Challenges in HIV and Aging

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Overview

- Social needs and Isolation
- Service Coordination between HIV and Geriatrics
- Housing/how to support housing

Objective: Inform and provide food for thought

Loneliness and Social Isolation in OPWH

- Loneliness = the discrepancy between one's preferred and actual social relations
  - U.S. Prevalence ~40-58%
    - Prevalence of loneliness was lower in PWH 60 yrs.+ compared to 50-59 yrs.
- Social isolation = objective deficit in number of relationships and frequency of contact
  - U.S. Prevalence unclear
    - 65-69% live alone
    - 81% do not have close friends

May not be emotionally distressing

Greene AIDS % Beh 2018, , Mazonson AIDS care 2021, Emlet Gerontologist 2013

What are the Costs?

LONELINESS	SOCIAL ISOLATION
• Associated with inflammation • Increased chronic pain • Impaired resilience • Reduced quality of life • Increased depression/anxiety • Increased SUD • Self reported functional impairment • Poorer quality of life	• 6.7 billion annually in costs for the care of socially isolated persons (Medicare) • Limited access to caregivers and other support (stress, lack of resources) -- Increased risk for hospitalization and all cause mortality -- Increased depression/anxiety -- Increased SUD (? boredom) -- Increased risk for cognitive decline

Marziali AIDS and Behavv2020, Pollack AIDS and Beh 2024, Greene AIDS and Behavior 2018, Holt-Lundstad Perspectives on Psychological Science 2015, Holt-Lundstad Plos Medicine 2010, Wilson Arch Gen Psychiatry 2007
Valtorta Heart 2016, Pollak AIDS and Beh 2024

Concentrated and Unique Experiences may Contribute to Loneliness and Social Isolation in Older PLWH

- Initial fatal diagnosis → opt out of work, stopped making new connections
- Significant loss of peers & partners → rapid depletion of social networks + AIDS survivor syndrome
- Stigma associated with HIV and age → limit new interactions to grow and develop social networks
- Mental health challenges → impairs social, cognitive function
- Medical co-morbidity → physical function impairment
- Socioeconomic factors → other basic needs sought out first

Brennan-Ing HIV and Aging. Interdiscpl Top Gerontol Geriatr 2017; Schrimshaw J Health Psychology 2003

Assessing for Loneliness and Social Isolation

- Campaign to End Loneliness Measurement Tool
  - I am content with my friendships and relationships
  - I have enough people I feel comfortable asking for help at any time
  - My relationships are satisfying as I would want them to be.

- Universal Implementation of the Medicare Annual Wellness Visit/Annual physical

Kotwal JAGS 2022, National Academies Social Isolation and Loneliness in Older Adults 2020

Strategies for Loneliness and Isolation

Individual

- Social prescriptions
- Warm phone lines
- Volunteerism
- Social CBT
- Adopt a pet
- Mindfulness, meditation
- Nostalgia

Institutional

- Group based activity programming
- IHHS/home based care
- Village models/ other community connection building
- In-person events

Societal

- Change the narrative: strong individualism, silent suffering should be the norm
- Change our infrastructure
  - Communal meals
  - Built environment
  - Mixed housing (senior + families)

Service Coordination between HIV and Geriatrics

HRSA: Optimizing HIV and Aging Care

Incorporating New Elements

Access affordable hearing aids, glasses, dental care

Assess functional and cognitive status (includes mental health and substances)

Ongoing discussions about sexual health

Supportive services should be viewed as essential (social support, food, housing, finance/benefits management)

Putting Together the Best Health Care Team

Geriatric Assessment Training for the healthcare teams

Clinical Pharmacists to assess polypharmacy

Behavioral health providers

Medical Case Managers

Geri-HIV Models of Care

Table 1. Overview of 3 Human Immunodeficiency Virus and Geriatric Care Models

Model Type	Overall Description	Institution Name	Location
Model 1: Outpatient referral/ consultation	Referral to a geriatrician for recommendations to enhance a patient's care plan; HIV provider remains as primary provider	Positive Aging Consultation, University of Colorado	Aurora, Colorado
Model 2: Combined HIV/geriatric multidisciplinary clinic	A multidisciplinary team is incorporated into existing HIV/infectious disease clinics to provide a comprehensive assessment and evaluation of each patient; primary care providers are provided with full evaluation and recommendations from the multidisciplinary team	The THRIVE Program	Baltimore, Maryland
		Comprehensive HIV and Aging Initiative of the Chronic Viral Illness Service, McGill University Hospital Center	Montreal, Quebec, Canada
		Chelsea and Westminster Hospital [11]	London, United Kingdom
		Silver Clinic [12]	Brighton, United Kingdom
		Golden Compass Program, University of California; San Francisco/Zuckerberg San Francisco General Hospital [14, 16]	San Francisco, California
		Center for Special Studies, New York Presbyterian/Weill Cornell Medical Center [13, 15]	New York City, New York
Model 3: Dually trained providers	An HIV provider with an invested interest in geriatric care performs assessments and provides recommendations	Age Positively Program, Massachusetts General Hospital	Boston, Massachusetts
	Dually boarded provider: a single provider with both geriatric and HIV expertise in 1 clinical home	Penn Community Practice and Penn Geriatrics, University of Pennsylvania Medical Center	Philadelphia, Pennsylvania

Davis CID 2021

Barriers to Implementation

Model of Care	Barriers
Geriatric consultations	Not enough Geriatricians; Geriatricians want to be the primary care provider; Geriatric clinics may have limitations to access (cut off age, health insurance, location); PWH may not want to see a Geriatrician (anticipatory HIV stigma, internalized ageism);
Combo HIV/Geri clinic	Not enough Geriatricians; Institutional buy in; most programs started with a grant and ongoing concern exists about how these programs will be sustained
Co-trained	UNICORNS!!!, institutional buy-in

ROLES AND RESPONSIBILITIES

The staffing needed to provide optimal care to people aging with HIV will vary from one health care setting to another, depending on the expertise and time availability of each member of the health care team. With appropriate training, HIV providers (physicians, nurse practitioners, and physician assistants) can assess for geriatric conditions and integrate geriatric principles into HIV care. For example, the Golden Compass program at San Francisco General Hospital and the New York–Presbyterian Hospital/Weill Cornell Medical Center have incorporated what is referred to as the "geriatric approach" into HIV care. When available, geriatricians can be consulted for specific issues related to aging (such as functional status or cognitive impairment), or they can serve in a co-management capacity to manage the non-HIV comorbidities and address social issues.[6] In areas where geriatricians are not readily available, telehealth or telemedicine may help fill the gaps in specialty services. Other members of the health care team also can be trained to perform screenings and assessments to ensure that comprehensive age-appropriate care is delivered.

HIV Med

- HIV and other co-morbidities
- Medication review (ART)
- Problem list

- Mental health

- Social circumstances
- Environment
- Multidisciplinary

As it relates to adherence barriers to care

Geriatrics

- Comorbidities and severity
- Med rev (inappropriate meds)
- Problem list
- Nutrition
- Mental health, cognition, fears
- Functioning
- Social circumstances
- Environment
- Multidisciplinary

As it relates to function, quality of life

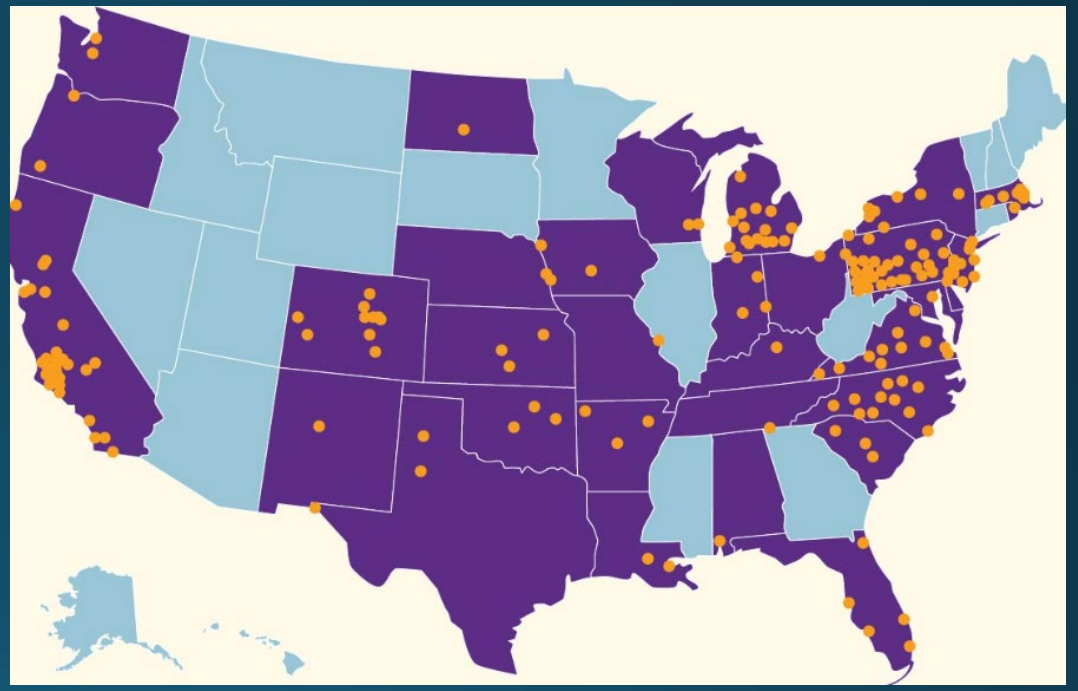
Welsh, Gordon and Gladman Int J Clin Pract 2014, Singh et al CID 2017

Medicare Annual Wellness Visit (Comprehensive Geriatric Assessment)

Components	Specifics
Medical Assessment	Patient concerns, hearing, vision, access to food
Functional Assessment	ADLs / IADLs, falls
Psychologic/Cognitive Assessments	PHQ-2, AD-8, MoCA
Social Assessment	Who they live with, do they get enough support
Environmental Assessment	Shower bars, lighting, rails, etc.
Wellbeing	What matters most? SSDoH
Sexuality and intimacy	Concerns, counseling
Advanced Care Planning	Prepare for your Care

Program for All Inclusive Care of the Elderly (PACE)

- Community-based comprehensive care model enables aging in place
- Capitated program, greater flexibility in services (focus on individual needs)
- Fully accountable for quality & cost
- Results: lower skilled home health visits, fewer hospitalizations, longer survival rates, increased number of days in the community, better quality of life, greater satisfaction with care, better functional status
- Equitable across race, functional status, and social support context



Hirth *J AM Med Dir Assoc* 2009,
https://www.npaonline.org/find-a-pace-program
g/find-a-pace-program

Implementing PACE … and backup

- Educate HIV providers and PWH
- Engage and coordinate with PACE programs
  - Educate substance use, stigma/intersectionality, mental health, sexual health
- Shore-up IHHS
  - Educate IHHS service providers
  - Integrate home health care –nursing, PT, OT
- Fund and educate geriatric case management/coordinate with insurance companies

San Francisco Principles (2020)

All HIV providers trained in geriatric care

Culturally appropriate mental health services including isolation/ loneliness, and SUD

Long term survivors MUST be included and be given prominent seats at the table

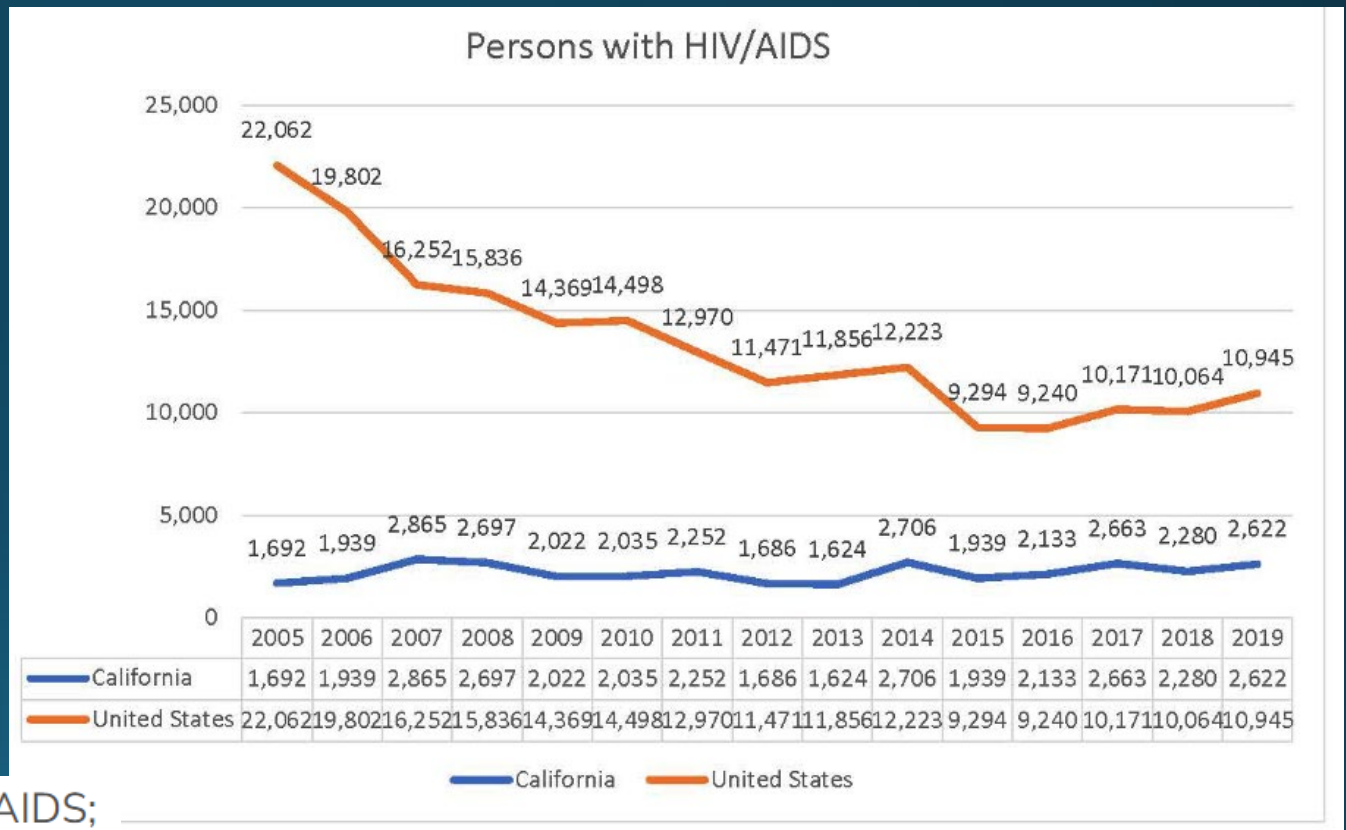
Resources must be allocated for HIV and Aging programs

Align our efforts with other movements to end racism, sexism, ageism, homophobia and transphobia

Housing/how to support housing

Unstably Housing

- 17% of all PLWH are homeless or unstably housed
  - Experience higher rates of mental health disorders, more likely to engage in activities associated with increased chances of HIV transmission, greater risk for inadequate care and treatment
    - In San Francisco 70% of PLWH who were housed were virally suppressed vs 33% of homeless



1. "Coordinate outreach efforts for persons living with HIV/AIDS;
2. Break down barriers through provider-client relationship;
3. Secure housing for persons living with HIV/AIDS;
4. Develop an individualized, integrated plan of care for PLWHA."

https://homelessstrategy.com/hundreds-of-persons-with-hiv-aids-continue-to-live-on-the-streets-and-in-shelters-in-california-according-to-recent-homeless-counts/

- **Not enough housing being built:** During the last ten years, housing production averaged fewer than 80,000 new homes each year, and ongoing production continues to fall far below the projected need of 180,000 additional homes annually.
- **Increased inequality and lack of opportunities:** Lack of supply and rising costs are compounding growin inequality and limiting advancement opportunities for younger Californians. Without intervention, much of the new housing growth is expected to be focused in areas where fewer jobs are available to the families that live there.
- **Too much of people's incomes going toward rent:** The majority of Californian renters — more than 3 million households — pay more than 30 percent of their income toward rent, and nearly one-third — more than 1.5 million households — pay more than 50 percent of their income toward rent.
- **Fewer people becoming homeowners:** Overall homeownership rates are at their lowest since the 1940s.
- **Disproportionate number of Californians experiencing homelessness:** California is home to 12 percent of the nation's population, but a disproportionate 22 percent of the nation's homeless population.
- **Many people facing multiple, seemingly insurmountable barriers — beyond just cost — in trying to find an affordable place to live:** For California's vulnerable populations, discrimination and inadequate accommodations for people with disabilities are worsening housing cost and affordability challenges.

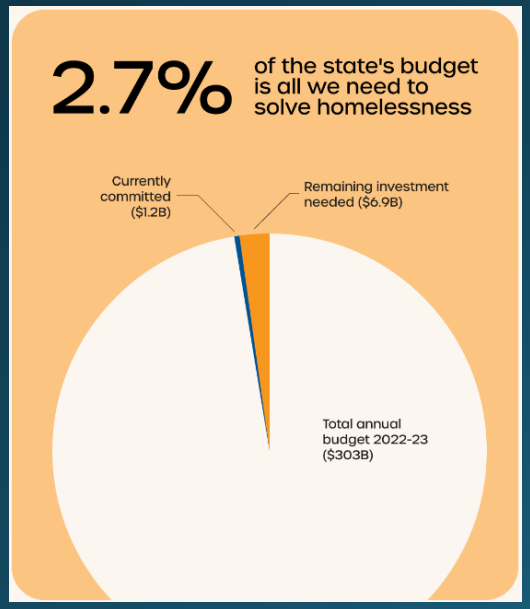
https://www.hcd.ca.gov/policy-and-research/addressing-variety-housing-challenges

Housing is an issue for all Californians

WE NEED A SEAT AT THE TABLE

- Resources must be allocated for HIV and Aging programs
- Align our efforts with other movements

California Homeless Housing Needs Assessment



BUILD

+112,527 affordable apartments

+ 225,053 subsidized operations and rents

Supportive housing services for +62,966 Californians with disabilities

Fund interim interventions for +32,235 individuals and families

Unmet housing need less pipeline commitments and projected turnover by region:

Region	Individual PSH Need (Units)	Family PSH Need (Units)	Individual AH Need (Units)	Family AH Need (Units)
Bay Area	15,164	662	21,794	5,656
Sacramento Area	3,989	209	6,672	1,800
Central Coast	3,074	179	5,025	1,267
Northern California	2,174	92	4,655	757
San Joaquin Valley	4,539	602	16,747	4,776
Los Angeles County	20,891	715	48,788	6,421
San Diego County	4,442	273	14,271	2,269
Southern California	5,272	524	16,375	4,288
Central Sierra	141	24	400	126
Total	**59,687**	**3,280**	**134,727**	**27,360**

Can San Diego Implement Novel Solutions

1. New methods for constructing and producing homes
2. Alternative forms of home ownership
3. Advance cross-sector housing solutions
4. Continue successful COVID-19 housing solutions
5. Transform surplus and underutilized land into affordable homes
6. Leverage infill housing and densify neighborhoods
7. Preserve existing lower cost housing

Next Steps

- Agenda Setting
- Policy formulation