County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578

WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

HIV PLANNING GROUP (HPG)
MEDICAL STANDARDS & EVALUATION COMMITTEE (MSEC)
MEETING PACKET

Tuesday, February 14, 2023 4:00 PM

NOTE: This meeting is audio and video recorded.

Online meeting

Group Charge: 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).

A quorum for this committee is 7

TABLE OF CONTENTS

Document	Page Number(s)
Continuation of Remote Meetings for Brown Act Boards and Commissions	002 – 004
Letter from Dr. Wooten – Health Officer Teleconferencing Recommendation	005
02/14/2023 MSEC Agenda	006 – 007
FYI: 11/08/2022 MSEC Meeting Cancellation	008
09/13/2022 MSEC Meeting Minutes	009 – 012
Practice Guidelines Compliance Chart Review: 10/01/2021 – 09/30/2022	013 – 015
RW 2019 Allowable Dental Services Rev 3.25.19	016 – 018
Ryan White (RW) Primary Care Practice Guidelines	019 – 029
Subcommittee Operating Guidelines	030 – 035
STDMonthlyReport Vol 15 Issue 1 (Released 01/31/2023)	036
Appendix (Provided for Informational Purposes)	
AB 2449 Checklist and Table	038 – 041

Effective October 1, 2021, a new law, AB 361, amends Government Code section 54953 to add subsection (e) ("Special Teleconferencing Rule") which, under specific circumstances, will allow continued suspension of the General Teleconferencing Rule. A recent modification to the Brown Act (the rules regarding open meetings in California) allows the HPG and Committees to continue to meet virtually while a state of emergency is in effect. In - person meetings will return when the state of emergency is over.

Continuation of Remote Meetings for Brown Act Boards and Commissions

State law requires local agency legislative bodies (which includes the HPG) to comply with the state's open meeting law referred to as the Ralph M. Brown Act (also called the "Brown Act"). Since March 2020, most legislative bodies have been operating under Executive Orders which suspended certain Brown Act provisions on teleconferencing allowing members to participate remotely. That Executive Order ended on September 30, 2021.

As of October 1, 2021, AB 361 allows for a continuation of teleconference meetings in certain circumstances. Following is a summary of AB 361 and its impact on public meetings and the steps required to utilize the teleconferencing option offered in AB 361.

At the next meeting, the HPG or Committee will need to take the actions detailed below if the members desire to continue meeting remotely.

I. Ordinary Brown Act Rules for Teleconferencing ("General Teleconferencing Rule")

Under the ordinary operation of the Brown Act (Gov. Code §54953(b)) a legislative body may use teleconferencing under the following circumstances:

a. Post agendas at all teleconference locations;
b. All teleconferenced locations are listed in the notice and agenda of the meeting;
c. At least a quorum of members are located within the jurisdiction of the legislative body; and
d. Members of the public are allowed to speak at each teleconferenced location.

II. Governor's Executive Orders Authorized Simplified Teleconferencing Rules, But These Ended on Sept. 30, 2021.

The County and other legislative bodies throughout the state have been using a simplified teleconferencing method, authorized by the Governor's Executive Orders related to the COVID-19 pandemic. This allowed members of legislative bodies attend meetings remotely without following the General Teleconferencing Rule set forth above.

III. New Teleconferencing Method Available Effective October 1, 2021, and Actions HPG and Committees Can Take ("Special Teleconferencing Rule

Effective October 1, 2021, AB 361 amends Government Code section 54953 to add subsection (e) which allows suspension of the General Teleconferencing Rule listed above if any of the following circumstances exist (underlining added):

a. <u>There is a proclaimed state of emergency and state or local officials have imposed or recommended measures to promote social distancing</u>; or
b. Legislative body, during a proclaimed state of emergency, holds a meeting for the purposes of determining by majority vote, that as a result of the emergency meeting in person would present imminent risks to the health or safety of attendees; or

c. Legislative body, during a proclaimed state of emergency, has previously determined (by majority vote) that as a result of the emergency meeting in person would present imminent risks to the health or safety of attendees.

After the first meeting, to continue to suspend the General Teleconferencing Rule and use the Special Teleconferencing Rule, the legislative body must make findings, at least every 30 days after that first meeting. The specific findings required are: 1) that legislative body has reconsidered the circumstances of the state of emergency; **and** 2) i. the state of emergency continues to directly impact the ability of members to meet safely in person; **or** ii. state or local officials continue to impose or recommend measures to promote social distancing.

IV. Operation of the Special Teleconferencing Rule

If a Brown Act body suspends the General Teleconferencing Rule as allowed under subsection (e), then the legislative body must (underlining added):

a. Notice the meeting as otherwise required by the Brown Act;
b. Agenda must identify and include an opportunity for all persons to attend via a call-in option or an internet based service option;
c. Allow members of the public to access meetings and an opportunity to address the legislative body directly as provided in the notice (call in or internet);
d. Conduct teleconferenced meetings in a manner that protects the statutory and constitutional rights of the parties;
e. In the event of a disruption that prevents broadcasting or call-in or internet based service; actions cannot be taken. Any action taken during a disruption may be challenged pursuant to 54960.1;
f. If a legislative body provides a timed public comment period for each agenda item, it cannot close the public comment period for the agenda or the ability to register on that item until the timed public comment period has elapsed (not likely applicable);
g. If a legislative body provides a general public comment period, public comment must remain open until public comment period closes; and
h. If a legislative body provides public comment on each agenda item, it must allow a reasonable time to register and speak (so likely until the matter is voted on).

V. Dr. Wooten has Issued a Social Distancing Recommendation, So Findings Have Been Met In Order to Use the Special Teleconferencing Rule

As of October 1, 2021, the elements to meet under the Special Teleconferencing Rule have been met. There is currently a State of Emergency and Dr. Wooten, the County's Public Health Officer, released a health recommendation on September 23, 202, which stated that utilizing teleconferencing options for public meetings is an effective and recommended social distancing measure to facilitate participation in public affairs and encourage participants to protect themselves and others from the COVID-19 disease.

VI. Next Steps

Under AB 361, on or after October 1, 2021, the first meeting of a legislative body under AB 361 can occur under the Special Teleconferencing Rule without anything

in particular on the agenda. In this case, Staff should note to the board that it is meeting pursuant to the Special Teleconferencing Rule and staff will bring back any future findings the board may need to take to continue to operate under the Special Teleconferencing Rule (i.e. within 30 days).

Alternatively, if time allows and the Chair approves, when the HPG or Committee first meets, an item will be placed on the agenda to determine whether the board wants to utilize the Special Teleconference Rule and if so, to adopt the initial Resolution.

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES

WILMA J. WOOTEN, M.D.
PUBLIC HEALTH OFFICER

HEALTH OFFICER TELECONFERENCING RECOMMENDATION

COVID-19 disease prevention measures, endorsed by the Centers for Disease Control and Prevention, include vaccinations, facial coverings, increased indoor ventilation, handwashing, and physical distancing (particularly indoors).

Since March 2020, local legislative bodies—such as commissions, committees, boards, and councils—have successfully held public meetings with teleconferencing as authorized by Executive Orders issued by the Governor. Using technology to allow for virtual participation in public meetings is a social distancing measure that may help control transmission of the SARS-CoV-2 virus. Public meetings bring together many individuals (both vaccinated and potentially unvaccinated), from multiple households, in a single indoor space for an extended time. For those at increased risk for infection, or subject to an isolation or quarantine order, teleconferencing allows for full participation in public meetings, while protecting themselves and others from the COVID-19 virus.

Utilizing teleconferencing options for public meetings is an effective and recommended social distancing measure to facilitate participation in public affairs and encourage participants to protect themselves and others from the COVID-19 disease. This recommendation is further intended to satisfy the requirement of the Brown Act (specifically Gov't Code Section 54953(e)(1)(A)), which allows local legislative bodies in the County of San Diego to use certain available teleconferencing options set forth in the Brown Act.

September 23, 2021

Wilma J. Wooten, MD

Wilma J. Wooten, M.D., M.P.H
Public Health Officer
County of San Diego

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578

WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

SAN DIEGO HIV PLANNING GROUP
Medical Standards and Evaluation Committee (MSEC)
Tuesday, February 14, 2023 at 4:00 PM
Meeting by Zoom

Group Charge: 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).

Members: Dr. Jeannette Aldous (Co-chair) / Dr. Laura Bamford / Dr. David Grelotti / Yessica Hernandez / Bob Lewis / Mikie Lochner / Shannon Ransom / Dr. Stephen Spector / Lisa Stangl / Dr. Winston Tilghman (Chair) / Karla Quezada-Torres / Dr. Adam Zweig

Quorum: Seven (7)

Agenda:

1) Welcome, introductions, moment of silence, comments from the Chair
2) **Action:** Continuance of Teleconferencing Meeting Option Pursuant to Government Code Section 54953(e):
    a. Find HPG has reconsidered the circumstances of the State of Emergency
    b. Find that State and Local officials have recommended measures to promote social distancing
3) Public comment (for members of the public)
4) Sharing our concerns (for committee members)
5) Approval of the February 14, 2023 meeting agenda
6) Approval of the September 13, 2022 meeting minutes
7) Old Business:
    a. Review final chart review tool
    b. **Discussion:** GTZ Community Engagement – next steps
8) New Business:
    a. **Action:** Add occlusal guards, including hard appliance (D9944) and soft appliance (D9945) to list of covered oral healthcare services

b. 2023 meeting dates, priorities, and work plan

c. **Discussion:** Discuss committee location for in-person meetings

d. Committee data requests for 2023

e. **Discussion:** Revisions to Ryan White primary care practice guidelines

f. Review and approval of revised committee operational guidelines

9) Other Updates:

a. STD and Mpox Update (Dr. Tilghman)

10)Agenda items for future meeting

11) Reminder of upcoming meeting date:

a. **Tuesday, May 9, 2023 at 4:00 PM Location: TBD**

12) Adjournment

WORK PLAN

February 14, 2023 •
May 9, 2023 •
September 12, 2023 •
November 14, 2023 •

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578
SAN DIEGO, CA 92110-3134
(619) 531-5800 • FAX (619) 542-4186

WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

SAN DIEGO HIV PLANNING GROUP
MEDICAL STANDARDS & EVALUATION COMMITTEE (MSEC)

Tuesday, November 08, 2022
4:00 PM

Meeting via teleconference (Zoom)

DRAFT MINUTES

Quorum = Seven (7)

Committee Members Present: Dr. David Grelotti / Mikie Lochner

Committee Members Absent: Dr. Jeannette Aldous (Co-chair) / Dr. Laura Bamford / Bob Lewis / Dr. Susan Little / Katherine Penninga / Shannon Ransom / Lisa Stangl / Dr. Winston Tilghman (Chair) / Karla Quezada-Torres / Dr. Stephen Spector / Dr. Adam Zweig

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	**Mikie Lochner**, HPG Chair, reported that the Chair and several members were not available to attend and that the meeting would not meet quorum. The meeting was cancelled at 4:07 PM.	

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578
SAN DIEGO, CA 92110-3134
(619) 531-5800 • FAX (619) 542-4186

WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

SAN DIEGO HIV PLANNING GROUP
MEDICAL STANDARDS & EVALUATION COMMITTEE (MSEC)

Tuesday, September 13, 2022
4:00 PM

Meeting via teleconference (Zoom)

DRAFT MINUTES

Quorum = Seven (7)

Members Present: Dr. Laura Bamford / Dr. David Grelotti / Katherine Penninga / Shannon Ransom / Dr. Stephen Spector / Lisa Stangl / Dr. Winston Tilghman (Chair) / Karla Quezada-Torres / Dr. Adam Zweig

Members Absent: Dr. Jeannette Aldous (Co-chair) / Bob Lewis / Dr. Susan Little / Mikie Lochner

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Tilghman called the meeting to order at 4:07 p.m. and noted the presence of a quorum. A moment of silence was observed.	
2. Action: Authorization of Teleconferencing Meeting Option Pursuant to Government Code Section 54953(e)	All votes at the meeting were taken by roll call. **Action:** Find the HPG has reconsidered the circumstances of the state of emergency and State and local officials have imposed or recommended measures to promote social distancing authorizing teleconferenced meetings pursuant to Government Code section 54953(e). **Motion/Second/Count (M/S/C):** Spector/Grelotti 7/0 **Abstentions:** Tilghman **Motion carries**	
3. Public Comment	A member of the public noted mouth guards are no longer provided via Ryan White (RW) dental services as they were in the past and they recommended mouth guards be added back to the list of available services.	
4. Sharing our Concerns	None	

Agenda Item	Action	Follow-up
5. Review and approve the September 13, 2022 meeting agenda	**Motion:** Approve the September 13, 2022 meeting agenda as presented. **M/S/C:** Ransom/Penninga 7/0 **Abstentions:** Tilghman **Motion carries**	
6. Review and approve the May 10, 2022 meeting minutes	**Motion:** Approve the May 10, 2022 meeting minutes as presented. **M/S/C:** Ransom/Grelotti 6/0 **Abstentions:** Bamford, Tilghman **Motion carries**	
7. Old Business:		
a. None	None	
8. New Business:		
a. **Workgroup Recommendations:** Consider Getting to Zero 3-Year Action Plan Recommendations	Dr. Delores Jacobs reviewed the four recommendations from the MSEC Work Group as noted: **Objective 1: Update Universal Standards** to ensure that clients, if interested, can participate in virtual medical visits, if appropriate and generally offered to clients. This change is intended to offer an opportunity for more equitable access vis-à-vis the provision of necessary equipment and some limited internet support. Resources are obtained either through Emergency Financial Services or Medical/Non-medical Case Management services. **Objective 2: Update Universal Standards/Intake Requirements** to include specific service information and assessments of food security, housing stability, transportation needs and emergency financial assistance **Objective 3: Update Client Rights and Responsibilities** to support inclusion of family and/or other identified support persons for clients in supporting their care. **Objective 4: Update Universal Standards** to include requirements for serving transgender clients, including whole-person care, hormone therapy and STD testing and treatment. Language to include in the Universal Standards for each of the above recommendations was outlined in the GTZ summary document reviewed at the meeting, which will also be forwarded to the Strategies and Standards Committee.	Forward the recommendations to the Strategies and Standards Committee for review along with the summary document which includes recommended language for changes to the service standards.

Agenda Item	Action	Follow-up
	Action: Forward the recommendations to the Strategies and Standards Committee for review as this involves changes to the Universal Service Standards. **M/S/C:** Zweig/Ransom 8/0 **Abstentions:** Tilghman **Motion carries**	
b. **Discussion:** MSEC Leadership	A member of the public had previously expressed concern that a staff member from the Recipient's office was chair of the committee. There is no rule against this from HRSA or in the HPG Bylaws. Dr. Winston Tilghman asked the members if anyone had concerns or would like to elect a new chair. Members expressed appreciation for Dr. Tilghman's work. Members also noted that the elected co-Chair had conflicts related to COVID and had been unable to attend meetings over the last year. The committee will continue to consider this topic.	
c. **Move the HIV Update presentation forward.**	**Motion:** Temporarily table the next two agenda items and move the HIV data presentation to occur that this point in the meeting. **M/S/C:** Grelotti/Bamford 7/0 **Abstentions:** Tilghman **Motion carries**	
d. HIV Update (Dr. Tweeten)	Dr. Samantha Tweeten provided an update on HIV Epidemiology for 2021 data and viral suppression data. The presentation was included in the meeting materials packet and an updated version will be placed on the HPG website, www.sdplanning.org.	Staff will place the updated presentation on the HPG website and email to committee members.
e. **Discussion:** Chart Review Tool – Jeanette Johnson	The committee reviewed the chart review tool and made the following recommendations: • Revise the definition of Viral Suppression to less than 200 (vs. less than 1000). For the purposes for resistance testing for patients on stable ART, the cutoff will remain 1000 since genotype testing typically requires a viral load of 1000 or higher. • For question #5 – add the date of test • Change syphilis screening from quarterly to "done within the review period". • Move the Annual Hepatitis C screening question to the top.	

Agenda Item	Action	Follow-up
	• Question #11 – Add Monkeypox and note if client is eligible for the vaccine/is in the high-risk category (if not, it should not be counted in the results) • Add Shingles vaccine	
f. **Discussion:** 2023 Committee Priorities and Workplan	The committee discussed whether the Practice Guidelines need to be updated and recommended it for early 2023. The committee will focus on the workplan at the November 2022 meeting.	Add updating Practice Guidelines to the MSEC workplan for 2023.
9. Other Updates:		
a. STD Update (Dr. Tilghman)	Dr. Tilghman noted the monthly STD reports were included in the meeting materials packet.	
10. Agenda items for future meeting	Tabled	
11. Reminder of upcoming meeting date:	**Date:** Tuesday, November 8, 2022 **Time:** 4:00 PM **Location:** Zoom	
12. Adjournment	5:32 p.m. (quorum lost at this point)	

RYAN WHITE PRIMARY CARE PROGRAM
Practice Guidelines Compliance Chart Review: 10/1/21 – 9/30/22

Case ID: _____ Reviewer: _____ Date: _____

HIV + ☐ AIDS DX ☐

Question 1 - Appointments -

Number of in-person visits in review period: _____ Number of telehealth visits in review period: _____
Follow-Up Appointment Documented: ☐ Yes ☐ No
Number of appointments (in-person or telehealth) missed by > 30 days: _____

Patient compliant (Did not miss more than one appointment (in-person or telehealth by 30 days): ☐ Yes ☐ No

Question 2 – Documentation that Antiretroviral Therapy was Prescribed

Was antiretroviral therapy prescribed: ☐ Yes ☐ No
Outcome: ❑ Prescribed ❑ Refused

Question 3 – Resistance Testing

Previous treatment with antiretroviral therapy: ☐ Yes ☐ No

Section 3A
VL > 1000 ☐ Yes ☐ No

Stable ART for at least 1 month prior to the VL >1,000 copies/mL? ☐ Yes ☐ No

Treatment Experienced Genotype: ☐ Yes ☐ No ☐ Not applicable

Section 3B
Date first diagnosis _____
Treatment Naïve Genotype: ☐ Yes ☐ No ☐ Not applicable

Question 4 – CD4 and VL Tests

Number of CD4 tests: _____				Number of VL tests: _____			
Date: 1st test	_____	Value	_____	Date: 1st test	_____	Value	_____
Date: 2nd test	_____	Value	_____	Date: 2nd test	_____	Value	_____
Date: 3rd test	_____	Value	_____	Date: 3rd test	_____	Value	_____
Date: 4th test	_____	Value	_____	Date: 4th test	_____	Value	_____
Date: 5th test	_____	Value	_____	Date: 5th test	_____	Value	_____
Date: 6th test	_____	Value	_____	Date: 6th test	_____	Value	_____
Date: 7th test	_____	Value	_____	Date: 7th test	_____	Value	_____

Question 4A – PCP Prophylaxis

PCP Prophylaxis: ❑ Yes ❑ No ❑ Exempt ❑ Refused/declined

Case ID: _____ Reviewer: _____ Date: _____

Question 5 - Sexually Transmitted Diseases

MSM ❑ Sexually Active ❑ Documented STD within last 12 months ❑ Newly enrolled in care ❑

Urogenital GC/CT: ❑ Yes ❑ No ❑ Refused/declined
Date of last test_____

GC Culture/NAAT (Throat): ❑ Yes ❑ No ❑ Refused/declined
Date of last test_____

GC Culture/NAAT (Rectal): ❑ Yes ❑ No ❑ Refused/declined
Date of last test_____

Chlamydia NAAT (Rectal): ❑ Yes ❑ No ❑ Refused/declined
Date of last test_____

Syphilis testing: ❑ Yes ❑ No ❑ Refused/declined
Date of last test_____

Sexual Risk and Drug Use Assessment: ❑ Yes ❑ No

Question 6 – Cervical Cancer Screening

Was cervical cancer screening status addressed? ❑ Yes ❑ No TAH ❑
Date of last Pap smear _____

Question 7 – Hepatitis A and B

Hep A screening? ❑ Yes _____ _____ _____
❑ No ❑ Immune/Vaccinated ❑ Refused/declined

Hep B screening? ❑ Yes _____ _____ _____
❑ No ❑ Immune/Vaccinated ❑ Refused/declined ❑ Active infection

Question 8 – Hepatitis C

Annual Hep C Screening during audit period? ❑ Yes ❑ No ❑ Refused/declined ❑ Active infection ❑Not applicable

Lifetime Hep C Screening? ❑ Yes ❑ No
❑ Prior confirmed Hep C ❑ Refused/declined

Is there ongoing risk of Hepatitis? ❑ Yes ❑ No. If Yes list risks
1. _____
2._____

Injection drug use (active or previous history, but not tested)? ❑ Yes ❑ No
Sexually active MSM? ❑ Yes ❑ No

Question 9 – Lipid screening

Case ID: _____ Reviewer: _____ Date: _____

Lipid screening? ❑ Yes ❑ No ❑ Refused/declined

Question 10 – Tuberculosis Assessment

Screening test (PPD or QuantiF) ordered during audit year? ❑ Yes ❑ No ❑ Prior positive ❑ Refused/declined

Type of test: ❑ PPD ❑ QuantiFERON
Documentation that PPD was placed? ❑ Yes ❑ No
Documentation that PPD was read? ❑ Yes ❑ No

Annual risk assessment done? ❑ Yes ❑ No (check if only prior positive)

10A –If positive, documentation of CXR or notation that CXR was done previously? ❑ Yes ❑ No (check if only TB positive)

Question 11 –Vaccination

Influenza vaccine? ❑ Yes ❑ No ❑ Refused/declined

Pneumococcal vaccine? ❑ Yes ❑ Pneumovax ❑ Prevnar
❑ No ❑ Refused/declined ❑ Exempt

Meningococcal vaccine (lifetime)? ❑ Yes ❑ No ❑ Refused/declined ❑ Exempt

COVID-19 vaccine ❑ Yes/addressed ❑ No/not addressed

Monkeypox vaccine ❑ Male ❑ Female ❑ Yes/addressed ❑ No/not addressed
❑ 1st dose ❑ 2nd dose

Shingles ❑ Yes/addressed ❑ No/not addressed ❑ Refused/declined

Question 12 – Treatment Adherence and HIV Risk Counseling

Treatment adherence counseling? ❑ Yes ❑ No ❑ N/A (not on treatment) ❑ Refused/declined
HIV Risk Counseling? ❑ Yes ❑ No ❑ Refused/decline

Counseling regarding disclosure to sex and needle sharing partners and/or referral to HIV Partner Services? ❑ Yes ❑ No ❑ Refused/declined
❑ N/A (Patient is virally suppressed)

Question 13 – Dental

Documentation of Dental Referral/Recommendation/Dental Care addressed: ❑ Yes ❑ No

County of San Diego, Health and Human Service Agency
Ryan White Primary Care Medical Care

Allowable Dental Services List

The following dental services may be billed to the Ryan White Primary Care when provided to enrolled Ryan White Primary Care Pool patients. HIV positive patients in need of dental services not specifically listed below should be referred to the Specialty Care Coordinator at AIDS Healthcare Foundation.

Service description restrictions are described on Page 2 of this document.

Code	Service Description
D0120	Periodic oral evaluation
D0140	Limited oral evaluation - problem focused
D0150	Comprehensive oral evaluation
D0210	Intraoral - complete series (including bitewings)
D0220	Intraoral - periapical, single, first film
D0230	Intraoral periapical, single, additional files (10 maximum)
D0272	Bitewings - 2 films [1]
D0274	Bitewings - 4 films [1]
D0330	Panoramic film [2]
D1110	Prophylaxis – adult
D2140	Amalgam, one surface, primary or permanent tooth
D2150	Amalgam, two surfaces, primary or permanent tooth
D2160	Amalgam, three surfaces, primary or permanent tooth
D2161	Amalgam, four or more surfaces, primary or permanent tooth
D2330	Resin-based composite – one surface, anterior
D2331	Resin-based composite – two surfaces, anterior
D2332	Resin-based composite – three surfaces, anterior
D2335	Resin-based composite – four or more surfaces, anterior
D2391	Resin-based composite – one surface, posterior
D2392	Resin-based composite – two surfaces, posterior
D2393	Resin-based composite – three surfaces, posterior
D2394	Resin-based composite – four or more surfaces, posterior
D2910	Recement inlay
D2920	Recement crown
D2950	Core build-up, including pins when required
D2951	Pin retention
D2952	Cast post and core, indirectly fabricated
D2954	Prefabricated post and core in addition to crown
D4341	Generalized periodontal scaling. Therapeutic, not prophylactic.
D4342	Localized periodontal scaling. Therapeutic, not prophylactic.
D4355	Full mouth debridement [5, 6, 7]
D4910	Periodontal Maintenance Procedures [8, 9]
D5110	Complete Denture - Maxillary [10]
D5120	Complete Denture - Mandibular [10]

Allowable Dental Services List

Code	Service Description
D5211	Maxillary Partial Denture, resin base [10]
D5212	Mandibular Partial Denture, resin base [10]
D5510	Repair broken complete denture base
D5520	Repair missing or broken teeth - complete denture
D6930	Recement fixed partial denture
D7111	Extraction, coronal remnants - deciduous teeth
D7140	Extraction, erupted tooth or exposed root
D7210	Removal of erupted tooth, surgical
D7220	Remove impacted tooth – soft tissue
D7230	Remove impacted tooth – partial bony
D7240	Remove impacted tooth – completely bony
D7241	Remove impacted tooth – unusual surgical complication
D7250	Surgical removal residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7285	Biopsy of oral tissue - hard
D7286	Biopsy of oral tissue - soft
D7310	Alveoplasty with extractions – per quadrant
D7320	Alveoplasty (no extractions) – per quadrant
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7510	Incision and drainage of abscess - intraoral soft tissue
D7510	Incision and drainage of abscess, intraoral
D7971	Excision pericoronal gingiva
D9110	Palliative (Emergency) treatment of dental pain, minor
D9630	Antibacterial (Peridex) mouth rinse – on formulary
D9930	Postoperative visit, complications (e.g., osteitis)

Footnotes (Restrictions)	
1.	**Once annually**
2.	**Once every 3 years**
3.	**Each quad limited to once every 24 months**
4.	**Periodontal procedures on the same date of service are not covered for any combination of the following codes: D1110, D1120, D4210, D4240, D4260, D4341, D4910**
5.	**Debridement allowed once every three years (provided D1110, D4910, D4341, have not been done within the last three years)**
6.	**Debridement is not a substitute for difficult prophylaxis**

7.	**Not allowed on the same day as D1110, D4910 or D4341**
8.	**Limit 2 within 12 months**
9.	**Requires history of periodontal therapy (D4210, D4211, D4240, D4260, D4341 [except D4249 and D4355])**
10.	**Once every 5 years**

Practice Guidelines for the Care of Persons Living with HIV/AIDS

Ryan White HIV Treatment Extension Act of 2009

San Diego County

In conjunction with United States (U.S.) Public Health Service (PHS) guidelines and accepted community practices, the San Diego County HIV Planning Group's Medical Standards and Evaluation Group recommends the following practice guidelines for the management of human immunodeficiency virus (HIV) infection in patients enrolled in the Ryan White Primary Care Program of San Diego County.

Antiretroviral therapy (ART) and opportunistic infection (OI) prophylaxis (primary and secondary) are recommended in accordance with the most recent PHS guidelines. Guidelines may have been updated since the versions listed below; current versions are available at https://clinicalinfo.hiv.gov/en/guidelines.

For San Diego County Ryan White Clinics, chart reviews and performance assessments conducted on behalf of the County of San Diego Health and Human Services Agency (HHSA) – Division of Public Health Services – HIV, STD, and Hepatitis Branch (HSHB) will be based upon these guidelines.

A. Guidelines for Staging and Baseline Evaluation (recommended to be completed within the first two visits)

1) Complete history, to include at least the following:
   a. *General background:*
      - Race/ethnicity
      - Current gender identity
      - Sex assigned at birth
      - Housing status
      - Family history
      - Social history
      - Travel history
      - Country of birth
   b. *Current/lifetime sexual history: (See Appendix A for example)*
      - Sexually transmitted infection/disease (STI/STD) history during lifetime and/or last 5 years
      - Relationship status
      - Detailed sexual history
      - Partner(s), including HIV status and history of pre-exposure prophylaxis (PrEP) use
      - Exposure sites – anorectal, genital, oropharyngeal
      - Use of condoms
   c. *Current/lifetime substance use history:*
      - Injection drug use (IDU), during lifetime and/or last 5 years
      - Non-injection drug use, during lifetime and/or last 5 years
      - Alcohol and/or drug treatment history
      - Sexual activity under the influence of substances
      - Tobacco use, during lifetime and/or last 5 years
   d. *HIV care history:*
      - HIV status, including recent/historical CD4+ T-cell count/HIV-1 viral load
      - Prior and current antiretroviral regimens
      - Resistance test results (if available)
      - Current prophylaxis
      - Prior HIV-related complications
   e. *General medical history:*
      - Immunizations

- Hepatitis history
- Tuberculosis (TB) risk http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SanDiegoRiskAssessment-Adults.pdf
- Reproductive history (persons assigned female at birth), including parity, last menstrual period (LMP), and method of birth control
- Current allergies
- Other current medications
- Significant childhood illnesses
- Surgical history
- Mental health history, past/current mental health conditions, symptoms of depression, and psychiatric medications
- Other medical history

2) Review of symptoms and general physical exam, including height, weight, temperature, blood pressure, pulse, respiratory rate, general appearance, skin, head, eyes, ears, nose and throat (HEENT), ophthalmoscopy, chest, heart, lungs, abdomen, rectum, anoscopy (if anorectal symptoms), pelvic (persons assigned female at birth), breasts, genitalia, extremities, lymph nodes, mental status, nervous system including reflexes
3) Laboratory tests
   a. For the current list of recommended labs and periodicity, please refer to PHS Guidelines for Laboratory Testing for Initial Assessment and Monitoring of Patients with HIV Receiving Antiretroviral Therapy.
   b. STI Testing
      - Should be performed at baseline and at least annually thereafter for sexually active clients, more frequently (i.e., every three to six months) if indicated based upon the client's sexual practices.
      - Syphilis serology
      - Gonorrhea/Chlamydia – Perform three-site testing (i.e., urogenital, throat, rectum) using nucleic acid amplification testing (NAAT). If antibiotic-resistant *Neisseria gonorrhoeae* is suspected, obtain *N. gonorrhoeae* culture from all exposure sites.
      - Trichomoniasis – Screening with NAAT should be performed annually for persons having vaginal sex.
      - Anal Pap test (optional) – See **Section G – Anal Cancer Screening**.
      - Resources:
        - Centers for Disease Control and Prevention (CDC) Recommendations for Providing Quality STD Clinical Services, 2020
        - CDC Interim Guidance for STD Care and Treatment During Disruption of Clinical Services
        - CDC STD Treatment Guidelines, 2015
        - Updated CDC Gonorrhea Treatment Recommendations, 2020
        - CDC Recommendations for the Laboratory-Based Detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae*, 2014
   c. TB Testing
      - Annual screening in the form of Annual Risk Assessment: http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SanDiegoRiskAssessment-Adults.pdf
      - Annual screening using purified protein derivative (PPD) or interferon-gamma release assay
        - If screening test is positive, the patient should have a chest x-ray.
      - Chest x-ray: At least one should be documented in the medical record if the individual has a history of TB or a positive screening test.
   d. Viral Hepatitis Testing
      - Hepatitis B screening should be performed by testing for hepatitis B surface antibody (HBsAb), surface antigen (HBsAg), and antibody to core antigen (anti-HBc or HBcAb). Those who are susceptible to infection should be vaccinated against Hepatitis B Virus (HBV) (see **Section C – Guidelines for Immunization**). Patients who are negative for HBsAg and

HBsAb but positive for anti-HBc should be screened for chronic HBV infection by determination of HBV deoxyribonucleic acid (DNA). Those without evidence of chronic infection should consider vaccination.
https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-b-virus-infection?view=full

- Hepatitis C screening with Hepatitis C Virus (HCV) antibody or, if recent (i.e., within last six months) infection is suspected, the patient has advanced immunodeficiency (CD4 count<100 cells/mm^3), or the patient has a history of successfully treated or spontaneously cleared HCV infection, ribonucleic acid (RNA) testing should be performed at baseline and at least annually for persons with ongoing risk factors (e.g., IDU) and sexually active men who have sex with men (MSM). HCV RNA should be ordered for all patients with a positive HCV antibody test to assess for active HCV disease.
https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-c-virus-infection?view=full

e. Other Testing:

- Measles antibody titer – All persons with HIV born in 1957 or after should be tested for immunity to measles by measuring antibody titers. The measles, mumps, and rubella (MMR) vaccine should be given to persons with CD4 ≥200 cells/mm^3 born in or after 1957 who have not received the vaccine or do not have immunity based on laboratory testing (see **Section C – Guidelines for Immunization**).

4) Appropriate referrals, including but not limited to:
   - Treatment adherence counseling
   - Ryan White dental program (recommended annually)
   - Ophthalmologist if CD4 <50 cells/mm^3 (recommended)
   - Case management (if eligible)
   - Medical nutrition therapy
   - Clinical trials
   - Mental health
   - Substance use treatment
   - Partner services/PrEP if client has not achieved sustained viral suppression

For a list of currently funded Ryan White Service Providers, please visit:
HIV/AIDS Care and Services Resources (sandiegocounty.gov)

B. Guidelines for Plasma HIV RNA (i.e., Viral Load) Measurements and CD4 Counts
https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/plasma-hiv-1-rna-viral-load-and-cd4-count-monitoring?view=full

1) HIV-1 RNA (i.e., Viral Load) – should be performed upon entry to care, before initiation of ART (if initiation of ART is deferred after entry to care), and within 2-4 weeks but no later than 8 weeks after ART initiation. After initiation or modification of ART, repeat at 4-8-week intervals until undetectable. Continue to monitor every 3-4 months during the first 2 years of ART, and then frequency can be decreased to every 6 months if the viral load is consistently undetectable for two years and the CD4 is >500 cells/mm^3.
2) CD4+ T-cell Count (i.e., CD4 Count) – should be performed upon entry to care and three months after initiation of ART (every 3-6 months in patients who defer ART). After initiation or modification of ART, repeat every 3-6 months during the first 2 years or if the CD4 count is <300 cells/mm^3 or if there is any viremia while on ART. May monitor every 12 months if the patient has consistently been on ART with a suppressed viral load and CD4 count 300-500 cells/mm^3. Optional once CD4 is consistently >500cells/mm^3 and viral load has been undetectable for >2 years.

C. Guidelines for Immunization
Adult Immunization Schedule by Vaccine and Age Group | CDC
Vaccines Indicated for Adults Based on Medical Indications | CDC

1) Should be offered as soon as possible after initial evaluation at recommended doses.
2) Viral loads should not be measured within three weeks of an immunization.
3) Pneumococcus (both types), influenza, tetanus, Hepatitis B (if not immune), Hepatitis A (if not immune), human papillomavirus (HPV), meningococcal

4) Influenza vaccine: recommended yearly with trivalent inactivated vaccine (live attenuated vaccine is contraindicated in persons living with HIV or PLWH).

5) HPV: Recommended for all PLWH through age 26 years as a three-dose series, regardless of the age at initial vaccination. Vaccination may be considered, based on shared clinical decision-making, for persons aged 27-45 years.

https://www.cdc.gov/mmwr/volumes/68/wr/mm6832a3.htm

6) Varicella zoster: Two doses of the Shingrix vaccines should be given to patients over the age of 50 years with CD4 count >200 cells/mm^3.

7) Hepatitis Vaccines:

a. Hepatitis B: Recommended in persons with negative serology or isolated positive core antibody (i.e., negative surface antigen and antibody). Double dosing (i.e., 40μg) of single-antigen three-dose vaccines is recommended to increase seroconversion rates. For those patients who do not seroconvert after the first series, a second series is recommended. If these persons do not seroconvert, they are unlikely to respond to a third series. The safety and efficacy of the two-dose vaccine has not been evaluated in PLWH but is an option if a two-dose regimen is preferred. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-b-virus-infection?view=full

b. Hepatitis A: Seroconversion rates are likely related to CD4 counts. The vaccine may be given in persons who are seronegative. However, if there is no response and the CD4 counts are less than 500 cells/mm^3, persons can receive a repeat series when CD4 counts are higher.

8) Pneumococcal: Both the 13-valent pneumococcal conjugate vaccine (PCV13) and the 23-valent pneumococcal polysaccharide vaccine (PPV23) are recommended, with the final dose of PPV23 given at ≥65 years of age and ≥5 years after previous PPV23 doses given before age 65 years. For specific recommendations regarding timing of PCV13 and PPV23 doses, see https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/community-acquired-pneumonia-cap?view=full.

9) Meningococcal: Vaccination against serogroups A, C, W, and Y is recommended for all persons living with HIV aged ≥2 years. https://www.cdc.gov/mmwr/volumes/65/wr/mm6543a3.htm. Vaccination against serogroup B is recommended for persons aged ≥10 years who are at increased risk for serogroup B meningococcal disease due to certain underlying conditions or a serogroup B outbreak. HIV disease is not one of the underlying conditions for which serogroup B vaccination is recommended. Serogroup B vaccination may be considered for adolescents and young adults aged 16-23 years on the basis of shared decision-making. https://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

10) Tetanus vaccines: Recommended every 10 years. Recommend that the next booster contain pertussis booster (Tdap) (make sure the patient has had the pertussis vaccine)

11) Live Vaccines (Live attenuated influenza vaccine, Varicella or Zoster vaccine, Vaccinia (small pox), Yellow Fever, Live Oral Polio, Measles*, Typhoid) are contraindicated in persons with severe immunosuppression based on the person's age (per Advisory Committee on Immunization Practices or ACIP): CD4<750 for those younger than 12 months, <500 for those aged 1-5 years, and <200 for those >6 years old.

*The MMR vaccine should be given to persons with CD4 ≥200 cells/mm^3 born in or after 1957 who have not received the vaccine or do not have immunity based on laboratory testing.

12) Booster doses as recommended by CDC guidelines.

D. Treatment:

1) All PLWH should receive ART, regardless of CD4 count, to reduce morbidity and mortality, improve health outcomes, and prevent transmission of HIV to others.

2) Whenever possible, treatment should be initiated immediately (or as soon as possible) after diagnosis.

a. Same-day treatment should be offered if there are no medical indications to defer therapy (e.g., signs/symptoms of intracranial OI).

b. If treatment is offered before the results of treatment-naïve genotype are available, an integrase inhibitor-based regimen is recommended.

3) All PLWH should be informed that maintaining a plasma HIV RNA (viral load) of <200 copies/mL, including any measurable value below this threshold value, with ART prevents sexual transmission of HIV to their partners. Patients may recognize this concept as Undetectable = Untransmittable or U=U.

4) Guidelines on antiretroviral treatment regimens can be found at https://aidsinfo.nih.gov/guidelines.

5) At the time of revision, an extended-release, injectable drug regimen (coformulation of cabotegravir and rilpivirine) was approved by the Food and Drug Administration (FDA) to replace the current antiretroviral regimen for patients with viral suppression on a stable ART regimen without history of treatment failure and with no known or suspected resistance to either agent. Long-acting injectable ART may be considered for eligible patients and should be administered according to Department of Health and Human Services guidelines: https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/hhs-adults-and-adolescents-antiretroviral-guidelines-panel.

6) For patients with HBV coinfection, as determined by a positive HBsAg or HBV DNA test result, tenofovir disoproxil fumarate or tenofovir alafenamide, plus either emtricitabine or lamivudine, should be used as part of the ART regimen to treat both HBV and HIV.

7) Patients with HCV coinfection should be managed based on the most up-to-date recommendations (http://www.hcvguidelines.org). In general, the goals of therapy, treatment regimen, and monitoring parameters for HIV/HCV-coinfected patients are similar to those recommended for HCV-monoinfected patients.

E. Metabolic and Other Noncommunicable Comorbidities Associated with HIV, ART, and Aging

1) The availability of highly effective HIV treatment has resulted in longer life expectancy for PLWH and a larger proportion of PLWH who are aged 50 years or older.
2) For all PLWH aged 50 years or older, providers should closely monitor for and promptly evaluate signs or symptoms of the following conditions that are associated with advanced age, long-term HIV infection, ART, or a combination of these:
   a. Cardiovascular disease and associated risk factors (e.g., hyperlipidemia, glucose intolerance or diabetes mellitus, hypertension, smoking)
   b. Osteoporosis and bone mineral density loss
   c. Hypogonadism
   d. Neurocognitive decline
   e. Mental health conditions, such as depression
   f. Polypharmacy
   g. Kidney disease
   h. Certain non-acquired immune deficiency syndrome (AIDS)-related cancers
3) Specific recommendations regarding metabolic and noncommunicable comorbidities include:
   a. Check lipid levels prior to and within 1-3 months after starting ART. Patients with abnormal lipid levels should be managed according to national guidelines.
   b. Random or fasting blood glucose and hemoglobin A1c (HbA1c) should be obtained prior to starting ART. If random glucose is abnormal, fasting glucose should be obtained. After ART initiation, only plasma glucose criteria should be used to diagnose diabetes. Patients with diabetes mellitus should have an HbA1c level monitored every 6 months with an HbA1c goal of <7%.
   c. Baseline bone densitometry (DXA) screening for osteoporosis in post-menopausal women and men aged ≥50 years. Screening for transgender persons should follow national recommendations based on sex assigned at birth and individualized risk of osteoporosis.
   d. Testosterone replacement therapy for cisgender men should be prescribed with caution and only in those with symptomatic hypogonadism diagnosed based on the presence of symptoms plus low serum testosterone documented on two separate morning lab tests.

   Primary Care Guidance for Persons with Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America: https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1391/5956736

F. Additional Guidelines for Care of Persons Assigned Female at Birth

1) Guidelines for Cervical Neoplasia (modified Algorithm 6 of AHCPR 94-0573):

https://hab.hrsa.gov/sites/default/files/hab/About/clinical-quality-management/adolescentadultmeasures.pdf

a. Age <21 years: Pap test within one year of sexual activity and no later than age 21
b. Age 21-29 years: Pap test at time of HIV diagnosis. Repeat yearly for three years. If all tests are normal, repeat Pap test every three years thereafter.
c. Age <30 years: No HPV testing should be performed unless abnormalities are found on Pap test.
d. Age ≥30 years: Pap only (same as for 21-29 years) or Pap with HPV testing. If both tests are negative, repeat Pap with HPV test every three years thereafter.
e. If three consecutive Pap tests are normal, then a follow-up test should be done every three years.
f. Patients with abnormal Pap smears or a history of an untreated abnormal Pap smear should be referred for colposcopy and should receive same management and follow-up as the general population.
Refer to American College of Obstetrics and Gynecology (ACOG) guidelines for management of abnormal cervical cancer screening results:
https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/10/updated-guidelines-for-management-of-cervical-cancer-screening-abnormalities
f. Cervical cancer screening should continue throughout the patient's lifetime and not, as in the general population, end at 65 years of age.

2) Annual mammograms initiated at age 50 or earlier depending on history
3) Treatment for pregnant persons living with HIV – recommend referral to specialist (i.e., UCSD Maternal, Child & Adolescent Program)

G. Anal Cancer Screening:

1) Persons with a history of receptive anal intercourse or abnormal cervical Pap tests and all persons with genital warts should have an anal Pap test if access to appropriate referral for follow-up, including high-resolution anoscopy, is available.
2) Digital anorectal exam should be performed at least annually for asymptomatic persons.

H. PrEP and Partner Prevention Services – Assess HIV status of partner(s) and evaluate for PrEP referral for all patients living with HIV who have not achieved sustained viral suppression. Please note that Ryan White does not provide reimbursement for PrEP services for HIV-negative partners.

1) For guidelines regarding evaluation for and provision of PrEP, please refer to the U.S. PHS Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update. Please note that parts of these guidelines may be outdated, as a second agent (coformulation of emtricitabine and tenofovir alafenamide) received FDA approval for use as PrEP for persons assigned male at birth and may be preferred for certain patients at higher risk of renal and/or bone toxicity.
https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf
2) For guidelines regarding partner services for PLWH, please refer to the Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection.
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm

I. HIV Management Guidelines for Transgender Individuals – Primary care of transgender PLWH should address the specific needs of this population and include careful attention to potential interactions between gender-affirming therapy and ART and/or OI prophylaxis medications. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, from the Center of Excellence for Transgender Health at the University of California, San Francisco, include recommendations for transgender individuals living with HIV and can be accessed at https://transcare.ucsf.edu/guidelines.

J. Interim Guidance for COVID-19 and PLWH – At the time of revision, the County of San Diego was in a state of emergency due to the rapidly evolving Coronavirus Disease 2019 (COVID-19) pandemic caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

While the limited data currently do not indicate that the course of COVID-19 in PLWH differs from that in persons without HIV, caution is warranted. Some people with HIV may have comorbidities (e.g., cardiovascular disease, lung disease, chronic smoking) that increase risk of more severe disease.

1) All patients should maintain on-hand at least a 30-day (and ideally a 90-day) supply of ART.
2) Influenza and pneumococcal vaccinations should be kept up to date.
3) COVID-19 vaccination should be administered based on CDC and Advisory Committee on Immunization Practices (ACIP) guidance. http://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html.
4) All patients should receive COVID-19 vaccination when eligible based on California state guidelines.
5) Telephone and virtual visits for routine non-urgent care should be considered as an option to encourage retention in care.
6) For further guidance, please refer to the U.S. PHS Interim Guidance for COVID-19 and Persons with HIV, available at https://clinicalinfo.hiv.gov/en/guidelines/covid-19-and-persons-hiv-interim-guidance/interim-guidance-covid-19-and-persons-hiv.

Source Documents

1. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS), accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines

2. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS), accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/whats-new-guidelines

3. San Diego Tuberculosis (TB) Risk Assessment, accessed on April 19, 2021 http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SanDiegoRiskAssessment-Adults.pdf

4. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV – Laboratory Testing – Laboratory Testing for Initial Assessment and Monitoring of Patients with HIV on Antiretroviral Therapy (DHHS), accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/tests-initial-assessment-and-follow?view=full

5. Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020 (CDC), accessed on April 19, 2021 https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm#:~text=CDC%20organized%2020the%20recommendations%20for,STD%20or%20STD-related%20conditions.

6. Interim Guidance for STD Care and Treatment During Disruption of Clinical Services (CDC), accessed on April 19, 2021 https://www.cdc.gov/std/dstdp/DCL-STDTreatment-COVID19-04062020.pdf

7. Sexually Transmitted Diseases Treatment Guidelines, 2015 (CDC), accessed on April 19, 2021 https://www.cdc.gov/std/tg2015/tg-2015-print.pdf

8. Update to CDC's Treatment Guidelines for Gonococcal Infection, 2020, accessed on April 19, 2021 https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm?s_cid=mm6950a6_w

9. Recommendations for the Laboratory-Based Detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* – 2014 (CDC), accessed on April 19, 2021

https://www.cdc.gov/std/laboratory/2014labrec/2014-lab-rec.pdf

10. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS) – Hepatitis B Virus Infection, accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-b-virus-infection?view=full

11. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS) – Hepatitis C Virus Infection, accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/hepatitis-c-virus-infection?view=full

12. County of San Diego HHSA Ryan White Primary Care Program Information for Patients https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/hiv_std_hepatitis_branch/HIVAIDSCareandServices/hiv-aids-care-and-services-resources.html#eligibility

13. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS) – Laboratory Testing – Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring, accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/plasma-hiv-1-rna-viral-load-and-cd4-count-monitoring?view=full

14. Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2021 (CDC), accessed on April 26, 2021 https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

15. 2021 Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2021 (CDC), accessed on April 26, 2021 https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html

16. Human Papillomavirus Vaccination for Adults: Updated Recommendations of the Advisory Committee on Immunization Practices, 2019 (CDC), accessed on June 4, 2021 https://www.cdc.gov/mmwr/volumes/68/wr/mm6832a3.htm

17. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (DHHS) – Community-Acquired Pneumonia, accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/community-acquired-pneumonia-cap?view=full

18. Recommendations for Use of Meningococcal Conjugate Vaccines in HIV-Infected Persons – Advisory Committee on Immunization Practices, 2016, accessed on April 19, 2021 https://www.cdc.gov/mmwr/volumes/65/wr/mm6543a3.htm

19. Meningococcal Vaccination: Recommendations of the Advisory Committee on Immunization Practices, United States, 2020, accessed on June 4, 2021 https://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

20. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS) – HHS Adults and Adolescents Antiretroviral Guidelines Panel Recommendation for the Long-Acting Injectable Antiretroviral Regimen of Cabotegravir and Rilpivirine, accessed on April 19, 2021 https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/hhs-adults-and-adolescents-antiretroviral-guidelines-panel

21. HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C – American Association for the Study of Liver Disease (AASLD) and Infectious Diseases Society of American (IDSA), accessed on April 19, 2021 https://www.hcvguidelines.org

22. Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America, accessed on April 19, 2021

https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1391/5956736

23. HIV/AIDS Bureau Performance Measures for Cervical Cancer Screening March 2016 https://hab.hrsa.gov/sites/default/files/hab/About/clinical-quality-management/adolescentadultmeasures.pdf

24. Updated Guidelines for Management of Cervical Cancer Screening Abnormalities, American College of Obstetrics and Gynecology (ACOG), accessed on April 19, 2021 https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/10/updated-guidelines-for-management-of-cervical-cancer-screening-abnormalities

25. U.S. Public Health Services Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update, A Clinical Practice Guideline, accessed on April 19, 2021 https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf

26. Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection (CDC), accessed July 24, 2017 https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm

27. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (UCSF Transgender Care), accessed on April 19, 2021 https://transcare.ucsf.edu/guidelines

28. Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States (CDC), accessed on April 19, 2021 https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=http%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html

29. Interim Guidance for COVID-19 and Persons with HIV (DHHS) https://clinicalinfo.hiv.gov/en/guidelines/covid-19-and-persons-hiv-interim-guidance/interim-guidance-covid-19-and-persons-hiv

APPENDIX A
SAMPLE Sexual Health
Risk Assessment Form

Sexually transmitted diseases (STDs) raise the amount of HIV in the body and can make HIV easier to pass to another person. Alcohol and drugs can harm your immune system, stop HIV medication from working properly and increase side effects. To help your doctor help you stay healthy and lower your risk of passing HIV and STDs to others, please answer the following questions honestly. Your answers are entirely confidential.

1. Have you had sex (oral, vaginal, anal) within the **last 3 months**? □ Yes / □ No / □ Decline
   (If you answered **No please skip to #6**)

2. In the **last 3 months**, how many sexual partners did you have? # _____ Male / # _____ Female / # _____ Transgender

3. How often did you use condoms?
   □ Always (100%) / □ Most of the Time (75% or more) / □ Sometimes (50%) / □ Seldom (25%) / □ Never (0%)

4. In the **last 3 months** how many times have you had sex without using a condom?
   # _____ Oral / #_____ Vaginal / # _____Anal; check one: □ Insertive (top) / □ Receptive (bottom) / □ Both

5. In the **last 3 months** what was the HIV status of your sex partner(s)? (Check all that apply)
   □ Positive / □ Negative / □ Unsure

6. Have you had any of the following symptoms in the **last 3 months**? **Yes** **No**

Discharge from penis/vagina	□	□
Burning feeling with urination	□	□
Sores on your genitals	□	□
Anal discharge or pain	□	□
Mucous or blood in your stool	□	□
Throat sores or pain	□	□
Skin rash	□	□

7. Have you been diagnosed with a sexually transmitted disease (STD, such as Syphilis, Chlamydia, Gonorrhea, NGU, Genital Warts, and Genital Herpes) in the **last 3 months**? (Check one): □ Yes / □ No / □ Don't know
   If you answered yes, did you complete treatment? (Check one): □ Yes / □ No / □ Don't know

8. In the **last 3 months** have you used **non-injection** street drugs 9i.e. marijuana, meth, crystal, speed, glass, crack, ecstasy. cocaine)? □ Yes / □ No

9. Have you **ever injected** steroids, hormones, vitamins or street drugs? □ Yes / □ No
   a. If you answered yes, when was the last time you injected? _____
   b. Did you ever share needles? □ Yes / □ No

10. In the **last 3 months** do you feel that your alcohol or drug use caused you to engage in risky activities (i.e. unprotected sex, needle sharing), even once? □ Yes / □ No

11. Would you be interested in help to inform your sex and/ or needle sharing partner(s) of possible HIV exposure?
    □ Yes / □ No / □ Maybe

If you answered Yes or Maybe and would like to speak to a Counselor, please tell us the best way to contact you:
Phone: _____ Can we leave a confidential message? □ Yes / □ No
Text: _____ Email: _____

Provider/Staff Signature: _____

Change History:

Originally adopted by the HIV Health Services Planning Council in July 2000
Proposed changes adopted by the HIV Health Services Planning Council in May 2003
Proposed changes adopted by the HIV Health Services Planning Council in June 2004
Proposed changes adopted by the HIV Health Services Planning Council in September 2007
Incorporated references updated as necessary
Proposed changes adopted by the HIV Planning Group on August 9, 2017
Proposed changes adopted by the HIV Planning Group on September 22, 2021

Medical Standards and Evaluation Group participants who contributed to the revised document include:

Jeannette Aldous, MD San Ysidro Health Center

Joe Burke, South Bay Alliance

Beth Davenport, LCSW, MBA San Diego LGBT Community Center

David Grelotti, MD UC San Diego

Bob Lewis, Family Health Centers of San Diego

Susan Little, MD UC San Diego

Katherine Penninga, LCSW San Ysidro Health Center

Shannon Ransom, MSW UC San Diego

Stephen Spector, MD UC San Diego

Lisa Stangl, NP UC San Diego

Winston Tilghman, MD County of San Diego

Karla Torres, San Ysidro Health Center

HIV Planning Group
Subcommittee Operating Guidelines
Ad Hoc Subcommittee(s)
Care Partnership Subcommittee
Consumer Subcommittee
Medical Standards and Evaluation Subcommittee
Non-Medical Standards and Evaluation Subcommittee
Needs Assessment Subcommittee
Strategies Subcommittee

Reviewed and Revised at the 11/13/2018 Steering Committee Meeting

Committee Meeting Guidelines:
Committee meetings provide opportunities for the public and HPG members who are not officially appointed to the committee to participate in committee discussions. All are welcome to attend and have the right and are encouraged to participate discussions throughout the duration of the meeting, as they inform the decisions of the committee. Committee agendas, minutes and reports are all available at least 72 hours prior to the committee meeting (24 hours prior to special meetings) on the website www.sdplanning.org. Copies for all attendees are available at the meeting. They are also available to be mailed upon request to the HPG support staff. A sign in sheet is used to track all those in attendance.

Meeting Structure:
1. The HIV Planning Group (HPG) and all of its Committees operate in accordance with the State of California's Robert M. Brown Act, which establishes guidelines that guarantee the public's right to attend and participate in meetings of local legislative bodies. A sample meeting agenda appears at the end of this document.
2. Before the meeting can begin, a quorum is established to confirm that a simple majority of the committee members are present. Committee members' names are listed on the agenda. If a quorum is not present, the meeting is called to order, attendance is taken and the meeting is adjourned or recessed until a quorum is present.
3. The meeting begins with a call to order, introductions and comments from chairs. Each committee member and all attendees introduce themselves with their affiliations. Comments from the chairs may include a welcome and reminders about the areas that are and are not the purview of the committee.
4. There is an opportunity for public comment not related to any agenda items at the beginning of the meeting and an opportunity for announcements at the end of the meeting. Discussion during the meeting should remain focused on the current agenda topic being addressed.
5. Action items to approve the day's agenda and to review and approve the last meeting's minutes may be accepted by consensus by verifying if any changes need to be made and confirming that all present committee members agree the minutes accurately represent the meeting.

6. During the old business section of the agenda, the committee addresses topics already introduced at previous meeting(s).
7. After old business is concluded, there are new business or agenda items presented for the first time.
8. During old and new business portions of the meetings to support participation and decision-making, the committee will attempt to reach consensus. If consensus cannot be reached, a formal vote of the voting members and a simple majority will be the deciding factor. All those in attendance are encouraged to provide information and/or express their consent or dissent on topics during the discussion.
9. Committee business should at no time be discussed outside of noticed meetings. Outside of meetings, any communications related to the business of the HPG or committee should be directed to support staff.

A few Additional Guidelines:

1. When speaking during the meeting, all are encouraged to participate and introduce themselves because it is important that everyone knows who is participating, their affiliations and their role in the planning process.
2. As possible, minimize use of acronyms and jargon, but if utilized please call them out and explain what they mean so that everyone understands.
3. To support the decision making process, there may be requests for information from different sources outside of what is available. This may require that the topic be deferred as old business until a future meeting when the additional information is available.

Becoming a Member of the Committee:

1. HIV Planning Group (HPG) members are appointed to committees by the HPG Chair based on the member's preference, expertise and availability.
2. Community members not on the HPG may also be appointed to the committee by informing the committee chair of their desire to participate on the committee. The committee chair confers with the HPG chair who makes the appointment and support staff document. Committee appointments must be made 72 hours prior to the committee meeting so all current committee member's names can be listed on the posted agenda for the meeting to support establishing a quorum for the meeting. If the request to be on the committee is made at the committee meeting, the appointment will become official at the subsequent committee meeting.
3. To remain in good standing with the right to vote, members must meet attendance requirements, such that in a 12-month period a member may not miss 4 consecutive meetings or 6 total meetings. Attendance is tracked by support staff and reviewed at the committee meetings. Members not able to participate in the required number of committee meetings may participate as non-voting members.
4. For the purpose of attendance, meetings are those which have been appropriately noticed and where a quorum is present.

Selection and Role of the Committee Co-chair

1. Any committee member may be elected as the committee's co-chair by consensus or a simple majority vote of the committee members regardless of their membership status on the HPG.
2. Nominees for the co-chair position can be made by committee members or through self-nomination.
3. Elections are held as vacancies occur.
4. The co-chair serves in the absence of the chair or when the chair has a conflict of interest. Duties include: conducting committee meetings, attending Steering Committee, and acting as a liaison with HPG support staff.

Subcommittee Charges and Definitions:

Documentation with the charge of each committee and definitions are available at (add link).

If you have any questions or concerns, please do not hesitate to ask HIV Planning Group support staff.

SAMPLE AGENDA:

HIV PLANNING GROUP, (name of subcommittee)
Date, Time, Location
Subcommittee Charge

DRAFT AGENDA

1. Call to order; introductions; comments from the chair
2. Public comment
3. Review and approve agenda for …
4. Review and approve minutes from …
5. AIDS Regional Information and Evaluation System (ARIES) update
6. Local Evaluation Online (LEO) update
7. Old business
   a) …
8. New business
   a) …
9. Suggested items for the committee agenda
10. Announcements
11. Confirm next meeting: date, time, location:
12. Adjournment

Telephonic Participation

HIV Planning Group members, committee members and the public have an option to participate in all public meetings telephonically (via conference call or webinar).

- Members of the public may participate in any HIV Planning Group or committee meeting telephonically by calling into the bridge line as noted on meeting agenda.
- HIV Planning Group and/or committee member may participate telephonically provided:
  - advise support staff 96 hours in advance of the location
  - location must be ADA accessible to members of the public
  - agenda for the committee must include the location
  - agenda must be posted at the remote meeting location with 24-hour access for public viewing 72 hours prior to the meeting
  - member(s) participating telephonically will count towards a quorum by may not vote
  - when member(s) participate remotely all votes of the committee must be taken individually through a roll call

Medical Standards and Evaluation Committee
Standard ~~Operation~~ Operating Procedures

The Charge of the Medical Standards and Evaluation Committee of the HIV Planning Group: To 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 People Living With HIV/AIDS (PLWHA)

Committee Meeting Guidelines:
Committee meetings are intended to provide opportunities for public (people living with or at risk for transmitting or acquiring HIV, community members, service providers, etc.) to participate in discussions and inform votes of the committee. Committee agendas, minutes and reports are all available at least 72 hours prior (24 hours prior for ad-hoc committee meetings) to the committee meeting (www.sdplanning.org) and for all attendees at the meeting, along with the sign in sheet for all attendees and committee members.

Meeting Structure:
Meetings begin with a call to order once quorum is established, committee introductions and comments from the Chair. A quorum is established to conduct business, including any votes, when 50% plus one of the total membership of the committee (committee members' names are listed on the agenda) is present. If there is not a quorum, the Chair will call the meeting to order, state there is not a quorum and immediately adjourn.

Following these explanations there is an opportunity for any **Non-Agenda Public Comment** (any public comments that concern items not listed on the day's agenda) prior to the review of the meeting's agenda.

Action items to **approve the day's agenda** and to review and approve the **last meeting's minutes** may be ~~accepted.~~ ~~**Participation**~~accepted. **Participation guidelines during the meeting are then discussed.** To ensure ample opportunity for all present to speak and be heard, **committee members** are limited to **2 minutes per comment** & limited to **two comments per item**. **Public comments** are welcomed **prior to each agenda item and again before the committee votes**. Public comments are limited to **one minute per person** (after they introduce themselves and state their affiliation (if any)), so that all have an opportunity to participate Following these explanations there is an opportunity for any **Non-Agenda Public Comment** (any public comments that concern items not listed on the day's agenda). Next begins the **Old Business** section of the agenda where the committee votes to **approve the day's agenda** and to review and **approve the last meeting's minutes**.

During business portions of the meetings to make certain all are able to participate, the committee utilizes amended **Roberts Rules of Order**. These include 6 basic steps that are followed in a vote of the committee:

1. Once an action item is introduced, a member of the committee **makes a motion** for an action related to the item.
2. That motion then has to be **seconded** by another member of the committee.

Field Code Changed

Formatted: Font: 12 pt

Commented [TW1]: This is already stated in the previous paragraph. Isn't this duplicative? I would suggest deleting here, as Non-Agenda Public Comment typically occurs more toward the beginning of the meeting, if I'm not mistaken.

Formatted: Font: 12 pt

Commented [TW2]: This also seems duplicative, as this is stated at the beginning of this paragraph. The day's agenda and last meeting's minutes are usually approved before the Old Business, not during it.

3. Once a motion is made and seconded, the committee chairperson will ask for **committee discussion** and/or any questions or concerns regarding the motion.
4. After the discussion the committee chair will ask for any further **public comment**.
5. Following all discussion, the committee chair will ask for a **vote on the motion**, including any opposition votes and/or any abstentions.
6. The motion then either carries or fails by counting the majority of votes in support or in opposition.

A few **additional guidelines**:

1. When speaking during the meeting, we encourage our community members and consumers to introduce themselves because it is important to us that we know who you are and are able to get to know you. For Ryan White funded service providers and county staff, we ask that you identify yourself and your affiliation prior to speaking.
2. When using acronyms, please call them out and explain what they mean so that everyone understands what you are saying.
3. At times there may be a request for a point of information from different sources in the audience in order to obtain additional information.

If you have any questions or concerns, please don't hesitate to ask Planning Group Support Staff.

Definitions:

County of San Diego Monthly STD Report

Volume 15 Issue 1: Data through August 2022; Report released January 31, 2023.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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

	2021		2022	
	Aug	*Previous 12-Month Period**	*Aug*	*Previous 12-Month Period**
Chlamydia	1606	18205	1779	18078
Female age 18-25	552	6650	492	6219
Female age ≤ 17	56	607	52	570
Male rectal chlamydia	145	1442	153	1682
Gonorrhea	714	7907	764	7914
Female age 18-25	109	1198	101	1216
Female age ≤ 17	14	146	9	102
Male rectal gonorrhea	128	1278	163	1506
Early Syphilis (adult total)	105	1298	76	1082
Primary	18	201	7	173
Secondary	32	429	25	349
Early latent	55	668	44	560
Congenital syphilis	0	20	1	35

* 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	11757	531.9	310	127.3	338	320.2	1178	155.3	1202	118.7
Gonorrhea	5275	238.7	131	53.8	314	297.4	803	105.9	827	81.7
Early Syphilis	722	32.7	38	15.6	65	61.6	306	40.4	219	21.6
Under 20 yrs										
Chlamydia	1614	273.5	41	74.9	62	215.2	176	69.8	129	58.8
Gonorrhea	413	70.0	6	11.0	44	152.8	69	27.4	31	14.1
Early Syphilis	13	2.2	1	1.8	2	6.9	8	3.2	2	0.9

Note: Rates are calculated using 2021 Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 9/2022.

* 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.

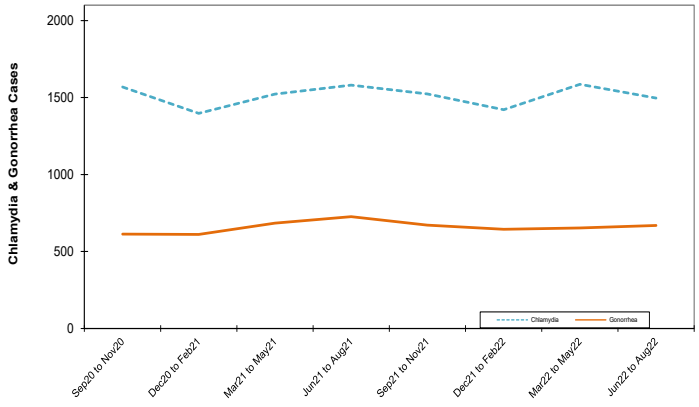
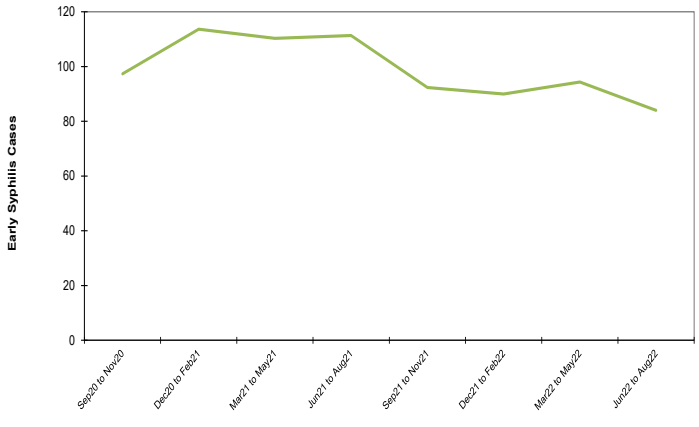


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Editorial Note: Multi-Drug Non-Susceptible Gonorrhea Identified in Massachusetts

The Massachusetts Department of Public Health reported a clinical isolate of *Neisseria gonorrhoeae* with decreased susceptibility to ceftriaxone, cefixime, and azithromycin and resistance to ciprofloxacin, tetracycline, and penicillin [1][2]. Molecular testing confirmed the presence of the *penA60* allele, which has been associated with ceftriaxone non-susceptible cases of gonorrhea reported from the United Kingdom [3]. A second case with the *penA60* allele was also identified in Massachusetts through molecular surveillance [1][2]. Although both cases were cured clinically and microbiologically following recommended treatment with ceftriaxone, these findings are concerning, as this is the first case of documented resistance to 6 of the 7 drugs tested routinely as part of gonococcal surveillance and the second and third cases in the United States in which the *penA60* allele was identified (the first was identified in Las Vegas, Nevada in December 2019) [4].

To prevent the development of antibiotic-resistant gonorrhea, providers should do the following:

- Conduct appropriate screening for gonorrhea based on Centers for Disease Control and Prevention (CDC) guidelines and United States Preventive Services Task Force Recommendations, including screening at extragenital sites (i.e., throat and rectum) when appropriate.
- Ensure compliance with CDC-recommended treatment for gonorrhea (ceftriaxone 500 mg IM as a single dose for persons weighing <150kg, 1 gram IM for persons weighing ≥150 kg).
- Be familiar with best practices and guidelines for management of patients with suspected gonorrhea treatment failure. For assistance, call (619) 609-3245 (Monday to Friday 8:00am-5:00pm; calls will be returned within one business day).
- Report all cases of suspected gonorrhea treatment failure within 24 hours to the HIV, STD, and Hepatitis Branch of Public Health Services department, in the County of San Diego Health and Human Services Agency, by calling (619) 692-8501.

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) 6928541
Sign up to receive Monthly STD Reports, email STD@sdcounty.ca.gov

ACCREDITED HEALTH DEPARTMENT • PHAB Advancing public health performance • PUBLIC HEALTH ACCREDITATION BOARD •

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578

WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

APPENDIX

(Page 037)

Effective October 1, 2021, a new law, AB 361, amends Government Code section 54953 to add subsection (e) ("Special Teleconferencing Rule") which, under specific circumstances, will allow continued suspension of the General Teleconferencing Rule. A recent modification to the Brown Act (the rules regarding open meetings in California) allows the HPG and Committees to continue to meet virtually while a state of emergency is in effect. In - person meetings will return when the state of emergency is over.

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 Circumstances (AB 2449)
In person participation of quorum	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 to 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 recommendation 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

March 2023 HIV Planning Group Committee Meetings

Location: 690 Oxford St. Chula Vista, CA 91911 (Room 194)

Meeting	Date	Time	Location
Strategies & Standards Committee	**Tuesday, March 7, 2023**	11:30 AM – 1:00 PM	Room 194
Membership Committee	**Wednesday, March 8, 2023**	11:00 AM – 1:00 PM	Room 194
Priority Setting & Resource Allocation Committee	**Thursday, March 9, 2023**	3:00 PM – 5:00 PM	Room 194
Steering Committee	**Tuesday, March 14, 2023**	11:00 AM – 1:00 PM	Room 194
Community Engagement Group	**Wednesday, March 15, 2023**	3:00 PM – 5:00 PM	Room 194

March 2023 HIV Planning Group Retreat*

Location: Valencia/Malcolm X Library
5148 Market St, San Diego, CA 92114 (Multi-purpose Room)

Meeting	Date	Time	Location
HPG Retreat	**Wednesday, March 22, 2023**	10:00 AM – 2:00 PM	Multi-purpose Room

*Attendance list to be determined (update as of 2/10/2022)