HIV/AIDS  Growing Older Demographic, Care and Service Challenges

Nathan L. Linsk, Ph. D, A.C.S.W.

Midwest AIDS Training and Education Center
Department of Family Medicine
University of Illinois at Chicago
Vienna Conference

- Two Satellites on HIV and Aging
- A number of posters including an exclusive poster session
- Acknowledgement in plenary and wrap-up

- Very different than previous conferences
- HIV/AIDS community has “discovered” aging!
- Good news --living longer
- Bad news --complex issues: medical, psychosocial, services, quality of life

- Include a few pieces from the conference in this presentation
Overview

Content

• How are Older Adults Affected by HIV?
• Psychosocial Issues
• Care and Service Issues: HIV and Aging

Hopes

• To provide some information helpful in addressing the HIV “senior” population
• That the presentation includes some tools useful for further training, services and advocacy

Note: Some of the slides are included as resource slides
How are Older Adults Affected by HIV?

– HIV at Risk– Prevention and Education

– HIV Infected– Living with HIV
  - Infected younger and growing into the older years
  - Newly diagnosed in older years
  - Newly infected in older years

– HIV Affected– Friends and Family

– HIV Caregivers– New Roles?
Why Over Fifty?

- CDC originally kept data only this way (fact or urban legend?)
- For HIV 50+ has been the older population.
- In their 50s people may at least begin to think and prepare for their older years (Age related changes, medications, vision, etc.; Retirement planning; Workplace discrimination)
- Some benefits begin at 50 (AARP, some OAA benefits)
- Does this mean 50+ means “old?” Probably not! May be older but age is in the eyes of the individual (or the beholder!)
In 1990, from the beginning of the epidemic there had been 160,000 people diagnosed with AIDS in the US.

By the end of 1990, almost 110,000 of these people had died.

In 2010 there are almost 1.1 million people living with HIV/AIDS in the US, and 30,000 of these die each year.

The CDC estimates that by 2015 half of the US HIV/AIDS population will be age 50 and older.

Source: S. Karpiak
Current U.S. Statistics

The following slides may be useful in training, especially with geriatricians, aging service providers and others who may not understand the implications of people living longer with HIV.

They are included as resource information.
We’ll just highlight a few thoughts now.
One of every seven new AIDS cases over age 50

18% of those diagnosed with AIDS in the U.S. today are over 50 (CDC HIV/AIDS Facts 2007 [Updated 2009]).

As many as 1 in 4, or even more in specific areas.

- 36.1% of people with AIDS in N.Y.C. age 50 or older
- This trend is also highlighted when looking at those 40+
- N.Y.C. reported 73.9% of PLWHA are 40+ (CDC, 2007)
USA AIDS Cases Over Age 50 - CDC

Source: Centers for Disease Control & Prevention
## HIV Cases: Selected States and Cities

Sources: State and City Health Department Data, 2005, 2007 or 2010

<table>
<thead>
<tr>
<th>State/County</th>
<th>40 - 49</th>
<th>50 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Florida</td>
<td>29%</td>
<td>15%</td>
</tr>
<tr>
<td>Illinois</td>
<td>24%</td>
<td>9%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>21%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>New York City</strong></td>
<td>30%</td>
<td>43%</td>
</tr>
<tr>
<td>Oregon</td>
<td>24%</td>
<td>9%</td>
</tr>
<tr>
<td>Portland</td>
<td>22%</td>
<td>10%</td>
</tr>
<tr>
<td>Washington DC (New AIDS Cases)</td>
<td>35%</td>
<td>21%</td>
</tr>
</tbody>
</table>
Percent of New AIDS Cases By Age, 2005 & 2007

Source: CDC Surveillance Report
Impact of HAART

Source: NYC Dept of Health & Mental Hygiene, 2010
Median Age at Death due to HIV Disease
United States, 1987-2007

Note: For comparison with data for 1999 and later years, data for 1987-1998 were modified to account for ICD-70 rules instead of ICD-9 rules.
Number and proportion of older and younger adults at first presentation for HIV clinical care (N=44,491)

Althoff, *AIDS Res Therapy* 2010
The US Centers for Disease Control & Prevention (CDC) predicts that in five years 50% of all people living with HIV will be over age 50.
## Life Expectancy on HAART Is Not Normal

<table>
<thead>
<tr>
<th>CD4 Cell Count (mm$^3$)</th>
<th>&lt;100</th>
<th>100-199</th>
<th>≥200</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At HAART Initiation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 20 yr old will live to (years)</td>
<td>52</td>
<td>62</td>
<td>70</td>
</tr>
<tr>
<td>A 35 yr old will live to (years)</td>
<td>62</td>
<td>65</td>
<td>72</td>
</tr>
<tr>
<td>% Remaining Life Lost (all ages)</td>
<td>46%</td>
<td>27%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Trends in the Percentage Distribution of Deaths due to HIV Disease by Age Group, United States, 1987–2007

Note: For comparison with data for 1999 and later years, data for 1987–1998 were modified to account for ICD-70 rules instead of ICD-9 rules.
International Data

UNAIDS & WHO previously did not report data for this age group “to ensure comparability across countries, especially for HIV prevalence.”

Stated in 2006, “it is now evident that a substantial proportion of people living with HIV are 50 years and older, as shown in age distributions of HIV and AIDS case reports, community studies and population–based surveys.”

Now present estimates of adults living with HIV, new infections and AIDS deaths among adults for all adults in 3 categories (1) 15 years and younger; (2) 15–49 years; and (3) 50 and above

Analysis of the difference between all adults and adults aged 15–49 shows that around 2.8 million adults aged 50 years and older were living with HIV in 2005. UNAIDS and WHO data

Prevention

- Ageism
- AIDSism
- Homophobia

Others on the panel will address this!
Prevention

Facts about Transmission

- Main risk behavior is older men having sex with men (but difficult to get current data!)

- Other transmission risks have increased: Heterosexual, Injection Drug Use, No identified Risk

- Transfusion risk has declined, but is still higher than other age groups

- Women are particularly vulnerable in the later years.

- The racial distribution parallels the epidemic—Blacks and Hispanics disproportionately represented
CDC Prevention Initiative: Implications for HIV over Fifty

- Age range for routine testing in medical settings
  - CDC recommends 14-64

- Possible message—Does HIV infect people over age 64????

- Or is this an issue of whether to invest in older adults?
  - Smaller number of positives expected
  - less years of life left
CDC Prevention Initiative: Implications for HIV over Fifty

- Confidentiality Issues

- Acknowledging older people have sex and use drugs!!

- Opt out issues

- Age sensitive testing issues
Treatment in HIV in People over age 50: A few thoughts
Comorbidity

Associated with

- Race, gender, age
- Socioeconomic status
- Tobacco, alcohol, drugs
- Other lifestyle behaviors (obesity, inactivity)

Caution:

- May confound association with HIV or ARVs
- Possibility of synergy—need to study populations at risk
Average Number of Comorbidities

Karpiak et al., ROAH, 2006
Median CD4 count and the percentage of patients with a CD4 count ≥350 cells/mm³, at first presentation for HIV clinical care, by age.

<50yo: absolute increase in median CD4 = 67 cells/mm³
≥50yo: absolute increase in median CD4 = 63 cells/mm³
Mean Increase in CD4 by Age 2 years after HAART

- 18-<30 years
- 30-<40 years
- 40-<50 years
- 50-<60 years
- ≥60 years

Althoff K. AIDS 2010
Comorbid Health Problems

- Depression
- Arthritis
- Hepatitis
- Neuropathy
- Hypertension
- Dermatologic...
- Herpes
- Vision loss
- Diabetes
- Neurological...
- STD
- Hearing loss
- Pneumonia
- Respiratory...
- Heart condition
- Broken bones
- Shingles
- Migraines
- Cancer
- Stroke
- Staph. infection

Percent
Number of non-HIV meds by age

% of participants

<50 years 50-64 years 65+ years

Age

Number of comedications

0 1 2 3 4+

B Haase CROI 2011
ROAH: Average Number of Comorbidities

55+ Year Old with HIV: 3.3
Typical 70+ Year Old: 1.1
Adherence Issues

- A number of studies now show that older adults' adherence is at least as good as younger adults.

- Medication utilization is normative for older adults.
A California study comparing 997 HIV+ patients over age 50 to 1834 patients 40-49 and 2259 patients 18-30 taking Anti-retroviral drugs.

People with HIV over 50 had higher levels of adherence to medications, less viral load rebound as well as higher increases in CD-4 cells after first year.

Source: Silverberg, et al. XVI International AIDS Conference poster TUPE0135
Treatment and Prognosis

- Age is IMPORTANT prognostic factor and is independent predictor of clinical progression (ART Cohort Collaboration Study)

- Viral suppression more common over 50 (HR 1.23)-possibly related to improved adherence

- Significantly slower CD4 cell reconstitution than younger patients-probably related to waning thymic output- despite a better virologic response

- Slow CD4 response associated with clinical progression risk (1.5 X higher on HAART) (FHDH)
AAHIVM: Guides for the Management of Older Adults with HIV

Expert Panel of 14 Leaders in HIV Treatment Research and Geriatric Care

American Academy of HIV Medicine

American Geriatrics Society

ACRIIA Center on HIV and Aging
The HIV and Aging Consensus Project

Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV

Sponsored by

American Academy of HIV Medicine
American Geriatrics Society
AIDS Community Research Initiative of America
The HIV and Aging Consensus Project

Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV

Sponsored by:
American Academy of HIV Medicine
American Geriatrics Society
AIDS Community Research Initiative of America

Christine K. Abram MD, University of Washington School of Medicine, Division of Gastroenterology and Hepatology, Seattle, WA
Jonathan S. Appelbaum MD, (Co-Principal Investigator), Center for Information and Knowledge, Florida State University, College of Medicine, Tallahassee, FL
Cynthia M. Boggs MD, University of Washington School of Medicine, Division of Geriatric Medicine and Gastroenterology, Department of Medicine, Seattle, WA
R. Scott Berardinelli MD, MPH, Professor, New York University School of Medicine, NY NY
Virginia C. Broady MD, Rush University Medical Center, University of Washington School of Medicine, Seattle, WA
Kenneth C. Ciorba MD, FACP, Associate Professor, Division of Gastroenterology, University of California San Francisco, CA
Kristine Anne Czaja MD, Assistant Professor, University of Washington School of Medicine, Seattle, WA
Robert Harrington MD, MPH, University of Washington School of Medicine, Seattle, WA
Marieka A. Iannucci, MD, University of Washington School of Medicine, Seattle, WA
Kelly G. Jacobs MD, MPH, University of Washington School of Medicine, Seattle, WA
Stafford W. Johnson MD, MPH, University of Washington School of Medicine, Seattle, WA
Karl Goodman MD, PhD, Professor, Psychiatry & Behavioral Sciences, David Geffen School of Medicine, UCLA, Los Angeles, CA
Richard J. Harthorn MD, MPH, LA Health & Aging Research Institute on Aging (HRI) and AIDS Community Research Initiative of America (ACRIA), NY NY
William Hazzard MD, MPH, University of Washington School of Medicine, Division of Gastroenterology & Hepatology, Seattle, WA
Kevin High MD, MS, FACP, Washington University School of Medicine, Saint Louis, MO
Pritulika M. Jha MD, Professor, University of Hawaii, San Francisco, San Francisco General Hospital, San Francisco, CA
Malcolm D. Jones MD, MPH, The Positive Care Center, UCSF Helen Diller Family Comprehensive Cancer Center, San Francisco, CA
Amy Justice MD, PhD, NYU School of Medicine, VA System, New York, NY
Stephan J. Karpik MD, MPH, AIDS Community Research Initiative of America (ACRIA) and New York University College of Nursing, NY NY
Wayne C. McDonald MD, MPH, (Co-Principal Investigator), University of Washington School of Medicine, Division of Gastroenterology and Hepatology, Seattle, WA
Jan R. McPherson PhD, BCPE, AANPCP WISE Practice Model Program San Francisco CA
Ann Newman MD, MPH, VA Mission Health System, Asheville, NC
Mark J. Simon, St. Louis University School of Medicine, Washington University School of Medicine, St. Louis, MO
Ken Strickland, MD, University of California, San Francisco, San Francisco General Hospital, San Francisco, CA
David A. Tompkins MD, MPH, University of Virginia School of Medicine, Charlottesville, VA
Victor Ugonji MD, University of Washington School of Medicine, Seattle, WA

*Exempt Panel Member, *Reviewer, *Contributor, *Staff
The Complications of Success
Lessons from Geriatrics: Tailoring Cared for Syndromes
Multi-Morbidity
Screening for HIV in Older Adults
When to Initiate Therapy in Persons Older than 50
CD4 and VL Monitoring
Immunizations
Smoking Cessation Serum Lipid Monitoring
The Kidney
Hypertension
Drug-drug Interactions Polypharmacy
Diabetes
CVH and HIV
Cancer
Chronic Pulmonary Disease
Sexual Health
Osteoporosis
Advanced Care Planning
Cognitive Screening
Depression
Anxiety Disorders
Substance Use Disorders
When considering persons with multimorbidity the sum is greater than the parts.

Aging plus debilitating conditions have the propensity to synergize to make morbidity and mortality worse than might otherwise seem apparent.

Incorporate geriatric, syndromic thinking into considerations of clinical guidance, separate from chronological age (aging acceleration).
Research on HIV and Older Adults

- Nichols, et al, Florida study
- VA Cohort Study (VACs)
- ROAH
  - New York
  - Chicago data
  - Others?
- British HIV Over Fifty Study (2009)
- Others address
  - Neuro-psychiatric issues (V. Valcour)
  - Specific psycho-social issues
Psychosocial Issues for the Older Adults Living With HIV
Cohort (Generational) Issues: History

How is life experience for over 50s different from younger adults with HIV?

– Within group variation
– Formative experiences: depression, world wars, fifties, sixties??
– From the closet to “silence=death”
Cohort Effects: HIV experience

- All of these people grew up and established their lives before HIV was known.
- Prevention was largely unknown.
- Experienced the:
  - discovery of the epidemic
  - the experience of devastation upon various communities
- May have lost friends and families, entire social networks.
- Some have been activists or have been very closeted related to HIV.
Changing Roles

“I’m not old, I’m HIV” versus “It doesn’t really change my life much; I’m old anyway!”

What’s HIV? What’s Aging? Separating the effects of

- "normal aging"
- unique concerns related to age
- the experiences living with HIV

HIV as an Off-time Experience: “Old before my time”
Extended Life With HIV

- Younger people maturing into old age living with HIV
- Long-term survivors
- Denial: e.g. “I don’t have AIDS, I’m HIV and who knows what that means” (Anderson, 1996)
Extended Life With HIV: What might it mean psychosocially to live 30, 40 or even 50 years with HIV?

- Prevention for positives issues
- Feelings of long life with a complex, infectious diseases
- Survival fatigue, depression
- Extreme isolation and loneliness
- Majority of their support system is deceased or alienated from them
- Need for ways to maintain positive experience
“In the 80s people expected the worst. In the 90s there was hope, followed by euphoria. Now... there are unforeseeable problems arising with long term survival. Life is not predictable for anybody, but this added uncertainty...”

(Gay man, 50Plus)
1000 NYC Older Adults Over Age 50 participated in this study
ROAH is COMPREHENSIVE

Demographics
Sexual Behavior
Social Networks
Psychological Well-Being
Distress – Depression
HIV Status/Health
Religiousness & Spirituality
Loneliness Among Older Adults
HIV Stigma and Disclosure
Older Adults with HIV: An In-depth Examination of an Emerging Population
Brennan, Karpiak, Shippy & Cantor

Table of Contents
1. The Emerging Population of Older Adults with HIV and Introduction to ROAH the Research Study, S. E. Karpiak & M. Brennan
2. Health Status, Comorbidities, and Health-related Quality-of-Life; R. J. Havlik
3. Mental Health; A. Applebaum & M. Brennan
4. Substance and Alcohol Use; A. Applebaum & M. Brennan
5. Sexual Behavior among HIV+ Older Adults; S. A. Golub, C. Grov, & J. Tomassili
6. HIV Stigma and Disclosure of Serostatus; M. Brennan & S. E. Karpiak
7. Social Support Networks of Older People with HIV; M. H. Cantor, M. Brennan, & S. E. Karpiak
8. Loneliness among Older Adults with HIV; M. Brennan & A. Applebaum
9. Psychological Well-being; M. Brennan & S. E. Karpiak
10. Religiousness and Spirituality; M. Brennan
11. Aging with HIV: Implications and Future Directions; S. E. Karpiak & M. Brennan
12. About the Authors
13. Appendix: Methodology of the ROAH Study
ROAH HIV Treatment Care

**Treatment facility**

- Private physician 21.9
- Public clinic / hospital 58.7
- VA Hospital 4.9
- ASO / day program 17.0

83% of ROAH Participants are Medicaid Dependent
Social Networks
ROAH Participants Social Networks

- 70% Live Alone
- Most are Socially Isolated
- Less than 15% have spouses/partners
- Less than 20% have children
- Fragile social networks – no informal caregivers
- A majority remain involved with their Congregations
- 20% provide care giving to others
- Resiliancy
CAREGIVERS are derived from SOCIAL NETWORKS

Social networks are a significant healthcare resource 400 Billion Dollars as people age
ROAH: Informal Social Network Composition

- Parent
- Child
- Sibling
- Other...
- Friend

[Bar chart showing the composition of informal social networks with categories: Living and Functional]
Depression
Depression

Studies generally described as several ranges—mild to severe

Heckman and Kalichman study of 113 PWHIVs 50+
  – 29% of the cohort moderately to severely depressed

  – Stressors related to depression: finances, lack of information, lack of support resources, AIDS related stigma and discrimination
Prior History of Depression in ROAH

- Yes: 51.9%
- No: 48.1%
Over 2/3 of the study group had moderate to severe depression.

Depression Causes Non-Adherence to ALL Medication including HIV Meds.

Although in Medical Care Their Depression Remains Unmanaged.
CES-D Symptoms of Depression

- Severe (23+) 43%
- Not Depressed (1 to 15) 37%
- Moderate (16-22) 20%
## Comorbidities and Depression Management in Older Adults with HIV

(from ROAH: in press by Havlik, Brennan, Karpiak)

<table>
<thead>
<tr>
<th>Comorbidity</th>
<th>Significance</th>
<th>% No Depressive Symptoms</th>
<th>% Moderate Depressive Symptoms</th>
<th>% Severe Depressive Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Loss</td>
<td>p&lt;0.05</td>
<td>18.3</td>
<td>27.5</td>
<td>54.2</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>ns</td>
<td>8.7</td>
<td>10.1</td>
<td>14.3</td>
</tr>
<tr>
<td>Dermatitis Problems</td>
<td>p&lt;0.05</td>
<td>24.7</td>
<td>23.5</td>
<td>51.8</td>
</tr>
<tr>
<td>Heart Condition</td>
<td>p&lt;0.05</td>
<td>26.6</td>
<td>20.2</td>
<td>53.2</td>
</tr>
<tr>
<td>Respiratory Condition</td>
<td>p&lt;0.01</td>
<td>20.2</td>
<td>20.2</td>
<td>59.6</td>
</tr>
<tr>
<td>Stroke</td>
<td>ns</td>
<td>13.8</td>
<td>41.4</td>
<td>44.8</td>
</tr>
<tr>
<td>Diabetes</td>
<td>ns</td>
<td>12.6</td>
<td>11.6</td>
<td>17.1</td>
</tr>
<tr>
<td>Broken Bones</td>
<td>p&lt;0.05</td>
<td>19.2</td>
<td>33.3</td>
<td>47.4</td>
</tr>
<tr>
<td>Impotence</td>
<td>ns</td>
<td>10.5</td>
<td>11.5</td>
<td>16.3</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>ns</td>
<td>27.6</td>
<td>30.0</td>
<td>32.6</td>
</tr>
</tbody>
</table>
### ROAH Sexual Behaviors 3 Months

<table>
<thead>
<tr>
<th>Number of sexual partners</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>– No sexual partners</td>
<td>43.3</td>
</tr>
<tr>
<td>– One sexual partner</td>
<td>43.4</td>
</tr>
<tr>
<td>– More than one sexual partner</td>
<td>13.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual activity in the last 3 months</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>– No sexual activity</td>
<td>49.8</td>
</tr>
<tr>
<td>– Oral sex</td>
<td>41.4</td>
</tr>
<tr>
<td>– Vaginal sex</td>
<td>30.1</td>
</tr>
<tr>
<td>– Anal sex</td>
<td>19.5</td>
</tr>
</tbody>
</table>
Substance Abuse
### ROAH: Tobacco Use

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57 %</td>
<td>84 %</td>
</tr>
</tbody>
</table>
## Substance Use Recovery

<table>
<thead>
<tr>
<th>Recovery Status</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever enrolled in 12-step</td>
<td>62</td>
</tr>
<tr>
<td>Currently in recovery</td>
<td>54</td>
</tr>
<tr>
<td>No substance use in past 3 months</td>
<td>48</td>
</tr>
<tr>
<td>In recovery for more than 1 year</td>
<td>44</td>
</tr>
</tbody>
</table>
Ongoing Concerns and Coping
Differences: Older and Younger with HIV

- Less life lost
- Age appropriate declines and changes
- Disclosure— I can’t tell
  - don’t want me around
  - see me as role model

Source: Linsk, 1998
Poverty and Income Changes

- HIV/AIDS and aging may each compound the economic losses of aging
- Financial conditions would have been better without HIV in lives (e.g. Nichols et al.)
  - Not having enough money to live on
  - Give up work earlier due to HIV
- Racial differences: white versus African Americans (Speer, et al.)
  - Annual income for African Americans half that of whites
Main concerns

- Financial difficulties (79%)
- Difficulties with self care (76%)
- Mental health/depression (73%)
- Inability to get healthcare (69%)
- Social stigma/discrimination (66%)
- Loneliness (61%)
- Employment (58%)
- Finding a partner (43%)

British HIV Over Fifty Study
Coping Strategies

- Search for meaning
- Spirituality—most frequent?
- Active resistance/determined attitude
  - “I can fight it!”
  - Problem solving
- Recovery from substance abuse
- Just get through it—one day at a time

Source: Linsk, 1997
Coping Methods

- Develop alternative activities
  - “Don’t dwell on it”
  - Support and activity groups
  - Senior citizen groups--e.g. theatre activities, pottery, etc.

- Living with uncertainty
  - Journaling, Prayer and Spirituality

- Stress reducers, e.g. Yoga, Massage, Tai Chi, exercise

- Counseling, Support Groups, Problem solving
Coping Methods: Advocacy and Service

- Participate in HIV planning process, organizing or advocacy

- Improve services for self and others as a way to find meaning
Psychosocial Issues for the Older Adults Living With HIV

Accessing Care and Services
Falling Through the Cracks

Ageism
- HIV providers may not see them and their age related needs

AIDSism
- Aging service providers may not see HIV or know how to help

Need for FAMILY CENTERED CARE
Needs for the future

- Health & treatment information (86%)
- Social care (78%)
- Social support/networking opportunities (76%)
- Physical therapy (75%)
- Counselling/emotional support (73%)
- Financial advice/debt management (63%)
- Housing advice/support (56%)
- Employment (46%)

Power, British HIV Over Fifty Study, 2010
Preferences for services—Variation among the participants.

- Several reluctant to use senior services
- Most felt need for specialized HIV services
- Most identified with HIV service networks and were skeptical of aging service programs being able to meet their HIV related and socialization needs

Source: Linsk, HIV Over Fifty, 1997
Comparison of the Older Americans and Ryan White Acts

**Older Americans Act**
- Funding: Administration on Aging, DHHS
- Decision bodies: Area Agencies on Aging (AAAs), State office on Aging
- Consumer/Community input: AAA Advisory councils include service eligible participants
- Service scopes: Community based social and nutrition services, case management, long term care advocacy (ombudsman), caregiver support, research/training and demonstration projects

**Ryan White Re-modernization Act**
- Funding: HRSA, DHHS
- Decision Bodies: HIV/AIDS Consortia and Planning Councils, State Part B contractors
- Consumer/Community Input: 1/3 of Planning councils are HIV infected individuals
- Service Scopes: Inpatient and outpatient medical care, medication (ADAP) and supportive services: case management, mental health, substance abuse, dental, etc. Training through AETCs
Comparison of the Older Americans and Ryan White Acts

Older Americans Act
- Caregiver support: National Caregiver Support Program
- Service providers: Local subcontractors
- Medication Assistance: No (but participants may qualify for Medicare D)
- Cost sharing: Yes, with limitations such as use of sliding fee scales for some services

Ryan White Re-modernization Act
- Caregiver support: Part D requires coordination of systems of care targeting HIV-affected children, youths, families and women
- Service providers: Local subcontractors
- Yes: AIDS Drug Assistance Program (ADAP)
- Cost sharing: Charging for services not allowed. Donations may be accepted.

Task Forces and Programs

HIV over fifty task forces have evolved in England and in several states in the United States. HIV over fifty task forces have been active in

– New York
– Massachusetts
– New Jersey
– Florida
– Illinois
– California
National Conference on HIV/AIDS and Aging: Prevention, care & Management: Identifying Challenges

Presented by New England Association on HIV Over Fifty, Boston, September 23, 2011

Selected Presentation Topics:
- Medical Update/New Info on Prep (Calvin Cohen)
- Care and Treatment of HIV Aging Patient (Liz Kass)
- HIV & Aging Patient Psychiatric and Neuro Considerations (Glenn triesman)
- Metabolic Manifestations (Steven Grinspoon)
- Complications of Success: The HIV Aging Population (Stephen Karpiak)

All presentation slides available at [http://neaetc.org/video/137](http://neaetc.org/video/137)
Faces of HIV Over Fifty: HIV+ Over Fifty and Supporters
HIV and Aging: A message of Hope

We all hope to live a long and meaningful lifetime with the resources, services and relationships we need! This is increasingly the norm for people living with HIV.

The good news is that people with HIV are living longer and into the later years—normal life span!!
Nathan L. Linsk, Ph. D.

Midwest AIDS Training and Education Center
University of Illinois at Chicago

www.matec.info
nlinsk@uic.edu