Tuesday, April 08, 2025, 4:00 PM – 5:30 PM
Seville Plaza – Live Well Support Center
5469 Kearny Villa Rd, San Diego, CA 92123
1st Floor, Training Room B

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

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Meeting Packet

Meeting Location & Directions:

Medical Standards & Evaluation Committee (MSEC)

Tuesday, April 08, 2025,
4:00 PM – 5:30 PM

Seville Plaza - Live Well Support Center
5469 Kearny Villa Rd.
San Diego, CA 92123
(1st Floor, Training Room B)

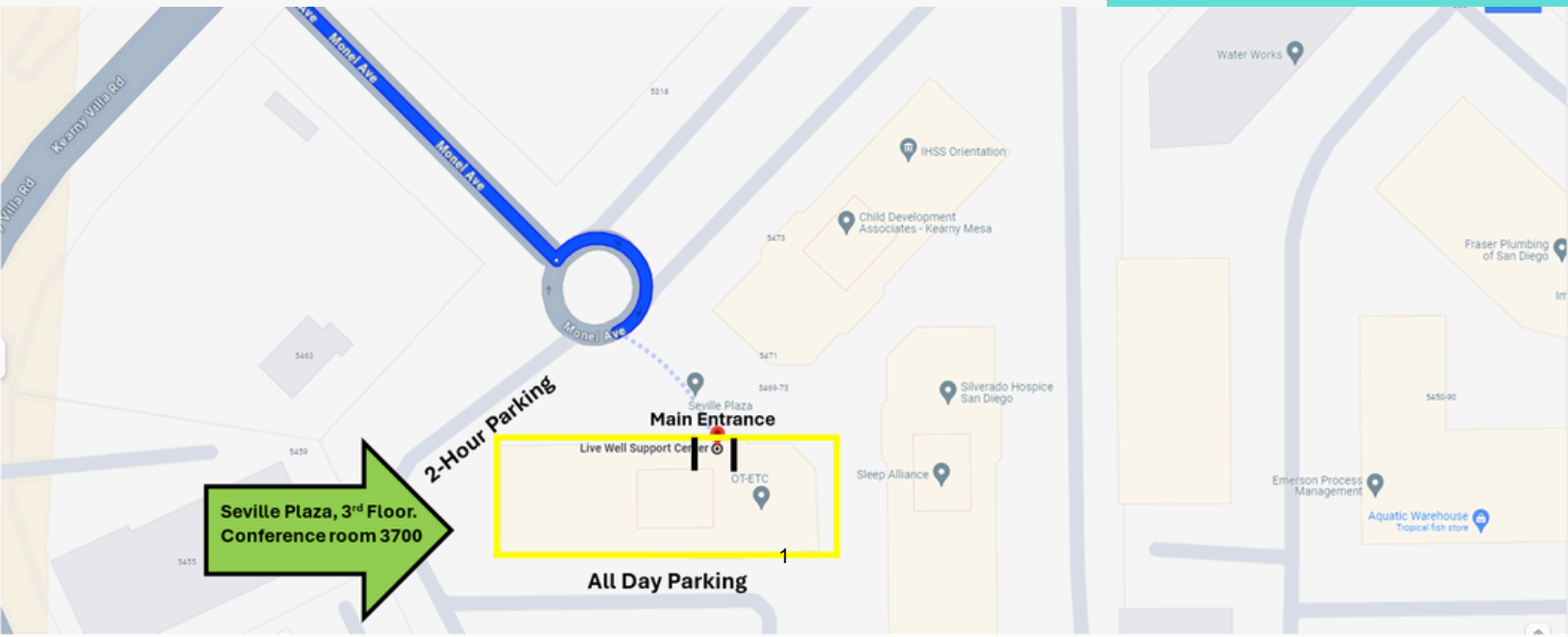
Parking is **free**. 2-hour parking and whole day parking is available in the parking lot. All visitors must check in with security at the main entrance of the building to be escorted to the elevator. Visitors include County employees who do not work in the building.

FROM I-63 S:

1. Use the right 2 lanes to turn left onto CA-163 N toward Escondido.
2. Merge onto CA-163 N
3. Take Exit 8 for Clairemont Mesa Blvd
4. Keep left, follow signs for Kearny Villa Rd
5. Sharp right onto Kearny Villa Rd
6. Turn Left onto Monel Ave

PUBLIC TRANSPORTATION

MTS Bus Routes:
27, 20, 120, 235



FROM TROLLEY & BUS:

1. Take the Blue Trolley Line to the Balboa Avenue Transit Center
2. Walk to Balboa Ave & Moraga Ave bus stop (about 7-minute walk, 0.3 miles)
3. Take Route 27 bus from Balboa Ave & Moraga Ave to Complex Dr & Clairemont Mesa Blvd
4. Head north on Complex Dr
5. Cross the street and turn left on Clairemont Mesa Blvd
6. Turn right onto Kearny Villa Rd
7. Turn right onto Monel Ave
8. Building 5469/Seville Plaza - Live Well Support Center will be on the **right** side at the end of the cul-de-sac

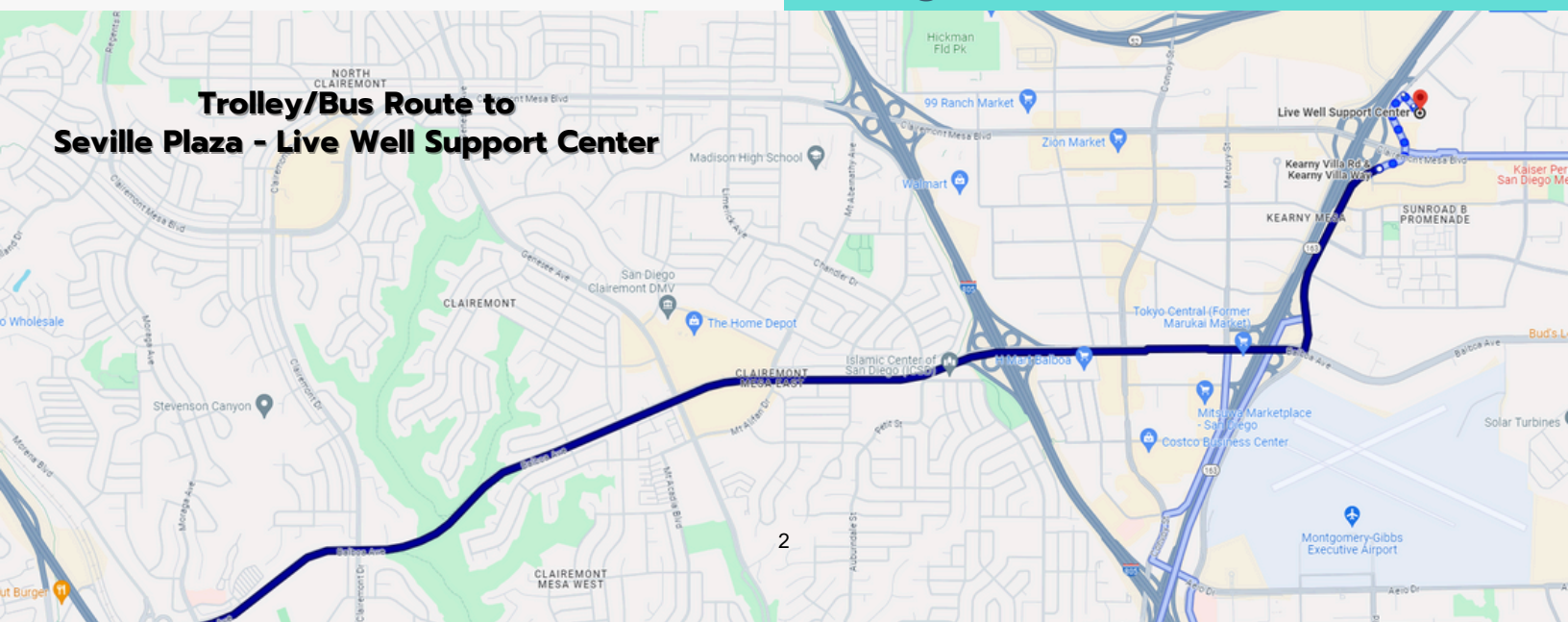
FROM BUS:

From Kearny Villa Rd & Kearny Villa Way:

1. Walk northeast on Kearny Villa Rd
2. Turn right onto Monel Ave
3. Enter the traffic circle
4. Building 5469/Seville Plaza - Live Well Support Center will be on the **right** side

From Clairemont Mesa Blvd:

1. Walk north on Complex Dr toward Clairemont Mesa Blvd
2. Turn left onto Clairemont Mesa Blvd
3. Turn right onto Kearny Villa Rd
4. Turn right onto Monel Ave
5. Enter the traffic circle
6. Building 5469/Seville Plaza - Live Well Support Center will be on the **right** side



MEDICAL STANDARDS AND EVALUATION COMMITTEE

Tuesday, April 08, 2025, 4:00 PM – 5:30 PM
Seville Plaza – Live Well Support Center
5469 Kearny Villa Rd, San Diego, CA 92123,
1st Floor, Training Room B

To participate remotely via Zoom:
https://sdcounty-ca-gov.zoom.us/j/84391377931?pwd=0aQAdexL884STJrEFblganmnCYD4bQ.1
Call in: 1-669-444-9171
Meeting ID: 843 9137 7931 **Passcode:** 426890

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. Rosemary Garcia | Dr. David Grelotti (Chair) | Yessica Hernández | Bob Lewis | Shannon Paugh | Karla Quezada-Torres | Dr. Martha Rodriguez | Dr. Stephen Spector | Dr. Winston Tilghman | Dr. Fadra Whyte

MEETING AGENDA
ORDER OF BUSINESS

1. Call to order, introductions, comments from the chair, and a moment of silence
2. Public comment (for members of the public)
3. Sharing our concerns (for committee members)
4. **Action:** Approve the MSEC agenda for April 08, 2025
5. **Action:** Approve the MSEC minutes from February 11, 2025
6. Old Business:
    a. **Action**: Update and approve Dental Practice Guidelines
    b. **Action**: Update and approve Oral Health Service Standards
    c. **Discussion:** Review meeting schedule and identify priorities for 2025 work plan
        i. November meeting date change
        ii. Identify subject matter experts
7. New Business:
    a. **Discussion**: Review Mental Health Services and Psychiatric Medication Management
8. Other Updates:
    a. STI and MPox Update
    b. Committee member updates
9. Future agenda items for consideration

10. Announcements
11. **Next meeting date:** May 13, 2025, from 4:00 PM – 5:30 PM

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

WORK PLAN
February 11, 2025 • Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services • Finalize 2025 work plan and priorities
April 8, 2025 • Finalize and Approve Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services • Finalize 2025 work plan and priorities • Review Mental Health Services and Psychiatric Medication Management
May 13, 2025 • Update Mental Health Services and Psychiatric Medication Management • Review 2024 Needs Assessment findings and identify priorities
September 9, 2025 • Finalize and approve Mental Health Services and Psychiatric Medication Management
November 4 or 18, 2025 • • Review Ryan White Quality Assurance Chart Review tool • Identify priorities and develop work plan for 2026

MEDICAL STANDARDS AND EVALUATION COMMITTEE (MSEC)

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

A quorum for this meeting is six (6).

Committee Members Present: Dr. Laura Bamford | Dr. David Grelotti (Chair) | Yessica Hernández | Bob Lewis | Shannon Paugh | Dr. Martha Rodriguez | Dr. Stephen Spector | Dr. Winston Tilghman

Committee Members Absent: Karla Quezada-Torres

Committee Members Joining Virtually: Dr. Jeannette Aldous (Co-Chair)

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Grelotti called the meeting to order at 4:12 PM and introductions were done. A moment of silence was observed. Lauren Brookshire was asked to provide a federal government update: there are a lot of Executive Orders being issued at the federal level, creating a lot of uncertainty at the local level. Congress must pass the budget by March 14. If not passed, it will cause immediate impact to local funding. California has a robust Medicaid system, unlike some of the states where Ryan White is the only source of funding for HIV/AIDS services. All updates are being watched closely, and County leadership is prepared to respond.	
2. Public Comment	None	
3. Sharing our Concerns	A committee member inquired whether the County has received the funding yet. Lauren Brookshire responded that at this time, only a partial funding has been awarded which is about 42 percent.	
4. **Action:** Review and approve the February 11, 2025 meeting agenda	**Motion:** Approve the February 11, 2025 meeting agenda as presented.	

Agenda Item	Action	Follow-up
	Motion/Section/Count (M/S/C): Spector/Lewis/7-0 **Discussion:** none **Abstentions:** Dr. Grelotti **Motion carries**	
5. Action: Review and approve the November 12, 2024 meeting minutes	**Motion:** Approve the November 12, 2024 meeting minutes as presented. **M/S/C:** Lewis/Tilghman/5-0 **Discussion:** none **Abstentions:** Dr. Grelotti **Motion carries**	
6. Old Business		
a. Update on the Ryan White Quality Assurance Chart Review tool	The comments made at the last MSEC meeting were submitted to Jeanette Johnson to be addressed and the tool was finalized.	
b. Discussion: Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services	The committee reviewed the Dental Practice Guidelines and the Oral Health Service Standards. The County of San Diego Chief Dental Officer Dr. Fadra Whyte was in attendance to offer subject matter expertise on night guards as well other questions related to oral health and dental services for people living with HIV. The following discussion was held: - Uncertainty about implants being an allowable service because the Health Resources and Services Administration (HRSA) has made it clear that it's not to be covered. - Dental services provided by Ryan White have historically mirrored Denti-Cal. - A need for clarification on what the allowable services are. - If services are not covered by Denti-Cal but will be covered by Ryan White, the committee needs to ensure there is a clear process and criteria for approval. - A recommendation to set a limit on the expenditures associated with night guard replacements.	The Recipients' Office will follow up with the Project Officer on whether implants are an allowable service.

Agenda Item	Action	Follow-up
	- Medical conditions need to be considered. - Funding allocations can support adding the provision of night guards as long as the committee can develop.	
c. Action: Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services	Tabled	
d. Discussion: Reviewed the meeting schedule and identify priorities for 2025 work plan	Tabled	
7. New Business		
a. Action: Approve the 2025 work plan	Tabled	
8. Other Updates		
a. STD and Mpox Update (Dr. Tilghman)	Tabled	
b. Committee member updates	Tabled	
9. Future agenda items for consideration	Tabled	
10. Announcements	Tabled	
11. Next meeting date:	**Date:** May 13, 2025 **Time:** 4:00 PM – 5:30 PM **Location:** TBD	The HIV Planning Group Support Staff (HPG SS) will work with the Chair to find alternative dates and times to hold another meeting before the scheduled May meeting.
12. Adjournment	The meeting was adjourned at 5:07PM.	

County of San Diego, Health and Human Service Agency Ryan White Primary Care Medical Care
Allowable Dental Services List

The following dental services may be billed to the Ryan White Primary Care Pool when provided to enrolled Ryan White Primary Care Pool patients. Additional specialty services may be approved on a case by case basis.

HIV positive patients in need of dental services not specifically listed below should be referred to the Specialty Services Program Coordinator for AIDS Healthcare Foundation.

Service description restrictions are described on Page 4 of this document.

Code	Service Description	Type of Service
D0120	Periodic oral evaluation	Primary
D0140	Limited oral evaluation - problem focused	Primary
D0150	Comprehensive oral evaluation	Primary
D0160	Detailed and extensive oral evaluation – problem focused, by report	Primary
D0180	Comprehensive periodontal evaluation -new or established patient	Primary
D0210	Intraoral - complete series (including bitewings)	Primary
D0220	Intraoral - periapical, single, first film	Primary
D0230	Intraoral periapical, single, additional files (10 maximum)	Primary
D0272	Bitewings - 2 films [1]	Primary
D0274	Bitewings - 4 films [1]	Primary
D0330	Panoramic film [2]	Primary
D1110	Prophylaxis – adult	Primary
D1206	Topical application of fluoride varnish	Primary
D2140	Amalgam, one surface, primary or permanent tooth	Primary
D2150	Amalgam, two surfaces, primary or permanent tooth	Primary
D2160	Amalgam, three surfaces, primary or permanent tooth	Primary
D2161	Amalgam, four or more surfaces, primary or permanent tooth	Primary
D2330	Resin-based composite – one surface, anterior	Primary
D2331	Resin-based composite – two surfaces, anterior	Primary
D2332	Resin-based composite – three surfaces, anterior	Primary
D2335	Resin-based composite – four or more surfaces, anterior	Primary
D2391	Resin-based composite – one surface, posterior	Primary
D2392	Resin-based composite – two surfaces, posterior	Primary
D2393	Resin-based composite – three surfaces, posterior	Primary
D2394	Resin-based composite – four or more surfaces, posterior	Primary
D2740	Crown - porcelain fused to predominately ceramic substrate	Primary
D2751	Crown - porcelain fused to predominately base metal	Primary
D2910	Recement inlay	Primary
D2920	Recement crown	Primary
D2950	Core build-up, including pins when required	Primary
D2951	Pin retention	Primary
D2952	Cast post and core, indirectly fabricated	Primary

Code	Service Description	Type of Service
D2954	Prefabricated post and core in addition to crown	Primary
D3310	Endodontic therapy [treatment of tooth root, dental pulp, and/or surrounding tissue], anterior tooth (excluding final restoration)	Primary
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	Primary
D3330	Endodontic therapy, molar (excluding final restoration)	Primary
D3410	Apicoectomy [root end surgery] – anterior	Primary
D3421	Apicoectomy – bicuspid (first root)	Primary
D3425	Apicoectomy – molar (first root)	Primary
D3426	Apicoectomy (each additional root)	Primary
D4341	Generalized periodontal scaling. Therapeutic, not prophylactic.	Primary
D4342	Periodontal scaling & root planing-one to three teeth per quadrant	Primary
D4342	Localized periodontal scaling. Therapeutic, not prophylactic.	Primary
D4355	Full mouth debridement [5, 6, 7]	Primary
D4910	Periodontal Maintenance Procedures [8, 9]	Primary
D5110	Complete Denture - Maxillary [10]	Primary
D5120	Complete Denture - Mandibular [10]	Primary
D5211	Maxillary Partial Denture, resin base [10]	Primary
D5212	Mandibular Partial Denture, resin base [10]	Primary
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Primary
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Primary
D5510	Repair broken complete denture base	Primary
D5520	Repair missing or broken teeth - complete denture	Primary
D6930	Recement fixed partial denture	Primary
D7111	Extraction, coronal remnants - deciduous teeth	Primary
D7140	Extraction, erupted tooth or exposed root	Primary
D7210	Removal of erupted tooth, surgical	Primary
D7220	Remove impacted tooth – soft tissue	Primary
D7230	Remove impacted tooth – partial bony	Primary
D7240	Remove impacted tooth – completely bony	Primary
D7241	Remove impacted tooth – unusual surgical complication	Primary
D7250	Surgical removal residual tooth roots (cutting procedure)	Primary
D7260	Oroantral fistula closure	Primary
D7261	Primary closure of a sinus perforation	Primary
D7285	Biopsy of oral tissue - hard	Primary
D7286	Biopsy of oral tissue - soft	Primary
D7310	Alveoplasty with extractions – per quadrant	Primary
D7320	Alveoplasty (no extractions) – per quadrant	Primary
D7471	Removal of lateral exostosis (maxilla or mandible)	Primary
D7472	Removal of torus palatinus	Primary
D7473	Removal of torus mandibularis	Primary
D7510	Incision and drainage of abscess - intraoral soft tissue	Primary

Code	Service Description	Type of Service
D7511	Incision and drainage of abscess, intraoral	Primary
D7971	Excision pericoronal gingiva	Primary
D9110	Palliative (Emergency) treatment of dental pain, minor	Primary
D9630	Antibacterial (Peridex) mouth rinse – on formulary	Primary
D9930	Postoperative visit, complications (e.g., osteitis)	Primary
D0330	Panoramic radiographic image	Specialty
D2740	crown- porcelain/ceramic substrate	Specialty
D2751	Crown- porcelain fused to predominantly base metal	Specialty
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Specialty
D3320	Endodontic therapy bicuspid tooth (excluding final restoration)	Specialty
D3330	Endodontic therapy, molar tooth (excluding final restoration)	Specialty
D4341	Periodontal scaling and root planning- 4 or more teeth per quadrant-	Specialty
D4342	Periodontal scaling and root planning – one to three teeth, per	Specialty
	quadrant	Specialty
D5213	3 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Specialty
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	Specialty
D7111	extraction, coronal remnants- deciduous tooth	Specialty
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Specialty
D7220	Removal of impacted tooth- soft tissue	Specialty
D7250	Surgical removal of residual tooth roots (cutting procedure)	Specialty
D7260	Oriental fistula closure	Specialty
D7261	Primary closure of a sinus perforation	Specialty
D7285	Biopsy of oral tissue - hard (bone, tooth)	Specialty
D7286	Biopsy of oral tissue - soft	Specialty
D7310	Alveoloplasty in conjunction with extractions- 4 or more teeth/tooth space, per quadrant	Specialty
D7320	not found	Specialty
D7471	Removal of lateral exotosis (maxilla or mandible)	Specialty
D7473	Removal of torus mandibularis	Specialty
D7510	Incision and drainage of abscess- intraoral soft tissue	Specialty
D9220	Deep sedation/general anesthesia- first 30 minutes	Specialty
D9221	Deep sedation/general anesthesia- each additional 15 minutes	Specialty
D9241	Intravenous Conscious Sedation/analgesia- each additional 30 minutes	Specialty
D9242	Intravenous Conscious Sedation/analgesia- each additional 15 minutes	Specialty
D9248	Non-intravenous conscious sedation	Specialty
D9310	Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician	Specialty
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Specialty

Code	Service Description	Type of Service
D7230	Removal of impacted tooth- partially bony	Specialty
D7240	Removal of impacted tooth- completely bony	Specialty
D2950	Core buildup, including any pins	Specialty
D2951	Pin Retention- per tooth	Specialty
D2952	Post and Core in addition to crown	Specialty
D3410	Apicectomy, separate surgical procedure, per tooth- anterior	Specialty
D3421	Apicectomy, separate surgical procedure, per tooth- bicuspid (first tooth)	Specialty
D3425	Apicectomy, separate surgical procedure, per tooth- molar (first root)	Specialty
D3426	Apicectomy, separate surgical procedure, per tooth- (each additional root)	Specialty

Footnotes (Restrictions)

[1]Once annually

[2]Once every 3 years

[3]Each quad limited to once every 24 months

[4]Periodontal procedures on the same date of service are not covered for any combination of the following codes: D1110, D1120, D4210, D4240, D4260, D4341, D4910

[5]Debridement allowed once every three years (provided D1110, D4910, D4341, have not been done within the last three years)

[6]Debridement is not a substitute for difficult prophylaxis

[7]Not allowed the same day at D1110, D4910 or D4341

[8]Limit 2 within 12 months

[9]Requires history of periodontal therapy (D4210, D4211, D4240, D420, D4341 [except D4249 and D4355])

[10]Once every 5 years

Oral Health Care

Service Category Definition

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

Purpose and Goals

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

Intake

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

Dental Benefits

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

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

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

Key Service Components and Activities

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

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

Personnel Qualifications

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

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

Assessment and Service Plan

Initial Assessment

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

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

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

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

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

Preventative Care and Maintenance

Education shall include:

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

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

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

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

Treatment Plan

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

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

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

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

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

County of San Diego

Original Source:
Los Angeles County
Commission on HIV Health Services

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

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

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

Contents

What Viral Load and CD4 Cell Count Mean to the Dentist

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

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

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

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

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

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

Antibiotic Prophylaxis

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

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

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

Commented [KE2]: define "well-controlled". May state instead those who are symptomatic and/or those who have severe neutropenia (ANC<500/uL) may benefit from antibiotic prophylaxis. Always consult the patients physician if unsure.

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

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

Commented [KE3]: AHA guidelines are just for those with cardiac conditions and are at risk for infective endocarditis and are not based on a patients risk of infection due to immunosuppression. I would suggest as just removing these statements since AHA guidelines, guidelines for those with prosthetic joints, and those with orthopedic surgeries are relevant to all patients regardless of their HIV status

other medications for patients who are living with HIV.

Medical Assessment

Annual Health History

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

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

Annual Extra-Oral (Head and Neck) Examination

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

When to Contact the Patient's Primary Care Physician

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

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

Commented [KE4]: Recommended lab values are scattered throughout the document, but may just want to state them in one section. There is a great chart Laboratory Information in this link:

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

Commented [KE5]: I would suggest removing "many different....prescribed medications" since this is applicable to every patient a dentist sees

Commented [KE6]: I combined many of these statements in order to be more clear and concise

Commented [KE7]: and to update on a regular basis

Commented [KE8]: This statement contradicts the one below that states "when medical conditions are well controlled, it is up to the dental care team..."

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

Commented [KE9]: hospital setting is not the only thing that should be consulted one. I would instead state "based on the medical history and lab results the dentist may want to consult with the physician to see if their should be modifications to treatment, including but not limited to need for hospital level care and medication dosage modifications". I would remove decision should be done in consult with physician because this insinuates the dentists cannot make that decision themselves-which they can-and then they will refer to proper follow up. (See "modification section below)

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

Commented [KE10]: remove these and combine with statement #2

Commented [KE11]: combine with statement above

Commented [KE12]: remove and combine with statement above

Treatment Considerations

Modifications of Dental Therapy

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

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

Commented [KE13]: For patients who it is determined to be high risk for caries, has periodontal disease, or is immunosuppressed, 3 month recalls should be considered.

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

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

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

Commented [KE14]: I would put this in medical history section

Annual Periodontal Examination

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

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

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

Commented [KE15]: LGE is associated with candida and is refractory to standard plaque control

Commented [KE16]: NUP should be updated to state "necrotizing periodontal diseases which includes necrotizing ulcerative gingivitis (NUG), necrotizing ulcerative periodontisis (NUP) and necrotizing ulcertive stomatitis (NUS/NS)

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

Commented [KE17]: also evidence that LGE is associated with CD4+ count below 200

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

Annual Updated Treatment Plan

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

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

Phase 1 Treatment Plan Completion

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

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

Commented [KE18]: Is this metric currently being tracked with Ryan White dental providers?

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

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

management/oralhealthmeasures.pdf.

Commented [KE19]: need updated link

Medications in HIV

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

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

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

More information on specific ARV medications is available at:

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

Commented [KE20]: These links need updated

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

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

Oral Health Education: Caries Prevention and Smoking

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

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

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

Nutritional Counseling

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

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

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

Post-Exposure Prophylaxis (PEP)

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

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

Management of Occupational Blood Exposure

Commented [KE21]: I will leave it to the medical team if there are any updates to this exposure guideline

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

Basic Overview:

Determine whether high or low risk depending on source

- Low titer exposure
- Higher titer exposure

Medications

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

Baseline Labs to Monitor for Adverse Reactions

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

Warmline: 800-933-3413

PEPline: 888-448-4911

Perinatal HIV Hotline: 888-448-8765

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

Monitor

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

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

Discrimination and Legal Issues

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

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

Privacy

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

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

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

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Abel, S., Croser, D., Fischman, S., Glick, M., Phelan, J. "Principles of Oral Health Management for the HIV/AIDS Patient", Dental Alliance for AIDS/HIV Care (DAAC) 2000.

"Dental Management of the HIV-Infected Patient," Supplement to JADA, American Dental Association, Chicago, 1995.

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

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

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

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

Kuhar, D.T., Henderson, D.K., Struble, K.A., et al. "Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis," Infect Control Hosp Epidemiol 2013;34(9):875-892.

Mulligan, R.A, Update on the HIV Epidemic: CDA 29:120-122, 2001.

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

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

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

Selected Websites for HIV/AIDS Information

Commented [KE22]: update links

Sites of Particular Interest to Dentists

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

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

HIVdent
http://www.hivdent.org/

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

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

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

The Internet drug index - side effects and drug interactions

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

Other Helpful Links

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

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

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

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

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

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

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

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

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

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

Psychiatric Medication Management Services

Service Category Definition

Psychiatric medication management services are the provision of outpatient psychiatric screening, assessment, diagnosis, and treatment services offered to clients living with HIV. Specifically, these include psychiatric medication assessment, prescription, and monitoring by a licensed psychiatrist or supervised resident or mid-level practitioner. Although they form a separate service category, psychiatric medication management services are part of the comprehensive array of mental and behavioral healthcare services that also may include individual, family, and group counseling and psychotherapy and crisis intervention. These other services are described in the **Mental Health Services Service Standards**.

Purpose and Goals

The goal of psychiatric medication management services is to provide medication assessment, prescription, and monitoring services to people living with HIV in order to alleviate or decrease psychiatric symptoms, stabilize mental health conditions, and improve and sustain quality of life. All services and interventions must be based on proven and evidence-based clinical methods and in accordance with legal and ethical standards. The services delivered shall reflect a philosophy that affirms a patient's right to privacy, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

Intake

Patient intake is required for all patients who request or are referred for psychiatric medication management services and shall be initiated at the time a patient presents for services. Intake is a time to gather registration information and provide basic information about psychiatric medication management services and other HIV services, as appropriate. It is also a pivotal moment for establishment of trust and confidence in the care system. In most cases, a client who receives psychiatric medication management services will already be receiving HIV primary care and enrolled in a medical care coordination program.

Providers will conduct a comprehensive client intake process that determines a client's need for psychiatric medications and other mental health services and the extent of services that need to be provided. Practitioners shall provide an appropriate level of information that is helpful and responsive to patient need. Staff shall conduct the patient intake with respect and compassion.

Key Service Components and Activities

Key activities for psychiatric medication management services include:

- Initial comprehensive assessment, including documentation of diagnosis and determination of need for psychiatric medications
- Development of individual treatment plans
- Referral to and/or coordination with other providers to ensure that the client has access to the full array of services that are required for optimal mental and physical health outcomes and coordination of pharmacologic and non-pharmacologic interventions
- Development of follow-up plans, if needed
- Case closure, when a client's condition is stabilized and/or the client can be referred back to the primary care provider for ongoing management

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

Standard	Measure
	Completion of the Client Transition Plan for clients deemed ineligible for psychiatric medication management or deemed ready to be transitioned out of these services

Personnel Qualifications

Psychiatric medication management services are provided by medical doctors who are board-eligible in psychiatry. A psychiatrist may collaborate with a psychiatric resident, registered nurse/nurse practitioner (RN/NP), or physician's assistant (PA) under the supervision of a medical doctor who is board-eligible in psychiatry. Intake may be conducted by other licensed mental health professionals (e.g., psychologists, licensed clinical social workers). All prescriptions shall be prescribed solely by physicians licensed by the state of California or by NPs or PAs who are practicing under their supervision.

All psychiatric medication management 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 psychiatric medication management 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 health conditions related to HIV and/or other medical conditions
- Mental health conditions that can be induced by prescription drug use
- Adherence to medication regimens
- Diagnosis and assessment of HIV-related mental health issues
- HIV legal and ethical issues
- Knowledge of human sexuality, gender identity, 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 providers.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees and board eligibility or certification in psychiatry
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

Psychiatric Assessment and Treatment Plans: Psychiatric assessments and treatment plans are core components of a psychiatry visit and should be clearly outlined in the medical record, typically using the "SOAP" format (i.e., Subjective, Objective, Assessment, Plan). Treatment plans should be developed collaboratively with the client. Assessment and treatment plans completed by unlicensed psychiatric providers must be cosigned by a medical doctor board-eligible in psychiatry.

Components of the assessment and plan generally include:

- A statement of the problems, symptoms, or behaviors to be addressed in treatment.
- Goals (desired outcomes) and objectives (measurable change in symptoms or behaviors)
- Interventions proposed (including pharmacologic and non-pharmacologic interventions)
- Appropriate modalities to address the identified problems
- Frequency and expected duration of services

- Service referrals (e.g., day treatment programs, substance use treatment, etc.)

Treatment Provision: All modalities and intervention in mental health treatment, including psychiatric medication management, will be guided by the needs expressed in the assessment and treatment plan. Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their client's presenting problems. Treatment shall conform to the standards of care recognized within the general community and supported by clinically published research for the client's condition. Psychiatric service providers shall adopt and follow performance standards as set forth in the latest HIV mental health guidelines. Programs providing psychiatric services shall be responsible for obtaining and maintaining staff, facility, and referral systems in compliance with American Medical Association standard guidelines.

Ongoing Psychiatric Sessions: Mental health treatment should include counseling regarding knowledge of modes of transmission, prevention, risk and harm reduction strategies (as well as root causes and underlying issues related to practices that may facilitate HIV transmission). Substance use, treatment adherence, development of social support systems and community resources as indicated by the client's circumstance are important areas to be explored. Focus should also be placed on maximizing social and adaptive functioning. When present in a client's life, the role of spirituality and religion should be understood and utilized as a strength when present. If clients begin to deteriorate physically, emotional distress can be relieved by helping them prepare for disability and even death. For the client whose health has improved, exploration of future goals, including returning to school or work, is indicated. When a signed release has been completed, sources of support and care can be recommended to significant others and family members. Many of these issues may also be addressed by other mental health professionals who are involved in the client's care and perform non-pharmacologic interventions based on the **Mental Health Services Service Standards**.

Psychiatric Evaluations, Medication Monitoring, and Follow-up: Psychiatrists shall use clinical presentation, evidence-based practice guidelines, and specific treatment goals to guide the evaluation, prescription, and monitoring of appropriate medication.

For medication monitoring and follow-up, visit frequency should be based on the acuity of the client's condition and the level of need.

Visits may be conducted in-person or via telehealth (telepsychiatry), based on client needs and preference.

For those patients on psychotropic medication, side effects of these agents shall be assessed at each visit, along with the provision of education regarding their medications. In addition, these patients should be regularly counseled about the importance of adherence to psychotropic medications.

The American Psychiatric Association (2001) suggests the following general pharmacologic treatment guidelines, especially for those patients with symptomatic HIV disease:

- Use lower starting doses and titrate more slowly.
- Provide the least complicated dosing schedules possible to achieve the desired outcome.
- Concentrate on drug side effect profiles as a means to avoid unnecessary adverse effects.
- Be aware of drug metabolism/clearance pathways to minimize drug-drug interactions and possible organ damage.

In general, refills shall not be written beyond three months of the last psychiatric visit. However, exception can be made in special circumstances or when the stability of the client warrants less frequent monitoring. Such exceptions shall be documented in the client progress notes.

Psychiatrists must coordinate the provision of psychiatric care with primary medical clinics and other related providers. Regular contact with a patient's primary care clinic and related providers will ensure integration of services and maintain care continuity.

Documentation: Treatment provision should be documented through progress notes and include the date and signature of the psychiatrist. For unlicensed psychiatric providers, progress notes will be cosigned by a medical doctor board-eligible in psychiatry.

Progress notes for evaluations, medication monitoring, and follow-up will include:

- Date, type of contact, time spent

- Treatment plan including current medical and psychotropic medications and dosages
- Progress toward psychiatric treatment plan goals
- Interventions and patient's response to interventions
- Referrals provided (e.g., psychotherapy, neuropsychological assessment, case management, medical services, etc.)
- Results of interventions and referrals
- Documentation that the provider has addressed existing and newly identified goals

Informed Consent: Informed consent is required of every patient receiving psychotropic medications.

When starting a new psychotropic medication, providers should ensure that the client understands:

- Medication benefits
- Risks
- Common side effects
- Side effect management
- Timetable for expected benefit

Informed consent for new psychotropic medications should be documented in the client medical record.

Standard	Measure
Psychiatric assessments and treatment plans are developed concurrently and collaboratively with the client and include interventions and modalities to address mental health conditions.	Assessment and treatment plan in client chart to include: • Statement of problem • Goals and objectives • Interventions and modalities • Frequency of service • Referrals
Assessments, reassessments, progress notes, and documentation of informed consent for new psychotropic medications completed by unlicensed psychiatric providers will be cosigned by a medical doctor board-eligible in psychiatry.	Co-signature in client record
Practitioners will use outcome research and published standards of care, as appropriate and available, to guide their treatment.	Progress note signed and dated by psychiatrist detailing interventions in the client file
Treatment, as appropriate, will include counseling about (at minimum): • Prevention and practices that may facilitate transmission, including root causes and underlying issues related to practices that may facilitate HIV transmission • Substance use • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life • Disability, death, and dying • Exploration of future goals	Progress note signed and dated by psychiatrist detailing counseling sessions in client file
Progress notes for psychiatric services will document progress through treatment provision.	Signed and dated note to be placed in the client file including: • Date, type of contact, time spent • Treatment plan including current medical and psychotropic medication and dosages • Progress toward psychiatric treatment plan goals

Standard	Measure
	• Interventions and client's response to interventions • Referrals provided • Results of interventions and referrals • Documentation of provider addressing existing and newly identified goals
Prior to initiating psychotropic medications, psychiatry providers will counsel clients on the risks, benefits, and common side effects of the medications.	Documentation in client chart indicating that the patient has been told about and understands: • Medication benefits • Risks • Common side effects • Side effect management • Timetable for expected benefit

Transition

Clients will be disenrolled from psychiatric medication management services when all action items on the individual care plan are competed, medical care is stabilized, the issue(s) for which the client requested or was referred for psychiatric medication management services are resolved or can be managed on an ongoing basis by the client's primary care provider, and the client meets all of the following criteria:

- Enrolled in HIV medical care
- Following her/his/their medical plan since the previous assessment
    - The medical plan may include other health-related issues (for example, mental health, substance use, smoking, hypertension, gynecological, etc.)
- Keeping medical appointments
- Taking medication as prescribed

Standard	Measure
Staff will document reasons for disenrollment in the client record	Documentation of reason for disenrollment
	Documentation of "inactive status" and maintenance of records and contact information to facilitate rapid re-enrollment, as appropriate

County of San Diego Monthly STD Report

Volume 17, Issue 3: Data through October 2024; Report released March 27, 2025.

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

	2023		2024	
	October	*Previous 12-Month Period**	*October*	*Previous 12-Month Period**
Chlamydia	1474	17800	1392	16112
Female age 18-25	441	5808	464	5292
Female age ≤ 17	56	596	45	589
Male rectal chlamydia	148	1743	106	1267
Gonorrhea	541	6664	547	6151
Female age 18-25	55	773	50	586
Female age ≤ 17	8	92	5	80
Male rectal gonorrhea	132	1533	114	1480
Early Syphilis (adult total)	76	1049	27	542
Primary	6	163	3	78
Secondary	24	309	10	149
Early latent	46	577	14	315
Congenital syphilis	0	39	3	26

* 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	13589	495.6	413	118.8	550	427.3	1473	154.5	1799	151.6
Gonorrhea	5137	187.3	207	59.5	329	255.6	1032	346.6	1101	92.8
Early Syphilis	414	15.1	26	7.5	42	32.6	176	18.5	116	9.8
Under 20 yrs										
Chlamydia	2025	296.3	34	47.1	82	260.0	204	68.5	290	122.4
Gonorrhea	336	49.2	4	5.5	26	82.4	61	20.5	41	17.3
Early Syphilis	14	2.0	1	1.4	2	6.3	7	2.4	1	0.4

Note: Rates are calculated using 2023 Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 01/2025.

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

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

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

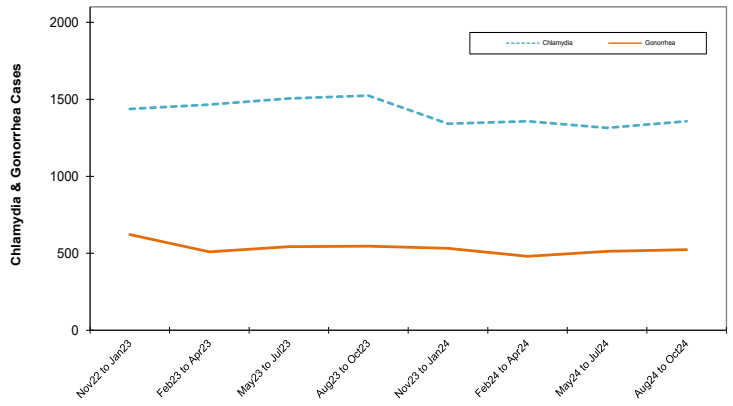
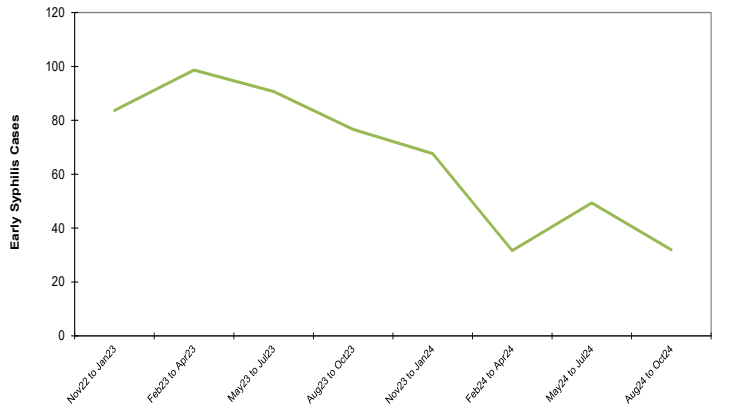


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Editorial Note: Combination Partner Therapy Reduces Bacterial Vaginosis Recurrence in Recent Randomized Trial

Bacterial vaginosis (BV), a dysbiosis of the vaginal microbiota, is associated with high rates of persistence and recurrence. Although it is not classified as a sexually transmitted infection, it is associated with having male sex partners, female partners, sexual relationships with more than one person, a new sex partner, and lack of condom use. Male circumcision is associated with lower risk of BV, and prevalence is higher among women with intrauterine devices (IUD) [1].

A recently published open-label randomized, controlled trial in Australia enrolled couples in which a woman had BV and was in a monogamous relationship with a male partner. In both arms, the partner with BV received first-line therapy. Couples were randomized for the male partner to receive combined oral and topical antimicrobial treatment for 7 days (metronidazole 400 orally twice daily plus 2% clindamycin cream applied to the glans penis and upper penile shaft, including the foreskin if applicable, n=81 couples) or no treatment (n=83 couples). The inclusion of topical treatment was designed to clear penile carriage of BV-associated organisms that may not be sufficiently cleared by oral agents alone. The primary outcome was recurrence of BV, based on both Amsel criteria and Nugent score, within 12 weeks [2].

The trial was stopped by the data and safety monitoring board after 150 couples had completed the 12-week follow-up period because treatment of the woman only was inferior to treatment of both the woman and her male partner, with recurrence within 12 weeks observed in 24 of 69 women (35%) in the partner treatment group compared to 43 of 68 women (63%) in the control group (incidence rates of 1.6 and 4.2 per person-year, respectively, absolute risk difference of -2.6 recurrences per person year, p<0.001). Stratification by IUD use and male circumcision did not significantly alter the treatment effect. Adverse events in treated men included nausea, headache, and metallic taste [2].

Routine treatment of partners of persons with BV is not currently recommended by the Centers for Disease Control and Prevention (CDC), based on guidelines last updated in 2021 [1].

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

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

HIV PLANNING GROUP
4-MONTH COMMITTEE TRACKING
March 2024 - February 2025

Medical Standards & Evaluation Committee					
MSEC	**Jun**	**Sep**	**Nov**	**Feb**	**#**
Total Meetings	1	1	1	1	**4**
(10) Members					
Tilghman, Dr. Winston	*	*	**JC**	*	**0**
Aldous, Dr. Jeannette [CC]	*	*	*	**JC**	**0**
Bamford, Dr. Laura	*	*	**1**	*	**1**
Grelotti, David [C]	**1**	*	*	*	**1**
Hernandez, Yessica	*	*	*	*	**1**
Lewis, Bob	*	**1**	*	*	**1**
Spector, Dr. Stephen	**1**	**1**	**1**	*	**3**
Quezada-Torres, Karla	*	*	*	**1**	**1**
Rodriguez, Martha			*	*	**0**
Paugh, Shannon				*	**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) 2302: THE USE OF JUST CAUSE AND EMERGENCY CIRCUMSTANCES (2025)

(An Amendment to AB 2449)

If the physical attendance quorum requirement is met, AB 2302 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 person. ▪ 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 **<u>two (2)</u>** virtual attendances due to "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 ***<u>not</u>*** 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:** 1. Make a request to the body to allow the member to meet remotely due to an emergency circumstance; and 2. Provide a general description of no more than 20 words of the circumstance justifying such attendance. A request from a member to attend remotely requires that the legislative body take action and <u>approve</u> the remote attendance at the start of the meeting for the member to be allowed to participate remotely for that meeting[1].

[1]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 2302 imposes the following three (3) additional requirements on legislative body members seeking to appear remotely at public meetings:

1. The member:
   - Notifies the legislative body at the earliest opportunity possible, including at the start of a regular meeting, of their need to participate remotely for just cause, including a general description of the circumstances relating to their need to appear remotely at the given meeting. **OR**
   - Requests the legislative body to allow them to participate in the meeting remotely due to emergency circumstances and the legislative body takes action to approve the request. *(See "requirements/limitations" for the use of emergency circumstances.)*
2. The member shall publicly disclose at the meeting before any action is taken, 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.
3. The member shall participate through both audio and visual technology.