Model Priority Setting and Resource Allocations (PSRA) Process for an EMA

**Purpose:** To provide a streamlined but inclusive Priority Setting and Resource Allocations (PSRA) process for an EMA that:

- Is data based.
- Involves the entire Planning Council (PC) in the process.
- Requires prior participation in a separate data presentation and in training/orientation to the PSRA process as a condition of participation in the decision making.
- Can be completed in one day (separate from the data presentation).

**Components:**
- Data presentation, including epi, needs assessment, client utilization, and cost data
- Orientation to the PSRA process
- Priority setting and resource allocations (in one day)
- Follow up on directives

**Steps:**

1. **Review the priority-setting and resource-allocation process and its desired outcomes.**
   Ideally, this should be done at a PC meeting prior to data presentation and the PSRA session or at the beginning of the data presentation session, then briefly reviewed the day of the PSRA. It should provide an overview of steps and also address the following:
   - **How decisions will be made** – By consensus if possible, and by voting individually or on a slate if there is disagreement.
   - **How you will manage conflict of interest:** Any funded Part A provider (staff member, Board member, or consultant) must declare all conflicts of interest based on funded service categories 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.
   - **The process for accomplishing the work:** The agenda, responsibilities for facilitation and presentations, as well as responsibilities for recording decisions, groundrules to be followed during the process, etc.
   - **How you will keep the process data-based and avoid “impassioned pleas.”** The data presented at an earlier session will be briefly summarized at the beginning of the session and can be referred to, but *no “new” data will be presented during the decision making* – since there is no time to discuss and assess it. 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. The officers or facilitators – or other Planning Council members -- should remind people when this principle is in danger of being violated.

2. **Review relevant legislative requirements and program guidances.** Be clear on the 75% core services requirement and the list of allowable services. Be sure everyone is familiar with
the service definitions, and have a copy of these definitions in everyone’s packet. Ensure a common understanding of requirements, expectations, and allowable service categories.

3. **Review materials in the packet that provide data “inputs,” including needs assessment summary data, cost and utilization data, and summary data on funding provided for major service categories through other funding streams.** Cost and utilization data and other funding streams data should have been discussed at the data presentation along with epi and needs assessment data.

4. **Agree on the process for discussing possible “directives” or recommendations** to the grantee on how best to meet the priorities established by the PC and other factors the grantee should consider in procurement of services. You may want to agree that you will discuss and record possible recommendations, then send them to a committee for final wording. 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 PC feels strongly that the grantee 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 PC needs to be aware of cost implications of directives – evening or weekend hours are important, but will increase costs. The grantee 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.

5. **Review and ensure agreement on the principles to be applied in decision making,** including the following (add others as needed):
   - **Priorities and allocations are data-based.** This means that decisions are based on the data, not on personal preferences or individual experiences. PC 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). Data used for decision making include epi data, other needs assessment data, and client utilization data and cost data from both the last full year and the current year. No new data will be presented the day of PSRA.
   - **Conflicts of interest are stated and managed.** PC members state areas of actual or perceived conflict. They do not participate in discussions about service categories in which they have a conflict unless they are asked a specific question.
   - **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, Town Hall meetings, focus groups, and/or 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 for the current program
year as submitted to HRSA/HAB, with any reallocations that have already occurred, as a base – and also looking at the end of year data for the prior year. MAI priorities and allocations are listed separately but included.

- **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 grantee 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/AIDS regardless of where they live in the EMA.

- **New HRSA/HAB requirements or policies resulting from the new legislation are stated and their implications discussed.** For example, the requirements for reaching HIV+/unaware are discussed, along with the expectation that programs will work to reduce the unmet need for HIV-related medical care by helping PLWH/AIDS enter care.

- **There will be a major focus on reducing unmet need** by getting people into HIV-related primary medical care and keeping them there. This means deciding how many “new” clients should be identified, estimating the mix of services they will need from 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 PC will give priority to getting more people key services (among them primary care and medications).

6. **Provide and discuss forms and aids**, including the Matrix of Service Needs and Gaps, the Priorities Work Sheet, and the Excel spreadsheets with multiple scenarios (which you project and fill in during the meeting).

7. **Review Groundrules.** Typically, these include at least the following:
   - The Chair runs the meeting or has a facilitator run it but serves as final decision maker when process questions arise.
   - Participants are expected to come for the whole day. A member who does not participate in priority setting cannot participate in resource allocations.
   - Everyone waits to be recognized before speaking.
   - The public is invited to attend but not to participate in the discussion (they should have been given an opportunity to participate during the data presentation). Only vetted PC members who are subject to conflict of interest procedures participate. A public comment period may be held at the end of the meeting if desired.
   - Resource experts from the Needs Assessment Committee and epi unit, and perhaps a consultant who prepared parts of the needs assessment, are available. Any PC member may ask them for a reminder of data around a specific population or service category that has already been provided to the PC in written form or through the data presentation.
   - The grantee is available as a resource to the PC in its decision making. The grantee provides its recommendations regarding both priorities and allocations in writing, preferably at several days prior to the session, and may be asked to explain them at any time. The PC may ask the grantee for content information such as an explanation of client cost and utilization data.
   - Rules of respectful engagement and communication apply.
8. Be sure everyone feels prepared to carry out the tasks specified and is comfortable with the Groundrules, principles, and procedures. Answer questions. Ensure clarity on the process.

9. **Do priority setting:** this includes reviewing the current year’s priorities and the list of eligible service categories, deciding whether to include each service category, then determining its relative priority. *Priority setting means determining what service categories are most important for PLWH/A in the EMA. 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. Before starting, review the steps in priority setting and agree on how decisions will be made. Emphasize that the PC will look at core medical-related services and at support services. Support services are funded specifically to improve access to and retention in care and improve medical outcomes. All priorities will be reviewed. All core services will be considered. The group will generate a rank-ordered list of priorities that identifies core and support services. Suggested process:

- Look at the full list of allowable service categories, and clarify service definitions. Be sure the list indicates which are core services and which are support services.
- Review the current list of priorities against the needs assessment data.
- Identify any changes in the legislation or in HRSA/HAB policies or guidelines that may make it important to consider additional service categories (such as Early Intervention Services as a way of finding HIV+/unaware people).
- Identify any service categories not prioritized in FY 2010 that appear important, given the data – receiving advice from the Priority Setting and Resource Allocations (PSRA) Committee and from the grantee.
- Remember that you should identify and include service categories that may not need to be funded because of other funding streams or that may not be fundable 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. This may not be difficult if needs remain relatively unchanged. If there is substantial disagreement, or if any members feel it is important to do priorities by “secret ballot,” vote anonymously and individually. Each PC member should have in his/her packet a Priority Setting Work Sheet that can be used for individual “voting.” Staff can then average the priority rankings to get a cumulative ranking. (This does, however, take an hour or so, which needs to be factored into the schedule – for example, done over a lunch break.)
- 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 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 and be sure notes are taken on the discussion, for inclusion in the application).
- 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. **Do resource allocations:** Begin by reviewing 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.** Review with the PC the importance of the following:

- Agree on use of multiple “scenarios.” For example, you may choose to first allocate assuming flat funding, then adjust for a 5% increase, and a 5% decrease. Begin with worksheets with the totals already determined.
- 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.
  - You must provide HRSA/HAB a rationale for not funding specific core services.
  - Support services must contribute to positive clinical outcomes for clients.
- Be sure there is understanding about the principles and decision-making process and about the use of three scenarios.
- Review the last full year’s allocations (as adjusted with any reallocations to date) and available utilization data and data from the current year if available, to see actual demand and expenditure. See how many clients you served in each service category.
- Review available data on the approximate cost per client per year for providing each service categories. This helps you decide how much to allocate based on how many clients you expect to serve in each service category. This information should be included in the Allocations Spreadsheet.
- Listen to any recommendations from the PSRA Committee and grantee, and ask questions about their recommendations and the rationale for them.
- Review information on how Minority AIDS Initiative funds are being used (information should be in the packets).
- 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 last year’s total number of clients and any projections for the current year. Then consider the number of new clients you expect to bring into care during next program year.
- Review available information on other funding streams, 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 – and project it using an LCD.
- 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 PC members participating.
- Once you have completed the first scenario, go to the plus and then the minus scenarios. In doing these allocations, you may want to fund additional service categories for the plus scenario, and fewer categories for the minus scenarios. Do not simply add X% to or
subtract X% 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 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 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. **Formally review and adopt your priorities and allocations.** Since the entire PC is participating, you can convene a PC meeting to do this as part of the process.

12. **Review possible recommendations/directives that have emerged during the priority setting and resource allocations.** Refer them to a committee for further review and refinement as needed. Perhaps the group will have general ideas for recommendations/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. If you feel more work is needed to get exact wording, that is fine – give this responsibility to a committee. Focus on identifying issues that need to be considered. It is very helpful to discuss ideas with the grantee and get cost estimates for implementing recommendations that involve changes in service delivery or additional expectations for funded providers.