



USING DATA FOR DECISION MAKING: PART 1 WEBINAR

- Molly Tasso: Thank you. Hello everyone, and welcome to today's webinar. Part one of the Using Data for Decision Making webinar series. My name is Molly Tasso, and I am a Technical Assistance for the Planning CHATT Project. Before we get started, here are a few technical details. First, attendees are in listen only mode, but we encourage you to communicate with each other and ask lots of questions using 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 Planning CHATT staff will take as many questions as we can at the end of today's session. If you think of a question after the webinar, that's fine too. You can always email us your questions at planningchatt@jsi.com.
- Molly Tasso: The easiest way to listen to our webinar is through your computer. If you can't hear very well, check to make sure your computer audio is turned on. If you still can't hear us, or you experience a sound delay at any point, try refreshing your screen. Finally, if needed, you can mute your computer audio and call us using the telephone number, and I'm going to share with you right now. The call in number, and we will also chat it out in the chat box, is 800-289-0459, and the passcode is 482318.
- Molly Tasso: We'll start off today with an overview of the importance of data in RWHAP planning, and types and sources of data commonly used for RWHAP planning. Then move into strategies to address gaps in data, assess data quality and usefulness, and talk about the importance of using multiple data sources for decision making. We'll go over some resources that you can refer to after the webinar, and then answer questions at the end. We'll be taking questions through the chat box throughout the webinar, but we'll wait to respond to them until the end of the presentation.
- Molly Tasso: As you can see here, by the end of the webinar, our objectives are that you are able to articulate the benefits of using data for HIV planning and decision making, define important data-related terminology, identify and describe types of data planning councils and planning bodies use for HIV planning and decision making, and assess quality and comprehensiveness of data.



Molly Tasso: As you all are aware, these webinars are put on by the Planning CHATT Project. The Planning CHATT Project builds the capacity of Ryan White Part A planning councils/planning bodies across the United States. Our goal is to help planning councils and planning bodies meet legislative requirements, strengthen consumer engagement, and increase the involvement of community providers in HIV service delivery and planning.

Molly Tasso: Again, my name is Molly Tasso, and I'm a Technical Assistance Coordinator with the Planning CHATT Project. Today, we're thrilled to have with us, Jesse Carter. He is a Planner with the Texas Department of State Health Services. Jesse is the lead planner for the Texas Department of State Health Services HIV/STD Prevention and Care Branch. He has worked in the HIV field for more than 20 years, in both prevention and care. He has served on HIV community planning bodies and planning councils, and has worked in supporting and administering care and prevention planning at local, regional and state-wide levels. Jesse will be presenting most of the information on today's webinar, drawing from his experience conducting planning activities for planning bodies across the state of Texas, and I will be popping in to help facilitate polls and discussion questions.

Molly Tasso: My colleague from the Planning CHATT Project, as well as Emily McKay from EGM Consulting, be answering questions together at the end of the presentation. Before we move into the content, I wanted to also introduce our colleagues, Lenny Greenwood, from Hersa, who is our Planning CHATT Project Officer, and I just want to hand it to him for a quick moment to welcome us.

Lenny Greenwood: Welcome everyone, to this very important subject in our series of webinars. This is part one, and we're looking forward to your participation today, as well as in part two, next week.

Molly Tasso: Great, thank you Lenny. With that, I'm going hand it over to Jesse, who is going to kick us off today talking with us about the importance of data and Ryan White Planning. Jesse?

Jesse Carter: Hi. Thank Molly, and thanks everyone for inviting me to be part of the conversation today. Starting off, this is a really great quote about the importance of using data in HIV planning, both in care and prevention, for Part A and Part B, and for all of our decision making. This is a great quote: "Without data, all we have, all anyone has are opinions. Data elevates the probability that

you'll make the right decision." That's sort of the point of all of this, is making sure that we're using the right data to make the best and most informed decisions.

Jesse Carter: What is data-based decision making? Decision making that's guided and supported by documented information and data, rather than based on personal experience, observation, anecdotes, who gets up and talks at a meeting, and the last person who gets a word in gets to drive the conversation. We want to make sure that we're using data to have those conversations and make decisions.

Jesse Carter: Data is used by planning councils and planning bodies, and just a note, moving on, I'll probably just be saying planning councils. Data is used and should include quantitative and qualitative information that's obtained and reviewed systematically with the best methods possible, and it should be from multiple sources, using many different approaches as possible. As the slide says, some experts prefer to say, and I usually will say data-informed decision making, since decisions really can't be based on multiple factors, that they should be informed at their core by the data that's available.

Jesse Carter: The difference between qualitative and quantitative data that you may see as planning council members and be working for, quantitative data is information that's usually expressed in numbers, it's counts, it's compared on scale. This is a lot of the epi data that you'll see, survey data when we're just doing raw counts of the number of people who responded in a certain way. That's quantitative data.

Jesse Carter: Qualitative data, it's not as easily measured, or expressed in numbers. It's usually narrative. It's from focus groups, or can inform in interviews, town hall meetings. It's more content enriching, and it can be used to build a story around quantitative data.

Jesse Carter: Qualitative data is also very useful, and it can provide a lot more rich information around quantitative data that you may be having. An example of that would be talking about the number of people who may need, or indicate that they need food bank for a service. You may have a lot of people who indicate that they need food bank, and you know that they need food bank.

Jesse Carter: Qualitative data, through focus grouping, can help you understand how those food bank delivery services should be delivered, how people want to access

them, whether that's through pre-payered boxes where they're picking them up, whether it's being delivered at their house, whether it's a grocery store. All of this information can be used to build a better picture, and to decide what services are funded, how they're funded, and how they're delivered. Go ahead Molly.

Molly Tasso: Okay, thanks Jesse. Before we move on, we're just going to take a quick poll. Go ahead and answer on the screen. Why is it important to use data for HIV planning? Please select all that apply. I'm just going to move quick to the previous screen really quickly, to just show you the answers.

Molly Tasso: First would be to help establish, support and improve systems of care, that data guide important HIV planning processes, that they help make accurate and appropriate planning decisions, help avoid decision making based on impassioned pleas, or all of these reason why we feel is so important to use data for HIV planning.

Molly Tasso: If you want to go ahead. Let's say, yes, overwhelmingly, everyone is picking up that all of these are reasons why it's very important to be using data for HIV planning. Yeah, so it looks like everyone is fully understanding that the benefits are myriad, so it's very important that we're taking the time this week and next week to go through this information. With that, I'm going to hand it back over to Jesse, who is going to go into a little bit more detail on this.

Jesse Carter: Thanks Molly. Yeah, as everyone indicated, data based decision making is essential to establishing and supporting, and improving our care systems. It should be informing the entire planning process that we conduct, so how people access care, or I'm sorry... It's essential for planning councils, so understanding how what people's service needs are, what the barriers are, what the gaps and service are, how people are accessing those services overall for the entire population of people living with HIV in a certain area, and for subpopulations, sub groups of people living with HIV in an area.

Jesse Carter: It's incredibly necessary for making sound decisions about the use of available funds. As everyone knows, we don't have unlimited funds, and so how we use every dollar counts and is incredibly important. Making sure that we're using the best data possible to understand where that money needs to go, and what we want to fund with that money. It's also for targeting particular service models or geographic areas, or as I said, subpopulations, understanding what

models of care may produce the best outcomes, or what clinical practices may increase capacity in clinics, what geographic areas need to be funded. Rural versus urban populations and even within urban populations, differences in neighborhoods and understanding what those needs might be.

Jesse Carter: Then understanding the diversity of people living with HIV in an area, and understanding that the diversity of needs based on who might be living with HIV. Of course, that feeds into improving the care for those folks who are disproportionately affected. As we look at data and break it down into different subpopulations, and how people are affected by HIV, and then what services they need, that can help us direct not only what services to fund, but where those services need to be directed, and how they need to be delivered.

Jesse Carter: There are some challenges in using data. Data can get incredibly complex, although we do all use data every day in our daily lives. We make decisions based on data constantly, we just may not interpret it in the same way as data, because we're not seeing it in a graph in front of us, but we all process this can of soda costs more than this can of soda, so which am I going to buy? We use it in a lot of different ways. This is just in councils and when we use it in planning, it's just a much more formal structure.

Jesse Carter: It can get really complicated when we start digging into data, and you start digging into the epidemiology of HIV. Getting training on terms and sources, and how data is used and what different systems, their strengths and weaknesses are, are important in understanding and measuring the data that you want to look at. It's not always presented in a user friendly format, that is definitely the truth. Sometimes the graphs can be incredibly confusing, and it's always important to work with your planning council support, and whoever's presenting the data to understand it. Encourage people whenever they're giving you data, or presenting data, to make it as friendly and clear cut as possible. The full discussion and review of data does take time. Even when you're comfortable, you know the terminology, really digging into the data and looking at it, and drawing conclusions, and understanding it can take time. It really just calls for you to stick into it, ask questions and stay with it.

Jesse Carter: I think some of the things that are challenging around data are our HIV language and data terminology. When you're looking at data and you have questions, I just always encourage people to ask questions to clarify your understanding, because there's a lot of terminology. I just had to check with somebody this

morning, about some terminologies around how we're referencing things. There's prevalence, there's known prevalence and estimated prevalence. There's prevalence versus incidents. We talk about data in terms of proportions and rates, and sometimes data gets confusing, because we'll present something as a percentage of a percentage, so sometimes things come out as 60%, or 27% of the 56% who responded this way. It can get very confusing. It's just, take your time, understand it and ask questions to make sure that you're really clear about what you're looking at. Go ahead Molly.

Molly Tasso: Great, thanks. Before we move on, we just wanted to take a moment and ask that you think about this question on the screen. What are some of your challenges in using data for HIV planning? You can go ahead and chat in any feedback or responses you have into the chat box.

Molly Tasso: These might be, for example, you might have challenges getting certain types of data, or it might take a while to get that data. If you have trouble understanding or interpreting certain pieces of data, or challenge in discussing or talking about it. Anything like that, we'd be interested in hearing, so go ahead and just take a few moments. Yeah, so it looks like the timing of data is something that is a problem for folks. It looks like by the time certain data reaches the planning council, it's a couple of years old. Yes, accessing the most current data can be a challenge, and developing the right questions. I think that's a really great point.

Molly Tasso: The data you've collected is really only as good as the questions you're asking the people that you're talking to, so that can be a challenge as well. I think we're going to move on, but please do continue chatting these responses in. This is all very interesting and helpful. I'm going to hand it over to Jesse, who is just going to kind of walk us through how we use data to illuminate and address disparities.

Jesse Carter: Thanks Molly. Go ahead and [inaudible 00:16:01] it, sorry. There are four common types of disparities addressed through HIV planning that I'm sure you may be aware of. There's addressing and understanding unmet need, understanding the gaps in service within your service system, understanding what services are available, and that can help feed into understanding what the gaps are. Then as I just said earlier, understanding where geographic disparities, understanding the differences in different populations, whether they be urban or rural.

Jesse Carter: Unmet need, this has been around, and commenting for HIV planning for a while. Unmet need refers to the individuals within an area who are living with HIV, who know their status and are living with HIV, but are not receiving medical care. They're not in care at the moment. It's based on HRSA/HAB Unmet Need Framework. A lot of people have been running this for a while. My understanding is that HRSA and HAB are updating it now. We determined the number of people living with HIV in an area through surveillance data, so working with our epi and surveillance partners to know how many people are diagnosed and living with HIV in a certain area. For example, here in Texas, we collect information through a lot of different systems on evidence of care. People living with HIV who have evidence of care, we collect it through our direct HIV reporting system that we used for Ryan White, and we partnered with all of our colleagues in Part A, B, C and D across the state. We also collect private insurance data. We have a robust way of collecting in care data, or evidence of people accessing care, which we then use and compare to the total number of people we know living with HIV in a jurisdiction, to understand how many people we don't have any evidence of care, how many people have unmet need for medical care.

Jesse Carter: This is incredibly important when understanding planning. It can help you understand how to provide funding for service categories that are going to help people link or relink back into care. Service categories like outreach and EIS can be used to help find people who know their status, who are out of care and bringing those people back into care. It can help to understand your need to build up and create a robust medical case management system in order to identify people who are at risk of falling out of care, and being able to support those people while they're staying in care.

Jesse Carter: It can be used to understand how of those people who are out of care, what their needs might be. It could be used to help direct needs assessment activities, which we'll talk about later on, in order to get a better understanding of what the needs of people who might be out of care, why they might be out of care, and how they can be supported whenever they decide to access care again. Go ahead Molly.

Jesse Carter: Service gaps. These are different, and we use the terms differently than unmet need service gaps, are unfilled needs for HIV related services other than primary medical care, because when we talk about primary medical care, we are talking

about unmet needs. These are service gaps for other services among people who are living with HIV who know their status in an area. The term, as I said, it's used to be very clear between unmet need and service gap. It's measured through needs assessments and recipient data, so through going on and talking to folks living with HIV in your service system, through your needs assessment processes. Also, talking to your provider networks, and understanding what gaps in service they might be seeing. If there are wait lists possibly for services, and those sorts of things, so understanding what the service gaps are.

Jesse Carter: Again, this is used for understanding where you need to place funding, directing how funding should be delivered and making services available for folks in your area.

Jesse Carter: The availability of services, this is the amount of service available in your area, so you may have services available. You may be funding services, but understanding how much of that service is available in your area, or other. The service maybe be funded by other providers or funding streams in your area, so the level or the number of available slots or capacity of a service category in your jurisdiction or your geographic area. It's usually measured as part of your resource inventory, or a profile of capacity within your area. It's done by asking providers about their capacity in terms of how many people, sometimes just directly, how many people can you provide a service to? How many slots can you provide for medical case management, or how many appointments can you handle in a particular day for mental health, and then multiplying that out to understand what the capacity is of that provider, to provide mental health services in your area.

Jesse Carter: Again, this is used to understand whenever you look at the need, and then comparing that to what is available, so that you can understand the level of funding that might need to go into a category, so you might understand that there is a need for mental health providers and mental health services, and you've talked to your service providers to understand their capacity, and then you may need to make a larger investment in that service category, in order to expand the capacity of the services available.

Jesse Carter: Then there's geographic disparities. These are differences in access to needed services, based on where people live. As I said, in a lot of areas, there a lot of difference between those folks who may be living in the suburbs of cities, particularly for Part A's, the suburbs of cities, versus the core of the city. The

jurisdictions for these may extend out into more rural counties around, and so understanding the needs of those folks who may be living in more rural areas, versus those people living in the core of a city is measured, by comparing the number or capacity of providers in an area to the needed services across the area.

Jesse Carter: Again, it can be used to direct services, to understand where services need to be delivered, which services need to be delivered, how they may need to be delivered. If you understand that you need transportation services across your entire area, but they may be greater for clients who are living out in the rural areas, and it may need to be a different form of transportation in a rural area, versus an urban area. You may be able to do bus passes in an urban area, whereas there may not be bus services out in the rural areas. Understanding the geographic disparities and the geographic makeup of who's living with HIV, and who your client population is, and who you're serving, and understanding how those needs may differ, and also how those needs may differ, and how they need to be met.

Molly Tasso: All right, [crosstalk 00:23:46] thanks so much Jesse. Oh, sorry. Okay, so we're going to move into a really deep discussion about the types and sources of data that are commonly used for Ryan White Planning, but before we do, I just want to take a couple quick polls. I'm just going to read this to you first, and then I'll move to the slide where you can answer. Which of these five data sources are you most comfortable working with? You just select one. Is it the epi profile data, care continuum data, needs assessment data, resource inventory, service expenditure and cost data, or client characteristics and service utilization data? This is what you are most comfortable working with.

Molly Tasso: It looks like epi profile and service expenditure, and needs assessment data are pretty comfortable for folks to work with. It looks like resource inventory, not so much. It looks like epi profile people really have a good handle on that. I'm going to guess that I know the answer to the next poll, but if we can go ahead and answer the same question, but tell us what you are least comfortable working with. The same response is available. It looks like, yes the resource inventory data is something that people are feeling like they might not have a great handle on, as well as care continuum data, and some service expenditure and cost data. I'll give us a few more seconds for these to roll in.

Molly Tasso: Looks like needs assessment data, people are feeling like that is their most, or most troublesome datasets. That's interesting. Yeah, it looks like research inventory, as expected, is something that folks might struggle with. I'm going to hand it back over to Jesse, who's going to walk us through each of these and give us a good overview of what these datasets are, and where they come from, and how they're doing.

Jesse Carter: Okay, thanks. It looks like most of you are really familiar and are comfortable with epi profile data. An epi profile is published. It's basically a document that describes the burden of HIV on a population, or the burden of HIV in an area, including the distribution of HIV among various populations. It can be broken down in terms of sociodemographic characteristics, age, race, ethnicity, by geography, by behavior. It can be broken down. A lot of times, it's presented by folks who are identified as gay, bisexual or other MSM, heterosexuals. We often break epi profiles down into what people determine as risk categories, are those folks who are most at risk for HIV.

Jesse Carter: It can be broken down in clinical characteristics sometimes, although a lot of people are moving away from it. At one time, epi profiles really were broken out between folks living with HIV, versus those folks who had received an AIDS diagnosis. That happens less, but you may still see some of that.

Jesse Carter: They often include characteristics of the general population. It may also compare the population of people living with HIV with census data, or characteristics of the general population, to point out the difference in particularly disease burden.

Jesse Carter: It can include people who are newly diagnosed, so you may see the number of cases newly diagnosed each year, versus the prevalence, or the number of people who are living with HIV. It can, again, provide information about groups that are more vulnerable or at heightened risk for HIV. Sometimes it will just provide breakdowns of living cases and new diagnosis by that. I know some of our epi profiles are now including estimates of population size, so that we can have a better understanding when we talk about, for example, Latinx gay men, how big that population is, so we have a better understanding of what the disease burden, or the HIV burden is for Latinx gay men here in Texas.

Jesse Carter: A lot of times, it will have trend data, so some of this will be presented for a calendar year, but a lot of times, it will have background data, so you can see trends over time. For example, the trend in new diagnosis over time. This comes from state and local surveillance staff. I know here in Texas, a lot of it comes from our epi and surveillance program here at the state, who collects it in eHARS. You'll hear eHARS a lot. It's the Enhanced HIV/AIDS reporting system, data system, so it collects all diagnosed cases in a jurisdiction. As I said, it's usually based on a calendar year, although sometimes, I have seen epi profiles, or mini profiles based on grant years, but most of the time, whenever you see them, they're going to be based on a calendar year.

Jesse Carter: I do want to say, I know that one of the things that people said about the challenges about data is the timeliness of data, and epi profiles are usually always... There's always a delay, so you might be looking at an epi profile, the most current one that you might have available to work with might be a year old. For example, we are currently working with epi profiles here from 2017, while we're waiting for the 2018 data to be finalized, so that the new epi profile is based on 2018 data will be produced later in 2019, so there's always a data delay.

Jesse Carter: Epi profiles are used to provide, again, an overall good picture of what people living with HIV may look like in a jurisdiction, who those populations are, who the subpopulations are. Again, where those people are living across the area, they can be used to understand where increasing rates of HIV may be happening, if there are any changes, again, in trend data. Are they useful in moderating to understand if you're seeing trends in new populations coming, or stable populations. They enable councils to develop and refine services to ensure that appropriate care is available for emerging groups. Again, looking at where new diagnoses are happening, compared to who is currently living with HIV to understand that if there are emerging populations that are coming up, either by age. I know a lot of times, we talk about and examine, and look very closely at young people and increasing diagnosis among people under the age of 35, for example. It's also important for integrated prevention and care in planning councils. It helps identify populations for primary prevention, testing, and prevention for HIV positive individuals.

Jesse Carter: This is a great slide from Washington, from their epi chart, their epi profile, just showing a five-year trend, as I said, of new diagnosed cases by gender. What

they're demonstrating here are a decrease. Overall, looking at this on face value, we're seeing that there's a decrease in new diagnoses within their jurisdiction. A pretty significant decrease actually, if you look at it between 2012 to 2016, they had a 46% decline in new diagnoses, which is a pretty good decrease in new diagnoses in their area.

Jesse Carter: You can also look at this. This is broken down by gender, so by male, female and transgender individuals. You can see that while they are declining, I think what's really interesting about this is while it's a steady decline and it seems to be the proportional for each population. You don't see a greater decline in one population at all, it seems to be representing a pretty steady overall decline in new diagnoses in their area. As a council, understanding that you may see fewer new diagnoses, or fewer new people coming into your system of care, and but also understanding that how people are entering care, who those people who are entering their care system are, and being able to plan accordingly for what the services needs for those people might be. Go ahead Molly.

Jesse Carter: HIV care continuum data. The care continuum is something that came on several years ago. It's an incredibly useful tool for being able to see a dashboard measure of how well your service system is working. It can be cut in lots of different ways to look at different populations, different ages. We use it all the time in various ways to measure and look at where strengths and weaknesses might be in a service system. It outlines the stages of medical care for people living with HIV, as they move through a system, going from diagnosis to viral suppression. Diagnosis to whether we have evidence of care, whether they have met need, to whether they're retained in care. Then finally, whether they are achieving viral suppression for those that are able to achieve viral suppression.

Jesse Carter: Those are the core measures. Sometimes, you may see variations on that. Sometimes there's estimates, or there's also between retaining care and ground suppression, more and more cascades or continuums, I'm sorry. Sometimes I will switch out and say the cascade. More and more continuums will share ART, antiretroviral therapy use, as well as to show a measure of how big system's doing. The data come from, again, local and state surveillance data. The same sort of systems they go into producing unmet need for us are used to understand where cascade data and where the population as a whole is across the cascade.

Jesse Carter: As I said, it is incredibly useful to understand the strengths and weaknesses of your system, to understand how populations are moving through the system. Where weak points might be in comparing those populations. I know we find that some groups, while they may achieve retention in care at the same rates as other groups, they're not achieving viral suppression at the same rates that should be expected. That can tell us that something, that there might be an issue in there, and that needs to be explored, either through further needs assessment, or also then how a council can allocate money and understand that one group may not be achieving viral suppression, because they have competing needs, or they may not be accessing services in the same way. The continuum data is a really good dashboard, and an incredibly great tool to help you understand where your attention may need to be focused in your service system.

Jesse Carter: Having said that, the continuum data and graphs can get a little confusing, and as I said, there are multiple variations, so you always have to be super careful and super clear on what you're looking at. In general, there are two different types of continuums. There's prevalence based, which we're looking at here, a prevalence based continuum. We call it prevalence based, because it's built on the total number of people living with HIV, including those people who are diagnosed and know that they are diagnosed, and living with HIV, and the estimate of those folks who are undiagnosed. It gives you a true population level, understanding the burden of HIV within a community, and across that whole community, both diagnosed and undiagnosed, where people fall.

Jesse Carter: For example, in this one, is we, in a very simple wide way, of we were to say that we know that 85% of folks in this area are diagnosed and living with HIV, and say that we estimate that there's... If we're saying that we estimate that there are 100 people diagnosed and undiagnosed in an area, so that's 85 people who know their status, and we have estimated that there's an additional 15 people who may be living with HIV, but don't know their status. That's a total of 100 people in the area, and that becomes the denominator for everything. 85% of the folks are diagnosed. 62% of all those people living with HIV are in care. 48% are retained in care, and 49% are virally suppressed. It's always important to understand the denominator. Move ahead to the next slide.

Jesse Carter: In talking about understanding the denominator or what kind of continuum you're looking at, this is a diagnosis based. The previous one accounted for both folks diagnosed and undiagnosed with HIV. This is just folks who are diagnosed

and know their status, who are living with HIV in an area. Out of that population, if we're talking about the previous, the denominator here would be the 85% of folks who are diagnosed and know their status. Out of that, 72% are in care in some form. 56%, almost 57% are retained in care, and almost 58% are virally suppressed. It's important to understand the denominator, because they can give you, if you change it, if you don't understand that it's not clear, you may perceive things differently. These percentages can dramatically change, if you're talking about a prevalence for diagnosis based continuum.

Jesse Carter: When you're looking continuum data, it's always one of the first things you want to talk about, is understanding what the denominator is. The other thing I will always say, is there are a lot of continuum that happened that the bars are based on the bar before them, so really understanding the denominators and the numbers in each of the bars, and how they're calculated, so that you can arrive at the best decisions and a clear understanding of what you're looking at.

Molly Tasso: Great. Thanks Jesse. We're going to do another quick discussion through the chat box, and if you just take a moment, we'd be curious to hear from you all which type of HIV care continuum you think is most useful for your planning council or planning body, a prevalence based, or a diagnosis based. If you just want to take a moment and tell us which one, and why you feel that way, in the chat box. That would be great.

Molly Tasso: We're getting a few prevalence based responses. Those are the first ones in. You can certainly think about this as we move through the presentation. We've gotten about six responses, and it looks like it's evenly split between prevalence and diagnosis based. I think it really, probably comes down to the data you have available and what is best for your planning purposes. I think it's important to just know which continuum you are looking at, when you are using data for planning, to understand, as Jesse said, the numbers, the denominators and such. Please feel free to continue chatting in questions too throughout. Again, we're going to have a Q&A at the end of the presentation, but we are going to move on to needs assessment data.

Jesse Carter: I think needs assessment data are what councils are usually most familiar with. I understand epi data and then needs assessment, council spend a lot of time developing, understanding, designing, implementing, and looking at needs assessment data. It's just the number of characteristics, the service needs, the barriers of people living with HIV, both in and out of care and jurisdiction. It can

incorporate provider resources available to meet those needs. It should look at what the gaps are, both overall and for various subpopulations. The data come from the needs assessments that councils do, that you design and work on over different planning cycles. Different councils do things differently. Usually, it's a multi-year cycle. I know councils that will do a large scale needs assessment every three years, and then in between those, they use that data to do smaller assessments, looking at subpopulations. It really is within your council how that is collected, what cycle you're on.

Jesse Carter: Again, it's used to set priorities. It should be used to allocate resources, to understand what the needs are, and how those needs can best be served, how to allocate the resources to do that, to develop directives, to tailor services for different populations improving service accuracy and quality, both overall and for specific populations.

Jesse Carter: This is a really good graph of some sample needs assessment data. Again, understanding and spending time with it to understand what you're looking at. Just really quickly, overall we can see that for the DC area, of all the participants in the needs assessment, not having enough money or access to food and necessities is their number need identified through this. That's their population overall, but when we start breaking it down and looking at different subpopulations, again, this is by gender, so we see that for folks who identify as male and female, access to food is still a high priority, but we also started to see that there is such an emergence of differences in homelessness and risk of homelessness and housing needs that start to emerge by men and women.

Jesse Carter: Then when we look at the transgender folks who answered the survey, we see that their actual number one need is homelessness. Their greatest need is housing, which can get masked if we're just looking at the general population. Again, I think this emphasized the need to start breaking data down in different ways, and looking at, for example, this is by gender, but looking at risk category, by looking at age in as many ways as we can, to get the best picture and understanding of what the needs are.

Jesse Carter: Resource inventories. These are rarely updated. It's a comprehensive list and description of what services are available usually, and that's done when it's regardless of the funding stream. You want to look at all the services available, both private and publicly funded in an area. It provides the information on what services are provided, where they are, who's providing them, what hours

they're available. It can, when done well, it usually will provide you with the capacity of the number of clients they serve and can serve. Who is funding those services, and this is usually presented in chart format. It is usually developed based on needs assessment data, again, through your planning council, your councils who direct those needs assessments. That's your opportunity to understand what data, in terms of resource inventory, which I think was indicated as one of the pieces of data that people struggle with the most. Really thinking about when you're doing your needs assessment data, what type of resource data information you want to collect is key in getting that, and understanding and getting the best data you can from your providers, and from the community, and digging into it to understand what it means to make some sense out of it.

Jesse Carter: It's used in developing your comprehensive plan. It is a requirement of comprehensive planning for Part A's and Part B's, but it's also incredibly useful whenever you're doing your priorities and resource allocation process to understand where money might go. You might have a tremendous, indicated large need for a service, but when you look at your resource inventory, there seems to be a lot of resource available, and a lot of slots available in the community for that, so you may not, just because there's a large need, you may not want to fund a lot of that, because there are other funders that are providing that service. You want to use your limited funds on other needs.

Jesse Carter: This is a good example of resource inventory, how they're usually laid out most commonly. You can see there's provider names, their location, where they are within the jurisdiction, their multiple funding sources. Here, you see there's some Part A, some C, some private funds, part D. There's some state money in there.

Jesse Carter: Then it breaks out by what their core medical services are, and their capacity around that, or the number of slots that they can serve, the number of clients they can serve. Then support services, and again, the capacity. I think this is a good example. For example, if you see your needs assessments, say that you're estimating that there's a need for around 750 clients who are going to be needing medical case management in your area, but you can look across these providers and see at this point, by their funding, their capacity within this area is only for about 450 people to receive medical case management.

Jesse Carter: The council, you need to consider that, and think about how you can invest your money to increase the capacity for medical case management within that area. You can also understand how, if you are Part A, and you're already funding medical case management, how you can amplify those funds through streamlining those processes. Can you fund other things that can meet those needs of medical case management? Can you do peer navigation? Really looking at that, and understanding how you can take the needs information that you have, based off of what the community is telling you. The resource information in terms of financial amount of money that you have available, and then applying that to make the best decisions within the resources that you have available within your community.

Jesse Carter: Then there's service expenditure and cost data, which is projected in actual expenditures by service category. Most of the time, it's broken down by a unit of service. For example, case management might be counted in a unit of 30 minutes. Understanding that the number of slots. If he's talking about a unit of case management is 30 minutes, how many units on average does a person need whenever they're accessing medical case management. Multiplying that out. Understanding the cost of one unit, either the actual expenditure cost, or the projected cost for one unit. Then applying that when you're determining how much money should go into any given service category that you're funding.

Jesse Carter: It comes from the recipient, or your grant administrator most often. Whoever's administrating your [inaudible 00:49:44] grant for your jurisdiction are usually able to provide that to you. It's usually provided in monthly, or can be done in monthly segments. Expenditure data can be monitored month to month, and it's best practice to monitor month to month, to understand how expenses are going across your area, to understand that if you need to reallocate money from one category to another, because you're underspent somewhere, or overspent in another category.

Jesse Carter: The next slide gives you some good examples of looking at some expense data, expenditure data. This exercise we're looking at, expenditure data collected at a 10-month and a 12-month period, and you can see that, for example, outpatient substance abuse in 10 months is already almost completely expended. It's 99% expended, and you have about two months left to do. Using that to understand how much need is left in the community. Do you need to then look at something that is underspent? For example, mental health might be underspent

at this point, so do you want to reallocate some money from your mental health allocation into outpatient substance abuse in order to boost that category for the remaining two months of your fiscal year?

Jesse Carter: There's client characteristics and service utilization data. That's about information, including the number and characteristics of clients. Again, talking about the client characteristics by age, by sociodemographics, by race, ethnicity, by geographic area. Looking at how people in different areas utilize services differently. This again comes from your grant administrator, and it usually comes from whatever data system that's being used to record client level data for your jurisdiction. That system plays into the Ryan White HIV/AIDS Program service report, or the RSR. Everyone should be collecting this data, and you should be able to request it from your grantor, or your grant administrator for your area. That can be used again to tailor and understand who's accessing services, what services need to be tailor, how services need to be moved or changed for any different area.

Jesse Carter: For example, here is an example of client data by an EMA just in general. This is Part A clients in this jurisdiction who are accessing services. You can see about 50% of them identify as Latino for the area, and then African American and white folks make up about an even proportion. Understanding that, and then this is incredibly useful in comparing this to your epi data for the area, to understand does your client base, the people who are accessing services that you're funding, does it look like the population of people living with HIV for your area, or are you under or over represented for certain populations? That can drive you in understanding your needs assessment data, focusing your needs assessment data, and focusing on specific service categories for specific populations.

Jesse Carter: If we see that a jurisdiction is that African American folks aren't accessing services at the same level, or at the same proportion that they make up among people living with HIV in the area, that warrants investigation and understanding what might be going on, and if there are unique barriers within your services for that community, and then figuring out how you can adjust your allocations, your priorities, direct services better, how you can indirect your access points within your community to better reach and support those communities. It's really important to look at who is using your services, and



compare that to who's living with HIV in your area in general, when you're making these decisions as well.

Molly Tasso: Great, thanks Jesse. Before we move on, we're going to do another quick poll. Just take a look at this, and then I'll move to the slide where you can answer. We're curious to learn what other types of data you use for HIV planning. You can select all that apply, HIV tests and diagnoses, unmet need data, clinical quality management, CQM data, recipient monitoring data, performance measures and clinical outcomes, or you might use other data. Go ahead and chat it in. We'd love to learn what is being used by you all.

Molly Tasso: It looks like all of these options are used by at least a good number of people. It looks like CQM data is used by many folks, as well as performance measures and clinical outcomes. Again, go ahead and chat in if you have other datasets or information resources that you use. It looks like about half of folks use recipient monitoring data, but performance measures and clinical outcome data seem to be something used by a lot of folks on the line. That's really interesting information to have.

Molly Tasso: Yeah, and again, if you have anything pop into your mind as we move on, please do chat it in. We're going to move on to addressing gaps in data. What we've talked about is sort of an ideal perfect world in which you have all the data that you want and need to do the work that you need to do, but sometimes that is just not the reality of this work. Jesse is going to talk to us about how to deal with some gaps in data that you might encounter.

Jesse Carter: I think we never have all of the data that we really would like to have available, when making the best decisions that we can. We always have to use what is, and what we do have access to, to make the best and the most data informed decision possible. Data gaps are always caused by limited resources, that's both financial and time resources. Resources in manpower who can collect data, who can analyze data. Limited needs assessment and data skills, and experience on the part of councils and grantees. Not everyone has the budget that they need to hire epidemiologists to process data. There's always a lack of challenge in agreements between state surveillance data, where I sit, and local data, and city or county staff data. A lack of agreement or lack of understanding and challenges between data sharing, both legal and professional can limit the amount of data available at any time. Limited time for gathering data and an

analysis that we're always moving. You have to make decisions on the go, and so there's always a time crunch.

Jesse Carter: There could be a limited data of digital agreements between you as a planning council and the administrator in your area. Again, understanding what your needs are, and as I said, they might be collecting data in their client utilization data system for RSR, but you may have a limited agreement or a challenge in agreement in accessing and understanding how that data is... You always have to work with the environment you have, and work with the relationships you have in order to get the biggest picture of data that you possibly can.

Jesse Carter: In addressing data gaps, it's important to become familiar with the data that should be available. The types of data that should be available and on hand for you, and become familiar with that, and begin to ask for that information. Asking for it, and then understanding those relationships, so developing MOU's with the parties that have that data, reaching out and developing those relationships, whether that be with your own administrator, whether that be, again, with the state health department in order to access the data that they have, and then exploring what needs can be met through the planning council, through your needs assessment processes. What you can do, expand your capacity to bring in data through if you're able to, to budget, to hire consultants to do needs assessments for you, to go out and do town halls, to do round tables. I always encourage people, you can invest in developing your own internal planning council capacity to do really good qualitative data analysis, where if you can find someone to come in and do some training for your own planning council members on how to do really good qualitative data gathering, then you've just recruited and expanded your capacity to go out into the community and collect really good quality data that you can have some faith in.

Jesse Carter: Continuing that, maximize the data that you do have. You can do that through improved analysis. Again, looking at different ways to compare and cut out the data that you do have, to get different pictures, a better understanding to mine the data, as much as you can. Always keep a chart of what data you need to track an understanding what you need as you're going along, because by the time you finish a priority setting process, which can take a month or two for someone, the thought that you had that it might have been really great to know something at the beginning of this process, by the time you're done, if you haven't kept a chart, if you haven't kept track of that, then you may not

remember it, and you may not be able to start working on those relationships to ensure that you get that data in the future. Always keep track of what's needed, what you have access to, what you don't, and strategies for doing that.

Jesse Carter:

Developing plans to fill in those gaps. Explore what your members can do, explore what your service providers have available, what they're collecting. I know you said that you're familiar with and you work a lot with QM data, so exploring and mining QM data, and what can be learned from that, both at your level, at your grantor level, and also at your service provider level. Then looking what other stakeholders, what community organizations might be collecting as well, and if you can create partnerships with them to look at their data and share data back and forth. If you live in an area with universities, there's usually a robust data gathering and research through different programs within a university. Reaching out and understanding what activities are going on there, and what they're collecting, and what capacity they may have also, in helping you to do analysis.

Jesse Carter:

Having said all that, it's always important to understand the quality and the usefulness. Not all data is created equal, so it's always important to understand what you're looking at, and to be critical and thoughtful of the data that you're looking at. Data may be outdated. Again, you're looking at care continuum data that might be several years old. Maybe it's not helpful or informative, so you want to make sure that the data that you have is as current as possible, and even if it's as current as possible, if it's 10 years old, that's probably not the best thing for you to be looking at. It might be incomplete, so expenditure data might be missing service categories. If you're looking at expenditure data, particularly as a council, if you're monitoring that, to understand how you might need to reallocate money. If providers aren't submitting for reimbursement, or submitting their expenditures to the administrator in a timely manner, some of that might be missing, and so you may not have a complete picture of how much money has been expended, how much money had gone unexpended in order to make those determinations.

Jesse Carter:

It may just be inaccurate. It might have been collected poorly, it may be biased data, so you really want to understand that, and it may be unclear. It may not specify, in terms of resource information, it may not specify whether this is Part A or Part B money. It may be unclear, because it may not tell you how many people they're talking about, so it may give you percentages and say 80% of

people said they needed food bank within an area, but not knowing how many people were surveyed gives you a really unclear picture. Understanding the data quality is key to making good decisions.

Jesse Carter: You should always be looking at reviewing data from multiple sources. You should always, always, always ask about how data was gathered, how it was tabulated, how it was analyzed, who did the analysis. You should be looking at and comparing data as much as possible from different sources, and we'll talk in a minute about triangulating data, but comparing data to make sure that they're all telling the same story, that you're getting the same conclusions from all of the data that you can possibly find.

Jesse Carter: Then you really have to decide how much confidence you place in any given set of data, and give the greatest weight to the decision-making, to the best data that you have possible. Understanding which datasets you have the most confidence in, and weighing those in your decisions. The role here, you can lean on your account, hopefully you can lean on your support staff, consultants and other folks to help understand and present data. You should always be free to ask questions of whoever's presenting data to you, to ask questions about how it was collected. I often get questions about data, and if I can't answer it, I'm not an epidemiologist, but I can always find you the answer. If you question data, you should always feel free to ask the questions, and press the data to understand it, so that you can have the confidence that you need to make decisions.

Jesse Carter: Again, understanding who is responsible for a study is important in assessing how much weight to give it. Did consumers and people living with HIV, were they involved in designing the study, or was it designed external from the population? Was the tool or the questions used, were they good? Were they clear? Do they generate reliable data? Did the question get asked in a way that you have confidence in the response?

Jesse Carter: I love to tell the story around this, is that once in a needs assessment data, we asked folks living with HIV if they needed case management, and we were shocked when we got the result back, because it was incredibly low. A really, really low percentage said that they needed case management, but we knew that most, almost 90% of the people in this community were accessing case management. We were able to decide that we had asked the question in a way, we didn't ask if they were used, we asked if they needed it, and they were

telling us we don't need it, because we already have it. Understanding how the question is asked is always super important.

Jesse Carter: What is the sample size? Again, if you say 50% of people said that they needed the service in a survey, but only two people took the survey versus 50% out of 200 people, those are dramatically different responses. The evidence is that it was collected appropriately by trained people. Untrained people can bias data collection really easily whenever they're collecting it, so it's always important to have an understanding of how the best methods for collecting data, and were there any quality controls, to be sure that the data gathering and the proper processes were followed.

Jesse Carter: The importance of using multiple datasets, and as I said just a couple of slides ago, talking about triangulating and looking across different datasets to make sure that they're all arriving at the same conclusion can strengthen your confidence in any data point that you have. If you look at a needs assessment data that's qualitative, or quantitative, so you've got a count that says 50% of people said that they needed mental health services, and then you've always done surveys, or focus groups of community and independently about half or more of the people, or a large percentage of the people in those focus groups also said that one of the services that they needed, and were challenged to find were mental health services, then you can have a lot more in the understanding that that is a needed service out in your community, and that you can make the decisions on where those allocations go.

Jesse Carter: The bottom line is, always, when possible, review more than one data source. Also, trying to review qualitative and quantitative data to get a better picture of what people really mean when they say they need a service, and how to best target that service, and fund that service for any group. It's just the process of comparing data on the same topic from two or more sources, seeing whether they report similar findings, cross checking, cross validate. There's a lot of terms, but it's really looking at different sources. Your own needs assessment data, versus other people's assessment data, to make sure that you're arriving at the same decisions. Again, it should increase your confidence in the findings, and that your confident in using those data points when making decisions.

Molly Tasso: Great, thank you so much Jesse. That brings to a close our presentation part of the day. I'm going to walk through... We've been receiving questions throughout, and please do continue to type those into the chat box. Jesse's



going to take a look at those questions, and while he does that, I'm going to talk to us about some resources that the Planning CHATT project has, that can help, or sort of a nice addition to what we've talked about today. As many of you know, the compendium of materials for planning council support staff is available on our website, and contains some great resources.

Molly Tasso: Just definitely thinking about what was discussed today, there is a resource called The Quick Definitions and Descriptions for Data Related Terms and Concepts used by Ryan White planning bodies. That is available in the compendium, as well as a model planning council training session, specifically on understanding and using data that you can access in the compendium. All of this will be linked to in an email that will be sent out following this webinar.

Molly Tasso: We also have the training guide that I think many of you are hopefully familiar with. It's designed to help planning councils and planning bodies conduct orientation and ongoing training to prepare members to participate fully in the planning and decision-making process. The training guide is composed of 10 modules. It includes things like trainer notes and presentation slides, and experiential activities. A whole number of really great handouts that you can download. It's a fantastic resource to help onboard new members, and also a great refresher for those who've been around for awhile. Specifically, I'm going to call out module four, includes needs assessments. Module five includes information on the PFRA process. Module seven is about maintaining and improving a system of care.

Molly Tasso: Very soon, we will be releasing module 10, which is called Database Decision Making, Understanding, Accessing and Using Data. This module includes a lot of the information that was discussed today, but really dives into more detail on these topics, and has a number of, again, really fantastic handouts and resources that you can pull from, and introducing your planning your council. All of this information, again, will be linking to and listing out in an email that will be following this webinar.

Molly Tasso: With that, we're going to move over to the Q&A. I will just... A lot of people have asked if the slides will be available to download after today's presentation, and they will be. They'll be sent out along with a transcript and audio recording. The goal is to actually get this out as soon as possible within the next couple days, because we have part two of this webinar, which is next week, next Thursday. Before we sign up today, I'm just going to provide a little bit of

information about that. The goal is that folks who joined today are able to join next week, and for anyone who wasn't able to join today, we would love to have them next week, and we'll provide the resources from today, the webinar transcript in time, so maybe they can kind of catch up before next week if they want to.

Molly Tasso: This first question, I believe Jesse is going to answer. The question is, how are other types of disparities addressed, for example, among age group, gender, race and sexual orientation? Jesse, is that a question... Oh yeah, go ahead.

Jesse Carter: I think for us, when we look at data, and when we process data, when I talk about cutting data in different ways, we're always looking at breaking it down into as many meaningful pieces as we can. Looking at data by... Yeah, the example that we gave through most of the slides were by gender, but looking at data by race and ethnicity, looking at it by sexual orientation, so you could look at the same thing around access to mental health services, for example. You should, hopefully, understand... I think it's important also, when you're developing those questions, you can understand how and what data is being collected. There is a lot of data systems, and when you're looking with a female, if you request a data dictionary from them, they'll give you all of the elements of data that they collect, and then you can use those elements to request different views of the same data.

Jesse Carter: If they're collecting information about client utilization, for example, based on race ethnicity, if they're collecting it based on risk category, or sexual orientation, then you can turn around and say, "I want to know what the group of folks that are accessing mental health services, for example, are, and I want to see that by subpopulations. I want to see that by people living with HIV who identify as MSM, people who identify as black, or white, or Latino. You can form those questions, and hopefully be able to put those questions to your data folks, in order to cut and look at that perspective, and even within your own needs assessment data.

Jesse Carter: I think that's important, whenever you're conducting your needs assessment data, to really think about everybody starts with basic demographic data whenever they're doing needs assessment data. That's really critical, because if you don't collect good demographic data on the people that you're assessing, then you can't begin to understand and take that information that you've

learned to your needs assessment, and start looking at it by different segments of the population that you're serving.

Molly Tasso: Great, thank you. Jesse, if you... I'll throw this to Jesse, or Emily, who is on the line. How do you quantify data about geographic areas, taking into account the fact that people might not seek services closest to their home, due to stigma. That's a really, really great question. Jesse, do you want to take that, or Emily?

Jesse Carter: Emily, did you want to take it, or do you want me to?

Emily: This is geographic areas?

Jesse Carter: Yes ma'am.

Molly Tasso: Yes.

Emily: All right, I'll start, and you add Jesse?

Jesse Carter: Super.

Emily: The key thing is that as Jesse says, if you ask questions about where people live in your needs assessment, and if you have data on where people live in your client level database. Actually, they're more likely to have it now in surveillance, because they update place of residence, then you can analyze things based on that. The nicest thing to do to get a broad sense is to map where people live, and map where the services are. Then link the people who say they get services at a particular place, with where they live. For example, you can pick a provider and you can ask that provider, or you should have it in that little database to say, what proportion of the people being served by that provider are in the same ward, or zip code, or part of town, or however you slice and dice your geography. How many of them are from a different county? That's very helpful to get a sense, because you can get a sense then, if people are going out of area to get care.

Emily: You should always think about asking in any kind of a survey of people living with HIV, do you prefer to get your services near home, or would you rather be farther away because of stigma? If you've done a good job on your subpopulation, your characteristics information, as Jesse said, you can say, "Aha." As we did, for example, in one place I did a lot of work. Immigrants from

Africa did not want to get services where anybody would know them, especially three or four years ago, big, big issue, so they allowed them to go other places in encouraged them, gave them extra transportation assistance. If you find that a particular population is more likely to go away from their home area, then you might want to do a focus group to take that quantitative data and get a better sense of why.

Molly Tasso: Jess?

Jesse Carter: I agree. I don't have much else to add. I do want to stress, I think that Emily pointed out more and more geo mapping, or actually looking at maps of where you're service providers are, versus where the people living with HIV live in your communities is incredibly helpful. What I think a lot of people, whenever they start doing that find, is that the providers aren't necessarily in the same areas that people live in, but that can be an issue. Also, to more addressing stigma, I agree with Emily. I think a lot of your service providers should be collecting that. Hopefully, your client level service data system should be able to pull that out to understand where people live, versus where they're accessing services. You should be able to reflect that information, and work with your providers and your administrator to get a better picture and understand what that is.

Molly Tasso: Great. Thank you Emily and Jesse. We have a quick question about any resources that Planning CHATT might have for reflectiveness. I know that the training guide deals with this as a part of the membership module, which I believe is module eight. Emily, do you have anything to add to that?

Emily: The only thing is, there is another kind of reflective. This is more data related, and I'm not sure what was meant, I just realized, and that would be, does the population you're serving reflect the overall population with HIV, and does the population being served in a particular service category reflect the population you're serving overall? In other words, are some groups over or under represented? The reason we want a reflective planning council, is to be able to ask those questions, and make sure we're addressing them.

Molly Tasso: Great, thank you. Jesse, this next question I think I'm going to have you respond to. What's the best practice for tracking transgender individuals, since many don't identify as trans, but rather just male or female?

Jesse Carter: I think the best practice that we use for identifying transgender individuals, is we ask a two-part question. We ask sex at birth, and current gender identity. That way, trying to capture folks and allow them to respond in a way that is gender affirming and comfortable for them, so asking what their science at birth was, and what their current gender identity are. That way, you can pull that out, because you're correct, not everyone may identify as trans male, or trans female, or trans gender individual.

Jesse Carter: I also think that a service provider is more and more. I know that this is a growing population, and it's fantastic. We're all becoming more aware, and trying to tailor our services. We here at the state in Texas are constantly evaluating and trying to do a better job of respectfully collecting this information, so that we can create a better picture, and untangle what has historically been a challenge for transgendered individuals about how they're getting counted in our systems. I also encourage providers, and use the system, if you have questions, reach out and find some folks, do some focus groups in your area and ask transgender folks what are their best practice? How do they want to be addressed, and what is the best practice for collecting that gender information from their community, and then respond accordingly. I do think one of the best practices that we do, and we've gotten it from national experts who is asking the two-part question about including that in whatever sort of intake processes, but what your science sex at birth was, and what your current gender identity is.

Molly Tasso: Great, thank you Jesse. I think we have one more question. Jesse, towards the end of the document, you'll see. I'm going to have either Jesse or Emily respond to this. What is the most common source of needs assessment data are jurisdictions conducting their own needs assessment, and if so, how often? Emily, do you want to start with that, and Jesse can add anything that he might-

Emily: Sure.

Molly Tasso: That would be great.

Emily: MMP, which is a Medical Monitoring Project, has some great data, but it's not everything you want in needs assessment. It's only, I believe 16 states in Puerto Rico, plus a small number of large EMA's of San Francisco, Los Angeles, Houston, Philadelphia, New York City, Chicago. That's not going to give you what you

need with a big enough sample, unless you're in one of those cities. In addition, the party manual and the training guide and everything else would tell you that there are a number of different components in your needs assessment. Some of those pieces you get from surveillance.

Emily: You get the epidemiologic profile from your surveillance folks, or your data folks. You usually get an estimate of unmet need from, and again, that process is being updated, the method for estimating and assessing on that need. You have to find the rest of the information, and you need to look at need for services, and service gaps. What are people getting, what do they think they need? You need to look at the resources available to meet those needs, in other words, that's the resource inventory and the profile provider capacity and capability, which goes into more detail about what populations, where they have waiting lists, things like that, and we say, availability, accessibility and appropriateness for overall and particular populations.

Emily: You put that together, along with some things that you receive from the recipient, like service utilization, and you say, "What are the service gaps?" We've looked at the needs and the barriers. We've looked at the system of care, HIV care funded by Ryan White or not, and what's different is we got gaps. It's a lot of different data, and you are really responsible, primarily for that needs and barriers piece, and for understanding the services available in your jurisdiction. Normally, it's very multi process. Some practices, generally, they have a three-year plan, so if you do a survey of people living with HIV, you do it every three years, you get an epi profile every year, but you made your pieces that require a lot of data collection on a rolling basis, so the data aren't more than three years old, ideally. You do it all the time, but you don't do everything all the time.

Molly Tasso: Great. Thank you so much Emily. We're going to move on. We have about a minute left, so I just want to thank everyone for joining today, and for your very thoughtful questions and participation throughout. Again, next week is part two of the webinar series. We are going to, in this webinar, delve into the ways that planning council and planning bodies can use data for HIV planning, and offer strategies and best practices for data visualization, and presentation, and also discuss the role of planning councils and planning body members as advocates and planners, and Ann Dills, who is also from Texas will be facilitating and presenting our next week's webinar, so we're very excited for that.



Molly Tasso:

The registration details are posted to our Planning CHATT website now, and we're also going to include the link to sign up in the follow up email that you will receive after this webinar is conducted. Also, please sign up for our list serve on our website, the Planning CHATT website, on Target HIV, if you haven't done so already. With that, again, I just want to thank everyone for joining today. An evaluation is going to pop up at the end of this call. Take a moment and please just fill that out, and let us know what you've got out of today's presentation, and we hope to talk with you next week. Thank you so much.