery, to ensure client understood their post-op instructions, escorted client home and assisted client with getting settled at home and with organizing newly prescribed medications.
- ARCH CM arranged for client to receive food from the Trillium food pantry so they do not have to go grocery shopping while recovering. HSN (peer) delivered food to client the day after surgery to provide another in-person check-in and any other emotional support that is needed following procedure.
- Due to the team working closely together to support client with all their needs regarding this procedure, client (who previously would not engage in case management due to stigma) came to trust care team and now engages actively in ARCH program for HSN, CM and RN support.

Case Study 3

Social Isolation: The Legacy of the AIDS Crisis

- During a routine visit, client was referred to ARCH following provider concerns and identified SDOH needs.
- Client is a long-term survivor, with an AIDS diagnosis and HIV-associated Neurocognitive Disorder resulting in forgetfulness with medical appointments, medication refills and adherence.
- Client came to the ARCH program with trauma associated with living through the AIDS crisis and a lack of external support as clients partner of 20 years passed away. Client has local family support whom occasionally assist with appointment coordination and finances, but due to client valuing their independence, often reports tension with this relationship.
- Client frequently reflects on the pain of losing so many friends and romantic partners throughout the AIDS crisis and afterwards. While this client has some family, they have only a few close friends that understand life after an HIV diagnosis.
- Since enrolling in ARCH, clients ARCH CM provides assistance with medical care coordination, thus relieving some of the tension with his niece. The ARCH RN provides weekly check-in's to assess clients functional status at home, and the ARCH HSN (peer) provides an invaluable listening ear as someone who understands the impact an HIV diagnosis can have. Leading this client to have improved medical outcomes and feeling supported.

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Contact Information

Zoe Gaby-Smith

- Zgabysmith@trilliumhealth.org

Jennifer Gough

- Jgough@trilliumhealth.org