Personalized Care in HIV and Aging

Insights from the Ryan White HIV/AIDS Program Special Projects of National Significance (SPNS) Aging with HIV Initiative

July 17, 2025

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Acknowledgment

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Zoom Reminders

- This webinar will be recorded.
- There will be 20 minutes for questions and answers at the end of both presentations.
- Please enter all questions in the chat.

Agenda

1. Welcome and Introduction

2. Presentation by Lysandra Hernández Arroyo, PA , Centro Ararat, Inc.

3. Presentation by Angela Condo, MD, Mount Sinai Beth Israel

4. Question and Answer Session

5. Upcoming Webinars & Closing

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The **SPNS Initiative, Emerging Interventions to Improve Health Outcomes for People Aging with HIV (SPNS Aging with HIV Initiative)** implements emerging interventions that comprehensively screen and manage comorbidities, geriatric conditions, behavioral health, and psychosocial needs of people with HIV aged 50 years and older.

The Aging with HIV Initiative's goals include:

Implementing emerging interventions that screen and manage comorbidities, chronic conditions, geriatric conditions, behavioral health, and psychosocial needs of people with HIV ages 50 and older;

Assessing the uptake and integration of emerging interventions; and

**Evaluating the impact of the emerging interventions.**

Demonstration Sites

University of Pittsburgh
Medical Center
Presbyterian Shadyside

University of Chicago

Boston Medical Center

Yale University

Mount Sinai Beth Israel

Family Health
Centers of San Diego

Wake Forest University
Health Sciences

Colorado Health
Network, Inc.

Empower U, Inc.

Centro Ararat, Inc.

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Patient-centered care models: Personalized care in HIV and aging - Premier Platinum Program

Lysandra Hernández Arroyo, PA, AAHIVS
Centro Ararat, Puerto Rico

Objectives

|	
Share	Share best practices applied through our intervention.
Reflect on	Reflect on implementation challenges.
Feature	Feature our success storyline.

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About us
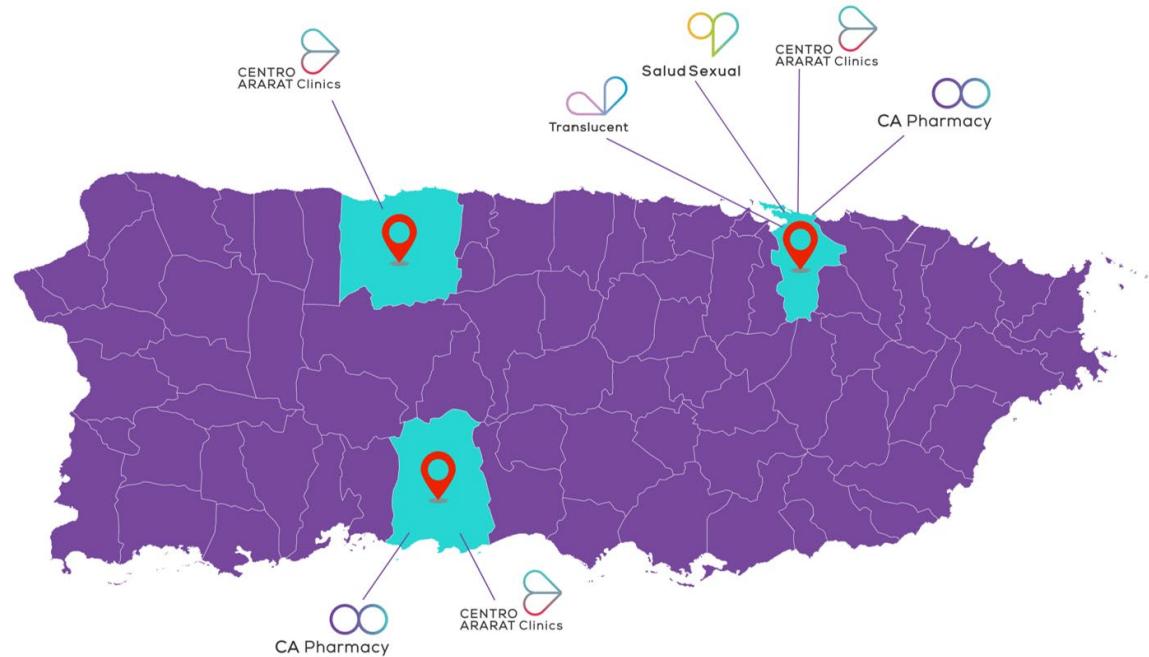
Centro Ararat, Inc. is a community-based, nonprofit organization founded in Ponce, Puerto Rico, in 2001.

SPNS Intervention

Premier Platinum Program
by Centro Ararat

Multimorbidity	Mobility	Medications	Mind	Matters Most	Empowerment Program

Physician Assistant (PA)

Psychology Neuropsychology evaluation

Registered Nurse (RN) Medical Case Management

Health care curriculum for participants

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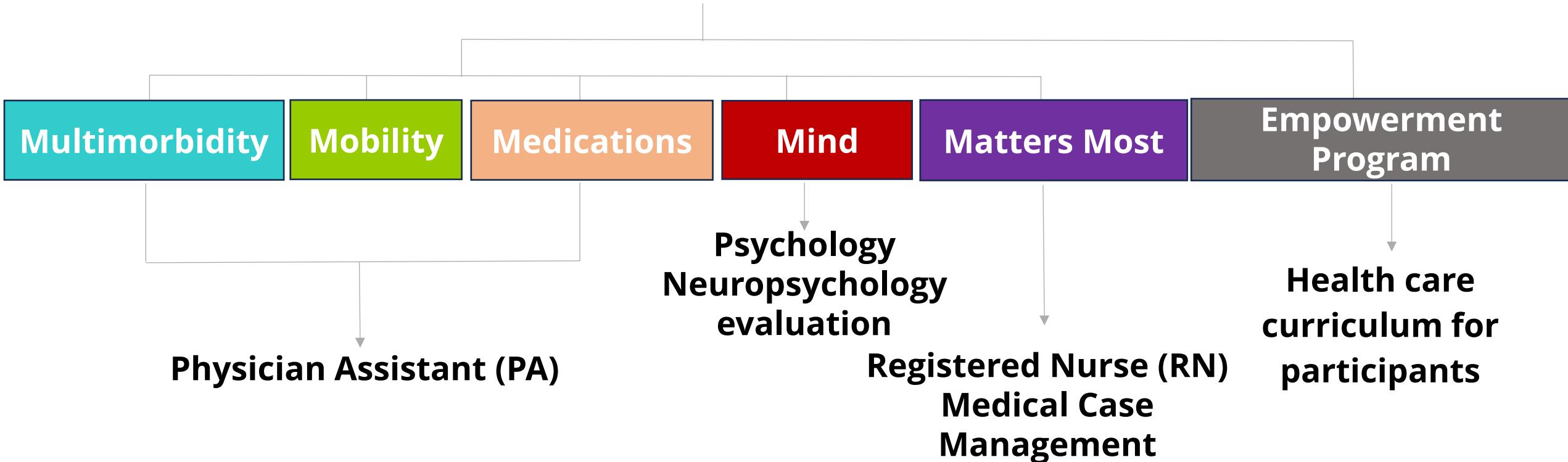
Comprehensive Geriatric Assessment

Visit 1

Multimorbidity/Mobility

- Multisystem Physical Examination
- Cancer screening
- Vaccines
- Socio-environmental

Visit 2

Medications/Neuromuscular

- Medication reconciliation
- Mental status/Cognition
- Coordination exam
- Balance

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Implementation – 3Ms performed by physician assistant

| Multimorbidity	Mobility	Medications
Bone Health: FRAX Assessment Tool Continence: NAFC Bladder Health Questionnaire Obesity and Lipohyperthrophy: Body Mass Index (BMI) Cancer: According to U.S. Preventive Services Task Force (USPSTF) Guidelines	Activities: Katz Activities of Daily Living (ADL) Gait and Balance: Timed Up and Go Test (TUG) Fall Risk: Stopping Elderly Accidences, Deaths, and Injuries (STEADI) Checklist Frailty: Comprehensive Geriatric Assessment (CGA) Toolkit Exercise: Action Guide Summary from American College of Sports Medicine Exercise is Medicine (EIM) Health Care Providers Action Guide	Beers criteria for Potentially Inappropriate Medications (PIMs) for Older Adults Screening Tool of Older Persons' Prescriptions (STOPP) and Screening Tool to Alert to Right Treatment (START) criteria for potentially inappropriate prescribing in older people Advisory Committee on Immunization Practices (ACIP) Guidelines

Implementation - MIND Performed by clinical psychologist

Mental Health Evaluation
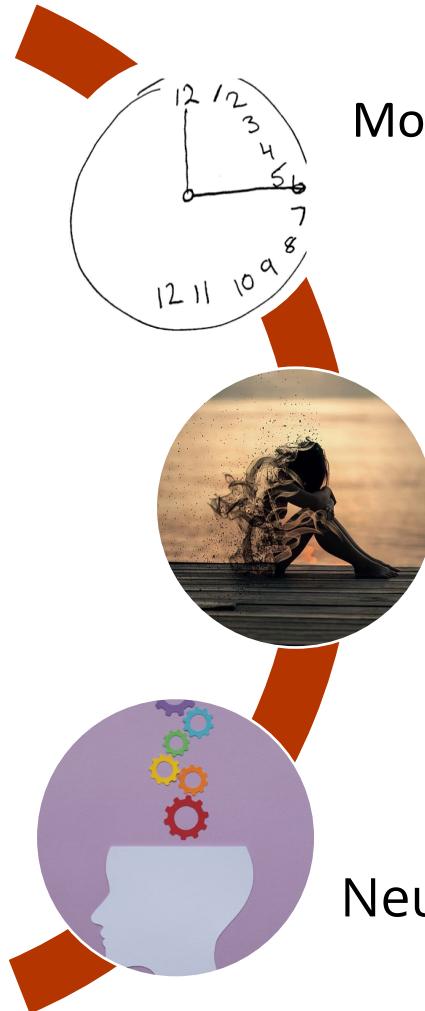
Montreal Cognitive Assessment (MOCA)

Drug Abuse Screening Test (DAST-10)
Patient Health Questionnaire (PHQ-9)
General Anxiety Disorder (GAD-7)
Loneliness scale
Alcohol Use Disorder Identification Test (AUDIT-C)
Fagerstrom

Neuropsychology referral

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Implementation - MATTERS MOST performed by case manager or nurse

Appointment coordination

Helping Hands

Referrals

Factors associated with health
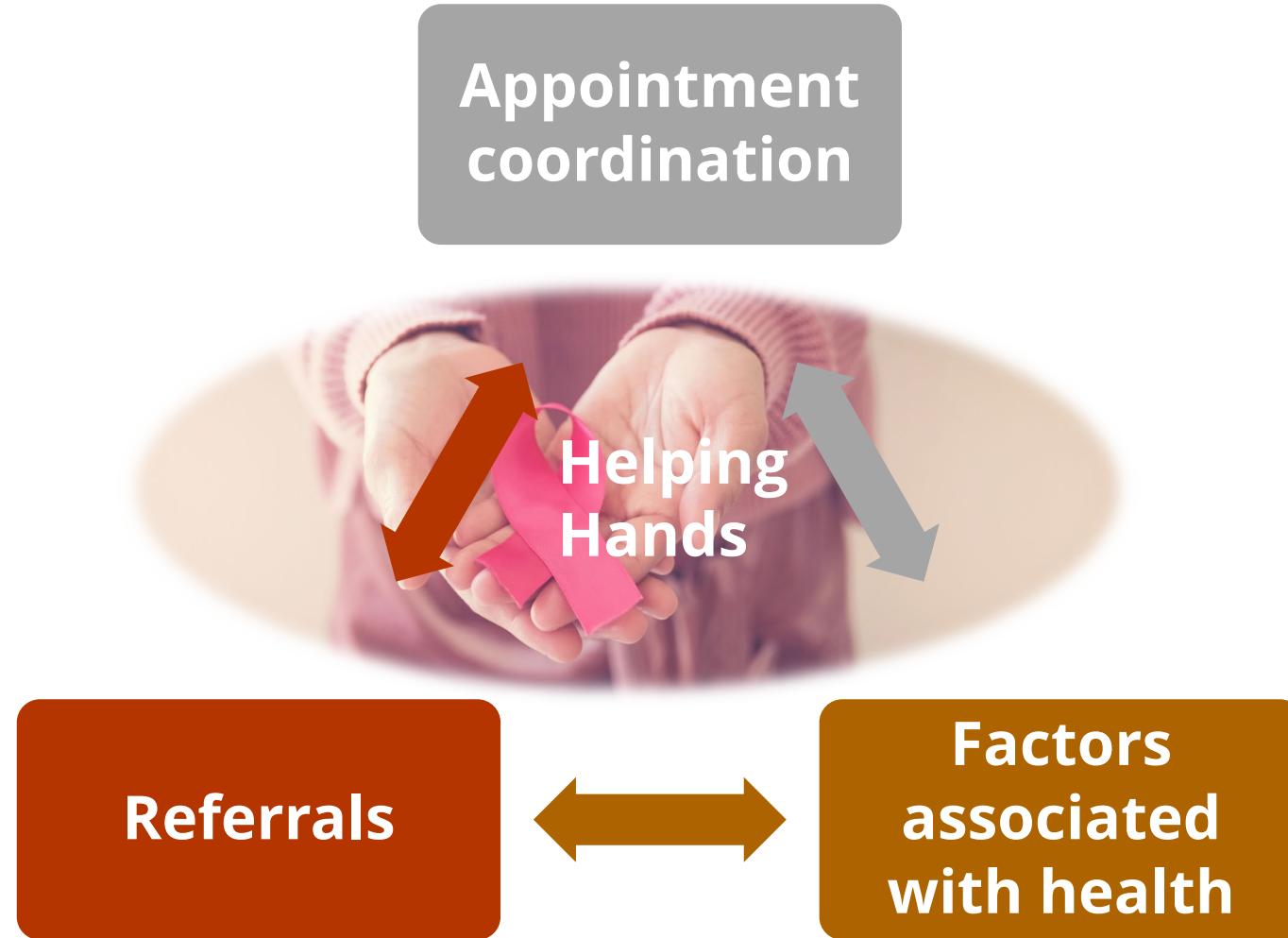
Educational and Empowerment curriculum consists of five educational workshops

Living a Healthy Life with Chronic Conditions
5TH EDITION
OVER 1.5 MILLION COPIES SOLD!

Self-Management Skills for Heart Disease, Arthritis, Diabetes, Depression, Asthma, Bronchitis, Emphysema and Other Physical and Mental Health Conditions
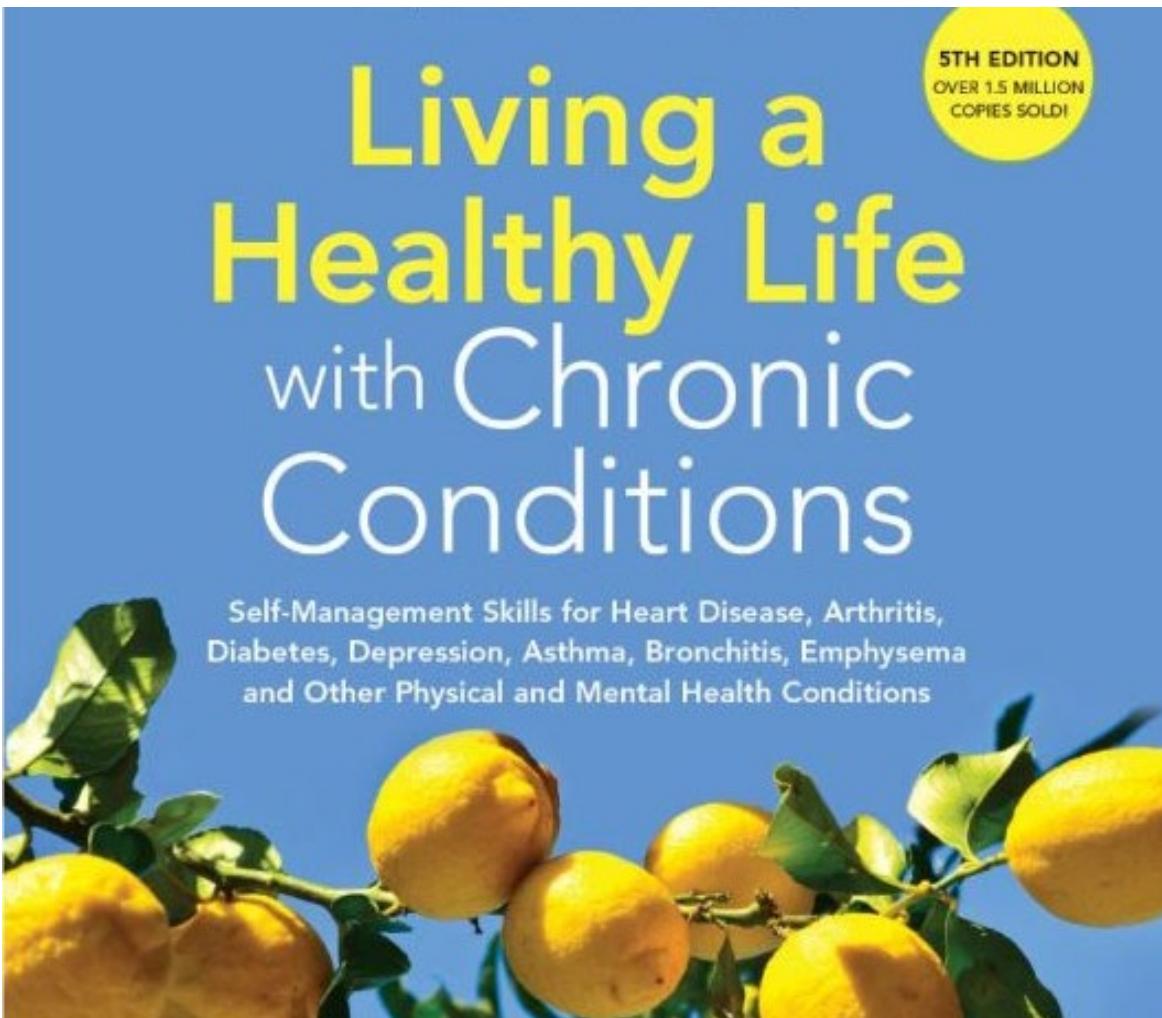
- Knowing own health and metabolic syndrome

- Medications, diet, and exercise

- Taking control of my mental health and effective communication

- Healthy aging and sexual health

- Navigating the future and grief

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Key barriers to implementation
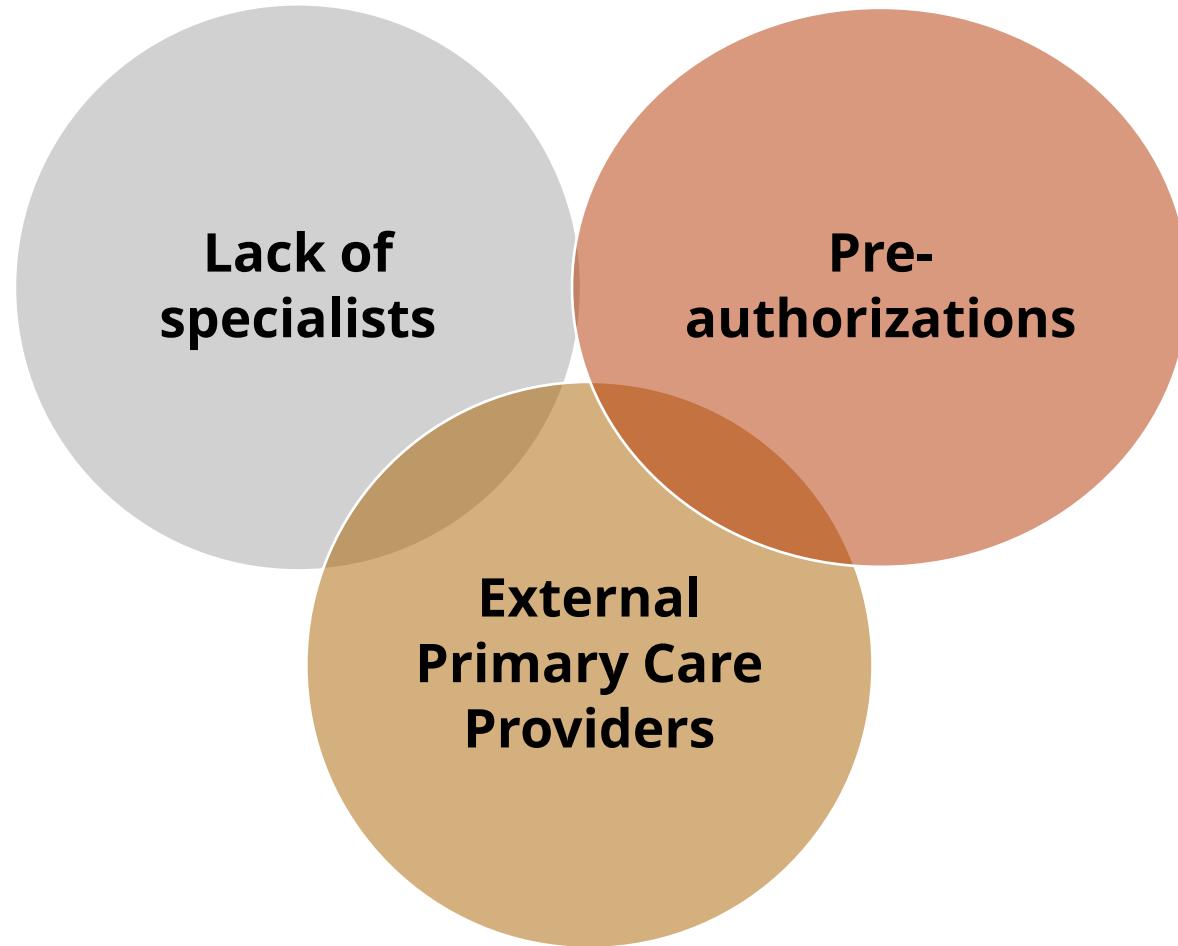
Our success storyline

31/March/2025

Participants	72=94% of initially enrolled
First PA Evaluation	72=100% of active participants
Second PA Visit	71 = 99%
Mental Health Evaluation	72 = 100%
Curriculum Enrollment	57 = 79%
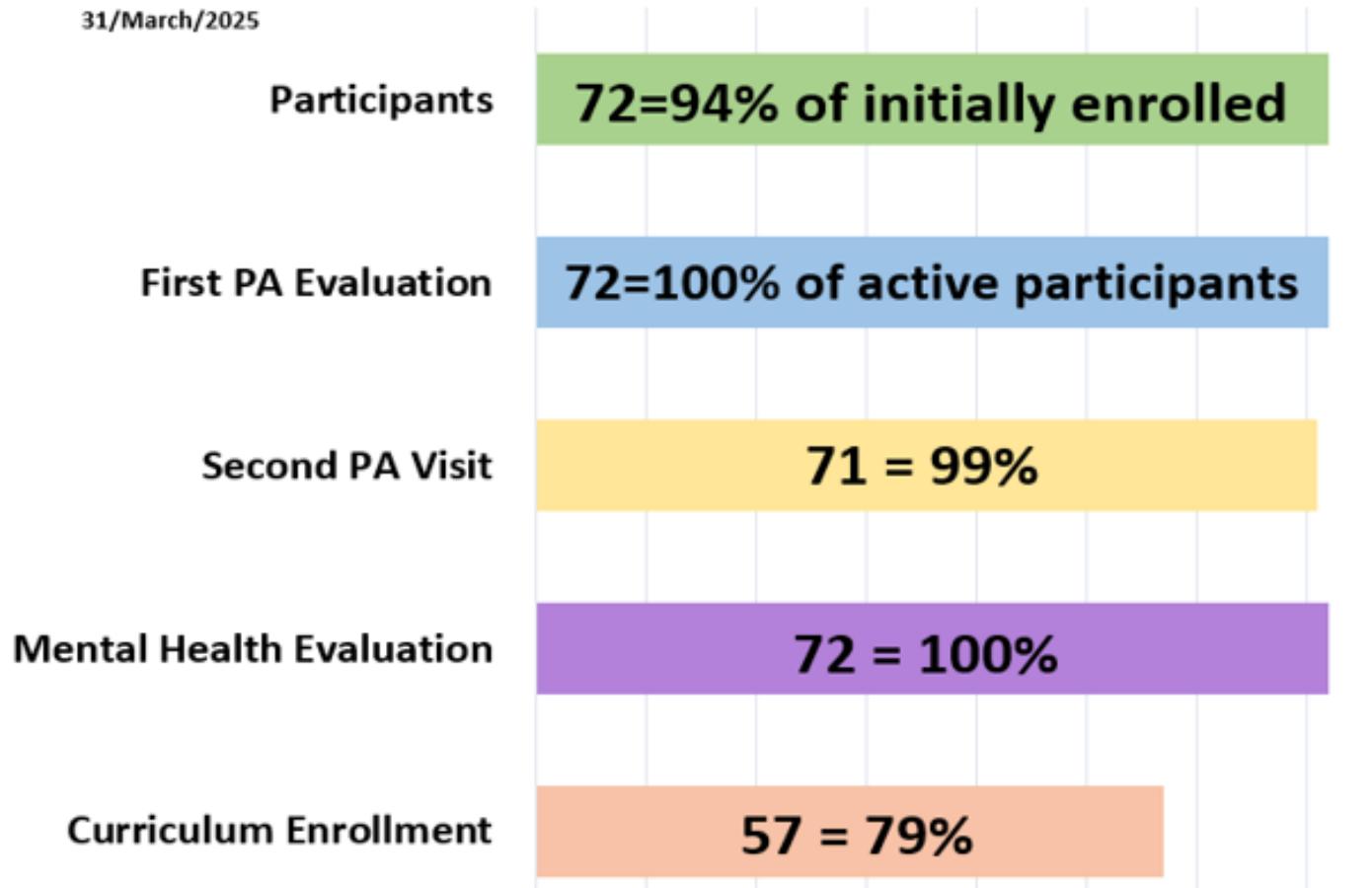
Participant satisfaction with PPP services was

high at 97%

Neuropsychologist Evaluations

72
- MoCA screenings (100%)

36
- Possible neurocognitive decline
- MoCA Scores under 22 (50%)

33
- Referred and Evaluated by Neuropsychologist
- 32 (97%) Possible cognitive impairment

Our success storyline

Clinical Pharmacy Evaluations

71
- PA Medication Evaluation (99%)

26
- Evaluated by the NOVA Pharmacy School Team

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Our success storyline*

Client Screenings

Δ910/140%

649

1559

# of screenings

1800
1600
1400
1200
1000
800
600
400
200
0

1   2   3

Timelines
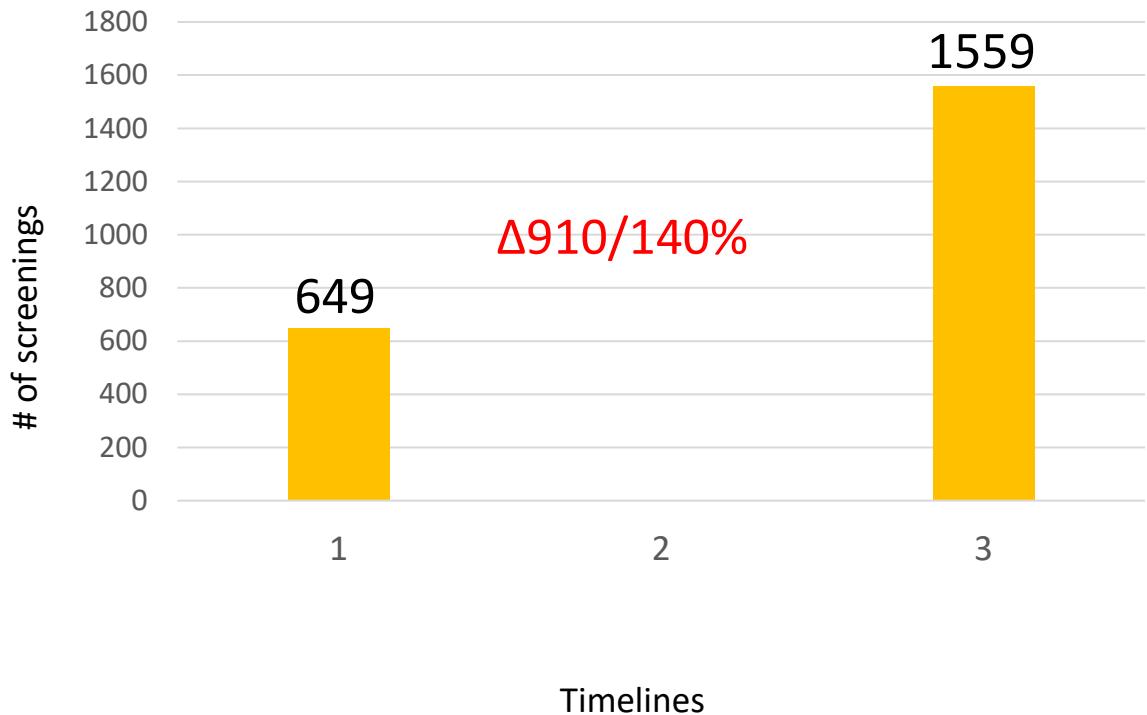
PEEP Knowledge Acquisition

57.6

79.2

Percent

100
80
60
40
20
0

Pre-Test   Post-Test

*Screenings included

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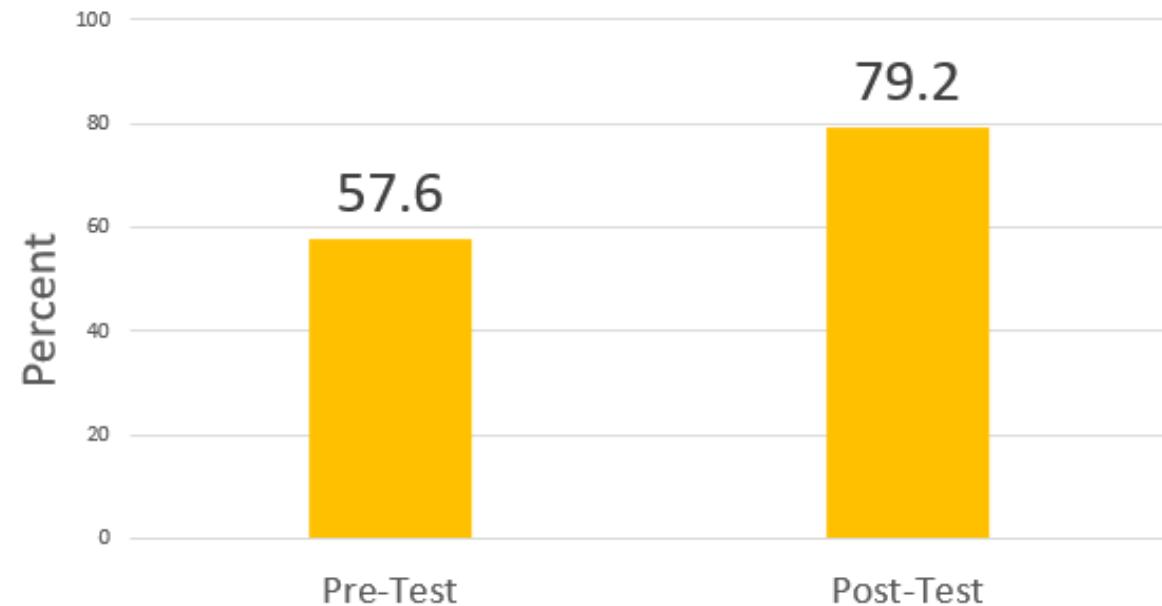
NORC results based on Chart Abstraction Tool

Mean Number of Screenings, Diagnoses, Referrals, and Services reported by Time Point

- Mean Number of Screenings: T1 = 9.01, T2 = 21.84
- Mean Number of Diagnoses: T1 = 3.9, T2 = 22.54
- Mean Number of Referrals: T1 = 0.87, T2 = 2.75
- Mean Number of Services: T1 = 3.91, T2 = 6.09

■ T1 ■ T2

Percentage of Clients with a reported Referral

- T1 = 38%
- T2 = 96%
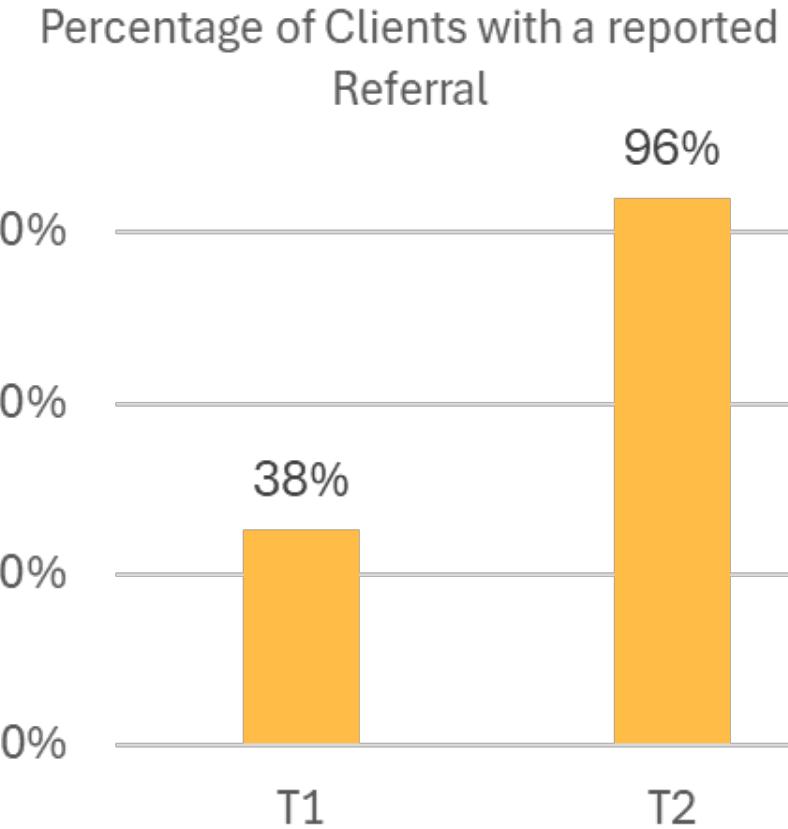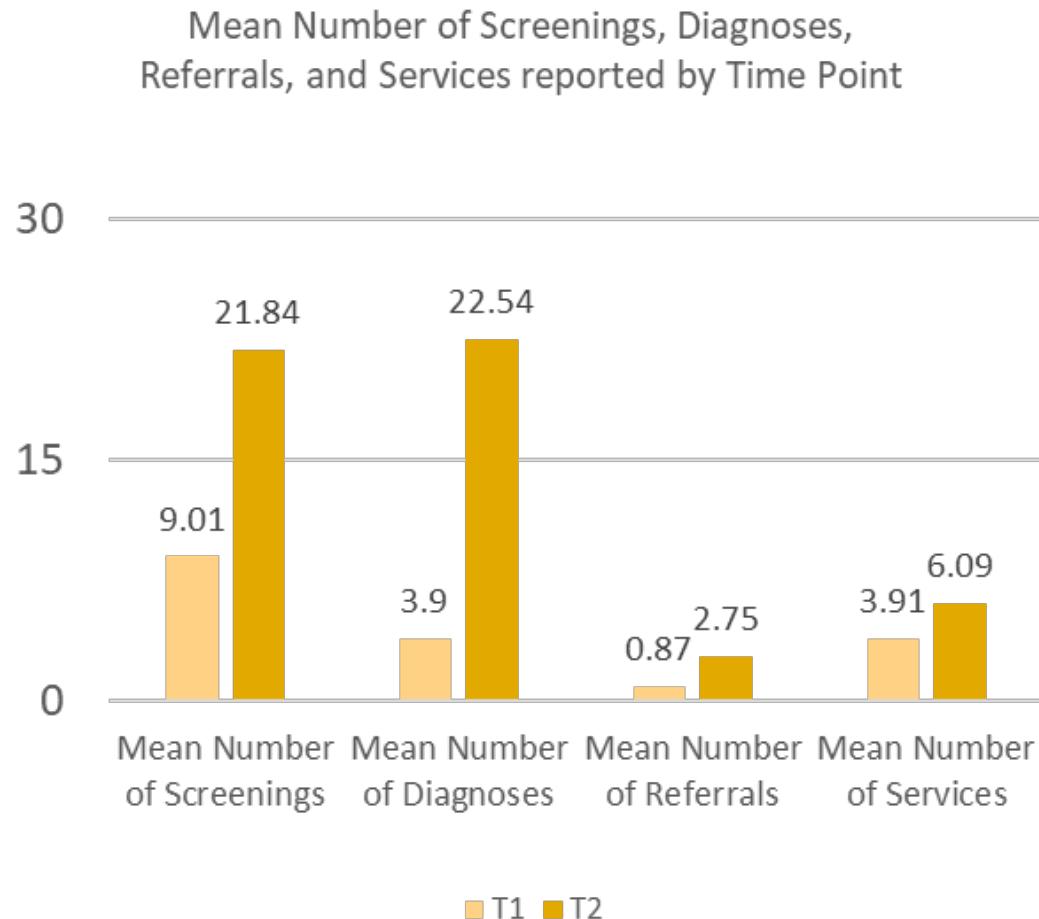
Looking towards the future...

- Incorporate a three-week physical fitness program to our current support group.

- Start group cognitive exercises to enhance memory, attention and emotional regulation.

- Create a Benzodiazepine withdrawal program supported by mental health department and PharmD.

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How to implement...

- Prepare the scenario:
  - *Identify:*
    - Team members to implement a patient centered model of care (5M's).
    - A provider to perform the Comprehensive Geriatric Assessment.
    - Personnel to perform mental health screening.

- Educational curriculum to empower participants on taking control of their health.

- Memorandum of agreement with specialists or external resources.

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Screenings

Mind

Comprehensive Mental Health:
- PHQ-9
- GAD-7
- UCLA Loneliness Scale
- DAST 10
- MoCA Test
- Referrals to Neuropsychological Evaluation as needed

Mobility

PA Evaluation:
- Activities: KATZ ADL
- Gait and Balance: Timed Up and Go Test (TUG)
- Fall Risk: CDC's Checklist
- STEADI Initiative
- Frailty: CGA Toolkit
- Exercise: Action Guide
- Summary from ACSM
- EIM Health Care Providers Action Guide

Medications

PA Evaluation:
- Beers criteria for potentially inappropriate medications (PIM's) for Older Adults
- STOPP/START criteria for potentially inappropriate prescribing in older people.
- Advisory Committee on Immunization Practices (ACIP) Guidelines

Multi-Morbidity

PA Evaluation:
- Bone Health: FRAX Assessment Tool
- Continence: NAFC Bladder Health Questionnaire
- Obesity and Lipohyperthrophy: BMI
- Cancer: According to USPSTF Guidelines.

Matters Most

Case Manager and Nurse Services:
- Referrals, Appointments Coordination
- Social Determinants of Health: Sexual Health, Intimate Partner Violence, Health Insurance Benefits & Employment, Substance Abuse, Housing, Legal Assistance, Financial Resources, Community Resources and Support.

Empowerment Program

- Designed by Clinical Staff and Patient Liaisons
- Textbook: Living a Healthy life with Chronic Conditions
- Five workshops offered in-person and asynchronous modality
- Participation incentive

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Thank You!

Bringing **Geriatrics** into **HIV** primary care

Institute for Advanced Medicine (IAM)

Peter Krueger Clinic (PKC)

Brookdale Department of Geriatrics and Palliative Medicine

IAM

PKC
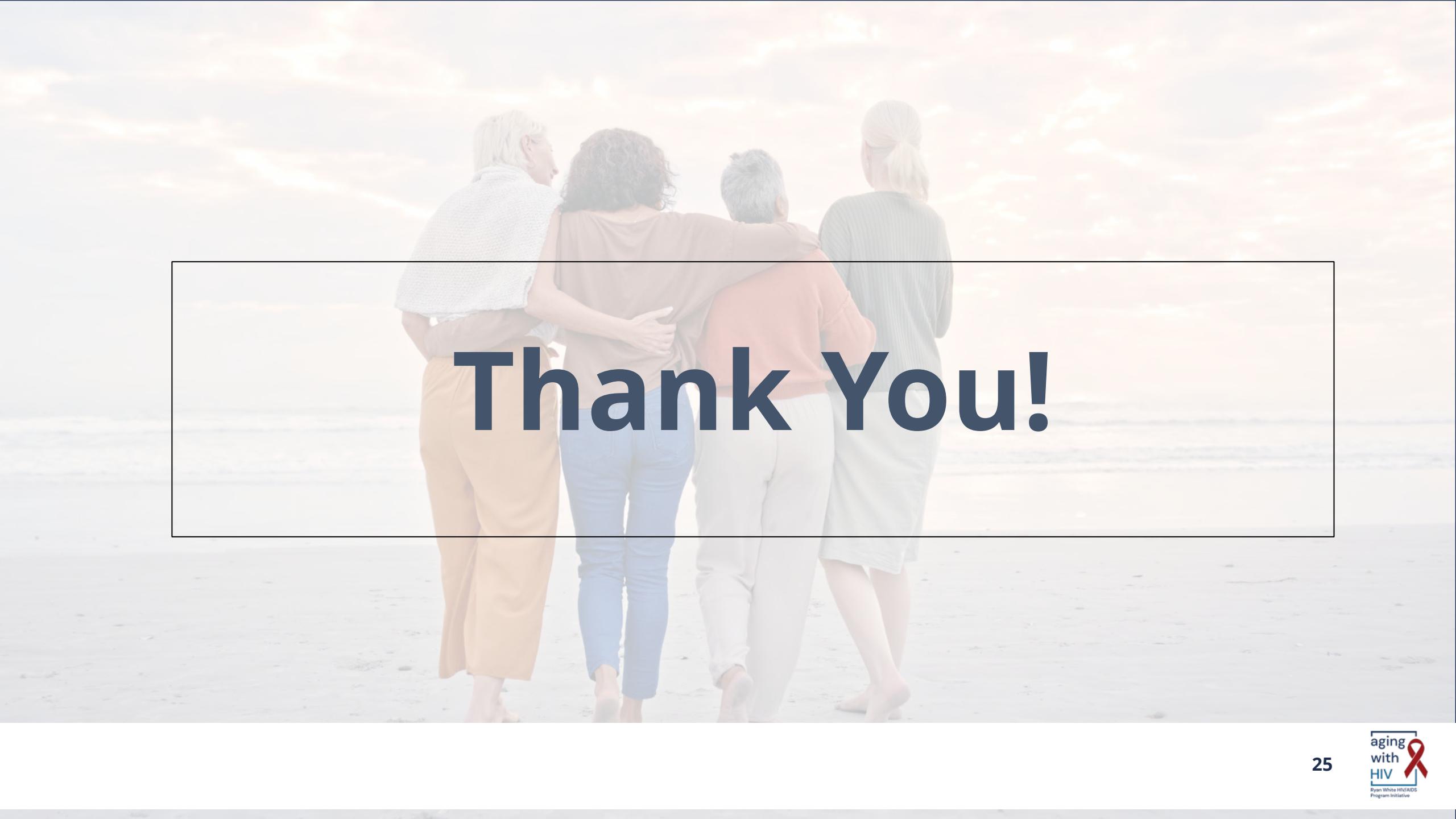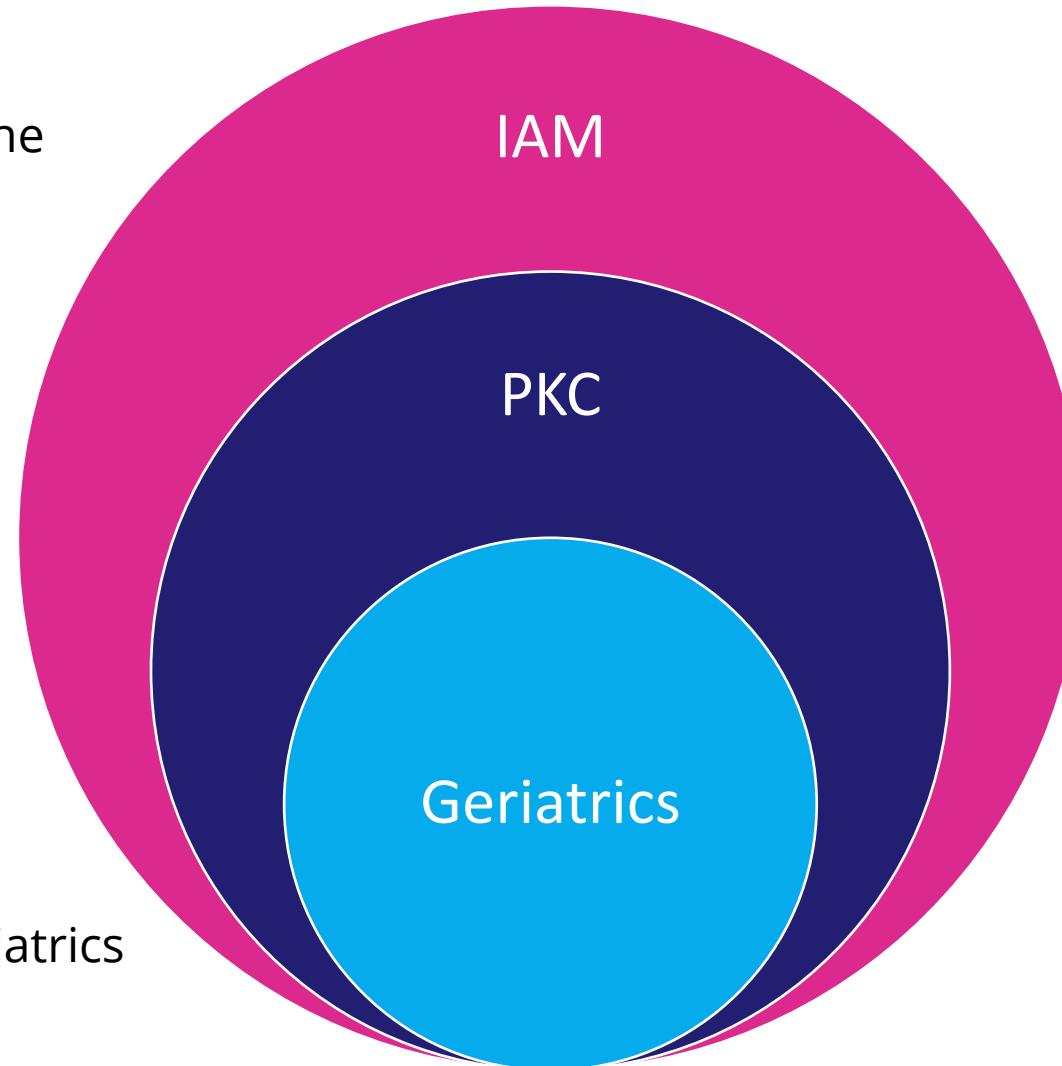
Geriatrics

Comprehensive Care for Older Adults with HIV

Keith Haring Foundation
Health Resources and Services Administration

https://www.haring.com/!/art-work/886

Interdisciplinary Team

- Geriatrician
- Nurse
- Pharmacist
- Social Worker
- **Community Health Worker (CHW)**

What is a Community Health Worker?

- Supports frontline healthcare delivery
- Liaison between healthcare system & community
- Navigates to clinic and community resources
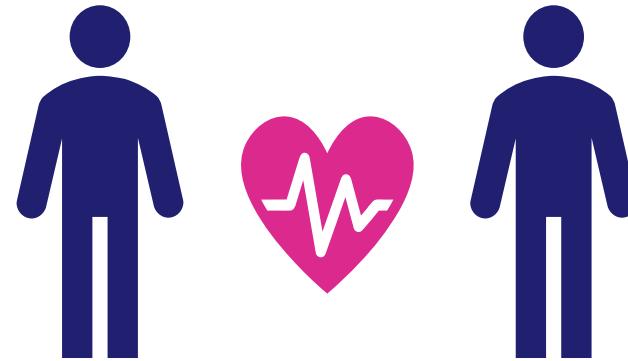
Geriatric-HIV Medicine: the 6 M's

Mind

Mobility

Medications

Matters Most

Multi-complexity

Modifiable
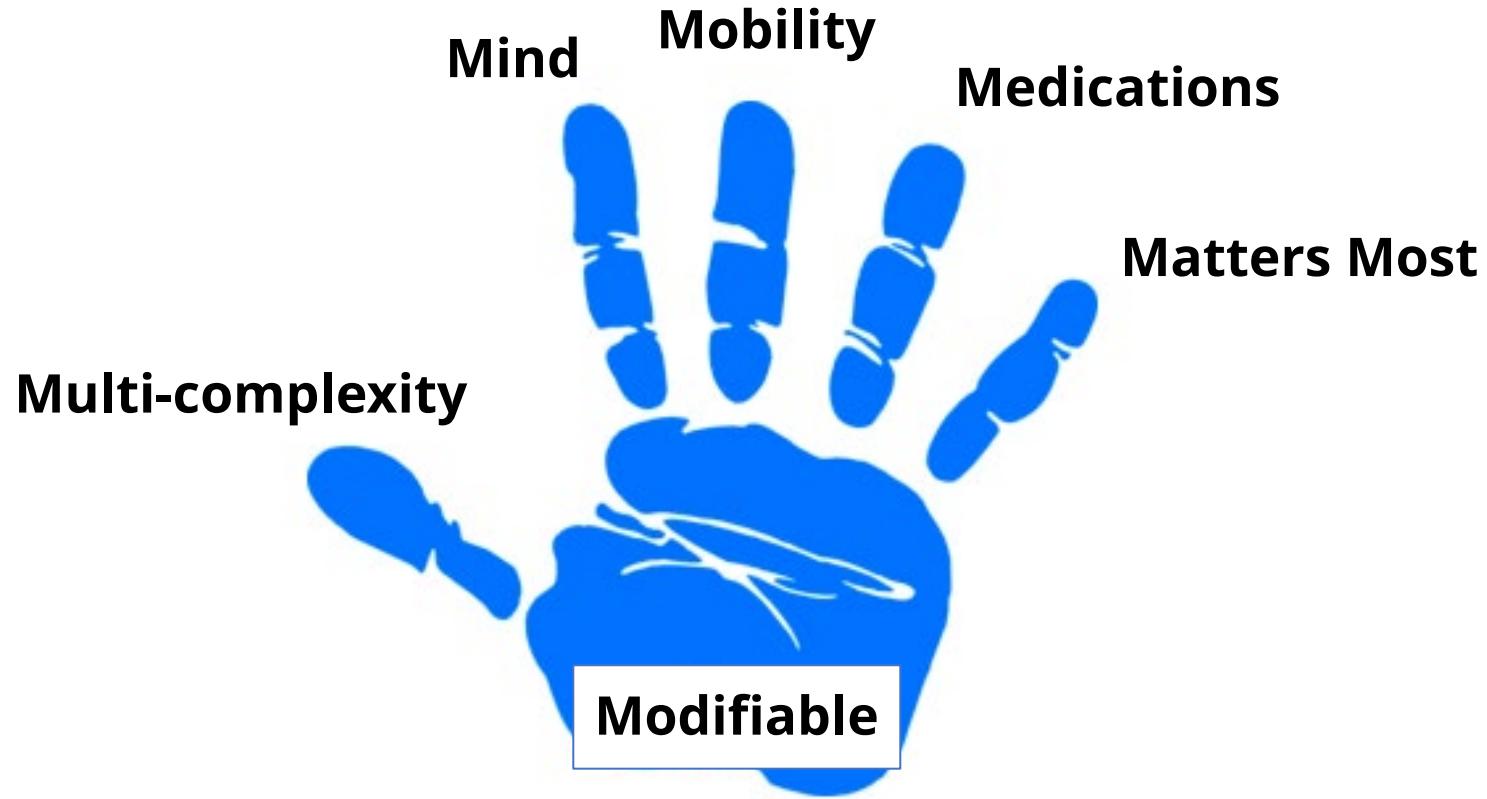
Erlandson KM, Karris MY. HIV and Aging: Reconsidering the Approach to Management of Comorbidities. *Infect Dis Clin North Am.* 2019;33(3):769-786.

Screenings

MIND
- **Depression - PHQ4/9***
- **Anxiety - PHQ4/Generalized Anxiety Disorder (GAD7)***
- **Cognition - mini-cog/MOCA**

MOBILITY
- **Functional status – ADLs and Instrumental Activities of Daily Living (ADLs)***
- **Frailty - Fatigue, Resistance, Ambulation, Illness, and Loss of weight (FRAIL) scale***
- **Falls - 2 item Falls Screening Questionnaire**

MODIFIABLE
- **Physical activity**
- **Alcohol/Tobacco/Drugs**
- **Nutrition**

MULTIMORBIDITY
- **Hearing/Vision**

MEDS
- **Polypharmacy/ Beers Criteria/ Anticholinergic burden score**

MATTERS MOST
- **Loneliness - University of California Los Angeles 3 Item Loneliness Scale***
- **Prognosis - Veterans Aging Cohort Study (VACS) Index**
- **Advance care planning - Health Care Proxy**

*Performed by CHW

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CHW Role

- Outreach
- Geriatric screenings

Assessment & Goals of Care

Care Planning

Review

Interventions

- Support
- Education
- Care coordination
- Health system navigation
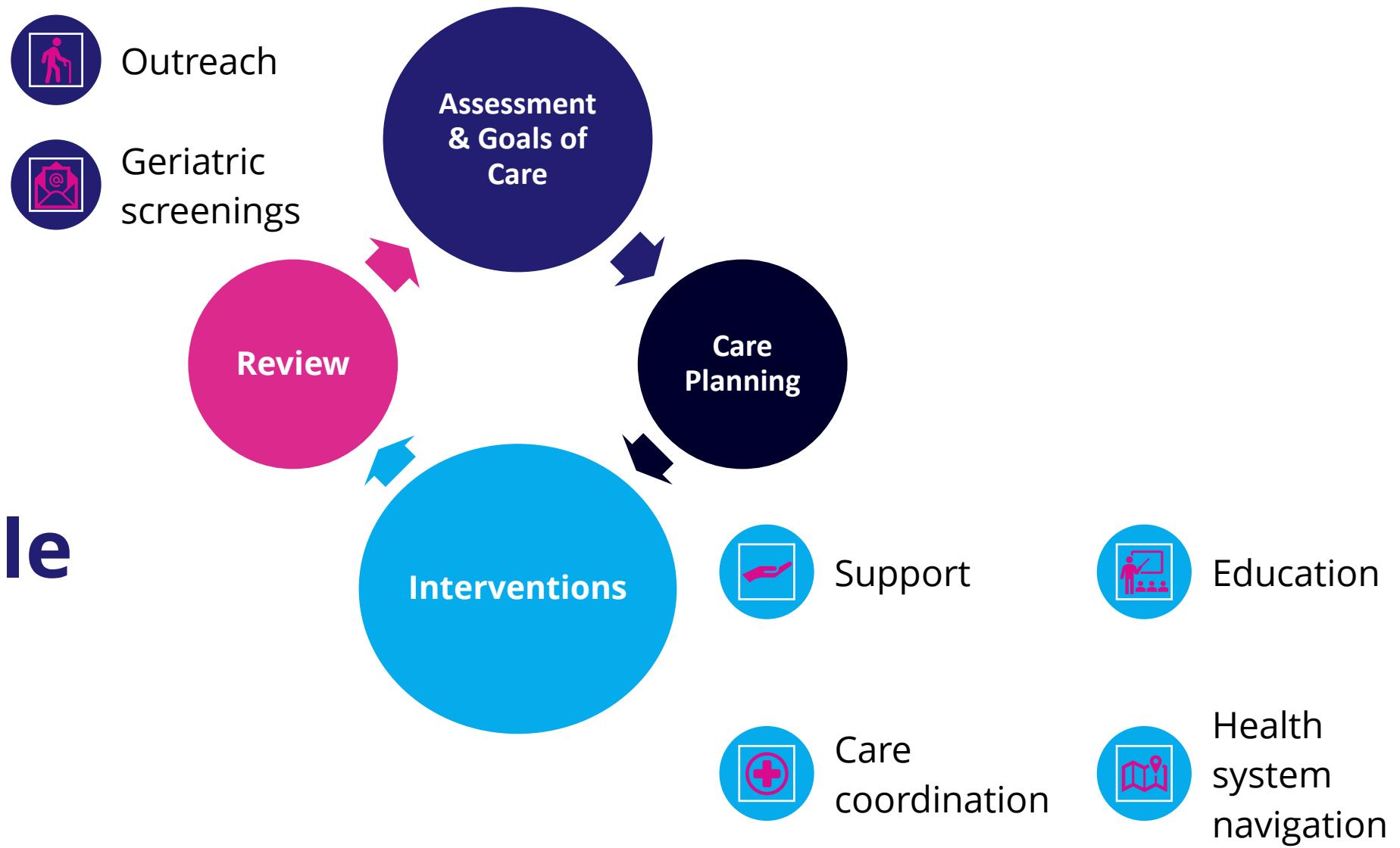
CHW Integration Improves Visit Attendance

Demographic		# (%) Patients
Average Age	68 yrs old	
Race	White	58 (25%)
	Black/African American	61 (26%)
	Hispanic	96 (41%)
	Asian	3 (1%)
	Unknown/Other	14 (16%)
Sex	Male	152 (66%)
	Female	80 (34%)
Total		232

CHW Pre-visit Contact Increased Completion Rate


*** *p* < 0.001
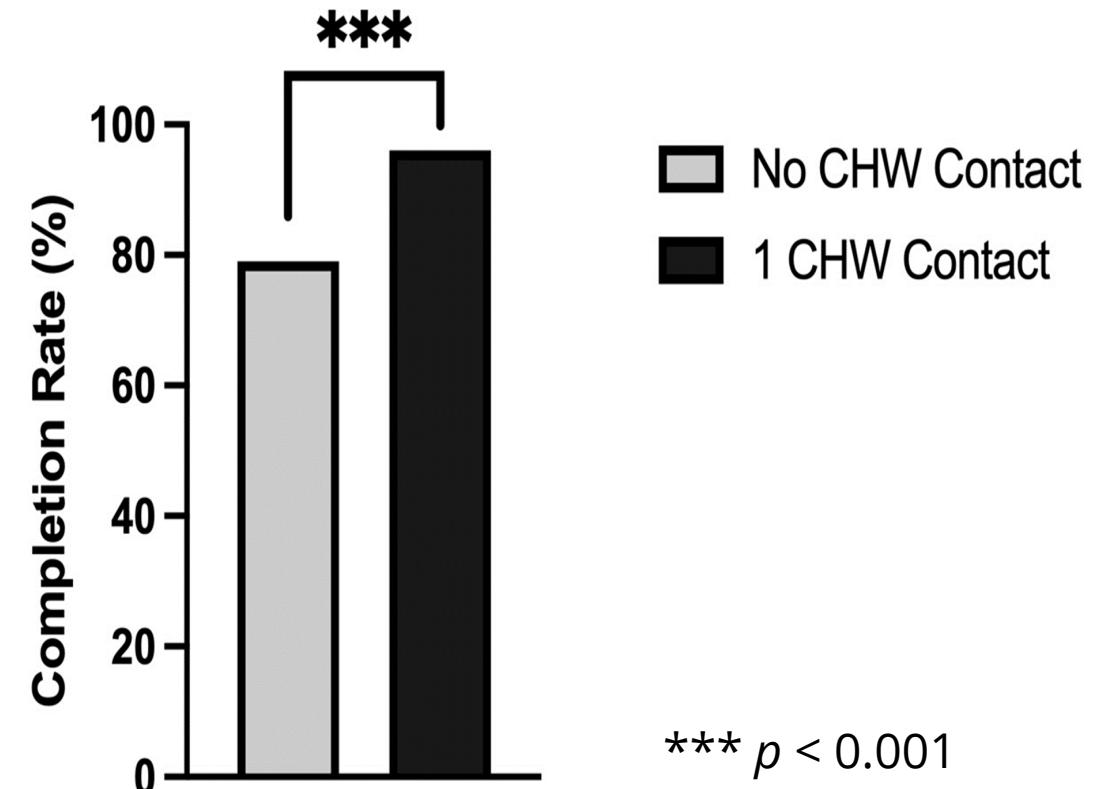
CHW Integration Improves Referral Completion

Fig. 3 CHW Integration Increased Referral Completion to Consultants

*** $p < 0.001$
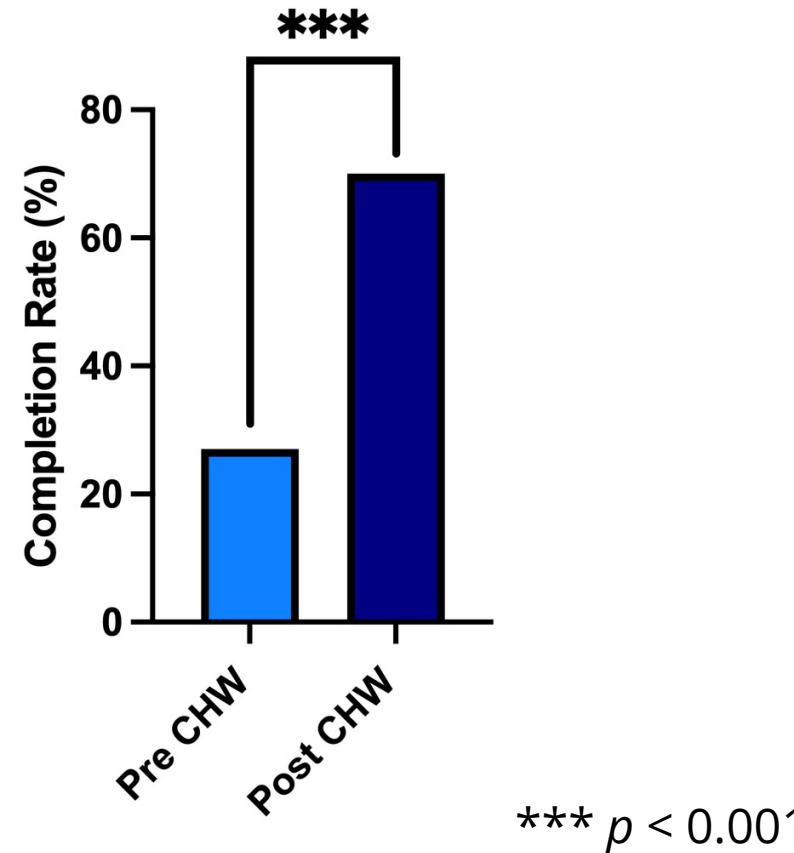
Fig. 4 CHW Integration Increased Imaging Completion

* $p < 0.05$
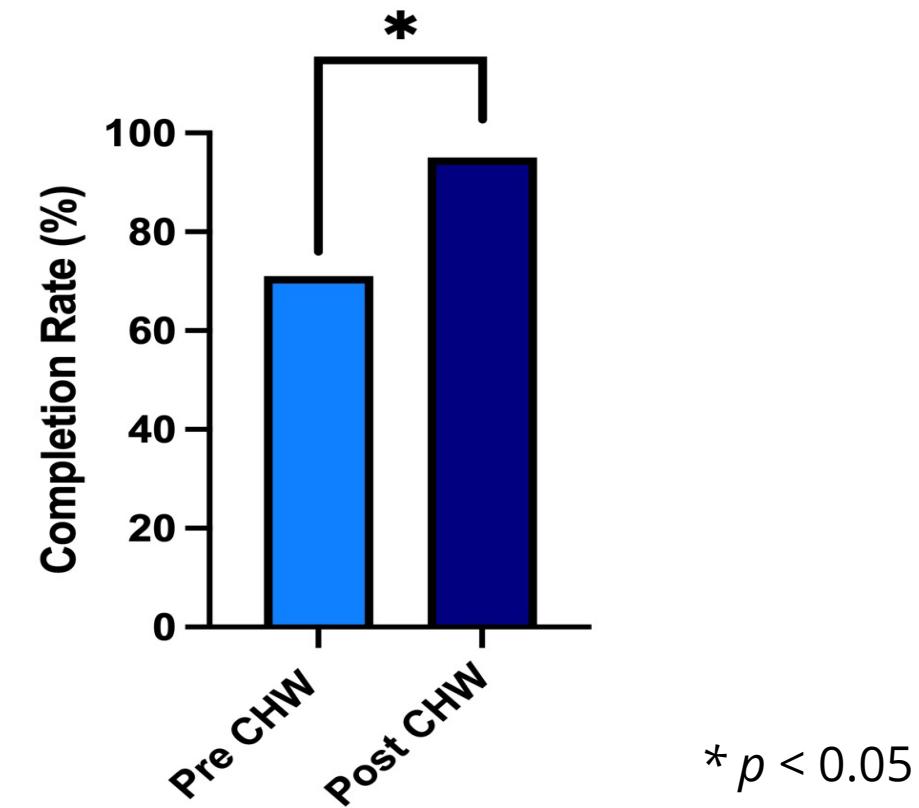
Facilitators
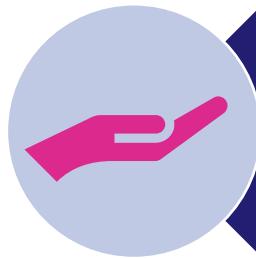
 Leadership support

 Perceived value

 Embedded geriatric workforce

Challenges

Providers and patients are not familiar with or aware of geriatric medicine

Financial sustainability

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Lessons Learned

- Importance of Leadership Support
- Need to Demonstrate Value to Different Audiences

Future Directions

- Partner with Community Organizations
- Expand Supportive Services

Conclusions

Geriatric care can be successfully brought into the HIV primary care clinic

The addition of a CHW to the geriatric interdisciplinary team improves team efficiency and coordination for patients

Meet Our Team

- Geriatric Physician
- Pharmacist
- Nurses
- Social Worker
- Community Health Workers

What We Do

- Discuss and assist with balance and mobility
- Future health planning
- Review medications
- Review overall functioning and daily activities
- Help with daily needs
- Evaluate memory
- And much more

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Q&A Session (20 minutes)

Presenter Contact Information

Centro Ararat, Inc.

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Mount Sinai Beth Israel

Angela Condo, MD

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Upcoming Webinars
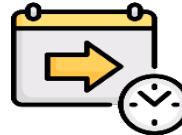
Webinar 5: Promoting Wellness for Aging Adults with HIV: Exercise, Nutrition, and Beyond

Date: July 28, 2025, 2:00pm – 3:00pm ET

Presented by: Wake Forest University Health Sciences & Empower U Inc.

Keep an eye on your inbox for a registration link!

Thank you!

Visit https://targetHIV.org/spns/aging for more information on the SPNS Aging with HIV Initiative.

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