A Geriatrician’s Approach To Aging With HIV

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October 5, 2019

http://agrayingpandemic.org

FIGURE 1.1: History of the HIV epidemic, NYC 1981-2016

HIV Surveillance Annual Report 2016 NYCDHMH
Disclosures

• I will be a consultant to Montefiore Medical Center, which has a grant from Gilead Sciences to develop an HIV and Aging program.

• In the recent past I have had support through an approved investigator-initiated research grant from Gilead Sciences.
Objectives

- Learn the domains of geriatrics and why they might apply to your patients
- Understand different models of care and barriers to creating clinical programs for OPH
- Recognize the challenge of applying geriatric principles to diverse needs of OPH
Stop and look at your patient

Is my patient thinking about aging?

Is my patient old?

Does my patient feel old?

What are my patient’s needs?

https://www.istockphoto.com/search/more-like-this/525198039?mediatype=illustration&sort=mostpopular
HIV and comorbidities are not your patients’ only concerns

Aging-related (geriatric) syndromes

Clinical conditions in older persons “that do not fit into discrete disease categories”

Aging-related syndromes differ from traditional ones

- **Traditional**
  - Example: AIDS (1983)
  - Rare
  - Unknown but specific cause
  - Multiple manifestations

- **Aging-related**
  - Example: Frailty
  - Common
  - Multiple causes
  - Defined but cross-disciplinary presentation

Frailty increases mortality risk in synergy with HIV

Piggott et al, 2013 PLOS ONE doi:10.1371/journal.pone.0054910
## OPH have multiple problems

**UCSF Silver Project**

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>50-59 (n=244)</th>
<th>60+ (n=115)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance Problem</strong></td>
<td>37.6%</td>
<td>33.3%</td>
<td>46.9%</td>
</tr>
<tr>
<td><strong>Excellent or vg health</strong></td>
<td>38.3%</td>
<td>42.1%</td>
<td>29.8%</td>
</tr>
<tr>
<td><strong>Poor-fair med adherence</strong></td>
<td>11.2%</td>
<td>14.6%</td>
<td>4.4%</td>
</tr>
<tr>
<td><strong>Slow gait speed (&gt;=6.21 sec for 4m)</strong></td>
<td>8.8%</td>
<td>6.2%</td>
<td>14.2%</td>
</tr>
</tbody>
</table>

- 85% M; 74.8% MSM
- 57.1% W (69.6% in 60+)
- 30.6% current smokers
- Median # meds: 11 (8-15)
- 40.7% had **fallen** in the past year
- 12.2% dependent in \( \geq 1 \) ADL
- 33.7% had **cognitive impairment** (MoCA <26)
- 34.1% were mod-sev **lonely**
- 26.8% were mod-sev **depressed**
- Only half had normal social supports

*John et al., JAIDS DOI: 10.1097/QAI.00000000000001009*
How might a geriatric approach help older people with HIV (OPH)?

We concentrate on the 5 Ms

- mind
- medications
- multimorbidity
- mobility
- matters most

https://britishgeriatricssociety.wordpress.com/2017/10/13/the-geriatric-5ms-the-5-simple-words-every-geriatrician-needs-to-know-the-new-mantra/
Comprehensive geriatric assessment covers the 5 Ms by evaluating multiple domains

- Basic ADL
- Instrumental ADL
- Geriatric syndromes/frailty
- Medical comorbidities
- Nutritional status
- Medication appropriateness

- Social network/financial status
- Living situation/environment
- Affect
- Cognition
- Advance directives
- Quality of life
Which OPH might benefit from CGA, and how should it be done?

Screen in
Age-based opt out
Want to discuss aging
Falls/functional impairment
Cognitive impairment
Multimorbidity
Polypharmacy
Incontinence
Isolated
Other (?)
<table>
<thead>
<tr>
<th>Location</th>
<th>Clinic/name</th>
<th>Resource</th>
<th>Venue</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston (US)</td>
<td>Mass General Hospital/Aging Positively</td>
<td>Fitch</td>
<td>Biweekly in ID clinic</td>
<td>Providers may refer anyone over 50 NP sees patients; develops plan with rest of team</td>
</tr>
<tr>
<td>Brighton (UK)</td>
<td>Brighton and Sussex U Hosp Silver Clinic</td>
<td>Vera</td>
<td>Monthly clinic sessions</td>
<td>Referral criteria: &gt;50, difficulty coping at home, multimorbidity, polypharmacy; HIV MD, geriatrician, HIV Clin NS, Pharm</td>
</tr>
<tr>
<td>Denver (US)</td>
<td>University of Colorado</td>
<td>Erlandson</td>
<td>Outside consultation</td>
<td>Geriatrician, pharmacist see complicated patients 1-3 times – refer back to 1° care</td>
</tr>
<tr>
<td>London (UK)</td>
<td>Chelsea/Westminster</td>
<td>Waters</td>
<td>Separate multidisciplinary clinic</td>
<td>Referral criterion: age Consultant, HIV NP, trainee; supported by specialist pharm and dietician</td>
</tr>
<tr>
<td>Montreal (CA)</td>
<td>McGill</td>
<td>Falutz</td>
<td>In HIV Clinic</td>
<td>Geriatrician sees referrals as needed as needed; planning pharm, CGA for &gt;60</td>
</tr>
<tr>
<td>New York (US)</td>
<td>CSS at WCM/NYPH</td>
<td>Siegler</td>
<td>Geriatrician weekly visit w/in HIV clinic</td>
<td>No fixed referral criteria Geriatrician follows longitudinally Sponsors arts, support groups, inservices</td>
</tr>
<tr>
<td>Salem, VA (US)</td>
<td>SAVI</td>
<td>Oursler</td>
<td>VA clinic</td>
<td>Assess multimorb, sarcopenia, frailty, cognition; Staff: Pharm, neuroψ, RD, endo</td>
</tr>
<tr>
<td>San Francisco (US)</td>
<td>Ward 86/Golden Compass</td>
<td>Greene</td>
<td>Geriatric HIV clinic: pharm, screen, geri consult</td>
<td>Referral &gt;70, falls; “navigation”: heart/ mind; strength/bones; screening/link to dental, vision, etc; SW, CBSS, support groups</td>
</tr>
</tbody>
</table>

Metabolic programs have evolved by expanding from comorbidity to geriatric syndromes

Hoy: Alfred Hospital/Monash University, Melbourne

Lui: Chinese University of Hong Kong

Guaraldi: University of Modena and Reggio Emilia, Modena, Italy

Some developing programs are starting with screening; some grow from cohorts.

<table>
<thead>
<tr>
<th>Location</th>
<th>Director</th>
<th>Program</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barcelona</td>
<td>Negredo</td>
<td>Germans Trias I Pujol University Hospital</td>
<td>Comprehensive geriatric assessment of all patients 60+</td>
</tr>
<tr>
<td>Bronx</td>
<td>Sharma</td>
<td>Center for Positive Living, Montefiore Hosp</td>
<td>Plan to test an integrated model of care</td>
</tr>
<tr>
<td>Cleveland</td>
<td>Kalayjian</td>
<td>Metrohealth VA Hospital</td>
<td>VA: screen for cog impairment, frailty Metrohealth: screen for depression</td>
</tr>
<tr>
<td></td>
<td>Van Epps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durham, NC</td>
<td>McKellar</td>
<td>Duke University</td>
<td>(cohort) to add physical function assess.</td>
</tr>
<tr>
<td>Kampala, Uganda</td>
<td>Castelnuovo</td>
<td>Mulago Hospital</td>
<td>Building simultaneous cohort/geri assessment program</td>
</tr>
<tr>
<td>Mexico City</td>
<td>Ávila-Funes</td>
<td>Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán</td>
<td>(cohort) MD to receive training abroad; will start specialized service in 2020</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>Krain</td>
<td>U. of Pennsylvania</td>
<td>Will have embedded dual trained geri/ID</td>
</tr>
<tr>
<td>Porto Allegre, BR</td>
<td>Sprinz</td>
<td>Universidade Federal do Rio Grande do Sul</td>
<td>Age specific screening/exams; referral to subspecialists; pharmacy consultation</td>
</tr>
<tr>
<td>San Diego</td>
<td>Karris</td>
<td>Univ. California SD</td>
<td>Screening for IADL impairment; referral to geriatrician</td>
</tr>
</tbody>
</table>
Some are reaching outside the office to engage OPH

Case management

Preventive care (Screening and prevention for co-morbidities)

Comprehensive care (Multi-disciplinary team approach)

Continuity of care (Case management system)

Family-oriented care (Empower patient and carers)

Coordination of care (Collaboration with other disciplines & NGOs)

These programs expand beyond comorbidity and screening towards social interventions

Mobile technology

https://www.mysmartage.org/

Weill Cornell’s HIV and Aging program is consultative, embedding geriatricians in an HIV clinic

- History and PE
- BADL and IADL
- PHQ-4 (depression, anxiety)
- Frailty screen
- Bone health
- Hearing, vision problems
- QoL, pain
- MoCA
- Prognosis
An internal poll was more positive than chart review of adherence to recommendations

<table>
<thead>
<tr>
<th>Recommendation type (n=76)</th>
<th>Patient directed adherence (%)</th>
<th>Provider directed adherence (%)</th>
<th>Total Adherence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>22/63 (35%)</td>
<td>38/120 (32%)</td>
<td>46/183 (33%)</td>
</tr>
</tbody>
</table>

- Respondents: 9 SW, 6 internists, 4 psychiatrists
- 17/19 said they implemented recommendations usually or always
- 16/19 said consultations were extremely or very useful

Bitas et al, JIAPAC 2019. DOI: 10.1177/2325958218821656
Why the discrepancy?

1. It takes a while to develop trust
2. We can’t change what we don’t control
3. What works in a geriatric clinic doesn’t work for OPH
4. The doctor’s office is not where health care happens
We don’t yet know how to adapt geriatrics to HIV care

Geriatric perspective

Comprehensive assessment for OPH
We don’t yet know how to adapt geriatrics to HIV care

Observations

Comprehensive assessment of OPH

Action

Feasible, useful recommendations
Example: Cognitive impairment

Underwood and Winston 2016; doi: 10.1007/s11904-016-0324-x
We don’t know how the components of care should be combined.
Referral Criteria/Prescreen
- Age? Social Supports
- Frailty/function
- Comorbidity (specific or number)

Assessment
- Tools
- Length
- Referral

Staffing/Location
- Embedded or freestanding
- Geriatrician or other specialist
- Nursing, social work, pharmacy

Focus/Feedback
- Management of diseases
- Reduction/prevention of frailty
- Improving supports

Outcome
- Criteria for success
- Financial viability

Linkages
- Relationship to primary care
- Community organizations
- Long term care

To Be Determined

The field of HIV/Aging is evolving

Every clinical program should get started
Take home points: How to get started

• Understand the demographics of your patient population: How many are over 50? Over 60?
• Determine what existing services and functions are available
  • Programs, personnel, funding sources, EMR
• Present the topic of aging to your community advisory board to determine their priorities
• If feasible, link with geriatrics
• Choose one aspect of aging and develop a screening and referral protocol
HIV and Aging toolkit -  http://www.necaaetc.org/node/149
http://agrayingpandemic.org
https://aahivm-education.org/hiv-age
https://www.cdc.gov/hiv/group/age/olderamericans/

Visit hivguidelines.org for clinical practice guidelines that address:
Selected References


5. Siegler EL, Burchett CO, Glesby MJ. Older people with HIV are an essential part of the continuum of HIV care. JIAS. 2018 Oct;21(10):e25188. PMID: 30303293; PMC6178281.

