5-30-2007

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Recommended Citation

Kimball, Ericka Lynn, "A Study of HIV Case Management Services Provided to People With a Triple Diagnosis Of HIV, Mental Illness, and Chemical Dependency" (2007). *Theses and Graduate Projects*. 337.
https://idun.augsburg.edu/etd/337

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MASTERS IN SOCIAL WORK THESIS

Ericka Lynn Kimball

A Study of HIV Case Management Services Provided to People With a Triple Diagnosis Of HIV, Mental Illness, and Chemical Dependency

2007

A STUDY OF HIV CASE MANAGEMENT SERVICES PROVIDED TO PEOPLE WITH A TRIPLE DIAGNOSIS OF HIV, MENTAL ILLNESS, AND CHEMICAL DEPENDENCY

ERICKA LYNN KIMBALL

Submitted in partial fulfillment of
the requirements for the degree of
Master of Social Work

AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

2007

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

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Date of Oral Presentation: May 30, 2007

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Acknowledgements

First, I want to thank my family and friends. I would like to thank my husband, Ben, who was supportive during my entire education. Thank you for reading countless drafts and offering me constructive feedback with a delicate hand. I would like to thank my children, Jaycie and Max, for understanding the importance of this project and my overall education. Thank you for letting me take so much time away from your childhood to complete my education. I want to thank the "Sister Club" for always providing humor and support when needed. I want to thank my Mom and Dad for supporting me and providing me with internet at the bowling alley so I could do my research while working.

I also want to thank the Augsburg College community. I would like to thank Dr. Lois Bosch for all the encouragement and support she offered in completing my thesis project. I would like to thank Michelle Sims, MSW, and all the staff at the Department of Human Services—HIV/AIDS Division for allowing me to do this project and being a sounding board for my ideas. I want to thank Dr. Nancy Rodenborg for taking the time to read my thesis and offering the great suggestions for revision. I want to thank Holley Locher for being supportive and proactive in assisting me with navigating the thesis project guidelines and rules. I also want to thank my Program Development, Policy, and Administration student colleagues for the support and encouragement in completing this project.

ABSTRACT

A STUDY OF HIV CASE MANAGEMENT SERVICES PROVIDED TO PEOPLE WITH A TRIPLE DIAGNOSIS OF HIV, MENTAL ILLNESS, AND CHEMICAL DEPENDENCY

EXPLORATORY STUDY OF HIV CASE MANAGEMENT SERVICES

ERICKA LYNN KIMBALL

MAY 30, 2007

This exploratory study researched the case management services provided to people with a triple diagnosis of HIV, mental illness, and chemical dependency. Data were gathered to determine what services were being provided and areas for improvement. Information was gathered from HIV case management survey providers and the Minnesota Department of Human Services HIV/AIDS Division. The study found that services were being provided to people with a triple diagnosis. However, case management services need to move from assessment practices to providing referral and follow up services. The social work profession needs to continue to advocate for this unique population while increasing education and advocacy on behalf of oppressed populations.

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Statement of Problem

Consistent access to primary medical care and antiretroviral medications are essential in the treatment and manageability of Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency syndrome (AIDS). For this paper, a triple diagnosis will be defined as a person who has HIV/AIDS, mental illness, and chemical dependency. It is estimated that 6-20% of people living with HIV/AIDS also have a combined mental illness and chemical dependency diagnosis (Bing et al., 2001; Stoff, Mitnick, & Kalichman, 2004). People with a triple diagnosis are at an increased risk for both non-adherence to antiretroviral medications and decreased access to primary medical care because of the complex interactions of the diseases (Andersen et al., 2003; Chander, Himelhoch, & Moore, 2006; Cook et al., 2006; Cunningham, Sohler, Berg, Shapiro, & Heller, 2006; Kalichman, 2004; Sealy, 1999; Tobias, Wood & Drainoni, 2006; Unger and Collins 2005; Wainberg & Cournos, 2000; Whetten et al., 2005). A review of literature showed that case management services can help to increase medication adherence and access to primary health care (Andersen et al., 2005; Ashman, Conviser, and Pounds, 2002; Chander et al., 2006; Gore-Felton et al, 2005; Kalichman, 2004; Wainberg & Cournos, 2000). It is inferred that these interventions can help increase the quality of life for people with a triple diagnosis. However, there are inadequate services available to meet the needs of people with a triple diagnosis.

The research project contained in this thesis will look at the case management services available from HIV service providers to examine the following questions. Are the HIV case management service providers addressing the needs of people with a triple diagnosis? Are the providers screening for mental illness and/or chemical dependency and making referrals when necessary? Are the providers assisting with medication adherence? What services are available to people living with HIV/AIDS, mental illness, and chemical dependency?

The information gained from this study will provide social workers with additional knowledge about how services are being provided and ways to improve service delivery to people with a triple diagnosis. Additionally, the information will help HIV service providers understand their programs better and determine if changes are needed. Lastly, the information will provide advocates with information needed to seek additional funding for programs for this unique population.

Chapter One

Literature Review

Human Immunodeficiency Virus (HIV) is the cause of Acquired Immunodeficiency Syndrome (AIDS). HIV is most commonly transmitted via unprotected sexual intercourse and the sharing of hypodermic needles (Goldfinger, Susser, Roche, & Berkman, 1998). These modes of transmission place people with mental illness and chemical dependency diagnosis at a higher risk of contracting HIV (Penner, 1994).

In 2006, more than 40 million people are living with HIV/AIDS (UNAIDS, 2006). There are 5,000 people living with HIV/AIDS in Minnesota (Rompa, 2006). Of these 5,000 cases, thirteen percent are injection drug users (Rompa, 2006). Furthermore, individuals with mental illness are more likely to have chemical dependency disorders (Chander et al., 2006). It is estimated that anywhere from 6-20% of people living with HIV/AIDS also have a combined mental illness and chemical dependency diagnosis (triple diagnosis) (Bing et al., 2001; Stoff et al., 2004).

The purpose and scope of this literature review is to understand how a triple diagnosis affects an individual's access to medical care. Consistent medical care affects access and adherence to the antiretroviral medications that are instrumental in treating HIV/AIDS. A better understanding of barriers to care and programs in development can lead to improved services for people with a triple diagnosis.

Importance

Twenty-five years after discovery, HIV/AIDS is now considered a manageable illness in the United States (Soto, Bell, & Pillen, 2004). Because of the manageability of the disease, attention has turned to long-term treatment (Soto et al., 2004). Few agencies work in collaboration to treat HIV/AIDS infection among people with mental illnesses and/or chemical dependency problems (Penner, 1994; Sealy, 1999; Seed, 2000; Tobias et al., 2006). It has been found that healthcare systems, whether private or public, are not prepared to concurrently manage chemical dependency, mental illness, and HIV infection (Seed, 2000; Tobias et al., 2006). Again, research indicates that half the people receiving care for HIV infection have a co-occurring diagnosis of chemical dependency and mental illness (Bing et al., 2001; Kalichman, 2004; Whetten et al., 2005). A triple diagnosis can contribute to the advancement of HIV disease to AIDS because of poor medication adherence and decreased access to primary health care (Chander et al., 2006; Cunningham et al., 2006; Kalichman, 2004; Tobias et al., 2006; Whetten et al, 2005).

Definition of Terms

Prior to beginning the literature review, it is important to understand the complex terms involved. HIV is a "retrovirus that destroys the immune system's T cell, the loss of which causes AIDS" (Encarta, 2006). Severe mental illness is defined as those people with a diagnosis of schizophrenia, schizoaffective disorder, recurrent major depression, and bipolar disorder (Chander, 2006; Lyon, 2001; Meade & Sikkema, 2005). Chemical dependency is defined as the inability to stop and misuse of mind-altering substances both legal and illegal including but not limited to marijuana, cocaine, heroin, methamphetamine, and alcohol (Encarta, 2006). Adherence to medication can be defined as the "match between the patient's behavior and health care advice" (Gore-Felton et al., 2005, p. 23). A diagnosis of HIV positive, chemical dependency and mental illness is the common definition of triple diagnosis in HIV literature.

Overview of Literature

Three themes were identified in the literature: 1) issues of adherence to antiretroviral medications, 2) access to primary health care services, and 3) service strategies.

Medication Adherence

The complex interaction between mental disorders and chemical dependency are compounded by HIV infection in regards to adherence to medication schedules (Kalichman, 2004; Whetten et al., 2005). Foremost, it is important to understand the difference between non-compliance and medication adherence. Non-compliance is an intentional decision not to take medication, whereas non-adherence to medication schedules is not intentional (Sealy, 1999). The reasons for non-adherence will be addressed throughout the literature review.

Once a medication regimen is started, it is important for a person to continue taking the medications as prescribed by a doctor. There are several different types of HIV treatment medications. The medications have different regimens and side effects. People with HIV may take up to twenty pills per day. There are several risk factors of not following the medical regimen, including the risk of developing resistant strains of HIV (Kalichman, 2004; Sealy, 1999; Wainberg & Cournos, 2000). In addition to developing drug resistant strains of HIV, suboptimal adherence to medication can lead to a reduction in efficacy of the antiretroviral drugs (Kalichman, 2004; Wainberg & Cournos, 2000). The success of the antiretroviral medications is dependent on 95% adherence to the treatment schedule (Wainberg & Cournos, 2000). For this reason, it is important to understand the barriers to medication adherence for people living with HIV who also have a mental illness and chemical dependency diagnosis. Individuals with a triple diagnosis are at an increased risk for non-adherence to antiretroviral medications because of the complexity in the medication regimen (Kalichman, 2004; Sealy, 1999; Whetten et al., 2005). This population may have difficulty understanding the amount and time of the medication treatment schedule. Furthermore, a triple diagnosis may affect a person's ability to access to the prescribed medications. However, it is also important to know that a triple diagnosis is not a predictor for difficulty with medication adherence (Wainberg & Cournos, 2000).

People with mental illness have a history of non-adherence to medication (Chander et al., 2006). Barriers to medication adherence include deficits in "cognitive, social support and social skills, symptoms of disorganization, avoidance, and paranoia" (Chander et al., 2006). Research has found that antiretroviral medication adherence increases when individuals receive adequate mental health services (Chander et al., 2006).

Depressive disorders are twice as common among HIV-positive individuals as those without HIV infection (Chander et al., 2006). Some long-term studies have found a link between the progression of HIV disease and depression. However, most of the information from the studies linking depression and disease progression has been inconclusive because of small samples and other study limitations. Research has shown that people with HIV and depressive disorders are less likely to adhere to antiretroviral medications. Women with depression and HIV are at a significant risk for increased mortality. Studies have found that people living with HIV who also have depression are more likely to adhere to antiretroviral medication regimens if they are concurrently receiving antidepressants (Chander et al., 2006).

The research indicated that people living with HIV who also have an active chemical dependency problem, are more likely to have poor medication adherence (Tobias et al., 2006; Wainberg & Cournos, 2000). Non-compliance is a major barrier to poor medication adherence. The barriers are include: "fear of side effects, disbelief regarding efficacy, concerns about 'exploitation' by medical community, desire for pregnancy, special dietary requirement and dosing schedule, interaction with other physical conditions and their medications, and concerns about the ability to maintain self-defined normalcy" (Gore-Felton et al., 2005, p. 28).

Access to Primary Medical Care

A triple diagnosis influences a person's ability to access primary health care. Contextual factors such as treatment settings, behavior of medical personnel, and referrals affect a person's perceptions and feelings about receiving treatment (Wainberg & Cournos, 2000). Programmatic barriers include limited walk-in services, absence of chemical dependency and/or mental health screening, and lack of knowledge among providers to care for people with a triple diagnosis (Cook et al., 2006; Tobias et al., 2006)

Women, African-Americans, Latinos, uninsured, and Medicaid insured people have an increased risk of not receiving quality health care (Andersen et al., 2005). The rates of HIV infection among women, African-Americans, and Latinos have progressively increased over the last several years (Kalichman, 2004; Meyerson, Chu & Mills, 2003). Additionally, women with a triple diagnosis face major barriers to accessing medical care such as lacking skills to make and keep appointments (Andersen et al., 2003). Unger and Collins (2005) report that female addicts who are receiving chemical dependency treatment are more likely to receive and adhere to antiretroviral medication than drug dependent women who are not receiving treatment.

A triple diagnosis increases the difficulty in accessing primary medical care in a typical health care system (Andersen et al., 2005). Substance abusers are less likely to receive primary care for HIV infection (Cunningham et al., 2006; Tobias et al., 2006). Cunningham et al. (2006) found that along with poor medication adherence, cocaine use was associated with substandard access to health care services. Additionally, substance abusers are less likely to access antiretroviral medications (Chander, et al., 2006; Cunningham et al., 2006). Barriers to care include inadequate insurance, difficulty obtaining healthcare, lack of education among providers about triple diagnosis and provider reluctance to prescribing antiretroviral medication due to poor adherence (Cunningham et al., 2006; Tobias et al., 2006).

Service Strategies

A study conducted by Ashman et al., (2002) found that HIV-positive individuals with mental illness and chemical dependency were more likely to access primary health care if they were receiving case management services. In addition, clients with case management services were also more likely to have a primary care provider. Clients with mental health needs were 1.8 times more likely to receive mental health treatment if they were receiving case management services. Likewise, substance abusers were 2.3 times more likely to receive chemical dependency treatment when receiving case management services. The receipt of mental health and chemical dependency treatment correlated with a client's access to primary medical care (Ashman et al., 2002).

Strategies to help reduce barriers to health care access include integrated treatment and patient-centered care models (Wainberg & Cournos, 2000). Integrated treatment emphasizes the connection of addiction and mental illness treatment models (Kalichman, 2004). Patient-centered models focus on the needs identified by the patient (Andersen et al., 2003; Andersen et al., 2005). There is limited research on services provided to people with a triple diagnosis and methods to improve those services.

The positive results of integrated treatment for dual diagnosis of mental illness and chemical dependency has led to the need to study models of integrated treatment for people with a triple diagnosis (Kalichman, 2004). The HIV Cost Study (Kalichman, 2004) researched the coordination of HIV, mental health and chemical dependency treatment services. The researchers are hoping to develop a set of best practices for people with a triple diagnosis (Kalichman, 2004).

The Well-Being Institute of Michigan conducted a study of using the LIGHT model of nursing interventions with women who have multiple diagnoses (Andersen et al., 2005). Personalized Nursing LIGHT model is an integration strategy that focuses on individual identified needs (Andersen et al., 2003). To enhance medication adherence, the LIGHT model uses weekly group sessions, individual nurse counseling, on-call phone support, pillboxes, daily journals, provision of necessities, transportation support, stress-reduction techniques, and health care support appointments (Andersen et al., 2003). The LIGHT model found that an increase in individual well-being was associated with a decrease in risky behavior and drug use.

The women studied were deemed “lost to follow-up” (Andersen et al., 2005). A team of nurses assessed these women using a “focal of concern” or the women’s perceptions of their immediate need. They then assisted with helping the women make and keep medical appointments. Assistance included connecting the women to case managers, helping with transportation and childcare, and accompanying women to health care appointments when needed. The study found that 95% of the women were able to attend their appointments with health care providers in the first three months of the intervention. However, the first three months of intervention included the time when nurses accompanied clients to their medical appointments. Over a prolonged period, there is less statistical significance in the difference in visits between the intervention and control groups implying the possible need for long-term case management. This study showed that with assistance, women with multiple diagnoses could maintain primary care services (Andersen et al., 2005).

The Healthy Living Project (HLP) is a behavioral intervention for people living with HIV/AIDS (Gore-Felton et al., 2005). HLP focuses on three factors of living with HIV: stress and coping, transmission risk behavior, and medication adherence (Gore-Felton et al., 2005). The study found there were a wide range of attitudes, beliefs, and motivations about HIV medication. The HLP consists of 15 sessions that are uniquely focused on the individual client goals. The goals are discussed at each session. Additionally, the individual focus of HLP is designed to work for diverse populations. The researchers hope to disseminate the results to professionals working with people with HIV in case management, treatment, and social service settings. However, HLP is still being evaluated so the efficacy is unknown (Gore-Felton et al., 2005).

Diversity Implications

The intricacies of race, class, and gender affect HIV diagnosis, health care access, and medication adherence. The research has shown that rates of HIV infection have increased for women and ethnic minorities even as rates of HIV infection for Caucasian males have leveled or dropped (Arias, 2006; Burke et al., 2003; Campo, Alvarez, Santos & Latorre, 2005; Cardelle et al., 2004; Heslin, Andersen, Ettner & Cunningham, 2005; King, Wong, Shapiro, Landon & Cunningham, 2004; London, Wilmoth & Fleishman, 2004; Mocroft, Gill, Davidson & Phillips, 2000; Morales, Cunningham, Galvan, Andersen, Nakazono & Shapiro, 2004; Shapiro et al., 1999; Steele, Richmond-Reese & Lomax, 2006; Zaidi et al., 2005). When mental illness and chemical dependency are added to the equation, the complexity of access to medical care and medication adherence are increased.

Race

Asian/Pacific Islanders. Along with women, racial and ethnic minorities are at an increased risk for HIV infection. In 2001, 51% of new HIV infections were among African-Americans (Arias, 2006). Latinos also have a higher rate of HIV infection in comparison to Caucasians (Campo et al, 2005). In comparison, Asian/Pacific Islanders (API) appear to have the lowest number of cases of HIV/AIDS infection (Zaidi et al., 2005). However, there is no evidence of APIs engaging in less risky sexual behavior (Zaidi et al, 2005). This population is often under diagnosed and understudied (Zaidi et al., 2005). There are two factors that contribute to the small number of APIs diagnosed with HIV/AIDS (Zaidi et al., 2005). First, the misclassification of their race/ethnicity in medical records could affect the reported number of APIs infected (Zaidi et al., 2005).

Second, APIs are less likely to report being tested for HIV. Several barriers to testing and early diagnosis exist including language, culture, economic status, and immigration status (Zaidi et al., 2005). It appears that these barriers negatively affect the health of APIs with HIV. In 2001, 41% of APIs were diagnosed with AIDS within one year of a HIV diagnosis (Zaidi et al., 2005). Further research is needed in the areas of access to primary health care and medication adherence.

African-Americans. As stated above, African-Americans have the highest rate of HIV infection in the United States (Arias, 2006). Of all United States racial groups, African-Americans have the lowest HIV survival rates (Hallfors, Iritani, Miller & Bauer, 2007). Furthermore, HIV is the fifth leading cause of death among African-American males between the ages of 35-44 (Clark-Tasker, Wutoch & Mohammed, 2005). AIDS diagnosis among African-Americans is eleven times that of Caucasians (Clark-Tasker et al., 2005). Early sexual maturation, high incidence of chemical dependency, and cultural attitudes towards homosexuality has been attributed to the high prevalence of HIV in the African-American community (Williams, 2003). Economic status, education/knowledge of HIV services, and mistrust of the medical community can affect access to health care and antiretroviral therapies (Williams, 2003).

Latinos. In addition to African-Americans, Latinos are less likely to receive quality HIV care than Caucasians (Steele et al., 1999). In 2002, 19% of people living with HIV were Latino (Campo et al., 2005). Additionally, 22% of all AIDS cases are Latinos between the ages of 20-24. Overall, Latinos accounted for 18% of AIDS deaths in 2002 (Campo et al., 2005). Men are more likely to be infected with HIV than women in the Latino community (Campo et al., 2005). HIV is most commonly transmitted via heterosexual sex and intravenous drug use (Morales et al., 2004). Cultural and social beliefs (i.e. stigma and mistrust of medical community), education (i.e. lack of HIV knowledge and lack of high school education), and socioeconomic status are attributed to high incidence rates and reduced access to health care (Campo, 2003). Immigration status can also affect Latino's access to medical care (Campo, 2003; Morales et al., 2004). Recent changes in Medicaid policies have changed eligibility for immigrants (Campo, 2003). These changes have made most immigrants ineligible for Medicaid services regardless of documented status. Therefore, many Latino immigrants lack adequate health insurance (Campo, 2003; Morales et al., 2004). These barriers also lead to delayed diagnosis (Campo, 2003). Finally, the complexity of the medication regimen can affect adherence because of language and education barriers (Campo, 2003).

Native Americans/Alaskan Natives. The high prevalence of intravenous drug use among Native American people places them at an increased risk of contracting HIV (Fisher, Cagle & Wilson, 1993). HIV rates among Native American populations have been rapidly increasing since 1991 (Weaver, 1999). Several risk factors contribute to greater risk of HIV infection. First, intravenous drug use is quite common among Native Americans and even more so for Native American women (Fisher et al., 1993). Furthermore, alcohol abuse often leads to unprotected sex (Weaver, 1999). Data has shown that 33% of HIV positive Native American had risk factors that included intravenous drug use (IV or IDU) (Weaver, 1999). Diabetes has also been shown to increase the risk for HIV infection related to the sharing of needles among Native Americans (Weaver, 1999). Similar to other racial groups, Native American HIV rates are often underreported due to misclassification (Weaver, 1999). Moreover, Native

Americans also face similar barriers to accessing healthcare as other racial minorities (Weaver, 1999). Socioeconomic barriers such as lack of transportation or access to health insurance are common among Native Americans (McNaghten, Neal, Li & Fleming, 2005). There is also the issue of mistrust of medical professionals, which is also common among African-Americans, Latinos, and women (Weaver, 1999). Ashman, Perez-Jimenez and Marconi (2004) report that Native Americans living in rural areas were in need of case management services as well as needing access to primary health care and traditional Native medicine.

Class

Socioeconomic status is an overarching issue among women and racial minorities in access to primary medical care. Mocroft et al. (2004) found that socioeconomic status was a significant barrier to access to medical care despite medication and medical services being free of charge. As indicated above, socioeconomic status influenced diagnosis and treatment for Asian/Pacific Islanders, African-Americans, and Latinos. People with HIV who are uninsured or have Medicaid have a less favorable view of medical personnel (Shapiro et al., 1999).

Cardelle et al. (2004) found that homelessness negatively affects access to HIV related services and treatment in a number of ways. First, people who are homeless may see medical care as a secondary priority over the need for food, money, shelter, and security (Cardelle et al., 2004). Second, distrust for medical providers can affect a person's desire to seek assistance (Cardelle et al., 2004). Lastly, systemic barriers such as transportation can inhibit a person's ability to access medical and social services (Cardelle et al., 2004).

Women

In recent years, the cases of HIV infection of women has increased at a faster rate then men (Heslin et al., 2005; King et al., 2004; London et al., 2004). In 2003, 27% of the new HIV infections were female (Heslin et al., 2005). The spread of HIV infection among women is mainly through heterosexual contact and intravenous drug use (Heslin et al., 2005; London et al., 2004; King et al., 2004). Furthermore, HIV/AIDS is a leading cause of death among females aged 25-44 (Burke et al., 2003). African-American women are twenty-five times more likely to be diagnosed with HIV then white women (Heslin et al., 2005; Steele et al., 2006). Between 2001 and 2004, 66-68% of new female HIV infections were African-American (Arias, 2006; Steele et al., 2006). Additionally, 70% of mother-to-child HIV transmissions were among African-Americans (Arias, 2006).

Research has not shown a difference in physical response to antiretroviral therapies based on gender (Mocroft et al., 2000). However, there are gender differences in access to health care (Burke et al., 2006; Campo et al., 2005; Mocroft et al., 2000; Morales et al., 2004). A study by Mocroft et al., (2000) found that women were less likely to start antiretroviral therapies. Burke et al. (2006) had similar findings. Women may have a more difficult time starting antiretroviral therapies because of family pressures, pregnancy issues, and socioeconomic status (Mocroft et al., 2000). Burke et al. (2006) also found that African-American women were more likely to be dissatisfied with health care services, which could affect their likelihood to start antiretroviral therapies. Morales et al. (2004) found that Latino women living in the Northeast United States were less likely to receive antiretroviral therapies in comparison to men and other women. The decreased use and access to these life-saving therapies can determinately affect a woman's prognosis (Mocroft et al., 2000).

Race, Class, Gender, Mental Illness and Chemical Dependency

Women, African-Americans, Latinos, uninsured, and Medicaid insured people have an increased risk of not receiving quality healthcare (Andersen et al., 2005). As stated above, the rates of HIV infection among women, African-Americans, and Latinos have progressively increased over the last several years. Additionally, people with diagnosis of HIV, mental illness and chemical dependency face significant barriers to accessing medical care such as lacking skills to make and keep appointments (Andersen et al., 2003). Substance use is a major mode of HIV transmission among women, African-Americans, and Latinos (Heslin et al., 2005; King et al., 2004; London et al., 2004; Morales et al., 2004; Williams, 2003). A triple diagnosis of HIV, mental illness, and chemical dependency further increases the difficulty in accessing primary medical care in a typical health care system (Andersen et al., 2005).

Critique of Methodology

The literature review on the effects of triple diagnosis on medical outcomes was a mix of qualitative and quantitative research. Both methods of research are effective in helping to understand the topic. The quantitative method of research was used mostly in evaluating program services. This was helpful in understanding the effectiveness of programs, but not necessarily, why the programs worked or areas for improvement. For example, the Ashman et al. (2002) study found that case management was effective in increasing an individual's access to primary care, but it does not explain the benefits from an individual's perspective. The qualitative method of research is helpful in gaining a better understanding of the complexities of the impact of a triple diagnosis.

Both research methods use specific target populations for samples. They are studying people receiving or who have previously received medical services. For this reason, the information gathered is not automatically applicable to larger populations. For example, the interview by Unger and Collins (2005) focused specifically on women in treatment programs. The information gathered was useful in understanding these women's stories and the effects of chemical dependency but cannot be generalized to other men or women. The sensitivity and stigmatization of HIV are most likely the reasons why researchers use targeted sample populations.

Gaps in Literature

There is an abundance of information on the topic of HIV infection and chemical dependency. Most of the information is about the transmission of HIV infection and unsafe sexual practices. There is also a considerable amount of literature available about HIV infection and mental illness. Again, most of the information is about the risks of transmission of HIV infection. There is limited information about triple diagnosis. Specifically, there is limited information about the affects of triple diagnosis on health care outcomes. In areas where information was unavailable, it was surmised that those with triple diagnosis would be affected similarly.

Another gap is the literature is that researchers rarely account for other contributing factors (such as poverty), which may create barriers to medication adherence and access to primary health care. Housing issues were not addressed as barriers to medication adherence and the ability to access medications. Inadequate insurance is briefly discussed in some of the literature, but is not the cited as the main barrier. Poverty, housing, and insurance may have an important impact on adherence and access. Further research on these issues are recommended.

Chapter Two

Theoretical Framework

The medical model, system and social justice perspectives, and behavioral theory construct the theoretical framework for understanding the complex interaction between medical needs and the integration of services for people with a triple diagnosis. This theoretical framework assists in understanding how and why medication adherence and access to primary medical care are essential in treating people with triple diagnosis.

Medical Model

The medical model focuses on the illness rather than on the individual. Typically, there is a focus on symptoms and the subsequent elimination of symptoms. Individuals are most frequently referred to as patients. This model is evident in most of the literature reviewed. The medical model is most relevant in discussing medication adherence. Chander et al., (2006) focused on the symptoms of depression and the interaction with HIV disease. They concluded that when symptoms of depression are treated with antidepressants, adherence to antiretroviral medication increased. Furthermore, the consequences of non-adherence to antiretroviral medication schedules are discussed in terms of the impact on the virus rather than on the individual. Research by Kalichman (2004), Sealy (1999), and Wainberg and Cournos (2000) discussed the implication of non-adherence on creating resistant strains of HIV and medication efficacy in treating HIV.

Systems Perspective

The systems perspective concentrates on the dynamic interaction between biological and social systems and is most apparent in the research areas of access to medical care and service strategies. The barriers to accessing primary medical care as described by Wainberg and Cournos (2000) showed the relationship between systems. For example, the way individuals are cared for by medical providers can be dependent on the knowledge that the medical provider has about triple diagnosis, which influence an individual's feelings about treatment. Moreover, strategies to reduce barriers to health care are dependent on the interaction of service providers. Kalichman's (2004) HIV Cost Study focused on the integration of HIV, mental health and chemical dependency services.

Social Justice Perspective

In addition to the systems perspective, the social justice perspective also looks at structural barriers to care. Barker defines social justice as, "an ideal condition when all members of a society have the same rights, protection, opportunities, obligations, and social benefits" (as cited in Finn & Jacobson, 2003, p. 15). The above review of literature has described the barriers that people of color, women, and low-income individuals face in accessing primary health care. Additionally, the lack of cultural competency in providing care creates even more barriers. The research showed that rates of HIV among oppressed groups were rising while rates among Caucasian males were stabilizing. Yet, additional services and outreach among these groups was lacking (Arias, 2006; Burke et al., 2003; Campo et al., 2005; Cardelle et al., 2004; Fisher et al., 1993; Heslin et al., 2005; King et al., 2004; London et al., 2004; McNaghten et al., Mocroft et al., 2000; Morales et al., 2004; Shapiro et al., 1999; Steele et al., 2006; Weaver, 1999; Zaidi et al., 2005). Misclassification and underreporting among these populations are also social justice issues (Campo et al., 2005; Weaver, 1999; Zaidi et al., 2005). Furthermore, the research has overwhelmingly missed economic barriers in discussing the obstacles of accessing primary healthcare and medication adherence. However, economic status was discussed in the literature on racial and gender barriers to accessing healthcare and medication adherence (Arias, 2006; Burke et al., 2003; Campo et al., 2005; Cardelle et al., 2004; Fisher et al., 1993; Heslin et al., 2005; King et al., 2004; London et al., 2004; McNaghten et al., Mocroft et al., 2000; Morales et al., 2004; Shapiro et al., 1999; Steele et al., 2006; Weaver, 1999; Zaidi et al., 2005).

Behavior Theory

A client's behavior is also important in understanding medication adherence and access to primary health care. As demonstrated by multiple research studies, substance use behaviors have a significant impact on medication adherence and access to primary care. Cunningham et al. (2006) found that cocaine use correlated with poor medication adherence. Gore-Felton et al. (2005) are currently implementing behavior interventions for people with a triple diagnosis.

Influence on Research Project

The medical model, systems and social justice perspectives, and behavior theory are important in understanding the complexity of triple diagnosis. The medical factors are important to understand when treating individuals to provide symptom reduction. The systems perspective is essential in coordinating services. The social justice perspective is important in understanding the barriers to care in regards to race, class, and gender. Behavior theory is important in understanding how individuals affect their own care. Case management appears to incorporate this theoretical framework. Case management works with individuals to coordinate medical and social services. A number of articles demonstrated the effectiveness of case management services in increasing an individual's access to primary medical care, which is instrumental in medication adherence (Ashman et al., 2002; Ashman et al., 2004; Andersen et al., 2003; Andersen et al., 2005; Chander et al., 2006; Gore-Felton, 2005; Kalichman, 2004; Under & Collins, 2005; Wainberg & Cournos, 2000). Therefore, in researching how case management providers in Minnesota are meeting the needs of people with triple diagnosis, the above theoretical framework was used.

Chapter Three

Research Methodology

Research Design

The design for this research project was a combination of qualitative and quantitative research methods. They were used to explore the following research questions. Are the HIV case management service providers addressing the needs of people with a triple diagnosis? Are the providers screening for mental illness and/or chemical dependency and making referrals when necessary? Are the providers assisting with medication adherence? What services are available to people living with HIV/AIDS, mental illness, and chemical dependency?

The primary source of data was from a self-administered questionnaire (Appendix A). The questionnaire was electronically delivered to HIV case management service providers to find out what services were being provided to people with triple diagnosis by HIV case management service providers. The questionnaire specifically asked about mental health and chemical dependency screening practices, referrals sources, types of services provided, and whether providers assess for medication adherence. The questionnaire consisted of mostly closed-ended questions with an open space available for respondents to elaborate on "yes" answers. The HIV case management service providers completed and submitted the questionnaire electronically.

Secondary data available from the Minnesota Department of Human Services (DHS) was also used. Information available through this secondary data source consisted of both demographics information and number of clients approved for mental health treatment through Program HH at DHS (Appendix B). Program HH provides health insurance, dental, nutrition, and drug coverage to HIV positive people in Minnesota. While not all case management clients were receiving Program HH services and vice versa, the demographics data provides information on services available to people living with HIV. Additionally, data gathered from chart reviews previously conducted by DHS at case management service provider agencies were used. The information provided from the secondary data source provided triangulation and elaboration of the data gathered from the HIV case management service providers.

Units of Analysis

The unit of analysis was the HIV case management service providers who currently have case management contracts coordinated by the DHS. The HIV case management providers were evaluated to determine how they were meeting the needs of people with triple diagnosis. The dependent variable of the research was the services provided to people with triple diagnosis. The independent variables were the type of organization, target population, assessment practices for mental illness and/or chemical dependency, internal and external referral sources, referral tracking, assessment practices for adherence to HIV, mental health and/or chemical dependency treatment, and types of services provided by the organization.

Conceptualization and Operationalization of Variables

The type of organization was defined as the main activity of the organization. Respondents were forced to choose one of the five different types of organizations: AIDS service organization, health clinic, community based organization, multi-service organization, or chemical dependency treatment facility.

A target population was defined as the population reached through specific action or intervention (Human Resources and Services Administration website, 2006). Respondents were able to choose any or all of the following five categories: race/ethnicity, gender, age group, special needs (e.g. injection drug users or homeless individuals), or none. If the participants answered in the affirmative, they were able to self-report the specific population targeted.

An assessment for mental illness and/or chemical dependency was defined as collecting information regarding current and past issues with mental illness and/or chemical dependency, treatments received, and client's perception of need treatments. Participants were asked to respond either yes or no. If a yes response was given, the respondent was asked to provide information on the assessment process.

Internal and external referral sources were the internal departments or external organizations the respondent used when making referrals for mental health or chemical dependency treatment. The participants were asked to answer yes or no to the question. If a yes response was given, the respondent was asked to provide information on where the referrals were made.

An assessment for adherence to HIV, mental health, and/or chemical dependency treatment was defined as collecting information regarding current and past issues with treatment adherence. Participants were asked to respond either yes or no. If a yes response was given, the respondent was asked to provide information on how the assessment was done.

Characteristics of Study Population

The population studied was the HIV case management service providers located in the Minneapolis/St. Paul metropolitan area (Twin Cities). All were contracted case management vendors who receive monies from the Ryan White Modernization Act (formerly the Ryan White CARE Act) or the State of Minnesota to provide case management services. The Ryan White Modernization Act provides federal funds to states for health care programs for people with HIV/AIDS. The State of Minnesota also supplied money for case management services, but the bulk of the funding was from the Ryan White Modernization Act. There were nine organizations with contracts for case management; three of them were invited to participate in the questionnaire portion of the research. The three providers invited to participate in the study represented various types of organizations currently providing case management services (i.e. community organization, clinic based, specific population served, and specialty in HIV/AIDS).

Location of Study and Data Sources

The location of the study was in the Twin Cities. The information was gathered from the services providers previously described. The primary and secondary data were stored at DHS in St. Paul, MN. The HIV service providers surveyed were chosen from a current list of contracted case management providers. The DHS Case Management Contract Coordinator selected the sample. The sample population was chosen based on the provider's relationship with DHS. Skepticism of the project and worry of provider's reaction to the study also influenced the choice of participants. The DHS Case Management Contract Coordinator did not want to over burden agencies with a request to complete the survey project. Two of the three service providers were located in the city of

Minneapolis; the other provider was located in St. Paul. Two of the providers had clinic-based settings. One service provider had an affiliation with a large urban hospital.

Study Limitations

Measurement Error

Systematic error. There was some inherent bias in the data collected because of the sample population. The sample population was hand picked by the Contract Case Management Coordinator based on the provider's relationship with DHS. Another risk of systematic error was that questions asked on the survey tool were those I deem important to evaluating how the needs of people with triple diagnosis were met. I may have been unaware of other important information needed to evaluate how services were provided. In order to reduce this bias, I adapted the questionnaire from a survey tool previously used by Human Resources and Services Administration (HRSA). Furthermore, I discussed the survey tool with four experts in the field to determine if the information collected was relevant to the research question. In addition, triangulation of the data also reduced systematic error. The data collected from providers was some of the same information available from DHS chart reviews.

Random error. Another area of concern was random error. The provider questionnaire was adapted from survey tool previously used by HRSA. I eliminated questions that were not relevant to the research question and reworded questions to reduce the use of jargon. Additional questions were included to focus the survey tool to service providers. I attempted to ask clear and concise questions with exhaustive categories. In an effort to reduce random error, I received feedback on the provider questionnaire from DHS HIV/AIDS staff, student colleagues, and other outside parties.

These individuals were provided with the purpose of the study but were given no other information. They were asked to check for ambiguities, biases, and overall formatting of the questionnaire. After the feedback was received, the questionnaire was revised. I discussed the secondary data sources with the Contracted Case Management Coordinator. I asked about how information was collected and entered into the computer system. I also reviewed the original data collection tool used by DHS to understand the context in which the data was collected.

Reliability and Validity

Reliability. In order to increase reliability, the questionnaire was designed to ask for data the respondents would be able to provide. I distributed the questionnaire to experts in the field to increase clarity and relevance. Although the questionnaire was adapted from a survey tool used by HRSA, it was changed enough to question its reliability. Therefore, I conducted a pilot test of the instrument with providers who were not included in the research study. The questionnaire was revised as needed. Only one version of the questionnaire was used so that all participants were asked the same questions. The questionnaire was self-administered by the participant. After the data was entered into Microsoft® Excel, it was "cleaned" to ensure the data was entered correctly. These measures, in addition to those described to reduce systematic and random error, helped to improve reliability.

Validity. There were several threats to validity that needed to be addressed in this research design. The use of peer and expert review and pilot testing of the questionnaire helped to increase face validity of the measure. Although it was unlikely, there was still a risk that the questionnaire was not measuring what I anticipated it to measure. Concerns about content validity were addressed by reviewing literature about the concepts being measured, discussing the measures with the Contract Case Management Coordinator, and providing space on the questionnaire for respondents to add additional information. In addition, both the peer and expert review and pilot testing of the questionnaire helped to increase content validity by reducing biases and ambiguities. The results of the questionnaire, along with data from the DHS chart reviews, were compared to indicate the concurrent type of criterion validity. One threat to this validity was history, because the chart reviews were performed up to five months prior to the questionnaire being completed. However, without using a classical experimental design, it was difficult to reduce the history threat to validity.

The theoretical framework for this research design was the medical model, systems perspective, social justice perspective, and behavior theory. The questions on the survey instrument were composed using this framework. Therefore, it was expected that the results from this research design would correspond with previous research.

Levels of Measurement and Classification of Variables

The main level of measurement for the questionnaire was nominal measure. A vast majority of questions asked for a yes or no answer. One question had a ratio measure because it asked for an estimate of the number of clients with a triple diagnosis. The remaining questions were nominal measures because they were mutually exclusive and exhaustive. Therefore, the variables for this research design were mainly discrete variables because they were finite. The estimate numbers of clients with a triple diagnosis were a continuous variable because the number can be infinite.

Data Collection Instruments

Data were collected using three methods. First, the primary source for data were electronically delivered questionnaires for HIV case management service providers to self-administer (Appendix A). The questionnaire measured mental health and chemical dependency screening practices, referral sources, types of services provided, and whether providers assess for medication adherence. Before the questionnaire was sent to the HIV case management service providers, the Contract Case Management Coordinator contacted participants to inform them about the research project. A cover letter with a link to the questionnaire was electronically delivered to HIV service providers by the researcher. A follow-up email was sent to non-respondents to remind them to complete and submit the questionnaire.

The other methods for collecting data were using secondary data from DHS records (Appendix B). As described previously, the data available from DHS data source consisted of demographics, prior authorizations for mental health, and data gathered from chart reviews previously conducted at HIV case management service providers by DHS staff and me. The chart reviews were performed as part of a quality review of the case management standards created by DHS. The demographics provided by DHS included all Program HH applicants. The applicants may or may not have received case management services. However, the demographic information helps to add information about the number of people who were receiving health care services through Program HH.

The HIV/AIDS Case Management Standards (2005) describe the duties and guidelines for providing case management services to people with HIV. The standards require case managers to assess clients and place them into one of the three tiers of service. Tier 1 was the lowest degree of case management needs. Clients who fall into Tier 1 services were those who have stable housing, an occasional need for specific services, need a verification of medical care, and require annual assessments. Tier 2 clients were those who need a moderate level of case management services. These clients typically initiate contact with a case manager, they need some safety net referrals, follow-up services, may have episodic crises, and require quarterly telephone contact and face-to-face contact every six months. Tier 3 clients were those with the most need. They typically need multiple referrals and follow-up. They may also have insurance issues, mental illness, and chemical dependency issues. These clients require coordination of medical services along with monthly telephone contact and face-to-face contact every two months. People with a triple diagnosis of HIV, mental illness, and chemical dependency were most likely to fall in Tier 3.

Data Analysis

The goal of the research was to find out how the needs of people with a triple diagnosis were being met by HIV case management service providers. This was done using descriptive statistics. In analyzing the quantitative data, I wanted to find the similarities and difference in services available from the service providers. Measures of central tendency and measures of dispersion were not analyzed. Neither of these statistical descriptors was helpful in evaluating the research question because of the small sample size. I used measures of association to understand relationships between variables. Microsoft® Excel was used to analyze the data.

The qualitative data were analyzed by identifying themes from the questionnaire answers. Qualitative data were also analyzed from DHS chart reviews. The themes from both data sources were compared. There was little statistical analysis on these sources of data. I used qualitative data to elaborate on barriers and to add context to the research. The information was not to be used to generalize to other populations but to add information about the services and providers.

Protection of Human Subjects

The protection of human subjects was of the utmost importance in conducting research. Before the questionnaire was sent to HIV case management service providers, the researcher gained approval from the Augsburg College Institutional Review Board: approval number 2007-11-02 (Appendix D). There was minimal risk to human subjects in this research project. A cover letter describing the risk and benefits of participation in this research project was electronically delivered to potential participants (see Appendix C). Participants were informed that the information given was voluntary and will not affect their relationship with DHS. Providers have the option of not participating and can choose not to answer any question. Furthermore, the information from the respondents was kept confidential.

Strengths and Limitations

The use of multiple data sources was a strength of this study. Triangulation can help reduce systematic errors and increase validity. An additional strength was the method used to collect data. Qualitative and quantitative data gathering methods were used in the research study. A variety of data collection methods allowed the researcher to gain a better of understanding of HIV case management services provided to people with triple diagnosis. The quantitative information presented information on the number of services provided, whereas the qualitative information showed how the services were provided. As a result, the data collected provided an array of information about how these providers were serving people with triple diagnosis.

The sample population was the main limitation of this study. The selection method used to gain the sample, along with a small sample size, was a limitation of the study. The handpicking of the sample can bias the responses. A positive relationship with DHS may have indicated that the sampled providers were of a higher quality than the other service providers were. The size of the sample was small and not be representative of all HIV case management service providers in Minnesota. Moreover, the sample did not include providers from suburban or rural areas, which have fewer resources available for people with a triple diagnosis. Therefore, the information gathered had limited external validity.

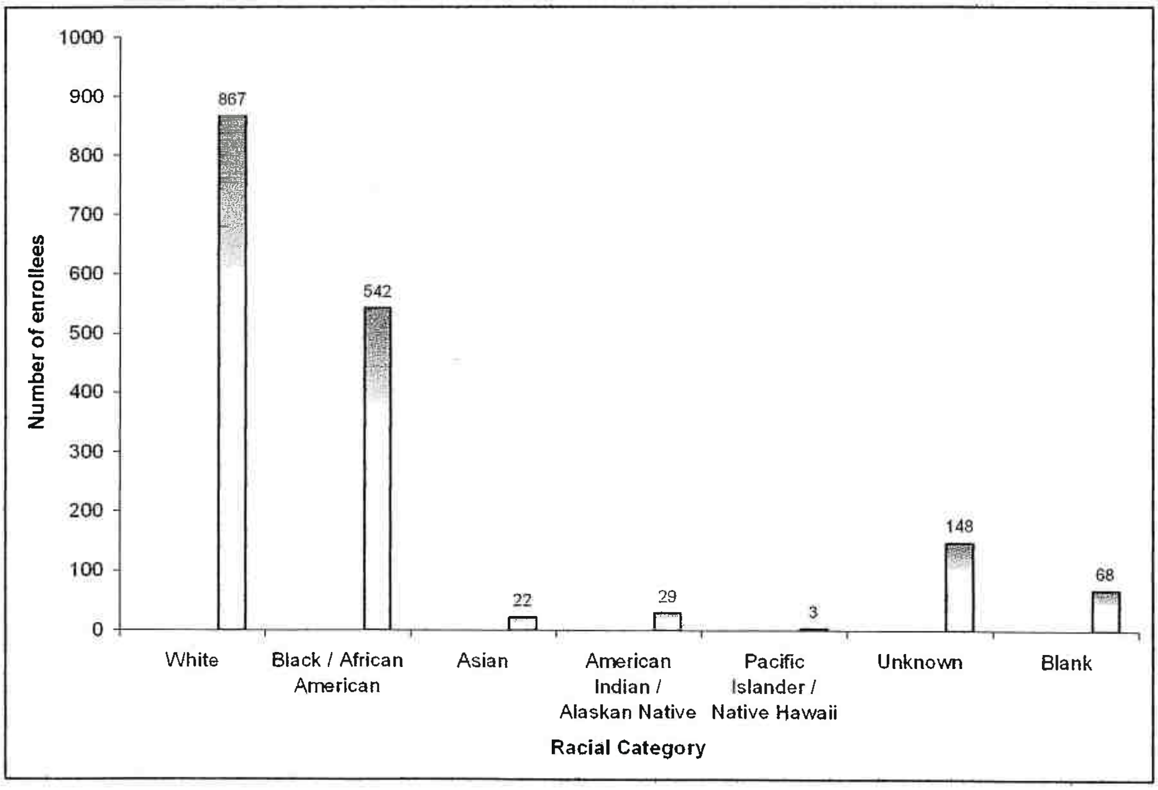
Chapter Four

Results

Summary of Data Collected from Program HH Applications

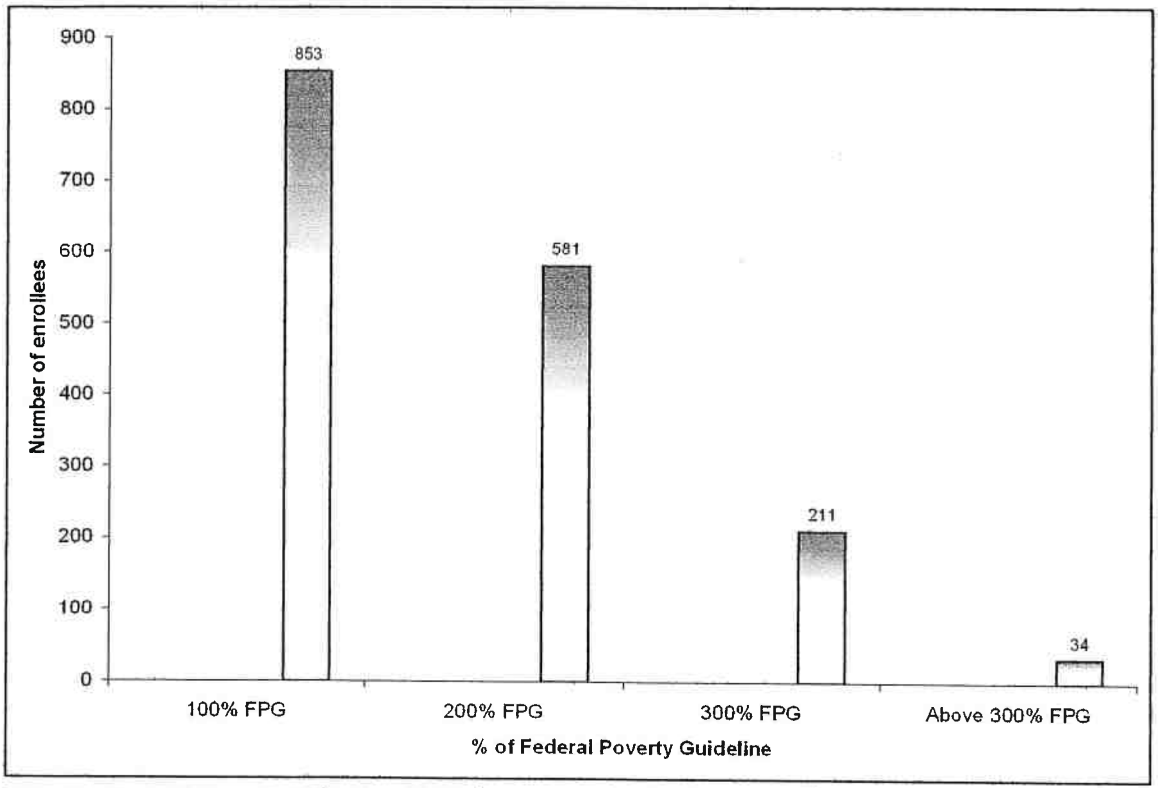
Program HH is a health care program administered by DHS. It provides health care, drug assistance, mental health services, dental, and nutrition services to HIV positive clients. Program HH is a payer of last resort, which means clients must exhaust all other payer options before they will be eligible for Program HH. From March 2006 to February 2007, more than 1600 people were enrolled in Program HH.

Figure 1. Self-selected race identification of Program HH enrollees from March 2006 to February 2007



From March 2006 to February 2007, 1679 people were enrolled in the DHS Program HH. Less than .01% (21) of enrollees had at least one prior authorization for mental health services in the selected 12-month period. Figure 1 shows the break down of self-selected racial identities of Program HH clients. Of those enrolled, 867 (52%) were white, 542 (32%) were black, 29 (2%) were Native American/Alaskan Native, 22 (1%) were Asian, and three (.2%) were Asian Pacific Islander. The remaining 216 (13%) were marked unknown or left the question blank. However, 123 (57%) of those respondents who checked unknown or left it blank did identify a Hispanic background.

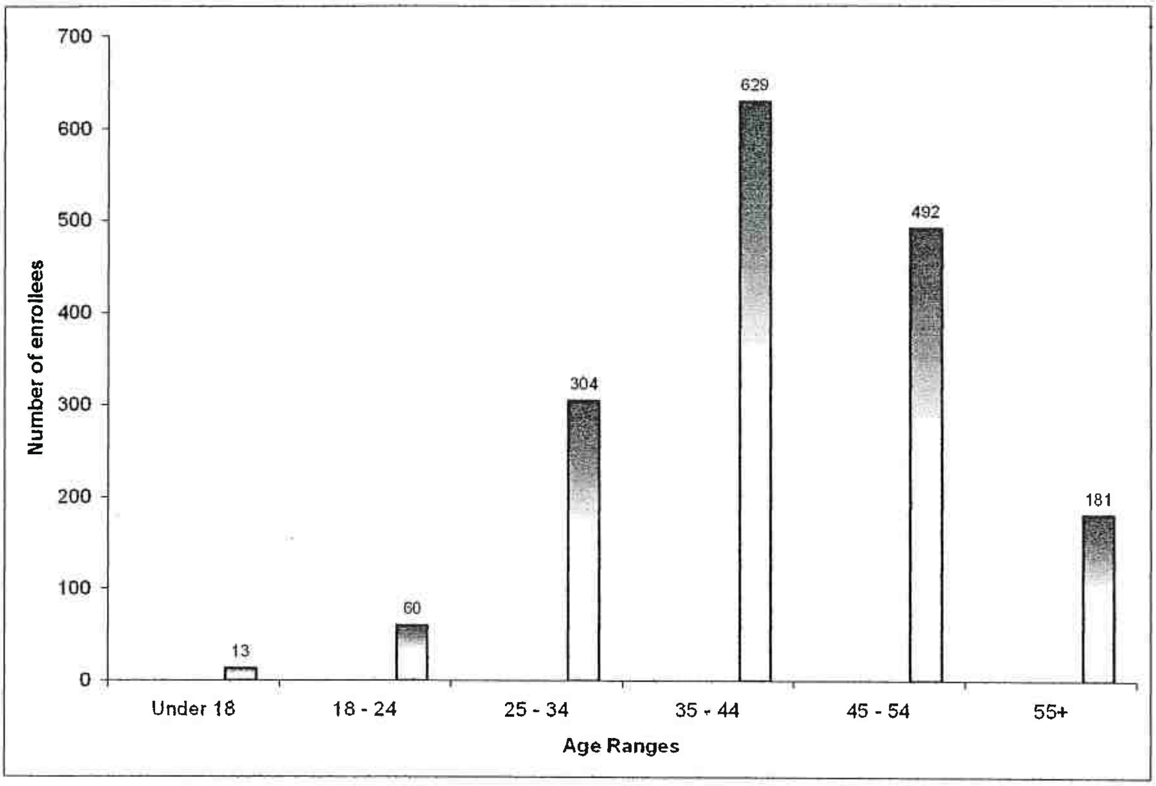
Figure 2. The number of Program HH enrollees with incomes in comparison to the Federal Poverty Guidelines.



Note. The Federal Poverty Guideline (FPG) is based on family size. A family of one with an annual income of $10,210 is at 100% of the FPG with $3,480 added for each additional family member.

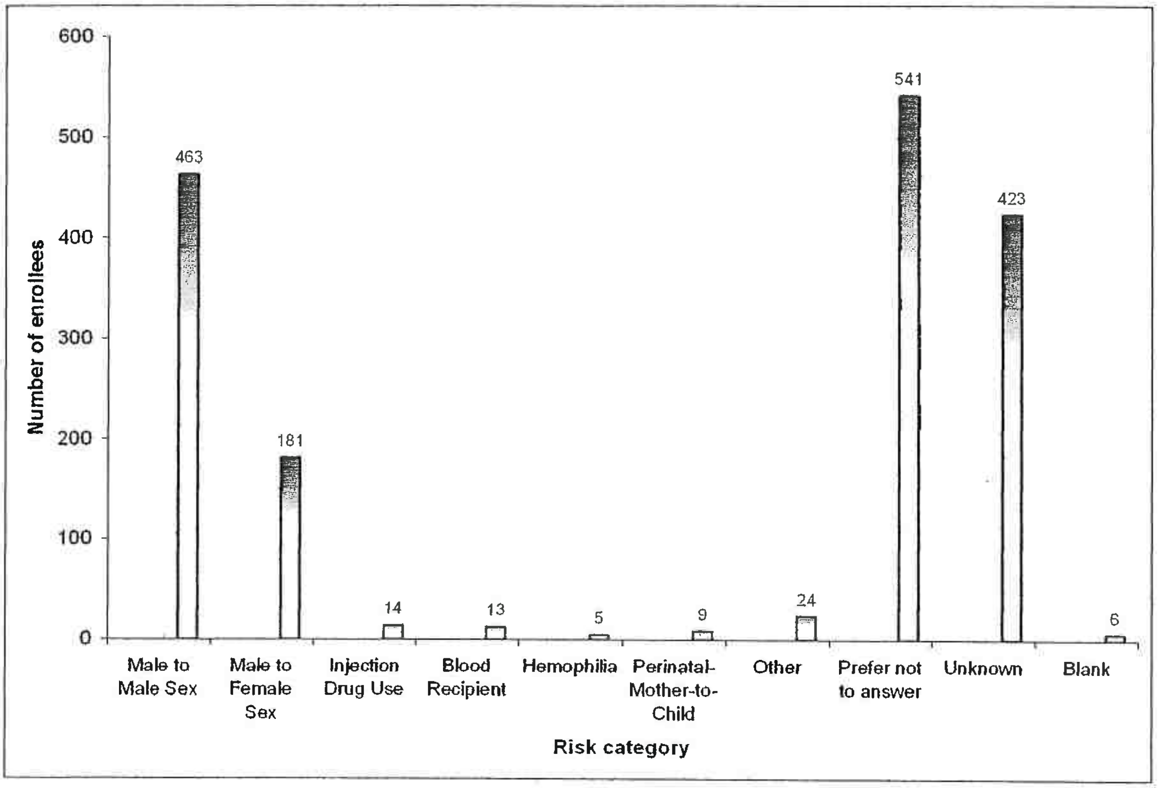
The number of enrollees with incomes in the percent of the Federal Poverty Guideline (FPG) are displayed in Figure 2. Eighty-five percent (1434) of the enrollees were between 100-200% of the FPG. The remaining 211 (15%) of enrollees were at 300% or above the FPG.

Figure 3. The age ranges of Program HH enrollees from March 2006 to February 2007



The number of Program HH clients in range of age is displayed in Figure 3. The majority of enrollees were between the ages of 35-44 years of age (629). The other two largest age groups were 45-54 years of age (492) and 25-34 years of age (304).

Figure 4. The self-reported transmission risk categories of Program HH enrollees from March 2006 to February 2007



The majority of people (32% or 541)) chose not to identify their risk exposure category. Another 25% (423) indicated they did not know their risk exposure category. Among those that cited a risk category, 463 (28%) cited male-to-male sex exposure category. Male-to-female sex was the second most common with 181 (11%) reporting this exposure category. Twenty-four people (1%) indicated “other” as their risk exposure category. Fourteen people (.8%) selected injection drug, thirteen people (.8%) identified themselves as a blood recipient, and nine people chose perinatal-mother-to-child transmission. Hemophilia has the smallest identified risk category with five people (.3%) citing this risk category.

Summary of Data Collected from Service Provider Chart Reviews

Table 1. The number of case management service providers (SP) documented assessment of mental health, chemical health, insurance, physical health and sexual risk behaviors.

	SP 01	SP 02	SP 03	SP 04	SP 05	SP 06	Totals
Mental Health	8	6	8	10	33	10	75
Chemical Health	8	6	8	10	33	9	74
Insurance Status	8	6	8	10	33	9	74
Physical Health	8	6	8	9	33	10	74
Sexual Risk Behavior	8	6	8	10	33	9	75
Total Charts Reviewed	8	7	8	10	33	10	76

As shown in Table 1, seventy-six client medical charts were reviewed at six different HIV case management service provider agencies. One service provider had 33 charts reviewed while the remaining five had a range of 7 to10 charts reviewed. Only one chart was missing a full assessment of mental health, sexual risk, chemical health, insurance, and physical health. One chart was missing a physical health assessment. One chart was missing chemical health, insurance, and sexual risk assessments. Three of the six providers successfully completed all assessments. The remaining three had one chart or more missing assessment information as described above.

Table 2. The number of case management service providers (SP) documented use of case management tier system.

	SP 01	SP 02	SP 03	SP 04	SP 05	SP 06	Total
Tier 1	1	0	0	2	0	0	3
Tier 2	2	0	0	1	0	0	3
Tier 3	3	0	0	0	0	0	3
Total number of charts reviewed	8	7	8	10	33	10	76

The number of charts with documentation of implementation of the previously described case management tier system is depicted in Table 2. Of all the charts reviewed, nine charts (12%) had documentation of using the case management tier system. Only two of the six providers implemented the case management tier system as described previously. Service Provider (SP) 01 used it on 75% of client charts reviewed, while SP 04 used it on 30% of the charts reviewed. Of those nine charts, three clients were assessed at a tier one, three at tier two, and three at tier three. People with a triple diagnosis are most likely to fall into Tier 3 of the case management system.

Qualitative data from the chart review provided the following information. Three charts (4%) of the 76 charts were found to have significant information regarding assessment practices. The remaining charts (96%) did not have any qualitative data relevant to the study. Chart 12 had a documented sexual risk behavior assessment that indicated the client practiced risky sexual behavior. However, there was no documented evidence of intervention in the client's care plan. Additionally Chart 18 showed documentation of a client being unable to access prescribed anxiety medication because of financial barriers. Again, there was no documentation of assistance in obtaining the prescribed medication. Chart 31 indicated active chemical dependency, but no documentation of chemical dependency treatment offered, sought, or discussed in the case plan.

Summary of Data Collected from HIV Case Management Service Providers

Questionnaires were sent to three HIV case management service providers in the Twin Cities metropolitan area. Two responses were received. One respondent reported providing HIV/AIDS outreach services, mental health assessments, and mental health services for people living with HIV/AIDS. One respondent reported providing Rule 25 assessment and follow-up referrals for clients. Additionally, both service providers reported providing psychiatric and psychotherapy service referrals within both their medical clinic and the Twin Cities metro area. Furthermore, both respondents indicated that case managers make the coordination with mental heath and chemical dependency treatment programs as part of the client individual goal plan.

Respondents reported assessing clients for medication adherence. One reported having a medication adherence program. The other reported having a medication therapy management program that includes one-on-one visits with a pharmacist. Furthermore, this respondent reported that physicians, nurses, and social service staff have the ability to provide information on medication, provide free medication counters, and provide information regarding adherence, medication side effects, and tips on reducing side effects.

Both respondents state they use the HIV case management tier system when assessing client. One respondent reported a range of 50-75 clients with identified HIV, mental illness, and chemical dependency diagnoses. The other respondent reported approximately 200-250 of their clients had HIV, mental illness, and chemical dependency diagnoses. One respondent reported serving 30-40 clients per month and the other reported serving 100 clients a month.

Discussion

The overall research questions: Are the HIV case management service providers addressing the needs of people with a triple diagnosis? Are the providers screening for mental illness and/or chemical dependency and making referrals when necessary? Are the providers assisting with medication adherence? What services are available to people living with HIV/AIDS, mental illness, and chemical dependency?

Are the HIV case management service providers addressing the needs of people with a triple diagnosis? The information obtained through the surveyed case management providers along with the secondary data indicates that the needs of people with a triple diagnosis are being met to some extent. The surveyed providers were able to identify clients with HIV, mental illness, and chemical dependency diagnoses. Respondent 02 reported that 25 (25%) of their clients have a triple diagnosis while Respondent 01 identified 50-75 (15%) clients with a triple diagnosis. Both respondents described their method for coordinating medical services for people with a triple diagnosis. Both state they provide psychiatric, psychotherapy, and chemical dependency treatment referrals to clients with a triple diagnosis. However, the chart reviews indicate that there is some inconsistency in documenting referrals and follow-up. Three client charts had identified mental health, chemical dependency, or risky sexual behaviors, but there was no documentation of referrals or follow-up. Although these charts represented only 4% of all the reviewed charts, it does indicate some inconsistency in the referral and follow-up process.

Are the providers screening for mental illness and/or chemical dependency and making referrals when necessary? The answer varies. The surveyed participants report they are assessing for mental and chemical health as well as making appropriate referrals. The chart reviews support this claim, but there is a lack of documentation regarding referral or follow-up at some agencies. This is not to say that the referrals are not made, but there was missing documentation in the charts, which indicates some service providers are not moving from assessment to referral as depicted in the HIV/AIDS Case Management Standards (2005).

Are the providers assisting with medication adherence? There is little concrete information regarding assessing for medication adherence. The chart reviews did not show any documentation about medication adherence assessments, but both survey respondents indicated having a medication adherence program. Respondent 01 stated, "Our clinic has a Medication Therapy Management program that includes one-on-one visits with a pharmacist." Respondent 02 simply stated they had a medication adherence program. The case management tier system as described in the HIV/AIDS Case Management Standards (2005) does not address medication adherence.

What services are available to people living with HIV/AIDS, mental illness, and chemical dependency? There are several different types of services available to HIV clients with mental illness and chemical dependency. The data on the breakdown of the types of services provided were unavailable to the researcher. However, all enrollees in Program HH are eligible for dental, nutrition, and mental health services. In addition to assisting clients with applying to Program HH, the HIV case management service providers reported providing outreach services, referrals to internal and external medical resources, offer bus cards, and referrals to community resources (i.e. food supports).

The findings indicate that case management service providers are attempting to address the needs of clients who have a triple diagnosis of HIV/AIDS, mental illness, and chemical dependency. Surveyed providers were able to identify people with a triple diagnosis and report having methods for coordinating healthcare services. However, the information from the chart reviews indicated that in practice, these methods are not being implemented or documented. Furthermore, the information from DHS indicates that people of color are underrepresented in Program HH services. Meanwhile, low-income families represent half of Program HH clients. Service delivery to people of color and low income individuals should be researched further to identify if needs are being met. Overall, the most interesting finding is that people with a triple diagnosis are being identified and there are programs in place that attempt to help this unique population, but there may be a gap in service delivery after needs are identified.

Chapter Five

Recommendations

Agency Recommendations

The literature review shows that people with a triple diagnosis are at risk for non-adherence to antiretroviral mediations and decreased access to primary medical care (Andersen et al., 2003; Chander, Himelhoch, & Moore, 2006; Cook et al., 2006; Cunningham, Sohler, Berg, Shapiro, & Heller, 2006; Kalichman, 2004; Sealy, 1999; Tobias, Wood & Drainoni, 2006; Unger and Collins 2005; Wainberg & Cournos, 2000; Whetten et al., 2005). These issues affect disease progression as well as quality of life. The research also indicated that case management services does improve medication adherence and increase access to primary health care adherence (Ashman et al., 2002; Ashman et al., 2004; Andersen et al., 2003; Andersen et al., 2005; Chander et al., 2006; Gore-Felton, 2005; Kalichman, 2004; Under & Collins, 2005; Wainberg & Cournos, 2000). The information from this study describes current services provided, if clients are being screened for mental illness, chemical dependency, and medication adherence. However, the research also indicates that while assessments are being performed, case managers are not consistently documenting the coordination of referrals and follow-up services. These are my recommendations for the Department of Human Service HIV/AIDS division in working with the case management system.

- Implementation of the case management tier system as described in the HIV/AIDS Case Management Standards at each service provider
    - Evaluation of tier system after implementation to determine if it is an effective system

- Incorporation of cultural competency in the HIV/AIDS Case Management Standards
    - Include cultural competency as a baseline skill
    - Include cultural competency in the case management training program
    - Evaluate cultural competency as a standard of care (i.e. during site visits)

I recommend that case managers implement the case management tier system as described in the HIV/AIDS Case Management Standards. The implementation of the tier system will assist in identifying those clients with a triple diagnosis of HIV, mental illness, and chemical dependency. The tier system also provides a description of required follow-up services. Furthermore, an evaluation of whether the tier system is effective in providing services should be conducted during the yearly quality reviews

The research indicates that the intricacies of race, class, and gender affect HIV diagnosis, health care access, and medication adherence (Arias, 2006; Burke et al., 2003; Campo, Alvarez, Santos & Latorre, 2005; Cardelle et al., 2004; Heslin, Andersen, Ettner & Cunningham, 2005; King, Wong, Shapiro, Landon & Cunningham, 2004; London, Wilmoth & Fleishman, 2004; Mocroft, Gill, Davidson & Phillips, 2000; Morales, Cunningham, Galvan, Andersen, Nakazono & Shapiro, 2004; Shapiro et al., 1999; Steele, Richmond-Reese & Lomax, 2006; Zaidi et al., 2005). As the rate of HIV infection for Caucasian males decreases, the number of women and ethnic minorities infected with HIV increases. Women and ethnic minorities are at an increased risk for delayed diagnosis, inadequate health insurance, and decrease access to medication. There is a general mistrust of the medical community among many ethnic groups. However, the research suggests that women and ethnic minorities typically have a more positive response to medical professionals who resemble them in race, gender, or are able provide culturally competent services. Furthermore, the research also indicates that clients with case management services are more likely to have a primary care provider, which increases medication adherence and decreases disease progression.

Therefore, it is important to ensure that HIV/AIDS case management service providers are offering culturally appropriate services. As a result, the proposed program recommendations would be to increase cultural competency in HIV case management services by including cultural competency in the case management standards. Culturally appropriate services are defined as the ability of service providers and others to accommodate language, values, beliefs, and behaviors of individuals and the groups they serve (Bronheim, n.d.; National Alliance for Hispanic Health, 2001). The current HIV/AIDS Case Management Standards (2005) require service providers to have culturally appropriate services including interpreter services, culturally appropriate referrals, translated materials, and bilingual staff and staff trained in cultural competence. However, cultural competency is currently not being specifically addressed in the baseline skills necessary for HIV/AIDS case manager nor is it seriously evaluated as a standard of care.

The proposed program recommendations would integrate cultural competency into the already established case management standards. I recommend using an organizational self-assessment tool (Appendix E) to identify an organization's strengths and weaknesses concerning cultural competency. After the self-assessment is completed, the organization should include weaknesses into their quality assurance (QA) plan. Furthermore, the QA plan should include formal and informal evaluations of cultural competency throughout the year. During annual site visits, DHS will review the organizational self-assessment and the QA plan. DHS will also discuss cultural competency with program directors and frontline staff as necessary. Lastly, incorporating cultural competency into the already established case management training program, which is provided by DHS, is also encouraged. Case managers are required to attend three case management training sessions provided by DHS throughout the year. Cultural competency skills can be included into these sessions to assist the case managers in providing culturally appropriate service.

Social Work Practice Recommendations

The review of literature found information about the affects of a triple diagnosis on medication adherence and access to primary care. The literature emphasized the barriers and risks of poor healthcare, but there was little information about solutions. Andersen et al., (2003), Andersen et al., (2005), Ashman et al., (2002), Chander et al., (2006), Gore-Felton et al., (2005), Kalichman, (2004) and Wainberg and Cournos (2000) emphasized the need for special programs for people with triple diagnosis, but only Andersen et al., (2003), Andersen et al., (2005), and Gore-Felton et al., (2005) discussed the programs available to help increase access and adherence.

Social workers are uniquely trained in understanding the importance of individualized care. Education in a variety of perspectives and theories offer macro practice social workers the knowledge they need to research and develop innovative integration services. Social work must take on the role of increasing awareness among practitioners in order to reduce barriers to health care access and increase medication adherence for people with a triple diagnosis. This education can help increase a medical provider's ability to serve people with a triple diagnosis. Social workers must collaborate with HIV prevention agencies in order to deliver services that treat mental illness, chemical dependency, and HIV prevention or treatment.

Additionally, social workers can take the information from this current literature review and the study to improve current case management services. Case management services appear to be an effective tool in helping people with a triple diagnosis. Macro practice social workers need to implement effective case management services for this specialized population. This means designing client centered programs that focus on the clients needs and integrated treatment programs that treat all three illnesses. Furthermore, macro practice social workers should implement culturally competent case management services that address the needs of specific cultural groups. Cultural competent case management services include the design of the agency environment as well as professional competencies. Lastly, social workers can use the information from the research and this study to advocate for additional funding and programs for people with triple diagnosis.

Social Work Policy Recommendations

Macro practice social workers are exceptionally trained to help build collaborations to bring much needed resources to people living with HIV both in the United States and globally. In the area of public policy, macro practice social workers need to advocate for the needs of this highly specialized population. The literature showed that health disparities among this population are widespread. Race, class, and gender further these complications. Macro practice social workers need to be advocating for policies that are helping these clients. The Ryan White Modernization Act contains a sunset clause that could impact the services available to people living with HIV. In 2009, the RWMA will be repealed forcing Congress to write a new policy or all services may be lost. Social workers were actively involved in the creation of the original Ryan White Care Act, so they need to continue their involvement to make sure safety net programs are available to people living with HIV. This is especially true in rural areas where many people living with HIV rely on the services provided by the Ryan White Modernization Act.

In addition, social workers needs to be working towards introducing policies that help eliminate the race, class, and gender health disparities in the United States. On a global scale, macro practice social workers need to help increase HIV awareness and education to help reduce the rapid spread of HIV in African countries. Macro practice social workers need to continue to bridge between micro practice needs and macro practice issues to help work towards improving the quality of lives of people living with HIV.

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Appendix A

1. Do you serve a specific population?

Race/ethnicity (please specify)
Gender (please specify)
Age group (please specify)
Special needs (e.g., injection drug users, homeless) (please specify)
Other (please specify)

2. What services does your organization provide

☐ HIV/AIDS prevention education

☐ HIV/AIDS outreach services

☐ Chemical dependency assessment

☐ Detox services (alcohol or drugs)

☐ Drug/alcohol/tobacco counseling

☐ In-patient drug treatment

☐ Out-patient drug treatment

☐ Self-help groups for substance users

☐ Mental health assessment

☐ Mental health care for infected adults

☐ Mental health care for infected adolescents (13-20 years old)

☐ Mental health care for infected children (under 13 years old)

☐ Professionally-facilitated support groups

☐ Peer-facilitated support groups

☐ Case management for medical services

☐ Case management for social services

☐ Case management for mental health services

☐ If service is provided to persons with HIV, please check.

3. Has your program implemented the Case Management Tier system?

○ Yes

○ No

4. Do you have clients with identified HIV, mental illness and chemical dependency?

○ No

○ Yes (estimate how many)

5. Describe how you coordinate services for clients with HIV, mental illness, and chemical dependency.

6. Does your program assess for HIV medication adherence?

○ No

○ Yes. If so, how?

7. Does your program assist with access to primary medical care (i.e. assist with applying for insurance, connecting client with a physician, etc.)?

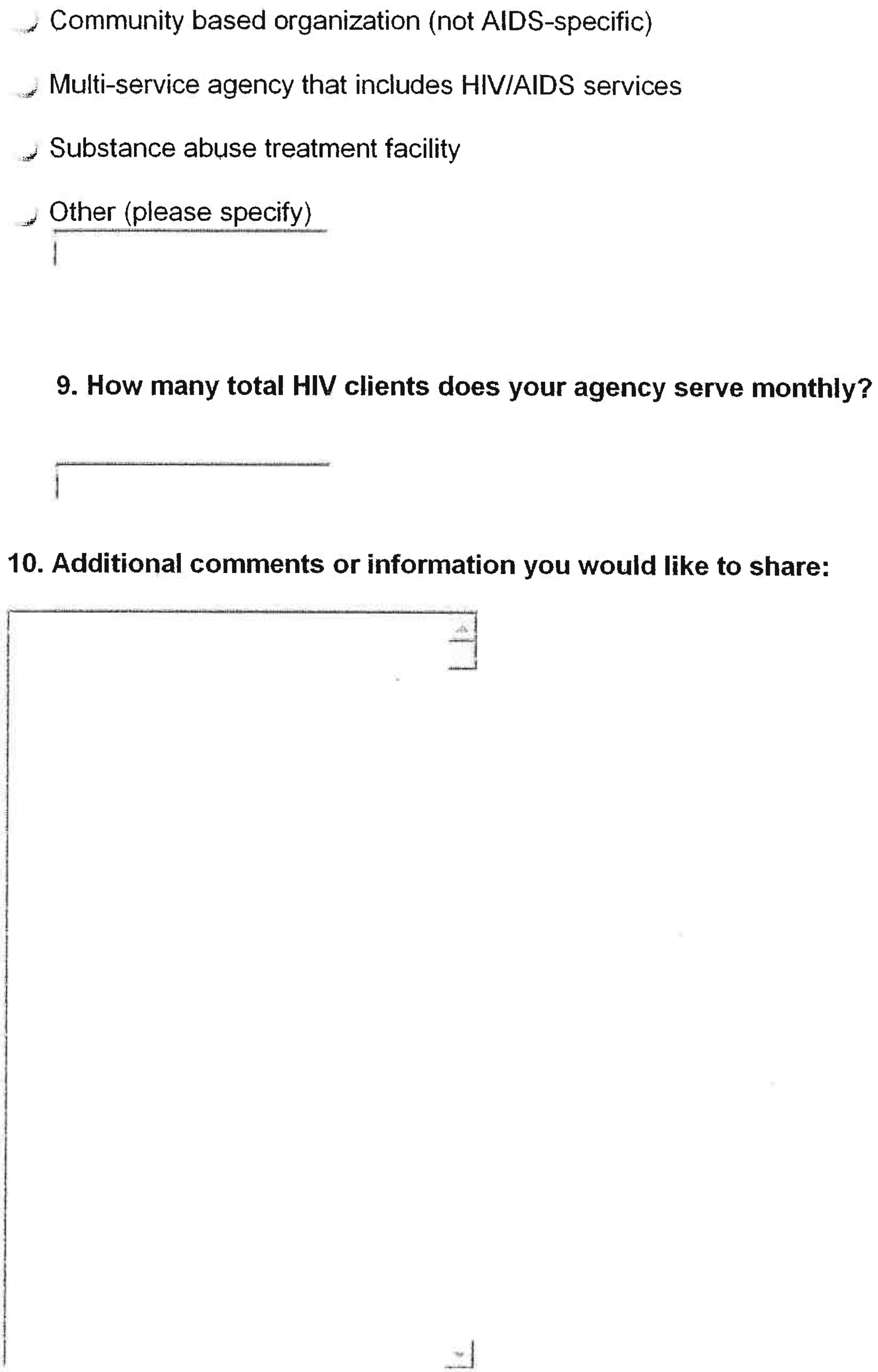
○ No

○ Yes. If so, how?

8. Which of these best describes your agency?

○ AIDS service organization

○ Health clinic



○ Community based organization (not AIDS-specific)

○ Multi-service agency that includes HIV/AIDS services

○ Substance abuse treatment facility

○ Other (please specify)

9. How many total HIV clients does your agency serve monthly?

10. Additional comments or information you would like to share:

Appendix B

Data Collection Tool for Data Available from the Department of Human Services

Using data collected from previous site visits write the number of HIV Service Providers completing:

_______ Mental Health Assessment
_______ Substance Abuse Assessment
_______ HIV Risk Behavior Assessment
_______ Insurance Assessment
_______ Physical Health Assessment

Using the data collected from previous site visits how many HIV Service providers are using the Tier System to determine level of case management needed? _________

Of those providers using the tier system, how many clients are currently receiving?

Tier 1 services _________
Tier 2 services _________
Tier 3 services _________

Using data available from DHS the number of client who have requested and received prior authorization for mental health treatment ______________

Using data available from DHS program applications:

Number of clients in each of the following age categories:
_____ 18-24 _____ 25-34 _____ 35-44 _____ 45-54 _____ 55+

Number of clients in each of the following racial/ethnic categories:
___ Caucasian
___ African-American
___ Asian/Pacific Islander
___ African Born
___ Hispanic
___ Other

Number of clients in each of the following income ranges:
_____ below 100% of Federal Poverty Guideline
_____ 100%-200% of Federal Poverty Guideline
_____ 200%-300% of Federal Poverty Guideline
_____ above 300% of Federal Poverty Guideline

Number of clients disclosing the following modes of transmission:
_____Male to male sex _____Male to female sex _____Injection drug use
_____ Blood recipient _____ Hemophilia _____Perinatal-mother to infant _____Other

Appendix C

Dear HIV Case Management Service Provider,

Earlier this month, Michelle Sims, DHS Case Management Coordinator, contacted you about a research project I am conducting to understand how Twin Cities metro area case management services are meeting the needs of people with HIV, mental illness and chemical dependency.

You are invited to be in a research study of services provided to people with co-occurring HIV infection, mental illness and chemical dependency (commonly referred to as "triple diagnosis). You were selected as a possible participant because of your affiliation and relationship with the Minnesota Department of Human Services.

This study is being conducted by me as a part of my summative/thesis project in the Master's of Social Work program at Augsburg College in Minneapolis, Minnesota. My advisor is Lois Bosch, Ph.D, LISW, Associate Professor at Augsburg College.

Please take a moment to fill out the short, ten-question questionnaire to help me evaluate how the needs of people with HIV, mental illness and chemical dependency are being met by case management services.

To access the questionnaire, click on the link below or copy the URL into your internet browser. http://www.surveymonkey.com/s.asp?u=937673015106. The survey will be open through March 5, 2007.

There are no known risks to your participation in this study. There are no direct benefits to your participation. Indirect benefits to participation are gaining a better understanding of your program and services. This knowledge may help you improve programs or policies if needed.

The records of this study will be kept confidential. If I publish any type of report, I will not include any information that will make it possible to identify you. All data will be kept in a locked file at the Minnesota Department of Human Services in St. Paul, Minnesota; only my advisor, Lois Bosch, Ph.D., LISW, and I will have access to the data.

If the research is terminated for any reason, all data and recordings will be destroyed. While I will make every effort to ensure confidentiality, anonymity cannot be guaranteed due to the small number of providers to be studied. Raw data will be destroyed by August 31, 2010.

Your decision whether or not to participate will not affect your current or future relations with Augsburg College and/or the Minnesota Department of Human Services. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

If you complete and submit the questionnaire, it assumes your consent is given. Additionally, you will be consenting to allow the use of direct quotations in the published document.

Should you have any questions, please contact Ericka.Kimball@state.mn.us.
Thank you.
Regards,
Ericka Kimball, MSW Student Intern
Minnesota Department of Human Services—HIV/AIDS Division

Appendix D

Institutional Research Board
Augsburg College
Box 107
2211 Riverside
Minneapolis MN 55454

February 8, 2007

To: Ericka Kimball

From: Norma C. Noonan, Chair

I am pleased to inform you that the IRB has approved your application for the project: **Study of HIV Case Management Services Provided to People with a Triple Diagnosis**

___ as submitted

__xx__ as revised with the additional form(s)/changes

_____ with the following conditions: .

Your IRB approval number which should be noted in your written project and in any major documents alluding to the research project is as follows:

2007-11-2

I wish you success with your project. If you have any questions, you may contact me: 612-330-1198 or noonan@augsburg.edu.

c. Lois Bosch

Appendix E

Organizational Self-Assessment Tool

This assessment tool helps an organization to identify its strengths and areas where it may want to enhance its ability to serve culturally diverse populations. The tool will focus on:

- service delivery and quality management
- human resources practices
- governance, community relations, and marketing
- administration and policy
- organizational culture

INSTRUCTIONS

For each statement below, circle the one response that best describes your current organization. If you do not have sufficient information to respond to the statement, leave it blank.

SERVICE DELIVERY AND QUALITY MANAGEMENT

1. The organization provides culturally-specific programs or services

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

2. Program design reflects input by people from diverse cultures

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

3. Intake procedures are compatible with the needs of cultural groups being served

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

4. Service authorization criteria are developed by, or in consultation with, professionals from the cultural communities being served.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

5. Our organization uses the expertise of individuals form diverse cultural backgrounds to assist in providing services to other individuals from similar cultural backgrounds.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

6. Referrals are made to culturally-specific organizations.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

7. The organization is able to serve culturally diverse individuals in their own languages, written and verbal.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

8. Client education materials are culturally appropriate and translated into the languages of diverse clients.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

Adapted from the Department of Human Services Organizational Self-Assessment Tool www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisorSelectionMethod=LatestReleased&dDocName=id_016429

9. Workers assess how clients' cultures and their own cultures affect their perceptions and decisions when assessing a client's needs and developing service plans.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

10. Cultural knowledge and cross-cultural skills are assessed as part of employee and contractor performance evaluations.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

11. Our organization has a clear process for evaluating the short and long-term impact of its programs and policies on culturally diverse clients.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

12. Service providers solicit the client's story and ask for feedback on service encounter.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

13. Resources are allocated in a manner that addresses the needs of diverse populations.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

14. Service providers and clinicians are knowledgeable about cultural differences regarding child rearing, role of family in decision-making, concepts of mental health and the nature of illness, and other culturally-specific needs and service-delivery considerations.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

15. Service providers and clinicians are knowledgeable about disparities in service outcomes among diverse cultural populations.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

16. Service providers and clinicians are knowledgeable about aggregate difference among cultural groups in area relevant to their disciplines, such as disease prevalence, variances in physiological response to medications, poverty levels, violence levels, and implications varying in levels of assimilation and acculturation.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

17. Providers are familiar with social problems that have a different impact on minority group members (socio-economic disadvantage).
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

HUMAN RESOURCES PRACTICES

18. The cultural make-u of the staff reflects the cultural diversity of clients served. The organization has developed a staff profile and compared it to a client demographic profile.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

19. The organizational actively recruits and hires bilingual staff.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

20. Culturally diverse staff occupies positions at every level of the organization.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

21. The organization provides opportunities for leadership development and advancement for all staff, including staff members from culturally diverse groups.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

22. Job descriptions and performance evaluations give explicit value to experience and competence in working with culturally diverse clients, staff, and contractors.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

23. Job announcements and descriptions indicate that candidates must have an understanding of and sensitivity to serving culturally diverse populations.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

24. Potential candidates are required to demonstrate cross-cultural interaction skills.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

25. The organization has been successful in retaining staff of diverse cultures.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

26. The organization has staff training and development programs to enhance cultural knowledge and cross-cultural skills.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

27. Supervisors are routinely evaluated on advancing cultural competence.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

28. Newly-hired staff are matched with mentors within the organization.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

29. Volunteer recruitment strategies target people from diverse cultural backgrounds.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

GOVERANCE, COMMUNITY RELATIONS, AND MARKETING

30. Members of diverse communities are incorporated into our decision-making processes. The composition of our decision-making bodies reflects the cultures of the communities we serve. Our organization has an articulated strategy to recruit governing board members from clients, parents, and community members who are representative of the communities we serve.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

31. New governing board members are provided with the skills-development, training, support, and orientation they need to become effective decision-makers. Board members have the opportunity to learn about cultural competency and how those issues affect the organization's functioning.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

32. Our organization solicits program ideas from an advisory committee with includes clients, parents, and community members from diverse cultural groups and our organization follows the advices of the advisory committee.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

33. Our organization collects and analyzes demographic and statistical information on culturally diverse populations for uses in its planning process and regularly discusses how policy decisions may affect diverse communities.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

34. The organization periodically report back to culturally diverse communities on progress made.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

35. The organization affords administrators and staff time to participate in the community's cultural activities and civic organizations.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

36. Our organization maintains a current list of culturally diverse media contacts, vendors, contractors, and organizations.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

37. Our organization advertises special events, program information, and funding opportunities in culturally diverse print and broadcast media and through community information networks and organizations that represent culturally diverse groups.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

38. Our organization makes its facilities available to diverse community groups.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

39. The location of the facility, programs and services, run by our organization are accessible by public transportation.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

ADMINISTRATION AND POLICY

40. Responsibility for our organization's cultural competency planning and implementation is assigned to a high-level manager.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

41. The organization has developed specific goals, objectives, and performance measures related to achieving outreach, service delivery, and other desired outcomes to culturally and ethnically diverse communities.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

42. Policies and procedures manuals enforce the practice and value of cultural competence.
1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

43. Our organization reviews our performance in serving individuals form diverse cultural backgrounds.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

44. Our organization ensures that the announcements of vacant positions are circulated through culturally diverse networks.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

45. Our organization supports the coordination and integration of services that appropriately and effectively serve culturally diverse populations.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

46. The organization has mechanisms in place to identify and resolve cross-cultural conflicts among staff; between management and staff; and between staff and clients.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

47. The organization collects race/ethnicity, language, and national origin data, explains its use to clients, and protects against using it in discriminatory ways.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

48. Our organization regularly discusses how its policy decisions affects progress toward culturally competence and is willing to adapt its programs and services to make them appropriate to people of different cultures.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

49. The organization has staff assigned to know and ensure compliance with federal and state laws and rules on language assistance and culturally diverse populations.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

ORGANIZATIONAL CULTURE

50. The organization communicates its values about cultural competency to staff and volunteers.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

51. The organization encourages staff to learn more about their own cultures and the effect their own cultures have on their day-to-day work.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

52. The informal (practices, attitudes, beliefs) operating structure is conducive to the development of cultural competency.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

53. The organization has demonstrated its commitment to cultural diversity in the past year through culturally relevant activities or programs.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

54. The organization considers client's language, race, ethnicity, customs, family structure, and community dynamics when developing its management and service delivery strategies.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

55. The organization views natural systems (family, community, church, healers, etc.) as primary mechanisms of support for culturally and ethnically diverse populations.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree

56. The organization affirms that an individual's culture is an integral part of the physical, emotional, intellectual, and overall development and well being of that individual.

1 Disagree 2 Somewhat Disagree 3 Somewhat Agree 4 Agree