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HIV PREVENTION NEEDS ASSESSMENT IN NORTHEAST COLORADO

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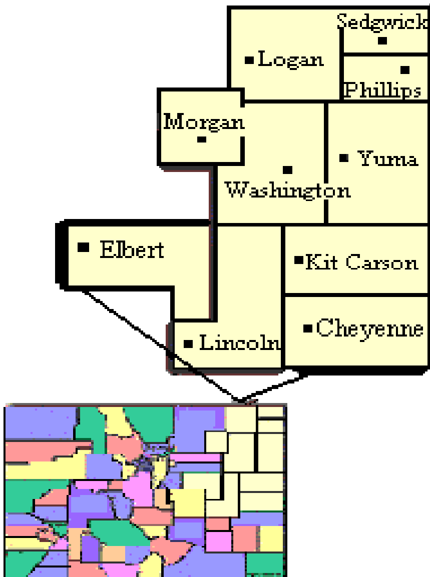
Overview of the 10 county region and History of HIV/AIDS Prevention Efforts



The Eastern Plains of Colorado is home to 105,870 residents and spans 17,626 square miles. The 10 counties within this region are very rural and eight of them are designated by the federal government as "frontier" counties. Because communities throughout Northeast Colorado are so rural and distances so great among communities, resources are very limited. Regional agencies such as Centennial Mental Health, Eastern Colorado Services for the Developmentally Disabled, and the Colorado Workforce Center provide services in all ten counties and Northeast Colorado Health Department provides services in six of the ten counties. Some of these agencies do not even have offices in all counties. Services are often very limited and residents often have to travel great distances for the services that may be available. Washington County, for example, has no hospital and no fulltime physician.

Rural communities such as those in Northeast Colorado face particular challenges in delivering HIV services to high-risk populations. Large geographic space is coupled with low population density to limit the array of services that can be offered. More generally, behaviors that are associated with higher risks of HIV infection are stigmatized and not openly acknowledged. Possibly as a consequence of this, some people in the region, particularly youth, believe that no one with HIV resides in the region and therefore they do not have to take protective measures.

Data Sources for the Needs Assessment

In a diverse, wide-spread region such as Northeast Colorado, data are not stored in one centralize placed, so multiple methods were utilized to acquire the data needed for the needs assessment. Data were acquired in the following methods:

- Information was culled from the comments of agency directors and other professionals that attended the Needs Assessment Planning Conference.
- Forty-seven providers throughout the 10 county region completed an electronic survey regarding what they perceived as the current state of HIV prevention activities in the region as well as their community's needs for HIV prevention activities.
- Twelve key informants, at least one from each county, completed a community readiness interview to assess how prepared their community currently was to implement HIV prevention activities. This interview included questions about current prevention activities, planning for new activities, as well as community support for current and anticipated activities.
- Data that could not be obtained from the planning conference or the survey were requested from the Northern Colorado AIDS Project, SALUD, from family planning clinics in Fort Morgan and Sterling through the Northeast Colorado Health Department, Colorado Health Information Dataset, One Morgan County, and Centennial Mental Health.

Chapter 1: Measurable objectives

1. Geographic availability of HIV prevention services

Summary: HIV prevention services are limited in the region. There are a wide range of STD educational efforts that sometimes incorporate HIV prevention information. At the high school level, nurses from family planning clinics provide 1-5 hours of instruction which often has a heavy emphasis on abstinence and little emphasis on HIV/AIDS. For the adult population, the majority of STD educational efforts are targeted toward heterosexual Caucasian women. This is not intentional; rather it reflects the population that tends to seek health care services in the region.

Table 1.1 HIV Prevention Activities by County

County	HIV Prevention Activity
Cheyenne	• Cheyenne County Public Health ▪ provides literature on HIV/AIDS prevention ▪ conducts annual presentation in two public school districts for 5th and 6th grade youth on reproductive health, including HIV/AIDS and other STDs.
Elbert	• Elbert County Public Health - Family Planning Program staff (nurses): ▪ conducts an assessment of client risk for HIV ▪ refers clients to larger medical facilities (e.g. Denver Health or the community health center in Colorado Springs) for HIV screening (testing) ▪ provides literature on HIV/AIDS prevention • The Public Health nurses provide classes to the public schools on reproductive health, including HIV/AIDS and other STDs.
Kit Carson	• Women's Health Program provides counseling on STDs and condoms. ▪ Interviews clients for risks and identifies resources for testing. ▪ Prenatal care program provides resources and referrals for pregnant clients who are HIV+. • Health Department provides education and health services in the schools. ▪ Health Department nurses provide a one week (one hour/day for 5 days) sexuality education program for 9th grade students that includes pregnancy and STD prevention with a focus on abstinence. ▪ The Health Department Family Planning Clinic includes information on STD prevention, but not specific to HIV/AIDS.
Lincoln	• Health Department has literature on HIV/AIDS prevention
Logan	• Heath Department - Family Planning Program staff: ▪ provides HIV risk assessments ▪ refers clients to NCAP for screening and testing ▪ provides information about HIV if requested • HIV and HCV outreach with Kidz Ark by NCAP. ▪ Kidz Ark is a Therapeutic residential child care facility in Sterling CO. • Presentation in the college dormitories by Nurse Practitioner on STI transmission, treatment and prevention every fall. STI testing is available in the Student Health Center. • Family Planning program staff at the Health Department refers individuals to NCAP for HIV testing and screening • Rural Communities Resource Center has some activities
Morgan	• Heath Department - Family Planning Program staff: ▪ provides HIV risk assessments ▪ refers clients to NCAP for screening and testing ▪ provides information about HIV if requested

Table 1.1 HIV Prevention Activities by County (continued)

County	HIV Prevention Activity
Phillips	• Heath Department - Family Planning Program staff: ▪ provides HIV risk assessments ▪ refers clients to NCAP for screening and testing ▪ provides information about HIV if requested • The Public Health nurses provide classes to the public schools on reproductive health, including HIV/AIDS and other STDs. • Holyoke Hospital has HIV testing available, based on CDC recommendations for screening
Sedgwick	• Heath Department - Family Planning Program staff: ▪ provides HIV risk assessments ▪ refers clients to NCAP for screening and testing ▪ provides information about HIV if requested • The Public Health nurses provide classes to the public schools on reproductive health, including HIV/AIDS and other STDs.
Washington	• Heath Department - Family Planning Program staff: ▪ provides HIV risk assessments ▪ refers clients to NCAP for screening and testing ▪ provides information about HIV if requested • Rural Health Communities Resource Center has a Women's Health Program and Regular Health Program that includes ▪ a library of information on STDs including HIV ▪ handouts for women, teens and men ▪ booklets with information on testing and what to do after a diagnosis. ▪ free condoms ▪ referrals to the health department ▪ presentations at schools, health and safety fairs • The Public Health nurses provide classes to the public schools on reproductive health, including HIV/AIDS and other STDs.
Yuma	• Heath Department - Family Planning Program staff: ▪ provides HIV risk assessments ▪ refers clients to NCAP for screening and testing ▪ provides information about HIV if requested • Rural Health Communities Resource Center has a Women's Health Program and Regular Health Program that includes ▪ a library of information on STDs including HIV ▪ handouts for women, teens and men ▪ booklets with information on testing and what to do after a diagnosis. ▪ free condoms, promote condom use ▪ referrals to the health department ▪ presentations at schools, health and safety fairs • Young women's leadership development group (ESTRELLAS) engages in HIV/AIDS prevention activities. • The Public Health nurses provide classes to the public schools on reproductive health, including HIV/AIDS and other STDs.

2. Availability of HIV antibody testing and counseling

Summary: While HIV testing can be done at one's doctor's office or a hospital, the barriers are substantial. Confidentiality is often compromised because individuals are likely will see people they know if they go to a hospital for testing. Costs at hospitals and doctor's offices may also be high because a sliding pay scale may not be offered and lack of insurance is a chronic problem in the region. Health departments in the region do not provide HIV testing. Many providers, clinics, and health departments refer their patients to larger cities where rapid testing can be provided. Rapid testing is provided for free

in Fort Morgan and Sterling by NCAP one day a month at the Northeast Colorado Health Department, but many providers we contacted were unaware of the service and those that were aware of it said that it was not widely advertised.

Table 1.2 HIV Testing and Counseling by County

County	HIV Antibody Testing	Counseling
Cheyenne	• Standard testing done at Keefe Memorial Hospital.	• No policy about offering counseling.
Elbert	• None	
Kit Carson	• Standard testing done at Kit Carson County Memorial Hospital ▪ Rapid test offered for employees only	• No policy about offering counseling.
Lincoln	• Standard testing done at Lincoln Community Hospital and Nursing Home.	• No information available at the time of the report.
Logan	• Rapid testing one time per month conducted by NCAP. ▪ Free • Standard testing available at Salud clinic. ▪ Sliding fee scale is available if the patient has a medical diagnosis that warrants the test (typically pregnancy). ▪ Full price charged if there is no medical diagnosis that warrants the test. • Sterling Regional Medical Center ▪ No information received from Sterling Regional Medical Center	• NCAP – Counseling available at the time of testing. • Salud – Counseling available for positive tests.
Morgan	• Rapid testing one time per month conducted by NCAP. ▪ Free • Standard testing available at Salud clinic. ▪ Sliding pay scale. • Standard testing at East Morgan County Hospital. • Colorado Plains Medical Center ▪ No information received from Colorado Plains Medical Center	• NCAP – Counseling available at the time of testing. • Salud – Counseling available for positive tests. • No information about counseling available for East Morgan County Hospital.
Phillips	• Standard testing available at Haxtun Hospital • Standard testing available at Melissa Memorial Hospital	• Haxtun Hospital: Presumption was that counseling would be done by physicians since the test results are sent directly to the physician that ordered the test. • No information about counseling available for Melissa Memorial Hospital.
Sedgwick	• Standard testing available at Sedgwick County Memorial Hospital	• Counseling is done by physicians if they are available.
Washington	•	•
Yuma	• Standard testing available at Wray Community Hospital • Rapid testing available at Yuma District Hospital ▪ Available as part of prenatal screen and for employees ▪ All others receive a standard test.	• No information about counseling available for Wray Community Hospital. • Counseling available for employees at Yuma District Hospital. No specific information available about counseling for non-employees.

3. Availability and accessibility of mental health and substance abuse services for at-risk persons

Services in general tend to be limited and difficult to access in rural regions such as Northeast Colorado; substance abuse and mental health services are no exception. The biggest and most consistent provider of mental health and substance abuse services in the 10 county region is Centennial Mental Health. Centennial Mental Health provides outpatient treatment services in all of the counties and provides community support programs in Fort Morgan and Sterling. Additional providers of services include NCAP which provides outpatient substance abuse and mental health services once a month in Fort Morgan and Sterling when they provide rapid HIV testing services. Their counseling services are available for no charge. Additionally, services can be obtained from hospitals and private practitioners.

Since Centennial Mental Health is the largest provider of services, we spoke directly to their executive director about the availability and accessibility of services for at-risk individuals in the 10 county region. All clients receiving services are required to complete an "Infectious Disease Medical Screen" and an "Infectious Disease Behavior Screen". The score indicates the level of risk for acquiring/transmitting HIV and/or hepatitis. People with moderate and high risk are encouraged to contact Northeast Colorado Health Department for testing and information. All staff members who possess a Certified Addictions Counselor (CAC) credential have taken a course in Preventing Infectious Diseases in the Alcohol and Drug Treatment setting or a similar course. Importantly, the executive director is open to having the staff that provides Mental Health services at Centennial Mental Health receive training in HIV prevention. She indicated her staff would be highly motivated to receive training and agreed to set aside time for her staff to be trained by the AIDS Education & Training Center if the Rural Solutions' Northeast Colorado HIV and AIDS Prevention Project is funded through CHAPP.

The executive director did note two ways in which high risk individuals are treated differently within the Centennial Mental Health system. During intake, individuals who are identified as intravenous drug users become high priority clients, and are a Target Population which ensures access to treatment within 48 hours of the initial call. Additionally, men who have sex with men (MSM) sometimes receive one-on-one treatment for substance abuse rather than group treatment which is the standard of care. The reason for altering the treatment protocol is that neither the MSM client nor the other group members tend to be comfortable in the group situation with the MSM client present. Centennial Mental Health has a limited number of counselors who work with these clients although their degree of expertise in HIV prevention is unknown.

4. Barriers that negatively impact the provision of HIV prevention services for those at-risk

Agency Directors and Providers utilized time at the Needs Assessment Planning Conference to brain storm ideas about institutional and community barriers to providing HIV prevention services for those at-risk for contracting HIV in the community. A broad range of ideas were suggested and these were included on the provider survey to determine the importance attributed to each by providers.

Awareness

One issue that everyone agreed on was that HIV prevention is not an issue that people are thinking about. Ten years ago, there was a much greater level of community awareness. That level of awareness created opportunities for conversations, education, and testing that have now been lost. The feeling in the community now is that HIV is not an urgent or high priority issue for Northeast Colorado. Without an agency or individual keeping HIV prevention awareness at a high level, the successes of the past have been lost. This issue will be discussed at greater length in the community preparedness interview section.

An important concern was that members of both the provider community and the broader community may not recognize who is at risk for contracting HIV and that the communities may not be engaging in necessary conversations about risky behaviors. People noted that they were not being asked about risky sexual behavior when they went to see their physician and wondered who was being asked those questions. Even though educational materials are available in communities, some professionals stated that they did not know where to send someone for information on HIV prevention. More importantly, professionals did not know where to direct clients to a trained provider who could engage in HIV prevention activities with them. A message that emerged was that there does not seem to be a coordinated system of care. Future

efforts need to integrate HIV prevention activities into the daily business of existing health care, public health, and human service organizations to ensure sustainability so that even when funding sources are minimal, prevention efforts will continue.

Funding

As expected, funding was raised as a barrier. Many thought the loss of funding years ago led to the current lack of HIV prevention activities. For example, when the Salud clinic had a grant, they were able to provide HIV testing in the community and do education and outreach efforts. Since the grant ended, Salud is no longer able to engage the community with those prevention activities. People felt that more funding was needed for training and education and to bring resources such as NCAP to the area. Currently NCAP offers rapid testing one day per month in Fort Morgan and Sterling, but that is not adequate.

Funding is also needed to ensure that HIV testing remains affordable for the community. Testing remains expensive. At the institutional level, rapid testing requires test kits, staff time, and outreach. Other than NCAP, we only identified one hospital, Yuma District Hospital, that made rapid testing available to the public, although they only made it available as part of their prenatal screening. Interestingly, several hospitals have the capacity and training to do rapid testing on-site, but choose to use the capacity only for their employees. It did not appear that any of the hospitals actively advertised that they do HIV testing, so it is unknown how aware the public is that this resource is available at their nearest hospital.

The fact that rapid testing can only be obtained in Fort Morgan, Sterling, and potentially Yuma (for pregnant woman) is a substantial problem in a region where it is not uncommon for an individual to travel 50 or 60 miles just to see a physician. The results from a standard HIV test cannot be returned the same day and should not be delivered over the phone. Consequently, if an individual has to travel to take a standard HIV test, it will require an overnight stay at a hotel or two round trip visits to take the test and get the results. The cost of the travel combined with the cost of the test is a major barrier to testing. Interestingly, during our community preparedness interviews, many people told us they referred clients to Colorado Springs or to Denver for rapid testing, presumably because they did not know it was occurring in Fort Morgan and Sterling.

Training

Agency directors and providers were questioned about whether they had the training they needed in HIV prevention and risk assessment. Particular areas of concern were HIV test counseling and HIV risk assessment. Some professionals felt they did not know how to bring up such a sensitive subject without offending patients or clients so this is another potential area of training. In the provider survey, we included multiple questions about the types of training that providers might be interested in receiving. More in depth information can be found in that section.

Geography

There are two AIDS service organizations that have jurisdiction over the ten county region: Northern Colorado AIDS Project (NCAP) and Southern Colorado AIDS Project (SCAP). NCAP partnered with the Northeastern Colorado Health Department to provide rapid testing in the area. This is a great step forward for the agency and the region. However, it is unrealistic to think that this agency alone can provide services to a region this size. Partnerships such as this collaboration are critical, but they need to be supported by a strong referral network, community support, and care network that coordinates HIV prevention activities in a manner that is not currently happening today.

Confidentiality

Confidentiality and anonymity were mentioned as potential barriers to the provision of prevention services by many participants. It is difficult for an individual to access services in these communities without other members of the community knowing exactly what type of services were accessed. A challenge for Rural Solutions and their partners will be to determine how to make prevention services accessible in an arena where the community will be comfortable accessing them. Some participants commented that the tight social networks can be an opportunity. If testing were to become normative, then social pressure could be applied to encourage everyone to be tested. In essence the lack of confidentiality that is a challenge in rural areas could be powerfully utilized to achieve the goal of increased testing.

Table 1.3 Barriers Identified by Agency Directors Combined with Survey Data Illustrating the Percent of Providers that Endorsed the Barrier to Providing Prevention Services and Comments Describing the Barrier

Barrier Identified by Agency Directors	%	Survey Comments
HIV is not an issue in most people's minds	46.8	• It isn't on anyone's radar here because of the low incidence (reported) of HIV. That is too bad because it isn't how many who have the disease that should drive the need for prevention. • Low incidence: 2 cases in 19 years. • Nationally, Colorado is considered a mid to low HIV incidence state and that affects attitudes, perceptions, funding. Then at the state level, when 85% of HIV is in 5 Denver-metro counties, it makes delivering HIV prevention services to rural/frontier counties challenging.
Lack of Training	38.3	• I am not sure how to approach the subject without offending someone. • We are a small agency and no one is trained in HIV prevention. • I think it's never been discussed with any of our developmentally disabled individuals. • The issue is usually not brought up.
Lack of Funding	31.9	• We'd like to do in office testing, but there are no funds available. At the moment, if we have someone at risk, we recommend they go to Denver Health or El Paso County. • I don't accept insurance at the Student Health Center. If a student wants to be tested, it is a $44 charge and most students don't have the money. The nearest testing center, that I know of is Fort Collins, and many of my students don't have cars, or are too young and immature to drive 2 hours to have this test.
I do not know where to send someone who is at risk for HIV	23.4	
There is no system in place to address HIV/AIDS in the region	19.1	
Confidentiality	14.9	
Insufficient Time	12.8	• Too busy with acute care. • Not necessarily a component of my job or part of my organization. In other words, there is only so much I can focus my attention on. • We provide education as necessary, but don't do education on a regular basis.
Stigma	4.3	• Hidden MSM and IDU communities. The MSM community is very stigmatized and rarely comes out even in confidential testing.

Table 1.4 Other Barriers to Providing Prevention Services Raised in the Provider Survey

Other Possible Barriers	Comments
Culture/Language	• Language.
Denial of High Risk Behaviors	• Haven't seen any IV drug users or other high risk individuals that I've been aware of • Dealing with parents of high school students: "My kids will never do this" attitude. School board policies. Parental retribution.

5. **Co-morbid issues impacting HIV/AIDS risk (other sexually transmitted infections, hepatitis, untreated mental illness and substance abuse, etc)**

NCAP reports that both Hepatits C and substance abuse are substantial co-morbid issues affecting HIV/AIDS risk in the region. They estimate that approximately 60% of the individuals they test have a substance abuse problem that warrants intervention.

6. Extent of sexual and drug-related risk behaviors among populations in your jurisdiction

To get a sense of sexual and drug-related risk behaviors, data were requested from family planning clinics overseen by the Northeast Colorado Health Department. Staff at the clinics conducted a chart review for patients seen during 2008 and early 2009 to obtain the desired data. The primary limitation to data obtained in this manner is that only women are seen at the family planning clinics. However, a common theme we heard at the needs assessment planning conference was that it was easier to provide health information to woman than to men because women were the ones who came in for health care services.

While none of the women reported testing positive for HIV or trading sex for money or drugs, rates of several risk factors were elevated as reported in Table 1.5. Almost seventy percent of the women reported having two or more sex partners in the past year. Further, over 6.5% of the women seen in the family planning clinics reported that they had injected street drugs.

Table 1.5 Sexual and Drug-Related Risk Behaviors among Populations in Northeast Colorado

Variable	Yes (%)	No (%)	Missing (%)
Drug and Alcohol Use			
Alcohol Use	53.95	40.79	5.26
Marijuana Use	35.53	60.53	3.95
Methamphetamine Use	19.74	71.05	9.21
Other Drug Use	23.68	75.00	1.32
Take Street Drugs by Needle	6.58	93.42	0.00
Sexual Risk Behaviors			
Greater than 2 sex partners in past year	67.11	30.26	2.63
Had sex with man who has had sex with other men	0.00	100.00	0.00
Traded sex for money or drugs	0.00	93.42	6.58
Tested positive for HIV?	0.00	96.05	3.95

N = 79
Source: Chart review of files from clients seen at Northeast Colorado Health Department Clinics during 2008 and early 2009.

Another way to assess sexual risk behaviors is to examine the rates of reported sexually transmitted infections (STIs). The Colorado Department of Public Health and Environment publishes rates of STIs at the county level (CDPHE, 2009). In Table 1.6, we report the rates for Chlamydia and Gonorrhea in each of the 10 counties during 2003 – 2007. Many of the rates for the counties in Northeast Colorado should be interpreted with caution. When there are fewer than 5 reported cases, calculated incidence rates are unstable; in Table 1.6, cells that are highlighted gray reflect years in which the rate was based on fewer than 5 reported cases.

As reported in Table 1.6 and consistent with overall state data, rates of Chlamydia were higher than rates of Gonorrhea in the 10 county region. The highest rates were reported in Kit Carson, Logan, and Morgan counties where rates of Chlamydia exceeded 200 per 100,000 persons in some years. These rates suggest that there is a need for greater access to and utilization of safe sex education and supplies in the region.

Table 1.6 Estimated Crude Incidence Rate per 100,000 persons in the 10 Counties in Northeast Colorado

County	STI	2003	2004	2005	2006	2007
Cheyenne	Chlamydia	91.2	46.2	93.9	48.8	0.0
	Gonorrhea	45.6	0.0	47.0	0.0	0.0
Elbert	Chlamydia	99.0	53.5	43.9	68.8	4.0
	Gonorrhea	0.0	0.0	0.0	12.9	0.2
Kit Carson	Chlamydia	235.8	100.6	152.2	166.3	178.2
	Gonorrhea	12.4	0.0	12.7	12.8	12.7
Lincoln	Chlamydia	97.7	16.6	50.8	17.3	85.9
	Gonorrhea	32.6	0.0	16.9	17.3	0.0
	Gonorrhea	4.6	9.2	13.9	18.4	31.8
Morgan	Chlamydia	162.9	179.8	183.4	238.3	281.3
	Gonorrhea	21.3	17.6	17.6	38.5	24.0
Phillips	Chlamydia	44.0	43.4	108.1	43.1	42.9
	Gonorrhea	22.0	21.7	0.0	21.6	0.0
Sedgwick	Chlamydia	0.0	37.1	0.0	38.3	113.9
	Gonorrhea	0.0	0.0	0.0	0.0	38.0
Washington	Chlamydia	39.2	20.1	0.0	20.2	40.0
	Gonorrhea	0.0	0.0	40.5	20.2	20.2
Yuma	Chlamydia	20.0	20.1	30.1	20.0	39.6
	Gonorrhea	0.0	0.0	0.0	20.0	19.8

*Note that the highlighted rates should be interpreted with caution.
Source: The Colorado Department of Public Health and Environment [CDPHE] Disease Control and Environmental Epidemiology Sexually Transmitted Infection/Human Immunodeficiency Virus Surveillance Program. (2009, February). Sexually transmitted infection surveillance report through December 31, 2007. Retrieved March 10, 2009 from http://www.cdphe.state.co.us/dc/HIVandSTD/HIV_STDSurv/07SurvReport.pdf.

With respect to drug related risks, intravenous drug use greatly increases the risk of HIV transmission. Over six percent of the women seen at the family planning clinics reported injecting street drugs using a needle. This is not inconsistent with data reported by the Colorado Department of Human Services' Alcohol and Drug Abuse Division. In the 2004 version of the Integrated Epidemiologic Profile of HIV and AIDS Prevention and Care Planning (CDPHE), Northeast Colorado tied the Denver Metropolitan region for the highest rate of injection drug users in the state of Colorado. Approximately 1.6% of the residents in Northeastern Colorado injected drugs at some point in their lifetime. It should be pointed out that the data reported were for substrate planning areas. The Northeast Colorado substrate planning area includes the 10 Rural Solutions counties as well as Larimer and Weld counties. We requested updated data from ADAD. Unfortunately, they were unable to replicate the original numbers and therefore could not provide us with updated numbers in time for this final report.

7. Disease burden, if known

We were not able to acquire any information on the disease burden in the 10 county region.

8. Services that address the specific needs of ethnic and racial minority populations regarding HIV prevention services.

The Northeast Colorado region has a growing minority population. Minorities represent at least 20% of the population (See Table 1.7) in five of the counties in Northeast Colorado: Kit Carson, Lincoln, Morgan, Phillips, and Yuma (US Census Bureau, 2009). As indicated in Table 1.7, many of these counties have a large Hispanic population that is drawn to the agricultural industry in the area. An additional minority population that is hidden in this table is a Somali refugee population in Morgan and Kit Carson counties.

Table 1.7. Race/Ethnicity and Home Language Other than English

County	Race/Ethnicity (%)		Home Language(%)*		County	Race/Ethnicity (%)		Home Language(%)*
Cheyenne	White, not Hispanic	88.8	7.6		Morgan	White, not Hispanic	63.7	25.6
	Hispanic	9.8				Hispanic	34.2	
	Other	1.4				Other	2.1	
Elbert	White, not Hispanic	90.7	4.8		Phillips	White, not Hispanic	79.6	10.9
	Hispanic	5.5				Hispanic	18.7	
	Other	3.8				Other	1.7	
Kit Carson	White, not Hispanic	76.3	13.2		Sedgwick	White, not Hispanic	82.6	9.3
	Hispanic	18.8				Hispanic	15.1	
	Other	4.9				Other	2.3	
Lincoln	White, not Hispanic	79.8	6.9		Washington	White, not Hispanic	90.1	5.2
	Hispanic	11.0				Hispanic	8.1	
	Other	9.2				Other	1.8	
Logan	White, not Hispanic	81.3	8.2		Yuma	White, not Hispanic	78.3	11.5
	Hispanic	13.9				Hispanic	20.6	
	Other	4.8				Other	1.1	

*Language other than English spoken at Home. Note this figure is from the 2000 Census and may be higher in 2009.

Source: U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, Census of Population and Housing, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report Retrieved March 2, 2009 from http://quickfacts.census.gov/qfd/states/08/08017.html.

According to their webpage (http://www.saludclinic.org/about.html), Plan de Salud de Valle was founded to provide healthcare services to migrant farm workers and their families. They pride themselves on being culturally competent. They are a community health center and provide health care to individuals who are uninsured and underinsured on a sliding pay scale. In the past, they were community leaders in HIV prevention and testing efforts. Their prior grant enabled them to do community outreach, education, and more extensive HIV testing in the community. Many of these efforts were with the Hispanic community, but they reached the broader community as well. We spoke with supervisors at both Salud clinics in Northeast Colorado to determine whether they offered any services to the racial and ethnic minority populations in the 10 county region. Salud does provide medical services to both the Latino and Somali populations. HIV educational pamphlets are available in English and in Spanish. However, the Salud clinics in Northeast Colorado do not offer formal, organized HIV educational programs beyond those pamphlets or one-on-one conversations with a provider. While it is possible that the broader Salud organization may have formal protocols, the clinics in the Northeast region currently do not routinely assess their patients' HIV risk. Risk assessments are provided only when requested by the patient. HIV testing is typically only conducted for pregnant women although the service is available at a higher cost for other patients.

We also spoke with the director of One Morgan County, a program that works closely with the Somali refugee community. She confirmed that their program does not provide any HIV prevention materials to the immigrant population nor are there any HIV prevention programs advertised in the community for the refugees. She did express a concern that it may be difficult to reach the Somali refugee community for several reasons. First, language will be a barrier as many refugees do not speak English. Somali and Swahili are the most common languages spoken. Second, on-going efforts in the community to raise awareness around domestic violence have been slow. It has taken a lot of time and persistence to develop trust and relationships within the community. Given the stigma around HIV, one should expect similar or greater effort will be needed.

Chapter 2: Survey of Providers

Background. Before launching any HIV prevention efforts, Rural Solutions felt it was important to gauge the provider community's current comfort discussing HIV risk behaviors with their clients/patients, their willingness to engage in HIV prevention activities, and their assessment of what HIV prevention training and resources were needed. We invited over 120 providers and agencies throughout the region to participate in an on-line survey through surveymonkey.com. Forty-seven providers completed the survey. Data from the provider survey are provided below.

The definition of provider was very broad for the purpose of this survey. This was intentional. Due to the limited availability of health care professional in rural regions as well as the distance that may have to be traveled to access a physician, other types of providers may be more likely to see an individual at risk and have a better opportunity to intervene. In rural regions, it will be important to train a broad spectrum of providers on HIV prevention and risk assessment, not just traditional health care providers in order to reach a broad spectrum of the community.

Current Provider Preparedness and Practices with Patients/Clients

In general, providers felt more prepared to talk with clients/patients about risky sexual behavior or drugs use than about HIV (See Table 2.1). They felt least prepared to conduct an HIV risk assessment with 53.2% reporting they were unprepared or very unprepared to conduct an HIV Risk Assessment.

Table 2.1 Provider Preparedness to Communicate with Patients or Clients about HIV Risk Factors

	Very Prepared	Prepared	Unprepared	Very Unprepared	Not Applicable / Missing
How prepared are you to talk to your patients/clients about HIV/AIDS?	14.9	42.6	36.2	4.3	2.1
How prepared are you to conduct an HIV Risk Assessment with a patient or client?	14.9	27.7	44.7	8.5	4.2
How prepared are you to ask your patients/clients questions about their sexual risk behaviors, such as "How often do you use condoms?"	31.9	38.3	17.0	6.4	6.4
How prepared are you to ask your patients/clients about their alcohol or drug risk behaviors, such as "Have you ever used drugs from a non-medical source?"	40.4	46.8	8.5	0.0	4.3

Almost half of all providers reported routinely asking their patients/clients about risky alcohol and drug behaviors (see Table 2.2). Forty percent of providers reported that they always asked about alcohol and drug use, while a large percentage of others indicated that whether they asked was influenced by their patient's/client's medical history, history of risky behavior, or the reason for the current appointment.

Table 2.2 Current Provider Practices – Alcohol and Drug Risk Behavior

Question	%
In the past year, did you routinely ask your patients/clients about risky alcohol or drug behaviors they might be engaging in?	
Yes	48.9
No	40.4
Other	8.5
Missing	2.1

Table 2.2 Current Provider Practices – Alcohol and Drug Risk Behavior (continued)

Question	%
Purpose of the visit is for a condition frequently associated with excessive alcohol or drug use	51.1
History of risky behavior	44.4
Past medical history	42.2
Current diagnosis	42.2
None: I always ask about alcohol and drug use	40.0
Patient/client reports a high level of stress or conflict in his/her life	28.9
Age less than 25	11.1
Other	10.6
None: I never ask about alcohol and drug use	4.4

More than half of all providers reported that they did not routinely ask about risky sexual behaviors (see Table 2.3) and fewer than 18% report always asking about risky sexual behaviors. This suggests that there is a huge opportunity to increase communication between providers and patients/ clients around the issue of sexual risk taking. It does not appear that we were surveying the wrong type of providers because almost half reported that they did discuss sexual risk taking if the purpose of the visit was for a condition associated with risky sexual behaviors.

Table 2.3 Current Provider Practices – Sexual Risk Behavior

Question	%
In the past year, did you routinely ask your patients/clients about risky sexual behaviors they might be engaging in?	
Yes	40.4
No	53.2
Other	4.3
Missing	2.1
Which of the following factors, if any, influence your decision to ask about alcohol and drug risk behaviors during appointments? (Check all that apply)	
Purpose of the visit is for a condition frequently associated with risky sexual behaviors	48.9
History of risky behavior	42.2
Past medical history	37.8
Current diagnosis	35.6
Age less than 25	26.7
None: I always ask about risky sexual behaviors	17.8
None: I never ask about risky sexual behaviors	17.0
Other	14.9

HIV Prevention Activities

We defined HIV prevention activities very broadly for providers. Included in that definition were educational activities (schools, community, targeted to high-risk groups, continuing education for providers), effective evidence-based interventions, rapid testing, promoting condom use, etc. Given our suspicion that few prevention activities were on-going, we wanted to use a broad definition to capture as many prevention activities as possible.

Despite a broad definition of prevention, very few providers said that they were currently active in any HIV prevention activities. The largest barriers to providing HIV prevention services were awareness, lack of training, and lack of funding (see Table 2.3).

Table 2.3 Current Participation in HIV Prevention Activities and Barriers to Participation in HIV Prevention Activities

	Yes	No	Don't Know / Missing
Are you currently active in any HIV prevention activities?	27.7	66.0	6.4
What are the major barriers that affect your ability to provide HIV prevention services to at-risk individuals? (Check all that apply)*			
Awareness – HIV isn't an issue that on most people's minds	46.8		
Lack of training	38.3		
Lack of funding	31.9		
Don't know where to send someone who is at risk for HIV/AIDS	23.4		
There's no system in place to address HIV/AIDS in the 10 county region	19.1		
Confidentiality	14.9		
Insufficient time	12.8		
Stigma	4.3		

*Other comments included in Chapter 1.

Continuing Education

We feel that education for a broad base of providers is a critical first step for implementing HIV prevention activities in Northeast Colorado and for sustaining those efforts. However, providers must also see a need for these educational activities. The survey found broad support for continuing education for providers. With respect to general HIV continuing education, almost 80% of providers thought that continuing education was needed on each of the topics need (see Table 2.4), with over 50% reporting that continuing education is currently not available to them on those topics.

Table 2.4 Availability and Necessity of HIV Continuing Education for Providers

	Available, Not Needed	Available, Needed	Not Available, Needed	Not Available, Not Needed
Counseling for Positive Tests	9.8	24.4	53.7	12.2
HIV Prevention Training for Substance Abuse and Mental Health Providers	7.5	30.0	52.5	10.0
Rapid Testing	9.8	26.8	53.7	9.8
Risk Assessment	9.5	33.3	50.0	7.1
Risk Reduction Counseling	4.8	38.1	52.4	4.8
Secondary Prevention	9.5	21.4	59.5	9.5

Providers expressed a great need for information on HIV treatment topics. More than 60% of providers reported that they needed continuing education on treatment topics, but that continuing education was currently not available to them (see Table 2.5.

Table 2.5 Availability and Necessity of Continuing Education on HIV Treatment Topics for Providers

	Available, Not Needed	Available, Needed	Not Available, Needed	Not Available, Not Needed
Co-Morbid Conditions	11.9	16.7	61.9	9.5
Medication Interactions	12.2	17.1	61.0	9.8
Medication Side Effects	12.2	17.1	61.0	9.8

*Other suggested topics: all STDs; how to deliver prevention services in a client-centered manner that incorporates harm reduction as an option;

Providers also expressed a strong need for educational resources such as quick reference guides, on-line resources, professional development opportunities, and tailored trainings on selected HIV topics (see Table 2.6).

Table 2.6 Availability and Necessity of HIV Prevention Resources for the Provider Community

	Available, Not Needed	Available, Needed	Not Available, Needed	Not Available, Not Needed
Compendium of on-line resources	10.3	28.2	53.8	7.7
In-house tailored training on selected HIV topics	2.6	10.3	64.1	23.1
Patient education materials	7.7	41.0	51.3	0.0
Professional development opportunities	7.9	18.4	65.8	7.9
Quick reference guides	8.1	13.5	73.0	5.4
Referral networks	8.1	32.4	56.8	2.7
Telephone consultations	8.1	29.7	54.1	8.1

*Other resources needed: Assurance of confidentiality; access to HIV experts; testing services within the county.

Finally, providers rated the availability and necessity of HIV prevention resources for the broader community. Again, providers reported a high level of need. More than 60% of providers reported that resources such as community awareness, comprehensive sexuality education, and outreach to at-risk populations were not currently available, but were needed by the community. Overall, the survey results suggest a provider community that is very open to continuing education and professional development opportunities that would enhance their HIV knowledge and improve their ability to communicate with their patients/clients about behaviors that increase their risks for contracting HIV.

Table 2.6 Availability and Necessity of HIV Prevention Resources for the Broader Community

	Available, Not Needed	Available, Needed	Not Available, Needed	Not Available, Not Needed
Community awareness building	5.0	20.0	67.5	7.5
Comprehensive sexuality education in the schools	4.9	31.7	63.4	0.0
Outreach to at-risk populations	4.9	19.5	70.7	4.9
Rapid testing sites	2.5	25.0	65.0	7.5

Data presented in Tables 2.7 – 2.9 present demographic information on the survey sample. Respondents were drawn from all 10 counties. More than half of the respondents were female. They held a variety of professional positions including community organizers, mental health counselors, health educators, nurses, and physicians.

Table 2.7. Demographic Data for Survey Respondents

Variable	%		Variable	%
Sex			Age Range	
Male	29.8		18 – 25	2.1
Female	57.4		26 – 30	6.4
Missing	12.8		31 – 35	10.6
			36 – 40	6.4
			41 – 45	10.6
			46 – 50	12.8
			51 – 55	14.9
			> 55	21.3
			Missing	14.9

Table 2.8

Variable	%
County Where Respondent Works*	
Cheyenne	12.8
Elbert	12.8
Kit Carson	17.0
Lincoln	29.8
Logan	21.3
Morgan	14.9
Phillips	12.8
Sedgwick	10.6
Washington	12.8
Yuma	21.3
Missing	6.4

*Responses will not total to 100% because some respondents work in more than one county.

Table 2.9 Employment Data for the Survey Sample

Variable	%		Variable	%
Type of Employer*			Professional Position	
AIDS Service Organization	4.3		Agency Director	12.8
Community Health Center	2.1		Case Manager	8.5
Family Resource Center	4.3		Emergency Medical Technician	2.1
Hospital	19.1		Community Organizer	4.3
Health Department	21.3		Health Educator	4.3
Human Services Department	12.8		Mental Health Counselor	6.4
Mental Health Agency/Private Practice	8.5		Nurse	14.9
Primary Care Office	8.5		Nurse Practitioner	4.3
School	4.3		Outreach Worker	2.1
Social Services Department	12.8		Physician	14.9
Substance Abuse Agency/Private Practice	4.3		Physician's Assistant	4.3
Other Type of Agency	10.6		Social Worker	2.1
Missing	12.8		Other	4.3
			Missing	14.9

Chapter 3: Community Readiness Assessment – Preliminary Findings

Introduction & Summary

This Community Readiness Needs Assessment is part of the Colorado HIV and AIDS Prevention Grant Program to Determine and Address Unmet Needs Research Project funded by the Colorado Department of Public Health and Environment to Rural Solutions. This coordinating agency works with other health and social service organizations in ten counties of Northeast Colorado to bring resources and programs to residents in this region. For this needs assessment, the Community Readiness model developed by the Tri-Ethnic Center for Prevention Research at Colorado State University (Plested, Edwards & Jumper-Thurman, 2006) was utilized. Interviews were conducted with professionals throughout the Northeast Region to assess key informants' knowledge of HIV prevention education and testing services and their perception of their respective community's readiness to participate in planning and more extensive prevention efforts. Interviews were completed with key informants in all of the 10 counties (Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Yuma, and Washington).

These interviews revealed that professionals perceive that few community members in the Northeast region have knowledge about HIV prevention education and testing services in their communities and that the prevailing attitude is that HIV is "not a concern," or "doesn't exist" in their communities. The public health clinics do provide educational programs at their family planning clinics and in the high schools on sexually-transmitted diseases and pregnancy prevention, but not necessarily specific to HIV/AIDS prevention. Some public health nurses noted that specialized training in HIV is lacking among the professional health care providers in their communities. Only two key informants acknowledged new planning efforts to bring greater HIV prevention and testing services to their communities. In terms of community readiness, on a scale from "1" (no awareness) to "9" (community ownership of the issue of HIV prevention), these preliminary interviews indicate that the Northeast region is Stage 2 – Denial (that the problem of HIV exists in their communities) and Resistance (other issues such as the economy have a greater priority).

Assessment Methods

Participants. Professionals in each of the 10 counties were selected to participate in the interviews. Whenever possible, individuals who were knowledgeable about HIV Prevention Education, testing, and resources as well as perceptions of the counties in which they live and work were selected. However, not all counties had an individual that was highly knowledgeable about HIV Prevention Education, testing, and resources. Identified individuals were contacted by a Rural Solutions staff member who requested their voluntary participation in this community needs assessment. A monetary incentive of $100 for each 30-60 minute interview was provided to each community member or their organization for their time. Most of the community members were health care providers who work in public health departments or community hospitals. From February 17 through April 6, 2009, 11 interviews with community members of the Northeast region were scheduled and conducted by two CRS evaluation staff. Most phone interviews took 45 minutes to complete. Responses to each question were recorded by hand and later typed up for each county interview. Community members were assured that their responses would be anonymous.

Stages of Community Readiness. Developers of the Community Readiness Model at the Tri-Ethnic Center for Prevention Research at CSU have noted that there are six key factors that influence a community's ability to take action on an issue. Depending on the level of readiness for a community to act on an issue, strategies can be developed to move the community to next level of preparedness for taking action. The continuum of a community's involvement in a particular issue includes:

Stage 1: No Awareness of the Issue
Stage 2: Denial and Resistance
Stage 3: Vague Awareness
Stage 4: Preplanning (group forms to address the issue)
Stage 5: Preparation (active leadership in addressing the issue)
Stage 6: Initiation (activities underway)
Stage 7: Stabilization (activities supported, staff trained)
Stage 8: Confirmation/Stabilization (community is comfortable accessing services, local data obtained)

Stage 9: A High Level of Community Ownership of the Issue

Dimensions of Readiness. Key factors that influence a community's preparedness to take action on an issue are summarized in six dimensions identified and measured in the Community Readiness Model. These dimensions are:

A. **Community Efforts**: Efforts, programs, and policies that address the issue.
B. **Community Knowledge of the Efforts**: The extent to which community members know about local efforts and their effectiveness, and whether the efforts are accessible.
C. **Leadership**: The extent to which appointed leaders and influential community members are supportive of the issue.
D. **Community Climate**: The prevailing attitude of the community toward the issue (e.g. helplessness or responsibility and empowerment).
E. **Community Knowledge about the Issue**: The extent to which community members know the causes of the problem, consequences, and how it impacts their community.
F. **Resources Related to the Issue**: The availability of local resources, e.g. people, time, money, space, etc. to support efforts that address the issue of concern.

The process for using the Community Readiness Model includes the following sequenced steps: 1) identify the issue, 2) define the community, 3) conduct key informant interviews, 4) determine community readiness by scoring the interviews, 5) develop strategies, and 6) implement community change. The community needs assessment process used in this project utilized the first four steps as described below:

1) The issue: HIV Prevention Education & Testing Services
2) The community: 10 counties in the Northeast region of Colorado (Cheyenne, Elbert, Kt Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Yuma)
3) Key Informant Interviews: A list of Individuals who would have information about the community's knowledge and readiness for HIV prevention education and testing services in the targeted counties was developed and individuals were contacted by Michelle Sharp, Project Coordinator at Rural Solutions. The 36-item survey was reviewed and edited for use with the targeted issue by a research team at the Center for Research Strategies (CRS), an evaluation and research consulting firm in Denver, Colorado. Phone interviews were conducted by two researchers at CRS. Each researcher typed the responses to each question so that the responses could be scored by both researchers on the six dimensions described in #4.
4) Interview Scoring: Using the scoring protocol developed by the Tri-Ethnic Center for Prevention Research, the two CRS researchers scored each item on a 9-point scale from no awareness ("1") to high level of community ownership ("9"). A portion of the survey items were used to determine the rating on each of the dimensions as indicated below:

    Dimension A: Community Efforts (10 items – Q1-3, 8-15; item #1 is not scored)
    Dimension B: Community Knowledge of Efforts (4 items – Q4-7)
    Dimension C: Community Leadership (4 items – Q16-19)
    Dimension D: Community Climate (5 items – Q20-24)
    Dimension E: Community Knowledge about the Issue (4 items – Q25-28)
    Dimension F: Resources for Prevention (8 items – Q29-36)

    An excel spreadsheet was used by the CRS researchers to record the determined score for each item based on the information provided by key informant. Each CRS researcher independently scored the dimensions of each interview. A mean score for six dimensions of readiness on each survey was calculated according to the Community Readiness protocol. For each dimension, scores for the survey items were added together and divided by the number of scored items to obtain the average score for each dimension. Two sets of scores for each interview and its dimensions were obtained and averaged.

    The mean score for each dimension corresponds to the community's readiness to act upon the issue and one of the nine stages described earlier. Scores are "rounded down" rather than "rounded up" to determine which stage the

mean score falls within. The mean scores were then classified into one of the stages of readiness, as indicated below:

Scores	Stage
1.00-1.99	(1) No Awareness
2.00-2.99	(2) Denial / Resistance
3.00-3.99	(3) Vague Awareness
4.00-4.99	(4) Preplanning
5.00-5.99	(5) Preparation
6.00-6.99	(6) Initiation
7.00-7.99	(7) Stabilization
8.00-8.99	(8) Confirmation / Expansion
9.00-9.99	(9) High Level of Community Ownership

An overall Community Readiness Score for each county was obtained by adding together the mean scores for the six dimensions and finding the average across those factors. A similar method was used to obtain the mean Community Readiness Score for the entire northeast region; all of the county scores for each dimension were summed up and averaged to obtain mean scores for each of the six dimensions and an overall Community Readiness Score for the northeast region.

Results

The mean score and standard deviation for each dimension was calculated and ranged from 1.86 to 2.13. Thus, key informants perceived their communities to be at Stage 1, “No Awareness” or Stage 2, “Denial and Resistance” with respect to HIV. According to CSU researchers, Stage 2 is described as “At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.” The overall Community Readiness Score of 1.99 falls within Stage 1 “No Awareness” of the issue of HIV within their communities and suggests that the issue is not generally recognized by the community or leaders as a problem. A description of the result obtained for each dimension based on the interviews is provided following the table.

Table 1. Mean Scores Obtained for Dimensions of Community Readiness (n=11)

Dimension	Range of Scores	Mean	Standard Deviation
A. Community Efforts	1.19 – 4.00	2.17	0.82
B. Community Knowledge	1.00 – 3.25	1.98	0.77
C. Leadership	1.13 – 3.00	1.86	0.56
D. Community Climate	1.13 – 4.90	1.92	1.14
E. Issue Knowledge	1.75 – 2.63	2.13	0.34
F. Resources for Prevention	1.50 – 2.94	1.91	0.55
Overall Community Readiness	1.47 – 3.14	1.99	0.49

A. Community Efforts. This particular dimension, which includes 10 interview questions, asks key informants to describe community efforts related to the issue of HIV prevention and testing, including the strengths and limitations of these efforts and policies in place to address the issue. The community professionals consistently noted that very few efforts focusing specifically on HIV prevention education or rapid testing services were available in their communities, as indicated by the mean score of 2.17, which falls into Stage 2 of Denial and Resistance. Typical comments in the interviews related to this dimension were:

> “There aren’t any [current efforts in my community to address HIV] as far as I know.”
>
> “The only services [for HIV prevention or testing] would be through the patient’s primary health care provider or physician.”

"If someone is concerned they can go to the health department or the health clinic."

"Most of our [patient] services are sent to the Front Range, the Denver area, sometimes Ft. Collins or Greeley. We do have a family planning clinic, but as far as specialists, e.g. infectious disease, none come out here [to our county]."

The professionals mentioned that public high school presentations on sexuality, sexually-transmitted disease or pregnancy prevention and family planning education are provided by county health department staff, primarily public health nurses. Testing for HIV via blood samples sent to an outside laboratory, rather than rapid testing, was mentioned by most of the professionals who were interviewed. No formal policies regarding HIV prevention or testing were mentioned in the interviews other than confidentiality with regard to HIV testing. The weaknesses of efforts cited was the lack of local HIV prevention, screening and follow-up in most of the counties or health care services for particular populations as indicated by the following comments:

"I guess our weakness is we're not a specialty hospital. Our physicians would see that our patients would be steered and referred to those [HIV patient] services."

"It would be more difficult for middle income who lack insurance and…our college-age who are not employed or don't have insurance – they fall through the cracks on getting health care."

B. Community Knowledge about HIV Prevention & Testing. Although the professionals interviewed appeared to be knowledgeable about the HIV prevention and testing services available in their counties, the overall rating in this dimension was 1.98, which is within Stage 1, "No Awareness." The professionals stated that most people in their community lack knowledge about any HIV prevention education or testing services that may be available through the local health department, hospital, or private health care providers. They commented:

"They [the community residents] probably know very little – even if they know little, they still have a feeling of confidence that a person with HIV needs would be met [in our community]."

"There's not a lot of advertisement or emphasis on things placed on it."

C. Leadership. The questions associated with this factor assess the extent to which appointed leaders and influential members of the community are supportive of the issue of HIV prevention and screening services. Responses from key informants indicated that the community leadership would not consider this an issue of concern or "on their radar" as reflected in the mean score of 1.88 which is within Stage 1, "No Awareness," that is, "The Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue)." Several professionals, however, indicated that the leadership, which was frequently identified as the public health department, health care providers and the medical community, would be supportive of efforts if HIV prevention and testing became a concern in their communities. They commented:

"The low knowledge, being in a rural area, the lack of knowledge and the social attitudes, the stigmatism, the stereotypes, get in the way."

"We just haven't had the incidence of HIV to make it alarming to anyone."

"They're [community leaders] very complacent about it."

"[It's] pretty low on their radar screen."

"The leaders [the medical community] are aware of it [HIV], but don't have funds to pursue it."

Generally, those interviewed stated that the leaders of their communities would be supportive of HIV prevention and testing efforts, if they were aware of this issue and saw the need for those services. Two community members, including one in

Logan County, where Rural Solutions is located, were somewhat aware of new efforts related to this issue. One person commented:

> "My understanding is that Rural Solutions is going to be doing that [be involved in efforts regarding providing services related to HIV prevention and screening] and exactly how they're going to do that, I'm not aware."

D. Community Climate. The questions associated with this factor assess the prevailing attitude of the community toward the issue of HIV prevention and testing services. Again, the mean rating of 1.92 on this dimension, as indicated in Table 1, is within Stage 1, "No Awareness." However, the individual mean scores obtained from evaluating the responses of the 11 professionals interviewed had the greatest variability of all the dimensions assessed and ranged from 1.00, Stage 1 "No Awareness" of the issue, to 4.90, Stage 4 "Preplanning", reflected by one professional in Logan County who was aware of the HIV assessment and planning efforts by Rural Solutions. One professional who was interviewed provided a comment that was stated in almost all of the interviews:

> "I don't think that they [community residents] think about it [the issue of HIV] – period."

With regard to "Community Climate," the Northeast counties were described as:

- "rural"
- "very rural"
- "rural, frontier community"
- "spread out" or "geographically isolated"
- "independent"
- "conservative"
- "fairly well educated"
- "mostly elderly"
- "farmers"
- "lots of leased farms"
- "hospital is the largest employer"
- "fortunate to have an acute care hospital

The professionals surveyed on this dimension commented:

> "The social norm is: If you talk about it, it will happen" [implying that people don't talk about HIV in their community].

> "They [the leadership] would support efforts if funding for it [was available]. Our community is so small. Here, we have to create a way to do public health awareness. They would support it. We have the Fatherhood Initiative and Tobacco Prevention Coalition."

> "I think the community is very willing to provide programs, assistance as needed in different things. I don't think the community would have any concerns [about HIV or think this is an issue in their community]."

> "Community makers don't have any awareness of it. They know it's in the city - that it's around. Worried about it? Probably not."

When asked about primary obstacles to efforts addressing HIV prevention or screening in their community, professionals stated:

> "Confidentiality in a small community. [The] Spanish community because of language and cultural barriers."

> "Anonymity - [in a] small community, it's a big deal to walk into the health department for screening. The prevention part is pretty easy. Big group settings might be the best way so no one feels targeted."

E. Community Knowledge about the Issue. The interview questions related to this dimension were designed to assess the extent to which community members know about the causes of the problem (HIV), consequences, how it impacts their community and sources of data related to the issue. The mean score for this dimension was 2.13, which is low on the Community Readiness Model and falls within Stage 2 of Denial/Resistance about the issue of HIV. Most interviewed commented that their communities lack knowledge about HIV and are unaware of available efforts by public health or the North Colorado AIDS Project (NCAP). Several public health professionals who were interviewed were aware of the education and rapid testing services available by NCAP in their counties, but remarked that the only publicity about these

services were in the "paid" newspaper, not in the free newspaper or via other advertising to various ethnic segments of their communities. One professional summarized what was shared by other key informants:

> "I think that unless a person seeks out information, they're probably not approached with information publicly…[I'm] not sure there's any information out there."

The state health department was frequently cited as the primary source for local HIV data, although those interviewed stated that due to their small county populations, public data on HIV were not available for their counties. One person commented:

> "Probably the only information they would get is from the health department or their private physician — a pamphlet. I don't know even if those exist."

F. Resources for Prevention. Questions associated with this dimension ask the extent to which local resources (e.g. people, volunteers, time, money, space) are available, the level of expertise and training among those working on HIV in their communities, new local efforts and evaluation of these efforts. The mean response for this dimension was 1.91 or within Stage 1 of "No Awareness." Professionals who were interviewed indicated that few community resources are allocated to HIV prevention and testing. Most of them remarked that individuals affected by HIV would turn to their primary physician for information, screening or testing if needed, and to find out about available resources related to HIV. Several people commented:

> "I don't know [where an individual affected by HIV would turn to first for help in my community]. I would hope they would turn to their physician first so they could be referred for testing and screening for treatment, probably NCAP."

> "I don't think they would look anywhere else [other than their local health care provider]."

The survey respondents commented that the level of expertise and training among those working on HIV in their counties was low. Although those interviewed acknowledged some expertise by public health professionals and health care providers, specific training on HIV was lacking, as reflected by their comments:

> "I only know of one person who would have some expertise. Others? They just don't have the expertise. Anyone with HIV will be referred to the Front Range or Denver. Ft. Collins and Boulder have clinics people use."

> "Me…I have some knowledge, but not a specialist in HIV. Physicians are knowledgeable, but are generalists."

Those interviewed stated that there were no volunteer efforts to address HIV prevention in their communities, although volunteer efforts for other causes, e.g. the Fatherhood Initiative, Tobacco Prevention, were in place. One professional commented about the potential for volunteerism or donations:

> "I think there's a big potential to volunteer with time and even finances. You'd be surprised at that."

With regard to the local business attitude and resources, several people stated:

> "I think it would be a little tough to get their buy-in or support, just because of the very conservative community and lack of knowledge."

> "On a small scale, a few people who would be willing to donate space, volunteer and financial support would likely be a harder sell because of the belief that HIV doesn't affect them."

Several survey respondents were aware of the four hours per month that NCAP staff members provide to their county and that Rural Solutions had either received or submitted a proposal for funding for HIV prevention efforts in their counties. However, no one was aware of any evaluation of efforts to address HIV prevention in their communities.

Overall Community Readiness. The overall mean rating for Community Readiness with regard to HIV prevention education and testing was 1.99, which would be classified as Stage 1, No Awareness or recognition by community leaders of HIV as a pressing issue. The key informants perceived that few community residents recognize HIV as a concern, that there is little evidence that the community members in these counties are knowledgeable about the issue, and few community members are engaged in efforts to address HIV. Unemployment, farming issues and other local concerns were cited as more pressing issues. Interviews with key informants within those counties, however, indicated the need for HIV educational and planning efforts within those counties.

Discussion and Conclusion

The results obtained from the Community Readiness Assessment are one indication that key informants from the Northeast region of Colorado perceive that an awareness by community members that HIV data, prevention resources, education, testing and counseling are not readily available in those communities. The interviews conducted indicate that HIV is not perceived to be a priority among those communities. There may be limited knowledge about HIV among residents in those counties. Professionals within the county health department and medical community are perceived to be leaders in this area, but may lack in-depth training and expertise about HIV. Resources for HIV prevention such as people, volunteers, time, money, and space, may be available in the Northeast region, but unless HIV prevention is "on the radar screen" and a concern, very little will be devoted to this health issue. The HIV planning efforts by Rural Solutions was cited by several key informants.

Reference:

Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006, April). *Community Readiness: A handbook for successful change*. Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

Appendix A
Community Readiness Assessment Provider Interview

Providers to be interviewed can include:

- Physicians, nurses, paraprofessionals, case managers, mental health providers, behavioral health providers, and
- individuals who are viewed as sources of medical information within their community.

Purpose of interviews: to explore in depth the community's readiness to engage in HIV/AIDS prevention efforts as well as barriers the community will face in implementing prevention efforts.

INTRODUCTION:

Hello, my name is _________ and I work for the Center for Research Strategies. The Center for Research Strategies is a research-evaluation firm based in Denver. We are working with Rural Solutions, an agency that provides resources for Northeast Colorado. Your name was given to us for an interview that is part of a Community Needs Assessment Process on HIV/AIDS Prevention and Screening. Your responses to a series of questions will be recorded, but your responses will be anonymous as part of this process. This interview will take 30-60 minutes. Do have any questions?

Date:_____________Time: ____________Interviewer: ____________ County: ___________

COMMUNITY EFFORTS (A) AND COMMUNITY KNOWLEDGE OF EFFORTS (B)

1. Using a scale from 1-10, how much of a concern is HIV/AIDS prevention and screening in your community (with 1being "not at all" and 10 being "a very great concern")? Please explain.
2. Please describe the current efforts (e.g. services) that are available in your community to address HIV/AIDS. **(A)**
3. How long have these efforts been going on in your community? **(A)**
4. Using a scale from 1-10, how aware are people in your community of these efforts (with 1 being "no awareness" and 10 being "very aware")? Please explain. **(B)**
5. What does the community know about these efforts or activities? **(B)**
6. What are the strengths of these efforts? **(B)**
7. What are the weaknesses of these efforts? **(B)**
8. Who do these programs serve? (Prompt: For example, individuals of a certain age group, ethnicity, etc.) **(A)**
9. Would there be any segments of the community for which these efforts/services may appear inaccessible? (Prompt: For example, individuals of a certain age group, ethnicity, income level, geographic region, etc.) **(A)**
10. Is there a need to expand these HIV/AIDS prevention efforts or screening services? If not, why not? **(A)**
11. Is there any planning for efforts/services going on in your community surrounding this issue? If yes, please explain. **(A)**
12. What formal or informal policies, practices and laws related to HIV/AIDS are in place in your community, and for how long? (Prompt: An example of "formal" would be established policies of schools, police, or courts. An example of "informal" would be similar to the police not responding to calls from a particular part of town, etc.) **(A)**
13. Are there segments of the community for which these policies, practices and laws may not apply? (Prompt: For example, due to socioeconomic status, ethnicity, age, etc.) **(A)**

If not, skip questions 14-15.

14. Is there a need to expand these policies, practices and laws? If so, are there plans to expand them? Please explain. **(A)**
15. How does the community view these policies, practices and laws? **(A)**

LEADERSHIP

16. Who are the "leaders" specific to HIV/AIDS in your community?
17. Using a scale from 1 to 10, how much of a concern is HIV/AIDS to the leadership in your community (with 1 being "not at all" and 10 being "of great concern")? Please explain.

18. How are these leaders involved in efforts regarding providing services related to HIV/AIDS prevention and screening? Please explain. (For example: Are they involved in a committee, task force, etc.? How often do they meet?)
19. Would the leadership support additional efforts/services? Please explain.

COMMUNITY CLIMATE

20. Describe _______________ (name of your community).
21. Are there ever any circumstances in which members of your community might think that the issue of HIV/AIDS is a concern that should be tolerated (i.e., meaning that nothing done to address this issue)? Please explain.
22. How does the community support the efforts to address HIV or AIDS prevention or screening?
23. What are the primary obstacles to efforts addressing HIV or AIDS prevention or screening in your community?
24. Based on the answers that you have provided so far, what do you think is the overall feeling among community members regarding HIV/AIDS?

KNOWLEDGE ABOUT THE ISSUE

25. How knowledgeable are community members about HIV/AIDS as an issue to address? Please explain. (Prompt: For example, dynamics, signs, symptoms, local statistics, effects on family and friends, etc.)
26. What type of information is available in your community regarding HIV and AIDS?
27. What local data are available on HIV/AIDS in your community?
28. How do people obtain this information in your community?

RESOURCES FOR PREVENTION EFFORTS (time, money, people, space, etc.)

29. To whom would an individual affected by HIV/AIDS turn to first for help in your community? Why?
30. On a scale from 1 to 10, what is the level of expertise and training among those working on HIV/AIDS in your community (with 1 being “very low” and 10 being “very high”)? Please explain.
31. Do efforts that address HIV and AIDS prevention have a broad base of volunteers?
32. What is the community’s and/or local business’ attitude about supporting efforts to address HIV/AIDS, with people volunteering time, making financial donations, and/or providing space?
33. How are current HIV and AIDS prevention efforts funded? Please explain.
34. Are you aware of any proposals or action plans that have been submitted for funding that address HIV/AIDS prevention in your community? If yes, please explain.
35. Do you know if there is any evaluation of efforts that are in place to address HIV/AIDS prevention in your community? If yes, on a scale of 1 to 10, how sophisticated is the evaluation effort (with 1 being “not at all” and 10 being “very sophisticated”)?
36. Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?

Appendix B: Interview Scores (n = 11)

Dimension	Cheyenne	Elbert	Kit Carson	Lincoln	Logan 1	Logan 2	Morgan	Phillips	Sedgwick	Yuma	Washington	Mean	StdDev
Community Efforts	1.50	3.07	2.00	2.00	2.32	2.76	4.00	1.50	1.72	1.19	1.79	2.17	0.82
Com. Knowledge About Efforts	1.63	3.00	2.38	1.88	1.25	2.00	2.63	1.75	1.00	1.00	3.25	1.98	0.77
Leadership	1.75	3.00	1.13	2.25	2.38	1.13	2.13	1.88	1.50	1.63	1.63	1.86	0.56
Community Climate	1.78	1.85	1.20	1.00	3.00	1.93	4.90	1.78	1.13	1.50	1.00	1.92	1.14
Issue Knowledge	2.63	2.75	2.00	2.13	2.25	1.88	2.25	2.25	1.75	1.75	1.75	2.13	0.34
Resources for Prevention	1.50	1.50	1.51	1.50	1.94	2.88	2.94	1.57	1.70	1.75	2.26	1.91	0.55
Overall	1.80	2.53	1.70	1.79	2.19	2.10	3.14	1.79	1.47	1.47	1.95	1.99	0.49