CONDUCTING RYAN WHITE HIV/AIDS PROGRAM PART A PLANNING COUNCIL/PLANNING BODY NEEDS ASSESSMENTS

Michelle V.: Hello everyone, and welcome to today's webinar, Conducting Ryan White HIV/AIDS Program Part A Planning Council/Planning Body Needs Assessments. My name is Michelle Vatalaro, and I am the training and technical assistance coordinator for the Planning CHATT project. And so before we get started, I just want to get some housekeeping technical details out there for you.

First, you're all in listen only mode, but we do encourage you to communicate with each other and ask a lot of questions in the chat box. You can submit your questions at any time during the call or during the question period at the end. Our presenters, along with the Planning CHATT staff will take as many of your questions as we can at the end of today's session. And if you think of a question after the webinar, that's fine too, you can always email us questions at planningchatt@jsi.com.

The easiest way to listen to our webinar is through your computer, but if you can't hear very well, do check to make sure that your computer audio is turned on. And if you still can't hear us, or if you experience a sound delay at any point, try refreshing your screen. But finally, if needed, you can mute your computer audio and call in using your telephone at the number you see on your screen. You will need to use a pass code, which is also listed there, and we put this information into the chat box, or you can chat us if you need that.

So let's go quickly through the agenda for the day. We'll start off with some introductions, and then we'll move into a conversation about how to conduct needs assessment. We'll talk about what a needs assessment is, and gain an understanding of HRSA expectations of what each needs assessment should include. We'll learn what needs assessment activities are usually conducted, and the steps that Ryan White HIV/AIDS Program part A Planning Councils and Planning Bodies need to take to complete the needs assessment. We'll also talk about strategies your planning council or planning body can use to engage community members in your needs assessment process. Lastly, we'll talk about how you can use the data that you gather through the needs assessment to drive the priority setting and resource allocation process. From there we'll provide answers to the questions that you've chatted in throughout the webinar. Any questions we don't have time to answer will be made available to you in the Q&A document after the webinar. Lastly, we'll give you a glimpse into the other training opportunities that are coming up.

So now let me please go ahead and introduce our HRSA HAB colleagues. First, Steven Young is the Director of the Division of Metropolitan HIV/AIDS Programs in the HIV/AIDS Bureau at HRSA. And Lenwood Green is a Project Officer at the Division of Metropolitan HIV/AIDS Programs in the HIV/AIDS Bureau at HRSA. And thank you both for your support of the Planning CHATT project, and of the Ryan White HIV/AIDS Program Part A Planning Councils and Planning Bodies. Do you have anything that you'd like to add at this time?

Steven Y.: Yeah, thank you. Hello, everyone. Good morning, or good afternoon, depending on where you are. And we just wanted to thank you for joining us in this series of webinars that we're running through the CHATT project. We're glad that you were able to join us, and we look forward to the presentation and the discussion. And I particularly wanted to thank our colleagues from the Houston area who are going to share some of their experiences and approaches as well. Lennie?

Lennie G.: Good afternoon. Welcome all. And I trust this will be a great learning experience for all. Thank you.

Michelle V.: Great thank you both. And now I think I'll hand it over to Chris LaRose, the Project Manager for the Planning CHATT project who will talk about the project and our team. Chris?

Chris L.: Thank you, Michelle. Good afternoon, everyone. As Michelle mentioned, my name is Chris LaRose, I'm the Planning CHATT Project Manager. And still given that some folks are still getting to know us, I'm going to tell you a little bit about our team and our project before I turn it over to our presenters.

So as you can see on screen, you're looking at some pictures of our core team members. Many of you have already heard from Mira Levinson, who's our Project Director, during the first couple of webinars that we did. Next to the photos of Mira and myself, you can see Emily Gantz McKay and Hila Berl from EGM Consulting. Emily and Hila are part of the core Planning CHATT team, and Emily is currently behind the scenes today facilitating the chat feature that I see all of you in. She will be assisting with answering some of your questions that come that way, facilitating the discussion in the chat forum, and will be referring some of the more detailed questions to be answered later during our question and answer period.

At the bottom, you can see Deborah Dean on the left hand side. She's our Materials Developer. She's been working closely with Emily, Hila and our HRSA colleagues on the Planning Council Primer and a variety of other resources. Of course you already know Michelle Vatalaro because of her work on this webinar and the other two webinars. Michelle is a training and technical assistance coordinator for Planning CHATT, as is Molly

Tasso next to her. Andi Goetschius is our Strategic Communications and Design expert. Dan Hostetler is our Data Manager, and Emily Breuer is our Project Associate.

If you ever want to reach any of us, or have any questions, you can email us at any time at planningchatt@jsi.com. And that's Planning CHATT with two Ts. We will share the email address with you again at the end of today's webinar.

For those of you who are new to Planning CHATT, let me tell you a little bit more about the project. The focus of Planning CHATT is on building the capacity of Ryan White HIV/AIDS Program Part A Planning Councils and Planning Bodies across the United States. Our goal is to help you all as planning council members, staff and Ryan White Part A recipients, to meet legislation requirements, strengthen consumer engagement, and increase the involvement of community providers in HIV service delivery planning.

Finally, before I turn things back to Michelle, I am incredibly excited that the Planning Council Primer has been updated, and as of yesterday is now available on the TARGET website for download. We'll chat a link out to you now, so that you can find it. I see some folks already saying, "Yay!" in the chat. So it's not currently possibly for us to print and mail copies to you all, but the new Primer has been designed to be printed on regular 8.5 X 11 paper, so we hope it makes it easy for you all to print it in your local jurisdictions. And if you've signed up for our email list, you'll also be receiving this announcement about the Primer of our email in the next day or so. Please feel free to forward that email on to others in your jurisdiction so that those folks who may have missed today's email, or missed the webinar, can receive it. And this will also enable you to show the update for the upcoming meetings that you might be having.

Now please stay in touch, and let us know what you think of the Primer. We want to know how you're using it, how you're sharing it, and if you have any feedback to inform future versions. I think that's it for me. With that I'll hand it back to Michelle.

Michelle V.: Thanks, Chris. And now it's my pleasure to announce our wonderful speakers for today. Our speakers from today come from Houston. So first we have Amber Harbolt, who's a health planner for the Houston Ryan White Planning Council Office of Support. She's worked as an HIV planner for seven years across HIV preventions, Ryan White Part A and Ryan White Part C. She's a member of the Austin planning council, and as a health planner Ms. Harbolt leads the support staff for ensuring completion of several council projects, including needs assessment, the comprehensive or integrated plan, the epidemiologic profiles, special studies, and selection of target population. Ms. Harbolt also co-facilitates Project LEAP, which is a training course to prepare people leaving with or affected by HIV to participate in HIV planning. Ms. Harbolt's background is in applied medical anthropology, and she seeks to apply rigorous quantitative and qualitative

methodologies to elevate the quality of data available to council members for decision making.

Also speaking today will be Rodney Mills, who's a member of the Houston Ryan White Planning Council where he serves as co-chair of the Effective Community Committee, and as a member of both the steering committee and the comprehensive HIV planning committee. Mr. Mills has been active as an advocate in the Houston hemophilia and HIV communities for over 20 years, and graduated from the LEAP training program in 2015. Mr. Mills has a background in electrical engineering, and in his spare time explores alternative energy.

Lastly, but certainly not least, we have Dr. Peta Gay Ledbetter, who's a 2013 graduate of the LEAP training prior to being appointed to the Houston Ryan White Planning Council. She holds a PhD, LPCS and RN credentials, and is the director of clinical services at the Alliance Wellness Center.

So at this time I'll hand it over to Amber, who will start us off by talking about what a needs assessment is. So Amber ...

Amber H.: Thank you so much, Michelle. Alright, so starting off with the birds-eye view and then moving down into specifically what a needs assessment is. So as defined by the Ryan White HIV/AIDS Program Part A manual, a needs assessment just describes the process of collecting information about the needs of both people who are living with HIV and receiving care, as well as those who are currently not in care, or have unmet need, or who are out of care. And steps involve gathering data from a wide variety of sources, including epi data on number of cases, and prevalence, and new diagnoses, and so on. The need of people living with HIV and the current resources available in the jurisdiction to meet those needs. And this information has been analyzed to identify what services are needed, and by which groups of people living with HIV.

So in plain language, I know that's a lot to absorb, needs assessment activities are ways of learning what people living with HIV need to enter care, return to care, or stay in care, and to reach viral suppression. So a great way to think about needs assessment activities is what is needed to bridge that gap along each step of the HIV care continuum. They also measure the extent to which available service or system components are capable of meeting those needs, and help identify service needs and gaps.

So in the big picture, while nothing can replace direct consumer involvement in the planning process, needs assessments give us that birds-eye view of needs in a jurisdiction. So opposed to being one consumer perspective, it is perspective of many people living with HIV within your jurisdiction.

And it's also important to note that needs assessments are distinct from client satisfaction surveys. Client satisfaction surveys are done by the administrative agents. They look at contract compliance and individual provider quality. It's not the purview of planning councils. So that's a question we get quite often, "Is this a client satisfaction survey?" And no, it's an entirely different process.

Michelle V.: Thanks Amber. So I just want to pop in for a moment to let you know that in this next section we're going to be providing you with a bunch of definitions, and all of these definitions come from the compendium of materials which is available on the Planning CHATT website. The compendium is designed to help the planning council staff carry out their duties supporting the planning councils and planning bodies. In it there's tools and templates, model orientation and training materials, and tips and practices from planning councils and planning bodies. It also contains a helpful list of definitions for data related words or concepts used by planning bodies during the needs assessment process. It can be a really good resource for y'all. You can see the link there on your screen.

And we want to check, just to see if you're listening, get you warmed up with some polls that we're going to have throughout this webinar. So first, where can the compendium of materials be found? On the Planning CHATT website, on the HRSA homepage, or on social media?

Alright, I'm seeing that most of you seem to be think that it's the Planning CHATT website, which is correct. It can be found on the planning CHATT website.

Okay, so now I'll hand it back to Amber to talk about what should be included in the needs assessment. So, Amber ...

Amber H.: Great, thank you so much. So we'll be going over the different elements of the needs assessment. One thing I'll ask everyone to keep in mind is that when we talk about needs assessment we are talking about a process. We are not talking about just one product. So we'll go over briefly the epidemiologic profile, resource inventory, profiles of provider capacity and capability, the estimate and assessment of unmet need, the estimate and assessment of people living with HIV who are unaware of their status, sometimes you'll hear this called undiagnosed proportion, as well as the assessment of service needs and gaps.

Alright, so the epidemiologic profile contains information on the number and characteristics of people who have been diagnosed living with HIV within a specific geographic area. So that would be in your jurisdiction. So some examples of the types of information that you can find in the epidemiologic profiles, or that should make it into the epidemiologic profiles you're completing one, is trends and new diagnoses. So looking at new diagnoses over time. Geographic distribution of the epidemic. So where

are you seeing prevalence in your jurisdictions, what zip codes are you seeing the highest rates of new diagnoses, and so on. As well as looking at emerging populations. So what populations are facing increasing new diagnoses, for example, within your jurisdiction.

The assessment of service needs and gaps. This just contains information about the service needs of people living with HIV, and barriers to obtaining these services. So when you hear me talk a little bit later about our needs assessment process in the Houston area, I'll be talking about a large consumer survey that we do. So just keep in mind that that survey is one part of the assessment process. But that should contain information on the necessity of services, which services are needed and how those rank with other services. Ease or difficulty in accessing services. And when services are needed and difficult to access, what are those barriers that are in place that are keeping people from accessing those needed services?

Next is a resource inventory, which is just a listing of both Ryan White funded and non-Ryan White funded providers within your jurisdiction who provide HIV related services, as well as the type of services they provide, where they're located within your jurisdiction, and who they serve. So one of the primary examples of that here in the Houston area is we put together the Houston Blue Book resource guide. Some things that you may want to include in your resource inventory are: funded providers, of course; Medicaid and Medicare providers and information; providers of other social support services, so a lot of the wrap-around services that, depending on the funding structure in your area, may provide critical support services for people living with HIV that otherwise would go unfunded; and the capacity to meet needs and gaps by service category.

Next is a profile of provider capacity and capability, and this is just information on the capacity of service providers in your area to meet the needs of people living with HIV, and that includes the extent to which services are available. So do they exist? Accessible? Can people access them? And are they appropriate to the needs of all people living with HIV as well as specific population groups. We want to make sure that providers have the capacity and capability to be able to serve anyone who walks through their door.

So some examples of that would be identifying areas of improvement. Two main areas of that would be looking at workforce capacity, so do providers have the ability to provide the volume of services needed, do they have enough staff, do they have enough resources for those staff, as well as knowledge of the workforce. So you may have a workforce that is ample and robust, but maybe they lack clinical competency, service efficiency, maybe there are customer service issues, particularly around serving clients who are transgender or gender non-conforming, or from other populations. As well as need resources. So one might be a lack of funding for social marketing in your jurisdiction. And this is something that we describe in the Houston area in the financial and human resource inventory in our integrated or comprehensive plan.

Estimate and assessment of unmet needs. And this really brings quantitative and qualitative data together. So the estimate of unmet need is the estimated number of people within your jurisdiction who know they are living with HIV. So they've been diagnosed, but they're not receiving HIV related primary medical care. So when we talk about someone being out of care or having unmet need, that's what we're referring to. And then the assessment of that unmet need is information about those people who are diagnosed, living with HIV, but they are not receiving primary medical care. So what groups do they fall in? What populations do they fall in? What areas do you need to be targeting for your jurisdiction to reengage people in care?

And one of the ways that we do that in the Houston area is through special studies. We know it's difficult to access people who are out of care, because if we were able to access them readily, the linkage would be less difficult, I think, than a lot of jurisdictions find it. So one of the ways we worked through that is doing a special study of people who have a history of being out of care, even if they are currently in care, and looking at what those needs were, and what those barriers were that led to them leaving care. And then, what supports were helpful in them returning into care. That's one of the ways we assess that.

Steven Y.: Thanks. This is Steven Young from the Bureau here. We just wanted to jump in and actually notice a comment in the chat box about unmet need no longer required in the application. We have taken a little bit of a time out on that this year. I wanted to point out that this slide ... So this definition of unmet need actually comes from our authorizing legislation. And over the years here in the bureau, we've developed an unmet need framework which provided an estimation methodology. We used it for over a decade, up until about 2015. And then we subsequently revised it a bit to be more in line with the HIV care continuum. And we found some dramatic differences when jurisdictions developed their estimates based on the old method versus the new method.

And so combined with our Part B colleagues here at the state programs, because it's also a requirement there, we've been conducting some work to think about developing a more robust and more valid unmet need estimation methodology. So we had a technical expert panel meeting about six or nine months ago, and we will be funding a contract to do some new developmental work. Hopefully that will not add a whole lot of burden, but will provide a meaningful estimate for jurisdictions and for us at the national level. So I just wanted to throw that out there, but the comment that Lori Jones made is correct. We have not required an updated estimate in this past year's application. And probably will not be in the FY2019 as well. So I just wanted to put that out there for everyone's information. Thanks.

Amber H.: Alright, thank you very much. Could we actually ... okay, we're good.

Okay, so one of the ways that we traditionally looked at unmet need, and this may change regarding Steven Young's update, but we looked at epidemiological profile data for information on the characteristics of people living with HIV who are out of care, who have unmet need.

Alright, next is the estimate and assessment of people living with HIV who are unaware of their status. So unaware or undiagnosed. And this is just the estimate usually calculated using national estimates from the medical monitoring project through CDC, but it's the individuals who are living with HIV, but who are unaware of their HIV status. It involved exploring which subpopulations are most likely to be unaware of their status. If you could advance the slide, please.

So one of the big sources of data for that in the Houston area is every year when we do our early identification of individuals with HIV/AIDS for our party grant applications, the assembled data that can help identify which individuals are at higher vulnerability of being undiagnosed or unaware of their positive status in the Houston area. So we look data elements like diagnosis rate, later concurrent diagnosis, the proportions of individuals with linked care soon after diagnosis, and we identify shared characteristics across many different populations. And you'll see a few there that we've identified in the Houston areas as being particularly vulnerable to being unaware or undiagnosed.

Next is the assessment of service gaps. And really that's just a review of the population living with HIV, their identified service needs and barriers, provider capacity and capability to meet those needs, as well as other data such as service utilization that helps determine the gaps in care both by service category, by location within your jurisdiction, and for specific sub-populations.

So here's where a lot of our needs assessment efforts really start to come together. We look at the analysis of our needs assessment survey data to identify who falls into particular service gaps, and how do we bridge those gaps. So we consider both barriers as well and supportive services that possibly fill the gap between the services that people need and what they are able to access. And we address the gap using funds available, which ... it's important to note that that may require changes in what is funded and at what levels in your jurisdiction. So for example, you may consider how changes in insurance payer or other policies affect people living in your jurisdiction. So how do you address those changes or gaps using the funds that you have available? As a general rule as jurisdictions we shouldn't be funding the same exact thing year-to-year. But we want to always take a look at what we're learning through needs assessments, what we're learning from utilization, and incorporate that into supporting councils to make funding decisions that are relevant to the needs of people in your jurisdiction.

Michelle V.: Thank you, Amber. And so now we want to take time for another poll. So tell me, here through the poll, which of the following are elements of a needs assessment? So we have the epidemiological profile, assessment of service needs and gaps, resource inventory, profile of provider capacity and capabilities, assessment of provider quality, estimate and assessment of unmet needs, estimate and assessment of people living with HIV, and assessment of service gaps.

Okay, so as I'm seeing the results come in, seems like a good number of you are recognizing that assessment of provider quality is not one of the elements of a needs assessment, but the rest are. So good listening. So like I said, assessment of provider quality is not one of the elements of needs assessment.

We have another poll here, and this is just to learn a little bit more about you and your planning councils and planning bodies. So tell us, which of the following elements of a needs assessment does your jurisdiction find most challenging? And you can check more than one, and we know that different planning councils and planning bodies struggle with different things, or maybe multiple things, so it's really to help us learn and to see what it, perhaps, is that you struggle with. And if you want to tell us more about what's challenging about this element that you're selecting here, or elements, you can do so in the chat. So you can feel free to tell us what makes something difficult or not.

It seems like the biggest challenge for everybody on the call today is the estimate and assessment of people living with HIV who are unaware of their status. Yeah, that can be pretty hard. As well as estimates of and assessment of unmet need, and the service gaps. So those are sort of the biggest challenges that we have, but hopefully, if we chat about what's challenging about that, maybe we can provide some peer learning. People can help people overcome these challenges that you've experienced.

Thanks for sharing, and now I'm going to hand it back to Amber, who is going to talk about needs assessment timing. Amber ...

Amber H.: Thank you, Michelle.

Alright, so the expectation is that jurisdictions will develop and follow and multi-year assessment plan. The expectation is also that there will be an epidemiologic profile updated every year, so that we're working off the most recent data available. And other components are often on a multi-year cycle. So it's important to emphasize that when you're doing the assessment survey, that's not something that needs to be required every year, but rather you should always be doing some type of needs assessment activity within that process.

So one of the ways we do it in the Houston area, is we do our needs assessment survey of quite a large number of consumers every three years. But each year we'll be doing new components, or tweaks, or projects like a special study. We'll be updating our epidemiological profile, we'll look at updating our resource inventory, so that we've always got needs assessment data infused into the process, even though we're not doing that large survey every single year.

In terms of annual timing, annual timing helps ensure that you have all the data you need for your priority setting and resource allocation process, as well as your service category selection and design. So we try to have any sort of needs assessment process data complete prior to service category selection and design. In the Houston area that occurs in April through the how to best meet the needs process. And then those needs assessment data inform priority setting and resource allocation in June. So every year that process is more and more updated depending on what data we collected in the previous year.

Michelle V.: Okay, so another quick little mini-quiz. How frequently should needs assessment activities be conducted?

Alright, let me give a little bit more time for people to respond.

Every year, every other year, every three years, up to five years.

Okay, so I'm seeing the results come in, and it does look like most of you knew that some type of needs assessment activity should be conducted every year. And that planning councils and planning bodies might vary the extent of the needs assessment activities from year-to-year, but there should be something done every year. Great job.

So one more. Tell me, when does your jurisdiction conduct needs assessment activities? We've got fall, winter, spring, summer, or N/A, we don't do this. And if you want to be more specific, tell us what month or something like that, or tell us more about your process, you can go ahead and do that in the chat.

Alright, I'm watching your answers come in. It seems like there's definitely a spread here, but I'm seeing that most people, about 55% of the planning councils and planning bodies do theirs in the spring. Followed by the summer with some in the fall, too. Which is good. Perhaps that indicates that we're doing something throughout the year, which is good. But most of you are doing it in the spring, like Amber mentioned.

And I just want to put out there that in the chat, Emily Gantz McKay asked a question, "Does anyone do needs assessment year-round?" So that can be a conversation that you have out there in the chat.

So I want to hand it back to Amber now, who is going to talk a little bit about how they do it in Houston.

Amber H.: Thank you, Michelle. So we'll be going over Houston case studies that describes our process for our needs assessment survey that we do typically every three years. It's a survey with people living with HIV. We also have a prevention survey that the Houston health department, which is the CDC-funded prevention provider in our jurisdiction, completes with anyone who has contact within the city, because they may be ... with their prevention messages. But again, there's always some type of needs assessment being conducted, so we always stay rather busy. But one important thing to note is that our process is designed for the needs of Houston, and your jurisdiction may need a different process. If you've got a more rural jurisdiction, you may have a different process. Or if you've got a smaller prevalence in your area, or maybe you've got a more concentrated area, your needs assessment survey process may look different. And it just needs to be one that is well thought out, is responsive to the needs in your area, and that meets good data collection practices.

Michelle V.: Thanks, Amber. And I'm going to hand it over to Rodney now, who's going to talk about consumer and community engagement in the needs assessment process. So, Rodney ...

Rodney: Hello, everyone. Here we're going to do a Houston case study on community leadership of these assessment process. The needs assessment group functions as a steering committee. It sets all the concepts and asks big questions. We work within work groups and we work with the staff to create the sampling plan, design the analysis, and that is how we answer the questions from the data we have. We also help determine a meaningful result from that data.

A Houston case study composition of the needs assessment group, here we refer to it as NAD, okay, it consists of co-chairs which are Ryan White Part A, Ryan White Part B, prevention, and planning bodies. Here that's the city of Houston. The second part is the body, the body that the needs assessment group has formed here in Houston. It has interested parties which all make up the general public.

For example, currently we have 18 people dealing with HIV on our needs assessment group. We have representatives from different parts of prevention, the Part B administrative agency, we have several FQHCs, we also have the Houston health department, and we have been working this past two years with several different hospitals to focus on HIV intervention. We also have several HIV task forces, and we also have different separate support groups around the Houston area. And we also have the state planning body, which is here is known as the Texas HIV Syndicate.

Here you can see a chart of the needs assessment group including the co-chair of the body. The needs assessment group co-chairs identify two work group co-chairs from each of the three work groups. Work groups are the epidemiological work group, excuse me, the survey work group, and the analysis work group. At least one of the co-chairs from each selected work group was a person living with HIV. The work group co-chairs are also selected from a professional or personal skills, and have experiences made into the function of the particular work group. Work group memberships in Houston typically range from 20-30 members in each work group. Here, a lot of our members have loss ... work in several different work groups.

Next, the work group functions. And what we have is this: the epidemiology work group comprised of both consumers and subject matters, and experts such as local and state health department staff. They are tasked with the creation of the epidemiologic profile, as well as setting the sampling frame for the needs assessment process based on our local epidemic here in Houston. While the staff calculates the total number of responses needed to have a representative sample size, the work group identifies how many respondents from the demographic groups and special populations to actually survey.

The survey work group provides the survey too, from the previous Houston HIV care and needs assessment cycle in 2016 to reflect the terminology, technology, HRSA, HAB guidance, as well as the state, local and national planning priority.

For example, one of the questions, one of the changes, that was made by the survey work group was made to include the question about prep. The question was asked about how many people living with HIV were aware of prep, and did they know where to send someone to access prep. The work group was also tasked with ensuring alignment of the Houston HIV prevention needs assessment based on questions that accept prevention service knowledge, needs, gaps, and barriers.

The next group, the analysis work group, reviewed and provided recommendations on the qualitative analysis code book, which is used to identify or classify open-response questions, discuss and update principles for data analysis, and provide input on data weighting and develop domains for the organizations, for the Houston HIV care services needs assessment re- ...

Michelle V.: Thank you, Rodney.

So we're going to take a minute and take another poll and see where we are. Okay, so tell me, does your jurisdiction currently involve consumers and community members in the needs assessment process? So let me know what's going on in your jurisdiction.

Alright, almost across-the-board I'm seeing that jurisdictions do include consumer and community membership in the needs assessment process. And we're really happy to see that, because that's really what we want. It's one of the things that makes the Ryan White HIV's programs so unique. And so if you're one of those 97% that involve consumers and community members in the needs assessment, tell us in the chat how you engage consumers and community members in the process. Let me hear what you're doing.

And while you're doing that, I'm going to pass it back over to Amber, who is going to tell us a bit about the process of conducting needs assessment in steps. Amber ...

Amber H.: Alright, thank you so much, Michelle. So what I'll be talking about are our steps in developing that needs assessment survey. And again, that survey is just one part of this larger process of needs assessment. Before I begin, I cannot stress enough that in Houston we have the resources to do a large-scale, in-depth, in-house needs assessment survey. That is office of support staff, council support staff, going out into the community and collecting these data. This is certainly not the expectation for all jurisdictions, so really the encouragement is to figure out the message that your jurisdiction ... For example, rural jurisdictions may want to provide a secure online survey option if transportation and travel present a problem for collecting surveys in person.

So our first step along the process is that we convene our developers. This is the needs assessment group that Rodney mentioned. We create the data collection instrument based on the previous needs assessment survey and make updates to it. We collect the data through administered surveys and interviews, sometimes we do focus groups if necessary to provide context. We enter and process the data, and then analyze the results. And I'll talk a little bit about those in the coming slides.

So data collection instrument development and administration of the survey instrument is developed by the survey work group, as Rodney mentioned. And essentially we go through the entire survey instrument. We see has the technology changed. So one of the things we changed was including questions about awareness of prep, and where prep resources are located in the area so that ... and would you know where to send a friend, or associate, or family member to access prep. As well as changes in terminology so that we're always making sure we're using people-first language, that we're being sensitive in responses in that way.

So data, at least the way we do it in Houston area, is collected in person on paper. And when I talk to other jurisdictions, there's always a slight gasp that we're going out and collecting these data in person. But we find that it helps with data validity and completeness, because the sites we go out and do our sampling, that allows us to make

sure we're going to areas that are most likely going to be serving or have people living with HIV. And also, it allows us the opportunity to check did the person completing the survey skip all of the questions on the back of the page. And we ask them, "Did you mean to skip this? Was this intentional, or did you just happen to miss it?" And a lot of times, people just happen to miss it. It also helps for administering surveys with people who have limited vision or limited literacy. So we are able to sit alongside them and help them through the questions. We also go out with interpreters who provide the survey, either instruction or walk-through, in Spanish.

Alright, so the next step is data analysis. So the analysis worker provides recommendations on how the data are to be analyzed and reported. They also help us develop domains, so basically chapters or concentration areas, that are going to be relevant to the type of planning activities we have here in the Houston area.

So talk about, on the right hand column, quantitative analysis first. So we go out, we gather our data. We come back and enter the data into ... The software we use is SPSS, but you can easily use just an Excel spreadsheet, whatever. If that's the resource that you have available to your jurisdiction that's perfectly fine. We go through and clean the data. And what we're really looking for is issues of duplications, so this may be someone who maybe we surveyed at a site a week apart, two different survey days, and maybe we caught them both times. So we look for data that are duplicative, so we clean it in that way. We also look for data in which maybe the person who completed survey was unclear about what they were completing. And so we want to make sure that our data are as useful and as helpful as possible.

Then we conduct analysis to make sure that all groups are represented. One of the ways we do that, since the data are more generalizable, one of the ways we do that is weighting. Which is adjusting your scores so that they are more representative of your epidemic. But there are many different ways that you can structure your analysis to make sure that your data are more representative.

And we look at frequencies and other types of basic statistics. So it's important to know that you don't need an advanced statistician on staff, just basic statistics like looking at frequencies. So, how many people you surveyed said this. Or measures of center range like mean, median, and mode. We can all think back to math in high school and learning all of those. And then calculating percentages will provide ample data for you to make planning decisions that are relevant to the people you serve.

So moving over to the column in the ... Oh, if you could go back please. Moving over to the column in the left, qualitative data analysis. So again we go through that process of gathering the data, entering it, and cleaning it. Then we do what's called coding for themes. So we do that in a type of software called NVivo; you can do it in a Word

document, and it's basically just looking at where people gave write-in responses. Where they told a particular story about barriers, or wait times, or staff interactions. You look for commonalities in what people were saying, and that helps provide depth or context to the quantitative data.

Michelle V.: Alright, so let's have another poll. Sorry for the prematurity there, Amber. Okay, so tell us true or false, needs assessments require complex statistics and data analysis.

Alright, and I see that a lot of you are paying attention. Because 80% of you recognize that needs assessments don't always require complex statistics and data analysis. I know Amber mentioned mean, median, and mode. We looked at measures of center and other things like that. So we can use simple tools like Excel or Word documents. We can use more complicated things if we want to, but they don't have to be complex to help us.

So now I'll hand it over to Dr. Peta who will talk a bit about how we can use needs assessment data to inform priority setting and resource allocation. So, Dr. Peta ...

Dr. Peta: Hi, good afternoon. So I'm going to be talking about priority setting and resource allocation, and how we use the data to inform priority setting. I do want to say that priorities are just one of many factors that determine allocation, and a needs assessment is just one of several processes that inform priority setting.

So all decisions are data driven. In the first column you see the decision, documented service needs with consumer perspective. But column two is where the source is. Where we get that data. So we have the needs assessment survey, special studies, and I'm not going to read everything on the columns for you. I just want to touch on how each data need for decision-making links to the sources of those data. So documented effectiveness of services, that comes from review of quality improvement and monitoring reports and program data. Documented response to the epidemiology of HIV in the jurisdiction comes from the epi-profile and program data. Documented response to emerging needs, reflecting the changing local epidemiology of HIV while maintaining services to those who rely on Ryan White funded services, that comes from the needs assessment survey, special studies, the epi-profile, and also program data.

Okay, so I want to talk a little bit about the steps in Houston planning council priority setting process. It's important to note that this is an example of priority setting in Houston. And other jurisdictions are encouraged to develop their own data-driven process that meets their needs. But what we do here in the Houston planning council, is we determine principles and criteria, we review the new data sources, we score measures from the needs assessment and service utilization data. We then adjust scores and then we rank scores as service priorities for the next fiscal year. Those two broad categories are core services, and then support services.

So let me talk about step one, determine principles and criteria. So the priorities and allocations committee, which I've been on for four years here in Houston, agrees on principles and criteria that is to be used during the priority setting and resource allocation. Examples: insuring on-going client access to comprehensive systems of core services as defined by HRSA, and eliminating barriers for services among affected subpopulations, racial, ethnic and behavioral. Also the low income, the unserved, underserved, and the severe need population, both rural and urban.

So step two, reviewing the new data sources. So the new data is discovered through the needs assessment. Again, that's just one source. We also have the service category selection and design. When we meet to review the new data, we look at availability, we look at utilization, we hear presentations from reps from other funding sources such as Prevention, HOPL, etc. So we take all of those into account.

Third, we score the measures from the needs assessment and the service utilization data. Scores are based on the service need, the use of services, and the accessibility of services. So you're going to see different scores for each of those three things.

And then we also adjust the scores. And we adjust the scores based on other documentation that we receive, and public comment, which is very important. And we try to hear public comments as often as we can.

So step five, and you're going to see this really huge-looking chart, but what it does is ... This chart is a comprehensive snapshot of the core services which are listed there on the left. Primary care, medical, local medication assistance, oral healthcare services, health insurance, mental health services, early intervention, day treatment, substance abuse. These are all core services.

Okay, so then you see what I was talking about before. That first column is the need. And so those scores are different than the second column, which is the score for use. Which is also different from the third column next to that, which is the score for access. So because we're measuring different things, we're going to have different scores. So each is defined ... Each score for each funded service stands alone by itself as far as the numbers are concerned, but we do establish a midpoint. So midpoint for need, midpoint for use, midpoint for access ease. And scores above that midpoint for that particular category are assigned as high designation, and below the midpoint are assigned low. Based on the high/low scores, which you see in the next three columns with Hs and Ls, services are then ranked in priority. Core medical services generally have the higher priority, as you can see.

And this chart shows support services. The first line showed core services. So support services are also scored based on need, based on use, based on access of ease. Again we

have a midpoint, above the midpoint is scored as high, below the midpoint is scored as low. We have our rankings, and so ... you want to see support services ... On the left we have some that don't have data because they're newly funded support services, and they're ranked with regard to their ability to support retention in care.

The needs assessment gives us an idea of what people living with HIV in a community need. The needs assessment data should be collected every year in time to ensure that you have all the data that you need for the priority setting and resource allocation process.

Michelle V.: Okay, thanks everyone. Thank you to all of our presenters. And so I just want to go through a conclusion of everything that we've talked about so far today.

And basically, today we learned that needs assessment should contain the epidemiologic profiles, an assessment of service needs and gaps, resource inventory, a profile of provider capacity and capability, an estimate and assessment of unmet needs, and an estimate and assessment of people living with HIV who are unaware of their status.

So, thank you again to all of our presenters who spoke, and a thank you to everyone who's been asking questions in the chat. We have plenty of time to answer some of the questions that you've been chatting in throughout the presentation. We've been taking note of them, and I'm sure you're all anxious to hear the answers. So what will happen is I will read through the questions that we have been collecting, and our presenters will answer them. If you have questions that you haven't asked yet, you can go ahead and chat them in, and we'll try our best to get them in before the end of the session.

And I just do want to make a note that the slides will be available after the presentation, so you'll be able to get all of that afterwards, and have this other resource.

So, let me go over here to questions and answers. So let's start with a question for Amber. So the first question that we'll go through is, "How many staff support the needs assessment group in Houston, and specifically paid staff?"

Amber H.: Thank you, that's a great question. So the Houston Ryan White Planning Council Office of Support has four staff members. But we conduct a large number of surveys, so even with four members on the support staff, it is a daunting task. So we do partner with one of the schools of public health in our area, and work with interns to assist with data collection and entry to make it more manageable.

Michelle V.: Great. Thank you, Amber.

And I have two questions for Rodney, if he can take a moment. So the first question is, "How many members of the needs assessment group are there? Because you said that there were 18 people living with HIV, so we wanted to know how many 18 is a part of."

Rodney: That's part of the 20-30 members of our group.

Michelle V.: Okay, thanks.

Amber H.: Michelle, we were actually able to pull a full number if you want to-

Rodney: Yeah, there were actually ... the question that you asked previously, there were 43 total number of needs assessment group members. So close to half of those were self-disclosed living with HIV.

Michelle V.: Great. Thanks, that's helpful.

And then, in addition to that question about the size... How many people have completed one of the needs assessment surveys?

Rodney: Slightly over 500. We shoot for a number between 500 and 1000, but it will vary depending on the number of people living with AIDS in your jurisdiction.

Michelle V.: Great, thank you.

So now we have a question for Amber. The question is, "With regards to your annual survey, how do you ensure that your results are generalizable? That is, do you take a random sample of respondents?"

Amber H.: That's a great question. So our main way of doing that is, first is, through sampling. So the epidemiology work group develops a sampling plan, and based on the epidemic in our area identifies a high number and a low number. So if our total sample size is between 500 and 1000, they help us identify how many people should be of a specific demographic category. And our process for more vulnerable populations, or populations that are harder to survey, or that are not traditionally represented in epidemiologic data, such as individuals who are transgender or gender nonconforming, people who are experiencing housing instability, or people who were recently released from incarceration, our role is to sample as many as possible to make sure that they are included.

Our other way is that, on the analysis side, is that we weight our data by age, sex at birth, and race/ethnicity to ensure that our scoring is more generalizable and more representative of the epidemic in the Houston area.

Michelle V.: Great, thank you. And we have another question, "Do jurisdictions need IRB, internal review board, approval for a survey or other types of primary data collection?"

Amber H.: That's a very good question as well. In the Houston area, we do not. But other jurisdictions may. Particularly if they are sampling within university health systems, or the learning institutions, or any other institutions that require IRB. So my advice would be to look at the locations where you're sampling and see, is that a location that needs IRB approval to do any sort of sampling within their system.

Michelle V.: Great, thank you. So a question about timing, "Does the needs assessment cycle need to be adjusted from every three to every five years to inform the 2017-2021 integrated plan?"

Amber H.: Y'all have some great questions. That's a fantastic question. We currently stick to the three year planning cycle because that allows us to make priority setting and resource allocation more responsive. If we had to wait five years between doing our needs assessment surveys, imagine what changes in terms of policy and just the demographic composition, diagnosis rate, all kind of new providers come on board, or providers leave. So we keep it at three years to be responsive. We also establish those three years in response to the Ryan White Part A manual. So I'd say we'd consider changing that if something substantial happened, or if there was a change in the recommendation or the requirement in the Part A manual, but as for now we keep it at three years to make sure that it stays responsive to the needs in our area.

Michelle V.: Okay, thank you for that. That's great. One of our questions relates to how to identify duplicates if there's no identifiers on a survey. Can you speak to that?

Amber H.: Yeah, absolutely. So we don't collect names or any other kind of identifiable information, so yeah, you're absolutely right. It can be difficult to identify duplicates. One of the ways we do that is we look for extremely similar answers that also fit the same or very, very similar demographic markers among people who were surveyed at the same site. So these aren't super common, but we'll look at it and we'll make a judgment call as to whether this is most likely the same person or not. If it seems like there's any sort of doubt that it could be a different person, we'll leave it. And again, we do rely on weighting to help us make it more representative. So if it's not an exact one-to-one response, that's okay.

Michelle V.: Great, thank you for that. So are there areas that may not be Ryan White HIV/AIDS program-funded agencies?

Amber H.: I'm a little confused by the question, but I think that means are there areas that may not have Ryan White funded agencies in them. And no, all jurisdictions in the United States

are covered with either Ryan White Part A and Ryan White Part B, or at least covered through Ryan White Part B if it's a more rural jurisdiction.

Michelle V.: Great, thank you. We have two similar questions, so I'll ask them both, and Amber I think you can speak to both of them. So there's some hope that you'll be able to address how planning councils can receive summaries from CQM, monitoring chart audits, etc. by service category but not by provider. It seems like the person who asked the question, their committee is not involved, but does get data. And then the second question is just asking whether the planning councils are able to review monitoring reports. And they wondered about chart audits as well.

Amber H.: That's a great question. So in the Houston area, the quality improvement committee and then the council review aggregate monitoring data, and they look at it by service. So that avoids any sort of involvement with provider level data. They don't know that a particular provider has these particular chart review results, or what have you. But they do look at it by service category.

Lennie G.: Hi, this is Lennie from HRSA. This is something also you can do in advance through your MOU by agreeing on what type of data you are going to need during certain points in the year for planning, and what that data should look like by service category. Thanks.

Amber H.: This is Amber. Just sort of briefly, in terms of needs assessment and how services are being provided, one of those key data elements is aggregate performance measures that the administrative agencies collect. So again, all of that is aggregate data, it's not within the council's purview to look at provider specific information, ever.

Michelle V.: Wonderful. Thank you Amber and Lennie for jumping in there as well.

So another question that we have is, "Do you have any advice on doing surveys that include those that high risk for HIV as well as people living with HIV, especially if you have an integrated planning body?" The person who asks says that they just started doing that.

Amber H.: Oh, I see. Okay. Well, first-off congratulations on trying to merge both of those surveys. It's a little bit of a daunting task, but it seems like that's something that an integrated planning body would be well-suited to tackle. In the Houston area, we have the Ryan White Planning Council that does care services planning, and the Houston Community Planning Group that does prevention planning. So we're still two separate bodies, but in the Houston area, the prevention provider, which is Houston health department, works with the community planning group, and they do surveys online, so it's a little easier to gather a large sample size that way. But they promote through social media, and at health fairs, testing events, and many other locations.

So some general advice on where to start with that is to look at locations where prevention services are already being provided. And then expand to other areas that may be underserved. And this is going to be something that's going to be revealed in that initial sampling within areas that prevention services are already provided. You'll start to see which demographic groups you're missing, or which types of services you're missing in your data. So that's another important component of the assessment, is that it shows you what information you're not getting, that you need to do additional efforts and special studies.

Michelle V.: And Lori, I do see that you just chatted in that you had a follow-up question. Could you just clarify, I just want to make sure that we answer your question. You wrote something about it being like a primer? So we just want to make sure that we try to get to answer your question.

In the meantime, while you're chatting that in, someone noted that one of the biggest challenges for them is that small TGAs have the same requirements as large EMAs without the same amount of budget and resources. So can you speak to that a little bit?

Amber H.: Sure, absolutely. So again, what I've described as far as the Houston model for doing these assessments, and our entire process, is one based on four paid staff members, and interns, and many kinds of resources that smaller jurisdictions may not have available. One of those ways of doing that would be to use secure online surveys. Those present their own problems with data validity in terms of methodology, but it's a quick and easy way to gather lots of data in a very short period of time, and not have the amount of staff time needed to manually enter data and all of that. You can skip right into cleaning and de-duplication and start your analysis.

Others would be to work ... again, I cannot thank our interns enough who come in and help us with data collection and data entry. Another option, too, is to piggyback survey sampling days, the days that you'll be going out sampling, on occasions where a larger number of people living with HIV would be present at a funded or non-funded provider. So one example of that would be, if have a provider in your area that has particular days where they do a food pantry you might have some staff members go and conduct surveys at that time. Or maybe you have a provider, either funded or non-funded, that has a large cab meeting, or community meeting, you might see if you can piggyback off of that so that you've got sort of a captive audience. And that will present a challenge for sampling for people who have unmet need, or who are out of care. But you can find other ways of getting those data through special studies or through looking at history of being out of care.

Michelle V.: Thanks, Amber. Those are really good strategies that people can use.

One question that we have gotten about your data, "Do you desegregate by demographics, for example gender, age, ethnicity, sexuality, etc. to assess specific needs?"

Amber H.: That's a great question. If at any point you want to check our website rwpchouston.org, you can find all of our planning products that we've pulled together, and you can find a full copy of our needs assessment. But within that, we go by each service category, and we create a profile for that service category, and we look at which populations find that service to be more accessible or less accessible, and what those barriers they encounter are.

We also started, we're not complete yet, but we've started doing a few profiles by special populations, which is just a little mini-report for a specific demographic group. We look especially at the special populations we identified in our comprehensive or integrated plan to do those initial analyses within those populations. And the problem that you're going to run into when you do that is you're going to have perhaps a sample size that's not representative. So always make sure you mention the caveats in your data, that you're not presenting data to council, or use for planning, that has a sample size of five or something. You want to make sure that you're presenting data when you've got a strong, robust sample for that particular population.

Michelle V.: Great, thank you so much.

Another question, "In Houston, for the needs assessment work group, does membership include a consumer advisor group? How do you maintain such a large membership? Are they all planning council members?"

Amber H.: So Rodney, I think you'd be a good one to answer that question.

Rodney: Can you repeat the question, please?

Michelle V.: Sure, so there are like three components to the question. So in Houston, for the needs assessment work group, does membership include a consumer advisory group? How do you maintain ... oh, sorry, go ahead.

Rodney: They are not all planning council members, but many serve on other committees and task forces. And I was just looking through some notes here, in Houston we have the African American State of Emergency task force, the Latino task force, and the Youth task force. And so a lot of people in our group actually come from those memberships. And those are outside of the Ryan White Planning Council. Those are separate groups that help with the work for the HIV community here in Houston.

Michelle V.: Great. And so then they go on to ask, "How do you maintain such a large membership? Are they all Planning Council members?"

Rodney: No, they are not. They serve in different capacities. A lot of our members are actually work for the health departments, and they also work for the Ryan White Part B, which serves the rural areas. They active in all of our meetings throughout the year. And they serve on part of our work groups as well. That's what makes up our membership, makes us aware, but like I said, a lot of us is just volunteers. Like I'm a volunteer. And they share similar missions and activities within their group. And they benefit from the needs assessment data as well, so it's a mutually beneficial process. And I can also make a personal note that I'm involved in three different organizations outside the Ryan White Council, and our memberships in those groups also overlap as well as several of those people actually serve on our actual Ryan White program here.

Michelle V.: Awesome-

Rodney: And they come from-

Michelle V.: Thank you so much-

Rodney: I just approve of volunteerism. A lot of them are volunteers in our local third agency provider.

Michelle V.: That's so great. Thanks, Rodney.

We have time for one more question before we wrap up, and so this question is, "Was the Primer vetted with CDC? Has HRSA considered what needs assessment should look like for integrated planning?" And this question was specifically addressed to HRSA, not Houston. So Lennie, if you'd like to take this one?

Lennie G.: To answer the question in regards to CDC approval, the Primer was vetted through the HHS protocol. In regards to the integrated planning, we're working with individual areas to work within the needs of those particular areas in regard to integrated planning. Not every area is the same, so the answer to that question would be providing support to those individual TGAs and EMAs. We also have a cooperative agreement that's focusing in on the integrated planning process. Thank you.

Michelle V.: That's great. Thank you so much for answering that question, and to all of you for all these really great questions and for listening so intently, and being so thoughtful as we go through our webinar today.

And so I hope you all enjoyed it, and I do want to make you aware of some upcoming webinars following this one, because we use needs assessment data for this purpose. We have our next webinar in the summer. Will be on priority setting and resource allocation. So you can look forward to that. As a reminder, today's webinar will be recorded and archived on our Target Center page, that's www.targethiv.org/planning-chatt with two Ts. All participants in today's call will also receive an email when it's posted so you can share it with your colleagues.

You can also find links on the TARGET Center for all of the tools that we've presented today, and if you forgot the direct link, you can just find us through the Target Center homepage or through the topics library.

So thank you all again. Thank you to our presenters, to HRSA, and to all of you for listening and staying to the end. Visit our website to sign up for our mailing list, download tools, and resources, view archived webinars, and more.