



Peer Linkage and Re-engagement of Women of Color Living with HIV

DISSEMINATION OF
EVIDENCE-
INFORMED.
INTERVENTIONS

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INTRODUCTION ---

PURPOSE AND BACKGROUND

The Peer Linkage and Re-Engagement of Women of Color Living with HIV intervention is designed to best serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained WoC living with HIV known as “peers” will link and re-engage clients in HIV primary care. Clients will be considered linked or re-engaged once they attended two medical appointments, attended one case management appointment, and have completed HIV lab work (all within six months to one year).

Peers offer a unique personal perspective and can provide coaching and emotional support to clients who may need assistance in managing medical

and case management appointments. In addition, peers who work closely with case managers and the clinical team can better provide individualized client-centered services over a short time period to address immediate client needs and build trust between the client and the clinic team.

This curriculum is based on activities and trainings from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) “Dissemination of Evidence-Informed Interventions” Project.

TARGET AUDIENCES

This intervention is intended for organizations, agencies, and clinics considering a short-term, peer-focused model to increase linkage and re-engagement of WoC living with HIV into HIV primary care to ultimately improve client health outcomes.

TRAINING DESIGN AND INSTRUCTIONAL APPROACH

The curriculum is broken into training modules. Each module tackles a key topic area related to the intervention. At the beginning of each module is a lesson plan that provides an overview. Modules include a PowerPoint training slide presentation, as well as a script, learning activities, and additional explanations.

Where possible, trainings encourage learning through interaction rather than lecture alone in order to familiarize participants more fully with the intervention. As such, there are a number of hands-on activities.

Where participants may need more information to reference or as a key takeaway, handouts are included as well as reference materials for further learning. All required handouts are found in the appendices of this manual.

ADDITIONAL RESOURCES

Care and Treatment Interventions (CATIs) are a series of evidence-informed interventions supported by HRSA/HAB to promote linkage, retention and viral suppression across Ryan White Programs. The CATIs replicate four previous HRSA/ HAB/SPNS initiatives. The CATI Manual provides the intervention protocol and implementation guidance; it will be linked throughout this curriculum. Additional resources from this project include an intervention summary, sustainability report, evaluation protocol, and technical assistance (TA) agenda, all of which can be found at: <https://targethiv.org/deii/deii-peer-linkage>

A NOTE ON LANGUAGE

Participant refers to someone in this training.

Client refers to a person who is eligible for or receiving HIV primary care services.

MATERIALS AND EQUIPMENT

Trainers will need the following items:

- A computer or flat screen/projector that can play each of the PowerPoint presentations.
- A printer and/or copier to produce the handout materials being reviewed in the training (or send electronically to participants if they are able to review in real-time online (e.g., on a laptop).

MANUAL FORMAT

Each training module begins on a new page and is identified by a section title and module number. Throughout the manual are explanations of slides, talking points, and activities. Below are the symbols used throughout the manual:



THE APPROXIMATE LENGTH OF TIME THE SESSION WILL TAKE.



POWERPOINT SLIDE



HANDOUTS



TRAINER'S NOTE



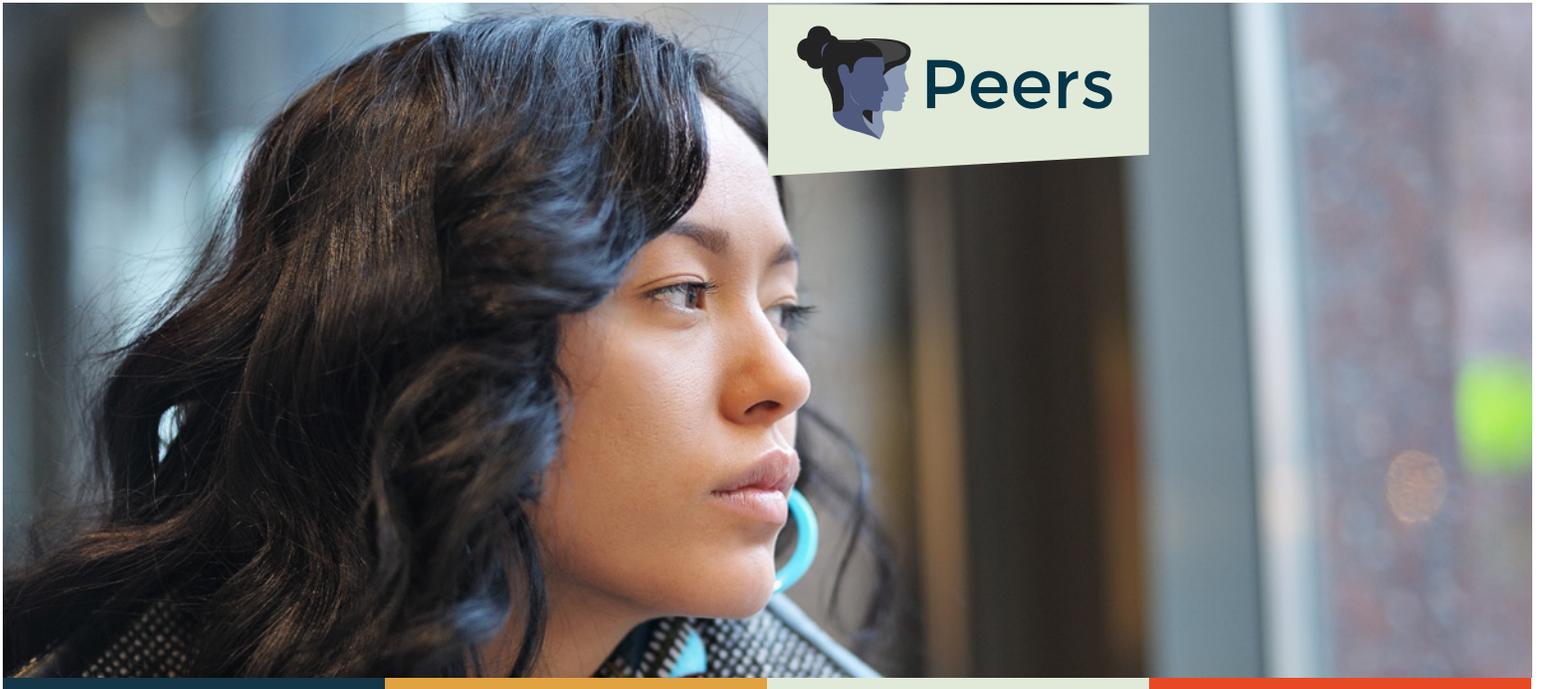
FLIP CHART SHEETS



REFERENCE MATERIALS



ACTIVITY MATERIALS



MODULE 1:

Introduction to the Peer Linkage and Re-Engagement of Women of Color Living with HIV

Topics Covered: Goals, roles, responsibilities, and multidisciplinary care team

OBJECTIVES

By the end of this module, participants will be able to:

- Participate in an introduction activity.
- Describe the goals and objectives of the Peer Linkage and Re-Engagement intervention that serves women of color with HIV.
- Identify peer staff roles and what makes an effective peer.
- Define core roles and responsibilities of peers
- State the skills, qualities, and knowledge that peer staff will need to be effective in their role.
- Define multidisciplinary teams and how team members collaborate to meet client needs.

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Peer Staff Roles and Responsibilities Activity and Answer Sheet, *Appendices 1 and 2*
- Four Categories of Peer Service, *Appendix 3*
- What Does It Take to Be a Peer? *Appendix 4*
- Identifying Roles of Multidisciplinary Team Members and Answer Sheet, *Appendices 5 and 6*



FLIP CHART SHEETS



REFERENCE MATERIALS

- Peer Linkage and Re-Engagement of HIV+ Women of Color CATI Manual

PROCESS

- Welcome participants.
- Introduce the training.
- Discuss logistics and obtain mutual agreement around ground rules.
- Review the background/need for the Peer Linkage and Re-Engagement intervention.
- Reference materials to be provided to and reviewed by participants in advance of the training; materials are placed in binders or available electronically, organized by session. Participants are expected to have access to all materials for reference through the entire curriculum.
- Arrange chairs and tables in a "U" shape.

INTRODUCTIONS

Presenters and participants introduce themselves, the organization they represent, and their role on the project. Each participant is asked to share one fun fact others in the room would not know about them.

LECTURE

Let's begin with a short lecture to introduce the peer linkage and re-engagement project and the definition of peer staff.

ACTIVITIES

Activity Sheet: Peer Staff Roles and Responsibilities worksheet.

Engage the Participants: Follow instructions for worksheet. Participants will work in pairs to complete the worksheet. Lead a group discussion of answers to ensure understanding. In addition, review Four Categories of Peer Services handout, [Appendix 3](#).

BRAINSTORM

Inform the group that the next activity will be a brainstorm. On three separate sheets of newsprint/large post-it paper write the words Knowledge, Skills, and Qualities then facilitate a brainstorm activity where the participants will share what comes to mind when they think of these words in relation to peer roles in the project. (slide 6, 10 minutes). Facilitate discussion of the responses in comparison to the Knowledge, Skills, and Qualities answer sheet.

Lead the group in understanding composition, goals, and function of multidisciplinary teams as part of the client's medical team.

Activity:

Identifying the Roles of the Multidisciplinary Team Members

Divide participants into three groups and have them work together in defining the roles of the team members. The facilitator will elicit a discussion as small groups report back to the large group.

Key Words and Phrases

- *Peer Definition*
- *Staff Roles*
- *Skills and Qualities of a Peer*
- *Multidisciplinary Care Team*



The approximate length of time the session will take.

Total: 80 minutes



Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Small Group Activity



SLIDE 1:

Welcome participants to the Peer Linkage and Re-Engagement of Women of Color Living with HIV intervention.



SLIDE 2:

Conduct introductory activity based on the slide.



SLIDE 3:

The Peer Linkage and Re-Engagement intervention serves women of color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. The intervention uses trained WoC living with HIV as peers to link and re-engage clients in HIV primary care. To link and re-engage WoC living with HIV, peers will assist clients in attending two medical appointments and one case management appointment in a six month to one year period. Clients will be considered linked or re-engaged once they have completed all three appointments as well as have completed HIV lab work. Peers provide a unique personal perspective and can provide coaching and emotional support to motivate clients in scheduling and attending medical and case management appointments. In addition, peers who work closely with case managers and the clinical team can better provide individualized client-centered services over a short time period to address immediate client needs and build trust between the client and the clinic team.

Goal

Re-engage WoC living with HIV who have fallen out of care (have not attended an appointment in the last six months) back into HIV primary care

This is a short-term intervention (six months to one year).

Objectives

The peers will work with clients (both recently diagnosed and those who have fallen out of care) to achieve the following milestones: attendance to two medical care visits with a prescribing provider, completion of one lab visit, and completion of one visit with a case manager.



SLIDE 4:

In the context of this intervention, peers are defined as people living with HIV and provide a unique perspective in connection with clients who are living with HIV and out of care. This module will define the role and responsibilities of peers in the intervention.



SLIDE 5:

Let's begin with a short lecture to introduce the concept of peer staffed programs. Peer programs share the following principles:

1. An understanding that people are more likely to hear and accept information that is presented and modeled by their peers.
2. A belief in the value and ability of people to bring about positive change in themselves and others.
3. Peer programs were first developed to serve youth in an effort to address youth sexual and reproductive rights according to the International Planned Parenthood Federation and to encourage positive student modeling and mentoring at high schools.
4. Success with youth has transcended to applying this model to chronic disease management and specifically utilizing peers to help re-engage women of color back in HIV medical care.

See handouts, "Peer Staff Roles and Responsibilities" and "Four Categories of Peer Services."

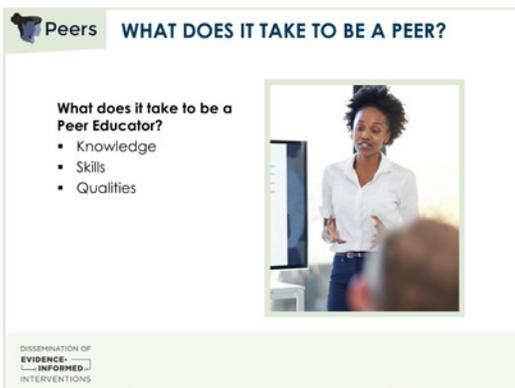
You are going to work in pairs and answer the three questions on the activity sheet titled "Peer Staff Roles and Responsibilities."

Please write 5 responses to the questions below:

- What is a peer?
- What makes an effective peer staff person?
- What is your role as a peer staff person?

Facilitator will elicit responses to questions and engage discussion within the group.

Facilitator will distribute handout and have participants review: Four Categories of Peer Services.



SLIDE 6:

We are going to do a brainstorm activity. A brainstorm allows for the group to generate ideas very quickly before considering them more carefully.

- **Let us first define knowledge as:** Formal learning or life experience.
- **Skills is defined as:** Actions and abilities learned to do something well.
- **Qualities are:** Attributes or characteristics possessed by someone.

When we think of a peer they are a person living with HIV who is in the capacity to help others living with HIV and for the purpose of this project, they are providing outreach to women who have not been in care and helping women return to HIV medical care.

With that framework in mind, let us brainstorm on large post-it paper or a sheet of paper and write down as many things that come to mind when you think of the possible knowledge that peer staff might have, the skills they will need to do fulfill their role, and the qualities that might best suit them in a peer capacity.



SLIDE 7:

We are going to learn about the vital role each person on a multidisciplinary team plays in working collaboratively to meet the needs of clients over the next 30 minutes. We will review slides, ask relevant questions, and have a group activity to help us understand the pivotal role peers play on the team.



SLIDE 8:

Let's start by first asking the question
What is a Multidisciplinary Team?

- Multidisciplinary teams are groups of professionals from diverse disciplines who come together to provide comprehensive assessments and consultation for a common goal (client).
- Multidisciplinary team members do not have to be all located at the same agency/clinic but are connected in the provision of services to the same client.
- Multidisciplinary teams are more prominent in health care (e.g., hospitals, clinics) and at social service agencies (e.g., nonprofit community-based organizations, state-funded agencies).
- Multidisciplinary teams are present in the business field and at schools. The title of the team may be different, but it will be comprised of professionals from diverse disciplines coming together to provide assessments for a common purpose.

In construction, for example, diverse disciplines would include marketing department, sales, mechanical and electrical engineers, etc. In schools, a Resource Team assists students by collaborating with diverse disciplines, including the school counselor, nurse, home room teacher, etc.

Peers MULTIDISCIPLINARY TEAMS

Multidisciplinary Teams are located at hospitals/clinics

- Occur weekly
- Diverse disciplines
- Complete client case conferences
- Speak of client respectfully



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SLIDE 9:

We know that Ryan White clinics are located in hospital systems or stand alone clinics and facilitate multidisciplinary team meetings to increase collaboration and communication with providers who are working with the same client. These multidisciplinary meetings:

- Ideally, occur weekly at a minimum. Some institutions have them monthly.
- Diverse disciplines comprise the multidisciplinary team and include social workers, case managers, physician, nurses, psychiatrist or mental health representative, peer or peer navigator, and others depending on the number of disciplines/services offered at the hospital or clinic.
- How the team decides which case to conference varies—some cases may be chosen because multiple agencies are involved in providing services to the client and this is an opportunity for everyone to be on the same page; a client maybe at risk of losing housing or insurance, a client has not been case conferenced in six months or the client is coming in for a medical appointment and there is concern about substance use that is affecting adherence to medications, etc.
- Lastly and most importantly: communicating information about the client must be shared in a respectful manner. I always say, pretend the client is in the room to ensure that what is shared is professional and represents the client with dignity.

Peers PEERS IN THE MULTIDISCIPLINARY TEAM



- Common Goal-assess client needs, develop care plan between client and team
- Holistic approach

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 10:

The value of the multidisciplinary team meeting is to ensure that all providers working with the same client are communicating about client needs and developing goals collaboratively with the client.

All providers from the myriad of disciplines are encouraged to share information they know about the client that will support a holistic assessment and explore resources for the client being case conferenced.

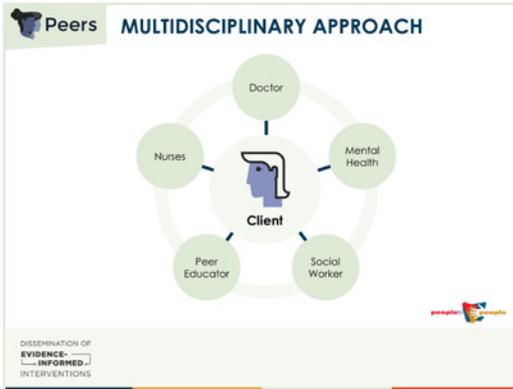
Peers TRADITIONAL APPROACH



DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 11:

This graphic depicts the Traditional Approach to case conferencing. As you see it's a top down approach with the team comprising of the doctor who gives direction to the nurse, social worker, and mental health clinician. Their decision is then filtered to the peer and as you can see there is no opportunity for the peer to provide insight that they may have gathered from their working relationship with the client that can benefit the direction of care planning to provide a holistic approach to service delivery. (From Building Blocks to Peer Success)



SLIDE 12:

So we saw in the Traditional Approach that the team is comprised of providers only, with the communication style being directive.

We want to demonstrate the approach we consider to be primary, which is the Multidisciplinary approach. This approach lends to the client being central to the team, with the other disciplines including the peer sharing information. There is no one person who has more power over the process and it allows for a coordinated team approach to assessing needs, developing care plans in conjunction with the client as services are delivered.

Let us emphasize that the peer is vital to the connections between the client and the multiple service providers. This approach is a collaborative communication style and a holistic approach.

So let's answer the following questions:

- What are the major differences between the traditional approach versus the multidisciplinary approach of collaborating with clients?
- What are some of the benefits to the multidisciplinary approach?
- How do you ensure that each discipline's role on the multidisciplinary team is valued?



SLIDE 13:

Activity

1. Instruct participants that they are going to do an exercise on defining the role of multidisciplinary team members. Explain to participants that understanding the role of co-workers is essential for a multidisciplinary team to work well together.
2. Break into small groups.
3. Give each group an Identifying Roles of Multidisciplinary Members activity sheet.
4. Explain that each group should ask one person to be a recorder and a reporter, and that each group should make a list of tasks for each multidisciplinary team member. Remind participants that some tasks will be shared and some will be unique to that team member.
5. *Remind participants that we have already spent time on the peer's role so they should do that quickly and then spend most of their time on the other team member's roles.*
6. After 10 minutes ask the small groups to stop.
7. Ask the groups to present their lists. Put a star next to common tasks.
8. Discuss different assignment of tasks between the groups.
9. Ask participants to comment on tasks that are shared by different team members ("listen to client concerns") as well as tasks that are unique to peers or medical personnel. Mark shared tasks among all job titles with asterisks using colored markers. Then emphasize unique tasks for peers.
10. Hand out "Identifying Roles of Multidisciplinary Members" answer key.



SLIDE 14:

Ask the group if they have any questions.

CLOSING

Next, we will review common myths and facts about HIV so that we are all on the same page before we proceed.



MODULE 2: HIV/AIDS Frame Basics

Topics Covered: HIV, AIDS, transmission, protection, stages of HIV/AIDS

OBJECTIVES

By the end of this module, participants will be able to:

- Define basic information about HIV/AIDS.
- Formulate misconceptions regarding how HIV is transmitted.

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Stages of HIV Infection, *Appendix 7*
- HIV 101: Understanding HIV and AIDS and Answer Sheet, *Appendices 8 and 9*
- What Stage Am I? and Answer Sheet, *Appendices 10 and 11*
- Modes of Transmission and Fluids and Answer Sheets, *Appendices 12 and 13*



FLIP CHART SHEETS

Key Words and Phrases

- *HIV/AIDS*
- *Acronyms*
- *Prevention Myths*



The approximate length of time the session will take.

Total: 25 minutes

PROCESS

Lead group discussion by asking questions about HIV and AIDS (5 minutes)
Lecture group on HIV definitions (10 minutes) and behavioral choices people can select to reduce acquisition of HIV (10 minutes)

SUMMARY

This activity is designed to ensure that everyone in the group has a basic definition and understanding of HIV/AIDS before proceeding with the rest of the training.

Answer any further questions from participants



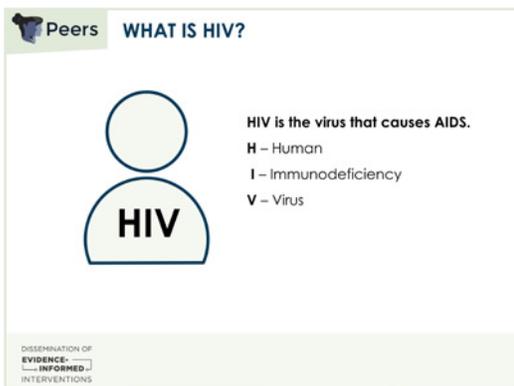
Method(s) of Instruction

- Large Group Discussion
- Lecture



SLIDE 1:

Introduce the topic of HIV/AIDS.



SLIDE 2:

We all hear stories about HIV and AIDS that include incorrect information and personal opinions that stirs up fear and stigma.

First, we want to give you basic information about HIV and AIDS.

Second, we want to clear up any misconceptions regarding how HIV is transmitted.

Ask: What do the letters H-I-V stand for?

H—Human (one can only get HIV from humans, person-to-person, blood-to-blood, sexual contact and/or fluids).

I—Immunodeficiency (affects immune system making it too weak to fight off disease and infection).

V—Virus whose survival depends on cells in the host.

What is HIV? The virus that causes AIDS.

Peers WHAT IS AIDS?



AIDS is a result of HIV.

- A** – Acquired
- I** – Immune
- D** – Deficiency
- S** – Syndrome

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SLIDE 3:

Ask: What do the letters AIDS stand for?

A—Acquired (must get it from someone)

I—Immune (collection of cells and substances that act like soldiers against germs)

D—Deficiency (weakens immune system causing opportunistic infections)

S—Syndrome (collection of symptoms or illnesses)

AIDS is the result of untreated HIV.

Activity:

Appendix 8-HIV 101: Understanding HIV and AIDS

Peers HIV TRANSMISSION

How do people get HIV?

- By having condomless vaginal, anal or oral sex with someone who has HIV and who is not virally suppressed
- By sharing syringes with someone who has HIV
- During pregnancy, birth or breast feeding from a mother living with HIV to her baby

Body fluids of a person living with HIV that spread HIV:

- Semen
- Blood
- Vaginal fluid
- Breast milk
- Any other body fluids containing blood

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 4:

Ask: How do people contract HIV?

- By having condom-less vaginal, anal, or oral sex with someone living with HIV who is not virally suppressed
- By sharing syringes with someone living with HIV
- During pregnancy, birth, or breast feeding from a mother living with HIV
- What are the body fluids of a person living with HIV that can spread HIV?
 - Semen
 - Blood
 - Vaginal fluids
 - Breast milk
 - Any other body fluids containing blood

Additional notes:

- Protected sex using a latex condom greatly lowers risk
- Recent research indicates that people living with HIV that are Undetectable are unable to transmit HIV, or Untransmittable (otherwise known as U=U)
- Injection drugs used either legally or illegally
- Safety precautions should be used for tattoos and body piercings

Peers HOW DO PEOPLE PROTECT THEMSELVES FROM HIV?

How do people protect themselves from getting HIV?

- People can choose not to have sex or use drugs
- People can choose ways to be affectionate that do not risk transmission of HIV or other STDs/STIs
- If people have sex, using a latex condom (barrier) the right way every time greatly reduces the risk of transmission of HIV and other STDs/STIs
- If people are injecting drugs; using sterile syringes or works reduces risk.
- Pre-Exposure Prophylaxis (PrEP)
- Having sex with a partner who is virally suppressed

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 5:

Activity:

Appendix 12-Modes of Transmission and Fluids

How do people protect themselves from getting HIV?

- People can choose not to have sex or use drugs
- People can choose ways to be affectionate that do not risk transmission of HIV or other STDs/STIs
- If people have sex, using a latex condom (barrier) the right way every time greatly reduces the risk of transmission of HIV and other STDs/STIs
- If people are injecting drugs; using sterile syringes or works reduces risk.
- Pre-Exposure Prophylaxis (PrEP)
- Having sex with a partner who is virally suppressed

Peers STAGES OF HIV/AIDS

Person contracts HIV

Acute stage – occurs 1 to 2 weeks after initial transmission

- Person may have flu-like symptoms
 - Fever
 - Headache
 - Tiredness
 - Enlarged lymph glands

Asymptomatic Period – chronic signs and symptoms are not present.

- Person may look healthy and feel well.

Symptomatic Period - Person may have enlarged lymph glands, tiredness, weight loss, fever, chronic diarrhea or yeast infections (oral or vaginal) among other conditions.

AIDS - The virus weakens and eventually destroys the immune system. When a person with HIV develops AIDS, his or her body has lost most of its ability to fight off certain bacteria, viruses, fungi, parasites and other germs.

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 6:

Activity:

See handouts, “Stages of HIV Infection”

Refer to handout - Optional Notes:

- Acute—After a person contracts HIV the first stage is Acute; everyone does not experience the symptoms. Most do not recognize symptoms as a sign of HIV infection.
- Asymptomatic—Chronic signs and symptoms are not present. A person may look healthy and feel well.
- Symptomatic— A person may experience symptoms such as enlarged lymph glands, tiredness, weight loss, chronic diarrhea or yeast infections among other conditions and a T-cell count at 200 or less and a physician may diagnose the person with AIDS.
- AIDS—people with an AIDS diagnosis may have illnesses healthy people don’t get; and may have more severe versions of other illnesses.
- Once a person is diagnosed with AIDS it remains even if their T-cell increases to above 200 as it indicates that your immune system is improved.



HANDOUT & ACTIVITY

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 7:

Activity:

See handouts, “What Stage Am I?” “Modes of Transmission and Fluids.”

CLOSING

This module was designed to ensure that everyone in the group has a basic understanding of HIV/AIDS before proceeding with the rest of the training. Next, we will learn about communication strategies to prepare us in introducing the program, educating our co-workers so that they understand the key role and responsibility that peers bring to the care teams and overall agency.



MODULE 3:

Communication

Topics Covered: Basic concepts of communication

OBJECTIVES

By the end of this module, participants will be able to:

- Define communication.
- Identify key concepts of communication.
- Discuss and practice the four elements of communication: open-ended questions, positive feedback, reflective listening, and summarizing.
- Describe the difference between open-ended and closed-ended questions.



The approximate length of time the session will take.

Total: 90 minutes

6 units/9 slides

MATERIALS NEEDED



POWERPOINT



FLIP CHART SHEETS



HANDOUTS

- Asking Open-Ended Questions and Answer Sheet, Appendices 14 and 15



REFERENCE MATERIALS

- Building Blocks for Peer Program Success: <http://www.cahpp.org/project/peer-center/>
- Best Practices for Integrating Peer Navigators into HIV Models of Care: www.aidsunited.org/resources
- Dutcher, Noely Phicil, Goldenkranz, Rajabiun, Franks, Loscher, Mabachi. Positive Examples”: A Bottom-Up Approach to Identifying. Best Practices in HIV Care and Treatment Based on the Experiences of Peer Educators. AIDS PATIENT CARE and STDs V25, n7, 2011.
- Peer Re-Engagement Project:
- Peer Program Resources and Training Curricula: <https://ciswh.org/project/peer-center/>
- Yanick, Mark, Velez, Miguel. HIV/AIDS Stigma Initiative Program: “HIV/AIDS Stigma & Access to Care.” National Minority AIDS Council, May 2006
- <http://open.lib.umn.edu/communication/chapter/1-2-the-communication-process/>

PROCESS

- The training will begin with a discussion designed to define communication and explore the complex dynamics of communication.
- The facilitator will introduce key concepts for effective communication and facilitate learning activities that provide participants with opportunities to practice.
- The facilitator will encourage participants to identify barriers to effective communication and coach them in developing strategies to address the identified barriers.
- The facilitator will help participants synthesize each content session and explore the relevance of effective communication in their peer role.

Key Words and Phrases

- *Effective Communication Skills*
- *Communication Strategies*
- *Communication Skills*
- *Communication Barriers*
- *Asking Open-Ended Questions*
- *Reflective Listening Skills*
- *Giving Positive Feedback*
- *Summarizing Skills*
- *Attentive Listening Skills*
- *Active Listening Skills*
- *Interpersonal Communication Skills*



Method(s) of Instruction

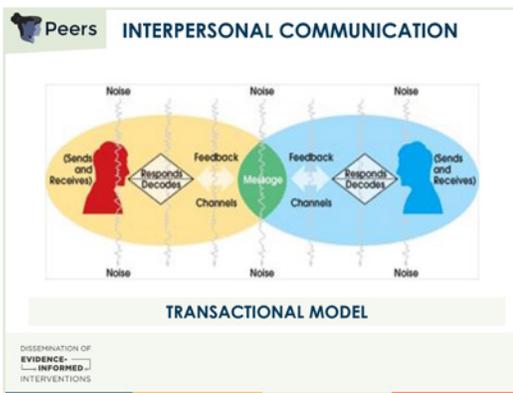
- Lecture
- Facilitated Discussion
- Small Group Activity

UNIT 1 



SLIDE 1:

Introduce the topic of communication.



SLIDE 2:

1. Ask the group to brainstorm “What is communication?”
2. Document responses on newsprint.
3. Communication is defined as the imparting or exchanging of information or news. Communication involves a process where communicators convert their thoughts into messages that are conveyed through content and symbols (e.g., verbal messages, emails, emojis, sign language, etc.). Processing the sent messages includes decoding and interpreting them through the receiving communicator’s values, attitudes, beliefs and life’s experience. Let’s take a closer look at some key concepts that will provide further perspective on the communication process. Talk about the parts listed below and call attention to parallels with the group’s responses to the previous question: What is communication?

Some key concepts of communication are:

Communicators – The Transactional Model shown in the slide, says communication involves communicators who are engaged in a simultaneous exchange of messages (both verbal and Non-verbal) For example, Communicator 1 tells a story that is of little interest to Communicator 2. While Communicator 1 is speaking, Communicator 2 is simultaneously sending a non-verbal message of disinterest by avoiding eye contact and yawning.

Message – The message refers to the content that is sent. The message includes the following expressions, verbal, non-verbal, facial expressions and tone of voice.

Channels – The channel refers to the physical means by which the message is transferred from one person to another. In a face-to-face context the channels which are used are speech and vision; however, during a telephone conversation, the channel is limited to speech alone. This varies depending on ability as well (i.e., if someone is challenged with hearing?) sign language or written text is best for communication.

Feedback – Feedback consists of messages the receiver returns, which allows the sender to know how accurately the message has been received, as well as the receiver’s reaction. The receiver may also respond to the unintentional message as well as the intentional message. Types of feedback range from

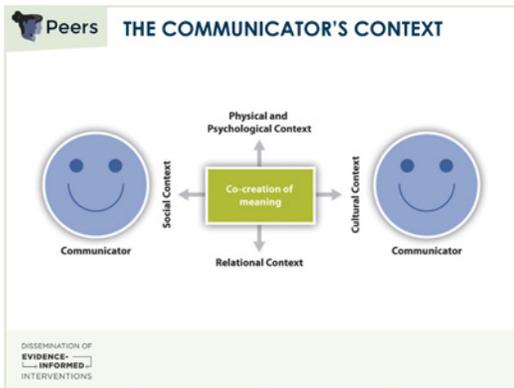
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SLIDE 2: Continued

direct verbal statements. For example “Say that again, I don’t understand,” to non-verbal facial expressions or changes in posture that might indicate that the receiver feels uncomfortable with the message. Feedback allows the sender to regulate, adapt, or repeat the message in order to improve communication.

Noise – Noise has a special meaning in communication theory. It refers to anything that distorts the message, so that what is received is different from what is intended by the speaker. While physical ‘noise’ (for example, background sounds) can interfere with communication, other factors are considered to be ‘noise’. The use of complicated jargon, inappropriate body language, inattention, disinterest, and cultural differences can be considered ‘noise’ in the context of interpersonal communication. In other words, any distortions that occur during an attempt to communicate can be seen as noise.

We can agree that communication involves simultaneous messages sent between and interpreted by the communicators, ideally with a goal of facilitating shared understanding.



SLIDE 3:

Context – The transactional model views communication as inclusive of all of the previous elements and adds a layer of context. As we just stated, each communicator has their own sphere of context through which they interpret and evaluate exchanged messages. Unique to this model are communicators’ context. A person’s context is made up of several factors:

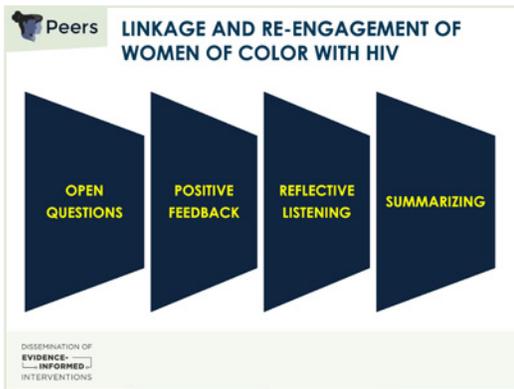
- **Physical context** includes the environmental factors in a communication encounter. The size, layout, temperature, and lighting of a space influence our communication.
- **Psychological context** includes the mental and emotional factors in a communication encounter. Stress, anxiety, and emotions are just some examples of psychological influences that can affect our communication.
- **Social context** refers to the stated rules or unstated norms that guide communication. As we are socialized into our various communities, we learn rules and implicitly pick up on norms for communicating.
- **Relational context** includes the previous interpersonal history and type of relationship we have with a person. We communicate differently with someone we just met versus someone we’ve known for a long time.
- **Cultural context** includes various aspects of identities such as race, gender, nationality, ethnicity, sexual orientation, class, and ability.

This process of developing understanding between the communicators is influenced by the amount of commonalities and differences between their two spheres of context. For example, if communicators share similar cultural contexts (e.g., race, sexuality), the shared experiences can help facilitate more effective communication whereas fewer commonalities lead to more challenges in understanding.

Summary

- The peer worker should be aware of the many facets of effective communication and that challenges can occur when communicators’ personal contexts are less alike; however, this provides an opportunity for openness to learn about each other.

UNIT 2



SLIDE 4:

As peers you will be spending a lot of time communicating with clients and what you communicate is sometimes as important as how you communicate. Peers need to make sure they understand the information they share with clients and ensure clients understand the message.

There are four methods that are useful when engaging clients in conversation (review slide 4) and practice allows for full command of the material.

The four elements of communication that are key for peers to learn are: open-ended questions, positive feedback, reflective listening, and summarizing. By utilizing each element, peers can develop better rapport and trusting relationships with clients.

UNIT 3



Peers LINKAGE AND RE-ENGAGEMENT OF WOMEN OF COLOR WITH HIV

ASKING QUESTIONS

Open -questions invite dialogue and conversation
Closed -questions invite only a "yes" or "no" answer

Examples
 Closed: "Is it going to rain today?"
 Open: "What will the weather be like today?"
 Closed: "Are you feeling well?"
 Open: "How are you feeling?"

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 5:

See the handout, "Asking Open-Ended Questions"

- The first element of communication is mastering open-ended questions.
- Peers are most successful with client engagement when they ask open-ended questions as this allows for clients to share more of themselves. We frequently ask closed questions which have one word responses, and require follow-up questions to gain understanding.
- As peers you will be spending a significant amount of time asking questions to gain an understanding about clients so how you ask is extremely important.
- Let's review the difference between open-ended and closed questions. Review examples on the slide.

Activity:

- Ask participants to find the Asking Open-Ended Questions worksheet.
- Tell participants that we are going to do a quick exercise, this time individually. You will have 7 minutes to convert the closed questions on the worksheet to open-ended questions.
- Tip: open-ended questions usually start with How, What, When, Where and Why. Be careful when using "Why" questions as it may make people defensive (Write these on flip chart paper for quick reference.)
- Ask for volunteers to share how they converted the questions from closed to open. Allow some report back and move on—there may not be enough time for everyone to debrief. Closed questions have their place in conversation, but if your goal is to gather information, open-ended questions are more effective.

Asking open-ended questions can help a peer support their client in more meaningful ways because you can better assess their needs.

UNIT 4



Peers LINKAGE AND RE-ENGAGEMENT OF WOMEN OF COLOR WITH HIV

Attentive Listening

- Hearing:** • Listening carefully to make sure you understand what someone is saying
- Interpreting:** • Confirming your understanding of what you have heard
- Evaluating:** • Asking questions regarding what you have heard

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 6:

Review slide with participants and elaborate:

Attentive listening is the second element of communication.

Almost anyone can listen, but how often have you had a conversation with someone only to feel that you were not really heard? What made you feel that way? Allow responses and facilitate discussion.

Brainstorm. Lead a brainstorm using the following question: How do you know when someone is listening to you? Document responses on flip chart paper and demonstrate the non-verbal skills as they are being discussed.

Make the following points:

Attentive listening is paramount to effective communication.

- We remember that communication happens simultaneously between communicators.
- We are ALWAYS communicating even when we are silent; thus, active listening includes hearing, interpreting, and evaluating received messages AS WELL AS being mindful of our verbal and non-verbal feedback.

Verbal forms of listening.

- Use questions such as “Really?” “What happened?”
- Comment directly on what is being said by the client.
- Restate the client’s statements in your own words to check for understanding: “Do you mean....?”
- Encourage the client to express feelings: “How did that make you feel?” “You must have felt...”
- Elicit more information: “Say more about that.”
- Don’t interrupt too frequently.

Non-verbal form of listening.

- Mindfulness—being fully present and focused in the interaction.
- Non-verbal listening skills show the client that you are interested without speaking.
- Make eye contact.
- Nod your head.
- Lean forward.
- Use positive facial gestures (e.g., smiling vs. rolling your eyes).

Eliminate “noise” distractions.

- These are the external barriers and internal barriers to effective communication and attentive listening.
- Address cultural and social barriers.
 - This may require prior preparation to schedule an interpreter, creating a safe environment, making agreements about the use of technology like cell phones or computers.
 - Ask participants, “What other considerations can you think of?”

Continued on next page...

SLIDE 6: Continued

Summarize:

- Attentive listening helps us better understand what clients are trying to tell us and communicates to them that we are interested in what they are saying.
- Listening is one of the best ways to support clients emotionally.
- You listening gives the client an opportunity to talk things through and, in talking, develop their own awareness of what's going on with them and how they feel about it.
- Being mindful that we are ALWAYS communicating whether we are speaking or not. Being self-aware and self-reflective can help peers recognize any habits that might positively or negatively impact their effectiveness in active listening.

UNIT 5



Peers LINKAGE AND RE-ENGAGEMENT OF WOMEN OF COLOR WITH HIV

Reflective Listening

"SO YOU FEEL..."

"IT SOUNDS LIKE YOU..."

"YOU'RE WONDERING IF..."

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 7:

The third element is reflection. Solicit definition of reflection and allow responses. When the definition emerges, write it on flip chart paper.

- Reflection has different connotations – the definition we're looking for is careful or long consideration or thought.
- Reflective listening means giving careful thought to what clients are saying. This kind of listening is the deepest form of engagement in conversation and build relationships.
- As a peer, you want to build trusting client relationships so that they open up to you.
- When you listen reflectively you can help the client say what they really mean, help clarify their thoughts and feelings, and bring out things that are just below the level of awareness. This can lead to further exploration of issues.
- Review slide 7. Tell participants that some people find it helpful to use some standard phrases like the ones in the slide.

Demonstration:

The following is a dialogue between a client and their provider. It will be quite obvious by the responses and body language of the client that they are really unaware of what the provider is talking about; yet, the client will not admit this to the provider. The topic is that the client's viral load has increased despite the client's indication that they have been 100% adherent to their medications. Trainers will use props to distinguish the client from the provider. Trainers will demonstrate throughout the role play what reflective listening looks like in a conversation. Ask participants to make note of the reflective listening skills being used in the role play.

Summarize:

How did the listener display reflective listening, what did they say or do? Briefly facilitate further discussion.

- Reflective listening can help peers increase their understanding of the client and their circumstances.
- Reflective listening can help both communicators clarify their thoughts and provide assurance that they have been heard and understood.
- Reflective listening can help communicators avoid the illusion of understanding.

UNIT 6



Peers LINKAGE AND RE-ENGAGEMENT OF WOMEN OF COLOR WITH HIV

Summarizing

"LET ME SEE IF I UNDERSTAND SO FAR..."

"HERE IS WHAT I HEARD YOU SAY, TELL ME IF I MISSED ANYTHING..."

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 8:

The fourth element is summarizing, which is particularly helpful at transition points in the conversation. For example, summaries are often helpful after someone has finished speaking or when an appointment is coming to an end. Summarizing helps to ensure that there is clear communication between speaker and listener.

- When you summarize, be brief!
- End summary statements with an invitation. For example: "Did I miss anything?" "If that's accurate, what other points are there to consider?" "Is there anything you want to add or correct?"

Practice Scenario:

Have participants identify a partner for practice. One person is the peer and the other is the client. Act out the following scenarios:

Develop a plan with your client for scheduling times to take their daily medication. After the terms are discussed, use your summarizing skills to end the interaction.

Your client feels overwhelmed with information regarding their new HIV diagnosis. The client has decided to commit to your offer for a mental health referral. You two discuss the steps for referral. Summarize your discussion and end the session.

Summary:

- Summarizing is a communication skill that provides a concise overview of the main points of the discussion.
- It is a helpful tool for confirming mutual understanding when working with clients.
- Summaries provide an opportunity to consider and address any outstanding questions or concerns regarding the topic.

Peers REFERENCES

Building Blocks for Peer Program Success:
<https://ciswh.org/resources/HIV-peer-training-toolkit>

Best Practices for Integrating Peer Navigators into HIV Models of Care:
www.aidsunited.org/data/files/Site_18/PeerNav_v8.pdf

Dulcher, Noely Phyll, Goldenkranz, Rajabun, Franks, Loscher, Mabachi. Positive Examples: A Bottom-Up Approach to Identifying, Best Practices in HIV Care and Treatment Based on the Experiences of Peer Educators. AIDS PATIENT CARE and STDs V25, n7, 2011.

Peer Re-Engagement Project:
 Peer Program Resources and Training Curricula:
<https://ciswh.org/project/minority-aids-initiative-retention-and-re-engagement-in-hiv-care-project/>

Yanicik, Mark, Velez, Miguel. HIV/AIDS Stigma Initiative Program:
 "HIV/AIDS Stigma & Access to Care". National Minority AIDS Council, May 2006.

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 9:

Review references with participants.

CLOSING

Next, we will review how to roleplay how to introduce the program services with clients.



MODULE 4:

Intervention Introduction

Topics Covered: Roleplay

OBJECTIVES

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

- Practice explaining the program to elicit client engagement.
- Assess strengths and opportunities to gain confidence in establishing rapport with clients through role play.

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Role Play Scenarios for Introduction of the Program Service, *Appendix 16*



The approximate length of time the session will take.

Total: 30 minutes

15 minutes lecture

15 minutes roleplaying

PROCESS

The training will begin with a review of objectives and goals of the program.

The facilitator will demonstrate via roleplay how a peer will introduce themselves and describe the program to clients who can benefit from the service.

The group will divide into smaller groups of three, with one person being the peer, the client, and an observer.

Each person will rotate roles and practice engaging clients, giving feedback on roleplay, and gaining confidence in establishing rapport.

The facilitator will elicit feedback from groups of what went well and what they wish could have been demonstrated to strengthen the roleplay. Allow for time to complete and manage group discussion.

FACILITATED DISCUSSION

As part of slide 3, the facilitator will engage participants in a guided discussion.

Key Words and Phrases

- *Roleplay*
- *Introduction of Program*
- *Rapport Building*



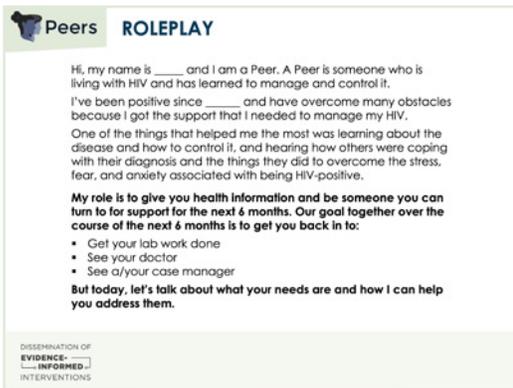
Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Roleplay



SLIDE 1:

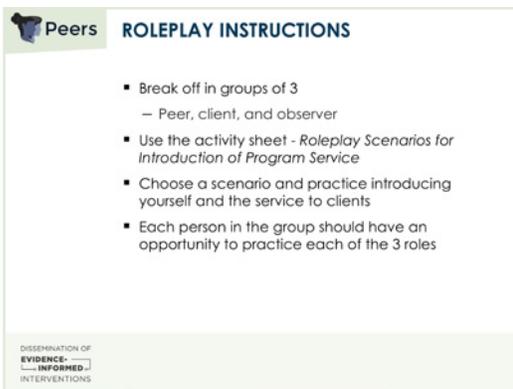
We will now have the opportunity to practice how we would introduce the intervention to prospective clients.



SLIDE 2:

When participants hear “roleplay” opportunities we tend to shy away from engagement. I encourage you to think of it as practice in preparation for introducing yourself and the service you provide to clients.

Facilitator reads the script on slide 2. Acknowledge that while this roleplay is scripted, participants can extract key points and make them their own, in their own voice. So let’s practice.



SLIDE 3:

See the handout, “Roleplay Scenarios for Introduction of Program Service.”

Break off in groups of three: peer, client, and observer.

- Use the activity sheet - Roleplay Scenarios for Introduction of Program Service.
- Choose a scenario and practice introducing yourself and the service to clients.
- Each person in the group should have an opportunity to practice each of the three roles.

Debrief:

The facilitator will process outcomes from the roleplay practice by asking the following questions of each person in the group:

- What went well in the roleplay as the peer?
- What could you have done to strengthen the role of the peer?
- Clients and observers in the roleplay can provide feedback.

CLOSING

Next, we will review how to facilitate your first client visit.



MODULE 5: Setting Up Your First Client Visit

Topics Covered: Roleplay

OBJECTIVES

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

- Review strategies to assist in building trust and rapport with the client.
- Identify Do's and Don'ts peers should follow at a client first meeting.
- Review program and administration needs that clients may be required to complete at a client first meeting.
- Assess questions peers can follow at a client first meeting.

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Sample of Questions to Use for Initial Meeting, *Appendix 17*



The approximate length of time the session will take.

Total: 30 minutes

Lecture- 20 minutes

Review of questions-
10 minutes

PROCESS

- Review purpose and objectives of a client first meeting.
- Discuss strategies peers can use to engage or re-engage clients back into healthcare.
- Discuss some do's and don'ts peers should be aware of at a client first meeting.
- Talk about program and/or administrative paperwork needed to enroll clients.
- Review handout with sample questions peers can ask to engage clients at the client's first meeting.

Key Words and Phrases

- *First Visit*
- *Introduction of Program*
- *Rapport Building*



Method(s) of Instruction

- Lecture
- Facilitated Discussion



SLIDE 1:

Introduce the topic of setting up your first client visit.



SLIDE 2:

The first meeting is the peer's opportunity to get to know the client and begin to develop trust. Developing trust with the client is one of the main objectives the peer tries to establish with the client. Establishing that relationship of trust goes a long way when trying to assess barriers that may have kept the client out of care. During the client visit, peers provide a sense of hope that living well with HIV is possible, provide emotional support to reduce fears about HIV disease, and seek to reduce isolation and stigma.

Peers ASSESSING CLIENT IS KEY

- Client's emotional state of mind at the time of the meeting (e.g. mental illness, trauma etc.)
- Client's comfort level with their diagnosis
 - Is the client in denial about their diagnosis?
 - Does the client have a support system?
 - Is the client newly diagnosed; however due to trauma never engaged in care?

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 3:

Several things to consider at a client's first meeting:

- The client's emotional state of mind at the time of the meeting. For example, is the client struggling with an untreated mental health diagnosis? Has the client been exposed to trauma or homelessness along with other psychosocial factors?
- What is the client's comfort level with their diagnosis? Are they in denial, do they have a support system, or were they traumatized to the extent that they never engaged in healthcare?

Peers GETTING TO KNOW THE CLIENT



Start the conversation by:

- Being open to listening to the client's story/experiences while providing emotional support if needed during the visit
- Asking open-ended questions
- Dispel myths about HIV/AIDS
- Share your own story – be brief, transparent, and relatable

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 4:

In getting to know the client, it's important to start a dialogue by:

- Being open to listening to the client's story/experiences while providing emotional support if needed during the visit.
- Asking open-ended questions.
- Dispelling myths about HIV/AIDS .
- Sharing your own story – be brief, transparent, and relatable.

Peers CLIENT FIRST MEETING DO'S AND DON'TS

Do:

- Use Active Listening skills
- Realize that the meeting and time of sharing is about the client
- Know your boundaries as a Peer ... (e.g. know when to refer a client to behavioral health or substance use services)
- Assess HIV knowledge and educate

Don't:

- Dominate the conversation, it's not about you
- Try to get your emotional needs met
- Over share information about your personal life or experience that the client does not need to know. It's often helpful to have a consistent script or way of providing details about your story.
- Work harder for the client than they are willing to work for themselves

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 5:

Client first meeting Do's and Don'ts

Do:

- Use Active Listening skills.
- Realize that the meeting and time of sharing is about the client.
- Know your boundaries as a peer (e.g., know when to refer a client to behavioral health or substance use services).

Don't:

- Dominate the conversation.
- Try and get your emotional needs met.
- Over share information about your personal life or experience that the client does not need to know. It's often helpful to have a consistent script or way of providing details about your story.
- Work harder for the client than they are willing to work for themselves.

Peers PROGRAM DOCUMENTATION REQUIREMENTS

Ensure accurate client contact information:

- Address
- Phone number
- Email

Ensure that client gives consent for participation in the program:

- Review consent form with the client
- Explain the Peer role to the client and answer questions about peer services
- Assist clients in scheduling appointments (primary care, case manager etc.)
- Explain HIPAA, and your organization's policies regarding the importance of confidentiality
- Inform the client of resources/services available at your organization

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 6:

Program and administrative paperwork is required to ensure the client has given permission to participate in the program and ensure the peer has the correct contact information to follow up with the client.

The peer will need to:

- Review the consent form with the client.
- Explain the peer role to the client and answer questions about peer services and how peers are different from other disciplines.
- Explain HIPAA (Health Insurance Portability and Accountability Act) and your organization's policies regarding the importance of confidentiality.
- Assist or encourage client to schedule labs, primary care, and case manager visits.

Tell the client about other resources/services available at your organization (i.e., including support groups, behavioral health, and other interventions); in addition, community resources.

HANDOUT-FIRST VISIT SAMPLE QUESTIONS

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 7:

See the handout, "Sample of Questions to Use for Initial Meeting."

CLOSING

The client first visit is the most important "first impression" meeting for peers to:

- Get to know the client.
- Develop trust.
- Establish a working relationship.
- Provide education and engage or re-engage the client back into healthcare.

Clients engaging in health care allows the peer to provide emotional support and reduces fear and isolation that some people living with HIV still feel. Building the peer-client relationship is empowering and provides a sense of hope that living well with HIV (a chronic disease) is possible.



MODULE 6:

Documentation Skills

Topics Covered: Documentation, reporting, care plans

OBJECTIVES

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

- Understand the importance of documenting services provided to clients.
- Practice Documentation Skills for care plans and case notes.

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Intervention Encounter Form *Appendix 18*
- Client Care Plan *Appendix 19*
- Documentation Scenario Scripts *Appendix 20*

Key Words and Phrases

- *Documentation*
- *Reporting*
- *Care Plan*
- *Client Notes*

PROCESS

Facilitator leads session with question, "What is documentation?" Then, after eliciting responses from the group, will share the definition and types of documentation suggested for the project.

Facilitator lectures on components and how to complete the Encounter Form and the Care Plan.

Instruction is provided to participants about the next activity:

- Each of you will receive a scenario about a peer interaction with a client.
- Read your scenario and then document the interaction using the "Encounter Documentation Form." You will have 10 minutes to complete your form. Also use the scenario to complete the Care Plan.

The facilitator will engage the group to share scenarios and documentation responses and will ask: What was easy and what was difficult?



Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Small Group Activity

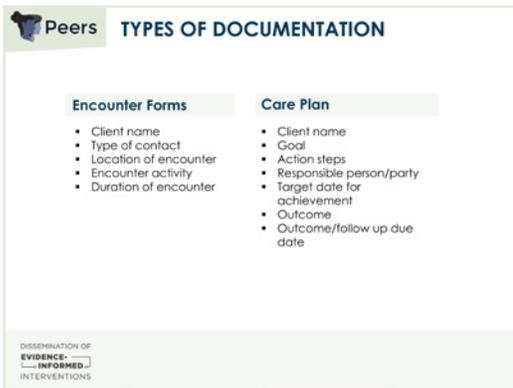


The approximate length of time the session will take.

Total: 40 minutes

**SLIDE 1:**

Introduce the topic of documentation.

**SLIDE 2:**

Let's first begin by defining, "What is documentation?"

Documentation is writing and recording the provision of client services that is part of a client's permanent record. Documentation is completed in Electronic Medical Records or Electronic Health Records, which can be used synonymously.

Elaborate and facilitate discussion: Documentation is describing the interaction between you and clients. We do this because there must be a record of your work with clients; otherwise, it's like your work never happened.

For the purpose of this project there are two types of documentation records you will use: first, **Intervention Encounter Forms**, which are the form you use to record the services rendered to a client; second, a **Client Care Plan** is used to record the goals that the client is working towards achieving, with clear steps to complete, staff who may support achievement, and a date by which the goal will be achieved. Client Care Plans can also indicate successes towards achieving goals and new goals to work towards. We will share examples of these forms shortly.

Let us look at both types of documentation:

Intervention Encounter Forms. As you can see, there is specific information required—the client's name; **type of contact** (whether it is by phone, email, text, face to face); location of encounter, which could be in the client's home, your office, medical provider's clinic office; **encounter activity** is what you and the client did and of course the **duration of the encounter** in minutes. The DEII project used an encounter form as part of its evaluation to document the level of effort it took to implement this intervention and the types of support clients most frequently needed. Your organization or project may use a different form to document client interactions; talk to your team about what forms will be needed. Review any instructions on how to complete the forms and practice filling them out.

Client Care Plan. Similarly, the **client's name**; the identified **goal** they want to work on, such as "Keeping their scheduled appointment;" **action steps** such as, "Staff will call to remind client of medical appointment the day before the scheduled time," or "Client will use the train or bus card received by the clinic to travel to their medical appointment;" **responsible person/party** would be the client and staff person dependent on the action step; the **target date** for achievement is the date the goals is to be achieved; **outcome** is that the client kept the medical appointment; and **outcome/follow up due** date can be if the client has another scheduled medical appointment or they missed the appointment and now there is a new date.

Peers DOCUMENTATION TIPS

- Peers must document their work with clients
- Use objectivity when writing progress notes (use phrases like "client states" or "according to client," etc.)
- Using a good tool can facilitate note writing (you may document in the EMR/EHR)
- Each unit of service (support group and individual) should have a corresponding progress note if required by your organization
- Some Peers may have difficulties with learning this new way of documenting services. Ask your supervisor for support.

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 3:

- Review slide with participants and facilitate a discussion.
- Documentation represents yet another potential boundary area because if progress notes are not objective the peer may be crossing the line in terms of how the client is being characterized.
- Supervisors play a role in teaching peers how to write appropriate progress notes; this can be achieved by reviewing all progress notes during supervision or randomly.
- Review peer documentation too.

Next, we are going to do a role play on documentation in which explicit personal information is revealed by the client.

Peers

ACTIVITY-ENCOUNTER FORMS

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 4:

See the handout, "Intervention Encounter Form and Patient Care Plans"

Instruct participants that they are going to do an exercise on documentation:

Ask Participants to find the Encounter Documentation Form.

Each of you will receive a scenario about a peer interaction with a client. Read your scenario and then document the interaction using the "Encounter Documentation Form." You will have 10 minutes to complete your form. Also use the scenario to complete the Care Plan.

Ask for volunteers to share their scenarios and what they checked on the form and notes they added. Allow several responses, and then ask: What was easy and what was difficult?

Peers **ACTIVITY-CARE PLAN DOCUMENTATION**



Let's Practice

- 1a First PCP Visit Attendance
- 1b Case Management Visit Attendance
- 1c Second PCP Visit Attendance

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 5:

See the handout, "Scripts for Documentation Exercise."

Scenarios

You were provided the list of clients who have not had a medical visit in the past 90 days. You left two messages for Ava Smith and she returned your call last week. You were lucky to get a medical appointment for her today. You meet her in the waiting room and attend her first medical visit. Your appointment was a success with Ava and after explaining case management services she has agreed to meet the case manager. You connect Ava to a case manager at your agency. You and Ava decide to meet weekly to help her learn about HIV, how to prepare for her doctor visits, and the importance about adherence to medications. After multiple visits, Ava is at her second medical appt. Use the worksheet to complete your documentation.

Action step: Met client at clinic appt.

Responsible Party: peer

Target Date: August 31 2016

Outcome: Completed Notes-Patient kept medical appt

Outcome Date: August 17, 2016



The slide titled "SMART GOALS" features a graphic of a blue profile of a head with a yellow lightning bolt icon above it. To the right of the graphic is a bulleted list of the SMART criteria: Specific, Measurable, Achievable, Realistic, and Time Sensitive. At the bottom left, there is a small logo for "DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS".

Peers SMART GOALS

- Specific
- Measurable
- Achievable
- Realistic
- Time Sensitive

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 6:

Let's review some basic goals that we are restating in the SMART goal format. Examples:

- Keeping medical appointment.
- Smart Goal: I will commit to my health by showing up for my medical appointment every 3 months.
- Work with my case manager.
- Smart Goal: I will meet with my case manager monthly to get assistance with my housing, insurance payment, and mental health services by 12-15-18.

Now that you have some practice let's also use the scenario to complete the Client Care Plan.

Ask for volunteers to share their scenarios and what they checked on the form and notes they added. Allow several responses, and then ask: What was easy and what was difficult?

CLOSING

Completing intervention encounter forms or case notes and client care plans is a skill that gets better with practice. If you do not document your interaction with your client, then it did not happen. Always ask members of your team for feedback and request support from your supervisor if additional training is needed.

Next, we will review how to facilitate client education on the viral life cycle.



MODULE 7: Viral Life Cycle

Topics Covered: Viral life cycle, HIV medications, RNA, and DNA

OBJECTIVES

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

- Define immune system and components essential for HIV replication.
- Demonstrate understanding of stages of the HIV viral life cycle and the medication classes in suppressing viral replication.

MATERIALS NEEDED



POWERPOINT



FLIP CHART SHEETS



HANDOUTS

- Assessing Adherence: 10 Questions to Ask Yourself Before You Begin HIV Treatment, *Appendix 21*
- HIV Lifecycle References and Resources, *Appendix 22*

Key Words and Phrases

- *History Of HIV Medications*
- *Viral Life Cycle*
- *Attachment*
- *Fusion*
- *Reverse Transcription*
- *Integration*
- *Transcription*
- *Assembly*
- *Budding*

PROCESS

The training will begin with definitions of key terms that are instrumental in the process of viral replication.

The facilitator will lecture on mnemonic **AFRITAB**, which will help with familiarity and recollection of the stages of HIV viral life cycle. The facilitator will write **AFRITAB** vertically down the left side of a sheet of flip chart paper..

The facilitator will lecture on each stage of viral replication in the life cycle. As facilitators introduce each step of viral replication, write the name of the stage horizontally next to the letter of its correlating stage on the flipchart paper.



Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Small Group Discussion



The approximate length of time the session will take.

Total: 45 minutes

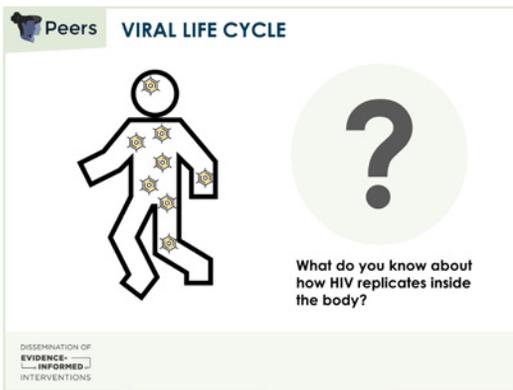
30 minutes lecture

15 minutes activity



SLIDE 1:

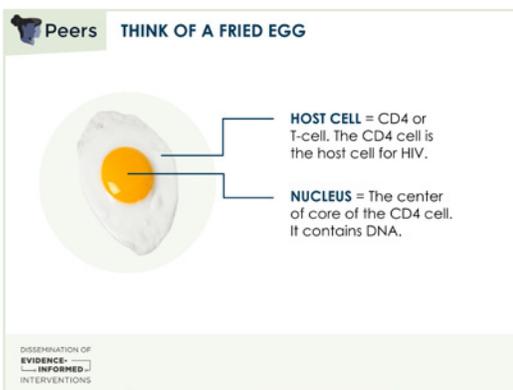
Introduce the topic of viral life cycle.



SLIDE 2:

Since the emergence of the HIV epidemic, many people have been shrouded by the myths, misconceptions, and fears about HIV’s effect on our bodies. Disturbing images of people clinging to life at the onset of the HIV/AIDS crisis have remained the prominent perspective for many even though medical breakthroughs in treatment have made living with HIV manageable. In this next section we will learn how HIV uses our immune cells to make more of itself and how antiretroviral medications interrupt HIV replication. We will describe each stage of HIV replication using an easy format to aid memorization. Understanding HIV replication has the potential to radically shift the perception of HIV/AIDS as a “Boogeyman” to recognizing the virus as a chronic, treatable medical condition.

Let’s begin by considering what you know about how HIV replicates inside the body. What did you learn about how the virus impacts a person’s health? As we move forward, keep these messages in mind to determine if they are confirmed or disproved.



SLIDE 3:

Before we move forward, we should define some key terms that will be instrumental to describing the process of viral replication. The first term is host cell. A host is an animal or plant (or specific part of an animal or plant) in which another organism or microorganism lives. HIV targets the CD4/T-cell as its host cell.

The CD4 cell is one member of a collection of cells and substances that make up our immune system. It is responsible for stimulating other immune cells to respond to infection. In this way, it is often thought of as the General of the immune system’s army.

Now, let’s get to this fried egg. The fried egg is made up of two distinct parts, the egg white and the egg yolk. This image beautifully illustrates two parts of human cells, the nucleus (egg yolk) and cytoplasm (egg white). Without getting too technical, let’s think of the CD4 cell as a fried egg.

The center of the CD4 cell is called the nucleus. Imagine that the egg yolk is the nucleus of a CD4 cell. The nucleus is important because it contains human DNA that will be used in the process of making more HIV.

To summarize, **HIV uses the CD4 cell as a host. Inside of the CD4 cell there is a core called the nucleus. The nucleus holds human DNA that will be used in the process of HIV replication.**

Peers RNA vs. DNA

RNA

- HIV carries RNA
- Contains **1 strand** of genetic information

DNA

- Humans carry DNA
- Contains **2 strands** of genetic information

DISSEMINATION OF EVIDENCE: INFORMED INTERVENTIONS

SLIDE 4:

There are two types of genetic material found in all living things, **DNA** (Deoxyribonucleic Acid) and **RNA** (Ribonucleic Acid). The main distinction that is important to how HIV replicates is knowing that HIV contains RNA, which is a **single strand** of genetic material. DNA is the genetic material stored in the nucleus of the CD4 cell and it contains **2 strands** of genetic material.

Definitions

DNA (Deoxyribonucleic Acid)—One of two types of genetic material found in all living cells and many viruses. (The other type of genetic material is RNA.) Deoxyribonucleic acid (DNA) carries the genetic instructions for the development and function of an organism. DNA allows for the transmission of genetic information from one generation to the next.

RNA (Ribonucleic Acid)—One of two types of genetic material found in all living cells and many viruses. (The other type of genetic material is DNA.) There are several types of (RNA). RNA plays important roles in protein synthesis and other cell activities.

Peers HIV LIFE CYCLE – THE BIG PICTURE

DISSEMINATION OF EVIDENCE: INFORMED INTERVENTIONS

SLIDE 5:

Let's take a look at the big picture. The image on the slide depicts the steps of HIV replication. HIV must follow several steps in order to make more of itself. You will notice that the green images represent the journey of one HIV virion* using a CD4 cell (the purple image) to replicate. In the next few slides we will describe what occurs at each one of the 7 steps.

Step 1: A = Attachment.

Step 2: F = Fusion.

Step 3: R = Reverse Transcription.

Step 4: I = Integration.

Step 5: T = Transcription.

Step 6: A = Assembly.

Step 7: B = Budding.

Definition: A virion is the complete, infective form of a virus outside a host cell, with a core of RNA or DNA and a capsid.

Peers **AFRITAB**

A	Attachment
F	Fusion
R	Reverse Transcription
I	Integration
T	Transcription
A	Assembly
B	Budding

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 6:

We will use the mnemonic AFRITAB to make it easier to remember each step of HIV replication. Each letter of AFRITAB represents a different step in the process of HIV making more of itself. Let's review the names for each step before we describe what happens during the individual phases.

Step 1

The letter A represents the first step of viral replication which is Attachment.

Step 2

The letter F stands for Fusion.

Step 3

The letter R represents the process known as Reverse Transcription.

Step 4

The letter I stands for Integration.

Step 5

The letter T refers to the fifth stage called Transcription.

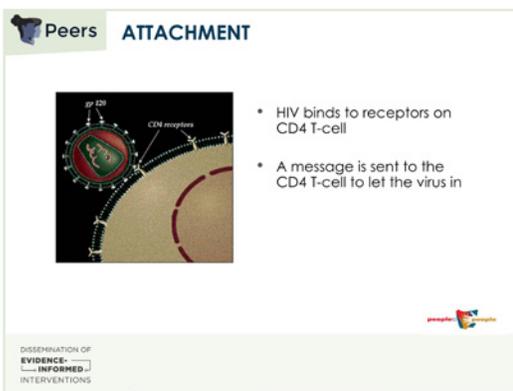
Step 6

The letter A stands for the process known as Assembly.

Step 7

The letter B represents the final step of viral replication known as Budding.

Take a minute to review the slide so that you'll become more familiar with the names of each stage. Be sure to use AFRITAB to support memorization. You might find it helpful to write AFRITAB vertically on a piece of paper and write the name of each corresponding step, essentially duplicating the slide. This will help you to commit the information to memory.



SLIDE 7:

Step 1: AFRITAB

A = Attachment.

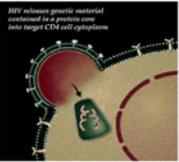
The first step in the HIV life cycle is Attachment.

Look at the image above and you'll see on the left an HIV virion (green and red image). The tan image on the right shows a portion of the CD4 cell. The image illustrates how HIV has located a CD4 (host cell) cell and has attached itself to the CD4 cell. Notice the "Y" like structures on the outside of the CD4 cell. These structures are called CD4 receptors. HIV attaches (binds) to the receptors on the CD4 cell and sends a message to the CD4 to let the virus enter.

HIV must connect to the CD4 cell receptors in a specific way in order for the message to the CD4 cell for entry to occur. If HIV does not attach correctly to the CD4 cell, the message for entry is not sent and that HIV virion will not be allowed entry into the cell.

In summary, the first step of HIV replication is Attachment. HIV attaches to the CD4 cell and sends a message to the CD4 cell to gain entry.

Peers FUSION



- Once bound, the virus is allowed to dump its contents into the CD4 T-cell
- Included in its contents are HIV RNA and reverse transcriptase

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

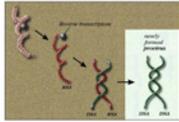
SLIDE 8:**Step 2: AFRITAB****F = Fusion****Step 2 of viral replication is Fusion.**

After HIV successfully attaches to the CD4 cell, it is ready to move to the second step called Fusion. Once bound, HIV enters and dumps its contents into the CD4 cell. The image illustrates the RNA and enzymes* carried inside of HIV.

Remember, the second step of viral replication is Fusion, when HIV enters the CD4 cell and dumps its contents. The contents include HIV RNA and reverse transcriptase (an HIV enzyme) along with other enzymes that will be described later.

Definition: Enzyme—A molecule, usually a protein, that catalyzes (increases the rate of) chemical reactions in the body. Enzymes are essential to all body functions. HIV requires specific enzymes, such as reverse transcriptase or integrase, to replicate.

Peers REVERSE TRANSCRIPTION



- The HIV RNA is turned into double-stranded DNA within the CD4 T-cell
- The enzyme reverse transcriptase aids in this process

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

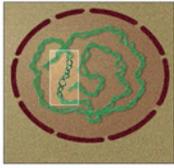
SLIDE 9:**Step 3: AFRITAB****R = Reverse Transcription****The third step of HIV replication is Reverse Transcription.**

We learned at the last stage that HIV dumps HIV RNA and reverse transcriptase* into the CD4 cell. During the third step of viral replication the HIV RNA makes a copy of itself to become double-stranded HIV DNA within the CD4 cell. The enzyme reverse transcriptase (pictured as the little ball next to the RNA in the image) aids in the process of HIV RNA becoming HIV DNA. HIV RNA must become HIV DNA in order to accomplish the next step in viral replication

The process of reverse transcription can be summarized as 1 strand of genetic material (RNA) becoming 2 strands of genetic material (DNA) using the enzyme reverse transcriptase.

Definitions: Reverse Transcriptase—An enzyme found in HIV (and other retroviruses). HIV uses reverse transcriptase to convert its RNA into viral DNA, a process called reverse transcription.

Peers INTEGRATION



- Once the DNA is formed, it hides itself in the human DNA housed in the CD4 T-Cell nucleus

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 10:
Step 4: AFRITAB

I = Integration

The fourth stage of replication is Integration.

Once the HIV DNA has been formed it moves into the nucleus of the CD4 to combine with the human DNA. The integrase* enzyme is used to integrate the HIV DNA into the human DNA. Again, Integration occurs when HIV DNA inserts itself or “integrates” into the host CD4 cell’s DNA.

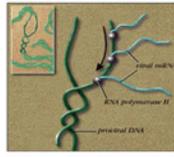
So far we have covered the first four steps of viral replication. It is a good time to review what we have learned so far.

- A = Attachment.** In step one, Attachment occurs when HIV attaches to the CD4 cell.
- F = Fusion.** In step two, Fusion happens when HIV enters the CD4 cell and dumps its contents.
- R = Reverse Transcription.** During step three, HIV RNA becomes HIV DNA (1 strand of genetic material to 2 strands of genetic material).
- I = Integration.** In step four, Integration happens when HIV DNA combines with the human DNA in the nucleus of the CD4 cell.

Let’s move on to the 5th stage of replication called transcription.

Definitions: Integrase—An enzyme found in HIV (and other retroviruses). HIV uses integrase to insert (integrate) its viral DNA into the DNA of the host CD4 cell.

Peers TRANSCRIPTION



- Copies of the HIV DNA are made and released from the nucleus in small ‘packages’
- Each of the small ‘packages’ contains information for creating a new HIV

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 11:
Step 5: AFRITAB

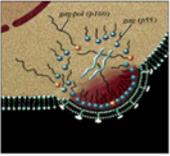
T = Transcription

Step 5 in the HIV replication cycle is Transcription.

After integration, HIV uses the CD4 like a manufacturing factory to create “packages” for making new HIV. The nucleus releases long chains of HIV RNA and proteins that contain information to make new HIV.

The key idea to remember about transcription is information for making new HIV is released from the nucleus in long chains of proteins.

Peers ASSEMBLY



The protease enzyme in the cell combines the DNA 'packages' to create active virus

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 12:
Step 6: AFRITAB

A = Assembly

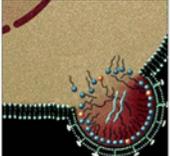
Step 6 of viral replication is Assembly.

Once the long chains are released from the nucleus, an enzyme called protease* is used to break down the long chains into smaller "packages" that line up along the edge of the CD4 cell in preparation for the final stage of viral replication. Everything needed to make new HIV is present at this point; however, it is not infectious.

In short, remember this is the stage where the "packages" of information for making new HIV line up along the edge of the CD4 cell.

Definitions: Protease—A type of enzyme that breaks down proteins into smaller proteins or smaller protein units, such as peptides or amino acids. HIV protease cuts up large precursor proteins into smaller proteins. These smaller proteins combine with HIV's genetic material to form new HIV.

Peers BUDDING



- Once the new HIV is formed, it pushes itself out of the CD4 T-cell
- The virus steals part of the CD4 T-cells protective coating

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

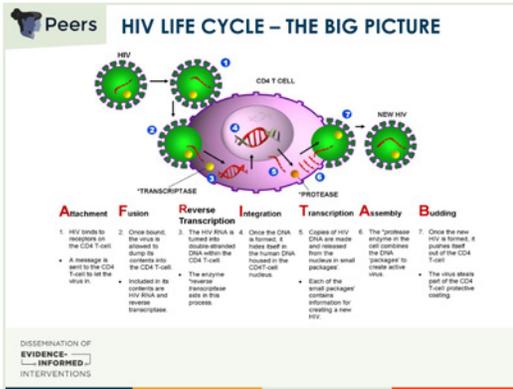
SLIDE 13:
Step 7: AFRITAB

B = Budding

The seventh and final step of viral replication is Budding.

Once the newly formed HIV has assembled along the cell wall, it pushes itself out of the CD4 cell stealing part of the cell's protective coating. The new virus matures and becomes infectious and seeks to attach to another host to begin the process again.

We've outlined the process of one HIV virion's journey of replication; however, this process happens repetitively by multiple HIV virions which can produce billions of copies daily.



SLIDE 14:

We have covered the seven steps of the HIV Life Cycle and used the mnemonic AFRITAB as a learning and memory aide. Let’s review the steps one more time as repetition helps to anchor information into memory.

1. **A = Attachment** In step one, Attachment occurs when HIV attaches to the CD4 cell.
2. **F = Fusion** In step two, Fusion happens when HIV enters the CD4 cell and dumps its contents.
3. **R = Reverse Transcription** During step three, HIV RNA becomes HIV DNA (1 strand of genetic material to 2 strands of genetic material).
4. **I = Integration** In step four, Integration happens when HIV DNA combines with the human DNA in the nucleus of the CD4 cell.
5. **T = Transcription** At step five, information for making new HIV is released from the nucleus in long chains of proteins.
6. **A = Assembly** Step six is where information for making new HIV line up along the edge of the CD4 cell.
7. **B = Budding** During the final step of replication, newly formed HIV pushes itself out of the CD4 cell stealing part of the cell’s protective coating.

Knowing how HIV replicates is important because it provides an explanation of what happens after someone contracts HIV. It is clear that HIV isn’t some mystical “Boogeyman”; rather it is a virus that uses the CD4 cell as a host to make more HIV. The process eventually destroys the CD4 host cell, which leads to poor immune function and makes it harder for the body to fight infection. Scientists use knowledge about the HIV life cycle to build an arsenal of HIV medications that are able to block replication at multiple stages of the process. When HIV medications are skillfully used, the amount of HIV in the body is drastically reduced, immune function is preserved, and people live healthier lives.

CLOSING

Next, we will review the classes of medications and how they interrupt HIV replication thus leading to viral inhibition.



MODULE 8:

Viral Life Cycle: HIV Medications

Topics Covered: HIV medications

OBJECTIVES

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

- Review the advancements of HIV medications over the span of the HIV epidemic.
- Demonstrate understanding of HIV medication classes in suppressing viral replication.



Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Small Group Activity

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- HIV Medications at Work -Activity, *Appendix 23*
- HIV Medication Drug Chart found at www.poz.com/drug_charts/hiv-drug-chart



FLIP CHART SHEETS



REFERENCE MATERIALS

- 2017 HIV Drug Chart – Positively Aware <https://www.positivelyaware.com/sites/positivelyaware.com/files/POSITIVELY%20AWARE%202017%20HIV%20Drug%20Chart.pdf> or search for newest HIV Drug Chart.

PROCESS

The training will begin with an overview of the advancement of HIV medications and its impact of extending the lives of people living with HIV.

The facilitator will review primary HIV medications within the six classes of HIV medications and link where each medication reduces replication in the viral life cycle.

The facilitator will incorporate review of classes of medications on the handouts, and emphasize once-daily medications that have positively impacted client adherence.

The facilitator will instruct participants on the activity, allow for time for completion, and manage the group discussion.

Key Words and Phrases

- *History of HIV Medications*
- *Viral Life Cycle*
- *Classes of HIV Medications*
- *Pharmacokinetic*
- *Enhancers*
- *NNRTI*
- *NRTI*
- *PI Integrase Inhibitors*
- *Entry Inhibitors*
- *Boosters*



The approximate length of time the session will take.

Total: 45 minutes

30 minutes lecture

15 minutes activity



SLIDE 1:

Introduce the topic of viral life cycle HIV medications.

Peers HIV MEDICATIONS:
A reflection of the early days

DATE	MILESTONE
1987	1 st medication, AZT was approved by FDA
1995	1 st FDA approval of combination therapy
1996	1 st protease inhibitor receives FDA approval
Today 2017	6 classes of HIV medications Several single tablet, once a day regimens

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 2:

Advancements in HIV medications have been a hallmark achievement for extending the lives of people living with HIV. When HIV was first identified in the early 1980's there was little that could be done to help those who were diagnosed with HIV. It wasn't until 1987, that the first drug, AZT, was approved by the FDA. AZT was useful in blocking replication until viral mutations caused resistance, decreasing AZT's efficacy as a single agent treatment.

Monotherapy (use of one drug) was the standard of care until 1995 when the FDA approved combination therapy (use of two or more drugs) with AZT and 3TC (Epivir®). Both AZT and Epivir worked to block HIV replication during the process of Reverse Transcription, when HIV RNA converts to HIV DNA. It wasn't until the following year, in 1996 that the first Protease Inhibitor was approved for use in combination therapy which allowed for interruption of viral replication at two different steps of the HIV life cycle.

Since HIV can easily develop resistance to single drug treatments, combination treatment was a game changer for many living with HIV. Life expectancy increased, but it was at the expense of treatment regimens containing numerous pills and multiple doses per day. The progress was slow during the onset of the epidemic; however, the new millennium brought a surge in newer, more tolerable therapies that have significantly lowered pill burden. In fact, today there are multiple single dose, once a day regimens that contain at least three different medications to fight HIV. Further, there are 6 different classes of medications, many with several medication options all designed to block HIV replication.

Finally, antiretroviral medications are not a cure for HIV; however, their benefits are significant to public health, life expectancy, and quality of life. HIV treatment medications help lower the amount of HIV in the blood, slows disease progression, reduces HIV transmission when undetectable and enable people living with HIV to have healthy, productive lives.

Note: The use of more than one drug is referred to multiple ways including, combination therapy, drug/treatment cocktails, medication regimen, HAART, ART, and cART (see below for explanation of abbreviations).

HAART- Highly Active Antiretroviral Treatment

ART- Antiretroviral Treatment

cART- Combination Antiretroviral Treatment

Peers HIV MEDICATIONS: 3 Names

HIV medications are referred to by 3 names

	EXAMPLE 1	EXAMPLE 2
Brand Name	Prezista®	Sustiva®
Generic Name	darunavir	efavirenz
Abbreviation	DRV	EFV

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

2017 HIV Drug Chart - Positively Aware

SLIDE 3:

Before we talk about the different classes of HIV medications, it's important to know that each HIV medication has 3 names:

- Brand Name
- Generic Name
- Abbreviation

In example 1, Prezista is the brand name, darunavir is the generic name and DRV is it's abbreviation. Example 2, shows Sustiva as the brand name, efavirenz as the generic and EFV as it's abbreviation.

This information is useful to know when reviewing lab results, client charts, providing adherence counseling, researching side effects and more. In fact, you may hear different disciplines use certain names more frequently. For example, a physician may refer to an HIV medication by its abbreviation or generic name when discussing a case study, but a peer might refer to the medication's brand name when working with a client. While it may not be a priority to remember the brand, generic, and abbreviation for every HIV medication, it is useful to know that a current HIV medication chart can be used as a quick reference guide. Medication charts often organize HIV medication by their class, list all three names per drug, show an image, and common dosage.

See an example of an HIV medication chart by clicking the link on the slide or copy and paste the link below into your web browser.

Peers NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIS)

NRTI's Inhibit Reverse Transcription

- Descovy®
- Emtriva®
- Efavirenz®
- Epizcom®
- Truvada®
- Viread®
- Ziagen®

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 4:

There are 6 Classes of HIV Medications:

1. NRTI's = Nucleoside Reverse Transcriptase Inhibitors
2. NNRTI's = Non-Nucleoside Reverse Transcriptase Inhibitors
3. PI's = Protease Inhibitors
4. II's = Integrase Inhibitors
5. Entry Inhibitors
6. Boosters = Pharmacokinetic Enhancers

The first class of HIV medications is Nucleoside Reverse Transcriptase Inhibitors.

Nucleoside Reverse Transcriptase Inhibitors are often referred to as NRTI's or "Nukes." This class of medications prevent HIV RNA from making HIV DNA, a process known as reverse transcription. NRTI's block the enzyme reverse transcriptase. If the HIV RNA is not converted into HIV DNA, it cannot continue on to the next phase of replication. Essentially replication is stopped when the medications intervene effectively.

The most commonly used medications in this class are listed on the slide.

NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIS)

NNRTI's Inhibit Reverse Transcription

- Efavirenz®
- Integrase®
- Sustiva®

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 5:

There are 6 Classes of HIV Medications:

1. NRTI's = Nucleoside Reverse Transcriptase Inhibitors
2. **NNRTI's** = Non-Nucleoside Reverse Transcriptase Inhibitors
3. PI's = Protease Inhibitors
4. II's = Integrase Inhibitors
5. Entry Inhibitors
6. Boosters = Pharmacokinetic Enhancers

The second class of HIV medications are Non-Nucleoside Reverse Transcriptase Inhibitors.

Non-Nucleoside Reverse Transcriptase Inhibitors are also known as NNRTI's and "Non-Nukes." Non-Nukes also work at Reverse Transcription by blocking a specific protein HIV uses for replication at this stage. This group of inhibitors also prevent HIV RNA from making HIV DNA by targeting a different point during reverse transcription.

Non-nukes are known for their sensitivity to cross resistance. According to the U.S Department of Health and Human Services AIDSinfo, "Cross resistance is when resistance to one HIV medicine causes resistance to other medicines in the same HIV drug class. (HIV medicines are grouped into drug classes according to how they fight HIV.) As a result of cross resistance, a person's HIV may be resistant even to HIV medicines that the person has never taken. Cross resistance limits the number of HIV medicines available to include in an HIV regimen.

The most common NNRTI's are listed.

PROTEASE INHIBITORS (PI'S)

Protease Inhibitor's help prevent the piecing together of HIV DNA into small 'packages'

- Evotaz®
- Prezcoibix®
- Prezista®
- Reyataz®

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 6:

There are 6 Classes of HIV Medications:

1. NRTI's = Nucleoside Reverse Transcriptase Inhibitors
2. NNRTI's = Non-Nucleoside Reverse Transcriptase Inhibitors
3. **PI's** = Protease Inhibitors
4. II's = Integrase Inhibitors
5. Entry Inhibitors
6. Boosters = Pharmacokinetic Enhancers

The third class of antiretroviral medications is Protease Inhibitors.

Protease Inhibitors are also called PI's. Protease inhibitors prevent the protease enzyme from cutting long chains of proteins into smaller packages that are used to form new HIV. These medication work at Assembly, the 6th stage of viral replication.

The most common PI's are listed.

Peers **INTEGRASE INHIBITORS (II'S)**



Integrase Inhibitors help to block HIV DNA from binding to the host cell DNA

- Isentress®
- Tivicay®

DISSEMINATION OF EVIDENCE: INFORMED INTERVENTIONS

SLIDE 7:

There are 6 Classes of HIV Medications:

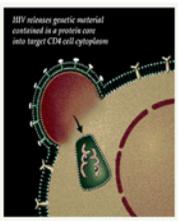
1. NRTI's = Nucleoside Reverse Transcriptase Inhibitors
2. NNRTI's = Non-Nucleoside Reverse Transcriptase Inhibitors
3. PI's = Protease Inhibitors
4. **II's = Integrase Inhibitors**
5. Entry Inhibitors
6. Boosters = Pharmacokinetic Enhancers

The fourth class of HIV medications is Integrase Inhibitors.

Integrase Inhibitors are also known as II's and work to prevent HIV DNA from binding to the CD4 host cell's DNA by disabling the integrase enzyme. Integrase Inhibitors gained FDA approval in 2007. These are potent antiretroviral agents that are well tolerated and provide options for people who may have developed resistance to several medications in other classes.

The most common II's are listed.

Peers **ENTRY INHIBITORS**



HIV releases genetic material contained in a protein coat into target CD4 cell cytoplasm

Entry Inhibitors help to block HIV's entry into the CD4 cell

- Selzentry®

DISSEMINATION OF EVIDENCE: INFORMED INTERVENTIONS

SLIDE 8:

There are 6 Classes of HIV Medications:

1. NRTI's = Nucleoside Reverse Transcriptase Inhibitors
2. NNRTI's = Non-Nucleoside Reverse Transcriptase Inhibitors
3. PI's = Protease Inhibitors
4. II's = Integrase Inhibitors
5. **Entry Inhibitors**
6. Boosters = Pharmacokinetic Enhancers

The fifth class of HIV medications is Entry Inhibitors.

Entry Inhibitors block HIV's entry into the CD4 host cell. Selzentry®, the most commonly used Entry Inhibitor is called a CCR5 antagonist because it blocks HIV from attaching to the CCR5 receptors on the surface of the CD4 cell. Another less commonly used medication in this category is Fuzeon®. Fuzeon® is a Fusion Inhibitor and prevents HIV from entering the CD4 cell to dump its contents for replication. Both medications block HIV's entry into the host cell in different ways and that's why this class is best categorized as entry inhibitors. Entry inhibitors work at the Attachment and Fusion stages of viral replication.

The most common medication is listed. Please refer to most up to date HIV Medication List.

Peers PHARMACOKINETIC ENHANCERS (BOOSTERS)

Boosters are used to boost the effectiveness of another drug.

- Tybost®
- Norvir®

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 9:

There are 6 Classes of HIV Medications:

1. NRTI's = Nucleoside Reverse Transcriptase Inhibitors
2. NNRTI's = Non-Nucleoside Reverse Transcriptase Inhibitors
3. PI's = Protease Inhibitors
4. II's = Integrase Inhibitors
5. Entry Inhibitors
6. **Boosters** = Pharmacokinetic Enhancers

The sixth class of HIV medications is **Pharmacokinetic Enhancers**.

Pharmacokinetic Enhancers are more commonly known as Boosters. Boosters are medications that are taken with another drug and used to increase the effectiveness of the other drug. They work by helping the other drug stay in the body longer at higher concentrations without increasing toxicity. Boosters are often included in single tablet regimens. These drugs do not block replication, but they boost the effects of accompanying HIV medications.

The most common medications are listed on the slide.

Peers ONCE-DAILY HIV MEDICATIONS

- Atripla®**
(Efavirenz, Emtricitabine, Tenofovir, Disoproxil Fumarate)
- Complera®**
(Rilpivirine, Tenofovir, Emtricitabine)
- Genvoya®**
(Etravirine, Cobicistat, Emtricitabine, Tenofovir, Alafenamide)
- Odefsey®**
(Rilpivirine, Tenofovir Alafenamide Emtricitabine)
- Stribild®**
(Etravirine, Cobicistat, Tenofovir, Emtricitabine)
- Triumeq®**
(Abacavir, Dolutegravir, Lamivudine)

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 10:

This final group isn't considered an official class of HIV medications, but it is useful to see them grouped together in this way. This is a grouping of **once-daily medications. Each medication is comprised of 2 or more medications that work together to block HIV replication.** This group has revolutionized HIV treatment regimens and greatly support client medication adherence. Once-daily regimens empower people living with HIV by helping to stop HIV progression, reduce amounts of HIV, and increase convenience for taking the daily dose. Continued advancements in HIV treatment move closer to a cure and provide hope for those living with this chronic, treatable medical condition.

Peers ACTIVITY-HIV MEDICATIONS AT WORK

Handouts

- HIV Medication Chart (<https://www.poz.com/drug-charts/hiv-drug-chart>)

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 11:

See handouts, "HIV Medication Chart" and "HIV Medications at Work."

Now that we have gained knowledge of how HIV medications work in supporting viral suppression we will next do an activity that can be life changing for clients who are challenged with adherence.

For this activity we will use:

- HIV Medication Chart can be found on credible websites such as **Poz.com** or Positively Aware , to name a few.
- Examples of HIV Medications at Work
- Share examples of medication regimen you are familiar with or that you are currently prescribed.
- From the prescribed example identify what class of medications the regimen falls under, for example Selzentry is found under the class of medications Entry or Fusion Inhibitor which will reduce replication at the Viral Life Cycle (VLC) Stage of Attachment.
- Facilitators will allow participants to work on the regimen examples and share with the group
 - The name of the medication
 - The drug class it falls under
 - The stage in the VLC where the medication will stop replication



SLIDE 12:

Ask the group what their questions are and respond.

CLOSING

Next, we will review understanding lab values.



MODULE 9: Understanding Lab Values

Topics Covered: Lab tests, viral load, CD4, Complete Blood Count (CBC), and resistance tests

OBJECTIVES

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

- Demonstrate importance of routine lab tests—viral load, CD4, Complete Blood Count (CBC), and resistance tests.
- Recognize the types of laboratory tests to monitor a person's HIV care and treatment.
- Link laboratory tests monitoring health in the management of HIV care leading to viral suppression.
- Understand what CD4 percentage and T-cell ratio indicate and review other significant subset tests.
- Understand what CBC and blood chemistry tests are performed and why they are checked.
- Understand the importance of having cholesterol, triglycerides, blood pressure, and glucose levels tested and how they may relate to HIV treatment adherence and care.
- Understand why laboratory tests are important in monitoring health and how they can be used to manage care.
- Identify the test name with the blood test most likely being performed.

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Lab Activity, *Appendix 24*
- HIV Resistance Testing from AIDSinfonet (which can be downloaded from www.aidsinfonet.org/fact_sheets/view/126)



FLIP CHART SHEETS



REFERENCE MATERIALS

- Care and Treatment Interventions (CATIs) Manual: Peer Linkage and Re-engagement of Women of Color Living with HIV: <https://targethiv.org/deii/deii-peer-linkage>

PROCESS

Lecture on the importance of routine lab tests as one of the most important ways clients and their healthcare provider can monitor their health.

Identify important lab tests and their frequency to monitor health—CD4, VL, CBC, resistance testing, and chemistry panel.

Define how each lab test is considered for prescribing HIV medications or medication changes. Monitor side effects and diagnosis of other co-occurring diseases.

ACTIVITY

Lab Sheet—Explain that the activity sheet identifies tests most important to HIV care and treatment and can be used for clients to track and monitor their own labs

Key Words and Phrases

- *HIV Viral Load*
- *CD4 Cell Count*
- *CD4 Percent*
- *CD4 Test*
- *Blood Chemistry Tests*
- *Viral Load Test*



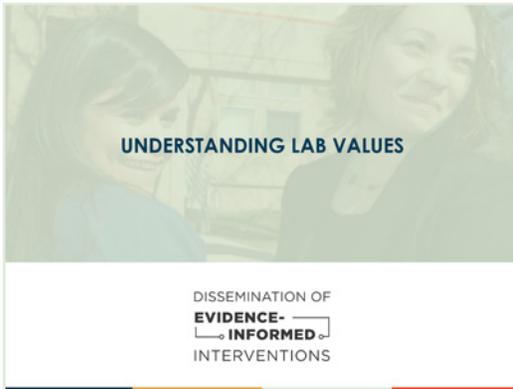
Method(s) of Instruction

- Training Methods
- Lecture
- Large Group Discussion
- Activity



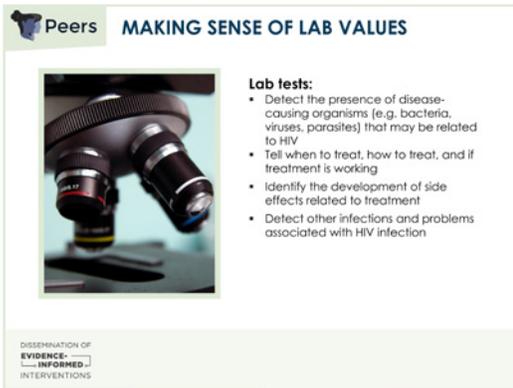
The approximate length of time the session will take.

Total: 60 minutes



SLIDE 1:

Introduce the topic of understanding lab values.



SLIDE 2:

What are the benefits of lab tests?

Lab tests are some of the most important ways clients and their healthcare provider can monitor and keep tabs on their health.

There are a wide variety of monitoring tests to help gauge HIV disease progression and the state of overall health.

It's important to be proactive and ask for a copy of their labs each and every time they meet with their doctor to review their labs.

Doctors Use Lab Tests to Monitor Health

If living with HIV, lab tests are one of the most important ways you and your versus their healthcare provider can monitor their health.

Lab tests:

- Detect the presence of disease-causing organisms (e.g., bacteria, viruses, parasites) that may be related to HIV.
- Tell the doctor when to treat, how to treat, and if treatment is working.
- Identify the development of side effects related to treatment.
- Detect other infections and problems associated with HIV infection.

As part of HIV care, the doctor will order several laboratory tests. The results of these lab tests, along with a physical exam and other information provided, will help the client and their provider work together to develop the best plan to manage HIV care so that HIV is under control, protect their health, and reduce the chance that the client will transmit the virus to others.

Peers LAB TESTS

Lab tests

- HIV viral load
- CD4 cell count
- Complete blood count (CBC)
- Lipids
- Glucose (blood sugar)
- Liver function
- Kidney function
- HIV drug resistance

TEST NAME	NORMAL	OUT OF RANGE	UNITS	REFERENCE RANGE
IMMUNOLOGY				
HIV VIRAL LOAD	< 50	> 50	RNA	< 50-125 U
CD4 T-CELL COUNT	> 500	< 500	CELLS/mm ³	500-1600
CD4 PERCENTAGE	> 15%	< 15%	%	15-35%
CD4/CD8 RATIO	> 1.5	< 1.5	RATIO	1.5-2.0
HIV DRUG RESISTANCE	N/A	N/A	N/A	N/A
COMPLETE BLOOD COUNT (CBC)				
WBC	4.0-11.0	< 4.0 or > 11.0	10 ⁹ /L	4.0-11.0
HGB	12-16	< 12 or > 16	g/dL	12-16
HCT	37-47	< 37 or > 47	%	37-47
PLATELET COUNT	150-400	< 150 or > 400	10 ⁹ /L	150-400
GLUCOSE (BLOOD SUGAR)				
FASTING GLUCOSE	< 100	> 100	mg/dL	< 100
HBA1C	< 5.7%	> 5.7%	%	< 5.7%
LIVER FUNCTION				
ALT	< 40	> 40	U/L	< 40
AST	< 40	> 40	U/L	< 40
ALP	< 120	> 120	U/L	< 120
BILIRUBIN	< 1.2	> 1.2	mg/dL	< 1.2
KIDNEY FUNCTION				
BUN	< 20	> 20	mg/dL	< 20
CREATININE	< 1.2	> 1.2	mg/dL	< 1.2
OTHER TESTS				
AMYLASE	< 50	> 50	U/L	< 50
LIPIDS	< 200	> 200	mg/dL	< 200
TRIGLYCERIDES	< 150	> 150	mg/dL	< 150
LDL CHOLESTEROL	< 100	> 100	mg/dL	< 100
HDL CHOLESTEROL	> 40	< 40	mg/dL	> 40
CHOLESTEROL	< 200	> 200	mg/dL	< 200
FASTING GLUCOSE	< 100	> 100	mg/dL	< 100
HBA1C	< 5.7%	> 5.7%	%	< 5.7%

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 3:

So what are the baseline lab tests the doctor will order? These are the most common, but they are not the only tests the doctor may request.

Baseline Tests:

- Complete blood count or CBC
- CD4 T-cell count and percentage
- Drug resistance test (this may not be required by your physician)
- Viral load test
- Chemistry panel

There are also other tests that the doctor will probably order as a baseline measurement—to be able to keep track if things change. As time goes on, these other tests will be ordered periodically, or if the doctor suspects a problem.

Let’s take a look at some of the most common tests:

- HIV viral load—provide a picture of viral activity.
- CD4 cell count—shed light on how strong is the immune system and it can help physicians predict—and therefore prevent—the development of opportunistic illnesses (OIs).
- Lipids Glucose (blood sugar)—This test measures blood sugar levels to check for signs of diabetes. This is a fasting test.
- Liver function—the liver helps process medications and can become overloaded so making sure it is functioning properly is important.
- Kidney function—some medicines affect the kidneys and may cause kidney damage.

Many factors such as time of day, recent vaccinations, and infections such as the flu may influence test results. A test that returns an unexplained or unexpected result should be repeated. A single abnormal lab result is not always cause for concern; upward and downward trends over time are usually more important.

Most labs include a “normal” range (high and low values) when they report test results. The most important results are the ones that fall outside these normal ranges. Test results often go up and down over time so don’t worry about small changes. Instead look for overall trends.

Peers WHY ARE LABS IMPORTANT?

Lab tests can help the client and their healthcare provider:

- Decide when to start HIV treatment
- Decide which HIV medicines are best
- Know whether medicines are working
- Know if any medicines are causing side effects
- Watch for other infections and problems

Understanding your labs helps you take charge of your health.

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 4:

Lab tests can help the client and their healthcare provider:

- Decide when to start HIV treatment.
- Decide which HIV medicines are best.
- Know whether medicines are working.
- Know if any medicines are causing side effects.
- Watch for other infections and problems.

For a person living with HIV, lab tests are some of the most important ways the client and their healthcare provider can monitor their health. They can help the client and provider decide when to start therapy; which medications are best, which are working, if medications are causing side effects; and helps doctors watch for other infections and problems associated with HIV.

Peers WHEN SHOULD LAB TESTS BE DONE?

When a person is first diagnosed with HIV, usually every 3 to 6 months, or whenever the healthcare provider feels they are necessary.

When a client starts taking medicines and before switching to different medicines

Even when you are feeling OK, labs can tell you things about your body that you may not be able to see or feel.

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 5:

Lab tests should be done:

- When a person is first diagnosed with HIV, usually every 3 to 6 months, or whenever the healthcare provider feels they are necessary.
- When a client starts taking medicines and before switching to different medicines.

HIV is a chronic disease and medications are so great now as compared to the early 80's when choices were fewer. Now doctors can choose when it's appropriate on a client by client basis if you need to be seen once every 4 months or 6 months depending on your health.

Peers WHAT IS A "NORMAL" LAB VALUE?

- "Normal" or "reference range" values are found on a lab report
- Lab results can be low, high, or within normal range.
- If labs are too high or too low, talk to the the healthcare provider



DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 6:

"Normal" or "reference range" values are found on a lab report.

Lab results can be low, high, or within normal range.

If labs are too high or too low, talk to the healthcare provider.

"Normal" values or reference ranges can vary from lab to lab, depending on the equipment and/or testing method used. It is important to compare results to the range shown on the lab report. Lab results can be low, high, or within normal range.

Test results can be affected by many factors, such as age or gender, the time of day when the sample was taken, active infections, HIV, and food. For example, some test samples need to be taken after fasting for several hours.

If any labs are too high or too low, it is important to discuss the results with the healthcare provider.

Peers HIV VIRAL LOAD

- Measures the amount of HIV in blood
- Very useful in deciding when to begin or change HIV medications

The goal: Keep your viral load as low as possible < 20 copies per ml blood

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 7:

HIV viral load measures the amount of HIV in blood. It is very useful in deciding when to begin or change HIV medications.

It's not necessary to cover the remainder of the lab slides. All information will be explained in the lab exercise while the class is completing the assignment and the facilitator explains as they go through the Lab worksheet.

Peers UNDERSTANDING VIRAL LOAD TEST RESULTS

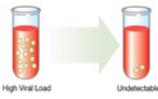
A person with HIV can have a viral load from less than 20 copies to over 1,000,000 copies per milliliter of blood (copies/mL)

Less than 20 copies/mL = "undetectable"

- Undetectable does not mean the person is cured

Less than 200 copies/mL = "virally suppressed"

- Virally suppressed means the person's virus has been controlled, but is still present but at low levels, suppressing or reducing the function and replication of a virus



One Goal: Undetectable

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 8:

A person with HIV can have a viral load from less than 20 copies to over 1,000,000 copies per milliliter of blood (copies/mL)

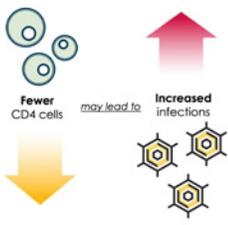
- Less than 20 copies/mL = "undetectable."
- Undetectable does not mean the person is virus free and cannot transmit the virus.
- Less than 200 copies/mL = "virally suppressed."

Virally suppressed means the person's virus has been controlled, but is still present at low levels, suppressing or reducing the function and replication of a virus.

A person's viral load can measure from less than 20 copies of HIV per milliliter of blood to more than one million copies. Although there is no cure for HIV, when your viral load is below 20 copies/mL, this is known as "undetectable" because the test is not sensitive enough to give a reliable number. Undetectable does not mean that the person is cured. You may also see less than 200 copies/mL referred to as undetectable when less sensitive tests are used.

An important goal of HIV therapy is to get viral load to undetectable.

Peers CD4 CELL COUNT



Fewer CD4 cells may lead to Increased infections

A CD4 cell count

- Measures the number of CD4 cells (also called T-helper cells) in the body
- Tells the health of your immune system
- The more CD4 cells the stronger your immune system

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 9:

A CD4 cell count

- Measures the number of CD4 cells (also called T-helper cells) in the body
- Tells the health of your immune system
- The more CD4 cells the stronger your immune system

CD4 cells are an important part of the immune system. Therefore, the CD4 cell count is a key measure of the health of the immune system. The more CD4 cells, the stronger your immune system is and the better to fight off infections.

Certain factors can cause your CD4 cell count to vary. These include time of day, fatigue, and stress. It's best to have blood drawn at the same time of day for each CD4 cell test and to use the same laboratory. When the body fights an illness, CD4 counts go up. Vaccinations can cause the same effect. Don't check CD4 cell count until two weeks after recovery from illness, or immediately after a vaccination.

Peers UNDERSTANDING CD4 CELL COUNT RESULTS

Results can be reported as two values:

- CD4 cell count (blips can be affected by stress)

500 – 1,500 cells/mm³

- CD4 cell percentage (no variance)

20% – 40%

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 10:

Results can be reported as two values:

- CD4 cell count (blips can be affected by stress).
- CD4 cell percentage (no variance).

CD4 cell tests are normally reported as the number of cells in a cubic milliliter of blood. Normal counts are between 500 and 1,500. Because CD4 cell counts can vary, some healthcare providers prefer to look at what’s called the CD4 cell percentage. The CD4 cell percentage refers to the proportion of all lymphocytes that are CD4 cells. For example, if the CD4 percentage is 34%, it means that 34% of the lymphocytes were CD4 cells. The normal range is between 20% and 40%.

Anyone who has less than 200 CD4 cells or a CD4 percentage less than 14% is considered to have an AIDS diagnosis.

In closing, understanding labs enables the client to:

- Play an active and proactive role in their health care.
- Use new knowledge of lab tests and lab values to be a partner with the medical team.
- Live a smarter, healthier life.

Peers ACTIVITY SHEET

Reviewing Sample Labs and Lab Values

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 11:

Peers ACTIVITY SHEET - LAB

DATE			
CD4	health of immune system		
CD4%	% of CD4's working		
VL	virus-enemy		
AST	liver-muscle disease		
ALT	liver-detects disease		
BUN	waste product-filtered/kidney liver dysfunction		
CREATININE	waste product-filtered/kidney liver damage		
Tigly	fat in blood		
total Ch	less than 200		
LDL	less than 130		
HDL	greater than 40		
Glucose	sugar in the blood <99		

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 12:

Let’s take a look at this Lab Activity Sheet handout.

Explain that the activity sheet identifies tests most important to HIV care and treatment and can be used for clients to track and monitor their own labs.

Peers SAMPLE – CD4 TEST

Clinical Laboratory Report

Patient Name	Date of Report	Date Drawn	Date Received
Doe, John	12/20/00	12/20/00	12/20/00
Sex	Age	Client Name/Address	I.D. Number
M	31	Medical Center 123 Main Street Anytown US 10023	78987654
Patient I.D./ Soc. Sec. Number		Specimen Number	Account Number
		918273	12343
TEST NAME	RESULT	UNITS	REFERENCE RANGE
CD3 Absolute	1942	cells/uL	625 - 2,460
CD3 Percent	82.0	Percent	60 - 90
CD4 Absolute	232.1	cells/uL	568 - 1,976
CD4 Percent	8.00%	%	35.58-65.42
CD8 Absolute	2469H	cells/uL	298-911
CD4/CD8 Ratio	0.1		>0.9

DISSEMINATION OF EVIDENCE: INFORMED INTERVENTIONS

SLIDE 13:

Point out the difference between CD4 Absolute and CD4 Percent (also see slide #10 and PowerPoint expanded notes for further explanation).

Reviewing our labs on CD4 Test, you see 4 columns:

1. **Test** – identifies the type of procedure performed.
2. **Result** – the client’s actual result or percent.
3. **Unit** – how are the results measured in cells or percent.
4. **Reference Range** – what are the normal or reference ranges for a person living without HIV as compared to the actual result of a person living with HIV. The result column will be identified as H for high or L for low when compared to the client’s actual result.

What is Mr. Doe’s CD4 Absolute or Count? **232**

Please write **232** on your Lab Activity Sheet beside CD4 Count.

Is this number considered High or Low compared to the Reference Range?

What is Mr. Doe’s CD4 Percent? **8%**

Please write **8%** on your Lab Activity Sheet beside CD4 Percent.

Is it low or high compared to the Reference Range?

The CD4 Percent is the better indicator for HIV progression for Mr. Doe. The CD4 Percent is not variable; percentages are usually more stable over time than absolute counts.

CD4 Absolute or cell counts often fluctuate due to factors including time of day (levels are usually higher in the morning), fatigue, stress, vaccinations, infections such as flu, and monthly menstrual cycles.

Peers SAMPLE – BLOOD CHEMISTRY TEST

Clinical Laboratory Report

Patient Name	Date of Report	Date Drawn	Date Received
Doe, John	12/20/00	12/20/00	12/20/00
Sex	Age	Client Name/Address	I.D. Number
M	31	Medical Center 123 Main Street Anytown US 10023	78987654
Patient I.D./ Soc. Sec. Number		Specimen Number	Account Number
		918273	12343
TEST NAME	RESULT	UNITS	REFERENCE RANGE
Sodium	135L	mmol/L	136-134
Potassium	3.8	mmol/L	3.6-5.1
Chloride	103	mmol/L	101-111
CO2	24	mmol/L	22-28
Glucose	119H	mg/dL	70-99
BUN	12	mg/dL	8-20
Creatinine	0.7	mg/dL	0.6-1.3
GFR African-American	>90	mL/min/1.73m ²	>60
GFR Non-African Am.	>90	mL/min/1.73m ²	>60
Bilirubin Total	0.4	mg/dL	0.3-1.2
AST	28	IU/L	15-41
ALT	18	IU/L	7-35

DISSEMINATION OF EVIDENCE: INFORMED INTERVENTIONS

SLIDE 14:

The chemistry panel is probably the most substantial portion of lab results, because it provides a lot of information about how the body is doing. Specifically, the chemistry panel indicates how major organs are working. The chemistry panel provides information on the heart, liver, kidneys, muscles, and bones.

Identify the test on the activity sheet – also see PowerPoint expanded notes for further explanation.

The blood chemistry, or chem panel, measures many important substances in the blood. Although the chem panel does not directly measure HIV disease progression, it can help indicate how well various organs are functioning and provide valuable information about drug side effects.

Find the Glucose, BUN, Creatinine, AST, and ALT.

Please write the results of all the procedures beside the name on the Lab Activity Sheet.

Let’s discuss one at a time:

- **Glucose** – sugar is carried in the blood in the form of glucose; it’s broken down by cells to provide energy. What is a normal glucose range?
- **BUN** – (blood urea nitrogen) is a metabolic waste product that is normally filtered out by the kidneys and excreted in the urine. Elevations may indicate kidney dysfunction or a body fluid imbalance (e.g., dehydration).

Continued on next page...

SLIDE 14: Continued

- **Creatinine** – waste product of protein metabolism is also normally excreted by the kidneys. Elevation may indicate kidney damage.
- **AST**- Aspartate Aminotransference is a measurement of liver disease.
- **ALT** - Alanine Aminotransference is a measurement of liver disease

Peers SAMPLE – VIRAL LOAD TEST

Clinical Laboratory Report

Patient Name	Date of Report	Date Drawn	Date Received
Doe, John	12/20/00	12/20/00	12/20/00
Sex	Age	Client Name/Address	I.D. Number
M	31	Medical Center 123 Main Street Anytown US 10023	78987654
Account Number	Specimen Number	Time Drawn	
12345	918273	11:00	
TEST NAME	RESULT	UNITS	REFERENCE RANGE
HIV-1 RNA, PCR	32,030	copies/ml	
	The reportable range for this assay is 20 to 10,000,000		
Log10 HIV-1 RNA	4.506	log 10copy/ml	

DISSEMINATION OF EVIDENCE: INFORMED INTERVENTIONS

SLIDE 15:

The viral load test is:

- One of the most important tests that occurs about every 3 months.
- Often considered the critical marker in the management of HIV.
- Measures the amount of HIV in the blood see slide #7 and PowerPoint expanded notes for further explanation.

Viral load tests measure the amount of HIV RNA or virus in the blood. The presence of RNA indicates that the virus is actively replicating (multiplying). Viral load is expressed as copies of RNA per milliliter of blood (copies/mL) or in terms of logs.

If the level of HIV is too low to be measured, viral load is said to be undetectable, or below the limit of quantification. However, undetectable viral load does not mean that HIV has been eradicated; people with undetectable viral load maintain a very low level of virus. Even when HIV is not detectable in the blood, it may be detectable in the semen, reproductive organs, tissues, lymph nodes, and brain.

What is this persons viral load? **32,030**

Please write the results of the HIV-1 RNA, PCR or viral load on the Lab Activity Sheet.

What is the recommended viral load for clients? Less than 20 or 40 depending on the lab.

Viral Suppression – what is meant by this term? Persons that are virally suppressed report a viral load of 200 copies or HIV-1 RNA, PCR or virus in the blood.

U=U a new term is *Undetectable= HIV Untransmittable*.

In September 2017, the CDC (Centers for Disease Control and Prevention) officially supported the medically proven claim that people who are **HIV-positive, Undetectable**, and remain **consistently undetectable** or **Virally Suppressed** (20-200 copies) for at least six months do not transmit HIV through condomless sex. Nearly 20,000 cases were studied and all HIV(-) persons remained HIV(-) (McCray & Mermin, 2017) (additional resources www.preventionaccess.org, CDC website, thebody.com - U=U What Providers Should know)

CLOSING

Understanding labs enables people living with HIV to work in partnership with their provider in their health care. Monitoring lab trends are important; however, labs should be viewed over time, not just once, to determine medical outcomes. Encourage clients to request copies of their labs prior to or at doctor visits so they can review and ask questions as this can lead to people living healthier and happier lives.



MODULE 10: Resistance

Topics Covered: HIV resistance

OBJECTIVES

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

- Define the importance of HIV drug resistance respective of HIV treatment.
- Assess when to complete testing and types of drug resistance testing.
- Understand when and what types of drug resistance testing are available.



Method(s) of Instruction

- Video
- Group Discussion
- Lecture

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- HIV Drug Resistance Cases *Appendix 25*
- GenoSure PRIme-Resistance Testing *Appendix 26*
- HIV Resistance Testing from AIDSinfonet, can be downloaded from http://www.aidsinfonet.org/fact_sheets/view/126



ACTIVITY MATERIALS:

Videos:

- HIV: Avoiding Resistance (3 minutes). Produced by Gilead Sciences, Inc 2020 at <https://www.youtube.com/watch?v=KHg61AU2zjA>

Key Words and Phrases

- *Drug Resistance*
- *Genotype*
- *Phenotype*
- *Clinical Resistance*



The approximate length of time the session will take.

Total: 65 minutes

**SLIDE 1:**

Introduce the topic of HIV/AIDS.

**SLIDE 2:****Video**

Play video on "HIV: Avoiding Resistance" Produced by Gilead Sciences, Inc.
<https://www.youtube.com/watch?v=KHg61AU2zjA>

Let's review what was discussed in the video.

What were key points you heard in the video?

Suggested responses include:

1. What resistance means.
2. How to avoid resistance.
3. How medications you take may help to fight resistance.
4. Viral load goes up when resistance occurs.
5. When levels of medications go down HIV can mutate.
6. Viral Load tests tell if your HIV medications are working.

Peers UNDERSTANDING DRUG RESISTANCE

What is drug resistance?

- Virus can adapt, grow and multiply in the presence of drugs
- A drug or class of drugs are no longer effective against the virus

What causes drug resistance?

- Rapid replication of HIV sometimes results in mistakes (mutations)
- These mutant viruses become resistant to therapy

If a drug does not work against a mutated virus, that virus will reproduce rapidly.

- Viral load increases
- May have to change drugs to get HIV under control

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 3:**What Is HIV Drug Resistance?**

HIV drug resistance means that the virus can adapt, grow, and multiply in the presence of the drugs.

Physical changes or mutations in parts of the virus that prevent the medications from working cause resistance.

These mutant viruses continue to make copies of themselves, further reducing the effectiveness of an individual's HIV therapy. HIV mutates almost every time a new copy is made. Not every mutation causes resistance. The "wild type" virus is the most common form of HIV. Anything different from the wild type is considered a mutation.

An antiretroviral drug (ARV) won't control a virus that is resistant to it. It can "escape" from the drug. HIV is considered to be drug resistant when a drug or class of drugs is no longer effective against it.

What causes resistance?

HIV replicates very rapidly and makes many mistakes (mutations) in the process. However, HIV doesn't have the ability to correct these mistakes. This results in mutant viruses that can be resistant to one or more of the drugs used in HIV therapy. These mutant viruses continue to make copies of themselves, further reducing the effectiveness of an individual's HIV therapy.

If HIV medications do not work against a mutated virus:

- Your viral load will increase.
- You may have to change your drug regimen to get your viral load under control.

In summary resistance can occur:

1. When a person misses or is non-adherent to their HIV medications.
2. During condomless sex with a person living with HIV who is not virally suppressed.
3. When a person who is not virally suppressed and is resistant to HIV medications transmits HIV to someone else.

Drug resistance is very common.

Peers UNDERSTANDING DRUG RESISTANCE

HIV drugs are used in combination to block reproduction in HIV's lifecycle

- Combination of drugs aimed at several different targets of the VLC

How common is drug resistance?

- Resistance is common and is a major challenge in HIV treatment:
 - Decreases ability of HIV drugs to control the virus
 - People with HIV and a history of substance use are more likely to have resistant virus
 - 3 out of 4 people failed treatment because of drug resistance
 - 1 out of 4 newly infected are already resistant to at least 1 class of drugs
 - Viral load tests help determine drug resistance

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 4:

Refer to slide for talking points.

Peers DRUG RESISTANCE TESTING

Drug resistance testing provides:

- A picture of therapy options
- Helps avoid unnecessary drug side effects and cost of meds associated with taking drugs that are not likely to work
- Development of effective treatment plan

How is drug resistance tested?

- **Phenotypic testing** - Assesses the ability of the virus to replicate in the presence of ARVs/medications
- **Genotypic testing** - Identifies genetic mutations in an individual's HIV which are known to be associated with drug-resistant HIV. Results indicate sensitivity or resistance to drugs; most common test

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 5:

Some resistance tests are called **genosure** or **phenosure tests**.

Both tests show if a person has become resistant to HIV medications and they no longer work. In this case a physician will need to change the client's medication regimen.

The test usually shows the word resistant or sensitive next to the name of the medication.

- **Sensitive** = client not resistant to the drug;
- **Resistant** = client is resistant to the drug;
- **Resistant Possible** = if the client continues on the path of not taking the drug properly they will soon develop resistance.

Genotypic tests are normally performed at the first lab visit to determine if the person that contracted HIV already has resistance from the person that transmitted the virus to them. Physicians may or may not tell the client they are performing the test.

Phenotypic test is offered after clients have been non-adherent and gone through most HIV medications with multiple resistance. For the test, HIV medications are in a petri dish and the person's blood sample is put into each medication slot and allowed to cure overnight. The test is costly but does show the physician which medications a client can still take that may provide benefit and slow the progress of the HIV.

Peers

RESISTANCE TEST RESULT EXAMPLE

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 6:

See the handout, "GenoSure PRIme-Resistance Testing." *Appendix 26*

Peers DRUG RESISTANCE TESTING



When should drug resistance testing be used?

- Before therapy begins
- Following treatment failure

How to prevent drug resistance?

- Taking HIV drugs on time, every time
- Not sharing needles or having sex without a condom with someone else who has HIV

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 7:

Genotype tests are generally performed **before therapy begins**. Because drug-resistant strains of HIV can be passed from one person to another, resistance testing can be used to evaluate drug resistance in newly diagnosed people. The results can help a healthcare provider work with an individual to design a targeted treatment plan that is more likely to be effective for a longer period of time. By using information about how resistance develops when certain drugs are used, healthcare providers can design combinations of drugs that will preserve more treatment options if therapy failure occurs later on down the road.

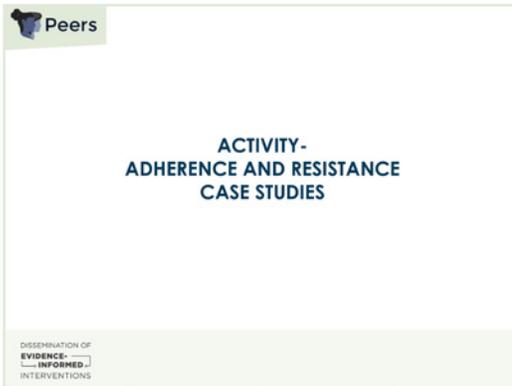
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SLIDE 7: Continued

Phenotypic is performed **when treatment has failed due to non-adherence**. When a person no longer benefits from their HIV therapy (treatment failure) and viral load is increasing, drug resistance testing can help determine which drug or combination of drugs is no longer effective. A treatment plan can then be developed that is more likely to slow HIV replication.

Being adherent is the best way to prevent drug resistance. Drug resistance testing can also be used **during the course of an individual's therapy**. Periodic testing when HIV is detected in plasma can help gauge therapy effectiveness and drug resistance, so that treatments can be altered as needed.

Treatment failure defined: Treatment failure occurs when an antiretroviral (ARV) regimen is unable to control HIV infection. Treatment failure can be clinical failure, immunologic failure, virologic failure, or any combination of the three. Factors that can contribute to treatment failure include drug resistance, drug toxicity, or poor treatment adherence. From: <https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/873/treatment-failure>

**SLIDE 8:**

See the handout, "HIV Drug Resistance Cases."

Let's look at a couple of case scenarios.

- Divide into 2 groups.
- Read the scenario and discuss as a group what you would do and How would you respond?
- Decide who will be reporter in the group that will present to the class.

If completing as a class activity, select the scenario, read to the class, and ask who would like to comment on what they would recommend.

CLOSING

Drug resistance is the body saying that the current HIV medications are not working to reduce replication of the virus. It is helpful for clients to understand how to reduce their chances of drug resistance.



MODULE 11:

Adherence

Topics Covered: Factors that affect adherence

OBJECTIVES

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

- Define medication adherence for people living with HIV.
- Discuss factors, at both an individual and environmental level, that impact adherence.
- Practice assessing adherence with clients and identifying resources to support adherence.



Method(s) of Instruction

- Lecture
- Brainstorm
- Activity Sheet

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Assessing Adherence : 10 Questions You Should Ask.
Appendix 27

PROCESS

In this activity you will:

- Share definitions with group (25 minutes).
- Review the handout, Assessing Adherence: 10 Questions You Should Ask.
- Provide different adherence tools that are used (10 minutes)
- Lead a group discussion to summarize about tools and strategies to use for adherence:
 - Follow the PowerPoint presentation on adherence;
 - Use slide notes as a reference during presentation.
- Ask questions provided and facilitate group discussion.
- Ask participants to brainstorm adherence tools that they and their clients have used.

Key Words and Phrases

- *Adherence*
- *Adherence Tools*
- *Viral Load*



The approximate length of time the session will take.

Total: 60 minutes



SLIDE 1:
Introduce the topic of adherence.



SLIDE 2
Ask—How do you define adherence?
Adherence means taking your medications correctly.

Ask—Has anyone missed or stopped taking a prescribed antibiotic?
If so, what were some of your barriers that kept you from finishing the antibiotic?

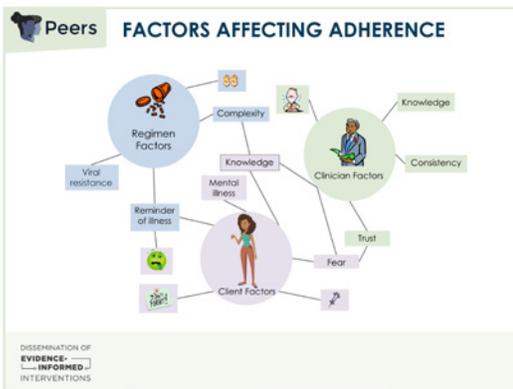
People living with HIV are told by their providers to take their HIV medications everyday; however, this has to be a skill that is learned, especially if they are a person that does not have a history of taking meds. If they don't take HIV medications every day, HIV might multiply out of control. For the best viral load results, it is recommended that people living with HIV should take over 90% of their pills correctly.

We often don't ask clients about their readiness to start medications.

Let's take a look at this handout—10 Questions to Ask Yourself Before You Start. Participants can take turns reading the questions on the handout.

Clients must be able to:

- Understand the regimen (the Who, What, When, Where, Why? of treatment).
- Believe they can adhere.
- Remember to take medications.
- Integrate medications into current lifestyle.
- Problem solve changes in schedule and routines.



SLIDE 3:
There are many factors that affect adherence.

Discuss client factors that affect adherence, such as the barriers to adherence pictured.

What behaviors may signal non-adherence?

Peers CLIENT FACTORS AFFECTING ADHERENCE



- Knowledge of treatment regimen
- "Fits" with lifestyle
- Stage of disease, level of wellness
- Support system
- Belief in HAART effectiveness
- Fear
- Ability to control side effects
- Mental health
- Substance use
- Stigma
- Believing that the drugs are ineffective
- Denial of HIV status

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 4:

Engage participants and teach from PowerPoint.

Client factors that often affect adherence.

HAART stands for Highly Active Antiretroviral Therapy.

Peers ENVIRONMENTAL FACTORS THAT IMPACT ADHERENCE

- Transportation
- Housing
- Food
- Drug treatment
- Mental health service
- Social network
- Child care
- Addressing cultural norms



DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 5:

Discussion: What are some of the walls or barriers that providers, agencies, and the community at large have built that make it difficult for clients to adhere?

Name some barriers created by organizations.

- Clinic hours—time flexibility.
- Clinic personnel that do not return calls.
- What about enrolling in insurance plans such as ADAP, Ryan White plan, or Affordable Care Act (ACA) insurance plans?
- Clinic employee breaching confidentiality or meeting someone you know.
- Finances—paying for HIV medications.
- Transportation—in the case of meds. Could a peer or specialty pharmacy help by mailing or pick-up?
- Do providers know or refer clients to practical (hands-on) resources (e.g., support groups, hot meals, etc.)

Can you think of any thing else that providers or agencies can do to help clients be successful in improving adherence?

Peers MANIFESTATIONS OF POOR ADHERENCE



- Not having prescription filled
- Taking an incorrect dose
- Taking medication at the wrong time
- Missing medication doses
- Stopping therapy too soon
- Taking over-the-counter medications that interfere with prescribed medication

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 6:

As we mentioned in our discussion, non-adherence can take many forms. These are more personal actions to non-adherence.

Peers PROBING QUESTIONS FOR ASSESSING ADHERENCE

What is the reason you are taking this drug?
 How do you take this medication?
 Are you taking this medication with food?
 Where did you receive information about this medication?
 What do you use to help you remember to take your medication?
 What do you do when you miss a dose?
 What problems have you encountered while taking this medication?

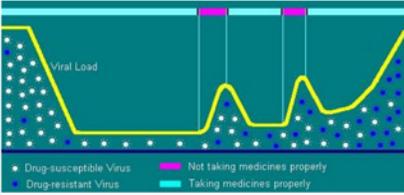


DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 7:

Here are some questions you can ask clients to assess their adherence to medications they are currently taking to possibly gauge how adherent they are.

Peers VIRAL LOAD AND NON-ADHERENCE



DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 8:

This chart shows a high viral load when a person is not taking medications. As you look to your left and see drug susceptible viruses that can be controlled by taking medication, there are fewer blue resistant viruses. However, to your right you see a lot of blue drug resistant viruses in the absence of medication.

Peers ASSESSING ADHERENCE

10 Questions You Should Ask Handout

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 9:

See the handout, "Assessing Adherence: 10 Questions You Should Ask" This handout may be used as a resource to assess adherence. Review the handout and allow for discussion.

**SLIDE 10:**

Have adherence tools available to pass around (e.g., medication watch, calendars, pill bottles, and trays etc.) for in person training.

What tools can peers use to support adherence with clients?

- Self-monitoring (pill boxes, tracking booklets).
- Pharmacy automatically refills medications.
- Location of pill boxes.
- Create individual adherence plan.
- Develop problem-solving skills.
- Habit building/cueing (integrating adherence into daily routines).
- Reinforcement (accountability coach, reviewing lab values).
- Incentives (better health, staying in relationships, connecting to values).
- Electronic reminders (Cadex watches, pagers, cell phones).
- Research on the medication options and a lengthy discussion with your doctor.
- Reduced pill burden.
- Scheduling medications based on dietary requirements, such as taking them at snack times or when your stomach is empty .
- Scheduling particular dates monthly on the calendar to request refills of medications.
- Planning ahead if you are going to be out of town to ensure you have sufficient medications.

CLOSING

It is important for the client to have open communication with their provider as they decide treatment options.

Wrap up by reminding the group that clients will have to make their own decisions about adhering to medications. What we can do is provide support and information regarding the important of adherence, and that's a lot!



MODULE 12:

Confidentiality and Creating Boundaries in the Workplace

Topics Covered: Confidentiality, boundaries

OBJECTIVES

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

- Define the importance of establishing and maintaining confidentiality and boundaries in the workplace.
- Assess the importance of confidentiality and HIPAA laws and exceptions to data sharing without consent in sensitive situations.
- Demonstrate understanding of consequences of breaking confidentiality through case-based scenarios.
- Understand why it is important to establish and maintain confidentiality and boundaries in the workplace.
- Understand the importance of confidentiality and HIPAA laws.
- Understand situations when HIPAA data can be released without consent.



Method(s) of Instruction

- Lecture
- Brainstorm
- Activity Sheet

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Confidentiality and Boundaries Scenio-Activity, *Appendix 28*
- Short Boundary Scenarios, *Appendix 29*



REFERENCE MATERIALS

- Boundaries with Brené Brown:
www.theworkofthepeople.com/boundaries



FLIPCHART

PROCESS

The facilitator will begin with a discussion on the definition and importance of confidentiality (HIPAA Laws) at organizations to protect privacy of both its employees and clients.

Lecture on HIPAA Laws that allow the release of information without the client's authorization in sensitive situations at the discretion of the providers' judgement and client's interest. Discuss impact of data sharing without consent.

Lecture on definition of types of boundaries in the workplace and in client/peer relationships with link to transference and counter transference. Facilitator to lead discussion and elicit feedback on examples of situations.

The facilitator will inform group of tips to boundary setting and steps to manage situations when boundaries are not honored.

ACTIVITY

- Divide class into groups and pass out confidentiality/boundary scenarios (dependent on size of class – 4 scenarios are available).
- Short Boundary scenarios (facilitator can opt to review short scenarios in class discussion).

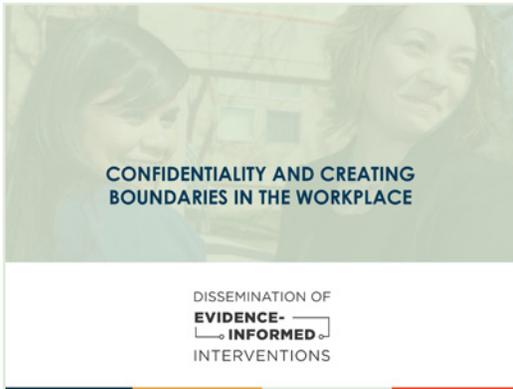
Key Words and Phrases

- Confidentiality
- Boundaries
- HIPAA
- Transference



The approximate length of time the session will take.

Total: 60 minutes



SLIDE 1:

Why would it be important to ensure that confidentiality and boundaries are established in the workplace?



SLIDE 2:

As previously mentioned, confidentiality ensures security of delicate information, protects clients, and prevents crimes and discrimination. In the wrong hands, client information can be misused which can result in costly lawsuits for the employer, healthcare worker, or peer.

HIPAA is a federal act established to maintain and protect the rights and interest of clients; any disclosure of sensitive information can lead to a loss of trust in the organization, and between the organization and client relationship.



SLIDE 3:

HIPAA regulates healthcare providers' use and disclosure of individually identifiable health information (known as Protected Health Information). Refer to the slide that defines HIPAA.

Privacy under HIPAA may also include discussions about client's medical information or for what can be viewed as a casual "ask" – **for example:**

- A clinic asking a client "what are you here to be seen for" in a room filled with waiting clients;
- A doctor or healthcare provider entering a client's hospital room talking about their HIV health status in the presence of family to whom the client has not disclosed;
- A pharmacy asking if a customer has had side effects and naming the medication in the presence of waiting customers.

Has a provider or pharmacist asked for your date of birth in the presence of waiting customers? Highly likely that the question was asked discreetly as most want to keep that information private.

Peers HIPAA

Situations when HIPAA data can be released without client's permission or consent:

- Reporting abuse, neglect or domestic violence
- Prevent serious threat to health and public safety
- Reporting to Department of Public Health for health purposes
- Inform appropriate bureau during disaster relief
- Workers Compensation
- Food and Drug Administration - expected drug side effect or food product defects and recalls
- Correctional institution
- Funeral directors, medical examiners, coroners, procurement of organ, or certain research purposes
- Notify family members, legal guardian involved in the client's care for notifying them of a person's location

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 4:

There are situations when HIPAA data can be released without a client's permission or consent.

Refer to the PowerPoint.

Another major exception is when medical care providers need to release information to other providers who are involved in the client's care.

Physicians do not need a specific authorization to share information with specialty consultants they talk to, with labs performing medical testing, or with a billing service who prepares the physicians' bills. These businesses that provide services to the medical care providers must agree to protect the client's information in the same way that the provider must protect it.

In special circumstances, HIPAA allows medical information to be released when necessary to identify clients.

In one case, a woman without identification was struck by a car and brought into the hospital in a coma. Her picture and medical condition were released to the press to try and find any relatives or others who could identify her.

Peers BREAKING CONFIDENTIALITY

Consequences of breaking confidentiality include:

- Employee reprimand, warning, or dismissal
- Client may be embarrassed
- Client will lose trust in Peer Educator and agency
- Client may file charges against Peer Educator and agency
- Agency could be fined criminal penalties for disregarding HIPAA



DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 5:

While HIPAA protects the confidentiality of certain information in the workplace there are severe consequences for breaking confidentiality that include:

Refer to PowerPoint.

Confidentiality is often assured under an organization's policies and anyone who breaches the agreement is liable to a lawsuit.

What steps can be taken to better protect confidential information?

- Written confidentiality policies and procedures
- Employee handbooks documenting/describing:
 - Type of information that is considered confidential.
 - Procedures that employees must follow for protecting confidential information.

Peers WHAT ARE BOUNDARIES?

Boundaries are standards and limits developed to create an environment of safety and well-being.

Common boundaries are:

- Physical boundaries- one's sense of personal space
- Time and place boundary - when, where to meet
- Emotional boundaries - feelings that separate an individual from others
- Personal belief

Boundaries can also be defined as

- A dividing line between you and anyone else, even a loved one
- The line represents both physical and emotional limits others may violate

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 6:

Refer to the PowerPoint to describe common boundaries.

Physical boundaries—examples when physical boundaries are not respected:

- When someone approaches to talk about an issue and they get too close.
- Looking through client files, documents without permission.
- Inappropriate touching, such as unwanted sexual advances.

Time and place boundary

Time boundaries refer to markers of time

Examples:

- Start times and end times for work.
- Allotting time to meet with a client that allows for enough time to achieve goals.
- Ending a meeting with a client after an appropriate period of time, even if the client wants to continue.

Place boundary

- Place boundaries—define best practices for where peers meet with clients (public places only, no home-visits alone, defined by the agency's rules).
- Consider safety issues and the role of peer work.

Emotional boundary

- Blaming others, not taking personal responsibility for actions.
- Imposing one's feelings or ideas on another.
- Allowing client statements to have a negative impact on services you (peer) are providing; client may insist that they are not being helped.

Personal boundary

- Personal beliefs include one's worldview, values, and life philosophies.
- Personal beliefs include one's religious beliefs and political beliefs, etc.
- We all have a right to our beliefs, but sometimes our actions must be controlled in order to respect the rights of others. This is an example of holding a boundary.

When we talk about boundaries being a dividing line, it's a limit or space between you and the other person; a clear place where you begin, and the other person ends.

Think of it as a fence in your backyard. You are the gate keeper and get to decide who you let in and who you let out, who you let into the whole backyard, or who you let just inside the gate. You may still be keeping a distance, but you are giving them a chance to prove their trustworthiness both physically and emotionally.

The purpose of setting a healthy boundary is, of course, to protect and take good care of yourself.

Peers TRANSFERENCE

- A term used in psychology to describe feelings that clients develop towards providers
- The term is used when a provider suspects that the client's feelings are strongly influencing the way the client is experiencing the provider and the services being received
- The term implies that the client's feelings partially arise out of the client's history, and are based on beliefs that were formed during prior relationship experiences

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 7:

Transference is a term used in psychology to describe feelings that clients develop towards providers.

So, these are feelings that can be experienced by clients toward their providers that might signal "caution" for you.

For example: Your client has mentioned that you remind them of a partner they had in a previous relationship. Then, without the client realizing it they begin bringing you gifts as one would do in a relationship.

What should you do? Answer: Seek out a clinical supervisor for coaching and support.

Peers CONFIDENTIALITY/BOUNDARIES WITH STAFF/CLIENTS/PEERS

Some situations that are not ethical and not allowed as a Peer:

- Sexual or romantic
- Financial and professional
- Housing relationships between Peer and clients
- Solving personal and financial problems
- Witnessing or engaging in destructive criticism or gossip about the agency, client, patients, or volunteers
- Peer providing services to someone who is also a friend*

*Advise discussion with supervisor

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 8:

This is very critical in working with all three entities i.e., clients, staff, and peers.

In these situations, boundaries that should not be crossed under any circumstances.

Let's read each one and give an example for each bullet.

Peers BENEFITS OF BOUNDARIES

- Crossing boundaries create intense feelings of anger, hurt, outrage etc....
- Boundaries ensure that others do not cross the line
- Boundaries make you feel safe, healthy, good
- Boundaries make others feel safe around you
- Boundaries let others know your limits
- Boundaries set relationship guidelines; people know how to behave around you



DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 9:

As mentioned previously, establishing and maintaining appropriate professional and personal boundaries allows the peer to better protect themselves, clients, and employers.

Setting clear personal boundaries is the key to ensuring relationships that are mutually respectful, supportive, and caring.

Other benefits of setting boundaries are:

1. **More compassion.** According to Brene Brown, Ph.D., people with strong boundaries are the most compassionate. Letting people know what's OK and what's not OK is kind and respectful. Watch this five minute video of Dr. Brown explaining the connection between boundaries and compassion for a deeper understanding. <https://www.theworkofthepeople.com/boundaries>
2. **Greater assertiveness.** Boundaries are a way of asserting your needs.
3. **Your needs are met.** We all have emotional and physical needs and we all deserve to have our needs met (some we meet ourselves and some are met in relationships). When you speak up and ask for what you need, you're much more likely to get it!
4. **Less anger and resentment.** When you let people walk all over you, you feel angry and resentful. You probably find you're self-critical and angry with yourself for being passive, fearful, and letting others take advantage of you. And you're angry and resentful at others for mistreating you. When you communicate your needs and expectations clearly (i.e., have healthy boundaries), you are unlikely to build up resentment and anger.

Continued on next page...

SLIDE 9: Continued

5. **Feeling of peace and safety.** Boundaries also provide emotional freedom from needless energy spent beating yourself up and second guessing yourself. When you don't set boundaries, you get stuck in shame and self-doubt. you criticize yourself for not asking for respect and allowing others to mistreat you.
6. **Time and energy to do things that nourish and bring joy to your body, mind, and spirit.** And, finally, when you say "No" to things you don't want to do and people who drag you down, you say "Yes" to spending time with people who fill you up emotionally, activities that you're interested in and enjoy, and to a happier, healthier self.

Peers TIPS FOR SETTING BOUNDARIES

- Do it clearly - without anger and few words
- Avoid justifying, rationalizing or apologizing
- Tell what the person did
- Don't set a boundary and take care of another's feelings
- Don't allow guilt to keep you from setting a boundary
- Be ready to enforce a boundary once it's set
- Follow through
- Be prepared for people to get angry when you set a boundary

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 10:

To set boundaries we have to communicate, be intentional and assertive.

Other tips for setting boundaries are:

- Do it clearly, without anger and in few words.
- Avoid justifying, rationalizing, or apologizing.
- Tell the person what they did that crossed your boundaries.
- Don't set a boundary and take care of another's feelings.
- Don't allow guilt to keep you from setting a boundary.
- Be ready to enforce a boundary once it's set.
- Follow through.
- Be prepared for people to get angry when you set a boundary.

Setting boundaries is not about making threats; it's about giving choices. We can have a healthy relationship doing peer work with appropriate boundaries.

SLIDE 11:

When a client crosses your boundaries:

- **Inform** – Let the person know what they are doing using "I" statements
- **Instruct** – Let them know what you want them to do
- **Take a stand** – Stop
- **Time Out** – Step out of the situation briefly for your safety

Peers WHAT TO DO WHEN SOMEONE CROSSES YOUR BOUNDARIES

Inform – Let the person know what they are doing using "I" statements

Instruct – Let them know what you want them to do

Take a stand – Stop

Time Out – Step out of the situation briefly for your safety

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

**SLIDE 12:****Group Activity:**

See handouts, "Confidentiality and Boundaries Scenarios 1-4," "Short Boundary Scenarios for Group class participation, or handout (optional)."

CLOSING

We have often been told that legal authorities (i.e., police, immigration etc.) have the right to gain information at will. However, we learned in one of the scenarios that there are proper and improper procedures that should be followed when information is being requested. Each agency should have their own protocols in place. Understanding confidentiality and knowing and exercising boundaries in the workplace or off-site keeps everyone safe and professional.



MODULE 13:

Developing a Network of Support

Topics Covered: Trusted support, self-disclosure

OBJECTIVES

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

- Define Trusted Support.
- Distinguish between the types of support needed for building a personalized network of support (e.g., informational, practical and emotional support).
- Identify specific people, institutions, or resources to fulfill roles in their support network.
- Brainstorm value to clients for using the process of identifying a network of support.
- Identify considerations for working with a client who is planning to disclose their HIV status.



Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Individual Activity

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Trusted Support Inventory Worksheet, *Appendix 30*
- Disclosure Tips Handout, *Appendix 31*



REFERENCE MATERIALS

- <https://effectiveinterventions.cdc.gov/en/2018-design/persons-living-with-hiv/group-4/willow>
- <http://www.shanti.org/pages/about-life.html>



FLIPCHART

PROCESS

The training will begin by defining trusted support and three types of support needed for building a network of support.

Facilitator will encourage participants to discuss their plans for helping clients develop their own personalized trusted support network.

Review key considerations when assisting clients with plans to disclose.

Key Words and Phrases

- *Trusted Support*
- *Peer Support*
- *Support Networks*
- *HIV Support*
- *Emotional Support*
- *Informational Support*
- *Practical Support*



The approximate length of time the session will take.

Total: 45 minutes

**SLIDE 1:****Instructions:**

Tell participants we are going to define trusted support and identify types of support that are helpful for people living with HIV. Discussing this topic can be liberating for some, while others engage with reluctance. With that understanding, offer participants the option of passing during discussions. Encourage participants to engage to their level of comfort. That said, let's delve into the topic of trusted support.

Ask participants:

What comes to mind when you hear the term trusted support?

Why trusted support instead of merely saying support?

Allow responses.**SLIDE 2:**

Thank participants for responding and define trusted support.

Trusted support is defined as someone with whom you feel comfortable and safe when sharing personal information. Trusted support is often found in a person, but it can also include institutions and resources. As we consider who might be trusted support, it is important to determine the type of support they can offer. Let's discuss three types of support.

Ask participants to provide examples of each type of support from their own experiences:

- **Informational support** is the type of support that someone provides by answering questions or giving professional advice or suggestions. Informational support usually comes from professionals such as doctors, nurses, social workers and so forth. It can also come from knowledgeable family members and friends.
- **Practical support** is a type of support that usually involves someone lending a helping hand. Practical support usually comes from family, friends or other people you are close to. Sometimes organizations provide practical support through various services rendered.
- **Emotional support** occurs when a help is provided with emotional issues, especially when we need a shoulder to lean on. Emotional support usually comes from family, friends, people we are very close to, and often counselors and spiritual leaders.

Peers WHO IS MY TRUSTED SUPPORT?

Name of possible trusted support person	Types of support
<ul style="list-style-type: none"> ▪ Janet Blue, Peer ▪ Dr. Friend ▪ Mama ▪ BFF 	HIV status, health concerns, relationship issues, financial problems, family problems, sexual issues, drug/alcohol use, stress and emotional issues, medical care, legal issues and other _____.

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 3:**Activity (Use Trusted Support Inventory Worksheet)**

- Instruct participants that they are going to create their own network of support by identifying key people, institutions, or resources that they trust to provide specific types of support.
- Direct participants to the Trusted Support Inventory Worksheet. Tell them to list as the people, institutions, or resources one per box on the left side of the worksheet. Once complete, circle the type of support you trust them to provide.
- Encourage participants to write additional areas of needed support in the spaces provided. Allow five to ten minutes to complete.
- Reconvene the group for discussion.
- Ask participants to share their support networks, allowing participants to share one to two responses.
- To deepen the discussion, ask any of the following questions:
 - What specific characteristics does this Trusted Support person/entity possess that influenced your decision.
 - Would you trust this person to provide other types of support (e.g., emotional or practical support)?
 - What value can creating a network of support bring to a client?
 - What benefits does this activity offer?
 - What barriers do you perceive with this activity?

Thank participants for sharing and summarize.

- Building a Trusted support network involves careful consideration for who can provide the types of support that is needed.
- It can be rare to have one trusted support person meet every need; therefore planning ahead is a proactive choice that can enable your client to respond to their needs quickly.
- Receiving and employing trusted support involves risk, but careful consideration may lessen the potential for a trust breach.
- People who have support they believe is trustworthy can experience health boosting effects from said support.

Bridge:

- Now that you have identified your trusted support network, we will discuss key factors for making plans to disclose.

Peers SELF-DISCLOSURE ACTIVITY



What considerations/best practices come to mind when preparing to reveal one's HIV status?

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 4:

See the handout, "Disclosure Tips".

Instructions:

Share: Now that you've developed a network of trusted support on paper, the next step is to consider how your clients might disclose to individuals who are not aware of their HIV diagnosis. This is often the point when people living with HIV become concerned for a number of reasons, many of which we explored in the previous exercise. For this reason we will work together to identify key considerations a person who wishes to disclose should keep in mind.

- Divide participants into pairs.
- Allow each partner three to five minutes to gather their responses to the following questions.
 - **What considerations/best practices come to mind when preparing to reveal one's HIV status? (Brainstorm as many factors in the time allotted)**
- Advise participants to be realistic and use their lived experiences or stories they have heard from their clients and acquired knowledge to inform their brainstorm.
- Reconvene the pair groups and facilitate a large group discussion. Ask participants to share their top three concerns and offer their rationale.
- Follow the discussion by acknowledging there is no cookie cutter approach to self-disclosure because people and their circumstances are different. There are some general guidelines that work well for most people. Show examples on the next slide.
- Note any overlap from group responses and the list of disclosure considerations.
- Distribute the Disclosure Tips Handout and use the information to summarize this section.
- Be sure to include that self-disclosure is a decision that can involve many factors. Participants are encouraged to review their state laws regarding any criminal codes for HIV prosecution.

Peers DISCLOSURE CONSIDERATIONS



- Be selective
- Consider the 5W's and H (who, what, when, where, why and how)
- Take your time and keep it simple
- No need to apologize
- Avoid isolating
- Trust your gut
- RELAX

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 5:

Use prompts on the slide for review and discussion.

CLOSING

Next, we will review the impact of stigma and access to care.

MODULE 14:

Stigma

Topics Covered: Stigma

OBJECTIVES

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

- Demonstrate understanding of stigma and its impact on access and engagement of services for people living with HIV.
- Practice changing stigmatizing language to promote empowerment.



Method(s) of Instruction

- Lecture
- Facilitated Discussion
- Individual Activity

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Stigmatizing Language, *Appendix 32*
- Identifying and Eliminating Stigma Self-Talk, *Appendix 33*



REFERENCE MATERIALS

- Building Blocks for Peer Program Success: <http://www.cahpp.org/project/peer-center/>
- Best Practices for Integrating Peer Navigators into HIV Models of Care: www.aidsunited.org/resources
- Dutcher, Noely Phicil, Goldenkranz, Rajabiun, Franks, Loscher, Mabachi. Positive Examples”: A Bottom-Up Approach to Identifying. Best Practices in HIV Care and Treatment Based on the Experiences of Peer Educators. AIDS PATIENT CARE and STDs V25, n7, 2011.
- Peer Re-Engagement Project: Peer Program Resources and Training Curricula: www.hdwg.org/prep/curricula
- Yanick, Mark, Velez, Miguel. HIV/AIDS Stigma Initiative Program: “HIV/AIDS Stigma & Access to Care.” National Minority AIDS Council, May 2006.



FLIPCHART

PROCESS

The training will begin with definition of stigma and its formation, history, and street terminology that affects HIV testing and treatment.

Discuss the intersectionality of stigma and language that influences community response to people living with HIV and their engagement in care. The facilitator will define and lead discussion of empowerment and impact of change in self-talk and healthcare choices.

The facilitator will lead the group in an activity to convert stigmatizing self-talk to empowering self-talk, instruct participants on the activity, allow for time to complete, and manage group discussion.

Key Words and Phrases

- *Stigma*
- *Empowerment*
- *Access to Care*
- *The Bug*
- *Media*

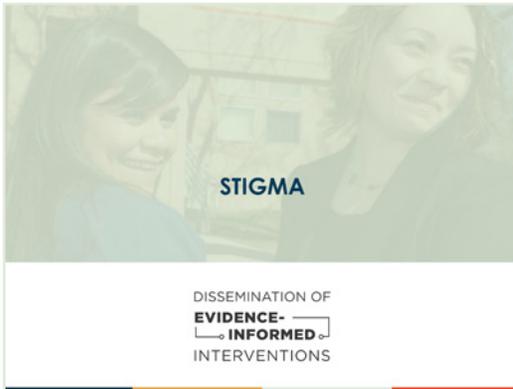


The approximate length of time the session will take.

Total: 45 minutes

30 minutes lecture

15 minutes activity



SLIDE 1:

Define stigma.

Can anyone tell me if they have ever experienced stigma?

According to a definition from Goffman, a sociologist (and there are many definitions for Stigma) is that “the person with a stigma is not quite human” (and I’m paraphrasing a little) but he goes on to say that “operating on this assumption, we often unthinkingly, reduce his life chances” (Goffman, 1963).

So...we deeply discredit the individual or group. From a whole person to a tainted, discounted one. It’s a sign of disgrace or shame. We brand or label them. We may even think of them as being “morally flawed” or to have behaved badly and therefore to be avoided by other members of society.



SLIDE 2:

The creation of stigma is the result of existing:

- Stereotypes
- Prejudice
- Biases, and other forms of oppression in our society directed at individuals and/or groups.



SLIDE 3:

I need volunteers to match the five terms with the definition.

Each volunteer participant will take turns matching the word to the definition. Please review the definitions with the group.

- **Stereotype**—A belief that all members of a group possess the same characteristics or traits exhibited by some members of that group.
- **Prejudice**—Preconceived judgment of members of a certain race, ethnicity, gender, religion, or group.
- **Racism**—Discrimination or mistreatment of an individual due to their belonging to a particular race or ethnic group.
- **Bias**—A strong inclination of the mind or a preconceived opinion about something or someone. Prevents objective thought of an issue or consideration.
- **Stigma**—Negative feelings, beliefs, and behavior directed toward an individual or group due to a particular label or characteristic.

Peers WHAT IS STIGMA

Short definition of stigma is "a mark of disgrace or reproach."
Webster's New World Dictionary

"Stigma is a perceived negative attribute that causes someone to devalue or think less of the whole person."
Kristalyn Salfers-Pedneault, Ph.D.

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 4:

Stigma is a deeply negative mindset and provides no value to society in general.

People with mental health disorders represent, perhaps, one of the most deeply stigmatized groups in American culture.

Many of the over 46 million Americans who suffer from some type of mental health disorder may describe and define stigma using one of these words or phrases: *hate, discrimination, prejudice, fear inducing, humiliating, hurtful*. Truly it boils down to discrimination and hate.

People with mental health disorders feel diminished, devalued, and fearful because of the negative attitude society holds toward them. As a result, people struggling with mental health challenges may not get the help they need for fear they'll be discriminated against.

Peers HIV AND STIGMA



HIV related stigma refers to prejudice, discounting, discrediting and discrimination directed at persons perceived to have HIV, as well as their partners, friends, families and communities.*

*Source: Herek GM. AIDS and stigma: A Conceptual Framework and Research Agenda. Research work of the National Institute of Mental Health, Pg. 1.

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 5:

HIV related stigma refers to prejudice, discounting, discrediting, and discrimination directed at persons perceived to have HIV, as well as their partners, friends, families, and communities.

THE HISTORY OF HIV LANGUAGE

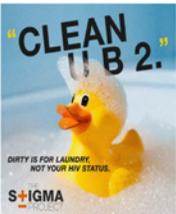
DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 6:

HIV Terminology—We frequently hear acronyms in our HIV work so let's be sure we know what they mean as we hear them and use them in the following slides.

- GRID—Gay Related Immune Deficiency
- AIDS—Acquired Immune Deficiency Syndrome
- ARC—AIDS-related complex
- HIV—Human Immunodeficiency Virus
- Late stage HIV or end stage HIV

Peers STREET SLANG TERMINOLOGY



- Are you clean?
- Dirty
- The bug
- Bug catchers
- Monster
- Ninja
- The germ
- Diseased
- Carrier/Diseased
- "You clean?"
- The Package

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 7:

Are any of these street slang language terms familiar to you?

Could you add more to the list?

Peers LANGUAGE AND STIGMA



Focusing on use of language may be the first place to start in order to address stigma, social exclusion, and discrimination against people living with HIV.

Language:

- Helps to shape our world
- It describes and gives meaning to our lives
- It persuades and changes minds
- It can destroy or empower

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 8:

Focusing on use of language may be the first place to start in order to address stigma, social exclusion, and discrimination against people living with HIV.

Language:

- Helps to shape our world.
- It describes and gives meaning to our lives.
- It persuades and changes minds.
- It can destroy or empower.

Negative language never empowers.

Peers MEDIA



DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 9:

How did the media get this language wrong?

These images are representative of the prevailing attitude of that time period.

November 7th

On this day in 1991 Ervin Magic Johnson announced that he had HIV and was quitting the National Basketball Association. Regarded as one of the best players in the 1980's.

The second picture - AIDS, which stands for acquired immunodeficiency syndrome, is a condition characterized by progressive failure of the immune system. It is caused by the human immunodeficiency virus type 1 (HIV-1).

Does the mother have a greater responsibility to be tested? Code language from the media.

This poster is one of a series produced by Clement Communications, a public relations company that researches, creates, publishes, and distributes programs and materials to help organizations communicate with their intended audience. Designed to appeal to specific racial groups, each poster in the series features a different child. Although the child in the photograph appears to be happy and healthy, we learn from the message that that there was a vertical or perinatal transmission from mother to child. (Today, this mode of transmission is rare.) We see an emotional appeal to women—African-American women in this case—which along with the text suggests they have a responsibility beyond themselves to be tested for HIV.

Peers HOW HIV STIGMA IS MANIFESTED

- Individuals with HIV
- Groups of people perceived to be likely to be infected, and
- Individuals, groups, and communities with whom these individuals interact



*Source: Herik GM. AIDS and stigma: A Conceptual Framework and Research Agenda. Research work of the National Institute of Mental Health. Pg. 1.

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 10:

Targets of stigma are:

Primary HIV stigma—defined as the stigma directed at people who are living with or are perceived to be living with HIV.

In order to cope with this form of stigma, individuals may resort to the concealment of their HIV status for fear of being shunned by others, including their medical provider. This may prove to be detrimental to issues of health care. Concealment of HIV status often leads to social isolation and internalized feelings of self-loathing and a cycle of hopelessness.

Secondary HIV stigma—is aimed at those individuals and/or groups associated with people living with HIV. This includes partners, family and friends, professionals, volunteers, and agencies that have close proximity with people living with HIV. Secondary stigma may also be directed towards individuals who are part of a group associated with HIV.

Peers COMMUNITY STIGMA

HIV stigma often reinforces existing social inequalities. Expressions of stigma include:

- Ostracism, rejection and avoidance
- Discrimination
- Mandatory HIV testing without prior informed consent or confidentiality protections
- Quarantine of persons who are HIV infected
- Violence

*Source: Herik GM. AIDS and stigma: A Conceptual Framework and Research Agenda. Research work of the National Institute of Mental Health. Pg. 1.

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 11:

HIV stigma often reinforces existing social inequalities based on gender, race, ethnicity, class, sexuality, and culture. HIV stigma is a problem throughout the world and has been expressed in a variety of ways, including:

1. Ostracism, rejection and avoidance of people living with HIV.
2. Discrimination against people living with HIV by their families, health care professionals, communities, and governments.
3. Mandatory HIV testing of individuals without prior informed consent or confidentiality protections.
4. Quarantine of persons who are living with HIV.
5. Violence against persons who are perceived to be living with HIV or belong to "high risk groups."

Peers IMPACT ON ACCESS TO SERVICES



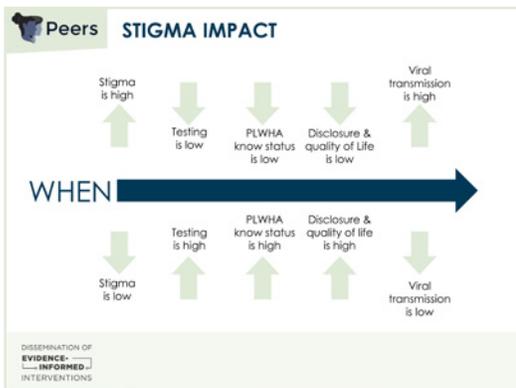
- Counseling and testing
- Individual and access to care
- Disclosure of status
- Health disparities

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 12:

Stigma Impacts: Access to services and care

- **Counseling and testing:** A person is less likely to seek HIV testing in environments where they perceive workers to be judgmental about sexual and drug use behavior.
- **Access to care:** Individuals who exhibit concerns about stigma are more likely to delay care and/or not adhere to care.
- **Disclosure of status:** The decision to reveal one's HIV status is associated with a person's level of comfort; the more accepting, caring, and nonjudgmental a social network is towards HIV, the more likely the individual is to disclose.
- **Health disparities:** The impact of racial/ethnic health disparities among communities of color when accessing HIV services.



SLIDE 13:

Review slide with participants; these findings came from a study done by Dr. Herek, a researcher from California.

- When stigma is high, testing is low, fewer people know their status, fewer people disclose, and new infections rise. When stigma is low, testing increases, more people learn their status, more people disclose, and new infections drop. The sad thing is that people are sometimes stigmatized even in places they go for medical care and other services.
- What are your own experiences with stigma? Facilitate discussion.

Citation: <https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.92.3.371>



SLIDE 14:

Empowerment "is a multi-dimensional social process that helps people gain control over their own lives. It is a process that fosters power in people, in their lives, their communities, and in their society by acting on issues that they define as important" (Page & Czuba, 1999).

Since the emergence of the HIV epidemic, many people have been shrouded by the myths, misconceptions, and fears about HIV's affect on our bodies. Disturbing images of clients clinging to life at the onset of the HIV crisis have remained the prominent perspective for many even though medical breakthroughs in treatment have made living with HIV manageable.

These are empowering images...What do you see empowering about these images?



SLIDE 15:

In your opinion what is this poster saying?

- HIV affected my body but not my mind.
- I am still a vibrant, productive member of my community.
- I am a valuable asset to my family, friends, and myself.

Peers STIGMATIZING SELF-TALK VS. EMPOWERING SELF-TALK

Stigmatizing Self-Talk	Empowering Self-Talk
I'm infected with HIV.	I am a person living with HIV.
It's my fault I got infected; injecting drugs	No one deserves HIV; HIV is not a punishment
Died of AIDS, to die of AIDS	Died of AIDS-related illness or AIDS-related complication, or end stage HIV
"Gay" people of color	Same gender loving

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

SLIDE 16:

See the handout, "Identifying and Eliminating Stigma Self-Talk."

Let's look at this short activity on stigmatizing versus empowering self-talk.

Stigmatizing talk - "I'm infected with HIV." Empowering self-talk - "I am a person living with HIV."

It's my fault I got infected; injecting drugs. No one deserves HIV; HIV is not a punishment. One could go on to say . . .

- Is perfect the goal; no one can meet that goal.
- No one deserves HIV.
- You are a person living with HIV.
- HIV is a human illness that can affect anyone.

Incarcerated=criminal. Being incarcerated does not define you as a person nor brand you as a criminal.

"Gay" people of color. Many people of color identify as same-gender loving rather than gay.

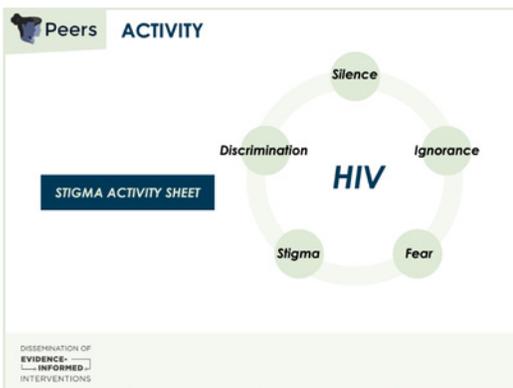
People who identify as transgender may use a pronoun that is different from what you might assume, so asking everyone what pronouns they use can help show trans people they are welcome in your organization. Respecting people's core identity and the words they use to describe themselves is at the heart of putting people first.

So let's take a closer look at stigmatizing language and positive self-talk. Distribute handout—Stigmatizing Language.

We want to avoid it in our communication with our community, how we refer to ourselves, and in media messages.

Activity:

Let's practice changing stigmatizing language. Think of three negative terms you don't like and change them to three positive terms.



SLIDE 17:

This activity can be completed in a small group brainstorm activity or large discussion group.

Directions for small group:

1. Divide into four groups.
2. Each group will be given a handout with one discussion question.
3. Appoint a recorder that will write the group responses on flipchart paper and a reporter that will discuss the groups' responses in the larger group.
4. Discussion should be free-flow; there is no right or wrong answer.

Discussion questions are below:

- How does stigma affect access to care for people living with HIV?
- How can one make an impact on stigma?
- Can you identify stigma in your workplace or community?
- How can one educate the community or workplace about the negative impact that stigma has on people?

Peers TAKEAWAY POINTS



- Use correct terminology – empowering terminology
- Use non-stigmatizing language and images
- Portray people with HIV living positively, not depressed or ostracized
- Empower yourself and others

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 18:

Refer to the slide for summary points.

Peers REFERENCES

1. Building Blocks for Peer Program Success: <http://www.caahpp.org/project/peer-center/>
2. Best Practices for Integrating Peer Navigators into HIV Models of Care: www.aidsunited.org/data/files/Site_18/PeerNav_v8.pdf
3. Dutcher, Noely Phicil, Goldenkranz, Rajabun, Franks, Loscher, Maboehl. Positive Examples!: A Bottom-Up Approach to Identifying Best Practices in HIV Care and Treatment Based on the Experiences of Peer Educators. AIDS PATIENT CARE and STDs V25, n7, 2011.
4. Peer Re-Engagement Project: Peer Program Resources and Training Curricula: www.hdwg.org/prep/curricula
5. Yanick, Mark, Velez, Miguel. HIV/AIDS Stigma Initiative Program: "HIV/AIDS Stigma & Access to Care". National Minority AIDS Council, May 2006.

DISSEMINATION OF EVIDENCE — INFORMED INTERVENTIONS

SLIDE 19:

Share references with participants.

CLOSING

Next, we will review discuss Safety and Outreach as many of you may have the opportunity to work with clients in the community.



MODULE 15:

Safety and Outreach

Topics Covered: Safety, outreach

OBJECTIVES

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

- Understand outreach principles and best practices for working with clients.
- Protect personal safety when doing field work and working at the agency.



Method(s) of Instruction

- Large Group Discussion

MATERIALS NEEDED



POWERPOINT



HANDOUTS

- Safety Tips for Home Visits, *Appendix 34*



REFERENCE MATERIALS

- Olivet, J.S., et al. (2010). Outreach and engagement in homeless services: A review of the literature. *Open health Services and Policy Journal*, 2, 103-121.
- Implementing Your Street Outreach Program Adapted from Trudee Able-Peterson @ Richard A. Hooks Wayman's "Streetworks."
- Midwest AIDS Training and Education Center of Missouri, Case Management Safety Training



FLIPCHART

Key Words and Phrases

- Safety
- Safety Plan
- Community Outreach
- Relationship Building
- Home Visits



The approximate length of time the session will take.

Total: 25 minutes

PROCESS

The facilitator will:

- Begin with a lecture around best practices and principles.
- Lecture on outreach principles and practices while engaging and building relationships with clients.
- Lecture on safety concerns with community outreach, including examples of strategies and plans peers can implement.
- Engage participants throughout the lecture, eliciting participants' ideas or examples as it relates to outreach and ensuring safety during outreach.



SLIDE 1:

Introduce the topic of safety and outreach.



SLIDE 2:

Outreach Principles

- Meet people where they are—geographically, emotionally, and physically.
- Help meet basic needs.
- Be respectful and treat everyone with dignity.
- Recognize that the relationship is central to outreach and engagement.
- Create a safe, open, friendly space, regardless of setting.



SLIDE 3:

Best Practices in Outreach

- Ensuring that you have a safe working environment regardless of the setting is paramount. Fieldwork is sometimes conducted in areas that can be unsafe, therefore we need ways to protect our personal safety when conducting home visits or individual outreach in the community.
- Based on the fact that you interact with your own community, make sure you have established your own personal boundaries before conducting outreach. You may anticipate dangerous situations that may come up when doing fieldwork and ways to handle them in advance.
- Complete in-depth assessment of the areas where your clients live.
- Visit the neighborhoods at different times and conduct outreach in pairs.
- Have your agency identification handy.
- Have a cell phone.
- Be yourself.
- Listen.
- Respond, don't react.

Peers **APPROACH, ENGAGE, BUILD RELATIONSHIP**

Approach

- Always have your agency ID available
- Identify yourself and affiliation quickly

Script – “Hi, my name is _____, and I’m a Peer worker with ACG. I just want to give you some information about our program.”

Script – “Hi, my name is _____ and this is my co-worker_____. We work for Howard Brown and we wanted to tell you about our services.”



DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 4:

Know and practice or role play your script before you go into the community, so you’re prepared.

Approach:

- Always have your agency ID available.
- Identify yourself and affiliation quickly.

Script – “Hi, my name is _____, and I’m a peer worker with (name of your organization). I just want to give you some information about our program.”

Script – “Hi, my name is _____and this is my co-worker_____. We work for (name of your organization) and we wanted to tell you about our services.”

Peers **APPROACH, ENGAGE, BUILD RELATIONSHIP**



- May happen the first time or after several attempts
- Leave your business card
- Remember names of people you meet
- Offer services they may need to get to the agency

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 5:

Show genuine concern by being engaged with the client.

If in a face to face meeting:

- Use eye contact.
- Watch non-verbals—closed arms versus open posture.
- Speak in plain language (remember health literacy if delivering education or medical information).
- Watch for literacy cues (if completing forms read them together in case the person has literacy challenges).

This is not an exhaustive list; bottom line is to be understanding and concerned about the client’s needs and well-being.

Peers **APPROACH, ENGAGE, BUILD RELATIONSHIP**

- Offer your services
- Empathize with their struggles
- Build a partnership with your client
- Be there or call when you say you will
- Listen to your clients
- Be respectful
- Follow up

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 6:

This list builds on the previous slide.

Ask the group if there are other things that should be on this list.

Peers SAFETY FIRST

- Safety planning
 - Emergency protocols
 - Know your exits
- Make sure your supervisor knows where you are/where you are going
- Put outreach location on the calendar
- Work with a partner whenever possible



DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 7:

Whether you are providing services within the agency or in the field, safety should always be considered first. Have a safety plan for emergencies and dangerous situations. Let your supervisor know where you are at all times. Put the location on the calendar. Work with a partner at every opportunity.

Peers PLAN AND BE MINDFUL



- What is the agency safety policy?
- Do a safety assessment
- Pay attention to signs of danger
- Don't become complacent

DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 8:

The first step in addressing personal safety is to plan and be mindful. Planning and being mindful is your best defense against workplace violence.

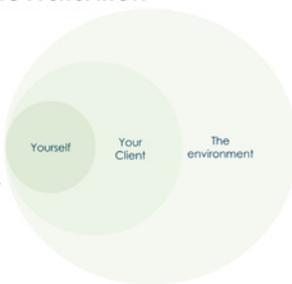
For example, the human service employees with the highest rates of workplace victimization include those with very little experience and those with extensive experience. Newer employees may not have gained the experience necessary to assess for violence among clients and may be trying to remember all of the aspects of their job and its requirements that they may forget to pay attention to even the most obvious signs of client aggression. And when that aggression occurs, they have no idea how to respond.

On the opposite end of the spectrum, longer-term employees may begin to feel complacent and may get stuck in a rut forgetting the dangers around them. Many have never been the victim of work related violence and therefore do not see it as an imminent threat in the future.

Planning and being mindful are separate skills that work together to prepare you to stay safe in an event of violence. These skills should be applied to how you set up your office, completing a safety assessment, paying attention to signs of danger, and avoiding complacency. We will be exploring these areas as we move through this module.

Peers MANAGING A SITUATION

- Know your client
- Know yourself
- Know your environment



DISSEMINATION OF EVIDENCE - INFORMED INTERVENTIONS

SLIDE 9:

There are three things which need to be managed before, during, and after an episode of aggression. First is your client, second is yourself, and third is your environment.

Each area may include not only the reason for client aggression, but also things which exacerbate violent behavior. Therefore, effectively managing these three areas will help to prevent and diffuse violence. We will be taking a closer look at just how to manage each of these areas in the following set of slides.

Peers KNOW THE CLIENT

- Review any documentation
- Past violence – is best predictor
 - Is there any history of violence?
 - Have there been issues with previous case managers?
- Drug and alcohol use and misuse
 - Is drug or alcohol misuse an issue?
- Explore history with other helpers
- Access to weapons
 - Does this client have access to weapons?
- Psychiatric hospitalizations and history
 - Have there been psychiatric hospitalizations?

DISSEMINATION OF EVIDENCE – INFORMED INTERVENTIONS

SLIDE 10:

A thorough assessment of your client’s potential for violent behavior begins with a review of any documentation available to you. Since the best predictor of future violent behavior is a history of past violent behavior, any available records should be reviewed for incidents of past violent behavior.

Since drugs and alcohol use can lead to erratic and sometimes violent behavior, it is important to review for a history of substance misuse. Even the most timid client can become threatening and violent while under the influence, so it is important not to assume that since a client’s usual personality is timid and shy that they will always be so.

It’s also a good idea to check with other colleagues about the client’s history and reputation. Asking colleagues about their experiences with that client may produce much needed and valuable information on individual idiosyncrasies and behavior.

Since weapons can be used by clients during violent behavior and aggression, it is important to assess your client’s access to them. Review the medical record for any information which indicates the client’s past access to and use of weapons. It is important to remember that in violent episodes almost anything can be used as a weapon. A pen, for example, in the hands of a calm client may be a great for instrument for writing reports and signing forms, but in the hands of a violent client that same pen may become a weapon. So it is important not to exclude ordinary items in your assessment of weapon access and use.

Peers IN THE COMMUNITY



- Avoid night time visits, early mornings are better
- Always let others know where you are going and how long you expect to be there
- Know the exact address of where you are going
- Scan the area for dangers before, during, and after a home visit
- Have a cell phone with you, emergency numbers should be easily accessed
- Dress for the street

DISSEMINATION OF EVIDENCE – INFORMED INTERVENTIONS

SLIDE 11:

For most peers, community and home visits are an essential part of the job. Sometimes this means going into a neighborhood that is unfamiliar or dangerous. Therefore, it is important that they pay close attention to and continually assess their surroundings.

Use your schedule or calendar to document your client appointments and location. Informing others where you are going and the address will help to ensure that emergency services and or other staff will be able to come to your aid.

Even if there appears to be no imminent aggressive behavior from your client, the environment is constantly changing. Dangers from other sources could appear at any time. Scanning the environment throughout the entire visit will help to ensure that if something changes you will be ready.

Lastly, carry a cell phone. Some of us will remember the days of having to run to find a pay phone to make an emergency call. Thankfully those days are over. Having a cell phone on you at all times will increase the response time of emergency services and will help keep open communication between you and your colleagues.

 **RESOURCES**

Olivet, J.S., et al. (2010). Outreach and engagement in homeless services: A review of the literature. *Open health Services and Policy Journal*, 2, 103-121.

Implementing Your Street Outreach Program Adapted from Trudee Able-Peterson @ Richard A. Hooks Wayman's "Streetworks."

Midwest AIDS Training and Education Center of Missouri, Case Management Safety Training

DISSEMINATION OF
EVIDENCE —
INFORMED
INTERVENTIONS

SLIDE 12:

Point out for participants the references for this unit.

CLOSING

This concludes our training! We have covered a great deal of information, including your role as a peer; information about the viral life cycle, medication, and resistance; as well as boundaries, safety, and confidentiality. This is intended to provide you with the foundations to begin your work as a peer.



APPENDICES

Appendix 1

Peer Staff Role and Responsibility Activity

Please write 5 responses to the questions below:

What is a peer?

What makes an effective peer staff person?

What are the roles and responsibilities of peer staff?

Appendix 2

Peer Staff Roles and Responsibilities (Answer Sheet)

What is a peer?

- Someone who is my age
- Similar experiences as me
- Someone I can relate to
- Someone who provides support
- Someone who fights the same fight
- Someone who I have something in common with
- Helps bring about positive change in others
- Someone who doesn't pass judgment

What makes an effective peer staff person?

- A person who instills a sense of hope to others
- Plants seeds of knowledge
- An effective communicator
- Provides general health information
- Helps gets people into care
- A good listener
- Is a good role model
- Problem solver
- Knows the Ryan White HIV/AIDS Program system of services
- Available when I need them
- Does not give me advice

What are the roles and responsibilities of a peer educator?

- Client advocate
- Educator
- Active listener
- Help find resources such as employment, social services, mental health and medical services
- Care about clients
- Model self-care
- Make themselves available to peers they serve
- Know that everyone has a different experience
- Encourage peers to ask questions
- Bridge gaps with providers and case managers
- Act direct, clear, and assertive

Appendix 3

Four Categories of Peer Service

Emotional	Informational	Instrumental	Affiliational
<ul style="list-style-type: none"> • Share personal story • Show empathy and positive regard • Listen attentively • Elicit client stories • Reassure clients that they can live a “normal” and productive life • Reassure clients they don’t have to get sick and die • Commit to being alive, give client full attention • Let clients know that there is hope • Actively remove stigma from interactions with clients • Be friendly and genuine • Be non-judgmental 	<ul style="list-style-type: none"> • Communicate health information • Teach clients to understand blood tests • Mentor clients on how to disclose • Role model health behaviors and management of HIV • Share information about opportunistic infections • Show clients how to take medications correctly and importance of adherence • Share information on managing side effects • Teach healthy eating habits • Guide clients on what question to ask providers/prepare for medical appointments • Teach about safer sex and risk reduction • Share basic information about HIV and the HIV life cycle 	<ul style="list-style-type: none"> • Assist patient in navigating the system of services • Interpret medical information/jargon • Make appointment reminders • Make and reschedule appointments • Work collaboratively with Case Managers • Participate in care team meetings • Follow up with clients that do not show up at appointments • Complete paperwork or track down documents that will allow clients to see medical staff • Teach clients how and when to refill medications • Visit client at the hospital 	<ul style="list-style-type: none"> • Connect clients to support groups • Find ways to connect clients to other people living with HIV through activities like outings, conference attendance, game nights, movie nights • Encourage clients to seek support from family and friends • Increase social networks

Dutcher, Phicil, Goldenkranz, Rajabiun, Franks, Loscher, Mabachi
 “Positive Examples”: A Bottom-Up Approach to Identifying Best practices in HIV Care and Treatment Based on the Experience of Peer Educators.
 AIDS Patient Care and STD
 Vol. 25, #7, 2011

Appendix 4

What Does It Take To Be a Peer?

KNOWLEDGE LIST

1. Basic HIV 101
2. Modes of HIV transmission
3. Risk reduction strategies
4. Aware of community services that are available to clients
5. HIV viral life cycle
6. How to disclose HIV diagnosis
7. How to describe CD4 and viral load results
8. Understand drug resistance
9. Basic principles of effective communication
10. Where to get STD testing
11. Name/know about opportunistic infections
12. Medication side effects
13. Knows what videos, pamphlets are good resources for clients
14. Aware of HIV State Laws
15. Where to get an HIV test
16. Daily tasks peer educators complete
17. Understand workplace code of conduct
18. Understand paperwork needed for client chart

SKILLS LIST

1. Ability to read and write
2. Can read verbal and non-verbal cues
3. Develops trust and engage a client
4. Can get client information as needed
5. Ability to manage time
6. Active listening
7. Effective communicator
8. Ability to ask open-ended questions
9. Gives options
10. Can document services provided to a client
11. Advocates for client
12. Ability to coach a client
13. Ability to use videos/ computer
14. Speaks clearly
15. Can brainstorm ideas with clients
16. Problem solver
17. Models behavior change

QUALITIES LIST

1. Open-minded
2. Non-Judgmental
3. Flexible
4. Patience
5. Compassionate
6. Connect with others
7. Truthful
8. Supportive
9. Positive attitude
10. Encouraging
11. Focused
12. Sincere
13. Respectful
14. Warm
15. Interested
16. Assertive
17. Empowers others

Appendix 5

Identifying Roles of Multidisciplinary Team Members

Peer	Supervisor	Physician	Nurse	Behavioral Health Therapist	Case Manager

Appendix 6

Identifying Roles of Multidisciplinary Team Members-Potential Answers-

Peer	Supervisor	Physician	Nurse	Behavioral Health Therapist	Case Manager
<ul style="list-style-type: none"> • Counsel • Advocate • Listen to concerns • Motivate • Empower • Advise • Refer • Identify barriers • Educate • Follow-up • Identify with client • Navigate • Provide options • Adherence education 	<ul style="list-style-type: none"> • Counsel • Advocate • Listen to concerns • Motivate • Empower • Advise • Refer • Identify barriers • Educate • Manage staff • Administrator 	<ul style="list-style-type: none"> • Counsel • Advocate • Listen to concerns • Motivate • Empower • Advise • Refer • Identify barriers • Educate • Examine • Diagnose • Show how to take meds • Discharge 	<ul style="list-style-type: none"> • Counsel • Advocate • Listen to concerns • Motivate • Empower • Advise • Refer • Identify barriers • Educate • Vital signs • Review orders • Show how to take meds • Discharge 	<ul style="list-style-type: none"> • Counsel • Advocate • Listen to concerns • Motivate • Empower • Advise • Refer • Identify barriers • Educate • Follow-up • Discharge 	<ul style="list-style-type: none"> • Counsel • Advocate • Listen to concerns • Motivate • Empower • Advise • Refer • Identify barriers • Educate • Follow-up • Help with entitlements

Appendix 7

Stages of HIV Infection

SESSION HANDOUT

Person becomes infected with HIV

Acute

Person may have flu-like symptoms:

- Fever
- Headache
- Tiredness
- Enlarged lymph glands

Asymptomatic

Person may look and feel well

Symptomatic

Person may have enlarged lymph glands, tiredness, weight loss, fever, chronic diarrhea or yeast infections (oral or vaginal) among other conditions.

AIDS

The virus weakens and eventually disables the immune system. When a person with HIV develops AIDS, their body has lost most of its ability to fight off certain bacteria, fungi, parasites and other germs.

A diagnosis of AIDS is made if:

- T-cell count is below 200ml and,
- There is a confirmed appearance of certain illnesses called opportunistic infections.

Window (1)

Incubation Period (2)

- A person who has HIV can transmit even if they look healthy and feel well.
- One person with HIV may have different combinations of signs and symptoms from someone else who is also living with HIV.
- Only an HIV test can show if someone is HIV-positive.
- Only a doctor can diagnose AIDS.

(1) Window Period: Time it takes for antibodies to become detectable in the body; usually within three months.

(2) Incubation Period: Time from point of seroconversion to development of AIDS.

Appendix 8

HIV 101: Understanding HIV and AIDS

1. Fill in the blank

H- _____

A- _____

I- _____

I- _____

V- _____

D- _____

S- _____

1. HIV is a _____, AIDS is a _____ (condition) and they are not the same.
2. HIV is a virus that can lead to infections and destroys your _____
3. AIDS is a syndrome or condition that is caused by _____.
4. AIDS is considered the _____ stage of HIV.
5. A person's AIDS status is determined by their _____ count when it is below _____.

True or False

6. _____ Symptoms for HIV and AIDS are different for each person.
7. _____ You can have an HIV infection without acquiring AIDS.
8. _____ You can become "undetectable" while living with AIDS even if your CD4 count is not above 200.
9. _____ An unsuppressed viral load and undetectable viral load are the same.

CD4 cells are a type of lymphocyte (white blood cell). They are an important part of the immune system. CD4 cells are sometimes called T-cells; tells how strong the immune system is.

Viral load tells the amount of HIV is in the blood.

Appendix 9

HIV 101: Understanding HIV and AIDS (Answer Sheet)

H-Human

I-Immunodeficiency

V-Virus

A- Acquired

I- Immune

D- Deficiency

S- Syndrome

- HIV is a virus, AIDS is a syndrome (condition) and, they are not the same.
- HIV is a virus that can lead to infections and destroys your immune system.
- AIDS is a syndrome or condition that is caused by HIV. It is considered the final stage of HIV.
- A person's AIDS status is determined by their CD4 count when it is below 200 and/or an opportunistic infection.
- Symptoms for HIV and AIDS are different for each person.
- You can have an HIV infection without acquiring AIDS.
- You can become "undetectable" while living with AIDS even if your CD4 count is not above 200.
- A suppressed viral load is when a person's viral load copies are anything above 200. An undetectable viral load is below 20 or 40 copies dependent on the test and how the clinic and/or hospital determines what their bench mark is of an undetectable viral load.

CD4 cells are a type of lymphocyte (white blood cell). They are an important part of the immune system. CD4 cells are sometimes called T-cells; tells how strong the immune system is.

Viral load tells the amount of HIV is in the blood.

Appendix 10

HIV 101: What Stage Am I?

Stages of HIV Infection – Complete questions 1-4 using the terms below:

- Symptomatic
- AIDS
- Acute
- Asymptomatic

1. _____ T-cell count is below 200 milliliter or less with the onset of this stage, clients are at the highest risk for opportunistic infections and malignancies.
2. _____ During this stage, chronic signs or symptoms are not present; person may look well. T-cell count may be used to monitor progression of the disease.
3. _____ Occurs about 1 to 2 weeks after initial infection. During this stage, the virus undergoes massive replication. Patients may be asymptomatic or have a flu like symptoms, fever headache, tiredness.
4. _____ Person may have enlarged lymph glands, weight loss, or other conditions.

Appendix 11

HIV 101: What Stage Am I? (Answer Sheet)

Stages of HIV Infection – Complete questions 1-4 using the terms below:

- Symptomatic
 - AIDS
 - Acute
 - Asymptomatic
1. AIDS T-cell count is below 200 milliliter or less with the onset of this stage, clients are at the highest risk for opportunistic infections and malignancies.
 2. Asymptomatic During this stage, chronic signs or symptoms are not present; person may look well. T-cell count may be used to monitor progression of the disease.
 3. Acute Occurs about 1 to 2 weeks after initial infection. During this stage, the virus undergoes massive replication. Patients may be asymptomatic or have a flu like symptoms, fever headache, tiredness.
 4. Symptomatic Person may have enlarged lymph glands, weight loss, or other conditions.

Appendix 12

Modes of Transmission and Fluids

True or False

1. _____ Modes of HIV Transmission are the ways that a person can contract HIV.
2. _____ There is a zero risk of transmission through oral sex.
3. _____ HIV can be spread through saliva, sweat, and tears, or coughing/sneezing.
4. _____ Kissing poses a zero risk always for being exposed to HIV.

Fill in the Blank

5. There are _____ actions of transmission and _____ fluids.

Modes of Transmission

A. Actions

1. _____
 - a. _____
 - b. _____
 - c. _____
2. _____
3. _____

B. Fluids

1. _____
2. _____
3. _____
4. _____

Appendix 13

Modes of Transmission and Fluids (Answer Sheet.)

- Modes of HIV Transmission are the ways that a person can contract HIV.
- There are 7 major modes of transmission (Big 7): 3 are actions and 4 are fluids.
- The most common way HIV is spread is through having condomless sex with someone who is HIV+ and may not be aware of their status or not on Antiretroviral Therapy (ARVs).

- 3 Actions of Transmission

1. Condomless Sex

- a. Anal
- b. Vaginal, and
- c. Oral sex

2. Sharing Needles/Drug “works”

3. Breastfeeding

- 4 Fluids of Transmission

1. Semen (cum or pre-cum)

2. Blood

3. Vaginal

- a. Anal or
- b. Rectal Fluids

4. Breast Milk

*Any other fluid that may contain blood (even a small amount)

Appendix 13

Modes of Transmission and Fluids (Cont.)

- About oral sex: **According to the [CDC](#): “Though oral sex carries a much lower risk of HIV transmission than other sexual activities, the risk is not zero. Several factors may increase the risk of HIV transmission through oral sex, including oral ulcers, bleeding gums, genital sores, and the presence of other sexually transmitted diseases (STDs).*

- There are MANY myths about how HIV is transmitted. These are ways that you CAN NOT transmit/contract HIV:
 - Hugging
 - Kissing (exceptions-open mouth)
 - *According to Centers for Disease Control and Prevention (CDC): Open mouth kissing can present a low risk especially if both partners are without sores or cuts on the mouth or lips. Saliva has certain proteins that make it an extremely poor carrier of HIV. As a result, kissing, sucking, and licking the lips, mouth, and tongue are basically safe.
 - Sharing dishes/glasses or food
 - Holding hands
 - Toilet seats/bath towels
 - HIV is NOT spread through saliva, sweat, tears or coughing/sneezing.

Appendix 14

Asking Open-Ended Questions

Convert the following closed-ended questions into open-ended questions:

1. Is it going to rain today?

2. Are you feeling OK?

3. Did your doctor explain how to take your medications?

4. Do you use protection when you have sex?

5. Did you tell anyone that you are HIV-positive?

6. Do you take your meds with food?

7. Did you ask your doctor any questions?

Appendix 15

Asking Open-Ended Questions (Answer Sheet)

Convert the following closed-ended questions into open-ended questions:

1. Is it going to rain today?

What is the weather forecast for today?

2. Are you feeling OK?

How are you feeling?

3. Did your doctor explain how to take your medications?

What suggestions did your doctor provide on how to take your medications?

4. Do you use protection when you have sex?

What protection do you use when having sex?

5. Did you tell anyone that you are HIV-positive?

Who knows your HIV status?

6. Do you take your meds with food?

Which meds do you take with food?

7. Did you ask your doctor any questions?

What questions did you ask your doctor?

Appendix 16

Roleplay Scenarios for Introduction of Program Service

Mercedes

Mercedes is a 36-year-old African American single mother of 3 children who was diagnosed with HIV two years ago. She is an assistant manager at Wendy's and has not been seen by a doctor in over a year. She was prescribed medication when she was diagnosed, but she only took them for two months. She is being seen at the clinic today to address a yeast infection that keeps coming back. Her provider refers her to you for peer support and enrollment.

Franda

Franda is a 23-year-old African American woman who was diagnosed with HIV seven months ago at your clinic. She was enrolled into case management and had scheduled her first doctor appointment, but she did not show up. All attempts to reach her by mail or phone were unsuccessful. Franda resurfaced on a referral from a local homeless shelter because she lacks stable housing. Your supervisor assigns her to you for reengagement.

Darcella

Darcella is a 43-year-old Mexican American woman who has received a positive test result from a community outreach testing event. She is shocked and afraid because she has been in a relationship with her partner for 15 years. They never married, but they live together to share living expenses. Both are under employed and need each income to make it. You receive a referral to contact Darcella to offer enrollment into the reengagement project.

NeeShay

NeeShay is a 19-year-old African American woman who recently completed a 30-day drug treatment program. While there, she tested positive for HIV and was referred to your clinic for follow-up and treatment. NeeShay was referred by your supervisor for enrollment and peer support.

Appendix 16

Roleplay Scenarios for Introduction of Program Service (Cont.)

Kayla

Kayla is a 49-year-old African American trans woman who has been living with HIV for 20 years. She was adherent with treatment for 18 years, but within the last two years she has acknowledged publicly who she is as a trans woman. Kayla lost her job and her insurance coverage, so she hasn't been able to afford her HIV medications. The process has been stressful, but she has been focused heavily on her transition. Additionally, many of her relationships have changed, forcing her to develop a new system of support. Kayla came to the clinic seeking information about hormone replacement. Her chart indicated that she had been lost to care so she was referred to you for reengagement support.

Markita

Markita is a 27-year-old African American woman who has been living with HIV for 1 year. She works as a customer service representative for a local department store. She leads a very active life and spends time traveling with friends for fun. Markita goes back and forth about believing she has HIV. Sometimes she believes it's cured and other times she is concerned about not taking the prescribed medication. She saw a provider and was prescribed meds when she first received the positive HIV test result. Markita was referred to you because she appeared on the clinic's lost to care list. Her chart notes indicate you can only contact her by her cell phone.

Appendix 17

Sample Questions to Use for First Meeting

How are you managing your HIV (medically, home life)?

Who in your life can provide you support?

Where are your supports located?

When was your last medical appointment?

What has worked well for you in managing your health?

What has been the most difficult challenge?

- Living with HIV since your diagnosis?
- Being able to get to medical appointments, and follow-up appointments

Do you have concerns/questions about the program?

How can I reach you; by phone, text, or email?

How often can we meet and what is the best time?

Please be advised that this format only serves as a relationship builder to set the tone for clients and help them feel more at ease. Questions posed will not fit the profile for all clients.

Source: Kansas City CARE Clinic, Peer Program. Protocols and Operational Activities Manual.

Appendix 18

Intervention Encounter Form

Intervention Encounter Form	
Date of Contact ___/___/_____	Staff ID: _____
Client ID: _____	Site: _____
Encounter made:	Location of Encounter(s): Check all that apply
<input type="checkbox"/> Yes (with the client or on behalf of the client)	<input type="checkbox"/> Client residence (permanent or non-permanent residence)
<input type="checkbox"/> No	<input type="checkbox"/> Intervention clinic
If "No," why?	<input type="checkbox"/> Medical, social service, or community based organization setting (external to intervention site)
<input type="checkbox"/> Unable to contact	<input type="checkbox"/> Name: _____
<input type="checkbox"/> Cancelled/Rescheduled appointment	<input type="checkbox"/> Correctional setting
<input type="checkbox"/> No show	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> N/A (not face-to-face)
Total duration of this encounter (in minutes): _____	

Type of Contact	
Face-to-face (Individual)	1
Electronic (email, text, phone, fax)	2
Collateral (client not present)	3
EMR	4
Other	5

Encounter content:

For each encounter that you had with a client in the course of one day, use the columns to the right to enter the type and duration of each type of encounter using the codes above. For example if you took a client to a medical appointment that lasted 1 hour-enter "1" in the "Type" column and "60" in the "duration" column next to the content. Please mark all types of encounters and duration of each type of encounter for the entire day.

Completed?	Encounter Activity	Type	Duration (minutes)
	1. Find client/conduct outreach		
	2. Conduct client intake and/or needs assessment		
	3. Develop a patient care plan		
	4. Conduct acuity assessment		
	HEALTHCARE-RELATED ACTIVITIES		
	5. Arrange HIV primary care appointment		
	6. Arrange mental health services appointment		
	7. Arrange for substance use treatment / services appointment		

	8. Arrange other medical care appointment (not for HIV, mental health, or substance use)		
	9. Accompany client to a medical appointment		
	10. Accompany client to a mental health appointment		
	11. Accompany client to a substance use related services appointment		
	12. Discuss medical appointments with client		
	13. Discuss lab values with client		
APPOINTMENT REMINDERS AND FOLLOW UP			
	14. Provide appointment reminders (medical and non-medical appointments)		
	15. Follow up with provider to discuss client		
EDUCATIONAL AND EMOTIONAL SUPPORT			
	16. Relationship building (e.g. checking in with client; providing emotional support)		
	17. Talk with a client about disclosure		
	18. Provide coaching on living skills		
	19. Provide general health education / risk reduction education		
	20. Provide basic HIV treatment education, support, and/or advocacy		
	21. Provide safer sex education		
	22. Provide harm reduction education and supplies (i.e. clean syringe/naloxone)		
	23. Mentoring/coaching on provider interactions		
	24. Provide education and emotional support to client's family/partners		
SOCIAL SERVICES-RELATED ACTIVITIES			
	25. Accompany client to social service appointments (i.e. related to benefits, housing, food, etc.)		
	26. Assist with obtaining transportation services		
	27. Assist with obtaining child care services		
	28. Assist with obtaining housing services (i.e. support for finding or maintaining housing)		
EMPLOYMENT AND OTHER PRACTICAL & SOCIAL SUPPORT			
	29. Assist client with finding employment/provide employment support		
	30. Assist client in obtaining legal assistance, obtaining legal documents, or obtaining legal advocacy services		
	31. Assist client with obtaining benefits (e.g. SSI, social security, disability, food assistance, or health insurance)		
	32. Provide practical support (i.e. obtaining cell phone, budgeting/financial planning)		
OTHER ACTIVITIES			
	33. Other 1: (specify)		
	34. Other 2: (specify)		
	35. Other 3: (specify)		
TRANSITION TO STANDARD OF CARE			
	36. Meet with client to discuss transitioning to the standard of care		
	37. Transition client to treatment with a case manager or treatment at external/partner agency		
	38. Officially transitioned client to the standard of care		

Progress notes (Optional):

Appendix 19

Client Care Plan

Patient Care Plan

Client Name:

Client Record Number:

Date Created

Section 1: Coordination of Care

1a. First PCP Visit Attendance:

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	

1b. Case management visit attendance:

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	

1c: Second PCP visit attendance:

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	

Section 2: Patient identified goals

2a: Patient identified goal

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	

2b. Patient identified goal

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/Other Notes:	

	Printed Name	Signature	Date
Client			
Peer			
PCP			

Appendix 20

Script for Documentation Exercise

Peer-Hi Lisa, thanks for coming in today.

Lisa-Yeah, I had to come in because I need your help with paying for the co-pay of the new medicine the doctor put me on. I had the \$50 dollars last week, but I can't afford that every month.

Peer-Oh, Lisa I didn't realize that your co-pay was so much. Yes, you know this would be a good time for us to schedule a meeting with the case manager I've been telling you about. Let's call and see if she can meet with us.

Lisa-You know I had an unpleasant experience with my case managers in the past, they never have time for me, so I try to do my own thing until it's necessary.

Peer-I hear you and sounds like you are open to giving the case manager a second chance. Let's call and schedule a time that works for you and I'll come too.

Peer-Lisa, the case manager says she is available on Wednesday next week at this time. Might be good since you're off on Wednesdays.

Lisa-Okay, I'll meet her and hope she can help me out. I don't know that I will have this co-pay every month especially since my job is reducing my weekly work hours.

Instructions:

- Complete the Encounter Form.
- Add goal of meeting with the case manager as part of the care plan.

Appendix 20

Script for Documentation Exercise (cont.)

Peer-Hello, my name is Maria and Dr. Smith suggested I come introduce myself to you. I am a peer support staff and help clients get settled back into the routine of medical care.

Angela-Yes, Dr. Smith mentioned you would come to see me and that you might be able to help me.

Peer-Well, I am happy to help. Let's talk about how we might work together.

Angela-I've not been seen Dr. Smith for about 7 months. I had enough refills, but they ran out and I stopped taking my HIV meds now for the past 3 months. I don't need a lecture because I've got many of those in the past. I need help to keep on track and move me along.

Peer-Okay, I help clients with similar concerns as you have mentioned. The program I work in allows me to work with you for at least 4 months, help you with scheduling and keeping your medical appointments, lab visit, and I can work to connect you with a case manager. We could check in with each other weekly to determine if things are going well for you and find resources you might need.

Angela-Well I am ready if you are. I need to get my life back on track.

Instructions:

- Complete the Encounter Form.
- Add goal of meeting with the case manager as part of the care plan.

Appendix 21

10 Questions to Ask Yourself Before You Begin HIV Treatment

- **Why do I want to start treatment?**
- **Am I ready?**
- **Which regimen will still let me live my life?**
- **Have I surrendered to the truth that I have HIV?**
- **Who will I tell about my regimen?**
- **Why this regimen?**
- **What side effects am I willing to tolerate?**
- **How can I expect to feel on this regimen?**
- **What if it doesn't work?**
- **Can I stop?**

By Heidi Nass; edited by Myles Helfand
From TheBody.com

Appendix 22

HIV Lifecycle References and Resources

Viral lifecycle references and resources

<http://www.thewellproject.org/sites/default/files/HIV%20drugs%20and%20lifecycle.6.2016.pdf>

<https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/19/73/the-hiv-life-cycle>

<https://www.niaid.nih.gov/diseases-conditions/hiv-replication-cycle>

<https://www.poz.com/basics/hiv-basics/hiv-life-cycle>

Videos

<https://www.youtube.com/watch?v=ej7MaNEZ09g&t=2s>

<https://www.youtube.com/watch?v=B7ITZgag6w0>

<https://www.youtube.com/watch?v=GR9d9wrOI5E>

HIV medication references and resources

1st drug approved for treatment of HIV

<https://www.fda.gov/ForPatients/Illness/HIVAIDS/History/ucm151074.htm>

Drug Resistance and Cross Resistance

<https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/56/drug-resistance>

HIV drugs and the life cycle

<http://www.thewellproject.org/sites/default/files/HIV%20drugs%20and%20lifecycle.6.2016.pdf>

HIV medications from POZ

https://www.poz.com/drug_charts/hiv-medications

FDA-approved HIV medications

<https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/58/fda-approved-hiv-medicines>

Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV

<https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/0>

Appendix 23

Activity: HIV Medications at Work (Case Scenarios)

Scenario A

- Your client is prescribed Biktarvy to manage their HIV. Biktarvy is a single tablet regimen with (bictegravir, emtricitabine, and tenofovir alafenamide).
- Ask participants to identify each medication present in that formula. Then locate the class each medication belongs to determine what stage of viral replication is interrupted. Have participants locate the stage of replication on the medications at work handout.

Scenario B

- Your client is prescribed Genvoya to manage their HIV. Genvoya is a single tablet regimen with (elvitegravir / cobicistat / emtricitabine / tenofovir alafenamide)
- Ask participants to identify each medication present in that formula. Then locate the class each medication belongs to determine what stage of viral replication is interrupted. Have participants locate the stage of replication on the medications at work handout.

Scenario C

- Solicit volunteers to share their current HIV treatment regimen or their client's for the purpose of identifying where their medications are working in the viral life cycle to impede replication.

Scenario D

- Your client is prescribed Triumeq to manage their HIV. Triumeq is a single tablet regimen with (abacavir sulfate, dolutegravir sodium and lamivudine).
- Ask participants to identify each medication present in that formula. Then locate the class each medication belongs to determine what stage of viral replication is interrupted. Have participants locate the stage of replication on the medications at work handout.

Scenario E

- Your client is prescribed Isentress and Truvada to manage their HIV. Truvada is a single tablet regimen with (emtricitabine, and tenofovir disoproxil).
- Ask participants to identify each medication present in that formula. Then locate the class each medication belongs to determine what stage of viral replication is interrupted. Have participants locate the stage of replication on the medications at work handout.

Appendix 24

Lab Activity Tracking Sheet

Enter dates and lab results

		Date/Result	Date/Result	Date/Result
CD4	health of immune system			
CD4%	% of CD4's working			
VL	virus-enemy			
AST	liver-muscle disease			
ALT	liver-detects disease			
BUN	waste product-filtered/kidney liver dysfunction			
CREATININE	waste product-filtered/kidney liver damage			
Trigly	fat in blood			
total Ch	less than 200			
LDL	less than 130			
HDL	greater than 40			
Glucose	sugar in the blood <99			

Continued >

	Date/Result						
CD4							
CD4%							
VL							
AST							
ALT							
BUN							
CREATININE							
Trigly							
total Ch							
LDL							
HDL							
Glucose							

Appendix 25

HIV Drug Resistance Cases

Scenario A

Jennifer is a 32 year old who you have been working with for the past 4 weeks. She started medications 3 weeks ago. The Peer Educator gives Jennifer a call to see how she has adjusted to her new medication regimen. Jennifer tells the Peer Educator that she was prescribed Triumeq. She reports that she is taking her medications faithfully; however, Jennifer said she was worried because she has been experiencing side effects since starting the medications. Jennifer reports that she has mild stomach cramps, headaches and diarrhea; she hasn't missed a dose, but she switches taking her medications from morning to night depending on how she feels and if friends are around since she has not disclosed her status.

1. What questions would the Peer Educator ask?
2. What barriers or factors would affect the client's adherence?
3. What strategies would the Peer Educator suggest?
4. What concerns exist regarding adherence or resistance?

Scenario B

Carmen contracted HIV March of 2017. First lab values indicated that her T cell count was approximately 600. She physically feels good physically but angry at herself for trusting her new partner despite suspicions she had about him cheating. Carmen has a diagnosis of depression, bone loss due to osteoporosis and a family history of diabetics.

To make things worse, Carmen's partner blamed her for transmitting HIV to him. Carmen started ART but when her 30 day prescription ran out she didn't get it re-filled. She told her mother she was done with horse pills and side effects from HIV medicines. Carmen's health began to spiral from good to poor; not getting out of bed, weak and her body ached to stand and walk. She often felt faint. Carmen decided to see her doctor due to her short-term disability running out. By now she weighed less than 100 lbs. At Carmen's doctor visit he introduced her to a Peer Educator or recently introduced her to a Peer Educator.

1. What questions would the Peer Educator ask?
2. What barriers or factors would affect the client's adherence?
3. What strategies would the Peer Educator suggest?
4. What concerns exist regarding adherence or resistance?

Appendix 25

HIV Drug Resistance Cases

Scenario C

Desiree, a 31-year-old transgender woman living in California, has been positive for 10 years and has yet to take a single HIV medication. Though she has had several conversations with her doctors about the possibility of starting treatment, she has a history of non-adherence with her anti-depressants and is afraid it will continue if she begins taking HIV meds.

Though Desiree has never been on HIV medications, she has been prescribed both antidepressants and hormones on a long-term basis. Desiree has always had trouble adhering to both of her pill regimens. “I always end up forgetting,” she explained. More than merely forgetting, Desiree hates the taste of her pills and feels overwhelmed by the prospect of having to take her medications every day.

“I usually end up thinking how much I don’t want to do it. I get concerned that, if I take this now, am I going to feel OK in a few hours to do whatever else I need to do?” she said. She is worried about her medication side effects impacting her work performance.

1. What questions would the Peer Educator ask?
2. What barriers or factors would affect the client’s adherence?
3. What strategies would the Peer Educator suggest?
4. What concerns exist regarding adherence or resistance?

Appendix 26

GenoSure PRIme-Resistance Testing



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Patient Name	DOB	Patient ID/Medical Record #	Gender	Monogram Accession #
Date Collected	Date Received	Date Reported	Mode	Report Status
Referring Physician	Reference Lab ID/Order #			
Comments	HIV-1 Subtype: B			

Drug		GenoSure PRIme™		Assessment*	Comments	
Generic Name	Brand Name	Drug Resistance Associated Mutations Detected		Drug		
NRTI	Abacavir	Ziagen	M184V	ABC	Sensitive	
	Didanosine	Videx	M184V	ddl	Resistance Possible	
	Emtricitabine	Emtriva	M184V	FTC	Resistant	
	Lamivudine	Epivir	M184V	3TC	Resistant	
	Stavudine	Zerit	None	d4T	Sensitive	1
	Tenofovir	Viread	None	TFV	Sensitive	1
	Zidovudine	Retrovir	None	ZDV	Sensitive	1
NNRTI	Efavirenz	Sustiva	K103N, Y188L	EFV	Resistant	
	Etravirine	Intelence	V179T, Y188L	ETR	Resistance Possible	
	Nevirapine	Viramune	K103N, Y188L	NVP	Resistant	
	Rilpivirine	Edurant	K103N, Y188L	RPV	Resistant	
INI	Dolutegravir	Tivicay	None	DTG	Sensitive	
	Elvitegravir	Vitekta	None	EVG	Sensitive	
	Raltegravir	Isentress	None	RAL	Sensitive	
PI	Atazanavir	Reyataz	E35D	ATV	Sensitive	
		Reyataz / r†	E35D	ATV/r	Sensitive	
	Darunavir	Prezista / r†	None	DRV/r	Sensitive	
	Fosamprenavir	Lexiva / r†	E35D	AMP/r	Sensitive	
	Indinavir	Crixivan / r†	None	IDV/r	Sensitive	
	Lopinavir	Kaletra†	None	LPV/r	Sensitive	
	Nelfinavir	Viracept	E35D	NFV	Sensitive	
	Ritonavir	Norvir	E35D	RTV	Sensitive	
	Saquinavir	Invirase / r†	E35D	SQV/r	Sensitive	
	Tipranavir	Aptivus / r†	E35D	TPV/r	Sensitive	

Appendix 27

Assessing Adherence: 10 Questions You Should Ask

- **Which meds are you currently taking?**
- **How frequently do you have to take each of your meds?**
- **What are the food restrictions for each of your meds (i.e., with or without food)?**
- **Why do you think some meds need to be taken with food and some on an empty stomach?**
- **Why do you think some meds are taken once a day and others twice a day?**
- **What helps you remember to take your meds?**
- **What do you do when you miss a dose?**
- **What problems have you encountered from taking meds?**
- **How soon before you run out of meds do you order refills?**
- **Do you believe that the meds are helping you and, if so, how?**

Appendix 28

Confidentiality and Boundaries Scenario

This activity can be completed in a small group brainstorm activity or large discussion group.

Directions for small group

1. Divide into 4 small groups.
2. Each group will be assigned one Confidentiality and Boundary scenario for the small group.
3. Ask each group to appoint a recorder that will write the group responses on flip chart paper and a reporter that will discuss the groups' responses in the larger group setting.
4. The group will have 10 minutes and discussion should be free-flow; there is no right or wrong answer.

Scenario:

Read the following scenario; then answer the questions that follow.

#1 Jessica receives HIV care at the Clinic at the same place where you, the peer, work. You have seen her in the clinic hallways and have acknowledged her as a client who receives services but in your mind her face is familiar to you. You, the peer, attend your building's monthly tenant meeting and sitting in the room is Jessica. Your eyes connect.

What do you do?

What do you say and when?

Is this a confidentiality or boundary issue?

Appendix 28

Confidentiality and Boundaries Scenario (cont.)

This activity can be completed in a small group brainstorm activity or large discussion group.

Directions for small group

1. Divide into 4 small groups.
2. Each group will be assigned one Confidentiality and Boundary scenario for the small group.
3. Ask each group to appoint a recorder that will write the group responses on flip chart paper and a reporter that will discuss the groups' responses in the larger group setting.
4. The group will have 10 minutes and discussion should be free-flow; there is no right or wrong answer.

Scenario:

Read the following scenario; then answer the questions that follow.

#3 You have just finished an educational session with your client Sarah. As you are walking her out she asks, "Can I borrow \$20 to buy some food for my kids to eat? I promise I'll give it to you next week when I get my check."

How would you handle this situation?

What else comes up?

Is this a confidentiality or boundary issue?

Building Blocks for Peer Program Success: http://peer.hdwg.org/program_dev

Appendix 28

Confidentiality and Boundaries Scenario (cont.)

This activity can be completed in a small group brainstorm activity or large discussion group.

Directions for small group

1. Divide into 4 small groups.
2. Each group will be assigned one Confidentiality and Boundary scenario for the small group.
3. Ask each group to appoint a recorder that will write the group responses on flip chart paper and a reporter that will discuss the groups' responses in the larger group setting.
4. The group will have 10 minutes and discussion should be free-flow; there is no right or wrong answer.

Scenario:

Read the following scenario; then answer the questions that follow.

You have been working with a client for the past 6 months and both of you decide that she is ready for graduation from the peer program. You decide to celebrate by going to lunch. Each of you pays your way, of course. You meet her at the restaurant and she brings a plant for you as a gesture of his appreciation for the work you have done together.

How do you handle this scenario?

What other issues does this bring up?

What if the gift was a \$25 gift certificate payable to you for a pedicure?

Is this a confidentiality or boundary issue?

Building Blocks for Peer Program Success: http://peer.hdwg.org/program_dev

Appendix 28

Confidentiality and Boundaries Scenario (cont.)

This activity can be completed in a small group brainstorm activity or large discussion group.

Directions for small group

1. Divide into 4 small groups.
2. Each group will be assigned one Confidentiality and Boundary scenario for the small group.
3. Ask each group to appoint a recorder that will write the group responses on flip chart paper and a reporter that will discuss the groups' responses in the larger group setting.
4. The group will have 10 minutes and discussion should be free-flow; there is no right or wrong answer.

Scenario:

Read the following scenario; then answer the questions that follow.

The Police come to the clinic and you are the first person they see. They ask if Justin Love, a clinic client, is here because they have a warrant for his arrest.

What issues arise for you?

What do you do?

Is this a confidentiality or boundary issue?

Building Blocks for Peer Program Success: http://peer.hdwg.org/program_dev

Appendix 29

Short Boundary Scenarios

What would you do?

I'm a little short on cash today and have no money for lunch, can I borrow \$5.00?

Would you like to go to the movies with me sometime?

Let me give you a ride home.

Listen, I don't like the open shower at the Shelter, can I take a shower at your place?

I really like that dress, can I borrow it for a wedding I've been invited to?

You've been so good to me; can I give you a wet one?

You look stressed out, let me give you a massage.

I bought you a gift for being so nice to me.

I brought you a cake for your birthday, I baked it myself.

How much money do you make doing this job?

Can I have your cell phone number in case I need to contact you at night?

Remember you told me that you use medical marijuana? I got some good weed if you want to buy some.

Appendix 29

Short Boundary Scenarios (Cont.)

It's really hard to come in to see you because I work until 5:00 p.m. and the office is closed. Can you meet with me at night?

Listen, I'm in a lot of pain, can you give me some pain killers?

I'd like to invite you to a 4th of July cookout.

My health has been so stable that I think I want to go back to work. Can you help connect me to training or employment programs?

My nurse did a TB test a couple of days ago and she told me to come back in a couple of days to measure it but I can't wait, can you measure it and let her know?

Can you take my blood pressure?

Since John is my new CHW now and I'm no longer your client, can we go out to dinner sometime?

Can you fill out this application for Medicaid for me?

I need you to give me a referral to housing.

I need you to get me into substance abuse treatment.

I need you to help me find a new doctor.

Appendix 30

Trusted Support Inventory Worksheet

Trusted support is defined as someone with whom you feel comfortable and safe when sharing personal information. Examples of the types of people who might be trusted support include: lovers, boyfriends, girlfriends, friends, family members, other L.I.F.E. participants, health providers, religious advisors, hot-line workers, L.I.F.E. staff, co-workers, and others. Please list below all people in your life that you think/feel/believe might be able to serve as trusted support for you; and circle the personal topics you would feel comfortable sharing with each person.

NAME OF POSSIBLE TRUSTED SUPPORT PERSON	TYPES OF INFORMATION I MIGHT SHARE WITH THIS PERSON (circle those that apply)
1.	HIV status; health concerns; relationship issues; financial problems; family problems; sexual issues; drug/alcohol use; stress and emotional issues; medical care; legal issues; and other
2.	HIV status; health concerns; relationship issues; financial problems; family problems; sexual issues; drug/alcohol use; stress and emotional issues; medical care; legal issues; and other
3.	HIV status; health concerns; relationship issues; financial problems; family problems; sexual issues; drug/alcohol use; stress and emotional issues; medical care; legal issues; and other
4.	HIV status; health concerns; relationship issues; financial problems; family problems; sexual issues; drug/alcohol use; stress and emotional issues; medical care; legal issues; and other
5.	HIV status; health concerns; relationship issues; financial problems; family problems; sexual issues; drug/alcohol use; stress and emotional issues; medical care; legal issues; and other
6.	HIV status; health concerns; relationship issues; financial problems; family problems; sexual issues; drug/alcohol use; stress and emotional issues; medical care; legal issues; and other

Appendix 31

Disclosure Tips



Whether you've just found out you are HIV positive or you've known for a while, at some point you will likely have to decide whether to disclose your HIV status. Choosing who to tell is a personal decision, and you may often find yourself trying to balance honesty with protecting your right to privacy.

As with many issues surrounding HIV, no answers are right for everyone, but here are some general disclosure tips:

- Be selective. In most instances, choosing who to tell is your personal decision. It's your choice and your right (Note: Some states have laws requiring you to disclose your status before sexual encounters, before sharing injection drugs or equipment or before receiving medical care.)
- Consider the 5 W's. Who do you need to tell? What do you want to tell them about your HIV infection, and what are you expecting from the people you are disclosing your HIV status to? When should you tell them? Where is the best place to have this conversation? Why are you telling them?
- Easy does it. In most situations, you can take your time to consider who to tell and how to tell them. Consider whether there is a real purpose for disclosing or whether you are simply feeling anxious and want to share your feelings. Telling people indiscriminately may affect your life in ways you haven't considered.
- No need to apologize. You have a virus. You don't have anything to apologize for simply because you are HIV positive.
- Keep it simple. Just stick to the facts. You don't have to tell the story of your life.
- Avoid isolating yourself. If you are unable to tell close friends, family members or other loved ones about your HIV status, allow yourself to draw upon the support and experience of others in the HIV community. Consider joining a support group or an online discussion, such as the POZ

Forums.

- Go with your gut. There's no perfect road map for how to disclose. Trust your instinct, not your fears.

- Relax. Millions of others have dealt with this experience and have found their way through it.

You will get through it too.

Disclosing to Significant Others

Studies have shown that most HIV-positive people disclose their HIV diagnosis to their significant other—their spouse or partner—within a few days of learning their status. It's important to have someone to listen to your concerns and to offer support. At first, your partner may feel anxiety about his or her own HIV status and may also feel angry and upset if the HIV infection occurred sexually outside the relationship. Disclosing your HIV status can strain your relationship, so it's important to give some thought as to when and how to disclose. Depending on the nature of your relationship, you might want to consider some professional couples counseling.

If you've had unprotected sex with your partner, it's important to alert him or her to the fact that he or she may be at risk and should get tested. Your partner's test results may impact how you practice safer sex together in the future.

It's also important to be aware of the partner-notification laws in your state. Partner notification refers to information conveyed to spouses, sexual partners, needle-sharing partners and others who might be at risk for HIV. Check with your state's department of health to find out the laws in your area.

Disclosing to Someone You're Dating

Some people prefer to disclose their status to a potential date or sexual partner immediately, sometimes even before a first date. Others prefer to wait and see whether the relationship develops before disclosing. Despite the fact that most people know about safer sex and how the virus is transmitted, fear and stigma can stir up very strong emotions and your status may deter some people from proceeding further in a relationship with you.

While in most cases, sharing your HIV status is a personal choice, in some states, specific laws actually make it a crime not to disclose your status to a sexual partner. Check with your state's department of health or get in touch with your local AIDS service organization if you have concerns about your state's laws regarding HIV disclosure.

General dating and sexual partner disclosure issues to consider:

- Keep what you say as simple and direct as possible.
- Give yourself credit if you have been practicing safer sex with the sexual partner you're disclosing your status to. You are already behaving responsibly with that person.
- If the person you're disclosing to reacts negatively, remember that's only one person. Not everyone is going to react the same way.
- Remember that you should give the person you're disclosing your status to some time to process the information. Whatever their reaction may be at first, whether negative or positive, be aware that reactions can change in time.

Disclosing to Family and Friends

Your family and friends are likely to be concerned about your future, and disclosing your status to them may lead to even stronger relationships. You may find yourself having to educate them about HIV, but your family and friends can be a good source of support depending on the nature of your relationship with them.

While most people will respect that what you have shared was told in confidence, you need to be aware that your HIV status may end up becoming the subject of gossip among other family members, friends and acquaintances. If you have a tight-knit family or social group or you live in a small community or a rural area, confidentiality may be harder to maintain.

General tips to consider when disclosing to family and friends:

- Keep what you say as simple and as direct as possible.
- Tell them you have something important to tell them.
- Offer to answer any questions they may have.
- Let them know they don't have to worry about your health.
- If you have particular HIV-related issues or concerns that you're trying to sort out, let them know.
- Request that what you're going to discuss be kept in confidence.

- Ask them to be there for you.
- Tell them how much they mean to you and how much you love them.
- Don't be afraid to show your feelings and to express how important this issue is for you.

Disclosing to Employers

If you're applying for a job, prospective employers do not have the right to inquire about your health or whether you have a disability prior to a conditional job offer per the Americans with Disabilities Act (ADA). However, they may legally inquire whether you are aware of any physical limitation that might interfere with your ability to perform the essential functions of the job.

If your HIV is interfering with your work to the extent that it might place your employment in jeopardy, you might consider disclosing to your supervisor. Or you could provide a letter from your doctor that states that you suffer from a "chronic condition" without specifically disclosing your HIV status. Your employer is required to reasonably accommodate your needs if you are otherwise qualified to perform the essential duties of your job. Knowing your company's policies will help you to determine whether or not you need to disclose your HIV status. Hopefully, you will not need to turn to legal recourse to protect your rights. However, if that becomes necessary, there are laws to protect you.

General tips to consider with regard to employers:

- Unless your HIV status affects your current ability to perform your job, you are under no legal obligation to disclose your status to your employer.
- Consider very carefully what your purpose is for disclosing your status to your employer.
- If you do disclose, tell the person you want to speak with that you have something important to discuss.
- Stress that you're requesting that what you're going to discuss be kept in strict confidence.
- Be mindful that a request for confidentiality is not an absolute guarantee that it will be respected.
- Some employers will rise to the occasion and be supportive. Others may be disappointing in their responses, and you will understandably feel hurt and angry.
- Keep what you say as simple and direct as possible.

- Let him or her know that you are receiving appropriate health care.
- If you may need a particular accommodation, such as occasional time off for a medical appointment, mention it.
- Tell your boss that you will make every effort to ensure that your work is properly covered and that you're committed to doing your job reliably and well.
- Medical-related employer decisions about HIV (or any other disability) must be based on facts about you, not simply an employer's opinions about HIV.

Disclosing to Coworkers

Think carefully before disclosing your status to your coworkers—even those you consider to be good friends. What you've disclosed in confidence could end up becoming the subject of gossip in the workplace, with unforeseen and possibly serious consequences.

General tips to consider with regard to the workplace:

- Tell the person you have something important to tell him or her.
- Stress that you are requesting that what you're going to discuss be kept in the strictest confidence.
- Keep what you say as simple and direct as possible.
- Tell the person why you want him or her to know.
- Let him or her know that you are sorting out issues related to your HIV status and his or her support is important to you.

Disclosing to Medical and Other Health Care Providers

All medical providers are supposed to use "universal precautions," which means special procedures to protect themselves against any transmissible infection, not just HIV. Regardless, it's helpful to inform your health care provider about your HIV status in order for him or her to give you the best possible care. Knowing that you are HIV positive can help your doctor identify certain health problems and ensure that he or she doesn't prescribe any medications that could interact with your HIV meds. Also, some states have laws requiring disclosure prior to receiving medical care. Be sure to check with your state's department of health or get in touch with your local AIDS service organization to find out about the laws where you live.

Your medical information (including your HIV status) is protected by the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule and cannot be released without your permission except in circumstances where not disclosing the information could result in harm to another person.

Health care providers cannot deny their services to someone simply because the person is HIV positive. If a doctor or other health care provider is uncomfortable treating someone with HIV and makes that known to you in any way, be aware that you have legal recourse in such situations.

General tips to consider with regard to medical and health care providers:

- All health care providers are bound by confidentiality laws.
- By telling a doctor, a nurse or other health care providers, you do give up a degree of privacy, but that does not release them from adhering to laws regarding confidentiality.
- Your status should be treated as privileged information. If, for instance, a doctor's employee discusses details with you that another patient might overhear, politely request that such conversations be discussed in private.
- A hospital or other health care provider may share HIV information with a patient's insurance company if the information is necessary to pay for medical care.
- If you're in doubt about whether you have to reveal your status for either medical or insurance purposes or indeed legally for any other reason, call your local department of health or AIDS service organization. In some instances you may learn that it's necessary to disclose in order to have access to medical resources and services.

Last Reviewed: February 27, 2018

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<https://www.poz.com/basics/hiv-basics/disclosure>

Appendix 32

Stigmatizing Language

Stigmatizing	Preferred
AIDS virus	HIV
HIV/AIDS	HIV AIDS (only when referring to AIDS) HIV and AIDS
HIV virus	This is a redundant; use HIV
Promiscuous	This is a value judgment and should be avoided
Risk group	Risk
Risky sex – Unprotected sex	Condomless sex
Stigmatizing	Preferred
PLHA or PLWHA	People living with HIV or Person with HIV
HIV patient, AIDS patient	Person living with HIV
Positives or HIVers	People living with HIV
AIDS/ HIV carrier	Person living with HIV
AIDS victim or AIDS sufferer	Person with HIV

Appendix 32

Stigmatizing Language (Cont.)

Stigmatizing	Preferred
Died of AIDS, to die of AIDS	Died of AIDS-related illness or AIDS related complications or end stage HIV
Victim	Person living with HIV
Sufferer	Person living with HIV
Contaminated	Do not use
Innocent (victim)	Do not use
AIDS orphans	Children orphaned by loss of parents or guardians who died of AIDS related complications
Full-blown AIDS	There is no medical definition for this phrase, simply use the term AIDS, or Stage 3 HIV
Zero new infections	Zero new transmissions/new cases
Stigmatizing	Preferred
Mentally ill people	Person with a mental health challenges
HIV infected	Person living with HIV
HIV infections	HIV transmissions, diagnosed with HIV
Number of infections	Number diagnosed with HIV/number of acquisitions

Appendix 32

Stigmatizing Language (Cont.)

Stigmatizing	Preferred
Compliant	Adherent
AIDS test	HIV test
To catch AIDS To contract AIDS To catch HIV	An AIDS diagnosis, developed AIDS, to contract HIV
Became infected	Contracted/Acquired/Diagnosed
Number of infections	Number diagnosed with HIV/number of acquisitions
HIV infected mother	Mother living with HIV
Mother to child transmission	Vertical transmission, perinatal transmission
HIV infected baby	Baby living with HIV
HIV exposed infant	Infant exposed to HIV

Appendix 33

Identifying and Eliminating Stigma

Stigma Self-Talk Activity

"Speech is the Mirror of the soul; as a man speaks, so is he."
-Publilius Syrus

Directions: Read the examples of stigmatizing self-talk below and ask yourself, "Is this a way that I sometimes talk to and about myself or my life situations?" If it is, then go to the 'Empowering Self-talk' column and write in the blank space a positive statement or thought to replace the negative one.

If the negative thought does not apply to you, then leave the space blank. Or, if you want to, you can write something positive that might help someone else. For your positive statements, use an 'I' statement. Remember, 'I' statements begin with the word 'I' and reflect something you are going to think, feel, or do, such as, 'I am going to stop talking negatively to and about myself.'

Stigmatizing Self-talk	Empowering Self-talk
I'm infected with HIV	
I'm HIV.	
I caught HIV by "being out there bad."	
I'm dirty because I'm infected with HIV.	
I'm dying from HIV.	
I can't get a partner because I'm infected with HIV/AIDS.	
I deserve what I got for doing what I did.	
I got AIDS from "shooting up."	
I got AIDS when I was a crackhead.	
I am _____ (stupid, ugly, fat, bad, lovable, etc.) because I got the package.	

Appendix 34

Safety Tips for Home Visits



Safety Tips for Home Visits From a Veteran NYC Social Worker

Pascale Victor, LMSW

*Pascale Victor, author of *Field Work with an Open Heart: Portraits that Unlock the Door to Your Clients' Secret Lives*, is a licensed social worker with a degree from the Columbia University School of Social Work in New York City. Her extensive experience encompasses both direct clinical work and social work administration. She also has experience providing short-term therapy to adolescents, adults, and families, serving as a bridge between her clients and community-based organizations for continued long-term mental health treatment. She was formerly employed as a hospital social worker where she worked closely with psychiatrists in order to provide social service intervention to the youth who were brought to the pediatric emergency room as a result of mental health or emotional/behavioral problems. From 2002 to the present Pascale Victor has been employed as a social worker for the New York City Housing Authority (NYCHA). There she provides social service intervention to the residents of NYCHA: youth, adults, elderly, as well as families. Responding to emergency situations and providing intervention in crises are part of her responsibilities.*

Ms Victor has compiled a list of safety tips for all social workers whose jobs, like hers, include field work. She believes some of them will also be helpful to other social work professionals who do not do field work.

Doing Home Visits? Err on the Side of Caution and follow these Safety Tips

- 1) For an initial home visit, try to schedule the appointment by telephone or letter so that the client will know to expect you and be prepared. If you speak to the client ahead of time, you may be able to get vital background information or an update on their current situation, which may have changed.
- 2) Whenever possible, conduct home visits accompanied by colleagues or employees from other agencies who are also working on the same case. If you are a woman about to conduct a home visit that is potentially unsafe, you may request that a male colleague accompany you. For example, I have a male co-worker who is 6'4" and wears sunglasses and an earpiece, so he looks like a secret service agent. He can definitely be intimidating, which is why I request his "bodyguard services" for some cases.
- 3) Depending on the nature of the case, some clients can come to an office, rather than have you meet them in their homes.
- 4) Always carry a charged cellular telephone.
- 5) Request a joint home visit with a police officer if you think the situation could become extremely dangerous.
- 6) Be sure to inform your supervisor and another colleague of your whereabouts.
- 7) Know where the exits are in a home and in building hallways.
- 8) Do not enter an elevator with people who are suspicious-looking or make you feel uncomfortable in any way. If you are feeling nervous, pretend that you are using your cellular telephone and cannot get on the elevator. When riding an elevator with someone who frightens you, immediately press the button of the next floor so that you can get off.
- 9) If you feel unsafe during an interview and believe you are or might be in danger, you should immediately end the interview and leave—run if necessary!
- 10) Depending on the case and any confidentiality issues, you can possibly get a client's trusted family member involved and conduct a joint home visit with that person.
- 11) Always be vigilant and assess the surroundings—both inside and outside a client's home.
- 12) Never stand too close to an apartment door. Clients often open their doors and allow their dogs to run out and jump on you. Request that the client put the dog or other pet in another room. It is also possible that a client could try and harm you, so stay back. It is rare but it is always better to be safe than sorry.
- 13) Always remember to keep your cool. Never show a client that you are scared. Always remain professional and if the situation gets out of control or dangerous—leave. Remember that you are the professional and are there to help the client. If you show that you are scared, the client might try to take advantage of the situation by being manipulative.

Appendix 34

Safety Tips for Home Visits (cont.)

14) Do not allow clients to play on your sympathy and good nature to get what they want. Stay firm and do your job to the best of your ability. Never allow a client to sway you in any way that is not for the good of the case. If you make a decision against your better judgment and only follow the client's wishes, the client may become very upset and refuse to be cooperative if you make contrary decisions later. A client may even "turn against you" and become belligerent and hostile.

15) Do not get too comfortable and let your guard down with clients. Remember that you are providing a service for them—they are not your friends.

16) Depending on the case, it may be possible to meet in a public place such as a nearby park, community center, senior center, coffee shop, etc.

17) Educate your clients about how to get rid of bedbugs with a professional pest service. Bedbugs often hide in living room furniture and bedrooms. Field workers who deal with bedbugs are most definitely at risk.

18) Wash your hands regularly. If you are out all day and are constantly touching door knobs, shaking hands and utilizing public transportation, it is easy to catch germs and spread them. Keep a hand sanitizer or wipes in your coat or bag.

19) If you are highly allergic to certain domestic animals then you should take that into account before conducting home visits. Many clients live with cats, dogs and other pets. If being around a particular animal triggers an allergic reaction, necessary precautions need to be taken into account ahead of time. In some cases you may need to see an allergist for guidance.

20) Always wear comfortable clothes and shoes while working in the field since you will be regularly walking, standing and climbing stairs.

For more information, or to contact Ms. Victor, please visit www.pascalevictor.com

