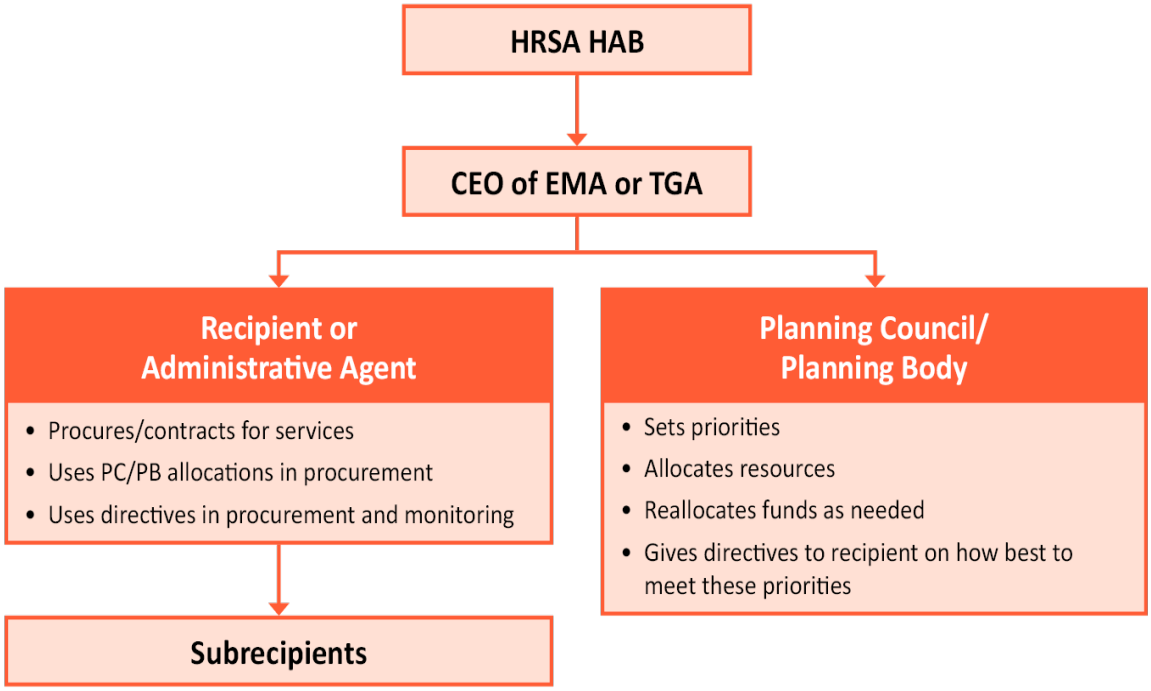
Quick Reference Handout 5.3: Priority Setting and Resource Allocation (PSRA) Overview

An Essential PC/PB Role

Priority Setting and Resource Allocation (PSRA) is the single most important legislative responsibility of RWHAP Part A planning councils/planning bodies (PC/PBs).[1] This duty is stated in the RWHAP legislation as follows: "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a recipient should consider in allocating funds under a grant" [*Legislation, Section 2602(b)(4)(C)*].

PSRA includes four closely interrelated components:

- **Priority setting:** The PC/PB determines what service categories are most important for people with HIV in the Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA) who depend on the Ryan White HIV/AIDS Program (RWHAP) Part A for their HIV care, and lists the service categories in priority order.
- **Resource allocation:** The PC/PB specifies how much RWHAP Part A program funding should go to each prioritized service, preferably specifying both the percent of program funding and the dollar amount for each funded service category. Often some service priorities with lower priority may not be funded, because the PC/PB believes they are adequately supported by other funding streams or because of Part A resource limitations.
- **Directives to the recipient:** The PC/PB provides written guidance to the recipient about how best to meet these priorities, usually with a focus on geographic location, tailoring services to subpopulations, use of innovative service models, or improving access to care, i.e., specifying what service models for which populations in which geographic areas of the EMA or TGA.
- **Reallocation of funds:** The PC/PB moves funds from one service category to another as necessary during the program year, to ensure that all RWHAP Part A funds are expended on needed services.



PSRA is important because PSRA decisions greatly influence the system of HIV care in the EMA/TGA, including such issues as:

- What services are available to people with HIV in the EMA or TGA, and the accessibility of those services, including where services are provided
- The capacity of funded providers to meet the needs of specific subpopulations and address HIV-related health disparities
- Service models used
- Access to and retention in care
- Clinical outcomes, such as viral suppression, for RWHAP clients

Program funds (funding for services) are at least 85% of the total RWHAP Part A grant award. Up to 10% may be used for administration (including PC/PB support) and up to 5% for Clinical Quality Management (CQM). Planning councils are decision makers in PSRA, while planning bodies make recommendations to the recipient.

RWHAP Part A-Fundable Service Categories

Core Medical Services (13)

AIDS Drug Assistance Program (ADAP) Treatments

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services (OAHS)

Substance Abuse Outpatient Care

RWHAP Support Services (15)

Child Care Services

Emergency Financial Assistance (EFA)

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services (e.g., Legal Services, Permanency Planning, Income Tax Preparation Services)

Outreach Services

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Guiding Principles

Examples of Principles Used in PSRA

PSRA decisions by the PC/PB will:

- Contribute to parity in access to care for all people with HIV regardless of where they live in the EMA/TGA.
- Consider the needs of specific populations, including disproportionately affected subpopulations.
- Help to reduce unmet need among people with HIV who know their status but are not in care.
- Contribute to an improvement in access to care, retention in care, and medical outcomes including viral suppression for all RWHAP clients.
- Be data-based, with greater weight given to data that have larger samples and are more representative.

The Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) recognizes that there are many "right ways" to carry out PRSA, but expects the process used to be appropriate for the EMA or TGA, carefully considered and discussed by the PC/PB, based on agreed-upon principles and criteria, and documented in writing. Policies approved by the PC/PB should be followed consistently, reviewed annually, and updated as needed.

HRSA HAB expects that:

- The entire PC/PB will participate actively in decisions about priority setting and resource allocation.
- Decisions will be made based on the best available data, not anecdotal information or "impassioned pleas" based on the personal experiences of a few individuals. In preparing for PSRA, the PC/PB reviews many types of information--such as needs assessment and service utilization data--and bases its PSRA decision-making on these data.
- PSRA meetings are open, with varied practices regarding public comment followed, but voting is done only by PC/PB members appointed by the Chief Elected Official (CEO).
- Conflict of interest is declared and managed, with clear policies and procedures that are consistently followed.
- Both the actual process and the results of PRSA meetings are documented in writing and available to the public.

Managing Anecdotes and 'Impassioned Pleas'

People with HIV, providers, and other community members should have an opportunity to present their perspectives prior to PSRA – at town hall meetings or during the annual data presentation. This includes hearing about the personal needs and challenges of people with lived experience. However, new information should not be presented during decision-making meetings, when there is no opportunity to look at other data to see whether it represents the experience of one or a few individuals or raises a broader issue that needs to be addressed through resource allocations. Training on using data for decision-making should help PC/PB members understand when they need to serve as advocates and when they should act as planners on behalf of all people with HIV in the jurisdiction. Resource allocation requires planners who make decisions based on the best available data.

Managing Conflict of Interest (COI) in PSRA

RWHAP defines a conflict of interest as "an actual or perceived interest in an action that will result – or has the appearance of resulting – in personal, organizational, or professional gain."[2] PC/PB members are considered to have a conflict of interest if they (or an immediate family member) are staff members, consultants, or board members of a Part A subrecipient or an entity seeking Part A funds. The PC/PB's conflict of interest policy and its PSRA process should describe how a member with potential conflict of interest is expected to behave. For example:

- A provider member that receives or is seeking funds under RWHAP Part A should have limited participation in discussion and should not vote on motions involving service categories where they have a COI. One exception: it is generally all right for such members to vote on the full slate of service priorities or allocations at the end of the process.
- Subrecipients can provide input to the PSRA process during town halls or a provider forum – but not during decision-making sessions on priority setting or resource allocation.
- New data should be introduced at the data presentation or a town hall or provider forum – but not at decision-making sessions, where there is no ability to review the accuracy of the information against other sources.
- Sound practice is not to allow a subrecipient to initiate discussion during decision-making.
- Content questions about a service category should be directed at, and answered by, recipient staff or the appropriate committee chair, not by a funded provider.

The PC/PB's policy should state how COI violations should be handled. Immediate response is often the responsibility of the Chair of the resource allocation session, with serious violations referred to a committee for further action.

Recipient Role in PSRA

Recipient staff play a very important role in the PSRA process. The recipient:

- Provides considerable data for PSRA, typically including overall and category-specific data on client characteristics, service utilization, service costs by unit or client, and summary information from clinical quality management (CQM) activities
- Is often asked to provide and present suggestions or factors to consider in setting priorities, framing directives, and making allocations
- Provides pre-meeting input on the costs of implementing proposed directives
- Has several staff present throughout the process to provide data and to answer questions
- Serves as a source of information about the system of care – so these questions are not addressed by subrecipients with potential conflicts of interest
- Does not vote or try to influence PC/PB decision-making.[3]

PSRA Models

In choosing or rethinking its PSRA model, the PC/PB should consider several questions, including:

1. Should initial work and recommendations be done in committee or by the entire PC/PB?
2. Should the process occur through meetings over several months, or in several days of intensive sessions?
3. How should the PC/PB provide and manage data to consider in decision-making – hold presentations over multiple PC/PB meetings with summaries just before PSRA, or one major data presentation that begins the PSRA process?
4. What aids are needed to support and maximize data-based decision making, and should they be hard copy or electronic (for example, data matrix summaries, scorecards to tally votes on service category priorities, spreadsheets to record and calculate allocations)?
5. How should the PC/PB develop and adopt directives?

A committee-based model of PSRA often involves work by several committees, depending on the PC/PB's committee structure. For example, if the PC/PB has a separate Needs Assessment Committee, it might manage the data presentation, the Care Strategy/System of Care Committee could take the lead on developing directives, and the PSRA Committee might develop recommended priorities and allocations for the full PC/PB.

Here are some sound practices:

- **Data presentation:** All PC/PB members should be expected to attend the annual data presentation, so all are familiar with the data used in decision-making and prepared to review and approve the recommended priorities, allocations, and directives.

- **PSRA Committee:** The committee with primary responsibility for PSRA has many responsibilities. It should be as diverse as possible, representing multiple subpopulations of people with HIV and many different PC/PB membership slots. The committee must not be provider-driven or consist primarily of individuals with conflicts of interest. Funded providers will not be permitted to vote on many or most decisions and if they are over-represented, there could be very few PC/PB members left to make those decisions. The committee should focus on the most recent available data and always be aware of when and how that information was obtained. It should include a clear rationale for its decisions.
- **Committee recommendations:** The committee's recommendations go first to the Executive Committee and then to the full PC/PB. Those recommendations should include a ranked list of priorities, a list of directives, and tables of allocations for Part A and Part A Minority AIDS Initiative (MAI) funds, preferably for three different funding scenarios (level funding, increased funding, decreased funding), as well as a summary report that includes the following:
  - The principles, criteria, and process used in decision-making
  - Key data inputs used
  - An overview of recommended allocations
  - A description of recommended changes in allocations by service category including specific data-based reasons for those changes
  - Information on the cost implications of directives
- **Executive Committee:** The Executive Committee reviews the recommendations, including the narrative report and the information on priorities, directives, and allocations, and identifies any data (from the data presentation) that may not have been fully considered. It may ask for revisions in recommendations or in the written rationale for them.
- **Full PC/PB:** The full PC/PB receives, reviews, discusses, and either modifies or approves committee recommendations. The PC/PB's role is not to simply approve the committee's recommendations. It should:
  - Schedule an in-depth presentation and review of recommendations;
  - Review data and ask questions about anything that is unclear or involves changes without a clear explanation;
  - Make needed revisions or send recommendations back to committee for further work if necessary; and
  - Approve recommendations based on a data-based, informed review.

The full PC/PB model of PSRA includes the same components, but involves the entire PC/PB. One or more committees may coordinate the process, but all PC/PB members participate in setting priorities, allocating resources, and discussing and approving directives. PC/PBs often use these sound practices:

- Members review the entire PSRA process each year to ensure that everyone is familiar with each step.

- Only members who participate in the data presentation may vote on PSRA, since being familiar with the latest data supports data-based decision making.
- Data presentation, priority setting, and resource allocations are scheduled on separate days, since each one is demanding and should not be hurried.
- Voting is used rather than consensus due to group size; if consensus is preferred, the PC/PB allows sufficient time for the necessary process.
- Directives are developed ahead by a committee or task force, but presented for approval just before resource allocation so the costs of implementation of the directives can be considered.
- The process reflects careful scheduling by leadership and PC/PB support staff and strong meeting management by a Co-Chair or outside facilitator.

End Notes

[1]Based on Module 5 PowerPoint slides 5-14and 48-58.

[2]Ryan White HIV/AIDS Program Part A Manual (2013).

[3]The following guidance is provided in a RWHAP Part A Recipient Letter from the Director of the Division of Metropolitan HIV/AIDS Programs (DMHAP): "A recipient representative whose position is funded with RWHAP Part A funds, provides in-kind services, or has significant involvement in the RWHP Part A grant, shall not occupy a seat in the PC/PB, nor have a vote in the deliberations of the PC/PB"; see https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/planning-council-planning-body-requirements-expectations.pdf.