

## **DHRPC – Preliminary Results**

### **State Data Review – please use the SPSS output for State Descriptive, and the data set for State Data May 2010**

Year – Results reveal acceptable distribution ~ 25% of the total being allotted to each of the 4 years included in the data pull

Gender – Expected results –more men (91%), fewer women (9%)

Race – Results consistent with the literature –more whites, followed by Hispanic (non-white) and African American (Non-Hispanic) individuals

Risk – Slightly more than 82% fall into the IDU, MSM, and IDU x MSM risk categories, with MSM being the largest, by far (66.8%). Non-behavioral risk categories (hemophilia, transfusion, mother with HIV, and pediatric) account for less 1% of the risk categories

HIV & AIDS County – More individuals with HIV/AIDS live in Denver County than the surrounding counties. However, it is important to note that missing data for individuals with AIDS are large enough to dislodge Denver from that distinction. It is recommended that HIV and AIDS county not be reported

Diagnosis – 99.7% of the individuals are adults when diagnosed. Data regarding age at time of HIV diagnosis are suspect as there exists a fairly uniform (and normally distributed) off-year phenomena. Beginning with age 22, there is a sharp increase in HIV diagnoses for individuals with ages in odd numbers. (See Age at HIV chart and graph). Because of the uniformity and normality of the distribution, these data are suspect. At the same time, Age at AIDS does not demonstrate that pattern, and more resembles the anticipated normal distribution of cases.

The mean age of individuals with HIV is approximately 5 years younger than the mean age of individuals with AIDS (33.12 and 38.06 years respectively). Should the HIV mean be reasonably accurate, long-range planning should include the gap, especially when the average individual with AIDS is over 40 years old –a focused category for job skills and jobs training programs.

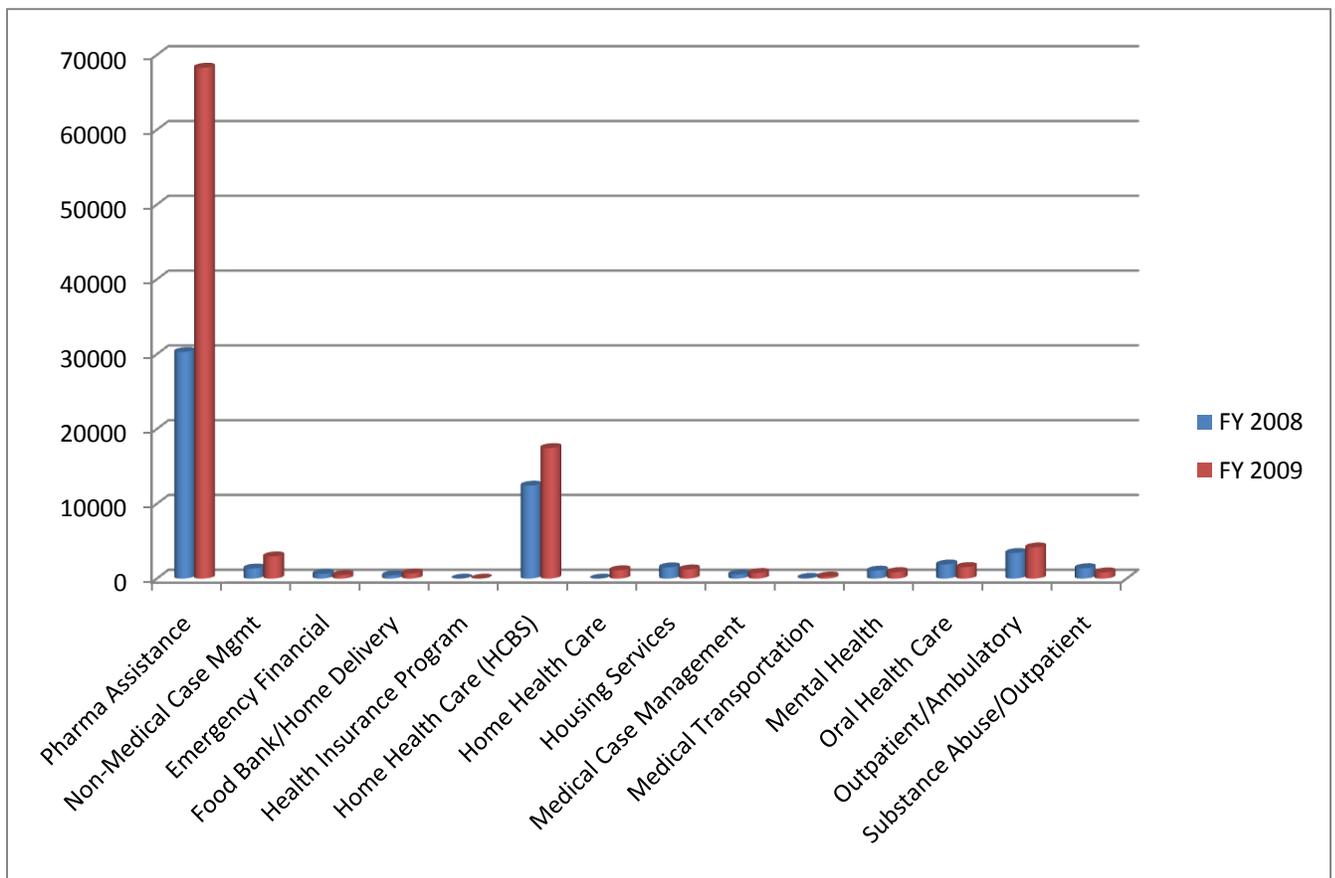
Finally, the correlated data (Dot Matrix) shows the tight relationship between HIV and AIDS age diagnoses. The bulk of the cases rest between 25 and 60 years old, with the relationship being strong ( $r = .92$ )

No statistically significant differences exist between groups or between years for AIV and AIDS age diagnosis

**CareWARE Data Review – Please use SPSS Output: CareWARE Analyses and Data File: Careware cleaned sorted 08 09 only**

Last Service Date – shows “pulses” clustered about the end of month. These data maybe indicative of the “press to input” data at the service delivery level. First service data does not show the same pattern.

Services – 2006 and 2007 categories were not included in the final analyses due to anomalies within the data. As results, trends could not be determined. Medical Case Management consistently proved to be the service with the highest level of demand, while Home Health Care (HCBS) proved to be the least in demand.



**Per-person yearly average expenditures by Service Category** (funding divided by number of individuals receiving those services) reveal large discrepancies in funding from year to year (2008 and 2009). Pharmaceutical Assistance, Medical Transportation and Non-Medical Case management increased over 50% from 2008 to 2009. At the same time, Emergency Financial and Housing Services saw a decline in per-person expenditures while also declining in demand (See Chart Below)

<b>Service</b>	<b>FY 2008</b>	<b>FY 2009</b>
Pharma Assistance	30298	68300
Non-Medical Case Mgmt	1351	2966
Emergency Financial	628	473
Food Bank/Home Delivery	431	683
Health Insurance Program	0	0
Home Health Care (HCBS)	12422	17450
Home Health Care	0	1118
Housing Services	1506	1226
Medical Case Management	552	751
Medical Transportation	98	286
Mental Health	1068	873
Oral Health Care	1885	1540
Outpatient/Ambulatory	3428	4172
Substance Abuse/Outpatient	1391	837
<b>TOTAL</b>	<b>1367</b>	<b>1530</b>

Age – the average age for first-time services dropped by slightly over a year. In 2008, the average age for first-service use was 42.54, and in 2009, that age dropped to 41.34. Should a similar drop in age of first-service use be witnessed for 2010 (and taking the 5 year spread between HIV and AIDS diagnoses from the state data) programming for younger HIV patients and older AIDS patients should be discussed. Furthermore, the average RW care recipient also lies within the prime earnings-age for most Americans. As HIV Disease has changed from a fatal to a chronic disease, job training and employment entrance programming should be considered.

HIV Status – Results were as anticipated, with the bulk of the RW service recipients resting in the CDC defined AIDS and HIV Positive/NOT AIDS categories.

Risk Categories –Results confirm state data

Hispanic – Results represent the population with approximately 1/4<sup>th</sup> of the RW recipients being Hispanic. Ethnicity – Results are consistent with state data

Gender – Slightly more women require RW Services (19%) and are over represented in the population. As women do not enjoy the same earning power as men, and they typically live in larger households (more dependents), over-representation within public assistance programs is not surprising

Households – The bulk of RW service recipients live alone; however approximately 25% live with at least one other individual. Additionally, most recipients live in stable/permanent housing situations with a little more than 1/5<sup>th</sup> living in non-permanent situations

Days in Service – the average RW recipient remains in the RW system for 18 months.

### **Survival Analyses – Same Output and Data Set**

Survival analyses reflect length of time in service. All categories should show a steady decline, as more individuals are in service those first months, and fewer individuals remain in service for longer periods of time.

Gender differences – Women typically remain with RW services longer than men. With the exceptions of Oral Health Care, Housing Services, and Substance Abuse, women remain within the RW system longer. Again, this is likely due to the general differences of socio-economic status between women and men in the USA.

Social Minority differences - The same is true for Hispanics and Non-Hispanics. Hispanics remain with the system of care for longer periods of time, than Non-Hispanics. With the notable exceptions of Emergency Financial and Pharmaceutical Assistance, all Hispanics remain within the system of care longer. Special attention should be given over to Pharmaceutical Assistance as the differences between Hispanic and Non-Hispanic are more than double. This may reflect an understanding of how to access the system long-term, undocumented status, or instability of housing situation

## HIV/AIDS Research Project

### Book Sources

Bray, J. H., & Stanton, M. (Eds.) (2009). *The Wiley-Blackwell Handbook of Family Psychology*. Malden, MA, Blackwell Publishing, Ltd.

- This book highlights two sections revolving around HIV/AIDS patients. The first section highlights Structural Ecosystems Therapy (SET) while the next section highlights the effects of HIV/AIDS on the families of HIV/AIDS patients. Within this section, the programs designed to assist families are discussed.
- The first section discusses a therapeutical approach (SET) to create a better environment for an individual who has been diagnosed by HIV/AIDS. The goal of this therapy is to build better relationships with individuals through the various ecosystems (church, family, friends, social organizations, etc.) by restructuring one's life to match the good ecosystems and abandon the ecosystems that had a negative impact on the HIV/AIDS patient and are often controlled by these negative systems. Routinely, these negative ecosystems evolve around poor relationships that cannot be mended, such as an ex-boyfriend or ex-girlfriend or around substance abuse. The timing of this therapy is routinely four to eight months, where the therapist wants to work themselves out of a job (Bray & Stanton, 2009, 367) and let the patient take control of their lives.
  - This program is designed to improve the social health of any HIV/AIDS patient, which allows them to have more control and healthier lives, as patients who require SET are heavy substance abusers. This therapy would improve access to medication and they are able to attend more counseling and doctor's appointments as a result of this therapy.
- The next section highlights the impact of HIV/AIDS on families who care for members of this chronic disease. It mentions the chronic poverty, homelessness and drug abuse often burdened by the entire family in many cases (Bray & Stanton, 2009, 718), along with the fear/stigma surrounding these families because of HIV/AIDS. The fear associated with caring for a relative is the removal from a social group that has kicked out the family. As a result, the family faces a risk of mental problems due to outside stress and the stress of caring for a dying relative, in addition to an increased risk of co-morbid conditions (alcohol, drugs and other chronic conditions).
- This section also discusses the role of parents and social organizations that are designed to continue communication to prevent the spread of HIV/AIDS onto adolescents. The first program, Keepin' it R.E.A.L. (Responsible, Empowered, Living), associated with a Faith Based Organization (FBO) is to improve the role of the father for adolescents ranging from 11-14. The next social program is Strong African American Families (SAAF),

designed to reduce risky behaviors for rural families. Other programs, Project TALC (Teens and Adults Learning to Communicate) and WiLLOW (Women Involved in Life Learning from Other Women), are designed to increase communication amongst those who might be infected with HIV/AIDS to prevent transmission of the disease.

Lyon, M.E., & D'Angelo, L.J. (Eds.) (2006). Teenagers HIV and AIDS: Insights from Youths Living with the Virus. (Wesport CT, Praeger Publishers).

- This highlights the affects of HIV/AIDS on American Youth. The purpose of this book was to discuss what the youth of this nation who have HIV/AIDS and what their lives are like with the disease. These individuals face discrimination from the disease, lack of knowledge about the disease, the loss of employment, the loss of a home, physical abuse and psychosocial effects. Those who have the illness typically live within the inner city which is a close-knit community and having the disease creates a stigma for those with the disease and along with their family members. Scary fact: 50% of all new cases of HIV appear in individuals younger than 25 (Lyon & D'Angelo, 2006, 6).
- Treatment options are a biggest concern due to the mental problems associated with patients at this young age. They are stressed with maintaining normalcy despite getting infected at the prime of their life. For those who wish to get pregnant do so with the knowledge of possibly infecting others, but do so because they wish to have a child, possibly maintain some sense of normalcy or they wish to save themselves in a child who will survive long after they are gone. What is demanded is improved mobility structure for testing and treatment of the disease. Two programs were designed to assist in communication, prevention and care, namely Choosing Life: Empowerment, Action, Results (CLEAR) and Teens Linked to Care (TLC).
- A third section of the book discusses the treatment options for HIV/AIDS patients. Many speak to others, many speak within blogs and groups. Many turn to religion, where they look for meaning or talk with a higher power to find out why they have the disease. Finally, patients with HIV/AIDS speak with their doctors, as they serve as constant companions with them throughout the treatment process. This section also highlights the lengths Black Americans will go to keep a loved one alive as they do not sign any termination or DNR's (Do Not Resuscitate) Form, due to a fear of discrimination within hospitals.
  - Patients also speak to each other and within their own support groups, even through blogs. Here is an example of a blog that acts as an online support group: <http://www.dailystrength.org/c/HIV/support-group>

## Government/Ryan White Funded Organizations Information

Department of Health and Human Resources. (2010, May 20). Ryan White HIV/AIDS Program. Retrieved from: <http://hab.hrsa.gov/aboutus.htm>.

- Ryan White HIV/AIDS Program is the biggest governmental support for patients of HIV/AIDS. It is the primary care and support services for over 500,000 individuals who have HIV/AIDS. It is designed for those who have minimal health care coverage or financial resources to pay for treatment. The program is broken down into five parts (A, B, C, D, F) which focus on different aspects of the program based on service required, specialty and the number of cases within a specific area.

Department of Health and Human Resources (2010, May 20). Ryan White HIV/AIDS Program: Part A. Retrieved from: <http://hab.hrsa.gov/aboutus.htm>.

- This section provides grants and funding for HIV/AIDS patients within metropolitan and transition areas. The key aspect of this funding is the number of HIV/AIDS patients within the region, which has to be at least 2,000 cases reported over five years. The funding for this program (\$627.149 million in the 2008 Fiscal Year) funds medical services for patients (75% of the cost) along with 25% for support services (dental, health care, hospice, nutrition, mental health) along with substance abuse services, linguistic services and respite care for those who are caring for a patient of HIV/AIDS. Below is an example location that receives Part A funding.

Denver's Office of HIV Resources. (2010, May 21). Denver's Office of HIV Resources. Retrieved from: [www.denver.gov/AboutUs/tabid/390969/Default.aspx](http://www.denver.gov/AboutUs/tabid/390969/Default.aspx).

- This describes the details and duties of this office regarding HIV/AIDS patients, who are provided funding for utilities, phone (no more than \$50 per month) and medical bills. This process allots for food, but for those at or below 300% of the Federal Poverty Line (FPL). As for home care, patients are provided \$800 per month if their income is 0% to 185% of the FPL or \$600 per month if their income is between 186% to 300% of the FPL.

Department of Health and Human Resources (2010, May 20). Ryan White HIV/AIDS Program: Part B. Retrieved from: <http://hab.hrsa.gov/aboutus.htm>.

- This provides funding to all fifty states, the District of Columbia and to all territories. Grants within Part B are supplied to areas that are considered to be 'emerging communities', where there have been 500-999 cases reported over five years. The primary function is similar to Part A, where most of the costs (75%) cover the medical services (health insurance premiums, cost-sharing assistance for Antiretroviral medications, and substance abuse). 25% of the costs go to social supports, such as linguistic services, respite care and outreach services. Over \$1.195 billion had been appropriated for these costs, with \$808.5 million earmarked for the AIDS Drug Assistance Program (ADAP).
- Part B is more extensive, as it provides funding to states with one percent of their population infected by HIV/AIDS, as reported in the past two years. Both public and non-profit entities that assist with supporting patients with HIV/AIDS are the main beneficiaries of Part B funding, but for-profit entities can receive Part B funding if and only if they are suppliers of medications, the sole providers within the region and provide the quality care as set by the Ryan White Care Act.
- ADAP is the program that supplies the medications for the Highly Active Antiretroviral Therapy (HAART). The cost for this therapy is about \$12,000 per year, of which not many individuals can afford. These funds can purchase health insurance premiums or purchase drugs directly or through pharmacies, of which the contents are mailed directly to clients. There is a recertification process associated with this process that occurs every six months to remain eligible for this funding. There are different criteria for each state, as ten states require a CD4 (white blood cell) count. Some require a median income to be eligible for this program of 300% of the FPL. The section ends that as drugs are improving, patients with HIV/AIDS live longer, while those being infected continue to increase, putting additional strain on funding for this program.

Colorado Department of Public Health and Environment. (2010, May 21). The Colorado HIV Care and Treatment Program History. Retrieved from: <http://www.cdphe.state.co.us/dc/HIVandSTD/RyanWhite/care.html>.

- This is an example of an organization that receives funding from Part B. It mentions it administers aid for all residence outside of the major metropolitan areas of Colorado along with the ADAP for the state of Colorado. It provides patients with case management services to assist patients navigate the complex care services.

Department of Health and Human Resources (2010, May 20). Ryan White HIV/AIDS Program: Part C. Retrieved from: <http://hab.hrsa.gov/aboutus.htm>.

- This section provides grants for all service providers, and ambulatory medical clinics. The primary purpose of this section is to provide intervention services and immediate diagnostic tests for anyone who is tested for HIV. In addition, they provide for funding of equipment and tests ranging from dental equipment, transportation care for medical

providers, medical evaluations, medical case management and electronic records. The core of the medical services provided under Part C is for the counseling of all HIV/AIDS patients. In the 2008 Fiscal Year, Part C provided funding of \$198.754 million for medical providers of HIV.

- Other items covered by Part C are home health care, hospice services, home and community based services. It also provides capacity grants and covers the administrative costs for providers of care.

Pueblo Community Health Center. (2010, May 21). Pueblo Community Health Center Services and Locations. Retrieved from: <http://www.pueblo.chc.org/services>.

- This falls under Part C as it provides immediate testing to those who think they have HIV, due to immediate screening procedures.

Department of Health and Human Resources (2010, May 20). Ryan White HIV/AIDS Program: Part D. Retrieved from: <http://hab.hrsa.gov/aboutus.htm>.

- This section focuses more on Family and Pediatric Services, with the intention to develop more family structured care. It provides funding for HIV infected infants, children, pregnant women and families. According to the 2008 Fiscal Year, \$685.29 million was funded for Part D programming.

University of Colorado Health Sciences Center. (2010, May 21). University of Colorado Health Sciences Center. Retrieved from: [www.ucdenver.edu/Pages/UCDWelcomePage.aspx](http://www.ucdenver.edu/Pages/UCDWelcomePage.aspx).

- This source just provides an example of the type of care provided for families, infants, children, pregnant women of HIV. This facility specializes with children services and provides information on how to not spread the infection to children and child care for those who are inflicted with HIV/AIDS.

Department of Health and Human Resources (2010, May 20). Ryan White HIV/AIDS Program: Part F. Retrieved from: <http://hab.hrsa.gov/aboutus.htm>.

- Part F of the Ryan White Care Act funds the Special Projects of National Significance that is relative to HIV/AIDS. All facilities, such as Academic Institutional Support (29%), Evaluation Centers (9%), Community Based Organizations (CBO's) and AIDS Service Organizations (ASO's) (24%), Local or State Health Departments (7%), Community Health Centers (11%), and Hospitals (20%). Each percentage in parentheses represents the amount of funding these types of institutions receive from the Ryan White Care Act. Part F funds the Minority AIDS Initiative (designed to address disparities as minorities are inflicted with HIV/AIDS), and Dental Programs.

Mountain Plains AETC. (2010, May 21). Mountain Plains AIDS Education Center. Retrieved from: [www.mpaetc.org/default.asp](http://www.mpaetc.org/default.asp).

- This final example of Colorado's Ryan White funded programs and centers that specializes in the training of staff for Oral Hygienic work for HIV/AIDS patients. The bulk of this training covers the handling of HIV/AIDS patients in addition the prevention of the transmission of the disease. This program provides training within eight states (North Dakota, South Dakota, Nebraska, Kansas, Colorado, Wyoming, New Mexico and Utah).

For further information on other organizations that receive funding from the Ryan White Care Act, here is the website: [www.careacttarget.org/community.orgs.asp?part=all&cat=all](http://www.careacttarget.org/community.orgs.asp?part=all&cat=all).

### **Government Agencies Assistance**

Social Security Administration. (2005, February). Social Security for People Living with AIDS. Retrieved from: [www.ssa.gov/pubs/10019.html](http://www.ssa.gov/pubs/10019.html).

- This government intervention describes AIDS as a chronic disease that falls under disability benefits programs. Those who are eligible for benefits are paid through Social Security Disability Insurance and Social Security Income, if the patient's income is relatively low. Monthly benefits often are dependent on the earnings for those who have applied.

The Kaiser Family Foundation. (2004, September). HIV/AIDS Policy Fact Sheet: Medicare and HIV/AIDS. Retrieved from: <http://www.kff.org/hivaids/upload/Fact-Sheet-Medicare-and-HIV-AIDS.pdf>

- This document provides an overview of the aid provided to HIV/AIDS patients through Medicare. It provides a hospital insurance program for low income individuals, along with inpatient hospital facilities, home health services and pays for hospice services. It provides supplemental medical insurance that is designed for physician services, outpatient hospital services along with lab tests. It also covers outpatient drug coverage, roughly 8% of those participating in ADAP (AIDS Drug Assistance Program),

(The Kaiser Family Foundation, 2004). Medicare also covers 55,000 individuals who have been diagnosed by HIV/AIDS (The Kaiser Family Foundation, 2004).

**Government Funded Research**

Tobias, C., Wood, S., & Drainoni, M.L. (2006). Ryan White CARE Act Title II Survey: Services for HIV-Positive Substance Users. *Aids Patient CARE and STD's*, 20(3), 205-212. Retrieved from: <http://www.liebertpub.com/products/product.aspx?pid=1>

- This article/survey provides an in-depth analysis of the Ryan White CARE Act and what it funds to help substance abusers who have been diagnosed with HIV/AIDS. Eighteen out of forty-seven states that responded provided some funding through Title II, but there are few programs that were designed to assist populations.
- Out of the funding, this is what the programs offer to various groups

Service Type	% of States Funding Services
Outpatient Counseling	21%
Methadone Maintenance	13%
Residential Treatment	9%
Acute Detoxification	9%
Acupuncture Detoxification	4%
Other (Supplemental Services and Collateral)	11%

- 66% of states did not know of availability of services to substance abusers or did not report the issue. Medicaid only pays for two outpatient therapies (individual therapy and group therapy), but only through approved chemical dependency programs. Medicaid also pays for only four days of detoxification treatment and does not cover inpatient treatment. Insufficient treatment capacity and citizens have many objections over this issue. In addition only a quarter of the states say patients have proper treatment or providers that specialize in substance abuse programs.
- Below is a list of barriers asked of respondents to this survey. These barriers are ranked as the top five barriers substance abuse HIV/AIDS Positive individuals encounter when seeking or obtaining treatment.

Barriers	Percentage (As Cited as one of top Five)
Lack of Housing Options	55%
Lack of Insurance Coverage	53%
Few Residential Programs	53%
Few Detoxification Programs	42%

Lack of Transportation	37%
Short Duration of Treatment	34%
Too Few Outpatient Programs	29%
Government Agencies do not collaborate in planning	24%
Little Capacity for after hours HIV medical care	16%
Waiting time for medical visits are too long	15%

- In addition to these barriers, there are barriers within the programs for substance abuse users who are HIV/AIDS positive as they do not cater to certain aspects of the population.
- Here is the list of Programming Barriers

Programming Barriers	% Respondents Cited	1 of top 5 Barriers Listed
Women with Children are not supported	57%	47%
Harm Reduction/Recovery Readiness not Provided	57%	38%
Substance Abuse Providers Need Training	57%	35%
Lack of Outreach to Provide Care	70%	35%
HIV and Substance Users fall in Cracks of Programs	70%	35%
Lack of Walk-In Services	55%	29%
Primary Care does not Screen for Substance Abuse	62%	24%
Language Barriers	62%	24%
Substance Services not linked to HIV medical care or substance abuse treatment	60%	21%
Programs are not culturally sensitive	53%	21%
Primary Care Providers do not know about Substance Abuse Treatment Options	62%	21%
Problems Situating in Substance Abuse Treatment	30%	18%
Primary Care Providers Lack Cultural Sensitivity	66%	18%
Waits at Patient Care Sites too long	40%	9%
Substance Abuse Programs Ignore Medical Issues	30%	6%

- There appears to be a substantial lack of knowledge or awareness of substance abuse treatment programs within Ryan White CARE Act Funded Facilities. These barriers create barriers to provide necessary care and many do not know of an optimal solution that can be done to assist these patients.
- Of the federal agencies (Medicaid, State, Ryan White CARE Act, Medicare, insurance providers, Veterans Administration, CSAT [Care for Substance Abuse Treatment]), do not know how to obtain or fund substance abuse treatments. These include the states.

This study was funded through the Health Resources and Services Administration

## Independent Organizations Fact Sheet

Elizabeth Glaser Pediatric AIDS Foundation. (2010, May 20). Retrieved from: <http://www.pedaids.org/>.

- This project works in Africa that focuses on HIV prevention along with care treatment for patients of HIV/AIDS. This organization provides necessary care for women and children of the disease through community engagement along with the provision of treatment to these patients. The important aspect is the work in developed countries of this organization and how they provide for both women and children of HIV/AIDS.

Faith Based Organizations. (2010, May 20). Faith Based Organizations Mission Statement. Retrieved from: [www.wcc.coe.org/wcc/what/mission/ny-statement.html](http://www.wcc.coe.org/wcc/what/mission/ny-statement.html).

- Faith Based Organizations fight against HIV/AIDS by providing support, mainly for women due to the discrimination they face when receiving treatment. Female HIV/AIDS patients are more vulnerable because of their gender and the fact they are caretakers for children, which means they do not have equal access to treatment. While this is not as prevalent within the United States, this is more prevalent in Africa, most likely due to the culture of the region. For many Faith Based Organizations (FBO's), most of their work is located in Sub-Saharan Africa, where the bulk of the pandemic is occurring.

Southern Colorado AIDS Project. (2010, May 20). Southern Colorado AIDS Project: Ways to Help. Retrieved from: [http://www.s-cap.org/WaystoHelp\\_A.html](http://www.s-cap.org/WaystoHelp_A.html).

- This program in Southern Colorado assists patients afflicted with HIV/AIDS by referring them to Substance Abuse clinics, they provide legal assistance due to the high amount of discrimination towards HIV/AIDS patients. The other services this organization provides is housing assistance, behavioral health programs and services along with medical transportation. These services are meant only for HIV/AIDS patients in Colorado Springs and Pueblo.

## Programming for Youth

Arizona State University. (2010, May 20). Keepin' It REAL. Retrieved from: <http://keepinitreal.asu.edu>.

- This program is designed to reduce drug use by creating anti-drug attitudes that enhance life skills. It is a very effective program, as for the 7,304 students, it greatly reduced their drug use and was very effective for acculturated Latino Youth, as they were less of a risk to abuse substances. The curriculum for this program is similar to the Just Say No program and by reducing drug use it reduces the chances of HIV infection through substance abuse.

Center for Disease Control. (2009, February 24). Women Involved in Life Learning from Other Women (WiLLOW). Retrieved from:  
<http://www.cdc.gov/Hiv/topics/research/prs/resources/factsheets/WiLLOW.htm>

- This program targets sexually active female clinic patients who have been diagnosed with HIV/AIDS. It is designed to enhance HIV-preventative ideals through psychosocial and structural factors to reduce the risky behaviors for HIV Transmission and Sexually Transmitted Diseases. The aspect of the program utilizes interactive training and support from women who have HIV/AIDS, with a focus on cognitive therapy using theory of Gender and Power. The overall result was reduced unprotected sex, reduced STDs and safe sex practices. This program had a high retention rate, which coincided in the reduced chance of the participants to contract a new STD.

Child Trends. (2007, September 18). Project TALC: For Parents with AIDS and their Adolescent Children. Retrieved from: <http://www.childtrends.org/lifecourse/programs/talc.htm>

- Project TALC was designed to improve parents who have HIV/AIDS mental health and relationships with their children. The teens who were involved in this program had drastically reduced levels of emotional distress conduct, family related stressors than they did at the beginning of the program with a higher level of self-esteem. Those involved in the study were mainly mothers who were of minority descent. This program assisted the children of the parents with HIV/AIDS to cope with the stresses associated with the stigma and the emotional reaction to HIV/AIDS. But most importantly, it maintained the family atmosphere, as it assisted with a normal environment where the disease took a smaller role in. The program reduced the anxiety levels of teens along with the behavioral problems these teens experienced, because before the program, they did not have a parent to supervise or teach them at home because of their affliction.

Child Trends. (2007, November 11). Strong African American Families. Retrieved from:  
<http://www.childtrends.org/lifecourse/programs/saaf.htm>

- This program was designed for African American Youths, with eleven year old children as the target audience, to reduce any risky behaviors they may partake. The program was catered to families who lived below the poverty line and most of the respondents were single mothers. The result of this program was increased, positive communication with their children. The children who were involved in the program did accomplish the program's goals while a control group that was started by the program had begun to partake in risky behaviors (mainly alcohol abuse) at the end of the program's fifteen month session.

#### **Independent Articles (Non-Government Affiliated)**

Conviser, R., & Pounds, M.B. (2002). Background for the studies on ancillary services and primary care use. *AIDS Care*. 14(1), 7-14. Retrieved from:  
<http://www.tandf.co.uk/journals/titles/09540121.asp>.

- This article focuses on eight studies that took place in what was considered to be the epicenters for the HIV/AIDS pandemic in the United States; (New York, Chicago, Los Angeles, San Francisco, Orange County (CA), Washington DC and smaller cities, such as St. Louis, New Orleans and Boston.) These studies were conducted about the effectiveness of health insurance and discussed the clinical complications for many patients. These complications range from other diseases to mental illnesses and drug addiction. The ancillary services that are provided do not have as big an impact for those who are assessed for those needs. Essentially, what works for one does not work well for the general population and the focus of this paper was to elaborate that all the needs of HIV/AIDS patients must be assessed on an individual basis.

Derose, K.P., Dominguez, B.X., Plimpton, J.H., & Kanouse, D.E. (2010). Project New Hope: A Faith Based Effort to Provide Housing for Persons with HIV/AIDS. *Journal of HIV/AIDS and Social Services*, 9(1), 90-105. doi: 10.1080/15381501003661562

- There are many homeless persons who are afflicted with HIV/AIDS. Many of whom are substance abusers and a great number of them were expelled by their family members and have been forced to sleep in the streets. There have been few published

descriptions of programs that match the need of homeless persons, with the exception of Project New Hope, which is a FBO based in Los Angeles, California. It is linked with Episcopal churches and in association of the Department of Housing and Urban Development. Many individuals part of this program were unable to find housing and in some cases, work because of the discrimination of HIV/AIDS patients in the workplace. As of this point, nearly six hundred individuals with HIV/AIDS have been provided with housing through this Faith Based Organization. This article highlights a large number of HIV/AIDS patients do not get the necessary aid through the Ryan White Program and a FBO has taken the initiative to provide these individuals with a necessity that would ensure a higher level of survival, self-esteem and most likely, a place to keep records of these individuals for medical purposes.

Driskell, J.R., Salomon, E., Mayer, K., Capistrant, B., & Safren, S. (2008). Barriers and Facilitators of HIV Disclosure: Perspectives from HIV Infected Men who have Sex with Men. *Journal of HIV/AIDS and Social Services*, 7(2), 135-156. doi: 10.1080/1538150080206523

- This was a study conducted on a population of Men who have Sex with Men (MSM), with the focus on the conduct of counseling and the effect of disclosure on their social lives. Sexual relationships were the key for these men in disclosing their disease with others, which has a strong prevalence as this group accounts for 70% of newly infected individuals of HIV/AIDS (Driskell, Salomon, Mayer, Capistrant & Safren, 2008). By disclosing, it is implied that the number of newly infected would decrease.
- The decision making of disclosing the disease was an important part of the intervention development, as informing others would decrease the risk of spreading the disease, but it would assist in the increased social death of the one who discloses it. It is because of this reason that roughly half of all individuals of all MSM disclose their status of the disease onto new partners. By disclosing, they are unable to maintain a relationship. If they do not disclose the disease to a new partner, they express shame of possibly infecting another with HIV (Driskell, Salomon, Mayer, Capistrant & Safren, 2008).
- Because of this dilemma, they are concerned about barriers, rejection, missed sexual opportunities, change of relationship, deferring responsibility and their environment. MSM are concerned about confidentiality as they do not want the community to know, as it would limit their sexual partners, their dating potential and their overall social life. In addition, many do not feel ethically obligated to disclose because of their relationships to others.
- As a result, this creates a dilemma within the gay community and many social services do not seem inclined to let others know, as disclosure of the disease is an important aspect of many intervention stages. This provides important research options as to measure the characteristics of gay men who disclose or those who do not and increase the chances of transmission of the disease through risky behaviors.

Harris, G.E. & Alderson, K.G. (2006). Gay Men Living with HIV/AIDS. *Journal of HIV/AIDS and Social Services*, 5(3&4), 9-26. doi: 10.1300/J187v05n03\_02

- This was a study of experience of a population of twelve gay men (who were from varying race and income) who have HIV/AIDS. The focus of this study was to gauge the changes of cognitive dimensions (thinking and affect) after their diagnosis with this chronic disease. The study elaborated these individuals took control through the empowerment of their lives, which was effective for their mental health when they were dealing with situations that could involve the transmission or disclosure of their disease to others. The higher empowerment/control one has over their life, they either grow or overcome a negative situation (such as the death of a partner). The ideas associated was the development of altruistic behaviors, with a focus on the here and now, rather than the future.
- All twelve participants were in individual counseling sessions and peer support groups. The struggle of those interviewed provided insight on how they viewed the spread of their disease (some disclosed it when meeting a new sexual partner and in some cases, they did not because the stigma associated with HIV/AIDS and the fear it would stunt their social life/health), (Harris & Anderson, 2006). The subjects were taught (by themselves or through counseling services) how to control their lives, growth, meaning of life, self acceptance and acceptance of death. These five stages created a successful coping mechanism that had more control over their diagnosis, which increased their retention to their medical check ups and they had better communication with their medical providers. This is a positive aspect for mental health with this disease, as many individuals who have been diagnosed have stressed the negative aspects of the illness, and has been the subject of research.

Henry, S.R., Hagedorn, H.J., Feld, J.E., Golden, J.F., Horns, H., Knapp, H.E., & Anaya, H.D. (2010). A Formative Evaluation of Organizational Readiness to Implement Nurse-Initiated HIV Rapid Testing in Two Veterans Health Administration Substance Use Disorder Clinics. *Journal of HIV/AIDS and Social Services*, 9(1), 7-26. doi: 10.1080/15381501003661513

- This article evaluates the rapid testing of military personnel using nurses and this evaluation was conducted through the Department of Defense and the Department of Housing and Urban Development. The question initially asked was how can one screen for HIV/AIDS in undetected patients, which is a significant problem as many do not know if they are infected until it is too late, using quick scans that are comfortable and crucial to identify if they are infected. The reason behind this is an individual who is unaware they have HIV/AIDS are 3.5 times more likely to infect another than those who do know (Henry, Hagedorn, Feld, Golden, Horns, Knapp & Anaya, 2010, 9). While the actual testing procedures have changed, there are at least 2.3 million each year who do not receive their test results, so the idea is to develop a process that is immediate (Henry,

Hagedorn, Feld, Golden, Horns, Knapp & Anaya, 2010, 9). Most tests for HIV/AIDS require the use of blood, but the use of saliva does not take as much time. This test was developed in combat situations (or situations applicable for the military), which demands rapid results due to the nature of the military. Because of the rapidness of these tests and the personnel (nurses, rather than doctors), it would be utilized within the urban environment and guarantee quicker results than usual, bringing down those undiagnosed significantly, also with a better response from the patient, since the test does not require blood (so no pain to get the test.) For those who are afraid of needles, or are ashamed of the many needle marks on them from substance abuse, this would be both a simpler and more effective solution to obtain the necessary response.

Hoover, D.R., Chung, S., Celentano, D.D., Vlahov, D., & Latkin, C.A. (2001). Access to Medical Care and Service Utilization Among Injection Drug Users with HIV/AIDS. *Drug and Alcohol Dependence*, 64(1), 55-62. doi: 10.1016/S0376-8716(00)00228-3

- This was a study conducted with 287 low income substance abusers, recruited by the AIDS Linked to the Intravenous Experiences (ALIVE) that described their views of access of care. Many of these patients are associated with less outpatient care, but more inpatient care and care within an Emergency Room. While care management and substance abuse care has been incorporated within the Ryan White CARE Act, the medical services do not show a strong sign of participation. However, the medical services used by gay men and those in psychological distress, not drug users, had better access. The respondents of this study stated that there was an adequate use of care, but little use for outpatient care facilities.
- The participants stated there was a high level of access, but little use of outpatient care facilities, as it seemed outpatient care was associated by individuals with higher income. What the participants to this study asked for was better drug treatment and case management that would facilitate more access to outpatient care. Also, the article concludes more funding should be placed into drug treatment programs and that drug treatment care should be part of the continuum for access. If this was made part of the curriculum for treatment, the article implies substance abusers would have a higher retention rate within their treatment protocols and medical check-ups.

Hrishikesh, K.B., & Muenig, P.A. (2008). Cost-Effectiveness of Needle and Syringe Exchange for the Prevention of HIV in New York City. *Journal of HIV/AIDS and Social Services*, 7(3), 229-240. doi: 10.1080/15381500802307492

- This program shows the cost-effectiveness to set up a needle exchange program and has many benefits from this program. This program averted four to seven infections for 1,000 clients, which reduces the risk of transmission. According to Hrishikesh and

Muenig (2008), there are between 103,290 and 143,402 people with HIV/AIDS and a drug user population of 162,500. The exchange of needles would provide clean needles to those who are infected and reduce the transmission of HIV through sharing needles. As for the program's efficiency, the transmission rate reduces by 0 to 5.8%, but the overall savings for the provision of funding for these students is \$3,000 for each client.

Kirshenbaum, S.B., Catz, S.L., Pinto, R.M., Johnson, M.O., Correale, J., Morin, S.F., Remien, R.H., Rotheraum-Borus, M.J., Goldstein, R.B., & Ehrhardt, A.A. (2007). Opening up Windows when Clients Keep Closing Doors: Key Elements in Engaging HIV-Positive Individuals in Prevention Interventions. *Journal of HIV/AIDS Social Services*, 6(3), 5-28. doi: 10.1300/J187v06n03\_02

- This survey was designed to examine the risks of individuals who have contracted HIV/AIDS and what programs/tactics are effective to maintain a high retention rate of the patients. One-third of individuals with HIV continue to take significant risks that increase the chance of transmission (Kirshenbaum, Catz, Pinto, Correale, Morin, Remien, Rotheraum-Borus, Goldstein & Ehrhardt, 2007). In addition, there are barriers associated with HIV patients that they put up or society has constructed around them. The first one is social isolation, because they are stressed by this disease and because not a lot of individuals know about the effects of the disease, except there is no cure, they generally remove most forms of contact from those who have contracted HIV. Additionally, the need for substance abuse treatment (which in some cases is how they contracted this disease and possibly transmit it onto others. Finally, housing is a chief concern for these individuals because they either reside in low income areas or they were forced out of their previous domicile by a relative and are forced to live in the streets.
- The article describes of a behavioral intervention project, where over fifteen sessions of therapy, individuals were taught about the dangers associated with the disease and how to protect themselves (safe-sex and substance abuse treatment) and others. This program, which went through the Helathy Living Project, had a high retention rate (75%), of which the members involved had a reduction of 36% of transmission. In addition, the participants were taught basic living skills and were provided with an interview guide for qualitative behavior. Overall, it was educating how to prevent transmission but the teaching of necessary skills improved their overall behavior towards life, which decreased their chances of partaking in risky behaviors.

Macmaster, S.A. (2006). Social Service Delivery Preferences Among African American Women who Use Crack Cocaine. *Journal of HIV/AIDS and Social Services*, 5(3&4), 161-179. doi: 10.1300/J187v05n03\_11

- This article describes the specific needs of African American women who are addicted or use crack cocaine and of the high risk (as it requires needles) of getting the drug in their system. As AIDS is a leading cause of death for African American women, there is a need for programs that would be effective just for African American women, as crack cocaine users have a three times bigger probability of getting infected with HIV (MacMaster, 2006). One cannot use conventional therapy or programs because of the great deal of mistrust African American women have of the current health system and mainstream services for HIV.
- Many subjects of this study were single and lived below the poverty line. As for their needs, this is the list of their top wants and needs.
  - Housing
  - Necessities for Living (Groceries, toiletries, basic needs)
  - Affordable/Free child care (as many of these women are single parents and trying to have a living)
  - Substance Abuse treatment
- To succeed and return to these programs, they need motivation, awareness of their services and long-term services (they view many as short term and since they have a chronic disease that shortens their lifespan, many are planning for their children). They want services that are offered 24/7, instead of a 9 to 5 situation, because, as many of them have said, they do not live in a 9 to 5 world. They require services that operate, as one put it, from 5 AM to 9 AM, because those times do not coincide with the drug dealers of her neighborhood (Macmaster, 2006).
- This study was a good start to get some input of this group, but unfortunately it had a very small sample size (n=89). Because of the small size of the population, there was no real way to gauge the true feelings and beliefs of this group. It's a good start, but it needs to be expanded upon.

Medina, C.K. (2009). Beyond Routine HIV Testing: Beliefs, Perceptions and Experiences of Low-Income Women of Color. *Journal of HIV/AIDS and Social Services*, 8(3), 219-237. doi: 10.1080/15381500903156103

- This was a qualitative study with 56 Black American and Latina women who described their experiences with the community, government and environment that concerned their disease. The perceptions of HIV/AIDS by the members within their communities were confusion and misunderstanding, creating significant prejudice against those who have it. These views do not help as these women of these two ethnic groups are experiencing the most significant increase of HIV/AIDS. Counseling and early testing helped to assess the risk in getting/spreading the disease, which contributed to a behavioral change. According to Media (2009), testing by the Center of Disease Control used to require a pretest of written consent, but that changed and testing is becoming more routine and mandatory. This is a complete change to the voluntary portion of the test.

- There is a large stigma within the community for those who have been tested or are positive. Since the test is no longer confidential, those with the disease are shunned by their society. The social constructivism for those with the virus is minimal after they have disclosed. Of the participants of the study, they have elaborated little sexual prevention or birth control in their communities. After disclosure, there is a positive aspect as there is a change of behaviors to be safer in their practices.
- The article also implies why men are less willing to get tested, as these women do not believe they are either afraid or their ego is in the way. Men do not like abstinence, as it threatens their relationship or non-penetration. Which means, they have to develop more communication with men to encourage testing, possibly catering it for them. These women also want more gender equality, condom access and needle exchange programs.

Okonow, O., Vance, D., Antia, L., Smith, B., Blanshan, S., Heirs, K., and Bodner, E. (2008). Service Utilization and Cognitive Complaints in Adults with HIV: Results from a Statewide Survey. *Journal of HIV/AIDS and Social Services*, 7(2), 175-194. doi: 10.1080/15381500802006771

- This study was conducted use CBO's and AIDS Service Organizations (ASO). The point of this study was to determine what problems were associated with the current system in place for HIV positive individuals as to improve the overall services. The important services the participants of this study wish to improve were those suffering from Mental Illness, who feel they cannot care for relatives or for themselves and they are skipped over by the regular social services. Drug abuse and the care associated for cleaning up their act was another key issue, as it is substance abusers who generally miss their appointments with their doctors. But overall, the bulk of the complaints associated with this study came from those who could not access the necessary services provided, but in many cases it was the result of their own behavior.
- Essentially, this study showed there are complaints within the system, but most of the complaints come from those who have access but choose to either abuse illegal substances or alcohol, which causes them to miss their necessary medical appointments and treatments.

Robillard, A.G., Gallito-Zaparaniuk, P., Braithwaite, R., Arriola, K.J., & Kennedy, S. (2009). Providing HIV Services for Incarcerated and Ex-Offender Populations: Perspectives of Frontline Staff. *Journal of HIV/AIDS and Social Services*, 8(1), 95-113. doi: 10.1080/15381500902736384

- Community Based Organizations (CBO's) are working to provide better services to inmates. For basic statistics, 57% of the state prison population and 48% of the federal prison population are drug users and 68% of all prison populations are dependent on alcohol and drugs (Robillard, Gallito Zaparaniuk, Braithwaite, Arriola & Kennedy, 2009,

96). While there has been a decrease of AIDS in the general population, the prison population has shown an increase of the HIV/AIDS symptoms and is perhaps the biggest group that is at risk for the disease, as it is eight to ten times more prevalent within prison (Robillard, Gallito Zaparaniuk, Braithwaite, Arriola & Kennedy, 2009, 97). Since this group is considered an 'invisible population' and can let its members join the general population at any time, there is a huge risk associated with these prisoners. As for treatment of prisoners, only a few jails allow funding of these services, and no major federal prison allows either funding or treatment of prisoners. But, there are positive aspects for this population. Because they are confined and kept in a routine schedule, the prison and jail environment provides the most opportune situation to educate the inmates about the HIV/AIDS. More needs to be done. There needs to be a staff created to provide services to prisoners with HIV/AIDS and educate the others regarding the spread of the infection. They also need to initiate therapy for the prisoners who have this disease, but more importantly initiate programming that will allow both treatment options and housing for these inmates, as these are chief concerns for these inmates (especially housing). But overall, the biggest concern in the transition from the prison to the community at large, just because they were in a dangerous environment that bred negative habits which produce a substantial risk to the rest of the general population.

Teti, M., Bowleg, L., & Spencer, S.B. (2009). Who Helps the Helpers? A Clinical Supervision Strategy to Support Peers and Health Educators Who Deliver Sexual Risk Reduction Interventions to Women Living with HIV/AIDS. *Journal of HIV/AIDS and Social Services*, 8(4), 430-446. doi: 10.1080/15381500903396840

- This is a description of the medical workers who assists women who have been diagnosed with HIV/AIDS. There are many peer processes that assist patients within social workers, but there is little that is done to assist the social workers. There is a high level of burn out associated with this job because of the high levels of stress, severity and fatality associated with this position (patients of these workers given a death sentence, and because there is no cure, workers get attached and burn out when a client passes away). What is recommended is a group of helpers to help the helpers, essentially initiate counseling for these patients and set up health education programs for the helpers.

Voisin, D.R. (2010). Improving Service Delivery and Care to HIV-Infected Populations. *Journal of HIV/AIDS and Social Services*, 9(1), 4-6. doi: 10.1080/15381501003727389.

- This short editorial describes the growing needs and ailments for those infected by HIV/AIDS by providing a profile of those who have the disease by discussing the growing

number of minority women, and the kinds of trauma an individual with HIV/AIDS encounters. In addition, Voisin (2010) writes about the intersections of stigma surrounding the disease, the discrimination of those who have HIV/AIDS and the lack of knowledge concerning legal rights of individuals who have this chronic disease. This article seems to make reference to the Jonathan Demme film *Philadelphia*; instead of a member of a law firm getting fired, it is a man off the street or from a low-income neighborhood who is not getting hired.

Wood, S.A., & Tobias, C. (2005). Barriers to Care and Unmet Needs for HIV-Positive Women Caring for Children. *Journal of HIV/AIDS and Social Services*, 3(2), 47-65. doi: 10.1300/J187v03n02\_04

- This article discusses the barriers and unmet needs for women and children who have HIV/AIDS. Many women are unable to have access because they are caretakers of their families and in some cases, of a child who has HIV/AIDS. They also have a unique parenting situation that centers on stress for these women, due to their being around disease on a constant basis. The issues these women wished for were provided by New Orleans --specifically free child care and transportation. (These programs helped to improve the retention rates of these women in their health programs and doctor visits. The Family Advisory Network conducted interviews with women who have HIV/AIDS and in addition to free child care and transportation, women addressed the issues of mental health, substance abuse and coping concerns that many of them are around or they themselves partake in. They also wish for a friendly environment that is designed to keep individuals rather than push them away and a stronger need for cultural sensitivity. (Either they were referencing a lack of knowledge about the races of these women or the culture of HIV/AIDS). In general, these women were satisfied with their providers and doctors, yet they indicate a desire for change to the system. A more thorough examination of the situation is mandated.

Wood, S.A., & Austin, S.A. (2009). Building Bridges in Newport for HIV Positive Substance Abusers. *Journal of HIV/AIDS and Social Services*, 8(1), 20-34. doi: 10.1080/15381500902736129

- This article discusses the social services provided for substance abusers who have HIV/AIDS, using the Family Services of Woodfield, CT as the focus of this article. It begins by stating 36% of all HIV/AIDS cases involve the direct or indirect injection of substances (Wood & Austin, 2009, 20). As this is a high number of patients who obtained the virus by the use of illegal substances, there should be necessary care provided. According to Woods and Austin (2009), there is not as much support as there should be. Of the 643 agencies funded by the Ryan White CARE Act, only 243 agencies provide any form of substance treatment (roughly 38%).

- The focus of the study conducted was to see if Community Based Organizations (CBO's) to create a comprehensive integrated service delivery for substance abusers. In addition, this program would provide strategies for these individuals to adhere to their medication schedule and routine, access better care for HIV/AIDS patients who abuse substances and encourage substance abuse treatment. The most successful community of this study, the Family Services of Woodfield, CT established collaborative relationships between the staff and patients, in addition to patients and patients, as to provide a better and less overseeing situation for these patients. But the important item addressed was the major lack of funding and care for substance abuse for these patients. Because they abuse substances, probably by sharing needles, they most likely will spread the infection onto others the same way they received HIV in the first place.

## Personal Communications

Blair, Richard. (2010, May 21). Personal Communication.

- Richard Blair is a member of the Southern Colorado AIDS Project who assisted by answering questions concerning the kinds of aid provided by this organization. The kinds of services provided revolve around medical and social services, such as organizing a meeting with a case manager to discuss treatment options and navigate around the health language. They also provide housing for the patients of HIV/AIDS by arranging affordable housing (as many were kicked out of their homes or did not feel welcome). They provide a food bank, where they store dry and frozen foods for their clients. S-CAP provides medical transportation and gas vouchers for trips to the doctor. As for behavioral health, they set up patients with professional programs but they primarily use peer to peer therapy that has many young professionals mentoring/counseling the patients. The Southern Colorado AIDS Project does not offer on-site services to HIV/AIDS patients, but provides information and education for their patients, almost acting like an intermediary figure.

Grove, JoAnn. (2010, May 21). Personal Communication.

- Dr. Grove provided more insight to the day to day operations for the Pueblo Community Health Center, as they provide walk-in HIV testing, pay for care and services along with a coordinator who goes out to the community and clarifies stigmas, myths associated with HIV/AIDS and encourages testing. Dr. Grove also confirmed Part C assists with the funding of the medical aspects of the Ryan White Care Act.

Hough, Lynn. Denver's office of HIV Resources. (May 21, 2010). Personal Communication.

- Clarified section regarding housing for patients of HIV/AIDS. Checks do not go directly to these patients, rather than landlords, public entities (for utilities). Reason behind this is so these patients are provided housing and do not spend these funds on anything else, specifically abused substances.

Sellon, David. (2010, May 20). Personal Communication.

- Mr. Sellon of the Pikes Peak Lesbian and Gay Center through a personal phone call discussed the services the PPLGC provides for patients who have HIV/AIDS. The main service provided was to set up a time for the test for anyone who believes they have contracted HIV/AIDS. They work in collaboration with the Southern Colorado AIDS Project to set up counseling for patients along with getting patients set up with a support group.

Walna, Heather. (2010, May 20). Personal Communication.

- Ms. Walna is an employee of the American Red Cross (ARC) and she informed me about the educational resources provided by this department. The first service is through their public website which lists all information regarding how to contract HIV/AIDS through blood/bodily fluids and what the ARC has done to prevent the spread of HIV/AIDS through blood. The second educational service is to through their presentations to youth and schools. Then Ms. Walna discussed the training opportunities for First Aid and bloodborne pathogen training that discuss HIV/AIDS.