Development of a frailty pathway to address the needs of older people living with HIV

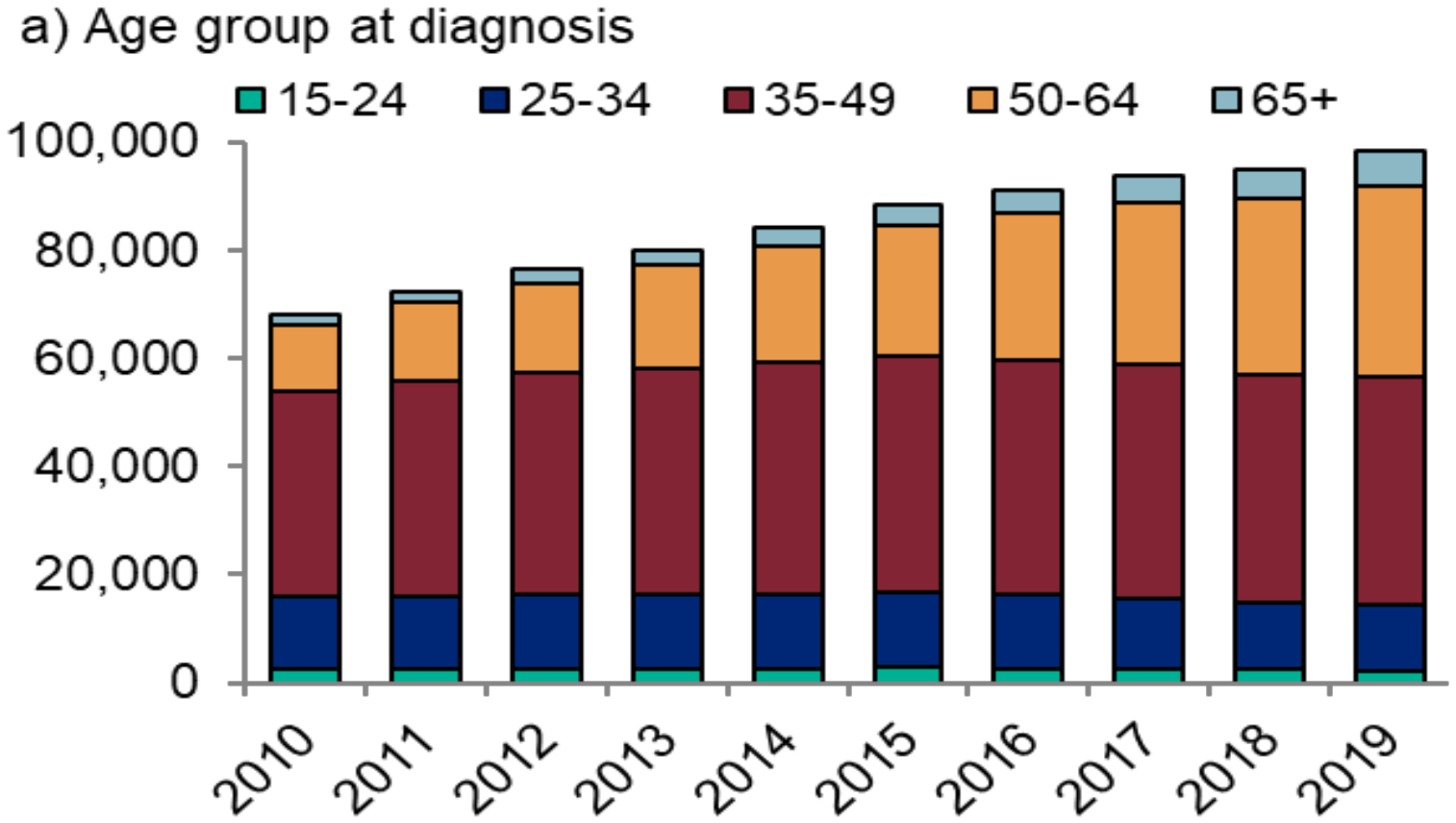
Justine Mellor, Manchester University NHS Foundation Trust

Conflict of Interest

In relation to this presentation I declare that I have no conflict of interest

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.

HIV ageing population



Public Health England Slide dataset 2020 Available from: https://www.gov.uk/government/statistics/hiv-annual-data-tables {Accessed 1/2/2021]

Background

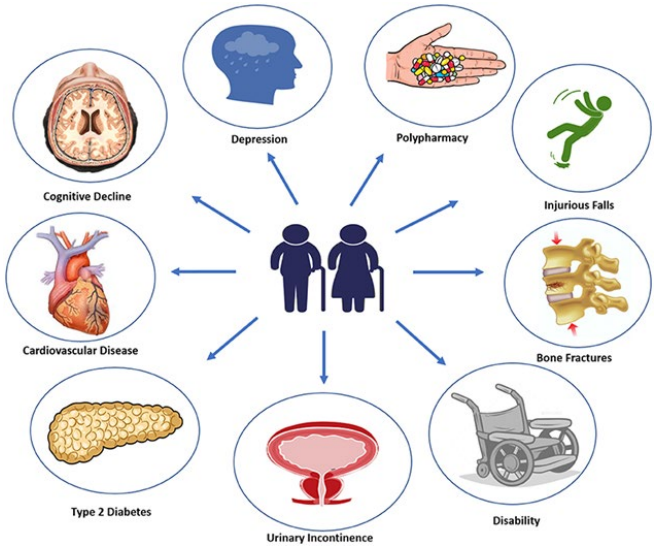
- Hathersage centre cohort = 2095

- >50 years n = 678 (32.3%)
- >60 years n= 163 (7.8%)
- >70 years n= 30 (1.4%)
- >80 years n = 4 (0.2%)

Data taken from HARS data set (Jan 2021)

Patients living with HIV (PLWH)

- Higher incidence of co-morbidities
- Co-morbidities appearing earlier than in the general population
- Combination of accelerated and accentuated risks plus increase in behavioural risks (eg smoking)
- Multi-morbidity, frailty and polypharmacy occur at higher rates and younger ages in PLWH



National Guidance

- BHIVA (2016) – Older patients (50 years and over)
- Medication review/DDI
- Close liaison with GP
- FRAX
- Symptoms of cognitive impairment, CVD, history of excessive alcohol – investigations should be considered
- Screening for ca breast and colorectal cancers as per HIV negative people

BHIVA (2016) BHIVA guidelines for the routine investigation and monitoring of adult HIV-1-positive individuals 2016 (2019 interim update) Available from: https://www.bhiva.org/file/DqZbRxfzlYtLg/Monitoring-Guidelines.pdf [Accesed 1/2/2021]

EACS guidelines (2019) - **Frailty in the context of ageing**

Frailty syndrome is more prevalent than expected in PLWH compared to HIV-negative matched controls.

Instruments to measure - frailty phenotype or frailty index

EACS –promote CGA aimed at personalising interventions according to benefits/priorities for patients – MDT approach to maximise overall health with ageing and improve quality of life

Recommend:

- Prescribe physical activity with weight resistance training component to sustain and recover physical function
- Address polypharmacy
- Screen for, and address modifiable causes of fatigue
- PLWH weight loss – screen for reversible causes and consider food fortification and protein/caloric supplement
- Prescribe Vit D in deficiency

EACS (2019)European AIDS Clinical Society guidelines version 10.0. Available from https://www.eacsociety.org/files/2019_guidelines-10.0_final.pdf [Accessed 1/2/2021]

How does the world of geriatric care, primary care and HIV care intersect?

Brighton – Silver clinic (monthly)
Referral criteria: age >50, difficulty in coping at home, multimorbidity, polypharmacy; staff include HIV MD, geriatrician, HIV clinical nurse specialist, pharmacist

London – Chelsea and Westminster – Separate MDT clinic - Referral criterion: age ≥ 50.
Consultant, HIV NP, trainee; supported by specialist pharmacist and dietician
https://hivglasgow.org/wp-content/uploads/2018/11/P153.pdf

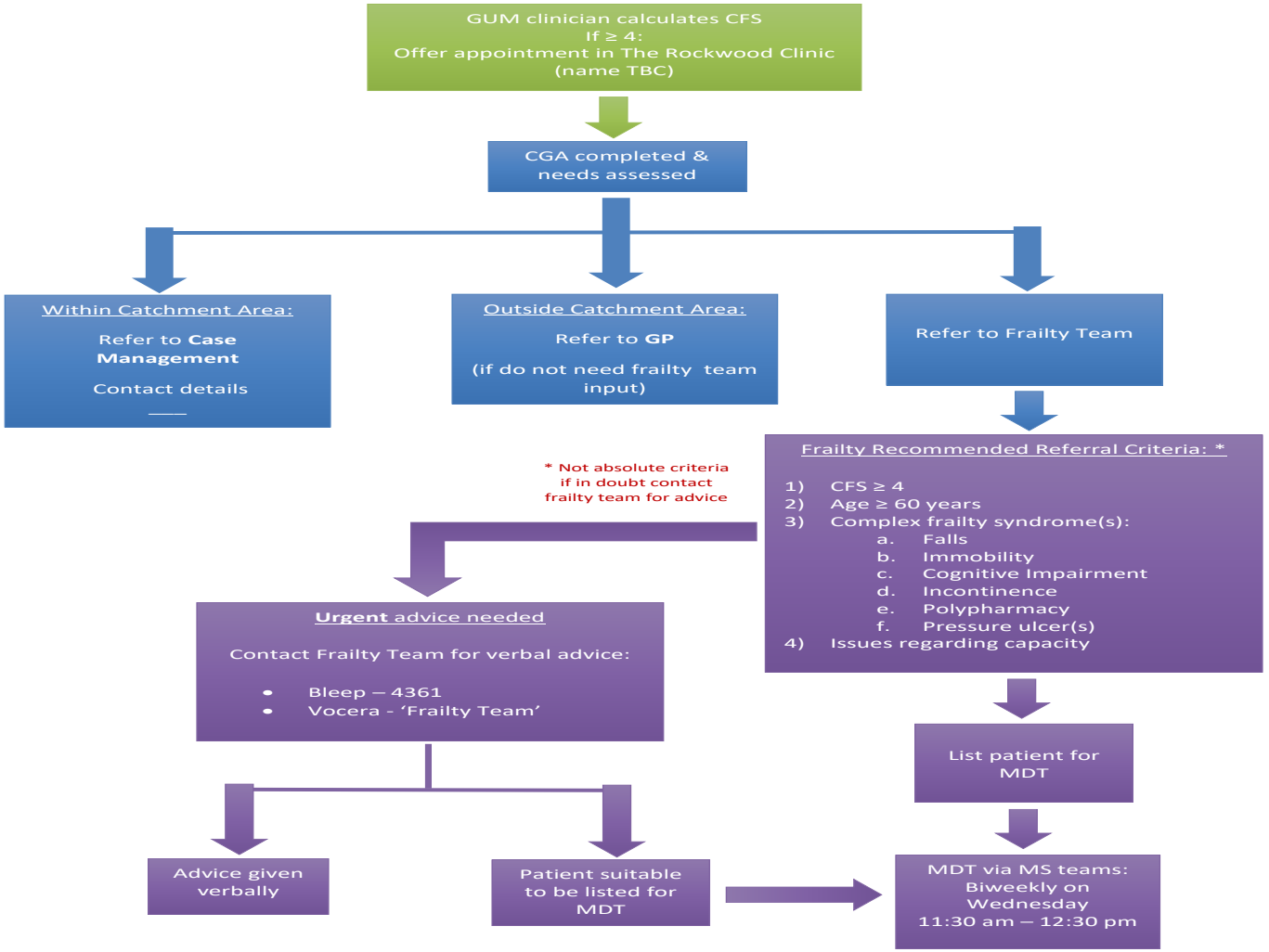
Liverpool – HIV Clinician /GP model - stable patients with HIV monthly virtual clinics
https://www.nhivna.org/file/5d2700a6807a7/MasChaponda-KateMcKinnell.pdf

Manchester – The DOCS GP practice/NMGH

What did we do next?

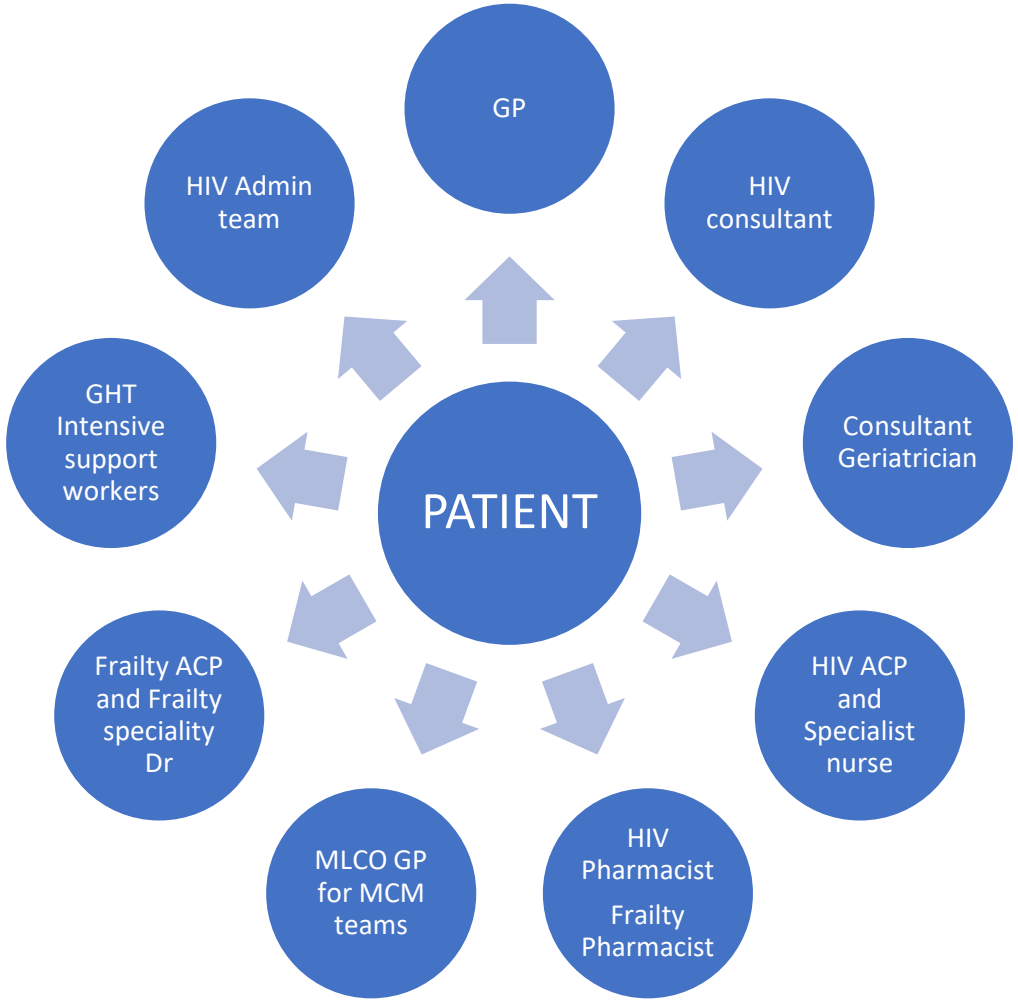
- ACP/HIV specialist pharmacy – links made with frailty team to start discussions
- Understanding of each others roles
- Shadowing
- Training
- CNS – complex database
- New model of care - proposing MDT approach to incorporate CGA. Will include remote support from frailty team and active case management teams in MLCO

HIV & Frailty Pathway



MDT via MS teams:
Biweekly on Wednesday(s)
11:30 am – 12:30 pm

Frailty team



- Increase on demand on the service
- Frailty clinicians not commissioned
- Business case required to expand the service

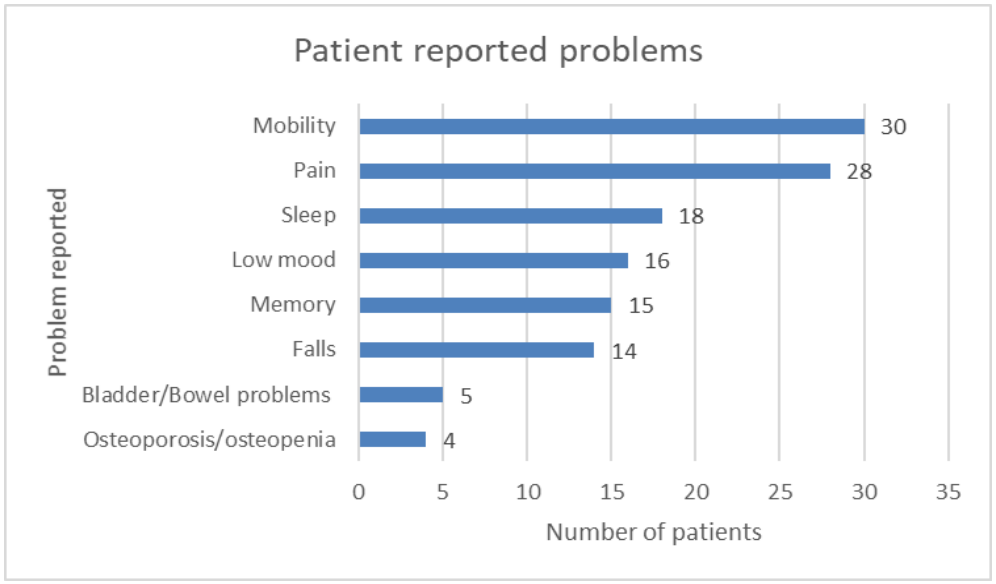
Initial results

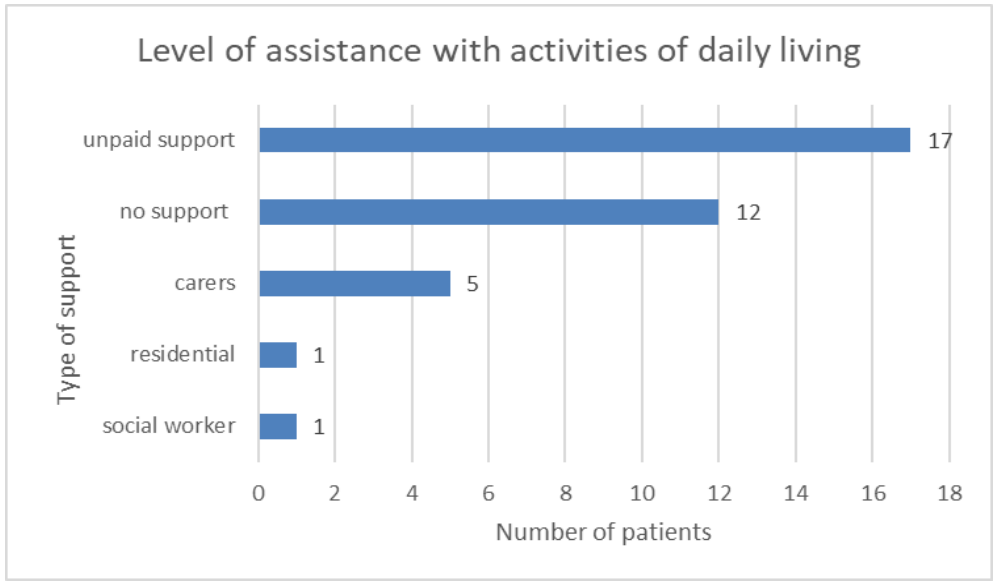
- 53 patients were assessed between October 2020 – March 2022.

- Out of these, 36 patients had a CFS score 4 and were eligible for CGA in the frailty clinic.

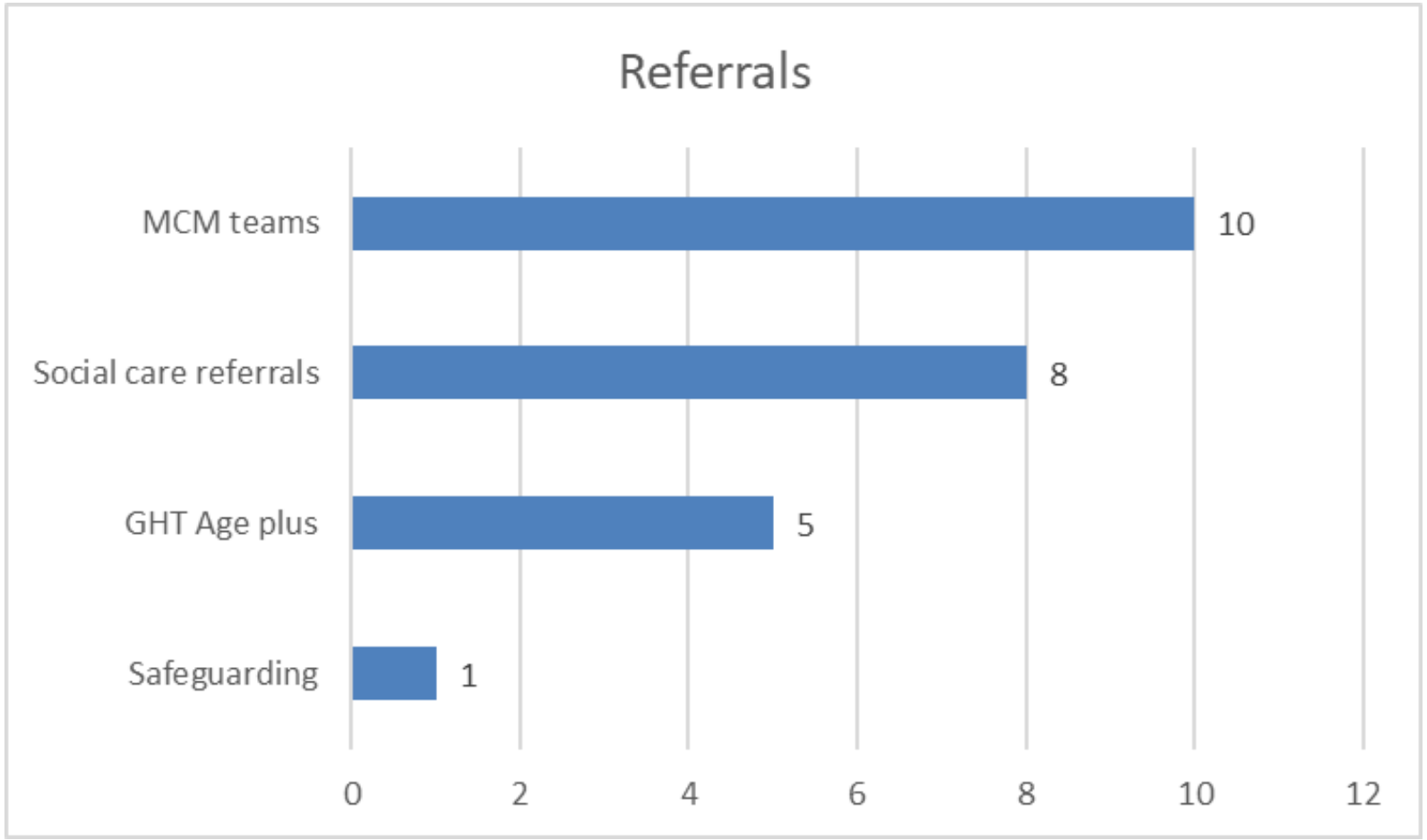
Sex	Male (including transmale) n=28 (77.7%) Female (including transfemale) n=8 (22.2%)
Age	Median age 67 years (range 52-84)
Rockwood clinical frailty score	Median CFS 5 (range 4-7)
Undetectable viral load	Median n=33 (92.6%)
Number of co-morbidities	Median n=3 (range 1-6)
Number of non HIV medications	Median n=11 (range 5-19)

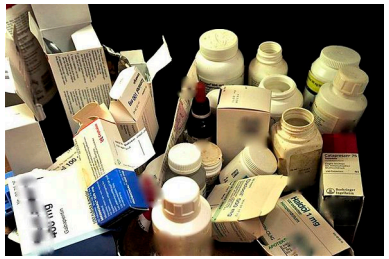
Initial Results





Initial results

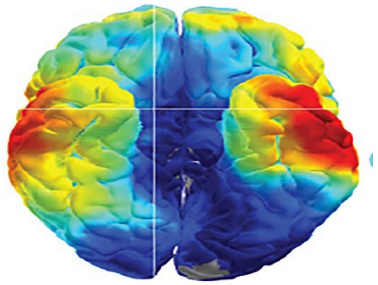




17 (47.2%) deprescribing recommendations were made
26 (72.2%) new medicine recommendations were made
Mainly around pain management, reduction in anticholinerginic burden meds

ART simplification was discussed with 26 (72.2%) patients
20 (55.5%) patients switched ART to reduce pill burden
25 (69.4%) now on a STR post switch compared with 13 (26.1%) pre frailty assessment

6 (16.6%) osteoporosis. 2 (5.5% osteopenia)
3 patients still waiting for DEXA
Diet, vitamin D supplements, referral to bone clinic for bisphosphonates



11 (30.5%) recommended GP to refer for memory assessment
8 (22.2%) direct referrals to gastro, respiratory, cardio, vascular clinic, COPD clinic, Geriatrician

Patient – social isolation

- Used to love reading, unable to get to library due to poor mobility
- Links with older age GHT project
- Now writing a book

Patient – low motivation

- Love of music
- Started drumming again with GHT

Patient – low financial difficulty
Unpaid carer

- GHT financial adviser
- Received large sum of money to cover for years of unpaid carer

Conclusions

- Many older patients living with HIV report a high number of co-morbidities, polypharmacy and factors affecting quality of life.
- A collaborative approach with frailty experts in primary and secondary care facilitates the formulation of action plans to address patients physical, psychological and social needs.
- Further audit of outcomes required to inform business case for further development of the clinic