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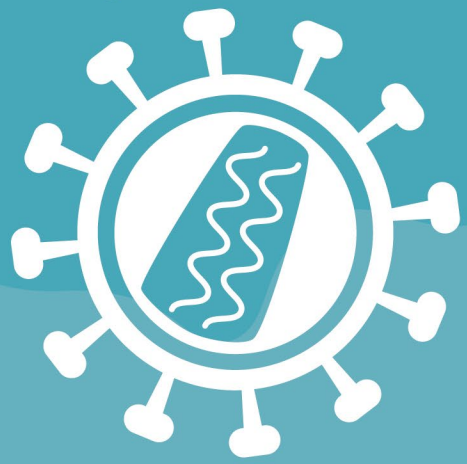

2022 Spring Conference

Wed 20th - Fri 22nd April

Manchester Central, Manchester

Living Well with HIV personalising multiple long term condition management

Chair: Dr Tristan Barber

Co-chairs:
Dr Yvonne Richards
Dr Jim Fielder
Dr Daniella Chilton
Dr Howell Jones
Dr Fiona Marra

This educational event is supported by an unrestricted medical education grants from

GILEAD Creating Possible MSD ViiV Healthcare

BHIVA
British HIV Association
2022 Spring Conference
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Manchester Central, Manchester

Living well with HIV - Personalising multiple long term condition management

Daniella Chilton

Guys and St Thomas' NHS Foundation trust

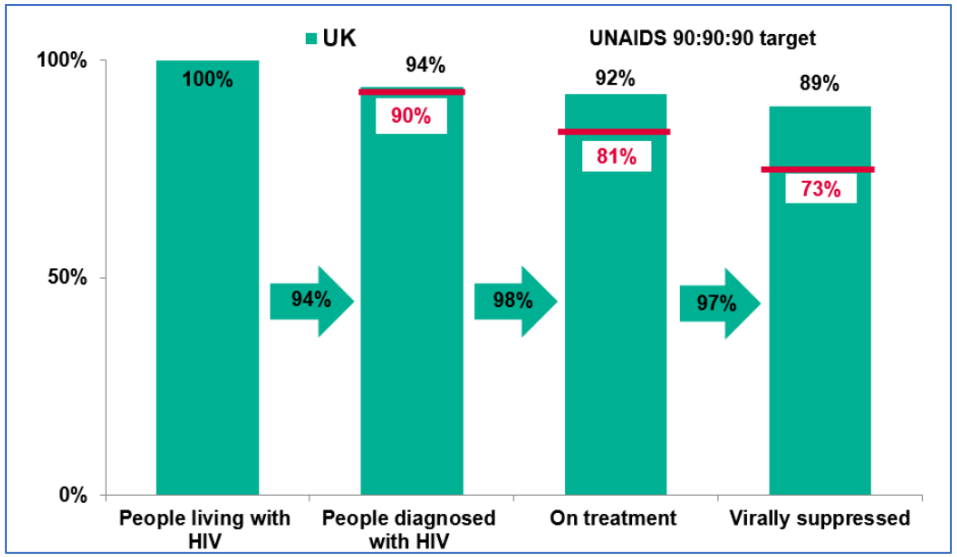
Conflict of Interest

Daniella Chilton has received:

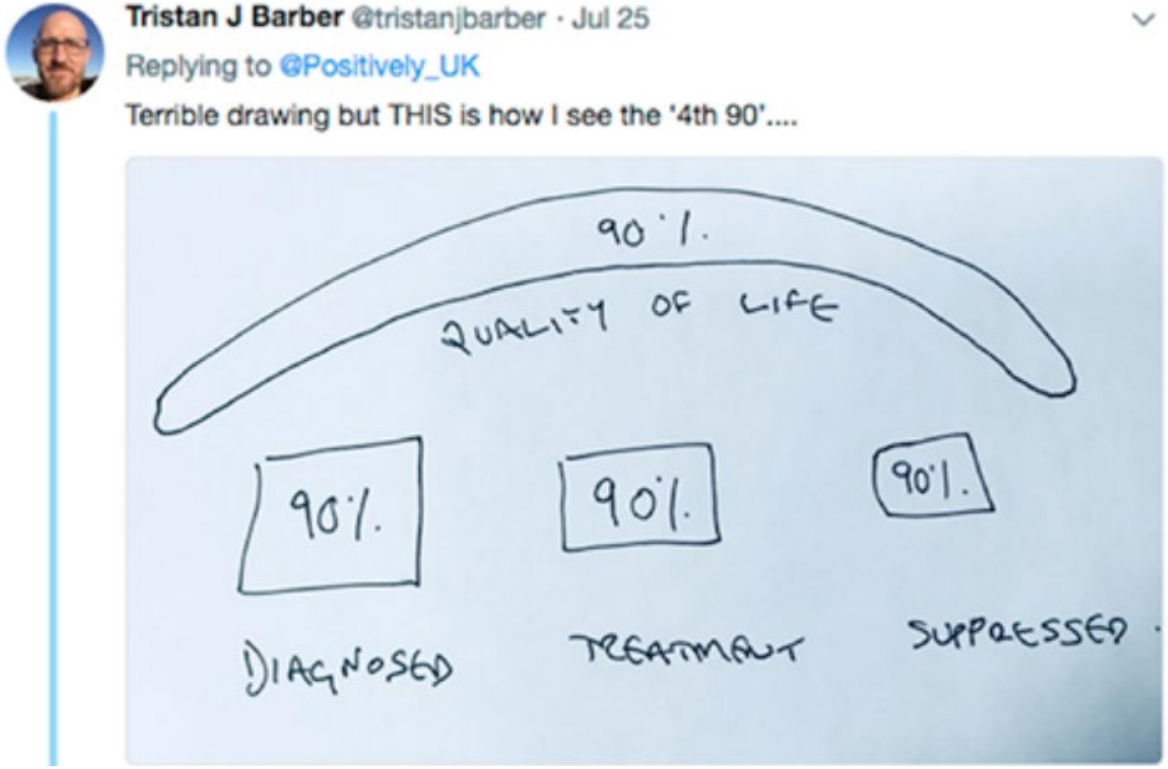
1. Grants from Gilead to develop services
2. Payments for involvement in advisory boards from Gilead and Viiv
3. Speaker fees from Gilead, Viiv and Jansen

Speakers are required by the Federation of the Royal Colleges of Physicians to disclose conflicts of interest at the beginning of their presentation, with sufficient time for the information to be read by the audience. They should disclose financial relationships with manufacturers of any commercial product and/or providers of commercial services used on or produced for patients relating to the 36 months prior to the event. These include speaker fees, research grants, fees for other educational activities such as training of health professionals and consultation fees. Where a speaker owns shares or stocks directly in a company producing products or services for healthcare this should also be declared. Finally, other conflicts of interest including expert functions in health care or healthcare guidance processes should be declared (eg if the professional is a member of a health board). The Federation considers it good practice to also make speakers' disclosures available in digital format(s) relating to the educational event.

The 4th 90 – good health related QOL



- 97% of our pt now undetectable
- Looking beyond VL to make sure that we are providing a quality service
- Service delivery promoting wellness rather thar survival – the 4th 90.
- ART is a clinician-led intervention vs adopting lifestyle changes to influence co-morbidities – taking into account ability to self-manage



1. Lazarus et al. BMC Medicine (2016) 14:94
2. Trends in HIV testing, new diagnoses and people receiving HIV-related care in the UK: data to end December 2019 Health Protection Report Volume 14 Number 20

What's important to our patients?

- Mental health
- Obesity management
- Loneliness and isolation
- Managing long term conditions – 1/3 living with 2 or more co-morbidities in addition to HIV
- Welfare needs – housing, employment, benefits applications

1. M Kall, C Kelly, M Auzenbergs, and V Delpech. Positive Voices: The National Survey of People Living with HIV - findings from the 2017 survey. January 2020. Public Health England: London.
2. Bailin SS, Gabriel CL, Wanjalla CN, Koethe JR. Obesity and Weight Gain in Persons with HIV. Curr HIV/AIDS Rep. 2020 Apr;17(2):138-150. doi: 10.1007/s11904-020-00483-5. PMID: 32072466; PMCID: PMC7719267.

What's important to our patients?

Positive Voices
the national survey of people living with HIV

- Mental health
- Obesity management
- Loneliness and isolation
- Managing long term conditions – 1/3 living with 2 or more co-morbidities in addition to HIV
- Welfare needs – housing, employment, benefits applications

We need to ask the right questions
?PROM / Proforma

All affect ability to self manage

1. M Kall, C Kelly, M Auzenbergs, and V Delpech. Positive Voices: The National Survey of People Living with HIV - findings from the 2017 survey. January 2020. Public Health England: London.
2. Bailin SS, Gabriel CL, Wanjalla CN, Koethe JR. Obesity and Weight Gain in Persons with HIV. Curr HIV/AIDS Rep. 2020 Apr;17(2):138-150. doi: 10.1007/s11904-020-00483-5. PMID: 32072466; PMCID: PMC7719267.

Measuring ability to self-manage: Patient activation measure (PAM)

- 13 point questionnaire
- Scored via algorithm
- PAM levels indicate:
  - Empowerment
  - Readiness to take charge of their health
  - Readiness to make changes

Higher PAM = Better outcomes

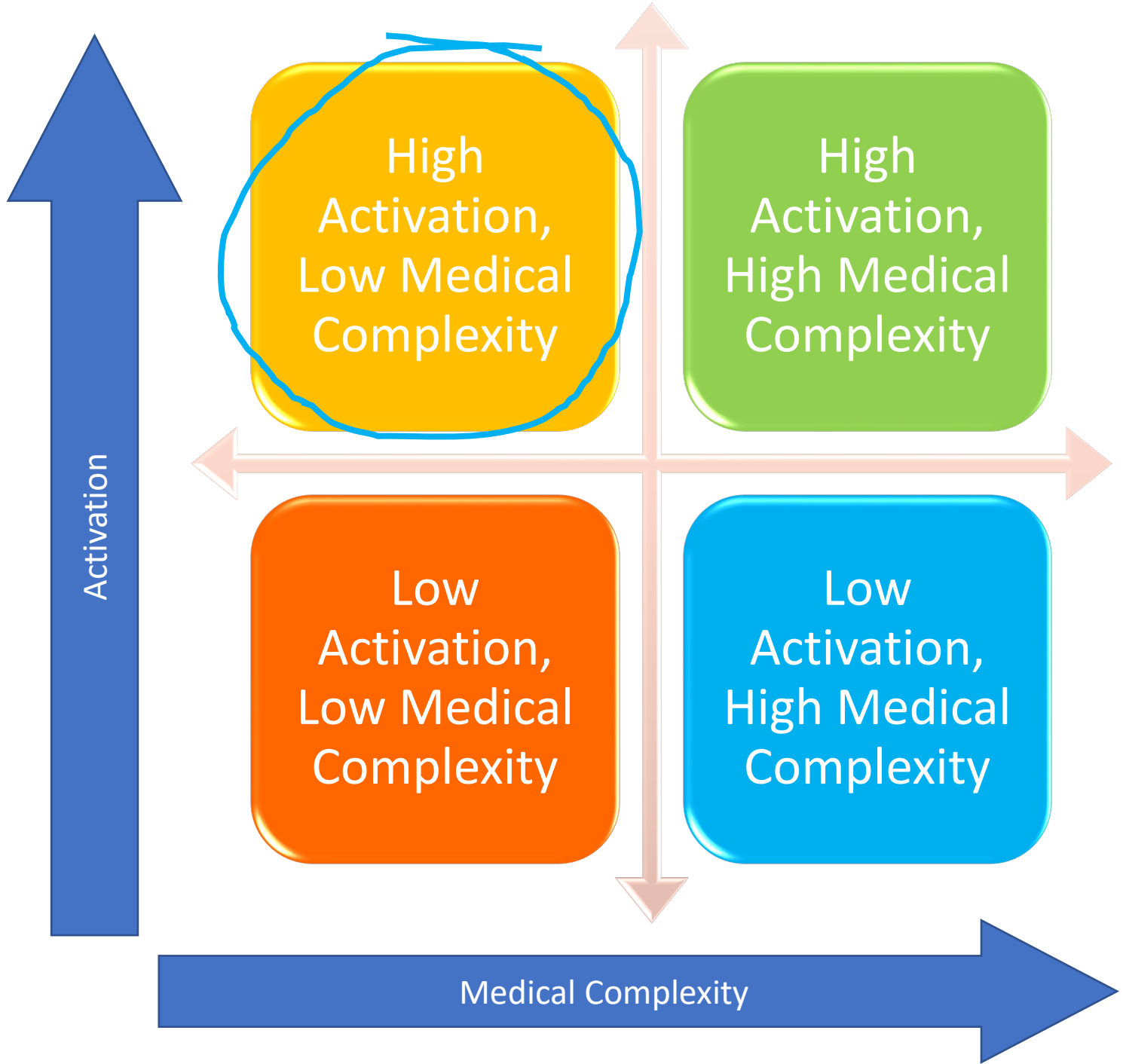
Tailored interventions can increase activation

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think others want you to say.

If the statement does not apply to you, circle N/A.

1. When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2. Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3. I am confident I can help prevent or reduce problems associated with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4. I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6. I am confident that I can tell a doctor concerns I have even when he or she does not ask	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7. I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

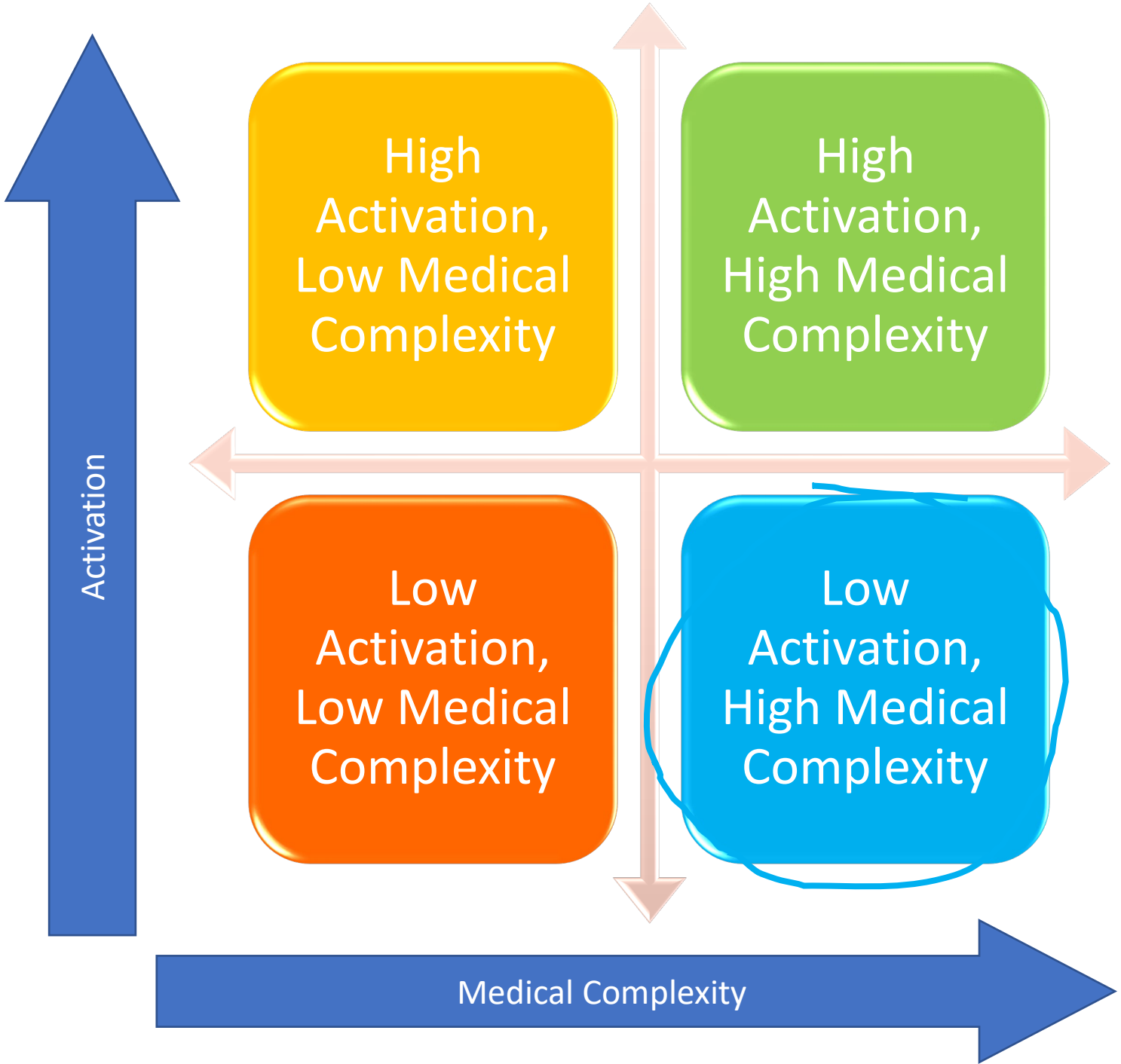
Kinney RL, et al. Patient Educ Couns. 2015 May;98(5):545-52
Mosen DM, et al. Is patient activation associated with outcomes of care for adults with chronic conditions?J Ambul Care Manage.2007;30:21–29
Hibbard JH et al. Res Brief. 2008:1-9



Quadrant model

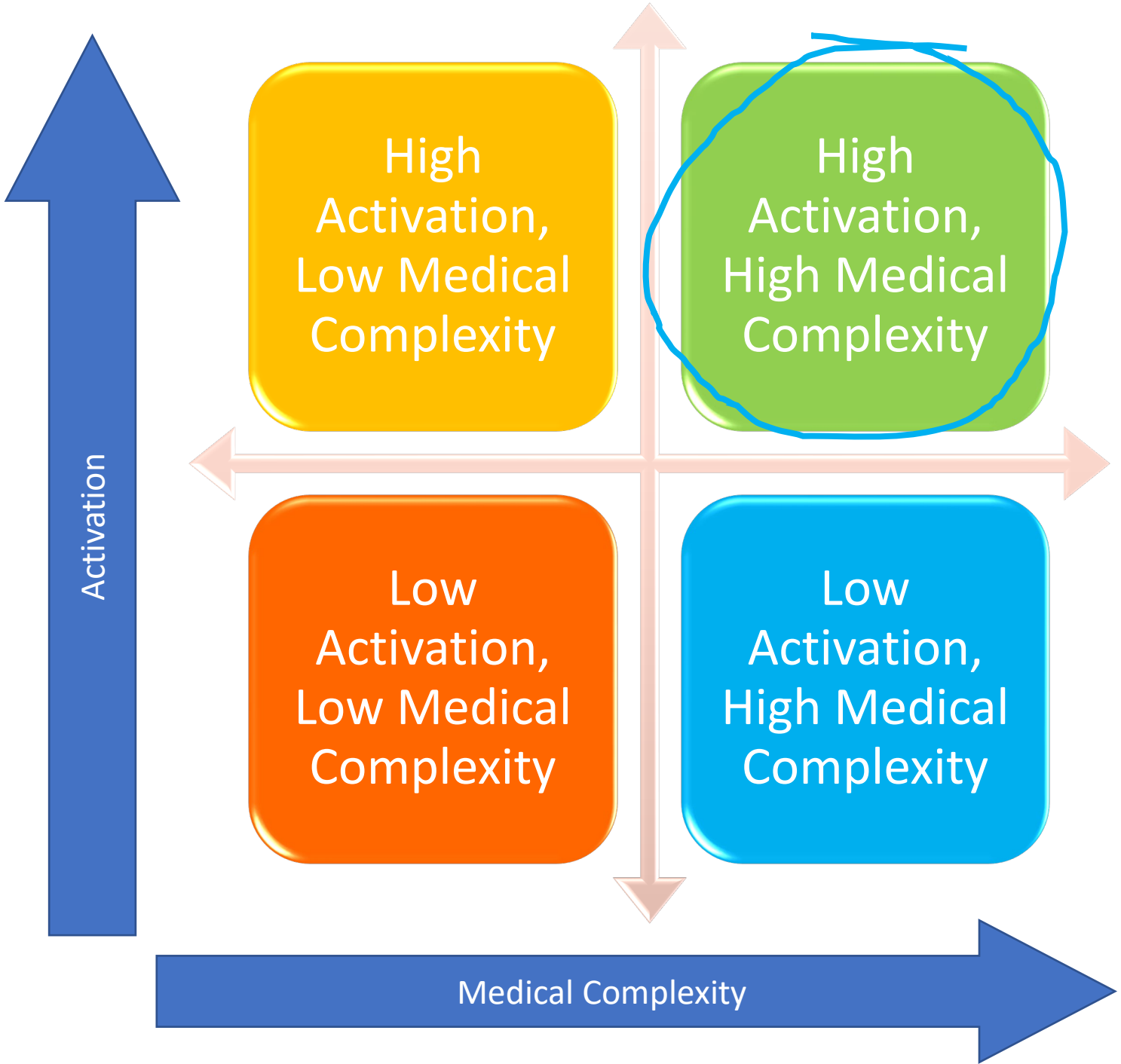
- Stable patient pathways
- Reduced monitoring
- Non-F2F – email / video / Tel
- Light touch support
- Screening / prevention

https://irp-cdn.multiscreensite.com/0856eb26/files/uploaded/New-Model-for-LTC-Management-FINAL.pdf



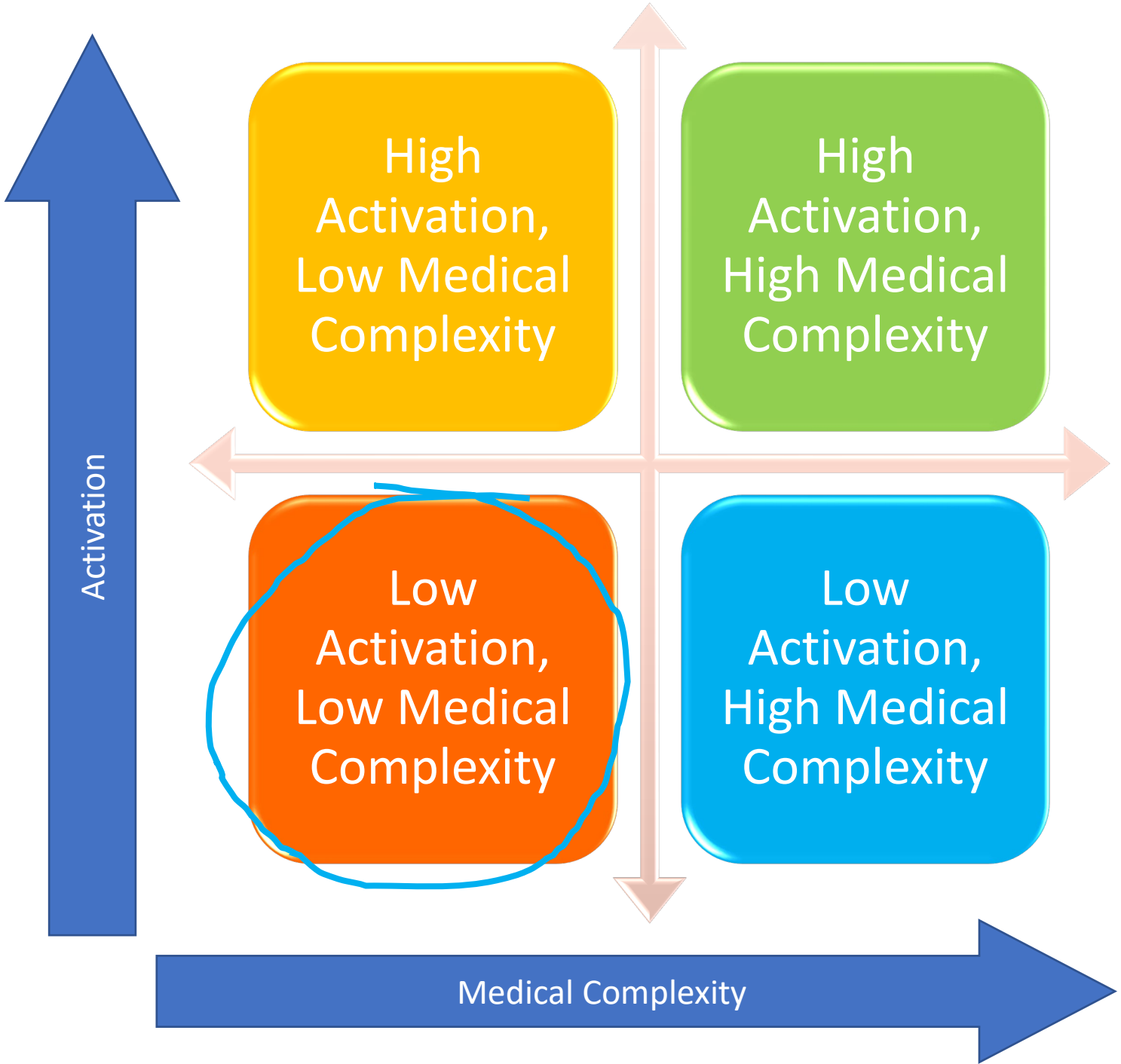
Quadrant model

- L2FU / DNA case work
- 3rd sector organisations
- Peer support
- 1 to 1 coaching
- Case management
- Group work
- Smaller goals



Quadrant model

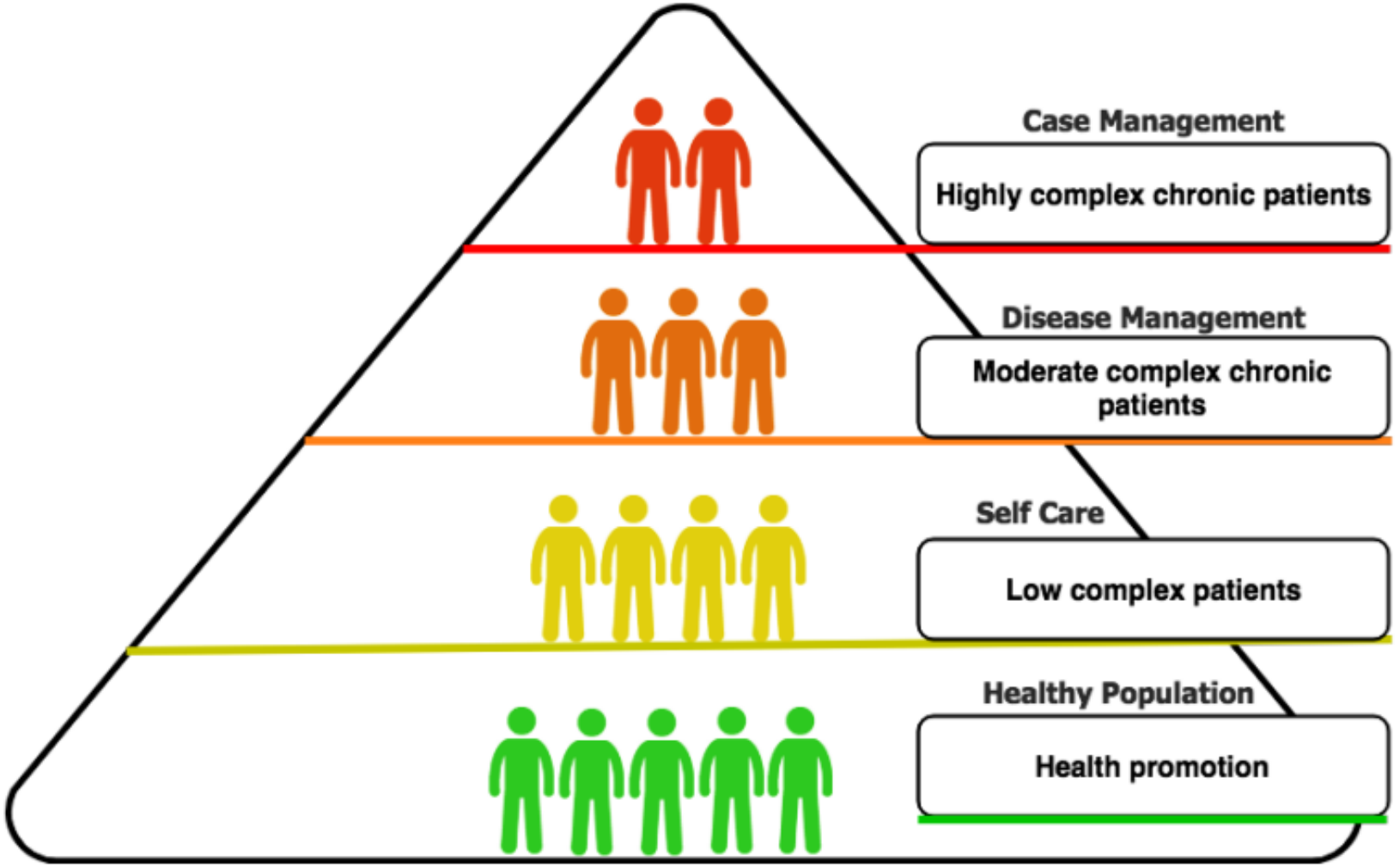
- 1 to 1 coaching
- Group work?
- Higher intensity FU
- Lifestyle interventions
- Bigger goals



Quadrant model

- Screening
- Prevention work
- Light touch

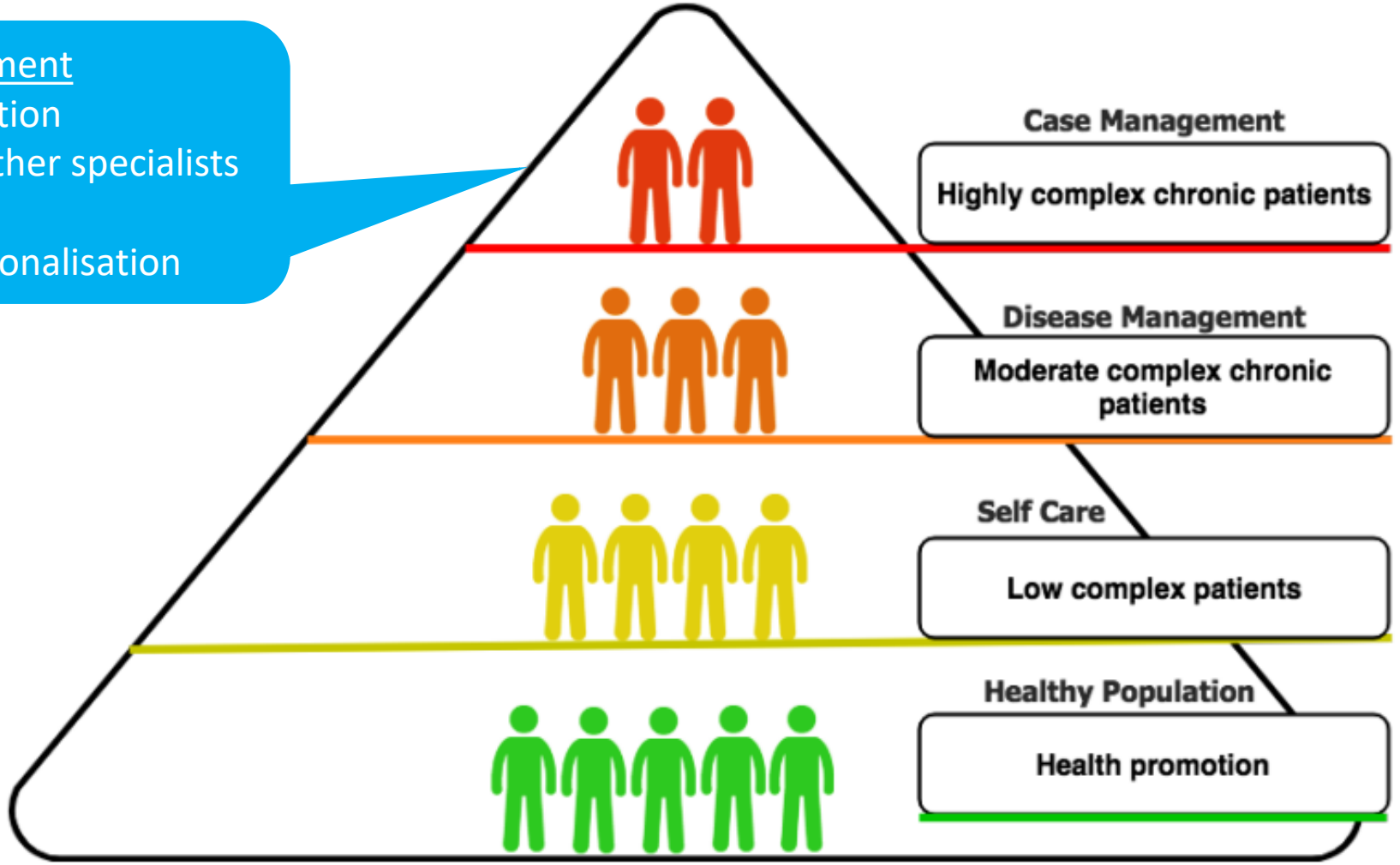
Developing pathways for unmet needs



Feachem RG, Sekhri NK, White KL. Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente. BMJ. 2002 Jan 19;324(7330):135-41. doi: 10.1136/bmj.324.7330.135. PMID: 11799029; PMCID: PMC64512.

Developing pathways for unmet needs

Case Management
Care-coordination
Liaison with other specialists and GPs
Medicines rationalisation



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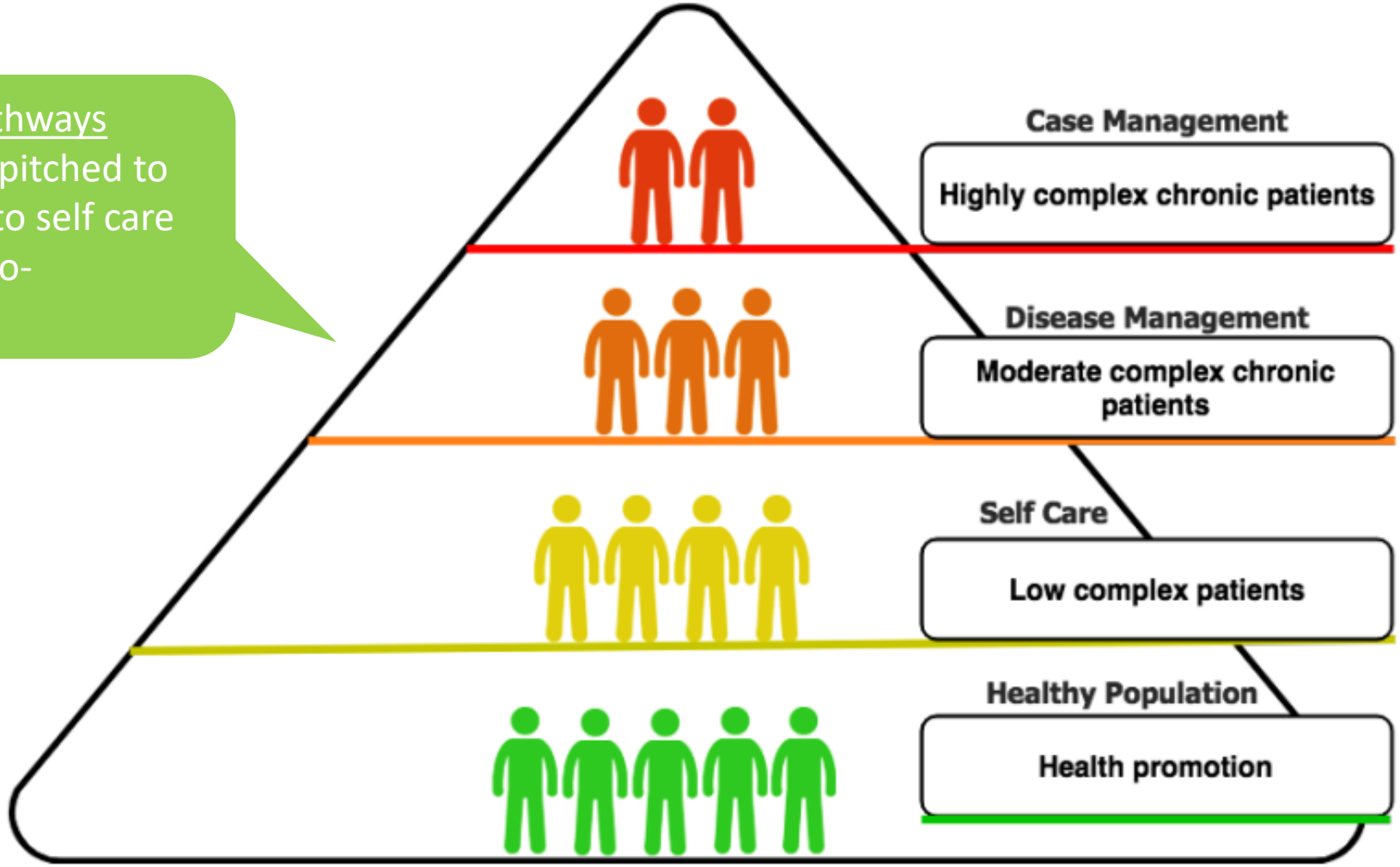
Developing pathways for unmet needs

Living well pathways
Interventions pitched to match ability to self care and manage co-morbidities



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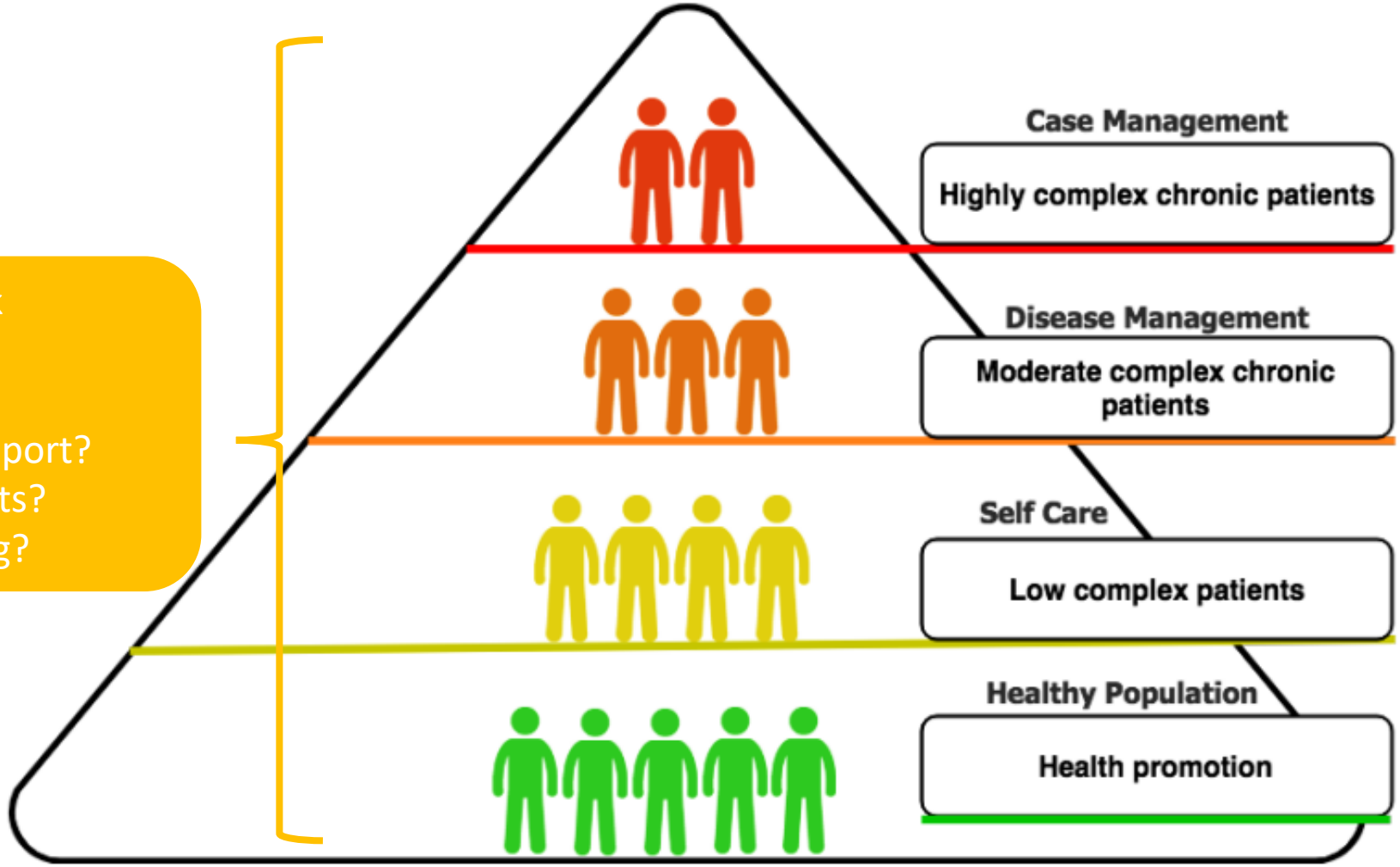
Developing pathways for unmet needs

LTFU / DNA work
Mental health
Peer support
Employment support?
Housing / Benefits?
Social prescribing?



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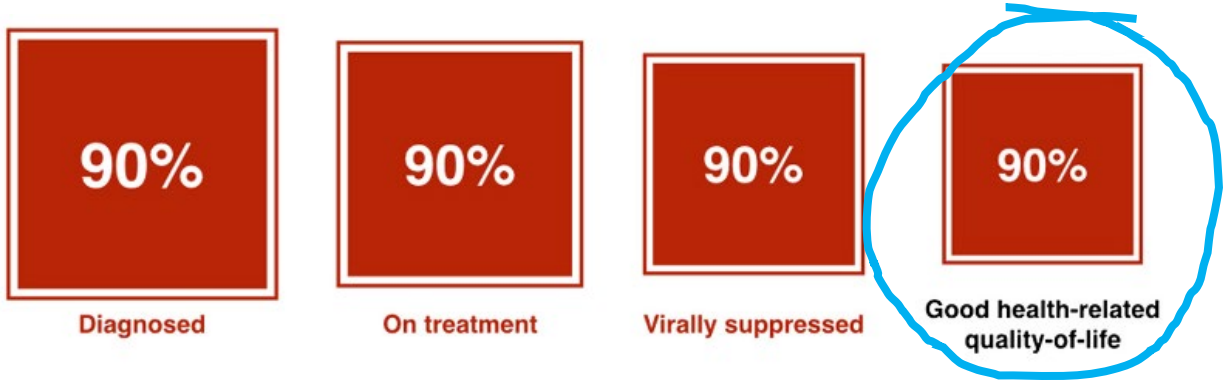
Personalising the care we give – summing up

- Taking into account ability to self-manage
- Asking the right questions to discover unmet needs
- Using tools to stratify care
  - Personalise the care we give
  - Utilise resource wisely, redirecting care where needed
- Developing pathways / signposting for unmet needs
  - Benefits / employment / social isolation
  - Addressing mental health
  - LTFU / DNA case work
  - MLTC case management



Lazarus et al. BMC Medicine (2016) 14:94

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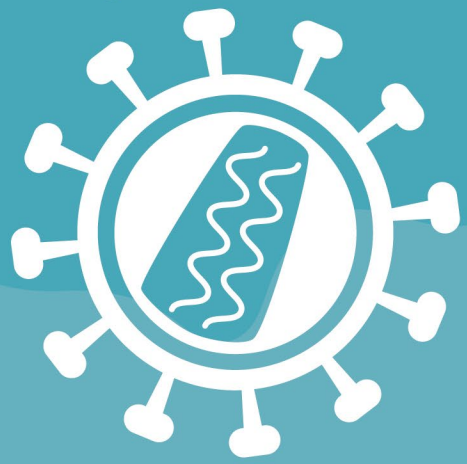

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Living well with HIV – Geriatric-HIV Medicine

Dr Howell T Jones

Academic Clinical Fellow in Geriatric Medicine, UCL

ST6 Geriatric and General (Internal) Medicine and Clinical Fellow in HIV Medicine, Royal Free Hospital and Mortimer Market Centre

Conflict of Interest

The Sage clinic the Sage Clinic was supported by an unrestricted grant from Gilead Sciences, Inc.

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Terminology

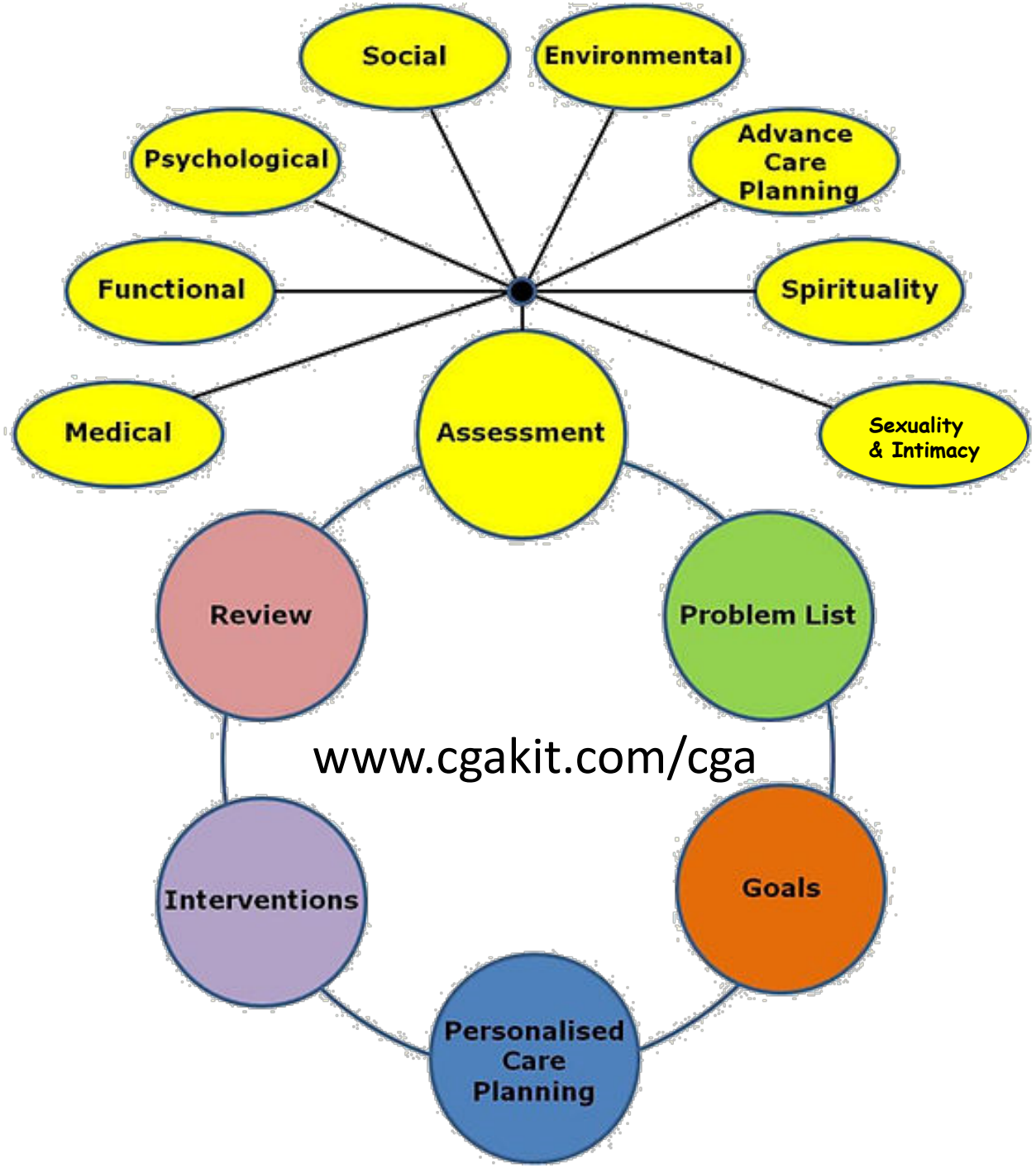
- Preferred terminology for the speciality is ‘Geriatric Medicine’ with doctors specialising in the field being ‘Geriatricians’[1].
- In 1995 the UN Committee on Economic, Social, and Cultural Rights of Older Persons rejected the term ‘elderly’ in preference for ‘older people’[2].
- The first time the term ‘Geriatric-HIV Medicine’ was used was in March 2017[3].
- This was to define the application of the geriatric medicine principles to the treatment of older people with HIV[3].
- Collaboration between geriatricians and other specialists has been successful e.g. ortho-geriatrics, cardio-geriatrics and onco-geriatrics[3].

Background

- By 2030 70% of people accessing HIV services in the UK will be older than 50 with almost 40% being over 65[3-7].
- One in six new cases of HIV diagnosed in Europe being in someone aged 50 (14% of new cases)[3,8].
- HIV is associated with high rates of multimorbidity and frailty in which geriatricians have a lot of experience in managing[9-12].
- A 2016 UK based survey of HIV clinicians reported half would refer complex older adults to a geriatrician[13].
- BHIVA promotes incorporating geriatricians into the care of complex older people living with HIV[14].

Comprehensive Geriatric Assessment (CGA)

- A multidimensional holistic assessment which considers health and wellbeing
- Formulates a plan to address identified issued (as per older person)
- Arranges interventions
- Reviews the impact



Views of Geriatricians

- Limited clinical studies
- None in UK (or Europe)
- 6 key barriers to involvement

(Jones and Barber, 2022) [15]

Existing Collaborative Services

- The Silver Clinic , Brighton, UK– 2016
- Golden Compass Programme, San Francisco, USA - 2017
- The Sage Clinic, London, UK – 2019

- Other models such as virtual clinics or MDTs have been trialled internationally

- What is the best model? (face-to-face versus virtual remains unclear)

Our Experience

- Sage Clinic – Ian Charleson Day Centre, Royal Free Hospital
- Launched 2019

Sage Clinic Multidisciplinary Team 2020

HIV MEDICINE | BHIVA British HIV Association

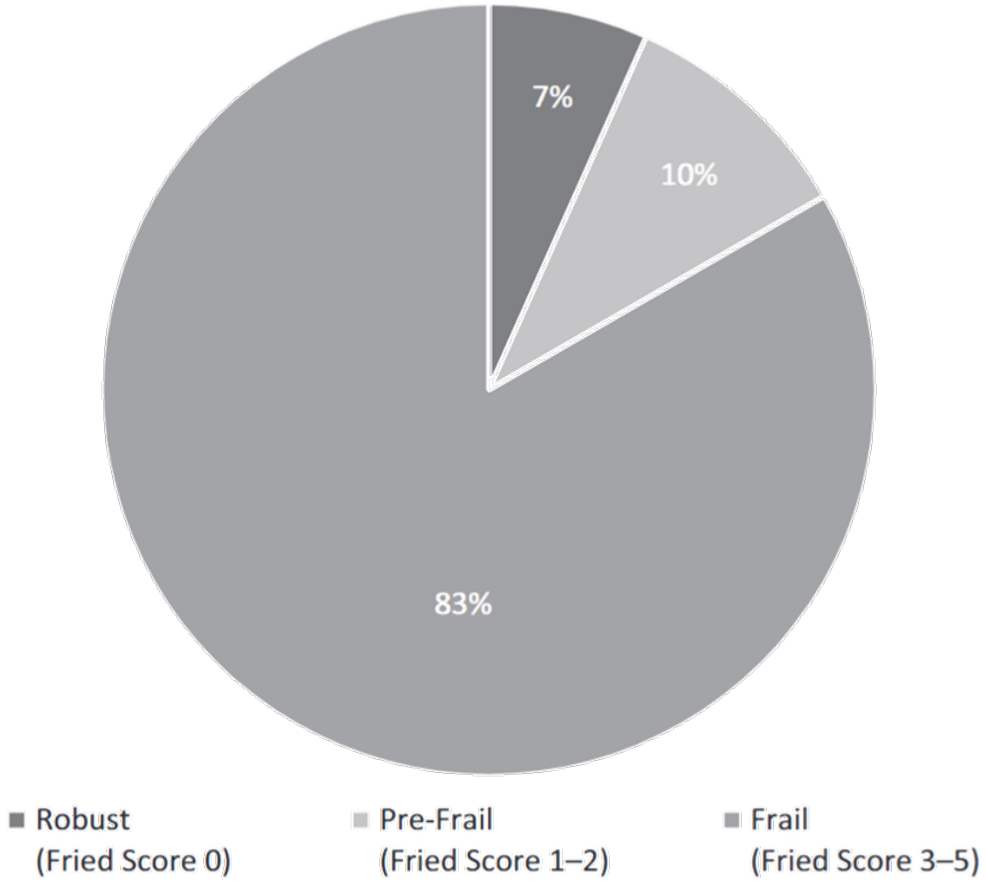
ORIGINAL RESEARCH

What problems associated with ageing are seen in a specialist service for older people living with HIV?

Howell T. Jones, Alim Samji, Nigel Cope, Joanne Williams, Leonie Swaden, Abhishek Katiyar, Fiona Burns, Aisha McClintock-Tiongco, Margaret Johnson, Tristan J. Barber ... See fewer authors

First published: 25 October 2021 | https://doi.org/10.1111/hiv.13193

Our Experience



Clinical characteristics ($n = 35$)	Results
Age (years) [median (range)]	69 (53–93)
Male [n (%)]	27 (77)
White ethnicity [n (%)]	22 (63)
Identified sexuality [n (%)]	MSM: 18 (51) Heterosexual: 17 (49)
Time since HIV diagnosis (years) [median (range)]	22 (3–37)
Duration of ART (years) [median (range)]	21 (3–32)
Current ART-based regimen [n (%)]	NRTI: 29 (83) NNRTI: 8 (23) PI: 11 (31) INI: 21 (60) CCR5 antagonist: 2 (6)
HIV RNA < 40 copies/mL [n (%)]	34 (97)
Nadir CD4 (cells/μL) [median (IQR)]	74 (182)
Current CD4 (cells/μL) [median (IQR)]	477 (319)
CD4:CD8 ratio [median (IQR)]	0.8 (0.8)
Previous AIDS-defining condition [n (%)]	21 (60)

(Jones et al., 2022) [16]

Our Experience

- Most common reported issues:
  - Mood
  - Memory
  - Falls
- Common ‘hidden’ issues:
  - Psychosexual issues e.g. Erectile dysfunction
  - Ageing as a member of a minority group especially as a gay/bisexual man

(Jones et al., 2022) [16]

Issue	Number of patients ($n = 35$)	Percentage of patients (%)
Affective symptoms and depression	18	51
Memory loss	13	37
Falls	10	29
Urinary symptoms	9	26
Pain	8	23
Weight loss	7	20
Breathlessness	5	14
Bowel symptoms	5	14
Haematological problems	5	14
Anxiety	4	11
Isolation and loneliness	4	11
Alcohol use disorder	3	9
Modifiable polypharmacy	3	9
Financial insecurity	2	6
Smoking	2	6
Complications of diabetes mellitus	2	6
Visual symptoms and loss	1	3
Immigration issues	1	3

Service user feedback

- *"…One thing I have sort of spin off illnesses from of HIV, well not necessarily always from HIV but I have had cancer and I have had illnesses that were probably related to HIV, like osteoporosis so excellent opportunity to discuss all these things and not just discuss them as single … I feel like is the real benefit of a clinic like this, I feel like it's a rare opportunity, actually to look it as a holistic picture."*

- *"Brilliant, absolutely brilliant, very, it was very professional and very patient led, I would say, client-led, so I don't feel like I was being put up on"*

- *"I mean it's just excellent care, isn't it? I've told other people about it and they say, 'how can I get referred*?'"

Recommendations

- Research needed into how best to deliver ageing related care to older people living with HIV in the UK.
- HIV services to review need and liaise with local ageing services to determine most appropriate service model for their cohorts.
- Current need for joint guidelines between HIV & Geriatric medicine.
- Focussed educational tools are needed for both groups of clinicians.

References

[1] British Geriatrics Society. BGS Strategic Plan:2020-2023. In: BGS;.2020.
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[16] Jones HT, Samji A, Cope N et al. What problems associated with ageing are seen in a specialist service for older people living with HIV? HIV Med 2022; 23:259-267.

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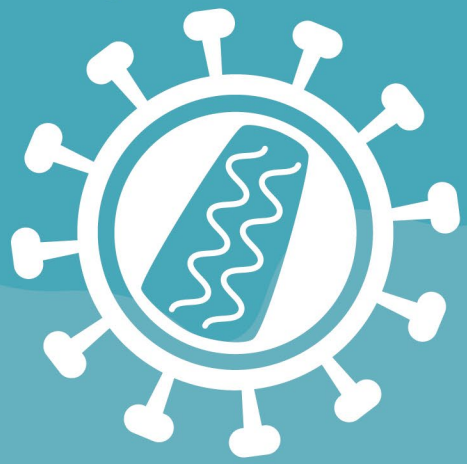

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Workshop: Living Well with HIV – personalising multiple long term condition management: *Role of Specialist Pharmacist*

Fiona Marra FRPharmS (Consultant)

Senior Pharmacist HIV/HCV, Glasgow

National Lead Clinician Paediatric Infection (SPAIIN)

Principal Pharmacist, University of Liverpool

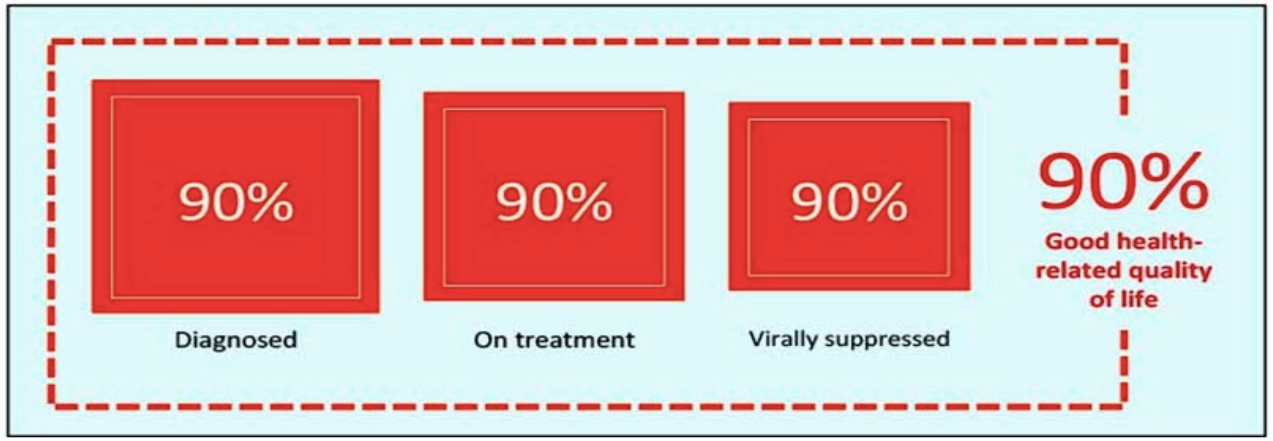
Conflict of Interest:

Research grants and/or educational honoraria from Gilead, Viiv, MSD

Understanding Multimorbidity

- Between 2015 and 2020 the global population of over 60's almost doubled.
- Multimorbidity needs considered at all ages
- Successes in HAART mean that often HIV is easiest co-mordidity to manage

Appropriate titration of medications and therapeutic symptom management is important to enable patients to achieve the 4th 90.



Role of the Specialist HIV Pharmacist in multimorbidity?

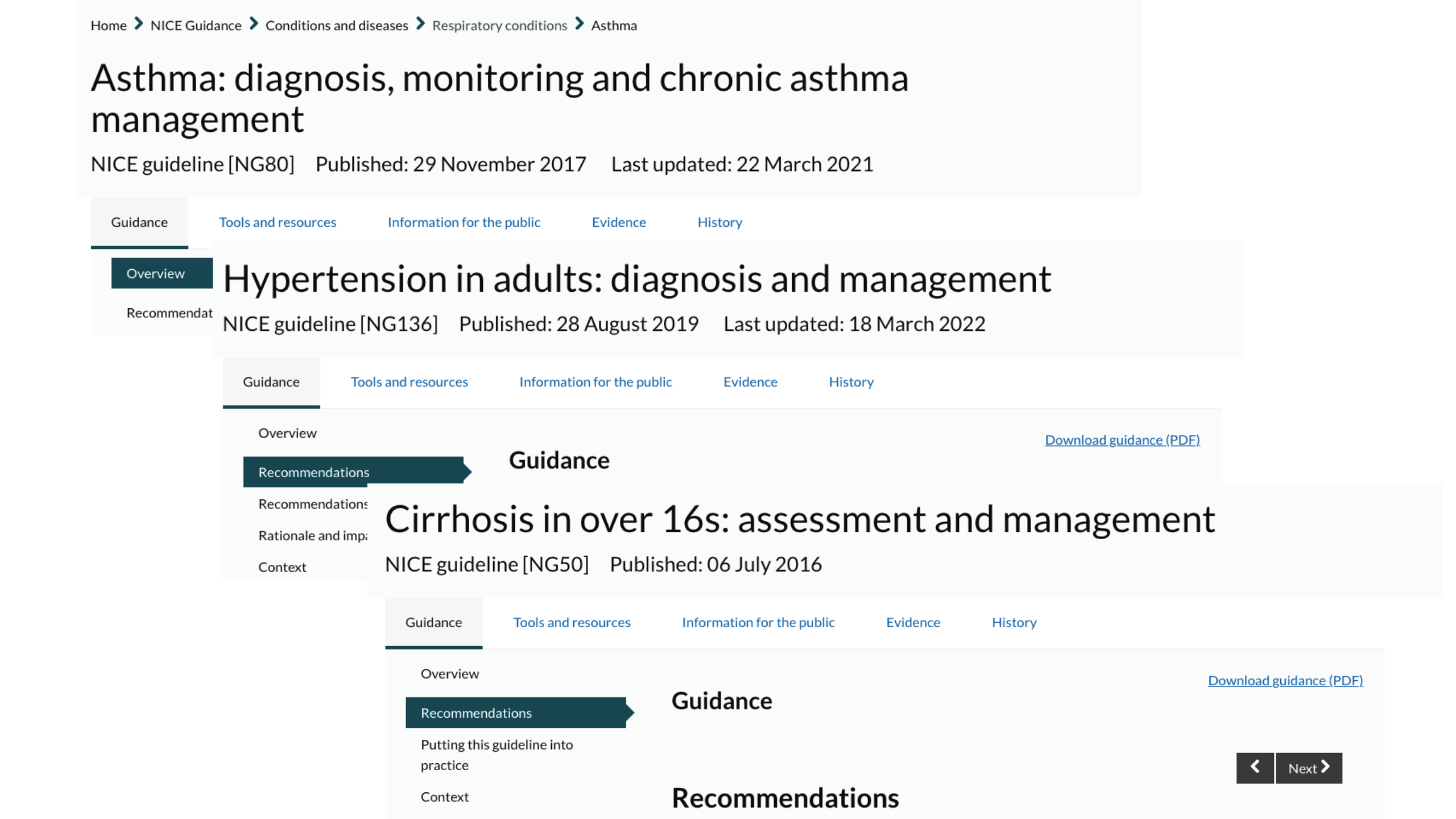
- Responsibility for prescribing and/or monitoring of ALL conditions?

- Titration or additional agents in uncontrolled hypertention/COPD etc?

  - Providing care for poor attenders in other specialities eg cirrhosis monitoring? Link in via MDT
  - What can be managed (via national guidelines) and what needs referred?

- Actively pursuing and following up DNA's in other services to understand why?

- Regular rationalisation of co-medications



Home › NICE Guidance › Conditions and diseases › Respiratory conditions › Asthma

Asthma: diagnosis, monitoring and chronic asthma management

NICE guideline [NG80] Published: 29 November 2017 Last updated: 22 March 2021

Guidance | Tools and resources | Information for the public | Evidence | History

Overview

Recommendat

Hypertension in adults: diagnosis and management

NICE guideline [NG136] Published: 28 August 2019 Last updated: 18 March 2022

Guidance | Tools and resources | Information for the public | Evidence | History

Overview

Recommendations

Recommendations

Rationale and impa

Context

Download guidance (PDF)

Guidance

Cirrhosis in over 16s: assessment and management

NICE guideline [NG50] Published: 06 July 2016

Guidance | Tools and resources | Information for the public | Evidence | History

Overview

Recommendations

Putting this guideline into practice

Context

Download guidance (PDF)

Guidance

Next

Recommendations

Identifying legacy DDI's

Patient DM

Started DRV/r + Truvada 2014

- On simvastatin – RED
- Switched to low dose pravastatin due to DDI

Switched to Triumeq 2016

- Remains on suboptimal statin and cholesterol not controlled

Patient TF

Started ATZ/r + Truvada 2016

- On Atorvastatin 80mg– AMBER
- Switched to Atorvastatin10mg due to DDI

Switched to Biktarvy 2020

- Dose never increased again

Patient FK

On Genvoya 2015

- Stable asthma at time, switched to beclomethasone instead of previous fluticasone due to DDI

Switched to Triumeq 2018

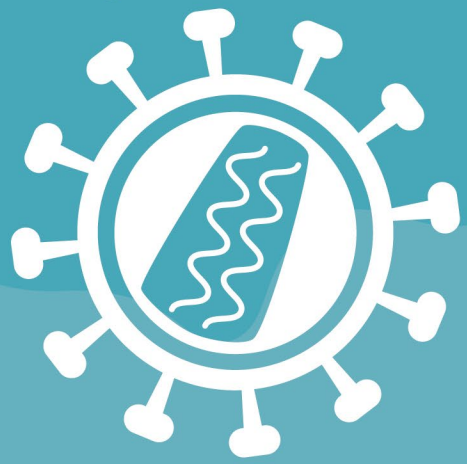
- Asthma decline
- Documented in notes still not for budesonide or fluticasone
- 15 salbutamol inhalers

Optimization and rationalization of non-HIV meds

- Is it a fixed term course i.e. 3 months apixaban?
- Are there long term conditions that can be optimized by pharmacists in HIV clinic in partnership with specialists?
- Are doses titrated to maximum required for efficacy i.e. SSRI, antihypertensives, pain medications?
- Can inappropriate prescribing be rationalized i.e. PPI?
- Can pharmacist clinics identify lack of adherence in non HIV care and add on monitoring in routine visits i.e. cirrhosis monitoring, TDM of other agents ie digoxin/carbamazepine/lithium levels etc for non compliance?

BHIVA

British HIV Association



2022 Spring Conference

Wed 20th - Fri 22nd April

Manchester Central, Manchester