

unsure of her menopause stage). Eight women identified as White, four as Indigenous, and one as having mixed ethnicity. All thirteen women had healthcare providers; seven were seeing an Infectious Diseases specialist, five a family physician, and one a nurse practitioner. Overall, a lack of menopause-related knowledge represented the main hindrance to menopausal care for all women with HIV. Women reported variable experiences in receiving care. Even among those who have discussed menopause with healthcare providers, many women still had ongoing informational needs, particularly about what to expect during menopause, available treatment options, and lifestyle strategies to manage symptoms. Women identified five barriers to engaging in menopause discussions: (1) women pushed menopause “to the back burner” due to their HIV care, with HIV management often overshadowing the specific needs associated with menopause, (2) issues related to women’s health were often de-emphasized by providers, (3) women had a sense of uncertainty regarding the origin of their symptoms, specifically whether symptoms were attributable to HIV, age-related comorbidities, or substance use, (4) societal stigma around menopause and (5) prior negative healthcare experiences.

**Conclusion:** This study sheds light on the unmet menopause-related needs of women living with HIV, many of which stem from a deficit of information about, and preparation for, menopause. Our findings emphasize the need for providers to establish a safe and open environment for discussing menopause in clinical spaces, not only to address women’s informational needs but also to de-stigmatize menopause. Moreover, our findings raise the question of whether menopausal education for women with HIV could benefit from conducting knowledge translation/transfer workshops through the involvement of peers. The latter could provide experiential knowledge and facilitate open discussions, potentially providing additional support for women around the menopausal transition.

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## Caregiving by Older People Living with HIV

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**Background:** People living with HIV (PWH) are living longer and are more likely to face psychosocial stressors related to stigma, social isolation, cognitive loss, and fragile social networks earlier than the general population. In addition, PWH may also become caregivers (CG) for their older partners, spouses, other family members or friends. In the United States, more than 50% of PWH are older than 50 years and it is anticipated that the number of PWH who are CG will increase with advances of medical care. Little is known about caregiving by PWH, the extent to which they are able to fulfill their roles, and the support they receive while caregiving and managing their own medical challenges. The purpose of this study was to determine the characteristics of PWH who are CG, identify their care recipients, and examine factors associated with caregiving by PWH.

**Methods:** PWH aged 50 and older from a New York City Clinic were randomly selected to complete the Research on Older Adults with HIV (ROAH 2.0) survey. Depression was assessed using the Center of Epidemiologic Studies Depression Scale, 10-item (CES-D 10), loneliness using the UCLA loneliness scale, generativity using the short form Loyola scale, and HIV-related stigma using the Sowell Stigma scale. Chronic conditions were obtained through both self-report questionnaire and analysis of the electronic health record (EHR) and HIV variables were extracted from the EHR. In addition to using descriptive statistics, we conducted correlation and regression analyses.

**Results:** In this sample of 331 PWH aged 50 years and older, 43.2% of PWH reported being CG in the previous 5 years. Among PWH who were CG in this sample, 70.9% reported financial strain with a mean CDC Social Vulnerability Index of 0.714 (SD=0.275), and 45.5% had more than 5 chronic conditions; these factors were not significantly different from the non-caregiver group. The majority of PWH who were CG cared for other family members (47.6%) or for a friend (28.7%);

79.6% cared for 1 care recipient, 13.9% for 2 care recipients and 6.6% for 3+ care recipients. The regression analyses revealed that being older ( $b=0.484$ ,  $SE=0.244$ ,  $p=0.037$ ), being a female ( $b=0.038$ ,  $SE=0.018$ ,  $p=0.047$ ), and having a high generativity score ( $b=0.074$ ,  $SE=0.031$ ,  $p=0.008$ ), were positively associated with caregiving in PWH. HIV-related variables were not significant in the model. Although caregiving was significantly associated with increased needs for support in instrumental activities of daily living ( $b=-0.246$ ,  $SE=0.136$ ,  $p=0.015$ ) and for emotional support ( $b=-0.218$ ,  $SE=0.127$ ,  $p=0.045$ ), there were no significant associations between caregiving and psychosocial determinants such as loneliness, depression, or HIV-related stigma.

**Conclusions:** As the well-known stressors of caregiving can negatively impact health and well-being, understanding caregiving in the context of living with HIV is fundamental in order to assess caregivers' needs and develop sensible interventions to promote feelings of generativity and reduce caregiver strain. Generativity might be a positive determinant of caregiving that could help mitigate caregiver burden, enhance meaning and purpose in life, and promote well-being.

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## Utilization of Medical Case Manager Assessment for Older Adults with HIV and Long-Term Survivors of HIV to Enhance Quality of Life and Well-Being

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**Background:** Nearly half of Persons living with HIV (PLWH) are over the age of 50. In the beginning of the HIV epidemic, few could have imagined that terms such as longevity and chronicity would become associated with the disease. Due to advances in treatment, PLWH have been living longer than anyone would have anticipated. As PLWH live longer, the concept of aging successfully has become increasingly more important as today's older adults focus on Quality of Life (QOL) and reaching an overall sense of well-being.

**Methods:** In February 2023, the Mary Washington Wellness Program (MWWP) created a Medical Case Manager Assessment for Older Adults and Long-Term Survivors with HIV. The assessment encompasses QOL concepts, such as physical and mental health, safety, and belonging. Additionally, the 5 M's of Geriatric Care were incorporated into the assessment. These 5 M's are defined as Mind, Mobility, Medications, Multimorbidity, and What Matters Most. To achieve a truly comprehensive perspective of the needs of older clients, a focus on dental and vision needs, as well as preventative care measures are also included. Medical Case Managers complete the assessments with clients aged 50 and older, and clients who are perinatally infected, as MWWP found it important to include individuals who have been aging with HIV their entire life. The assessments are completed every six months.

**Results:** Currently, 50% of the HIV population the MWWP serves are 50 years of age and older. In the past six months, 10% of clients within the criteria have completed the assessment with a medical case manager. A small number of assessed clients (approximately 2%) have expressed concerns regarding their cognition or mobility, while a higher number reported a lack of social support and mental health concerns (40%). All the clients assessed were engaged in the assessment process and provided positive feedback regarding the focus on recognizing the needs for older adults living with HIV.

**Conclusions:** Overall, answers regarding what matters most have been particularly insightful. Clients shared concerns about the ability to live independently, but they also conveyed a concerted effort to remain actively involved in their care regimens. Most of the assessed clients also demonstrated high levels of health literacy regarding their medications and multimorbidities. As PLWH continue to age, more research focusing on what it means to age successfully, and achieve quality of life, is needed.