

HIV & Aging:

New Developments in Research and Practice

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Realize (formerly CWGHR)

PAN Webinar
September 27, 2017

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- ⦿ National organization
- ⦿ Research, education, policy and practice
- ⦿ Rehabilitation lens
- ⦿ My focus: HIV and Aging

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Agenda

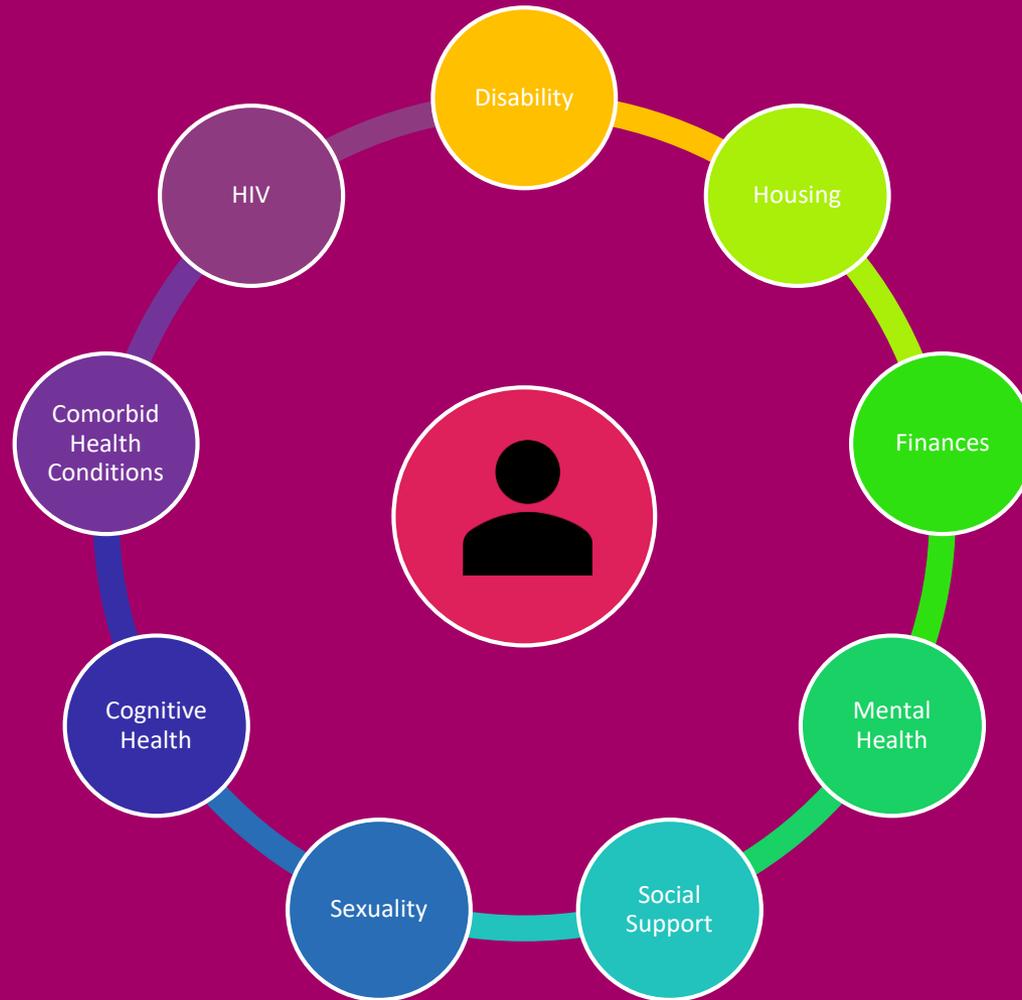
- Introduction to Realize
- Epi data limitations re: aging
- New Research on HIV and Aging: The “Wizard of Oz” Approach
 - Ongoing work on each topic
 - Local interventions/responses
- Q & A

Data Limitations

- Only 10-year age bands are available for most of the data (15-19, 20-29, 30-39, 40-49, 50+)
- PHAC is unable to disaggregate any age groups past the age of 50, therefore making the highest age group available 50+
- Age information is available for 93.9% of all cases since reporting began in 1985, and for 99.9% of cases reported in 2014

PHAC Slides, Realize Forum, September 2016

The Complexity of Aging with HIV Distilled Using the 'Wizard of Oz Approach'



Cardiovascular and Metabolic Health



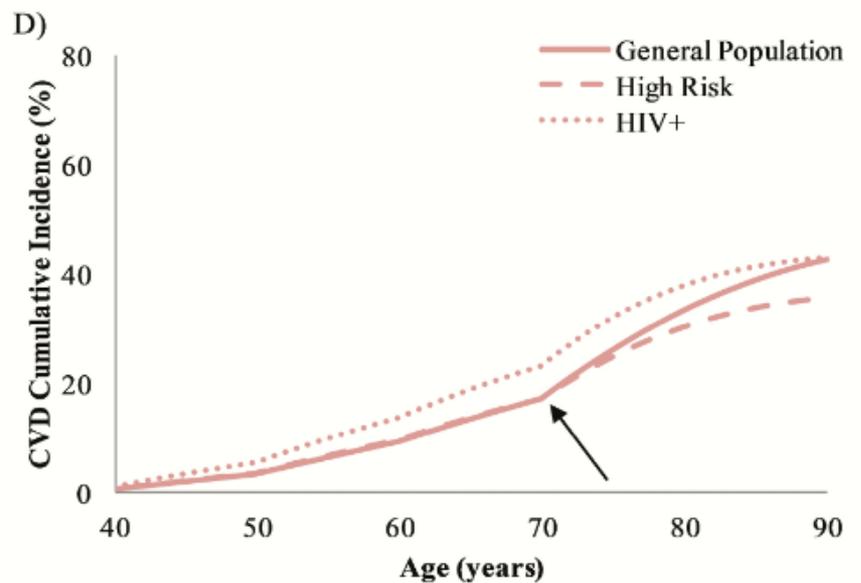
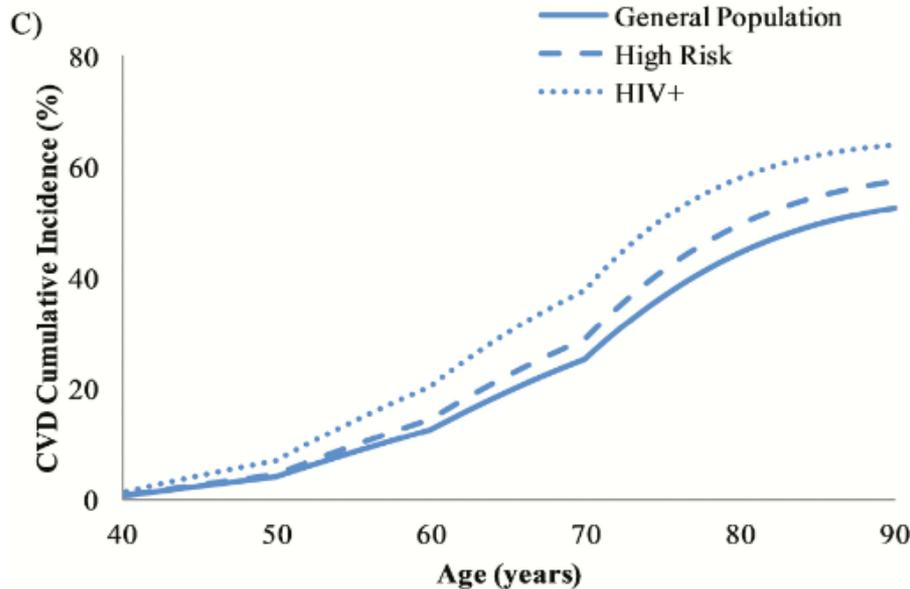
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CVD Risk in HIV

- Based on mathematical modelling, the increased relative CVD risk from HIV is similar to that of diabetes (Losina et al 2017)
*RR HIV = 1.75, RR Diabetes = 2.1 (men)/2.0 (women)
- The good news is that age-standardized relative risk of cardiovascular disease (CVD) in people living with HIV does not increase the longer you live with HIV, or with treatment initiation (Rasmussen et al. 2015)



Losina et al, Clinical Infectious Diseases 2017

High burden of metabolic comorbidities in a citywide cohort of HIV outpatients: evolving health care needs of people aging with HIV in Washington, DC

Levy, Greenberg, Hart, Powers Happ, Hadigan and Castel (May 2017)

Rationale

- EuroSIDA, D:A:D, Swiss HIV Cohort, HOPS, VACS, MACS, WIHS, NA-ACCORD, NYC EMR studies have all assessed metabolic comorbidities in context of HIV, however:
 - Most data was from pre-2010
 - Metabolic variables collected only at baseline
 - Study samples not necessarily representative of larger population of people living with HIV

Objectives

- To estimate the citywide prevalence of hypertension, type 2 diabetes, dyslipidaemia and obesity
- To examine differences by sex, age and race/ethnicity
- To assess demographic, behavioural and clinical correlates of these conditions

Characteristics of Study Participants

Table 1 Sociodemographic and clinical characteristics of HIV-infected patients in the DC Cohort; 1 January 2011 to 30 June 2015 (n = 7018)

Characteristic		
Sex at birth		
Male	5135 (73.2)	
Female	1883 (26.8)	
Age		
< 40 years	1778 (25.3)	
40–49 years	1697 (24.2)	
50–59 years	2253 (32.1)	
60–69 years	1081 (15.4)	
≥ 70 years	209 (3.0)	
Race/ethnicity		
Non-Hispanic black	5414 (77.1)	
Non-Hispanic white	972 (13.9)	
Hispanic	340 (4.8)	
Other/unknown*	292 (4.2)	
Age (years) [median (IQR)]	50 (39–57)	
Housing status		
Permanent/stable	4468 (63.7)	
Temporary/unstable	437 (6.2)	
Homeless	96 (1.4)	
Unknown	2017 (28.7)	
Employment status		
Employed	1955 (27.9)	
Unemployed	1580 (22.5)	
Unknown	3483 (49.6)	
Insurance status		
Medicare	955 (13.6)	
Medicaid	2331 (33.2)	
Ryan White/ADAP	85 (1.2)	
Public, other	896 (12.8)	
DC Alliance	86 (1.2)	
Private	1833 (26.1)	
Unknown	832 (11.9)	
Smoking history		
Current	2851 (40.6)	
Previous	1067 (15.2)	
Never	2297 (32.7)	
Unknown	803 (11.4)	
Alcohol abuse history		
Current	997 (14.2)	
Previous	990 (14.1)	
Never	3282 (46.8)	
Unknown	1749 (24.9)	
Recreational drug use history		
Current	873 (12.4)	
Previous	1602 (22.8)	
Never	2326 (33.1)	
Unknown	2217 (31.6)	
HIV transmission risk		
MSM	2693 (38.4)	
High-risk heterosexual	2201 (31.4)	
IDU	476 (6.8)	
MSM and IDU	82 (1.2)	
Perinatal	141 (2.0)	
Unknown	1425 (20.3)	
Time since HIV diagnosis (years) [median (IQR)]†	12.3 (6.7–19.5)	
AIDS diagnosis	2889 (41.2)	
Most recent CD4 count		
< 200 cells/μL	628 (8.9)	
200–500 cells/μL	2246 (32.0)	
> 500 cells/μL	4133 (58.9)	
Unknown	11 (0.2)	
Nadir CD4 count		
< 200 cells/μL	2702 (38.5)	
200–500 cells/μL	3159 (45.0)	
> 500 cells/μL	1146 (16.3)	
Unknown	11 (0.2)	
Most recent HIV viral load		
< 200 copies/mL	5792 (82.5)	
≥ 200 copies/mL	1177 (16.8)	
Unknown	49 (0.7)	
History of ARV therapy‡		
Any regimen	6813 (97.1)	
PI-based regimen	3499 (49.9)	
NNRTI-based regimen	2955 (42.1)	
INSTI-based regimen	2667 (38.0)	
Whether primary care is received at the site		
Yes	5194 (74.0)	
No	1741 (24.8)	
Unknown	83 (1.2)	
Anxiety/stress disorder	619 (8.8)	
Depression	1287 (18.3)	
Hepatitis C	1120 (16.0)	
Chronic kidney disease	517 (7.4)	

73% male

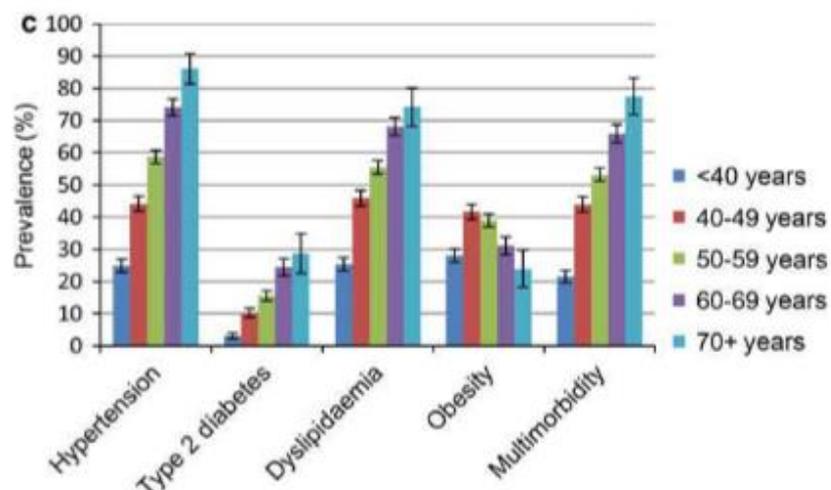
50% over age 50

Average of 12.3 years since diagnosis

40% current smokers

Well-controlled HIV, but 40% have history of AIDS diagnosis

Prevalence of Metabolic Comorbidities by Age



	All ages n=7018	Age 50-59 n=2253	Age 60-69 n=1081	Age 70+ n=209	By gender
Hypertension	49.8%	58.8%	74.1%	86.1%	
Type 2 diabetes	12.9%	15.6%	24.4%	28.7%	Women>Men
Dyslipidemia	48.0%	55.5%	68.1%	74.2%	Men>Women
Obesity	35.2%	39.0%	31.1%	23.9%	Women>Men
Metabolic Multimorbidity	45.6%	53.2%	66.0%	77.5%	

What affects the risk of metabolic comorbidities among people living with HIV?

Traditional CVD risk factors

- Odds of hypertension with current smoking = 1.49
- Odds of hypertension with former smoking = 1.43

Longer time since HIV diagnosis

- Odds of type 2 diabetes and dyslipidemia 1.01 per 1-year increase

Longer time on treatment

- Odds of dyslipidemia with PI-based ARV = 1.11
- Odds of hypertension with NNRTIs = 1.03
- Odds of dyslipidemia with NNRTIs = 1.09
- Odds of hypertension with any treatment = 1.05
- Odds of dyslipidemia with any treatment = 1.07

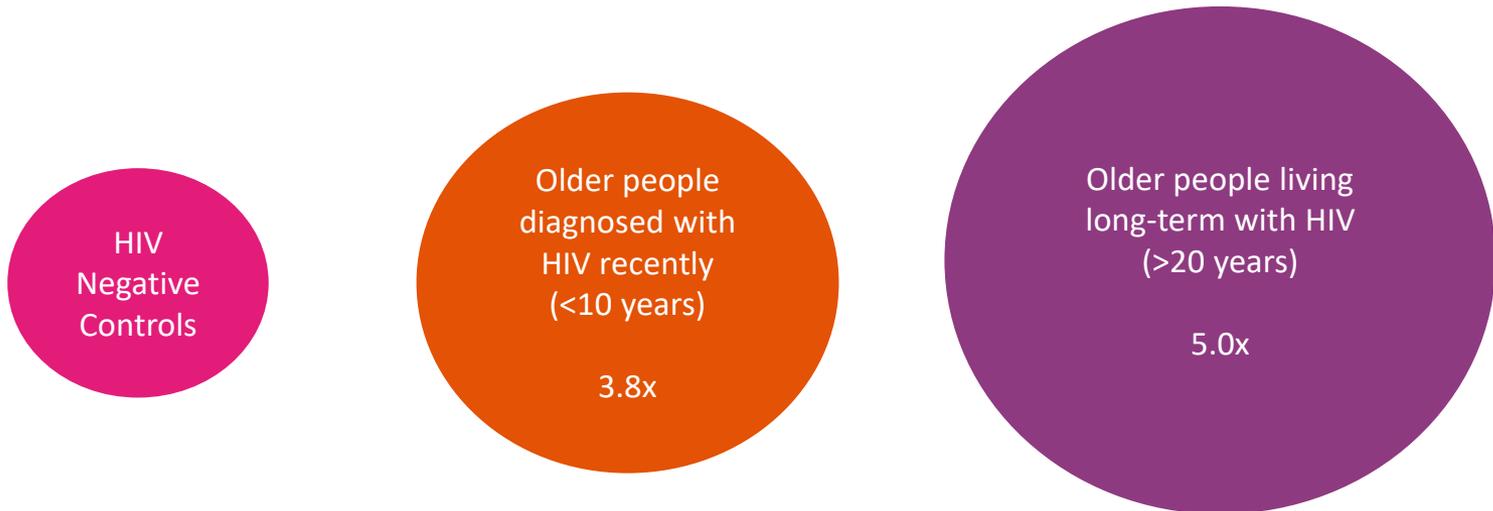
CD4 Nadir

- Odds of hypertension with <200 cells/ μ L = 1.35

Just as longer time since HIV diagnosis and longer time on treatment impact odds of individual metabolic syndromes, living long-term also impacts the odds of CVD/metabolic multi-morbidity.

These circles represent the likelihood of having >2 non-infectious illnesses.

(heart disease, high blood pressure, Type 2 diabetes and chronic kidney disease)



Guaraldi, Zona, Brothers et al. (2015). Aging with HIV vs. HIV Seroconversion at Older Age: A Diverse Population with Distinct Comorbidity Profiles. PLoS ONE, 10(4): e0118531.

Take Home Messages

High prevalence of metabolic comorbidities despite access to healthcare and newer ARV regimens

Large proportions of patients classified as having metabolic comorbidities lacked documented evidence in their medical record of having received a prescription for treatment

- Provider disagreement with clinical recommendations?
- Overestimation of effectiveness of lifestyle change?
- Failure to appreciate potential impact of metabolic comorbidities?
- Treatment uptake affected by mental health issues?

Diet, exercise and smoking cessation programs have been shown to improve metabolic and cardiovascular outcomes in this population

Community-Based Exercise Intervention

Kelly O'Brien
kelly.obrien@utoronto.ca

Evaluating a community-based exercise intervention with adults living with HIV: protocol for an interrupted time series study (O'Brien et al, BMJ Open 2016)

What is being assessed?

- Long-term impact of exercise on PLWHIV
- Ability of PLWHIV to integrate exercise into their daily lives
- Ability to integrate CBE into the HIV community

Who is involved?

- Adults living with HIV
- Fitness instructors from the YMCA

When?

- Study is in progress
- 22 months (8-month baseline + 24 week intervention + 8-month follow up)

The Intervention

Exercise program informed by individual needs

- Aerobic + resistive + neuromotor + flexibility components
- Can incorporate individual and group fitness activities
- 1.5 hours, 3x per week for 24 weeks
 - Weekly supervision from YMCA coaches
 - Weekly fitness logs

Group education sessions on self management topics (once/month)

- Help frame exercise in broader context of health

Assessments

Baseline Monitoring Phase 1 (0-8 months):

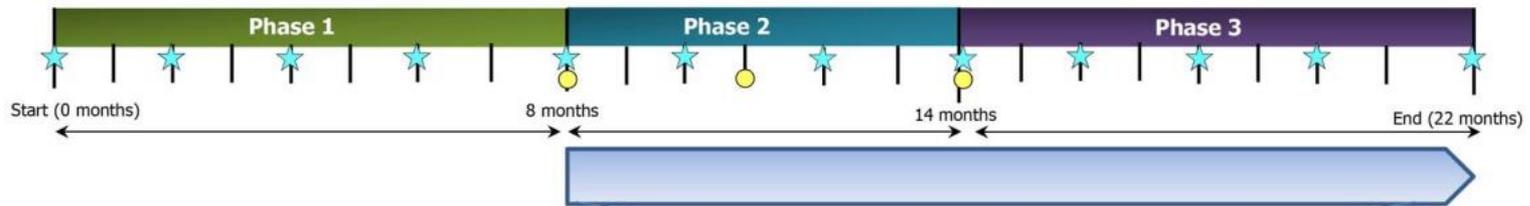
Participants will be monitored monthly at the baseline (pre-intervention phase) for 32 weeks. This will identify the pattern of pretest outcomes and will serve as the 'control' phase in which to compare the level and trend of outcomes during and post-intervention.

Intervention-Exercise and Self-Management Education Phase 2 (8-14 months):

Participants will attend exercise sessions for 1.5 hours, three times per week (1 supervised, 2 unsupervised) for 24 weeks. Sessions will be supervised weekly by a fitness instructor who will monitor progress of participants and exercise intensity accordingly. Participants will also attend monthly educational sessions.

Post-Intervention Self-Monitored Exercise Phase 3 (14-22 months):

Participants will be encouraged to continue to engage in unsupervised exercise three times per week. A fitness instructor will be available at the YMCA to see participants monthly during this time to monitor their progress.



Participants will document

- 1) **adherence** to exercise in weekly online exercise log
- 2) ongoing **physical activity** (steps, distance, calories burned) using Fitbit monitor

★	<p>YMCA Objective Health Assessment</p> <p>Indicates when the administration of objective physical health assessments will occur: A) Cardiopulmonary Fitness (VO2 Max) resting and maximal Blood Pressure (mmHg), resting and maximal heart rate (beats per minute), B) Strength (Grip Strength, Vertical Jump, Back Extension, Push Ups and Partial Curl Ups), C) Weight, Body Composition & Anthropometrics (Body weight (kg), Waist and hip circumference (cm), Body Mass Index (BMI) (kg/m²), Body Fat (%), Lean Body Mass (kg), Fat Free Mass (lbs) D) Flexibility (Sit and reach test)</p>
★	<p>Self-Reported Questionnaire Assessment</p> <p>Indicates when the administration of the following self-reported questionnaires will occur: HDQ, EQ5D, MOS-HIV, PHQ-8, MOS-Cognitive Scale, Brief COPE, Pearlin Mastery Scale, HIV Stigma Scale, MOS-SSS, items from the demographic and disease questionnaire, RAPA</p>
●	<p>Qualitative Interviews</p> <p>Face-to-face interviews with approximately 15 participants living with HIV and 5 recreation providers to assess a) the perceived impact of CBE and b) the process of the implementation (strengths and challenges, feasibility, accessibility, and long term sustainability) of implementing a CBE program</p>

Other studies on HIV, aging and cardiovascular health



Durand M, Chartrand-Lefebvre C, Baril J-G, Trottier S, Trottier B, Harris M et al. (2017). **The Canadian HIV and aging cohort study – determinants of increased risk of cardiovascular diseases in HIV-infected individuals: rationale and study protocol.** BMC Infectious Diseases, 17:611.

Bachmann JM, Kundu S, So-Armah K, Justice A, Sico, J, Marconi V et al. (2017). Abstract P323: **Cardiac rehabilitation is associated with decreased mortality in HIV patients with cardiovascular disease.** Circulation, 135 (American Heart Association conference).

Mental Health & Resilience



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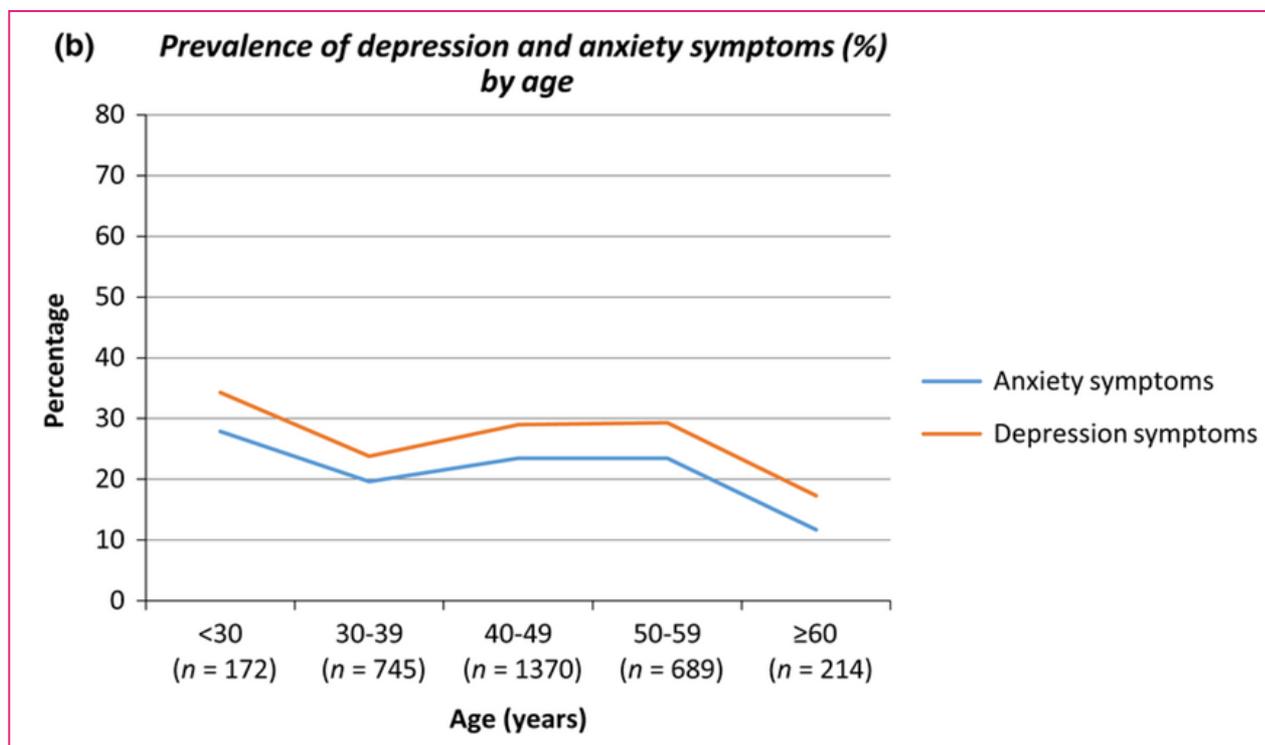
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18

Mental Health and Aging with HIV

The Good News



Age, time living with diagnosed HIV infection, and self-rated health
McGowan et al, HIV Medicine 2016

Mental Health, HIV & Aging

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress (APA)

- As people age, they are more likely to describe that they are aging successfully, despite any health issues ([Jeste et al 2013](#))
- Older PLWHIV appear to be extremely resilient, many remain optimistic and in control of their lives ([Emlet, Tozay & Raveis 2011](#))

Mental Health, HIV and Aging An Invisible Burden

Non-descript symptoms of mental health in older persons

(Canadian Psychological Association, 2015)

- No pleasure in activities one once enjoyed
- Less energy/tired
- Aches and pains
- Difficulties concentrating
- Changes in sleep patterns
- Changes in appetite

Assumptions about resilience and
'limitless coping' among
HIV service providers



Uncertainty Related to Aging with HIV

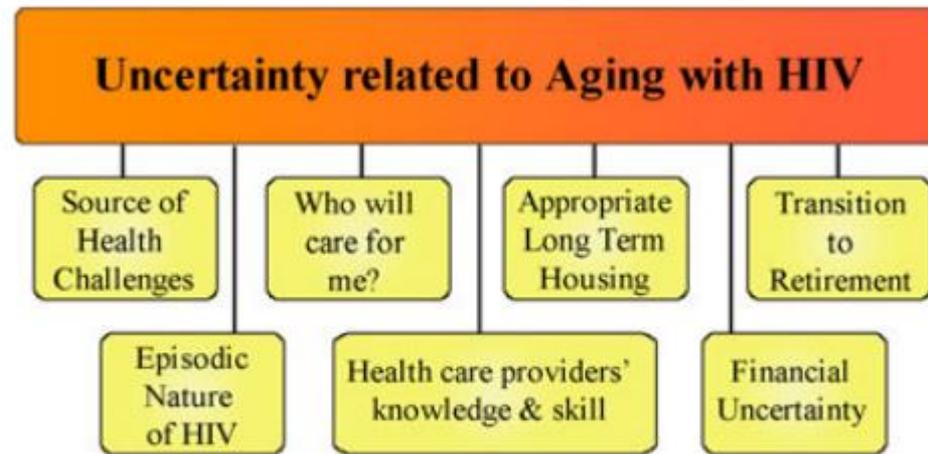


Figure 1. Source of uncertainty related to aging with HIV.

Aging with HIV and disability: The role of uncertainty
Patricia Solomon, Kelly O'Brien, Seanne Wilkins & Nicole Gervais
AIDS Care 2014

Mental Health Experiences of Older Adults Living with HIV: Uncertainty, Stigma, and Approaches to Resilience

Furlotte & Schwartz (March 2017)

Qualitative interviews with 11 older adults living with HIV in Ottawa (age 52-67)

Participant characteristics:

- Mostly white
- Well-educated
- Various income and work histories (mean time since retirement = 11 years)
- Eight people diagnosed with HIV for 10+ years
- Seven people diagnosed at age 45+
- Six people reported diagnosed mood disorders; three reported problematic substance use
- Five people had previously accessed mental health services; eight had accessed peer support at HIV orgs

Major Themes

Table 1: Major themes and associated issues in mental health experiences

Theme	Participant-identified issues
Uncertainty	Unexpected survival Interpreting one's symptoms Medical uncertainty
Stigma	Discrimination in health care interactions Misinformation Physical appearance Compounded stigma Anticipated stigma
Approaches to resilience	Reducing space that HIV takes up in one's life Accommodating HIV Engaging with social support



Preparing for death that never came

Not dying perceived as a loss

Lack of clarity about what's causing symptoms

Cautious monitoring of lab/test results

Limits to current medical knowledge of HIV and aging

Major Themes

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Discrimination by health care providers on basis of HIV status, behaviours, LGBTQ identity

Misinformation about HIV prognosis/survival

Visible changes to body shape (wasting, lipodystrophy) can lead to social exclusion, distress

Combined effects of being labelled disabled, old, having mental health issues

Fear of stigma limits disclosure

Major Themes

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Resilience strategies:

- Focusing on other areas of life besides HIV
- Managing pain through rest and pacing
- Connecting with others
- Families of choice
- Spiritual support
- Social pruning
- Activism / volunteering
- Saying no, self care
- Formal support services



Take Home Messages

- Uncertainty and stigma are barriers to mental health among people aging with HIV; this population also utilizes diverse coping strategies
- Oppression contributes to mental distress
- Acknowledge impact of multiple losses on people living with HIV long-term
- HIV organizations do not have the capacity to deliver all of the mental health supports needed by people living with HIV
- Individual capacity-building interventions can be used to foster mastery, coping and social support
- People working in fields of HIV and aging need to understand how they intersect

Developing a capacity building intervention for people aging with HIV and/or HCV and experiencing uncertainty

Realize
(formerly the Canadian Working Group on HIV and Rehabilitation)

Contact: Kate Murzin
kmurzin@hivandrehab.ca

THE GROUNDWORK

Currently assembling an advisory committee

Literature review on how people living and aging with HIV:

- Cope with and tolerate uncertainty
- Self-advocate
- Maintain autonomy over health decision-making

Develop organizational policy briefs

Developing a capacity building intervention for people aging with HIV and/or HCV and experiencing uncertainty

THE INTERVENTION

- A 1-day workshop for people living with HIV to be facilitated by local service providers and peers
- Six monthly follow-up touch point communications - include self assessment and a task/activity that encourages skill application in the context of the individuals' own life circumstances

Desired outcomes:

- Increased knowledge of coping strategies
- Increased **self-efficacy** for tolerating uncertainty
- Mastery of new coping skills
- Increased **perception of personal control** over health decision-making
- Increased **confidence** to communicate values and wishes for future care
- **Mastery** of self advocacy skills
- Increased understanding and **favourable attitude** toward an integrated palliative approach to care
- Increased awareness of tools and resources for advance care planning
- **Engagement** in advance care planning

Training and workshop materials (curriculum, facilitator guide and touch point communications and activities) will be provided to **local facilitators**

Cognitive Health



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HIV-Associated Neurocognitive Disorder (HAND)

- ⦿ Common, but usually mild or asymptomatic
- ⦿ Some people describe issues with:
 - Concentration/attention
 - Information processing speed
 - Learning
 - Recall memory
 - Prospective memory (the ability to execute a future intention)
 - Word-finding
 - Executive functioning challenges (multi-tasking, etc.)
- ⦿ May interfere with taking medication on time/regularly
- ⦿ Similar symptoms can be caused by depression

What is the impact of HIV on neurocognitive impairment? Is there an age effect?

Data from the Women's Interagency HIV Study (Maki et al., 2015)

- Women living with HIV performed less well on tests of verbal learning, information processing speed and attention as compared to HIV- women
- HIV had less of an effect on cognitive performance than education, age, race/ethnicity, income and *reading level*
- Level of impact on cognition resulting from HIV similar to that of poverty, depression
- Unclear whether there is an age x HIV effect

Evaluating the accuracy of self-report for the diagnosis of HIV-associated neurocognitive disorder (HAND): defining “symptomatic” versus “asymptomatic” HAND

Obermeit et al (2017)

277 people living with HIV from the CHARTER study cohort

- Average age = 44 years
- 75% male
- 48% white
- 64% diagnosed with AIDS
- Average CD4 nadir = 186.6

Purpose

“To determine whether, in cognitively impaired people living with HIV, self-reported dependence in daily functioning and self-reported causal attribution of this dependence are associated with relevant supporting objective variables and, as such, whether such self-reports are valid stand-alone tools for diagnosing ‘symptomatic’ HAND subtypes.”

Measures

Subjective

Self-reported function
on 16 ADLs and IADLs

Causal attribution of
functional impairment

Objective

Neuromedical clinician
rating of health-related
functioning

Currently employed?

Neurocognitive Testing

Psychiatric Interview

Study participants stratified by self-reported functional dependence

- 159 (57%) people reported decreased independence in at least two ADLs (“functionally dependent”)
- The other 118 people were categorized as “functionally independent”

Similarities between groups	Differences between groups (dependent > independent)
Demographic profile	Clinician –assessed disability
HIV health and treatment status	Current depressive symptoms
Substance use history	Current and lifetime depression
Severity of cognitive impairment	Unemployment rate
Cognitive domain T scores	All physical examination variables

Study participants stratified by attribution of functional impairments

- 80 (50%) attributed their impairments to cognitive problems
- 79 (50%) attributed their impairments to physical problems

Similarities between groups	Differences between groups (Physical attribution > Cognitive attribution)
Current major depressive disorder	Age
History of substance use	Longer duration with HIV
Employment	Lower CD4 nadir
Severity of cognitive impairment	Higher rates of AIDS diagnoses
Clinician-assessed functioning	
Cognitive domain T scores	Differences between groups (Physical attribution < Cognitive attribution)
	Depressive symptoms
	Lifetime major depressive disorder

Nature of disability attribution

Most frequently reported difficulties:

- Employment
- Planning and initiating social activities
- Housekeeping
- Understanding TV programs and reading materials

28% of physical attributors showed no physical abnormalities on examination

Significant numbers of physical attributors reported difficulty with primarily cognitive tasks:

- Understanding TV and reading materials (29%)
- Planning and initiating social activities (62%)
- Financial management (13%)

Validity of Self-Assessed Attribution

IF.... attributions of the cause of ADL dependence were valid:

- People who attributed their dependence to strictly physical causes would have worse objective neuromedical physical findings; and
- People who attributed their dependence to cognitive causes would perform more poorly on neuropsychological testing

BUT.... This was not what the data showed.

Evidence that study participants were not able to accurately assess the cause of their functional impairment

Cognitive attributors  Measures of psychiatric disability

Cognitive attributors  Any objective measures including: cognitive scores, neuromedical findings, daily functioning

>25% of physical attributors showed no current physical problems upon medical examination

Few significant differences in ability to complete tasks between the cognitive and physical attributor groups

- 1/3 physical attributors reported difficulty understanding television and reading materials (primarily cognitive tasks)
- 51% of cognitive attributors reported difficulty with housekeeping (a primarily physical task)

Conclusion & Take Home Messages

- Self reported attribution, especially of cognitive difficulties, may be more closely related to affective distress than objective or real-world indicators of causation
- Potential cause: Poor metacognition?



- Relying on self-reports regarding causative attribution of reduced functioning may lead to misdiagnosis of “asymptomatic” HAND

CTNPT 029: Psychosocial intervention for older HIV+ adults with HAND

Principal Investigator

Andrew Eaton

AIDS Committee of Toronto (ACT),
Factor-Inwentash Faculty of Social
Work at the University of Toronto

aeaton@actoronto.ca

Purpose:

- To test the feasibility and acceptability of cognitive remediation group therapy in older adults living with HIV who have been diagnosed with HAND

Intervention group* will take part in:

- Weekly 3-hour sessions facilitated by a social worker and a peer
- Tablet-based cognitive training
- Mindfulness-based stress reduction

*Control group will receive standard HIV group therapy

Supportive Housing



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Who will care for people aging with HIV?

- A recent study found that only 24% of adults living with HIV had an informal caregiver (Schnall et al 2017)
 - Odds increased among those age 65+ (36%), those with a previous AIDS diagnosis (29%), and those with a greater number of HIV-associated-non-AIDS conditions
- Older adults living with HIV experience high levels of disability and may experience increased care and support needs
 - About 25% report difficulty with one or more activities of daily living (ADLs) and 18% - 46.5% report difficulty with one or more instrumental activities of daily living (IADLs) (Avila-Funes et al, 2016)
 - 25.8% had fallen in the past year (Greene et al., 2015)

HIV Stigma Experienced by Older Adults

Negative stereotypes, attitudes or beliefs about people living with HIV

- Depression among older people living with HIV is largely related to HIV stigma and isolation (Groves et al, 2010)
- Older people living with HIV report feeling that others don't want to be around them due to their HIV status (Emlet 2006). One strategy they use to deal with this is selective disclosure. This can decrease access to social support.

Intersectionality

- Higher HIV-related stigma scores for women; highest among Black women
- Older heterosexual men and women may be more likely to experience depression than older gay men ([Brennan et al 2013](#))

“It has been a challenge to obtain cooperation from Management at the Long-Term Care (LTC) Facilities. Over the next 6 months, we plan to meet with staff from different homes hoping to educate staff and residents. Currently, we support someone in a LTC Facility and find the staff uncooperative regarding medical orders from the HIV specialist as well as assisting the client with daily routines and therapy.”

Case Manager, Urban CBHO, Southern Ontario

Murzin K and Furlotte C. (2015) HIV and Aging: A 2013 Environmental Scan on Programs and Services in Canada. Accessed from <http://realizecanada.org/wp-content/uploads/Community-Report-EN-Web-Ready-Low-Resolution.pdf>

Nursing home admission of aging HIV patients: Challenges and obstacles for medical and nursing staffs

Naudet et al, 2017

Purpose: To understand the obstacles and attitudes, as identified by physicians and care workers, regarding admission of people living with HIV into nursing homes in France

Survey sent to physicians and chief nurses in 100 nursing homes in Spring 2013

- 49 physicians and 201 staff (nurses and other healthcare workers) from 53 nursing homes responded

Attitudes toward residents living with HIV

PHYSICIANS

- 12.2% of physicians had previously received a request to admit a person living with HIV into their home
- 8.2% (n=4) physicians had previously admitted a patient living with HIV
- One physician refused to admit a patient because the entire staff team refused to provide care

STAFF

- 67.2% said people living with HIV should be admitted without restriction
- 13.4% supported admission with restrictions

Main reasons for refusal to admit people living with HIV

Lack of HIV training/teaching

- 28.6% of doctors and 64.2% of other healthcare staff said they needed training on HIV
- 38.8% of doctors and 25.9% of other staff had received HIV training in the past five years

Concerns about fear of contamination for staff or other residents

- No occupational infections since 2005
- Lack of understanding of U=U

Nursing home not equipped to provide level of care needed by people with HIV

Working Together Across Canada

Continuing Education for Service Providers on HIV and Older Adults

- Bridging the gap between HIV and aging sectors
- In-Person training piloted in GTA (2014)
- Translated into 'blended learning' format (2016)
 - 4 online modules
 - Social determinants of health, HIV and older adults
 - Myths about older adults, sex and HIV
 - HIV as a complex chronic illness
 - Mental health, HIV and older adults
 - Interactive session (in person, or web-based options)
 - Over 100 participants in Toronto, Winnipeg & Halifax

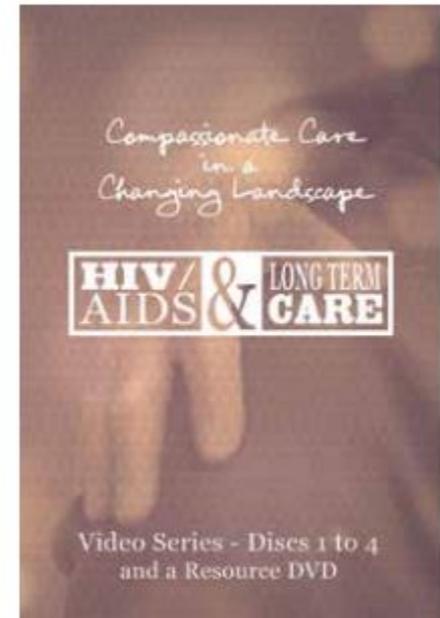
Compassionate Care in a Changing Landscape

Casey House & The Rekai Centres

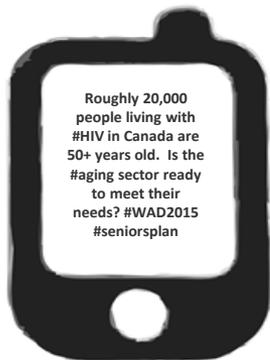
- Training videos for staff in Long Term Care
- Eight videos, including:
 - Introduction to HIV/AIDS Care
 - Bedside Care
 - HIV/AIDS and Dementia
 - Focus on Families and Support Networks

<http://www.hivlongtermcare.com/>

Siou K, Mahan M, Cartagena R and Chan Carusone S. (2017).
A growing need – HIV education in long-term care. *Geriatric Nursing*, 38:199-206.



National Coordinating Committee on HIV and Aging (NCC)



HIV + Older Adults Prevention and Screening



1/5 new HIV diagnoses in Canada are among adults age 50 and older.



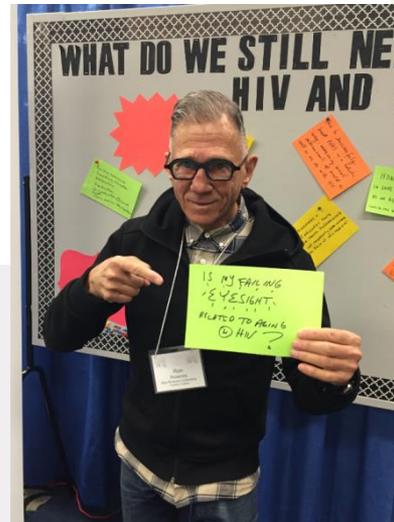
Late HIV diagnosis is more common among older people.



Virologic response to treatment is good among older adults, but immune system recovery slows with age. Prompt access to treatment is key.



Targeted HIV prevention and screening messages for older adults are needed.



Thank you!

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POSITIVE CHANGE
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