HIV-Endurance Clinic

aging with HIV
Ryan White HIV/AIDS Program Initiative

Protocol

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INTERVENTION OVERVIEW

The HIV Endurance ("HIVE") intervention is a referral-based, consultative geriatric clinic integrated within an infectious disease clinic. The clinic uses a collaborative care model to enhance the care for people with HIV aged 50 and older with a specific focus on performing a comprehensive geriatric assessment and addressing related care needs. The referral consists of a visit in the geriatric clinic with the geriatric care team, development of a care plan, and a follow-up telemedicine visit with the HIV Medical Provider. The core components of a visit to the clinic include: (1) comprehensive geriatric assessment; (2) medication reconciliation and optimization; and (3) care coordination and referral services to ensure cohesive delivery of care between the HIV and geriatric care teams.

Each visit is tailored to the client's needs and priorities and is organized around the "**5M**" model of geriatric care – **m**ind (memory, mood, sleep, social support), **m**obility (balance, gait, fall risk), **m**ulti-morbidity, **m**edication, and what **m**atters most (goals, healthcare proxy, advanced planning). Visits are scheduled for 90 minutes. The intervention includes a collaborative team-based approach to care, designed to ensure streamlined referrals and engagement between the HIVE Intervention Team and the infectious disease clinic. This involves continuous coordination of care to address the geriatric assessment results and geriatric-specific care plan.

Each client seen in the geriatric clinic has a follow-up telemedicine visit scheduled with the *HIV Medical Provider* one month after the consultative geriatric clinic visit. The purpose of this 30-minute telemedicine visit is to ensure that action items developed in the individualized geriatric care plan are completed or in progress, and to ensure that the client has received or is in the process of receiving services.

INTERVENTION POPULATION(S)

The intervention was demonstrated with clients meeting the following criteria:

- Diagnosed with HIV
- 50 years of age or older

INTERVENTION STAFFING

HIV Medical Provider

The HIV Medical Provider is a position that connects the intervention team and the client's HIV primary care clinic team and is responsible for coordinating care and follow-up between the two. Staff appropriate for this role include physicians, nurse practitioners, and physicians' assistants experienced in providing HIV care and treatment.

Intervention Responsibilities

- Perform orientation for new clients to the geriatric clinic on the elements of a geriatric clinic visit and what to expect.
- Attend the scheduled geriatric care clinical visit and assist in the development and documentation of the individualized care coordination plan with clients.
- Conduct follow-up telemedicine visits with each client to monitor and support progress on the care plans.
- Communicate each client's progress with their care plan to their HIV primary care provider and assure appropriate continuation of care during routine HIV care visits.
- Provide clinical guidance on HIV treatment and care during the geriatric clinic session.
- Train intervention team members on protocol and procedures.
- Provide oversight of the integration of assessments, plans and visit schedules into the HIV clinic's systems.

Geriatric Medical Provider

This team member conducts comprehensive geriatric assessments and leads the development of the care plan in response to the assessment findings and oversees the plan implementation. Staff appropriate for this role include geriatricians, Adult Gerontology Nurse Practitioners, or physicians, nurse practitioners, and physicians' assistants with experience in providing specialized medical care for older adults.

Intervention Responsibilities

- Provide clinical guidance during the geriatric clinic session.
- Conduct a comprehensive geriatric assessment.
- Lead the care coordination team meeting to develop responsive care plans.
- Refer patients to needed community and specialty clinical services, as indicated.

Nurse

The nurse assists in conducting comprehensive geriatric assessments, screening patients for community resource needs, and developing individualized care plans and referrals. Staff appropriate for this role include Registered Nurses or Licensed Practical Nurses.

Intervention Responsibilities

- Conduct a review of past and present medical history, laboratory and other testing results and ensure these are available to the geriatrician at the clinic visit.
- Complete elements of comprehensive geriatric assessments with the patient.
- Assist the medical provider during the clinic visit.
- Refer patients to needed community and specialty clinical services, as indicated.

Pharmacist

The pharmacist conducts medication reconciliation and optimization assessment. Staff appropriate for this role include a Doctor of Pharmacy (PharmD) or Registered Pharmacist (RPh).

Intervention Responsibilities

- Review client medications and calculate the Medication Regimen Complexity Index.
- Assess and counsel clients on medication adherence.
- Recommend and coordinate changes to medications when appropriate.
- Coordinate changes with medical provider and pharmacies.
- Document changes to medications.

INTERVENTION STRATEGIES

Pre-Visit Planning

Outreach to referred clients includes a brief orientation to the intervention, as well as visit scheduling, and coordination of transportation and language interpretation services when applicable. The pharmacist begins preparing for medication reconciliation ahead of the meeting with the calculation of the Medication Regimen Complexity Index (MRCI) and the nurse completes a chart review and prepares forms and resources that will be helpful during the visit.

Geriatric Assessment and Care Plan Development

Upon arrival, the nurse introduces the client to the geriatric care team, provides an outline of what to expect at the visit, and asked about the priority issues they would like to address. The

geratric care team perform geriatric screenings and assessments that are suggested by the referring provider and priority for the client. The geratric care team also asseses the client's need for community resources and specialty clinical care referrals.

Following the geratric assessment, an individualized care plan is developed and discussed with the client. The care plan may include referrals to specialty providers, community resources, and other supports. Care plans document the follow-up tasks and delineate which staff are responsible for completing each task.

Medication Reconciliation and Optimization

At the visit, the pharmacist meets with the client to review their prescribed medications, any drug to drug interactions and side-effects and challenges to adhering to the medications. The pharmacist identifies and recommends opportunities for minimizing the number of medications and simplifying the frequency and dosages of medications. The pharmacist also provides treatment strategies and tools (e.g., pill boxes, calendar reminder systems, etc.) to support clients with medication adherence.

Care Coordination and Follow-Up

Care coordination tasks are clearly delegated among the interdisciplinary team members, and the status of care plan activities are tracked biweekly and discussed monthly at team meetings. The nurse communicates the care plan to the referring HIV primary care provider. The HIV Medical Provider from the geriatric team holds a follow-up telemedicine visit with the client one-month following the initial clinic visit to review progress on the care plan's action items. When all specialty and community referrals are completed, the client has "graduated" from the intervention. The nurse sends a summary email is sent to the HIV primary care provider, listing any remaining follow-up items and offering to re-engage with the Geriatric Clinic intervention team as needed.

INTERVENTION PROCEDURE

Pre-Visit Planning

1. **Identify eligible clients**: Assess potential clients against predefined eligibility criteria, ensuring they meet inclusion requirements.
2. **Offer the intervention**: Introduce the program to eligible clients by providing detailed information about its purpose and benefits.
3. **Schedule an appointment with the clinic**: Arrange a convenient time for clients to receive a comprehensive geriatric screening and care planning.
4. **Prepare for client visit:** Review the client's past and current medical history, medication list, and insurance type to identify potential community and aging services resources.
5. **Conduct reminder call:** Remind the client of their scheduled visit and ask them to bring all their current medications to the visit.

Geriatric Assessment and Care Plan Development

1. **Provide orientation to the clinic visit:** Welcome client, let them know what to expect from the visit, introduce the team members and roles, ask the client about their priority issues for clinic visit, and answer questions.
2. **Conduct the screening and physical assessments**: Using validated geriatric tools, tailor the assessment towards the reason for referral and the client's identified priorities.
3. **Document assessment results**: Record assessment outcomes in a structured assessment tool.
4. **Identify referral options**: Review and select appropriate internal and external community and specialty services to address needs identified in the assessment.
5. **Develop care plan**: Develop an individualized care plan, incorporating findings from pharmacist and geriatric assessments, documenting action items, and delegating follow-up responsibilities.
6. **Discuss care plan with client:** Summarize the assessment results and discuss recommended referrals, relevant educational materials, and next steps.
7. **Schedule follow-up telemedicine visit:** Select date and time for the follow-up telemedicine visit to check-in and support care plan progress.
8. **Complete referrals and share details for accessing resources**. Ensure referral documentation is complete and information for accessing referrals is provided to clients via email and/or printed.
9. **Ensure relevant releases of information are complete**: Secure permissions needed to share participant information with service providers.

Medication Review and Optimization

1. **Provide orientation to the medication review process:** Welcome client, explain the role of the pharmacist in the clinic and discuss client goals related to medication.
2. **Perform the medication review:** Compare the current list of prescribed medications documented in the electronic health record (EHR) with the medications (including over the counter medications and supplements) brought to the clinic by the client – document any differences found and identify expired medications.

3. **Provide medication education:** Discuss the reason that each medication is prescribed and any specific instructions for taking the medication (e.g., time of day, with food, etc.).
4. **Perform assessment of medication adherence:** Review any challenges and barriers the client has taking medications as prescribed.
5. **Identify ways to simplify the prescribed medications:** Assess the full list of medications for adverse drug reactions, therapy duplications, inappropriate medications, and medication gaps – identify ways to reduce the number and frequency of medications taken.
6. **Develop a medication care plan:** Discuss the results of medication review with the intervention team – adjust medications that are within the scope of practice and document other recommended changes for the HIV Primary Care Provider.
7. **Review the medication care plan:** Share the medication care plan with the client for input, answer questions, and provide any educational materials and medication adherence tools (e.g., pill boxes).
8. **Document the encounter:** Record the medication care plan and encounter notes in a structured template within the EHR.
9. **Schedule necessary follow-up visits with the pharmacist:** Arrange a follow-up visit as necessary (e.g., visit for client to receive education about medication administration).

Care Coordination

1. **Schedule a routine care coordination meeting:** Arrange a convenient time for the intervention team to meet to coordinate care for clients.
2. **Track progress and completion of care plan tasks and referrals:** Monitor clients' engagement with services and completion of tasks assigned to intervention team members – adjust the care plan and task lists as needed.
3. **Close-out care coordination when the care plan is achieved:** Discontinue the tracking of care plan progress when the client reports that all specialty and community referral services have been completed.
4. **Share updates to the care plan with the primary care provider:** Document any updated information through the EHR, summarizing outcomes and any remaining follow-up items.

Telemedicine Follow-up Visit

1. **Schedule a follow-up telemedicine visit:** Schedule a telemedicine visit one month following client's initial visit to the clinic.
2. **Discuss progress on care plan:** Review the client's care plan, share progress that has been made by the client and the intervention team, and address any challenges.
3. **Document updates to care plan:** Track completed referrals, appointments, and next steps and ensure appointments are scheduled.
4. **Share updates with the primary care provider:** Document telemedicine notes in EHR and notify PCP upon completion.

INTERVENTION OUTCOMES

The following measures can be used to monitor fidelity to the intervention, opportunities for process improvement, and intervention effectiveness.

Implementation Outcomes

- Number of clients referred to the intervention clinic
- Percentage of referred clients meeting eligibility criteria for intervention clinic
- Percentage of eligible clients successfully scheduled for appointments
- Percentage of scheduled clients who attend their appointment (i.e., show rate)
- Percentage of clients with individualized care plan developed
- Percentage of clients with documented health care proxy or advanced care planning
- Percentage of clients referred to specialty services
- Percentage of clients with documented completion of specialty referrals

Health Outcomes

- Reduction in Medication Regimen Complexity Score

Basic Intervention Measures

A less complex series of process measures may be utilized, for example:

- Number of clients referred to the clinic
- Percentage of clients with geriatric specific care plan developed
- Percentage of completed referrals to community services from the intervention clinic

INTERVENTION FACILITATORS AND CHALLENGES

There are several key considerations for organizations that implement this intervention.

Facilitators	Challenges
• Multidisciplinary staff, including geriatricians, nurses, infectious disease doctors, and pharmacists, brought diverse expertise.	• Limited clinic scheduling reduced appointment availability
• Agreements between multidisciplinary team and primary care providers allowed for streamlined medication adjustments.	• High administrative burden due to extensive follow-up and care coordination.
• Strong team collaboration enhanced workflow and service delivery.	• Difficulty in onboarding and retaining appropriate staff initially disrupted care continuity.

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