

Colorado Health Network

Denver, CO

The Initiative

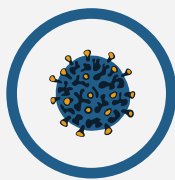
The Emerging Strategies to Improve Health Outcomes for People Aging with HIV (Aging with HIV) Initiative supports and evaluates 10 demonstration sites as they implement groundbreaking interventions that seek to improve whole-person care of people with HIV ages 50 and older served by the Ryan White HIV/AIDS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

The Program

The Colorado Health Network's *Integrated Care for Health Aging and Navigation of Geriatric Effects* (iCHANGE) program expanded their previous model of integrated care for older adults with HIV to include:

- Screening for geriatric conditions and determining aging services using the 5Ms framework.
- Integrated, multidisciplinary care plans, coordinated service delivery, and referrals.
- Client milestones and service utilization tracking.
- Follow-up and iCHANGE reassessment.

Notable Client Outcomes



Increased percent of clients with CD4 count within normal range



Increased general health scores



No unmet mental health needs at follow-up



Improved documentation of number of drugs prescribed



100% of clients

received screenings for comorbid conditions, geriatric conditions, and/or behavioral and psychosocial needs by the end of the Initiative



81% of clients

received referrals out to external services to support the needs identified during the screening

Total clients completing the evaluation: 42

Implementation Lessons Learned

Colorado Health Network benefited from a number of facilitators and worked as a team to overcome several barriers.

Facilitators



Strong team collaboration and patient liaison engagement supported workflow improvements and played an important role in outreach, care planning, and collecting ongoing client feedback to guide implementation.



Staff expertise and reciprocal programmatic design encouraged collaboration between iCHANGE's individualized care and existing programmatic opportunities to reinforce client-centered care coordination and behavior change.



Empowering clients through **prioritizing what matters most** to them and encouraging continuous client feedback informed updates to care delivery, screening tools, and referral strategies.

Challenges



Programs and services at other agencies may have fit a client's particular needs well for a given referral, but **the other agency was at capacity, out of clients' travel ability, or the client was otherwise ineligible** for that agency's services. This was especially true for clients aged 50-59, deemed too young for most aging services. Program staff sometimes had to find less-preferred alternatives to provide a necessary referral.



The client-centered design of iCHANGE can take longer than a typical case management visit. Turnover among case managers and patient liaisons, older adults who may be planning for their retirement, highlights the need to create **formal mechanisms for transferring knowledge to new patient liaisons** to ensure client continuity.



iCHANGE team members needed **organizational champions** to sustain the program long-term; leadership support required further engagement to obtain buy-in and recognize that these services are covered by existing Ryan White funding.

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