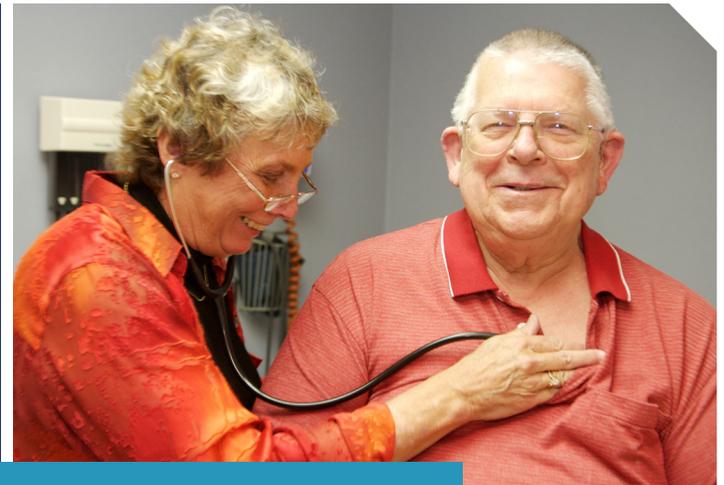




Ryan White HIV/AIDS Program

POPULATION FACT SHEET | DECEMBER 2014

OLDER ADULTS



A significant portion of people living with HIV are older adults. Advances in antiretroviral therapy (ART) have extended the life expectancy of people living with HIV, and because of this an increasing number of HIV-infected adults are aging. Additionally, new infections continue to occur in adults over age 50, due in large part to a lack of HIV education in older populations and the biological changes that occur during menopause. Older adults face more health related issues such as age-related comorbidities and taking more prescription medications which may accelerate HIV progression and increase the likelihood of drug interactions.¹

RYAN WHITE HIV/AIDS

In 2012, 269,278 (or 50.2%) of all Ryan White HIV/AIDS Program clients were 45 to 64 years of age and 18,946 (or 3.5%) were over the age of 65.

CRITICAL ISSUES

Just 1 in 9 new HIV infections in the United States occur in individuals age 50 or older. Yet, approximately one-third of all adults with HIV today are over the age of 50 and this number is expected to increase to one-half by 2015.^{2,3} Sexual contact is the most common mode of HIV transmission in adults over 50, and specific risk factors include the formation of new and multiple sexual relationships, as well as the popularity of sexual performance enhancing drugs.

Many older adults lack sufficient knowledge about transmission and perceive themselves to be at low risk. The problem is exacerbated by the common misperception that older adults are sexually inactive, resulting in a lack of targeted educational health campaigns and low levels of HIV education and screenings by health care providers.⁴ Older adults demonstrate low levels of HIV testing, delayed HIV diagnosis and treatment, and inconsistent condom use. Because birth control is unnecessary after menopause, older adults may be unfamiliar with or reluctant to use condoms.⁵ Vaginal dryness is also common among

menopausal women, potentially leading to vaginal abrasions that increase the risk of HIV infection.⁵

The predicted life expectancy of people living with HIV is 75 years, nearly that of HIV-negative peers.⁷ Improvements in HIV treatment have transformed what was once a fatal disease into a manageable chronic condition. Because of this, an increasing percentage of the HIV population is aging.⁸

Improved life expectancy has increased the risk of developing comorbidities, particularly age-related chronic conditions such as cardiovascular and kidney disease and cancers. Health care providers now face the challenge of treating both HIV and any age-related comorbidities simultaneously, as well as observing the long-term effects of antiretroviral toxicity. This combination can have a “synergistic effect” that leads to increased immunosuppression, altered T-cell functioning, muscle loss, and decreased bone density.^{9,10}

The need to treat multiple medical conditions at once has made medication management a critical concern. Patients over 50 years of age are more likely to have potential drug interactions than younger individuals. Older patients’ risk is heightened by the fact that adults with HIV often experience premature aging that requires non-ART medications.¹¹

Coinfection with hepatitis B and C is common among people living with HIV and further increases the need for multiple medications.¹² In fact, most individuals infected with hepatitis C (HCV) in the United States were born between 1945 and 1965 (“baby boomers”).¹³ HCV has emerged as a major contributing factor to morbidity and mortality among people living with HIV who are coinfecting. Complications from chronic HCV — such as end-stage liver disease and liver cancer — are among the leading cause of death for HIV-infected individuals.^{14,15,16,17} Additionally, HIV accelerates HCV progression.¹⁸

Older adults with HIV experience more psychosocial stressors than younger counterparts, making them susceptible to mental health conditions including suicidal ideation and depression.¹⁹ This population must cope not only with the stigma of being HIV positive, but also the stigma of old age, potentially worsening feelings of social isolation. This may lead to negative health behaviors such as poor medication adherence, over eating, and substance abuse.²⁰

HIGHLIGHTS OF THE HIV/AIDS BUREAU'S RESPONSE

The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau supports numerous mechanisms to provide HIV primary medical and social support services to HIV-positive patients as they age.

- ▶ The *HRSA Guide for HIV/AIDS Clinical Care* and *A Guide to the Clinical Care of Women with HIV* are both important resources for treating HIV-positive clients, including older adults. (See www.hab.hrsa.gov/deliverhivaidscares/clinicalguidelines.html)
- ▶ HRSA has also produced numerous publications on medical issues that disproportionately affected older

adults. For example, HRSA has released a hepatitis C training pocket card as well as a hepatitis C training manual. (See www.hab.hrsa.gov/abouthab/files/spnshepatitiscinhivaids-pocketcard.pdf and <https://careacttarget.org/ihip>)

- ▶ HRSA has also released a newsletter on HIV-associated neurocognitive impairment. (See www.hab.hrsa.gov/deliverhivaidscares/neurocognitiveimpairment.pdf)
- ▶ To focus on the topic of aging and the unique needs of older adults, the HRSA AIDS Education and Training Center has created an HIV and Aging Workgroup. This workgroup is developing resources and recommendations for providers. (See <http://aidsetc.org/community/hiv-aging-workgroup>)
- ▶ Additionally, the HRSA TARGET Center technical assistance site contains a myriad of publications around HIV and aging to help inform the broader Ryan White HIV/AIDS Program community. (See <https://careacttarget.org/searches/aging>)

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²⁰Hansen NB, Harrison B, Fambro S, et al. The structure of coping among older adults living with HIV/AIDS and depressive symptoms. *Journal of Health Psychology*. February 2013;18(2):198-211.

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⁵Orel NA, Stelle C, Watson WK, Bunner BL. No one is immune: a community education partnership addressing HIV/AIDS and older adults. *Journal of Applied Gerontology*. June 2010;29(3):352-270.

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⁸Gedela K, Vibhuti M, Pozniak A, et al. Pharmacological management of cardiovascular conditions and diabetes in older adults with HIV infection. *HIV Medicine*. May 2014;15(5):257-268.

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¹²Tseng A, Szadkowski L, Walmsley S, Salit I, et al. Association of age with polypharmacy and risk of drug interactions with antiretroviral medications in HIV-positive patients. *Annals of Pharmacotherapy*. November 2013;47(11):1429-1439.

¹³Smith BD, Beckett GA, Yartel A, et al. Previous exposure to HCV among persons born during 1945-1965: prevalence and predictors, United States, 1999-2008. *American Journal of Public Health*. 2014 Mar; 104(3): 364-365.

¹⁴U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), Special Projects of National Significance. Delivering Hepatitis C Treatment in an HIV Care Setting. 2014 Sep. Available at: <https://careacttarget.org/sites/default/files/file-upload/resources/HepC.pdf>.

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²⁰Hansen NB, Harrison B, Fambro S, et al. The structure of coping among older adults living with HIV/AIDS and depressive symptoms. *Journal of Health Psychology*. February 2013;18(2):198-211.

