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HIV Frontline

A Newsletter for Professionals Who Counsel People Living With HIV

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Managing Work and HIV

Helping Clients Achieve a Productive and Rewarding Working Life

Before the advent of highly active antiretroviral therapy (HAART), a diagnosis of HIV/AIDS meant leaving the workplace, often permanently. HIV-infected individuals who were symptomatic frequently went on permanent disability, and most of them went home to die. Now, thanks to effective combination therapies, broadened medical knowledge, and improved prophylactic treatments, many people can continue to work, with few or no absences related to their illness. Those who have left the workplace temporarily are able to return to their old jobs or seek new ones.

Nonetheless, managing HIV at work presents unique problems and issues, with implications in the legal, medical, and psychosocial arenas as well as real challenges to time-management skills. Counselors have an important role to play when their clients express the desire to continue working or return to work after a diagnosis of HIV disease.

This issue of **HIV Frontline** looks at HIV and the challenges it can bring to the workplace.

To Work or Not to Work: The Medical Issue

Steve had been teaching for 20 years when he took medical leave, too ill from HIV to cope with a roomful of kids. He's been out of the classroom for 5 years, but he's feeling much stronger, thanks to his combination therapy. It has been more than 1 year since he's had any symptoms. He thinks he's ready to go back to work and believes it is essential to his emotional and physical well-being. He talked to his healthcare provider, who gave him the "OK" to return to work but emphasized the importance of continuing the therapy that has made this possible. He will need to adhere strictly to his regimen, get regular medical checkups (including viral load monitoring and CD4 counts), and follow a healthy diet and lifestyle.

For many people with HIV/AIDS, caring for their health is, in itself, a full-time job and should be considered the Number One priority. Although financial need may be a concern, the question of whether their health can be properly managed along with full- or part-time work is first and foremost a question to discuss with medical providers.

In Steve's case, the healthcare provider assessed his current medical status, the drugs and other therapies he was taking, his cognitive status (that is, his memory and attention span), his stamina, and the effect the stress of work might have on his medical status.

For a person who is physically healthy enough to work, the benefits can be psychological as well as financial. For some, work is empowering and a potential source of dignity and pride. Work gets a person out of the house; activity and time spent around people in the work environment can foster a sense of normalcy for many HIV-infected individuals. For people whose illness has put parts of their lives on hold, returning to work can be a milestone on the road to recovery. This achievement can improve the patient's mental health and self-esteem.

Work is often a source of stress, however, difficult for even healthy people to manage. A recent study conducted by Dr Jane Lesserman, psychiatric researcher at the University of North Carolina, found that stress may speed the progression from HIV to AIDS. The report noted that men in stressful situations with little social support were two to three times more likely to develop full-blown AIDS than individuals with lower stress and more support.

Work-related stress, combined with continued concern about their health and about disclosure of their HIV status, can be especially harmful to HIV-infected employees. People with HIV/AIDS need to take special care to minimize stress in their lives.

Keeping Benefits: Safety Net for HIV-Infected People in the Workplace

Tony worked at a succession of unskilled jobs before he left work on disability because of HIV/AIDS. He's been pretty healthy for the past 2 years, and his combination therapy has driven his viral load below detectable levels; however, he feels useless; except for his clinic visits, he has no reason to get out of bed in the morning. Someone in his support group suggested that he look for work, but Tony doesn't know where to begin. His last job—moving boxes around a warehouse—was meaningless, and

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besides, it's long gone. Tony figures he'll lose his government benefits if he returns to work, and what if he gets sick again? Tony never expected to live long enough to worry about questions like this.

Tony is a classic example of the "Lazarus syndrome"; he's an HIV-infected person who thought he had no future, only to find himself faced with an extended one and the problem of how to live it. His work life before contracting HIV wasn't fulfilling, and his current prospects for employment are slim. It is likely that any work he could get would not provide him with enough income to cover his considerable medical costs.

Tony could benefit from exploring vocational training. He may be able to enter a vocational-training program, get paid, and still receive his full benefits. What benefits he is eligible for and is able to maintain after employment can depend on whether he receives Supplemental Security Income or Social Security Disability Insurance (SSDI) through the Social Security Administration. Once he gets a job, he will retain his full SSDI during a trial work period (TWP) totaling 12 months (9 months followed by review and 3 months of additional coverage, regardless of income). In addition, his Medicare coverage will continue for at least 39 months after the TWP. After that, if his job does not provide comparable or better health insurance, Tony can buy his own Medicare coverage on a monthly basis. Because of his HIV status, he is still considered disabled under Medicare, whether or not he is able to work.

After the TWP, Tony's benefits will end only when his monthly earnings reach the level of substantial gainful activity (SGA). The amount so defined changes periodically and is currently $500 per month for a person with a disability and $1110 per month for a person who is blind. Clients with cytomegalovirus retini-

Letters to the Editor

In your article on Why Getting Tested Is So Important (Getting Tested for HIV, June/July 1999) you wrote about early treatment with HAART after an individual tests HIV positive. How can I explain the benefits of HAART to HIV-positive clients who are asymptomatic?

Experts caution that early initiation of HAART in asymptomatic patients has both benefits and risks. Benefits include control of viral replication and mutation, lower levels of viral load, and prevention of progressive immunodeficiency. Early initiation may maintain or restore a normal immune system, delay progression to AIDS, prolong life, decrease risk of selection of resistant virus, and lower the risk of drug toxicity due to treating an asymptomatic patient.

While this information may confuse clients, counselors can explain these benefits better by using a metaphor/analogy. Counselors have found that metaphors are effective in educating their clients about the positive effects of initiating HAART. A commonly used metaphor describes a "battle scene" in which CD4 cells fight the virus. For example, you may want to start by explaining to your clients that the immune system, like a fortress, is responsible for keeping the body healthy. Although the fortress is usually capable of keeping most of its enemies at bay successfully, the HIV-virus army is virulent enough to threaten the health of the CD4 army. To help prevent attack, the CD4 army should arm itself with the best weapons, ie, combination therapy.

This metaphor is one method that can be used to describe the benefits of therapy for the asymptomatic client; however, both the benefits and the risks of initiating HAART early should be considered before a decision is made.

Questions or comments about the "back to work" issue? Please write to Frontline Editor via fax at (212) 481-8532, E-mail at fronteditor@whcom.com or snail mail at World Health CME, Attention: Frontline Editor, 41 Madison Avenue, 41st Floor, New York, NY 10010-2202.

tis may fall into the latter category. Work expenses that are related to Tony's impairment will be deducted from his earnings when it is determined whether he exceeds this level. These include any specialized equipment he may need, possibly even transportation to and from work, and, most importantly, the antiretroviral medication that makes it possible for him to keep a job.

With his counselor's help, Tony got involved with the Social Security Administration's Plan for Achieving Self-Support (PASS) program. Under PASS, he can direct some of his income and assets toward his approved plan, further extending the time during which his income remains below the SGA cutoff.

Tony worries that his good health might not last. If he has a temporary health setback and his earnings fall below the SGA, his benefits will resume. This safety net is available for up to 36 months after Tony's TWP ends. If he is unable to work after that, his disability status and full SSDI benefits can be restored.

Sticking It Out: HIV on the Job

Eva, a cashier at a large chain variety store, has never felt ill. To put her mind at ease, however, she had an HIV-antibody test and discovered she was positive. At her physician's recommendation, she has begun ART. The only trouble is, her work and medication schedules are not compatible. Her break time does not coincide with when she needs to take her pills, and there is no refrigerator available in the store for her medications. So far, she has been able to schedule clinic visits during her time off, but she worries that her shift might change to a time that would interfere with clinic appointments. She is afraid to talk to her manager about her needs, because she fears he will be hostile and may even fire her if he knows the truth.

Eva may not consider herself disabled by her infection, but she is protected under the ADA (see sidebar on page 3). Although she is asymptomatic, her need to take life-sustaining medication and to receive regular medical care qualifies her for reasonable accommodations. She knows that if her supervisor becomes aware of her illness, any discrimination that results from his perception of a disability will be regarded as unlawful.

With her counselor's help, Eva learned about how the ADA applies to her. She asked her physician for a letter outlining the accommodations she requires: a change in her work schedule on days when she has clinic appointments, break times to coincide with her medication schedule, and installation of a small refrigerator in a storage area at the back of the store where she can keep her pills. As long as she remains well and her drug regimen is effective, these are all the accommodations Eva needs. If at some point in the future her needs change, she can request further accommodations. If, for example, she needs an extended period off for illness, she can ask for an extension of 12 weeks' unpaid leave under the Family and Medical Leave Act.

Eva still has not decided whether to disclose her condition at work. On one hand, she hates the idea of keeping a secret from her coworkers, many of whom have become her friends. On the other hand, she knows how gossip spreads and fears that not only her boss but some of the regular customers will treat her differently if they know. To address this fear, her counselor will need to examine Eva's communication and negotiation skills, possibly including a role-play exercise involving Eva talking to her boss.

HIV and the Americans with Disabilities Act (ADA)

The employment provisions of the ADA make it unlawful to discriminate against people who have or are perceived to have disabilities. A disability is defined as a "physical or mental impairment that substantially limits one or more major life activities." The ADA also protects individuals with histories of such disabilities or who are perceived by employers as having disabilities.

The ADA, which applies to public- and private-sector employers with 15 or more employees, covers HIV-infected individuals, even when they are asymptomatic.

Job seekers are protected against questions during interviews about the existence, nature, or severity of disabilities. Prior to making a job offer, the employer cannot mandate a medical examination, and if the offer depends on the satisfactory results of a postoffer examination, that examination requirement must apply to all potential employees in the same category.

At no time during the hiring process may an employee be required to disclose details of a disability. Any information the employer may have about the disability must be held in the strictest confidence.

Disabled persons have the right to request and be granted "reasonable accommodations" that will enable them to participate in the application process and/or to perform functions essential to the job. Reasonable accommodations might include adjustments or modifications to the job or work environment such as tailoring schedules to employees' needs and providing specialized equipment or modifying existing equipment.

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Eva knows that what laws mandate and what actually happens in the workplace are not always the same. Although she has worked at the store for 3 years and has always received good reports from her supervisor, there is the chance that knowing she has HIV will change his attitude. He might exert subtle pressure and make demands that undermine her morale. Some employees who believe that they are subject to unlawful discrimination resort to legal action, but others are reluctant to add the stress of a lawsuit to the strain of living with a serious illness. For them, looking for a new job in a more HIV-friendly workplace may be a better option.

Making a Change: Job Seekers Living With HIV

Helen is a reporter for a daily newspaper. HIV positive for 4 years, she is doing well on HAART, but she is exhausted most of the time and knows that that could spell disaster. To make matters worse, a new city editor is making the staff prove themselves against long odds. Most of her buddies are tuning up their resumes and looking for new jobs, and they have urged Helen to do the same; but she worries about losing her benefits, about answering questions that reveal her status, and about asking for accommodations that would make it possible for her to work in this environment. She feels miserable at her current job and scared to look for another, and the stress is getting to her.

Like Eva, Helen can and should avail herself of protections guaranteed under the ADA. As a job seeker, she is not required to disclose her illness, and she does not have to mention her need for accommodations until she has received and accepted a job offer. Nevertheless, finding a new job is rarely easy, and Helen needs as much help as she can get.

Fortunately, Helen's counselor was able to link her with an employment counselor who specializes in HIV- and ADA-related job searches. They have put together a winning resume and sent it to newspapers, magazines, and other media known to be HIV friendly. The employment counselor has been coaching Helen on how to navigate the interview minefield, and Helen has enlisted friends to rehearse "killer" interviews with her.

In looking for a new job, Helen also needs to consider medical and other benefits. Will she get the same or better coverage for her substantial medical and pharmaceutical bills? Will there be a gap because she has a preexisting condition? Medical insurance policies differ widely on these extremely important details. Fortunately, the Health Insurance Portability and Accountability Act was designed to remedy the problem, and it may help in Helen's case. Another option would be to pay for continuation of old coverage through COBRA (the Consolidated Omnibus Budget Reconciliation Act) until her new insurance is fully in effect.

Staying Healthy: Adhering to ART and Medical Appointments

HIV-infected workers need to be doubly vigilant about their health. They must take care not to overcompensate, immersing themselves in their work so deeply that they become exhausted; not to neglect their medical and personal needs; and not to allow themselves to be overwhelmed by stress.

Continued strict adherence to drug regimens is of paramount importance. Employees should discuss with their medical teams how to make their medication and work schedules compatible. It may be necessary to modify their prescriptions. To allow more user-friendly dosing at work and to minimize side effects, HAART regimens may need to be simplified by a reduction in the number of pills and frequency of dosing.

Simplified regimens are more likely to increase adherence. They also help reduce the numbers of breaks required during the workday. Newly approved antiretroviral agents, such as abacavir (a nucleoside reverse transcriptase inhibitor [NRTI]), amprenavir (a protease inhibitor), and efavirenz (a nonnucleoside RTI [NNRTI]), offer potent treatment options with lighter dosage schedules. According to the May 1999 US Department of Health and Human Services HIV-treatment guidelines, examples of simplified-dosing combinations include lamivudine/zidovudine plus efavirenz (two NRTIs plus one NNRTI) or lamivudine/zidovudine plus abacavir (three NRTIs).

Keeping medical appointments, including regular viral load and CD4 cell testing to monitor health status, is also essential. If medication schedules and/or alleviation of drug-related side effects require special accommodations on the job, workers should ask their care providers for letters to employers explaining what modifications are needed. Time off for medical appointments can also be requested as a reasonable accommodation under the ADA.

HIV-infected workers need emotional support—to deal with stress, to discuss work issues, to engage in and enjoy recreational activities, to stay connected with people who know about their illness and who support them, and to deal with the strain of disclosure.

What Counselors Can Do

Counselors whose clients wish to remain in or return to the workforce should educate themselves as completely as possible about benefits and legal protections applicable to their clients. They should build referral networks of experts in the many complex areas related to HIV/AIDS in the workplace. Counselors can also help their clients by

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- Discussing the many aspects of the "to work or not to work" question—Urge clients to talk to their physicians, recommend specific benefits and job counselors, and arrange for peer and other types of support, regardless of what decision is made. This is an ongoing process, and the issue may have to be revisited as a client's health status changes
- Identifying accommodations that will make it possible for them to work—For clients who believe they have been or fear they may be subjected to disability-related job discrimination, provide referrals for legal advice and assistance
- Providing support and referrals to help clients decide whether, when, and how to disclose their HIV status at work—Counselors should help clients manage stress that is associated with disclosure
- Discussing the pros and cons of a job change and helping coordinate the job search—This might include exploring options for health insurance and benefits and making referrals to support groups, employment counselors, and service agencies that specialize in HIV- and ADA-related job candidates
- Working with clients and medical teams to optimize adherence to ART regimens at work
- Providing support and referrals to help clients manage stress and other threats to health at work
- Providing continued psychosocial support and exploring transitional options for clients who are not yet ready to rejoin the workforce

Counselors can help clients better understand their health benefits by

- Examining the medical benefits, preexisting-illness clauses, length of time after employment coverage begins, etc
- Determining whether a change in health coverage due to employment will require that the client change health-care providers, therapists, hospitals, pharmacies, etc—and, if these changes will be required, process the pros and cons with the client, care providers, etc
- Working with the client's current health benefits and medical providers to ensure that there are no gaps in coverage during the transition period, that prescriptions have been filled, and that "stopgap" measures have been taken ■

Counselor-to-Counselor

The Back to Work Issue

By Sue Gallego, MSSW, LMSW-ACP*

Michael Sherrill, a veteran of 9 years in HIV case management in Austin, Texas, told me he responds to each client who contemplates returning to work in a "supportive, enthusiastic, and realistic" manner. So when my client, Bob, visited my office excited about feeling much better and wanting to return to his old job, that's how I approached the subject. Bob had been on Social Security disability income for 3 years and had become restless and bored at home. Bob was clearly a person whose identity had been tied to his work and career and who had difficulty adjusting to a "disabled lifestyle."

It was important to acknowledge how much healthier Bob was feeling, looking, etc, and to support the potential of new possibilities opening up for him. We focused on walking him through, step by step, what it would be like to return to work. It's easy to forget all the details of "work life" when you've been unemployed for 3 years. We talked about what working again would entail: getting up at 8:00 AM 5 days a week (even when he felt nauseous), checking the status of his car, making extra income, having additional expenses, changing to an evening support group, meeting and talking to new people at work, and experiencing exhaustion.

It was important to approach these steps in a nonjudgmental and supportive manner. Equally significant, was ensuring that information provided on Social Security disability income and Medicare was accurate and realistic.

Bob needed to be aware that he would probably lose his assistance from the State HIV Medication Program and might have to deal with a "preexisting medical condition" clause with his new employer's health-benefit plan. He also had to think through the pressures of the job, learning new guidelines, using new office equipment, and being the "new guy" again. We discussed what it might be like to leave the job at some point if he became ill again. Some of our clients talk about "going through it all over again"—that is, working for a year and then becoming ill or too exhausted to continue—in other words, reliving the feelings of grief and loss, saying good-bye to a working lifestyle, and having to reapply for Social Security and live on a fixed income.

Bob was lucky in that his past employer was glad to have him back, and they decided on a flexible part-time schedule that allowed Bob to focus on his health and maintain his Social Security benefits.

As counselors, we know that some clients may have more issues to consider than Bob did. Those who don't have employers welcoming them back will need to consider disclosure concerns, difficult medication schedules, side effects, and the total loss of disability benefits. While Bob had resumed a desk job, other clients, especially those with little work experience and limited education, may seek work that is physically intense—and therefore in not very healthy working environments.

Counselors need to consider the type of work clients are seeking, since it is an important factor in foreseeing potential adherence difficulties (due to hectic and/or inconvenient schedules).

**Sue Gallego is a private practitioner/consultant in Austin, Texas and a member of the HIV Frontline Editorial Advisory Board.*

HIV-RELATED CONDITIONS

Focus On: Tuberculosis

(Second in a two-part series)

The subject of last issue's article was tuberculosis (TB): signs and symptoms, mode of transmission, and epidemiology, especially within HIV-infected populations. TB in HIV-infected individuals is of particular concern, not only because of the increased risk for developing active disease but also because of problems inherent in diagnosing and treating TB in conjunction with HIV. Part II of our focus on TB will examine the issues related to diagnosis, prophylaxis, and treatment.

Diagnosis

TB can be difficult to diagnose in HIV-infected individuals because of the impaired immunity that characterizes HIV and the overlapping clinical signs of the two diseases. The key to early diagnosis of TB in HIV-infected individuals is to be vigilant in looking for signs and symptoms. According to Michael L. Tapper, MD, Chief of Infectious Diseases at Lenox Hill Hospital, New York, providers must always "think TB."

Anyone with HIV should be screened for TB. For high-risk populations, 6 months is the recommended interval between TB screenings. The standard TB screen is the Mantoux skin test, in which a small amount of purified protein derivative is injected just below the skin. Within 48 to 72 hours, an individual with prior exposure to *Mycobacterium tuberculosis* will present with some hardening (induration) at the site of infection. This reaction is evidence of infection, not necessarily of active disease. A person with advanced HIV disease whose immune system is so damaged that it cannot mount a reaction to the skin test may yield a false-negative result.

Anyone who tests positive should be given a chest X-ray. Chest X-ray is also recommended for HIV-infected individuals who test negative but have clinical signs of active TB. Additional tests include sputum smear and culture, in which a specimen coughed or aspirated from the lungs is cultured in the laboratory and examined for evidence of *M tuberculosis*. If extrapulmonary disease is suspected, other tests that are appropriate for the probable sites may be performed. Drug-susceptibility tests on an active bacterial culture are used for treatment planning, to determine whether the strain of TB is resistant to one or more of the standard drugs used.

Latent TB Infection: Prophylaxis

The latent phase of TB infection refers to infection in which clinical disease is inapparent, yet infection of the host has been established. Although people with latent TB infection are not ill and cannot infect others, they require prophylactic treatment to ensure that the disease is not activated. This is particularly important for HIV-infected patients, since the virus puts them at high risk for developing active—often aggressively active—disease.

The Centers for Disease Control and Prevention (CDC) recommends TB prophylaxis for all HIV-infected individuals with positive skin tests. Recommendations are for a 9- to 12-month course of the anti-TB agents isoniazid and pyridoxine. Shorter courses of a two-drug combination (rifampin and pyrazinamide) are sometimes used. Adding preventive treatment for TB infection to an existing HIV-treatment regimen, as well as coping with potential drug-related side effects, may be difficult for some patients. It is essential, nonetheless, that the full course of medication be taken faithfully to avoid the development of active disease.

Active Disease: Treatment

When an HIV-infected person has active TB, treatment should be initiated as quickly as possible, since the course of TB in the presence of HIV is swift and often deadly.

Combining ART and anti-TB drug therapy is a complex matter. From a practical point of view, the number of pills that should be taken faithfully and on schedule can be daunting. Side effects may be difficult to tolerate, and interactions between drugs may interfere with their effectiveness. In particular, rifampin and its "cousin" rifabutin have known interactions with methadone, hormonal contraceptives, several antifungals, coumadin, protease inhibitors, and NNRTIs. According to Dr Tapper, "[Treating] the coinfected patient involves the adroit management of several different classes of drugs and requires a clinician experienced in both diseases."

Adherence

Shortly after beginning anti-TB therapy, the patient will no longer be infectious. Symptoms will disappear, and the patient will feel markedly better. Improvement may also cause patients to stop treatment, however, which can result in a relapse and the possible development of drug-resistant disease.

Drug regimens for both prevention and treatment of TB can be arduous, particularly for individuals coinfected with HIV, and adherence is a major challenge. It is believed that the development of drug-resistant strains of TB, which coincided with the high point of the TB epidemic of the mid-1990s, was largely caused by poor adherence.

DOT (directly observed therapy) was developed to improve adherence and eliminate the specter of multidrug-resistant TB. It is now among the CDC

(continued on page 8)

H·I·V N·E·W·S B·R·I·E·F·S

News From the 1999 National HIV-Prevention Conference, Atlanta, Georgia, August 29-September 1

Despite the continued decline in the incidence of AIDS-associated deaths and a decrease in the number of new HIV cases, morbidity and mortality continue to strike disproportionately in certain populations. Reports from the first National HIV Prevention Conference, sponsored by the CDC, focus on an ongoing state of emergency in specific groups. Studies released at the conference indicated elevated annual rates of HIV infection among prison inmates, young gay men, people with other sexually transmitted diseases (STDs), intravenous-drug users, women, and minorities.

- Inmates at Correctional Facilities: The prevalence of AIDS among US prisoners is five times higher than that in the general population. There are between 35,000 and 47,000 HIV-infected inmates, of whom approximately 8900 have AIDS.
- African Americans: The rate of new AIDS cases among African Americans is 10 times higher than that among whites. The incidence of AIDS-associated deaths in 1998 was nearly 10 times higher among African Americans, representing 49% of all deaths from the disease.
- Young Gay Men: A survey conducted in Baltimore, Dallas, Los Angeles, Miami, New York, San Francisco, and Seattle found a 7% infection rate among gay men between the ages of 15 and 22, with a 3% annual increase in the incidence of new infections. Young African Americans and those of mixed race were particularly affected. Failure to follow safe sex practices appears to be a major factor.

Rates of Vertical Transmission Decline

The CDC reported significant declines in the incidence of perinatal HIV infection in the wake of United States Public Health Service recommendations regarding prenatal HIV testing and zidovudine therapy. According to the report, cases of perinatal AIDS reached a high point in 1992 and dropped a total of 67% through 1997. During that period, the percentage of HIV-infected women who received zidovudine increased from 7% to 91%. Implementation of zidovudine therapy and elective cesarean delivery provide hope for the elimination of vertical transmission of HIV in the United States.

Nonetheless, a CDC study found that HIV-infected women in the United States receive substandard prenatal care. The study reported that 68% of women with HIV had inadequate or no prenatal care from 1987 to 1996.

In developing nations, where access to antiretroviral drugs is limited by economics as well as by other factors affecting continual care, a new, simplified, and cost-effective strategy for preventing mother-infant transmission of HIV may provide an answer. Researchers in the United States and Uganda found that a single dose of the NNRTI nevirapine given to the mother during labor and to the infant after birth was highly effective in reducing the incidence of perinatal HIV infection.

CDC Reports Big Drop in TB Incidence

In 1998, 18,361 cases of active TB disease were reported in the United States, an 8% decline from 1997. This overall decline for the sixth straight year provides continued evidence that the United States has recovered from the resurgence of TB that began in the 1980s. These trends point, nonetheless, to a number of remaining challenges for the next era of TB elimination. These include the impact of the global TB epidemic in the United States and multidrug-resistant TB, of which 45 states reported cases between 1993 and 1998. According to the CDC, effectively addressing these concerns will require specific approaches for identifying and treating those populations at greatest risk, as well as a sustained US commitment and increased global collaboration.

Adherence Is Key to Differences Between Clinical Trials and "Real World"

A study by researchers at The Johns Hopkins University School of Medicine in Baltimore, Maryland, published in the *Annals of Internal Medicine,* compared the progress of people receiving HAART as outpatients with that of participants in clinical trials. After 1 year of therapy, researchers reported that HAART appears to be more effective in clinical trials than in the real world. The difference was attributed to missed clinic visits, which physicians said was the most frequent causal factor in reducing the effectiveness of HAART.

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Focus On: Tuberculosis *(continued from page 6)*

recommendations for all people with active TB. DOPT (directly observed preventive therapy) has been adopted in some localities for individuals with latent infection. DOT/DOPT can take various forms and be performed in a variety of locations. Basically, people receive anti-TB therapy in the presence of trained healthcare workers to ensure that medications are taken regularly and in the prescribed dosage.

Counseling Implications

Counselors play a key role regarding TB in HIV-infected clients. It begins with maintaining high levels of knowledge and awareness of the signs and symptoms of TB and working with clients and medical providers to ensure that all clients have regular TB skin tests. For clients with latent infection, counselors should promote adherence to preventive therapy and ensure that the importance of completing the course of treatment is understood. For clients with active disease, the need for adherence is especially important.

The health and lifestyle complications of coinfection will necessitate additional support and services. Legal issues such as contact notification and, for nonadherent patients, involuntary isolation may require counselor intervention. Coordination with the treatment team can help clients deal with the substantial burdens of HIV/TB coinfection.

Counselors should be aware of their own occupational risk and be screened for TB every 6 months. Regular screenings are especially critical for HIV-positive counselors.

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Resources

Returning to Work
National AIDS Fund Return-to-Work Initiative
The National AIDS Fund
1400 I Street NW, Suite 1220
Washington, DC 20005-2208
(202) 408-4848; www.aidsfund.org
Includes "Medical Checklist and Return to Work Issues for Persons Living with HIV and AIDS: A Personal Assessment Tool"

Americans with Disabilities Act
Equal Employment Opportunity Commission
1801 L Street NW
Washington, DC 20507
(800) 669-3362; (800) 800-3302 (TDD); www.eeoc.gov
ADA Helpline: (800) 669-4000; (800) 669-6820 (TDD)
Job Accommodation Network: (800) 232-9675 (voice and TDD)
Office on the Americans with Disabilities Act
Civil Rights Division
US Department of Justice
PO Box 66118
Washington, DC 20035-6118
(202) 514-0301; (202) 514-0383 (TDD)

Benefits

AIDS Benefits Handbook: Everything You Need to Know to Get Social Security, Welfare, Medicaid, Food Stamps, Housing, Drugs and Other Benefits, by Thomas P. McCormack, Yale University Press, 1990
Social Security Administration
Office of Public Inquiries
6401 Security Boulevard
Room 4-C-5 Annex
Baltimore, MD 21235-6401
(800) 772-1213; TTY: (800) 325-0778; www.ssa.gov
Social Security Administration publications: "Disability," Pub #05-10029; "SSI," Pub #05-11000; "Working While Disabled—How Can We Help," Pub #05-10095; "Working While Disabled: A Guide to Plans for Achieving Self-Support (PASS)," Pub #05-11017

Online

Websites with valuable information on benefits, discrimination, and other employment issues:
Gay Men's Health Crisis (GMHC): www.gmhc.org
AIDS Project Los Angeles: www.apla.org
The Body: www.thebody.org

To add your name to the mailing list for this publication, please send your request to **HIV Frontline**, World Health CME, 41 Madison Avenue, New York, New York 10010-2202. **HIV Frontline** is also available on the World Wide Web, through the HIV Information Network℠ at http://www.HIVLine.com.