Julie Hook: Good afternoon. Welcome to this webinar on resource allocation, guidelines, emerging practices. My name is Julie [Hook 00:00:08] from the Integrated HIV/AIDS Planning Technical Assistance Center, or the IHAP TAC, and I want to thank everyone for making time to be on today's webinar. During today's webinar, we'll present key definitions and requirements for resource allocation and effective resource allocation processes including tips, strategies, and resources. And representatives from the Philadelphia Office of HIV Planning and the Virginia Department of Health present the strategies on optimizing resource allocation approaches in their jurisdictions.

Julie Hook: The IHAP TAC began in 2016, and our current work continues through 2023 to support Ryan White HIV/AIDS program, Part A and Part B, recipients and CDC grantees and their respective planning bodies with their overall integrated planning efforts and the implementation and monitoring of their integrated HIV prevention and care plans. And we provide both national and targeted technical assistance and training activities.

Julie Hook: We provide support in the following areas: plan activity implementation, communicating progress on plan activities, engaging community in integrated planning efforts, monitoring and evaluating plan activities, optimizing resource allocation, aligning plan activities with other efforts and collaborating across jurisdictions.

Julie Hook: If you have any questions during today's webinar, you can put them into the chat feature and we'll answer as many as possible during the end of the call. And I also want to mention that after the webinar ends, we'll have an evaluation pop up immediately. We hope you fill this out and thank you for filling it out in advance as it informs our future webinars and trainings.

Julie Hook: Following the webinar, we hope that participants will be able to describe at least two key requirements for resource allocation for Ryan White HIV/AIDS Program, Part A and Part B, describe at least one key activity for conducting an effective resource allocation process, describe at least one model for resource allocation implementation, and identify how to access resource allocation resources and tools on TargetHIV.

Julie Hook: And now I'd like to turn it over to Rene Sterling, the Deputy Director of DSHAP for a welcome.

Rene Sterling: Hi, yes. Good afternoon everyone. Thank you for joining today's webinar, and thank you to the IHAP TAC for leading this effort and carving out time for me to give a few brief updates and reminders on behalf of HRSA.

Rene Sterling: First, we are very much looking forward to the 2020 National Ryan White Conference and the Clinical Conference. Both the Ryan White Conference and Clinical Conference will be held in August in Washington DC at the Marriott Marquis. We received over 600 abstracts which are now going under internal

review. The submission period for abstracts has closed. If you have any questions about your submission, you can email agenda@ryanwhiteconference.org, and we hope to see many of you there. Registration for the conference will open soon, and an announcement will go out when it's available. Feel free to go to the conference website for updates at ryanwhiteconferencedothersa.gov.

Rene Sterling: On the programmatic side, we wanted to make sure everyone was aware of the deadline for Ryan White HIV/AIDS program service report submission or RSR submission for 2019. The due date is March 30th. As a reminder, we have implemented eligible services reporting for 2019 RSR submission, and under eligible services reporting recipients and sub-recipients submit client level data for all Ryan White eligible clients that receive an allowable service that's funded either by the grant award or grant related funding which would include program income and pharmaceutical rebates. If you have questions regarding the content of the RSR and the submission, you can email ryanwhitedatasupport@wrma.com, and I've also provided on the slide a link to information and resources available on TargetHIV.

Rene Sterling: For those of you who do AIDS Drug Assistance Program, or ADAP reporting, we wanted to be sure you were aware that HRSA is proposing several changes to the ADAP data report including both the recipient report and the client report. You have the opportunity to review and comment on these changes. There is an announcement in the federal register that you can review. I've provided a link there. If you search for AIDS Drug Assistance Program data report, it should come up quite quickly. You can also use the OMB number. So we are providing opportunity for broad comments on that, and we encourage your review and comment by the deadline which is February 3rd.

Rene Sterling: For those who are using Careware for either RSR or ADR reporting, please keep in mind that you must update to version six build 47. This is the minimum build required to generate your 2019 RSR ADR. You can get downloads for that build and technical support through the HRSA website. And for our Ryan White Part B recipients, January 31st is the deadline for submitting your estimated UOB an estimated carryover request. Please keep in mind that if you do not submit those estimates, you will not be allowed to carry over funds. If you have any questions about these announcements, please contact your project officer.

Rene Sterling: So as we transitioned into our primary presentation for today, I just wanted to share a little bit of background on the IHAP TAC. In June, 2017, the AIDS Bureau conducted a technical expert panel with representatives from both Ryan White Parts A and B to explore opportunities for strengthening both the priority setting and resource allocation process. And during this panel discussion, several challenges were raised by recipients staff, planning body staff. Some of those included data sharing across programs, use of data by different stakeholders, coordinating and implementing planning processes before you even get to priority setting and resource allocation, which can be as extensive.

And also survey burden was noted for both sub-recipients from whom information is requested and also people with HIV.

Rene Sterling: So as a result of the findings from this technical expert panel, HRSA broadened the scope of the IHAP TAC to go beyond just supporting you in the development of your integrated plan and to really think about what tools, training, technical assistance opportunities might be helpful in improving priority setting and resource allocation processes. So today's webinar is one of several activities that are planned under this expanded scope to support your work in this area, and we really encourage you to stay in communication with the IHAP TAC about the types of things that would be most useful, what you found useful about today's presentation and future work, and also share with them any approaches or tools that you may have that has shown some success in your jurisdiction.

Rene Sterling: I do really want to take a moment to thank the Part A team in Philadelphia and the Part B team in Virginia who will be speaking today and have been willing to share some of what they're doing. I encourage others to do the same. So with that I'll turn it back over to the IHAP TAC.

Julie Hook: Great. Thanks so much Rene. Now I would like to introduce today's speakers. Ann Marie Rakovic and Alissa Caron are both JSI IHAP TAC team members, and they lead our teams resource allocation research efforts and development of resource allocation [inaudible 00:08:08]. We also have Maril Ross-Russell who is the Director of the City of Philadelphia Office of HIV Planning, which supports the Ryan White Part A Planning Council and is responsible for completion of the integrated HIV prevention and care plan and the joint [inaudible 00:08:23] prevention and care. Prior to this, she was the Co-Director of Health Planning at the Office of HIV Planning beginning in the fall of 2000, and she worked also for the Philadelphia AIDS Consortium beginning in the early part of 1994.

Julie Hook: Safere Diawara is The Clinical Quality Management Coordinator for the Virginia Department of Health. He developed Virginia's first and subsequent quality management plans when Virginia was selected by HRSA one of the five States to participate in the Cross Parts Quality Management Collaborative, and he also convenes the Virginia Ryan White collaborative teams. Safere is also joined by Ashley Yocum who is the HIV Care Services Planner for the Virginia Department of Health. She also previously worked as an HIV Care Services Coordinator for the Virginia Department of Health where she provided oversight and support to the Ryan White Program, Part B sub-recipients.

Julie Hook: Now I'd like to turn it ... Actually before we go there, before we transition from our presentations, we'd like to know who is on the phone. So please tell me who do you are. Are you a Ryan White HIV/AIDS program, Part A recipient? Are you a member of the part a planning council or planning body? Are you a Ryan White HIV/AIDS Program Part A stakeholder? Are you a recipient for the Part B program or part of the Part B consortium rep or planning body? We would love to hear just so we have a sense of who's also on the phone. All right, so it looks like we have a pretty good mix of folks from Part B and Part a, so recipients. And

also for others, it looks like there's some TA providers on as well. So this is really helpful to see that there's a good mix of people. So thank you for joining us today.

Julie Hook: So one other quick poll to really get an understanding is what is your level of confidence with your current resource allocation planning implementation process for your jurisdiction? So low, not really certain that our current process is really effective. Medium, our process works well, but I'd like to sort of hear about some potential modifications that I can make. Or high, our process has been perfected over the years. All right, so it looks like majority ... Again, there's some good mix of folks with the majority saying medium, that they think their process works well, but there could be some things that they could potentially learn and do a little bit better.

Julie Hook: Well, great. So now I'd like to turn it over to Ann Marie Rakovic from the JSI team.

Ann Marie R.: Thank you, Julie. Much of the information that we're presenting today will be available in a future release of a resource allocation guide to help support Ryan White White HIV/AIDS Program, Part A and Part B recipients. And as such, we've begun to think about resource allocation as having three phases. The first is planning and preparation. The second is priority setting and resource allocation. And the third phase is optimization and reallocation.

Ann Marie R.: Over the years, the priority setting process has been very well documented, and it's the process of deciding which HIV services are most important for ensuring that a high quality and comprehensive system of care is available for all people with HIV in Ryan White HIV/AIDS Program Part A and Part B jurisdictions. The priority setting process should be informed by up to date available data from surveillance, needs assessments, clinical quality management projects, or other data collection available to the program. The priority setting process should address unmet need and service gaps identified within the jurisdiction. Resource allocation is an essential step in planning for the optimal use of available resources by assigning funds to prioritize services based on what is allowable. Resource allocation is informed by identifying and prioritizing unmet needs and selecting categories of core medical and support services that can best meet the selected priorities. The resource allocation Ryan White HIV/AIDS Program funds are assigned to priority services again in order to best meet local HIV care and treatment needs.

Ann Marie R.: Core medical services include, for example, AIDS Drug Assistance Program, ADAP treatments, medical case management, home and community based health services, oral health care, and health insurance premium and cost sharing assistance for low income individuals. Funding decisions are informed by utilization and outcomes data, sub-recipient performance, and the availability of other non Ryan White HIV/AIDS Program funds including other federal and state government funds, also rebates, program income, and private funding. Support services would include for example, health and education and risk reduction,

food bank and home delivered meals, housing services, emergency financial assistance, and medical transportation and legal services.

Ann Marie R.: PRSA matters because the decisions made through this process influence the system of care including the availability and accessibility of services and the capacity of funding providers to meet specific needs for different groups of people with HIV. And ultimately, priority setting resource allocation impacts client outcomes across the full care continuum including service retention, viral suppression rates, and HIV related health disparities.

Ann Marie R.: And now I'd like to turn the session over to my colleague Alissa Caron who will talk to you about Ryan White HIV/AIDS Program requirements and HRSA guidance.

Alissa Caron: Thank you, Ann Marie. As she said, we're now going to review some of the key legislative requirements and HRSA policies and program requirements for resource allocation for both Part a and Part B and highlight some of the commonalities between both parts.

Alissa Caron: For legislative requirements for metropolitan areas, the planning body is really quite critical. Under Ryan White Part a, the responsibility for managing Ryan White funds falls to the chief elected official, the CEO, and the CEOs are responsible for establishing a planning body that will spearhead the development of comprehensive services in the metropolitan area. Most party planning bodies are planning councils. There are some exceptions for TGAs that began received funding during or after 2006. They're not required to establish a planning council, but they must establish another mechanism for gathering community input into resource allocation. So for those planning bodies, they may use a process similar to planning councils to arrive at allocations, but ultimately are making recommendations to the recipient.

Alissa Caron: The party recipients roles and responsibilities for resource allocation include receiving written directions from the planning council on how to allocate funds, or as I mentioned, written recommendations from the planning body on how to allocate funds. The recipient must then implement a procurement process to issue contracts to sub-recipients who will then implement the Ryan White services, and the recipient then monitors the contract's status to track spending and ensure that funds are used according to the contract terms. The recipient also will make corrective actions to improve the procurement process if there are any shortcomings in the performance of the sub-recipients.

Alissa Caron: And as I noted a moment ago, the party planning council itself has a leading role in resource allocation for the jurisdiction. The planning council or planning body determines the dollar amount or proportion of Ryan White party funds to allocate to each of the prioritize service categories. The planning council must document these decisions in writing and provide that documentation to the recipient. The planning council may also issue directives which specify how the

recipient should implement the resource allocation plan, for example, by focusing on specific high priority populations or geographic regions.

Alissa Caron: For Ryan White Part B recipients, Ryan White Part B recipients may determine whether they will lead resource allocation processes on their own through a lead agency or through a consortia. Unlike Part a, the Ryan White Part B planning body is not defined in the legislation, and so there is more variation in the structure and membership of planning groups. That said, I'm Ryan White Part B recipients must ensure that they gather stakeholder input into their resource allocation process. In addition, Part B recipients must develop and submit a statewide coordinated statement of need, which is a mechanism to identify and address significant HIV issues in the state and to maximize coordination, integration and effective linkage across all Ryan White parts.

Alissa Caron: The Part B recipient, as I just said, may choose to oversee resource allocation on its own or to planning bodies [inaudible 00:19:25]. [inaudible 00:19:21] meaning that the resources are available to support these services, so funding resources must be utilized first. In addition, as Ann Marie mentioned, there are requirements around spending on core medical services and support services. For both Ryan White, Part A and Part B at least 75% of awarded funds must be spent on core medical services, and up to 25% of the awarded funds may be spent on support services. And there's some additional terms around administration planning an evaluation. Lastly, both for Ryan White, Part A and Part B, recipients must implement a schedule of charges [inaudible 00:20:48] delivered to clients with incomes above a hundred percent of the federal poverty level, and those charges are incorporated as program income.

Alissa Caron: [inaudible 00:21:03] for those of you who are involved in one component or the other. The Part A award has a formula based component based on the number of people in the metropolitan area in the most recent year who were living with HIV. There's also a supplemental award that's awarded competitively based on demonstrated need, and a formula based minority AIDS initiative award that focus focuses on improving access to HIV care and services for disproportionately affected minority populations.

Alissa Caron: B award has some additional components, including the base award, the AIDS Drug Assistance Program base award, the Minority AIDS Initiative award for those states that choose to apply, and Emerging Communities award that focuses on areas that have a growing HIV epidemic, and supplemental awards that are again competitive and based on demonstrated need.

Alissa Caron: In closing for this section, I wanted to highlight some of the common roles and responsibilities across both parts, Part A and part B. Both Part A and Part B of course work with sub-recipients who are the service providers who received funding from the recipient to deliver services. And certainly for both Part A and Part B there are a range of stakeholders involved in resource allocation from planning bodies to government representatives to consumers themselves who

have a say in the outcomes of resource allocation. And lastly, jurisdictions may work with consultants to help guide the resource allocation process.

Alissa Caron: And now I'd like to turn it back to Ann Marie to talk about effective resource allocation practices.

Ann Marie R.: Thank you, Alissa. So the first key phase that we've identified to an effective resource allocation process, which is planning and preparation, is to commit the time people and non-financial resources. And it involves at minimum ensuring that all involved understand the Ryan White HIV/AIDS Program legislation and HRSA guidance, some of which Alissa just went over with us, and providing ongoing orientations and trainings as needed to keep parties involved up to date in about developing the resource allocation plan that outlines the process that you will undertake and the timelines for achievement, also establishing clear roles and responsibilities and ensuring an integrated planning process, incorporating community engagement, making sure that data sharing is accomplished across Ryan White HIV/AIDS Program parts and federal agencies, which also involves identifying relevant data and information, collecting it, preparing it for both analysis and decision making, and developing and utilizing tracking tools to track at least three years worth of information and funding, service allocation and utilization and performance data, developing and implementing a sub-recipient performance review process, which is a legislative and regulatory requirement, and finally developing a re-allocation plan which assesses expenditures at minimum during the grant cycle midpoint and at the end during the fourth quarter. Doing so allows the jurisdiction to determine if some intervention is needed to address any spending shortfalls, which could also include, for example, accessing TA, increased oversight, recouping funds in some way and reallocating funds to a different organization if needed.

Ann Marie R.: To date, we've identified at least three approaches toward the PSR process that are being used by Ryan White HIV/AIDS Program, Part A and Part B recipients, a regional approach, and a jurisdiction wide approach, and efforts towards a performance based approach. We've also identified what can be considered hybrid models, which recipients have customized to their specific needs over time and include elements of the three approaches that I just mentioned.

Ann Marie R.: The regional allocation model seems to be appropriate for large states that distribute funds to multiple regional contractors like health departments and large community based organizations, or for EMS that cross multiple regions like Philadelphia. Maril Ross-Russell will be talking to us shortly about how they manage across region planning process. This is a preferred resource allocation approach used to address specific regions which have diverse populations with HIV and service availability and capacity differences. The approach we think has some limitations, however. For example, when implemented in large states where resource allocation is planned at the regional level rather than at the state level, if a Ryan White HIV/AIDS Program, Part B recipient subcontracts with local health departments and community based organizations for example to provide services in their state, they may have less direct involvement and

knowledge of how resources are being allocated, and they cannot manage duplication of effort between contractors overlapping regional boundaries unless they achieve high levels of coordination. And again, Maril is going to talk with us about that.

Ann Marie R.: In the jurisdiction wide approach for coordinating funding, it involves conducting a comprehensive assessment of all types of funding and priority services available to Ryan White HIV/AIDS Program consumers within a jurisdiction. Recipients assess the amount and type of funding available for all priority services, which allows them to have a full understanding of service needs, funding and gaps within the jurisdiction. And it also helps to ensure that their Ryan White HIV/AIDS Program award is allocated with the highest level of coordination and responsiveness. Typically, we're seeing four elements to this model; service prioritization through consumer needs assessment, epi-data and other data sources, looking at prior years service utilization, and addressing historical and current provider capacity and capability, and funding levels for all the Ryan White Program parts and CDC prevention services to the degree possible within the jurisdiction.

Ann Marie R.: One of the advantages of this approach is that you can obtain a full understanding of service needs, available funding, and service and funding gaps. We've seen this work well in New Hampshire and Rhode Island Part B programs, for example. They were two of our States that we conducted key informant interviews with. One of the challenges is that recipients have indicated that it's not always easy to coordinate getting the right information at the right time for their planning process.

Ann Marie R.: We haven't yet seen the performance based resource allocation approach perfected in the field so we're considering it an emerging model, but there's definite interest in understanding how best to tie resource allocation to align with HRSA's performance measure a portfolio. And a key advantage of implementing an approach like this is that a performance based model would help to ensure that Ryan White HIV/AIDS Program dollars are allocated based not only on service needs, gaps, and cross program funding levels, but also based on improvements in consumer health outcomes and achievements and milestones along the HIV care continuum. One of the challenges with the approach is that monitoring sub-recipient performance in this way requires a high level of recipient effort and the use of additional tools that do not seem readily available.

Ann Marie R.: We can say that hybrid models represent customized resource allocation approaches and systems that borrow from a variety of proven practices.

Ann Marie R.: So what I'd like to do now is, based on these models that we've presented, get a sense of whether or not any of these four approaches align with today's webinar participants and the process that they implement for resource allocation in their jurisdictions. So we put up a poll, we'd like to give you the opportunity to tell us whether or not you think the work that you conduct aligns

with a regional approach, a jurisdiction wide approach, the performance based emerging model, a hybrid model, or something different. And you can chat that into the chat box. People are still responding, so we'll let that continue to go. It's looking good for jurisdiction wide. Okay, thank you so much. Yeah, so jurisdiction wide and regional approach is what we also understood by assessing the field thus far are the most common approaches that people are using. And I'm really interested in what that other model is.

Ann Marie R.: But before I pass the Baton onto Maril Ross-Russell, I'd like to invite you to contact IHAP. As both Rene and Julia mentioned at the start of the webinar today, if you'd like to share your resources or tell us more about your resource allocation process so that we can consider incorporating your work into our upcoming guide and also the tools that we have listed on TargetHIV.gove. And I want to thank you, and with that turning it over to Maril.

M. Ross-Russell: Thank you, Ann Marie. And I would just like to start off by talking briefly about some of the considerations for our process. Our annual process is a year long, and we actually look at data and information during the entire year, and there are presentations which are made to the HIV Integrated Planning Council as well as at the committee level. And some of the information that we look at is client utilization data, intake data, various needs assessments, any updates to the integrated planning process. We also do an epidemiologic update, a care continuum update. And the quarterly over underspending is one of the ways in which we try to address, or the finance committee and the planning council tried to address the need for reallocations throughout this process. That way that if there are issues specifically related to underspending that happens or overspending, we can follow what the process is for reallocations in order to shift money rapidly. In addition to the various trainings that are listed here, we also included understanding census data, a health equity training, as well as social determinants of health and an HIV treatment update.

M. Ross-Russell: So most of our allocations processes are actually carried out by the various committees of the planning body, and the full planning body is involved in the actual votes and discussions. The comprehensive planning committee and the finance committee actually work on trainings and discussions that happen throughout the year, and it includes the recipients staff, which we are lucky that we have recipients, staff that actually participate in our process from the Department of Public Health AIDS Activities Coordinating Office. We also have individuals who participate at the planning council level from the Pennsylvania Department Of Health Division of HIV Disease, the New Jersey Department of Health, Division of HIV, STD and TB, as well as other health divisions and community members. So we get input from a lot of different sources throughout this process.

M. Ross-Russell: One of the things that we realized a long time ago was that in order for this process to work, we have to actually have a fairly good working relationship with our planning partners because that essentially is how we are able to obtain the information and to share information back and forth. While we recognize

that this is not necessarily easy, but what it does do is enable better collaboration, coordination, and it increases trust in the various individuals who are participating this process.

M. Ross-Russell: So the resource allocation definition was actually provided earlier, but just the simplest definition is that we look at documented needs and priorities of people living with HIV in our jurisdiction to determine the distribution or allocation of Ryan White funds and to try and meet what those needs are.

M. Ross-Russell: The role of the planning body was actually discussed earlier, so I'm not really going to get into it. But for us documented need, we try to make sure that our decisions are based on documented need, and how we define that is through a surveys, focus groups, town halls, listening sessions, analysis of the latest local research, and a lot of that research comes from the health department and our recipient. So that enables us to actually utilize a lot of the local information. We also will go back and analyze and look at national data and use national data sets and information that may be available on HRSA's data warehouse and at other federal sources such as [SAMSA 00:36:57], Et cetera.

M. Ross-Russell: Again, the considerations, when we start looking at funding, the thing that we try to remind everyone as we go through our process is that HIV program funds are funds of last resort. So we look at whether or not the existing program funds will adequately cover the identified needs in the community, as well as what other sources are available throughout the EMA.

M. Ross-Russell: The planning council works with the recipient and the community. A good portion of the latest local research and data actually comes from our health departments and within the EMA. The planning council staff also work with other funded providers such as the Part Cs, the FQHC clinics, both Part B's, the Part D's, the AETC, and the dental and Part F, as well as the [inaudible 00:38:08] provider are also included and also work with us to try and make sure that the information that we have is both relevant, up to date, and can be included in the allocation process.

M. Ross-Russell: So for the regionalized allocation process description, one of the things that we did as far as looking at the regions was to take into consideration that, one, there are a lot of differences from a geographic standpoint, but also taking into consideration that there are just some differences when you consider the characteristics of the populations, the needs, the health care delivery systems that are available in each of the areas as well as the non Part A resources. For us, the regions have been divided by the city of Philadelphia, which represents approximately 71% of our local epidemic. Then there are the four PA counties which are Bucks, Chester, Delaware, and Montgomery. They represent about 16 and a half percent of the local epidemic. And then the New Jersey counties, which are Burlington, Camden, Gloucester, and Salem, and they represent about 12 and a half percent of the overall epidemic locally.

M. Ross-Russell: The way that we actually go about our sessions are there are three regional sessions that are convened, one for each of the three geographic regions referenced previously. And each regional group generally has planning council members from each of the respective regions, community members. We also include non-voting participants as well as there are individuals from recipients staff which are available so that we can answer questions. The support staff from our office are also participating throught this process. While only planning council members are eligible to vote on the final allocation decisions within the region, all of the participants actually participate and are involved in the discussion. Each regional session follows the standardized format. The planning body support staff of the Office of HIV Planning actually presents, describes, and explains a set of financial documents which were developed for use for the sessions. A member of the planning council's finance committee facilitates the meetings and presents and explains the current level funding budget for each region. The level funding amount is actually based on the proportion of that region's people living with HIV percentage. Each region is provided with the total amount that is allocated for that region.

M. Ross-Russell: Now because every year the of people living with HIV generally changes, the level funding allocation also changes. So the starting point is slightly different each and every year. Participants then deliberate until they have arrived at majority approval for the following, which is the level of funding budget, a 5% decrease budget, as well as a 5% increased budget. And then once we receive the final award the following year, whichever budget is actually closest is the one that the planning council generally starts with as far as their deliberations in order to make the decisions related to the allocations for that contract year. So it is still based on whether it's the level funding budget, the 5% increased budget, or a 5% decrease budget. And then from that point forward, the information related to that is then provided to the recipient so that the recipient can make the awards, and part of that process is to try and ensure that there is a rapid distribution of funds at the beginning of the contract year.

M. Ross-Russell: So while I would have hoped that this this worksheet that was sent in was a little bit clear. Unfortunately, essentially what it is trying to demonstrate is a sample of the actual worksheets that each of the regions starts with as part of their deliberations process. And at the very bottom of this is actually a breakout of what the percentages are for each of the regions, what the overall funding is in total, and what the people living with HIV percentages are. So when we start on the level funding budget, we are basing it on whatever that percentage is, and then we are working across so that we can have a 5% increase and a 5% decreased budget.

M. Ross-Russell: As previously stated, at each of the meetings we also talk about whether or not there are instructions to the recipient or directives as it was defined earlier. All of the voting actually happens at the regional level, but the final vote on the EMA wide decisions, which falls upon the planning council. The three regional budgets are actually combined so that we have one EMAY budget, and then the presentation actually happens from the finance committee co-chair. And then

any discussion regarding those allocations or the decisions happen at the fine happen at the planning council meeting, and the final vote is made by those members of the planning council.

M. Ross-Russell: So the materials that we actually provide, there are a lot of materials that we hand out during this process, but a lot of the information that we have related to allocations we try to make sure is actually on the HIVPhilly.org website ahead of time so the people can actually review those materials before coming in. So what is actually handed out is the allocations for the current fiscal year, any report noting. There is a report that is provided by the recipient noting any over or under spending that had occurred during the course of the year. A table or chart that actually shows Ryan White Part A funding in the context of all other parts, so it includes the Part B, Part C, Part D, Part F spins as well as [inaudible 00:45:48] that was included this year, and it is usually presented at a regionalized level.

M. Ross-Russell: The unit costs and service utilization for each service category is provided. That information is at the EMA level. We also include the policy clarification, notices, any kind of needs assessment data. And the recipient provides contextual information such as whether or not there was an increase in the number of clients who utilize the service or not, whether or not there's an increase in the number of units that were provided or not, and why to the best of their knowledge,this happened so that those individuals present can ask questions about that. And it also gives some additional information for some changes that may have happened either systemically or with a given service.

M. Ross-Russell: So this is just an overview. This is just an example of the information that we provide for each of the service categories, and it is broken out for both core services as well as support services. And while we call it a one pager, in essence this is approximately 60 some pages worth of information. This is actually an overview of the agenda that we have as well as the table of contents that we provide with all of the materials.

M. Ross-Russell: So I know that I was supposed to move a little bit faster, but I would just like to thank you for my ability to participate in this, and I would like to turn this over to Virginia at this time.

Safere Diawara: [inaudible 00:48:02].

Ashley Yocumm: Hi. So my name is Ashley Yocumm, and I am the HIV Care Services Planner for the Virginia Department of Health. And I also have with me Safere Diawara who is the Quality Management Coordinator, and today we're going to be talking about the Virginia Ryan White Part B resource allocation process. And so each year the Virginia Department of Health has to make decisions regarding allocations of Ryan White Part B funds, and then report them to the health resources and servicesadministration in the form of a program terms report. And we allocate funds to sub-recipients in each region of the state based on information collected from a variety of sources. And among all of the sources

that VDH uses to allocate funds, my presentation will focus on how Virginia uses sub-recipient performance to assess and allocate funds.

Ashley Yocumm: And so some of the things we look at are the HIV care continuum, which looks at the health outcome, which also looks at our health outcome performance measures; contractor performance, so timely submission of invoices and monthly reports and expenditures; progress towards service utilization goals is outlined in their submitted work plans with smart goals and objectives that also align with the goals of Virginia's integrated HIV and care prevention plan, their quality management program; so including sub-recipient quality improvement projects and their quality management plan; attendance to required meetings such as our quality management advisory committee meeting, our contractors meetings, and the Virginia's quarterly ADAP stakeholder meeting calls. We also look at usage and tracking of program income collection and expenditures, compliance with grants management, and contractual terms for goods and services, allocations across all Ryan White parts, as well as looking at sub-recipient.

Ashley Yocumm: VDH has also formalized a risk assessment for a program and administrative [inaudible 00:50:09] fiscal operations of sub-recipients. So risk assessments are conducted under various scenarios, either prior to issuing initial contracts to new providers, and also throughout the performance year if there are performance concerns related to pace of spending, which is based on monitoring algorithm of 5% of expected pace of spending of the total award for the period of time that has passed in the grant year, fiscal oversight including conduct and submission of A-133 audits by sub-recipients and vendors as require, as well as for not meeting service delivery goals.

Ashley Yocumm: And so since moving to a five year grant cycle, while VDH does know the expected amount of our work from HRSA, because allocations are done prior to award notification, VDH doesn't always know if we will receive a full or partial award from HRSA, which can sometimes affect how we allocate funds. And so our HIV care services service coordination team utilizes a variety of data sources to project allocations based on the gathered information for the upcoming grant year, and then the service coordinators present proposed allocation information to our HCS leadership staff and make recommendations for funding for each sub-recipient.

Ashley Yocumm: VDH uses the following data sources to make informed decisions on how to allocate resources each year. That includes our invoice tracking sheets, our monthly and annual progress reports, site visit reports, our peer review site visit team, which utilizes key recommendations and issues from the report which looks at quality of services provided, and that includes the consumer perspective section, our annual report surveillance data, the Virginia client level data system, our HIV continuum of care, which is pulled on a quarterly basis and shared with contractors, and then agencies develop quality improvement projects to improve their agency continuum of care data, which is then reviewed at the end of the grant here, our annual contractor performance

evaluation, which looks at delivery performance, quality of services and contractors responsiveness to correct deficiencies.

Ashley Yocumm: Okay. And so then all of this information is collected and correlated beginning approximately three to six months prior to the end of the grant year. And our allocations process is done when VDH completes the program terms report, and then contract renewal process begins in October. So starting in October, our services coordinators revise and complete the contract justification tables, and then service coordinators also engage with sub-recipients for projecting service needs. Then in November, we finalized our budget and justification tables, which is then presented to the HCS management team and then presented to our division of disease prevention leadership. And then in December we begin renewal processes for the new grant year, and all contracts are executed no later than March 31st of each year.

Ashley Yocumm: Okay. And so this is just an example of our VDH funding justification template. So we have all of the HRSA funded service categories in column one, and then what we look at are what services the agency is currently funded for, and then their year to date spending for it by service category. Previously, we looked at the prior two years spending trends for agencies, but recently due to Medicaid expansion, we now just look at the previous grant year's sending trends. And this is because as clients move to Medicaid expenditures for Medicaid services should begin to decline, and so VDH is taking that into consideration as we allocate funds. We also look at funding across all Ryan White parts, so including Part A, Part C, Part D and Part F. And then service coordinators write a narrative in the justification section that addresses all of the data that is collected.

Ashley Yocumm: And so at the bottom of that form, this just include examples of what VDH factors in to determine resource allocation for sub-recipients. And so overall, VDH utilizes all of this data and information to decide whether to give level funding, decreased funding, increased funding, or also conditional funding, which can be used where agencies need to meet certain performance goals before receiving their full funding.

Ashley Yocumm: And then this is just our contact information if anyone has questions. Then I am going to pass it back to JSI for a few minutes.

Julie Hook: Great. Thanks so much, Ashley and Maril. We have a couple minutes left. And if people need to drop off, I just wanted to remind folks to fill out the webinar evaluation at the end, but also to let everybody know that IHAP TAC has a resource allocation group of resources, some of which we've identified from jurisdictions that can help others with their resource allocation process. So encourage folks to take a look at that website.

Julie Hook: Maril, there were a few questions that came in for you. One of which was how are potential conflicts of interest, i.e. providers or sub-recipients, handled in the discussion of voting in the P and A process? Even if they abstained from voting, are they also abstaining from discussion on the process?

M. Ross-Russell: Sorry, I muted my part.

Julie Hook: Maril.

M. Ross-Russell: Yeah. Yeah, so the answer to that is that we do have a conflict of interest policy, which we review at the beginning of the process. But the expectation is that everyone can participate in the overall discussion, but they have to identify whether or not they have an existing conflict. That means that if you are a medical care provider and you receive Part A money, then as part of that discussion you need to identify that that is who you are. If you are a sole recipient for a service, which we do have a couple of in Philadelphia, then generally they are not allowed to vote. They can participate in the discussion. And again, they have to disclose what their conflict is at the very, very beginning. We go through a process to try and make sure that people are aware who's in the room and what they represent, either service or recipient. And we do not have discussions around individual providers as part of our process, but we do present the data in aggregate form. I think that answered that particular question.

M. Ross-Russell: The second is that the recipient themselves actually provides some very, very detailed information, and that information happens throughout the course of the year. There are presentations on it to the planning council as a whole, as well as in the conference of planning committee meetings. So information related to individual services, utilization needs, et cetera is more expansive in the actual committees as opposed to the information that we give out, but we try to make sure that we review it and discuss it. And that was the answer to the second question.

Julie Hook: Great. Yeah, that [inaudible 00:58:21] to ask that. So one other just quick question, and then we can close. Do the awardees, recipients of funds have an opportunity to advocate for or present their case for funding? And I think that question can go to either Maril or Safere and Ashley.

Ashley Yocumm: Hi, so this is Ashley from Virginia. And so yes, we have ongoing conversations with our sub-recipients throughout the resource allocation process to allow agencies to advocate if they want to expand a service or add a new service category. We do allow for them to present their case, and then that's where we also look at similar data to decide if we are going to include that in our resource allocations for the next year.

M. Ross-Russell: So our answer that no, we don't. We try very hard not to have conversations with or about any specific sub-recipient of services because we view that as something that needs to be overseen by the actual recipient themselves. So no, because the procurement process is something that happens at the recipient level. So no, we do not get involved in discussions around individual funding for agencies.

Julie Hook: Great, thanks so much. And I did want to just mention that we appreciate all of you hanging in there. We were having some tech problems in the middle of the webinar in terms of having trouble hearing, so thank you to everybody that hung on to the end. And I did want to plug, let people know that we'll have our slides available for today's webinar up on our website tomorrow as well as the recording and transcript within 48 hours. And then want to just do a quick plug, we do have a webinar tomorrow from three to four Eastern time around incorporating hepatitis C and integrated HIV prevention and care planning. So we encourage you to register and listen in on that as well. And just wanted to thank everyone again for attending and Maril, Safere, and Ashley for presenting. And we thank you for listening in this afternoon, and please fill out our-