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Feature Article

HIV in Older Adults: New Challenges for Prevention, Recognition and Management

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Most healthcare professionals view HIV/AIDS as a problem affecting younger adults, but actually, this is a disorder that is affecting older adults with increased frequency. While the likelihood of contracting this disorder is increasing in the over 50 population, the increased longevity of those infected with HIV is also contributing to the rising elderly HIV/AIDS population. What had been viewed as a terminal illness during the previous decade has been transformed into what appears to be a chronic disease because of the impact of treatment strategies for HIV/AIDS. Many aspects of HIV/AIDS in older adults are significantly different from this disorder in the younger population. The clinical manifestations, rate of progression, psychosocial aspects of care, and response to medical interventions demonstrate significant differences in the older HIV/AIDS patient as compared to their younger counterparts. [1,2]

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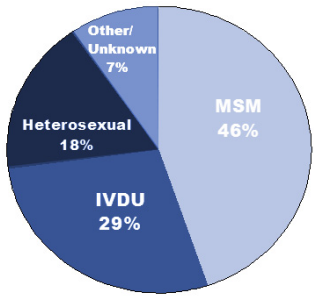
EPIDEMIOLOGICAL FACTORS

Nationally, between 11 and 15% of HIV infections occur in those over age 50. In fact, the elderly represent the most rapidly growing segment of the population with HIV/AIDS. New AIDS cases rose twice as fast in persons over 50 (22%) than in persons less than 50 (9%). HIV transmission in older adults demonstrates some characteristic findings and notable changes in exposure have been observed over the past decade. Currently, men having sex with men (MSM) represent the largest reason for exposure in the over 50 population living with AIDS (46%) followed by IV drug use (IVDU) (29%), heterosexual transmission (18%), and then no identifiable risk factor/ other / unknown etiology (7%). (Figure 1*)

Previously, transmission through blood transfusions, prior to the initiation of blood screening in 1987, represented the largest reason for exposure for those over 65. Currently, the rate of transmission through blood transfusions in the elderly has greatly declined with only a 1 in 600,000 chance of acquiring HIV from a blood transfusion. While the frequency of acquiring HIV from MSM has been relatively unchanged over the past several years, the likelihood of acquiring HIV through IVDU and heterosexual sex has

Figure 1: Adults 50 or Older Living with AIDS in the **United States** in 2000, by Exposure*



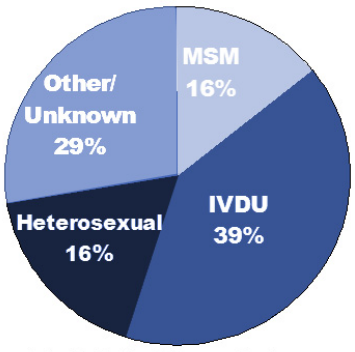
*Reference #3

**Note: These figures are from Table 21, HIV/AIDS Surveillance Supplemental Report, Vol. 9, No.1. These figures are for adolescents and adults living with AIDS in the U.S. in 2000, reported as of December 31, 2002.*

significantly increased in the older population for both men and women. The likelihood of there being no identifiable risk factor for HIV is highest in the older adult population. The reason for this is not clear but it may relate to the fact that older adults are less likely to reveal their sexual orientation.[4]

Data regarding the mode of transmission for New Jerseyans living with AIDS demonstrates a pattern somewhat different from the national statistics. In 2000 in New Jersey, IVDU was the leading cause for HIV/AIDS transmission (39%) followed by other and unknown etiology (29%), heterosexual contact (16%), and MSM (16%). When looking at the impact of gender on the mode of transmission for New Jerseyans living with AIDS, while IVDU represents the leading mode of transmission for men over 50 (40.8%); for women, heterosexual contact (34.4%) is the leading mode of transmission. Certainly, HIV in older adults is emerging as a significant issue in the arena of women's health.[5] Figure 2 (Note that the U.S. data and New Jersey data are both for persons living with AIDS in 2000 and reported through 2002.)

Figure 2: Adults 50 or Older Living with AIDS in **New Jersey** in 2000, by Exposure*



** As of 12/31/02: Reference: New Jersey Department of Health and Senior Services*
** Reference #3*

AGING AND HIV

The impact of the aging process is thought to greatly contribute to the differences observed in this disorder in the older population compared to younger HIV/AIDS patients. This can be attributed to many age related alterations such as a decrease in reserve in a number of organ systems; a decline of the immune response of the elderly; altered pharmacodynamics and pharmacokinetics, leading to increased risk for adverse drug reactions; and the increased prevalence of comorbid illness. As a result, there is evidence suggesting that the progression from HIV to AIDS is more rapid in the elderly than in the younger population. There is also evidence to suggest that AIDS progresses faster in the elderly so that age becomes a predictor of both disease progression and death. Once exposed to HIV, the elderly are also more likely to seroconvert.[6]

Several factors, therefore, contribute to why the elderly are at increased risk for HIV. In addition to the age related changes described above, a thinning of the vaginal and anal mucosa may facilitate viral entry. Other factors include the increased incidence of transfusion in the elderly; the lack of perceived risk and, therefore, low frequency of condom use and HIV testing; and the lack of education for physicians and other healthcare professionals concerning risk behaviors in the elderly population.[7] A recent University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine survey of primary care physicians in New Jersey revealed that only 20% of the physicians routinely inquire and provide counseling for HIV risk to their patients over 50, as compared to 64% of the primary care physicians for their patients between the ages of 18 and 35. Additionally, only 7% of New Jersey primary care physicians were able to correctly rank, in the order of frequency, the risk factors for HIV in older adults. These findings certainly substantiate the need for more professional education for physicians and other healthcare professionals regarding HIV/AIDS.[8]

CLINICAL MANIFESTATIONS

Misdiagnosis early in the disease is believed to be common in the older population because AIDS may mimic other disorders that commonly present in older adults. Constitutional symptoms such as fatigue, weight loss or anorexia may be early signs of AIDS but may be mistaken for common disorders in the elderly such as depression, thyroid disease or nutritional deficiencies. Non-opportunistic infections such as pneumonia, varicella-zoster virus or tuberculosis may be an initial manifestation of HIV/AIDS in the elderly. The older adult may also present with an opportunistic infection such as pneumocystis, candidiasis, or cytomegalovirus. Often these are not recognized as opportunistic infections and the diagnosis of HIV/AIDS may be unrecognized. Neuropathy seen in HIV/AIDS may be related to other disorders common in this age group such as diabetes which is associated with peripheral neuropathy. Hematologic manifestations include anemia, thrombocytopenia or non-Hodgkins lymphoma. Also, dermatologic manifestations of HIV/AIDS in older adults include severe psoriasis or seborrheic dermatitis. These disorders are common in the elderly and, therefore, may not be attributed to HIV/AIDS leading to a misdiagnosis or delayed diagnosis.[9]

Dementia is common in older adults afflicting 10% of those over the age of 65 and 40% over the age of 80. AIDS-related dementia is more likely to be an initial presentation of AIDS in those over 50 than those under 50. AIDS-related dementia may easily be misdiagnosed as Alzheimer's disease in older adults but can be distinguished from Alzheimer's disease because it may present with extrapyramidal symptoms, apathy and social withdrawal which are not typical features of Alzheimer's. In addition, word finding difficulty or aphasia, which is a common manifestation of Alzheimer's disease, is usually absent in AIDS-related dementia. Other characteristics of AIDS- related dementia such as leg tremors, parasthesias and peripheral neuropathies are typically absent in Alzheimer's disease.[10] (Table 1)

Studies on AIDS-related *pneumocystis carinii pneumonia* (PCP) in older adults reveal that misdiagnosis is not uncommon in the elderly. PCP may initially be misdiagnosed as congestive heart failure or various lung diseases which may contribute to a delay in recognition of this disorder. Studies have also shown that PCP in older adults is associated with a higher hospital mortality rate and a delay in diagnosis compared to AIDS patients under the age of 50.[11] Other data on the clinical course of HIV/AIDS in the elderly have revealed that older adults have a shorter interval between HIV infection and AIDS, and are more likely to have an AIDS diagnosis at the time of recognition of HIV infection. One study suggested this disorder is often unrecognized and demonstrated a 6.2% prevalence in hospitalized elderly men and 8.9% prevalence in women who died from other causes.[12,13]

Comparison of Alzheimer's Disease and AIDS Dementia

	Alzheimer's disease	AIDS dementia
Early behavioral changes	Absent	Present
Focal neurologic signs	Absent (in early disease)	Possibly present
Aphasia	Present	Rare
CSF studies	Normal	Elevated protein Monocytic pleocytosis

Table 1: Comparison of Alzheimer's Disease and AIDS Dementia

PSYCHOSOCIAL ISSUES

Older people with HIV have a greater difficulty in disclosing their HIV status to their children or family for fear of rejection and shame. They utilize support services only half as often as their younger counterparts for fear of being identified at a program offering AIDS services. Also, services in the aging network may not have programs or staff knowledgeable in psychosocial issues affecting those afflicted with HIV disease. Compared to their younger counterparts, people over 50 receive little or no HIV information and show significantly lower rates of HIV knowledge compared to younger populations. As a result, the elderly are far less likely to have their blood tested for HIV than those under the age of 50.[14]

HIV/AIDS TREATMENT

Little is known about the tolerability and efficacy of pharmacologic treatment of HIV/AIDS in older adults. This is a result of a paucity of clinical trials in the elderly with HIV. Because the risk for adverse drug reactions increases with age, it is expected that the elderly would experience increased drug side effects from medications used to treat HIV disease. Likewise, because the elderly are likely to be on multiple medications, it is believed that drug interactions between non-HIV related drugs and HIV medications will also be increased. Some small studies have demonstrated a favorable response to the treatment of older adults with HIV/AIDS. In one study, mortality rates for those over 50 treated with ART decreased by 51% compared to 61% for all ages. Similar rates of viral suppression with a blunted CD4 count response were observed in both older and younger adults treated for HIV disease.[15] Another small study performed at the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine also demonstrated similar treatment regime as viral load responses, and compliance rates when comparing younger vs. older HIV patients.[16] Although mortality rates are higher in older adults, this is thought to be related to the increased degree of comorbidities in the older group. There is a significant need for more studies on the treatment of HIV/AIDS in older adults.[17]

For more information, see Resources for older people with HIV on page 7.

CONCLUSION

With an increase in the elderly population, and the increased longevity of those with HIV/AIDS due to successful treatment strategies, the number of elderly with this disorder will be greater than expected. A low index of suspicion, and the fact that HIV/AIDS may mimic disorders commonly seen in the elderly, can result in a delay in diagnosis and a poorer prognosis. In New Jersey, there is evidence of shifting modes of transmission for older adults, with IVDU and heterosexual exposure as more common methods of transmission. In addition, HIV/AIDS is emerging as a significant issue in women's health. As a result, there is a need for greater primary prevention in the elderly through education of both healthcare professionals and the older community-at-large. Healthcare providers need to do a better job in identifying risk factors, and raise issues of sex and sexual health in their older patients. Community and health services for the elderly need to be better prepared and equipped to care for the rising number of elderly patients with HIV/AIDS. Older adults are believed to derive significant benefit from treatment; however, the impact of treatment is still unclear. More research regarding HIV/AIDS in the elderly is needed in order to adequately respond to the healthcare needs of the rapidly growing aging population. (Table 2)

Summary of Highlights about HIV/AIDS in the Older Adult	
1.	**Older adults represent the most rapidly growing segment of the population to acquire HIV/AIDS.**
2.	**While male homosexual activity represents a common mode of HIV transmission, IV drug use and heterosexual activity have greatly increased as modes of transmission for older adults.**
3.	**An altered immune system, thinning of vaginal and anal mucosa, and the lack of preventive measures are believed to result in a higher risk for HIV infection in this age group.**
4.	**Signs of HIV/AIDS in older adults are frequently unrecognized and attributed to other disorders common in this age group.**
5.	**HIV in the elderly is associated with a significant delay in diagnosis and an increased mortality rate.**
6.	**Both healthcare professionals and the elderly are not adequately aware of the risks of acquiring this disorder in later years.**
7.	**Older adults with HIV/AIDS have difficulty accessing programs that offer AIDS services.**
8.	**Primary prevention of HIV/AIDS in the elderly is paramount.**
9.	**Treatment of HIV/AIDS with currently used interventions is beneficial but is associated with a higher mortality rate and increased likelihood of adverse reactions and drug interactions.**
10.	**There is a need for more research into the manifestation, recognition, and management of this disorder in the elderly.**

Table 2: Summary of Highlights about HIV/AIDS in the Older Adult

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In the Field

Interview with Patricia C. Kloser, MD, MPH

Dr. Kloser is a Board Certified Internist and Infectious Disease Specialist at UMDNJ where she is Clinical Director of AIDS Services for University Hospital, Associate Professor of Clinical Medicine and Preventive Medicine, and Clinical Director of the Division of AIDS Education, Center for Continuing and Outreach Education. Dr. Kloser is best known for her work with women with AIDS. In 1988, she founded the Newark Women's AIDS Clinic, the first female-specific clinic to serve HIV-infected women, providing gynecologic/STD screening as well as a full spectrum of clinical and psychological care. She was also a member of the Board of Directors of Broadway House for Continuing Care in Newark during its first 4 years, from 1996 - 1999.

Editor: *This issue of AIDSLine will focus on the current hot topic of HIV infection in the population of adults over 50. What is the rate of the current HIV population who are over age 50?*

Dr. Kloser: I would say that approximately 30% of my patients are in the "over 50" age group; perhaps that's because I've been following some patients for almost 20 years that now are older. So it's not necessarily that those patients have newly acquired the disease at that age. However, a significant population that I do see is people newly diagnosed in that age group.

I think I am just continually struck by the fact that I am getting newly diagnosed people in their later years and most of these people have seen a physician within the last year, and the diagnosis was not thought of or even entertained as a part of the possibilities for their complex of symptoms.

Editor: *Many physicians will not even consider HIV/AIDS as a diagnosis in this 50+ population. When or how do the clinicians decide it might be wise to perform an HIV test on someone in this group of patients?*

Dr. Kloser: Many times the doctors do not consider HIV/AIDS to be a (possible) diagnosis. I think many times the test is done in hospital when they get admitted for another cause, because we do try to offer testing in our endemic area and perhaps it's the last test that gets done when all other diagnoses have failed. So many times it is in an acute care facility as an exclusionary case, or when there is another diagnosis made that makes AIDS obvious as in a PCP pneumonia, or toxoplasmosis in the brain. Or another test has shown presence of an opportunistic infection - then the HIV test is done, after the fact. But, as far as offering the test, most physicians are reluctant or uneducated about ordering the test early on as part of a healthcare workup. Even my young students will say, "Oh, she has no risk," and this is in a patient that obviously does have risks.

Editor: *What is the most common route of transmission in your HIV- positive patients over 50?*

Dr. Kloser: Most of it is heterosexual transmission, although occasionally we do have some overt substance abuse issues.

Editor: *Is the majority of the HIV-positive population that you see female?*

Dr. Kloser: In my population, yes, but this may be a selective bias because I tend to treat more female patients.

Editor: *For non-infected women, menopause can be a struggle both emotionally and physically. How is menopause different in HIV-infected women?*

Dr. Kloser: well, it certainly does complicate the issue, because sometimes there are symptoms involved in menopause that can be confused or suggestive of symptoms of HIV and vice versa; certainly increased candidiasis of the oral or genital area, irritability, trouble with sleeping - so a lot of these symptoms apply. In fact, there are concerns with transmission particularly in older women, because with menopause there is the thinning of the vaginal mucosa, which actually promotes infection with HIV, not unlike that trauma that occurs in younger girls that we hear so much about. So there is trauma that occurs because there are estrogen-depleted membranes that make older women more susceptible, and this may in fact help a woman get into care. Or it may be confused with a lot of things she can blame on the menopause that may in fact not be attributable to that.

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SAVE THE DATE!

Don't miss The New Jersey Summit on HIV/AIDS and Aging on October 21st, 2004 in Iselin, NJ. See page15 for more information and registration.

Editor: *Are there any specific treatment regimens that are more appropriate for the 50-plus HIV-positive patient?*

Dr. Kloser: I have been aware of this problem of older women with HIV disease since the early nineties. In fact, I presented an abstract in Amsterdam in the early 90's and we had noticed in a series of approximately 50 women, when we looked at these women there was no woman who did not have another diagnosis. So the women had a minimum of one other medical diagnosis in addition to the AIDS, most had 2-3. These would include, but not be limited to hypertension, arthritis, coronary artery disease, obesity, diabetes, and chronic headaches - so chronic kinds of conditions. And when you think about a woman who is HIV positive and comes in with underlying medical diseases you certainly have to be very concerned about the treatment options. So if you have a woman who by CD_4 count or opportunistic infection history needs treatment, you have to be very concerned about the administration of protease inhibitors because of what they might do to the diabetes, coronary disease, or lipid profile. You have an older woman who may be chronically anemic from her underlying disease and you then have to be very careful about the toxicity of many of our medications including prophylaxis for PCP, and zidovudine. You also have to be concerned about the pill burden in women who have so many stresses of later years, Maybe neuropathy, particularly in someone who is diabetic or older or unstable on his or her feet or who has a concomitant arthritic problem. So it basically just complicates the prescribing. As well as the symptomotology: how do you know in a 60 year-old woman that the leg pain is not due to diabetes, not due to a neuropathy of another cause, and that's it's due to the stavudine? You just don't know. So it just makes it more difficult, more complicated, and someone really has to be paying attention and know the drugs, know their drug-drug interactions and know not only the HIV disease but know your underlying disease in your older women patients as well.

Editor: *In the past year, there has been much more attention given to the HIV-positive patient who is over 50. What do you think is the reason for this special attention?*

Dr. Kloser: well I think it's a number of things. If you remember at the beginning of the disease, we didn't even think women got it. And then we had sort of an awakening, an "aha" experience, and my guess is that we are now having an "aha" experience, and unless you treat a large number of people you may not see this. I happen to treat a large number of patients so, early on, I saw the presence of this population. Many practitioners who treat smaller numbers or are new to the treatment are just noticing- the older population for the first time.

Editor: *Are there any specific instructions or advice you give to your over-50 positive patients?*

Dr. Kloser: I just tell them that whatever their other chronic disease is - "diabetes, we can't cure that, coronary artery disease, we can't cure that, arthritis, we can't cure that," whatever that other disease is. And now we have another chronic disease (HIV/AIDS) and no, we can't cure that, but just like those other diseases we can control and certainly help you to live with this other chronic disease that you have.

This brings me to another point, which is the psychosocial problem which is a very difficult problem for people in their mid and later years, to disclose this disease. There are issues with your community, church, family - how do you tell your adult children that you are HIV positive? How do you sing in the church choir and know that church ladies would not like this or would think ill of you knowing that you were in this situation?

I recently had a woman this past month, 72 years old, newly diagnosed. I had been doctoring for 2 years to get to the bottom of her underlying condition and it turns out that it's HIV disease. She was exposed to her husband who was a merchant seaman. An unsuspecting bystander would think oh, she's a middle class, and nice married lady, only has sex with her husband, no risk, right? Wrong.

Her husband was not monogamous. People in their middle or later years were not brought up on condoms like people in their 20s-30s are, so to then to have sexual contact in those later years, we think we're too old to have those kids' diseases. I'm not a drug user, he looks clean or she looks clean - and it has nothing to do with looks, and the reality is that it's a STD and the virus does not know or care about the age of the host

In our city, as well as others, you have the first of the month sexual contacts and that works for men as well as women. Men get their checks, and the young girls are looking to make money for their families or whatever reason, they are eager to serve older men. And then you have the older women who may have handy men or young men who may help them around the home, delivering groceries, etc. who may befriend them for economic gain or for whatever and end up infecting the women.

I had an 81 year-old woman who came into the hospital in cardiogenic shock who was found to have PCP and was found to be HIV-positive, and the family was shocked and dismayed. But later they remembered that 10 years ago Mom had a "friend" that used to be around the house or hanging around her. So someone in their 70's may be incapacitated

and sick now, but 10 years ago they weren't and may have had a sexual partner or two that left them sick. It doesn't have to be in the present, it could be something 5-10 years ago.

Editor: *Do you find that the over-50 positive individuals have different support systems from those in their earlier years?*

Dr. Kloser: They certainly do. My guess is they may be reluctant (to go) for the support because that's not the paradigm of where they've come from, so it's very difficult to support women in that age group. Their needs are certainly different than that of younger women who have children, and a partner, and are sexually active or actively using drugs. The needs are more that of a diabetic or hypertensive in the same age group than it would be what we see younger on, and looking at how we deal with the adult children and how to deal with you. That would be the feelings you have about this disease.

Editor: *Finally, what advice would you give health educators on how to approach this population to do prevention work, and where do you think educators should go to do outreach for this specific population?*

Dr. Kloser: Certainly to talk about the importance of being protected when you have sex. What a lot of women will do in this age group - I've found that the female condom, although it's not for everyone, but sometimes we've found that an older woman will use female condoms. It certainly protects the internal as well as external female mucosa. The older population is usually not sexually active 3-4 times a day like the younger sexually active population may be. Frequent sexual activity might be once a month, once a week, once every couple of weeks, and that makes it (female condom) more acceptable to them for female or male, and also if the male decides he's not going to use anything, she can have the option of wearing the female condom. She's in control.

Educators can go to senior citizen homes, to the churches, to the beauty shops - any place the "little old ladies" go, you know the half price shops, Weight Watchers, the gym. Find where the older lady goes and that's where you go. Don't eliminate alcohol and drugs. There are a number of older people who may have used in their younger years and will still occasionally take a hit off the "good stuff" and it's a way to socialize, just as you may go out on a Friday night and have a glass of wine with a friend and it's not an everyday use. I do have some women who are in their 60's who do a little drugs now and then, but by far the more common means of transmission is sexual in this age group.

Resources: Older People with HIV

Organizations

National Association on HIV Over Fifty (NAHOF)

www.hivoverfifty.org (617) 233-7107

New York Association on HIV Over Fifty

www.nyahof.org (212) 481-7594

HIV Wisdom for Older Women

www.hivwisdom.org (913) 722-3100

Video

AIDS is Ageless: HIV Over Fifty

Produced by AIDS Project Hartford

www.aidsprojecthartford.org (860) 951-4833

Books

AIDS in an Aging Society: What we need to Know *Riley, Ory & Zablotsky 1989*
HIV & AIDS and Older People *Kaufman 1995*
HIV/AIDS and the Older Adult *Nokes 1996*
Aging with HIV: Psychological, Social, and Health Issues *Nichols, et al. 2002*
HIV/AIDS and Older Adults: Challenges for Individuals, Families, and Communities *Emlet 2004*
Midlife and Older Adults and HIV: Implications for Social Services Research, *Practice, and Policy Poindexter & Keigher 2004*

Research Journals (issues devoted to HIV/AIDS in Older adults)

Research on Aging, **November 1998, Special issue, 20 (6)**
Journal of AIDS, **June 2003, Volume 33 Supplement 2**
AIDS, **January 2004, Volume 18 Supplement 1**

Some community centers and medical facilities offer groups for older people living with HIV. Call the organizations in your area to see what is available.

RAPID TESTING IN NEW JERSEY

Bearer of Bad News

By JEREMY SIMMONS as told to EDWARD LEWINE

Telling people they are H.I.V.-positive is the only thing about my job I don't like. People's reactions vary. A lot of people shut down; they start to space out; they want to bolt. We can't make them stay and talk with us about how they are feeling and what the next steps are, but that is what we try to do. I do H.I.V. testing at H.O.P.E. Inc., a clinic in Tulsa, Okla. In my six years doing this, I've had some people become very upset, because they were pretty certain about who infected them. They said they were going to attack the person. In one case, a client started screaming about how he was going to go kill his partner. But the people who react the most strongly are those who don't consider themselves to be in the ''high risk'' groups. When those people are positive, it's a lot to deal with.

Until recently, there was a two-week wait before the results came in. But in the past few months, we have started using the new OraQuick test, which gives the patient a result in around 20 minutes. There are so many good things about the new test. We deal with a lot of the high-risk people who have unstable lives; there is a good chance they are not going to come back for their result. With OraQuick, we don't have to worry. On the other hand, we are right in the room with the client when we get the results. Sometimes, a result shows up in 5 or 10 minutes. You have no idea how stressful it is to know that someone is positive while you are sitting in front of him or her. It would be a lot easier if you could just tell them the information as soon as you know, but you have to give the test 20 minutes to work.

The client comes in. You take a small amount of blood, put it in the tube, mix it up. Then you put a device that gives a readout, sort of like a home-pregnancy test, in the tube. So we take the sample, and I put the tube where the client can't really see it. There are certain lines that appear on the stick. I try to block that out as much as possible, and to find out why they think they might be positive. I make a point not to look at it every two minutes, because the client will be wondering what's going on. It's hard; you want to look, but you can't.

The two-week waiting period with the old test used to allow us to think about the information we had on the client and gave us time to psych ourselves up to give him or her the bad news. I especially needed the time to prepare emotionally when I started out doing this. When someone who tested positive was about to come in to hear his or her result I would think about it the day before. Just before the client came in, I would start to think that any moment I was going to have to tell someone they had H.I.V. I would hope that the person was not going to completely freak out, and I would try to prepare myself for that. I'd get that feeling of dread, but I would just block it out.

Most of the time I feel as if I have done everything I can. But there are times when I have read the situation wrong. There was a case when somebody had an H.I.V.-positive sex partner, and he knew that there was a very good chance that he was going to be positive. When he got the news, he didn't really react. He wanted to go, so I let him. I asked him, ''Is everything going to be O.K.?'' He said, ''Yes.'' At that point I thought he was going to need some time to let it settle in but that he'd get into services pretty quickly. Two or three days later, his partner contacted us and told us that my client had tried to kill himself. That is the worst-case situation, the one I look back on and say I don't want to have happen again.

The OraQuick test is more stressful because I am looking at the result and have to act as if everything is O.K. and keep doing the basic counseling. I remember one male patient who had a small number of female partners and no history of drug use but wanted to see if he was H.I.V.-positive just to be on the safe side. With his OraQuick test, the result showed immediately for some reason, and I knew from the beginning that it was going to be positive. I went through my regular procedure, but it was weird asking someone, ''Have you thought much about what would happen if this test came back positive?'' when I knew that it was not a hypothetical situation. When I told him, he did not take it well. His face completely lost expression. He was shocked. He came from a background where he didn't know anyone who was positive.

After he left, I went and sat down on the couch we have here at the office and watched TV for a while and relaxed, because it was such an emotional experience and it was hard not to ride that roller coaster with him. Whenever I give somebody a positive result, I go home and do what I have to do otherwise. But there is a cumulative effect. The job takes its toll over time. One night I had a dream that I was positive, and I was thinking about the medicines that I had to take and the hassle of it. As if it had become a part of me. I woke up, and I was in the bathroom trying to take medicines, but there were no medicines there. That was a powerful sign to me that I needed to take a break.

Rapid Testing in New Jersey

In the Field

Interview with Danielle Bush, NJCRI

Danielle Bush is the Project Manager for the HIV Counseling and Testing program at the North Jersey Community Research Initiative (NJCRI). NJ AIDSLine had an opportunity to discuss the benefits and obstacles when it comes to providing Rapid HIV testing.

Editor: *How long have you been doing counseling and testing?*

Ms. Bush: I have been providing counseling and testing for the past 16 years. I started out at Saint Michael's, so I have seen the many faces of HIV and how it has changed over the years, not just with testing but also with treatment and care.

Editor: *How long has NJCRI been performing the rapid HIV test?*

Ms. Bush: NJCRI was actually chosen to participate in a CDC conducted pilot resource study entitled, "RESPECT 2". The study was administered in 3 major cities, including Denver, CO, Long Beach, CA and Newark, NJ. The resource study lasted about 4 years and was started with a pilot at a Newark STD clinic. The clinic would randomly test people with either the rapid or the standard method of testing. We would then gather all the data and information and come up with an analysis of what we thought the patients felt. From the Newark perspective, most of our clients were eager to receive the rapid test. Each time we picked an envelope to see who was going to be tested (selected randomly) everyone was on pins and needles, hoping that they would get selected to take the rapid test because that is really what they wanted.

From the Newark perspective, most of our clients were eager to receive the rapid test. Each time we picked an envelope ... ***everyone was on pins and needles*** *hoping that they would get selected to take the rapid test, because...*

Editor: *With the rapid HIV test, results are given within 20-40 minutes. Have you found that individuals are more apprehensive about receiving their results so quickly?*

Ms. Bush: Initially, I thought that this would be too much hitting the person at one time. First, getting the person to come in to get tested, and to then wait and hear results, all within the same day. However, as I started doing my research and getting more involved, my fears and my doubts departed because I saw the benefits of early intervention, early treatment and care, along with a decrease of spreading the virus if the person is found to be HIV infected. It was really more positive than negative, and the clients grab hold of that as well. They still have that fear of waiting to hear "the news," but I have found that they (clients) would prefer to hear it then (within minutes), rather then wait 5-10 days.

Editor: *From a counselor's perspective, is it more difficult with the person sitting there and finding out results, as opposed to having them come back in a few days or weeks for their results?*

Ms. Bush: I do not think it is difficult because of the procedure here at NJCRI. Before anything happens, the entire process is explained to the client and they will sign a consent form. The client will then have a seat in the mini-lab that is located away from the counseling room. We then have someone else that is in the mini lab monitoring the test while the counseling is going on, so the patient is not sitting there looking at the device.

If the test was being processed in front of the client, they would never hear anything the counselor is saying and we obviously do not want that to happen. Should it ever happen that the client must receive counseling in the same room that the testing is taking place, it is recommended that some sort of barrier be used. This would be the extreme case- like if there was only one counselor available.

Editor: *How many people provide counseling and testing at your facility?*

Ms. Bush: I supervise 6 counselors that can perform the test. We can run about 3 tests at any given time. NJCRI is not doing the oral rapid test yet, although it is something projected for the future.

Editor: *Since NJCRI has begun conducting the rapid HIV test, do you still have clients come in that prefer to take the Orasure test (in which no blood is taken), and wait 5-10 days to receive their results?*

Ms. Bush: Yes, there are individuals that come in and want the Orasure test because they do not want to be "stuck" in any way and we accommodate them. However, most people do want to know their results as soon as they can.

Editor: *Does NJCRI provide anonymous testing?*

Ms. Bush: Both confidential and anonymous testing is offered by NJCRL.

Editor: *Since NJCRI has begun performing the rapid HIV test, approximately how many preliminary positive results have been given?*

Ms. Bush: Since NJCRI first started providing OraQuick, we have had 4 confirmed positives. These individuals had no idea they were infected. They came in because of the risk of having unprotected sex and being unsure about their partner's past.

Editor: *Approximately how many rapid tests has NJCRI performed?*

Ms. Bush: Over 50.

Editor: *Can you tell me what occurs after someone is given a preliminary positive test result?*

Ms. Bush: We really try, prior to even performing the test, to explain to the client how the results can come back. We explain the negative result, we explain the preliminary positive result, and we explain that if the test should come back preliminary positive we must then take a tube of blood for the confirmatory test. Within 24-72 hours, those confirmatory results will be back. About 20 minutes after the finger prick, we knock on the door. We fold the result and hand it to the counselor. The counselor will at that point explain to the client that their result has come back as preliminary positive, then the counselor goes over again what had previously been stated - that we do not know for sure about the result until the confirmatory test comes back. The counselor will then give the client a time to come back in and receive the confirmatory results. They will also get an ID card with a number on it for their identification.

Editor: *Does NJCRI offer the HIV positive individual referrals (and if so, to what agenicies)?*

Ms. Bush: After we receive the confirmation that the result is positive, within NJCRI we have another department called DSOI, where case management will follow up with care and treatment. Our linkages are with UMDNJ and St. Michael's Medical Center. At NJCRI we have a mental health counselor, a nutritionist, and a variety of support programs (for women, men, people with alternative lifestyles, couples, Prevention for Positives. We also have a food bank here, and a substance abuse program entitled, Project Source.

Editor: *What is the process when someone is given a negative test result?*

Ms. Bush: Prior to performing the test, we try to get as much information as possible from the client. We want to find out if there has been risky behavior, so we can tell if they are in a window period, and if so, before they leave we like to give them a date to come back in to get tested. We also try to encourage them to continue practicing safer habits to reduce their exposure to HIV.

Editor: *The main focus of this issue of AIDSLine is HIV in people over 50. Have you had many clients come in to get tested that were in this category?*

Ms. Bush: Usually we have extended invitations during block parties or health fairs for people to come in to be tested. One of the health fairs is with the Newark Housing Authority, where we have participated with several senior citizen buildings. Because NJCRI has the mobile unit, many times we will sit right there in front of the building, and folks will come right up to the van to get tested. We do a small presentation on HIV and HIV testing for the seniors, and they are inquisitive about it. They will talk to us about Viagra; we have some that are open to us about their "once a month" contact with sex workers . It is difficult to talk with someone who is not used to using condoms, to start to practice safe sex to avoid HIV or STI's in general.

Editor: *Is there any sort of debriefing that goes on between you and your staff after tests are given? Especially when a positive result is given?*

Ms. Bush: We have to do a debriefing session. Sometimes it may not be on the same day; it depends how the counselor is doing. At first, they (counselor) may need a little space. The debriefing session is not always with me, sometimes it is a peer debrief. The CDC had done a pilot workshop here at NJCRI entitled, "Identifying Burn-out" It was a great training tool. My staff had that training and can now look to make sure that they are using those specific avenues if they see a difficult challenge coming on.

Actually, I had a situation like that occur just this week. A 19 year old tested positive and the counselor just needed to talk, it really affected him. Unfortunately, the confirmatory test did come back positive. The first thing that bothered him (counselor) was that the client took the positive result so "calmly" and the client would not "open up" to the counselor. Eventually, the counselor asked the young man if he'd like to come in and meet with his supervisor, and the client obliged and came to meet with me. Sometimes it's easier when someone's there. The stress level can be very high.

What I try to do with some of the down time here with my counselors is celebrate birthdays. Once a month we might just take 2 hours and I'll get food and we'll just talk and laugh. It is important to get some down time in, otherwise, you really can burn out. Once a year NJCRI holds a company picnic. There is a great sense of community within NJCRI.

Editor: *Do you have any last thoughts about rapid testing?*

Ms. Bush: I think more people will come in as the oral rapid test becomes available, I believe so because basically, people are afraid of needles. We will have people come in and they will be like, "I don't know if I can take that needle." They don't want to be stuck, and we talk to them and let them know we can still do the oral (Orasure) test, but that means they will have to wait about 5 days for the results to come in.

I believe the oral rapid test would be very effective and we'll get a much better response. We are getting a good response now with the rapid test, but I believe it will be much greater once the oral rapid test is available.

Internet Resources

NJDHSS-DHAS Website

www.state.nj.us/health/aids/aidsprv.htm

Epidemiological reports, policies, and clinical guidelines for HIV/AIDS care and services in New Jersey.

Free CME: articles and credit (1.0 hours) provided through New Jersey Medicine (the Medical Society of New Jersey)

www.state.nj.us/health/aids/aidsqtr.htm

New Jersey HIV/AIDS Semi-annual Newsletter (statistical report)

UMDNJ - CCOE AIDS Education Website

ccoe.umdnj.edu/aids

New York/ New Jersey AIDS Education and Training Center, additional training programs for HIV/AIDS health and social service professionals.

www.peopleware.net/o646a

Registration for most UMDNJ HIV/AIDS continuing education courses

AETC National Resource Center

www.aids-etc.org

HIV treatment guidelines and key journal articles and news releases, links to all AIDS Education and Training Centers, training materials and curricula, and evaluation tools.

Rapid Counseling and Testing Sites in New Jersey By County

**NJDHSS publicly funded sites*

Atlantic

Atlantic City Health Department, 609-347-6457

Bergen

Bergen County Counseling Center, 201-487-3243

Camden

Camden County Health Department, 856-374-6134

Essex

East Orange Health Department, East Orange, 973-266-5454

Newark Beth Israel Medical Center, Newark, 973-926-5197 or 973-926-8474

Newark Community Health Center, 973-483-1300

North Jersey Community Research Initiative, Newark, 973-413-8300

St. Michael's Medical Center, Newark, 973-877-5525

Hudson

Jersey City Medical Center, Jersey City, 201-915-2545

Hunterdon

Hunterdon County Department of Health, Flemington, 908-806-4893

Mercer

Henry J. Austin Health Center, Trenton, 609-278-5946

Middlesex

Robert Wood Johnson Medical School, New Brunswick, 732-235-7114

Monmouth

Monmouth Regional Screening Center (Jersey Shore University Medical Center), Neptune, 732-774-0151

Morris

Morristown Memorial Hospital, Morristown, 973-889-6810

Ocean

Ocean County Health Department, Toms River, 732-341-9700 ext. 7502

Passaic

St. Joseph's Hospital and Medical Center, Paterson, 973-754-4720

Union

Hyacinth AIDS Foundation, Plainfield, 908-755-0021

Plainfield Community Health Center, Plainfield, 908-753-6401 ext. 138

Trinitas Hospital, Elizabeth, 908-994-7300

In the News!

June 10, 2004 3rd Annual Clinical Update Conference in Woodbridge

On June 10, 2004, the Division of AIDS Education at the UMDNJ-Center for Continuing and Outreach Education, Division of AIDS Education (UMDNJ-CCOE- AIDS) held its 3rd Annual HIV Clinical Update conference at the Sheraton Hotel at Woodbridge Place in Iselin, NJ. The collaborative program was the result of the combination of two highly successful, but formerly separate conferences: the annual statewide HIV update sponsored by the New Jersey Department of Health and Senior Services' Division of HIV/AIDS Services (NJDHSS-DHAS), and the New York/New Jersey AIDS Education and Training Center's annual HIV clinical update for northern New Jersey providers, by UMDNJ-CCOE- AIDS.

HIV Clinical Update 2004: The State of HIV Care in New Jersey and Beyond was designed to update both clinical health care and social service providers on the most recent developments in the care and management of HIV disease. With over 250 participants, faculty, staff and corporate sponsors in attendance, this year's jointly sponsored HIV clinical update received some of the highest evaluation feedback in either program's separate history for content, faculty presentation skill and logistical operation.

Featured program speakers included Patricia Kloser, MD, MPH (Medical Director for UMDNJ-CCOE- AIDS), Sindy Paul, MD, MPH (Medical Director for NJDHSS-DHAS) and Kathleen Casey, MD, who, as Medical Director for the A-Team Clinic, the Jersey Shore University Medical Center's premier HIV specialty clinic in Neptune, NJ, provided the program's keynote address on the latest advances in the medical management of HIV/AIDS.

During the morning plenary sessions, participants received training from expert infectious disease specialists on cutting-edge clinical topics including HIV disease management, drug-drug interactions, treatment of opportunistic infections and immunization protocols for immune-compromised patients. During breaks throughout the day, participants had opportunities to meet with representatives from over 20 pharmaceutical and healthcare exhibitors to discuss new medications, laboratory diagnostic tests and equipment, and to pick up educational materials and other adherence tools for use with their patients.

Participants were able to select two afternoon breakout workshop sessions from a wide array of topics. Sessions offered intensive presentations and discussion on specialized HIV disease management including differential diagnosis in HIV/MICA patients, gender and age-specific treatments, culturally competent approaches to care, application of resistance testing for treatment-experienced and treatment-naïve patients, prevention with positives, and using the newly approved HIV rapid test. Following the afternoon workshops, participants re-convened for a concluding plenary address on the state of HIV care in sub-Saharan Africa by Dr. Kloser, who travels frequently to the region as part of the international efforts to reduce Mother-to-Child HIV transmission.

By David Rosen MSW, LCSW

New Jersey Statewide Coordinated Statement of Need: 2004 *Coming Soon*

What are the needs and gaps in HIV/AIDS services in New Jersey?

The Statewide Coordinated Statement of Need (SCSN) has been completed and will be submitted to the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau on November 1, 2004. This document, which compiles the needs assessment work of all of the HIV/AIDS planning bodies throughout the state and makes recommendations on how to fill gaps in services, had been in process when HRSA informed the states that the submission deadline had moved to January 2006. The New Jersey document is the responsibility of the SCSN Planning Task Force (the Task Force), which was reassembled by the NJDHSS, Division of HIV/AIDS Services in 2003. The Task Force decided to continue their process and to submit the document at its original due date.

The 2004 New Jersey SCSN features a new, more accessible format. The report will also feature a summary of the input received from participants at the New Jersey All-Titles conference, held November 18, 2003 (see NJ AIDSline, Winter 2004 issue). It is designed to assist both HRSA and local planning bodies and individuals in their efforts to understand the medical and other related needs of persons living with HIV/AIDS throughout New Jersey.

The document will be available to the public by January 1, 2005, and will be posted on the New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services website: www.state.nj.us/health/aids/aidsprv.htm

The New Jersey SCSN Planning Task Force, which has the responsibility for the SCSN document and the New Jersey Ryan White CARE Act Title II Comprehensive Plan, meets monthly. The Task Force meetings are open to the public, and interested citizens are invited to provide public comment, participate in working committees, and to apply for membership. The Task Force will be seating new members in November 2004, and is accepting applications for membership through October 21, 2004.

Meetings are generally held the fourth Wednesday of the month at the Rutgers University Administrative Services III Building in New Brunswick, NJ. For more information please contact State Co-chair Virginia Allen at virginia.allen@nj.doh.state.us or (609) 633-1306.

HIV/AIDS Open Clinical Trials in New Jersey

TMC114 (TMC114-C202)

This randomized antiretroviral treatment study will look at the safety, efficacy, and tolerability of TMC114, a new protease inhibitor (PI), given with low-dose ritonavir (Norvir). Laboratory research suggests that TMC114 may be effective against HIV that has developed resistance to other PIs.

Eligibility:

This Phase II trial is for treatment-experienced subjects who have taken the first three classes of anti-HIV drugs -- nucleoside reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs), and PIs. They must have been on a stable (unchanged) antiretroviral regimen that does not include an NNRTI for at least eight weeks prior to the start of the study. In addition, they must previously haven taken at least one NNRTI and two PIs. They must have a viral load of at least 1,000 copies/mL, and must have evidence of at least one PI-resistance mutation. Participants may not have any active AIDS-defining illness or hepatitis A, B, or C, and must not be using any other investigational agents. Eligible participants must be at least 18 years of age.

Study Design:

This clinical trial is a randomized, Phase II, 48 week study of TMC-114 in 300 volunteers with drug resistant HIV. Volunteers will be randomly assigned to one of five study groups, including four different doses of TMC114 and a control group that will receive an Optimized Basic Regimen (OBR) of antiviral therapy.

Contact: Debbie Goraj, RN (856) 963-6890
Southern New Jersey AIDS Clinical Trials
3 Cooper Plaza, Suite 513
Camden, NJ 08103

TMC125 (TMC125-C223)

This randomized antiretroviral treatment study will assess the safety, tolerability, and most effective dose level of an investigational nucleoside reverse transcriptase inhibitor (NNRTI), TMC125. In earlier studies, TMC-125 worked against wild type HIV and drug resistant HIV.

Eligibility:

This Phase II trial is for treatment-experienced subjects who are currently on HAART for at least 3 months, or on a Structured Treatment Interruption, with at least 3 months of NRTI experience on a failing regimen. They must have a viral load of at least 1,000 copies/mL, and must have documented resistance to currently available NNRTIs and at least 3 primary PI mutations. Participants may not have Hepatitis A, B or C coinfection, and must not be using any other investigational agents. Eligible participants must be at least 18 years of age.

Study Design:

This clinical trial is a randomized, Phase II, 48 week study of TMC-125 in 150 volunteers with drug resistant HIV. Volunteers will be randomly assigned to one of three study groups, including two treatment arms with different doses of TMC-125 and a control group which will receive an Optimized Basic Regimen (OBR) of antiviral therapy.

Contact: Pamela Gorman, RN (856) 963-6890
Southern New Jersey AIDS Clinical Trials
3 Cooper Plaza, Suite 513
Camden, NJ 08103

*** If you would like the opportunity to recruit for your clinical trial in NJ AIDSline, please contact: editor Laura De Noble at 973-972-1972 or email denobllr@umdnj.edu**

Training Highlights

HIV/AIDS Medical Update Series

Extended through March 2005

This series of FREE, on-site 1-hour presentations by expert faculty is available for health care sites throughout New Jersey. For information and to request one or more presentations, call or email Debra Bottinick at the American Academy of CME, Inc. (AACME) and complete a brief request form: (609) 921-6622 or dbottinick@aacme.org.

SPONSORS: Center for Continuing and Outreach Education-Division of AIDS Education at UMDNJ (UMDNJ-CCOE-AIDS) and the American Academy of CME, Inc. (AACME), with funding from the New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services. The AACME is providing CME/CE for physicians and nurses.

Topics Available

1. **Diagnosis and Initial Management of HIV/AIDS: What the Primary Care Physician Should Know**
2. **HIV/AIDS and Hepatitis C Co-Infection**
3. **Immunizations for HIV Positive Adults**
4. **Managing Occupational Exposure**
5. **Prophylaxis and Treatment of Opportunistic Infections in Patients with HIV Disease**
6. **Medical Intervention to Reduce the Risk of Vertical HIV Transmission**
7. **New Topic! Rapid HIV Testing**

Diirector's Editorial

In 1990, a man of 64 came to me for treatment. "Jerry" was an openly gay man, who was in his words, "dying of AIDS". He was coming to me to help relieve the constant tightness in his neck and upper back that seemed to be increasing as he lost weight and tried to bring his affairs together. Jerry was a successful businessman, had lived with his partner for more than 5 years, and seemed very comfortable speaking about his life and his imminent death. My job was to be part of the healthcare team that would assist him in his quest to die with grace and dignity. I didn't know very much about HIV/AIDS at that time, and neither did most of the other professionals caring for him. What mattered at that time was that I knew enough about pain management to provide Jerry with some relief.

My job was to be part of the healthcare team that would assist him in his quest to die with grace and dignity.

Jerry did not know exactly when he had become HIV positive, but he thought it must have been "at least 5 years ago, because I have never been unfaithful to Phillip". Jerry died soon after this, and the community added his name to the long list of friends whose lives were abruptly ended by AIDS. Of the people living with HIV and AIDS that I had met up to that point in 1990, Jerry had been the most accepting of the cruel toll that the disease had taken on his life. (Over the next decade, I was to meet many more who had chosen the path of acceptance with grace and bravery). What was different about Jerry was that he felt that he had lived a full life. Unlike many of my other patients, he was more philosophical about what was happening to him. Contracting the virus possibly as late as 59 years of age, as Jerry had, was not unusual in the gay community.

Fourteen years later, the average age of people living with HIV in New Jersey is approaching 50, and many of them have lived with the virus since their 20's. Medical care for people living with HIV is intersecting with mainstream family medicine. The aches, pains and maladies of middle and advanced age combine with the intricacies of keeping this insidious virus from replicating within the immune system of those infected. What a miraculous place to be in less than a decade since the first protease inhibitor. Yet, as people are living longer, the complexity of care has increased, putting increasing strain on our already imperfect healthcare infrastructure.

On the eve of the 2005 reauthorization of the Ryan White Care Act, we are looking at a different paradigm of chronic disease management for the person living with HIV. A fully trained healthcare team is more important than ever to meet the needs of the client. Each and every person involved in the care of HIV positive clients must renew their efforts to stay informed of the ever-evolving healthcare developments in the field of HIV/AIDS. Meeting and exceeding the standard of care for our clients requires active participation in learning by every member of the team, including the client. As New Jersey's HIV positive community adds new layers of medication to cope with the effects of aging, long term HIV infection, and 10 years on combination antiretroviral therapy, the algorithm of HIV care becomes more and more complex. There are many easily accessible and low-cost learning opportunities, thanks to the Ryan White Care Act and the strong support of the pharmaceutical industry. It is vital that these resources remain part of the healthcare infrastructure in New Jersey and throughout the nation. Education for all members of the healthcare team for people living with HIV/AIDS is a key component of quality care. As we struggle to balance diminishing medical care resources with the growing needs of the people who need it most, we must find room for apportioning appropriate resources for education and training. Please keep this in mind as you work on prioritizing healthcare and support services as you reach out to our legislators and leaders.

Fourteen years later, the average age of people living with HIV in New Jersey is approaching 50.

In our sophomore issue of the "New and Improved" New Jersey AIDSLine, the Division of AIDS Education is focusing on HIV/AIDS in New Jerseyans in their middle to later years. It is our intent to highlight New Jersey's successes and challenges in providing quality healthcare for people living with HIV/AIDS in our state. We have appreciated the feedback from those of you who took the time to share your reactions to our first issue. The Division of AIDS Education will continue to incorporate this feedback into our ongoing development of New Jersey AIDSLine. We look forward to hearing your comments on this issue. We are especially interested in hearing from you about your educational needs around HIV/AIDS and related issues.

Dion A. Richetti, DC, Director
Division of AIDS Education, Center for Continuing and Outreach Education, A Local Performance Site of the NY/NJ AETC, University of Medicine and Dentistry of New Jersey

The New Jersey Summit on HIV/AIDS and Aging

Thursday, October 21, 2004, 8:00 AM – 4:00 PM
Sheraton at Woodbridge Place Hotel, Iselin, New Jersey

Sponsor: Newark Beth Israel Medical Center, in honor of the 15th Anniversary of the Family Treatment Center
Jointly sponsored by: UMDNJ-CCOE-Division of AIDS Education
This conference will bring together professionals and advocates in the fields of Gerontology/ Senior Services and HIV/AIDS, to address the impact of HIV/AIDS on older adults in New Jersey and throughout the United States.
Faculty: Nathan Linsk, PhD, LCSW (Midwest AETC and Jane Addams School of Social Work) and **Kathy Nokes, PhD, RN** (Hunter-Bellevue School of Nursing), **Co-Founders/ Chairpersons, National Association on HIV Over Fifty (NAHOF)**; Eliahu Bishburg, MD (Newark Beth Israel Medical Center- Family Treatment Center), Denise Clark, PhD (William Paterson College), Rose Marie Martin, MPH (NJDHSS), Beulah E. Hendricks, MA, ACRN (Bureau of HIV/AIDS, HRSA), Jeanine Reilly, LNHA, BSN (Broadway House for Continuing Care), Riva Touger-Decker, PhD, RD (UMDNJ-School of Health Related Professions)

Continuing Education Credit provided through UMDNJ-CCOE:

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the UMDNJ Center for Continuing and Outreach Education (CCOE), the UMDNJ-CCOE-AIDS Division, and Newark Beth Israel Medical Center – Family Treatment Center. The UMDNJ-CCOE is accredited by the ACCME to provide continuing medical education for physicians and takes responsibility for the content, quality, and scientific integrity of this CME activity.

Medicine: The UMDNJ-CCOE designates this educational activity for a maximum of 5.0 CME credit hours in Category 1 Credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in this educational activity.

Nursing: The UMDNJ-CCOE is an approved provider of continuing education by the New Jersey State Nurses Association, Activity Number P173-9/2003-2006. The NJSNA is accredited by the ANCC Commission on Accreditation of the American Nurses' Association. This activity is approved for 6.0 CEN Contact Hours.

Social Work: According to the regulatory criteria established by the New Jersey Board of Social Work Examiners, and by our compliance with that criteria, the UMDNJ CCOE offers this program at 5.0 CEH contact hours toward meeting the continuing education requirements for the renewal of New Jersey social work license/ certification.

Dietitian: The UMDNJ-CCOE is a Continuing Professional Education (CPE) Accredited Provider with the Commission on Dietetic Registration (CDR), Provider Number NJ001. Registered dietitians (RDs) and dietetic technicians, registered (DTRs) will receive 5.0 continuing professional education units (CPEUs) for completion of this program.

The UMDNJ CCOE certifies that this continuing education activity meets the criteria for 5.0 CEU (Continuing Education Units), as defined by the National Task Force on the Continuing Education Unit. One CEU is awarded for 10 contact hours of instruction.

The New Jersey Summit on HIV/AIDS and Aging

NAME (PLEASE PRINT) _____

PHONE _____

SPECIALTY _____

ORGANIZATION _____

ADDRESS _____

CITY/STATE/ZIP _____

Select one from the following:

Workshop Preference:
- _A Patient Care
- _B Long Term Care
- _C Caregivers
- _D Nutrition
- _E Outreach and Advocacy

Lunch Preference:
- _1 Salmon
- _2 Chicken
- _3 Vegetarian Pasta

DIRECTIONS_

SHERATON AT WOODBRIDGE PLACE HOTEL
515 Route 1 South
Iselin, New Jersey 08830
(732) 634-3600

New Jersey Turnpike North/South:
Exit 11 off NJTP to Garden State Parkway North to Exit 131a (Wood Avenue).
At 4th traffic light make right on Middlesex-Essex Turnpike. At 3d traffic light make right on Gill Lane. Sheraton is 1-1/2 miles on right.

Garden State Parkway:
Traveling **SOUTH**: EXIT 130 to Route 1 North. Continue ½ mile. Sheraton is on left. Make u-turn at traffic light.
Traveling **NORTH**: Exit 131a (Wood Avenue), continue with directions above from NJTP.

Please fill out the registration form and mail/fax:
Make check for $60 registration fee payable to:
NBIMC FAMILY TREATMENT CENTER

Mail to: Newark Beth Israel Medical Center
201 Lyons Ave., G-3, Newark, NJ 07112
Fax to: (973) 926-8182

SPACE IS LIMITED! You must pre-register by fax!
After 10/13/04: pre-register by fax to reserve your place. Your registration payment will be accepted on site.

For more information: Robert Skeist, RN, MS, NBI Family Treatment Center: (973) 926-6826
A limited number of scholarships are available.

SAINT BARNABAS HEALTH CARE SYSTEM
Newark Beth Israel Medical Center

CCOE UMDNJ Division of AIDS Education

NYANJ AIDS Education Training Center

New Jersey AIDSline Volume 2, Fall Issue
Online at: *http://ccoe.umdnj.edu/aids*

SAVE THE DATES!

December 2-5, 2004: Dallas, TX

3rd Annual Elements of Success: An International Conference on Adherence to Antiviral Therapy.

A forum for examination of scientifically sound and practical strategies to enhance adherence.

Sponsored by American Academy of HIV Medicine (AAHIVM), Association of Nurses in AIDS Care (ANAC), American Psychological Association (APA), International Association of Physicians in AIDS Care (IAPAC), Society for Infectious Disease Pharmacists (SIDP), and National Association of AIDS Education and Training Centers (NAAETC); continuing education credit provided through UMDNJ-CCOE.

For questions re: conference logistics and content, contact Adherence Elements: 716-837-5115 or adelements@netzero.net, or visit Elementsconference.com. Discounted registration for current members of sponsoring organizations. Registration may be completed online at www.peopleware.net/0646a or call UMDNJ-CCOE at 800-227-4852.

Thursday, October 21, 2004, 8 AM - 4 PM

New Jersey Summit on HIV/AIDS and Aging

Iselin, NJ

SEE P. 15 FOR DETAILS AND REGISTRATION FORM

Thursday, November 18, 2004, 1 - 3 PM

Rapid Testing: Advances for HIV Prevention: CDC satellite conference

Newark: UMDNJ (parking only with tag)

Trenton: NJN

Pre-registration required! Call Laura De Noble, 973-972-1972 or email: denobllr@umdnj.edu. Updated broadcast information and handouts: www.cdcnpin-broadcast.org/scripts/current/1118/start.htm

December 8, 2004: Cherry Hill

15th Annual HIV Medical Update

Jointly Sponsored By: Division of AIDS Education at UMDNJ-Center for Continuing and Outreach Education and
Garden State Infectious Disease Associates, PA.

For information and to register: www.peopleware.net/0646a or call 800-227-4852

Center for Continuing & Outreach Education Division of AIDS Education

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We want to hear from you!

Do you want to receive future NJ AIDSLine newsletters and conference brochures from UMDNJ, CCOE- Division of AIDS Education? Please check the appropriate box and **fax this page, including your mailing label, to: 973-972-3371**

- ❑ **Yes**, please continue to send me mail.
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