HRSA/HAB Ryan White HIV/AIDS
Program Training and Technical Assistance

May 2018

Needs Assessment:

Sustainable Strategies for RWHAP Community Organizations

PRIMARY CARE DEVELOPMENT CORPORATION

HRSA
Health Resources & Services Administration

Needs Assessment conducted by Primary Care Development Corporation with funding from the Health Resources Services Administration.

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I. Needs Assessment Methodology

In 2017, the Primary Care Development Corporation (PCDC) was awarded a three-year cooperative agreement from the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) in the focus area of Enhancing Community Organization Models within the Health Care Delivery System for People Living with HIV. The goal of PCDC's project, "Sustainable Strategies for Ryan White HIV/AIDS Program (RWHAP) Community Organizations," is to help AIDS Service Organizations (ASOs) and Community-based Organizations (CBOs) increase their capacity to provide direct HIV care and treatment by revising and/or developing service models and establishing business agreements with core medical and support providers to increase engagement and retention of people living with HIV (PLWH). To guide the development of training and TA resources, PCDC conducted this needs assessment.

Engagement of Key Stakeholders in Developing the Needs Assessment: A needs assessment advisory group, including HIV/AIDS training/TA providers and RWHAP stakeholders, met every other week from September through December 2017. The group reviewed existing needs assessment data, identified gaps in available information, and developed the needs assessment survey tool. Nine individuals were regularly involved in the needs assessment advisory group, including managers, directors and evaluators from PCDC, HRSA, the AIDS Education Training Centers (AETC), the Asian Pacific Islander American Health Forum (APIAHF) and PROCEED.

Building on the Evidence Base: An important consideration in the development of this needs assessment was to leverage existing data, reduce duplication of work done by others, and ensure that data collected would be of broad use to the HIV/AIDS/RWHAP community. To this end we reviewed a wide array of existing data sets, needs assessments, and validated tools. A full list of resources used in the development of this needs assessment survey can be found at the end of this report.

Survey Dissemination: In March of 2018 a link to the online needs assessment survey was disseminated to approximately 700 RWHAP recipients and sub-recipients. The link was disseminated in three ways: 1) The link was sent by email to directly-funded RWHAP organizations (from a HRSA generated list of Project Directors, as listed on notices of award), with a request to forward the needs assessment survey link to ASO/CBO subrecipients; 2) The link was posted on PCDC's landing page on the TARGET Center website; and 3) The link was included in the HAB information email. In total, the needs assessment survey remained open for approximately three weeks.

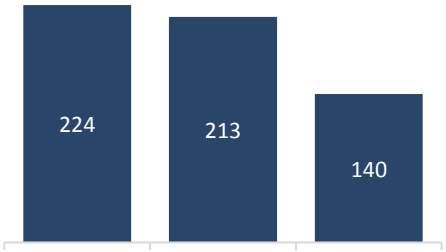
Reaching our Target Audience: To narrow our reach specifically to RWHAP-funded ASOs and CBOs, the first two survey questions were designed as "screen-out" questions for anyone outside of our target audience.

> *Survey Question 1 (screen-out): Are you currently a Ryan White HIV Program grantee? (Yes/No)*
>
> *Survey Question 2 (screen-out): Are you an AIDS Service Organization (ASO) or Community-Based Organization (CBO)? (Yes/No)*

Additionally, to ensure survey respondents were able to answer specific financial and infrastructure questions about their organizations, we encouraged the survey be completed by staff in leadership/executive/management roles such as Executive Directors, Chief Executive Officers, Chief Financial Officers, Program Directors and Managers. We also structured "opt-out" opportunities within the survey for respondents who may not have felt able to answer the detailed questions being asked. "Opt-out" questions allowed respondents to leave the survey and refer us to other staff within their organizations who would be appropriate contacts for completing the needs assessment survey. PCDC's staff followed up individually with those referred individuals to solicit their participation in the survey.

As seen in Figure 1 to the right, of the 224 individuals who started the survey, 213 were Ryan White grantees, 140 of whom were individuals from RWHAP-funded ASOs and CBOs.

Figure 1:
Reaching Our Target Audience



Limitations: The primary limitation to the survey design utilized for this needs assessment was the implementation of convenience sampling. Without a complete list of all RWHAP-funded ASOs/CBOs, we cannot assess whether survey respondents were representative of the larger community of potential respondents. In addition, the survey was collected at an individual level rather than an organizational level, thus multiple individuals from one organization may have completed the survey. This could create over-representation of key issues as multiple staff report on the same organizational context.

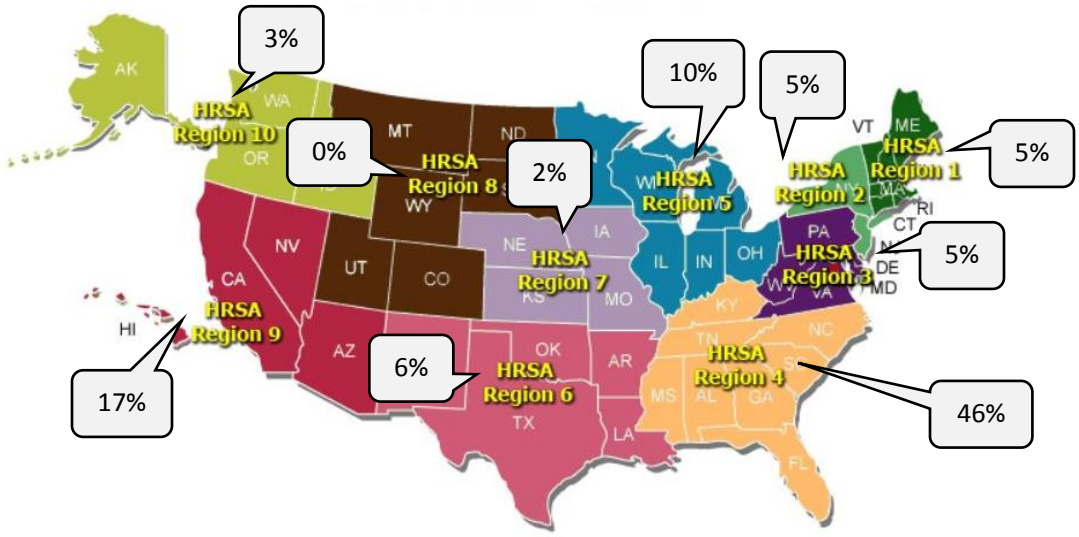
II. Who Responded to the Needs Assessment?

140 Individuals from 31 States and 9 HRSA regions responded to the needs assessment survey. Figure 2 to the right and Figure 3 below show the number/percentage of respondents from each state and region.

Figure 2: Geographic Participation of Survey Respondents from 31 States

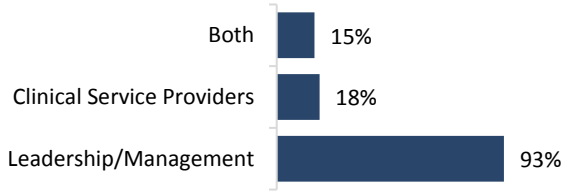
AL (8)	ID (1)	MI (7)	NY (4)	VI (1)
AR (1)	IL (4)	MN (1)	OR (2)	WA (1)
AZ (1)	KY (1)	MO (2)	PA (4)	WI (1)
CA (11)	LA (2)	MS (3)	PR (1)	Missing state (11)
CT (2)	MA (3)	NC (4)	SC (3)	
FL (29)	MD (2)	NJ (3)	TN (3)	
GA (8)	ME (1)	NV (10)	TX (5)	

Figure 3: Map of HRSA Regions Represented



93% Were Management/Leadership such as Executive Directors, Chief Executive Officers, Chief Financial Officers, Program Directors/Managers (see Figure 4, right). 18% of respondents were Clinical Service Providers (MDs, PAs, NPs, etc.) and 15% were both

Figure 4: Respondents' Roles



Highly Experienced Organizations: As seen in Figure 5 below, 95% of respondents reported that their organizations had over ten years of experience delivering HIV services. The full range of billable services that respondents reported delivering is shown in Figure 6 below.

Figure 5: HIV Experience

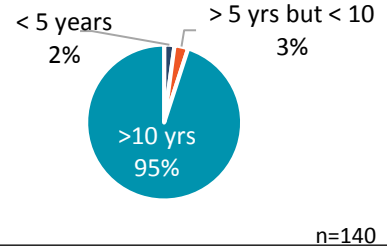
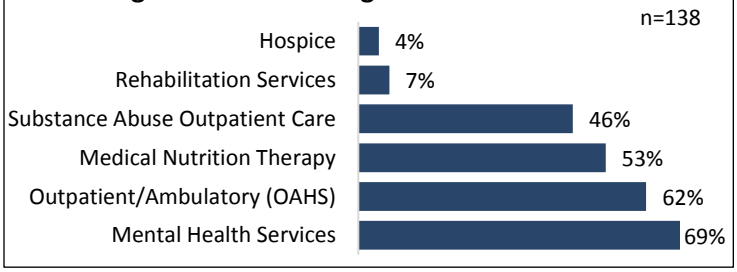


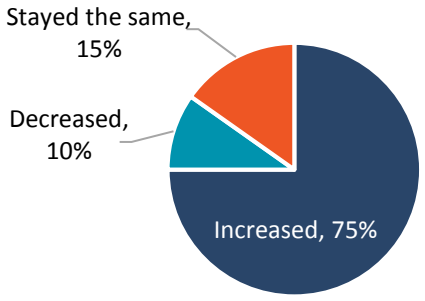
Figure 6: % Delivering Each Service



III. Financial Landscape for Ryan White HIV/AIDS Program Funded ASOs and CBOs

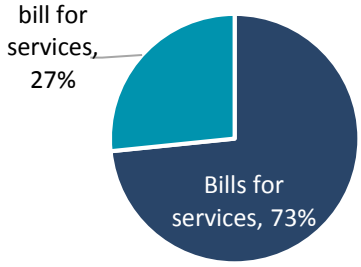
In general, RWHAP-funded AIDS Service Organizations (ASOs) and Community-Based Organizations (CBOs) reported a healthy financial landscape. As seen in Figures 7 and 8 below, 75% reported overall budgetary increases over the past five years and 73% reported that their organizations bill for at least some of the Ryan White services they provide.

Figure 7: Five-Year Budget Changes



n=92

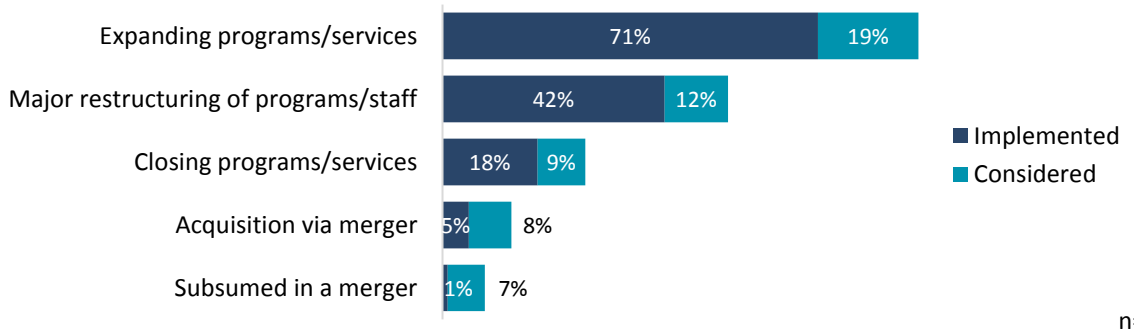
Figure 8: Billing for Services



n=124

A. Major Finance Related Organizational/Programmatic/Service Changes: Given the overall healthy financial climate that ASOs/CBOs reported, it is not surprising that 71% report expanding their programs and services within the past two years. The second most commonly reported fiscal climate-related change was restructuring of programs and staff. Figure 9 below shows the percent of survey respondents who reported implementing or *considering* a variety of fiscally-related changes. Even in an overall positive financial climate, 18% of respondents reported closing programs/services and 1% reported being acquired by another organization through a merger.

Figure 9: Major Fiscal Changes within the Past 2 Years



n=100

B. Diversification of Funding Sources: Respondents noted what appears to be a healthy diversification of funding. As seen in Figure 10a below, only 5% (5 people out of 102 respondents) reported receiving only Ryan White funding, 25% reported one additional funding source, and 70% reported 2 or more.

The most commonly reported funders were State and Local Health Departments. Figure 10b, below, shows the percent of respondents reporting funding from each funding source. In open-ended comments, respondents also reported receiving funding from: Contract pharmacy and 340B revenue (5 people), City/County/State (8), Fundraising Events/Donations (8), Housing-related funding (HOPWA) (6), Federal funders (HRSA, SAMHSA, etc.) (9), Research and Clinical Trials, and Universities.

Figure 10a: Number of Funding Sources other than Ryan White (n=102)

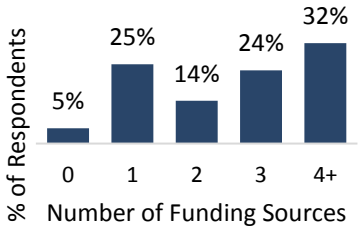
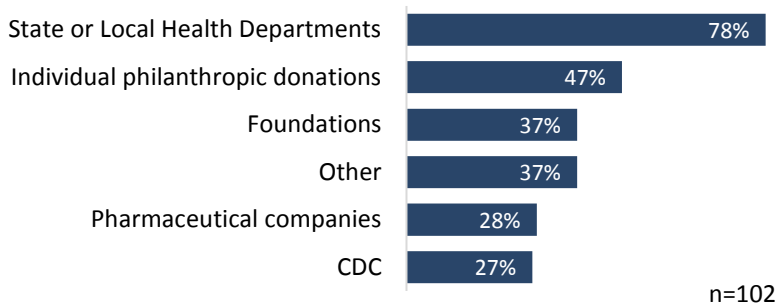
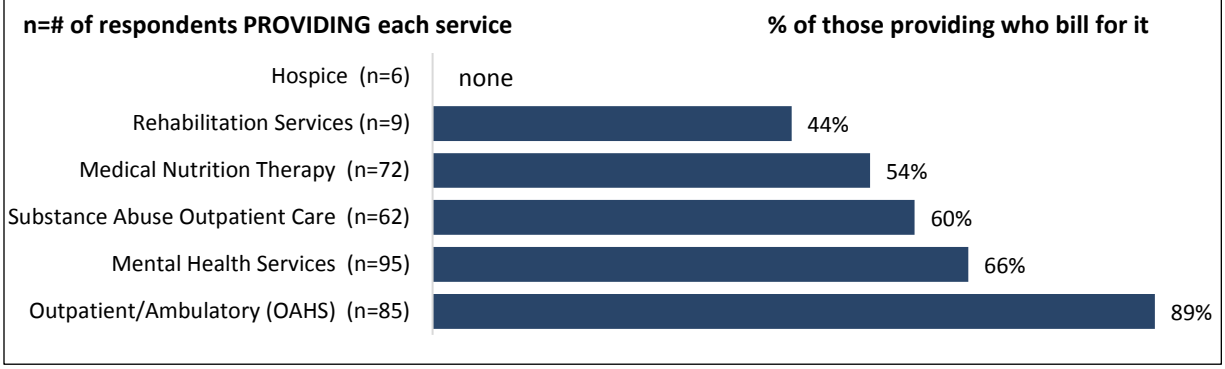


Figure 10b: Funding Sources



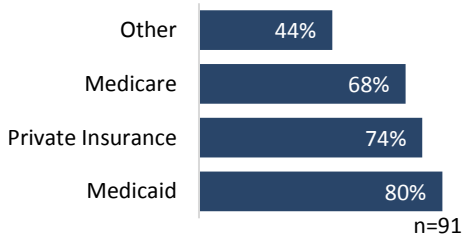
C. Billing for Services: Of the 90 respondents who reported that their organizations bill for at least some of their currently offered billable services, the most commonly billed service (89%) was outpatient ambulatory health services while the least billed service (none) was hospice. Figure 11 below shows the percent of respondents reporting billing for each category of Ryan White billable services. Denominators vary by service and percent are reported out of the total number providing each service.

Figure 11: Billing for Services



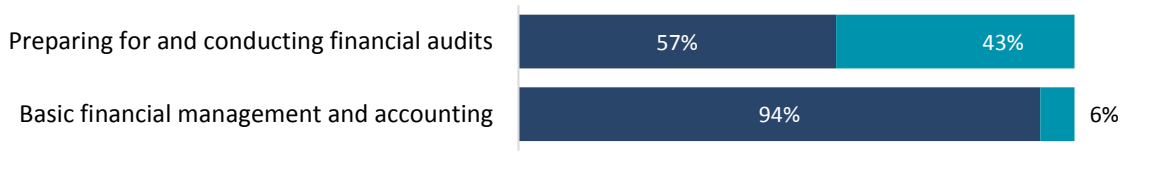
As seen in Figure 12 to the right, the most commonly reported billing sources were Medicaid (80%) and Private Insurance (74%), followed closely by Medicare (68%). In open-ended comments, respondents also identified ADAP programs, PrEP programs, sliding scale and flat rate fees collected directly from clients, partner organizations (lead agencies, grantees, etc.), hospital systems, City, County and State Health Departments, and housing programs as sources they billed.

Figure 12: Who are Organizations Billing?



D. Overall Infrastructure and Financial Management Capacity: Related to the discussion of billing, respondents also noted specific infrastructure and capacity that enabled their organizations to bill for services, namely having the internal capacity for basic financial management. As seen in Figure 13 below, while almost all respondents (94%) noted this as an *internal* capacity, in contrast, almost half of respondents (43%) reported that their organizations relied on *external* consultants for higher level financial functions such as preparing for and conducting financial audits.

Figure 13: Financial Infrastructure



Out of 82 responses about the type of financial management software used, the most commonly named was QuickBooks (33 respondents), followed by Financial Edge/Blackbaud (10), Abila and Sage (6), Great Plains, Microsoft Dynamics, MUNIS and Razors Edge (2 each) and Axiom, BA2C, EasyACCT, eClinical Works, EPSI, FIRS, Fund EZ, Intaact, Intergy, MIP, One Solution, People Soft, Quantum, and SAP (1 each).

E. Financing Models: The final set of needs assessment questions related to financial climate asked about value-based payment systems (payments based on clinical outcomes). Only 14.5% of respondents reported participating in value-based payment structures (Figure 14 below). As seen in Figure 15 below, of those receiving value-based payents, 72% reported one-sided/upside payments (incentives for meeting performance expectations, no penalties if performance expectations are unmet) with 17% reporting two-sided/downside payments (incentives for meeting performance expectations plus penalties if performance expectations are unmet)

Figure 14: Receives Value-Based Payments

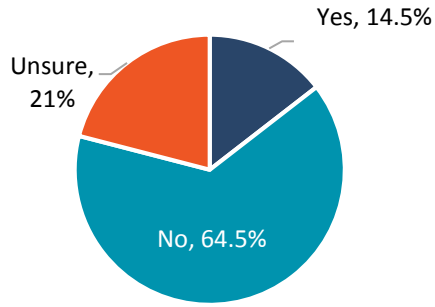
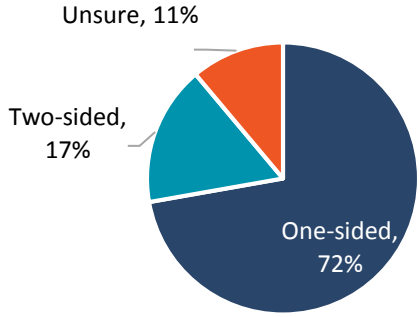
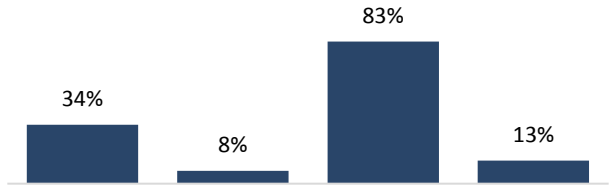


Figure 15: Type of Value-Based Payments



Finally, as seen in Figure 16 to the right, over 80% of respondents reported that clinicians were paid through salary with smaller numbers reporting payment through fees for service (34%) or capitation (8%).

Figure 16: How are Clinicians Paid?



F. Challenges to Financial Sustainability: Seventy three comments were received in response to an open-ended question about the greatest challenges to financial sustainability that organizations faced. The most commonly reported themes were the following:

Inadequate Funding: Although 75% of respondents had reported in an earlier survey question that their overall budgets had increased over the past five years (see Figure 7, page 4), in their comments, twenty-five individuals cited insufficient funding and recent cuts to federal, state and local budgets as a significant threat to their organizations' fiscal sustainability. Respondents also noted declining ability to fundraise and the increasing cost of health care as contributors to funding shortfalls. Several respondents also noted an increase in the competitiveness of receiving funding. A sample of comments in this area are included below:

"Decrease in government funding."
"Lack of ability to fundraise enough funds."
"Federal budget cuts"
"Competing with local and national organizations for grant funding."
"Flat grant revenue vs. increasing cost of health services."
"Insurance will not cover costs of services."
"Inability to generate revenue."
"Loss of federal funding."
"Low Medicaid reimbursement rates."
"The need in the [our] geographic area is greater than the level of funding received."
"More money goes out than comes in."

Instability of the Policy Climate: Respondents cited concerns about the uncertainty of future funding levels as well as potential changes resulting from shifts in the national policy landscape such as changes to the Affordable Care Act. Unpredictability was viewed as a significant threat to fiscal sustainability. Example comments included:

"A constantly shifting payer environment with our state's Medicaid managed care program."
"Changes in political arena."
"Ending of the Affordable Care Act and expanded Medicaid in our state."
"Instability in federal funding and threatened budget cuts from the executive office…It is unsure what will happen to ensure program sustainability after 2021 if federal/state funding…is cut."
"Stability of Federal and State funding, changes in healthcare payment structures."
"The year-to-year uncertainty of our federal funding."

"Fluctuations in the amount of grants (RW) makes difficult to build capacity."

Inadequate Cash Flow and Delays in Payment: The third most commonly cited threat to financial sustainability was challenges with cash flow resulting from long delays in payment by both government funders and third-party billing. Example comments related to this theme are seen below.

"Cash flow and not being given advances as appropriate to continue services without interruptions. Slow reimbursement of RW funds."
"Not receiving payment from our funding sources in a predictable time period."
"Delays in payment from funders."
"As a Ryan White Part C Recipient, we must use all of our program income as we would our grant funding. Due to the restrictions, we are not able to keep a cash reserve, or we are not able to draw our funds. This greatly restricts us from being prepared financially. Example: Hurricane Irma caused a delay in billing that led to decreased and late payments that slowed our ability to provide services and put a financial strain on our agency."
"Reimbursements on time. We run a Housing Program that require a great deal of cash to operate, but we have to carry the cost of the program for 6-7 months until we get reimbursed."

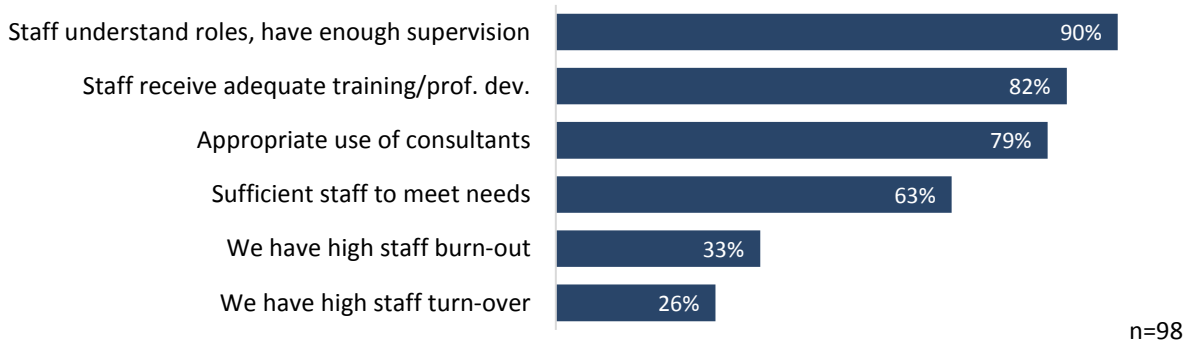
Other: A wide array of other concerns were described by respondents, including limitations on how funding could be spent (four comments), diversification of funding sources (five comments), and 340B negotiated rates (four comments). A few sample comments are below.

"Administrative support (HR, finance, quality management, data) are severely limited as grant funds do not cover this level of support needed to fully implement programming."
"Changes in regulations i.e. 340B pricing pharmacy regulations."
"Being highly dependent on one main grant."

IV. Staff Capacity

In general, RWHAP-funded ASOs/CBOs reported strong positive perceptions of their staffing capacity. When asked to respond to a series of questions about varying staff functions, the majority of respondents agreed/strongly agreed with statements about having sufficient capacity and only a minority of respondents agreed/strongly agreed with statements highlighting common staffing challenges such as high turn-over and staff burn-out. Figure 17 below shows agree/strongly agree rates for each staff capacity statement.

Figure 17: Percent of Respondents who Agree/Strongly Agree with the Following Statements about their Staffing



A. Challenges in Leadership and Staffing: 69 comments were received in response to an open-ended question about the greatest challenges that organizations faced in the areas of staffing, leadership, and systems. Respondents identified the following staffing/leadership-related challenges:

Hiring and Retaining Qualified Staff: Despite the fact that the majority of survey respondents (63%, see Figure 17 above) reported having sufficient staff to meet their program needs, of the 69 comments about challenges in leadership/staffing/systems, the single largest group of comments related to challenges hiring and retaining staff due to financial limitations, specifically, difficulty offering competitive salaries and benefits. A sample of these comments is seen below.

"Higher salaries would attract and maintain talented and motivated leadership."
"Keeping and retaining qualified staff can be a challenge when salaries aren't always competitive."
"The ability to find young staff willing to come on at the salaries a non-profit can afford."
"Retaining staff due to non-profit status with no health, dental care, no retirement provided."

Although the majority of survey respondents did not identify staff burn-out or high staff turn-over as problems in an earlier survey question (Figure 17 above), in open-ended comments, both burn-out and turn-over were frequently mentioned along with the difficulty providing sufficient training and professional development opportunities for staff. A sample of comments in this area is seen below.

"The majority of the staff is overwhelmed and underpaid."
"Difficult population to serve, staff needs a great deal of training to avoid burn out."

"High staff turnover can be challenging, particularly among medical providers due to the length of time it takes to credential and onboard."
"Lack of resources for professional development and limited time to participate in professional development activities."
"Lack of time for adequate training and quality management."

Insufficient Leadership: The second most common area for comments was related to ineffective/insufficient leadership within organizations. Fourteen respondents mentioned specific challenges in this area that ranged from leadership being too "hands-on" (i.e. micromanaging) to insufficient guidance and oversight to lack of succession planning. Difficulties guiding staff through change processes and staff "resistance to change" were also noted in this section. A subset of comments also highlighted difficulty ensuring supervision and oversight for responsibilities that were outsourced (for example, functions performed by consultants). A sample of comments falling into these themes is included below.

"Staff are not as supported by leadership as [they] should be."
"Leadership…does not allow directors to "own" their programs, despite repeated calls to do so."
"Leadership is very hands-on thereby limiting the capabilities of supervisors."
"Unwillingness to change or incorporate what's new."
"Mobilize staff buy-in with constant changes."
"We work with a number of sub-contractors and it is sometimes difficult to provide adequate oversight."

Communication was also frequently cited as a leadership/management challenge, however only one respondent elaborated,

"No written information on how things were done in the past. This results in it being more difficult at times to know how to do things in the best and most efficacious manner."

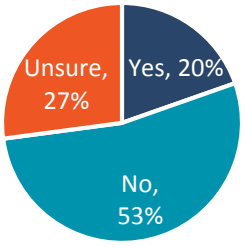
V. Infrastructure and Systems

In general, RWHAP-funded ASOs/CBOs also reported strong positive perceptions of their infrastructure and systems capacities. When asked to respond to a series of questions about collaboration, marketing, policies and procedures, and strategic planning, most respondents agreed/strongly agreed with all statements about having sufficient capacity. The lowest capacity ratings were reported around effective marketing and use of strategic plans. Figure 18 below shows agree/strongly agree rates for each infrastructure/systems capacity statement.

Figure 18: Percent of Respondents who Agree/Strongly Agree with the Following Statements about their Infrastructure/Systems

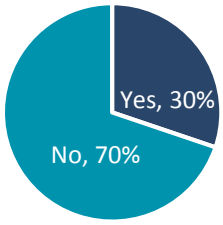
In specific questions about current formalized collaborative relationships, only 20% of respondents reported that their organizations were currently engaged in an Accountable Care Organization (ACO) or Independent Physician Association (IPA) arrangement with Medicare or private insurers (see Figure 19, right).

Figure 19: Organizations Currently in ACO/IPA Agreements



n=107

Figure 20:
Respondents who are FQHCs



n=106

Similarly, as seen in Figure 20 to the left, only 30% of respondents reported that their organizations were Federally Qualified Health Centers (FQHCs) or FQHC look-alikes.

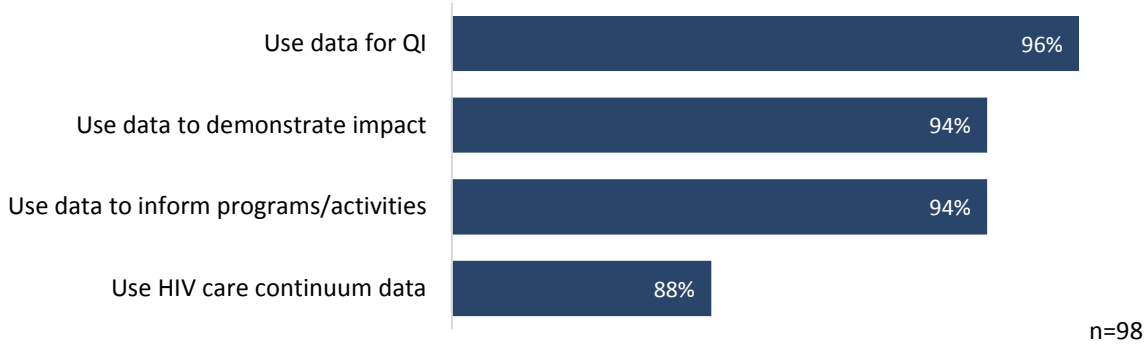
A. Challenges in Infrastructure and Systems (non-staff-related): In the same open-ended question about challenges in leadership, staffing, and systems (described on pages 9 and 10), 8 respondents (11.5% of those giving comments) described challenges related to information technology (IT) and software systems. Computers and data management systems were described as old and slow and challenges were often reported with the variation between software and systems used by partners. Organizational/programmatic growth was also cited as a cause of inadequate systems/infrastructure. All 8 respondents describing IT and software system challenges were from organizations with over 10 years' experience delivering HIV services. A sample of comments in this area is seen below.

"In the last few years, we've grown as agency and our systems are still catching up."
"IT systems do not keep up with the demand of client data input needs."
"Our technology, phones, computers are old and need to be updated. It affects staff member's ability to work, causing burnout."
"The different platforms and programs each organization uses."
"Electronic medical records & connect[ing]…with the gov't system."

VI. Use of Data

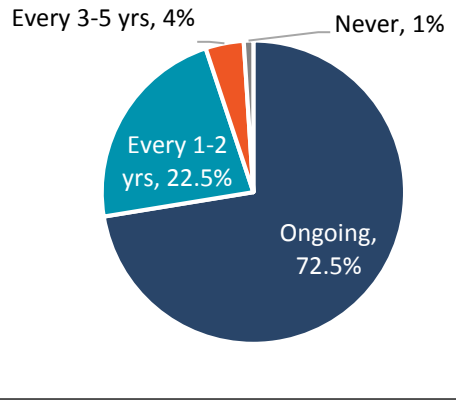
RWHAP-funded ASOs/CBOs were almost unanimous in reporting strong data capacity—nearly 90% reported current collection of, and use of, a variety of key data including care cascade and quality improvement data. Figure 21 below shows agree/strongly agree rates for each data capacity statement asked in the needs assessment survey.

Figure 21: Percent of Respondents who Agree/Strongly Agree with the Following Statements about their Use of Data



In addition to HIV care continuum and program performance data, 99% of respondents reported collecting consumer satisfaction data directly from clients (see Figure 22, right). Only 1% reported never collecting such data. Figure 22 to the right shows the frequency of collection of consumer satisfaction data.

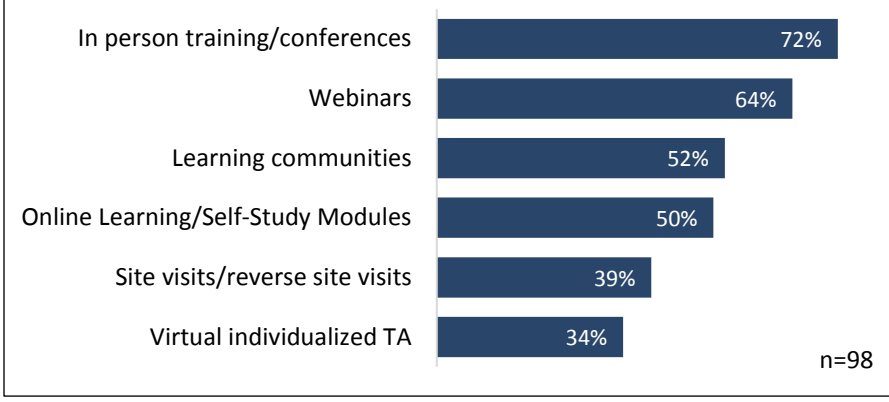
Figure 22: Frequency of Collecting Consumer Satisfaction Data



VII. Identified Needs for Training and Technical Assistance (TA)

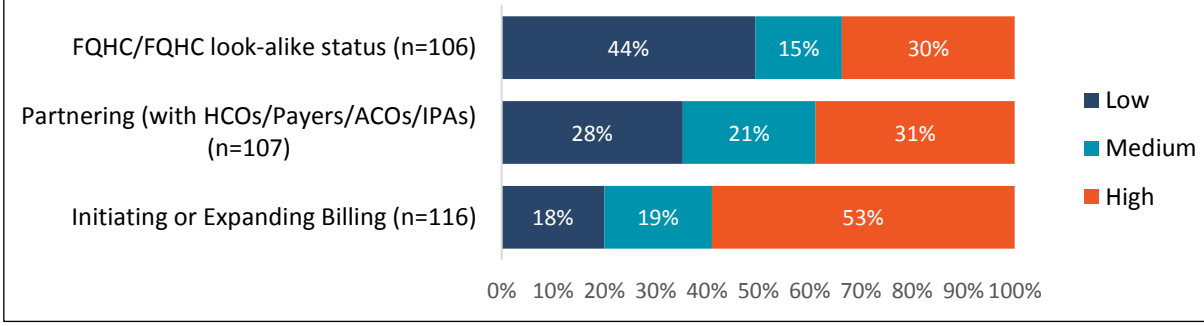
Respondents expressed a strong preference for in-person trainings and conferences as their preferred form of receiving technical assistance. Figure 23 below shows the order of preference for TA formats.

Figure 23: Preferred Training/TA Formats



Respondents expressed significant interest in participating in learning communities around three specific topics already selected to be delivered within the project period. Figure 24 below shows the percentages of respondents expressing medium or high likelihood of participating in each of the three topic areas: 1) Initiating or Expanding Billing for Services (72% of respondents expressed medium or high likelihood that their organizations would be interested in participating); 2) Partnering with HCOs/ACOs/IPAs (52% medium/high likelihood); and 3) Becoming an FQHC/FQHC look-alike (45% medium/high likelihood).

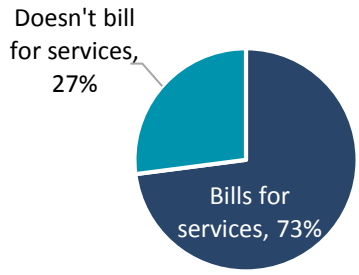
Figure 24: Likelihood to Participate in TA around…



A. TA for Initiating or Expanding Billing for Services:

Although 73% of respondents reported that their organizations already billed for at least some services (Figure 25, right), *Initiating or Expanding Billing for Services* was by far the most popular TA topic. As seen in Figure 24 on the previous page, 72% of respondents expressed medium or high likelihood that their organizations would be interested in participating in a learning community on this topic as opposed to 54% and 45% respectively for the other two topics proposed.

Figure 25: Billing for Services



n=124

When asked about services currently being provided that they would *like to bill for,* the largest need was seen for hospice followed by rehabilitation, medical nutrition therapy, and substance abuse outpatient therapy. Figure 26 below shows the percentage of respondents providing each service who reported that they would like to bill for it (do not currently bill for it).

Figure 26: Provides the Service and Would Like to Bill for It

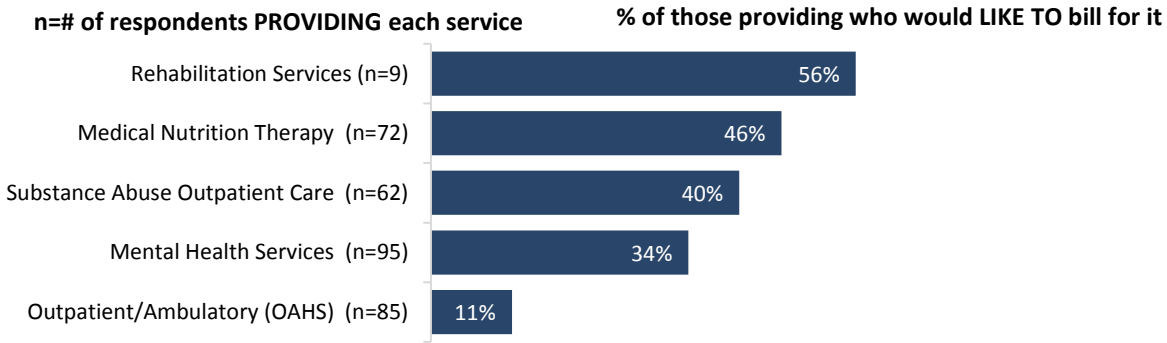
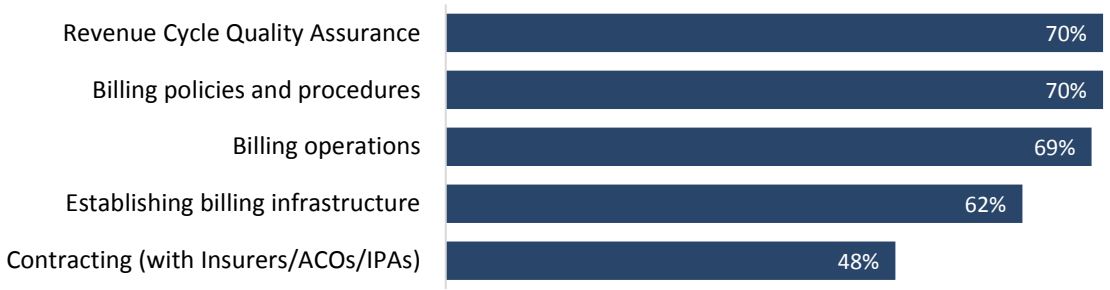


Figure 27 below shows priority areas for TA within the area of Initiating or Expanding Billing for Services. The needs assessment survey question allowed respondents to select all areas in which they were interested in receiving TA. Percentages below show the percent of respondents selecting each option.

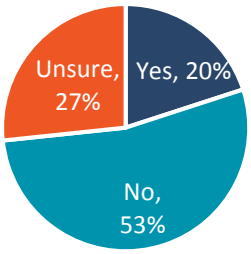
Figure 27: Priority Areas for TA -- Billing for Services



n=81

B. TA for Partnering with HCOs/ACOs/IPAs: TA around partnerships with HCOs/ACOs/IPAs ranked second among the three proposed learning community topics (As seen in Figure 24 on page 14, 52% of respondents expressed medium or high likelihood that their organizations would be interested in participating in TA around these partnerships.) In an earlier survey question (Figure 28, right), only 20% of respondents had reported that their organizations were currently engaged in an ACO or IPA arrangement with Medicare or private insurers.

Figure 28: Organizations Currently in ACO/IPA Agreements



n=107

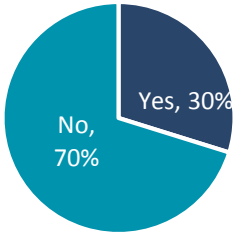
Figure 29 below shows priority areas for TA within the area of Partnering with HCOs/ACOs/IPAs. The needs assessment survey question allowed respondents to select all areas in which they were interested in receiving TA. Percentages below show the percent of respondents selecting each option.

Figure 29: Priority Areas for TA -- Effective Partnerships

n=55

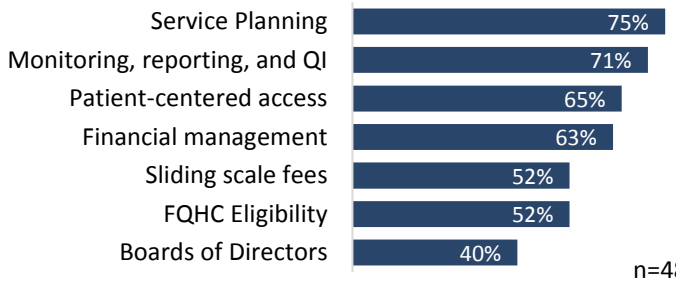
C. TA for Becoming an FQHC/FQHC look-alike: 45% of respondents expressed medium or high likelihood that their organizations would be interested in participating in a learning community on becoming a Federally Qualified Health Center (FQHC) or FQHC look-alike (see Figure 24, page 14). In an earlier survey question (Figure 30 below), 70% of respondents reported that their organizations were not currently FQHC/FQHC look-alikes. Figure 31 below shows priority TA areas within the topic of FQHC status.

Figure 30: Respondents who are FQHCs



n=106

Figure 31: Priority Areas for TA -- FQHC Status



n=48

D. Other Training and TA Needs: When asked in an open-ended question about their other training and TA needs, 54 respondents identified specific areas for TA. Their responses included a variety of finance related areas as well as staff training/development. In addition, board development, organizational/programmatic planning, marketing, collaboration, use of data and specific computer/software skills were also mentioned.

Other Finance-Related Needs: Twenty respondents mentioned specific finance-related training and TA needs which included fund development, grant-writing, book-keeping, diversifying funding sources, obtaining Medicaid certification, and how to negotiate with insurance companies.

Staff Training and Development: Twelve respondents specifically requested additional staff training. Staff training topics requested varied widely (with few topics mentioned more than once). Topics included: crisis intervention, dealing with difficult populations, customer service, recruitment, ethics and boundaries, diversity/inclusion/cultural sensitivity, staff burnout, program management, work flow management, motivational interviewing, and pre-exposure prophylaxis (PrEP) training for clinicians.

Other: Other training/TA requests ranged from board development to marketing (including social media). Four comments were received around collaboration (team-based models, collaborating with other agencies, becoming part of a larger system, and identifying appropriate referrals), nine comments around software and data (Microsoft Access, CareWare, EHRs, data dashboards, and quality improvement), and seven comments around long-term planning and organizational transitions (strategic planning, succession planning, etc.).

VIII. Resources Used in the Development of the Needs Assessment Survey Tool

AETC, Practice Transformation Organizational Assessment

APIAHF/C4H, ASO CBO Stability Sustainability Assessment Report (2013)

CDC, DHAP CBO Capacity Building Assistance (CBA) Needs Assessment for PS11-1113 (2013)

CDC, DHAP CBO Capacity Building Assistance (CBA) Needs Assessment for PS15-1502 (2015)

Clinical Practice Transformation Questions from: Common Wealth, NACHC, Physicians Foundation survey, MEPS, APC, OneCity, Merritt Hawkins, AHRQ (compiled by PCDC)

Health HIV, State of ASO/CBOs in the United States Survey (2017)

Integrated HIV Prevention and Care Plans for: Atlanta, Boston, Chicago, Dallas, Washington DC, Los Angeles, and New York (2016/2017)

Millery and Messeri. What Is Capacity Building? Lessons from a National Demonstration Program of HIV Education for Social Service Providers. Journal of HIV/AIDS & Social Services, Vol. 4(2) 2005.

National Center for Innovation in HIV Care, Needs Assessment Report (2014)

Non-Profit Coordinating Committee of New York (NPCCNY), Non-Profit Domains of Excellence (2017)

Smith, Dawn K., et al. What Community-Based HIV Prevention Organizations Say About Their Role in Biomedical HIV Prevention. AIDS Education and Prevention, 28 (5), 426-439, 2016.

TARGET Center Survey, USCA (2017)

USAID, Organizational Capacity Assessment for Community-Based Organizations (2012)

Washington University, Program Sustainability Assessment Tool (2017)

IX. Complete Assessment Tool

Introduction: Thank you in advance for taking the time to tell us more about your organization and your current needs. Your feedback is anonymous and will help us tailor the training and technical assistance we offer to Ryan White HIV Programs to support the development and implementation of sustainable business models.

- This assessment should only take 15 minutes to complete.
- Executive Directors and Ryan White HIV Program Directors/Coordinators are the most appropriate staff to complete this.
- If you do not feel you are the appropriate staff member to complete this assessment, please forward the link to the appropriate staff at your agency.

PART 1. CURRENT SERVICES AND BILLING MODELS

1. **Are you currently a Ryan White HIV Program grantee?** Yes/No (if no, go to closing/end of survey)

2. **Are you an AIDS Service Organization (ASO) or Community-Based Organization (CBO)?** Yes/No

3. **How long has your organization been providing HIV services?**
   - Under 5 years
   - > 5 and ≤ 10 years
   - Over 10 years

4. **Which of the following Ryan White HIV Program services do you currently bill for:** *(grid)*

	We don't currently provide this service	*We DO provide this service and we DO bill for it*	*We DO provide this service and we would LIKE TO bill for it*	*Unsure*
Outpatient/Ambulatory Care (HIV)				
Mental Health Services				
Substance Abuse Outpatient Care				
Medical Nutrition Therapy				
Hospice				
Rehabilitation Services				

5. **Who do you currently bill for your services?** *(select all that apply)*
   - Medicare
   - Medicaid
   - Private Insurance
   - Other (please specify)
   - We don't currently bill for services

6. **Does your site currently participate in any value-based payment structures? (payments based on clinical outcomes)** Yes/No/Unsure

7. *(skip pattern, if yes)* **Which type of value-based payment structures?** *(select all that apply)*
   - One sided (incentive for meeting performance expectations, no penalty if performance expectations are unmet)
   - Two sided (incentive for meeting performance expectations, incur penalty if performance expectations are unmet)
   - Other (please explain)

8. **Which mechanism(s) are used to pay clinical and/or support providers at your site?** *(select all that apply)*
   - Fee-for-service
   - Capitation
   - Salary
   - Other (please explain)

9. If you have been unsure of how to answer the questions asked so far in this needs assessment, or feel you are not the appropriate person from your organization to be completing this, please provide us with the name and email address of the person(s) you feel would be the appropriate contact person. Please note that we will use this information to email them regarding completing this needs assessment. You may also forward them the email you received and/or the needs assessment link.
   - Name of contact person 1
   - Role of contact person 1
   - Email address for contact person 1
   - Name of contact person 2
   - Role of contact person 2
   - Email address for contact person 2

10. **How likely is <u>your organization</u> to participate in training or TA on Initiating and/or Expanding Billing for Services?** *Low/Medium/High/Unsure*

11. (If Med/High) **Within the area of Initiating and/or Expanding Billing for Services, please rank as 1 the area in which you <u>need the most support</u>, rank as 5 the area in which you need the least support:**
   - Contracting with insurance companies or participating with Accountable Care Organizations (ACOs)/Independent Physician Associations (IPAs)
   - Establishing billing infrastructure within your organization (credentialing, IT infrastructure, electronic medical records, practice management software, clearinghouse, electronic funds transfer, and lockbox))
   - Billing operations (staffing model and roles, qualifications and skills, and workflow basics)
   - Policy and procedure development (corporate compliance, HIPPA, billing and reimbursement, human resources, occupational safety and health, clinical laboratory improvement amendments, medical record documentation, and proper use of non-physician providers)
   - Revenue Cycle Quality Assurance (key performance indicators, reports, reconciliation, and re-credentialing)

12. **Is your organization currently participating in, or preparing to participate in, an Accountable Care Organization (ACO) or Independent Physician Association (IPA) arrangement with Medicare or private insurers?** Yes/No/Unsure

13. **How likely is <u>your organization</u> to participate in training/TA on Partnering with Health Care Settings/Payers/Accountable Care Organization (ACOs)/Independent Physician's Associations (IPAs)** *Low/Medium/High/Unsure*

14. **(If Med/High) Within the area of Partnering with Health Care Settings/Payers/ACOs/IPAs, please rank as 1 the area in which you <u>need the most support</u>, rank as 6 the area in which you need the least support:**
    - Exploring partnership models
    - Technical skills such as writing MOUs/MOAs, developing referral agreements, etc.
    - Effective collaboration
    - Building a "case" for partnership, for example, developing marketing materials/plans, pitching to potential partners, etc.
    - Building efficient systems for service delivery in partnerships
    - Evaluating delivery of services

15. **Are you currently a Federally Qualified Health Center (FQHC) or FQHC look-alike?** Yes/No

16. **How likely is <u>your organization</u> to participate in training/TA on FQHC/FQHC look-alike status?** *Low/Medium/High/Unsure*

17. (If Med/High) **Within the area of FQHC/FQHC look-alike status, please rank as 1 the area in which you <u>need the most support</u>, rank as 7 the area in which you need the least support:**
    - Assessing your eligibility to become an FQHC, for example, identifying the maximum number of FQHCs in your region, whether you meet minimum service requirements, and which FQHC classification you are eligible for.
    - Planning for service expansion (if necessary to meet requirements)
    - Providing patient-centered access (appointment availability, non-traditional days or hours of operation, clinical advice by phone, patient portal)
    - Setting appropriate levels for sliding scale fees
    - Conducting monitoring, reporting, and ongoing quality improvement activities
    - Financial management: accounting, billing and collections
    - Establishing and training of Board of Directors

18. **What other training/TA topics would be useful to support your organization's sustainability?**

PART 2. OVERALL FISCAL SUSTAINABILITY

19. **Other than the Ryan White HIV Program, which of the following sources do you receive funding from** (check all that apply):
    - CDC funding
    - State or Local Health Department funding
    - Pharmaceutical company funding
    - Funding from a foundation

- Individual philanthropic donations
- Other funding sources (please specify)

20. Over the past 5 years, has your organization's current annual operating budget…

- Increased
- Decreased
- Stayed the same
- Unsure

21. Within the last 2 years has your organization experienced, or thought about, any of the following major fiscal changes:

	Have implemented	*Have considered*	*Unsure*	*NA*
A merger with another organization where you were subsumed under their organization/program				
A merger with another organization where you subsumed/acquired them				
A major restructuring of your programs, departments, or staff				
Closing programs or services				
Expanding or adding programs or services				

22. Which of the following fiscal management functions do you currently provide internally:

	We have this capacity internally	*We use an outside consultant/agency*
Basic financial management and accounting		
Preparing for and conducting financial audits		

23. Do you currently use financial management software? *Yes/No*

- *If yes, which software? (open ended)*

24. What do you feel are your organization's greatest challenges or barriers to financial sustainability? (open ended)

PART 3: STAFFING, LEADERSHIP, AND SYSTEMS

25. How strongly would you agree or disagree with the following statements about your staffing:

	Strongly Agree			*Strongly Disagree*	
1. We have sufficient numbers of staff to meet program/community need.	1	2	3	4	Unsure/ NA
2. We use consultants to provide specific expertise when needed.	1	2	3	4	Unsure/ NA
3. Staff understand their roles and receive adequate supervision and support, so they can execute their job functions well.	1	2	3	4	Unsure/ NA
4. High staff turn-over is affecting our ability to deliver quality services.	1	2	3	4	Unsure/ NA
5. Staff burn-out is affecting our ability to deliver quality services.	1	2	3	4	Unsure/ NA
6. Staff receive adequate training and ongoing professional development.	1	2	3	4	Unsure/ NA

26. How strongly would you agree or disagree with the following statements about your systems and infrastructure:

	Strongly Agree			*Strongly Disagree*	
1. We have policies and processes in place to guide our work/service delivery.	1	2	3	4	Unsure/ NA
2. We have a current strategic plan, updated within the past 5 years.	1	2	3	4	Unsure/ NA
3. We use our strategic plan regularly to guide the development of programs and services.	1	2	3	4	Unsure/ NA
4. We create and use an HIV care continuum to support our work. (The HIV care continuum includes # and/or % of people: HIV diagnosed, linked to care, retained in care, on ART, and virally suppressed)	1	2	3	4	Unsure/ NA
5. We collect and use data for quality improvement.	1	2	3	4	Unsure/ NA
6. We collect and use to inform the direction of future programs/activities.	1	2	3	4	Unsure/ NA
7. We use data about our programs to demonstrate their impact to funders and community partners.	1	2	3	4	Unsure/ NA
8. We are a highly respected leader/participant in key planning groups and/or coalitions in our community.	1	2	3	4	Unsure/ NA
9. We have strategic partnerships with important organizations in our community.	1	2	3	4	Unsure/ NA
10. We do a good job of marketing our organization and our services.	1	2	3	4	Unsure/ NA

27. **How often do you collect any type of client/consumer satisfaction data?**
    - Ongoing
    - Every 1-2 years
    - Every 3-5 years
    - Never
    - Unsure

28. **What do you feel are your organization's greatest challenges or barriers in the areas of leadership, staff capacity and organizational systems?** *(open ended)*

29. **What other training/TA topics would be useful to support your organization's sustainability?**

30. **Please rank the following training/TA formats in terms of which would be best for your organization's needs?** *(1 = best, 5=worst)*
    - In person training/conferences
    - Webinars
    - Online Learning/Self-Study Modules that can be accessed at any time
    - Virtual individualized technical assistance
    - Site visits or reverse site visits to facilitate practical experience
    - Learning communities with similar organizations that share barriers and best practices

31. **What is your role at your organization: Are you part of the Leadership/Executive/Management (ED, CEO, CFO, Director, Manager)?** Yes/No

32. **Are you a clinical service provider (MD, NP, PA, RN, MA)?** Yes/No

33. **What state or territory is your organization in?** *(select one)*

- AL
- AK
- AZ
- AR
- CA
- CO
- CT
- District of Columbia (DC)
- DE
- FL
- GA
- Guam
- HI
- ID
- IL
- IN
- IA
- KS
- KY
- LA
- ME
- MD
- MA
- MI
- MN
- MS
- MO
- MT
- NE
- Northern Mariana Islands
- NV
- NH
- NJ
- NM
- NY
- NC
- ND
- OH
- OK
- OR
- PA
- Puerto Rico
- RI
- SC
- SD
- TN
- TX
- US Territory (Other)
- US Virgin Islands
- UT
- VT
- VA
- WA
- WV
- WI
- WY

General Closing: Thank you for taking the time to complete this needs assessment and for sharing your experiences with us.

If sent to survey end after Q1: In order to support the development of effective training and TA for Ryan White grantees, we are only surveying current Ryan White grantees. We apologize if you received this survey in error. Thank you for your time.