# Guidance: Addressing the Needs of Older Patients in HIV Care

*May 2023*

| Box 2: Six Steps to Integrating Needs of Older Patients Into HIV Medical Care |
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| **1. Assess the clinic's ability to meet the needs of older patients with HIV:** |
| • Review the demographics of the patient population to identify the number of patients in need of aging-related services at present and in the near- and long-term. <br> • Track patient requests for aging-related services and identify options for responding to those requests. <br> • Identify resources needed to address any aging-related priorities identified by a community or clinic advisory board. <br> • Identify clinic care providers who are experienced in geriatrics or the care of older patients. <br> • If the clinic is not able to provide multidisciplinary, comprehensive services, identify how the clinic can assist patients in accessing needed services. <br> • Anticipate problems with finances and insurance coverage for those approaching age 65 (earlier for those on disability) who are transitioning to Medicare. |
| **2. Engage older patients with HIV in program planning:** |
| • Provide ample opportunities for patients and clinical care providers and staff to identify needs to be addressed. This is an essential step for programs of any size. The University of California San Francisco used extensive patient input to develop its Golden Compass program for older individuals with HIV [Greene, et al. 2015]. <br> • Provide opportunities for discussion of ageism and stigma, so patients and clinical care providers and staff can understand and identify its effects and how to address them. <br> • Develop a wish list of services and be realistic about what is possible. Set goals and a timeline for program development. |
| **3. Consider options and develop protocols for identifying patients in need of aging-related care and services. For example, patients may be identified based on:** |
| • Age: At base, a clinic can implement a policy that all patients with HIV who are ≥50 years old should undergo general screening; the clinic might also create a protocol that would add more focused and detailed screening (e.g., for memory or gait) to be initiated at an older age. <br> • Prognosis, such that a prognostic threshold for referral is established based on measures such as the Veterans Aging Cohort Study (VACS) Index Calculator <br> • Clinical criteria, such as a recent history of falls, deteriorating memory, polypharmacy, or frailty <br> • Patient request |
| **4. Develop an assessment strategy:** |
| • Identify who will perform assessments and how results will be communicated to patients and other care providers involved with the patient. <br> • Determine the scope of assessment: Will it focus on one particular problem (e.g., gait disorders, cognition), or will assessment address a broad array of problems? Examples of assessment types include the following: <br>    – **Global simple geriatric screening tools:** Global geriatric screening tools are available for administration by clinical staff or patient self-administration, at home or in the clinic. Dedicated time for assessment may be scheduled as part of primary care, following a model such as the Medicare Annual Wellness Visit [CMS 2022]. <br>    – **Comprehensive assessment:** Some clinics may collaborate with aging specialists, such as geriatricians or nurse practitioners who specialize in gerontology and can perform a more detailed geriatric assessment as a consultation. <br>    – **Specific screening tools:** If a clinic has decided to focus on specific assessments, these can be built into the workflow. For example, a clinic may determine that all patients ≥55 years old will be screened for fall risk and cognitive impairment. In this case, patients could be asked to complete a fall-risk evaluation, such as the Centers for Disease Control and Prevention STEADI Algorithm for Fall Risk Screening, Assessment, and Intervention, before the visit, or a nurse could administer a timed walk test while the patient is walking from the waiting room to the exam room. <br>    – Any of the domains listed in Table 1: Assessment Domains for Older People With HIV and Selected Tools and Resources would be appropriate for inclusion in a program to enhance the care of older individuals with HIV. |

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| **5. Develop protocols for referral:** |
| • Identify aging-related care and services that can be provided on-site and care and services that require referral to an external source. Referral protocols can be problem-specific. For example, if a patient is assessed as being at high risk for falls, the clinic should take a standard approach to address that risk, which could include referral to physical therapy, podiatry, or neurology; medication review; home safety assessment; and/or an exercise program. <br> • Identify local specialty care providers to whom patients can be referred. |
| **6. Link to the Aging Network for services:** |
| • Connect individuals with HIV who are ≥60 years old to the Aging Network, an interconnected group of agencies that assists older adults in living independently. The Aging Network was initiated through the Older Americans Act of 1965 [National Health Policy Forum 2012]. <br> • Become familiar with locally offered services and assist clients in preparing for the transition to Medicare when medication benefits and care coordination change. |

**References**

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