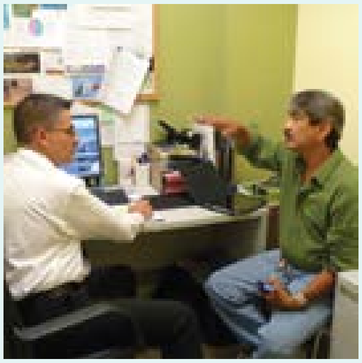
PREParing PEERS FOR SUCCESS

PEER CORE COMPETENCY TRAINING

A curriculum for engaging out-of-care or newly diagnosed people living with HIV in care and treatment



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This curriculum draws heavily from an earlier peer training toolkit, Building Blocks to Peer Success (http://peer.hdwg.org/training_toolkit). We are indebted to everyone acknowledged in that toolkit for their work, which was the starting point for this curriculum.

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INTRODUCTION

Purpose of this curriculum

The purpose of this curriculum is to support the training of HIV positive peers who work to re-engage and retain people living with HIV/AIDS (PLWHA) who have fallen out of HIV medical care, link newly diagnosed PLWHA into HIV medical care, and to improve the overall health-related quality of care of PLWHA. This training curriculum was developed through a Health Resources and Services Administration (HRSA) funded Minority AIDS Initiative (MAI) Project. Peer programs are viewed as an opportunity to help bridge the divide between people living with HIV and the health care system, in recognition of two important aspects of the HIV/AIDS epidemic in the U.S.:

1. The HIV/AIDS epidemic is growing rapidly among traditionally underserved, minority, and marginalized segments of American society.

2. Antiretroviral therapy can have a dramatic impact on health outcomes of people living with HIV infection, yet a significant proportion of underserved individuals living with HIV are not accessing this care.

Where this curriculum has been used

This curriculum was developed as part of the Peer Re-Engagement Project (PREP), a three-year randomized control study evaluating a program that brings HIV-positive peers—individuals from the community who are living with HIV—into the HIV care team to support patients who have fallen out of care or who are newly diagnosed with HIV and at risk of falling out of care. The project focuses on supporting racial and ethnic minorities struggling with behavioral health issues, and/or unstable housing, a population that is at high risk of not engaging or staying in HIV care. Through HRSA MAI funding, three sites—CARE Resource in Miami, FL; PR CoNCRA in San Juan, PR and The PATH Center in Brooklyn, NY—have used this peer training curriculum to prepare their peers to work with PLWHA to engage and retain them in continuous HIV medical care. This curriculum is designed to provide a complete set of training materials, along with

> *When you have just received this diagnosis, there is nothing better in life than to have someone by your side on whom you can count. A person who has had the same experience, who is living it, who is taking medications—a living witness. One of the most important things for the success of treatment is that you have someone who supports you.*
>
> Dr. Roberto Calderón Santiago
> PR CoNCRA
> San Juan, PR

instructions about how to use them to train peers in your community. More information about the Peer Re-engagement Project can be found at http://www.hdwg.org/prep/

What is a peer?

For this initiative and other similar HIV initiatives, peers are defined as "individuals who are affected by or infected with HIV, share similar background characteristics with the patients being served, and are not clinically trained health care professionals. They may have the title of peer counselors, community health workers, promoters, outreach workers, treatment educators, peer educators, consumer trainers, and/or peer advocates. Peers are incorporated into the HIV health care team to work in conjunction with medical, mental health and service providers.

Who should use this curriculum?

The primary audiences for this curriculum are Ryan White and Community Health Center clinics interested in training and incorporating peers into their clinical team. This curriculum will train peers to work as members of the clinic health care team to assist new PLWHA in engaging and staying in continuous HIV medical care as well re-engaging and retaining PLWHA who have fallen out of HIV medical care. This curriculum is an introduction, and continuing education will be necessary for peers depending on program/agency objectives, peer and patient needs, and new developments in treatments, services and research.

How this curriculum was developed

Much of the curriculum presented here is drawn from a toolkit titled *Building Blocks to Peer Success,* which can be found on the Web at http://peer.hdwg.org/training_toolkit *Building Blocks* combines the expertise and materials of several organizations that provide peer training. It contains additional training modules that can be used to address your organization's specific training needs related to peer core competencies, topics for continuing peer education, classroom activities, and case studies for discussion. The toolkit guide includes lots of tips for developing and conducting peer trainings, with sample materials from

Peer:

(within the context of this initiative)

An individual who is affected by or infected with HIV, shares similar background characteristics with the patients being served, and is not a clinically trained health care professional.

> "Peer is synonymous with HIV. The friends and companions to those first cases in the early 80's were peers, advocating, listening, nurturing, feeding and lending comfort. When I first heard of the position as peer educator for the PREP Program, I thought, this is my dream position. Almost three years later, the journey has provided me endless opportunities to assist, advocate and educate the clients who enrolled and were assigned to me. Sometimes when we meet for a session, I can't help but see Michael looking back at me."
>
> A peer at CARE Resource in Miami

other programs. We recommend that you familiarize yourself with this information as you plan a peer training within your organization.

How this curriculum is organized

Peer-Patient Educational Sessions

The curriculum for the PREP intervention is intended for a five-day peer training to prepare peers to interact with patients through a series of 30-60 minute face-to-face educational sessions. The purpose of these educational sessions is to inform patients about a variety of issues that they may face as individuals living with HIV. The following is a list of the topics covered by the peer with their patients in each session.

Session 1– Introduction & Assessment
Session 2 – HIV Transmission & the Viral Life Cycle
Session 3 – Effective Communication and Self-Advocacy (on-going)
Session 4 – Understanding Lab Values
Session 5 – HIV Medications
Session 6 – Drug Resistance & Adherence; Understanding & Managing Side Effects
Session 7 – Disclosure and Stigma
Session 8 – Harm & Risk Reduction

A Peer-Patient Educational Session Conversation Guide is included in Training Handout #2 on pages 14-21. A more detailed explanation of how peers worked with patients in these individual sessions in the PREP intervention is outlined in the Intervention Manual, available on the Web at http://www.hdwg.org/prep/curricula

The curriculum is presented here in roughly the order in which peers will present it to patients in the eight sessions outlined above. It is divided into the suggested sequence for each day of training, as presented in the sample agenda in Training Handout #1 on pages 9-13.

Other considerations for using this curriculum

Powerpoint slides accompany many of the activities outlined here, and you will find specific slides referenced by number throughout the curriculum. These slides can be found on the PREP curricula page at http://www.hdwg.org/prep/curricula

Finally, please note that the final session on day 5 is dedicated to exploring how peers and case managers may work together as part of the interdisciplinary team. It is recommended that case managers who will be working with the peers being trained be invited to attend the Case Manager Question and Answer portion of this session. For more information, please see Session XX: Case Manager Q&A on page 236.

Climate-setting activities

The Sample Training Agenda for each day, included in Training Handout #1 on pages 9-13, allows time for several climate-setting activities, including icebreakers, energizers, and wrap-up and evaluation. These activities are not part of the core competencies the peers are being trained in. They are nevertheless important to help facilitate group interaction and learning, break up the day, reinforce what is being learned, and bring closure to the training.

Icebreakers

Icebreakers are a way to get everyone's voice in the room. Once people have spoken, they are more likely to speak again. Icebreakers help participants feel more comfortable and engage them in a participatory manner right from the start of any training. It is useful to begin each day with an icebreaker. This curriculum includes explicit icebreakers on Day 1 and Day 2. For the remaining three days, you may wish to select an appropriate icebreaker from the many activities offered in the *Building Blocks to Peer Success* Activities page at http://peer.hdwg.org/training_toolkit/activities

Energizers

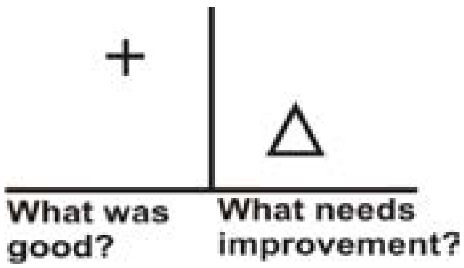
Energizers enliven a training by re-invigorating the group after lunch, after a serious discussion, or late in the day. They increase the energy in the room. For examples of energizers that can be incorporated into your training, see the Building Blocks to Peer Success Activities page at http://peer.hdwg.org/training_toolkit/activities

Building in repetition

The Sample Training Agenda in Training Handout 1 on pages 9-13 allows for a few minutes of review at the beginning and end of each day. The curriculum for each day concludes with a summary of the main points discussed in the sessions presented on that day and how these lessons relate to the peer-patient educational sessions outlined above. These summaries may be used to reinforce learning and ensure understanding before new material is introduced. As participants gain in knowledge, you may wish to vary the routine by using the Jeopardy Game that is part of the *Building Blocks to Peer Success* toolkit, available at http://peer.hdwg.org/training_toolkit/jeopardy

Wrap up and evaluation

Time is allotted in the Sample Training Agenda for Wrap-up and Evaluation at the end of each day. A quick plus-delta exercise can help to elicit feedback from the group. In this exercise, an upside-down "T" chart can be drawn on a flip chart:



Participant comments are written under each symbol to generate a list of areas of strengths and where improvements are needed.

More resources

Many more considerations and ideas for conducting a training, including preparation, facilitation, and evaluation, can be found in the *Building Blocks to Peer Success Toolkit* at http://peer.hdwg.org/training_toolkit

What peers will learn

Some of the material in this curriculum provides peers with the knowledge they need to discuss topics with patients, such as HIV life cycle, HIV medications, disclosure, and harm reduction. The curriculum also equips peers with skills they can draw on when interacting with patients and with the interdisciplinary team within the organization—such as communication skills, motivational interviewing, confidentiality, understanding the peer role and working with managers. At the conclusion of the training, peers will have a greater understanding of the effects of HIV/AIDS on their lives and on the lives of others, and they will be better able to communicate and comprehend their role in helping other HIV-positive individuals conquer the challenges and obstacles to living a healthy, full life.

> “*I identify with her because she went through the same process that I’m going through. When I started to identify with her, I was able to cleanse myself of my bad habits. She has helped me a lot.*
>
> A patient talking about her peer”

SAMPLE TRAINING AGENDA

Below is a sample five-day training agenda. This curriculum is intended to prepare peers to interact with patients through a series of eight 30-60 minute educational sessions. The purpose of these sessions is to inform patients about a variety of issues that they may face as individuals living with HIV. See page 7 for a list of the topics covered by the peer with their patients in each session.

DAY 1

Time	Duration	Activity
8:30 - 9:00	30 minutes	Arrival and breakfast
9:00 - 9:25	25 minutes	Welcome and trainer introductions Training and project overview Logistics and agreements
9:25 - 9:55	30 minutes	M&M ice breaker
9:55 - 12:00	2 hours 10 minutes*	**Session I: Peer Role** (15-minute break)
12:05 - 12:50	45 minutes	Lunch
12:50 - 1:05	15 minutes	Energizer**
1:05 - 2:30	1 hour 15 minutes*	**Session II: Peer Communication Skills - Part 1** (15-minute break)
2:30 - 3:30	1 hour	**Session III: HIV Basics**
3:30 - 4:00	30 minutes	Review, Wrap-up and Evaluation (+/Δ)***

* Includes break time between session topics

** Energizers enliven a training by re-invigorating the group after lunch, after a serious discussion or late in the day. They increase the energy in the room. For examples of energizers that can be incorporated into your training, see the *Building Blocks to Peer Success* Activities page at http://peer.hdwg.org/training_toolkit/activities

***See page 8 for an explanation of the Plus/Delta exercise that is part of the wrap-up and evaluation.

DAY 2

Time	Duration	Activity
8:30 - 9:00	30 minutes	Arrival and breakfast
9:00 - 9:15	15 minutes	Burden Basket Icebreaker**
9:15 - 9:20	5 minutes	Review of previous day
9:20 - 10:55	1 hour 35 minutes*	**Session IV: The Immune System and the HIV Life Cycle** (15-minute break)
10:55 - 12:20	1 hour 25 minutes*	**Session V: HIV Medications** (10-minute break)
12:20 - 1:20	1 hour	Lunch
1:20 - 1:35	15 minutes	Energizer**
1:35 - 3:05	1 hour 30 minutes*	**Session VI: Peer Communication Skills - Part 2** (10-minute break)
3:05 - 4:00	55 minutes	**Session VII: Peer Disclosures**
4:00 - 4:30	30 minutes	Review, wrap-up and evaluation (+/Δ)***

* Includes break time between session topics

** Icebreakers help participants feel more comfortable and engage them in a participatory manner right from the start of any training. Energizers enliven a training by re-invigorating the group after lunch, after a serious discussion or late in the day. They increase the energy in the room. For examples of icebreakers and energizers that can be incorporated into your training, see the *Building Blocks to Peer Success* Activities page at http://peer.hdwg.org/training_toolkit/activities

***See page 8 for an explanation of the Plus/Delta exercise that is part of the wrap-up and evaluation.

DAY 3

Time	Duration	Activity
8:30 - 9:00	30 minutes	Arrival and breakfast
9:00 - 9:20	20 minutes	Icebreaker**
9:20 - 9:25	5 minutes	Review of previous day
9:25 - 11:35	2 hours 10 minutes*	**Session VIII: Assessing Adherence** (10-minute break)
11:35 - 12:35	1 hour	**Session IX: Drug Resistance**
12:35 - 1:20	45 minutes	Lunch
1:20 - 1:35	15 minutes	Energizer**
1:35 - 2:10	35 minutes	**Session X: Understanding Labs**
2:10 - 3:05	55 minutes	**Session XI: HIV Stigma**
3:05 - 4:40	1 hour 35 minutes*	**Session XII: Values** (10 minute break)
4:40 - 5:00	20 minutes	Review, wrap-up and evaluation (+/Δ)***

* Includes break time between session topics

** Icebreakers help participants feel more comfortable and engage them in a participatory manner right from the start of any training. Energizers enliven a training by re-invigorating the group after lunch, after a serious discussion or late in the day. They increase the energy in the room. For examples of icebreakers and energizers that can be incorporated into your training, see the *Building Blocks to Peer Success* Activities page at http://peer.hdwg.org/training_toolkit/activities

***See page 8 for an explanation of the Plus/Delta exercise that is part of the wrap-up and evaluation.

DAY 4

Time	Duration	Activity
8:30 - 9:00	30 minutes	Arrival and breakfast
9:00 - 9:20	20 minutes	Icebreaker**
9:20 - 9:25	5 minutes	Review of previous day
9:25 - 11:25	2 hours*	**Session XIII: Motivational Interviewing** (10-minute break)
11:25 - 12:30	1 hour 5 minutes*	**Session XIV: Supporting Patients with Disclosure** (10-minute break)
12:30 - 1:05	35 minutes	Lunch
1:05 - 1:20	15 minutes	Energizer**
1:20 - 2:20	1 hour*	**Session XV: Depression and HIV** (5-minute break)
2:20 - 3:15	55 minutes*	**Session XVI: Harm Reduction** (5-minute break)
3:15 - 4:45	1 hour 30 minutes*	**Session XVII: Sexual Health** (5-minute break)
4:45 - 5:00	15 minutes	Review, wrap-up and evaluation (+/Δ)***

* Includes break time between session topics

** Icebreakers help participants feel more comfortable and engage them in a participatory manner right from the start of any training. Energizers enliven a training by re-invigorating the group after lunch, after a serious discussion or late in the day. They increase the energy in the room. For examples of icebreakers and energizers that can be incorporated into your training, see the *Building Blocks to Peer Success* Activities page at http://peer.hdwg.org/training_toolkit/activities

***See page 8 for an explanation of the Plus/Delta exercise that is part of the wrap-up and evaluation.

DAY 5

Time	Duration	Activity
8:30 - 9:00	30 minutes	Arrival and Breakfast
9:00 - 9:20	20 minutes	Icebreaker**
9:20 - 9:25	5 minutes	Review of previous day
9:25 - 10:25	1 hour*	**Session XVIII: Documentation** (10-minute break)
10:25 - 12:35	2 hours 10 minutes*	**Session XIX: Confidentiality and Boundaries** (5-minute break)
12:35 - 1:15	40 minutes	Lunch
1:15 - 1:30	15 minutes	Energizer**
1:30 - 3:40	2 hours 10 minutes*	**Session XX: Peer Case Manager Session [optional]** (15-minute break)
3:40 - 3:55	15 minutes	Continuing education plan***
3:55 - 4:25	30 minutes	Review, wrap-up and written evaluation
4:25 - 4:40	15 minutes	**Graduation Ceremony and Closure**

* Includes break time between session topics

** Icebreakers help participants feel more comfortable and engage them in a participatory manner right from the start of any training. Energizers enliven a training by re-invigorating the group after lunch, after a serious discussion or late in the day. They increase the energy in the room. For examples of icebreakers and energizers that can be incorporated into your training, see the *Building Blocks to Peer Success* Activities page at http://peer.hdwg.org/training_toolkit/activities

***Use this time to discuss additional topics for training that you didn't have time to address in a 5-day training course. These could be offered at subsequent trainings, reunion meetings, or provided as part of orientation for newly hired peers. Ideas and curricula for continuing education topics can be found on the *Building Blocks to Peer Success* Continuing Education page at http://peer.hdwg.org/training_toolkit/continuing_education

PEER-PATIENT EDUCATIONAL SESSION CONVERSATION GUIDE

This curriculum was developed and used to train peers as part of the Peer Re-Engagement Project (PREP), a three-year study evaluating a program that brings HIV-positive peers—individuals from the community who are living with HIV—into the HIV care team to support patients who have fallen out of care or who are newly diagnosed with HIV and at risk of falling out of care. In this study, peers were trained to interact with patients in a series of eight interactive sessions, 30-60 minute face-to-face meetings that were scheduled roughly on a bi-weekly basis. The purpose of these educational sessions was to inform patients about a variety of issues that they may face as individuals living with HIV. Below is a conversation guide that outlines the education sessions that were used in this study. Your organization may wish to make adjustments to the content, number or length of sessions or frequency of meetings with patients, depending on the goals of the peer program within the organization.

These sessions are meant to be flexible. The content of the curriculum can be adapted to suit the needs of the particular patient. Additionally, peers recognize that life events can sometimes interfere with educational sessions. Part of the peer role is to provide emotional support as needed, and if this is the case, it will often cut into the time of the more structured educational sessions. The peers use their time with patients to provide this kind of support and provide education and are always flexible depending on the current situation of their patients.

Tips for Preparing for a Peer–Patient Session

- Check notes from previous encounters
- Check progress notes from other providers (if have access to these)
- Check latest labs
- If possible, meet with team to discuss progress of particular patients (during team huddles) for patients that are having difficulty engaging in care or are dealing with particularly difficult issues at the time.

Peer–Patient Session Materials

- Educational Session 2: *HIV Life Cycle—the Big Picture* (pg. 70); *Stages of HIV Infection* (pg. 57); *Routes of Transmission Risk* (pg. 54)
- Educational Session 3: *How to Prepare for a Visit with your Doctor* (pg. 120); Symptoms Log (pg. 121); *HIV Patient Bill of Rights* (pg. 124); *HIV Patient Bill of Responsibilities* (pg. 125)
- Educational Session 4: *Monitoring Tests for People with HIV* (http://www.thebody.com/content/art2599.html)
- Educational Session 5: *Medications at Work in the HIV Life Cycle* (pg. 78); *Medications in the HIV Life Cycle (pg. 79)*
- Educational Session 6: *Assessing Adherence* (pg. 108); *Symptoms Log* (pg. 121)
- Educational Session 7: *Some Considerations Before You Disclose* (pg. 173)
- Educational Session 8: *Substance Use and Harm Reduction* (pg. 187)

Educational Session 1 - Introduction and Assessment

Conversation starter: Introductions

- Hi, my name is _____ and I am a peer. A peer is someone who is living with HIV and has learned to manage and control it.
- I've been positive since ______ and have overcome many obstacles because I got the support that I needed to take control of HIV.
- One of the things that helped me the most was learning about the disease and how to control it, and hearing how others were coping with their diagnosis and the things they did to overcome the stress, fear, and anxiety associated with being HIV-positive.
- My role is to give you health information and be someone you can turn to for support.
- Tell me about yourself. When did you receive your diagnosis and how have you been coping with the disease (medically, home life)? Do you have family or any other support?
- For patients that are new to the clinic or been out of care; not newly diagnosed:
  - o How did you find out you have HIV? How long have you been positive?
  - o When were you last seen by a doctor? Where were you receiving care in the last year? What has been getting in your way of coming into the clinic?
  - o Are you taking medications? If yes, how is it going?
  - o Who is your doctor/medical provider? What is it that you like about the way your doctor/medical provider manages your care? Is there anything that you would like to talk about with your doctor/medical provider? Is there anything that you wanted to say to your doctor but didn't dare to? Is there anything that you dislike in the way he/she manages your medical care?
  - o Where are you living now/what is your living situation?
  - o Do you have anyone in your life that provides social support? Who else knows you have HIV?
  - o Have you made any medical appointments? Other appointments? How can I help you get to your appointments?
- For patients that are newly diagnosed with HIV:
  - o How did you find out you have HIV?
  - o Where are you living now/what is your living situation?
  - o Do you have social supports? Who else knows you have HIV?
  - o Have you made any medical appointments? Other appointments? How can I help you get to your appointments?
  - o How do you feel about your diagnosis? (PEER may want to share their feelings about first learning about their diagnosis, how long he/she has been positive, and what the experience was like for them)
- What do you know about HIV? Where did you get this information?
- Your participation with me in this program will allow us to work together on your learning about HIV transmission/viral life cycle, meds, and resistance etc. over the next several weeks.
- These are some of the things we'll be going over in our meetings – how does this sound? Is there anything else you'd like to discuss?
- What particular questions do you have about HIV?
- Thanks for taking the time to meet with me today. Let's plan to meet again on_______________

Session 2 – HIV Transmission and The Viral Life Cycle

Conversation starter: Transmission

- Today I'd like to discuss how HIV is transmitted and the different stages it goes through once it enters your blood. This includes the body fluids that transmit HIV and the ones that don't, the pathways that allow HIV to enter the body, HIV symptoms and AIDS symptoms.
- We'll also discuss the immune system, the stages of HIV infection, and how HIV invades CD4 cells to multiply and then destroy those cells. This is called the viral life cycle.
- Knowing how the virus works gives you the power to control it.
- In a couple of weeks, we will learn where/how medications work in reducing replication of HIV that allows the viral load to be low and your immune system strong.
- Let's plan to meet again on ___________________

Suggested materials: *HIV Life Cycle—the Big Picture* (pg. 70); *Stages of HIV Infection* (pg. 57); *Routes of Transmission Risk* (pg. 54)

Educational Session 3 - Effective Communication and Self-Advocacy

Conversation starter: Effective communication and self-advocacy

- Let's review the importance of communicating effectively with your providers and how that impacts your health, as well as the importance of advocating for yourself.
- Having a partnership with your health provider is important because you want to have equal ownership about health decisions. Usually as a patient we follow whatever the doctor/nurse tells us to do; however research has shown that patients who ask questions increase their knowledge of their health/disease and have better health outcomes when fully involved in making health decisions.
- Suggestions to communicate more effectively are to come prepared with a list of questions for your medical appointments and/or I can help you prepare the list before your appointment, writing down any symptoms you experience between medical appointments is helpful – it's called a "symptom log," letting your provider know if you have missed appointments, honestly telling your doctor that you are uncomfortable with changes they may be recommending, and being truthful with your providers are ways to increase communication; yet advocate for yourself.
- Sometimes it may take a while to gain a trusting relationship, but know that I can attend your appointments with you, or if there is a supportive person in your life, you can ask them to attend the appointments with you.
- Let's plan to meet again on ___________________

Suggested materials: *How to Prepare for a Visit with your Doctor* (pg. 120); Symptoms Log (pg. 121); *Questions for Your Doctor about Medications* (pg. 123); *HIV Patient Bill of Rights* (pg. 124); *HIV Patient Bill of Responsibilities* (pg. 125)

Educational Session 4 - Understanding Lab Values

Conversation starter: Understanding lab values

- Your doctor will order blood tests on a regular basis to check HIV progression, see if your medications are working (if you're on meds), and determine the effects of HIV and meds on your organ function. This is why it's so important to come in to get your blood drawn every 3-4 months; if you don't, it will be very hard to take control of HIV and understand how the medications impact the virus.
- We're not going to cover every single blood test in this session, just the most common ones including: CD4 count, CD4 percent, viral load count, complete blood-cell count, liver function, kidney function, lipid profile, blood pressure, glucose levels, cholesterol, etc. These tests tell a story about your health and what needs to be done to keep you healthy.
- We'll also discuss healthy heart and the effects of HIV disease.
- Another reason to get your labs done regularly and understand what the numbers mean is that you and your doctor can do certain things to change the lab values whenever they're not normal. For example, if your cholesterol is too high, you and your doctor can intervene to lower it. If your CD4 is too low, you and your doctor can intervene to increase it.
- It's kind of like checking the oil in your car engine or taking your car in for a tune-up. If you don't do these things, what will happen to your car eventually? [Responses: Your car will need costly repairs or you may need a new car.]
- Routine screenings for preventive care are very important such as: eye exams, mammograms, PAPS, prostate, STD screenings. In addition, preventive care vaccines like flu, pneumonia and hepatitis are essential to maintaining good health.
- Have you had labs done, and what were the results?
- Let's review them to ensure that you understand the different labs that are monitored. We can also track your results on a spreadsheet. That way you can monitor independently and increase understanding of labs and your health. Always ask for a copy of your labs and keep them in one place so that if you move or change physicians, your new physician has a history of your care and treatment.
- Let's plan to meet again on ____________________

Suggested materials: *Monitoring Tests for People with HIV* (http://www.thebody.com/content/art2599.html)

Educational Session 5 - HIV Medications

Conversation starter: HIV medications

- HIV medications are beneficial for you. Because of HIV meds, many people are living longer, fuller lives. I don't think many of us would be alive today if it weren't for HIV meds. Many people are living longer – 10, 20, 30 years and beyond – because of HIV meds. You can do it too!
- Taking meds is one of the most important things you can do to take control of HIV.
- Each individual responds differently to meds: some people get intense side effects, while others get mild or no side effects; some people have side effects in the first 30 days and then they disappear. Because of this, it is important not to judge how your body will respond to meds by other people's experiences but from your own experience.
- Remember: the benefits of taking meds outweigh any difficulty taking them. Remember, too, that if they don't work for you, your doctor can put you on different meds until you find the ones that are just right for you.
- We're fortunate that today there are many meds to choose from, and newer meds have fewer side effects than the older ones.
- Taking meds can be complicated at first, but once you develop a daily routine, it gets easier.
- I can give you ideas about how to remember to take meds on time, how to take them correctly, and I will be here for you whenever you need to talk about them.
- It's a big commitment, but one that eventually becomes second nature for most, and one that could bring you good, stable health and longevity.
- Together we – you, me, the doctor, case manager and anyone else involved in your care – can minimize any negative experiences that may (or may not) develop.
- Now, let's take a look at the goals of HIV meds and how they work to stop HIV from multiplying in order to give your immune system a fighting chance.
- Let's look at the different combination of medications that are available and where they work in the viral life cycle to reduce the virus.
- Let's plan to meet again on ____________________

Suggested materials: *Medications at Work in the HIV Life Cycle* (pg. 78); *Medications at Work in the HIV Life Cycle* (pg. 79); *Assessing Adherence* (pg. 108)

Educational Session 6 - Drug Resistance & Adherence; Understanding & Managing Side Effects

Conversation starter: Drug resistance & adherence

- Today's session builds on the last session we had on HIV meds: adherence, resistance and managing side effects.
- Adherence means "sticking to your medication schedule" at least 95% of the time. It means taking your meds correctly and on time every day. It also means managing side effects so that you're not discouraged from continuing to take your meds.
- Most people who stop taking meds do so because of side effects. Perhaps they didn't have information about how to manage side effects, or no one helped them learn how to manage them. But you have a team of people supporting you in sticking to your meds and identifying possible barriers to adherence, including me. In addition, there are many methods and tools (pillboxes, calendars, alarm watches etc…) available to help.
- We'll also talk about medication resistance; there are different types, and some are the direct result of non-adherence.
- Resistance means that the meds no longer work in blocking HIV from multiplying. HIV usually becomes resistant when it is not totally controlled by medications. Now, let's get started.

Conversation starter: Managing side effects

- Many side effects are related to your digestive system, e.g., nausea, diarrhea, bloating, gas, etc. Many people manage these with other medications or certain foods:
    - Apples and apple products like apple juice and apple sauce (Possible concern about arsenic levels in the current apple supply.)
    - Black or green decaf tea
    - Boiled white rice
    - White toast
    - Ginger and ginger products like ginger tea, candied ginger, ginger ale, ginger snaps, etc.
    - Yogurt
    - Soda crackers
    - Fiber-rich foods or supplements
    - Medication: Imodium AD (loperamide)
- It's always important to contact your provider immediately to let them know if you're experiencing side effects.
- Never stop taking your medications without getting guidance from your providers.
- Let's plan to meet again on ____________________

Suggested materials: *Assessing Adherence* (pg. 108); *Symptoms Log* (pg. 121)

Educational Session 7 - Disclosure and Stigma

Conversation starter: Disclosure and stigma

- To tell or not to tell. To whom should I tell, everyone or a few? Whether you've been positive for a while or newly diagnosed, disclosing your status is different for each of us and sometimes can be complicated. There is no exact way of knowing when the right time is or the right way.
- Is there anyone you feel that you **must** tell, like a spouse, a partner, or perhaps someone whom you've been dating? It takes time to adjust to being HIV-positive, but keep in mind that there are HIV laws and statues in each state that are different. In some states, it is unlawful for a person living with HIV to engage in sexual activity with another person, donate organs or blood, or share needles. Condoms are not always a defense, despite the fact that condoms have been proven to reduce the risk of HIV infection, so know the laws in your state. With that in mind, it's a good idea not to rush into disclosing your status without first giving it some thought.
- There are some general tips:
  - Consider the five "Ws"-who, what, when, where and why.
    Who do you need to tell?
    What do you want to tell them about your HIV infection, and what are you expecting from the person you are disclosing your status to?
    When should you tell them?
    Where is the best place to have this conversation?
    What are you telling them?
  - ***Keep it simple. You don't have to tell your life story.***
- Let's plan to meet again on ____________________

Suggested materials: *Some Considerations Before You Disclose* (pg. 173)

Educational Session 8 - Harm & Risk Reduction

Conversation starter: Prevention messages – sexual health

- Today we are going to discuss sexual health. My goal is not to pry into your sex life, but to give you information about how to prevent HIV and sexually transmitted infections.
- This is an important topic, because your sexual health is related to your overall health and well-being.
- As sexual beings, sex is an important aspect of our lives, and there's no reason why we couldn't have a gratifying and fulfilling sex life just because we have HIV.

(cont. next page)

Educational Session 8 - Harm & Risk Reduction (cont.)

- For the longest time, health care and other service providers refrained from discussing the sexual lives of their HIV patients. They often felt that having that conversation could further stigmatize people with HIV, as it could trigger judgment on the part of the provider, and also because they themselves were uncomfortable having that kind of conversation. But people with HIV were clamoring for information about safer sex because, by and large, they didn't want to infect their sexual partners and also wanted to protect themselves from STI/STD, HCV and drug resistance. Now we are taking the time to have this conversation with all of our patients.
- Please remember that whatever information you share about your sex life is strictly confidential.
- Let's go over HIV transmission first, then STIs.

Risk hierarchy of sexual HIV transmission for HIV+ people:

High risk:

- Unprotected anal sex
- Unprotected vaginal sex
- MSM only: having unprotected anal sex as a bottom

Note: risk-reducing methods in high-risk sexual encounters: using lube, pulling out before ejaculating, having fewer exposures, having fewer partners, having an undetectable viral load, having regular STI screening (at least twice a year), being vaccinated against hep A&B, avoiding vaginal sex during menstruation, avoiding alcohol and drugs before or during sex (impairs decision making)

Low risk:

- Receiving oral sex
- Anal sex with condom
- Vaginal sex with condom

Note: risk-reducing methods in low-risk sexual encounters: not brushing or flossing before giving oral sex, not having oral sex when oral infection is present (bleeding gums), using condoms correctly, using water- or silicone-based lubricant

No risk:

- Giving oral sex
- Mutual masturbation
- French kissing
- Golden showers
- Sex toys (must be washed after each partner's use)
- Massage
- Ejaculating on partner's body (where there's no cavity or portal into blood stream)
- Abstinence

(cont. next page)

Educational Session 8 - Harm & Risk Reduction (cont.)

Conversation starter: Prevention messages - drug use (for patients who use alcohol and/or drugs)

- This portion of the harm reduction session focuses on recreational drug use including alcohol.
- It is important to know that alcohol and other drugs can suppress your immune system. They also reduce your inhibitions and may cause you to take risks you wouldn't normally take.
- Because all drugs are processed through your liver, it is important to know that too many drugs being processed at the same time can increase liver function and make you feel sick; it can cause liver failure or permanent liver damage.
- If you take HIV meds and then recreational drugs, the recreational drug has to "wait in line" to get into the liver and be processed. This can lead to a situation called "inhibition" which can cause an overdose of the recreational drug.
- If you take recreational drugs and then HIV meds, this could lead to a situation called "inducing" which means that your HIV meds would get processed too quickly and not get fully absorbed by your body. It could also lead to harmful drug interactions.
- If you inject drugs, make sure you use a new needle every time to avoid abscesses.
- Do not share your needle with anyone else, as this is the easiest way to transmit HIV.
- If you use a needle that someone else has used, you may acquire hepatitis C (this is the easiest way to acquire hepatitis C).
- If you do share needles and works, make sure you clean your needle and works with bleach and water (add cleaning instructions here).

Suggested materials: *Substance Use and Harm Reduction* (pg. 187)

PREParing PEERS FOR SUCCESS: DAY 1

PEER CORE COMPETENCY TRAINING

A curriculum for engaging out-of-care or newly diagnosed people living with HIV in care and treatment

PEER ROLE

PEER COMMUNICATION SKILLS

HIV BASICS

August 2014

Health & Disability Working Group, Boston University School of Public Health

DAY 1: Peer Role, Peer Communication Skills (pt.1), HIV Basics

An Overview of Today's Sessions and Topics

Topic	Duration	Slides	Page
Peer Competency Training Introduction	15 min.	1-5	25-26
M&M Icebreaker*	30 min.	6	27-28
Session I: Peer Role	**1 hr. 55 min. (total)**	**7-12**	**29-44**
Topic: What is a Peer?	35 min.	8	29-30
Topic: Peer Roles	20 min.	9	31-33
Topic: Peer Role Readings	15 min.	10	34-36
Topic: What Makes Peers Unique?	15 min.	11	37-38
Topic: What Does it Take to be a Peer?	30 min.	12	39-44
Energizer*	15 min.		
Session II: Peer Communication Skills, Part 1	**1 hr. (total)**	**13-17**	**45-49**
Topic: Elements of Communication	5 min	14	45
Topic: Asking Questions	5 min	15	46
Topic: Converting Questions Exercise	15 min	16	47-48
Topic: Name That Celebrity	35 min	17	49
Session III: HIV Basics	**1 hr. (total)**	**18-23**	**50-59**
Topic: Defining HIV and AIDS	10 min	19	50
Topic: HIV Transmission	10 min	20	51-52
Topic: Routes of Transmission	15 min	21	53-54
Topic: The Stages of HIV Infection	15 min	22	55-57
Topic: The HIV Train	10 min	23	58-59
Review, wrap-up, and evaluation*	30 min.		60

* See pages 7-8 for an explanation of these climate-setting activities

Throughout this curriculum, *italicized words* are intended to be spoken directly to the class.

This publication is part of the online curriculum *PREParing Peers for Success: Peer Core Competency Training*. For the complete curriculum, accompanying PowerPoint slides, and other curricula in the series, visit http://www.hdwg.org/prep/curricula

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PEER COMPETENCY TRAINING INTRODUCTION

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #1-5

Objectives:

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

- Introduce the training and the program

Training Methods: Presentation

In this activity you will:

- Welcome participants
- Introduce the training
- Discuss logistics and agreements

Materials:

- None

Preparation:

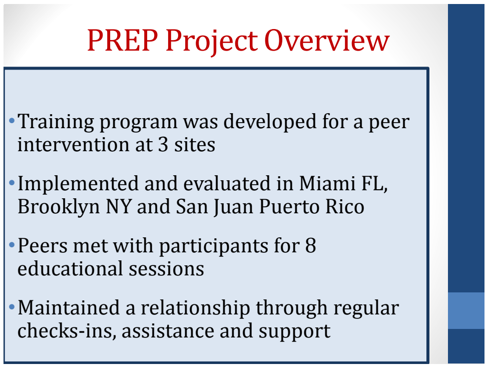
- None

Instructions

1. Welcome participants

2. Introduce facilitators

3. Review slide 2:



PREP Project Overview

- Training program was developed for a peer intervention at 3 sites
- Implemented and evaluated in Miami FL, Brooklyn NY and San Juan Puerto Rico
- Peers met with participants for 8 educational sessions
- Maintained a relationship through regular checks-ins, assistance and support

- *This training program was designed to train peers to implement a peer intervention to re-engage HIV positive out-of-care minority patients in HIV primary care, or to connect newly diagnosed or new patients into care if they present with a need for mental health services, substance abuse treatment, or housing services.*

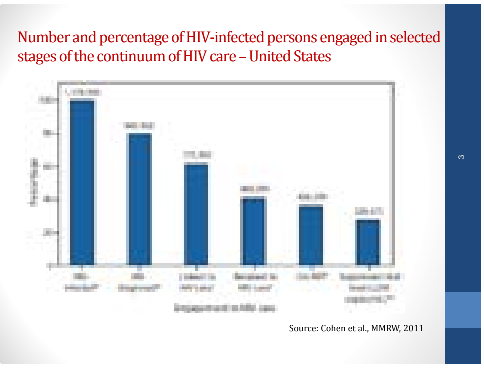
- *It was funded by the Health Resources & Services Administration (HRSA)/Bureau of HIV/AIDS, and implemented at three HIV primary care clinics in San Juan, Puerto Rico, Brooklyn, New York and Miami, Florida. These clinics worked with the Health and Disability Working Group (HDWG) at Boston University School of Public Health in Boston, Massachusetts to implement and evaluate the intervention.*

- *Peers were trained to conduct eight educational sessions with patients, addressing a range of topics. They maintained a relationship with patients over the course of the intervention through regular check-ins, assistance, and support.*

PEER COMPETENCY TRAINING INTRODUCTION

- *The program was evaluated to find out if this intervention was successful in keeping HIV-positive patients in care, increasing HIV knowledge and awareness, empowering people to manage their HIV care and treatment, and improving clinical outcomes such as viral load suppression.*

4. Review slide 3:

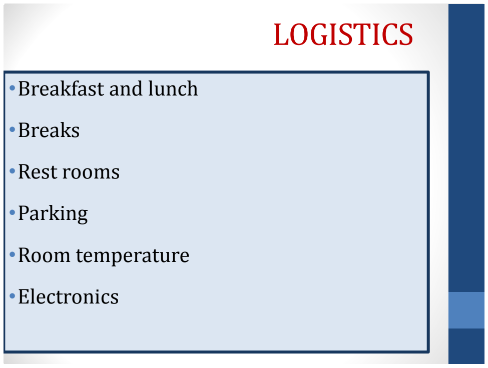


Number and percentage of HIV-infected persons engaged in selected stages of the continuum of HIV care – United States

Source: Cohen et al., MMRW, 2011

- *To reap the full benefits offered by modern HIV medicine, it is essential that infected patients be diagnosed, link to HIV care, retained over time, adhere to potent ART, and achieve viral suppression. Unless we close these gaps, some of which cause us to lose 23% – 33% of patients at each step, even treatment as prevention will fail to achieve its potential in curbing the epidemic and improving quality outcomes.*

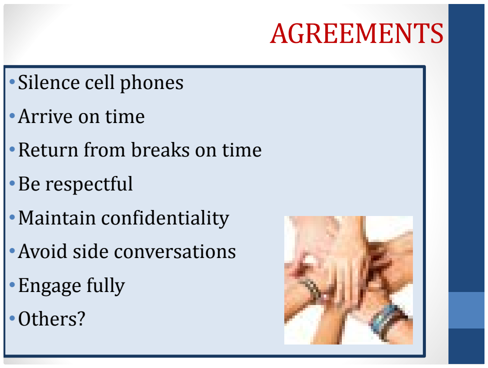
5. Review slide 4: Logistics



LOGISTICS

- Breakfast and lunch
- Breaks
- Rest rooms
- Parking
- Room temperature
- Electronics

6. Review slide 5: Agreements



AGREEMENTS

- Silence cell phones
- Arrive on time
- Return from breaks on time
- Be respectful
- Maintain confidentiality
- Avoid side conversations
- Engage fully
- Others?

PARTICIPANT INTRODUCTIONS: M&M ICEBREAKER

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #6

Objectives:

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

- Be energized to participate in the training
- Get to know each other in more depth

Training Methods: Individual activity

In this activity you will:

- Ask participants to pass a bowl of M&Ms and to take one
- Explain the exercise
- Participate in the exercise

Materials:

- M&Ms/Skittles
- Bowl
- M&Ms activity sheet
- Pens or pencils

Preparation:

- Put candy in bowl
- Make copies of M&M Activity sheet

Instructions

1. Pass around a bag of M&Ms and ask each person to pick their favorite color.
2. Pass around the activity sheets and ask each person to take one.
3. Instruct participants to find the color of the M&M on the activity sheet and write the answer to the corresponding question. For example, the question for red is: "If you were a piece of candy, what would you be and why?" Let people know they have 5 minutes to answer their question.
4. At the end of 5 minutes, ask for a volunteer to start by sharing their response to the question.
5. Ask participants to introduce themselves first and then state their response to the question.
6. Go around the room until everyone has had a chance to share their responses.

Summarize

- *This activity gave us an opportunity to share something about ourselves before we embark on this training for the next few days. Knowing something about each other makes it easier to work together.*

- *Note that what was shared was just a little part of ourselves and not everything about us.*

- Ask: "*How would it feel if you had to share everything about yourself with strangers on day one?*" Expected answers: uncomfortable, unsafe, too much information, etc.

- *It is very important to remember this when you embark on your work as peers. Peer work involves meeting new people who come to the clinic for services. You will be introducing yourself to these people for the first time and it will be important for you to share something about yourself to "break the ice" and start forming a relationship with the patient. However, sharing too much on day one may be overwhelming and not helpful. By the same token, asking the patient to share too much about themselves on day one can have the same effect.*

PARTICIPANT INTRODUCTIONS: M&M ICEBREAKER

M&M ICEBREAKER

Red

If you were a piece of candy, what would you be and why?

Blue

If you could meet any three people, dead or alive, who would they be and why?

Yellow

If you were reincarnated, what would you come back as if you could not be a human being and why?

Green

If you could visit any place in the world, where would you go and why?

Orange

If you could be only two of the following three which would you choose and why:
HEALTHY, WEALTHY, WISE?

Brown

If you were banished to a deserted island and could choose three things to take with you, what would they be and why?

SESSION I: PEER ROLE

Topic: What is a Peer?

TOTAL TIME FOR SESSION I: 1 hour, 55 minutes
SLIDES: #8-12

ABOUT THIS ACTIVITY

Time: 35 minutes

Slides: #8

Objectives:

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

- Define emotional readiness to be a peer

Training Methods:

- Lecture
- Group discussion
- Dyads

In this activity you will:

- Define the word peer
- Facilitate a discussion about peers
- Conduct an exercise to help people think about their emotional readiness to be a peer

Materials:

- None

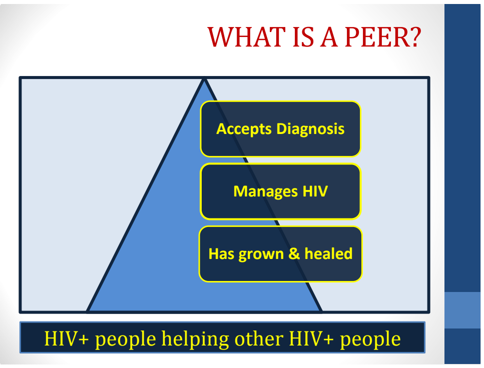
Preparation:

- None

Instructions

1. Open the session by defining the word "peer." The dictionary definition of a peer is: "a person who is equal to another in abilities, qualifications, age, background, or social status."

2. Review slide 8 with participants and facilitate discussion.



WHAT IS A PEER?

Accepts Diagnosis

Manages HIV

Has grown & healed

HIV+ people helping other HIV+ people

- Tell participants that just having HIV isn't enough to be a peer.

- *If a person is in denial about having HIV, how can s/he support another person with HIV?*

- *Generally, it can take a year or many years to grow and heal enough from the experience of learning your HIV status. If a person is still in crisis, has not dealt with the reality of living with HIV, or has not engaged in medical care, s/he is not emotionally ready to be a peer.*

3. Ask participants if they have received or provided peer support.
   - *Are there experiences in the room of giving or receiving peer support?* Allow responses and facilitate discussion.

4. Dyad exercise instructions
   - Tell participants: *We are going to do an exercise to help us think about our own emotional readiness to be a peer.*

SESSION I: PEER ROLE

Topic: What is a Peer?

- Ask them to pair up with someone sitting next to them.
- Ask them to discuss with each other the following questions (write these on newsprint for everyone to see):
  a. *What helped you accept your status?*
  b. *How are things different today from when you were first diagnosed?*
  c. *Where are you in your healing process?*

- Dyads should be brief in telling their stories, no need to say everything, just the highlights.

- Allow 10 minutes; go around and make sure that everyone understands the instructions.

Summarize

- Ask for volunteers to report out what their partners shared; allow a few to report out and move on.

- *Peers are people who have risen above the grief, fear, and hopelessness of learning their HIV status, people who have come to believe that good health and longevity can be achieved despite HIV.*

SESSION I: PEER ROLE

Topic: Peer Roles

ABOUT THIS ACTIVITY

Time: 20 minutes

Slides: #9

Objectives:

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

- Identify 4 broad categories of peer support
- Describe the role of emotional support in facilitating the other 3 categories

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Identify different peer roles
- Review the "Peer Roles" handout
- Show the peer-patient video and debrief

Materials:

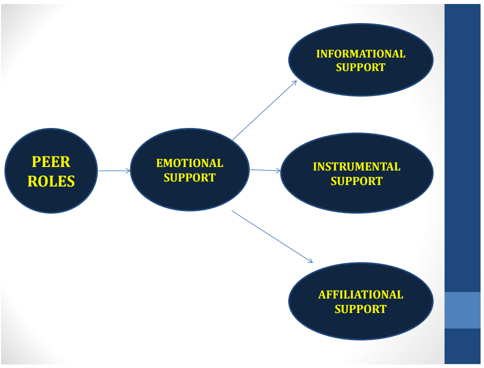
- "Peer Roles" handout
- Peer/patient video (digital story)

Preparation:

- Make copies of the "Peer Roles" handout
- Set up the peer patient video, located at:
  http://peer.hdwg.org/peer_stories/video-peer-program-makes-big-difference
- Set up the computer, projector, and screen

Instructions

1. Review slide 9 with participants and tell them that these are broad categories of what peers do. Within each category there are a number of activities.



PEER ROLES

EMOTIONAL SUPPORT

INFORMATIONAL SUPPORT

INSTRUMENTAL SUPPORT

AFFILIATIONAL SUPPORT

2. Explain emotional support as the essence of peer support: *Providing emotional support creates a connection/bonding between peer and patient, one that helps develop a relationship of trust. This trust makes it easier to provide the other service categories.*

3. Define Informative, Instrumental, and Affiliational
   - *Informative means providing information, mentoring, enlightening, role modeling.*
   - *Instrumental means serving as a means or influence, help, assist.*
   - *Affiliational means the state of being associated with others, communal, belonging to the people of a community.*

4. Draw participants' attention to the "Peer Roles" handout and review together:
   - Emphasize role modeling: *People see you as their leader, as an example that they can follow; not leading by example would make the peer leader seem hypocritical and perceived as having a double standard.*

SESSION I: PEER ROLE

Topic: Peer Roles

- Ask participants and facilitate discussion: *How would you feel going to a dentist who has rotten teeth? How would you feel about a peer leader who advocates disclosure but never discloses?*

5. Show peer-patient video and debrief
   - Link Role of Peers handout with peer-patient video. *Can you give an example from the video of how the peer demonstrated emotional, informational, instrumental, or affiliational support?*

Summarize:

- *Peers are hired because they have overcome many obstacles, have learned to manage the challenges of HIV, and can be a good example to others. This doesn't mean that peers have to be perfect or have no challenges of their own.*

- *Peers are part of a broader goal to end the epidemic by helping people with HIV engage in care, stay engaged, and adhere to treatment.*

Segue

- Tell participants that peers can have many different roles, however, the role of peers is unique from that of other service providers.

PEER ROLES

Emotional	Informational	Instrumental	Affiliational
• Share personal story • Show empathy and positive regard • Listen attentively • Elicit patient stories • Reassure patients they are not alone • Reassure patients that they can live a "normal" and productive life • Reassure patients they don't have to get sick and die • Commit to being available, give patient full attention • Let patients know that there is hope • Actively remove stigma from interactions with patients • Be friendly and genuine • Be non-judgmental	• Communicate health information • Teach patients to understand blood tests • Mentor patients on how to disclose • **Role model healthy behaviors and management of HIV** • Share information about opportunistic infections • Show patients how to take medications correctly and the importance of adherence • Share information on managing side effects • Teach healthy eating habits • Guide patients on what questions to ask providers/prepare for medical appointments • Teach about safer sex and risk reduction • Share basic information about HIV and the HIV life cycle	• 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 patients that do not show up at appointments • Complete paperwork or track down documents that will allow patients to see medical staff • Teach patients how and when to refill medications • Visit patient at the hospital	• Connect patients to support groups • Find ways to connect patients to other people living with HIV through activities like outings, conference attendance, game nights, movie nights • Encourage patients to seek support from family and friends • Increase social networks

SESSION I: PEER ROLE

Topic: Peer Role Readings

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #10

Objectives:

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

- Explain the value of peer support from others' perspectives

Training Methods:

- Individual activity
- Group discussion

In this activity you will:

- Ask volunteers to read quotes out loud

Materials:

- Quotations from people involved in peer support

Preparation:

- Prepare card sets with quotations

Instructions

1. Turn to slide 10.

READINGS

2. Ask participants to find the set of cards with quotes in their packets.

3. Ask for volunteers to read the quotes out loud.

Summarize:

- *Peer support does not only benefit the people who receive it but those who give it, the care team and the organization.*

SESSION I: PEER ROLE

Topic: Peer Role Readings

Quote from Patient:

> ...My peer gives me tips on how to take [my meds]...I take my medicine better than the way I was taking it...

Quote from Patient:

> ...I found out all the details [about HIV]....
> I knew HIV was something people had but
> I didn't know how they cared for themselves or
> how they could get it, how it's transferred...
> I didn't know any of that until I sat down with
> [my peer]...

Quote from Patient:

> ...I know if I work long enough with [my peer]
> she can show me the tricks to reach out to other
> women like me...how to go out and get people
> to come and not be ashamed of their status,
> I would like to help somebody...

Quote from a peer in Boston:

> It is much easier for people to tell their doctor that a specific goal is impossible to reach than tell a peer who has already accomplished that goal. A little peer pressure can go a long way in motivating people to attempt things once thought to be impossible.

SESSION I: PEER ROLE

Topic: Peer Role Readings

SESSION HANDOUT (Cont.)

Quote from Ralph Waldo Emerson:

> It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself.

Jackie Howell, HATS peer, Harlem Hospital:

> I like seeing the patients come in and reach a different level when they leave. The patients looked at the peers and saw how they lived—that they stopped using drugs, they were working, they were taking their medication. They saw how much better the peers were getting, and they would say ‘I want to be like that.

Rebecca Denison, Founder of WORLD:

> When I was diagnosed I felt like nobody could possibly understand what I was going through. I would have given anything to have another HIV+ woman to talk to right away. When I finally did meet another HIV+ woman, she gave me hope. She had information. She gave me courage.

Dr. Kathleen Clanon, Physician, Alameda County Medical Center, Oakland, CA:

> I think the most important things my patients get from working with a peer is hope for the future. No matter how much I talk to them about the potential for them to live long and healthy lives, seeing someone living that promise is more powerful.

SESSION I: PEER ROLE

Topic: What Makes Peers Unique?

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #11

Objectives:

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

- Define the role of the peer in the care team.

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Facilitate discussion about the specific role peers have as part of the health care team

Materials:

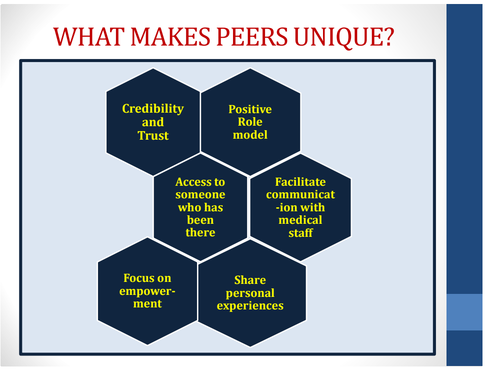
- None

Preparation:

- None

Instructions

1. Turn to slide 11.



WHAT MAKES PEERS UNIQUE?

Credibility and Trust

Positive Role model

Access to someone who has been there

Facilitate communication with medical staff

Focus on empowerment

Share personal experiences

2. Review the slide with participants; elaborate on each point, and facilitate discussion:

- *It may take a non-peer provider longer to develop a relationship with patients and earn their trust.*

- *Being able to talk with someone who is experiencing some of the same things as you gives you a valuable resource or "model" from whom to learn.*

- *Sometimes doctors speak in medical jargon and peers can help patients understand what the professionals want them to know and do.*

- *Non-peer providers do not generally share their personal experiences with their patients; in some cases it might be considered inappropriate to do so.*

- *While medical professionals focus on sickness, peers focus on empowerment and wellness; peers promote a wellness model which considers patients to be normal (as opposed to a medical model which considers patients to be ill).*

- *Peers help patients resolve ambivalence (indecision) through their own example and through the knowledge, skills, and qualities they have acquired; decisions like whether to go on meds or not, whether to disclose or use condoms.*

SESSION I: PEER ROLE

Topic: What Makes Peers Unique?

> I have learned that people who have problems with using controlled substances, people who have mental health problems, need someone to give them a hand, someone who has gone through the same thing.
>
> A Peer at PR CONCRA

Summarize:

- *The concept of peer support asserts that individuals who are living with HIV can better understand and relate to other individuals dealing with the same disease.*
- *In general, people are often more likely to hear and accept information that is presented and modeled by someone who has been there.*

SESSION I: PEER ROLE

Topic: What Does It Take to Be a Peer?

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #12

Objectives:

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

- Identify positive peer characteristics

Training Methods:

- Individual activity
- Group activity
- Discussion

In this activity you will:

- Facilitate an activity to match peer concepts to one of three key peer characteristics

Materials:

- Newsprint (3 sheets)
- Laminated cards with knowledge, skills, and qualities concepts/phrases. One concept/phrase should be listed on each card. Knowledge, Skills, and Qualities concepts/phrases are included in Handout 1
- Masking tape
- Sample Peer Job Description

Preparation:

- Tape 3 newsprints to the wall with headings "Knowledge," "Skills, and "Qualities."
- Write the definition below each word: knowledge=information acquired through experience or education; skills=action, the ability to do something well; qualities=personality traits
- Pieces of masking tape that participants can use to attach the concepts/phrases to the 3 categories

Instructions

1. Turn to slide 12.

WHAT DOES IT TAKE TO BE A PEER?

Knowledge

Skills

Qualities

2. Tell participants that peers need certain knowledge, skills and qualities that allow them to be emotionally supportive, informative, instrumental and affiliational.

3. Distribute 2-4 cards to each participant from the "Knowledge, Skills and Qualities" laminated cards until all are distributed.

4. Ask them to tape each phrase/concept to one of the 3 categories on the newsprints.

5. *You can work individually on this activity or problem-solve with each other if you're not sure where the card belongs.*

6. Allow a few minutes to tape concepts/phrases onto categories.

Debrief

Review each heading and matching concept/phrase with participants. Correct any misplaced cards.

- Ask group if there are additional concepts/phrases that they would associate with the headings and add them as well and document them on newsprint.

- Draw participants' attention to the handout list of "Knowledge, Skills and Qualities" in their training packets and quickly go over them.

SESSION I: PEER ROLE

Topic: What Does it Take to Be a Peer?

- Note that some of the concepts/phrases overlap among the three categories of peer roles.

- Refer and review with group the sample of a Peer Job Description. Connect examples of the knowledge, skills and qualities identified in the exercise with the job description.

> *When I tested positive at eighteen, I was labeled mentally and physically handicapped because of my HIV condition, and I thought I would not be able to do anything with my life. When I got this opportunity, I showed myself that I can have a good future doing something that I like, working with other patients.*
>
> A peer about her role

Summarize

- *As part of your preparation to be a peer, it is very important that you assess which knowledge, skills and qualities you already have and which ones you don't. This will help you focus your continuing education on areas that need further development.*

- *While this training will help increase your knowledge, skills and qualities, your development doesn't end here. Peers need to continue developing their capacity to progressively improve their abilities and skills to support patients.*

- *At the end of this training you will have an opportunity to identify areas of development and receive suggestions on how to continue your peer education.*

SESSION I: PEER ROLE

Topic: What Does it Take to Be a Peer?

SESSION HANDOUT #1

PEER LEADER KNOWLEDGE, SKILLS, AND QUALITIES

KNOWLEDGE LIST

- Body fluids that can transmit HIV
- The difference between HIV and AIDS
- How HIV is transmitted
- Harm reduction
- Services for people with HIV
- How HIV medications work
- Medication adherence and resistance
- Side effects
- T-cells and viral load
- Role of Peer Leaders
- Disclosure
- Stigma
- Documentation

SKILLS LIST

- Ability to read and write
- Ability to develop a trusting relationship with patients
- Listening skills
- Speaking clearly
- Asking good questions
- Demonstrating proper condom use
- Ability to advocate for self and others
- Ability to find services
- Adhering to own medications
- Ability to disclose to others
- Managing own side effects
- Managing own medical appointments
- Preparing for medical appointments

SESSION HANDOUT #1(cont.)

PEER LEADER KNOWLEDGE, SKILLS, AND QUALITIES (CONT.)

QUALITIES LIST

Open-minded

Non-judgmental

Flexible

Patient

Compassionate

Truthful

Supportive

Positive Emotion/Attitude

Encouraging

Focused

Sincere

Respectful

Warm

Engaging

Assertive

Genuine

Empathetic

Accepting

Optimistic

SESSION I: PEER ROLE

Topic: What Does it Take to Be a Peer?

CARE Resource PEER SUPPORT JOB DESCRIPTION

Job Title: Peer Support	**Status:** Part Time
Department: Information & Quality Services	**Revised:** March 20XX
Reports To: Intervention and Evaluation Coordinator	

JOB SUMMARY: The Peer Support is responsible for providing emotional and educational support for clients who are HIV positive and have mental health, substance abuse and homelessness issues. S/he is responsible to engage, inform, support and empower those who are eligible for services and would like to receive services from Care Resource. He/She also is responsible for assisting in the intake process by gathering documentation and by providing administrative support in order to expedite service delivery.

ESSENTIAL JOB RESPONSIBILITIES:

Outreach and Social Networking

- Assists in identifying male patients (age of 18 or older and men of color) who have been lost to care for four months or more, or newly diagnosed with HIV and have a mental health, substance abuse treatment or a housing need for program participation.
- Welcomes clients into the agency and provides orientation/education regarding the agency and its services.
- Accompanies clients to medical, mental health, substance abuse treatment or social service appointments in order to improve attendance.
- Helps clients to schedule medical appointments and follows up with providers to ensure clients attend appointments.
- Contacts clients to verify and/or remind them of appointments with other departments or other agencies.
- Communicates with clients one to three days before a foreseen hurricane/natural disaster according to emergency plan procedure.

Health Education and Promotion

- Provide emotional support to patients around topics such as disclosure options and dealing with stigma.
- Provide emotional and educational support to patients who have mental health, substance abuse and homelessness issues.
- Serves as mentor regarding interaction with medical providers, helping patients prepare for visits and then debriefing what happened, depending on patient need.
- Provides educational support to clients to enhance their knowledge and understanding of medication protocols, side effects and adherence.
- Walks clients through initial appointments for medical care or other social services in order to ensure that clients have a clear understanding of initial steps that need to be taken to obtain appropriate services.
- Monitors clients adherence as required.
- Educates new clients on the process and what to expect from the HIV service delivery system.

CARE Resource PEER SUPPORT JOB DESCRIPTION (CONT.)

- Participates in staff training sessions and other meetings as required by the agency and/or the funding sources.

Documentation, Compliance and Quality Assurance

- Maintains timely, accurate, legible and clear chart documentation according to agency requirements.
- Maintains record keeping requirements and assists with chart reviews for Q/A purposes as requested.

Other

- Participates in agency developmental activities as requested.
- Other duties as assigned.

Safety

- Ensures proper hand washing according to Centers for Disease Control and Prevention guidelines.
- Understands and appropriately acts upon assigned role in Emergency Code System.
- Understands and performs assigned role in agency's Continuity of Operations Plan (COOP).

JOB SPECIFICATIONS

Education: High school diploma required.
Training and Experience: One year of related experience working in programs with at risk populations and performing outreach is required. Knowledge and trainings in HIV/AIDS are required.
Licenses and/or certifications: N/A
Job Knowledge: Bilingual (English-Spanish/English Creole) highly preferred. Computer knowledge should include Microsoft Word and Excel. Good communication, problem solving, team work and organizational skills are required in order to engage participants. Ability to work with multicultural and diverse population is required. Must be self-motivated, detail oriented, able to travel locally and work flexible hours.
Contact Responsibility:the responsibility for external contacts is frequent and important.
Other: Own transportation is required.

PHYSICAL REQUIREMENTS

This work requires the following physical activities: constant talking in person, talking on the phone, hearing/ the visual acuity. Frequent driving, walking, sitting and bending. Occasional standing and climbing are required. Work is performed in an office or community settings.

STATEMENT OF ACCEPTANCE OF RESPONSIBILITIES

I, ____ verify that I meet the qualifications specified above for the position of Peer Support. I have read my job description and accept my stated responsibilities.

Signature: __________________________________ Date: ____________

SESSION II: PEER COMMUNICATION SKILLS, PART 1

Topic: Elements of Communication

TOTAL TIME FOR SESSION II: 1 hour
SLIDES: #13-17

ABOUT THIS ACTIVITY

Time: 5 minutes

Slides: #14

Objectives:

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

- Identify and describe 4 major categories of interpersonal communication

Training Methods:

- Lecture

In this activity you will:

- Discuss how different elements of communication help to engage patients

Materials:

- None

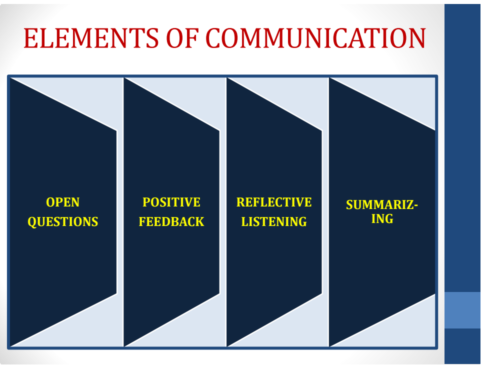
Preparation:

- None

Instructions

1. Tell participants: *As peers, you will be spending a lot of time communicating with patients and what they communicate is sometimes as important as how they communicate. Peers need to make sure they understand the information patients are sharing with them and make sure patients understand what peers are saying.*

2. *There are 4 methods that are useful when engaging patients in conversation* (review slide 14).



ELEMENTS OF COMMUNICATION

OPEN QUESTIONS

POSITIVE FEEDBACK

REFLECTIVE LISTENING

SUMMARIZ-ING

3. *Although these four methods appear simple, they are not always easy to use. They require considerable practice. Peers must think about how to incorporate them into their meetings with patients.*

4. *The reward is patients moving in the direction of positive change.*

Summarize

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

Segue

Coming up, there are various exercises that will help us learn skills associated with these methods. We'll start with asking open questions.

SESSION II: PEER COMMUNICATION SKILLS, PART 1

Topic: Asking Questions

ABOUT THIS ACTIVITY

Time: 5 minutes

Slides: #15

Objectives:

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

- Describe the difference between open-ended and closed-ended questions

Training Methods:

- Group discussion

In this activity you will:

- Discuss how wording of questions can help faciltate discussions with patients.

Materials:

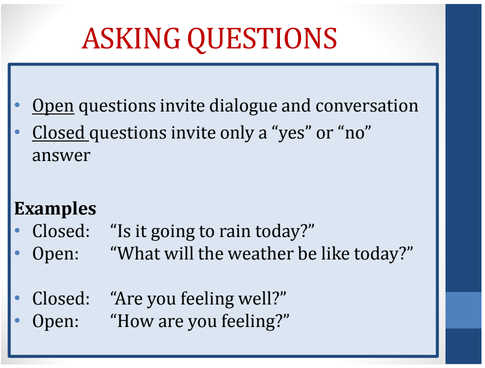
- None

Preparation:

- None

Instructions

1. Tell participants: *In order for peers to support patients, they have to engage them. To engage them, they have to ask questions.*
2. *As peers you will be spending a significant amount of time asking questions. How you ask those questions is extremely important. Why?* Allow responses.
3. *One reason is that people don't like to be asked too many questions; it makes them feel defensive and resistant.*
4. *How do you feel when someone asks you a lot of questions?* Allow responses. Responses: feels like you're being interrogated, makes one defensive, etc.
5. *This is why peers have to learn how to gather information about patients with as few questions as possible.*
6. Review slide 15 with participants and facilitate discussion.



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?"

Summarize

Asking open questions can help peers support their patients in more meaningful ways because they can better determine their patients' needs. However, it is also important not to ask too many questions because it may make the patient feel uncomfortable or like the peer is being pushy.

Segue

In the next exercise you will have an opportunity to practice using open questions.

SESSION II: PEER COMMUNICATION SKILLS, PART 1

Topic: Converting Questions Exercise

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #16

Objectives:

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

- Feel comfortable asking open-ended questions

Training Methods:

- Individual activity
- Group discussion

In this activity you will:

- Set up an individual exercise to convert closed-ended questions to open-ended questions
- Facilitate a debriefing session

Materials:

- "Asking Open-Ended Questions" handout

Preparation:

- None

Instructions

1. Turn to slide 16.

CONVERTING QUESTIONS EXERCISE

2. Ask participants to find the "Asking Open-Ended Questions" handout.

3. Tell them: *We are going to do a quick exercise, this time individually. You will have 7 minutes to convert the closed questions in the worksheet to open questions.*

- Clue: *Open questions usually start with How, What, When, Where and Why. Be careful when using "Why" questions—it may make people defensive, especially when loaded with sarcasm.*

Summarize

At the end of 7 minutes, ask everyone to stop. Ask for volunteers to share how they changed the questions from closed to open. Allow some report back and move on—there may not be enough time for everyone to debrief.

This does not mean that you can never use closed questions—they have their place in conversation, but if you're asking questions to get more information, open questions will elicit more information.

Segue

The next exercise will demonstrate how much more information you can get with open questions.

SESSION II: PEER COMMUNICATION SKILLS, PART 1

Topic: Converting Questions Exercise

SESSION HANDOUT

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 you meds with food?

____

7. Did you ask your doctor any questions?

____

SESSION II: PEER COMMUNICATION SKILLS, PART 1

Topic: Name that Celebrity

ABOUT THIS ACTIVITY

Time: 35 minutes

Slides: #17

Objectives:

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

- Explain the advantage of open-ended questions and practice formulating them

Training Methods:

- Game

In this activity you will:

- Play 2 question games, one with closed-ended questions and one with open-ended questions
- Debrief the exercises

Materials:

- Papers with the names of celebrities on them
- Tape

Preparation:

- Write the names of celebrities on individual pieces of paper, twice as many names as participants in the training

Instructions

1. Turn to slide 17.

NAME THAT CELEBRITY

2. Tell participants: *We are going to play a game.*
3. Trainers tape a "celebrity name" sheet on the back of each participant.
4. *There's a famous person's name on each name sheet. The goal of this exercise is to figure out the name of the celebrity by asking only closed questions, such as "Am I a woman?" "Am I famous?" etc.*
5. Instruct participants to circulate the room and ask different people who the celebrity might be. If someone asks an open question, do not answer.

Summarize

After 10 minutes, bring group back together and process with the following questions: *How difficult was it to guess who your celebrity was? What made it difficult?* Facilitate discussion.

Instructions (Part 2)

Using the additional names of famous people, put new celebrity names on participants' backs again and have them repeat the exercise only this time they can only ask open questions. If someone asks a closed question, do not answer.

Summarize (Part 2)

At the end of 10 minutes, bring group back together and debrief: *How was this time different from the last time? What made it easier?*

SESSION III: HIV BASICS

Topic: Defining HIV and AIDS

TOTAL TIME FOR SESSION III: 1 hour, 15 minutes
SLIDES: #18-23

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #19

Objectives:

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

- Define HIV and AIDS

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Review HIV and AIDS definitions

Materials:

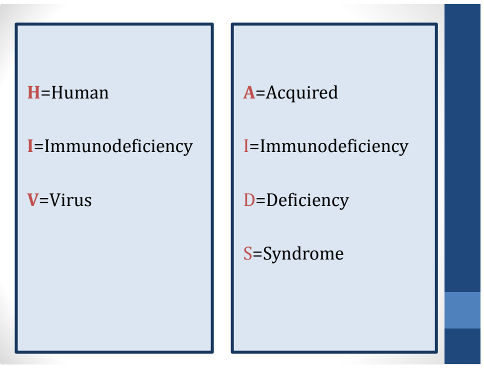
- None

Preparation:

- None

Instructions

1. Turn to slide 19.



H=Human
I=Immunodeficiency
V=Virus

A=Acquired
I=Immunodeficiency
D=Deficiency
S=Syndrome

2. Elaborate on "What is HIV?" with participants:

- *H – Human (HIV is transmitted from human to human);*
  I – Immunodeficiency (attacks the immune system);
  V – Virus (survives only by attacking cells in the human body)

- *HIV uses the genetic machinery of a cell to reproduce.* Ask: *What is genetic?* Let participants respond and make sure the definition is clear before moving on.

- *The progression of the weakening of the immune system leads to a stage called AIDS.*

3. Elaborate on "What is AIDS?" with participants:

- *A – Acquired (something specific has to happen to get it; you just don't "catch it" like a cold*
  I – Immune (major damage to the immune system)
  D – Deficiency (the body's ability to defend itself against diseases is completely compromised)
  S – Syndrome (collection of illnesses or symptoms, infections, the presence of illnesses or symptoms)

- *AIDS is a late stage of the disease resulting from several years of living with HIV infection; in other words, AIDS is advanced HIV.*

- *When a person has AIDS, it means his/her immune system has been so worn down by HIV that it can no longer protect the body from infections and there's a higher risk of acquiring life-threatening opportunistic infections and cancers.*

SESSION III: HIV BASICS

Topic: HIV Transmission

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #20

Objectives:

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

- Identify body fluids that can and cannot transmit HIV

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Review HIV transmission process

Materials:

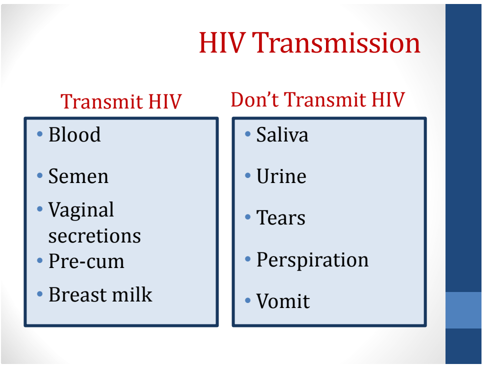
- None

Preparation:

- None

Instructions

1. Review slide 20 with participants and make the point that the body fluids that can transmit HIV have been listed hierarchically (*Blood has the most virus, followed by semen* and so forth).



HIV Transmission

Transmit HIV

- Blood
- Semen
- Vaginal secretions
- Pre-cum
- Breast milk

Don't Transmit HIV

- Saliva
- Urine
- Tears
- Perspiration
- Vomit

- *This is why blood is the most infectious body fluid (easiest way to give and get HIV) and it's why needle sharing carries the highest transmission risk (blood on or in the needle makes direct contact with the blood of the person being injected).*
- Explain that semen is also highly infectious because it has a lot of the virus, second only to blood; this is why ejaculation inside the rectum or vagina carries high transmission risk (more on this later).
- *Vaginal secretions have fewer copies of the virus than semen; this is one of the reasons that women are less infectious than men.*
- *Breast milk has the lowest amount of virus; what makes breast feeding risky is not only the fact that breast milk contains HIV but the high quantity consumed by a baby.*
- *Quantity of fluid also plays a role in HIV transmission; the more fluid the more virus. How much fluid was the person exposed to? Was it a drop of blood or a pint of blood? Was it a drop of semen or a full ejaculate?*

- *The other body fluids don't transmit HIV; this explains why people don't get HIV from kissing, giving a shoulder to cry on, sweating bodies touching each other, or even "golden showers."*

Summarize

Both **type** and **quantity** of body fluid play a role in transmission.

- *Avoiding contact with body fluids that transmit HIV is the best defense against transmission.*

Segue

There's yet a third factor that plays a role in transmission: the route of transmission (move to next slide).

SESSION III: HIV BASICS

Topic: Routes of Transmission

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #21

Objectives:

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

- Explain the HIV transmission pathways

Training Methods:

- Lecture
- Brainstorm
- Group discussion

In this activity you will:

- Lead a brainstorm activity to discuss routes of transmission

Materials:

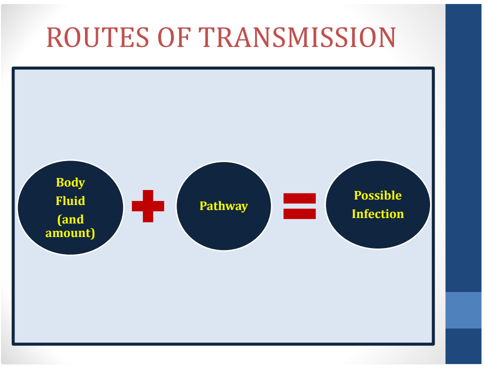
- “Routes of Transmission” handout
- Newsprint
- Tape

Preparation:

- None

Instructions

1. Review slide 21with participants.



ROUTES OF TRANSMISSION

Body Fluid (and amount) + Pathway = Possible Infection

2. Lead a brainstorm about the kinds of pathways that allow HIV entry into the body. Expected answers: open sores, needle prick, mouth, vagina, anus, veins. Record responses on newsprint and post on the wall.

3. Explain to the group that you need a fluid **and** a pathway for HIV transmission to occur (doesn’t necessarily mean that you will get infected – not every exposure results in infection).

4. Ask: *If body fluids that transmit HIV make contact with your skin, is that considered a pathway?* Allow responses.

5. *There are human behaviors that produce the fluid and pathway to HIV transmission.*

6. Ask participants to find the “Routes of Transmission” handout and review together. (This activity sets the stage for the harm reduction module later in the training).

Summarize

There are two components for HIV transmission to occur: a fluid (breast milk, semen, vaginal fluid, or blood) and a pathway into the body (a cut/sore/break in the skin, intravenously). With good health practices (always using a condom, being on treatment to suppress viral load), the risk of transmitting HIV is greatly reduced.

Segue

Next we will discuss the stages of HIV from the moment of infection to its progression over time.

SESSION III: HIV BASICS

Topic: Route of Transmission

SESSION HANDOUT

ROUTES OF TRANSMISSION RISK

Infectious Fluids and Transmission Routes	
Infectious fluids of an infected person that spread HIV	**Transmission Routes with an HIV+ person**
• Semen • Blood • Vaginal fluid • Breast milk • Any other body fluids containing blood	• Unprotected vaginal and anal sex • Sharing needles or syringes through IV drug use or tattoos • Breastfeeding from an HIV+ mother to her baby

You may wish to share this handout with the patient during Peer-Patient Educational Session #2, HIV Transmission and Life Cycle (see guide on page 16)

SESSION III: HIV BASICS

Topic: The Stages of HIV Infection

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #22

Objectives:

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

- Explain the progression of HIV from infection to AIDS

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Review "The Stages of HIV Infection" handout
- Facilitate a group discussion

Materials:

- "The Stages of HIV Infection" handout

Preparation:

- None

Instructions

1. Turn to slide 22.

THE STAGES OF HIV INFECTION

2. Tell participants: *We will be discussing how HIV infection affects the human body.*

3. Distribute "The Stages of HIV Infection" handout to each participant and review together.

4. Point to the circle "Person becomes infected with HIV" and explain that for an infection to occur, a "germ" (disease agent) must enter into the body in a particular way ("route") and in the sufficient amount ("dose"). Explain what is meant by each term: *the germ is HIV, and HIV is a particular kind of germ called a "virus."*

5. *Viruses are different from other kinds of germs, such as bacteria or fungi, because viruses cannot reproduce and survive on their own. Viruses have to have a host cell in order to survive and reproduce. In the case of HIV, the host cell is the T-helper cell or CD4+ cell, a white blood cell essential to the body's immune system.*

6. *HIV can get into cells because a part of HIV and the host cell fit together like pieces of a jigsaw puzzle. The primary host cell used to reproduce more HIV is the T-helper cell.*

7. *On average, it takes about eight to ten years from infection with HIV to development of an AIDS diagnosis in most people who have not received treatment. This number is just an average—HIV infection progresses at different rates in different people.*

SESSION III: HIV BASICS

Topic: The Stages of HIV Infection

8. *A small number of people progress very quickly (a few years) from initial infection to an AIDS diagnosis; some progress very slowly or remain healthy without treatment for more than 10 years after becoming infected.*

9. Review each of the stages and terms with participants and facilitate discussion. *The stages of HIV infection begin when an exposure becomes an infection. The first stage is the **Acute** stage*—read out loud the signs that characterize this stage, then do the same for **Asymptomatic**, **Symptomatic**, and **AIDS**.

10. Ask participants if they remember the acute stage in their own infection and allow responses.

Summarize

When a person becomes infected with HIV, they may not have many symptoms. The window period in which HIV can be detected in the body is commonly within three months of infection. An infected person could even go many years without any physical signs or symptoms; however, the virus is spreading daily within the person's body, creating a higher viral load. When a person has a high viral load, it is much easier for them to spread HIV. A person is diagnosed with AIDS when they have a T-cell count below 200 ml, there is a confirmed appearance of a certain illness called opportunistic infections (i.e., tuberculosis, hepatitis, cancer), or the CD4% is less than 14%. The time from infection to the development of an AIDS diagnosis is called the incubation period.

Segue to next slide

To better understand this progression, next we will take a stop on the HIV train.

THE STAGES OF HIV INFECTION

You may wish to share this handout with the patient during Peer-Patient Educational Session #2, HIV Transmission and Life Cycle (see guide on page 16)

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 Diagnosis

The virus weakens and eventually destroys the immune system. When a person with HIV is diagnosed with AIDS, his or her 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 opportunisitc infections.

Window (1)

Incubation Period (2)

- A person who has HIV can infect others 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 infected.
- Only an HIV test can show if someone is infected with HIV.
- 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 infection to development of an AIDS diagnosis

SESSION III: HIV BASICS

Topic: The HIV Train

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #23

Objectives:

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

- Discuss how HIV progresses using the HIV train metaphor

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Lead a discussion around the progression of HIV infection

Materials:

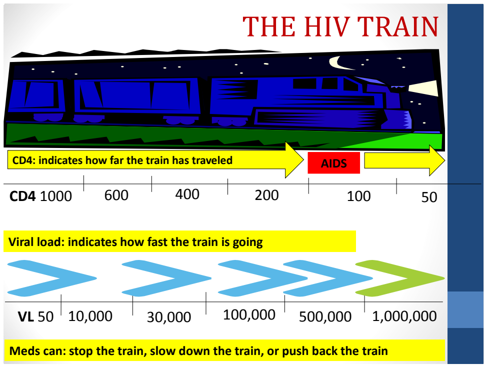
- Newsprint
- Markers

Preparation:

- None

Instructions

1. Review slide 23 with participants and facilitate discussion.



THE HIV TRAIN

CD4: indicates how far the train has traveled

AIDS

CD4 1000 600 400 200 100 50

Viral load: indicates how fast the train is going

VL 50 10,000 30,000 100,000 500,000 1,000,000

Meds can: stop the train, slow down the train, or push back the train

2. Ask: *How do people with HIV track their health status and what stage they might be in?* Allow responses.

3. Focus on the 3 most common ways to track HIV disease progression: 1) CD4 count, 2) viral load, and 3) health status (how people feel); write them on newsprint in bold or color for emphasis.

4. CD4: Ask the group what they know about CD4 cells. *What is a CD4 cell?* Allow responses.

5. *CD4 cells are particular cells in the immune system that are responsible for coordinating immune responses. That is, CD4 cells tell the immune system what to do to fight infections, as generals in an army. The number of CD4 cells is called the CD4 count.*

6. Explain: *A normal CD4 cell count for an uninfected person varies in range between 500 and 1500 cells per milliliter of blood. A milliliter is equal to roughly ¼ teaspoon. Emphasize that everyone has a different normal range for their CD4 cell count.*

7. Explain how HIV gradually reduces the CD4 count and immune function over the eight- to ten-year timeframe. Point to the graph in the slide to show the initial gradual CD4 decline. *CD4 is a marker of how far the disease has progressed* (how far the train has traveled).

SESSION III: HIV BASICS

Topic: The HIV Train

8. Viral Load: Ask: *What is viral load? How low or high can the viral load be?* Allow responses. *Viral load is a measure of how many copies of HIV can be found in one milliliter of blood and is associated with how fast the disease is progressing (how fast the train is going). As HIV progresses, the T-cells drop.*

9. *An uninterrupted train speed means HIV is traveling non-stop toward an AIDS diagnosis and beyond.*

10. *Later in this training we will be covering how HIV meds work to stop the train or slow it down or push it back.*

11. *This image also illustrates the difference between HIV and AIDS; it's the same disease but AIDS is more advanced.*

Summarize

There are three main ways to track HIV disease progression: 1) CD4 count, 2) viral load, and 3) health status. HIV disease progression can take different lengths of time for everyone; however, remaining untreated, HIV is traveling on a non-stop train towards an AIDS diagnosis and beyond.

Segue

Tomorrow we will take a more in-depth look at the immune system and its composition.

DAY 1: REVIEW

Review and remind participants how they will use their knowledge in working with patients. Refer to the Peer-Patient Educational Session Conversation Guide handout (pages 14-21) as you review.

Let's look at the Peer-Patient Educational Session Conversation Guide handout for a moment. Some of the things you learned in Day 1 are things you will need to keep in mind throughout all these sessions with patients, while other things come in to play in specific educational sessions.

Session I Review

For example, we talked about the ***role of the peer****, that's something that will be constant throughout all your interactions with patients. You will also be explaining your role to patients in the first peer/patient educational session when you introduce yourself.*

- *Who can tell me the four kinds of support peers provide?* (emotional, informational, instrumental, and affiliational support)
- Request an example of each kind of support
- *Which of these is the essence of peer support?*

Session II Review

Then you learned some ***communication skills****, also something that you will be using throughout all your interactions with clients.*

- *We talked about four elements of communication that are useful in talking with clients? What are they? Can you give an example?* (open-ended questions, positive feedback, reflective listening, summarizing)

Session III Review

After that, we talked about ***HIV basics****. These are things that you will be talking about in the second educational session on HIV transmission and the viral life cycle.*

- *For HIV to spread from one person to another, two things have to be present. Do you remember what they are?* (body fluid and pathway)
- *So which of these body fluids can transmit HIV: blood* (yes), *tears* (no), *saliva* (no), *semen* (yes), *breastmilk*, (yes) *vomit* (no)
- *For the virus to enter the body, they need a way to get in, a route of transmission. Name some routes of transmission.*

Once a person has become infected, the virus goes through different stages.

- *What are those stages?* (acute, asymptomatic, symptomatic, AIDS)
- *What is a CD4 cell? As the disease progresses, does the CD4 count go up or down?*
- *What is the T-Helper cell?*
- *How can people with HIV determine what stage they are in?* (CD4 count, viral load, health status)

PREParing PEERS FOR SUCCESS: DAY 2

PEER CORE COMPETENCY TRAINING

A curriculum for engaging out-of-care or newly diagnosed people living with HIV in care and treatment

THE IMMUNE SYSTEM AND THE HIV LIFE CYCLE

HIV MEDICATIONS

PEER COMMUNICATION SKILLS, PART II

PEER DISCLOSURES - TELLING YOUR STORIES

August 2014

Health & Disability Working Group, Boston University School of Public Health

DAY 2: The Immune System and HIV Life Cycle
HIV Medications
Peer Communication Skills (Pt. 2)
Peer Disclosures - Telling Your Stories

An Overview of Today's Sessions and Topics

Topic	Duration	Slides	Page
Burden Basket Icebreaker*	15 min.	24	63
Review of previous day*	5 min.		60
Session IV: The Immune System and the HIV Life Cycle	**1 hr. 20 min. (total)**	**25-38**	**65-70**
Topic: What is the Immune System?	45 min.	26-30	65-66
Topic: HIV Life Cycle	35 min.	31-38	67-70
Session V: HIV medications	**1 hr. 15 min .(total)**	**39-45**	**71-79**
Topic: HAART	20 min.	40	71-72
Topic: Goals of HIV Medications	15 min.	41-43	73-74
Topic: Adherence to HAART	10 min.	44	75
Topic: Medications at Work in the HIV Life Cycle	30 min.	45	76-79
Energizer*	15 min.		
Session VI: Peer Communication Skills, Part 2	**1 hr. 20 min (total)**	**46-51**	**80-93**
Topic: Attentive Listening	15 min.	47	80-81
Topic: Reflective Listening	20 min.	48	82-84
Topic: Summarizing	10 min.	49	85
Topic: Self-Assertiveness	10 min.	50	86-87
Topic: Communication styles	25 min.	51	88-93
Session VII: Peer Disclosures - Telling Your Stories	**55 min (total)**	**52-54**	**92-102**
Topic: Overview	10 min.	52	94
Topic: Tips for Telling Your Stories	10 min.	53	95-96
Topic: Telling Your Story Exercise	20 min.	54	97-100
Topic: Affirmations Exercise	15 min.	55	101-102
Review, wrap-up, and evaluation*	30 min.		103-104

* See pages 7-8 for an explanation of these climate-setting activities

Throughout this curriculum, *italicized words* are intended to be spoken directly to the class.

This publication is part of the online curriculum *PREParing Peers for Success: Peer Core Competency Training*. For the complete curriculum, accompanying PowerPoint slides, and other curricula in the series, visit http://www.hdwg.org/prep/curricula

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BURDEN BASKET ICEBREAKER

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #24

Objectives:

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

- Identify ways of to relieve stress to better focus on training

Training Methods:

- Large group exercise

In this activity you will:

- Explain the concept of a burden basket (3 minutes)
- Facilitate a group activity to place burdens in the basket (7 minutes)

Materials:

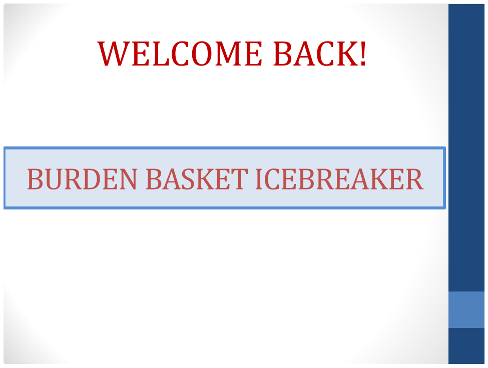
- Marbles
- Paper or rocks for the burden basket (10-15 of each, so each participant has a choice of material)
- Pens and pencils
- Basket

Preparation:

- None

Instructions

1. Turn to slide 24.



WELCOME BACK!

BURDEN BASKET ICEBREAKER

2. Introduce the concept of the Burden Basket.

- *Many times, especially during trainings or meetings, it may be hard to relax and really participate since we all have so many things on our minds. There are jobs to do, children to take care of, mouths to feed, and bills to pay.*

- *But during this time, I hope that you can put those things aside. It is important to take time out for you—to clear your mind, renew your spirit, and energize your soul. I hope this training will help you do that.*

- *At this time, I will ask you to put aside all those things that are cluttering your mind. To help you do this we have a Burden Basket. This basket will hold all your burdens throughout the workshop.*

3. Explain the "Burden Basket." Participants can "put their worries" (in the forms of pieces of paper, marbles, etc.) in the Burden Basket. This allows participants to fully participate by encouraging them to release their burdens. Distribute material (paper or rocks). Participants can write their worries on pieces of paper, or they can assign their worries to the rocks. If participants want to reclaim their worries at the end of the session, they need to put some sort of identifying mark (their initials, a symbol, etc.) on the piece of paper or rock.

BURDEN BASKET ICEBREAKER

- If using paper: *Write two or three of your worries on a piece of paper. If you want your worries back, put some sort of symbol such as your initials, a number, or a design on the piece of paper. That way you will be able to tell which worries are yours.*

- If using marbles or rocks: *Take two or three marbles or rocks. Hold them in your hand while you think of your worry.*

4. Pass around the Burden Basket, while participants place their worries in the basket. Put the Burden Basket aside. *Put your burdens in the basket. Now since your burdens are in this basket, we can enjoy this time together and learn about peer education.*

Summarize

It is important to recognize that we all have other responsibilities and concerns. People learn better when they can concentrate and put other concerns aside and pay full attention to the training.

> *When I was depressed or had a problem, then I liked to talk with her… she never told me no, I can't do that. I could count on her for whatever I needed.*
>
> A patient about her peer

SESSION IV: THE IMMUNE SYSTEM AND THE HIV LIFE CYCLE

Topic: What is the Immune System?

TOTAL TIME FOR SESSION IV: 1 hour, 20 minutes
SLIDES: #15-38

ABOUT THIS ACTIVITY

Time: 45 minutes

Slides: #26-30

Objectives:

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

- Explain the make-up of the human immune system

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Review how the immune system functions
- Review what happens when the immune system encounters HIV

Materials:

- None

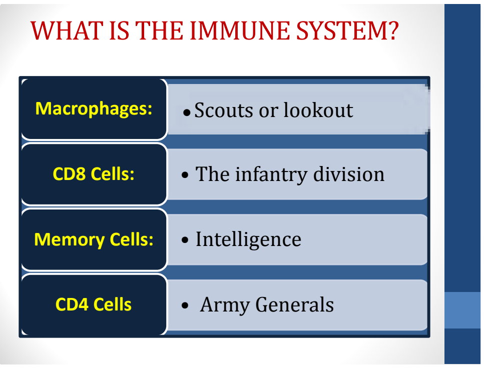
Preparation:

- None

Instructions

1. Open by stating that the immune system is a vast group of cells and organs in the body that work together to protect the body from infections. Different cells in the immune system serve different functions.

2. Review slide 26 with participants using a military analogy to explain the role of each type of cell in fighting HIV.



WHAT IS THE IMMUNE SYSTEM?

Macrophages:	• Scouts or lookout
CD8 Cells:	• The infantry division
Memory Cells:	• Intelligence
CD4 Cells	• Army Generals

3. Explain that HIV can't reproduce on its own unless it uses the generals and hijacks their plans.

4. *Macrophages – cells that recognize invading germs (scouts or lookout)*

5. *CD8 – cells that attack and kill invading germs (the infantry division)*

6. *Memory – cells that remember how to kill invading germs in case of a future attack (intelligence)*

7. *CD4 – cells that coordinate the entire immune response (the army generals)*

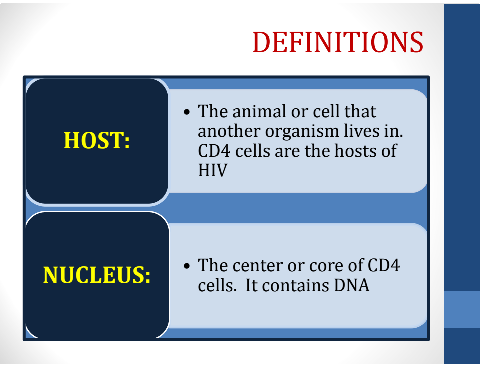
SESSION IV: THE IMMUNE SYSTEM AND THE HIV LIFE CYCLE

Topic: What is the Immune System?

Segue

Next we will discuss what happens when HIV invades and hijacks the CD4 cells (the army generals).

8. Review definitions on slide 27

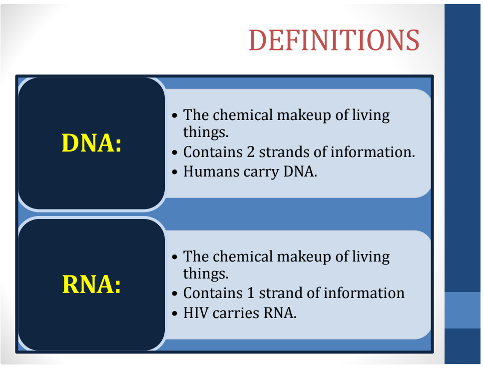


DEFINITIONS

HOST:
- The animal or cell that another organism lives in. CD4 cells are the hosts of HIV

NUCLEUS:
- The center or core of CD4 cells. It contains DNA

9. Review definitions on slide 28

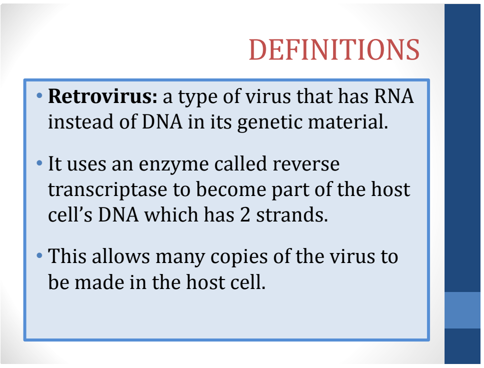


DEFINITIONS

DNA:
- The chemical makeup of living things.
- Contains 2 strands of information.
- Humans carry DNA.

RNA:
- The chemical makeup of living things.
- Contains 1 strand of information
- HIV carries RNA.

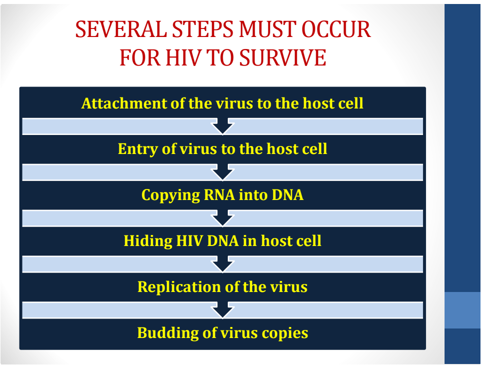
10. Review definitions on slide 29



DEFINITIONS

- **Retrovirus:** a type of virus that has RNA instead of DNA in its genetic material.
- It uses an enzyme called reverse transcriptase to become part of the host cell's DNA which has 2 strands.
- This allows many copies of the virus to be made in the host cell.

11. Review definitions on slide 30



SEVERAL STEPS MUST OCCUR FOR HIV TO SURVIVE

Attachment of the virus to the host cell

Entry of virus to the host cell

Copying RNA into DNA

Hiding HIV DNA in host cell

Replication of the virus

Budding of virus copies

Summarize

The virus changes cells in the body which allow the virus to make copies of itself and affect how the immune system fights off other illnesses.

SESSION IV: THE IMMUNE SYSTEM AND THE HIV LIFE CYCLE

Topic: HIV Life Cycle

ABOUT THIS ACTIVITY

Time: 35 minutes

Slides: #31-38

Objectives:

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

- Visually explain what happens when HIV gets into the CD4 cell using the AFRITAB HIV Life Cycle

Training Methods:

- Lecture
- Discussion
- Repetition

In this activity you will:

- Teach the stages of the HIV life cycle using multiple visual methods

Materials:

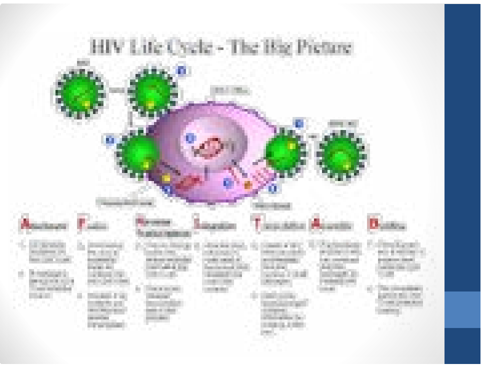
- "HIV Life Cycle – the Big Picture" handout/posters of the life cycle
- Newsprint

Preparation:

- Write AFRITAB vertically on the left hand side of a sheet of newsprint

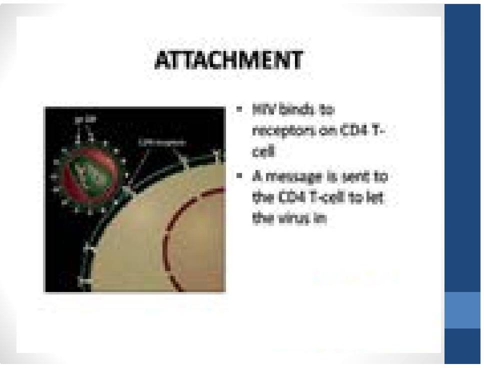
Instructions

1. Tell participants: *We are now going to walk through the entire life cycle.* Ask them to find the "AFRITAB" handout in their training packet (show slide 31 – same content) and explain that AFRITAB is a mnemonic-*the word mnemonic means something intended to assist the memory, a great way to recall each of the stages in the viral life cycle.*



HIV Life Cycle - The Big Picture

2. Step 1: *Attachment- HIV binds to receptors on the CD4. A message is sent to the CD4 to let the virus in. This is the first letter in the mnemonic.* Write the word "Attachment" on the AFRITAB newsprint next to the letter "A." Show slide 32.



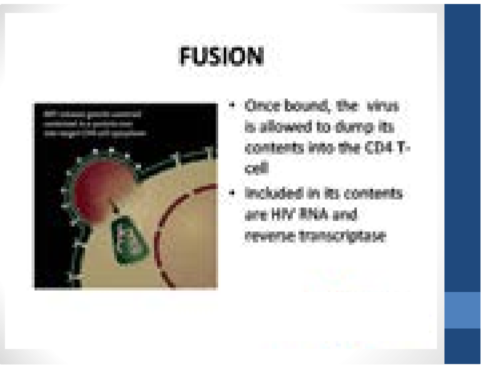
ATTACHMENT

- HIV binds to receptors on CD4 T-cell
- A message is sent to the CD4 T-cell to let the virus in

SESSION IV: THE IMMUNE SYSTEM AND THE HIV LIFE CYCLE

Topic: HIV Life Cycle

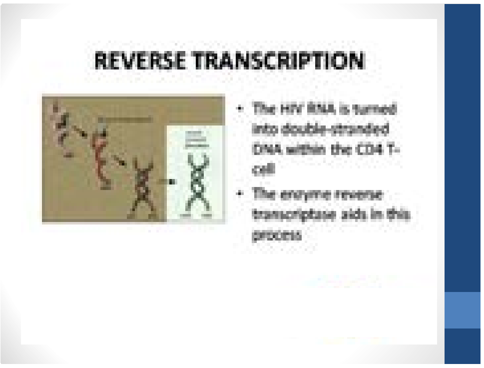
3. Step 2: *Fusion once bound to the cell, the HIV virus is allowed to dump its content into the CD4 T-cell. Its content is composed of one strand of HIV RNA.* Write the word "Fusion" on the newsprint next to "F", the second letter in the mnemonic. Show slide 33.



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

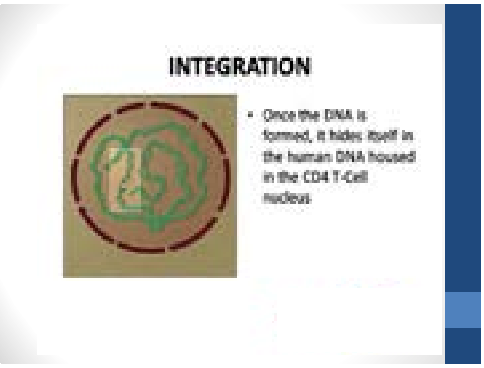
4. Step 3: *Reverse Transcription - the HIV RNA is turned into double-stranded DNA within the CD4, the enzyme reverse transcriptase aids in this process.* Write the words "Reverse Transcription" on the newsprint next to the third letter of the mnemonic "R". Show slide 34.



REVERSE TRANSCRIPTION

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

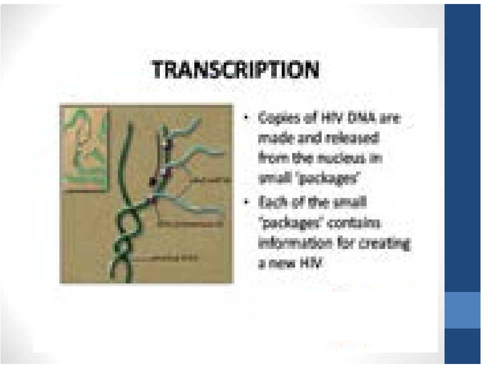
5. Step 4: I*ntegration - once the DNA is formed, it hides itself in the human DNA housed in the CD4 nucleus.* Write the word "Integration" on the newsprint next to the letter "I" of the mnemonic. Show slide 35.



INTEGRATION

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

6. Step 5: *Transcription - copies of HIV DNA are made and released from the nucleus in small "packages"; each of the small "packages" contains information or instructions for creating new HIV.* Write the word "Transcription" on the newsprint next to the "T". Show slide 36.



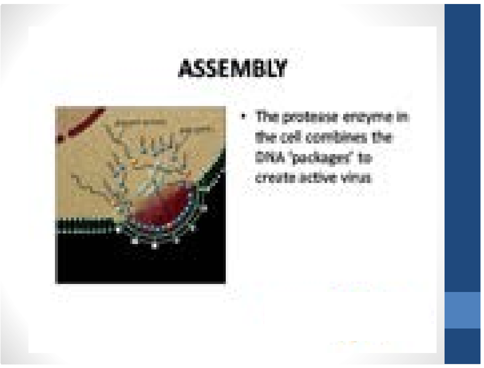
TRANSCRIPTION

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

SESSION IV: THE IMMUNE SYSTEM AND THE HIV LIFE CYCLE

Topic: HIV Life Cycle

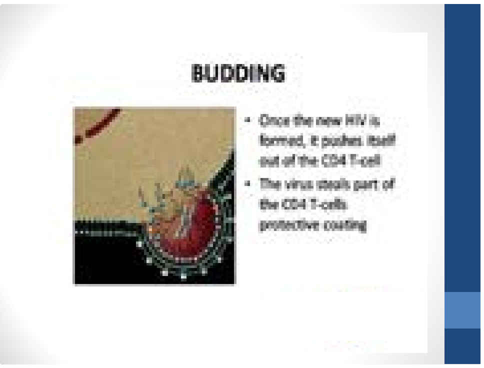
7. Step 6: *Assembly - The protease enzyme in the cell combines the DNA "packages" to create active HIV virus.* Write the word "Assembly" on newsprint next to the seventh letter "A". Show slide 37.



ASSEMBLY

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

8. Step 7: *Budding - Once the new HIV is formed, they push themselves out of the CD4; the virus steals the CD4's protective coating and the CD4 dies.* Write the word "Budding" on the newsprint next to the last letter "B". Show slide 38.



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

9. Allow questions and facilitate discussion.

10. Repetition exercise: *Ask participants to direct their attention to the AFRITAB newsprint and lead them into a repetition exercise by reading each AFRITAB letter out loud and asking them to finish the word. Increase speed as you go through the exercise.*

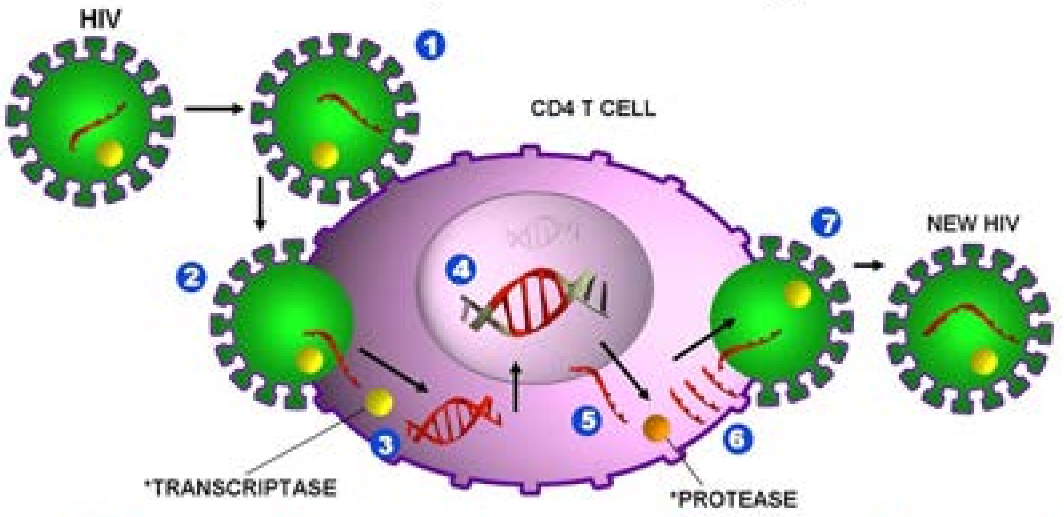
SESSION IV: THE IMMUNE SYSTEM AND HIV LIFE CYCLE

Topic: HIV Life Cycle

SESSION HANDOUT

You may wish to share this handout with the patient during Peer-Patient Educational Session #2, HIV Transmission and Life Cycle (see guide on page 16)

HIV Life Cycle - The Big Picture



Attachment	**F**usion	**R**everse Transcription	**I**ntegration	**T**ranscription	**A**ssembly	**B**udding
1. HIV binds to receptors on the CD4 T-cell. • A message is sent to the CD4 T-cell to let the virus in.	2. 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.	3. The HIV RNA is turned into double-stranded DNA within the CD4 T-cell. • The enzyme 'reverse *transcriptase* aids in this process.	4. Once the DNA is formed, it hides itself in the human DNA housed in the CD4T-cell nucleus.	5. Copies of HIV DNA are made and released from the nucleus in small packages'. • Each of the small packages' contains information for creating a new HIV.	6. The 'protease enzyme in the cell combines the DNA 'packages' to create active virus.	7. Once the new HIV is formed, it pushes itself out of the CD4 T-cell • The virus steals part of the CD4 T-cell protective coating.

SESSION V: HIV MEDICATIONS

Topic: HAART

TOTAL TIME FOR SESSION V: 1 hour, 15 minutes
SLIDES: #39-45

ABOUT THIS ACTIVITY

Time: 20 minutes

Slides: #40

Objectives:

By the end of this session, participants will be:

- Familiar with the classes of HIV medications.

Training Methods:

- Lecture
- Group discussion
- Demonstration

In this activity you will:

- Review medication classes
- Discuss how medications should be taken

Materials:

- Current medication chart (*can order charts online at http://crine.org/our-research/hiv-medication-chart/ or by phone at 617.502.1726)
- Newsprint
- Tape

Preparation:

- Write out the words in HAART (Highly Active Anti-Retroviral Therapy) on newsprint and post on the wall

Instructions

1. Show slide 40.

HIGHLY ACTIVE
ANTIRETROVIRAL THERAPY
(HAART)

2. Ask participants: *What is HAART?* Allow responses, then show the prepared newsprint with the words written out. Answer: combination therapy.

3. Ask participants to find the “Medication Chart” in their packets and review together. Emphasize the classes of meds rather than each med. Each class of meds has a role in interrupting the HIV life cycle and, taken together, produce an assault on HIV.

4. **Taking HAART as prescribed.** Engage participants in a conversation about taking meds properly for maximum effect. Write the following questions on newsprint, post them on the walls, and facilitate discussion.

   a. *How many people in the room have to take meds once a day? Twice a day?*

   b. *Is anyone taking, or has anyone taken, meds three times a day?*

   c. *How many of you are taking meds with food? Without food?*

   d. *How many have to refrigerate meds?*

SESSION V: HIV MEDICATIONS

Topic: HAART

   e. *Why are meds taken together?*

   f. *Why are there differences in the way meds are taken?*

5. **Answer Key**

   a. Meds taken once a day have a 24-hour life before being eliminated by the body; meds taken twice a day have a shorter life of 12 hours.

   b. For people who are or have taken meds three times a day, the life of those meds is 8 hours.

   c. Some meds are best absorbed with food, while some are best absorbed without food.

   d. Some meds have a short shelf life and have to be refrigerated.

   e. Most meds are taken together because they fight HIV in different ways, and that fight is stronger when you send multiple soldiers (meds) in at the same time.

   f. The difference among the meds is that they combat HIV from different angles and are thus made differently. As a result, the human body absorbs each medication differently and we have to adjust the way we take them to assure optimal levels of medication in the blood.

6. Write the correct answers to each question on the posted newsprint in fewer words.

> *For fifteen years I've had the condition and went to clinics in Puerto Rico and in the United States, and I didn't have the support that I received here with this program. I learned a lot of information that I did not know. I didn't know that the medications had to be taken… at the same time each day. [The peer] taught me the importance of taking one's medications correctly.*
>
> A patient about her peer

SESSION V: HIV MEDICATIONS

Topic: Goals of HIV Medications

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #41-43

Objectives:

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

- State the goals of HAART

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Review the goals of HIV medications and recommendations for treatment

Materials:

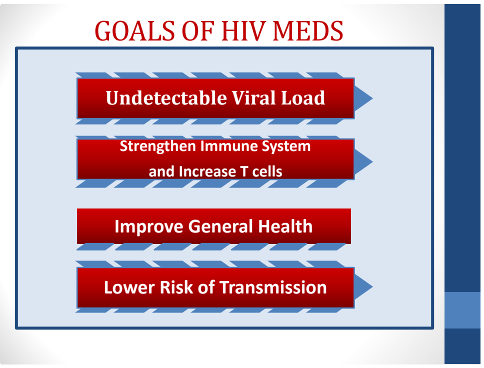
- None

Preparation:

- None

Instructions

1. Review slide 41 with participants and elaborate:



GOALS OF HIV MEDS

Undetectable Viral Load

Strengthen Immune System and Increase T cells

Improve General Health

Lower Risk of Transmission

- *Undetectable viral load keeps HIV from multiplying and causing serious harm to the immune system. This is the only way to block HIV replication; the more HIV in the blood, the greater the likelihood of disease progression and life-threatening illness. Undetectable does not mean a person no longer has the virus, it means the virus is being blocked from replicating.*

- *Having an undetectable viral load can not only keep you healthy for a long time, it can prevent transmission of HIV to your sexual partner(s) (fewer viral copies means lower infectivity).*

2. Group Discussion. Ask participants if anyone has ever developed medication resistance and what that experience was like. Allow responses and facilitate discussion.

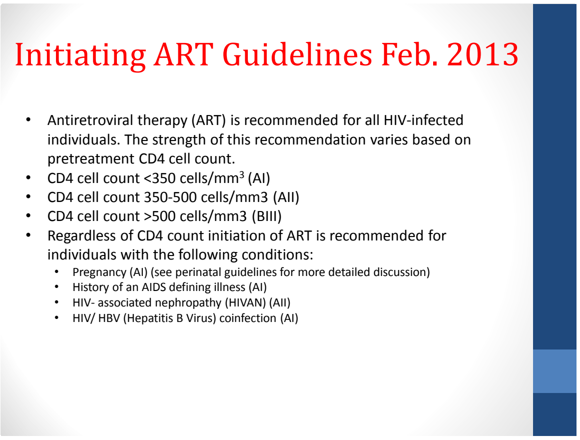
- *Sharing with patients your personal experience with resistance (story telling), how you felt and how you handled it, can be very supportive when they face resistance.*

- *Supporting them so that they don't develop resistance will be one of your primary roles as peers.*

SESSION V: HIV MEDICATIONS

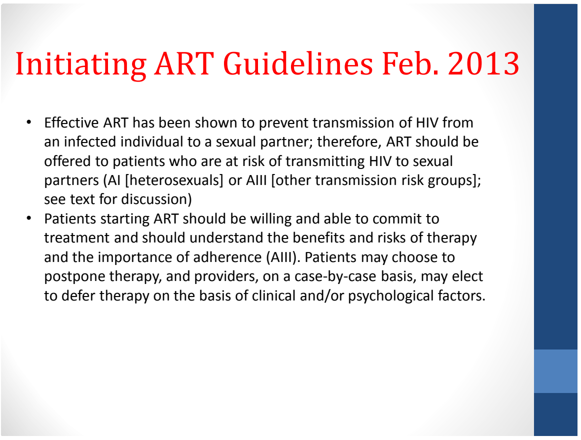
Topic: Goals of HIV Medications

- Review slides 42 and 43.



Initiating ART Guidelines Feb. 2013

- Antiretroviral therapy (ART) is recommended for all HIV-infected individuals. The strength of this recommendation varies based on pretreatment CD4 cell count.
- CD4 cell count <350 cells/mm^3 (AI)
- CD4 cell count 350-500 cells/mm3 (AII)
- CD4 cell count >500 cells/mm3 (BIII)
- Regardless of CD4 count initiation of ART is recommended for individuals with the following conditions:
  - Pregnancy (AI) (see perinatal guidelines for more detailed discussion)
  - History of an AIDS defining illness (AI)
  - HIV- associated nephropathy (HIVAN) (AII)
  - HIV/ HBV (Hepatitis B Virus) coinfection (AI)



Initiating ART Guidelines Feb. 2013

- Effective ART has been shown to prevent transmission of HIV from an infected individual to a sexual partner; therefore, ART should be offered to patients who are at risk of transmitting HIV to sexual partners (AI [heterosexuals] or AIII [other transmission risk groups]; see text for discussion)
- Patients starting ART should be willing and able to commit to treatment and should understand the benefits and risks of therapy and the importance of adherence (AIII). Patients may choose to postpone therapy, and providers, on a case-by-case basis, may elect to defer therapy on the basis of clinical and/or psychological factors.

SESSION V: HIV MEDICATIONS

Topic: Adherence to HAART

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #44

Objectives:

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

- Discuss the importance of adherence of medication

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Discuss the challenges of adherence and strategies for managing adherence

Materials:

- None

Preparation:

- None

Instructions

1. Turn to slide 44.

ADHERENCE TO HAART

2. Ask participants how they define adherence. Allow responses and facilitate a discussion.

3. Expected responses: *"sticking to your meds," "taking your meds on time every day," "taking your meds as prescribed."*

4. Facilitate a discussion around how participants manage adherence in their own lives and challenges they may be facing.

Summarize

- *Many people find it difficult to adhere to their meds for any number of reasons. As a result, adherence is a topic you will find yourself discussing with patients time and again, and it's important to be prepared to have those conversations.*
- *Those of you currently on meds already have knowledge and experience taking meds that will be useful in your work with patients.*
- *Later we will discuss how to assess adherence and support patients to achieve adherence.*

SESSION V: HIV MEDICATIONS

Topic: Medications at Work in the HIV Life Cycle

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #45

Objectives:

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

- Discuss how medications fight HIV

Training Methods:

- Lecture
- Group discussion
- Individual exercise

In this activity you will:

- Facilitate a group discussion on how medication works.
- Facilitate an individual exercise, and a group exercise.

Materials:

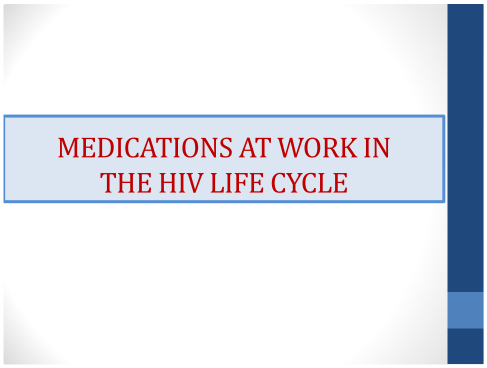
- Current medication charts (*can order charts online at http://crine.org/our-research/hiv-medication-chart/ or by phone at 617.502.1726)
- AFRITAB Medications at Work in the HIV Life Cycle handout (or alternative Spanish activity)
- 2 sets of cards with one medication class per card (total of 5 cards in each set).

Preparation:

- Enlarge the AFRITAB life cycle picture onto 2 large posters.

Instructions

1. Turn to slide 45.



MEDICATIONS AT WORK IN THE HIV LIFE CYCLE

2. Ask participants to find the “Medications at Work in the HIV Life Cycle” handout and quickly connect the dots between the stages of HIV replication and where the medications work within those stages.

3. *At what stage do Fusion Inhibitors work?* Allow responses and make corrections as needed—response is step 1; *What does it do?* Answer: blocks the first step of HIV replication; blocks the lock on the door, keeps the virus from entering and dumping its RNA.

4. *At what stage do Non-nucleosides (NNRTIs) or “non-nukes” work?* Answer: reverse transcriptase; *What do they do?* Answer: blocks HIV from using this enzyme to turn from 1 strand of RNA to 2 strands of DNA.

5. *At what stage do Nucleosides or “nukes” work?* Answer: reverse transcriptase; *What do they do?* Answer: same as non-nukes, however, these medications are structurally different and bind to the enzyme at a different place (fakes out the virus and messes up the translation).

6. *At what stage do Integrase Inhibitors work?* Answer: Integration; *What do they do?* Answer: keep HIV from binding to the host cell nucleus.

SESSION V: HIV MEDICATIONS

Topic: Medications at Work in the HIV Life Cycle

7. *At what stage do Protease Inhibitors work?* Answer: Assembly; *What do they do?* Answer: blocks the protease enzyme. When protease is blocked, the new viral particles cannot mature; prevents new HIV from forming.

8. **Individual exercise.** Ask participants to take a few minutes to look at the medication chart and identify which classes of medications they take. See if they can identify where their own meds work. Ask for a few volunteers to report out where their meds work and facilitate discussion.

9. **Reinforcement exercise.** Ask participants to put away the "Medications at Work in the HIV Life Cycle" handout, and break out into 2 groups.

10. Give each group a set of cards with the 5 classes of medications in each set. Each group will tape its cards in order on the 2 life cycle posters. Members of each group should work together without looking at the other group. Participants cannot look at notes or the handout during the exercise.

Summarize

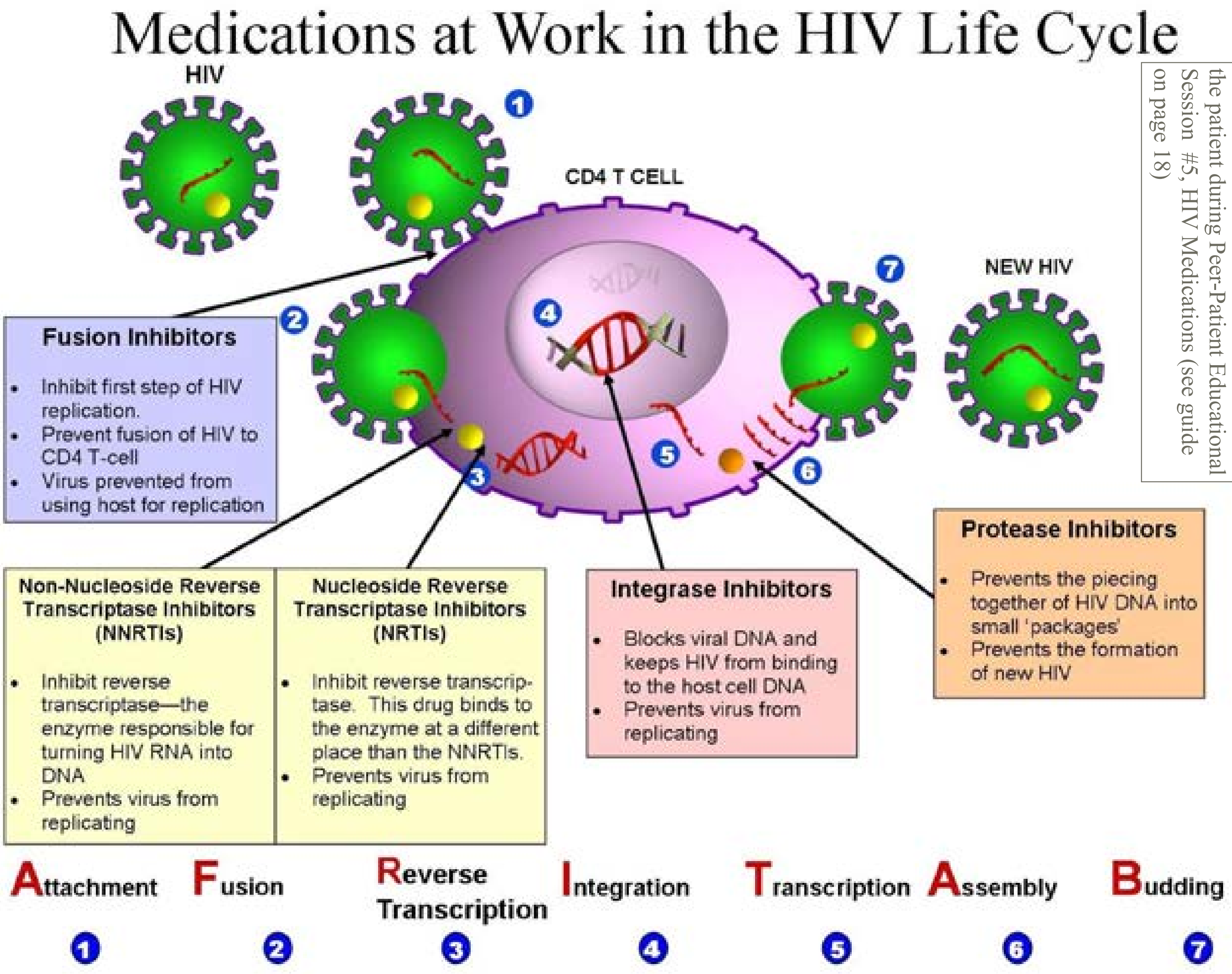
- Ask each group to report out and correct any mistakes made.

SESSION V: HIV MEDICATIONS

Topic: Medications at Work in the HIV Life Cycle

You may wish to share this handout with the patient during Peer-Patient Educational Session #5, HIV Medications (see guide on page 18)

SESSION HANDOUT #1



Medications at Work in the HIV Life Cycle

Fusion Inhibitors

- Inhibit first step of HIV replication.
- Prevent fusion of HIV to CD4 T-cell
- Virus prevented from using host for replication

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

- Inhibit reverse transcriptase—the enzyme responsible for turning HIV RNA into DNA
- Prevents virus from replicating

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)

- Inhibit reverse transcriptase. This drug binds to the enzyme at a different place than the NNRTIs.
- Prevents virus from replicating

Integrase Inhibitors

- Blocks viral DNA and keeps HIV from binding to the host cell DNA
- Prevents virus from replicating

Protease Inhibitors

- Prevents the piecing together of HIV DNA into small 'packages'
- Prevents the formation of new HIV

SESSION HANDOUT #2

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

Fusion Inhibitors

Integrase Inhibitors

Protease Inhibitors (PIs)

You may wish to share this handout with the patient during Peer-Patient Educational Session #5, HIV Medications (see guide on page 18)

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Attentive Listening

TOTAL TIME FOR SESSION VI: 1 hour, 20 minutes
SLIDES: #46-51

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #47

Objectives:

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

- Identify differences in verbal and non-verbal listening skills
- Practice verbal and non-verbal listening skills

Training Methods:

- Brainstorm
- Demonstration
- Group discussion

In this activity you will:

- Facilitate a brainstorm around active listening
- Demonstrate non-verbal skills

Materials:

- Newsprint

Preparation:

- None

Instructions

1. Review slide 47 with participants and elaborate:

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.

- *Attentive listening is a technique that can optimize 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.

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

3. **Make the following points:**

   a. **Verbal form of listening**

   - *Use questions such as "Really?" "What happened?"*
   - *Comment directly on what is being said by the patient.*
   - *Restate the patient's statements in your own words to check for understanding: "do you mean….?"*

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Attentive Listening

- *Encourage the patient 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.

b. **Nonverbal form of listening**

- *Nonverbal listening skills show the patient that you are interested without speaking.*
- *Make eye contact*
- *Nod your head*
- *Lean forward*
- *Facial gestures (smiling vs. rolling our eyes)*

Summarize

- *Attentive listening helps us better understand what patients 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 patients emotionally.*
- *Your listening gives the patient 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.*

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Reflective Listening

ABOUT THIS ACTIVITY

Time: 20 minutes

Slides: #48

Objectives:

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

- Describe and demonstrate the three components of motivational interviewing

Training Methods:

- Lecture
- Discussion
- Demonstration

In this activity you will:

- Describe and demonstrate reflective listening

Materials:

- Newsprint
- Reflective Listening Script

Preparation:

- None

Instructions

1. Open by asking if anyone knows the definition of reflection and allow responses. When the definition emerges, write it on newsprint. *Reflection has different connotations—the definition we're looking for is careful or long consideration or thought.*

2. *Reflective listening means giving careful thought to what patients are saying. This kind of listening is the deepest form of engagement in conversation and deep conversations build relationships.*

3. As a peer, you want to build relationships of trust with patients so that they can open up to you. This helps you figure out what they need.

4. *Reflective listening appears easy, but it's not; it takes focus to do it well.*

5. *People who are reflective in their own lives find it easier to be reflective about what other people say and do.*

6. *When you listen reflectively you can help the patient 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.*

7. Review slide 48. Tell participants that some people find it helpful to use some standard phrases like the ones in the slide.

REFLECTIVE LISTENING

"So you feel…"

"It sounds like you…"

"You're wondering if…"

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Reflective Listening

Demonstration

The following is a discussion between a patient and his/her provider. It will be quite obvious by the responses and body language of the patient that he or she is really unaware of what the provider is talking about; yet, the patient will not admit this to the provider. Trainers will use props to distinguish the patient 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 he or she say or do?*
- Briefly facilitate further discussion and move on.

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Reflective Listening

Reflective Listening Script

Provider: Well, as I said earlier, I think it's time to start you on medications. Your T-cell counts are at 300 and your viral load is up at 50,000. How do you feel about starting meds at this time?

Patient: Okay…

Provider: It sounds like you're anxious about starting the medications…..are you sure you're okay with this option?

Patient: No, it's okay, I guess, if you think I need to.

Provider: It feels like you're ambivalent. We have the option to start with a combination of medicines and see how it goes. If you should start having any side effects, such as high fever or rash, let me know as soon as possible.

Patient: High fever or rash. Okay, I will … I'll let you know.

Provider: Sounds like we have a plan. You take your medicines as prescribed—every dose, every day—and I'll see you back in about a month to see how it's going and to check on your liver. Any questions?

Patient: No, I don't think so.

Patient leaves, saying to herself/himself: T-cells and viral load…wonder what he meant by that? And if this stuff is going to cause me to have a fever and a rash, I don't know if I want to take it. Plus he said something about my liver. I feel fine right now, I don't know about taking this stuff.

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Summarizing

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #49

Objectives:

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

- Ask questions during a conversation to ensure they are understanding their patient correctly
- Summarize a conversation with a patient to begin closing the session

Training Methods:

- Lecture
- Discussion
- Demonstration

In this activity you will:

- Describe and demonstrate summarization.

Materials:

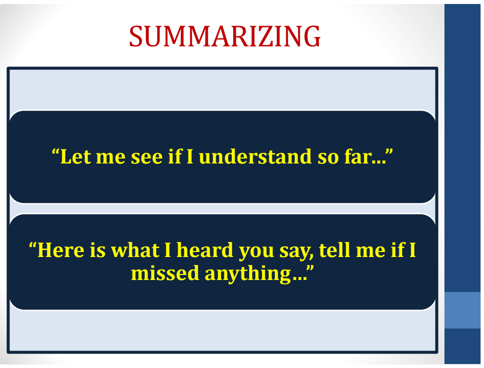
- None

Preparation:

- None

Instructions

1. Open by stating that summarizing 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.* Show slide 49.



SUMMARIZING

"Let me see if I understand so far…"

"Here is what I heard you say, tell me if I missed anything…"

2. *Summarizing helps to ensure that there is clear communication between speaker and listener.*

3. *When you summarize, be brief!*

4. 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?"*

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Self-Assertiveness

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #50

Objectives:

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

- Identify ways that self-assertiveness impacts in the lives of HIV+ people.

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Discuss assertiveness

Materials:

- None

Preparation:

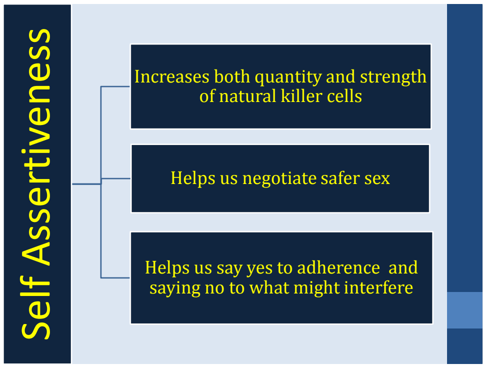
- None

Instructions

1. Ask: *What is assertiveness?* Answer: *Assertiveness means expressing what we want or believe in; confident and direct in claiming one's rights or putting forward one's views.*

2. *Assertiveness has been shown to make HIV+ people healthy; long-term survivors are usually assertive.*

3. Review slide 50 with participants and facilitate discussion:



Self Assertiveness

Increases both quantity and strength of natural killer cells

Helps us negotiate safer sex

Helps us say yes to adherence and saying no to what might interfere

- *A UCLA study found that long-term survivors with low CD4 counts, who remain healthy without treatment, are assertive and have high natural killer cells (T-cells)*

- *Self-assertiveness helps you stick to your plan regarding safer sex and healthy living; it helps you communicate what you want and don't want, what you're willing to do and unwilling to do. For example, assertiveness can help you tell your doctor what treatment routines you can and can't adhere to.*

4. Ask participants: *What do you think of these facts? How does this reflect your communication style? How can we as peers model assertiveness?* Allow responses.

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Self Assertiveness

Summarize

By modeling self-assertiveness in words and actions, peers can help their patients become assertive.

Segue

Next we will be doing an exercise that will help us distinguish assertiveness from other styles of communication.

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Communication Styles

ABOUT THIS ACTIVITY

Time: 25 minutes

Slides: #51

Objectives:

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

- Distinguish among communication styles

Training Methods:

- Lecture
- Small group exercise
- Report out

In this activity you will:

- Describe different communication styles
- Facilitate a small group exercise and report out

Materials:

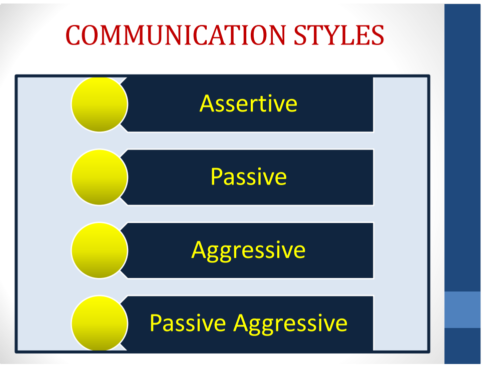
- Communication styles activity sheet

Preparation:

- None

Instructions

1. Open by stating that discussing assertive communication brings up other styles of communication, such as “passive, aggressive, and passive aggressive” as shown on slide 51.



COMMUNICATION STYLES

- Assertive
- Passive
- Aggressive
- Passive Aggressive

- *Being assertive means expressing what we want or believe in and is an important part of clear communication.*

- *Being passive means repressing the emotions, feelings, and thoughts that we have even if by doing so we feel uncomfortable and unhappy with ourselves.*

- *Being aggressive means interacting with others without respect for their rights and/or feelings.*

- *Being passive aggressive means displaying behavior in which feelings of aggression are expressed in passive ways as, for example, by stubbornness, sullenness, procrastination, or intentional inefficiency.*

2. Facilitate discussion and give examples.

3. **Exercise.** Tell participants that we are going to do a small group exercise. Ask them to find the “Communication Styles Activity Worksheet” in their packets.

4. Break out into 3 small groups and assign a case scenario to each group. Groups should choose a recorder and reporter.

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Communication Styles

5. *You will have 10 minutes to go through your scenario and write in the spaces provided the communications style of each statement on the worksheet.*

Summarize

Ask for volunteers to report out their answers. Facilitate discussion and correct any wrong answers.

SESSION HANDOUT

Communication Styles Activity

Being assertive means expressing what we want or believe in and is an important part of clear communication.

Being passive means repressing the emotions, feelings, and thoughts that we have even if by doing so we feel uncomfortable and unhappy with ourselves.

Being aggressive means interacting with others without respect for their rights and/or feelings.

Being passive aggressive means displaying behavior in which feelings of aggression are expressed in passive ways as, for example, by stubbornness, sullenness, procrastination, or intentional inefficiency.

Scenario 1: Provider-Patient

Your provider informs you that you have developed resistance to one of your HIV medications. She tells you that your resistance occurred due to non-adherence and wants you to be more consistent with a newly prescribed medication.

1. "You had better take this new medication more seriously or you won't have to worry about any medication."	
2. "I am so sorry this is happening to you. Maybe there is something else I should have done to prevent this from happening. I don't know if you even want to try the new medication..."	
3. "The results of your tests indicate that you have developed resistance to one of your medications. I would like to prescribe another medication, but before I do, I would like to know how I can support you in adherence."	
4. "You have developed resistance to one of your medications. I always tell my patients that nothing should keep them from taking every dose, every time. That's why things like this happen."	

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Communication Styles

Scenario 2: Peer-Patient

Your patient comes to your second appointment reeking of alcohol. His speech is slurred and he is not able to pay attention during the session. It appears you will be unable to accomplish anything together.

5. "Why would you come to our session like this? I don't know what you want me to do for you."	
6. "Maybe we should try to meet another time. I am okay with rescheduling at a convenient time for you."	
7. "Thank you for keeping your appointment today, but unfortunately we will not be able to continue our session today because of your alcohol consumption.	
8. "No worries. Come to our session any way you would like. It's not like I have anything important or meaningful to do with my time."	

Scenario 3: Peer-Staff

A staff member has angrily expressed her belief that you are trying to do her job. She believes you are telling a mutual patient he is eligible to receive certain services.

9. "If you were any good as a case manager, your patient wouldn't have to ask me!" You need to stop thinking about your job and do it!"	
10. "I would never try to do your job. You are far more skilled at helping people access services than I could ever be."	
11. "I am happy to discuss your concerns, but I would prefer to do so when we are able speak calmly and respectfully to one another."	
12. You say nothing. You sigh loudly and make glaring eye contact with your colleague.	

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Communication Styles

Communication Styles Activity

Being assertive means expressing what we want or believe in and is an important part of clear communication.

Being passive means repressing the emotions, feelings, and thoughts that we have even if by doing so we feel uncomfortable and unhappy with ourselves.

Being aggressive means interacting with others without respect for their rights and/or feelings.

Being passive aggressive means displaying behavior in which feelings of aggression are expressed in passive ways as, for example, by stubbornness, sullenness, procrastination, or intentional inefficiency.

Scenario 1: Provider-Patient

Your provider informs you that you have developed resistance to one of your HIV medications. She tells you that your resistance occurred due to non-adherence and wants you to be more consistent with a newly prescribed medication.

1. "You had better take this new medication more seriously or you won't have to worry about any medication."	Aggressive
2. "I am so sorry this is happening to you. Maybe there is something else I should have done to prevent this from happening. I don't know if you even want to try the new medication…"	Passive
3. "The results of your tests indicate that you have developed resistance to one of your medications. I would like to prescribe another medication, but before I do, I would like to know how I can support you in adherence."	Assertive
4. "You have developed resistance to one of your medications. I always tell my patients that nothing should keep them from taking every dose, every time. That's why things like this happen."	Passive-Aggressive

SESSION VI: PEER COMMUNICATION SKILLS, PART 2

Topic: Communication Styles

SESSION HANDOUT ANSWER KEY (Cont.)

Scenario 2: Peer-Patient

Your patient comes to your second appointment reeking of alcohol. His speech is slurred and he is not able to pay attention during the session. It appears you will be unable to accomplish anything together.

5. "Why would you come to our session like this? I don't know what you want me to do for you."	Aggressive
6. "Maybe we should try to meet another time. I am okay with rescheduling at a convenient time for you."	Passive
7. "Thank you for keeping your appointment today, but unfortunately we will not be able to continue our session today because of your alcohol consumption.	Assertive
8. "No worries. Come to our session any way you would like. It's not like I have anything important or meaningful to do with my time."	Passive Aggressive

Scenario 3: Peer-Staff

A staff member has angrily expressed her belief that you are trying to do her job. She believes you are telling a mutual patient he is eligible to receive certain services.

9. "If you were any good as a case manager, your patient wouldn't have to ask me!" You need to stop thinking about your job and do it!"	Aggressive
10. "I would never try to do your job. You are far more skilled at helping people access services than I could ever be."	Passive
11. "I am happy to discuss your concerns, but I would prefer to do so when we are able speak calmly and respectfully to one another."	Assertive
12. You say nothing. You sigh loudly and make glaring eye contact with your colleague.	Passive-Aggressive

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Topic: Overview

TOTAL TIME FOR SESSION VII: 55 minutes
SLIDES: #52-54

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #52

Objectives:

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

- Define the concept of story telling
- Explain how storytelling can be a helpful tool

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Describe how stories can help inspire and support patients
- Facilitate a discussion about how to tell stories in a way that is helpful

Materials:

- None

Preparation:

- None

Instructions

1. Tell participants that telling stories is one of the most important and inspiring things they will do as peers.

- *Story telling can help patients understand that they are not alone, that there are people who have experienced similar struggles with HIV that are living and thriving.*

- *Hearing what you went through and how you got through it can inspire people to become motivated and face their fear.*

- *Your story telling can also inspire patients to tell their own stories, which has therapeutic value. One of the best ways to solve problems is by talking about them while someone who cares is listening; in fact, it is one of the first steps in problem solving and behavior change.*

2. Ask participants:

- *How can we tell our stories in a way that's helpful?* Allow responses and facilitate discussion.

- *Have you ever heard people telling an endless story? They just go on and on and sometimes you end up forgetting what the story's about. How did hearing such a long story make you feel?* Allow responses.

3. Suggest to participants:

When you tell your story:

- *Keep it short and to the point*
- *Make sure it's related to the issue the patient is going through*
- *End on a positive note*

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Topic: Tips for Telling Your Stories

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #53

Objectives:

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

- Explain the framework for telling peer stories

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Discuss story telling techniques

Materials:

- None

Preparation:

- None

Instructions

1. Review slide 53 with participants and elaborate.

TIPS FOR TELLING YOUR STORIES

DO	DON'T
• Be concise • Make it relevant • Be appropriate - don't give "too much information" • Share your feelings at the time • Say what helped and how you got through it • Make it inspiring	• Monopolize the conversation or make it about you • Don't make it about another topic • Over dramatize • Make it depressing

- *Be concise: get to the point quickly.*
- *Make it relevant: if you're having a conversation about disclosure, tell a story about your experience with stigma, not something else.*
- *Be appropriate: no need to share "too much information."*
- *Always share the turning point, what helped you get through the issue.*
- *Story should inspire, not depress.*
- *The patient session is not about your issues.*
- *People need to hear a flow to the story: talk about where you were at the beginning of your diagnosis and how you evolved – what made the difference? What was the turning point and how did that transform you?*
- *Stories should not be negative; you don't want to fall apart in front of the patient. Remember, you're there to support the patient, not for the patient to support you.*
- *Share your feelings, struggles, and then move on to how much better things are today*

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Topic: Tips for Telling Your Stories

Summarize

You don't have to share everything about you.

- *Don't try to tell all of your stories in one session; be selective and strategic about which stories you share and how you share them.*

Segue

Next you will have an opportunity to practice telling your stories.

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Topic: Telling Your Story Exercise

ABOUT THIS ACTIVITY

Time: 20 minutes

Slides: #54

Objectives:

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

- Frame a story and tell it concisely

Training Methods:

- Lecture
- Dyads
- Individual writing
- Practice
- Group discussion

In this activity you will:

- Facilitate and observe participants sharing stories effectively

Materials:

- Elements of Effective Story Worksheet
- Index cards
- Pens
- Newsprint

Preparation:

- Write the heading: "Telling Your Story" on newsprint and the following questions underneath:
  1) What happened?
  2) How did you feel?
  3) What made the difference? What was the turning point?
  4) How were you transformed by the experience?
  5) Where are you now?

Instructions

1. Turn to slide 54

TELLING YOUR STORY EXERCISE

2. Tell participants: *We are going to do an exercise about story telling.*

3. Exercise Instructions Part I:

- Ask participants to find the "Elements of an Effective Story" Worksheet in training packets and review together.

- *The topics in the worksheet represent things that usually come up in conversation with patients. Go through them and pick one topic. Write a two-minute story about yourself that relates to the topic. You don't need to write out the whole story, just a few words to help prompt your memory.*

- Turn to slide 53.

TIPS FOR TELLING YOUR STORIES

DO	DON'T
Be concise Make it relevant Be appropriate - don't give "too much information" Share your feelings at the time Say what helped and how you got through it Make it inspiring	Monopolize the conversation or make it about you Don't make it about another topic Over dramatize Make it depressing

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Topic: Telling Your Story Exercise

- *The dos and don'ts slide will be shown during this exercise for reference. Also, try to answer the questions on the newsprint and sequence them in the same order as the questions. You will have 5 minutes.*

4. One of the trainers should tell a short story following the instructions just given.

5. Exercise Instruction Part II

- *Break out into dyads, one of you will play the peer and the other will play the patient. The peer should tell his/her story in 2 minutes.*

Summarize

- Ask the person in the role of listener: *"What about your partner's story made it interesting or affecting?" How did the story make you feel, how was it useful to you?"* Allow responses and document on newsprint.

- If time allows, go back into same dyads, only this time the partner in the listening role tells the story. Repeat the debriefing process.

Continuing Education

- As part of your preparation to become a storyteller, use the worksheet to write a story about every topic listed and practice telling them to your friends, family or coworkers.

- Memorize the stories so that you can easily share them with patients whenever these topics come up in conversation.

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Elements of an Effective Personal Story Worksheet

1. Life prior to being HIV+

2. Personal risks factors leading to infection

3. HIV testing experience

4. Dealing with being HIV+

5. Medical care experience

6. Social support (or peer support) experience

7. Experience of discrimination

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Topic: Telling Your Story Exercise

8. Finding love as an HIV+ person

9. Dealing with sex as an HIV+ person

10. Personal progress from moment of diagnosis to today

11. Experience with stigma

12. Disclosure Experiences

13. Life issues beyond HIV

14. Drug/alcohol use

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Topic: Affirmations Exercise

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #55

Objectives:

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

- Identify affirmations
- Express affirmations

Training Methods:

- Large group exercise

In this activity you will:

- Instruct participants in a group activity
- Facilitate the activity

Materials:

- Light ball
- Strips of paper with affirmations
- Hat (or bag)

Preparation:

- Prepare the paper in strips ahead of time
- Cut them up and put them in a hat (or bag)

Instructions

1. Turn to slide 55.

AFFIRMATIONS EXERCISE

2.Tell participants that we are going to do an activity.

3. Give activity instructions: *I would like for everyone to stand up and form a circle.*

4. Pass around a hat or bag with strips of paper containing affirmations; ask participants to take one and pass it to the next person until everyone has one affirmation.

5. Start by throwing the ball to someone in the circle; when that person catches the ball, he or she will read the affirmation assertively. Then that person throws the ball to someone else and that person reads the affirmation, and so forth…until all have had a chance to read their affirmation.

6. Encourage participants to say their own affirmation; if time permits extend the game to see how many more affirmations participants are able to think of.

Summarize

How did it feel when you stated your affirmation assertively? How did it feel to hear others' affirmations? Allow responses and facilitate discussion.

SESSION VII: PEER DISCLOSURES: TELLING YOUR STORIES

Topic: Affirmations Exercise

Examples of affirmations

- “If no one has ever survived HIV, I can be first.”
- “If someone else survives with HIV, I can be second.”
- “I can live a long and healthy life.”
- “I am not a victim.”
- “Having HIV is not shameful.”
- “I can live each day to the fullest.”
- “I can overcome stigma.”
- “I know I can adhere to my meds.”
- “I don’t let others defeat me.”
- “I can take care of myself.”
- “I can hold my head up high.”
- “I can have a satisfying sex life.”
- “I keep a positive attitude about my future.”
- “I tell my doctor when I feel I’m not getting proper attention.”
- “I don’t do things that can harm my health.”
- “I decide who I tell about my status.”
- “I am capable of growth and change.”
- “I’m in control of my health.”
- “Si se puede” (Obama’s slogan, Yes we can!)

DAY 2: REVIEW

Review and remind participants how they will use their knowledge in working with patients. Refer to the Peer-Patient Educational Session Conversation Guide handout (pages 14-21) as you review.

Let's take a moment to relate what you've learned so far to the Peer-Patient Educational Session Conversation Guide handout.

Session IV Review

We started Day 2 with a session about the immune system and the ***HIV life cycle****. That's something that you will be talking with patients about in Educational Session 2, HIV transmission and the viral life cycle. You may want to share the HIV life cycle handout with patients for this session.*

- *We used a mnemonic to help you remember the different stages of the viral life cycle. Do you remember what it is?* (AFRITAB) And what does each of those letter stand for?
  - A Attachment - Virus binds to receptors on the CD4 cells. Using our army comparison, what are the CD4 T cells (the generals)
  - F Fusion – the virus is attached and now it dumps its RNA into the CD4 T cell.
  - R Reverse transcription – the RNA turns into DNA inside the CD4 T cell
  - I Integration – the DNA hides inside the CD4 T cell
  - T Transcription - Copies of the HIV DNA get bundled up into small packages in the CD4 T cell. Each one of those packages has instructions for making more HIV.
  - A Assembly – This thing called a protease enzyme mixes with these packages to create active virus.
  - B Budding – the new HIV pushes itself out of the CD4 T cell. It takes some of the CD4 cell's protective coating along with it and the CD4 cell dies.
- *Why is it important to learn about the viral life cycle?* (Because it helps us understand how HIV meds work to interrupt this process, leading to an undetectable viral load, which keeps us healthy and makes spreading the virus less likely.)

Session V Review

Then we spent some time learning about ***HIV medications****. This is something that you will be sharing with patients in Educational Session V, HIV medications. You will probably want to share the medication chart with patients for that conversation.*

- *Does anyone remember what the HIV drug medications are called?* (HAART – Highly Active Antiretroviral Therapy or ART-Antiretroviral Therapy)
- *What are some of the things that are important to know about taking HIV medication?* (How often to take them, do you have to refrigerate them, do you have to take them with or without food)
- *What are some of the goals of HIV meds?* (undetectable viral load, strengthen immune system and increase T cells, improve health, lower transmission risk)
- *You will probably want to show the Medications at Work in the Life Cycle chart to patients during Educational Session V because it shows the different stages of the HIV life cycle and that different classes of meds work to interrupt the process. What are the names of some classes of HIV meds?* (Fusion Inhibitors, Non-Nucleoside Reverse Transcriptase Inhibitors, Nucleoside Reverse Transcriptase Inhibitors, Integrase Inhibitors, Protease Inhibitors)
- What happens if you don't take meds the way you are supposed to? (Resistance)

Session VI Review

Then we switched topics to talk about ***peer communication skills.*** *These are skills you will always be using when you communicate with patients.*

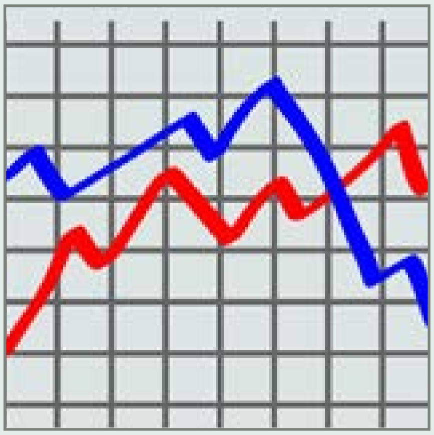
DAY 2: REVIEW

- *What are some ways you can show a patient that you are actively listening to what they're saying?* (Verbal—ask questions, make comments, restate what they say in your own words to make sure you understand, ask about how that made a patient feel, "say more about that." Nonverbal—eye contact, nod your head, lean forward, facial gestures such as smiling and how you sit/cross your legs means closed and arms crossed may mean that you're uninviting)
- What are some other ways of listening that we talked about? (Reflective – giving careful consideration to what a patient says, summarizing)
- *Do you remember 4 communication styles we talked about?* (assertive, passive, aggressive, passive aggressive)
- *Which of those styles do we want to model with patients?*
- *What is self-assertiveness?* (expressing what we want or believe in)
- *How does self-assertiveness help patients?* (increases "killer" T cells, makes us healthier, helps us adhere to treatment/ negotiate safer sex)

Session VII Review

Towards the end of the day we talked about ***disclosure****, both you telling your story to patients, as you may do in Educational Session I, and also helping them to figure out who to tell about their status, as you will do in Educational Session 7 which is about disclosure and stigma.*

- *What are some tips for things to do or not do when telling your story?* (Do: keep it short, don't give too much info, share how you felt, share what helped and how you got through it, end on a positive note Don't: run on for too long, talk about other things, be overly dramatic, make it depressing)
- *And we ended with a few affirmations. Can you give some examples?* (I'm in control of my health. Si, se puede, I can live a long and healthy life, I can adhere to my meds, etc.)



PREParing PEERS FOR SUCCESS: DAY 3

PEER CORE COMPETENCY TRAINING

A curriculum for engaging out-of-care or newly diagnosed people living with HIV in care and treatment

ASSESSING ADHERENCE

DRUG RESISTANCE

UNDERSTANDING LABS

STIGMA

VALUES

August 2014

Health & Disability Working Group, Boston University School of Public Health

DAY 3: Assessing Adherence Drug Resistance Understanding Labs Stigma, & Values

An Overview of Today's Sessions and Topics

Topic	Duration	Slides	Page
Icebreaker*	25 min.		
Review of previous day*	5 min.		152
Session VIII: Assessing Adherence	**2 hours (total)**	**55-69**	**107-128**
Topic: Assessing Adherence	30 min	56	107-111
Topic: Adherence Barriers	25 min	57	112-113
Topic: Adherence Case Scenarios	30 min	58	114-117
Topic: Doctor-Patient Communications	35 min	59	118-128
Session IX: Drug Resistance	**1 hour (total)**	**60-62**	**129-131**
Session X: Understanding Labs	**35 min (total)**	**63-79**	**132-134**
Session XI: HIV Stigma	**55 min (total)**	**80-84**	**135-142**
Topic: Stigma	15 min	80	135-136
Topic: HIV-Related Stigma	15 min	81	137
Topic: The Effects of Stigma	10 min	82-83	138-139
Topic: What Not to Say	15 min	84	140-142
Energizer*	15 min.		
Session XII: Values	**1 hr. 25 min (total)**	**85-89**	**143-151**
Topic: Overview of Values	5 min	85	143
Topic: (Un)Push My Buttons—Examining Our Personal Values	10 min	86	144
Topic: Self-Assessment—What Pushes Your Buttons?	35 min	87	145-147
Topic: Patient-Centered Approach	25 min	88	148-149
Topic: Principles of Peer Work	10 min	89	150-151
Review, wrap-up, and evaluation*	20 min.		152-153

* See pages 7-8 for an explanation of these climate-setting activities

Throughout this curriculum, *italicized words* are intended to be spoken directly to the class.

This publication is part of the online curriculum *PREParing Peers for Success: Peer Core Competency Training.* For the complete curriculum, accompanying PowerPoint slides, and other curricula in the series, visit http://www.hdwg.org/prep/curricula

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SESSION VIII: ASSESSING ADHERENCE

Topic: Assessing Adherence

TOTAL TIME FOR SESSION VIII: 2 hours
SLIDES: #56-69

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #56

Objectives:

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

- Ask questions that assess prescription adherence

Training Methods:

- Role-play
- Group discussion
- Brainstorm

In this activity you will:

- Review the adherence handout
- Conduct a role-play
- Debrief the exercise

Materials:

- Assessing Adherence Questions handout
- Assessing Adherence Role-Play Script
- Assessing Adherence Role-Play Trainer Answer Key
- Current medication chart

Preparation:

- Prepare the handouts, including a copy of the provider and patient role-play scripts

Instructions

1. Ask participants to find the "Assessing Adherence Questions" handout and review together.
2. Ask for a volunteer to play the role of patient while one of the trainers plays the role of the peer [give the volunteer the "Assessing Adherence Role-Play" script]
3. The trainer playing the peer role should use the "Trainer Answer Key" to provide feedback to the patient after each question.

Summarize

- *Peers must learn how to assess adherence—it's one of the most important parts of the job. Make sure you know well the answers to these questions before engaging the patient in the assessment.*
- *Over time, experience on the job will improve your knowledge and how to respond to adherence issues patients present with.*
- *Peers are responsible for providing accurate information to patients about meds and how they work.*
- *Medications are really hard to take for a long period of time. In the general population, even a 7- or 10-day regimen is difficult to finish.*

Segue

- *Next we will be exploring barriers that many HIV+ people face in taking HIV meds faithfully. We hope that you will bring up some of the adherence barriers that you face or have faced.*

SESSION VIII: ASSESSING ADHERENCE

Topic: Assessing Adherence

SESSION HANDOUT 1

ASSESSING ADHERENCE: 10 QUESTIONS YOU SHOULD ASK

1. Which meds are you currently taking?

2. How frequently do you have to take each of your meds?

3. What are the food restrictions for each of your meds (i.e., with or without food)?

4. Why do you think some meds need to be taken with food and some on an empty stomach?

5. Why do you think some meds are taken once a day and others twice a day?

6. What helps you remember to take your meds?

7. What do you do when you miss a dose?

8. What problems have you encountered from taking meds?

9. How soon before you run out of meds do you order refills?

10. Do you believe that the meds are helping you and, if so, how?

You may wish to share this handout with the patient during Peer-Patient Educational Session #5, HIV Medications and Session #6 Drug Resistance and Adherence (see guide on pages 18 and 19).

ASSESSING ADHERENCE ROLE-PLAY SCRIPT

One of the trainers plays the interviewer; a volunteer from the audience plays the patient.

Provider: Are you currently taking meds? If so, which ones?

Patient: Reyataz with Norvir, ziagen, 3TC, AZT.

Provider: Do you know why you are taking HIV meds?

Patient: I take them because I have HIV.

Provider: Do you know what the meds do when they get into your body?

Patient: Not really.

Provider: When do you take your meds?

Patient: I take Reyataz and Norvir once a day and Ziagen, 3TC and AZT twice a day.

Provider: How do you take your meds?

Patient: I have to take Reyataz and Norvir with food, and Ziagen, 3TC and AZT with food or empty stomach.

Provider: Why do some meds need to be taken with food and some on an empty stomach?

Patient: I don't know.

Provider: Why are some meds taken once a day and some twice a day?

Patient: I don't know.

Provider: What helps you remember to take your meds?

Patient: I rely on my memory.

Provider: What do you do when you miss a dose?

Patient: I double up next time.

Provider: What problems have you encountered while taking this medication, and how are you managing these problems?

Patient: Nausea and diarrhea, sometimes I take Pepto Bismal.

ASSESSING ADHERENCE: 10 QUESTIONS YOU SHOULD ASK

Question 1 (Which meds are you currently taking?): Congratulate the patient on remembering the names of her HIV meds.

Question 2 (Why are you taking HIV meds?): Validate this response – patient is right, she's taking meds because she has HIV; however, a patient's knowledge about why she is taking meds should be more expansive, and this is addressed in the next question.

Question 3 (What do the meds do when they get into your body?): This is an opportunity to discuss the HIV life cycle (keep it simple):

- When the medications get into your body they go into the T-cell to fight HIV and keep it from multiplying and infecting other T-cells. Without medications the virus can continue to multiply until there are too many viruses for your immune system to fight.
- Reyataz and Norvir are protease inhibitors and they prevent the formation of new HIV.
- Ziagen, 3TC and AZT are Nucleoside Reverse Transcriptase Inhibitors or "nukes" and they block HIV from changing, which it needs to get into the center of the T-cell. By preventing access to the center of the T-cell, the virus is unable to create more copies of itself.

Question 4 (When do you take your meds?): Validate this response—patient knows when each medication is supposed to be taken.

Question 5 (How do you take your meds?): Validate this response—patient knows how to take each medication.

Question 6 (Why do some meds have to be taken with/without food?): Some meds work better with food. Your body is better able to absorb them if taken with food. Some meds work better with an empty stomach. Your body is better able to absorb the medication if taken <u>one hour before</u> or <u>two hours after you eat</u>. Not following these rules can lead to poor absorption, which can decrease the medication in the blood to a level below what is needed to fight the virus. This can lead to resistance.

Question 7 (Why are some meds taken once/twice a day?): Every medication has a "life" in the blood before your body eliminates it; once-a-day meds have a 24-hour life. If you go more than 24 hours without taking the once-a-day med, the level of medication in the blood drops below the level needed to fight HIV. Twice-a-day meds have a 12 hour life before your body eliminates it. If you go more than 12 hours, the level of medication in the drug drops below the level needed to fight HIV. When medication levels drop, a window of opportunity opens up for HIV to replicate as fast as possible. If the level of medication in the blood drops frequently (more than twice a month), you can develop resistance.

SESSION VIII: ASSESSING ADHERENCE

Topic: Assessing Adherence

SESSION HANDOUT 3 (Cont.)

Question 8 (What helps you remember to take your meds?): Give patients different ideas for how to remember to take meds:

- Alarm clock or timer (including cell phone)
- Pill boxes
- Storing them visibly
- Have someone in your life to remind you
- Put in the shoes you're wearing the next day.
- Keep some meds at work and some at home (if the person is employed).
- Make an association between a daily activity and taking your meds, i.e., mealtime, before or after the gym, lunchtime, when you first get up in the morning, etc.

Question 9 (What do you do when you miss a dose?): Doubling up can be toxic and may exacerbate your side effects, or can lead to adverse reaction. If you forget to take a dose, try to take it within 3 or 4 hours of the time you were supposed to take it. Otherwise, wait until your next dose.

Question 10 (What problems have you encountered taking meds?): Nausea and diarrhea can be addressed with or without medicine. If your preference is with medicine, you can ask your doctor to give you a prescription to treat diarrhea and nausea. Or you may opt to use certain food to relieve these side effects, such as white toast, crackers, bread, bananas, white rice, apples/applesauce, tea, ginger ale or ginger snacks, etc.

SESSION VIII: ASSESSING ADHERENCE

Topic: Adherence Barriers

ABOUT THIS ACTIVITY

Time: 25 minutes

Slides: #57

Objectives:

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

- Identify and discuss barriers to adherence that HIV+ people face

Training Methods:

- Brainstorm
- Group discussion
- Small-group exercise

In this activity you will:

- Facilitate a brainstorm on barriers to adherence
- Conduct a small-group exercise on solutions to a barrier
- Debrief the small-group exercise

Materials:

- Newsprint
- Markers
- Tape
- Video on adherence barriers

Preparation:

- Prepare video for playing, if available.
- Contacting pharmaceutical reps may be useful in order to obtain a video related to this topic.
- Additionally, there are a variety of medication adherence barriers/side effect videos on youtube.com from which to choose. Here are some example videos to choose from:
    - http://www.youtube.com/watch?v=myLpW7ThXkw
    - http://www.youtube.com/watch?v=xLvGK8aYk3A
    - http://www.youtube.com/watch?v=evRon-OKs9E

Instructions

1. Turn to slide 57.

ADHERENCE BARRIERS

2. Facilitate a brainstorm on barriers to adherence and document on newsprint.

3. Encourage participants to name the barriers they themselves face or have faced. Some possible answers include: side effects, fear of toxicity, fear of lipodystrophy, constant reminder of HIV status, forgetfulness, breaking daily routine, living or working with people who don't know your status, not getting refills on time.

4. Once a list of barriers has been generated, break participants out into groups of 3.

5. Assign each group three of the barriers and ask them to come up with possible solutions for each barrier assigned. Each group should assign a recorder and a reporter.

6. Ask each group to report out their solutions.

7. Ask the larger group if they would add anything to the list of solutions.

8. Trainer should review all possible solutions.

9. Play a video on adherence barriers and side effects.

10. Facilitate discussion after the video.

SESSION VIII: ASSESSING ADHERENCE

Topic: Adherence Barriers

Summarize

- *The most common reason that people stop taking their meds is side effects; sometimes people won't start meds because of the anticipation of side effects.*
- *Helping patients find solutions to barriers leads to better adherence and better health.*
- *Peers should learn as much as possible about adherence barriers and solutions so that they can be responsive to patients' adherence issues; try to offer more than one solution.*
- *If you don't know the solution, it's OK to tell the patient that you don't have the answer right now but will find it and get back to them. Don't be afraid to ask people you work with such as the care team. You can also conduct your own research by visiting HIV-related websites, e.g., Project Inform, the Body, Kaiser, Poz, etc.*

SESSION VIII: ASSESSING ADHERENCE

Topic: Adherence Case Scenarios

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #58

Objectives:

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

- Discuss adherence with patients

Training Methods:

- Small groups
- Large-group discussion

In this activity you will:

- Facilitate a small-group activity around adherence
- Lead a discussion of results

Materials:

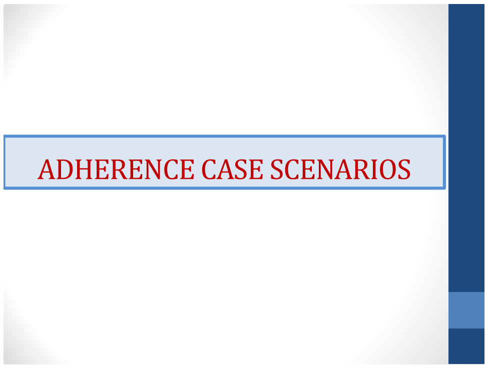
- Adherence Case Scenarios
- Playing cards

Preparation:

- Print out scenarios
- Spread playing cards face down on a table.

Instructions

1. Turn to slide 58.



ADHERENCE CASE SCENARIOS

2. Tell participants that we are going to do an activity. Ask them to go to the table with playing cards spread out facing down and to pick one card.

3. Ask participants whose cards are hearts to go to one corner, those with diamonds to another corner, clubs to the third corner and spades to the fourth corner. (This is another way to randomly group participants).

4. Give each group a case scenario for discussion and ask that each group answer the questions for their scenario (these questions appear at the bottom of each case scenario).

5. Ask for a recorder and a reporter from each group.

6. At the end of 20 minutes, ask participants to stop.

7. Ask each group to report out by reading their scenario out loud and presenting their answers to the 3 questions.

8. After each group reports out, ask the larger group to add any other ideas.

9. Give a round of applause after each presentation.

SESSION VIII: ASSESSING ADHERENCE

Topic: Adherence Case Scenarios

Summarize

- *Adherence is achievable with education/mentoring, reminder strategies, side effects management and emotional support.*

- *Everyone on the care team plays a role in adherence, not just the patient or the peer.*

- *Always remember to talk to patients about challenges you've faced with your own adherence (storytelling) and how you came to address them—this is what role modeling means!*

ADHERENCE CASE SCENARIOS

Michelle

Michelle receives her HIV care at MGH and has been referred to you for adherence support. Michelle has been complaining about side effects that include intense nausea and diarrhea and overall sickness every day. She was prescribed 3 HIV meds, 1 has to be taken twice a day, and 2 only once a day. She takes the once-a-day meds with her dinner at 7:00 p.m. and has no trouble remembering to take them because she has made a connection between eating dinner and taking her meds. However, because she often forgets to take the second dose of the twice-a-day pill, she has decided to take ALL of her pills at the same time.

Questions for your group

1. What might be the reason for Michelle's intense side effects?
2. What would you say to Michelle about the way she's taking her meds?
3. What would you recommend to her?

Darlene

Darlene just saw her doctor who informed her that her viral load is higher than the last time it was checked. He asked her if she was taking her meds as prescribed and she said yes. The doctor asked her to come back in a month to have her viral load checked again and referred her to you in the meantime. Upon checking in with Darlene, you discover that she skips her meds on weekends because she likes to drink alcohol and doesn't want to mix the two.

Questions for your group

1. What may be the reason for Darlene's higher viral load?
2. What would you say to Darlene about the way she's taking her meds?
3. What is she at risk for?
4. What would you recommend?

SESSION VIII: ASSESSING ADHERENCE

Topic: Adherence Case Scenarios

Lisa

Lisa has been referred to you because she is about to start meds for the first time. You go over the instructions and find that one of her meds must be taken with food and one must be taken without food. She doesn't understand what difference it makes to take them with or without food. She tells you that she's just going to take all of them with food because it would be easier on her stomach. She also said she's going to take them every other day to give her digestive system a break between meds because she's afraid of side effects.

Questions for your group

1. What would you say to Lisa about how she plans to take her meds?
2. What reasons would you give her about why some meds need to be taken on an empty stomach?
3. What would you say to her about giving her digestive system a break between meds?

Carmen

Carmen was told by her doctor that she has developed resistance to her meds. She was given a new prescription and was referred to you for support. Her doctor said to stop the old meds today and start the new ones tomorrow. Carmen tells you that she doesn't know why her current meds aren't working anymore; she's confused and doesn't know what it all means. She also shares that she's experiencing the same negative feelings she felt when she went on meds for the very first time and starts to cry.

Questions for your group

1. What do you do when Carmen starts crying?
2. How would you explain why her meds aren't working anymore?
3. How would you support her during this transition?

SESSION VIII: ASSESSING ADHERENCE

Topic: Doctor-Patient Communication

ABOUT THIS ACTIVITY

Time: 35 minutes

Slides: #59

Objectives:

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

- Build skills in preparing for visits to the doctor

Training Methods:

- Brainstorm
- Large-group discussion
- Role-play
- Skills practice

In this activity you will:

- Brainstorm visit preparation activities
- Conduct two role-play activities to practice visit preparation skills
- Debrief both exercises

Materials:

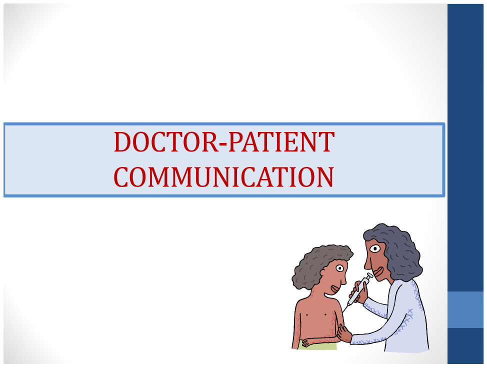
- Skit props (Hats, white coat, stethoscope, clipboard, bag, scarf)
- How To Prepare for a Visit to Your Doctor handout
- Symptoms Log sheet
- Questions for your Doctor about Medications
- Patient Rights handout
- Patient Responsibilities handout
- Role-play #1 and #2 scripts

Preparation:

- Prepare role-play character instructions and scenarios (one for each role in the 2 skits)
- Identify participants to volunteer for the role-play and prepare them ahead of time.

Instructions

1. Turn to slide 59.



DOCTOR-PATIENT COMMUNICATION

2. Tell participants that we are going to do an activity: *This activity is a brainstorm about what you need to do to prepare for a visit with your doctor.*

3. Ask: *What are some things you do to prepare and be ready for a visit with your doctor?* Document responses on newsprint. Possible answers: Keeping a journal or calendar of symptoms, being prepared to describe side effects including symptoms, bringing medications in a bag or have them on a list, bringing a friend, bringing a list of questions for the doctor, etc.

4. Draw participants' attention to the handout "How to Prepare for a Visit with Your Doctor and Symptoms Log" and review together.

5. *These suggestions are ways to help us better communicate with our doctor. As patients, we all have the right to ask questions and get answers. Be honest with your doctor and have a dialogue. Your relationship with your doctor plays an important role in your health. One important part of communicating with your doctor is knowing and asking about your medications. If your doctor gives you a prescription, what questions should you ask?* Document responses on newsprint. Possible answers:
   a. *Why have I been prescribed this medication?*

   b. *How should I take it?*

SESSION VIII: ASSESSING ADHERENCE

Topic: Doctor-Patient Communication

   c. *Are there any special storage requirements?*

   d. *Should I take it with or without food? Will it make me feel worse? What are the side effects? How many and how often should I take them?*

   e. *What do I do if I forget a dose?*

   f. *How long will I have to take it? Will it interact with other medication?*

6. Draw participants' attention to the handout "Questions about Medications" and review together.

7. Introduce and set up role-play #1. (Participants will recognize this conversation from the Day 2 Reflective Listening exercise. This time the focus is on the doctor-patient communication.)

   a. A trainer and a volunteer act out the first role-play. The trainer is the doctor and the volunteer is the patient. Don't forget to use props and script. Co-trainer helps volunteer get into patient role and serves as the narrator.

   b. Debrief first role-play:

   Ask participants: *What do you think about this meeting?*

   Responses may include:
   - *The patient didn't appear to understand the word "T-cells" or "viral load"*
   - *The patient didn't really seem to be ready to start therapy but didn't reveal this to the doctor.*

Next, ask the group what the patient could have done to improve the meeting. [Answer: the patient could help to improve the meeting by asking the questions discussed above— Items 5a-5f].

8. Introduce and set up role-play # 2.

   a. Have two participants volunteer to be the patient and the doctor and conduct second role-play.

   b. Debrief second role-play:

   What do you think about this patient-doctor meeting? Answers:

   - *The patient received information about the numbers (T-cells and viral load).*
   - *Although the patient still wasn't sure about starting therapy, he or she discussed this with the doctor and made a plan to get more information through the peer, and then decide by the next medical appointment.*
   - *The patient was honest.*
   - *The patient understood he or she had the right to refuse until receiving more information.*

Summarize

- *It's important to take charge of your own health care and help patients take charge of theirs (mentoring, role modeling), to know what information to share with your doctor and what questions to ask, and to know your rights and responsibilities as a patient and how to be a partner with your doctor.*
- Draw participants' attention to the handouts "Patient Rights and Responsibilities" and "Preparing for a Visit with Your Doctor."

SESSION VIII: ASSESSING ADHERENCE

Topic: Doctor-Patient Communication

SESSION HANDOUT 1

HOW TO PREPARE FOR A VISIT WITH YOUR DOCTOR

1. Keep a journal or calendar of symptoms.
2. Be prepared to describe side effects including symptoms.
3. Bring medications in a bag or have on a list.
4. Bring a friend.
5. Bring a list of questions.
6. Bring food and something to stay busy.
7. Be prepared to let provider know how many doses of HIV medications were missed in a week or month.

You may wish to share this handout with the patient during Peer-Patient Educational Session #3, Effective Communication and Self-Advocacy. (See guide on page 16.)

SESSION HANDOUT 2

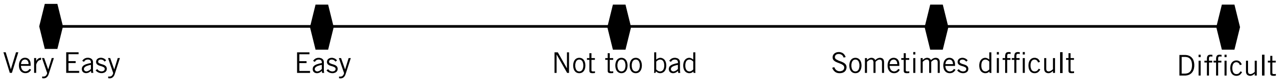
SYMPTOMS LOG

NAME ____ DATE________________

1. Is it hard for you to take your HIV medicines the way your healthcare provider told you to?

☐ Yes ☐ No

2. How hard are your HIV medicines to take? Mark an X on the line below.



3. If you miss a dose, is it in the morning, evening, or middle of the day?

☐ Morning ☐ Evening ☐ Middle of the day ☐ I don't forget or skip doses

4. Do you ever skip a dose because the medicines make you feel bad? ☐ Yes ☐ No

5. Do you ever go a day without taking your HIV medicines?

☐ Yes; why? ____

☐ No

6. Do you ever have any of these possible side effects?

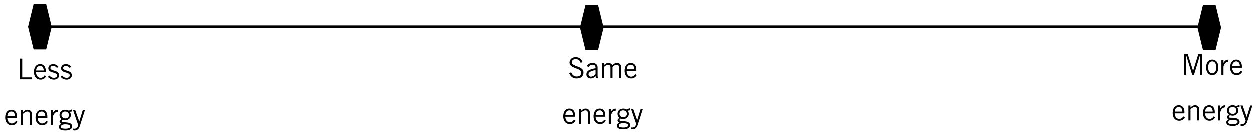
Side Effect	**How many times a month?**	**How long have you had this side effect?**	**How much does it affect your daily activities?** 0=none; 1=somewhat; 2=always
Feeling sick to my stomach			
Vomiting			
Diarrhea			
Headache			
Feeling tired			
Rash			
Shortness of breath			
Trouble sleeping			
Change in skin color			
Bad dreams			
Nervousness			

SESSION VIII: ASSESSING ADHERENCE

Topic: Doctor-Patient Communication

SESSION HANDOUT 2 (Cont.)

7. Has your energy changed since you started taking your current HIV medicines? Mark an X on the line below.



8. Are you concerned that the HIV medicines you are taking now might cause either of these side effects?

a. Weight loss in the arms, legs, buttocks, or face	☐ Yes	☐ No
b. Weight gain in the upper back and neck, breast, or trunk	☐ Yes	☐ No

9. Would you be interested in talking to your healthcare provider about whether a change to your HIV regimen is right for you? ☐ Yes ☐ No

10. If you could change one thing about your HIV treatment, what would it be?

____

____

____

____

Use your answers to talk to your healthcare provider.

You may wish to share this handout with the patient during Peer-Patient Educational Session #3, Effective Communication and Self-Advocacy. and Session #6 Medications and Adherence (See guide on pages 16 and 18.)

SESSION VIII: ASSESSING ADHERENCE

Topic: Doctor-Patient Communication

SESSION HANDOUT 3

QUESTIONS FOR YOUR DOCTOR ABOUT MEDICATIONS

1. Why have I been prescribed this medication?

2. How should I take it?

3. Are there any special storage requirements?

4. Should I take it with or without food? Will it make me feel worse? What are the side effects? How many and how often should I take them?

5. What do I do if I forget a dose?

6. How long will I have to take it? Will it interact with other medication?

You may wish to share this handout with the patient during Peer-Patient Educational Session #3, Effective Communication and Self-Advocacy. (See guide on page 16.)

SESSION VIII: ASSESSING ADHERENCE

Topic: Doctor-Patient Communication

You may wish to share this handout with the patient during Peer-Patient Educational Session #3, Effective Communication and Self-Advocacy. (See guide on page 16.)

HIV PATIENT BILL OF RIGHTS

- The person with HIV has the right to considerate and respectful care regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender, or payment source.
- The person with HIV has the right to, and is encouraged to obtain current and understandable information concerning diagnosis, treatment and prognosis.
- The person with HIV has the right to know the identity of the physician, nurses and others involved in her care, including those who are students, residents or other trainees.
- The person with HIV has the right to work with the physician or nurse in establishing their plan of care, including the refusal of a recommended treatment, without the fear of reprisal or discrimination.
- The person living with HIV has the right to privacy.
- The person living with HIV has the right to expect that all records and communication are treated as confidential except in the case of abuse.
- The person living with HIV has the right to review his/her own medical records and request copies of them.
- The person living with HIV has the right to expect that an advance directive (such as a living will, health care power of attorney) will be honored by the medical staff.
- The person living with HIV has the right to receive timely notice and explanation of changes in fees or billing practices.
- The person living with HIV has the right to expect an appropriate amount of time during their medical visit to discuss their concerns and questions.
- The person living with HIV has the right to expect that his/her medical caregivers will follow universal precautions.
- The person living with HIV has the right to voice his/her concerns, complaints and questions about care and expect a timely response.
- The person living with HIV has the right to expect that the medical caregivers will give the necessary health services to the best of their ability. If a transfer of care is recommended, she should be informed of the benefits and alternatives.
- The person living with HIV has the right to know the relationships his/her medical caregivers have with outside parties (such as health care providers or insurers) that may influence treatment and care.
- The person living with HIV has the right to be told of realistic care alternatives when the current treatment is no longer working.
- The person living with HIV has the right to expect reasonable assistance to overcome language (including limited English proficiency), cultural, physical or communication barriers.
- The person living with HIV has the right to avoid lengthy delays in seeing medical providers; when delays occur, he/she should expect an explanation of why they occurred and, if appropriate, an apology.

Source: Wilder, Terri. “A Guide to Getting Good HIV/AIDS Medical Care.” *Survival News.* 01 July 2000: 1-3.

SESSION VIII: ASSESSING ADHERENCE

Topic: Doctor-Patient Communication

SESSION HANDOUT 5

HIV PATIENT BILL OF RESPONSIBILITIES

- Provide your medical caregivers with accurate and complete information, and convey your understanding about what is expected of you in regard to your treatment. If you believe you cannot follow through with your treatment, let them know.
- Meet your financial obligations as promptly as possible.
- Be considerate of the rights of other patients and medical personnel in the control of noise and respect of property at your appointments or in the hospital.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of the health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about your health care plan.
- Report wrong doing and fraud to the appropriate personnel or legal authorities.
- Keep appointments and notify the clinic if unable to do so.
- Inform the clinic of the existence of, and any changes to, advance directives.
- Notify the clinic of changes in your condition or care situation.

You may wish to share this handout with the patient during Peer-Patient Educational Session #3, Effective Communication and Self-Advocacy. (See guide on page 16.)

ROLE-PLAY #1

Narrator: The following is a discussion between a patient and his/her provider. It will be quite obvious by the response and body language of the patient that s/he is really unaware of what the provider is talking about; yet, the patient will not admit this to the provider. Trainers will use props to distinguish the patient from the provider.

Provider: Well, as I said earlier, I think it's time to start you on medications. Your T-cell counts are at 300 and your viral load is up at 50,000. How do you feel about starting meds at this time?

Patient: Okay…

Provider: Are you sure you're okay with this, you sound a little anxious.

Patient: No, it's okay, I guess, if you think I need to.

Provider: Well, let's start with this combination of medicines and see how it goes. If you should start having any side effects, such as high fever or rash, let me know as soon as possible.

Patient: High fever or rash. Okay, I will … I'll let you know.

Provider: I'll see you back in about a month to see how it's going and to check on your liver. Any questions?

Patient: No, I don't think so. The patient leaves, saying to herself/himself: T-cells and viral load… wonder what he meant by that? And if this stuff is going to cause me to have a fever and a rash, I don't know if I want to take it. Plus he said something about my liver. I feel fine right now, I don't know about taking this stuff.

ROLE-PLAY #2

Narrator: Now let's take another look at a conversation between a provider and patient. This patient is more empowered and has a better understanding of the provider/patient relationship. This patient understands that s/he has rights and responsibilities. These rights ensure that he or she is working together with the provider to maintain the best of health.

Provider: Well, as I said earlier, I think it's time to start you on medications. Your T-cell counts are down at 300 and your viral load is up at 50,000. How do you feel about starting meds at this time?

Patient: To tell the truth, I'm not really sure. Can I ask you a couple of questions first? I wrote them down so I would remember.

Provider: Sure, what is it that I can help you with?

Patient: Well, I know you told me this before, but I'm still not sure if my T-cells are supposed to be down and viral load up or is it the other way around. I still get confused.

Provider: I understand. It confuses a lot of people. We like to see your T-cells up because it is a measure of how well your immune system is doing, and the viral load we want to be down because viral load is the amount of virus in the body.

Provider: I think there's someone in our office that can help you understand all these terms better. If you'd be interested in meeting with him or her, I can refer you to our peer for more information. But do you understand a little better now?

Patient: Yes, I think I would like to meet with the person you're talking about. But I have another question. Why do you think I should start meds now? I'm feeling just fine, and I heard those meds can sometimes make you feel bad.

Provider: Well, the reason I think we should start now is because we want to keep your immune system strong. Remember, we want to keep those T-cells up and we want to get that viral load down. The medicine will help make that happen if you take it correctly. Yes, you may feel bad at first and experience some side effects, but those should go away once your body has adjusted to the meds.

Patient: I heard about side effects. They can make you feel really bad. I'm still not sure I'm ready to do the medicine thing. Can I talk to this counselor or educator you were talking about for more information before I begin?

SESSION VIII: ASSESSING ADHERENCE

Topic: Doctor-Patient Communication

Provider: I understand, it is a very important decision to make and we want you to be sure you're ready to start these meds. We will need you to do your best to take these medicines exactly as prescribed in order for them to work. I'll make contact with the peer and he or she will give you a call to set up a time to meet with you and discuss your concerns. Then, you and I will talk again in a couple of weeks. Is that okay with you? Let's be sure to set your return appointment before you leave today.

Patient: Yes, doctor, I would feel much better doing it that way first. This way I'll get all the information I need before starting these medicines. I really don't think I'm ready to do this medicine thing right now. I appreciate your understanding.

SESSION IX: DRUG RESISTANCE

TOTAL TIME FOR SESSION IX: 1 hour
SLIDES: #60-62

ABOUT THIS ACTIVITY

Time: 60 minutes

Slides: #60-62

Objectives:

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

- Define and understand drug resistance

Training Methods:

- Large-group discussion
- Lecture

In this activity you will:

- Review and explain materials on the slides
- Facilitate group discussions

Materials:

- Video: HIV Resistance — What It Is.....And What You Can Do About It
- Laptop
- Projector

Preparation:

- Prepare video for playing by downloading it onto the computer. Instructions for download and a link to the video may be found at **http://hdwg.org/prep/HIV-resistance-video**

Instructions

1. Play the video.

2. Facilitate a discussion of the video.

Ask participants about the patient vignettes in the video:

A. Jose
- New on medications.
- Works in construction.
- Wants to take all his medications at once.
- “Organize it so it works for me.”
- “Every dose, every day, every time.”
- “Nothing to it but to do it.”

B. Christy
- Mutant strain or wild-type strain.
- Resistance to therapy.
- Re-assess with genotype testing.
- She is not agreeing to a new therapy maybe because she will do some research on medications and resistance before starting another medication therapy.

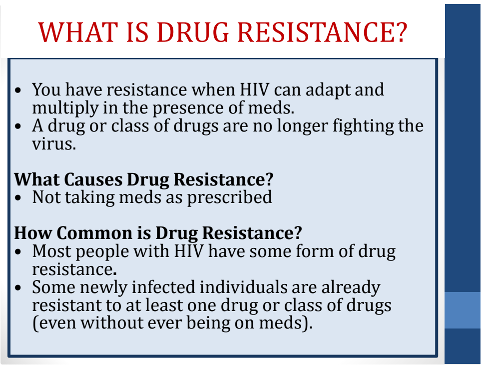
C. Warren
- Has a new job.
- Stigma of his sexual orientation and being HIV positive.
- Options to help with adherence-Christopher (his partner) and his new watch.
- Realistic fears of feeling sick from side effects to medications.

SESSION IX: DRUG RESISTANCE

3. Facilitate a discussion of the picture in slide 60 and meaning of resistance.

SESSION IX: DRUG RESISTANCE

4. Review slide 61 – What is drug resistance?



WHAT IS DRUG RESISTANCE?

- You have resistance when HIV can adapt and multiply in the presence of meds.
- A drug or class of drugs are no longer fighting the virus.

What Causes Drug Resistance?
- Not taking meds as prescribed

How Common is Drug Resistance?
- Most people with HIV have some form of drug resistance.
- Some newly infected individuals are already resistant to at least one drug or class of drugs (even without ever being on meds).

a. *The dictionary definition of* **resistance** *is "the act or power of opposing or withstanding; the opposition offered by one force to another; opposition, defiance, intransigence."*

b. *The best way to prevent resistance is by achieving 95% adherence; that means not missing more than 1½ doses per month (for people on protease inhibitors).*

c. *Having to switch to another medication regimen is difficult both physically and psychologically - you don't know what new side effects to expect and you may feel as anxious as you felt the first time you were faced with the decision to start taking meds. It's best to stay on the same medication regimen for a long time. If the regimen you currently take is working, why would you want to switch?*

d. *Link vignettes to common reasons drug resistance occurs.*

5. *Ask participants if they know how a newly diagnosed person, never on meds before, can have resistance to a medication or a whole class of medication?* Allow responses. Answer: the person who infected the newly diagnosed person was resistant to the same medication or class of medication. There is significant evidence that it is possible to transmit HIV that is already resistant to medications.

Summarize

- *Only 25% of people living with HIV in the U.S. and territories have an undetectable viral load. You are likely to have patients with resistance, so you have an important job to do as peers to help improve this number.*
- *The adherence support that you provide can significantly help reduce the threat of resistance for your patients.*
- *Becoming resistant to medication or classes of medication reduces your treatment options.*
- *Until everyone living with HIV has an undetectable viral load, we won't be able to stop the spread of HIV (unless a vaccine is developed first).*

6. Review slide 62 – More on Resistance.

MORE ON RESISTANCE

- Take meds every day, every dose, at the same time
- Avoid drug holidays
- Not taking meds is better than taking them poorly
- Beware of food and drug interactions
- Taking meds is like a marriage

a. *Since no HIV medication has a life span of more than 12 or 24 hours, skipping a day or a weekend can lead to resistance.*

b. *Ongoing development of resistance can deplete treatment options for people who have gone through multiple drug regimens.*

c. *Like a marriage, you have to participate every day, you must be faithful, if you cheat you lose, sometimes you need counseling, sometimes you need encouragement, sometimes it's rocky but doesn't have to mean the end. It's also true that poor adherence is like a bad marriage.*

d. *Some foods and drugs interact with HIV meds and can increase the severity of side effects (More on drug interactions later during the HIV and Substance Use module).*

7. *Foods that interact with HIV meds.*

a. *Antacids (with protease inhibitor Rayataz).*

b. *Grapefruit (particularly with Norvir).*

c. *High fat meal with Sustiva (this interaction is actually good because high fat reduces the side effects of Sustiva).*

d. *As research continues and new medications are developed, other foods that interact with HIV meds are discovered, so these will continue to change in the future.*

SESSION X: UNDERSTANDING LABS

TOTAL TIME FOR SESSION X: 35 minutes
SLIDES: #63-79

ABOUT THIS ACTIVITY

Time: 35 minutes

Slides: #63-79

Objectives:

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

- Understand the purpose of different lab tests and the meaning of values

Training Methods:

- Lecture
- PowerPoint presentation

In this activity you will:

- Conduct a lecture on the purpose of different laboratory tests and the meaning of values

Materials:

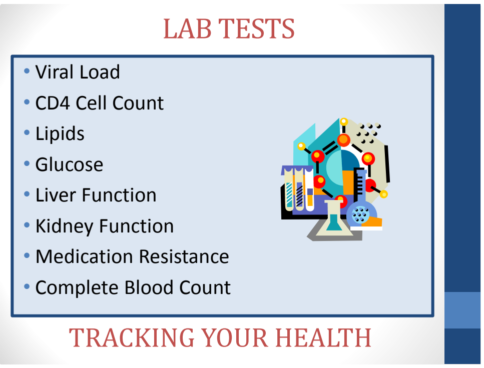
- Monitoring Tests for People with HIV handout printed out from http://www.thebody.com/content/art2599.html

Preparation:

- None

Instructions

1. Explain that we are going to review the purpose of eight different laboratory tests and discuss the meaning of different laboratory values (slide 64).

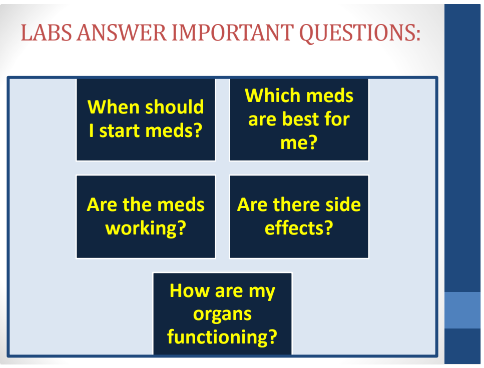


LAB TESTS

- Viral Load
- CD4 Cell Count
- Lipids
- Glucose
- Liver Function
- Kidney Function
- Medication Resistance
- Complete Blood Count

TRACKING YOUR HEALTH

2. Go through slides 65-79.



LABS ANSWER IMPORTANT QUESTIONS:

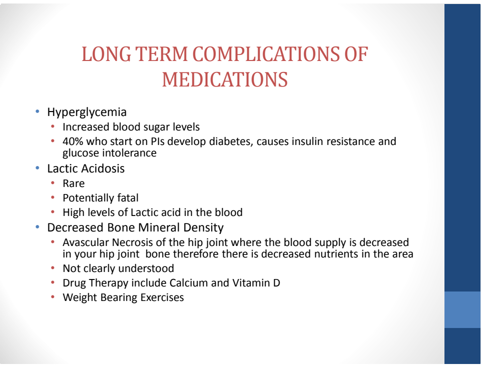
When should I start meds?

Which meds are best for me?

Are the meds working?

Are there side effects?

How are my organs functioning?

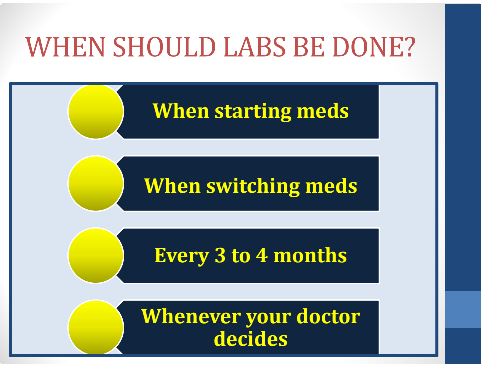


LONG TERM COMPLICATIONS OF MEDICATIONS

- Hyperglycemia
  - Increased blood sugar levels
  - 40% who start on PIs develop diabetes, causes insulin resistance and glucose intolerance
- Lactic Acidosis
  - Rare
  - Potentially fatal
  - High levels of Lactic acid in the blood
- Decreased Bone Mineral Density
  - Avascular Necrosis of the hip joint where the blood supply is decreased in your hip joint bone therefore there is decreased nutrients in the area
  - Not clearly understood
  - Drug Therapy include Calcium and Vitamin D
  - Weight Bearing Exercises

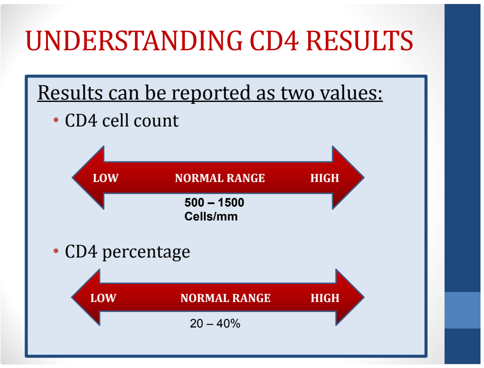
SESSION X: UNDERSTANDING LABS

Topic: Understanding Labs



WHEN SHOULD LABS BE DONE?

- When starting meds
- When switching meds
- Every 3 to 4 months
- Whenever your doctor decides



UNDERSTANDING CD4 RESULTS

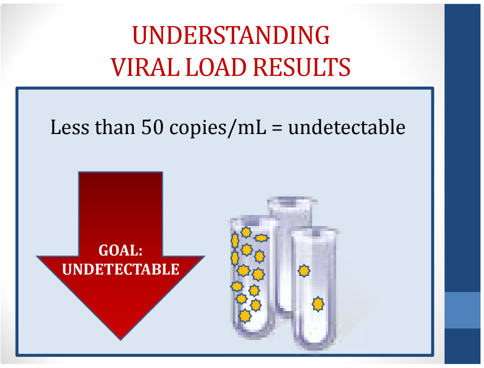
Results can be reported as two values:

- CD4 cell count

500 – 1500 Cells/mm

- CD4 percentage

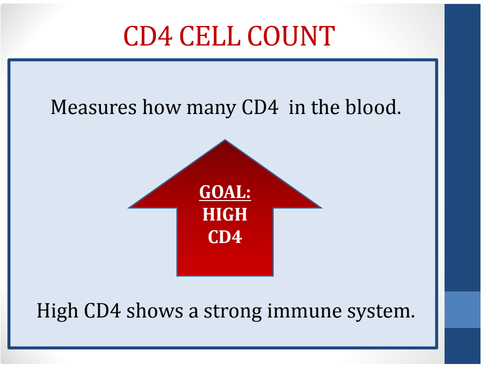
20 – 40%



UNDERSTANDING VIRAL LOAD RESULTS

Less than 50 copies/mL = undetectable

GOAL: UNDETECTABLE

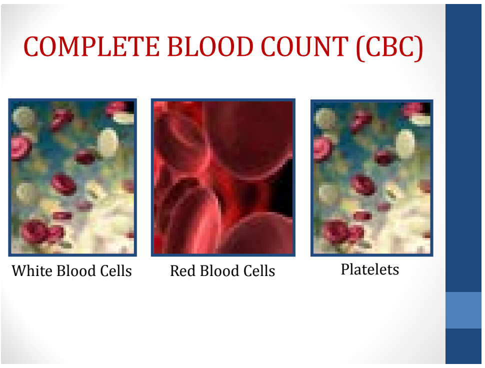


CD4 CELL COUNT

Measures how many CD4 in the blood.

GOAL: HIGH CD4

High CD4 shows a strong immune system.

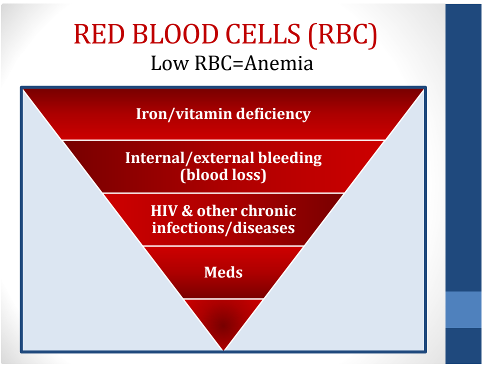


COMPLETE BLOOD COUNT (CBC)

White Blood Cells

Red Blood Cells

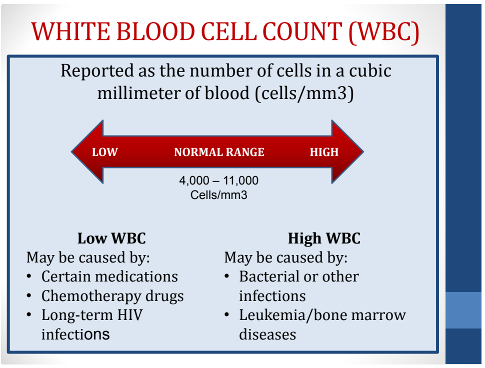
Platelets



RED BLOOD CELLS (RBC)

Low RBC=Anemia

- Iron/vitamin deficiency
- Internal/external bleeding (blood loss)
- HIV & other chronic infections/diseases
- Meds



WHITE BLOOD CELL COUNT (WBC)

Reported as the number of cells in a cubic millimeter of blood (cells/mm3)

4,000 – 11,000 Cells/mm3

Low WBC

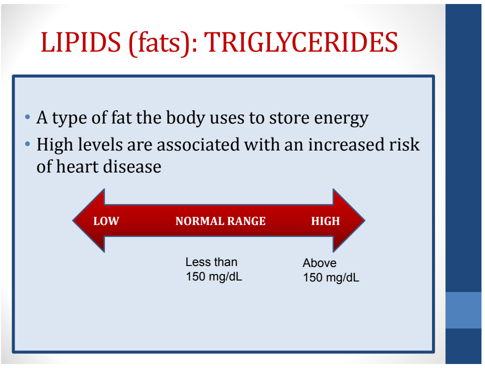
May be caused by:

- Certain medications
- Chemotherapy drugs
- Long-term HIV infections

High WBC

May be caused by:

- Bacterial or other infections
- Leukemia/bone marrow diseases



LIPIDS (fats): TRIGLYCERIDES

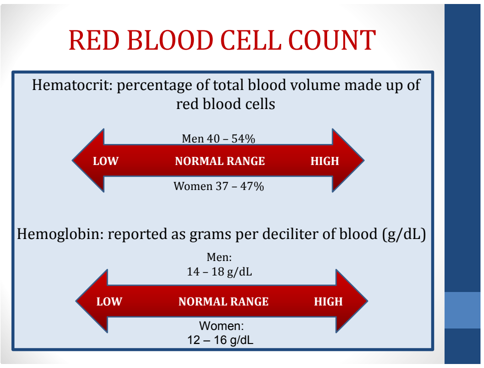
- A type of fat the body uses to store energy
- High levels are associated with an increased risk of heart disease

Less than 150 mg/dL

Above 150 mg/dL

SESSION X: UNDERSTANDING LABS

Topic: Understanding Labs



RED BLOOD CELL COUNT

Hematocrit: percentage of total blood volume made up of red blood cells

Men 40 – 54%

LOW NORMAL RANGE HIGH

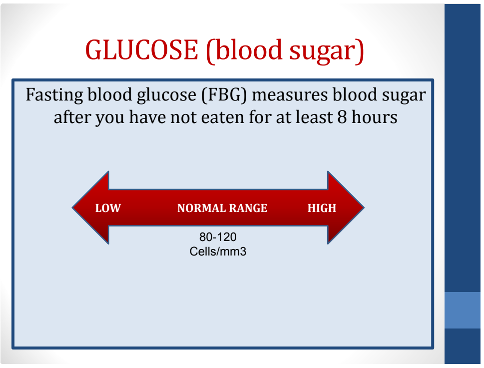
Women 37 – 47%

Hemoglobin: reported as grams per deciliter of blood (g/dL)

Men:
14 – 18 g/dL

LOW NORMAL RANGE HIGH

Women:
12 – 16 g/dL

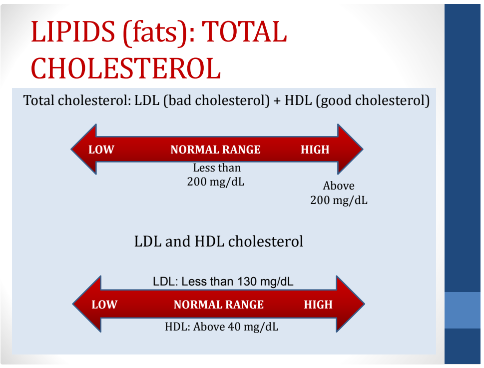


GLUCOSE (blood sugar)

Fasting blood glucose (FBG) measures blood sugar after you have not eaten for at least 8 hours

LOW NORMAL RANGE HIGH

80-120
Cells/mm3



LIPIDS (fats): TOTAL CHOLESTEROL

Total cholesterol: LDL (bad cholesterol) + HDL (good cholesterol)

LOW NORMAL RANGE HIGH

Less than
200 mg/dL

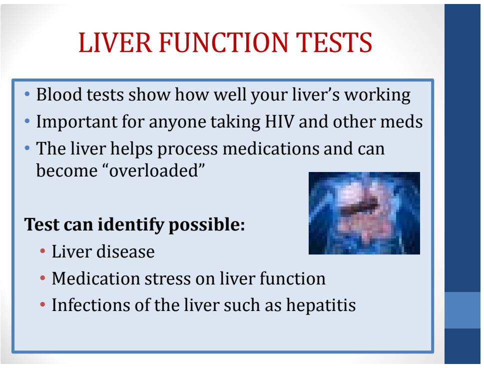
Above
200 mg/dL

LDL and HDL cholesterol

LDL: Less than 130 mg/dL

LOW NORMAL RANGE HIGH

HDL: Above 40 mg/dL

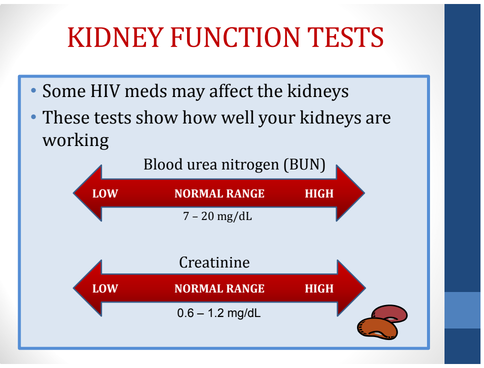


LIVER FUNCTION TESTS

- Blood tests show how well your liver's working
- Important for anyone taking HIV and other meds
- The liver helps process medications and can become "overloaded"

Test can identify possible:

- Liver disease
- Medication stress on liver function
- Infections of the liver such as hepatitis



KIDNEY FUNCTION TESTS

- Some HIV meds may affect the kidneys
- These tests show how well your kidneys are working

Blood urea nitrogen (BUN)

LOW NORMAL RANGE HIGH

7 – 20 mg/dL

Creatinine

LOW NORMAL RANGE HIGH

0.6 – 1.2 mg/dL

3. In "Understanding Viral Load Results," be sure to make the following points:

   a. *A person with HIV can have a viral load from less than 50 copies to over 1 million copies per milliliter of blood.*

   b. *Undetectable does not mean the person is cured.*

4. Under "Complete Blood Count (CBC)," make the point that CBC tests measure the amount of:

   a. White blood cells (fight infections).

   b. Red blood cells (hematocrit, hemoglobin) carry oxygen throughout the body.

   c. Platelets, that help blood to clot.

5. Under "Red Blood Cells," note that high RBCs are very rare.

SESSION XI: HIV STIGMA

Topic: Stigma

TOTAL TIME FOR SESSION XI: 55 minutes
SLIDES: #80-84

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #80

Objectives:

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

- Explore manifestations and consequences of internal and external stigma

Training Methods:

- Large-group discussion

In this activity you will:

- Lead a large-group discussion of stigma and provide examples and explanations to the participants

Materials:

- None

Preparation:

- None

Instructions

1. Ask participants: *What is stigma?* Allow responses and facilitate discussion. Direct participants' attention to the images on the slide and ask them what they see. Associate this kind of behavior with stigma.

    a. *Stigma can be described as an attribute or quality which significantly "discredits" an individual in the eyes of others. This means that people will look at someone and have a negative attitude towards that person because of a certain quality or characteristics.*

    b. *Stigma is synonymous with a mark of disgrace or infamy; a stain or reproach, as on one's reputation.*

    c. *Back in the early days of the epidemic, stigma was really high because there was so much ignorance about how HIV is transmitted; people didn't want to be around you if you had AIDS, let alone touch you. In some cases people lost their homes and their jobs, their families. Stigma came in all forms: your own community, family, significant other, and of course, the larger society.*

2. Describe some causes of stigma

    a. *Heterosexism/homophobia and trans-phobia can lead others to stigmatize individuals because of sexual orientation and gender identity and expression. Sex work is also highly stigmatized, as is injection drug use.*

    b. *Shifting focus away from the patient by overly focusing on risks to the patient's partner instead of the health and well-being of the patient.*

    c. *Giving directives; telling people how they should live their lives.*

SESSION XI: HIV STIGMA

Topic: Stigma

d. *Profiling: assuming transmission modes and behavior based solely on a person's race, gender, or sexual orientation.*

3. Explain external stigma

a. *External stigma refers to experiences of being treated unfairly and differently from everyone else. This discrimination may include oppression, rejection, punishment, harassment, blame, and exclusion. It can also sometimes lead to violence against people living with HIV/AIDS.*

b. *Because HIV infection is connected to the taboos of sexuality and addiction, people face stigma upon stigma upon stigma.*

c. *If I'm a man and I tell you that I'm living with HIV, what's the first thing people might think about me?* Allow responses.
Expected response: gay.

d. *If I'm a woman and tell you I have HIV, what's the first thing people might think about me? Allow responses.* Expected answer: loose, promiscuous.

e. *What if I'm a child with HIV, what's the thing people would think about me?* Allow responses.
Expected answer: innocent victim.

f. *Generally, when people ask how you got HIV, it is often to determine if you're innocent or guilty.*

g. *Children born with HIV and women who got HIV from their cheating husbands are considered "innocent victims" while everyone else simply got what they "deserved." This attitude or label can induce stigma.*

4. Explain Internal Stigma

a. *Internal stigma is the way a person feels about themselves. For example, shame, fear of rejection and discrimination are all examples of internal stigma.*

b. *Internal stigma is the worst kind of stigma because it comes from deep inside the person. It means that you have come to believe the negative messages people have about you and this leads you to feel shame, self-loathing, and a feeling that you got what you deserved.*

c. *Stigma can be damaging to a person's dignity, and without dignity, people cannot be fully human. This alone can cause people to remain in denial or disconnect from medical care and services.*

SESSION XI: HIV STIGMA

Topic: HIV-Related Stigma

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #81

Objectives:

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

- Gain an understanding of how stigma affects individual access to care

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Facilitate a group discussion

Materials:

- None

Preparation:

- None

Instructions

1. Turn to slide 81.

HIV-RELATED STIGMA:
A barrier to disclosure and engagement in medical care

2. Engage participants in a conversation about stigma.
   - *What role has stigma played in your life?*
   - *How did it feel to be stigmatized?*
   - *How did stigma influence your decision to get tested, get into care or disclose to others?*
   - *What did you do to get rid of the stigma inside of you?*
3. Allow responses and facilitate discussion.
4. This is an opportunity for participants to tell some of their stories—ask them to follow the frame and brevity learned earlier.

Segue

Unfortunately, 30 years since the beginning of the epidemic, stigma is still alive and well. Stigma still plays a role in whether or not people get tested, enter care, remain in care, disclose HIV status or practice safer sex. The next slide clearly illustrates this.

SESSION XI: HIV STIGMA

Topic: The Effects of Stigma

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #82-83

Objectives:

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

- Describe the effects of stigma on an individual

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Review the materials on the slides

Materials:

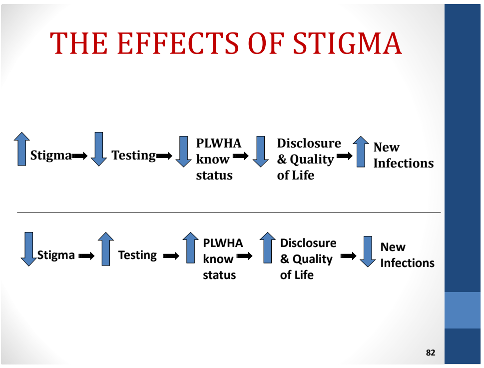
- None

Preparation:

- None

Instructions

1. Review slide 82 with participants. *These findings came from a study done by Dr. Herek, a researcher from California.*



THE EFFECTS OF STIGMA

↑ Stigma → ↓ Testing → ↓ PLWHA know status → ↓ Disclosure & Quality of Life → ↑ New Infections

↓ Stigma → ↑ Testing → ↑ PLWHA know status → ↑ Disclosure & Quality of Life → ↓ New Infections

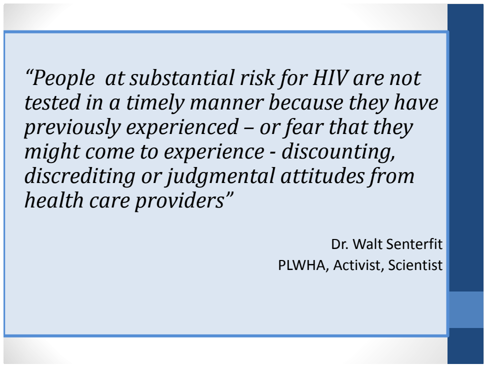
82

2. *When stigma is high, testing is low, fewer people know their status, fewer people disclose and new infections rise.*

3. *When stigma is low, testing increases, more people learn their status, more people disclose and new infections drop.*

4. *The sad thing is that people are sometimes stigmatized even in places they go for medical care and other services.*

5. Ask for a volunteer from the audience to read the quote on slide 83 out loud.



"People at substantial risk for HIV are not tested in a timely manner because they have previously experienced – or fear that they might come to experience - discounting, discrediting or judgmental attitudes from health care providers"

Dr. Walt Senterfit
PLWHA, Activist, Scientist

SESSION XI: HIV STIGMA

Topic: The Effects of Stigma

6. *The care system ought to be a place where people can find respite from oppression, a stigma-free zone; unfortunately, this is not always the case. Sometimes people drop out of care because they were stigmatized by their own doctor.*

7. Ask: *Why do you think stigma has gone down since the early epidemic?*

   Expected responses: *There's less ignorance about how you get HIV and how you don't; more PLWHA have disclosed to partners, family, friends, coworkers and this has led to greater acceptance because it puts a face on the disease.*

> "*I first became aware of the disease in the early 80's when my best friend, Michael was infected with 'the gay cancer.' I watched him wither away to nothing. He died at home in his mother's arms one cold February morning. I would continue to endure the passing away of many friends.*
>
> *I have been positive since 1994. So much has changed since those dark days. We are now able to sustain and live our lives through the use of antiretrovirals. We still have a long road ahead. Stigma, misinformation, lack of compassion and ignorance are but a few of the day-to-day battles that anyone diagnosed with HIV faces.*"
>
> A peer at CARE Resource in Miami

SESSION XI: HIV STIGMA

Topic: What Not to Say

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #85

Objectives:

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

- Recognize and address stigma

Training Methods:

- Lecture
- Group discussion
- Large-group exercise

In this activity you will:

- Model stigmatizing statements that are not intended to stigmatize
- Lead a discussion on how to address stigma

Materials:

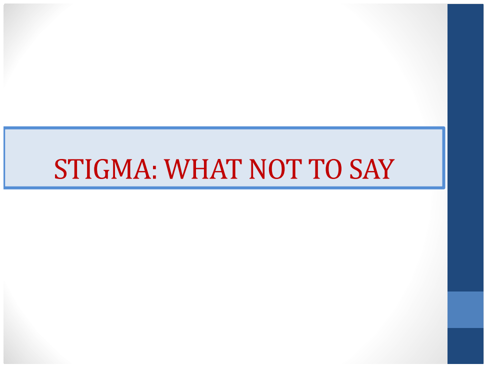
- Stigma Exercise: What Not to Say trainer sheet

Preparation:

- None

Instructions

1. Turn to slide 84.



STIGMA: WHAT NOT TO SAY

2. Tell participants that sometimes we can stigmatize people inadvertently even as we are trying to support them.

3. Go around the room and make eye contact with individual participants while reading a statement of things peers might say to patients that can stigmatize them (see statements on “Stigma Exercise: What Not to Say” trainer sheet); ask participants how they felt when each statement is made.

4. Move to the peer role in supporting patients who are experiencing stigma. Ask: *What is the role of peers with regard to stigma? What can you do to reduce stigma in people’s lives?*

5. Allow participants to respond and facilitate discussion. Expected answers (document on newsprint):

   - *Actively remove stigma from your interactions with patients.*
   - *Call out stigma when you see it in the workplace (but do so with respect and in a way that people can hear it; remember, sometimes people stigmatize without being aware of it).*
   - *Help the care team understand how people experience stigma and how their words and actions can sometimes stigmatize people (remember, your role can include educating your colleagues who may not have anyone in their lives living with HIV and thus may not understand how words and actions can stigmatize).*

SESSION XI: HIV STIGMA

Topic: What Not to Say

- Help patients work through internal stigma, the worst type of stigma, but one they can do something about.

6. Some important messages:

   - You are not alone.

   - Being HIV+ is not shameful.

   - HIV is a health issue not a moral or social issue.

   - HIV doesn't see race, gender, or sexual orientation, it only sees humans.

   - No human being is more or less valuable than another simply because of a disease.

Summarize

- *Modeling how you manage stigma in your own life can inspire patients to do the same—share your experiences (story telling) with patients and how you've been able to manage stigma in your own life.*

- *Be careful not to minimize people's feelings around stigma; these feelings are real and need to be handled with care.*

SESSION XI: HIV STIGMA

Topic: What Not to Say

SESSION HANDOUT

STIGMA EXERCISE: WHAT NOT TO SAY

- “HIV is not a big deal anymore.”
- “HIV is a manageable chronic illness, like diabetes.”
- “Now that you have HIV you need to disclose to your sexual partner immediately.”
- “I’m really worried about you infecting your HIV-negative partner.”
- “How many people do you think you’ve infected so far?”
- “Having sex without a condom is like putting a gun to someone’s head.”
- “You have full-blown AIDS.”
- “Turn to Jesus.”
- “You got HIV because of your sins.”
- “Now that you are HIV instead of “now that you have HIV or are living with HIV.”
- “I’m a mandated reporter, so if you infect other people, I have to report you.”
- “Your behavior is what got you in trouble in the first place.”

SESSION XII: VALUES

Topic: Overview of Values

TOTAL TIME FOR SESSION XII: 1 hour, 25 minutes
SLIDES: #85-89

ABOUT THIS ACTIVITY

Time: 5 minutes

Slides: #85

Objectives:

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

- Explain the meaning of values

Training Method:

- Discussion

In this activity you will:

- Conduct a group discussion

Materials:

- None

Preparation:

- None

Instructions

1. Ask participants: *What are values?*
2. Answer: *The term "values" implies qualities of mind and character, or moral excellence; implies intrinsic excellence or desirability; a person's principles or standards of behavior; one's judgment of what is important in life.*
3. *Keep this in mind for the next discussion and exercise.*

SESSION XII: VALUES

Topic: (Un)Push My Buttons: Examining Our Personal Values

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #86

Objectives:

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

- Identify their personal values and how they affect their actions

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Facilitate a group discussion

Materials:

- None

Preparation:

- None

Instructions

1. Turn to slide 86.

(UN)PUSH MY BUTTONS:
EXAMINING OUR PERSONAL VALUES

2. Lead a discussion about how we all have buttons based on our values that when pushed can make us upset, angry, or even panicky.

   - *In the context of peer work, this can influence how we view patients who "push our buttons" and can render us ineffective or judgmental and, in some cases, punitive.*

   - *We all have these buttons and they are based on past experience, upbringing, culture, religious beliefs, etc.*

3. Ask participants: *What are some things that push your buttons about people in general?* Take a few responses and facilitate discussion; share some of your own button pushers.

4. Document these on newsprint and post on the wall.

Segue

- *In the next exercise, we will be exploring buttons based on our personal values that we may not even know we have and yet we react to them.*

SESSION XII: VALUES

Topic: Self-Assessment: What Pushes Your Buttons?

ABOUT THIS ACTIVITY

Time: 35 minutes

Slides: #87

Objectives:

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

- Express how their personal values might interfere within their work as peers

Training Methods:

- Individual exercise
- Debriefing
- Group discussion

In this activity you will:

- Review common areas of discomfort for service providers
- Facilitate an individual activity where people self-identify their own levels of comfort
- Convene a report-back session
- Facilitate a group discussion

Materials:

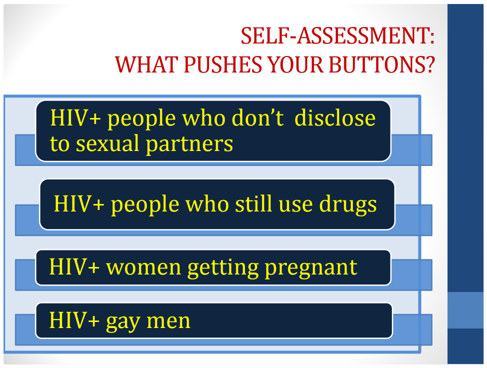
- Unpush My Buttons worksheet
- Newsprint
- Markers

Preparation:

- None

Instructions

1. Review slide 87 with participants; explain that research shows these as 4 areas of discomfort for many HIV service providers.



SELF-ASSESSMENT:
WHAT PUSHES YOUR BUTTONS?

- HIV+ people who don't disclose to sexual partners
- HIV+ people who still use drugs
- HIV+ women getting pregnant
- HIV+ gay men

2. Ask participants to find the “UnPush My Buttons” worksheet in their training packets and ask them to self-identify their own level of comfort in these key situations on the comfort inventory scale (very comfortable to very uncomfortable). Ask them to *circle the number that best reflects how comfortable you are in each of these situations.*

3. Encourage participants to be completely honest about their responses (otherwise the activity won't work); reassure them that no one will judge them for being honest about their values and feelings.

4. *If comfortable with all of these issues, think about a time when you weren't as comfortable as you are today. The worksheets will not be collected, so feel free to write how you really feel.*

5. *Once you rate yourself, identify the most uncomfortable area and the SOURCE of your discomfort (could be religion, culture, upbringing, personal history, etc.) and write it down.*

6. When participants are done proceed to debriefing.

7. Ask participants to report out their assessment and to state the area of most discomfort and source of discomfort.

SESSION XII: VALUES

Topic: Self Assessment: What Pushes Your Buttons?

8. Try to get every participant to report out – one way to do this without calling anyone out is to give an item like a pencil or ball to the first participant – as the item is being passed around that next participant reports out and so forth.

9. As participants report out, record on newsprint their <u>source of discomfort</u>; this should generate a long list of sources of discomfort. When documenting responses on newsprint, start every source of discomfort with an "I" or "My" statement; for example, "**I feel** HIV+ people should always disclose to sexual partner" or "**MY** religious beliefs prevent me from using drugs."

10. Once everyone has had a chance to report out, ask participants to take a few moments to contemplate the list generated, then ask *"What do you see, what stands out for you?"* Expected response: these sources of discomfort represent our own personal values and beliefs (all are "I" and "My" statements).

11. If an expected response is not forthcoming, prompt participants by asking:

    - *"To whom do these issues/values belong?"* Expected answer: to us, to every person in this room; then ask:

    - *"What do our values have to do with the patient sitting in front of us?"*
      Expected response: nothing

12. Ask: *How does this apply to our work as peers? What is the lesson in this exercise?*

Expected answer: Don't judge your patients; don't project your own <u>stuff</u> onto your patient.

Summarize

- *No one can tell you how to feel or ask you to change your personal beliefs and values; however, as peers, you are required to suspend your judgment during your interactions with patients.*

- *If we show our patients, through words and action, that we don't approve of what they are doing or that we judge them for who they are and what they do, they may feel stigmatized and may never engage with us again. Because of our own biases, we will have missed opportunities to empower patients to make more informed choices about their health and well-being.*

- *Values are very personal, so don't impose yours or expect patients to share yours.*

- *This is a good exercise to do in your head when faced with uncomfortable feelings elicited by the patient: Ask yourself, "Why am I suddenly feeling uncomfortable?" You will find that you're likely to be experiencing countertransference* and having this awareness in the moment will enable you to identify the feeling as your own "stuff" trying to get in the way.*

- *What other situations do you think will push your buttons or make it difficult for you to remain objective when you are with patients?* Allow responses and facilitate discussion.

Segue

Instead of passing judgment on our patients and projecting our feelings onto them, we ought to focus on being patient-centered.

* *countertransference is the peer's response (often negative) to the transference behavior of the patient in which the patient unconsciously transfers feelings and attitudes from a person or situation in the past onto the peer.*

SESSION XII: VALUES

Topic: Self-Assessment: What Pushes Your Buttons?

(UN)PUSH MY BUTTONS EXERCISE

This is an individual exercise. You will not be asked to hand in this worksheet or show it to anyone else, so feel free to assess your discomfort level or "button pushers" as honestly as possible.

Please circle the number that best describes how you would feel in the three situations listed below: (1 being very comfortable and 5 being very uncomfortable)

1	2	3	4	5
Very Comfortable	**Comfortable**	**Somewhat Comfortable**	**Uncomfortable**	**Very Uncomfortable**

1. Working with sexually active HIV+ people who don't disclose	1	2	3	4	5
2. Working with HIV+ people who actively use drugs	1	2	3	4	5
3. Working with HIV+ people planning a pregnancy	1	2	3	4	5

<u>Source of Discomfort</u>

Take a moment and consider what might be at the root of your discomfort.

What is it that makes this situation a button pusher for you? *(Could be personal history, religious/ cultural beliefs, inexperience/unfamiliarity with behaviors or situations)*

SESSION XII: VALUES

Topic: Patient-Centered Approach

ABOUT THIS ACTIVITY

Time: 25 minutes

Slides: #88

Objectives:

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

- Explain the patient-centered approach

Training Methods:

- Group discussion
- Round robin

In this activity you will:

- Lead a group discussion around the patient-centered model
- Facilitate an activity designed to elicit participant examples of patient-centered approaches

Materials:

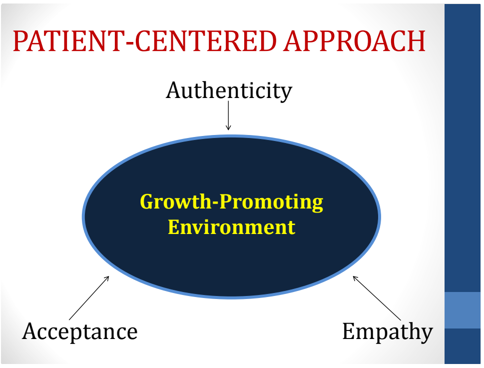
- Newsprint
- One marker for each participant

Preparation:

- Prepare 3 newsprints on the walls, in separate corners of the room, with the headings: Authenticity, Acceptance, Empathy

Instructions

1. Present slide 88 to the group and explain that this model was created by Carl Rogers, American Psychologist from the 1940s. *Carl Rogers believed that when these three conditions are present during interactions with patients, you are actually creating a growth-promoting environment, one in which patients can find solutions. This model can be applied to any relationship in which the growth of the individual is the goal, e.g., parent and child, teacher and student, etc. The patient is in the driver's seat, which often leads to taking control of his or her health and life.*



PATIENT-CENTERED APPROACH

Authenticity

Growth-Promoting Environment

Acceptance

Empathy

2. **Authenticity:** Ask participants: *What is authenticity?*

    - Expected answer: being genuine, being yourself, being real, being true, candor, trustworthiness, credibility, dependability.

3. **Acceptance:** Ask participants: *What is acceptance?*

    - Expected answers: favorable reception, positive regard, understanding, unconditional engagement. *You accept patients even when you know they are doing things that can harm them or that "push your buttons."*

SESSION XII: VALUES

Topic: Patient-Centered Approach

4. **Empathy:** Ask participants: *What is empathy?*

    - Expected answer: identification with the feelings, thoughts, or attitudes of another; understanding and imaginatively entering into another person's feelings; the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner. Synonymous with communion, appreciation, compassion, sympathy. Imagining yourself in another person's shoes.

5. Listening empathetically is one of the most powerful forces for movement and change.

6. Round robin exercise: Pass out some markers and ask participants to go to each newsprint and write words/phrases that describe how a peer leader can demonstrate being Authentic, Accepting, and Empathetic.

7. Tell participants they are allowed to go around again and again if they have more than one word/phrase for each heading.

8. At the end of the exercise, summarize what participants wrote and add any not mentioned.

Summarize

- *Your role as peers is not to change patients but to create a space/conditions that allows them to do that for themselves.*

Segue

- *Following certain principles will help us assure that we are creating the appropriate environment for patients.*

SESSION XII: VALUES

Topic: Principles of Peer Work

ABOUT THIS ACTIVITY

Time: 25 minutes

Slides: #89

Objectives:

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

- Describe the principles that honor the dignity of their patients

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Facilitate a discussion around a patient-centered approach to care

Materials:

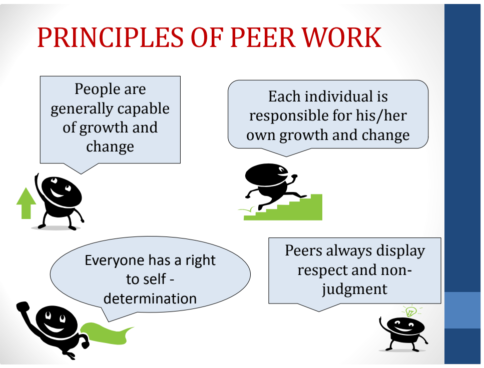
- None

Preparation:

- None

Instructions

1. Show slide 89 on the screen and ask for volunteers to read what's in each callout box, then elaborate and facilitate discussion.



PRINCIPLES OF PEER WORK

People are generally capable of growth and change

Each individual is responsible for his/her own growth and change

Everyone has a right to self - determination

Peers always display respect and non-judgment

2. 1st callout box: *Being in the driver's seat; believing in patient's capability of their own growth will help keep us from forcing our will upon them.*

3. 2nd callout box: *Growth and change is dependent on the patient; your responsibility as a peer is to provide the tools for growth and change, such as mentoring, motivating and supporting.*

4. 3rd callout box: *What is self-determination?* Take a few responses – expected response: the right of each individual to make their own decisions about their lives. *Everyone has a right to decide their own lives; PLWHA did not give up these rights when they tested positive for HIV. The right to self-determination includes the right to have sex, get married, have a baby, the right to say no, the right to refuse treatment or even peer support services, and the right to be treated with respect and dignity even if we disagree with patients' choices.*

5. 4th callout box: *Respecting our patients values their dignity as human beings: If we respect a person's individual rights we won't point the finger at them, tell them what they should or must do, or try to rescue them. Resist the temptation to rescue people from their behaviors—no one is quite that powerful (even licensed professionals).*

SESSION XII: VALUES

Topic: Principles of Peer Work

Summarize

Real, meaningful, sustainable change comes from within the individual, not from the outside.

DAY 3: REVIEW

Review and remind participants how they will use their knowledge in working with patients. Refer to the Peer-Patient Educational Session Conversation Guide handout (pages 14-22) as you review.

Let's take a moment to relate what you've learned so far to the Peer-Patient Educational Session Conversation Guide handout. Today we learned a lot of things that will be helpful in Educational Session 6 when you talk about drug resistance and adherence and understanding and managing side effects.

Session VIII Review

You will probably want to use the 10 questions handout to help you remember to ask patients some important questions about adhering to their meds.

- *What are some questions to ask?* (refer to handout on pg. 108 for answers)
- *What are some things that prevent people from adhering to their meds?* (side effects, fear of toxicity, forgetting, living with people who don't know their status, a break in daily routine, not getting refills, etc.)
- *What are some things that help to overcome these barriers?*
- *In Educational Session 3, you will be talking with patients about how to communicate with providers. What are some things we can suggest to patients so they are ready for a visit with their doctor?* (keeping a journal of symptoms or side effects, bringing medications, bringing a list of questions, etc.)

Session IX Review

We also talked about ***drug resistance****. This is something you will be discussing with patients in Educational Session 6.*

- *What's the result of becoming resistant to medications?* (medications no longer work to keep you healthy, reduces your treatment options, sometimes you have to switch treatments)
- *What's the best way to prevent resistance?* (adhering to treatment and engaging in safe sex by using condoms)

Session X Review

In Educational Session 4, you will be talking about ***lab values*** *with patients. The article about the different lab tests that we went over would be helpful when you talk with patients about their lab values.*

- *What are some of the lab tests you might go over with patients?* (CD4 count, lipids, glucose, liver function, kidney function, medication resistance, complete blood count)
- *Why should you get your labs done regularly?* (keep you healthy, an indication of whether things are going well or not so well for you)

Session XI and XII Review

We also talked about external and internal kinds of **stigma**.

- Can you give an example of each?
- *This is something that might come up any time when you talk with patients but especially when you talk with them about disclosure in Educational Session 7.*
- *What are some affirming messages we can use to counteract stigma?* (Being HIV+ is not shameful, HIV doesn't see race, gender or sexual orientation, only humans; HIV is a health issue, not a moral or social issue, etc.)
- *We also talked about how our own values can get in the way of working with patients. Can you give an example of what a patient might do that "pushes your button?"*

DAY 3: REVIEW

- *Another thing we learned about is the patient-centered approach. What are the three conditions that help create a growth-promoting environment for our patients?* (acceptance, authenticity, and empathy, give an example of each.)
- *We wrapped up the day talking about some principles of peer work. Can you tell me what they are?* (people are capable of change, each person is responsible for his or her own growth and change, everyone has a right to decide their own lives, peers show respect and do not judge.

This publication was supported by grant #U69HA23262, “Minority AIDS Initiative Retention and Re-Engagement Project,” through the U.S. Department of Health and Human Services, Health Resources and Services Administration’s HIV/AIDS Bureau, National Training and Technical Assistance. The contents of this publication are solely the responsibility of the Health & Disability Working Group and do not necessarily represent the views of the funding agencies or the U.S. government.

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PREParing PEERS FOR SUCCESS: DAY 4

PEER CORE COMPETENCY TRAINING

A curriculum for engaging out-of-care or newly diagnosed people living with HIV in care and treatment

MOTIVATIONAL INTERVIEWING

SUPPORTING PATIENTS WITH DISCLOSURE

DEPRESSION AND HIV

HARM REDUCATION

SEXUAL HEALTH

August 2014

DAY 4: Motivational Interviewing, Supporting Patients with Disclosure, Depression and HIV, Harm Reduction, Sexual Health

An Overview of Today's Sessions and Topics

Topic	Duration	Slides	Page
Icebreaker*	20 min.		
Review of previous day*	5 min		152-153
Session XIII: Motivational Interviewing	**1 hr. 50 min (total)**	**90-95**	**157-166**
Topic: Defining Motivational Interviewing	5 min	90	157
Topic: Change Talk: Evoking Change	15 min	91-92	158
Topic: Change Talk: Assessing Importance	15 min	93	159
Topic: Change Talk: Assessing Confidence	15 min	94	160
Topic: Cost-Benefit Analysis	20 min	95	161-162
Topic: Change Talk Exercise	40 min	96	163-166
Session XIV: Supporting Patients with Disclosure	**55 min (total)**	**97-99**	**167-173**
Topic: Overview of Disclosure	5 min	97	167
Topic: I would always tell/I Would Never Tell	20 min	98	168-170
Topic: Mentoring on Disclosure	30 min	99	171-173
Energizer*	15 min		
Session XV: Depression and HIV	**55 min (total)**	**100-102**	**174-184**
Topic: Depression and HIV	15 min	100	174
Topic: What is Depression?	10 min	101	175-176
Topic: Responding to Depression	35 min	102	177-184
Session XVI: Harm Reduction	**50 min (total)**	**103-106**	**185-199**
Topic: Harm Reduction	5 min	103	185
Topic: Principles of Harm Reduction	20 min	104	186-192
Topic: The Harm Pyramid	10 min	105	193
Topic: Substance Use/Abuse	15 min	106	194-199
Session XVII: Sexual Health	**1 hr. 25 min (total)**	**107-108**	**200-203**
Topic: Sexual Risk and STIs	1 hour	107	200-202
Topic: Condom Relay Race	25 min	108	203
Review, wrap-up, and evaluation*	15 min.		204

* See pages 7-8 for an explanation of these climate-setting activities

Throughout this curriculum, *italicized words* are intended to be spoken directly to the class.

This publication is part of the online curriculum *PREParing Peers for Success: Peer Core Competency Training*. For the complete curriculum, accompanying PowerPoint slides, and other curricula in the series, visit http://www.hdwg.org/prep/curricula

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SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Defining Motivational Interviewing

TOTAL TIME FOR SESSION XIII: 1 hour, 50 minutes
SLIDES: 90-95

ABOUT THIS ACTIVITY

Time: 5 minutes

Slides: 90

Objectives:

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

- Define motivational interviewing

Training Methods: Discussion

In this activity you will:

- Introduce the concept of motivational interviewing

Materials:

- None

Preparation:

- None

Instructions

Discuss with the group:

1. *The motivational interviewing approach is a way of being with patients. It is not only* what *you do (ask questions), but* how *you do it that's important.*

2. *What does interviewing mean?*
Answer: *Viewing together, between.*

3. *What does motivational (motivation) mean?*

   Answer: *Providing with a reason to act in a certain way, incentive, interest or drive.*

4. *Motivational interviewing in the context of working with HIV+ patients, then, means viewing together what's going on with the patient and what interest or drive they have to make changes in their lives.*

SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Change Talk: Evoking Change

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #91-92

Objectives:

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

- Create statements/questions that can evoke change

Training Methods: Discussion

In this activity you will:

- Review types of questions and statements that can evoke change
- Conduct a role-play with trainer and participant

Materials:

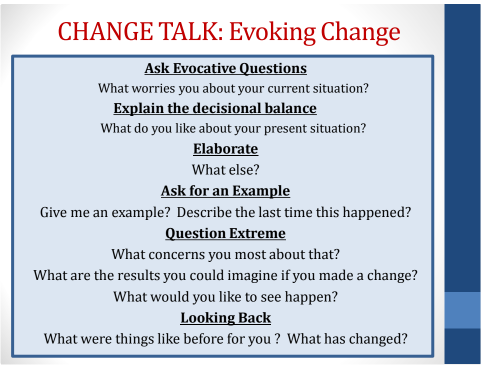
- None

Preparation:

- Prepare role-play to conduct (trainer and participant as peer/patient)

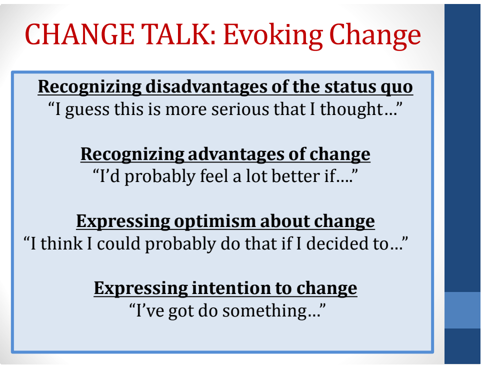
Instructions

1. Introduce slides 91 and 92. Review the points and lead a discussion using the questions on the slides.



CHANGE TALK: Evoking Change

Ask Evocative Questions
What worries you about your current situation?
Explain the decisional balance
What do you like about your present situation?
Elaborate
What else?
Ask for an Example
Give me an example? Describe the last time this happened?
Question Extreme
What concerns you most about that?
What are the results you could imagine if you made a change?
What would you like to see happen?
Looking Back
What were things like before for you ? What has changed?



CHANGE TALK: Evoking Change

Recognizing disadvantages of the status quo
"I guess this is more serious that I thought…"

Recognizing advantages of change
"I'd probably feel a lot better if…."

Expressing optimism about change
"I think I could probably do that if I decided to…"

Expressing intention to change
"I've got do something…"

2. Trainer conducts a brief role-play with volunteer participant using some of these questions to evoke change between peer and patient.

Summarize

- *Eliciting change talk is a direct strategy for resolving ambivalence (uncertainty). The communication skills we learned earlier in the training, asking open-ended questions, attentive listening, reflective listening, and summarizing, may not be enough to elicit change in some patients. It's still possible for a patient to remain stuck in uncertainty.*

- *The idea is to have the peer help the patient engage in change talk, that is, for the patients themselves to present the arguments for change.*

SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Change Talk: Assessing Importance

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #93

Objectives:

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

- Measure the level of motivation for change with their patient

Training Methods:

- Discussion
- Role-play on assessing importance

In this activity you will:

- Facilitate a discussion
- Conduct a role-play using the trainers

Materials:

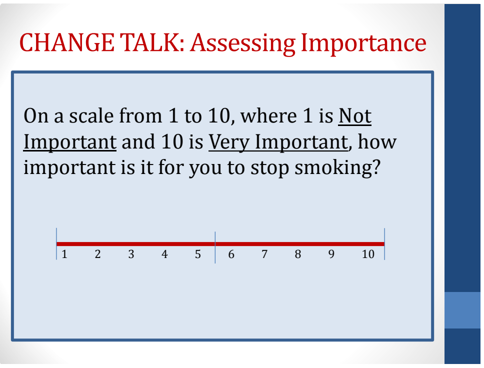
- None

Preparation:

- Prepare a role play exercise to conduct with a fellow trainer

Instructions

1. Review slide 93 with participants and facilitate discussion:



CHANGE TALK: Assessing Importance

On a scale from 1 to 10, where 1 is Not Important and 10 is Very Important, how important is it for you to stop smoking?

1 2 3 4 5 6 7 8 9 10

- *When you hear change talk from your patient, it's important not to ignore it, because that shows that the patient is motivated to make a change.*
- If the patent rates himself/herself a 6, you should ask: *Why did you rate yourself a 6 and not a 7 or an 8?* This will elicit information about where he or she is in level of motivation. Then you should ask: *What would it take to raise the level of importance?*

2. Trainers conduct a role-play on how to assess importance.

> *I realized [the patient] was ready to break the [drug] habit when she told me herself that she needed help. First we worked on adherence to her mental health medications, then she started adhering to her HIV treatment.*
>
> A peer at PR CoNCRA

SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Change Talk: Assessing Confidence

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #94

Objectives:

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

- Assess the level of confidence to change with their patient

Training Methods:

- Discussion
- Demonstration exercise

In this activity you will:

- Lead a discussion about having the confidence to change behaviors
- Demonstrate how to assess the confidence level with a patient

Materials:

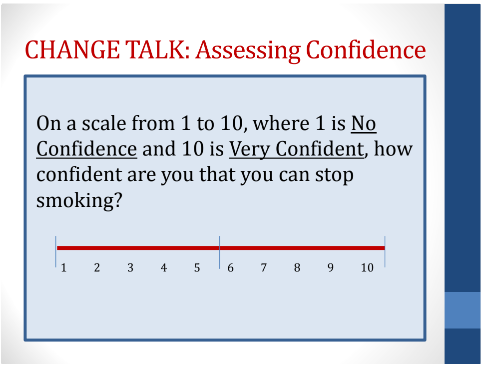
- None

Preparation:

- Prepare a role-play with a fellow trainer

Instructions

1. Review slide 94 with participants and facilitate discussion:



CHANGE TALK: Assessing Confidence

On a scale from 1 to 10, where 1 is No Confidence and 10 is Very Confident, how confident are you that you can stop smoking?

- Once you have assessed importance, take it to the next level and assess confidence. A person may place high importance on something they want to change but may not have enough confidence that they can do it.
- If the person rates himself or herself a confidence level of 4, ask: *What would it take to bring you confidence up to 5 or 6?* This will elicit information about where he or she is in level of confidence.

2. Trainers conduct a role-play on assessing confidence.

SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Cost-Benefit Analysis

ABOUT THIS ACTIVITY

Time: 20 minutes

Slides: #95

Objectives:

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

- Demonstrate a method for weighing options

Training Methods:

- Small-group exercise
- Large-group exercise

In this activity you will:

- Introduce a cost-benefit analysis
- Facilitate small- and large-group discussions around cost-benefit analyses created by participants

Materials:

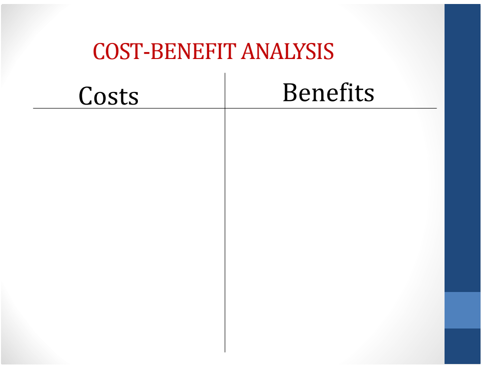
- Newsprints
- Markers

Preparation:

- Prepare two newsprints, one with the heading "Cost" and another with the heading "Benefit"
- Place them on opposite walls

Instructions

1. Tell participants: *A "Cost-Benefit Analysis," also known as a "Pros-Cons list," is a good way to help patients weigh their options about making changes in their lives. This method can be used when the patient is ambivalent or uncertain about whether or not to abandon a personal behavior that may be negatively impacting on their health and well-being.* Show slide 95.



COST-BENEFIT ANALYSIS

Costs	Benefits

2. Ask participants to break out into 2 groups; ask one group to go to the "Cost" newsprint on the wall and write down "**The price of disclosure for many people**," and ask the other group to do the same with "**The benefits of disclosure.**"

3. Ask each group to select a recorder and reporter.

4. After 10 minutes, ask the 2 groups to stop and place the two newsprints next to each other.

5. Ask each group to report out. After each report out, ask the other group to add anything left out. Add costs and benefits not listed.

6. In some cases, as in this example, the costs and benefits may cancel each other out; in other words, the number of costs may equal the number of benefits. In this case the patient may decide that the benefits far outweigh the costs OR the patient may become ambivalent.

SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Cost-Benefit Analysis

7. *As a peer, you can explore how much the patient* values *the benefits over the costs. To help the patient make this determination, use the "Assessing Importance" scale we discussed earlier to help the patient understand the level of importance he or she places on the benefits over the costs.*

8. Also, if there are too many costs, check and see if some of those costs might be eliminated with the provision of services. If so, help the patient begin working towards addressing them.

Segue

In the next exercise we will explore how you can help motivate a person who is preparing to disclose.

SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Change Talk Exercise

ABOUT THIS ACTIVITY

Time: 40 minutes

Slides: #96

Objectives:

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

- Use eliciting change talk in a conversation with patients

Training Methods:

- Role-plays with observer

In this activity you will:

- Facilitate small-group role plays
- Debrief after each role-play

Materials:

- Case scenarios worksheet

Preparation:

- Put each scenario on a separate piece of paper and place in a box

Instructions

1. Turn to slide 96.

CHANGE TALK EXERCISE

2. Divide participants into groups of three and assign a specific role to each person in the working groups: the peer who is conducting the interview, the patient being interviewed, and an observer.

3. Ask the "patients" to select a scenario from the box and read it. They should not reveal the scenario ahead of time to the persons in either the peer or observer roles.

4. The person in the peer role begins by asking an open-ended question, such as *"How might I be of help?"* or *"What brings you here today?"*

5. The person in the patient role should create a personal story around the scenario.

6. The peer's goal is to use the skills to understand the patient's situation, thoughts, and feelings.

7. The job of the people in the observer role is to jot down examples of the peer's use of motivational interviewing skills.

8. Allow about eight to ten minutes for each interview. After each role-play, the three participants should debrief for about four minutes around the discussion questions listed on the newsprint.

9. If time permits, allow each working group to repeat the role-play using different scenarios so that everyone has an opportunity to play all three roles.

10. These role-plays are simultaneous, so trainers should go around, listen and support the process.

11. Ask the groups: *What did you learn from this exercise?*

SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Cost-Benefit Analysis

CASE SCENARIOS

You are a 17-year-old, homeless Caucasian youth who has tested positive for HIV. To survive, you make money by having sex, usually unprotected, with various regular customers.

You are a young Latina who is in early pregnancy and is infected with HIV. You are afraid to see your doctor, because you are ashamed of your HIV status.

You are a 50-year-old African American man who is infected with HIV. You have remained drug-free for the past three months since you successfully completed a long-term residential treatment program for your heroin addiction. You report that you've recently been having intense cravings to use again.

You are an immigrant man in your thirties from West Africa. You recently tested positive for HIV. You don't believe that you could possibly be infected, and you refuse to discuss it with anyone.

You are a formerly homeless Native American woman in your early forties living with HIV. You've recently found permanent housing, but it seems to be more of a problem than a solution. You report that you feel walled in, that you don't like being alone, and that people are constantly knocking on your door trying to sell you drugs that threaten your recovery. You report feeling more and more depressed and are considering moving out. You say you were happier living on the streets.

SESSION XIII: MOTIVATIONAL INTERVIEWING

Topic: Cost-Benefit Analysis

CASE SCENARIOS (CONT.)

You are a 29-year-old Caucasian woman who is infected with HIV. You are trying to regain custody of your two young children. You recently moved into clean-and-sober transitional housing after successfully completing in-patient treatment for polysubstance use. You tell your provider in confidence that you've been drinking and using crack occasionally, but you are not doing any of that "other stuff." You report that you only use on the weekends when you are away from the transitional housing facility.

You are a man in your thirties who is infected with HIV. A few months ago you were released from prison after serving a lengthy sentence for multiple drug-related offenses. You are currently on parole with the requirement that you not use drugs. For the first month after release, you went back to smoking crack almost every day, but now report feeling very proud that you've been able to cut back to smoking crack only on weekends.

You are a 28-year-old Latino male who has tested positive for HIV. You probably contracted the virus by having anonymous unprotected sex with men at gay sex clubs. You are married with a child and do not consider yourself to be homosexual. You are afraid to disclose your HIV status to your family.

You are a 25-year-old woman who is involved in a long-term abusive relationship with a partner who is infected with HIV and uses injection drugs. You are quite concerned that you might also test positive for HIV, but your partner refuses to let you get tested or seek medical help. Your partner says in a dismissing manner, "What you don't know won't hurt you."

SESSION XIV: SUPPORTING PATIENTS WITH DISCLOSURE

Topic: Overview of Disclosure

TOTAL TIME FOR SESSION XIV: 55 minutes
SLIDES: #97-99

ABOUT THIS ACTIVITY

Time: 5 minutes

Slides: #97

Objectives:

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

- Provide an overview of disclosure

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Explain why some patients and people in general may have difficulty disclosing personal traits/ characteristics
- Lead discussion about disclosure and why it is important

Materials:

- None

Preparation:

- None

Instructions

1. Give an overview of disclosure:

Many PLWHA have different reasons for telling or not telling others about their HIV status; there are some risks and benefits to disclosing your status. It is important to know that everyone has his or her own unique experiences with disclosure. It's not a question of whether or not you disclose, but rather that people disclose to some people but not others.

2. Lead a discussion around disclosure:

- Why are people's choices to disclose or not disclose his or her *HIV status to family and friends important?*
  - *Telling others about your HIV status is your personal choice. You have a right to keep it a secret, with the exception of telling: current and past sex partners, anyone you may have shared needles with, and your doctor or dentist.*
  - *People have different reasons for telling or not telling others about their HIV status. There are some risks and benefits of disclosure.*
  - *It is important to know that everyone has his or her own unique experiences with disclosure.*
  - *Peers may not agree with, but need to respect, the decisions that others make about disclosure.*
  - *Think about an experience when you told someone about your HIV status. In that experience, was the person or the group supportive, angry, violent, judgmental or confused? There are many reactions that may be associated with disclosure, some of which we could never have anticipated.*

Segue

The next exercise will help us learn why people choose or do not choose to disclose their HIV status.

SESSION XIV: SUPPORTING PATIENTS WITH DISCLOSURE

Topic: I Would Always Tell - I Would Never Tell

ABOUT THIS ACTIVITY

Time: 20 minutes

Slides: #98

Objectives:

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

- Discuss reasons why individuals chose to disclose or withhold personal information.

Training Methods:

- Individual activity
- Group activity

In this activity you will:

- Facilitate a large-group discussion on disclosure

Materials:

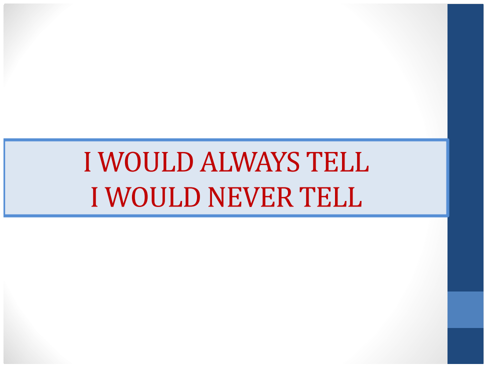
- I would always tell and I would never tell sheet (cards)

Preparation:

- Print and cut 6-8 cards from the "Disclosure Exercise" sheet

Instructions

1. Turn to slide 98.



I WOULD ALWAYS TELL
I WOULD NEVER TELL

2. Let participants know that as peers they will encounter some patients who don't disclose. *In these cases you may not agree with, but need to respect, the decisions that patients make about disclosure.*

3. Set up the exercise: *At this time we want you to think about an experience of when you told someone about your HIV status; you don't have to say it, just think about it. Think about who they were: your mother, partner, brother, sister, friend or child. In that experience, was the person supportive, angry, violent, judgmental or confused?*

4. Exercise instructions:

- Hand out "I Would Always Tell and I Would Never Tell" cards to several people in the room, and tell participants the cards are part of an activity on disclosure.
- *Those of you who received cards should stand up and say who you would always tell or who you would never tell; for example: "I would always tell my employer because I may need to take time off from work to go to my medical appointments," and I would never tell my sister because she can't keep a secret.*

SESSION XIV: SUPPORTING PATIENTS WITH DISCLOSURE

Topic: I Would Always Tell - I Would Never Tell

5. Once all the card holders have had a chance to respond, ask the following questions:

    - *Who were the people who were always told?*
    - *Who was never told?*
    - *What did you notice about these people?*
    - *What helped you get through your disclosures?*

6. Allow participants to comment and facilitate discussion.

Summarize

It's important to remember that we all disclose to different people for different reasons. It is not up to the peer or anyone to push patients to disclose or decide to whom patients should disclose.

People will disclose when they are ready, not on anyone else's time line. Your role as a peer is to give people the tools to disclose, and give them ideas about how to disclose in a thoughtful manner that feels safe.

Segue

In the next exercise we will discuss one practical way peers can support patients who are considering disclosure.

SESSION XIV: SUPPORTING PATIENTS WITH DISCLOSURE

Topic: I Would Always Tell - I Would Never Tell

SESSION HANDOUT

DISCLOSURE EXERCISE

I WOULD ALWAYS TELL	I WOULD ALWAYS TELL	I WOULD ALWAYS TELL
I WOULD ALWAYS TELL	I WOULD ALWAYS TELL	I WOULD ALWAYS TELL
I WOULD NEVER TELL	I WOULD NEVER TELL	I WOULD NEVER TELL
I WOULD NEVER TELL	I WOULD NEVER TELL	I WOULD NEVER TELL

SESSION XIV: SUPPORTING PATIENTS WITH DISCLOSURE

Topic: Mentoring on Disclosure

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #99

Objectives:

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

- Deepen participants' understanding of how to help patients think about disclosure

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Present information on how to help patients think about disclosure
- Lead a discussion about disclosure framework

Materials:

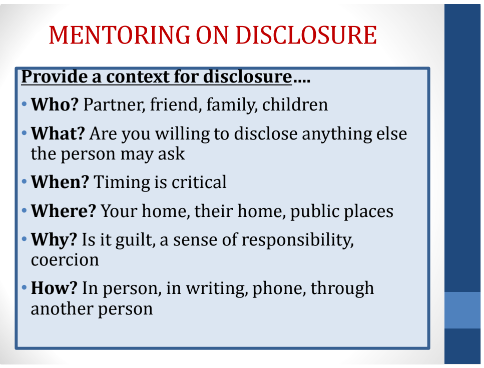
- Some Considerations Before You Disclose Handout

Preparation:

- Make copies of handout

Instructions

1. Review slide 99 with participants and stress that people don't need to disclose everything about themselves when disclosing HIV status.



MENTORING ON DISCLOSURE

Provide a context for disclosure….

- **Who?** Partner, friend, family, children
- **What?** Are you willing to disclose anything else the person may ask
- **When?** Timing is critical
- **Where?** Your home, their home, public places
- **Why?** Is it guilt, a sense of responsibility, coercion
- **How?** In person, in writing, phone, through another person

- **Who?:** *You don't have to tell everyone; think about who you would like to tell or "would always tell."*

- **Why?:** *Think about why you would want to tell the person. Is it guilt, sense of obligation, because you want their support, or to unburden yourself from a "secret"; be clear about why.*

- **What?:** *What are you ready to share and what are you not ready to share?* Ask participants: "*What is the first question people ask when you tell them that you are positive?*" Allow responses. Expected answer: *How did you get it? How important is it to tell the person how you got it? Does that really matter? Sometimes people are curious and sometimes they want to determine if getting HIV was your fault as discussed earlier. Is that a good enough reason to tell them how you got it?*

- **When?:** *Don't disclose if the person you are disclosing to has had a bad day or is otherwise moody, cranky or pugnacious; find the right time for you and the person.*

- **Where?:** *A public place such as a park can discourage a person from becoming violent; also, disclosing in your own turf is better than in theirs.*

SESSION XIV: SUPPORTING PATIENTS WITH DISCLOSURE

Topic: Mentoring on Disclosure

- **How?:** *There are other ways to disclose besides face to face; what other methods can we use?* Allow responses. Expected answers: *Letter, phone, or having a trusted person do it for you.*

2. Review handout with participants and further elaborate about the questions on the slide. *As peers, your role involves helping patients think through these questions. Providing a framework for disclosure can make it easier and safer for patients to disclose.*

3. Ask for a volunteer to play the role of the patient or use their personal experience of disclosing their status to a friend; while the trainer plays the role of the peer using the framework to speak with the patient (volunteer).

4. Discussion: Ask - *What do you think about this framework? What did you like about the example? What would you have done differently?* Facilitate a discussion and answer questions that come up.

SESSION XIV: SUPPORTING PATIENTS WITH DISCLOSURE

Topic: Mentoring on Disclosure

SESSION HANDOUT

SOME CONSIDERATIONS BEFORE YOU DISCLOSE

Peers should encourage their patients to consider several things before disclosing to someone. These include:

- *What do you need most from the person you are telling?* Have the patient think about how this person knowing can help their situation or make it worse.
- *Who are you most comfortable telling?* Have the patient think of someone who can support them in a non-judgmental way while coping with their own feelings.
- *How important is privacy to you?* Have the patient consider how the person s/he's considering disclosing to regularly deals with others' confidential information.
- *Prepare for reactions.* Have the patient consider if the person s/he's going to tell might get upset. S/he might also provide written information on HIV to the person.
- *Where will you tell?* Have the patient choose a place that is comfortable and provides enough privacy.
- *What are some of the risks?* Have the patient think about the risks associated with disclosing, such as jeopardizing a job or telling someone who might become violent.

You may wish to share this handout with the patient during Peer-Patient Educational Session #7, Disclosure and Stigma (See guide on page 20.)

SESSION XV: DEPRESSION AND HIV

Topic: Depression and HIV

TOTAL TIME FOR SESSION XV: 55 minutes
SLIDES: #100-102

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #100

Objectives:

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

- Describe the experience of stress and depression as they relate to HIV

Training Methods:

- Discussion

In this activity you will:

- Facilitate a discussion on the stress and challenges participants have faced due to their HIV status

Materials:

- None

Preparation:

- None

Instructions

1. Start out by stating that we all have things that create stress in our lives. *Studies have shown that most people living with HIV will experience clinical depression at some point or throughout the course of HIV disease. The stress of living with HIV and its daily challenges can make us anxious or depressed.*

2. *There are other forms of mental illness, but since it's the most common, we will focus on depression.*

3. *Some stressors are small and easy to deal with, while others can be overwhelming.*

4. *HIV is a long-term stressor that is difficult to live with. For some people, it may be the most stressful thing in their lives, but other people may have other things that stress them out even more, such as substance abuse, domestic violence, death of a loved one, poverty, or other serious problems.*

Discussion

Ask participants: *What is one thing you find stressful and how do you cope with it? What is one way that you deal with stress?* List coping strategies on newsprint.

SESSION XV: DEPRESSION WITH HIV

Topic: What is Depression?

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #101

Objectives:

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

- Identify the symptoms of depression

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Facilitate discussion about the specific role peers have as part of the health care team

Materials:

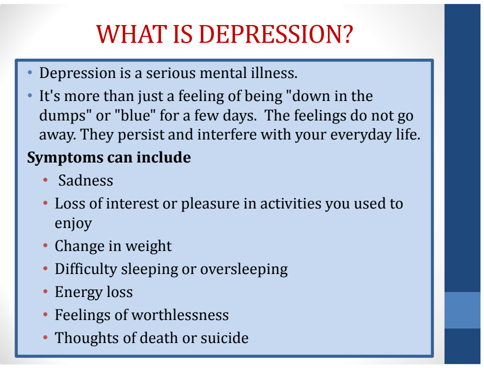
- None

Preparation:

- None

Instructions

1. Review slide 101 with participants and facilitate discussion.



WHAT IS DEPRESSION?

- Depression is a serious mental illness.
- It's more than just a feeling of being "down in the dumps" or "blue" for a few days. The feelings do not go away. They persist and interfere with your everyday life.

Symptoms can include

- Sadness
- Loss of interest or pleasure in activities you used to enjoy
- Change in weight
- Difficulty sleeping or oversleeping
- Energy loss
- Feelings of worthlessness
- Thoughts of death or suicide

   a. *Many people who are depressed are not aware of it. Mental illness is also highly stigmatized and often even people who are aware don't talk about it.*

   b. *Peers need to know how to recognize the symptoms of depression in the lives of patients and in their own lives. By this we don't mean that you should diagnose depression or provide therapy, but simply recognize it, raise the patient's awareness of it, and then coordinate a referral through the case manager for a mental health evaluation.*

2. *Because mental health and physical health are so closely linked, it is important not to ignore the symptoms of depression.*

3. *Peers can help the person become aware that these symptoms are often associated with depression and how important it is to pay attention to them.*

4. *Peers should share with the care team when they see these symptoms in their patients so that the team can conduct a mental health assessment and coordinate a referral to a mental health expert if necessary.*

SESSION XV: DEPRESSION AND HIV

Topic: What is Depression?

Summarize

Peers will need to document the work they provide to patients on progress notes and communicate with the team about these types of symptoms; when doing so, it's important to be objective *and share what symptoms were observed, rather than being* subjective *by saying that "the patient is depressed."*

SESSION XV: DEPRESSION AND HIV

Topic: Responding to Depression

ABOUT THIS ACTIVITY

Time: 35 minutes

Slides: #102

Objectives:

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

- Gain experience in responding to depression

Training Methods:

- Group exercise

In this activity you will:

- Lead a group activity
- Facilitate a discussion

Materials:

- Helpful and Unhelpful Responses handout
- Green, yellow and red colored paper
- "Green-Yellow-Red Light Situations" handout
- Mental Health Emergencies Handout
- Tips for Stress, Anxiety and Depression Handout
- "Symptoms of Clinical Depression" Handout
- "Symptoms of Anxiety Disorders" Handout
- Tape

Preparation:

- Prepare individual cards, each with a different response (helpful or unhelpful) (see "Helpful and Unhelpful Responses" handout)
- Prepare 2 newsprints with the headings: "Helpful Response" and "Unhelpful Response"
- Cut blank green, yellow, and red cards (one set for each participant and one set for trainer(s))
- Print a copy of the "Green-Yellow-Red Light Situations" for the trainer(s)

Instructions

1. **Exercise 1:**

   - Distribute cards and explain what participants will do: *When someone is feeling depressed or anxious people want to help. Some of the things they say may be helpful, and others are not helpful. Here are some common responses. Please take a card. When you are ready, come up and tape the card up under the heading where you think it belongs – helpful or unhelpful.*

   - Once all of the cards are placed, read the responses and discuss some of them with the group. If time permits, ask group members to think of other helpful things they could say. Hand out the "Helpful and Unhelpful Responses" handout as a reference for participants.

2. **Further Discussion**

   - *Sometimes problems are more complex. You might encounter a patient who needs more help than you can provide.*

   - *Here are a few signs of more serious problems: Feeling depressed or anxious for more than two weeks, not keeping appointments, not getting out of bed, not eating, bathing or dressing, thoughts of hurting themselves or someone else.*

3. **Exercise 2:**

   - Introduce the exercise by telling participants that we are going to do another activity – the Green-Yellow-Red light activity:

   - *There are different levels of depression that are important to know. We are going to do an activity to demonstrate them. I am going to distribute colored cards in green, yellow and red that represent lights. I am going to read some different situations. Each of you should hold up the color of the card you think corresponds to the situation.*

SESSION XV: DEPRESSION AND HIV

Topic: Responding to Depression

- *A green-light situation would be what you would consider typical levels of stress, anxiety, or depression; a yellow-light situation is more serious and requires action; a red light situation indicates an emergency and requires immediate action.*

- Conduct the exercise, debrief and facilitate discussion.

Summarize

- *Over time you will discern green-, yellow- or red-light situations more easily.*

- *Never say to a patient that you are certain they have mental illness, and resist the temptation to give advice. Do say: "Some of the things you are describing are similar to the symptoms of depression and the only way to know for sure is by going through a mental health assessment. Your case manager can refer you to a mental health counselor.*

- *HIV, mental health issues, and substance abuse have a lot in common. In all three, adherence to treatment or programs can be challenging. There can be stigma around all three. People dealing with any of them may find it hard to ask for help and feel very alone.*

- *As a peer, you may be the first person a patient opens up to.*

- *You can't diagnose or treat, but you can make a big difference by providing non-judgmental listening and referral to members of the team.*

SESSION XV: DEPRESSION AND HIV

Topic: Responding to Depression

SESSION HANDOUT #1

HELPFUL AND UNHELPFUL RESPONSES

Usually helpful

- I know you are hurting.
- You’re not alone in this.
- I’m here for you.
- Do you want a hug?
- These feelings will pass; you’ll get through this.
- I’m sorry you’re in so much pain.
- If you need someone to talk to, I’m here for you.

Usually unhelpful

- It’s all in your mind.
- No one ever said life was fair.
- There are a lot of people worse off than you.
- You should count your blessings.
- Stop your pity party
- Stop thinking about yourself and focus on your kids.
- You think you’ve got problems!
- Cheer up! Come on and give me a smile.

SESSION XV: DEPRESSION AND HIV

Topic: Responding to Depression

SESSION HANDOUT #2

GREEN-YELLOW-RED LIGHT SITUATIONS

Green means typical response to difficult things in life, yellow means referral is needed, and red means emergency referral. Some of these may vary depending on the context, so it's ok if different group members have different opinions about them.

- Your patient is feeling really blue on the anniversary of his partner's death [green]
- Your patient has a history of suicide attempts and is feeling REALLY blue today on the anniversary of his partner's death [yellow or red]
- Your patient is feeling unusually tense and angry today. [green]
- Your patient is so anxious and panicky lately that she can't eat and is losing a lot of weight [yellow]
- You call your patient to find out why he missed his appointment, and he says he just can't get out of bed. [yellow]
- Your patient tells you he wanted to tell you goodbye, because he plans to kill himself tonight. [red]
- Your patient says she can't come to her appointments anymore because she feels too panicky when she leaves her apartment. [yellow]
- Your patient says her meds have been making her feel moody and depressed. [green to yellow]
- Your patient says she has had really bad insomnia for over two weeks. [yellow]
- Your patient is making plans to kill the person who infected her. [red]
- Your patient says "Nothing matters to me anymore. I wish I were dead." [probably red – peer may need to probe for more information to find out if actively suicidal]
- Your patient says he has been "cutting" himself to help him cope with all the emotional pain he is going through. [yellow to red]

SESSION XV: DEPRESSION AND HIV

Topic: Responding to Depression

MENTAL HEALTH EMERGENCIES

If a patient expresses thoughts about suicide or homicide or wanting to hurt himself or herself or others:

DO NOT try to decide whether the person is "serious" or "just wants attention." If she or he says it, it IS serious.

What can you do in an emergency? Depending on the situation and resources in your area, you can:

- Ask members of your team to help you make an emergency referral.
- Refer to physician or specialist.
- Accompany your patient to the emergency room or mental health center.
- Call the crisis line.
- Call 911.
- Make sure they are not alone.

SESSION XV: DEPRESSION AND HIV

Topic: Responding to Depression

SESSION HANDOUT #4

TIPS FOR DEALING WITH STRESS, ANXIETY, OR DEPRESSION (MILD)

- Talking to a trusted friend, family member or religious leader
- Exercising (Exercise has been found to be as effective as medications in treatment of depression)
- Helping others
- Keeping busy, finding something positive to do
- Writing in journals
- Taking deep breaths
- Spending time in nature
- Relaxation, meditation
- Prayer
- Creative projects, arts, crafts, hobbies, or gardening
- Attending a support group meeting
- Attending religious services or other gatherings
- Add self-care tips that work well for you

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SESSION XV: DEPRESSION AND HIV

Topic: Responding to Depression

SESSION HANDOUT #5

SYMPTOMS OF CLINICAL DEPRESSION

Not everyone experiences clinical depression in the same way. Different people have different symptoms. The National Mental Health Association recommends that you see a doctor or a qualified mental health professional if you experience five or more of these symptoms for longer than two weeks, or if the symptoms are severe enough to interfere with your daily routine.

- A persistent sad, anxious or “empty” mood
- Sleeping too little or sleeping too much
- Reduced appetite and weight loss, or increased appetite and weight gain
- Loss of interest or pleasure in activities once enjoyed
- Restlessness or irritability
- Persistent physical symptoms that don’t respond to treatment [such as headaches, chronic pain, or constipation and other digestive disorders]
- Difficulty concentrating, remembering, or making decisions
- Fatigue or loss of energy
- Feeling guilty, hopeless or worthless
- Thoughts of death or suicide

SESSION HANDOUT #6

SYMPTOMS OF ANXIETY DISORDERS

There are several types of anxiety disorders and not everyone experiences the same symptoms. An accurate diagnosis and treatment should be made by a qualified mental health provider.

- Excessive worry more days than not
- Inability to control the worry
- Restlessness, feeling keyed up or on edge
- Fatigue, feeling easily tired
- Irritability, or sudden anger outburst
- Muscle tension
- Trouble falling asleep or staying asleep
- Fatigue or loss of energy
- Repeated, unexpected “attacks” when you are suddenly overcome by intense fear or discomfort for no apparent reason
- Repeated, distressing memories or dreams of a life-threatening event you experienced
- Feeling “on guard”
- Feeling detached from other people
- Intense, persistent fear of a social situation in which people might judge you
- Extreme anxiety with pounding heart, trembling or shaking, sweating, nausea or abdominal discomfort, fear of losing control
- Feeling worthless or guilty

SESSION XVI: HARM REDUCTION

Topic: Harm Reduction

TOTAL TIME FOR SESSION XVI: 50 minutes
SLIDES: #103-106

ABOUT THIS ACTIVITY

Time: 5 minutes

Slides: #103

Objectives:

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

- Define harm reduction

Training Methods:

- Discussion

In this activity you will:

- Introduce and explain harm reduction
- Facilitate a discussion about harm reduction

Materials:

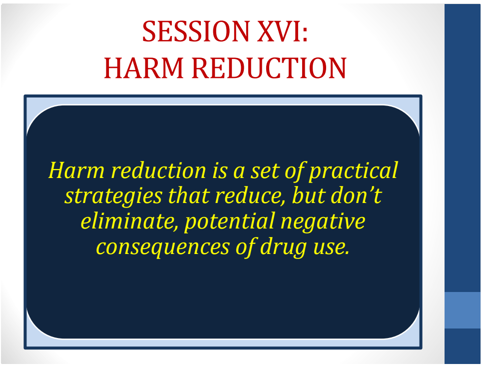
- None

Preparation:

- None

Instructions

1. Facilitate discussion by asking the following questions:
    - *What is harm reduction?*
    - *Can anyone provide an example of when we need to use harm reduction?*
2. Review slide 103 and assess participants' knowledge of harm reduction.



SESSION XVI:
HARM REDUCTION

Harm reduction is a set of practical strategies that reduce, but don't eliminate, potential negative consequences of drug use.

SESSION XVI: HARM REDUCTION

Topic: Principles of Harm Reduction

ABOUT THIS ACTIVITY

Time: 20 minutes

Slides: #104

Objectives:

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

- Understand the principles of harm reduction

Training Methods:

- Discussion
- Lecture

In this activity you will:

- Review harm reduction handouts
- Facilitate a discussion

Materials:

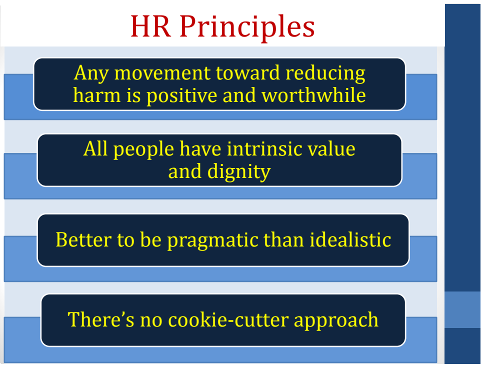
- "Substance Use and Harm Reduction" handout
- "Opiate Overdose Prevention and Survival" handout
- "Patient Information on HIV and Injecting Drugs" handout

Preparation:

- Make copies of the handouts

Instructions

1. Review slide 104 with participants and facilitate discussion:



HR Principles

Any movement toward reducing harm is positive and worthwhile

All people have intrinsic value and dignity

Better to be pragmatic than idealistic

There's no cookie-cutter approach

- *Any movement, regardless of the amount of movement is worthwhile; important to notice, acknowledge and give positive reinforcement for taking even the smallest steps to reduce harm.*
- *Everyone has the right to human dignity and value regardless of personal behavior.*
- *Your idealism may get in the way of doing something practical to help a patient reduce harm; resist the tendency to rescue people (none of us is that powerful); recognize that doing something is better than doing nothing.*
- *Each person is an individual and what works for one does not work for all.*

2. Review "Facts about Substance Use and Harm Reduction" handout, "Opiate Overdose Prevention and Survival" handout and "Patient Information on HIV and Injecting Drugs" handout.

   - Ask participants to find the three handouts in their packets and review them together; no need to read everything - just paraphrase each section.

SESSION XVI: HARM REDUCTION

Topic: Principles of Harm Reduction

You may wish to share this handout with the patient during Peer-Patient Educational Session #8, Harm and Risk Reduction (See guide on page 20).

SESSION HANDOUT #1

SUBSTANCE USE AND HARM REDUCTION

Principles of Harm Reduction

Harm reduction is a set of practical strategies that reduces potential negative consequences of drug use. This approach incorporates a spectrum of strategies from safer use, to managed use, to abstinence. Harm reduction strategies meet drug users “where they’re at,” addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

However, the Harm Reduction Coalition considers the following central to harm-reduction practice.

- Accept, for better and for worse, that licit and illicit drug use is part of our world.
- Work to minimize potential harmful effects of drug use rather than simply ignore or condemn users.
- Understand that drug use is a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledge that some ways of using drugs are clearly safer than others.
- Establish quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.
- Call for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensure that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirm drugs users themselves as the primary agents of reducing the harms of their drug use, and seek to empower users to share information and support each other in strategies that meet their actual conditions of use.
- Recognize that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.
- Do not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

Adapted from: www.harmreductioncoalition.org

SESSION HANDOUT #2

OPIATE OVERDOSE PREVENTION AND SURVIVAL

Opiates include: heroin, OxyContin, methadone, morphine, Percocet, fentanyl, and Vicodin

What is an Overdose?

Overdose (OD) happens when a person takes too much of a drug (or a combinations of drugs), and the body is overwhelmed – especially the brain and other important organs like the liver, heart, lungs and kidneys. When OD happens, the body loses the ability to cope with the drug. The person may pass out, stop breathing, have heart failure, or have seizures. All of these can kill a person, **but overdose doesn't have to be fatal.**

Risk Factors

- **Mixing drugs**-When drugs are mixed, especially alcohol or benzos.
- **Lowered tolerance**-Tolerance is down due to not using heroin or methadone- after incarceration, detox, or drug-free drug treatment.
- **Using alone** behind closed, locked door, where you cannot be found, esp. in single-room occupancies.
- **Other factors**-Major illness, change in the quality of the drug, depression, etc.
- **A prior overdose**-Might be a sign that the person is at risk of overdosing again

Prevention:

- Using one drug at a time; **not mixing drugs**
- **Doing a tester shot** if unsure about the purity of the drug or after a period of abstinence
- Not using alone; **using with other people**
- **Leaving doors unlocked**
- **Having an overdose prevention plan** and discussing it with friends and family
- Taking the **Narcan training***

Recognition of Overdose

- Person is unresponsive
- Person is unconscious, breathing very slowly
- Blue lips and nail beds
- Shallow breathing

---

*Narcan™ (naloxone) is a prescription medicine that blocks the effects of opioids such as heroin or prescription pain pills and reverses an overdose. It cannot be used to get a person high. With basic training, nonmedical professionals, such as friends, family members or even concerned bystanders, can recognize when an overdose is occurring and give Narcan.™ After a dose of Narcan™, the person should begin to breathe more normally and it will become easier to wake them. This gives concerned helpers a window of opportunity to save a life by providing extra time to call 911 and carry out rescue breathing and first aid until emergency medical help arrives. Source: http://stopoverdoseil.org/narcan.html

SESSION XVI: HARM REDUCTION

Topic: Principles of Harm Reduction

Responding to an Overdose:

- **Call 911**
    - Give address/location.
    - Say “my friend is unconscious and I can’t wake him or her up” or “my friend isn’t breathing.”
    - You don’t need to say that any drugs have been taken until the ambulance arrives.
- **Rescue breathing**
    - Make sure there is nothing in the mouth.
    - Tilt head back, lift chin, pinch nose.
    - Give a breath every 5 seconds.
- Stay (if you can) with the person until help arrives.
- **Recovery position so the person will not choke if s/he vomits**
- **If overdosing on heroin or other opiates, give Naloxone (Narcan)**
    - Blocks the effects of an opiate.
    - Is safe and effective in reversing opiate overdose.
    - Can be delivered as a spray in the nasal passage of someone who has overdosed.

Adapted from: “Get the S.K.O.O.P Brochure,”
published by The Boston Public Health Commission.
AHOPE Needle Exchange Program, www.bphc.org/needleexchange

SESSION HANDOUT #3

PATIENT INFORMATION ON HIV AND INJECTING DRUGS

Do you inject drugs?

There are things you can do to reduce the risk of getting HIV and other diseases and lower your chance of injuries and overdoses.

If I think my drug use is a problem for me, how can I get help?

- There are many programs that can help you to stop using. If you aren't ready to stop using, there are also many programs that can help you to reduce the harms your use might cause.

What are the risks that come from injecting drugs?

- You can get HIV, hepatitis, and other infections if you share needles, cottons, injection water, or other equipment.
- Some infections can make you very sick.
- You can get blood poisoning, tetanus, and an infection of the heart from bacteria in needles.
- You can get cotton fever from bacteria found in cotton.
- You can also get infections from using lemon juice or vinegar to dissolve your shot.
- If you use dirty equipment or if you don't wash your skin, you can get abscesses. Missing your vein when you inject can also cause them.
- Overdosing is easy with drugs like heroin because they slow down your heart rate and breathing. Mixing heroin with other drugs is even more likely to lead to an overdose.

How can I lower my HIV risk if I inject?

- Use a clean, sharp, sterile needle. Visit a needle exchange site for clean supplies.
- You may be able to get new needles from pharmacies.
- If you must share equipment, clean your syringe.
- Use the cleanest water you can find for mixing and injecting drugs and rinsing equipment.
- Mark your equipment so you know for sure that it is yours and you do not pick up someone else's by mistake.

What can I do to lower other risks from injecting?

- Before you inject, clean your injection site with an alcohol wipe or soap and water.
- Rotate your injection sites. This gives them time to heal and cuts down on scarring. When you hit near a spot that is healing, try to hit closer to your heart from where you last hit.

SESSION XVI: HARM REDUCTION

Topic: Principles of Harm Reduction

- Use Vitamin C powder and lots of water to dissolve your shot. Try not to use lemon juice or vinegar. They can cause serious infections.
- Always clean up after yourself! Remember that your blood could harm someone else.
- Go to the nearest hospital emergency room if you have a fever, chest pains, or a red, painful area that's not going away. You may need medicine to help.

What if I share drugs with someone else?

Sharing drugs with someone else can pass HIV and other infections. Be safer by following these steps:

- Use separate syringes, cookers, cottons, and water for dividing your shots.
- If everyone must reuse their own supplies and water, do a dry divide: split the drugs on a clean surface before adding the water.
- If you can't do a dry divide, and only one person has a sterile or new syringe, use the sterile syringe to draw up the water and divide the shot.
- Be aware that it is going to take time and patience to change your habits and do things differently, especially if you are part of a group.

What can I do to lower the chance of overdosing?

- Find out as much as you can about the drugs you are injecting. Do you trust the dealer? Do the drugs taste and smell the same as usual? If you know about what you are using, it can keep you safer.
- If you are unsure about the drugs, snort a little bit before you shoot up or take a small test shot first.
- Avoid mixing drugs that have the same effects. For example, don't mix heroin with alcohol or benzos like Xanax®, Klonopin®, or Valium®.
- Know how much of a drug you can handle. If you have not used lately, your body might not be able to handle as much drug as before. Try to do less at first. The amount you can handle goes down after only one or two days of not using. Even if you are dopesick, your body might not be able to handle the same amount it could before.
- If you have any health problems or if you have been sick, your body may not be able to handle as much drug as usual. Be careful after any time you have been sick. If you have hepatitis C and your liver isn't working well, it won't be able to process the drug well. This could lead to an overdose.
- When you can, avoid injecting drugs alone. If you are alone, make sure you have someone you can reach right away if you are afraid you might be overdosing.
- There are a few programs that offer naloxone (Narcan®), which is a drug used to help people who overdose on opiates like heroin.

SESSION XVI: HARM REDUCTION

Topic: Principles of Harm Reduction

How do I clean a needle?

- Before using the bleach, rinse the syringe with water three times to rinse out any wet or dried blood that may still be in the barrel, needle, or cap. The more blood left in the needle, the harder the bleach has to work.
- Then fill the needle all the way up with bleach and shake it for a full two minutes. Use full-strength bleach; don't water it down.
- Get rid of the bleach and repeat with new, clean bleach two more times.
- Rinse the needle three times with water when you are finished.

What should I do if I have shared a needle or had unprotected sex with someone who has HIV or likely has HIV?

- You can reduce your risk by taking certain medicines for one month after having unprotected sex or sharing a needle.
- These medicines have to be started less than 72 hours after your risk. The sooner you start taking these medicines, the better.
- Your nearest hospital emergency room or health care provider can help you decide if these medicines are right for you. If they are, the doctor can give them to you or tell you where to get them.

Adapted from HIV and Injecting Drugs brochure
by the Massachusetts Department of Public Health.

SESSION XVI: HARM REDUCTION

Topic: The Harm Pyramid

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #105

Objectives:

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

- Illustrate harm reduction

Training Methods:

- Discussion

In this activity you will:

- Explain the harm-reduction pyramid

Materials:

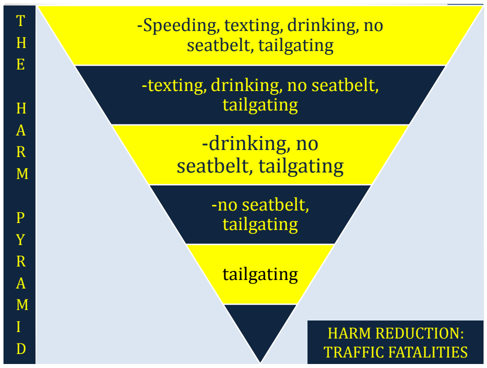
- None

Preparation:

- None

Instructions

1. Show slide 105 and describe how the pyramid works.



THE HARM PYRAMID

-Speeding, texting, drinking, no seatbelt, tailgating

-texting, drinking, no seatbelt, tailgating

-drinking, no seatbelt, tailgating

-no seatbelt, tailgating

tailgating

HARM REDUCTION: TRAFFIC FATALITIES

2. *None of these elements alone would greatly reduce traffic fatalities but, collectively, they reduce traffic fatalities considerably.*

SESSION XVI: HARM REDUCTION

Topic: Substance Use/Abuse

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #106

Objectives:

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

- Apply harm-reduction principles to substance use

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Explain substance abuse and what it entails
- Lead a discussion to help participants understand how substance use become abuse and the effects abuse has on one's health

Materials:

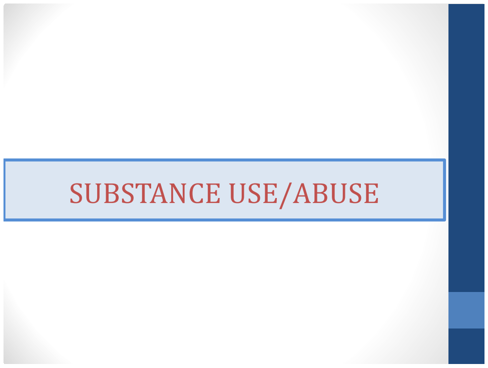
- "HIV and Substance Abuse" handout
- "Party Drugs" handout

Preparation:

- None

Instructions

1. Turn to slide 106.



SUBSTANCE USE/ABUSE

2. Introduce the topic of substance use and abuse. *When I say "substance abuse", what kind of substances do you think of?* Allow responses and document on newsprint. Expected answers: *Cocaine, heroin, methamphetamine (crystal meth), alcohol, ecstasy; prescription drugs can also be abused, including pain killers like OxyContin, Percoset, Vicodin, Valium, and other licit legal drugs.*

3. *Drugs can change the way we feel; what are some reasons people take drugs?* Answer: *celebrate, reduce stress, improve appetite, feel socially comfortable, overcome fear about having sex, forget, self-medicate, cope with stress, control anger, etc.*

4. Use: *Many people can drink alcohol or use recreational drugs from time to time without any problems – these are recreational/social users.*

5. Abuse: *Abuse is when you develop a pattern of use and addiction. It is when the drug takes over the person; they use regularly and it takes more and more to get the same high as before; the drug becomes more important than everything else.*

   - *Addicts often chase the high, they want to feel as good as the first time, but they can't, so they end up using more and more.*

SESSION XVI: HARM REDUCTION

Topic: Substance Use/Abuse

6. Effects on health: *Substance abuse compromises the immune system and makes it harder for the body to suppress the virus and use HIV meds properly.*

   - *Some drugs interact with meds: the liver breaks down meds used to fight HIV, and breaks down recreational drugs, including alcohol.*
   - *When drugs and medications are both "in line" to use the liver, they might both be processed much more slowly. This can lead to a serious overdose of the meds or the recreational drug. An overdose of HIV meds can cause more serious side effects—an overdose of recreational drugs can be deadly.*
   - *Recreational or addictive drugs have been linked to poor adherence and can lead to treatment failure.*
   - *They also impair a person's decision-making around sexual behavior.*

HIV AND SUBSTANCE USE:

Drug Interactions

The liver is involved in metabolism of most HIV meds and recreational drugs. Metabolism is the body's mechanism for processing, using, inactivating and ultimately eliminating foreign substances (including both HIV meds and recreational drugs). When HIV meds and other substances are taken at the same time, there can be different effects. Drugs can act as *inhibitors* or *inducers* (or both), which determine the kind of drug interactions that occur.

Inhibitors	Inducers
Competition • When 2 drugs are "waiting in line" to be broken down by the liver, they must compete to be processed. The drug that wins this competition (usually HIV meds) is acting as an inhibitor. • The liver is so busy processing the HIV meds (inhibitors), that recreational drug processing is delayed, eventually resulting in a high level of recreational drug and potential overdose.	**Enhancement** • Inducers are the drugs that, once present in the liver, have the effect of triggering more rapid clearance of drugs that follow leading to lower drug level (meds or other recreational drugs).

HIV Meds and Opioids

Methodone is an opioid analgesic (a.k.a. painkiller) used as treatment for heroin addiction because it reduces cravings and blocks the ability of heroin to produce euphoria, making it less desirable.

- It acts as inducer and inhibitor: Hinders absorption of didanosine (ddI) and stavudine (d4T) (inhibitor), and increases AZT (inducer).
- Research has shown that methadone hinders absorption of the drugs didanosine (ddI) and stavudine (d4T), due to increased degradation in the gastrointestinal tract.

- When taken together, research has shown that protease inhibitors (PIs) act as inducers (leading to reduced methadone concentrations), or methadone acts as an inhibitor (causing PI toxicity).
- PI-related toxicity (and other HIV meds-related toxicity) include nausea, vomiting, and diarrhea, which are also symptoms of heroin or methadone withdrawal.

Heroin is an opioid used as an analgesic, but also used as a recreational drug. Frequent and regular use of heroin is associated with increased tolerance and physical dependence, which can develop into addiction.

- PIs acting as inducers can decrease heroine levels in the blood by 50%, causing a more rapid onset of and/or more severe withdrawal symptoms.
- This also leads to a desire to increase dose to compensate for the lesser effect, leading to even more dependence.

HIV Meds and Hallucinogens

Ketamine, also called “K,” is a mild hallucinogen. K causes feelings of mind/body separation, possible seizures, respiratory depression, mild hallucinations (referred to as ‘K-Holes’), and increased heart rate (HR).

- PIs intensify the already harmful effects of K, including increased HR, blood pressure and increased sedation.
- K increases the likelihood of experiencing “chemical hepatitis,” drug-induced hepatitis: an inflammation of the liver that is permanently damaging.
- Norvir, Kaletra, Viracept, Agenerase, Lexica, Rescriptor and Sustiva have the greatest potential to cause toxicity.

PCP is a powerful hallucinogen which can cause feelings of empowerment and invulnerability. Potentially dangerous effects include seizures, hypertension, hyperthermia, and rhabdomyolysis.

- Mixed use with PIs, Delavirdine and possibly Efavirenz, may result in elevated PCP concentrations and resultant toxicity.

LSD is a powerful hallucinogen that is easily available which causes intense hallucinations, agitation, psychosis, and perception disorders known as “flashbacks.” Side effects of the drug include higher body temperatures, increased heart rate, blood pressure, sweating, sleeplessness and tremors.

- The likelihood of experiencing these effects is greater when mixed with PIs.

SESSION XVI: HARM REDUCTION

Topic: Substance Use/Abuse

HIV Meds and Erectile Dysfunction (ED) Drugs

Viagra, Levitra and *Cialis* are all medications prescribed for ED which are also used recreationally.

- For example, many individuals mix ED drugs with crystal meth (which can cause a loss of erection) and engage in sexual activity for an incredibly long duration of time with multiple partners. Individuals are less likely to use protection because crystal meth makes them less inhibited.
- When ED drugs, crystal meth, and HIV meds are mixed: extended half-life and drug toxicity (due to elevated drug levels in the blood) means there is a greatly increased likelihood of experiencing adverse side effects: stroke, changes in blood pressure and heart attacks.

HIV Meds and Alcohol

Alcohol is a drink containing ethanol which is a psychoactive drug that has a depressant effect. High blood alcohol content is considered to be drunkenness because it reduces attention and slows reaction speed. The state of alcohol addiction is known as alcoholism.

- Chronic use causes liver damage, making it unable to perform its bodily function as effectively, weakens immune system, and can cause peripheral neuropathy (meaning nerves don't work properly) and pancreatitis (inflammation of the pancreas).
  - o Alcohol acts as an inducer, triggering the liver to process PIs more rapidly resulting in insufficient amounts to fight HIV.
  - o When d4T or ddI are mixed with alcohol, there is an increased risk of pancreatitis.
- Acute use can cause alcohol poisoning.
  - o PIs act as inhibitors, preventing alcohol from being processed properly. The consequence is alcohol toxicity, and an elevated risk of alcohol poisoning.
  - o Some cases have been reported of individuals experiencing increased levels of Ziagen because of acute alcohol use, which means an increased risk of corresponding side effects (life threatening body rash and fever)

Key Points

It is essential to have intensive discussions about potential drug interaction problems with patients using recreational drugs who are simultaneously taking HAART. Routinely discuss use of all drugs with your patients.

PARTY DRUGS AND HIV MEDICATIONS

Ecstasy (MDMA is the chemical name for ecstasy): Ecstasy is amphetamine-derived. Ecstasy's primary effect is to stimulate the release of large amounts of serotonin as well as dopamine and noradrenaline in the brain, causing a general sense of openness, energy, euphoria and well-being. Tactile sensations are enhanced for some users, making general physical contact with others more pleasurable. Furthermore, ecstasy pills are often "cut" with other hard drugs—particularly crystal meth or heroin—to increase their effects. More importantly (for the purposes of this training), MDMA increases the likelihood of problematic interactions w/HIV meds. Users are more likely to experience adverse side effects.

- HIV meds and Ecstasy: Protease Inhibitors (PIs) slow down the liver enzyme that breaks down Ecstasy. As a result, the Ecstasy dose becomes 5-10 times stronger. Norvir is the most dangerous PI.

Crystal Meth: Crystal meth can be huffed, injected, snorted or smoked. Crystal meth use is characterized by the following: angry, hostile, and anxious feelings; violent behavior; confusion; mental illness that looks like schizophrenia (paranoid feelings, picking at your skin, hallucinations).

The user also frequently experiences the following: being haunted by his or her thoughts; increased physical activity; loss of appetite, which can result in severe weight loss (anorexia); inability to sleep; increased heart and pulse rate; permanent damage to the blood vessels in the brain, which can lead to strokes; convulsions and body tremors; chest pain and raised blood pressure, which could lead to a heart attack and then death; irregular heartbeat; an AIDS diagnosis or hepatitis C resulting from shared needles or syringes; mental dependence; tolerance and addiction to the drug.

- HIV meds and Crystal Meth: Norvir makes Crystal meth dose 2-3 times stronger.

GHB: In the past, GHB was used medically as a general anesthetic and as a hypnotic in the treatment of insomnia. It is also known as the "date rape drug."

- HIV meds and GHB: GHB is highly potent when combined w/ Rescriptor (NNRTI) and possibly Sustiva. However, when mixed with all PIs, its effect is much stronger. There is a greater risk of adverse side effects. For example, interaction with Norvir makes GHB 5-10 times stronger and longer lasting. High dose can cause sedation, confusion, coma and death. Because it is chemically unstable, GHB interacts negatively with many drug categories.

SESSION XVII: SEXUAL HEALTH

Topic: Sexual Risk and Sexually Transmitted Infections (STIs)

TOTAL TIME FOR SESSION XVII: 1 hour, 25 minutes
SLIDES: #107-108

ABOUT THIS ACTIVITY

Time: 1 hour

Slides: #107

Objectives:

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

- Identify the hierarchy of sexual risk and STIs

Training Methods:

- Large-group activity
- Risk game

In this activity you will:

- Facilitate the risk game group activity

Materials:

- "Route of Transmission" Risk Behavior cards
- Newsprint

Preparation:

- Draw a vertical double arrow on the left-hand side of a newsprint sheet, with a point at each end. Write the word "high" at the top and "low" in the middle, and "no risk" at the bottom.

Instructions

1. Make the following points:

   - *Sexual health is an important part of overall health. Sexual health involves not just preventing acquisition and transmission of HIV, but being sex-positive and having a gratifying sex life.*

   - *HIV+ people can more easily acquire STIs and more easily transmit HIV.*

   - *As peers, it's important to carve out time to talk with your patients about their sexual health. Do they understand how HIV is transmitted? STIs? Would they recognize the symptoms of STIs? Sometimes there are no symptoms. Do they know how to protect themselves or their partners from acquisition and transmission of disease?*

   - *One way you can support patients with sexual health is assessing their level of sexual risk and giving them information about what sexual behaviors constitute high risk, low risk and no risk (informational support).*

2. Conduct Exercise

   - Pass around the "Route of Transmission Risk Behavior" cards; each participant should have at least one. Ask participants to work together ranking each behavior from no risk to high risk, taping them on the scale.

   - After the group has finished go over each risk and ask the group if they have questions and if any of the answers surprises them.

   - Make corrections as the hierarchy of risk is being debriefed.

   - Once all the cards are taped on the risk scale, facilitate discussion around difference of opinions around what's high risk and what's low risk.

SESSION HANDOUT #1

ROUTE OF TRANSMISSION RISK BEHAVIOR CARDS

Anal sex	Mutual Masturbation
Vaginal sex	Body rubbing
Oral sex	Sweaty body rubbing
Anal sex with orgasm	Kissing
Vaginal sex with orgasm	Kissing tears
Oral sex with orgasm	Kissing sweaty body
Anilingus (oral-anal contact)	Golden showers (urine play)
Masturbation	Massage

SESSION XVII: SEXUAL HEALTH

Topic: Sexual Risk and STIs

HANDOUT #1 ANSWER KEY

ROUTE OF TRANSMISSION RISK BEHAVIOR CARDS

Anal sex High Risk	Mutual Masturbation No Risk
Vaginal sex High Risk	Body rubbing No Risk
Oral sex Low Risk	Sweaty body rubbing No Risk
Anal sex with orgasm High Risk	Kissing No Risk
Vaginal sex with orgasm High Risk	Kissing tears No Risk
Oral sex with orgasm High Risk	Kissing sweaty body No Risk
Anilingus (oral-anal contact) Low Risk	Golden showers (urine play) No Risk
Masturbation No Risk	Massage No Risk

SESSION XVII: SEXUAL HEALTH

Topic: Condom Relay Race

ABOUT THIS ACTIVITY

Time: 25 minutes

Slides: #108

Objectives:

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

- Correctly put on a condom

Training Methods:

- Demonstration
- Games

In this activity you will:

- Explain and facilitate group activity

Materials:

- 2 condom demo models
- Safer sex kits including condoms, female condoms, latex gloves and water-based lube.

Preparation:

- Prepare two condom demo tables at the front of the room with penis model and different kinds of condoms (enough for all participants to practice).

Instructions

1. Ask participants to form 2 lines (team A & B) in front of the 2 tables set up with condoms, lube, and a penis model.
2. The 2 teams will race against each other, one person putting on the condom at a time.
3. The trainers observe whether the condoms are being used correctly by each participant.
4. Wrap up session by reminding participants that it's very important for us, as mentors, to have a positive attitude about sex and safer sex.

DAY 4: REVIEW

Review and remind participants how they will use their knowledge in working with patients. Refer to the Peer-Patient Educational Session Conversation Guide handout (pages 14-22) as you review.

Session XIII Review

- *Today we talked about something called* ***motivational interviewing*** *that you can use in working with patients. What is that and why does it matter?* (It helps patients identify any changes they might want to make to improve their lives.)
- *What were some methods of motivational interviewing we learned about?* (evoking change, assessing importance of a change, assessing patient's confidence in being able to make a change, cost-benefit analysis.)

Session XIV Review

Then we spent some time talking about ***helping patients with disclosure,*** *which is something that you will do in Educational Session 7.*

- *What are some things you can help the patient think through before they disclose their status to someone?* (See session handout on page 173 for possible responses)

Session XV Review

Because most people living with HIV will experience ***depression*** *at some point, it is likely that you will see some patients who show signs of depression, so we spent some time talking about that.*

- *What are some symptoms that might mean a person is depressed?* (sadness, loss of interest in activities they used to like, change in weight, problems sleeping, low energy, feeling of worthlessness, thoughts of suicide)
- *We also talked about green, yellow and red light situations. What are some red light situations?* (patient shares plans to kill himself or another, for example)
- *What should you do if a patient shows signs of wanting to hurt themselves or someone else?* (Use mental health emergencies handout on page 181 for possible responses or contact a mental health provider at your agency)

Session XVI Review

The eighth and last educational session you will cover with patients is about ***harm and risk reduction****, and the rest of the day was devoted to helping you acquire the knowledge you need to address these topics.*

- *What are some of the principles of harm reduction?* (any movement toward reducing harm is worthwhile, all people have value, better to be pragmatic than idealistic, there is no cookie-cutter approach)
- *What should patients know about HIV and alcohol and drug use?* (can result in risky behavior, can negatively impact how HIV meds help, sharing needles can spread HIV and Hep C, interaction between drugs can lead to harmful drug interactions.)

Session XVII Review

The final session of the day was devoted to sexual health and risk of STIs, which you also will talk about with patients in Educational Session 8.

- *What are some high-risk sexual behaviors?* (unprotected anal, vaginal sex)
- *What can be done to reduce the risk of these behaviors?* (using lube, fewer exposures, fewer partners, having an undetectable viral load, avoiding alcohol and drugs before or during sex)

PREParing PEERS FOR SUCCESS: DAY 5

PEER CORE COMPETENCY TRAINING

A curriculum for engaging out-of-care or newly diagnosed people living with HIV in care and treatment

DOCUMENTATION

CONFIDENTIALITY AND BOUNDARIES

PEER-CASE MANAGER SESSION

August 2014

Health & Disability Working Group, Boston University School of Public Health

DAY 5: Documentation
Confidentiality and Boundaries
Peer-Case Manager Session

An Overview of Today's Sessions and Topics

Topic	Duration	Slides	Page
Icebreaker*	20 min		
Review of previous day*	5 min		204
Session XVIII: Documentation	**50 min (total)**	**109-112**	**207-215**
Topic: Documentation: Why It Matters	10 min	110	207-208
Topic: Documentation Tips	10 min	111	209
Topic: Documentation Exercise	30 min	112	210-216
Session XIX: Confidentiality & Boundaries	**2 hr. 5 min (total)**	**113-118**	**217-231**
Topic: What is Confidentiality?	10 min	114	217
Topic: Confidentiality - Questions to consider	10 min	115	218-219
Topic: Confidentiality & HIPAA	45 min	116-118	220-222
Topic: Breaking Confidentiality	15 min	119	223
Topic: Boundaries in Professional Relationships	10 min	120	224-225
Topic: Managing Workplace Boundaries	35 min	121	226-231
Energizer*	15 min		
Session XX: Peer-Case Manager Session	**1 hr. 55 min (total)**	**122-127**	**232-237**
Topic: Interdisciplinary Team	5 min	123	232
Topic: Interdisciplinary Approach to Care	10 min	124	233
Topic: Role of Team Members	30 min	125	234
Topic: Survival Team Exercise	40 min	126	235-236
Topic: Case Manager Q&A	30 min	127	237
Continuing education plan**	15 min		
Review, wrap-up and written evaluation*	30 min		238
Graduation Ceremony	15 min	128	239

*See pages 7-8 for an explanation of these climate-setting activities

**Use this time to discuss additional topics for training that you didn't have time to address in a 5-day training course. These could be offered at subsequent trainings, reunion meetings, or provided as part of orientation for newly hired peers. Ideas and curricula for continuing education topics can be found on the *Building Blocks to Peer Success* Continuing Education page at http://peer.hdwg.org/training_toolkit/continuing_education

Throughout this curriculum, *italicized words* are intended to be spoken directly to the class.

This publication is part of the online curriculum *PREParing Peers for Success: Peer Core Competency Training*. For the complete curriculum, accompanying PowerPoint slides, and other curricula in the series, visit http://www.hdwg.org/prep/curricula

SESSION XVIII: DOCUMENTATION

Topic: Documentation: Why It Matters

TOTAL TIME FOR SESSION XVIII: 50 minutes
SLIDES: #109-112

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #110

Objectives:

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

- Understand the importance of documentation

Training Methods:

- Group discussion

In this activity you will:

- Lead a group discussion

Materials:

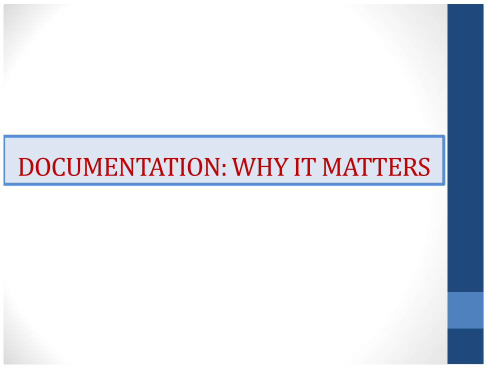
- None

Preparation:

- None

Instructions

1. Turn to slide 110.



DOCUMENTATION: WHY IT MATTERS

2. Ask participants: *What is documentation?* Allow responses. Expected answers: *Writing, recording, paperwork. It's synonymous with authentication, attestation, corroboration.*

3. Elaborate and facilitate discussion: *Documentation is writing about your meetings with patients. We do this because there has to be a record of your work with patients; otherwise, it's like your work never happened.*

4. *It's important to have a record of patients' progress, so that each member of the care team knows what's going on with them. It's also used to evaluate your performance on the job.*

5. Ask participants: *What may make documentation* easier *for you?* Allow responses and facilitate discussion.

6. *Some peers find it challenging because they may not have good writing skills or because they worry about compromising patient trust due to the sensitivity of the information that patients often share with peers. As discussed earlier, patients often share information with peers that they wouldn't necessarily share with other providers, such as the case manager or the doctor. They do this because they may*

SESSION XVIII: DOCUMENTATION

Topic: Documentation: Why it Matters

have a higher level of trust in the peer. Peers can feel that if they write down everything patients share, that somehow they may be violating trust.

7. *Documentation represents yet another boundary area because if progress notes are not objective, the peer may be* crossing the line *in terms of how the patient is being characterized.*

Segue

The information in this session is designed to help you address some of these concerns.

SESSION XVIII: DOCUMENTATION

Topic: Documentation Tips

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #111

Objectives:

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

- Complete documentation forms

Training Methods:

- Group discussion

In this activity you will:

- Explain documentation tips to participants
- Lead a group discussion about correctly documenting peer interaction sessions

Materials:

- Documentation form for the program*

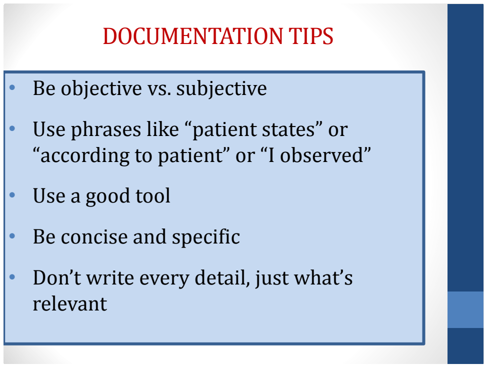
Preparation:

- None

Instructions

Note: This session should be tailored to the specific documentation requirements of the agency or program.

1. Review slide 111 with participants and facilitate a discussion.



DOCUMENTATION TIPS

- Be objective vs. subjective
- Use phrases like “patient states” or “according to patient” or “I observed”
- Use a good tool
- Be concise and specific
- Don’t write every detail, just what’s relevant

2. Define objective vs. subjective: *Objective means not influenced by personal feelings, interpretations, or prejudice; based on facts; unbiased; undistorted by emotion or personal bias. Subjective is the opposite of objective, it means belonging to, proceeding from, or relating to the mind of the thinking subject and not the nature of the object being considered; emanating from a person’s emotions, prejudices existing only as perceived and not as a thing in itself.*

3. Review a program-specific form* section by section and answer any questions that come up.

Segue

There will be times when you have to write a narrative of what the patient shared or what you observed. In the next exercise we are going to practice using the sample form as well as writing a narrative that captures relevant information.

*For this exercise, on page 212, actual form that will be used by the peer is recommended. We have provided the form used by the Peer Re-Engagement Project (PREP) as an example. Additional sample forms used by other peer programs can be found at http://peer.hdwg.org/program_dev/resources (Section 7, Evaluating Peer Programs).

SESSION XVIII: DOCUMENTATION

Topic: Documentation Exercise

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #112

Objectives:

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

- Practice documentation skills

Training Methods:

- Individual Exercise
- Group discussion

In this activity you will:

- Explain documentation of case scenario activity
- Facilitate discussion after participants complete their documentation exercise

Materials:

- Program documentation form*
- Documentation scenarios scripts 1 and 2

Preparation:

- Make copies of the scenarios, enough for each participant to have a least one scenario

Instructions

1. Turn to slide 112.

DOCUMENTATION EXERCISE

2. Ask participants to find the "Program Documentation Form*" in their packets.

3. Give exercise instructions: *Each of you will receive a scenario about a peer interaction with a patient. Read your scenario and then document the interaction using the "Program Documentation Form." You will have 10 minutes to complete your form.*

4. 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 challenging?*

5. Tell participants that each scenario had information that could not be checked off and ask whether they wrote such information on the back of the form. Ask for volunteers to share what they wrote.

*For this exercise, on page 212, actual form that will be used by the peer is recommended. We have provided the form used by the Peer Re-Engagement Project (PREP) as an example. Additional sample forms used by other peer programs can be found at http://peer.hdwg.org/program_dev/resources (Section 7, Evaluating Peer Programs).

SESSION XVIII: DOCUMENTATION

Topic: Documentation Exercise

6. *Sometimes patients give us "too much information," more than we need to know. With some patients, all you have to do is ask an open question like "how are you doing?" and they spill their guts. They do this because they trust you, and that's a good thing. A peer has to listen attentively without interrupting because there are things embedded in the story that are important for the peer, and by extension, the team to know.*

7. *A peer has to sort through the story to find the things that are relevant to the person's care and at the same time listen attentively and be empathetic!*

8. *One good way to sort through and find what's relevant is to ask yourself the following questions: What exactly does the medical team need to know about what was shared by the patient? Would the team do anything different from knowing every detail?*

Summarize

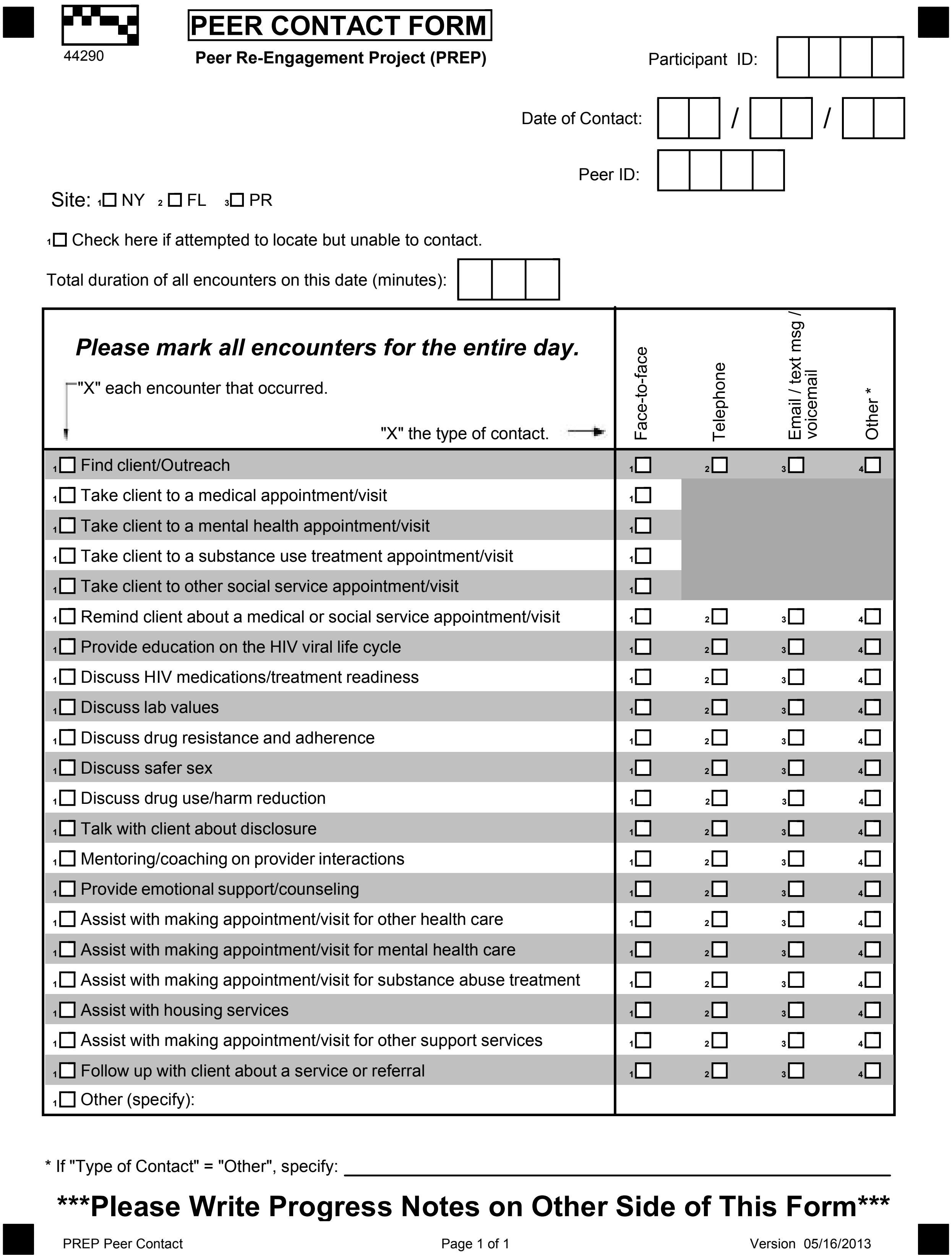
- *If the patient asks the peer not to share the story with anyone in the team and there are health implications in the story, the peer should encourage the patient to talk with his or her doctor and even offer to attend the appointment. If the patient still refuses, then the peer's duty is to tell the patient that he or she is required to share what's going on in general terms, but that the private/intimate details will not be shared. In most situations the patient signed a consent form with the care team that allows the peer to share pertinent information regarding the patient's health with the team.*

- *Writing clear progress notes takes practice. Ask members of the team to give you feedback on your progress notes and turn to your supervisor for support and additional training.*

SESSION XVIII: DOCUMENTATION

Topic: Documentation Exercise

SESSION HANDOUT #2



44290

PEER CONTACT FORM

Peer Re-Engagement Project (PREP)

Participant ID: ☐☐☐☐

Date of Contact: ☐☐ / ☐☐ / ☐☐

Peer ID: ☐☐☐☐

Site: 1☐ NY 2☐ FL 3☐ PR

1☐ Check here if attempted to locate but unable to contact.

Total duration of all encounters on this date (minutes): ☐☐☐

Please mark all encounters for the entire day.

"X" each encounter that occurred.

"X" the type of contact.

	Face-to-face	Telephone	Email / text msg / voicemail	Other *
1☐ Find client/Outreach	1☐	2☐	3☐	4☐
1☐ Take client to a medical appointment/visit	1☐			
1☐ Take client to a mental health appointment/visit	1☐			
1☐ Take client to a substance use treatment appointment/visit	1☐			
1☐ Take client to other social service appointment/visit	1☐			
1☐ Remind client about a medical or social service appointment/visit	1☐	2☐	3☐	4☐
1☐ Provide education on the HIV viral life cycle	1☐	2☐	3☐	4☐
1☐ Discuss HIV medications/treatment readiness	1☐	2☐	3☐	4☐
1☐ Discuss lab values	1☐	2☐	3☐	4☐
1☐ Discuss drug resistance and adherence	1☐	2☐	3☐	4☐
1☐ Discuss safer sex	1☐	2☐	3☐	4☐
1☐ Discuss drug use/harm reduction	1☐	2☐	3☐	4☐
1☐ Talk with client about disclosure	1☐	2☐	3☐	4☐
1☐ Mentoring/coaching on provider interactions	1☐	2☐	3☐	4☐
1☐ Provide emotional support/counseling	1☐	2☐	3☐	4☐
1☐ Assist with making appointment/visit for other health care	1☐	2☐	3☐	4☐
1☐ Assist with making appointment/visit for mental health care	1☐	2☐	3☐	4☐
1☐ Assist with making appointment/visit for substance abuse treatment	1☐	2☐	3☐	4☐
1☐ Assist with housing services	1☐	2☐	3☐	4☐
1☐ Assist with making appointment/visit for other support services	1☐	2☐	3☐	4☐
1☐ Follow up with client about a service or referral	1☐	2☐	3☐	4☐
1☐ Other (specify):				

* If "Type of Contact" = "Other", specify: ____

*****Please Write Progress Notes on Other Side of This Form*****

PREP Peer Contact   Page 1 of 1   Version 05/16/2013

SESSION XVIII: DOCUMENTATION

Topic: Documentation Exercise

SCRIPT 1 FOR DOCUMENTATION EXERCISE

Peer: “Thanks for coming in to see me today.”

Pam: “It’s been rough the last week or so since finding out that I’m HIV+.”

Peer: “I remember how difficult it was for me too. Who have you talked to since then?”

Pam: “Well I have my best friend, and she is trying to be there for me, but she is busy with her family.”

Peer: “What do you know about HIV?”

Pam: “I remember when Magic came out. I see bus signs telling people they should get tested, and I know you get it from sex. I didn’t think it would happen to me.”

Peer: “How about we focus our time today on the basics of HIV? Then, there are other components that we can talk about during our time in this project.”

Pam: “Okay.”

Peer: “HIV stands for Human Immunodeficiency Virus. It is the virus that causes AIDS which stands for Acquired Immune Deficiency Syndrome. When you break it down, HIV is a virus that is passed on from one person to another, that’s why H stands for human. The virus attacks the immune system, I think of the immune system as “my soldiers” because it tries to fight off any disease, germs that may come in contact with my body. So, HIV attacks my immune system or my soldiers, so the stronger my soldiers, the better they work for me.”

Pam: "So that makes sense to me. Is that why I was so sick last month? I thought I had the flu, you know its winter and all, but I just couldn’t shake it. I ended up going to the doctor and my doctor’s nurse was telling me about HIV testing being part of routine screening that they were doing with all patients. I thought, ah well, sure I’ll do the test."

Peer: “It’s possible that the flu-like symptoms were your body’s response to the HIV infection. Other symptoms that a person may experience include night sweats, diarrhea, trouble sleeping or flu symptoms. Let’s talk about how HIV is transmitted. HIV is transmitted through unprotected anal, vaginal or oral sex with an HIV+ sex partner. It can also be transmitted from an HIV+ pregnant mother to her unborn child and from sharing of needles among IV drug users—I think of these as transmission routes. There are certain infectious fluids that are shared in the transmission routes we just talked about: infectious blood, breast milk from mother to child, semen and vaginal fluids.”

SESSION XVIII: DOCUMENTATION

Topic: Documentation Exercise

Pam: “Wow, yeah it’s all coming back to me. I remember learning about this before and didn’t think it would happen to me. I need to take time for all this to sink in. I’m glad I’m meeting with you because you know what I’m going through, you’ve been there.”

Peer: “Yes, I can relate and I’m here for you.”

SESSION XVIII: DOCUMENTATION

Topic: Documentation Exercise

SCRIPT 2 FOR DOCUMENTATION EXERCISE

Peer: “Hi Mike, it’s good to see you again. How are you doing?”

Mike: “I’m feeling kinda bad today.”

Peer: “Well what’s going on?”

Mike: “You know my attendance at that substance abuse group at Vital Bridges has been hit or miss, but last Tuesday I went. It’s kind of embarrassing, but I hooked up with one of my old tricks.”

Peer: “I’m glad you went to the group because you’ve said that it helps you sometimes.”

Mike: “It didn’t help Tuesday, that’s for sure.”

Peer: “I hear you. What do you mean when you say hooked up?”

Mike: “We did some meth, lots of sex and some more meth.”

Peer: “You know, Mike, I’m glad you came by today because we can figure out some next steps. What do you want to do?”

Mike: “That’s why I came to you, Pappy, you help me figure things out and don’t judge me. If I went to someone else, I’d just get a lecture and I’ve gotten enough of that in my life.”

Peer: “Did you use any condoms?”

Mike: “What you think? Sorry man, no.”

Peer: “So let’s see if we can get you an appointment to checks for STDs/STIs.”

Peer: “I know you don’t like going to groups, what do you think about talking to a substance abuse counselor? Yeah, it’s one more person to see but you know what they say, 'Don’t knock it till you try it, man.'”

Mike: “I’ve done this counseling thing before and didn’t mesh well with the guy.”

SESSION XVIII: DOCUMENTATION

Topic: Documentation Exercise

SESSION HANDOUT #2 (Cont.)

Peer: “You know there is a new substance abuse counselor who just got hired. Maybe we can see if your case manager can make a referral for you.”

Mike: “You mean I have to tell her, too.”

Peer: “Mike, you’re working with a team here, man. Let’s talk to her together. She’s on your side.”

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: What Is Confidentiality?

TOTAL TIME FOR SESSION XIX: 1 hour 20 minutes
SLIDES: #113-118

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #114

Objectives:

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

- Explain the meaning of confidentiality

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Facilitate a discussion about confidentiality

Materials:

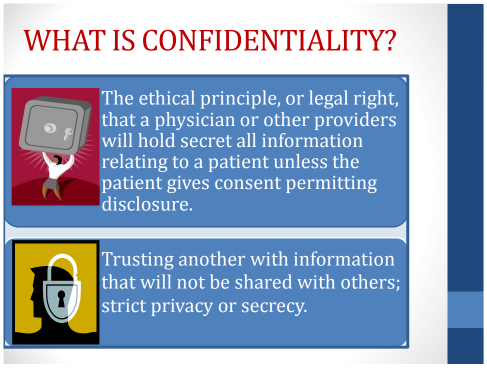
- None

Preparation:

- None

Instructions

1. Ask group: *What is confidentiality?* Allow a few responses, then present slide 114 and elaborate.



WHAT IS CONFIDENTIALITY?

The ethical principle, or legal right, that a physician or other providers will hold secret all information relating to a patient unless the patient gives consent permitting disclosure.

Trusting another with information that will not be shared with others; strict privacy or secrecy.

- *Unauthorized viewers can vary from one organization to the other, but, generally, unauthorized users are people who are not employees of the organization.*
- *In many cases, even among employees, only those working directly with a patient and their supervisors have access to patient files.*
- *Patients trust us with their personal information and we have to honor that trust by not sharing this information with anyone not authorized.*

Summarize

As peers, it is important that you understand your employer's policy regarding access to patient information. When you start your new jobs, you will receive an orientation on employers' privacy and confidentiality policies.

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Confidentiality-Questions to Consider

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #115

Objectives:

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

- More deeply understand confidentiality

Training Methods:

- Lecture
- Brainstorm
- Group discussion

In this activity you will:

- Facilitate a discussion around important considerations for confidentiality

Materials:

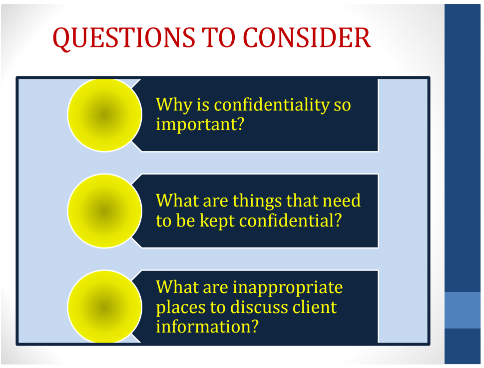
- None

Preparation:

- None

Instructions

1. Pose questions on the slide 115



QUESTIONS TO CONSIDER

Why is confidentiality so important?

What are things that need to be kept confidential?

What are inappropriate places to discuss client information?

Question 1: Possible answers:

- *People need to be able to trust their peer and other providers.*
- *People need to feel safe.*
- *If patients don't trust us, we may lose them to follow up.*
- *It's the organization's policy.*
- *There are liability issues for you and the agency.*

- *Beyond file access, peers hold a lot of personal information about patients and have an ethical responsibility to guard that information from unauthorized users. This can be tricky because, as people with HIV, you may travel in some of the same circles as your patients, and when your patients see you in those circles, they may wonder if you will guard their information.*

- *Remember, because you travel in the same circles, any "leaks" will get back to your patients and, before you know it, other patients will know that you can't be trusted. This will render you an ineffective peer and can lead to negative consequences.*

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Confidentiality-Questions to Consider

Question 2: Quickly brainstorm with group specific things that should be kept confidential and document on newsprint; summarize by stating that everything about the patient is confidential.

Possible answers:

- *HIV status*
- *Substance use*
- *The relationship you have with the patient*
- *Patient's phone number, address, in other words personal information*

Question 3: Conduct another quick brainstorm on inappropriate places to discuss patient information and document on newsprint.

Possible answers:

- *Hallways of agency or clinic*
- *In public places*
- *Where others can hear your conversation*

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Confidentiality & HIPAA

ABOUT THIS ACTIVITY

Time: 45 minutes

Slides: #116-118

Objectives:

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

- Understand the importance of confidentiality and the Health Insurance Portability and Accountability Act
- State the reasons an organization can break confidentiality

Training Methods:

- Didactic
- Large group

In this activity you will:

- Elicit from the group responses to "What is confidentiality?"
- Affirm responses
- Follow talking points

Materials:

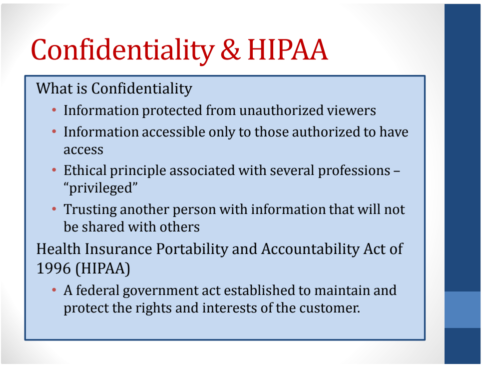
- Newsprint
- Markers
- Confidentiality and HIPAA Handout

Preparation:

- None

Instructions

1. Ask participants to respond to question "What is confidentiality." Document responses on newsprint. Review slide 116 below.

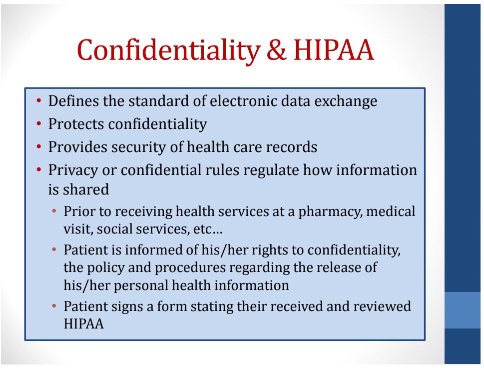


Confidentiality & HIPAA

What is Confidentiality
- Information protected from unauthorized viewers
- Information accessible only to those authorized to have access
- Ethical principle associated with several professions – "privileged"
- Trusting another person with information that will not be shared with others

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- A federal government act established to maintain and protect the rights and interests of the customer.

2. Review slide 117 with participants. Explain the Health Insurance Portability and Accountability Act (HIPAA): *The federal government established this act to maintain and protect the rights and interests of the customer. HIPAA defines the standard for electronic data exchange, protects confidentiality and security of healthcare records. The privacy or confidential rules regulate how information is shared. Upon engagement of health services—pharmacy, medical visit, social services, etc.—the patient is informed of his or her rights to confidentiality and the policy and procedures regarding the release of personal health information. The patient signs a form stating that he or she received and reviewed the HIPAA law.* Draw participant's attention to the HIPAA handout.



Confidentiality & HIPAA

- Defines the standard of electronic data exchange
- Protects confidentiality
- Provides security of health care records
- Privacy or confidential rules regulate how information is shared
  - Prior to receiving health services at a pharmacy, medical visit, social services, etc…
  - Patient is informed of his/her rights to confidentiality, the policy and procedures regarding the release of his/her personal health information
  - Patient signs a form stating their received and reviewed HIPAA

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Confidentiality & HIPAA

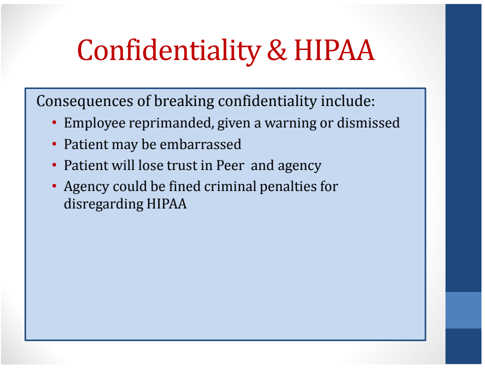
3. Offer to the group that there are times when the HIPAA law is broken. Solicit from group situations when this may occur. Review slide with participants that indicates situations when HIPAA is broken.

   - *If a patient says they are going to commit suicide or gives you reason to believe that, you have an obligation to report this to your supervisor; the same holds true regarding a threat or actual homicide.*
   - *Child and elderly neglect and abuse must also be reported to your supervisor.*
   - *You should tell your patients at the onset of your relationship that this is the only time the agency must break confidentiality; however, this does not give the agency permission to reveal everything about the patient, including HIV status.*
   - *The only thing that gets reported is why you believe the patient is suicidal/homicidal or suspect abuse/neglect of children/elderly.*

4. Important: Tell participants that not disclosing HIV status to a sexual partner or someone with whom you share needles does NOT constitute a threat of, or actual, homicide.

Summarize

- *Don't take it upon yourself to make a report to the proper authorities. Mandated reporting should be bumped up to your program director or manager who will ensure that the agency's policy is followed.*
- Review slide 118 that illuminates to the group that there are consequences to breaking confidentiality:



Confidentiality & HIPAA

Consequences of breaking confidentiality include:
- Employee reprimanded, given a warning or dismissed
- Patient may be embarrassed
- Patient will lose trust in Peer and agency
- Agency could be fined criminal penalties for disregarding HIPAA

CONFIDENTIALITY AND HIPAA

○ **What is Confidentiality?**
  - › Keeping information protected from unauthorized viewers
  - › Ensuring that information is accessible only to those authorized to have access
  - › Refers to an ethical principle associated with several professions-“privileged”
  - › Trusting another person with information that will not be shared with others

○ **Health Insurance Portability and Accountability Act (HIPAA)**:

The federal government established this act to maintain and protect the rights and interest of the customer. HIPAA defines the standard for electronic data exchange, protects confidentiality and security of healthcare records. The privacy or confidential rules regulate how information is shared. Upon engagement of health services—pharmacy, medical visit, social services etc.—the patient is informed of his or her rights to confidentiality and the policy and procedures regarding the release of personal health information. The patient signs form stating that they received and reviewed the HIPAA law.

○ **Situations when data can be released without the patient’s permission or consent:**
  - › For the purpose of reporting abuse, neglect or domestic violence to the proper social service or protective services agency
  - › To prevent serious threat to health and public safety
  - › To the department of public health for health reporting purposes
  - › Inform appropriate bureau during disaster relief
  - › Workers' compensation
  - › Food and drug administration for expected side effect to drugs or food product defects to enable product recall
  - › Correctional institution
  - › To medical examiners, coroners, procurement of organ, or certain research purposes.
  - › Notify family members, legal guardian involved in the patient’s care for notifying them of a person's location

○ **Consequences of breaking confidentiality include:**
  - › Employee reprimanded, given a warning or dismissed from the agency.
  - › The patient/patient may be embarrassed
  - › The patient will lose trust in the peer and the agency
  - › The patient may file charges against the peer and the agency
  - › The agency could be fined criminal penalties for disregarding HIPAA

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Breaking Confidentiality

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #119

Objectives:

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

- Learn the reasons an organization can break confidentiality

Training Methods:

- Lecture
- Group discussion

In this activity you will:

- Facilitate a discussion about when it is appropriate to break confidentiality

Materials:

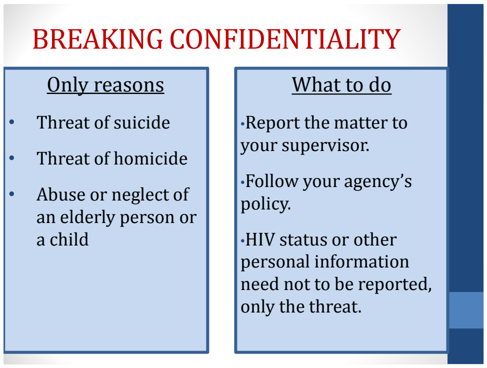
- None

Preparation:

- None

Instructions

1. Review slide 119 with the group and elaborate:



BREAKING CONFIDENTIALITY

Only reasons

- Threat of suicide
- Threat of homicide
- Abuse or neglect of an elderly person or a child

What to do

·Report the matter to your supervisor.

·Follow your agency's policy.

·HIV status or other personal information need not to be reported, only the threat.

- *Can you recall from the last lesson some of the situations when you are obligated to break confidentiality?* Answers include:

If a patient says they are going to commit suicide or gives you reason to believe that, you have an obligation to report this to your supervisor; the same holds true regarding a threat or actual homicide.

Child and elderly neglect and abuse must also be reported to your supervisor.

You should tell your patients at the onset of your relationship that this is the only time the agency must break confidentiality; however, this does not give the agency permission to reveal everything about the patient, including HIV status.

The only thing that gets reported is why you believe the patient is suicidal/homicidal or suspect abuse/neglect of children/ elderly.

Summarize

a. *Not disclosing HIV status to a sexual partner or someone with whom you share needles does* NOT *constitute a threat of, or actual homicide.* (Verify the laws of the place where the training is being conducted.)

b. *Don't take it upon yourself to make a report to the proper authorities. Mandated reporting should be bumped up to your program director or manager who will ensure that the agency's policy is followed.*

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Boundaries in Professional Relationships

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #120

Objectives:

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

- Understand the importance of boundaries

Training Methods:

- Brainstorm
- Group discussion

In this activity you will:

- Facilitate a conversation about boundaries and their importance

Materials:

- Newsprint
- Markers

Preparation:

- None

Instructions

1. Turn to slide 120.

BOUNDARIES IN
PROFESSIONAL RELATIONSHIPS

2. Ask participants: *What are boundaries and why are they important?* Allow responses and document on newsprint. Possible responses: *a line that you can't cross, a limit; to prevent peer burnout, to prevent misinformation, to prevent liability, to keep patients engaged with the organization, etc.*

3. Tell participants that people have different needs and expectations around boundaries.

4. *Some boundaries are non-negotiable, as established by professional codes and agency policy, while others are more personal, and may be different from person to person or situation to situation.*

5. *Peer-related boundaries have always been a concern for service providers; there is often more concern about peer boundaries than with other employees—why do you think this is so?* Take a few responses. Possible responses: *higher level of intimacy, the sharing of personal information between peer and patient, lack of experience in the workplace, peers wanting to be all things to patients, not knowing the limits of the peer role.*

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Boundaries in Professional Relationships

6. Ask participants to consider:

- *What constitutes a professional relationship?* Allow responses. Expected answer: *a professional relationship is the kind you have that are associated with your job, i.e., coworkers, patients, supervisor, etc.*

- *What boundaries have you struggled with in the workplace?* Allow responses and facilitate discussion.

- Tell participants that in this module we will explore workplace boundaries for peers (although they are applicable to all employees).

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Managing Workplace Boundaries

ABOUT THIS ACTIVITY

Time: 35 minutes

Slides: #121

Objectives:

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

- Practice handling boundary dilemmas

Training Methods:

- Role-play
- Group discussion

In this activity you will:

- Facilitate group activity
- Debrief role-play activity

Materials:

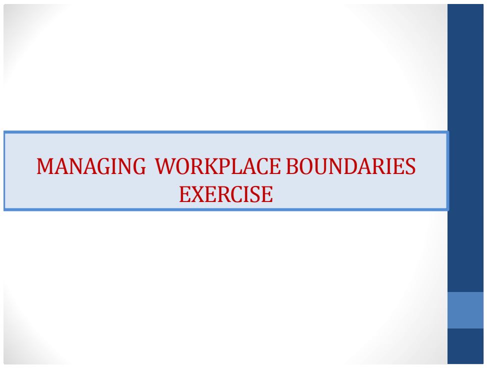
- Cards with boundary dilemmas
- Hat or bag

Preparation:

- Cut the boundary dilemmas into a set of cards, place in a hat or bag.

Instructions

1. Turn to slide 121.



MANAGING WORKPLACE BOUNDARIES EXERCISE

2. Exercise Part I

   a. Break out into two groups and have each group line up on either side of the room.

   b. Designate the two groups as lines A and B; Line A will play the peer and line B will play the patient.

   c. Each person in Line B will be given an index card containing a boundary dilemma raised by patients.

   d. The two people at the front of the lines sit facing each other in front of the room; the patient (line B) reads his/her boundary scenario to the peer and the peer has to respond; if the person in the peer role needs help s/he can ask for a lifeline.

   e. Once each pair finishes role-playing, the audience and trainers will give feedback on the peer's response before the next pair role-play.

   f. The two people in the role-play then go to the back of their line and the next two people in line repeat the role-play and so forth until the end of the lines.

   g. Ask everyone to be seated for Part II of the exercise.

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Managing Workplace Boundaries

3. Exercise Part II

   a. Use peer-initiated boundary dilemmas. Trainer reads boundary dilemmas out loud and the audience has to respond by saying how they would feel if they were the patient or coworker being propositioned by the peer.

   Peer-initiated boundary dilemmas:

   - I'm only supposed to give you one bus pass, but I'll give you two. Don't tell anyone.
   - Call me any time, day or night, to tell me what happened.
   - You have to tell your partner today that you have HIV.
   - God has blessed me with good health since I've been positive. Go to my church and you'll see that you will be blessed too.
   - I need a hug.
   - Since you're not my patient any more, we can be partners, like you wanted.
   - I'm going to help you pay the light bill, but don't tell anyone.
   - Your case manager is a fool.

Debrief

a. Ask: *How is this exercise helpful as you think about your role as a peer?*

b. *What else would you like to know about boundaries?*

Summarize

- *When gray areas come up consult with your colleagues, clinical supervisor, other peers, etc. and then make the best possible decision for you, your patients and your organization.*

- *If you don't know what to do, don't do anything until you speak with your supervisor.*

- *Peer boundaries are not different from boundaries among other agency staff; the potential may be greater due to the sharing of intimate information, but the actual boundary principles are not.*

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Managing Workplace Boundaries

SESSION HANDOUT

PATIENT-INITIATED BOUNDARY DILEMMAS

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?

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Managing Workplace Boundaries

SESSION HANDOUT (cont.)

You look stressed out, let me give you a massage.

I brought 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 weed if you want to buy some.

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Managing Workplace Boundaries

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 peer now and I'm no longer your patient, can we go out to dinner sometime?

SESSION XIX: CONFIDENTIALITY & BOUNDARIES

Topic: Managing Workplace Boundaries

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.

SESSION XX: PEER-CASE MANAGER SESSION

Topic: Interdisciplinary Team

TOTAL TIME FOR SESSION XX: 1 hour, 55 minutes

SLIDES: #122-127

ABOUT THIS ACTIVITY

Time: 5 minutes

Slides: #123

Objectives:

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

- Define the interdisciplinary team

Training Methods:

- Discussion

In this activity you will:

- Facilitate a dialogue on interdisciplinary teams

Materials:

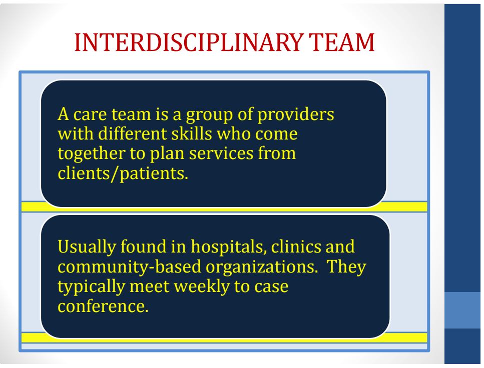
- None

Preparation:

- None

Instructions

1. Review slide 123 with participants.

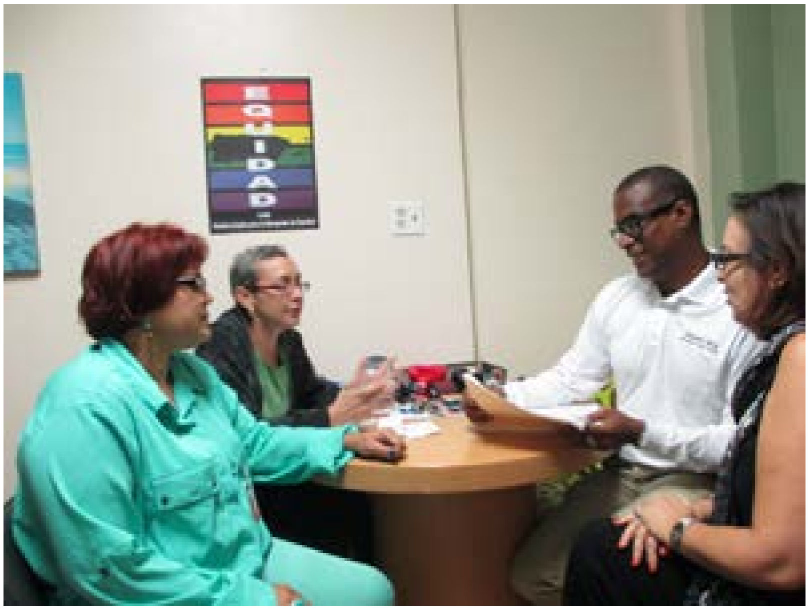


INTERDISCIPLINARY TEAM

A care team is a group of providers with different skills who come together to plan services from clients/patients.

Usually found in hospitals, clinics and community-based organizations. They typically meet weekly to case conference.

- *Team members are connected in the provision of services to the same patient.*



A peer participates in an interdisciplinary team meeting at PR CoNCRA.

SESSION XX: PEER-CASE MANAGER SESSION

Topic: Interdisciplinary Approach to Care

ABOUT THIS ACTIVITY

Time: 10 minutes

Slides: #124

Objectives:

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

- Describe the interdisciplinary team approach to care

Training Methods:

- Lecture
- Discussion

In this activity you will:

- Guide participants through the interdisciplinary approach to care

Materials:

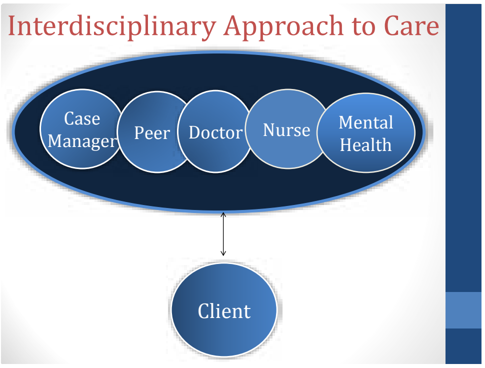
- None

Preparation:

- None

Instructions

1. Tell participants that the illustration on slide 124 is how a team is structured.



Interdisciplinary Approach to Care

Case Manager

Peer

Doctor

Nurse

Mental Health

Client

2. *Communication is between the patient and the team. This doesn't mean the entire team communicates with the patient at the same time; it means that whenever there's a communication to and from patients, everyone in the team is informed.*

3. *Care teams meet on a regular basis, typically once a week, to discuss the patients currently being seen. The meetings are an opportunity to share important information, coordinate patient care, and plan for services.*

4. *None of the members try to assume anyone else's role; the individual in each role is an expert in his or her field. The peer is also an expert, an expert in living with and managing HIV.*

Segue

- *In the next exercise you will have an opportunity to define the roles of each member of the team.*

SESSION XX: PEER-CASE MANAGER SESSION

Topic: Role of Team Members

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #125

Objectives:

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

- Delineate roles within the care team

Training Methods:

- Small-group discussion
- Large-group discussion

In this activity you will:

- Facilitate group activity about the roles of team members in an interdisciplinary team
- Debrief participants as one group

Materials:

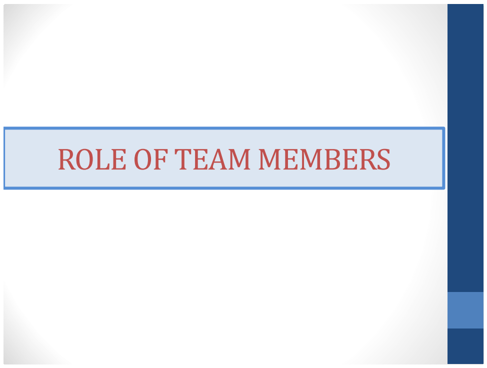
- Newsprint for small-group activity
- Markers

Preparation:

- None

Instructions

1. Turn to slide 125.



ROLE OF TEAM MEMBERS

2. Tell participants that we are going to do an exercise on defining the role of interdisciplinary team members. Explain that understanding the role of each member is essential for a team to work well together.

3. Break out into small groups; give each group a sheet of newsprint and markers. Each team should assign a recorder and a reporter.

4. Ask each group to brainstorm and write down the roles and responsibilities of each team member. Remind participants that we have already spent time on the peer role so they should do that quickly and then spend most of their time on the other team member roles.

5. After 15 minutes, ask the groups to stop, then ask each group to present their lists and facilitate discussion. Emphasize that there may be overlap in some tasks, particularly between peer and case manager; give some examples of overlap.

Segue

In the next exercise you'll have a chance to practice being in a team and appreciate what each member of the team brings to the work.

SESSION XX: PEER-CASE MANAGER SESSION

Topic: Survival Team Exercise

▶ ABOUT THIS ACTIVITY

Time: 40 minutes

Slides: #126

Objectives:

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

- Understand the power of team work

Training Methods:

- Small-group exercise
- Debriefing, group discussion

In this activity you will:

- Introduce and guide participants through the survival team exercise
- Lead a debriefing discussion

Materials:

- Cards with possessions and roles of team members
- Newsprint
- Markers

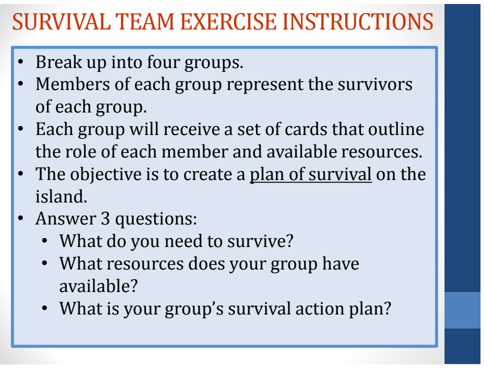
Preparation:

- Prepare the cards
- Prepare newsprint and hang on wall

Instructions

1. Begin by explaining:
   It's very important to work well with your team to achieve the goal of providing the best possible care to the patient. This next exercise will help us understand how much stronger a team is than its individual parts.

2. Show slide 126.



SURVIVAL TEAM EXERCISE INSTRUCTIONS

- Break up into four groups.
- Members of each group represent the survivors of each group.
- Each group will receive a set of cards that outline the role of each member and available resources.
- The objective is to create a plan of survival on the island.
- Answer 3 questions:
  - What do you need to survive?
  - What resources does your group have available?
  - What is your group's survival action plan?

3. *There are four different groups of people who became stranded in four different areas on a deserted island. The island is small enough to walk the entire circumference. The island has several different types of palm trees, including coconut trees, banana trees, and a volcano. They are illustrated on the 3 sheets of newsprint posted on the wall. Please assign a recorder and a reporter for your group.*

4. Have participants count off into groups: 1, 2, 3, 4. Assign a section of the room for each group to meet.

5. Go around the room and give each group the cards:

   - Group 1: Chef, ship captain, licensed social worker, body builder, rope, flashlight, 3 blankets, bucket of coal, 6 pairs of shoes, skis;

   - Group 2: Farmer, teacher, nurse practitioner, carpenter, magnifying glass, 4 pairs of pants, 2 long-sleeve shirts, screwdriver, 10 wire hangers, 6 pairs of shoes, 20 condoms;

SESSION XX: PEER-CASE MANAGER SESSION

Topic: Survival Team Exercise

   - Group 3: Deep sea diver, plumber, eagle scout, gardener, lighter, 2 fleece sweaters, fishing pole, peanut butter, 3 pairs of shoes, nylons, 40 tampons, pencil, pad of paper;
   - Group 4: Boy or girl scout, policeman or woman, carpenter, lawyer, hatchet, guide to survival, flare gun, 3 towels, 3 pairs of shoes, 50 condoms, camera, 5 toothbrushes, compass.

6. Each group has to answer the 3 questions on the slide and document responses; you will have 20 minutes.
7. Go around and give each group newsprint and markers for recording their group's action plan.

Debrief

- Ask each group to report out their survival plan.
- Give each group a round of applause after each presentation; note how creative the groups were in terms of utilizing all of their resources to survive on the island.
- At the end of each presentation ask:
    - ○ *What would happen if even a single team member did not perform his/her role?* Expected responses: *We would not have survived, or we would have had to do without some basic necessities to survive, etc.* Allow responses and facilitate discussion.
- Note if any groups decided to find the other groups on the island in order to maximize their resources.
- Ask:
    - ○ *How does this exercise apply to your work as peers working in a multidisciplinary team? What lessons did you learn?* Allow responses.
        - ▪ Expected responses: *as members of a multidisciplinary team everyone's role is essential and the person impacted most is the patient.*
    - ○ *It's about creating a plan of action for the survival of whom?*
        - ▪ Answer: the patient.
- Other Important Lessons
    - ○ *Participate in case conferencing, communicate with members of your team about what's going on with the patient, take notes so you can remember what to share, don't be absent from work on team meeting days, listen attentively to what other team members share with you, and listen attentively to the patient to assure that you are accurately representing what's going on with them.*

Summarize

- *It's important to identify unique things you have to offer to other team members and what they can offer you.*
- *Learn to recognize things that are sharable and share them from the unique perspective of someone living with HIV.*
- *Don't be afraid to ask questions during team meetings.*

SESSION XX: PEER-CASE MANAGER SESSION

Topic: Case Manager Q&A

ABOUT THIS ACTIVITY

Time: 30 minutes

Slides: #127

Objectives:

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

- Increase understanding of the peer program services
- Understand the role of the peer as a part of the treatment team
- Express concerns and ask questions

Training Methods:

- Large-group discussion
- Small-group work
- Brainstorm

In this activity you will:

- Facilitate a group discussion

Materials:

- Newsprint
- Markers
- Copies of peer job description (Use the actual peer job description from the program where the peer will be working. If none is available, use the job description found on page 43)

Preparation:

- Invite one or more case managers to this part of the session
- Have copies of Job Description as handouts

Note: This topic is most effective if case managers are present.

- If peers are being introduced into the interdisplinary team, having peers and case managers interact will facilitate communication between the two groups and help each group understand how the role of peer and case manager can complement each other to benefit the patient.
- If new peers are being included in an established interdisciplinary team, having an experienced case manager on hand to answer peers' questions and talk about how the two groups work together helps the peer understand his or her role as it relates to case management.
- In either case, this exercise introduces case managers and peers to each other and helps build the foundation for a working relationship.

For more about orienting non-peer staff, please refer to *Building Blocks to Peer Program Success,* Section 5 Read More: Orienting Non-Peer Employees on Peer Support, Philosophy, and Program Models at http://peer.hdwg.org/sites/default/files/C_ReadMore_OrientingNonPeerStaff.pdf

Instructions

1. Review the services the peer program provides to shared agency patients.
2. Distribute job descriptions if case managers are unclear of the role that peers will facilitate.
3. Facilitate an open forum for case managers to give them a chance to ask questions, express concerns about roles, etc.
4. Divide large group in 2 small groups.
5. Ask group to assign a scribe and a reporter for the small group.
6. Facilitate a brainstorm activity to respond to the questions.
    a. What are the advantages of the program?
    b. What are the fears with implementation of the program?
7. Ask reporter for each group to review answers to questions
8. Identify an avenue to resolve unanswered concerns from activity with agency management.

DAY 5: REVIEW

Review and remind participants how they will use their knowledge in working with patients. Refer to the Peer-Patient Educational Session Conversation Guide handout (pages 14-22) as you review.

This last day of training was devoted to topics related to peers working within the organization.

Session XVIII Review

*We started with **documenting peer work.***

- *Why is documentation important?* (to have a record of patient's progress, helps team members know what's going on, provides a record of your work)
- *What are some tips for good documentation?* (be objective, be concise, only include what is relevant)

Session XIX Review

*Then we went on to talk about **confidentiality**.*

- *What are some examples of patient information that should be kept confidential?* (HIV status, substance use, your relationship with the patient, personal information)
- *What are some situations where we are obliged to break confidentiality?* (threat of suicide, threat of homicide, abuse or neglect of an elderly person or child)
- *What's HIPAA?* (Health Insurance Portability and Accountability Act, a federal law to protect confidentiality of patients' health information)

*After that we talked about **boundaries** in the workplace.*

- *What are some situations you should be careful about when working with patients?* (answers depend on organization guidelines, refer back to boundaries exercise)
- *What about when working with colleagues?* (answers depend on organization guidelines)

Session XX Review

In the last session, we talked about the interdisciplinary team and especially how peers work with case managers.

- *What's special about the interdisciplinary approach to care?* (communication is between the patient and the whole team, everyone on the team knows what's going on, team meets regularly to discuss patient cases)
- *What are some things that came up when talking with case managers that you want to keep in mind?* (all members of the team are focused on helping the patient be well, everyone follows HIPAA guidelines, confidentiality is paramount and we all have individual responsibilities in working with patients).

GRADUATION CEREMONY

ABOUT THIS ACTIVITY

Time: 15 minutes

Slides: #128

Objectives:

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

- Place closure on the training experience
- Express gratitude and share appreciation of others

Training Methods:

- Large group

In this activity you will:

- Hand out certificates and/or tokens of appreciation such as gift bag; water bottle; t-shirt
- Invite participants to share an appreciation of fellow peers

Materials:

- Certificates
- Tokens of appreciation for each participant

Preparation:

- Print certificates with participant names and have them signed by training team
- Have tokens of appreciation for all participants

Instructions

- Tell participants how much you have enjoyed working with them for the course of the training.
- Identify areas of growth observed.
- Ask participants to come together to form a circle. Ask that they hold their right hand palm up and the left hand palm down as they hold hands with each other.
- State: *It is time to think about what you have learned in the training and to offer gifts to each other as we end and continue on the journey of peer work.*
- Member of the training team goes first and looks in the eyes of the person to their right and by example says "Trainee's name-I give the gift of compassion"; then that person looks to the next person on their right and says "Trainee's name-I give the gift of…………." until the circle is complete and everyone has had a change to share gifts.

This publication is part of the online curriculum *PREParing Peers for Success: Peer Core Competency Training.* For the complete curriculum, accompanying PowerPoint slides, and other curricula in the series, visit http://www.hdwg.org/prep/curricula

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