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aging with HIV
Ryan White HIV/AIDS Program Initiative

SPNS Aging with HIV

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2024 National Ryan White Conference on HIV Care and Treatment

August 20-23, 2024

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HRSA Ryan White HIV/AIDS Program
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"Improving the 6M's at PACT" (IMPACT) Mind, Mobility, Matters Most, Multi-Complexity, Medications, Modifiable

Intervention Reach:

139 completed surveys and received screening

Purpose:

Enhance care for those aging with HIV by improving the skill set of providers, restructuring electronic medical record (EMR) visit template, and using workflow adaptions to refer patients with appropriate healthcare and community resources.

Rationale:

Those living with HIV over age 65 were found to have a hazard of mortality 3.6 times that of those without HIV. As they age, even with excellent HIV control, this population is more likely to have multiple chronic conditions than those without HIV. As of December 2023, 64% of our patients are in the 50+ age demographic group, with an average age of 53 years and a median age of 55 years. Given the medical complexity of those aging with HIV and the early onset of geriatric conditions in this population, screening.

Erlandson KM, Karris MY. HIV and Aging: Reconsidering the Approach to Management of Comorbidities. Infect Dis Clin North Am. 2019 Sep;33(3):769-786. doi: 10.1016/j.idc.2019.04.005. PMID: 31395144; PMCID: PMC6690376.

iCHANGE: Integrative Care for Healthy Aging & Navigation of Geriatric Effects

Intervention Reach:

50 enrolled participants

Purpose:

iCHANGE (Integrative Care for Healthy Aging and Navigation of Geriatric Effects) is an integrated care model that aims to manage comorbidities and geriatric conditions of older PLWH; in addition to Healthy Aging Programs' current efforts to assess and coordinate supportive services for psychosocial and behavioral health needs. Expanding upon its existing model, iCHANGE includes strategies for care coordination and management of geriatric conditions related to cognitive and functional status, mobility and gait, and increased frailty.

Rationale:

Older PLWH are at greater risk for conditions such as social isolation and depression, non-AIDS-defining cancers, cognitive impairment, cardiovascular disease, and frailty. By 2030, more than 80% of PLWH will have at least one age-related non-communicable disease. Given the unique challenges faced by older PLWH, there is a critical need for specialized holistic health programs designed to support and navigate the complexities of these issues and foster innovative solutions.

Centers for Disease Control and Prevention. (n.d.). HIV Among People Aged 50 and Older. Centers for Disease Control and Prevention. Retrieved March 1, 2023, from https://www.cdc.gov/hiv/group/age/olderamericans/index.html
Cahill, S., & Valadéz, R. (2013). Growing older with HIV/AIDS: New public health challenges. American Journal of Public Health, 103(3), e7–e15. https://doi.org/10.2105/ajph.2012.301161

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HIV-Endurance (HIVE) Clinic: Where the Geriatric Care Comes to You Your New One-Stop Shop for your Healthcare Needs!

Intervention Reach:

15 patients

Purpose:

Enhance geriatric-centered care to persons with HIV aged 50+ within the infectious disease clinic using an integrated clinic model.

Rationale:

The population with HIV at BMC is growing older and will continue to age with time. The previous clinical referral pathway from ID to Geriatrics had poor engagement from PWH due to patients not wanting to leave their ID care team.

Premier Platinum Program

Intervention Reach:

72 enrolled participants

Purpose:

The purpose of this intervention is to introduce a comprehensive and multifaceted care model that will help identify the common healthcare and social needs of people who are aging with HIV through specific screenings and assessments. The focus is on improving health outcomes by adopting a multi-disciplinary approach that balances quality of life with medical necessity by establishing a specialized geriatric team that can manage the unique needs of people aging with HIV.

Rationale:

People aging with HIV have highlighted the need for integrated care models, including multi-disciplinary teams of geriatricians, HIV specialists, pharmacists, and allied health practitioners (such as clinical case managers) offering holistic patient-centered care from the perspectives of people with lived experience in the affected communities.

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Embedded HIV Dementia Champion Program

Intervention Reach:

4 enrolled providers

Purpose:

The goal of this intervention is to expand dementia assessment and management capacity within HIV specialty care clinics through the training of multi-disciplinary HIV clinic staff as “dementia champions,” an emerging strategy to meet the needs of older adults with cognitive impairment throughout their contact with the health care system.

Rationale:

Approximately 25% of adults aged 50 and older with HIV experience cognitive impairment. Older adults with HIV are at higher risk for Alzheimer's and vascular dementia due to factors like cardiovascular disease. depression, and social isolation. To provide appropriate support. NHS Scotland implemented a program training health care staff in dementia management, which was later replicated at the University of Chicago to enhance dementia assessment and management in HIV Specialty Clinics through multidisciplinary staff trained as HIV Dementia Champions.

1.Davis AJ, Greene M, Siegler E, et al. Strengths and Challenges of Various Models of Geriatric Consultation for Older Adults Living With Human Immunodeficiency Virus. Clinical Infectious Diseases. 2021;doi:10.1093/cid/ciab682
2. 2021 Alzheimer's disease facts and figures. Alzheimer's & Dementia. 2021;17(3):327-406. doi:https://doi.org/10.1002/alz.12328

Targeting Frailty in Persons Aging with HIV - Working together to address aging challenges and support and improve quality of life!

Intervention Reach:

16 enrolled participants

Purpose:

Increase provider and client recognition of frailty and offer individualized interventions to mitigate frailty and pre-frailty in people with HIV age 50 and older, followed by the Infectious Disease Specialty Clinic.

Rationale:

The rationale behind this was that frailty predicts worse health outcomes. Frailty occurs more commonly in people with HIV and may occur at younger ages when compared to the general population. We believe rapid identification of older persons with HIV most likely to benefit from frailty-focused management and integration within HIV care clinics are needed.

Morse, C.G. and J.A. Kovacs, *Metabolic and skeletal complications of HIV infection: the price of success.* JAMA, 2006. **296**(7): p. 844-54.
Yang, H.Y., M.R. Beymer, and S.C. Suen, *Chronic Disease Onset Among People Living with HIV and AIDS in a Large Private Insurance Claims Dataset.* Sci Rep, 2019. **9**(1): p. 18514.
Fried, L.P., et al., *Frailty in older adults: evidence for a phenotype.* J Gerontol A Biol Sci Med Sci, 2001. **56**(3): p. M146-56.

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The Empowering & Educating People living with HIV (E&E) intervention

Intervention Reach:

144 participants attended

Purpose:

The goal of the E&E Intervention is to improve health outcomes and quality of life for older adults with HIV by addressing co-morbidities, including diabetes, hypertension, hypercholesterolemia, and obesity, through lifestyle and dietary changes, addressing psychosocial health, behavioral health, loneliness, and cognition through screening, and the provision of Social Support Groups and individual Behavioral Health Services. Providing Dental and Nutritional Services based on the patient's baseline needs assessment.

Rationale:

The rationale for this intervention was to provide a patient-centered medical home so that this aging population can be screened for various comorbidities, Behavioral Health needs, dental needs, and can receive all the necessary services under one roof. To reach this goal of providing a 'one-stop shop' model of care, EUCHC implemented service integration and care coordination under this project.

4F Intervention for Collaborative Care to Assess Risk and Eliminate Polypharmacy, Falls, and Fragility Fractures for Patients Aging with HIV

Intervention Reach:

125 patients

Purpose:

The purpose of the 4F intervention is to enhance the expertise of the HIV primary care providers and clinics to assess and improve health outcomes of clients aging with HIV with a focus on polypharmacy, falls, fragility, and fractures (the 4F).

Rationale:

The 4F Intervention for Collaborative Care Model trains interested or self-selected HIV providers in geriatric assessment focusing on polypharmacy, falls, and fragility fracture, who will be the clinic "HIV champion providers." Necessary tools, resources, and referral guidelines are developed to build knowledge and improve the practice of HIV providers caring for people with HIV. The 4F Intervention is implemented in the context of a collaborative care, patient-centered, interdisciplinary team approach.

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Incorporating a Community Health Worker (CHW) into a Comprehensive Program of Integrated Care for Older Adults with HIV

Intervention Reach:

444 patients seen, **366** follow-up appointments

Purpose and Rationale:

CHWs: Trusted community members, working as a bridge between healthcare systems and community-dwelling resources to support system navigation. They enhance the work of professional teams by integrating patient needs while redistributing efforts to optimize each team member's work.

In our Program, the CHW:
Supports older adults living with HIV in care engagement;
Supports the team by completing screening components;
Normalizes geriatrics-oriented services within HIV clinics;
Provides referral and coordination support for clinical and community-based services.

CHW Added to Geriatric-HIV Interdisciplinary Team Creates More **Efficient, Patient-Centered Care** for Older Adults with HIV**!**

Intensive Individualized Care Coordination to Enhance Health and Quality of Life for HIV-Positive Older Adults in San Diego, California (I^2C^2)

Intervention Reach:

49 individuals enrolled

Purpose:

Improve assessment and management of co- and multi-morbidities to improve health status; reduce social isolation using community partnerships and resources; and improve the infrastructure of services for a population of focus on people aging with HIV with co- or multi-morbidities utilizing intensive care coordination.

Rationale:

Improving the assessment process for the population of focus helps to better address barriers to care for co- and multi-morbidities. Additionally, improved assessment also helps to identify and address unmet needs. Lastly, providing person-centered peer support services and community-based activities addresses social isolation.