IMPROVING CARE FOR OLDER ADULTS WITH HIV: IDENTIFYING PROVIDER PREFERENCES AND PRIORITIES

Recent progress in antiretroviral therapy has greatly extended the survival of people living with human immunodeficiency virus (PLWH).[1] Research found that several geriatric syndromes, such as falls, frailty, and polypharmacy, are more common among aging PLWH than among the general population.[2–4] Currently, most PLWH receive all of their care from their infectious diseases (ID) providers. Therefore, they are important stakeholders in future efforts to care for older PLWH (aged ≥50 y). However, there is neither a clear consensus on the optimal care model to meet this population's needs nor a body of evidence defining ID providers' perspectives on the best models for incorporating geriatrics care into current practices.

Proposed models to improve care for this population include increasing the number of double board-certified geriatrics and ID physicians and creating interdisciplinary clinics, a few of which already exist.[5–8] Additionally, providers could adapt the practitioners of other medical specialties who have developed multidisciplinary models of care for complex older adult patients. These include providing geriatric consultation, developing formal guidelines for target aging populations, and engaging interdisciplinary teams.

To better understand current ID provider priorities and to identify methods for optimizing the care of older PLWH, we conducted a cross-sectional survey of providers in North Carolina (NC) interested in caring for PLWH. We developed our own 10-item survey and distributed it to healthcare workers in NC using the NC AIDS Training and Education Center (NC ATEC) listserv that includes 4624 providers who have participated in NC ATEC trainings or events (File S1). We designed the survey to better understand the following topics: (1) perceived importance of preventive medicine recommendations for older adults to understand current provider priorities, (2) interest in help diagnosing and managing 14 of the most common geriatric syndromes, and (3) perceptions of models to optimize geriatric care for PLWH. In addition to these questions about provider preferences and priorities, we also asked participants about backgrounds and experience. The data were not normally distributed. Therefore, the median is presented where appropriate.

We received 99 responses from the 4624 responders on the listserv (2.1%). For our study, we required that responders currently care for PLWH and had the ability to prescribe. Therefore, of the 99 responses, we included 27 in the final analysis (.6% of the NC ATEC listserv). The remaining 72 respondents did not consent to participation, could not prescribe, or did not currently care for PLWH. Overall, 17 of the 27 included respondents were physicians (.3% of the listserv), 6 advanced practice providers, and 4 pharmacists. Most included respondents (55%) had spent more than 10 years caring for PLWH. Despite all of the survey respondents reporting that they cared for older PLWH, most providers (65% of physicians and 90% of nonphysicians) said they had not received formal geriatrics-specific training (eg, Continuing Medical Education, Maintenance of Certification).

We gave respondents a list of 24 US Preventive Services Task Force recommendations and asked them to select the five most important priorities in their own practice. Respondents most frequently prioritized the following: screening for blood pressure (58% of participants included it in their top five), depression (46%), diabetes (46%), and colorectal cancer (42%). When considering several conditions frequently found among older adults, participants were most interested in help with diagnosing and managing multiple comorbid conditions (median of 85 on a scale of 0-100), polypharmacy (median = 83), cognitive impairment (median = 80), and mood disorders (median = 80). ATEC providers identified formal guidelines for older PLWH as helpful (68% of respondents included guidelines among their top-three most important structural changes). Participants were also supportive of training sessions in geriatrics topics (60%). Additionally, the use of allied health professionals in the care of older PLWH found support among the surveyed providers (60%).

Although the sample size from this study is small and likely included some non-ID providers, the results suggest that providers for PLWH are already considering important age-related preventive measures. Provider priorities about screening for blood pressure, diabetes, and colorectal cancer align with recent data identifying heart disease and cancer as the top-two causes of death for older adults.[9] The study also found that providers are interested in help with geriatric syndromes. They additionally support multiple potential

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changes to address the needs of this growing population. Formal guidelines could expand on the consensus statement by the American Academy of HIV Medicine.[10] Online or in-person curricula developed by geriatricians and ID providers could be another possible solution. Future research should focus on how to implement these changes in clinical practice.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article.

Supplementary File S1: Copy of survey distributed to North Carolina AIDS Training and Education Center providers