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Heart and Brain Health Quality Improvement Campaign Kick-Off Meeting

Allie Hypes, MPH and Dan Belanger, MSW
John Wikiera and Dana Diamond

EDCC Approved

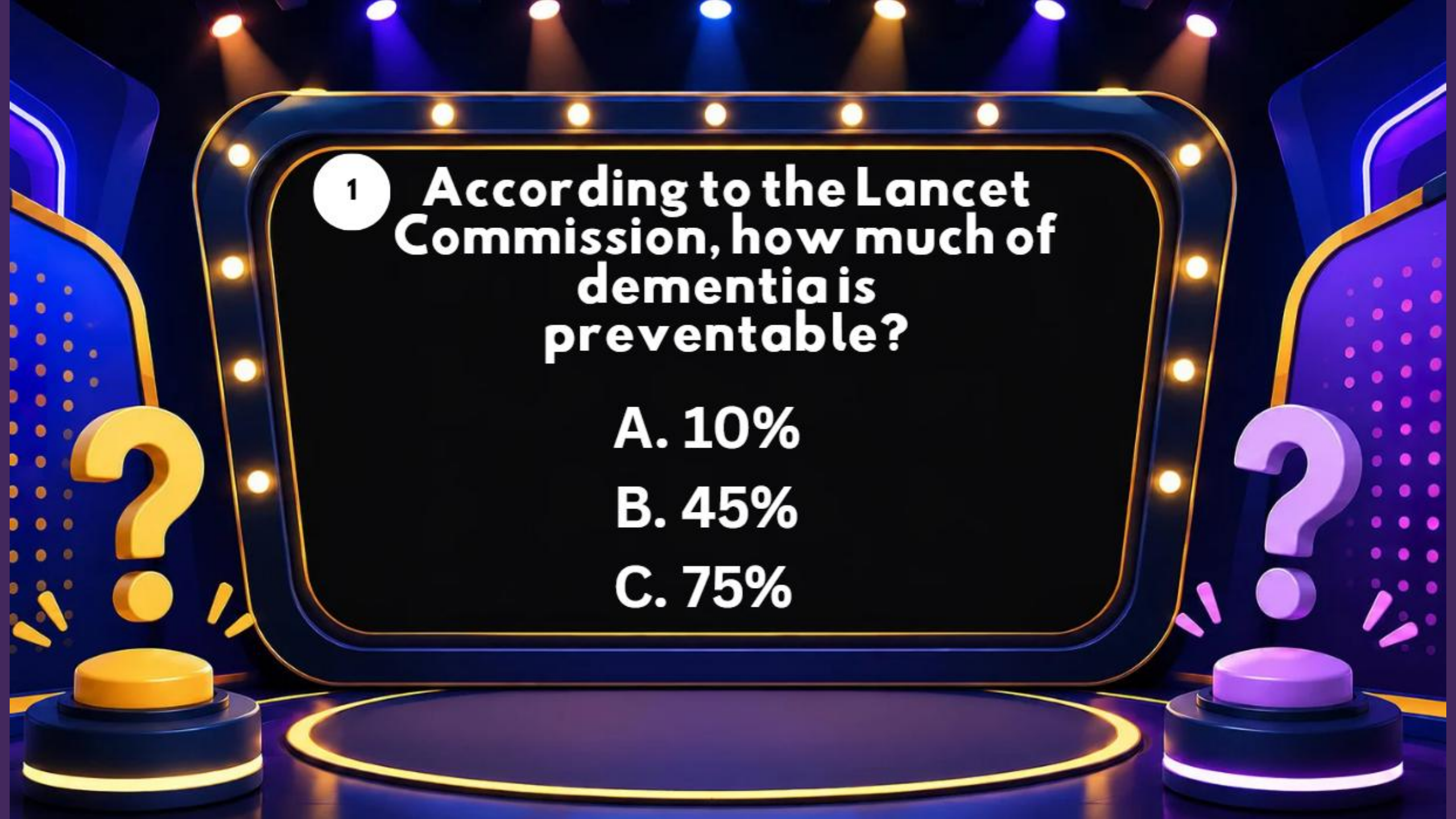
NOVEMBER 13, 2026 | HEART AND BRAIN HEALTH MEETING

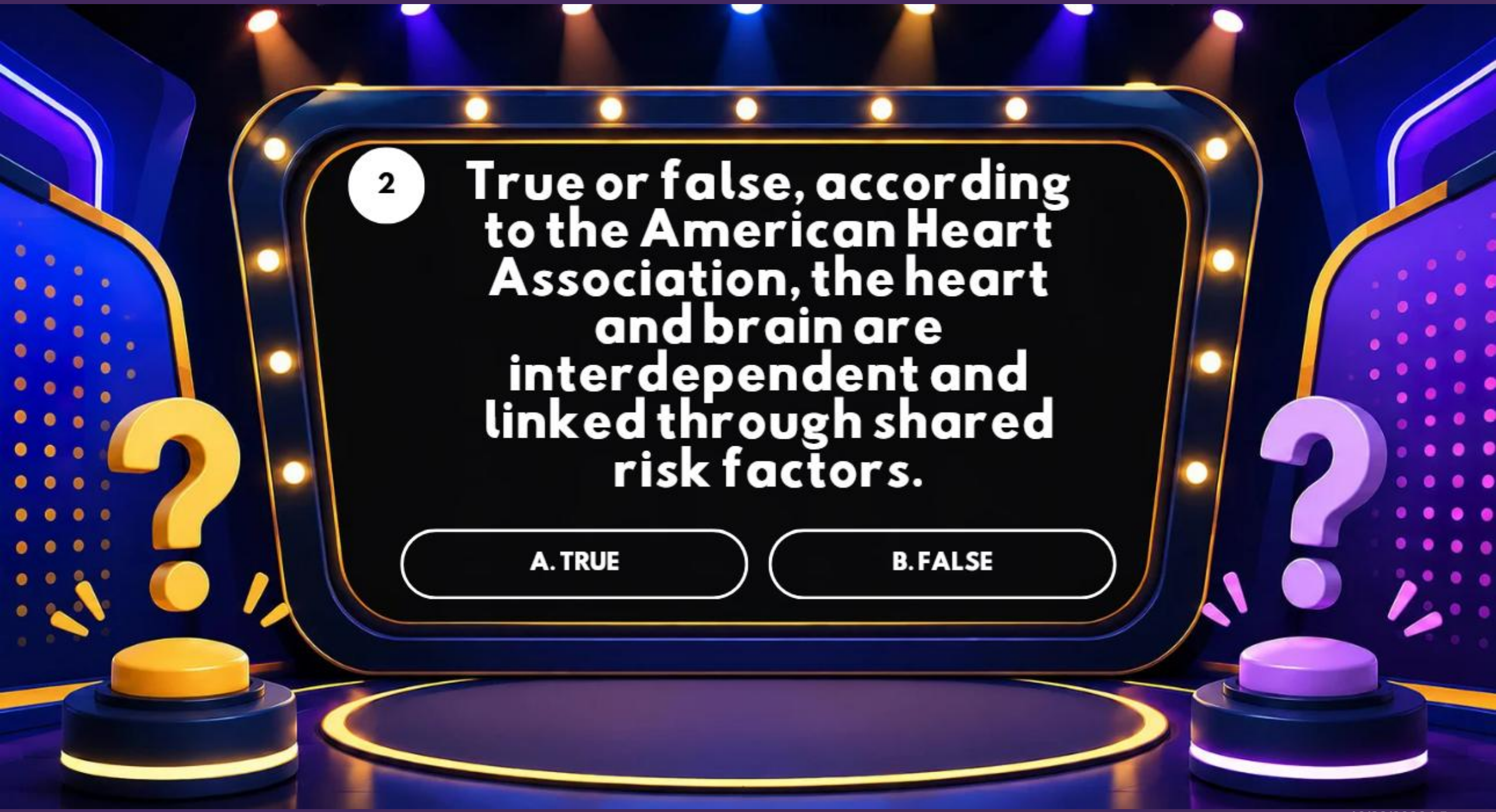
Agenda

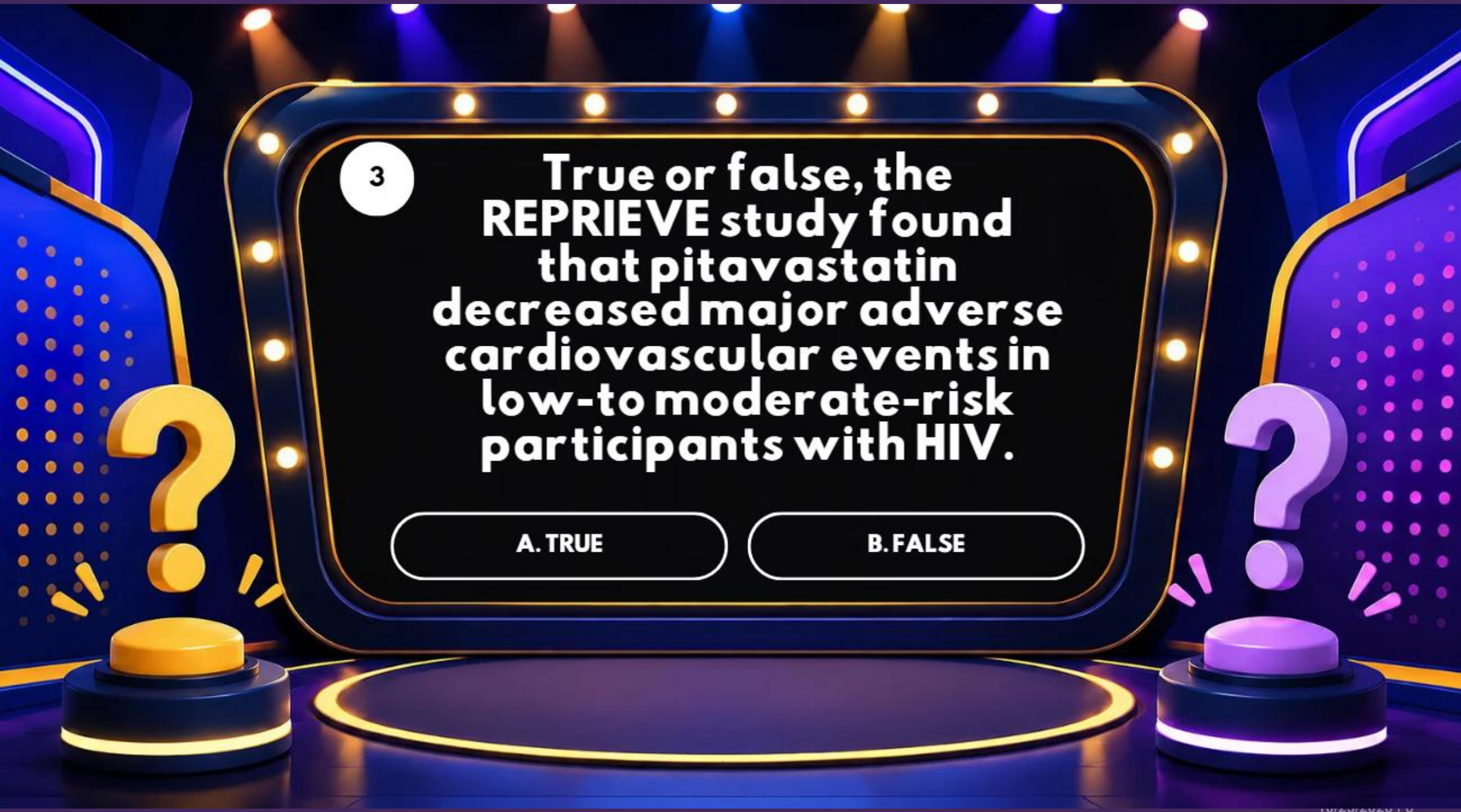
12:00-12:10	Welcome, Game Show
12:10-12:20	Heart and Brain Health Overview - Emily Frey, MD
12:20-12:35	Provider and Peer Heart and Brain Health Programming Discussion - Susan Olender, MD, David Demotte, Luis Velazquez
12:35-12:55	Modified Integrated Care for Older People (ICOPE) Screening Training Presentation - James Learned, Robert Curry
12:55-1:05	Quality Improvement Project Overview - Dan Belanger, Allie Hypes
1:05-1:20	Force Field Analysis
1:20-1:30	Closing and Next Steps

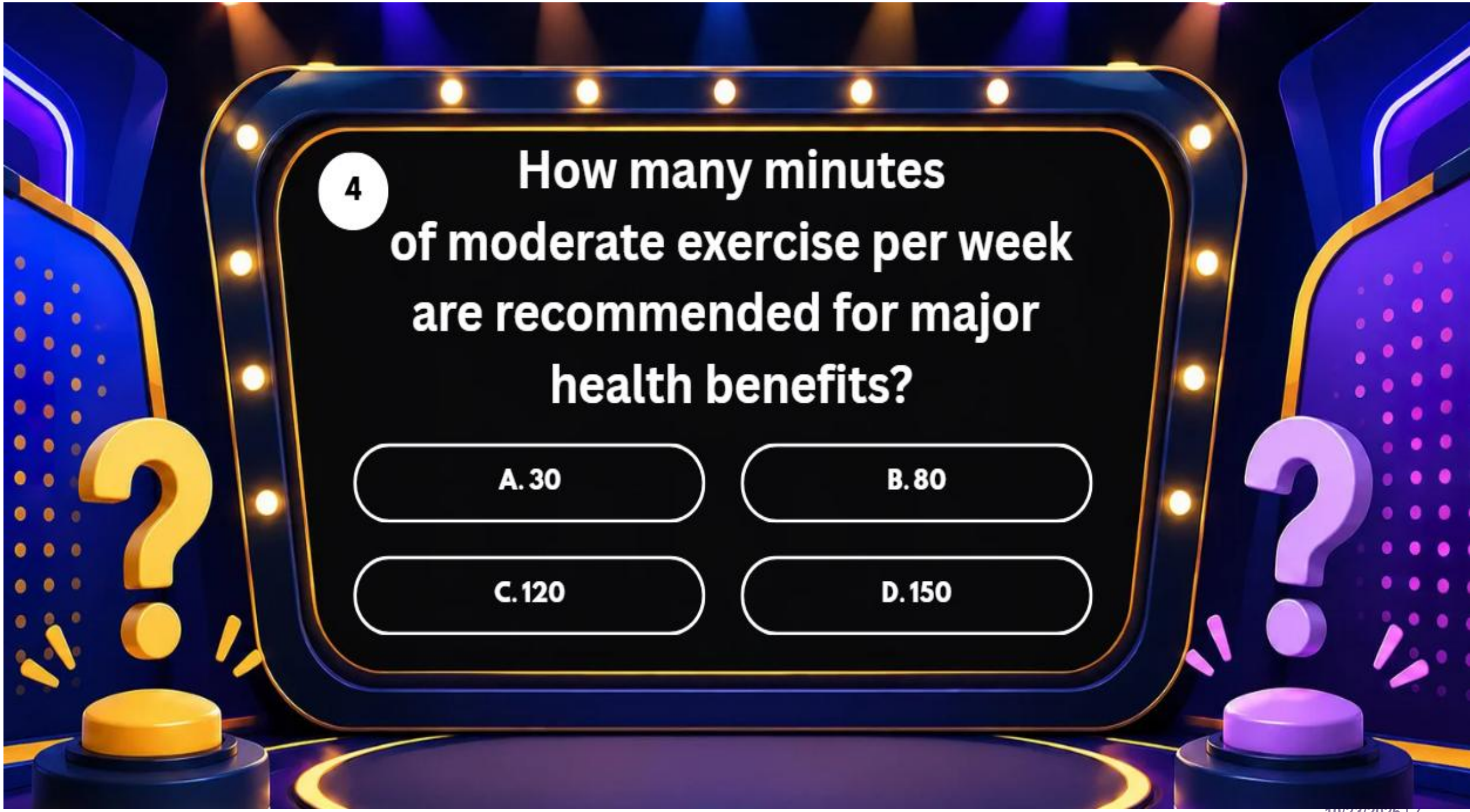
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THE QUALITY OF CARE PROGRAM PRESENTS..
THE HEART AND BRAIN GAME
START


1
According to the Lancet Commission, how much of dementia is preventable?
A. 10%
B. 45%
C. 75%


2
True or false, according to the American Heart Association, the heart and brain are interdependent and linked through shared risk factors.
A. TRUE
B. FALSE


3
True or false, the REPRIEVE study found that pitavastatin decreased major adverse cardiovascular events in low-to moderate-risk participants with HIV.
A. TRUE
B. FALSE


4
How many minutes of moderate exercise per week are recommended for major health benefits?
A. 30
B. 80
C. 120
D. 150

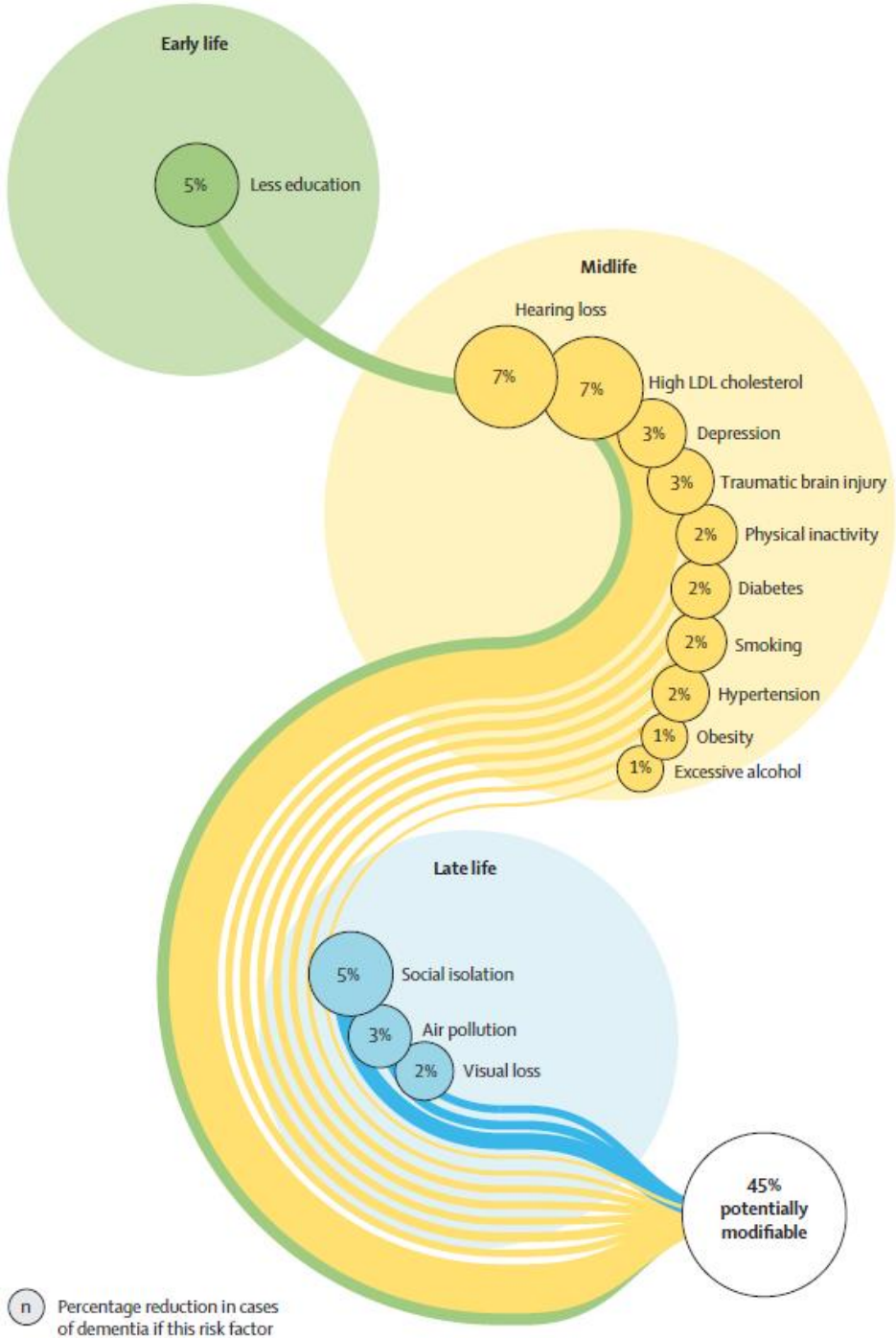
HEART – BRAIN CONNECTION

The **Heart-Brain Axis** shows that there is a complex and bi-directional relationship between heart and brain health that becomes pronounced among people aging with HIV.

- Shared risk factors – Poor health behaviors and other risk factors which affect heart health often affect brain health and vice versa.
- Compounding effects – The bi-directional relationship creates a feedback loop in which cognitive and cardiac health outcomes influence one another.
- Studies show that even in the absence of disease, subclinical changes in heart health can contribute to cognitive vulnerability.

Because people aging with HIV have more comorbidities at an earlier age than the general population, implementing dual interventions that address heart and brain health is a complementary and effective strategy for supporting healthy aging among people with HIV.

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How much of Dementia is preventable according to the Lancet Commission?

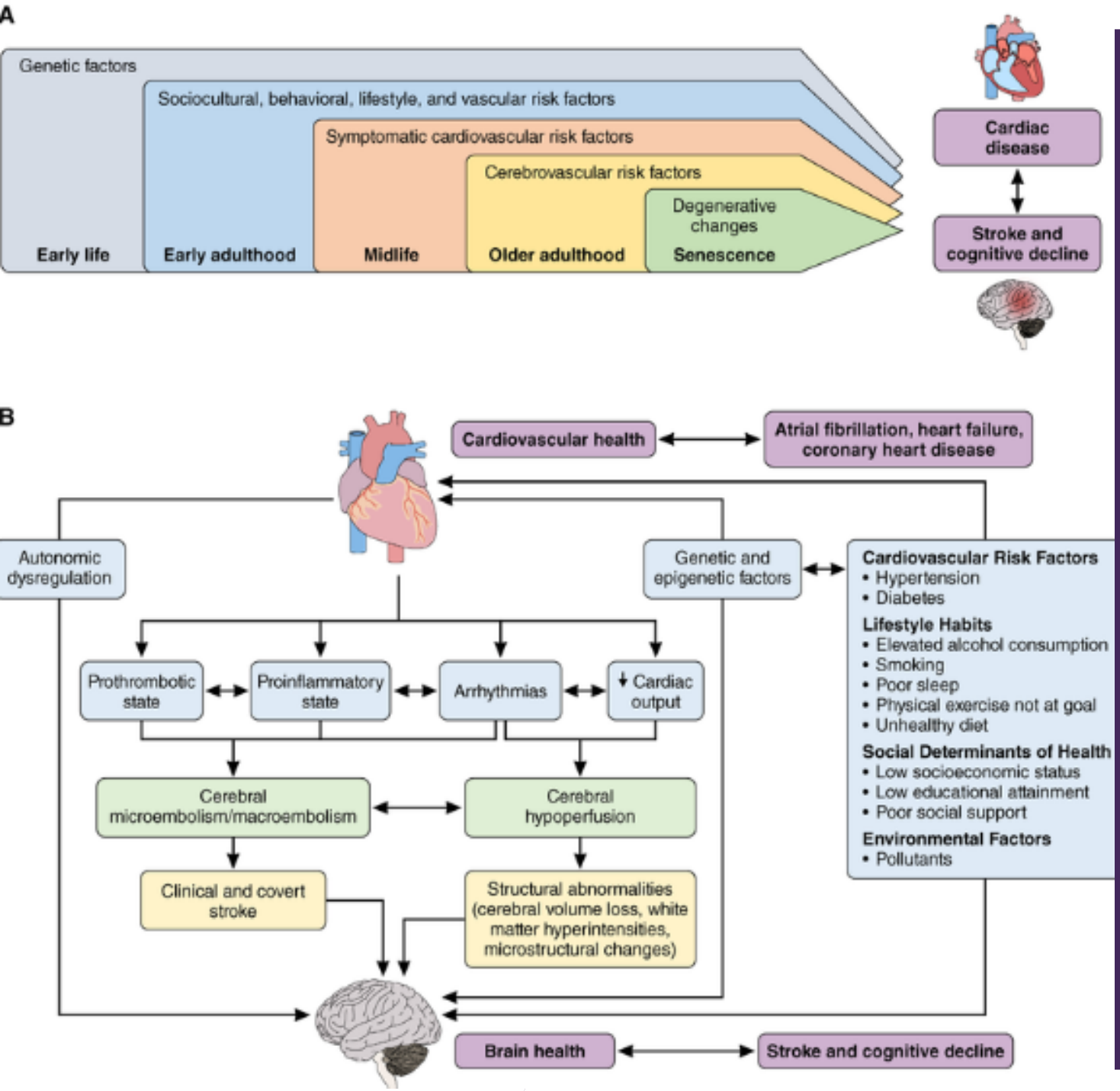
Answer: B. 45%

In 2024, the Lancet Commission published a report on dementia prevention, intervention and care.

This report found that new evidence suggests that, in addition to the previously identified 12 risk factors (seen to the left), high low-density lipoprotein (LDL) cholesterol and vision loss are additional modifiable risk factors for dementia.

The report found that addressing these modifiable risk factors could help to prevent and delay dementia.

Notably, many of the risk factors for dementia also affect heart health such as high LDL cholesterol, smoking, hypertension, obesity, alcohol use, diabetes, and physical inactivity. This points to the capacity for interventions addressing these risk factors to improve both heart and brain health.



True or False, according to the American Heart Association, the heart and brain are interdependent and linked through shared risk factors.

Answer: A. True

Known as the Heart-Brain Axis, findings show, as seen in the diagram here, that genetic, social, environmental and lifestyle habits across the age continuum can promote or harm cardiac and cognitive health.

Cardiovascular risk factors can lead to inflammation or cardiovascular and cerebrovascular alterations which can lead to stroke and cognitive impairment.

‘Despite the demonstrated increased risk of atherosclerotic cardiovascular disease in people with HIV, statin prescription is suboptimal, clinicians are not as attentive to primary prevention in this population.’

True or False, according to the REPRIEVE Study, pitavastatin decreased major adverse cardiovascular events in participants with HIV.

Answer: A. True

Research shows that heart disease arises earlier and progresses faster in people aging with HIV and suggests that comorbidities are likely to affect brain health.

The Randomized Trial to Prevent Vascular Events (REPRIEVE Trial) in HIV found that participants with HIV who received pitavastatin had a lower risk of a major adverse cardiovascular event than those who received the placebo over a median follow-up of 5.1 years.

This is significant because the risk of atherosclerotic cardiovascular disease, including myocardial infarction and stroke, is up to twice as high among people with HIV than the general population.

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Due to the higher rate of bone mineral density loss among people with HIV due to antiretroviral therapy (ART) regimens, exercise is especially important for supporting bone health in this population, rendering it an impactful intervention for improving cognitive, cardiac and bone health among people aging with HIV.

How many minutes of moderate exercise per week are recommended for major health benefits?

Answer: D. 150 minutes

About 150 minutes per week has been found to be linked to more than 30% lower risk of morbidity, mortality, disability, frailty, and dementia compared with being inactive. (Cho & Yang et al. 2022)

Studies show that physical activity has a strong correlation with both **cognitive** and **cardiac** health. In this study physical inactivity had the strongest correlation with the risk of dementia among cardiovascular health metrics (which also include smoking, healthy weight, diet, blood pressure, fasting blood glucose, total cholesterol)

In fact, this study found that the risk of dementia decreased as the number of optimal cardiovascular health metrics increased. This again highlights the interdependence of cardiovascular and cognitive health.

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Heart and Brain Health Toolkit

In development since 2024, the Heart and Brain Health Toolkit was collaboratively developed by the Consumer Advisory Committee, Quality Advisory Committee, and the Quality of Care Program.

The toolkit was designed to support the development and implementation of quality improvement projects aimed to improve heart and brain health for people aging with HIV.

The goal of the toolkit is for consumers and providers to work together on a quality improvement initiatives that work to improve both heart and brain health for people aging with HIV.

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HEART AND BRAIN HEALTH TOOLKIT

- Offers quality improvement approaches and tools to plan quality improvement projects as well as measure and evaluate interventions.

- Links to guidelines, standards of care, and recommendations pertaining to heart and brain health for people aging with HIV.

- Provides a list of validated screening tools to assess cognitive and cardiovascular health for people aging with HIV.

- Provides examples of quality improvement activities that can be implemented to address heart and brain health.

- Contains other resources that can aid in the development and implementation of a heart and brain health project for people aging with HIV.

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QR Code to Toolkit

After years of development, the toolkit is now **available** and this meeting is an official kick-off to launch the toolkit and propose the Heart and Brain Health Quality Improvement Project, which we will provide an overview of later in the meeting.

[*Quick Response (QR) code will be made once the toolkit is approved by public affairs office, who currently are in the process of finalizing it]

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Heart and Brain Health Programming

~Provider & Peers Discussion~

Susan Olender, MD
David Demotte, Luis Velazquez

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PROVIDER & PEER DISCUSSION

Provider

Please provide us with a brief overview of your projects working to address heart and brain health in people aging with HIV, highlighting:

- Lessons learned,
- Challenges faced,
- Outcomes and impact, and
- Recommendations for providers planning to implement these types of projects.

Peers

Please provide us with an overview of your work in the development, design and implementation of these projects, highlighting:

- Explaining your responsibilities as peers to these projects,
- How you think peers should be involved in these types of projects,
- Impact of peer involvement on project outcomes, and
- Recommendations for peers planning to implement these types of projects.

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Modified Integrated Care for Older People (ICOPE) Screening Tool Training Presentation

James Learned

NOVEMBER 13, 2026 | HEART AND BRAIN HEALTH KICK-OFF MEETING

Older Adults Living with HIV Functional Screening Tool



Department of Health
AIDS Institute



Presented By: The Family Center, James Learned

Screening Older Adults Living with HIV

HIV care has been acknowledged only recently as a domain of geriatrics. Geriatric assessment provides a complete view of a patient's function, cognition, and health, and improves prognostication and treatment decisions.

As the population with HIV grows older, the application of the principles of geriatrics can enhance the quality of care.

Screening Tool: Background

Tools for general geriatric screening are simple and cover a wide variety of domains. The use of general screening tools can improve case-finding and, when coupled with referral, can enable targeted interventions.

- The World Health Organization (WHO) Integrated Care for Older People (ICOPE) Screening Tool.
- Modified by the AIDS Institute.
- For use with people aging with HIV (PAWH) and long-term survivors (LTS).

A key preventative measure to identify the early stages of medical complications/concerns, so that we may provide treatment to avoid progression and ease symptoms.

Who Are We Screening?

People Aging with HIV (PAWH)

Individuals living with HIV who are over age 50.

Long-Term Survivors (LTS)

Individuals living with HIV for at least 15 years.

Lifetime Survivors

Individuals who have been living with HIV since birth or early in life.

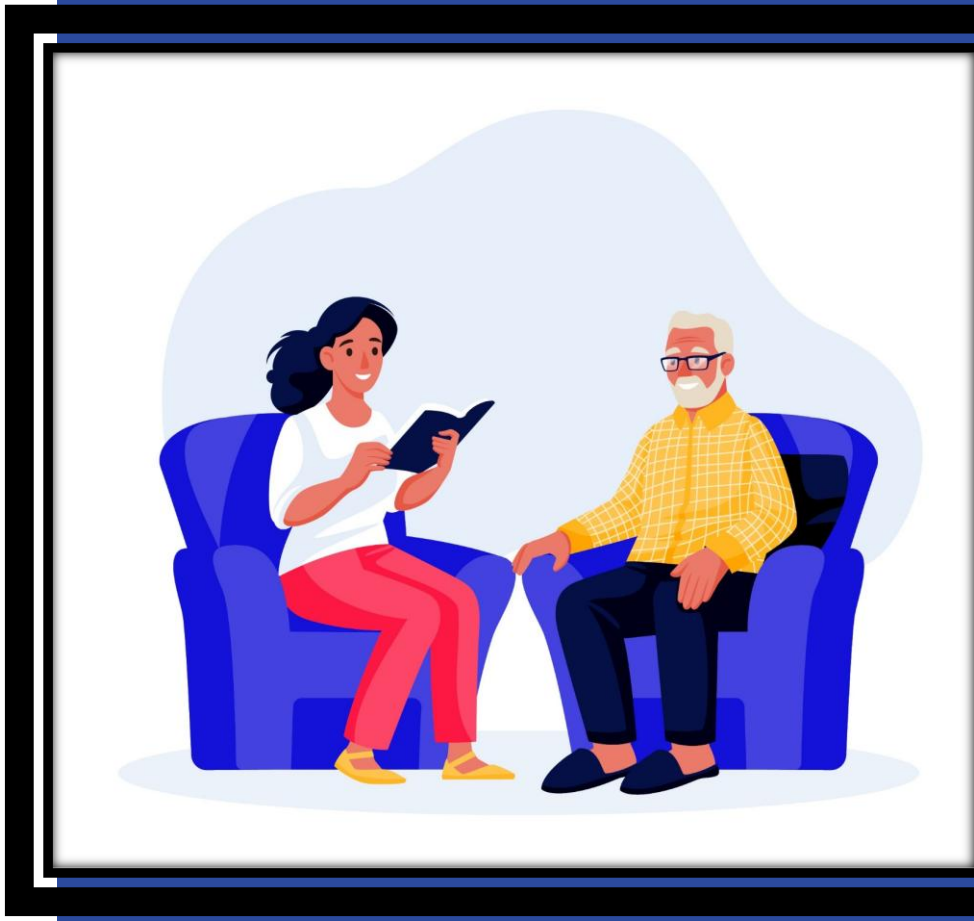


Who Conducts the Screening?

Peers

Other Support Staff

Social Workers
Clinicians
Front Desk Staff



The Purpose of Conducting a Screening



Presented By: The Family Center, James Learned

Impact of HIV on Older Adults

- Introduction of Highly Active Antiretroviral Therapy (HAART) in 1996.
- Resulted in:
  - dramatic decrease in mortality.
  - longer life expectancy among people living with HIV.
- In 2026, over half of people living with HIV in the U.S. are over age 50.

Impact of HIV on Older Adults

- Long-term survivors may experience earlier or greater burdens of some age-related and HIV-associated health conditions.
- People aging with HIV experience comorbidities that are a natural part of aging.
- Cumulative effects of HIV medication.
- Effective HIV treatment has transformed HIV into a chronic condition for many people—but healthy aging requires attention to more than viral suppression.

Screening Helps Identify Concerns Early—Before They Become more Difficult to Address

- Identify functional changes early.
- Identify unmet health and psychosocial needs.
- Connect clients/patients to appropriate services.
- Support individualized care planning,
- Promote healthy aging and quality of life.

People Aging with HIV and Health

Older adults living with HIV have a higher risk of developing certain medical complications:

- Memory and cognition
- Vision
- Mental health
- Hearing
- Mobility

The physical and psychosocial needs of people aging with HIV can become more complex as they age.

The 5 Ms of Geriatrics

- By keeping in mind the 5 Ms of Geriatrics, providers can better address them.
- The 5 Ms:
  - **M**ind 🧠
  - **M**obility 🚶
  - **M**edications 💊
  - **M**ulti-Complexity 🔄
  - What **M**atters Most ❤️
- The structure of the screening tool is inspired by the themes addressed by the 5 Ms.

The Functional Screening Tool

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

Presented By: The Family Center, James Learned

Next Virtual Training Opportunity

...

Functional Screening for People Aging with HIV

January 13 & 14, 2027

Register at HIVtrainingNY.org

Presented By: The Family Center, James Learned

Training Objectives

By the end of the training, participants will be able to:

- Describe to clients the importance of functional screening for people aging with HIV.
- Recall the components of the Modified World Health Organization's Integrated Care for Older People (ICOPE) Screening Tool.
- Define who should receive the screening.
- Recall the 5 Ms (mind, mobility, medications, multi-complexity, what matters most).
- Conduct the screening in an affirming, effective, and sensitive way.
- Understand the meaning of the results of the screening.
- Recall the steps in communicating results to other members of the care team.

Training Agenda

- Background
- Purpose of Conducting a Screening Tool
- Exploring the Screening Tool
- Effective and Sensitive Screening
- Modeled Role-Play
- Administering the Screening Tool
- Interpreting Results
- Skills Practice
- Pitching the Screening Tool
- Telehealth Best Practices
- Case Study
- Working with a Care Team
- Best Practices

Presented By: The Family Center, James Learned

For more information, please contact:

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Quality Improvement Project Overview

Dan Belanger, MSW
Allie Hypes, MPH

NOVEMBER 13, 2026 | HEART AND BRAIN HEALTH KICK-OFF MEETING

Quality Improvement Project Overview



Each participating site will conduct a quality improvement project targeting heart and brain health outcomes.



Sites will co-produce a heart and brain health intervention with staff and peers.



Sites will utilize the modified integrated care for older people (ICOPE) screening to assess the impact of the intervention.



Sites will share progress and lessons learned in the form of presentations to the collaborative.

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QUALITY IMPROVEMENT CHECKLIST FOR IMPROVING HEART AND BRAIN HEALTH

Section A: What are we trying to improve?

- Are staff trained in quality improvement as well as heart and brain health for people aging with HIV?
- Provides measures to assess staff readiness.

Section B: How will we know if there is a change and if the change is an improvement?

- Develop a measurement plan to assess heart and brain health indicators over time as the project progresses.

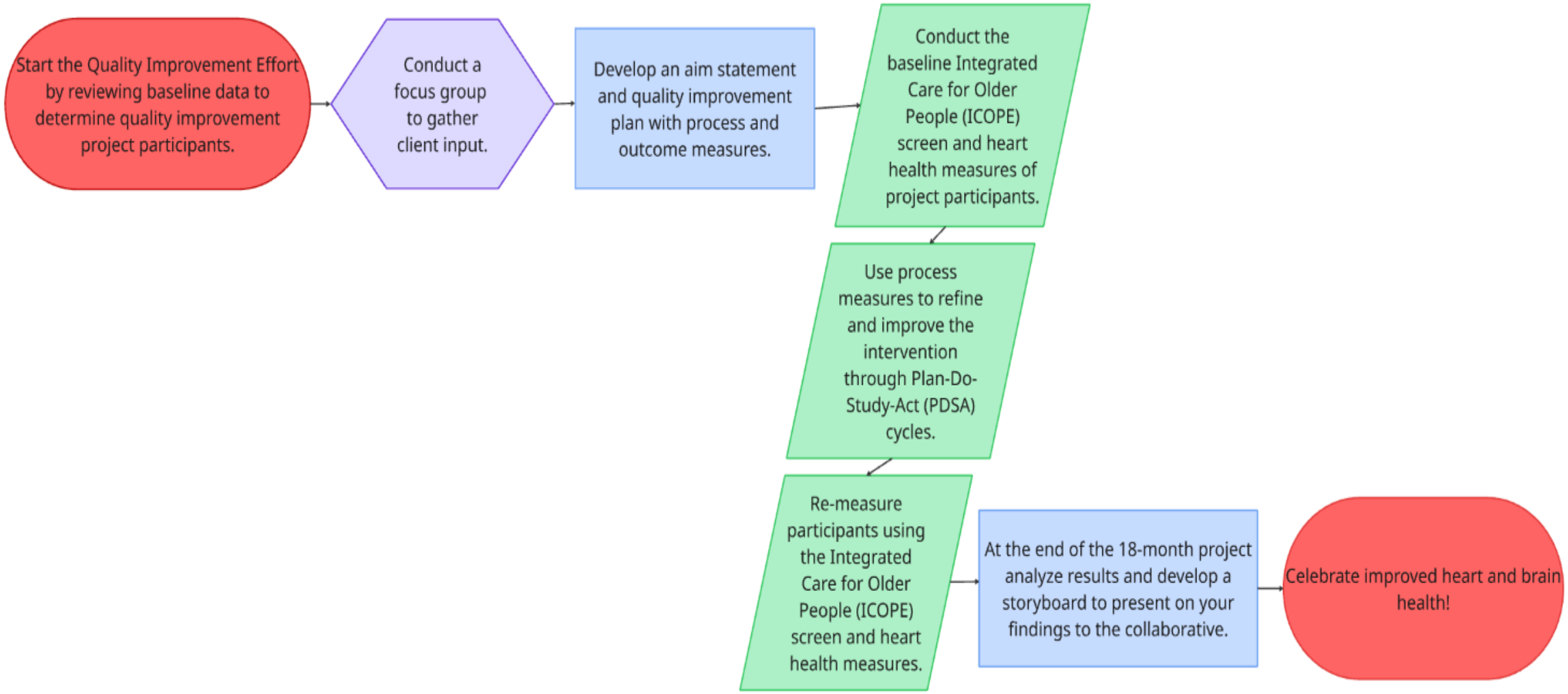
Section C: What changes can we make that will lead to an improvement?

- Review data to assess patient needs,
- Review current processes to address heart and brain health,
- Consider possible changes to processes to better support heart and brain health,
- Use quality improvement tools to strategize improvement ideas.

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Heart and Brain Health Quality Improvement Project Flow Diagram

(*All Quality Improvement projects must participate in quarterly collaborative peer learning discussions.)



FLOW DIAGRAM STEP-BY-STEP

Use Quality Improvement Project Steps to guide your project:

- Step 1: Review, collect and analyze baseline data.
- Step 2: Select intervention participants.
- Step 3: Conduct a focus group to gather client input.
- Step 4: Develop an aim statement and quality improvement plan with process and outcome measures.
- Step 5: Conduct baseline Integrated Care for Older People (ICOPE) and heart health measures of project participants.
- Step 6: Implement the intervention and use process measures to refine and improve the intervention through Plan-Do-Study-Act (PDSA) cycles.
- Step 7: Re-measure participants at the end of the project using the Integrated Care for Older People (ICOPE) and selected heart health measures.
- Step 8: Evaluate and present results to the collaborative.

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PARTICIPATION IN THE COLLABORATIVE

The quarterly collaborative meetings will involve peer learning discussions among quality improvement project teams on:

- Lessons learned,
- Challenges identified,
- Progress updates,
- Peer exchange of ideas,
- Plan-Do-Study-Act (PDSA) cycles, and
- Monitoring and evaluation.

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SELECT AN INTERVENTION

Choose a strategy from ideas generated from discussion with peers and staff. Example interventions can also be found in the toolkit.

Interventions may include:

- Exercise wellness groups (e.g., dance movement therapy, qigong, yoga).
- Brain stimulation group activities (e.g., book clubs, poetry group, dinner club).
- Nutrition and cooking classes (e.g., featuring trips to farmers markets, courses on meal planning, and group discussion to connect).

THE MODEL FOR IMPROVEMENT

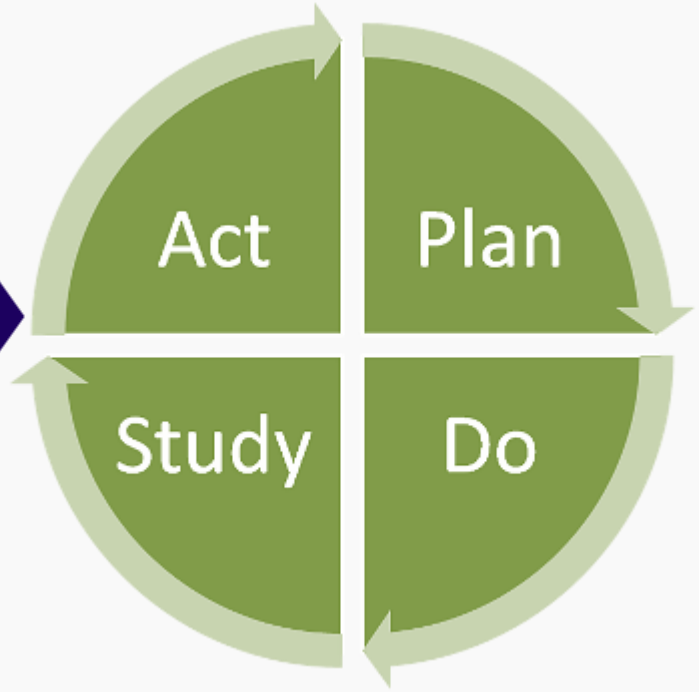
AIM
WHAT ARE WE TRYING TO ACCOMPLISH

MEASURES
HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT

CHANGE
WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN IMPROVEMENT

TEST CHANG E

The PDSA cycle for learning and improvement



Rapid Improvement Cycles

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Aim Statement Example

Aim: To increase the viral suppression rate of clients seen at ABC clinic from 75% to at least 80% by December 31, 2026.

What are you trying to improve?	viral suppression rate
What is the current situation (baseline)?	rate is currently 75%
How much will it improve?	to at least 80%
When will it improve?	by December 31, 2026
For whom will it improve?	clients seen at ABC clinic

HEART HEALTH METRIC EXAMPLES

While the World Health Organization's modified Integrated Care for Older People (ICOPE) screening tool lacks a cardiovascular health measure, you and your team can select a heart health metric pertaining to your project's intervention and goals that you can measure alongside the Integrated Care for Older People (ICOPE) screening tool. Some examples of heart health metrics are:

1. Resting heart rate,
2. Blood pressure,
3. Cholesterol and blood sugar,
4. Heart rate recovery after exercise,
5. Body composition and waist measurements, and
6. Inflammation (e.g., C-reactive protein blood test).

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PROPOSED TIMELINE (18 MONTHS)

Phase 1

Planning and Setup

- Select heart and brain focus areas and measures based on baseline data.
- Co-produce heart and brain health intervention with peers and staff.

Phase 2

Intervention Implementation

- Implement heart and brain health intervention.
- Monitor progress using the Modified Integrated Care for Older People (ICOPE). Assessment and selected heart health metrics (baseline, halfway, end of project).

Phase 3

Evaluation and Report on Outcomes

- Re-screen patients at the end of the project and evaluate outcome measures.
- Present storyboard of the final data at collaborative meeting.

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SITE REPORTING AND PARTICIPATION

Sites will attend quarterly collaborative meetings.

Sites will share quality improvement progress updates at each meeting.

All sites will participate in collaborative discussions.

At project completion, sites will develop and present a storyboard summarizing their quality improvement project.

Quality Improvement Project

If you are interested in implementing a quality improvement project addressing heart and brain health, please sign up in the Zoom poll now!

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FORCE FIELD ANALYSIS

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THANK YOU FOR JOINING US

- Heart and brain health are interdependent and especially important for people aging with HIV.
- Quality improvement projects can be implemented to address both heart and brain health due to their interrelated nature.
- Peers are an essential part to implementing effective quality improvement projects as described by Susan Olender, MD, at the Comprehensive Health Program which includes peer wellness champions as key team members, building engaged care for people aging with HIV guided by quality improvement.
- The Heart and Brain Health Toolkit is available for use to guide the development and implementation of Heart and Brain Health Quality Improvement Projects.
- The World Health Organization's Modified Integrated Care for Older People (ICOPE) Screening has trainings available soon. Links to register will be posted in the follow up email.

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REGISTER TO PARTICIPATE

Earlier you were polled for **interest** in implementing a quality improvement project.

If you are now ready to **register** to implement a Heart and Brain Health Quality Improvement Project, follow the Quick Response (QR) code here:

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Heart and Brain Health Toolkit

To find the Heart and Brain Health Toolkit follow the Quick Response (QR) code here:

[*will insert once we have approved toolkit from public affairs]

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Questions?

Thank you for joining us!

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CONTACT US

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TOOLKIT GUIDELINES & RECOMMENDATIONS REFERENCE LIST

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TOOLKIT GUIDELINES & RECOMMENDATIONS REFERENCE LIST

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SLIDE DECK REFERENCE LIST

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RESOURCE LIST OF FOCUS AREAS

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EXAMPLE FOCUS AREAS WITH SUGGESTED MEASURES

1. Routinely perform mental health screens:

Indicator: Mental Health Screens

Measures:

- Numerator: number of clients screened for mental health.
- Denominator: number of eligible clients.

2. Using support groups, therapy groups, etc. to address isolation:

Indicator: Loneliness Scale

Measure:

- Numerator: all clients with improved or continued low level loneliness.
- Denominator: all clients involved in the activity.

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EXAMPLE FOCUS AREAS WITH SUGGESTED MEASURES

3. Prescribe Exercise:

Indicator 1: Minutes Spent Exercising per Week
Measures:
- Numerator: all clients with increased engagement in exercise.
- Denominator: all clients prescribed exercise.

Indicator 2: Healthy Weight Achievement or Maintenance
Measures:
- Numerator: all clients involved in activity in activity who achieve progress towards health weight goals.
- Denominator: all clients involved in the exercise.

4. Increase brain stimulation through book clubs, poetry groups, dinner clubs, social gatherings, storytelling, etc.:

Indicator 1: Mental Health Scores
Measures:
- Numerator: all clients with improved mental health outcomes.
- Denominator: all clients involved in the activity.

Indicator 2: Blood Pressure
Measures:
- Numerator: all clients with improved or continued normal blood pressure.
- Denominator: all clients involved in the activity.

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EXAMPLE FOCUS AREAS WITH SUGGESTED MEASURES

4. Increase brain stimulation through book clubs, poetry groups, dinner clubs, social gatherings, storytelling, etc.:

Indicator 1: Mental Health Scores
Measures:
- Numerator: all clients with improved mental health outcomes.
- Denominator: all clients involved in the activity.

Indicator 2: Blood Pressure
Measures:
- Numerator: all clients with improved or continued normal blood pressure.
- Denominator: all clients involved in the activity.

5. Regular check-ins from a person with lived experience, a peer worker or case managers to ensure medical concerns (including those that may be related to heart and brain health) that arise between medical visits are addressed:

Indicator 1: Client Satisfaction
Measures:
- Numerator: all clients satisfied with treatment.
- Denominator: all clients who receive regular check-in visits.

Indicator 2: Engagement and Retention in Care
Measures:
- Numerator: all clients who maintain visits.
- Denominator: all clients who receive regular check-in visits.

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EXAMPLE FOCUS AREAS WITH SUGGESTED MEASURES

6. Peer-led wellness checks and programming:

Indicator 1: Memory Screens

Measures:

- Numerator: all clients with improved memory outcomes.
- Denominator: all clients involved in the activity.

Indicator 2: Blood Pressure

Measures:

- Numerator: all clients with improved or continued normal blood pressure.
- Denominator: all clients linked to care.

Indicator 3: Healthy Weight Achievement or Maintenance

Measures:

- Numerator: all clients involved in activity who achieve progress towards healthy weight goals.
- Denominator: all clients linked to care.

7. Other interventions such as medications:

Indicator 1: Blood Pressure

Measures:

- Numerator: all clients with improved or continued normal blood pressure.
- Denominator: all clients involved in the activity.

Indicator 2: Healthy Weight Achievement or Maintenance

Measures:

- Numerator: all clients involved in activity who achieve progress towards healthy weight goals.
- Denominator: all clients involved in the activity.

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EXAMPLE FOCUS AREAS WITH SUGGESTED MEASURES

8. Linkages to primary and specialty care, such as registered dietitian or other certified nutrition providers:

Indicator 1: Linkages Made
Measures:
- Numerator: all clients who have improved memory screen results.
- Denominator: all clients linked to care.

Indicator 2: Healthy Weight Achievement or Maintenance
Measures:
- Numerator: all clients involved in activity who achieve progress towards healthy weight goals.
- Denominator: all clients linked to care.

9. Screen for Cognitive Impairment:

Indicator 1: Cognitive Screens Completed
Measures:
- Numerator: all clients who completed a cognitive screen.
- Denominator: all clients linked to care.

Indicator 2: Positive Cognitive Screens
Measures:
- Numerator: all clients who had positive cognitive screens.
- Denominator: all clients who received a cognitive screen.

Indicator 3: Cognitive Linkages Made
Measures:
- Numerator: all clients with a cognitive linkage made.
- Denominator: all clients who had a positive cognitive screen.

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EXAMPLE FOCUS AREAS WITH SUGGESTED MEASURES

10. Use of people with lived experience and peer workers to facilitate heart and brain health activities:

Indicator 1: Peer Training
Measures:
- Numerator: all clients who become trainers.
- Denominators: all clients engaged in the activity.

Indicator 2: Peer Education
Measures:
- Numerator: all clients who receive. education
- Denominator: all clients linked to care.

11. Use of resource lists for brain, nutrition, and heart activities:
Indicator 1: Cognitive Screens Completed
Measures:
- Numerator: all clients who completed a cognitive screen.
- Denominator: all clients linked to care.

Indicator 2: Tool Utilization by Clients
Measures:
- Numerator: all clients using the tools.
- Denominator: all clients receiving care at the clinic.

Indicator 3: Linkages Made
Measures:
- Numerator: all clients who are linked to care.
- Denominator: all clients using the tools.

Indicator 4: Tool Utilization by Providers
Measures:
- Numerator: all providers using the tools.
- Denominator: all providers working at the clinic.

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EXAMPLE FOCUS AREAS WITH SUGGESTED MEASURES

12. Use of brain stimulation exercises such as memory games or puzzles:

Indicator 1: Cognitive Screens

Measures:

- Numerator: all clients with improved or maintained cognition score post-intervention.
- Denominator: all clients screened pre-intervention.

13. Use of social connections interventions such as group art therapy:

Indicator 1: Loneliness Scores

Measures:

- Numerator: all clients with improved or maintained loneliness scores post-intervention.
- Denominator: all clients screened for loneliness pre-intervention.

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