HRSA
Health Resources & Services Administration

Integrating Geriatric Services into the RWHAP Clinic

HIV/AIDS Program

2020 National Ryan White Conference on HIV Care and Treatment

August 12, 2020

Marlene Matosky, MPH, RN
Chief, Clinical and Quality Branch
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

Disclosures

Marlene Matosky has no relevant financial or non-financial interests to disclose.

Health Resources and Services Administration (HRSA) Overview

- Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically vulnerable through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

- Every year, HRSA programs serve tens of millions of people, including people with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

HRSA's HIV/AIDS Bureau (HAB) Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all.

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people with HIV/AIDS and their families.

HRSA's Ryan White HIV/AIDS Program

- Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV
  - More than half of people with diagnosed HIV in the United States – nearly 519,000 people – receive care through the Ryan White HIV/AIDS Program (RWHAP)
- Funds grants to states, cities/counties, and local community based organizations
  - Recipients determine service delivery and funding priorities based on local needs and planning process
- Payor of last resort statutory provision: RWHAP funds may not be used for services if another state or federal payer is available
- 87.1% of Ryan White HIV/AIDS Program clients were virally suppressed in 2018, exceeding national average of 62.7%

Source: HRSA. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018; CDC. HIV Surveillance Supplemental Report 2018;21(No. 4)

HRSA Ryan White HIV/AIDS Program

Learning Objectives

By the end of this session, participants will be able to:

- Learn about the role of a geriatrician and aspects that can be integrated into the RWHAP clinic
- Identify common geriatric screenings and assessments
- Explain models to integrate geriatric services into the RWHAP from a person aging with HIV and a provider

How To Claim CE Credit

If you would like to receive continuing education credit for this activity, please visit:

ryanwhite.cds.pesgce.com

Aging Institute

Session 1: Understanding the medical and psychosocial needs of people aging with HIV in the Ryan White HIV/AIDS Program and the community response (16793)

- Tuesday, August 11th from 3:15 p.m.-4:45 p.m. ET

Session 2: Integrating Geriatric Services into the RWHAP Clinic (16794)

- Wednesday, August 12th from 2:30 p.m.- 4:00 p.m. ET

Session 3: Accessing Community Resources for People Aging with HIV (16795)

- Thursday, August 13th from 2:30 p.m.-4:00 p.m. ET

Aging Poster

Title: Older adults served by HRSA's Ryan White HIV/AIDS Program: Present and future

Poster number: 15750

Authors: Dr. Laura Cheever, Stacy Cohen, Antigone Dempsey, Pamela Klein, Marlene Matosky, Robert Mills, and Chris Redwood

Presenters

Mark Brennan-Ing

Meredith Green

Esther Ross

Eugenia Siegler

Contact Information

Marlene Matosky, MPH, RN
Chief, Clinical and Quality Branch
Division of Policy and Data
HIV/AIDS Bureau
Health Resources and Services Administration
Email: mmatosky@hrsa.gov
Phone: 301-443-0798
Web: hab.hrsa.gov

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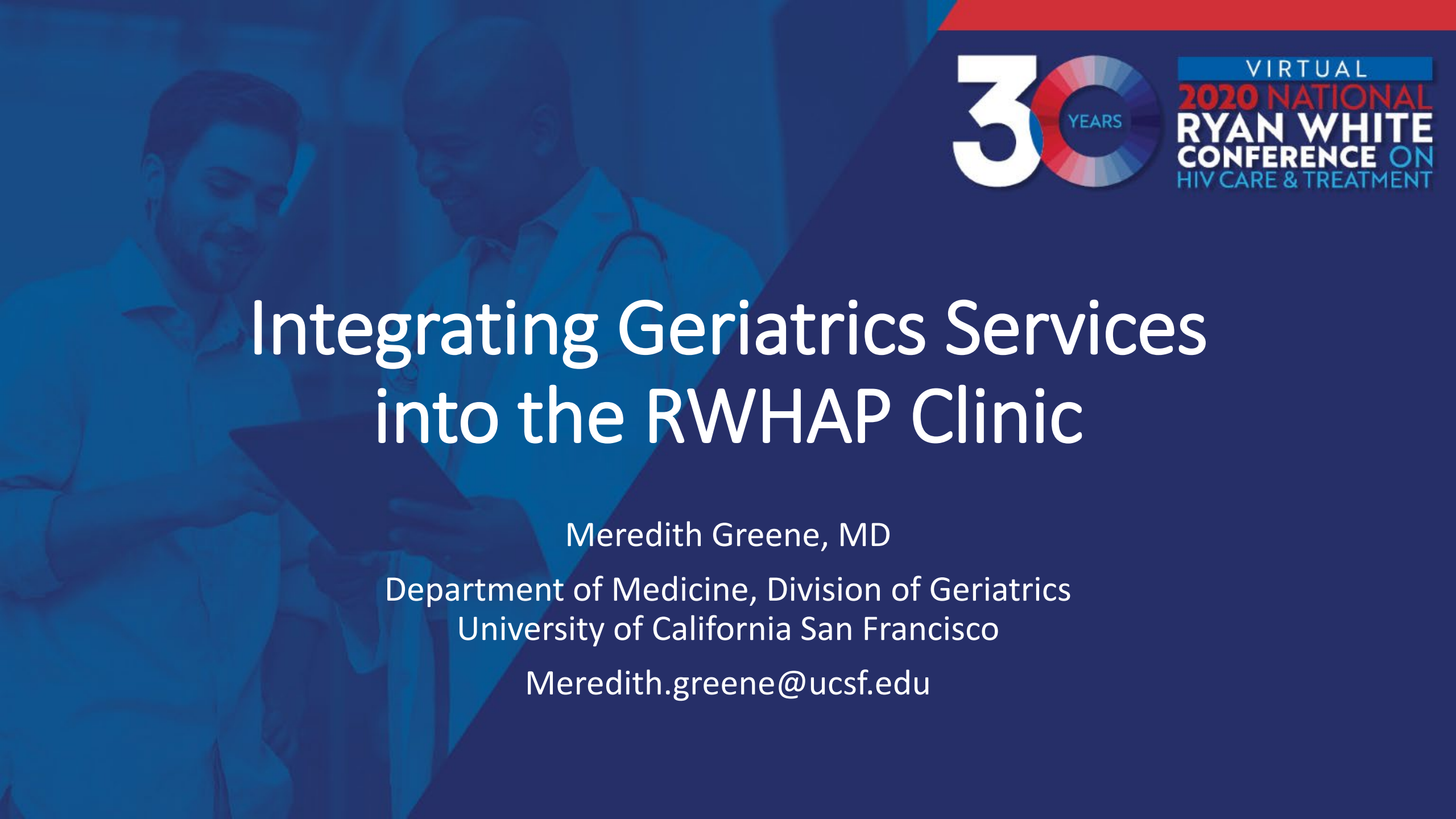


VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Integrating Geriatrics Services into the RWHAP Clinic

Meredith Greene, MD

Department of Medicine, Division of Geriatrics
University of California San Francisco

Meredith.greene@ucsf.edu

Disclosures

- Receive grant support from Gilead Inc.
- Disclosure will be made when a product is discussed for an unapproved use. This continuing education activity is managed and accredited by AffinityCE in cooperation with HRSA and LRG. AffinityCE, HRSA, and LRG Staff, as well as planners and reviewers, have no relevant financial or non-financial interests to disclose. Conflict of interest, when present, was resolved through peer review of content by a non-conflicting reviewer. Commercial support was not received for this activity.

Objectives

- Learn about the role of a geriatrician:
  - What is the geriatrics perspective & similarities with HIV care
  - An example of my role providing geriatric consults in HIV clinics
  - Practical considerations for incorporating geriatric services

What is Geriatrics?

- "Geriatrics" often used interchangeably with "Geriatric Medicine" clinical care of older adults
  - Can be for any age but often "65 +"

- "Gerontology" often defined as study of aging across lifespan

Still a newer field:

1988-Geriatric Medicine board certification

Geriatrics Perspective

- **Focus on function**
  - How does a disease(s) affect social, emotional, and physical functioning?
  - How can the environment (physical, social) support function?

- Working across different settings
  - Clinic, Hospital, Home, Long term care

- Align care with patient goals

Geriatrics Perspective: similarities with HIV care

- Dealing with Complexity:
  - Multimorbidity, polypharmacy, complex social situations
- Focusing on social context of care/social determinants of health
- Working in multidisciplinary teams
  - Relevant to RWHAP clinics

Geriatrics & Similarities with HIV Care

- Roles of HIV and Geriatrics Clinicians
  - Specialty Care vs. Primary Care?

- Workforce concerns in both fields

The New York Times

Opinion

The Scary Shortage of Infectious-Disease Doctors

HEALTH

As Population Ages, Where Are the Geriatricians?

By KATIE HAFNER JAN. 25, 2016

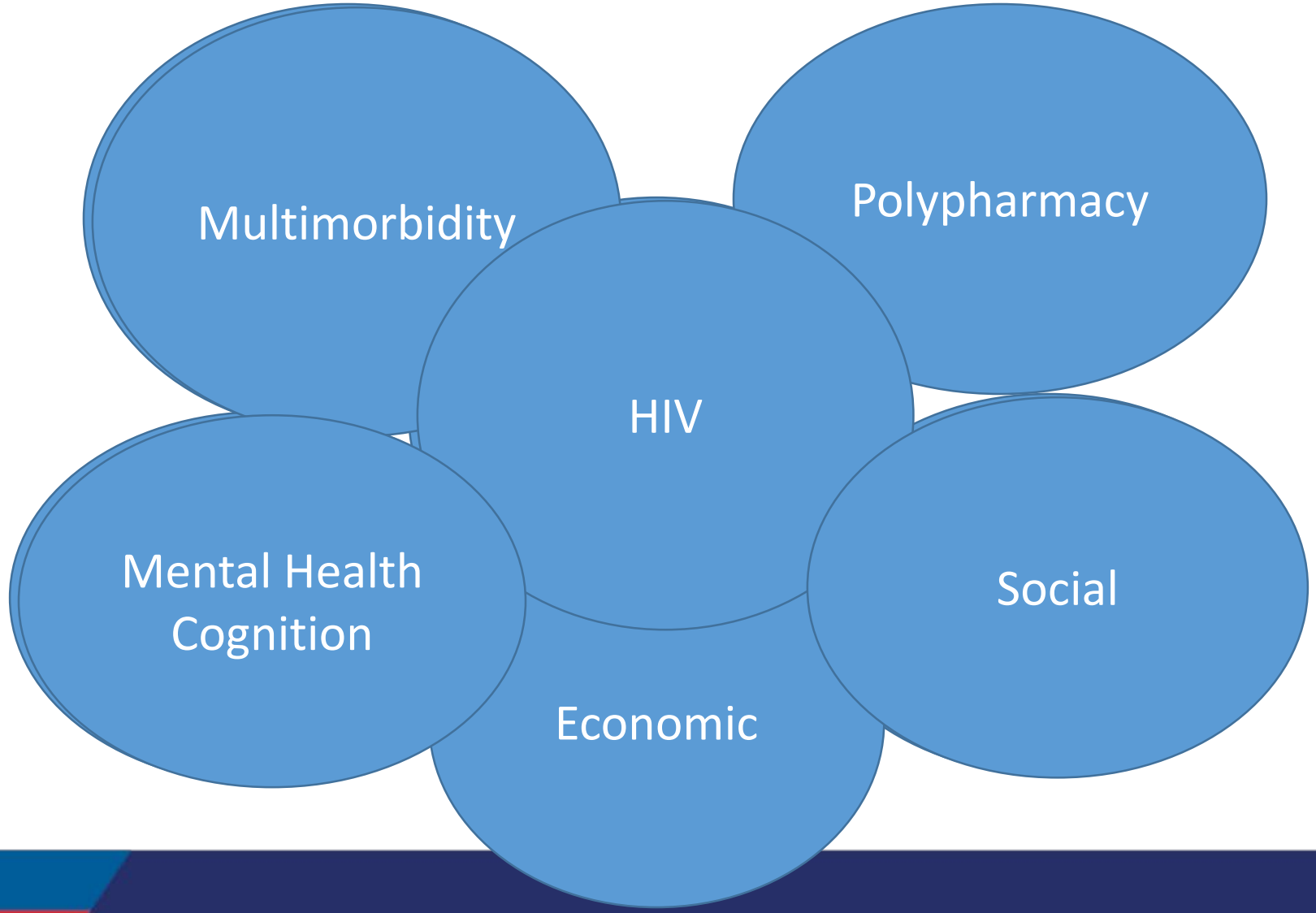
What do geriatricians do? And what would this look like in an HIV clinic?

Focus on outpatient clinical settings like in RWHAP

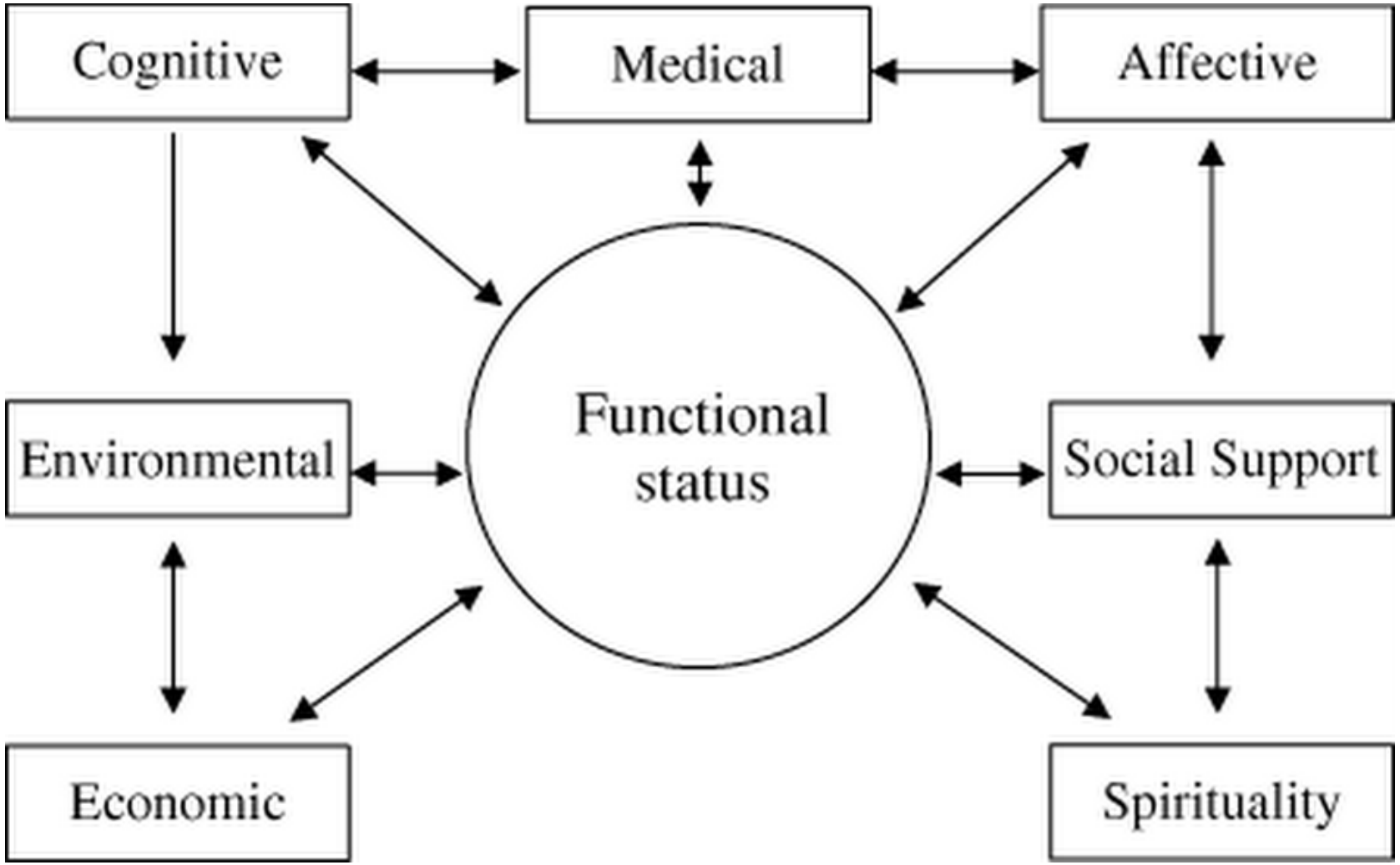
A typical clinic patient

- 62 y/o Latino male, HIV long term survivor
- Hypertension, diabetes, enlarged prostate with symptoms,
- Meds: lisinopril, amlodipine, finasteride, tamsulosin, DTG/3TC/ABC, oxybutynin, atorvastatin, ranitidine
- Blood pressure medications were being adjusted, PCP notes also indicate grief

Older Adults living with HIV: Medical Complexity



Comprehensive Geriatric Assessment



Reuben DB, Hazzard's Principles of Geriatric Medicine

Functional Status

Activities of Daily Living (ADLs)

- Bathing
- Dressing
- Toileting
- Transferring
- Feeding

Instrumental Activities of Daily Living (IADLs)

- Telephone
- Transportation
- Housekeeping
- Meal preparation
- Medications
- Finances
- Shopping
- Laundry

Comprehensive Geriatric Assessment

- "multidisciplinary evaluation in which the multiple problems of older persons are uncovered… need for services assessed, and a coordinated care plan developed to focus interventions"
- Team: MD, NP, SW, pharmacist, PT/OT
- Different models but 3 key steps:
    1. Screen/target
    2. Assessment/develop recommendations
    3. Implementation

National Institute of Health Consensus Development Conference Statement. *Geriatric Assessment Methods for Clinical Decision-making*. Washington, DC: U.S. Department of Health and Human Services; 1987:6(13).

Evidence for Comprehensive Geriatric Assessment

- Most data is from inpatient setting
- Always identifies geriatric problems
- Mixed results on outcomes overall including hospitalizations but several studies have shown benefit

Reuben DB, Frank JC, Hirsch SH, et al. J Am Geriatr Soc. 1999 Mar;47(3):269-76
Cohen HJ, Feussner JR, Weinberger M, et al. N Engl J Med. 2002 Mar 21;346(12):905-12.

“M’s” framing of geriatrics

- Matters Most
- Mind
- Mobility
- Medications

4M

- Multi-complexity/Multi-morbidity

5M

- Modifiable

6M

Learn more at Session 15761; *Caring for Older People living with HIV: Moving Beyond Viral Suppression to Promote Healthy Aging*

An example from San Francisco

GOLDEN COMPASS PROGRAM
Ward 86

1) Literature review

2) Demonstration/pilot program (Silver Project)

3) Surveys and focus groups with patients and providers --- stakeholder engagement

NORTHERN POINT:
Heart and Mind
Components: Cardiology clinic on-site, brain health and memory classes, cognitive assessment testing

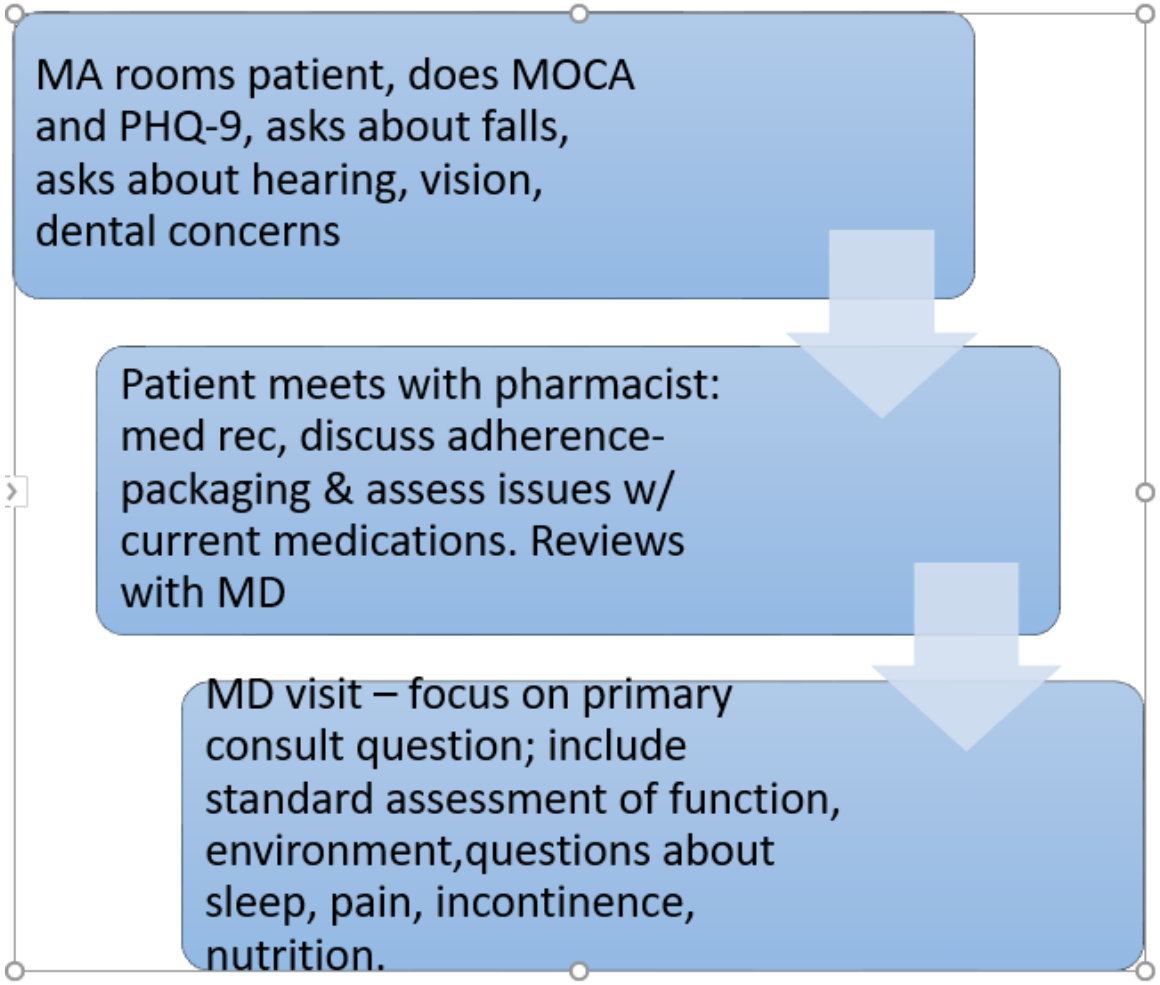
WESTERN POINT:
Dental, Hearing and Vision
Components: Medical assistant navigation to these three services

EASTERN POINT:
Bones and Strength
Components: Frailty and fall assessments, chair exercise classes, DEXA machine on-site (coming)

SOUTHERN POINT:
Network and Navigation
Components: Social support groups, link with community programs, peer navigators and helpers

Greene M, PLOS One 2018

Geriatrics Clinic in Golden Compass



Common reasons for referral:

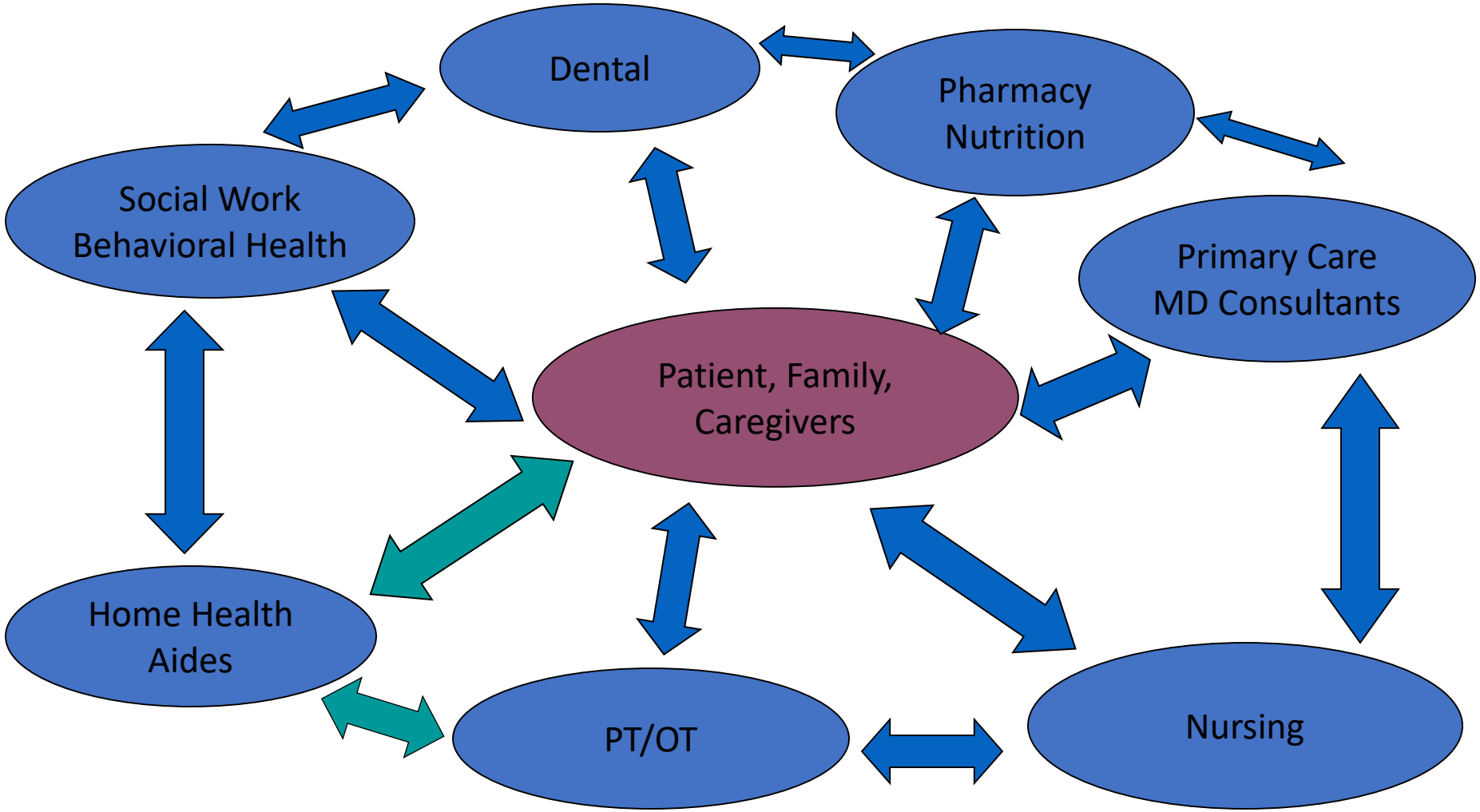
- General evaluation
- Cognition
- Falls

After geriatrics clinic

- Independent in ADLs & IADLs but was not doing as much as used to since family member's death
- Reported Dizziness: confirmed was orthostatic – his blood pressure and prostate meds adjusted & dizziness resolved
- Grieving loss family member and already felt isolated
  - Connected to volunteer who still meets with him weekly
  - Given list therapy resources, social work follow-up
  - Became highly engaged in classes

Reflecting on improvements in both physical and mental health: *"I'm in a good place compared to how I was before I started in the program."*

It Takes a Village….



What if you don't have a geriatrician in clinic?

- What are your local resources?
  - Telehealth options with geriatrics?
- Which areas (like in 5Ms) are you already addressing?
  - Pick one to start;
- What is your staffing and availability to help with doing assessments?
  - And follow-up after screening/assessment
  - Team approach but can break into visits or telehealth sessions

UCSF example: Teaching the “Ms”

- HRSA Bureau of Health Workforce: Geriatric Workforce Enhancement Program (GWEP)
  - 48 programs across the US
- Northern California: Optimizing Aging Collaborative
  - Teaching “4Ms” to include HIV clinic staff and community partners

The **Optimizing Aging Collaborative at UCSF** is empowering San Francisco to meet the needs facing older adults.

Summary

- Similarities exist between geriatrics and HIV medicine
- 5Ms can be a way of remembering core elements of geriatrics; supporting function is the core principle
- You can adapt Comprehensive Geriatric Assessment to your setting

Acknowledgments

Thank you!

Golden Compass Program (Ward 86)

AIDS Walk San Francisco

DIFFA Design Industries Foundation Fighting AIDS

San Francisco General Hospital Foundation
Supporting the Heart of Our City

Tideswell at UCSF

Contact

Meredith Greene

Meredith.Greene@ucsf.edu

Geriatric Assessment & Integration of Models of Care

Eugenia L. Siegler, MD
Weill Cornell Medicine
els2006@med.cornell.edu

Mark Brennan-Ing, PhD
Hunter College
mark.ing@hunter.cuny.edu

30 YEARS
2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT
HRSA Ryan White HIV/AIDS Program

Disclosures

- Dr. Siegler has received support through an investigator-initiated research grant from Gilead Sciences and will be a consultant to Montefiore Medical Center, which has a Gilead funded program to establish a program in HIV and Aging.
- Dr. Brennan-Ing has received support through an investigator-initiated research grant from Gilead Sciences and is a member of the HIV and Aging policy committee convened by SAGE (Service & Advocacy for GLBT Elders) that is supported by Gilead.
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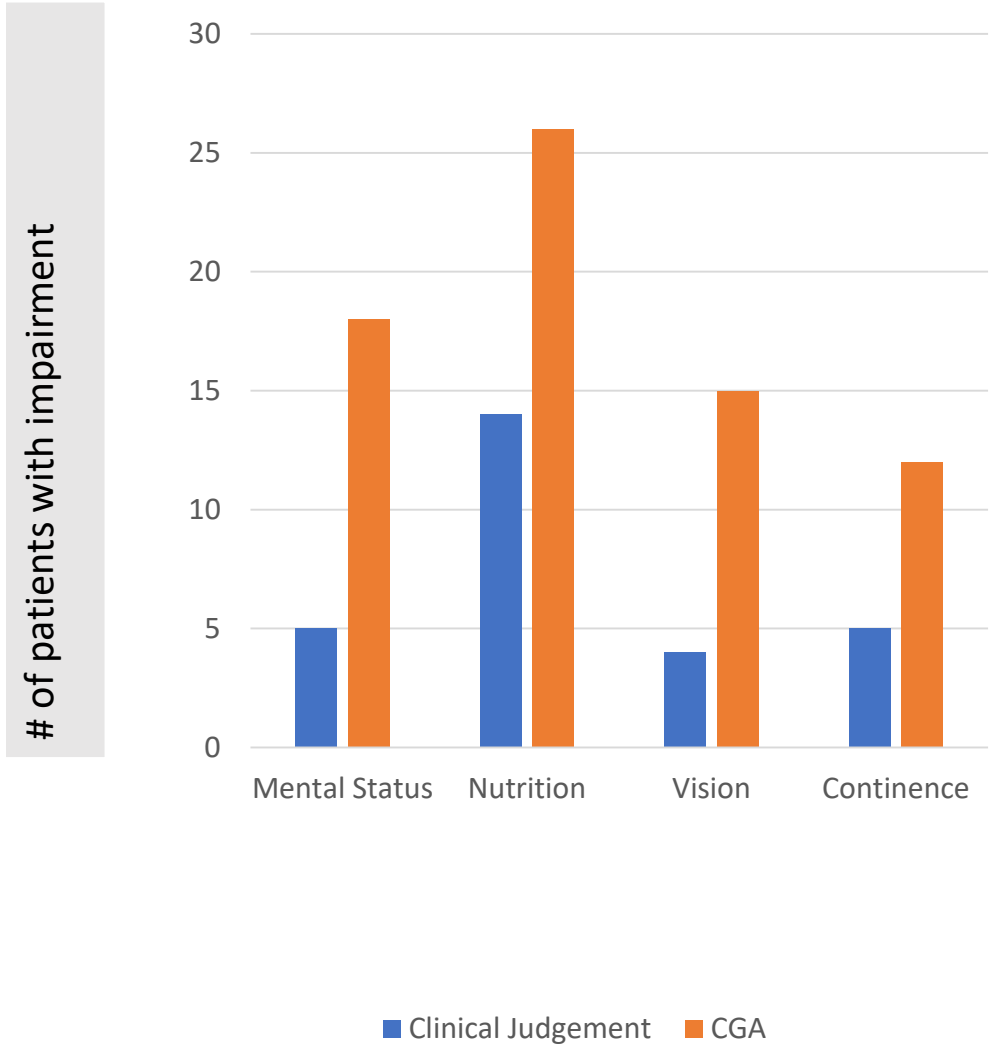
Choosing and Using Tools for Assessment

Why screen? Formal assessment is more sensitive than clinical judgment

- Clinical judgment can identify **severe** impairment
- Recognition of **moderate** impairments is better with formal assessment (CGA)

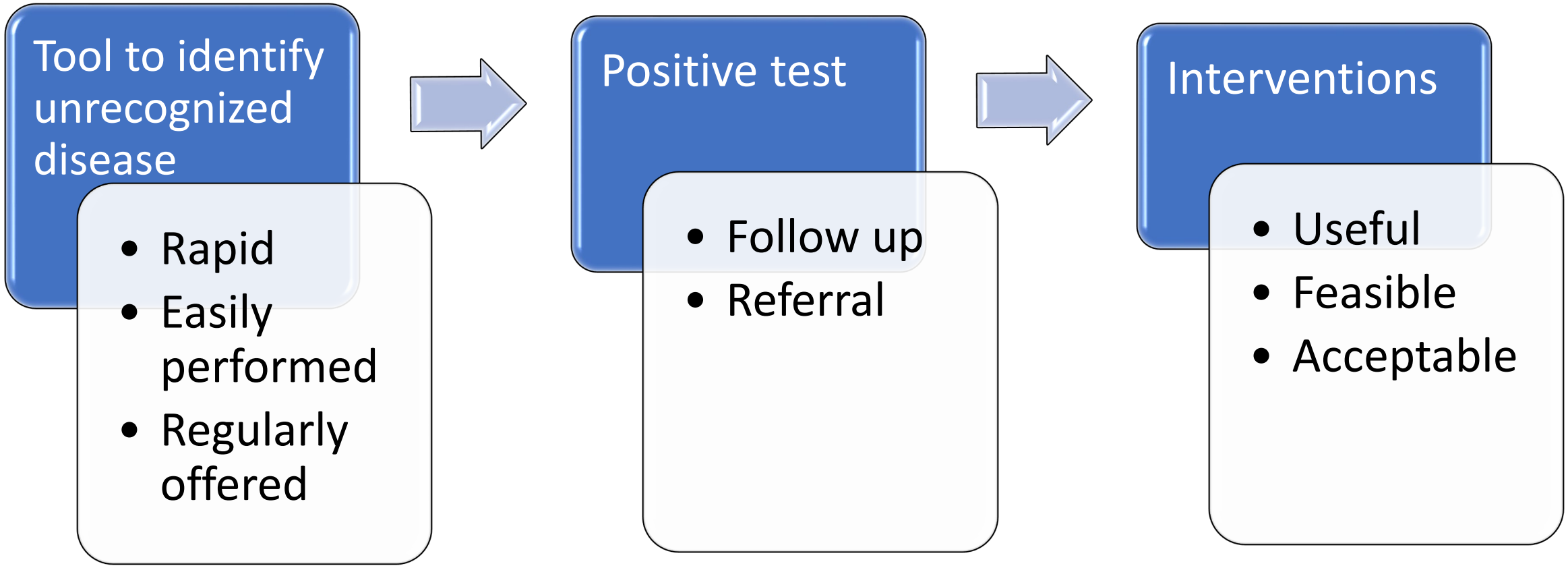


Pinholt et al. *Arch Intern Med* 1987;147:484-488

Comprehensive geriatric assessment includes multiple screens … but is often unavailable

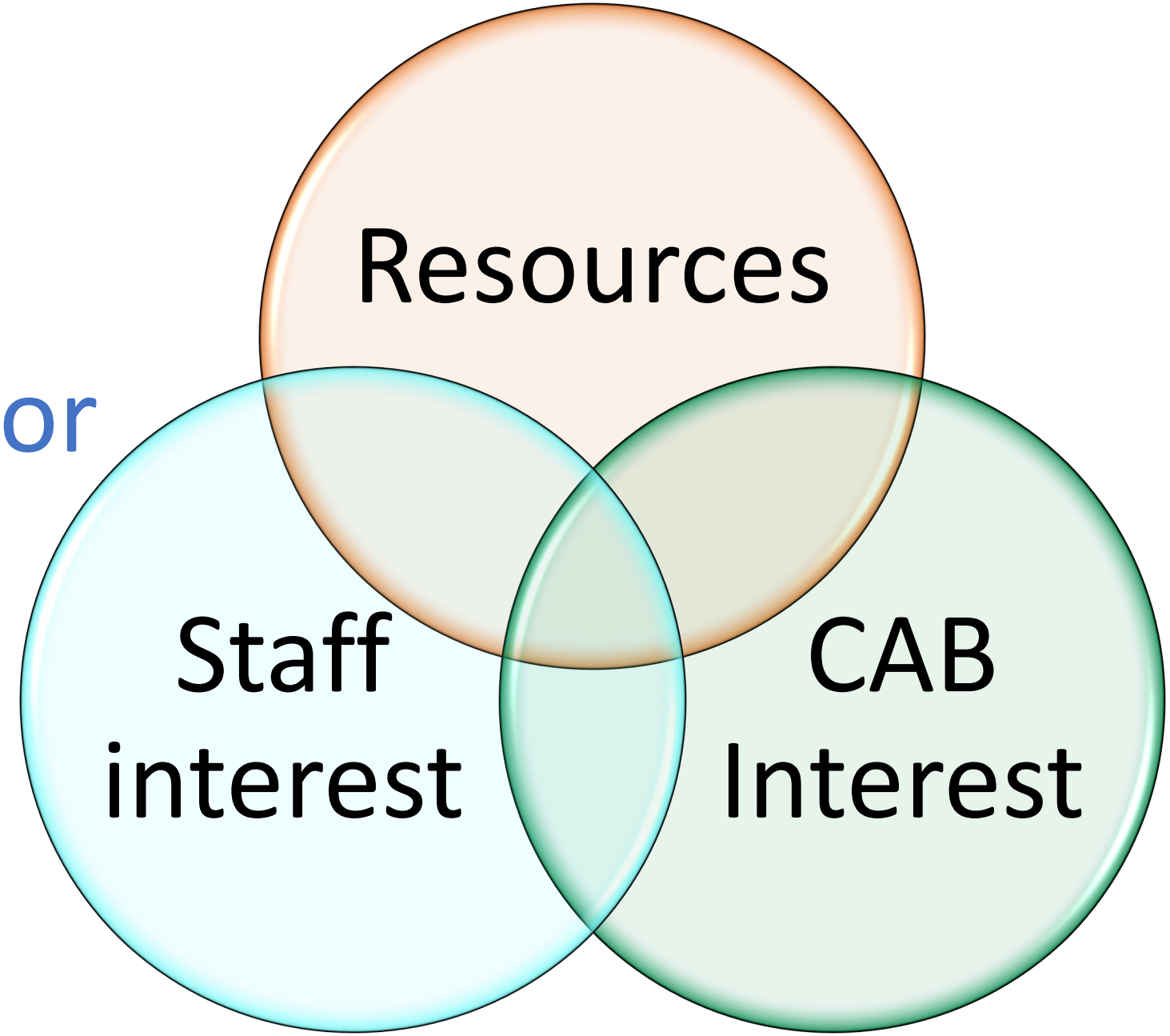
- Activities of Daily Living (ADL)
  - Basic ADL
  - Instrumental ADL
- Geriatric syndromes/frailty
- Medical comorbidities
- Nutritional status
- Medication appropriateness
- Social network/financial status
- Living situation/environment
- Affect
- Cognition
- Advance directives
- Quality of life

Screening is a process

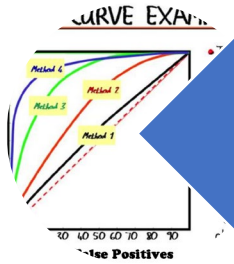


https://www.who.int/cancer/prevention/diagnosis-screening/screening/en/

Do you want to focus on one domain or do a general screen?



For a specific domains, choose assessment tools that are useful in your setting



Test characteristics

Time/ Ease of administration

Availability in the EHR

Patients can fill out a general screen before the visit

A local PCP may have a Medicare Annual Wellness Visit template

https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/hra.pdf

Name:_____ Date:_____ Date of Birth:_____

A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with

5 During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle your own money without help?	☐	☐
11. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair

The WHO defines healthy aging as developing and maintaining the functional ability that fosters well being

KEY DOMAINS OF INTRINSIC CAPACITY

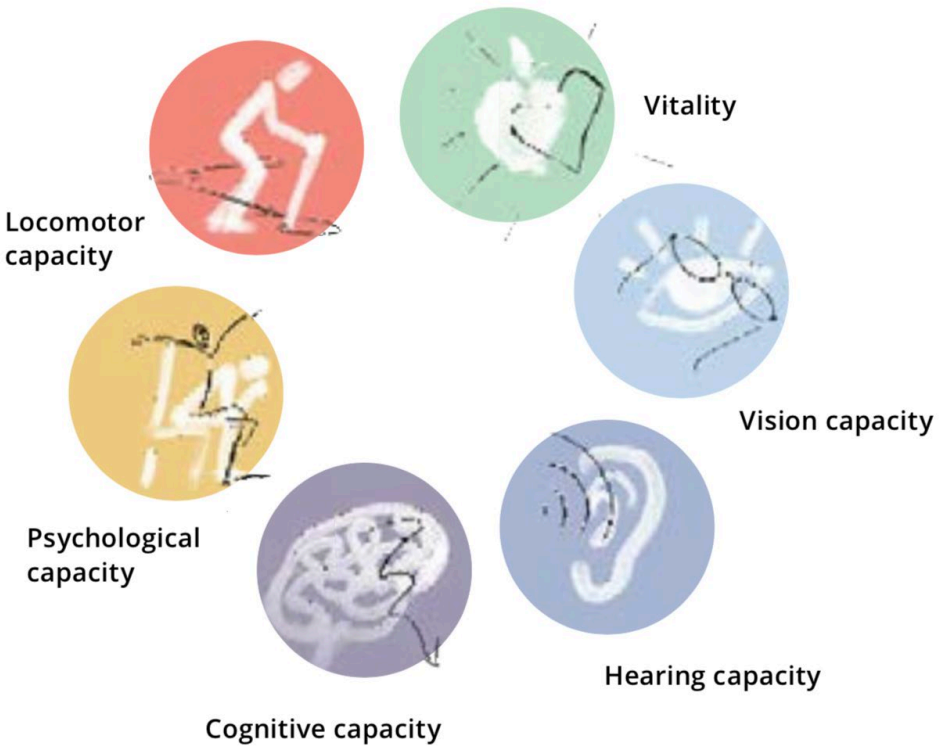
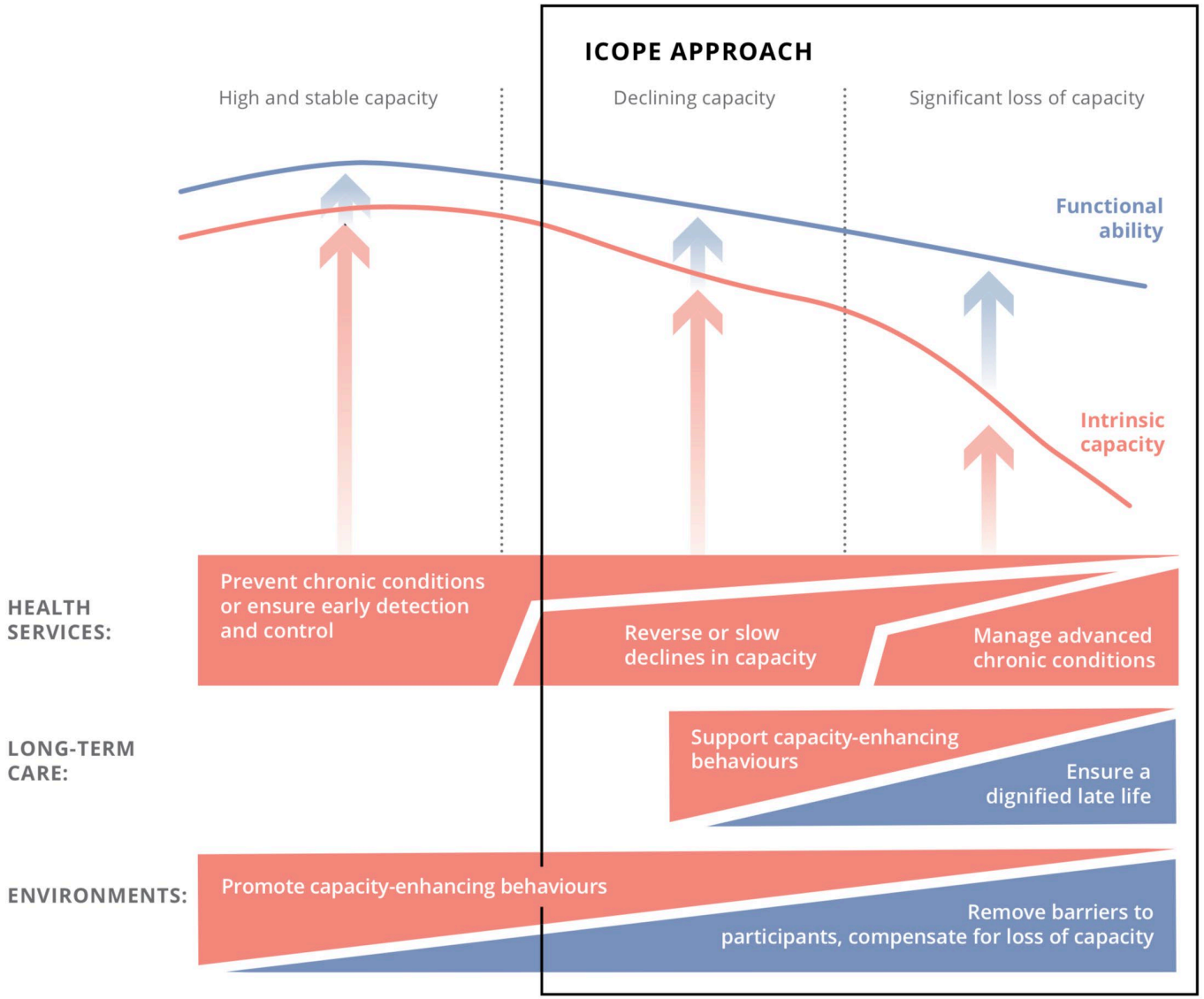


FIGURE 2. A PUBLIC-HEALTH FRAMEWORK FOR HEALTHY AGEING: OPPORTUNITIES FOR PUBLIC HEALTH ACTION ACROSS THE LIFE COURSE



Source: World Health Organization, 2015 *(1).*

Example: Mobility

Begin with a screen, but have a plan if the person screens in

5

Locomotor capacity

Care pathways to improve mobility

Multimodal exercise → 5.1

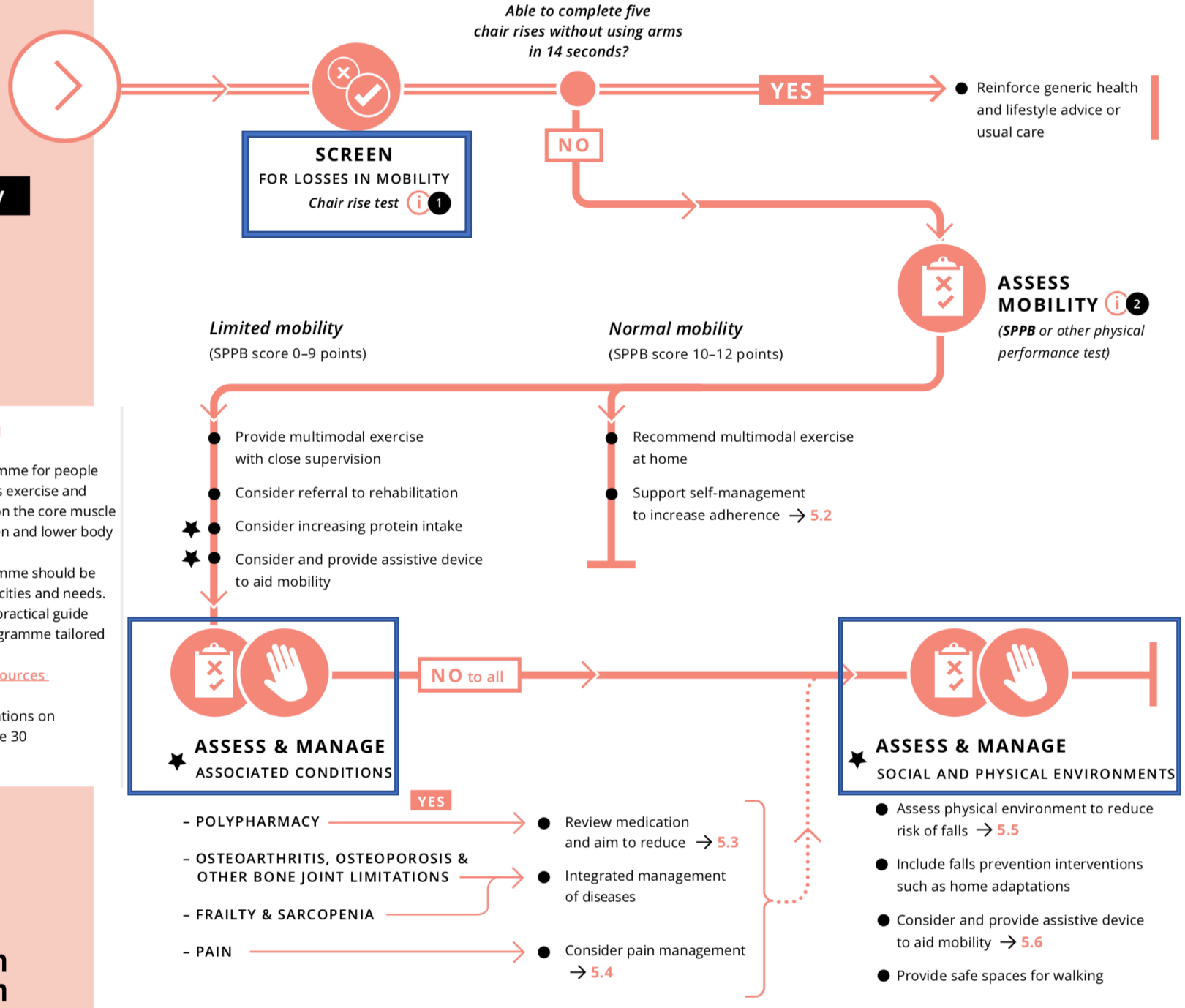
A multimodal exercise programme for people with limited mobility combines exercise and cross-training with emphasis on the core muscle groups of back, thigh, abdomen and lower body

A multimodal exercise programme should be tailored to suit individual capacities and needs. The **Vivifrail project** offers a practical guide to developing an exercise programme tailored to capacities
http://www.vivifrail.com/resources

For WHO global recommendations on physical activity, see box, page 30

★ Specialized care needed

World Health Organization



Mobility and gait: Chair Rise Test

1

CHAIR RISE TEST

A simple test can decide whether an older person needs further assessment for limited mobility.

Instructions: Ask the person, "Do you think it would be safe for you to try to stand up from a chair five times without using your arms?" (Demonstrate to the person.)

If YES, ask them to:

– sit in the middle of the chair
– cross and keep their arms over their chest
– rise to a full standing position and then sit down again
– repeat five times as quickly as possible without stopping.

Time the person taking the test – further assessment is needed if they **cannot stand up five times within 14 seconds.**

Mobility and Gait: Timed Up and Go Test

Time:	*Rating:*
<10 seconds	Freely mobile
>=12 seconds	Higher risk of falling

Patient: Date: Time: AM/PM

The Timed Up and Go (TUG) Test

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters or 10 feet away on the floor.

Instructions to the patient:

When I say **"Go,"** I want you to:

1. Stand up from the chair
2. Walk to the line on the floor at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

On the word **"Go"** begin timing.

Stop timing after patient has sat back down and record.

Time: _____ seconds

An older adult who takes ≥12 seconds to complete the TUG is at high risk for falling.

Observe the patient's postural stability, gait, stride length, and sway.

Circle all that apply: Slow tentative pace ■ Loss of balance ■ Short strides ■ Little or no arm swing ■ Steadying self on walls ■ Shuffling ■ En bloc turning ■ Not using assistive device properly

Notes:

For relevant articles, go to: **www.cdc.gov/injury/STEADI**

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

STEADI Stopping Elderly Accidents, Deaths & Injuries

Now what?

Multimodal exercise → 5.1

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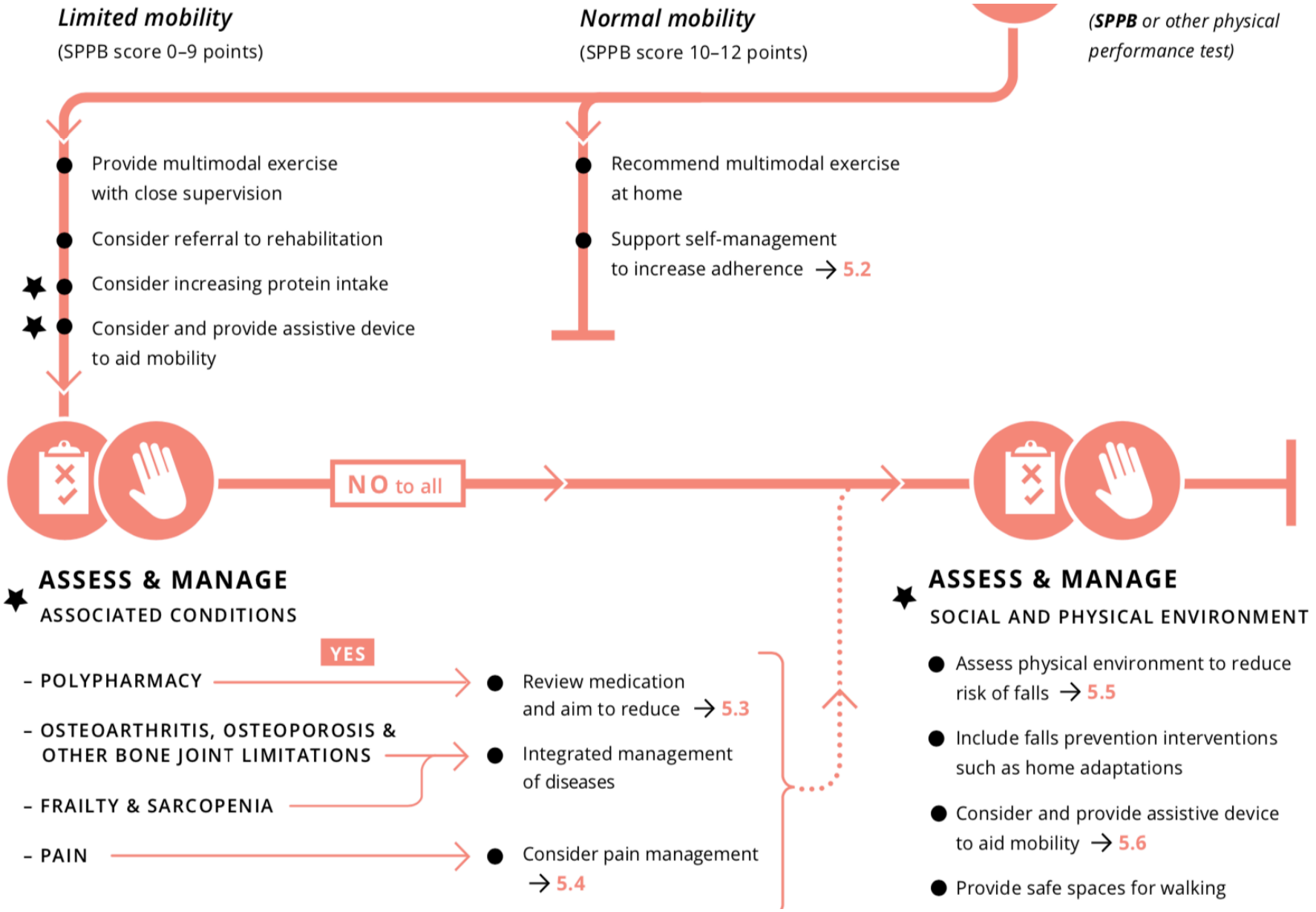


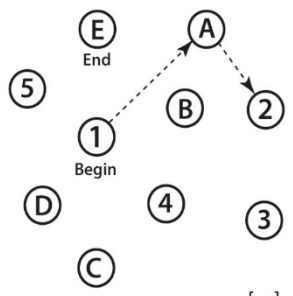
Example: Cognition

MONTREAL COGNITIVE ASSESSMENT (MOCA)

Version 7.1 Original Version

NAME :
Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE — POINTS



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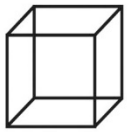


[ ] [ ]

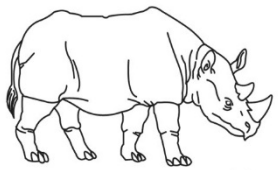
Draw CLOCK (Ten past eleven) (3 points)

[ ] Contour [ ] Numbers [ ] Hands

__/5

NAMING

[ ]



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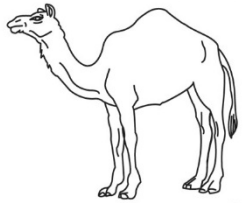


[ ]

__/3

MEMORY — Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.).
Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2

__/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

__/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

__/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ]

__/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

__/1

ABSTRACTION — Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

__/2

DELAYED RECALL

	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
Has to recall words WITH NO CUE	[ ]	[ ]	[ ]	[ ]	[ ]	
Optional Category cue						
Optional Multiple choice cue						

__/5

ORIENTATION — [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

__/6

© Z.Nasreddine MD — www.mocatest.org — Normal ≥26 / 30

TOTAL __/30

Add 1 point if ≤ 12 yr edu

Administered by: _____

These are useful tools for measuring cognition but there is a fee!

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: ***Ask the questions in the order listed. Score one point for each correct response within each question or activity.***

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

Source: www.medicine.uiowa.edu/igec/tools/cognitive/MMSE.pdf

VAMC
SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu

Name_____ Age_____

Is the patient alert?_____ Level of education_____

__/1 (1) **1. What day of the week is it?**

__/1 (1) **2. What is the year?**

__/1 (1) **3. What state are we in?**

4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car

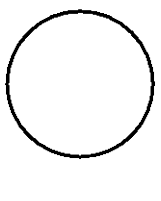
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
(1) **How much did you spend?**
__/3 (2) **How much do you have left?**

6. Please name as many animals as you can in one minute.
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 **7. What were the five objects I asked you to remember? 1 point for each one correct.**

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
__/2 (0) 87 (1) 648 (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
(2) Hour markers okay
__/4 (2) Time correct



(1) **10. Please place an X in the triangle.**

__/2 (1) **Which of the above figures is largest?**

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

__/8 (2) **What was the female's name?** (2) **What work did she do?**
(2) **When did she go back to work?** (2) **What state did she live in?**

_____ **TOTAL SCORE**

SCORING

High School Education		Less than High School Education
27-30	Normal	25-30
21-26	mild Neurocognitive disorder	20-24
1-20	dementia	1-19

CLINICIAN'S SIGNATURE DATE TIME

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. *Am J Geriatr Psych* 14:900-10, 2006.

These are free of charge

MINI-COG™

Instructions

ADMINISTRATION	SPECIAL INSTRUCTIONS
1. Get patient's attention and ask him or her to remember three unrelated words. Ask patient to repeat the words to ensure the learning was correct.	• Allow patient three tries, then go to next item. • The following word lists have been validated in a clinical study:[1-3] **Version 1**: • Banana • Sunrise • Chair **Version 2**: • Daughter • Heaven • Mountain **Version 3**: • Village • Kitchen • Baby **Version 4**: • River • Nation • Finger **Version 5**: • Captain • Garden • Picture **Version 6**: • Leader • Season • Table
2. Ask patient to draw the face of a clock. After numbers are on the face, ask patient to draw hands to read 10 minutes after 11:00 (or 20 minutes after 8:00).	• Either a blank piece of paper or a preprinted circle (other side) may be used. • A correct response is all numbers placed in approximately the correct positions AND the hands pointing to the 11 and 2 (or the 4 and 8). • These two specific times are more sensitive than others. • A clock should not be visible to the patient during this task. • Refusal to draw a clock is scored abnormal. • Move to next step if clock not complete within three minutes.
3. Ask the patient to recall the three words from Step 1.	Ask the patient to recall the three words you stated in Step 1.

Scoring

3 recalled words	Negative for cognitive impairment
1-2 recalled words + normal CDT	Negative for cognitive impairment
1-2 recalled words + abnormal CDT	Positive for cognitive impairment
0 recalled words	Positive for cognitive impairment

References

1. Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive "vital signs" measure for dementia screening in multi-lingual elderly. Int J Geriatr Psychiatry. 2000;15(11):1021-1027.
2. Borson S, Scanlan JM, Chen P, Ganguli M. The Mini-Cog as a screen for dementia: validation in a population-based sample. J Am Geriatr Soc. 2003;51(10):1451-1454.
3. McCarten JR, Anderson P Kuskowski MA et al. Finding dementia in primary care: the results of a clinical demonstration project. J Am Geritr Soc. 2012;60(2):210-217.

Mini-Cog

(Borson et al, 2000; 2003)

- Three-item recall + Clock Drawing Test
- Quick
- Minimally dependent on education

Review of brief cognitive tests for patients with suspected dementia (2014) doi: 10.1017/S1041610214000416

Frailty can be assessed phenotypically or by accumulation of deficits

- Fried Phenotype
  - https://doi.org/10.1093/gerona/56.3.M146
- Frailty Trait Scale – short (FTS_5)
  - https://doi.org/10.1016/j.jamda.2019.12.008
- Clinical Frailty Scale - Performance status
  - https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html
- FRAIL Scale – 5 item
  - https://link.springer.com/content/pdf/10.1007/s12603-012-0084-2.pdf
- Rockwood Frailty Index
  - https://doi.org/10.1186/1471-2318-8-24
- Gérontopôle Frailty Screening Tool
  - https://doi.org/10.1007/s12603-013-0363-6

Falutz; Current HIV/AIDS Reportshttps://link.springer.com/article/10.1007/s11904-020-00494-2

Assessing Mental Health

Depression scales vary in length

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Simplest Screen: Are you depressed?

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____

Instructions: Choose the best answer for how you felt over the past week.

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / NO	
2.	Have you dropped many of your activities and interests?	YES / NO	
3.	Do you feel that your life is empty?	YES / NO	
4.	Do you often get bored?	YES / NO	
5.	Are you in good spirits most of the time?	YES / NO	
6.	Are you afraid that something bad is going to happen to you?	YES / NO	
7.	Do you feel happy most of the time?	YES / NO	
8.	Do you often feel helpless?	YES / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES / NO	
10.	Do you feel you have more problems with memory than most?	YES / NO	
11.	Do you think it is wonderful to be alive?	YES / NO	
12.	Do you feel pretty worthless the way you are now?	YES / NO	
13.	Do you feel full of energy?	YES / NO	
14.	Do you feel that your situation is hopeless?	YES / NO	
15.	Do you think that most people are better off than you are?	YES / NO	
		TOTAL	

Scoring:

Assign one point for each of these answers:

1. NO	4. YES	7. NO	10. YES	13. NO
2. YES	5. NO	8. YES	11. NO	14. YES
3. YES	6. YES	9. YES	12. YES	15. YES

A score of 0 to 5 is normal. A score above 5 suggests depression.

Source:

- Yesavage J.A., Brink T.L., Rose T.L. et al. Development and validation of a geriatric depression screening scale: a preliminary report. J. Psychiatr. Res. 1983; 17:37-49.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Mental Health: GAD-7 is the most common anxiety screen

- 7-item
- Administration time 2-5 min

Spitzer RL et al Arch Intern Med. 2006;166:1092-1097.

Most efficient: PHQ-4 measures depression and anxiety

Total scores range from 0-12:

None	0-2
Mild	3-5
Moderate	6-8
Severe	9-12

On each subscale, a score of **3 or greater** is considered positive for screening purposes

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "□ " to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Anxiety subscale: sum of items 1 & 2 (range, 0-6) (>=3 sens 95.2%)
Depression subscale: sum of items 3 & 4 (range, 0-6) (>=3 sens 93.4%)

Kroenke K, Spitzer RL, Williams JBW, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4 Psychosomatics 2009;50:613-621.

Assessment Tools: Conclusions

- Formal assessment is more accurate and sensitive than clinical judgment
- Select assessment tools based on characteristics, time/ease of administration, EHR availability
- Identify action steps for positive screens in advance (planning!)
- Check the WHO ICOPE Guidance for ideas
  - https://www.who.int/ageing/publications/icope-handbook/en/

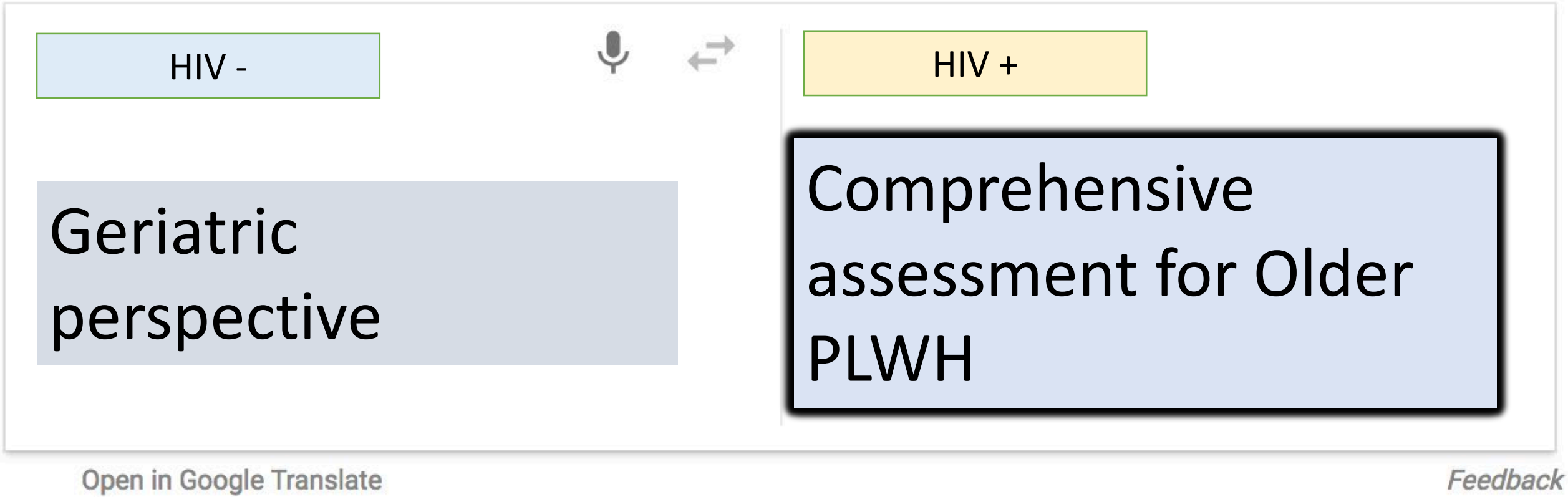
Integrating Models of Geriatric Care

Should we really be talking about clinical programs for HIV/Aging now? YES!

https://reflectionsipc.files.wordpress.com/2014/07/silver-lining.jpg

1. Practices must reconfigure after having shut down
2. Funders and agencies are more aware of the consequences of social isolation and loneliness
3. TELEHEALTH

We don’t yet know how to adapt geriatrics to HIV care



We don’t yet know how to adapt geriatrics to HIV care

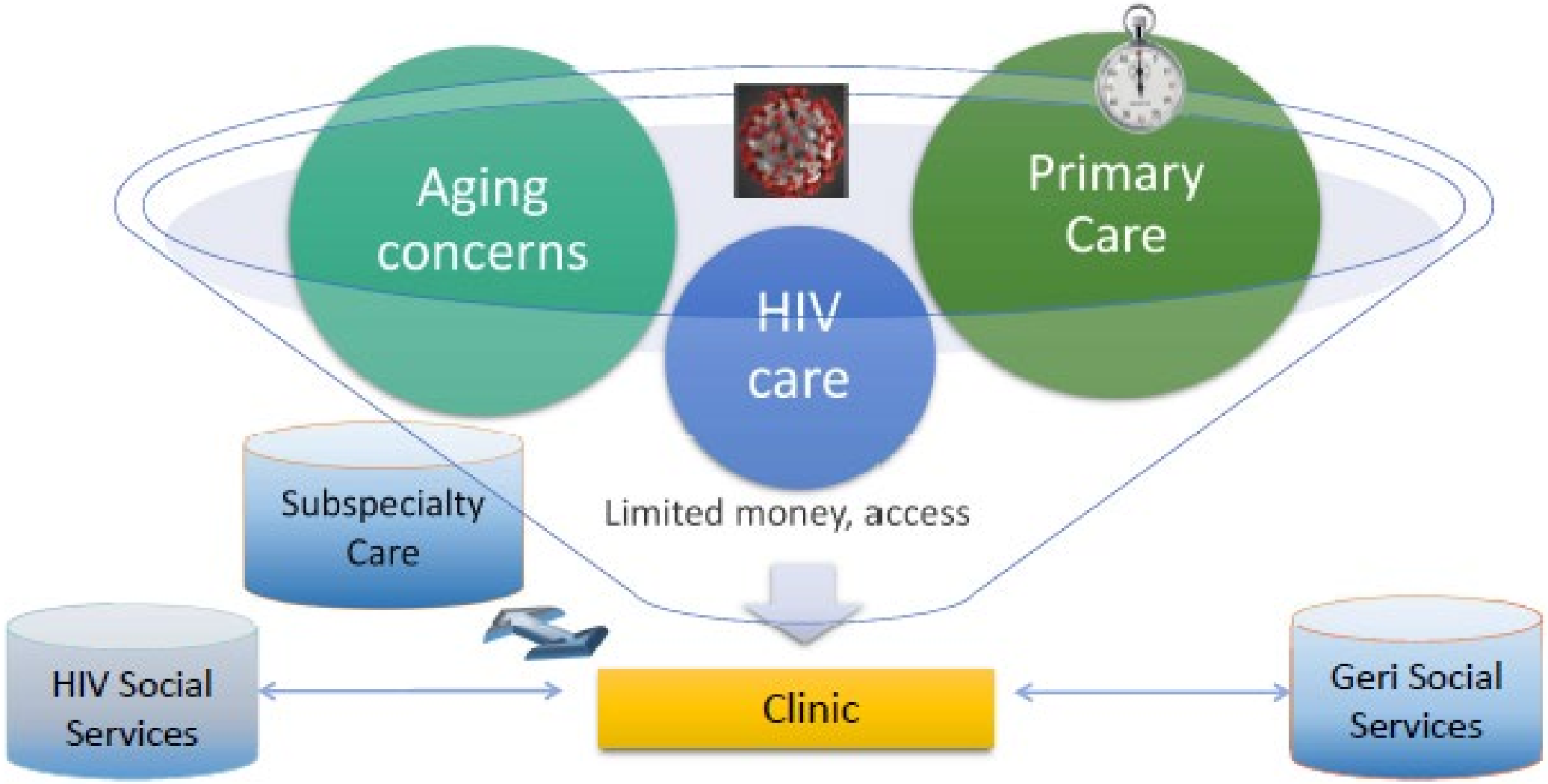
Observations

Comprehensive assessment of Older PLWH

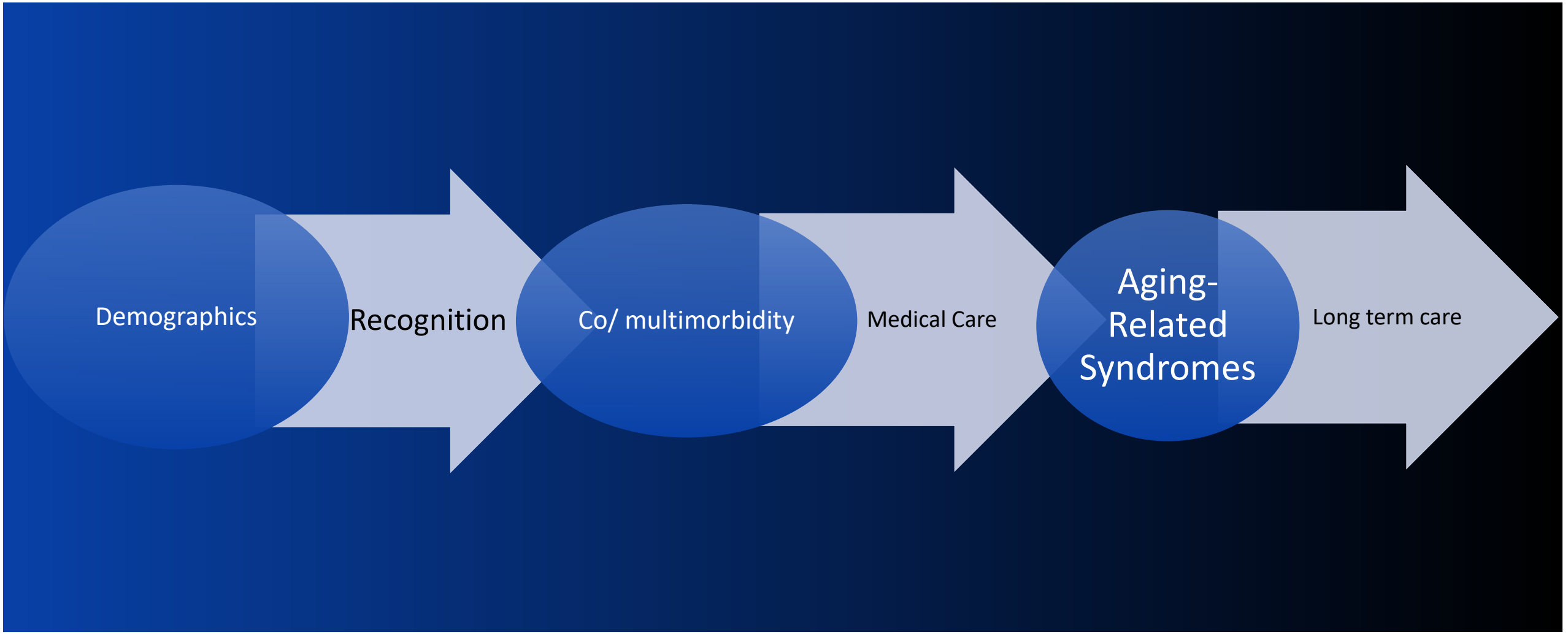
Action

Feasible, useful recommendations

We don’t know how the components of care should be combined



The field of HIV/Aging is evolving



We must also begin to plan for long term care needs

Older PLWH have varying programmatic needs

- Consumers use ASO and CBOs
- They are often dissatisfied
  - Different groups have different needs
  - Everyone wants opportunities to socialize
- Older PLWH want to give back

Burchett et al, Using Focus Group Feedback to Identify Patient-Centered Initiatives for Older Persons with HIV. *Clinical Gerontologist*, in press

Most common Geri-HIV program is consultative clinic

Location	Clinic/name	Resource	Venue	Comment
Baltimore	**STRONG** program, U MD	Schmalzle,	HIV clnic	50+, opt in; gift card. cognitive, mental health, physical, and social assessments; comorbidity and med review; referrals based on results
Boston (US)	MGH/**Aging Positively**	Fitch	Biweekly in ID clinic	Providers may refer anyone over 50 NP sees patients; develops plan with rest of team
Brighton (UK)	Brighton and Sussex U Hosp **Silver Clinic**	Vera	Monthly clinic sessions	Referral criteria: >50, difficulty coping at home, multimorbidity, polypharmacy; HIV MD, geriatrician, HIV Clin NS, Pharm
Chicago	CHAI program (Cook Cty Hosp)	Adeyemi		
Denver (US)	University of Colorado	Erlandson	Outside consultation	Geriatrician, pharmacist see complicated patients 1-3 times – refer back to 1^{o} care
London (UK)	Chelsea/ Westminster	Waters	Separate multidisciplinary clinic	Referral criterion: age Consultant, HIV NP, trainee; pharm and dietician support
Montreal (CA)	McGill	Falutz	In HIV Clinic	Geriatrician sees referrals as needed; planning pharm, CGA for >60
New York (US)	CSS at WCM/NYPH	Siegler	Geriatrician weekly visit w/in HIV clinic	No fixed referral criteria. Longitudinal follow up. Has sponsored arts, support groups, inservices – adding on telehealth
Salem, VA (US)	**SAVI**	Oursler	VA clinic	Assess multimorb, sarcopenia, frailty, cognition; Staff: Pharm, neuroψ, RD, endo
San Francisco (US)	Ward 86/ **Golden Compass**	Greene	Geriatric HIV clinic: pharm, screen, geri	Referral >70, falls; “navigation”: heart/ mind; strength/bones; screening/link to dental, vision, etc; SW, CBSS, support groups

Some developing programs are starting with screening; some grow from cohorts

J Int AIDS Soc. 2018 Oct;21(10):e25188. doi: 10.1002/jia2.25188

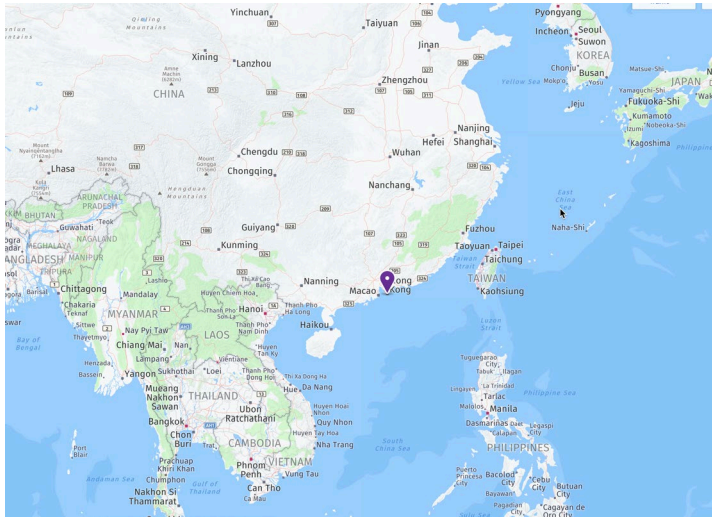
http://myantarlife.blogspot.com/search/label/sprouting%20seed%20resources

Location	Director	Program	Focus
Baltimore	Jones	Bartlett Clinic, Johns Hopkins	MCR AWV; form completed during intake and reviewed with provider; also promoting advance directive completion
Barcelona	Negredo	Germans Trias I Pujol University Hospital	Comprehensive geriatric assessment of all patients 60+
Bronx	Sharma	Center for Positive Living, Montefiore Hosp	Plan to test screening program
Cleveland	Kalayjian Van Epps	Metrohealth VA Hospital	VA: screen for cog impairment, frailty Metrohealth: screen for depression
Durham, NC	McKellar	Duke University	(cohort) to add physical function assessment
Kampala, Uganda	Castelnuovo	Mulago Hospital	Building simultaneous cohort/geri assessment program
Mexico City	Ávila-Funes	Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán	(cohort) MD to receive training abroad; will start specialized service in 2020
Philadelphia	Krain	U. of Pennsylvania	Planning embedded dual trained geri/ID
Porto Allegre, BR	Sprinz	Universidade Federal do Rio Grande do Sul	Age specific screening/exams; referral to subspecialists; pharmacy consultation
San Diego	Karris	Univ. California SD	Screen for IADL impairment; refer to geriatrician (diff campus) Putting together team for home visits

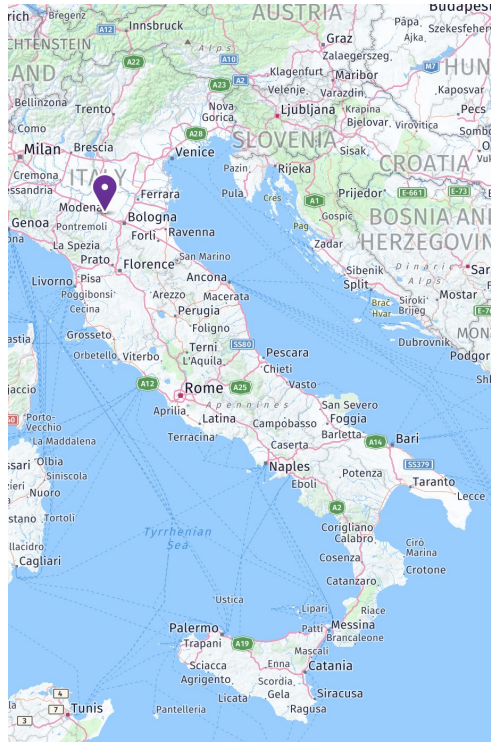
Metabolic programs have evolved by expanding from comorbidity to geriatric syndromes

Hoy:
Alfred Hospital/Monash University, Melbourne

Lui:
Chinese University of Hong Kong



Guaraldi:
University of Modena and Reggio Emilia, Modena, Italy



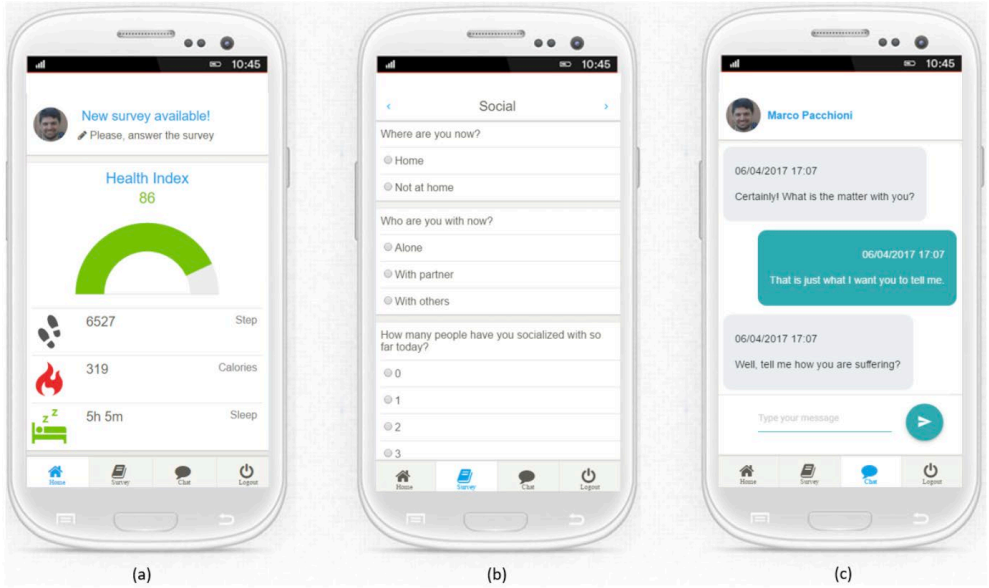
J Int AIDS Soc. 2018 Oct;21(10):e25188. doi: 10.1002/jia2.25188

Some are reaching outside the office to engage older PLWH

Statewide Coalitions

Maryland Coalition
On HIV and Aging

Villages Model (Karris)



Orsini et al. 2018. https://zapdf.com/my-smart-age-with-hiv-an-innovative-mobile-and-iomt-framewor.html

Mobile technology

https://www.mysmartage.org/

These programs expand beyond comorbidity and screening towards social interventions

While structure and goals may differ, programs share common barriers

Tenuous finances

Lack of expertise

Inexact targeting

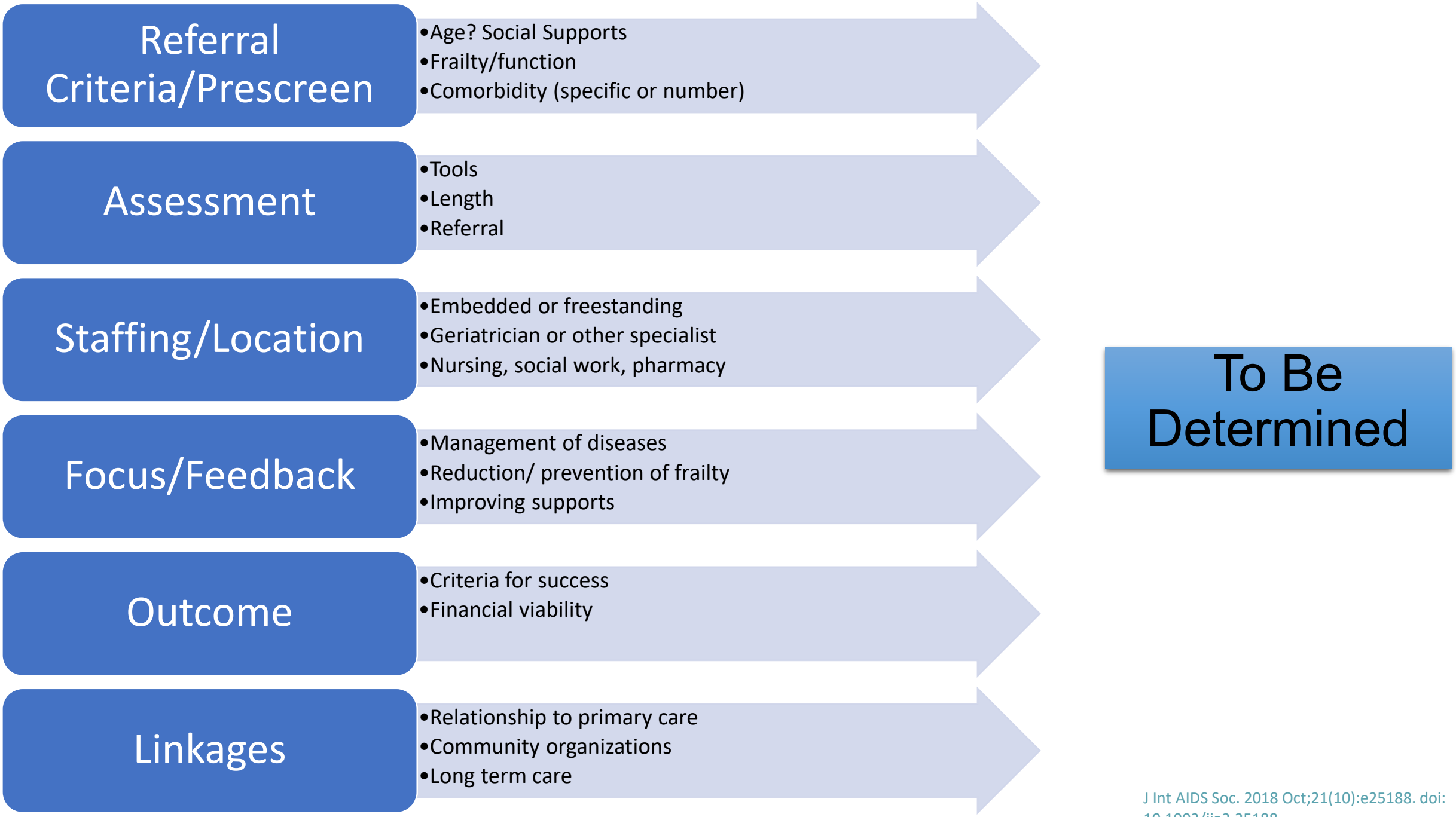
Insufficient buy-in

Unclear outcomes

Inadequate social resources

theotheri.wordpress.com

https://goo.gl/images/iwZSD8



J Int AIDS Soc. 2018 Oct;21(10):e25188. doi: 10.1002/jia2.25188

Community practices must have access to training and resources and be funded to make necessary changes

- Upgrading provider skills
- Finding and incorporating geriatric expertise
- Blending access to geriatric and HIV community-based services and supports
- Creating linkages with community agencies
- Reaching patients who are isolated

Siegler and Brennan-Ing http://dx.doi.org/10.1016/j.jana.2017.05.006

How to begin

- Understand the demographics of your patient population: How many are over 50? Over 60?
- Determine what existing services and functions are available
  - Programs, personnel, funding sources, EMR
- Present the topic of aging to your community advisory board to determine their priorities
- Link with geriatrics, if possible
- Decide your assessment strategy
  - Global or specific?
  - Who will do the screening?
  - What will the referral protocol be?

What consumers can ask

- When will the office open again and what changes will be in place to help older PLWH?
- How can telehealth be used to my advantage?
- How will you meet psychosocial needs?
- How will you foster physical fitness and nutrition?
- How will the office do an aging assessment?
- How will you translate assessment into action?
- How will you coordinate care?
- What community-based services are right for me?

HIV and Aging toolkit - http://www.necaaetc.org/node/149

https://aahivm-education.org/hiv-age

https://www.cdc.gov/hiv/group/age/olderamericans/index.html

HIV and Aging Resources

Integrating models of geriatric care: Conclusions

- We are still learning how to adapt geriatric care for older PLWH
- One size doesn't fit all
  - Older PLWH have diverse program needs
  - Each program starts with a unique combination of available services and talents
- Programs must address a range of needs (multimorbidity, geriatric syndromes, long-term care)
- Integrating geriatric models into HIV care requires resources

Contacts

Eugenia L. Siegler, MD
Weill Cornell Medicine
els2006@med.cornell.edu

Mark Brennan-Ing, PhD
Hunter College
mark.ing@hunter.cuny.edu

HIV & Aging

An In-Depth Perspective

Esther Ross Hines, MA, BSW, AAS

Disclosures

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Disclosure will be made when a product is discussed for an unapproved use. This continuing education activity is managed and accredited by AffinityCE in cooperation with HRSA and LRG. AffinityCE, HRSA, and LRG Staff, as well as planners and reviewers, have no relevant financial or non-financial interests to disclose. Conflict of interest, when present, was resolved through peer review of content by a non-conflicting reviewer. Commercial support was not received for this activity.

Learning Objectives

By the end of this session, participants will be able to:

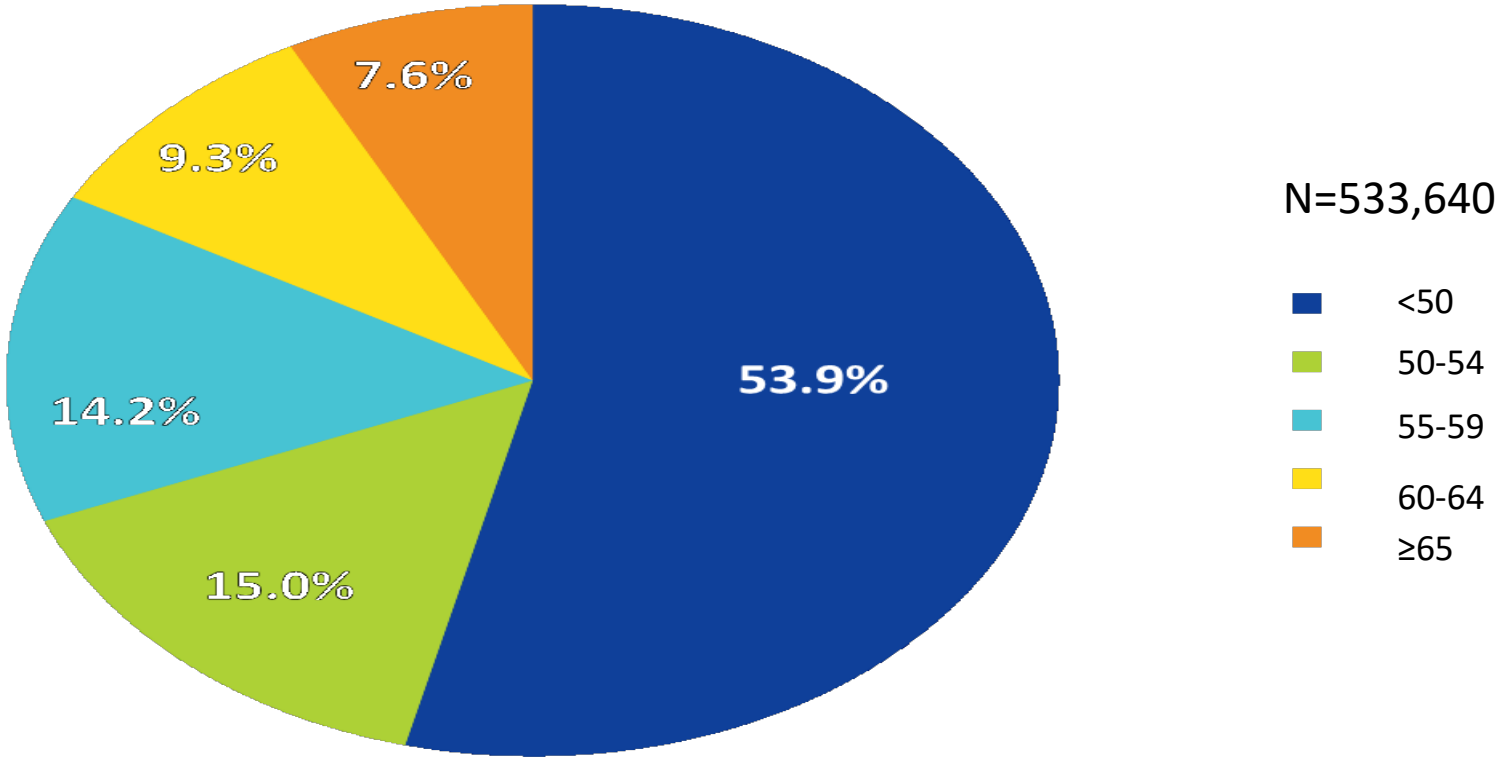
- Explain models to integrate geriatric services into the RWHAP from a person aging with HIV and a provider

- Dx 1993; pill burden (21); lipodystrophy; stigma
- Clean Date 8/8/97
- Support System-SW
- Advocacy-1999
- Stigma
- Mental Illness
- Abuse/Violence
- Sexual Relationships
- Family Relationships
- Coping
- Stress
- Social Isolation

New Approaches needed to address the growing HIV & Aging Population

Those who experienced the early days of the HIV/AIDS epidemic remember the generation we lost, and the enduring impact that has had on our community. Since then, we've made tremendous progress. This is the first time in American history when nearly 50% of people living with HIV are over the age of 50. It's now expected that by 2030, 70% of people living with HIV will be over the age of 50.

Clients Served by the Ryan White HIV/AIDS Program, by Age Group, 2018—United States and 3 Territories



***Guam. Puerto Rico, and the U.S. Virgin Islands. HRSA Ryan white & Global HIV/AIDS Program**

Diverse Elders Coalition Facts and Factors:

Older patients (>50 years of age) should be initiated on treatment as soon as possible after diagnosis because this population[1]:

Experiences accelerated CD4 loss

Has decreased immune recovery

Is at increased risk of serious non-AIDS illnesses

Age Related Concerns

As people age, they typically have more comorbidities, take more medications, and are more vulnerable to side effects—complicating management of their disease.[1]

Age-associated non-communicable comorbidities (including hypertension, myocardial infarction, and peripheral artery disease) were numerically more prevalent among people living with HIV than HIV-uninfected controls[5]

Aging people with HIV often develop inflammation and cardiovascular, kidney, liver, bone, and neurologic disease[6-8]

Potential side effects and drug-drug interactions for aging-associated comorbidities can further complicate ART management[1]

Social Work Perspective HIV & Aging

Resiliency Theory

Seen as successful adaptation to negative life events, trauma, stress, and other forms of risk and as having the capacity to cope with significant change (Green & Conrad, 2002). Protective factors, such as family and community supports, act as buffers against negative outcomes and help promote adaptation (Wagnild, 2003)

Strengths Perspective

Recognizes that there is reciprocity between the older person and their social environment even in the most difficult circumstances. Fast and Chapin (1997) suggests that this places self-determination of older adults as a central value, magnifying the worth, dignity, and uniqueness of older adults, in contrast to the medicalization of aging, which highlights disabilities and seeks to protect them from injury and debilitation. Such perspectives are very relevant to older people living with HIV/AIDS.

LAMPS:

Leaders, Advocating, Mentoring, Personal growth and Support

Peer Leaders	Educate WOCLWH 50+ using BLOC (Building Leaders of Color) to mentor other WLWH to increase positive health outcomes and engagement in HIV planning, delivery and evaluations (GIPA/MIPA).
Community Leaders	Educate WOCLWH using GLOW (Growing Opportunities for Women) to provide sexual health education and prevention (STD/HIV) to women living in communities impacted by HIV/STD to decrease Stigma and address treatment concerns, fears and treatment literacy.
EHE	Partnership in Ending the HIV epidemic in our communities in the south.

LAMPS MOVEMENT

RESILIENCY

LAMPS Graduate

- Intentional involvement
- Model Positive Behaviors
- Partner with Health Care Team
- Leaders in their community

LAMPS

Creative ways to address external and internal stigma

Website Development (https://Lifeskillsupport.org)

Community Engagement

Fundraising

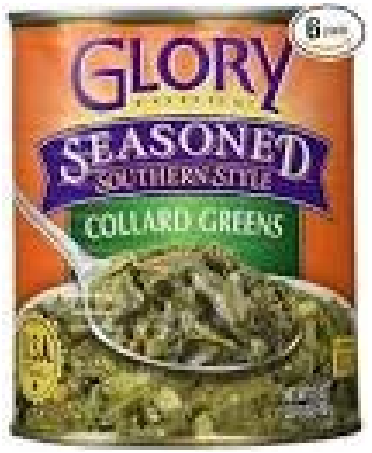
Support Group

Red Carpet-World AIDS Day

Received grant award from Gilead COMPASS Initiative & Southern AIDS Coalition - $40,000

AGING GRACEFULLY

59 YEARS YOUNG LIKE
SEASONED COLLARD GREEN’S



Contact Information & Resources

Esther Ross Hines, MA, BSW, AAS
BLOC & GLOW Trainer
Circle of Friends Task Force, Executive Director
252-286-3613
Estherr1961@gmail.com
Https://lifeskillsupport.org
circleoffriendstf@gmail.com

NMAC: www.nmac.org/programs/thecenter