What we need to know about advanced aging

If you don't address social determinants of health, you're not going to improve health outcomes, says a leading geriatrician

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"Our society really treats aging as a disease, but it is not a disease," said Dr. Meredith Greene, an associate professor of medicine in geriatrics at the University of California San Francisco. "It is actually a physiologic process that we're all going through from the time we're born." Dr. Greene spoke to medical providers on World AIDS Day on *Geriatric Principles for People with HIV*, including psychosocial changes. Her virtual presentation to the Midwest AIDS Education and Training Center (MATEC) is adapted here.

Everybody's different

PEOPLE AGE DIFFERENTLY. There's a saying in geriatrics, "If you've seen one 80-year-old, you've seen one 80-year-old." You cannot make assumptions that the next person will be the same.

Not all older people are frail. Not all are unable to think for themselves. I wanted to highlight that as people age, that is a time when there's more heterogeneity than at any other age. If you think of pediatrics, there are certain milestones. There are certain ages that pediatricians track, but for older adults, it is actually the opposite. People age based on their whole life experience, and so everyone ages very differently.

You have to ask about geriatric conditions. Older adults might not volunteer the information. Frailty and other geriatric syndromes add up to vulnerability. Addressing polypharmacy and exercise—non-pharmacologic interventions—can address multiple concerns.

We need to understand what is a normal part of the aging process, and what is not normal. Knowing that can help combat stigma as well.

Physical changes

AT SOME OLDER AGES, there's a decline in kidney function. There is a decrease in lean body mass and an increase in fat mass. There is decreasing bone density. There are changes that happen in our cardiovascular system, in our blood vessels, which means the arteries are sometimes stiffer. There are changes in blood pressure, and there are changes that occur via output from our heart. And then there are changes in our eyes and in our ears, which is why some people need a screening process and some people need to get hearing aids for high-frequency sounds, because that is a normal part of aging that affects hearing.

Some of these things are also impacted by HIV, or its treatment. We talk a lot about medication changes and kidney function—the way that body mass changes will absolutely affect how medication metabolizes and processes in the body.

We talk about individuals who are age 50 and older. Not that 50 is old, but the literature [study data] supports the idea that comorbid conditions and geriatric conditions do tend to occur at relatively younger ages in people living with HIV compared to the general population. A lot of this may be in part because of chronic inflammation.

Psychosocial needs

IT'S IMPORTANT TO RECOGNIZE that in HIV care, you're already often dealing with complex psychosocial situations. Both the fields of HIV medicine and geriatrics are essentially good at acknowledging that if you don't address the social determinants of health, you're not really going to be able to improve health outcomes. There are actually a lot more similarities between the two fields than are often recognized or talked about.

One piece of the complexity with psychosocial aspects is that often there is not just depression, but there is the trauma that long-term survivors, especially, might be facing. We think about COVID retriggering trauma, especially for the patients I work with. There is the intersection of stigma, COVID, and HIV. So racism, homophobia, transphobia—all of these things contribute to significant trauma.

There were people isolated before COVID. How do we address that?

First, it is important to know that

ISTOCK

loneliness is different from social isolation. You could be alone and not feel lonely, or you could be surrounded by lots of people and feel completely alone. So again, it's subjective. It's usually more about the quantity of relationships—and the quality of those relationships—and in general, feelings of loneliness, that have the most impact on health.

In the general population, isolation has been related to depression, loneliness, cognitive decline, and even increased mortality similar to smoking 15 cigarettes a day, according to one often-touted figure that came out of a meta-analysis. Again, you don't have to be isolated to feel lonely.

There's controversy over directly asking, "Do you feel lonely?" Some people see it as stigmatizing. You can ask about social support. "How many people do you feel you can depend on or feel close to?" You can use the three-item UCLA loneliness scale: *I feel left out. I feel isolated. I lack companionship.* The responses are *hardly ever, some of the time*, or *often.*

In people with HIV, there's evidence behind combatting loneliness through online support groups, mindfulness-based cognitive therapy, and group interventions for smoking cessation. And also notably, interventions that were not meant to address loneliness, for example, peer-to-peer counseling around sexual risk behaviors.

We should recognize resilience, and partner with community organizations for direct interventions reaching people who are the most lonely. I think more and more we have to break down the silos between health care and community organizations.

This is even more important during COVID-19. Other consequences of COVID include increased isolation, increase in mental health concerns and substance use, decreased physical activity (fear of leaving home), and difficulty keeping caregivers. These may lead to decline in cognitive and physical function, and falls.

Ask about who else is around who can be an emergency contact, so that somebody could be a surrogate decision maker, if someone is ever too sick to make decisions or speak for themselves. Many people may not be able to identify a single person—normalize that, because it is, unfortunately, far too common. But I think if we can normalize it, then we can talk about ways we can document their preferences, without having a decision maker.

Many parts of geriatric assessment can be adapted to telehealth. With video, we can look at their gait and see how they get up from a chair.

Related to telehealth, especially in current times, we can ask about access to phone and video when asking about social support. We do so much online. But not everyone has internet access, and unfortunately, that's [another aspect of health disparities]. We have to think through strategies to address the digital divide.

But I will say there are some upsides to telehealth, including helping improve access for some patients, especially people who have limited mobility. PA

Physiological changes with aging

- Decreased GFR (glomerular filtration rate, a measure of kidney function) and decreased lean body mass (with resulting increased fat mass), both of which can affect pharmacokinetics
- Decreased bone density
- Decreased cardiac output and increased myocardial and arterial stiffness
- Decreased vision and hearing

Why do we need a different approach for older adults?

Diseases often present atypically. May not have the "usual" signs and symptoms.

Older individuals have less physical reserve—small insults (injuries) can cause significant problems.

Ockham's razor (the idea that in problem solving, a simple explanation may be preferable to a complicated one): one unifying diagnosis may not apply.

The 5 Ms 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 (thinking); dementia; delirium; depression

Mobility: amount of mobility and 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

"Mobility" includes being able to navigate around the home or out in the community. Mobility is associated with "activities of daily living" (ADLs), which include bathing, dressing, toileting, transferring (being able to get in and out of bed, a chair, or a wheelchair), and feeding. There are also "instrumental activities of daily living" (IADLs), which include telephone services, finances, transportation, laundry, housekeeping, shopping, meal preparation, and medications.

RESOURCES

STEADI—Older Adult Fall Prevention website includes other clinical resources such as brochures for patients and caregivers.
cdc.gov/steadi/index.html

STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention among Community Dwelling Adults 65 Years and Older.
cdc.gov/steadi/pdf/steadi-algorithm-508.pdf

Selected top 10 drug classes to avoid in elderly PWH, from the European AIDS Clinical Society:
eacs.sanfordguide.com/drug-drug-interactions-other-prescribing-issues/other-prescribing-issues/selected-top-10-drug-classes-to-avoid-in-elderly-plwh

HIV Drug Interactions Checker:
hiv-druginteractions.org/checker

Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV:
aahivm-education.org/hiv-age and aahivm.org/wp-content/uploads/2017/02/Aging-report-working-document-FINAL-12.1.pdf

HealthHIV's National Resource Center for Care Coordination and Pozitively Aging with HIV
healthhiv.org/pozitivelyaging

The Veterans Aging Cohort Study Index (VACS Index) from the Yale School of Medicine predicts all-cause mortality, cause-specific mortality, and other outcomes in people living with HIV. It features a calculator, summary of validation work to date, and a clinical interpretation of index scores.
medicine.yale.edu/intmed/vacs/cohorts/vacsresources/vacsindexinfo

State of Illinois Senior Health Insurance Program (SHIP) offers free counseling for seniors or their caregivers about available Medicare and insurance options. Services available throughout Illinois.
(800) 252-8966
uofi.box.com/v/seniorhealthinsurance

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