BHIVA
British HIV Association

2022 Spring Conference
Wed 20<sup>th</sup> - Fri 22<sup>nd</sup> 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
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 (e.g., 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 than 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

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

What’s important to our patients?

• Mental health
• Obesity management
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• Managing long term conditions – 1/3 living with 2 or more co-morbidities in addition to HIV
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We need to ask the right questions
PROM / Proforma

All affect ability to self manage

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

Quadrant model

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

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
Developing pathways for unmet needs

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

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

Developing pathways for unmet needs
Developing pathways for unmet needs

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

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. orthogeriatrics, 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 issues (as per older person)
- Arranges interventions
- Reviews the impact

www.cgakit.com/cga
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

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

Our Experience

(Jones et al., 2022) [16]

<table>
<thead>
<tr>
<th>Clinical characteristics ($n = 35$)</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years) [median (range)]</td>
<td>69 (53–93)</td>
</tr>
<tr>
<td>Male [$n$ (%)]</td>
<td>27 (77)</td>
</tr>
<tr>
<td>White ethnicity [$n$ (%)]</td>
<td>22 (63)</td>
</tr>
</tbody>
</table>
| 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) |
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]
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

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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
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-morbidity 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 hypertension/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
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?
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