Since the beginning of the Ryan White Care Act the legislation has included the requirement of community-driven planning bodies. The Health Resources and Services Administration (HRSA) provides the funding and oversight of this legislation and all activities related to it. Similarly, the Centers for Disease Control and Prevention (CDC) require a community-driven planning group for the HIV prevention and testing efforts of each state/territorial grantee. While the CDC and HRSA are both entities under the U.S. Department of Health and Human Services, the functions, guidelines, and requirements for HIV/AIDS prevention (CDC) and care (HRSA) were very separate and little communication was exchanged between entities. For this reason, the Pennsylvania Department of Health had two separate sections within the Division of HIV/AIDS, a prevention section and a care section. Each section then organized and conducted separate community planning bodies. Over the past several years there has been increased communication between the CDC and HRSA regarding HIV/AIDS funding. In 2011, the PA Department of Health (DOH) and the separate planning bodies began brainstorming a new, integrated HIV prevention and care planning group.

As of January 2014, the newly integrated community planning body, the PA HIV Planning Group (HPG), began meeting. In this new role all members basically started from the beginning and needed to set-up the structure and processes for all statewide planning activities. The HPG formed three subcommittees; Membership/Stakeholder Engagement, Needs Assessment, and Priority Setting and Resource Allocation (PSRA). The PA DOH asked me to consider chairing the Priority Setting and Resource Allocation subcommittee due to my experience conducting the process in my own region. After gaining subcommittee support I agreed to chair the subcommittee. I chose this work to complete as my practicum because it was a nice fit with the competencies of the practicum experience. The primary goals created for this practicum included, 1) develop the priority setting process for the PA HIV Planning Group through the Priority Setting and Resource Allocation (PSRA) subcommittee and 2) implement the priority setting process for the PA HIV Planning Group. While work on building this statewide process began in January of this year, my practicum focused on the actual priority setting and resource allocation sessions that were conducted between September and November. All of the planning and developing of policies and procedures that led up to these sessions are important to the process and therefore I will also provide that information as it supports my practicum work. As the subcommittee chair I worked with the PA Department of Health to develop the priority setting session and conduct it, analyzed and aggregated the data from individual members to reflect group results, reviewed best practices in conducting priority setting, developed the resource allocation process and conducted that process, and documented the entire process with focus on rationale for the priorities and resource allocations.

The first step in being able to effectively lead the PSRA subcommittee in developing these processes was to review the Ryan White legislation and appropriate manuals. Reviewing these documents ensured that I was familiar with all requirements and accounting for all necessary elements of each process. Section 2617(b)(3) of Ryan White legislation requires grantees (usually state departments of health) to submit an application. This application must outline the statewide planning body activities and include a comprehensive plan. This plan must...
pay particular attention to established priorities and the process of setting those priorities as well as a description of the allocation of funds among priority categories. The Ryan White Part B Manual provides suggested steps in the priority setting and resource allocation process. I utilized the Manual heavily throughout the subcommittee work to ensure that each piece of the process and all requirements were met.

At the start of the year, the PSRA subcommittee began laying the foundation for the priority setting process. I worked with the group to review all related steps of the process as defined by HRSA for Part B grantees. In addition to reviewing the HRSA requirements, we also reviewed the priority setting process as conducted by other states. After familiarizing the group with the steps of the process, we identified our first steps. The group developed a timeline for the process in order to conclude the process by the November meeting of the HPG. In addition to the timeline, we identified what presentations would be needed in order to facilitate a data-based decision-making process. Once the presentations were identified, we established a list of questions to request each presenter answer throughout the year so that all necessary information for the process was provided. These questions were then sent out in advance of each meeting so that the presenters had ample time to prepare. One of the presentations planned for the year included information on the service categories. Because this was one of the first meetings to begin the process, I walked the subcommittee through all of the service categories and the corresponding definitions. This was beneficial to the group as not all members are fully versed in Ryan White service categories and those who may be familiar may not realize the specificity of each definition until thoroughly reading each as not all categories are intuitive. By the end of this meeting, the subcommittee had documented the outline for the process and identified the desired outcomes, the roles and responsibilities of subcommittee and full committee members, a timeline for completion, and all available inputs to the process.

Between the January and March and during the March meeting, the subcommittee continued to develop the process. The next steps involved identifying the principles which would guide the priority setting process. I led the group through several existing examples of these principles and the group altered them to meet the needs and expectations of the HPG. Although principles from other jurisdictions were reviewed, those principles selected were taken largely from the Ryan White Part B Program Manual. The principles selected to serve as the foundation for decision-making are:

- Decisions must be based on documented needs.
- Services must be responsive to the epidemiology of HIV in the State of PA.
- Priorities should contribute to strengthening the agreed-upon continuum of care which for the PA HPG is the Prevent-Test-Link-Treat-Retain Model.
- Decisions are expected to address the overall needs within the service area, not narrow advocacy concerns.
- Services must be culturally and linguistically appropriate.
- Services should focus on the needs of low-income, underserved, and disproportionately impacted populations.
- Equitable access to services should be provided across the State and across subpopulations. (equitable access used here to mean all services should be available in each region, this is regardless of funding stream)
- Services should meet Public Health Service treatment guidelines and other standards of care and be of demonstrated quality and effectiveness.

It was explained to the subcommittee that during the decision-making process, the HPG should consider whether the proposed priorities are consistent with these principles. The group agreed that these principles would specifically be addressed and stressed at the beginning of the priority setting session scheduled for November. In addition, the subcommittee discussed
that when documentation does not exist to apply all principles, lack of information should be specified for future years to the appropriate subcommittee as a gap in data. This documentation of gaps in data would be another important part of our process.

After the principles for the decision-making process were created, the subcommittee moved on to determine the criteria for the decision-making process. Again, the criteria selected came from the Ryan White Part B Manual and were adapted to meet the needs of the PA HPG. The final criteria included:

- Documented need, based on;
  - The epidemiology of the epidemic in PA
  - Service needs specified in the needs assessment including unmet needs of individuals who are HIV-positive but not in care (aware and unaware) and of historically underserved communities
  - Other standard sources of information (inputs provided on an annual basis)
- Quality, cost-effectiveness, and outcome effectiveness of services, as measured through outcomes evaluation, clinical quality management programs, client satisfaction surveys, and other evaluation methods.
- Consumer input for priorities, including services and interventions for particular populations, especially those with severe needs, historically underserved communities, and individuals who know their status but are not in care.
- Consistency with the Prevent-Test-Link-Treat-Retain Model, and its underlying priorities.
- Balance between ongoing service needs and emerging needs, reflecting the changing epidemiology of HIV/AIDS.

The subcommittee concluded the discussion and determining of criteria with acknowledging that the priorities should reflect the HPG’s judgment concerning what services are needed to provide the continuum of care. This judgment should be regardless of how these services are being funded; therefore these criteria do not and should not include considerations such as the availability of other funding streams.

One of the criteria selected, consumer input for priorities, needed further examination and development. The subcommittee discussed how to gather and incorporate consumer input into this process. After discussion the group decided to conduct mini-priority setting sessions in each region of the State. At that time there were seven existing regions. The subcommittee felt that there were enough HPG members with access to existing consumer groups that this task could be accomplished. The subcommittee then began to brainstorm what existing groups there are throughout the State and identified which HPG members we could ask for assistance in gathering those groups. The group determined that we would make the request of the current fiscal agents in each region. While the priority setting process is not a focus group, I walked the subcommittee through various aspects of a focus group that we could utilize in this process in an attempt to ensure a level of consistency between groups. The end result of this discussion was a framework by which the consumer groups would be conducted. First, the groups would be co-facilitated by 1) the regional fiscal agent/HPG member so that region specific questions could be addressed, and 2) a University of Pittsburgh staff member (they are under contract with the DOH to provide assistance with these planning activities). The facilitators would use the same PowerPoint presentation with each of the seven groups. This PowerPoint was created by the subcommittee reviewing priority setting session presentations that were used in other jurisdictions (Maryland and western Washington D.C). After creating the presentation, all slides were the same for each region with the exception of about 4 slides which contained information about the disease characteristics in each specific region. The last portion of the consumer groups would be asking them to complete a priority ranking form. This form had
all of the available service categories listed and definitions were provided and reviewed so that everyone knew what each service category meant. The consumers would be asked to rank the top 7 priorities for their region. These consumer meetings were targeted to be conducted between July and August. Due to the fact that the fiscal agent in the North Central region was not represented on the HPG, I offered as an HPG member to also host that meeting. The North Central region is one of my neighboring regions and the region in which I grew up; therefore I had adequate familiarity with it to co-facilitate the meeting. I worked with the University of Pittsburgh staff to schedule the meetings back-to-back. We conducted mine (Northeast region) on a Tuesday afternoon and followed it with the North Central meeting the next evening.

There was considerable leg-work to be done to coordinate these meetings. For the two regions that I co-facilitated, there are no existing consumer groups that meet on an on-going basis. For this reason, I worked with the medical case management providers in each region to send out letters to all clients. I wrote the letter, printed enough for each provider, and delivered them to each office. Once the letters were sent out, the RSVP for my region came directly to me and in the North Central region the medical case managers were kind enough to accept the RSVPs so that consumers would not risk long-distance charges to call my office. About one week before the date of the meetings, the final count for each was provided the facilities being used to host the meetings. The State permitted me to use some of my meeting expense funds in my contract to provide food for the Northeast meeting. This was very helpful as providing a meal or refreshments generally provide some more incentive for clients to attend the meeting. For the North Central region, the University of Pittsburgh had some funds available to provide reimbursement to me for refreshments for the group. In addition, the agency in North Central that provided meeting space offered a $25 gift card for a local grocery store. This was then used to do a drawing at the end of the meeting. Because each group that I conducted were primarily rural areas of the state it is difficult to get consumers to attend. Any incentive that may be offered is very helpful to gather even more than a handful.

All of the consumer priority setting sessions were conducted by the end of August. The results of these sessions were then aggregated so that at the September meeting the results could be shared with the full HPG.

In addition to the consumer meetings, between July and September I worked with the subcommittee to develop the first steps of the priority setting session for the September meeting. It had already been decided that the first step would be for each HPG to individually complete a priority ranking tool. In order for the members to do this they would each need the materials necessary to make informed decisions. For this reason we developed a packet of information for them so that all of the information was in one location. Then at the September meeting we went through each portion of the packet and asked that the members complete the ranking and turn it in by the end of day two of the meeting. The packet began with brief summaries of the key findings from each presentation that was provided throughout the year. These key findings were identified by each presenter and were those most directly relevant to priority setting. The presenters submitted these summaries to University of Pittsburgh staff for compilation. In addition, the decision-making principles and criteria were provided next in the packet. These were provided so that all members were reminded to use them in the decision-making process and so that they could cite the principles or criteria as reasons for prioritizing as they did. The next portion of the packet included the service definitions as defined by Ryan White. These definitions are very important for the group to have on-hand as some categories may seem logical however after reading the definition it is realized that the category is more specific than originally thought. Or perhaps the name of the category does not immediately indicate what is covered under it. For example, a category like food bank/home delivered meals may not need further explanation while a category like early intervention services may require some further detail. The next piece of the packet included considerations prior to ranking as well
as questions for the HPG members to ask themselves as they worked through the priority ranking process. This portion included the following items:

**Before You Begin:**

**Definition:** Priority setting is the process of deciding which HIV/AIDS services are the most important according to the criteria the HPG has established.

**Familiarity with Guiding Documents:** Am I familiar with the decision-making principles and criteria for priority setting? Have I reviewed the Ryan White HIV/AIDS program core and support service definitions provided in this packet? And the priority ranking tool?

**Knowledge of Data:** Have I reviewed the key findings from the epidemiological data, service utilization, and other priority-setting presentations given at HPG meetings in 2014?

**Need for Assistance:** Do I have any questions? Should I ask members of the Priority Setting and Resource Allocation subcommittee for assistance?

**As You Prioritize:**

- Am I ranking highest the services most needed by the low-income, underserved, and disproportionately impacted population of people living with HIV/AIDS (PLWH) in all parts of the state?
- Am I ranking services in order of importance, regardless of how they are being funded?
- Am I placing a special emphasis on eliminating service gaps and disparities in access to services? Am I making sure that all services are available to all PLWH in all parts of the state?
- Does my ranking reflect and address identified needs of individuals who are in care and individuals who are out of care?
- Am I adhering to the Conflict of Interest policy? Are my decisions addressing the overall PLWH needs within the state rather than my personal concerns or those of an agency with which I am affiliated?

The final piece of the packet was the ranking tool itself. The HPG members were asked to use this information to rank all service categories 1 through 29, with 1 being the highest priority. The members also had a column on the tool to provide rationale for why they ranked each service as they did. We asked that they try to provide rationale for the top 10 services. This rationale will help us during the final priority setting session as one of the last steps will be to identify the rationale for our final rankings. In the case that any HPG member had questions or needed any type of assistance in completing the ranking tool, a University of Pittsburgh staff member and I were available after the meeting ended on day one so that assistance could be provided. We reserved a room for an hour in the evening so that any committee member could get questions answered and any necessary help with working through the ranking.

These individual ranking tools were completed by members at the September meeting. During the subcommittee time, we worked through planning each piece of the agenda and process for the priority setting session and the resource allocation session. I arrived at the September meeting prepared for this discussion and walked the subcommittee through each step, proposed various ways of completing the different tasks, and had the group discuss and make a final decision of each step. We also discussed approximate timeframes for each step of the process. This was further discussed during steering committee so that the overall agenda for the November meeting was accommodating enough time for each of these sessions.

Following the meeting I spent time creating a document which outlines the process for each session. This document is important because the grievance procedure for the group is based upon whether an aspect of the process was or was not followed correctly. Therefore if someone has a grievance it must be concerning in what manner the process was not followed as planned leading to whatever decision was made with which the individual does not agree. A grievance cannot be simply that someone does not like the decision that was made. Outlined below are
the activities planned for each session of the priority setting process. I have kept it in the format provided to the group, therefore wherever mention of the facilitator is made, I am referring to myself.

**Overview of priority setting:**
Facilitator will cover the scope, expected outcomes, and responsibilities of members during the priority setting process. The decision-making principles and criteria will be presented as a reminder for decision-making and discussion. A list of questions will be provided to the members so that the session may remain focused on the expected outcomes and priority ranking for the state (this list is provided above).

**Conflict of Interest:**
Management of conflict of interest will be mentioned as part of membership responsibilities. Prior to the in-person priority setting session, the Conflict of Interest disclosure information will be electronically mailed out to all members. This will provide the opportunity of members to update the information if necessary. Prior to the start of the priority setting session all members will be expected to have submitted a signed conflict of interest disclosure form. Members who do not complete this form will not be permitted to participate in the process.

After the overview of the process, the facilitator will address the specifics of the conflict of interest disclosure and the responsibility that HPG members have to manage conflict of interest during the process. It was decided by the PSRA subcommittee that one subcommittee member will maintain a list of all disclosures and affiliations. It is the responsibility of all members to speak up if they believe there is an actual or perceived conflict of interest occurring during the discussion and the subcommittee member with access to the list will keep close account of any potential conflicts also speaking up if necessary.

**Key Findings:**
Each presentation provided throughout the year for the purposes of the PSRA subcommittee will be provided 10 minutes on the priority setting agenda. During these 10 minutes each presenter will provide the key findings of the presentation which are most relevant to the priority setting process. A time-keeper will be assigned in order to keep this portion of the session moving ahead.

**Preliminary aggregated ranking results:**
The University of Pittsburgh staff will present the aggregated results of the priority rankings completed by HPG members at the previous meeting. Three charts will be presented to the group and will include: 1) HPG members-only aggregated rankings, 2) consumer session aggregated rankings, and 3) both HPG members and consumer groups’ rankings.

**Electronic voting:**
The process for electronic voting will be explained to the group prior to taking the first vote. After the aggregated rankings are displayed to the group, all members will vote using the electronic voting devices. The three options for voting will include, fully support, support with minor issues, and cannot support. All members will have an index card available to them at their seat. Those members voting either support with minor issues or cannot support will write what issues they have with the current ranking. These issues will be consolidated and presented to the group for discussion. After addressing each issue, a change may or may not be suggested. If a change to the current rankings is suggested, the full committee will vote yes or no to make that change. After the first round of issues is addressed and any majority voted modifications are made to the rankings another round of, fully support, support with minor issues, or cannot support will be conducted. This process will continue until the majority of HPG members are voting to fully support. If there are a few remaining minor issues to address the committee may vote yes or no to continue working through issues or to bring it to a final vote.

**Producing rationale:**
After the final vote is conducted and the majority is able to fully support the priority rankings, the group will spend time citing the rationale for setting the priorities is this way. The
group will focus on providing rationale for the top 10 priorities. During this portion of the session
the group will be reminded to use the principles, criteria, continuum of care, treatment model,
and information from any of the presentations to support the rankings.

All of the activities described above were followed as planned. During each these
activities the group was able to ask questions of me or the presenters of the key findings
presentations. As a starting point for the discussion and voting we used the HPG aggregated
rankings so that we had an approximate priority order that would be as close a starting point for
the group as possible. We began the priority ranking with an opening vote to sense where we
were with support for only the first 10 priorities. Of course, immediately we knew that there were
services that many thought should be in the top ten and were not. An example of this was
Substance Abuse – Outpatient Services. Because many of our clients have mental health or
substance abuse issues, several members of the group wanted to see Substance Abuse –
Outpatient Services in the top ten. After discussion and numerous rounds of voting…and I
stress numerous…the following chart shows the final decisions for the top ten priorities.

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>AIDS Drug Assistance Program (SPBP)</td>
</tr>
<tr>
<td>2</td>
<td>Outpatient/Ambulatory Medical Care</td>
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<tr>
<td>3</td>
<td>Medical Case Management</td>
</tr>
<tr>
<td>4</td>
<td>Housing Services</td>
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<tr>
<td>5</td>
<td>Oral (Dental) Health Care</td>
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<tr>
<td>6</td>
<td>Early Intervention Services</td>
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<tr>
<td>7</td>
<td>Medical Transportation Services</td>
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<td>8</td>
<td>Mental Health Services</td>
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<tr>
<td>9</td>
<td>Emergency Financial Assistance</td>
</tr>
<tr>
<td>10</td>
<td>Health Insurance Premium &amp; Cost Sharing Assistance</td>
</tr>
</tbody>
</table>

HPG members were asked to keep in mind that these are the services that we consider
as essential services for our clients. In addition, the purpose of Ryan White supportive services
is to provide the ability to gain or maintain medical care. While Substance Abuse – Outpatient
Services was discussed at length regarding its place in the top ten, the group placed it at
number eleven choosing to keep all those which had already been in the top ten and those
which had been moved into the group. Overall, I was not surprised in the discussion or outcome
of the top ten selections. These services certainly represent the services most needed for our
clients and those services which lend themselves to helping clients access care or be
maintained in care. During this process, specifically the top ten ranking, it was surprising to me
that HPG members had such a difficult time separating the funding element from the priority
setting process. It seemed at times that question after question was based on or angled toward
gaining more information about how the services are funded. For example, the number one
priority, the AIDS Drug Assistance Program obviously is a Ryan White Part B service however it
receives an earmark under Ryan White legislation and corresponding funding. Some committee
members suggested dropping it from the top ten due to the group not having the need to
eventually allocate funds to it as the earmark currently covers the need. We continually needed
to go back to the fact that during priority setting the services should be considered regardless of
the funding available or what funding specifically is meeting the need. I suppose when I
embarked on this process I thought that the concept of identifying which services are essential
to our clients without consideration of funding was easier than it turned out to be. To think that
the suggestion was made to drop the very category providing the life-saving medications to our clients is the perfect depiction of this. The majority of HPG members voted in support of these ten priorities before we moved on to the next set of ten.

This set of ten services took a little less time to determine and gain support of the full committee. The primary discussion for these ten services surrounded the food bank/home delivered meals and non-medical case management categories. Food bank/home delivered meals had been lower on the list in the initial rankings but after considerable discussion and voting the group chose to move it higher in the rankings. Discussion surrounding non-medical case management involved supporting those clients who need some support but not the more intensive support of medical case management. After discussion and voting the group kept it at number 20.

| 11 | Substance Abuse Services – Outpatient |
| 12 | Food Bank/Home Delivered Meals |
| 13 | Health Education/Risk Reduction |
| 14 | Medical Nutrition Therapy |
| 15 | Treatment Adherence Counseling |
| 16 | Psychosocial Support Services |
| 17 | Outreach Services |
| 18 | Substance Abuse Services – Residential |
| 19 | Home Health Care |
| 20 | Non-Medical Case Management |

The final nine categories did not take much time to discuss and vote upon. These service categories were somewhat of a toss-up as to the exact order of them. The need illustrated for these service categories was much less than those of the services in the top twenty. In addition, this process was a very lengthy process and a very long day. I felt that while there was continued thoughtful discussion and adequate consideration for these services, the group was at an end-point and wanted to move quickly to voting and concluding this portion of the process.

| 21 | AIDS Pharmaceutical Assistance (local) |
| 22 | Legal Services |
| 23 | Home & Community-Based Health Services |
| 24 | Linguistic Services |
| 25 | Referral for Health Care/Supportive Services |
| 26 | Rehabilitation Services |
| 27 | Child Care Services |
| 28 | Hospice Services |
| 29 | Respite Care |

At the end of the ranking process we conducted one last vote. This vote was asking the group one last time to indicate 'yes, I support these rankings as listed' or 'no, I cannot support the rankings as listed'. To my amazement, and relief, the group voted 100% in support of the
rankings as listed. I was very happy that this was the outcome because I could be confident that the group supported the process and results.

Although we conducted the final vote, the last piece for our day was to specifically site why we prioritized the top ten as we did. For some of this information we could refer back to our discussions that took place during the process, but for a few of the services in the top ten we had not specifically sited our reasons and referred back to specific data sources. The following were some of the items stated as the rationale for the top ten priorities.

1. AIDS Drug Assistance Program: Adherence to medications is of utmost importance in better health outcomes for our clients as well as preventing the spread of the disease. This service provides medications and lab services and therefore in addition to the benefits to clients, it supports numerous elements of the treatment cascade.

2. Outpatient/Ambulatory Care: Regular medical care is important for better health outcomes and adherence to medication regimens. This service provides medical visits, at these visits clients are able to properly monitor the virus, get prescription refills, and keep track of treatment plans moving toward viral suppression.

3. Medical Case Management: This service contributes to retention in care as medical case managers provide the intensive scheduling and follow-up necessary for clients to remain in medical care. Treatment adherence counseling is also an activity provided as part of the medical case management visit. And finally, this service is the gatekeeper for most support services across the Commonwealth.

4. Housing: This service is a key in stabilizing clients so that medical care and adherence are possible.

5. Oral Health care: There has been documented increase in need for this service category and oral health is essential in supporting overall health.

6. Early Intervention Services: This category supports counseling, testing, and referral services under RW. These are essential services in addressing all portions of the treatment model, most directly Prevent-Test-and Link.

7. Medical Transportation: This is an ongoing need and there has been an increase in need in this category across the state. The service aims to eliminate transportation as a barrier to care. While it is a large barrier in rural areas of the state due more directly to availability, it is also an existing barrier in urban areas due more to accessibility.

8. Mental Health Services: Stabilizing mental health issues is a key component of successful HIV/AIDS treatment and is an ongoing need across the state according to data presented.

9. Emergency Financial Assistance: This is an ongoing need for clients across the state and helps to alleviate costs related to emergency food, prescriptions, or housing needs.

10. Health Insurance Premiums and Cost Sharing Assistance: This is an ongoing need for clients across the state and the impact of the ACA is not yet fully known.

I do not yet have the official recorded minutes and notes from the session. It was discussed at the conclusion of the session that the recording would be analyzed to capture all of the reasons which were mentioned during the active discussion specific to the rationale for the top ten services.

As I mentioned above, it was surprising to me that it was so difficult for members to exclude the funding element during the discussion of priority setting. I knew that in the beginning of the discussion this would be an issue that needed to be addressed, however it was more ongoing than expected. Overall, the entire experience was a positive one. I enjoyed reviewing how other jurisdictions conduct the priority setting process and how the process was structured. Knowing that it was the first time the state of Pennsylvania was doing this and trying to mold it to
be our own was exciting to do. I was flattered that the PA Department of Health values my work and finds me to be a credible professional enough to ask me to chair the subcommittee. Throughout the process I received positive feedback on my leadership, organization, and knowledge of the process. Receiving this feedback was very motivating in that it reinforced the quality of work that I was doing. Being very much entrenched in the work it was difficult at times to assess for myself whether other members thought the process was going well or whether they were simply going through the motions or actually engaged. The feedback reinforced their active engagement and made me feel good about the work that I was doing. It was very rewarding to see the process completed with tangible results. This was rewarding not only for me, but for the full group as well. To begin the process in January and much of it being creation of procedure or policy, it was a very long time to discuss the process and brainstorm how it would or should go. The November meeting and active sessions brought the entire process full circle for the full group to understand all of the pieces.

One element that classroom experiences in both undergraduate community health and graduate public health cannot afford a student is the interaction of professionals and volunteers or a rulebook on the management of personality differences. In many of the settings I have been in professionally, there are strong, difficult, weak, apathetic, and moderate personalities, balancing these traits during group process is difficult and has taken me several years to hone my skills in balancing these traits. This process was no different. There were meetings I went into knowing that conflict would arise based on who was in the room. There were times I wished the more passive, but still very knowledgeable members in the room would speak up more. These group process skills are very necessary in many realms of public health practice and can only be gained through interactive processes such as this priority setting process. As my career moves forward I can certainly use this experience as insight to remind me that no sector of public health can be conducted in a bubble, there are always moving parts. Those moving parts are people, people who are coming to the table to make public health decisions. The strong and weak personalities needing to be balanced are all part of the public health field in order for those people to make the best possible decisions so that the lives of others may be improved. Throughout this process it was of greatest importance to me to keep in mind the clients we serve and to drive a decision-making process which will continue to meet the needs of individuals living with HIV/AIDS in Pennsylvania to the best of our ability.

References:
