Tuesday, February 11, 2025, 4:00 PM – 5:30 PM
County Operations Center
5570 Overland Ave, San Diego, CA 92123,
Room 1047 - Medical Examiner's Office

The Charge of the Medical Standards & Evaluation Committee: Ensure that HIV Primary Care services provided through local Ryan White-funded clinics meet or exceed established HIV clinical practice standards and Public Health Services (PHS) guidelines, assuring availability and access to state-of-the-art medical care for all eligible persons living with HIV (PLWH).

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Meeting Packet

Meeting Location & Directions:

Medical Standards & Evaluation Committee

Tuesday, February 11, 2025
4:00 PM - 5:30 PM

County Operations Center
5570 Overland Ave.
San Diego, CA 92123
(Room 1047 - Medical Examiner's Office)

Parking is **free**. 3-hour visitor parking is available in the parking lot and parking structure. For County business exceeding 3 hours, please park in the numbered spaces in the parking structure.

FROM I-163 SOUTH:

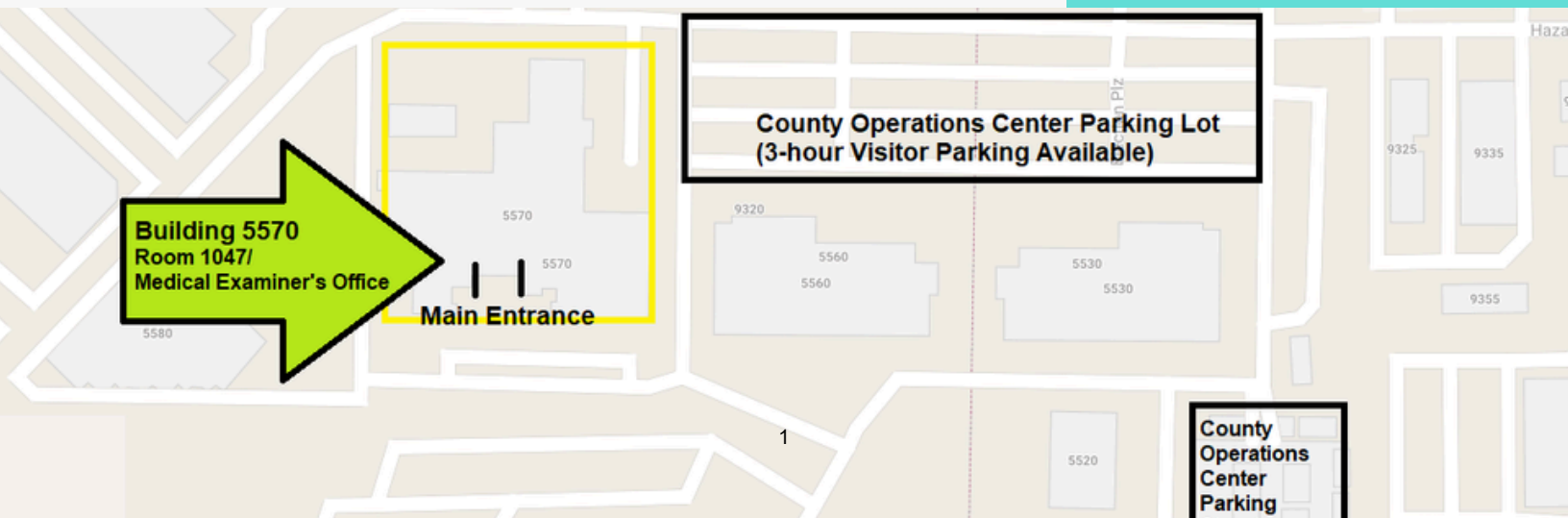
1. Take I-163 North to Exit 8 for Kearny Villa Road.
2. Keep right, follow signs for Kearny Villa Road.
3. Turn right onto Chesapeake Dr.
4. County Operations Center will be on your right.

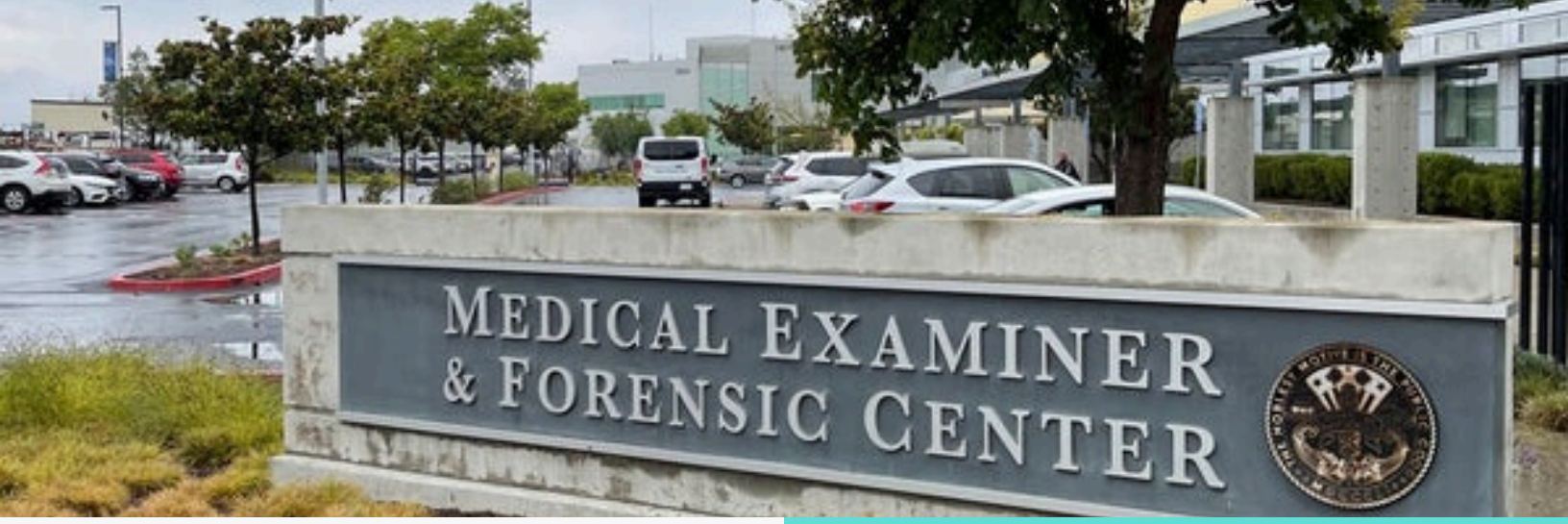
FROM I-15 SOUTH:

1. Take I-15 North to Exit 10 for Clairemont Mesa Blvd.
2. Turn left onto Clairemont Mesa Blvd.
3. Turn right onto Overland Ave.
4. Continue straight to stay on Overland Ave.

PUBLIC TRANSPORTATION

MTS Bus Routes:
25, 235, 928





FROM TROLLEY & BUS:

1. Take the Blue Trolley Line to the Balboa Avenue Transit Center.
2. Walk to Balboa Ave & Moraga Ave bus stop (about 7-minute walk, 0.3 miles).
3. Take Route 27 bus from Balboa Ave & Moraga Ave to Complex Dr & Clairemont Mesa Blvd.
4. Head north on Complex Dr.
5. Cross the street and turn right on Clairemont Mesa Blvd (after U.S. Bank Branch on the right).
6. Cross the street and turn left onto Overland Ave. and head north.
7. Building 5570/Medical Examiner's Office will be on the left side at the end of the cul-de-sac.

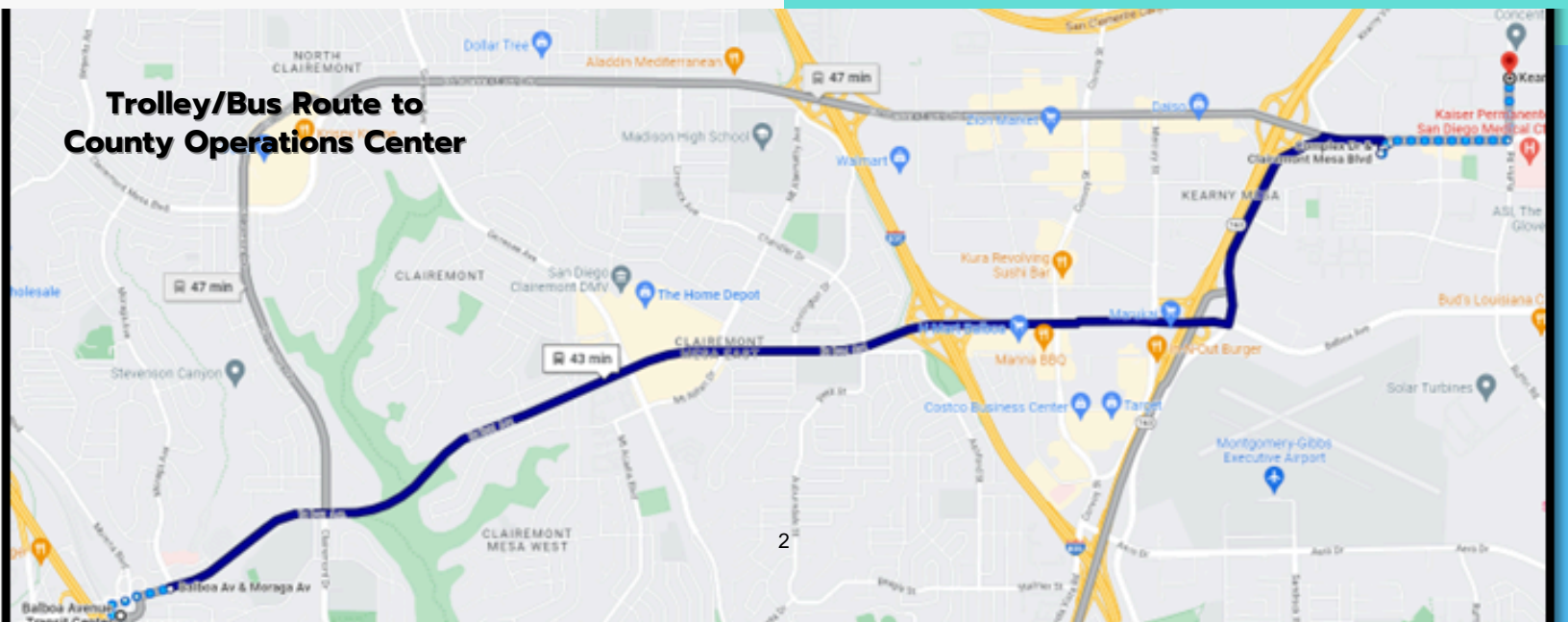
FROM BUS:

From Ruffin Road:

1. Walk north towards Ruffin Road.
2. Turn left on Hazard Way.
3. Enter through County Operations Center entrance/black gate and head further west. Access to County Operations Center buildings will be on your **left**.

From Overland Ave.:

1. Walk north on Overland Ave.
2. Building 5570/Medical Examiner's Office will be on the **left** side at the end of the cul-de-sac.



MEDICAL STANDARDS AND EVALUATION COMMITTEE

Tuesday, February 11, 2025, 4:00 PM – 5:30 PM
County Operations Center
5570 Overland Ave, San Diego, CA 92123, Room 1047 - Medical Examiner's Office

To participate remotely via Zoom:
https://us06web.zoom.us/j/84265220872?pwd=TGRydGxvcm40dEVIQUhmd0IsWUIZUT09
Call in: 1-669-444-9171
Meeting ID: 842 6522 0872 **Passcode:** 428631

Language translation services are available upon request at least 96 hours prior to the meeting. Please contact HPG Support Staff via e-mail at hpg.hhsa@sdcounty.ca.gov.

A quorum for this meeting is six (6).

Committee Members: Dr. Jeannette Aldous (Co-Chair) | Dr. Laura Bamford | Dr. David Grelotti (Chair) | Yessica Hernández | Bob Lewis | Shannon Paugh | Karla Quezada-Torres | Dr. Martha Rodriguez | Dr. Stephen Spector | Dr. Winston Tilghman

MEETING AGENDA
ORDER OF BUSINESS

1. Call to order, introductions, comments from the chair, and a moment of silence
2. Public comment (for members of the public)
3. Sharing our concerns (for committee members)
4. **Action:** Approve the MSEC agenda for February 11, 2025
5. **Action:** Approve the MSEC minutes from November 12, 2024
6. Old Business:
    a. Update on the Ryan White Quality Assurance Chart Review tool
    b. **Discussion:** Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services
    c. **Action**: Approve Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services
    d. **Discussion:** Review meeting schedule and identify priorities for 2025 work plan
        i. November meeting date change
        ii. Identify subject matter experts
7. New Business:
    a. **Action**: Approve the 2025 work plan
8. Other Updates:

a. STI and MPox Update

b. Committee member updates

9. Future agenda items for consideration
10. Announcements
11. **Next meeting date:** May 13, 2025, from 4:00 PM – 5:30 PM

    Location: To be determined AND virtually via Zoom
12. Adjournment

WORK PLAN
February 11, 2025 • Approve Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services • Finalize 2025 work plan and priorities
May 13, 2025 *(from May 14)* • Update Mental Health Services and Psychiatric Medication Management • Review 2024 Needs Assessment findings
September 9, 2025 • Approve Mental Health Services and Psychiatric Medication Management •
November 4 or 8, 2025 *(from May 11)* • • Review Ryan White Quality Assurance Chart Review tool • Identify priorities and develop work plan for 2026

MEDICAL STANDARDS AND EVALUATION COMMITTEE (MSEC)

Tuesday, November 12, 2024,4:00 PM – 5:30 PM
Seville Plaza – Live Well Support Center
5469 Kearny Villa Rd, San Diego, CA 92123
(3rd Floor, Conference Room 3700)

A quorum for this meeting is six (6).

Committee Members Present: Dr. Jeannette Aldous (Co-Chair) | Dr. David Grelotti (Chair) | Yessica Hernández | Bob Lewis | Karla Quezada-Torres | Dr. Martha Rodriguez | Lisa Stangl

Committee Members Absent: Dr. Stephen Spector | Dr. Laura Bamford

Committee Members Joining Virtually: Dr. Winston Tilghman

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Grelotti called the meeting to order at 4:07 PM and introductions were done. A moment of silence was observed. Lisa Stangl announced that this will be her last MSEC meeting as she is retiring. HPG Chair acknowledges their background is in psychology but expresses confidence in relying on the committee's expertise to establish best practices. The chair expresses gratitude for the committee's support and hopes for positive outcomes through collaboration to address systemic challenges, such as issues with insurance.	
2. Public Comment	A member of the public stated - The medical profession that a lot of consumers are being sent to specialist in the regular medical system (outside the HIV system). As providers you need to prepare your patients that this system is not the same. There needs to be better collaboration between providers-clients. Going	

Agenda Item	Action	Follow-up
	outside of the HIV care system is completely a different game.	
3. Sharing our Concerns	None	
4. Action: Review and approve the November 12, 2024 meeting agenda	**Motion:** Approve the November 12, 2024 meeting agenda as presented. **Motion/Second/Count (M/S/C):** Aldous/Stangl/6-0 **Discussion:** none **Abstentions:** Dr. Grelotti **Motion carries**	
5. Action: Review and approve the September 10, 2024 meeting minutes	**Motion:** Approve the September 10, 2024 meeting minutes as presented. **M/S/C:** Aldous/Hernandez/4-0 **Discussion:** none **Abstentions:** Dr. Grelotti, Lewis, and Rodriguez **Motion carries**	
6. Old Business:		
a. Action: Outpatient/Ambulatory Health Service Standards	**Motion:** Approve the Outpatient/Ambulatory Health Service Standards with an Appendix of the sources/links used in the document. **M/S/C:** Lewis/Quezada-Torres/7-0 **Discussion:** It was recommended that the document include an appendix with the links/sources used throughout the document. **Abstentions:** Dr. Grelotti **Motion carries**	HPG Support Staff (HPG SS) to bring the approved Service Standards to the HIV Planning Group (HPG) meeting. HPG SS to confirm links work and to add an Appendix with the links/sources.
b. Discussion: Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services	The County of San Diego Chief Dental Officer Dr. Whyte provided recommendations for night guard language to be included in the guidelines specifically for teeth grinding and jaw pain. The following discussion was held: - Preventive dental care is covered, but everything else is considered specialty. - The service standards document recommendations	The HPG SS to share the comments with MSEC members for review and input before the February 2025 meeting. HPG SS to invite Dr. Whyte to the

Agenda Item	Action	Follow-up
	are clear and understood. The committee would like Dr. Whyte to clarify some of the comments on the Dental Practice Guidelines.	February 2025 meeting.
7. New Business:		
a. Action: Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services	Tabled	
b. Discussion: Reviewed the Ryan White Quality Assurance Chart Review tool	Jeannette Johnson reviewed the tool. A discussion was held, and the following recommendations were noted: - Adding language to section 3a "Is client suppressed: Yes/No. If yes, skip question 4, CD4's are optional". - Changed VL >1000 to VL>200 under question 3A and CD4 > 500. - Replacing "exempt" with "not applicable" in question 4a. - In question 5, add condom use (always, sometimes, never) when "sexually active" is checked. - Update the language from STD to STI.	
c. Discussion: Reviewed the meeting schedule and identify priorities for 2025 work plan	Tabled	HPGSS will move Update Mental Health Services and Psychiatric Medication Management to May.
8. Other Updates:		
a. STD and Mpox Update (Dr. Tilghman)	Tabled	
b. Committee member updates	Tabled	

Agenda Item	Action	Follow-up
9. Future agenda items for consideration	Tabled	
10. Announcements	None	
11. Next meeting date:	**Date:** February 11, 2024 **Time:** 4:00 PM **Location:** TBD	
12. Adjournment	The meeting was adjourned at 5:34 PM.	

Scan this QR code to access the HIV Service Standards report and go to page 54 for Oral Health Care Services.

Scan this QR code to access the San Diego County Dental Practice Guidelines approved in 2020.

Oral Health Care

Service Category Definition

Oral Health Care services include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Purpose and Goals

The goal of oral health care is to improve oral systemic health outcomes for clients and prevent further deterioration resulting from oral disease.

Intake

To be eligible for oral health services, clients shall have a confirmed diagnosis of HIV or AIDS.

Dental Benefits

Exams and x-rays	Denture relines
Cleanings (prophylaxis)	Root canals (front and back teeth)
Fluoride treatments	Prefabricated crowns
Tooth removal (extraction)	Partial and full dentures
Fillings (restorations)	Periodontal maintenance
Emergency services	Deep cleanings (scaling and root planing)
Minimally invasive services	Laboratory crowns
Caries arrest services	
Sedation	
Other medically necessary dental services	

Single tooth implants are not a benefit of the Ryan White Dental Program
Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed. Exceptional medical conditions include, but are not limited to:

i. cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
ii. severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
iii. skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
iv. traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

Key Service Components and Activities

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments of all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard medical care management form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients

Standard	Measure
	Completion of the Client Transition Plan for clients who are deemed ineligible for oral health services or deemed ready to be transitioned out of these services

Personnel Qualifications

Prior to performing HIV/AIDS oral health services, all dental staff will be oriented and trained in policies and procedures of the general practice of dentistry and, specifically, the provision of dental services to people living with HIV.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff
These training programs shall include (at minimum): • Basic HIV information • Orientation to the office and policies related to the oral health of people living with HIV • Infection control and sterilization techniques • Methods of initial evaluation of the patient living with HIV disease • Education and counseling of patients regarding maintenance of their own health • Recognition and treatment of common oral manifestations and complications of HIV disease • Recognition of oral signs and symptoms of advanced HIV disease, including treatment and/or appropriate referral	Training documentation on file maintained in personnel record.

Assessment and Service Plan

Initial Assessment

At the start of Oral Health Services, a baseline dental evaluation must be conducted.

Medical history. The provider shall perform a complete medical history for every new patient. This should include:

- Client's chief complaint
- HIV medical care provider
- Current medication regimen(s) and adherence, including HIV medications
- Alcohol, drug, and tobacco use
- Allergies
- Usual oral hygiene
- Date of last dental examination, and name of last dentist if known

Oral examination. Each patient should be given a comprehensive oral examination and assessment. An oral examination should include:

- Documentation of the client's presenting complaint
- Medical and dental history
- Caries (cavities) charting
- X-rays: Full mouth radiographs or panoramic and bitewing x-rays
- Complete oral hygiene and periodontal exam
- Comprehensive head and neck exam
- Complete intra-oral exam, including evaluation for HIV-associated lesions or sexually transmitted infections (STIs)
- Soft tissue exam for cancer screening
- Pain assessment
- Risk factors

Preventative Care and Maintenance

Education shall include:

- Instruction on oral hygiene, including proper brushing, a strategy to remove plaque from between the teeth, and mouth rinses
- Counseling regarding behaviors that may influence oral health (e.g., tobacco use, unprotected oral sex, body piercing)
- General health conditions that may compromise oral health
- The effect of nutrition on oral health.

Clients should be scheduled for routine dental health maintenance visits, as follows:

- Routine examination. Prophylaxis and fluoride varnish or silver diamine fluoride (SDF) twice a year
- Comprehensive cleaning at least once a year
- Other procedures, such as root planing/scaling as needed

Standard	Measure
Conduct a baseline dental evaluation that shall include at a minimum: • Medical history • Intra-oral and extra-oral ~~Oral~~ examination • Education	Performance of a timely initial assessment, including evidence of a medical history, oral examination, and education as specified above, as well as provision and documentation of applicable referrals/linkages, will be monitored via site visit chart review.
Oral Health providers should emphasize prevention with fluoride varnish application. Clients should always be provided with information regarding prevention, early detection of oral disease, and preventive oral health practices, including what to do if having a dental emergency.	All client contacts, findings, procedures, diagnoses, education, and other information pertinent to patient care must be recorded in the client chart.
Clients will receive an intra-oral and extra-oral ~~oral~~ examination (this includes head and neck exam) by an oral health provider at least annually. The oral examination should include fluoride varnish application and an oral cavity exam	Clients who received an oral examination by an oral health provider.

Treatment Plan

Oral Health providers should create an individualized dental treatment plan for each patient. The plan should:

- Identify and prioritize the patient's caries control status, periodontal status, and dental care needs
- Incorporate client input
- Describe the proposed interventions and treatment schedule
- Include any referrals and linkages to specialty care or other needed services
- Be signed and dated by the provider

The treatment plan should be reviewed at each appointment and revised as needed.

Standard	Measure
Clients requiring specialized care should be referred for and linked to such care via the client's case manager and/or Ryan White oral health provider with documentation of that referral in the client file and available upon request.	Development and revision of individualized treatment plans that meet the requirements laid out above will be monitored via review of client charts and/or electronic health records during site visits.

Practice Guidelines for the Treatment of People Living with HIV in General Dentistry

County of San Diego

Original Source:
Los Angeles County
Commission on HIV Health Services

Revised by:
San Diego County Standards of Care Dental Working Group, 9/4/08 and 4/7/11
San Diego County HIV Planning Group Dental Working Group 5/26/20 and 6/22/20

Recommended by:
Joint Planning Council/Grantee HIV Standards of Care Committee, 7/12/11
HIV Planning Group Strategies and Standards Committee, 7/7/20

Received and approved by:
San Diego County HIV Health Services Planning Council, 10/26/11
San Diego County HIV Planning Group, 7/22/20

Contents

What Viral Load and CD4 Cell Count Mean to the Dentist

The CD4 count and the viral load are the two laboratory markers that are used to monitor HIV infection. The CD4 cells are a subset of T-lymphocytes (synonyms are the T4 cell count or helper cells), which correlate with the patient's immune status. The normal value for adults is 750 – 1000 cells/mm^3. Patients with values less than 200 cells/mm^3 are considered to have advanced immunosuppression. Those with a value of less than 50 cells/mm^3 are considered to be in a very advanced stage and are usually symptomatic. Patients with low CD4 cell counts (less than 200 cells/ml) are at risk for developing the diseases associated with the acquired immune deficiency syndrome or AIDS (opportunistic infections and cancers.) Those with high counts (greater than 350 cell/mm^3) usually manifest no AIDS related illnesses.

The viral load is a test that measures the amount of viral ribonucleic acid (RNA) in a milliliter of plasma and reflects how much the virus is replicating. While the viral load does not indicate the immune status of the patient, it reflects the viral burden in the body and the risk of clinical progression and immunosuppression. The goal of therapy with antiviral drugs is to reduce the viral load to an "undetectable" value. The significance of an "undetectable" viral load is that minimal viral replication is occurring, and the virus is unlikely to deplete CD4 cells and cause immunosuppression. It also means that there is little risk of the virus being able to mutate which can result in drug resistance and treatment failure. Further, recent data have demonstrated that patients with sustained viral suppression do not transmit HIV to sexual partners. Based on these benefits and the improved safety and tolerability of newer antiviral treatment options, antiretroviral (ARV) therapy is recommended for all persons living with HIV, regardless of the CD4 count.

The dentist can play an important part in reminding patients of the need for regular follow up and monitoring of these markers.

For the dentist, the CD4 count indicates the immune status of the patient and the risk for certain conditions that can affect oral and overall health. The viral load itself does not directly influence dental treatment, but a detectable viral load may indicate to the dentist that the patient is not on an optimized ARV regimen and may benefit from timely follow-up with the primary care provider. High viral loads may be present in a patient with early asymptomatic disease, while low viral loads can be seen in very advanced patients on suppressive antiviral therapy. The dentist can play an important role in reminding patients of the need for regular follow up and monitoring of these markers. It is recommended that viral load determinations be done at least every three to six months.

With respect to CD4 counts and viral load testing, best practices for the dentist include the following:

- At each visit, find out the patient's last CD4 count and viral load as part of the general health assessment.
- If the patient has not had viral load testing or a CD4 count in the last 12 months, determine if the patient is receiving primary care for HIV and if the patient is taking ARV medications. If there is concern that the patient has fallen out of care, direct the patient to resources for re-linkage to care.
- Remind patients of the need for regular follow-up and monitoring of CD4 counts and viral load.
- Reinforce the importance of adherence to the ARV medication regimen and the fact that missing just a few doses a month can result in the virus becoming resistant and harder to treat.

Antibiotic Prophylaxis

For patients who are living with HIV, there are no data supporting the need for routine antibiotic coverage to prevent bacteremia or septicemia arising from dental procedures. In fact, patients with AIDS have shown a higher incidence of allergic reactions to antibiotics and other medications, so it may endanger the patient's health by over-prescribing antibiotics.

Prophylactic antibiotics should not be prescribed routinely for the dental visit when the HIV infection is well-controlled. The American Heart Association (AHA) guidelines for antibiotic prophylaxis should be followed as with any patient. Consult the patient's physician to determine the need for antibiotic prophylaxis for the patient with multiple co-morbidities and with prosthetic joint replacements or intravascular devices. As with any patient, it is the standard of care to investigate all possible drug interactions before prescribing antibiotics or

Commented [KE1]: Emphasize there is no contraindication for dental treatment for patients who are asymptomatic (usually CD4+ count more than 350/uL)

Commented [KE2]: Emphasize there is no contraindication for dental treatment for patients who are asymptomatic (usually CD4+ count more than 350/uL)

Commented [KE3]: define "well-controlled". May state instead those who are symptomatic and/or those who have severe neutropenia (ANC<500/uL) may benefit from antibiotic prophylaxis. Always consult the patients physician if unsure.

https://www.ada.org/resources/ada-library/oral-health-topics/hiv

https://decisionsindentistry.com/article/managing-dental-patients-with-hiv/

Commented [KE4]: AHA guidelines are just for those with cardiac conditions and are at risk for infective endocarditis and are not based on a patients risk of infection due to immunosuppression. I would suggest as just removing these statements since AHA guidelines, guidelines for those with prosthetic joints, and those with orthopedic surgeries are relevant to all patients regardless of their HIV status

other medications for patients who are living with HIV.

Medical Assessment

Annual Health History

Many different oral mucosal lesions have been associated with HIV infection. Some, such as candidiasis and hairy leukoplakia, may indicate HIV disease progression. Medications used for treatment of HIV and associated diseases or prophylaxis of opportunistic infections may have significant adverse effects or may interact with other prescribed medications. To develop an appropriate treatment plan, the oral health care provider should obtain complete information about the patient's health and medication status. Past and/or present use of tobacco, alcohol, and other substances affects oral health, and such information should be collected during the (initial or updated) annual health history.

If there is any doubt about the accuracy of the information provided by a patient, the dentist should contact the patient's physician.

Annual Extra-Oral (Head and Neck) Examination

Patients who are living with HIV may develop associated skin manifestations and cervical lymphadenopathy along with bilateral salivary gland enlargement. Therefore, in addition to oral soft-tissue examinations, extra-oral head and neck examination should be performed routinely.

When to Contact the Patient's Primary Care Physician

It is recommended that the dental provider consult with the patient's physician when additional information is needed to safely provide dental care. This is handled the same way as a consultation request for any other medical condition.

- It is the standard of care to ask the patient about any health conditions, and to collect information about the status of each condition.
- It is also the standard of care to ask the physician to confirm or provide more complete medical information to that already obtained from the patient if needed.
- When medical conditions are well controlled, it is up to the dental care provider, based on his or her diagnosis of the patient's treatment needs, to determine the need for a consultation with the patient's physician.
- The dental health provider should use the medical history and laboratory test results to decide if treatment should occur in a hospital setting. Such a decision should be made in consultation with the patient's physician.

Commented [KE5]: Recommended lab values are scattered throughout the document, but may just want to state them in one section. There is a great chart Laboratory Information in this link:

https://decisionsindentistry.com/article/managing-dental-patients-with-hiv/

Commented [KE6]: I would suggest removing 'many different....prescribed medications' since this is applicable to every patient a dentist sees

Commented [KE7]: I combined many of these statements in order to be more clear and concise

Commented [KE8]: and to update on a regular basis

Commented [KE9]: This statement contradicts the one below that states 'when medical conditions are well controlled, it is up to the dental care team...'

I would suggest combining three statements 'if more information is needed than the patient can provide (including but not limited to lab values, medications/dosages) or clarification is needed, then the dentist should contact patients treating physician.

Commented [KE10]: hospital setting is not the only thing that should be consulted one. I would instead state 'based on the medical history and lab results the dentist may want to consult with the physician to see if their should be modifications to treatment, including but not limited to need for hospital level care and medication dosage modifications'. I would remove decision should be done in consult with physician because this insinuates the dentists cannot make that decision themselves-which they can-and then they will refer to proper follow up. (See 'modification section below)

- If a patient with advanced HIV disease does not know the most recent CD4 count or viral load, the dentist should contact the physician for the correct information, and then determine whether to provide routine care or only emergency care at that time.
- If there is any doubt about the accuracy of the information provided by the patient (i.e., inconsistent or illogical answers to questions about medical history), the dentist should contact the patient's physician.
- If the patient's symptoms have changed, the dentist should consult with the physician to review the impending care and determine if treatment modifications are needed. For example, if there is liver or kidney involvement, the dentist may need to adjust the dosage of analgesics or antibiotics prescribed.
- The medical history should be updated on a regular basis to ensure all medical changes are noted. The medication list should also be updated, as dosages and regimens are subject to change. Sometimes medications and dosages may need to be clarified with the physician of record.
- Thrombocytopenia, anemia, and hepatobiliary diseases may occur in the course of HIV disease progression and with opportunistic infections. Laboratory tests prior to extensive surgical intervention should be obtained.

Commented [KE11]: remove these and combine with statement #2

Commented [KE12]: combine with statement above

Commented [KE13]: remove and combine with statement above

Treatment Considerations

Modifications of Dental Therapy

Discriminatory practices, such as the modification of dental treatment based solely on a patient's HIV status, are prohibited. However, if the patient's medical condition is compromised, treatment adjustments may be necessary, as would be the case with any medically compromised patient. The dentist should determine what treatment modifications, if any, are necessary. It is essential for all practitioners to understand that most people living with HIV, even if symptomatic, can be treated safely in a typical dental office or clinic.

- A pre-treatment antibacterial mouth rinse will reduce intraoral bacterial load, especially for those patients with periodontal disease.
- A six-month recall schedule should be instituted to monitor any oral changes. If the patient is severely immunosuppressed (i.e., CD4 count of <100 cells/mm^3), a shorter recall period such as a three-month interval should be considered.
- Oral hygiene and the use of silver diamine fluoride (SDF) are important in a medically compromised patient, as poor hygiene may be responsible for more rapid progression of oral disease. A proactive attitude and an emphasis on prevention should be encouraged. Dental treatment should also be prioritized based on the patient's health and circumstances (e.g. patients without the ability to tolerate long appointments, ability to perform oral hygiene, etc. should be treated with SDF to arrest existing caries and restored

Commented [KE14]: For patients who it is determined to be high risk for caries, has periodontal disease, or is immunosuppressed, 3 month recalls should be considered.

with a glass ionomer cement when necessary until more definitive treatment can be comfortably and appropriately provided).

- Infectious diseases, such as Hepatitis B, Hepatitis C, or Tuberculosis, should be ascertained and preventative protocols followed.
- Severely or terminally ill patients, for example, will require alterations in care similar to those in patients suffering from other conditions that cause debilitating illness, such as cancer or mental health impairment. These cases frequently lend themselves to minimally invasive dentistry and include the use of SDF and restoration with a fluoride-releasing glass ionomer material.

It is essential for all practitioners to understand that most HIV patients, even if symptomatic, can be treated safely in a typical dental office or clinic.

Commented [KE15]: I would put this in medical history section

Annual Periodontal Examination

Oral health care is an important component of the management of patients with HIV infection. A poorly functioning dentition can adversely affect the quality of life, complicate the management of medical conditions, and create or exacerbate nutritional and psychosocial problems. When the oral cavity is compromised by the presence of pain or discomfort, maintaining adherence to complicated ARV therapy regimens becomes more difficult.

Gingival/periodontal disease, specifically linear gingival erythema (LGE) and necrotizing ulcerative periodontitis (NUP), have been associated with HIV infection. There is now evidence that these diseases also occur in HIV-negative immunocompromised individuals and are not specific to HIV infection. The prevalence of these two diseases remains unclear with current estimates of occurrence among HIV-infected individuals in the 5-10% range. There is some evidence that NUP is associated with a low CD4 count (<200 cells/mm^3). Early recognition of periodontal problems allows treatment that can prevent progression of these conditions, including severe attachment/bone loss.

HIV-associated gingivitis has been renamed linear gingival erythema (LGE) and HIV-associated periodontitis has been renamed necrotizing ulcerative periodontitis (NUP).

Commented [KE16]: LGE is associated with candida and is refractory to standard plaque control

Commented [KE17]: NUP should be updated to state "necrotizing periodontal diseases which includes necrotizing ulcerative gingivitis (NUG), necrotizing ulcerative periodontisis (NUP) and necrotizing ulcertive stomatitis (NUS/NS)

https://www.ncbi.nlm.nih.gov/books/NBK558499/

Commented [KE18]: also evidence that LGE is associated with CD4+ count below 200

https://www.researchgate.net/publication/326631816_Correlation_Linear_Gingival_Erythema_Candida_Infection_and_CD4_Counts_in_HIVAIDS_Patients_at_UPIPI_RSUD_Dr_Soetomo_Surabaya_East_Java_Indonesia#pf2

Annual Updated Treatment Plan

A comprehensive treatment plan that includes preventive care and maintenance should be developed and discussed with the patient. Various treatment options should be discussed and developed in collaboration with the patient. As with all patients, a treatment plan appropriate for the patient's health status, financial status, and individual preference should be chosen.

Medications may interfere with dental treatment and cause adverse effects, such as decreased salivary flow, altered liver function, and bone marrow suppression, resulting in anemia, thrombocytopenia, and neutropenia.

Phase 1 Treatment Plan Completion

Phase 1 treatment includes procedures related to prevention, maintenance, and/or elimination of oral pathology that results from dental caries or periodontal disease. This may include minimally invasive dentistry to include caries control using SDF, restorative treatment, basic periodontal therapy (non-surgical), basic oral surgery that includes simple extractions and biopsy, non-surgical endodontic therapy, and space maintenance and tooth eruption guidance for transitional dentition. Dental services that are part of Phase 1 Treatment as indicated as "Primary" in the County of San Diego, Health and Human Services Agency Ryan White Primary Care Medical Care Allowable Dental Services List.

Community and migrant health center oral health programs seek to increase access to oral health care for the underserved. Completing Phase 1 Treatment Plans within twelve months addresses two fundamental areas within these dental programs: 1) the need to perform a comprehensive oral health exam that culminates with an accompanying treatment plan and 2) assuring that quality care is incorporated in the process of completing needed treatment in a timely manner. Completion of the Phase 1 Treatment Plan facilitates the identification of contributing and restricting factors and practical low-cost improvement options relevant to significant areas listed above. With access to codes associated with comprehensive oral exams and Patient Treatment Completion (PTC), most information management systems will be able to provide an average length of time associated with completion of treatment. With this information, staffing patterns, financial costs (overhead expenses) and efficiency of the oral health program can be assessed. These additional benchmarks could also be measured across health center programs at the local, regional, and national levels. The ultimate goal is to measure and assure that health centers routinely and systematically deliver comprehensive, quality oral health services, and patient treatment is completed within a reasonable amount of time.

Commented [KE19]: Is this metric currently being tracked with Ryan White dental providers?

Completion of Phase 1 Treatment Plan within 12 months is comprehensive in that subsequent performance analysis can broach a number of significant areas, such as: appointment scheduling, ratio of oral health providers to dental operatories, ratio of oral health providers to support staff, collaboration with medical colleagues emphasizing oral health as an essential component of an interdisciplinary approach to patient care, prioritization of patients and/or procedures, general productivity and efficiency.

Additional clarification is available on pages 13-15 of the HAB HIV Oral Health Performance Measures document: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-

management/oralhealthmeasures.pdf.

Commented [KE20]: need updated link

Medications in HIV

> Medications may interfere with dental treatment and cause adverse effects, such as decreased salivary flow, altered liver function, and bone marrow suppression, resulting in anemia, thrombocytopenia, and neutropenia.

HIV Medicine is a dynamic field and knowledge of ARV medications is constantly evolving. It should be emphasized that long-term clinical data on drug interactions does not exist for many of the newer medications. It is very important to keep an updated list of a patient's ARV medications as it may change. Patients taking some ARV medications may suffer from photophobia, so the dental team can make them more comfortable by avoiding a direct light source at the patient's eyes or offering dark glasses during the treatment. In addition, these patients may suffer from xerostomia as a side effect from some of the ARV medications. Use of prescription medications such as pilocarpine and bethanechol as salivary gland stimulants should be considered. Excellent oral hygiene home care, topical fluoride and frequent hygiene recall visits, as well as nutritional counseling and saliva enhancers (sugarless gum, water, and saliva substitutes) will be critical for prevention of periodontal disease and dental caries. Patients should also be assessed for consumption of unexpected sources of sugar such as over the counter medications including products like antacids (e.g. Tums, Rolaids); cough drops; suspensions (e.g. Nystatin); and, fungal troches (e.g. Mycelex). All of these may contribute to dental caries.

Currently, there are no known drug interactions between ARV medications and local anesthetics used in general dentistry. There are, however, some medications (especially certain sedative-hypnotics) that are prescribed by dentists or used in the office that may be contraindicated in patients taking ARV medications. It is recommended that the dental care provider consult a reference that thoroughly discusses drug side effects and interactions prior to prescribing any medications or consult with the patient's primary care provider.

More information on specific ARV medications is available at:

- https://aidsinfo.nih.gov/drugs
- https://medlineplus.gov/hivaidsmedicines.html
- http://hivinsite.ucsf.edu/InSite?page=ar-drugs

Commented [KE21]: These links need updated

To look at specific drug-drug interactions, excellent clinical tools include:

- http://www.hiv-druginteractions.org
- http://hivinsite.ucsf.edu/insite?page=ar-00-02

Oral Health Education: Caries Prevention and Smoking

A higher risk of dental caries in patients with HIV may be caused by decreased salivary flow, which may occur as a result of salivary gland disease or as a side effect of a number of medications. Also, some topical antifungal medications have high sugar content, possibly resulting in increased susceptibility to caries. In these cases, the frequent application of fluoride varnish (every three month ~~up to five times per year~~) or targeted applications of SDF several times a year as needed should be considered. The adverse effects of using tobacco should be discussed with the patient. If the patient is a tobacco user, cessation should also be discussed.

For in-office consumer and provider materials on tobacco cessation programs, dentists can access https://smokefree.gov/help-others-quit/health-professionals.

Oral health education may be provided and documented by a licensed dentist, dental hygienist, dental assistant and/or dental case manager.

Nutritional Counseling

Because of certain oral conditions, people living with HIV may have difficulty consuming a balanced diet. The patient may suffer from changes in taste and decreased ability to chew and swallow because of drug-induced xerostomia. This can lead to gastrointestinal upset and nausea, further inhibiting the intake of a balanced diet. It is the role of the dentist to recognize oral manifestations, which are associated with nutritional deficiencies that can cause intraoral manifestations such as vitamin B 12, folic acid, etc. Nutritional supplements or referral to the patient's physician or a registered dietitian may be necessary. Some areas to be aware of include:

- Poor oral intake of food or fluid
- Difficulty chewing and swallowing due to continuous mouth sores resulting from candidiasis, herpes simplex, aphthous ulcers, etc.
- Severe dental caries
- Changes in perception of taste or smell

- Patient complaints of economic inability to meet caloric and nutrient needs

Post-Exposure Prophylaxis (PEP)

Most occupational HIV exposures do not result in the transmission of HIV. There have been no documented reports of transmission from a dentist to a patient. Documentation of the event and assessment of risk remain important. The person who is exposed should be referred immediately to a physician who can provide counseling, testing, and appropriate medications. The interval within which PEP should be initiated for optimal efficacy is not known, but it should be started as soon as possible, ideally within 24-36 hours and no later than 72 hours following the exposure. The need for PEP should be treated as a medical emergency.

Please refer to 2013 guidelines at https://www.jstor.org/stable/10.1086/672271#metadata_info_tab_contents.

Management of Occupational Blood Exposure

Commented [KE22]: I will leave it to the medical team if there are any updates to this exposure guideline

- Wash wounds and skin with soap and water
- Flush mucous membranes with water
- The incident should be reported to a supervisor if applicable and should be documented in an injury/exposure log
- Report to a medical provider for testing, and access to PEP

Basic Overview:

Determine whether high or low risk depending on source

- Low titer exposure
- Higher titer exposure

Medications

- Start within hours of exposure (as soon as possible)
- Triple therapy for 4 weeks

Baseline Labs to Monitor for Adverse Reactions

- Pregnancy test if applicable
- Complete Blood Count with differential and platelets

Warmline: 800-933-3413

PEPline: 888-448-4911

Perinatal HIV Hotline: 888-448-8765

- Urinalysis
- Renal Function Tests (Blood Urea Nitrogen and Serum Creatinine)
- Liver Function Tests (Aspartate and Alanine Aminotransferase, Alkaline Phosphatase, Total Bilirubin)

Monitor

- Baseline
- If combination antigen-antibody testing is used, blood should be tested for HIV at 6 weeks and 4 months following exposure.
- If antibody testing is used, test for HIV at 6 weeks, 12 weeks and 24 weeks. (Note: combination antigen-antibody HIV testing is generally used now)

The National Clinicians' Post-Exposure Prophylaxis Hotline is the PEPline. This excellent resource for questions is open 9:00am-8:00pm Eastern Time Monday through Friday and 11:00am-8:00pm Eastern Time on weekends and holidays. Their number is (888) 448-4911.

Discrimination and Legal Issues

Referrals to a specialist or to a hospital setting must always be based on the clinical needs of the patient, not the ignorance or fear of the dentist, staff, or other patients. The legal obligation of the dental provider is to refer patients for testing and follow-up.

It is a violation of the Americans with Disabilities Act, California law, and the law of some local jurisdictions, and of the ethical standards of the California Dental Association and the American Dental Association to refuse to care for patients with HIV because of fear of the risk of infection.

Privacy

Many patients are reluctant to disclose HIV status to the dentist because they fear discrimination, even when they understand that full disclosure is essential for providing the best possible care.

- Dentists **must** establish an atmosphere in which patients feel comfortable in disclosing their status by indicating on the medical intake form that patients are not discriminated against on the basis of disability, and that all medical information disclosed is confidential.
- Dentists are responsible for training staff to ensure that all patient information is kept confidential and is in accordance with all state laws and the Health Insurance Portability and Accountability Act (HIPAA).

- A thorough discussion of HIV privacy law, including practice tips for protecting the privacy of dental records, can be found in the Schulman article in the Journal of the California Dental Association: https://pubmed.ncbi.nlm.nih.gov/7508498/
- HIPAA guidelines are found at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/index.html.
- Dentists should also refer to information available from the California Department of Health Services, Office of AIDS at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx.
- In the state of California, written consent of the patient is not required for exchange of treatment-related information between health care providers, as long as that information is obtained for the patient's benefit. However, many medical and dental offices are reluctant to provide lab data over the phone because of the especially sensitive nature of the information. You can more easily obtain medical information related to patient treatment if you offer to fax or mail a consent form.

Selected Bibliography

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Dental Asepsis Review, from the Sterilization Monitoring Service, Indiana University School of Dentistry, Vol. 22, No. 9, September 2001

Gostin, Lawrence, Feldblum, Chai, and Webber, David, "Disability Discrimination in America: HIV/AIDS & Other Health Conditions." JAMA 281:8, 745-52 (Feb. 24, 1999).

Hahn, James K. and Schulman, David I., "Perspective: The Supreme Court Deals with a Dentist's Fear". AIDS Policy and Law (Jul. 24, 1998), p.10.

"Hepatitis C Prevention," CDC Website, updated October 2, 1998 [cited Apr 14, 1999]. http://www.cdc.gov/ncidod/diseases/hepatitis/c/lbtinfo.htm

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Official Publication of the Organization for Safety and Asepsis Procedures (OSAP), Pub. No. 10, 2001d

Schulman, David I., "The Dentist, HIV and the Law: Duty to Treat, Need to Understand." CDA: Journal of the California Dental Association, 21:9. 45-50 (Sept. 1993).

Wilson, W., Taubert, K.A., Gewitz, M., Lockhart, P.B., Baddour, L.M., Bolger, A., et al. "Prevention of Infective Endocarditis: Guidelines from the American Heart Association: a Guideline from the American Heart Association Rheumatic Fever, Endocarditis, and Kawasaki Disease Committee, Council on Cardiovascular Disease in the Young, and the Council on Clinical Cardiology, Council on Cardiovascular Surgery and Anesthesia, and the Quality of Care and Outcomes Research Interdisciplinary Working Group." Circulation 2007 Oct 9;116(15):1736-54.

Selected Websites for HIV/AIDS Information

Commented [KE23]: update links

Sites of Particular Interest to Dentists

HAB HIV Performance Measures: Oral Health
https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/oralhealthmeasures.pdf

American Dental Association
https://www.ada.org/en

HIVdent
http://www.hivdent.org/

National Institute of Dental & Craniofacial Research
http://www.nidcr.nih.gov/

Pacific AIDS Education and Training Center
http://paetc.org/

American Nursing Association Safe Needles Save Lives
https://www.nursingworld.org/practice-policy/work-environment/health-safety/safe-needles/safe-needles-law/

The Internet drug index - side effects and drug interactions

- https://aidsinfo.nih.gov/drugs
- https://medlineplus.gov/hivaidsmedicines.html
- http://hivinsite.ucsf.edu/InSite?page=ar-drugs

Other Helpful Links

HIV-Insite (UCSF)
http://hivinsite.ucsf.edu/

AIDS Info: US Department of Health and Human Services
https://aidsinfo.nih.gov/

HIV/AIDS Prevention (CDC)
https://www.cdc.gov/hiv/dhap/about.html

Morbidity and Mortality Weekly Report (CDC)
http://www.cdc.gov/mmwr/

The Body - A Multimedia AIDS & HIV Information Resource
http://www.thebody.com/index.shtml

National HIV/AIDS Clinicians' Consultation Center (Warmline and PEP line)
http://www.nccc.ucsf.edu/

L.A. Public Health Organization: AIDS Info
http://publichealth.lacounty.gov/dhsp/

American Medical Association
http://www.ama-assn.org/

County of San Diego HIV/AIDS Reporting
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/hiv_aids_epidemiology_unit/reporting.html

MSEC Work Plan

WORK PLAN
February 11, 2025 • Approve Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services • Finalize 2025 work plan and priorities
May 13, 2024 • Update Mental Health Services and Psychiatric Medication Management • Review Needs Assessment findings
September 9, 2025 • Approve Mental Health Services and Psychiatric Medication Management •
November 4 or 8, 2025 (*from May 11*) • • Review Ryan White Quality Assurance Chart tool • Identify priorities and develop work plan for 2026

County of San Diego Monthly STD Report

Volume 17, Issue 1: Data through August 2024; Report released January 29, 2025.

Table 1. STDs Reported Among County of San Diego Residents, by Month and Previous 12 Months Combined.

	2023		2024	
	August	*Previous 12-Month Period**	*August*	*Previous 12-Month Period**
Chlamydia	1687	17907	1284	15493
Female age 18-25	519	5964	435	5040
Female age ≤ 17	61	581	49	596
Male rectal chlamydia	180	1738	90	1334
Gonorrhea	580	6945	500	6124
Female age 18-25	61	847	65	584
Female age ≤ 17	17	91	6	86
Male rectal gonorrhea	139	1550	119	1465
Early Syphilis (adult total)	87	1082	27	582
Primary	16	193	8	75
Secondary	24	308	6	165
Early latent	47	581	13	342
Congenital syphilis	5	45	0	23

* Cumulative case count of the previous 12 months.

Table 2. Selected STD Cases and Annualized Rates per 100,000 Population for San Diego County by Age and Race/Ethnicity, Year-to-Date.

	All Races*		Asian/PI		Black		Hispanic		White	
	cases	*rate*	*cases*	*rate*	*cases*	*rate*	*cases*	*rate*	*cases*	*rate*
All ages										
Chlamydia	10085	460.2	302	105.6	382	399.8	1119	149.5	1340	143.8
Gonorrhea	4056	185.1	152	53.1	247	258.5	818	340.6	841	90.3
Early Syphilis	308	14.1	19	6.6	28	29.3	136	18.2	84	9.0
Under 20 yrs										
Chlamydia	1527	277.4	22	38.7	61	256.3	155	64.5	231	128.4
Gonorrhea	266	48.3	3	5.3	23	96.6	45	18.7	35	19.5
Early Syphilis	9	1.6	0	0.0	1	4.2	5	2.1	1	0.6

Note: Rates are calculated using 2022 Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 10/2023.

* Includes cases designated as "other," "unknown," or missing race/ethnicity.

Note: All data are provisional. *Case counts are based on the earliest of date of diagnosis, date of specimen collection, and treatment date. Totals for past months might change because of delays in reporting from labs and providers.*

Figure 1. Chlamydia and Gonorrhea Reported Among County of San Diego Residents, by 3-Month Period.

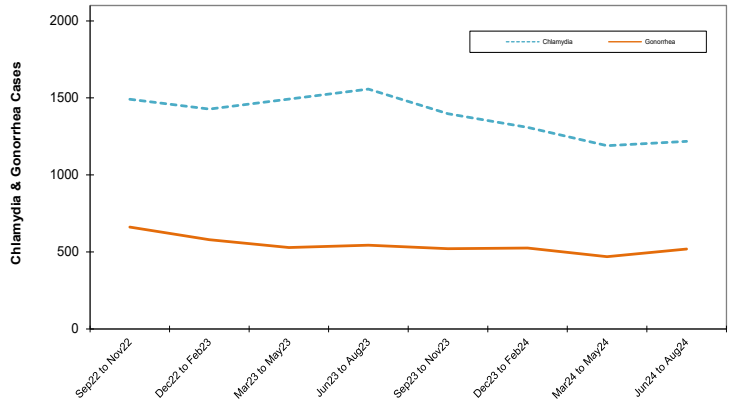
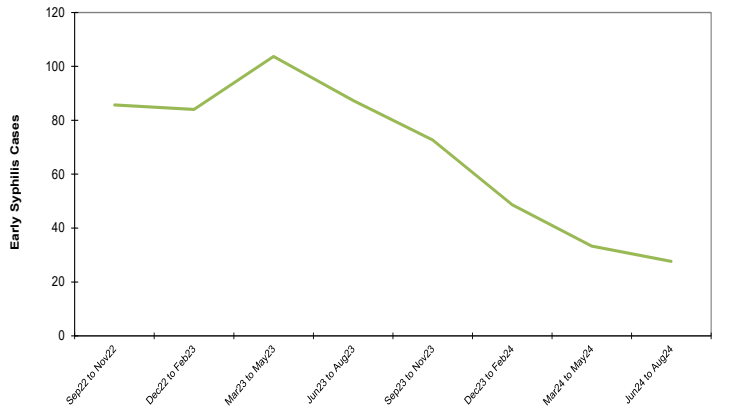


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Editorial Note: New Studies Indicate Real-World Effectiveness of Doxy-PEP

Doxycycline post-exposure prophylaxis (i.e., doxy-PEP), or a 200-mg dose of doxycycline taken within 72 hours of condomless sex, reduced bacterial sexually transmitted infection (STI) incidence among cisgender men who have sex with men (MSM) and transgender women (TGW) in two randomized trials [1][2]. Based on these results, local and state health departments and the Centers for Disease Control and Prevention (CDC) have issued guidance regarding doxy-PEP use [3][4][5][6][7]. While questions remain regarding the effect of doxy-PEP use on antimicrobial resistance and the efficacy of doxy-PEP for STI prevention in other populations (e.g., cisgender women), two recent studies from northern California have demonstrated decreases in bacterial STI incidence following doxy-PEP implementation.

- One study utilized reportable disease surveillance data in San Francisco to evaluate citywide STI incidence among MSM and TGW before and 13 months after the dissemination of doxy-PEP guidance by the San Francisco Department of Public Health. The observed incidence of chlamydia and early syphilis cases decreased by 49.6% (95% confidence interval [CI] -59.1% to -38.1%) and 51.4% (95% CI -58.2% to -43.5), respectively, compared to projected incidence. However, gonorrhea cases increased by 25.6% (95% CI -0.4% to 58.3%) compared to projected incidence.
- Another study examined electronic health record data on HIV pre-exposure prophylaxis (PrEP) users at Kaiser Permanente Northern California (KPNC) and compared quarterly STI incidence rates 24 months before and 12 months after starting doxy-PEP and compared quarterly STI rates among those dispensed and not dispensed doxy-PEP. Among 2,253 patients who were dispensed doxy-PEP, quarterly chlamydia and early syphilis incidence decreased by 79% (rate ratio [RR] 0.21, 95% CI 0.16-0.27, p<0.001) and 80% (RR 0.20, 95% CI 0.11-0.37, p<0.001), respectively. Gonorrhea incidence declined by 12% (RR 0.88, 95% CI 0.77-1.00, p=0.048), with significant site-specific declines for rectal and urethral gonorrhea but not for pharyngeal gonorrhea. STI incidence remained stable among those not prescribed doxy-PEP.

County of San Diego STD Clinics: www.STDSanDiego.org
Phone: (619) 692-8550 **Fax:** (619) 692-8543
STD Clinical Consultation Line: (619) 609-3245 (8am-5pm, M–F)

Provider STD Reporting: (619) 692-8520; fax (619) 692-8541
Sign up to receive Monthly STD Reports, email STD@sdcounty.ca.gov

HIV PLANNING GROUP
4-MONTH COMMITTEE TRACKING
Feb 2023 - November 2024

Medical Standards & Evaluation Committee					
MSEC	**Feb**	**Jun**	**Sep**	**Nov**	**#**
Total Meetings	1	1	1	1	**4**
(9) Members					
Tilghman, Dr. Winston	*	*	*	**JC**	**0**
Aldous, Dr. Jeannette [CC]	**1**	*	*	*	**1**
Bamford, Dr. Laura	**JC**	*	*	**1**	**1**
Grelloti, David [C]	*	**1**	*	*	**1**
Hernandez, Yessica	**1**	*	*	*	**1**
Lewis, Bob	*	*	**1**	*	**1**
Spector, Dr. Stephen	*	**1**	**1**	**1**	**3**
Stangl, Lisa	*	**1**	**1**	*	**2**
Quezada-Torres, Karla	*	*	*	*	**0**

To remain in good standing and eligible to vote, the committee member may not miss 3 consecutive meetings or 6 meetings within 12 months.

* = Present

1 = Absence when there are multiple meetings that month. Member needs to attend at least one (1) meeting for attendance to count for that month.

JC = Just Cause

EC = Emergency Circumstance

NM = No Meeting

NQ = No Quorum

ASSEMBLY BILL (AB) 2449: JUST CAUSE AND EMERGENCY CIRCUMSTANCES (2023)

If the physical attendance quorum requirement is met, AB 2449 permits a member who is not physically present to request virtual attendance at the local legislative body's meeting under two circumstances: (1) for "just cause" and (2) due to "emergency circumstances".

Qualifying Reason	Provisions to attend remotely	Requirements/Limitations
Just Cause	• There is a childcare or caregiving need (for a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner) that requires the member to participate remotely • A contagious illness prevents the member from attending the meeting in • There is a need related to a defined physical or mental disability that is not otherwise accommodated for • Traveling while on official business of the legislative body or another state or local agency	A member is limited to **two (2)** virtual attendances based on "just cause" per calendar year
Emergency Circumstances	"A physical or family medical emergency that prevents a member from attending the meeting in person." A member is not required to disclose any medical diagnosis or disability, or any personal medical information that is already exempt from existing law.	A member of the legislative body must make a request to the body to allow the member to meet remotely due to an emergency circumstance, and further must provide a general description of the circumstance justifying such attendance. A request from a member to attend remotely due to an emergency circumstance requires that the legislative body take action and approve the remote attendance at the start of the meeting for the member to be allowed to participate remotely for that meeting*.

**If the request does not allow sufficient time to be placed on the agenda as a proposed action item, then the legislative body may take action at the beginning of the meeting.*

ADDITIONAL REQUIREMENTS FOR A MEMBER PARTICIPATING REMOTELY:

In addition to making a request either for "just cause" or due to an "emergency circumstance" for remote appearance, AB 2449 imposes the following three (3) additional requirements on legislative body members seeking to appear remotely at public meetings:

1. Before any action is taken during the meeting, the member **must** publicly disclose whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.
2. A member of the legislative body participating from a remote location must participate through both audio **and** visual technology.
3. A member's remote participation cannot be for more than three (3) consecutive months or 20 percent of the regular meetings for the local agency within a calendar year. And if the legislative body regularly meets fewer than ten (10) times per calendar year, a member's participation from a remote location cannot be for more than two meetings.

AB 2449 Checklist

(Applicable January 1, 2023 to December 31, 2025)

Procedures for Public Participation

- ☐ Public must be able to remotely hear, visually observe, and address the legislative body either remotely or in person in real time
- ☐ Public must have the opportunity to participate via: 1) two-way audio or 2) a telephonic service with a webcasting service
- ☐ Public cannot be required to submit comments prior to the meeting

Procedures for Member to Teleconference from a Remote Location

- ☐ Member must participate through both audio and visual technology
- ☐ Member must disclose adults who are present in the room at the remote location with the member and the general nature of the relationship with those individuals
- ☐ Member must submit a general description of the need to teleconference to the legislative body at the earliest opportunity (do not disclose any medical diagnosis or disability)
- ☐ Member may teleconference for just cause. Just cause is limited to 2 meetings per calendar year (see "Limits per Member" below). Just cause is defined as:
  - Child care or caregiving need of a child, parent, grandparent, grandchild, sibling, spouse or domestic partner
  - Contagious illness that prevents member from attending in person
  - A need related to a physical or mental disability
  - Travel on official business of the legislative body or another state or local agency
- ☐ Member may teleconference due to emergency circumstances, which requires approval of the legislative body and which is defined as a physical or family medical emergency that prevents a member from participating in person
- ☐ Limits per Member: Just cause and emergency circumstances cannot be invoked collectively for more than: 1) two meetings if the legislative body has fewer than 10 meetings per calendar year, or 2) three consecutive months or 20 percent of regular meetings per calendar year if the legislative body has 10 or more meetings per year. Just cause cannot be invoked more than twice per calendar year.

Procedures for the Board/Commission/Committee/Group

- ☐ Include instructions on the agenda how the public can participate remotely
- ☐ A quorum of the members of the legislative body must participate in person at the noticed location that is open to the public
- ☐ A majority of the membership must approve a request by a member to teleconference due to emergency circumstances; include the request on the agenda if received in time
- ☐ All votes must be taken by roll call
- ☐ Meeting must be stopped and no action taken if the broadcast of the meeting or ability of the public to comment is disrupted

TELECONFERENCING RULES UNDER THE BROWN ACT

	Default Rule	Declared Emergency (AB 361)	Just Cause (AB 2449)	Emergency Circumstance (AB 2449)
In person participation	Required	Not Required	Required	Required
Member participation via teleconferencing	Audio or Audio-visual	Audio or Audio-visual	Audio-visual	Audio-visual
Required (minimum) opportunities for public participation	In-Person	Call-In or internet-based	Call-in or internet-based and in person	Call-in or internet-based and in person
Disruption of broadcast or public's ability to comment	Meeting can proceed	No further action taken	No further action taken	No further action taken
Reason must be approved by legislative body	No	Yes (Initial findings and renewed findings every 30 days)	No, but general description to be provided by legislative body	Yes and general description to be provided to legislative body
Votes must be taken by roll call	Yes	Yes	Yes	Yes
Member's remote location included on agenda	Yes	No	No	No
Declared emergency and health official's recommendations for social distancing	No	Yes	No	No
Annual limits	None	None	Twice per calendar year (limits for emergency circumstances also apply for collective number of times AB 2449 can be used per year)	3 consecutive months/ 20% of regular meetings per calendar year; or 2 meetings per calendar year if body meets less than 10 times per year (collectively with just cause)
Effective Dates	Ongoing	Expires 12/31/2023	Expires 12/31/2025	Expires 12/31/2025