

Voices From The Field



Participation of Racial and Ethnic Minority Providers in Clinical and Social Support Services Funded by the Ryan White CARE Act: Report 1, 2001

PROJECT AIMS

- Improve HAB's understanding of the organizational structure and services provided by racial/ethnic minority agencies receiving funds from the CARE Act
- Identify effective policies and practices used by HAB and CARE Act grantees to include minority providers in planning activities and resource allocation
- Gain a better understanding of barriers experienced by minority providers in obtaining CARE Act funds and recommend strategies to reduce those barriers
- Ascertain best practices used to reduce barriers to the funding of minority providers and recommend how those best practices might be adopted

PROJECT OBJECTIVES

- Develop a taxonomy to define minority provider status
- Describe policies of Titles I and II grantees regarding representation of minority providers on planning groups, the roles they play in those groups, and methods used to gain their active participation
- Characterize efforts of Titles I and II grantees to specifically fund minority providers, including targeted procurement procedures
- Identify measures taken by HAB to directly fund minority providers
- Profile the organizational structures of minority providers and the services they provide
- Examine the relationship between the rates of HIV-infected racial/ethnic minority groups in service populations and participation of minority providers in CARE Act networks
- Characterize barriers experienced by minority providers in obtaining CARE Act funds and develop recommendations to HAB to reduce those barriers
- Identify best practices used by HAB and their grantees to reduce funding barriers and develop recommendations to HAB regarding adoption of new and enhanced policies and procedures

METHODS

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) supported the study in which data presented in this brief were collected. Grantee lists were obtained from HAB to identify agencies throughout the US funded by the CARE Act. Grantees of Titles I, II, III, or IV or SPNS funds in FY 1999-2000 were asked to provide lists of their contractors or agencies receiving funds through fee-for-service or other mechanisms. State Title II grantees using consortia to distribute funds provided consortia contact information. Consortia were then asked to provide list of agencies receiving Title II funds via the consortia. All grantees provided contractor and/or consortia lists. The agency lists were unduplicated to obtain a list of CARE Act grantees totaling 2,691 agencies. They were contacted via facsimile and asked to complete a two-page consultation form. Agencies without facsimiles were sent the form via the mail. The current agency response rate is 51%. The consultation form profiles geographic location, the types of services provided, the setting in which the agency is located, sources of financing, minority provider status, participation in planning activities, and barriers to funding and participation in planning and resource allocation activities. Results of the agency consultation were nationally representative, as well as representative for most states. Check out the POI website for more information about this project and other reports:
www.positiveoutcomes.net

MINORITY PROVIDER: OPERATING DEFINITION

- Agencies in which racial/ethnic minority members make up at least a simple majority (i.e., 51% or greater) of board members (such agencies may include public and not-for-profit organizations); or
- Racial/ethnic minority individuals make up at least a simple majority of staff members engaged in direct service; or
- Individual providers (e.g., office-based clinicians) who are members of racial/ethnic minority groups.

KEY FINDINGS

Participation of Minority Providers Funded by the CARE Act

- Over one-third (39%) of responding agencies meet the minority provider criteria used by this project. About one-third (37%) of responding agencies self-identify as “traditional” providers that historically serve minority clients but do not meet the minority provider criteria. Another 18% of agencies do not meet either the minority or traditional provider criteria and 6% did not respond.

MINORITY PROVIDER STATUS AMONG AGENCIES FUNDED BY THE CARE ACT AND RESPONDING TO A CONSULTATION REQUEST		
MINORITY PROVIDER STATUS	#	%
Minority Providers		
Minority Board Only	62	4.7
Minority Staff Only	239	18.0
Minority Board and Minority Staff	184	13.8
Minority Board, Minority Staff, and Solo or Group Practice	5	.4
Minority Staff and Solo or Group Practice	9	.7
Solo or Group Practice Only	14	1.1
Traditional Providers	497	37.4
Other Providers	240	19.2
TOTAL	1,330	100.0

GEOGRAPHIC LOCATION

- Significant regional differences were identified in the proportion of CARE Act providers that meet the minority provider criteria. About one-half (45%) of Northeastern providers meet the minority provider criteria, compared to 40% of Southern providers, 34% of Western providers, and 30% of Midwestern providers. Among minority providers, 35% are located in the Northeast, 32% in the South, 21% in the West, and 12% in the Midwest.
- Being a minority provider is significantly associated with location in a Title I EMA. Over three-quarters (79%) of minority providers are located in EMAs and 21% in other jurisdictions.
- The distribution of minority providers differs significantly between EMAs and non-EMAs. In EMAs, 52% of agencies are minority providers, 34% are traditional providers, and 15% are other providers. In contrast, in communities outside EMAs, 50% of agencies are traditional providers, while minority and other providers constitute 24% and 27%, respectively.

ORGANIZATIONAL SETTING

- Minority providers operate in a variety of organizational settings. About 10% of minority providers are hospitals or hospital-based clinics, 51% are community-based organizations (CBOs), 14% are publicly funded community health centers (CHCs), 4% are health departments, 3% are publicly funded community mental health centers, 3% are publicly funded drug treatment centers, and the remainder are in variety of other health and non-health related settings.
- The proportion of minority providers within organizational settings varies significantly. Publicly funded CHCs have the highest proportion of minority providers (64%), compared to 37% of community mental health centers, 36% of publicly funded drug treatment centers, 35% of hospitals and hospital-

based clinics, 32% of solo or group private health care practices, 16% of health departments, and 22% of other health agencies. Less than one-half (44%) of CBOs are minority providers, compared to 62% of coalitions of people living with HIV and 35% of other non-health agencies.

- Significant differences in the board and staff race/ethnicity of minority providers also are identified when comparing organizational settings. Among agencies that met the minority provider criteria based on having predominantly minority boards and staff, 45% of CHCs (45%) meet the criteria based on their boards and staff compared to 41% of CBOs. Agencies in other organizational settings tend to meet the minority provider criteria based on their staffing alone. For example, 75% of health departments meet the criteria based on staffing only, compared to 67% of hospitals, 56% of community mental health centers, 48% of CBOs, 41% of drug treatment centers, and 23% of CHCs.

SERVICES PROVIDED

- Consulting agencies provide almost 100 different types of services. Minority providers constitute 40% of agencies that provide clinical services, 30% of agencies providing case management, and 43% of agencies providing other services. Minority providers are more likely than their counterparts to provide core HIV services including: case management child day care, drug treatment, health education and adherence counseling, prevention, primary care, and support groups. Other providers are significantly more likely than are minority providers to provide home health and transportation.

Percentage Of Agencies Providing Core HIV Services, By Minority Provider Status			
SERVICES	% OF TOTAL AGENCIES	% OF MINORITY PROVIDERS	% OF OTHER PROVIDERS
Buddy Services	16%	15%	17%
Case Management*	66%	73%	62%
Child Day Care*	9%	11%	8%
Dental	20%	21%	20%
Drug Treatment*	22%	26%	20%
Emergency Assistance	37%	36%	37%
Food Bank/Home Delivered Meals	24%	23%	25%
Health Education/ Adherence Counseling*	51%	55%	50%
HIV Counseling And Testing	48%	51%	47%
Home Health*	13%	11%	15%
Mental Health	38%	40%	37%
Outreach, Case Finding, etc.	45%	53%	41%
Prevention*	47%	51%	44%
Primary Care*	33%	36%	31%
Specialty Care	22%	21%	22%
Support Groups*	45%	53%	41%
Transportation*	46%	44%	46%

* Significant Chi-square at p <.05 or less

FUNDING

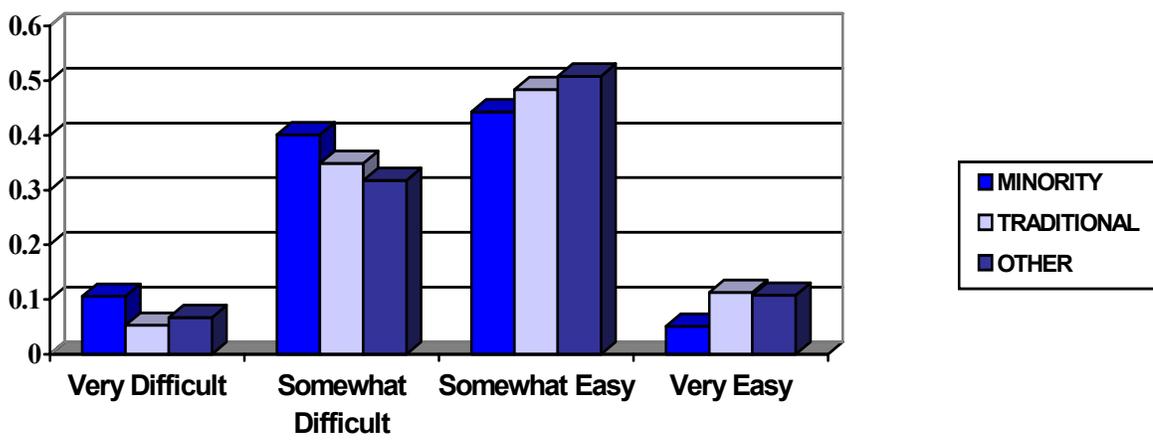
- In EMAs, consulting agencies tend to rely heavily on Title I and II funds to support their HIV programs. Almost one-half (43%) of agencies report that Title I is their only source of CARE Act funds. Minority provider status is not associated with reliance on Title I funds. About one-half (45%) of minority providers receive Title I funds only, compared to 42% of traditional providers and 41% of other providers. In contrast, 15% of other providers receive Title II funds only, compared to 7% of minority providers and 11% of traditional providers.
- In communities outside EMAs, over two-thirds (69%) of agencies report that Title II is their only source of CARE Act funds. Minority providers are less likely to receive only Title II funding (60%) than traditional providers (67%) and other providers (77%).

- HIV agencies commonly manage multiple CARE Act funding streams. Almost one-half (45%) of consulting agencies in EMAs report receiving funds from two or more titles of the CARE Act or SPNS. Combination funding is not significantly associated with minority provider status, with 45% of minority providers, 46% of traditional providers, and 41% of other providers receiving combination funding. In some but not all states with EMAs, Titles I and II contracts are awarded in an integrated fashion to reduce burden on agencies. Consulting agencies report, however, that multiple funding streams result in complex grant application, reporting, and fiscal management challenges.
- Combination funding is less common in communities outside EMAs than in EMAs. About one-fifth (21%) of consulting agencies report that two or more CARE Act funding streams support their programs. Less than three-quarters (69%) report receiving only Title II, with the remaining agencies receiving only Titles III or IV or SPNS funds. A slight, but not statistically significant difference was identified between minority and other providers. Minority providers were slightly more likely to receive multiple funding streams than traditional and other providers.
- Minority clinical providers are significantly less likely to receive Title II funding than their counterparts. About one-half (51%) of minority providers, 65% of traditional providers, and 72% of other providers receive Title II funds.
- Among case management agencies, minority providers are more likely to receive Title I funds than their counterparts. Most (91%) minority providers in EMAs receive Title I funds compared to 85% of traditional providers and 73% of other providers. In contrast, being a non-minority provider is strongly associated with receipt of Title II funding, with 55% of minority providers, 78% of traditional providers, and 82% of other providers receiving Title II funds.

BARRIERS AND FACILITATORS IN RECEIVING CARE ACT FUNDS

- Being a minority provider is strongly associated with the perception that obtaining CARE Act funds is very or somewhat difficult to obtain. About one-tenth (11%) of minority providers report that CARE Act funds are very difficult to obtain and 40% report that they are somewhat difficult to obtain.

EASE OF OBTAINING CARE ACT FUNDING BY MINORITY PROVIDER STATUS



- Among agencies reporting CARE Act funds are very difficult to obtain, 57% are minority providers, 28% are traditional providers, and 15% are other providers. Among agencies reporting that CARE Act funds are very easy to obtain, 54% are traditional providers, 24% are minority providers, and 24% are other providers.
- Slightly less than one-half (43%) of consulting agencies report barriers to receipt of CARE Act funds. Minority providers are significantly more likely (46%) to report barriers to such funding than traditional providers (45%) and other providers (33%).

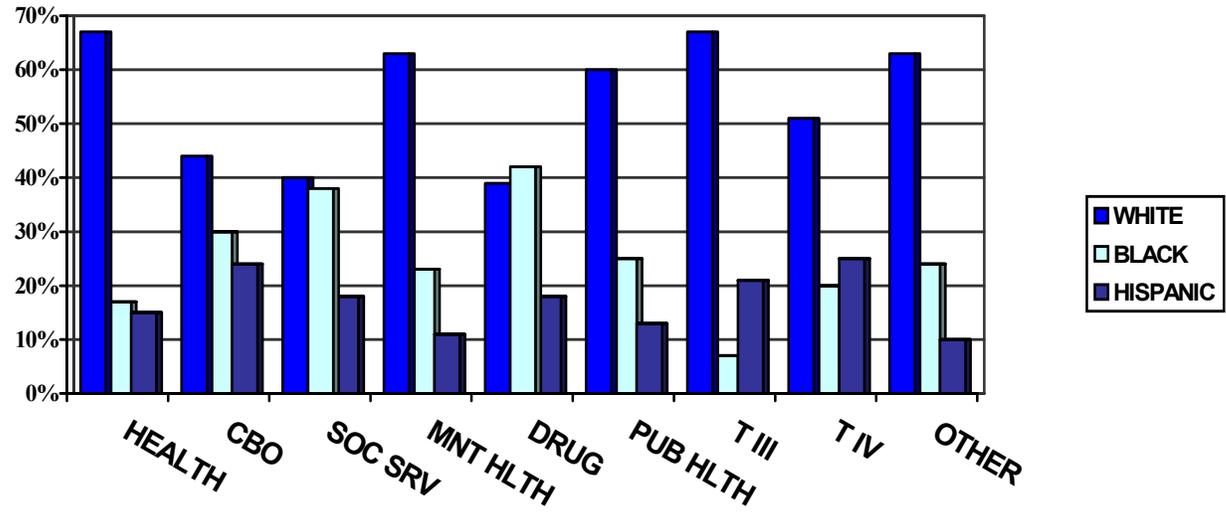
- Numerous barriers were identified in obtaining and sustaining CARE Act funding. The most consistent concern expressed was the increasing demand for services by HIV-infected individuals at a time of flat or diminished funding. Agencies expressed concern over the tradeoffs occurring in HIV financing between sustaining a social support infrastructure and gearing up to meet increasing demands for clinical care and therapeutics. There also was substantial tension expressed about sustaining funding for existing programs and broader distribution of funding across greater numbers of agencies.
- Systemic problems were identified by many respondents. The CARE Act procurement, grants management, and reporting systems are identified as being burdensome, onerous, unnecessary, and unreasonable. Grant making and reimbursement mechanisms also are identified as being highly problematic. Respondents expressed concern about the effect of administrative caps on their ability to meet increasing administrative demands and to expand service capacity and related infrastructure.
- Having a high quality, well organized, and experienced HIV program is perceived to be a distinct advantage in getting and sustaining CARE Act funding. Having a good reputation in the HIV care network and collaboration with other providers also are considered helpful. Participation in planning activities is considered advantageous, as well as the establishment of a strong relationship with grantee staff. Serving a particular high-risk population, like women or addicts, also is considered an advantage. No more important single facilitator, however, outweighs the perceived benefit of having staff available for and experienced in grant writing.

Policies and Practices to Gain Representation of Minority Providers in Planning and Resource Allocation Activities

PLANNING COUNCIL MEMBERSHIP

- Planning Council members serving in 1999 were studied. In that period, representatives of direct service agencies made up 49% of Council membership. Minority Council members made up 47% of all direct service agency representatives and 23% of all Council members. White Council members predominantly represented most types of direct service agencies, except for drug treatment programs where Blacks made up 42% of representatives and Hispanics 18%. Whites were particularly likely to represent health care, mental health, public health, Title III, Title IV, and other federally funded direct service agencies.

PERCENTAGE DISTRIBUTION BY AGENCY TYPE AND THE RACIAL/ETHNIC GROUP OF TITLE I PLANNING COUNCIL PROVIDER MEMBERS, FY 1999-2000



- Racial/ethnic minority Council members representing direct service organizations tend to be predominantly employed by social service agencies, with only 9% of Council members employed by a health care provider and 4% by a Title III grantee. Another 11% of Council members are employed by public health agencies
- There is a strong relationship between racial/ethnic group membership and the type of direct service agencies that minority Council members represent. Hispanics are more likely than Blacks to represent health care providers, CBOs, Title III grantees, and Title IV grantees. In contrast, Blacks are more likely than Hispanics to represent social service agencies, substance abuse, and other federally funded providers.
- Based on the reflectiveness criterion used, representatives of direct service agencies serving on Councils do not reflect the AIDS/HIV epidemic in Title I EMAs. Only 6% of Councils had a rate of racial/ethnic minority members representing direct service agencies that is within $\pm 10\%$ of the aggregate AIDS rate for Blacks, Hispanics, Asians, and Native Americans. The extent to which Councils reflect the HIV epidemic in minority populations is even less when comparing Council membership with the aggregate HIV rate, with only 4% of the Councils having a reflectiveness rate that was within $\pm 10\%$ of the EMA's HIV case rate.

REFLECTIVENESS FORMULA

Formula 1

$$\frac{\# \text{ of [racial/ethnic group] on Planning Council}}{\text{Total \# of Planning Council Members}} = \frac{\# \text{ of prevalent AIDS cases in [racial/ethnic group]}}{\text{Total \# of prevalent AIDS cases}}$$

Formula 2

$$\frac{\# \text{ of [racial/ethnic group] on Planning Council}}{\text{Total \# of Planning Council Members}} = \frac{\# \text{ of prevalent HIV cases in [racial/ethnic group]}}{\text{Total \# of prevalent HIV cases}}$$

Where: Racial/ethnic group includes Black/non-Hispanic, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native

SUMMARY REFLECTIVENESS ANALYSIS: TOTAL AND PERCENT OF TITLE I PLANNING COUNCILS WITH A $\pm 10\%$ DIFFERENCE BETWEEN RACE/ETHNICITY OF PLANNING COUNCIL MEMBERS AND AIDS AND HIV PREVALENCE RATES

RACE/ETHNICITY	AIDS Prevalence Rates			HIV Prevalence Rates		
	# Of EMAs W/ > 1 AIDS Case In Race Category	# Of EMAs W/In + 10%	% Of EMAs W/In + 10%	# Of EMAs W/ > 1 HIV Case In Race Category	# Of EMAs W/In + 10%	% Of EMAs W/In + 10%
Total Minority PC Members	49	27	55%	48	22	46%
Total Minority PC Members Representing Direct Service Providers	49	3	6%	48	2	4%
Black, Non-Hispanic	42	11	26%	41	9	22%
Hispanic	43	25	58%	42	25	60%
Asian	14	14	100%	13	13	100%
American Indian/Alaskan Native	6	6	100%	6	6	100%

Note: Some EMAs did not report AIDS or HIV prevalent cases in individual race/ethnicity categories.

- The disparity between Council participation among minority providers and minority AIDS and HIV rates is contributed to largely by the under-representation of Blacks on Councils. Over one-half (58%) of Councils have rates of Hispanic representatives of direct service provider agencies within 10% of Hispanic AIDS rates and 60% within 10% of Hispanic HIV rates. Rates of non-Hispanic Black minority Council members representing direct service providers are much less reflective. Only 26% of Councils have rates of Black representatives of direct service agencies that are within 10% of Black AIDS case rates in their EMAs and only 22% are within 10% of Black HIV case rates.

REGIONAL AIDS AND HIV REFLECTIVENESS SCORES		
	AIDS	HIV
West	-21 %	-21 %
Midwest	-28 %	-35 %
South	-32 %	-33 %
Northeast	-46 %	-41 %

- Regional differences were identified in the reflectiveness of direct service providers serving on Councils. Mean differences between the rate of minority representatives serving on Councils and the rate of minority AIDS cases were computed. Similar analyses were conducted using minority HIV case rates. Using Census region designations, regional differences were compared for EMAs located in the West, South, Midwest, and Northwest. Statistically significant regional differences between minority representatives of direct service providers and the AIDS epidemic among AIDS cases is greatest in the Northeast and smallest in the West. Similar statistically significant differences were identified when comparing Council membership and HIV case rates. Similar analyses were conducted comparing Black and Hispanic Council representatives and Black and Hispanic AIDS and HIV rates, with similar statistically significant results.
- The lack of reflectiveness of Councils membership based on minority representatives of direct service providers was examined to determine if there was an offset by the reflectiveness of minority representatives in general. Almost 45% of Councils are outside the reflectiveness criterion when comparing Council membership to minority AIDS rates. Over one-half (54%) of Councils are outside the reflectiveness criterion. Eighteen EMAs have reflectiveness scores that range from -.11% to -.46%, indicating that Councils are under-representative of racial/ethnic minorities based on AIDS prevalence rates in those EMAs.
- Other factors contribute to reflectiveness and representation of Councils membership. While Council members may not be minority group members, their agencies may be minority providers. Conversely, White Council members may represent minority providers. Moreover, during the time-period studied, some Councils had vacancies that have since been filled.

PRACTICES USED BY GRANTEES TO INCLUDE MINORITY PROVIDERS IN PLANNING AND RESOURCE ALLOCATION

- Groups such as Planning Councils, consortia, Statewide Coordinated Statement of Need (SCSN) advisory groups, and other HIV planning bodies heavily influence the nature and scope of the HIV care delivery and financing system. They either directly set service priorities and funding allocations or heavily influence the decisions made by government policy makers. Being “at the table” is an important means for minority providers to assure that the interests of their clients, agencies, and communities are well served.
- Title I Planning Council bylaws are silent regarding the appointment of minority providers to Councils. Based on an electronic review of all Council bylaws submitted to us by Title I grantees, no EMAs were identified that set aside Council seats for minority providers.
- Titles I and II annual reapplications were reviewed to assess the extent that grantees use committees or task forces to gain the participation of minority providers in planning, resource allocation, or service delivery. Several Planning Councils and States have established standing committees or task forces to address minority provider issues. For example, in Orange County California, a Minority Access Committee addresses capacity building and outreach of minority providers. In Florida, a minority CBO network supports community planning.

- Title II annual reapplications were reviewed to determine if grantees routinely monitor contracting by consortia with minority providers. Several states routinely require information about the minority provider status of Title II contractors and subcontractors.
- Based the results of a focus group with HAB staff, the Bureau is challenged in their ability to monitor policies and practices to gain representation of minority providers in CARE Act planning and resource allocation activities. Routine sources of information provided by CARE Act grantees to HAB, such as the Titles I and II application guidance, do not require that grantees submit information regarding their current or planned activities related to minority providers. While annual programmatic reporting does gather information regarding the minority provider status of contractors submitting service data, these data are untimely and do not address policy or practices related to the inclusion of minority providers in planning and resource allocation activities.

FACILITATORS AND BARRIERS TO PARTICIPATION IN HIV PLANNING ACTIVITIES

- Consulting agencies were asked if they participate in the various HIV planning activities. Participation rates vary significantly between minority providers and their counterparts. Traditional providers are more likely to participate in state HIV service planning groups or subcommittees than are minority providers and other providers. Traditional providers also are more likely to participate in state HIV prevention planning groups than are minority providers and other providers. Minority providers are significantly less likely than are their counterparts to participate in Title II consortia. Other providers are significantly less likely to participate in public hearings or other planning functions, with 54% of other providers, 67% of traditional providers, and 41% of minority providers participating in these activities.
- In EMAs, minority provider status is not associated with participation in Planning Councils, with participation rates varying from 44% of minority providers to 43% of traditional providers and 38% of other providers. Minority providers are significantly more likely than are their counterparts to participate in HIV prevention planning groups.
- In communities outside EMAs, traditional providers are more likely to participate in statewide HIV service planning groups (64%) than minority providers (55%) and other providers (48%). A similar pattern of participation is found for HIV prevention planning groups and public hearings.
- The relationship between types of services provided and participation in planning groups was studied among minority provider agencies. Among the minority providers responding to the consultation, the type of services provided is significantly associated with participation in statewide HIV service planning groups. About two-thirds (63%) of minority agencies providing clinical services participate compared to 54% of case management agencies and 37% of agencies providing other services. Participation in Title II consortia also varies significantly, with participation rates varying from 46% of agencies providing clinical services to 42% of agencies providing case management and 23% of agencies providing other services participating.
- Respondents identified several key factors that can help or hinder participation. Participants in planning activities are highly motivated by the desire to advocate on behalf of their agency's clients, especially for particularly disenfranchised segments of the HIV-infected community. Respondents also report that support from their agency's leadership for participation in planning activities is important. Collaboration, coordination, information gathering, and networking are strong motivators. Regardless of these factors, some of the most important facilitators associated with participation in planning are the perception of the usefulness of the planning group in furthering HIV care and the accessibility of meetings that accommodate care provision.
- Over one-half (52%) of the respondents identified one or barriers to participation in planning activities. These concerns were expressed by minority and other providers alike. Consulting agencies expressed concern that the planning process is inaccessible due to the time, location, or other aspects of the meetings. Many respondents voiced concern that participation in planning activities impaired their ability to conduct their care delivery responsibilities. Respondents commented on the

time-consuming nature of planning, the lack of staff available to participate, the lack of measurable impact, and the financial burden that participation places on their agencies. Agencies reimbursed on a fee-for-service or unit cost basis are particularly concerned that they are not allowed to claim planning time as a unit of service, often despite mandatory attendance requirements placed on them by grantees. Conflict of interest is mentioned as a concern among respondents, as is the stressful and political nature of the planning groups. Lack of representation among a wide spectrum of groups also is considered a barrier to furthering the goals of HIV care planning.

RECOMMENDATIONS

- HAB should systematically review the grant and contract systems at the State and local levels to identify ways in which those systems can be streamlined. A similar systematic review should be conducted regarding planning and resource allocation activities.
- HAB should clearly articulate CARE Act program activities and policies related to racial and ethnic minority providers.
- Funds should be earmarked to expand HAB staffing to monitor the expenditure of Minority AIDS Initiative funds, provide technical assistance (TA), organize training, and evaluate the impact of those funds on the health status of impacted community and the capacity and fiscal viability of racial and ethnic minority care providers.
- Criteria used to award funds to racial and ethnic minority providers should be sufficiently broad to reflect the various ways in which these agencies are organized and staffed.
- HAB should require grantees to submit annually a complete list of contractors receiving CARE Act, including up-to-date contact information. HAB should support the maintenance of a registry of agencies funded by the CARE Act. Such a registry could serve as a resource for information dissemination, training, and TA
- HAB should require that grantees routinely provide information regarding their policies and procedures related to the inclusion of minority providers in planning, resource allocation, and care funding.
- Administrative data collected by HAB should be disseminated to agencies funded by the CARE Act in a timely fashion to ensure its relevance in planning and evaluation activities.
- TA to agencies funded by the CARE Act should be provided at start-up and throughout the course of infrastructure development and maintenance to ensure sustainability.
- Coordination should be improved between programs within HAB charged with programmatic, policy, TA, and training focusing on racial and ethnic minority providers.
- Coordination should be improved between national organizations, HAB, NIH, and the pharmaceutical industry in the planning and conduct of clinical and other training programs to reduce redundancy and eliminate gaps.
- Clinical training programs sponsored by HAB should be conducted in a more organized fashion. Trainers should be experienced in HIV care in a variety of settings and in the treatment of the diverse populations served by the CARE Act.
- In designing clinical training programs, the multi-cultural nature of HIV care should be considered to ensure its relevance.
- HAB should facilitate the inclusion of CARE Act funded care sites in HIV clinical trial programs. Additionally, HAB should act in collaboration with NIH and the AHCPR to identify opportunities for the inclusion of clinical and non-clinical investigators in HIV sponsored research.

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Positive Outcomes, Inc.
117 Jordan Taylor Lane Harwood MD 20776 (443) 203-0305 (T) (443)
(203-0306 (F) www.positiveoutcomes.net
2001