

# HIV Care Continuum



## OBJECTIVES

**At the end of this unit, participants will be able to:**

- Describe how Community Health Workers (CHWs) fit into achieving the National HIV/AIDS Strategy Updated to 2020, which include engaging people in care and retention
- Describe the HIV Care continuum in more detail
- Identify factors that impact a person's ability to achieve the steps in the HIV Care continuum



## INSTRUCTIONS

1. Prior to the session, visit the website [www.hiv.gov](http://www.hiv.gov) for any updated data about the care continuum and update slides accordingly. If you do not have access to Microsoft PowerPoint, you can write the contents of the slides on flip chart to share with participants.
2. Welcome participants.
3. Review the unit objectives.
4. Review slide 3 about the National HIV/AIDS Strategy Updated to 2020.
5. Facilitate think-pair-share discussion about how CHWs can help achieve the National HIV/AIDS Strategy Updated to 2020 and record responses on a flipchart.
6. Review slides 4 & 5 about the HIV care continuum and proportion of people engaged at each step.
7. Facilitate think-pair-share discussion about gaps in care.
8. Wrap up. Ask participants for any questions about the HIV care continuum and share that next we are going to discuss more specifically CHWs' role in the HIV care continuum.



## Related C3 Roles

Care coordination, case management, system navigation

## Related C3 Skills

Service coordination, navigation skills



## Method(s) of Instruction

Large group discussion



## Estimated time

15 minutes



## Key Concepts

*HIV care continuum*



## Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

## Handouts

- *HIV Care Continuum*

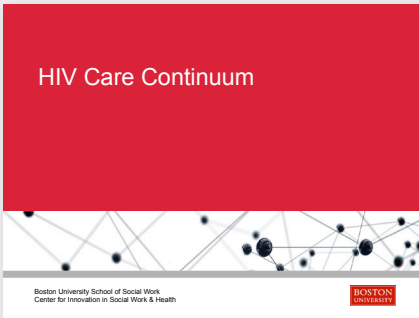


## Resources

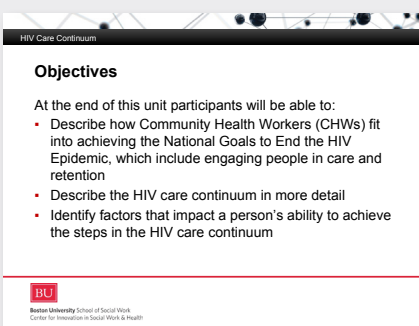
Websites:

[www.hiv.gov](http://www.hiv.gov), <https://www.cdc.gov/hiv/>

National Goals to End the HIV Epidemic infographics, available at <https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update>

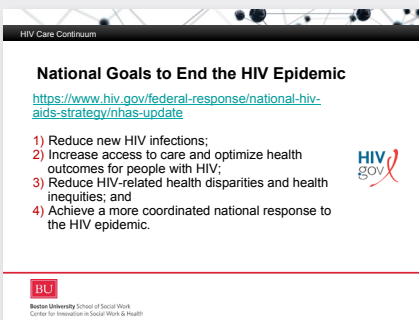


## SLIDE 1



## SLIDE 2

Review objectives.



## SLIDE 3

- Review the National HIV/AIDS Strategy Updated to 2020. Ask participants if they have heard of this national plan. If respondents have heard of the plan, where did they learn about it?
- The National Plan to End the Epidemic is the federal government's national strategy to address the HIV/AIDS epidemic in the United States.
- Ask participants to read each goal.
- Ask participants for examples of how a Community Health Worker (CHW) might play a role in achieving these goals.

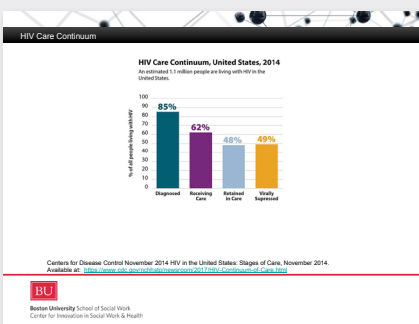
Sample answers to share:

- Reduce new infections: CHWs can help screen and test people at risk for HIV infection; help educate partners of people with HIV to take medications, called PrEP, that can reduce HIV transmission; educate the community about risk reduction techniques including safer sex practices such as condom use and not sharing needles with IV drug use to prevent HIV transmission.
- Increase access to care: Help people with HIV find a HIV care provider or clinic; provide support and education about antiretroviral treatment; support clients with transportation assistance to appointments and other basic needs, like food, so they can get the medical care they need.
- Reduce disparities: Educate members of their community about how HIV affects them; provide information about where to access treatment, especially for people who may be at risk.



## SLIDE 4

Review the HIV care continuum model. The care continuum outlines the sequential steps or stages of HIV medical care that people with HIV go through from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body).



## SLIDE 5

The care continuum also shows the proportion of people with HIV who are engaged at each stage. It is the framework for which HRSA/HAB measures Ryan White HIV/AIDS programs' success.

Describe Health Resources and Services Administration's (HRSA) specific definitions for each stage:

- Linkage to care: within 30 days of diagnosis
- Retained in care: 2 appointments at least 90 days apart in a 12-month period, or no gaps in care of 6 months or greater in a 24-month period
- Prescribed antiretroviral treatment
- Viral suppression: < 200ml/copies

The Centers for Disease Control (CDC) has found that there are many gaps in our health care system that make it challenging for a person to achieve this continuum of care. This is what the current HIV care continuum looks like across the United States (review the data on the slide).

Think-pair-share activity. Ask participants to discuss in pairs:

- What are some of the reasons for these gaps in care for people with HIV?
- What are some of the factors that impact whether someone is diagnosed?
- What impacts linkage to care?
- What impacts engagement/retention in care?
- What impacts whether someone is prescribed medications?
- What impacts whether someone can achieve viral suppression?

Ask participants to share responses; record on flip chart sheets.

To close, ask, "How is your work as a CHW unique in impacting the HIV care continuum?"

# HIV Care Continuum

## HIV CARE CONTINUUM:

THE SERIES OF  
STEPS A PERSON  
WITH HIV TAKES  
FROM INITIAL  
DIAGNOSIS  
THROUGH THEIR  
SUCCESSFUL  
TREATMENT WITH  
HIV MEDICATION



DIAGNOSED  
WITH HIV



LINKED TO  
CARE



ENGAGED OR  
RETAINED  
IN CARE



PRESCRIBED  
ANTIRETROVIRAL  
THERAPY



ACHIEVED  
VIRAL SUPPRESSION

# Acknowledgments

This curricula draws from and is adapted from other training curricula for peer educators and community health workers, such as the Building Blocks to Peer Success (<https://ciswh.org/resources/HIV-peer-training-toolkit>) and the Community Capacitation Center, Multnomah County Health Department (<https://multco.us/health/community-health/community-capacitation-center>)

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