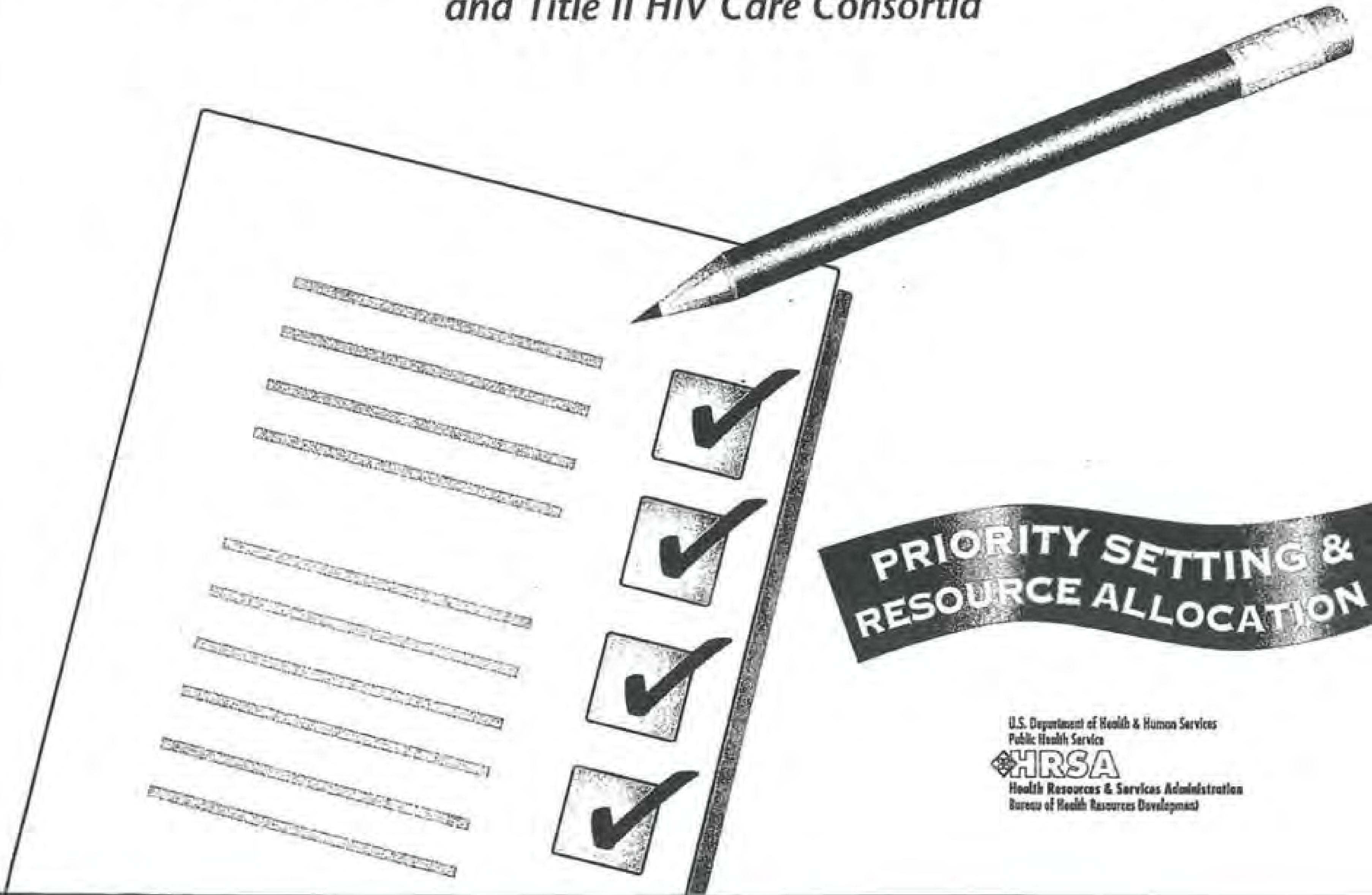
SELF-ASSESSMENT MODULE

for Ryan White CARE Act Title I HIV Health Services Planning Councils and Title II HIV Care Consortia



U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Bureau of Health Resources Development

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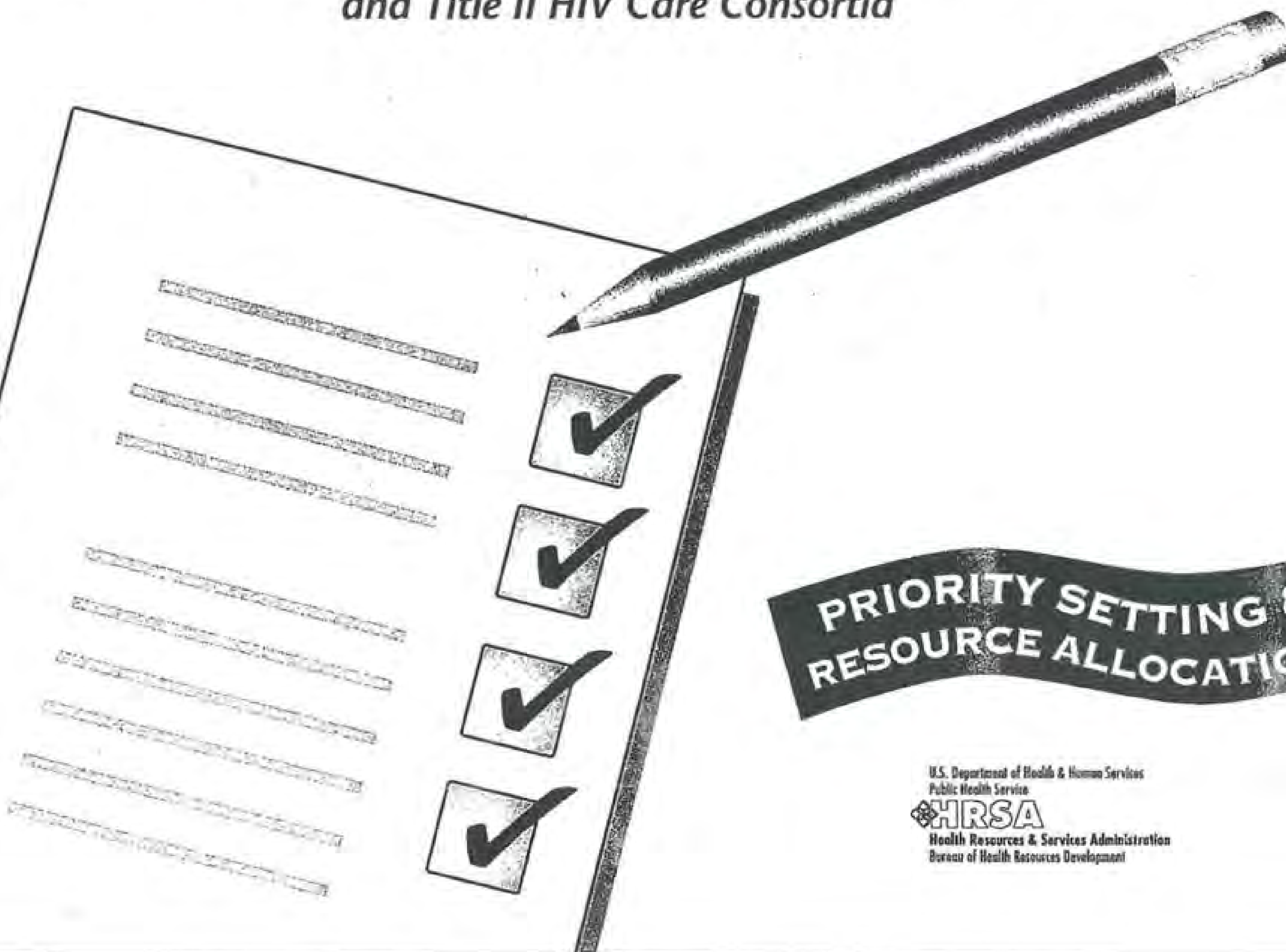

ACKNOWLEDGEMENTS

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INTRODUCTION

The Self-Assessment Module Series

The Division of HIV Services (DHS) and the Office of Science and Epidemiology (OSE) at the Health Resources and Services Administration (HRSA) have developed a series of tools to help HIV planning councils and consortia assess their effectiveness in critical areas of responsibility defined by the Ryan White CARE Act. The areas covered in the series are: Comprehensive HIV Services Planning, Continuum of Care, Developing and Pursuing the Mission, Needs Assessment, Priority Setting and Resource Allocation, and Representation and Diversity.

Each area is covered in a separate module. At the same time, information is complementary across the modules and cross-referenced when appropriate. The modules can be used independently of each other or as a full series.

The tools have been designed to facilitate **self-assessment** by planning councils and consortia. **Use of any and all modules in the series is completely voluntary. Councils and consortia are free to determine which area(s) they want to assess, when to conduct the self-assessment, how extensive the scope of the assessment will be, and with whom they will share results.**

DHS staff and the Technical Assistance Contractor are available to introduce the modules or to respond to any concerns raised through the self-assessment process. Please contact your DHS project officer if you have any questions about the self-assessment modules or would like assistance.

Purpose of the Priority Setting and Resource Allocation Module

Before Title I and Title II grantees contract with service providers to deliver HIV care services, Title I Planning Councils, Title II Consortia, and grantees must set service priorities and decide how funds should be allocated to various categories of HIV services. A well-managed priority-setting and resource-allocation process will result in available funds being used to fill service gaps effectively. The goals of the process are to increase access to services for populations in need and to strengthen the continuum of care.

This module is designed to help councils and consortia assess the **scope, structure, process,** and **results** of their priority-setting and resource-allocation efforts. Once you have completed this self-assessment, you will know whether CARE Act funds have been allocated wisely. In addition, the module encourages councils and consortia to improve their operations using sound organizational practices. Current legislative and administrative requirements are included where appropriate.

Legislative and Administrative Requirements

The legislative requirements and administrative guidance regarding priority setting and resource allocation are far more clearly defined for Title I Planning Councils than for Title II Consortia.

For Title I

- A mandated function of Title I HIV Health Services Planning Councils is to "establish priorities for the allocation of funds" within the eligible metropolitan area (EMA), including how best to meet each priority. According to the CARE Act of 1996, a planning council should also consider the following when allocating funds:
  - documented needs of the HIV-infected population;
  - cost and outcome effectiveness of proposed strategies and interventions to the extent that such data are reasonably available;
  - priorities of the HIV-infected communities for whom the services are intended; and
  - availability of other governmental and non-governmental resources.
- The 1996 CARE Act also requires that "in accordance with planning council established priorities" the percentage of funds spent on services to infants, children, and women is not less than their percentage of the EMA's AIDS cases.
- Grant application guidance typically requests Title I grantees to describe the priority-setting and resource-allocation process, including opportunities for community input, use of quantitative and qualitative information, and provision for other available funding streams.
- Title I applications include a summary of priority services to be funded in the coming fiscal year. Grantees are expected to list service categories (often including affected populations and/or geographic areas) by level of priority and to indicate the amount of formula and supplemental Title I funds to be used for each.
- The Chief Elected Official of the EMA is required to certify that "the allocation of funds and services within the EMA will be made in accordance with priorities established... by the HIV Health Services Planning Council that serves the EMA."

For Title II

- States are required to develop "a comprehensive plan for the organization and delivery of HIV health care and support services," and as part of this plan, they must "describe the purposes for which the state intends to use the grant assistance, including the services and activities to be provided."
- Title II Care Consortia must establish a service plan that addresses the special care and service needs of populations and sub-populations.
- The 1996 CARE Act also requires that each state spend a percentage of funding for services to infants, children, and women with HIV disease that is not less than their percentage of the state's total AIDS cases.
- Title II application guidance typically provides a list of HIV-related service categories, but grantees are not required to use these categories in their implementation plan for the coming year or to list service categories by priority area.
- Title II application guidance requires that the state application include, for each funded consortia, the services that were funded and the dollar amounts for each service.

When the National Alliance of State and Territorial AIDS Directors conducted a review of state Title II planning activities, it found that although information about priority setting and resource allocation is not required in the preparation of the implementation plan, some states do provide it.

Definitions and Terms

The following definitions and descriptions of terms are consistent with DHS practice, as reflected in CARE Act guidance.

- **Priority setting** refers to the establishment of numerical priorities among various categories of HIV services, such as case management and transportation, and among geographic areas, populations, or sub-populations if needed. Priority setting is also conducted for planning council or consortium support, and program support (e.g., capacity building, technical assistance, and quality assurance). In this module, references to priority setting for HIV services include these categories as well. As indicated in the Title I guidance, the number one priority should reflect the service category or community considered the most critical for the use of Title I funds, based on specific criteria including documented unmet service needs for which there are insufficient alternative funding sources. The setting of priorities should be based on needs assessment results.
- **Resource allocation** refers to the allocation of amounts or percentages of CARE Act funds to established priorities—service categories, geographic areas, populations, or sub-populations. It does NOT involve contracting with or disbursing funds to specific service providers; this is a separate function that is the responsibility of the grantee or administrative agency. Some consortia serve as administrative agencies and are involved in the contracting process. However, a planning council may not participate in the procurement of AIDS services. Therefore, this module does not address the details of procurement.

- **Service categories** refers to various types of HIV-related services, such as medical and behavioral health services, case management, and support services. This module uses the service categories specified in the Title I and Title II guidances and can be found on page 72 of this module.
- **Decision making** is used in this module to refer to both the priority-setting and resource-allocation process.
- **Methods for decision making** include a variety of structured and semi-structured procedures for reaching group agreement on service priorities or amounts of funding to be allocated to specific service categories. Some of these methods are described in the Title I grant application guidance: *Examples of Decision-Making and Priority-Setting Methods* included on page 68. This module does not assume that the planning body should use any specific decision-making method, but it does suggest the need for a clearly defined procedure allowing for equitable input from all planning body members.
- **Conflict of interest**—in the context of priority setting and resource allocation—occurs when a member of a planning body also serves as a director, trustee, salaried employee, or otherwise benefits materially from association with any public or private agency which may seek funds from the grantee, and that member either fails to disclose this relationship or participates in a process that relates to the source of the conflict. Any individual member agency that is bidding for services may not be on review panels if it is bidding for those services.

CONDUCTING THE SELF-ASSESSMENT

This section discusses how to conduct the self-assessment. It provides tips to make the self-assessment process efficient, productive, and positive. While the recommendations are based on experience and pilot tests of the modules, each planning council and consortium should adapt these processes to fit local constraints and issues. The discussion covers the following questions.

- Who should use this module?
- Who conducts the self-assessment?
- What activities should be part of the self-assessment?
- How much time and money are required?

WHO SHOULD USE THIS MODULE?

This module is designed for use primarily by planning councils and consortia that have participated in at least one cycle of priority setting and resource allocation for their service area. This cycle begins with the setting of priorities based on a needs assessment and other data and ends with contracting.

A newly established planning council or consortium may find the module—and especially its benchmarks—useful as a checklist of issues to consider and results to strive for in designing and implementing a priority-setting and resource-allocation process.

All planning councils must undertake priority-setting and resource-allocation activities as a part of their legislative mandate, although the structures and processes used may vary. Title II Consortia are often involved in some aspect of priority setting and/or resource allocation but are not specifically required to carry out such a process. While sound practice is likely to be similar for the two titles, Title II planning bodies may want to modify or eliminate some questions in the module if they do not engage in a structured priority-setting and resource-allocation process. Benchmarks that apply to a particular title are clearly identified.

Use of this module is completely voluntary. The decision to conduct the self-assessment belongs to the membership of the council or consortium and to no one else. Councils and consortia are free to determine when to conduct the self-assessment and how large or small the scope will be.

WHO CONDUCTS THE SELF-ASSESSMENT?

A committee or workgroup should oversee the implementation of the self-assessment. This could be the same group that made the recommendation to do the self-assessment or a newly convened group. A group of five to ten is suggested and should include representatives of the infected community. Attention to sexual orientation, racial, ethnic, and gender diversity is also critical. Geographic representation should be considered, especially when the service area is diverse. Some of the group should be drawn from existing council or consortium membership, but it is also possible to go outside the membership for specific expertise. In general, it is desirable to include a grantee representative in order to promote a cooperative and collaborative relationship. Including representatives from the grantee or others outside the planning council or consortium membership (such as from colleges or universities) may facilitate access to information and/or provide additional resources for completing the module.

The person(s) directly responsible for priority setting and resource allocation should not lead the self-assessment because it may be difficult for him or her to be objective. However, his or her participation in the workgroup will provide an important perspective and may help ensure that improvements are implemented. The self-assessment workgroup should receive a written charge from the planning council or consortium authorizing the self-assessment.

This and all the other self-assessment modules have been designed to be completed by groups of volunteers—members of councils and consortia and others. However, council or consortium staff may also be involved, depending on local circumstances and availability. For instance, council or consortium staff may be needed to assist in the gathering of documents and in ensuring effective communication among members during the process. Consultants should not be used to conduct the self-assessment. However, they may be helpful in modifying this module for the local environment or in facilitating the self-assessment process. DHS staff and the Technical Assistance Contractor are also available to assist with using the module.

WHAT ACTIVITIES SHOULD BE PART OF THE SELF-ASSESSMENT?

There are five major activities that must occur to complete the self-assessment:

1. Review and adapt the module to the local environment.
2. Collect information and documents needed to answer the questions in the module.
3. Answer and score the questions in the module.
4. Develop an action plan to guide future activities.
5. Apply results of the self-assessment.

Tips are offered for each of these activities.

1. **Review and adapt module.** After the decision is made to proceed with the self-assessment, the first step is to review the module and adapt it as necessary. For example, questions that are irrelevant should be eliminated. Careful review of all the module's sections at the outset will facilitate its implementation and minimize frustration among workgroup members.

   The module should be distributed to all members of the self-assessment workgroup approximately one week before the first workgroup meeting. This meeting, in person if possible, should be used to determine the specific scope and content of the self-assessment to be implemented, clarify the purpose of the self-assessment, define the process and time line by which the self-assessment will be conducted, assign roles and responsibilities of workgroup members, and clarify specific questions for all members. If a chairperson has not been appointed, one should be elected at this meeting.

2. **Collect information and documents, conduct interviews.** Once the workgroup has agreed on the scope of the self-assessment, members should proceed with collecting and reviewing related documents and information. Interviews with key people involved in priority setting and resource allocation should also be scheduled.

   Documents could include the tools used in priority setting and resource allocation like survey instruments, the most recent needs assessment, meeting minutes, and attendance logs from meetings of committees or advisory boards which participated in the process, as well as council or consortium meetings where the process was completed

or approved, or other working papers and reports used to set priorities and allocate resources. **The module will be much easier to fill out if you have the list of services and community priorities readily available.**

Interviews could be conducted with members of the council or consortium committee that oversaw the process; council or consortium staff or consultants who worked on the priority setting and resource allocation process; and people representing affected populations. To keep these interviews focused, remember, the goals are to gain understanding about how well the process was conducted and to identify areas for improvement in subsequent activities, not to repeat the process itself. Interviews should be conducted by more than one person in order to be completed in a timely way.

3. **Answer and score the questions.** After collecting relevant information and conducting key interviews, the workgroup should convene to discuss the questions in the module. Depending on the number of questions being addressed, the discussion could take four to six hours. The discussion may occur in a single meeting, in a series of meetings, or by telephone conference calls. The questions have been subdivided into sections to facilitate a segmented discussion.

   Many questions will require significant discussion and coming to consensus. It is important to choose an individual who can focus and facilitate discussion.

   There are two important parts to answering the questions. First, and most important, is a qualitative discussion of the question, what the council or consortium did well, and what it could do better. Second is assignment of a score when scoring is indicated. Numerical scoring is provided on several questions to help the council or consortium identify areas of strength and weakness. The scores can also provide a baseline for future self-assessments.

   A question-by-question overview and discussion of scoring is provided at the end of each section. The overview elaborates on each question and how to interpret your score and answers. It may be helpful to refer to this overview while answering the questions.

   The points in each section are added up then divided by the number of scored questions (and subquestions) in the section. By dividing the total points by the number of scored questions, you will have a single score of 0 to 3 for each section. That score can be compared to the score in other sections. Combined with a qualitative assessment of strengths and weaknesses in each section, the scores can be helpful in highlighting areas where a planning council or consortium has done very well (high scores, e.g., 2 to 3), as well as areas in which changes or enhancements should be considered (low scores, e.g., 0 to 1).

There is no single approach to scoring the module. Workgroup members can arrive at a meeting with their modules scored throughout and use these scores to track consensus or disagreement. Alternatively, members, working in teams, can take responsibility for answering the questions in a section, score the section, and then provide their averaged scores to the full group for discussion. Some planning councils and consortia may want to tabulate everybody's score in advance of the meetings, so that averages for all the scored questions can be referred to throughout the meeting and used as the basis for deliberation.

Assigning scores is not the ultimate goal of the self-assessment. It is much more important that the group engage in substantive discussion of the questions. If you get stuck on scoring, move on. All scores are confidential and are not compared across planning councils and consortia or shared with DHS.

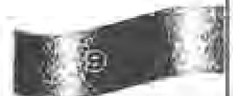
4. **Develop action plans.** Each section of questions concludes with the development of an action plan for that section. The self-assessment will be most successful if it keeps what works well, modifies what doesn't, and adds important aspects that are missing. The action plans are intended to lead a planning council or consortium forward. Particular attention should be paid to questions that were scored 0 or 1, because these may be problem areas. You should not, however, lose sight of areas of strength when planning future activities.

   A format is provided for developing the action plan for each section, but it may be modified to meet the needs of a particular planning council or consortium. For each section you are asked to list objectives, time line, resources needed, and person responsible for completing the objective. Once the section-specific action plans are done, an overall plan with priorities should be developed.

5. **Apply results.** The results of the self-assessment, including answers to questions, scores, and action plans, belong to the planning council or consortium and to no one else. However, a planning council or consortium may decide to share part or all of its results with the grantee, with DHS, or with the community.

   The overarching purpose for conducting a self-assessment is to improve the functioning of the council or consortium. There may be other reasons for conducting the self-assessment, such as responding to local questions or concerns, but the self-assessment modules have been designed primarily to give councils and consortia tools to help them improve the quality of their operations. The action plan component of the module is intended to lead to such improvements. Viewing the module as a quality improvement tool supports the premise that results of the self-assessment are for internal use and do not need to be shared, except at the discretion of the council or consortium.

   At the conclusion of the self-assessment, the planning council or consortium may want to develop a brief report in order to keep colleagues informed. The report could address the charge to the workgroup or committee, workgroup membership, and process used to complete the module (e.g., number of meetings, time lines, people interviewed, documents reviewed).



How Much Time and Money Are Required?

The self-assessment process has been designed to be very low cost. Time is the principal investment required of those who help complete the module.

Once a planning council or consortium has decided to proceed with the self-assessment, the process should take between eight and twelve weeks, beginning with tailoring the module to the local environment and ending with an action plan and reporting of results to the council or consortium.

A suggested time line for the self-assessment follows. →

Phase I — Deciding to do Self-Assessment

Week 1: Convene group to consider the self-assessment process; make recommendations to planning council or consortium.

Week 2: Planning council or consortium decides to proceed with self-assessment; identifies *ad hoc* workgroup to conduct assessment; writes charge to the workgroup; decides who will get results.

Phase II — Beginning the Self-Assessment

Week 3: Self-assessment module distributed to workgroup members for review; first meeting of workgroup scheduled.

Week 4: Workgroup meets, elects chair, reviews and modifies questions, assigns responsibilities.

Weeks 5-6: Documents collected and reviewed; interviews conducted.

Phase III — Answering Questions

Week 7: Workgroup meets to discuss and to score questions; develops action plans for completed sections.

Week 8: Workgroup meets to complete discussion and action plans.

Phase IV — Reporting and Implementing

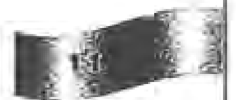
Week 9: Workgroup presents results to planning council or consortium; reports on process and preliminary action plan.

Weeks 10-12: Planning council or consortium decides on action plan; requests technical assistance if needed.

Information Sources

To complete the Priority Setting and Resource Allocation module, you will need:

- charts or tables developed by your council or consortium that show the agreed-upon priorities and resource allocations for the past year. The document used at the meeting where the council or consortium made its decisions should be a primary source. Also, for Title I Planning Councils, you should have the *Summary of Priority Services to Be Funded* table from the supplemental grant application; for Title II Consortia, this information may be contained in the consortium service plan, or in the state HIV/AIDS plan submitted to DHS.
- copies of the most recent needs assessment reports, particularly those sections which identify (1) populations and communities of greatest need and (2) service needs and gaps
- documentation of contracts awarded during the past fiscal year, showing the amount and percentage of funding allocated by service priority
- bylaws, policies, and other written documents which specify the structures facilitating priority setting and resource allocation, and the process to be used for this decision making
- results of evaluation of client satisfaction, cost and outcome effectiveness, and quality assurance
- information about resources for AIDS services other than Ryan White funds
- bylaws or policies involving the management of conflict of interest, including any specific materials addressing conflict of interest in the priority-setting and decision-making process
- minutes or other documentation of the process actually used for priority setting and resource allocation, and the results agreed upon (The Title I supplemental grant application provides a summary of this process; consortium service plans may include such information but are not required to do so.)
- the HRSA Priority Setting and Resource Allocation technical assistance document (available late 1997).



Self-Assessment Questions

Scope and Structure of Priority Setting and Resource Allocation

A. Scope

1 Which of the following activities are currently carried out by your council or consortium?

- Both priority setting and resource allocation ❑
- Priority setting only (Answer question 2; skip question 3.) ❑
- Resource allocation only (Skip to question 3.) ❑

2 What are the scope and frequency of your *priority-setting* activities?

a *Scope* of priority-setting activity

3 The council sets priorities among service categories, geographic areas, and/or populations, or the consortium sets priorities or makes recommendations for priorities to the grantee.

0 Few, if any, members of the council or consortium are consulted regarding priorities.

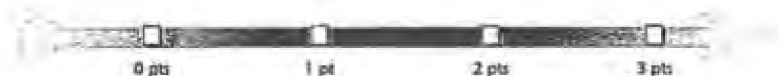
b *Frequency* of priority-setting activity

3 Priorities are established or revised annually by the planning council or consortium.

2 Priorities are reviewed/revised by the planning council or consortium less frequently than annually.

1 Priorities are not reviewed/revised on any routine basis.

0 Priorities are not reviewed.



3 What are the scope and frequency of your *resource-allocation* activities?

a *Scope* of resource allocation

3 The council allocates resources to service categories, geographic areas, and/or populations, or the consortium allocates resources or makes recommendations for allocations to the grantee.

0 Few, if any, members of the council or consortium are consulted regarding resource allocation.

b *Frequency* of resource allocation

3 The council or consortium allocates resources annually and reviews and reallocates funds, as needed, within the year.

2 The council or consortium allocates resources annually but does not reallocate funds within the year.

1 The council or consortium reviews resource allocations annually to see whether or not they need revision.

0 The council or consortium does not review/revise resource allocations on a routine basis.

Title I Planning Councils are required by the CARE Act and HRSA guidance to establish priorities for the allocation of funds on an annual basis. The CARE Act does not specifically require consortia to conduct these activities.

Resource allocation refers to the allocation of amounts or percentages of CARE Act funds to established priorities—service categories, geographic areas, populations, or sub-populations. It does NOT involve contracting with or disbursing funds to specific service providers; this is a separate function that is the responsibility of the grantee or administrative agency.

B. Structure

Answer the questions in this section for the most recent priority-setting and resource-allocation process.

4 What structure or entity has *final* responsibility for priority setting and/or resource allocation?

	priority setting	resource allocation
The full planning council or consortium	❑	❑
A formally constituted committee or task force of the council or consortium Name of entity: ______________________	❑	❑
An informal committee, task force, planning body, or a small leadership group, such as co-chairs Identify roles/titles of those involved: __________ ______________________ ______________________	❑	❑
Grantee	❑	❑
Lead or administrative agency	❑	❑
Other: ______________________ ______________________ ______________________	❑	❑

5 If an entity within the full council or consortium was assigned a role in the priority-setting process, identify the entity: ______________________.*

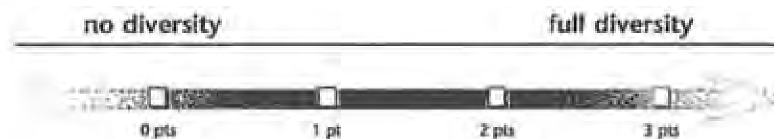
* This entity will be referred to as the *priorities committee* throughout the module. This commitee may also be responsible for resource allocation.

a To what extent were the responsibilities of the priorities committee clear in comparison to the responsibilities of the full council or consortium?

not clear — **clearly defined**

b Did the composition of the priorities committee consist of a full range of perspectives, including PLWH? (Note: See the Representation and Diversity module for how to assess diversity generally.)

no diversity — **full diversity**



Total Points for Question 5 ☐

While Title I Planning Councils may assign priority-setting activities to a smaller entity, the full council is ultimately responsible for setting priorities.

6 If any score was 0 or 1, explain why.

7 Did the priorities committee report directly to the entity with final responsibility for priority setting?

no	yes
0 pts	3 pts

If no, describe the reporting structure.

8 To what extent were the structures adequate to facilitate priority setting?

inadequate			fully adequate
0 pts	1 pt	2 pts	3 pts

Summary: Scope and Structure

Scoring

To score, follow these steps:

STEP 1 Add up the points for questions 1 through 8 and put that amount in the TOTAL POINTS box.

STEP 2 Add up the number of scored questions (and subquestions) answered and put it in the TOTAL NUMBER OF SCORED QUESTIONS ANSWERED box.

STEP 3 Calculate your final score: TOTAL POINTS divided by TOTAL NUMBER OF SCORED QUESTIONS ANSWERED.

STEP 4 Record your final score in the SCORE box.*

SCORE

TOTAL POINTS ☐

divided by

TOTAL NUMBER OF SCORED QUESTIONS ANSWERED ☐

equals

SCORE ☐

**If your score equals more than 3, double-check your addition of points and counting of subquestions answered.*

Strengths and Weaknesses

What aspects of the scope and structure of your priority setting and resource allocation worked well?

____

____

____

____

What aspects of the scope and structure should be improved?

____

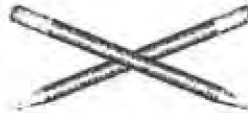
____

____

____

Action Steps

Based on your responses to Questions 1 through 8, list the key areas where action should be taken to improve the scope and structure of priority setting and resource allocation. →



ACTION STEPS FOR QUESTIONS 1–8

OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:
OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:
OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:

SCOPE AND STRUCTURE: DISCUSSION OF SCORING AND QUESTIONS 1–8

Following is a discussion of **questions 1-8**.

Question 1 is not scored. It is important to identify whether your council or consortium conducts both priority setting and resource allocation. If it conducts only one, score and answer the relevant questions.

Questions 2 and 3 ask about the scope and frequency of priority setting and resource allocation. Title I Planning Councils are required by the CARE Act and HRSA guidance to establish priorities for the allocation of funds on an annual basis. Low scores on these questions indicate that a planning council is not fulfilling one of its primary mandates. The CARE Act does not specifically require consortia to conduct these activities. If you are conducting these activities, this module will help you to assess how well you're doing. Resource allocation refers to the allocation of Ryan White CARE Act funds. Some planning groups, especially consortia, may include other funding streams in their resource allocation.

Under Title I, final responsibility for decision making rests with the planning council. Under Title II, either a grantee or a consortium has final responsibility for priority setting and resource allocation. **Question** 4 lists five choices for who has final responsibility. The lead or administrative agency is used primarily by Title II Consortia to administer funds. This question is not scored.

In **question 5**, you are asked to assess whether a smaller entity within the full council or consortium was assigned a role in the priority-setting process. The responsibilities of the entity should be clearly defined. It should be diverse and comprise a full range of perspectives, including PLWH. An assessment of committee membership should be considered if participation was nominal and not active.

Question 6: It is helpful to describe the reasons for a low score.

Question 7 explores the reporting relationship between the priorities committee and the entity with final responsibility. A clear reporting structure will facilitate a more open and successful decision-making process.

Question 8: This question looks at the priority-setting structure. A low score indicates that the structure needs improvement to get the job done.

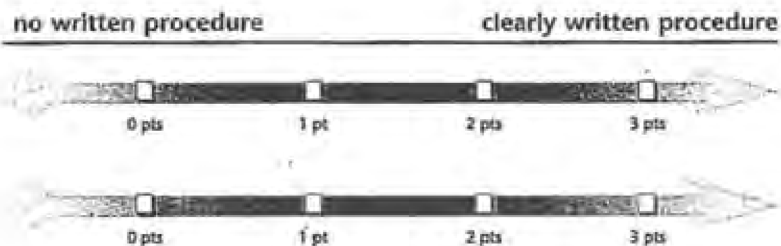
Priority Setting and Resource Allocation Process and Results

C. Process of Setting Priorities

9 To what extent did the priority-setting process include a clearly written procedure for obtaining input to decision making from:

a Council or consortium members?

b Representatives of populations identified in your service area as underserved?



POPULATIONS TO CONSIDER IN PRIORITY SETTING

Underserved populations might include:

- Racial or Ethnic Minorities
- Women
- Men who have sex with men
- Gay men of color
- Adolescents
- Injection drug users

Populations with severe need might include:

- Individuals with HIV disease and co-morbidities, such as sexually transmitted diseases, substance abuse, tuberculosis, or severe mental illness
- Newly emerging populations or sub-populations with HIV disease
- Individuals with HIV disease who are also homeless

c PLWH who are not council or consortium members?

no written procedure — clearly written procedure

Total Points for Question 9

10 To what extent did the priorities committee publicize opportunities for input from:

no publicity — extensive publicity

a PLWH?

b Representatives of populations identified in your service area as underserved?

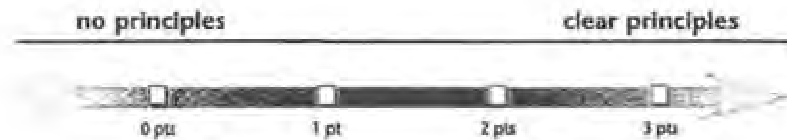
Total Points for Question 10

11 If any score was 0 or 1, explain why.

12 Summarize the process used to obtain input.

13 To what extent did the priorities committee begin its decision-making process with:

a Clear principles for guiding decision making?



b An analysis of data sources (epidemiologic trends, needs stated by PLWH, etc.)?

c A proposed list of service categories, including a definition of each service?

Total Points for Question 13 ☐

Question 14 Which of the following elements were part of the decision-making process?

ELEMENT	ELEMENT INCLUDED? No	ELEMENT INCLUDED? Yes
Open process	0 pts	3 pts
Ground rules for discussion at meetings	0 pts	3 pts
Quorum required for decision making	0 pts	3 pts
Diversity of individuals needed to make decisions	0 pts	3 pts
Level of PLWH involvement needed to make decisions	0 pts	3 pts
Rules regarding the level of agreement required for decisions (e.g., consensus, majority vote, two-thirds majority)	0 pts	3 pts
Background information to be available before and during meetings	0 pts	3 pts

Total Points for Question 14 ☐

15 Did the priorities committee use one or more decision-making methods such as those listed below?

no	yes
0 pts	3 pts

Identify the method(s) used:

- ❑ Nominal group process
- ❑ Delphi method
- ❑ Continuum approach
- ❑ Aggregate checklists or score sheets
- ❑ Group discussion
- ❑ Consensus model
- ❑ Other: ______________________

Note on decision-making methods: The attachment on page 68 describes a set of decision-making methods. The first five methods listed in question 15 are described in the attachment. There are other models for decision making. Contact your project officer if you would like additional information about decision-making models.

Question 16 To what extent was the decision-making process for priority setting:

NOT AT ALL EXTENSIVELY

a Described in a public document?

b Implemented as described?

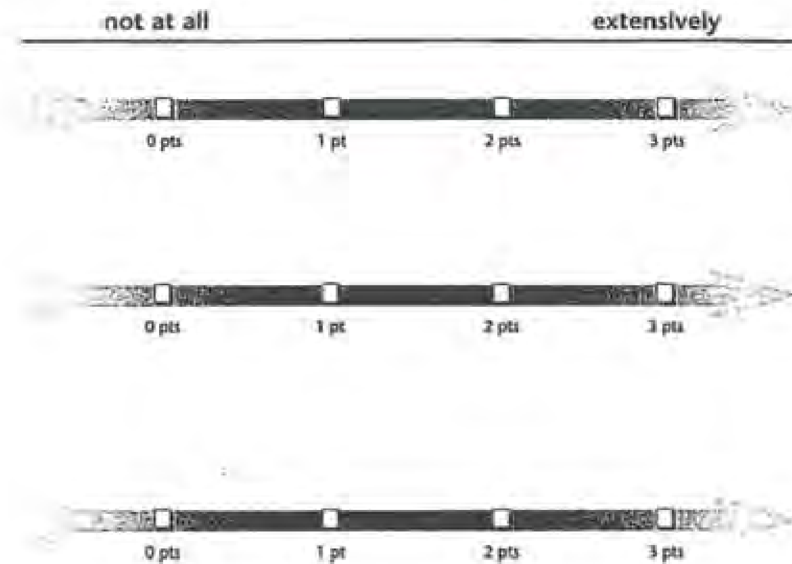
c Documented in writing to planning council or consortium members?

d Able to ensure participation of individuals representing diverse interests?

e Consistent with legislative and administrative requirements?

Total Points for Question 16 ☐

17 To what extent did the priorities committee use the needs assessment to target priorities based on:



a Identified gaps in the availability of services?

b. The needs of populations or sub-populations? (See page 22.)

c Availability and accessibility of services within geographic areas?

Total Points for Question 17 ☐

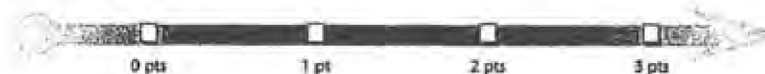
18 If any score was 0 or 1, explain why.

19 To what extent did the priorities committee use the council or consortium's core continuum of care (if one exists) to inform the priority-setting process?

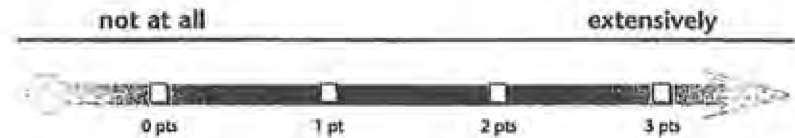
not at all — extensively

20 To what extent did the priorities committee use the comprehensive HIV services plan (if one exists) to inform the priority-setting process?

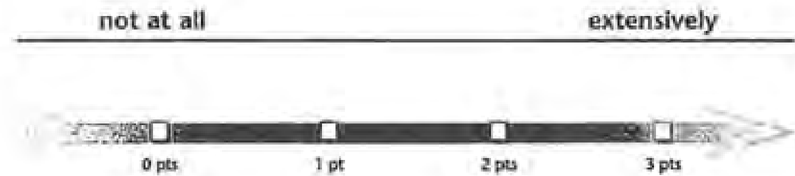
not at all — extensively



21 To what extent did the priorities committee use a full range of perspectives, including PLWH, to inform the priority-setting process?



22 Addressing conflict of interest:



a To what extent do the council or consortium's bylaws or policies define conflict of interest in regard to participation in priority setting?

b To what extent do the council or consortium's priority-setting procedures specify how conflict of interest is to be managed in setting priorities?

Total Points for Question 22

23 Overall, how was conflict of interest in the decision-making process managed?

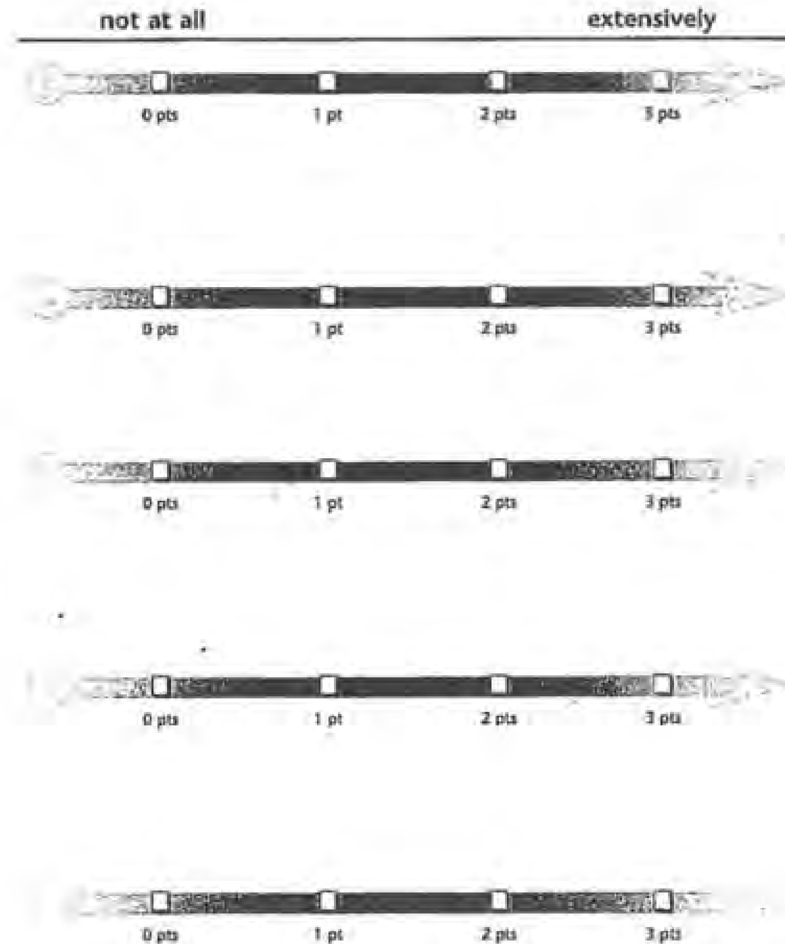
a Were members of the decision-making entity required to disclose relationships to current and potential CARE Act service providers?

b Were members of the decision-making entity required to identify the services provided by their affiliate agencies?

c Did the decision-making criteria stress the importance of making decisions based on overall community needs rather than narrow interests?

d Did the leadership of the decision-making entity emphasize the importance of preventing conflict of interest in the decision-making process?

e Was "bargaining" among planning body members addressed ("I'll support your priorities if you'll support mine")?



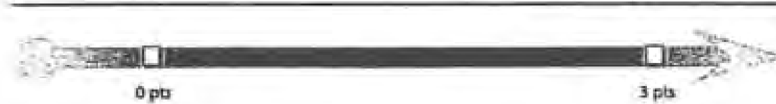
Total Points for Question 23

24 If any score was 0 or 1, explain why.

25 Opportunities for public input:

a Were public hearings held regarding the proposed use of funds?

no — yes



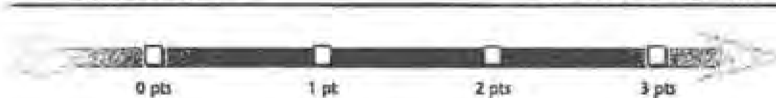
How many public hearings were held? ___________

Where? ___________

b In what other ways was public comment sought?

c To what extent did the effort to solicit public comment generate feedback?

no feedback — extensive feedback



Total Points for Question 25 ☐

Summary: Process of Setting Priorities

Scoring

To score, follow these steps:

STEP 1 Add up the points for questions 9 through 25 and put that amount in the TOTAL POINTS box.

STEP 2 Add up the number of scored questions (and subquestions) answered and put it in the TOTAL NUMBER OF SCORED QUESTIONS ANSWERED box.

STEP 3 Calculate your final score: TOTAL POINTS divided by TOTAL NUMBER OF SCORED QUESTIONS ANSWERED.

STEP 4 Record your final score in the SCORE box.*

SCORE

TOTAL POINTS ☐

divided by

TOTAL NUMBER OF SCORED QUESTIONS ANSWERED ☐

equals

SCORE ☐

**If your score equals more than 3, double-check your addition of points and counting of subquestions answered.*

Strengths and Weaknesses

What aspects of the priority-setting process worked well?

____

____

____

____

What aspects of the process should be improved?

____

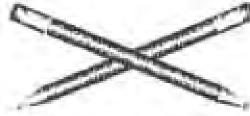
____

____

____

Action Steps

Based on your responses to Questions 9 through 25, list the key areas where action should be taken to improve the process of setting priorities and allocating resources. →



ACTION STEPS FOR QUESTIONS 9–25

OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:
OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:
OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:

PROCESS OF SETTING PRIORITIES: DISCUSSION OF SCORING AND QUESTIONS 9–25

Questions 9a-c ask about the input of infected and affected groups in the priority-setting process. A high score should be given if the council or consortium has a clearly written procedure for obtaining input from these groups. Question 10 asks if the priorities committee publicized opportunities for input. Questions 11 and 12 are not scored but give you the opportunity to review the process of obtaining input and to discuss any weaknesses.

Questions 13a-c ask you to consider the beginning of your decision-making process. In question 13a, a high score is given to a council or consortium that defines clear principles, such as meeting standards of care and cultural appropriateness. A full list of principles to guide decision making is included in the Priority Setting chapter in the Title I Manual. Question 13b should prompt council or consortium members to discuss various data sources for documenting need. These include epidemiological data, information from surveys, interviews, public hearings, and focus groups; and evaluation data on program quality, and cost and outcome effectiveness. A proposed list of service categories should be part of the decision-making process as indicated in question 13c. This list must be compatible with the service categories described in HRSA guidance (see page 72) and in accordance with the allowable costs described in DHS Policy 97-02: "Allowable Uses of Funds for Discretely Defined Categories of Services."

Question 14 identifies several elements to consider in the decision-making process. Perhaps the most important element in priority setting is the specific method selected to make decisions.

Question 15 identifies several methods to use for making decisions and asks if you've used one or more of them. Questions 16a-e ask whether your decision-making process for priority setting meets five different criteria. A description of the legislative and administrative requirements referred to in question 16e can be found on pages 3 and 4 of the Introduction.

Questions 17a-c ask whether your needs assessment helped identify gaps in services and priorities for sub-populations and geographic areas. Effective services need to be targeted. If priorities are not being targeted, question 18 asks you to explain why. Note: Your needs assessment is a primary source of information for the priority-setting process.

Questions 19-21 ask whether the core continuum of care, the comprehensive HIV services plan, and a full range of perspectives have been used to determine priorities. The self-assessment modules on continuum of care and comprehensive HIV services planning can help in the first two areas. Methods for obtaining diverse perspectives can include focus groups, interviews, PLWH caucuses, or public hearings.

Questions 22a and 22b and 23a-e help councils and consortia assess their ability to address and manage conflict of interest. In general, council or consortium members disclose their conflicts of interest while continuing to participate in discussions and voting, since priority setting does not involve decisions to fund particular providers. Question 24 promotes discussion about conflict of interest policy.

Questions 25a-c ask whether and how public comment was sought on priorities and if input was generated. Public hearings and other public comment are required of Title II grantees.

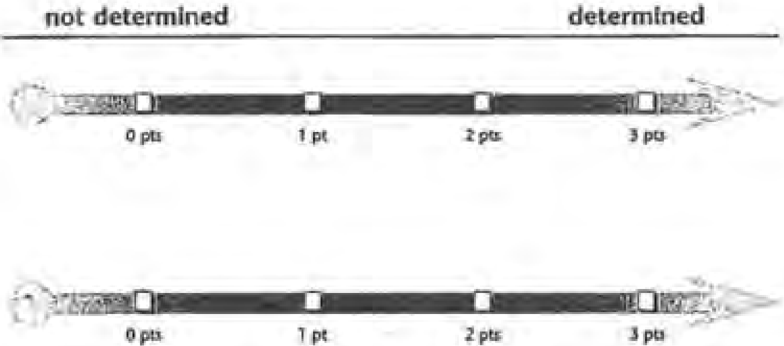
D. PROCESS OF ALLOCATING RESOURCES

The process of resource allocation follows the setting of priorities. This process, including principles and the decision-making method, is similar to priority setting with some refinements. The self-assessment questions in this section build upon the information collected about the priority-setting process. This section of the module refers to the "allocations committee" which may be the same group as your priorities committee.

26 To what extent did the allocations committee begin its process by determining:

a The funding streams it was responsible for allocating (e.g., Title I, Title II, HOPWA, state, local)?

b The non-direct-service functions to which it might allocate funds (e.g., council or consortium support and program support, including capacity building)?

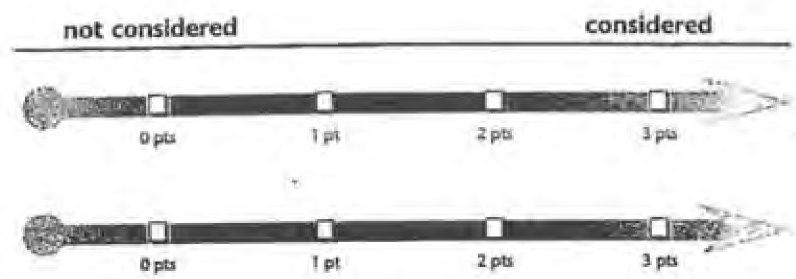


Total Points for Question 26 ☐

27 To what extent did the allocations committee consider additional principles, such as the following, to guide its decisions:

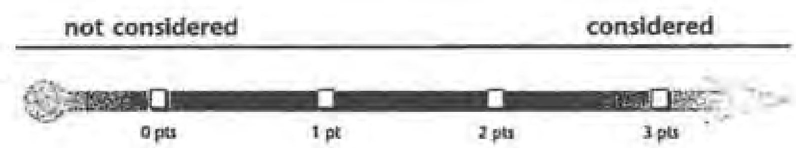
a All identified needs won't be met?

b The CARE Act will be considered the payer of last resort?

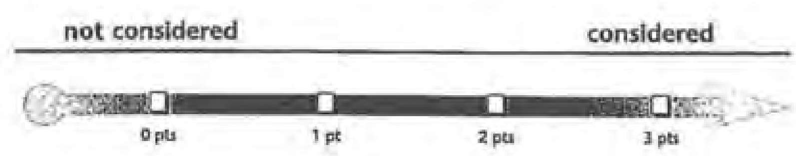


Total Points for Question 27

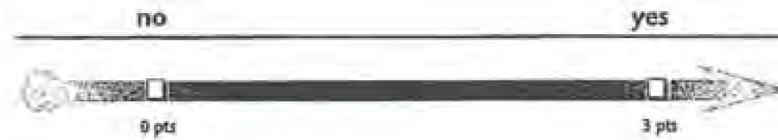
28 To what extent did the allocations committee consider the availability of other governmental or non-governmental resources?



29 If a planning council and consortium are located in the same geographic area but operate separately, did the allocations committee consider the other's funded activities?



30 Were local conflict of interest guidelines utilized to determine the degree to which a member should be allowed to participate?



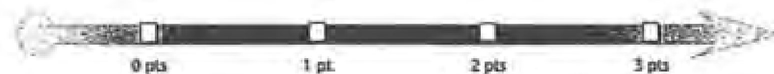
31 Did the allocations committee base its allocations on several possible funding levels, such as current level, a specified percentage lower, or a specified percentage higher?

32 Did the allocations committee use any of the following approaches?*

a Zero-based budgeting
(allocations using zero as a starting point)

Was the approach used? **no** ☐ **yes** ☐

If used, how effective was the approach? **not effective** **very effective**



b Review of allocations from the previous year

Was the approach used? **no** ☐ **yes** ☐

If used, how effective was the approach? **not effective** **very effective**

* See the HRSA Priority Setting and Resource Allocation technical assistance document (available late 1997) for more detail on these approaches.

c Use of resource-allocation scenarios
(multi-step process that can't be reduced to a formula)

Was the approach used?	no ☐	yes ☐
If used, how effective was the approach?	not effective	very effective

d Use of allocation formulas
(all priorities increased or decreased by a set percentage)

Was the approach used?	no ☐	yes ☐
If used, how effective was the approach?	not effective	very effective

Total Points for Question 32 ☐

Summary: Process of Allocating Resources

Scoring

To score, follow these steps:

STEP 1 Add up the points for questions 26 through 32 and put that amount in the TOTAL POINTS box.

STEP 2 Add up the number of scored questions (and subquestions) answered and put it in the TOTAL NUMBER OF SCORED QUESTIONS ANSWERED box.

STEP 3 Calculate your final score: TOTAL POINTS divided by TOTAL NUMBER OF SCORED QUESTIONS ANSWERED.

STEP 4 Record your final score in the SCORE box.*

SCORE

TOTAL POINTS ☐

divided by

TOTAL NUMBER OF SCORED QUESTIONS ANSWERED ☐

equals

SCORE ☐

**If your score equals more than 3, double-check your addition of points and counting of subquestions answered.*

Strengths And Weaknesses

What aspects of the resource-allocation process worked well?

____

____

____

____

What aspects of the process should be improved?

____

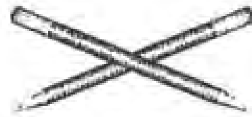
____

____

____

Action Steps

Based on your responses to Questions 26 through 32, list the key areas where action should be taken to improve the process of setting priorities and allocating resources. →



ACTION STEPS FOR QUESTIONS 26–32

OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:
OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:
OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:

PROCESS OF ALLOCATING RESOURCES: DISCUSSION OF SCORING AND QUESTIONS 26–32

Question 26a asks if the allocations committee has clarified which categories of funds it has responsibility for allocating. **Question 26b** is scored high if the council or consortium considered allocation of non-direct-service funds (such as planning council support).

Many of the principles used in priority setting are applicable to resource allocation. **Questions 27a** and **27b** ask about principles pertaining to resource allocation.

Question 28 asks whether the allocations committee considered the availability of other resources. It is important that the council or consortium have accurate and complete information about other significant categories of funding, so it does not duplicate funding. Note: Priority setting is usually done independent of funding sources. It is especially important to take into account other Ryan White funds in areas of overlapping jurisdiction as suggested by **question 29**.

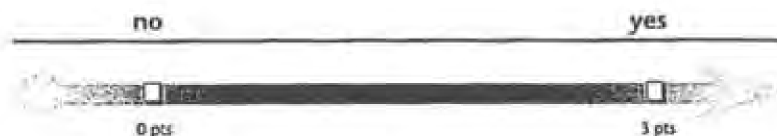
Question 30 asks if local conflict of interest guidelines were utilized to determine whether a member should be allowed to vote. Currently, DHS requires that local guidelines be in place when resolving voting procedures and conflicts of interest.

Question 31 asks if allocations were based on different funding levels. Generally, a planning body will have to allocate resources before it has final figures on available funding. By anticipating different funding levels, a council or consortium will be prepared to move forward quickly when the actual funding amount becomes known.

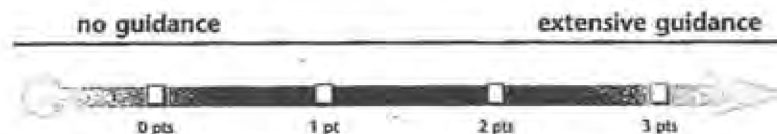
Questions 32a-d ask about the approaches used by the allocations committee. A description of each of these approaches can be found in the HRSA Priority Setting and Resource Allocation technical assistance document (available late 1997). Briefly, the zero-based budgeting approach in **question 32a** suggests that allocations are made without using the previous year's allocations as a base. **Question 32b** asks if the allocations from the previous year were used in this year's allocation process. The use of allocation scenarios is assessed by **question 32c**. One scenario may separate service categories into different tiers; another may continue to fund all priority services but create a fixed percentage increase or decrease and use remaining funds for new services. **Question 32d** suggests the use of allocation formulas.

E. Results of Setting Priorities

33 Did the priorities committee agree on a list of service categories? (See page 72.)



34 Did the priorities committee specify (i.e., by including geographic area, type of intervention, type of organization, or sub-population) how best to meet service priorities?

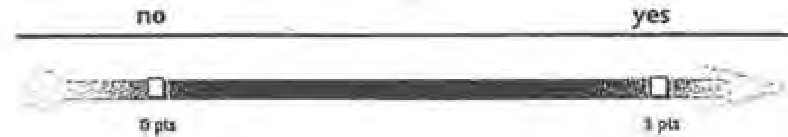


35 To what extent did the priorities resulting from the priority-setting process differ from those determined by the needs assessment process?

Please describe the reasons, if any, for this difference.

36 *(This question should be answered by planning councils only.)*
Did resource allocations cover both formula and supplemental grant funds?

no yes



37 *(This question should be answered by planning councils only.)*
What percentage of the EMA's AIDS cases were infants, children, and women?

A [ ] %

What was the percentage of funds spent for care and support services to serve infants, children, and women with HIV disease?

B [ ] %

Was the percentage of funds spent for care and support services to serve infants, children, and women with HIV disease (box A) equal to or greater than their percentage of the EMA's AIDS cases (box B)?

no yes

38 To what extent did the allocation of dollars to service categories attempt to meet primary care needs?

no attempt — serious attempt

0 pts | 1 pt | 2 pts | 3 pts

39 Cost and Outcome Effectiveness

a To what extent did the allocations committee have information concerning the actual or projected costs and outcome effectiveness of services?

no information — information on all services

0 pts | 1 pt | 2 pts | 3 pts

b To what extent did this information influence resource allocation?

no influence — extensive influence

0 pts | 1 pt | 2 pts | 3 pts

Total Points for Question 39 ☐

40 If any score was 0 or 1, explain why:

41 The table on page 51 is designed to help answer questions 41a-b.

The table summarizes the results of the planning body's entire priority-setting and resource-allocation process, and the results of the grantee or administrative agency's contracting process for the most recent program year for which contracting has been completed. To use the table, first list in column 2 the service categories (including geographic area, type of intervention, type of organization, or sub-population) established by the council or consortium, in order of priority. In column 3, specify the amount of CARE Act funds allocated to each service priority. After filling out columns 2 and 3, rank each service priority in column 4 according to the amount of dollars allocated (1 equals highest dollar amount, 2 equals second highest, etc.). Finally, enter in column 5 the actual dollars awarded by the grantee or administrative agency to that category of services in the contracting process.

You will need your list of priorities and resource allocations and a list of contracted amounts for each service category to complete this table. →

Comparison of Service Priorities, Resource Allocations, and Funding

1 Service Priority	2 Service Category (geographic area, type of intervention, type of organization, or sub-population)	3 Dollars Allocated	4 Ranking of Dollars Allocated	5 Dollars Contracted
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

41 Using the table on page 51:

a Compare the ranking of service priorities (column 1) with the ranking of dollars allocated (column 4).

List any service priority where the ranking doesn't match.	Provide the reason(s) why rankings don't match.*

* Reasons could include: service is high priority but unmet need is small, unit cost of service priority is relatively low or high, or another funding source pays for the service.

b Still using the table on page 51, compare the dollars allocated (column 3) with the dollars contracted (column 5) for each service priority.

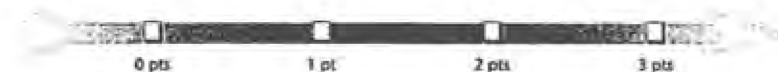
List any service priority where dollars allocated doesn't match dollars contracted.

Provide the reason(s) why numbers don't match.

42 Continuum of Care

To what extent did resource allocation strengthen the core continuum of care?

not strengthened — strengthened



SUMMARY: RESULTS

SCORING

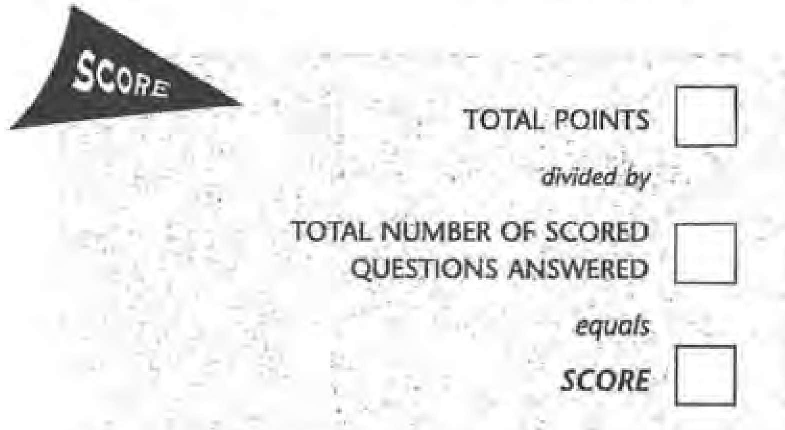
To score, follow these steps:

STEP 1 Add up the points for questions 33 through 42 and put that amount in the TOTAL POINTS box.

STEP 2 Add up the number of scored questions (and subquestions) answered and put it in the TOTAL NUMBER OF SCORED QUESTIONS ANSWERED box.

STEP 3 Calculate your final score: TOTAL POINTS divided by TOTAL NUMBER OF SCORED QUESTIONS ANSWERED.

STEP 4 Record your final score in the SCORE box.*



*If your score equals more than 3, double-check your addition of points and counting of subquestions answered.

STRENGTHS AND WEAKNESSES

Which results are you satisfied with, and why?

____

____

____

____

What results need to be improved?

____

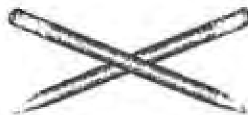
____

____

____

ACTION STEPS

Based on your responses to Questions 33 through 42, list the key areas where action should be taken to improve the results of priority setting and resource allocation. →



Action Steps for Questions 33–42

OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:
OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:
OBJECTIVE:	RESOURCES:
TIME LINE:	PERSON RESPONSIBLE:

RESULTS:
DISCUSSION OF SCORING AND QUESTIONS 33–42

Question 33 asks if a list of service categories was developed as part of your priority-setting process. A list of categories is an important foundation for the development of comprehensive HIV services. Council and consortium members rely on this list when weighing the need for services. The definition of service categories is a crucial aspect of setting priorities. Council and consortium members rely on definitions to develop a common understanding of services.

Question 34 asks if your service priorities include information specifying how best to meet them. The more specific the service priority, the more it will help the council, consortium, or grantee provide the needed service. A service priority might name a geographic area, type of intervention, type of organization, or a sub-population. For example, instead of the categories "case management," "transportation," or "food," you may have "case management—Spanish-speaking clients," "transportation—North County," or "food—home-delivered meals." The 1996 CARE Act Amendments require planning councils to give grantees this level of guidance. It is suggested that consortia follow a similar format.

The definition of the service priority should be specific enough to provide guidance regarding how best to meet it.

Benchmark: In some Eligible Metropolitan Areas (EMAs) and for some service priority categories with a small provider pool, language on how best to meet the priority may result in only a few or a single provider applying for funds. As long as the planning council does not name a particular provider, the council is not in violation of the conflict of interest requirements in the law. A planning council's designation of the state ADAP program and/or a local health department program as the best way to meet a service priority similarly does not violate conflict of interest requirements.

Question 35 asks to what extent priorities set by the committee differ from the priorities identified in the needs assessment. The priority-setting process can include factors, such as new epidemiologic data or additional information about the severity of a particular need, that may not be part of your needs assessment process. The reasons for any difference help clarify the results of priority setting.

Question 36 asks whether or not Title I Planning Councils allocated resources for both formula and supplemental funds. As of FY 1998, there will be one application for formula and supplemental funds.

Title I requires that the percentage of funds spent for services to infants, children, and women with HIV disease be equal to or greater than the percentage of AIDS cases among infants, children, and women in the EMA. Title II requires the same of states. **Question 37** assesses whether funds have been spent in a way to meet that requirement.

Question 38 asks whether resource allocation addresses primary care needs adequately.

Questions 39a and **39b** ask about the use of cost and outcome effectiveness measures in resource allocations. Cost and outcome effectiveness can be determined through a range of evaluation methods. The 1996 CARE Act emphasizes the use of cost and outcome effectiveness measures. A low score indicates that additional effort is needed to begin the use of these measures.

Question 40 looks at why cost and outcome effectiveness is not utilized.

Questions 41a asks you to compare the ranking of service priorities with the ranking of dollars allocated. Unexplained inconsistencies should be discussed thoroughly among workgroup members. **Question 41b** compares dollars allocated to dollars contracted for each service priority. A good explanation is needed for over- or underspending of dollars allocated.

Question 42 asks whether the allocation of resources has helped strengthen the core continuum of care in your service area. This is a major goal of resource allocation.

RESOURCES

Below is a list of legislation, HRSA documents, articles, and books related to this topic.

LEGISLATION

- CARE Act of 1990 as amended by the Ryan White CARE Act Amendments of 1996.

HRSA DOCUMENTS

- Activities of Ryan White CARE Consortia, FY 1993, Conviser, R. October, 1994.
- First Year Experience of Title I Eligible Metropolitan Areas with Standard Protocol for Baseline Data Collection, Division of HIV Services.
- FY 1998 Title I Grant Application Guidance.
- FY 1997 Title I Formula Grant Application Guidance.
- FY 1997 Title I Supplemental Grant Application Guidance.
- FY 1997 Title II Application Guidance.

ABSTRACTS, ARTICLES, AND REPORTS

- Ganiats, T.G. and Wong, A.F. Evaluation of Cost-Effectiveness Research: A Survey of Recent Publications. *Family Medicine* 23 (1991): 457-462.
- Gorsky, R.D., Farnham, P.G., Holtgrave, D.R., and Guinan, M.E. Model to Allocate Resources Among HIV Prevention Programs. Paper presented at the *Institute for Management Sciences/Operations Research Society of America Conference,* Chicago, IL, May 18, 1993.
- Holtgrave, D.R., Valdiserri, R.O., and West, G.A. Quantitative Economic Evaluation of HIV Prevention and Treatment Services: A Review. *Risk* 5 (1994): 29-47.
- Vilnius, D. and Dandoy, S. A Priority Rating System for Public Health Programs. *Public Health Reports* 105 (1990): 463-470.

BOOKS

- Bierman, H., Bonini, C.P., and Hausman, W.H. *Quantitative Analysis for Business Decisions.* Homewood, IL: Irwin, 1986.
- Patrick, D.L. and Erickson, P. *Health Status and Health Policy: Allocating Resources to Health Care.* New York: Oxford University Press, 1993.

Suggested Steps in Priority Setting and Resource Allocation

SUGGESTED STEPS IN PRIORITY SETTING AND RESOURCE ALLOCATION

The following steps can be used to plan for and implement priority setting and resource allocation and are part of the technical assistance document on priority setting and resource allocation that will be available in late 1997. The steps are listed in the order in which they are likely to begin, but there may be a considerable time overlap among steps. For example, while some members of a planning body or committee are reviewing relevant legislative requirements and guidances (Step 3), others might be determining and obtaining available information "inputs" such as needs assessment data (Step 4), and still others might be identifying a list of service categories for consideration (Step 5).

1. Agree on the priority-setting and resource-allocation process and its desired outcomes.
2. Agree on responsibilities for carrying out the decision-making process.
3. Review relevant legislative requirements and guidances.
4. Determine and obtain available information "inputs," including comprehensive plans and needs assessments.
5. Identify a list of service categories for consideration, including definitions, components, and how best to deliver the service.
6. Agree on principles to be applied in decision making.
7. Determine the criteria to be used in priority setting.
8. Determine the decision-making process and method to be used.
9. Carry out the process—set service priorities, including how best to meet them.
10. Define the scope of the resource-allocation process.
11. Agree on the principles, criteria, process, and methods to be used in allocating funds to service categories.
12. Estimate needs by service category.
13. Allocate resources to service categories.
14. Provide decisions to the grantee or administrative agent for use in contracting.
15. Identify areas of uncertainty and needed improvement, especially data needs.

BENCHMARKS

Benchmarks for Sound Practice

Legislation/Guidances

The following benchmarks are based on legislation and guidances and are therefore stated separately for Title I and Title II. Benchmarks that were added or revised to reflect the reauthorized legislation are identified with the following symbol: ■.

TITLE I

Structure:

- Priority setting and resource allocation to priority services are done by the planning council.
- A clearly specified entity within the planning council has a role in the priority-setting process.
- Resource allocation is coordinated by a clearly specified entity within the planning council (not necessarily the same entity as priority setting).

Process:

- Priority setting and resource allocation to service categories involve all members of the planning council except those who may not participate due to local conflict of interest guidelines.
- Priority-setting and resource-allocation procedures protect against conflict of interest.
- Decision making considers the resources available and service needs identified through needs assessment and other planning activities.

Outcomes:

- Priority setting and resource allocation cover both formula and supplemental funding.
- Service priorities and resource allocation reflect the service categories stated by DHS in grant application guidance.
- Service priorities and resource allocations consider the priorities of the HIV-infected communities for whom the services are intended. ■
- Service priorities and resource allocations demonstrate an attempt to meet the primary care needs for underserved populations, sub-populations, and geographic areas in the EMA.
- Service priorities and resource allocations consider cost and outcome effectiveness of proposed strategies and interventions to the extent that such data are reasonably available. ■
- Service priorities and resource allocations consider documented service needs of HIV-infected communities. ■
- Service priorities strengthen the core continuum of care.

- Resource allocations are consistent with the service priorities established by the planning council.
- Resource allocations consider the availability of other resources, governmental, and non-governmental. ■
- Resource allocations include specification of how best to meet each priority. ■
- The percentage of Ryan White funds spent for services to infants, children, and women with HIV disease are not less than their percentage of the EMA's total AIDS cases. ■

TITLE II

Structure:

No structural requirements are stated.

Process:

- The state holds public hearings regarding the proposed use and distribution of funds.
- The state invites public comment within 120 days after it is awarded funds.
- Funds are allocated to consortia based on a clear process and rationale.
- The decision-making process protects against conflict of interest.

Outcomes:

- The percentage of Ryan White funds spent for services to infants, children, and women with HIV disease are not less than their percentage of the state's total AIDS cases. ■
- The allocation of dollars to service categories addresses identified gaps in care for specific populations.
- The allocation of dollars to service categories takes into account the epidemiologic characteristics of the state's AIDS epidemic.
- The allocation of dollars to service categories by both the state and the consortia demonstrates an attempt to meet the primary care needs of HIV-infected populations with no other source of payment.

ADDITIONAL BENCHMARKS

The following benchmarks address quality and adequacy of processes and outcomes. Because they represent sound practice as described in CARE Act assessments and other literature and determined through the experience of planning bodies, they should generally apply to both Title I and Title II Planning Councils and Consortia.

Structure:

- Where a role in the decision-making process is assigned to an entity smaller than the entire planning council or consortium, it is to a clearly structured entity with a defined relationship to the full planning council or consortium.

- An entity smaller than the entire planning council or consortium, with a role in priority setting, should be diverse in its composition and include PLWH.
- The decision-making tasks assigned to the entity are clearly stated, including the results it is expected to achieve and any limits on its autonomy.

Process:

- The planning council or consortium obtains organized, publicized, substantive input to the decision-making process from people living with HIV disease and underserved populations.
- Individuals who have a potential or actual conflict of interest disclose the nature of the conflict and may not participate in voting on aspects of the priority-setting process based on local conflict of interest guidelines.
- Individuals who have a potential or actual conflict of interest disclose the nature of the conflict and may not participate in the resource-allocation process based on local conflict of interest guidelines.
- The decision-making process and criteria are defined and agreed upon prior to the decision-making process, publicly stated, and implemented as stated.
- The decision-making process is rational (based on facts) and equitable (ensures participation of individuals representing diverse interests).
- Decision-making procedures include full review of available information about community needs from the needs assessment process.

Outcomes:

- Allocation of resources to priorities reflects relative need, based on the need for services and the availability of other resources within their service areas.

EXAMPLES OF DECISION-MAKING AND PRIORITY-SETTING METHODS

The information below describes several different decision-making methods which Title I Planning Councils may have used or may consider using as they evaluate information and data collected during the needs assessment process and undertake the task of setting service priorities. Detailed information about each method may be found in the public health, community health planning, and community organization literature.

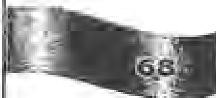
a) **Nominal Group Process:** This is a method for assessing community perceptions of problems in a way that overcomes many of the traditional problems of unequal representation of opinions. The method consists of a series of small group procedures designed to compensate for the usual dynamics of social power that emerge in most planning meetings. The method consists of several sequential steps:

   1. Arrange for a representative and knowledgeable small group of participants.
   2. Pose a single question to the group, such as, "What do you consider to be the priority service needs of persons with AIDS and HIV disease in the EMA from those identified in the needs assessment?"
   3. Participants are encouraged to write down their individual responses in silence without interaction.
   4. Individual responses are then elicited in a round-robin fashion until all contributions have been offered and recorded.
   5. Clarify the meaning of all responses.
   6. Conduct a preliminary vote where participants first select a predetermined number of their top priorities and, second, rank them in priority order. A summation of votes determines the top ranked priorities.

   This method can be used with variations to include several groups operating at once with total votes across groups calculated. In addition, it may be useful to go through a second round of voting to refine priority services further.

b) **Delphi Method:** In this method a series of questionnaires is mailed to the membership of a decision-making body. Thus, differences of opinion can be resolved without face-to-face confrontation. A first questionnaire would provide an open-ended format for participants to "indicate those items which you feel are the top priority service needs of persons with AIDS and HIV disease in the EMA." A second questionnaire to the same group would provide collated categories from the first questionnaire and ask for a ranking and comment on each of the items. A third questionnaire would provide an initial vote total for every item plus a summary of participants' comments and ask participants for a final ranking of the priority areas. This final ranking is collated and used as the list of priority service areas.

   Planners are able to work with a variety of representatives through this process. Since it is mailed or faxed, the format makes a wide distribution possible. During the process, the participants remain anonymous, thus protecting the generated ideas from the influences of group conformity, prestige, power, and politics.



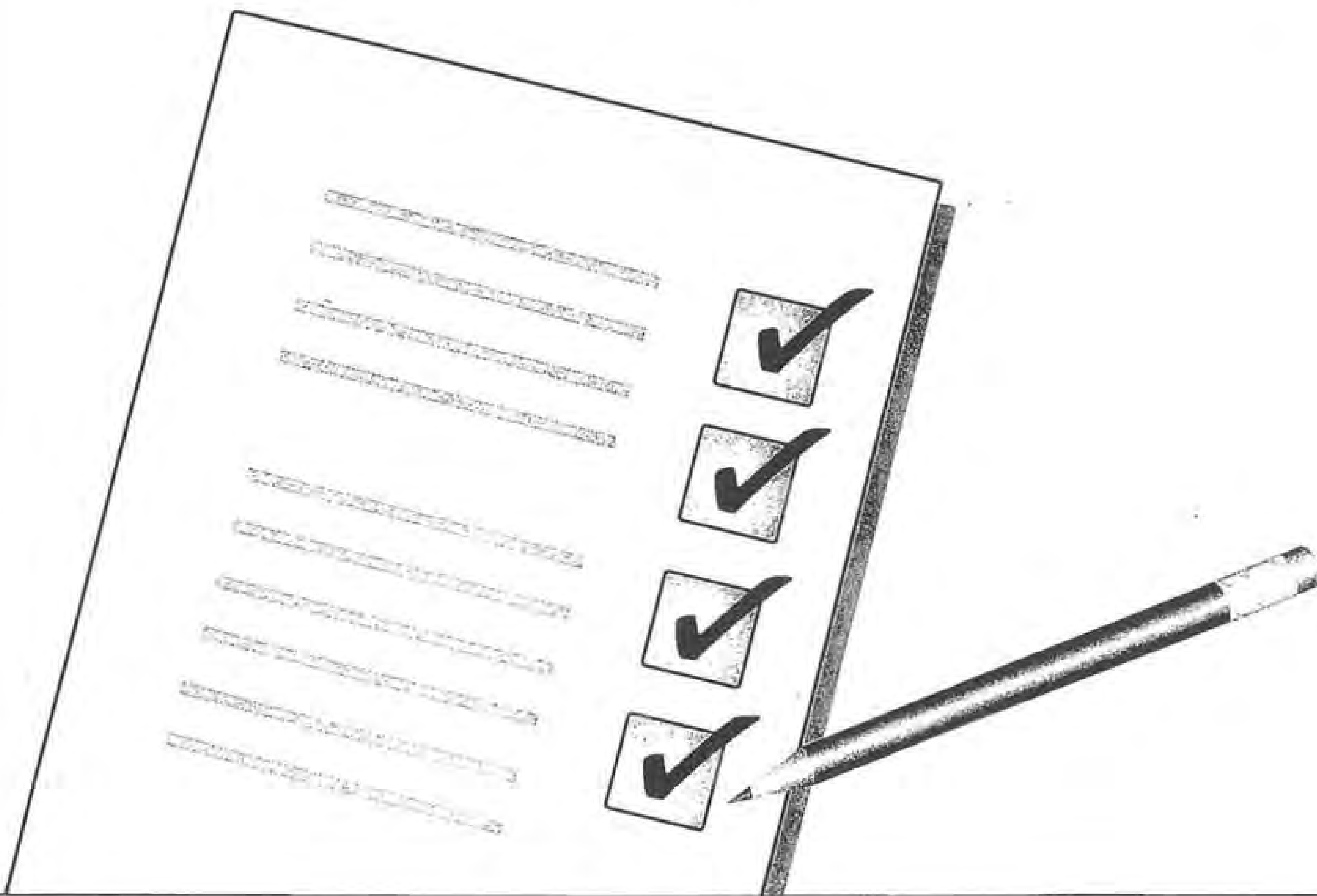
c) **Continuum Approach:** This method encourages participants to look at the current availability and accessibility of services relative to an optimal continuum and elicits responses necessary to move that continuum to the ideal. For example, in this strategy, participants are asked to indicate the level of quality of life for persons with AIDS and HIV disease in their EMA by placing an X on a continuum numbering from one to ten equal units.

The assumption is that the distance between X and 10 is representative of the area for potential improvement in perceived quality of life. Participants are then asked why they perceive the quality of life for persons with AIDS and HIV disease to be anything less than 10. As an answer to that question, they are asked to list several conditions that they believe stand as barriers to the improvement of quality of life. Thus, specific data on perceived problems, needs, and priority areas in the EMA are generated. An advantage of this method is that it is appropriate for use in small and large groups as well as in one-to-one settings.

d) **Aggregate Checklists or Score Sheets:** This is a simpler method where participants indicate their preferences for service priorities in rank order, and the results are aggregated to establish average scores for each priority. This can also be done to establish percentages for funding allocations.

e) **Group Discussion:** This is a much more subjective process where group dynamics can influence the final decisions about priority service areas. If used by an EMA, this discussion will need to be summarized in narrative form by the applicant, including steps taken to minimize the effects of group dynamics.

SERVICE CATEGORIES



Glossary of HIV-Related Service Categories

Ambulatory/Outpatient Medical Care: Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient, community-based, and/or office-based setting. This includes diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care.

Case Management: A range of client-centered services that links clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, on-going assessment of the client's and other family members' needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and revision of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

Dental Care: Diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.

Drug Reimbursement Program: Ongoing service/program to pay for approved pharmaceuticals/medications for persons with no other payment source.

a. **State-Administered Drug Reimbursement Program:** Title II CARE Act-funded and administered program or other state-funded Drug Reimbursement Program, or

b. **Local/Consortium Drug Reimbursement Program:** A program established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a state-operated Title II or other state-funded Drug Reimbursement Program.

Health Insurance: A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or receive medical benefits under a health insurance program, including risk pools.

Home Health Care: Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals. Component services are defined separately below:

a. **Para-Professional Care:** Homemaker, home health aide, and personal/attendant care;

b. **Professional Care:** Routine and skilled nursing, mental health, developmental, and rehabilitation services;

c. **Specialized Care:** Intravenous and aerosolized medication treatments, diagnostic testing, parenteral feedings and other high-technology services;

d. **Durable medical equipment:** Prosthetics, devices, and equipment used by clients in a home/residential setting (e.g., wheelchairs, inhalation therapy equipment, or hospital beds).

Hospice Services:

a. **Home-Based Hospice Care:** Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting.

b. **Residential Hospice Care:** Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

Mental Health Therapy/Counseling: Psychological and psychiatric treatment and counseling services, including individual and group counseling provided by a mental health professional licensed or authorized within the state, psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors.

Nutritional Services: Provision of nutrition education and/or counseling which should be reported as a part of, or sub-category of, Counseling (Other). Provision of food, meals, or nutritional supplements should be reported as a part of, or sub-category of, Food Bank/Home-Delivered Meals/Nutritional Supplements.

Rehabilitation Care: Services provided by a licensed or authorized professional in accordance with an individualized plan of care which is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology, and low-vision training services.

Substance Abuse Treatment/Counseling: Provision of treatment and/or counseling to address substance abuse (including alcohol) problems in an outpatient or residential health services setting.

Support Services:

a. **Adoption/Foster Care Assistance (Permanancy Planning):** Assistance in placing children younger than 20 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.

b. **Buddy/Companion Services:** Activities provided by peers or volunteers to assist a client in performing household or personal tasks. Buddies also provide mental and social support to combat loneliness and isolation.

c. **Client Advocacy:** Assessment of individual need, provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments.

d. **Counseling (Other):** Individual and/or group counseling, other than mental health counseling provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education.

e. **Day or Respite Care:** Home- or community-based medical assistance designed to relieve the primary care-giver responsible for providing day-to-day care of client or client's child.

f. **Direct Emergency Financial Assistance:** Provision of short-term payments to agencies, or establishment of voucher programs to assist with emergency expenses related to food, housing, rent, utilities, medications, or other critical needs.

g. **Food Bank/Home Delivered Meals/Nutritional Supplements:** Provision of food, meals, or nutritional supplements. Not nutritional education and counseling which is reported under the category, Counseling (Other).

h. **Health Education/Risk Reduction:** (1) Provision of information, including information dissemination about medical and psychosocial support services and counseling or (2) preparation/distribution of materials in the context of medical and psychosocial support services to educate clients with HIV about methods to reduce the spread of HIV.

i. **Housing Assistance/Housing-Related Services:** This includes assistance in locating and obtaining suitable, ongoing or transitional shelter; costs associated with finding a residence and/or subsidized rent; and, residential housing services, which are the provision of housing assistance in a group home setting.

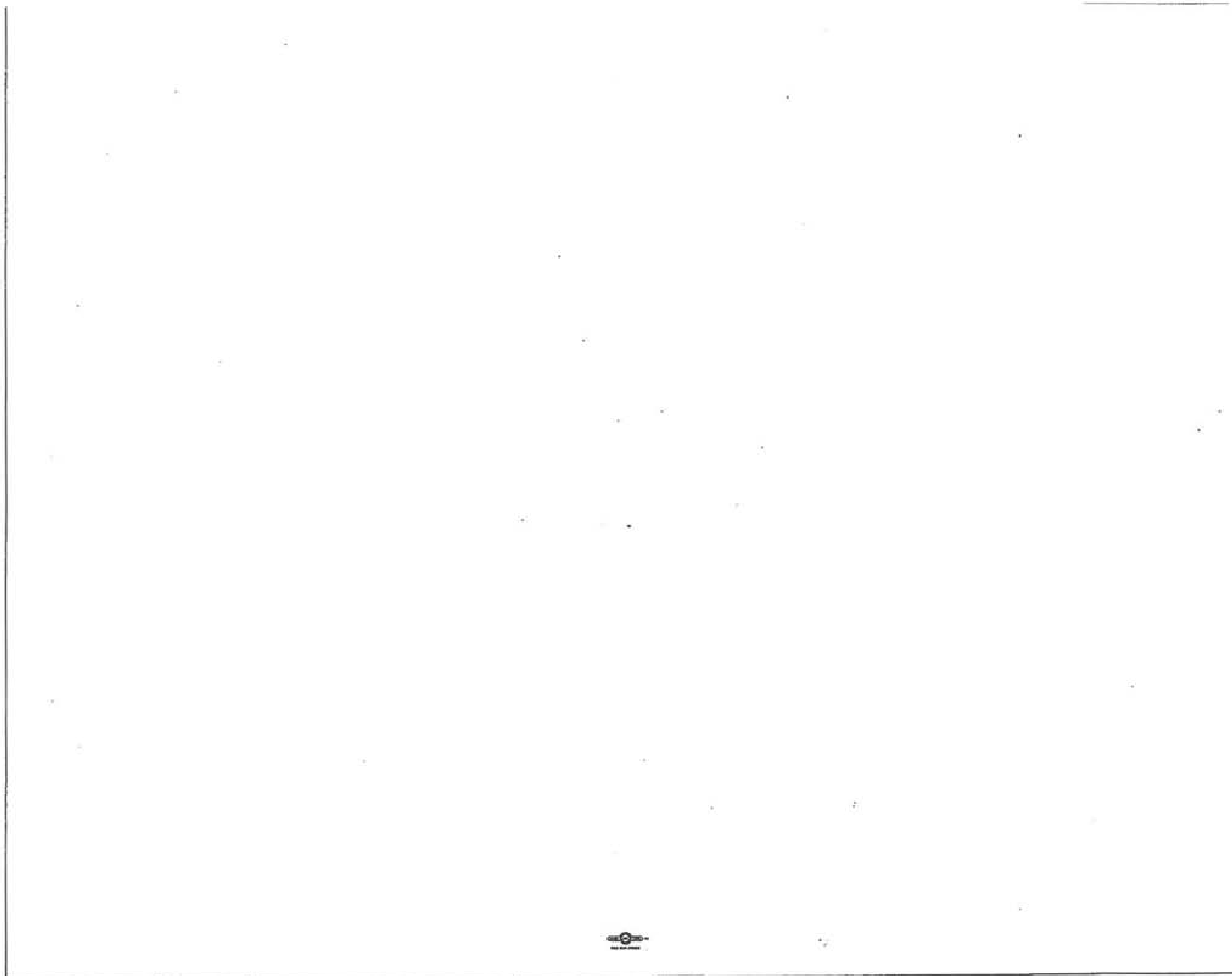
j. **Outreach:** Programs which have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services, not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached, and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

k. **Referral:** The act of directing a person to a service in person or through telephone, written, or other type of communication. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, or informally through support staff.

l. **Transportation:** Conveyance services provided to a client in order to access health care or psychosocial support services. May be provided routinely or on an emergency basis.

m. **Other Support Services:** Direct support services not listed above, such as translation/interpretation services.

NOTES



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