

***Detection and Screening for HIV in Older Adults**

- Providers must reduce barriers to effective prevention and detection of HIV in older adults. However, because providers and patients are unable to reliably estimate HIV risk in older patients, 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.

We recommend routine, opt-out screening for HIV in all adults, including those over the age of 65. As described below, HIV screening based on identification of risk factors alone is not effective, especially since older adults may be more likely than the general population to have unrecognized risks, and are therefore more likely to present late in the course of infection with HIV/AIDS. Since early initiation of antiretroviral therapy is critical to successful treatment, and routine screening is more effective than risk-based screening in identifying HIV earlier in older adults, we recommend that all adults regardless of age should be screened for HIV.

The number of older adults with HIV/AIDS is increasing, partly because people with HIV/AIDS are living longer. In 2010, 19% (217,300) of those with HIV in the U.S. were over the age of 55, and it is estimated that by 2015 this will increase to 50% (CDC 2013, CDC 2011). There has also been a continued lack of attention to the rate of new infections in older adults. In 2011, 47% of new infections were in those 50-55 years old, and in 2010, 5% of new infections were in those over 55 years old (CDC 2013). One in 6 of all new HIV infections in the US occur in the older adult (CDC 2011), and in 2011 older adults accounted for 24% of AIDS diagnoses (CDC 2013).

Detecting HIV in older adults is not only important because of the increasing incidence and prevalence, but also because older adults are more likely to present late, with greater associated mortality (Chadborn et al. 2006). A UK study found that 48% of older adults were late presenters vs. 33% of younger adults (Smith et al. 2010). Older adults in this study were 14 times more likely to die within a year of diagnosis compared with older adults who were not diagnosed late. Reasons for late diagnosis include lack of awareness by both patients and providers.

Screening for HIV/AIDS requires awareness of risk factors, which may be different in older adults. In contrast to younger adults, the main risk factor in older adults is heterosexual intercourse, though the route of HIV infection is often unknown (Grabar et al. 2006; Martin et al. 2008; Sherr et al. 2009). There are however differences based on gender, with 60% of men over 50 years old contracting HIV by male-male sexual contact, 23% heterosexual contact, and 14% injection drug use, as compared to women with 82% by heterosexual contact and 16% by injection drug use (CDC 2013). Older women may be at increased risk of HIV due to age-related vaginal thinning and dryness, and also because older women starting a new sexual relationship after many years of being in a monogamous relationship may find it

difficult to initiate discussions about risks and the use of condoms (CDC 2013).

Additionally, increasing prevalence of erectile dysfunction as men age may make condom use even more challenging, while the availability of medication to treat erectile dysfunction may also allow for increased sexual activity in older men (CDC 2013).

Minority races/ethnicities may also have increased risk factors (Zingmond et al. 2001, Linley 2012). The rate of new HIV diagnoses in older Blacks and Hispanics/Latinos was 12.6 and 5.0 times higher than Whites (Linley et al. 2012). Older adults who are lesbian, gay, bisexual or transgender (LGBT) are an additional group at increased risk, especially men who have sex with men, who account for just about half of all new HIV infections (CDC 2013). Older LGBT adults are often invisible to the health care profession for multiple reasons, which can further impair effective communication and reduction of risk (Grossman 1995; Simone & Appelbaum, 2011).

Barriers to effective prevention and detection include:

1. Lack of knowledge about HIV/AIDS by older adults/reluctance to discuss sexuality: Older women have poor knowledge about HIV risk factors (Henderson et al. 2004). Older adults are also often ignored or forgotten in typical prevention campaigns that generally target youth (Pratt et al. 2010). Older patients also report receiving little information about sexual health, HIV, and other STIs from their physicians, despite still being sexually active (Lindau et al. 2007; Stall & Catania 1994). Many older people do not consider themselves at risk for contracting HIV and therefore do not get tested. A 2009 survey of over 12,000 older adults found that only 25% had ever been tested, and of those tested, 70% had been more than 5 years ago (Adekeye et al. 2012). Respondents identified very low perceived risk of HIV infection

(98% reported risk as low or none), and lower perception of risk was associated with decreased likelihood of being tested. Older adults are much less likely to use condoms than younger adults. For instance, only 20% of men and 24% of women reported condom use during their last sexual encounter, and yet the majority of men (64.4%) and women (68.9%) reported that they had not received an STI test within the past year (Schick et al. 2010). A systematic review of HIV prevention programs that target older adults suggests three models of education: group education programs delivered by social workers or other health professionals, peer education models, and one-on-one early intervention models including HIV/AIDS testing (Milaszewski et al. 2013). Increasing attention has been paid to the critical need for more effective prevention programs for older adults, as was discussed at a White House summit on HIV and aging in 2010. Various resources and campaigns now exist (Brooks et al. 2012).

Underestimation of risk by healthcare providers/ageism: Healthcare providers may not consider discussing HIV/AIDS with older patients, and may also lack the correct knowledge about risk factors in older patients (Skiest & Keiser 1997). They may incorrectly assume that older patients are not sexually active or do not use drugs, or may be uncomfortable raising these issues with older patients (CDC 2013, Brooks 2012). Providers are also much less likely to document the sexual history of older adults (Loeb et al. 2011). However, older adults remain sexually active: 53% of those 65-75 years old, and 26% of those 75-85 years old, report sexual activity (Lindau et al. 2007). In addition, older adults with HIV also remain sexually active (27%), with only 68% reporting consistent condom use (Onen et al. 2010). A national survey of providers found that they had difficulty ranking the four most common

risk factors for HIV infection in older adults, and only 6% was able to correctly rank all four (Hughes 2012).

Misdiagnosis/delay: Making the diagnosis of HIV/AIDS in older adults can be challenging because the symptoms can mimic normal aging or other medical conditions common in the elderly, such as fatigue, weight loss and mental confusion (Lekas et al. 2005). A retrospective analysis of HIV positive women found missed opportunities for diagnosis in their older cohort (>44 years old), who were also more likely to be late-testers (diagnosed with AIDS <12 months of diagnosis of HIV), and they were more likely to have no identifiable risk factor for HIV transmission (Duffus et al. 2012).

Stigma: HIV-infected older adults with HIV may be more likely to experience greater stigma from their peers due to the association of HIV with homosexuality and substance abuse, leading them to hide their diagnosis or risk factors from providers or family (CDC 2013). Unfortunately, older patients have little interest in HIV testing, even in the presence of risk factors (Akers et al, 2007; Lekas et al. 2005; Mack & Bland, 1999).

Communication between health care providers and patients is critical for HIV prevention and detection, and providers must address the barriers to effective screening and discussion. For example, providers need to discuss safer sex methods with their older patients. Providers must use medical histories that include questions regarding older adults' sexual behavior, sexual orientation, and substance use. Providers play an important role in testing since provider endorsement is associated with higher rates of screening (Craig et al. 2012). Not only should providers have a lower threshold to screen for and consider the diagnosis of HIV in older patients, but they must also engage patients of all ages in discussions about sexual health and

risk prevention. (see Sexual Health section). Removing unnecessary barriers to testing, such as the need for written consent, also improves screening rates (Nayak et al. 2012).

The Centers for Disease Control and Prevention (CDC) recommends voluntary, routine opt-out HIV screening for all adults age 13-64, regardless of risk factors (Branson et al. 2006). Those with known risk factors should have repeat HIV screening at least annually. These guidelines discourage screening based solely on risk factors, because targeted testing in the general population on the basis of risk behaviors alone fails to identify a substantial number of persons who are HIV infected (Branson et al. 2006). In 2013, the U.S. Preventive Services Task Force updated their screening recommendations, and similar to the CDC, recommend routine screening for all adolescents and adults age 15-65 (grade A recommendation) (Moyer et al. 2013). These recommendations unfortunately provide a cut-off at 65 years old, at which point routine screening is no longer recommended, despite the fact that older adults and providers are unable to correctly identify risk factors for HIV infection (Henderson et al. 2004; Skiest & Keiser, 1997). Analyses of HIV screening in older adults show that one-time routine screening of adults up to the age of 75 may also be cost-effective (Sanders et al. 2005).

Given that the cost and risk of physical harm from an HIV test is much less than other established screening tests (e.g. colonoscopy), and since the potential benefits of earlier detection are great, we recommend routine screening of all older adults. Routine screening is more effective than risk-based screening, perhaps even more so in older adults, where providers and patients are less likely to identify risks for HIV infection. In addition to the public health benefit of reduction in HIV transmission in older patients, routine screening may also improve

individual outcomes as a result of earlier treatment (the treatment of HIV/AIDS in older adults is discussed separately in this document). Unlike most screening recommendations in the elderly which should account for the individual's functional status, comorbidities, and predicted life expectancy, we recommend routine testing of all older patients, regardless of age or individual factors, since effective and acceptable treatment options exist, and routine detection would reduce further transmission of HIV in the older population.

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