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.

TOP

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.

TOP **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

TOP **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.

TOP **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.

TOP **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.

Checklist of Data/Information for Priority Setting and Resource Allocation			
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		

TOP

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.

TOP **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.

TOP

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.

TOP **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.

TOP **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

If the planning body is responsible for resource allocations as well as priority setting, as is the case for all Part A planning councils, it should now define the scope of this activity. The extent of the effort depends upon the planning body's scope of responsibility. Some planning bodies are responsible for allocating funds from multiple sources.

Step 1 identified typical outcomes for the priority-setting and resource-allocation task. The desired outcome of the resource-allocation process is typically a chart showing the percent and dollars to be allocated to each service category or subcategory. To reach this outcome, the resource-allocation process typically requires the following activities:

- Specify the sources and categories of funds to be allocated.
- Use the results of the priority-setting process to specify the service categories to which funds may be allocated (priority service categories and administrative expenses including planning body support and program support).
- Determine funding gaps for prioritized services by reviewing both last year's utilization data and the sources and amounts of funding allocated by other sources to support particular services. This will enable the planning body to determine if there is a funding gap to which it should respond (See Step #12 for methods for determining unmet service needs and funding gaps).
- Project the expected amount of funding (or minimum and maximum funding levels) from each source that must be allocated, based on the projected number of PLWHA to be served and the cost per client.
- Allocate a specific number of dollars to the service categories, ensuring that at least 75% of service dollars are allocated to core medical services and not more than 25% to approved support services.

Present the results of the resource allocations task in summary form. This might mean preparing a chart indicating service priorities and resource allocations to each of those services-in terms of dollars or percent of funds-with a separate column for each funding stream for which the planning body is responsible. The format for presenting the completed task might be as shown in the sample Priorities and Resource-Allocations Chart at the end of Step 13-if the planning body were allocating funds from a single source.

Generally, resource allocations will need to be completed before final figures are available on funding, since they are included in the application to HAB/DSS for funding. Therefore, allocations can be based on various funding assumptions or multiple "scenarios,", such as:

- Funding will be unchanged from the prior year
- Funding will be a specified percent—such as 5 percent or 10 percent—below the prior year, or
- Funding will be a specified percent—such as 5 percent or 10 percent—above the prior year.

Or allocations can be based on an expected minimum level of funding, with information about how additional funds will be allocated, as in the first scenario described in Step 13.

TOP **11. Agree on principles, criteria, decision-making process, and methods to be used in allocating funds to service categories**

Factors to use in resource allocation are usually similar to those used for priority setting, with some refinements. The principles and criteria used for priority setting should be modified as needed for use in the allocations process. If a committee is delegated responsibility for recommending resource allocations to the full planning body, the committee should recommend and the planning body should review and approve, these factors.

Regarding principles, the planning body might want to add the following, which reflect Ryan White legislative requirements:

- Ryan White will be considered the funder of last resort.
- Ryan White will not be able to meet all identified needs.

Regarding criteria, the planning body might want to add the following:

- **Lack of other funds.** Resources from other sources are not available to meet this service need.
- **Cost-benefit.** The service provides a high level of benefit for PLWHA relative to its cost.

Regarding the decision-making process, many issues need to be considered. If the planning body uses a committee process to set priorities, it can use the same committee to do the resource allocations, including the same attention to scheduling and publicizing meetings and ensuring public access. The complexity of the resource-allocation process makes especially important a committee process-supported by staff work and followed by review and decision making at a full planning body meeting. Often, the committee works closely with the grantee to develop estimates of the number of PLWHA likely to need each service and the costs involved. Sometimes the acutal allocations process is done by the full planning body, and the committee's responsiblities are to define theprocess and ensure that needed information is available to the planning body for decision making.

As with priority setting, the committee should recommend the process to the planning body, and the planning body should review and approve it. Many of the considerations are identical to those identified in Step 8; some additional considerations are described below.

ADDITIONAL ISSUES TO CONSIDER
IN DEFINING THE RESOURCE-ALLOCATION PROCESS

- **Baseline or Starting Point for Resource-allocation Decisions.** Several different starting points can be used for resource allocation decisions. For example:
    - **The planning body can use a "zero-based budgeting" approach,** which means that all allocations are determined without using last year's allocations as a starting point. If this approach is used, be sure to consider multi-year commitments and the content of your three-year comprehensive plan, as well as HAB/DSS requirements that 75% of service funds go to core services.
    - **Allocations from the previous year** can be used as a starting point, if you believe that last year's allocation process was sound.
    - **This is likely to be easier for most planning bodies.** It requires attention to changes in service priorities as established in Step 9, the extent to which the planning body feels it implemented a fair process, changes in the epidemic within the service area, information about service costs and unmet needs, and the availability of other funding streams to support priority service categories.
- **Processes or Formulas for Resource Allocations.** Many planning bodies find it helpful to use alternative scenarios or allocation formulas in resource allocation. Most often, the planning body first allocates funds assuming flat funding, then makes adjustments for once scenario assuming a specified percentage in additional funds, and one assuming reduced funding.
- **Decision-making Methods.** Methods such as consensus, nominal group process, and/or discussion and voting might be used in making decisions about resource allocations. This should be determined "up front."
- **Minimizing Conflict of Interest.** Both the committee and full planning body need to agree on how to manage and minimize conflict of interest in the resource-allocation process. The decision-making process may create temptations for members to advocate narrowly for the allocation of resources for the service interventions, populations, and/or geographic areas served by a member's agency, public or private, or to a member's own community. Members may also oppose funding to a particular category of service or population based on personal viewpoints. At a minimum, the committee and full planning body should require full disclosure of member relationships with funded R yan White service providers and the types of services they provide, and limitations on voting. Most planning bodies use the same procedures for both priority setting and resource allocations (see Step 8, above). [2]

TOP **12. Estimate needs by service category**

Thoughtful resource allocation depends upon information available on:

- The need and demand for specific services
- The costs of those services

  As explained in Step 7, some planning bodies consider service gaps in setting their priorities. If your planning body uses this approach, you may already have compiled this information by the time you begin the resource-allocation process. If so, make sure the materials described below are available for review as you determine resource allocations.
- The availability of other resources to support them

  Several of your analyses will require an inventory of the sources and levels of other governmental and nongovernmental resources available to support AIDS services in your community. Such information is also necessary to assess and, to the extent possible, quantify gaps in services. This inventory may be a part of your needs assessment.
- Capacity development needs of providers.

A planning body that has incomplete information on these topics can make best use of available information by compiling it in a summary format and examining it alongside the service priorities.

The planning body should gather available information by service category. If information is available only for some types of services, use what is available and identify information gaps. It is particularly helpful to prepare charts that list service priorities in order and provide information needed for the allocations process. Examples of particularly useful analyses and charts follow.

Prepare a comparison of the service priorities for the upcoming year with the priorities and allocations identified for the current year. The chart format might look like this:

Service Priorities Comparison				
Service Category	**Priority for Next Year**	**Priority for Current Year**	**Percent of Current Year's Allocation**	**Amount of Current Year's Allocation**
Outpatient/Ambulatory Medical Care	1	1	39.5	$1,020,000
AIDS Drug Assistance Program (ADAP treatments)	2	2	0	0
AIDS Pharmaceutical Assitance (local)	3	3	7.8	200,000
Oral Health Care	4	5	5.8	150,000
Medical Case Management	5	4	17.0	400,000

Obtain information on the units of service provided and the costs per unit of service or per client for the service categories or components within them. The most easily obtainable information might be the number of clients served in a year and the estimated costs per client per year. Your chart might look like this:

Services and Costs			
Service Category	**No. of Clients Served Per**	**Average Cost Per Client Per Year**	**Funding**

	Year		for Current Year
Outpatient/Ambulatory Medical Care City X County A County B	1,008 734 170 104	$1,012	$1,020,000
AIDS Drug Assistance Program (ADAP treatments)	0	0	0
AIDS Pharmaceutical Assitance (local)	360	$576	200,000
Oral Health Care	207	725	150,000
Medical Case Management	991	$444	440,000

\If available, provide a more extensive analysis of your most recent completed program year funding levels. For example, did funds for certain services (*e.g.*, oral h ealth care) run out before the end of the year, or were funds reallocated because of under-expenditure or low demand? Obtain the grantee's or administrative agent's projection of the unspent funds for each service category. If this information is available, make it a separate column on your chart.

Estimate current service gaps in terms of unmet service demand by priority. For example, given the current funding situation, estimate the number of PLWHA who are not receiving primary care, medical case management, etc., and are in need of such services. If possible, provide this information by service priority, and estimate the costs for meeting that need. Review unit costs for the past year, and modify as needed to project for next year. Use a format such as the following:

Service Gaps and Cost Estimates		
Service Gaps	**Estimated Number of Persons Needing But Not Receiving Service**	**Estimated Additional Cost of Meeting Need (Above Current Funding)**
AIDS Pharmaceutical Assitance (local)	125	$72,000
Substance Abuse Treatment – women-focused	85	$97,155
Medical Case Management–Family-Centered; for Spanish-speaking clients	55	$24,420
Ambulatory Medical Care in Outlying County X	80	$80,960
[List other unmet service needs or service gaps]		

Prepare a combined chart of estimated total needs by service priority, both met and unmet, and available funding. Using the format shown in the chart below, include the following:

- Service priorities, including specific components like subpopulations and geographic area needs (Column 1).
- Total need (including met and unmet need), in terms of either number of clients or service units (as shown in Column 2).
- Average cost per client estimated for the next year (Column 3).
- Total funds required to meet the need (Column 4).
- Identification of other available funds to meet service needs, by service priority, or (if dollar amounts are not available) the number of individuals served (Column 5).
- The level of gaps in service by needs category (Column 6), which is the difference between total funds required to meet the need (Column 4) and other available funds (Column 5) — or the total number of clients not served by other sources (Column 2 minus Column 5) multiplied by the Part A cost per client (Column 3).

The chart might look like the following:

Estimated Service Needs					
1 Service Priority	**2 Total Need Per Year (Number of Clients)**	**3 Average Cost Per Client Per Year**	**4 Total Funds Required to Meet Need**	**5 Other Available Funds/Clients Served**	**6 Unmet Need or Service Gap**
Ambulatory Medical Care	2,100	$1,040	$2,124,000	1,052 clients - Medicaid	$1,089,920
AIDS Drug Assistance Program (ADAP)	1,450	$11,344	$16,550,896	$16,550,896 - Part B	$0
AIDS Pharmaceutical Assitance (local)	471	$576	$271,296	0	$271,296
Oral Health Care	622	$725	$450,950	300 clients seved through Medicaid, local dental clinics	$233,450
Medical Case Management	1,546	$444	$686,424	396 clients - Part C and D grantees	$510,600
Emergency Financial Assistance (Housing)	420	$796	$334,320	$38,000	$296,320
Food and Nutrition Services					
Home-Delivered Meals	80	$1,620	$129,600	$75,000 - State funds	$54,600
Food Pantry/Food Bank	350	$582	$203,799	$155,000	$48,799
Food Vouchers	200	$160	32,000	$5,000	27,000
[List other service categories]					

Once you have prepared this information for all prioritized service categories, you are ready to carry out your agreed-upon resource-allocation process.

TOP **13. Allocate resources to service categories**

To allocate resources to the established priorities, you will need to agree upon and review the principles, criteria, and processes described in Step 11, and to develop and review the information described in Step 12. The allocations process might then proceed to the development of alternative scenarios or funding formulas. Most planning bodies allocate funds based on three different funding scenarios:

- Flat funding (same amount as prior year)
- Increased funding (a specified percentage increase, such as 5%)
- Decreased funding (a specified percentage decrease, such as 5%)

Based on the Step 12 information charts, you can develop alternative scenarios or allocation formulas for the committee's and full planning body's review. Following are four possible resource-allocation scenarios:

Sample Approaches for Resource Allocations

Approach #1

Divide priorities into tiers of services and other activities, as follows:

- First-tier categories that are considered "core" or "essential" services, including the most important core services and the most important support services
- Second-tier priorities that should be funded if funds permit, and
- Third-tier categories that should not receive funding this year, unless the program receives a funding increase.

Start by using Approach #1 (the flat funding scenario). First allocate the funds needed to ensure continuation of first-tier services for the same number of clients as the current year, if continued funding is needed. Once these"essential" services have received needed funding, allocate a specified proportion of additional expected funds (*e.g.*, 60 percent) to second-tier service categories, deciding on amounts per category based on number of clients to be served and costs per client. Divide funds among categories based on your priorities and needs assessment results. Use the remaining funds to expand funding for first-tier categories towards the estimated total need. When you use the second (increased funding scenario, first increase first-tier service categories to fill identified service gaps, then allocate funds to the second-tier services using the same allocations procedure as before.See how much money is left, and decide which, if any, of the third-tier categories to fund. When you use the third (decreased funding) scenario, consider which second-tier categories you may want to zero-fund in order to maintain essential services.

Approach #2

Using the first (flat funding) approach, decide which services are most important — perhaps your first 5-7 categories), and begin by allocating full needed funding to those categories. Determine how much funding remains, and allocate it to other prioritized services based on the number of people you need to serve in each service category and the cost per client per year. Under this scenario, you will profvide most of your funding to the service categories you define as "essential," and therefore will fund fewer service categories. Under the increased funding secnario, you will add service categories to the funding list. Under the decreased funding scenario, you will eliminate additional categories.

Approach #3

Continue to fund at the same level those services with high priority rankings, or those identified in the continuum of care as essential to life or essential to providing access to care. Cut other services by a specified percent (*e.g.*, 21 percent). Use the pool of funds created by the cuts to fund new priorities or unmet components of high-priority service categories (*e.g.*, substance abuse treatment services for women, medical case management services for Spanish-speaking PLWHA, ambulatory medical care in an outlying county). If the funding level is higher than expected, a set percentage of increased funds might go to new services, high-priority existing services, and lower-priority existing services. If the funding level is lower, a set percentage in cuts might be applied across all services.

Approach #4

Divide services into tiers as in Scenario #1. Continue to fund existing services in first and second tier, but decrease funding levels for second-tier services. Base these reductions on a careful review to identify services that are lower in priority, level of unmet need, and/or availability of other resources. Make sufficient cuts to generate a pool of $X dollars to allocate to new service priorities and to increase allocations to specific high-priority services that have high levels of unmet need and low availability of other resources.

In any scenario or approach, because the planning body does not consider resource availability in the priority-setting process, the highest-priority services within the EMA/TGA are not always the services that receive the largest allocations. The highest-priority services may cost less than other services and/or other Ryan White or non-Ryan White resources may be available to fund them. [3] A planning body might, for example, identify outpatient primary health care as its top service priority, but allocate little Part A funding to the service category if funds were available from other sources such as Medicaid and local programs for the uninsured. Similarly, a service category that was relatively lower priority but was not funded through other available funding streams might be allocated a large proportion of Ryan White funds. This approach to priority setting and resource allocation has the advantage that it applies regardless of changes in other funding streams. For example, if severe cuts were to occur in funding for outpatient primary health care, the planning body might want to reallocate some of its resources, but would not need to change its priorities. Similarly, if the demand for medications grew beyond the Part B State ADAP's capacity to meet it, a planning body might choose to allocate additional funds for ADAP rather than other services.

Resource allocations are finalized at a full planning body meeting. As with the draft service priorities, the committee presents and justifies recommended resource allocations — or presents the three funding-level scenaros and lets the planning body do the allocations — at an open meeting. Principles, criteria, needs and resource data, and the selected scenarios and approach are also presented and discussed. The full planning body reviews the entire process and either does the allocations using the process specified or reviews the recommended allocations from the committee and suggests modifications if needed, based on the criteria and the needs and resource information. The planning body either reaches consensus on the resource allocations, or adopts them through a formal vote.

Staff document the resource-allocation process along with the priority-setting process and results (See Step 1 for a sample format for documentation). Once this process is completed, the

These priority-setting and resource-allocation decisions are reported to the community. The planning body publicizes its decisions through public hearings or meetings in several locations. Since the allocations are likely to be refined after the Part A award is made and the precise funding level is known, some Part A programs wait to present their allocations until after they have been finalized.

TOP **14. Provide decisions to the grantee for use in procurement**

The planning body must provide the grantee or administrative agent with the results of the priority-setting and resource-allocation process, both to include in the Part A application and as a basis for the selection of providers (the procurement process). The planning body's priorities and accompanying directives on how best to meet the priorities will reflect specific population groups, geographic areas, and service delivery mechanisms. In a Part A program, the grantee handles procurement. The planning council must not be involved in the selection of providers.

TOP **15. Identify areas of uncertainty and needed improvement**

Once the entire process has been completed for the year, the committee and the full planning body should review the experience and identify ways to improve the process in future years. A designated group should:

- Identify missing or incomplete information that affected decision making, with emphasis on new legislative requirements or guidelines
- Consider how the allocations for non-service activities, as well as other initiatives that may not involve additional funds, could improve the amount and quality of information "inputs" for the following year
- Review the decision-making process for weaknesses or problems and seek solutions, with special attention to any aspects of the process that might make the planning body vulnerable to a grievance
- Review how conflict of interest was managed, and whether additional efforts are required, and
- Make recommendations and plans for improvement, then assign responsibility for follow up to be sure they are carried out.