Older Adults and HIV/AIDS – What Community Health Centers Need to Know

Presented by the National Center for Health and the Aging
Overview:

About this training: This webinar will provide health center professionals with a better appreciation for the epidemiology of the ever increasing numbers of people 50+ infected with HIV, response on local, regional and national level to these issues; including the AIDS services community, and local and federal government, and specific treatment recommendations for the 50+ HIV infected population in the United States.

Community health center providers will:
• Get the facts about HIV/AIDS and older adults.
• What makes older adults different?
• Learn key steps to take to prevent HIV/AIDS in older adults.
• Break down the barriers that prevent healthcare providers from recognizing and treating older adults living with HIV/AIDS.
• Identify policy opportunities to seek funding for services, outreach, training and research on issues of concern to older HIV-positive older adults.
Webinar FAQ:

• How do I listen to the audio conference?

  This webinar is using a teleconference service for audio presentation. The details are as follows:

  Call-In number: 1-605-475-5950
  Participant Code: 9905621

• Why can no one else hear me on the teleconference?

  Due to the number of participants, this webinar is using a “presentation mode” to avoid excessive audio static. Only the presenters will be speaking.
Webinar FAQ:

- How do I ask a question?

  Participants will be able to use the Q&A feature during the webinar. Presenters will answer questions to the best of our ability.
Webinar FAQ:

- How do I enlarge the presentation?

  Participants will be able to use the “Full Screen” feature to maximize the presentation area.
Older Adults and HIV/AIDS: What Community Health Centers Need to Know

Provided by:
The National Center for Health and the Aging and the National Council on Aging’s Center for Healthy Aging

April 5, 2012
Agenda

- Welcome
- Overview: Why focus on HIV/AIDS
- The facts about HIV/AIDS and older adults.
- Key steps to take to prevent HIV/AIDS in older adults.
- Barriers that prevent healthcare providers from recognizing and treating older adults living with HIV/AIDS.
- Policy opportunities to fund services, outreach, training and research
- Raising awareness & Training Opportunities
- Question & Answer
Our Speakers

- Kelly Horton, MS, RD, Policy Director, Center for Healthy Aging, NCOA,
- Ken South, Manager for the HIV & Aging Consensus Project, American Academy for HIV Medicine
- Greg Case, Director, Office of Home and Community Based Services, Administration on Aging
- Aaron Tax, Director of Federal Government Relations, SAGE (Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders)
NCOA is a nonprofit service and advocacy organization.

Our mission is to improve the lives of millions of older adults, especially those who are vulnerable and disadvantaged.
How NCOA accomplishes its mission

- **Collaborative Leadership**

  NCOA brings together nonprofit organizations, businesses, and government to address key challenges of an aging society.

- **Innovation**

  NCOA helps to develop and “bring to scale” innovative services that improve health and financial well-being.
How NCOA accomplishes its mission

- **Advocacy**
  
  NCOA is the leading national voice and advocate for vulnerable and disadvantaged older adults and the organizations that help them.

- **Services**
  
  NCOA works with thousands of organizations across the country to help seniors find jobs and benefits, improve their health and live independently.
Healthy Aging

- Improve the health of 4 million older adults with multiple serious health problems through participation in cost-effective evidence-based programs.
- Make self-care an integral part of U.S. health care for people with multiple chronic conditions.

http://ncoa.org/cha
Partnering with Health Care Centers

Why focus on HIV/AIDS?

• In the United States, more than 1.1 million individuals are living with HIV/AIDS

• Roughly 21% do not know their HIV status (CDC, 2008).

• 2015, 50% of HIV infected individuals in the U.S. are likely to be 50 and older.
Why focus on HIV/AIDS?

• Community Health Centers are a major source of HIV prevention, care and treatment in America's safety net.

• According to UDS data, health centers provided HIV testing to 781,750 patients in 2010.

• About 10 percent of health centers receive funding through Part C of the Ryan White HIV/AIDS Program
Why focus on HIV/AIDS?

• Older Adults and those with HIV/AIDS are at greater risk for:
  – Multiple Chronic conditions
  – Disability
  – Mental distress
  – Social isolation
  – Economic vulnerability
Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV

Published in the fall of 2011

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• By the middle of this decade, most individuals with HIV in the US will be over 50 years old.
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• *Most will have had HIV infection, and will have been on antiretroviral therapy, for over 15 years. As these adults develop illnesses more commonly associated with aging than with HIV, they represent a unique challenge for their medical providers.*
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• **An HIV clinician, very comfortable with the nuances of antiretroviral therapy, may be increasingly uncomfortable managing multiple age-related, but not necessarily HIV-related, illnesses in older patients.**
• By the middle of this decade, most individuals with HIV in the US will be over 50 years old.

• As these adults develop illnesses more commonly associated with aging than with HIV, they represent a unique challenge for their medical providers.

• An HIV clinician, very comfortable with the nuances of antiretroviral therapy, may be increasingly uncomfortable managing multiple age-related, but not necessarily HIV-related, illnesses in older patients.

• While these patients have substantial medical morbidity, and may appear considerably older than their chronological age, they are typically too “young” to be seen by a geriatrician, who may be more comfortable with multi-morbidity, but less comfortable managing antiretroviral therapy.
This summary represents the results of a two-year collaboration among members of the American Academy of HIV Medicine (AAHIVM), the American Geriatrics Society (AGS), and the AIDS Community Research Initiative of America (ACRIA) regarding the clinical management of HIV-infected older persons.

As the lines of communication have grown between HIV providers and geriatricians, common themes have emerged regarding the care of HIV-infected older adults. Recognizing the lack of information from clinical studies pertinent to the care of these older individuals, an Expert Panel was formed in 2009 to formulate clinical treatment approaches to these patients.

The Panel adopted the convention that the term “older”, in the context of persons with HIV infection, pertained to age 50 or greater. The composition of the Panel was made up of equal proportions of experts from a geriatrics background and an HIV medicine background (7 each), many of who were also acknowledged leaders in research.

The working document evolved after multiple iterations of input / feedback which contributed to consensus on a list of areas most in need of clinical guidance. Six independent reviewers (half geriatricians, half HIV clinicians) then reviewed the document.
Older persons with HIV often have multiple illnesses of aging and HIV, and can be thought of as having multi-morbidity.

Multi-morbidity is a syndrome; it is more than simple co-morbidity. Multi-morbidity is conceptualized as several serious health conditions that cannot be cured, occurring in an older person and engendering functional and/or cognitive debility.

When considering persons with multi-morbidity, 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.
In HIV-infected patients over 50, the Expert Panel reached consensus on the following treatment strategies:

**Screening, Monitoring, and Initiating Antiretroviral Therapy in HIV and Aging**

- Providers must reduce barriers to effective prevention and detection of HIV in older adults. We suggest that primary care providers perform routine, opt-out HIV screening in *all adults, regardless of age or individual factors, with repeat HIV screening at least annually in patients at known risk.*
- Antiretroviral therapy should be initiated in all patients older than 50 who have a CD4 count less than 500 cells/mm³.
- Antiretroviral therapy should be initiated in all patients older than 50, regardless of CD4 cell count, with the following conditions: AIDS-defining illness, HIV-associated nephropathy, or chronic hepatitis B virus infection.
- For patients over age 50 who have a CD4 count greater than 500 cells/mm³, antiretroviral therapy should be considered. Factors favoring initiating therapy include plasma HIV RNA levels greater than 50,000 copies/ml, greater than 100-point decline in CD4 count in prior 12 months, or risk factors for cardiovascular disease.
- For patients who have diabetes or hyperinsulinemia (and no baseline antiretroviral drug resistance), an initial ritonavir-boosted protease inhibitor-based regimen should be avoided, if possible.
- The routine monitoring of CD4 cell counts and HIV RNA levels in patients older than 50 should follow the same general approach recommended for all HIV-infected patients. A CD4 cell count and HIV RNA level should be obtained at the initial evaluation and followed every 3-4 months prior to initiating antiretroviral therapy. Patients initiating antiretroviral therapy should have more intensive monitoring of HIV RNA levels, including a baseline HIV RNA level prior to starting therapy, a follow-up 2-4 weeks after initiating therapy, and continued monitoring every 4-8 weeks until HIV RNA levels become undetectable. Once HIV RNA levels become undetectable, the frequency of monitoring HIV RNA can revert to routine checks every 3-4 months. Monitoring of CD4 cell count and HIV RNA level can be extended to every 6 months in adherent patients who have sustained suppression of HIV and stable clinical status for at least 2-3 years.
Cardiovascular Risk Reduction, Diabetes in HIV and Aging

- Providers should counsel patients at every visit to stop smoking. Providers should make use of community smoking cessation resources, on line quit sites, and pharmacotherapy to assist patients in quitting tobacco use.

- There is insufficient evidence to alter current recommendations for management of dyslipidemia or CVD/ cerebrovascular disease screening by specific age criteria. It is reasonable to recommend Framingham Risk Score assessment in addition to aggressive primary prevention using standardized guidelines for cholesterol and blood pressure (JNC-8).

- Whether or not screening for CVD/cerebrovascular disease and treatment of hyperlipidemia in the setting of HIV should be modified for age and/or for HIV itself remains unknown and will require further study.
The most important prevention for adult onset diabetes mellitus is to avoid excess weight gain. Since most HIV patients come into care at or below normal weight, patients initiating ART should be encouraged to avoid excess weight gain.

Screening for diabetes should be done regularly, before and after the initiation of antiretroviral therapy, using glycosolated hemoglobin with appropriate diagnosis follow up. For patients with diabetes, glycosolated hemoglobin should be checked at least twice yearly.

The target glycosolated hemoglobin (6.5% for younger patients) should be increased to 8% for frail patients, especially if their life expectancy is less than 5 years, since they are at high risk for hypoglycemia, polypharmacy or drug interactions.
Older individuals should have annual measurements of serum creatinine, eGFR and urinary protein excretion, including those with known HIV infection.

All older individuals with a history of injection drug abuse or new onset proteinuria should be screened for HIV and other infections (e.g. HCV, HBV, SBE).

Individuals with an acute change in kidney function need to be evaluated for all causes of kidney disease. Because of the broad differential diagnosis in older, HIV-infected persons, consultation with a nephrologist is appropriate, and kidney biopsy may be indicated.

Careful consideration of the need to adjust drug dosage of all medications in older patients is essential.

Older HIV-infected persons with chronic kidney disease of known etiology who are being managed by current NKF Kidney Disease Outcomes Quality Initiative guidelines should be referred for discussions of renal replacement therapy (dialysis or transplantation) when eGFR reaches 15–29 ml/min. As in all individuals evaluated for renal replacement therapy, issues of co-morbidities, life expectancy, and functional status should be considered during joint decision making.

Because hypertension accelerates the rate of progression of cardiovascular disease, kidney disease, and complications of diabetes, as well as risk for stroke, it is an important contributor to the overall impact of multi-morbidity. For this reason, special attention should be paid to modifying factors (e.g. salt intake, weight, exercise) that reduce hypertension. When medication is required, hypertension should be treated in older HIV-infected individuals using recommended guidelines and goals, with avoidance of pressures < 130/70 mm Hg. Selection of specific agents will also need to be tailored to the complex multi-morbid state of the patient and their overall drug regimen, while preventing development of hypotension.

Although some individuals, particularly older individuals, lack evidence of activation of the renin-angiotensin–aldosterone system, they may still respond to angiotensin converting enzyme inhibitors and angiotensin receptor blockers. As these agents confer better risk reductions for cardiovascular events and ESKD, their use may be considered in all individuals with hypertension.

Because of the increased risk for orthostatic hypotension and electrolyte abnormalities, treatment of hypertension in older persons should be initiated with low doses of medications and monitoring for side effects before increasing the dose to achieve therapeutic goals.
Drug–drug Interactions and Polypharmacy in HIV and Aging

- The primary care provider is highly encouraged to perform annual medication reconciliation and a medication review at every visit so that a complete and active medication list is available. This process is not complete until the prescriber discontinues medications no longer indicated and notifies the dispensing pharmacy and patient thus reducing the risk for toxicity and/or drug–drug interactions.

- To reduce the risk of polypharmacy, it is recommended that patients utilize one pharmacy or a pharmacy with an integrated pharmacy computer network and where possible, utilize a HIV specialty pharmacy.

- For patients with renal insufficiency, the Cockcroft–Gault derived creatinine clearance calculation should be used to determine the appropriate medication dosage or frequency adjustments. While less accurate in older patients, this equation is still widely used in renal dosing charts by the FDA and within package inserts. The renal function estimated by MDRD if unadjusted for body surface area may also be a reasonable substitute.

- In the setting of hepatic dysfunction certain medications need dose adjustment.
Viral Hepatitis Screening in HIV and Aging

- All HIV–infected patients should be screened for hepatitis A, hepatitis B and hepatitis C upon entry into care.

- Any unexplained elevations in liver enzymes should prompt a rescreening in those with negative screening tests at initial evaluation. Screening for occult HBV can be considered in this setting, particularly in HCV/ HIV coinfected patients. However, until there are more prospective studies on occult HBV disease, it is not practical to recommend general screening for this entity with HBV DNA testing on those without serologic evidence of chronic HBV infection. Screening for acute HCV infection is important because therapy may be more effective and of shorter duration than in chronic HCV / HIV coinfection. Treatment of HCV may be improved if initiated at an earlier age.

- No formal recommendation can be made at this time for ongoing routine screening in asymptomatic HIV–infected patients at high risk for HCV. However, given increasing evidence of sexual transmission of HCV in high risk populations of men who have sex with men, the increased sexual activity among older individuals, and the lower rates of sustained virologic response to HCV treatment in older patients, sexual behavior counseling as it relates to HCV transmission may be warranted in older individuals living with HIV.
Cancer Screening in HIV and Aging

- As part of general health maintenance practices, cancer screening in clinically stable HIV–infected patients 50 years and older should be in accordance to current guidelines for the general population.

- For cervical cancer, anal cancer and liver cancer where HIV–specific recommendations exist, these guidelines should be adhered to instead.

- For all patients, providers should take into consideration functional status and life expectancy in applying these recommendations.
Sexual Health in HIV and Aging

- Consistent with HIV primary care guidelines, the health care team should screen older persons at each visit for high-risk behavior or evidence of sexually-transmitted diseases, and then provide a tailored prevention message. A more general prevention message should be given at each visit to all patients. Developing a routine way to elicit the patient’s sexual history that avoids judgmental attitudes and asks the patient for permission to discuss sexual function will make it easier to gather the necessary information.

- In HIV discordant couples, there is a special need to emphasize safe sexual practices and full adherence to ART use.

- Use of erectile dysfunction medications or other measures for impotence in men and topical estrogen products for vaginal dryness in women can enhance sexual satisfaction, but care in their use is necessary. The prescription should be linked to specific educational efforts on safe sexual practices.
Since older patients have bone loss due to osteoporosis, and since many HIV–infected patients on ART have accelerated bone loss, screening for (and aggressive treatment of) osteoporosis should be done.

Since vitamin D deficiency is prevalent in older HIV–infected persons, screening for vitamin D deficiency is warranted.
Older HIV-infected patients, especially those with substantial illness burden, should be counseled in completing a durable power of attorney for health care and an advance directive, such as the Physician Order for Life Sustaining Treatment (POLST), or similar document.
Screening for cognitive impairment is important. A two-tiered approach, assessing symptoms with follow up testing, is a reasonable paradigm for busy practices. Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV

Older HIV-infected patients should be screened for depressive disorder with an appropriate standardized measure (such as the Geriatric Depression Scale) that minimizes the impact of somatic depressive symptoms.

Many anxiety disorders can be addressed with SSRIs rather than benzodiazepines with fewer consequences.

If pharmacotherapy is indicated for acute control of anxiety, the short to intermediate acting benzodiazepines with no active metabolites are preferred.

Non-benzodiazepine agents are preferred for longer term anxiety control, when longer term pharmacotherapy is judged to be warranted.

Patients should be encouraged to discontinue or minimize their alcohol and substance use and be referred to a counseling program or offered pharmacologic treatment if found to have abuse or dependence disorders.

Hazardous alcohol consumption or binge drinking should be routinely assessed and advice to cut down or stop given in the context of clinical care accompanied by a list of conditions experienced by the patient that are likely exacerbated or caused by their heavy alcohol use (e.g. reflux, elevated liver function tests, low platelets, difficulty taking their ART, difficulty tolerating GI side effects of treatment, etc).

No level of alcohol consumption is known to be safe or beneficial among HIV-infected individuals.
Conclusion

Because this area of interest is rapidly evolving, with new information coming forth weekly, the results of the Panel’s work now appears in blog / wiki format at the following website:

www.aahivm.org/hivandagingforum.
AoA Older Adults and HIV/AIDS Toolkit

HIV: Know the RISKS. Get the FACTS.

Greg Case
Administration on Aging
If You Think Your Too Old to Worry About HIV/AIDS, Think Again

• To commemorate the 30th Anniversary of AIDS, AoA began a campaign focused primarily on prevention.

• A website was established to disseminate information.

• In 2012, we decided to focus on prevention and assist aging service providers with a tool kit to assist them in their work with older adults.

• Later this year AoA will begin to look at the complications of treatment for older adults with HIV/AIDS.

• Older Adults & HIV/AIDS Toolkit
How to **Access** the Older Adults and HIV/AIDS Toolkit

HIV: Know the RISKS. Get the FACTS

Visit [www.aoa.gov](http://www.aoa.gov)

Click this button on the right-hand slide of the AoA homepage
Older Adults & HIV/AIDS Toolkit
HIV: Know the Risks. Get the Facts

Toolkit Introduction by Kathy Greenlee,
Assistant Secretary for Aging

http://www.youtube.com/watch?v=UiUPA2ya54c
Fact Sheet

Designed for professionals to use with older adults or other service providers

HIV: Know the RISKS. Get the FACTS.

If you think you’re too old to worry about HIV/AIDS, think again. HIV risk doesn’t stop at 50. In fact, men and women over age 50 account for 17 percent of all new HIV and AIDS diagnoses in the 40 states that have long-term confidential name-based reporting. Every 10 minutes someone in the United States is infected with HIV. Make sure it’s not you.

Risk does not diminish with age.
You’re at risk if you don’t use a condom when having sex with a man or a woman who has HIV. Oral sex also carries a risk of infection. The risk can be especially high for women with age-related vaginal thinning and dryness that can lead to tears in the vaginal area.

Many older adults find it awkward to talk to a new partner about their sexual history and HIV, and most don’t discuss sex with their doctors at all. That’s a risk you don’t have to take.

- Before having sex with a new partner, discuss your HIV status. You both have a right to know.
- Ask your health care provider for an HIV test if you are having unprotected sex or injecting drugs. Medicare covers it. If you are a man who has had sex with other men, get tested at least once a year. If you are a woman, get tested whenever you have a new sex partner.
- Get tested before engaging in sex with a new partner, and be sure your partner has been tested for HIV too.
- Protect yourself. If you have multiple partners, use a latex condom and lubricant every time you have sex. Avoid contact with another person’s blood, and be sure to never share or re-use needles.
- Be alert to possible symptoms. HIV can go undetected in older people because the illnesses associated with it—such as weight loss, pneumonia, fatigue, confusion, and vision problems—also occur more frequently with age.

For more information about HIV and AIDS, visit www.AIDS.gov or www.ACTAGANISTAIDS.org. To find an HIV testing site near you, go to www.HIVTest.org or call 1-800-CDC-INFO

Administration on Aging
www.aoa.gov | Email: aoainfo@aoa.hhs.gov
HIV/AIDS and Older Americans

HIV risk does not diminish with age.

You are at risk if you don’t use a condom when having sex—whether it’s vaginal, oral, or anal—with a man or a woman who has HIV.

Age-related vaginal thinning and dryness can lead to tears that expose the vaginal area to HIV infection.

If you think you’re too old to worry about HIV/AIDS, think again.

In 2009, men and women 50 and older accounted for:

• 17% of all diagnoses of HIV infection (in 40 states with confidential HIV reporting)

• 23% of all AIDS diagnoses (in the 50 states and Washington, D.C.)

PREVENTION

Get tested.

• Ask your health care provider for an HIV test as a routine part of medical care, if you are having unprotected sex, injecting drugs or have never been tested before. Medicare covers annual HIV testing.

• Get tested before having sex with a new partner, and be sure your partner has been tested for HIV too.
  - If you are a gay or bisexual man, get tested at least once a year.
  - More frequent HIV testing—every 3 to 6 months—may be beneficial.
  - If you are a woman, get tested whenever you have a new sex partner.

• To find an HIV testing site near you, go to [http://www.HIVTest.org](http://www.HIVTest.org) or call 1-800-CDC-INFO
HIV: Know the Risks. Get the Facts. Toolkit Video
Toolkit Promotional Info sheet designed to help you understand how you can use each section of the toolkit.

HIV: Know the RISKS. Get the FACTS.

In 2009, people aged 50 and older accounted for 23% of AIDS diagnoses in the United States. Yet older adults are often overlooked in the ongoing HIV/AIDS conversation. Developed for States, Area Agencies on Aging, Tribal Organizations, senior centers, and other local service providers within the National Aging Network, the U.S. Administration on Aging HIV: Know the Risks. Get the Facts. Older Adults and HIV/AIDS Toolkit contains helpful resources and materials specifically designed to inform older adults about the risks of HIV/AIDS and to encourage older adults to know their status.

Older Adults and HIV/AIDS Toolkit

Resources available in the toolkit include:

Poster Series.
Raise the level of HIV/AIDS awareness among older adults in your community by putting up posters in places of interest. Your own facility or office is a great place to start, but also put up posters in local grocery stores, pharmacies, and doctors’ offices.

Factsheet.
Print several copies of the HIV: Know the Risks. Get the Facts. factsheet and make them available in your office or senior center. If you are hosting an educational event, print a few extra copies for event participants to take home and review.

Know the Risks. Get the Facts. Video.
This video is an engaging resource with a variety of possible uses. When holding discussion groups, webinars, or information sessions about HIV/AIDS among older adults, consider opening with this video.

PowerPoint Template.
This template provides a few key facts about HIV/AIDS among older adults but also leaves plenty of space for you to add information relevant to your community. Feel free to customize it to fit your needs.

Education is the first line of defense against HIV/AIDS. Use these materials as you educate older adults on how to protect themselves against—or live with—this disease.

Administration on Aging
www.aoa.gov | Email: aoainfo@aoa.hhs.gov
Resources

• AoA Older Adults & HIV/AIDS

• www.AIDS.gov

• AIDS Education and Training Centers National Resource Center (funded by HRSA)
  – www.aidsetc.org

• National HIV/AIDS and Aging Awareness
  – www.NHAAAD.org

• National Resource Center on LGBT Aging HIV and Aging Resources
  – www.lgbtagingcenter.org/resources/index.cfm?s=12
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CDC Advocacy

- Goal – universal:
  - Testing
  - Tracking

- Advocacy update
Older Americans Act (OAA) Advocacy

- Background
- Greatest Social Need
- Progress on Capitol Hill
- LCAO Consensus Recommendations
  - Briefing
  - Senator Sanders
National Resource Center on LGBT Aging

- Background
- Resources
- Trainings

http://www.lgbtagingcenter.org/
Question & Answer
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The 2012 National Primary Care Conference on Aging will take place on April 30, 2012 at the Westin Hotel in Alexandria, Virginia. This one day national conference will highlight innovative senior programs and services, address issues including physical and mental health, multicultural aging, workforce, resources and the latest research findings to improve access to quality care and improve health outcomes of seniors in underserved communities.

Invited guest speakers include leaders of federal agencies, nonprofits, academic institutions and businesses of diverse multi-disciplines in aging, healthcare and senior health education.

**Continuing Education Units will be offered**
Please visit our website [www.healthandtheaging.org](http://www.healthandtheaging.org) for details and registration.
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Thank You