Philadelphia EMA Ryan White Part A Planning Council
Priority Setting Process
October 2016

[Note: A separate process exists for the resource allocation for fundable service categories.]

Timeline for Priority Setting:
The Comprehensive Planning Committee recognizes that the overall needs and priorities of the EMA often remain stable from year to year. The committee moved to an as-needed timeline from an annual timeline for the priority setting process in order to allow more time for comprehensive planning and the Planning Council's work. If there are any significant changes to the HIV service system, the Comprehensive Planning Committee will determine if there is a need to re-prioritize Ryan White service categories. Reasons for re-prioritization include but are not limited to changes to:

- HRSA policy
- HRSA and other allocations for HIV care (including other RW Parts and funding streams)
- Local epidemic shifts

The Comprehensive Planning Committee must carry out their priority setting process every three (3) years, or sooner as necessary.

Part One: Gathering of Information

Throughout the year, the staff of the Office of HIV Planning conducts needs assessment activities (such as surveys, focus groups, key informant interviews) and gathers new information from outside sources (data, literature) in order to keep the Planning Council informed about consumer needs and barriers, and relevant epidemiological changes and trends. These data sources may include:

- Epidemiology data (by region and for the EMA as a whole)
- Service utilization data (by region and for the EMA as a whole)
- Review of the current research literature
- Results of PDPH/AACO conducted research and evaluation projects
- Other relevant local data from PDPH or other sources (PADOH, NJDHSTS, Census data, Medical Monitoring Project, etc.)
- Client Services Unit data from the MCM Central Intake
- Results of needs activities (surveys, focus groups, key informant interviews, town hall meetings, etc.)

It is highly important that community feedback is captured and considered. The information presented to the Planning Council must be broad-based, clearly providing documentation of the community's needs as expressed by community members; many and varied opportunities for community input must be represented in the information provided. This information must be taken into account and cited directly in the Council's explanation of its priorities *(described below)*.]

Part Two: Comprehensive Planning Committee Recommendations

The Comprehensive Planning Committee meets to develop a recommended list of service categories prioritized in order of importance to the overall continuum of care. To ensure that decisions are based on documented need, the Committee follows these steps:

The staff distributes information related to service categories that are fundable by Part A which may include the following and any other information as determined by the Comprehensive Planning Committee:

- HRSA's definition of what activities can be funded under each category
- AACO's definition of what activities are currently funded under each category
- EMA's care and treatment continuum, including relevant subpopulations, when data is available
- Any existing "instructions to the grantee" that are in effect
- Information from the Integrated Plan related to needs, barriers or service gaps
- Service utilization and cost effectiveness data
- Highlights from the needs assessment reports

The committee's deliberations are facilitated by the chairperson(s) with the support of the staff of the Office of HIV Planning. All Comprehensive Planning Committee meetings are open to all Planning Council members and community members, including the meetings dedicated to the priority setting process. Decisions are made using a formal decision-making process in which each service category is scored based on weighted factors that may include the following:

- Consumer preference (collected through the Ryan White consumer survey or other mechanism of consumer feedback)
- Documented unmet need/service gaps (through Medical Monitoring Project, Client Services Unit, and or Ryan White consumer survey data)
- Service impact on the HIV care and treatment continuum
- Whether the service is an Essential Health Benefit under the Affordable Care Act
- Any other factor/s determined necessary by the Comprehensive Planning Committee or Council

The committee determines the number of factors, weights of the factors, and the scoring scale prior to the implementation of this process. The Planning Council must approve any changes to the factors, weights and or scales. These factors, weights, and scoring scales may change from year to year due to data availability, changes in policy, or changes to the local HIV system.

For service categories in which substantial changes to the previous priority ranking are recommended, the committee must present the reasons for the changes. These reasons must clearly state and describe the documentation on which the decision is based. Ultimately, this documentation will be used to support and justify the Council's approved list of prioritized service categories and for possible inclusion in the Part A grant application.

Throughout the deliberations, Council members are reminded that priority setting decisions and instructions to the grantee must be based on documented need.

The committee members formally vote to recommend that the approved priorities be adopted by the full Planning Council. The committee's standing rules on voting determine eligibility to vote.

Part Three: Full Planning Council Priority Setting Session

The full Planning Council receives and considers for approval the Comprehensive Planning Committee's recommended priority list. The Comprehensive Planning Committee Chair/s or his or her designee presents the recommendations along with any accompanying justification and explanation. OHP staff assists the Committee Chair/s, as needed.

The Planning Council members then deliberate until they have arrived at a list of priorities and any instructions to the grantee. These deliberations are facilitated by the Co-Chairs of the Planning Council. Only Council members are permitted to vote, following the Council's usual process for voting.

The Planning Council may also authorize the Comprehensive Planning Committee to address any changes in the Part A fundable service categories with revisions/changes to the service priorities at any point due to changes in legislation or HRSA policy.