# Delta Region AETC Training Survey

**What is your Profession/Discipline?**
❑ Physician ❑ Physician Assistant ❑ Dentist ❑ Advance Practice Nurse ❑ Nurse ❑ LPN
❑ Pharmacist ❑ Other:_____

**In what state hospital and/or medical center do you work?**
Facility Name:_____
❑ Urban ❑ Rural ❑ Suburban

**Does your facility/organization receive any Ryan White Funding?**
❑ Yes ❑ No ❑ Do Not Know

**What length of program do you prefer to participate in?**
❑ 1 – 2 hours ❑ 2 -3 hours ❑ Half day ❑ Full day ❑ 2-3days ❑ Duration is not a factor

**In general, HOW FAR are you willing/able to travel for training?**
❑ On-site ❑ Off-site nearby ❑ City where you work ❑ State where you work ❑ Nearby state ❑ Anywhere in U.S.

**What are your TOP THREE (3) most preferred ways to learn**
❑ Clinical case discussions ❑ Clinical practicum ❑ Skill-building sessions ❑ Panel discussion
❑ Self-teaching ❑ Lecture/presentation ❑ Internet based ❑ Other: (specify)_____

**1. HIV/AIDS treatment and management topics**

| Topic | Would you like training on this topic? |
|---|---|
| **Adherence issues** | ❑ Yes ❑ No |
| **Protease inhibitor/antiretroviral therapies** | ❑ Yes ❑ No |
| **Treatment sequencing** | ❑ Yes ❑ No |
| **Viral Load /CD4 measurements/ Resistance testing** | ❑ Yes ❑ No |
| **HIV primary care/ HIV treatment guidelines** | ❑ Yes ❑ No |
| **Opportunistic Infections** | ❑ Yes ❑ No |
| **Hepatitis (A, B & C) & HIV** | ❑ Yes ❑ No |
| **STDs & HIV** | ❑ Yes ❑ No |
| **TB & HIV** | ❑ Yes ❑ No |
| **Nutrition** | ❑ Yes ❑ No |
| **Dental Care** | ❑ Yes ❑ No |

**2. HIV Transmission and testing**

| Topic | Would you like training on this topic? |
|---|---|
| **Post exposure prophylaxis** | ❑ Yes ❑ No |
| **Perinatal Transmission** | ❑ Yes ❑ No |
| **Primary & secondary prevention** | ❑ Yes ❑ No |
| **Counseling & Testing/ Taking a Sexual History/ Risk Assessment** | ❑ Yes ❑ No |

**Please Turn Over.**

**3. Special Populations and HIV**

| Topic | Would you like training on this topic? |
|---|---|
| **Women & HIV** | ❑ Yes ❑ No |
| **Pediatrics/Adolescents with HIV** | ❑ Yes ❑ No |
| **Elderly & HIV** | ❑ Yes ❑ No |
| **HIV care of incarcerated patient** | ❑ Yes ❑ No |
| **Psychosocial issues/ Cultural Issues** | ❑ Yes ❑ No |
| **Mental Health/ Substance Abuse** | ❑ Yes ❑ No |
| **Palliative Care/End of Life issues** | ❑ Yes ❑ No |

**4. Other topics of interest**: 1) _____, 2) _____, 3) _____

**5. Hands-on training/ clinical consultation**

**Are you interested in clinical consultation and/or hands-on training?**
**ON-SITE (at your work place)** ❑ Yes ❑ No
**OFF-SITE (not at your work place)** ❑ Yes ❑ No

| Mode of Clinical Consultation | Prefer to Use |
|---|---|
| **Telephone consultation** | ❑ Yes ❑ No |
| **Face-to-Face** | ❑ Yes ❑ No |
| **Email** | ❑ Yes ❑ No |
| **Videoconference/ Telemedicine** | ❑ Yes ❑ No |
| **None** | ❑ Yes ❑ No |
| **Other:_____** | ❑ Yes ❑ No |

**Have you used the DAETC Clinical Consultation Service?** ❑ Yes ❑ No
**If yes, please give us your comments**: _____
_____
_____
_____

**6. Have you ever attended a Delta AETC training?** ❑ Yes ❑ No
**If yes, please give us your comments**: _____
_____
_____
_____

**7. Do you believe the DAETC influenced your practice in some way?** ❑ Yes ❑ No
**If yes, please tell us how:**_____
_____
_____
_____

**8. What could the DAETC do to help support your program?** _____
_____
_____
_____
_____

**Thank you for your time!**