Voices From The Field

MINORITY PROVIDERS IN THE RYAN WHITE CARE ACT: THEIR ROLES AND CHALLENGES: Report 3, 2002

INTRODUCTION

This report summarizes the results of a consultation conducted with agencies funded by the Ryan White CARE Act in FY 2000-2001. The report profiles minority providers, discusses their need for additional resources, and reviews their technical assistance (TA) and training requirements.

731 agencies, or 39% of agencies receiving CARE Act funds, identify themselves as minority providers, based on these criteria:

- 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*
- Agencies in which 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.

Another 371 responding agencies (20%) report that they have historically served minority patients or clients but do not meet the minority provider criteria. We refer to these agencies as "traditional" providers in this report. An additional 782 agencies (41%) do not meet either the minority or traditional provider criteria.

METHODS

The HIV/AIDS Bureau (HAB) of HRSA 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 2000-2001 provided 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 their consortia. All grantees provided contractor and/or consortia lists. The agency lists were unduplicated to obtain a list of CARE Act grantees. A total of 3,242 agencies were identified. They were contacted via facsimile and asked to complete a three-page consultation form. Agencies without facsimiles were sent the form via the mail. The agency response rate is 58%. Check out the POI website for more information about this project and other reports: **www.positiveoutcomes.net**

Among the 731 minority agencies studied, 12% have a board of directors made up of 51% or more racial/ethnicity minorities but do not have predominantly minority staff. Another 37% of minority agencies have a predominately minority staff but do not have a minority board. Almost one-half of minority providers (45%) have both a predominantly minority board and staff. Another 6% of minority providers operate in solo or group clinical practices in which the majority of clinicians are racial/ethnic minorities.

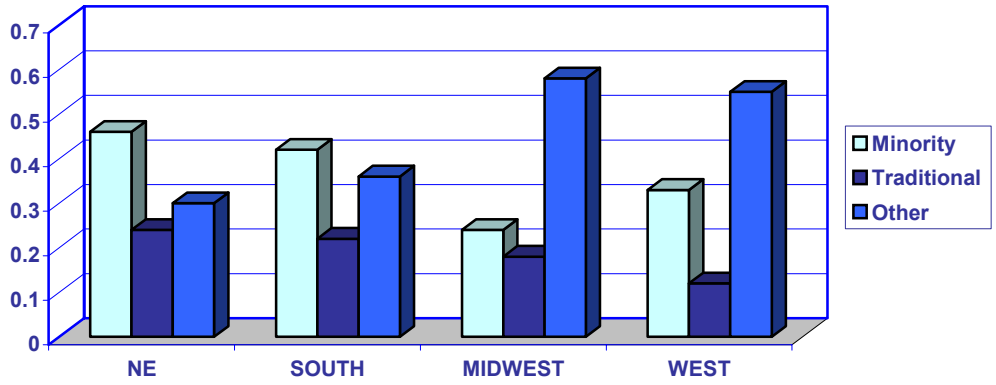
MINORITY PROVIDER STATUS AMONG RESPONDING AGENCIES FUNDED BY THE CARE ACT

Provider Status	#	%
Minority Providers		
Minority board only	89	4.7
Minority staff only	269	14.3
Minority board and minority staff	328	17.4
Minority board, minority staff, and solo/group practice	17	0.9
Minority staff and solo/group practice	3	0.2
Minority board and solo/group practice	2	0.1
Solo/group practice only	23	1.2
Traditional Providers	371	19.7
Other Providers	782	41.5
Total	1,884	100.0

GEOGRAPHIC CHARACTERISTICS OF MINORITY PROVIDERS

Significant regional differences were identified in the proportion of CARE Act providers that meet the minority provider criteria. Almost one-half (46%) of Northeastern agencies meet the minority provider criteria, compared to 42% of Southern providers, 33% of Western providers, and 24% of Midwestern providers ($p < 0.05$). Among minority providers, 31% are located in the Northeast, 41% in the South, 18% in the West, and 10% in the Midwest. Agencies located in the Northeast are 2.7 times more likely to be a minority provider than Midwestern agencies. Southern agencies are 2.3 times more likely than Midwestern agencies to be a minority provider.

PERCENTAGE DISTRIBUTION OF AGENCIES, BY CENSUS REGION AND MINORITY PROVIDER STATUS

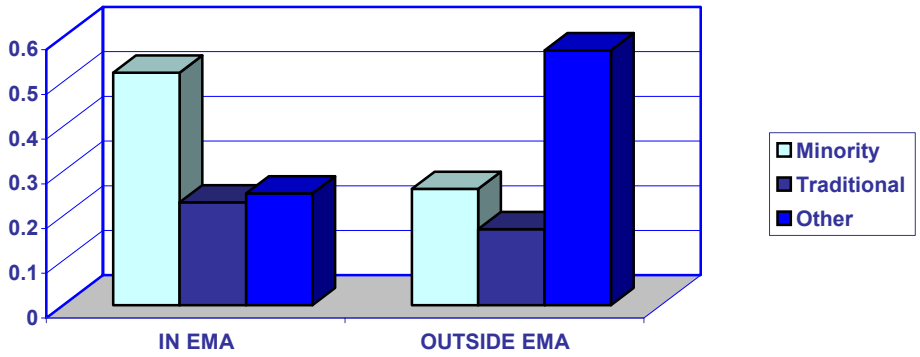


Minority providers tend to be located in Title I EMAs ($p < 0.05$). Three-quarters (64%) of minority providers are located in EMAs, while 36% are located in communities outside of EMAs. In contrast, only 26% of agencies in communities outside of EMAs meet the minority provider criteria.

In EMAs, 52% of agencies are minority providers, 23% are traditional providers, and 25% are other providers. In contrast, in communities outside EMAs, 57% of agencies are other providers, 26% are minority providers, and 17% are traditional providers.

The distribution of non-minority providers varies geographically, with significant regional differences found in the distribution of traditional and other providers. For example, a quarter of Northeastern agencies (24%) are traditional providers, compared to 22% of Southern agencies, 18% of Midwestern agencies, and 12% of Western agencies. In contrast, other providers make up 58% of Midwestern agencies, 55% of Western agencies, 29% of Northeastern agencies, and 36% of Southern agencies.

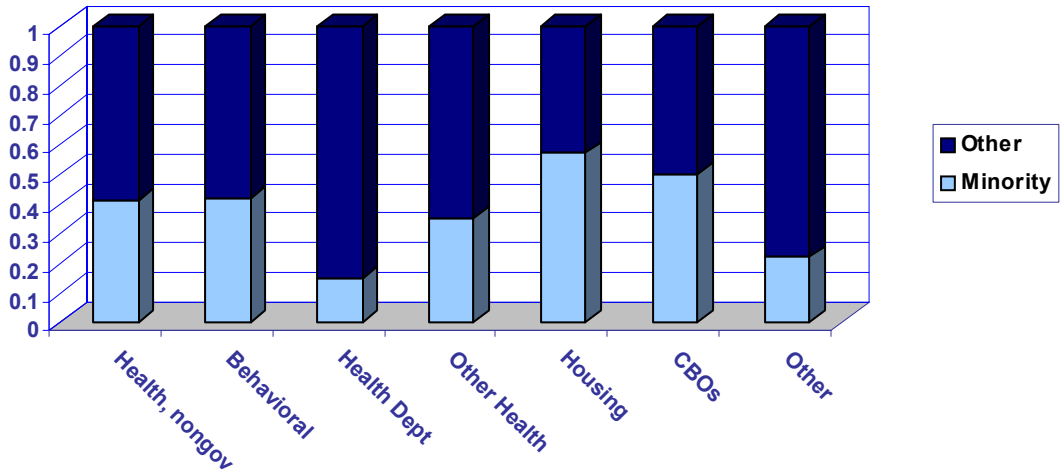
PERCENTAGE DISTRIBUTION OF AGENCIES, BY LOCATION IN A TITLE I EMA AND MINORITY PROVIDER STATUS



ORGANIZATIONAL STRUCTURE OF MINORITY PROVIDERS

Minority providers operate in a variety of organizational settings. Almost one-half (40%) of minority providers are community-based organizations (CBOs) such as AIDS service organizations (ASOs) or organizations operated by persons living with HIV/AIDS. Another 29% of minority providers are non-government health agencies such as hospitals or hospital-based clinics, solo or group private medical practices, or publicly funded community health centers (CHCs). Another 8% of minority providers are behavioral health agencies (publicly funded community mental health or drug treatment centers), 5% are health departments, 9% are other health agencies, 4% are housing programs, and 5% operate in other settings. The distribution of minority providers among organizational settings varies significantly ($p < 0.05$) from non-minority providers who are more likely to be health departments or other type of agency.

PROPORTION OF MINORITY AND OTHER PROVIDERS, BY ORGANIZATIONAL TYPE



Within organizational settings, the rate of minority providers varies significantly ($p < 0.05$). Housing programs have the highest proportion of minority providers (57%), followed by CBOs (50%), behavioral health agencies (42%), and non-government health agencies (41%). The rate of minority providers is lower for other organizational settings, including 15% of health departments, 35% of other health agencies, and 22% of other types of non-health agencies.

The minority provider criteria that agencies meet are significantly associated with their organizational setting ($p < 0.05$). Over one-half of minority CBOs (51%), 47% of behavioral health agencies, and 44% of non-governmental health agencies meet the minority provider criteria based on their boards *and* staff compared to 42% of housing programs and 17% of health departments. Agencies located in these other settings tend to meet the minority provider criteria based on their staffing alone. In contrast, 74% of health departments and 55% of housing programs meet the criteria based on staffing only compared to 36% of CBOs, 40% of behavioral health agencies, and 26% of non-governmental health agencies.

SERVICES PROVIDED BY MINORITY PROVIDERS

CARE Act providers offer a wide array of services that are supported by the CARE Act and other payers. Responding agencies provide almost 100 different types of clinical, case management, employment, housing, prevention, and social and clinical support services.

Minority providers constitute 40% of agencies that provide clinical services, 45% of agencies providing case management but not clinical services, and 30% of agencies providing other non-clinical and non-case management services. Traditional providers make up 23% of agencies that provide clinical services, 16% of agencies providing non-clinical case management, and 20% of agencies providing non-clinical, non-case management services. Other providers represent 37% of agencies that provide clinical

services, 39% of agencies providing non-clinical case management, and 50% of agencies providing non-clinical non-case management services.

Minority providers are significantly more likely ($p < 0.05$) than their counterparts to provide core HIV services including: case management, child day care, drug treatment, health education and risk reduction, treatment adherence counseling, HIV counseling and testing, outreach, HIV prevention, support groups, and transportation. Minority providers also are more likely than their counterparts to provide other support services including: referrals to clinical trials, developmental assessment, housing assistance, employment/vocational services, advocacy, translation/interpreter services, and complementary services.

No significant differences were found between minority and other providers in the likelihood that they provide primary care, specialty care, mental health, dental care, buddy/companion services, emergency assistance, food bank/home delivered meals, rehabilitation, nutritional services, adult day care, child welfare services, or legal services.

PERCENTAGE OF AGENCIES PROVIDING CORE HIV SERVICES, BY MINORITY PROVIDER STATUS

SERVICE	% OF TOTAL AGENCIES PROVIDING THE SERVICE	% OF MINORITY AGENCIES PROVIDING THE SERVICE	% OF OTHER AGENCIES PROVIDING THE SERVICE
Buddy services	16%	17%	16%
Case management*	60%	69%	54%
Child day care*	5%	8%	4%
Dental care	19%	21%	18%
Drug treatment*	23%	27%	20%
Emergency assistance	30%	28%	30%
Food bank/home delivered meals	28%	30%	27%
Health education, risk reduction, etc.*	56%	63%	52%
Treatment adherence*	37%	42%	34%
HIV counseling and testing*	50%	54%	47%
Home health*	8%	6%	10%
Mental health	36%	37%	35%
Outreach, case finding, etc.*	34%	45%	27%
Prevention*	30%	34%	27%
Primary care	32%	34%	30%
Specialty care	22%	21%	22%
Support groups*	43%	48%	40%
Transportation*	39%	45%	36%

* Significant Chi-square at $p < 0.05$ or less

SOURCES OF FUNDING

CARE Act providers tend to rely heavily on Title I and II funds to support their HIV programs. In EMAs, 60% of agencies report that Title I is their only source of CARE Act funds. Receipt of Title I funds only is most common for non-minority, non-traditional providers, with 59% of minority providers receiving Title I funds only compared to 53% of traditional providers and 68% of these other providers ($p < 0.05$). In contrast, no providers were identified in EMAs that only receive Title II funds. Receipt of both Title I and II funds is common, with 15% of minority providers, 17% of traditional providers, and 15% of other providers receiving funds from both sources.

In communities outside EMAs, 67% of agencies report that Title II is their only source of CARE Act funds. Minority providers outside of EMAs are significantly less likely ($p < 0.05$) to receive only Title II (50%) than traditional providers (61%) and other providers (76%). Minority providers outside of EMAs also are more likely to receive Title III or Title IV funds than other providers ($p < 0.05$).

HIV agencies commonly manage multiple CARE Act funding streams. Over one-third (40%) 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 40% of minority providers receiving combination funding compared to 46% of traditional providers and 32% of other providers.

Combination funding is less common for communities outside of EMAs than in EMAs. Only 12% of consulting agencies outside of EMAs report that two or more CARE Act funding streams support their programs. In communities outside of EMAs, minority providers are significantly more likely than non-minority providers to receive a combination of funds (18% versus 10%) ($p < 0.05$). Approximately 16% of traditional providers and 8% of other providers receive a combination of funds.

The relationship between types of service provided and sources of funding were evaluated. Agencies providing clinical services are significantly more likely than case management agencies or agencies providing other services to participate in Medicaid managed care, Medicaid fee-for-service, Title III, Medicare, commercial managed care, or private insurance. In contrast, agencies providing case management are significantly more likely than other agencies to receive Title II, CDC prevention funds, State or local funds, or charitable contributions. Agencies providing clinical services are significantly less likely (17%) than case management providers (32%) and other agencies (38%) to receive Title I funds only ($p < 0.05$). Other service agencies are less likely (6%) than clinical and case management agencies (18% each) to receive CDC counseling and testing funds. These other service agencies also are less likely to receive other Federal funds.

Minority clinical providers (57%) and traditional clinical providers (52%) are more likely to receive Title I funding than other providers of clinical services (26%; $p < 0.05$). Non-minority clinical providers are significantly more likely to receive Title II funds than minority clinical providers, with 55% of traditional clinical providers and 60% of other clinical providers receiving Title II funds compared to 36% of minority clinical providers ($p < 0.05$).

Minority agencies providing case management are significantly more likely to receive Title I funds than clinical or other providers ($p < 0.05$). Over two-thirds (69%) of minority case management providers receive Title I funds, compared to 52% of traditional providers and 27% of other providers. In contrast, minority case management providers are the least likely to receive Title II funds ($p < 0.05$). While 43% of minority providers receive Title II funds, 54% of traditional providers and 80% of other providers receive Title II funds.

PERCENTAGE OF AGENCIES RECEIVING SOURCES OF FUNDING, BY TYPE OF SERVICES PROVIDED

Funding Source	% of Agencies Providing Clinical Services	% of Agencies Providing Case Management	% of Agencies Providing Other Services
Title I funds only*	17%	32%	38%
Title II funds only*	26%	42%	38%
Title III funds only*	14%	1%	6%
Title IV funds only	2%	3%	2%
Medicaid fee-for-service*	59%	20%	15%
Medicare*	50%	5%	11%
Medicaid managed care*	39%	8%	9%
Commercial managed care*	24%	3%	5%
Private insurance*	45%	5%	13%
CDC counseling/testing funds*	18%	18%	6%
CDC prevention funds*	17%	27%	8%
Other federal funds*	20%	20%	8%
Other state/local funds*	44%	54%	28%
Charitable contributions*	31%	58%	33%

* Significant Chi-square at $p < 0.05$ or less

Minority and traditional providers that offer services other than clinical care and case management were significantly less likely (35% and 36%, respectively) than other providers (56%) to receive Title II funds ($p < 0.05$). Non-minority agencies that do not provide clinical care or case management also are significantly more likely than minority or traditional providers ($p < .05$) to receive Medicaid fee-for-service reimbursement, Medicaid managed care capitation, Medicare, and private insurance.

Third party insurers such as Medicaid, Medicare, and commercial insurance are more likely to cover the types of services provided by clinical providers than case management and other agencies. Agencies

providing case management are more likely to receive CDC prevention funds, State or local funds, and charitable contributions than those agencies providing clinical services or other non-clinical, non-case management services.

Minority providers are significantly more likely to receive CDC prevention funds and charitable contributions than are non-minority providers. Non-minority providers are significantly more likely to receive Medicare funds, commercial managed care, or private fee-for-service reimbursement. There is no association between minority provider status and receipt of State or local funds, Medicaid fee-for-service reimbursement, Medicaid managed care, or CDC counseling and testing funds.

FACTORS ASSOCIATED WITH MINORITY PROVIDER STATUS

Several factors are associated with being a minority provider:

- Non-government health agencies including hospitals, hospital-based clinics, CHCs, or office-based solo or group practices are 4.2 times more likely than health departments to be a minority provider. CBOs are 5.9 times more likely than health departments to be a minority provider. Non-government health agencies (e.g., hospitals, hospital-based clinics, CHCs, or office-based solo or group practices) in EMAs are 3.6 times more likely than health departments to be a minority provider. CBOs in EMAs are 5.0 times more likely than health departments to be a minority provider.
- Agencies providing case management are 1.5 times more likely to be minority providers than agencies providing psychosocial support or other services. Agencies offering psychosocial support or other services are 0.6 times less likely to be minority providers than clinical and case management agencies. Agencies in EMAs providing case management are 1.9 times more likely to be a minority provider than agencies providing services other than clinical care or case management. Agencies in EMAs offering other psychosocial support services are 0.5 times less likely to be minority providers than clinical and case management agencies.
- Agencies receiving Title II are 0.4 times less likely to be a minority provider than agencies receiving Title I funds. Agencies receiving private fee-for-service insurance are 0.4 times less likely to be a minority provider than agencies receiving Title I. Agencies receiving CDC counseling and testing funds are 0.6 times less likely than agencies receiving Title I to be a minority provider. In turn, agencies receiving other state or local funding are 0.6 times less likely than agencies receiving Title I to be a minority provider.

MINORITY PROVIDER'S PARTICIPATION IN HIV PLANNING ACTIVITIES

Planning Councils, consortia, 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. In an earlier study conducted by POI, minority providers stated that "being at the table" is an important means to assure that the interests of their clients, agencies, and communities are well served.

Participation rates of minority providers vary by type of planning body. Minority providers are significantly more likely than their counterparts ($p < 0.05$) to participate in state HIV/AIDS prevention planning groups, HIV housing planning groups, and HIV/AIDS public hearings. Minority providers are significantly less likely to participate in Title II consortia than are traditional or other providers. In addition, traditional providers and minority providers are more likely to participate in other organized HIV/AIDS services planning groups than other providers. There was no significant difference between the different types of providers in participation in their rates of state HIV/AIDS services planning groups or ADAP advisory groups.

RATES OF PARTICIPATION IN HIV PLANNING GROUPS BY MINORITY AND OTHER PROVIDERS			
PLANNING GROUP	% MINORITY PROVIDERS	% TRADITIONAL PROVIDERS	% OTHER PROVIDERS
State HIV Services Planning Group	55%	54%	49%
ADAP Advisory Group	15%	13%	14%
Title I Planning Council	50%	47%	43%
Title I Planning Council Committees	47%	48%	46%
Title II Consortia*	36%	42%	41%
HIV Prevention Planning Group*	46%	40%	37%
HIV Housing Planning Group*	31%	26%	24%
HIV/AIDS Public Hearings*	64%	60%	47%
Other HIV/AIDS Services Planning Group*	65%	64%	47%
* Significant Chi-square at $p < 0.05$ or less			

In EMAs, minority provider status is not associated with participation in Planning Councils. Participation rates vary from 55% of minority providers to 52% of traditional providers and 58% of other providers. Minority provider status is significantly associated ($p < 0.05$) with participation in statewide HIV prevention planning groups, with 46% of minority providers, 32% of traditional providers, and 38% of other providers participating in these groups. Minority provider status also is significantly associated with participation in HIV/AIDS public hearings, with 69% of minority providers, 64% of traditional providers, and 60% of other providers participating in these groups. In EMAs, there is no significant difference between minority and other providers in their participation in statewide HIV services planning groups, ADAP advisory groups, Title I Planning Council committees, Title II consortia, HIV housing planning groups, or other organized HIV/AIDS services planning activities.

Consulting agencies were asked if they participate in the following activities:

- State HIV/AIDS service planning groups or subcommittees,
- State HIV/AIDS prevention planning groups or subcommittees,
- AIDS Drug Assistance Program (ADAP) advisory groups,
- Title I Planning Councils or their committees,
- Title II consortia,
- HIV housing planning groups,
- Public hearings or other planning functions, or
- Other organized HIV/AIDS services planning activities.

In communities outside EMAs, traditional providers are more likely to participate in statewide HIV service planning groups (57%) than minority providers (55%) or other providers (46%). A similar pattern of participation is found for HIV prevention planning groups, Title II consortia, and public hearings. There is no significant difference between minority and other providers in their participation in ADAP advisory groups and HIV housing planning groups. Minority providers outside of EMAs are more likely than their counterparts to participate in Title I Planning Council committees and in other organized HIV/AIDS services planning groups.

The relationship between types of services provided by minority providers and their participation in planning groups was studied. Among minority providers, the type of services provided is not significantly associated with participation in statewide HIV service planning groups. About two-thirds (60%) of case management agencies participate compared to 55% of clinical agencies and 48% of agencies providing other services. Participation in statewide HIV prevention planning groups does vary significantly ($p < 0.05$) with type of services provided, with participation rates ranging from 55% for case management agencies, 46% for clinical services agencies, and 32% for agencies providing other services participating. The type of services provided is also significantly associated with participation in ADAP advisory groups, with participation rates varying from 22% for agencies providing clinical services to 14% for agencies providing case management and 8% for agencies providing other services. Participation in Title II consortia varies significantly, with participation rates varying from 41% for agencies providing clinical services to 38% of agencies providing case management and 21% of agencies providing other services participating. Almost one-half (47%) of case management agencies participated in HIV housing planning groups compared to 21% of agencies providing clinical services and 21% of agencies providing other services ($p < 0.05$). Participation in HIV/AIDS public hearings varied significantly, with 76% case management agencies, 59% of agencies providing clinical services, and 53% of agencies providing other services indicating involvement with these activities. Over three-quarters (76%) of agencies providing

case management participate in other organized HIV/AIDS services planning activities compared with 63% of clinical providers, and 52% of other service providers ($p < 0.05$).

Among minority provider agencies located in EMAs, participation in statewide HIV services planning groups and Title I Planning Council Committees is not associated with the type of service provided. In contrast, participation in statewide HIV prevention planning groups, Title I Planning Council, HIV housing groups, HIV/AIDS public hearings, or other organized HIV/AIDS services planning activities are significantly associated with the type of service provided ($p < 0.05$). Over one-half (52%) of minority agencies providing case management participate in statewide HIV prevention planning groups compared to 46% of agencies providing clinical services and 37% of agencies providing other services. Minority case management agencies are more likely than other minority agencies to participate as a member of Title I Planning Council (55%) than agencies providing clinical (52%) or other services (37%). Minority case management agencies also are more likely to participate in HIV housing groups (49%) than clinical agencies (24%) or agencies providing other services (24%). Participation in HIV/AIDS pubic hearings was greatest for minority agencies providing case management services (77%) compared to 69% participation by clinical providers and only 57% participation for other agencies. Minority case management agencies were also more likely to participate in other organized HIV/AIDS services planning activities (78%) compared to 63% of agencies providing clinical services and 57% of agencies providing other services.

MINORITY PROVIDER STATUS AND THE ADEQUACY OF HIV PROGRAM RESOURCES

CARE Act providers tend to report that funding and staffing currently are inadequate. Almost two-thirds of responding agencies (63%) indicate that they do not have enough funding for their HIV program to meet the needs of clients or patients that they currently serve. Almost one-half (47%) report that they do not have enough direct service staff to meet the needs of their service population.

Minority providers are significantly more likely ($p < 0.05$) than non-minority providers to respond that their program does not have enough direct service staff (55% versus 41%), non-direct service staff (53% versus 38%), physical capacity (51% versus 38%), non-personnel resources (50% versus 35%), or funding for their HIV program (70% versus 58%).

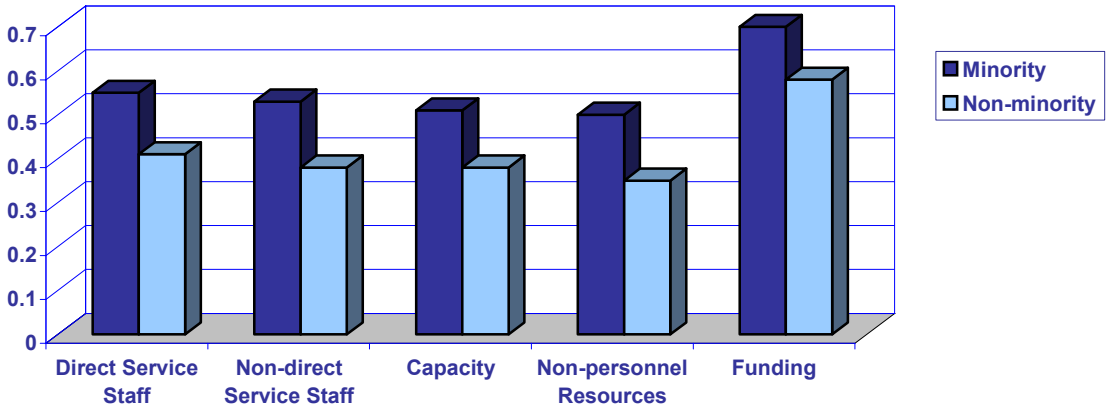
The most frequently identified unmet needs do not vary significantly between minority and non-minority providers:

- Among agencies needing direct service staff, case managers, nurses, and doctors were most commonly needed.
- Providers listed clerical staff, support staff, and data entry personnel as the most commonly needed non-direct service staff.
- Office space, storage space, and interview/counseling space were listed as the most common unmet physical capacity requirements.
- Computers, printers, and software were the most commonly needed non-personnel resources.
- Funding for direct services, operations, and more staff were identified as the most common funding needs.

Identifying Resource Needs

Consulting agencies were asked to think about the number and types of clients/patients that their program currently serves and indicate the adequacy of their HIV program resources in meeting their service needs. The consultation focused on five specific resources: direct service staff, non-direct service staff, physical capacity for the program, non-personnel resources such as computer hardware and software, telephone lines, and office supplies, and funding for the program. If the agency felt that any of these resources were not adequate, they were asked to lists the top three needs within each category.

PERCENTAGE OF AGENCIES WITH NEED FOR RESOURCES, BY MINORITY PROVIDER STATUS

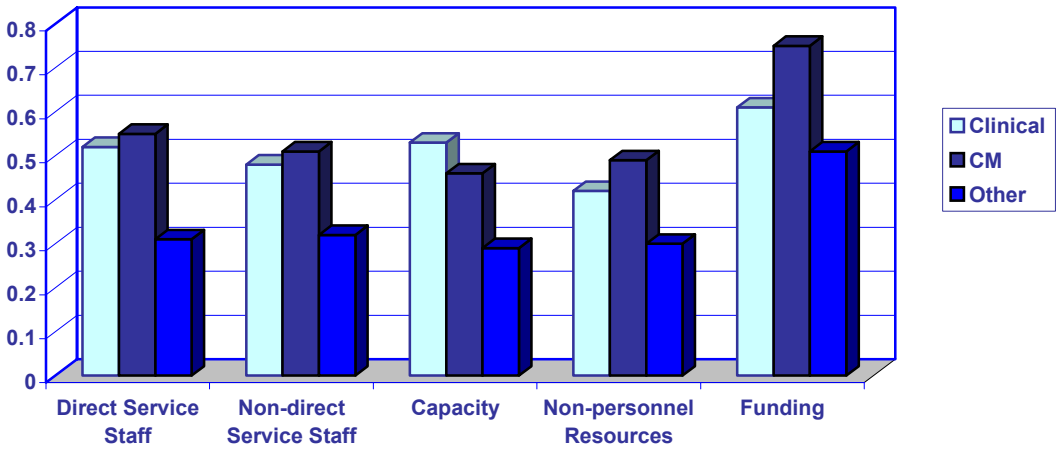


For agencies in an EMA, minority status was significantly associated with the need for direct service staff, non-direct service staff, and funding ($p < 0.05$). Minority provider status was not associated with the need for more physical capacity for the agency's HIV program or with the need for more non-personnel resources.

For agencies outside of an EMA, minority provider status was significantly associated with the need for direct service staff, non-direct service staff, physical capacity, non-personnel resources, and funding. Minority and non-minority agencies identified the same top unmet needs for all resources but physical capacity needs and non-personnel resources. For minority providers in communities outside an EMA, the top three capacity needs were office, storage, and records space. The top three non-personnel resources were computers, telephone lines, and software.

The adequacy of an agency's HIV program resources varied by type of the services provided. Case management agencies are significantly more likely ($p < 0.05$) than clinical and other types of agencies to feel that their program does not have enough direct service staff (55% case management versus 52% clinical and 31% other), non-direct service staff (51% case management versus 48% clinical and 32% other), non-personnel resources (49% case management versus 42% clinical and 29% other), and funding (75% case management versus 61% clinical and 51% other). Clinical programs were significantly more likely to indicate that the physical capacity of their program was inadequate than other types of providers. Over one-half (53%) of these clinical agencies said that they needed more physical capacity versus 46% of case management agencies and 29% of other service agencies ($p < 0.05$).

PERCENTAGE OF AGENCIES WITH NEED FOR HIV PROGRAMMATIC RESOURCES, BY SERVICE TYPE



The top resource needs vary slightly by service type. Non-clinical, non-case management agencies list lawyers as one of their top needs for direct service staff. Case management agencies list case manager supervisors as a top need for non-direct service staff. Non-clinical, non-case management agencies identify the need for administrative staff. Clinical providers list exam rooms as one of their top needs.

Minority provider status is significantly associated with differentials in unmet need:

- Minority clinical providers are significantly more likely than their counterparts ($p < 0.05$) to report needing more non-direct service staff (57% minority versus 42% non-minority), more physical capacity (62% minority versus 47% non-minority), more non-personnel resources (51% versus 36%), and additional funding (67% minority versus 57% non-minority). Traditional clinical providers were more likely to need additional direct service staff.
- Minority case management providers (51%) are significantly more likely than non-minority case management providers (41%) to report needing more physical capacity ($p < 0.05$).
- Minority providers who offer non-clinical and non-case management support services are more likely than their counterparts ($p < 0.05$) to report that their HIV program lacked direct service staff (45% versus 26%), non-direct service staff (43% versus 28%), physical capacity (35% versus 27%), non-personnel resources (42% versus 25%), and funding (64% versus 46%).

HIV PROGRAM STAFF'S SKILLS AND ABILITIES AND NEED FOR TA

Agencies were asked to rate their HIV program's skill level as great, good, or poor for a variety of topics. They also were asked to indicate if their program needs TA in those topics. Minority providers were significantly more likely than others to rate their ability as great in finding the health care and support service needs of people living with HIV/AIDS in their community who are not being served ($p < 0.05$). A quarter (25%) of minority providers rate their program as great in conducting such needs assessment, 58% as good, and 17% as poor. In contrast, only 16% of non-minority providers rate their program as great, 54% as good, and 30% as poor.

Although minority providers tend to rate their HIV programs' skill level as relatively higher than their counterparts, they are significantly more likely ($p < 0.05$) than non-minority providers to indicate a need for TA for all the skills and abilities listed in the consultation form. The two exceptions are developing linkages with other HIV organizations in their community and finding out the health care and support service needs of people living with HIV/AIDS in their community who are not being served.

Regional differences were identified in the rate of TA requests for some topics. Among agencies located in an EMA, the need for TA for managing and reporting data for individual clients and for developing clinical outcome measures is not associated with minority provider status. In communities outside an EMA, there are no differences in the rate of TA required by minorities and their counterparts for using computer hardware and software, providing support services that lead to improved health outcomes, providing HIV care that meets Public Health Service guidelines, developing a quality assurance program, developing clinical outcome measures, or evaluating how well the agency provides care and services.

After controlling for type of service provided, minority provider status is significantly associated with the rating of skills and abilities. Minority case management agencies rate themselves higher than non-minority case management agencies in providing HIV care that meets PHS guidelines, with 42% of minority agencies reporting being great compared to 28% great for non-minority providers. Over one-half (58%) of minority case management providers also rate themselves as being great at developing linkages with other HIV organizations compared to 47% of non-minority case management providers. Minority case management agencies also rate themselves highly for finding out the health care and support service needs of people with HIV/AIDS in the community, with 29% of minority providers rating themselves as great compared to 14% of non-minority case management providers ($p < 0.05$).

After stratifying by type of services provided, differences were also identified between minority and other providers in their need for TA. Among clinical providers, the need for TA in organizational management was significantly higher ($p < 0.05$) for minority providers (11%) than among non-minority providers (5%).

Minority case management organizations are more likely than non-minority case management providers to report the need for TA in developing linkages with other HIV organizations, organizational management, knowing when and how to grow, and getting more funds.

Minority agencies that provide services other than clinical care and case management are less likely than their non-minority counterparts to report the need for TA in developing clinical outcome measures, developing linkages with other HIV organizations, and finding out the health care and support service needs of people with HIV/AIDS in the community.

MINORITY PROVIDERS' RATING OF THEIR PROGRAM'S SKILLS AND ABILITIES AND THEIR NEED FOR TECHNICAL ASSISTANCE (TA)

Skills and Abilities	Minority Provider	% Rated Great	% Rated Good	% Rated Poor	% Needing TA
Using computer hardware and software	Yes	15	76	9	22*
	No	16	76	9	16
Managing and reporting data and information for individual clients/patients	Yes	20	70	10	18*
	No	19	71	10	12
Providing support services that lead to improved health outcomes	Yes	36	60	4	10*
	No	34	63	3	6
Providing HIV care that meets Public Health Service guidelines and established HIV clinical practices	Yes	48	50	2	5*
	No	45	53	2	3
Developing a quality assurance program	Yes	19	66	15	26*
	No	17	65	18	19
Developing clinical outcome measures	Yes	20	64	16	21*
	No	16	65	19	15
Evaluating how well you provide care and services to your clients/patients	Yes	21	68	11	23*
	No	20	67	13	17
Developing linkages with other HIV organizations in your community	Yes	47	48	5	6
	No	44	49	7	5
Finding out the health care and support service needs of people living with HIV/AIDS in your community not receiving services	Yes*	25	58	17	16
	No	16	54	30	17
Organization management (e.g., planning, grievance procedures, Board of Directors, purchasing)	Yes	31	62	7	15*
	No	26	68	6	6
Knowing when and how to grow, expand or develop your organization	Yes	20	67	13	25*
	No	16	70	14	15
Financial management (e.g., accounting systems, unit cost development, managed care contracting, third party reimbursement)	Yes	25	64	11	19*
	No	24	67	9	11
Getting more funding (e.g., grant writing, fund raising)	Yes	13	65	22	34*
	No	11	64	25	23

* Significant Chi-square at $p < 0.05$ or less

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