YOUR ICHANGE JOURNEY

Next steps to support your health, your goals, and what matters most!

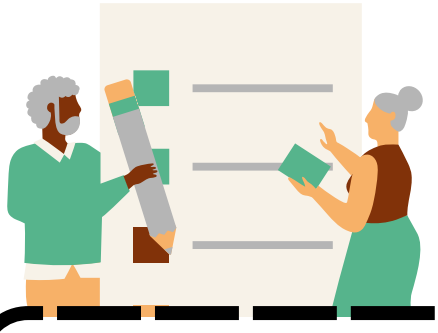
What is iCHANGE? iCHANGE, or **Integrative Care for Healthy Aging & Navigation of Geriatric Effects**, is a program that helps you and your care team build a plan for aging well with HIV.

iCHANGE Step-by-Step Guide for Healthy Aging w/ HIV

Use this journey map to guide you through the **iCHANGE Program**.

1

Complete the iCHANGE Screener
With your HIV provider



2

Review your needs and priorities
Talk with your HIV provider about what matters most to you

3

Use your iCHANGE care plan to create goals
Choose what health goals you would like to prioritize and take steps to make it happen

4

Connect to helpful services and resources
Receive referrals, tools, and support to achieve your milestones

5

Feel Empowered!
Take charge of your health and use supportive services as needed

Talk to your HIV provider about how the **iCHANGE Program** can support your health and goals as you age.

THE ICHANGE PROJECT:
Optimizing Aging w/ HIV Through an Integrative Geriatric Approach

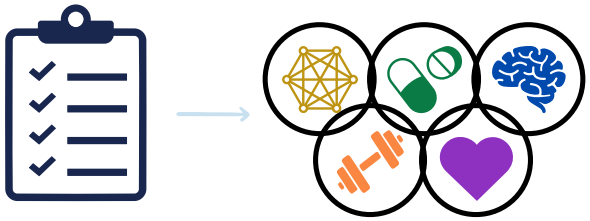
What is the iCHANGE Project?

The **iCHANGE (Integrative Care for Healthy Aging and Navigation of Geriatric Effects) Project** is a nationally recognized initiative that integrates geriatric principles into HIV care for people aging with HIV aged 50 years and older, using the **Geriatric 5Ms Framework**—**Multicomplexity**, **Medications**, **Mentation**, **Mobility**, and **Matters Most**—to assess and support their evolving needs.

The iCHANGE Project includes two key components:

PART 1 : iCHANGE Screener

A geriatric-informed screening process using evidence-based tools to identify aging-related risks across the 5Ms.



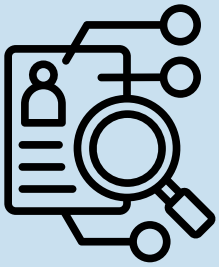
PART 2: Personalized Care Planning

Co-created care plans and milestone tracking tailored to each client's goals, values, and health needs.

Collaborate **Milestones** **Progress**

What are the iCHANGE objectives?

SCREEN



Offers comprehensive geriatric screenings for older people with HIV at the community level.

EMPOWER

Supports early risk detection and client self-advocacy for aging in place.

CONNECT

Improves access to specialized, client-centered aging services and coordinated care.

iCHANGE reimagines HIV care to reflect the realities of aging with HIV, offering providers a framework to address the multiple needs of older people with HIV and promote quality of life as they age.

Scan to see how iCHANGE supports **whole-person care** for older people with HIV.

ICHANGE PROJECT PROCESS MAP

Led by Colorado Health Network's Healthy Aging Programs with the University of Colorado Anschutz Medical and School of Public Health, and funded by HRSA SPNS HIV & Aging Initiative.

PART 1: ICHANGE SCREENER

Supporting Aging-Informed HIV Care Using the Geriatric 5Ms

Part 1 of the iCHANGE Project begins with a holistic screening process to identify the unique health needs of older people with HIV. This screener draws on validated tools to assess key areas that impact aging and well-being. The following section outlines five core domains we evaluate—each guided by principles of geriatric care—and highlights the specific screeners used within each.

Domain 1: Multicomplexity

Measures complex **biopsychosocial** factors related to HIV & aging health.

Domain 2: Mobility

Falls in People with HIV

12%-41%

FACT: The prevalence of falls in older people with HIV. They are **2-3X** more likely to experience fractures, increasing fall risk.

Measures the interactions between **physical function, fall risk, vision, hearing, & instrumental activities of daily living** (IADLs). Screening tools include:

- **Zibrio Balance Scale**
- **HearWHO**
- **WHOeyes**
- **Lawton IADLS**

Domain 3: Medication

Polypharmacy, HIV, & Aging

FACT: Polypharmacy is common among older people with HIV, with reported rates ranging from **15% to 94%** across studies.

Measures **prescribed medications, and HIV treament adherence** to identify risks related to polypharmacy & potential drug-drug interactions. Screening tools include:

- **HIV Treatment Adherence Visual Analog Scale**

Domain 4: Mentation

Cognitive & Functional Health

FACT: **~40%** of older people with HIV experience mild to moderate cognitive impairment due to increasing age and living with HIV.

Assesses key factors of mental and emotional well-being, including **cognitive status, depressive symptoms, perceived loneliness, & social support.** Screening tools include:

- **Montreal Cognitive Assessment**
- **Patient Health Questionnaire**
- **DeJong Loneliness Scale**
- **Duke Social Support Index**

Domain 5: Matters Most

Dignity in End of Life

FACT: Advance directives ensure medical wishes are respected if a client becomes unable to speak for themselves.

Measures **personal values, health goals, and care preferences to guide decision-making** and align services with what matters most to the individual. Screening tools include:

- **Elder Abuse Suspicion Index**
- **(Adapted) Serious illness Conversation Guide**

"It felt good to be seen as a whole person—not just my HIV. The questions made me think about my life, my goals, and what really matters as I age."

~ iCHANGE Participant, 67, Female

CONTINUE TO PART 2: PERSONALIZED CARE PLANNING

PART 2: PERSONALIZED CARE PLANNING

Supporting Aging-Informed HIV Care Using the Geriatric 5Ms

Part 2 of the iCHANGE Project builds on screening outcomes to develop a client-centered care plan that identifies key goals, sets realistic milestones, and connects older people with HIV to aging-related services. This process ensures that care aligns with the client's values, priorities, and well-being as they age.

Centering What "Matters Most": Step-by-Step Care Planning

A collaborative **4-step process** rooted in client goals, values, and health needs.

STEP 1: IDENTIFY CLIENT PRIORITIES

To Do: Review the iCHANGE screener outcomes together.

- Prioritize outcomes based on client values and needs.

Ask the Client: "What matters most to you based on your screener results"

STEP 2: CO-CREATE MILESTONES

To Do: Collaboratively define short- & long-term milestones.

- Link to one or more of the Geriatric 5M domains.

Ask the Client: "What do you want to work on to support your goals, values, & aging needs?"

STEP 3: DEVELOP AN ACTION PLAN

To Do: Identify steps, referrals, resources for each milestone.

- Ensure steps are appropriate, realistic, and achievable.

Ask the Client: "What kind of support would be most helpful for reaching this goal?"

STEP 4: TRACK PROGRESS

To Do: Schedule regular check-ins to monitor progress and update goals as needed.

- Adjust plan based on evolving needs.

Ask the Client: "How are you doing in achieving your milestones?"

Example iCHANGE Care Plan

GERIATRIC 5M DOMAIN	MILESTONE IDENTIFIED	ANTICIPATED COMPLETION DATE	RESOURCES/ REFERRAL	PROGRESS
MATTERS MOST	**End-of-Life Planning**: Complete Advanced Directive	06/15/2025	Colorado Legal Services	**In progress**: Appt. made w/ counselor
MENTATION	**Address Depression**: Seek Behavioral Health Counseling	05/19/2025	CHN Behavioral Health	**Pending**: Schedule appt. w/ client
MOBILITY	**Improve Balance**: Attend at least one (1) group exercise class	05/01/2025	Center on Colfax	**Complete**: Attended group yoga (4/30/2025)

For information about the iCHANGE Project, implementation support, or access to iCHANGE tools, contact:

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