Implementation of an HIV and Aging Clinical Program

October 5, 2019

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Disclosures

- Grant support from Gilead Sciences
- Grant support from NIA

Overview

In depth look at developing a program:

-Formative evaluation

-Current operations and evaluation

-Future directions

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Context: San Francisco & Ward 86

- 67% of PLWH Age 50+

	Total	10,691
Gender[1]	Men	9,953 (93)
	Women	563 (5)
	Trans Women	172 (2)
Race/Ethnicity	White	6,983 (65)
	African American	1,283 (12)
	Latinx	1,657 (15)
	Asian/Pacific Islander	438 (4)
	Native American	39 (0)
	Other/Unknown	291 (3)
Transmission Category	MSM	7,994 (75)
	TWSM	73 (1)
	PWID	650 (6)
	MSM-PWID	1,411 (13)
	TWSM-PWID	97 (1)
	Heterosexual	333 (3)
	Other/Unidentified	133 (1)

- Part of San Francisco Health Network Clinics (safety net system)
- Ryan White funding recipient
- 2400 publically insured and uninsured PLWH

  >1200 are age 50 or older

Photo: Steve Ringman

Development of a designated HIV & Aging care program in San Francisco

1) Literature review

2) Demonstration/pilot program (Silver Project)

3) Surveys and focus groups with patients and providers --- stakeholder engagement

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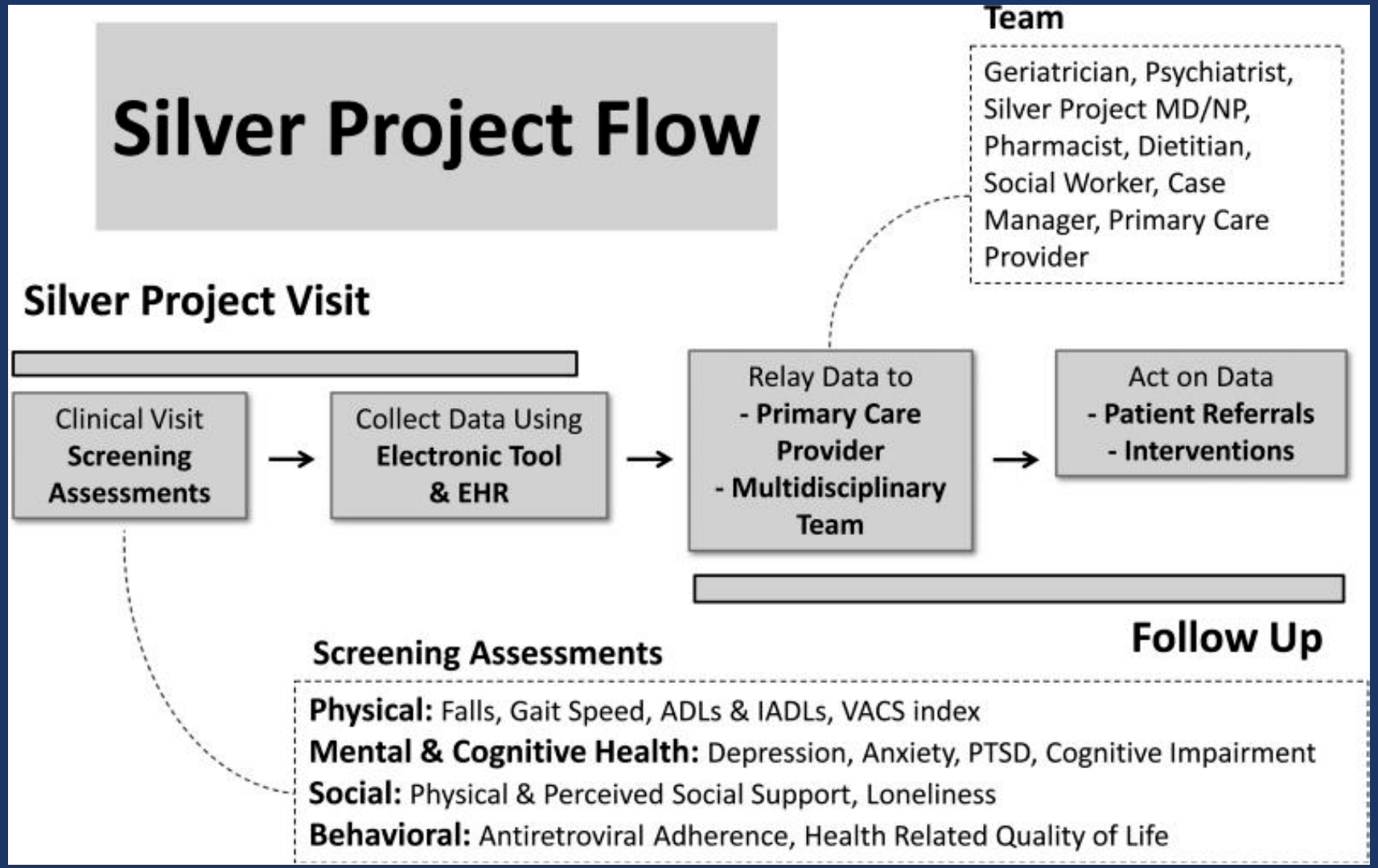
Silver Project: 2012-2014



Greene M & John M. *JAIDS* 2016

Patient and Provider Perspectives on Geriatric Assessments

Patients	Providers
• Depression	• Falls
• HIV Med Adherence	• Memory
• Social Support	• Depression
• Falls	• Function
• Memory	• Loneliness
• Function	• HIV Med Adherence

Greene M, PLOS One 2018

Themes from Focus Groups

- Four overarching themes:
  1) Knowledge of HIV and aging topics
  2) Health/aging needs for Older HIV+ adults
  3) Importance of Social Networks
  4) Need for integrated services
     -consultative services

- Program name: theme of navigation healthcare systems; “golden years” acceptable term for aging

Greene M, PLoS One 2018

Golden Compass: Helping PLWH Navigate their Golden Years

NORTHERN POINT:
Heart and Mind
Components: Cardiology clinic on-site, brain health and memory classes, cognitive assessment testing

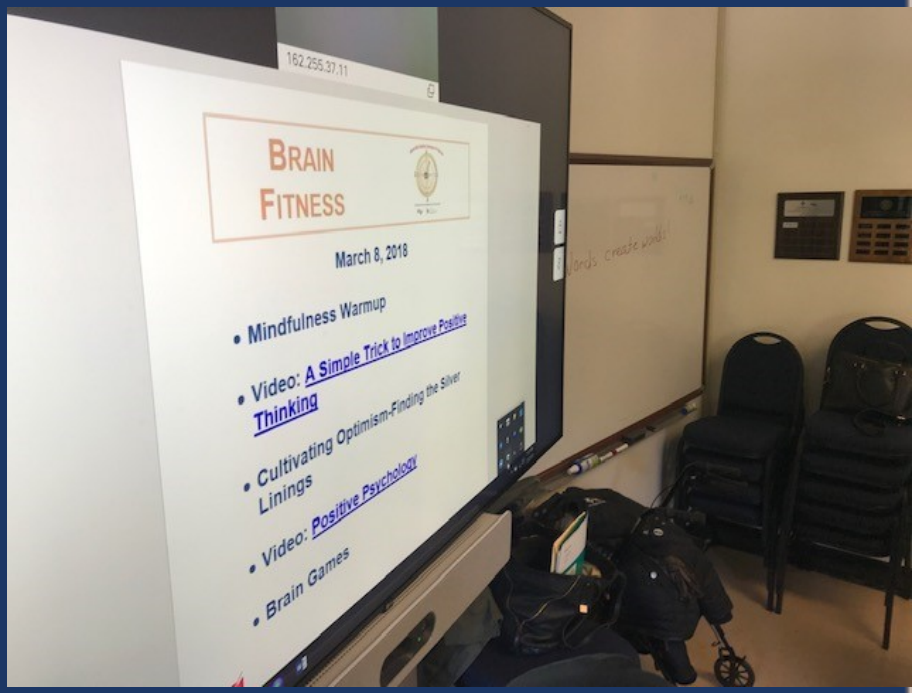
WESTERN POINT:
Dental, Hearing and Vision
Components: Medical assistant navigation to these three services

EASTERN POINT:
Bones and Strength
Components: Frailty and fall assessments, chair exercise classes, DEXA machine on-site (coming)

SOUTHERN POINT:
Network and Navigation
Components: Social support groups, link with community programs, peer navigators and helpers

Greene M, PLOS One 2018

Current Operations



- **Northern Point (Heart & Mind)**
  - Monthly cardiology clinic by HIV-cardiologist Dr. Hsue
  - Recurrent offerings Brain Health Classes
  - Cognitive screenings and assessments in geriatrics clinic

- **Western Point (Dental, Hearing, & Vision)**
  - Screenings & linkage to services to address sensory impairment

Current Operations

- **Eastern Point (Bones & Strength)**

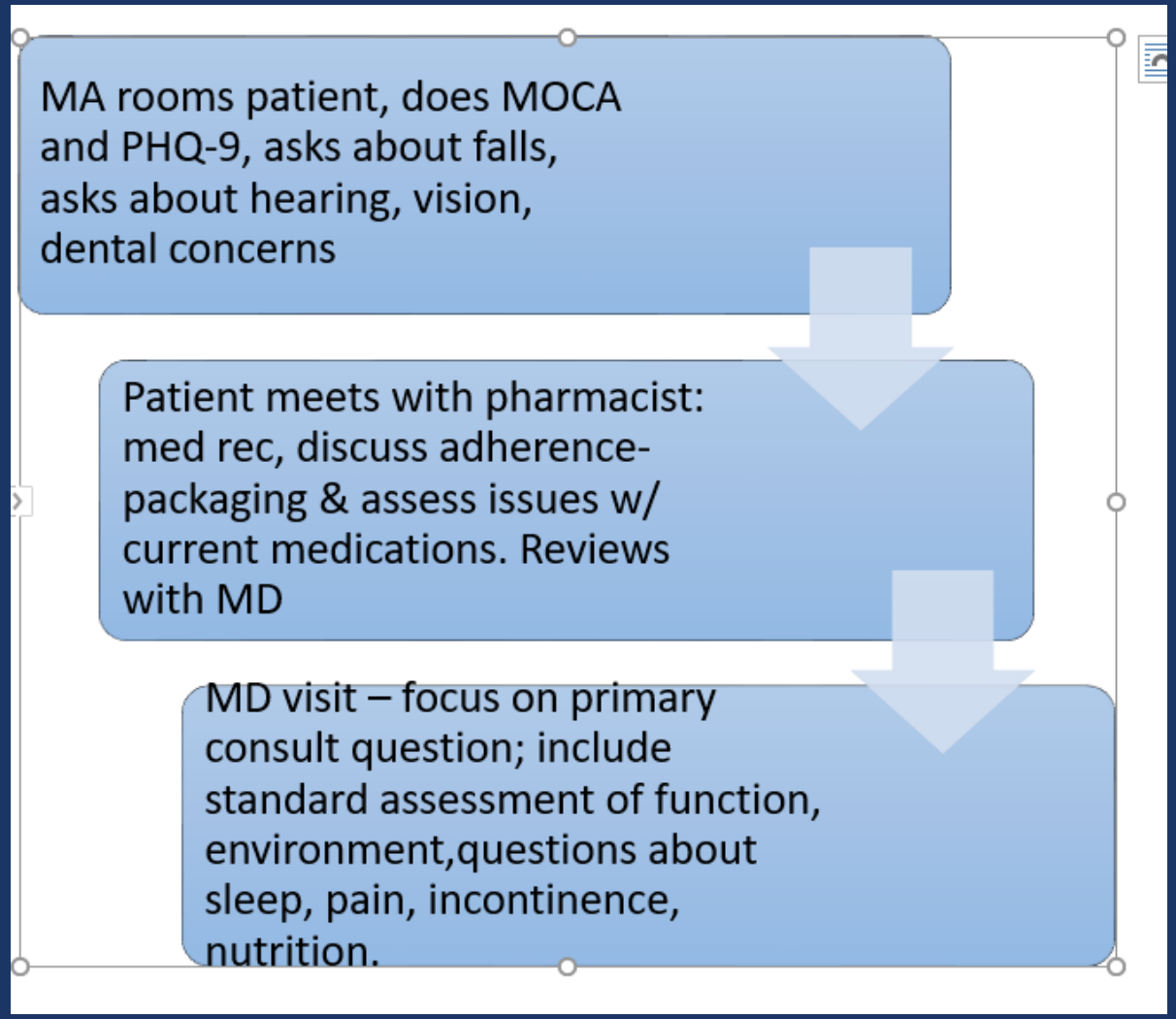
-Assess functional status geriatrics clinic

-Weekly chair based exercise class “Wellness Club”

- **Southern Point (Networking & Navigation)**

- Coordinate with community partners/services
- Networking in classes

Geriatrics Clinic in Golden Compass



Common reasons for referral:

- General evaluation
- Cognition
- Falls

Initial Evaluation of Golden Compass

RE-AIM framework:

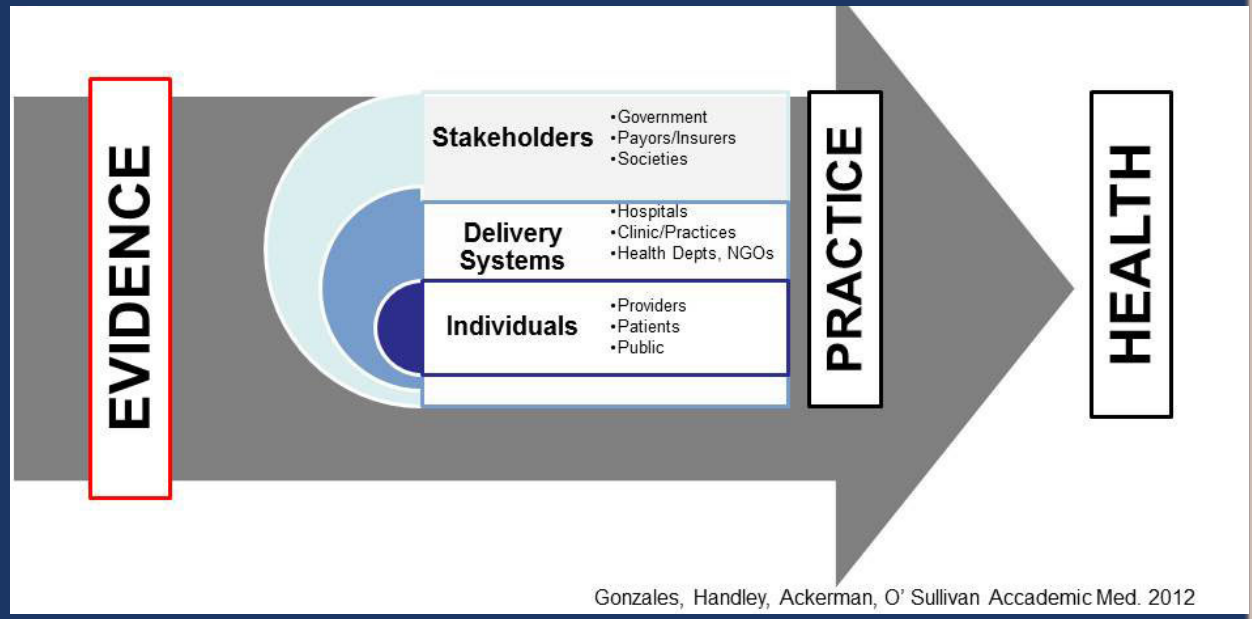
Reach: number/demographics participants

Effectiveness: satisfaction, acceptability

Adoption: referrals by providers

Implementation: fidelity to what proposed

Maintenance



Gonzales, Handley, Ackerman, O' Sullivan Accademic Med. 2012

Greene M, publication under review

Initial Evaluation of Golden Compass

Reach: >200 in 1.5 years

Effectiveness:

Acceptability: 96% would recommend to another person

Satisfaction with services: >90% very satisfied/satisfied

Meds, mobility, cognition (mind) appreciated

Greene M, publication under review

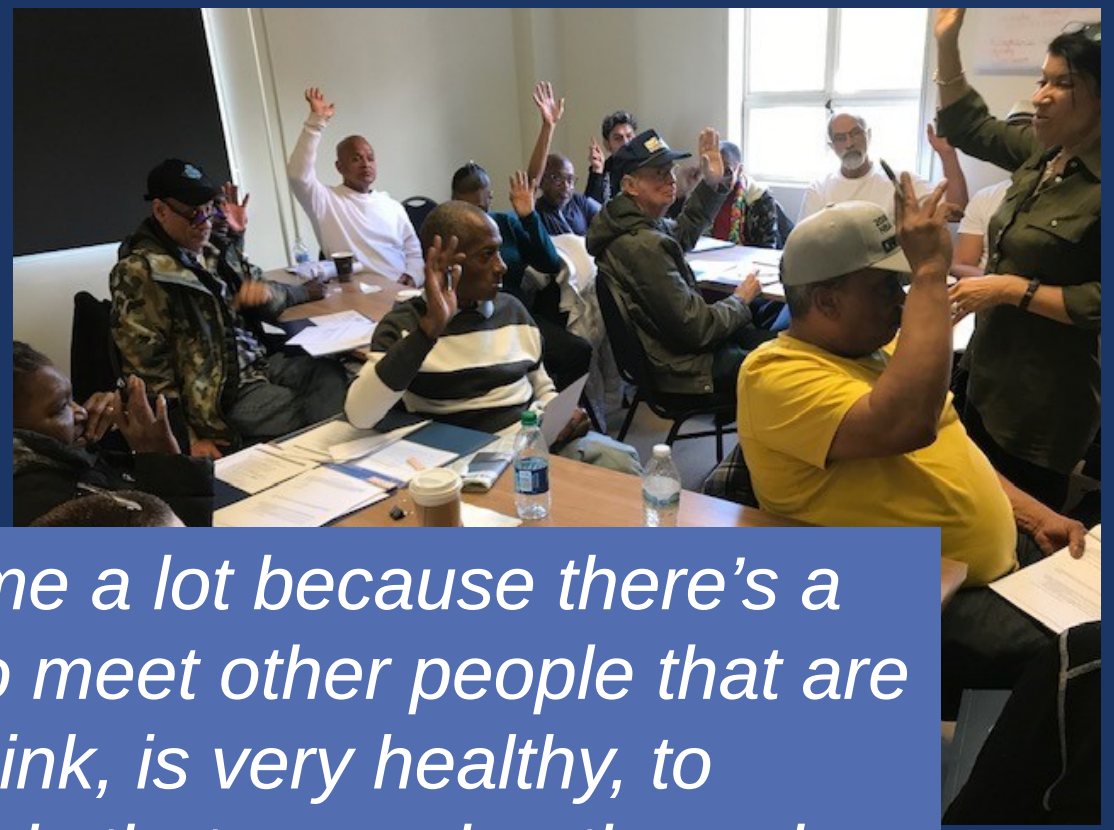
Initial Evaluation of Golden Compass

- Adoption- 85% of providers referred ≥ 1 patient to geriatrics clinic

- Implementation- implemented largely as intended
  - Co-location of services helpful

Greene M, publication under review

Southern Point- Fostering New Connections



On classes: *“….helped me a lot because there’s a social aspect to it, I get to meet other people that are just like me, and that, I think, is very healthy, to connect to other individuals that are going through the same things that I'm going through.”*

One story

- 62 y/o Latino male, long term survivor
  - Geriatrics clinic: dizzy; bp/prostate meds adjusted & dizziness resolved
  - Grieving loss family member; isolated : connected to volunteer who still meets with him weekly
  - Highly engaged in all classes

Reflecting on improvements in both physical and mental health: *“I’m in a good place compared to how I was before I started in the program.”*

Lessons Learned

- Framing still challenge– stigma of aging & geriatrics
  -Staying healthy as living longer with HIV

- Challenges for the field
  – Should everyone over 50 be seen/who benefits most
  – Role of consultant

Future Directions

Expand program reach

- E-consult/chart review
- Expanded screenings done by RNs

- Increasing knowledge providers & patients
  - Partnering with Geriatrics Workforce Enhancement Program

Summary

- Adapting services to meet the needs of aging HIV+ population critical
- Stakeholder engagement & local resources important in developing program
- Implementation science frameworks to help guide development and evaluation of programs

Acknowledgments

Patients, providers & staff at Ward 86

Monica Gandhi, MD, MPH

Diane Havlir, MD

Mary Lawrence Hicks, NP

Mary Shiels, RN

Bill Olson, MS

Janet Grochowski, PharmD

Yenifer Breganza Lopez

Priscilla Hsue, MD

Judy Tan, Janet Myers, Cinthia Blat

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Thank you!

Questions?