Model Priority Setting and Resource Allocations (PSRA) Process[1]

Introduction

Following are suggested processes and steps in priority setting and resource allocations (PSRA) for a Ryan White HIV/AIDS Program (RWHAP) Part A program. This model reflects guidance from the *RWHAP Part A Manual* as well as practical experience. It was originally developed for use by several new Transitional Grant Areas (TGAs) facing the challenges of getting their programs and planning councils up and running and at the same time planning for the following year. The model has also been used, with refinements, by experienced TGAs and Eligible Metropolitan Areas (EMAs) that wanted to transition from a committee-based PSRA process to a more inclusive process with the full planning council actively involved in decision making about priorities, allocations, and directives.

Preparations

1. **Agree on the priority-setting and resource-allocation process and its desired outcomes.** Decide on the procedures, and address such factors as the following:
   - **How decisions will be made –** by consensus? By voting individually or on a slate? In some way that provides a "secret ballot" (and requires time for aggregation)?
   - **How you will manage conflict of interest:** A suggested policy is that any funded RWHAP Part A provider must declare all funded service categories (e.g., areas of conflict of interest) at the beginning of the session, and neither initiate discussion nor vote on priorities or allocations for those service categories. S/he can answer questions directed by other members, and can vote on priorities and allocations when they are presented as a whole list.
   - **What groundrules you will need to keep order and accomplish the work.** You will need to develop an agenda, responsibilities for facilitation and presentations, as well as recording decisions, how to deal with questions about policy and process, etc.
   - **How you will keep the process data-based and avoid "impassioned pleas."** Ideally, "new" data should not be presented during the decision making – information should be presented as part of the data presentation, when there is time to discuss and assess it. This may be hard to accomplish if the data presentation is the same day as the PSRA process. However, members should avoid presenting anecdotal information or personal experiences during the decision making, focusing on needs assessment and cost/utilization data rather than a single person's experience. Someone (staff or facilitator or a member of the Planning Council) should be responsible for reminding people when this principle is being violated.

[1] Prepared by Mosaica in 2007, for use by several newly established TGAs and later used with EMAs.

Updated many times, most recently for EGM Consulting, LLC (EGMC) in December 2016.

2. **Agree on responsibilities for carrying out the decision-making process.** This first year, presumably it will be the partially formed initial Planning Council with input and assistance from the recipient staff.
3. **Be sure everyone is aware of the National HIV/AIDS Strategy goals, the HIV Care Continuum/Treatment Cascade definitions,** and the TGA's own goals and priorities from the most recent comprehensive/integrated plan.
4. **Review relevant legislative requirements and program guidances.** Be particularly clear on the 75% core services requirement. Become familiar with the new service definitions.[2] Arrange to have these materials available at the PSRA meeting, and to present them at the beginning of the meeting to ensure a common understanding of requirements, expectations, and allowable service categories.
5. **Determine and obtain available information "inputs," including needs assessment and cost and utilization data,** and prepare user-friendly summaries for use by the Planning Council. Ideally, summarize findings in a brief, user-friendly document. One approach is to develop two sheets that summarize information to be used in priority setting and resource allocations:
    a. **Service Categories Data Sheet—**The first data sheet will focus on service categories (listed in the first column in order of their current priority), including all 13 core services and those support services that were prioritized in the current program year, plus others that are of possible interest. There will be a column for each available data/information source – e.g., epi data, service utilization and cost data, PLWH survey, estimate and assessment of unmet need, focus groups, and provider profiles.
        - Data from each source will be summarized – major findings related to demands for and use of that category, whether PLWH indicated problems in access or quality, trends, etc.
        - A very small number of charts or tables or other data summaries can be presented along with the summary data sheet for each information source – for example, a utilization chart that indicates budgeted versus actual expenditures by service category for all of the past program year [might be services funded through the Emerging Communities Grant for a new TGA] and available information for the first few months of the current year, along with unit or per client costs.
        - This information will be valuable for priority setting and/or allocations. For example, the epi data and client interviews will be particularly helpful for priority setting, while utilization and unit costs data will be useful for allocations.
    b. **Populations Data Sheet -** The second data sheet will focus on populations (listed in the first column) and use the same data sets as the first data sheet in the remaining columns.

[2] See Policy Clarification Notice 16-02, at https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

- This data sheet will include in the first column such population groups as women and men, various age groups, racial/ethnic groups, and populations by location (e.g., central city/county, outlying counties).
- The other columns will summarize types of information about these populations, from the various needs assessment sources and from client utilization data epi data versus client characteristics (to see which groups are over- or under-represented among clients), major barriers to care, service gaps, unmet need for HIV-related primary medical care, and client satisfaction with services.
- Information from this data sheet will be drawn from all data sources. Some desired information will not be available – but might be sought as part of needs assessment in future years.
- This information will be useful in priority setting and allocations, and will be particularly helpful in preparing directives for the recipient on how best to meet the priorities.

6. **Prepare a summary chart of the funding provided for major service categories through other funding streams** (sample provided). Be sure this is available for the PSRA process.
7. **Identify a list of service categories for consideration, including definitions, components, and how best to deliver each service.** Begin with those funded the current year, but consider all 13 core services and any support services that may possibly be of interest. Prepare a worksheet that lists all the service categories to be considered. Present them putting current prioritized services first, in their order of priority (sample attached).
8. **Agree on principles to be applied in decision making,** such as the following:
   - **Priorities and allocations are data-based.** This means that decisions are based on the data, not on personal preferences or individual experiences. Planning Council members are required to participate in the data presentation in order to participate in priority setting and resource allocations, and to be part of the full PSRA process (cannot come in for allocations but miss priority setting and review of requirements/expectations/procedures).
   - **Conflicts of interest are stated and managed.** Planning Council members state areas of actual or perceived conflict. They do not participate in discussions about service categories in which they have a conflict. Voting on priorities and allocations is done through completion of individual forms, to minimize the likelihood that any member feels pressured to take a particular position about priorities or allocations.
   - **Data from different sources are "weighted."** The more reliable the data source and the larger the number of PLWH perspectives involved, the greater weight given to that data in setting priorities and allocating resources. Anecdotal data and "impassioned pleas" may have been presented in discussions or in focus groups and surveys, and they become one of the data sources considered. But they should be given less weight than a survey of hundreds of people or other more formal needs assessment data sources.
   - **The priorities and allocations from the prior year serve as the base for decision making this year.** This means using the priorities and allocations form submitted to HRSA/HAB in

last year's application. The group may well make major changes based on experience gained, and on additional information about service needs/gaps and availability. The full-year experience from the prior year [for new TGAs, when part of the TGA was an Emerging Community] should also be considered – including priorities, allocations, and any unmet demand for services such as waiting lists.

- **Needs of specific populations and geographic areas are an integral part of the discussion,** in the data presentations and the decision making. They also lead to directives to the recipient on how best to meet the priorities.
- **Decisions should help to ensure parity in access to care,** for all Ryan White-eligible HIV/AIDS population groups and for PLWH/A regardless of where they live in the TGA.
- **There will be a major focus on improving performance on the HIV Care Continuum/Treatment Cascade,** focusing on areas of concern – such as linkage to care or retention in care. Reducing unmet need (the number of people who know they are HIV-positive but are not in care) requires deciding how many "new" or "lost to care" clients should be identified, estimating the mix of services they will need from RWHAP Part A, and allocating funds sufficient to meet those needs. Where a choice needs to be made between providing a wider range of services to more individuals and getting additional people into care, the Planning Council will give priority to getting more people key services (among them primary care and medications).
- **The Planning Council will keep in mind current TGA goals, objectives, and priorities from its comprehensive integrated plan** to be sure they receive appropriate attention in decision making.

9. **Agree on the process for priority setting:** this includes the criteria for deciding whether to include a particular service category and determining its relative priority, and the decision-making/voting process. ***Priority setting means determining what service categories are most important for PLWH in the TGA. Priorities should not be influenced by availability of funding or by who provides the funding for these services.*** You cannot allocate funds to a service category unless you have prioritized it. At a minimum, this process should include:
   - Look at the full list of allowable service categories, and clarify service definitions. Clarify which are core services and which are support services.
   - Review the current list of priorities against the needs assessment data.
   - Identify any service categories not prioritized last year that appear important, given the data.
   - Identify and agree to include some service categories that may not be fundable next year due to resource limitations, but that appear to be needed – in other words, prioritize more service categories than you believe you can fund. That way, you can add them if you get more funding or need to reallocate.
   - Agree as a group on priorities if possible. If there is substantial disagreement, or if any members feel it is important to do priorities by "secret ballot," vote anonymously and individually. One approach: Each Planning Council member receives a Priority Setting Work Sheet or a set of index cards that each lists and defines one service category, and

puts them in desired priority order. Staff then averages the priority rankings to get a cumulative ranking.

- Review the aggregate rankings and adjust as needed.
- Review the priorities against the core services list and be sure there is a rationale if any are *not* prioritized (you are required in the RWHAP Part A application to give a rationale if you do not fund any core service – it is OK not to prioritize or fund them, but you should *consider* them all).
- Agree on a final list of priorities based on your chosen decision-making process and be sure everyone understands the list and its implications. Differentiate core and support services before you start making allocations.

10. **Agree on the process for resource allocations:** principles, criteria, decision-making process, and data to be available for allocating funds to service categories. ***Resource allocation is the process of deciding how much funding to allocate to each priority service category.*** In allocating resources, it is important to:
    - Decide whether to use multiple "scenarios." A typical approach is to allocate assuming flat funding, a 5% increase, and a 5% decrease. Develop worksheets with the totals already determined (samples provided).
    - Review the needs assessment data and cost and utilization data to learn whether there are any waiting lists for currently funded services or whether there is limited access to some services.
    - Keep in mind key legislative requirements that:
        - 75% of service dollars must be used for identified core medical services.
        - RWHAP Part A programs are required to include in their applications a rationale for *not* funding specific core services.
        - Support services must contribute to positive clinical outcomes for clients.
    - Review current allocations and available utilization data to see if there appears to be the expected level of demand and expenditure (data may be limited). [For new TGAs, review Emerging Communities data if available.]
    - If possible, determine the approximate cost per client per year for providing the service. This helps you decide how much to allocate based on how many clients you expect to serve in each service category.
    - Begin with the flat funding scenario.
    - Consider the total number of clients you expect to serve, and make rough estimates for the number of clients you will serve in each service category. First look at current clients. Then consider the number of new clients you expect to bring into care during the next fiscal year. Hopefully you will have information from staff about the mix of services they are likely to need and the proportion that are likely to need medical care funded by the program. Include them in your estimates of number of clients by service category.
    - Have available information on other funding streams (sample provided), since Ryan White is the payer of last resort. Review those data just before doing the allocations.

- Begin to allocate funds to each service category based on costs per client. Use a worksheet that calculates costs and totals for you (sample provided).
- If there are disagreements, vote as you go on key decisions like number of clients to be served.
- Review initial allocations to see the totals, and adjust as needed.
- Review to be sure you are meeting the requirement that 75% of service funding be allocated to core services. Adjust as needed.
- Complete the worksheet, and have a final vote or use a consensus process to be sure it has the support of the majority of the Planning Council members participating.
- Once you have completed the first scenario, go to the plus 5% and then the minus 5% scenarios. In doing these allocations, you may want to fund additional service categories for the plus 5% scenario, and fewer categories for the minus 5% scenarios. Do not simply add 5% to or subtract 5% from each service category, although you may want to see what that would provide. Consider the following:
  - It doesn't make sense to simply make percentage reductions to all categories. Core services may need their full funding, and because sometimes the amount left becomes so small that the contribution to care will be minimal and/or it is no longer a reasonable program for a provider.
  - It may make sense to fund additional service categories with the plus 5% scenario, to broaden the system of care. Or you may prefer to bring more people into care, and add funds to key service categories to support them. Decide based on your unmet need, other needs assessment, and cost and utilization data. Use a cost-per-client approach to determine final allocations.

  Be sure to vote or get final consensus.

11. **Agree on a process for developing directives.** ***Directives are guidance to the recipient on how best to meet the priorities and other factors to consider in procurement.*** They often specify use or non-use of a particular service *model*, or address *geographic access to services, language issues, or focus on specific populations.* They will arise as the group discusses issues of parity – how to ensure there are services in outlying counties – and obstacles to care – like the need for evening and weekend hours at primary care facilities. Where the Planning Council feels strongly that the recipient needs to take a particular action regarding a service model or access issue in order to implement the services as prioritized, it can prepare a directive. The Planning Council needs to be aware of cost implications of directives – evening or weekend hours are important, but will increase costs. The RWHAP Part A recipient must follow Council directives in procurement and contracting, but the directive must not limit the procurement process by making only one or two entities eligible to apply.

PSRA Implementation

1. **Provide a Data Presentation to the Planning Council, using the Data Sheets and supporting information.** This may happen at a meeting before PSRA is done (ideally) or be the first segment of the same meeting. A typical process:
   - Staff will present data from each source, with the involvement of Planning Council members (in future years, hopefully the Needs Assessment Committee will review different kinds of data and help with the presentations). Recipient staff will present data from their work (e.g., utilization, unit costs and costs per clients, quality management – whatever is currently available).
   - Greatest attention during the presentation will be on data that need the most interpretation or explanation to be understood and used by Planning Council members.
   - Ideally, the presentation should occur at a meeting prior to the priority setting and resource allocations process, so Planning Council members have time to discuss and absorb the information before using it in decision making.
   - Planning Council members will be instructed to give more weight in their decision making to data that is more reliable and represents information from larger number of PLWH.
2. **Introduce the PSRA process.** Begin the PSRA session (or the second segment of a combined data presentation-PSRA session) by reviewing the tasks to be accomplished and your own groundrules, principles, and procedures. Answer questions. Ensure clarity on the process and recognition of the need to work some things out as you go.
3. **Carry out priority setting.** This process should follow the principles already determined (see Preparations, #8). Be sure there is a clear presentation of the steps in priority setting and agreement on how decisions will be made *before* starting. Emphasize that the Planning Council will look at essential and core services and at other services that may be important based on needs assessment data. All priorities will be reviewed. All core services will be considered. Be sure there is an understanding of the service definitions for each service category. Generate a rank-ordered list of priorities that identifies core and support services.
4. **Allocate resources to the priority service categories.** Use the principles and process developed earlier (see Preparations, #9) to allocate resources. Be sure there is understanding about the principles and decision-making process and about the use of three scenarios.
5. **Provide directives to the recipient on how best to meet the priorities.** Usually there will be only a few directives. Perhaps the group will have general ideas for directives, or perhaps there will be concerns that need to be met – for example, make sure services are available and accessible in outlying counties, make sure there are providers with Spanish-speaking staff, deal with cultural competency issues within all providers. Don't worry about the precise language – focus on identifying issues that the recipient should consider, and the recipient can help figure out how to address them in the procurement or contracting process.

6. **Schedule a review of the process within a month after implementation,** and identify changes needed for next year. Many programs ask Planning Council members to assess the PSRA process at the end of the meeting, and use this information for process improvement.