BHIVA Lunchtime Workshop 3

Tregonwell Seminar Room 1
Aging and HIV: 
Who Should Co-ordinate Care?

Speaker:
Dr Tom Levett, Brighton and Sussex University Hospitals NHS Trust
Ageing and HIV: who should coordinate care?

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Honorary Consultant Geriatrician

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Disclosures

• Received payment for provision of educational sessions from Gilead Sciences.
Objectives

• Epidemiology of ageing in the UK
• To give a (brief) overview of HIV and ageing
• To describe frailty and geriatric syndromes
• To describe current practice models in elderly medicine
• To consider how geriatric principles can be incorporated in to HIV care
• To consider models of care for older adults with HIV
Geriatric-HIV Medicine Is Born

Giovanni Guaraldi\(^1\) and Kenneth Rockwood\(^2\)

From One Syndrome to Many: Incorporating Geriatric Consultation Into HIV Care

Harjot K. Singh,\(^1\) Tessa Del Carmen,\(^2\) Ryann Freeman,\(^2,3\) Marshall J. Glesby,\(^1\) and Eugenia L. Siegler\(^2\)

Divisions of \(^1\)Infectious Diseases and \(^2\)Geriatrics and Palliative Medicine, Weill Cornell Medical College; and \(^3\)ACRIA, Center on HIV and Aging, New York
How young are “young people”? Most Brits believe only those under 30 are young

Respondents were asked at what they would stop describing a person to be “young”, and at what ages they would start describing them as “middle aged” and “old”

The majority of people in each coloured section describe a person this age as...

- young
- middle aged
- old

Age of person being described

The majority of people think a person this age is either young or middle aged

The majority of people think a person this age is middle aged

The majority of people think a person this age is old
In 2016:

- UK population was 65.6 million – projection >74 million by 2036
- 18% of population aged 65 and over and 2.4% aged 85 and over.
- 285 people aged 65 and over for every 1,000 people aged 16-64 years
  - = old age dependency ratio (OADR) and it is increasing.

Table 1: Age distribution of the UK population, 1976 to 2046 (projected)

<table>
<thead>
<tr>
<th>Year</th>
<th>0 to 15 years (%)</th>
<th>16 to 64 years (%)</th>
<th>Aged 65 and over (%)</th>
<th>UK population</th>
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<tr>
<td>1976</td>
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<td>76,342,235</td>
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</table>

Source: Office for National Statistics
## Survival and life expectancy: UK population

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<tr>
<th>UK</th>
<th>Females</th>
<th>Males</th>
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</thead>
<tbody>
<tr>
<td>LE from birth</td>
<td>82.8</td>
<td>79.1</td>
</tr>
<tr>
<td>LE gain at 65</td>
<td>20.9</td>
<td>18.5</td>
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<tr>
<td>LE at 65</td>
<td>85.9</td>
<td>83.5</td>
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<td>LE gain at 85</td>
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<td>LE at 85</td>
<td>91.8</td>
<td>90.8</td>
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<tr>
<td>Healthy LE</td>
<td>63.6</td>
<td>63.0</td>
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</table>

**Graphical Representation**

- **Life Expectancy**: 79.4 years
  - 79.7% of life in "Good" health
  - 63.3 years in "Good" health
- **Females**: Life Expectancy 83.1 years
  - 76.9% of life in "Good" health
  - 63.9 years in "Good" health

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ONS, National Life tables 2015
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/20132015
Ageing

Successful ageing

Well-being, QoL, Health, functional ability

Frailty

Physiological reserve

Successful aging

Accelerated aging

Physical frailty and sarcopenia

Disability / Loss of independence

Age (years)
UK age distribution for HIV service users

What is driving the ageing ‘epidemic’?

1. The success of ART in prolonging lifespan of those on treatment

2. Decreasing HIV incidence in younger individuals shifts burden of disease to older ages

3. Acquisition of new disease later in life
UK CHIC: life expectancy

Male LE 78 years

Female UK LE 82 years

ART, antiretroviral therapy; LE, life expectancy; UK CHIC, UK Collaborative HIV Cohort; VL viral load
May M et al. AIDS 2014.
Annual change HIV notification by age group, 2004-2015

- Increasing in those aged 15-49 AND ≥50
- Increasing in those aged ≥50
- Decreasing in those aged 15-49 AND ≥50
- No significant change

Figure 2: Average annual percentage change in new HIV diagnoses in people aged 50 years or older in the European Union and European Economic Area, 2004-15.

Ageing in HIV: The issues

• Older adults being newly infected, with greater risk of late presentation\(^1\)

• Potential for lesser immune restoration when initiating HAART at an older age, despite good viral suppression\(^1,2\)

• Increased prevalence and incidence of non-infectious comorbidities\(^1,3\)

• Consequent problems of multimorbidity and polypharmacy\(^1\)

• Earlier occurrence of ageing syndromes compared to HIV-negative\(^3\)

• Many potential barriers to successful ageing

HAART, highly active antiretroviral therapy
French Dat’AIDS cohort: Elderly vs Geriatric

Comorbidities in the elderly and geriatric groups

- Diabetes
- Hypertension
- CKD
- Dyslipidaemia
- CVD
- Osteoporosis
- Depression
- Cancer

CKD, chronic kidney disease; CVD, cardiovascular disease
https://doi.org/10.1371/journal.pone.0203895
A model of integrated pathophysiology of ageing with HIV infection

Presenting conditions
- Immune dysfunction and senescence
- Microbial translocation ‘Leaky gut’
- Chronic inflammation
- HIV + non-HIV treatment toxicity
- Oxidative stress
- Associated co-morbid disease

Interacting pathophysiologic processes
- Viral hepatitis
- Alcohol, tobacco and other drug use

Incremental depletion in organ system reserve (frailty)

Geriatric Syndromes
- Cognitive and functional decline
- Organ system failure
- Repeated hospitalization/nursing home placement

Death

Adapted from Cresswell and Fisher, 2013: https://doi.org/10.1016/j.mpmed.2013.05.014
Premature ageing or premature conclusions?

Alternative explanations:

• Cross-sectional (‘snap-shot’) rather than longitudinal (over-time)
• Poorly matched control populations for comparison
  – ethnicity and sexuality
  – age distribution
  – alcohol, smoking and drug-use status
  – Cytomegalovirus and hepatitis C status
• Ascertainment bias:
  – does seeing a doctor make you more likely to be diagnosed with things?

Fisher and Cooper, Curr Opinion Infect Dis, 2012
• No formal guidance but recommendations on ageing syndromes increasing
• Chronologic vs biological ageing - ? benefit from ‘geriatric’ approach
• Some principles they set out:
  – Ageing cannot be defined or measured solely by the presence of disease
  – Impact of MM not the same as adding the impacts of multiple individual comorbidities
  – Ageing-related (geriatric) syndromes are distinct from classic medical syndromes
  – These can be seen among HIV-infected adults before they are chronologically elderly
A word on geriatric syndromes:

“Clinical conditions in older persons that do not fit into discrete disease categories” and instead “cross organ systems and discipline-based boundaries” [doi: 10.1111/j.1532-5415.2007.01156.x]

How geriatric syndromes differ from classic syndromes:

• They are common.
• They are often defined by a single symptom (eg, urinary incontinence).
• Single aetiologies may precipitate multiple syndromes
  − Pneumonia precipitating falls and delirium
• Individual syndromes may have multiple aetiologies:
  − delirium might be caused by an infection, dehydration, constipation
• Older patients often have multiple geriatric syndromes at one time.

DOI: 10.1093/cid/cix311
Geriatric syndromes

- Frailty
- Falls
- Immobility
- Functional impairment
- Incontinence
- Cognitive impairment – acute (delirium) and chronic
- Multi-morbidity
- Polypharmacy and increased risk of iatrogenic harm
- Mood disorder
Geriatric syndromes in HIV:
Greene et al. JAIDS. 2015

- 155 HIV-positive adults
- Median age 57 (54-62)
- 94% male, 63% white
- All on ARVs, median CD4 537
- Median comorbidities 4
- Median non-ARV meds 9
- 54% had ≥2 geriatric syndromes
- Geriatric syndromes assoc’d with non-white ethnicity, lower CD4 nadir and higher comorbidity

ADL, Activities of Daily Living; IADL, Instrumental Activities of Daily Living
Burden of geriatric syndromes: FOAL Study
Levett et al. Age and Ageing, Volume 47(3), 2018

**PROPORTION OF PARTICIPANTS BY NUMBER OF GERIATRIC SYNDROMES REPORTED**

- 0 syndromes: 37.9%
- 1 syndrome: 22.5%
- 2 syndromes: 12.7%
- 3 syndromes: 9.5%
- 4 syndromes: 9.5%
- 5 syndromes: 5.9%
- 6 syndromes: 2%

**DISTRIBUTION OF GERIATRIC SYNDROMES BY PERCENTAGE**

- Disability: 17%
- Frailty: 19%
- Cognitive imp: 21.7%
- Polypharmacy: 30%
- Mobility: 30.8%
- Falls: 37.2%
What is frailty?
Complexity, reserve and the route to frailty
What is frailty?

• Age-related decline in multiple physiological systems
• Threshold of homeostatic reserve reached, resulting in:
  • An ‘at risk’ state
  • Vulnerability to minor stressor events
• **Disproportionate changes** in health status:
  • From mobile to immobile
  • From lucid to confused
  • From independent (‘managing’) to requiring help
• An increased risk of adverse events

Underpins the ‘non-specific nature’ of some medical presentations in older adults

Frailty is more prevalent amongst PLWHIV, compared to those without HIV

- Cl, confidence interval; M-H, Mantel-Haenszel; OR, odds ratio; PLWHIV, people living with HIV.
Predictors of frailty in HIV

**HIV-related factors:**
- Longer duration
- Greater immune suppression (lower CD4, current & nadir)
- Detectable viral load
- AIDS diagnosis
- Use of protease inhibitors
- High CD4:8 ratio
- Low CD4 nadir

**Comorbidities:**
- Hepatitis C
- Diabetes
- Kidney disease
- Depression
- Cognitive impairment

**Body composition:**
- Low BMI
- High BMI
- Lipodystrophy

**Social factors:**
- Lower education
- Unemployment
- Low income
- Food insecurity

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*BMI, body mass index; CD4, cluster of differentiation 4; HANA, HIV-associated non-AIDS; VL, viral load.*
In PLWHIV aged ≥ 40 years, frailty was associated with recurrent (≥ 2) falls within 12 months.

Prospective multicentre cohort study of PLWHIV aged ≥ 40 years (n=967) enrolled in ACTG A5322: 6% were frail, 39% prefrail.

- ACTG, AIDS Clinical Trials Group; CI, confidence interval.
- Tassiopoulos K et al. AIDS 2017;31(16):2287–94.
Does frailty predict other adverse outcomes? Effect of aFRP on mortality in VACS

Kaplan–Meier survival curves among (A) HIV+ detectable, (B) HIV+ undetectable, and (C) uninfected stratified by frailty state. Dashed dark lines are not frail, gray lines are prefrail, and solid lines are aFRP.

aFRP, adapted survey-based frailty-related phenotype
Integrating elderly medicine into HIV care

Why do we need to?
How might we do it?
Challenges to ageing well with HIV

- Comorbidity and polypharmacy
- Frailty and frailty syndromes
- Mental health issues
- Reduced physical functioning
  - Challenges to independence
  - Concerns around care
- Cognitive decline
- Late diagnosis
- Adaptation to new diagnosis
  - vs. ‘survivors’ – resilience?
- Adverse lifestyle risk factors
  - Especially smoking
- Work and financial disadvantage
- Limited social networks
  - Loneliness
- Stigma and discrimination
  - Now the addition of AGEISM
- Uncertainty (personal and service led)
- Cultural, ethnic & gender inequalities
- Institutional unpreparedness

HAND, HIV associated neurocognitive disorder
Expert opinion of presenter
So why now for ageing services?

- Ageing demographic
- Documented multi-morbidity and geriatric syndromes
- Complexity compounded by psychosocial issues
- Patient demand/concern
- Lesser degree professional demand
- Changing approaches elsewhere i.e. primary care
  - Proactive frailty identification (older adults)
  - Multi-morbidity approach (all ages)
  - Lesser emphasis on ‘single organ’ approaches
Making our health and care systems fit for an ageing population

Authors
David Oliver
Catherine Foot
Richard Humphries
Healthy active ageing and supporting independence
Living well with simple or stable long-term conditions
Living well with complex comorbidities, dementia and frailty
Rapid support close to home in crisis
Good acute hospital care when (and only when) needed
Good discharge planning and post-discharge support
Good rehabilitation and re-ablement after acute illness or injury
High-quality nursing and residential care for those who truly need it
Choice, control and support towards the end of life

(King’s Fund, 2013)
Frailty focussed approach: Royal Sussex County Hospital, Brighton

- Offer ‘front-door’ frailty service
  - Consultant geriatrician cover to the acute floor (ED, AMU, Short stay)
  - 7-day service, Mon-Fri 8am-7pm, Weekends 8am-5pm
  - See all new admissions and offer reviews/advice
  - Frailty rather than age-based cut-off – Rockwood Clinical Frailty Scale
- Frailty in-reach to other ward areas
- Frailty phone- for advice and community calls
- Rapid Access Clinic for Older People
  - Mon-Fri – consultant/associate specialist clinics
  - Outpatient assessment with same day tests where possible
  - Aim to see referrals within 2/52, within 72 hours where urgent
Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

Development and validation of an electronic frailty index using routine primary care electronic health record data

Andrew Clegg*, Chris Bates1, John Young1, Ronan Ryan1, Linda Nichols1, Elizabeth Ann Te Mohammed A. Mohammed1, John Parry1, Tom Marshall3

Box 1. List of 36 deficits contained in the eFI.

- Activity limitation
- Anaemia and haematocrit deficiency
- Arthritis
- Arrhythmia
- Arrhythmia and heart rhythm disorder
- Chronic kidney disease
- Diabetes
- Dizziness
- Dyspnoea
- Falls
- Foot problems
- Frailty fracture
- Hearing impairment
- Heart failure
- Heart valve disease
- Housebound
- Hypertension
- Hypotension/syncope
- Ischaemic heart disease
- Memory and cognitive problems
- Mobility and transfer problems
- Osteoporosis
- Parkinsonism and tremor
- Peptic ulcer
- Peripheral vascular disease
- Polypharmacy
- Requirement for care
- Respiratory disease
- Skin ulcer
- Sleep disturbance
- Social vulnerability
- Thyroid disease
- Urinary incontinence
- Urinary system disease
- Visual impairment
- Weight loss and anorexia

Table 1. Baseline characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Development cohort (n = 207,814)</th>
<th>Internal validation cohort (n = 207,720)</th>
<th>External validation cohort (n = 516,007)</th>
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<tr>
<td>Age (years)</td>
<td>75.0 (7.2)</td>
<td>75.0 (7.3)</td>
<td>75.0 (7.3)</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
<td>45%</td>
<td>45%</td>
<td>44%</td>
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Figure 1. Five-year Kaplan–Meier survival curve for the outcome of mortality for categories of fit, mild frailty, moderate frailty and severe frailty (internal validation cohort).
Fig. 1. Five-year Kaplan–Meier survival curve for the outcome of mortality for categories of fit, mild frailty, moderate frailty and severe frailty (internal validation cohort).
Comprehensive Geriatric Assessment

A process not an event
- Interdisciplinary
- Multidimensional
- Produces problem lists
- Integrated plan for treatment, rehabilitation, support and long term care
Multi-morbidity (MM)

• 2 or more long-term health conditions:
  • physical and mental health conditions
    • (incl learning disability, substance misuse, sensory impairment)
  • symptom complexes such as frailty or chronic pain

• Single organ guidance may lead to a high-burden of Rx
  • Especially managing RFs for future disease
  • evidence-base may not be robust as you move into older ages.

• May benefit from a MM approach if:
  • difficulty managing treatments/day-to-day activities, frailty or falls
  • multiple services involved
  • frequently seeks unplanned/emergency care
  • prescribed multiple regular medicines (10 or more!)
Principles focus on:
- Effect of health conditions & treatments on QOL
- individual needs, Rx preferences, health priorities, lifestyle and goals
- benefits and risks of following ‘single organ condition’ guidance
- improving coordination of care across services.

Using an MM approach:
- Review medicines & other treatments
- Agree an individualised management plan:
  - goals and plans for future care (including advance care planning)
  - who is responsible for coordination of care?
  - how is the above communicated to all professionals and services involved
  - timing of follow-up and how to access urgent care – ‘crisis plan’
Care plans:

- Personal details
- Views of patient and carers
- Views of professionals
- Medical history
- Identified goals
- Care and support arrangements
- End of life
- Named contact
- Action plan

- What is important to them? What are their concerns?
- Medical history including test and diagnosis
- Priorities
- Description Status (achieved, on hold, abandoned)
- Description of action Barriers to completion Support needed to overcome

- Name and contact details
- Communications needs
- Current provision
  - Contingency planning
  - Early warning signs
  - Trigger points
- Preferred places of death?
  - Advanced decision to refuse treatment?
  - Lasting power of attorney
  - ‘Just in case’ meds
  - CPR decision

- Individual responsible for coordinating care in the community
Care-coordination

HIV service

GP
A case study: Mr X aged 76

• HIV background:

  • Diagnosed 1994, aged 50
  • Initial CD4=48
  • PCP: opportunistic infection so AIDS defining event

  • Started ARVs 1994- AZT monotherapy
  • Now nevirapine/tenofovir/raltegravir

  • Current CD4 559, Viral Load <50 (undetectable)
  • ‘Well-controlled’ chronic HIV infection

• Further PMHx :

  • IHD
  • T2DM
  • Hypertension
  • Peripheral neuropathy
  • Anxiety and depression
  • Benign prostatic hypertrophy and bladder instability
  • Hypothyroidism

• Polypharmacy on 11 co-medications
But what was actually going on?

• Falls (recurrant):
  • Musculoskeletal pains
  • Worsening peripheral neuropathy
  • Postural hypotension
  • Poor mobility: uses stick & electric scooter.

• Fatigue

• Memory concerns
  • MoCA 14/30

• Persistent low mood
  • HADS 24/42

• Polypharmacy (≥5 drugs)
• Multimorbidity (>1 comorbidity):
  • Poor diabetes control

• Functional dependence:
  • ADL scores: Barthel 17/20 Lawton 5/8
  • Daughter is main carer

• Continence issues:
  • Bladder and bowels, uses pads

• Frailty syndrome
National drivers

NHS 5-year forward plan 2014 & NHS long term plan 2019

Establishment of:

• 44 Sustainability and Transformation Partnerships
  • Only 7 mention HIV, mostly around prevention
  • SE London- LT comorbidities in PLWH
  • Services and care models are developing in real time
  • Scope for stakeholders to contribute to evidence based for care models

• Moving towards Integrated Care Systems
  • Joint ventures NHS organisations and local councils
  • Coordinate services around the whole needs of each person.
  • Care and treatment, in the right place, at the right time.

• These are not legal entities:
  • commissioning still central or via CCGs
• Self-management and peer support
  • Physical and mental health, and overall well-being

• Participation in care
  • Design, planning, delivery and review of services.

• Comorbidities, co-infections and cancers
  • Seek local arrangements for comorbidity management
  • Clear protocols and agreed pathways for care between primary and secondary care

• Supporting people with higher levels of need
  • Many reasons why complexity
  • No validated approach to ‘risk stratification’
  • Advocates:
    • MM approach
    • ‘personalised care plan’ or ‘individualised management plan’
    • Care coordination

• Complex HIV care
  • Involvement of a geriatrician with HIV knowledge
  • Co-specialty clinics, mentoring or provision of advice and guidance.
  • MDT- HIV pharmacists, older age pharmacists, physiotherapy and occupational therapy.
• Greater reliance + preference for HIV services:
  • Greater comorbidity, longer duration HIV

• Concerns over lack of knowledge, skills and understanding in GP

• Lack of confidence – assumptions symptoms HIV-related or concern DDIs
  • Ping-ponging between services

• HIV teams perceived to be more:
  • ‘on it’
  • Holistic

• Perception HIV teams could provide faster referrals

• Communication, care-coordination, confidentiality
A national study of ageing and HIV (50 Plus)

September 2010

This report describes the needs, concerns and characteristics of people aged 50 and over who are living with HIV in the UK.
**Uncharted Territory**

- MM is high: 92% at least one other comorbidity vs. 58% >60yrs HIV-neg
- 65% on medications other than ARVs
- 8/10 fearful for memory loss and ability to self-manage their HIV

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**Table:**

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<th>Age 65+</th>
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<th>Sometimes</th>
<th>No but refers me</th>
<th>No never</th>
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<tr>
<td>50-60</td>
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<td>50%</td>
<td>28%</td>
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Providing a model of HIV community nursing

The complexity of care in the community has increased...nursing teams are required to find new ways to support complex care and manage workloads.” (Jones, 2005)

Key relationships

- Specialised HIV commissioning (CGG, local authority)
- GPs and local GP practices including district nurse teams, dental practices and allied healthcare professionals
- Person living with HIV, their families, friends and carers-givers
- Voluntary HIV support agencies and services (such as social care, welfare and safeguarding)
- Continuing care agencies (residential and nursing homes)
- Community specialist palliative care providers, providers of out-of-hours care

- Acute and inpatient HIV services including HIV consultants, clinic-based clinical nurse specialists/practitioners

Guidance and resources:

- The Code: Professional standards of practice and behaviour for nurses and midwives (Nursing and Midwifery Council, 2015)
- NICE guidance community assessment (National Institute for Health and Care Excellence, 2016)
- Five Year Forward View including New Care Models and integrated care, sustainability & transformation (NHS England, 2014)
- Co-ordinated care for people with complex chronic conditions (King’s Fund, 2013)
- Compassion in practice (Department of Health, 2012)
- Leading Change, Adding Value (NHS England, 2016)
- Ageing (Uncharted Territory: a report into the first generation growing older with HIV, 2-17) (Terrence Higgins Trust, 2017)
- The future of HIV services in England (Baylis et al., 2017)
- The future of primary care: creating teams for tomorrow (Health Education England, 2015b)
- Advanced Nursing Practice (NHVNA, 2016)
- Shared Care (MacLeIan et al., 2016)
- NAT (HIV Support Services – the state of the nations, 2017)
- King’s Fund: Case management: what it is and how it can be best implemented (King’s Fund, 2011)
- King’s Fund: Avoiding hospital admissions: what does the research evidence say? (King’s Fund, 2010)
- BHIVA Standards of Care (BHIVA, 2013)
Liverpool Community Nursing Service

https://www.rlbuht.nhs.uk/departments/community-serv

• Roles:
  • Home care if cannot attend for psychological, financial reasons, physical disability.
  • Prescribing, medicines management, care coordination, blood monitoring, diagnosis support.
  • Shared care: To manage patients who are poor attenders-
    • safety visits
  • Referral / liaison / fast track to HIV clinical services in acute settings
  • Link between Primary, Secondary, Tertiary, social care and voluntary Services
  • Facilitate joint visits with MDT to ensure needs are appropriately met.
  • Community awareness-raising
  • Nurse-led drop in sessions at HIV voluntary service
  • Consultancy, teaching, health promotion for MDT staff within community settings.
A word on ageing services
Where next for older adults with HIV?

HIV has become a long term condition:

- Long term outcome of treated HIV unknown- new issues may arise
- Stigma is still an issue and may influence service choice
- Proportion have complex needs (advanced disease, resistance, co-infection)

Current issues:

- Level of experience in dealing with elderly care issues generally
- Comorbidities have become major part of HIV care
- Expertise, links to community/MDT services, funding
- Elderly medicine services may not be designed to cater for younger patients
Specialist care of older adults with HIV infection in the UK: a service evaluation

FV Cresswell¹ and T Levett¹,²

¹Brighton and Sussex University Hospitals NHS Trust, Brighton, UK and ²Brighton and Sussex Medical School, Brighton, UK

Fig. 2 Reasons for lack of current need for a dedicated HIV ageing service (n = 73). Respondents were permitted to provide more than one answer. BHIVA, British HIV Association.

Source: DOI: 10.1111/hiv.12481
Service Models: Ageing clinics

- Age based clinics?
  - Where do you set your age?

- Targeted clinic?
  - Selection criteria (age, multimorbidity, functional decline)
    - Use of clinical risk indicators (VACS index, Frailty index, Frailty generally)
  - Individuals with most perceived need filtered in to clinic

- Even need a clinic?
  - Utilise existing services
  - Establish pathways of care

- Who does the clinic?
  - GP alone, HIV team only, HIV team + GP, HIV team plus geriatrician, HIV + GIM?
  - Access to MDT- physio, social work, OT

Developing new models of shared primary and specialist HIV care in the UK: a survey of current practice

Facilitators

• Good clinical leadership
• Good professional relationships & communication
• Development of ‘HIV-friendly’ practices
• Treating HIV infection like any other chronic disease
• Training in HIV medicine

Barriers:

• Lack financial incentive to provide HIV care
• Inaccurate perception HIV infection
• Impact of stigma
• Need for minimum caseload
• Lack of formal framework supporting HIV care provision
• Infrastructure issues
Why involve Geriatricians?

- Trained as generalists
- Experience in cross-disciplinary working (surgical specialties, A&E)
- Used to dealing with atypical presentations
- Specialists in managing complex multi-morbidity
- Focus on balance of problems and benefits of treatment over time
- Focus on preserving function or developing plans to manage loss
  - Multi-disciplinary management
  - Advanced Care Planning
- Recognition from US National Institute for Health, that geriatric models of care and research may benefit patients, with focus on function over cure.

(High et al. doi: 10.1097/QAI.0b013e31825a3668)
The Brighton Model: The Silver Clinic

Hosted within the Lawson Unit
- Runs monthly
- Preassessment visit
- Pre-clinic MDT
- Four clinic slots, 40mins

The Silver Clinic team:
- HIV physician
- Geriatrician
- HIV Clinical Nurse specialist
- Pharmacist

Indications for referral:
- Patients over 50 years old
- Multiple comorbidities
- Polypharmacy
- Frailty syndromes e.g. falls, immobility
- Functional decline

Referrals from:
- HIV clinicians
- Can be from other regional clinics
- Hope to expand
The Brighton Model: The Silver Clinic

Pre-assessment: HIV-CNS

- **Health:** EQ-5D-5L
- **Frailty:** Frail scale
- **Quality of life:** OPQOL-brief (older people’s QOL)
- **Cognitive:** MOCA (Montreal cognitive assessment)
- **Mental health:** Hospital anxiety and depression questionnaire
- **Routine bloods:** including PSA, TFT, B12/folate, (Vit D)

Clinic Objectives:

- To review polypharmacy and DDI
- To optimize comorbidity management
- To identify functional, social and psychological problems
- To formulate health interventions
  - Medical: Investigations, referral to other specialties
  - Social: Occupational therapy, social services
  - Psychological: Referral to mental health
  - Others: Exercise interventions, peer support groups

DDI, drug drug interaction
Challenges and future steps?

Challenges:
• Monthly timetable means may be less responsive, but ‘in-reach’ possible
• MDT lacking key allied health professionals
• Need to make use of existing community services
  − Problems with geography, capacity and service specification
  − Staying up to date with peer support

Future:
• Expansion in numbers – 2 geriatricians to provide more capacity
• Screening based on frailty
  − Proactive approach to intervene before problems arise
  − Virtual model for some to cope with increase capacity
• Better, more responsive MDT links or MDT in the clinic?
• Merge with cognitive clinic? Multi-specialty MDTs to avoid multiple ‘joint-clinics’?
Summary

• Ageing of the HIV-positive cohort is bringing new challenges of:
  – Geriatric syndromes and medical complexity

• Care coordination will be key for some people
  – Likely demand to be driven by HIV services
  – May be difficult to commission/sustain – service user involvement essential

• Ageing services may help
  – The ideal format is unknown and one size will not fit all
  – Think about the need for:
    • Bespoke dedicated service
    • Pathways to established services
    • Links to a full MDT able to provide functional and social interventions
    • Community signposting to 3rd sector organisations

• This is the future face of chronic HIV
Thanks for listening.

Any Questions?
25th Annual Conference of the British HIV Association (BHIVA)

2–5 April 2019, Bournemouth International Centre (BIC)