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Results of a Multi-Disciplinary Approach Involving Geriatricians of a Clinic for Older People Living with HIV

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To the Editor:

OLDER PEOPLE (>50 YEARS) living with HIV (PLWH) experience a high burden of multi-morbidity, which presents a need for co-ordinated care provided by a multi-disciplinary team to help effectively manage their conditions. To provide such care, a dedicated joint specialty HIV and geriatric clinic, named the PLUS50 clinic, was established at Chelsea and Westminster Hospital in 2015, with further specialty HIV clinics (cardiology, metabolic, menopause, renal, neurology, etc.) introduced to meet additional needs as identified by an analysis of 10 years of clinic activity.¹ We present the findings from a retrospective analysis of patient records from the aforementioned clinic with the aim of providing support and advocate for the importance of specialist HIV geriatric clinics, as well as identifying and discussing potential improvements to the care of older PLWH.

Two years of retrospective data going back from first attendance at the PLUS50 clinic was collected from patient records of PLWH who attended between November 2019 and May 2022 to identify trends in multi-morbidity (≥ 2 non-HIV-related comorbidities), and subsequent antiretroviral therapy (ART)-excluded polypharmacy (≥ 5 non-ART co-medications),² as well as frequency and nature of specialty visits in the patient population. The COVID-19 pandemic coincides with the period of interest in our letter, and we assume this reduced the number of patients ($n = 68$) attending the clinic.

Of the patient population, >85% were male and almost 70% were White. The mean age was 62 years [standard deviation (SD)=9]. All patients were on ART, with a mean CD4 count of 537 (SD=328). The overall prevalence of multi-morbidity was 75.4%, and of polypharmacy was 46.6%. Individual comorbidity classes with highest prevalence were overweight/living with obesity (60.9%), musculoskeletal disorders (59.4%), and cardiovascular diseases (56.5%). An average of 16 hospital encounters in the 2 years before latest PLUS50 clinic visit was calculated, with the

most visited medical specialties outside routine HIV clinics being endocrinology/metabolic (11.0%), gastroenterology (9.4%), orthopedics (8.0%), and psychiatry (7.5%).

It was found that the sample population, due to the high prevalence of multi-morbidity and polypharmacy, requires regular care tailored to individual needs. This results in frequent use of health care services and resources, indicated by the average number of hospital visits per person per year in the cohort. Evidence has emerged supporting integrated health care models, such as the PLUS50 clinic at Chelsea Westminster, over regular outpatient referral pathways, as they can provide better health care outcomes through holistic and interdisciplinary collaboration.

Aging with HIV is a multi-dimensional process that requires a level of flexibility, which is not being met by current health care systems.³ Moreover, the multi-disciplinary nature of the PLUS50 Clinic provides co-ordination of care, communication, and convenient access for patients through co-location of services, therefore mitigating the risk of nonattendance. In the similarly structured Silver Clinic in Brighton, >90% of patients reported they were “very satisfied” with the service provided.⁴

In summary of the strengths and challenges of various models of geriatric consultation for older PLWH, multi-disciplinary care services were recognized as important by providers and the main challenges were logistical, such as a limited budget, rather than due to lack of clinical benefit.⁵ However, such logistical challenges remain a significant barrier to the wider implementation of joint specialty HIV geriatric clinics. Given this, the authors’ suggestion for appropriate geriatric involvement in locations where it is infeasible to run a joint specialty HIV geriatric clinic, is ensuring the use of frailty assessments in standard practice, and referral through existing pathways.

Several studies have recommended the use of frailty assessments, specifically the comprehensive geriatric assessment (CGA) in standard care of older PLWH.^{6–8} The CGA can be used to monitor PLWH as they age and identify where

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a geriatric referral should be considered. For example, more than half the patients seen in the PLUS50 clinic have musculoskeletal impairment, and the CGA can aid in early identification of disorders leading to this, and so early management. Further, the CGA involves regular medication review providing opportunity to reduce polypharmacy. This is an area requiring further intervention, as adherence with guidelines surrounding frailty-related assessments is often not followed in PLWH, even in specialized centers.⁹

Recent evidence has also linked frailty among older PLWH to ART nonadherence.¹⁰ Within our sample population White males were over-represented compared with both regional (London) and national data on those receiving HIV care.¹¹ Populations dissimilar to our sample, with a larger proportion of underserved minority groups, experience greater ART nonadherence.¹⁰ In such populations, wider support to adhere to ART and clinic visits may need to be considered first before the introduction of the more complex interspecialty collaborations we propose.

Our study utilizes data from the health care experiences of almost 70 patients to identify four key factors to improve health outcomes for older PLWH, making it one of the largest sample-sized studies to address the health care needs of the aging population of PLWH. We found that a lack of effective collaboration between the different specialties handling and prescribing to older PLWH contributed to the causes of poor health outcomes, including inefficient and uncomfortable patient experiences, and nonattendance resulting thereof.

These findings further emphasize the need for a holistic multi-disciplinary approach to the care of older PLWH. Within a multi-disciplinary system, three further key factors stated in this report for improved outcomes for older PLWH were frailty assessment, modifiable health factor analysis, and deprescribing. The data presented and discussed support the suggestion that with the implementation of these key factors in the management of aging PLWH, both the patient experience, and outcome can be greatly improved.

Author Disclosure Statement

No competing financial interests exist.

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