ATTACHMENT 1 (Revised)

COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS

HIV AMBULATORY OUTPATIENT MEDICAL (AOM) SERVICES REIMBURSEMENT GUIDELINES AND PERFORMANCE MEASURES

INTRODUCTION

The County of Los Angeles, Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) supports evidence-based preventive, diagnostic and therapeutic HIV ambulatory outpatient medical (AOM) services provided by medical care professionals to Ryan White Program (RWP) eligible HIV-positive patients through outpatient medical visits. Services must be culturally and linguistically appropriate and provided to persons living with HIV (PLWH) throughout the entire continuum of their disease. AOM services must be consistent with the most recent Department of Health and Human Services (DHHS) HIV Treatment Guidelines (www.aidsinfo.nih.gov), the Los Angeles County Commission on HIV (COH) Standards of Care (http://hiv.lacounty.gov/Standard-Of-Care), the California Business and Professions code, local laws and regulations, and best practices and ethical standards. AOM services are subject to change based on new evidence and treatment guidelines.

AOM services include medical evaluation and clinical care, AIDS Drug Assistance Program (ADAP) enrollment services, disease monitoring, clinically indicated laboratory testing and secondary HIV prevention strategies intended to interrupt or delay the progression of HIV disease, prevention and treatment of opportunistic infections, promotion of optimal health and quality of life, and reduction of HIV transmission by supporting risk reduction strategies. In addition, AOM providers are required to provide referral and access to medical care coordination and medical subspecialty care to fully comply with current standards and best practices.

Clinical staff providing AOM services (including, but not limited to physicians, physicians' assistants, and nurse practitioners) must be California-licensed health care professionals that have appropriate training, expertise, and certifications to provide quality clinical HIV medical care to HIV-positive patients. Additional RWP and Health Resources and Services Administration (HRSA) grant reimbursement requirements include HIV Specialist certification, as outlined in HIV/AIDS Specialist Form for all AOM providers. Clinical and support staff should have access to ongoing training and clinical education in HIV care management.

PURPOSE AND SCOPE OF GUIDELINES

The Division of HIV and STD Programs developed the Ambulatory Outpatient Medical (AOM) Services Reimbursement Guidelines and Performance Measures to support and enhance the quality of medical services for persons living with and/or affected by HIV in Los Angeles County to achieve the following three goals:

1. Optimize the care, treatment, and HIV medical services provided to HIV-positive persons in Los Angeles County;
2. Support the development of robust and sustainable clinical quality management (CQM) programs and infrastructure throughout the network of contracted AOM providers; and
3. Create a culture of enhanced service quality and efficiency through the use of a graduated and incentivized reimbursement structure.

Additionally, these reimbursement guidelines and performance measures move Los Angeles County toward reaching the goals set forth in Los Angeles County's HIV/AIDS Strategy (LACHAS) for 2020 and Beyond, which can be viewed online at https://www.lacounty.hiv/.

REIMBURSEMENT RATE DETERMINATION AND TIMELINE

Definition of a Billable Client Visit

A billable client visit (lasting a minimum of 15 minutes) is a medical visit in which the HIV Specialist (PA, NP, or MD) or designee* sees the patient in a private room and obtains the patient's history, including any new health problems or concerns; preforms a physical examination of the patient, as necessary; completes an assessment and plan for the patient; and, communicates the plan with the patient.

**Designee must have patient's note from the visit reviewed and signed by an HIV Specialist.*

Contract Initial Term

Contract Years (CY) One (1) and Two (2):

An initial reimbursement rate of **$312.40** per client visit has been established for CY one (1) and CY two (2). This initial rate is the maximum per-visit reimbursement amount possible for services provided during this period and will be applied universally regardless of measure performance. AOM providers are encouraged to proactively initiate improvements for any performance gaps identified during this initial period to ensure eligibility for additional reimbursement incentives made available starting in CY three (3).

Beginning Contract Year (CY) Three (3):

Beginning with CY three (3), contracted providers who meet or exceed the minimum performance threshold for the two (2) Core Performance Measures will be eligible to receive an additional reimbursement incentive of up to **$63.00** in per-visit reimbursements based on their performance on the ten (10) Supplemental Performance Measures. Contracted providers who successfully meet or exceed the minimum performance threshold for each of the two (2) Core Performance Measures and all ten (10) Supplemental Performance Measures will receive a *maximum* reimbursement of **$375.40** per visit.

The Performance Monitoring and Reimbursement Timeline below outlines in detail, the monitoring period(s) used to determine the annual per-visit reimbursement rate(s) for CY one (1) through five (5).

	Initial term			Optional Term 1	Optional Term 2
Contract Year (CY)	**CY1**	**CY2**	**CY3**	**CY4**	**CY5**
Reimbursement Rate	$312.40/ per visit		Initial rate + additional incentives based on CY1 data	Initial rate + additional incentives based on CY 2 data	Initial rate + additional incentives based on CY 3 data

Sampling and Measure Inclusion Criteria:

Client records eligible for inclusion in the annual performance review (APR) are generated from the pool of clients entered by providers into DHSP's Automated Case Management System (ACMS). A randomized sample of all clients with a minimum of one (1) RWP funded medical visit with the AOM provider within the first six (6) months of the calendar year are eligible for inclusion in the APR. The number of records used in the APR is based on the total number of eligible records and is standardized using a non-gender sorted sampling table taken from the National HIVQUAL Project. To more accurately reflect clinical performance, DHSP has eliminated client level exclusions for all but one measure and reduced the minimum performance threshold to 80% for both the Core and Supplemental Performance Measure sets to reflect the existence of factors outside a provider's immediate control. **PERFORMANCE MEASURES**

Core Performance Measures:

The following two (2) Core Performance Measures and performance thresholds represent the *minimum* expectation for all contracted AOM providers. Only AOM providers who meet and/or exceed the minimum performance threshold for both core measures are eligible for additional reimbursement incentives as outlined in the Supplemental Performance Measures.

In alignment with LACHAS, the minimum performance threshold for Core measure 1.1 HIV Viral Load Suppression is set at 80% for contract years one (1) and two (2) but will be increased to 85% in contract year three and increases again to 90% for the remainder of the contract term.

The minimum performance threshold for Core measure 1.2 HIV Medical Visit is 80% throughout the life of the contract term.

Core Performance Measures		Performance Threshold		
1.1	**HIV Viral Load Suppression – all clients**	**CY 1-2 80%**	**CY 3 85%**	**CY 4-5 90%**
1.2	**HIV Medical Visits – all clients**	**80%**		

AOM providers that do not meet the 80% threshold after CY 1 for the core goals of HIV viral load suppression and HIV medical visits in a twelve (12) month period will be provided technical assistance by DHSP in CY 2 to assist those providers to meet this minimum threshold. If the

thresholds are not met after receiving technical assistance by the midpoint of CY 3, contracts will not be renewed. Note, viral load suppression data will be posted annually on the LACHAS website (https://www.lacounty.hiv/) for public viewing.

Supplemental Performance Measures:

There is a total of ten (10) Supplemental Performance Measures. Similar to the Core Performance Measures, each Supplemental Performance Measure has a pre-established performance threshold to identify the minimum performance score that must be achieved in order to meet the specific measure and qualify for the additional reimbursement incentive. To adjust for measure complexity, each of the supplemental measures was scored from 1 to 3 with higher scores representing increased complexity and subsequently higher reimbursement amounts.

Supplemental Performance Measures		Performance Threshold	Complexity Score	Additional Incentive
2.1	**PCV13 Pneumococcal Vaccination – All Clients**	**80%**	**1**	**$3.00**
2.2	**MCV4 Meningococcal Vaccination – All Clients**	**80%**	**1**	**$3.00**
2.3	**Annual Hepatitis C Screening – Males Only**	**80%**	**1**	**$3.00**
2.4	**Annual Urogenital GC/CT Screening – All Clients**	**80%**	**2**	**$6.00**
2.5	**Annual Pharyngeal GC Screening – Males Only**	**80%**	**2**	**$6.00**
2.6	**Annual Rectal GC/CT Screening – Males Only**	**80%**	**2**	**$6.00**
2.7	**Annual HIV Risk Assessment – All Clients**	**80%**	**3**	**$9.00**
2.8	**Bi-annual Syphilis Screening – All Clients**	**80%**	**3**	**$9.00**
2.9	**Annual Substance Use Screening – All Clients**	**80%**	**3**	**$9.00**
2.10	**Annual Depression Screening – All Clients**	**80%**	**3**	**$9.00**

MEDICAL VISIT UTILIZATION AND REIMBURSEMENT OF ADDITIONAL VISITS

Contracted AOM service providers will furnish medical visits as stipulated in the Statement of Work of this contract. To ensure appropriate utilization of medical visits, a *maximum* of ten (10) visits per client, per contract year has been established. The limit on visits applies only to clients who receive AOM services that are RWP funded. Accordingly, all AOM service providers are required to monitor the number of RWP funded medical visits provided to ensure compliance with the following per-contract year limits:

- Total number of annual medical visits = maximum ten (10) per client; and

- Total number of annual medical visits = maximum budget allocation per clinic.

DHSP recognizes that there may be clinical indications or other special circumstances that may necessitate the need for additional medical services and reserves the right to request additional clinical justification for medical visits provided beyond the stated limits. If requests for additional clinical justification are insufficient or not provided within the specified timeframe, DHSP reserves the right to deny reimbursements requested for additional medical visits.

<table>
<tr><td>Core 1.1</td><td>HIV Viral Load Suppression – All Clients</td><td>*DHSP (April 2017)</td></tr>
<tr><td>Description:</td><td colspan="2">Percentage of clients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test in the calendar year</td></tr>
<tr><td>Numerator:</td><td colspan="2">Number of clients in the denominator with a HIV viral load less than 200 copies/mL at the last HIV viral load test in the calendar year</td></tr>
<tr><td>Denominator:</td><td colspan="2">Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year</td></tr>
<tr><td>Client Exclusion(s):</td><td colspan="2">None</td></tr>
<tr><td>Data Element(s):</td><td colspan="2">1. Did the client have a HIV viral load result less than 200 copies/mL at the last HIV viral load test in the calendar year? (Y/N)</td></tr>
<tr><td>Minimum Performance Threshold:</td><td colspan="2">• Greater than or equal to 80% - Contract Years 1 - 2
• Greater than or equal to 85% - Contract Year 3
• Greater than or equal to 90% - Contract Years 4 onward</td></tr>
<tr><td>Comparison Data:</td><td colspan="2">in+care Campaign: Percentage of clients, over the age of 24 months, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year http://incarecampaign.org
<table>
<tr><td></td><td>2011</td><td>2012</td><td>2013</td></tr>
<tr><td>Mean</td><td>70%</td><td>72%</td><td>72%</td></tr>
<tr><td>Top 25%</td><td>82%</td><td>84%</td><td>85%</td></tr>
</table></td></tr>
<tr><td>U.S. Department of Health & Human Services Guidelines:</td><td colspan="2">“Adult guidelines: For the purposes of clinical trials, the AIDS Clinical Trials Group (ACTG) currently defines virologic failure as a confirmed viral load less than 200 copies/mL, which eliminates most cases of apparent viremia caused by blips or assay variability. This definition also may be useful in clinical practice (see Virologic and Immunologic Failure). For most individuals who are adherent to their antiretroviral (ARV) regimens and who do not harbor resistance mutations to the prescribed drugs, viral suppression is generally achieved in 12 to 24 weeks, although it may take longer in some patients.”[1]</td></tr>
</table>

Use in other Federal Programs	Included in the following Centers for Medicare and Medicaid Services quality, reporting and payment programs: Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Medicare Physician Quality Payment Program, Medicare Shared Savings, Physician Compare, Physician Feedback/Quality and resource Use Reports, Physician Value-Based Payment Modifier (search for each program at https://www.cms.gov). As of April 2017. in+care campaign (http://www.incarecampaign.org)

References/ Notes:	[1] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. 2016. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed April 6, 2017, [C-2, Table 3] *Adapted from the HRSA-HIV/AIDS Bureau's Core Measures HIV Viral Load Suppression (updated January 2015). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.

<table>
<tr><td>Core 1.2</td><td>HIV Medical Visits – All Clients</td><td>*DHSP (April 2017)</td></tr>
<tr><td>Description:</td><td colspan="2">Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the <u>first 6 months</u> of the calendar year <u>and</u> at least one medical visit in the <u>last 6 months</u> of the calendar year with a <u>minimum of 60 days</u> between medical visits</td></tr>
<tr><td>Numerator:</td><td colspan="2">Number of clients in the denominator who had at least one medical visit in the last 6 months of the calendar year, no less than 60 days since previous medical visit</td></tr>
<tr><td>Denominator:</td><td colspan="2">Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year</td></tr>
<tr><td>Client Exclusion(s):</td><td colspan="2">Clients who died at any time during the measurement year.</td></tr>
<tr><td>Data Element(s):</td><td colspan="2">1. Did the client have at least one medical visit in the last six months of the calendar year? (Y/N)</td></tr>
<tr><td>Minimum Performance Threshold:</td><td colspan="2">Greater than or equal to 80%</td></tr>
<tr><td>Comparison Data:</td><td colspan="2">in+care Campaign: Percentage of HIV clients, regardless of age, who did not have a medical visit with a provider with prescribing privileges in the last 180 days of the measurement year.
<table>
<tr><th></th><th>Dec. 2011</th><th>Dec. 2012</th><th>June 2013</th></tr>
<tr><td>Mean</td><td>16%</td><td>15%</td><td>14%</td></tr>
<tr><td>Top 25%</td><td>6%</td><td>6%</td><td>5%</td></tr>
</table></td></tr>
<tr><td>U.S. Department of Health & Human Services Guidelines:</td><td colspan="2">“Numerous studies describe the adverse impacts of poor retention in care on patient outcomes. In particular, poor retention in care is associated with the following outcomes: decreased likelihood of receiving antiretroviral therapy, higher rates of antiretroviral therapy failure, increased HIV transmission risk behavior, increased hospitalization rates, and worse survival. Patients with greater initial retention in care had the greatest survival over 5 years of follow-up, and patients with the worst initial retention had the poorest survival.” [1]</td></tr>
</table>

U.S. Department of Health & Human Services Guidelines (cont.):	Treatment guidelines recommend testing CD4 at entry into care then follow-up every 3-6 months before Antiretroviral Treatment (ART), every 3-6 months when on ART, then, in clinically stable patients with suppressed viral load, CD4 count can be monitored every 6–12 months.[2] For adherent patients with suppressed viral load and stable clinical and immunologic status for greater than 2–3 years, some experts may extend the interval for HIV RNA monitoring to every 6 months. All patients who are clinically stable should be monitored at least every 4 months; this includes both patients who are receiving ART and those who are not. Visits may require more frequent scheduling at entry to care, for management of acute problems, or when starting or changing ART regimens.[3] Patients infected with HIV face a complex array of medical, psychological, and social challenges. A strong provider-patient relationship, the assistance of a multidisciplinary care team, and frequent office visits are key aspects of care. Through both the specific services they provide and their overall approach to patients, clinics can have a substantial impact on the quality of care for HIV-infected persons.[4]
Use in Other Federal Programs:	Included in the following Centers for Medicare and Medicaid Services quality, reporting and payment programs: Medicare and Medicaid Electronic Health Records (EHR) Incentive Program for Eligible Professionals, Medicare Physician Quality Payment Program, Medicare Shared Savings, Physician Compare, Physician Feedback/Quality and resource Use Reports, Physician Value-Based Payment Modifier (search for each program at https://www.cms.gov/). As of April 2017. in+care campaign (http://www.incarecampaign.org)

References / Notes:	[1] Giordano, Thomas P. Retention in HIV Care: What the Clinician Needs to Know. Topics in Antiviral Medicine. 2011;19(1):12-16 ©2011, IAS–USA https://www.iasusa.org/sites/default/files/tam/19-1-12.pdf Accessed April 6, 2017 [2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. 2016. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed April 6, 2017. [3] Medical Care Criteria Committee. Primary Care Approach Guideline. New York State Department of Health, AIDS Institute. April 11, 2011. http://www.hivguidelines.org/adult-hiv/primary-care-approach/ Accessed April 26, 2017. [4] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Rockville, MD: U.S. Department of Health and Human Services, 2014 https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf Accessed April 6, 2017 *Adapted from the HRSA-HIV/AIDS Bureau's Core Performance Measures HIV Medical Visit Frequency (updated January 2015). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.

Supp. 2.1	PCV13 Pneumococcal Vaccination – All Clients	*DHSP (April 2017)
Description:	Percentage of clients, regardless of age, with a diagnosis of HIV who have ever received the PCV13 pneumococcal vaccine	
Numerator:	Number of clients in the denominator who have ever received the PCV13 pneumococcal vaccine	
Denominator:	Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Is there documentation in the chart that the client has received the PCV13 pneumococcal vaccine? (Y/N)	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	In 2011, the National HIVQUAL reported the percentage of clients who had at least one clinical visit in each 6-month period of the review period who received a pneumococcal vaccination either in the review period or the 4 years preceding the start of the review period is 70% (mean). https://www.ehivqual.org/scripts/eHIVQUAL%202011%20Report%20-%20National.pdf	

U.S. Department of Health & Human Services Guidelines:	The Advisory Committee on Immunization Practices (ACIP) recommends routine use of 13-valent pneumococcal conjugate vaccine (PCV13; Prevnar 13,) for adults aged ≥19 years with immunocompromising conditions, citing that the Invasive Pneumococcal Disease (IPD) rates for adults aged 18–64 years with human immunodeficiency virus (HIV) was 173 per 100,000 (CDC, unpublished data, 2012) more than 20 times those for adults without high-risk medical conditions. PCV13 should be administered to eligible adults in addition to the 23-valent pneumococcal polysaccharide vaccine (PPSV23; Pneumovax 23). The following is a summary of the ACIP pneumococcal vaccination schedule for HIV-infected persons regardless of CD4 count. <u>No prior history of PPV23 vaccination:</u> One dose of PCV13, followed by either: • for CD4 ≥200 cells/µL: administer one dose of PPV23 ≥ 8 weeks after receiving PCV13 • for CD4 <200 cells/µL: PPV23 can be offered at least 8 weeks after receiving PCV13 or can await increase of CD4 to >200 cells/µL on ART <u>Prior history of PPV23 vaccination:</u> • One dose of PCV13 vaccine ≥1 year after PPV23 vaccination[1]
Use in Other Federal Programs:	None
References/ Notes	[1] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Downloaded from http://aidsinfo.nih.gov/guidelines on 4/7/2017 H-8. *Adapted from the HRSA-HIV/AIDS Bureau's Adolescent/Adult Measures Pneumococcal Vaccination (updated March 2016). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

Supp. 2.2	MCV4 Meningococcal Vaccination – All Clients	DHSP (April 2017)
Description:	Percentage of clients, regardless of age, with a diagnosis of HIV who received at least two (2) doses of the MCV4 meningococcal vaccine since HIV diagnosis	
Numerator:	Number of clients in the denominator who received at least two doses of the MCV4 meningococcal vaccine since HIV diagnosis	
Denominator:	Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Is there documentation in the chart that the client received at least two doses of MCV4 (Menveo® or Menactra®) meningococcal vaccine since HIV diagnosis? (Y/N)	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	None	
U.S. Department of Health & Human Services	"Persons aged ≥2 years with HIV who have not been previously vaccinated should receive a 2-dose primary series of meningococcal conjugate vaccine. Persons with HIV who have been previously vaccinated with meningococcal conjugate vaccine should receive a booster dose at the earliest opportunity (at least 8 weeks after the previous dose) and then continue to receive boosters at the appropriate intervals. If the most recent dose was received before age 7 years, a booster dose should be administered 3 years later. If the most recent dose was received at age ≥7 years, a booster should be administered 5 years later and every 5 years thereafter throughout life." [1] Note: MCV4 is included on the AIDS Drug Assistance Program (ADAP) formulary.	
Use in Other Federal Programs:	None	
References/ Notes:	[1] MacNeil JR, Rubin LG, Patton M, Ortega-Sanchez IR, Martin SW. Recommendations for Use of Meningococcal Conjugate Vaccines in HIV-Infected Persons — Advisory Committee on Immunization Practices, 2016. MMWR Morb Mortal Wkly Rep 2016;65:1189–1194. DOI: http://dx.doi.org/10.15585/mmwr.mm6543a3	

Supp. 2.3	**Annual Hepatitis C Screening – Males Only**	***DHSP (April 2017)**
Description:	Percentage of male clients, regardless of age, with a diagnosis of HIV who were tested for Hepatitis C (HCV) at least once in the calendar year	
Numerator:	Number of clients in the denominator who were tested for Hepatitis C (HCV) at least once in the calendar year	
Denominator:	Number of male clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Is the client male? (Y/N) a. If yes, was the client tested for Hepatitis C (HCV) at least once in the calendar year? (Y/N)	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	None	
U.S. Department of Health & Human Services Guidelines:	"Approximately, 20% to 30% of HIV-infected patients in the United States are coinfected with HCV. Heterosexual transmission of HCV is uncommon but more likely in those whose partners are co-infected with HIV and HCV. Existing data also suggest that sexual contact is a relatively inefficient mode of transmission between HIV seronegative men who have sex with men (MSM). However, in HIV-infected MSM, multiple outbreaks of acute HCV infection demonstrate that sexual transmission is an important mode of acquisition in this population. Risk factors include unprotected receptive anal intercourse, use of sex toys, non-injection recreational drug use, and concurrent sexually transmitted diseases (STDs). Temporally, the increase in the incidence of sexual transmission of HCV among HIV-infected MSMs coincides with an increase in high-risk sexual behaviors following the introduction of antiretroviral therapy (ART). On entry into HIV care, all HIV-infected patients should undergo routine HCV screening. Initial testing for HCV should be performed using the most sensitive immunoassays licensed for detection of antibody to HCV (anti-HCV) in blood. For at risk HCV-seronegative persons, HCV antibody testing is recommended annually or as indicated by risk exposure."[1]	
Use in Other Federal Programs:	None	

References/ Notes:	[1]Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Accessed May 22, 2017. [R-1, pg. 249]. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. *Adapted from the HRSA-HIV/AIDS Bureau's Adolescent/Adult Measures Hepatitis C Screening (updated March 2016). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.

Supp.2.4	**Annual Urogenital GC/CT Screening – All Clients**	***DHSP (April 2017)**
Description:	Percentage of clients, regardless of age, with a diagnosis of HIV who were tested for urogenital gonorrhea and chlamydia at least once within the calendar year	
Numerator:	Number of clients in the denominator who were tested for urogenital gonorrhea and chlamydia at least once within the calendar year	
Denominator:	Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Was the client tested for urogenital gonorrhea and chlamydia during the calendar year? (Y/N) Note: Urogenital testing includes a specimen from one or more of the following source(s): urine, vaginal, cervical or endo-cervical.	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	In 2011, the National HIVQUAL reported the percentage of clients with at least one clinical visit in each six-month period of the review period who had one or more tests for gonorrhea or chlamydia during the review period as: • Females: Gonorrhea: genital 60%, rectal 0%, and pharyngeal 0%; Chlamydia: genital 65%, rectal 2%, and pharyngeal 2%. • Males: Gonorrhea: genital 60%, rectal 0%, and pharyngeal 0%; Chlamydia: genital 55%, rectal 3%, pharyngeal 8%.	
U.S. Department of Health & Human Services Guidelines:	"Bacterial and viral sexually transmitted diseases (STDs) in HIV-infected men and women receiving outpatient care have been increasingly noted, indicating ongoing risky behaviors and opportunities for HIV transmission. Rising STD rates among MSM indicate increased potential for HIV transmission, both because these rates suggest ongoing risky behavior and because STDs have a synergistic effect on HIV infectivity and susceptibility." [1]	

Use in Other Federal Programs:	Similar Measure(s) found in the "Clinical Quality Measures for 2014 CMS EHR Incentive Programs for Eligible Professionals' table at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_EP_MeasuresTable_June2013.pdf. • CMS153v2, NQC# 0003 – Chlamydia Screening for Women
References/ Notes:	[1] CDC. Recommendations and Reports: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV." July 18, 2003/52(RR12); 1-24. Accessed April 7, 2017. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm *Adapted from the HRSA-HIV/AIDS Bureau's Adolescent/Adult Measures Chlamydia Screening (updated March 2016) and Gonorrhea Screening (updated March 2016). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

Supp. 2.5	Annual Pharyngeal GC Screening – Males Only	DHSP (April 2017)
Description:	Percentage of male clients, regardless of age, with a diagnosis of HIV who were tested for pharyngeal gonorrhea at least once within the calendar year	
Numerator:	Number of clients in the denominator who were tested for pharyngeal gonorrhea at least once within the calendar year	
Denominator:	Number of male clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Is the client male? (Y/N) a. If yes, was the client tested for pharyngeal gonorrhea at least once in th calendar year? (Y/N)	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	In 2011, the National HIVQUAL reported the percentage of clients with at least one clinical visit in each six-month period of the review period who had one or more tests for gonorrhea or chlamydia during the review period as: • Females: Gonorrhea: genital 60%, rectal 0%, and pharyngeal 0%; Chlamydia: genital 65%, rectal 2%, and pharyngeal 2%. • Males: Gonorrhea: genital 60%, rectal 0%, and pharyngeal 0%; Chlamydia: genital 55%, rectal 3%, pharyngeal 8%.	
U.S. Department of Health & Human Services Guidelines:	"Bacterial and viral sexually transmitted diseases (STDs) in HIV-infected men and women receiving outpatient care have been increasingly noted, indicating ongoing risky behaviors and opportunities for HIV transmission. Rising STD rates among MSM indicate increased potential for HIV transmission, both because these rates suggest ongoing risky behavior and because STDs have a synergistic effect on HIV infectivity and susceptibility." [1]	

U.S. Department of Health & Human Services Guidelines (cont.):	"Routine laboratory screening for common STDs is indicated for all sexually active MSM. The following screening tests should be performed at least annually for sexually active MSM: • A test for rectal infection with *N. gonorrhoeae* and *C. trachomatis* in men who have had receptive anal intercourse during the preceding year (NAAT of a rectal swab is the preferred approach); and A test for pharyngeal infection with *N. gonorrhoeae* in men who have had receptive oral intercourse during the preceding year (NAAT is the preferred approach). Testing for *C. trachomatis* pharyngeal infection is not recommended."[2]
Use in Other Federal Programs:	None
References/ Notes:	[1] CDC. Recommendations and Reports: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV." July 18, 2003/52(RR12); 1-24. Accessed April 7, 2017. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm [2] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. Accessed April 2017. Available at: http://www.cdc.gov/std/tg2015/specialpops.htm Note: Although the CDC's 2015 STD screening guidelines recommend gonorrhea and chlamydia screening tests annually for sexually active MSM based on the sites of contact (urethra, pharynx, and rectum), emerging data suggests that exposure-based screening made lead to missed asymptomatic infections in MSM. In addition, HIV-positive patients may experience additional barriers to disclosing sexual activity to their medical providers, such as stigma and potential criminalization. Based on this, in 2016 the Division of HIV and STD Programs extended the annual screening requirements to include all HIV-positive men regardless of the sexual exposure or activity reported by the patient. CDC recommendations for STD and HIV related risks for transgender patients should be based on current anatomy and sexual behaviors. Because of the diversity of transgender persons regarding surgical affirming procedures, hormone use, and patterns of sexual behavior, providers must remain aware of symptoms consistent with common STDs and screen for asymptomatic STDs on the basis of behavioral history and sexual practices (https://www.cdc.gov/std/tg2015/specialpops.htm).

Supp. 2.6	Annual Rectal GC/CT Screening – Males Only	DHSP (April 2017)
Description:	Percentage of male clients, regardless of age, with a diagnosis of HIV who were tested for rectal gonorrhea and chlamydia at least once within the calendar year	
Numerator:	Number of clients in the denominator who were tested for rectal gonorrhea and chlamydia at least once within the calendar year	
Denominator:	Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Is the client a male? (Y/N) a. If yes, was the client tested for rectal gonorrhea and chlamydia during the calendar year? (Y/N)	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	In 2011, the National HIVQUAL reported the percentage of clients with at least one clinical visit in each six-month period of the review period who had one or more tests for gonorrhea or chlamydia during the review period as: • Females: Gonorrhea: genital 60%, rectal 0%, and pharyngeal 0%; Chlamydia: genital 65%, rectal 2%, and pharyngeal 2%. • Males: Gonorrhea: genital 60%, rectal 0%, and pharyngeal 0%; Chlamydia: genital 55%, rectal 3%, pharyngeal 8%.	

U.S. Department of Health & Human Services Guidelines:	"Bacterial and viral sexually transmitted diseases (STDs) in HIV-infected men and women receiving outpatient care have been increasingly noted, indicating ongoing risky behaviors and opportunities for HIV transmission. Rising STD rates among MSM indicate increased potential for HIV transmission, both because these rates suggest ongoing risky behavior and because STDs have a synergistic effect on HIV infectivity and susceptibility."[1] "Routine laboratory screening for common STDs is indicated for all sexually active MSM. The following screening tests should be performed at least annually for sexually active MSM: • A test for rectal infection with *N. gonorrhoeae* and *C. trachomatis* in men who have had receptive anal intercourse during the preceding year nucleic acid amplification test (NAAT) of a rectal swab is the preferred approach); and • A test for pharyngeal infection with *N. gonorrhoeae* in men who have had receptive oral intercourse during the preceding year (NAAT is the preferred approach). Testing for *C. trachomatis* pharyngeal infection is not recommended."[2]
Use in Other Federal Programs:	None
References/ Notes:	[1] CDC. Recommendations and Reports: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV." July 18, 2003/52(RR12); 1-24. Accessed April 2017. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm [2] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. Accessed April 2017. Available at: http://www.cdc.gov/std/tg2015/specialpops.htm Note: Although the CDC's 2015 STD screening guidelines recommend gonorrhea and chlamydia screening tests annually for sexually active MSM based on the sites of contact (urethra, pharynx, and rectum), emerging data suggests that exposure-based screening made lead to missed asymptomatic infections in MSM. In addition, HIV-positive patients may experience additional barriers to disclosing sexual activity to their medical providers, such as stigma and potential criminalization. Based on this, in 2016 the Division of HIV and STD Programs extended the annual screening requirements to include all HIV-positive men regardless of the sexual exposure or activity reported by the patient. CDC recommendations for STD and HIV related risks for transgender patients should be based on current anatomy and sexual behaviors. Because of the diversity of transgender persons regarding surgical affirming procedures, hormone use, and patterns of sexual behavior, providers must remain aware of symptoms consistent with common STDs and screen for asymptomatic STDs on the basis of behavioral history and sexual practices (https://www.cdc.gov/std/tg2015/specialpops.htm).

Supp. 2.7	Annual HIV Risk Assessment – All Clients	*DHSP (April 2017)
Description:	Percentage of clients, regardless of age, with a diagnosis of HIV who received a comprehensive HIV risk assessment at least once within the calendar year	
Numerator:	Number of clients in the denominator who received comprehensive HIV risk assessment at least once within the calendar year	
Denominator:	Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Did the client receive a comprehensive HIV risk assessment at least once within the calendar year? (Y/N) Note: The minimum expectation is documentation in the client's medical record to demonstrate that **EACH** of the following four (4) HIV risk reduction strategies was addressed: 1. Benefit of HIV disclosure to partner(s); 2. Treatment as prevention; 3. Use of condoms; 4. Availability of post and pre-exposure prophylaxis for partner(s). HIV risk counseling occurs in the context of comprehensive medical care and can be provided by any member of the multidisciplinary primary care team.	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	None	

U.S. Department of Health & Human Services Guidelines:	"HIV-infected patients should be screened for behaviors associated with HIV transmission by using a straightforward, nonjudgmental approach. This should be done at the initial visit and subsequent routine visits or periodically, as the clinician feels necessary, but at a minimum yearly. Any indication of risky behavior should prompt a more thorough assessment of HIV transmission risks. Clinicians providing medical care to HIV-infected persons can play a key role in helping their patients reduce risk behaviors and maintain safer practices and can do so with a feasible level of effort, even in constrained practice settings. Clinicians can greatly affect patients' risks for transmission of HIV to others by performing a brief screening for HIV transmission risk behaviors; communicating prevention messages; discussing sexual and drug-use behavior; positively reinforcing changes to safer behavior; referring patients for such services as substance abuse treatment; facilitating partner notification, counseling, and testing; and identifying and treating other STDs."[1]
Use in Other Federal Programs:	None
References/ Notes:	[1] CDC. Recommendations and Reports: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV." July 18, 2003/52(RR12); 1-24. Accessed April 2017. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm *Adapted from the HRSA-HIV/AIDS Bureau's Adolescent/Adult Measures HIV Risk Counseling (updated March 2016). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.

Supp. 2.8	Bi-annual Syphilis Screening – All Clients	*DHSP (April 2017)
Description:	Percentage of clients, regardless of age, with a diagnosis of HIV who were tested for syphilis a minimum of two times, at least three months apart, within the calendar year	
Numerator:	Number of clients in the denominator who were tested for syphilis a minimum of two times, at least three (3) months apart, within the calendar year	
Denominator:	Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Was the client tested for syphilis via an appropriate serologic test a minimum of two times, at least three (3) months apart within the calendar year? (Y/N)	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	During 2015, there were 74,702 reported new diagnoses of syphilis in the United States and 5,022 in Los Angeles County, representing a 20% increase locally from 2014. In 2015, the majority of Primary and Secondary (P&S) syphilis cases occurred among gay, bisexual, and other men who have sex with men (MSM). In 2015, MSM accounted for 81.7% of all P&S syphilis cases among males in which sex of sex partner was known and 60% of all P&S syphilis cases overall. However, in recent years, the rate of P&S syphilis has been increasing among MSM as well as heterosexual men and women. (https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm).	
U.S. Department of Health & Human Services Guidelines:	"Routine serologic screening for syphilis is recommended at least annually for all HIV infected patients who are sexually active, with more frequent screening (every 3–6 months) for those who have multiple partners, unprotected intercourse, sex in conjunction with illicit drug use, or use methamphetamines (or whose partners participate in such activities)."[1] "Bacterial and viral sexually transmitted diseases (STDs) in HIV-infected men and women receiving outpatient care have been increasingly noted, indicating ongoing risky behaviors and opportunities for HIV transmission. Rising STD rates among MSM indicate increased potential for HIV transmission, both because these rates suggest ongoing risky behavior and because STDs have a synergistic effect on HIV infectivity and susceptibility."[2]	

Use in Other Federal Programs:	None
References/ Notes:	[1] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Accessed May 22, 2017. K-3. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf [2] CDC. Recommendations and Reports: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV." July 18, 2003/52(RR12); 1-24. Accessed April 2017. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm *Adapted from the HRSA-HIV/AIDS Bureau's Adolescent/Adult Measures Syphilis Screening (updated March 2016). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.

Supp. 2.9	**Annual Substance Use Screening – All Clients**	***DHSP (April 2017)**
Description:	Percentage of clients, regardless of age, with a diagnosis of HIV who were screened for substance use at least once within the calendar year	
Numerator:	Number of clients in the denominator who were screened for substance use at least once within the calendar year	
Denominator:	Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Is there documentation in the medical record that the client was assessed for the use of activities at least once within the calendar year? (Y/N) Note: The minimum expectation is documentation in the client's medical record to demonstrate that the client was assessed for use/misuse of **EACH** of the following substances: • Alcohol • Illicit drug(s) • Tobacco/Tobacco product(s) DHSP recommends the use of standardized and validated assessment tools to ensure adequacy of screening and documentation such as NIDA Quick Screen V1.0 https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf Additionally, DHSP recognizes that substance use screening occurs in the context of comprehensive medical care and can be initiated by any member of the multidisciplinary primary care team.	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	The National HIVQUAL reported the percentage of patients with whom substance use was discussed and documented in the chart as: 90.1% in 2007, 93.5% in 2009, and 92% in 2011.	

U.S. Department of Health & Human Services Guidelines:	"Patients living with HIV infection often must cope with many social, psychiatric, and medical issues that are best addressed through a patient-centered, multi-disciplinary approach to the disease. The baseline evaluation should include an evaluation of the patient's readiness for ART, including an assessment of high-risk behaviors, substance abuse, social support, mental illness, comorbidities, economic factors (e.g., unstable housing), medical insurance status and adequacy of coverage, and other factors that are known to impair adherence to ART and increase the risk of HIV transmission. Once evaluated, these factors should be managed accordingly."[1]
Use in Other Federal Programs:	Similar Measure(s) found in the "Clinical Quality Measures for 2014 CMS EHR Incentive Programs for Eligible Professionals' table at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_EP_MeasuresTable_June2013.pdf. • CMS137v2, NQC# 0004 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment • CMS 138v2, NQC# 0028 – Tobacco Use: Screening and Cessation Intervention
References / Notes:	[1]Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf Accessed April 7, 2017. B-1. *Adapted from the HRSA-HIV/AIDS Bureau's Adolescent/Adult Measures Substance Abuse Screening (updated March 2016). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.

Supp. 2.10	Annual Depression Screening – All Clients	*DHSP (April 2017)
Description:	Percentage of clients, regardless of age, with a diagnosis of HIV who were screened for depression, using a standardized, validated depression screening tool at least once within the calendar year	
Numerator:	Number of clients in the denominator who were screened for depression, using a standardized, validated depression screening tool, at least once within the calendar year	
Denominator:	Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit within the first six months of the calendar year	
Client Exclusion(s):	None	
Data Element(s):	1. Was the client screened for depression using a standardized, validated depression screening tool at least once within the calendar year? (Y/N) The minimum expectations for DHSP's Depression Screening measure includes documentation in the medical record to demonstrate the client was assessed for depression using one or more of the following standardized, validated screening tool(s): • Patient Health Questionnaire (PHQ9) • Beck Depression Inventory (BDI or BDI-II) • Center for Epidemiologic Studies Depression Scale (CES-D) • Depression Scale (DEPS) • Duke Anxiety-Depression Scale (DADS) • Geriatric Depression Scale (SDS) • Cornell Scale Screening and PRIME MD-PHQ2	
Minimum Performance Threshold:	Greater than or equal to 80%	
Comparison Data:	The National HIVQUAL reported the median percentage of patients who received all required components of a mental health screen during the review period as: 20.9% in 2007, 26.1% in 2009, and 36% in 2011. In addition, the components of the mental screening include cognitive function, depression, anxiety, sleep disturbance, appetite, domestic violence, and post-traumatic stress disorder screenings.	

U.S. Department of Health & Human Services Guidelines:	"Patients living with HIV infection often must cope with many social, psychiatric, and medical issues that are best addressed through a patient-centered, multi-disciplinary approach to the disease. The baseline evaluation should include an evaluation of the patient's readiness for ART, including an assessment of high-risk behaviors, substance abuse, social support, mental illness, comorbidities, economic factors (e.g., unstable housing), medical insurance status and adequacy of coverage, and other factors that are known to impair adherence to ART and increase the risk of HIV transmission. Once evaluated, these factors should be managed accordingly."[1]
Use in Other Federal Programs:	Similar Measure(s) found in the "Clinical Quality Measures for 2014 CMS EHR Incentive Programs for Eligible Professionals' table at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_EP_MeasuresTable_June2013.pdf. • CMS161v2, NQC# 0104 – Adult Major Depressive Disorder (MDD): Suicide Risk Assessment • CMS2v3, NQF #0418 – Screening for Clinical Depression and Follow-up Plan • CMS160v2, NQC #0712 - Depression Utilization of the PHQ-9 Tool
References/ Notes:	[1]Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf Accessed April 7, 2017. B-1. *Adapted from the HRSA-HIV/AIDS Bureau's Adolescent/Adult Measures Substance Abuse Screening (updated March 2016). https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.