Evolving a Fully Comprehensive Care/Prevention Continuum and Standards: A Los Angeles County Case Study

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Coordination and Linkages: H-9  
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Evolving a Fully Comprehensive Care/Prevention Continuum and Standards

LEARNING OBJECTIVES

Learning Objective #1: The continuum of care/prevention should not be just a visual representation of services, but should show how services are planned and implemented and their outcomes. Workshop participants will learn to use the HIV continuum as a fully dynamic planning/implementation and quality management tool in which quantifiable data can be identified and inserted to forecast/predict linkages into care, patient/health outcomes and health and population impacts—information essential for developing and adapting standards and interventions and implementing, prioritizing, allocating and procuring service delivery.
Learning Objective #2: Audience members will leave with a better understanding of the impact and influence of standards of care, and what measures are being taken to ensure that they are kept up-to-date and continue to be shaped as services change and/or best practices are learned and incorporated. Examples of the procedures the planning council has put into place to maintain the standards and how the standards have changed service delivery in LA will be provided.
LEARNING OBJECTIVES

Learning Objective #3: Guided by LA County’s new continuum of care/prevention, workshop participants will learn how to quantitatively model and assess 1) services/interventions, 2) patient flow, and 3) outcomes/impacts and integrate the findings into local planning and service implementation by using 1) patient flow diagrams (to determine patient status, such as low risk, newly diagnosed, entering care, adhering to treatment plans), 2) systems mapping (to define factors and indicators, and show how they impact patient status and outcomes), and 3) evaluation scorecards (to show how to assess outcome effectiveness, cost-efficiency/effectiveness and best practices).
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- Continuum of Care is not just a visual diagram . . .
  - It’s pretty and all, but what does it do?
  - It’s a nice pretty package of how services are supposed to interact, but is it really an accurate picture?
  - It’s simple and concise, but are those really the characteristics we are seeking to depict a system of care with 20+ service categories serving 18,000 people?
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- Continuum of Care is your guide to . . .
  - Plan
  - Do
  - Evaluate
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Starting with Standards of Care (2005) . . .

- represent “minimum service delivery expectations” required in the provision of services,
- describe the primary interventions used to improve patients’ health outcomes,
- are the basic elements against which quality and effectiveness are measured,
- provide coherent definitions of services used to help the planning council prioritize services and allocate resources,
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- form the basis for considering and integrating “best practices” into service delivery,
- empower consumers with the knowledge of what they can expect from their services,
- instruct agency administrators and providers as they develop and implement programs,
- identify gaps and disparities in service delivery, and respond to technical assistance needs, and
- help ensure consistency of services across diverse geographic, income and population spectrums.
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- Standards of Care are the foundational building blocks for most of the primary health system management components:
  - Planning (continuum of care, comprehensive care plan),
  - Procurement (RFPs, solicitations, bids),
  - Service Delivery (service protocols, treatment guidelines, clinical procedures)
  - Contracting (contract monitoring, performance audits),
  - Quality Management (chart review and abstraction, grievances),
  - Evaluation (service effectiveness, cost efficiency, outcome evaluation),
  - Research (best practices, service, disease and population impact),
  - Financing (rate reimbursement structures, service unit costs).
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The Commission prioritized standards of care development for the following reasons:

- Promises to develop standards of care to HIV stakeholders for several years,
- Increasing federal focus on quality management and its critical components,
- Compliance with federally mandated responsibilities,
- HRSA Project Officer directive to create standards of care,
- Possible negative impact on the annual Ryan White Part A funding award,
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- Significant variability in the same services that weakened consistent, effective and cost-efficient service delivery,
- Resulting service and quality gaps yielding a less responsive and reliable system of care,
- Multiple unspecified service variations led to inaccurate, irrelevant or inadequate planning decisions,
- Recognition that standards are continuum of care fundamentals essential for other decisions that would be needed in the future,
- Taking advantage of renewed community support/investment in the Commission, and
- Need to demonstrate new Commission effectiveness as an independent County entity.
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Local political and partnership dynamics at the time
- New Commission reporting relationship to the LAC Board of Supervisors
- Commission previously reported to the Office of AIDS Programs and Policy (OAPP), Part A administrative agency (Grantee)
- OAPP responsible for quality management, procurement, contracting; Commission previously not involved in service design or delivery structure/implementation
- No existing Memorandum of Understanding (MOU) between PC and Grantee
- Main source of service design guidance for providers comes from contracts, established at the provider level in earlier stages of the epidemic
- Lack of service model uniformity creates intense provider-level ownership and investment in individually designed services
### Assessing Local Readiness to Develop Standards of Care in 2004-2005

#### STRENGTHS
- New reporting authority to Board of Supervisors
- Renewed community support for Commission

#### WEAKNESSES
- No relationship definition between Grantee/PC
- Limited guidance about PC’s standards authority

#### OPPORTUNITIES
- Stakeholders acknowledge need for service uniformity
- Consumers demand more service accountability

#### THREATS
- Grantee/providers resist greater PC role in services
- Grantee/providers refuse to incorporate standards

#### Future
- Standards improve client/patient outcomes
- Standards underscore PC relationship to services

#### External
- Educate stakeholders on importance of standards
- Provide stakeholders opportunity to participate

#### Internal
- Adopt standards at a fast pace to reduce anxiety
- Ensure standards have “real-world” applications

#### Present
- Develop standards using existing contracts/models
- Define how standards should be used/applied
## Evolving a Fully Comprehensive Care/Prevention Continuum and Standards

**Standards of Care Approval Process (followed for each Standard of Care)**

<table>
<thead>
<tr>
<th>Steps:</th>
<th>Activity(ies)</th>
<th>Time Needed:</th>
</tr>
</thead>
</table>
| **Step #1:**| Draft the standard, using:  
  - existing contracts schedule,  
  - HIV standards from other jurisdictions, and  
  - existing, relevant literature and clinical/service guidelines | (two months)                      |
| **Step #2:**| Convene an Expert Review Panel (ERP) to review and modify the draft standard                                                                   | (one month)                       |
| **Step #3:**| Incorporate ERP interests into the standard and send second draft of the standard to the ERP for final input                                    | (one month)                       |
| **Step #4:**| Incorporate ERP final input, when appropriate, into the standard and forward to the SOC Committee for review and edits                        | (one month)                       |
| **Step #5:**| Incorporate SOC interests into the standard and forward second draft to the full Commission                                                  | (one month)                       |
| **Step #6:**| Present the draft standard to the full Commission and open public comment until the next SOC meeting                                            | (one month)                       |
| **Step #7:**| SOC determines what, if any, public comment to incorporate into the final draft                                                                | (one month)                       |
| **Step #8:**| Present changes resulting from SOC’s review of public comment to Commission, and adoption of the standard, with or without additional revisions/modifications | (final adoption)                  |

Steps #1 and #2, combined, took no longer than two months;  
Steps #3 - #5, combined, took no longer than two months;  
Steps #6 - #8, combined, took no longer than one month (unless extended due to months in which the Commission did not meet/hold special meetings—meaning four standards presented at the subsequent Commission meeting)  
Step #8, allowed to be extended one month depending on extent of Commission input at the meeting
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- **Standards of Care Development Process Summary:**
  
  - **6,000+ hours of total time dedicated**
    - Contracted/staff work: 5,000+ hours
    - Volunteer/expert contributions: 3,000+ hours
    - 250+ participants
  
  - **33 service standards**
    - Nine (9) new service categories
    - 15 Special Population Guidelines
    - New Continuum of Care
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Policy on Standards of Care Development and Oversight:

- The Commission recently adopted a policy regulating how often formal updates to the standards will be performed (every four years in alternating years), under what circumstances and when revisions can be performed, and the Commission’s process to ensure Grantee compliance with the standards in its annual contracting and procurement processes.
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Continuum of Care:

- The development of the Los Angeles County’s HIV Standards of Care led the Commission on HIV to begin reviewing the relationships between services through a systems mapping process. Systems mapping led to a patient flow diagram that showed where and how patients engage various levels of care and treatment, and the systems maps identified how services link to stages in the patients’ progression through care and treatment. From those relationships, health and patient outcomes were revealed and indicators identified demonstrating whether or not patients and services were achieving those outcomes.
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Health Status
- HIV+, unaware
- becoming HIV aware

Quality of Life
- UNMET NEED
  - Aware of HIV status, but not receiving services
  - Entering/accessing services
  - Dropping out of services
- PUBLIC CARE
  - PLWH/A patients accessing services
  - Not complying with care plan
- Level of Effective Clinical Management
- Level of Effective Medical Care Coordination
- Level of Effective Case Management
- Quality of Care Plan
- No. of Appropriate Referrals
- Level of Capacity of Clinics/Hospitals
- Level of Effective Case Management...
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Progression for more effective care/treatment

Progression for more effective prevention services
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POPULATION-BASED IMPACT

Health Status  Quality of Life  Self-Sufficiency

Impact
Health Outcomes (including Health Indicators)
Goals, objectives, measurements, benchmarks to be determined

Population Flow Structure
(with Stocks and Flows)
System Mapping
(including Core System, Process and Structural Indicators)
Goals, objectives, measurements, benchmarks to be determined

Interventions
(with Service Category Clusters)
Service levels and measures to be determined

Fundamental System Requirements

PROCESS INDICATORS

Health Care Support  Lifestyle Management  Challenges/Barriers to Care  Social/Community Support

STRUCTURAL INDICATORS

Capacity of Service Delivery Network

Prevention  Community Support  Social Support  Primary Health Care

In Patient Health Care

RESOURCES

STANDARDS OF CARE
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2005 Continuum of Care
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Support Services

Core Medical Services

Primary Health Care

In Patient Health Care

Prevention

Community Support

Social Support

Support

Services

RESIDENTIAL CLUSTER
- Substance Abuse
- Residential, Transitional
- Residential, Permanent

COUNSELING/EDUCATION CLUSTER
- Mental Health, Psychotherapy
- Health Education/Risk Reduction (HERR)
- Treatment Education
- Peer Support
- Psychosocial Support

COORDINATION CLUSTER
- Medical Care Coordination
- Benefits Specialty
- Case Management, Transitional
- Case Management, Home-Based

PRIMARY HEALTH CLUSTER
- Substance Abuse, Treatment
- Medical Nutrition Therapy
- Skilled Nursing Care
- Home Health Care
- Hospice Care
- Rehabilitation

BARRIERS CLUSTER
- Medical Transportation
- Nutrition Support
- Legal
- Language/Interpretation
- Child Care
- Respite Care
- Workforce Entry/Re-entry
- Direct Emergency Financial Assistance (DEFA)

ACCESS CLUSTER
- ADAP Enrollment
- Early Intervention Programs (EIPs)
- Outreach
- Referral
- Counseling and Testing in Care Settings

MEDICAL CLUSTER
- Medical Outpatient/Specialty
- Local Pharmacy Program/Drug Reimbursement (LPP/DR)
- Oral Health
- Mental Health, Psychiatry
- Health Insurance Premiums and Cost-Sharing
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1. How our services improve individual/overall health
2. How we help patients/clients optimize their care/treatment
3. How our services actually help PWH/A maximize health care benefits
4. What the services are and how they integrate with other community support systems
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**EXAMPLE: CHILD CARE RESOURCE INVENTORY**

- 170,000 child care service units available in community; 150,000 from DCFS, OAPP contracts another 20,000 from DCFS.
- 11,000 service units from ASOs; OAPP contracts for 5,000.
- OAPP contracts for 25,000 service units total; need is 35,000.
- Do we allocate for an additional 10,000, or assume that clients can access services in the community?
- How do we allocate?

**Data Is NOT Real**
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Progression for more effective care/treatment

Progression for more effective prevention services
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- **63,000**
  - **15,000**
  - **15,000**
  - **33,000**

**HIV**

- **No HIV/low risk**
- **High risk for HIV**

**UNMET NEED**

**PRIVATE CARE**

- **Becoming HIV**
- **But not aware**
- **But unawares**

**PUBLIC CARE**

- **Receiving services**
- **Not complying with regimen**
- **Airing care plan**

**RUBICARE**

- **Patients accessing services**
- **Dropping out of care**
- **Not complying with regimen**
- **Airing care plan**

**Low risk**

- **Becoming HIV**
- **Becoming HIV**
- **Becoming HIV**
- **Becoming HIV**
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Health Status
- UNMET NEED: Aware of HIV status, but not receiving services
  - becoming HIV aware
  - entering/accessing services
  - dropping out of services

Quality of Life
- PUBLIC CARE: PLWH/A patients accessing services
  - adhering to care plan

Self Sufficiency
- PRIVATE CARE: PLWH/A patients following care plans
  - not complying with care plan

Level of Effective Clinical Management
- Level of Effective Self-Management
- Level of Motivation of the Patient
- Level of Income Stability
- Emotional and Physical Wellbeing
- Level of Social/Family Support
- Quality of Care Plan
- Level of Insurance Coverage
- Level of Effective Medical Care Coordination
- Level of Effective Case Management
- Level of Capacity of Clinics/Hospitals
- Level of Effective PLWH/A with Unmet Needs

Benefits Specialty
- Medical Care Coordination
  - Case Management, Transitional
  - Case Management, Housing
  - Case Management, Home-Based

Funding for Coordination Cluster
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PRIVATE CARE

PUBLIC CARE

PWH/A patients accessing services

Adhering to care plan

Not complying with care plan

10%

5%

25%

10%

Clinical Management

Self-Management

Medial Support

Social/Family Support

Patient Motivation

19,000

14,000

20,000

13,000
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- Commission on HIV:
  - created standards of care in 33 service categories (2006)
  - significantly revised its Continuum of Care (2008)
  - Introduced and integrated Medical Care Coordination into the Continuum of Care (2009)

- Next step is to evaluate service effectiveness
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① Is the system of care effective?

② Are services provided effectively?

③ Are services provided cost-efficiently?
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SERVICE EFFECTIVENESS DATA:

① is useful information in the annual priority- and allocation-setting process, and can help rank priorities and steer allocations;

② identifies targets for needed technical assistance;

③ focuses additional and enhanced quality assurance and management efforts and activities;

④ detects areas of concern/comfort for increased/decreased management emphasis;
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5 ascertains where best practice attention can be more effectively addressed;

6 assesses how successfully the local jurisdiction is investing federal and other revenues in service delivery; and

7 reports to consumers and the community the strengths and weaknesses of the current service delivery system, and where improvements are needed.
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- ESE may indicate where QM or best practices focus is needed
- ESE is not a continuous measurement; QM is continuous measurement
- ESE measures service categories, service delivery; QM measures provider- and patient-level performance
- ESE is only a snapshot of the effectiveness of services within a specific period of time; QM measures over time
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- ESE requires re-assessment/re-measurement and comparability—all elements built into a standard QM process;
- ESE may have a moral hazard effect: biasing overall improvement and re-measurement when consumers respond to “scorecard” results; QM aims for continuous improvement;
- Both are needed to for different pictures of the service delivery system.
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① **System Effectiveness:** Are services (the system of care) effective?

*Does the continuum of care achieve its health outcomes: maintenance or improvement in health status, quality of life and self-sufficiency?*

② **Service Effectiveness:** Are services (the interventions) provided effectively?

*Do interventions (services) in the continuum of care achieve patient outcomes: entry into care, retention in care, and adherence to care/treatment?*
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③ Cost Effectiveness: Are services delivered in a cost-efficient manner?

Are interventions delivered in a manner that optimizes health and patient outcomes while maximizing available resources (funding)?
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- Balanced Scorecard® is widely used as a framework for evaluating effectiveness in health care and hospital systems

- Using the Balanced Scorecard methodology, the system/institution measures a limited number of indicators in four critical domains—
  - Customer
  - Internal
  - Financial
  - Innovation/Learning and Growth
Evolving a Fully Comprehensive Care/Prevention Continuum and Standards

- Balanced Scorecard® links domains/elements to the organization’s strategic plan (in EMAs, comprehensive care plan)

- Commission on HIV interpreted domains as follows:
  - **Customer:** Consumer Satisfaction
  - **Internal:**
    - Productivity (Health Outcomes)
    - Engagement (Patient Outcomes)
    - Unmet Need
  - **Financial:** Cost Efficiency
  - **Innovation/Learning and Growth:** Best Practices
Evolving a Fully Comprehensive Care/Prevention Continuum and Standards

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### Balanced Scorecard: CUSTOMER PERSPECTIVE

<table>
<thead>
<tr>
<th>Consumer Satisfaction</th>
<th>Needs Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are consumers satisfied with the services they received?</td>
<td>LACHNA service effectiveness survey</td>
</tr>
<tr>
<td>Do consumers feel that services meet their needs?</td>
<td>Survey to be developed during Fall 2009, survey run through February – June 2009.</td>
</tr>
<tr>
<td>Do consumers feel that services accessible?</td>
<td></td>
</tr>
<tr>
<td>What do consumers feel are their greatest barriers?</td>
<td></td>
</tr>
<tr>
<td>Why are consumers staying in care?</td>
<td></td>
</tr>
<tr>
<td>Why are consumers falling out of care?</td>
<td></td>
</tr>
</tbody>
</table>
# Evaluating Service Effectiveness: Developing Methodology (cont.)

<table>
<thead>
<tr>
<th>Balanced Scorecard®: INTERNAL PERSPECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Productivity</strong></td>
</tr>
<tr>
<td>- Are we achieving health and process outcomes?</td>
</tr>
<tr>
<td>- Have our current models of care maximized outcomes?</td>
</tr>
<tr>
<td>- Are services meeting established performance goals?</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
</tr>
<tr>
<td>- How many people are we getting into care?</td>
</tr>
<tr>
<td>- Are we meeting service objectives?</td>
</tr>
<tr>
<td>- Are we meeting the need?</td>
</tr>
<tr>
<td>- Are services accessible?</td>
</tr>
<tr>
<td>- How do barriers impact service access?</td>
</tr>
<tr>
<td>- How seamless is our service delivery system?</td>
</tr>
<tr>
<td>- Where are there service gaps?</td>
</tr>
<tr>
<td>- Is there adequate infrastructure to support services?</td>
</tr>
<tr>
<td><strong>Unmet Need</strong></td>
</tr>
<tr>
<td>- How much are we reducing “unmet need”?</td>
</tr>
</tbody>
</table>

- Driven by systems mapping process; outcomes finished by Steuner 2006; data to be collected and compiled by December 2009.
- Driven by goals and objectives in the Comprehensive Care Plan, corresponding to fulfillment of these goals.
- Commission and OAPP to form work group to develop goals/objectives for CCP, to define service delivery criteria and to quantify measures.
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<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Financial/Service Modeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Are models of care cost effective?</td>
<td>- Various financial models</td>
</tr>
<tr>
<td>- How cost effective is service delivery between models?</td>
<td>- Begin developing the financial modeling in Fall 2008, compiling data by June 2009</td>
</tr>
<tr>
<td>- Are we providing services at optimal levels?</td>
<td></td>
</tr>
<tr>
<td>- What is “system capacity”?</td>
<td></td>
</tr>
<tr>
<td>- Are we operating at capacity?</td>
<td></td>
</tr>
</tbody>
</table>
Evolving a Fully Comprehensive Care/Prevention Continuum and Standards

<table>
<thead>
<tr>
<th>Balanced Scorecard®: INNOVATION and LEARNING/GROWTH PERSPECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6. Innovation</strong></td>
</tr>
<tr>
<td>- Are we maximizing the best service delivery practices?</td>
</tr>
<tr>
<td>- Are we meeting the standards’ minimum expectations?</td>
</tr>
<tr>
<td>- How effectively are we achieving outcomes?</td>
</tr>
</tbody>
</table>
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- Generate an “annual service effectiveness” scorecard
- Scorecards will entail “scores” for each of the services evaluated, and for the service cluster overall
- Begin with Medical Cluster of Services
  - Core service categories and most data available
- Medical Cluster of Services
  - Medical Outpatient/Specialty
  - Oral Health
  - Mental Health Psychiatry
  - Pharmaceutical Assistance Programs
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<table>
<thead>
<tr>
<th>Overall Score</th>
<th>Balanced Scorecard: CUSTOMER PERSPECTIVE</th>
<th>Sum (1:1:1)</th>
<th>TBD</th>
<th>TBD</th>
<th>E x F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Consumer Satisfaction</strong></td>
<td>[Balanced Scorecard: CUSTOMER PERSPECTIVE]</td>
<td>Sum (1:1:1)</td>
<td>TBD</td>
<td>TBD</td>
<td>E x F</td>
</tr>
<tr>
<td>a. Services received</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Meeting consumers’ perceived needs</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Perceived service accessibility</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Perceived barriers</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Staying in care</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Falling out of care</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Balanced Scorecard: INTERNAL PERSPECTIVE**

<table>
<thead>
<tr>
<th>Overall Score</th>
<th>Balanced Scorecard: INTERNAL PERSPECTIVE</th>
<th>Sum (2:2:2)</th>
<th>TBD</th>
<th>TBD</th>
<th>E x F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Productivity</strong></td>
<td>[Balanced Scorecard: INTERNAL PERSPECTIVE]</td>
<td>Sum (2:2:2)</td>
<td>TBD</td>
<td>TBD</td>
<td>E x F</td>
</tr>
<tr>
<td>a. Achieving outcomes</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Maximizing outcomes</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Meeting performance goals</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Balanced Scorecard: FINANCIAL PERSPECTIVE**

<table>
<thead>
<tr>
<th>Overall Score</th>
<th>Balanced Scorecard: FINANCIAL PERSPECTIVE</th>
<th>Sum (6:6)</th>
<th>TBD</th>
<th>TBD</th>
<th>E x F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Unmet Need</strong></td>
<td>[Balanced Scorecard: FINANCIAL PERSPECTIVE]</td>
<td>Sum (6:6)</td>
<td>TBD</td>
<td>TBD</td>
<td>E x F</td>
</tr>
<tr>
<td>a. Unmet need</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
<td></td>
<td></td>
</tr>
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</table>

**5. Efficiency**

<table>
<thead>
<tr>
<th>Overall Score</th>
<th>Balanced Scorecard: FINANCIAL PERSPECTIVE</th>
<th>Sum (4:4)</th>
<th>TBD</th>
<th>TBD</th>
<th>E x F</th>
</tr>
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<tbody>
<tr>
<td>a. Cost effectiveness</td>
<td>TBD %</td>
<td>TBD %</td>
<td>B x C</td>
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</tbody>
</table>
Evolving a Fully Comprehensive Care/Prevention Continuum and Standards

<table>
<thead>
<tr>
<th>Domain/Dimension/Indicator</th>
<th>Measure</th>
<th>Sum and Weight</th>
<th>Weight</th>
<th>Adjust Score</th>
<th>Weight</th>
<th>Adjust Score</th>
<th>Weight</th>
<th>Adjust Score</th>
<th>Adjust Score</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Balanced Scorecard®: CUSTOMER PERSPECTIVE (cont.)</strong></td>
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<tr>
<td>1. Consumer Satisfaction (cont.)</td>
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<tr>
<td>c. <strong>Oral Health</strong></td>
<td>76.33% x 15 %</td>
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<tr>
<td>1) Satisfied with care received</td>
<td>75%</td>
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<tr>
<td>2) Services meet clients' needs</td>
<td>74%</td>
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<tr>
<td>3) Never encountered barriers to care</td>
<td>80%</td>
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<tr>
<td>d. <strong>Mental Health, Psychiatry</strong></td>
<td>76.67% x 15 %</td>
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<tr>
<td>1) Satisfied with care received</td>
<td>74% x 33%</td>
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<tr>
<td>2) Services meet clients' needs</td>
<td>73% x 33%</td>
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<tr>
<td>3) Never encountered barriers to care</td>
<td>83% x 33%</td>
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<td><strong>B. Balanced Scorecard®: INTERNAL PERSPECTIVE</strong></td>
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<tr>
<td>2. Productivity (Health/Clinical Outcomes)</td>
<td>C x D x 40%</td>
<td>E x F x 50%</td>
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<tr>
<td>a. <strong>Medical Outpatient/Specialty</strong></td>
<td>Sum (2a)</td>
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<tr>
<td>1) CD4s</td>
<td>xx% x 40%</td>
<td>OAPP (Casewatch): CD4 data (ratio: % &lt;= 400)</td>
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<tr>
<td>2) Viral loads</td>
<td>xx% x 15%</td>
<td>OAPP (Casewatch): Viral load suppression (% undetectable; ratio to ARV)</td>
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<tr>
<td>3) Opportunistic Infections (OIs)</td>
<td>xx% x 15%</td>
<td>OAPP (Casewatch): proportion on PCP prophylaxis (% of total patients)</td>
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<tr>
<td>4) Physical pain related to HIV</td>
<td>xx% x 15%</td>
<td>OAPP (Audit Sample): SF 1-10/neuropathy (% global pain scale panel)</td>
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<td>5) Resistance</td>
<td>xx% x 15%</td>
<td>Commission (Survey): # of genotypes/results (vs. baseline resistance testing)</td>
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<tr>
<td>b. <strong>Pharm./Med. Access Programs</strong></td>
<td>Sum (2b)</td>
<td>x 30%</td>
<td>Responsibility (method): indicator(s) (% formula)</td>
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<tr>
<td>1) Adherence</td>
<td>xx% x 100%</td>
<td>OAPP (Audit Sample): % of patients reporting 95% or better adherence (% of total)</td>
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<tr>
<td>2) HIV/Epi (MMP): ARV adherence from RW sites (from total client population)</td>
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<tr>
<td>c. <strong>Oral Health</strong></td>
<td>Sum (2c)</td>
<td>x 15%</td>
<td>Responsibility (method): indicator(s) (% formula)</td>
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<tr>
<td>1) Pocket depth</td>
<td>xx% x 30%</td>
<td>OAPP (Audit Sample): average pocket depth (% of pocket depth range)</td>
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<tr>
<td>2) Decayed teeth</td>
<td>xx% x 15%</td>
<td>OAPP (Audit Sample): # of patients getting fillings/extractions (% of total)</td>
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<tr>
<td>3) Discomfort when eating</td>
<td>xx% x 15%</td>
<td>OAPP (Audit Sample): pain assessment (% of total)</td>
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<td>4) Presence of symptoms</td>
<td>xx% x 40%</td>
<td>OAPP (Casewatch): # of patients’ tooth replacements (% of 50% progress)</td>
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