Tuesday, February 27, 2024, 4:00 PM – 5:30 PM
Southeastern Live Well Center
5101 Market Street, San Diego, CA 92114
(Tubman Chavez Room A)

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 (MSEC)
Tuesday, February 27, 2024
4:00 PM - 5:30 PM

Southeastern Live Well Center
5101 Market St, San Diego, CA 92114
Tubman Chavez Room A

Visitor/Employee parking available in parking structure. Main entrance can be accessed by exiting the parking structure on the 2nd floor and walking down the sidewalk to the left.

FROM I-805 SOUTH:

1. Head northwest on I-805 North.
2. Take exit 12B for Market St.
3. Turn right onto Market St.
4. The destination will be on your right.

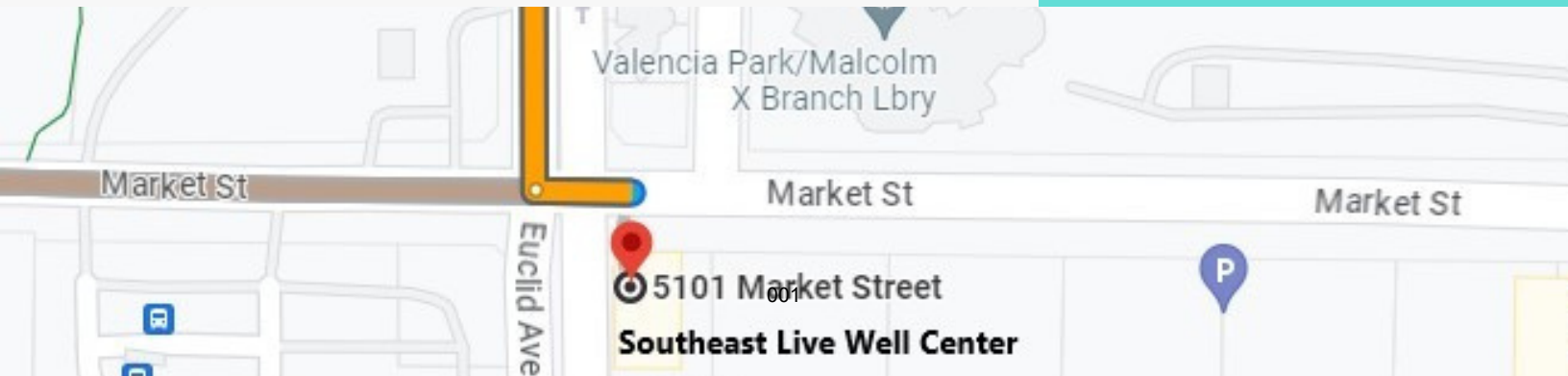
FROM I-805 NORTH:

1. Head southeast on I-805 South.
2. Take exit 13A for CA-94-E/M L King Jr. Fwy.
3. Merge onto CA-94 E.
4. Take exit 4A for Euclid Ave.
5. Turn left onto Euclid Ave.
6. Use the left 2 lanes to turn left onto Market St.
7. The destination will be on your right.

PUBLIC TRANSPORTATION

MTS Trolley:
Orange Line

MTS Bus Routes:
3, 4, 5, 13, 60, 916, 917 and 955



MEDICAL STANDARDS AND EVALUATION COMMITTEE

Tuesday, February 27, 2024,4:00 PM – 5:30 PM
Southeastern Live Well Center
5101 Market Street, San Diego, CA 92114
(Tubman Chavez Room C)

To participate remotely via Zoom:
https://us06web.zoom.us/j/84265220872?pwd=TGRydGxvcm40dEVIQUhmd0IsWUlZUT09
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 | Yessica Hernández | Bob Lewis | Mikie Lochner | Ivy Rooney | Dr. Stephen Spector | Lisa Stangl | Dr. Winston Tilghman (Chair) | Karla Quezada-Torres

MEETING AGENDA
ORDER OF BUSINESS

1. Call to order, roll call, 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 27, 2024
5. **Action:** Approve the MSEC minutes from November 14, 2023
6. Old Business:
    a. **Discussion:** Getting to Zero (GTZ) Community Engagement – next steps
    b. **Discussion:** MSEC committee meeting logistics
7. New Business:
    a. **Action:** Approve 2024 work plan
    b. **Discussion:** Review Outpatient/Ambulatory Health Service Standards and identify needed revisions
    c. **Discussion:** MSEC leadership succession planning
8. Other Updates:
    a. STI and MPox Update (Dr. Tilghman)
    b. Committee member updates
9. Future agenda items for consideration

10. Announcements
11. **Next meeting date:** May TBD, 2024, from 4:00 PM – 5:30 PM

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

WORK PLAN
February 27, 2024 • Finalize 2024 work plan and priorities • Review Outpatient/Ambulatory Health Service Standards and identify needed revisions • Discuss succession planning
May TBD, 2024 *(from May 14)* • Review Executive Report of Ryan White Quality Assurance Chart Review • Finalize and approve Outpatient/Ambulatory Health Service Standards • Develop plan for updating Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services
September 10, 2024 • Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services
November 12, 2024 • Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services (if not completed in September 2024) • Review Ryan White Quality Assurance Chart Review tool • Identify priorities and develop work plan for 2025

MEDICAL STANDARDS AND EVALUATION COMMITTEE

Tuesday, November 14, 2023,4:00 PM – 5:30 PM
Southeastern Live Well Center
5101 Market Street, San Diego, CA 92114
(Tubman Chavez Room C)

To participate remotely via Zoom:
https://us06web.zoom.us/j/84265220872?pwd=TGRydGxvcm40dEVIQUhmd0IsWUIZUT09
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A quorum for this meeting is six (6).
Committee Members Present: Dr. Jeannette Aldous (Co-Chair) | Dr. Laura Bamford | Dr. David Grelotti | Yessica Hernández | Bob Lewis | Dr. Stephen Spector | Lisa Stangl | Dr. Winston Tilghman (Chair) | Karla Quezada-Torres
Committee Members Absent: Mikie Lochner

MEETING MINUTES

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Tilghman called the meeting to order at 4:11 PM and noted the presence of a quorum. There have been several resignations since the last meeting: Dr. Zweig is unable to make future meetings due to ongoing scheduling conflicts and Shannon Ransom has stepped down to focus on the Strategies and Standards Committee. A moment of silence was observed.	
2. Public Comment	A member of the public expressed concern about the timeliness of the agenda and that the draft agenda must be sent out two weeks prior. The agenda for this meeting was sent eight hours prior to the meeting. They also stated that the HPG has not been in compliance with sending out the materials in a timely manner. They also expressed concern about absences of members of the committees that meet less frequently than once per month.	
3. Sharing our Concerns	None	

Agenda Item	Action	Follow-up
4. Review and approve the November 14, 2023 meeting agenda	**Action:** Approve the November 14, 2023 meeting agenda as presented. **Motion/Second/County (M/S/C):** Spector/Aldous/7-0 **Discussion:** none **Abstentions:** Tilghman **Motion carries**	
5. Review and approve the September 19, 2023 meeting minutes	**Action:** Approve the September 19, 2023 meeting minutes with change to the Old Business section to reflect that the first dot point in section b is two separate thoughts. **M/S/C:** Lewis/Quezada-Torres/7-0 **Discussion:** A member of the public made a comment about the frequency of care for those who have been in care for a long time. There needs to be a general change to the guidelines that addresses the minimum length of services and the frequency of care for those who have been in care for a long time. **Abstentions:** Tilghman **Motion carries**	HPG SS to change the first dot point in section b of Old Business to be two separate thoughts.
6. Old Business:		
a. Discussion: GTZ Community Engagement – Next Steps	The committee made the following recommendations: • Incorporate comparison data from the rest of the nation, especially integrating this in other areas of care, besides HIV. • The guidelines incorporate a syndemic approach to care. The service standards need to be focused on more HIV-related measures due to the scope of the supported services. • Include not just HIV, but also Hepatitis B and C, especially for children. • There is an overlap in populations for those with HIV and those with Hepatitis C, which is approximately 10 percent.	

Agenda Item	Action	Follow-up
	• It is important to be focused because it's hard to mandate activities that are not HIV-focused. There are recommendations we can use to educate partners on HIV screening; the guidelines must be specific to HIV and Ryan White.	
b. Review/Approve: Revisions to Ryan White primary care practice guidelines	Dr. Tilghman reminded the committee that the packet includes a draft of the practice guidelines with tracked changes that incorporates all input and a clean version. The major changes to the document were reviewed. **Public comment:** A member of the public expressed concern about time periods for appointment follow-ups not in the guidelines. When the appointment is cancelled, having to reschedule impacts access and continued access. The committee made the following recommendations: • Remove the words "optional" for cancer screening guidelines in section G and make a reference to section H where it is more specific. There are no national guidelines in place, but the URL leads to the New York State Department of Health guidelines. • Make the guidelines more prescriptive in nature and available to all providers, urging them to find a way to create access. • There are no national standards, but data will be available in the next 12 months that may inform the committee's decisions. • Compare with the Los Angeles Guidelines and potentially incorporate some of those. • Remove shared decision making.	Dr. Tilghman to have the finalized guidelines available at the next meeting.

Agenda Item	Action	Follow-up
	• Add a statement on the national guidelines and emerging data. **Action:** Approve the Revisions to Ryan White primary care practice guidelines with the noted changes: 1. Remove shared decision making 2. Add statement to section H regarding the integration of the national standards as they become available. 3. Add language on access to appropriate referrals for follow-up. **M/S/C:** Aldous/Grelotti/8-0 **Abstentions:** Tilghman **Motion carries**	
7. New Business:		
a. MSEC attendance policy	**Public comment:** A member of the public stated it was a mistake for this committee to become official. If this committee goes back to being a joint advisory committee, the HPG guidelines will no longer be applicable. There has been some discussion around the attendance policy at the Membership Committee. The committee recommended that after two consecutive absences, a member will not be in good standing until they have attended two additional consecutive meetings.	HPG SS to add an appendix to the HPG committee guidelines on MSEC attendance.
b. Review chart review tool for 2023	**Public comment:** A member of the public asked the reason marijuana is on the risk assessment form. The changes to the chart review tool were reviewed. A committee member asked if the documents can be updated internally by Dr. Tilghman as part of the role at the County. Dr. Tilghman responded that while it can be done, everyone's feedback is important, and the Recipients' Office	

Agenda Item	Action	Follow-up
	uses this chart review tool as a quality assurance measure, so this committee's input is valuable.	
c. Discussion: 2024 Meeting Schedule and Priorities i. February meeting date change	Tuesday afternoon seems to be the best meeting time for most committee participants. The committee might want to consider making this meeting two hours long. The February meeting date is going to change; more information on the new date will be sent via email.	
8. Other Updates:		
a. STD and Mpox Update (Dr. Tilghman)	Tabled, but the updates are in the packet for review.	
b. Committee member updates	None	
9. Future agenda items for consideration	**Public comment:** A member of the public made a comment about the meeting going over time and that this requires a proper vote. They made a recommendation to remove the committee from being an official HPG committee.	
10. Announcements	None	
11. Next meeting date:	**Date:** February 13, 2024 (this date will be changed) **Time:** 4:00 PM **Location:** TBD	
12. Adjournment	5:49 PM	

Consultant Memo: D. Jacobs, PhD
HPG Steering Committee
June 2023

DRAFT FOR STEERING COMMITTEE INPUT

Summary & Recommendations GTZ Community Engagement Project:
Consumer Recommendations & Implementation 2023

Background

The San Diego County HIV Planning Group's (HPG) *Community Engagement Project for Getting to Zero and Ending the HIV Epidemic* began in January 2020 and the recommendations continue to help to guide HPG planning and HPG committee work. The Consumer Recommendations and the 2022-23 committee progress are contained in this report. HPG has envisioned a 3-year Action Plan to incorporate this consumer feedback and 2022-23 is year 1 of this 3-year Action Plan. A total of 30 Action Items were presented for HPG Committees to address: 40% of items (12 items) were fully completed, an additional 30% (9 items) are currently in various stages of completion in the committee process, and 30% (9 items) remain not yet addressed by the committees. Items and their completion status are listed in this report. Finally, consultant observations and recommendations are provided at the end of this report.

Community Engagement Methodology

This project included **160 community participants** living with or vulnerable to HIV. Participation included: 1 large group, in-person community member event (98 participants), 2 rounds of extended key informant telephone interviews (64 participants), 12 Advisory Committee meetings, 32 small regional team meetings , and a final framework for a 3-year action plan for HPG implementation. The final action plan contains 11 recommendations for addressing consumer needs and redressing disparities in late HIV diagnoses, retention in care, and viral suppression rates.

Participant Demographics & Descriptors

- ¾ participants living with HIV, ¼ participants vulnerable to HIV
- 78% identified as MSM, 8% of participants identified as women, and 14% as Transgender/Nonbinary.
- 77% of interview participants identified as community members of color: 36% as Black/African American; 36% as Latinx; 20% as White; and 6% as Bi-racial
- Ages of participants ranged from 20-71 years of age
- Among interview participants, 70% endorsed a history of **one of the following experiences** -
    - Substance use (primarily alcohol and/or methamphetamine)
    - or homelessness & food insecurity,
    - or significant traumatic experiences
    - or mental health symptoms.
- For 11% of the 70% indicating at least one of the above difficulties, the use of drugs included injection drug use.
- Further, among the 70% endorsing at least one of above, 83% of those participants discussed a history **that included all of the above experiences -** not only drug and alcohol use, but also struggles with homelessness, food insecurity, significant traumatic experiences, and mental health symptoms.
- 90% of **those indicating all of the experiences** above also indicated periodic struggles to remain in HIV care and adherent to medication protocols.

Consumer Recommendations Overview

Participants appeared very engaged and thoughtful. Responses were focused both on broad themes including: experiences which have created and reinforced care system mistrust; the need for greater transparency and improved communication about available resources; and the need for greater access to mental health and substance use treatment resources. Participants also offered descriptions of their every-day challenges in

prioritizing their healthcare and the barriers to accessing the systems of HIV care, as well as their suggestions for improvements that might reduce those barriers. These suggestions included improved workforce representation, enhanced communications and improved access to service and health information, greater and more rapid access to mental health and substance use treatments, greater and more rapid access to basic support resources (housing, food, transportation, emergency financial assistance), improved access to peer navigators, access to social support groups, and reduced duplicative, confusing bureaucratic barriers to service.

Brief Listing Consumer Recommendations & Committee Progress thru June 2023

Recommendation 1: Acknowledge and address medical system mistrust
REPRESENTATION **1a.** Ensure progress toward a contracted **HIV service-delivery workforce representative of those living with and at higher risk for HIV in San Diego County and ensure ongoing recruitment, support and retention of this representative workforce**
PROGRESS: Completed. Cultural Humility and Competence Standards including instruction to service providers to "Recruit staff members with lived experience at all levels of the organization and provide appropriate supports to ensure their success."
1b. Acknowledge systemic racism, missteps, mistakes and harms of the past and ensure plans are created and implemented to ensure ongoing training to help to ensure this past is not repeated.
PROGRESS: Partially completed. Anti-racist Retreat conducted, now awaiting consultant recommendations for further training or dialogues.
1c. WORKFORCE TRAINING CULTURAL HUMILITY, TRAUMA INFORMED CARE Provide access via links to **enhanced, skill-based trainings** to HIV service-delivery staff which improve the ability to consistently communicate **cultural respect, knowledge, and humility**, as well as the skills required for **trauma-informed care**.
Recommendation 2: Improve communications and outreach strategies for those living with and at higher risk for HIV who live, work or participate in historically-underserved, Low Information communities.
2a. Use multiple communications platforms and outreach strategies to better provide HIV services information to HIV community members and historically-underserved communities impacted in San Diego County, including the following HIV services information: What services are available? Where are services located? Who is eligible for services? What is the cost of services to the eligible community member? What is the contact information for scheduling or for more information? **This recommendation is intended to proactively provide the information to the community rather than placing the burden of information seeking solely on consumers.**
PROGRESS: Partially completed and ongoing. Enhanced Communication Plan begun and continuing weekly via email and social media. Awaiting app completion and deployment. Awaiting completion of services App.
2b. Provide increased and readily available **basic health information** to low information, historically-underserved community members and communities, including: **What is early disease detection and why is it important? Where is HIV, HCV, STD testing available? What is PrEP and who is eligible? Importance of early connection to HIV treatment and medication, What does an undetectable viral load mean for transmission of HIV? Information regarding mental health or substance use treatment (both out-patient and residential treatment).**
PROGRESS: Completed and ongoing. Health messaging via social media begun and continuing X2 monthly.
Recommendation 3: Ensure that all HIV community members have opportunities for equitable access to tele-health appointments and to participation in public meetings, address the digital disparities present for those with lower-income who are also living with or at higher risk for HIV
3a. For low-income HIV consumers, and HPG members who have not been able to access County or City digital resource programs, provide opportunities to gain access to affordable or no-cost, broadband internet connectivity and the hardware necessary to participate in healthcare appointments and public meeting opportunities.
PROGRESS: Completed and ongoing. Addressed via standards to allow telehealth to continue (as appropriate) and to provide for access to internet and hardware to those who need it.

3b. For those HIV community members who have experienced digital disparities, provide information regarding virtual training opportunities to learn digital/virtual skills that can allow them to more easily participate in virtual meetings and resources.
Recommendation 4: Provide increased mental health and alcohol/substance use treatment opportunities for those living with or at higher risk for HIV. Additionally, more widely communicate information about these opportunities to HIV community members.
4a. **Coordinating** with the existing harm reduction task force, provide **guidance** to contracted HIV service providers designed to **increase the availability of harm reduction services** for substance misuse treatment.
PROGRESS: Completed and ongoing. Guidance provided
4b. Expand and augment the current syringe exchange program(s) in San Diego County to allow services to be provided for an increased number of community members (including HIV community members) and to include more opportunities for connection to additional needed services (i.e., wound care, MAT, Case management, vaccinations, etc.)
PROGRESS: Completed approval syringe exchange (BOS), 2 programs up in County and ongoing.
4c. **Coordinating** with County drug and alcohol services personnel, ensure the design and implementation of a **coordinated system for rapid response** for HIV community members who desire to enter substance use residential or out-patient treatment.
4d. In light of reported treatment disruptions which often occur for those without secure housing, design and deploy more rapid interventions for consumers, **particularly when insecure housing and either substance misuse or mental health symptoms are co-occurring**.
4e. Investigate the current opportunities for substance use treatment for methamphetamine and, if inadequate opportunities exist, expand those available.
4f. Continue to increase the opportunities for s**ame-site location of medical providers, mental health providers and alcohol/substance use counselors** for those living with or at higher risk for HIV.
4g. **In collaboration with UCSD and AETC,** provide links and resources for **skill-based training for HIV service personnel** regarding the stigmatizing behaviors faced by substance using HIV community members and ways to reduce those stigmatizing behaviors within the health care system itself.
Recommendation 5: More consistently provide rapid access to **basic support services: housing, food, transportation, emergency financial assistance including shut-off** & **eviction prevention. Additionally, more widely communicate information about these opportunities and the processes to access them.**
5a. Chief among those mentioned above and directly related to community members' ability to meaningfully participate consistently in health care is **Housing**.
PROGRESS: Partially completed and continuing. Emergency Housing resources increased and continuing to monitor. Continuing to monitor PARS. Awaiting guidance/outcome of transportation recommendations.
Recommendation 6: Continue to expand the opportunities to hire, support and utilize peer navigators, peer health educators, peer outreach specialists, benefits navigators, and housing specialists.
PROGRESS: Partially completed. Peer Navigation deployed, awaiting housing case management and benefits specialists.
Recommendation 7: Design, integrate, and deploy strategies to address the stigmas faced by HIV community members including: the multiple layers of stigma faced by those living with HIV who are also Black and Latino MSM; Transgender person;, Immigrants who may be under-documented or undocumented; those struggling with mental health symptoms or alcohol/substance use challenges or those without stable housing.
7a. Increase opportunities/programs for participation in Psychosocial Support Groups for those living with or at higher risk for HIV who may, as a function of family or community stigma, have fewer social supports.
PROGRESS: Partially completed. Provided funding for Psychosocial support groups category, but not yet deployed.
Recommendation 8: Increase the number of HIV service sites that have the capacity for whole person-whole health services including PrEP, mental health services, substance use treatment services, hormone treatment, case management, and housing resources. This should include the capacity for coordinated, integrated, same-day, appointments when requested.

PROGRESS: Partially completed. Standard approved to ensure inclusion of Transgender/Nonbinary clients and hormone treatments. Coordinated service centers include mental health and substance use treatment services. Same-day appts not yet widely available to those who prefer them.
Recommendation 9: Design, create and execute improved community engagement and outreach strategies that utilize community organizing principles and personal relationship building. Strategies should include: transportation and meal reimbursements, as well as appropriate and respectful incentives, engaging, interesting meeting opportunities for planning participation and routine report-outs regarding what has been done with HIV community feedback.
Recommendation 10: Revise and refine the documentation processes that create a barrier to access services for persons living with or at increased risk for HIV.
10a. Reduce the duplication of forms and paperwork required to access HIV services.
PROGRESS: Awaiting completion of reduced paperwork process for initial/renewal RW eligibility.
10b. Explore use of an electronic signature system that does not require in-person, wet signatures for eligibility or authorization forms.
PROGRESS: Not available at this time in RW or County systems.
Recommendation 11: Design and deploy a variety of brief, on-line trainings for those living with or at higher risk for HIV. Trainings include but are not be limited to: what is the HIV Planning Group and options for involvement; What is the HPG Consumer group and how to get involved; What are HPG committees and how to get involved; How to effectively advocate for the HIV community.

Additional Data

Several of the community/consumer recommendations listed above are likely familiar to HPG members as they mirror findings from other relevant sources. These findings and their sources are listed below.

- San Diego County and City remain in a "Housing Crisis" with very limited availability of "affordable" housing options, an ever-growing unhoused and insecurely housed population, as well as ten-year wait-lists for government subsidized housing options (Section 8, HOPWA). Further, in Needs Assessment data, consumers continue to endorse being insecurely housed or unhoused in concerning numbers.
- Previous findings contained in Needs Assessment data have found that in order to remain in care, priority populations need basic support services (disproportionately Black MSM, Latinx MSM, Transgender populations and additionally women, specifically black and Latinx women).These support categories include: housing, food, transportation and emergency financial assistance.
- Additionally, the need for improved access to mental health and substance use service opportunities continues to be reflected in Needs Assessment focus groups discussion and themes. Needs Assessment data contained in the Co-Occurring Conditions report also reflects rates of mental health symptoms and substance use challenges that far exceed those endorsed by the non-HIV community sample.
- Two additional data points are provided by several 2021 consumer comments to the HIV Planning Group. These include 1) the need and desire for increased availability of Peer Navigators and/or Educators and 2) the need for Psychosocial Support Groups, particularly for those without familial support in their HIV health pursuits.

Overview HPG & Committee Progress 2022-23

Below listed are the 2022-23 HPG and HPG Committee activities addressing the Consumer Recommendations.

HPG

- Continuing to build a more welcoming, inclusive and supportive HPG culture
- HPG Retreat (initial anti-racist training/dialogue completed) and awaiting consultant recommendations for further dialogue training r/e anti-racist activities)

- Approved below-listed Standards
- Approved allocations for increased Housing Funds, Psychosocial Support Groups and Peer Navigation

Strategies & Standards

- Acknowledge and Address Mistrust
  - Crafted JEDI Principles
  - Potential JEDI Task Force (awaiting future consultant recommendations regarding JEDI Trainings/Dialogue)
- Crafted and approved Standards to ensure:
  - Access to Telehealth
  - Access to Primary Care, including Transgender clients
  - Cultural humility & culturally competent care
    - * Note that this Standard includes below language:
      - "Clients receive education and support to advocate for what they need, speak out when their needs are not being adequately addressed, and receive timely and adequate responses and supports to address their needs."
      - "Client support needs are assessed and reasonable accommodations are available to allow clients to participate in and receive benefit from services."
      - "Recruit staff members with lived experience at all levels of the organization and provide appropriate supports to ensure their success."

PSRAC

- Recommended allocations to increase access to Housing supports
- Continues to evaluate and focus upon capacity building for mental health services
- Recommended allocations for Peer Navigation and Psychosocial Support Groups

Membership

- Drafted HPG Recruitment Plan and continues to discuss list of items and to discuss in-person outreach
- Attempting to build an HPG culture of consistent, ongoing Recruitment for consumers to recieve personal invitations to join HPG & HPG Committees

Communications Task Force

- Enhanced Communications Work Plan drafted which includes weekly emails and social media posts. Work to target and expand lists continues.

2022-23 Completed Tasks

Below listed are the specific tasks enumerated in this first Action Plan year and progress to date. **(Initial Tasks Assigned are described in Bold)**

1. ***Completed initial retreat and awaiting consultant recommendations for ongoing trainings/dialogue, Completed Steering, Strategies, HPG.*** **JEDI Principles & Taskforce.**
2. ***Completed, Strategies, HPG.*** **Equitable Access Telehealth: Updating Primary Care standards** to ensure that clients, if interested, can participate in virtual medical visits, including provision of necessary equipment and Internet access
3. ***Completed, Strategies, HPG.*** **Updating Primary Care standards** to include requirements for **serving transgender clients,** including whole-person care, hormone therapy and STD testing and treatment.
4. ***Completed, Strategies, HPG.*** Updating **Client Rights and Responsibilities** to support inclusion of **family members/chosen others in supporting care.**
5. ***Completed, Strategies, HPG.*** **Cultural Humility & Competency: Updated Universal Standards including recruitment and retention of those with lived experience.**
6. ***Completed, Strategies, PSRAC.*** **Requested expanded and completed epi data (including demographic data) and continuum of care (viral loads) as well as multivariate analysis. Strategies and Standards Committee to**

identify any additional data needs to support planning and implementation of services to reduce disparities in health outcomes.

7. ***Completed, Steering and HPG.*** Establish clear processes and timelines for **addressing requests from the public** to the HIV Planning Group
8. ***Completed Membership. (for on-line recruitment, now discussing in-person recruitment)*** *With Community Engagement Committee, **further develop and implement a Recruitment Plan for recruitment**
9. ***Completed and ongoing, Communications*. Develop and communicate a list of community engagement opportunities** beyond the HIV Planning Group.
10. ***Completed and ongoing, Communications. Continue to refine frequency based on need as further described below.*** The frequency and modes of communications for Communications Plan.
11. **Completed and ongoing, Communications. Continue to review: Post HPG meeting ICYMI emails, Community Events and participation emails at least twice monthly; HIV monthly themes(CDC); membership recruitment for HPG and committees once monthly Describe the types of messages that will be communicated**
12. **Completed and ongoing, Communications. Continue to review use of Instagram, Facebook, Twitter: Strategies for membership recruitment for HPG and committees and community awareness of HPG Describe strategies for use of social media platforms**

Items in active committee process

1. ***In process; Trauma-Informed Care components draft to be submitted in August Strategies Committee.**
2. ***Strategies - Strategies and Standards Committee to review models and resource requirements that would support drop-in services for primary care, mental health, and substance use treatment. In process currently with contract awarded. Services began March 01 2023. Awaiting data to evaluate resource requirements, particularly with regard to drop-in mental health, substance use treatments.**
3. ***Strategies - Strategies and Standards Committee to explore the feasibility and effectiveness of further expanding HIV testing into nontraditional testing sites. In process currently with RFP/Award. Awaiting data to evaluate resources and effectiveness.**
4. ***Steering - Completed and awaiting ongoing consultant recommendations.** Participate in **HPG retreat focused on GTZ Recomendation1: Acknowledge and Address Mistrust (JEDI Principles & Task Force)**
5. ***** **Membership - Discuss the feasibility and desirability of focusing recruitment efforts for service provider seats on frontline staff rather than supervisorial or managerial staff. Membership Committee discussing feasibility now**.
6. ***Community Engagement Committee - Membership committee with Community Engagement Committee to develop Community Engagement Outreach Plan. in process for in-person out-reach plans**.
7. ***Communications – Outline strategies for in-person and on-line outreach. Communications Task Force Currently working on continuing to identify on-line influencers and providers willing to help increase list for communications**
8. ***Communications- Strategies to expand and create consistent culturally respectful communications into high mistrust, low information communities, including communications in Spanish. Communications Task Force *has identified review process for accuracy and appropriateness for Spanish translation but requires further standardization*.**

Remaining Tasks Not yet addressed.

1. *Not yet addressed. **Strategies and Standards Committee** to Update standards for **emergency financial assistance** to identify circumstances where same-day response is warranted
2. *Not yet addressed. **Strategies and Standards Committee** to incorporate strategies for **dismantling HIV-related stigma** among Black, Hispanic and transgender persons living with or vulnerable to HIV
3. *Not yet addressed **Strategies and Standards Committee** to review and **re- evaluate eligibility criteria for basic needs support**

4. *Not yet addressed. **Strategies and Standards Committee** to explore the potential effectiveness and feasibility of funding **mobile health clinic**s
5. *Not yet addressed. **Steering Committee -** Discuss the feasibility and desirability of developing **an online orientation and training** for members of the HIV Planning Group
6. *Not yet addressed.****Membership, Steering** - Strategies to **develop and maintain relationships in neighborhoods** and communities and to involve existing groups and community leaders
7. *Not yet addressed. **Steering** - develop an **evaluation plan** for the communications plan
8. *Not yet fully addressed. **Communications Task Force** - Strategies for development and dissemination of **printed materials**
9. *Not yet fully addressed. **Communications Task Force** - Needs standardization.*Strategies for ensuring that all messaging is accessible to people regardless of **literacy levels or health literacy levels**

Consultant Observations & Recommendations – HPG and HPG Committee Ongoing work

This year HPG and its committees, with the help of HPG support staff, has completed 40% of the 3-year Action Plan items, with an additional 30% introduced into the committee process. This is indeed an encouraging and promising beginning! However, with HPG membership at a reduced number of members (27) and a reduced number of committee participants (especially Membership and Community Engagement Committees), it appeared challenging for many members to consistently participate as fully as they would like. Further complicating this has been the recent transitions in HPG support staff personnel and the return to in-person meetings, which created the additional time demands of travel for members and staff. Additionally, next year (2024) brings the end of the HPG terms of ¼ of the current HPG members. Those members terming out are primarily long-term members, many of whom are existing committee members and chairs. These circumstances underline the **need for HPG recruitment, particularly consumer recruitment.**

Recruitment and Training. Consumer recruitment for both HPG and HPG committees seems a priority concern for HPG and likely will require active participation and focus by all HPG members and service providers. In addition, to better ensure success, recruitment will also be accompanied by a need for enhanced training and support. As longer-term members step back to provide training and support, newer members can more confidently step forward to begin their participation and leadership.

Consultant Recommendations for 2023-2024 work

1. Focus upon building the HPG recruitment culture, including fully utilizing the successful Project PEARL program. This focus can include encouraging all HPG members and service providers to reach out to consumers who may be interested in opportunities to participate in HPG and/or it's committees and personally invite them to apply to HPG.
    a. It may be the case that small recruitment events (perhaps held in a variety of provider identified support groups in all regions) may also be effective.
2. Continue to focus upon building and sustaining a welcoming, inclusive, and supportive HPG culture
3. Continue to complete work on items (listed above) that are still in the committee processes
    a. As a part of that work - receive consultant recommendations regarding trainings, dialogues r/e anti-racist work and begin to implement
4. Begin the designated committee work on items not yet addressed (listed above)
5. **Note:**
    a. Unfinished work remains on Recommendation 10 - bureaucratic duplication for enrollment/recertification – Continue to routinely check on estimated completion
    b. Unfinished work remains on Recommendation 2a - Services Availability application – Continue to routinely check on estimated completion

   c. Unfinished work remains on transportation service recommendation(s) – continue to check on progress
   d. **Note also** the periodic consumer comments this year about difficulties in accessing mental health services including: uncertainties about whom to call to access, delays of weeks to obtain initial appointments and difficulties in scheduling timely routine appointments once treatment begins. It may be the case that Strategies and Standards needs to review and address Standards of Care for mental health services.

6. In both Steering Committee and Strategies Committees - Begin to discuss potential strategies to comprehensively address the ongoing, multiple **stigmas** encountered by HIV consumers/community members.
7. As MediCal recipients renew and MediCal itself expands eligibility and enhanced services, the potential for decreased demands for RW Part A services exists. HPG can monitor service utilization and explore any potential for increasing funds in other service categories. If funds are available for the basic support services categories, it may help those with the greatest need to more consistently remain in care.

Outpatient/Ambulatory Medical Care Services

Service Category Definition

Outpatient/ambulatory health services (OAHS) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, and urgent care facilities for HIV-related visits. Emergency department visits are not considered outpatient settings. See **Appendix 1: 2020 RWPCP Provider Handbook** for a list of provider locations.

Primary activities for OAHS include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and mental/behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment (by referral if pediatric services are not available onsite)
- Prescription and management of medication therapy
- Early intervention and risk assessment
- Continued care and management of chronic conditions
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology
- Telehealth

Primary medical care for the treatment of HIV includes the provision of care that is consistent with the United States (US) Public Health Service (PHS)'s Clinical Guidelines and the San Diego HIV Planning Group Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Current PHS guidelines are available online at https://aidsinfo.nih.gov/guidelines. Current Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS are available online at http://www.sdplanning.org/downloads/practice-guidelines/.

Diagnostic testing includes only testing procedures and applications as approved by the Health Resources and Services Administration (HRSA) for funding under the Ryan White Act. The policy describing the use of Ryan White Act Program funds for HIV diagnostics and laboratory tests is available online at https://hab.hrsa.gov/sites/default/files/hab/Global/hivdiagtestpn0702.pdf.

Purpose and Goals

The goal of OAHS is to ensure accessible HIV/AIDS primary and medical specialty care and to enable adherence to treatment plans, that is consistent with the US PHS Guidelines. In addition, OAHS are designed to interrupt or delay the progression of HIV disease, prevent, and treat opportunistic infections, prevent onward transmission of HIV, and promote optimal health. All services and interventions must be based on proven and evidence-based clinical methods and in accordance with legal and ethical standards. The services delivered shall reflect a philosophy of service delivery that affirms a patient's right to privacy, confidentiality, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

The service standards are provided to ensure that San Diego County's Ryan White-funded OAHS:

- Are accessible to all persons living with HIV/AIDS (PLWH) who meet eligibility requirements

- Promote continuity of care, patient monitoring, and follow-up
- Enhance coordination among service providers to eliminate duplication of services
- Provide opportunities and structure to promote patient and provider education
- Maintain the highest standards of care for patients
- Protect the rights of PLWH
- Increase patient self-sufficiency and quality of life
- Provide a framework to foster ethical and nondiscriminatory practices

Intake

Patient intake is required for all patients who request OAHS and shall be initiated at the time a patient presents for services. Intake is a time to gather registration information and provide basic information about OAHS and other HIV services, as appropriate. It is also a pivotal moment for establishment of trust and confidence in the care system. Practitioners shall provide an appropriate level of information that is helpful and responsive to patient need. Medical care provider staff shall conduct the patient intake with respect and compassion.

If a patient is receiving multiple Ryan White services with the same provider, intake need only be conducted one time. *With the exception of Releases of Information specific to medical information and Mental Health Consent for Treatment*, it is acceptable to note that eligibility, registration, and required documents discussed in this section were verified and exist in another patient service record at the same provider agency.

1. **Timeframe.** Intake and ART shall take place as soon as possible, especially for those who are newly diagnosed with HIV. If there is an indication that the patient may be facing imminent loss of medication or is facing other forms of medical crisis, the intake process will be expedited, and appropriate intervention may take place prior to formal intake.
2. **Eligibility Determination.** The provider shall obtain the necessary information to establish the patient's eligibility. This includes verifying documentation of the patient's HIV status, lack of medical care coverage, income, and residency within San Diego County.
3. **Demographic Information.** The provider shall obtain the appropriate and necessary demographic information to complete registration. This includes basic information about the patient's HIV medical history, living situation, employment and financial status, service linkages, and emergency contact information. Based on this information, the provider may also determine the patient's share-of-cost for services.
4. **Provision of Information.** The provider shall provide information to the patient about the medical services they are receiving. The provider shall also provide the patient with information about resources, care, and treatment, which is available at https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/hiv_std_hepatitis_branch/hiv_aids_care_and_treatment_services.html.
5. **Required Documentation.** The following forms shall be provided in accordance with state and local guidelines and shall be signed and dated by each patient:
    a. **ARIES Consent:** Patients shall be informed of the AIDS Regional Information and Evaluation System (ARIES). The ARIES consent must be signed at intake prior to entry into the ARIES database and every three years thereafter. The signed consent form shall indicate: 1) whether the patient agrees to the use of ARIES in recording and tracking their demographic, eligibility, and service information and 2) whether the patient agrees to share select information contained in ARIES with other agencies in the Ryan White system of care.
    b. **Confidentiality and Release of Information:** When discussing patient confidentiality, it is important not to assume that the patient's family or partner knows about the HIV-positive status of the patient. Part of the discussion about patient confidentiality should include inquiry about how the patient wants to be contacted (e.g., at home, at work, by mail, by phone). If there is a need to disclose information about a patient to a third party, including family members, patients shall be asked to sign a Release of Information form,

authorizing such disclosure. A Release of Information form describes the situations under which a patient's information can be released and includes the name of the agency and/or person with whom information will be shared, the specific information to be shared, duration of the release consent, and the patient's signature. This form may be signed at intake prior to the actual need for disclosure. Releases of information may be cancelled or modified by the patient at any time. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the Release of Information must be a HIPAA-compliant disclosure.

c. **Consent for Treatment:** This form shall be signed by the patient, agreeing to receive medical care services/treatment.
d. **Notice of Privacy Practices (NPP):** Patients shall be informed of the provider's policy regarding privacy rights based on the provider's confidentiality policy. For agencies and information covered by HIPAA, providers shall comply with HIPAA guidelines and regulations for confidentiality.
e. **Client Rights and Responsibilities:** Patients shall be informed of their rights and responsibilities.
f. **Client Grievance Process:** Patients shall be informed of the grievance process. Grievance appeals specifically related to medical, clinical, and/or HIPAA issues should be filed first with the agency where the client is receiving services. Issues that the client would like to elevate and/or are not addressed to the client's satisfaction by the agency should be directed to the County of San Diego HIV, STD, and Hepatitis Branch (HSHB).

Key Service Components and Activities

Key service components and activities include the following:

Medical Evaluation: Proper assessment/evaluation of patient need is fundamental to medical care services. OAHS providers shall provide a thorough evaluation of all patients to determine the appropriate level of care and to develop a therapeutic treatment plan. Each patient living with HIV who is entering into care should have a complete medical history, physical examination, laboratory/diagnostic evaluation, and counseling regarding the implications of HIV infection. The purpose is to confirm the presence of HIV infection, obtain appropriate baseline historical and laboratory data, assure patient understanding about HIV infection, and initiate care as recommended by the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS, which are available at http://www.sdplanning.org/downloads/practice-guidelines/. Baseline information then is used to define management goals and plans.

Psychosocial Assessment: Patients living with HIV infection must often cope with multiple medical, social, and psychiatric issues that are best addressed through a multidisciplinary approach to the disease. The evaluation must also include assessment of mental illness, nutritional status, oral health, substance use, economic factors (e.g., unstable housing), social support, high-risk behaviors, and other factors that are known to impair the ability to adhere to treatment and that promote HIV transmission. Once evaluated, these factors should be managed accordingly. Psychosocial assessments shall be conducted by providers of OAHS annually. More details about the components of the psychosocial assessment are available in the Mental Health Services Service Standards for Ryan White Care and Treatment, which are available at http://www.sdplanning.org/downloads/service-standards/page/3/.

Comprehensive Health Assessment: Patients living with HIV infection must often cope with multiple medical, social, and psychiatric issues that are best addressed through a multidisciplinary approach to the disease. The evaluation must also include assessment of mental illness, nutritional status, oral health, substance use, economic factors (e.g., unstable housing), social support, high-risk behaviors, and other factors that are known to impair the ability to adhere to treatment and that increase risk of HIV transmission. Once evaluated, these factors should be managed accordingly.

Treatment Provision: All medical care will be consistent with the US PHS treatment guidelines (www.aidsinfo.nih.gov/) and the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS (http://www.sdplanning.org/downloads/practice-guidelines/) and will be guided by the care needs expressed in the treatment plan. Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their patient's presenting problems. Medical treatment and the prescription of antiretroviral and prophylactic medications shall conform to the standards of care recognized within the general community and supported by published clinical research for the patient's condition.

Treatment provision is documented through progress notes, treatment plans, problem lists, and medication lists.

Medical Subspecialty Care. In order to fully comply with the PHS Guidelines, medical specialty services are provided by tertiary care providers for medical services that are beyond the scope of Ryan White outpatient/ambulatory primary medical care clinics. Specialty medical care services include the provision of outpatient infectious disease and other specialty medical care, including but not limited to: Obstetrics, Hepatology, Neurology, Oncology, Immunology, Pulmonology, Ophthalmology, Dermatology, Radiation Oncology, and Psychiatry. Specific services include diagnostic testing, preventive care and screening, practitioner examination, medical history, and treatment of common physical and mental conditions.

OAHS providers are responsible for assessing a patient's need for specialty care, completing prior authorization as needed, and providing appropriate referrals as needed. Medical specialty care appointments shall be provided within three (3) weeks of the request for service or sooner, if the medical condition warrants. Specialty care services are considered consultative and, as such, patients shall be referred back to the original outpatient/ambulatory clinic for ongoing HIV medical care.

Medical subspecialty care shall be limited to those services authorized by the County of San Diego HSHB specialty services provider. A prior authorization form authorizing medical specialty care services shall be completed for each specialty referral. A copy of the specialty referral, in addition to a copy of a signed prior authorization form, shall be retained in each patient's service record. All referrals to medical specialty care shall be tracked and monitored by both the referring provider and the medical specialty care administrator.

Medical specialty care appointments shall be provided within three (3) weeks of the request for service or sooner, if the medical condition warrants.

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments for 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 in the medical record
	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
	Completion of the Client Transition Plan for clients who are deemed ineligible for the Ryan White Primary Care Program or deemed ready to be transitioned out of certain services

Standard	Measure
Medical evaluation is performed at baseline and at follow-up visits in accordance with practice guidelines and clearly documented in the medical record	Annual quality assurance (QA) review of patient medical record
General health assessment is performed and documented in the medical record	Documentation of general health assessment, findings, and actions taken
Treatment plan is in the medical record, includes all required elements, and is updated at each medical visit	Documentation of treatment plan and updates
Needs for medical specialty services are identified, and patients who require such services are linked to them within the required timeframe	Documentation of need for medical specialty services and referral for services

Personnel Qualifications

Professional diagnostic and therapeutic services under this service category must be provided by one of the following clinicians licensed by the State of California and operating within the scope of their license:

- Physicians (MD/DO)
- Physician's Assistant (PA)
- Nurse Practitioner (NP)

Other professional and non-professional staff may provide services appropriate for their level of training, education, and licensure as part of a care team in coordination with or under the supervision of a clinician in a manner consistent with State of California requirements for licensure or certification. These staff may include, but are not limited to:

- Nurses (RN, LVN/LPN)
- Medical assistants (MA)
- Pharmacists
- Pharmacy assistants
- Health educators

Any non-clinician staff providing services must be 1) supervised by a clinician; 2) hold current licensure as required by the State of California when applicable; 3) provide services appropriate for their level of training/education; and 4) be trained and knowledgeable about HIV.

All staff providing OAHS must have training appropriate to their to their job description and will provide services to those with HIV. Training should be completed within 60 days of hire. Topics should include:

- General HIV knowledge, such as HIV transmission, care, and prevention
- HIV counseling and testing
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care

Ongoing Training: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of 1) in-person, 2) articles, 3) home studies, or 4) webinars, and must be clearly documented and tracked for monitoring purposes.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees

Standard	Measure
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

Assessment and Service Plan

Initial Assessment:

1. **Medical Evaluation:** At the start of OAHS, a baseline medical evaluation must be conducted. This evaluation should be performed in accordance with HHS guidelines, HIV primary care guidelines, and the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS, and must include the following components as described in the local guidelines:
    a. Complete history, which includes general background, current/lifetime sexual history, current/lifetime substance use history, HIV care history, and general medical history
    b. Review of symptoms and physical examination
    c. Laboratory testing, which includes recommended baseline laboratory tests for PLWH, as well as testing for sexually transmitted diseases (STDs) and tuberculosis
2. **HIV Education:** Patients should always be provided with information regarding the results of diagnostic tests, prognosis, risks and benefits of treatment, instructions on treatment management and follow-up, and treatment adherence. In addition, they should be given HIV risk reduction and prevention education.
3. **Partner Services:** Partner Services is defined as a confidential service that provides a safe way for PLWH to tell their sexual or needle-sharing partners that they may have been exposed to HIV, to provide education and information about HIV, and to link to HIV testing. For clients who are not virally suppressed, information and counseling should be offered, and referrals made for clients according to established processes.
4. **Referral/Linkage:** Clients requiring specialized care should be referred for and linked to such care, with documentation of that referral in the client file and available upon request. These services may include, but are not limited to, treatment adherence counseling, Ryan White Oral Health, Ophthalmology (if CD4<50 cells/mm^3), case management (if eligible), medical nutrition therapy, clinical trials, mental health, substance abuse, and partner services (including HIV pre-exposure prophylaxis or PrEP). Providers should assess for transportation needs and ensure that transportation is available, using available services.
5. **Documentation:** All patient contacts, findings, procedures, diagnoses, education, and other information pertinent to patient care must be recorded in the patient chart.

Treatment Plan:

OAHS providers should create an individualized treatment plan for each patient that identifies and prioritizes the patient's medical care needs and incorporates client input. All treatment plans must be signed and dated by a provider and should follow national and local guidelines, including review and reassessment of the plan at each care appointment.

Treatment Provision:

Antiretroviral treatment is recommended for all PLWH, regardless of CD4 count, and should be provided as soon as possible after diagnosis. Same-day treatment is encouraged when feasible and where available. If same-day treatment is offered, use of an integrase inhibitor-based regimen is recommended. Treatment regimens should be selected based on HHS guidelines, as stated in the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS.

Standard	Measure
Baseline evaluation and reassessments are conducted in accordance with HHS guidelines and the Practice Guidelines for the Primary Medical Care of Persons Living with HIV/AIDS	Annual quality assurance (QA) review of patient medical record
Practitioners shall document results and outcomes of visit	Signed and dated progress notes in patient medical record
Treatment plans must be completed and/or reviewed and revised at each routine medical visit and must be signed and dated by the medical care practitioner who completed the assessment/evaluation	Signed and dated treatment plan documented in patient medical record
Treatment is consistent with US PHS guidelines	Annual QA review of patient medical record

Transition and Discharge

Since medical care services are considered the most critical services to preserve a patient's physical and psychological wellbeing throughout the lifespan and to prevent adverse health outcomes from HIV infection, closure from OAHS must be carefully considered, and reasonable steps should be taken to assure that patients in need of medical care continue to receive services. The process includes formal client notification regarding pending case closure and the completion of a case closure summary to be maintained in the client chart. That process is described in the **Universal Service Standards**. Disenrollment may occur for the following reasons:

- Client has died.
- Client requests to be disenrolled.
- Client enrolls in another primary care program.
- Client cannot be located within 120 days after repeated efforts, including attempted written, oral and personal contact.
- Client relocates outside of San Diego County.
- Client demonstrates repeated non-compliance or inappropriate behavior in violation of specific written policies of the provider, especially with regard to violation of confidentiality of other client information.
- Client is incarcerated longer than 30 days.
- Client does not qualify for OAHS based on eligibility requirements.

Eligible clients may reenroll in the Ryan White program at any time in most cases. For clients who were disenrolled because of inappropriate behavior or violation of specific written policies, reenrollment will be considered on a case-by-case basis.

Standard	Measure
Staff will document reasons for disenrollment in the client record	Documentation of reason for disenrollment
Staff will determine client eligibility for other programs and re-instatement in Ryan White Outpatient Ambulatory Care Services	Documentation of "inactive status" and maintenance of records and contact information to facilitate rapid re-enrollment, as appropriate

County of San Diego Monthly STD Report

Volume 16, Issue 1: Data through August 2023; Report released February 5, 2024.

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

	2022		2023	
	Aug	*Previous 12-Month Period**	*Aug*	*Previous 12-Month Period**
Chlamydia	1721	18356	1463	17227
Female age 18-25	572	6400	442	5748
Female age ≤ 17	54	571	61	581
Male rectal chlamydia	181	1729	179	1738
Gonorrhea	795	7841	590	7037
Female age 18-25	100	1193	61	857
Female age ≤ 17	9	103	17	93
Male rectal gonorrhea	177	1508	142	1570
Early Syphilis (adult total)	84	1124	62	929
Primary	7	179	10	176
Secondary	29	363	15	257
Early latent	48	582	37	466
Congenital syphilis	1	38	6	46

* 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	11421	521.1	316	110.5	318	332.8	1093	146.1	1420	152.4
Gonorrhea	4447	202.9	150	52.4	227	237.6	664	88.7	769	82.5
Early Syphilis	594	27.1	24	8.4	68	71.2	261	34.9	172	18.5
Under 20 yrs										
Chlamydia	1582	287.4	27	47.5	62	260.5	140	58.3	203	112.8
Gonorrhea	293	53.2	3	5.3	28	117.7	56	23.3	18	10.0
Early Syphilis	12	2.2	1	1.8	2	8.4	8	3.3	0	0.0

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.

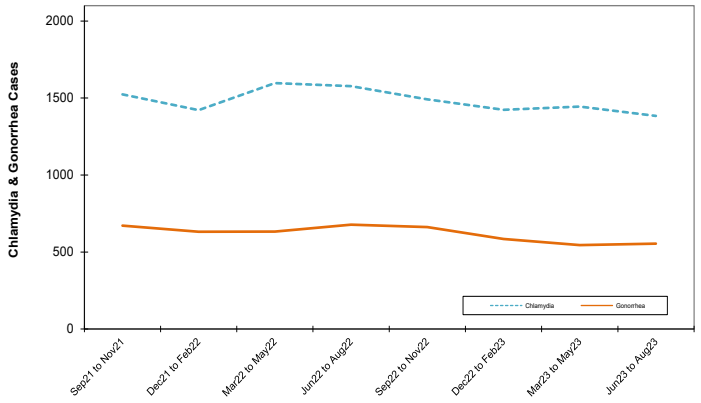
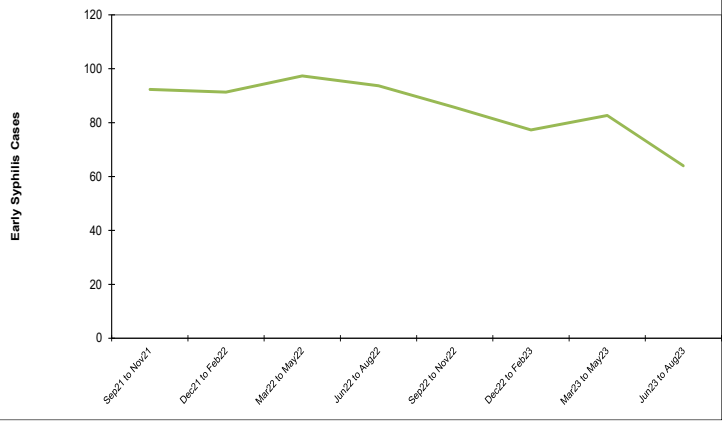


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Editorial Note: Syphilis Updates – Temporary Importation of Extencilline and Pilot Hotline

The Food and Drug Administration (FDA) recently exercised enforcement discretion to allow the temporary importation and use of Extencilline (benzathine benzylpenicillin injection, powder, for suspension) to mitigate the effects of the ongoing Bicillin® L-A shortage [1]. Extencilline has been determined to be equivalent to Bicillin® L-A. However, there are differences in the preparation and administration of the medication and the contraindications for prescribing. For further information, please refer to the manufacturer's Dear Healthcare Provider Letter and Dear Colleague Letter from the Centers for Disease Control and Prevention. Availability of Extencilline does not change the recommendation to limit use of Bicillin® L-A to syphilis treatment of pregnant persons and persons with medical contraindication to doxycycline, as described in previous communications [2][3][4][5][6].

In other news, the California Prevention Training Center, in collaboration with the National Network of Prevention Training Centers, is now piloting a hotline for urgent clinical consultations involving congenital syphilis (CS) or syphilis in pregnancy. California clinicians with CS-related questions requiring immediate attention can visit www.stdccn.org, indicate that they have an urgent inquiry, and receive a same-day call back from a subject matter expert. The CS hotline will be available 24/7 (including nights and weekends) and will run from January through March 31, 2024. Use of this service does not replace mandated reporting to the local health department, and providers are encouraged to use the County of San Diego's STD Clinical Consultation Service (619-609-3245) for syphilis-related questions that arise during regular business hours (Monday-Friday 8:00am-5:00pm).

HIV PLANNING GROUP

12-MONTH COMMITTEE TRACKING

Feb 2023 - Nov 2023

Medical Standards & Evaluation Committee

MSEC	**Feb**	**May**	**Sep**	**Nov**	**#**
Total Meetings	1	1	1	1	**4**
Member					
Tilghman, Dr. Winston [C]	*	*	*	*	**0**
Aldous, Dr. Jeannette [N CC]	*	*	*	*	**0**
Bamford, Dr. Laura	*	*	*	*	**0**
Grelotti, Dr. David	*	*	*	*	**0**
Hernandez, Yessica	*	*	*	*	**0**
Lewis, Robert	**1**	**1**	**JC**	*	**2**
Lochner, Mikie	*	*	*	**1**	**1**
Ransom, Shannon	*	*	**1**		
Spector, Dr. Stephen	**1**	**1**	*	*	**2**
Stangl, Lisa [N]	*	**1**	*	*	**1**
Quezada-Torres, Karla	*	*	**1**	*	**1**

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 = Absent for the month

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

YOUR VOICE MATTERS!

2024 COUNTY OF SAN DIEGO HIV NEEDS ASSESSMENT SURVEY

TELL US ABOUT:

- Access to HIV prevention and treatment services
- Things that work well
- Challenges and concerns
- Your well-being

Learning about the impact of HIV in San Diego County will help us improve HIV services and access!

TAKE THE SURVEY ONLINE!

hpg.hhsa@sdcounty.ca.gov

026

CHECK OUT OUR NEW APP FOR COUNTY'S HIV RESOURCES

GETTING 2 ZERO STOP HIV

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