RYAN WHITE PART A

# 2011

# PRIORITY SETTING Handbook

Austin Area Comprehensive HIV PLANNING COUNCIL

**Created expressly for the Needs Assessment Committee.**
**Content Source: Ryan White Part A Program Manual**
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# CONTENTS

## The Priority Setting Process





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## PLEASE NOTE THE FOLLOWING:

- According to HRSA's description of the Priority Setting Process, Resource Allocations is a "companion" planning task of Priority Setting.
- The acronym "PSRA" in this handbook stands for "Priority Setting / Resource Allocations".
- The processes are related in that "PS" feeds into and informs "RA."
- The overarching principles of both processes are similar; however the Austin HIV Planning Council has strategically designed these two planning tasks to be carried out exclusive of one another.
- Needs Assessment sub-committee carries out the priority setting process and Allocations sub-committee carries out the resource allocations process.
- At the completion of Needs Assessment Committee's process, the information that was generated will be provided to Allocations Committee to complete their work with regards to resource allocations.
- The HIV Planning Council is an official public entity with federal legislative authority to conduct the processes described in this handbook. In essence, the Council has been entrusted to spend the public's money and make decisions that will affect the public health arena, particularly the local area.
- With few exceptions, any information related to the Planning Council---what they do and how they do it---is subject to public scrutiny and available for public inspection.
- The Priority Setting and Resource Allocations processes are subject to grievance, meaning a formal complaint can be waged about the process.
- Transparency, Consistency, and Objectivity are key criteria for effective decision-making.
- Data-based decisions are not an "option"---- they are a requirement in this process set forth by HRSA.

**NOTES/ADDITONAL POINTS:**

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# Ryan White HIV/AIDS Program Part A Manual

## VII. Program Guidance

### 2. Priority Setting and Resource Allocation



**Introduction**

Ryan White HIV/AIDS Program resources are limited and need is severe. This heightens the responsibility of planning councils to use sound information and a rational decision-making process when deciding which services and other program categories are priorities (priority setting) and how much to fund them (resource allocation).

The process of priority setting and resource allocation (PSRA) is linked to other planning tasks because it draws upon information compiled from those efforts. For example, which needs are higher priorities depends on data compiled through the needs assessment. However, planning councils must often make decisions with incomplete information, such as limited information on the unmet need for services or lack of outcomes evaluation for current services. A thorough PSRA process can help planning councils address these information gaps when they make crucial decisions about which services to fund.

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**A. Legislative Background and HAB/DSS Expectations**

Part A planning councils are responsible for setting service priorities, determining how best to meet those priorities, and allocating resources to them as stated in Section 2609(d)(1)(A). (TGAs that are not required to create planning councils, and that decide not to do so, must establish a process to obtain community input (particularly from those with HIV) in the transitional area for fomulating the overall plan for priority setting and allocating funds.) Planning councils should consciously link needs assessment and comprehensive planning with priority setting so that the planning council has the information needed to make sound decisions about service priorities and use of resources. (Note: The 2006 legislation stipulates that not less than 75 percent of service dollars are to be used for core medical services. This requirement, along with waiver provisions established by HRSA, needs to be factored into the priority setting process, up front.)

**Priority Setting**

Section 2602(b)(4)(C) states that Part A planning councils are required to "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider

in allocating funds under a grant based on the:

i. "'size and demographics of the population of individuals with HIV/AIDS'" and 'the needs of such population...;'

ii. demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available;

iii. priorities of the communities with HIV/AIDS for whom the services are intended;

iv. coordination in the provision of services to such individual with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment for such abuse;

v. availability of other governmental and non-governmental resources, including the State Medicaid plan under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act to cover health care costs of eligible individuals and families with HIV/AIDSs; and

vi. capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities."

**Resource Allocation**

PSRA requires allocating resources across service categories, whether by absolute dollar amounts or as percents of total funds. The planning council must decide the amount or proportion of Part A program funds to be allocated to each of the service priorities it establishes.

Resource allocation does not mean procurement. Planning councils are strictly prohibited from involvement in the selection of particular entities to receive Part A funding. As stated in Section 2602(b)(5)(A), selection of those entities is the responsibility of the grantee, and "the planning council may not designate (or otherwise be involved in the selection of) particular entities as recipients of any of the amounts provided in the grant."

As part of their responsibility to determine how best to meet stated priorities, planning councils may stipulate what provider characteristics the grantee should look for in its request for proposals (RFP) process (*e.g.*, community-based AIDS service providers, multi-service organizations or public agencies that provide a specific service or target a specific population). They may also specify that providers should be sought in specific parts of the Elligible Metropolitan Area (EMA) or Transitional Grant Area (TGA). However, they must not be involved in the selection of providers.

**Legislative Requirements and Use of Funds**

Ryan White legislation contains a number of provisions relating to use of funds that must be factored into the priority setting and resource allocation process. They include the following:

- **Core Medical Services and Support Services.** Section 2604(c) of the 2006 legislation stipulates that not less than 75 percent of service dollars are to be used for core medical services. Additionally, HRSA has established a waiver provision regarding this provision.
- **Early Intervention Services.** The 2006 legislation specifies that Part A and Part B funds may be used for Early Intervention Services (EIS) if the Chief elected official certifies that Federal, State, or local funds are otherwise inadequate and if funds expended for EIS will supplement and not supplant other funds available to the entity for EIS for the fiscal year.
- **Priority Setting and Services to Women, Infants, Children, and Youth With HIV/AIDS .** The Ryan White legislation requires that a certain proportion of Part A funds be used for care and support services to women, infants, children, and youth with HIV/AIDS. The percent of the EMA's/TGA's total Part A service funds that go to services for women, infants, children, and youth must not be less than their percent of the total population with AIDS in the EMA/TGA. This provision does not require planning councils to create a special priority for services to these populations. A waiver to this provision can be granted when EMAs/TGAs can demonstrate that the needs of each population or combination of these populations is being met through other programs such as Medicaid, Children's Health Insurance Program (CHIP), or other Ryan White Parts.

## Addressing Priority Setting Factors

Below is additional guidance for addressing each of the priority setting factors outlined in the legislation.

- **Size/Demographics of Population with HIV/AIDS, Priorities of Communities.** See Needs Assessment chapter in this manual.

- **Coordination of Services/Availability of Other Resources.** See Coordination chapters in this manual.
- **Capacity Development.** The PSRA process conducted by the planning council must focus on efforts to minimize disparities in the availability and quality of treatment for HIV/AIDS in the EMA/TGA. Where disparities exist, Ryan White funds may be used to support service specific capacity development activities. The planning council must determine, through its needs assessment, if underserved communities or populations exist. Congress places special emphasis on identifying and responding to unmet needs/service gaps of PLWHA from underserved geographic communities and people who know they have HIV/AIDS but are not in care. HAB policy guidance defines capacity development as "activities that increase core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services." Capacity development should be directed toward agencies and service providers located in communities or with a history of serving PLWHA populations the planning council has identified as underserved. The result of capacity development activities must be an increase in the number of underserved PLWHA receiving treatment for HIV/AIDS.

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## B. A Model for Priority Setting and Resource Allocation

### Overview

The following decision-making model is intended to help plan and implement decision-making processes to set Ryan White priorities and allocate resources among service categories and other program-related activities. It suggests steps that use documented needs in making decisions.

Examples are provided. The model is designed to meet legislative requirements and address HAB/DSS expectations. Also provided are guidelines and additional considerations for those with more experience, information, and/or resources. The model recognizes that the process used locally may vary based upon these factors.

Note that because of the Minority AIDS Initiative (MAI), this process may need to be carried out more than once in a year. Under the 2006 Ryan White legislation, MAI funding is competitive, and is applied for on a different funding cycle than other Part A funds. However, HAB/DSS expects a Part A planning council to decide on service categories and funding priorities for the MAI. It also expects the planning council to consider MAI funding when it establishes priorities and allocations for other Part A funds, to ensure a single, coordinated system of funding and care.

### Assumptions

This model includes the following assumptions:

- There is no one "right" way to set priorities and allocate resources. This model provides a flexible approach that meets Ryan White requirements and HAB/DSS expectations and reflects actual planning body experience. Case study examples illustrate the process. For purposes of this document, one approach is carried through all the required steps. However, alternative approaches are suggested.
- Decisions about priorities and allocations should be data-based.
- Priority setting must be guided by Ryan White requirements for planning and priority setting, particularly the emphasis on determining the unmet need for services and eliminating disparities in access and services.
- Emphasis must be on sound practice, not merely meeting legislative requirements.
- Priorities should be reviewed annually, though decisions may be continuation of existing services.
- The decision-making process should consider many different perspectives. It should be responsive to identified consumer needs and preferences across diverse populations and address the needs of those Ryan White clients.
- Ryan White planning bodies are official decision-making entities. Their priority-setting and resource-allocation decisions are subject to public scrutiny and to grievance procedures. The process used to reach these decisions must therefore be public and fully documented in writing. Conflict of interest requirements must be fully addressed.
- Priority setting is the responsibility of the whole planning body. While much of the preliminary work may be delegated to a committee, the entire planning body should make decisions about priorities and the allocation of resources among service categories.

**Steps in Priority Setting and Resource Allocation**

The following 15 steps outline how to conduct priority setting and resource allocation and should be carried out over a period of several months, probably by committees and the full planning body.

For purposes of this document, priority setting and resource allocation are described as separate steps, carried out in sequence by a special committee and the full planning body. Two different committees might also be used, or the two processes might be combined. Each planning body should view the steps provided as one example of a sound process and should feel free to adapt it as appropriate, given their unique circumstances.

**STEPS IN PRIORITY SETTING AND RESOURCE ALLOCATION**

1. Agree on the priority-setting and resource-allocation process and its desired outcomes.
2. Agree on responsibilities for carrying out the decision-making process.
3. Review relevant legislative requirements and program guidances.
4. Determine and obtain available information "inputs," including comprehensive plans and needs assessments.
5. Identify a list of service categories for consideration, including definitions, components, and how best to deliver each service.
6. Agree on principles to be applied in decision making.
7. Determine the criteria to be used in priority setting.
8. Determine the decision-making process to be used.
9. Implement the process: set service priorities, including how best to meet them.
10. Define the scope of the resource-allocation process.
11. Agree on principles, criteria, decision-making process, and methods to be used in allocating funds to service categories.
12. Estimate needs by service category.
13. Allocate resources to service categories.
14. Provide decisions to the grantee for use in procurement.
15. Identify areas of uncertainty and needed improvement.

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**1. Agree on the priority-setting and resource-allocation process and its desired outcomes**

First, agree on the specific tasks to be carried out and the expected outcomes. Usually the tasks will be decision making to set priorities and allocate resources to those priorities and provide guidance to the grantee on how best to meet each priority. The planning council ma prioritize and allocate funding to any of the core and support service categories approved for funding. The grantee and planning council should discuss and agree on the funding needed for planning council operations, which is considered part of administrative costs. The grantee may set aside up to 10 percent of the total grant for administrative costs and up to 5 percent or $3 million, whichever is less, for Clinical Quality Management (CQM). The planning council's responsibility is priority setting and resouce allocations for the remaining funds — not less than 85% of the total grant. In setting the tasks and desired outcomes, agree on a format and level of detail for the completed priorities and resource allocations. In doing so, look back to the previous year and identify any changes or improvements needed in the service categories to be considered or the level of detail to be specified. For example, the following specific outcomes might be selected:

- **A prioritized list of service categories,** including a description of populations that will be served, geographic

areas in which services are delivered, or service models that will be used to provide these services, as well as an explanation regarding any core service the planning council did not prioritize.

- **A chart showing the percent or dollars of planning body resources to be allocated to each service category or subcategory** (see step 10), and
- **A fully documented description of the steps and decision-making processes used,** which can be shared with the community and used to support decisions.

Each step in the planning and decision-making process should be documented. Use the following outline as a starting point. Such documentation will make it clear at the end of the process how decisions were made. Remember, if for any reason a grievance is filed against the planning council regarding how decisions were made, this documentation will be very important.

**DOCUMENTING THE DECISION-MAKING PROCESS:**
**SUGGESTED LIST OF MATERIALS TO BE COMPILED**

I. OVERVIEW
   - A. The Task and Desired Outcomes: Service Priorities and Resource Allocations
   - B. Legislation and Guidances
   - C. List of HRSA-approved Service Categories
   - D. Service Categories and Priorities for the Past Year
   - E. Policies and Procedures for Managing Conflict of Interest

II. FACTORS IN DECISION MAKING
   - A. Committee Responsibillities
   - B. Information Inputs (*e.g.*, epidemiologic data, needs assessment, cost and utilization data, performce measures)
   - C. Principles
   - D. Criteria

III. THE DECISION-MAKING PROCESS
   - A. Ground Rules and Overall Approach
   - B. Agreed-upon Process and Decision-making Methods
   - C. Summary of the Priority-setting Process as Implemented
   - D. Summary of the Resource-allocations Process as Implemented
   - E. Areas of Uncertainty and Missing Information

IV. RESULTS
   - A. Chart of Service Priorities and Resource Allocations
   - B. Explanations/Rationale for the Grantee or Administrative Agent
   - C. Adjustments for Increased or Decreased Funding

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## 2. Agree on responsibilities for carrying out the decision-making process

Next, decide who will be responsible for carrying out various steps. While final decisions should be made by the full planning body, preliminary work can be delegated to a special committee, usually a standing committee . The planning

body may decide to create a separate Priority-setting Committee from the Resource-allocation Committee. If a committee approach is chosen, ensure that the committee:

- Is large and diverse enough to reflect the various population groups, counties or cities, and types of technical skills and experience needed for an inclusive and sound process (a committee of 11-15 people is typical)
- Documents its work and brings process decisions such as proposed procedures and criteria for decision making to the full planning body for review and approval (see below), and
- Returns to the entire planning body for review of its preliminary work and receives participation from the entire planning body in determining priorities and/or resource allocations.

Priority setting and resource allocation is generally done by a committee including only planning body members, because of the background information required and the issues around conflict of interest.

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### 3. Review relevant legislative requirements and program guidances

The group responsible for coordinating the priority setting and resource allocations process should review legislative requirements and HAB/DSS guidances to ensure that the decision-making process is compatible with them. For example, the process needs to:

- Base priorities on the size and demographics of the population of individuals living with HIV/AIDS, needs of individuals who are not in care, disparities in access and services, the priorities of communities with HIV/AIDS,coordination with HIV prevention and substance abuse prevention and treatment programs, and compliance with the core medical services funding requirement
- Comply with HAB/DSS guidance regarding the core medical and support service categories that may be funded, and
- Adhere to conflict of interest policies (State and local as well as Ryan White legislative requirements).

Because Ryan White policies may change over time, planning bodies should consult the most recent application guidances from HAB/DSS to identify other legislative factors and HAB/DSS expectations. Information obtained should be summarized in writing and used in deciding on a decision-making process and criteria.

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### 4. Determine and obtain available information "inputs," including comprehensive plans and needs assessments

Ideally, most or all of the information listed in the table below will be available as "inputs" to decision making. This information will help in making decisions about service priorities and resource allocations. HAB/DSS does not expect all of these data components to be used, but many planning bodies find that using a combination of data provides the best results.

Identify missing information before priority setting begins to avoid conflict over any limitations in the process caused by a lack of data. Identifying information gaps will also help to improve the information inputs for next year's decision making.

Often, the information listed will be available but not in an easily usable form. For example, the needs assessment may be quite lengthy. An important task is to determine the kinds of information needed from each of these inputs and prepare summaries in narrative or chart form for use in decision making. For example:

- Needs assessment information might be summarized to provide a prioritized list of service needs as identified by the various needs assessment activities.
- Non-Ryan White funding might be presented in terms of dollars available for each service category, broken down by service model, target group, and/or geographic location where available.

Where possible, data from all these sources should be prepared into a user-friendly summary and presented to the entire planning body during a data presentaion held before priority setting begins. This allows time for members to ask questions about the data and clarify any information gaps. Many planning bodies require members to attend the data presentation in order to participate in priority setting and resource allocations.

| Check if used | Data/Information Used for Priority Setting and Allocation of Funds | Current as of (Mo./Yr.) | Used by: |
|---|---|---|---|
| *Epidemiologic Data* | | | |
| | Trends/changes in HIV incidence and/or prevalence | | |
| | Trends/changes in AIDS incidence and/or prevalence | | |
| | Changes in the demographics of the EMA's/TGA's HIV/AIDS cases in relation to the total population as a measure of disproportionate impact on specific populations | | |
| | Information regarding populations with special needs, including barriers to care and other access issues | | |
| | Quantitative data regarding persons living in the EMA/TGA who know they have HIV but are not receiving HIV/AIDS primary medical care | | |
| | Other: | | |
| *Outcomes Evaluation Data (e.g., effects on clients receiving specific services).* | | | |
| | Client-level health status outcomes – primary medical care | | |
| | Other health status outcomes | | |
| | System-level health status outcomes | | |
| | Other: | | |
| *Service Utilization Data (by service category)* | | | |
| | Numbers of unduplicated clients; numbers of units of service provided | | |
| | Demographic information regarding who is and is not accessing care | | |
| | What percent of previous year's funding was spent | | |
| | Existence of a waiting list for services | | |
| | Other: | | |
| *Service Cost Data* | | | |
| | Unit costs for each service, known or estimated | | |
| | Cost-effectiveness data, if available | | |
| | Other: | | |
| *Needs Assessment Data* | | | |
| | PLWHA survey results | | |
| | Key informant interview findings | | |
| | Focus group findings | | |

| | | | |
|---|---|---|---|
| | **Estimates of unmet need** | | |
| | **Assessment of unment need findings** | | |
| | **Profile of Provider Capacity and Capability findings** | | |
| | **Results of any special needs assessment studies** | | |
| | **Other:** | | |
| *Other Relevant Data* | | | |
| | **Co-morbidity, poverty, insurance status data** | | |
| | **Information on other funding streams** | | |

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## 5. Identify a list of service categories for consideration, including definitions, components, and how best to deliver each service

Because different terms are sometimes used to describe similar services, and certain activities can be provided in more than one service category, a consistent listing can greatly simplify discussions about needs and priorities. An EMA or TGA may choose a more limited definition than specified in the HAB/DSS service category definitions, but may not use a more expansive definition or fund service cateories not on the approved list. Following are helpful steps in defining the service categories:

- Review the approved list of service categories and definitions provided by HAB/DSS in its annual application guidance.
- Review last year's service priorities.
- Consider components and delivery mechanisms that are important to your continuum of care**.** They may need to be separately identified for consideration in priority setting and resource allocation. These might include:
    - **Types of service interventions** (*e.g.*, the category of Food Bank/Home Delivered Meals/Nutrition Supplements might include home-delivered meals, food banks or food pantries, and food vouchers and nutritional supplements).
    - **Specific subpopulations** who must be served (*e.g.*, women, MSM of color, homeless, injecting drug users, Latinos, African Americans).
    - **Specific geographic areas** (*e.g.*, the major cities or counties included in the EMA/TGA service area).
    - **Characteristics or capacities of organizations that might deliver the services.** Priority setting might stipulate what provider characteristics or capacities should be looked for in the RFP that is issued for funding of service providers (such as bilingual/bicultural staff or weekend or evening service hours). However, selection of particular providers/agencies that should deliver a given service must be left to the contracting process.

Remember that the service categories should be listed so they illustrate options for consideration in meeting documented needs. For each HIV health care need identified, choose the service interventions that work best in your area. For example, your needs assessment might indicate that PLWHA need to have their care coordinated. This might be accomplished through case management or through some other service intervention. This might be accomplished through medical case management or through some other service intervention, such as colocated services. Once a list of service categories and interventions is developed, the committee should provide it to the full planning body for review and approval. The box suggests two ways to approach defining service categories.

*TWO MODELS FOR DEVELOPING SERVICE CATEGORIES*

**Model A.** A service priority may be specified as a broad service category with several "subcategories" within it, such as:

- Medical case management, including family-based case management, early intervention, and intensive models; culturally appropriate case management for gay men of color, Latinos, African Americans, and women must be available as needed in each of the three counties in the service area.
- Outpatient medical care, with specific capacity for serving women with HIV/AIDS including pregnant women, to be available in each of the three counties in the service area.

**Model B.** Services for specific populations or geographic areas, or using different types of interventions, may be specified as separate priorities.

For example, a planning body might specify several different priorities that involve case management services for different groups of clients, different geographic areas, or different service models, such as:

- Medical case management for Spanish-speaking/Latino clients
- Medical case management for African Americans, and
- Medical case management in a rural county.

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### 6. Agree on principles to be applied in decision making

Sound priority setting must be based on principles and criteria for decision making, which must be clearly stated and consistently applied. A first step is to identify-and obtain any needed review and approval of-the principles that will be used in guiding the decision-making process (see examples below**).** Often, such principles have been discussed and reflected in the area's comprehensive HIV services plan. In making decisions about priorities, the decision-making body should consider whether proposed priorities are consistent with these principles.

Sometimes documentation may not exist to apply all these principles. For example, cost effectiveness and outcome-effectiveness data may not be available. Note how the lack of information limits the quality of decision making and specify additional information needed in future years.

**POSSIBLE PRINCIPLES TO GUIDE DECISION MAKING**

1. Decisions must be based on documented needs.
2. Services must be responsive to the epidemiology of HIV in this service area.
3. Priorities should contribute to strengthening the agreed-upon continuum of care.
4. Decisions are expected to address overall needs within the service area, not narrow advocacy concerns.
5. Services must be culturally appropriate.
6. Services should focus on the needs of low-income, underserved, and disproportionately impacted populations.
7. Equitable access to services should be provided across geographic areas and subpopulations.
8. Services should meet Public Health Service treatment guidelines and other standards of care and be of demonstrated quality and effectiveness.

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### 7. Determine the criteria to be used in priority setting

In addition to principles, agree on the criteria to be used in setting priorities. These criteria should be "weighted" to determine which ones are most important in making decisions. Suggest a limited number of criteria and indicate which are most important. The box below provides sample criteria.

An experienced planning body with extensive information "inputs" may want to add more criteria, based on the principles

agreed upon in Step 6. The criteria and their relative weight should be discussed and agreed upon by the full planning body.

Note that these sample criteria do not include financial considerations, such as availability of other funding streams or unmet demand. *This priority-setting model assumes that priorities will reflect judgment concerning needed services to provide a continuum of care, regardless of how these services are being funded and the extent of unmet demand for these services.* Funding availability and unmet needs associated with these service priorities are considered in Step 12, as part of the resource-allocation process.

**SAMPLE CRITERIA FOR PRIORITY SETTING**

1. **Documented need,** based on:
   - The epidemiology of the local epidemic
   - Service needs specified in the needs assessment including unmet needs of individuals who are HIV-positive but not in care and of historically underserved communities, and
   - Other structured sources of information.
2. **Quality, cost effectiveness, and outcome effectiveness of services,** as measured through outcomes evaluation, clinical quality management programs, client surveys, and other evaluation methods.
3. **Consumer preferences or priorities,** including services and interventions for particular populations, especially those with severe need, historically underserved communities, and individuals who know their status but are not in care.
4. **Consistency with the continuum of care,** and its underlying priorities.
5. **Balance between ongoing service needs and emerging needs,** reflecting the changing local epidemiology of HIV/AIDS.

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## 8. Determine the decision-making process to be used

Once all the prior steps have been completed, principles and criteria for decision making, and arrangements will have been adopted, and arrangements will have been made to obtain summaries of available information "inputs" for review during the decision-making process. Ideally, a separate data presentation will have been held before priority setting begins.

The recommended decision making-process should be reviewed and revised as needed. There is no one decision-making process or method for priority setting. However, the considerations described below, reflecting the experience of several planning bodies, can help develop a practical method.

As noted earlier, some planning bodies may want to combine the priority setting and resource allocation processes.

### Issues to Consider in Defining the Priority-Setting Process

Consider the following issues in defining a decision-making process:

- **Openness of Process.** All decisions should be made in an open forum, whether a committee or full planning body meeting. The public might not be asked to participate in the decision making but should be free to observe it. Therefore, a calendar of meetings should be agreed upon and publicized within the community, and all decision-making meetings should be held in large and accessible locations and at scheduled times designed to encourage community attendance. A planning body serving a large geographic area might hold meetings in several different locations.
- **Information Base for Decision Making**. Documented information in the form of summaries of the needs assessment and other information inputs should be made available to everyone through a single "point person," such as a committee member or staff member. All members should have access to the same summary information and be able to request full copies of documents if desired before the data presentation. Training or other assistance should be provided to members less familiar with the Ryan White HIV/AIDS Program so they will

feel comfortable using the information.

- **Quorum Requirements.** Explicit quorum requirements should be stated for the committee and the full planning body.

- **Minimizing Conflict of Interest.** The decision-making process may create temptations for members to advocate narrowly for service categories or for interventions for populations and/or geographic areas served by a member's agency (public or private). Define conflict of interest and establish mechanisms to minimize it. This is particularly important because many planning bodies have a high proportion of members who are service providers. Mechanisms might include:

    - Require full disclosure of relationships with HIV/AIDS service providers and the types of services they provide
    - Limit involvement in descussion by members with conflicts of interest by: not allowing them to participate in disucssion of service categories in which they have a conflict of intereste, allowing them to answer questions but not initiate disucssion, or allow them to participate in discussions but not vote
    - Limit participation in discussion to service categories where there is no potential conflict of interest.
    - Exclude providers with potential conflicts of interest from serving on the Priority-setting Committee or ensure that individuals with a potential conflict constitute a minority on the committee.
    - Begin each meeting by reminding members of the mission of the planning body and the purpose and importance of priority-setting.

    The challenge is to manage conflict of interest without excluding from the discussion those with needed service knowledge and experience.

- **Voting Procedures.** Voting procedures should be agreed upon in advance and approved by the full planning body.
- **Decision-making Method.** The procedure to be used in making decisions should be specified "up front." Examples include a consensus method, a nominal group process, or some other procedure. Several of these methods are described below . [1]

**METHODS FOR DECISION MAKING**

- **Group discussion and consensus.** The decisions to be made are listed, discussed formally or informally, and decisions reached without a formal vote.
- **Aggregate checklists or score sheets.** The decision makers rank a list of items such as service categories in order of priority, individual rankings are aggregated, and the items with the top scores are selected or become the group's priorities.
- **Nominal group process.** A series of small-group procedures are used that limit verbal communication so that ideas will not suffer due to premature evaluation, social pressures, etc. This method can be used with variations to include several groups operating at once, or calculation of the total votes across groups. The following sequential steps are typical:
    1. A small group such as a committee comes together and is asked a single question
    2. Members write down their individual responses (such as service priorities), in silence
    3. Individual responses are then elicited in a round-robin fashion (one at a time) until all responses have been offered and recorded by a moderator so everyone can see them
    4. The group discusses and clarifies all responses, and
    5. Members vote individually to select a predetermined number of responses and rank them in order of priority. A summation of votes determines the top-ranked priorities.

- **The Delphi method.** This consensus-seeking technique relies on a series of questionnaires to generate

anonymous ideas that are successively reviewed and refined without any group interaction or discussion. A questionnaire is emailed or mailed to each decision maker, who responds individually and sends it back; responses are ranked and sent back for further ranking and refinement. This technique is most useful when participants cannot be brought together because of geographical or scheduling problems, when decision making involves several stages and some of them need to occur without meetings, or when the number of decision makers is large.

- **Leadership.** The planning body should decide who will lead the decision-making process. Cochairs might provide leadership to ensure that everyone is heard, the agreed-upon process is followed, and time limits are placed on discussion.
- **Decision-making Responsibility.** Responsibilities of the committee and the full planning body should be defined. The committee might begin by reviewing its definition of the task and planned outcomes, as decided in Step 1 of this process, and the agreed-upon responsibilities of the committee and full planning body, as decided in Step 2.
    - **Committee Responsibilities.** The committee might be charged with developing an initial list of recommended priorities. Its responsibility might include presentation of summary information documenting needs, discussion of identified needs and service interventions to best meet these needs, and time-limited discussion of recommended priorities.
    - **Full Planning Body Responsibilities.** The full planning body is ultimately responsible for approving the priorities. If preliminary work is done by a committee, the planning council should review their recommendations and adjust them to reflect the consensus of the full body, resolving any areas of disagreement.
- **Meeting Schedule.** Meetings necessary to carry out the process should be scheduled in advance and publicized.
    - The first committee meeting might be held after the planning body has approved a decision-making process, to review the process, criteria, and information "inputs" and train participants on the decision making method.
    - The committee might then hold a second meeting, or more as needed, at which it will implement the priority-setting process and be prepared to recommend service priorities to the full planning body.
    - The entire planning body might participate in a data presentation.
    - The entire planning body might meet, so the committee could recommend and the planning body review and revise suggested priorities and agree on a final list of service priorities. Note: This meeting could be the first part of a combined priority setting and resource allocations session.

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## 9. Implement the process: set service priorities, including how best to meet them

Once the planning body has adopted a priority-setting process, including an agreed-upon method to make decisions, implement the priority-setting process, with staff support where available. Following is a detailed "case study" example of how one planning body carries out the decision-making meetings and follow up, involving both a preliminary priority-setting meeting of a committee and a final priority-setting meeting of the full planning body.

### A PRELIMINARY PRIORITY-SETTING COMMITTEE MEETING

1. A roll call ensures that committee members present represent the diversity necessary for an informed priority-setting process.
2. To address conflict of interest concerns, the chair asks members of the committee to disclose any relationships with current and potential Ryan White service providers (*e.g.*, employment **as** staff or consultant, board membership, spouse/partner employment or board membership, other financial relationship) and indicate the kinds of HIV/AIDS-related services these providers offer. Two provider representatives disclose that they are the only provider in the service area that delivers a particular type of service. All committee members are permitted to participate in discussion, but those with a conflict of interest may not participate in any individual vote regarding the services

category where they have a conflict of interest. They are permitted to vote on a slate of priorities.

3. The chair reads the principles and criteria that have been adopted to guide the priority-setting process, and asks whether they are clear and understandable to all members. The chair also reminds the committee that they are expected to represent the interests of all PLWHA in the service area when they set service priorities.

4. Several members of the committee and planning body staff (previously assigned this responsibility) remind members of the previously completed data presentation to the entire planning council. They indicate that, as needed, they are prepared to review summary information on documented need-including the needs of individuals who know their status but are not in care-as well as service quality and outcomes and consumer preferences. All members have received handouts summarizing this information in narrative or chart form. Included is a chart showing the number of people with HIV and AIDS in the service area, by stage of illness. These data are presented by population group, location within the EMA/TGA, and risk factor, where available.

5. The committee reviews the HAB/DSS list and definitions of allowable service categories, including both core medical and support services. The committee reviews the list of prioritized service categories established last year.

6. The committee reviews the agreed-upon list of service categories, with reference to priorities established last year.

7. The committee discusses how best to meet each identified need, in terms of specific service interventions and the service categories through which they might be provided. Specific components or interventions are specified within service categories, populations and geographic areas of focus identified, and service categories added to the list where needed. To generate this information about needed services, the committee uses a "nominal group process," writing down individual lists, and then sharing their responses using a "round robin" process, until all contributions have been presented and recorded on an easel pad or whiteboard. Responses are clarified as needed. The group attempts to reach consensus around the scope and components of each service category and identifies areas of disagreement for presentation to the full planning body.

8. Committee members present their recommendations for service priorities through a structured discussion, with time limits enforced by the chair.

9. During the discussion, all committee members are expected to base their recommendations on the agreed-upon principles and criteria. If a recommendation violates the principles or does not reflect the criteria, other members take responsibility for pointing this out and challenging the member to meet these requirements.

10. Once the discussion period has been completed, the chair restates the principles and criteria to be used in decision making. Then each committee member is asked to individually rank the service categories, using prepared sheets.

11. Individual rankings are tabulated and an aggregate listing of service priorities is generated. The committee reviews these priorities and makes needed adjustments, by consensus in most cases, and by vote in two situations where consensus was not possible. Areas of disagreement are recorded for presentation to the full planning body.

12. The committee identifies Administrative Expenses (planning body support and program support) that are expected to require resources during the program year. Examples include: planning body staffing, an updated needs assessment to gather data about the needs of PLWHA who know their status but are not in care, an updated comprehensive plan, and evaluation of cost effectiveness and outcome effectiveness. A "nominal group process" is used to add to the list of possible Program Support activities. Then the committee conducts a preliminary vote to select the top three priorities. Activities not among the aggregate top three are listed as "low priority" but retained for full planning body review. Remaining activities are then ranked in priority order through a tabulation of individual committee member rankings, for presentation to the full planning body.

13. Selected committee members and/or staff document the process and recommendations for use in

the presentation to the planning body.

**A PLANNING BODY MEETING TO SET SERVICE PRIORITIES**

1. Prior to the meeting, the planning body receives the following:
   - Summary information on documented needs, consumer preferences, and service quality and outcomes, as part of the data presentation
   - A list of the agreed-upon decision-making principles and criteria, and
   - The committee's recommended service priorities, along with a summary documenting the process used, their rationale for adding or refining service categories, and any areas of serious disagreement.
2. At the beginning of the meeting, the chair addresses possible conflict-of-interest concerns by asking members to disclose any relationships with current and potential Ryan White HIV/AIDS Program service providers and indicate the cataeories of AIDS-related services these providers offer. All members indicate whether they have such conflicts. Several provider representatives also disclose that they are the only providers of certain services; they are asked to respond to questions about those services but not to serve as their primary advocates. All planning body members are permitted to participate in discussion, but those with a conflict of interest may not participate in any individual vote regarding the services category where they have a conflict of interest. They are permitted to vote on a slate of prioirities.
3. The chair reads the principles and criteria adopted to guide the priority-setting process and ensures that all members understand them. The chair also reminds the committee members that they are expected to represent the interests of all PLWHA in the service area when they set service priorities.
4. Committee representatives present the recommended list of service priorities, including specific components, populations, and geographic areas identified within service categories. Priorities are justified in the context of documented need (with special attention to historically underserved communities and the needs of individuals who know their status but are not in care), consumer preferences, and evaluation data. Areas of consensus and disagreement are identified.
5. Planning body members raise issues and concerns, and committee members justify their recommendations by explaining how they reflect the decision-making criteria and principles.
6. Planning body members suggest refinements to the priorities. They are asked to justify their recommendations through the agreed-upon criteria. Most changes are made by consensus.
7. Several areas remain where consensus is not possible, so the planning body members are asked to individually rank these possible service priorities using a scoring sheet. Results are tabulated, and the revised priorities are reviewed and further refined where necessary. The chair indicates that if one-third or more of members feel further refinement is needed, time-limited discussion will be permitted and members will be asked to vote on the ranking of specific categories about which there is no consensus. Because there is a high level of disagreement about the relative ranking of two service categories, voting is used for these service categories. The results of the vote generate a final list of service priorities, which is approved by consensus.
8. The planning body ensures adequate written documentation throughout the process, including specific notation of areas for possible improvement, such as missing or incomplete information. Follow-up discussion is planned to be sure that these needs are adequately recognized in the resource allocations process, to improve the amount and quality of information available for the following year's priority-setting process.

TOP

**10. Define the scope of the resource-allocation process**

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