USING DATA FOR DECISION MAKING: PART 2 WEBINAR

Molly Tasso: Welcome to today's webinar. Part two of the using data for decision making webinar series. Again, my name is Molly Tasso, and I am the technical assistance coordinator for the Planning CHATT Project. Before we get started, just a few technical details. First, attendees are on listen only mode, but we do encourage you to communicate with each other, and ask lots of questions using the chat box. You could 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 questions as we can at the end of today's session. And if you think of a question after the webinar, that's completely fine too. Just shoot us an email and we'll get back to you. Our email address is planningCHATT@jsi.com, and you can see that on the screen there.

Molly Tasso: The easiest way to listen to our webinar is through your computer. And if you can't hear very well, check to make sure that your computer audio is turned on. And if you still can't hear us, or you are experiencing a sound delay at any point, try refreshing your screen. And finally, if needed, you can mute your computer audio and call in using your telephone at the number you see on your screen. You'll need to use a passcode, which is also listed on the screen. And we'll also put this information into the chat box. Today we'll begin the presentation with an overview of best practices for preparing and presenting data for use by planning councils and planning bodies. Then move into a discussion about how to use data to carry out legislative responsibilities and identify and address specific needs in setting priorities. The presentation will then end with a conversation about the role of planning councils members as both planners and advocates.

Molly Tasso: And then will end with a Q&A session. And as you can see here, by the end of the webinar, our objectives are that you are able to describe how planning councils use data to carry out legislative responsibilities, including updating its integrated HIV care and prevention plan. Identify ways to make data presentations understandable for planning councils members and useful for HIV planning purposes. And differentiate between member roles of advocate and planner, and understand how planning councils members can operate in each of these roles. As I stated earlier, these webinars are put on by the Planning CHATT project. And the project ... Excuse me, it builds on the capacity of Ryan White

HIV/AIDS program, Part A, planning councils/planning bodies, across the United States. And the goal is to help planning councils meet their legislative requirements, strengthen consumer engagement, and increase the involvement of community providers in HIV service delivery planning.

Molly Tasso: And today I'm excited to have with me two fantastic presenters who will guide us through the presentation. First we have Ann Dills from the Texas Department of State Health Services HIV/STD program. Ann has been working in HIV/AIDS since 2000, and prior to moving to Texas she worked as a medical case manager at an infectious disease clinic. She started at the Department of State Health Services with the HIV/STD program in 2007 as an HIV case management training specialist, and she developed the Texas HIV case management training program. Currently she works as a systems consultant with the HIV/STD program, with a focus on working with communities to create pathways from diagnosis to care, with a focus on health disparities. We also have with us Allen Murray who serves as the co-chair of the operations committee of the Houston area Ryan White Planning Council. Where he also sits on the priority and allocations steering committee. And he's also made significant contributions to the 2017 to 2021, the integrated plan, and is highly involved in local and state advocacy efforts in Houston's plan to end the HIV epidemic.

Molly Tasso: And before I hand it over to Ann though I do want to quickly just also introduced Lenny Green who is our HRSA project officer, who is here with us today. We're thrilled to have him, and I think he just wants to ride a quick welcome before we get into the presentation.

Lenny Green: Good afternoon, and welcome to the webinar on data. Data is really crucial in our decision making in regards to planning, and I hope everyone gets a lot of information out of the activity today. Ask questions and listen up. Have a good day.

Molly Tasso: Thanks so much, Lenny. And with that I'm going to hand the presentation over to Ann, who is going to start us off by talking with us about how to prepare and present data for use by planning councils.

Ann Dills: Awesome. Thank you, Molly. As Molly said, my name Ann Dills, and currently I worked with the Department of State Health Services HIV/STD program. And I'm directly funded under our Ryan White's Part B funding, but I really work across the continuum and across the branch to put data into the hands of communities

in a way that's accessible so that they can use it to make their systems of care meet the needs of those who are trying to access it. I do a lot of work around the data doing ... Right now doing a lot of data presentation. Those are Part B only recipients. And I also work really closely with our five priorities in their planning councils to also help them make sense of the data that's available as they [inaudible 00:05:39] move into their decision making processes. And then finally, I'm also the governmental co-chair of RC white planning body. I've got a lot of experiences in planning in a kind of a variety of ways. Hopefully I'll be able to ...

Ann Dills: Sorry. I got to Kelly, can you hear me better now? So [crosstalk 00:05:56]-

Kelly: Yeah, Ann that's great. Thank you.

Ann Dills: Thank you. And we've got some friends from Texas out here, I'm happy to see some familiar faces and names. And I have a little bit of experience in working with a variety of settings, both rural and urban. And hopefully I'll be able to kind of talk a little bit about our experiences with that as we're moving through this. Once ... We want to start by talking about the importance of how data are presented. This is including all kinds of presentations through both written reports, oral presentations, and even the types of charts that we're developing can have influence on the understanding of, and the use of data. Planning councils and planning bodies can become strong users of data in a variety of ways. Using well designed, clear reports, and presentation, not only for internal reporting but also to report out to their community.

Ann Dills: Providing sound basic training on data sources and uses. Really making sure that everybody understands the context, and the limitations of the data that they're working with. And also providing mini-trainings provided along with presentation. We really want to make sure that our planning councils and planning bodies are representatives of the communities we're trying to serve. And that sometimes means that a lot of folks that are coming on board don't come in with a background in data analysis. And making sure that we're providing the proper support for people to look at and understand the data they're being given is really crucial. And making sure that we're giving plenty of time to discuss and clarify it. There's a lot of contextual information around data that's important to make sense of it.

Ann Dills: And just reading through a chart is never going to be able to help us fully understand the impact of what that data is trying to tell us, and where we can go next with it. Making sure there is a lot of time to really dig in, and explore, and create opportunities for conversations around it. And then the planning councils, planning bodies, and recipients commitment to ensuring that everybody feels comfortable asking questions, and know that they're going to receive thoughtful, useful answers. When I do that at presentations, I always like to tell people that if I'm doing my job well, that they're going to walk out of the room or in the presentation with more questions than they started with, because that's what data should do. It should really make people think differently about the care that we're providing and what communities look like.

Ann Dills: But when we look at written data reports, and when they're being prepared for planning councils and planning bodies, we want to make sure that it has a variety of ways of displaying data. It's narrative, and tables, and in charts. All that information can be useful. We have a lot of different eyes coming in with a lot of different experiences. And making sure that that is displayed in ways that can reach a variety of different folks is important. Making sure that we're getting information on the data sources, what the sample sizes are. It's for some times we are may be talking about really small populations. For example, in Texas when we talk about our transgender community, in a lot of areas the population is really small. It's still important for that community to be represented. Being able to put that caveat there and present the data, but understanding what it means to have a small sample size, and what that means in regards to the results or the outcomes that you're looking in data is important.

Ann Dills: And also understanding the limitations of your data, where are your data gaps. Your surveillance departments or the other folks who are collecting this data should be able to know what their limitations are, and what they can and can't present, or what data can and can't tell them. And that's just as much an important part of the picture. Everybody knows about using plain language. And I think plain language can get over used sometimes. You really want to make sure that you're using language that meets the needs of your audience. If I'm presenting information to a group of epidemiologists, the language that I use is going to be different than I'm presenting to a group of case managers, or if I'm presenting to a group of planning councils staff. And I'm going to be adapting

the language in those reports based on the audience that I'm presenting to, so that it's meaningful to them.

Ann Dills: And a document like this, it looks good, it's organized logically, and it's really understandable the first time you see it. And that's especially means making sure that you're using terminology that's familiar to the audience. We're only going to use technical terms when it's necessary, and make sure that we're still always defining and explaining. Just because we think that people understand, or they're in the field, so they must know this acronym, or they know what it means when we say viral suppression for example, it doesn't mean that they're actually operating under the same definition as us. We definitely want to make sure that we're being clear on that. And then for all of our data points, we want to make sure to include, if not an overall executive summary, at least some kind of explanatory statements for each of our data points. So folks understand, what is the focus, what's really the main thing that they should be looking at kind of with this information with this table.

Ann Dills: And we always want to make sure that before we're putting this together and putting out in the public, that it's reviewed in draft form by whatever committees on your bodies, your planning councils or bodies are responsible for in regards to data, or in regards to materials review. Making sure that folks are seeing it, and that everything is clear, and the other eyes are on them. When we look at doing oral data presentations, again, the ... Most of this is going to be really similar in the concept of using plain language and making sure to define new or unfamiliar terms. And for me, I make a point to try to define almost all terminology. Especially as we continue to try to bring more and more folks into the room that may not have a direct connection with HIV.

Ann Dills: I don't want to make an assumption about what language people use, and making sure we're really defining the key terms. Maximizing use of visuals, of charts and other things, and minimizing the use of text. It's using text to explain, not having text to be the bulk of the presentation. And we definitely want to avoid data overload. And I'll say personally, this is an area that I struggle with. Because there can be so much data, and we want to make sure that everybody has the information that they need to do what ... To do effective work. But sometimes too much data can be a barrier to that. Making sure that we're only giving useful data, or if we do have a lot of data that we want to put into the

hands of membership, that we're doing it in a methodical way, and we're not trying to do it all at once, and not in a way that people can't digest it .

Ann Dills: For the folks that ... Before presentations, we may need to have some kind of structured mini-training to maximize the understanding of data presented. I know that we have our friends from Houston and they're going to be speaking later. They do a pretty specific onboarding of their new members, their new council members. That includes a mini-training about data, and kind of where it comes from, and how it's generally used. I think it's also useful for folks to try to look at, you can put things like this into an online training that folks access in advance. Basic concepts about where your data comes from, defining terminology, really basic overviews of what data can show us, anything like that to kind of help set people up for success when they walk into the room and have a data presentation to try to do something with.

Ann Dills: And then again, just like with our written reports, we want to make sure that any oral presentations that are done are reviewed by the committees that are appropriate, that it is meeting the need of the planning councils and the planning body. And it should be available electronically before the meeting, and available for people to look at in hand, at the meeting. Folks sometimes need to see data in different ways, or need to be able to focus on it more clearly, and ... Having something for folks to be able to walk through within their hands can make it easier for people to kind of access the information. When we look at charts that are on visuals, other kinds of data visuals that are going to be used in, either written reports or oral presentations, there's some pretty basic guidelines that we'll want to follow when we're trying to put that out there.

Ann Dills: It doesn't mean that we can't be innovative in the ways that we visually display data, but we want to be ... And make sure that we're ... It's clear and easy to read. If you're not ... If you're presenting in a room, or you're projecting it, know what it's going to look like. Make sure you're using the right font size. I can't tell you how many folks who I see do presentations where they put so much text on the screen, the font is way too small, and it's impossible to read. Don't try to put too much information into your slides, or on a page. And make sure that you're using the appropriate color contrasts as the data labels are there when necessary. And that everything is really large and visible to read.

Ann Dills: And if you think it's big enough, you probably should go step it up one size more. You can't have information to be too big for folks to be able to access and

read. And we definitely want to make sure that we're meeting the needs of folks with differing abilities. Text is important to highlight and explain content, but it should be really brief. A good data presentation shouldn't have a lot of text on the screen, that should come from the presentation. And when we're looking at written reports, you just need enough text to kind of orient people to the visual you're displaying. Graphics are great for highlighting key data, and I would really encourage people to explore different kinds of graphics. And I'll show some examples, and a little bit of some different graphics that we use.

Ann Dills: But it's ... People are more ... A lot of people are able to easier access data when it's visual, and it's not just in a kind of tabular format. And then we want to make sure we're using consistent format. The same type of chart for the same type of data throughout, so that I can easily kind of track data. If I'm wanting to present data on Latinx, white, and black MSM, that I want to use the same kind of color system and chart system for that. When I'm presenting data on that community over and over, it's easier for the folks who are following along to track that information over time, to see how it connects. Same thing with using similar colors for a population or other variables. And then again, providing a lot of that explanatory context around your data.

Ann Dills: How many people? If I'm talking about percentages, what's the total sample size? What does that end look like? What's my denominator? If my denominator switches, if we're looking at, for example, in-care viral suppression compared to community viral suppression, explaining that to people and to kind of walking folks through that, and making sure that it's really clear. When we're actually talking about the data, the person who's leading this conversation should make sure that there's ample time for discussion. I like to build in time throughout my presentations, because I don't want people to wait until the very end to ask questions. I try to create key conversation points throughout to elicit from folks what they're seeing on the slide, what meaning that may have to them. I think using the opportunity, and breaking data up in that way also helps make it more digestible.

Ann Dills: If I am only having to take two or three data points, and having a small group conversation at my table about it, is far easier than trying to have a small group conversation about an hour's worth of data that was presented. We kind of already discussed about encouraging questions about the source and the quality. It's important to be really transparent about the limitations of your

data, so that folks trust it. Explaining to folks where ... What you do have and what you don't have is just as important to get people on board with believing that they can use that data in a meaningful way. When we're also leading, identifying and highlighting findings that would benefit from diverse input and interpretation. Talking about, for me like I said, a good data presentation leaves folks with more questions. And data can tell you what is happening, but data is never going to tell you why the thing is happening.

Ann Dills: And as the leader of this discussion, I like to create opportunities to kind of stop and talk about who else would we want to talk to, to find out more about this data point? What other questions will be have, and who will be want to bring those questions to you? How can we fill in the full context and get the full story of the static presentation, this conversation? Making sure that we're kind of summarizing major points of discussion, and that those are in any minute, that it's really easy to come back to later and see what the kind of key findings or key points where from that conversation. And then definitely making sure to document any questions and follow up on that. And some of that may mean more questions to your surveillance staff, or the staff where you're getting these data sets from, on additional data runs that they can do. And then at ...

Ann Dills: But at a certain point, a lot of that is going to be kind of going out into communities. And following up with those questions out there, but making sure that we have kind of a summary of that, so none of that falls through the cracks. Okay. We're going to move on to kind of looking at some ... How to make data more user friendly in practice. I'm going to go through a few slides just to kind of show you some examples. These are Texas specific data sets that I put together that I currently and actively use. And I'm going to be using my friends in Houston to illustrate some of our data examples. I want to start off by talking about this table.

Ann Dills: This is a busy table. There is a lot of really, really good high quality information in this table. But just on its face, just the display of it, can be overwhelming for people. It can look like it's too much, it can be really hard to focus on what I'm even seeing here. And for some people seeing something like this with all these numbers and all of these rows, and if I don't have a strong background in data, I might just be put off by this from the beginning, and not think that I had the ability to access it. One way that we can do, there's a few ways of some formatting that we can make information like this a little bit more accessible to

people. This is a written report that I put together for all of the service delivery areas in Texas.

Ann Dills: This is that same table. Already, we can kind of see that it's formatted in a way that's a little bit cleaner, that's visually more appealing. Already just from a wide range view, I can see how the categories are differentiated differently, and it's a little bit easier for me to follow it. Just to kind of zoom in on a couple of key points. With tables like this, we start off at the top by providing some explanation. These are the key points, this is the key point that folks need to come away from this table with. Who has the fewest opportunities to achieve retention, who has the fewest to achieve viral suppression, and who is achieving our goals? And then always I like to make sure to continually reflect what our goals are, so people are able to see that over and over.

Ann Dills: To focus in a little bit more specifically on the table, we can see that I split the categories up by the different characteristics we're tracking, gender identity, race, ethnicity, age, motor transmission. And then at the bottom you can see our five priority populations. And it allows a lot of ... There's a lot of different opportunities for conversation just within this table where you can talk about the differences and outcomes between race, within age groups, within gender. And then really honing in on how that, the intersectionality of these different points can come together within our priority population. Walking across the table, the characteristics of the points of leverage that I'm looking at are a little bit clear to follow and understand here with the formatting different. And then additionally, one thing that we've been also trying to do is to help folks understand how to prioritize their energies, when they're trying to think about which communities they need to focus their understanding on to create better systems of care.

Ann Dills: We've developed a stoplight system, to kind of help people hone in, our focus in on knowing what's important or where to start. I think that in our friends at prevention have long understood, and been able to follow along with the idea of prioritizing prevention services to specific populations. It's something that I don't think that us in Ryan White have traditionally done. We kind of say everybody should deserve quality care, but our data shows that that's not what's happening. And a lot of this is really getting people to focus on and understand that if they want to change and adapt their systems of care, that they really do need to do it based on the needs of specific communities. They

can't just create a general care system for everybody and expect for it to be functional for the folks who are trying to access it.

Ann Dills: And using a stoplight system, red, yellow, green, it's a really quick and easy way for a person to look in and focus on, what communities do I need to focus on, who is achieving their goals? At a glance I can kind of tell what's happening across the continuum and are key measures. This is a written report and a way to kind of just display information, and a lot of information in a small area. This is another table. Now and we include tables like this. A lot of people like pie charts, I think pie charts can be useful in some settings. This is a chart showing the distribution of people living with HIV, and the distribution of new diagnoses among our priority population. One of the things though that can be really difficult with pie charts, is doing comparisons.

Ann Dills: And being able to easily and readily say, "Well, what's different about who's entering our care system than who is currently accessing it." Another way to kind of visualize that could be these little people. And I really like using people graph. I think it's an easy way for folks to process information much easier than a pie chart. I can tell much easier at a glance that's a population of the distribution of new diagnoses looks much different than the distribution of people living with HIV. I can see that the folks who are entering my care system are significantly more from black, and Latinx, gay, and bisexual, and other men who have sex with men. And at a glance I can already see that if I want to adapt my entry system and to care to meet the needs of the community, it should be really focused on black, and Latino, gay, bisexual, and other men who have sex with men.

Ann Dills: Okay. And then a couple more displays. This is another ... A lot of people like to do treatment cascades, and treatment cascades of a lot of different populations at once. This is kind of looking at a treatment cascade again of our five priority populations, this is in the Houston area. This is here, and a lot of people, and especially my surveillance staff really love charts like this, but my community groups can have a hard time sense-making from a chart like that. I've tried to take some of this information and translate it, and take into account some of the other ways that we're visually displaying data. This is taking the same idea of those the bar charts for a treatment cascade. We're just going to be looking at ... This is just looking at one point on a treatment cascade, it's just looking at in-care viral suppression.

Ann Dills: And this is looking at across all of our Part A cities. And it's looking at the disparity ... It's able to ... It's a way for us to visualize disparities and care between populations. It's much easier for me to understand and look at what communities have the fewest opportunities to achieve in-care viral suppression, this way than I would be able to with one of those bar charts. It's a way for me to also start to talk to people about how population disparities don't indicate behavioral change. That population disparities mean that I have to change my system. And it can create a lot of opportunity in groups to move discussions towards that direction. Whereas I know, and my in past experience, a lot of folks tend to want to focus on client level interventions as being where a lot of their energy goes to.

Ann Dills: And using kind of visuals like this, help us see that a client level intervention is not going to have the impact that we want. That if we want it to be able to address the needs of communities, we're really going to have to change our systems of care. Because you see population disparity, the same population disparities across areas, and it speaks to what's happening within our systems. And this is a ... And this way I'm also able to show not just one area, I'm able to show all of our priority areas. And it's a really easy way to also help folks visualize what systemic racism looks like, for example. And have a conversation around that, and what that means for planning a council as in regards to priority setting or our resource allocation.

Ann Dills: The name or type of this current chart, this is a homegrown chart. I call it the stoplight chart because it's ... We've been using that kind of color coding system. I've been working with our surveillance group to set those tiers are, what is red, what is yellow. And then of course, our green is based on our 90, 90, 90. And at this point now we're going to be able to set these tears moving forward. And so we're using this with our statewide [inaudible 00:27:44] epidemic plan. It will be easy to see movement over time as folks start moving up these bars year to year. And we'll be able to start showing hopefully increases and health outcomes in a similar way. And a lot of folks have really responded to this.

Ann Dills: I'm pretty stoked on it, because I do think it creates more opportunities for conversation. Usually when I display this chart, I'll pop up each population one by one. I'll start with just, let's look at where Latino gay men are, and then white gay men. We can talk a lot. We have a lot of conversation about how our

systems of care were built by and for white gay men back in the '90s, and they haven't really changed much to meet the needs ... It haven't been to meet the needs of the current community who's trying to access. And I do think it can create a lot of interesting different conversation that we don't often get to talk about with the standard data presentation. Okay. And then one more thing, and this is more of a personal pet peeve. This is some pie charts that are looking at a variety of things.

Ann Dills: It is great because it does use contrast in colors, so it's really easy to distinguish between the different categories. The challenge is with this chart there was the same color coding system was used for a variety of characteristics. As an example, the top pies are looking at race, ethnicity, the bottom ties are looking at motor transmission. But because it's using the same color system, I can't really track these categories over the course of the presentation. It can be really challenging to come up with a variety of different color coding system. But as much as possible, especially around the characteristics that you want people to retain information on, trying to stick with just one set of colors for population, the different set of colors for motor transmission, would be a little bit more helpful in helping people to kind of stay with it and access that over time. Vanessa says she doesn't see the pie chart, is anybody else having problems seeing these six pies?

Ann Dills: And then I'm glad to hear that Portland that you all were able to transition over to that, that's exciting. I'm grateful to ... I'm always excited to see people get into presenting data. I'm really excited about it. Those are just a few examples of different ways to visualize data. And more than anything, I think it's about being creative and trying to find ways to get away from our standard data presentations, which generally tend to come from surveillance staff, and their audience is almost always technical staff. And really thinking about who our audiences, and different ways that we can make it meaningful for them. Okay. We're going to look now at some more sound practices around data use for planning councils and planning bodies. In regards to facilitating decision making we definitely want to make sure that we're going to develop and consistently follow a process to weigh, summarize, compare, and use data to reach decisions.

Ann Dills: And that's understanding again, what are your data sources? Making sure that you know the full range of data that you can bring in, how it connects together,

and which ones have more impact. And then being consistent with that as you're doing reports. I'll just emphasize more on report because it tells the information you want to tell here, and then use a completely different report because it's a different audience. Making sure that we're connecting all that together. Giving us specifically organize opportunities for individual and research-based data to be presented before decision making. And I think beyond just again, it's not ... When we talk about giving those organized opportunities, part of that opportunity is the presentation of data. But I think a more important part of the opportunity is giving the space and time for planning councils to digest that data, and not having to make immediate decisions based on following the presentation.

Ann Dills: A lot of times folks really need to sit with this and think about it, and really examine their understanding, how this reflects on what they thought they knew, and how it changes that. And to allow them time to come up with the additional questions they may need to have. Make sure that there's a policy and a process to manage potential conflicts of interest. And then empowering all members to use data, and help uphold the commitment to data-based decision making. I think one of the most useful things around the data presentations I've been doing the last two years, has been trying to break the mythology and stories that a lot of our community members tend to carry with them.

Ann Dills: A lot of folks that are engaged in this work have been engaged in this work for a really long time. They all have special populations that are more meaningful to them to work with. And it can be hard for folks to sometimes change that point of view even though maybe that population has improved outcomes now. It's important to make sure that everybody agrees that data is important in making decisions. That decisions should be evidence based, and they can't just be solely based on stories. Stories are really important to add context to data, but they can't exist in a vacuum, and they can't be the only thing that we're using to make decisions.

Ann Dills: For planning councils and planning body members and committee members, you all will want to make sure that you're planning council members numbers are familiar with all the data types and sources. What I kind of found in the first round of our data presentations around Texas was that folks kept saying, "Well, the data that I see in my database isn't what you're presenting?" And they didn't understand the wide range of sources that we have for data here in Texas. And I

started doing, with every data presentation, a real brief overview of where all of our data comes from. Because I think a lot of folks that's ... Really don't understand the variety of sources that are ... Or the variety of data that's available. Make sure you're always looking for appropriate and timely data to answer specific questions.

Ann Dills: Always looking at different populations. You can't just ... And I think more specifically really looking at the intersectionality of identities as much as possible when your sample size is large enough for that data point to have meaning. For example, even in all of our Part A areas, Dallas, Houston, San Antonio, Fort Worth, Austin, not only are we able to look at priority populations, we're also able to look at priority populations by age. And we're able to slice that data down a little further because the numbers are large enough in those areas to do that. As much as you can be able to look at data through a variety of intersections, because everybody is ... All our clients are coming into the room with a lot of identities. And if we're just looking at one of them and only looking at data by one of those points, we're missing the full story.

Ann Dills: And then definitely weighting to make sure to identify what our data gaps are, where are our data weaknesses, who aren't we getting data from? And then reviewing all those multiple data sources and giving the most weight to the best data. And I think the best data, is the data that has a lot of ... Has a variety information. It's not just the hard data points that come from our surveillance system, it also includes some qualitative data to provide some of that context around it. And really figuring out how to integrate the data that you have to give a complete a picture as possible. You'll definitely want to use quantitative and qualitative data. Those are all of our different data.

Ann Dills: And it's important for folks to understand that those all have meaning. What I see and what I hear can be just as important as what our surveillance system spits out. And what I see and what I hear helps make sense of what our surveillance system spits out. For example client utilization and characteristics data show that Latinas were much less likely to use mental health services last year than in prior years. And then in addition, a Latina focus group indicates that two bilingual clinical social workers left their jobs a year ago, and were replaced by staff who do not speak Spanish, and sometimes no interpreter is available. We can kind of take these two different data points together and it gives us a

fuller picture. On their own, it wouldn't have as much meaning, but together it's able to ... It allows just a wider breadth.

Ann Dills: And then finally we're talking about, and maybe not finally, but definitely talking about how to use data to carry out our legislative responsibilities. Unfortunately all of our planning council or planning bodies have some sort of legislative responsibility that they're beholden to. And data can be a big key part of that and really useful, especially in using data for priority setting and resource allocation. What services we're focusing on, what parts of our regions we're focusing on, how we want to determine and define resources in different places. And beginning this process with the data presentation, summarizing data from all these sources is key. And this includes our needs assessments, the epi report, any service utilization you're able to fill out, other client characteristics. And I think it's also incredibly important, especially as Ryan White providers, that we look outside of our Ryan White system of care when we're trying to find this information as well.

Ann Dills: If we just focus on Ryan White and the people that are in care in our system, we're missing a significant number of people who are living with HIV in our communities that could benefit from our services. Making sure that we take our kind of Ryan White blinders off, and that when we're trying to look at community data that we're truly looking at community data. And that sometimes means accessing data outside of our Ryan White service areas. And then making sure to use a structured process to allow individuals and organizations, members and non members, to speak about their concerns and needs. And not trying to have a response for every concern or need. Data isn't going to always give us the answers that we need, data sometimes gives us just the question. We want to make sure to solicit and answer any data related questions before or during the meetings where priorities and allocations are set.

Ann Dills: We'll want to make sure to review data on other funding streams. That's looking at all of the Ryan White parts, and not just Part B or Part A, or whatever you're funded for, but also data from Part C and part D. You also want to look at other non Ryan White funding streams that go into communities. All of your communities are getting funding from the CDC. Your communities are probably getting funding from SAMHSA, and a lot of these services look really familiar and similar to Ryan White services. Especially the money that's been coming from the CDC lately is more and more similar to Ryan White care than it is to

traditional ... What we traditionally have expected from CDC and prevention funding. Making sure we have data on all the other monies and services that are impacting our clients in the area, to make sure that we have the full picture.

Ann Dills: And that we're not duplicating services that may already be happening through a different funding stream. And then have readily available previous year's service priorities, previous year's allocations and expenditures by service category, and unit and per client cost by service category. Having that available in advance so people can review it, and kind of come into the room with it so they understand a little bit of the trends that have happened in regards to priorities and allocations in the past. So they know where they came from, so they can see where they want to go to. You want to prepare and discuss data by service category that summarizes the service needs and gaps as identified through service category-based findings from needs assessment, service utilization, and client characteristics data from the Ryan White Service report. Overall service quality.

Ann Dills: And this can be identified through care continuum data for Ryan White clients. Your surveillance, your epi staff or your surveillance staff, should be able to create treatment cascades or just Ryan White treatment cascades. They should also be able to create clinic level treatment cascades that look at non Ryan White clients as well. Understanding all that information will help us understand the needs of folks who are accessing care, and the needs of folks who want to or need to access Ryan White care. Also, we want to make sure we bring in clinical quality management and other performance data. There's a lot of CQM projects that are happening right now in a lot of our areas, so making sure that information is being utilized effectively, making sure we're getting client feedback through those processes and our needs assessment processes.

Ann Dills: Looking at our unmet need estimates, and a summary of whatever monitoring that you're doing around your service categories. And that's probably going to be a little bit different everywhere, but being able to provide as broad a picture as possible of what those service categories look like on the ground. And then finally, you want to make sure definitely to focus on and understand disparities in care. You can look at disparities within service categories by a lot of those characteristics. Again, you'll want to work with your data folks to know what data you're able to kind of slice out, or get ... How far down you can drill into your data. If you're only looking at a population of 10, that may not be very

meaningful for you to really focus on. Making sure that you're working with your data folks on what level of data you need, what size you need to have meaning in your analysis.

Ann Dills: And then finally looking at needs assessment data on the service needs and gaps, and performance along the Ryan White care continuum. I see that somebody is having some issues with the sound. If anybody else is having issues with that, let me know if it's a problem on my end. When we're looking to data for developing directives, we want to develop these directives prior to the priority setting and resource allocation process for inclusion in those decisions. Kind of like we discussed before, we'll want to review and triangulate data describing service gaps, barriers, or disparities in care that may need special recipient attention. And carefully considering in-depth information from focus groups, key informant interviews, and group sessions, all that kind of qualitative data that can really help us make sense of the hard data that we get through the ... Your epidemiology or your surveillance sets, or your programs data.

Ann Dills: You definitely also want to consider, and we'll go until a bit more detail here, the geographic areas, different service models and then again, your priority populations, especially when we're seeing disparities. Let's kind of focused in more of those. When we're talking about our populations, you're going to want to ... One of the things we're really wanting to move towards is developing directives to require services appropriate for specific groups based on service utilization, client characteristics, and HIV care continuum data. Showing those populations that are underserved or have low retention in care or viral suppression. We likely kind of saw in one of the graphs that I displayed earlier, we saw systemically across our priority areas that black, gay, and bisexual and other men who have sex with men, and black women, and our transgender community, has the fewest opportunity to achieve in-care viral suppression.

Ann Dills: The directive that kind of says to me is, that we need to identify what practices and models would best meet the needs of those communities, and adopt our service system around that. And again, this is something that I think our prevention partners have long understood. They've long had focus testing, focus prevention, and have understand prioritizing prevention services. And we really need to take some tact from that, and understand how to prioritize services to those communities who aren't able to access and stay in our systems of care as they currently exist. When looking at new or refined service models, using

clinical quality management data to show good results for new service model, so that we can direct expanded use of that. One thing that I think we're starting to see a lot of programs move more towards is, rapid start, for example, and the processes that need to be in place for rapid start to happen.

Ann Dills: And because of the clinical quality management data that showed or has been showing really, really positive results for increased viral suppression, quicker time to viral suppression, and a lot of those other key measures from rapid start, it's really led to the expansion of rapid start into a lot of programs. They moved from where I think San Francisco and New York were probably the first areas to do rapid start, and now I think we're really seeing it, I know for sure, in Texas and a lot of our rural areas. And that's because the CQM data shows results for it. And then finally looking through and understanding different geographic areas. Again, looking at utilization in different geographic areas, looking at focus groups survey data on disparities and access to care, to make sure that your services are being offered in the right parts of your region.

Ann Dills: And I feel like we probably have a few different kinds of folks on this call, so we probably have some Part A's, and then we probably have some ... I'm not sure if we have any Part B's, or full on planning bodies. Depending on the size of your region, that could be looking at things at the county level, it could be looking at things at zip code level, or a census track level, or you may have some other way to determine your region. Really making sure that you're understanding how to drill it in that regard too. Not just looking at by identity or population, but also looking at location and trying to separate things out like that. One of the things that we've been doing is those similar kind of color coding systems around retention and in-care viral suppression, we create zip code based heat maps, to show what parts of town folks have the hardest time achieving in-care viral suppression.

Ann Dills: And that can direct me to say, "Well, this is where we need to do testing. This is where we need to maybe focus outreach. Do we need to do a mobile clinic in this area?" There's a lot of things that could result in. For our ... And all of you are probably familiar, years ago, HRSA and the CDC came together for an integrated HIV prevention and care planning. And the HIV plan that is your jurisdictional requirement is supposed to be an integrated prevention and care planning. We're definitely going to want to make sure that we're using a variety of data to set challenging but reasonable goals and objectives for these plans.

And again, that's making sure we're looking at across the continuum, and that we're understanding all the varieties of data available that's outside of Ryan White to understand communities and needs.

Ann Dills: Make sure we're using HIV care continuum and other performance measures and outcomes data to assess progress. Again, especially if we're wanting to look at progress along our different priority populations, and populations who are most impacted by HIV in our areas, we definitely want to make sure that we're updating this plan regularly with new epidemiology data. I'm not sure what it looks like in other areas for Texas, where we are able to put out an annual data set every year. We get data sets from all of our partners that we collaborate with, Medicaid, and insurance companies, and all the ELR data. And we are able to synthesize data and put out an annual report, and we're able to update our plans annually. At a local level, you may be able to look at things more frequently, especially if you're looking at Ryan White specific data or clinic specific data, you may be able to look at things quarterly.

Ann Dills: Understanding what makes sense to you for how frequently you want to kind of access and look at data, but it should at least be annual for your planning requirements. And then making sure that we're refining annual work plans, based on new needs assessments, service utilization, and client characteristics data. I think that our populations have been changing pretty rapidly over the last decade, but a lot of our systems of care are still are based on the client populations or the communities who were trying to access care 10, 15, 20 years ago. Making sure that we really do understand what the current face of HIV looks like in our communities.

Ann Dills: We'll want use recent data to answer questions about current systems of care. These could be needs assessment findings on client needs and service participation, and gaps, and barriers. Some of these could be from either client satisfaction surveys, maybe you're hosting focus groups, maybe there's people in your area that are doing special studies. If you have universities in your area there're ... I guarantee, there might be somebody within that, that's doing their own special study around the health needs of people in your community. And I think just as much as it's important to look at the ... Do needs assessments on the people who are currently and actively accessing Ryan White care, it's just as important for us to understand the needs of our community overall. Because

again, a large majority of people living with HIV could benefit from Ryan White care, but don't know that it exists.

Ann Dills: And making sure that we're kind of reaching out to a lot of different folks within that needs assessment data, and not kind of limiting it to the traditional ways we've been doing it over time. We want to look at needs about assessment data specifically on services from a provider inventory. And looking at the profile of capacity and capability. We want to look at your ... We can look at your Ryan White Service report, and client characteristics, and other service utilization data. Recipient data on service expenditures including percent of funds expended by service category. You can look at data on linkage, retention, and viral suppression from your HIV care continuum for Ryan White clients, and then priority populations within that. And I would say if you're going to look on data on linkage, you definitely to make sure you're including your prevention partners. Like I said, the CDC is continuing to fund more and more activities that look like Ryan White, and that look like HIV care and treatment.

Ann Dills: If we're not including their data and this information, then we're missing a big part of our system. We want to look at clinical quality management and other data that looks at your performance measures and outcomes. And then again, data on all those other funding streams that are coming into your community. Just to make sure that you really have a full picture of what's happening, and that you're able to respond to true needs. And then again, to continue on, to kind of make sure how to understand our current systems of care. You'll want to make data review a work plan task for the committee that's responsible for care strategy or systems of care.

Ann Dills: And they can kind of get into a rhythm of how to do this quickly and easily on a rotating and ongoing basis. But again, it's just to make sure that you're being responsive enough to current needs and you're not kind of lagging behind. You want to discuss the data to identify changes that are needed in service priorities, allocation of funds, different ... The directives on what our kind of mission, or our goals are putting out in communities, and what our standards of care look like. One of the things that has resulted in our data use here is our trying to redefine how we fund salaries for positions.

Ann Dills: A lot of folks have 100% of their salary coming from the case management service categories. And that's resulted in a lot of barriers to care, because we're gate keeping clients through case management. And based on being able to look

at that data that we've pulled from a variety of sources, and understanding that it's changing how we fund staff. And what service categories do we look at to provide access and making sure that we're not gate keeping. You want to work with your recipients on new or revised service models that address identified limitations. And again, it's what's really going to happen within our systems of care and our service delivery, we're going to have to have a major disruption if we're going to end the HIV epidemic. That's a statement of fact.

Ann Dills: Maintaining the status quo or the systems of care that have existed for the last 20 years, aren't going to help us meet our needs. And we really need to work with our recipients to understand what is working in their system, and what they need to change and adapt. And make sure that they are familiar with new service models, that they're familiar with different opportunities to meet the needs of the communities who are having challenges in accessing care in their system, and helping provide support around that. And then finally you want to assess improvements in your system of care through reviewing data annually to identify changes in service utilization, disparities, performance, and clinical measures. As a data prisoner, I often get bogged down, and the problems or challenges within our systems. And it can sometimes be challenging to remind myself to also look for the promising practices and what's working well.

Ann Dills: And that should be a key part of doing a data examination, to not just understand disparities but also understand what is the effective, what is working, so that we can replicate it where possible or enhance it were possible. And then I think before we turn it over, I'm going to do one last bit looking to use data to identify and address health disparities. And we've been talking a lot about that over the course of this conversation, but just to really kind of focus in on it, identifying and addressing HIV related health disparities should be an integral part of all planning done by planning councils and planning bodies. One thing to do, would be to consider population specific needs and setting priorities. An example of this, people living with HIV who are parents of young children, may be a small percent of clients, but a special study or focus group shows that they require child care to keep appointments.

Ann Dills: The service category needs high enough priority to ensure funding if other funding streams aren't available. We can also kind of think about what are population specific needs in regards to our access to EMRs or ELRs. Are data systems collecting all the identity information that we need in a way to make

sure that we're setting priorities appropriately. Number two, we can address disparities through allocation. Some examples of this, providers report that they are serving immigrants who speak less frequently needed languages. So funds need to be allocated for interpretation and translation in the absence of bilingual staff. This could be a change in the demographics of your community, you may have an increasing immigrant community coming in. In the past you didn't need funds for interpretation services, but now we can see through the data that it's changing our needs in regards to that service category.

Ann Dills: Another example, clinical quality management data indicates that male immigrants are missing appointments at a growing rate. These groups have a high rate of employment, and case managers point to the recent elimination of evening and weekend hours at several clinics due to funding cuts. How can we readjust our allocations in order to provide evening and weekend access? And this is the kind of an example too of being able to be kind of quick on our feet and flexible, and being able to make these adjustments as data reveals it. We can use data to develop directives to address disparities. And example can be a focus group and clinical quality management data indicate that young MSM of color need case managers with special training and skills. A directive can require that subrecipients hire such staff. We continue to see study after study show the impact of peer navigation for example. That has ...

Ann Dills: Especially for young gay men of color who are entering care being able to have that entry to care navigated by somebody who looks like them, can be really important. And that can give a directive to our agencies to say, "When you're looking at folks who are working with newly diagnosed clients in their first six months of care, you need to make sure that you have staff that represent the population that is coming into your system of care." Another example, CQM data and the results of a recent pilot project indicate that young MSM of color that receive peer navigator services keep appointments, adhere to medications, and have higher rates of viral suppression compared to others. Like we said, you can do a directive and allocate specifically for an expansion of this model. What kind of service categories could you use to fund peer navigation services, and how would that change your service delivery system? Most of us aren't going to be getting increased funding. How are we redirecting funds? What service categories are we pulling from in order to create more opportunities to hire peer navigation?

Ann Dills: And then finally, and an expert to kind of ... Finally, for the way he sees data. Develop or refine services to increase access to you and retention in care. Needs assessment data show that transgender people living with HIV face special barriers to care, including stigma and negative responses from some service providers. The planning council or planning body may work with the recipient on a development of trans-specific and trans-appropriate service models, and/or training for all subrecipients on serving this population, using allocations and directives to get these improvements implemented. Not just making sure that the funds are available, but also directing this as a priority for your recipients on how they can better address the needs of the communities who are trying to access them. Those are all some kind of a different ways to use data to impact how you look at allocation, how you look at priority setting, and how maybe you can create better directives for your communities based on data to ensure that the folks who are trying to access care are able to truly meet their needs. And I think with that, I'm turning it over to Allen.

Molly Tasso: Actually, Ann and I'm just going to ... I just want to thank you for that. That was so interesting and helpful. I know it's a lot of information to get through, but I appreciate everything that you have talked to us about. Before I hand it over to Allen, I just want to remind folks to go ahead and chat in questions or even comments that you might have about what we just talked through, or anything that you might want to ask Ann or Allen after he presents about, and we'll have a Q&A at the end. I am ... And I just want to again introduce Allen from the Houston .. Excuse me. The Houston Planning Council. And Allen is going to talk to us about sort of balancing the role of planning council members as the role that they have as both planners and advocates.

Molly Tasso: And members, planning councils and planning body members, they are both advocates who represent their constituents, their population, their agency, or their organization, and not just solely their individual needs and concerns. But also they act as planners who are planning and allocating services and funds for ... On behalf of all people living with HIV in their jurisdiction. There is some times or sort of, you're walking a tight rope at times. And Allen is going to talk with us about how he sees these roles play out, and sort of how it's played out for him as a planning council member in Houston. Allen, go ahead and take it over.

Allen Murray: Hi, everybody. It's good to be here. Like she said, I do a lot of advocacy work and planning council work, and balancing the two can be challenging, that's for sure. But let's go on and start with the slides here. Members often come to the planning council as advocates bring passion, provide a voice for their own communities, or for populations or organization serves. Also learn to advocate on behalf of other subpopulations that may not be represented in a planning council deliberations. In Houston, I ... We definitely have a very passionate planning council, we get into some pretty heated discussions sometimes. But as long as it's done in a professional manner, I think that's a good thing. It drives us into doing better services. And as far as providing a voice, I think it's really important for planning processes that we have people representative of the communities that we're trying to help and serve, that we have those voices on the planning council.

Allen Murray: And I think we do a pretty good job of that here in Houston also. And as far as learning and on behalf of the advocate for subpopulations that's really important. We all come to the table with our own personal experiences and personal ideas and agendas to a certain extent. And I think it's important to remember that we're representing everyone, and try to make sure that we're doing that in the planning process. Members learn when and how to be planners. Consider the entire community, seek win-win verses win-lose, listen to others, come prepared, review data and reports, ask questions. Use data to make decisions, not impassioned pleas, understand the boundaries, and remain passionate and committed. I kind of covered considering the entire community and again, and that's hugely important. Reviewing data and reports, and ask questions.

Allen Murray: One of my ... The most frustrating thing for me is when we go into a meeting and spend the first 20 minutes going over the data and kind of catching people up. We usually have those, in Houston, we have those agendas and documents and stuff. I had a chart for the meeting so that people came here prepared, and when we get to the meeting, we can actually start on the work that we're trying to get done. I think it's important to, if possible, to try to review that data and the agenda and stuff like that ahead of time. And it makes the meetings follow a whole lot easier. And like I said, we do, our support staff, here in Houston does a really good job of that they ... We always have the data that we need.

Allen Murray: And in the rare circumstances that we don't have it, it's there within a few minutes and we move on. I think that's important to try to focus on too. Using data to make decisions and not impassioned pleas. I think we get really involved in the community, I know I do, and sometimes I see things in the community that I get really frustrated with, and I really want to try to help these people with this particular idea or program or something like that. But you have to have the data to back it up, and you have to make decisions driven on data, and your experiences. But you have to have the data to back it up. And understanding boundaries is important. There's a lot of things that I would like to be able to do, and I have the data to show that it would be a good thing to do, but it doesn't fit in with the boundaries of what we're allowed to fund and provide services for.

Allen Murray: And that's just the nature of dealing with publicly or federally funded programs. And you have to work within the budget constraints. And then ... Yeah. Acting as an advocate in discussing service needs, sorry. Call attention the needs of the specific group or subpopulation, their own community or other group that is not represented. During needs assessment, ensure that the needs of this group are studied and documented. During PSRA, support targeting of services to this group. And during integrated and comprehensive planning, question assumptions, help ensure that important factors are considered, ask how plan addresses service access, quality for this group. During the evaluation, provide the perspective of a consumer from this group. And as far as in discussing service needs, call attention to groups that need that to be represented. One of the best examples of that, if we have finally started to make some headway on, is in the transgender community.

Allen Murray: It has been our frustrate, or at least mine, I can't speak for everybody, my frustration for a while now that we don't have the proper data ... You need proper data to properly identify the transgender community and provide services for them. And we have been, as a planning body, been asking the state for a few years now to provide us with some metadata. And that has actually started to come through. I've seen some real improvements this year, which I am thrilled about. And let's see what ... And during evaluation, providing perspective of a consumer from this group, I think that's huge. Because at the end of the day, that's who we're trying to serve. And who better knows what they need and what possibly might get them there than the person that's using the service that we're trying to ... Excuse me, that we're trying to develop.

Allen Murray: Yeah. Acting as a planner. In needs assessment and integrated, comprehensive planning. Ensure that the needs of a diverse people living with HIV communities are studied and documented. In decision making, consider the needs of all communities and people living with HIV populations in the service area. Prioritizing needs and allocations resource to services based on needs assessment data, objective criteria, not personal experiences. Help prevent and manage conflict of interest, including their own and that of other members. Take responsibility for helping to ensure an equitable and data informed decision making process. That was a mouthful. In needs assessment and integrated, comprehensive planning, ensure that the needs of a diverse community that is studied, I think that is huge. And one thing that I know that we're doing with this upcoming needs assessment that I am really thrilled about, because I think that will give us some new information, is trying to, not get rid of, but not focus entirely so much on ... What's the word?

Allen Murray: People they're in the doctor's offices, in clinics, and trying to get out into the general community anymore to get the perspectives of people that aren't necessarily in care or are engaged in care as highly as other people that you will [inaudible 01:10:26]. I'm sorry, Ryan White. Yeah, that's what I was trying to say. Thank you, [inaudible 01:10:32]. And I think they're huge. I'm really glad to see that, because I think it'll give us a little bit better perspective. Consider the needs of all communities with populations in the service area, I think that is huge. We are ... I come to the table with my experiences, and my ideas, and I believe everybody else kind of does too. And it's important to remember that we're here to represent the entire population, not just the people that we love and care about.

Allen Murray: Not that we don't love and care about the other people, but they're not as important, maybe. Prioritize the needs and allocates resources, that is not an easy to do all the time. Yeah. It's the ... It's important that we use the data once again, and let that drive the allocations. And sometimes that can be a struggle, but it's important that we do that. Help prevent and manage conflict of interest, that's one thing because we do have a lot of people from various agencies and people that do have conflict of interest. It's important that we keep that in mind when we're making planning decisions. And I think we do a really good job of that here. And taking responsibility to ensure equitable and data informed decision making process. Just focus on the data and where it fits into the service plans that you are trying to initiate, is important.

Molly Tasso: Great. Thank you so much, Allen. This was such a interesting and helpful overview of sort of what it's like, the work that you're doing, and what it's like to balance the roles of advocate and planner. Excuse me. Again, we have about 15 minutes. I'm just going to roll us through some of the resources that the Planning CHATT Project has developed, and put together, and posted online to help you sort of take the information that we've learned both today and from last week's webinar, and begin to sort of put it into action in your planning councils and planning bodies. But again, just an encouragement to chat in the questions. We only have a few right now, so we definitely have some time to take any that you might have. As most of you hopefully know the ... Excuse me. The Compendium of Materials for Planning Council Support Staff is posted on the planning CHATT website, and have some fantastic resources that we strongly encourage you to check out.

Molly Tasso: Specifically on the screen there, there are two resources. The first is quick definitions and descriptions for data related terms and concepts. And the second is understanding and using data. It's a model planning council training session. Both are available online, and I think you would find super helpful. We also have the training guide that I hope many of you are familiar with. The training guide is designed to help planning councils and planning bodies conduct orientation and ongoing training that prepares members to participate fully in the Ryan White project planning and decision making process. The training guide is composed of 10 modules, and each module has things like trainer notes and presentation inside, activities, and quick reference handouts. And it's just a really great resource to help onboard new members. And specifically there are a handful of data specific training guide modules that we encourage you to check out.

Molly Tasso: Module four is all about the needs assessment. Module five is the priority setting and resource allocation module. Module seven is focused on the topic of maintaining and improving a system of care. And then we are in the final stages of putting together and finalizing and soon posting module 10. Which is that data based decision making module. And much of the presentation both today and last week was pulled from this module. You can even download copies of the slides. Again, competing much of the information that we presented today and last week, and reformat and sort of personalize it to your planning council. That is a really exciting resource that we have coming out soon. And we will

send an email to our Listserv, letting you know when it's posted. Make sure that you are signed up for that.

Molly Tasso: I'm just going to move into the Q&A portion really quickly. Ann, I know that you got a couple of questions about the in-care viral suppression, the slide, the charts, let me pull it up, that folks who are pretty jazzed about that you said was homegrown. I just pulled it up again on the screen. And you talked to us a little bit about how ... What type of chart it is, but people are curious how you went about creating it. We were wondering if you could speak to that. Ann, I think you're on mute.

Ann Dills: I sure am. Okay. I work with my surveillance department to run a lot of different kinds of data sets. And over the last few years we've really refined the kinds of data sets we run. At this point it's just pretty easy for them to kind of update the code on the back end, and spit out that data into kind of your traditional Excel table. I usually receive all the data in an Excel format. Some of that is in pie charts, and a lot of it is just tabular. I use mainly PowerPoint to put together that to the sexual content. Most of these are just different shapes. And then I play a lot with innovation that helps me get a little bit more user friendly during the actual presentation of it.

Ann Dills: But yeah, all of this is developed in a PowerPoint. And then I ... For the ... Some of the other data visuals that I do are Office Publisher, but nothing technical. We have some staff that can ... That do know how to use Tableau, and they ... I'm working with them on moving some things into a Tableau format, but all of this is done in different OfficeSuite stuff. Pretty basic and most people can ... I think you said that's pretty easy to access. And then I did have a ... I thought there was another question about concerns about calling people or communities red versus green, and using these kind of stoplight system. And that's definitely a huge challenge. I mean a lot of what I find really crucial in the other presentations is the framing of language.

Ann Dills: I do use the red, yellow, green stoplight. You can see here that it goes green, then yellow, then red. But when I kind of talk about it and presented it, I don't usually talk about populations are red or populations are green. As much as possible, I really try to talk about it and refocus the conversation around systems. What we can see here is not that black gay men have a poor health outcomes or health outcomes in the red, what I see here are systems of care that have created a fewest opportunities for in-care viral suppression for black

gay men. And I'm kind of shifting the conversation tone on where to place responsibility and accountability away from an individual behavior, and more towards a system of care.

Ann Dills: Then I can talk about my system of care is in the red and meeting the needs of the in-care viral suppression for different population. And then it's not a person being red or green, it's ... Or a community being red or green, it's the system, and a system is something that I can change. And it's kind of, I think trying to reframe it around the things that we as service providers and our planning council, bodies have influence on changing. We don't need to change our community, we don't need to change our population, we need to change our systems. I think that, that addresses the two questions that I thought come up. For the folks that asked them, did that help?

Molly Tasso: Thanks so much, Ann, I think that is very helpful. We ... And someone did just ask in the chat, and we answered or responded in the chat, but it's about the slides in the presentation today, how to access that. And I don't see any other questions, we'll go ahead and wrap up. But to that question, everyone will be receiving an email after today's webinar, probably in the next week or so, with a link to download the slides from today, as well as a YouTube recording of the actual presentation, and a transcript of the presentation you can access as well.

Molly Tasso: All of that information will be sent to you, and it will be also posted to our website. Our website, you can see here on the screen targetHIV.org/planning-CHATT. With that, we're going to go ahead and end today a few minutes early. Thank you everyone so much for participating today. Thank you so much to Ann and Allen for a fantastic presentation. If you could please complete the evaluation that will pop up after we end the webinar, that would be great. And again, please don't hesitate to reach out with any questions that you might have following the presentation. And have a great day. Thank you everyone.