Ryan White Planning Council (RWPC) of the Philadelphia Part A (Title I) EMA
and Philadelphia Community Planning Group (CPG)
Points of Integration Workgroup
Meeting Minutes of
Wednesday, May 27, 2009
1:00 p.m. – 3:00 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: David Acosta, Jay Grant, Ann Ricksecker, Nurit Shein

Staff: Briana Morgan, Michael Milsop

Call to Order/Introductions:
N. Shein called the meeting to order at 1:10 p.m.

Approval of Agenda:
N. Shein presented the agenda for approval. The agenda was approved by general consensus.

Approval of Minutes *(25 November 2008)***:**
N. Shein presented the November 25, 2008 minutes for approval. A. Ricksecker stated that she had previously sent comments on the draft minutes to Joseph Ellis. **Motion:** A. Ricksecker moved, N. Shein seconded to approve the November 25, 2008 minutes. **Motion passed**: All in favor.

Report of Staff:
M. Milsop stated that there would be a statewide conference on HIV care and prevention at Harrisburg Community College on October 14 and 15. N. Shein replied that they ought to have representation there. M. Milsop added that they would be looking for presentations for the conference. N. Shein replied that she hoped that this would give them an opportunity to present on their group.

Report of Co-Chair:
None.

Discussion Items:

- **Best Practices Guide for Prevention with Positives**

N. Shein stated that she had gotten a copy of the Best Practices Guide for Prevention with Positives from San Francisco, and that M. Milsop had gotten an updated version that had been sent to committee members. She explained that it would be important for them to have a guide on which interventions are most successful, how the grantee can prepare for them, and other related topics. She went on to say that they ought to look at what parts of the guide would be suitable for Philadelphia, and then present the finished product to the RWPC. A. Ricksecker replied that they should present this to both the RWPC and CPG. D. Acosta asked about indicators that are a part of the quality assurance process that might include screening for certain diseases. A. Ricksecker

replied that this is in the minutes from the previous meeting, and that it included some kind of risk assessment. D. Acosta said that he wonders how that would factor into Philadelphia's system, and that they would need to look at what they already did before implementing this. N. Shein stated that screening for STDs was already a measure, but that this did not mean that it should not be included in the best practices. She noted that this guide would include things that all providers were already doing, things that some providers were and some were not doing, and some things that no one was doing.

A. Ricksecker stated that she liked page seven of the guide that is separated by each type of provider for care and prevention, as well as mental health. She added that it felt user-friendly without too many changes. N. Shein replied that it was interesting to look at preventions by provider type, but that she had questions on the appropriateness of certain preventions as associated with certain providers. M. Milsop then asked the group to start at the beginning of the guide and work toward the back.

N. Shein stated that they would first need to agree the language on page one that referred to "reduction of HIV and other STDs, helping HIV positive achieve… and assist those that don't know they are positive." A. Ricksecker suggested that they explicitly include "viral hepatitis" after HIV in the first line. D. Acosta asked if they wanted to include something about TB. N. Shein replied that there were a lot of questions about whether TB screening was necessary for PLWHA. The group agreed to include "other STDs and viral hepatitis."

D. Acosta asked if they should include another bullet on helping PLWHA with issues surrounding disclosure, which was a huge stressor for PLWHA that did not get as much attention as it should. N. Shein replied that it was listed as an intervention. D. Acosta said that they should include "to assist people in disclosure" because that is a challenge found in literature on MSM. A. Ricksecker stated that this had been a goal in Philadelphia. N. Shein suggested including a bullet that stated "to reduce stigma and assist individuals in disclosures." She went on to say that this would not just help by assisting individuals, but by creating a social environment in which this could happen. A. Ricksecker said that they should make a fourth goal for this.

N. Shein stated that it was interesting that the guide started with the provider preparedness rather than the interventions that would help them reach their goals. M. Milsop said that this would go along with what they had heard before about providers being prepared. D. Acosta stated this had implications for capacity-building, training, and technical assistance, noting that all providers were different and had different resources. M. Milsop asked the group to review the goals of the document.

D. Acosta moved to page three, and stated that it could be complicated in terms of the information that they were giving to PLWHA. N. Shein replied that it would depend on the intervention being done. D. Acosta then asked if the document defined what the core was. N. Shein replied that they addressed it throughout the document. A. Ricksecker stated that they are looking at something that was more grantee-oriented, and that they might have a fourth question for page two that would brands the guide as

coming out of the Points of Integration Workgroup. D. Acosta suggested something about ongoing work to ensure integration of prevention and care. He asked if they wanted to name the grantee, the RWPC, and the CPG. M. Milsop stated that they were looking at a toolkit, and they might want to ask if this satisfies their needs. A. Ricksecker asked if he was saying that talking about planning was superficial. M. Milsop replied that it was not, but this statement might not be relevant to put there.

N. Shein said the third question reflected what M. Milsop was saying. D. Acosta suggested including the question, "how do we insure comprehensive integration of prevention and care services at all levels of planning and implementation?"

N. Shein asked if they wanted to start with providers or interventions. A. Ricksecker replied that whoever put this together did a great job, and that they just wanted to add some Philadelphia-specific text. N. Shein stated that she had some questions about provider type, and A. Ricksecker replied that they would have to review this to make it relevant to Philadelphia.

M. Milsop stated that there were health literacy tools for clients, which might be a good term to add to the core skills section on page three. A. Ricksecker said that this section looked complete to her, but she could run it by her curriculum requirement. D. Acosta stated that the care side had not been trained on some of the things listed. A. Ricksecker said that these should be broad enough to span the landscape of all providers. D. Acosta replied that the core elements for provider preparedness should be embodied in case management as well as prevention. He explained that this would have to happen at both ends. A. Ricksecker stated that they should go to the beginning of the provider preparedness section to write a sentence that would brand it. She explained that she thought they should say that they view this as the responsibility of both the prevention system and care system. D. Acosta replied that they should include something mentioning cross-training. A. Ricksecker stated that they would have M. Milsop figure out what this sentence should be and where it should go in the guide.

M. Milsop said that health literacy was a hot topic, and that it was included in the new case management materials. N. Shein replied that this was specifically addressed in #6 under prevention with positives. A. Ricksecker replied that they should add the term "health literacy" to that section. M. Milsop suggested adding it to the beginning of that sentence. A. Ricksecker stated that they should add "including viral hepatitis" to #4 under prevention with positives-related, as well as anywhere else the document said "HIV and other STDs." M. Milsop suggested making #7 consistent with the prevention plan, pointing out that disability would soon be added to the plan. A. Ricksecker stated that she had seen "influences of trauma" as another catchword. M. Milsop said that depression, anxiety, and PTSD were the named influences for risk-taking behavior. A. Ricksecker said that those with trauma were more likely to contract HIV later in life, although she was not sure if they should add that if it was not yet in the plan. M. Milsop replied that they were looking at hard data, and they could include this. D. Acosta agreed that they had had discussions on trauma and looked at research on the impact of trauma on black MSM.

The group moved on to review the interventions definitions. A. Ricksecker said she liked "system level interventions." She then stated that D. Acosta would be best informed to review this list. D. Acosta replied that it was a comprehensive list.

The group moved on to page seven. D. Acosta stated that they would have to ask whether medical providers had time to accomplish all that was listed. For example, he knew that STD screening was a standard, but he was not sure if medical providers could do skills building. M. Milsop replied that they could look at this as a goal, and treat it like an opportunity. D. Acosta stated that they had been talking about imbedding prevention into primary care programs in a meaningful way. A. Ricksecker said that this model was a three-minute script that had been tested, and trust in the doctor meant a good deal. She added that she believed "medical providers" referred to "HIV medical providers."

N. Shein, referring to the section on assessment and referral for mental health, stated that referral definitely happens but the assessment does not. She questioned whether this referred to a comprehensive assessment, or rather assessing that a person needs to be referred to mental health services. A. Ricksecker replied that "basic" was an important word included in the description. N. Shein replied that they should add the word "basic" to the bullet on page seven.

A. Ricksecker said disclosure assistance and partner services under medical and case managers might have specific language to use in this jurisdiction. D. Acosta stated that the provider gives the options available to the client, and this can include assistance with disclosure. N. Shein stated that options included the client disclosing by himself or herself, the client disclosing along with his or her case manager, or having an outside body disclose. M. Milsop noted that this was mentioned on page eleven. D. Acosta stated that they might need to add something else after reviewing the PCRS options in their jurisdiction.

A. Ricksecker asked if "disclosure assistance and partner services" was a term used in this jurisdiction. M. Milsop replied that they had just changed the name to something else. D. Acosta stated that this was CDC language, and N. Shein said that she liked the term as it was.

N. Shein asked whom health educators/peer educators would be, asking whether this would include Philadelphia FIGHT. D. Acosta replied that this probably referred to frontline prevention staff in CBOs. N. Shein replied that they talk about counseling and testing staff. M. Milsop replied that the health educators would do Voices or HERR.

D. Acosta pointed out that PCM would have to be changed.

N. Shein questioned medication adherence under counseling and testing. M. Milsop replied that it was introducing the topic, and they should look at page twelve. D. Acosta

stated that their prevention system was not generally versed in that conversation. J. Grant said that he was surprised that they termed it as "medication adherence."

N. Shein asked what the purpose of counseling and testing staff would be for people already living with HIV/AIDS, and questioned whether they would have a medication conversation immediately after learning their status. J. Grant said that he could see this topic coming up, but that he thought it was strange to call it by that term. N. Shein replied that she would call it "HIV and health education." M. Milsop stated that CT referred to test decision counseling, which would address whether or not a person would be able to deal with the results of a test. J. Grant stated that they would look at whether the person was on other medication based on other issues. N. Shein stated that they would not be getting medication at the time of CT, so that was not the time for medication adherence.

N. Shein reviewed what HIV education would include, pointing out that CT has more education then medication adherence. The group agreed to remove medication adherence and add HIV education in.

D. Acosta asked if they should talk about STI and hepatitis under mental health. N. Shein pointed out that mental health included HIV and health education, which would address these topics.

A. Ricksecker asked whether vocational rehabilitation applied to this jurisdiction, as the RWPC had chosen not to fund it. The group agreed to take this part out.

M. Milsop stated that San Francisco had drop boxes for needles on every corner. N. Shein asked where they got the needles. M. Milsop replied that they gave away over five million needles, and that they were available at drugstores.

The group agreed that they would review these changes at the next meeting.

- **Update on Health Department Integration Meetings**

A. Ricksecker stated that the next meeting would be on June 9, and that the meetings had been going well. She pointed out that the systems were more interconnected than they had been a year and a half ago. She noted that Christie Moon would be taking charge of the project, and that there would also be a new Hepatitis director. D. Acosta said that they were looking for best practices in other jurisdictions, and that they had learned that Philadelphia was more integrated than they had previously thought. He went on to say that they had invited substance abuse representatives to the table.

N. Shein stated that each system had its own separate data collection mechanism, and asked how thorough integration could be with inconsistent data collection. M. Milsop stated that PCSI had more to do with integration on the client level than integration in data collection. N. Shein replied that this reflected integration on the client side, but not on the system side. D. Acosta stated that AACO had been meeting with OAS for the past year, and that they were trying to figure out how to have meaningful conversations

between providers from both branches. He noted that there was a risk assessment form that would ask for the same information from AACO, OAS, and STD. A. Ricksecker stated that this was an incremental change, and that the EMA would eventually like to have surveillance integration. She went on to say that K. Brady had been talking to TB about how to share their data.

M. Milsop stated that the UCHAPS Steering Committee had recently had a meeting with the CDC around PCSI. He noted that UCHAPS had created a spreadsheet on each city's progress, and that they had pointed out Houston and Philadelphia in particular. A. Ricksecker replied that this was great news.

- **Next Meeting Date**

N. Shein suggested holding another meeting after June 9, which would be the day of the next internal meeting. The group discussed possible meeting dates in the second week of July.

Old Business:
None.

New Business:
None.

Announcements:
None.

Adjournment:
The meeting was adjourned at 2:27 p.m. by general consensus.

Respectfully Submitted by,

Briana L. Morgan, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from November 25, 2008
- Best Practices Guide
- OHP Calendar

Ryan White Part A Planning Council (RWPC) & Philadelphia Community Planning Group (CPG) Points of Integration Workgroup

Meeting Agenda
Wednesday, May 27th, 2009
1:00 - 2:30 pm
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

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Call to Order/Introductions

Approval of Agenda

Approval of Minutes (*November 25th, 2008*)

Report of Staff

Report of Chair

Discussion Items:
- **Best Practices Guide for Prevention with Positives**
- **Update on Health Dept. Integration Meetings**
- **Next Meeting Date**

Old Business

New Business

Review/Next Steps

Announcements

Adjournment

The next meeting of the Points of Integration Workgroup is TBD
Please refer to the Office of HIV Planning's attached Calendar of Events or its website, www.hivphilly.org, for updated committee meeting information.

Please contact the office at least 5 days in advance if you have any special needs

Points of Integration Workgroup
Meeting Minutes
Tuesday, March 17th, 2009
10:00 a.m. - 12:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 203, Philadelphia, PA 19107

Present: Tony Daniel, Ann Ricksecker, Nurit Shein (Chair)

Excused: David Acosta, Jay Grant, Jeffrey Jenne, Ken McGarvey Susan Spencer

Staff: Joseph Ellis, Michael Milsop

Call to Order
N. Shein called the meeting to order at 10:05 am.

Approval of Agenda
Motion: A. Ricksecker moved and N. Shein seconded to approve the agenda. **Motion Passed:** All in favor.

Approval of Minutes (*November 25th, 2008*)
Motion: After the group took a moment to review the minutes from their last meeting, A. Ricksecker moved and N. Shein seconded to approve the document. **Motion Passed:** All in favor.

Report of Staff
None

Report of Chair
None

Discussion Items:
- **Outstanding Issues**

M. Milsop directed the group's attention to the handout entitled *Points of Integration Workgroup Outstanding Issues*. He explained that he had compiled the list because, as part of the prevention application, he had to determine what the workgroup's accomplishments had been over the course of the past few years. In so doing, he continued, he had discovered a number of unresolved items and so he brought them to the group so that they could determine whether to drop or follow up on them. He said that the current list was incomplete; however, he felt that there were enough items to discuss to start the process. Getting to the first item on the list, he reminded the group that they had considered creating an assessment tool to ascertain whether an individual in care was ready and/or willing for prevention services. N. Shein stated that system-wide changes in the intake process were already dealing with the issues that such an assessment tool would address. She clarified that the changes, which were being integrated as a standard part of case management, were designed to notify providers that a patient required prevention services. A. Ricksecker confirmed that there was a new risk assessment

indicator in Careware as part of quality improvement. She also noted that most clinics that dealt with prevention with positives had another instrument for risk assessment. As a result, the group agreed to remove the item from their list of outstanding issues.

Moving on to the second issue, M. Milsop noted that there had been some developments in embedding PCRS into case management. He informed the group that the new partner services guidelines would separate the elicitation and notification modules, which would prevent testing agencies from having to do the notification while still allowing them to inquire about one's partners. N. Shein added that there had also been some pilot projects by AACO and the Health Department that used community agencies for partner notification. She said that the impetus for the projects was the fact that PCRS had become a major component in identifying exposed individuals. However, she was unsure as to whether the pilots had been completed. A. Ricksecker supported the statement that a pilot project had been initiated; however, she too was unsure of its current status. N. Shein suggested that the group check up on the pilot project before making any determinations about what to do with the outstanding issue. The rest of the group agreed.

A. Ricksecker noted that items 1 and 3 from the handout were basically the same issue. The rest of the group agreed; however, N. Shein did not recall the discussion around exploring the role of PCRS in family planning. A. Ricksecker stated that she had some updates on the matter, adding that they would also address the fourth item on the handout. She informed the group that DIS workers would be conducting STD testing in family planning clinics and that local family planning clinics were already funded and trained for HIV testing. Nationally, she continued, there was a grant out to evaluate the integration of family planning services in an HIV clinical setting and vice versa, with part of the project being conducted through a clinical residency training at Drexel University. She said that she would be attending a HRSA meeting in the next week where the model would be discussed. She offered to report on the discussion so that the group could decide whether to further pursue PCRS in family planning.

M. Milsop informed the group that they had a few other unresolved issues to discuss, including PEMS variables and the grid of prevention services in care settings. He said that he would bring the remaining issues to the Points of Integration Workgroup at their next meeting.

- **Update on Health Dept. Integration Meetings**

A. Ricksecker provided an update on the ongoing Health Department Integration Workgroup meetings; however, she said that she had not brought an updated copy of the collaboration grid because the group's next meeting was scheduled for later in the week. She started her report by lamenting the group's loss of T. Brickham, who had relocated to Houston. However, she informed the group that T. Brickham had agreed to provide Philadelphia with information on Houston's integration efforts, which were greatly advanced. Additionally, she reported that Los Angeles had contacted Philadelphia for information on the integration efforts resulting from the Health Department meetings. She said that, as a result, another student working with M. Fernandez-Viña was also compiling information on Los Angeles' integration efforts.

Continuing her report, A. Ricksecker detailed some of the changes that had taken place at the Health Department level as a result of the integration workgroup. She said that routine HIV testing was now available through the TB, Hepatitis, and STD systems and that the TB system's Flick Center was now conducting rapid testing. She noted that the Health Department's Integration Workgroup was investigating ways to combine the various data sets for better service planning. A. Ricksecker also reported that the workgroup had a great deal of interest in San Francisco's consumer-driven website. N. Shein asked whether Inspot would be included in the website, noting that Philadelphia had its own Inspot site that was being updated and revamped. A. Ricksecker said that Inspot would be a part of the updated Philadelphia site, noting that the Health Department's representative from the STD system was in charge of the project. Lastly, she reported that OAS had been included in the Health Department Integration discussions and that M. Fernandez-Viña had done an inventory of the newly added system and included it in the grid. She then praised the work that M. Fernandez-Viña had done, saying that the process would be much more complicated without his tracking of the data. In closing, she told the group that she would have more information after the meeting on Friday and promised to forward the updated grid.

- **San Francisco Practices for Prevention with Positives**

N. Shein directed the group's attention to the excerpts from the draft *Prevention with Positives: Best Practices Guide*. She said that she had learned about the document at the last CAEAR Coalition meeting in San Francisco and had a copy forwarded to M. Milsop. She explained that only the table of contents and introduction had been included in the handouts to give the group a sense of the document without having to print multiple copies of the entire thing. M. Milsop noted that the timing of the document's arrival was convenient because the CPG would soon prioritize populations and the Points of Integration Workgroup would likely be the best source for information on prevention with positives.

After the group had a chance to review the introduction, N. Shein gave her support for the document, saying that it was thorough, sensibly organized, and readable. She agreed with the idea of adopting the document locally, but stressed the need for it to be introduced systematically and with training provided. A. Ricksecker informed the group that two EBIs had already been introduced locally for the purpose of prevention with positives, namely, Healthy Relationships and Ask, Screen, Intervene. She then gave her support to the best practices guide but said that the issue would be to ascertain the role of the planning bodies and the grantee in introducing the document locally. N. Shein replied that the Points of Integration Workgroup would first review the document and make any revisions they felt were necessary for it to be adopted locally. Afterwards, she continued, the group would recommend it as the guide for standard procedures of prevention with positives. M. Milsop noted that, after the group had made its revisions, the guide would then go to the CPG and the RWPC for approval before going to the Health Department for implementation.

N. Shein felt that the group would not have to put much work into revising the document because it already seemed exhaustive. She then reiterated her support for its

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implementation locally, noting that a best practices guide on the issue would help funding for both the care and prevention systems in Philadelphia. A. Ricksecker wondered whether the individuals who had created the document in San Francisco would be opposed to other jurisdictions adopting it. M. Milsop said that he would investigate the matter at the next UCHAPS meeting.

- **Next Steps/Next Meeting Date**

After discussing their schedules, the group scheduled their next meeting for Monday, April 27th, from 11:00 am – 1:00 pm.

Old Business
None

New Business
None

Announcements
None

Adjournment
The meeting was adjourned by general consensus at 10:44 am.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:
- Meeting Agenda
- Meeting Minutes (*November 25th, 2008*)
- Points of Integration Workgroup Outstanding Issues
- Excerpts from the Prevention with Positives: Best Practice Guide (draft)
- OHP Meeting Calendar

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Prevention with Positives: Best Practices Guide

DRAFT – March 16, 2009

acknowledgments

We would like to thank all who contributed to the process of developing the Prevention with Positives Best Practice Guide. Special thanks goes to the Points of Integration/Prevention with Positives workgroup members who contributed their knowledge and experience to make this guide useful. We would also like to thank the San Francisco Department of Public Health HIV Prevention Section and HIV Health Services for funding this effort and the HIV Prevention Planning Council (HPPC) and HIV Health Services Planning Council (HHSPC) for lending their support.

creating the guide

The Prevention with Positives (PwP) Best Practice Guide is intended to serve as a "tool kit" of resources and guidelines for providers and program managers working with persons living with HIV/AIDS. The creation of the Best Practice Guide involved an innovative approach that brought together HIV Prevention and Care sections, resulting in a comprehensive perspective on PwP. Providers, community members and consumers from diverse agencies and backgrounds met monthly to develop and review the content of the guide. In addition, input was gathered through a community forum held toward the end of the process. An extensive review of the existing literature and guidelines on PwP also contributed to the content (see end of document for a list of resources consulted).

This document is the result of ongoing efforts by the San Francisco Department of Public Health HIV Prevention Section and HIV Health Services to develop tools for carrying out PwP. This work builds on the work done for the 2004 HIV Prevention Plan and the 2005 "Thinking Big" document created by the 2004 and 2005 PwP committees of the San Francisco HPPC.

This guide is designed to be flexible enough to meet the needs of the many types of providers who work with HIV positive individuals, including but not limited to clinicians, case managers, health educators, peer educators, and mental health and substance use service providers. Different types of providers will engage in PwP to varying degrees depending on their level of training, comfort level and time constraints. Rather, the goal is that providers at every point of care engage in PwP to some degree, finding the appropriate place on the continuum from screening and referral, to brief interventions, to in-depth PwP counseling. Consequently, different types of providers will use the information in this guide to varying degrees.

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1. Introduction: Laying the Foundation

HIV prevention strategies need to be consistent in addressing the distinct prevention needs of HIV positive persons, and service providers working with these individuals have a significant opportunity to ensure that prevention services prioritize persons living with HIV/AIDS. In order to highlight the importance of engaging in prevention with HIV positive persons, the Centers for Disease Control and Prevention (CDC) published "Advancing HIV Prevention" (AHP) in 2003, which identified Prevention with Positives (PwP) as a key strategy for preventing new infections. Since then, the San Francisco HIV Prevention Planning Council and the HIV Health Services Planning Council have worked to draw attention to and develop goals for PwP. This Best Practice Guide is the next step in making sure providers have the tools to effectively integrate prevention into services for persons living with HIV/AIDS.

Definition: Prevention with Positives is any strategy or intervention that addresses the specific prevention needs of HIV positive persons.

The San Francisco HIV Prevention Planning Council defines the goals of PwP as follows:

1. To reduce the spread of HIV and other STDs;
2. To help HIV positive persons achieve and maintain physical, emotional, mental, sexual and reproductive health, economic stability and well-being; and
3. To assist those HIV positive persons who do not know they are positive in learning their HIV status when they are ready.

The UCSF Center for AIDS Prevention Studies states, *"HIV positive persons live with both the experience of being infected…and the tremendous responsibility of knowing that they can infect other people."* Prevention strategies for HIV positive persons can address the complexity of this responsibility through HIV education and skills-building interventions, counseling and emotional support, disclosure support, and testing and services for partners of HIV positive persons.

It is important to think of prevention broadly, from a perspective that includes STD screening and treatment, substance use and mental health assessment, and an assessment of clients'/patients' immediate concerns and associated issues including homelessness, hunger, violence and stigma. PwP services must see the whole person, not just sexual risk behaviors and drug use behaviors. PwP practices should be validating, empowering, sex positive and efficacy enhancing for

> **"HIV positive persons live with both the experience of being infected…and the tremendous responsibility of knowing that they can infect other people."**
>
> UCSF Center for AIDS Prevention Studies

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clients/patients. Services should be linguistically and culturally competent and client-centered. HIV positive persons should be involved in the planning and implementation of prevention with positives programs, and should be included in a way that is respectful of their skills and experiences and does not "tokenize" them.

Why a Best Practice Guide?

A Best Practice Guide for PwP programs is important because there is currently no common structure for PwP, and PwP needs to be implemented among providers and across provider types in a consistent, evidence-based way. The Best Practice Guide is meant to serve as a "tool kit" of resources and guidelines for providers and program managers. The guide is intended to address the prevention needs of HIV positive persons in the SF Eligible Metropolitan Area (EMA)[1] and to ensure consistency and high standards across the multiple services utilized by persons with HIV/AIDS.

The goals of this document are to provide a set of guidelines that address the following questions:

- What type of qualifications and training do providers need in order to carry out PwP?
- What interventions, activities and strategies best address the prevention needs of persons who are HIV positive?
- What needs to happen to ensure that providers, agencies and systems are ready to carry out PwP?

Overview of the document

Chapter	Description
Provider Preparedness	Identifies guidelines for provider skills and knowledge
Positive Prevention	Describes PwP interventions and strategies
Ensuring Readiness	Recommends changes to ensure agency and system readiness for PwP
Provider Resources	Provides scripts for providers based on potentially challenging situations; lists community resources and model local programs

[1] The San Francisco EMA includes the counties of San Francisco, San Mateo and Marin.

2. Provider Preparedness

As PwP continues to be integrated into diverse settings, and as the number of persons living with HIV/AIDS increases with improved medical care, greater numbers of both HIV and non-HIV service providers will be working with persons with HIV/AIDS. In order to ensure consistency and high standards across the multiple services utilized by persons with HIV/AIDS, it is necessary that providers have common knowledge, language and skills about PwP-related topics.

While different types of providers will be able to carry out PwP with clients/patients to varying degrees depending on their level of training, comfort level and time constraints, providers should be able to engage with clients/patients in discussions about sex and drug use; identify individuals who are at risk of transmitting HIV; and be familiar with existing PwP programs to enable appropriate referrals for clients/patients. This section lays out guidelines for the skill set and knowledge providers should have in order to carry out PwP, broken down into the following categories:

A. Core skills related to client/patient engagement
B. Core skills specific to PwP
C. Core knowledge of PwP-related topics

> At a minimum, all providers should be able to screen and identify individuals at risk of transmitting HIV and be familiar with community resources for those in need of further PwP services.

Providers should use the elements that are applicable based on the degree to which they will be carrying out PwP. See the *Provider Resources* chapter for examples of tools and scripts for providers.

A. Core skills related to client/patient engagement

Providers should be capable of using active listening techniques to build rapport and create a safe, trusting and comfortable environment for clients/patients using a nonjudgmental, harm reduction approach. It is also essential that providers are aware of their own comfort level, limitations and assumptions when working with HIV positive persons.

1. Allow time and space to **build rapport and trust** before delving deeper into sensitive topics.
2. Use a **harm reduction approach** by meeting clients "where they're at."
3. Use **active listening** and **motivational interviewing** techniques (see *Provider Resources* chapter for general guidelines for motivational interviewing).
4. Engage in **nonjudgmental discussion** with clients/patients. It is critical for all providers to maintain a nonjudgmental tone about situations and behaviors with HIV positive clients. Providers should be supportive, empathic, and focus on clients'/patients' strengths and resiliencies.
5. Assess the situation and the **client's comfort level** and allow the client/patient to set the limits.
6. **Keep clients/patients engaged** in prevention – "keep the spark alive" long enough to engage clients/patient and make appropriate referrals.
7. Prior to service delivery conduct a **provider self-assessment/personal inventory**. Providers should be aware of their own comfort level, limitations and assumptions when it comes to engaging in PwP.

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8. When providing services, providers should **understand and respond to clients'/patients' culture**, beliefs, language, gender identity, sexual orientation, education level and values.

B. Core skills specific to PwP

Providers should be capable of engaging with clients/patients around topics that are of particular importance and relevance for persons living with HIV/AIDS.

1. Initiate and maintain an **open dialogue around sex and drug and alcohol use**.
2. Help clients/patients make **informed decisions about HIV status disclosure**. The traditional message has been that HIV positive persons should always disclose their HIV status to their partner(s). In reality, disclosure is complex and difficult, and some individuals may not wish to disclose their status. Providers should be able to help clients/patients make informed decisions about disclosure.
3. Help clients/patients **negotiate safer sex** with their partner(s) in a way that is sex positive and sexually satisfying.
4. Educate clients/patients on **harm reduction**.
5. Address **stigma, shame and power.**
6. **Communicate medical information regarding prevention** in language that is appropriate and understandable.

C. Core knowledge of PwP-related topics

One of the goals of the PwP Best Practice Guide is to ensure that clients/patients can receive consistent responses from a variety of providers. Clients/patients should feel that they can go to any provider and either have their question answered or be referred to the appropriate place. Providers of PwP services should have common knowledge about PwP-related topics, including but not limited to the following:

1. The **continuum of risk and safety**, including "more risky" and "less risky" behaviors. The continuum cuts across the primary modes of transmission defined by the HPPC: sharing needles, unprotected insertive or receptive anal intercourse, and unprotected vaginal intercourse.
2. **Substance use as a co-factor** that increases transmission risk across all sexual risk behaviors.
3. **Basic sex education on HIV transmission** for clients who may not have this knowledge**.**
4. The relationship between **HIV and other STDs.**
5. The relationship between **viral load and HIV transmission.**
6. The relationship between **antiretroviral therapy and HIV transmission,** including the importance of medication adherence**.**
7. Awareness of **factors that may influence behavior**, including housing instability, mental health issues, substance use, incarceration, domestic violence, disempowerment, unemployment, racism, homophobia and immigration status.
8. **Community resources and referrals.** It is essential that, at a minimum, providers are knowledgeable about appropriate community resources where they may refer clients/patients who need further assistance (see *Provider Resources* section for specific resources).

3. Positive Prevention: Best Practices for PwP Interventions in Care Settings

While many prevention strategies can be carried out with either HIV positive or HIV negative individuals, persons living with HIV/AIDS have unique prevention needs. HIV positive individuals deal with distinct issues related to disclosure, stigma, medication adherence, safer sex and safer injecting. The interventions and activities in this guide aim to address these distinct prevention needs by highlighting areas for emphasis when working with HIV positive persons.

Not all HIV positive persons are in need of PwP services. It is important that providers assess each person's risk behaviors and target services to those who are at risk of transmitting HIV.

PwP interventions may be led by medical clinicians, specialists (case managers, social workers, health educators, counselors) and/or peers. Interventions can be implemented at the individual, group, community and system level. [2]

- **Individual level interventions** are activities conducted one-on-one between a provider and a client/patient for one or more sessions. Individual-level interventions are best used to increase self efficacy, teach specific skills, coach clients/patients around sexual communication or negotiation, identify barriers to behavior change, or identify specific activities that a client/patient can adopt to reduce risk. The effectiveness of interventions tends to increase as the duration and number of sessions increases.
- **Group level interventions** are activities conducted between a provider and at a minimum three clients. Group level interventions tend to be skills-based. Depending on the goal of the intervention, smaller groups of 10 or fewer clients may be more effective than larger groups in increasing self-efficacy, skills, or social support for risk reduction behaviors. Interventions conducted in larger group settings such as classrooms may be effective in influencing peer pressure or changing personal perceptions of risk. Interventions that consist of multiple sessions have a greater likelihood of being successful. (add something about how effectiveness of group interventions compares to individual level?)
- **Community level interventions** are directed at a specific priority population or community and aim to bring about changes by addressing norms regarding knowledge, attitudes or behaviors.
- **System level interventions** aim to improve outcomes for individuals by implementing changes that influence the overall system of care.

PwP services should have clearly defined target audiences and should include multiple components that look at the whole person, not just sexual risk behaviors and drug use behaviors. Relationships, employment, health care, housing, stigma and discrimination should be addressed as needed. PwP services should be empowering, sex positive and efficacy enhancing for clients/patients. Services should involve HIV positive persons in planning and implementation and should be client-centered and linguistically and culturally competent.

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The following sections of this chapter provide descriptions and implementation recommendations for key PwP interventions and activities. The interventions and activities included here are not meant to be used in isolation, but instead can and should be mixed and matched according to the specific needs of the populations being served.

Many interventions are similar when working with high-risk individuals regardless of their serostatus. In order to help providers focus on PwP, the interventions in this section draw attention to key areas to emphasize when working with HIV positive persons. You will see this under the headings **"Areas for emphasis"** or **"Implementation tips."**

In addition, note that under the heading for each intervention there is a list of the most appropriate providers for the intervention. Providers are not expected to carry out all of the interventions described in this chapter. As mentioned previously, different types of providers will engage in PwP to different degrees and as such will select the interventions/activities that are relevant and useful. If a provider does not have the necessary skills and training to carry out a particular intervention, he/she should refer the client to an appropriate community resource.

PwP Interventions and Intervention Type

PwP Interventions, Activities and Strategies	**Intervention Type**			
	Individual	Group	Community	System
HIV transmission risk assessment (p. 8)	✓			
HIV and health education (p. 9)	✓	✓		
STD screening and treatment (p. 10)	✓			
Disclosure assistance and partner services (p. 11)	✓			
Medication adherence (p. 12)	✓			
Skills building (p. 13)	✓	✓		
Assessment and referral for mental health and substance use services (p. 14)	✓			
Individual risk reduction counseling (IRRC) and Prevention case management (PCM) (p. 15)	✓			
Curriculum-based group workshops or sessions (multiple session workshops or single session groups) (p. 16)		✓		
Social marketing/community education (p. 17)			✓	
Social events (p. 18)		✓	✓	
Integrate PWP Interventions into primary care settings (p. 19)				✓
Integrate PWP Interventions into supportive services (p. 20)				✓

[2] Descriptions of Individual, Group and Community Level Interventions are taken from the CA STD/HIV Prevention Training Center

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PwP Interventions by Provider Type

Provider type	PwP Interventions, Activities and Strategies
Medical providers	▪ HIV transmission risk assessment (p. 8) ▪ HIV and health education (p. 9) ▪ STD screening and treatment (p. 10) ▪ Disclosure assistance and partner services (p. 11) ▪ Medication adherence (p. 12) ▪ Skills building (p. 13) ▪ Assessment and referral for mental health and substance use services (p. 14)
Case managers/social workers	▪ HIV transmission risk assessment (p. 8) ▪ HIV and health education (p. 9) ▪ Disclosure assistance and partner services (p. 11) ▪ Medication adherence (p. 12) ▪ Skills building (p. 13) ▪ Assessment and referral for mental health and substance use services (p. 14) ▪ IRRC and PCM (p. 15) ▪ Curriculum-based group workshops (p. 16)
Health educators/peer educators	▪ HIV transmission risk assessment (p. 8) ▪ HIV and health education (p. 9) ▪ Disclosure assistance and partner services (p. 11) ▪ Medication adherence (p. 12) ▪ Skills building (p. 13) ▪ Assessment and referral for mental health and substance use services (p. 14) ▪ Curriculum-based group workshops (p. 15)
PwP counselors	▪ HIV transmission risk assessment (p. 8) ▪ HIV and health education (p. 9) ▪ Disclosure assistance and partner services (p. 11) ▪ Medication adherence (p. 12) ▪ Skills building (p. 13) ▪ Assessment and referral for mental health and substance use services (p. 14) ▪ IRRC and PCM (p. 15) ▪ Curriculum-based group workshops (p. 16)
Counseling and testing staff	▪ HIV transmission risk assessment (p. 8) ▪ Disclosure assistance and partner services (p. 11) ▪ Medication adherence (p. 12) ▪ Assessment and referral for mental health and substance use services (p. 14)
Mental health and substance use providers	▪ HIV transmission risk assessment (p. 8) ▪ HIV and health education (p. 9) ▪ Disclosure assistance and partner services (p. 11) ▪ Medication adherence (p. 12) ▪ Skills building (p. 13) ▪ Assessment and referral for mental health and substance use services (p. 14) ▪ IRRC and PCM (p. 15) ▪ Curriculum-based group workshops (p. 16)
Vocational rehabilitation counselors	▪ HIV transmission risk assessment (p. 8) ▪ HIV and health education (p. 9) ▪ Disclosure assistance and partner services (p. 11) ▪ Medication adherence (p. 12) ▪ Skills building (p. 13) ▪ Assessment and referral for mental health and substance use services (p. 14)

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HIV Transmission Risk Assessment

Appropriate providers

- Medical providers
- Case managers/social workers
- Health educators/Peer educators
- PwP counselors
- Counseling and testing staff
- Mental health and substance use providers
- Vocational rehabilitation counselors

HIV transmission risk assessment helps identify individuals who are at risk for transmission and might need further PwP services. The risk assessment process can also help reduce rates of infection through prevention messaging and developing risk reduction strategies.

Components

- The assessment should address those behaviors or characteristics directly linked to transmission including serostatus of partners, number of partners, substance use (including injection and noninjection drugs and alcohol use) and viral load.
- The assessment should also address clients'/patients' immediate concerns and associated issues such as violence, homelessness, hunger, disempowerment, and other basic needs that may be a higher priority for the client/patient.

Implementation tips

- Providers should adopt HIV transmission risk assessment during intake or when taking routine history with new patients.
- Assessment should be conducted twice a year (according to the CDC and the State of California) by multiple providers.
- Agencies should use standardized assessment tools (see *Provider Resources* chapter for examples).
- Providers should discuss clients'/patients' PwP needs in multidisciplinary case conferencing.
- Providers should address questions in a gender- or sexuality-specific context wherever possible.

Providers should be able to screen, identify and refer clients/patients at risk for transmission. Providers should only conduct risk assessments if they are able to develop a sense of trust and familiarity with clients and engage in conversations about sensitive topics.

Provider Notes and Resources

- All types of providers can do some sort of HIV risk assessment – whether it be a quick screening or a more in-depth assessment.
- Medical providers can do a quick 5-minute assessment to identify patients at risk of transmission (see *Provider Resources* chapter for sample questions).
- Providers who work more in-depth with clients (such as case managers, social workers or PwP counselors) can tease out more complex issues with a longer assessment (see *Provider Resources* chapter for sample questions).

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HIV and Health Education

Appropriate providers

- Medical providers
- Case managers/social workers
- Health educators/Peer educators
- PwP counselors
- Mental health and substance use providers
- Vocational rehabilitation counselors

Many types of providers can provide some sort of HIV and/or health education, including medical providers, case managers/social workers, health educators and peer educators – whether it be brief prevention messaging or a more in-depth education session.

Providing brief transmission prevention information in routine medical visits is something that **medical providers** can do with very limited time.

Components

Provide HIV and health education on topics including:

- Basic HIV and other STD symptoms and transmission;
- The relationship between HIV and other STD transmission/susceptibility;
- The relationship between viral load and HIV transmission;
- The relationship between antiretroviral therapy and HIV transmission;
- Possible interaction between Hepatitis C treatment and antiretroviral medications
- Importance of medication adherence and potential barriers to maintenance of treatment (e.g., mental health issues, substance use);
- Substance use, including injection/non-injection drug use and alcohol use;
- Promoting healthy, fulfilling sexuality and affirming the sexual and reproductive rights of people living with HIV;
- Education about the hierarchy of risk and safer sex without barriers; and
- Family planning education.

Implementation tips

- Providers should be able to effectively determine the extent of clients'/patients' knowledge of HIV and provide appropriate education.
- Providers should be able to explain complex medical information in language understandable to their clients/patients.
- Providers should take into account clients' culture, gender and sexuality when providing services. For example, providers should be sensitive to the needs of HIV positive women and men who might want to have children or HIV positive women who are pregnant. Providers should also use appropriate language and pronouns when providing services to transgender individuals.

Provider Notes and Resources

- Add?

STD Screening and Treatment

Appropriate providers

- Medical providers
- Medical intake staff

There is substantial biological evidence that the presence of STDs increases the likelihood of both transmitting and acquiring HIV. Because of the link between HIV and STD transmission/susceptibility, all HIV positive persons should receive comprehensive STD screening and treatment.

Components

- Conduct STD screening and treatment for syphilis, gonorrhea and chlamydia.
- Provide education about HIV and STDs and the link between STDs and HIV transmission/susceptibility.
- Encourage screening and treatment for sexual partners of HIV positive individuals.

The recommended frequency of STD screening will depend on each patient's sexual risk behaviors.

Implementation tips

- Ensure baseline STD screening for all HIV positive patients, including screening for syphilis, gonorrhea and chlamydia of the throat, rectum, urethra or vagina.
- Follow-up screenings should be performed every 3-6 months, depending on patient's sexual activity and number of partners. (check consistency with CDC guidelines)
- Screen for STDs in symptomatic and asymptomatic individuals.
- Provide prompt STD treatment.
- Encourage screening and treatment for sexual partners of HIV positive individuals, and provide partners with referral information to San Francisco City Clinic.
- Providers should orient patients to public health policies regarding chlamydia, gonorrhea and syphilis. Patients who are positive for any of these three STDs will be asked to disclose the name(s) of their sexual partner(s). Partners of patients who test positive for syphilis will be contacted directly by City Clinic in order to ensure prompt treatment. (add note about what is providers' legal responsibility?)

Provider Notes and Resources

- In San Francisco, partners of patients with an STD can be referred to City Clinic: (phone number)
- Patients can go to www.inspot.org to notify their partners anonymously that they may have been infected with an STD.
- Individuals can go to www.stdtest.org to take an online quiz, get recommendations on the types of STD tests they should take, and download a lab slip for the tests.
- For more information on the CDC STD screening standards, see: (website)

Disclosure Assistance & Partner Services

Appropriate providers

- Medical providers
- Case managers/social workers
- Health educators/Peer educators
- PwP counselors
- Counseling and testing staff
- Mental health and substance use providers
- Vocational rehabilitation counselors

HIV status disclosure assistance and partner services should be included in all PwP interventions and should include the following components.

Components

- Help clients/patients make informed decisions about disclosure.
- Introduce partner notification options, including self disclosure, dual disclosure, third party disclosure and in-spot (see text box at right).
- Help clients/patients learn to negotiate safer sex whether or not they choose to disclose their status to their partner(s).
- Provide support and/or referrals to address issues surrounding stigma, shame and fear of disclosure, including fear of violence.

Self-Disclosure: The client will disclose his/her status to partners independently. A counselor will offer coaching or other assistance as appropriate.

Dual Disclosure: The client will disclose his/her status to partners in the presence of a counselor or another third party.

Anonymous 3rd Party Notification: Trained field staff at City Clinic will provide anonymous notification to partners. The HIV positive person who named the partner(s) will never be identified.

Anonymous Web-Based Disclosure: A client will go online to www.inspot.org and send e-postcards to his or her partners alerting the recipient that they may have been exposed to HIV or STDs and should be tested.

Implementation tips

- Introduce the topic of disclosure. Discuss why disclosure is important and beneficial for clients/patients, as well as different types of disclosure, including disclosure to sexual partners, family members and medical providers.
- Introduce partner notification options and encourage partners to get tested.
- Try to identify clients'/patients' motivation for disclosure (e.g., self protective, altruistic).
- Understand how clients'/patients' culture might influence their decision to disclose their status.

Examples of fear of disclosure

- Discrimination or rejection by partners, family, friends or coworkers
- Domestic violence
- Losing employment

Provider Notes and Resources

- See *Provider Scripts* section; hivdisclosure.org
- Provide City Clinic info for partner services

Medication Adherence

Appropriate providers

- Medical providers
- Case managers/social workers
- Health educators/Peer educators
- PwP counselors
- Counseling and testing staff
- Mental health and substance use providers
- Vocational rehabilitation counselors

Medication adherence is a vital aspect of prevention with positives. All types of providers should include conversations and messaging about medication adherence with their clients/patients.

Components

- Discuss the importance of medication adherence.
- Discuss possible barriers or challenges to adherence that clients/patients may face.
- Discuss possible ways to overcome barriers to adherence or refer client to further counseling.

Implementation tips

- Introduce the topic of medication adherence. Discuss why adherence is medically important and beneficial for clients/patients.
- Try to identify barriers to adherence for clients/patients, including social, emotional, economic, cultural and medical barriers.
- Discuss possible ways or tips for dealing with barriers to adherence, or refer client/patient to further counseling.

Possible Barriers to Medication Adherence

-Not having disclosed HIV status to work colleagues, friends, lovers, or family

-Active substance use

-Depression

-Current or past problems with side effects

-Cultural beliefs

-Lack of health insurance

-Homelessness

-Other life stresses, such as employment, dating and relationships, or childcare

Provider Notes and Resources

- Add?

Skills Building

Appropriate providers

- Medical providers
- Case managers/social workers
- Health educators/Peer educators
- PwP counselors
- Mental health and substance use providers
- Vocational rehabilitation counselors

Skills building activities are interactive exercises that promote and reinforce safe behavior. They provide an opportunity for clients/patients to learn and practice skills and gain confidence in their ability to use those skills.

Components

Teach negotiation and communication skills regarding:

- **Disclosure.** Disclosure or non-disclosure to sexual partners, family, co-workers, medical providers and other providers (see *Disclosure Assistance and Partner Services* section above).
- **Safer sex/harm reduction.** Barrier use, lubrication and withdrawal, and seroadaptation.[3]
- **Safer drug use/harm reduction.** Safer injecting, syringe access, and reducing use.
- **Interpersonal communication.** Dating, maintaining intimacy in relationships, domestic violence, and developing communication skills such as negotiating safe sex with partners.

Implementation tips

- Send clients/patients to places where they can practice the skills they need to use
- Others?

Provider Notes and Resources

- If time, medical providers can engage in brief skill building; otherwise they can identify and refer patients to additional PwP services.
- For more on syringe access and contact information for syringe access programs see Syringe Access Guidelines – http://www.sfhiv.org/syringe.php
- Add STOP AIDS and other referrals

[3] Seroadaptation includes a range of HIV risk reduction practices and refers to the selection of sexual partners, sexual practices and sexual positioning based on one's own and one's partner's known or assumed serostatus, in order to reduce the risk of contracting and/or transmitting HIV. This definition of seroadaptation was approved by the 2007 POI committee of the HPPC.

Assessment and Referral for Mental Health and Substance Use Services

Appropriate providers

- Medical providers
- Case managers/social workers
- Health educators/Peer educators
- PwP counselors
- Counseling and testing staff
- Mental health and substance use providers
- Vocational rehabilitation counselors

Assessment and referral for mental health and substance use services is essential in all PwP interventions.

Mental health services: Counseling and support groups can be important components of HIV prevention for persons with HIV. Mental health services can address issues related to depression, anxiety, trauma, stress, substance use, and sexual impulsivity.

Substance use services: Substance use counseling and/or treatment is an essential element of prevention for HIV positive individuals. This includes counseling and treatment for substance use, including alcohol, and counseling around safer drug use behaviors and syringe access.

Components

- Assess whether client/patient is in need of and open to receiving additional mental health and/or substance use services.
- Refer to appropriate services.

Implementation tips

- In all provider visits, conduct a basic assessment of client's/patient's need for mental health and/or substance use services.
- Consider the role of client's/patient's culture and other possible stigma related to accessing mental health services.
- Respect clients'/patients' right to refuse services and if appropriate come up with beneficial alternatives (e.g., church, spiritual healing).
- Conduct follow-up and reassessment with clients/patients.

Provider Notes and Resources

- All providers can assess basic needs of client related to mental health and substance use.
- Providers should be familiar with community resources to refer clients in need of services.
- Only trained professionals should provide mental health and substance use services.

Individual Risk Reduction Counseling (IRRC) & Prevention Case Management (PCM)

Appropriate providers

- Case managers/social workers
- Mental health and substance use providers
- PwP counselors

Historically these models have been used with high-risk HIV negative persons. These models have been tested and can be used with HIV positive persons as well.

IRRC: Individual Risk Reduction Counseling is an approved intervention in the San Francisco HIV Prevention Plan. It is a time-limited intervention designed to assess clients' personal perception of risk; the context in which risk behaviors occur; barriers to reducing risk; and clients' level of readiness to change risk behaviors. If a client's needs extend past five sessions, the client should be referred to a mental health specialist or to Prevention Case Management.

PCM: Prevention Case Management is an approved intervention in the San Francisco HIV Prevention Plan. PCM is a hybrid of risk-reduction counseling and traditional case management that promotes the adoption and maintenance of HIV risk-reduction behaviors. PCM is a more intensive, longer-term intervention than IRRC that is designed for high-risk clients who often have co-occurring disorders (mental health and/or substance use).

Components

- HIV/STD information and education (*see HIV and Health Education*)
- Discussion of risk behaviors and development of realistic risk reduction steps
- Counseling
- Skills building (see *Skills Building*)
- Assessment of client's readiness and motivation to change their behavior
- Written risk reduction plan
- Referrals to appropriate health and social services

Areas for emphasis

- Disclosure assistance (see *Disclosure Assistance and Partner Services*)
- Assess issues related to shame and stigma
- Assess whether client is combining sex with drugs/alcohol

Provider Notes and Resources

- Add?

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Curriculum-Based Group Workshops

Appropriate providers

- Case managers/social workers
- Health educators/Peer educators
- PwP counselors
- Mental health and substance use providers

Group workshops are a pragmatic, cost-effective tool for reaching many people at once with prevention messaging. Groups tend to be skills-based and have demonstrated effectiveness at reducing a variety of sexual risk behaviors. Groups also allow providers to potentially recruit patients into medical care and/or prevention care. Curriculum-based group workshops are versatile because the content can be tailored to almost any population.

Components

- **Multiple session workshops (MSWs)** or **single session groups (SSGs)** focus on information about HIV, motivational activities, skills-building, self-esteem issues, and social support.
- A group or workshop can also be an intervention in and of itself for the purpose of community building.

Implementation tips

- For HIV positive individuals, groups should be sure to address issues related to stigma and discrimination and skills-building related to disclosure, safer sex and safer injecting.
- Multiple session workshops have been shown to more effective than single session groups. Single session groups should only be used when multiple sessions are not feasible due to cost or when clients are unlikely to attend multiple sessions.
- Group workshops can be implemented as planned or drop-in groups.
- Groups might be less effective with populations that have mental health issues or populations that are less likely to disclose or discuss their risk behaviors.
- Smaller groups of 10 or fewer clients may be more effective in increasing self-efficacy, skills, or social support for risk reduction behaviors, while interventions conducted in larger group settings such as classrooms may be effective in changing personal perceptions of risk.

Provider Notes and Resources

- Add?

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Social Marketing & Community Education

Appropriate providers

- Prevention programs with an HIV education component

Social marketing and community education activities are directed at a specific priority population or community and aim to bring about changes by addressing norms regarding knowledge, attitudes or behaviors.

Components

- Community outreach activities
- Community events
- Media geared toward specific communities.

Areas for emphasis

- For HIV positive individuals, social marketing and community education might address:
  - Stigma and discrimination
  - Issues related to HIV status disclosure
  - The relationship between viral load and HIV transmission and the importance of medication adherence
  - The relationship between HIV and STD transmission/susceptibility and the importance of getting screened/treated for STDs

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Social Events

Appropriate providers

- Prevention programs with an HIV education component

A number of HIV prevention programs incorporate social events as a way to increase the sense of community among program participants, offer HIV prevention education, and allow persons with HIV to socialize in an accepting, safe environment.

> The effectiveness of social events in reducing new HIV infections has not been proven, but many HIV prevention programs include social events as a way to promote HIV education and community building.

Components

- Socialization
- HIV prevention education

Implementation tips

- Events are best geared toward a specific group (e.g., Latino MSM, African American women, or youth).
- Events can combine educational presentations with socialization.
- Social events are not meant to be a stand-alone intervention; rather they are meant to be combined with other PwP interventions and activities.
- Keep in mind the influence the culture of program participants might have on the structure of social events. For example, consider how a social event for Latina women would look different from an event for African American MSM.

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System-Wide Strategies

This Best Practice Guide was developed in part because PwP is not consistently incorporated into the various systems that serve persons living with HIV/AIDS. The following system-wide strategies aim to influence the overall system of care by promoting the integration of prevention into systems serving HIV positive persons.

Integrate PwP into Primary Care Settings

While medical providers will not likely carry out time intensive PwP services, medical providers in busy medical practices have the opportunity to address the prevention needs of HIV positive persons by conducting brief risk assessments and prevention messaging, and by identifying individuals in need of further PwP services.

RECOMMENDATIONS

- Ensure that medical providers have the skills and tools to identify and refer patients to PwP services as needed, and make sure medical providers have PwP-related materials to hand out to their patients.
- Studies have indicated that there are effective, brief risk assessments that medical providers can carry out (see *Provider Resources* chapter).
- Include brief transmission prevention information in routine visits to medical providers – something that medical providers can do with very limited time.

Integrate PwP into Supportive Services

Providers of supportive services play an important role in addressing the prevention needs of HIV positive individuals, but are not consistently incorporating prevention messages into their work.

RECOMMENDATIONS

- Integrate PwP into service settings such as:
  - Medical treatment for non-HIV related medical conditions
  - Mental health services (including individual counseling and support groups)
  - Substance use services
  - Syringe exchange
  - Provision of housing
  - Provision of food
  - Vocational rehabilitation
  - Alternative healing (including holistic treatment, alternative medicine, traditional healing, and spiritual counseling)
- Ensure that providers of support services are adequately trained to engage in PwP with clients (see *Provider Preparedness* section).
- Ensure that providers of other support services are familiar with referral resources and processes.

4. Ensuring Readiness: Creating an Effective PwP System

In order for providers to be able to carry out Prevention with Positives, certain agency and system-wide structures need to be in place. This chapter looks at the concept of "PwP readiness" and lays out recommendations at the provider/agency, system, and Department of Public Health levels.

- **Agency/Provider Readiness:** What are the necessary steps to ensure that individual agencies or providers can effectively carry out PwP interventions?
- **System Readiness:** What are the necessary steps and/or structural changes to ensure that the service system supports PwP?
- **Department of Public Health:** What changes need to happen at the DPH level to support PwP practices?

Agency/Provider Readiness

Staffing and Training

- **Assess staff capacity**: Agencies and/or providers should determine whether they have adequate capacity to carry out PWP interventions with identified target populations, and if not, what steps need to be taken to ensure providers are equipped.
- **Ensure necessary provider training (internal or external):** Different types of training will be necessary depending on the needs of the provider and the planned intervention(s). Medical providers may need more training about client/patient engagement, while non-medical providers (including case managers, mental health and substance use service providers) may need more training related to the medical aspects of HIV prevention. See the *Provider Preparedness* chapter for standards related to provider skills and knowledge. See the *Provider Resources* chapter for a list of existing training resources. Agencies/providers should assess the need for training in the following areas:

    1. Incorporating HIV prevention messaging into patients' medical visits.
    2. Speaking with patients about sexual risk behaviors and drug use behaviors, and giving explanations in simple, everyday language.
    3. Working with clients/patients who have co-occurring disorders (mental health/substance use).
    4. Staying current with the science of HIV transmission and new prevention technologies and interventions.
    5. Becoming familiar with underlying causes of and concerns related to risk behaviors among HIV positive persons.
    6. Implementing behavioral counseling approaches to support patients in reducing HIV/STD transmission, such as client-centered counseling, motivational interviewing, stage-based counseling, and risk reduction/harm reduction counseling.

7. Exploring issues around disclosure, stigma and client/patient empowerment.
8. Understanding the relationship between STD and HIV transmission/susceptibility.
9. Understanding the impact of viral load and antiretroviral treatment on transmission and susceptibility and the importance of medication adherence.
10. Understanding addiction issues (including substance use, sexual compulsivity, among others).
11. Working with clients/patients from different cultures and understanding the influence of culture both in terms of prevention related issues as well as the provider relationship.
12. Knowing community resources that address risk reduction.

- **Designate a PwP point-person:** A PwP point-person/advocate can serve as a "champion for PwP," promoting PwP practices and ensuring that providers receive ongoing training about PwP approaches and that PWP becomes an integrated practice among providers. However, it is important to ensure that the burden of carrying out PwP services does not fall all on one person and that staff have sufficient support.
- **Consider PwP experience when hiring:** Look for candidates with PwP experience when hiring new staff or when replacing staff due to turnover.

Relationships with other service providers

- **Establish formal relationships:** Agencies should strengthen relationships and referral processes with prevention, care and other support service providers.

System Readiness

Interagency collaboration and referral networks

- **Establish networks and referrals:** Establishing network relations and an effective provider referral process is critical to linking patients to medical, mental health, substance use and other services.
- **Engage in multidisciplinary case conferencing:** A client/patient may offer different information to different providers, and a client's/patient's comfort level may increase as he/she continues to see a provider regularly. Case conferencing with a multi-disciplinary team of providers ensures communication between providers and helps providers best serve their clients/patients. This approach should be considered both within and across agencies, provided that the client/patient has authorized this through a release of information.

Department of Public Health

- **Integrate prevention and care services.** Create bridges between prevention and care services to facilitate networking, referrals and a smooth system of care for clients/patients.
  Note: Standards of Care for linkage from HIV testing to care are currently being developed.
- **Strengthen linkages between different service systems**. Integrate STD and HIV testing and screening, ensuring that STD testing sites offer HIV testing and vice versa.
- **Ensure that agencies/providers have adequate funding to engage in PwP.**
- **Consider developing Standards of Care for Prevention with Positives.** The next step after developing a Best Practice Guide is to create Standards of Care, which would outline requirements for Prevention with Positives programs carried out by DPH-contracted agencies.

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5. Provider Resources

Useful literature and websites

- California STD/HIV Training Center: http://stdhivtraining.org/
- The Role of STD Detection and Treatment in HIV Prevention - CDC Fact Sheet: http://www.cdc.gov/std/hiv/STDFact-STD&HIV.htm
- San Francisco HIV Prevention Section: www.sfhiv.org
- Inspot.org
- Hivdisclosure.org
- Stdtest.org
- Vocational rehabilitation: Positive Resource Center
- Others?

Training

- California STD/HIV Training Center – http://stdhivtraining.org/
- AHP training (if still funded…)
- Others?

Local programs and contact information

+SHE program

Shanti LIFE program

PLUS seminars from Stop AIDS Project

Aguilas extended programs

Others?

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Provider Scripts

Some providers who are looking to incorporate PwP into their practice might not know exactly where to begin, or might feel unsure about how to bring up certain topics. The scripts and guidelines in this section are designed to give you ideas for how to start prevention-related conversations with your clients/patients.

1. Beginning the Conversation

- You can be open and comfortable about your intention to discuss sex and prevention.
- Be non-judgmental, compassionate, and curious.
- Be specific when discussing sexual behaviors.
- Don't overreact if risk behavior is described.
- Be satisfied just by uncovering risk behavior; dealing with it can happen over time.

Sample Scripts

- Acknowledge that it can be very difficult to navigate sex as an HIV+ person
- *"I ask all of my patients how they are handling sex and relationships as a positive person. How is it going for you?"*

- Elicit the patients' goals about preventing transmission
- *"How important is it for you to prevent your partners from getting HIV?"*

- Ask about strategies used to prevent transmission
- *"Do you have rules that you use to help you and your partners stay safe?"*

- Discuss risk behavior
- *"When was the last time you broke one of your rules? Can you tell me about it?*

2. Disclosure/non-disclosure

The following are some examples of ways to talk with clients/patients about the issue of disclosure.

Sample Scripts

- *"Do you want to tell someone you have HIV?"*
- *"Who do you want to tell?"*
- *"Telling can be really difficult. Do you struggle with it? Can I help?"*
- *"How do you think they will react when you tell them? Have you thought about that? What is the worst thing that could happen?"*
- *"Do you want to practice, with me, what you are going to say to the person when you tell them?"*
- *"Okay what is your plan – who, where, when, what you are going to say?"*

3. Safer sex without barriers and negotiating safer sex

This conversation can be difficult for a provider; learning that a client is not 100% safe can alter a client/provider relationship. An open dialog can help a lot. Providers often fear this conversation because they feel they are giving permission to clients to have sex without condoms. The reality is clients sometimes do this and sometimes with the wrong information. Oftentimes clients have the right information but could still use support in maintaining healthy behavior.

- *“Condom use is not the only way to prevent infecting others – what do you know about preventing HIV other than condoms?”*
- *“How often are your sexual partners positives. Do you ask them? How do you ask them?”*
- *“There are lots of ways to have sex: oral, vaginal, anal, and each has different risks. For example, oral sex is very low risk for transmitting HIV, so some folks will have only oral sex with new partners.”*
- *“What do you know about reducing risk to a partner when not using condoms? For example, being a bottom for anal sex puts a person more at risk for HIV than being a top. Therefore, if you are positive and you want to reduce your partner’s chance of becoming infected it is less risky to the partner if are the bottom.”*
- *“So you don’t use condoms when you top, do you come inside your partner(s)? Not cumming inside them does a lot to reduce infecting them, but it does not eliminate the risk. Using lube can also help reduce risk when having anal sex. Is this something you knew?”*

4. Enhancing Safety

HIV risk reduction often includes “negative” language (e.g., “reduce” and “risk” versus “enhance” and “safety”). For some clients the use of more positive language can help to reframe the experience of talking about HIV transmission. Reframing can foster client self empowerment and reduce stigma, shame and client perceptions of provider judgment. It is also important to focus on attaining both safety goals and pleasure goals. From this perspective, discussions about enhancing sexual and physical safety are not neutral but rather sex positive.

Sample Scripts

- *“I'm wondering what "safe sex" means to you.” (Pause for response) “How do your ideas about safe sex influence your getting pleasurable sex?”*
- *“What are your goals around your sexual pleasure?”*
- *“What are your goals around sexual safety?”*
- *“How do you combine sexual pleasure and safety?”*
- *“I'm wondering about what is pleasurable sex for you? Where does sexual health and safety fit into these ideas?”*
- *“What pleasure successes have you had in having sex with others that HIV negative or unknown status?”*

- *"What safety successes have you had in having sex with others that are HIV negative or unknown status?"*
- *"How do you get both pleasure and safety goals met?"*
- *"Has anyone ever forced you to have sex or sexual activity that you didn't want to have?"*
- *"Have you ever been emotionally or physically abused by a partner or someone close to you?"*

5. Condom Use

The following are some tips for working with clients/patients who may indicate that they do not use or do not want to use condoms.

Sample Scripts

- *"Tell me about what you do to have safer sex with partners. I know that not all people find it pleasurable or practical to always use condoms. Do you feel like that? If so – are there other strategies you have considered or are using?"*
- Elicit whether lack of condom use is due to a desire for physical or emotional closeness with partner, inconvenience, interruption of sex or other cause – which may leave room for further discussion.
- *"I heard you say earlier that you don't use condoms. Many patients here in clinic say the same thing. Can you tell me more about what you don't like about them?"*

6. Condom use and undetectable viral load

The following are some examples of ways to talk with clients/patients who may indicate that they do not want to use condoms because they have an undetectable viral load.

Sample Scripts

- *"You are doing very well on your ARV regimen, with an undetectable viral load. This is great! You may know that having a very low viral load decreases the risk of transmitting HIV to partners, but we still cannot guarantee that it is 100% risk-free. Have you heard about this from friends or elsewhere? How do you think it will impact the decisions you make about sex?"*
- *"Some clients/patients tell me that they take their viral load results into account when deciding about sex. What do you think? Do you have any questions about this?" (Then explain viral 'blips' can occur due to vaccination, systemic illness, STDs, or normal variation.)*
- *[More general] "What are the approaches you are taking to protect your health and the health of your sex partners? There are no right or wrong answers, but talking about it today may generate ideas to maximize the good steps you are already taking."*
- *"Here is what we know now about viral load and HIV transmission: Undetectable viral load is associated with less transmission but not zero transmission. The thing to consider is that we don't know*

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everything. Are you willing to live with the consequences if it turns out an undetectable viral load does not stop transmission to your partner?"

7. Sexual compulsivity

Societal stigma against sexuality, including the type of sexual experience, frequency of encounters and partner selection has created additional barriers for service providers to assist clients. Stigma often impedes clients from understanding their motivations and from feeling empowered to make changes in their sexual behavior. Providers may get a strong sense that a patient's sexual behavior is not resulting in fulfillment but rather in negative emotional experiences and/or self injurious behavior. These negative outcomes for the clients often seem similar to addictive or compulsive behavior.

The primary models of "sexual compulsivity" are derived from either a medical model of addiction to substances or psychiatric models of compulsions. Both of these theoretical approaches focus on the diagnosis and treatment of an "illness". Intervening when there is a concern about sexual compulsivity can be very challenging. Given the historical realities of many populations disproportionately affected by HIV and mental health and substance abuse co-morbidities, clients may experience interventions based on these models as stigmatizing, sex negative, judgmental and/or homophobic. It is very important to address client perceptions of provider judgment and intervene in ways that support the client and build trust and open and honest dialogue.

Sample Scripts

- *"I notice that you are having frequent sexual encounters. Yet you seem to be saying that your desires, needs and hopes are not being met through these encounters. If I got that right, what is missing for you that you are looking for and not getting?"*
- *"How do you feel about the amount and type of sex that you are having?"*
- *"How in control of your sex life do you feel?"*
- *"What kind of support would help you have the kind of sex that you want?"*
- *"I am concerned about two things that seem in opposition to one another. On the one hand that what I want to ask you might give you the feeling that I am judging you. On the other hand I feel that if I don't ask I won't have honestly shared with you my concern for your well being. Is it o.k. with you for me to ask?" (Pause for client's answer). "The way you describe sexual experiences makes me question if you have a sexual addiction. Would it be ok with you to explore this idea with me?"*
- *"I am concerned. It sounds to me like your sex life is running you instead of the other way round. What do you think?"*
- *"What do you give up in order to spend time looking for and having sex?" (Pause, and if no answer add:) "Some examples of things that other clients share that they felt needed more of their focus included spending time with friends, maintaining their home, exercise, and work responsibilities."*
- *"How would you feel about taking some referrals to a twelve step group such as Sex and Love Addicts Anonymous or to a therapist to explore this issue further?"*

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8. PWP issues specific to vulnerable populations (e.g., women, transgender individuals, sex workers)

- Acknowledge that many people may not feel safe discussing their HIV status and HIV prevention with their partner(s).
- *"Do you feel safe discussing your HIV status with your partner(s)? Are you comfortable talking about ways to have sex safely?"*

- Acknowledge that many men are not interested in protecting themselves, even when they are aware of their partner's status.
- *"Do your partner(s) have the same interest in protecting themselves as you do in protecting them? Are you comfortable with their choices?"*

- Ask about sex work and how it may affect safe sex choices.
- *"Can I ask if you have ever traded sex for money, drugs or something else? Did those situations make it harder to disclose your HIV status or to have safer sex? Can you tell me more about some difficult situations you have faced doing sex work?"*

9. Closing the session

Given time and professional role constraints it is often necessary to conduct an appointment in a fairly brief time frame. Often discussion related to sex takes more time than can be allotted in one appointment. At times a care provider's role is necessarily limited to opening a discussion and then referring the client to another provider. In all circumstances it is important to distinguish between ending a session and concluding the conversation forever. Effective interventions to close a given session do one or more of the following:

1) Demonstrate the provider's interest to continue to support the client;
2) Focus on developing a plan or strategy with the client or summate a plan or strategy if one has been developed;
3) Reference continuing the conversation at a later date;
4) Provide referrals for immediate and/or ongoing support.

Sample Scripts

- *"I am glad that we are having this conversation and that you have opened up to me. We have a few minutes left today. Could we take a moment to review the strategies that you have developed and plan to talk about this some more at your next scheduled visit?"*
- *"You have brought up a number of very important issues that I want you to get support to explore. We have a staff person who I feel confident would be a good person to connect you with. This is her area of expertise. Could I have an appointment set up for you?"* (Pause for client's response) *"I'd check back with you to see how it went at our next appointment."*
- *"So we have about ten minutes left today. Let's take a moment to sum up the ideas we've come up with and then make a plan."*

Glossary

In progress. Make sure to include:

Harm reduction
Motivational interviewing
ARVs
PCM
IRRC
Sexual compulsivity