ASSESSMENT OF HIVS/AIDS SERVICES IN NEW MEXICO

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June 9, 2011

Prepared for: Infectious Disease Bureau, State of New Mexico

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EXECUTIVE SUMMARY

Purpose

The purpose of this report is to provide an assessment of services provided at the six federally-funded clinics for people living with HIV/AIDS (PLWH). The *Ryan White CARE Act Needs Assessment Guide* outlines five key components to the scope of work: (1) Assessment of service needs among affected populations; (2) Profile of provider capacity and capability; (3) Resource inventory; (4) Epidemiologic profile; and (5) Assessment of unmet need and service gaps. This report provides information on each of the five areas with much greater emphasis on the first two components.

Data Collection

The data collection included components for each of the five components of Ryan White. For the clients, we conducted 7 focus groups with 50 clients at the six HMA clinics. In addition, we conducted 2 one-on-one interviews and spoke with about 10 clients on the phone. Additionally, there were a total of 344 clients who completed a survey (14 in Spanish and the remaining in English). The survey included questions about the following: (a) where they get services and their satisfaction in general with services, (b) use and satisfaction with specific services; (c) barriers faced in seeking services; (d) their interaction with their providers; (e) medication adherence; (f) perception of social support and social undermining; (g) self-rated health and quality of life (including physical and mental health); (h) risk factors; and (i) demographics.

For providers, we conducted 6 focus groups with 53 providers at five of the six HMA clinics. In addition, we did a one-on-one interview with one provider from Truman St. Additionally, 47 providers completed a survey that included questions about the following: (a) their role and where they provide services; (b) their perceptions of services offered, their need for training, and satisfaction with services; (c) their perception of barriers faced by clients; (d) their interaction with their clients; (e) perception about specific at-risk client populations; (f) medication adherence and perception of co-morbid medical conditions; (g) perceptions about their interactions in their organizations; (h) self-rated health and burnout; and (i) demographics.

For the resource inventory, we compiled information about each of the HMA clinics in terms of number of clients serviced and specific resources provided by each clinic. For the epidemiological profile, the State of New Mexico Department of Health completes an annual epidemiologic report and we reviewed this report and talked with those who compiled the profile to develop the profile presented in this report. For the unmet need, we compared the epidemiological profile to the resource inventory and complete an estimate of unmet need. Further, we used the focus groups and surveys to identify the service gaps as reported by clients and providers.

Findings

First, clients are generally quite satisfied with their services and self-report positive health outcomes. Specifically, the system is working well for about 75-80% of clients—77% report

good to excellent health, 83% agree or strongly agree that they are satisfied with their services, and 71% report complete medication adherence. Further, there is satisfaction with specific services utilized for the most part and in particular medications and medical treatment. Additionally, this portion of clients reports positive perceptions about their interactions with providers and in their own social networks. Specifically, they report receiving good social support, have low levels of social undermining, and low barriers to seeking services. The only variable that approached a negative evaluation was isolation, which approached the midpoint on the scale.

At the same time, there are about 20% of the clients for whom the system is not working (i.e., low satisfaction or low utilization), have poor health outcomes, and/or poor psycho-social variables. We identified some patterns for this portion of the population:

a) Overall satisfaction is lower for people who perceive negative interaction with providers.
b) Medical adherence and efficacy is lower for people who have low satisfaction with services and face isolation from their social networks.
c) Self-rated health is lower for people who face isolation from their social networks and have communication/trust barriers with providers (it is higher for those who received adequate information from providers).
d) Physical health is lower for people who perceive not receiving instrumental (tangible) support from their social networks, not receiving respect from their providers, and receiving critical appraisal from their social networks.
e) Depression is higher for those who are isolated from their social networks, who receive critical appraisal from their social network, and who face communication/trust barriers with providers. It is lower for those who receive adequate information from providers.

These findings provide a complement to the service gaps and needs identified in the focus groups and surveys. Specifically, clients and providers identified key services that are needed and are not being provided to the level desired. The first table identifies the top 10 service needs of clients in the survey (they were specifically asked whether they need particular services in the survey):

Rank	Reported Service Needs of Clients	Percentage Reporting Need
1	Help paying medical bills	67%
2	Advice and help getting medical, social, community, legal, financial or other needed services	57%
3	Emergency help paying for food, housing or medicine	45%
4	Making a plan for health care	45%
5	Outpatient medical care	41%
6	Support groups or counselling	38%
7	HIV testing and diagnosis	36%
8	Mental health services	32%
9	Medical transportation services	28%
10	Legal services	25%

The second table identifies the top 10 services that PLWH (or providers of PLWH) note are important and are not being adequately provided.

Rank	Service Gaps
1	Case management including medical case management
2	Social support groups/counselling
3	Coordination of care including help with health care costs
4	Dental services /oral health care
5	Mental health services including substance abuse
6	Cultural competence including translational /linguistic services
7	Medical transportation services
8	Food bank/nutritional services
9	Outreach and education including special needs population (homeless, undocumented)
10	Legal services

Second, providers are also generally satisfied with the services that are provided and feel their clinics are doing a good job of meeting client needs. Providers report that their colleagues have good capability and cultural sensitivity with particular segments of the population (e.g., MSM, African Americans, Hispanics, and American Indians) although they recognize the importance of cultural competence with these populations. Providers also rated several factors consistently with clients: a) They feel there is positive interaction with clients; b) Their estimates of medication adherence are consistent with what the clients reported; and c) They identify service gaps in terms of case management, mental health, support groups/counselling, and dental services.

Providers recognize that a certain segment of the population needs more assistance than others, although they overestimate (relative to the self-reports of clients) how many clients face barriers to care and have mental health or substance use problems. They also identify communication with certain clients as a challenge; specifically, they report that getting a hold of clients can be problematic.

Providers also report some problems in their organizations and within themselves. First, about 30% report some level of burnout, which was found to be related to the level of critical appraisal and teamwork (negatively related to burnout) in their organizations. This is consistent with two themes identified in the focus groups: organizational and interorganizational communication. Further, two other themes are presumably related to burnout—overload of providers and a not user-friendly structural/funding system.

Third, the epidemiologic profile identified about 3,480 active cases of PLWH in New Mexico and yet only 1,362 clients were seen during FY2010 at the HMAs. Accounting for private insurance, the estimate is that there is an unmet need of about 25% of the PLWH in New Mexico (or about 870 individuals). This unmet need is consistent with the theme that the system works for about 75-80% of PLWH and it does not work for about 20-25%.

Fourth, the HMAs provide a comprehensive set of services for PLWH although there are certainly constraints to how many people they can serve and the number of services they can provide. The vast majority of patients are served by Truman St/NMAS and SW Care (accounting for approximately 80% of the total client load). Not surprisingly, these two HMAs had the highest satisfaction rating with services. Las Cruces and Roswell serve a rural and geographically dispersed population and we had a several clients complain that services were not available in their specific communities—they didn't like having to travel to Las Cruces or Roswell. First Nations serves a specific population (i.e., American Indians) and most of the

clients reported using services at both First Nations (for support services) and Truman St. (for medical services). Overall, the system of funding has constraints and cannot adequately meet every need for every client.

Recommendations

Based on the findings, we have the following recommendations for the future:

1) Feel good about quality of care provided. We think it is important to note the high levels of satisfaction and health outcomes for the clients. As noted, the system is working well for about 80% of the people who participated in the survey. The providers and administrators of the HMAs have a difficult job providing services with limited funding and are to be commended for performing well under difficulty circumstances.
2) Maintain quality of medical care. Clients in the focus groups and surveys noted that medications and medical care are the most important services provided and rate these aspects very well. To enhance the quality of care, it appears that case management is a critical aspect and it was identified as a service gap. Additionally, mental health/substance use and dental care were service gaps also mentioned by clients and providers.
3) Enhance communication within the organizations, with clients, and across organizations. The quality of communication was a key psycho-social variable for a variety of client outcomes and for satisfaction. Further, the quality of communication was also important for the level of provider burnout reported. Additionally, the quality of communication was a strong theme in both client and provider focus groups. For example, many noted a lack of understanding about how the funding structure works and yet reported receiving very little information about it. Another example is that providers note that there is very little interaction with other HMAs (even when they are in close proximity). Overall, the importance of quality communication is well recognized and very little effort toward improving the quality of communication is put forth (an exception to this is the quality of interaction between clients and providers which is reported to be very high). We recommend developing and implementing a communication plan for enhancing the information shared with clients and providers and also for improving the two-way process of communication with clients and providers (i.e., there has to be an opportunity for feedback). One key mechanism of this communication plan could be an advisory group of clients who work locally with a specific HMA and also with the state overall.
4) Facilitate on-line/client-led support groups. Everyone we talked with recognized that there are funding constraints and that support groups/counselling is less of a priority than medical care. We are realistic that funding is limited and that medical care takes priority over support. However, the evidence is clear that there is a service need and gap for support groups and that the social support is a critical factor associated with patient outcomes. One way to address this is to facilitate the creation of client-led support groups. The HMAs can help clients establish face-to-face and/or on-line support groups with very little resources. An advisory group of clients might be the mechanism to establish and maintain the support groups.
5) Improve the structural/bureaucratic issues to make work easier. Over the past three years, every industry has faced shrinking resources and expanded work requirements. It is a difficult situation and makes “working smarter not harder” a key mantra. Clients and providers both reported that there are structural/bureaucratic issues that could be

addressed to make the work easier. The specific issues were beyond the scope of this needs assessment so we cannot comment on any particular issues. However, working with the providers and clients to identify these issues might be worth the initial time and effort. If nothing else, it might provide the opportunity for enhanced communication and creating better understanding about why the bureaucracy exists (e.g., it may be HRSA or State government driven).

6) Examine resources in the community to identify potential duplications and savings. There are clearly service gaps and there are also clearly limited resources to meet these gaps. In the next needs assessment, effort needs to focus on developing a comprehensive resource inventory to identify if there are other ways to meet client needs.
7) Find out more about the 20-25% underserved and unmet need. There is about 20-25% of the clients whose needs are not being met. We know a little about the people who are using the current services and what they desire (i.e., service gaps and enhancing communication with these clients). We know nothing about the unmet—those PLWH who know about their status and are not getting care. Future needs assessments will need to focus on this portion of the population.

INTRODUCTION

The report summarizes the findings of an assessment of services provided at the six federally-funded clinics for people living with HIV/AIDS (PLWH). The *Ryan White CARE Act Needs Assessment Guide* outlines five key components to the scope of work: (1) Assessment of service needs among affected populations; (2) Profile of provider capacity and capability; (3) Resource inventory; (4) Epidemiologic profile; and (5) Assessment of unmet need and service gaps. This report is organized around these five components.

CLIENTS

The assessment of service needs among PLWH included two core data collection methods: client focus groups and client survey. This section is organized around these two methods with the focus groups and then the survey being presented. Throughout this section and the report, we interchange the terms patient and client. These were used interchangeably by clients and thus made it difficult to use one term or the other.

Client Focus Groups

Focus Groups Conducted

We conducted 7 focus groups with clients at the six HMA clinics. Table 1 presents the size, dates, and locations of the focus groups. In addition, one-on-one interviews were conducted with clients from Santa Fe (2). We also spoke to about 10 clients on the phone who shared concerns (including the areas of Las Cruces, Roswell, and Santa Fe).

Table 1. Location and dates of client focus groups

Location	Number of Participants
NMAS	N = 2
Santa Fe	N = 11
Las Cruces	N = 14 (English) N = 2 (Spanish)
Roswell	N = 1
Truman St.	N = 10
First Nations	N = 10

The purpose of the focus groups was to identify key themes about the perception of HIV services. During groups, we attempted to get all participants to share their perspectives, but focus here on identifying the common issues of concerns. Appendix 1 at the end of this report displays the questions we asked in each focus group.

During analysis, we identified all of these key points across the groups and then categorized those points into core themes. The analysis does not provide direct answers to the interview questions or count how many people supported each statement. Focus groups are not conducted for this purpose as people share stories and overlap with each other. What we did find out is what are the strongest themes—both in terms of frequency (i.e., multiple people have to assert a point for a theme to emerge) as well as those stated with assertiveness (i.e., we look for the most

important themes). The survey provides the quantified information (i.e., how many people feel certain ways). The themes are listed below and some example statements from specific groups are noted. The themes are listed randomly (i.e., the order does not imply importance).

Key Themes

Regardless of region or clinic, HIV-related medication and medical treatment were the most cited needs for PLWH in New Mexico. Clients who attended the focus groups overwhelmingly expressed the importance of being able to receive their medication in a timely and cost effective manner. Clients also indicated that they were pleased overall with the majority of the medical services received through the CARE Act clinics. While medical related services were consistently mentioned as the primary need for PLWH, other necessary services that PLWH reported are case management and social services, such as support groups and educational programs.

Theme 1: Importance of case management

Case management appeared to be a priority for PLWH in New Mexico, especially for the clients served in the Las Cruces and Roswell regions. This need presented itself among individuals who had a long-term diagnosis, as well as individuals who were newly diagnosed with HIV. These focus groups revealed that case managers are frequently the client's main point of contact regarding their HIV services. Consistent access to case management provides a critical intervention, as many of the clients have various levels of understanding about what services they are eligible for through the CARE Act. The high turnover rate within case management was a great concern in the focus groups because clients develop strong trusting relationships with most case managers; almost all of the clients expressed anxiety about this lack of consistency. Despite this apprehension, case managers are viewed as an invaluable resource, as professionals who can orient individuals and help them navigate resources, including a variety of organizations and services within the community. This may be of particular interest, as effective case management can direct clients to services provided by non-CARE Act funded organizations, which may ultimately eliminate an overlap in services provided. The following are some of the specific points made by clients in the groups:

- Currently no case manager in Las Cruces. Two participants get their case managing in Santa Fe, but are worried that they will no longer be able to access those services due to impending residency issues. (LC)
- Many concerns related to the "newbies" of HIV diagnosis—some "old timers" expressed their concern about the ability of newly diagnosed people to navigate the system. For example, one man with a new diagnosis said that he was told to get his labs, but he didn't even know what that meant, or why it was important. Another example: a man said he did not know that he was eligible for ANY services at all (LC)
- I have a case manager assigned to me but he/she has not worked a plan of care for me. Case manager turnover is high (FN)
- There is no case management. We need it. We used to have some case management but it was "case management humiliation" we were humiliated. Who wants to feel humiliated when we should be getting our much needed services. (LC)

- We should have like case managers, to talk to, to someone like us, to someone who can relate to us, like a gay man, not a woman. They always put these women to talk to us, what do they know about what it feels like to be us, to be gay men or Transgendered and what we are going through and here they are trying to counsel us. Why can a woman say " I want to speak with a female" but a gay man cannot say anything. We just have to go with who they give us. You don't know what we are living, (LC)
- No case manager for over a year. They don't want to work with him. He submitted a complaint for two/three months ago, but hasn't heard anything back. (LC)
- Case manager training, a standardized system of what they are supposed to do would be nice. (NMAS)
- Better communication between the medical case manger and nurse. (T)
- I don't have a case manager; it is about the money and not about the clients. A case manager who is competent and will help clients is key. I would like the intake to be more confidential—I'm concerned about being outed here. (R)

*Theme 2: Improving communication with clients (Comments in **bold** relate to theme but are positive statements)*

Communication between clients and providers was one of the most consistently referenced themes within the focus groups. This includes everything from one-on-one interactions between medical care professionals and PLWH, to phone calls regarding medical appointments, to reminder mailings about renewing their medical contracts with their clinics and the state. While most of the participants felt as though they had high quality rapport with their primary HIV medical doctor, many still felt as though there was a degree of uneasiness when dealing with other staff members of the clinic who appeared to lack sensitivity with this client population. Many clients indicate degrees of shame, and felt as though there was a lack of respect that trickled through the clinics. The tensions created by this perceived stigma appeared to impact the quality of care that clients felt they were receiving. There was also a consistent thread of confusion regarding accessing accurate information about what is available to PLWH under the CARE Act. Many clients expressed the desire for some sort of accessible database that contained information about different services available to PLWH in New Mexico. The following are some of the specific points made by clients in the groups:

- Doctors are difficult to get a hold of—no return phone calls, no reminders about appointments; Old clinic used to do monthly check in phone calls, even if there was no appointment scheduled—people seemed to miss this service. (LC)
- Transparency is something that patients need—from knowing exactly what services are available and that they qualify for, to knowing what the breakdown for funding in Las Cruces is; Concerns about what the DoH is actually required to provide (LC)
- They felt there were so many problems in Las Cruces. They stated that they wished it was like Albuquerque and or Santa Fe. Both participants felt that there was a lot of stigmatization by the public and even the service providers to people who have HIV and are in great need of services. (LC)
- They stated "nosotros tenemos la humilidad de aceptar servicios" "we have the humility to accept services" you think that they could have the decency to

treat us right. Antes eramos communidad, we were community before, we had a case manager. It was personal, we felt very important. It has changed, it is now agency and client, and there is no longer a personal touch. We are just numbers now!, now the staff makes it clear that work is the priority, work first "somos numeros, primero el trabajo, que el service de los clients". Work first before the service to the clients. We don't believe we have staff receptive to us or that believe in what they are doing in their actions pertaining to us. Many times we ask questions, and we don't get responses from them, from the agency. There is not clear communication and it certainly does not feel like a caring agency. We have lost our dignity and now we have to deal with people giving us attitude over services that should be given to us with at least some dignity of respect. (LC)

- What happens is that all of us get unmotivated, and we stop taking our meds, or pills. You know how it feels when you don't think people care for you, and especially those who are supposed to be providing services. All of us have had non-compliance issues at different times. It's like why should be care, when the people who are suppose to be caring for us don't even appear to care or to respect us. (LC)
- Service Facilities need to come up with a set of multiple reminder systems so that we the participants can pick the one that is most appropriate for us. (FN)
- Many of us feel that we are walking around with a dark cloud around our heads when we enter these clinics. We don't get treated well for the most part. Our favorite person or the person who treats with the greatest courtesy and respect is our doctor/doctors (FN)
- Also an important question asked was: Are you coming back again? This is really good for us, to be able to give back feedback and participate this way. No one ever checks in with us to see what we think. This is important. Are you coming back again? (FN)
- Need more information about how the Ryan White Program works--What is available at the clinic (Would like a list of what is available and what they are able to access); Want to know if it is "entitlement program" or a "charity program" and Want to know more about dental --"How does it work?" & "How do you get it?" (SF)
- Need some one who is willing to discuss with the patient--Spend face-to-face time; Feel like doctor only prescribes medications without getting a status report, and they are shoved out the door; Worried about doctors not caring and Want more time for doctor/patient consultation. "Doctors aren't good because they won't go the extra mile" (SF)
- Language used in documents is too high, difficult to understand. Providers should avoid technical/medical language and make language that the clients can use and comprehend (LC)
- Bad communication between the front office staff and walk-ins--Doesn't take walk-ins is the policy of new manager; ***However, overall, communication rated high; Truman St. is good--Listen to the suggestions of clients and never had a problem; Few problems with nurses*** (T)

Theme 3: Need for social services such as support groups and educational programs

Clients expressed satisfaction and appreciation that there are any support groups available, as well as access to social services. Social services and education were frequently referenced as areas that need improvement within the services provided to PLWH in New Mexico. While some support groups are available to some clients, there could be greater consistency or structure built into sustaining them over time. Clients expressed sentiments of isolation, not only from one another, but also from society as a whole, which makes the role of support groups an essential resource. Many communicated the desire to have consistent and well-facilitated meetings for a variety of demographics (such as MSM, heterosexual individuals, Native Americans, etc.). Some also expressed the need to have just general support networks built into the HIV care system. Peer education was mentioned in many of the focus groups as a possibility for combining social support with education from people who know the system best. Clients in all of the locations were very concerned about the lack of educational materials.. The following are some of the specific points made by clients in the groups:

- Community Health Representatives (CHP's) to do home visits and care with tribal people just like they have in the reservations (FN)
- Social support--Helps with isolation; Allowing the people with HIV to communicate with one another; New Mexico needs a way for people with HIV/AIDS for a way to communicate; HIPPA regulations keep them from getting to know each other and communicating; Need social support—Heterosexual & Married couples (T)
- The clients are connecting and helping each other out – finding the right doctor, reading blood work, etc. Clients need more opportunities for socializing using the clinic as a central location. (SF)
- Need to promote activist actions, promoting social access (FN)
- There is no outreach to clients, no HIV-related announcements or educational information for people who have HIV. (LC)

*Theme 4: Desire for improvement in medical care (Comments in **bold** relate to theme but are positive statements)*

The overwhelming majority of clients appeared to be genuinely satisfied with the medical services they receive through the CARE Act. Most clients expressed appreciation that the medical doctors provided top quality services. However, the most common issues of concern that came up during the focus groups were waiting time for appointments, the lack of infectious disease specialists across the state, the lack of access to high quality dental care, and the lack of access to nutrition services. It should be noted that clients from Southwest Care, Truman Street, and First Nations all vocalized satisfaction with the quality of medical care once they received it. The following are some of the specific points made by clients in the groups:

- Discussion about doctors who are not qualified to treat super strains and mutations, but are practicing in LC.
- The participants stated that the caliber of services and the atmosphere had really changed over time. It used to be that they received great care from a provider who respected them. Then a new director took over and the clinic became anti-service. To the clients it appeared that it was a very bad time which the area never recuperated from. The Director seemed anti-service in

attitude and seemed biased against providing services to the clients needing it. Since that time all the clients experienced a severe deterioration in services and also attitudes. (LC)

- Hard to get services include Referral services to specialists (neurology & radiology); Obtaining copies of medical records--Hard from UNMH; alcohol and substance use counseling (Mental health is available, but once a week**;** Very difficult to get an appointment) (T)

- Most of the time when you call for services, it can be a few weeks wait, and some times you can't afford to wait. If they had another doctor on staff, it would make it easier to get services. Many times they get pushed off. (SF)
  - No nutritionist and Not having access to Ryan White Dental ; Dental Hygiene issues (T)
    - Needs to be readily available & affordable
    - Not just pulling teeth, but preserving teeth
    - Prone to more dental problems than the general population
    - Some dentists from Ryan White not very good dentists
    - Need central information center on dental
    - Many problems getting into dental service; Teeth care is so important for health (SF)
- ***Extremely competent doctors--Excellent internists; Truman St. Clinic is a great clinic--Care about the patient and what is best for the patient*** (T)
- Feel that SWC has too many clients and not enough providers--Feel like they might be compensating for deficits in the southern part of the state; Need more case managers and doctors; SWC overwhelmed (SF)
- Need a Standard of Excellence for the providers at the clinic; Inconsistent experiences with service, some good, some bad (doctors and social workers) (SF)
- Mental health services need to be expanded (SF)
  - Many clients cannot access services provided by the staff psychiatrist. (SF)
- ***Lots of discussion about the generous funding and resources available in Santa Fe—everyone who has been to Santa Fe is happy with it.*** (LC & FN)

Theme 5: Structural/Funding Concerns

The Department of Health's HIV/AIDS Online Resource Guide addresses many of the questions raised by clients, however few of the clients knew this resource was available. Concerns surrounding funding were frequently discussed at the focus groups. PLWH had questions about how funding was allocated amongst the clinics, as well as what the CARE Act funding would pay for. Transparency about funds was requested. Many of the clients in Las Cruces communicated being charged for services that they thought were covered under the CARE Act, only to find out later that they would be required to pay for services out of pocket. The financial burden of extra medical costs was clearly an issue for these clients. The same clients in Las Cruces also expressed frustration with what they considered funding discrepancies between the southern and northern portions of the state. They felt as though the clinics in Santa Fe and Albuquerque were given preference in terms of both money and attention.

Along those lines, specific concerns about Native American and Hispanic/Latino populations were raised within these conversations. Services often do not take into account the multiple populations that they are being offered to, leaving some clients feeling alienated from care. Lack of linguistic services and culturally competent care were noted as being important within the focus groups particularly at Las Cruces and First Nations. The following are some of the specific points made by clients in the groups:

- Where is the money going to at home when it doesn't' come to the tribal members who are living in an urban setting. Who can answer those questions? What happens to money that was meant for me that they won't give me because I have left my tribal home and am in an urban environment? (FN).
- What we see currently happening is service agencies putting up a lot more barriers to get access to anything, we in turn get discouraged, they want more system checks for us and we get lets in return. (FN)
- One participant stated that non-citizens sometimes seem to get more services, while citizen residents seem to have to show more documentation and get over-surveillance in order to maintain any level of services for themselves. As much as he had lots of friends who were Hispanic and undocumented, he had to compete and fight for resources with them as everyone was now scraping at the bottom. (FN)
- If they are receiving money to provide services to us what happens to that money? To whom are they accountable to in terms of how they are spending the money that is suppose to go to us? They don't have the money to support us but they do have the money to move to a better building, public misuse of money. (LC)
- Concerned about where SW fundraising funds go**;** Want less bureaucracy as it makes it hard to get the services (SF)
- Lab work is not covered in its entirety, some are paying as much as $600 for their blood work that needs to be done four times a year. (LC)
- Concerns about the degree of poverty you have to be in order to receive services—you must be destitute to qualify, but the meds and other costs can make you destitute if you make money and have to pay. (LC)

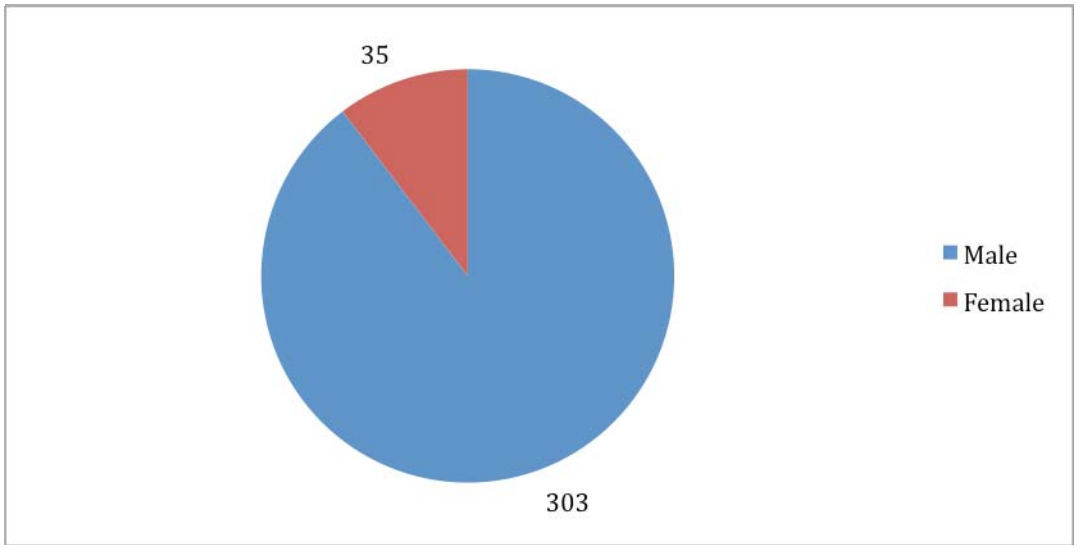
CLIENT SURVEY

Participants and Data Collection

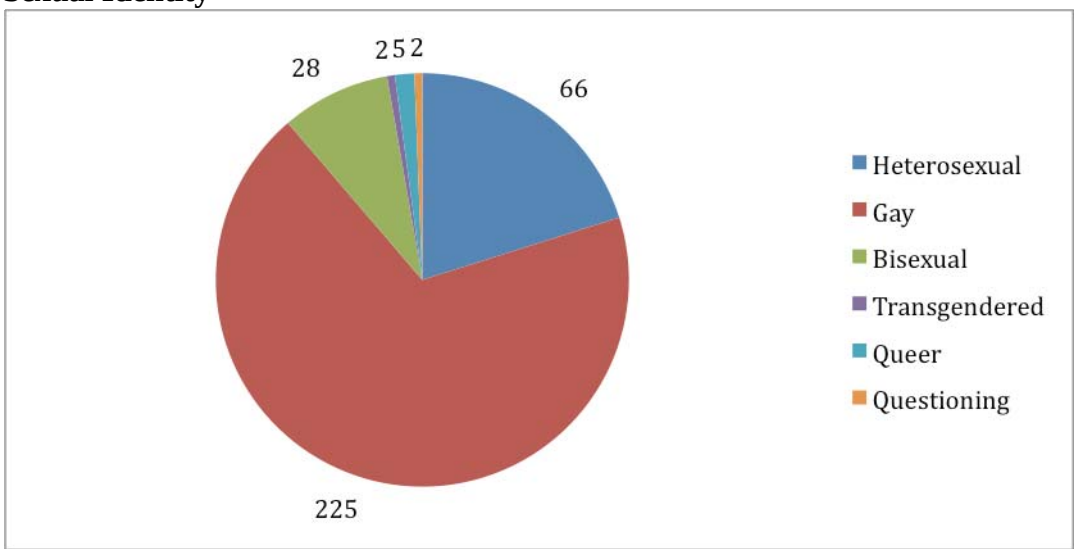
The client/patient survey complemented the focus groups. There were a total of 344 clients who completed a survey (13 in Spanish and the remaining in English). The survey included questions about the following: (a) where they get services and their satisfaction in general with services, (b) use and satisfaction with specific services; (c) barriers faced in seeking services; (d) their interaction with their providers; (e) medication adherence; (f) perception of social support and social undermining; (g) self-rated health and quality of life (including physical and mental health); (h) risk factors; and (i) demographics. The actual survey is displayed in Appendix 2. Prior to administering the survey, we asked a health literacy expert to review it and suggest

wording changes so the survey was accessible at a 7th grade reading level. The following figures offer information about where surveys were collected (i.e., at a clinic, via internet, or mail) and demographic information about the clients. In addition, the media age of the sample was 49 with a range of 21-78. The median monthly income of the sample was $1,493 with a range of 0-$10,000.

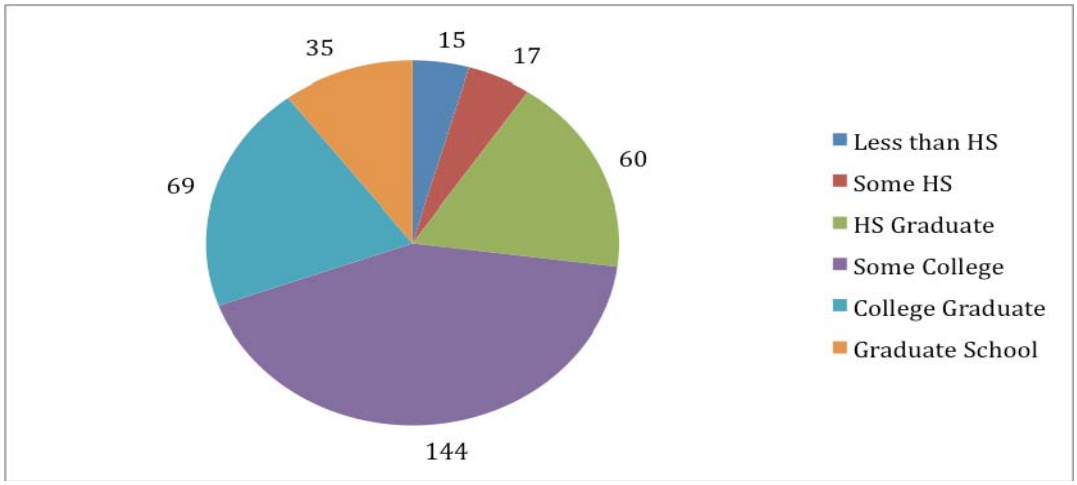
Sex



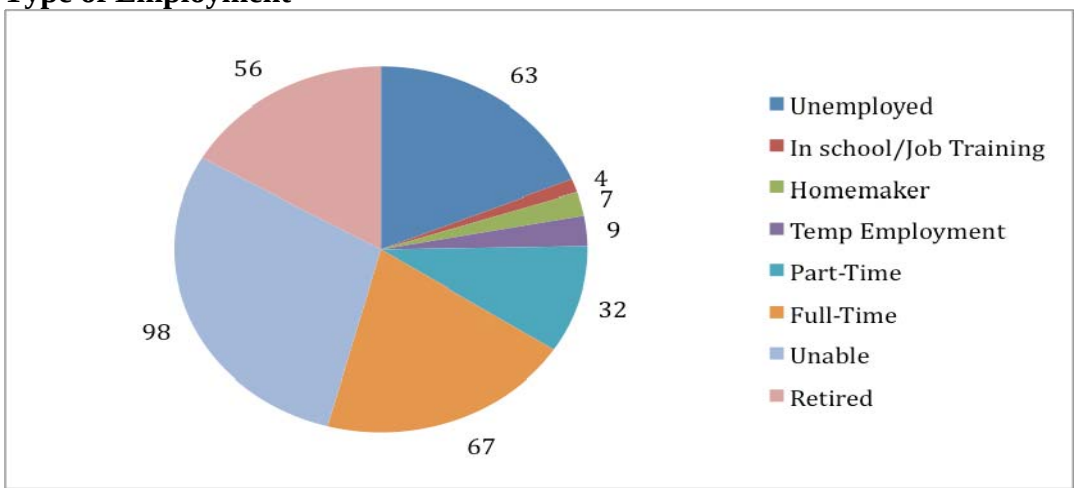
Sexual Identity



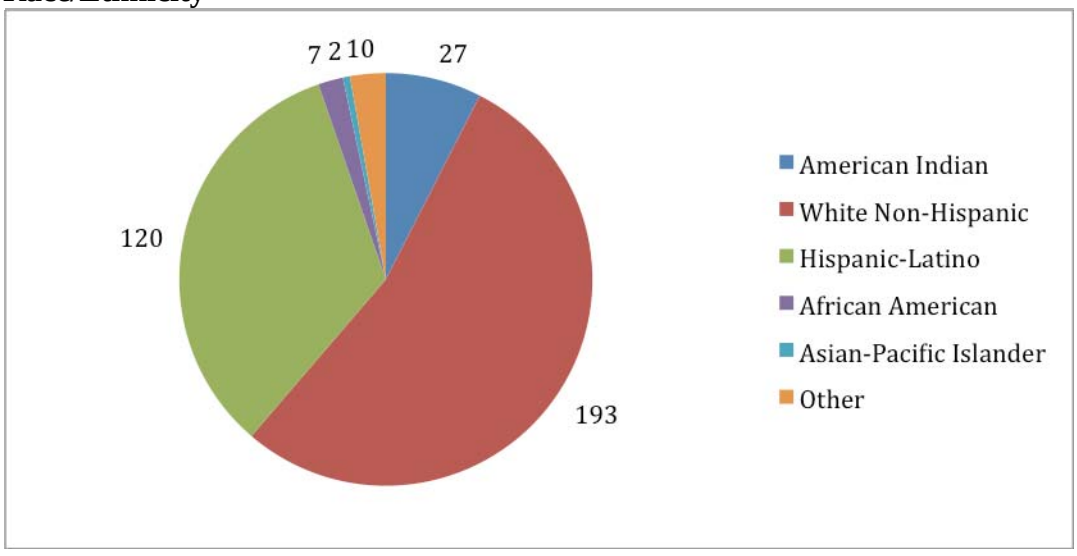
Education



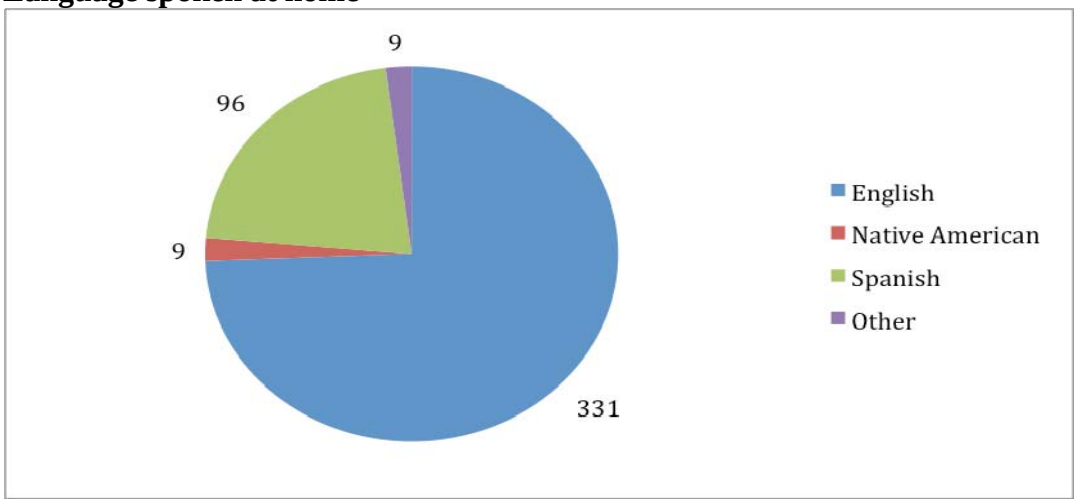
Type of Employment



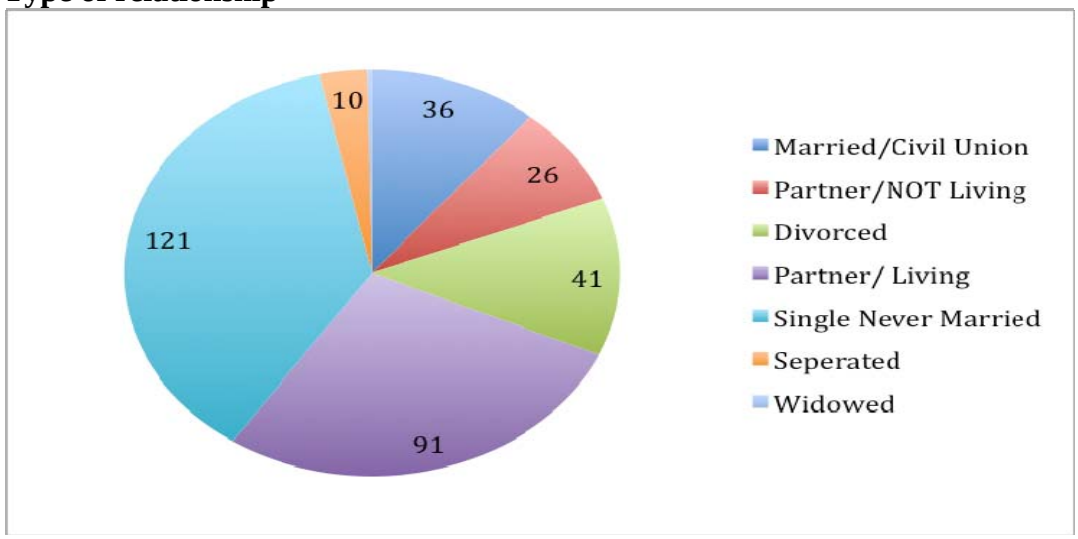
Race/Ethnicity



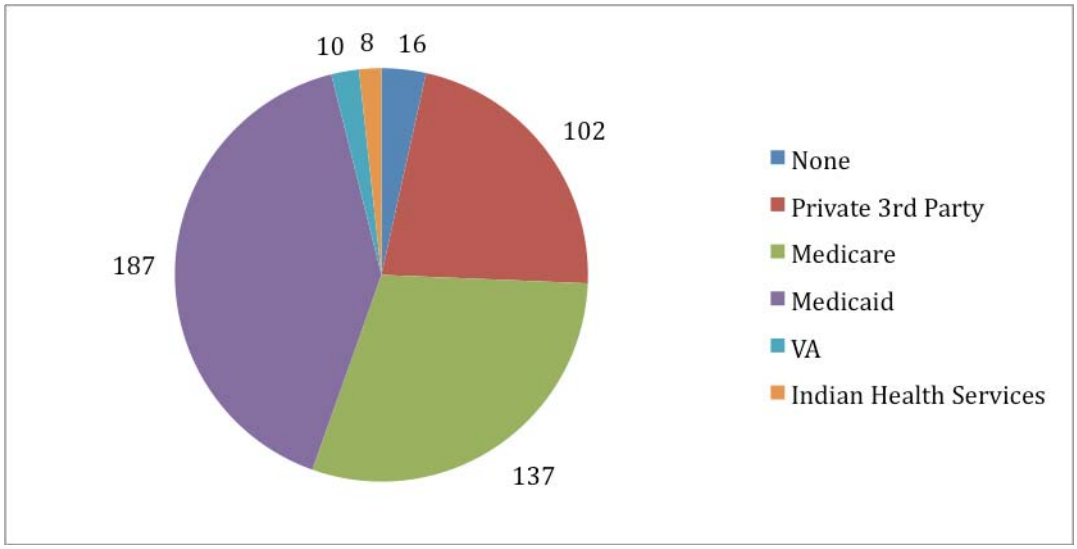
Language spoken at home



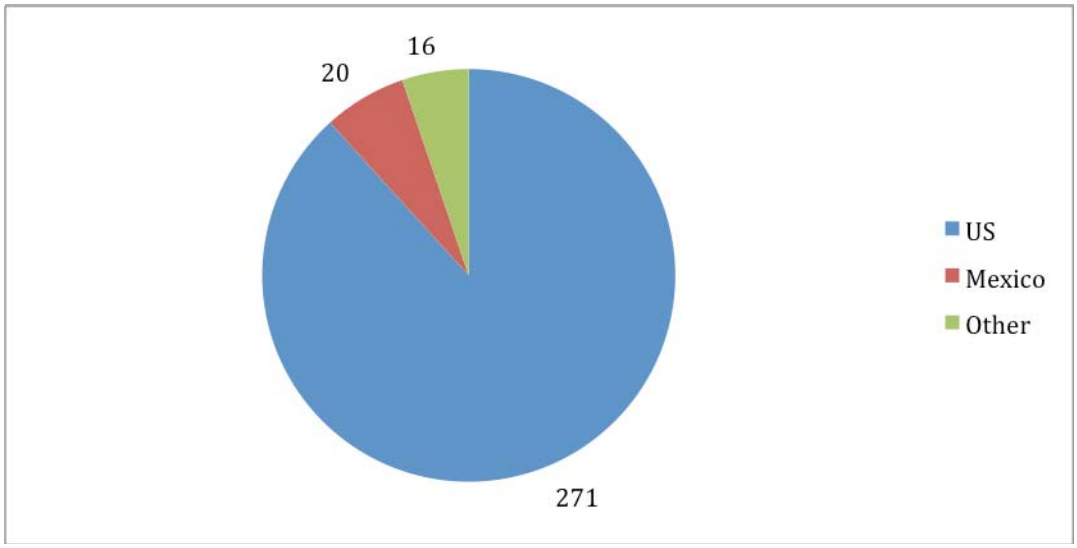
Type of relationship



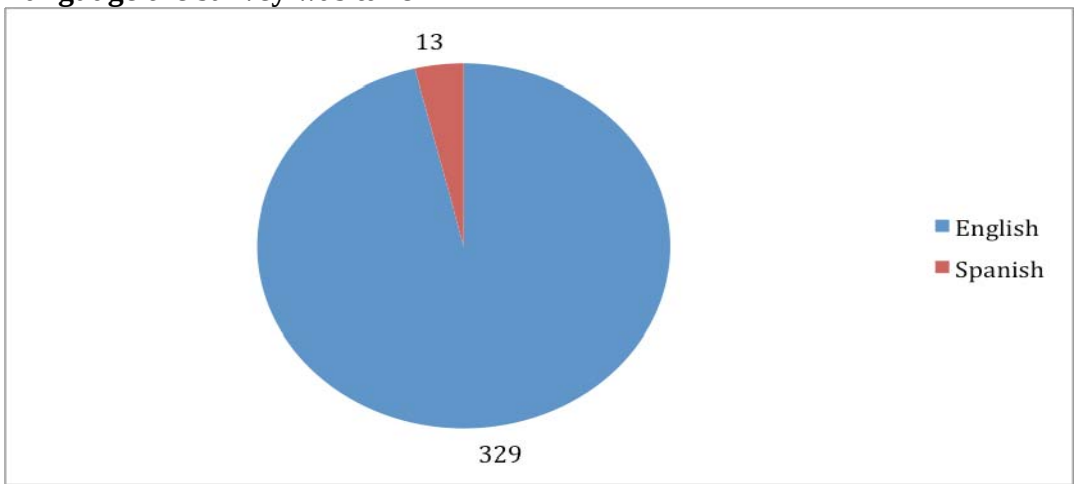
Insurance



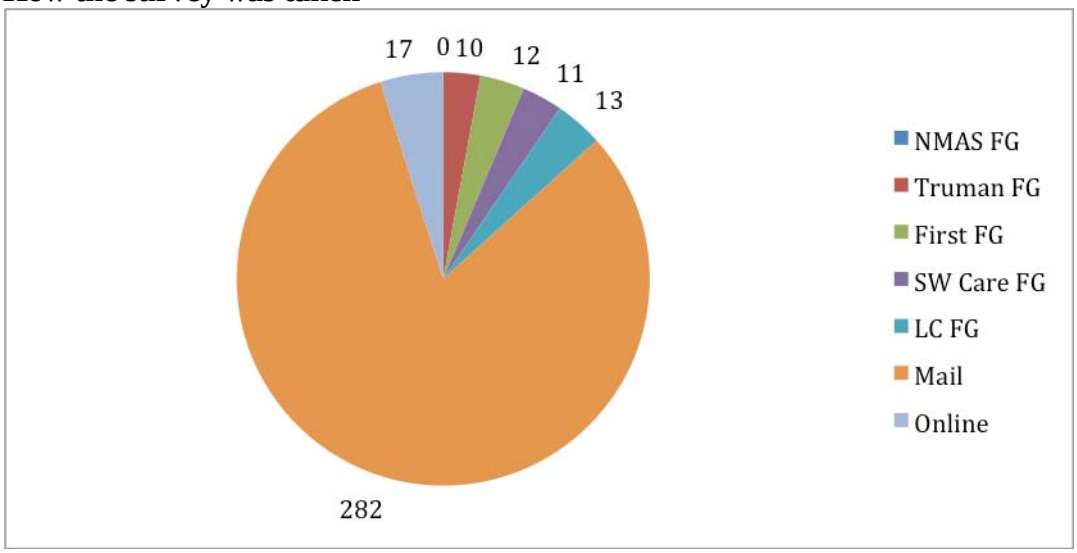
Place where born



Language the survey was taken in



How the survey was taken



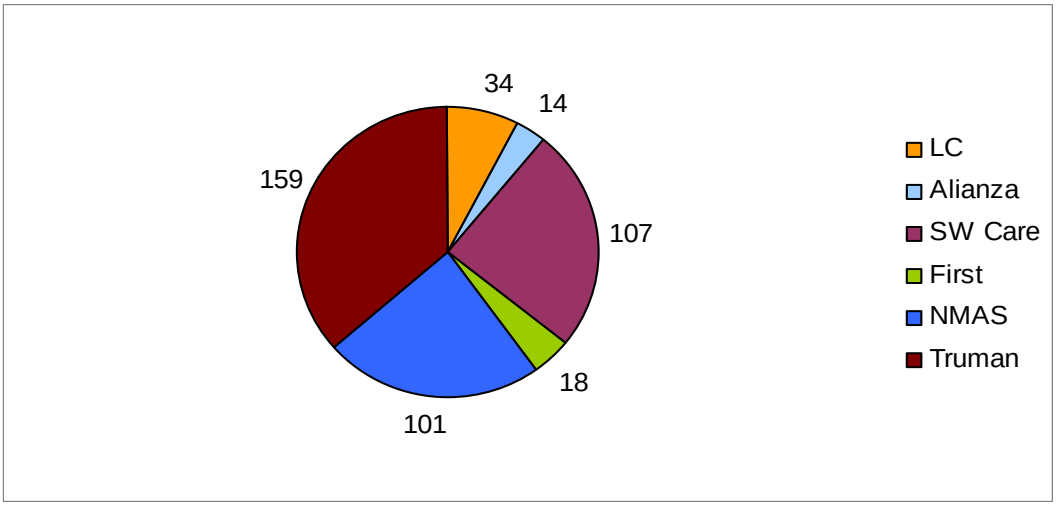
Findings

We organize these findings in the following sections: (a) client use and satisfaction of specific services; (b) psycho-social factors; (c) overall satisfaction and related factors; and (d) health outcomes and related factors.

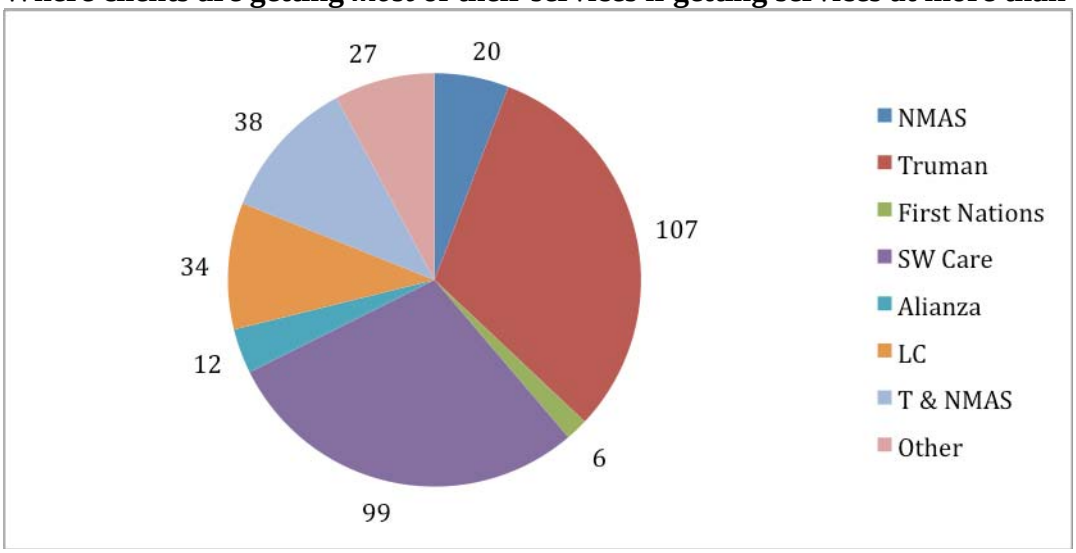
Client Use and Satisfaction with Specific Services

The following two figures demonstrate where clients are getting their services and where they get most of their services.

Where clients are getting their services



Where clients are getting *most* of their services if getting services at more than one clinic



The following tables display all of the services that are eligible for funding under Ryan White. The first table shows medical services, while the second table shows support services. We asked clients three questions about each service: Do you need this service? Have you used this service in the past year? and How satisfied are you with the service (on a 4 point scale: 1 = very dissatisfied, 2 = dissatisfied, 3 = satisfied, and 4 = very satisfied)? The tables display the number

of people responding yes to the first two questions and the mean of the satisfaction with the service.

For medical services, the only service that was reported being needed by more than 50% of the clients was paying medical bills (67% saying yes). Medical case management (45%) and outpatient medical treatment (41%) were the next highest needed services. Most likely the outpatient medical treatment was not understood by the clients as presumably all clients need medical treatment. Overall, medical services were highly rated with most clients being satisfied. The highest rated services were testing, premium assistance, medical case management, and outpatient medical treatment. The lowest rated service was for alcohol and drug treatment (2.6 out of 4.0).

For social services, the three highest needed services are advice/referrals (57%), emergency help for paying for services (45%), and support groups/counselling (38%). Social services were rated lower than medical services with only translation receiving a rating of 3.0 or above. The remaining services were rated between dissatisfaction and satisfaction with the lowest being legal services at 2.3 (out of 4.0).

Table 2. Satisfaction and use of specific medical services

Medical Services	**Do you need this service?**	**Have you used this service in the past year?**	**How satisfied are you with the service?**
a. Home health care	**Yes : 26**	**Yes: 17**	3.0 on a 4.0 scale (n = 33)
b. Mental health services	**Yes: 111**	**Yes: 83**	2.9 on a 4.0 scale (n = 109)
c. Advice and supplements from a dietician (nutrition therapy)	**Yes**: **95**	**Yes: 47**	2.7 on a 4.0 scale (n = 82)
d. Making a plan for your health care (medical case management)	**Yes**: **156**	**Yes: 132**	3.2 on a 4.0 scale (n = 165)
e. Outpatient treatment for alcohol and drug problems	**Yes**: **21**	**Yes: 17**	2.6 on a 4.0 scale (n = 39)
f. Outpatient medical care	**Yes**: **142**	**Yes**: **132**	3.1 on a 4.0 scale (n = 157)
g. Help paying medical bills (help with premiums/cost sharing)	**Yes**: **229**	**Yes**: **187**	3.3 on a 4.0 scale (n = 216)
h. HIV testing and diagnosis	**Yes**: **123**	**Yes**: **113**	3.6 on a 4.0 scale (n = 133)

Table 3. Satisfaction and use of specific support services

Support Services	**Do you need this service?**	**Have you used this service in the past year?**	**How satisfied are you with the service?**
a. Child care while you are at the clinic	**Yes: 3**	**Yes : 2**	2.8 on a 4.0 scale (n = 13)
b. Emergency help paying for food, housing, or medicine	**Yes**: **156**	**Yes**: **104**	2.9 on a 4.0 scale (n = 136)
c. Food bank or home-delivered meals	**Yes**: **92**	**Yes**: **57**	2.7 on a 4.0 scale (n = 86)
d. Help getting emergency housing	**Yes**: **39**	**Yes**: **15**	2.6 on a 4.0 scale (n = 41)
e. Translation of information—either written or spoken	**Yes**: **26**	**Yes**: **21**	3.2 on a 4.0 scale (n = 39)
f. Medical transportation services (direct rides or vouchers)	**Yes**: **95**	**Yes**: **119**	2.7 on a 4.0 scale (n =91)
g. Support groups or counseling	**Yes**: **129**	**Yes**: **95**	2.8 on a 4.0 scale (n = 118)
h. Advice and help getting medical, social, community, legal, financial, or other needed services	**Yes**: **195**	**Yes**: **121**	2.9 on a 4.0 scale (n = 175)
i. Legal services	**Yes**: **86**	**Yes**: **28**	2.3 on a 4.0 scale (n = 58)

Psycho-social Factors

We considered a number of psycho-social factors that have been found to relate to patient satisfaction and/or other health outcomes to help provide a sense of patient needs. These include the following: barriers to care, interaction with providers, and social support/social undermining. Barriers to care are those factors the inhibit clients from seeking services and include several categories: desire for privacy, communication/trust with providers, and transportation. Interaction with providers includes several factors including whether providers share information with clients (information), whether they share information with providers (communication), and the degree of respect providers show clients (respect). Social support is the communication factors that show support including emotional support and instrumental support (tangible help).

Social undermining are the negative communication factors in interacting with others including feeling isolated and being criticized (critical appraisal).

Table 4 presents the means and standard deviations on the barriers when seeking services on a 5-point scale: 1 = Strongly Disagree to 5 = Strongly Agree. Overall, the participants do not have concerns in terms of communication/trust, privacy, and tangible barriers.

Table 4. Means of barriers when seeking services

	Mean	Standard Deviation
Communication & Trust Barriers	**2.02**	**1.05**
The staff and I have had problems understanding each other.		
I don't trust the staff.		
I worry about prejudice or discrimination.		
Privacy Barriers	**2.09**	**.93**
I don't feel comfortable talking about my sex life.		
I don't want anyone to know I have HIV.		
I've been afraid of a lack of privacy, or that staff would talk to other people about me.		
I don't want to tell my partner or spouse about my HIV status.		
I've been worried about what others might think.		
Tangible Barriers		
I don't have child care.	**2.4**	**1.4**
I don't have a reliable ride.	**2.0**	**1.3**

Table 5 presents the means and standard deviations on the interaction with providers on a 5-point scale: 1 = Strongly Disagree to 5 = Strongly Agree. Overall, the participants report that they receive good information from providers, respect from providers, and do not have trouble communicating with providers (i.e., asking questions).

Table 5. Means of interaction with providers

	Mean	Standard Deviation
Information	**4.08**	**.95**
My provider makes sure I understand treatment side effects.		
My provider told me what treatment would do.		
I understand the medical plan for me.		
I have a good idea about the changes to expect in my health.		
Treatment procedures were clearly explained to me.		
Communication	**1.98**	**.98**
It's hard to get conflicting information straightened out.		
It's hard to ask about something I don't understand.		
It is hard for me to talk about new symptoms.		
It's hard for me to ask how treatment is going.		
I have trouble asking my provider questions.		

Respect	**4.30**	**.87**
My provider is warm and caring toward me.		
My provider makes me feel comfortable talking about personal issues		
My provider really respects me.		
Sometimes I feel insulted when talking to my provider. (scoring reversed)		
My provider doesn't seem interested in me as a person. (scoring reversed)		

Table 6 presents the means and standard deviations social support and social undermining on a 5-point scale: 1 = Strongly Disagree to 5 = Strongly Agree. Overall, the participants report a moderate amount of instrumental and emotional support and relatively low levels of critical appraisal. The amount of isolation was somewhat, nearing the midpoint with a 2.6 on a 5.0 scale.

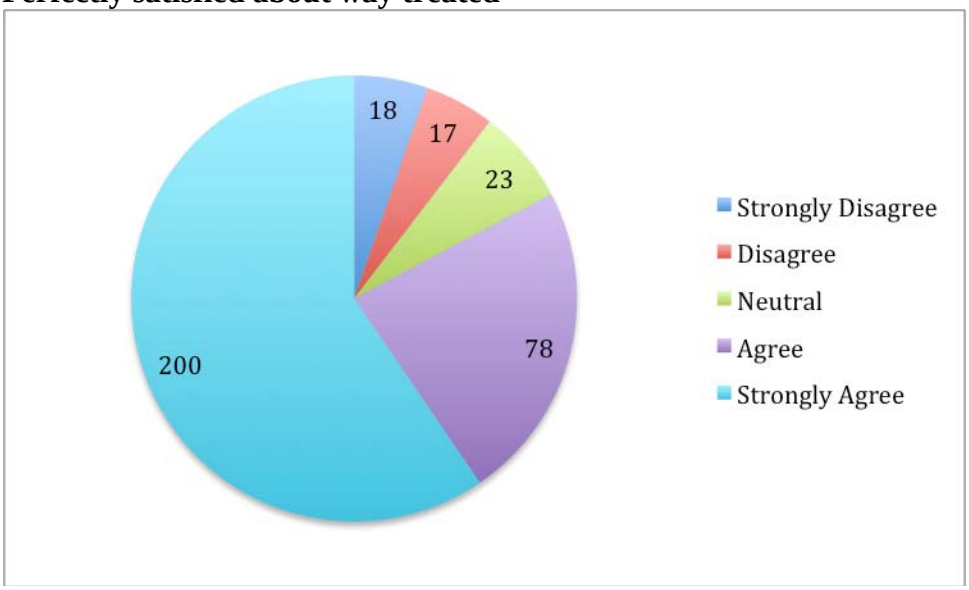
Table 6: Means of social support and social undermining

	Mean	**Standard Deviation**
Instrumental Social Support	**3.70**	**1.02**
There is someone I know who would lend me a car or drive me.		
There's someone I know who would lend me money if I needed it in an emergency.		
There's someone I know who will attend social activities with me.		
There's someone I know whom I could count on to check in on me regularly.		
I can rely on my friends or relatives for help if I have a serious problem.		
Emotional Social Support	**3.80**	**.88**
I can talk to my friends or relatives about my worries.		
Most people who are important to me know that I'm HIV-positive.		
My friends or relatives understand the way I feel about things.		
I can relax and be myself around my friends or relatives.		
My friends or relatives really appreciate me.		
My friends or relatives really care about me.		
Critical Appraisal	**2.21**	**.85**
My friends or relatives often get on my nerves.		
My friends or relatives argue with me often.		
My friends or relatives make too many demands on me.		
My friends or relatives criticize me often.		
My friends or relatives drink or use drugs too much.		
Isolation	**2.60**	**1.04**
I feel isolated from others.		
My friends or relatives often let me down when I'm counting on them.		
I often avoid family gatherings.		
When I do go to family gatherings, I'm likely to leave early.		

Overall Satisfaction and Related Factors

Overall, clients are generally satisfied with the care they receive at the clinics. The overall satisfaction rating is 4.1 out of 5.0; thus they agree that they are receiving good care at the clinics. The score is an average of the five items for the second question (2a-e). These items ask about satisfaction in different ways to ensure that most facets of satisfaction are included. For example, 83% of clients agree or strongly agree with the statement, "I feel perfectly satisfied about the way I am treated at this clinic" (see chart below).

Perfectly satisfied about way treated



The ratings of satisfaction have some variation across clinics or combinations of clinics. The table below shows that the highest rated care if for clients who receive care at Truman Street and NMAS with the second highest for Southwest Care Clinic. The lowest rated care is for First Nations and Las Cruces Collaborative Care.

Table 7. Overall satisfaction across clinics

Clinic	Number of Clients	Mean Satisfaction
NMAS	**20**	**3.6**
Truman Street	**107**	**4.2**
First Nations	**6**	**3.5**
Southwest Care Clinic	**99**	**4.3**
Alianza	**12**	**3.7**
Las Cruces Collaborative Care	**34**	**3.5**
Truman St. & NMAS	**38**	**4.5**
Other locations or combinations	**27**	**4.3**

We also examined which barriers, interaction with providers, and social support/undermining relate to overall satisfaction. Specifically, we utilized a technique called stepwise multiple regression. This technique identifies factors that are uniquely associated with the outcome

variable one step at a time. Thus, the most strongly associated factor is entered into the equation first and then a second factor is entered and so on until there is not any unique variance in the outcome variable that can be accounted for. This technique helps to identify the most important psycho-social variables and how much variance is explained. The more variance explained, the better we understand the scores on the outcome variable.

There were three factors associated with overall satisfaction accounting for 59% of the variance (which is a very large amount).

Table 8. Significant psycho-social factors for overall satisfaction

Significant Factors for Overall Satisfaction
1) Respect
2) Communication/trust barriers
3) Information

These findings demonstrate that factors directly involving interaction with providers/staff are the most important factors for satisfaction with services. Specifically, information and respect were positively associated with satisfaction, while communication/trust barriers were negatively associated. A positive association means that the higher in one variable, the higher in the outcome variable (e.g., the more information, the more satisfaction). A negative association means that the higher in communication/trust barriers, the lower the satisfaction.

Health Outcomes and Related Factors

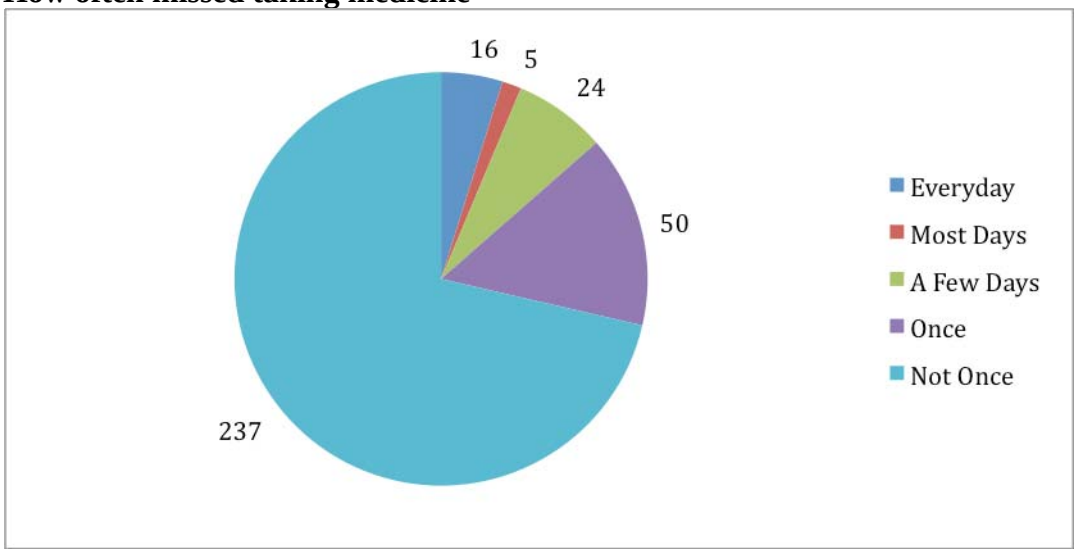
We considered four patient health outcomes: medication adherence, self-rate health/quality of life, physical health, and depression. We also considered a variety of psycho-social factors that have been shown to relate to the health outcomes (that were reported in a section above).

Medication adherence

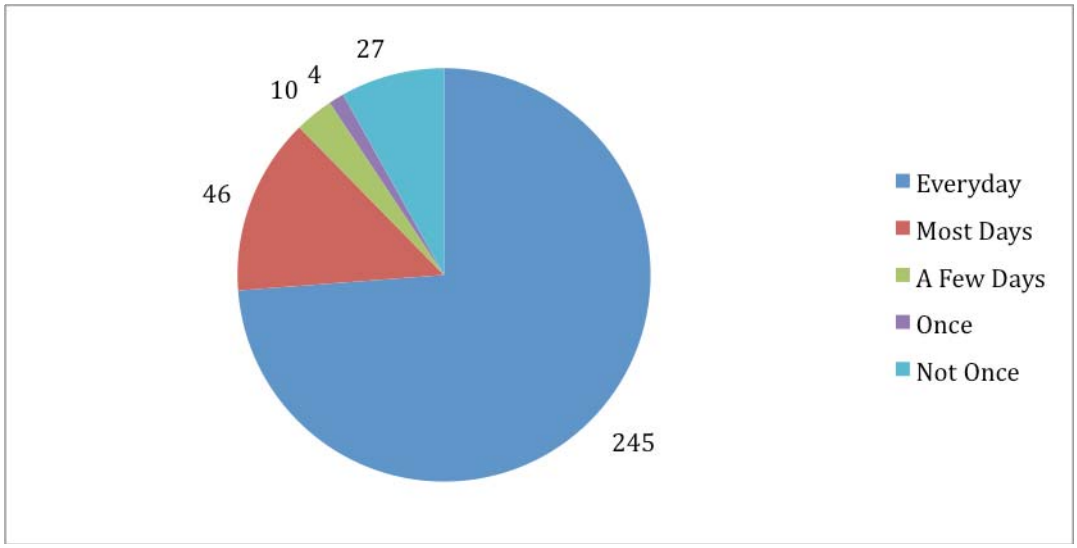
One of the key indicators of good health is that clients adhere to their medication regimen to keep their viral load and C4 in check. As the charts below demonstrate, 71% of clients self-reported that they did not miss a single dose of their medicines, while 74% reported that they maintained their time schedule. Overall, these are very positive indicators of patient compliance with their medicines.

Further, we asked clients about their self-efficacy to take medicines on time in the coming weeks using 5 items. Clients self-reported that their physical health was 3.50 on a 4 point scale (with 1 = not at all sure, 2 = fairly sure; 3 = very sure, and 4 = extremely sure). Thus, there is high levels of self-efficacy to take medication on schedule.

How often missed taking medicine



Took medications on their time schedule



We examined factors that were associated with medication adherence using stepwise multiple regression. We considered the barriers, interaction with providers, social support/undermining, and overall satisfaction. We found that two factors were associated with medication adherence and accounting for just 7% of the variance.

Table 9. Significant psycho-social factors for medication adherence

Significant Factors for Medication Adherence
1) Overall Satisfaction
2) Isolation

Specifically, the more satisfied people are with their services, the more likely they are to adhere to their medicine regimen. Additionally, the less isolated people feel, the more likely they are to

adhere to their medicine regimen. These factors were important for medication adherence and also only explained a small portion of the variance.

We also examined factors that were associated with medication efficacy using stepwise multiple regression. We considered the barriers, interaction with providers, social support/undermining, and overall satisfaction. We found that three factors were associated with medication efficacy accounting for 16% of the variance.

Table 10. Significant psycho-social factors for medication efficacy

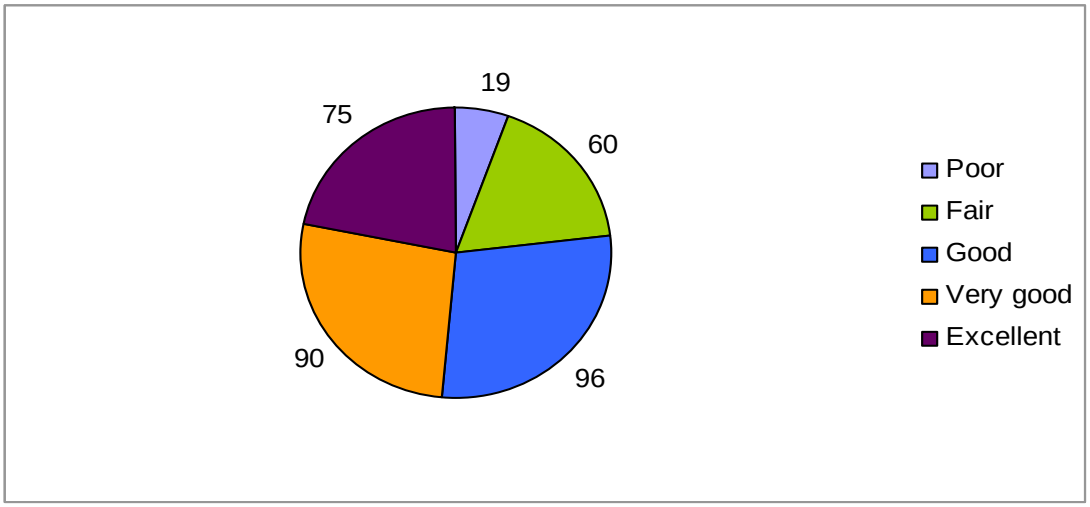
Significant Factors for Medication Efficacy
1) Isolation
2) Overall Satisfaction
3) Communication—sharing with providers

Specifically, the more isolation and less willing they were to share with provider the more likely they felt efficacy in taking their medications. Additionally, the more satisfied with services, the more likely they were to feel efficacy. The factors explained a moderate amount of the variance in medication efficacy.

Self-rated health

The chart below demonstrates that self-rated health is variable: 77% reported good, very good or excellent health, while 23% fair or poor health.

Self reported overall health



We also examined factors that were associated with self-rated health using stepwise multiple regression. We considered the barriers, interaction with providers, social support/undermining, and overall satisfaction. We found that three factors were associated with self-rated health accounting for 29% of the variance.

Table 11. Significant psycho-social factors for self-rated health

Significant Factors for Self-Rated Health
1) Isolation
2) Information
3) Communication/trust barriers

These findings demonstrate that isolation and communication/trust barriers were negatively associated with self-rated health, while information was positively related to self-rated health. The factors explained a moderate amount of the variance in self-rated health.

Physical health

We asked clients about their physical health; specifically, we were interested if their physical health limited their ability to perform six activities. Clients self-reported that their physical health was 2.44 on a 3 point scale (with 3 being not limited to 1 being very limited). Thus, there is relatively high levels of physical functioning in the overall sample.

We also examine factors that were associated with physical health using stepwise multiple regression. We considered the barriers, interaction with providers, social support/undermining, and overall satisfaction. We found that three factors were associated with physical health accounting for 15% of the variance.

Table 12. Significant psycho-social factors for physical health

Significant Factors for Physical Health
1) Instrumental support
2) Respect
3) Critical appraisal

These findings demonstrate that instrumental support and respect were positively associated with physical health (i.e., more instrumental support results in fewer limitations), while critical appraisal was negatively related to physical health (i.e., more comm./trust barriers and critical appraisal results in more limitations). The factors explained a moderate amount of the variance in physical health.

Depression

We asked clients about their level of depression; specifically, we were interested in how often they experience nine symptoms of depression. Clients self-reported that their depression was 3.11 on a 4 point scale (with 1 being nearly everyday, 2 = more than half of the days, 3 = several days, and 4 = not at all—thus, higher numbers indicate lower depression). Thus, there are relatively low levels of depression in the overall sample.

We also examined factors that were associated with depression using stepwise multiple regression. We considered the barriers, interaction with providers, social support/undermining, and overall satisfaction. We found that four factors were associated with depression accounting for 37% of the variance.

Table13. Significant psycho-social factors for depression

Significant Factors for Depression
1) Isolation
2) Communication/trust barriers
3) Information
4) Critical appraisal

These findings demonstrate that isolation, comm./trust barriers and critical appraisal were positively associated with depression (i.e., more of these variables results in high levels of depression), while information was negatively associated with physical health (i.e., more information results in lower levels of depression). The factors explained a large amount of the variance in depression.

PROVIDERS

PROVIDER FOCUS GROUPS

Focus Groups Conducted

We conducted 6 focus groups with providers at five of the six HMA clinics. In addition, we did a one-on-one interview with one provider from Truman St.

Table 14. Location and dates of focus groups for providers

Location	Number and Date
NMAS	N = 10
Santa Fe	N = 15
Las Cruces	No providers showed up
Roswell	N = 8
Truman St.	N = 10 N = 4
First Nations	N = 6

The purpose of the focus groups was to identify key themes about the perception of HIV services. During groups, we attempt to get all participants to share their perspectives, but focus on identifying the common issues of concerns. Appendix 1 at the end of this report displays the questions we asked in each focus group. The development of themes is consistent with the report in the client focus group section and is not repeated here.

Key Themes

Theme 1: Structural/Funding concerns

Based on structural and funding concerns, there appears to be a need for a user-friendly service centered model that benefits both providers and clients. Just as an online resource guide has been

developed for PLWH, a similar resource for providers would be beneficial. This resource guide could house the different forms that are spread out over different agencies, and would provide an essential access point for providers for to better serve their clients.
The pipeline of services has become too formalized for providers to be able to efficiently expedite services to clients. Paperwork, funding constraints, and leadership within agencies lead to disparities of services provided and clients served. In the continuum of services, those most impoverished and those most financially secure are serviced, while those in the middle are most apt to be overlooked. The following are some of the specific points made by providers in the groups:

- Bureaucracy concerns
  - There is a lot of frustration that derives from funding issues, especially the bureaucracy of funding and where dollars are spent (FN)
  - Progress is difficult with so many levels of accountability (T)
  - Problems with Prior Authorization forms—too many hoops to jump through—links back to consistency of care and provider (T)
  - However, they were vocal about their strong dislike of the bureaucracy that they deal with on a daily basis. They were especially concerned with paperwork. Participants cited that paperwork is redundant, and prevents clients from receiving care in a timely manner. One person spoke about how the services that clients need are offered however, there are too many "hoops" that they need to go through. (SF)
  - Gaps for clients in access to care, and access to medications because of the paperwork that they have to complete – It is counter intuitive to have gaps because that hurts their health. There should be an easier system. (SF)
  - Ryan White is a great program, but it goes through the DOH first, and it gets tied up in bureaucracy. They don't have regulations in writing that sticks. Problem has increased over the past five years. There is no communication in the DOH – they don't share important information with each other. There is a big need for streamlining in the DOH, to simplify the process at the clinic. (SF)
  - Glad we can get anyone into medical care, and can get almost anyone medication—not satisfied with how the process goes. (NMAS)
    - Streamlined—universal healthcare, situations are all over the place, coordinating where people are getting meds from month to month, so many people involved in the process (NMAS)
    - Challenges at the bureaucratic level—working with the state, not due to specific people, but it can impeded the services and the care that clients are (NMAS)
    - We are beholden to certain conditions—sometimes financial—want clients to see counselor immediately, but can't bill for that, so they have to eat that cost—have to wait to provide some services because have to wait until you bill; General attitude at state that clients will be "eating up services" but people need this; NMAS—we won't deny anyone services, but unfortunately the state won't pay; Bureaucratic wait is not conducive to good client care (NMAS)
    - Enrolling a client is cumbersome and time consuming—fixable, but currently problematic and part of what is not working well in

the system—frustrates clients, one of the barriers to returning to care (NMAS)

- Not enough money
  - They wanted us to know that while nurses at Truman Street actually DO case management (it is built into the job description), they do not have any dedicated staff for this function, and therefore do not get funding for it; Case management funding is lacking—30% are NOT enrolled in CM, but are using the services any way. Issue falls onto the nurses to try and negotiate. (T)
  - We don't have enough money, we don't know if we can keep open past March. The thought of having to cut staff to keep us, the agency open is difficult. Everything we have done in January is not billable. We are the red-headed step children in South Eastern New Mexico. We are one of the poorest. There is a vicious cycle (R)
  - We don't see as much of the financial issues…In some ways it's excellent, it's something that no other disease has. However, funding could be better. Gaps of medication--Forced non-adherence because of funding; Undocumented patients can't get basic care—Funding issues across the board. Dental funding is running out. Better oversight, management. Funding changes from year to year (T)
  - HMAs created to make sure that services were equal throughout the state, but the way the feds are swinging things are changing… (NMAS)
  - We only get Part B—C and D were taken back (NMAS)
  - Access to dental care…we have dental funds, but they run out halfway through the year. Access and money for dental care (T)
- Change in leadership at university and state level is necessary—increase in transparency, because there is currently a degree of deniability when dealing with the state—nothing is in writing, everything is under the table (T)
- Really poor you can get services, really wealthy you can afford services, but there is a group of people in the middle class who aren't served—no sliding scale (NMAS); Back to sliding scale—affordable healthcare—pay certain fee when you need to be seen—pay as little as you can for meds—get help from the state in doing this

Theme 2: Overload of providers

The disproportionate burden of services to PLWH creates an unending demand for services that is not currently being met. Diminishing resources contribute to a service situation where the needs can never be met, resulting in increased waiting periods for client services and frustration within the agencies. Their potential to maximize services is limited by this overload. The following are some of the specific points made by providers in the groups:

- As one provider noted, "we all feel pretty stretched. Follow up with patients takes a long time because of the lack of staff and number of external organizations they work with. (T)
- Case managers are overloaded; Need more bodies, more management for continuous care. (SF)
- Client load has increased a lot—not able to keep up, can't get people on as quickly as used to; Clients are increasing, but funding is not—difficult for

everyone, clients, providers and clinic; Clients not getting acute care because they don't have the time or the money (NMAS)

- Long wait times (FN)
  - Need to humanize wait experience
  - Understaffed in case management

Theme 3: Need for and issues around cultural competence

Culturally relevant care was identified as an important area of service delivery within the majority of the focus groups. Providers expressed a need for training to better serve the diverse client population they work with on a daily basis. Specifically, the needs of tribal populations throughout New Mexico, Spanish speakers, and various sexual minorities need to be addressed. The following are some of the specific points made by providers in the groups:

- Very important to be culturally competent at First Nations
- Need prevention that emphasizes cultural needs; Need prevention programs that are culturally relevant/ tying in with traditional culture (FN)
- Cultural competence needed in interactions with office staff (FN)
  - Lack of courtesy/pleasantries
  - Privacy
  - Need more training on working for IHS
- Need services that build community (FN)
- Undocumented population needs special attention (T)
- Native American population—worst no show, adherence and substance abuse rates—worst health outcomes (SF)
- Trouble over in the clinic with linguistic services and translation (NMAS)
- Specific population issues (T)
  - Spanish mono-lingual Hispanics
  - Native American—geographic (transportation), stigma factor is enormous—impacts late diagnosis
  - One deaf patient who has needs that are difficult for the clinic to meet
  - Trans population—not enough training in dealing with trans issues
  - Homeless population—basic—where do we send the pills? To the clinic, to the case management?
  - Heterosexual population—sexual minority, sometimes I say things that are embarrassing because I am so used to dealing with MSM
  - Need a more diverse staff. (T)

Theme 4: Lack of specialists/specific providers or limitations in quality of care

Services provided within the CARE Act clinics are generally perceived as being multidisciplinary and high quality. While providers realize that overall client needs are extensive, they do their best to meet client satisfaction by directly addressing concerns and acknowledging agency capacities. The majority of concerns pertain to case management, provider availability, mental health services, support services, dental care, and other general services (i.e., nutrition and pain management). The following are some of the specific points made by providers in the groups:

- Lack of providers
  - Would like HIV specialist in house (FN)

        - Lack of providers to take care of medical care; Need a competent medical director; Case management services we do well; however there is a critical gap in medical case management, this area needs to be improved. No one does anal peps in Roswell, MSM or anyone having anal sex needs to have a yearly anal pap (R)
        - Short-staffed and already cross-trained; Staff can do rapid test-like a glucometer test, can have results in two hours instead of two weeks however organization or Southeastern New Mexico can't (R)
    - Lack of consistent provider presence and continuity of care.
        - The few MDs who are working with Truman are at the clinic very little—half a day a week, maybe. (T)Case-management
        - Case management is lacking; No full-time pharmacy/pharmacist/pharmacy tech; Need more psychiatric services (T)
        - Case management is a real problem—outreach to people in the community, getting people to advocate for themselves; Geographically/situationally out of the system; Case management—unclear what it does and does not cover, frustrated that some case managers are not doing what they should be doing; case managers don't have training/credentials, lack of accountability, definition of "medical case management" is not clear (T)
        - People who get to the clinic get good treatment multidisciplinary…but it's about getting them there. (T)
    - Mental health/substance abuse
        - Psych services are good, but limited by time (T)
        - Population is a lot of substance abusers—don't get enough training to deal with them (alcohol, IVDU) (T)
        - Not satisfied with mental health options, inpatient mental health (NMAS)
    - Dental
        - No dental care providers (R)
        - Strong need for dental (SF)
        - Dental—limited, waiting lists, run out of funding (NMAS)
    - Support services
        - Housing—huge issue; Transportation; Nutrition; Income—SSI is not a huge paycheck for a month (NMAS)
        - In general, I am concerned about the movement away from support services for cost saving. DoH and HRSA. Keep poverty in the forefront. (NMAS)
        - Access to social work (T)
        - No patient education programs, have to source out to NMAS and other organizations—health literacy and patient understanding needs to become a focal point (T)
    - Others Services Needed
        - No dietician at the clinic, nutrition; Pain management—chronic diffused pains related to HIV, dedicated provider for issues related to pain for PLWH (T)
        - Good options for HIV meds, no options for NON-HIV meds—like diabetes (NMAS)
        - Want more focus on preventative health. Lifestyle intervention as well. (SF)

        - Early intervention
        - Universal testing and universal insurance access are services that are necessary but aren't provided. No testing on site (T)
        - Need more services for transgendered people (FN); Need more outreach to straight men and women, as well as people who are transgendered (T)
    - Other quality of care comments
        - Satisfied with their service delivery, but recognize the deficits through out the state. Many people who attend Southwest CARE come from other parts of the state to attend SW. (SF)
        - Quality of care varies greatly—satellite office in Farmington, quality is low outside of the urban areas—not all, but some. (NMAS)
        - More community-based model (Alianza), the model in Las Cruces doesn't work as effectively, they are not beholden to anyone. We Alianza are beholden to the community, Las Cruces are beholden only to The State. There is a difference between the medical model and social services model. We need to have both, not just one or the other. Clients need a "hug" they need the support, they need the individual attention, People living with HIV, they need support group. (R)

Theme 5: Barriers

Providers highlighted many systemic barriers their agencies encounter in providing care to PLWH. These barriers are social/health, educational, and cultural. Poverty appeared as an overarching barrier to care and limited ability to access resources. Other social/health barriers identified were related to client privacy and stigma of HIV, and access to transportation. Educational barriers included low literacy levels among the client population that severely impacts life-skills and HIV management. Cultural barriers identified by providers were linguistic and communication based. Of particular significance was the concern expressed related to HIV care for incarcerated individuals. Providers within three focus groups (NMAS, Southwest CARE, and Alianza) mentioned this population as being difficult to access. The following are some of the specific points made by providers in the groups:

- Stigma/privacy
    - Privacy—"Everyone knows it's an HIV clinic" (T)
    - Stigma – many people live isolated lives in NM and makes it hard to be adherent. Don't want to come to the clinic because people may see them; When applying for a job, there is at least one place in town that ask if the applicant is HIV positive. They believe that many others probably do to. This needs to be eliminated. (SF)
- Poverty
    - Barriers – homeless clients, undocumented clients, poverty (SF)
    - Housing—insecurity relates to compliance; (T)
    - No money for anything—housing food transportation dental services (service that needs improvement); Poverty—fed and state are moving just toward medical, really need to look at needs of our clients, (NMAS)
    - Help take care of basic needs: food, housing, transportation, health insurance (FN)
    - Food is a huge issue—youth they are working with are hungry, and if they don't have that taken care of, nothing else they do is relevant. (T)

        - MIP and ADAP require patients to be destitute in order to qualify—does not allow the patients to be independent (T)
        - Housing a huge barrier to care; Access to food bank; Emergency Financial Restrictions; (R)
    - Communication
        - Communication/Language Communication (R)
        - Language barriers—translation services—cultural barriers (T)
    - Education
        - Literacy-one extreme to the other. From zero education, 3rd grade, average seems to be high school; they do have clients who have a college education. (R)
        - Clients education and attitude are the biggest barrier to them—mental health, stigma, wait until the last minute with everything (health and housing, etc), they wait until crisis mode (NMAS)
    - Rural and transportation
        - Rural nature of the state appears to present issues with pre-natal care—women have a harder time getting transportation (T)
        - Most challenging issue for clients: transportation and distance; Issues of Stigma and being seen getting services (R)
        - Transportation to medical appointments; (T)
        - Transportation (NMAS)
    - Other health issues
        - Other health barriers—(T)
        - Clients have so many problems—HIV is the least of their problems—HIV care is not horribly problematic, but a lot of our clients have so much stuff going on in their life that HIV is not their main problem—mental health issues, substance abuse issues, homeless, so much else going on—it makes things difficult (NMAS)
    - Other
        - Life skills: Challenge of clients who aren't focused and can't prioritize, have a difficult time managing their over life, health issues, financial issues and how they impact the rest of their lives—a lot of hand holding and education in how to start managing their lives; Life Skills—esp in mental health, treating HIV through will power and denial; Deadlines—you lose your insurance for a year—with certain clients this is a serious issue (NMAS)
        - Undocumented—can't get work, so we can't help with rent or food (NMAS)
        - Prison—can't get housing because of felony background (NMAS)
        - HIV care in long-term prison and short-term jail—dept of health is great about this (SF)
        - Incarcerated Clients-coordinating care; Medical providers in jails are now for profit, so that is a barrier for incarcerated clients. (R)
        - Some of my ladies have a harder time because they put their families before themselves—getting them to come in is hard, because they can't, they have to take care of their kids (NMAS)

Theme 6: Communication

Communication pathways among providers and clients were identified as some of the most challenging domains within the focus groups. Inconsistent communication avenues within client populations was a concern for the providers. The inability to use multiple communication channels limits the providers' ability to do their job effectively. Linguistic concerns appeared again within this theme, especially pertaining to translation and interpreter services. The following are some of the specific points made by providers in the groups:

- Patients are hard to get a hold of—phone call is only option, no texting or email or web based services (T)
- Language barriers—use phone interpreters, which are difficult to negotiate and just generally not liked (T)
- Lack of communication between clients and agency: Clients come in and then changes happen all at once, and when they come in things have changed; Internet is an effective tool; Text Messaging; E-mail: clients must initiate contact first by email, the agency can not initiate first; A huge lack of client involvement "mistrust" (R)
- Need "Clear communication between the funding agency and the clients." (SF)
- Contacting patients—non stable phone number (T)
- Getting PLWH into care; For a lot of our clients, we are the only stable, sane place where they can go—until we create a relationship with them, they aren't going to come right away. Getting them to that place take time (NMAS)

Theme 7: Organizational issues

Certain sites displayed an extraordinary level of teamwork within the organization and the community. Commitment and dedication to care were leading traits within these clinics. Other sites demonstrated varied degrees of collaboration and were more bureaucratically formal. The following are some of the specific points made by providers in the groups:

- People who make decisions are too far removed from the day to day operations and reality of the clinic; Medical group is run as a business; Lack of staff empowerment (T)
- No autonomy within the clinic—too tied to UNM; Clinic staff feel as though the providers are beholden to the University and academia more than they are the PLWH (T)
- It's all of us together that makes this work. Different members of the team conveyed their dedication-by offering to TCB (taking care of business) to step up to the plate. Everyone wants to do their part. The staff was very happy with this group encounter as part of the focus group. People in that community have been stepping up to participate, to be active, after the old leadership, people are returning again to the agency. They are coming by and asking for brown bags, (condoms) (R)
- Lack of communication between providers, and it trickles into the patients (T)

Theme 8: Interorganizational issues

Interagency communications are complicated by perceptions of agency roles, responsibilities, and expectations. The lack of a centralized model of care leads to miscommunication and strained relationships. Project ECHO is a model of effective interagency collaboration that the

clinics can implement. The following are some of the specific points made by providers in the groups:

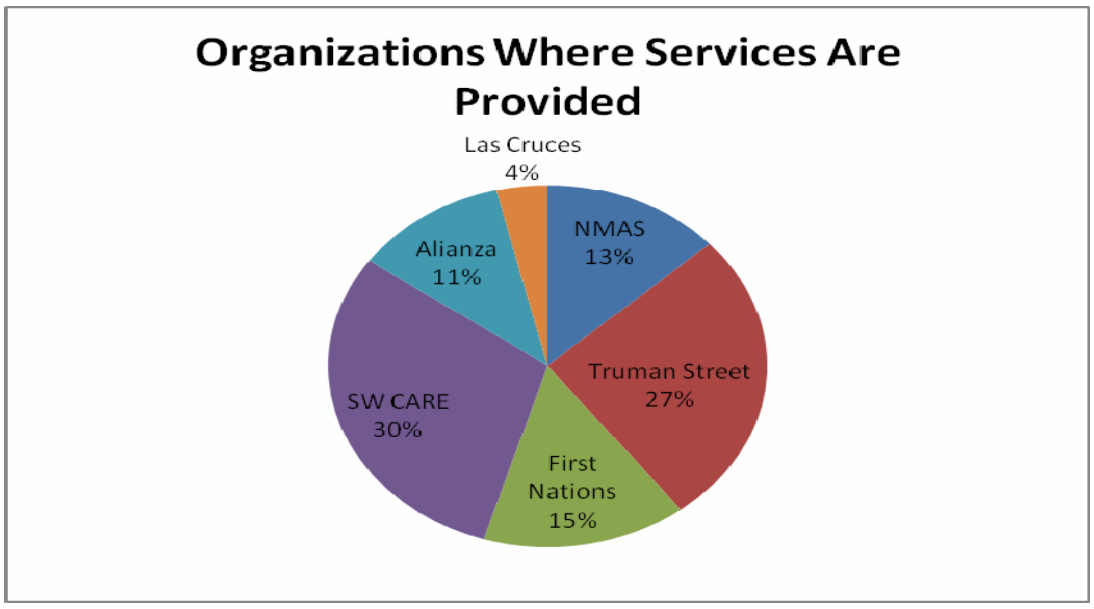
- Communicating with other agencies and orgs is difficult and time consuming (T)
- Care is not centralized—have to send patients out into other parts of town—not a good model (T)
- CARE Act is a huge administrative burden—contracts are negotiated and there is favortism. Perception is that NMAS got more money and Truman lost funding—animosity about this is apparent. There is a communication breakdown between these organizations even though they share a building. (T)
- ECHO – has been a good improvement. Facilitates collaboration between the clinics and other providers. Supported by UNM. Especially good for people in the outlying areas. Would like more collaboration between the clinics etc. (SF)
- One area that we sometimes get into trouble—in patient care and outpatient care…hospital workers needs to know how to collaborate with outside organizers (T)
- HIV social worker once upon a time…but now we see a lot of miscommunication about what is and isn't available. (T)
- Relationship between the social service support folks and the medical is some what fractured, and it needs to improve communication between the areas. (T)

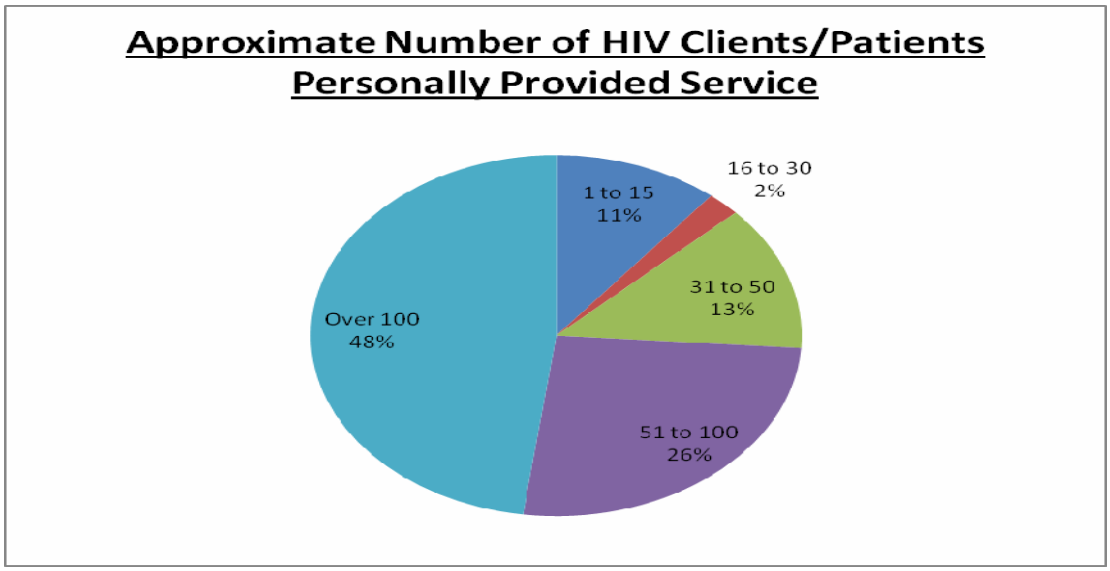
PROVIDER SURVEY

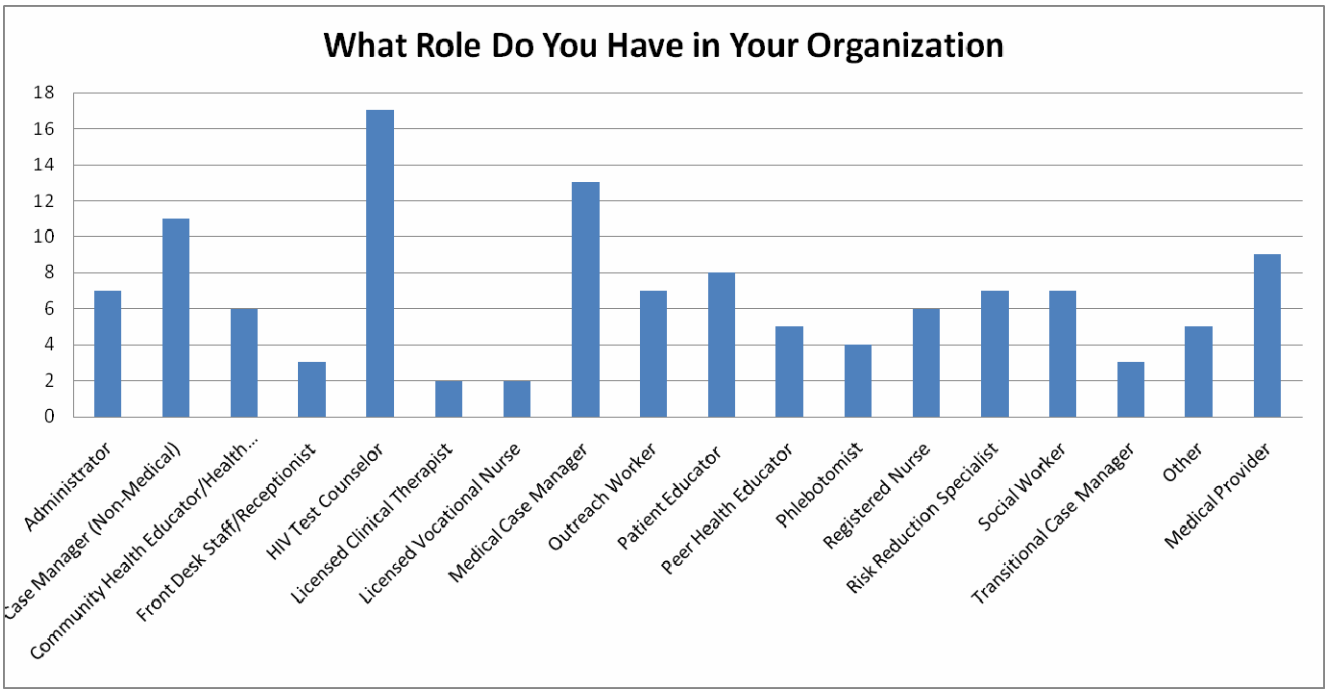
Participants and Data Collection

The provider survey complemented the focus groups. Most of the providers participated in the focus groups and the survey although a few providers only completed the survey and a few only participated in the focus groups. The survey included questions about the following: (a) their role and where they provide services; (b) their perceptions of services offered, their need for training, and satisfaction with services; (c) their perception of barriers faced by clients; (d) their interaction with their clients; (e) perception about specific at-risk client populations; (f) medication adherence and perception of co-morbid medical conditions; (g) perceptions about their interactions in their organizations; (h) self-rated health and burnout; and (i) demographics. The actual survey is displayed in Appendix 3.

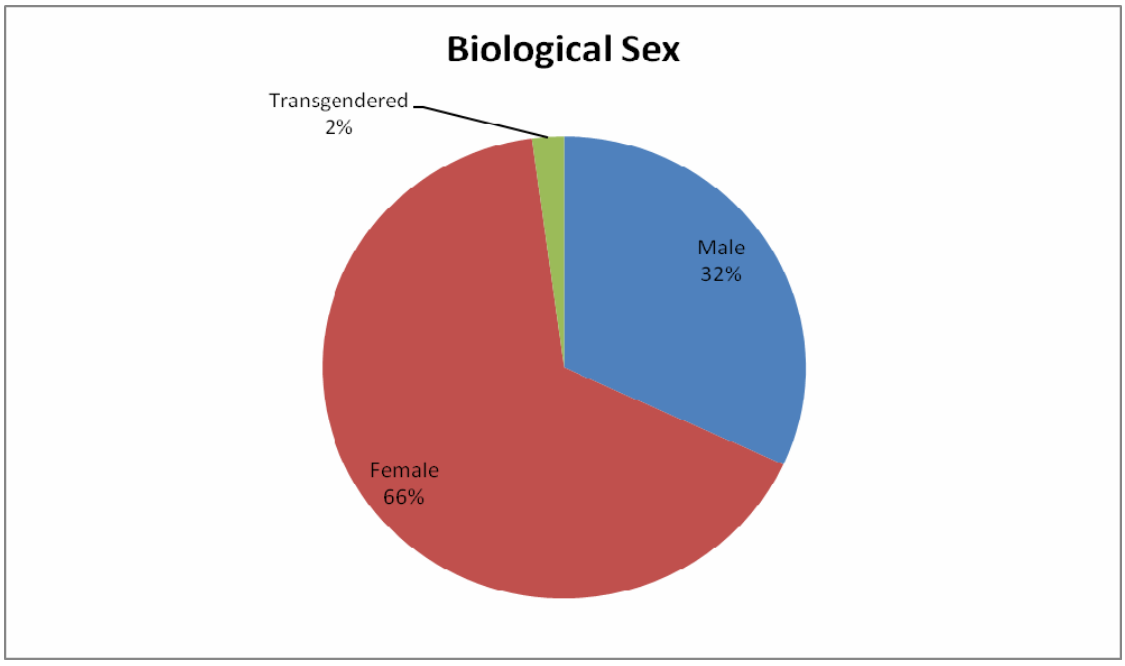
The following figures offer information about where surveys were collected and demographic information about the providers. There were a total of 47 providers who participated.

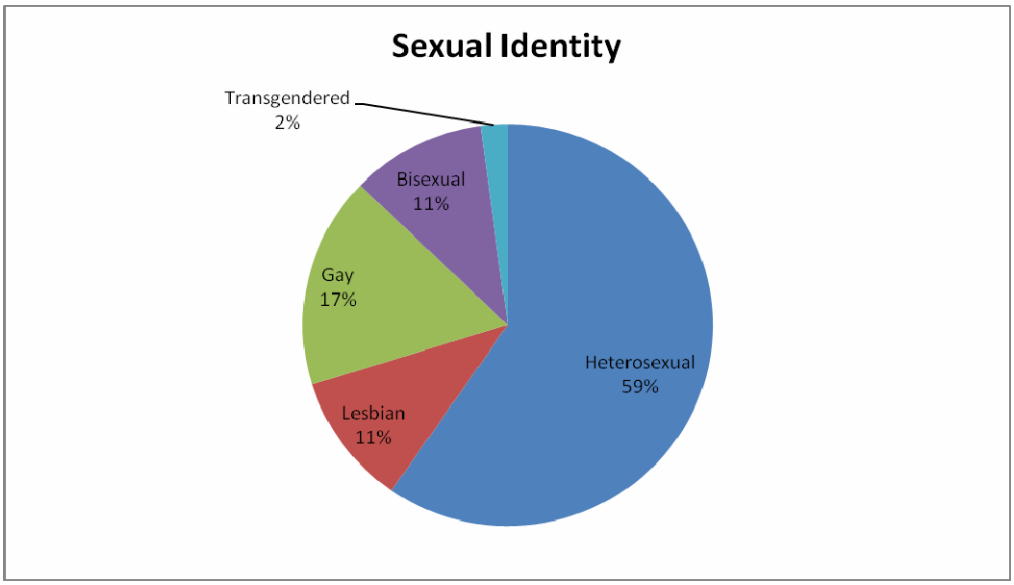

Organizations Where Services Are Provided
Las Cruces 4%
NMAS 13%
Alianza 11%
Truman Street 27%
SW CARE 30%
First Nations 15%

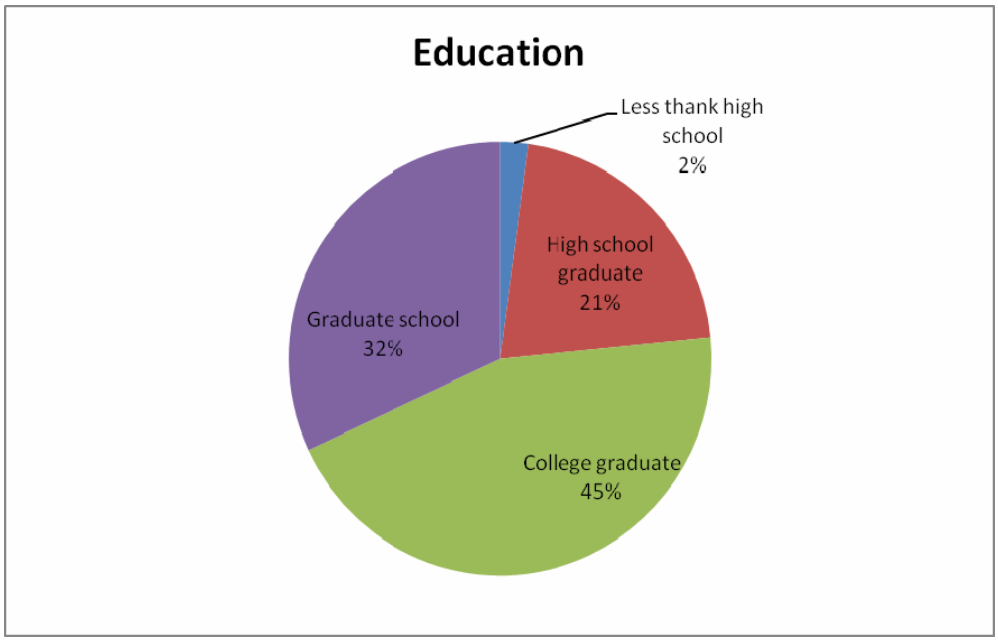

Approximate Number of HIV Clients/Patients Personally Provided Service
1 to 15 11%
16 to 30 2%
31 to 50 13%
51 to 100 26%
Over 100 48%

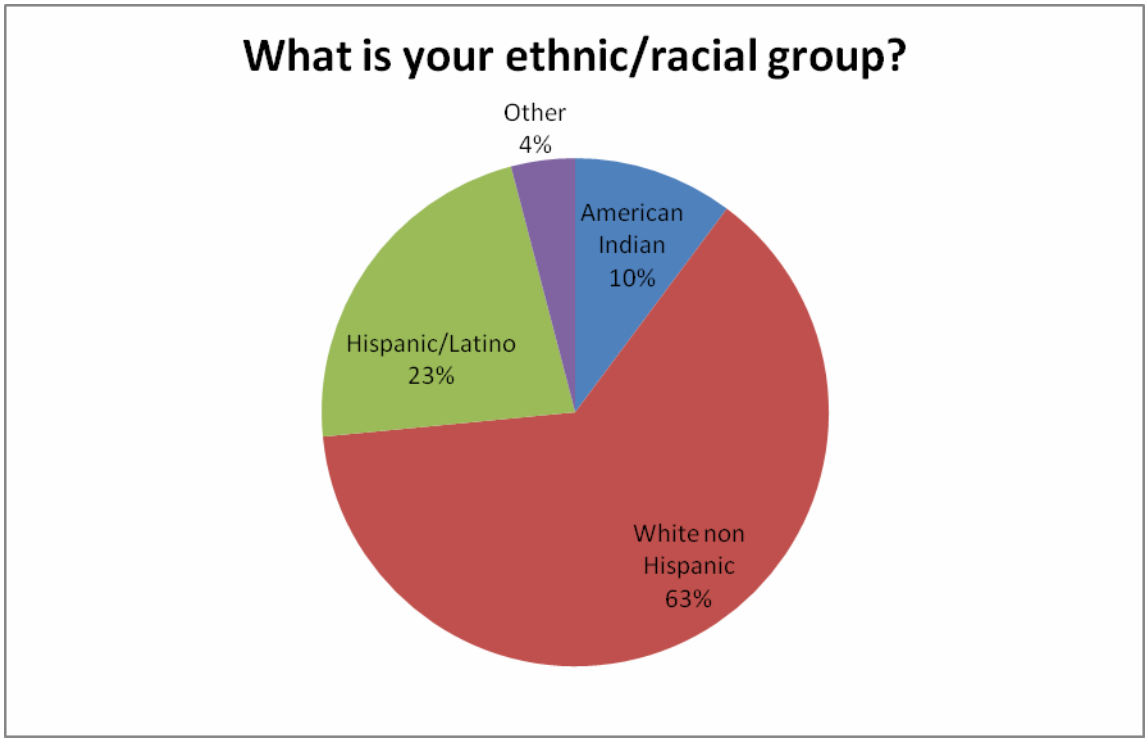


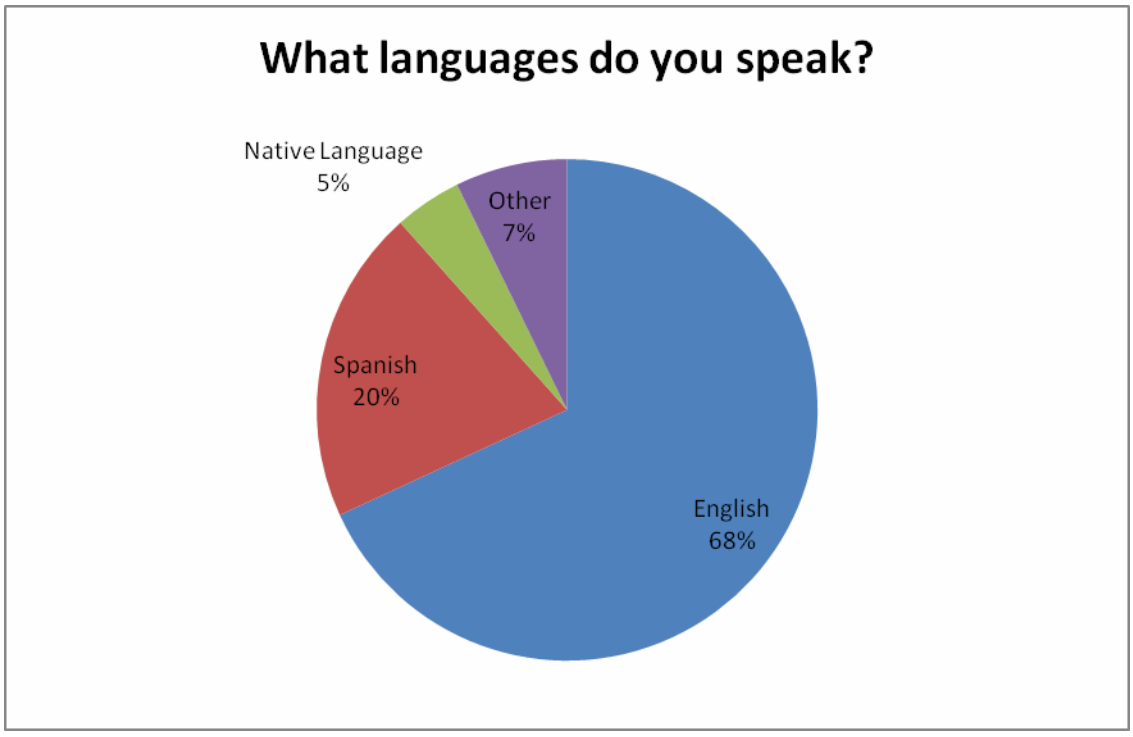
Note: This figure exceeds 47 as providers could select multiple roles.

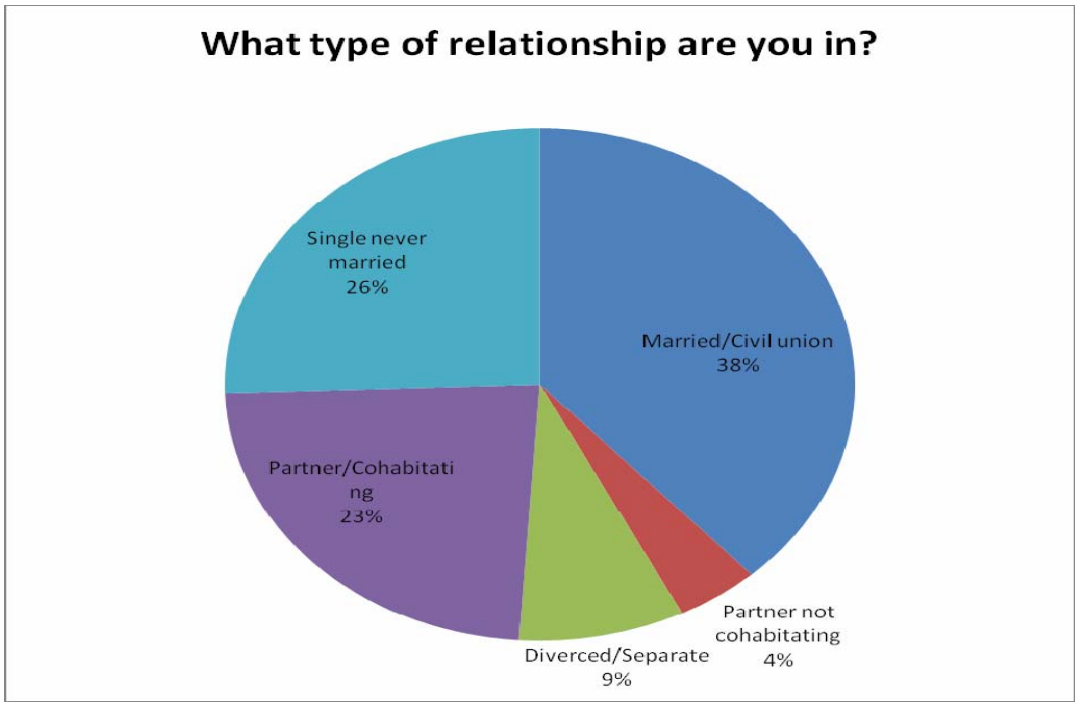



Sexual Identity
Transgendered
2%
Bisexual
11%
Gay
17%
Heterosexual
59%
Lesbian
11%


Education
Less thank high
school
2%
High school
graduate
21%
Graduate school
32%
College graduate
45%


What is your ethnic/racial group?
Other
4%
American
Indian
10%
Hispanic/Latino
23%
White non
Hispanic
63%


What languages do you speak?
Native Language
5%
Other
7%
Spanish
20%
English
68%

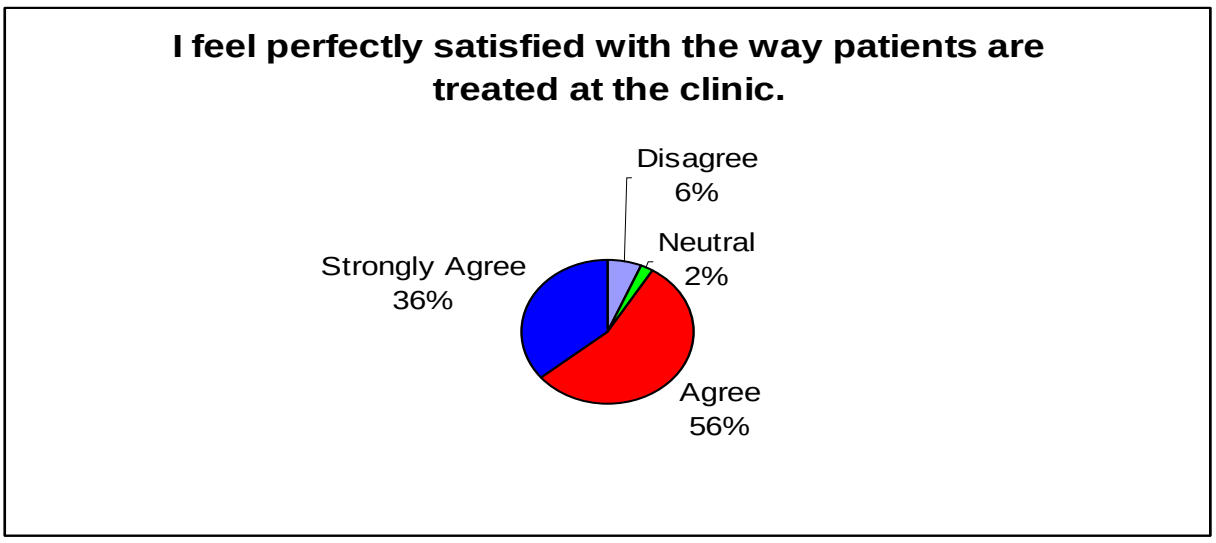


Findings

This section is organized around the following sections: overall satisfaction, provision and satisfaction with medical and support services, perception of patient outcomes, factors related to patient outcomes (barriers and communication with patients), working with specific populations, and burnout, quality of life/self-rated health and related factors.

Overall Satisfaction

Overall, providers were quite satisfied with the care that is provided in their clinics. There were four items that measured satisfaction (questions 4a-d) and the mean of these items was 4.20 on a 5.0 scale. The vast majority either agree or strongly agree with the statement as illustrated in the pie chart for one of the items:



Medical and Support Services: Provision and Satisfaction

A key evaluation of the survey is the rating of medical and support service by providers. We asked providers four questions about the possible medical and support services that could be provided (i.e., under Ryan White). We asked whether they provide the specific service, whether they received training on the service in the past year, whether they need more training, and the satisfaction with the specific service. The tables below illustrate the answers to these questions.

Overall, there is satisfaction to moderately high satisfaction with the medical services provided. The ratings are highest on outpatient medical care and testing (above 3.3). Further, there appears to be a desire for people to receive additional training on these services and this appears reasonable given the number of people providing the specific service.

There is less satisfaction with the support services than the medical services. Most of the means are lower than the satisfaction point (3.0). The lowest rates are child care and legal services at around 2.4. The remaining services are near the 3.0 rating. Further, there appears to be less of a desire for people to receive additional training on these services compared to medical services.

Table 15. Satisfaction and provision of specific medical services

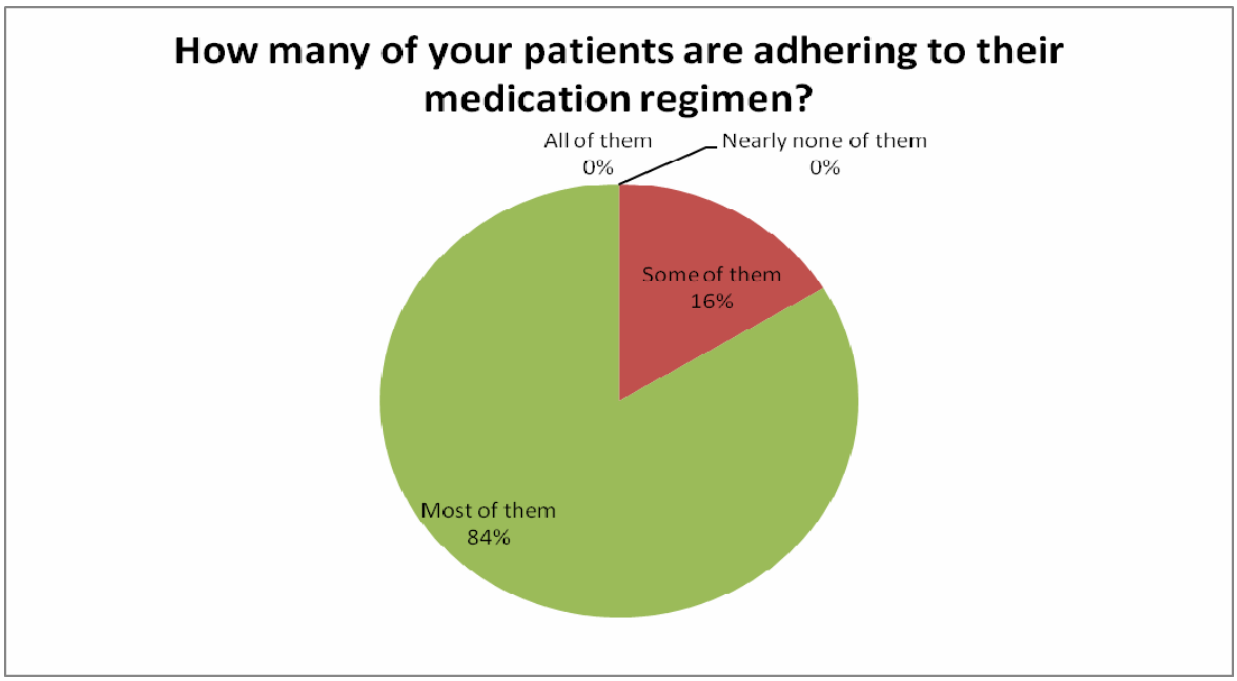
Medical Service	**a Have you provided this service in the past 12 months?**	**b. Have you received training in the past 12 months on providing or improving this service?**	**c. Do you need further training on how to provide this service?**	**d. How satisfied are you with the quality of this service at your clinic?** **Mean is provided. Original scale: 1 = Very unsatisfied, 2 = Unsatisfied, 3 = Satisfied, 4 = Very Satisfied**
a. Home health care	**11 Yes** **34 No**	**3 Yes** **38 No**	**16 Yes** **22 No**	**3.0 on 4.0 scale (n = 15)**
b. Mental health services (assessment and treatment of a mental illness)	**28 Yes** **17 No**	**21 Yes** **19 No**	**27 Yes** **11 No**	**3.0 on 4.0 scale (n = 38)**
c. Medical nutrition therapy (advice and supplements provided by a dietician outside of the primary care visit)	**22 Yes** **23 No**	**9 Yes** **31 No**	**26 Yes** **13 No**	**2.74 on 4.0 scale (n = 34)**
d. Medical case management	**31 Yes** **14 No**	**16 Yes** **25 No**	**23 Yes** **17 No**	**2.94 on 4.0 scale (n = 36)**
e. Outpatient substance abuse services	**27 Yes** **18 No**	**21 Yes** **20 No**	**28 Yes** **12 No**	**2.94 on 4.0 scale (n = 31)**
f. Outpatient medical care	**25 Yes** **19 No**	**19 Yes** **19 No**	**14 Yes** **25 No**	**3.39 on 4.0 scale (n = 31)**
g. Health insurance premium/cost sharing assistance	**29 Yes** **15 No**	**11 Yes** **27 No**	**19 Yes** **18 No**	**2.88 on 4.0 scale (n = 28)**
h. Early intervention services (testing and diagnosis of HIV status and extent of immune deficiency)	**33 Yes** **11 No**	**30 Yes** **10 No**	**19 Yes** **19 No**	**3.3 on 4.0 scale (n = 40)**

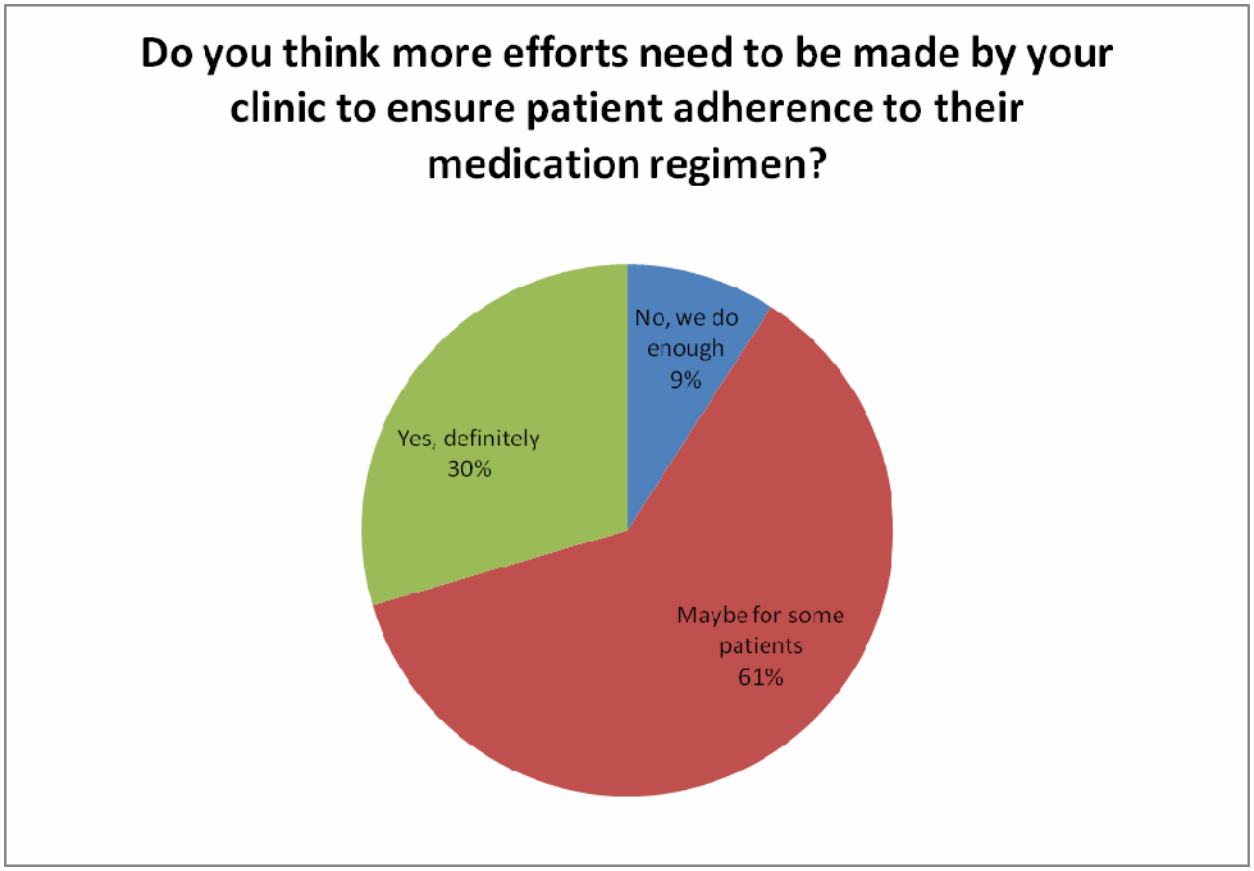
Table 16. Satisfaction and provision of specific support services

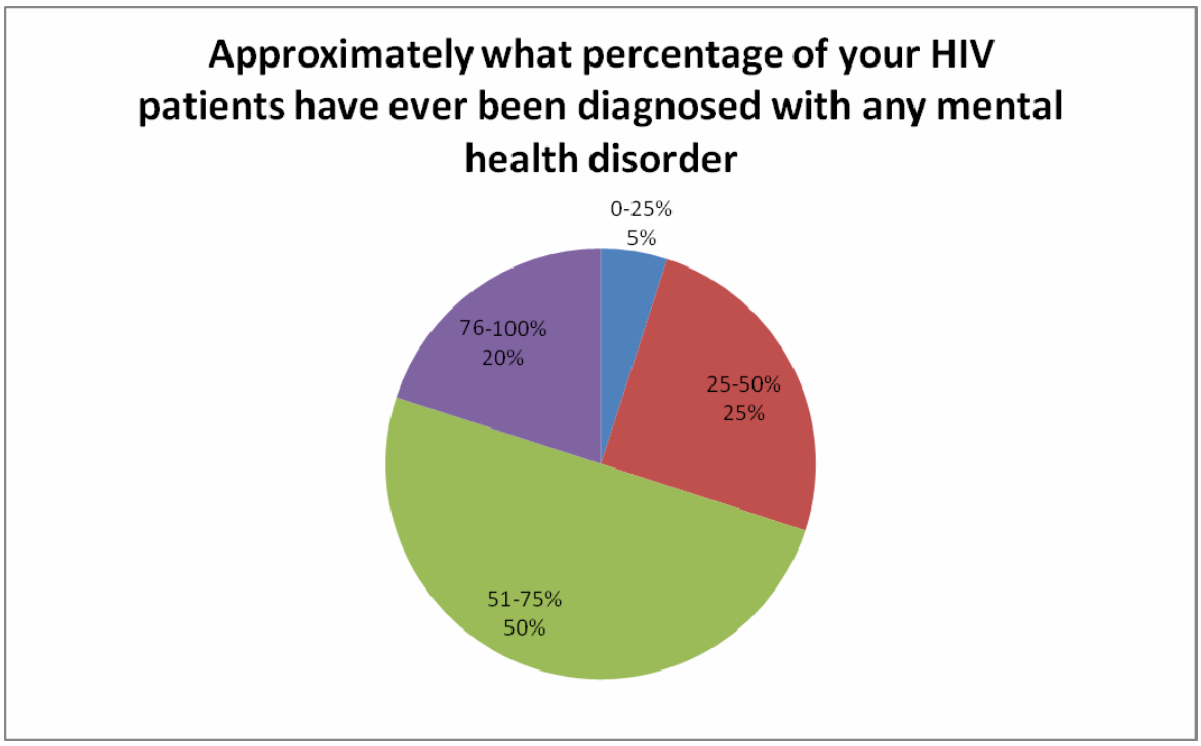
Support Service	a Have you provided this service in the past 12 months?	b. Have you received training in the past 12 months on providing or improving this service?	c. Do you need further training on how to provide this service?	d. How satisfied are you with the quality of this service at your clinic? Mean is provided. Original scale: 1 = Very unsatisfied, 2 = Unsatisfied, 3 = Satisfied, 4 = Very Satisfied
a. Child care services	**0 Yes 46 No**	**0 Yes 38 No**	**8 Yes 29 No**	**2.34 on 4.0 scale (n = 14)**
b. Emergency financial assistance (short-term payments for essential items)	**26 Yes 19 No**	**14 Yes 25 No**	**16 Yes 23 No**	**2.89 on 4.0 scale (n = 28)**
c. Food bank/home-delivered meals	**23 Yes 22 No**	**15 Yes 25 No**	**13 Yes 27 No**	**2.96 on 4.0 scale (n = 28)**
d. Housing services (short-term assistance for emergency housing)	**24 Yes 22 No**	**16 Yes 23 No**	**13 Yes 25 No**	**2.90 on 4.0 scale (n = 29)**
e. Linguistic services	**21 Yes 24 No**	**9 Yes 30 No**	**14 Yes 24 No**	**2.97 on 4.0 scale (n = 29)**
f. Medical transportation services	**21 Yes 25 No**	**8 Yes 33 No**	**9 Yes 30 No**	**2.77 on 4.0 scale (n = 31)**
g. Other support services (support groups or counseling)	**36 Yes 10 No**	**20 Yes 22 No**	**20 Yes 20 No**	**3.05 on 4.0 scale (n = 39)**
h. Non-medical case management (advice and assistance in obtaining medical, social, community, legal, financial or other needed services)	**34 Yes 12 No**	**17 Yes 24 No**	**20 Yes 20 No**	**2.97 on 4.0 scale (n = 35)**
i. Legal services	**10 Yes 36 No**	**4 Yes 35 No**	**13 Yes 25 No**	**2.44 on 4.0 scale (n = 18)**

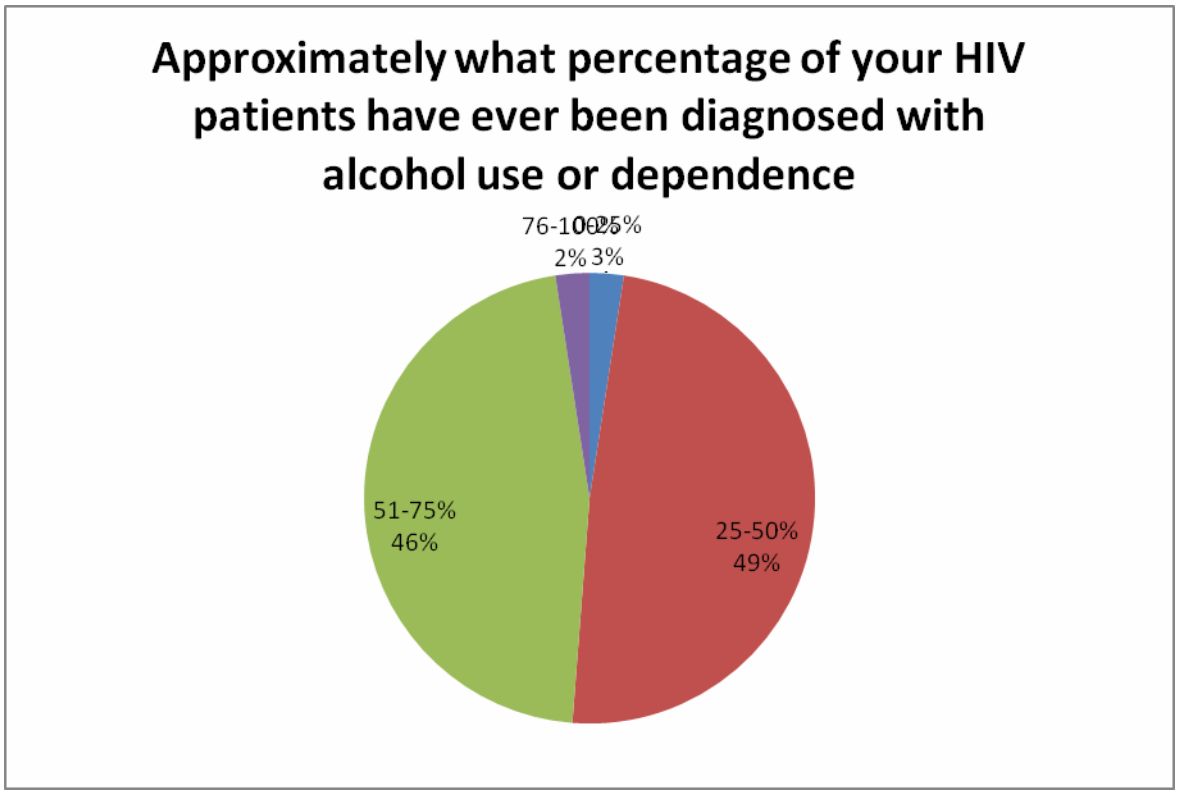
Perception of Patient Outcomes

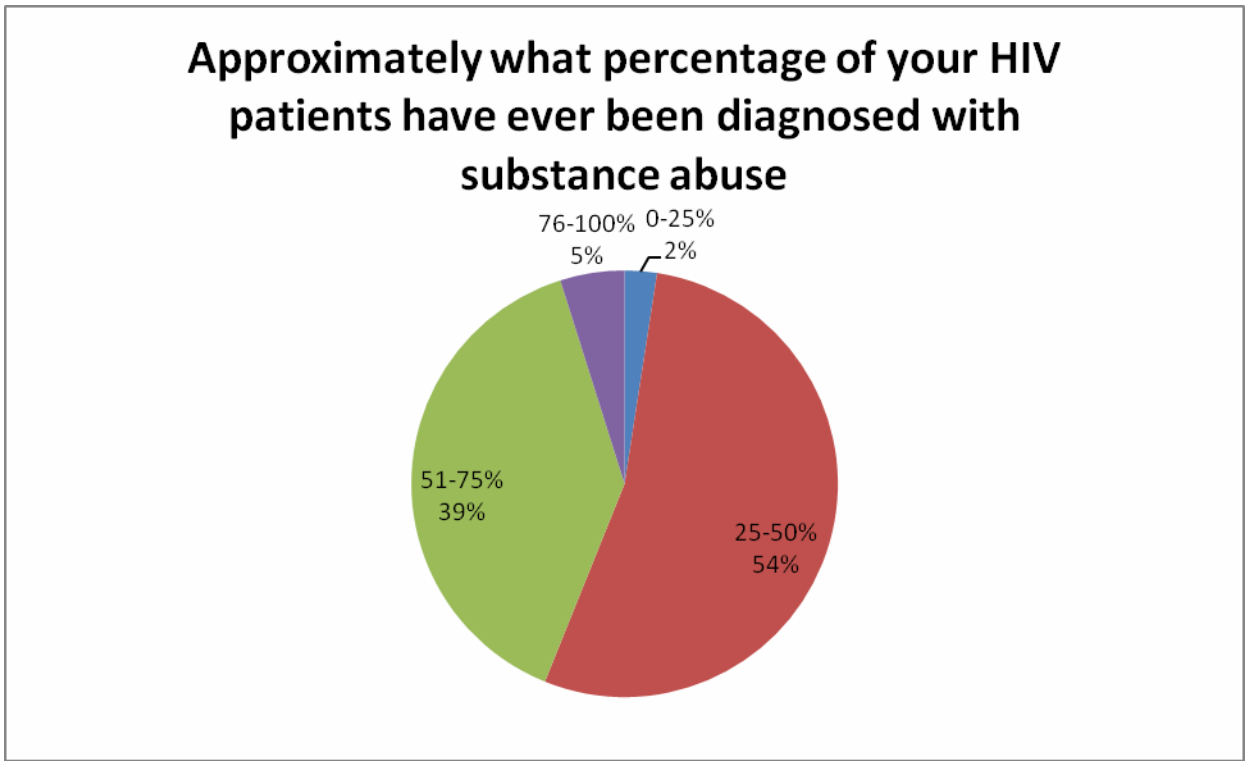
We asked providers to share their perceptions of medication adherence and co-morbid conditions in order to see if their perspectives are consistent with that reported by clients and also by the epidemiological profile (for co-morbid conditions). The charts below illustrate that provides feel most of their patients are adhering to their medications, that provides think some more efforts by the client might be needed for some patients, and that providers perceive that the majority of their patients have co-morbid conditions (i.e., mental health, alcohol abuse, or substance abuse).


How many of your patients are adhering to their medication regimen?
All of them
0%
Nearly none of them
0%
Some of them
16%
Most of them
84%


Do you think more efforts need to be made by your clinic to ensure patient adherence to their medication regimen?
No, we do enough
9%
Yes, definitely
30%
Maybe for some patients
61%


Approximately what percentage of your HIV patients have ever been diagnosed with any mental health disorder
0-25%
5%
25-50%
25%
51-75%
50%
76-100%
20%


Approximately what percentage of your HIV patients have ever been diagnosed with alcohol use or dependence
25-50%
49%
51-75%
46%



Factors Potentially Related to Patient Outcomes: Barriers to Care and Communication with Patients

This section considers the percentage of HIV patients who expressed to providers barriers to seeking or receiving care for their HIV and related conditions. The scale was the following (1 = 0-25%; 2 = 26-50%; 3 = 51-75%; 4 = 76-100%). There were three barriers: privacy (Concerns about sharing their status--generally related to stigma; trust (concerns about communication and trust of providers; and other (child care and transportation). Overall, providers perceived that a small portion of their patients have barriers to care. The largest barrier was transportation impacting between 26 and 50% of patients. The tables below display the means and standard deviations for these variables.

Table 17. Means of barriers to seeking services

	Mean	**Standard Deviation**
PRIVACY	**1.60**	**.54**
a. They fear a lack of privacy, or that staff would talk to other people about their HIV status.		
b. They are concerned about what others might think.		
c. They do not want anyone to know they are HIV positive.		
d. They do not feel comfortable talking about their sexual behavior.		
h. They do not want to inform their partner or spouse about their HIV status.		
TRUST: Concerns about communication and trust of providers.	**1.46**	**.50**
e. They do not trust the staff.		
f. They worry about prejudice or discrimination.		

g. They and the staff have problems understanding one another		
OTHER: Child care and transportation.		
i. They do not have child care.	**1.20**	**.33**
j. They do not have reliable transportation.	**2.00**	**1.0**

We also asked providers to report on their interaction with patients. This section includes three different interaction variables: information (the degree to which providers share information with patients); sharing (the degree to which patients share with providers), and respect (the degree to which provider show respect and caring for their patients. The scale was the following: strongly agree = 5, agree = 4, neutral = 3, disagree = 2, strongly disagree =1. Overall, providers report high quality interaction with patients on information and respect. They also report that patients are in the midpoint of sharing—indicating that about the same number of patients have difficulty sharing information as do not sharing information. The tables below display the means and standard deviations for these variables.

Table 18. Means of interaction with clients

	Mean	**Standard Deviation**
INFORMATION	4.05	.55
a. I make sure that my patients understand treatment side effects.		
b. I help them get conflicting information straightened out.		
d. I help them ask about things that they do not understand.		
e. I tell my patients what treatment will do.		
j. I help my patients understand their medical plan.		
SHARING	**2.82**	**.46**
g. My patients have a hard time telling me about new symptoms.		
h. My patients have a hard time telling me about how treatment is going.		
m. My patients have difficulty asking me questions.		
RESPECT	**4.62**	**.44**
c. I am warm and caring toward my patients.		
f. I make my patients feel comfortable discussing personal issues.		
i. I really respect my patients.		

Finally, we examined the degree to which provides perceive that barriers to care and communication with patients relates to medical adherence. There were no significant relationships between these variables and whether they perceive that patients are adherent with their medications.

Working with Specific Populations

This section consider specific populations that are of interest to HRSA and/or relevant in New Mexico. The purpose of these questions was to see is providers perceive a problem with their colleagues interacting with these populations. The scale was the following: strongly agree = 5, agree = 4, neutral = 3, disagree = 2, strongly disagree =1. Providers reported high comfort from their colleagues and high quality interaction with these populations. There was also some

moderate desire to learn more about these populations. The tables below display the means and standard deviations for these items.

Table 19. Means of interaction with specific populations

My colleagues are comfortable interacting with people from this group.	Mean	Standard Deviation
a. Men who have sex with men	4.57	.88
b. African Americans	4.49	.86
c. Hispanics	4.55	.90
d. American Indians	4.47	.95
e. Adolescents	4.26	1.06
f. Women of child bearing age	4.45	.93
g. Substance users	4.25	1.11

My colleagues' communication with people from this group is culturally sensitive.	Mean	Standard Deviation
h. Men who have sex with men	4.28	1.17
i. African Americans	4.15	1.14
j. Hispanics	4.30	1.08
k. American Indians	4.19	1.12
l. Adolescents	4.17	1.10
m. Women of child bearing age	4.28	1.08
n. Substance users	4.04	1.23

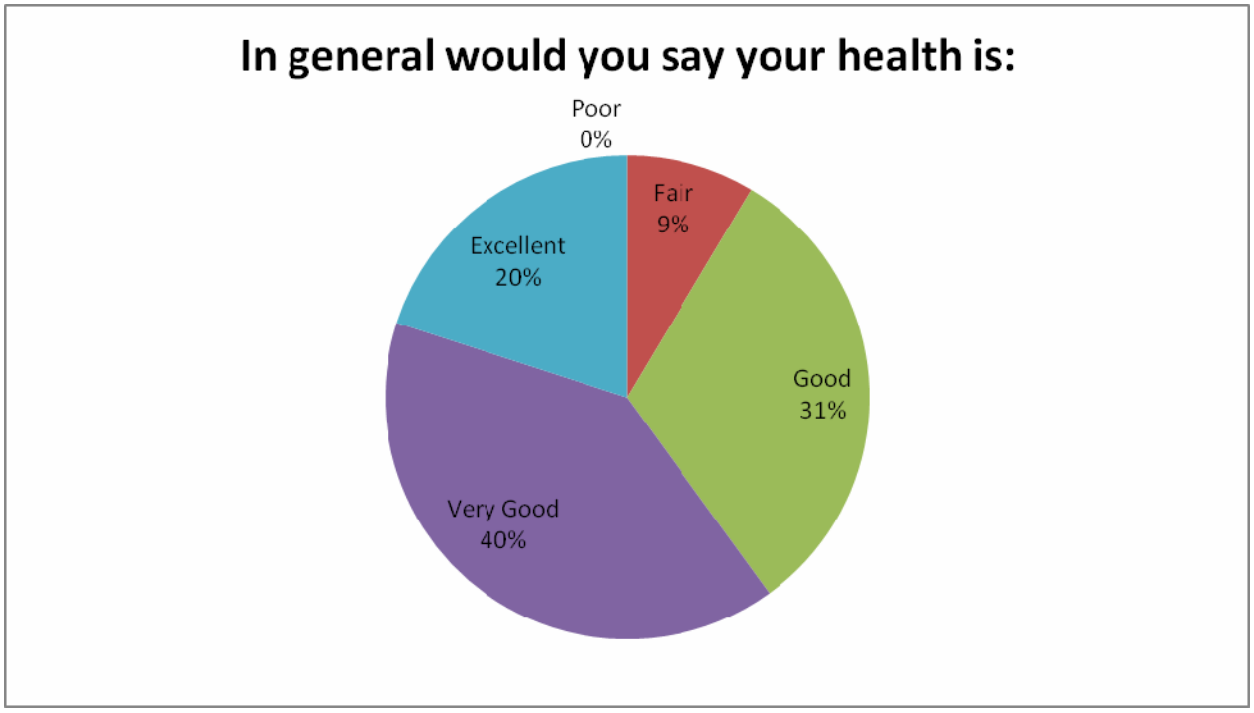
I'd like to learn more about this group to become for culturally aware about this group.	Mean	Standard Deviation
o. Men who have sex with men	3.61	1.11
p. African Americans	3.84	.95
q. Hispanics	3.73	.99
r. American Indians	3.91	1.0
s. Adolescents	3.78	.97
t. Women of child bearing age	3.63	1.04
u. Substance users	3.71	1.12

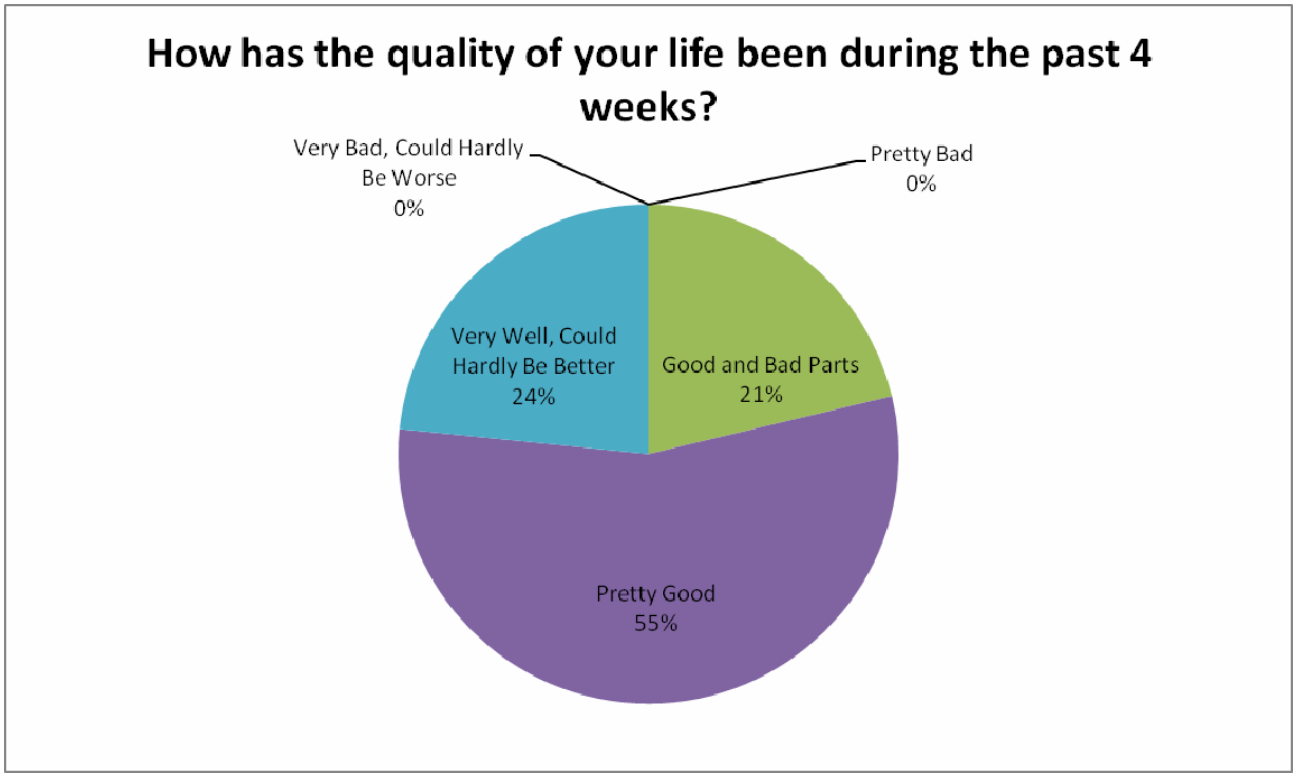
Burnout, Quality of Life, Self-Rated Health and Related Factors

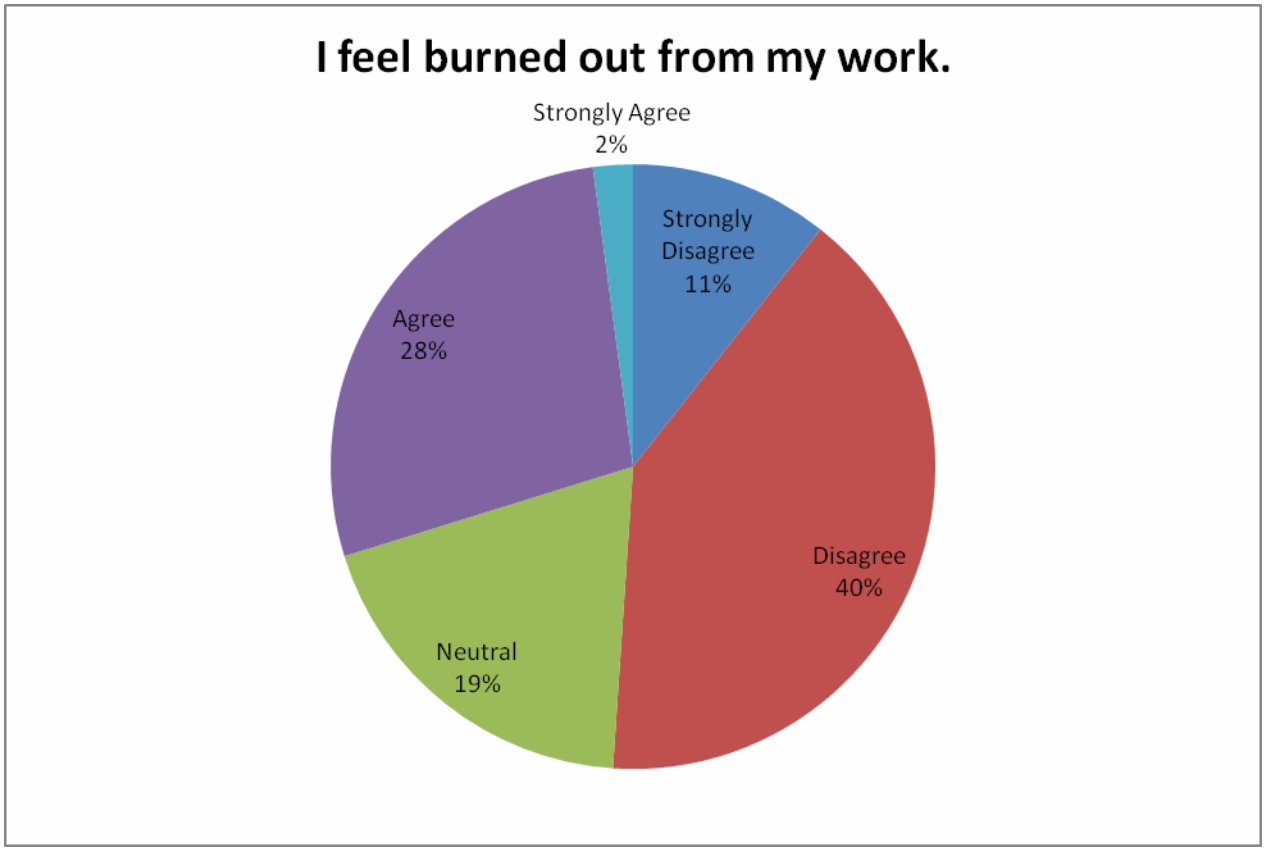
We consider key outcome factors for providers that are not in the HIV-provider literature: burnout, quality of life, and self-rated health. The scale was 5-points with 5 being highest and 1 being lowest for each item. The table below shows the means and standard deviations, while the pie charts below show the number of responses for each item. Overall, it shows that providers report good self-rated health and quality of life. There is also very little callousness, but a moderate amount of burnout. The pie charts illustrate the number of providers reporting each response.

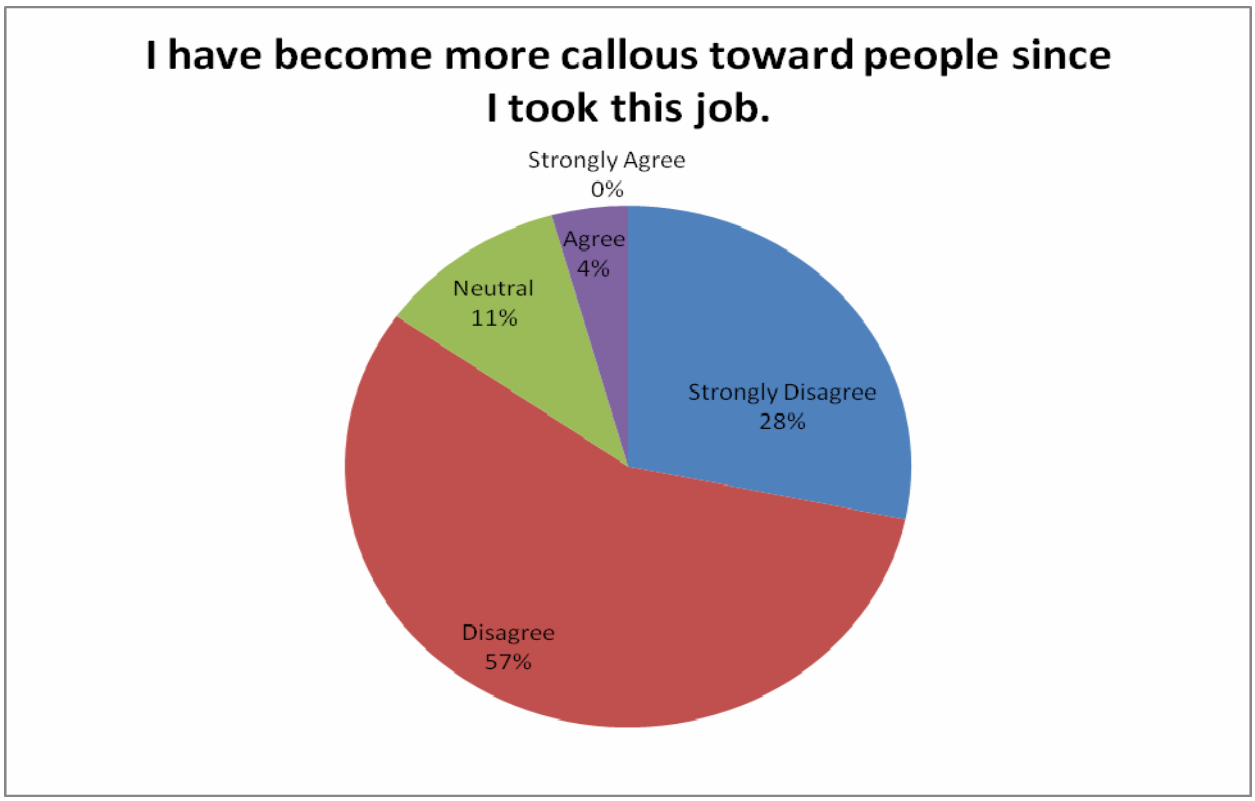
Table 20. Means of burnout, quality of life, and self-rated health

	Mean	Standard Deviation
Self-rated health	3.71	.89
Quality of Life past four weeks	4.02	.68
I feel burned out from my work.	2.70	1.06
I have become more callous toward people since I took this job.	1.91	.75




How has the quality of your life been during the past 4 weeks?
Very Bad, Could Hardly Be Worse 0%
Pretty Bad 0%
Very Well, Could Hardly Be Better 24%
Good and Bad Parts 21%
Pretty Good 55%


I feel burned out from my work.
Strongly Agree 2%
Strongly Disagree 11%
Agree 28%
Disagree 40%
Neutral 19%



We also considered factors that might explain these factors for providers. One of these factors is the quality of communication with co-workers and within the organization. We considered three variables: teamwork (the degree to which co-workers collaborate), critical appraisal (the degree to which co-workers are critical and negative during their interactions), and involvement (the degree to which the organization involves providers in decisions). The scale was the following: strongly agree = 5, agree = 4, neutral = 3, disagree = 2, strongly disagree =1. Overall, providers reported a high level of teamwork and involvement and low levels of critical appraisal in their organizations.

Table 21. Means of quality of communication within the organization

	Mean	**Standard Deviation**
TEAMWORK	**3.90**	**.61**
a. People I work with resolve disagreements cooperatively.		
c. People I work with accept criticism without becoming defensive.		
d. People I work with are good listeners.		
f. People I work with are cooperative and considerate.		
i. People I work with are direct and honest with each other.		
l. People I work with function as a team.		
o. People I work with constructively confront problems.		
p. People I work with are concerned about each other.		
CRITICAL APPRAISAL	**1.90**	**.62**
b. People I work with often let me down when I am counting on them		

g. People I work with criticize me often.		
j. People I work with make too many demands on me.		
m. People I work with often get on my nerves.		
q. People I work with argue with me often.		
INVOLVEMENT	**3.85**	**.71**
e. I am asked to make suggestions about how to do my job better.		
h. I have a say in decisions that affect my work.		
k. This clinic values the ideas of workers at every level.		
n. My opinions count in this organization.		

Finally, we examined whether these communication factors related to the health and burnout variables. We found that critical appraisal was negatively related to self-rated health and quality of life. Thus, the more critical appraisal providers face, the worse they rate their own health (r = -.36) and their quality of life (r = -.33). We also found that teamwork and involvement were negatively related to burnout and callousness. Thus, the more teamwork and involvement providers reported, the less likely they were to report burnout (teamwork, r = -.43; involvement, r = -.40) or callousness (teamwork, r = -.36; involvement, r = -.32). In contrast, the more critical appraisal providers reported, the more burnout (r = .38) and callousness (r = .45) they reported. In summary, providers own health and burnout is related to the communication they have with colleagues and within the organization.

RESOURCE INVENTORY

Ryan White CARE Act Funded Services

The New Mexico Department of Health has designated five regional HIV/AIDS specialty care agencies known as Health Management Alliances (HMA's). The HMA's are tasked with administration of HIV related services provided within its designated service area to foster a continuum of coordinated care. As of fiscal year 2010, the current HMA's are Alianza of New Mexico, First Nations Community Healthsource, New Mexico Aids Services (partnered with Truman Health Services), Public Health Office, Region 5 (Community Collaborative Care), and Southwest CARE Center. Contracted services were provided to 1,362 people in fiscal year 2010.

Ryan White CARE Act services under contract for fiscal year 2011 are Ambulatory/Outpatient Medical Care, Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance, Home Health Care, Mental Health Services, Medical Nutrition Therapy, Medical Case Management (including treatment adherance), Outpatient Substance Abuse Services, Non-medical Case Management, Child Care Services, Emergency Financial Assistance, Food Bank/Home-delivered Meals, Housing Services, Legal Services, Linguistic Services, Medical Transportation Services, and Psychosocial Support Services.

The resource inventory is an essential component in conducting a comprehensive needs assessment under the Ryan White CARE Act. Used in conjunction with other analytical tools

(surveys, focus groups, epidemiologic profile) a profile of provider capacities, barriers to care, unmet needs, and gaps in services for PLWH in the service area can be developed to ensure that PLWH have access to a high standard of care funded under the Ryan White CARE Act.

Description of Contracted Services

Core Medical Services

Core medical services are a set of essential, direct health care services provided to persons living with HIV/AIDS and specified in the Ryan White HIV/AIDS Treatment Modernization Act.

Outpatient/ambulatory medical care includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

NOTE: Early Intervention Services provided by Ryan White Parts C and D programs are reported under outpatient/ambulatory medical care.

Early intervention services for Parts A and B include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.

Health insurance premium and cost sharing assistance is the provision of financial assistance for eligible individuals living with HIV to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Home health care is the provision of services in the home by licensed health care workers, such as nurses, and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Mental health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Medical nutrition therapy including nutritional supplements is provided by a licensed registered dietitian outside of a primary care visit. The provision of food may be provided

pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician.

Nutritional services and nutritional supplements not provided by a licensed, registered dietician shall be considered a support service. Food not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician also shall be considered a support service.

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face, telephone, and any other forms of communication.

Substance abuse services (outpatient) are medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel.

Support Services

Support services are a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS.

Case management services (non-medical) include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow up of medical treatments.

Child care services are care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or RWHAP-related meetings, groups, or training. These do not include child care while the client is at work.

Emergency financial assistance is the provision of short-term payments to agencies or the establishment of voucher programs to help with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication, when other resources are not available. Part A and Part B programs must allocate, track, and report these funds under specific service categories, as described under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).

Food bank/home-delivered meals is the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, also should be included in this item. The provision of food and/or nutritional supplements by a non-registered dietician should be included in this item as well.

Housing services are short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with

them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

Legal services are services to individuals with respect to powers of attorney, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program.

NOTE: Legal services do not include any legal services to arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistics services include interpretation and translation services, both oral and written.

Medical transportation services are conveyance services provided, directly or through a voucher, to a client to enable him or her to access health care services.

Psychosocial support services are support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. They include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements.

Treatment adherence counseling is counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

<u>Contracted Providers by New Mexico Department of Health HMA Region:</u>

Allianza of New Mexico, Roswell - Region 4

First Nations, Albuquerque - Region 3

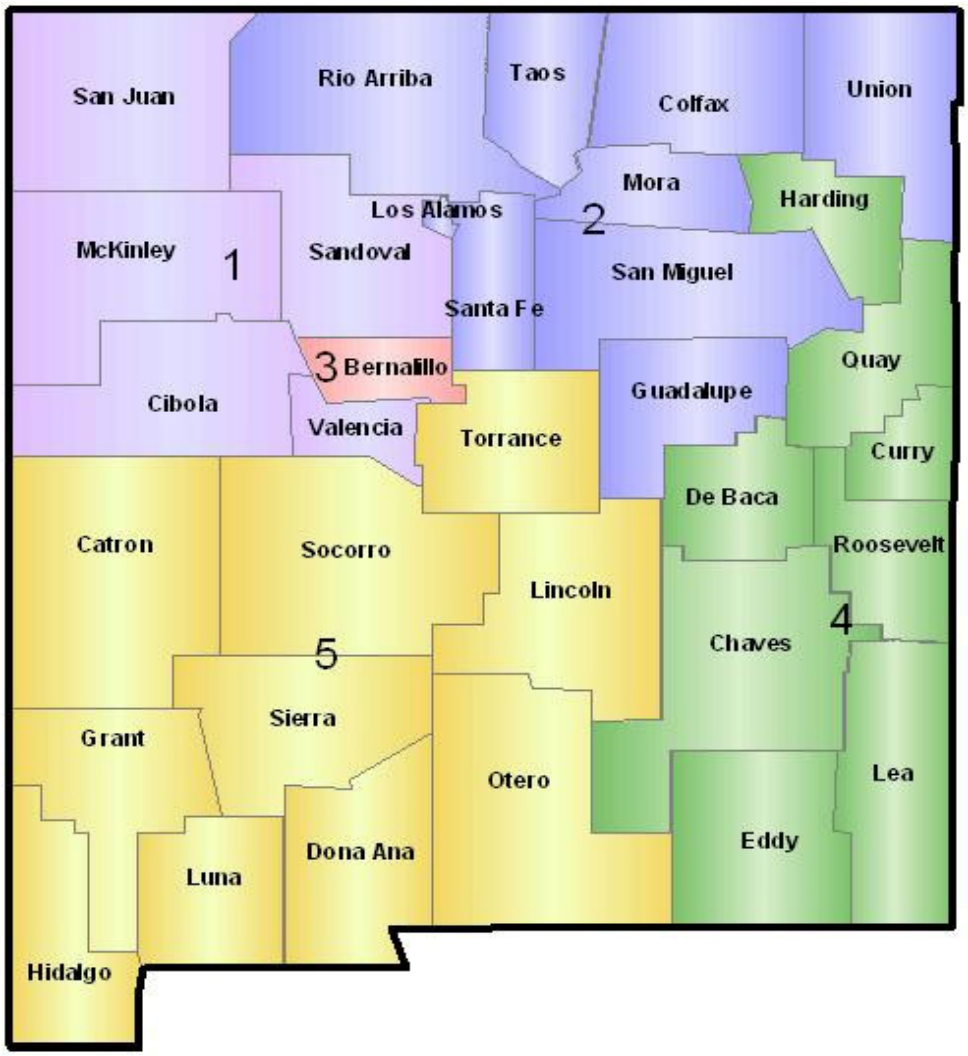
New Mexico AIDS Services, Albuquerque - Regions 1 and 3

(Including Truman Health Services)

Public Health Office, Las Cruces (Community Collaborative Care) - Region 5

Southwest CARE Center, Santa Fe - Region 2

New Mexico Department of Health Regions (1-5)



HMA contracted services for fiscal year 2011:

1. Allianza of New Mexico
311 W. 2nd Street
Roswell, NM 88201
phone: 575-623-1995
fax: 575-623-1998
http://www.alianzanm.org/

Office Hours
Monday - Friday: 9:00 am-12:00 pm 1:00 pm-4:45 pm

Service area (NM counties): Chaves, Curry, De Baca, Eddy, Guadalupe, Harding, Lea, Lincoln, Otero, Quay, and Roosevelt.

Total clients served (2010): 82

Contracted services provided (fiscal year 2011):

Core Medical

- Ambulatory/Outpatient Medical Care

- Early Intervention Services
- Health Insurance Premium and Cost Sharing Assistance
- Mental Health Services
- Medical Case Management

Support Services

- Emergency Financial Assistance
- Food Bank/Home-delivered Meals
- Housing Services
- Medical Transportation Services
- Non-medical Case Management

2. First Nations Community Healthsource
5608 Zuni Road SE
Albuquerque, NM 87108
505.262.2481 Phone
505.262.0781 Fax
http://www.fnch.org/

Office Hours
Monday - Friday: 8:00am-9:00pm
Wednesday: 8:00am-12:00pm; 5:00-9:00pm
Saturday: 9:00am-1:00pm

Service area (NM counties): Bernalillo and statewide.

Total clients served (2010): 44

Contracted services provided (fiscal year 2011):

Core Medical

- Ambulatory/Outpatient Medical Care
- Health Insurance Premium and Cost Sharing Assistance
- Mental Health Services
- Medical Case Management

Support Services

- Emergency Financial Assistance
- Food Bank/Home-delivered Meals
- Housing Services
- Legal Services
- Medical Transportation Services

- Non-medical Case Management

3. New Mexico AIDS Services (Main)
625 Truman St. NE
Albuquerque, NM 87110
(505) 938-7100 phone
(888) 882-2437 toll free
http://www.nmas.net/

Office Hours
Monday-Friday 9:00am-5:00pm

Service area (NM counties): Bernalillo, Cibola, McKinley, Sandoval, San Juan, and Valencia.

Total clients served (2010): 728

Contracted services provided (fiscal year 2011):

Core Medical

- Home Health Care
- Mental Health Services
- Medical Nutrition Therapy
- Medical Case Management
- Outpatient Substance Abuse Services

Support Services

- Child Care Services
- Emergency Financial Assistance
- Food Bank/Home-delivered Meals
- Housing Services
- Linguistic Services
- Medical Transportation Services
- Non-medical Case Management
- Psychosocial Support Services

4. Truman Health Services (Truman Street Clinic)
625 Truman St. NE
Albuquerque, NM 87110
(505) 272-1312 phone
(505) 272-2240 fax
http://unmmg.org/truman/

Office Hours
Monday-Friday 8:00am-4:30pm
Closed (lunch) 12:00pm-1:00pm

Service area (NM counties): Bernalillo, Cibola, McKinley, Sandoval, San Juan, and Valencia.

Total clients served (2010): Clients served included in New Mexico AIDS Services totals.

Core Medical

- Ambulatory/Outpatient Medical Care
- Health Insurance Premium and Cost Sharing Assistance
- Mental Health Services
- Medical Case Management (Adherance)

5. Public Health Office Region 5
(Community Collaborative Care)
1170 N. Solano,
Las Cruces, NM 88001
(575) 528-5001 phone
(866) 668-0882 toll free
(575) 528-6024 fax
http://www.health.state.nm.us/phd/dist3/index.htm
http://www.health.state.nm.us/phd/dist3/Region5HIVServices2.html

Office Hours
Monday-Friday 8:00am-5:00pm

Service area (NM counties): Catron, Dona Ana, Grant, Hidalgo, Lincoln, Luna, Otero, Sierra, Socorro, and Torrance.

Total clients served (2010): 132

Contracted services provided (fiscal year 2011):

Core Medical

- Ambulatory/Outpatient Medical Care (Rio Grande Medical Group, MMC/Family Practice, La Clinica de Familia)
- Health Insurance Premium and Cost Sharing Assistance (Rio Grande Medical Group, MMC/Family Practice, La Clinica de Familia)
- Medical Case Management

Support Services

- Emergency Financial Assistance (Community of Hope)
- Food Bank/Home-delivered Meals (Community of Hope)
- Housing Services (Community of Hope)
- Medical Transportation Services
- Non-medical Case Management

6. Southwest CARE Center
649 Harkle Road, Suite E
Santa Fe, NM 87505
(505) 989-8200 phone
(888) 320-8200 toll free
(505) 989-8131
http://www.southwestcare.org/

Office Hours
Monday-Wednesday 8:00am-5:00pm
Thursday 8:00am-12:00pm
Friday 8:00am-5:00pm

Service area (NM counties): Colfax, Los Alamos, Mora, San Miguel, Santa Fe, Union, Rio Arriba, Taos.

Total clients served (2010): 376

Contracted services provided (fiscal year 2011):

Core Medical

- Ambulatory/Outpatient Medical Care
- Mental Health Services
- Medical Case Management

Support Services

- Child Care Services
- Emergency Financial Assistance
- Housing Services
- Medical Transportation Services
- Non-medical Case Management

According to Ryan White CARE Act guidelines Title II funds to state Grantees can be used to deliver the following services:

- Ambulatory (non-hospital) health care, including HIV specialty care; substance abuse and mental health treatment; oral health; home health; hospice; and
- Comprehensive treatment services including treatment education, antiretroviral therapies, and prophylaxis/treatment for opportunistic infections.
- Case management that prevents unnecessary hospitalization or delays in releases.
- Support services that "facilitate, enhance, support, or sustain the delivery, continuity, or benefits of health services for individuals and families with HIV disease."
- Outreach and early intervention services (EIS) to identify people with HIV disease who know their HIV status but are not receiving HIV-related services in order to bring them into care. EIS can be funded as long as the grantee can demonstrate that other sources of funds are insufficient to meet current needs.

  Table 22 reports services provided under Title II funding for designated service categories.

Sources for items in this section:

Ryan White Care Act Needs Assessment Guide. 2003. U.S. Department of health and Human Services Division, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). http://hab.hrsa.gov/tools/needs/index.htm

Ryan White HIV/AIDS Program Services Report Instruction Manual 2.1. hab.hrsa.gov/manage/RSRInstructionManual.pdf

Table 22. Provider resource inventory

	Allianza	First Nations	N.M. AIDS Services	Truman Street Clinic	Public Health Office Las Cruces	Southwest CARE Center
Core Medical						
Ambulatory/Outpatient Medical Care (5)	**X**	**X**		**X**	**X**	**X**
Early Intervention Services (1)	**X**					
Health Ins Premium & Cost Sharing Asst. (4)	**X**	**X**		**X**	**X**	
Home Health Care (1)			**X**			
Medical Case Management (5)	**X**	**X**		**X**	**X**	**X**
Medical Nutrition Therapy (1)			**X**			
Mental Health Services (5)	**X**	**X**	**X**	**X**		**X**
Outpatient Substance Abuse Services (1)			**X**			
Oral Health care (0)						
Support Services						
Child Care Services (2)			**X**			**X**
Emergency Financial Assistance (5)	**X**	**X**	**X**		**X**	**X**
Food Bank/Home-delivered Meals (4)	**X**	**X**	**X**		**X**	
Health Education/Risk Reduction (0)						
Housing Services (5)	**X**	**X**	**X**		**X**	**X**
Legal Services (1)		**X**				
Linguistics Services (1)			**X**			
Medical Transportation Services (4)	**X**	**X**	**X**			**X**
Non-medical Case Management (5)	**X**	**X**	**X**		**X**	**X**
Outreach Services (0)						
Psychosocial Support Services (1)			**X**			
Rehabilitation Services (0)						
Respite Care (0)						
Treatment Adherance Counseling (0)						
Total Clients Served (FY 2010)	**82**	**44**	**728**	[a]	**132**	**376**

Note a: Included in NMAS figure.

EPIDEMIOLOGICAL PROFILE OF HIV/AIDS IN NEW MEXICO

New Mexico presents unique geographic and demographic challenges that impact the care of people living with HIV (PLWH). While certain health care and maintenance strategies may be effective within urban populations, such as PLWH Albuquerque and Las Cruces, the majority of the state is rural and may pose challenges for patients as well as providers. Better understanding of local, regional and statewide HIV data related to populations and health-oriented needs are vital to providing a high quality standard of care for PLWH within the state.

Profile of New Mexico and Its People

New Mexico is geographically the fifth largest state in the United States, with a total land area of 121, 598 miles. 85% of the state's terrain is at or above 4,000 feet in elevation, and includes the southernmost band of the Rocky Mountains, the Sangre de Cristos. The Rio Grande River also runs through the state.

The majority of New Mexico is rural, and is ranked 36th in the nation in terms of population. The current population is 2.059,179. According to 2010 Census data, the state's population increased by 13.2% from 2000 to 2010. New Mexico is ranked 47th in the nation with regards to population density, with 84.7 people per square mile. The four largest cities in New Mexico are Albuquerque, Las Cruces, Rio Rancho and Santa Fe. Albuquerque, Santa Fe and Rio Rancho are located northwest of the center of the state, and Las Cruces is located in the southern part of the state, just along the border of Texas and Mexico.

Because of its diverse population, New Mexico is one of only four states (other than Hawaii, California and Texas) that boast a majority-minority, with less than 45% of the population being comprised of Whites. 45% of the state identify as Hispanic or Latino, 9.2% are American Indian, 2.2% are African American, 1.4% are Asian/Pacific Islander, and 3.1% identify themselves as biracial or multi-racial. Around 9.4% of New Mexican residents are born outside of the United States. 36% of the state's population speaks a language other than English at home, while the nationwide average being 19.5%. 28.4% of New Mexico residents speak Spanish as their primary language, and 10.5% of the population self-report low levels of English literacy.

Profile of HIV/AIDS in New Mexico

HIV/AIDS first appeared in New Mexico in 1981. By the end of 2007, a total of 5,464 cumulative cases of HIV/AIDS had been reported to the New Mexico Department of Health HIV/AIDS Epidemiology Program. Of these total cumulative cases, the majority (4,041 or 74%) had a diagnosis of AIDS, with the remaining 1,423 cases (26%) being HIV that had not progressed. The total number of individuals currently living with HIV/AIDS in New Mexico is 3,480 .62% of these cases have been diagnosed as AIDS; 38% of these cases are of HIV. Around one-fifth (21%) of all cases were diagnosed out-of-state, meaning that the diagnosis was given in

another jurisdiction, but the patient currently resides and receives treatment and services in New Mexico.

The overwhelming majority of HIV/AIDS cases in New Mexico are found in men who have sex with men (MSM). Around 90% of all cases in the state have been found in men, which has stayed stable over the years. Racial and ethnic demographics also appear to influence the infection rates within the state, with Hispanic/Latino and American Indian populations having the greatest distribution of the disease.

Common Modes of Exposure in New Mexico

MSM: As mentioned above, the most prevalent mode of exposure to HIV/AIDS is through MSM. When including MSM who are IV drug users (MSM/IDU), 73% of cumulative and 72% of current living cases are represented.

Injection Drug Users (IDU): 10% of cumulative and current living cases of HIV/AIDS in New Mexico are comprised of IDU.

High-risk Heterosexual Contact: This group represents a small portion of HIV/AIDS cases, but there is evidence that it is a risk factor that is growing. 8% of cumulative cases in the state are through this exposure, but 10% of the current living cases are from high-risk heterosexual contact.

Age at HIV/AIDS Diagnosis

Most PLWH in New Mexico were diagnosed while in their 30s (41%). The 40s (25%) and 20s (24%) follow in positive testing age brackets. Recently, the state has seen an increase in diagnoses while individuals are in their 20s. This may be a result of increased testing and awareness of HIV/AIDS within younger populations, but it may also signal an increased infection rate among people in their teens and 20s.

Racial and Ethnic Groups

Whites: This group has decreased in infection rates over the course of the HIV/AIDS epidemic in New Mexico, from 52% of cumulative cases to a current 50% of cases in those living with the disease.

Hispanic/Latino: This demographic has increased in proportion over the course of the HIV/AIDS epidemic in New Mexico, from 35% of cumulative cases to 36% of living cases. 2007 brought 72 new incident cases of HIV/AIDS in the state, accounting for 48% of all new diagnoses.
American Indians: This group accounts for 7% of all cumulative and living cases of HIV/AIDS in New Mexico.

African American: Based on their small population within this state, this group is overrepresented within cumulative and living cases of HIV/AIDS, accounting for 6% total of each. National trends support this data, with the highest infection rates being within the African American community.

Asian/Pacific Islanders: This group accounts for less than 1% of all cumulative and living cases of HIV/AIDS in New Mexico.

Trends in HIV/AIDS in New Mexico

Concurrent Diagnosis with HIV and AIDS

Concurrent diagnosis with HIV and AIDS happens when individuals have an AIDS diagnosis within one year of being given a diagnosis of HIV. People who learn of HIV in later stages of their disease tend to have a worse prognosis than those who catch the disease in earlier stages. Those who have a later diagnosis also present a greater risk of transmission of HIV to other individuals. New Mexico has one of the highest rates of concurrent HIV and AIDS diagnosis in the country, with 58% of all cases.

Hepatitis C Co-Infection

Hepatitis C and HIV co-Infections are on the rise in New Mexico. 17% of living cases of HIV in New Mexico are also living with Hepatitis C. The risk factor of IDU is related to this co-infection rate.
Sources for all items in this section:

Apportionment Data for New Mexico, 2010 Census Data, United States Census Bureau,

http://2010.census.gov/2010census/data/

Epidemiologic Profile of HIV/AIDS Cases in New Mexico Through 2007, HIV & Hepatitis Epidemiology Program,

New Mexico Department of Health, www.health.state.nm.us/pdf/HIV_Epi_Profile_2006.pdf

New Mexico Comprehensive HIV Prevention Plan 2009-2011, New Mexico HIV Prevention Community Planning

and Action Group and New Mexico Department of Health HIV Prevention Program, June 2009,

www.nmcpag.org/pdf/nm%20plan-2009%20final.pdf

New Mexico HIV/AIDS Annual Surveillance Report: 2008, New Mexico Department of Health,

www.health.state.nm.us/erd/HealthData/HIV/HIV_annual_report_2008.pdf

UNMET NEED AND SERVICE GAPS

According to the 2006 New Mexico Integrated Epidemiologic Profile, by the year 2005, the majority (75%) of PLWH in New Mexico were enrolled in some form of medical care. This coverage is either funded by the CARE Act or through private insurance. These numbers are calculated through the collection of laboratory results that are indicative of an HIV/AIDS infection, required by the New Mexico Administrative Code to be reported to the New Mexico Department of Health. Met need is calculated by dividing the number of persons receiving HIV care by the number of persons who have been reported to NMDOH. Unmet need is calculated by the number of persons not in care by the total number of individuals reported. The unmet need of PLWH in New Mexico is at 25% or approximately 870 New Mexicans. At this point, we do not know a lot about the unmet need of PLWH and will have to target this portion of the population in later assessments.

Service gaps provide a measure of all support services not being currently met for PLWH who know their status whether in care or not. Services include both primary health care and additional support services. The table below reports the 10 most often cited themes from client and provider focus groups conducted at locations within each of the HMAs. The need for a greater level of case management services, coordination of care across agencies, organizations, and providers, and rising medical costs were central areas of concern. New Mexico's rural character and diverse population may also contribute to an increased demand in the areas of medical transportation, translation services, and culturally appropriate treatment.

Table 23. Service gaps identified in focus groups/surveys with providers and clients

Rank	Service Gaps
1	Case management including medical case management
2	Social support groups/counselling
3	Coordination of care including help with health care costs
4	Dental services /oral health care
5	Mental health services including substance abuse
6	Cultural competence including translational /linguistic services
7	Medical transportation services
8	Food bank/nutritional services
9	Outreach and education including special needs population (homeless, undocumented)
10	Legal services

CONCLUSIONS AND RECOMMENDATIONS

This final section provides a synthesis of all of the findings and offers recommendations based on this synthesis. First, clients are generally quite satisfied with their services and self-report positive health outcomes. Specifically, the system is working well for about 75-80% of clients—78% report good to excellent health, 82% agree or strongly agree that they are satisfied with their services, and 75% report complete medication adherence. Further, there is satisfaction with specific services utilized for the most part and in particular medications and medical treatment. Additionally, this portion of clients reports positive perceptions about their interactions with providers and in their own social networks. Specifically, they report receiving good social support, have low levels of social undermining, and low barriers to seeking services. The only variable that approached a negative evaluation was isolation, which approached the midpoint on the scale.

At the same time, there are about 20% of the clients for whom the system is not working (i.e., low satisfaction or low utilization), have poor health outcomes, and/or poor psycho-social variables. We identified some patterns for this portion of the population:

a) Overall satisfaction is lower for people who have negative interaction with providers.
b) Medical adherence and efficacy is lower for people who have low satisfaction with services and face isolation from their social networks.
c) Self-rated health is lower for people who face isolation from their social networks and have communication/trust barriers with providers (it is higher for those who received adequate information from providers).
d) Physical health is lower for people who perceive not receiving instrumental (tangible) support from their social networks, not receiving respect from their providers, and receiving critical appraisal from their social networks.
e) Depression is higher for those who are isolated from their social networks, who receive critical appraisal from their social network, and who face communication/trust barriers with providers. It is lower for those who receive adequate information from providers.

These findings provide a complement to the service gaps and needs identified in the focus groups and surveys. Specifically, clients and providers identified key services that are needed and are not being provided to the level desired. The first table identifies the top 10 service needs of clients in the survey (they were specifically asked whether they need particular services in the survey):

Rank	Reported Service Needs of Clients	Percentage Reporting Need
1	Help paying medical bills	67%
2	Advice and help getting medical, social, community, legal, financial or other needed services	57%
3	Emergency help paying for food, housing or medicine	45%
4	Making a plan for health care	45%
5	Outpatient medical care	41%
6	Support groups or counselling	38%
7	HIV testing and diagnosis	36%

8	Mental health services	32%
9	Medical transportation services	28%
10	Legal services	25%

The second table is a repeat from unmet need section and identifies the top 10 services that PLWH (or providers of PLWH) note are important and are not being adequately provided.

Rank	Service Gaps
1	Case management including medical case management
2	Social support groups/counselling
3	Coordination of care including help with health care costs
4	Dental services /oral health care
5	Mental health services including substance abuse
6	Cultural competence including translational /linguistic services
7	Medical transportation services
8	Food bank/nutritional services
9	Outreach and education including special needs population (homeless, undocumented)
10	Legal services

Second, providers are also generally satisfied with the services that are provided and feel their clinics are doing a good job of meeting client needs. Providers report that their colleagues have good capability and cultural sensitivity with particular segments of the population (e.g., MSM, African Americans, Hispanics, and American Indians) although they recognize the importance of cultural competence with these populations. Providers also rated several factors consistently with clients: a) They feel there is positive interaction with clients; b) Their estimates of medication adherence are consistent with what the clients reported; and c) They identify service gaps in terms of case management, mental health, support groups/counselling, and dental services.

Providers recognize that a certain segment of the population needs more assistance than others, although they overestimate (relative to the self-reports of clients) how many clients face barriers to care and have mental health or substance use problems. They also identify communication with clients as a challenge—specifically, they report that getting a hold of clients can be problematic.

Providers also report some problems in their organizations and within themselves. First, about 30% report some level of burnout, which was found to be related to the level of critical appraisal and teamwork (negatively related to burnout) in their organizations. This is consistent with two themes identified in the focus groups: organizational and interorganizational communication. Further, two other themes are presumably related to burnout—overload of providers and a not user-friendly structural/funding system.

Third, the epidemiologic profile identified about 3,480 active cases of PLWH in New Mexico and yet only 1,362 clients were seen during FY2010 at the HMAs. Accounting for private insurance, the estimate is that there is an unmet need of about 25% of the PLWH in New Mexico

(or about 870). This unmet need is consistent with the theme that the system works for about 75-80% of PLWH and it does not work for about 20-25%.

Fourth, the HMAs provide a comprehensive set of services for PLWH although there are certainly constraints to how many people they can serve and the number of services they can provide. The vast majority of patients are served by Truman St/NMAS and SW Care (accounting for 81% of the total client load). Not surprisingly, these two HMAs had the highest satisfaction rating with services. Las Cruces and Roswell serve a rural and geographically dispersed population and we had a several clients complain that services were not available in their specific communities—they didn't like having to travel to Las Cruces or Roswell. First Nations serves a specific population (i.e., American Indians) and most of the clients reported using services at both First Nations (for support services) and Truman St. (for medical services). Overall, the system of funding has constraints and cannot adequately meet every need for every client.

Recommendations

Based on these findings, we have the following recommendations for the future:

1) Feel good about quality of care provided. We think it is important to note the high levels of satisfaction and health outcomes for the clients. As noted, the system is working well for about 80% of the people who participated in the survey. The providers and administrators of the HMAs have a difficult job providing services with limited funding and are to be commended for performing well under difficulty circumstances.
2) Maintain quality of medical care. Clients in the focus groups and surveys noted that medications and medical care are the most important services provided and rate these aspects very well. To enhance the quality of care, it appears that case management is a critical aspect and it was identified as a service gap. Additionally, mental health/substance use and dental care were service gaps also mentioned by clients and providers.
3) Enhance communication within the organizations, with clients, and across organizations. The quality of communication was a key psycho-social variable for a variety of client outcomes and for satisfaction. Further, the quality of communication was also important for the level of provider burnout reported. Additionally, the quality of communication was a strong theme in both client and provider focus groups. For example, many noted a lack of understanding about how the funding structure works and yet reported receiving very little information about it. Another example is that providers note that there is very little interaction with other HMAs (even when they are in close proximity). Overall, the importance of quality communication is well recognized and very little effort toward improving the quality of communication is put forth (an exception to this is the quality of interaction between clients and providers which is reported to be very high). We recommend developing and implementing a communication plan for enhancing the information shared with clients and providers and also for improving the two-way process of communication with clients and providers (i.e., there has to be an opportunity for feedback). One key mechanism of this communication plan could be an advisory group of clients who work locally with a specific HMA and also with the state overall.

4) Facilitate on-line/client-led support groups. Everyone we talked with recognized that there are funding constraints and that support groups/counselling is less of a priority than medical care. We are realistic that funding is limited and that medical care takes priority over support. However, the evidence is clear that there is a service need and gap for support groups and that the social support is a critical factor associated with patient outcomes. One way to address this is to facilitate the creation of client-led support groups. The HMAs can help clients establish face-to-face and/or on-line support groups with very little resources. An advisory group of clients might be the mechanism to establish and maintain the support groups.
5) Improve the structural/bureaucratic issues to make work easier. Over the past three years, every industry has faced shrinking resources and expanded work requirements. It is a difficult situation and makes "working smarter not harder" a key mantra. Clients and providers both reported that there are structural/bureaucratic issues that could be addressed to make the work easier. The specific issues were beyond the scope of this needs assessment so we cannot comment on any particular issues. However, working with the providers and clients to identify these issues might be worth the initial time and effort. If nothing else, it might provide the opportunity for enhanced communication and creating better understanding about why the bureaucracy exists (e.g., it may be HRSA or State government driven).
6) Examine resources in the community to identify potential duplications and savings. There are clearly service gaps and there are also clearly limited resources to meet these gaps. In the next needs assessment, effort needs to focus on developing a comprehensive resource inventory to identify if there are other ways to meet client needs.
7) Find out more about the 20-25% underserved and unmet need. There is about 20-25% of the clients whose needs are not being met. We know a little about the people who are using the current services and what they desire (i.e., service gaps and enhancing communication with these clients). We know nothing about the unmet—those PLWH who know about their status and are not getting care. Future needs assessments will need to focus on this portion of the population.

APPENDIX 1: FOCUS GROUP QUESTIONS

Client Questions

Top of Mind Service Needs

1. What services do you need that you can't get?
2. What services do you need that are hard to get?
3. What would be the single most important change you would suggest to improve HIV services?

Accessing Care

4. What are the most important HIV-related services you and/or your children are using now or have used in the last year?
5. How do you feel about the particular services you have used?
6. While seeking services, have you experienced any problems in trying to get services for you or your children?
7. If you have a friend that is like you that is diagnosed with HIV, what would youtell him (her) about getting HIV medical care? What advice would you give?

Communicating with Service Providers and Staff

8. How would you describe your interaction with HIV/AIDS service providers and staff?

Dropping Out of Care

9. Have you ever dropped out of HIV medical care?

Additional information

10. Is there anything else you would like to us to know?

Provider/Staff Questions

Services

1. What are the most important HIV-related services for PLWH?
2. Are you satisfied with service options for PLWH?
3. What would be the single most important change you would suggest to improve HIV services?

Accesing Care

4. What challeneges do you face in providing services to PLWH?
5. What other service needs do you find difficult to meet? Do these needs vary by population?
6. What other barriers to care are faced by your clients—consider each priority population—MSM, AA men, adolescents, women of child bearing age, substance users

Organizational Concerns

7. Do you have concerns about the services your organization offers?
8. How well is the CARE Act funded system working now?

Additional Information

9. Is there anything else you would like to us to know?

APPENDIX 2: SURVEY FOR CLIENTS

We're going to ask you some questions about your HIV services and your own experiences. Please answer truthfully. There are **no** right or wrong answers.

1. Do you currently get services for HIV/AIDS at one of these clinics? (Check all that apply.)

- □ NM AIDS Services in Alb.
- □ Truman Street Clinic in Alb.
- □ First Nations Community Health Source in Alb.
- □ Southwest CARE Center in Santa Fe
- □ Alianza in Roswell
- □ La Clinica de Familia in Las Cruces

If you get services at more than one clinic, where do you get **most** of your services?_____

Please answer the questions below about the clinic where you get most of your services.

2. Circle the answer that's closest to your feeling about each statement below. **Like this: (1)**	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
a. I feel perfectly satisfied with the way I am treated at the clinic.	1	2	3	4	5
b. I have thought about changing to another clinic.	1	2	3	4	5
c. I am not satisfied with my doctor.	1	2	3	4	5
d. Patients get the best care at this clinic.	1	2	3	4	5
e. I have faith in the providers at this clinic.	1	2	3	4	5

3. Circle the best answer to the questions about each service. Like this: Yes	**Do you need this service?**	**Have you used this service in the past year?**	**How satisfied are you with the service?** **Very Dissatisfied**	**Dissatisfied**	**Satisfied**	**Very Satisfied**
a. Home health care	**Yes** → **No**. Go to **b.**	**Yes** → **No.** Go to **b.**	1	2	3	4
b. Mental health services	**Yes** → **No**. Go to **c.**	**Yes** → **No.** Go to **c.**	1	2	3	4
c. Advice and supplements from a dietician (nutrition therapy)	**Yes** → **No.** Go to **d.**	**Yes** → **No.** Go to **d.**	1	2	3	4
d. Making a plan for your health care (medical case management)	**Yes** → **No.** Go to **e.**	**Yes** → **No.** Go to **e.**	1	2	3	4
e. Outpatient treatment for alcohol and drug problems	**Yes** → **No.** Go to **f.**	**Yes** → **No.** Go to **f.**	1	2	3	4

f. Outpatient medical care	**Yes** → **No**. Go to **g.**	**Yes** → **No.** Go to **g.**	1	2	3	4
g. Help paying medical bills (help with premiums/cost sharing)	**Yes** → **No.** Go to **h.**	**Yes** → **No.** Go to **h.**	1	2	3	4
h. HIV testing and diagnosis	**Yes** → **No.** Go to question **4.**	**Yes** → **No.** Go to question **4.**	1	2	3	4

4. Circle the best answer to the questions about each service.	**Do you need this service?**	**Have you used this service in the past year?**	**How satisfied are you with the service?**			
			Very Dissatisfied	**Dissatisfied**	**Satisfied**	**Very Satisfied**
a. Child care while you are at the clinic	**Yes** → **No.** Go to **b.**	**Yes** → **No.** Go to **b.**	1	2	3	4
b. Emergency help paying for food, housing, or medicine	**Yes** → **No.** Go to **c.**	**Yes** → **No.** Go to **c.**	1	2	3	4
c. Food bank or home-delivered meals	**Yes** → **No.** Go to **d.**	**Yes** → **No.** Go to **d.**	1	2	3	4
d. Help getting emergency housing	**Yes** → **No.** Go to **e.**	**Yes** → **No.** Go to **e.**	1	2	3	4
e. Translation of information—either written or spoken	**Yes** → **No.** Go to **f.**	**Yes** → **No.** Go to **f.**	1	2	3	4
f. Medical transportation services (direct rides or vouchers)	**Yes** → **No.** Go to **g.**	**Yes** → **No.** Go to **g.**	1	2	3	4
g. Support groups or counseling	**Yes** → **No.** Go to **h.**	**Yes** → **No.** Go to **h.**	1	2	3	4
h. Advice and help getting medical, social, community, legal, financial, or other needed	**Yes** → **No.** Go to **i.**	**Yes** → **No.** Go to **i.**	1	2	3	4

services						
i. Legal services	**Yes** → **No.** Go to question **5.**	**Yes** → **No.** Go to question **5.**	1	2	3	4

5. Following are some things that may keep you from seeking services. Please circle the number under the answer that best matches your feeling about each statement.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
a. I don't have child care.	1	2	3	4	5
b. I don't trust the staff.	1	2	3	4	5
c. I don't feel comfortable talking about my sex life.	1	2	3	4	5
d. I worry about prejudice or discrimination.	1	2	3	4	5
e. I don't want anyone to know I have HIV.	1	2	3	4	5
f. The staff and I have had problems understanding each other.	1	2	3	4	5
g. I don't have a reliable ride.	1	2	3	4	5
h. I've been worried about what others might think.	1	2	3	4	5
i. I've been afraid of a lack of privacy, or that staff would talk to other people about me.	1	2	3	4	5
j. I don't want to tell my partner or spouse about my HIV status.	1	2	3	4	5

6. The following statements are about your visits with providers. Think about the person you get most of your care from. Then circle the number under the answer that best matches your feeling about each statement.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
a. My provider makes sure I understand treatment side effects.	1	2	3	4	5
b. My provider told me what treatment would do.	1	2	3	4	5
c. I understand the medical plan for me.	1	2	3	4	5
d. I have a good idea about the changes to expect in my health.	1	2	3	4	5
e. Treatment procedures were clearly explained to me.	1	2	3	4	5
f. It's hard to get conflicting information straightened out.	1	2	3	4	5
g. It's hard to ask about something I don't understand.	1	2	3	4	5
h. It is hard for me to talk about new symptoms.	1	2	3	4	5
i. It's hard for me to ask how treatment is going.	1	2	3	4	5
j. I have trouble asking my provider questions.	1	2	3	4	5
k. My provider is warm and caring toward me.	1	2	3	4	5
l. My provider makes me feel comfortable talking about personal issues	1	2	3	4	5
m. My provider really respects me.	1	2	3	4	5

n. Sometimes I feel insulted when talking to my provider.	1	2	3	4	5
o. My provider doesn't seem interested in me as a person.	1	2	3	4	5

7. The next few questions are about your medications. We know it's hard to always remember your pills. You may get busy and forget. It may be hard to follow instructions, like taking the pills with food or drink. So please don't worry about telling us if you don't take all your pills. We need to know how people are really doing. Please circle the best answer to each question.

a. In the last week: How often have you missed taking a dose of any of your HIV medic**ine**?	**Everyday**	**Most Days**	**A Few Days**	**Once**	**Not Once**
b. Most HIV medicines need to be taken on a time schedule, such as "2 times a day," "3 times a day," or "every 8 hours." **During the last week:** How often did you follow your time schedule?	**Everyday**	**Most Days**	**A Few Days**	**Once**	**Not Once**
c. During the last 4 weeks: How often have you missed taking a dose of any of your HIV medicine?	**Everyday**	**Most Days**	**A Few Days a Week**	**About Once a Week**	**Less Than Once a Week**
d. During the last 4 weeks: How often did you follow your time schedule?	**Everyday**	**Most Days**	**A Few Days a Week**	**About Once a Week**	**Less Than Once a Week**
e. Over the *next* 4 weeks: How sure are you that you'll be able to take all your HIV medicines as your doctor prescribed?		**Not at all sure**	**Fairly sure**	**Very sure**	**Extremely sure**
f. Over the *next* 4 weeks: How sure are you that you'll be able to fill your HIV prescriptions on time?		**Not at all sure**	**Fairly sure**	**Very sure**	**Extremely sure**
g. Over the *next* 4 weeks: How sure are you that you'll be able to take your HIV medicines following all the **instructions**, such as "with fluids"?		**Not at all sure**	**Fairly sure**	**Very sure**	**Extremely sure**
h. Over the *next* 4 weeks: How sure are you that you'll be able to take all your HIV medicines at the **times** you're supposed to?		**Not at all sure**	**Fairly sure**	**Very sure**	**Extremely sure**
i. Over the *next* 4 weeks: How sure are you that you'll be able to take **all** your HIV medicines, even if it's hard?		**Not at all sure**	**Fairly sure**	**Very sure**	**Extremely sure**

8. The following statements are about your relationships with your family and friends. Please circle the number under the answer that best matches your feeling about each statement.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
a. I can talk to my friends or relatives about my worries.	1	2	3	4	5
b. Most people who are important to me know that I'm HIV-positive.	1	2	3	4	5
c. My friends or relatives often let me down when I'm counting on them.	1	2	3	4	5
d. My friends or relatives understand the way I feel about things.	1	2	3	4	5
e. There is someone I know who would lend me a car or drive me.	1	2	3	4	5
f. My friends or relatives often get on my nerves.	1	2	3	4	5
g. I can relax and be myself around my friends or relatives.	1	2	3	4	5

h. My friends or relatives argue with me often.	1	2	3	4	5
i. My friends or relatives drink or use drugs too much.	1	2	3	4	5
j. My friends or relatives really appreciate me.	1	2	3	4	5
k. My friends or relatives make too many demands on me.	1	2	3	4	5
l. There's someone I know who would lend me money if I needed it in an emergency.	1	2	3	4	5
m. I feel isolated from others.	1	2	3	4	5
n. There's someone I know who will attend social activities with me.	1	2	3	4	5
o. My friends or relatives criticize me often.	1	2	3	4	5
p. I often avoid family gatherings.	1	2	3	4	5
q. My friends or relatives really care about me.	1	2	3	4	5
r. When I do go to family gatherings, I'm likely to leave early.	1	2	3	4	5
s. There's someone I know whom I could count on to check in on me regularly.	1	2	3	4	5
t. I can rely on my friends or relatives for help if I have a serious problem.	1	2	3	4	5

9. The following statements are about your current health in general. Please circle the best response to each statement.

a. In general, how would you rate your health?	**Poor**	**Fair**	**Good**	**Very good**	**Excellent**
b. I am somewhat ill.	**Definitely true**	**Mostly true**	**Not sure**	**Mostly false**	**Definitely false**
c. I am as healthy as anybody I know.	**Definitely true**	**Mostly true**	**Not sure**	**Mostly false**	**Definitely false**
d. My health is excellent.	**Definitely true**	**Mostly true**	**Not sure**	**Mostly false**	**Definitely false**
e. I have been feeling bad lately.	**Definitely true**	**Mostly true**	**Not sure**	**Mostly false**	**Definitely false**
f. Does your health limit the vigorous activities you can do, like lifting heavy objects, running, or playing strenuous sports?	**Yes limited a lot**	**Yes limited a little**	**No**		
g. Does your health limit the moderate activities you can do, like moving a table, carrying groceries, or bowling?	**Yes limited a lot**	**Yes limited a little**	**No**		
h. Does your health limit walking uphill or climbing a few flights of stairs?	**Yes limited a lot**	**Yes limited a little**	**No**		
i. Does your health limit bending, lifting, or stooping?	**Yes limited a lot**	**Yes limited a little**	**No**		
j. Does your health limit walking one block?	**Yes limited a lot**	**Yes limited a little**	**No**		

k. Does your health limit eating, dressing, bathing, or using the toilet?	**Yes limited a lot**	**Yes limited a little**	**No**		
l. How has the quality of your life been during the past 4 weeks?	**Very Bad, Could Hardly Be Worse**	**Pretty Bad**	**Good and Bad Parts**	**Pretty Good**	**Very Well, Could Hardly Be Better**

10. Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle the best answer to each statement.	**Nearly Every Day**	**More Than Half the Days**	**Several Days**	**Not at All**
a. Little interest or pleasure in doing things	1	2	3	4
b. Feeling down, depressed, or hopeless	1	2	3	4
c. Trouble falling or staying asleep, or sleeping too much	1	2	3	4
d. Feeling tired or having little energy	1	2	3	4
e. Poor appetite or overeating	1	2	3	4
f. Feeling bad about yourself—or that you've failed or have let yourself or your family down	1	2	3	4
g. Trouble concentrating on things, like reading the newspaper or watching TV	1	2	3	4
h. Moving or talking so slowly that other people could notice. Or the opposite—being so fidgety or restless that you move around a lot more than usual.	1	2	3	4
i. Thinking you'd be better off dead, or thinking of hurting yourself	1	2	3	4

j. Which of the following happened to you during the last 6 months? **Please check *all* that apply.**

□ I was homeless.

□ I was in jail.

□ I used illegal drugs.

□ I shot up (used illegal injection drugs).

□ I used prescription meds to get high.

□ I shared needles with someone I knew to be HIV-positive.

□ More than once, I drank alcohol even though a doctor suggested that I stop drinking because of a problem with my health.

□ More than once, I drank alcohol or was hung over while I was working, going to school, or taking care of children.

□ More than once, I missed or was late for work, school, or other activities because I was drinking or hung over.

□ More than once, I had a problem getting along with other people while I was drinking.

□ More than once, I drove a car after having several drinks or after drinking too much.

11. The next question is very personal. Remember, this survey is 100% private and confidential. It's also anonymous: No one will know who you are.

Which of the following happened to you during the last 12 months? Please check *all* that apply.

□ I had sex (vaginal, oral, anal) while I or my partner was "high" on drugs or alcohol.

□ I was trading, giving, or getting sex (vaginal, oral, anal) for money, drugs, or gifts.

□ I had sex (vaginal, oral, anal) without using a condom.

□ None of the above applies to me.

12. Finally, please tell us about yourself.

a. What is your date of birth? _____

b. Biological Sex: (Check one) □ Male □ Female

c. Sexual Identity: (Check one) □ Heterosexual □ Lesbian □ Gay □ Bisexual □ Transgendered □ Queer □ Questioning

d. Education: (Check one) □ Less than high school □ Some high school □ High school graduate □ Some college □ College graduate □ Graduate school

e. Work situation: (Check one) □ Unemployed □ In school or job training □ Homemaker □ Temp employment □ Employed part-time □ Employed full-time □ Unable to work □ Retired

f. Monthly Household Income: _____

g. Number of Household members: _____

h. What is your ethnic/racial group? (Check all that apply) □ American Indian □ White non Hispanic □ Hispanic/Latino □ African American □ Asian/Pacific Islander □ Other (Please write it)_____

i. What languages do you speak at home? (Check all that apply) □ English □ Native American Language □ Spanish □ Other (Please write it)_____

j. What kind of relationship are you in? (Check one) □ Married/Civil union □ Partner/**Not** living together □ Divorced □ Partner/Living together □ Single never married □ Separated

k. Health insurance: □ No insurance □ Private 3rd party insurance □ Medicare
(Check all that apply) □ Medicaid (Ryan White, ACCESS) □ VA
□ Indian Health Service

l. In what city were you born? _____

APPENDIX 3: SURVEY FOR PROVIDERS

We are going to ask you to respond to statements and questions about your HIV services and your own personal experience. Please answer truthfully as there are no right or wrong answers.

1. What organization do you provide services for? *(Please check* all that may apply*)*

□ New Mexico AIDS Services in Albuquerque;
□ University of New Mexico Health Sciences Center, Truman Street Clinic in Albuquerque;
□ First Nations Community Health Source in Albuquerque;
□ Southwest CARE Center in Santa Fe;
□) Alianza, located in Roswell;
□ Community Collaborative Care in Las Cruces
□ **None of the above (Please stop as you do not meet the criteria for completing this survey)**

2. Approximately how many HIV clients/patients do you personally provide services to in a year? *(Please check* one only*)*

□ 1-15 clients/patients
□ 16-30 clients/patients
□ 31-50 clients/patients
□ 51-100 clients/patients
□ Over 100 clients/patients

3. What role(s) do you have in your organization? *(Please check* all that may apply*)*

□ Administrator (CEO, CFO, Director, Medical Director, Program Manager, Supervisor)
□ Administrative Assistant/Secretary
□ Bridge Worker
□ Case Manager (Non-Medical)
□ Community Health Educator/Health Educator/Promotora
□ Front Desk Staff/Receptionist
□ HIV Test Counselor
□ Licensed Clinical Therapist (e.g., LCSW, MFT, etc.)
□ Licensed Vocational Nurse
□ Medical Case Manager (also includes RN Case Manager)
□ Outreach Worker
□ Patient Educator (provided in clinical settings)
□ Peer Health Educator (person living with HIV helping other HIV clients/patients)
□ Phlebotomist
□ Psychologist
□ Registered Dietician/Nutritionist
□ Registered Nurse
□ Risk Reduction Specialist
□ Social Worker
□ Transitional Case Manager (work with incarcerated & recently released populations)
□ Other-Please specify_____
□ ***Medical Provider/Physician*** - please identify specialty(ies):_____

4. Please think about the services that your clinic provides. Tell us the degree to which you agree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. I feel perfectly satisfied with the way patients are treated at the clinic	1	2	3	4	5
b. Patients express their satisfaction with their providers.	1	2	3	4	5
c. Patients receive the best care at this clinic.	1	2	3	4	5

d. Patents should have faith in the providers at this clinic.	1	2	3	4	5

5. Please consider the following medical services. For each of the following four questions, please circle the best response.	**a Have you provided this service in the past 12 months?**	**b. Have you received training in the past 12 months on providing or improving this service?**	**c. Do you need further training on how to provide this service?**	**d. How satisfied are you with the quality of this service at your clinic?**				
a. Home health care	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
b. Mental health services (assessment and treatment of a mental illness)	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
c. Medical nutrition therapy (advice and supplements provided by a dietician outside of the primary care visit)	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
d. Medical case management	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
e. Outpatient substance abuse services	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
f. Outpatient medical care	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
g. Health insurance premium/cost sharing assistance	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
h. Early intervention services (testing and diagnosis of HIV status and extent of immune deficiency)	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**

6. Please consider the following support services. For each of the following four questions, please circle the best response.	**a Have you provided this service in the past 12 months?**	**b. Have you received training in the past 12 months on providing or improving this service?**	**c. Do you need further training on how to provide this service?**	**d. How satisfied are you with the quality of this service at your clinic**				
a. Child care services	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
b. Emergency financial assistance (short-term payments for essential items)	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**

c. Food bank/home-delivered meals	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
d. Housing services (short-term assistance for emergency housing)	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
e. Linguistic services	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
f. Medical transportation services	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
g. Other support services (support groups or counseling)	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
h. Non-medical case management (advice and assistance in obtaining medical, social, community, legal, financial or other needed services)	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**
i. Legal services	**Yes or No**	**Yes or No**	**Yes or No**	**Very Unsatisfied**	**Unsatisfied**	**Satisfied**	**Very Satisfied**	**Not able to rate**

7. What percentage of your HIV patients have expressed to you or another staff member the following concerns about seeking or receiving care for their HIV and related conditions?

a. They fear a lack of privacy, or that staff would talk to other people about their HIV status.	**0-25%**	**26-50%**	**51-75%**	**76-100%**
b. They are concerned about what others might think.	**0-25%**	**26-50%**	**51-75%**	**76-100%**
c. They do not want anyone to know they are HIV positive.	**0-25%**	**26-50%**	**51-75%**	**76-100%**
d. They do not feel comfortable talking about their sexual behavior.	**0-25%**	**26-50%**	**51-75%**	**76-100%**
e. They do not trust the staff.	**0-25%**	**26-50%**	**51-75%**	**76-100%**
f. They worry about prejudice or discrimination.	**0-25%**	**26-50%**	**51-75%**	**76-100%**
g. They and the staff have problems understanding one another	**0-25%**	**26-50%**	**51-75%**	**76-100%**
h. They do not want to inform their partner or spouse about their HIV status.	**0-25%**	**26-50%**	**51-75%**	**76-100%**
i. They do not have child care.	**0-25%**	**26-50%**	**51-75%**	**76-100%**
j. They do not have reliable transportation.	**0-25%**	**26-50%**	**51-75%**	**76-100%**

8. Please consider the degree to which you agree with the following statements about your interaction with your patients in general:

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
a. I make sure that my patients understand treatment side effects.	1	2	3	4	5

b. I help them get conflicting information straightened out.	1	2	3	4	5
c. I am warm and caring toward my patients.	1	2	3	4	5
d. I help them ask about things that they do not understand.	1	2	3	4	5
e. I tell my patients what treatment will do.	1	2	3	4	5
f. I make my patients feel comfortable discussing personal issues.	1	2	3	4	5
g. My patients have a hard time telling me about new symptoms.	1	2	3	4	5
h. My patients have a hard time telling me about how treatment is going.	1	2	3	4	5
i. I really respect my patients.	1	2	3	4	5
j. I help my patients understand their medical plan.	1	2	3	4	5
k. I make sure my patients have a good idea about the changes to expect in their health	1	2	3	4	5
l. I sometimes insult my patients.	1	2	3	4	5
m. My patients have difficulty asking me questions.	1	2	3	4	5
n. I make sure that treatment procedures are clearly explained.	1	2	3	4	5
o. I'm not very interested in my patients as people.	1	2	3	4	5

9. Consider each of the following patients of the HIV population and address each of the following

My colleagues are comfortable interacting with people from this group.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
h. Men who have sex with men	1	2	3	4	5
i. African Americans	1	2	3	4	5
j. Hispanics	1	2	3	4	5
k. American Indians	1	2	3	4	5
l. Adolescents	1	2	3	4	5
m. Women of child bearing age	1	2	3	4	5
n. Substance users	1	2	3	4	5

My colleagues' communication with people from this group is culturally sensitive.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
h. Men who have sex with men	1	2	3	4	5
i. African Americans	1	2	3	4	5
j. Hispanics	1	2	3	4	5
k. American Indians	1	2	3	4	5
l. Adolescents	1	2	3	4	5
m. Women of child bearing age	1	2	3	4	5
n. Substance users	1	2	3	4	5

I'd like to learn more about this group to become for culturally aware about this group.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
o. Men who have sex with men	1	2	3	4	5
p. African Americans	1	2	3	4	5
q. Hispanics	1	2	3	4	5
r. American Indians	1	2	3	4	5
s. Adolescents	1	2	3	4	5
t. Women of child bearing age	1	2	3	4	5
u. Substance users	1	2	3	4	5

10. The next questions are about your patient's medications. We realize that many people with HIV find it hard to always remember their pills. Some people get busy and forget to carry their pills with them and others find it hard to take their pills according to all the instructions such as food or fluids.

a. How many of your patients are adhering to their medication regimen?	Nearly none of them	Some of them	Most of them	All of them
b. Do you think more efforts need to be made by your clinic to ensure patient adherence to their medication regimen?		No, we do enough	Maybe for some patients	Yes, definitely

11. Approximately what percentage of your HIV patients, have ever been diagnosed with any of the following medical conditions?

a. Hepatitis B & C	0-25%	26-50%	51-75%	76-100%
b. Infections	0-25%	26-50%	51-75%	76-100%
c. Any STD	0-25%	26-50%	51-75%	76-100%
d. Any mental health disorder	0-25%	26-50%	51-75%	76-100%
e. Alcohol use or dependence	0-25%	26-50%	51-75%	76-100%
f. Substance abuse	0-25%	26-50%	51-75%	76-100%

12. At this point, we want to know a little about your own personal experiences and feelings at your work. Please consider these questions in the context of providing services for patients living with HIV.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. People I work with resolve disagreements cooperatively.	1	2	3	4	5
b. People I work with often let me down when I am counting on them.	1	2	3	4	5
c. People I work with accept criticism without becoming defensive.	1	2	3	4	5
d. People I work with are good listeners.	1	2	3	4	5
e. I am asked to make suggestions about how to do my job better.	1	2	3	4	5
f. People I work with are cooperative and considerate.	1	2	3	4	5
g. People I work with criticize me often.	1	2	3	4	5
h. I have a say in decisions that affect my work.	1	2	3	4	5

i. People I work with are direct and honest with each other.	1	2	3	4	5
j. People I work with make too many demands on me.	1	2	3	4	5
k. This clinic values the ideas of workers at every level.	1	2	3	4	5
l. People I work with function as a team.	1	2	3	4	5
m. People I work with often get on my nerves.	1	2	3	4	5
n. My opinions count in this organization.	1	2	3	4	5
o. People I work with constructively confront problems.	1	2	3	4	5
p. People I work with are concerned about each other.	1	2	3	4	5
q. People I work with argue with me often.	1	2	3	4	5

13. The following statements are about your current health in general. Please circle the best response to each statement.

1. In general, how would you say your health is?	**Poor**	**Fair**	**Good**	**Very good**	**Excellent**
2. How has the quality of your life been during the past 4 weeks?	**Very Bad, Could Hardly Be Worse**	**Pretty Bad**	**Good and Bad Parts**	**Pretty Good**	**Very Well, Could Hardly Be Better**
3. I feel burned out from my work.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
4. I have become more callous toward people since I took this job.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**

14. Finally, please answer the following demographic questions.

l. What is your date of birth? _____

m. Biological Sex: □ Male □ Female

n. Sexual Identity: □ Heterosexual □ Lesbian □ Gay □ Bisexual
□ Transgendered □ Queer □ Questioning

4. Education: □ Less than high school □ Some high school □ High school graduate
□ Some college □ College graduate □ Graduate school

5. What is your ethnic/racial group? (check all that apply)
□ American Indian □ White non Hispanic □ Hispanic/Latino
□ African American □ Asian/Pacific Islander
□ Other (please specify)_____

6. What languages do you speak? (check all that apply):
□ English □ Spanish □ Native Language □ Other_____

7. What type of relationship are you in?

□ Married/Civil union □ Partner not cohabitating

□ Divorced □ Partner/cohabitating

□ Single never married □ Separated