opendoor
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VOLUME 8 ISSUE 12

DECEMBER

NEWS & VIEWS

ELENA WELCOME TO OPEN DOOR

Name: Elena Alvarado
Title: Medical Case Manager

What did you do before coming to Open Door? Before coming to Open DoorI was earning my masters degree in social work from Aurora University. I also interned as case manager at Outreach Community Center in Carol Stream and as a clinical therapy intern at Central DuPage Hospital in Winfield.

How long have you been with Open Door? Since the end of July 2014.

What types of things do you do or would like to do with Open Door? I am currently a Medical Case Manager so I am working with Ryan White clients helping them with insurance issues to medication issues, and everything in between to ensure they are able to keep up their medical care and stay on their medication. I am not really sure what other things I want to do at Open Door because I'm still trying to learn all I can about case management.

Describe your family (define family however you want)? Both of my parents are retired high school teachers. I have two older sisters; Lauren is a 5th grade teacher in Wheaton and Lexie is a PA at a health care clinic in Indiana. I have one nephew named Evan who is 2 years old. I have two pugs named Sammie and Lulu.

What do you enjoy doing in your free time? I enjoy spending time with friends and family, especially with my 2 year old nephew. I love to travel to different countries and experience different cultures. I love reading, watching movies and playing with my 2 dogs.

Where is the farthest place from home you have ever been? I've been to Mexico, Costa Rica, Spain, Sweden and Denmark.

What is your favorite food? I love pesto and anything with cheese.

What one thing do you want to do that you haven't done yet? I want to travel to London and Ireland.

Who is the most impactful person in your life or most impactful person on humanity (dead or alive)? Currently I think Malala Yousafzai is one of the most impactful people in the world. The way she is able to stand up for her beliefs and push for the education of women not only in her country but in the world is very impressive to me, especially for her being so young. I think she is someone we can all emulate and learn from in our daily lives.

INSIDE THIS ISSUE

OPEN DOOR'S EXTENTION LIST IS NOW AVAILABLE

Open Door has recently changed their extensions. Below is a list of the new extensions. When you hear the automated attendant you can enter in the extension. If you call the Elgin office and want to speak with someone in the Aurora Office you can enter it. The system will allow for either extension to work.

ELGIN - 847-695-1093

First Name	Last Name	Title	Ext.
Barbara	Cox Harris	Director of Finance	218
Bryan	Gooding	Peer Educator	223
CAC		Client Advisory Committee	275
Carol	Winters	Administrative Assistant	220
Christina	Rivera	Billing Coordinator	235
Christine	Mitchell	Director of Resource and Development	225
Connie	Pachuki	Medical Director	221
David	Roesler	Executive Director	211
Diane	Henning	Behavioral Health Coordinator	226
Elena	Alvarado	Case Manager	228
Juan	Mercado	Nurse Practitioner	320
Jennifer	Genzlinger	Case Manager	222
Lizbeth	Ramirez	Certified Medical Assistant	230
Lynne	Kennedy	Facilities Coordinator	219
Marcos	Bostho	Outreach, Education & Prevention Coordinator	224
Michelle	Villar	Case Manager	212
Monica	Dominguez-Banuelos	Case Manager	234
Perry	Maier	Assistant Director	319
Sarah	Campbell	HIV-RN/Treatment Coordinator	217
Sharon	Marach	Case Manager	216
Tifini	Steif	Case Manager	236
Yelica	Hernandez	Front Desk Patient Assistant	210

AURORA - 630-264-1819

First Name	Last Name	Title	Ext
Bryan	Gooding	Peer Educator	322
CAC		Client Advisory Committee	275
Connie	Pachuki	Medical Director	313
Esther	Hancock	Front Desk Patient Assistant	310
Jaime	Salazar	Case Manager	325
Joanna	Ruiz	Case Manager	321
Juan	Mercado	Nurse Practitioner	320
Lisa	Guzman	Case Manager	315
MaDonna	Nash	Case Manager	317
Marcos	Bostho	Outreach, Education & Prevention Coordinator	314
Martha	Gonzalez	Nurse	324
Mary	Hodges	Outreach, Education & Prevention Coordinator	
Pat	Lev	Director of CM/CQI	
Perry	Maier	Assistant Director	319
Rosie	Pina	Medical Assistant	323
Sally	Bice	Case Manager	339
Shannon	Lane	Mental Health	316

WHAT DOES 2015 HOLD IN STORE FOR HIV RESEARCH?

From TheBodyPRO.com

While current HIV treatment allows patients to live long, healthy lives, there are still concerns over tolerability, adherence and general quality of life. We also continue to see new infections, despite prevention efforts. Therefore, we asked some of the leading HIV experts what research they're most looking forward to over the next year.

David Wohl, M.D.

Dr. Wohl is an associate professor of medicine at the University of North Carolina School of Medicine and the co-director of HIV services at the North Carolina Department of Corrections.

I think you're going to see more of the long-acting [injectables]. I think you're going to see the battles over hepatitis C, and how we treat hepatitis C, for coinfected and non-coinfected [patients].

I think we're going to be treating people but it's going to be the whole: What are the restrictions? If I drink alcohol, why can't I get therapy and get cured? Are the restrictions going to be too restrictive?

And then there's going to be all new therapies. And how does the marketplace deal with that? And what happens with the pricing? It's obviously not clear-cut, so I think the hepatitis C thing is a big deal.

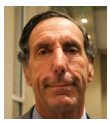
I'm really into the single-tablet regimens. I think coformulation helps. And I think that we have a cobicistat/darunavir, and eventually maybe a cobicistat/darunavir/TAF mega combination that does almost all things to all people.

I think TAF [tenofovir alafenamide] will be really great because the nucleoside/nucleotide family that we've been living with for so long just hasn't kept up with our expectations.

Sharon Dian Lee, M.D.

Dr. Lee is an assistant clinical professor of medicine at the University of Kansas and the founder and director of Southwest Boulevard Family Health Care.

More about nucleoside-free treatment options. I look forward to having more treatment choices that are focused on viral mechanisms and have fewer interactions with human enzymes/metabolism. Also, additional pre-exposure prophylaxis [PrEP] options will be forthcoming.



Henry Masur, M.D.

Dr. Masur is a clinical professor of medicine at George Washington University and chief of the Critical Care Medicine Department at the NIH Clinical Center.

There are many issues inherent to operational research, in terms of what's effective for changing behavior, what's effective for getting people onto therapy. In terms of HIV research, I think we're all fascinated by the potential to cure HIV. There's so little that is promising in terms of data. The clinical arena is a little bit disappointing. Yet we're understanding more about reservoirs; we're understanding more about drugs that might be able to eradicate this retrovirus. So what I'm looking for in the next few years is both animal and human data on how we might be able to get closer to not suppressing HIV, but actually curing it.

Paul Sax, M.D.

Dr. Sax is director of the HIV Program and Division of Infectious Diseases at Brigham and Women's Hospital in Boston.

Well, it will be interesting to see what happens with two-drug maintenance therapy, in general, and in particular with cabotegravir [CAB, GSK1265744] and rilpivirine [Edurant], whether it's as a single, tiny little pill, or it's as an injectable -- if that premise works out. It could really give patients and providers a lot to think about. Whether that's the right approach, we'll see.

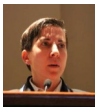
what we've done.

[In terms of injectable HIV drugs], as initial treatments, we're not even close. But as a way of maintaining virologic suppression, I do think there will be a subset of patients who will really prefer that it be taken out of their hands, that they're tired of taking pills, that they're not good at taking pills. But if you said to them, "We can give you an injection once a month, or once every two months, and have someone come to your house and do it for you, or have just a community center that you can get it," then they're going to offer that. And that would be very much a change .

Michael Saag, M.D.

Dr. Saag is a physician and HIV researcher at the University of Alabama at Birmingham.

What's happening inside the cell at the molecular level that inflammation is either inducing, or is causing the inflammation itself? We need to just dive deep, because otherwise we aren't going to have targeted therapies for these types of disorders. And it transcends HIV, or even hepatitis. It's for all of us as we age. Inflammation is a driving common factor. And if we can understand inflammation better at a molecular level, I think we can start finding targeted therapies to combat that.



Jen Kates, Ph.D.

Dr. Kates is vice president and director of Global Health Policy and HIV at the Kaiser Family Foundation.

There is much to anticipate in a variety of areas, but one that I am particularly anticipating is emerging data on the role and effect of the Affordable Care Act on access to health insurance coverage for people with HIV in the U.S. With almost one year of experience behind us and the next open enrollment just ahead, we will soon be able to examine its impact.

How many people with HIV have gained new coverage? Where do barriers still exist? How are state decisions about Medicaid expansion affecting coverage?

We have baseline data on some of these questions and going forward, it will be important to assess how coverage is changing..

Kenneth Mayer, M.D.

Dr. Mayer is a professor of medicine and community health at Brown University and an attending infectious disease physician at Miriam Hospital.

In the next year or so the biggies are that there's a tiebreaker vaginal microbicide that's called the FACTS 001 study. So, if the FACTS 001 study shows efficacy, even if it's not a total home run, it will lead towards a path towards licensure of the vaginal gel. If there's compelling data that gel can make a difference in the epidemic, you might see rapid uptake of gel.

The implication of that may be that some of the work in rectal microbicides will move more quickly, as well, because you'll have proof of concept. On the flip side, if the study is negative because of poor adherence, it may be harder to convince people to do studies of rectal microbicides.

And then the other biggie for women is the whole issue of vaginal rings. There are two studies now that are efficacy trials going on. If both studies show consistent data, you might have then a ring formulation. The reason why that's particularly relevant is that there already are hormonal contraceptive rings so the vaginal ring would have immediate implications for men who have sex with men, or people who engage in anal intercourse.

But the idea that you could coformulate preventive technology, where you could have one ring that could be only hormonal contraception; the same looking ring could have hormonal contraception and anti-HIV protection; and a third could be only anti-HIV protection alone. And that might destigmatize women going in for family planning and being able to get the right ring. So I think those are biggies in terms of the field of HIV prevention.

Theo Katsivas, M.D.

Dr. Katsivas is an associate physician at the Owen Clinic at the University of California, San Diego.

It would be interesting to see treatment that would be available with less, smaller pill burdens. Possible injectable, possible long-acting [treatment] -- those are very promising initial research that we've heard about.

Then also the ability of doing point-of-care testing for HIV, and identifying more cases. I'm really focusing on testing because the people that we're really treating we tend to treat really well. Once someone gets to clinic, gets clinical care and gets connected to clinical care, I think they fare very well. But the problem is getting people into treatment.

The other possibility is to use treatment as prevention -- the concept of PrEP. And there's controversies regarding that. I share the concerns of some of my colleagues, claiming that this could lead into increase in STDs [sexually transmitted diseases], liberalization of sexual behavior, less use of condoms, and might actually drive rates higher up for other STDs as well as HIV. It's a concern. But I think overall getting people in treatment will have a positive effect.

Pablo Tebas, M.D.

Dr. Tebas is an associate professor of medicine at the University of Pennsylvania School of Medicine and principal investigator in the AIDS Clinical Trials Unit (ACTU) at the University of Pennsylvania.

I'm very excited about neutralizing antibodies, in both prevention and therapeutics. I think they are going to change the way we approach this disease. I am very excited also about implementation of PrEP in the community, and implementation of hepatitis C treatment in the community, both in the hepatitis C monoinfected, and HIV infected. I think those will be the big themes over the next year. It's going to be how we deliver what we know now about PrEP and hepatitis C treatment, and then how these new classes of antibodies, as we're understanding how they fit in our prevention efforts, and how they fit in our therapeutic efforts.

Roy Gulick, M.D.

Dr. Gulick is a professor of medicine and chief of the Division of Infectious Diseases at Weill Medical College of Cornell University, and an attending physician at the New York Presbyterian Hospital in New York City.

One interesting investigational drug is cabotegravir, which is the injectable integrase inhibitor that you only have to dose every three months. And so we are expecting to see some phase-2 data on that compound in prevention, as well as treatment, in combination with the injectable rilpivirine. If we really had two long-acting injectables, that could be a strategy, both for treatment and, importantly, for prevention. So I'm interested in that.

HIV DRUG DEVELOPMENT PIPELINE UPDATE, FALL 2014 EDITION

By: Thebody.com

Some might say that the golden age of HIV drug development has come and gone. Those people might just be right.

But if there are fewer HIV antiretrovirals in the pipeline these days than there were in the late 1990s and much of the 2000s, it's with good reason: The drugs that made it through that grind transformed HIV treatment from a toxicity-filled, resistance-prone mountain of a pill burden into a highly manageable, tremendously effective intervention.

However, HIV treatment remains far from perfect, and there are still seats at the table available for improved antiretrovirals. At IDWeek 2014 in Philadelphia, Paul Sax, M.D., made the case for this new generation of drugs, and provided an update on several of the most noteworthy candidates currently in development.

The High Bar for New Drugs

"I don't think any talk about drugs in the pipeline can go on without acknowledging how extraordinarily good our treatments are right now," Sax began.

Clinical trials utilizing popular first-line antiretroviral regimens in the U.S. now regularly boast virologic suppression rates of 90% or higher, even after 96 weeks of therapy, he noted. Even in a true clinical setting, current regimens are highly successful. An examination of the Johns Hopkins HIV Clinical Cohort -- a group of patients living in a large, urban area -- found overall virologic suppression rates of just 37% in the late 1990s. By 2010, that rate had increased to 87%.

Since 2010, the number of highly effective treatment options has grown larger. The past year alone has brought two new integrase inhibitors -- dolutegravir and elvitegravir -- along with a new booster drug, cobicistat. These drugs are "very widely used, and some would argue that they're among our best therapies," Sax said. "It's very rare to find people who cannot be virologically suppressed on current treatments."

With HIV treatment success rates so high, what qualities can a new drug exhibit that will make it likely to win U.S. Food and Drug Administration (FDA) approval -- or that will make a pharmaceutical company feel that the drug is worth developing?

HOW TO MEET THE BAR

Despite the strength of our current crop of antiretrovirals, there is still a place for new drug development, Sax said. The key lies not in a drug's ability to suppress viral replication, but in its ability to bring a unique benefit. "It has to offer something novel," Sax said.

There are a number of characteristics in particular that can make experimental antiretrovirals stand out from the crowd, Sax noted:

- Drug resistance. It still happens, usually due to insufficient adherence, and it can severely restrict a person's treatment options.
- Short-term toxicity. Gastrointestinal issues, rash and central nervous system side effects are not uncommon among our popular regimens.
- Long-term toxicity. As long as HIV treatment remains a lifelong commitment, there will be concerns about issues that can emerge over years (rather than weeks) on treatment.
- Drug-drug interactions. We are at the dangerous intersection of an aging HIV-positive population, increasing comorbidity rates and the rising use of medications to treat them.
- It may seem obvious, but HIV still can't be cured -- at least, not in any way that's realistically scalable.

The well of HIV drugs in development may not be deep, but a number of candidates seek to hit one or more of these sweet spots.

NEW NRTIS TAKE THE STAGE

The NRTI class has not seen a new entry since the FDA approved emtricitabine (FTC, Emtriva) more than a decade ago. Yet NRTIs remain the backbone of first-line antiretroviral therapy, despite their well-known and increasingly well-established toxicity risks.

It is those toxicity risks -- renal and bone concerns with tenofovir (Viread, TDF), a years-old debate over cardiovascular concerns with abacavir (Ziagen) -- that leave the door open for new NRTIs, Sax said.

Three NRTIs of note are currently in development, according to Sax. One, known variously as festinavir, BMS-986001 or OBP-061, is a Phase 2 thymidine analog that has been engineered to cause very little mitochondrial toxicity. A dose-ranging study presented earlier this year found that a 400-mg dose had similar efficacy to TDF, but resistance concerns led Bristol-Myers Squibb to decline further development, Sax said. The drug is now back in the hands of Oncolys, a small biotech firm, to determine its next step forward.

Another NRTI, EFdA, was designed with a "distinctive structure" and a novel mechanism of reverse transcriptase inhibition, Sax said. It has proven highly potent in vitro, but its current status is not well known, he said.

The experimental NRTI furthest in development is tenofovir alafenamide (TAF), a reformulation of the tenofovir dipovoxil fumarate (Viread, TDF) we have known since the early 2000s.

HIGH MARKS FOR TAF

"TAF gets very high intracellular concentrations and has very, very low plasma levels," Sax explained. "The hope is that with this combination, it would have preserved antiretroviral activity but reduced renal and bone toxicity" compared to TDF.

Phase 2 clinical trials comparing TAF to TDF appear to bear out these hopes; research to date points to much lower increases in glomerular filtration rate, lower markers of renal tubular toxicity, lower negative changes in spine and hip bone mineral density, and lower markers of bone turnover among people on TAF -- all while retaining the same levels of HIV suppression, Sax said.

Another TAF plus: The drug's high intracellular concentration may yield drug doses as low as 10 mg, which could significantly lower production costs, Sax said. The new formulation may even have greater activity than TDF does against TDF-resistant strains, he added.

One quirky downside, however: The high levels of TDF in patients currently taking the drug appear to have a cholesterol-lowering effect, Sax noted. If a patient replaces TDF with TAF, an increase in cholesterol levels may be an unintended result.

Phase 3 research on TAF is now ongoing; studies include a single-tablet regimen combining the drug with cobicistat, darunavir (Prezista) and emtricitabine (which Sax referred to as DCF-TAF). TAF is also being studied for anti-hepatitis B virus (HBV) activity, and this research is expected to confirm that TAF shares TDF's propensity for HBV suppression.

A TRICKLE OF NNRTIS

NRTIs aren't the only long-standing drug class that could benefit from a new addition or two: Non-nucleosides are also in need of fresh options, Sax suggested. Whether it's the neuropsychiatric toxicity of efavirenz (Sustiva, Stocrin), drug interactions with etravirine (Intelence), "numerically better" virologic suppression rates after 24 weeks, Sax said; those

results were presented earlier this year at CROI.the hypersensitivity risk of nevirapine (Viramune), or underperformance of rilpivirine (Edurant) in people with high viral loads or low CD4 counts, "all of our NNRTIs that we use now have some problem with them," Sax said.

The NNRTI pipeline is no longer as flush with candidates as it once was, but one drug that has built momentum is doravirine, alternately known as MK-1439. A Phase 2 dose-ranging trial pitting the drug against efavirenz yielded The 100-mg, once-daily dose that was selected for further development appears to hit a sweet spot of antiretroviral activity, Sax said, with good response both against wild-type virus as well as virus with NNRTI mutations.

ILONG-ACTING ANTIRETROVIRALS

But enough about once-daily HIV medications. The era of long-acting antiretrovirals appears to be drawing closer, and excitement is rising for this potentially less-intensive dosing option.

The key selling point for these drugs, of course, is that they may help separate a person with HIV from the heavy sense of burden that can accompany daily antiretroviral therapy. Sax offered a case example of a patient who has been "on and off, but mostly off" of antiretroviral therapy since his diagnosis in 2006. "He understands that he should take his medications, but he says he hates taking them every day, he hates being reminded he's HIV positive," Sax said. "Even the idea that he could be treated with a shot or a patch is very exciting to him, and he would definitely be interested."

NJECTIONS ONCE PER MONTH -- AT MOST

Enter cabotegravir, an integrase inhibitor formerly known as S/GSK1265744 or 744. The drug has been under study for years as a potential long-acting option, either taken orally or via parenteral injection. For its Phase 2b study, cabotegravir was paired with rilpivirine, the FDA-approved once-daily NNRTI that allows for nanoformulation, making it ideal for further development as a long-acting drug.

This cabotegravir/rilpivirine duet is the star of the LATTE study, a uniquely designed induction-maintenance trial intended to quickly suppress a treatment-naive patient's viral load with multi-class, once-daily oral therapy and then switch them to the experimental regimen after 24 weeks. The dose-ranging trial yielded comparable virologic efficacy for the induction-maintenance approach to the current efavirenz-based standard of care, Sax said.

Next up for this unique drug combo is the LATTE-2 study, which will examine the relative efficacy and safety of cabotegravir/rilpivirine injected intramuscularly either once every four weeks or once every eight weeks.

While LATTE-2 progresses, long-acting antiretrovirals are also being explored for another key use, Sax noted: pre-exposure prophylaxis (PrEP). "If the major problem with pre-exposure prophylaxis is adherence, what better way to take adherence out of the picture than to give an injectable agent every three months?" Sax asked.

SOLVING PAN-CLASS RESISTANCE

Extensive multi-drug resistance has not become nearly as prevalent as some experts predicted in the early 2000s. But it *does* happen -- and when it does, it's a serious problem.

"These patients are rare, but they are a cause of great consternation for those of us who manage them, because it's very unusual not to have [antiretroviral] options," Sax said.

Offering some hope is the attachment inhibitor BMS-663068 (or "068" for short), which binds to the gp120 on HIV's surface. Unlike the attachment inhibitor maraviroc (Selzentry, Celsentri), 068 is tropism agnostic. Even better, in vitro testing has shown no evidence of cross-resistance between 068 and any other antiretroviral class, Sax said. Efficacy and safety have also looked promising in early monotherapy trials, he noted.

One caveat with 068 is that roughly 5% of the HIV-1-infected patient population appears to have a variant of HIV that makes the drug "intrinsically inactive," Sax said. Once predictors have been determined, Sax suggested that some sort of pre-treatment assessment of drug susceptibility will be necessary.

A Phase 3 study of 068 is being planned, but "it is going to be very, very challenging, of course, to find patients who are eligible for this study," Sax said. "I hope they have very, very broad inclusion criteria, because these are difficult patients to treat, they have no other options, and there isn't a whole lot coming soon in this area."

ALSO WORTH NOTING

Sax wrapped up his waltz through the drug development ball with a brief mention of two other experimental antiretrovirals of note: cenicriviroc and ibalizumab.

Cenicriviroc is a CCR5 antagonist in the same general vein as maraviroc. "So far, our CCR5 antagonists have all been not quite good enough," Sax said. Maraviroc is a little-used drug with antiretroviral activity that doesn't quite match the most effective drugs we have today, he said. A once-promising anti-CCR5 candidate, vicriviroc, was killed partway through development for similar reasons.

But cenicriviroc has one quality that other CCR5 antagonists lack: It also inhibits attachment to the CCR2 receptor, which appears to give the drug an anti-inflammatory effect. "Maybe the CCR2 thing with cenicriviroc will help see it through, though it's not as effective as efavirenz," Sax said. He noted that the drug was tentatively set to be investigated as a coformulation with lamivudine (3TC, Epivir), which would set it up as a new backbone combination to compete with abacavir/lamivudine (Epzicom, Kivexa) and tenofovir/emtricitabine (Truvada).

And then there was ibalizumab. The monoclonal antibody is the marathon runner of experimental HIV drugs: "It's been in development for over a decade now, and that probably is telling us something," Sax said. Although "it definitely has antiviral activity," he said, its future remains uncertain.

DONT FORGET THE NEW SOCIAL ACTIVITIES PROGRAM STARTS AT THE HOLIDAY PARTY COME AND JOIN AND ENJOY THE PARTY

ALL YOU HAVE TO DO IS … PICK UP A CARD AT ONE OF THE SOCIAL EVENTS, ATTEND THE CAC EVENTS DURING THE PROGRAM YEAR , AND GET YOUR CARD STAMPED AT EACH EVENT. THE MORE YOU ATTEND THE BETTER YOUR CHANCES TO WIN!

AT THE END OF THE PROGRAM YEAR TURN IN YOUR CARDS AND YOU JUST MIGHT BE ONE OF THE LUCKY FOUR WHO WILL BE CHOOSEN TO ATTEND A VERY SPECIAL VIP EVENT IN YOUR HONOR

HEALING STIGMA IN HEALTHCARE

By: Diane H.

What is stigma? Stigma is complex and occurs on multiple levels in our society and tends to be self perpetuating. According to Graham Davey (2013), a psychologist, stigma on an individual level can be divided into 2 forms; social stigma and internalized stigma. Social stigma is the negatively biased beliefs, attitudes and behaviors (discrimination) about something like a disease, sexual or gender orientation, mental health or substance use condition. Internalized stigma occurs when the individual who has the disease, mental health or substance use condition accepts and/or abides by these beliefs. Stigma is often based on misinformation, miscommunication and a double dose of fear and shame. Stigma twists and obscures the facts and is problematic in the health care community because it often prevents individuals from getting needed care. Unfortunately, people or groups of people who perpetuate stigma often times don't have all the information needed to make a good decision. They may be motivated by fear, low self esteem or a sense of powerlessness regarding the issue. The take home point of the last sentence is the fact that stigma has little or nothing to do with the person. We have seen the spread of stigma flourish because many people still buy into the belief that HIV/AIDS is a disease that only "those" people get. I ask, how many people have contracted HIV because they did not believe they were one of "those" people, and did not use protection. How many people needlessly experienced the advanced stages of the disease because they didn't seek medical care again thinking that it's only "those" people. Even within the HIV/AIDS community there is stigma about being diagnosed with HIV as opposed to AIDS. The discomfort associated with being a part of a stigmatized group can also be seen in other parts of the health care community. Individuals who have mental health and/or alcohol/drug problems fear coming in for care due to stigma.

Making the decision to disclose or not disclose your personal health care information needs to be carefully considered . It is important to select trustworthy individuals who you can share your health care information with because stigma can and does sometimes lead to discrimination. Clients might find it helpful to come in and explore trust issues n groups and individual therapy sessions.

There are many things individuals can do to reduce the impact and control they give stigma in their lives. A diagnosis is a small aspect not your whole life. Although we don't have control over social stigma or what other's chose to believe about us, but we do have control over what we chose to believe about ourselves. Open Door provides both individual and group therapies that take place in safe and confidential environments. At Open Door we have found that providing a non-judgmental caring environment allows clients to share their concerns about disclosure, sorting and healing the impact of stigma, and one of its most disabling symptoms, shame.

To learn other skills to combat stigma and its impact in your life schedule an appointment with Shannon or Diane Aurora (630) 264-1819, Elgin (847) 695-1093.

Ask about our Recovery Group Motivational Incentives Program.

Davey, G. (2013, August). Why We Worry: Mental Health and Stigma. *Psychology Today*. Retrieved from http://www.psychologytoday.com/blog/why-we-worry/201308/mental-health-stigma

DECEMBER EVENTS

01 - WORLD AIDS DAY
01 - Substance Use Group (A) 11a - 12p
02 - Positive MH (A) 4p - 5:30p
03 - Positive MH Group (E) 12p - 1:30p
05 - HIV/AIDS Activity Education Group (A) 4p -6p
08 - Positive MH Group (E) 12p - 1:30p
12 - HIV/AIDS Activity Education Group (A) 4p - 6p
15 - CAC Meeting 5:30p (G)
15 - Newsletter Articles Due
15 - Substance Use Group (A) 11a - 12p
16 - Positive MH Group (A) 12p - 1p
19 - Positive MH Group (E) 12p - 1:30p
19- HIV/AIDS Activity Education Group (A) 4p - 6p
22 - Newsletter to Clinics
22 - Substance Use Group (A) 11a - 12p
23 - Positive MH Group (A) 12p - 1p
24 - Christmas Eve (Closed)
25 - Christmas Day (Clinics Closed)
26 - Positive MH Group (E) 12p - 1:30p
26 - HIV/AIDS Activity Education Group (A) 4p - 6p
26 - Bingo Night (E) 4p - 6pm
27 - Pain Management Group (A)1p - 2p
31 - New Years Eve (Closed)

(A) Aurora Clinic
157 S. Lincoln Ave Rm K
Aurora, IL 60505
(E) Elgin Clinic
164 Division St, Suite 607
Elgin, IL 60120
(G) First Congregational Church
321 Hamilton
Geneva IL 60134

IF YOU ARE INTERESTED IN RECEIVING OPEN DOOR'S MONTHLY NEWSLETTER VIA E-MAIL OR HAVE ANY SUGGESTIONS YOU WOULD LIKE TO SEE IN THE NEWSLETTER.
PLEASE EMAIL DEAN AT
deanbnewsletter@yahoo.com

ELGIN

164 DIVISION STREET
SUITE # 607
ELGIN, IL 60120
PHONE (847) 695-1093
FAX (847) 695-0501

AURORA

157 S. LINCOLN AVE.
ROOM K
AURORA, IL 60505
PHONE (630) 264-1819
FAX (630) 229-0182

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