

# Family Health Centers of San Diego's Intensive Individualized Care Coordination (I<sup>2</sup>C<sup>2</sup>) to Enhance Health and Quality of Life for HIV-Positive Older Adults | San Diego, CA



*"We want to break down silos between geriatric and HIV care, ensuring older adults with HIV have access to the coordinated care they need."*

- Felipe Garcia-Bigley, MHA, Principal Investigator

## BACKGROUND

Family Health Centers of San Diego is the largest comprehensive HIV service provider in San Diego County, California, serving clients at 29 primary care clinics and 25 behavioral health facilities.

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, Family Health Centers of San Diego implemented a new intervention called the Intensive Individualized Care Coordination (I<sup>2</sup>C<sup>2</sup>) to Enhance Health and Quality of Life for HIV-Positive Older Adults to address the unique needs of people with HIV ages of 50 and older, many of whom live at or below the federal poverty level and experience unmet needs.

**Prior to I<sup>2</sup>C<sup>2</sup>,** Family Health Centers of San Diego's programs were either specialized in HIV or geriatric care, but not both.

Older clients with HIV who transitioned to older adult services reported receiving high-quality geriatric care but were referred to external specialists for their HIV and comorbid conditions, which they found overwhelming to navigate without support. I<sup>2</sup>C<sup>2</sup> was established to break down the silos between HIV and geriatric care provision.

*I<sup>2</sup>C<sup>2</sup> program director Felipe Garcia-Bigley explained, "Even clients who followed through with referrals experienced uncoordinated care. Our organization had expertise with older adults and HIV but not combined. Older clients with HIV, and particularly long-term survivors, often have limited support systems, resulting in social isolation."*

## INTERVENTION DEVELOPMENT

This process began with the creation of an interdisciplinary **Intensive Coordinated Care Team**, based on the differentiated service delivery model, to assess clients' clinical, behavioral, and psychosocial needs, including social isolation and disease self-management and provide peer support services and community-based activities. The **Intensive Coordinated Care Team** used assessments of other intensive care coordination models and inputs from Family Health Centers of San Diego organizational leaders and local external interested parties (see text box) to inform I<sup>2</sup>C<sup>2</sup>.

A **Registered Nurse Care Coordinator (RNCC)** led the I<sup>2</sup>C<sup>2</sup> team. They leveraged their professional experience and training to talk to and understand the needs of HIV and geriatric providers and managers. *"The RNCC steered the ship in regard to 'client engagement and support' with the providers and support team,"* explained Garcia-Bigley.



**External Interested Parties** providing clinical, behavioral, and wraparound supports included:

- Housing service providers
- HIV community social and educational support program
- LGBT community center's senior services
- Area university's center for healthy aging
- Community referral hotline

## INTERVENTION SERVICES

Initial training for case management and support staff focused on navigation and care coordination for co-morbid conditions separate from HIV. Additional training occurred in tandem with the intervention to support HIV and geriatric providers and staff around the needs of clients aging with HIV and the logistics of I<sup>2</sup>C<sup>2</sup> itself.

Following the training, the RNCC initiated **client recruitment**, identifying potential participants by reviewing electronic health records for clients who had HIV aged 50 and older, qualified for RWHAP services, had attended at least one HIV medical appointment in the last 12 months, and were diagnosed with at least one comorbidity (e.g., heart disease, diabetes, kidney disease, depression, or substance use disorder). Clients who met the requirements and agreed to enroll in the intervention engaged in a **special 1.5-hour screening** that encompassed the following:

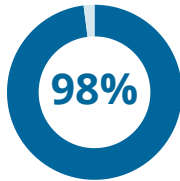
- **HIV and Medical Case Management** and **RNCC Assessment** (identifies clinical, behavioral, and wraparound services);
- **World Health Organization (WHO) Integrated Care for Older People (ICOPE) Screening**; and
- **Social Isolation Screening** assessing clients' social support access.
- Clients identified as socially isolated then completed an **Individual Socialization Action Plan**, designed to encourage the uptake of resources that increase social connectedness.

Through this special appointment, clients received a comprehensive health assessment and an individualized care plan with a tailored list of personalized referrals. The RNCC worked with the program manager, program coordinator, case managers, and patient liaison to implement clients' care plans, track and monitor referrals and follow-up visits, conduct medication reconciliations, and accompany clients to specialist appointments as needed. Clients also received additional social support, with the RNCC and patient liaisons conducting

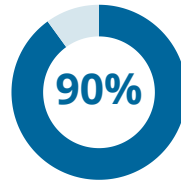
home visits and encouraging engagement in community activities led by the Family Health Centers of San Diego's Peer Board (similar to a community advisory board), which recommends and leads community and educational events geared to clients aging with HIV.

## OUTCOMES

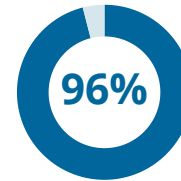
Thus far, the I<sup>2</sup>C<sup>2</sup> has increased HIV and geriatric staff competency and improved delivery for clients aging with HIV. Among the 49 clients enrolled in the intervention:



Completed the initial screening process.



Established an individualized care plan.

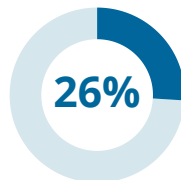


Attended medical appointments of all types during the established six-month period.

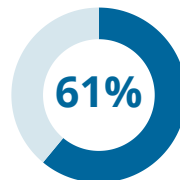
Of the 47% of participants experiencing social isolation:



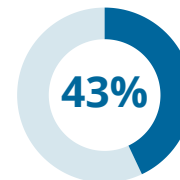
Participated in the Individual Socialization Action Planning.



Pursued social group activities held by external partners.



Joined an internal social group.



Accessed mental health services.

*"We had an older client from Washington State who moved to San Diego and was dealing with isolation and mental health issues," explains Darren 'Bo' Andras, Patient Liaison. "We were able to connect him with a psychiatrist, as well as help him with housing and overcome his isolation. We also referred him to the [Center], where he attends two meetings per week for men who are 50 or older with HIV." This client has experienced improved engagement in care, increased client satisfaction, and decreased social isolation.*

## FACILITATORS AND CHALLENGES

Family Health Centers of San Diego benefited from lessons learned during the implementation of its initial programs supporting clients aging with HIV, as well as input from partners who were prepared to support service referrals, and a multidisciplinary team coordinated by a diligent RNCC skilled in working with clinicians and support staff.



The I<sup>2</sup>C<sup>2</sup> intervention also prioritized both clinical (i.e., geriatric, HIV, comorbid conditions) and psychosocial needs. The RNCC, care coordinators, and patient liaisons provided tailored support for clients who faced challenges leaving their house to seek care in the clinic and/or receiving social support. Challenges arose during the implementation of intervention components addressing social isolation, such as social and educational events. These events often provided food and other amenities that cannot be supported by RWHAP funding. Family Health Centers of San Diego overcame this challenge by leveraging relationships with community partners and other programs, who shared access to resources with their clients, such as gift cards, yoga classes, and more. These partnerships, in turn, supported clients' individual socialization action plans.

***“One of I<sup>2</sup>C<sup>2</sup>’s first clients,” explains Garcia-Bigley, “had a new cancer diagnosis and a lot of barriers to care, including unstable housing and no transportation. Our team worked together to address her needs,” he says. “Even the security guard pitched in, ensuring she didn’t miss her ride to treatment. Today, she is cancer-free and engaged in HIV and geriatric services. Her experience, like many of our clients, reveals how complex our healthcare system can be—and that interdisciplinary support is integral to improving health outcomes.”***

## LESSONS LEARNED

Family Health Centers of San Diego personnel found that the intervention worked best when clinicians and staff invested the time needed to fully understand the logistics and screenings involved in delivering HIV and geriatric care for clients with HIV aged 50 and older. This included not only diagnostic assessments, but health care plan authorizations, referrals, and overall care coordination. Intervention managers also found that they could expand intervention activities, build rapport through community events, and supplement RWHAP funds through relationships with community partners, who provided access to resources and amenities not funded by RWHAP.

