

The background of the entire page is a photograph of two men embracing. The man on the left is older, with white curly hair and a beard, wearing glasses and a light-colored shirt. The man on the right is younger, with dark hair and a beard, wearing a dark shirt. The image is overlaid with a semi-transparent blue filter. In the center, there is a white graphic consisting of a square frame with a ribbon symbol on the right side. The text 'aging with HIV' is written in white, lowercase letters, with 'aging' and 'with' on the top line and 'HIV' on the bottom line, all contained within the white graphic.

aging  
with  
HIV

Ryan White HIV/AIDS  
Program Initiative

**Collaborative Care to Assess Risk and  
Eliminate Polypharmacy, Falls, and  
Fragility Fractures (4F) for People Aging  
with HIV**

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## INTERVENTION OVERVIEW

This collaborative care model trains a cadre of HIV champion providers at the clinic to assess and prevent risks associated with aging among their patients. The intervention is designed to train HIV providers on how to integrate screening and prevent risks related to polypharmacy, falls, and fragility fractures (the “4F intervention”) as part of an annual wellness visit for people aging with HIV (age 50 and older), as well as to develop appropriate care plans to address these risks. HIV champion providers are clinicians who volunteer to enthusiastically promote and facilitate implementation of the intervention. The goals of the intervention are to build the capacity of Ryan White HIV/AIDS Program providers in geriatric care and to improve the quality of life of patients aging with HIV.

## INTERVENTION POPULATION(S)

The intervention was demonstrated with patients meeting the following criteria:

- Diagnosed with HIV
- 50 years of age and older

# INTERVENTION STAFFING

## Intervention Coordinator

This staff member plays a key role in supporting the implementation of the intervention within the day-to-day clinic operations. Staff appropriate for this role might include clinic or program manager, coordinator of client services, case manager, and nurse.

### Intervention Responsibilities

- Oversee the implementation of the intervention, monitor project progress, address challenges, and facilitate effective communication among team members
- Manage the training logistics of intervention team members
- Support recruitment, enrollment, and assessment of patients
- Provide oversight of the integration of assessments and wellness visits into agency systems
- Conduct assessments and provide educational resources for the patients

## Medical Provider

This role is responsible for providing direct care for people aging with HIV (i.e., a physician, nurse practitioner, or physician assistant). The medical provider will be trained to implement the intervention protocol and procedure. Where applicable a medical provider with geriatric care experience can be designated as the “lead medical provider” to serve as a consultant and support to the care team as they implement the intervention.

### Intervention Responsibilities

- Conduct geriatric screening and assessment
- Develop care plans to address polypharmacy, falls, and fragility fracture risks
- Refer patients to needed services, as indicated
- Monitor and support patients with care plans as part of routine HIV care



## INTERVENTION STRATEGIES

### HIV Champion Provider Training

A comprehensive training curriculum supports HIV champion providers in implementing the intervention. The curriculum goal is to enhance the HIV champion providers' knowledge and practice in conducting geriatric screenings, assessments and developing care plans to address polypharmacy, risk of falls, and fragility fractures ("4F") among people aging with HIV.

The training package consists of on-line materials and resources to implement the intervention (<https://medicine.yale.edu/internal-medicine/infdis/research/hiv-aids/aging/>). It includes training videos – *How to Think Like a Geriatrician*; *Polypharmacy*; *Preventing Fall Risks and Fragility Fractures*; and *Live Gait and Balance Sessions*. In addition, there are Tip Sheets for providers to reference as they implement the intervention elements, as well as a geriatric screening tool that is based on validated geriatric assessment tools and used to document the results of the assessment. The package also includes educational videos and materials on key topics related to aging with HIV for patients to access.

### Geriatric Wellness Visit

The intervention is designed to be integrated into existing scheduling systems, as an annual medical visit for patients who are age 50 years and older. These visits expand the time that

the HIV provider spends with a patient to 60 minutes. The visit consists of a series of brief screenings of patients' health literacy, behavioral health and substance use, as well as for fall risk and sleep quality. The HIV champion provider also conducts medication review and medication reconciliation, a foot exam, vision exam, gait assessment, and screens for fall risk, osteoporosis, and fragility fracture risk. The HIV champion provider and client then discuss a care plan based on the assessment results. Many EHRs have templates for documenting assessment results and care plans for each step of the visit. At the end of the visit, the patient receives appropriate educational material (link to educational videos and tip sheet).

## INTERVENTION PROCEDURE

### HIV Champion Providers Training

1. **Recruit HIV champion providers.** Engage HIV clinicians (physicians, physician assistants, and nurse practitioners), interested in implementing the intervention to participate in training.
2. **Prepare for the training sessions.** Review the online training videos and materials, create a sample training schedule and create access to the online training modules for HIV champion providers.
3. **Create access to specialists in geriatric medicine.** Provide resources for HIV champion providers to access specialty clinical consultations – this might include a partnership with local geriatric care providers, the [National Clinical Consultation Center](#), or with the regional [AIDS Education and Training Center](#).
4. **Complete the on-line training.** Provide HIV champion providers with the foundational knowledge of geriatric care principles and how to assess and prevent risk related to polypharmacy, falls, and fragility fractures in people aging with HIV.
5. **Review the wellness visit protocol:** Familiarize the HIV provider champions with screening tools and guidelines to ensure standardized and effective implementation.
6. **Align protocol with current clinic workflows:** Integrate the wellness visits and protocols into existing organizational processes for seamless operation.
7. **Conduct screening simulation:** HIV champion providers practice the intervention's screening process to build confidence and accuracy in real-world applications.
8. **Shadow the intervention's process:** HIV champion providers observe experienced staff conducting the intervention's screenings to understand best practices and workflow.
9. **Conduct supervised process:** HIV champion providers perform the screenings under supervision to ensure quality and adherence to standards.
10. **Spotlight those providers who have completed the training.** Publicly celebrate the HIV champion providers that have completed the training.

11. **Evaluate the HIV Champion provider training.** Conduct the pre- and post-training assessment and modify next training course based on feedback.

## Assessment Wellness Visit:

1. **Identify eligible patients:** Assess patients for eligibility for the intervention.
2. **Offer the intervention:** Introduce the intervention to eligible patients, providing detailed information about its purpose and benefits.
3. **Schedule participant for the wellness visit appointment:** Arrange a convenient time for patients to undergo the comprehensive intervention screening.
4. **Conduct the assessment:** Use the validated assessment tool to evaluate patients for polypharmacy, falls, and fragility fracture risk.
5. **Document assessment results:** Record assessment outcomes in a structured assessment tool and care plan.
6. **Identify relevant options for referrals:** Review and select appropriate internal and external services to address identified needs from the assessment.
7. **Develop and discuss a care plan with the patient:** Summarize the assessment results, and discuss recommended referrals, next steps and provide relevant educational materials to the patient.
8. **Schedule the follow-up annual well-visit for a reassessment:** Select the date and time for the next wellness visit to repeat the assessment and address the findings in twelve months.

# INTERVENTION OUTCOMES

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

## Implementation Outcomes

- Percentage of HIV providers trained in the HIV Champion provider intervention
- Percentage of HIV champion providers reporting increased confidence with assessing for and preventing risks associated with polypharmacy, falls and fragility fractures in people aged 50 and older with HIV
- Percentage of eligible patients completing the annual wellness visit intervention

## Health Outcomes

- Percentage of enrolled patients who report a decrease in fall frequency
- Percentage of enrolled patients with a high fracture risk assessment tool (FRAX) score referred to for a bone density test (DXA scan)
- Percentage of patients with a documented reduction of medications prescribed

# INTERVENTION FACILITATORS AND CHALLENGES

The evaluation identified several key considerations for organizations that implement this intervention.

## Facilitators

- The team used funding to develop tools and resources for use after the funding ended. They incorporated the tools into standard clinic workflows.
- Peer liaisons' experience and involvement contributed to success development and refinement of the geriatric wellness visit.
- The creation of client-facing educational videos provided a sustainable educational resource, with minimal ongoing costs beyond occasional content updates.

## Challenges

- Disruptions in scheduling and limited appointment availability early in the project, which delayed client recruitment.
- The initial development and later refinement of the screening tool was time and effort intensive.

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