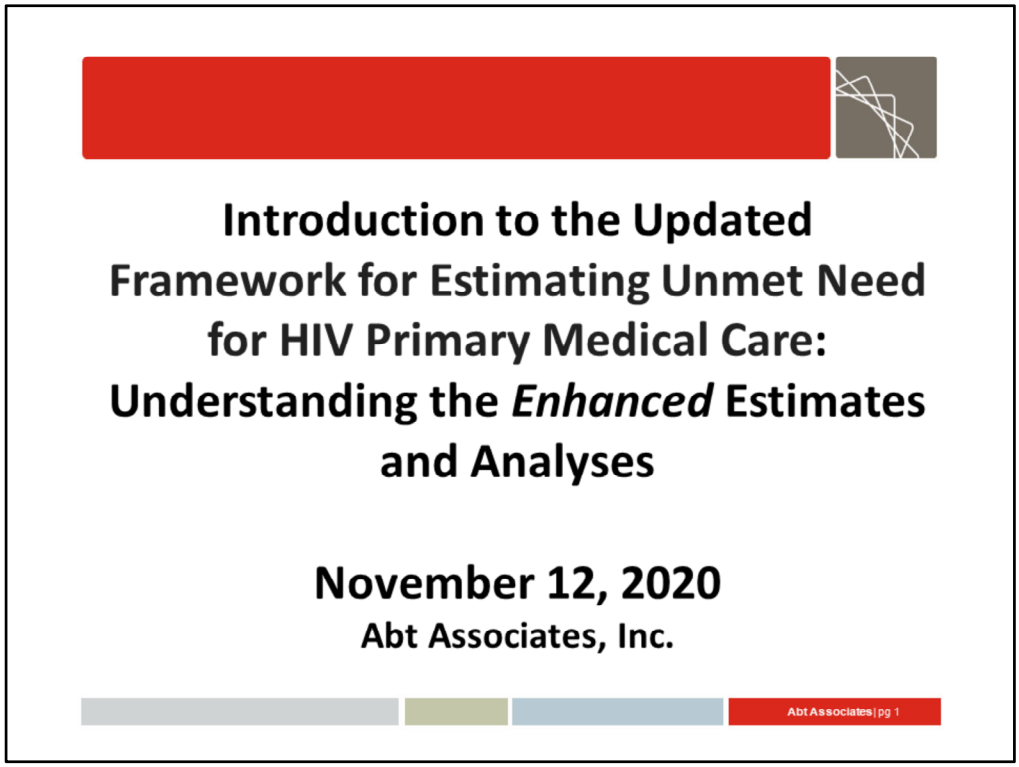
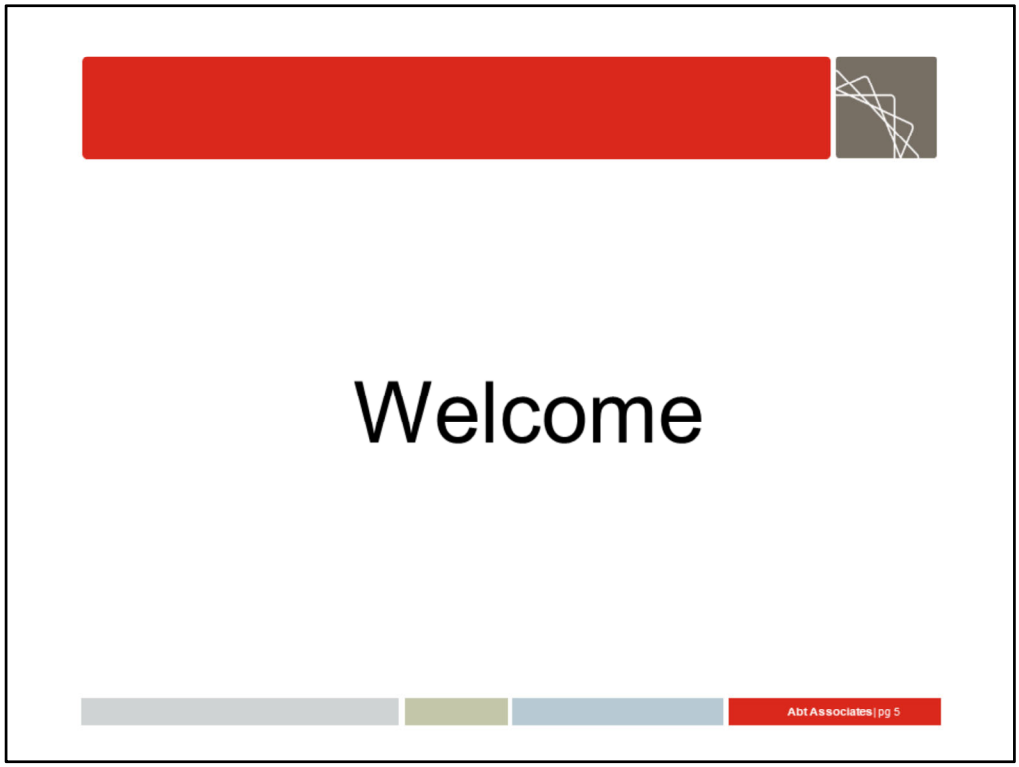
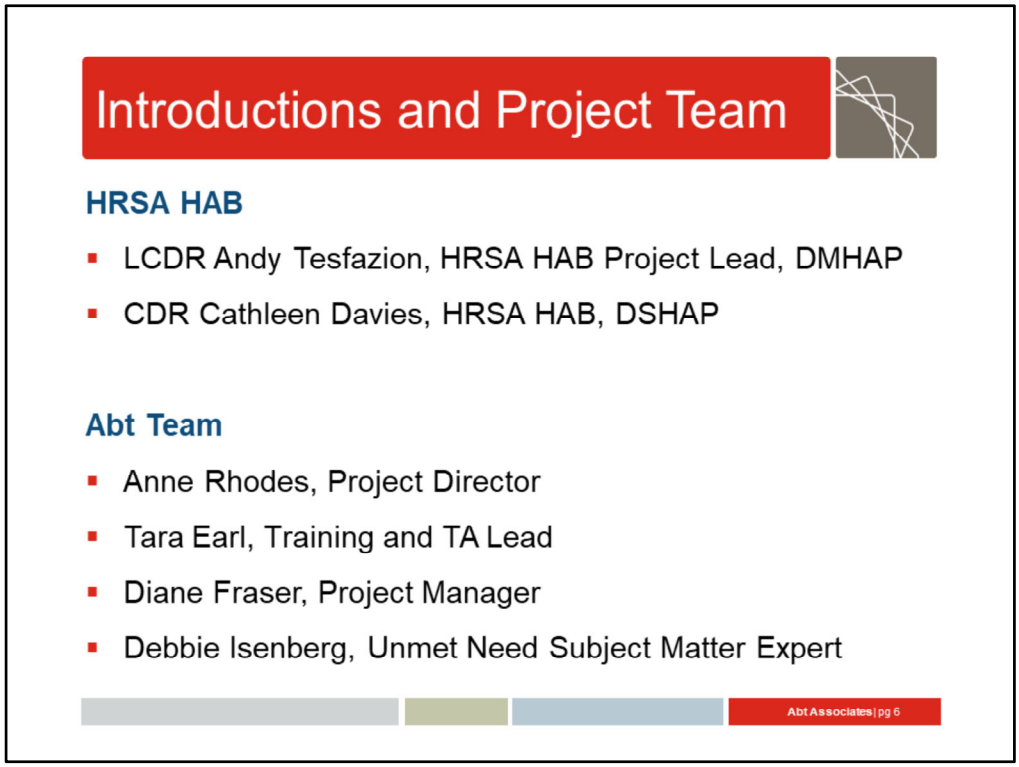


Tara. Hello everyone. My name is Tara Earl and my company, Abt Associates is contracted by HRSA HAB to deliver a series of webinars to support the implementation of the Updated Framework for Estimating Unmet Need for HIV Primary Medical Care. For this project, you'll come to know us as the Ryan White HIV/AIDS Program Unmet Need Training and Technical Assistance Team and I'll introduce everyone soon.

If you joined us a few weeks ago, welcome back. If this is your first time, also welcome. This is the second of six webinars that the Abt team is presenting to ensure that you all have proper guidance and information as you seek to implement the updated framework. This webinar is focused on the enhanced estimates and analyses, where as the previous webinar focused on the required estimates and analyses. Again, thanks for joining today, we'll get started in a few minutes.



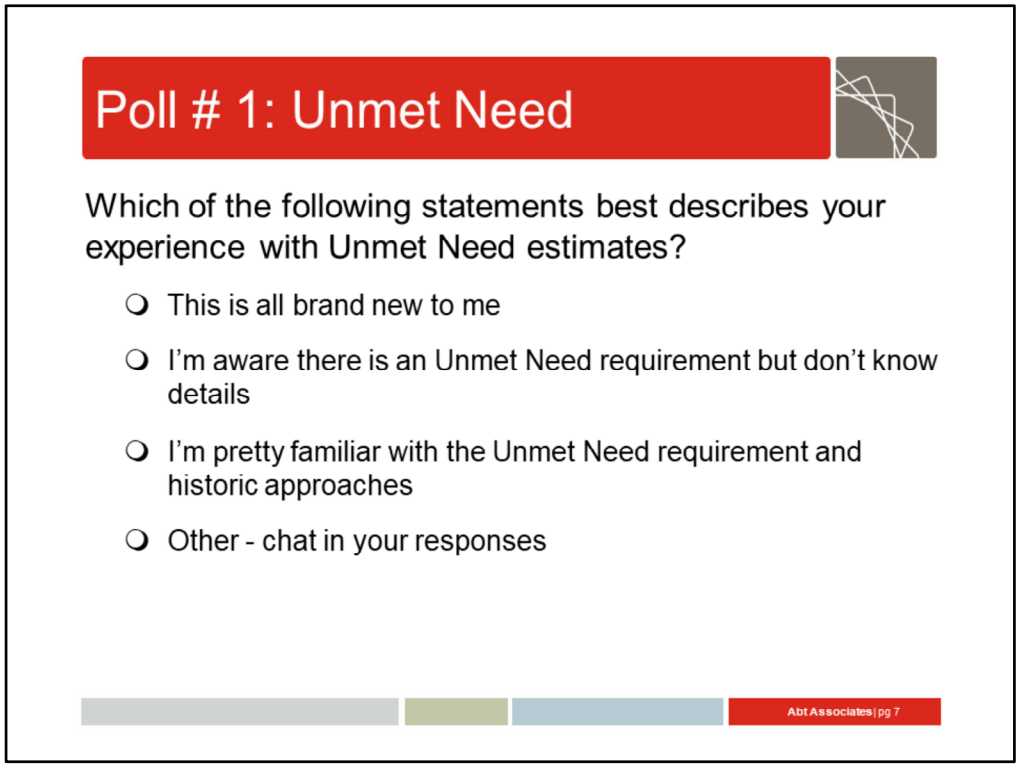
- Good morning! My name is Andy Tesfazion. I am a Senior Advisor in the Division of Metropolitan HIV/AIDS Programs (DMHAP, also known as the Part A program) and the Health Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) lead for the development and implementation of the new Unmet Need Framework I want to welcome and thank you all for attending today's training; and I want to extend a thanks to the Abt Associates team for putting this training webinar, which is the second of six training webinars on the new Unmet Need Framework geared towards RWHAP Part A and Part B recipient staff and other staff at the recipient level who may work on Unmet Need estimates and analyses.



Introductions

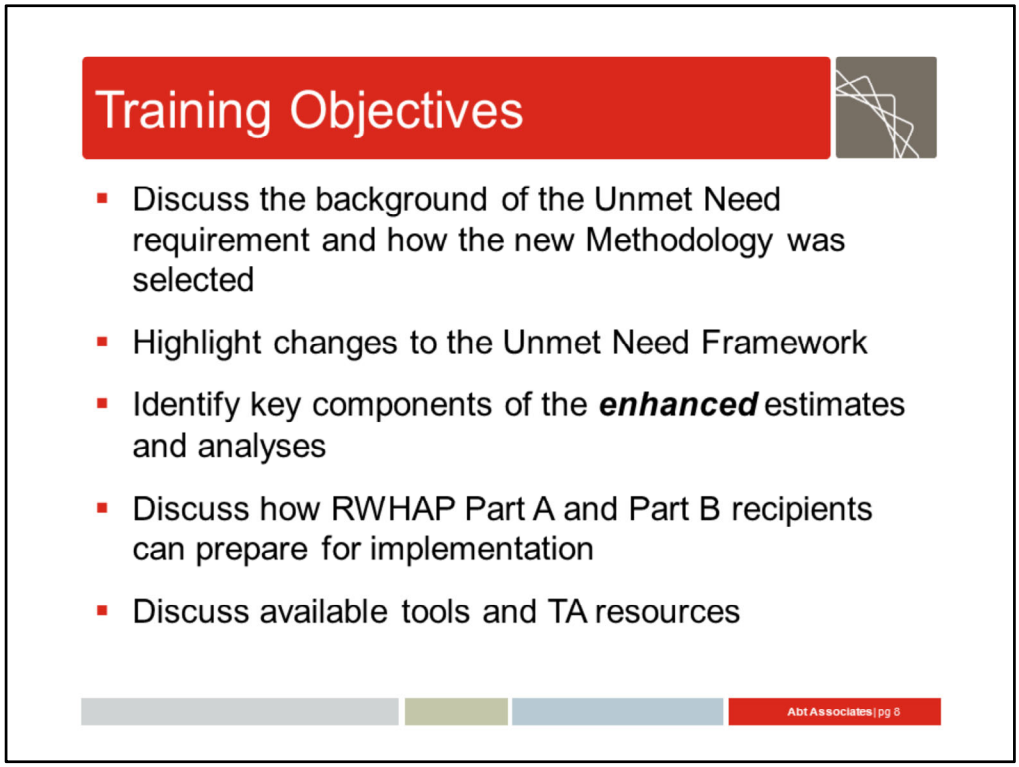
Thanks Andy! I would like to take a few minutes to introduce key members of this project. Andy Tesfazion from the Division of Metropolitan HIV/AIDS Programs (DMHAP: D-MAP) and Cathleen, or Cat, Davies from the Division of State HIV/AIDS Programs (DSHAP: D-SHAP) are senior advisors who will guide this work as well as serve as a resource to the HRSA HAB Project Officers.

Earlier I mentioned that my colleagues and I have been working closely with Andy and others at HRSA HAB to update the Unmet Need Framework. Known as the Ryan White HIV/AIDS Program Unmet Need Training and Technical Assistance Team, our team includes Anne Rhodes, myself, Diane Fraser and Debbie Isenberg. Today, you'll hear from both Anne and Debbie. We're excited to have Debbie as part of our team given her extensive experience and expertise with the Unmet Need framework.



Poll 1: Unmet Need

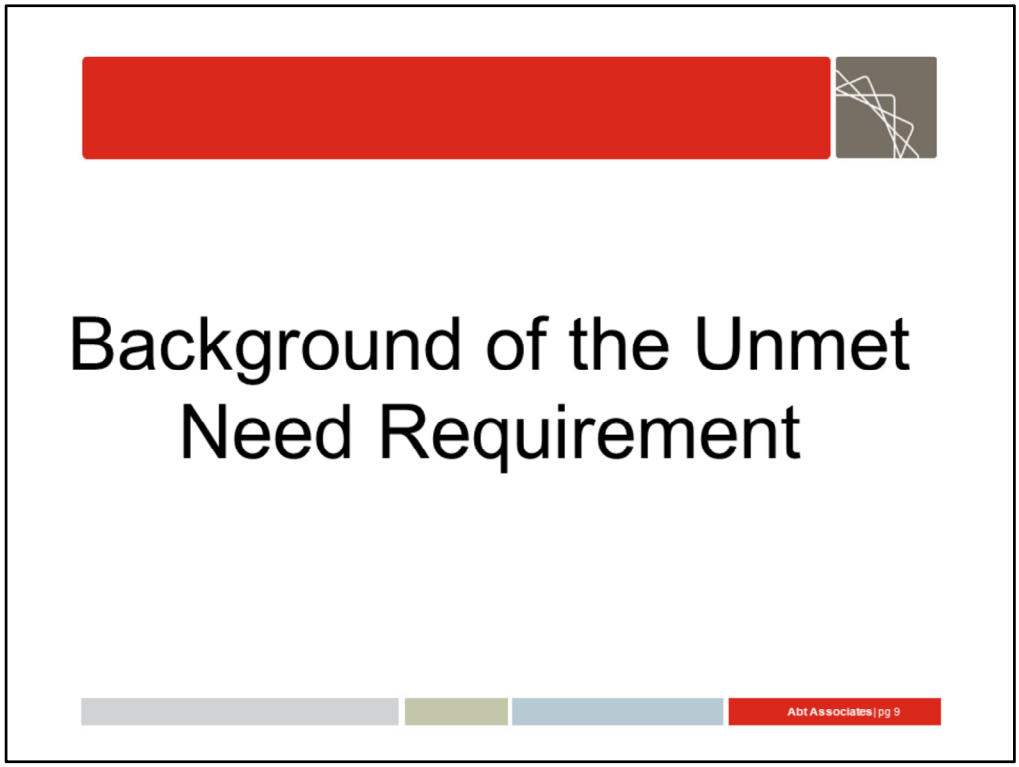
Before we jump into all things unmet need, we'd like to do a quick poll to find out how much you all know about the exciting world of unmet need. Diane will launch the poll and you should see it on your screen – this is a choose only one answer. I'll give people a minute to respond.



Training Objectives
Today we are going to:

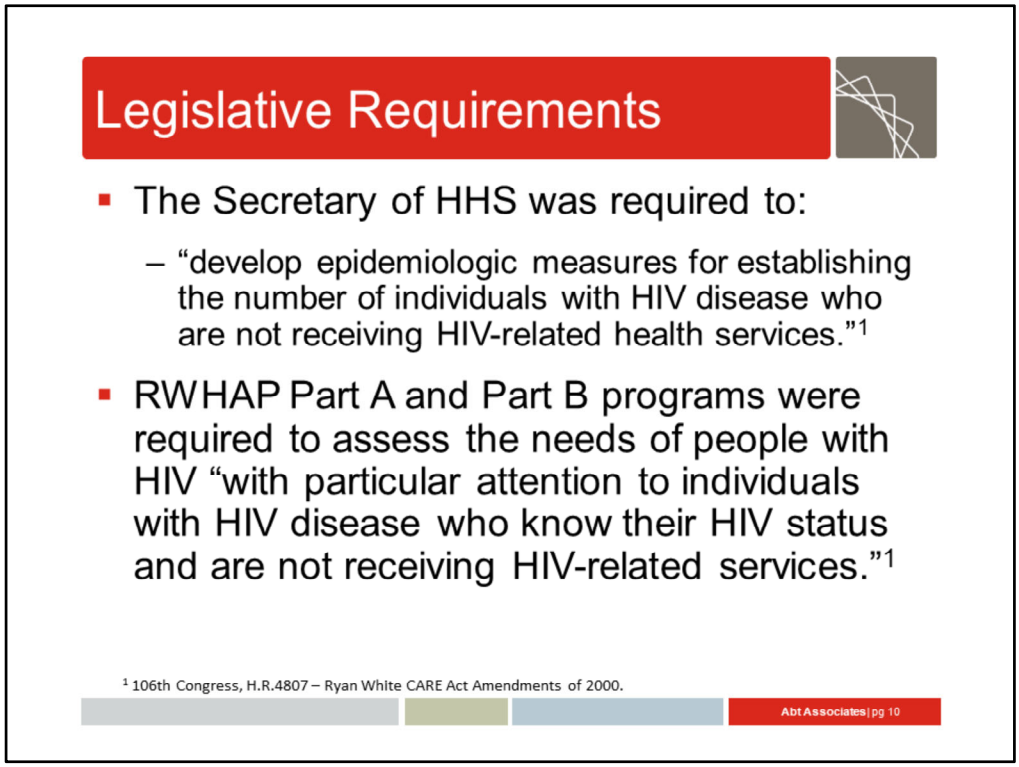
- Discuss the background of the Unmet Need requirement and how the new Methodology was selected
- highlight the updates to the Unmet Need Framework,
- review the Framework's **enhanced** estimates and analyses...remember this webinar focuses on **the enhanced instead of the required estimates and analyses**,
- explain how recipients should prepare for implementation, and most importantly,
- discuss the tools and resources that will be available to you as you prepare to do Unmet Need estimates and analyses.

We'll spend about an hour covering this information and then we'll have about 30 minutes for discussion and questions. We will also highlight upcoming activities and webinars.
The information that we cover is provided in more detail in the *Methodology for Estimating Unmet Need Instruction Manual*. The manual, additional implementation support materials, as well as today's slides and audio-recording will be available on the TargetHIV website. The manual and implementation materials are already available and Diane has included a link to them in the chat box.
Again, if you have questions, please don't hesitate to post them using Q&A. You can do this at anytime during the presentation and we'll review.



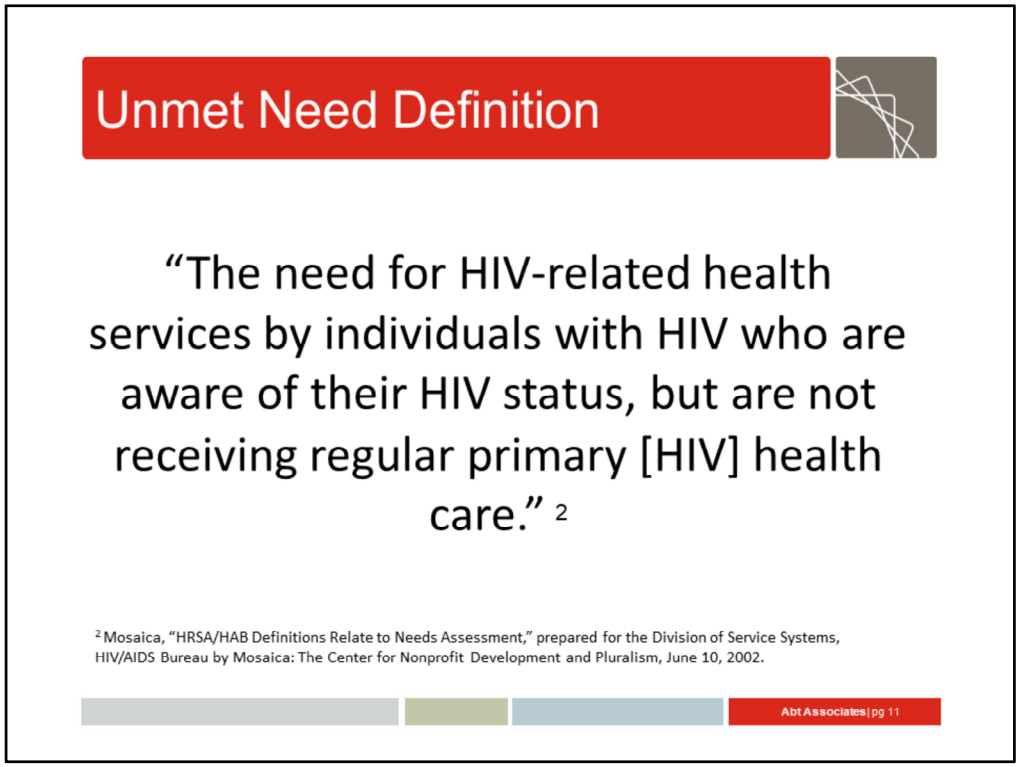
RWHAP Unmet Need Framework and Methodology Transition Slide

Ok, let's dive in. I'm going to start with some background about the Unmet Need requirement and what it is. For people who attended our first webinar in October, this will be a review of information.



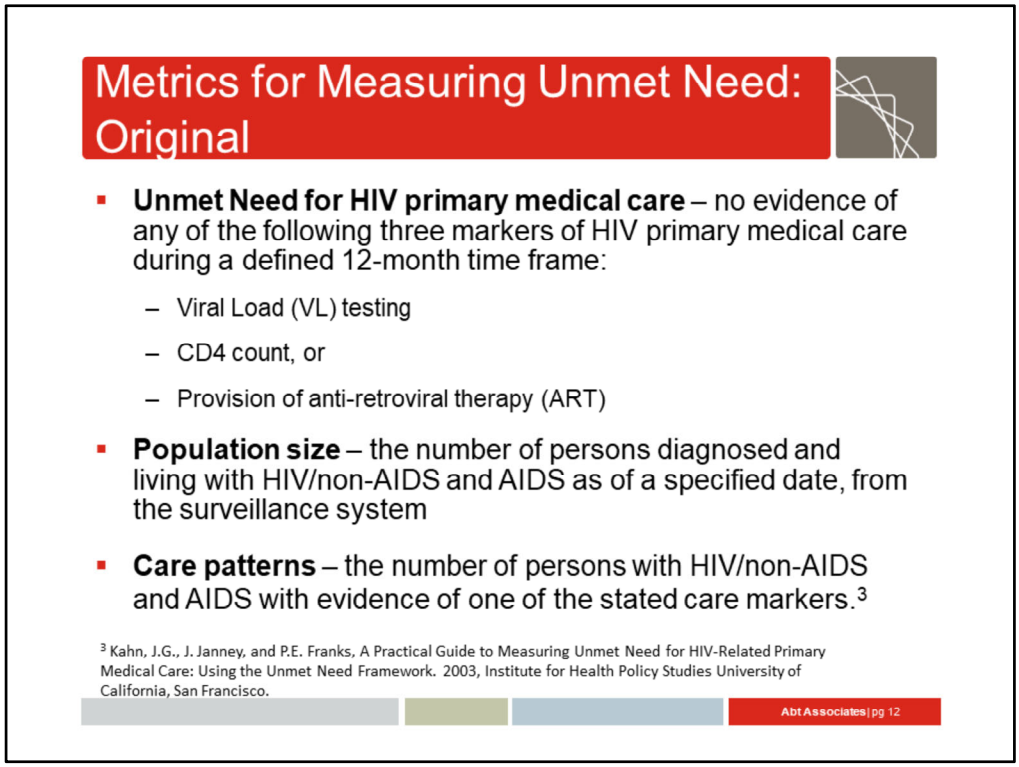
Legislative Requirements

Unmet need was first introduced in the Ryan White CARE Act amendments of 2000. The Secretary of HHS was required to develop epidemiologic measures for establishing the number of individuals with HIV disease who are not receiving HIV-related health services. RWHAP Part A and Part B programs were charged with assessing the needs of people with HIV (PWH) "with particular attention to individuals with HIV disease who know their HIV status and are not receiving HIV-related services."



<u>Unmet Need Definition</u>

The formal definition for unmet need is – "The need for HIV-related health services by individuals with HIV who are aware of their HIV status, but are not receiving regular primary [HIV] health care." – So this was prior to the idea of the care continuum, but was looking at similar issues.



Metrics for Measuring Unmet Need: Original

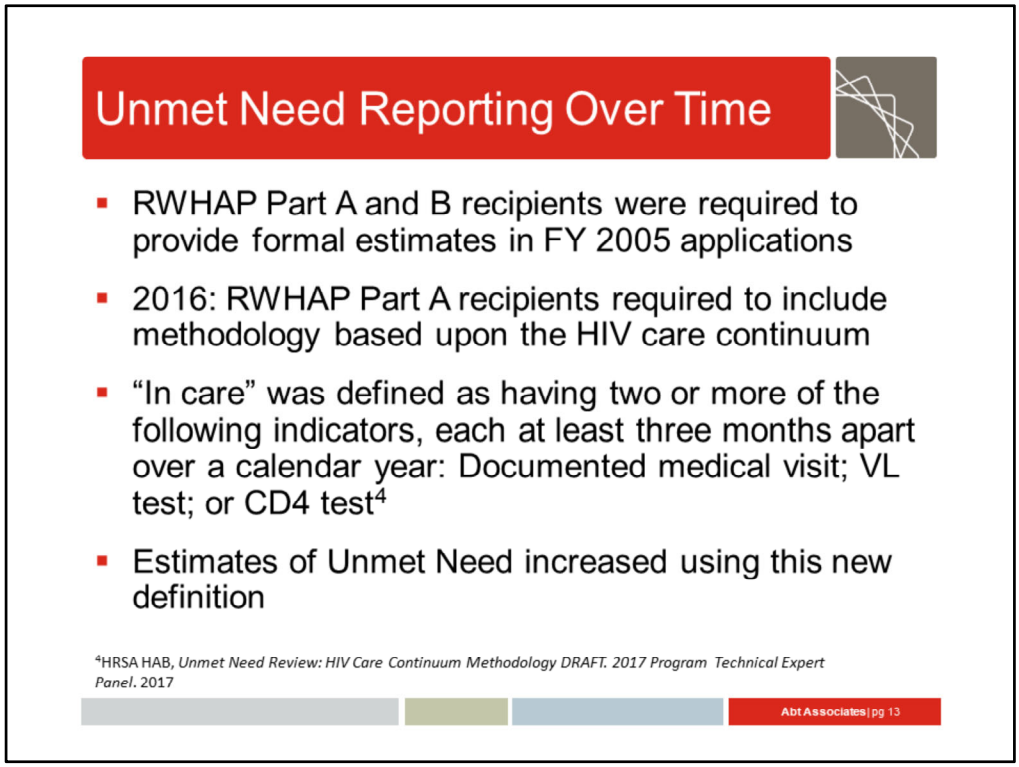
So let's do a quick review of the original elements used to measure unmet need. They included:

Unmet need for HIV primary care, which was defined as no evidence of any of the following three markers of HIV primary medical care during a defined 12-month time frame:

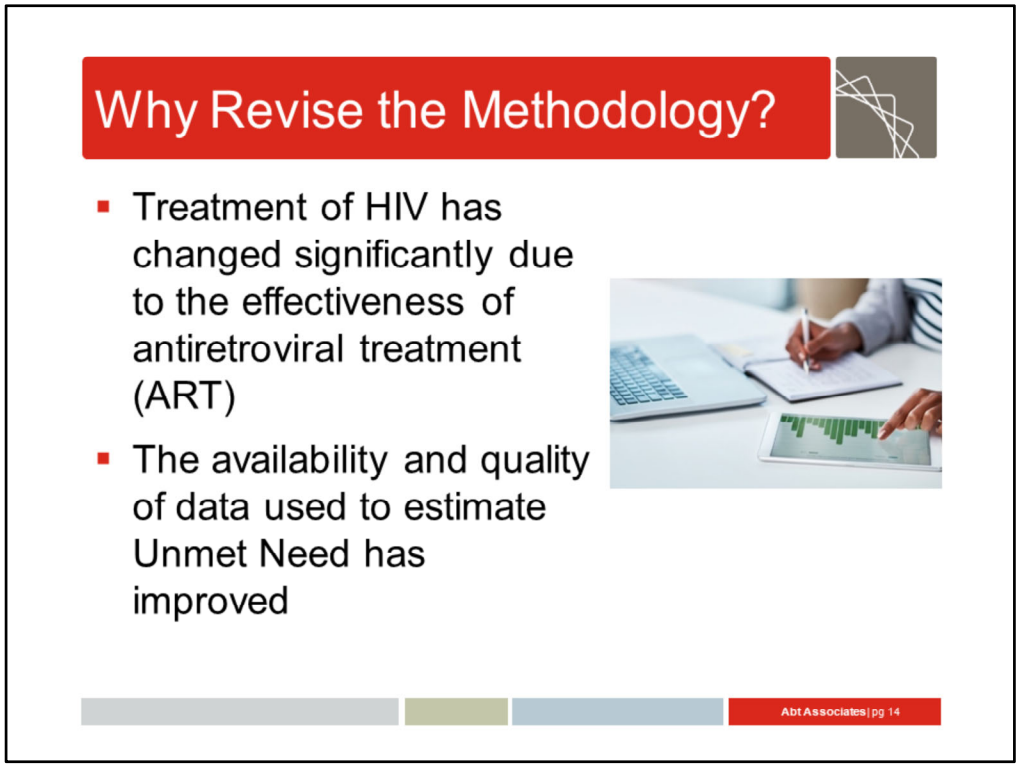
Viral Load (VL) Testing
CD4 count, or;
Provision of anti-retroviral therapy (ART)

Population Size was defined the number of persons diagnosed and living with HIV/non-AIDS and AIDS as of a specified date, from the surveillance system

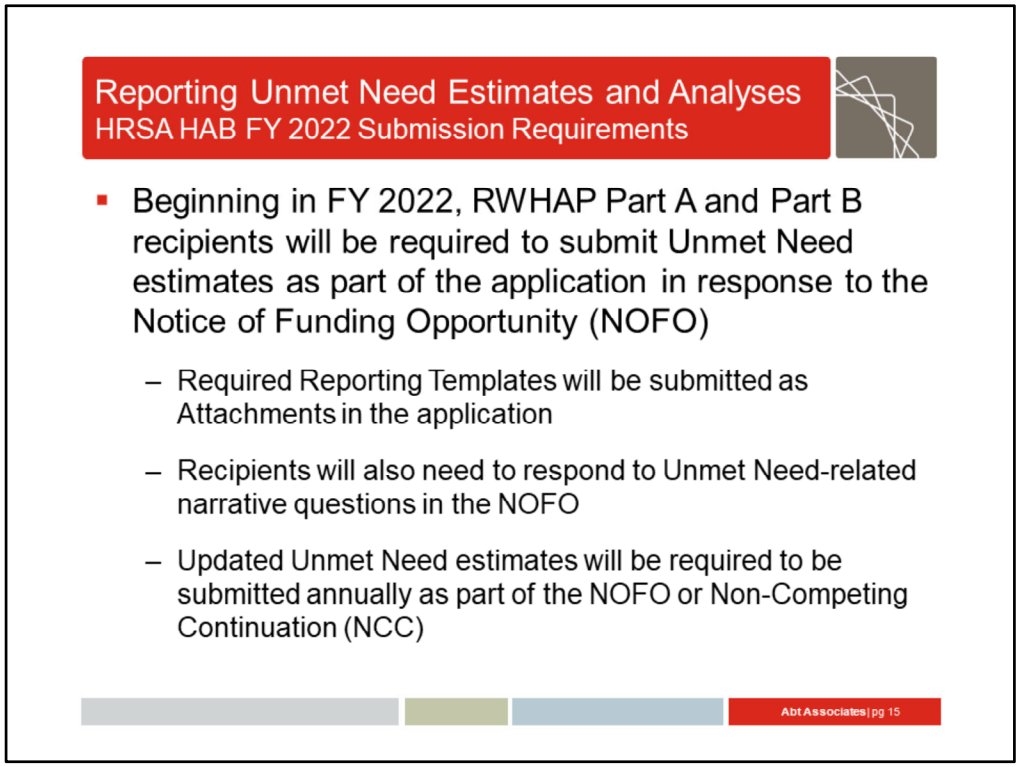
And Care patterns were defined the number of persons with HIV/non-AIDS and AIDS with evidence of one of the stated care markers.



Implementing Changes to Unmet Need Reporting Part A and Part B recipients began reporting unmet need estimates in FY 2005 applications. In 2016, HRSA HAB required Part A recipients to utilize a new methodology that was based on the HIV care continuum. In care was defined as having two or more of the following indicators, each at least three months apart over a calendar year: Documented medical visit; VL test; or CD4 test. This was similar to the retention in care measure used in the continuum. This estimation method showed increased unmet need compared with the original definitions.



Why Revise the Methodology In the years since the original Unmet Need methodology was put in place, the treatment of HIV disease has changed significantly due to the effectiveness of antiretroviral treatment (ART). The availability and quality of data used to estimate unmet need have improved during this time as well. In response, HRSA HAB has been exploring ways to more effectively estimate unmet need—meeting both the legislative requirements and providing a better tool that jurisdictions can use to identify needs and develop interventions in response to those needs.

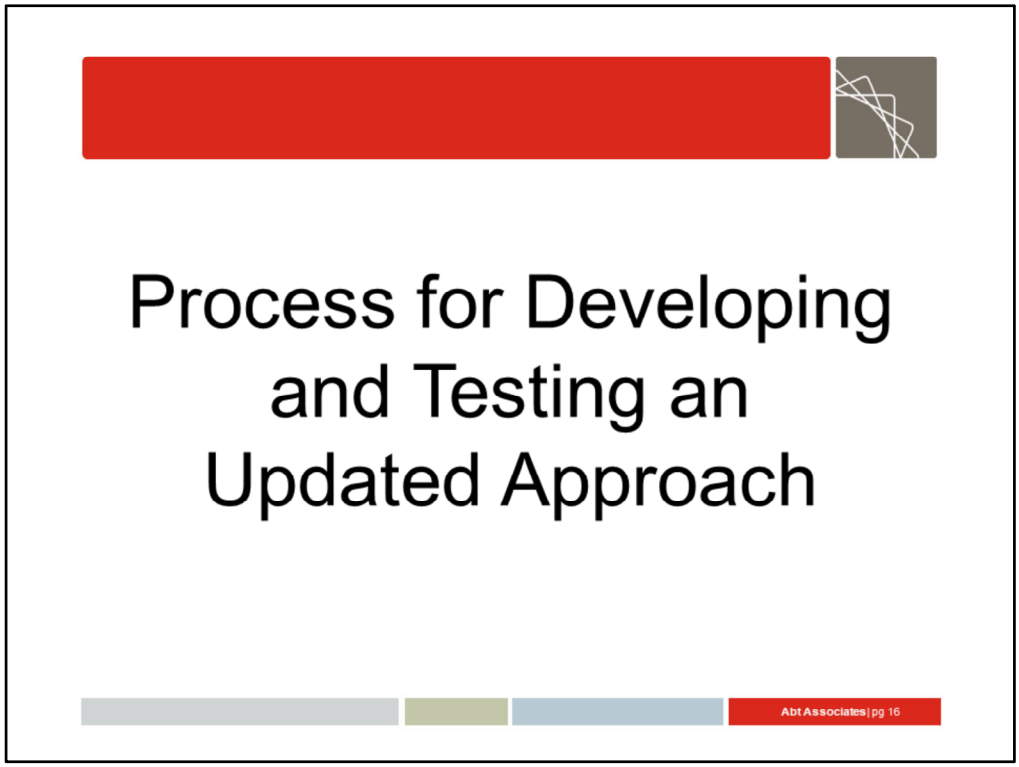


<u>Reporting Unmet Need Estimates and Analyses</u>
Beginning in FY 2022, recipients will be required to submit Unmet Need estimates as part of the application in response to the Notice of Funding Opportunity (NOFO).

Recipients will use the Required Reporting Templates (which Debbie will review today) as attachments in the application. Only the required estimates and analyses have to be submitted but recipients can submit enhanced estimates and analyses, which we will be reviewing in detail today.

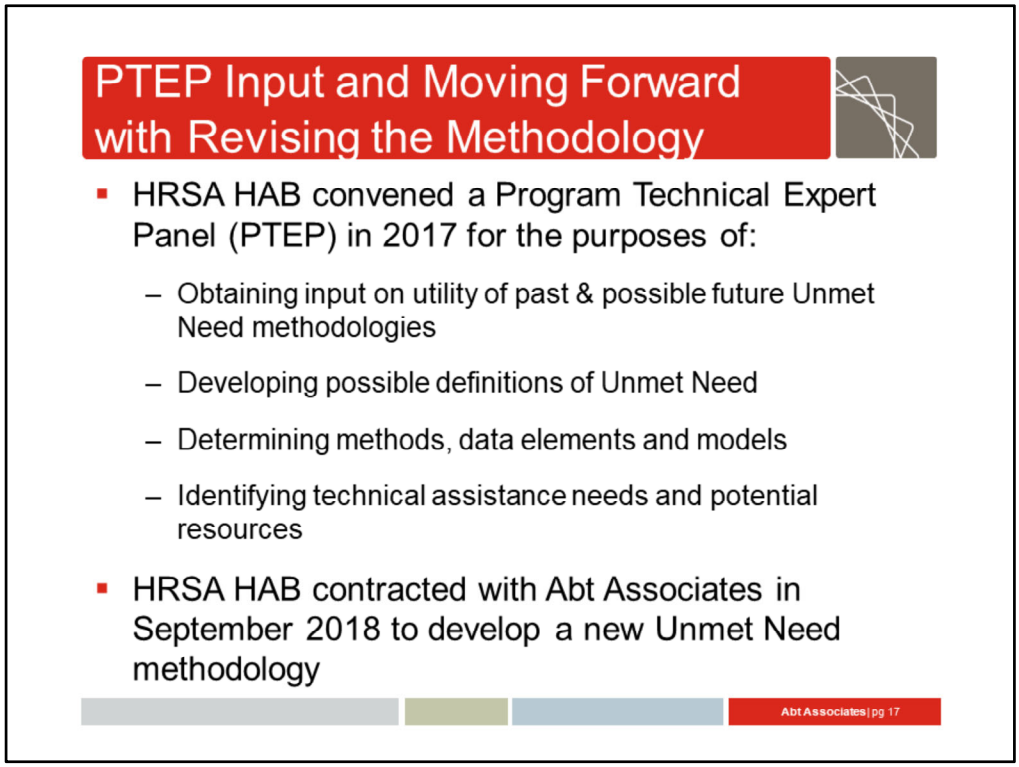
There will also be narrative questions related to unmet need that will need to be addressed based on the data in the reporting template. The Unmet Need estimates will be required to be updated annually and submitted as part of the Part A and Part B NOFOs and/or non-competing continuations.

So now, I'm going to pass this over to Debbie Isenberg to discuss the process for changing the Unmet Need framework and walk us through the specific elements of the new framework. As a reminder, please use the Q&A feature to submit any questions that you have and we will review these at the end of the presentation.



Process for Developing and Testing an Updated Approached Transition Slide

Thanks so much Anne. I'm going to start by sharing an overview of the process that HRSA HAB undertook to develop and test an updated Unmet Need Methodology.

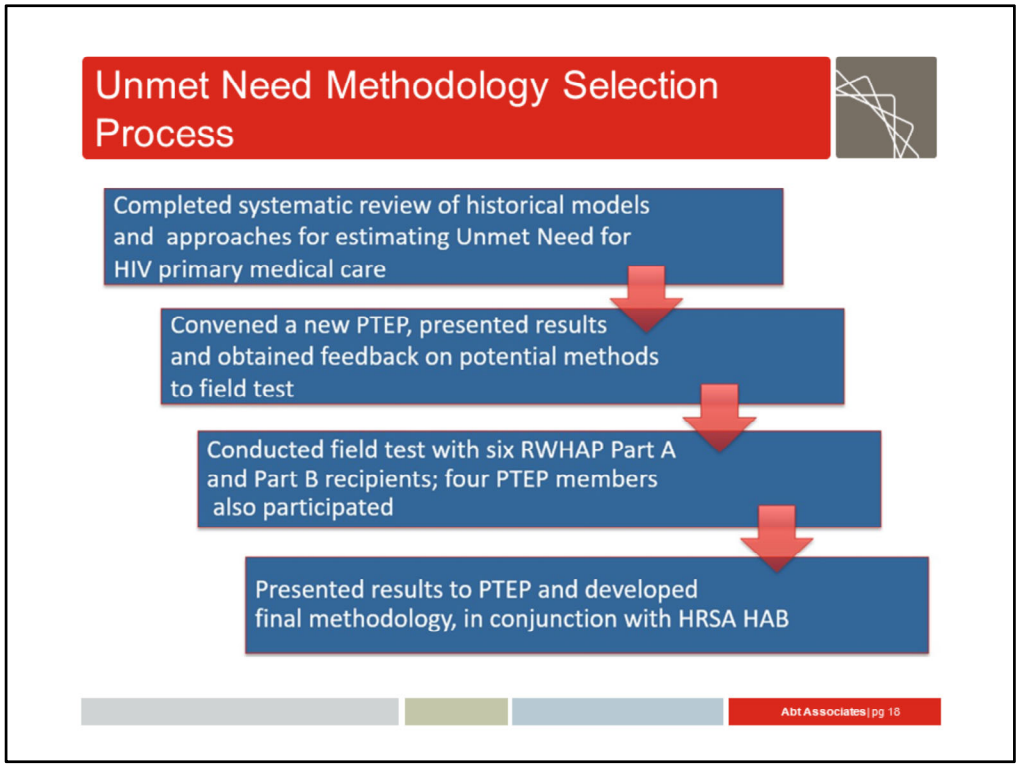


PTEP Input and Moving Forward with Revising the Approach

HRSA HAB convened a Program Technical Expert Panel or PTEP in 2017 for four purposes:

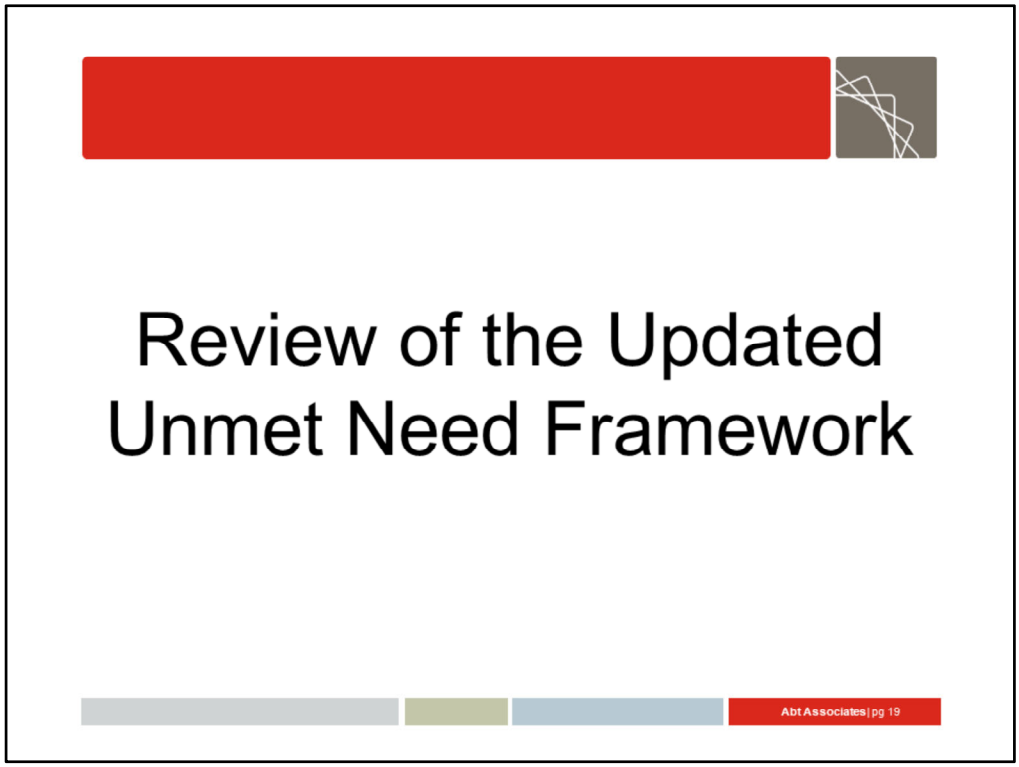
- Obtain input on the past and possible future methodologies
- Develop possible definitions to be used for Unmet Need
- Determine methods, data elements and models for assessing jurisdictional Unmet Need
- And identify TA needs and resources for implementing Unmet Need

In the Fall of 2018, HRSA HAB contracted with Abt Associates to build on the work of the 2017 PTEP. The purpose of the contract is to conduct an analysis of historical models and approaches for estimating Unmet Need to inform recommendations for a practical measure for estimating Unmet Need for HIV primary medical care that can be implemented across RWHAP Part A and Part B grant recipients.



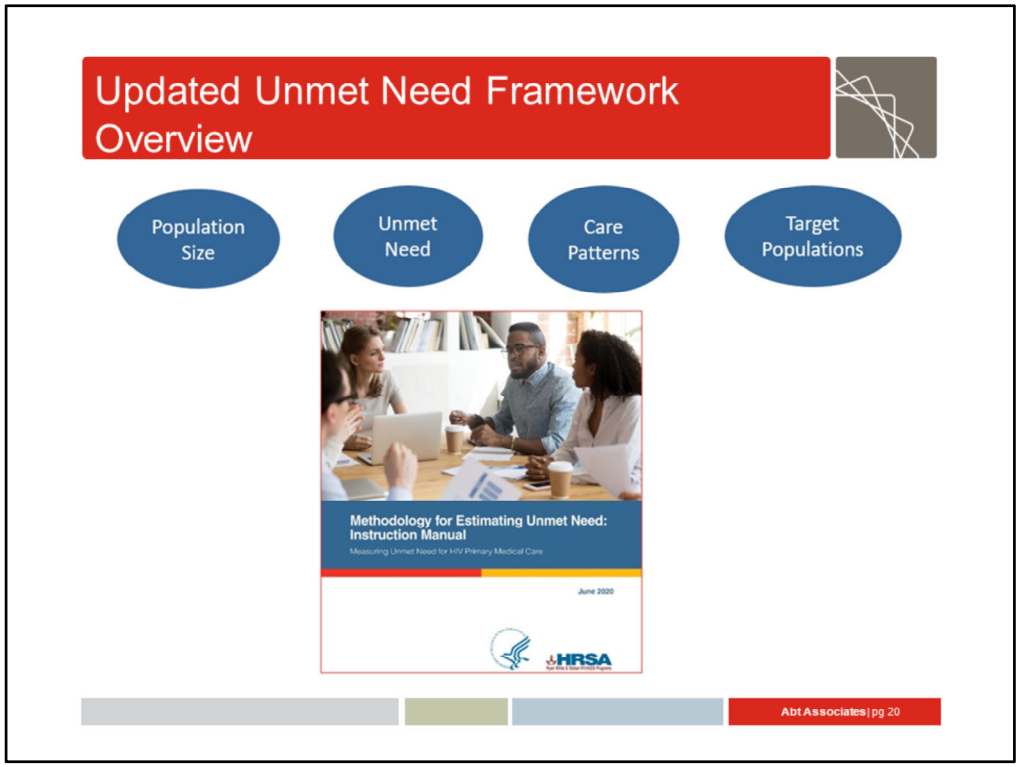
<u>Unmet Need Methodology Selection</u>
Activities have included several key steps.

1) First, the Abt team completed a literature review of existing models and approaches for estimating Unmet Need.
2) A summary of what was learned was presented to a new PTEP (many of whom were on the previous PTEP) who then shared recommendations for field testing. The Abt team, in conjunction with HRSA HAB, synthesized the information to develop guidance for field test sites to test the updated methodology.
3) Three Part A recipients and three Part B recipients were chosen to participate, representing multiple characteristics that may impact the ability of recipients to complete the Unmet Need estimates and analyses including: a Part A that crossed state lines, a Part A and B from the same state, a Part B with no Part A and a state in which the HIV surveillance program does not meet CDC completeness criteria. PTEP members who were also Part A and B recipients also volunteered to participate (2 As and 2 Bs). For Part As, both TGAs and EMAs were represented. Geographic representation was also taken into consideration.
4) The results of the field test were presented to the PTEP who provided feedback for the final methodology. Abt developed the final methodology in conjunction with HRSA HAB.



RWHAP Unmet Need Framework Transition Slide

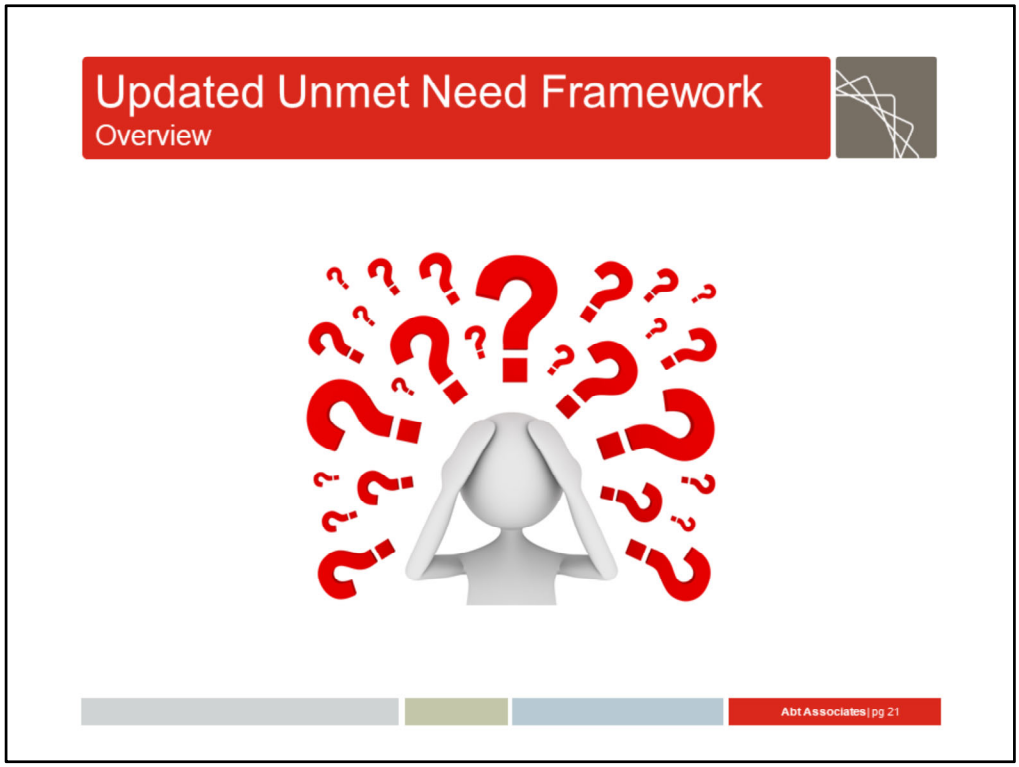
So now we're going to review the Updated Unmet Need Framework. For those of you who joined us during the October webinar, this will be a little bit of a review.



Updated Unmet Need Framework: Overview

One of the things about the framework is that there are lots of definitions! Population size, unmet need, care patterns and target populations just to name a few. We're going to review the definitions for the required estimate and analyses today but will also encourage you to read the manual.. There is a lot of detail in the manual that will be helpful.

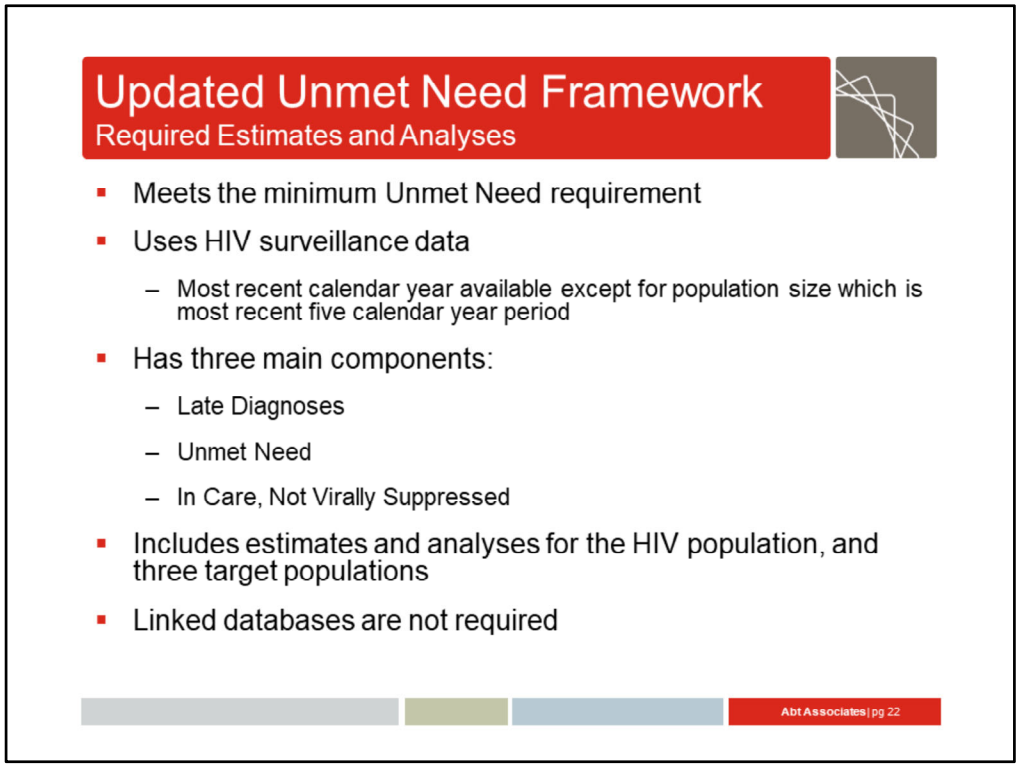
Over the next several slides, I'm going to review the required Unmet Need estimates and analyses.



Updated Unmet Need Framework: Required Estimates and Analyses

Now wait a minute! Didn't I just make it sound like there was more than one framework?

Well, there is only one framework. However, within the framework there are required estimates and analyses and enhanced estimates and analyses. Let me show you what I mean.

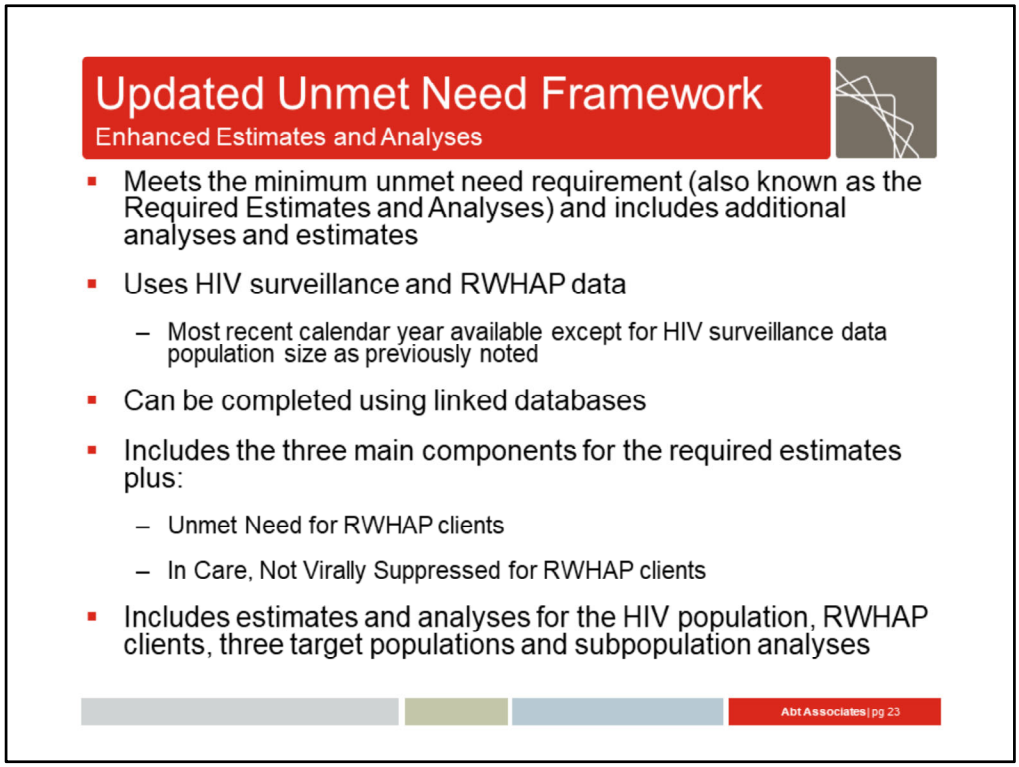


<u>Updated Unmet Need Framework: Required Estimates and Analyses</u>

The required estimates and analyses meet the minimum requirement for all Part A and B recipients. The required estimates and analyses use HIV surveillance data for the most recent calendar year except for population size which uses the most recent five calendar year period. There are three main components: Late Diagnoses, Unmet Need and In Care Not Virally Suppressed.

Recipients are expected to complete estimates and analyses for the HIV population (including all new diagnoses and people living with diagnosed HIV infection) and three target populations that are selected by the jurisdiction. These may be the same as Early Identification of Individuals with HIV/AIDS (EIIHA) or Minority AIDS Initiative (MAI) target populations but this is not required. Additional guidance will be included in the NOFO.

Linked databases are not required for the required estimates and analyses.



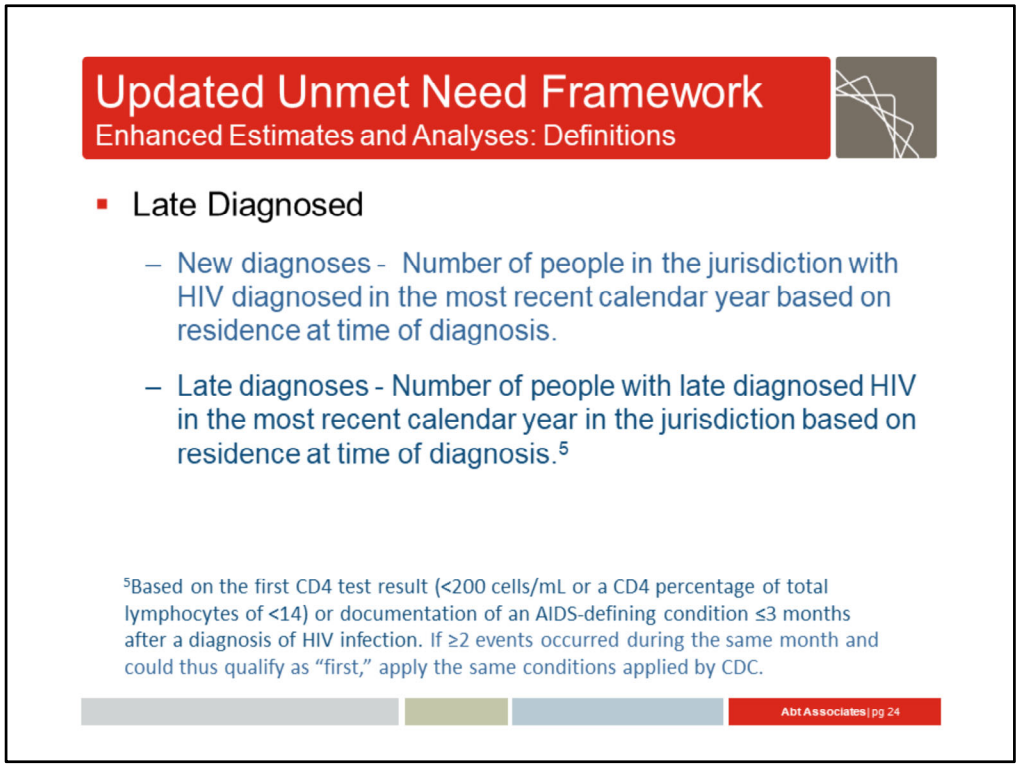
Slide 26: Updated Unmet Need Framework: *Enhanced* Estimates and Analyses

While the ***required*** estimates and analyses using HIV surveillance data are very helpful, they can be limiting for RWHAP planning or resource allocation purposes for jurisdictions. The enhanced estimates and analyses include ALL of the requirements I just reviewed PLUS additional estimates and analyses that can be useful for RWHAP planning and resource allocation. These additional estimates and analyses are optional but are recommended if feasible; how much of the additional estimates and analyses are completed are also up to the recipient.

The additional estimates and analyses use both HIV surveillance AND RWHAP data for the most recent calendar year except for population size. The most recent calendar year must be the same for all data sources. Jurisdictions can also choose to use linked databases but that is not required. The additional estimates and analyses includes all of the key components that we just reviewed for HIV surveillance data plus two others for RWHAP data-unmet need and in care not virally suppressed.

This means that recipients are expected to run estimates and analyses for the HIV population (all new diagnoses and people living with diagnosed HIV infection) and target populations. In addition, they can run estimates and analyses for RWHAP clients including the same three target populations they ran for HIV surveillance data. Additional subpopulation analyses (by age, current gender identity, etc) are also recommended for both HIV surveillance and RWHAP data.

Now let's review these definitions in more detail.



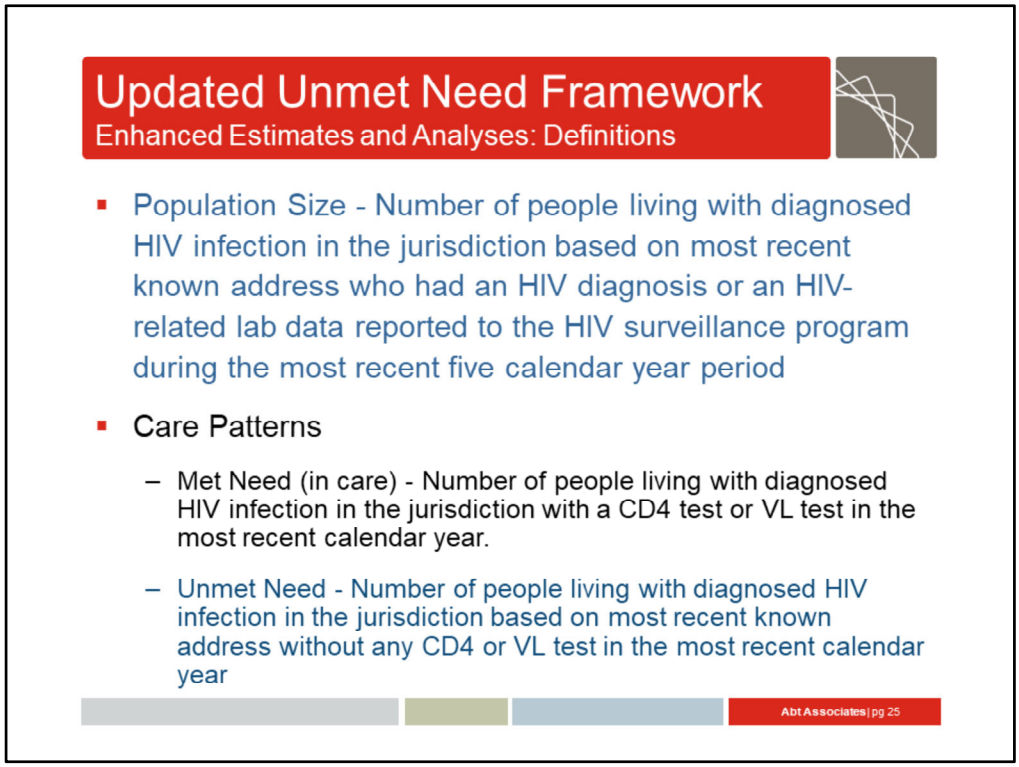
Updated Unmet Need Framework: Required Estimates and Analyses: Definitions

So I just shared that the enhanced estimates and analyses include all of the required estimates and analyses plus additional estimates and analyses. As I mentioned, in the manual there are two separate sections-one for the required estimates and analyses and one for enhanced estimates and analyses. There is no need to flip back and forth to get what you need. We're taking the same approach today so as I review the definitions, I'll be using the term enhanced estimates and analyses.

Now you'll notice as I review the definitions that some are highlighted in a different color. These are considered key components and are what have to be reported to HRSA HAB. The other data elements will need to be calculated but do not have to be reported. I also want to point out that when the estimates and analyses use HIV surveillance data, HIV surveillance definitions are used. What that means is that these definitions are commonly used by HIV surveillance programs and CDC.

The first data elements that I'll review are for late diagnosed individuals. There are two data elements here: new diagnoses and late diagnoses.

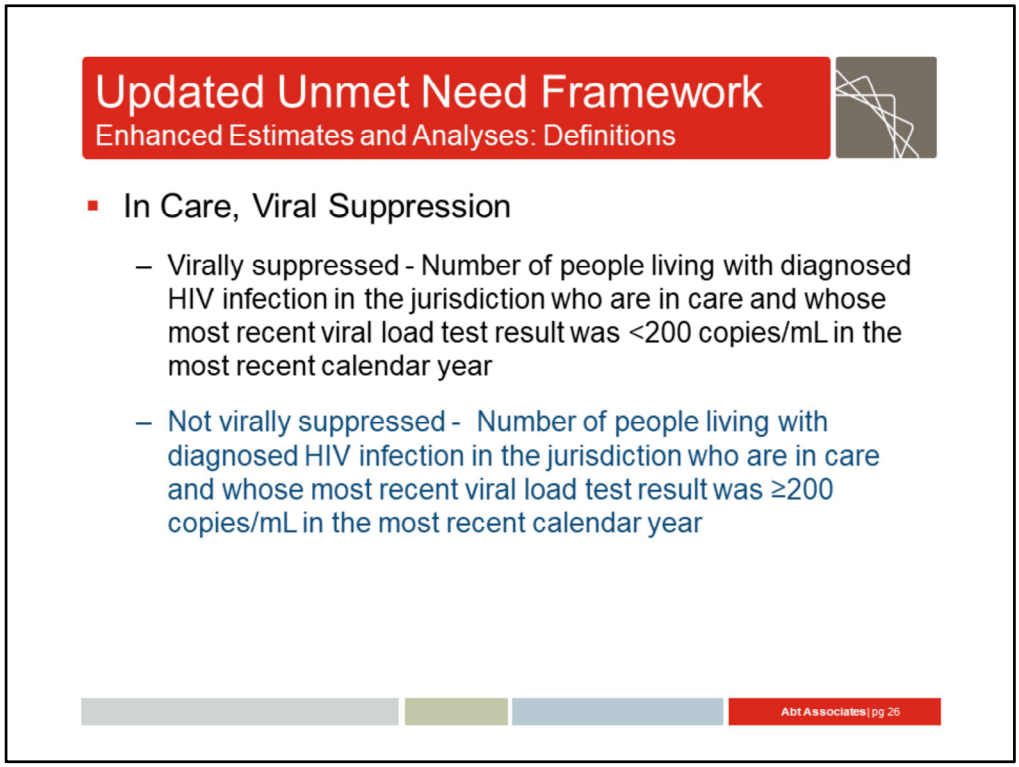
Recipients will first calculate new diagnoses-specifically the number of people in the jurisdiction with HIV diagnosed in the most recent calendar year. Residence at time of diagnosis should be used. Of those individuals with a new HIV diagnosis, recipients will then calculate the number with late diagnosed HIV. The definition for late diagnosed HIV is the first CD4 test result <200 cells/mL or documentation of an AIDS-defining condition less than three months after diagnosis of HIV infection – this is the CDC definition. The manual provides additional guidance regarding the criteria for late diagnoses.



<u>Updated Unmet Need Framework: Required Estimates and Analyses: Definitions</u>
Now let's review population size and care patterns.

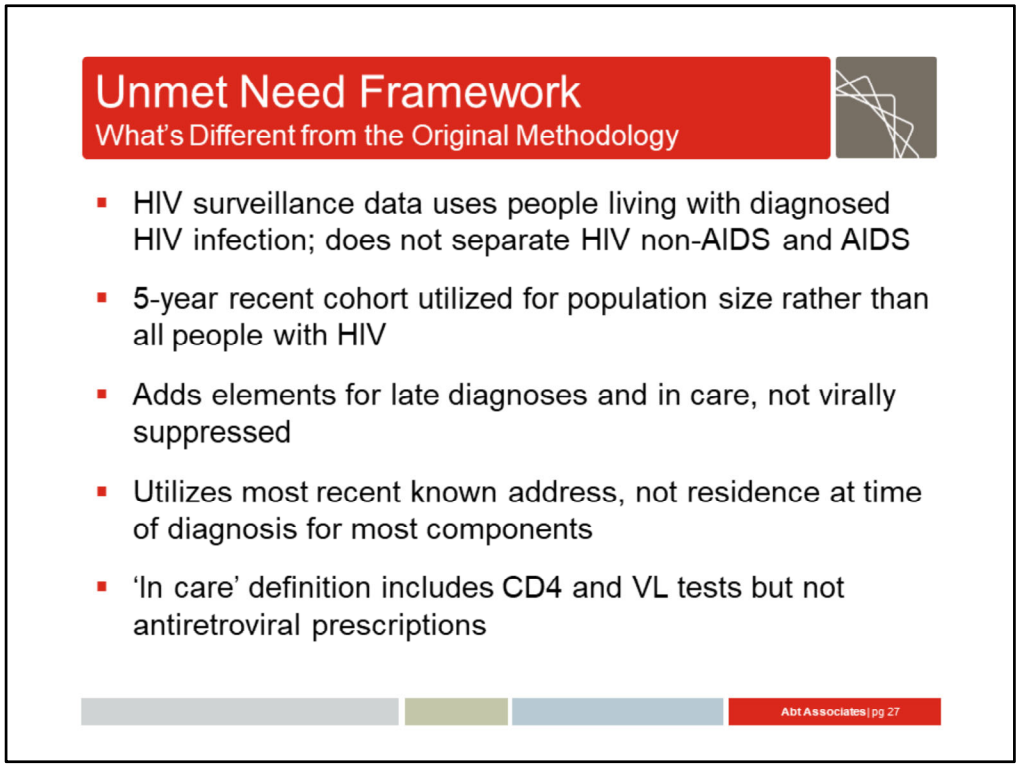
Population size uses a 5 year cohort instead of cumulative data. Specifically, it is the number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address who had an HIV diagnosis or an HIV-related in the most recent five calendar year period. HIV labs may include labs such as CD4s, viral loads, genotypes and HIV tests and again, there is more information in the manual. So you start with everyone who is living with diagnosed HIV infection but you only count those in population size who had an HIV-related lab reported in the most recent five calendar year period

Care Patterns mean met need and unmet need. Met need is those people in the population (that we just defined) who had a CD4 or a VL test in the most recent calendar year. Unmet need is defined as the number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD4 or VL test.



<u>Updated Unmet Need Framework: Required Estimates and Analyses: Definitions</u>
Finally, let's look at viral suppression for those in care (with a met need). Viral suppression is defined as those people living with diagnosed HIV infection in the jurisdiction who are in care (had at least one CD4 or VL test) whose most recent viral load test result was <200 copies/mL. By most recent, we mean in the calendar year that you are using in the care pattern definition.

In care not virally suppressed are people living with diagnosed HIV infection in the jurisdiction whose most recent viral load test result was greater than or equal to 200 copies/mL.

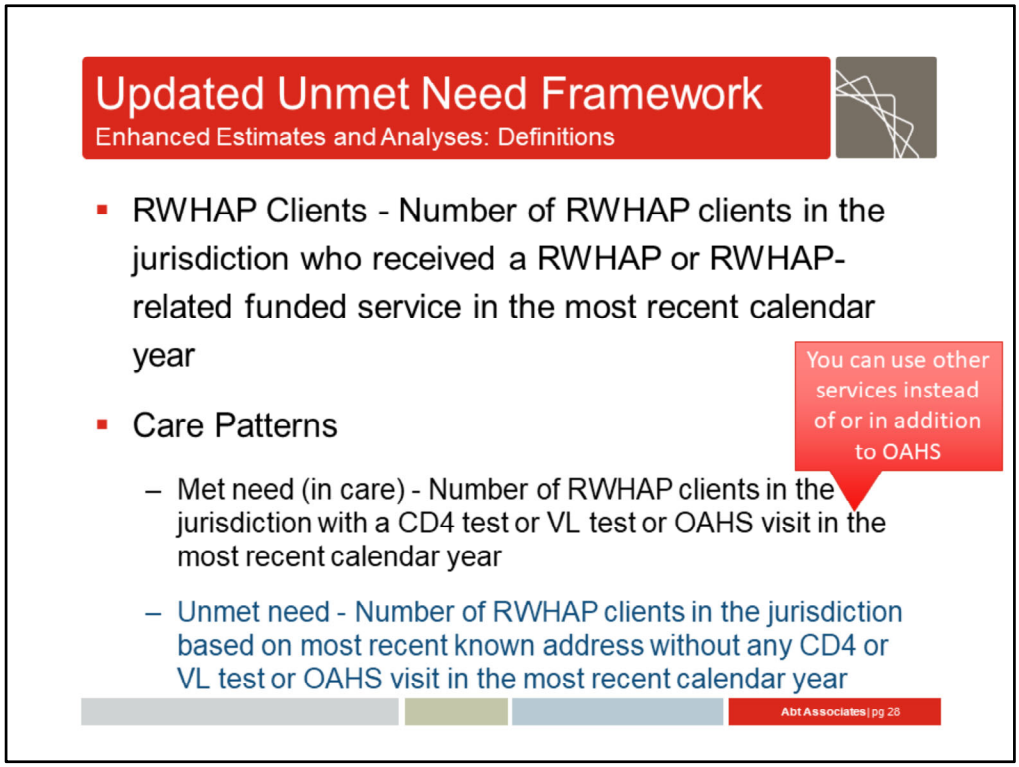


Updated Unmet Need Framework : What's Different from the Original Estimate

Since some of you may remember the original methodology, I'm going to highlight some of the differences between the estimates using HIV surveillance data that I just reviewed and the original methodology.

1) The original methodology differentiated between HIV non-AIDS and AIDS whereas now we use people living with diagnosed HIV infection. This aligns with changes with how HIV surveillance data are presented.
2) A second change is that rather than use all people living with diagnosed HIV infection, the population size is limited to those who have had an HIV-related lab in the most recent 5 calendar year period for which data are available. This makes it more likely that individuals who have moved or died are not included in the estimate.
3) The updated methodology adds late diagnoses and in care not virally suppressed. Late diagnoses provide additional understanding of how many people living with diagnosed HIV infection in the jurisdiction were not tested soon after becoming infected with HIV. In care, not virally suppressed data can help identify disparities among people living with diagnosed HIV infection. It's also very similar to data that are already being calculated for the HIV care continuum.
4) All estimates use most recent known address except for late diagnoses. This is consistent with broader changes in how data are presented by CDC and better reflects where people are now than when they were diagnosed.
5) Finally, the historic 'in care' definition also included antiretroviral prescriptions; the updated definition includes only CD4 and VL tests. ARV prescriptions are not available

in HIV surveillance data.



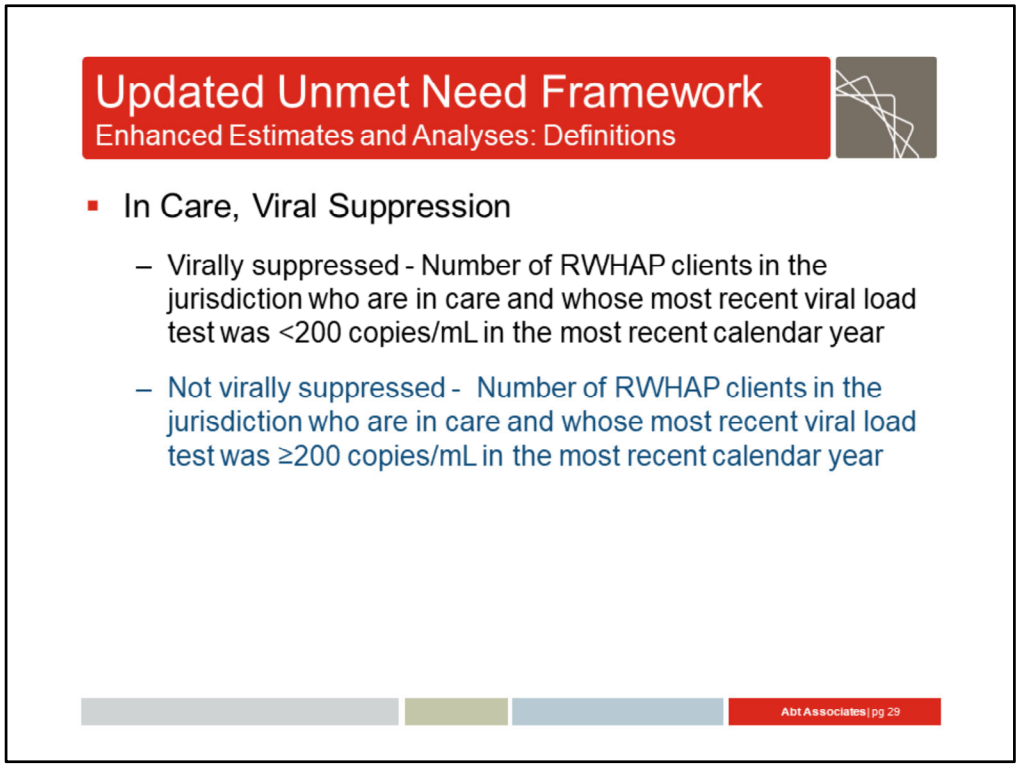
Updated Unmet Need Framework: Enhanced Estimates and Analyses: Definitions

Now let's review the additional definitions that are part of the enhanced estimates and analyses.

RWHAP clients are the number of RWHAP clients in the jurisdiction who received a RWHAP or RWHAP-related funded service in the most recent calendar year for which data are available.

Care Patterns mean met need and unmet need. Met need is those RWHAP clients (that we just defined) who had a CD4, VL test or an outpatient/ambulatory health services (or OAHS) visit in the most recent calendar year. Now an important note (click)-jurisdictions have the flexibility to use other services instead of or in addition to OAHS. In choosing another service or adding services, jurisdictions should consider services that reflect clients in HIV primary medical care. You'll need to explain why you chose the additional services in narrative provided to HRSA HAB.

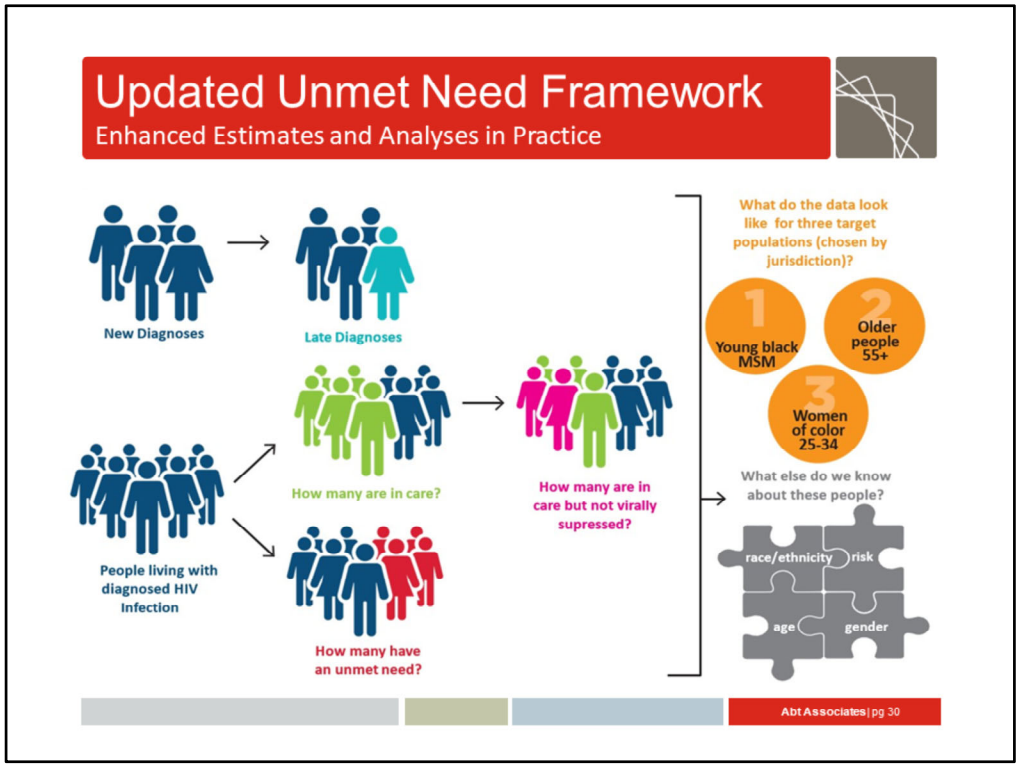
Unmet need is defined as the number of RWHAP clients in the jurisdiction based on most recent known address without any CD4 or VL tests or OAHS visit.



Updated Unmet Need Framework: Enhanced Estimates and Analyses: Definitions

Finally, let's look at viral suppression for those in care (with a met need). Viral suppression is defined as those RWHAP clients in the jurisdiction who are in care (had at least one CD4 or VL test or OAHV visit) whose most recent viral load test result was <200 copies/mL. By most recent, we mean in the calendar year that you are using in the care pattern definition.

In care not virally suppressed are those RWHAP clients in the jurisdiction who are in care whose most recent viral load test result was greater than or equal to 200 copies/mL.



<u>Updated Unmet Need Framework: *Required* Estimates and Analyses in Practice</u>

Let's walk through this conceptually. Let's start with HIV surveillance data.

Enhanced Estimates and Analyses

1) The first thing that recipients will need to do is to determine the number of people in the jurisdiction with new HIV diagnoses in the most recent calendar year based on residence at time of diagnosis. That is represented in the graphic in the left hand corner

2) Next, using the late diagnoses definition, determine how many people who were newly diagnosed were late diagnosed.

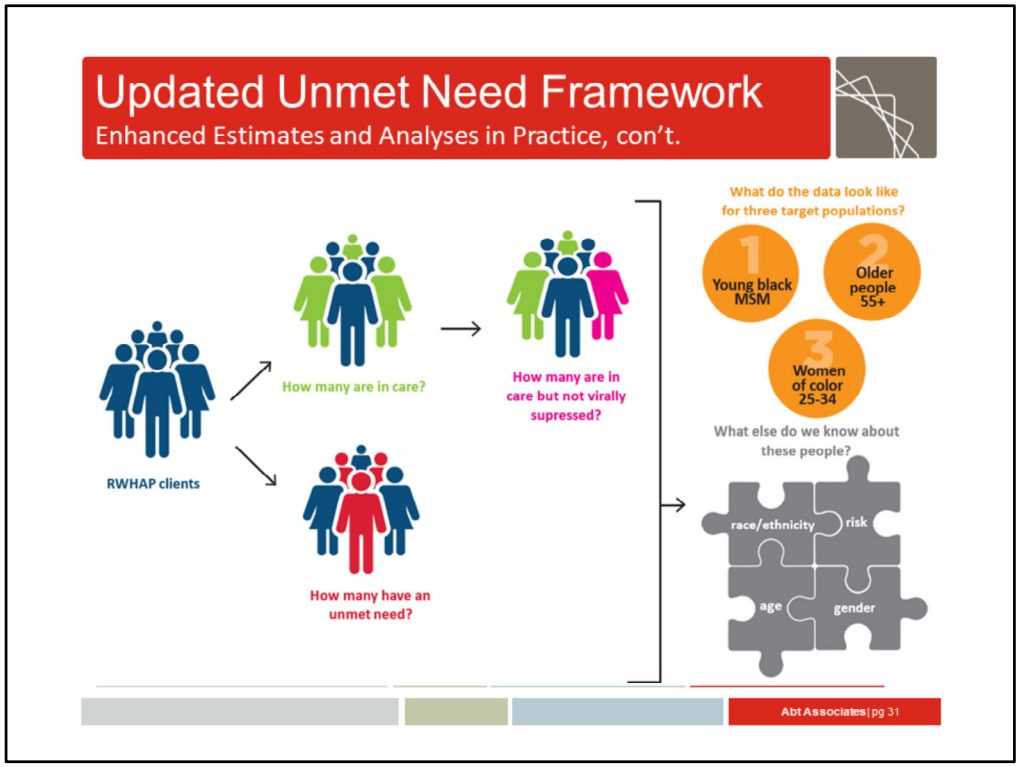
3) The process for people living with diagnosed HIV infection is similar. First, recipients will determine the number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address who had an HIV diagnosis or other HIV-related lab data (e.g., CD4, VL, genotype, or HIV test even if already diagnosed) reported to the HIV surveillance program during the most recent five calendar year period. A difference from new diagnoses is that the most recent **five calendar year** period is used. That means that you aren't including everyone. You're only including people who had an HIV diagnosis or HIV-related lab in the most recent five calendar year period.

4) Next, using the definition for in care (at least one CD4 or one VL test), determine how many people are (click) in care and how many (click)are not in care which means they have an unmet need.

5) For those people in care, (click) determine the number whose most recent viral load test result was ≥200 copies/mL, meaning they were not virally suppressed

6) Now that the estimates and analyses are completed for everyone, (click) rerun these for three specific target populations. A recipient may choose the populations and the criteria to use in selecting them. These might be the same populations used in the grant applications that address Early Identification of Individuals with HIV/AIDS or the Minority AIDS Initiative.

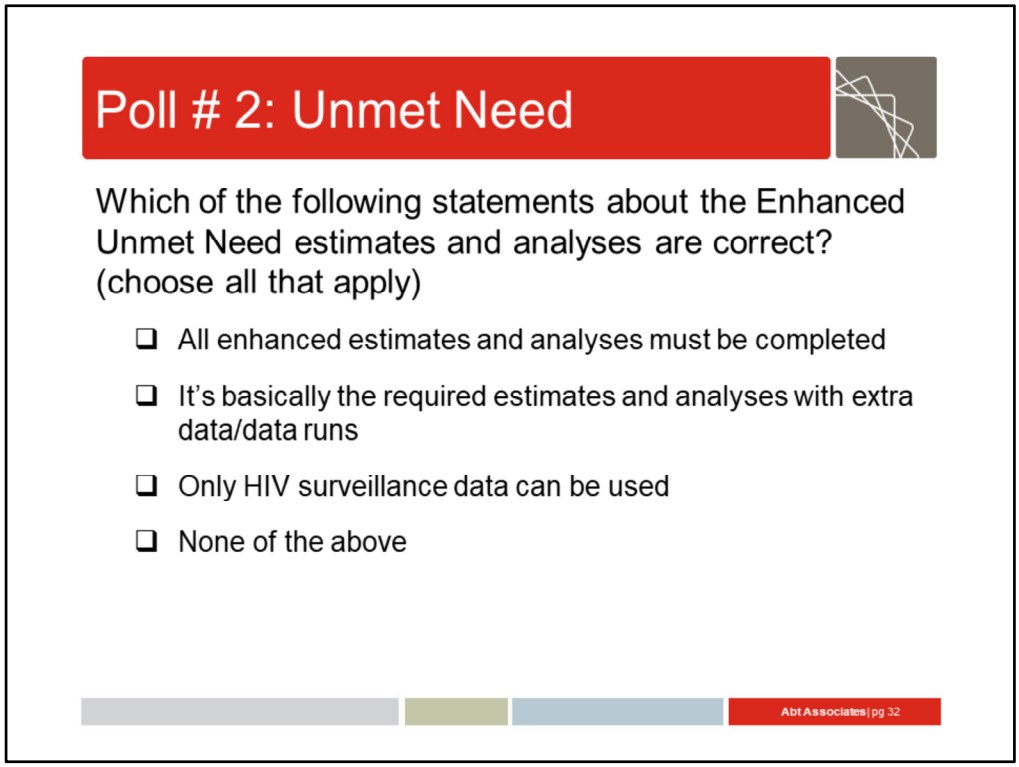
7) The final step for HIV surveillance data is to examine the different characteristics of individuals from the previous runs. For example, how many people with an unmet need were women? How many were 13-24?



Updated Unmet Need Framework: *Enhanced* Estimates and Analyses, con't.

The enhanced estimates and analyses also include the use of RWHAP data and may also include linked databases. Recipients can use additional datasets beyond RWHAP if linked databases are being used. However, other databases can only be used for care pattern definitions and in care, not virally suppressed, but not to determine the population size or number of RWHAP clients.

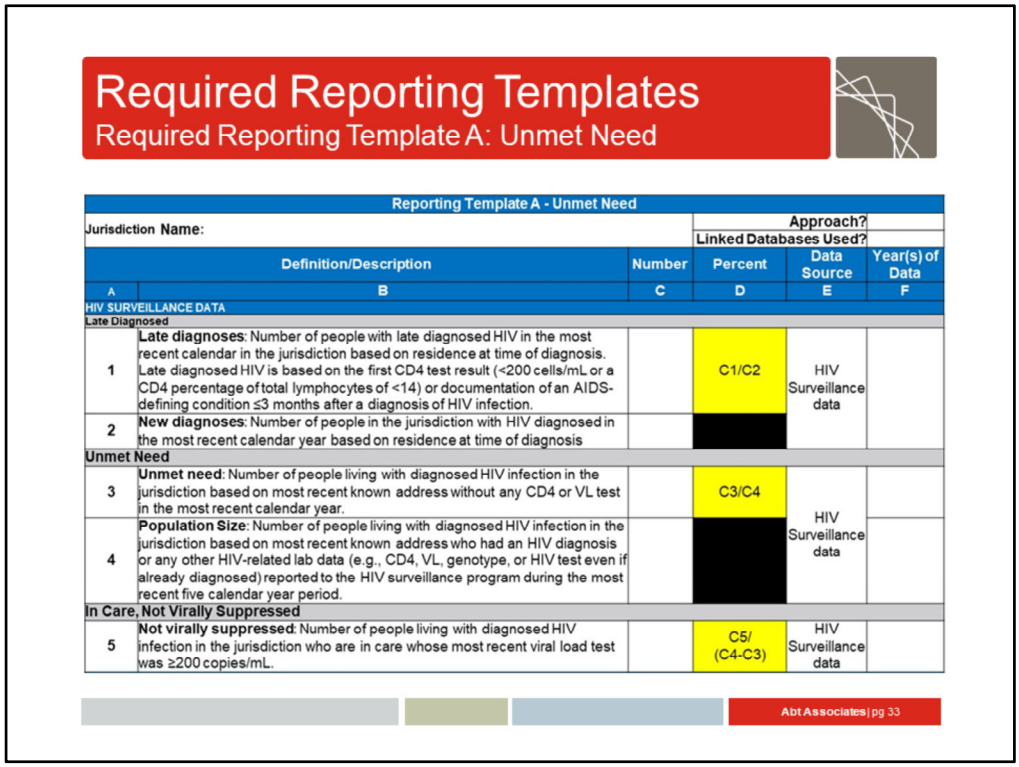
1) The first thing that recipients will need to do is to determine the number of RWHAP clients in the jurisdiction who received any RWHAP or RWHAP-related funded service. This is also for the most recent calendar year which should be the same year as what was used for the HIV surveillance data.
2) Next, using the definition for in care, determine how many RWHAP clients are in care and how many are not in care which means they have an unmet need.
3) For those RWHAP clients in care, determine the number whose most recent viral load test result was ≥200 copies/mL, meaning they were not virally suppressed
4) Now just like for HIV surveillance data, recipients will rerun these for three specific target populations. These should be the same three target populations used for the HIV surveillance data runs.
5) Recipients will also examine different characteristics of individuals from the previous runs For example, how many RWHAP clients with an unmet need were Black or African American? How many were men who have sex with men?



Poll 2: Unmet Need

So let's stop again and check knowledge with a poll. Which of the following statements about the Enhanced Unmet Need estimates and analyses are correct?

- ❑ All enhanced estimates and analyses must be completed
- ❑ It's basically the required estimates and analyses with extra data/data runs
- ❑ Only HIV surveillance data can be used
- ❑ None of the above



Required Reporting Templates

Required Reporting Template A: Unmet Need

Reporting Template A - Unmet Need					
Jurisdiction Name:			Approach?		
			Linked Databases Used?		
	Definition/Description	Number	Percent	Data Source	Year(s) of Data
A	B	C	D	E	F
HIV SURVEILLANCE DATA					
Late Diagnosed					
1	**Late diagnoses**: Number of people with late diagnosed HIV in the most recent calendar in the jurisdiction based on residence at time of diagnosis. Late diagnosed HIV is based on the first CD4 test result (<200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining condition ≤3 months after a diagnosis of HIV infection.		C1/C2	HIV Surveillance data	
2	**New diagnoses**: Number of people in the jurisdiction with HIV diagnosed in the most recent calendar year based on residence at time of diagnosis				
Unmet Need					
3	**Unmet need**: Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD4 or VL test in the most recent calendar year.		C3/C4	HIV Surveillance data	
4	**Population Size**: Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address who had an HIV diagnosis or any other HIV-related lab data (e.g., CD4, VL, genotype, or HIV test even if already diagnosed) reported to the HIV surveillance program during the most recent five calendar year period.				
In Care, Not Virally Suppressed					
5	**Not virally suppressed**: Number of people living with diagnosed HIV infection in the jurisdiction who are in care whose most recent viral load test was ≥200 copies/mL.		C5/ (C4-C3)	HIV Surveillance data	

<u>Required Reporting Templates:</u>

I'm going to provide an overview of the Required Reporting Templates. You can find these in Appendix B of the manual. In addition, we have Excel templates that you can use for reporting. Diane is posting the link to the Excel files in the chat.

There are two templates that recipients must use in order to report their Unmet Need Estimates. Template A-Unmet Need is where recipients will report Late Diagnoses, Unmet Need and In Care, Not Virally Suppressed using HIV surveillance data and Unmet Need and Not Virally Suppressed using RWHAP data. If linked databases are used, jurisdictions would note this under the data source for the care pattern definitions (unmet need). The cells highlighted in yellow will be auto-calculated as part of the Excel tool.

Required Reporting Templates

Required Reporting Template B: Target Populations

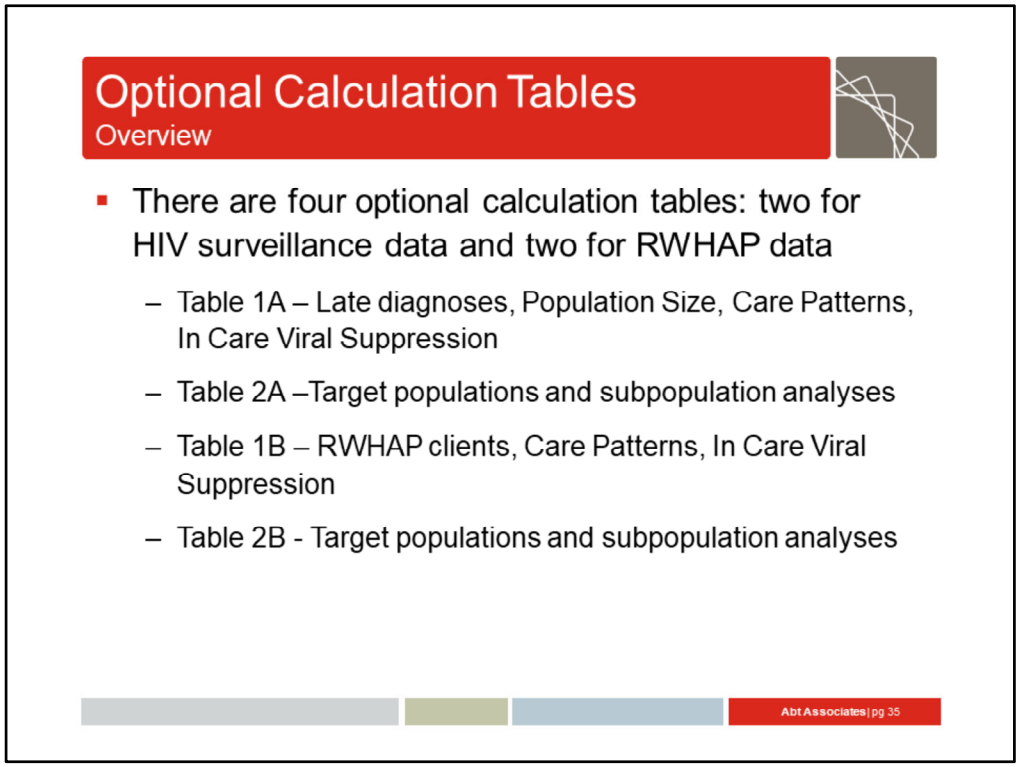
Reporting Template B - Target Populations

Jurisdiction Name: | Approach?

		Totals	Numerical Inputs				Auto-Calculated Percentages					
							Within Categories			Across Categories		
	Category	# of People Living with Diagnosed HIV Infection	# New Diagnoses	# Late Diagnosed	# Unmet Need	# In Care, Not Virally Suppressed	% Late Diagnosed	% Unmet Need	% In Care, Not Virally Suppressed	% Late Diagnosed	% Unmet Need	% In Care, Not Virally Suppressed
A	B	C	D	E	F	G	H	I	J	K	L	M
HIV SURVEILLANCE DATA												
1	Total											
2	**TARGET POPULATIONS (Determined by Jurisdiction)**											
	Target Population #1											
	Target Population #2											
	Target Population #3											
RYAN WHITE HIV/AIDS PROGRAM (RWHAP) DATA												
		Totals	Numerical Inputs				Auto-Calculated Percentages					
								Within Categories			Across Categories	
	Category	# of RWHAP Clients			# Unmet Need	# In Care Not Virally Suppressed		% Unmet Need	% In Care Not Virally Suppressed		% Unmet Need	% In Care, Not Virally Suppressed
A	B	C			F	G		I	J		L	M
5	Total											
6	**TARGET POPULATIONS (Determined by Jurisdiction)**											
	Target Population #1											
	Target Population #2											
	Target Population #3											

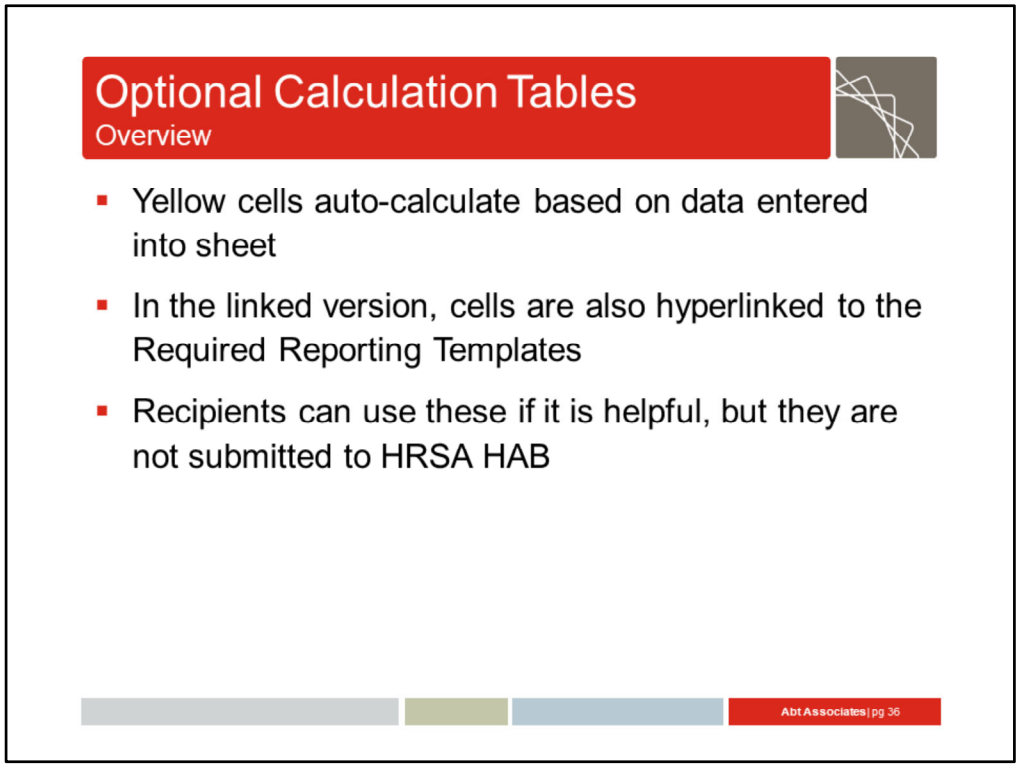
<u>Template B:</u>

Template B is for reporting the target populations. Similar to template A, recipients can report target populations for both HIV surveillance data and RWHAP data.



Optional Calculation Tables:
There are also four optional calculation tables. These are provided to help recipients in completing the Required Reporting Templates.

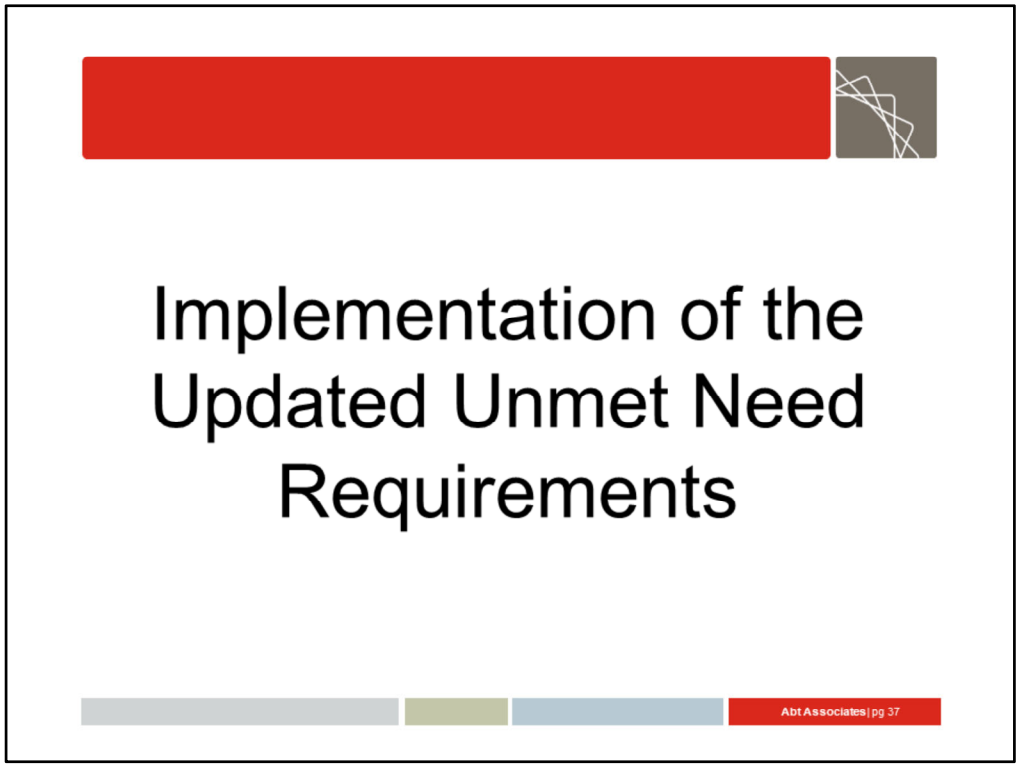
Tables 1A and 2A are used for HIV surveillance data. Table 1A includes Late Diagnoses, Population Size, Care Patterns and Viral Suppression while Table 2A includes target populations and subpopulation analyses. Tables 1B and 2B are used for RWHAP data. Table 1B includes RWHAP Clients, Care Patterns and Viral Suppression and Table 2B includes target populations and subpopulation analyses.



Optional Calculation Tables:
As I already mentioned, the yellow cells reflect values that will be auto-calculated when other cells are populated.

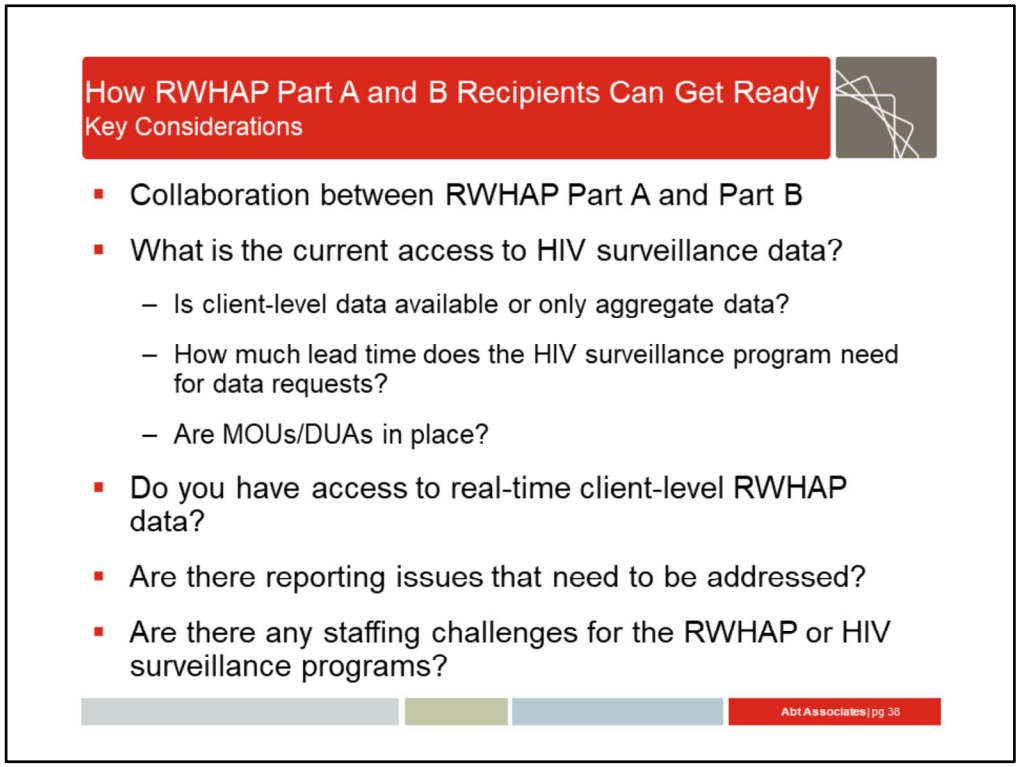
There is also a version of the Excel tool that takes everything entered in the Optional Calculation Tables and auto-populates the Required Reporting Templates. These tables are not required to be used.

Now, I'm going to turn it back over to Anne to review some resources available for recipients to support Unmet Need.



Getting Ready for Implementation of the Updated Unmet Need Requirements Transition Slide

That was a lot of information. But we have lots of resources and technical assistance available to help with completion of Unmet Need.



<u>How Part A and B Recipients Can Get Ready</u>

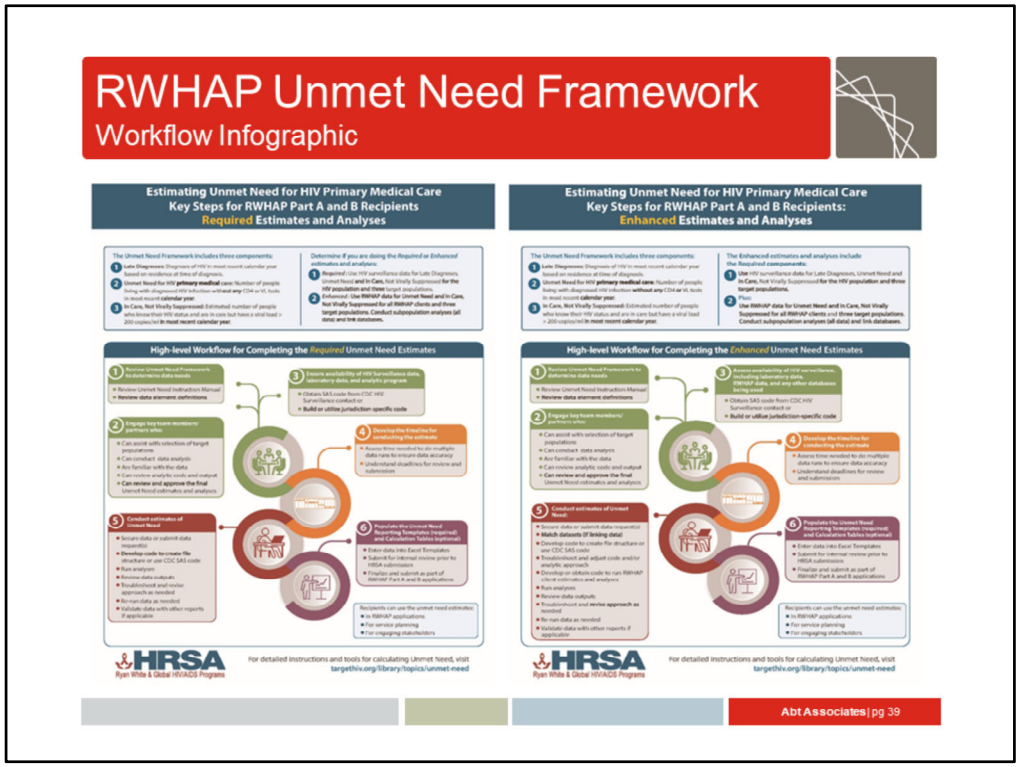
What are some things to consider when you are getting ready to do Unmet Need estimates and analyses?

First, in jurisdictions with both Part A and B recipients, are you already collaborating on other HRSA HAB requirements? If so, you may be able to collaborate on the unmet need requirement as well.

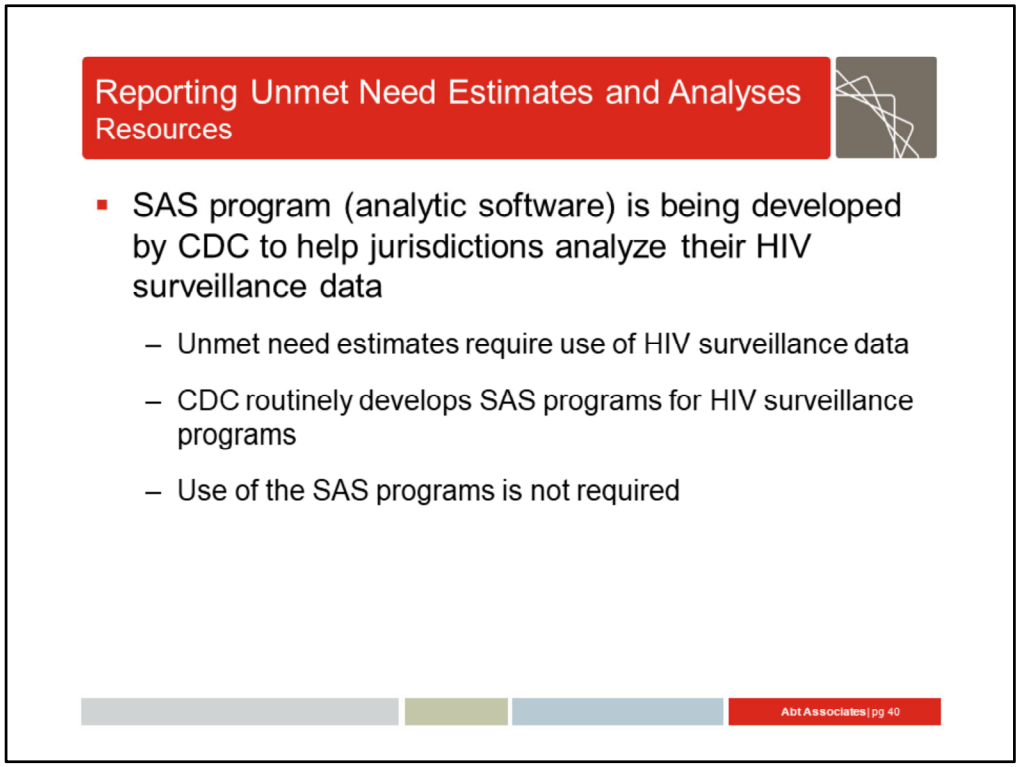
Second, what access does your RWHAP currently have to HIV surveillance data? Can you receive only aggregate data or is client-level data available? It is also important to know how much lead time the HIV surveillance program needs for data requests. Finally, if needed, do you already have memorandum of understanding (MOUs) or data use agreements (DUAs) in place?

Third does your program have access to real time client level RWHAP data? By real time I mean having a centralized network or having data reported to you routinely. If you don't receive client-level data, that may pose a challenge in completing enhanced estimates and analyses.

Other things to consider include whether your jurisdiction currently has reporting issues with HIV surveillance or RWHAP data including delayed or missing labs or other data. Also, are there staffing issues for Ryan White or HIV surveillance programs that may require additional time to complete the Unmet Need estimates and analyses.



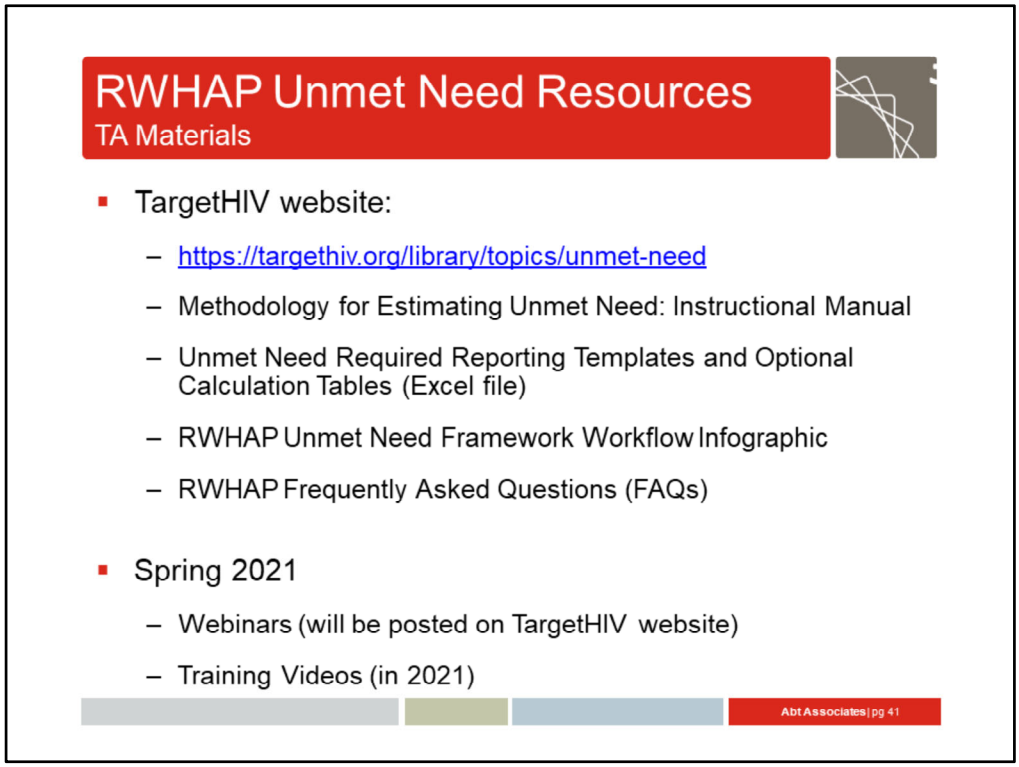
RWHAP Unmet Need Framework Infographic We've put together two infographics that can help you think through the steps needed to complete the Unmet Need estimates and analyses: one for required estimates and analyses and one for enhanced estimates and analyses. The pictures on this slide are small, but you can download the PDF from the TargetHIV website and Diane will put the link for that in the chat. This infographic describes the process for unmet need visually. It shows a number of steps, including determining data sources, engaging team members, developing a timeline for completing the work and populating the required tables. This graphic can assist recipients in organizing their work for successful completion of the Unmet Need requirement.



<u>Resources for Reporting Unmet Need</u>

Let's talk about tools and resources that will be available to help with completing the Unmet Need estimates and analyses. These include a SAS program that is currently being developed by the CDC HIV Surveillance team and tested by recipient staff and will be available to the HIV Surveillance contacts in each jurisdiction by early 2021. CDC routinely provides SAS programs to jurisdictions to assist with data reporting and quality assurance. Using the CDC SAS program is not required, as jurisdictions can develop their own programs.

We will also be doing a webinar in the spring of 2021 to review how to use these tools.



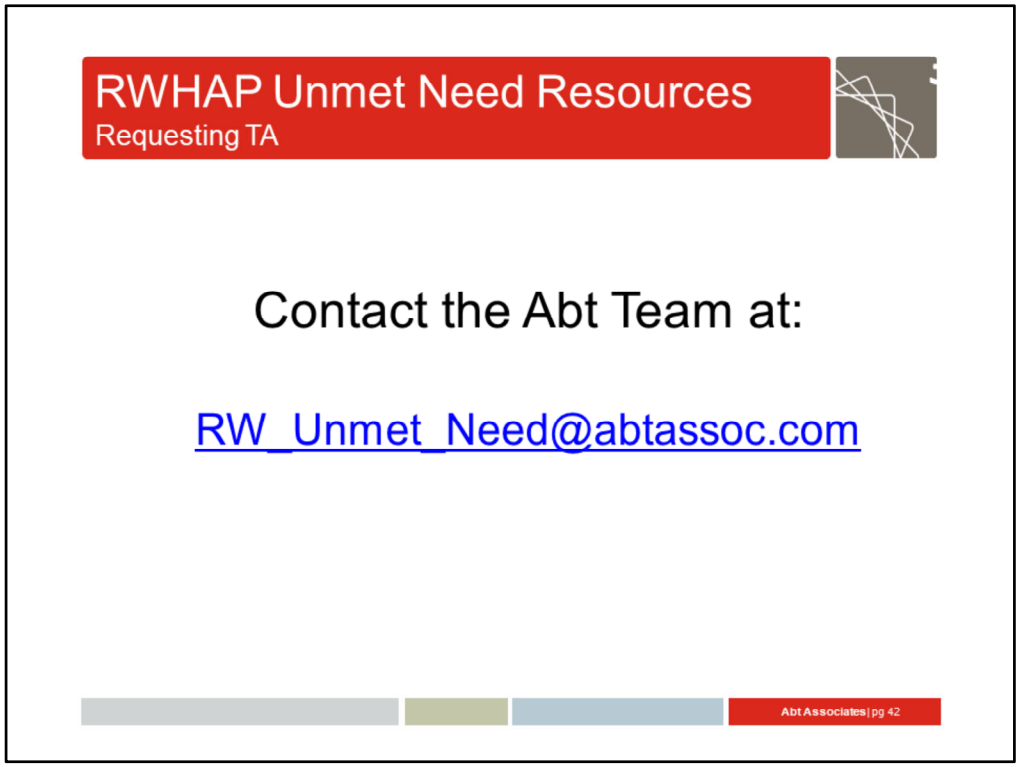
RWHAP Unmet Need Resources: TA Materials

Technical Assistance materials are posted on the TargetHIV website and the link is in this slide and Diane will also put that in the chat. These resources include:

- The manual which contains detailed information on how to complete the estimates and use the Excel files. As Debbie mentioned, there is a section for the required estimates and analyses and a different section for enhanced estimates and analyses. Once you determine which one you are doing, you can just use that section of the manual.
- The Excel files which have both a reporting template and calculation tables.
- The infographic which provides a high level overview of completing the Unmet Need requirement.
- An FAQ document that will be continuously updated

Future webinars will be done in early 2021 covering a variety of topics including considerations for which types of estimates and analyses to complete, how to utilize Unmet Need data for planning, and the tools available to complete the estimates and analyses.

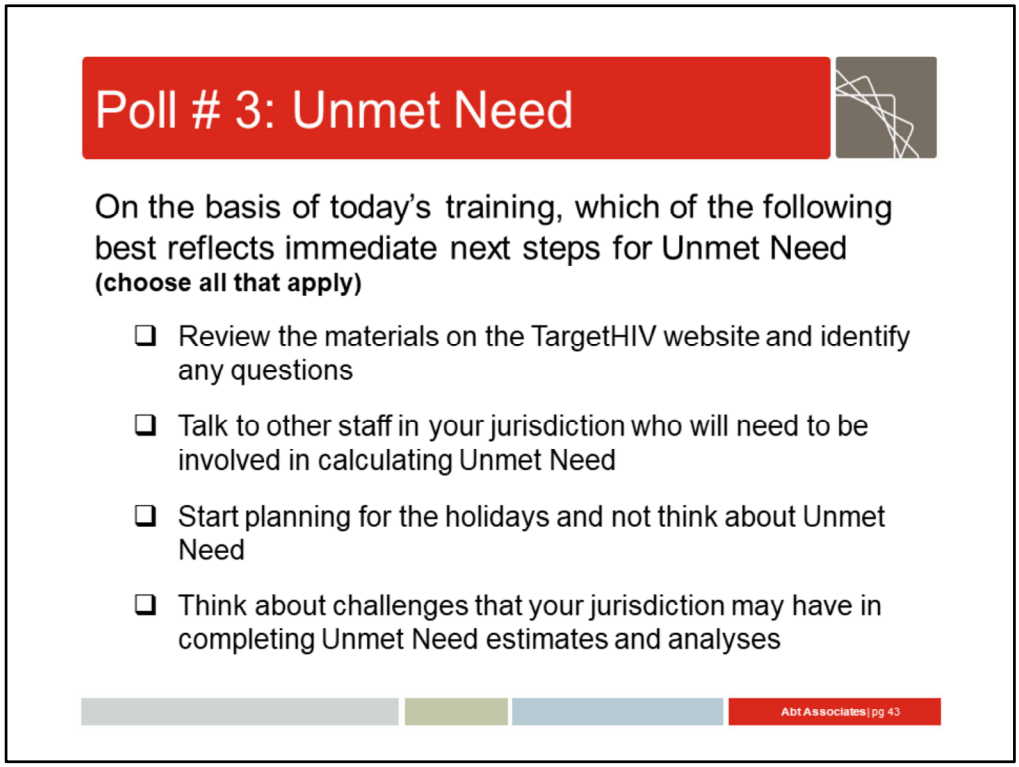
There will also be specific training videos posted to the Target HIV website in 2021 for recipients to view at anytime. We will also be presenting on a CDC HIV Surveillance call in January to ensure that recipient HIV surveillance staff are aware of Unmet Need and how surveillance data are being utilized.



RWHAP Unmet Need Resources: TA Materials, con't.

Also, we have an email available for specific questions and to also request technical assistance. It is on this slide and we will also put it in the chat. If you think of something now or later, please email us. We are here to help and this will also help inform targeted TA.

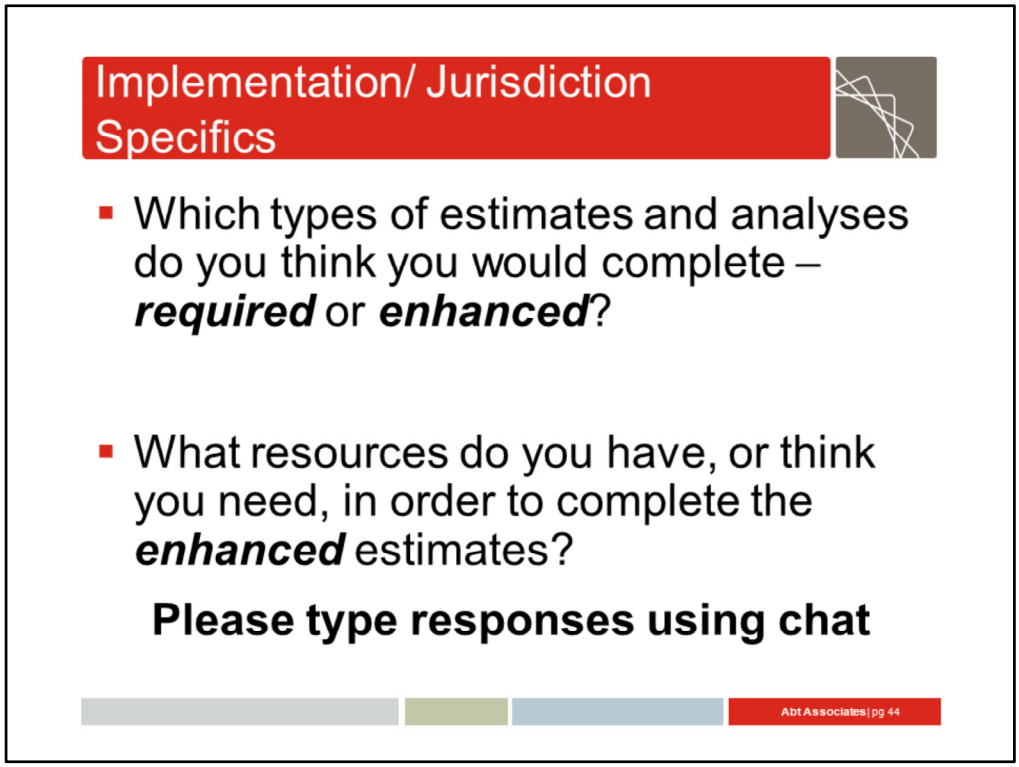
Now I'm going to hand it back over to Tara to wrap up.



Poll 3

Ok let's try another poll. On the basis of today's training, which of the following best reflects immediate next steps for recipients (choose all that apply)

- ❑ Review the materials on TargetHIV and identify any questions
- ❑ Talk to other staff in your jurisdiction who will need to be involved in calculating Unmet Need
- ❑ Start planning for the holidays and not think about Unmet Need
- ❑ Think about challenges that your jurisdiction may have in anticipation of the unmet need launch



Open-Ended Discussion

So we have done a lot of talking. We'd like to hear from you about specific concerns or thoughts you have about implementing Unmet Need in your jurisdiction. This will help us in thinking about future webinars and will also help other jurisdictions as they do this work.

Please use the chat box to answer this question - Which types of estimates and analyses do you think you would complete – ***required*** or ***enhanced***? Or maybe you don't know right now and you can chat that in. Think about what is feasible for your program. I'll give people a few minutes to type in thoughts.

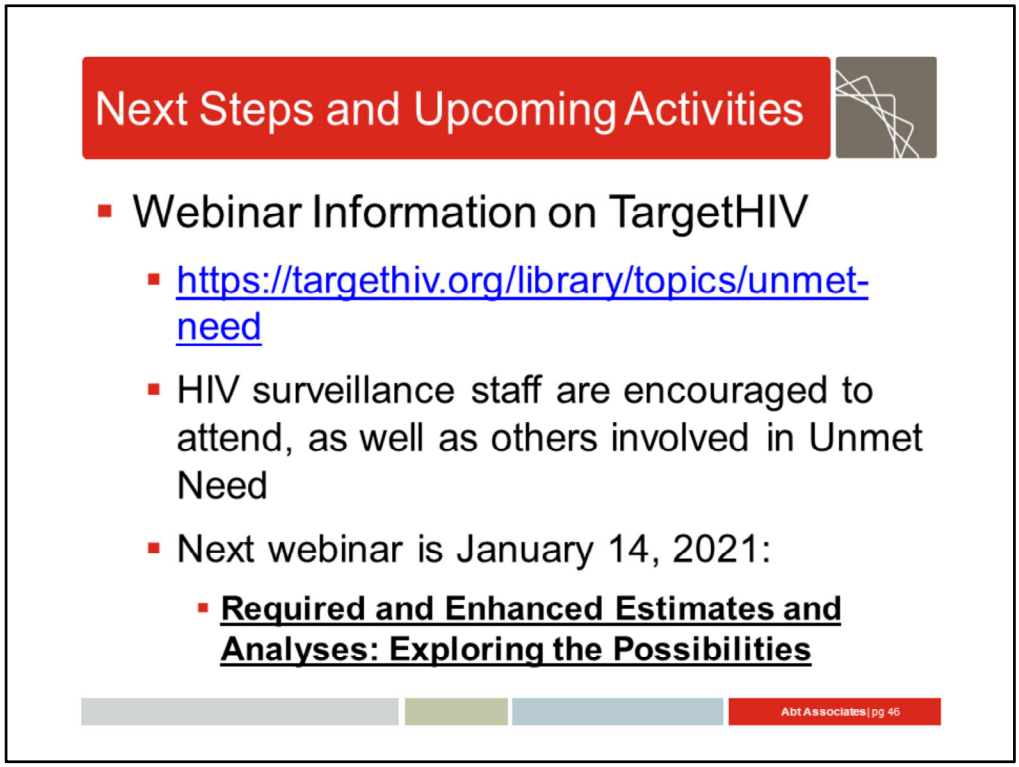
These are great responses and very helpful for us to see what some of you are thinking as you consider the types of estimates and analysis to use.

Here's the second question - What resources do you have, or think you need, in order to complete the ***enhanced*** estimates? Things like access to Ryan White client level data and the ability to link databases.

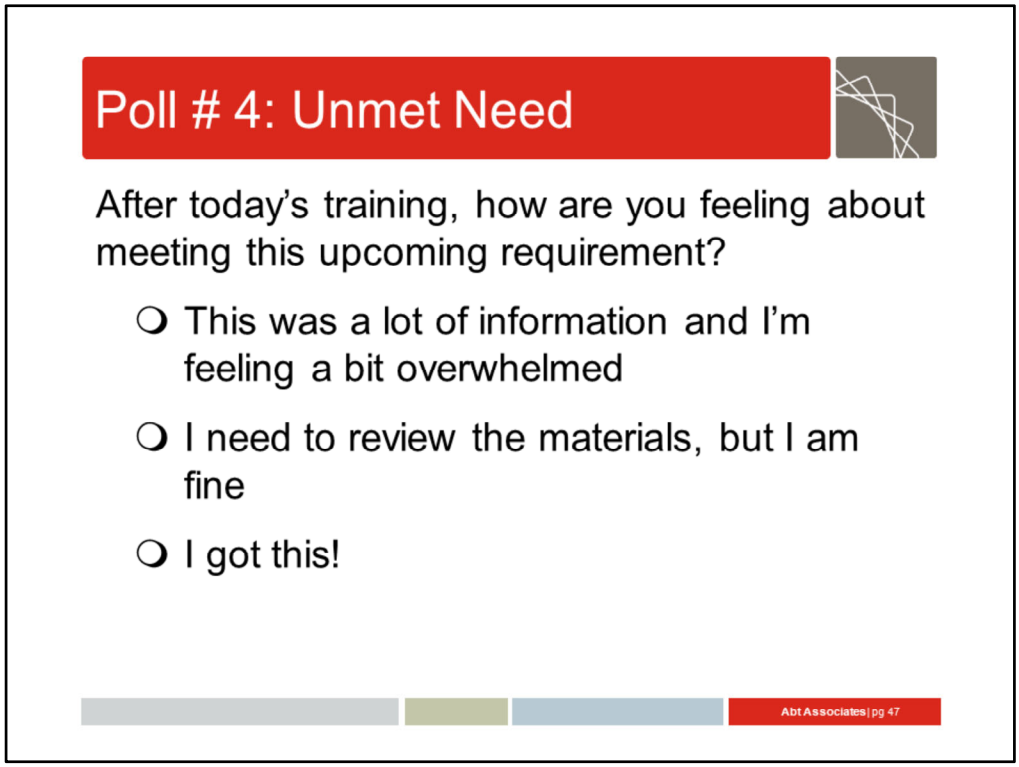
These are great, we will definitely take this information into consideration as we refine our training and technical assistance materials. We may reach out to some of you to get more information.

Next Steps Transition Slide

That was a great discussion. Let's talk about next steps!



Next Steps and Upcoming Activities We are doing a series of webinars about Unmet Need, with 4 more webinars scheduled in 2021. Topics will include building data infrastructure to meet the unmet need requirement, using the enhanced unmet need estimates and analyses for local planning and tools for completing the Unmet Need estimates and analyses. Please encourage any staff from your jurisdictions who will be involved in Unmet Need to attend, including HIV surveillance staff. Our next webinar is January 14th and will focus on how to decide which types of analyses your program will do for Unmet Need. Diane will put the link to register for that webinar in the chat and it is also on the TargetHIV website.



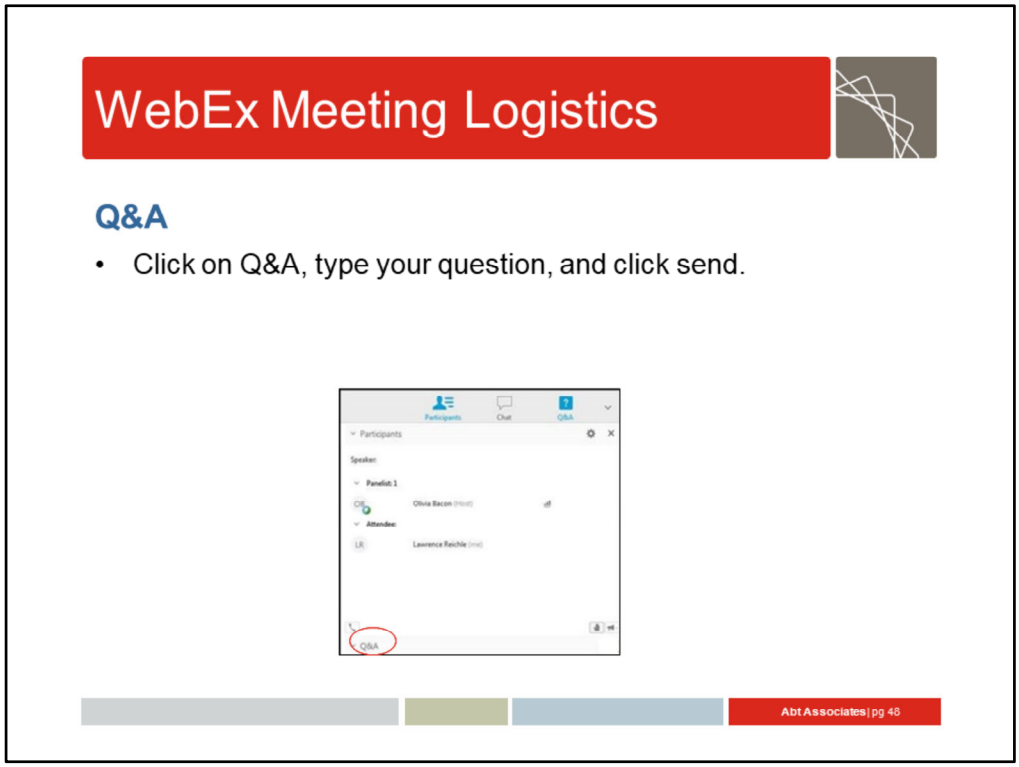
Poll 4: Unmet Need

Let's take one last poll.

After today's training, how are you feeling?

- This was a lot of information and I'm feeling a bit overwhelmed
- I need to review the materials, but I am fine
- I got this!

If you are feeling overwhelmed and would like to have a discussion with our team about how your program can prepare for Unmet Need, please send an email to our team or put your email in the chat. Diane will put the Unmet Need email in the chat.

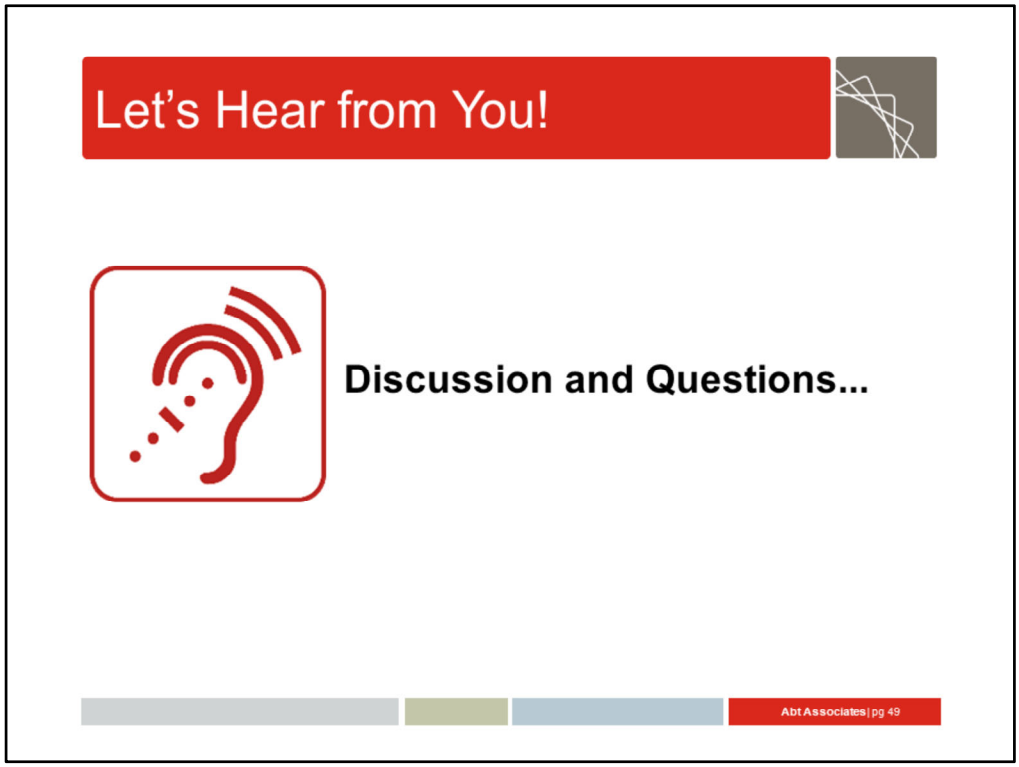


Before I turn the presentation over to Anne to review the questions that you've sent through Q&A, let me remind everyone of how to use the feature. If you want to send a question, click on Q&A, enter your question, and click send.

We encourage all questions as they could help someone else with their implementation process. Depending on the question, we'll be sure to include it and the answer in the FAQ document on the TargetHIV site.

Before we start the discussion, let me remind everyone that the slides that today's slides and the audio recording of this webinar will be available on TargetHIV in about two weeks. You will receive a notification when they are available and can review as you work to implement the framework.

Okay, Anne, let's review and discuss the questions that we have received.



Let's Hear from You: Discussion and Questions

Thanks for your participation, please remember to complete the evaluation that will come up at the end of the webinar, we want to hear your feedback on this training!

Thanks and have a great day!