Boston Medical Center

Boston, MA

The Initiative

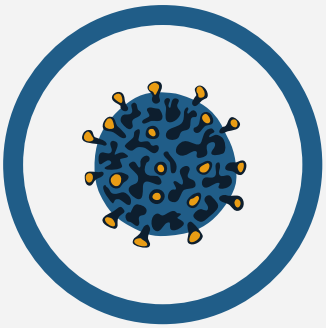
The Emerging Strategies to Improve Health Outcomes for People Aging with HIV (Aging with HIV) Initiative supports and evaluates 10 demonstration sites as they implement groundbreaking interventions that seek to improve whole-person care of people with HIV ages 50 and older served by the Ryan White HIV/AIDS Program (RWHAP).

The Program

Boston Medical Center created the *HIV-Endurance (HIVE) Clinic*, a referral-based integrated infectious disease-geriatrics clinic, to identify, refine, and assess strategies that comprehensively screen and manage comorbidities, geriatric conditions, behavioral health, and psychosocial needs of people living with HIV aged 50 years and older by:

- Developing a referral workflow to the HIVE clinic based on geriatric care needs identified by the referring provider (e.g. polypharmacy, frailty).
- Performing a comprehensive geriatric assessment and create individualized care plans for HIVE clinic clients.
- Assessing medication regimens to reduce polypharmacy and complexity.
- Establishing a framework for initiating and documenting advanced care planning decisions for Center for Infectious Disease Clinic patients.
- Offering connections to community resources and services like food delivery, adult day health, and home health care.

Notable Client Outcomes



Improved viral load and CD4

Increase in the percentage of patients with a healthy viral load and a significant increase in the percentage of patients with a healthy CD4 count.

Increased retention in care

Defined as two HIV medical care encounters in the last 12 months, at least 90 days apart.

Total clients completing the evaluation: 30

Implementation Lessons Learned

Boston Medical Center benefited from a number of facilitators and worked as a team to overcome several challenges.

Facilitators

Multidisciplinary staff brought a range of expertise. For example, a geriatrician and a geriatric nurse conducted initial assessments. Infectious disease doctors were the link to the infectious disease department, and a dedicated pharmacist conducted medication reviews.

A **blanket agreement** with primary care providers for the HIVE clinic facilitated small medication changes if no harm was suspected (e.g., referrals to physiotherapy or changing medication strength).

Strong team collaboration supported improvements to workflow and service delivery.

Challenges

Busy provider schedules made it difficult to find time for program-led provider meetings and to estimate the time providers needed to dedicate to the intervention.

Clinic scheduling barriers limited the number of HIVE appointments available and when patients could be scheduled.

Follow-up after clinic visits often involved a lot of outreach to other providers and community partners to coordinate care, contributing to administrative burden.

Onboarding and retaining the right staff was an initial barrier to care continuity.

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aging with HIV
Ryan White HIV/AIDS Program Initiative