



LOS ANGELES COUNTY
COMMISSION ON HIV



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POLICY/ PROCEDURE:	NO. 09.5203	Priority Setting and Resource Allocations (PSRA) Framework and Process
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APPROVED 7.11.24

SUBJECT: The Commission’s Priority Setting and Resource Allocations (PSRA) framework, process and specifics.

PURPOSE: To outline the Commission’s service prioritization and resource allocations process, as mandated by the Ryan White Treatment Modernization Act (Ryan White) and Los Angeles County Charter Code 3.29.

BACKGROUND:

- Service prioritization and resource allocations are two of the Part A planning councils’ chief responsibilities, detailed specifically in Ryan White legislation and confirmed in County Charter Code.
- In accordance with Health Resources and Services Administration (HRSA) guidance, the Commission sets service priorities based on consumer need and determines allocations from priorities and other factors such as service capacity, other sources of funding, service utilization and cost-effectiveness.
- As defined in its ordinance, the Commission establishes priorities and allocations of Ryan White Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review the grantee's allocation and expenditure of these funds by service category or type of activity for consistency with the Commission's established priorities, allocations and Comprehensive HIV plan, without the review of individual contracts; provide and monitor directives to the grantee on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the Board of Supervisors and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan.

POLICY:

- This policy outlines the Priority Setting and Resource Allocation (PSRA) process used to

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- prioritize services and allocate resources—in accordance with governing Ryan White and County code legislation—encompassing the specific partners, responsibilities, steps, tasks, and timelines associated with the process.
 - The PSRA process is led by the Commission’s Planning, Priorities and Allocations (PP&A) Committee. The Division of HIV and STD Programs (DHSP) provides critical information; consumer input is collected through the Comprehensive HIV Plan and other assessments; and provider input is collected through focus forums, surveys, and Commission participation.
 - The policy details the expectations and timing of stakeholder involvement in the multi-year Ryan White Part A funding cycle determined by the HRSA Ryan White HIV/AIDS Program (RWP). The process allows for ongoing stakeholder input at several key junctures. Multi-year allocations are intended to conclude prior to the submission of the RWP Part A application. Allocations are reviewed annually to ensure alignment with and responsiveness to community needs and funding requirements.
- A. **Priorities and allocations are data based.** Decisions are based on the data, not on personal preferences. Commissioners should avoid presenting anecdotal information or personal experiences during the decision making, focusing on needs assessments, and cost/service utilization data rather than a single person’s experience.
- B. **Conflicts of interest are stated and followed.** Commission members must state areas of conflict according to the approved Conflict of Interest Policy at the beginning of meetings. As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity. Any funded RWHAP Part A provider must declare all funded service categories (e.g., areas of conflict of interest) at the beginning of the meeting(s). They can participate in discussions, answer questions directed by other members, and can vote on priorities and allocations presented as a slate.
- C. The data provide the basis for changes in **priorities or allocations from the previous year**. The data indicate changes in service needs/gaps and availability based on information from the various data sources.

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- D. **Needs of specific populations and geographic areas** are an integral part of the discussion in the data presentations and the decision making. They may also lead to recommendations to the Recipient on how best to meet the priorities.

- E. **Final vote** on the complete priorities and allocations will be presented by the Planning, Priorities and Allocations Committee Co-Chairs to the full planning council for a roll-call vote. Commissioners must complete the required annual Priority Setting and Resource Allocation training prior to voting. Commissioners must notify staff once training is complete and a record of the completed training will be kept on file by Commission staff. Commissioners who have not completed the training are not eligible to vote.
*Planning, Priorities and Allocations Committee-only members must also complete the annual Priority Setting and Resource Allocation training. Training materials can be found on the Commission website at: <https://hiv.lacounty.gov/events-training/>.

- F. **Paradigms and operating values** are selected and used by the PP&A Committee to help guide their decision-making in setting service priorities and resource allocations. The PP&A Committee reviews the paradigms and operating values selected and approved from the previous year as the foundation for current year PSRA process or reallocations. (Attachment 1)

- G. **The Commission's Status Neutral HIV and STI Delivery System framework** is used by the PP&A Committee to ensure that service priorities and resources allocations emphasizes high-quality care to engage and retain people in services regardless of if the services are for HIV treatment or prevention. This approach continually addresses the healthcare and social service needs of all people affected by HIV so that they can achieve and maintain optimal health and well-being. (Attachment 2)

- H. Decisions should help to ensure **parity in access to care**, for all Ryan White-eligible HIV/AIDS population groups and for PLWH/A regardless of where they live in the County.

- I. Discussions and decisions should have a major focus on **improving performance on the HIV Care Continuum/Treatment Cascade**, focusing on areas of concern – such as linkage to care or retention in care. Reducing unmet need (the number of people who know they are HIV-positive but are not in care) requires deciding how many “new” or “lost to care” clients should be identified, estimating the mix of services they will need from RWHAP Part A, and allocating funds sufficient to meet those needs. Where a choice needs to be made between providing a wider range of services to more individuals and getting additional people into care, the Planning Council will give priority to getting more people key services (among them primary care and medications).

- J. The Commission members will keep in mind current goals, objectives, and priorities from its **Comprehensive HIV Plan (CHP)** to be sure they receive appropriate attention in decision making.

PROCEDURE(S):

1. The priority setting process should consider services needed to provide and/or support a continuum of care, regardless of how these services are being funded and the extent of unmet demand for these services. Funding availability and unmet needs associated with these service priorities are considered during the resource allocation process.
2. The list of HRSA fundable service categories (core and support) and the definitions of these services will be presented by the Commission staff.
3. The list of HIV prevention categories from the most recently approved Prevention Service Standards will be presented by the Commission staff.
4. DHSP compiles service utilization reports (including, but not limited to, clients served, priority populations, expenditures per client), anticipated service delivery goals/objectives, expenditures reports, surveillance reports, prevention data (including, but not limited to, counseling and testing and PrEP and PEP utilization), and programmatic and fiscal challenges and opportunities for service improvements.
5. The PP&A Committee will consult with all Caucuses prior to the start of the annual priority setting and resource allocation process to:
 - a) Gather opinions from consumers on which services should be prioritized and how resources should be allocated;
 - b) go over the main points from the latest Ryan White Program Service Utilization Reports and HIV prevention data provided by DHSP;
 - c) Look at the most recent financial reports on HIV prevention and care from DHSP;
 - d) Examine the main goals, objectives, and measures from important documents like the Comprehensive HIV Plan and Ending the HIV Epidemic Plan:
6. The PP&A Committee formally organizes focus groups at various provider stakeholder meetings or conducts provider surveys as needed to inform the PSRA process.
7. During July-August, the PP&A Committee deliberates and prioritizes services categories in rank order (highest need is #1 priority). The principal data and information used for priority-setting are the Comprehensive HIV Plan, relevant needs assessment, the HIV epidemiology report, fiscal and programmatic reports, and service utilization reports.
 - a) The PP&A Committee only ranks service priorities once—regardless of funding scenario—as they indicate the services most needed regardless of changes in the funding picture or in which different resources available.
 - b) The PP&A Committee compiles and/or reviews the data and feedback it has collected from DHSP, community listening sessions and/or surveys and reviews it in June, prior to service prioritization.

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8. During July-August after the service categories have been ranked and prioritized, the PP&A Committee determines resource allocations for services:
 - a) Allocations can be made by actual amounts or percentages based on specific expenditure proposals, although percentages allow more flexibility to respond to variances in the funding awards.
 - b) Allocations may change in each of the selected funding scenarios.
 - c) It is strongly encouraged that stakeholders who suggest funding allocations for specific service categories also present accompanying recommendations to advise how the continuum of care will accommodate those suggested modifications to funding levels.
 - d) Additional streams of funding are identified in each service category, with amounts locally dedicated for HIV services where the information is available.
 - e) The PP&A Committee, in collaboration with DHSP, compiles a resource inventory for allocation-setting, and uses it to help determine capacity and other resources when allocating funds.
9. The PP&A Committee recommends and secures approval for service priorities and funding allocations at the August or September Commission meeting, prior to the RWP Part A grant application submission deadline and/or annual report and program terms report.
10. When a reallocation of funds is necessary, adequate data to support the movement of funds between service categories will be presented, considered, and fully documented in the minutes of the meeting during which the reallocation of funds is approved. Proposed re-allocations must be submitted to the Commission for approval. All changes in allocations must be accompanied with a written justification detailing the reasons for the modifications. Reallocations should occur in June or July with a presentation of recommendations and memorandum from DHSP explaining the reasons for the reallocations. In alignment with County policy, the Commission grants authority to DHSP to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to the Commission for approval.
11. During the month (30 days) following the approval of resource allocations by Commission, the PP&A Committee will consider appeals regarding its PSRA process. Appeals must be presented to the PP&A Committee at its monthly meeting immediately following the Commission meeting in which the allocations were adopted. The following two types of appeals will be considered:
 - a) new factual information that may have led to different decisions if the information had been available during the PSRA process, and/or
 - b) questions or complaints about decision-making that did not conform to the process as outlined.
12. In September-November, the PP&A Committee compiles information and suggestions made throughout the PSRA process to further elaborate on its priority and allocation decisions by developing "directives."

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- a) These “directives” are framed as “guidance”, “recommendations”, and/or “expectations” and are intended to detail “how best to meet the need” or as “other factors to be considered” to be forwarded to DHSP the Commission and/or its various committees, and/or other stakeholders, as appropriate.
 - b) The guidance, recommendations and expectations further define minimum quality of care standards, implementation practices and/or mechanisms to respond to specific operational or system needs.
 - c) Once completed and approved by the PP&A Committee, the directives are forwarded to the Executive Committee and the Commission for approval.
 - d) The approved directives are transmitted to DHSP for consideration and implementation if deemed to be feasible by DHSP. DHSP will review the directives and provide a written response to the PP&A Committee which recommendations are feasible with a timeline for implementation.
 - e) DHSP shall provide periodic updates at PP&A Committee meetings.
13. In addition to its other business, the PP&A Committee devotes the intervening months between each year’s PSRA process to further study identified service categories, populations and/or related planning issues, and implements committee activities accordingly to compile the necessary data.

**NOTED AND
APPROVED:** _____

**EFFECTIVE
DATE:** _____

Original Approval: May 1, 2011

Revision(s): July 11, 2024



PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE PARADIGMS AND OPERATING VALUES (Approved - PP&A 11/19/2024)

PARADIGMS (Decision-Making)

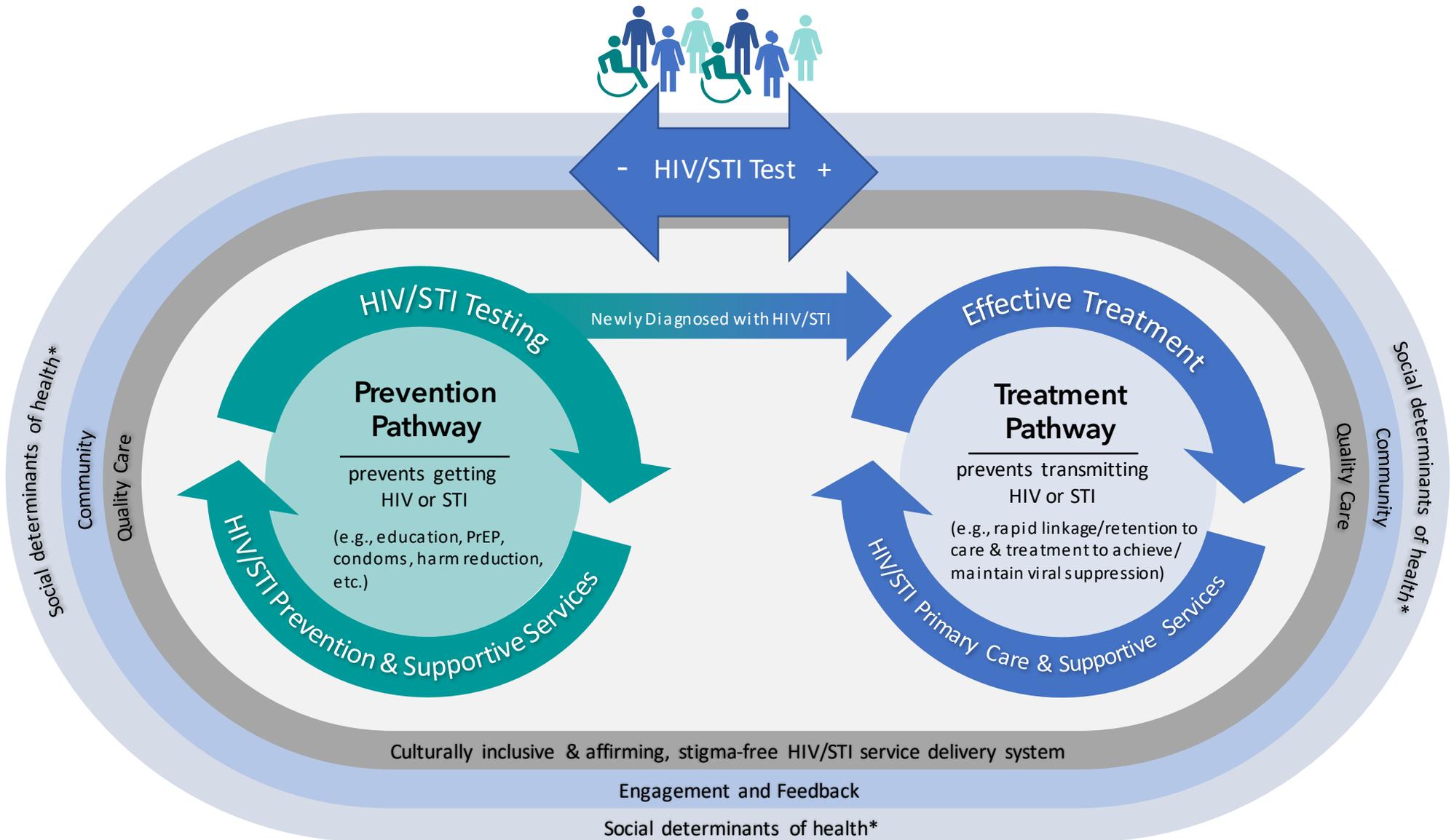
- **Equity:** Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically.
- **Compassion:** Response to suffering of others that motivates a desire to help.
- **Restorative Justice:** [correction of past inequities¹](#).

OPERATING VALUES

- **Efficiency:** Accomplishing the desired operational outcomes with the least use of resources.
- **Quality:** The highest level of competence in the decision-making process.
- **Advocacy:** Addressing the asymmetrical power relationships of stakeholders in the process.
- **Representation:** Ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process.
- **Humility:** Acknowledging that we do not know everything and willingness to listen carefully to others.
- **Access:** [Assuring access to the process for all stakeholders and/or constituencies.](#)

1. *Restorative justice seeks to examine the harmful impact of a crime and then determines what can be done to repair that harm while holding the person who caused it accountable for his or her actions. Accountability for the offender means accepting responsibility and acting to repair the harm done.*

Status Neutral HIV and STI Service Delivery System



Revised 10/18/23

* Social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

See [Healthy People 2030](#) for more details on the social determinants of health.