

# ADVANCES *in Aging*

## HIV in Older Adults: Still Underneath the Radar

by Nancy Volkers

They make up almost 11% of all HIV cases in the United States. They are often diagnosed very late in the disease's progression; many don't survive more than a month beyond diagnosis. They don't know they're at risk for HIV infection, and neither do their health care providers.

They are people over 50, and they get AIDS.

"It's been ignored," says Janet Yellowitz, DMD, about HIV infection in older adults. "Most people are really surprised that 10 or 11 percent of HIV cases are in people 50 and older. It's a small



Chris Wisnom, Jane Fowler, Janet Yellowitz

percentage but it is a huge number, and growing."

Yellowitz, associate professor and director of geriatric dentistry, and Christine Wisnom, RN, BSN, infectious disease nurse, both of the University of Maryland

Dental School, attended a national conference in Chicago in November that centered on HIV in older adults. They presented results from a survey of more than 300 Maryland dentists.

Yellowitz simplified the findings of the survey: "One, [dentists] don't know [about HIV in older adults]. Two, they're not suspicious. And three, nobody's telling them."

But dentists aren't alone in overlooking the spread of HIV in older adults. Older adults themselves are less likely to believe they are at risk; in fact, data from 1992 show that more than two-thirds of adults over the age of 50 do not believe they are at risk for HIV infection. This group also has a lower basic level of knowledge than any other age group; 16 percent knew nothing about risk factors for infection.

"One of the big problems with the older population in terms of getting infection is that this is not a population that grew up with safe sex," says Yellowitz. "They think that if they can't reproduce,

they don't need to worry about it . . . Heterosexual contact is the number-one reason for female infection in this age group. And there are many more single women in the older years than men."

Older adults see their physicians more often than they do their dentists, she said, but physicians often don't discuss the topic.

"Physicians rarely talk to old people about sex," she says. "They figure that [older adults] don't have sex, so what's to talk about? And if they do have sex, we don't want to talk about it! So no one asks questions like, could you be susceptible? Are there any high-risk behaviors? And if physicians don't ask, dentists definitely don't ask."

Many health care providers don't consider HIV infection as a possible diagnosis, Yellowitz says. "They sort of run the gamut of every other possibility of ailment," she says, which can include pneumonia, Alzheimer's disease, menopause, and depression. "Health care providers are not trained to think about [HIV infection] as a differential diagnosis in this age group."

Dentists can be instrumental in early detection and diagnosis of HIV, Wisnom states. Oral manifestations of HIV infection, such as fungal infections, often appear before other clinical signs, and may alert dentists to the possibility of an HIV diagnosis.

"One of the earliest HIV symptoms patients have is oral candidiasis, which presents during acute seroconversion syndrome, which occurs about six weeks after they're exposed," she says. "If you have someone astute enough to evaluate that condition and possibly

Continued on page 7

UNIVERSITY OF MARYLAND  
CENTER FOR RESEARCH ON AGING

presents  
**Aging Research Poster Day**

February 11, 2000  
(See page 3.)

# Teaching the Team Approach

The concept of interdisciplinary teamwork seems like a given in geriatrics. But learning the “team approach” in the field, without previous experience, can be difficult. That’s why Connie Saltz Corley, PhD, LCSW, in the School of Social Work, and others at the University of Maryland are spearheading an effort to treat teamwork as a teachable topic.

This spring, the fruits of their labor are borne through a three-credit course called “Interdisciplinary Team Practice,” which will meet for a one-and-a-half day intensive session and 10 Wednesday evenings. The course was preceded by a winter minimester on the same topic, which evolved from a 1995 and 1996 summer course offered through the Western Maryland Area Health Education Center (AHEC) in Cumberland.

The AHEC course included students from the University of Maryland’s nursing and social work schools, the physical therapy program in the medical school, and the occupational therapy (OT) program at Towson University. The minimester attracted UM nursing and pharmacy students and Towson OT students. The spring course will include UM nursing, social work, and pharmacy students, as well as Towson OT students.

The AHEC course was made possible through a grant from the United States Public Health Service, and the minimester received funding from the Geriatrics and Gerontology Education and Research program (GGEAR).

Now, with the spring course, “We’re trying to combine the best of the course and the minimester,” says Corley. Corley will team-teach the spring course with Gail Mazzocco, EdD, RN, assistant professor in the School of Nursing and director of Western Maryland outreach; and Nicole Brandt, PharmD, assistant professor in the School of Pharmacy and deputy director of the Lamy Center for Drug Therapy and Aging. “The course gives a broad exposure to working with older people, not just patients,” she says. Students interact with people who range from the well elderly to the frail. They observe teamwork in action, and then work as teams on simulated cases.

“Each faculty member brings experience in aging and an interdisciplinary connection,” says Corley. “No one school at the University could offer this course.”

Teamwork as a “buzzword,” she says, is enjoying a renaissance. “From the post-World-War-Two period until about 1980, teams were big,” says Corley. “Since then, there’s been a decrease in federal funding and in interest. But now, changes in how institutions offer services, and changes in the way we communicate – the Internet, for example – are bringing back the idea of teamwork.”

Changes in services include the advent of managed care, which has altered the structure and function of many health-care-based teams. “Managed care and less reimbursement have forced some team

members ‘off the team’, so to speak, so others must take over for them,” Corley says. Differences in coverage – Medicare versus private insurance, for example – also produce differences in who can be a part of a patient’s team.

Although interdisciplinary teamwork is important in any field, she says, it is crucial in geriatrics.

“The aging population is very diverse; older people range from very healthy people to those with multiple chronic illnesses,” she says. “Older people are more likely to have complex medical and social issues, so the team approach is ideal. And because of these complexities, it’s important for practitioners to learn the points of view of other professionals.”

She adds, “The beauty is that the faculty members learn from one other – not only about other professions, but also about how to function as a team.”

Corley says that a common refrain from students who have taken the AHEC course or the minimester was that “before the course, they never knew enough about what the other professions did. Now, when they enter careers, even if they are not directly involved in a teamwork situation, they will have a better understanding of other professionals’ responsibilities.

“The centerpiece of the course is how teams function,” says Corley. Students discuss the concept of teamwork, observe it in action, then create their own team and analyze it. They learn the different contexts of team operation (inpatient, outpatient, managed care, and others) and how these contexts influence the structure of the team.

“Then there’s the process – what actually happens in terms of communication, leadership, et cetera,” she says. “And finally there’s the outcome – not only what happens to the patient, but how the team has operated and how that will affect them in the future.”

The course, with its interdisciplinary basis, can be an administrative challenge.

“We’re trying to find avenues for bringing students together,” says Corley. “All the [professional] schools have different schedules and requirements. We would like to have the flexibility across the schools to make these opportunities continue to happen. We also need settings large enough for observations; many places only have room for two or three students.”

In the future, she says, faculty members are interested in creating modules for inclusion in other courses, to make the information more accessible to students. Information, she emphasizes, that is key to providing better services to the aging population.

“Nurses teach nursing, social workers teach social work, but there is a piece missing, and [most] students have to learn teamwork on their own,” she says. “Most people don’t get formal training in teamwork.”



Connie Saltz Corley

To our readers—

## *Happy New Year*

The sponsors and editorial staff of *Advances In Aging* want to extend sincere wishes for a Happy New Year. We also want to take this opportunity to thank those who have contributed time and effort to the newsletter over the past year and encourage your continued support.

### **Aging Research Poster Day**

**The University of Maryland Center for Research on Aging is sponsoring a poster day program on February 11, from 2-4:30 p.m., in the Terrace Lounge of the Baltimore Student Union.**

**The program will provide an opportunity for faculty and trainees to display posters used at national conferences, and to subsequently learn more about each other's aging research interests. The Center's Leadership Group will judge the posters displayed.**

**All interested faculty and trainees are invited to become members of the University of Maryland Center for Research on Aging, and to take advantage of the Center's facilities in implementing interprofessional or interdisciplinary research in the field of aging at the University of Maryland, Baltimore.**

**For more information regarding Poster Day and/or membership in the Center for Research on Aging, please call the Center at 410.706.4567, or e-mail, [Smiller@som.umaryland.edu](mailto:Smiller@som.umaryland.edu).**

### **Obstacles to Pain Management**

DIANE HOFFMANN, professor of law, is co-



**Diane Hoffmann**

principal investigator, with Ben Moulton, executive director of the American Society of Law, Medicine and Ethics, on a \$350,000 grant to study obstacles to pain management, including legal, insurance, attitudinal, educa-

tional, and institutional barriers, in the state of Connecticut.

The comprehensive study includes focus groups with pain patients and physician specialists and primary care physicians, surveys of physicians and patients, telephone interviews with representatives of hospitals, nursing homes, hospices, home health agencies, and pain centers, and reviews of investigations of physicians by the state licensing board. She is working on the project with Anne O'Neill, PhD, and Anita Tarzian, PhD. The 16-month study will be completed in June 2000.

# NEWS

# RESEARCH

## Highlights

### Dietitians Instrumental in Research Studies

*The research dietitian has a very important role in aging studies in the University of Maryland, Division of Gerontology, Claude D. Pepper Older Americans Independence Center, and the VA Maryland Health Care System, Baltimore GRECC. Under the directorship of Dr. Andrew Goldberg, Kelly Barton and Linda Bunyard, registered dietitians, are active in all of the studies that require expertise in nutrition, diet modification, and obesity and behavior modification.*



“Let’s face it, we all gain weight as we age,” says Linda Bunyard, MS, RD, LD. “Currently, about 50% of all adults in the United States are either overweight or obese, and none of us are getting any younger.” According to Bunyard, understanding the factors that contribute to age-related weight gain could improve our ability to prevent it in the future, and possibly to care for many that are already overweight.

In a recent article published in *American Journal of Clinical Nutrition*, Bunyard examined the contribution of aerobic exercise to the daily caloric requirements of healthy middle-aged men. Daily calorie needs includes the calories burned at rest, those used in digestion, and those spent on activity in any 24-hour period. The number of calories burned by each of these sources decreases with age but is not usually matched by a similar reduction in the number of calories consumed. This leads to weight gain. It is generally assumed that an increase in physical activity will raise total calorie requirements, but some studies have been unable to show this. In this article, the number of calories needed for weight maintenance was measured before and after both lean and obese sedentary men aged 46-76 years participated in a six-month exercise-training program. They were compared to a group of highly trained athletes of similar age who deconditioned for a period of three months.

Results show that both average weight and obese men required



Linda Bunyard



Kelly Barton

more calories for weight maintenance while moderate exercise (30-40 minutes, 3 times per week) was part of their lifestyle than they did when they were sedentary. Trained athletes required significantly fewer calories after deconditioning. It was also shown that total calorie needs for any of these men was related only to cardiac fitness level at baseline (VO<sub>2</sub>max), not to body weight, body fat, or age.

“Many people consider obesity to simply be a cosmetic problem,” says Bunyard. “They fail to recognize the serious health problems that are closely associated [with obesity] such as diabetes, heart disease, gallbladder disease, and high blood pressure.”

“It is also easy to assume that weight gain and inactivity are a normal part of aging,” Bunyard says. “However, this study suggests that regular exercise in the older adult can help counter the age-related tendency toward obesity and its associated health risks.”



“Do you wonder how successful your weight loss efforts would be if only someone else would plan, shop, prepare, and package your food—and make sure that it is food you like?” asks Kelly Barton, MS, RD, LD. A short-term underfeeding outpatient study is being conducted in the GRECC with a similar question. The investigators are examining the role genetics play in adipose tissue metabolism and energy expenditure. “Dietary non-compliance has to be avoided,” says Barton, “so it’s necessary that we provide the food to the participants.”

Barton and research assistant, Christina Bravo, BS, are responsible for the nutrition component of the study. From beginning to end of the study, close communication between the nutrition office and the participant is essential to plan the diet, monitor satisfaction with the menus, and to optimize participant compliance. According to Barton, this begins with an interview to find out the participant's habits, food and beverage preferences, and a baseline seven-day food record that is completed by the participant. Caloric needs for weight maintenance and fluid needs are estimated using baseline test results and the seven-day food record analysis. With the goal of weight maintenance, a rotating menu is developed from food and beverage preferences, food is purchased, prepared, weighed to the gram, and packaged for each participant.

"Each stage is important," says Barton, "but the planning stage is the foundation for the diet and is very detailed." Along with meeting the participant's preferences and caloric needs, the macronutrient percentage, fiber and fluid intake need to remain essentially the same each day to avoid weight fluctuations.

Barton explains that throughout the study, participants are responsible for their daily body weight monitoring and for biweekly pick ups of packaged food at the GRECC. Weight maintenance is determined through daily communication between the participant and the nutrition office. If necessary, food items are adjusted when a participant dislikes a food or has a significant weight change.

"It usually takes one week of weight monitoring to confirm that the diet supports weight maintenance," says Barton. "At that point, post-weight maintenance testing is done and the participant starts the three-week underfeeding diet."

Barton explains that the underfeeding diet is planned to be hypo-caloric by 25% of weight maintenance calorie needs, and consists of the same, or very similar, foods as in the weight maintenance diet. Macronutrient percentage, fiber and fluid intake remain the same as the amount planned for the weight maintenance diet. Compliance is encouraged through close communication with the participant, and food items are changed when requested.

"Surprisingly, no participant has reported an increase in physiological hunger during the underfeeding phase of the study," says Barton.

At the end of the three weeks, the post-underfeeding testing is done. "Since this is an outpatient study, complete compliance cannot be confirmed," Barton states. "However, participant response to the nutrition component has been good for this potentially difficult weight loss study."

## Research Data Sets Available

**The UM Center for Research on Aging has published a listing of research populations (data sets and ongoing longitudinal studies) available to promote interdisciplinary and interprofessional research activity at the University of Maryland among faculty and trainees. The data sets were compiled by Mona Baumgarten, PhD, associate professor, Dept. of Epidemiology & Preventive Medicine on behalf of the Center.**

**The inventory of research populations, which can be accessed through the Center for Research on Aging web site, <http://gerontology.umaryland.edu/docs/datasets.html>, describes 11 data sets and includes a description of the National Archive of Computerized Data on Aging. The data sets are: University of Maryland Stroke Data Bank, NINDS Stroke Data Bank, Stroke Registry, Medicare Current Beneficiaries Survey, Study of Osteoporotic Fractures, Baltimore Hip Studies, Epidemiology of Dementia in Nursing Home Admissions, Coping with Incontinence after Prostate Cancer Surgery, Urinary Incontinence in Working Women, Canadian Study of Health and Aging, and the Canadian Study of Health and Aging-2.**

**Periodic updates to the inventory are planned. For further information about the research populations call the Center office, 410-706-4567.**

# Cutting Edge

# NEWS

## Faculty & Staff



**Sandra J. Fulton Picot**

Barbara R. Heller, EdD, RN, FAAN, dean and professor, School of Nursing, is pleased to announce the appointment of **SANDRA J. FULTON PICOT, PhD, RN, FAAN**, to the Sonya Ziporkin Gershowitz Endowed Chair in Gerontology. Picot is a noted authority and gerontological researcher with expertise in the phenomenon of family caregiving among African Americans and the recruitment and retention of under-represented minorities into healthcare research. She has received more than 2 million dollars in funding from private and public sources, including the National Institute of Nursing Research, the National Institute on Aging, the U.S. Department of Education, and from state commissions including the Ohio Commission on Minority Health, in addition to private foundations and local chapters of Sigma Theta Tau International. The studies focused predominantly on African American female caregivers of the elderly, the rewards of caregiving, and the physiological responses of caregivers to the stresses of caregiving.

---

DENISE ORWIG, PhD, Division of Gerontology, Department of Epidemiology and Preventive Medicine, has been appointed to the Board of Directors of the Maryland Gerontological Association.

---

LOIS WEHREN, MD, Division of Gerontology, Department of Epidemiology and Preventive Medicine, has been appointed to the Governor's Council on Women's Health by Governor Glendenning.

---

CYNTHIA PORT, PhD, has joined the Division of Gerontology, Department of Epidemiology and Preventive Medicine, as a postdoctoral fellow in primary care. She received a doctorate in Counseling Psychology from the University of Minnesota in 1998. Port is the recipient of the Alzheimer's Associations' 1999 Hatfield Award for Clinical Research in Alzheimer's Disease. This award includes a \$225,000 grant for her study, "Family Involvement in Long-term Care." She is also receiving post-doctoral training in neuropsychology through the Department of Neurology where she conducts clinical work with patients with epilepsy and dementia.

---

LESLIE I. KATZEL, MD, PhD, Division of Gerontology, Department of Medicine recently accepted the position as Vice Chair of the Institutional Review Board for the University of Maryland at Baltimore, effective November 1, 1999.



**Les Katzel**

---

ANN MARIE SPELLBRING, PhD, School of Nursing, recently chaired the Task Force on Quality of Care in Nursing Facilities work group on the topic of Quality and Practice. The Task Force was convened by the General Assembly as a result of Senate Bill 740 and House Bill 791. Sue Fryer Ward, Secretary of the Department of Aging, chaired the Task Force. William Bechill, a former faculty member of the School of Social Work, chaired the work group on Consumer Protection and Patient Rights. The Task Force was charged to study the quality of care in Maryland nursing homes.

---

STANLEY S. HERR, PhD, JD, School of Law, received three awards and a prestigious fellowship in 1999. In March, he received the Maryland Bar Foundation's Legal Excellence Award for Advancing the Rights of the Disadvantaged; in April, he received the Rosemary F. Dybwad Distinguished Leadership Award from the National Institute for People with Disabilities, and the University System



**Stanley Herr**

of Maryland presented him with the Regents Faculty Award for Excellence in Public Service. From the research community, he has been named the Mary Switzer Distinguished Research Fellow for 1999-2000. This fellowship is awarded by the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education. It will be used to support his comparative research on the disability discrimination laws of the United States and Israel.

## HIV in Older Adults

Continued from page 1

link it to a systemic condition like HIV disease, they can refer that patient for diagnosis and treatment before there is a tremendous amount of viral replication.”

Although research on AIDS in older adults is sparse, currently it is thought that an older adult's immune system is not as responsive to an insult such as HIV, and that once T cells are destroyed, the immune system has difficulty replenishing them. Thus, early detection is critical.

Patients who know they are HIV-positive are not required to confide in their dentists, Yellowitz said, and most probably will not volunteer the information.

“Older adults have a different perspective on what dentists need to know,” she says. “They think, ‘These are my teeth; fix them. I don't need to tell you about my diabetes,’ or what have you. And if they find out they have HIV, it's certainly not something they want to talk to a dentist about.

“One of the seminal findings is that 54 percent of the population of dentists that responded don't think they see HIV-infected people in their practice at all,” Yellowitz says. “It's scary.”

Says Wisnom, “The primary reason for identifying these patients is for patient safety. Dentists may prescribe medications that are hepatotoxic (dangerous to the liver), or there can be complications from routine dental medications. HIV-positive people have problems with clot formation, and invasive dental procedures (periodontal surgery, extractions) put them at risk for hemorrhage. They can develop opportunistic infections, very severe infections, following dental treatment.”

These complications can be reduced or eliminated through diagnosis and medical and dental management, she says.

If a dentist is concerned that a patient might be HIV-positive, said Yellowitz, communication can be difficult.

“We're really not trained well to talk with patients,” she says. “If I become suspicious that a patient might have HIV, how am I going to tell them?” Currently, she states, the standard health history form does not require information on high-risk behaviors.

While females over 50 are most likely to be infected through heterosexual contact, the top three infection sources for males are homosexual contact, intravenous drug use, and heterosexual contact. However, Yellowitz says, “Dentists still think that the number-one way that adults over 50 are infected is through contaminated blood transfusions. The fact is that the blood in the Red Cross pool

has been checked for HIV disease since 1985, which demonstrates that many dentists do not have up-to-date knowledge on HIV infection.

“[Dentists are] really no different from anyone else – but they're clearly uninformed,” she says.

What next? Education and training, certainly – but with the understanding that most dentists don't feel the issue is relevant to them. Wisnom recounted an occurrence from a recent meeting:

“The spokesperson for HIV disease in women over the age of 50 is Jane Fowler – she's very educated and outspoken. She was a presenter at a national HIV meeting in an auditorium full of healthcare professionals. When she got up to the podium to speak, half of the auditorium got up en masse and left.”

The idea, then, says Yellowitz, is to coordinate discussions of HIV in older adults as part of infectious disease topics. Also, she and colleagues are looking into developing educational models using CD-ROMs or Web-based applications.

“That will require some funding, some work,” she says, “but it's clear there is a need.”

***Advances in Aging* is published quarterly by the University of Maryland Claude D. Pepper Older Americans Independence Center, the University of Maryland Center for Research on Aging, the University of Maryland Geriatrics and Gerontology Education and Research Program, and the Geriatrics Research, Education and Clinical Center of the VA Maryland Health Care System, Baltimore, Maryland. For further information about the newsletter and gerontology programs at the University of Maryland, Baltimore, call 410.706.4567, or visit our web site, <http://gerontology.umaryland.edu>.**

### **Editorial Staff**

**L. Jean Hetmanski**

**Nancy Volkers**

# CALENDAR *of Events*

**A quarterly listing of educational programs on aging research and clinical practice in the mid-Atlantic region. Contact information is listed with each program.**

## **February 11, 2000**

UM Center for Research on Aging  
**Aging Research Poster Day**  
Terrace Lounge, Baltimore Student Union, UMB  
410.706.4567, or  
[umcra@som.umaryland.edu](mailto:umcra@som.umaryland.edu)

## **February 24-27, 2000**

Association for Gerontology in Higher Education  
**26th Annual Meeting**  
Myrtle Beach, South Carolina  
202.289.9806

## **March 9, 2000**

UM Center for Research on Aging  
Lecture Series  
**Assessing Care in Nursing Homes Utilizing the SAGE Database**  
*Vincent Mor, PhD, Brown University*  
Howard Hall, UMB  
410.706.4567, or  
[umcra@som.umaryland.edu](mailto:umcra@som.umaryland.edu)

## **March 9-11, 2000**

Association for Gerontology & Human Development in Historically Black Colleges and Universities 18th Annual Meeting  
**Caregiving & Dementia: Trends & Challenges for Families in the 21st Century**  
Winston-Salem, North Carolina  
404.752.1626

## **March 12-15, 2000**

American Association for Geriatric Psychiatry Annual Meeting  
**New Horizons for Geriatric Psychiatry: Images of Aging**  
Miami Beach, Florida  
301.654.7850

## **March 18-21, 2000**

Alzheimer's Association 12th Annual Public Policy Forum  
**Alzheimer's Advocacy: The Future Is Now**  
Washington, D.C.  
202.393.7737

## **March 25-28, 2000**

American Society on Aging  
**Annual Conference**  
San Diego, California  
415.974.9628

## **March 30-April 2, 2000**

Southern Gerontological Association  
**21st Annual Meeting**  
Raleigh, North Carolina  
850.222.3524

## **April 13, 2000**

Claude D. Pepper Center, UM Center for Research on Aging, GRECC, and GGEAR  
**Geriatrics Day: Longevity**  
VA Maryland Health Care System  
Baltimore, Maryland  
410.706.4567

---

### **Abbreviations**

UM - *University of Maryland*  
UMB - *University of Maryland, Baltimore campus*  
GGEAR - *UM Geriatrics and Gerontology Education and Research Program*  
GRECC - *Baltimore VA Maryland Health Care System Geriatric Research, Education and Clinical Center*

UNIVERSITY OF MARYLAND  
BALTIMORE

Division of Gerontology  
VA Maryland Health Care System  
BT/18/GR  
10 North Greene Street  
Baltimore, MD 21201-1524

Non-Profit Org.  
U.S. Postage  
**PAID**  
Baltimore MD  
Permit No. 5186