Psychosocial Care & Supportive Services for People Aging with HIV

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

May 15, 2025

aging with HIV
Ryan White HIV/AIDS Program Initiative

Acknowledgment

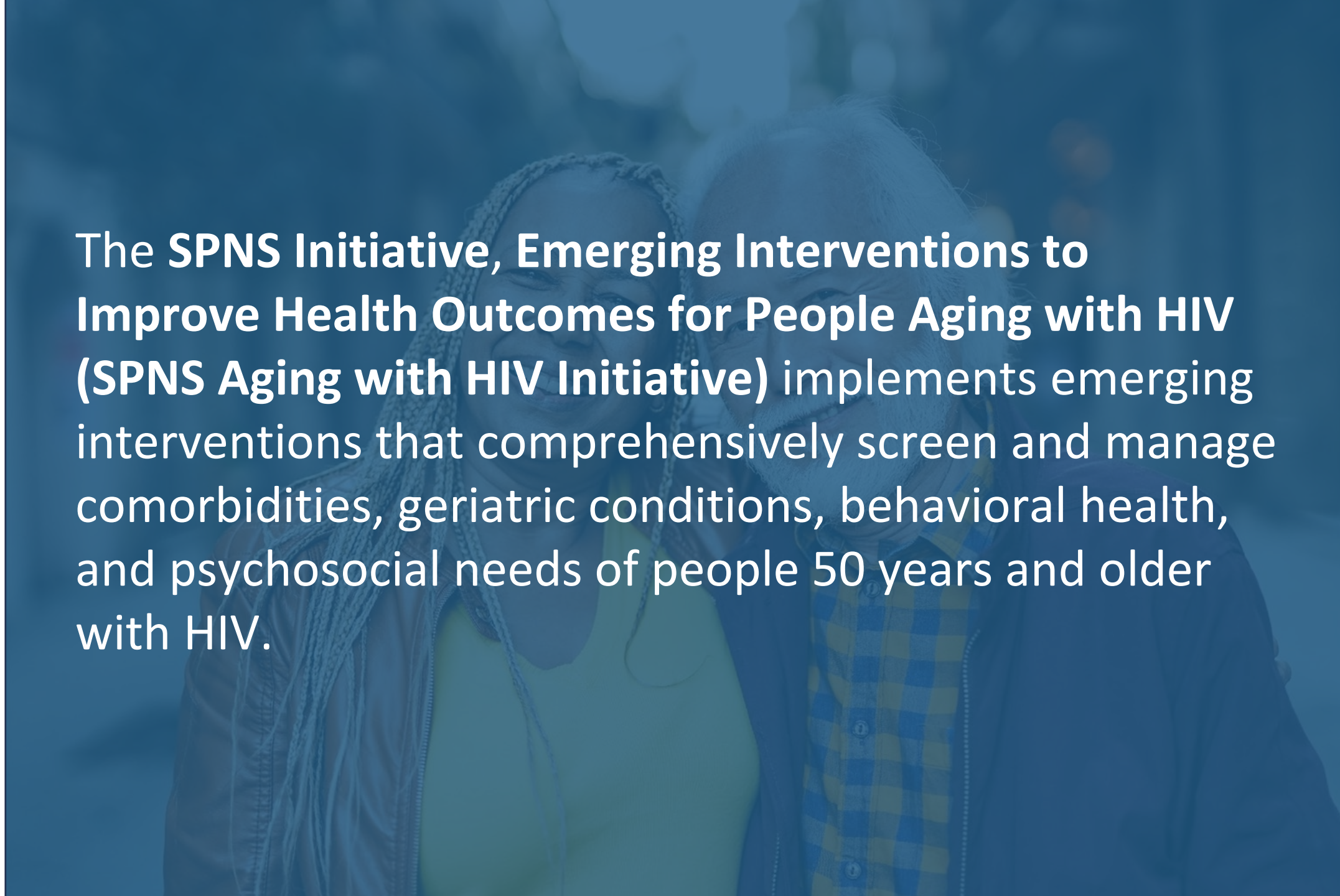
This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2,400,000 with zero percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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

- Welcome and Introduction
- Presentation by Colorado Health Network, Inc.
- Presentation by Family Health Centers of San Diego
- Question and Answer Session
- Upcoming Webinars & Closing



aging with HIV
Ryan White HIV/AIDS Program Initiative

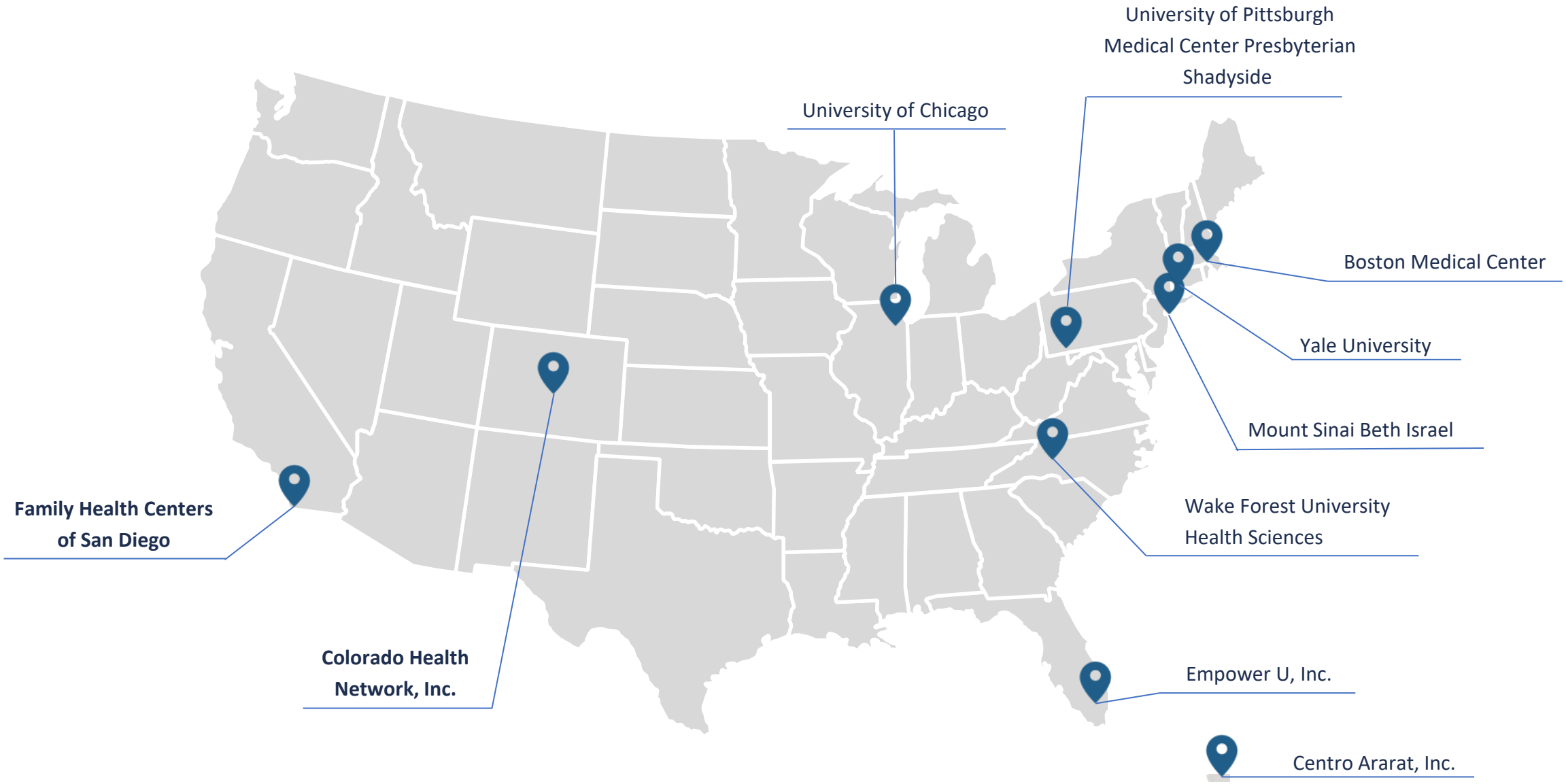
The **SPNS Initiative, Emerging Interventions to Improve Health Outcomes for People Aging with HIV (SPNS Aging with HIV Initiative)** implements emerging interventions that comprehensively screen and manage comorbidities, geriatric conditions, behavioral health, and psychosocial needs of people 50 years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

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.


University of Pittsburgh
Medical Center Presbyterian
Shadyside
University of Chicago
Boston Medical Center
Yale University
Mount Sinai Beth Israel
Wake Forest University
Health Sciences
Family Health Centers
of San Diego
Colorado Health
Network, Inc.
Empower U, Inc.
Centro Ararat, Inc.

Overview

Why Focus on Psychosocial Care and Supportive Services?

- Address the complexities of aging with HIV – increased comorbidities, chronic conditions, and social isolation
- Coordinate care
- Improve healthcare navigation
- Address needs that matter most to people aging with HIV

Colorado Health Network, Inc.

iCHANGE (**I**ntegrated **C**are for **H**ealthy **A**ging & **N**avigation of **G**eriatric **E**ffects):

A HRSA SPNS HIV & Aging Emerging Strategy

COLORADO HEALTH NETWORK INC.

aging with HIV

Ryan White HIV/AIDS Program Initiative

Erin Burk-Leaver
Director, Community Engagement
HRSA SPNS PI/PD

Haley Sanner
Healthy Aging Program (HAP) Manager
HRSA SPNS Co-PI

Janette Romero Saenz
Public Health Research Lead

Alexa Cousineau
Aging Services Coordinator

Presenters - Colorado Health Network, Inc.

Robert Riester
Client Services Manager
HRSA SPNS Patient Liaison

Monica Black
Geriatric Medical Case Manager (GMCM)

Alison Abraham, PhD*
Aging & HIV Research Specialist
HRSA SPNS Contractor

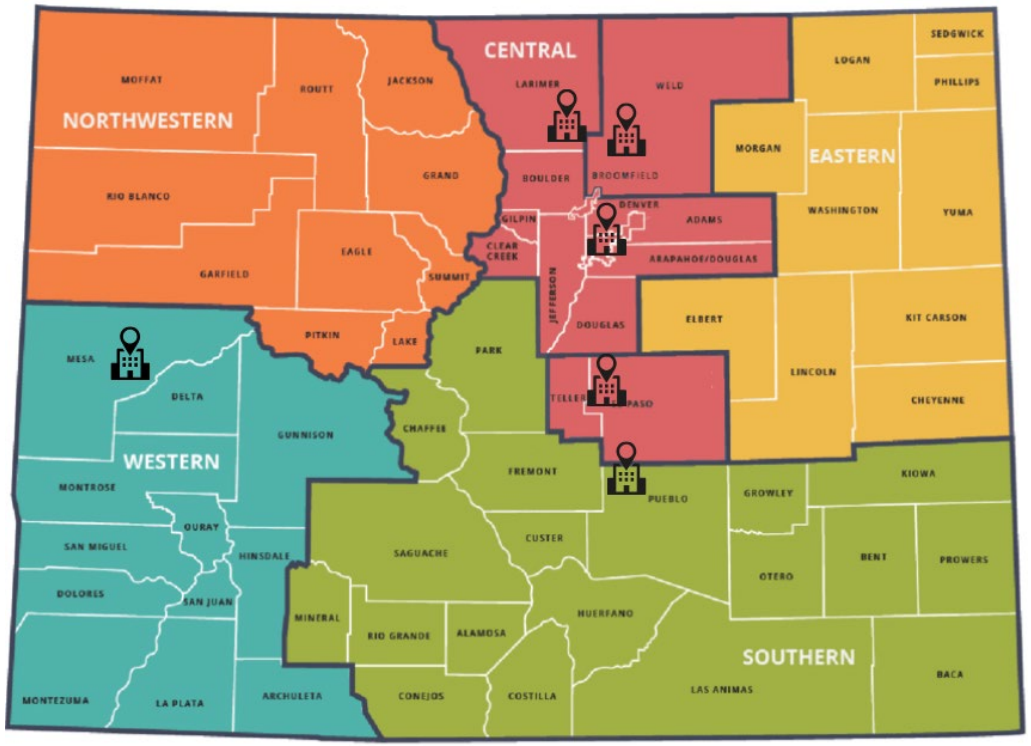
Kristine Erlandson, MD**
Aging & HIV Research Specialist
HRSA SPNS Contractor

***University of Colorado School of Public Health**

****University of Colorado Anschutz Medical**

Team Members & Partners – Colorado Health Network, Inc.

Colorado Health Network, Inc.



6 Regional Offices:

Denver, Colorado Springs, Pueblo, Greeley, Fort Collins, and Grand Junction

Statewide AIDS Service Organization

- **Serving 5,600 client living with HIV/AIDS**
- **Provide spectrum of services**
  - Medical Case Management
  - Housing Aid & Rental Assistance
  - Emergency Financial Assistance
  - Dental & Medical Care
  - Prescription Coverage (SDAP)
- **>50% clients are 50 years old or older with HIV**

iCHANGE Aims

- **Aim 1)** Integrate routine geriatric screening and care coordination for older (50+) people with HIV.
- **Aim 2)** Increase client's ability to age in place and improve overall quality of life with early detection of geriatric risks.
- **Aim 3)** Improve client-centered, specialized aging services, access, and navigation when seeking HIV care.

iCHANGE Process & Design

Intervention Process/Core Elements

1) **Train iCHANGE Personnel**
2) **iCHANGE Screener**
   - Geriatric 5Ms Model
3) **Care Plan Development (Milestones), Coordination, Referral**
4) **Milestone Tracking & Service Utilization**
5) **Follow-Up: iCHANGE Reassessment**

(2) iCHANGE Screener (Geriatric 5Ms Model)

- Multicomplexity
  - Intake (biopsychosocial)
- Mobility
  - Zibrio Balance Scale
  - HearWHO App
  - WHOEyes
  - Lawton Instrumental Activities of Daily Living (IADLs)
- Mentation
  - Montreal Cognitive Assessment (MoCA)
  - DeJong Loneliness Scale
  - Duke Social Support Index
  - Patient Health Questionnaire (PHQ-9)
- Medication
  - HIV Analogue Scale (HVAS)
- Matters Most
  - Elder Abuse Suspicion Index (EASI)
  - (Adapted) Serious Illness Conversation Guide

iCHANGE Core Elements

Care Plan and Milestones:

- **Co-Created with participants**
- **Review screener outcomes**
- **Discuss milestones to work towards:**
  - Example: Attending water aerobics to support balance and physical activity.
- **Complete interested referrals for external and internal programs:**
  - Example: Internal Behavioral Health Therapy referral or external Project AngelHeart application.
- **Coordination with care team:**
  - Example: Case manager, provider, etc.

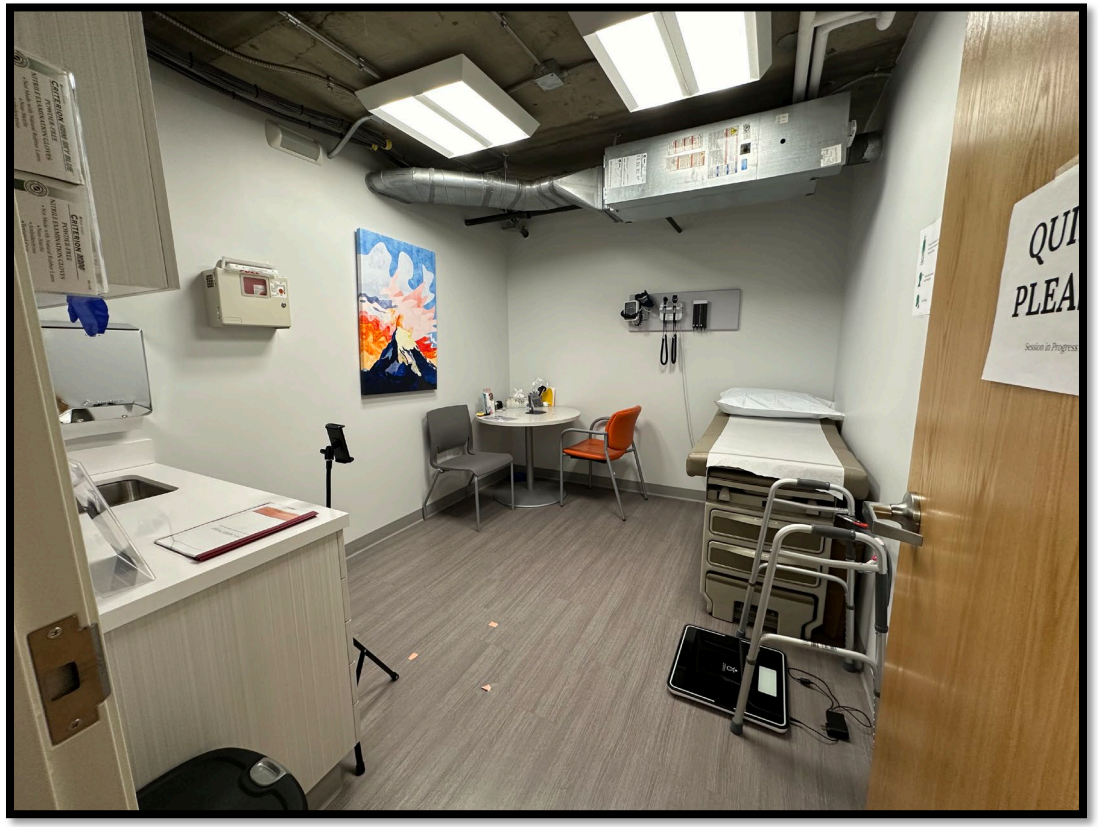
iCHANGE Reassessment:

1) **Review previous milestones**
2) **Complete mini intake**
3) **Repeat iCHANGE screeners**
4) **Schedule for Care Plan appointment**

Key Implementation Strategies:

1) **Collaboration with case managers for recruitment and continued care**
2) **Reciprocal loop with ongoing engagement through existing HAP programs.**
3) **Expanded criteria to include non- case managed individuals**

iCHANGE Process & Design



Case Study 1:

Screener:	iCHANGE #1:	Notes and Milestones:	iCHANGE #2:	Reassessment Notes:
Cognition:	21	Interest in getting back into reading	 26	**In Progress:** Utilize Kindle account to read 1 book per month
Depression:	6	Review Behavioral Health Resources Referral - Engage in 1-2 sessions within 90 days	 5	**Completed:** Engaged in weekly individual 1-hr counseling with referred organization
IADL's:	7	Dental challenges need extensive procedures and dentures; impacting eating	 8	**Completed:** Received CHN dental services and received new teeth, adjusting new foods
De Jong EL:	1	Interest in additional social opportunities and re-engagement with the community	 0	**Completed:** Completed 6-week psychosocial group. Attended an event with community
Matters Most:	Sobriety Support	Review Community Sobriety Resources (virtual & in-person) including AA meetings - Consider attending 1-2 weekly meetings.	N/A	**Completed:** Engaged in AA meetings for 90 days; completed 8-month weekly group therapy program;
Matters Most:	Case Management	Application for CHN Case Management referral	N/A	**Completed:** Actively engaged in CHN Case Management at CHN

Case Study 2:

Screener:	iCHANGE #1:	Updates and Milestones:	iCHANGE #2:	Reassessment Notes:
Cognition:	25	Get library card and continue participating in writing workshops	↑ 28	**In Progress:** Goal to publish a book, working with publisher and interested in starting a business based on life experience.
Depression:	4	Needs support navigating life stressors and interpersonal relationships – Complete Intake Referral to CHN Behavioral Health and engage within the month	↓ 2	**Completed:** Graduated from weekly CHN Behavioral Health services, with plans to complete co-created therapy goals.
DSSI:	10	Recently retired, experiencing isolation and transition	↑ 11	**In Progress:** Actively engaged in CHN's PATH2Wellness program including weekly walks, social circle and CHN' World AIDS Day Event
Matters Most:	Social & Mental Wellness	Experience as a psychosocial facilitator, engages in self-care including journaling, writing, and social activities, passionate about sharing these skills with others	N/A	**In Progress:** Worked with HAP to engage in peer leadership as a means of sharing and showcasing lived experience.
Matters Most:	Hearing	Audiology and Screening referral: Request PCP complete the referral process for hearing assessment.	N/A	**Completed:** Audiologist supported client in fixing their hearing aids at appointment - working to incorporate into daily life

Lessons Learned through iCHANGE

Individual Level: Empowering Clients

- Support clients in identifying and prioritizing what matters most to them.
- Promote self-advocacy and increased confidence in managing health.

Interpersonal Level: Reciprocal Approaches

- Strengthen mutual trust and communication through the PATH-iCHANGE/iCHANGE-GMCM approach.
- Foster collaboration by ensuring clients' voices are central in care planning.

Organizational Level: CHN-wide Integration

- Adopt a multidisciplinary approach to integrate geriatric and HIV care principles (iCHANGE-GMCM).
- Align internal referrals and external partnerships to reduce care fragmentation.

Leveraging Community Health Workers (CHWs)

- Expand CHW roles in delivering iCHANGE interventions, enhancing client engagement, and whole person-centered care.

Billing & Reimbursement Opportunities

- Utilize Medicare and Medicaid billing codes to sustain iCHANGE services, for fall risk assessments and chronic care management.
  - Demonstrate cost-effectiveness to secure ongoing funding and scalability of the program.

Future Direction of iCHANGE

Thank you!

Family Health Centers of San Diego, Inc.

Intensive Individualized Care Coordination to Enhance Health and Quality of Life for HIV-Positive Older Adults in San Diego, CA (I^2C^2)

aging with HIV
Ryan White HIV/AIDS Program Initiative

Stock photos. Posed by Models.

INTENSIVE INDIVIDUALIZED CARE COORDINATION OVERVIEW/GOALS

Client-level goals of the I2C2 program:

- Improve assessment and management of co- and multi-morbidities (including medical, cognitive, depression, and substance) to improve health status.
- Reduce social isolation using community partnerships and resources.

Structural goal of the I2C2 program:

- Improve the infrastructure of services for a population of focus of people aging with HIV with co- or multi-morbidities utilizing Intensive Care Coordination.

Intensive Individualized Care Coordination to Enhance Health and Quality of Life for HIV-Positive Older Adults in San Diego, California (I^2C^2)

- Comprehensively screens and manages medical and psychosocial co- and multi-morbidities, specifically heart disease, diabetes, kidney disease, depression, and substance use disorder, among older adults with HIV through intensive care coordination.
- Provides interdisciplinary staff training between Older Adult and HIV Services programs.
- Addresses the experiences of social isolation among older adults with HIV through intensive care coordination, individual socialization action planning, and staff training.

I^2C^2 Team

F. Garcia-Bigley, MHA
Project Director/PI

J. Kua
Program Manager/Trainer

A. Badeel
Program Coordinator/Trainer

J. Barajas, RN, BSN
Registered Nurse, Care Coordinator

S. Maldonado
Case Manager

D. Andras
Case Manager/Patient Liaison

V. Trang, MPH
Evaluation Manager

S. Watson, MS, MPH
Quality Improvement Liaison

Screening and intake

- Performed by case manager
- Confirm Program Eligibility
- Complete program screening (determine level of case management and program support needed)
- Provide an overview of the program and services provided
- Clarify expectations during the initial appointment
- Acquire or complete required program documentation and forms
- Review initial visit Program Forms
- Identify any missing documents needed
- Identify if isolation is a challenge

Comprehensive Assessment

Information collection tool that describes in detail the clients medical, physical, psychosocial, and social service's needs.

- Includes comprehensive assessment, individualized care plan, and possible referrals needed
- Isolation screening is conducted (Also asked in the initial program screening and WHO ICOPE)
- Initial individual Care Planning

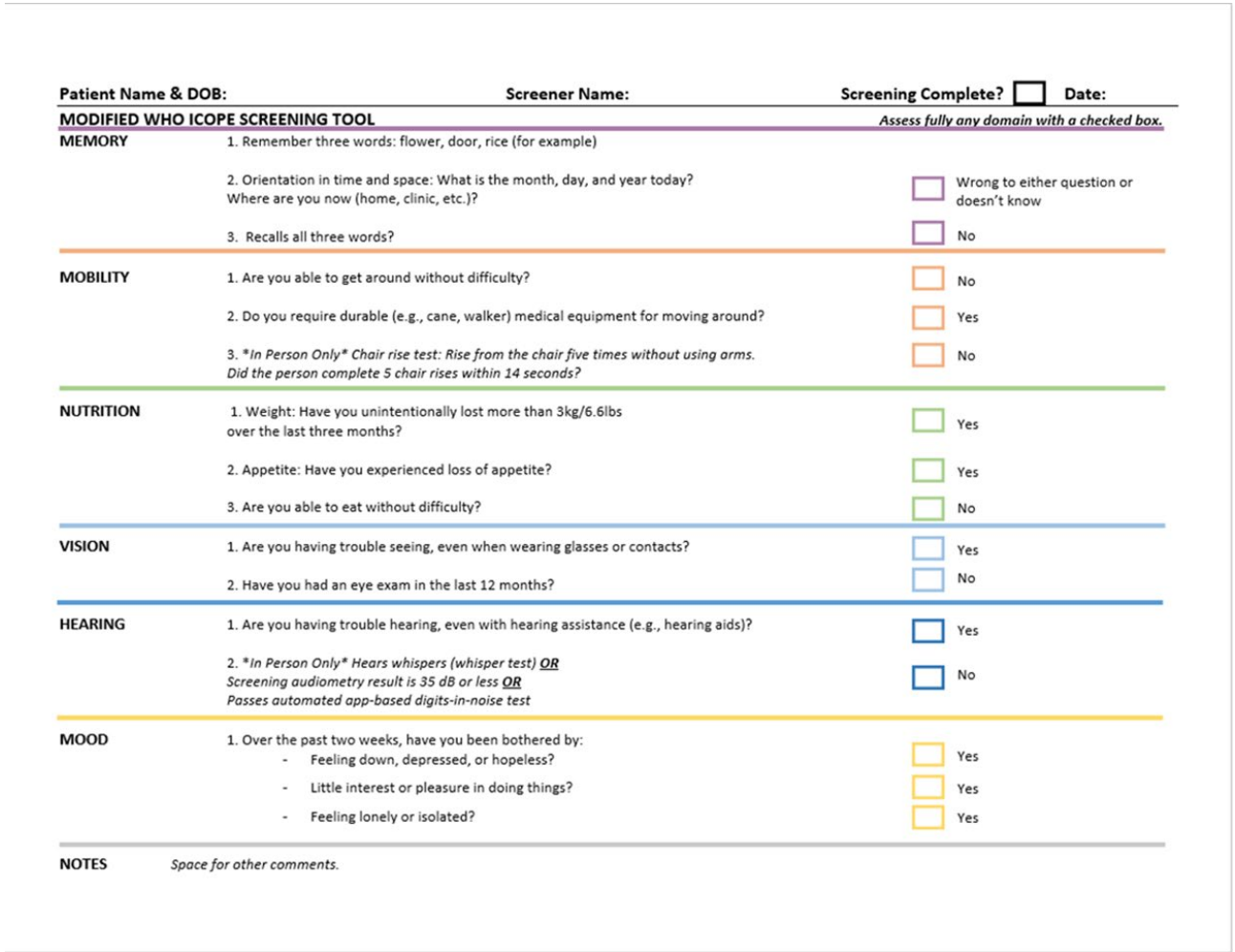
Registered Nurse, Care Coordinator (RNCC) Initial Assessment

Assessment gathers information regarding a whole person's wellness including medical, psychological, and sociological needs.

- Review electronic health record with participant
- Prioritize current needs
- Prioritize diagnoses needs
- Develop Wellness action steps (include barriers)
- Involve support staff and providers with follow up care
- Provide RNCC care planning

World Health Organization Integrated Care for Older People - Modified ICOPE Tool

- Guidance for person-centered assessment and pathways in primary care
- Tool utilized to address components of the 5 Ms (Medication, Mind, Mobility, Multi-complexity, and what matters most)
- May be implemented by a non-licensed care staff
- Allows for an additional layer in the care continuum for assessment.
- Supports normalizing discussions regarding Memory, Mobility, Nutrition, Vision, Hearing, Mood, and "What else?"



Patient Name & DOB: **Screener Name:** **Screening Complete?** ☐ **Date:**

MODIFIED WHO ICOPE SCREENING TOOL *Assess fully any domain with a checked box.*

MEMORY	1. Remember three words: flower, door, rice (for example)	
	2. Orientation in time and space: What is the month, day, and year today? Where are you now (home, clinic, etc.)?	☐ Wrong to either question or doesn't know
	3. Recalls all three words?	☐ No
MOBILITY	1. Are you able to get around without difficulty?	☐ No
	2. Do you require durable (e.g., cane, walker) medical equipment for moving around?	☐ Yes
	3. **In Person Only* Chair rise test: Rise from the chair five times without using arms. Did the person complete 5 chair rises within 14 seconds?*	☐ No
NUTRITION	1. Weight: Have you unintentionally lost more than 3kg/6.6lbs over the last three months?	☐ Yes
	2. Appetite: Have you experienced loss of appetite?	☐ Yes
	3. Are you able to eat without difficulty?	☐ No
VISION	1. Are you having trouble seeing, even when wearing glasses or contacts?	☐ Yes
	2. Have you had an eye exam in the last 12 months?	☐ No
HEARING	1. Are you having trouble hearing, even with hearing assistance (e.g., hearing aids)?	☐ Yes
	2. **In Person Only* Hears whispers (whisper test) **OR** Screening audiometry result is 35 dB or less **OR** Passes automated app-based digits-in-noise test*	☐ No
MOOD	1. Over the past two weeks, have you been bothered by: - Feeling down, depressed, or hopeless? - Little interest or pleasure in doing things? - Feeling lonely or isolated?	☐ Yes ☐ Yes ☐ Yes
NOTES	*Space for other comments.*	

Individualized Socialization Action Planning

- Identify Isolation as a barrier
- Client may self identify based on screeners
- Client discloses they do not have local community, relationships, partnerships, or support systems
- Client discloses other mental health challenges impacting quality of life and social connections
- Identify stage of change
- Initiate and develop socialization action plan

Intensive Care Coordination

- Coordinates and discusses next steps during weekly case conference
- Facilitated by Program Coordinator and RNCC. Standardized meeting agenda identifies time used to check in, review programming, identify challenges, problem solve, and case conference patient supports.
- RNCC delegates tasks to team relating to identified patient needs.
- I^2C^2 Case Manager (CM) assists with transportation scheduling, home-visits, checking referral updates, calling clients, and assisting RNCC with daily tasks.
- For clients with urgent Ryan White HIV/AIDS Program needs, RNCC schedules case conferences with existing CM for expanded coordinated support.
- Patient Liaison supports the participant with reminder calls and accompanies RNCC or CM on home and non-FHCSD clinical and social services visits.

Case Study Participant A

Background

- 64-year-old male
- Relocated from Washington in 2022
- Connected with medical case management and found permanent housing
- Missed having his Spanish HIV support group
- Encountered additional issues with housing and medical care

Assessment

- Comorbidities: Hypertension (HTN), Coronary Artery Disease (CAD), dyslipidemia, Type II Diabetes (DMII), and history of Myocardial Infarction (MI)
- Isolation: attends church, but has not been able to find a support system since his move to San Diego
- Mental health: depression; anxiety (exacerbated with increase in stress levels, particularly when learning to manage multiple medical conditions and find new housing)

Case Study Participant B

Background

- 62-year-old male, previous case management
- Inconsistent medical care and case management
- Reconnection to PCP and CM post release
- Referred to I^2C^2 post release

Assessment

- Comorbidities: hypertension, polyneuropathy, Type 2 diabetes, chronic kidney disease - stage 3, heart failure, obesity, osteoarthritis, chronic back pain
- Low health literacy (barriers navigating health systems)
- Disability: unable to work
- Isolation: lack of community post release

Lessons Learned

Best practices for integrating supportive care, addressing mental health, and ensuring that aging adults with HIV receive comprehensive psychosocial and support services.

- Allow the RNCC to be at the helm and lead the process.
- Partner with and utilize community resources.
- Be client centered and meet them where they are at.

Integration of Modified ICOPE Tool

- Integrate modified ICOPE tool into standard intake for case management for all older adult clients

Continued partnerships to support efforts addressing social isolation

- Formalize partnerships with local organizations identified as resources for addressing social isolation
- Leverage internal resources and peer group momentum to strengthen community

Future Direction of I^2C^2

Thank you.

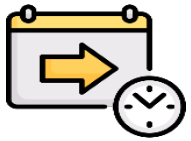
Q&A Session (20 minutes)

Contact Information

Colorado Health Network, Inc.
Erin Burk-Leaver
(e) Erin.Burk-Leaver@coloradohealthnetwork.org
(p) 303.962.5336

Haley Sanner
(e) Haley.Sanner@coloradohealthnetwork.org
(p) 303.962.4466

Family Health Centers of San Diego
John Kua
(e) johnk@fhcsd.org
(p) 619-798-3634

Upcoming Webinars 

Webinar 3: Promoting Wellness for Aging Adults with HIV: Exercise, Nutrition, and Beyond

Date: TBD

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

Webinar 4: Personalized Care in HIV and Aging

Date: TBD

Presented by: Centro Ararat, Inc. and Mount Sinai Beth Israel

Webinar 5: Optimizing Medication Management of People Aging with HIV

Date: TBD

Presented by: Boston Medical Center and UPMC Presbyterian Shadyside

Keep an eye on your inbox for registration links!

Thank you!

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