Case Study

Colorado Health Network's iCHANGE Project | Denver, CO

aging with HIV
Ryan White HIV/AIDS Program Initiative

> ***"iCHANGE allows me to walk alongside a client in a really intentional way, co-creating milestones and learning their interests and motivations for their health" said Haley Sanner, Colorado Health Network's Healthy Aging Programs Manager. "I get to know my clients at a deeper level. It's empowering to watch them take steps toward their goals even before those goals are formalized."***

BACKGROUND

Colorado Health Network (CHN) serves 5,000 clients across six regional offices statewide. More than half of their clients are aged 50 and over, necessitating novel and coordinated approaches to HIV and geriatric care delivery.[1,2] CHN developed the PATH2Wellness (People Aging & Thriving with HIV) program to increase physical activity, interpersonal connection, and nutrition support among aging clients with HIV. However, CHN providers and stakeholders noted their clients also had unaddressed geriatric conditions. A comprehensive geriatric screener for clients with HIV aged 50 and older found that half of participating CHN clients exhibited at least mild cognitive decline along with ongoing unmet behavioral and psychosocial needs. In response, CHN designed the Integrative Care for Healthy Aging and Navigation of Geriatric Effects, or iCHANGE, intervention with support from the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS) Aging with HIV Initiative.

INTERVENTION DEVELOPMENT

iCHANGE is grounded in the Public Health Prevention Model.[3] It was informed with input from the CHN iCHANGE team which encompasses cross-departmental staff, patient liaisons, and academic advisors. The team incorporated the perspectives of intervention participants, older adults with HIV, by facilitating focus groups, interviews and surveys to inform design, implementation, and evaluation leading to better systems integration and participant empowerment.

INTERVENTION SERVICES

Clinicians and staff engaged in extensive training on geriatric screenings and aging-related services coordination, case management, and peer support prior to implementing the intervention. (See also "Training Resources.")

- An **aging services coordinator** identified clients with HIV aged 50 and older, informed them about the intervention, and completed enrollments.
- Enrolled clients then underwent a geriatric screening by an iCHANGE team member, a non-clinical professional with specialized training in geriatric care coordination. The two-hour screening measured client function across the 5Ms: *mind* (cognitive and mental health); *mobility* (vision, hearing and balance); *medications* (potential HIV medication adherence and potential polypharmacy concerns); *multicomplexity* (comorbidities); and *matters most* (client goals and care preferences).
- Clients were connected to the **geriatric medical case manager**, a RWHAP-funded position staffed with a caseload of clients aged 50 years and older who received specialized training on HIV and aging as well as iCHANGE screening procedures from CHN iCHANGE team.
- Clients also received support from a **patient liaison**—a client with HIV aged 50 and older—who supported their engagement in treatment and care.

> ***"In our intervention, providers review with clients their geriatric screening results," shared Erin Burk-Leaver, MPH, CHN Director of Community Engagement. "We work with them to create an effective and holistic treatment plan that aligns with their health goals."***

Next, providers meet with clients to review their screening outcomes to develop a client-centered care plan that identifies key goals, sets realistic milestones, and connects clients to aging-related services. Milestones are individualized goals, tailored to each client, centering on what "matters most" as they age, such as creating an exercise plan, making their home more accessible, engaging in new social engagements, or completing advance care planning.

Clients' care reassessment timeline is triaged based on a cognition score (MoCA). Screening reassessment occurs every three (higher cognitive impairment), six (mild cognitive impairment), or twelve (no cognitive impairment) months.

Throughout this process, providers revisit these milestones with the client to ensure they still align with the client's values, priorities, and overall well-being as they age, updating them as necessary.

OUTCOMES

CHN found that clients who participated in the PATH2Wellness program were likely to be interested in participating in the iCHANGE intervention, and vice versa, due to their unique yet complementary benefits. Participants reported a statistically significant 12% increase in overall health. Factors that encouraged clients to remain engaged in the intervention included consistent provider-client communication and rapport, client engagement in other programmatic opportunities, client empowerment and motivation to complete milestones, and peer support with patient liaison and other program peers. Most reported following through on their "matters most" health goals, such as reading more books, participating in a swimming class, and completing an advanced directive, among others.

FACILITATORS AND BARRIERS

iCHANGE had several significant facilitators, including a firm theoretical grounding, intensive training and buy-in from staff, and support from internal and external partners. The primary challenge lay with the geriatric screening itself; clients had to come in for the two-hour assessment, which proved challenging for those dealing with cognitive decline, limited access to transportation, and/or limited time. To help overcome this, the patient liaison provided additional social support to clients, while staff incorporated appointment reminders and follow-up information during regular appointments.

> ***"We were very intentional about the screeners and approaches we implemented in our intervention, knowing that sustainability is an essential aspect of the project and ensuring that our clients aging with HIV receive the best care," said Burk-Leaver.***

LESSONS LEARNED

CHN's success began with understanding client needs, beginning with client data reviews and community and staff forums to identify gaps in HIV treatment and care for clients with HIV aged 50 and older. Rather than start from scratch, they leveraged the framework of the PATH2Wellness program, expanding academic and community partnerships to create a streamlined geriatric assessment and coordinated care approach for clients. The geriatric assessment takes 50 to 60 minutes and may seem time-consuming for clients and staff; however, it provides an in-depth snapshot of clients' cognitive, physical, and psychosocial needs. Clients can work with their providers to use this information in making informed decisions that support optimal health and quality of life as they age with HIV.

iCHANGE demonstrated that incorporation of key programmatic and organizational changes, such as a geriatric assessment, an interactive provider-client treatment and care planning session, and coordination of HIV, geriatric, and wraparound services, can dramatically improve client care engagement, satisfaction with services, and overall health.

REFERENCES

[1] Colorado Department of Public Health & Environment. HIV in Colorado, HIV epidemiology annual report for cases diagnosed through December 2022. *HIV & AIDS in Colorado*. 2025 January.

[2] Colorado Health Network. *Healthy Aging & Wellness for Folx (50+) Living with HIV*. 2025. https://coloradohealthnetwork.org/healthy-aging/

[3] Ishizumi A, Kolis J, Abad N, Prybylski D, Brookmeyer KA, Voegeli C, Wardle C, Chiou H. Beyond misinformation: developing a public health prevention framework for managing information ecosystems. *The Lancet Public Health*. 2024 Jun 1;9(6):e397-406.