

# NEWS & VIEWS

NOVEMBER



VOLUME 9

ISSUE 11

## AIDSWATCH HAS NEVER BEEN MORE CRITICAL! REGISTRAR TODAY!

From AIDSWatch

Join hundreds of advocates from across the country in Washington DC from February 29 - March 1, 2016 to educate Congress on HIV/AIDS and related policy and funding priorities. In this political and fiscal environment it has never been more important to make your voice heard! Register Today!

AIDSWatch Registration: is

Open and Space is Limited! While the majority of costs for AIDSWatch are generously covered by sponsors, there is a nominal \$20 registration fee. If this presents an obstacle to your participation, please apply for a scholarship or please contact us at [aidswatch@aidsunited.org](mailto:aidswatch@aidsunited.org).

We highly recommend that you register early. If you are dependent on a scholarship to attend, please do not register, as scholarship recipients will be automatically registered after selection.

Scholarship Applications: You have 30 Days - Just 30 Days - To Submit Your Application! Scholarships

cover travel, hotel, and the registration fee. Get more information and the application here. Completed scholarship application packets are due no later than November 20, 2015 at 8pm ET.

Speak Up. Be Heard. Be Part of the Movement.

Learn more about or register at: [www.aidsunited.org/aidswatch](http://www.aidsunited.org/aidswatch).

## MEN WITH HIV TWICE AS LIKELY TO HAVE LOW TESTOSTERONE

From TheBody.com

Hypogonadism -- low serum testosterone -- affected more than one in 10 HIV-positive men in a preliminary single-center study in France. That rate is twice higher than in the general population of similarly aged men. A high percentage of total body fat and more than 5.5 years of antiretroviral therapy (ART) independently predicted hypogonadism.

The study, which was presented at ICAAC 2015, notes that research has linked male hypogonadism to an array of conditions, many of them highly prevalent in men with HIV, including osteoporosis, metabolic syndrome, depression and decreased lean body mass. With the arrival of potent antiretroviral combinations, hypogonadism no longer correlates with low CD4+ count or weight loss, but rather with aging and comorbidities. The researchers conducted this cross-sectional study to determine the prevalence of

hypogonadism in a contemporary HIV population of virologically suppressed men and to identify factors associated with hypogonadism.

The study involved 113 men younger than 50 years old with a viral load below 50 copies/mL for more than six months while in care at a single center in Tourcoing, France. Researchers measured free testosterone twice before 9 AM (when testosterone levels are highest). They assessed depression by the Hamilton rating scale, erectile dysfunction by the International Index of Erectile Function-5 score and quality of life by the Aging Male Symptoms scale. Participants had DXA scans to measure bone mineral density and body fat.

Fourteen of 113 men (12.4%) had hypogonadism, with all cases attributed to hypothalamic-pituitary axis dysfunction. Men with hypogonadism were older than eugonadal men (median 45.5 versus

41 years). More than 90% of men with and without hypogonadism were white, and the groups did not differ substantially in body mass index (23.5 and 23 kg/m<sup>2</sup>), total fat (20% and 19%), proportion of smokers (50% and 41.4%), psychoactive drug users (14.3% and 10.1%), those engaged in physical activity (57.1% and 57.6%) or those who drank more than 20 g of alcohol daily (7.1% and 12.1%).

Median sex hormone-binding globulin measured 61.65 nmol/L in hypogonadal men versus 40.4 nmol/L in eugonadal men ( $P = .001$ ). Men with hypogonadism also had significantly lower estradiol (13.5 versus 18 pg/mL,  $P = .001$ ) and prolactin (6 versus 18 pg/mL,  $P = .01$ ), a higher prevalence of osteoporosis (15.4% versus 9.6%,  $P = .03$ ), a longer duration of ART (median 9 versus 6 years) and almost a twice-longer duration of antiretroviral therapy.

Logistic regression analysis

identified three independent predictors of hypogonadism: (1) total fat mass above 19% (adjusted odds ratio [aOR] 6.41, 95% confidence interval [CI] 1.3 to 32.6,  $P = .03$ ), (2) more than 5.5 years of antiretroviral therapy (aOR 8.54, 95% CI 1.7 to 42.86,  $P = .01$ ), and (3) more than two years of integrase inhibitor therapy (aOR 17.03, 95% CI 2.2 to 129.6,  $P < .01$ ). The researchers caution that the association with integrase inhibitors should be interpreted cautiously because of the wide confidence interval.

The French team concludes that hypogonadism is common in HIV-positive young and middle-aged men. They suggest that thresholds of five years of antiretroviral therapy and 19% total fat could be used to identify men at risk of hypogonadism. The researchers will try to confirm these findings in a larger sample of men.

## INSIDE NOVEMBER'S ISSUE

2	CLIENTS RIGHTS	3	HEALTH ESTEEM CHECK ANYONE	5	IMPORTANT TIPS WHEN TALKING TO YOUR DOCTOR
2	PLEASE RSVP FOR CAC EVENTS HERE'S HOW	4	OPEN DOOR RECOMMENDS IMPORTANT NUMBER	6	WHAT'S UP WITH TELEVISION
3	SAVE THE DATE	5	JOIN OR VOLINTEER ON THE CAC	6	OCTOBER EVENTS

## WHAT CAN BE DONE FOR PEOPLE WHOSE HIV TREATMENT HISTORY IS WRITTEN ON THEIR BODIES

From TheBody.com

"I am 50 now and anticipate another 30 years on this earth. The one thing that sucks is that I have to live those 30 years looking like a freak."

In 2008, activist and long-term HIV survivor Nelson Vergel conducted an online survey of more than 1,000 people living with HIV to find out how lipodystrophy, or body shape changes, impacted their lives. Most respondents had been diagnosed more than 15 years prior and had taken a wide range of HIV medications. The survey asked whether participants had felt depressed or anxious, or altered their behavior, due to the changes in their bodies.

The results? More than 87% of those surveyed had experienced depression or anxiety due to this condition. Almost 74% had less sex because of it. Sixty-five percent stopped socializing; 60% worried that others could tell from their appearance that they were living with HIV. Nearly 29% had drained their finances looking for solutions. And a full quarter had considered taking their own lives because of the effects of lipodystrophy on their

bodies.

Most devastating of all, Vergel believes that if he conducted the survey again today the results would likely be similar.

Lipodystrophy refers to a disturbance in the way a person's body stores, uses and makes fat that can result in visible changes to the way body fat is distributed. Lipoatrophy (fat loss) and lipohypertrophy (fat gain) fall under this umbrella. In people living with HIV, these conditions can show up as a "buffalo hump" on the back below the neck; sunken cheeks and buttocks or skinny, veiny limbs due to fat loss; breast enlargement (gynecomastia) in men as well as women; and fat increases around the abdominal area (visceral fat) and other parts of the body.

The specific causes of HIV-related body shape changes remain mysterious. It's well documented that Retrovir(zidovudine, AZT), Zerit (stavudine, d4T) and Videx (didanosine, ddI) are linked to fat loss, and that early protease inhibitors (PIs) like Crixivan (indinavir) played a key role in fat gain. "As good as these drugs were in their day to save lives," says

longtime HIV care provider and researcher Dr. Benjamin Young, "they caused a lot of collateral damage" -- including the disfiguring, often stigmatizing condition of lipodystrophy. These drugs virtual elimination from U.S. HIV treatment regimens have cut down on experiences of body shape changes in the community; moreover, switching regimens can help in regaining lost fat. But for fat accumulation, switching treatments offers no benefit. "It's like another organ," Vergel explains: "Once [fat] grows, it's very hard to get rid of."

The reality is that those who have taken only more recent HIV med regimens will not see such dramatic changes in their bodies, and clinicians report seeing fewer and fewer cases. In fact, a recent large study showed that abdominal fat gain after starting HIV meds had more to do with how high people's viral load was when they started than with their specific drug regimen -- amplifying the call for people with HIV to start treatment early. This fat-gain study effectively destroyed the notion that integrase inhibitors, the newest HIV drug class, are more

body-friendly than boosted PIs.

Overall, this is good news for the newly infected, but for many who've been living with HIV for decades, their treatment history is written on their bodies and faces.

"Has research on this disfiguring side-effect gone on the back-burner because everyone says these new meds don't cause it, therefore no one cares about the ones who are wearing long sleeves and pants in 90 degree weather ... too bad for them?"

Once upon a time, there was dedicated research interest in treating lipodystrophy in people with HIV; that interest has waned. Studies looking at a number of promising products to combat body shape changes in people with HIV, including leptin and low-dose growth hormones, were discontinued. "This isn't even part of activists' conversations anymore," Vergel remarks, "because we have nothing exciting to talk about."

Lipodystrophy "seems to be turning into an 'orphan' condition that is seen only in long-term survivors, who are shrinking in numbers and also growing older," explains Jeff



The CAC wants to thank  
**Dr. Pachucki and Michelle Villar**  
 for all that they have done for the clients of  
**Open Door** you will be missed.  
 We all wish them both well on their  
**New and Exciting Future Adventures.**

*Best of luck!*

Taylor, an activist with AIDS Treatment Activists Coalition, Let's Kick Ass Palm Springs and The Reunion Project. He says this "makes it all too easy for clinicians to blame it on age." Meanwhile, says Vergel, long-term survivors experiencing lipodystrophy may have problems finding clothing that fits, may feel bloated or out of breath because of extra visceral fat putting pressure on their organs, and may not want to go out or look in a mirror.

"People are asking about lipodystrophy all the time," Vergel says of his "Ask the Experts" forums on "Aging with HIV" and "Nutrition and Exercise" on TheBody.com. There are fewer questions about fat loss than fat accumulation, in part because effective treatments for lipodystrophy exist. In the U.S., there are two products approved for facial wasting in people with HIV: the injectable fillers Sculptra (poly-L-lactic acid, New-Fill) and Radiesse (calcium hydroxylapatite, Radiance). Unfortunately, these products can be difficult to access because in recent years once-generous patient-assistance programs have become more restrictive or fallen away altogether. For fat loss in the buttocks, which can cause severe discomfort when sit-

ting, a long-term HIV survivor developed butt-lifting shorts to increase volume in the area. (Check them out at Lip-oWear.com.) Buttock fillers like PMMA (polymethylmethacrylate, Artefill), while also expensive and challenging to access, have also provided some relief.

But what about treating fat accumulation? People living with lipohypertrophy got a burst of hope in 2010, when the U.S. Food and Drug Administration approved Egrifta (tesamorelin) as the first-ever treatment for belly fat gain in people living with HIV. Egrifta is also an injectable, but rather than a professional administering the product, as with Sculptra and Radiesse, the injections must be done at home -- once a day -- with a solution mixed from a powder. "It's quite a few steps," comments Vergel. Its price can also be prohibitive and the product can take months to show results, which are not visibly dramatic if they occur at all. Add to this lukewarm assessment the fact that Theratechnologies, the makers of Egrifta, experienced shortages of the product in 2014 and temporarily stopped making it and it is no wonder that hope for this treatment has begun to flag.

"With regular exercise and weight loss, will the fat deposits [on my body] go away, or if not, reduce?"

More than 70% of respondents to Vergel's survey reported exercising and watching what they eat to combat body shape changes. Many participants in his forums inquire about such steps, and Vergel has dedicated numerous articles, posts, and even videos to sharing his fitness wisdom. But the benefits of diet and exercise interventions in reducing visceral fat gain also need further study -- ideally in a combination approach with Egrifta.

Vergel wonders if the makers of Egrifta have promising reports to share about its use that could renew interest in the product. If it were his money, he says, he'd fund online peer support for patients, especially during their first month using the injections. "Community-based education should be coming from community peer educators who have gone through the experience of lipodystrophy," he says. "Egrifta comes in a wonderful package with lots of brochures, but people benefit from peer support." He'd also bankroll small studies on the use of Egrifta along-

side other products like metformin, an old diabetes drug with fat-burning potential that's been explored as a treatment for lipodystrophy in people with HIV.

Fellow activist Taylor agrees. "We desperately need research into multi-modal approaches," he says, "since the single treatments do little, if not nothing. These kind of combo studies are difficult to design and conduct, and expensive -- but they're all we've got." Taylor adds that this kind of research needs to be a priority for people studying aging and HIV, and for long-term survivors themselves.

Dr. Young believes that advances in lipodystrophy treatment will be informed by more basic research into fat, and how HIV affects it. He also champions exercise. Along with its numerous health benefits, it's also helped his patients with the visual appearance of visceral fat. He also supports advocating for increased access to existing treatments, however imperfect. That's how he originally learned about Sculptra (and got trained to administer it): because his patients consistently asked him about it. "The goal is increasing access to things that improve lives," he says.

***CAC Annual Holiday Party  
December 12, 2015  
Look For More Information at  
Both Health Center (Clinics)***



## TO DISCLOSE OR NOT TO DISCLOSE? SEVEN THINGS TO KNOW ABOUT MEDICAL FORMS AND HIV

From TheBody.com

If you are a person living with HIV/AIDS (PLWHA) or a physician treating PLWHAs, you may face a dilemma when completing medical forms -- the type required for employment, school, camp, guardianship, and other activities. Should you disclose HIV/AIDS information? Must you? What if patient and doctor do not agree? This article provides guidance so that you -- patient or doctor -- can make decisions thoughtfully. On one hand, disclosing HIV-related information can lead to discrimination and stigma. On the other hand, it may be necessary to determine medical fitness for the job, educational or sports program, or other opportunity. The following seven points should help you decide whether and how to disclose this sensitive information.

### 1: Is Disclosing HIV Status Medically Necessary?

The discussion should start here. Employers and others that require medical forms generally do so to assess fitness for the job or other opportunity -- with or without a reasonable accommodation. Read more about reasonable accommodation requirements in *Are You Somebody With HIV/AIDS?*

Therefore, the patient and doctor should discuss whether there is a legitimate medical reason to share HIV-related information. For example, an employer may not need to know the HIV status of an applicant who is medically fit and does not need a reasonable accommodation. Likewise, a school may not need HIV-related information

about a child who does not require medical attention during the school day. But a sleepaway camp might need to know a camper's HIV status to dispense medication.

### 2: Is Preventing HIV Transmission a Reason to Disclose?

The risk of HIV transmission in a job, school, or most other settings is remote. It almost never justifies disclosing HIV information. Medical and public health authorities endorse the full participation of PLWHAs in almost every form of employment, sports, and schooling if their physicians deem them medically fit. If there is exposure to blood and certain bodily fluids, the authorities recommend using Universal Precautions, such as rubber gloves to prevent transmission of blood borne diseases such as HIV. Such precautions are standard practice and are not limited to cases of known HIV infection.

### 3: Do You -- the Patient -- Want to Disclose Your HIV Status?

Maybe you prefer to limit disclosure of your HIV status because of pervasive stigma and discrimination. Or maybe you are comfortable disclosing it. Discuss your wishes with your doctor. For information about HIV confidentiality in the workplace, read our HIV/AIDS FAQs.

### 4: Does the Form Require HIV/AIDS Disclosure? Read It Carefully!

Medical forms may not always seek HIV-related information. Read the form carefully!

These questions may require disclosure. Even so, check to

make sure the question is legal (read #7):

*"List all medications."* "All"

means "all." If the patient is taking HIV medications, they must be listed.

*"List all diagnoses."* HIV and AIDS are diagnoses, so they must be disclosed. But if you, the physician, believe that your patient's HIV/AIDS does not impair his/her fitness for the job or other activity at issue, you could write something like "none that impair his ability to perform the job of [fill in type of job]." The employer might request more specifics, and you may then need to disclose. But be careful: writing only "none" -- without the qualification -- could be considered untruthful. Read #5, below.

These questions

may not require disclosure:

*"List any communicable, infectious or sexually transmitted diseases."* HIV is not classified as a "communicable," "infectious," or "sexually transmitted disease" in New York's health regulations (10 N.Y.C.R.R. § 2.1 and 23.1). Other states may be similar. In such a state, someone with HIV/AIDS could truthfully answer "no" to these questions.

Some medical forms do not explicitly ask about HIV/AIDS. Instead, they seek information about medical conditions that would impair an individual's ability to successfully perform the job, participate in camp or school, successfully be a foster parent, etc. Physicians should decide whether HIV/AIDS is relevant to the patient's fitness. If not, the answer truthfully can be "none."

### 5: Do Not Give False Answers. Do Not Leave Out

### Legally Required Information.

Medical forms must be completed truthfully. False information -- especially in response to legal questions -- can result in disqualification. For example, if a person checks "no" next to a box about "HIV or AIDS?" and the employer later learns that is untrue, the employer can legally deny employment because of the inaccurate information. The same is true in most other contexts. In contrast, using HIV information to deny you a job or admission to school can sometimes be illegal discrimination. For more information, read *Are You Somebody With HIV/AIDS?*

### 6: Get Consent for the Disclosure When You Need It

Doctors generally need a patient's written consent to disclose HIV-related information to employers and others requiring medical forms. These consent requirements are in HIPAA and many state laws, including New York's. You may download New York's authorization form here.

### 7: Is It Legal to Ask About HIV/AIDS?

It depends on who is asking and when. Under the Americans with Disabilities Act, employers may not ask about HIV or any other "disability" until after making an offer conditioned on passing a medical exam or completing a medical form. Even then, there are limits. The rules for schools and other contexts vary. But even if the question is legal, excluding someone because of HIV/AIDS may be illegal discrimination.

## GOOD COMMUNICATION STRATEGIES TO MAKE HIV CARE CLICK

From TheBody.com

Some of our most important relationships, and some of the most difficult to navigate, are the ones we have with our health care providers. Finding the right balance between respecting their opinions and questioning their advice can be hard. We can feel reluctant to tell them the truth for fear of being embarrassed or judged -- or in the case of HIV, leaving a record that could even be held against us in the unlikely event of criminalization. And, too often, we feel so rushed through the entire encounter that we leave more confused than when we arrived. Being able to hold open, honest conversations with your providers is vital to good health. That's why it is important to feel at ease with your providers, and to feel that you can trust them -- even in discussions that can make either or both of you uneasy.

Here are some tips toward building a comfortable and healthy relationship with your provider.

### Find a Provider You Click With

Though we usually choose our health care providers based on their expertise, location and whether they accept our insurance, the most important factor is often their personalities and bedside manners -- all of which can be impossible to know before the first visit.

Consider that initial visit a trial run, and notice your first impressions. As the appointment proceeds, take mental notes on the provider's style. Some are laid back and treat you like a pal, while others are more formal. Some are used to being the last word on every health subject and speaking definitively; others are more open to discussing options with you and plotting a course together.

Ask yourself: What are your first impressions? Do you feel comfortable discussing personal issues like sex or depression? Do you feel like you could ask questions or challenge professional opinions? Do you feel judged? If you are LGBT, how does the

provider react when you bring that up, both in verbal reaction and body language?

Take note of things outside the room as well. Was the front office staff friendly? Did they keep you waiting too long? Was there a waiting room full of people making you and the provider feel rushed? How can you contact your provider between appointments? Will you have direct communication, either through voice mail, email or an electronic medical records site, or do you have to go through office staff first?

While these may seem like trivial details, they can become very frustrating in the long run. It is not absurd to switch providers simply because the office staff is nasty, appointments are impossible to get, or no one ever calls you back to answer questions.

Trust your gut to decide whether this is a provider and an office you want to get into a long-term relationship with. Though health insurance or geographic issues may limit your choices of clinics or practices, there may be other options such as a different provider at the same clinic. Remember, providers may be the experts, but you are the customer.

Mark S. King made a practical and entertaining video showing how he went about finding "Doctor Right" that can help you in your quest.

### Plan Ahead

Office visits are not very long and much of that time is spent being poked and prodded. It can be easy to walk out without asking the one question that's been on your mind for months. The best way to prevent regret is to plan ahead. Make yourself a list including the questions and concerns you have as well as the things you want to make sure your provider knows (see the "Telling the Truth" section below). And don't censor yourself out of a fear of looking foolish -- your headaches probably aren't brain tumors, but telling your provider that the thought has

crossed your mind can both help determine what is really going on and put you at ease as well.

A list is also a good way to extend the visit if you feel rushed or sense that the provider is trying to get out of the room. Saying, "I know this visit is getting a little long but I have just three more things on my list to discuss with you," can be a good way to set parameters and get what you need.

### Telling the Truth

Whether they are trying to diagnose a new problem or manage your existing condition, health care providers are relying on the information you give them. But sometimes it's hard to give them the full story because of embarrassment or a fear of judgment. You may not want to admit that you didn't follow the advice you got at the last visit. Maybe you haven't quit smoking, changed your eating habits, or taken your medication exactly as prescribed. Revealing this can make you feel like a child being sent to the principal's office -- but keeping it to yourself can have negative repercussions on your care. Try to remember that you're an adult and, though it may feel this way, health care providers should not be the behavior police. Go ahead and tell the truth.

It can be intimidating to share details of your life, especially when those details include typically taboo topics like the number of sexual partners you have, interpersonal violence or drug use. Most providers have heard it all before and should take it in stride. (If your provider doesn't and you really do feel judged, consider a switch because this attitude can get in the way of an honest relationship and good care.)

It can be particularly hard to discuss mental health and relationship issues, but again, this information is important to your overall health. Depression and anxiety, for example, can be the cause behind physical symptoms. They can be treated but only if your provider is aware of them. Relationship issues such as interpersonal violence are

also relevant to your care as they can put you at risk for reinfection, other STDs or injuries.

If you have a history of trauma that can make medical exams difficult, it can help to let your provider know that you have experienced past or recent trauma. The National Council for Community Behavioral Healthcare suggests you let providers know what's helpful to you, such as requesting that they ask permission to do a procedure, keeping as many of your clothes on as possible, or having a supporter with you in the room.

It may be easier to bring up these sensitive topics when health care providers ask the right questions, and many will -- especially those who specialize in patients living with HIV. Unfortunately, some doctors are just as reluctant to bring up uncomfortable subjects as their patients. Others are too rushed to remember. Ultimately, it is up to you to make sure your health care provider is operating on full information. Again, try writing down a list of things you want to share ahead of time to make sure you don't forget.

### Considering Criminalization

When it comes to HIV, it's important to be aware of your -- and your health care provider's -- legal obligations under HIV criminalization laws and policies without letting those get in the way of your health care and your patient-provider relationship. Most states have laws or regulations that require people with HIV to disclose their HIV status to sex partners (even if condoms or low viral load means there's a low-to-incredibly-low risk) or face specific legal charges. If you don't know what your state or territory's HIV-specific laws are, learn about them. Although the chance that you will be involved in an HIV criminalization case is extremely low, it is highly likely that your medical providers will be asked to testify if you find yourself being prosecuted.

There are a few steps you can

Continue on Page 6

## GOOD COMMUNICATION STRATEGIES TO MAKE HIV CARE CLICK

### Continued from Page 5

take to ensure that you share information with your provider in a safe and mutually beneficial way. You can ask your provider to document in your medical records that you have disclosed your status to sex partners. Some people have even brought their HIV-negative partners to the doctor with them to have the conversation recorded in person, which is also an opportunity for their partners to get prevention questions answered. And if your viral load is undetectable, your provider can also document that you have had a conversation about what that means for HIV prevention. You can also talk with your providers about whether or not they need to document any conversations about your drug use or sexual behavior. There are a number of guidelines about this, including one for nurses in Canada and another for clinical providers in the U.K. that may help facilitate this conversation.

"It is usually suggested that records around risk and disclosure are kept to minimum, and that recording nondisclosure and lots of risk-taking is not necessary," says Edwin J. Bernard, coordinator of the U.K.-based HIV Justice network, "whereas recording that disclosure has taken place, and

that clinician information regarding effectiveness of undetectable viral load on HIV prevention has taken place, is a good idea."

It is up to you whether you obtain safer sex support from your medical provider. Discussing these issues with community-based or peer counselors may be easier. At times, some providers may have a different approach or agenda based on public health priorities (preventing new infections), rather than individual support (promoting your sexual health).

### Ask Questions, Speak Up and Bring a Friend

Sometimes it can be hard to absorb everything our health care providers are telling us. They may talk too fast or use too much medical jargon -- or they might just have a lot of information to offer. Don't worry if you don't understand it all the first time. You are well within your rights to ask them to go back, say it again, or explain it differently. It is OK to say "I don't understand." That doesn't make you stupid and it doesn't mean you're a difficult patient.

It's also OK to question the information they've given you. Medicine is not an exact science and health care providers don't all have the same opinions about the best course of action. If something your provider says contradicts

advice you've gotten from another health care provider or doesn't jibe with what your partner's provider suggested, ask for clarification. And if you aren't comfortable with the advice your provider gives, based on past experience or things you've read, speak up. It's better to give your provider the chance to explain than to try to sort it all out with information you find on the Internet when you get home. It is also better to tell your doctor that you disagree than to leave the office under the assumption that you're satisfied when you really have no intention of following the advice.

Advocating for ourselves can be tricky especially when we're still trying to absorb information. Consider bringing a partner, friend or family member who you feel comfortable with to your appointment. Another set of ears often helps, and your companion may have an easier time saying "Wait, I don't understand" or "Are you sure that's the very best course of action?" than you do.

We can't promise that these pieces of advice will guarantee a relationship free of awkward moments. But we do think that this can set the stage for an honest relationship with someone whose job it is to help manage your health.

## ELGIN CENTER

1665 LARKIN AVE  
ELGIN, IL 60123

PHONE (847) 695-1093  
FAX (847) 695-0501

## AURORA CENTER

157 S. LINCOLN AVE.  
ROOM K  
AURORA, IL 60505

PHONE (630) 264-1819  
FAX (630) 229-0182

[www.opendoorclinic.org](http://www.opendoorclinic.org)

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 B AT [deanb.odcac@outlook.com](mailto:deanb.odcac@outlook.com)

## NOVEMBER EVENTS

- |   |   |   |
|---|---|---|
| 03 - Positive Support Group (A)<br>4p - 5p    | 12 - Recovery Support Group (E)<br>12p - 1p   | 19 - Recovery Support Group (E)<br>12p - 1p   |
| 04 - Positive Support Group (E)<br>12p - 1p   | 13 - Support Group (A)<br>4p - 6p             | 20 - Support Group (A)<br>4p - 6p             |
| 05 - Recovery Support Group (E)<br>12p - 1p   | 13 - Positive Support Group (E)<br>12p - 1p   | 23 - Health & Wellness Group (A)<br>10a - 12p |
| 06 - Support Group (A)<br>4p - 6p             | 16 - CAC Meeting<br>5:30p - 7p                | 23 - Latino Support Group (E)<br>3p - 4p      |
| 09 - Health & Wellness Group (A)<br>10a - 12p | 16 - Health & Wellness Group (A)<br>10a - 12p | 23 - Pain Management Group (E)<br>12p         |
| 09 - Pain Management Group (E)<br>12p         | 16 - Latino Support Group (E)<br>3p - 4p      | 24 - Positive Support Group (A)<br>4p - 5p    |
| 09 - Latino Support Group (E)<br>3p - 4p      | 17 - Positive Support Group (A)<br>4p - 5p    | 25 - Positive Support Group (E)<br>12p - 1p   |
| 10 - Positive Support Group (A)<br>4p - 5p    | 18 - Positive Support Group (E)<br>12p - 1p   | 26 - Happy Thanksgiving<br>Centers Closed     |
|   |   | 27 - Centers Closed                           |



- (A) Aurora Center  
157 S. Lincoln Ave STE K  
Aurora, IL 60505
- (E) Elgin Center  
1665 Larkin Ave. Elgin, IL 60123
- (G) First Congregational Church  
321 Hamilton Geneva IL 60134