HIV and Older Adults

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Disclosures

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Data Considerations

Data in this presentation offer a limited perspective of how systemic, social, and economic factors impact health. We recognize that racism, not race, creates and perpetuates health disparities.

To Learn More:
https://www.cdc.gov/minorityhealth/racism-disparities

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Objectives

- Describe common medical & social challenges facing older people with HIV
- Describe key components of Geriatric Assessment through the 5Ms framework and how to apply to the care of older people with HIV
  - Multicomplexity, Mind, Medications, Mobility, Matters Most
- Describe practical approaches to integrating geriatric assessment in clinical practice

Case: 74 y/o diagnosed with HIV 1984

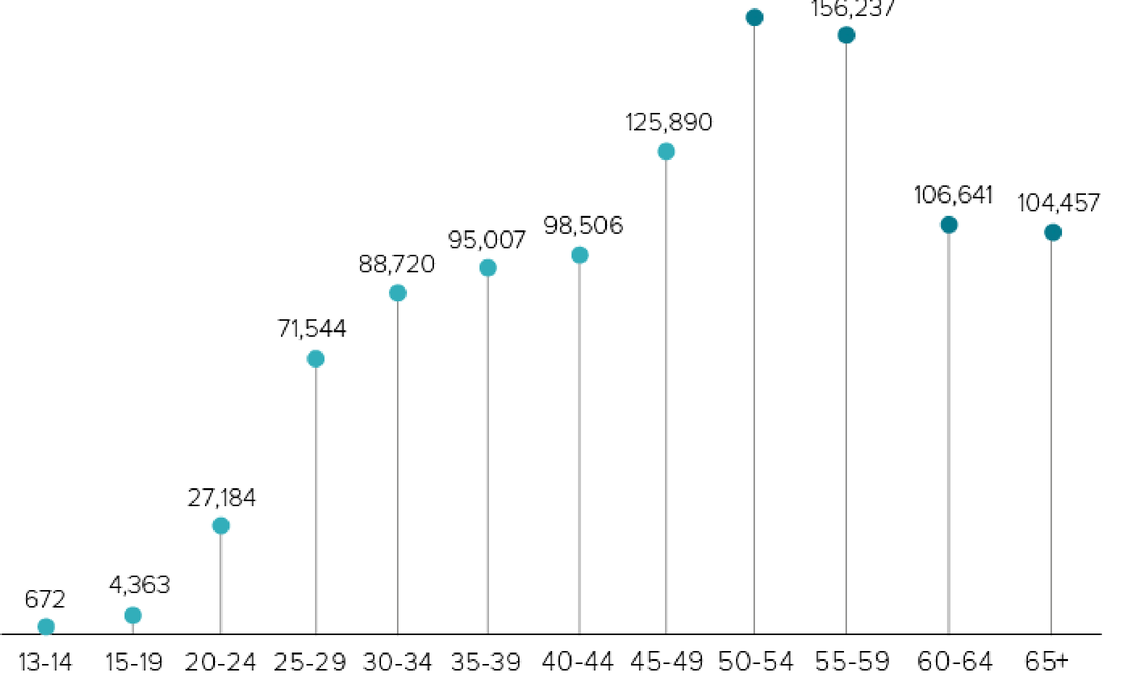
- CD4 count 440, viral load UD
- Hypertension, CKD, osteoporosis, depression, treated anal SCC
- 9+ medications daily
- Quit his job when diagnosed
- lost many friends in 80s/90s

> "When you got HIV in those days it was a death sentence. That was what was expected—you would die. To live even 5 years was a surprise to me..."

Greene M. *JAMA* 2013

Adults and Adolescents with Diagnosed HIV in the US and Dependent Areas by Age, 2018

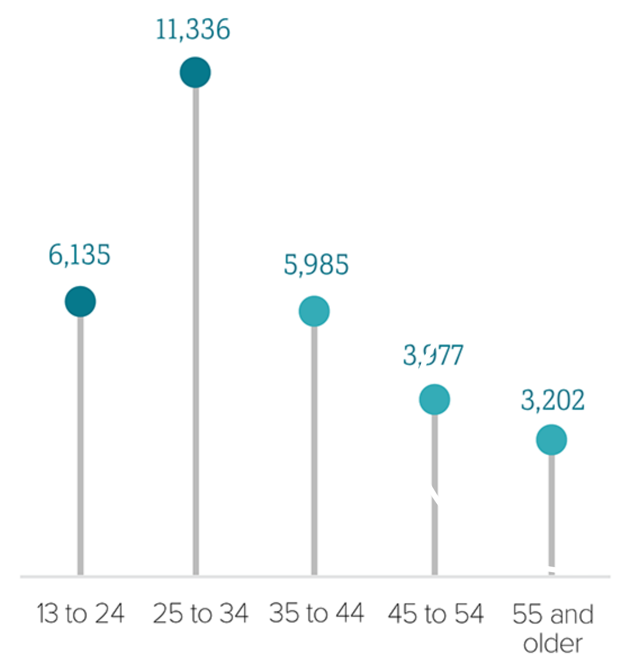
Over half of people with diagnosed HIV were aged 50 and older.



Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2018 (updated). *HIV Surveillance Report* 2020;31.

New HIV Diagnoses in the US and Dependent Areas by Age, 2020

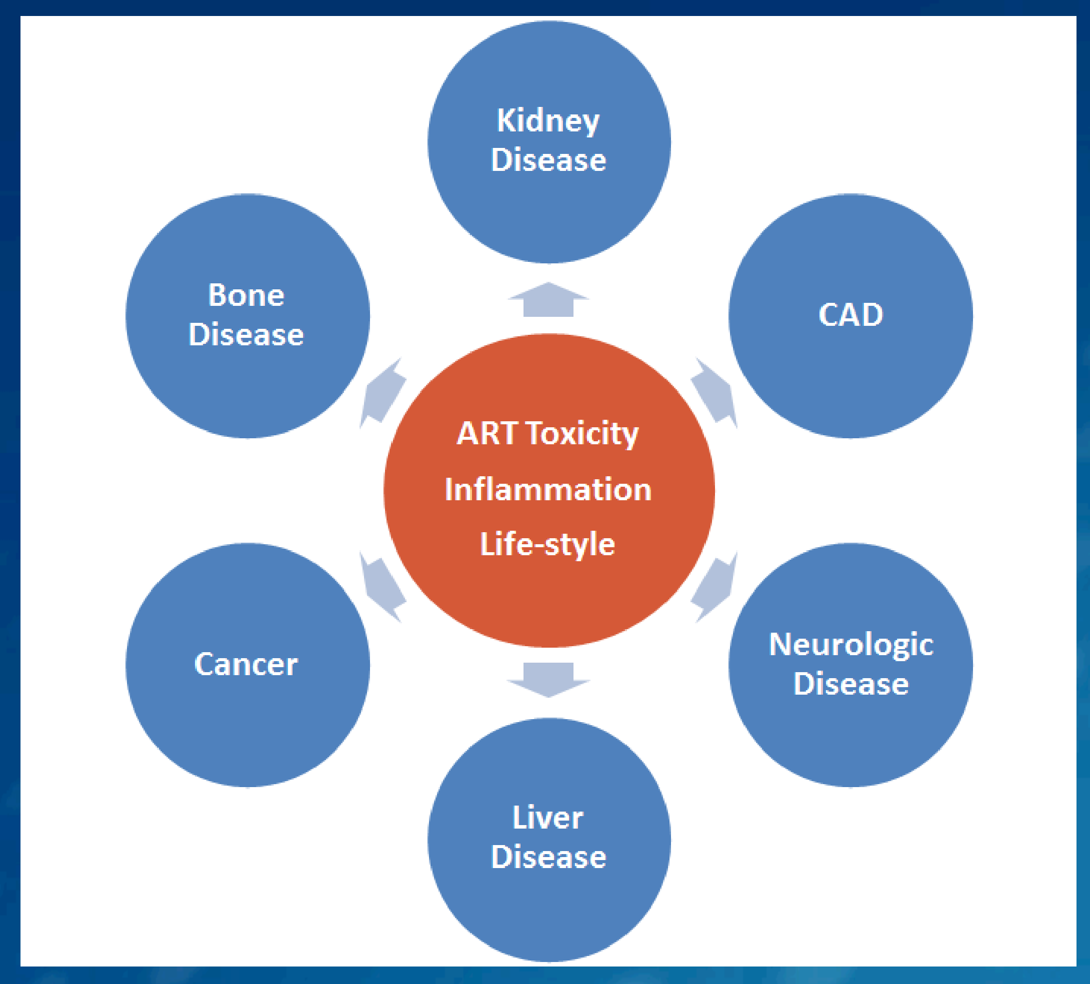
People aged 13 to 34 accounted for more than half (57%) of new HIV diagnoses in 2020.



Data for 2020 should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, care-related services, and case surveillance activities in state and local jurisdictions.

Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2020. *HIV Surveillance Report* 2022;33

HIV increases the risk of other chronic conditions



Geriatric Syndromes in Older HIV+ Adults

Syndrome	Percentage
Frailty	9.0%
Hearing Impairment	14.2%
Mobility	21.9%
Difficulty ≥1 ADL	25.2%
Incontinence	25.2%
Falls	25.8%
Visual Impairment	34.8%
Depression	40.0%
Cognitive Impairment	46.5%
Difficulty ≥1 IADL	46.5%
Pre-frailty	56.1%

0% 10% 20% 30% 40% 50% 60%

Greene M, JAIDS 2015

Increasing complexity: Geriatrics Approach can Help

- Multimorbidity
- Polypharmacy
- HIV
- Mental Health Cognition
- Social
- Economic

Care Cascade Needs to Go Beyond Viral Suppression

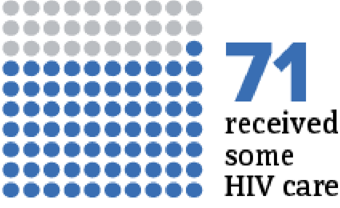
People Aged 55 and Older with HIV in the 50 States and the District of Columbia

At the end of 2018, an estimated **1.2 MILLION AMERICANS** had HIV. Of those, 379,000 were aged 55 and older.

people aged 55 and older knew they had the virus.

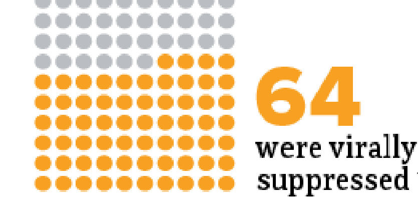
It is important for people aged 50 and older to know their HIV status so they can take medicine to treat HIV if they have the virus. Taking HIV medicine every day can make the viral load undetectable. People who get and keep an undetectable viral load (or stay virally suppressed) can live a long and healthy life. They also have effectively no risk of transmitting HIV to HIV-negative sex partners.

Compared to all people with HIV, people aged 55 and older have higher viral suppression rates. In 2018, for every **100 people aged 55 and older with HIV**:



71 received some HIV care

57 were retained in care *



64 were virally suppressed †

For comparison, for every **100 people overall** with HIV, **65 received some HIV care**, **50 were retained in care**, and **56 were virally suppressed**.

* Had 2 viral load or CD4 tests at least 3 months apart in a year.
† Based on most recent viral load test.

Source: CDC. Estimated HIV incidence and prevalence in the United States 2014–2018. *HIV Surveillance Supplemental Report*. 2018;25(1).
Source: CDC. Selected national HIV prevention and care outcomes (slides).

5Ms of Geriatrics

MULTICOMPLEXITY ...describes the whole person, typically an older adult, living with multiple chronic conditions, advanced illness, and/or with complicated biopsychosocial needs	MIND	▪ Mentation ▪ Dementia ▪ Delirium ▪ Depression
	MOBILITY	▪ Amount of mobility; function ▪ Impaired gait and balance ▪ Fall injury prevention
	MEDICATIONS	▪ Polypharmacy, deprescribing ▪ Optimal prescribing ▪ Adverse medication effects and medication burden
	WHAT MATTERS MOST	▪ Each individual's own meaningful health outcome goals and care preferences

5Ms and HIV Clinical Guidelines

- Adverse drug events from ART and concomitant drugs may occur more frequently in older persons with HIV than in younger individuals with HIV. Therefore, the bone, kidney, metabolic, cardiovascular, cognitive, and liver health of older individuals with HIV should be monitored closely.
- Polypharmacy is common in older persons with HIV; therefore, there is a greater risk of drug-drug interactions between antiretroviral drugs and concomitant medications. Potential for drug-drug interactions should be assessed regularly, especially when starting or switching ART and concomitant medications.
- The decline in neurocognitive function with aging is faster in people with HIV than in people without HIV. HIV-associated neurocognitive disorder (HAND) is associated with reduced adherence to therapy and poorer health outcomes including increased risk of death. For persons with progressively worsening symptoms of HAND, referral to a neurologist for evaluation and management or a neuropsychologist for formal neurocognitive testing may be warranted **(BIII)**.
- Mental health disorders are a growing concern in aging people with HIV. A heightened risk of mood disorders including anxiety and depression has been observed in this population. Screening for depression and management of mental health issues are critical in caring for persons with HIV.
- HIV experts, primary care providers, and other specialists should work together to optimize the medical care of older persons with HIV and complex comorbidities.

Box 6. Recommendations for Polypharmacy, Frailty, and Cognitive Function Screening for Older People With HIV

- Close and sustained attention to polypharmacy is recommended in the management of older people with HIV (evidence rating: AIII)
- Assessment of mobility and frailty is recommended for patients aged 50 years or older using a frailty assessment that is validated in all persons with HIV (evidence rating: BIa); the frequency of frailty assessment is guided by the baseline assessment and should be more frequent (every 1-2 years) in patients who are frail or before becoming frail, and less frequent (up to 5 yearly) in patients who are robust (evidence rating: BIII)
- In patients who are frail or prefrail, management of polypharmacy, referral for complete geriatric assessment, exercise and physical therapy, and nutrition advice is recommended (evidence rating: AIII)
- Routine assessment of cognitive function every other year using a validated instrument is recommended for people with HIV who are older than 60 years (evidence rating: BIII)

JAMA 2020

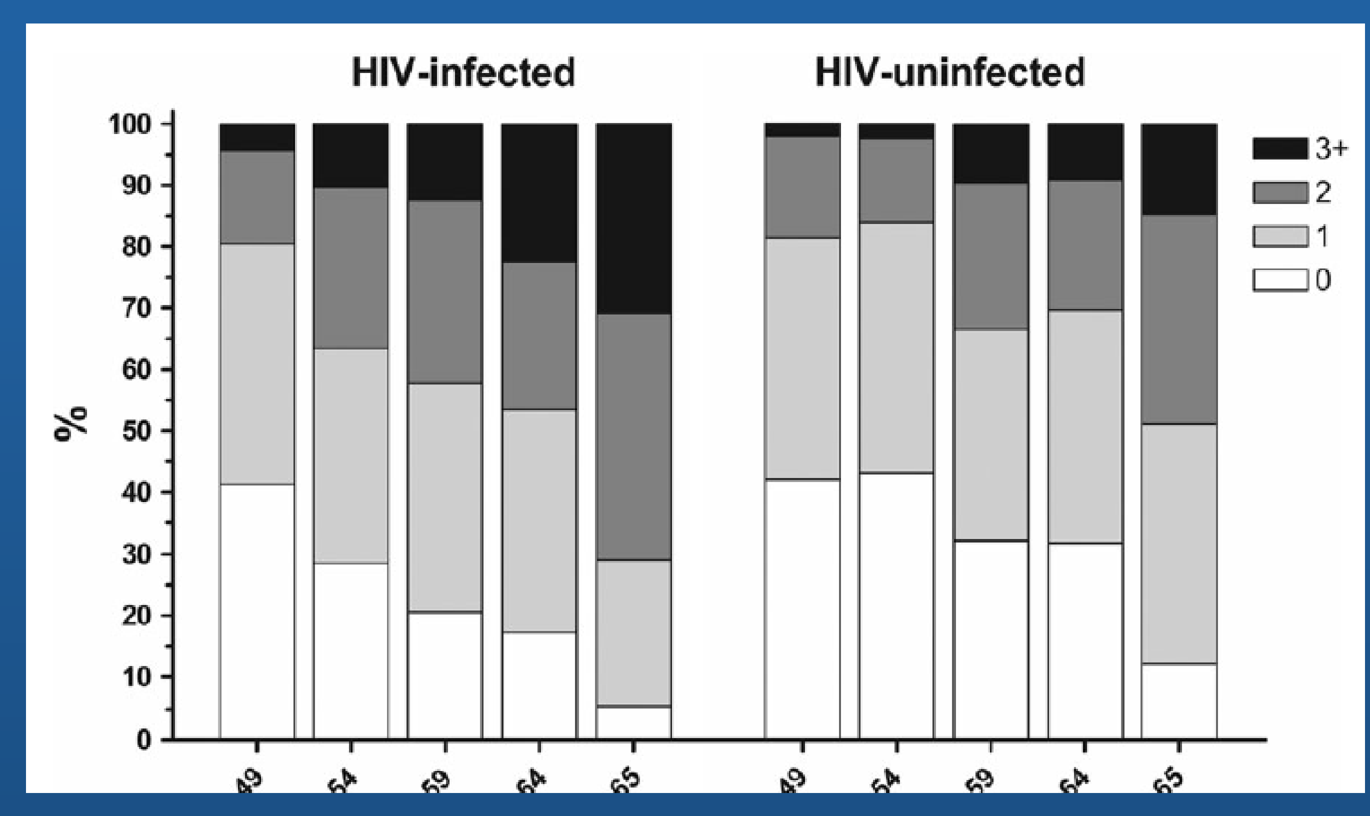
https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/hiv-and-older-person

Multi-complexity: Relevance to HIV and geriatrics

Multi-morbidity & polypharmacy

Geriatric Syndromes

Complex psychosocial situations



Multimorbidity Higher in PWH

Conditions included: CAD, HTN, PAD, CVD,COPD, DM, Renal Dz, Non-AIDS CA, Osteoporosis

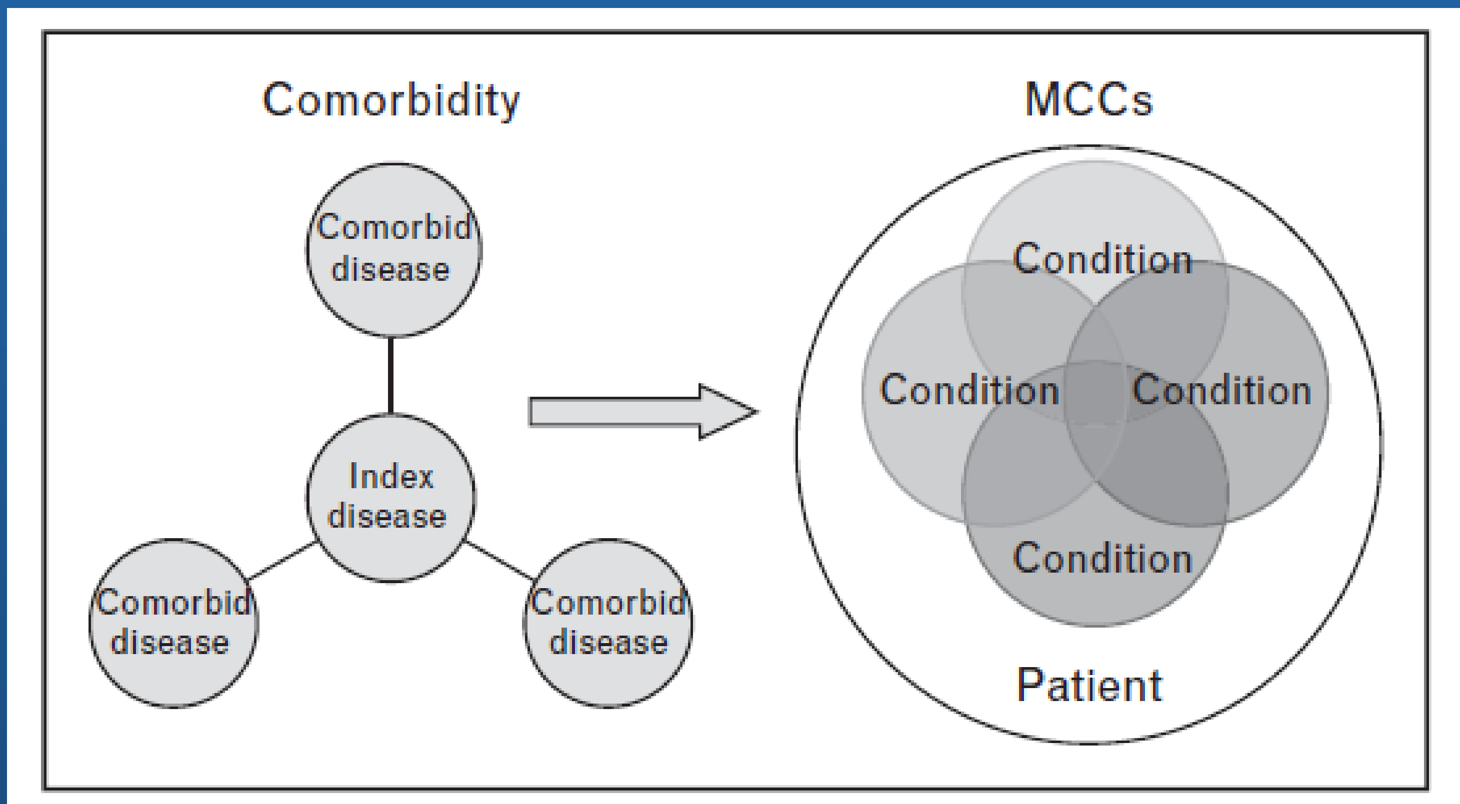
Schouten *CID 2014*

Multimorbidity Requires a Different Approach

Not just individual problems on a problem list:

-Individual disease and screening guidelines focus on Dx and Rx- adding medications

-Treatment Interactions



Boyd, Lucas *Curr Opin HIV/AIDS 2014*

Multimorbidity often leads Polypharmacy

- Polypharmacy higher in PWH, especially age >50
- May affect adherence to ART & non-ART meds
- Drug-drug interactions with ART
- Associations with falls, symptoms in PWH

(Halloren, 2019), (Siefried, 2018), (Ware, 2018), (Kim, 2018)

Case: Routine Follow-up visit

- 68 y/o male, HIV long term survivor
- CD4: 600 cells/mm3, viral load <40 copies/mL
- PMH: hypertension, hyperlipidemia, peripheral neuropathy, Type 2 diabetes, benign prostatic hypertrophy, renal insufficiency (CrCl 45), insomnia
- Exam: Afebrile, P 76, BP 130/70, 98% RA
- "So many pills…"

Medications	
DTG/ABC/3TC qd	Metformin 500 mg bid
Atorvastatin 40 mg qhs	Zolpidem 10 mg qhs prn
Lisinopril 20 mg qd	Tamsulosin 0.8 mg
Gabapentin 300 mg tid	Finasteride 5 mg qd
Amlodipine 5 mg qd	

Approach to Polypharmacy

1. Is there an indication for each medication?
2. Is the dose appropriate for age, liver and renal function?
3. Could any of the patient's symptoms be related to medications?
4. Are there drug-drug interactions?
5. Are there any potentially inappropriate medications?
6. Are there other medication concerns? (cost, adherence, complexity regimen)

Scott *JAMA Intern Med.* 2015

Prescribing in Elderly PWH

Age related comorbidities ► polypharmacy + Age related physiological changes ► impact pharmacokinetic (PK)/ pharmacodynamic (PD) effects of drugs

Drug-drug interactions (DDI) | Inappropriate drug/dosage use

↑ risk of adverse drug reactions; nonadherence; cognitive impairment; impaired balance and falls; morbidity and hospitalisation

Perform periodic medicines reviews[(i)]

Questions to consider when reviewing a prescription

- Is there an indication for the medicine?
- Is this medicine appropriate for elderly PLWH?
- Is the dose correct (e.g. adjusted for the renal function)?
- Is there a significant drug-drug interaction?
- Is there a significant drug-disease interaction (e.g. delirium)?
- Is the duration of treatment acceptable?
- Is there any missing medicine?
- Is the person able to manage his/her own medicines or does he/she need assistance?

Check for DDI with HIV drugs: http://www.hiv-druginteractions.org

Check for inappropriate drugs use: Beers[(ii)] and STOPP/START[(iii)] criteria

2020 EACS guidelines

Potentially Inappropriate Medications

- AGS Beer's Criteria
- START/STOPP criteria

O'Mahony *Age and Ageing* 2015; *J Amer Geri Soc* 2019

Selected Top 10 Drug Classes To Avoid in Elderly PLWH

Drug class	Problems/alternatives
First generation antihistamines e.g., clemastine, diphenhydramine, doxylamine, hydroxyzine	Strong anticholinergic properties, risk of impaired cognition, delirium, falls, peripheral anticholinergic adverse reactions (dry mouth, constipation, blurred vision, urinary retention). Alternatives: cetirizine, desloratadine, loratadine
Tricyclic antidepressants e.g., amitryptiline, clomipramine, doxepin, imipramine, trimipramine	Strong anticholinergic properties, risk of impaired cognition, delirium, falls, peripheral anticholinergic adverse reactions (dry mouth, constipation, blurred vision, urinary retention). Alternatives: citalopram, escitalopram, mirtazapine, venlafaxine
Benzodiazepines Long and short acting benzodiazepines e.g., clonazepam, diazepam, midazolam Non-benzodiazepines hypnotics e.g., zolpidem, zopiclone	Elderly are more sensitive to their effect, risk of falls, fractures, delirium, cognitive impairment, drug dependency. Use with caution, at the lowest dose and for a short duration. Alternatives: non-pharmacological treatment of sleep disturbance/sleep hygiene.
Atypical antipsychotics e.g., clozapine, olanzapine, quetiapine	Anticholinergic adverse reactions, increased risk of stroke and mortality (all antipsychotics). Alternatives: aripiprazole, ziprasidone
Urological spasmolytic agents e.g., oxybutynin, solifenacin, tolterodine	Strong anticholinergic properties, risk of impaired cognition, delirium, falls, peripheral anticholinergic adverse reactions (dry mouth, constipation, blurred vision, urinary retention). Alternatives: non-pharmacological treatment (pelvic floor exercises).
Stimulant laxatives e.g., senna, bisacodyl	Long-term use may cause bowel dysfunction. Alternatives: fibres, hydration, osmotic laxatives
NSAIDs e.g., diclofenac, indomethacin, ketorolac, naproxen	Avoid regular, long-term use of NSAIDs due to risk of gastrointestinal bleeding, renal failure, worsening of heart failure. Alternatives: paracetamol, weak opioids
Digoxin Dosage > 0.125 mg/day	Avoid doses higher than 0.125 mg/day due to risk of toxicity. Alternatives for atrial fibrillation: beta-blockers
Long acting sulfonylureas e.g., glyburide, chlorpropamide	Can cause severe prolonged hypoglycemia. Alternatives: metformin or other antidiabetic classes
Cold medications Most of these products contain antihistamines (e.g., diphenhydramine) and decongestants (e.g., phenylephrine, pseudoephedrine)	First generation antihistamines can cause central and peripheral anticholinergic adverse reactions as described above. Oral decongestants can increase blood pressure. Avoid

Table: 2020 EACS guidelines

MWAETC

Simple Interventions Effective at Reducing PIMS

- Cluster RCT pharmacies in Quebec
  - Randomized to usual care or given brochure
- At 6 months:
  - 27% stopped benzo compared with 5% in control group
  - 11% had dose reduction

You May Be at Risk

You are taking one of the following sedative-hypnotic medications:

- Alprazolam (Xanax®)
- Chlorazepate
- Chlordiazepoxide-amitriptyline
- Clidinium-Chlordiazepoxide
- Clobazam
- Clonazepam
- Diazepam (Valium®)
- Estazolam
- Flurazepam
- Loprazolam
- Lorazepam (Ativan®)
- Lormetazepam
- Nitrazepam
- Oxazepam (Serax®)
- Temazepam (Restoril®)
- Triazolam (Halcion®)
- Eszopiclone (Lunesta®)
- Zaleplon (Sonata®)
- Zolpidem (Ambien®, Intermezzo®, Edluar®, Sublinox®, Zolpimist®)
- Zopiclone (Imovane®,

Tannenbaum JAMA Intern Med 2014 (EMPOWER trial)

Approach to Polypharmacy

Confirm all medications including OTC, herbal, also alcohol & other substance use

1. Is there an indication for each medication?

2. Is the dose appropriate for age, liver and renal function?

3. Could any of the patient's symptoms be related to medications?

Medication list and PMH

- Takes 4 vitamins, also prn naproxen
- DTG/ABC/3TC
- Atorvastatin, lisinopril, amlodipine, gabapentin, zolpidem, metformin, tamsulosin, finasteride
- PMH: neuropathy, htn, hyperlipidemia, diabetes, insomnia, BPH, renal insufficiency (CrCl 45)

Prescribing Cascade Occurs Often!

nsaids → Blood pressure → amlodipine → Ankle swelling → furosemide → Hypokalemia → potassium → nausea → Anti-emetic

Approach to Polypharmacy

4. Are there drug-drug interactions?

5. Are there any potentially inappropriate medications?

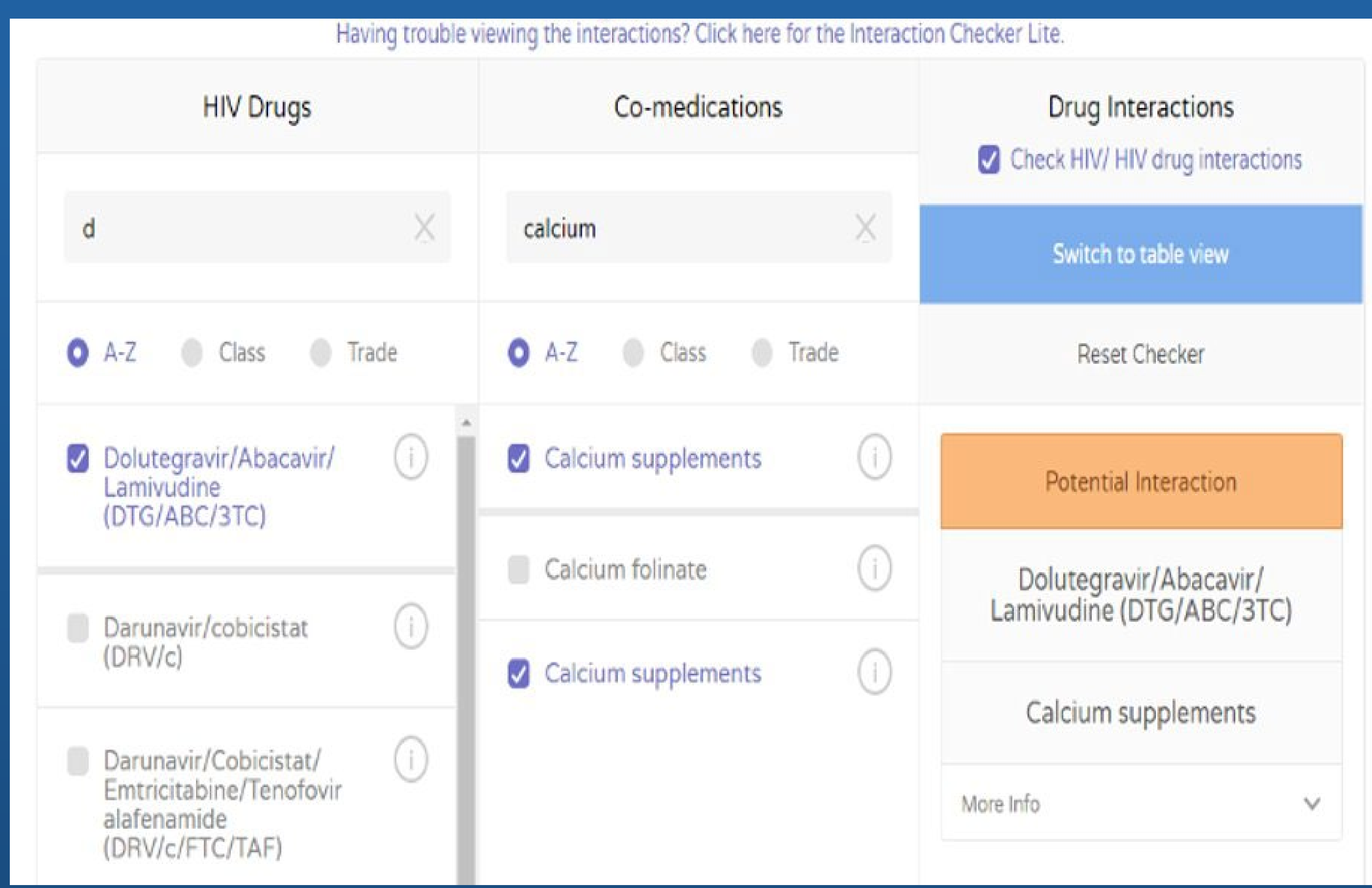
6. Are there other medication concerns? *(cost, adherence, complexity regimen)*

Medication list and PMH

- Takes 4 vitamins, also prn naproxen
- DTG/ABC/3TC
- Atorvastatin, lisinopril, amlodipine, gabapentin, zolpidem, metformin, tamsulosin, finasteride
- PMH: neuropathy, htn, hyperlipidemia, diabetes, insomnia, BPH, renal insufficiency (CrCl 45)

Drug-Drug Interactions

- Watch for ritonavir and cobicistat!
- Have to consider inhaled and intranasal steroids
- Vitamins & supplements



https://www.hiv-druginteractions.org/

Deprescribing Research and Clinical Resources

US Deprescribing Research Network

Join the Network

ABOUT US | NETWORK ACTIVITIES | NEWS | RESOURCES | MEMBERSHIP | FOR PATIENTS

Advancing research to optimize medication use among older adults.

Explore the US Deprescribing Research Network (USDeN)

- Investigator Development
- Grant Opportunities
- Engaging Stakeholders
- Data and Resources
- Working Groups
- Resources for Clinicians

Deprescribing.org

5Ms: Mind

Classic HAND symptoms:

- Executive function (multi-tasking)
- Attention (perceived as memory trouble)
- Slowing, motor symptoms
- Fluctuating course

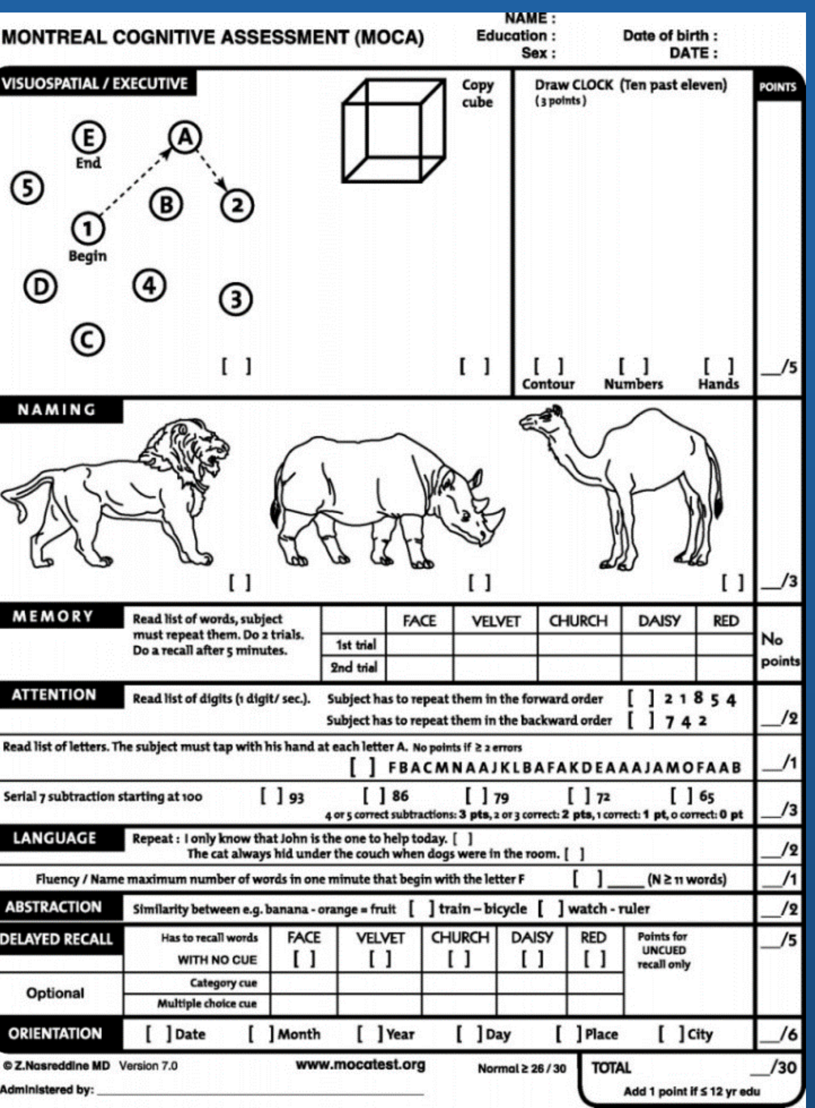
Cognitive symptoms can have many contributing factors- comorbidities, medications, substance use

Typical age-related memory loss and other changes compared to Alzheimer's

Signs of Alzheimer's	Typical age-related changes
Poor judgment and decision making	Making a bad decision once in a while
Inability to manage a budget	Missing a monthly payment
Losing track of the date or the season	Forgetting which day it is and remembering later
Difficulty having a conversation	Sometimes forgetting which word to use
Misplacing things and being unable to retrace steps to find them	Losing things from time to time

5Ms: Mind

- Mini-cog
  - (3-item recall & clock draw)
- MMSE
- **MOCA**
  - Likely best for HIV, mild Alzheimer's
- HIV Dementia Scale
  - Detect severe cases
- Digital Assessment



MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME :
Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE — E End, A, 5, B, 2, 1 Begin, D, 4, 3, C [ ] — Copy cube [ ] — Draw CLOCK (Ten past eleven) (3 points) [ ] Contour [ ] Numbers [ ] Hands — POINTS __/5

NAMING [ ] [ ] [ ] __/3

MEMORY	Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.		FACE	VELVET	CHURCH	DAISY	RED	No points
		1st trial						
		2nd trial						

ATTENTION — Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4. Subject has to repeat them in the backward order [ ] 7 4 2 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors [ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65 — 4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt __/3

LANGUAGE — Repeat : I only know that John is the one to help today. [ ] The cat always hid under the couch when dogs were in the room. [ ] __/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] ____ (N ≥ 11 words) __/1

ABSTRACTION — Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler __/2

DELAYED RECALL	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only	__/5
Optional	Category cue							
	Multiple choice cue							

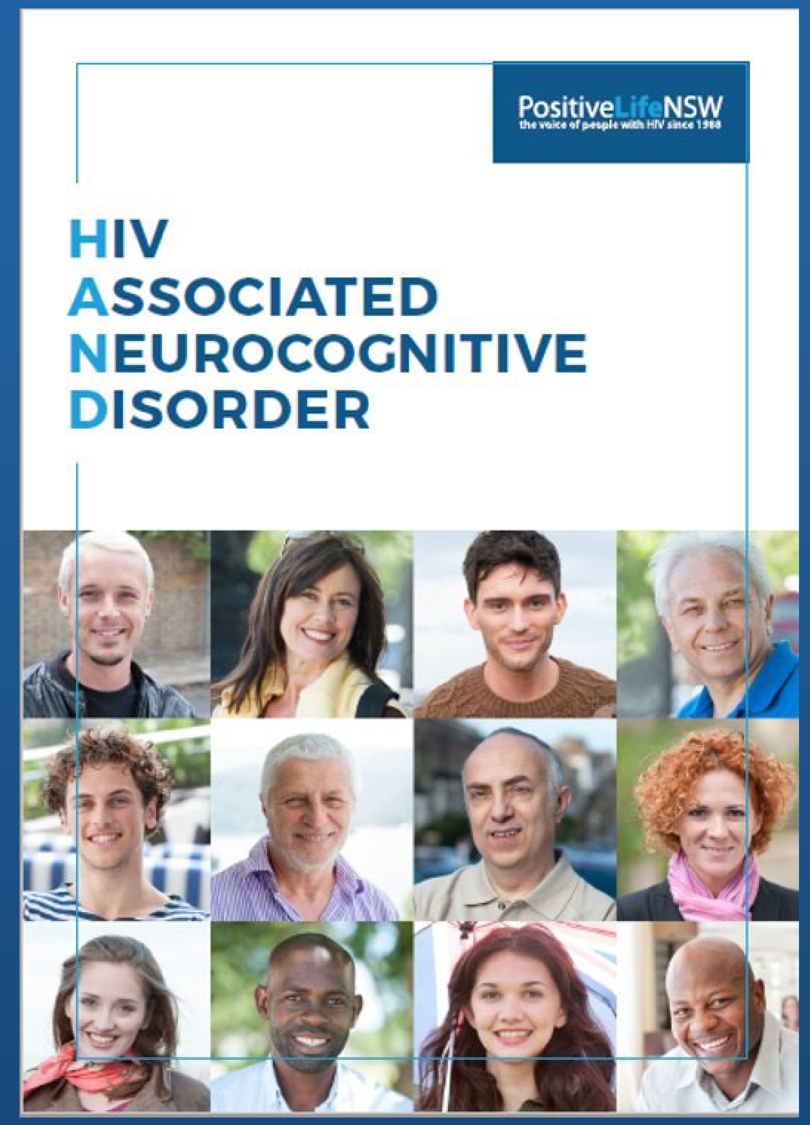
ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

© Z.Nasreddine MD Version 7.0 www.mocatest.org Normal ≥ 26 / 30 TOTAL __/30

Administered by: ____ Add 1 point if ≤ 12 yr edu

5Ms: Mind- Addressing Cognitive Symptoms

- CSF escape is rare- consider if rapid progression
- ART! ART!
- Address polypharmacy
- Treat comorbidities –vascular risk factors
- Treat depressive symptoms
- Address sleep
- Address sensory impairment
- Exercise
- Compensatory strategies – using lists, calendars, avoid multitasking
- Advanced care planning



Not Just Depression

- Traumatic Loss and Complicated Grief
- Stigma -- & often multiple stigmas
- History of trauma
- Substance use disorders

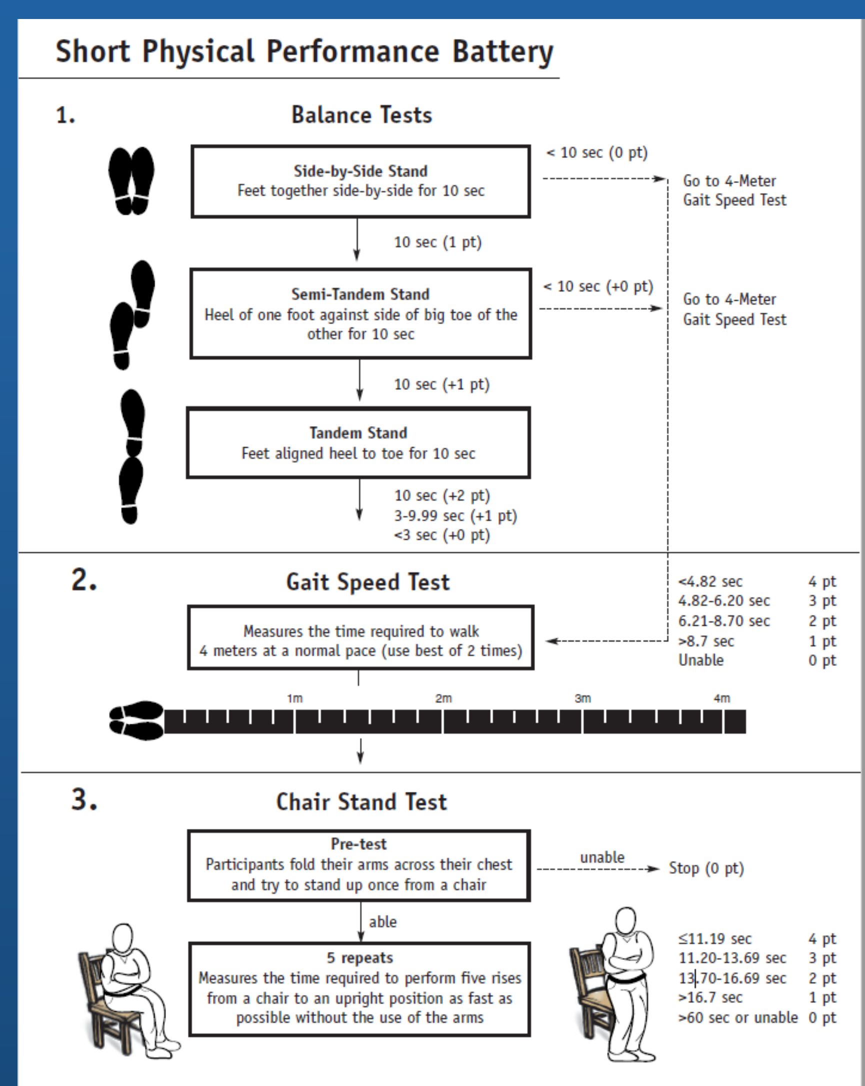
5Ms: Mobility & Function

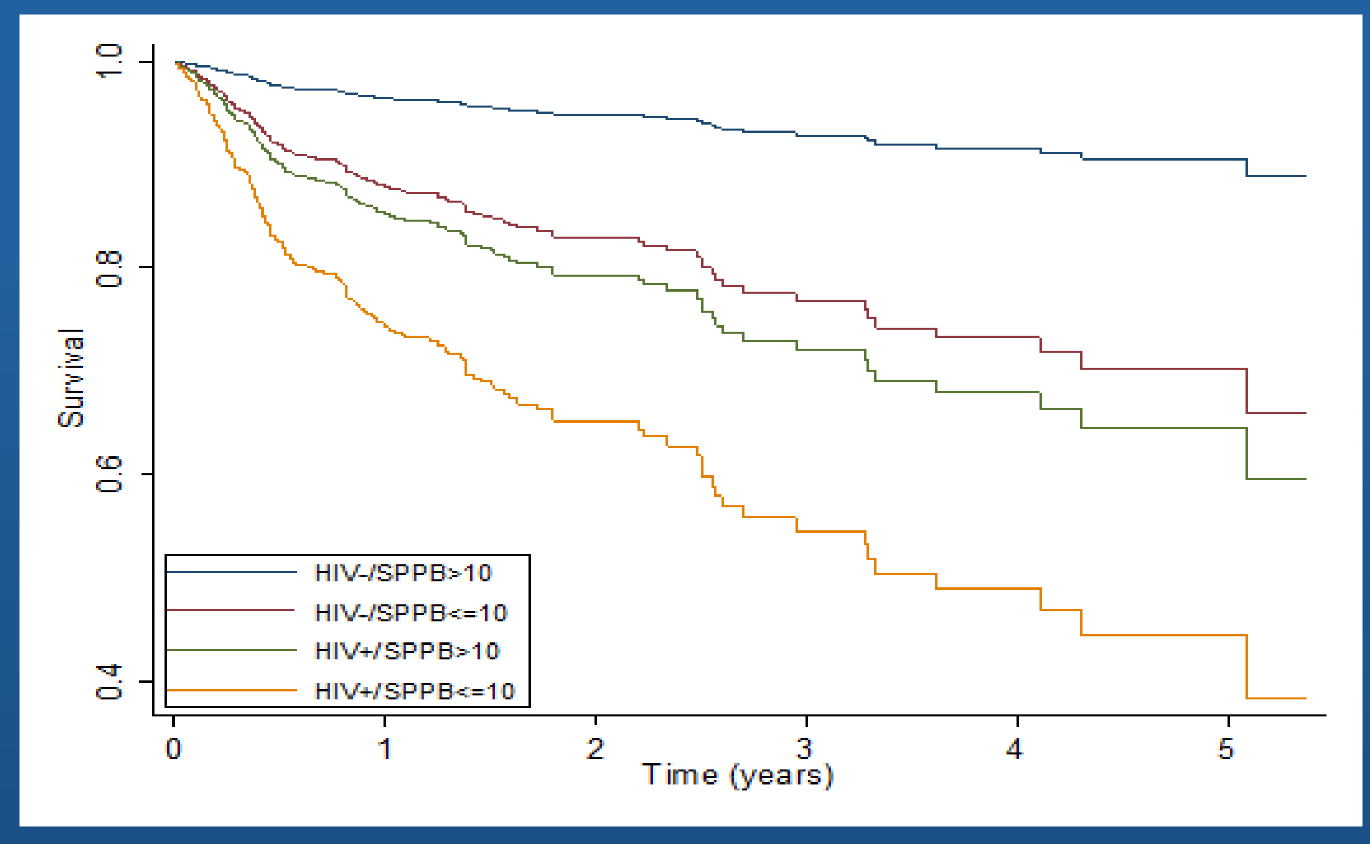
Mobility:
Stairs Room/House
Community

Activities of Daily Living (ADLs):
Bathing
Dressing
Toileting
Transferring
Feeding

Instrumental Activities of Daily Living (IADLs):
Telephone
Finances
Transportation
Laundry
Housekeeping
Shopping
Meal preparation
Medications

5Ms: Mobility- Short Physical Performance Battery





*Adjusted for gender, race/ethnicity, age, comorbidities

Greene *AIDS* 2014

5Ms: Screen for Falls

1. Do you feel unsteady when standing or walking?
2. Do you worry about falling?
3. Have you fallen in the past year?

cdc.gov

SCREENED NOT AT RISK

PREVENT future risk by recommending effective prevention strategies.

- Educate patient on fall prevention
- Assess vitamin D intake
  - If deficient, recommend daily vitamin D supplement
- Refer to community exercise or fall prevention program
- Reassess yearly, or any time patient presents with an acute fall

SCREENED AT RISK

2 ASSESS patient's modifiable risk factors and fall history.

Common ways to assess fall risk factors are listed below:

Evaluate gait, strength, & balance
Common assessments:
- Timed Up & Go
- 30-Second Chair Stand
- 4-Stage Balance Test

Identify medications that increase fall risk (e.g., Beers Criteria)

Ask about potential home hazards (e.g., throw rugs, slippery tub floor)

Measure orthostatic blood pressure (Lying and standing positions)

Check visual acuity
Common assessment tool:
- Snellen eye test

Assess feet/footwear

Assess vitamin D intake

Identify comorbidities (e.g., depression, osteoporosis)

Back to the Case: Mind and Mobility

68 y/o with well controlled HIV, multimorbidity & polypharmacy

Function	ADL: independent with all IADL: difficulty with managing medications, housekeeping
Cognition/MOCA	28/30

Fall risk screen: (CDC STEADI)

- **Have you fallen in the past year?** No
- **Do you feel unsteady when standing or walking?** Yes
- **Do you worry about falling?** No

Falls in PWH

Cohort	Mean age (years)	Any Fall	Recurrent Falls
HAILO	51	18%	7%
Colorado	52	30%	18%
MACS/WIHS	51	24%	13%
MACS-BOSS	61	41%	20%
WIHS	48	41%	25%
San Francisco	57	26%	--
ARCH 4F	55	34%	12% with 5+

Tolentino *JAIDS* 2021; Womack *JAIDS* 2019; Tassiopoulos K *AIDS* 2017; Erlandson *HIV Med* 2016; Erlandson *JAIDS* 2012; Sharma *Antivir Ther* 2019; Sharma *Antivir Ther* 2018; Greene *JAIDS* 2015

Case: Positive Screen

- Feels unsteady: gets dizzy when gets out of chair (lisinopril, amlodipine, tamsulosin, zolpidem)
- Reports decrease visual acuity (or do Snellen)
- No home hazards
- Has not had DXA to assess osteoporosis

- Exam:
  - Orthostatics: 130/70 (lying) to 110/68 (standing)
  - Decreased sensation feet, wearing supportive shoes
  - Difficulty with tandem stand

SCREENED AT RISK

2 **ASSESS** patient's modifiable risk factors and fall history.

Common ways to assess fall risk factors are listed below:

Evaluate gait, strength, & balance
Common assessments:
- Timed Up & Go
- 30-Second Chair Stand
- 4-Stage Balance Test

Identify medications that increase fall risk (e.g., Beers Criteria)

Ask about potential home hazards (e.g., throw rugs, slippery tub floor)

Measure orthostatic blood pressure (Lying and standing positions)

Check visual acuity
Common assessment tool:
- Snellen eye test

Assess feet/footwear

Assess vitamin D intake

Identify comorbidities (e.g., depression, osteoporosis)

Develop a Comprehensive Plan

- Stop amlodipine and monitor blood pressure; tamsulosin at night
- Discuss alternatives to zolpidem
- Referral to Physical therapy and/or exercises to support balance
- Referral to ophthalmologist

INTERVENE to reduce identified risk factors using effective strategies.

Reduce identified fall risk
- Discuss patient and provider health goals
- Develop an individualized patient care plan (see below)

Below are common interventions used to reduce fall risk:

Poor gait, strength, & balance observed
- Refer for physical therapy
- Refer to evidence-based exercise or fall prevention program (e.g., Tai Chi)

Medication(s) likely to increase fall risk
- Optimize medications by stopping, switching, or reducing dosage of medications that increase fall risk

Home hazards likely
- Refer to occupational therapist to evaluate home safety

Orthostatic hypotension observed
- Stop, switch, or reduce the dose of medications that increase fall risk
- Educate about importance of exercises (e.g., foot pumps)
- Establish appropriate blood pressure goal
- Encourage adequate hydration
- Consider compression stockings

Visual impairment observed
- Refer to ophthalmologist/optometrist
- Stop, switch, or reduce the dose of medication affecting vision (e.g., anticholinergics)
- Consider benefits of cataract surgery
- Provide education on depth perception and single vs. multifocal lenses

Feet/footwear issues identified
- Provide education on shoe fit, traction, insoles, and heel height
- Refer to podiatrist

Vitamin D deficiency observed or likely
- Recommend daily vitamin D supplement

Comorbidities documented
- Optimize treatment of conditions identified
- Be mindful of medications that increase fall risk

FOLLOW UP with patient in 30-90 days.

Discuss ways to improve patient receptiveness to the care plan and address barrier(s)

Case

Polypharmacy:

- Stopped naproxen and amlodipine, blood pressure ok
- Considering zolpidem taper

IADL difficulty:

- Able to get IHSS once a week to help cleaning
- Adherence packaging

Fall risk:

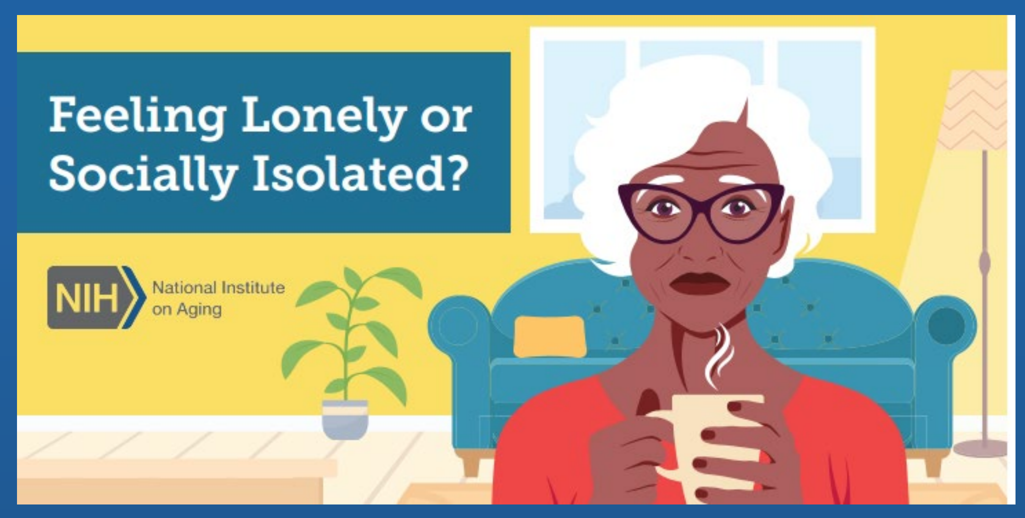
- Dizziness resolved after adjusting bp meds and timing of tamsulosin
- Went to ophthalmology (got new glasses)
- Had DXA with normal results

5Ms: Matters Most- Addressing Loneliness & Isolation

Loneliness is
the ***subjective*** feeling of
being alone.

Social Isolation relates to
a ***quantifiable*** number
of relationships

Not the same as living alone



Health impacts:

- Depression
- Cognitive & functional decline
- Increase mortality – similar to smoking 15 cigarettes/day

Ask!

Controversy over asking directly
 “do you feel lonely?”

Ask about social support
“How many people do you feel
 you can depend on or feel close to?

Related:
Ask about access phone, video
Ask about emergency contact
leading to surrogate decision maker

3-item UCLA Loneliness scale
1. I feel left out
2. I feel isolated
3. I lack companionship ***Hardly Ever, Some of the Time, Often***

Cudjoe *JAGS* 2020;Campaigntoendloneliness.org; Natl Academies of Science, Engineering & Medicine 2020 *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*.

Interventions for Loneliness in HIV+

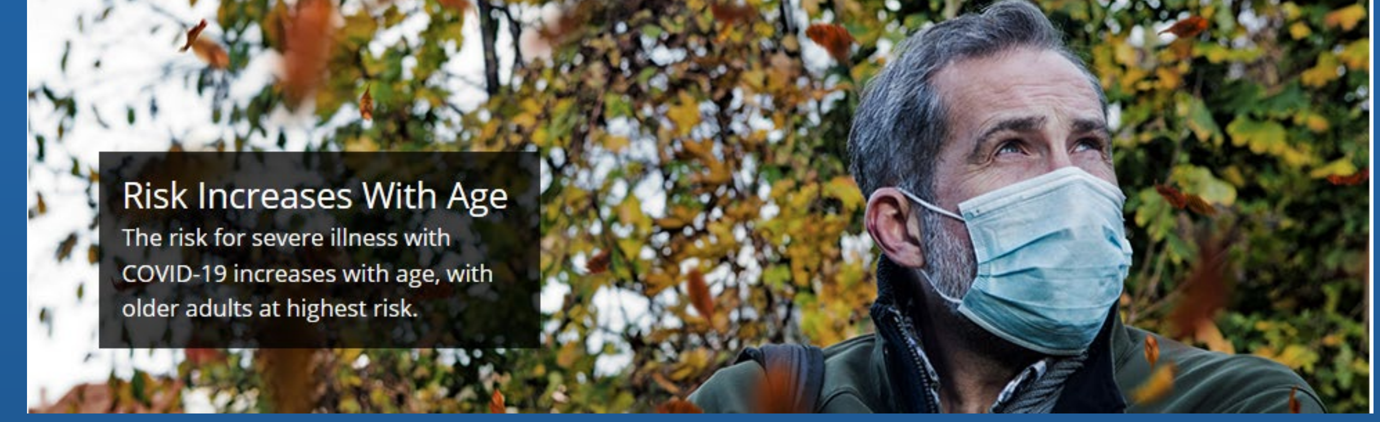
- Online support groups
- Mindfulness based cognitive therapy
- Telephone based interventions
- Group interventions for smoking cessation, peer counseling sessions on sexual risk behaviors

- Choose questions and services feasible to you
- Partner with community organizations
  - Direct interventions
  - Reaching most lonely
- Recognizing resilience

Mo *Pt Educ & Couns* 2013; Stanton *AIDS Care* 2015; Samhkaniyan *J Med Life* 2015; Heckman *Ann Int Med* 2006; Hart *Plos One* 2016, Wu *Health Psych & Behav Med* 2014

Even more important during COVID-19

Other consequences COVID:



- Increased isolation
- Increase in mental health concerns & substance use
- Decreased physical activity (fear leaving home)
- Difficulty keeping caregivers

Geriatric Assessment During COVID

- Telehealth is here to stay –hopefully (& as supplement)
- Self-report of falls, function can be asked on phone
- Can still observe gait, getting up out of chair
- Advantages to video visits in home:
  - See parts of environment
  - Med review!!!
  - Improve access limited mobility

What if you don’t have a geriatrician in clinic?

- What are your local resources?
- Telehealth options with geriatrics?

- Which areas (like in 5Ms) are you already addressing?
  - Pick one to start;

- What is your staffing and availability to help with doing assessments?
  - and follow-up after screening/assessment
  - team approach but can break into visits or telehealth sessions

It takes a village...

Dental

Pharmacy
Nutrition

Social Work
Behavioral Health

Primary Care
MD Consultants

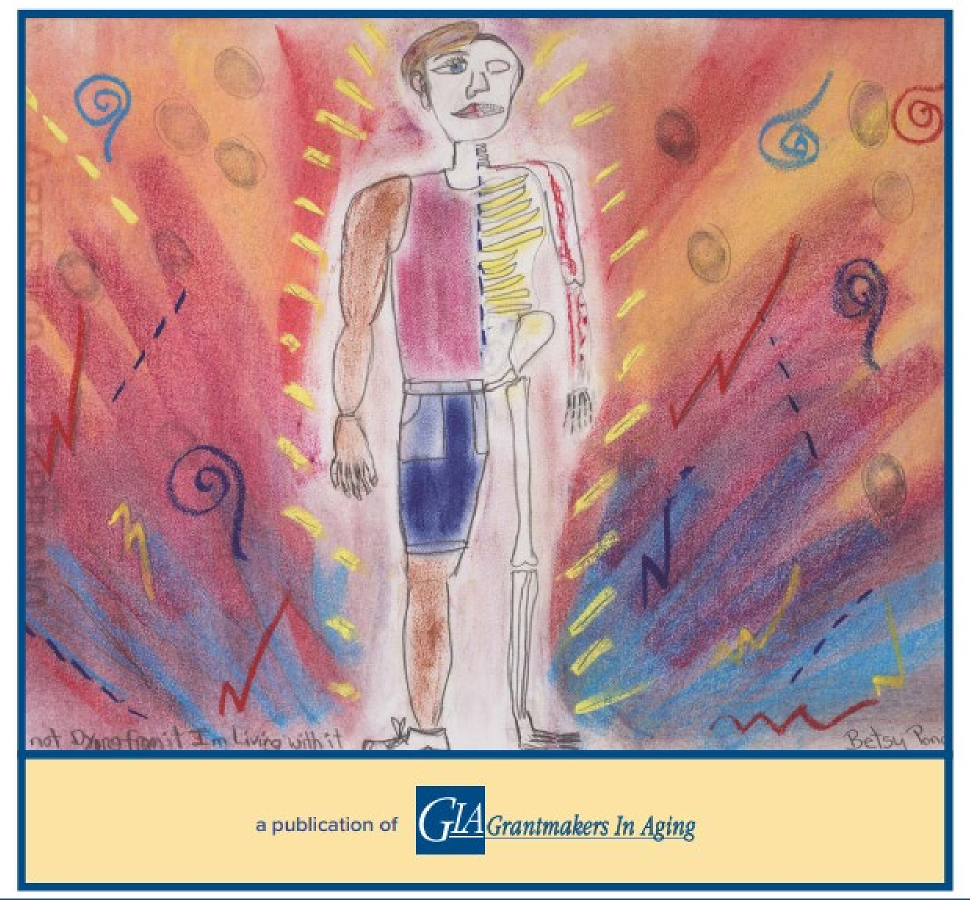
Patient, Family,
Caregivers

Home Health
Aides

PT/OT

Nursing

It also takes policy...



Ryan White TargetHIV:
https://targethiv.org/library/topics/aging

Quality of Life in National HIV/AIDS Strategy

Multi-dimensional:

- Self-rated health
- Mental health
- Nutrition/Food insecurity
- Employment
- Housing

Summary

- 5Ms of Geriatrics Approach can help improve care & address **Multi-complexity** many Older PWH experience
- **Mobility:** Ask about function (ADL, IADL) and falls
  - Objective assessments –SPPB, CDC STEADI
- Mind: Assess mental health and cognition
  - MOCA may be best clinic-based tool for HAND, cognitive symptoms
- Matters most: Ask about loneliness & social isolation (normalize!)
  - UCLA loneliness scale

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Questions?

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