Feature

Adapting Systems of Care for People Aging With HIV

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People aging with HIV have medical and psychosocial needs that require more than the HIV services network can provide. HIV providers may lack experience managing multimorbidity or the functional consequences of aging. Social support services may be unable to provide necessary services for people living with HIV (PLWH) who are becoming increasingly frail or facing cognitive impairment. HIV providers will be caring for aging PLWH whose HIV management may seem simple compared with the significant burdens of stigma, mental health needs, social isolation, multimorbidity, and aging-related syndromes. Although practices can incorporate geriatric expertise and develop facility with the aging services network, a more comprehensive integration would adapt existing geriatric long-term care models for those aging with HIV. The diversity of aging PLWH and the tenuousness of the health safety net will necessitate innovative and flexible collaboration between content experts and social service agencies.

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In 2014, 45% of people living with HIV (PLWH) in the United States were 50 years of age and older (Centers for Disease Control and Prevention [CDC], 2016), a figure that will likely reach 70% by 2020 (Services and Advocacy for GLBT Elders, 2016). This demographic shift is due largely to the success of antiretroviral therapies (ART), and PLWH can now expect near-normal life expectancy (Samji et al., 2013). Growth in this population is also due in part to new HIV infections; in 2015, PLWH ages 50 years and older accounted for 17% of new HIV and 29% of new AIDS diagnoses in the United States (CDC, 2016).

Although a relatively young population, with 70% between ages 50 and 59 years (CDC, 2016), many PLWH ages 50 years and older present with medical and psychosocial issues typically observed in geriatric patients (John et al., 2016; Schouten et al., 2014). Older PLWH report, on average, two to three comorbidities (Balderson et al., 2013; Havlik, Brennan, & Karpiak, 2011). Older PLWH have both a greater burden of disease compared to noninfected age peers and younger adult PLWH (Rodriguez-Penney et al., 2013), and have a higher rate of aging-related syndromes (Greene et al., 2015). Cost of care for PLWH is higher than in uninfected controls across all age strata, and in those ages 60 years and older, cost of care for comorbidities exceeds that of HIV care (Guaraldi et al., 2013).

Rates of depression in this population are five times greater than in non-HIV-infected groups (Applebaum & Brennan, 2009). Depression severity in older PLWH is linked to multimorbidity, as well

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as to psychosocial factors such as HIV stigma and loneliness, and is one of the most reliable predictors of nonadherence to ART (Grov, Golub, Parsons, Brennan, & Karpiak, 2010; Havlik et al., 2011). Older PLWH report high rates of lifetime and current tobacco, alcohol, and substance use, and many remain sexually active and engage in high-risk behaviors (Brennan-Ing, Porter, Seidel, & Karpiak, 2014; Golub et al., 2010). Older PLWH are also less likely than their younger counterparts to receive mental health care (Zanjani, Saboe, & Oslin, 2007).

In one study of Medicare beneficiaries 65 years of age and older, those who were HIV infected were more likely to be African American, Hispanic, younger, and male (Friedman & Duffus, 2016). Older gay and bisexual men, as well as people of color, have been disproportionately affected by HIV (CDC, 2016), and many older PLWH experience discrimination and multiple stigmatized intersecting identities (i.e., HIV serostatus, sexual orientation, race/ethnicity, gender, age; Emlet, 2006). Such stigma not only negatively affects mental health (Grov et al., 2010; Porter, Brennan-Ing, Burr, Dugan, & Karpiak, 2017), but can also fuel social isolation.

The informal social networks of older PLWH are often fragile and inadequate to meet their support and caregiving needs (Shippy & Karpiak, 2005a; 2005b). Sizeable proportions are socially isolated or rely on friend-centered social networks that are unlikely to meet their needs for caregiving due to short- or long-term disability (Brennan-Ing, Seidel, & Karpiak, 2016). Lacking informal supports, older PLWH will have to rely on formal community-based medical care and social services that are largely unprepared for the aging of the HIV epidemic (Brennan-Ing, Seidel, London, Cahill, & Karpiak, 2014; Emlet, Gerkin, & Orel, 2009).

A recent British survey of people aging with HIV documented the diversity of the population and how living with HIV added an extra level of need beyond that of aging itself. The study's authors concluded that determining how to meet those needs was "uncharted territory" (Terrence Higgins Trust, 2017).

Thus, although ART has been a great success, that success now poses challenges for primary care for PLWH, who are often too young to consider or accept geriatric care; when they are interested in consultation, access is limited by a shortage of nurses and physicians trained in aging (Cohen, 2009; Lee & Sumaya, 2013), even in resource-rich nations. In light of the rapid increase in aging PLWH, we discuss factors that should be considered when preparing an integrated clinical program to meet the needs of aging PLWH.

Programs for Aging PLWH Must Have Breadth and Flexibility

PLWH have different backgrounds, risk factors, comorbidities, support systems, age at HIV acquisition, and physical and psychological responses to the infection. Each PLWH ages differently, amplifying the underlying heterogeneity of the population with HIV. PLWH who are 50 years and older have very different needs, only one of which is the management of HIV infection. Comorbidity, frailty, stigma, and mental health burdens are likely to be greater than for those not infected with HIV (Ambroziak, Havlik, Brennan-Ing, Seidel, & Karpiak, n.d.; Rodriguez-Penney et al., 2013).

PLWH in their 50s and early 60s may not think of themselves as aging and may require assistance preparing for the future or counseling about retirement. Those who are older may be coping more with the consequences of aging and comorbidities than with HIV itself.

Newly diagnosed patients may have very different mental health needs from those who have been living with the diagnosis for decades. Those with dementia or significant functional impairment will require long-term care services at home or in a facility. Others will require significant resources to help them and their providers manage multimorbidity and aging-related syndromes.

Any system designed to provide care for aging PLWH must meet the medical, psychological, and social needs of all of these individuals. Services must be accessible and tailored to each individual–not just physically frail, chronologically old (Foebel, Hirdes, Lemick, & Tai, 2015), or long-term survivors.

This heterogeneity of needs poses significant challenges for the creation of a comprehensive geriatric HIV program. Will the program be self-contained