SAN DIEGO HIV PLANNING GROUP (HPG)

MEDICAL STANDARDS & EVALUATION COMMITTEE (MSEC)

MEETING PACKET

TUESDAY, SEPTEMBER 19, 2023, 4:00 PM – 5:30 PM

SERRA MESA – KEARNY MESA LIBRARY

9005 AERO DRIVE, SAN DIEGO, CA 92123

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).

TABLE OF CONTENTS

Meeting Location & Directions:

Medical Standards & Evaluation Committee (MSEC)

Tuesday, September 19, 2023
4:00 PM - 5:30 PM

Serra Mesa - Kearny Mesa Library
9005 Aero Drive
San Diego, CA 92123

Parking - 88 parking spaces, including 4 disability accessible spaces and 2 motorcycle spaces.

FROM I-15 N:

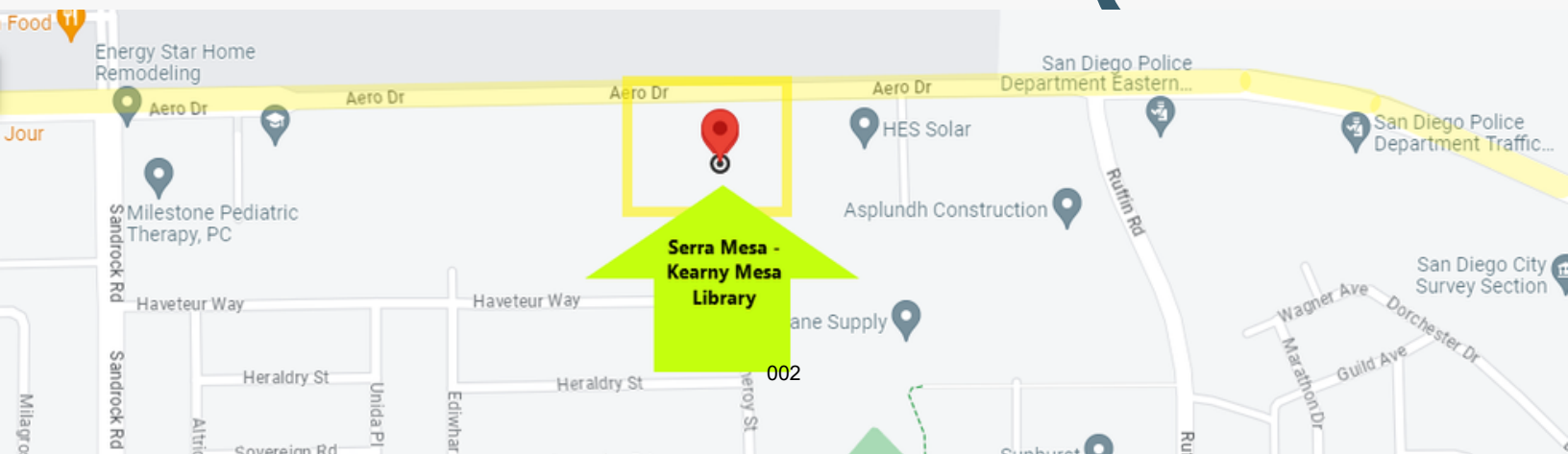
1. Follow I-15 South to Aero Drive.
2. Take Exit 8 for Aero Drive.
3. Use the right 2 lanes to turn right onto Aero Drive.
4. The destination will be on the left (pass the San Diego Police Department).

FROM I-15 S:

1. Follow I-15 North to Aero Drive.
2. Take Exit 8 for Aero Drive.
3. Use the left 2 lanes to turn left onto Aero Drive.
4. The destination will be on the left.

PUBLIC TRANSPORTATION

MTS Bus Routes:
25, 928



SAN DIEGO HIV PLANNING GROUP (HPG)

MEDICAL STANDARDS AND EVALUATION COMMITTEE (MSEC)

MEETING AGENDA

TUESDAY, SEPTEMBER 19, 2023, 4:00 PM – 5:30 PM

SERRA MESA – KEARNY MESA LIBRARY

9005 AERO DRIVE, SAN DIEGO, CA 92123

To participate remotely via Zoom:

https://us06web.zoom.us/j/84265220872?pwd=TGRydGxvcm40dEVlQUhmd0IsWUlZUT09

Call in: 1-669-444-9171 United States Toll

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 seven (7).

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

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 September 19, 2023
5. **Action:** Approve the MSEC minutes from May 9, 2023
6. Old Business:
    a. **Discussion:** Getting to Zero (GTZ) Community Engagement – next steps
        i. **Review:** Summary & Recommendations GTZ Community Engagement Project 2023
    b. **Review/Approve:** Revisions to Ryan White primary care practice guidelines.
7. New Business:
    a. **Discussion:** Develop MSEC attendance policy
8. Other Updates:
    a. STD and MPox Update (Dr. Tilghman)
9. Future agenda items for consideration
10. Announcements
11. **Next meeting date:** November 14, 2023, from 4:00 PM – 5:30 PM.
    Location: Southeastern Live Well Center; 5101 Market St. San Diego, CA 92114 (Tubman Chavez Room C) AND virtually via Zoom.

12. Adjournment

WORK PLAN
February 14, 2023 •
May 9, 2023 • Finalize Practice Guidelines • Executive Report for review
September 19, 2023 • Finalize Practice Guidelines
November 14, 2023 • Occlusal guards, including hard appliance (D9944) and soft appliance (D9945) to list of covered oral healthcare services • Review chart review tool for 2023.

SAN DIEGO HIV PLANNING GROUP (HPG)
MEDICAL STANDARDS AND EVALUATION COMMITTEE (MSEC)
DRAFT MINUTES
TUESDAY, MAY 9, 2023, 4:00 PM – 5:30 PM
COUNTY OPERATIONS CENTER
5560 OVERLAND AVE, SAN DIEGO, CA 92123 (TRAINING ROOM 171, BUILDING 5560)

To participate remotely via Zoom:
https://us06web.zoom.us/j/84265220872?pwd=TGRydGxvcm40dEVIQUhmd0lsWUlZUT09
Call in: 1-669-444-9171 US Toll
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 at **619-403-8809** or via e-mail at **hpg.hhsa@sdcounty.ca.gov**.

A quorum for this meeting is seven (7).
Committee Members Present: Dr. Laura Bamford, Dr. David Grelotti, Yessica Hernández, Mikie Lochner, Shannon Ransom, Dr. Winston Tilghman (Chair), Karla Quezada-Torres, Dr. Jeannette Aldous (Co-Chair) virtual using "Just Cause"
Committee Members Absent: Dr. Stephen Spector, Bob Lewis, Lisa Stangl, Dr. Adam Zweig

ORDER OF BUSINESS

Agenda Item	Discussion/Action	Follow-Up
1. Call to order, roll call, comments from the chair, and a moment of silence	Dr. Winston Tilghman called the meeting to order at 4:15 PM and noted the presence of an in-person quorum. A moment of silence was observed.	
2. Public comment (for members of the public)	None	
3. Sharing our concerns (for committee members)	None	
4. **Action:** Approve the MSEC agenda for May 9, 2023	**Motion:** Approve the May 9, 2023 meeting agenda as presented with the following change: ▪ Switch to New Business before Old Business to allow for time for presentation on the Executive Report on Compliance with Practice Guidelines 2022.	

Agenda Item	Discussion/Action	Follow-Up
	Motion/Second/Count (M/S/C): Lochner / Quezada-Torres 7/0 **Abstentions:** Tilghman **Motion carries**	
5. **Action:** Approve the MSEC minutes for February 14, 2023	**Motion:** Approve the February 14, 2023 meeting minutes as presented. **M/S/C:** Lochner / Grelotti 7/0 **Abstentions:** Tilghman **Motion carries**	
6. Old Business:		
a. **Discussion:** Getting to Zero (GTZ) Community Engagement – next steps?	Dr. Delores Jacobs presented and asked for suggested next steps for the following: 1. How to better coordinate availability of non-urgent primary care, case management, mental health services appointments (batched appointments) 2. How to achieve increased availability of drop-in/after hours. Members will be given time to think about these questions and recommendations for the September 2023 meeting. These questions are also being considered at the Strategies and Standards Committee as well.	Agenda item to remain for next meeting.
b. Add occlusal guards, including hard appliance (D9944) and soft appliance (D9945) to list of covered oral healthcare services.	This agenda item was tabled to the next meeting and until additional data is collected in the Fall during the Needs Assessment process.	
c. **Review:** Revisions to Ryan White primary care practice guidelines.	This agenda item was tabled to the next meeting. It was recommended to send a Microsoft Word Document version draft for review to members and any recommendations be sent to HIV Planning Group Support Staff.	HPG Support Staff to distribute a draft of guidelines to the MSEC committee members and collect any recommendations for changes.
7. New Business:		

Agenda Item	Discussion/Action	Follow-Up
a. **Review:** Executive Report on Compliance with Practice Guidelines 2022	The report on the results of the Executive Report on Compliance with Practice Guidelines 2022 was presented by Jeanette Johnson of United Healthcare.	
b. **Presentation/Discussion:** Doxycycline Post-Exposure Prophylaxis for Sexually Transmitted Disease (STD) Prevention (Dr. Tilghman)	An oral presentation was given by Dr. Tilghman regarding Doxycycline Post-Exposure Prophylaxis (Doxy-PEP) for STD prevention. The California Department of Public Health (CDPH) and County of San Diego are recommending Doxy-PEP for men who have sex with men (MSM) and trans women who have a history of sexually transmitted infections (STIs) in the last year. It was noted that several providers at the University of California, San Diego Owen Clinic have been prescribing this medication. A member asked how this information is going out to providers and clinicians as this is a new development.	
8. Other Updates:		
a. STD and MPOX Update (Dr. Tilghman)	Dr. Tilghman reviewed the County of San Diego Monthly STD Report in the meeting packet.	
9. Future agenda items for consideration	None.	
10. Announcements	No announcements.	
11. Next meeting date	**Date:** Tuesday, September 19, 2023 **Time:** 4:00 PM – 5:30 PM **Location:** In-person and remotely/virtually via Zoom. Meeting location to be determined. Please note: The meeting was moved from September 12, 2023, to September 19, 2023, due to a scheduling conflict for members.	
12. Adjournment	5:45 PM	

Consultant Memo: D. Jacobs, PhD
GTZ Community Engagement 2023
June 2023

DRAFT Final 2023 Report

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 persons; 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 accomplishments and progress toward 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

Communications Task Force

- Enhanced Communications Work Plan drafted which now includes weekly emails and social media posts, including: monthly ICYMI, HIV & Health, Engagement and Participation opportunities. Also includes website enhancement and continuing work to target and expand lists.

Strategies & Standards

- Acknowledge and Address Hesitation& 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 additional items
- Attempting to build an HPG culture of consistent, ongoing Recruitment opportunities for consumers to learn about HPG and receive personal invitations to join HPG & HPG Committees

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 is 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. Consult with the Recipient's office regarding the potential tools (standards, contract language, etc.) to provide guidance to contracted HIV service providers as they educate and support consumers in their awareness of and participation in planning opportunities with HPG.
    b. 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 an effective vehicle for consumer awareness, education and opportunity to seek participation.
    c. Additionally, pursuing non-RW, private funds to subsidize small stipends for those with lived experience may increase consumer interest in participation.
2. Continue to focus upon building and sustaining a welcoming, inclusive, and supportive HPG culture
3. Continue to complete work on items (listed below) 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 below)
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 app 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.

Listing 2022-23 Completed Items and 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**

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~~ Committee 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 g~~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, for partners living with HIV, treatment status and presence/duration of viral suppression~~ and history of pre-exposure prophylaxis (PrEP) use~~
      - Exposure sites – anorectal, genital, oropharyngeal
      - ~~Use of condoms~~Protection from HIV and STIs: including condoms, HIV pre-exposure prophylaxis (PrEP), and doxycycline STI post-exposure prophylaxis (i.e., Doxy-PEP)
      - Pleasure, performance, and any issues affecting these
   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
      - History of overdose or use of naloxone on self or others
      - 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 results
      - Prior and current antiretroviral regimens

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- 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~~https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SD_TB%20Risk%20Assessment%202018.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~~ STI Treatment Guidelines, 20~~15~~21
  - Updated CDC Gonorrhea Treatment Recommendations, 2020
  - California Department of Public Healthhttps://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CDPH-Doxy-PEP-Recommendations-for-Prevention-of-STIs.pdf
  - 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_pro

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gram/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)~~HIV 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

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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~~ Vaccines 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, 15-valent, or 20-valent pneumococcal conjugate vaccine (PCV13, PCV15, or PCV20) 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).
~~10)~~11) Mpox (formerly known as monkeypox): Vaccination with the JYNNEOS vaccine should be offered to PLWH who have had recent or anticipate potential Mpox exposure. For persons aged 18 years and older, dosing via the subcutaneous or intradermal route is acceptable. For persons less than 18 years of age, subcutaneous administration is recommended. For all regimens, two doses are recommended, with an interval of four weeks (28 days +/- three days) between doses. Further information is available at https://www.cdc.gov/poxvirus/mpox/clinicians/vaccines/vaccine-basics-healthcare.html.

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~~11)~~12) Live Vaccines (Live attenuated influenza vaccine, Varicella or Zoster vaccine, Vaccinia (~~small pox~~smallpox), 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)~~13) 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, t~~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 for patients who are initiating ART can be found at ~~https://aidsinfo.nih.gov/guidelines~~https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/table-7-antiretroviral-regimen?view=full.

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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:~~Guidelines for the management of treatment-experienced patients, including treatment optimization for patients using oral or long-acting injectable medications, can be found at 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 or modifying ART. Check lipid levels annually for those with normal baseline values who have risk factors for cardiovascular disease. 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) A large randomized clinical trial demonstrated that treatment of high-grade squamous intraepithelial lesions (HSIL), which are precursors to anal cancer, significantly reduced progression to anal cancer among adult PLWH compared to active monitoring without treatment.
2) At this time, no national recommendations exist for routine anal cancer screening.
~~1)~~3) 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

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referral for follow-up, including high-resolution anoscopy, is available.

~~2)~~4) 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 oral and long-acting injectable PrEP, please refer to the U.S. PHS Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – ~~2017~~ 2021 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~~https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.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

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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~~https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SD_TB%20Risk%20Assessment%202018.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

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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

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APPENDIX A
SAMPLE Sexual Health Risk Assessment Form

Commented [TW6]: Is there a newer version of this or any additional examples that should be provided?

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

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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 Committee 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
      - 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, for partners living with HIV, treatment status and presence/duration of viral suppression
      - Exposure sites – anorectal, genital, oropharyngeal
      - Protection from HIV and STIs: including condoms, HIV pre-exposure prophylaxis (PrEP), and doxycycline STI post-exposure prophylaxis (i.e., Doxy-PEP)
      - Pleasure, performance, and any issues affecting these
   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
      - History of overdose or use of naloxone on self or others
      - 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 results
      - 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 https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/tuberculosis_control_program/SD_TB%20Risk%20Assessment%202018.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 STI Treatment Guidelines, 2021
  - Updated CDC Gonorrhea Treatment Recommendations, 2020
  - California Department of Public Healthhttps://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CDPH-Doxy-PEP-Recommendations-for-Prevention-of-STIs.pdf
  - 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 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) Vaccines 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, 15-valent, or 20-valent pneumococcal conjugate vaccine (PCV13, PCV15, or PCV20) 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) Mpox (formerly known as monkeypox): Vaccination with the JYNNEOS vaccine should be offered to PLWH who have had recent or anticipate potential Mpox exposure. For persons aged 18 years and older, dosing via the subcutaneous or intradermal route is acceptable. For persons less than 18 years of age, subcutaneous administration is recommended. For all regimens, two doses are recommended, with an interval of four weeks (28 days +/- three days) between doses. Further information is available at https://www.cdc.gov/poxvirus/mpox/clinicians/vaccines/vaccine-basics-healthcare.html.
12) Live Vaccines (Live attenuated influenza vaccine, Varicella or Zoster vaccine, Vaccinia (smallpox), 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.

13) 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) 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 for patients who are initiating ART can be found at https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/table-7-antiretroviral-regimen?view=full.

5) Guidelines for the management of treatment-experienced patients, including treatment optimization for patients using oral or long-acting injectable medications, can be found at 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 or modifying ART. Check lipid levels annually for those with normal baseline values who have risk factors for cardiovascular disease. 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) A large randomized clinical trial demonstrated that treatment of high-grade squamous intraepithelial lesions (HSIL), which are precursors to anal cancer, significantly reduced progression to anal cancer among adult PLWH compared to active monitoring without treatment.
2) At this time, no national recommendations exist for routine anal cancer screening.
3) 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.
4) 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 oral and long-acting injectable PrEP, please refer to the U.S. PHS Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2021 Update.
   https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.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

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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:

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County of San Diego Monthly STD Report

Volume 15, Issue 8: Data through March 2023; Report released September 5, 2023.

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

	2022		2023	
	Mar	*Previous 12-Month Period**	*Mar*	*Previous 12-Month Period**
Chlamydia	1706	18250	1415	17834
Female age 18-25	609	6473	185	5798
Female age ≤ 17	50	617	56	533
Male rectal chlamydia	161	1668	128	1658
Gonorrhea	666	8147	562	7575
Female age 18-25	100	1261	73	1042
Female age ≤ 17	8	127	9	87
Male rectal gonorrhea	131	1471	111	1573
Early Syphilis (adult total)	98	1203	85	1030
Primary	18	177	22	189
Secondary	29	397	21	292
Early latent	51	629	42	549
Congenital syphilis	3	34	4	37

* 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	4212	508.2	109	119.4	116	293.0	415	145.9	471	124.1
Gonorrhea	1719	207.4	50	54.8	83	209.7	251	88.3	272	71.6
Early Syphilis	218	26.3	7	7.7	24	60.6	105	36.9	163	42.9
Under 20 yrs										
Chlamydia	596	269.3	6	29.2	27	250.0	51	53.9	74	89.9
Gonorrhea	109	49.2	1	4.9	9	83.3	19	20.1	6	7.3
Early Syphilis	8	3.6	1	4.9	1	9.3	5	5.3	0	0.0

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, date of onset, and date received. 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.

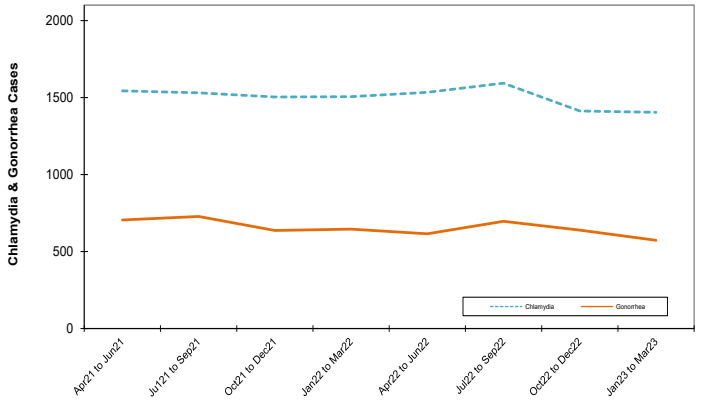
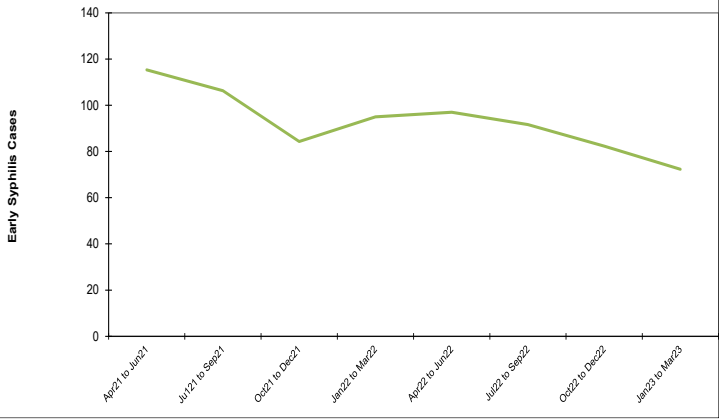


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Editorial Note: STOMP Study of Tecovirimat for Mpox

Tecovirimat (also known as TPOXX or ST-246) is an antiviral medication that is currently recommended for patients who have or are at high risk for severe mpox (formerly known as monkeypox) disease or have involvement of anatomic areas that might result in serious sequelae. It is approved by the Food and Drug Administration (FDA) for treatment of human smallpox disease caused by variola virus in adults and children. It is not FDA-approved for mpox but is currently available under an expanded access Investigational New Drug (EA-IND) protocol held by the Centers for Disease Control and Prevention (CDC) [1].

Currently there is a paucity of data on the effectiveness of tecovirimat treatment for mpox, although data from animal studies have indicated efficacy of tecovirimat for treatment of non-variola orthopoxviruses and safety trials have been favorable [2]. The Study of Tecovirimat for Human Mpox Virus (STOMP) is a Phase 3, randomized, placebo-controlled, double-blind trial of tecovirimat for the treatment of human mpox disease. There is also an open-label component of the study that will provide tecovirimat to people with severe mpox disease, pregnant and breastfeeding individuals, persons less than 18 years of age, individuals on potent inducing concomitant medications, and people with severe immune suppression or skin lesions placing them at higher risk for severe disease.

Editorial Note (Continued) :

CDC encourages providers to inform patients with mpox about STOMP and to recommend that they consider enrollment [1]**.** This includes people who have an indication for tecovirimat (who would be included in the open-label protocol) and other people with confirmed or presumptive mpox (who would be included in the randomized protocol). Eligibility criteria include: 1) laboratory-confirmed or presumptive mpox infection, 2) mpox illness of less than 14 days duration, and 3) at least one active (not yet scabbed) skin or mouth lesion or proctitis. While providers should have mechanisms in place to provide tecovirimat to patients who are unable or unwilling to enroll in STOMP, referral to STOMP is recommended as the first-line approach to mpox treatment. Further information about STOMP is available at https://www.stomptpoxx.org or by contacting the UCSD Antiviral Research Center at (619) 543-8080.

While mpox case activity remains low in San Diego County compared to 2022, cases are still occurring in the region, and providers should continue to be vigilant, vaccinate persons who are vulnerable to mpox (or request the vaccine) [3], and test and treat for mpox when clinically indicated [4].

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

APPENDIX

(Page 041)

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

HIV PLANNING GROUP
12-MONTH COMMITTEE TRACKING
Sep 2022 - May 2023

Medical Standards & Evaluation Committee

MSEC	Sep	Nov	Feb	May	#
Total Meetings	1	0	1	1	**3**
Member					
Tilghman, Dr. Winston [C]	*	NM	*	*	**0**
Aldous, Dr. Jeannette [N CC]	**1**	NM	*	JC	**1**
Bamford, Dr. Laura	*	NM	*	*	**0**
Grelotti, Dr. David	*	NM	*	*	**0**
Hernandez, Yessica			*	*	**0**
Lewis, Robert	**1**	NM	**1**	**1**	**3**
Lochner, Mikie	**1**	NM	*	*	**1**
Ransom, Shannon	*	NM	*	*	**0**
Spector, Dr. Stephen	*	NM	**1**	**1**	**2**
Stangl, Lisa [N]	*	NM	*	**1**	**1**
Quezada-Torres, Karla	*	NM	*	*	**0**
Zweig, Dr. Adam [N]	*	NM	**1**	**1**	**2**

To remain in good standing and eligible to vote, a committee member may not miss three (3) consecutive meetings or six (6) meetings within twelve (12) months.

***** = Present

1 = Absent for the month

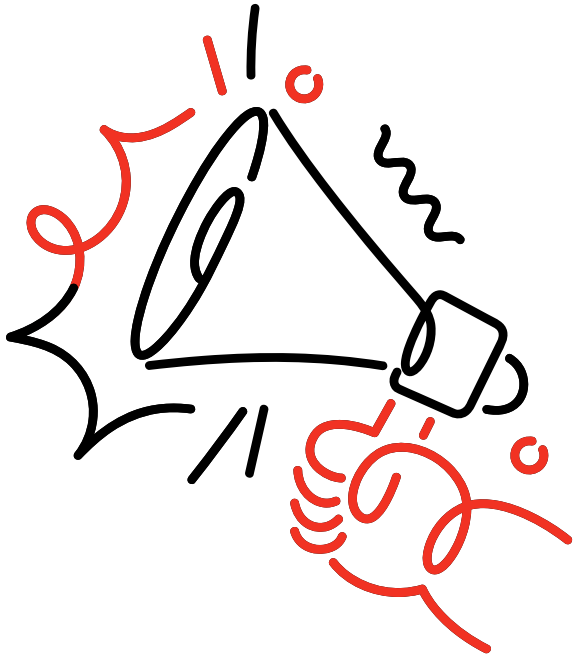
1 = Absence when there are multiple meetings that month. Member needs to attend at least one (1) meeting for attendance to count for that month.

JC = Just Cause

EC = Emergency Circumstance

NM = No Meeting

DR. A. BRAD TRUAX AWARDS



2023 Call for Nominations

Due by **3:30 PM** on
Sunday, October 1, 2023

Each year, the **San Diego HIV Planning Group** recognizes individuals who have served the community and made outstanding contributions to the fight against the HIV/AIDS epidemic.

This award is named in honor of Dr. A. Brad Truax and in memory of his tireless dedication to the prevention and treatment of HIV/AIDS. Dr. Truax chaired the first advisory board on HIV/AIDS in San Diego County. He was a persistent and diplomatic person who encouraged people with different interests and agendas to work together to achieve goals that benefit the community.

The Selection Committee, composed of former Dr. A. Brad Truax Award winners, will select one (1) individual to receive the Dr. A. Brad Truax Award. Awards will be presented at a reception honoring all nominees on **World AIDS Day, Friday, December 1, 2023**.

From all nominations, awards are given in three (3) service categories:

- HIV Education, Prevention, and/or Counseling and Testing
- HIV Care, Treatment, and/or Support Services for persons living with HIV/AIDS
- HIV Planning, Advocacy, or Policy Development related to HIV education, prevention, counseling, testing, care, treatment, and/or support services

Who is Eligible:

- A volunteer, board member, or staff person who has provided service within the last year that improves the quality of life of people living with HIV/AIDS in San Diego.
- If the nominee is employed by an HIV service provider, the nomination must be for service above and beyond what is expected for their paid position.

Nomination Procedure:

- Submit the **Nomination Form** (print or typed).
- Attach relevant supporting information (limit to 3 pages).
- Include a high-resolution picture of the nominee.
- All nominations are due **by 3:30 PM on October 1, 2023**.

Please submit the nomination by email to **HPG.HHSA@sdcounty.ca.gov** with the subject line: "**Truax Nomination**"

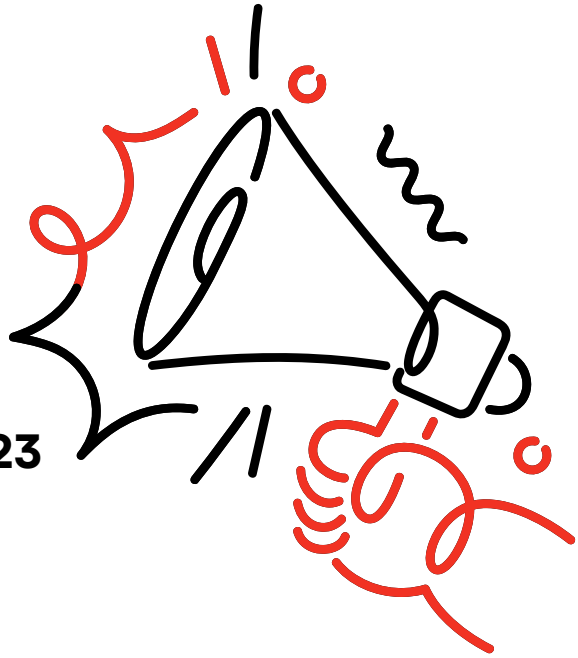
Scan QR Code for Nomination Form

Who Can Nominate:

- Anyone may submit a nomination.
- Self-nominations must include a letter of recommendation from a third party.

TO LEARN MORE, VISIT SDPLANNING.ORG

DR. A. BRAD TRUAX AWARDS



Convocatoria de Nominaciones 2023

Vencimiento antes de **las 3:30 p. m. del domingo 1 de octubre de 2023**

Cada año, **el Grupo de Planificación del VIH de San Diego** reconoce a las personas que han servido a la comunidad y han hecho contribuciones sobresalientes a la lucha contra la epidemia del VIH/SIDA. Extendemos una cordial invitación a todos los miembros de la comunidad para participar en la presentación de nominaciones.

Este premio lleva el nombre en honor al Dr. A. Brad Truax y en memoria de su incansable dedicación a la prevención y tratamiento del VIH/SIDA. El Dr. Truax presidió la primera junta asesora sobre VIH/SIDA en el condado de San Diego. Fue una persona persistente y diplomática que alentó a personas con diferentes intereses y agendas a trabajar juntas para lograr objetivos que beneficien a la comunidad.

El Comité de Selección, compuesto por ex ganadores del Premio Dr. A. Brad Truax, seleccionará a una (1) persona para recibir el Premio Dr. A. Brad Truax. Los premios se entregarán en una recepción en honor a todos los nominados en **el Día Mundial del SIDA, el viernes 1 de diciembre de 2023**.

De todas las nominaciones, los premios se otorgan en tres (3) categorías de servicio:

- Educación, prevención y/o asesoramiento y pruebas del VIH
- Servicios de atención, tratamiento y/o apoyo para personas que viven con VIH/SIDA
- Planificación, defensa o desarrollo de políticas relacionadas con la educación, prevención,
- asesoramiento, pruebas, atención, tratamiento y / o servicios de apoyo del VIH

Quién es elegible:

- Un voluntario, miembro de la junta o miembro del personal que ha brindado servicio en el último año que mejora la calidad de vida de las personas que viven con VIH/SIDA en San Diego.
- Si el nominado es empleado por un proveedor de servicios de VIH, la nominación debe ser para el servicio más allá de lo que se espera para su puesto remunerado.

Procedimiento de nominación:

- Envíe el formulario de nominación.
- Adjunte información de apoyo relevante (límite a 3 páginas).
- Incluye una imagen de alta resolución del nominado.
- Todas las nominaciones deben presentarse antes de **las 3:30 PM del 1 de octubre de 2023**.

Por favor, envíe la nominación por correo electrónico a **HPG.HHSA@sdcounty.ca.gov** con el asunto: "**Nominación Truax**"

Escanear código QR para la nominación Forma

Quién puede nominar:

- Cualquier persona puede presentar una nominación.
- Las autonominaciones deben incluir una carta de recomendación de un tercero.

PARA OBTENER MÁS INFORMACIÓN, VISITE SDPLANNING.ORG