CONDUCTING RWHAP PART A PLANNING COUNCIL/PLANNING BODY PRIORITY SETTING AND RESOURCE ALLOCATION (PSRA)

July 17, 2018 Webinar

Michelle Vatalaro: Hello everyone and welcome to today's webinar: Connecting Ryan White HIV/AIDS Program Part A Planning Council and Planning Body Priority Setting and Resource Allocation, also known as PSRA. My name is Michelle Vatalaro, and I'm the training technical coordinator for the Planning CHATT project.

Before we get started, I just want to give you some technical details. First, attendees are in listen-only mode, but we encourage you to communicate with each other and ask a lot of questions both of us and of each other in the chat box. You can submit your questions at any time during the call, or during the question period at the end. Our wonderful presenters along with the Planning CHATT staff will take as many of your questions as we can at the end of today's session. And if you think of a question after the webinar, that's fine too. You can always email questions to us at planningCHATT@jsi.com. I'm pleased to see that people are already using the chat.

And so, the easiest way to listen to our webinar is through your computer. If you can't hear us very well, make sure to check that your computer audio is turned. If you still can't hear us, or if you experience sound delay at some point, try refreshing your screen. Finally, if you need to, you can mute your computer audio and call using a telephone at the number that you see on your screen. You'll need to use a passcode, which is also listed on the screen, and we'll put this information in the chat box as well so that you have it there.

So let's quickly go through our agenda for the day. We're going to start off with some introductions, and then we'll move into our conversation about how to conduct PSRA. From there, we'll provide answers to the questions that you chatted in throughout the webinar. Any questions we don't have time to answer will be made available to you in a Q&A document, a question-answer document, after the webinar, and then we'll go from there.

So please, let me start by introducing our HRSA colleagues: Steven Young, the director of the Division of Metropolitan HIV/AIDS Program in the HIV/AIDs Bureau HRSA. Lennwood Green is a Project Officer at the Divisional of

Metropolitan HIV/AIDS program in the HIV/AIDs Bureau HRSA. Thank you both for your support of the Planning CHATT project, and of the Ryan White HIV/AIDS Program Part A planning councils and planning bodies. At this time I'd like to invite them to say a few words.

Steven Young: Sure. Lennie, do you want to go first, or would you like me to?

Lennwood Green: No, I just wanted to say good afternoon and welcome everyone, and we look forward to your participation.

Steven Young: Great. I'd like to welcome everyone as well in advance, thank our colleagues at JSI, and the local presentations that we're going to hear today. It's very exciting for us to be able to roll out this information to everyone, and thank you all for participating. You know the critical importance that our Part A planning councils and bodies serve. This particular topic, priority setting and resource allocation, though the concept of community planning has a rich history, this is one that's really unique to federal programs, and the groups that you all serve on are certainly more than advisory and actually take up information and data and turn it into identifying priorities to fill the gaps in the services needs that people living with HIV have. So we're really excited about the presentation and the topic today. Thank you.

Michelle Vatalaro: Okay. Thank you so much for that. I know that some people who are trying to call in are struggling with the conference line. I'm just going to introduce and talk a little bit about Planning CHATT while everybody gets logged on to the phone line.

Our project, the Planning CHATT project, is tasked with providing technical assistance and training to build the capacity of Ryan White HIV/AIDS program Part A planning councils and bodies across the United States. Our goal in doing this training and technical assistance is to help planning councils and planning bodies meet legislative requirements to strengthen consumer engagements on the planning councils and planning bodies, and increase the involvement of community providers in HIV service delivery planning.

And so, now I'm going to introduce our webinar presenters for today, and call out some other special helpful people. My name is Michele Vatalaro, like I said. I'm the person on the top left. Also, here you'll hear from Emily Gantz-McKay and Hila Berl, who are from EGM Consulting. They're going to be limiting our chat, and will be answering some questions in there as we go, and helping us with our question and answer process.

Presenters who will be speaking to you today are: Alison Frye, Amanda Hurley, Sandra Vincent, and Trevor Pearson. So, let me tell you about them. Starting with Alison Frye. She has served on the Portland area HIV services planning council for 14 years including nine years as a co-chair. Her public health career stands two decades including more than 12 experience working with underserved populations in HIV care and prevention services both providing direct service as well as program administration.

She started working in HIV because of her interest in public health and its connection to social justice. She currently does grant and program development for the Multnomah County Health Department, and has a masters at Public Health from Portland State University. With her in Oregon in Portland is Amanda Hurley who joined the Portland Oregon TGA grantee team in October of 2014, and is currently the manager of HIV Care Services. Prior to working at Multnomah County, she worked at the Cascade AIDS Project, the largest and oldest HIV service organization in Oregon as a director of housing and support services. Amanda has worked in the HIV service field for 13 years, and in housing homeless services for 15 years. She has a masters of science and family studies and human services from Kansas State University.

And then, we also have with us Sandra Vincent, who is the project officer for the Metropolitan Atlanta HIV Health Services Planning Council, where she's worked for the past 12 years. In addition to Ryan White, Sandra has over 20 years of experience managing various federal programs including home and CDBG. In 2017, Sandra worked with JSI consultants to develop the new target center compendium of materials designed to help planning council support staff facilitate the work of Ryan White HIV/AIDS program Part A planning councils and planning bodies. She is a strong advocate for the continued support of planning councils in the implementation of the Ryan White Part A program.

Last but certainly not least, we have Trevor Pearson, who serves as the chair of the Metropolitan Atlanta HIV Health Services Planning Council. He's worked in the media, teaching and business development fields. Trevor holds a master's from Columbia University, a Bachelor's from City College, and has completed course work towards a master's degree in business administration from Borough College all in New York city.

So thank you all so much for joining us today, and we're looking forward to hearing from you. At this point, I'm going to turn it over to Sandra Vincent, who is going to start us off by talking about what priority setting and resource allocation are.

Sandra Vincent: Greetings everyone, and thanks again for joining us today. The timing of planning councils and planning council's report is critical to the success and sustainability of Ryan White Part A planning councils and planning bodies. We're extremely excited about today's webinar. That brings us to the question of the hour which is, what is priority setting and resource allocation, also known as PSRA?

PSRA is the annual determination of service priorities and related fund allocations, as well as the timely direction to the administrative agency, also known as the recipient, on the best ways in which to provide those services. Section 2602B14 of the Public Health Act states that Ryan White Part A planning councils or planning bodies are required to establish priorities for the allocation of fund within the eligible area, including how to best submit each priority, and additional factors that a recipient should consider in allocating funds under a grant based on size and demographics of the population, demonstrated a probable course effectiveness, priorities of the communities with HIV/AIDs, coordination and the provision of services, and availability of other governmental and non-governmental resources.

The priority setting and resource allocation process includes four components. They are: priority setting, directives, resource allocation, and reallocation. The single task of PSRA is the most important decision making process of any planning body, and should rely heavily on data. Data is the equalizer, and it helps to eliminate the use of the impartial please or anecdotal information, which may sometimes overshadow the true documentable needs of the jurisdiction.

Priority setting is the process of deciding which HIV/AIDS services are the most important according to the criteria your EMA or TGA has established. In setting priority, the planning council should consider what service categories are needed to provide a comprehensive system of care for people living with HIV in the EMA or TGA. The planning council must prioritize only service categories that included in the Ryan White HIV/AIDS program legislation as core medical services or support services. These are also the same service categories that can be funded by Ryan White HAB Part B, and Ryan White HAB Part C programs. There is another component that's a part of our PSRA process called directors and I'll now refer to my colleague, Trevor, who will discuss directives.

Trevor Pearson: Directives provide recipients with a road map of how the planning council expects its staff to satisfy the needs of people living with HIV. The planning council and planning body can recommend whether it wants to start a specific

service, or a specific population based on the data reviewed. For example, in Atlanta, data of central CAREWare provided by recipients show that there were instances of a time lapse of more than 30 days between someone being diagnosed, and receiving medical care.

A few years ago, the priorities committee recommended that there will be a program called Rapid Entry in which a person living with HIV will see a medical provider within 72 hours of diagnosis. This recipient then had to develop an RSP, the specifications relevant to this population. After a year, the priorities committee then full planning council review the program, and determine that this should become a standard of care for this community. Additional Atlanta directives are available later in the presentation.

Resource allocation does not mean procurement or deciding how much funds any agency will receive, or which agencies will receive money. Planning councils and planning bodies are strictly private from involvement in the selection of particular entities to receive Ryan White Part A funding. As stated in section 2602 (b)(5)(a), "Selection of those entities is the responsibility of the Ryan White HAB Part A recipient, and the planning council may not designate, or otherwise be involved in the selection of particular entities as recipients of any amounts provided in the grant."

Sandra Vincent: Planning council should consciously link its needs assessment, and integrated planning with priority setting so that the planning council, or planning body has the information needed to make sound decisions about service priorities, and use of resources. It is important to know that since 2006, the Ryan White legislation has stipulated that not less than 75% of service dollars are to be used for core medical services. There are some jurisdictions which, for various reasons, are not able to meet the 75, 25% goal. And in those instances, a request for waiver to HRSA should be made at the time in which the grant application is submitted.

Reallocation is the process of moving program funds across service categories after the initial allocations are made. The final award may be higher or lower than what was requested in the grant application. The planning council must then make reallocation. Remember, the planning council or planning body is only involved in moving funds from one service category to another. The recipient does not consult planning council or planning body if funds are moved within service category. A good way to look at this process is to think about making budget amendment.

Michelle Vatalaro: Great. At this point, I want to stop, pause for a second, and get everybody clicking around and doing some things. Tell me a little bit about what you just heard. True or false, resource allocation is the same thing as procurements. Right. I'm seeing that 98% of you are correct that resource allocation is not the same thing as procurement. They're different, and they should be different. Good thing people are responding in the chat. That's great. All right. Okay. Trevor, do you want to talk to us now about the steps in the PSRA process?

Trevor Pearson: Thank you very much. Yes. Each planning council or planning body has to set the needs of its consumers, and at such the PSRA process has to be a deliberate attempt to satisfy the needs of those that are already being served, as well as those who are not already in tier. Due to this delivery process, some of the steps in the following slides may be helpful in your discussion, and final motions and/or actions that are made in your communities.

The planning council/planning body takes the lead in developing and carrying out a need assessment too, which will be useful in the PSRA process. However, it must be a joint effort between the planning council/planning body and the recipient. This does not mean that the process will be incomplete without a yearly needs assessment tool as it is usually too expensive and too cumbersome to carry out this practice every year. Remember that you can also use data from surveys or focus groups.

However, there should be at a minimum data such as the groups of individuals who are people living with HIV, and estimate the numbers and characteristics of community members with gaps and services on met needs such as housing, and those who are unaware of their status. What are some of the barriers they face to access and stay and care, the types of additional resources that are available to them, and the numbers of service providers, and their capability and capacity?

There is no right ways to set priorities and allocate resources. Remember each planning council/planning body has different populations that it serves. As a result, there are different ways of ensuring that people living with HIV are provided with the services that they most need to help them to be healthy in mind, as well as in body.

Before the PSRA process begins, ensure that each person knows his or her role as agreed upon previously. The following three slides can be extremely helpful as you go through this process. Determinant obtain available information or input such as a comprehensive plan, needs assessment, client utilization data,

and performance and outcome data. Review core medical and support service categories including HRSA service definition. Agree in the principles criteria and decision making process could be used in priority setting. Implement the process, set service priorities including how best to meet them.

Agree on principles criteria, decision making process, and methods to be used in allocating funds to prioritize service categories. Review data, estimate the needs and cost by service category, allocate resources for service categories, provide directives to the Part A recipient on how to best meet the priorities. Identify areas of absurdity and needed improvement, reallocate funds across service categories when the award arrives, and later in the year as needed. Finally, you can schedule a review of the process within a month after implementation, and identify changes needed for the next year.

Michelle Vatalaro: Thank you so much, Trevor. At this point, I'm going to hand it over to our presenters from Portland, who are going to talk about data for decision making.

Alison Frye: Good morning or afternoon everyone. This is Alison Frye. I'm going to start us off by, like Michelle said, talk about how we use data decision making. As Trevor went over a little bit, needs assessment findings are a big part of what we use to support the decisions we make. In Portland, some of the things we can focus on are plant satisfaction surveys. We use our medical modeling project data, which I realize that not every jurisdiction has, but it's a big thing that we use and it's a large samples clients.

We use our epidemiological trend data. We tend to bring a lot of key informants in for interviews. And this mostly includes providers of different services, but sometimes we include consumers as well. Just some other examples of data resources could include focus groups either with client providers, or case manager, other provider surveys just depending on the things that you have access to in your jurisdiction.

The next two data points I'm going to combine as I talk about them. First I was going to focus on the service cost and utilization data. One thing we've developed here in the Portland TGA, and Amanda will describe this in detail later, we found that this tool has been really helpful for planning council members to really reveal the utilization and cost data, and we call these scorecards. We look at average cost per client for each service.

Also, things that we look at are how we can maybe implement lower cost inner ventures such as peers and navigators so that different type providers can work for top of their qualifications, and also just as a note, we really value these

services of the support clients not just because they're really cost interventions, but we do a value of a unique perspectives that these types of workers can bring to supporting clients.

We also look at, in addition to the needs and gaps, priorities of people who'll use services. So, we use ... Here like I said medical monitoring project, we used to do our needs and gaps analysis, but we generally turned to our medical monitoring project data to look at the services that clients say they need, and then the ones they can't get. We also do focus groups and surveys, and then also consider public testimony as a way to validate some of the things that data are telling us.

Some other things that we use to support our decisions is how as to how we're going to allocate Ryan White Part A funds are the amount of funds provided by other sources. So, this can include: Medicaid, Medicare, state and local government funds, private funders, [inaudible 00:23:37] Ryan White. I think someone already mentioned this as a pair of last resort. So, we really look to where we can leverage other resources to support our services.

And then finally, I guess I said this already, but a good example of how we use Ryan White funds to work with other services like prevention service treatment would be as how we use [HAPO Fund 00:24:06], for example, to pay rent subsidies as well. Ryan White Part A services focuses on the staffing STE to provide the support for people in those housing units. So, we really try to coordinate with other folks that are supporting services provided to people living with HIV in our jurisdiction so we can really create a coordinating system of care.

Amanda Hurley: Okay. As Alison was discussing, we really have to rely on other leverage resources. So we do have a small list here, but by no means this is an exhaustive list of resources that we want to leverage. We do want to ensure that we're not duplicating services, and that we're collaborating across other systems of care. In particular, we often get information about, or we have additional resources from the Ryan White Part B, C, D, and F. Specifically, we actually received some program income from our Part B program, which helps provide enhance services within our TGA.

We also work very closely with our housing continuum care. That would include: working closely with our helpless system, we have access to shelter plus care vouchers, and then also working with other state and local housing funds to ensure that Ryan White clients are able to access housing.

SAMSA is another example of leverage resource to be aware of. And then also when we think about Medicaid and Medicare, we have to consider some of the limitations of the coverage, and how we can use Ryan White to help offset some of those limitations.

We often work within treatment ... look at treatment services. And as Alison was discussing, we do use ... We use treatment services to leverage both beds within home based recovery models in addition to actually paying for treatment. And then within our state, our state funds application assistance, which help ensure people living with HIV have access to insurance. And so then of course we can ensure that Ryan White offer the last resort.

And so, within our council, we want to ensure that we bring in panels of experts to present data and present their systems of care at our planning council meetings, or we want to have them as representatives within our council.

Michelle Vatalaro: Great, thank you. Now we're going to stop pause for a minute for another knowledge check. Which of the following should be considered in the decision making process? Needs assessment finding, service cost and utilization data, the priorities of people living with HIV, the amounts of other funding available, and Part A funds used to work with other service providers? Check if all apply. Whichever you think apply here let's see. Your answers are coming in fast and furious.

A few more seconds because I'm seeing that everybody is doing really well here because all of these factors that are up here should be used in the decision making process, which is really great, and it's good to see that everybody is thinking about all of these different factors that we're considering during our processes. And so, at this point, I'm going to head it back to Alison who is going to talk a little bit for just a moment before we move into some case studies.

Alison Frye: One thing that we wanted to just recognize is we realize that depending on your size of jurisdiction, folks may have a different level of funding that supports their planning council. For example, here in Portland we only have part-time planning council staff support, whereas some other bigger areas that are mainly EMAs might have a full-time planning council staff. So I think that's really important to consider when you develop the way you're going to do your PSRA, and how you really make the most of the staffing support that you have.

That's just something I wanted to acknowledge because I think that some people that are listening might think, "Oh, wow, I'm never going to be able to do

all that because we don't have in our staffing." I think there are creative ways you can look at that.

Michelle Vatalaro: Thanks so much for that. I think that's a really important point, and we're glad that it's being made. I'm seeing in my room a lot of heads nodding, so I'm glad that we're making that point known. At this point I'm going to hand it over to Sandra who is going to talk about the priority setting and resource allocation process in Atlanta.

Sandra Vincent: As Alison indicated, there are differences between the various planning councils in relation to size and planning council support. In the Atlanta EMA, we have almost 150 members of which more than 53% are persons living with HIV/AIDS. This representation makes it easy to engage non-align individuals living with HIV, and the practice follows closely the Denver principle of nothing about us without us, which is used to communicate the idea that no policy should be decided by any representative without the full indirect participation of members of the group affected by the policy.

In Atlanta, the planning council bylaws requires that the committee shall be comprised of only non-aligned members of the planning council. Non-aligned is defined as someone who is not an employee, consulting, or a board member of the Ryan White Part A fund service provider.

Atlanta's priorities committee is structured this way to allow for maximum consumer representation, and to ensure the conflict of interest is avoided during the initial PSRA process. While committee members request to be placed on the priorities committee to the greatest extent possible, efforts are made to ensure a reflective and diverse committee based on age, race, gender, and sexual orientation.

The Atlanta priorities process typically lasts for three days. Day one is an orientation of the process. Because we see the new planning council annually, some of our members are returning and others are new. So it's important for the planning council support staff to ensure that everyone has a clear understanding, and is prepared for the work ahead.

On occasion, some individuals may be unable to make the orientation, so staff provide one-on-one, or a small group of orientation for those individuals. On day one, the planning council support staff goes over the entire process. The Ryan White planning council's video, which many of you were familiar with you make the difference, we found to be very helpful in connecting the priorities process with the other work of the planning council.

We also review the prior year's allocation, and the recipient reports of snapshots of where our services are within the EMA. This is an important element within the process as it allows members to ask questions of the recipients, which may have originated from some of the data reports. PC staff reviews conflict of interest provisions, and all materials included in the PSRA package including the Ryan White Part A legislation.

Day two is all things data. On the second day, we have various committees, like the assessment committee, which manages the needs assessment and other data elements, the comprehensive plan committee, consumer coccus, et cetera to present any data specific information that they feel needs to be highlighted in the decision making process.

Also on this day, members from the community have an opportunity to present as well as the state department of public health, possible grantee, EFY, and other entities. It is important to note that agencies are not allowed to present, but data regarding core and support services are allowed. In order to maximize the review of data, the entire planning council is provided the various information in advance. All questions are welcome from both the committee members, the PC members, and the audience.

Planning in and of itself is a continuum. So in addition to data, it is important to review those key planning documents like the grant application, the needs assessment, and the integrated plan. All of these elements should agree and support the goals and objectives which have already been established. It is not worthy to mention that on occasion there are emerging trends which may not be reflected as a priority in prior established goals and objectives. In this case, careful consideration of the data being presented along with the appropriate justification is needed.

Day three is the combination of the process. Special effort would have been taken on day two to answer any questions, or prepare any additional requested materials needed for deliberation. Staff in conjunction with the Ryan White Part A recipients work hard to provide the needed data, but occasionally the committee may request trends, forecast, or other information stratified differently than originally presented. The goal in presenting data is always to make it user friendly by producing information in its clear, clearer, and clearest form. What this means is if there is a question, or a request for information being presented in a different way, it is the responsibility of staff to ensure that that information is available for the members of the committee.

Day three starts with a roll call of committee members, and self at station of their online status, a court reporter is procured to capture the meetings, and motions, and seconds are made within the deliberation process. First day is a review of all HRSA fundable core and support services. The decision is made to add or delete from currently funded service categories. And on occasion, some categories no longer necessitate funding as it was Atlanta's experience where we no longer have a need to fund hospice due to better health outcome.

After the categories are decided upon, the committee writes the services. A noble mention of the fact of categories may not, and do not, have to have a corresponding funding amount. Even though an area may be ranked at a particular level does not mean that the funding amount has to be come into risk. Housing is the good example of this. State decent and sanitary housing is extremely important, and affordable housing continues to be a challenge within the Atlanta EMA. However, due to the city of Atlanta being a recipient to HOPWA Funds, Ryan White, as a planning council, has elected not to fund housing.

The next step in the PSRA process is the allocation of funds per service category. This starts with an assessment of where we currently are, and progresses based on the stated need within the data process. The group works towards consensus utilizing Robert's Rules of Order within the voting framework. The committee chair navigates us master spreadsheet, which the group views, and uses to make adjustments scenarios, and to record the committee's action. This spreadsheet is visible by all parties in attendance.

After the funding allocations are made, the committee establishes funding ranging scenarios, which are used in the event of a funding at a greater or lesser amount. Trevor will speak more about this later. The committee outcome is then forwarded to the executive committee, and subsequently forwarded it to the planning council for an upper down vote. This practice was adopted in an effort to eliminate the potential for conflict of interest as the Atlanta EMA is comprised of a number of agencies as well.

After full view of the motions and supporting data, the planning council deliberates both the motion upper down, and in the event that there is a concern or a problem in terms of the recommendations which have been made. The committee will then reconvene for the purpose of further discussing the outcome of the planning council meeting.

Trevor Pearson: Thanks, Sandra. In your current slide, you'll note that there are five examples of directives that were given last year. I'm going to focus primarily on medical transportation. And because Georgia is such an expansive place, and many of our consumers have concerns about getting to their appointments, what we have done is to provide greater access to care by funding additional forms of medical transportation such as our market card, which is the name of our original transportation system, other right sharing cards, right sharing opportunities as well as gas card.

As Sandra was mentioning in our priorities meeting on the third day, we wanted to give you some figures. The Atlanta planning also actually receives about $25 million each year in Ryan White Part A funds. Since 2011, there has never been a year in which the PC received less than requested. As a result, if you look at this slide, we have focused primarily on ensuring that any additional funds received can be spent in a timely manner. Therefore, allocations which were shown for last year and [inaudible 00:40:09] the priorities committee treaty meeting, and the provide for planning council are made in the form of budget revision.

As Sandra has already said, preliminary work is performed by the priorities committee. All planning council members are requested to attend and participate in the treaty priorities committee meetings. Work done in the committee should be an open process where all documents are available to participants, and where questions are welcome. Only members of the priorities committee can make motions at this stage. All priority committee member motions are then presented in the executive committee, which is made up of the PC chair, first vice chair, second vice chair, and chair of the nine standing committees.

Michelle Vatalaro: Thank you so much to both of you for sharing all data Atlanta PSRA process. It's really insightful and we're glad to have that experience. So now we're going to switch from Atlanta EMA to a case study from Portland, Oregon's TGA. And so at this point I'll hand it over to Amanda.

Amanda Hurley: Yes, hello again. We wanted to start this case study presentation with a graphic that we designed. We use this throughout the year to update the planning council, or let the planning council know where they're at within their planning process. And so, the graphic itself it shows all the various presentations, all the data that's used, and when it's presented throughout the year. I definitely understand that you probably can't see the writing on this graphic. We're definitely happy to share that out with anyone who might want a copy of it.

And so, we do update this annually. As you can see, our planning council meetings in our operation's meetings occur every other month on opposite months. I did highlight the all-day planning process, or planning day that we have, which just occurred last Friday. And then some of our planning process happens throughout the year, and not just on the four-day planning days, and which I'll go into a little more details on the next slide.

Alison Frye: Good afternoon again. Just a note Amanda just mentioned something called the operations committee, which is a term that we use here that people might not be familiar with, and that's just our executive committee. As a note to what I was saying earlier about jurisdictions with different resources to support the planning council, years ago we made a move to really reduce the number of meetings and number of committees that we have throughout the year so that we could save money when a mention of funds were reduced.

We don't like Atlanta to have a bunch of committees that do this. We do most of our work as a full council, and some things occur as operations committee, but not our party setting and resource allocation. As a note to that, this slide is about our priority setting process. We do that separately from our resource allocation process. As just our founder was saying just because something receives number one priority doesn't necessarily mean they received the most amount of funds.

We generally review our priorities from year before, then we review data from this year or the previous year to see if our priorities should be changed. We don't do an extensive prioritization process. We mostly focus on our resource allocation process. So, if you want to move to the next slide.

Sort of how our resource allocation process works here is we do our initial resource allocation during our full day retreat, which we just had as Amanda referenced. How we do that is we start by reviewing public testimony and highlights throughout the year so that people remember all the data, and all the information that we've received throughout the year when they go into their decision making.

We have people declare that conflict of interest prior to allocation. As I referenced before, our planning council used to do resource allocation, and one committee made up of just a few people that didn't have conflicts. We found that really it was a really narrow process, and we wanted to expand that to get more input how dollars should be spent.

We also, like I was saying before, we use data for decision making for just client demographics and outcomes and service utilization. In Portland one thing that we've done that makes it fun is we have several skits or interactive activities about how to use data. So if people are interested in the scripts for any of those, we are happy to share those out just to give you ideas of any activities that you might want to implement in your area.

What we do is the starting to the actual allocations is we break into small groups who all have an Excel spreadsheet where they can move funds around. In the past, the Part A recipient has to present sample scenarios based on trends. We did not actually do that this year. We just had ... We gave a guideline on how much money we thought would be a good place to start as far as putting our grant proposal together. And then folks decided based on the data where to put additional dollars.

Then we reconvene as a large group, and we go through a presentation of each group scenario, and then we use ... Here we moved as opposed to Robert's rules, we move several years ago to a consensus making decision model, which work pretty well for us. We do have people abstain from voting if they a conflict for whatever part we're voting on. I think that's it for my part.

Amanda Hurley: Yes, we want to move to this slide. This is an example of our scorecard, and this is where we try to showcase our service cost in utilization. We present this annually. It's two-sided. We do a condensed scorecard at the medial point just to show progress and how we're doing as a grantee. So, the first section it shows what our initial allocation was, was there additional money reallocated there, did we put any carryover funds, and then the final allocation at the year end.

The second section is a trend of our allocation and expenditures. You can easily see through the graphic how closely aligned we are with expenditures compared to the actual allocation. Then the third section is our performance. We generally list a number of clients served, and then number of service units, and service units can vary based on visits, or hours, or context depending on the various service. I should say that we do a scorecard for every service category that we fund throughout the year.

On the second page of the scorecard, if you want to advance to the next slide. On the second page is our outcome section. Every service has various outcomes that we're monitoring. Generally, it's around medical engagement and viral suppression, although sometimes there may be some unique outcomes based

on the scorecard. And then our section five. This is where we compare the clients that receive Ryan White services, to the people living with HIV in the Portland TGA. And if there's any kind of significant difference, we do try to call that out in the graphic, and make sure that the planning council is aware of any major differences.

And then the final section six, this is where we add any comments from the grantees. This could be any caveats to consider, any leverage resources that we want to make sure we know, or if there's any major trends that just may be spending a little lower, or maybe service utilization was lower than expected. We might have some explanation that we would want to include on the scorecard. Now we move on to our contingency planning practice, which Alison will discuss.

Alison Frye: So, like I talked before, our all-day retreat we really focus on approving the amount of funding that we ask for in our grant application based on our needs in the TGA. So we do not do contingency planning at this time. At that time, we agree on philosophy about where we think additional dollars should go. And then two additional meetings in the fall are focused on what we do in the case that we get flat funding up to a 5% decrease, or any kind of increase that's zero to 5%, so not as much we ask for in the grant, but a little bit in between.

We've really gotten positive feedback about this process. I think that people like doing the one process at the retreat, and then breaking the other process into two different meetings. We use the same process where we have small groups. We get into the same small groups we had at the retreat to make recommendations about what to do in those scenarios of flat funding decrease or smaller increase.

Like I said, we try to agree on our philosophy that it can be tricky. For example, if we decide that medical case management needs an increase, but in flat funding we'd have to cut from somewhere else. So it doesn't always work as planned, but we do go through that exercise with people and try to really use the same logic that we did in our original party setting and resource allocation process.

Michelle Vatalaro: Thank you so much for sharing that. I think that that's really helpful. It gives a different perspectives, and the different amount of resources, and how that can affect how we do priority setting and resource allocation. But regardless, we can have a great data-driven priority setting and resource allocation experience. And so, at this point we're going to start preparing for our question and answer session. So, I would encourage you to ask more questions in through the chat.

And while you're taking a moment to do that, I will talk about some of the resources that are available to you to help you through your PSRA process.

The first is the Compendium of Materials for Planning Council Support Staff. They have a really nice mode. PSRA process in the compendium. It's in section four, implementing legislative requirements. You can see the link that has come in through the chat, and you can go find that on the Target Center website. It's a really good resource for you to take a look at as a model.

The other thing I'd recommend you to take a look at is the Planning Council Primer, which, as many of you may know, has been updated and is available on our Planning CHATT website as well, and again Emily is going to put that into the chat for us so you can click right to it.

And so, now I think ... Now I think we're going to take a moment and move to our question-answer session. I'm just going to ask some questions, and our lovely presenters are going to be gracious to answer them. And so, the first questions that came in going all the way back to the beginning are around the waiver process. And so I'm hoping that Lennie could provide some clarity on the waiver process.

Lennwood Green: Okay. When the waiver is introduced or requested, there have got to be evidence in the waiver request that the 75% of the unmet need, or the clinical need, as in primary care, is being met by some other sources. For example, you can't reduce your medical requirement to 65% without showing that the other 10% is covered by other sources other than Ryan White.

Michelle Vatalaro: Okay. Thanks, do we want, I know this is answered in the chat, but do we want Lennie just clarify for everyone when can the waiver request be submitted?

Lennwood Green: The waiver request can be submitted after four months into the grant year with the application.

Michelle Vatalaro: Great, thank you so much.

Steven Young: Can I answer that, Lennie?

Lennwood Green: Sure.

Steven Young: Actually, there was a question in the chat box, which I posted something in there. There are actually three points in time when a waiver may be submitted in a year. It can be submitted in the advance of the annual grant application, or

it can be submitted with the application, or it can be submitted after four months into the grant year, which would be since the grant year starts March 1st that would be March, April, May, the end of June. So, for any particular year, the last step date is submission the end of June.

Michelle Vatalaro: Great. Thanks so much for clarifying that. I think that's really helpful for everyone to Know. Our next question is going to be for our Portland folks. The question is, you talked about using utilization and cost data, is this used during allocation process, or as a part of your priority setting process?

Alison Frye: Hi. This is Alison. It is used during our resource allocation process.

Michelle Vatalaro: Okay. Thanks. Another question for Portland, how do you bring in service providers as key informants to planning council meetings without violating the necessary separation of the planning council and provider?

Amanda Hurley: Often our operations committee will help us determine what panel experts they want to bring into the planning council to present. For example, we recently funded some peers to help people connect to mental health services. And so, we are able to bring in multiple peers from various organizations to talk about their role within the community. We also always talk about being provider blind whenever we are making decisions. But we do bring in, like I said, multiple and either Ryan White funded, or non-Ryan White funded programs in order for the council to get a full view of what's happening out in the community.

Michelle Vatalaro: Great. Thank you so much. Our next question is for our Atlanta folks. Could you please clarify the role of the provider at the planning council meeting?

Trevor Pearson: Okay. In Atlanta, specifically we have taken the opportunity of ensuring that provider don't present at the meeting except as noted if they come in as a subject matter expert on a particular topic. So, they're not going to be talking about their agency. They're going to be talking about a service that's being provided. So that's how we get around the point of ensuring that providers don't talk about their agency.

Sandra Vincent: I'll answer that. In having subject matter experts coming in, they aren't just individuals from a particular agency. It would be a group of service provider experts. So there might be three separate agencies representatives from those agencies which are presenting, but they are not presenting as an individual agency.

Michelle Vatalaro: Great, thank you. Thank you for clarifying that. Just a reminder, you could go free to continue to ask questions if you'd like to. Okay. And so then here we have a question. I'll let Portland start. How do you consider and use data about particular populations of people living with HIV such as differences in service utilization or something like that? So specifically talking about young MSM of color or other groups.

Alison Frye: Yeah, that is definitely a consideration here in Portland and in a populations as small and non-diverse as we have here. Sometimes it's really difficult for us to figure out how to best target these special subpopulations. A couple of ways that we do this is we have looked at our two continuum data, and targeted our MAI dollars in combination with Part A service dollars for navigation programs focused on Latinos, Black African American communities, and immigrants and refugees due to either differences, and linkage or power suppression.

We also collaborate pretty closely with our Part D recipient for interventions focusing on the women and youth population. We really try to do what we can to target those populations. We don't have the ability to create specific programs for really specific populations because of our amount of dollars and amount of population we have, but we do ... Those are some of the strategies that we use to do that.

Michelle Vatalaro: Thank you. Atlanta?

Trevor Pearson: Yes. So in Atlanta, we also do some of the similar work that you do in Portland. For example, some of our targeted populations are young MSM of color, the transgender population, African American women, and Hispanic or Latino women. We have looked at those in terms of looking at the numbers of people who are in tier, and we've also looked at numbers of people who are already suppressed. And looking at those numbers, we've come up with those as categories that we really want to focus on.

Particularly for young MSM of color, we have looked at our MAI dollars to ensure that that particular community receives the types of services that it needs to ensure that it reaches the same level of help that other communities are currently experiencing.

Alison Frye: We also utilize CAREWare a great deal in making our projections and identifying those hard hit populations. I mentioned earlier that our assessment committee often initiates various studies to find out which populations have desperate health outcomes. And in utilizing that particular data, then we are able to better

respond to the needs of the EMA based on the information that we receive through CAREWare and other state studies.

Michelle Vatalaro: Thank you both. Another question for Atlanta, the three-day process that you use for priority setting and resource allocations. Are these consecutive days, or are they scattered throughout the month?

Sandra Vincent: They are consecutive days. I'd like to add to that point as well. Throughout the year, we are receiving EFY data concerning where we are within the EMA in terms of actual linkage to care and in utilization of services. So, even though we have the three-day process, in addition to that, we are continuously planning and evolving in terms of the information that we're actually getting out to our planning council. But yes, those days are three consecutive days.

Michelle Vatalaro: Thank you so much. Another question here. Question for HRSA. Is there any collaborative efforts for other players outside of the Ryan White HIV/AIDS program? Kind of asking for an example in Virginia. Oh, no, examples ... Not Virginia, the VA, the veteran's group. Lennie.

Lennwood Green: Well, one of the examples given is that the veteran's administration. I'm assuming that's what meant by VA. There is another entity such as the veteran's administration that provides service to veterans who might be living with HIV. Then that would be included in the resource inventory as just as you would include in Medicaid, or other funded entities that also provide service.

When there is a standard or a need that's not met by that entity, then the Ryan White program can help to provide services to bring it into 100% for services required. An example would be Meals on Wheels versus nutritional assistance for someone who is acutely and chronically ill. We know that Meals on Wheels provides a meal to folks based on income and need, and also the ability to cook. We also know that sometimes folks need particular nutritional assistance, and especially in acute needs in regards to requirements.

So in that case, we would supplement through a nutritional program, or some reasonable facts for those who are acutely in need of nutritional counseling. Or in the case of the VA, if there were primary medical services that are being provided that didn't match the need that we've established in areas where we provide care with Ryan White. An example would be transportation to the physician's office. Then we might look to see what we can do to remove that barrier in medical transportation. These are right off the top of my head.

It's really important to establish a resource inventory, what is there, and look at what you have established based on your jurisdiction, and move from that point in regards to collaboration, and ensuring that you are not utilizing funds for services that are already there, but by the same token that those services meet the requirements as defined by the needs assessment.

Michelle Vatalaro: Thanks for that. Our next question if for Atlanta. Atlanta EMA indicated that one of the data pieces that they use is the profile provider capability and capacity. The questionnaire says that they'd be interested in seeing how this information is gathered and what it looks like.

Sandra Vincent: This is the part where I have the pleasure of saying that if you are not working harmoniously with your Part A recipient, then you need to because there is information that the planning council would not have access to if we were not working directly with the recipient. So, in day one of our process, the recipient is there sharing information specifically about agencies without mentioning the agency name. We're only talking about service categories.

And so, much of the information that's referenced here, we get from the recipient, but there are models of how that information can be determined, and I understand that the link is going to be provided to you as well.

Michelle Vatalaro: Yeah, we have a model tool that is used in multiple jurisdictions that we can share if folks want. So we'll pull that together for you.

Our next question is, are these processes universal to all planning councils that receive Ryan White funds, or is the process different by day? Portland, do you want to take this?

Alison Frye: Sure. I think one thing that Michelle stated I was talking about earlier and that this was intentional on the part of JSI organizing the Planning CHATT webinar is that processes are really going to vary by jurisdiction depending on the size of your council, the amount of money that you have to spend, the geographic area where you are, and I think lots of different factors. I think you heard Atlanta and Portland use very different processes to go through the party setting and resource allocation process. I had to think of what that states for Oregon. I think that it definitely has the requirements of the what it should include, but the how you carry that out I think really can vary based on lots of different factors which I stated.

Michelle Vatalaro: Okay. I'll just to remind you that you can ask questions in the chat. We do have a little bit more time before we finish up today if anybody has more questions.

Oh, I'm hearing that people would love to see those skits that folks were talking about, those data skits. We'll definitely try to help you guys try to pull that together as well. Feel free ... Oh, Atlanta, do you want to address this question? What specific information are you pulling from CAREWare?

Sandra Vincent: We're pulling a lot of utilization data from CAREWare. We're looking at the number of people that are being served, what those services are. We determine our cost analysis in terms of cost per service using CAREWare. We also looked at our quality measures. Our quality measures are aligned closely with HRSA measures. So we're constantly receiving reports from our quality management team that basically informs our decision in relation to how things are working.

As an example, a couple of years ago, we embarked upon a pilot program involving peer navigators. And so, during that first year we closely monitored who was using peer navigators, and what the outcome was from that particular pilot. And as a result, we saw that retention and care was actually better and so was linkage. And so, we ended up continuously funding this particular project until it became no longer a pirate, but it's the staple in the funding that the recipient does as well.

I think another notable mention also is we've been tracking very closely what we call rapid entry. And rapid entry is basically efforts to get people within care in link to care within the first 72 hours of diagnosis. And so, we closely monitor that through CAREWare in terms of identifying who those individuals are, the number of people, how fast it was that they were actually linked to care and received ART as a result of that linkage. So there are number of things.

I'll admit since we've made the effort of hiring an EFY person as a part of our staff, which was a huge investment, what that has yielded is the deeper dive into the data. There were things that we probably didn't know to ask for, but because we're getting so much information now more intelligent questions are emerging from the data that we're receiving. As so, we're able to continue to get insights on how effective our service delivery is.

Michelle Vatalaro: Does Portland has something to add, Amanda?

Amanda Hurley: Yeah. I just wanted to just remind people that we had showed an example of our scorecard. And the majority of that information is pulled from CAREWare, so primarily the client demographics as well as service utilization. We also do include some of our performance measures we're able to pull back from CAREWare. Not all of them, but most of them we are able to pull directly out of

care wear. We also have access to state surveillance data. We are days away from being able to import state surveillance data into CAREWare.

Michelle Vatalaro: That's great. I'm really, really happy to hear that. I'm just looking through the last couple of questions that have come in. The question is, is the cost analysis based on the cost under priority proclaim, or per unit of service for dollars allocated or spent?

Trevor Pearson: It depends, it's both. In some cases, you can look at the cost per client, and you know what the cost is based on how many people use the service, and then you can use the cost per unit. In our case, in many of our instances we use a 15-minute period. So if the client is there for an hour, those are four units of service.

Michelle Vatalaro: Okay. Great. Okay. Well, thank you everybody. We're going to ... I think we're going to try finish up here for the day. Thank you again to all of our presenters, to HRSA, and for all of you for participating today. If you have questions that we didn't get a chance to answer on this webinar, please you can always email us at planningCHATT@jsi.com, you can see on our slide here. You could also come to our Target center website, which is targetHIV.org/planning-CHATT. On that website, you can sign up for our mailing list, download tools and resources, view archived webinars and more.

Here is some contact information. Again, you can reach us at planningCHATT@jsi.com, and Atlanta also provided their contact information. You can contact them at the link you see on the screen there. Just one plug, please do complete our evaluation that we have. In public health, we know that evaluations are very important. They help us provide better webinars to you in the future, help you meet your needs and your goals. So we really do hope you take the time to complete that. Thank you all, again, for joining us today. Have a great afternoon.