STRATEGIES AND STANDARDS COMMITTEE

Tuesday, October 1, 2024, 3:00 PM – 4:30 PM
Southeastern Live Well Center
5101 Market St., San Diego, CA 92114
(Tubman Chavez Room C)

The Charge of the Strategies & Standards Committee: To oversee the Getting to Zero (GTZ) Plan to direct objectives, strategies, and activities to get to zero new infections and continue to support those living with and vulnerable to HIV in living well in San Diego.

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Meeting Location & Directions:

Strategies & Standards Committee
Tuesday, October 1, 2024
3:00 PM - 4:30 PM

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

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

FROM I-805 SOUTH:

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

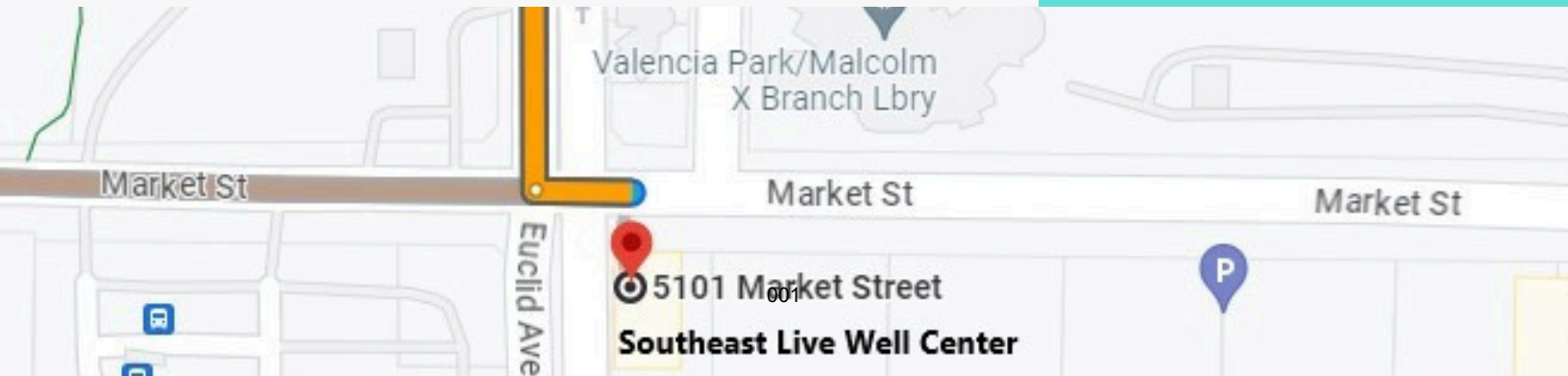
FROM I-805 NORTH:

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

PUBLIC TRANSPORTATION

MTS Trolley:
Orange Line

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



STRATEGIES & STANDARDS COMMITTEE

Tuesday, October 1, 2024, 3:00 PM – 4:30 PM
Southeastern Live Well Center
5101 Market St, San Diego, CA 92114
(Tubman Chavez Room A)

To participate remotely via Zoom:
https://us06web.zoom.us/j/85772860296?pwd=Ym1jWit6cWhnL05BOTlyR25LbWhqQT09
Call in: +1 (669) 444-9171
Meeting ID (access code): 857 7286 0296 **Password:** 630634
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 five (5).
Committee Members: Allan Acevedo (Co-Chair) | Amy Applebaum | Dr. Beth Davenport | Joseph Mora | Venice Price | Ivy Rooney | Dr. Winston Tilghman | Jeffery Weber | Michael Wimpie (Chair)

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 Strategies & Standards Committee agenda for October 1, 2024
5. **Action:** Approve the Strategies & Standards minutes for August 6, 2024
6. Review follow-up items from last meeting
7. Old Business:
    a. Transportation Standards – update by Maritza Herrera
    b. Discussion: Co-chair
8. New Business:
    a. **Action**: Remove Allan Acevedo as Co-chair
    b. Presentation: HIV and Aging – Dr. Karris
    c. Mental Health Services Standards – review and update
    d. Universal Standards – review and update
        i. Trauma-Informed Care – review and update
9. Routine Business:
    a. Discussion: Recommendations from Priority Setting & Resource Allocation Committee

10. Recommendations to the HIV Planning Group, HIV Planning Group committees, and requests of recipient
11. Suggested items for the future committee agenda
12. Announcements
13. Next meeting date: **December 3, 2024 at 3:00 PM – 4:30 PM**
    Location: **Southeastern Live Well Center; 5101 Market St, San Diego, CA 92114 (Tubman Chavez Room A)** AND online via Zoom.
14. Adjournment

STRATEGIES AND STANDARDS COMMITTEE

Tuesday, August 6, 2024, 3:00 PM – 4:30 PM
Southeastern Live Well Center
5101 Market St, San Diego, CA 92114
Tubman Chavez Room C

A quorum for this meeting is six (6).

Members Present: Amy Applebaum | Dr. Beth Davenport | Joseph Mora | Shannon Ransom | Ivy Rooney | Dr. Winston Tilghman | Jeffery Weber | Michael Wimpie (Chair)

Members Absent: Allan Acevedo | Moira Mar-Tang | Venice Price

ORDER OF BUSINESS

Agenda Item	Discussion/Action	Follow-Up
1. Call to order, roll call, comments from the chair, and a moment of silence	Michael Wimpie called the meeting to order at 3:00 PM.	
2. Public comment (for members of the public)	None	
3. Sharing our concerns (for committee members)	None	
4. **ACTION:** Approve the Strategies and Standards Committee agenda for June 20, 2024	**Motion:** Approve the Strategies and Standards Committee agenda for August 6, 2024 as presented. **Motion/Second/Count (M/S/C):** Davenport/Ransom/7-0 **Abstentions:** Wimpie **Motion carries**	
5. **ACTION**: Approve meeting minutes from October 3, 2023	**Motion:** Approve meeting minutes for June 20, 2024 as presented. **M/S/C:** Davenport/Applebaum/6-0 **Abstentions:** Wimpie, Tilghman **Motion carries**	
6. Review follow-up items from last meeting	• The Recipient's Office will provide updates and changes to the Transportation Services Standards at the next meeting. Status: In progress • HIV and Aging presentation – will occur in October. Status: In progress • September HIV and Aging Conference reminder for HPG. Status: Completed	HPG Support Staff (SS) will request of Dr. Karris to add the following to the HIV and Aging presentation: - Isolation and social needs - Service co ordination

Agenda Item	Discussion/Action	Follow-Up
	• Whole Person Approach to Care presentation on goals and funding. Status Completed • The Recipient's Office will provide available data on the refugee population that is currently experiencing high rates of HIV positivity. Status: In progress • The Community Engagement Group (CEG) will review and discuss the anti-racism statement item at its September meeting. Status: In progress Committee should review the anti-racism statement and JEDI document, as it has already been worked on previously, before they determine what to do next and how to move forward regarding creating an anti-racism statement.	
7. Old Business		
a. Presentation: California Statewide Integrated Strategic Plan – Felipe Ruiz and Maritza Herrera	Felipe Ruiz and Maritza Herrera presented on the California Statewide Integrated Strategic Plan. Ending the Epidemic addresses HIV, HCV, and STI in California. The California Statewide Integrated Strategic Plan will be implemented from 2022 to 2026. The HIV, STD and Hepatitis Brach is partnering with Facente Consulting. The Final Blueprint for implementation was released on August 2023. It includes 30 different strategies with specific activities that work with existing programs, resources, education, and care to reduce new diagnoses	HPG SS to follow up with Felipe to share the Strategic Plan with the committee.

Agenda Item	Discussion/Action	Follow-Up
	The Plan will be using a results-based accountability framework to measure the services with three key questions: - How much did we do? - How well did we do it? - Is anybody better off? The focus is on Black/African American (AA) and Latinx Communities using the status neutral framework.	
b. Update: Transportation Standards – Maritza Herrera	Maritza Herrera will provide a final draft in the next meeting.	
c. Draft Work Plan for FY 25 (March 1, 2024 – February 28, 2025)	Reviewed, no recommended changes from the committee.	HPG SS will update the work plan to move HIV and Aging to October.
8. New Business		
a. Presentation: Key Findings on HIV Positive Aware and Out of Care – Dr. Tweeten	Dr. Tweeten presented on key findings on people living with and aware of their HIV status, but out of care. The following points were made: - Several age groups show a significant increase in out-of-care, particularly among youth. - The central region has the largest out-of-care population and the largest population, followed by the South region. - The highest race/ethnicity not in care is Black/AA, followed by Hispanic. The highest transmission risk is the Drug users, with 34%.	HPG SS to follow up with Dr. Tweeten to obtain an updated data set to send to the committee
b. Status Neutral Approach to Improve HIV Prevention and Health Outcomes for Racial and Ethnic Minorities Initiative/Whole Person Approach to Comprehensive Services – Patrick	The Whole Person Care (Status Neutral Approach) is a two-year pilot program funded by the United States until July 2026. We are one of the four jurisdictions piloting the Whole Person Care program. Current service standards in the Ryan White program will be updated to include the Whole Person approach to care.	

Agenda Item	Discussion/Action	Follow-Up
	The pilot program currently focuses on the Latinx population in the South region. Once the program is successful, it will be rolled out to other demographics and will assist HIV patients and others who need support and care services, such as career development, housing, childcare, and health care. The pilot program is based on system navigation from recruitment and social networking to encourage individuals to get tested and stay in treatment. The Recipient's Office is revising some Service Standards which will be released in October. These standards will serve as a universal language for all patients, ensuring a consistent and high-quality level of care.	
c. Discussion: Co-chair	Joseph Mora was recommended for committee co-chair. He has experience as a co-chair from previous years.	HPG SS follow up with Joseph Mora to see if he is willing to accept the nomination and if so, have an action item on the next agenda to vote.
9. Routine Business		
a. Discussion: Recommendations from Priority Setting & Resource Allocation Committee (PSRAC)	PSRAC had a focused and lengthy discussion on the Mental health service category. They were concerned about the decrease in allocation for the next fiscal year due to the lack of money spent last fiscal year. The committee recommended a thorough investigation of Mental Health Services procedures and services, including why the funds were not fully spent.	

Agenda Item	Discussion/Action	Follow-Up
	- What are the various issues that cause people to be unserved? - Should this go to the Medical Standards and Evaluation Committee (MSEC) for review? - How are the funds being utilized? Why are patients not getting access to start and complete their treatment? - MSEC may need to review the psychiatric medication management service category.	
10. Recommendations to the HIV Planning Group (HPG), HPG committees, and requests of recipient	None	
11. Suggested items for future committee agenda	None	
12. Announcements	None	
13. Next meeting date	**Date:** Tuesday, October 1, 2024 **Time:** 3:00 PM – 4:30 PM **Location:** In-person and via Zoom Southeastern Live Well Center, 5101 Market Street, San Diego, CA 92114 (Tubman Chavez Room A)	
14. Adjournment	Meeting adjourned at 4:26 PM.	

Challenges in HIV and Aging

Maile Young Karris, MD

Associate Professor

Divisions of ID & GPH and Geriatrics, Gerontology, and Palliative Care

Overview

- Social needs and Isolation
- Service Coordination between HIV and Geriatrics
- Housing/how to support housing

Objective: Inform and provide food for thought

Loneliness and Social Isolation in OPWH

- Loneliness = the discrepancy between one's preferred and actual social relations
  - U.S. Prevalence ~40-58%
    - Prevalence of loneliness was lower in PWH 60 yrs.+ compared to 50-59 yrs.
- Social isolation = objective deficit in number of relationships and frequency of contact
  - U.S. Prevalence unclear
    - 65-69% live alone
    - 81% do not have close friends

May not be emotionally distressing

Greene AIDS % Beh 2018, , Mazonson AIDS care 2021, Emlet Gerontologist 2013

What are the Costs?

LONELINESS	SOCIAL ISOLATION
• Associated with inflammation • Increased chronic pain • Impaired resilience • Reduced quality of life • Increased depression/anxiety • Increased SUD • Self reported functional impairment • Poorer quality of life	• 6.7 billion annually in costs for the care of socially isolated persons (Medicare) • Limited access to caregivers and other support (stress, lack of resources) -- Increased risk for hospitalization and all cause mortality -- Increased depression/anxiety -- Increased SUD (? boredom) -- Increased risk for cognitive decline

Marziali AIDS and Behavv2020, Pollack AIDS and Beh 2024, Greene AIDS and Behavior 2018, Holt-Lundstad Perspectives on Psychological Science 2015, Holt-Lundstad Plos Medicine 2010, Wilson Arch Gen Psychiatry 2007
Valtorta Heart 2016, Pollak AIDS and Beh 2024

Concentrated and Unique Experiences may Contribute to Loneliness and Social Isolation in Older PLWH

- Initial fatal diagnosis → opt out of work, stopped making new connections
- Significant loss of peers & partners → rapid depletion of social networks + AIDS survivor syndrome
- Stigma associated with HIV and age → limit new interactions to grow and develop social networks
- Mental health challenges → impairs social, cognitive function
- Medical co-morbidity → physical function impairment
- Socioeconomic factors → other basic needs sought out first

Brennan-Ing HIV and Aging. Interdiscpl Top Gerontol Geriatr 2017; Schrimshaw J Health Psychology 2003

Assessing for Loneliness and Social Isolation

- Campaign to End Loneliness Measurement Tool
  - I am content with my friendships and relationships
  - I have enough people I feel comfortable asking for help at any time
  - My relationships are satisfying as I would want them to be.

- Universal Implementation of the Medicare Annual Wellness Visit/Annual physical

Kotwal JAGS 2022, National Academies Social Isolation and Loneliness in Older Adults 2020

Strategies for Loneliness and Isolation

Individual

- Social prescriptions
- Warm phone lines
- Volunteerism
- Social CBT
- Adopt a pet
- Mindfulness, meditation
- Nostalgia

Institutional

- Group based activity programming
- IHHS/home based care
- Village models/ other community connection building
- In-person events

Societal

- Change the narrative: strong individualism, silent suffering should be the norm
- Change our infrastructure
  - Communal meals
  - Built environment
  - Mixed housing (senior + families)

Service Coordination between HIV and Geriatrics

HRSA: Optimizing HIV and Aging Care

Incorporating New Elements

Access affordable hearing aids, glasses, dental care

Assess functional and cognitive status (includes mental health and substances)

Ongoing discussions about sexual health

Supportive services should be viewed as essential (social support, food, housing, finance/benefits management)

Putting Together the Best Health Care Team

Geriatric Assessment Training for the healthcare teams

Clinical Pharmacists to assess polypharmacy

Behavioral health providers

Medical Case Managers

Geri-HIV Models of Care

Table 1. Overview of 3 Human Immunodeficiency Virus and Geriatric Care Models

Model Type	Overall Description	Institution Name	Location
Model 1: Outpatient referral/ consultation	Referral to a geriatrician for recommendations to enhance a patient's care plan; HIV provider remains as primary provider	Positive Aging Consultation, University of Colorado	Aurora, Colorado
Model 2: Combined HIV/geriatric multidisciplinary clinic	A multidisciplinary team is incorporated into existing HIV/infectious disease clinics to provide a comprehensive assessment and evaluation of each patient; primary care providers are provided with full evaluation and recommendations from the multidisciplinary team	The THRIVE Program	Baltimore, Maryland
		Comprehensive HIV and Aging Initiative of the Chronic Viral Illness Service, McGill University Hospital Center	Montreal, Quebec, Canada
		Chelsea and Westminster Hospital [11]	London, United Kingdom
		Silver Clinic [12]	Brighton, United Kingdom
		Golden Compass Program, University of California; San Francisco/Zuckerberg San Francisco General Hospital [14, 16]	San Francisco, California
		Center for Special Studies, New York Presbyterian/Weill Cornell Medical Center [13, 15]	New York City, New York
Model 3: Dually trained providers	An HIV provider with an invested interest in geriatric care performs assessments and provides recommendations	Age Positively Program, Massachusetts General Hospital	Boston, Massachusetts
	Dually boarded provider: a single provider with both geriatric and HIV expertise in 1 clinical home	Penn Community Practice and Penn Geriatrics, University of Pennsylvania Medical Center	Philadelphia, Pennsylvania

Davis CID 2021

Barriers to Implementation

Model of Care	Barriers
Geriatric consultations	Not enough Geriatricians; Geriatricians want to be the primary care provider; Geriatric clinics may have limitations to access (cut off age, health insurance, location); PWH may not want to see a Geriatrician (anticipatory HIV stigma, internalized ageism);
Combo HIV/Geri clinic	Not enough Geriatricians; Institutional buy in; most programs started with a grant and ongoing concern exists about how these programs will be sustained
Co-trained	UNICORNS!!!, institutional buy-in

ROLES AND RESPONSIBILITIES

The staffing needed to provide optimal care to people aging with HIV will vary from one health care setting to another, depending on the expertise and time availability of each member of the health care team. With appropriate training, HIV providers (physicians, nurse practitioners, and physician assistants) can assess for geriatric conditions and integrate geriatric principles into HIV care. For example, the Golden Compass program at San Francisco General Hospital and the New York–Presbyterian Hospital/Weill Cornell Medical Center have incorporated what is referred to as the "geriatric approach" into HIV care. When available, geriatricians can be consulted for specific issues related to aging (such as functional status or cognitive impairment), or they can serve in a co-management capacity to manage the non-HIV comorbidities and address social issues.[6] In areas where geriatricians are not readily available, telehealth or telemedicine may help fill the gaps in specialty services. Other members of the health care team also can be trained to perform screenings and assessments to ensure that comprehensive age-appropriate care is delivered.

HIV Med

- HIV and other co-morbidities
- Medication review (ART)
- Problem list

- Mental health

- Social circumstances
- Environment
- Multidisciplinary

As it relates to adherence barriers to care

Geriatrics

- Comorbidities and severity
- Med rev (inappropriate meds)
- Problem list
- Nutrition
- Mental health, cognition, fears
- Functioning
- Social circumstances
- Environment
- Multidisciplinary

As it relates to function, quality of life

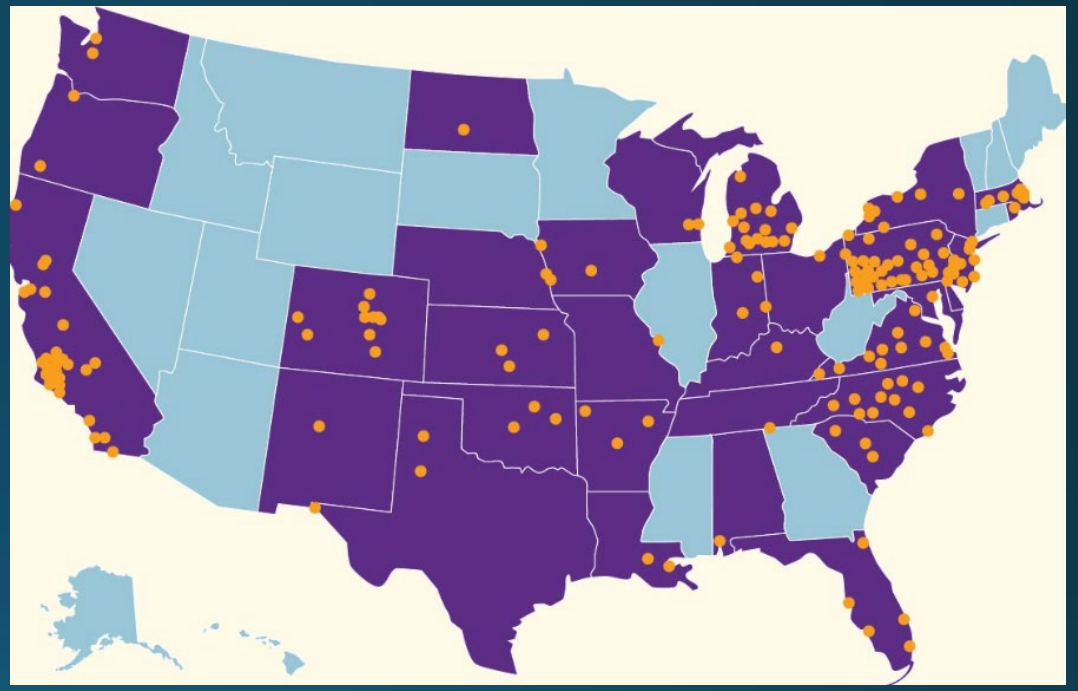
Welsh, Gordon and Gladman Int J Clin Pract 2014, Singh et al CID 2017

Medicare Annual Wellness Visit (Comprehensive Geriatric Assessment)

Components	Specifics
Medical Assessment	Patient concerns, hearing, vision, access to food
Functional Assessment	ADLs / IADLs, falls
Psychologic/Cognitive Assessments	PHQ-2, AD-8, MoCA
Social Assessment	Who they live with, do they get enough support
Environmental Assessment	Shower bars, lighting, rails, etc.
Wellbeing	What matters most? SSDoH
Sexuality and intimacy	Concerns, counseling
Advanced Care Planning	Prepare for your Care

Program for All Inclusive Care of the Elderly (PACE)

- Community-based comprehensive care model enables aging in place
- Capitated program, greater flexibility in services (focus on individual needs)
- Fully accountable for quality & cost
- Results: lower skilled home health visits, fewer hospitalizations, longer survival rates, increased number of days in the community, better quality of life, greater satisfaction with care, better functional status
- Equitable across race, functional status, and social support context



Hirth *J AM Med Dir Assoc* 2009,
https://www.npaonline.org/find-a-pace-program
g/find-a-pace-program

Implementing PACE … and backup

- Educate HIV providers and PWH
- Engage and coordinate with PACE programs
  - Educate substance use, stigma/intersectionality, mental health, sexual health
- Shore-up IHHS
  - Educate IHHS service providers
  - Integrate home health care –nursing, PT, OT
- Fund and educate geriatric case management/coordinate with insurance companies

San Francisco Principles (2020)

All HIV providers trained in geriatric care

Culturally appropriate mental health services including isolation/ loneliness, and SUD

Long term survivors MUST be included and be given prominent seats at the table

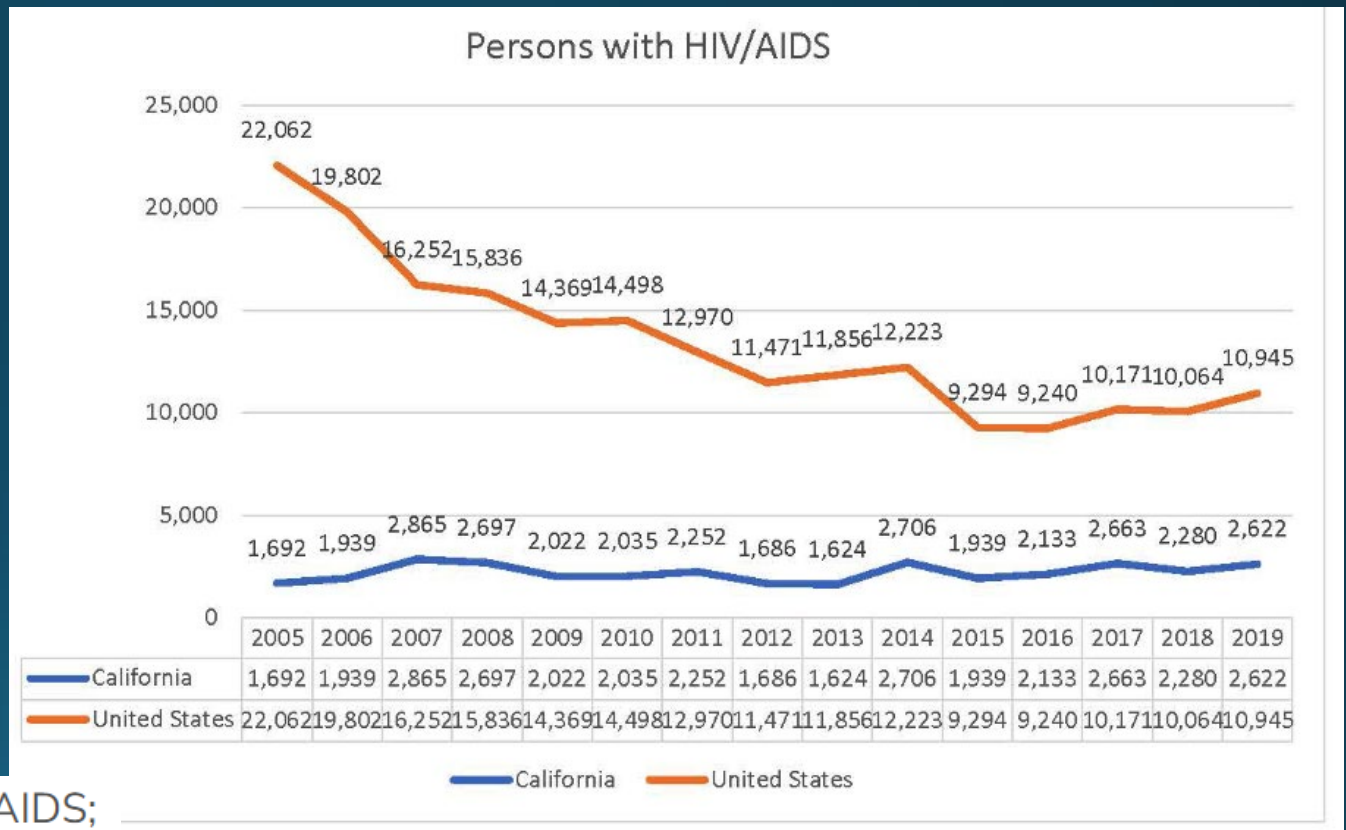
Resources must be allocated for HIV and Aging programs

Align our efforts with other movements to end racism, sexism, ageism, homophobia and transphobia

Housing/how to support housing

Unstably Housing

- 17% of all PLWH are homeless or unstably housed
  - Experience higher rates of mental health disorders, more likely to engage in activities associated with increased chances of HIV transmission, greater risk for inadequate care and treatment
    - In San Francisco 70% of PLWH who were housed were virally suppressed vs 33% of homeless



1. "Coordinate outreach efforts for persons living with HIV/AIDS;
2. Break down barriers through provider-client relationship;
3. Secure housing for persons living with HIV/AIDS;
4. Develop an individualized, integrated plan of care for PLWHA."

https://homelessstrategy.com/hundreds-of-persons-with-hiv-aids-continue-to-live-on-the-streets-and-in-shelters-in-california-according-to-recent-homeless-counts/

- **Not enough housing being built:** During the last ten years, housing production averaged fewer than 80,000 new homes each year, and ongoing production continues to fall far below the projected need of 180,000 additional homes annually.
- **Increased inequality and lack of opportunities:** Lack of supply and rising costs are compounding growin inequality and limiting advancement opportunities for younger Californians. Without intervention, much of the new housing growth is expected to be focused in areas where fewer jobs are available to the families that live there.
- **Too much of people's incomes going toward rent:** The majority of Californian renters — more than 3 million households — pay more than 30 percent of their income toward rent, and nearly one-third — more than 1.5 million households — pay more than 50 percent of their income toward rent.
- **Fewer people becoming homeowners:** Overall homeownership rates are at their lowest since the 1940s.
- **Disproportionate number of Californians experiencing homelessness:** California is home to 12 percent of the nation's population, but a disproportionate 22 percent of the nation's homeless population.
- **Many people facing multiple, seemingly insurmountable barriers — beyond just cost — in trying to find an affordable place to live:** For California's vulnerable populations, discrimination and inadequate accommodations for people with disabilities are worsening housing cost and affordability challenges.

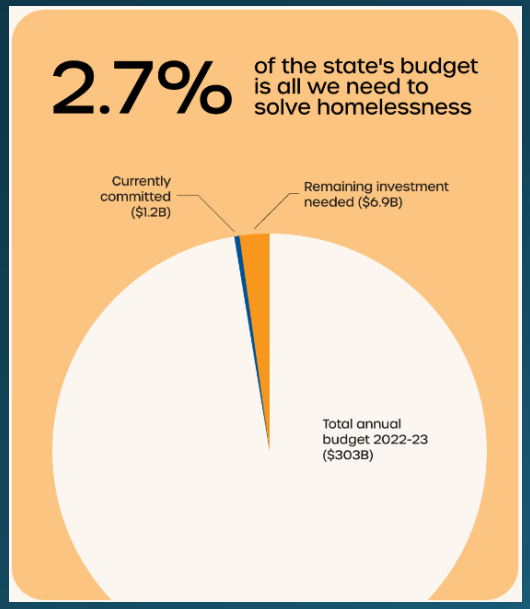
https://www.hcd.ca.gov/policy-and-research/addressing-variety-housing-challenges

Housing is an issue for all Californians

WE NEED A SEAT AT THE TABLE

- Resources must be allocated for HIV and Aging programs
- Align our efforts with other movements

California Homeless Housing Needs Assessment



BUILD

+112,527 affordable apartments

+ 225,053 subsidized operations and rents

Supportive housing services for +62,966 Californians with disabilities

Fund interim interventions for +32,235 individuals and families

Unmet housing need less pipeline commitments and projected turnover by region:

Region	Individual PSH Need (Units)	Family PSH Need (Units)	Individual AH Need (Units)	Family AH Need (Units)
Bay Area	15,164	662	21,794	5,656
Sacramento Area	3,989	209	6,672	1,800
Central Coast	3,074	179	5,025	1,267
Northern California	2,174	92	4,655	757
San Joaquin Valley	4,539	602	16,747	4,776
Los Angeles County	20,891	715	48,788	6,421
San Diego County	4,442	273	14,271	2,269
Southern California	5,272	524	16,375	4,288
Central Sierra	141	24	400	126
Total	**59,687**	**3,280**	**134,727**	**27,360**

Can San Diego Implement Novel Solutions

1. New methods for constructing and producing homes
2. Alternative forms of home ownership
3. Advance cross-sector housing solutions
4. Continue successful COVID-19 housing solutions
5. Transform surplus and underutilized land into affordable homes
6. Leverage infill housing and densify neighborhoods
7. Preserve existing lower cost housing

Next Steps

- Agenda Setting
- Policy formulation

Medical Transportation

Service Category Definition

Medical transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

Purpose and Goals

The goal of medical transportation is to provide assistance to people with HIV in accessing non-emergency, assisted or non-assisted transportation services to improve access to appointments and ensure linkage to and retention in care.

Intake

Case managers will assess the need for transportation services to determine if clients do not have access to transportation that meets their needs.

Key Service Components and Activities

Three key types of transportation services are provided:

- **Unassisted Transportation:** Reserved for individuals who are unable to access or stay in HIV medical care as determined by medical case managers.
    - Transportation is provided in the form of bus and train passes. Day passes may be issued for individuals who do not qualify for the disabled monthly passes and for those eligible for disabled monthly passes who have fewer than three medical or support service visits.
        - Individuals who receive day passes can be issued two extra day passes to cover unexpected or emergency medical visits. Clients are limited to two unused emergency day passes at a time.
    - Disabled monthly passes may be issued for individuals who qualify for the disabled monthly pass and have more than three medical or support service visits in a one-month period.
- **Assisted Transportation:** Only used for transportation to core medical services (e.g., Medical, dental, mental, medical case management and substance abuse counseling appointments). ADA Para-Transit passes, and certified medical transport ***may*** be used if a client is unable to access unassisted transportation **and** does not already qualify from another program or funding source.
- Transportation provided in an agency or personally owned vehicle.

Other forms of transportation may include but are not limited to: taxis, ride sharing programs and/or mileage reimbursement.

Unallowable services include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a personally owned vehicle
- Payment of any other costs associated with a personally owned vehicle such as lease, loan, insurance, license, or registration fees

Standard		Measure
Staff maintains records of eligibility, intake, and assessments		Documentation of eligibility and need
		Maintain a single record for each client
Staff ensures clients are connected to the appropriate transportation services when needed		Documentation (on a standard transportation services form) of all services provided/offered to clients with justification based on need

Mental Health Services

Service Category Definition

Mental health services are the provision of outpatient psychological, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Psychiatric services related to medication is covered in a separate service standard.

Purpose and Goals

The goal of mental health services is to provide outpatient, assessment, diagnosis, and treatment to persons living with HIV.

Intake

Providers will conduct a comprehensive client intake process. This process determines a client's need for mental health services and the extent of services that need to be provided. A client intake will be completed for all clients who request or are referred to mental health services. The intake process also acquaints the client with the range of services offered and determines the client's interest in such services. Mental health services are allowable for HIV-infected clients only.

Key Service Components and Activities

Key activities for mental health services include:

- Initial comprehensive assessment including documentation of diagnosis and determination of needs
- Development of individual treatment plans
- Treatment provision in individual, family, and/or group settings, crisis intervention and psychiatric consultation.
    - **Individual Counseling/Psychotherapy**: Frequency and duration of individual counseling or psychotherapy is determined based upon client need or as outlined in the Treatment Plan.
    - **Family and Conjoint Counseling/Psychotherapy:** The overall goal of family and conjoint counseling/psychotherapy is to help the client and his/her family improve their functioning, given the complications of living with HIV. The frequency and duration are based on upon client needs or as outline in the Treatment Plan.
    - **Group Treatment:** Group treatment can provide opportunities for increased social support vital to those isolated by HIV. Provider will assure an appropriate clinician facilitates the groups and limit the groups to a maximum of 12 persons per group (unless it is a couples-specific group).
        - Group counseling sessions consists of face-to-face contact between one or more therapists and a group of no fewer than two Ryan White eligible clients.
    - **Crisis Intervention:** This is an unplanned service provided to an individual, couple or family experiencing psychosocial stress. Crisis interventions are provided in order to prevent deterioration of functioning or to assist in the client's return to baseline functioning. Client safety will be assessed and addressed. This service may occur as often as necessary to ensure client safety and maintenance of baseline functioning.

- **Psychiatric consultation:** Providers will provide psychiatric referrals as appropriate.

- Referral/coordination/linkages
  - **Referral/Coordination:** Providers will establish linkages and collaborative relationships with other providers for client referral to ensure integration of services and better client care, including, but not limited to, additional mental health services (psychiatric evaluation and medication management, neuropsychological testing, day treatment programs and in-patient hospitalization); primary care, case management, dental treatment, and substance use treatment.
- Development of follow-up plans if needed
- Case closure

Standard	Measure
Staff assesses clients' eligibility and needs	Documentation of interviews and assessments all potential clients and their respective needs
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients
	Maintain a single mental health record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients

Personnel Qualifications

All mental health practitioners will have training and experience with HIV related issues and concerns. It is recommended that practitioners participate in continuing education and training on issues related to HIV and mental health. At a minimum, practitioners providing mental health services to people living with HIV will possess knowledge about the following:

- HIV disease process and current medical treatments
- Psychosocial issues related to HIV
- Cultural issues related to communities affected by HIV
- Mental disorders related to HIV and/or other medical conditions
- Mental disorders that can be induced by prescription drug use
- Adherence to medication regimes
- Diagnosis and assessment of HIV-related mental health issues
- HIV legal and ethical issues
- Knowledge of human sexuality, gender, and sexual orientation issues
- Substance use theory, treatment, and practice

In accordance with State licensing and practice rules and regulations, all direct services will be provided by culturally sensitive, linguistically appropriate, and competent licensed counselors or duly supervised interns.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State of California
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Comprehensive **Assessment:** This is an assessment completed during a face-to-face interview in which the client's history and current presentation are evaluated to determine diagnosis and treatment plan. This assessment will be provided to all persons receiving individual, family/conjoint, and/or group psychotherapy. Persons receiving crisis intervention or drop-in psychotherapy groups only do not require this assessment. The assessment will be based on clinical standards appropriate to the modality chosen with knowledge of HIV risk and harm reduction.

Reassessments: A reassessment is ongoing and driven by client need, such as when there is significant change in the client's status. The reassessment will be documented in the client chart.

Treatment Plans: Treatment plan is developed with the client and is required for persons receiving individual, family/conjoint, and/or group psychotherapy. The provider will continue to address and document existing and newly identified treatment plan goals. The Treatment Plan will include at minimum:

- Diagnosed mental illness or condition
- Treatment modality (group or individual)
- Date for mental health services
- Recommended number of sessions
- Date for reassessment
- Projected treatment end date
- Any recommendations for follow up
- Signature of the mental health professional rendering service

Regular follow-up procedures are provided to encourage and help maintain a client in treatment. The documentation of attempts to contact the client will be in the progress notes. The follow-up may include telephone calls, written correspondence, and direct contact.

Standard	Measure
Staff will assess client's condition and needs	Documentation of comprehensive assessment
Staff will develop a treatment plan. Staff will also monitor and continuously reassess clients' needs	Documentation of the existence of a detailed treatment plan.
Staff will ensure that services meet Ryan White and local guidelines and are consist with the treatment plan	Documentation of service provided to ensure that: • Services provided are allowable under Ryan White, state, and local guidelines • Services provided are consistent with the treatment plan

Universal Standards

Intake Requirements

To receive Ryan White services, clients must establish eligibility by providing:

- Documentation of HIV infection (only required one time at initial enrollment)
- Documentation of residency in San Diego County
- Documentation that their income does not exceed 500% of the federal poverty level
- Documentation of insurance status and any other third-party payers.

Once a client has established eligibility, they will be enrolled in the Ryan White program. Clients maintain their enrollment by completing an annual re-enrollment at 12 months. Documentation of residency, income and insurance status is required for all annual re-enrollments.

Beginning in March 2021, once a client has established eligibility, they will appear on a secure eligibility list, updated weekly, at which time they can receive services from any Ryan White Part A or B provider in San Diego County without having to provide any additional documentation to establish eligibility for Ryan White services.

For all service categories except Emergency Financial Assistance and Housing, clients can receive services for up to 30 days before providing all documentation required to complete enrollment.

At the time of intake, providers are required to verify that any client seeking Ryan White Services has been enrolled in the AIDS Regional Information and Evaluation System (ARIES). For clients who are new to the Ryan White system of care, providers must obtain a signed ARIES consent form from the client and enter new client into ARIES. All service utilization data will then be reported in the ARIES system. Clients who do not sign an ARIES consent form are not eligible to receive Ryan White Part A and B funded services.

Also, at the time of intake, providers are required to assess needs of client and their ability to meet these needs through Ryan White services or offer appropriate referrals. Additionally, providers are required to review client rights and responsibilities, complaint and grievance policies and confidentiality and sharing of protected health information. At intake, providers also assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, and service location and available transportation.

Providers of prevention services must integrate the Local Evaluation Online (LEO) Privacy Notice into intake processes. Clients need to be presented with a privacy notice and are not required to consent to having their personal information entered into LEO in order to receive services.

Standard	Measure
Clients must meet local and federal program requirements to be eligible to receive Ryan White Part A/B services	Documentation of annual enrollment and mid-year recertification retained in client file OR documentation in client file that the client appears on the Ryan White eligibility list.
Clients seeking Ryan White funded services are enrolled in ARIES and sign a consent form	Documentation of consent form is required and retained in client file
Clients seeking prevention services are presented with a privacy notice	Documentation of provision of privacy notice are retained in client file

Service providers must be mindful of the amount of paperwork required and seek to consolidate as feasible. Clients are encouraged to communicate if they do not understand any part of the intake process.

Client Rights and Responsibilities

Clients have the right to receive services that address their needs, as well as refuse services. Clients may actively engage in decision making. All providers must have written policies and procedures regarding client rights and responsibilities. Clients are informed of these rights and responsibilities during intake and a written copy is made available.

Clients are informed of expectations when accessing services. If a client does not meet these expectations, the provider is responsible for informing the client of needed changes and a contract may be implemented in order for client to continue receiving services. Failure to comply with a contract may require additional corrective action. Clients will not be denied service due to knowledge of current or prior substance use.

Clients shall not be denied services from a provider based on client's unwillingness to participate in other services.

Standard	Measure
Clients are informed of their rights and responsibilities	Documentation of client rights and responsibilities during intake

Complaint and Grievance Process

In the event clients feel that they are not being heard or services are not being delivered in a way that addresses their needs after providing input, they have the right to make a formal complaint. Clients are to be actively engaged in the services they receive, during assessment, planning and delivery phases. This includes regular feedback to providers regarding their needs and when the services are not meeting their needs.

All providers are required to have written policies and procedures for an internal client complaint process. The policy will identify staff responsible, an appeal process, tracking system, follow-up procedures, and a timeline. Service providers will use relevant federal, state and county regulations for investigating and resolving complaints. A copy of the complaint policy will be displayed in an observable location where services are provided. Complaints and investigation results will be forwarded by the provider to the County within 24 hours of both the receipt and resolution of the complaint.

In addition to the internal complaint process, all providers are required to have written grievance policy and procedure for escalation of unresolved complaints. In addition to the internal complaint process, information on how clients may contact the County of San Diego's HIV, STD and Hepatitis Branch will be provided.

Grievance procedures must specifically note that there will be no retaliation against clients for filling a verbal or written grievance. They also must clarify that clients will not be suspended or terminated from services based on filing a complaint or grievance.

Clients will be informed of the complaint and grievance policies during intake. Providers will also post a copy of the Client Service Evaluation form ("Goldenrod") in an observable place. Copies of the form must be easily accessible to clients, along with a stamped self-addressed envelope to the County for review. The form may also be accessed, completed and submitted on the HIV Planning Group website at www.sdplanning.org. Providers shall not require a client to give a form directly to them.

The following is the Goldenrod process:

1. Staff at the HIV, STD and Hepatitis Branch will process this service evaluation. If the client wishes to be contacted, staff will reach out to them within three (3) business days of receiving the form. The client will be asked for additional information (if needed) and asked if the client is comfortable sharing their name with the agency.
2. County staff will contact the agency to report the issue. The agency will be asked to respond to the client either directly or through County staff, and to follow-up in writing to staff within thirty (30) days describing the resolution.
3. Notify the Ryan White Program Manager if there are concerns.

Standard	Measure
Clients' rights are protected, and clients have access to complaint and grievance processes and are made aware of such processes and the outcomes	Documentation of a complaint and grievance policies and client orientation of processes
Clients can file a complaint and grievance without being subject to retaliation	Verification of confidential Client Service Evaluation "Goldenrod" (available in English and Spanish) and mechanism to mail form in an observable location at sites where services are provided

Case Closure

Case closure is a systematic process for removing clients from an active caseload. A case can be reopened in the event the clients' situation and reasons for closure change.

The process includes formal client notification regarding pending case closure and the completion of a case closure summary to be maintained in the client chart. Clients are considered active providing they receive services at the minimal interval as defined by the individual service standard. Case closure may be initiated by a provider and/or client and may occur for the following reasons:

- Case resolved and/or successful attainment of goals
- Client relocated outside San Diego County
- Client initiated case closure of services
- Client does not adhere to treatment plan
- An inability to contact client for 120 days
- Client exhibits inappropriate behavior
- Client's health needs cannot be adequately addressed by the service
- Client's care is transferred to another provider

A case closure summary will be completed for each client and provided to the client when possible for each occurrence of case closure for the following service categories:

- Medical / Dental
- Medical / Non-medical Case Management
- Mental Health / Psychiatry
- Outpatient / Residential Substance Use Disorder Treatment
- Legal
- PARS

Standard	Measure
Client's case is closed based upon at least one of the approved criteria	A case closure is noted in the client chart For specified service categories, a case closure summary including the following: • Most recent assessment and/or diagnosis • Care plan at time of closure • Referrals not yet completed • Reason for case closure For clients who drop out of care without notice, case closure summary including the above and the following: • Documentation of attempts to contact client, including written correspondence and results of these attempts

Termination of Services

A provider may terminate a case (permanently close) when:

- Client is deceased
- Client demonstrates repeated non-adherence
- Client exhibits inappropriate behavior in violation of specific written policies of the provider
- Client violates confidentiality of other client(s)

The client shall be notified in writing with the reason for termination and provided a list of alternative sources of care and support services.

A termination of service summary will be completed for each client, included in the client's record, and provided to the client upon request.

Standard	Measure
There is documentation with reason(s) for termination in the client record	A termination of service summary including the following documentation: • Most recent assessment and/or diagnosis • Care plan at time of termination • Referrals not yet completed • Reason for termination
Staff determine client eligibility for other programs and re-instatement in services	Documentation of "inactive status" and maintenance of records and contact information to facilitate rapid re-enrollment, as appropriate

Cultural and Linguistic Competency

All providers must have an understanding of cultural nuances of communication and the ability to provide appropriate and acceptable services to potential and current clients, including people of color, gay and men who have sex with men, men or women vulnerable to HIV, bisexual men and women, transgender individuals, gender non-binary individuals, persons who use substances, persons with mental health concerns, persons of differing abilities, and others. Providers who serve any of these groups will make reasonable accommodations in service provisions.

All providers must have policies and procedures that address cultural competency, diversity, and inclusiveness. Provider's intake procedures will assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, and service location. Staff working directly with clients must receive a minimum of four hours of cultural competency training each year.

Providers will identify staff and volunteers who can provide bilingual/bicultural services to individuals who need or prefer to communicate in other languages. If there are no staff members or volunteers who can perform this function, the provider will develop alternate methods to ensure language appropriate services are available. Providers will employ proactive strategies such as partnering with other local organizations to develop a diverse workforce.

Providers will assess and ensure the training and competency of individuals who deliver language services to assure accurate and effective communication between clients, staff, and volunteers to transcend language barriers and avoid misunderstanding and omission of vital information.

Standard	Measure
Agency policies address cultural and linguistic competency	Documentation in policies on cultural and linguistic competency
Staff receive annual training on cultural competency	Documentation of all staff trainings on cultural competency
	Copies of the curriculum and handouts etc. kept on file (If training is provided by the provider)
Staff and volunteers are bilingual and can address the language needs of the populations they serve. If there are no appropriate bilingual staff or volunteers, a plan is in place to ensure language needs are met	Copy of written plan to address language needs
Provider has available written materials in the appropriate languages for the communities being served	Materials available in appropriate languages

Privacy and Confidentiality

All providers must develop written policies and procedures that address security, confidentiality and access and operations.

- All physical case and electronic files are secured at all times
- All activities that relate to client data have appropriate safeguards and controls in place to ensure information security
- All employees and volunteers working have signed a confidentiality agreement
- All staff orientation materials include client confidentiality policies and procedures and indicate how they are communicated to staff and volunteers

Policies and protocols regarding confidentiality and sharing of protected health information are explained to clients and a confidentiality agreement is signed by clients and maintained in their case files. Except in the case of medical and dental referrals, a separate Release of Information form must be signed by clients in order for information to be shared.

The form must contain:

- Name of the program or person permitted to make the disclosure
- Name of the client
- Party with whom information will be shared
- Purpose and content (kind of information to be disclosed) of the disclosure; information related to mental health, substance use disorder and HIV status require specific consent to release information
- Effective date of Release of Information (when does the form no longer authorize the exchange of information)
- Client's signature or legal representative's signature

Provider must ensure a private, confidential environment for clients to discuss their case(s).

Standard	Measure
Providers develop written policies and procedures that address security, confidentiality, access, and operations	Documentation of policies and procedures
All files are secured	Files inspected and noted during site visits
Staff and volunteers will receive training on privacy and confidentiality	Documentation of all staff/volunteer trainings on privacy and confidentiality
	Copies of the curriculum and handouts etc. kept on file (if training is provided by the provider)

STRATEGIES AND STANDARDS COMMITTEE

FY 24-25 TRAINING/WORK PLAN

MEETING DATE	OBJECTIVES
May 7, 2024	Meeting Cancelled
June 20, 2024	• Transportation Standards
August 6, 2024	• Transportation Standards • Key Findings on HIV Positive Aware and Out of Care (Dr. Tweeten) • Getting to Zero Community Engagement Plan – review progress and develop next steps
October 1, 2024	• HIV and Aging • Mental Health Services Standards – review and update • Universal Standards – review and update ○ Trauma-Informed Care – review and update
December 3, 2024	• Eligibility Criteria for Basic Needs Support Categories – review and update • Emergency Financial Assistant and Housing Standards – review and update
February 4, 2025	• Testing Standards – review and update

HIV PLANNING GROUP

6-MONTH COMMITTEE TRACKING

September 2023 - August 2024

STRATEGIES	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	#
Total meetings		1		0		0		0	0	1	0	1	3
Member													
Acevedo, Allan [cc]		**1**		NM		NM		NM	NQ	**1**	NM	**1**	**3**
Applebaum, Amy		*		NM		NM		NM	NQ	*	NM	*	**0**
Davenport, Dr. Beth		*		NM		NM		NM	NQ	*	NM	*	**0**
Mora, Joseph		**1**		NM		NM		NM	NQ	*	NM	*	**1**
Mar-Tang, Moira		*		NM		NM		NM	NQ	*	NM	**1**	**1**
Price, Venice		*		NM		NM		NM	NQ	**EC**	NM	**1**	**1**
Ransom, Shannon [c]		*		NM		NM		NM	NQ	*	NM	*	**0**
Rooney, Ivy						NM		NM	NQ	*	NM	*	**0**
Tilghman, Dr. Winston		*		NM		NM		NM	NQ	**1**	NM	*	**1**
Weber, Jeffery		**1**		NM		NM		NM	NQ	*	NM	*	**1**
Wimpie, Michael		*		NM		NM		NM	NQ	*****	NM	*	**0**

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

***** = Present

1 = 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

NQ = No Quorum

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

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

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

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

ADDITIONAL REQUIREMENTS FOR A MEMBER PARTICIPATING REMOTELY:

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

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

AB 2449 Checklist

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

Procedures for Public Participation

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

Procedures for Member to Teleconference from a Remote Location

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

Procedures for the Board/Commission/Committee/Group

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

TELECONFERENCING RULES UNDER THE BROWN ACT

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