



Meeting Minutes  
**NEEDS ASSESSMENT COMMITTEE**  
Lee Hildebrand, DSW, Chair

Thursday, January 10<sup>th</sup>, 2013  
Cicatelli Associates at 505 Eighth Avenue at 35<sup>th</sup> Street  
9:00 am – 11:00 am

**Members Present:** Angela Aidala, PhD, H. Daniel Castellanos, DrPH, Carrie Davis, Guillermo Garcia-Goldwyn, Lee Hildebrand, DSW, Sabina Hirshfield, PhD, Rosemary Lopez, Frank Machlica, Jan Carl Park, Glen Phillip, Marcy Thompson, Ricardo Vanegas-Plata, DDS

**Members Absent:** Randall Bruce, Terri Faulkner, Graham Harriman, Natalie Humphrey, PhD, Jennifer Irwin, Rebecca Kim, Tamella McCowen, Ariel Negron, Robert Shiau

**NYC DOHMH Staff Present:** Amber Casey, Stephanie Chamberlin, Rafael Molina, Nina Rothschild, DrPH, Ellen Wiewel

**Public Health Solutions Staff Present:** Julie Cohen, Lauren Feldman Hay

**Others Present:** Felicia Carroll, Billy Fields, Ron Joyner

**Material Distributed:**

- Agenda
- Minutes from the December 13<sup>th</sup> Needs Assessment Committee Meeting
- Follow-Up Presentation on Using the Treatment Cascade for Special Populations
- Planning Council Calendar for January 2013

**Welcome/Introductions/Moment of Silence/Review of the Meeting Packet/Review of the Minutes:** Dr. Lee Hildebrand welcomed meeting participants. Committee and audience members introduced themselves. Carrie Davis led the moment of silence. Nina Rothschild reviewed the

contents of the meeting packet. The minutes from the December meeting were approved for posting on the Planning Council website at nyhiv.org.

**Needs Assessment Presentation:** Stephanie Chamberlin of the Research and Evaluation Unit delivered a presentation on needs assessment, first providing a brief overview of what constitutes a needs assessment and then suggesting some ideas for how the Planning Council's Needs Assessment Committee can put a needs assessment together. Her presentation is posted on the Planning Council website at nyhiv.org. A needs assessment determines whether there is a need for a program and identifies services most appropriate to address the need. The audience for the Committee's planned needs assessment is our federal partner, the Health Resources and Services Administration (HRSA), the Planning Council and its Committees, the Grantee (including City government), the HIV/AIDS community, and the public.

HRSA advocates doing a needs assessment every three years, looking at epi data annually, adding data on new populations, and looking at the impact of changes – for example, medical progress. The tasks of a Needs Assessment Committee include identifying unmet need, identifying existing services, determining discrepancies between unmet needs and existing services, and examining needs of providers and the care system.

Step 1 of a needs assessment involves understanding the purpose of the project and determining the level of the assessment (e.g., state, community, or neighborhood). Step 2 involves determining whether the data you need exists or can be produced. Step 3 involves designing methodology. Step 4 involves collecting and analyzing data. Step 5 involves preparing a report to summarize the needs assessment. Step 6 is the dissemination of findings. Ms. Chamberlin provided two examples of a needs assessment – one for child care and the other an assessment of South Asian medical needs in New York City.

Ms. Chamberlin's proposed report outline includes an executive summary with aims and objectives, a bulleted summary of relevant findings, a discussion of information gaps, and recommendations for action. A wealth of information exists, including the consumer satisfaction survey, the CHAIN needs and utilization report, the report by service category on the Comprehensive Plan for HIV/AIDS Services in the New York EMA, and HIV epidemiologic data, the focus groups, Community Advisory Board reports, AIDS Institute reports, Quality Learning Network data, and presentations on the policy landscape. We can assess the data available and not available, provide a summary, make recommendations, and include all the information in a binder.

Defining special populations is challenging, but it helps us to figure out where we want to target our resources. We can identify populations based on various parameters, such as socio-demographics, location/geography, psychosocial categorizations, and time (i.e., length of participation in a program, fiscal year, etc.). Jan Carl Park reminded the group that a needs assessment must include the Tri-County region, comprised of Westchester, Rockland, and Putnam Counties. The next round of the client satisfaction survey may include the Tri-County region. The needs there, for services such as transportation and housing, are different. No organization comparable to New York City's HASA – the HIV/AIDS Services Administration – exists in the Tri-County region. The order of chapters in Ms. Chamberlin's proposed needs assessment is based on when data are expected to become available. Dr. Lee Hildebrand, Committee Chair, asked whether Committee members want to intensify their role in this production. Participation is really important.

**Follow-Up on Using the Treatment Cascade for Special Populations:** Ellen Wiewel of the HIV Epidemiology and Field Services Program prepared several slides to follow up on her previous presentation on the treatment cascade as a means of identifying special populations – estimated number of PLWH, number of PLWH identified, number of PLWH identified and linked to care, number of PLWH identified, linked to care, and retained in care, etc. She proposed looking at engagement in care along a continuum and noted that each bar in her presentation is a subset of the bar to the left. At the Committee's request, she prepared a slide showing the NYC vs. the national (CDC) treatment cascade. The second bar (HIV-diagnosed), for example, shows a 14% drop-off from the previous bar (estimated HIV-infected). The biggest loss is from linkage to care (74% in New York City) to retention in care (55% in New York City), with a drop-off of 19%.

Dr. Angela Aidala noted that there are no differences in demographics regarding where clients are tested, linked, and treated. Ms. Wiewel noted that being tested at a site that offers medical care or actively facilitates entry into care leads to a greater likelihood of linkage. Dr. Hirshfield noted the importance of syndemics – two or more co-occurring illnesses in a population, each of which may exacerbate the other – as a barrier to treatment and care.

Nina Rothschild noted that the guidance for our annual application for funding to the Health Resources and Services Administration requires that the EMA designate and discuss several special populations but leaves the designation up to the Planning Council. No requirement exists, for example, to utilize the traditional approach and designate young men who have sex with men or heterosexual women of color as special populations; rather, we are able to use the treatment cascade if we choose. Dr. Daniel Castellanos suggested examining the factors that produced these outcomes (linked to care but not retained, retained in care but not on ART, etc.).

Dr. Ricardo Vanegas-Plata asked whether the institutions providing services did not provide retention services, noting that 60% of potential clients are lost to care. Ms. Wiewel suggested focusing on the 19% who started care but dropped out in order to earn the biggest bang for the buck. Dr. Aidala noted that people leave care for a variety of reasons – they are tired of it, they have a job, etc. – but return because they become sick. Committee members also noted the increased proportion of people who know that they are positive but don't go to the doctor because of issues of medical literacy – not fully understanding, for example, the importance of regular monitoring and sustained contact with a health care professional.

**Next Steps:** Committee members discussed next steps for the needs assessment and for the Committee as it receives presentations. Stephanie Chamberlin noted that the client satisfaction survey (CSS) will inform us about the client's perception of services and will tell us about the impact of client education levels and literacy issues. Dr. Vanegas-Plata pointed out that the CSS, by definition, is a survey of people retained in care and is therefore biased. He also asked about whether we have any evidence of the impact of the work of the Needs Assessment Committee. Dr. Castellanos favored focusing on the treatment cascade and barriers and suggested that the designation of special populations should be the end product of the needs assessment. Identifying the need for additional information is also one of the outcomes of a needs assessment. Julie Cohen suggested that people become sick and return to care and that we have a substantial emphasis on linkage to but not retention in care. Dr. Aidala noted that not having a regular source of medical care prior to diagnosis strongly influences whether a client will stay in care.

Committee members discussed integrating the language of the treatment cascade in describing service utilization patterns. Dr. Aidala suggested looking at service utilization patterns of people who have a history of dropping out of care and looking at what predicts their reentry to care. She agreed to provide a presentation on CHAIN cohort members: utilization, delayers, and dropouts.

**Public Comment:** No members of the public commented.

**Adjournment:** The meeting was adjourned.

**Follow-Up:** The following are several of the major questions/issues for discussion at subsequent NA Committee meetings:

- 1) What are we going to do about the approximately 60% of PLWH who are lost to care?

- 2) The PLWH who participate in the client satisfaction survey are, by definition, clients – and, therefore, do not provide us with complete information about barriers to care. Can we obtain a fuller understanding of barriers to care by looking at people who are not in care? (A presentation by Dr. Aidala on delayers and dropouts will help to address this question.)
- 3) What are the factors that produced these outcomes in the treatment cascade (linked to care but not retained, retained in care but not on ART, etc.)? Can we look at the treatment cascade and at barriers to care and arrive at a designation of special populations as an end product of the needs assessment?
- 4) What is the impact of syndemics – diseases co-occurring within a population and potentially exacerbating each other – on access to and retention in care?