



AIDS Line

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Recommendations for New Jersey Clinicians & Public Health Practitioners

Robert Skeist, ACRN, MS; Elijah Bishburg, MD; Cindy Paul, MD, MPH, FACPM; Rose Marie Martin, MPH



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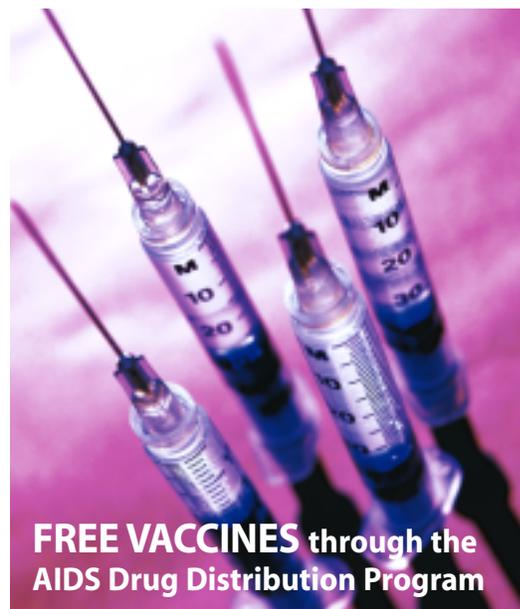
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Improved Access to Immunization Through the AIDS Drug Distribution Program

Sindy M. Paul, MD, MPH, Linda Berezny, RN, Ronald Weinstein, MBA, Matthew Aibel, Colin T. Campbell, DVM, CPM, Nancy M. Borsuk, RN, MPH, and Christina G. Tan, MD

THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) has recognized primary prevention through vaccines as one of the most important public health advances of the 20th century.¹ Although the protection that immunizations provide is important for all patients, it is particularly critical in patients with immunocompromising illnesses, such as HIV/AIDS. In the care of HIV-infected patients, immunizations are an opportunity to prevent serious and potentially life threatening diseases. However, the immunization schedule for HIV-infected persons, in all age groups, differs from those who are not infected with HIV.²

In recommending immunizations to HIV-infected patients, it is important to remember the following general principles. First, humoral and cellular responses to antigens are inversely correlated with the patient's CD4 count. Because of this, single-dose vaccines should be given as soon as the patient's HIV status is identified. In cases in which the patient's HIV status is identified late in the course of the disease, and immunocompromise is already present (CD4 count is less than 200 cells/uL), consideration should be given to treating the patient with highly active antiretroviral therapy (HAART). In the event that the patient will be treated with HAART, it may be prudent to delay the administration of one-time immunizations until after immune reconstitution has occurred. Secondly, in general, for HIV-infected people, live virus vaccines are usually contraindicated, and inactivated vaccines are not. Finally, it is important for the clinician to avoid checking patients' viral load for one month after the administration of immunizations, because they may cause a transient rise in these viral load numbers.^{3,4}



FREE VACCINES through the AIDS Drug Distribution Program

The New Jersey AIDS Drug Distribution Program (ADDP) provides free medication coverage for individuals with HIV/AIDS who have incomes up to 500% of federal poverty level, and no other prescription coverage. ADDP also covers medically-appropriate vaccines through the participating network of ADDP pharmacies. The cost of the administration of the vaccine is not covered. Many independent pharmacies participate in the ADDP network and will deliver the vaccine to the provider's office free of charge. In order to facilitate the utilization of vaccines within the ADDP population, a patient can use an independent pharmacy for vaccines only, and still maintain their primary pharmacy for all other medications covered by the ADDP. The Independent Pharmacy Association can be contacted at (609) 395-8616 for information regarding individual pharmacies within the provider's service area.

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CONTINUING EDUCATION INFORMATION

Prevention and Treatment of HIV Infection in Persons 50 and Over: Recommendations for New Jersey Clinicians & Public Health Practitioners

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Sponsorship

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Target Audience:

This activity is designed for physicians and nurses, and for other health care professionals in New Jersey who are involved in the care of persons with HIV/AIDS.

Statement of Need

In New Jersey and nationwide, public health officials have documented a dramatic increase in the number and proportion of adults 50 and over infected with the Human Immunodeficiency Virus (HIV), including those who have progressed to Acquired Immune Deficiency Syndrome (AIDS).^{1,2} By June 2006, the New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services (NJDHSS-DHAS) reported that the percentage of the HIV/AIDS-infected population who were 50 or older had risen to 30% of all cases of HIV/AIDS in New Jersey, a total of 10,082 people age 50 or older.²

This article is designed to enhance the role of New Jersey's clinicians in reducing the transmission of HIV among people 50 and older, identifying those who are HIV-positive but not yet in treatment, and enhancing care of the growing population of patients coping simultaneously with HIV infection and aging.

1. Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention. Number of adolescents and adults living with AIDS, by age as of December 331, 2000 and race/ethnicity – United States, 2000.

2. NJDHSS. New Jersey HIV/AIDS Report – June 30, 2006. <http://www.state.nj.us/health/aids/qtr0606.pdf>

Learning Objectives

Upon the completion of this activity, participants should be able to:

1. Describe the characteristics of people age 50 and older, in New Jersey and nationally, with HIV/AIDS.
2. Identify factors in the aging process which complicate the effects and treatment of HIV infection.
3. Discuss age-specific recommendations for effective HIV screening and testing.
4. Outline common co-morbidities and appropriate diagnostic approaches for the HIV-positive patient 50 and older.

Method of Instruction

Participants should read the learning objectives and review the activity in its entirety. After reviewing the material, complete the self-assessment test consisting of a series of multiple-choice and True/ False questions.

Upon completing this activity as designed and achieving a passing score of 70% or more on the self-assessment test, participants will receive a credit letter and the test answer key four (4) weeks after receipt of the self-assessment test, registration, and evaluation materials. Estimated time to complete this activity as designed is 1.0 hour.

Accreditation

Physicians: UMDNJ-Center for Continuing & Outreach Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. UMDNJ-Center for Continuing and Outreach Education designates this educational activity for a maximum of 1.0 category *AMA PRA credit*[™]. Each physician should claim only those credits that he/she actually spent in the activity.

Nurses: The University of Medicine and Dentistry of New Jersey-Continuing Education and Outreach Education is an approved provider of continuing nursing education by the New Jersey State Nurses Association, Provider Number P173-10/06-09. New Jersey State Nurses Association is accredited by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is awarded 1.0 contact hour.

UMDNJ-Center for Continuing and Outreach Education is an approved provider of continuing education by the California Board of Registered Nursing, Provider Number CEP 13780 for a maximum of 1.0 contact hour for this activity.

Review: The activity was prepared in accordance with the ACCME Essentials. This activity was reviewed for relevance, accuracy of content, balance of presentation, and time required for participation by Patricia Kloser, MD, MPH. This activity was reviewed for relevance, accuracy of content, balance of presentation, and time required for participation by Bonnie Abedini, MSN, RN; Mary C. Krug, MSN, RN, APN-C; and Debbie Y. Mohammed, MS, APRN-BC, ACRN.

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Faculty Disclosure Declarations

Patricia Kloser, MD, MPH (Field Tester and Activity Director) has the following financial relationships to disclose: Speaker's Bureau: GlaxoSmithKline, Abbott; Consultant: Gilead, Boehringer Ingelheim. The following have no financial relationships to disclose: Robert Skeist, ACRN, MS; Eliahu Bishburg, MD; Sindy Paul, MD, MPH; Rose Marie Martin, MPH and field testers: Bonnie Abedini, MSN, RN; Mary C. Krug, RN, MSN, APN-C; and Debbie Y. Mohammed, MS, APRN-BC, ACRN.

Off-Label Usage Disclosure

This activity does not contain information of commercial products/ devices that are unlabeled for use or investigational uses of products not yet approved.

Disclaimer

The views expressed in this activity are those of the faculty. It should not be inferred or assumed that they are expressing the views of NJDHSS-Division of HIV/AIDS Services, UMDNJ, or any manufacturer of pharmaceuticals. The drug selection and dosage information presented in this activity are believed to be accurate. However, participants are urged to consult the full prescribing information on any agent(s) presented in this activity for recommended dosage, indications, contraindications, warnings, precautions, and adverse effects before prescribing any medication. This is particularly important when a drug is new or infrequently prescribed.

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Prevention and Treatment of HIV Infection in Persons 50 and Over:

Recommendations for New Jersey Clinicians & Public Health Practitioners

Robert Skeist, ACRN, MS; Eliahu Bishburg, MD; Sindy Paul, MD, MPH, FACPM; and Rose Marie Martin, MPH

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INTRODUCTION: THE AGING OF AIDS

In New Jersey and nationwide, public health officials have documented a dramatic increase in the number and proportion of adults 50 and over infected with the Human Immunodeficiency Virus (HIV), including those who have progressed to Acquired Immune Deficiency Syndrome (AIDS).^{1,2,3}

In just over a decade, the number of HIV-positive individuals 50 and over in New Jersey increased seven-fold, from 1,047 cases in 1992 to 7,440 cases in 2003. One third (31.4%) of this group represent new cases, those whom the prevention message did not reach and who contracted the virus after reaching the age of 50. The other two-thirds (68.6%) became infected at a younger age and have now joined a growing population aging with the virus in the era of highly active anti-retroviral therapy (HAART).¹ By June 2006, the New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services (NJDHSS-DHAS) reported that the percentage of the HIV/AIDS-infected population who were 50 or older had risen to 30% of all cases of HIV/AIDS in New Jersey, a total of 10,082 people age 50 or older.³

This article is designed to enhance the role of New Jersey's clinicians in reducing the transmission of HIV among people 50 and older, identifying those who are HIV-positive but not yet in treatment, and enhancing care of the growing population of patients coping simultaneously with HIV infection and aging.

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CLINICAL INSIGHTS

Age, Immunity & HIV Infection

A number of studies have found that AIDS survival is inversely proportional to age at the time of AIDS diagnosis. Factors associated with advanced age, such as the natural decline of the immune function, and delayed diagnosis, contribute to shortened survival.⁴

Older patients with chronic HIV infection have a more pronounced depletion of CD4 cells than younger ones. In a recent European study, immune recovery for 1,956 patients was found to be inversely related to age, with older patients experiencing poorer recovery and a shorter life span.⁵ Although an age of over 55 was associated with decreased AIDS-free survival, it was not associated with decreased time from diagnosis of AIDS to death.⁶

The progression from HIV to AIDS to death is affected not only by age at time of diagnosis but also by co-morbidities commonly associated with aging such as cardiovascular disease, cerebrovascular disease, diabetes mellitus, and chronic lung disease, all of which are statistically significant predictors of shortened survival, independent of age over 55 years.^{7,8}

Further study found that patients over 50 years were more likely to meet criteria for AIDS at the time of diagnosis of HIV infection than younger patients.⁷ Due to delayed diagnosis, older patients are more likely to die within the same month as their AIDS diagnosis.⁷ In contrast, another study did not observe any difference between older and younger individuals in viral suppression, immune recovery, or clinical outcome, despite the greater presence of comorbid conditions in the older age group.⁹



Opportunistic Infections & Other Conditions

Elderly patients with AIDS present with similar opportunistic infections (OI) as younger patients, but they may be misdiagnosed as having other diseases that occur in their age group, such as Alzheimer's disease,¹⁰ bacterial or viral pneumonia,¹¹ malnutrition, and occult malignancy.¹² Among AIDS patients older than 50 years, as with younger patients, the most common opportunistic infections are pneumocystis jiroveci pneumonia (PCP), wasting syndrome, candida esophagitis, and Kaposi's Sarcoma. These conditions are treated similarly regardless of age.¹³

Confronted with the same opportunistic infections as younger AIDS patients, older patients have poorer outcomes, including higher morbidity due to PCP, higher rates of disseminated tuberculosis and more severe herpes zoster.¹⁴ Additional challenges for clinicians are reflected in several reports describing atypical presentation of diseases leading to delayed diagnoses. The introduction of highly active antiretroviral drugs (HAART), and the related recovery of immune systems in treated patients of all ages, have led to a dramatic drop in the frequency of most AIDS-related OI's, especially those related to very low CD4 count. This has produced a modified clinical picture with significantly reduced morbidity and mortality.¹⁵

Anti-Retroviral Therapy

Older age is associated with a reduction in renal and hepatic function, which may lead to higher drug levels, increased toxicity, and reduced tolerability of antiretroviral medications. Interaction with non-HIV related medications may further increase their toxicity and influence the tolerability of antiretroviral therapy. In one study, only 36% of older patients who were started on a protease inhibitor (PI) stayed on this class of drugs beyond 24 months, and adverse events were twice as common during receipt of the PI containing regimen in persons older than 60 years (64% in persons over 60 years, compared with 35% in the younger age group).¹⁶

Cardiac, metabolic, oncologic, and psychiatric comorbidities, conditions commonly associated with the elderly, impact the safety of and compliance with antiretroviral therapy. In a study of older patients on antiretroviral medications in New York, 89% had comorbid conditions, and 81% were taking non-HIV-related medications.¹⁷ For the patient coping with both HIV and comorbidities associated with aging, it is crucial for the clinical team to monitor the use of both HIV and non-HIV medications.

No specific antiretroviral guidelines have been developed yet for the treatment of the elderly with HIV. This is due, in part, to the frequent exclusion of older patients from studies because of their multiple medical problems or concomitant use of other medications. Therefore, current treatment of the elderly with HIV is based on the same recommendations made for the general adult population.

Most challenges clinicians face in the pharmacological management of HIV disease in the elderly overlap with considerations for the general adult population. Insufficient compliance with cumbersome regimens leads to treatment interruption or failure. Reduction in drug elimination due to decreased renal function may cause increased toxicity. Toxicity associated with ARV has been well described, including increased

hypercholesterolemia, hypertriglyceridemia, and abnormalities in glucose metabolism associated with insulin resistance. These toxicities may progress more rapidly and become more serious in elderly patients with underlying atherosclerosis. Treatment of elevated cholesterol with statins, specifically atorvastatin and pravastatin, are first choices because of expected reduced interaction with the metabolism of protease. Hypertriglyceridemia should be treated with a fibrate.

Fat redistribution syndrome – involving fat accumulation, peripheral fat atrophy, or both – is a familiar consequence of ARV. In older patients, its impact is magnified by the loss of lean body mass commonly associated with aging.

Internists caring for older patients taking multiple non-HIV related medications should consider the possibility of reduced bioavailability and increased drug-drug interactions. For example, caution is advised regarding protein pump inhibitors such as omeprazole, anti-tuberculous medications such as rifampin, antifungal agents such as itraconazole, and neuroleptics such as antidepressant benzodiazepines.

Cardiovascular Disease

With the introduction over the past decade of an array of medications used in combination and referred to as Highly Active Anti-Retroviral Therapy (HAART), patients of all ages living with HIV/AIDS have experienced a very significant increase in survival rates. Unfortunately,



HAART has also led to an increased incidence of dyslipidemia and insulin resistance, further increasing the potential for cardiovascular disease in the HIV infected elderly. In a recent study, longer exposure to combination ARV which included either a protease inhibitor (PI) or non-nucleoside reverse transcriptase inhibitor (NNRTI) was associated with a 26% increase in the rate of myocardial infarction per year of exposure; older age was consistently associated with an increased risk.¹⁸

Bone Disease

Both aging and HIV are associated with lowered bone density. Reduced bone mineral density in HIV-infected patients was initially attributed to their exposure to HAART, specifically to PIs. Further studies have shown, however, that bone mineral density was reduced in HIV-infected patients regardless of their exposure to ARV medications and is most likely related to HIV infection itself.^{19,20} Osteopenia and avascular necrosis can have more severe consequences in the older patients, who are already coping with decreased bone density and efficiency of blood flow. In addition, peripheral neuropathy, another adverse event of ARV, may make the elderly more prone to falls and trauma.

For the HIV-positive patient 50 and over, especially females, physicians are encouraged to order baseline and periodic DEXA bone density evaluations. Evaluation of nutritional status is advisable, and nutritional supplementation should be optimized. For overt osteoporosis hormone replacement, bisphosphonates, raloxifene or calcitonin should be considered. The risk of falls may be reduced by patients who engage in appropriate weight-bearing and balance-enhancing exercise.

Neurological Conditions

HIV disease in the patient 50 and over may imitate a broad spectrum of neurological disorders. HIV-associated dementia must be differentiated from Alzheimer's disease and dementia associated with atherosclerotic disease. Similar to other dementias, HIV-associated dementia presents with decreased attention and concentration,



apathy, withdrawal and psychomotor retardation. In contrast with Alzheimer's dementia, however, HIV-associated dementia progresses more rapidly (over months, not years) and does not include features of cortical dysfunction such as dysarthria. HIV dementia is also often associated with peripheral neuropathy and occasionally with myelopathy.

Cerebrospinal fluid (CSF) findings in HIV dementia may be associated with mild protein elevation and monocyte pleocytosis, as opposed to Alzheimer's disease which presents with normal CSF. HIV-associated dementia improves after initiation of HAART.^{10,21}

Additional precautions

Given the weakening of the immune system associated with either aging or HIV alone, care of the HIV patient age 50 and over should include close attention to testing for and treatment of syphilis and other sexually transmitted diseases, tuberculosis, and hepatitis C. Clinicians are encouraged to provide vaccinations to induce protection against influenza, pneumococcal infection, and hepatitis A and B.

It is advisable that clinicians including primary care physicians, nurse practitioners, infectious disease specialists, and geriatricians develop collaborative relationships as they care for a growing population of HIV-positive older adults in New Jersey and throughout the nation.

(Continued on next page)



THE PUBLIC HEALTH RESPONSE

The increase in HIV/ AIDS among persons 50 and over emphasizes the need for new public health educational and intervention strategies targeted to this age group.²³

Behavioral surveys of older Americans have indicated the relative lack of use of precautions or participation in HIV testing among older persons with known risk factors.²³ Older persons tend to be less knowledgeable about HIV than younger persons.^{24,25} Social marketing campaigns should include images and issues related to persons 50 and over in their educational and prevention efforts.²⁴ The older age group needs targeted HIV prevention education to heighten their awareness of HIV/AIDS.²⁶ New venues for prevention programs such as senior centers and retirement communities should be considered.²⁷

Two new statewide initiatives of NJDHSS, DHAS involve making rapid HIV testing available in emergency departments and in mobile vans. The goal is to improve access to HIV counseling and testing for persons at risk, including those age 50 and over.

It is encouraging to note that testing rates of the 50 and over population in counseling and testing centers have increased during the past decade. Yet, in spite of this increase, people over the age of 50 in New Jersey get tested for HIV at only one-sixth the rate of the population under 50. When those over 50 are tested they return a higher rate of HIV-positive results.¹ Increased HIV testing of people age 50 and over should be encouraged throughout the state. Undiagnosed patients do not know that they are infected, are not

referred for treatment, or for prevention or social services, and pose a continuing risk for HIV transmission.

The Role of Clinicians

Physicians and other health care providers should integrate thorough sex and drug risk assessments as part of routine care for their patients 50 and older, with those at risk offered HIV counseling and testing. Clinicians can help prevent HIV transmission by communicating prevention messages, positively reinforcing changes to safer behavior, referring patients for services such as substance abuse treatment, facilitating partner notification, and identifying and treating other sexually transmitted diseases (STDs).²⁸ When prescribing medications for erectile dysfunction, clinicians should routinely provide condoms and information on safer sexual practices.

The Centers for Disease Control and Prevention (CDC) recommends that HIV counseling and testing should be integrated into clinical practice.²⁸ CDC recommends testing of all patients with a known sexual or needle-sharing exposure to the virus, of patients in settings serving populations at increased behavioral or clinical risk, and of all patients in areas in which the prevalence of HIV disease is 1% or greater. Patients with clinical signs or symptoms of HIV disease (e.g., fever, illness of unknown origin, oral thrush, unexplained lymphadenopathy with or without weight loss, or psoriasis) should be offered counseling and testing. In addition, patients with a diagnosis suggesting increased risk of HIV disease such as opportunistic infections, tuberculosis, cervical or anal cancer, Kaposi's sarcoma, lymphoma, recurrent pneumonia or bacteremia, hepatitis B, hepatitis C, or a sexually transmitted disease should

be offered HIV counseling and testing. A thorough sexual and social history is important to guide the need for testing in persons 50 and over.

Partners in Public Health

In recognition of this issue, The General Assembly of the State of New Jersey designated May 27, 2005 as "HIV Infection in Persons 50 Years of Age and Older Awareness Day" and encouraged the establishment of HIV/AIDS education programs that target older persons. The resolution called upon "public officials and citizens of this State to observe the day with appropriate activities and programs."²⁹

The New Jersey Association on HIV Over Fifty (NJAHOF), an affiliate of the National Association on HIV Over Fifty (NAHOF), contributes to enhanced public awareness on this topic and offers opportunities for mutual support and public advocacy on the part of HIV-positive individuals over 50.³⁰ NAHOF can be contacted at www.hivoverfifty.org.

Additional research is needed on how to increase the participation of the older population in the counseling and testing services available to them, along with further research into the epidemiology, prevention, and clinical course of HIV in persons 50 and over.³⁰ The CDC currently recommends HIV screening for all persons 13 to 64 years of age. For those at risk for HIV, annual screening is recommended.³¹

Working together, primary care clinicians, infectious disease specialists, geriatricians, public health agencies, public officials, community based advocacy organizations, and researchers can prepare to provide optimum health care for the growing population of people who are aging with HIV.

RESOURCES FOR FURTHER INFORMATION

- New Jersey Department of Health & Senior Services, Division of HIV/AIDS Services. (609) 984-5940. www.state.nj.us/health/aids
- New Jersey HIV/AIDS Hotline: 1-800-624-2377
- Family Treatment Center of Newark Beth Israel Medical Center. (973) 926-5212 or EBishburg@sbhcs.com
- New Jersey Association on HIV Over Fifty: RSkeist@sbhcs.com
- National Association on HIV Over Fifty: www.hivoverfifty.org. Includes extensive bibliography and list of national resources
- Research on Older Adults with HIV. AIDS Community Research Initiative of America, New York, NY. www.acria.org

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Self-Assessment Test – Page 1 of 2

Questions refer to the content of the article and the notes that follow. To receive CME/CEU credit: complete exam, registration, and evaluation forms on-line at <http://ccoe.umdj.edu/aids> or fill in the forms on the next two (2) pages, and mail or fax to UMDNJ-CCOE (see Registration Form).

- 1. As of June 2006, how many people age 50 and over living in New Jersey were HIV positive, accounting for what percentage of all cases of HIV/AIDS in the state?**
 - A. Approximately 20,000 people, 60% of all cases.
 - B. Approximately 10,000 people, 30% of all cases.
 - C. Approximately 5,000 people, 15% of all cases.
 - D. Approximately 1,000 people, 3% of all cases.

- 2. Which factor, aging or HIV, is associated with lower bone density?**
 - A. Both aging and HIV
 - B. Aging only
 - C. HIV only
 - D. Neither aging nor HIV

- 3. A 71-year-old man is bussed from his apartment in a senior residence to an appointment with his geriatrician. After discussing hypertension, mild congestive heart failure, osteoarthritis, and related prescriptions, the patient requests medication for erectile dysfunction.**

How should the physician respond?

 - A. In weighing the benefits and risks of prescribing medications for erectile dysfunction, the geriatrician should take into consideration the patient's other medical conditions and possible drug interactions.
 - B. This class of medications is contraindicated for elderly patients.
 - C. The medication should be provided without asking questions that might be embarrassing to the physician or the patient.
 - D. In addition to A, the physician should discuss safe sex and recommend HIV testing.

- 4. A 58-year-old woman was divorced three years ago and has gone through menopause. At her annual physical, she feels comfortable talking with her nurse practitioner and mentions that she has been asked out on a date by a man she finds very attractive.**

What topics should the NP discuss with this patient?

 - A. Condoms as contraception.
 - B. Condoms as precaution against acquiring HIV infection.
 - C. HIV testing, vaginal lubrication, and honest communication.
 - D. B and C.

- 5. A 57-year-old man, with no insurance or primary care physician, goes to an Emergency Department at an urban hospital. He complains of frequent colds, a worsening cough, weakness, fatigue, and swollen lymph nodes. The Resident assigned to this patient notices "track marks" on the man's arms and asks about them. The patient tells the resident he has been "clean" for 5 years.**

Should the resident consider testing this patient for HIV? For any other infections?

 - A. No. Since the patient has not used intravenous drugs for 5 years, he is not at risk for any IDU (Intravenous Drug Use)-related infection.
 - B. Yes, for HIV. The patient could have been exposed to HIV when sharing a "dirty needle" over five years ago. No other tests are needed.
 - C. Yes, HIV and Hepatitis C. A history of IDU has put the patient at risk for HIV and Hepatitis C, and the patient should be tested for both viruses.
 - D. No. Unfortunately, the man has no insurance. He should be treated symptomatically for his cough and cold and discharged.



Self-Assessment Test – Page 2 of 2

Questions refer to the content of the article and the notes that follow. To receive CME/CEU credit: complete exam, registration, and evaluation forms on-line at <http://ccoe.umdj.edu/aids> or fill in the forms on the next two (2) pages, and mail or fax to UMDNJ-CCOE (see Registration Form).

6. A 66-year-old man confides to his registered nurse: “I’ve been cheating on my wife,” with recurrent episodes of unprotected sex with other men.

What is the best advice for the RN to give?

- A. The patient, his wife, and his male partners should all be tested for HIV and receive safe sex education; the patient and his wife should be referred for couples counseling.
- B. The patient and his male partners should be tested for HIV, and the patient should keep his behavior secret so as not to hurt his wife’s feelings.
- C. The patient should speak honestly with his wife about his sexual behavior and she should take sole responsibility for using or not using a condom.
- D. Sexuality is a private matter, so the nurse should not intervene

7. Toxicities frequently associated with antiretroviral therapies include:

- A. Hypercholesterolemia and hypertriglyceridemia only.
- B. Abnormalities in glucose metabolism and fat redistribution only.
- C. Both A and B.
- D. Neither A nor B.

8. How may HIV-associated dementia be differentiated from Alzheimer’s disease and dementia associated with atherosclerotic disease?

- A. All dementias present with decreased attention and concentration, apathy, withdrawal and psychomotor retardation. These dementias are impossible to distinguish with current medical technology.
- B. HIV-associated dementia progresses more rapidly – over months, not years - and does not include features of cortical dysfunction such as dysarthria.
- C. CSF findings in HIV dementia may be associated with mild protein elevation and monocyte peocytosis, as opposed to Alzheimer’s disease, which presents with normal CSF.
- D. Both B and C.

9. People over the age of 50 in New Jersey get tested for HIV at twice the rate of the population under 50. True or False?

- A. False. There is no documentation of any difference in rates of HIV testing based on age.
- B. False. The over-50 population gets tested at only half the rate of the younger population.
- C. False. The over-50 population gets tested at only one-sixth the rate of the younger population.
- D. True.

10. A 62-year-old woman is diagnosed with lymphoma and admitted for chemotherapy. After treatment, she develops neutropenia and spikes a temperature of 102°F. Antibiotics fail to relieve her fever and cough. A bronchoscopy reveals the presence of pneumocystis jiroveci pneumonia (PCP).

What test or treatment should the physician order next?

- A. No action is necessary. PCP is not associated with HIV/AIDS and it will resolve itself without treatment.
- B. The PCP should be treated symptomatically with antibiotics. PCP is not associated with HIV/AIDS and no further testing is called for.
- C. Since PCP is an AIDS-defining illness, in addition to treating the PCP, the physician should seek patient approval for HIV testing.
- D. Since PCP is an AIDS-defining illness, the patient should be started on anti-retroviral medications immediately.



CONTINUING EDUCATION REGISTRATION

Prevention and Treatment of HIV Infection in Persons 50 and Over: Recommendations for New Jersey Clinicians & Public Health Practitioners

Registration Form



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In order to obtain continuing education credit, participants are required to:

- (1) Read the learning objectives, and review the activity, and complete the self-assessment.
- (2) Complete this registration form and the activity evaluation form on the next page, and record your test answers below.
- (3) Send the registration and evaluation forms to: UMDNJ-Center for Continuing and Outreach Education
• VIA MAIL: PO Box 1709, Newark, NJ 07101-1709 • VIA FAX: (973) 972-7128
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Individuals who fail to attain a passing score will be notified and offered the opportunity to complete the activity again. This activity will be posted online at <http://ccoe.umdj.edu/aids>.

Please note: CE credit letters and long-term credit retention information will only be issued upon receipt of completed evaluation form.

SELF-ASSESSMENT TEST <i>Circle the best answer for each question.</i>	1. A B C D	3. A B C D	5. A B C D	7. A B C D	9. A B C D
	2. A B C D	4. A B C D	6. A B C D	8. A B C D	10. A B C D

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CONTINUING EDUCATION REGISTRATION

Prevention and Treatment of HIV Infection in Persons 50 and Over: Recommendations for New Jersey Clinicians & Public Health Practitioners

Activity Evaluation Form



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The planning and execution of useful and educationally sound continuing education activities are guided in large part by input from participants. To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few moments to complete this evaluation form. Your response will help ensure that future programs are informative and meet the educational needs of all participants.

Please note: CE credit letters and long-term credit retention information will only be issued upon receipt of completed evaluation form.

PROGRAM OBJECTIVES: Having completed this activity, are you better able to:	Strongly Agree		Strongly Disagree		
<i>Objective 1:</i> Describe the characteristics of people age 50 and older, in New Jersey and nationally, with HIV/AIDS.	5	4	3	2	1
<i>Objective 2:</i> Identify factors in the aging process which complicate the effects and treatment of HIV infection.	5	4	3	2	1
<i>Objective 3:</i> Discuss age-specific recommendations for effective HIV screening and testing	5	4	3	2	1
<i>Objective 4:</i> Outline common co-morbidities and appropriate diagnostic approaches for the HIV-positive patient 50 and older	5	4	3	2	1

OVERALL EVALUATION:	Strongly Agree		Strongly Disagree		
The information presented increased my awareness/understanding of the subject	5	4	3	2	1
The information presented will influence how I practice.	5	4	3	2	1
The information presented will help me improve patient care.	5	4	3	2	1
The faculty demonstrated current knowledge of the subject.	5	4	3	2	1
The program was educationally sound and scientifically balanced.	5	4	3	2	1
The program avoided commercial bias or influence.	5	4	3	2	1
Overall, the program met my expectations.	5	4	3	2	1
I would recommend this program to my colleagues.	5	4	3	2	1

If you anticipate changing one or more aspects of your practice as a result of your participation in this activity, please provide us with a brief description of how you plan to do so.

Please provide any additional comments pertaining to this activity (positives and negatives) and suggestions for improvement. Please list any topics that you would like to be addressed in future educational activities:

Please check all applicable demographic information, which will be used for program evaluation and improvement.

<input type="checkbox"/>	Physician	<input type="checkbox"/>	Hispanic	<input type="checkbox"/>	Male
<input type="checkbox"/>	Nurse	<input type="checkbox"/>	Caucasian	<input type="checkbox"/>	Female
<input type="checkbox"/>	Nurse practitioner	<input type="checkbox"/>	African American/Black	<input type="checkbox"/>	Transgender
<input type="checkbox"/>	Physician's Assistant	<input type="checkbox"/>	Other:		
<input type="checkbox"/>	I provide HIV patients with general primary care.		Number of HIV patients I saw this past month		
<input type="checkbox"/>	I provide HIV patients with infectious disease care.		I do not see patients.		

Statewide Voluntary Rapid HIV Testing in New Jersey Emergency Departments

Sindy M. Paul, MD, MPH, FACPM; Maureen Wolski; Rhonda Williams; Lorhetta Nichol; Skip Drumm; Monica Harvey-Talbot; Linda Berezny, RN; Aye Maung Maung; Evan M. Cadoff, MD; and Eugene Martin, PhD



Introduction

The Centers for Disease Control and Prevention (CDC) recommends that voluntary HIV testing be included as part of patient care services. Emergency departments (EDs) represent an important venue for integration of voluntary HIV testing into routine patient care.¹ Emergency departments account for 10% of all ambulatory care visits in the United States. In 2002, 17% of the civilian population in the United States had at least one ED visit and 5% made two or more visits.² For many patients, EDs may be their only access to the health care system. Relatively high HIV infection rates have been found in selected large city hospital EDs through use of rapid HIV testing, and entry into treatment for HIV infection was found to be expedited by having test results, and referrals for care

provided in one site, such as the ED.^{3,4} The advent of the U.S. Food and Drug Administration (FDA) approved rapid HIV test, makes it practical to implement rapid HIV testing in emergency departments. The counseling and testing component can be integrated into patient flow within the emergency department. As patients are waiting to go for diagnostic imaging, or waiting for other laboratory results, rapid HIV testing can be completed. Those who are negative receive their final results immediately. Persons at high risk for HIV can be referred to a prevention program for more intensive risk reduction. Those who have a preliminary positive result can have their confirmatory test specimens obtained, and referred to an appropriate clinic or physician to receive confirmatory results and immediately get into care and

treatment. Although acceptance has not been found to be universal, rapid HIV testing has been found to be feasible in the ED, and it improves the receipt of HIV test results by the client.⁵

Availability of rapid HIV testing in emergency departments is also helpful for the diagnosis and management of patients within the EDs. For example, it is particularly helpful in the differential diagnosis of pneumonia. Pneumocystis jiroveci pneumonia (PCP) would be much higher on the differential diagnosis of a patient with a preliminary positive rapid HIV test, whereas, it would not be an important consideration for a patient with a negative rapid HIV test.

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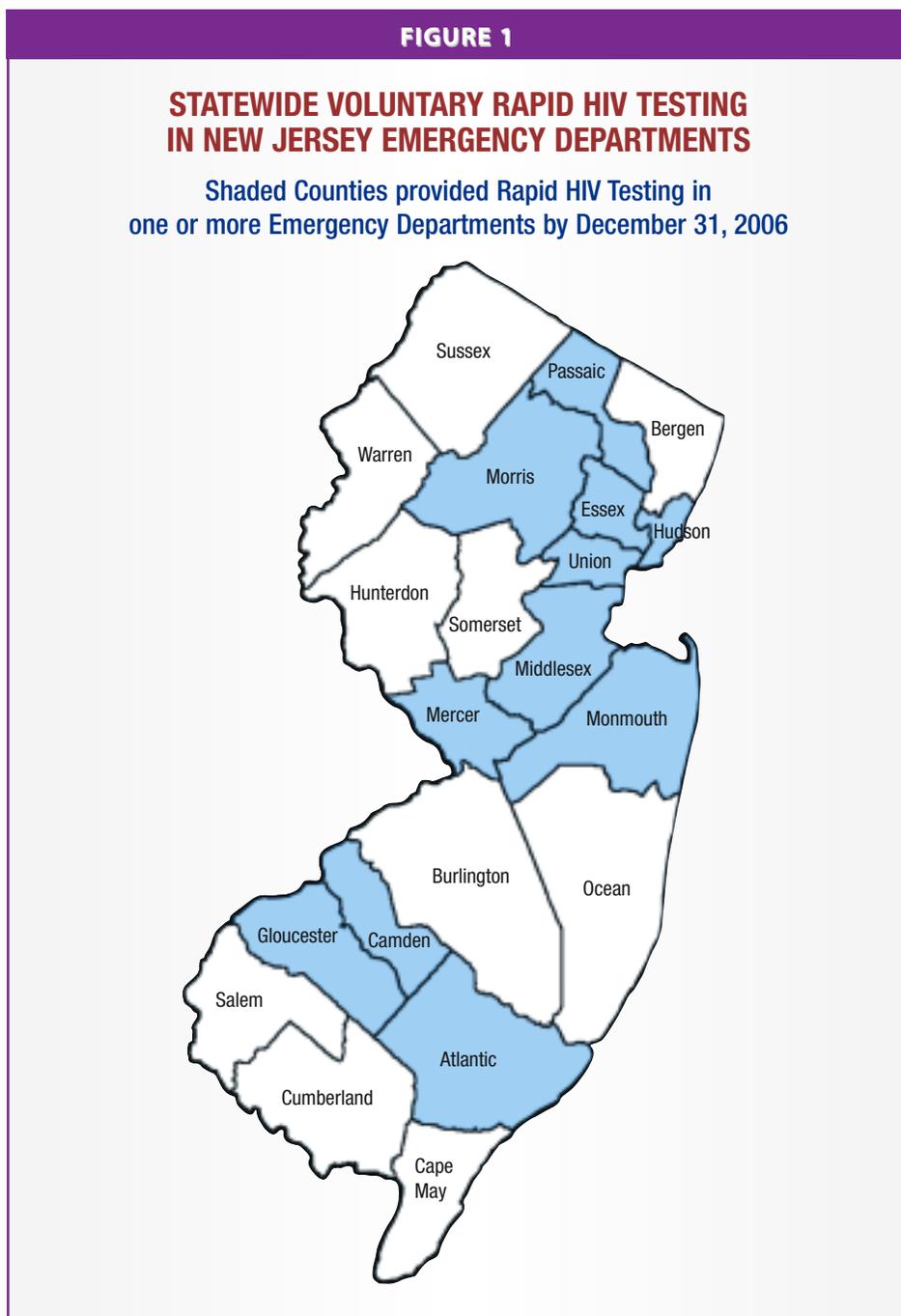
Methods

The New Jersey Department of Health and Senior Services (NJDHSS), Division of HIV/AIDS Services (DHAS) issued a request for proposals to conduct HIV counseling and testing in 2004. The criteria for hospital applicants included voluntary rapid HIV testing in the EDs. Non-hospital applicants were encouraged to include rapid HIV testing in the EDs in their proposals. To conduct rapid HIV testing in New Jersey EDs, rapid HIV testing needs to be added to the laboratory license issued by the NJDHSS, Division of Public Health and Environmental Laboratories.

All sites used OraQuick® HIV-1 until Ora-Quick® ADVANCE HIV-1/HIV-2 antibody test (OraSure Technologies, Bethlehem, PA) became available. Specimen collection for OraQuick® was via a fingerstick or venipuncture.

Sensitivity for OraQuick® Rapid HIV-1 Antibody Test is 99.6% and specificity is 100.0%.⁶ Specimen collection for Ora-Quick® Advance is a fingerstick, venipuncture, or oral mucosal. Sensitivity for OraQuick® ADVANCE HIV-1/HIV-2 is 99.3% for the oral mucosal test, and 99.6% for fingerstick or venipuncture blood test. Specificity for this test is 99.8% for the oral mucosal test, and 100.0% for the blood tests.⁷ Confirmatory Western blot testing for all preliminary positive rapid HIV test was done at the NJDHSS laboratory using the Genetic System kit that is sold by Bio-Rad.

The data used in this study was collected using the standard CDC HIV counseling and testing data collection tool. Publicly funded counseling and HIV antibody testing services are required to report services provided at each person's visit to the CDC through the respective state HIV services agency. Publicly funded counseling and testing sites are supported by CDC funding through state and local health departments. State funding is also provided for HIV counseling and testing sites.



Results

As of December 31, 2006, 21 EDs in 11 counties were licensed to provide rapid HIV testing, and were offering voluntary rapid HIV testing in their EDs. The shaded areas in Figure 1 indicate the distribution of the ED sites by county.

Data through December 31, 2006 indicate that: 11,531 tests were performed in the EDs, 11,323 (98.2%) of persons received results, 11,146 (96.7%) were negative, 295 (2.6%) tested positive, 209 (70.9%) of the 295 persons testing positive, were newly identified as infected, and 90 (0.08%) had a discordant test result.

(Continued on next page)

Statewide Voluntary Rapid HIV Testing in New Jersey Emergency Departments (Cont. from pg. 13)

“The Centers for Disease Control and Prevention (CDC) recommends that voluntary HIV testing be included as part of patient care services. Emergency departments (EDs) represent an important venue for integration of voluntary HIV testing into routine patient care.”

Discussion

An anonymous unlinked seroprevalence survey conducted at an urban hospital in New Jersey found that 10.4% of persons 18 years of age or older were infected with HIV. Of the 332 persons testing positive, 134 (40%) were unaware of their HIV status⁸ (see the following article). These findings indicated that EDs in New Jersey were a venue in which HIV testing should be integrated into routine clinical care. In addition, a review of literature from studies of emergency departments offering routine HIV screening to patients presenting in the EDs, concluded that evidence existed to recommend that EDs

offer HIV screening to high-risk patients (those with identifiable risk factors) or high-risk populations, where the HIV seroprevalence is at least 1%.⁹ The issue was whether HIV testing could be incorporated in the patient flow of New Jersey EDs and would HIV testing in EDs be acceptable to patients.

The data through December 31, 2006, shows that rapid HIV testing can be successfully integrated into New Jersey emergency departments. The results speak compellingly to the need to implement the CDC policy recommenda-

tions to incorporate HIV testing into routine clinical care, and to expand the availability of rapid HIV testing to sites such as EDs that reach populations that are at high risk, and may not be reached by other testing sites.^{1,10} Other experts also believe that HIV testing should be routinely offered to any person who is sexually active, and that HIV testing should be a routine component of health care. This would include offering HIV testing routinely in settings such as emergency departments.¹¹

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Emergency Department-Based HIV Testing in New Jersey: Data to Action

Charlotte Sadashige, MSS, Barbara Bolden, PhD, and Helene Cross, PhD

Introduction

The Centers for Disease Control and Prevention (CDC) estimates that undiagnosed and unreported cases of HIV and AIDS comprise upwards of one-quarter of all HIV infections in the United States.¹ The advent of treatment has dramatically improved survival rates of patients with HIV. However rates of diagnosis earlier in the course of patients' disease progression have improved only modestly.² "Late testers" develop full-blown AIDS within one year of their HIV diagnosis.³ About 30% of patients in New Jersey have already progressed to AIDS at the time of their initial diagnosis with the HIV virus. More than 10% additionally develop AIDS within a year of their HIV diagnosis, such that two-fifths or more of persons diagnosed with HIV disease in New Jersey are identified late in their disease progression.⁴

In 1993, the CDC encouraged hospitals with HIV seroprevalence rates of >1% to routinely offer voluntary HIV counseling and testing to all patients ages 15-54.⁵ In 2003, the CDC recommended HIV testing as a routine part of medical care on the same voluntary basis as other diagnostic tests.⁶ The CDC's 2006 HIV testing recommendations continue to advocate for increased screening of patients in health care settings and the earlier identification of persons with unrecognized HIV infection to link them to services.⁷

In 2002, the New Jersey Department of Health and Senior Services (NJDHSS), Division of HIV/AIDS Services in collaboration with University Hospital (UH), part of the University of Medicine and Dentistry of New Jersey system, conducted a needs assessment of HIV testing of adults using the UH Emergency Department (ED). This report describes the study along with actions taken as a result of the study's findings.

Methods

An anonymous unlinked survey was used to eliminate any self-selection biases associated with the consent requirement of voluntary HIV testing.⁸ The patient population included consecutive de-duplicated adults 18 years and older who had blood drawn for clinical tests in the UH ED between October 7 and December 31, 2002.⁹ Once it was determined the samples were no longer needed for patient care, the remnant specimens were aliquoted, labeled with a coded study identification number, and frozen until testing. Samples from patients under age 18 and duplicate specimens were excluded.

Demographic data and clinical history were abstracted from patient medical records using a standardized template, and were temporarily linked to specimens.

Abstracted information included age group, sex, race/ethnicity, reported HIV risk behaviors such as illicit drug use, health insurance status, HIV testing history, and reason for emergency visit. Reason for visit was then coded by UH medical staff into the following six categories: surgical/trauma, psychiatric, medical (including HIV-related conditions), gynecologic, drug-related, and other/unknown. After samples and accompanying information



were verified and recorded, the study identification number was replaced with an unlinked random identification number. After all links connecting specimens with patient identifiers were removed, samples were tested by the New Jersey Department of Health and Senior Services Public Health and Environmental Laboratories for the HIV-1 antibody.¹⁰

Results

The study population is summarized in the table at the end of this article. During the study period, 3,193 specimens had a usable blood specimen. The study population was almost equally distributed between men (50.8%) and women (49.2%), and included 68.1% African Americans, 10.6% Hispanics, and 9.6% Whites. Almost equivalent percentages of patients were between ages 18-29 (22.9%), 30-39 (23.5%), and 40-49 (22.7%), with 13.5% between 50-59, and 17.4% over age 60. Six percent (6.4%) of patients used the emergency department for life threatening conditions, 48.5% for urgent care, and 37.5% for non-acute reasons. One-fifth of study patients (20.9%) were admitted as inpatients.

(Continued on next page)

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Emergency Department-Based HIV Testing in New Jersey: Data to Action *(Cont. from pg. 15)*

IN TOTAL, 332 of 3,193 (10.4%) patients tested positive for HIV. Men had an overall seroprevalence rate of 11.1% (180 of 1,623) and women had an overall seroprevalence rate of 9.7% (152 of 1,570). The highest HIV seroprevalence was found among persons ages 40-44 (20.7%). Of seropositive patients, 198 (59.6%) reported a previous positive HIV test. A greater proportion of HIV-seropositive women, 65.1% (99 of 152) than seropositive men, 54.4% (98 of 180) reportedly knew their HIV serostatus. More HIV seropositive patients who reported they knew their serostatus had health insurance than seropositive patients who reported they did not know their serostatus. Less than three fifths or 57.6% (68 of 118) of seropositive patients indicating no health insurance were previously diagnosed compared with two-thirds or 67.1% (108 of 161) of patients with Medicare/SSI, Medicaid, and Private/HMO insurance combined. Of patients reporting a previous HIV diagnosis, 47 (23.7%) indicated using antiretroviral therapies. Overall, only one in seven (14.2%) seropositive patients reported using antiretroviral therapies.

Limitations

The above findings are subject to at least two limitations. First, the study population was a non-probability convenience sample of the patient population who had blood drawn in conjunction with their medical care during the data collection period. Therefore, the sampling technique may limit extrapolation of the findings to the broader UH ED population that did not have blood drawn during their visit. Second, information about previous HIV diagnoses was self-reported by patients and kept anonymous and was not verified against the New Jersey HIV/AIDS registry.

TABLE 1. HIV Seroprevalence by Sex, Age Group, Race/Ethnicity, Category of Patient Visit, Health Insurance Status

Sex	Tested No.	HIV+ No.	HIV+ %
Women	1,570	152	9.7
Men	1,623	180	11.1
Age Group			
18-24	429	9	2.1
25-29	302	17	5.6
30-34	357	43	12.0
35-39	393	64	16.3
40-44	381	79	20.7
45-49	345	56	16.2
50-54	248	32	12.9
55-59	184	13	7.1
60-64	182	10	5.5
>65	372	9	2.4
Race/ Ethnicity *			
African American	2,174	277	12.7
Hispanic	339	22	6.5
White	308	11	3.6
Other/Unknown	372	22	5.9
Reason for Visit			
Surgical/Trauma	997	56	5.6
Psychiatric	226	21	9.3
Medical	1,473	205	13.9
Gynecologic	191	8	4.2
Drug-related	161	24	14.9
Other/Unknown	145	18	12.4
Health Insurance Status			
Medicare/SSI	384	24	6.3
Medicaid	42	88	20.9
Private/HMO	785	49	6.2
None	1,215	118	9.7
Other/Unknown	387	53	13.7
Total	3,193	332	10.4

* African Americans and Whites do not include Hispanics. Hispanics include anyone of Hispanic origin regardless of race.

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- The study was approved by the New Jersey Department of Health and Senior Services' Institutional Review Board (IRB) and the University Hospital's IRB.
- The University Hospital Emergency Department discharges about 57,000 adult patients annually; blood for clinical testing is drawn from over one-third of adult ED patients (estimated from data available October to December 2002).
- Specimens were initially screened for the HIV-1 antibody by Enzyme Immunosorbent Assay (EIA) (Vironstika HIV-1 Microelisa System, Organon Teknika / Biomerieux, Durham, NC). If repeatedly reactive, specimens were tested by Western blot (Bio-Rad Inc., Hercules CA). Specimens were considered HIV-1 positive if antibodies to at least two of the following three gene products were detected: p24, gp41, and gp120/160.
- HIV Counseling and Testing Sites (CTS) as of March 15, 2007. The NJDHSS began rapid HIV testing at publicly-funded clinics in November 2003. As of April 2007, rapid testing is offered at 164 clinics including 22 emergency departments in 13 NJ counties.

DATA to ACTION

In February 2005, results from this study were used as the rationale to implement rapid HIV testing of University Hospital adult ED patients when clinically appropriate, when it will not interfere with the primary reason for the emergency visit, or with an assessment of a patient's high-risk behavior. Following implementation at University Hospital, HIV testing was subsequently put into practice at more than twenty additional hospital emergency departments throughout New Jersey. As of March 2007, 4,084 patients were tested in the UH ED; 221 (5.4%) were seropositive, and 3,968 (97.2%) patients received their HIV test results. This seroprevalance rate is almost three-and-one-half times higher than the seroprevalence (1.6%) found at New Jersey's publicly-funded rapid testing sites overall and about 60% higher than

In total, 332 of 3,193 (10.4%) patients tested positive for HIV. Men had an overall seroprevalence rate of 11.1% (180 of 1,623) and women had an overall seroprevalence rate of 9.7% (152 of 1,570).

the seroprevalence found at 21 NJ emergency departments combined that offer HIV testing and had reported cases of HIV/AIDS to the NJDHSS as of March 2007. Since University Hospital began HIV screening in the ED, it became the single largest volume reporter of newly identified HIV/AIDS cases to the NJDHSS.¹¹

Conclusions

The level of HIV infection, and particularly the level of reportedly undiagnosed, and therefore untreated HIV infection at UH is substantial. Because the University

Hospital ED did not previously offer HIV screening, a majority of newly identified HIV positive patients would likely have not have been identified until later in the course of their disease, thereby unable to more fully benefit from clinical care and possibly unknowingly exposing others to HIV. HIV testing, counseling, and referral in emergency departments may broaden the reach of patients' access to HIV prevention and care, offer a point of entry into HIV/AIDS services, and provide more accurate and critical epidemiologic data on which to base HIV programs.

ACKNOWLEDGEMENTS

Michael Jaker, MD, University of Medicine and Dentistry of New Jersey, New Jersey Medical School, Newark, and Cheryl Biber, DMD, MPH, University of Medicine and Dentistry of New Jersey, New Jersey Dental School, Newark, contributed to the data collection and analysis of the needs assessment.

Rapid HIV Testing in the Emergency Department at University Hospital, Newark: Case Histories

Atiya Brooks, Kristen Black, Nitza Vargas, Michael Jaker, MD, and Debbie Mohammed, MS, MPH

CASE SCENARIOS

CASE SCENARIO #1:

Joseph, a 42-year-old Black Hispanic male, came to the Emergency Department complaining of shortness of breath. He had been having chills, fevers, and night sweats for three days. The evening before, he had been getting high with a friend. He remembers telling his friend to get help before he passed out.

Joseph has used intravenous heroin and cocaine for 26 years. He shares needles with friends on the streets and cleans his 'works' sometimes. He is heterosexual but has not been sexually active in over a year. His Rapid HIV Test results came back preliminary positive and he was admitted for bilateral pneumonia. We attempted to get the names of his partners so that they could be contacted by the Department of Health, Notification Assistance Program

(NAP) and be tested for HIV disease. However, the best he could do was to give the street names of his friends and the check-cashing place where they met at the beginning of each month. He was given referrals to local community-based organizations in Newark for drug rehabilitation. Today he is in a rehabilitation program, in HIV medical care and drug free.

(Continued on next page)

Atiya Brooks, BA, Kristen Black, and Nitza Vargas are HIV Counselors at University Hospital in Newark. Michael Jaker, MD, is Medical Director of the HIV Counseling, Testing, and Referral Service (HIV CTRS) at University Hospital in Newark, Associate Professor at UMDNJ- NJMS and an Inpatient Attending Physician at University Hospital; Debbie Mohammed, MS, MPH, BSN, APRN-BC, ACRN, is an Advanced Practice Nurse and Project Director for HIV-CTRS at UMDNJ-University Hospital.

Rapid HIV Testing in the Emergency Department at University Hospital, Newark: Case Histories

CASE SCENARIOS

CASE SCENARIO #2:

Justine, a 65-year-old African American female, was asked by her doctor to be tested for HIV disease when she came in for abdominal and chest pains. She said she was a heterosexual and denied any sexual relations in the past two years. Justine tested preliminary positive for HIV disease by Rapid HIV Test. She was counseled and scheduled for a visit in one week to receive her confirmatory HIV results. Justine did not come for any of her scheduled appointments. After several phone calls her case was referred to NAP so that they could locate her and inform her of her HIV-positive results.

CASE SCENARIO #3:

A young African American male, aged 32, came into our office and requested Rapid HIV Testing with his partner. He has been in this relationship for the past six months. Prior to this relationship he engaged in unprotected sexual encounters with other men, as well as bisexual men who were also IVDU. His partner is a younger Caucasian male who reports a history of prostitution, bisexual relationships and other drug usage. He has been clean for about 3 years. They have had unprotected sex since the day they met, as his partner said that he was HIV negative prior to this relationship. They both tested preliminary HIV-positive. They were both instructed on safe sex practices to lessen the chance of transmission of resistant HIV viruses, and are now in HIV medical care.

CASE SCENARIO #4:

Around 7:30 pm on a cold night in February 2007, a 27-year-old Hispanic woman named Karen came into the fast track emergency room because she felt a lump on the crown of her head. After being examined, doctors told her that it might be cancer, and that she needed further tests and lab work. When the lab and x-ray results came back, everything was normal. Upon being discharged from the ER, Karen requested an HIV test, and we were called to do a Rapid HIV test. Karen stated that her last HIV test was performed in June 2006, and her results were negative. Her risk factors include a homemade tattoo performed in June 2006 and unprotected heterosexual sex in 2003. A Rapid HIV test was performed on Karen and the result came back preliminary positive. When the results were given to Karen, she did not take the news very well; she was in a state of shock and disbelief. She was told that she needed to have blood drawn to send to the laboratory for additional testing; however, Karen refused as she had other obligations that she had to take care of immediately. She was given a card with the clinic's phone number, and told to give us a call when she could come back.

The following day Karen was contacted by phone. She was crying and extremely upset over the phone, however she agreed to come in the next day to do the necessary blood work. When Karen came in she brought her boyfriend to be tested for HIV; the boyfriend tested HIV-negative. Three

days after the blood work was done, confirmatory test results were in, which were positive for HIV-1 by Western blot, and her CD4 level was 374. Today, Karen is in medical care and dealing with the psychological issues that go with her new diagnosis. She and her boyfriend have been instructed on safe sex practices, and she is being encouraged to have her 4 year old son tested for HIV at the FXB clinic for children.

CASE SCENARIO #5:

Joe is a 39-year-old Hispanic, heterosexual, married male who was brought to the Emergency Department right after his airplane landed at Newark International Airport. During his flight, he began experiencing difficulty breathing and fever. He received oxygen to help with his breathing until the plane landed. In the ER, he was admitted to an Isolation Room until TB could be ruled out. A Rapid HIV test was ordered, and after 20 minutes the results were preliminary positive. When given the results, he admitted to taking two prior tests for HIV. The first was 12 months ago, the second was 11 months ago, and the results were both positive. Joe has a history of snorting cocaine and having unprotected sex. His wife of three years was asked to come in and be tested. She also tested HIV positive. They are both preparing for follow up medical care in an outpatient clinic.

*** All names are fictitious.

FOR MORE INFORMATION:

New Jersey Rapid HIV Testing Website: www.state.nj.us/health/aids/rapidtesting

New Jersey HIV (Testing) Helpline: 1-866-HIV-CHEC



(Continued from page 1)

ADULT IMMUNIZATIONS

Recommended by the Centers for Disease Control and Prevention for Individuals with HIV/AIDS: October 2006 – September 2007

Haemophilus influenzae B

Hib conjugate vaccines are licensed for children aged 6 weeks to 71 months. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults with the chronic conditions associated with an increased risk for Hib disease. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection or who have had splenectomies; administering vaccine to these patients is not contraindicated.

Hepatitis A

Medical, behavioral, occupational, and other indications.

Hepatitis B

Medical, behavioral, occupational, and other indications.

Human Papilloma Virus

Females < 26 years of age.

Influenza

Trivalent inactivated influenza vaccine can be used, however, CDC does not recommend use of FluMist or any other “live” vaccine to treat or prevent influenza for any immunocompromised individual.

Meningococcal

Medical and other indications.

Mumps, Measles, Rubella

This vaccine is not recommended for HIV-infected patients with evidence of severe immunocompromise. Severely immunocompromised patients and other symptomatic HIV-infected patients who are exposed to measles should receive immune globulin (IG) prophylaxis regardless of vaccination status, because they may not be protected by the vaccine.

Pneumococcal Polysaccharide

Vaccinate as close to the diagnosis as possible when CD4 cell counts are highest.

Rabies

The New Jersey Department of Health and Senior Services' (NJDHSS) “Guide to Postexposure Rabies Treatment for the Healthcare Professional” is available at the NJDHSS website: www.state.nj.us/health/cd/pxrabies.htm. Representatives of the NJDHSS' Infectious and Zoonotic Diseases Program are available to assist physicians in making treatment decisions. They can be reached by calling (609) 588-3121 or (609) 588-7500 between 8 a.m. and 5 p.m. on workdays and (609) 392-2020 during holidays, weekends and off-hours.

Tetanus, Diphtheria, and Acellular Pertussis (Td/Tdap)

Uncertain history of complete vaccination, booster doses, and wound management see:

<http://www.cdc.gov/nip/publications/acip-list.htm>

or consult the ACIP statement for recommendations

for administering Td as prophylaxis in wound management at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/00041645.htm>.

Travel

Since travel-related vaccination recommendations are updated frequently, information about these vaccinations should be obtained by contacting the NJDHSS Vaccine Preventable Disease Program at (609) 588-7512 or the Centers for Disease Control and Prevention at: www.cdc.gov/travel/vaccinate.htm.

Varicella

Not recommended for adults infected with HIV.

For more information on recommended adult immunizations go to:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5540-Immunizationa1.htm>

For information on the NJ AIDS Drug Distribution Program (ADDP), including applications for patients, prescribers, and pharmacies:

<http://www.state.nj.us/health/aids/freemed.htm>

ADDP Hotline: 1-877-613-4533

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The Ryan White Modernization Act (2006)

Stephen Scheuermann and Debbie Mohammed

How will HIV/AIDS services be changed by the 2006 Ryan White Modernization Act? In New Jersey, members of each of the five HIV Planning Councils came together to strategize to assure that people living with HIV/AIDS in New Jersey will continue to receive the services and support they need. They formed the NJ State HIV/AIDS Coalition (NJSHAC) as an umbrella organization for service providers and consumers to work together to coordinate dwindling resources.

Changes in Funding for HIV Services

According to HRSA, under the Ryan White Modernization Act, more money will be spent on direct health care for Ryan White clients. Under the new entitlement law, which will expire in three years, grantee organizations receiving funds under Parts A, B, and C (formerly called Titles I, II and III) must spend at least 75 percent of funds on "core medical services." The re-authorized legislation passed by Congress on December 19, 2006 revamped funding formulas, shifting money away from urban areas such as New Jersey and New York (where the need is still great and increasing) to rural areas like Alabama, Kentucky, and North Carolina, where dramatic increases in HIV incidence have been reported. The Administration and Congress want to make sure that grantees target Federal funds to pay for essential medical care.

That care includes:

- outpatient and ambulatory health services;
- pharmaceutical assistance;
- substance abuse outpatient services;
- oral health;
- medical nutritional therapy;
- health insurance premium assistance;
- home health care;
- hospice services;
- mental health services;
- early intervention services; and
- medical case management, including treatment adherence services.

Previously, no core set of medical services was specified in statute. Remaining funds may be spent on support services, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS. The law outlines support services as:

- outreach;
- medical transportation;
- language services;
- respite care for persons caring for individuals with HIV/AIDS; and
- referrals for health care and other support services.

Perhaps the most disruptive change is that Community-Based Case Management is no longer considered one of the 'core' services. This service has been the crux of the network of care put in place not only in New Jersey, but throughout the nation. Removing 'core' service funding for Community-Based Case Management totally destabilizes the care network and risks putting the HIV community in the untenable position of not being able to access resources to combat the effects of HIV, similar to where we were 10 to 15 years ago.

Parts of the Act: A to F

Part A funds eligible metropolitan areas (EMAs) and transitional grant areas. The Newark Eligible Metropolitan Area (NEMA) and the Philadelphia EMA, which includes five Southern New Jersey Counties, remains unchanged. However, the other EMAs in the the State of New Jersey have been 'downgraded' to Transitional Grant Areas (TGAs). They have received significantly less funding for the coming year than they did previously and may not exist at the end of the next three years. These TGAs are:

- Middlesex – Somerset – Hunterdon
- Paterson – Passaic – Bergen
- Hudson
- Vineland – Millville – Bridgeton

Part B funds states and AIDS Drug Assistance Programs.

Part C funds early intervention services.

Part D grants support services for women, infants, children & youth.

Part F comprises Special Projects of National Significance, AIDS Education & Training Centers and Dental Programs.

Stephen Scheuermann is Chair of NJ State HIV/AIDS Coalition (NJSHAC) and Bergen/Passaic HIV/AIDS Planning Council in addition to being the Executive Director of Buddies of New Jersey, Inc., an HIV/AIDS Resource Center located in Hackensack, NJ (www.njbuddies.org)

Debbie Mohammed is an Advanced Practice Nurse, providing care and treatment to PLWHA and is Project Director for Targeted Rapid HIV Testing at University Hospital, Newark. She serves as Vice Chair of the Priority Setting Committee at Newark EMA, member of NJ SHAC, and President of ANAC-NJ. (debbiemoha@aol.com)

New Jersey's HIV Services Advocacy

Public education to support the Reauthorization of the Ryan White CARE Act began well over a year and a half ago in 2006. At that time these advocates included the New Jersey Department of Health and Senior Services – Division of HIV/AIDS Services (DHAS), and other agencies and providers throughout the state, as well as a number of national AIDS lobbying groups. The message from New Jersey AIDS services advocates getting through to the Senate and the Congress was often mixed and somewhat contradictory. The “needs” differed somewhat depending on the geographic region of the state. Our Representatives were not united, and as reauthorization came closer, there was a constant request for one unified position from the State of New Jersey.

To this end the **NJ State HIV/AIDS Coalition (NJSHAC)** was formed. It was made up of volunteers from members of all the five planning councils of the Title 1 Eligible Metropolitan Areas, Consortia members from those outside the Title 1 areas, and consumers. These were the grassroots people dealing everyday with the people around the State who were infected and affected with HIV/AIDS (PLWH/A).

In addition to the position paper, a network was set up throughout the state to instantly link any legislator wishing to talk directly to constituents in his home district.

In April 2006, this group drafted the NJ Statewide Position Paper on the Reauthorization of the Ryan White CARE Act. This paper was presented to the entire NJ Congressional Delegation and became the centerpiece of New Jersey's fight on Capitol Hill.

Working with Representative Pallone and Ferguson's offices along with both Senate offices, the Coalition was in weekly (if not daily) contact, supplying information as requested related to the HIV/AIDS epidemic in New Jersey.

The Coalition mobilized agencies/providers, and consumers throughout the state with e-mail campaigns, resulting in hundreds of e-mails and petitions, to the New Jersey Congressional Delegation at every turn of the reauthorization process. This included e-mails to the Governor, State Senators and Assemblymen/woman.

In May 2006, the Coalition was the only organization asked to join Representative Pallone in a press conference in New Brunswick about the upcoming Reauthorization.

It was this same group of volunteers that was present in Washington, DC, for the House of Representatives stakeholders meetings. It was the only organization from the State of New Jersey given a chance to speak with Representative Pallone and Ferguson to make the case for New Jersey's dire need for funding to provide prevention, care and treatment services to PLWH/A.

During this period, NJSHAC members made numerous trips to Washington, walking the halls of Congress and meeting with the elected delegation as well as the office of Senator Kennedy from Massachusetts. NJSHAC involved the press and pushed for coverage wherever and whenever possible to get out the word that the need of PLWH/As was great and should be addressed.

As the votes were coming close, in our last effort to be heard, we organized another massive campaign of e-mails and petitions

to our Representatives, particularly our Republican Representatives, to support New Jersey's stance in the fight for funding which would support prevention, care and treatment services.

It was at this time that NJSHAC reached out to New Jersey Gay and Lesbian Coalition/Garden State Equality (NJGLC) for their help and support. This collaboration was a huge success and resulted in over 6,500 e-mails of support for our position to our Congressional delegation in Washington.

During the final week, just before the votes were taken, at the request of Senators Lautenberg and Menendez, NJSHAC organized two phone conferences to map out strategies that could impact the upcoming voting in the House of Representatives. Participants included many of our House Representatives, members of the Coalition throughout the State, as well as the Governor's office. NJSHAC was online with Representative Pallone's office as he battled for us in the House for continued funding and with the Senate offices as the battle continued in the Senate.

Despite promises that New Jersey EMAs would maintain their status under the revised act, four of five EMAs have been downgraded to TGAs. It is estimated that New Jersey will lose \$27 million over the next three years. These severe cuts in funding will destabilize New Jersey's ability to provide prevention, care, and treatment services. Currently, it is projected that New Jersey will suffer a 30-40% reduction in overall funding.

Mission of NJSHAC (NJ State HIV/AIDS Coalition)

The mission of NJSHAC is to continue to represent the PLWHA in New Jersey, to collaborate efforts statewide, and continue the fight for funding. Steve states, “I am extremely proud of this Coalition, all volunteers, and the time, work and dedication they have put into this campaign. It proved the power people can have when they come together to make sure they are heard. We have been told by both our Senate offices as well as Representative Pallone's office that we did a better job at staying with the message and keeping our legislators focused than any of the national advocacy groups and lobbyists fighting for this bill.”

HIV/AIDS Treatment Information Resources

HIV/AIDS TRAINING



HIV/AIDS MEDICAL UPDATE SERIES *Free On-site Training*

Sponsors:

Division of AIDS Education at UMDNJ-Center for Continuing and Outreach Education with funding from the NJ Department of Health & Senior Services, Division of HIV/AIDS Services

To schedule a free 1-hour HIV medical education program at your health care site on any of these topics, contact Kimi Nakata at (973) 972-1246 or ccnakata@umdnj.edu

- Diagnosis and Initial Management of HIV/AIDS:
What the Primary Care Physician Should Know
- HIV in Pregnancy – Preventing Perinatal Transmission
- HIV/AIDS and Hepatitis C Co-Infection
- Immunizations for HIV Positive Adults
- Non-Occupational Post-Exposure Prophylaxis
- Prevention and Prophylaxis for Occupational Exposure to HIV and Other Blood Borne Pathogens
- Prophylaxis and Treatment of Opportunistic Infections in Patients with HIV Disease
- Rapid Diagnostic HIV Testing

This series of online medical education activities is funded through an educational grant from NJDHSS Division of HIV/AIDS Services through a MOA titled "Education and Training for Physicians and other Healthcare Professionals in the Diagnosis and Treatment of HIV/AIDS." Many of the activities appeared in prior issues of New Jersey AIDSLine.

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Division of AIDS Education**

www.umdnj.edu/ccoe/aids

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- HIV Treatment Update
- Immunization for HIV Infected Children and Adolescents
- Reducing Vertical HIV Transmission in NJ
- Beyond HIV: Lesbian, Gay Bisexual and Transgender (LGBT) Health
- Hepatitis B and HIV Co-Infection
- Treating The HIV & TB Co-Infected Patient In The Correctional Setting
- Rapid Diagnostic Testing for HIV

HIV/AIDS Treatment Information Resources

GUIDELINES AND STATISTICS

New Jersey Department of Health & Senior Services Division of HIV/AIDS Services (DHAS)

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

NJ HIV/AIDS Semi-annual Newsletter (statistical report); policies, and guidelines for HIV/AIDS care and services in New Jersey

New Jersey rapid testing site:

[www.state.nj.us/health/aids/rapid testing](http://www.state.nj.us/health/aids/rapid%20testing)

New Jersey HIV (Testing) Helpline: 1-866-HIV-CHEC

New Jersey AIDS/STD Hotline: (800) 624-2377

- 24-hour professionally-staffed service
- Consultation, testing referrals, free materials

US Dept. of Health & Human Services

www.aidsinfo.nih.gov • 1-800-HIV-0440 (1-800-448-0440)

HIV/AIDS treatment guidelines; prevention, treatment, and research. National Institutes of Health-sponsored searchable clinical trials database: <http://clinicaltrials.gov>

CDC National Prevention Information Network (NPIN)

HIV, STD, and TB news, funding, materials, conference and satellite broadcast announcements.

<http://www.cdcnpin.org>

Centers for Disease Control (CDC) – Division of HIV/AIDS Prevention

HIV/AIDS research, surveillance reports, funding announcements, research and reporting software, epidemiology slide sets

<http://www.cdc.gov/hiv/hivinfo.htm#WWW>

Rapid Testing: http://www.cdc.gov/hiv/rapid_testing

MMWR [Morbidity and Mortality Weekly reports]:

<http://www.cdc.gov/hiv/pubs/mmwr.htm>

FDA MedWatch

Updated reports on medication interactions and warnings:

1-800-FDA-1088; Subscribe to e-bulletin:

<http://www.fda.gov/medwatch/elist.htm>

National HIV/AIDS Clinicians' Consultation Center

<http://www.ucsf.edu/hivcntr>

Consultation on antiretroviral therapy, drug resistance, opportunistic infection prophylaxis and treatment, laboratory evaluation; occupational exposure, perinatal intervention.

Warmline: 800-933-3413

National Clinicians' Post-Exposure Prophylaxis Hotline

(PEpline): 888-448-4911 (888-HIV-4911)

National Perinatal HIV Consultation and Referral Service:

888-448-8765 (888-HIV-8765)

TRAINING RESOURCES



NY/NJ AIDS Education & Training Centers (AETC)

New York/New Jersey regional training calendar, resource directory, clinician support tools and references including training slide sets, wall charts.

<http://www.nynjaetc.org>

Local Performance Sites of the NY/NJ AETC can provide onsite training throughout NJ. Please see the website for contact information to request clinical training:

Northern New Jersey

- UMDNJ-CCOE – Division of AIDS Education
- Rutgers University – School of Nursing

Central New Jersey

- ID Care (formerly ID Associates)
- Raritan Bay Medical Center

Southern New Jersey

- Garden State Infectious Disease Associates

AIDS Education and Training Centers (AETC)

National Resource Center www.aids-etc.org

HIV treatment guidelines, training materials/curricula, evaluation tools, Daily HIV/AIDS Treatment News; clinical resources including PDA tools

STD/HIV Prevention Training Centers (PTC)

Medical: www.nyc.gov/html/doh/html/std/ptc.shtml

Behavioral: www.urmc.rochester.edu/chbt

Title X Family Planning Regional Training Center (RTC)

[DHHS/OPA funded]: training www.cicatelli.org/titlex/home

Northeast Addiction Technology Transfer Center (NEATTC)

Addiction training, treatment news: <http://www.neatcc.org>

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Division of HIV/AIDS Services**



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