# The Planning Council Data Presentation

Needs Assessment and Integrated Plan

# The Integrated HIV/AIDS Needs Assessment

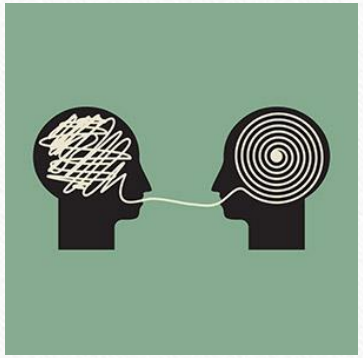
2016-2019

# What is a Needs Assessment?


As Defined by the Ryan White HIV/AIDS Program Part A Manual:

- **Needs Assessment:** A process of collecting information about the needs of people living with HIV (PLWH)—both those receiving care and those not in care.
- Steps involve gathering data from multiple sources on the number of HIV and AIDS cases, the needs of PLWH, and current resources available to meet those needs (Ryan White HIV/AIDS Program and other).
- This information is then analyzed to identify what services are needed and by which groups of PLWH.

# In Plain Language



**Needs assessment activities are ways of learning:**

- What people living with HIV need to enter, return to, or stay in HIV medical care, and reach viral suppression
- The extent to which available services/system of care are meeting those needs (e.g., service needs, and gaps)

# What should be included in a needs assessment?

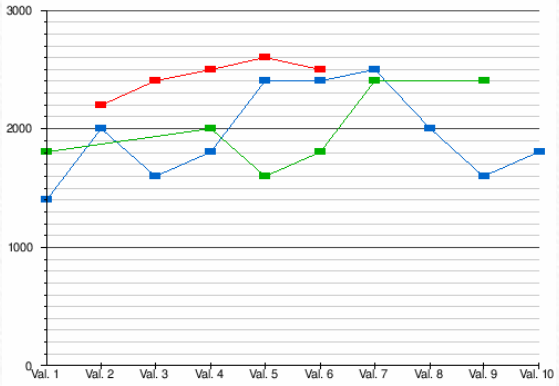

## Elements of a Needs Assessment

- Epidemiologic Profile
- Resource Inventory
- Profile of provider capacity and capability
- Estimate and assessment of unmet need
- Estimate and assessment of people living with HIV who are unaware of their status
- Assessment of service needs and gaps

What should be included in a needs assessment?

## Epidemiologic profile

Information on the number of characteristics of people in a specified geographic area who have been diagnosed with HIV.




Examples include:

- trends in new diagnosis
- geographic distribution of the epidemic
- emerging populations.

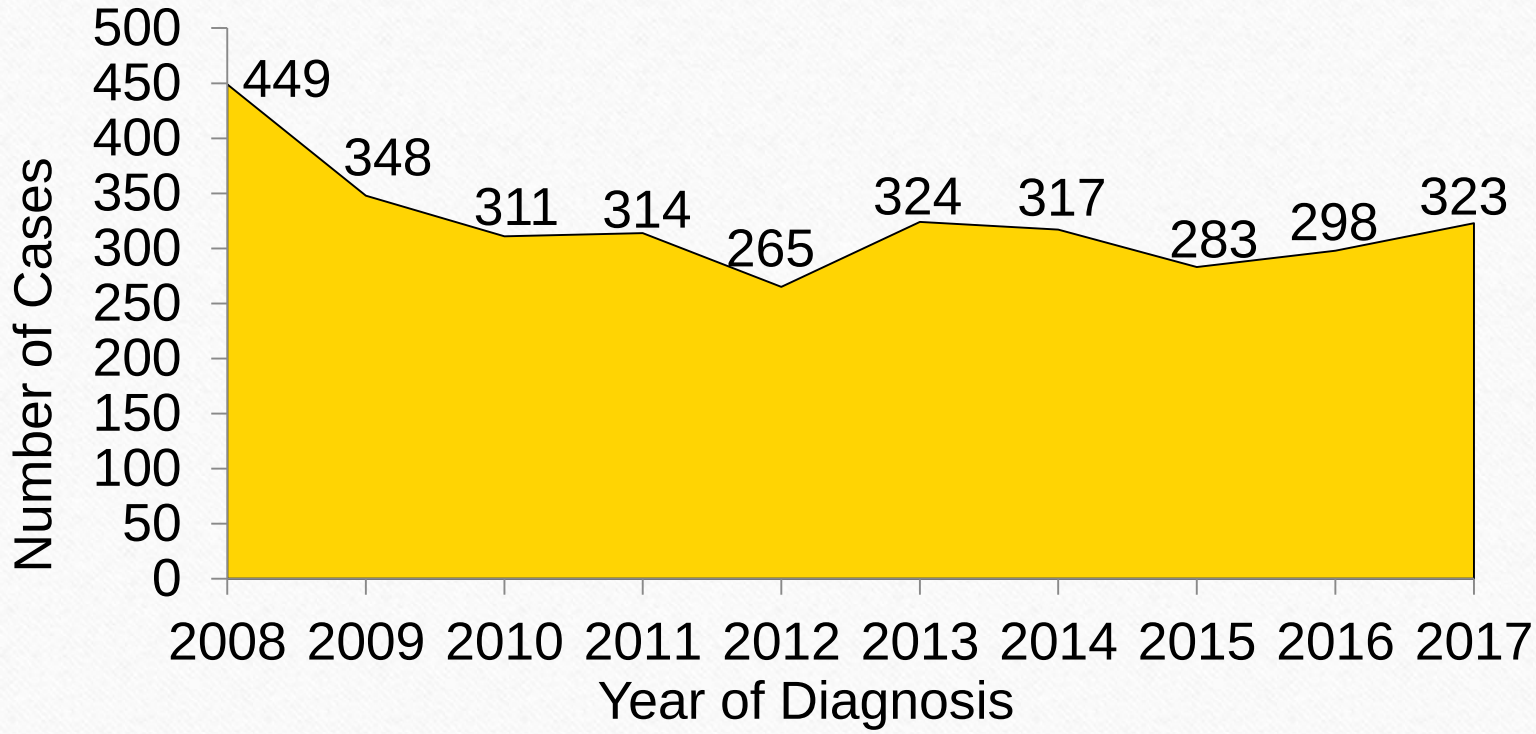
**As home to one of the nation's highest rates of new HIV diagnoses, South Florida** will receive help from the federal government to raise awareness of the virus that causes AIDS and to ultimately reduce new infections as part of the President's national plan to end the epidemic.

Miami Herald, June 17, 2019

# HIV Cases by Year of Diagnosis, Palm Beach County, 2008–2017

**Diagnosis of HIV/AIDS**

10 Year % Change (2008 to 2017) =28% Decrease



HIV IN FLORIDA

# *The Epidemic in Palm Beach County

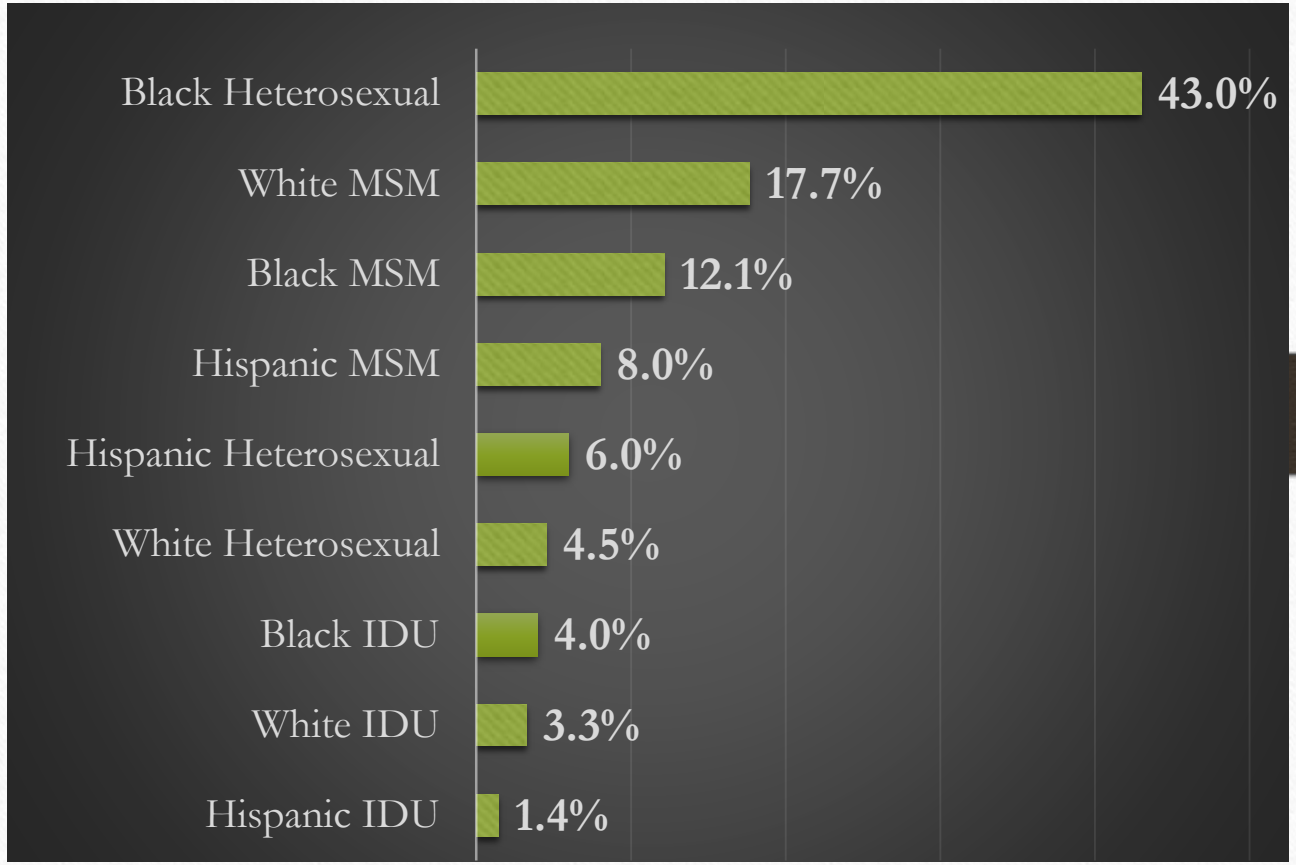
| | 2016 | 2017 | Trend |
|---|---|---|---|
| Population | 1,395,117 | 1,411,054 | 1.1% increase |
| Diagnosed HIV cases | 298 | 323 | 8.4% increase |
| Diagnosed AIDS cases | 144 | 151 | 4.9% increase |
| Pediatric AIDS cases diagnosed | 1 | 1 | |
| Perinatal HIV cases | 0 | 0 | |
| People diagnosed living with HIV (Prevalence) | 8,383 | 8,488 | 1.3% increase |
| HIV-related deaths | 54 | 62 | 14.8% increase |

*Information retrieved from the Florida Department of Health, Division of Disease Control and Health Protection, December 2018

# One-In-Statements for Adults (Age 13+)

**Living with HIV on Palm Beach County, Year-end 2017**

- One in 144 adults in Palm Beach County were known to be living with HIV
- One in 355 Whites were living with HIV
- One in 192 Hispanics were living with HIV
- One in 41 Blacks were living with HIV

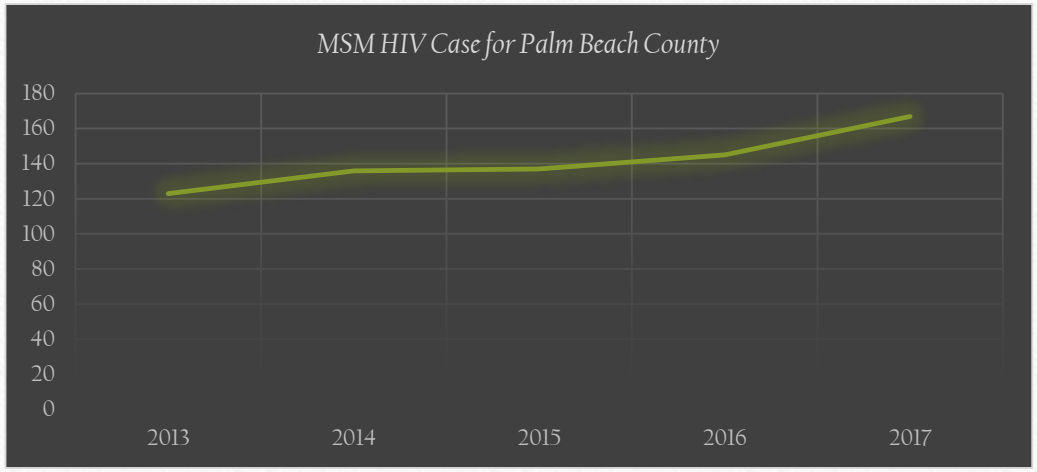

[1]MSM= (MSM and MSM/IDU Diagnosis) and IDU= (IDU and MSM/IDU Diagnosis), therefore the data is not mutually exclusive

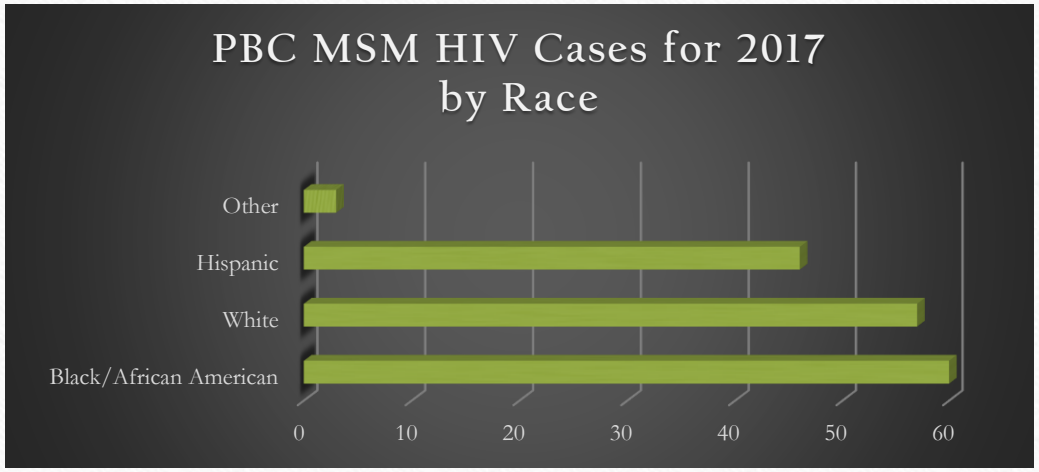
*(One-In-Statements, FLDOH)*

# Palm Beach County HIV/AIDS Epidemiological Profile
## 2017 HIV Cases, MSM

| Palm Beach County<br>HIV Cases, MSM | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2016 | 2015 | 2014 | 2013 |
| County | Count | Count | Count | Count | Count |
| Florida | 3,046 | 2,866 | 2,861 | 2,720 | 2,505 |
| Palm Beach | 166 | 137 | 145 | 136 | 123 |

| Palm Beach County<br>MSM HIV Cases, by Race 2017 | |
|---|---|
| Black/African American | 60 |
| White | 57 |
| Hispanic | 46 |
| Other | 3 |
| Total | 166 |




*(MSM-Men who have sex with men or male-to-male sexual contact. The term MSM indicates a behavior that allows for HIV transmission, it does not indicate how individuals self-identify in terms of sexuality or gender)*

# PLWHA FOCUS GROUPS (2018)

**Solution Driven Approach**

The focus groups initiated had a "solution driven" approach. In addition to asking participants what is wrong with Ryan White services, we also ask for solutions to their issues. Questions that steer participants towards solutions for their issues rather than focusing on their stated problems or needs. Respondents were asked how they see the problems being solved rather than just stating problems faced accessing services.

**Participant Recruitment**

Our focus groups, with the help of providers and other CBOs, targeted participants in and out of care and those who are willing to verbalize their concerns and their solutions. We asked providers for recommendations in addition to asking CARE Council members to make recommendations for participation.

# Focus Group #1 (Riviera Beach) (2018)

CONCERNS

- The group spoke at length about how individuals at social service agencies many times would disclose their status to people in the community. The facilitator interjected that this a violation of HIPPA regulations and anyone they know to violate this law, should be reported.

SOLUTIONS

- "Individuals that work in these social service agencies and doctor's offices should have training in confidentiality and they should be taught that to disclose somebody's status is a violation of the law"
- "You should market to Black communities with culturally focused materials and ideas surrounding stigma and Black people"
- "There should be some movement for the waiting list for HOPWA. Cities need to start building affordable housing for their residents."

# Focus Group #2 (Belle Glade) (2018)

- Confusion of new Health Care District procedures regarding pharmacy and referrals.
- Transportation-The issues of not having adequate transportation for doctor appointments without having to be on the road all day. "Because of the lack of door-to-door transportation services, I have to wait mostly all day for one doctor's appointment because of the length of time riding the bus"
- When asked why do they think people are not in care and how do you get them in care they stated that there were two issues: Stigma and Drugs. That people did not come into care for "fear of someone recognizing them" and the other reason included substance abuse issues and "being too high to care."

# Focus Group #3 (Lake Worth) (2018)

Most significant findings for this group included the issues of how to target gay men of color for the purpose of testing and bringing them into care.

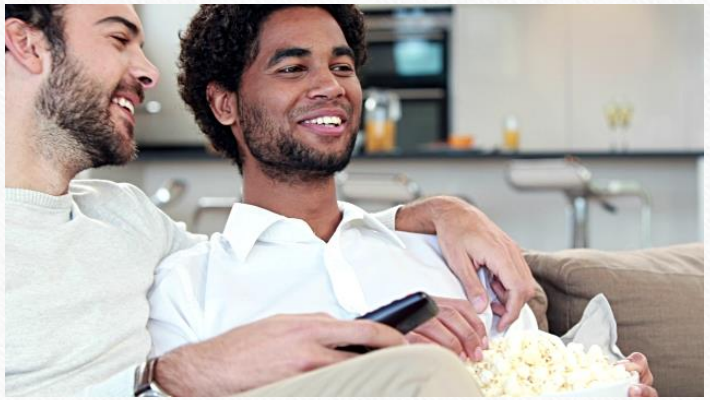
**CONCERNS**

- The group talked about how to target (for marketing) gay men. Areas like clubs, theaters (the art scene) and where they congregate. Media advertisement in art magazines, professional magazines, "off the beaten path" areas and "scenes".

- The group discussed mental health services once a person is tested positive and access to those services once in care.

- "I do not need a case manager all the time. Sometimes I just want a bus pass or a food voucher. Why do I need to see one every month?"

# Focus Group #3 (Lake Worth) (2018)



SOLUTIONS

- "Housing is an issue that we need but cannot access due to waiting lists and lack of funding. There should be a creation of a program that considers income guidelines and affordable housing.

- "People making over a certain income should not be totally dropped from the Ryan White program or denied services. There should be a way to phase them and pair them with other individuals to help mentor them and to help them navigate the care system."

# Focus Groups (2018)
# Self-Reported Data (Questionnaires)

| | Zip Code | Age | Gender | Identification | Race | School | Employment | Health Coverage | HIV Positive? | Income | "If you could have three services that would make your life easier, what would they be? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Riviera Beach | | | | | | | | | | | |
| | 33401 | 45-54 | Male | Straight | Black | Graduate Degree | Full-time | Molina | Yes | $40,000-$60,000 | Transportation, Food, Dental |
| | 33404 | 55+ | Male | Straight | Black | High School | Less than 35 hours | HCD | Yes | $0-$20,000 | Housing, Bus Pass, Food |
| | 33404 | 45-54 | Female | Straight | Black | Less than High School | Unemployed | None | Yes | $0-$20,000 | Housing, Food |
| Belle Glade | | | | | | | | | | | |
| | 33430 | 35-44 | Female | Straight | Black | Less than High School | Unemployed | None | Yes | $0-$20,000 | Transportation, Pharmacy, Pantry |
| | 33476 | 45-54 | Male | Gay | Black | High School | Unemployed | None | Yes | $0-$20,000 | No answer |
| | 33493 | 55+ | Male | Straight | Black | Less than High School | Unemployed | HCD | Yes | $0-$20,000 | No answer |
| | 33493 | 55+ | Female | Straight | Black | High School | Less than 35 hours | HCD | Yes | $0-$20,000 | No answer |
| | 33476 | 45-54 | Male | Gay | Black | High School | Unemployed | HCD | Yes | $0-$20,000 | No answer |
| | 33430 | 55+ | Female | Straight | Black | High School | Homemaker | Medicaid | Yes | $0-$20,000 | Transportation |
| | 33430 | 55+ | Female | Straight | Black | High School | Unemployed | Medicare | Yes | $40,000-$60,000 | No answer |
| | 33430 | 55+ | Female | Straight | Black | High School | Unemployed | Medicaid | Yes | $0-$20,000 | Laughter, Love, Happiness |
| Lake Worth | | | | | | | | | | | |
| | 33415 | 55+ | Male | Gay | Hispanic | Associates Degree | Unemployed | Private Insurance | Yes | $0-$20,000 | Injectable Medication |
| | 33463 | 25-34 | Male | Gay | Hispanic | Graduate Degree | Unemployed | None | Yes | $0-$20,000 | Food, Housing, Transportation |
| | 33409 | 45-54 | Male | Gay | Black | Associates Degree | Less than 35 hours | Private Insurance | Yes | $0-$20,000 | Eye Care, Employment, Housing |

# Elements of a Needs Assessment


## Profile of provider capacity and capability

Information on the capacity of service providers in a specified geographic area to meet the needs of people with HIV, including the extent to which services are available, accessible, and appropriate to PLWH overall and to specific population groups.

Examples include identifying areas for improvement in:

- workforce capacity (e.g. the ability to provide the volume of service needed)
- knowledge of workforce (e.g. clinical competency, service efficiency

# Provider Interview Findings

## Capacity Building Opportunities:

- Food security: RW is not taking full advantage of food bank networks; agencies should be working with United Way, who is the collective impact backbone organization; agencies need to be involved in this process; food vouchers should be a supplement to the food bank network
- Develop EIS quality markers for all agencies
- Clarify expectations of MCM: level of knowledge of staff; communication with clinical providers; in-house vs. out-of-house MCM
- For MAI, develop a model of (1) Patient-Centered Medical Home; (2) Behavioral health integration; (3) Integrated care coordination as a model program and extension of SPNS project

# Provider Interview Findings, Cont'd

## Administrative Functions:

- Identify ways to incorporate feedback from quality management projects back into the system of care
- Clarify budget submission requirements for services that are reimbursed based on CPT-codes
- Require agencies to document and map referral relationships for medical and support services
- Clarify three-year contracting process at bidder's conference
- Document referral relationships in agency proposals
- Consider extending the submittal deadline for RFPs

# Provider Interview Findings, Cont'd

## Programmatic Functions:

- EIS should be evaluated on the speed at which people are linked to care
- Develop EIS quality markers for all agencies
- Sliding fee scale: how is payment collected and managed across network
- Bring back/allow funding for Peer Mentoring to multiple agencies to allow sharing of clients
- Clients requesting Emergency Housing should be screened for substance abuse services and referred appropriately- not deny services just add the referral

# Survey Highlights

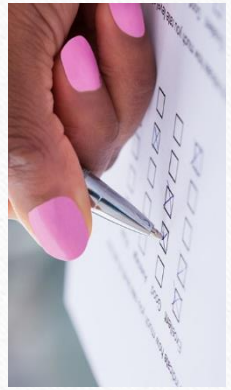
- A 77-item survey was developed and implemented to collect information from PLWHA regarding service priorities and needs. Demographic data elements included gender, sexual orientation, race, ethnicity, age, and geographic area of residence.

- There were three hundred fifty-seven (357) surveys administered to PLWHA in locations, including clinics and high-risk neighborhoods. Surveys were also promoted and distributed at community forums and other appropriate venues. After completing the survey, each respondent received a $15 gift card.

# PLWHA Survey Finding Highlights

- **357 survey respondents** participated in the Integrated Needs Assessment 2016-2019. Of these, 287 (83.4%) indicated they were currently in primary medical care. When asked where they received HIV/AIDS medical care, 330 of the 357 (100%) indicated a response. Of the 330 in care correspondent who indicated one source, 45.8% said doctor's office and 28.8% said public clinic/health department.

- Out of the total 357 respondents that indicated, they were currently on antiretroviral (HIV medication) therapy, 69 (20.8%) respondents that they missed the HIV medications over the past month. When asked about the reasons why they missed taking the medication, the three most frequently mentioned reasons were: they forgot (48.4%, 49), needed to get my prescription renewed (17.2%, 21), and changed insurance plan (10.7%, 13).



- 57 out of 357 (100%) survey respondents indicated they were out of care. When asked about the reasons for not being in care, the three most frequently mentioned reasons included transportation (34.6%, 18), Treatment by staff in the clinic or doctor's (26.9%, 14), and long wait times to get to see the doctor (23.1%, 12).

# Highlights Regarding Populations of Special Concern

**African-American Heterosexual Survey Respondents**

Out of the total 357 Needs Assessment survey respondents:

- Two hundred forty two (242) respondents indicated they were African-American heterosexuals.
- Two hundred eighty seven (287) or (83.4%) indicated they were in HIV/AIDS medical care and,
- Fifty seven (57 ) or (16.6%) were out of care.

**MSM Survey Respondents**

- Seventeen point three percent (17.3%) or (57) of all survey respondents identified themselves as MSM.
- Only seven individuals of this population identified as Transgender (male to female).

# Highlights Regarding Populations of Special Concern

**Haitian Men and Women Survey Respondents**

- Thirty-three (33) or (10.9%) of all survey respondents indicated they were Haitian.

**Hispanic Men and Women Survey Respondents**

- Out of the total 357 Needs Assessment survey respondents, forty-eight (48) or (15.8%) indicated they were Hispanic.

**Youth Survey Respondents**

- When asked if they knew of any PLWHA not in HIV/AIDS medical care, and the reasons for them not being in care respondents cited fear, stigma from the community, and a lack of understanding of how to access services as barriers to being in care.

# Elements of a Needs Assessment

## Assessment of service needs and gaps

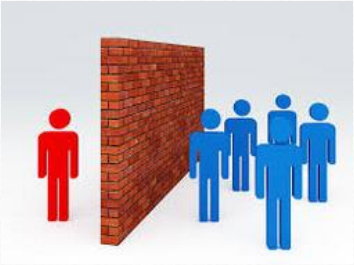
Information about the service needs of people with HIV and barriers to obtaining these services

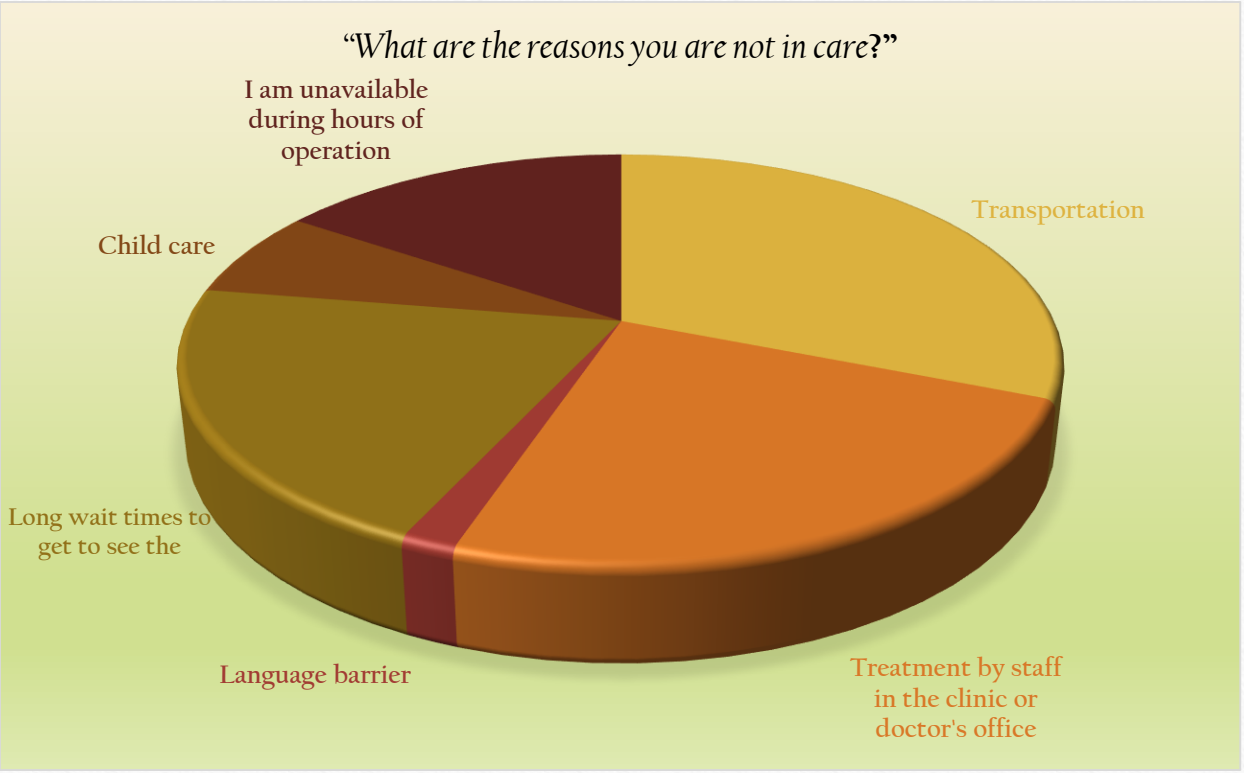
Examples include:

- The necessity of services
- The ease or difficulty in accessing services, and
- The identification of barriers

# Barriers to HIV Medical Care

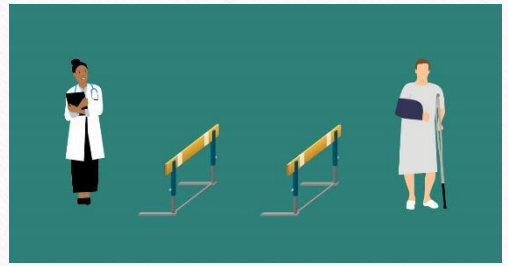
| Reason not in care | Number | Percentage |
|---|---|---|
| Transportation | 18 | 34.6% |
| Treatment by staff in the clinic or doctor's office | 14 | 26.9% |
| Language barrier | 1 | 1.9% |
| Long wait times to get to see the | 12 | 23.1% |
| Child care | 4 | 7.7% |
| I am unavailable during hours of operation | 9 | 17.3% |

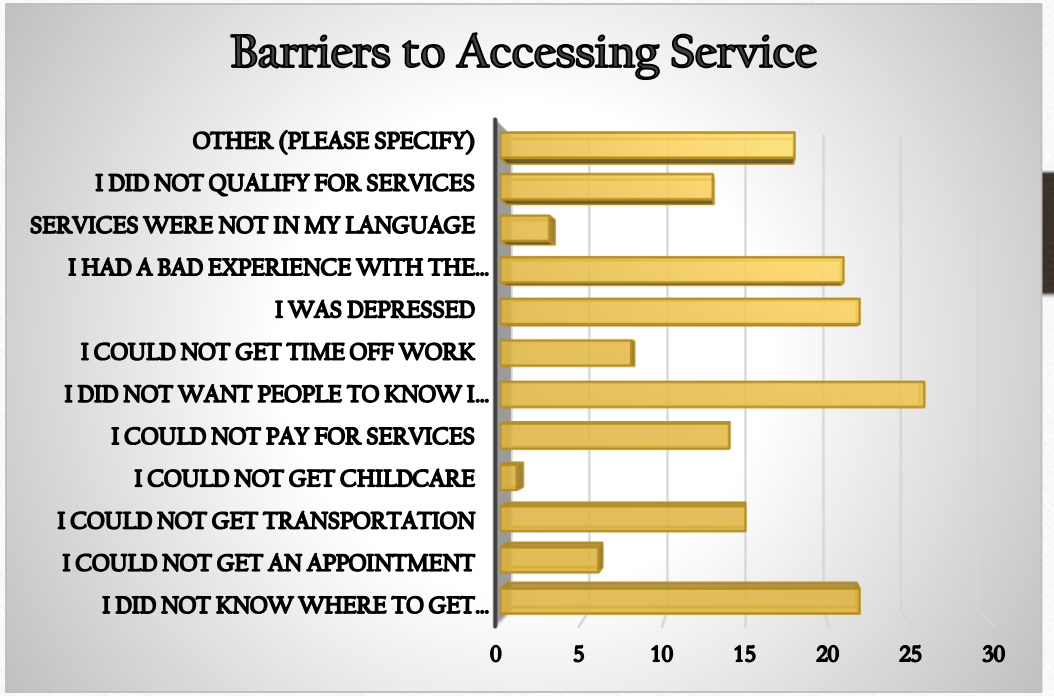




# Barriers to Accessing Services

| Barriers to Medical/Support Services | Number | Percentage |
|---|---|---|
| This does not apply to me. I had no problems receiving services. | 229 | 64.1% |
| I did not know where to get services | 22 | 6.2% |
| I could not get an appointment | 6 | 1.7% |
| I could not get transportation | 15 | 4.2% |
| I could not get childcare | 1 | 0.3% |
| I could not pay for services | 14 | 3.9% |
| I did not want people to know I have HIV | 26 | 7.3% |
| I could not get time off work | 8 | 2.2% |
| I was depressed | 22 | 6.2% |
| I had a bad experience with the staff | 21 | 5.9% |
| Services were not in my language | 3 | 0.8% |
| I did not qualify for services | 13 | 3.6% |
| Other (please specify) | 18 | 5.0% |
| No Response | 26 | 7.3% |





# Needs Assessment Timing

- The large Needs Assessment survey is typically every 3 years
  - PLWH Survey
  - Prevention Survey (done by FDOH)
- There is always some type of Needs Assessment activity being conducted
  - Special studies
  - Epidemiological profiles
- Our last large needs assessment was from 2017-2020.

# Conclusion for Needs Assessment


- Needs assessment process gives us an idea of what PLWH in a community need

- Needs assessment data should be collected every year and timed to ensure you have all the data you need for Priority Setting and Resource Allocation

# The Integrated HIV Prevention and Care Plan

2017-2021

# What is Integrated Planning?

"… local HIV planning efforts across prevention, care, and treatment to effectively meet the needs of people living with HIV and those at risk for HIV infection"

# What is the Integrated Plan?


- A plan for jurisdictions to better support the integration of HIV prevention and HIV care service delivery
- It is a vehicle to develop a coordinated approach to addressing the HIV epidemic at the state and local levels

# Why Integrated Planning?


- To develop a coordinated Statewide response to HIV/AIDS
- To avoid duplication of processes
- Many points of intersection and shared knowledge, data and processes (ex. epidemiological profile, by-laws, nominations, community involvement)
- More economical (sharing resources)
- May have some of the same people on both groups already
- Increased collaboration and communication

# Benefits of Integrated Planning

- Allows development of common mission/vision
- Encourages sharing of knowledge and data
- Combines/maximizes limited resources
- Reduces planning costs in the long term
- Creates comprehensive services/encourages linkage of services
- Fosters integration of prevention into care services and vice versa

# GOAL 1:
# REDUCE NEW HIV INFECTIONS

***Objective 1: Increase the percentage of PLWHA who know their sero-status from 87.2% to 90%.***

*Strategies:*

- Develop and implement a targeted, coordinated, culturally-appropriate multi-faceted social marketing campaign
- Conduct targeted outreach and testing in non-traditional venues
- Promote routine HIV testing in medical care facilities
- Increase knowledge of and access to Non-occupational Post Exposure Prophylaxis (nPEP)/Pre-Exposure Prophylaxis (PrEP) for High Risk HIV negative persons.

***Objective 2: Reduce the number of new diagnoses by at least 10%***

*Strategies:*

- Conduct coordinated, community-level interventions, in alignment with High Impact Prevention principles to address risk behaviors.
- Develop meaningful collaborations among service providers across funding sources and traditional areas of focus
- Support more comprehensive sex education in the Palm Beach County School District
- Assure opt-out testing adoption in all medical facilities

# GOAL 2:
# INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PLWHA

***Objective 1: Increase the percentage of homeless who are retained in care by 5%***

Strategies:

- Foster meaningful partnerships among entities serving the homeless population, outside of the traditional HIV system of care.
- Address concurrent issues impacting the homeless population, such as mental health and substance abuse
- Conduct education for medical providers on the nature of homelessness and how to more effectively serve a homeless client/population

***Objective 2: Increase the percentage of newly diagnosed persons linked to medical care within one month of their HIV diagnosis to at least 85%.***

*Strategies:*

- Restructure service-related quality measures related to linkage programs
- Implement peer strategies to effectively guide newly-diagnosed individuals through critical points in their care
- Develop, implement, and support local Test to Treat Initiatives.

# GOAL 3:
# REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES

***Objective 1: Increase the percentage of Black, Hispanic, and Homeless individuals who are virally suppressed by 5%***

*Strategies:*

- Enhance health outcomes monitoring for Medical Case Management services to improve care
- Employ motivational/empowerment techniques to encourage and support clients to understand and achieve viral suppression.
- Develop innovative peer mentor strategies to support clients as they work towards viral suppression.

***Objective 2: Reduce disparities in the rate of new diagnoses by at least 10% among gay/bisexual men, young black gay/bisexual men, and black females.***

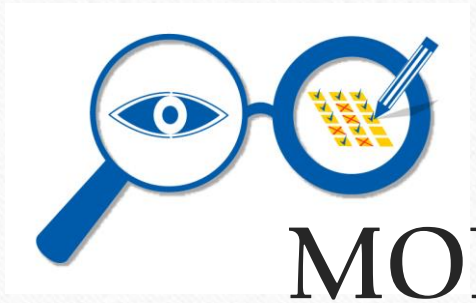
*Strategies:*

- Address issues related to stigma among these populations which contribute to disparities in health outcomes
- Develop a targeted, comprehensive Minority AIDS Initiative program


***Objective 3: Reduce the percentage of PLWHA who experience untreated non-HIV related chronic conditions through treatment and prevention***

*Strategies:*

- Adopt the Expanded HIV Care Continuum model to include prevention and whole health/wellness
- Develop a health outcome monitoring plan to better track management of chronic conditions
- Incorporate strategies and efforts towards whole health, including the prevention and management of chronic conditions throughout the continuum of care



# GOAL 4:
# MONITORING AND EVALUATION

***Objective 1: Develop an integrated planning and evaluation process***

*Strategies:*

- Identify key evaluation stakeholders
- Convene a work group representing the CPP and CARE Council to manage the evaluation plan
- Develop metrics for the Integrated Plan goals and objectives
- Identify data sources to support evaluation goals


***Objective 2: Utilize evaluation findings to improve services and client-level health outcomes***

*Strategies:*

- Identify evaluation questions
- Report evaluation findings
- Develop targeted training to implement evaluation recommendations


The End

# For more information regarding this presentation, please contact:

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