

MEDICAL STANDARDS & EVALUATION COMMITTEE (MSEC)



Tuesday, May 12, 2026, 4:00 PM – 5:30 PM
Seville Plaza – Live Well Support Center
5469 Kearny Villa Rd, 1st Floor
Training Room D

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 Location & Directions:

Medical Standards & Evaluation Committee (MSEC)

Tuesday, May 12, 2026

4:00 PM – 5:30 PM

Seville Plaza - Live Well Support Center

5469 Kearny Villa Rd.

San Diego, CA 92123

(1st Floor, Training Room D)



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:

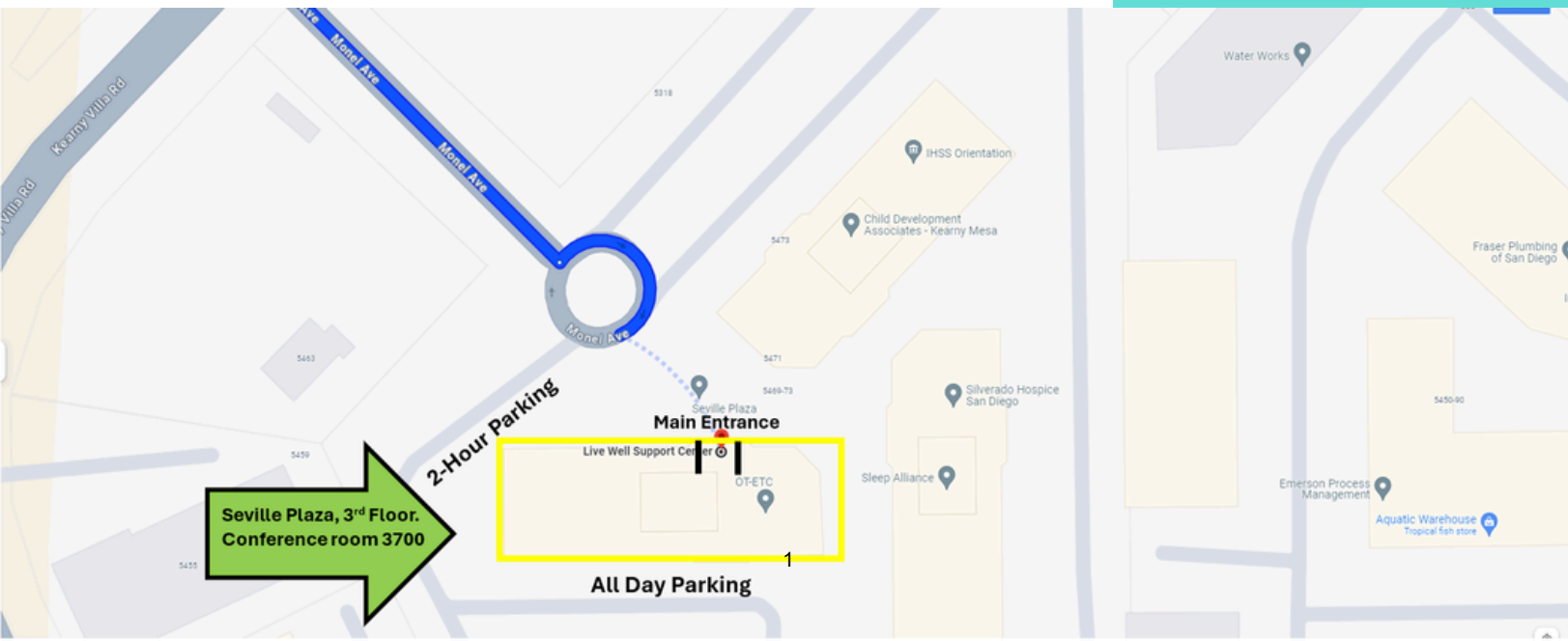
1. Use the right 2 lanes to turn left onto CA-163 N toward Escondido.
2. Merge onto CA-163 N
3. Take Exit 8 for Clairemont Mesa Blvd
4. Keep left, follow signs for Kearny Villa Rd
5. Sharp right onto Kearny Villa Rd
6. Turn Left onto Monel Ave



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

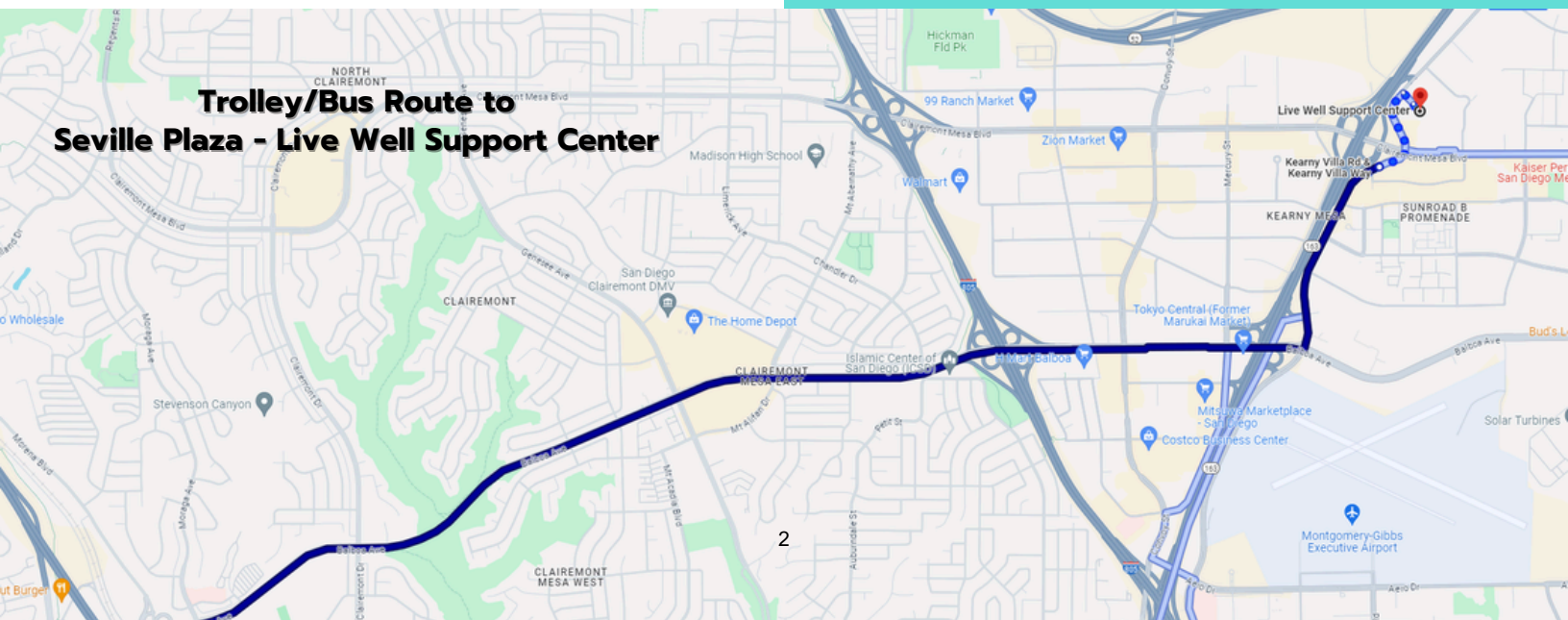
FROM BUS:

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



HPG CONFLICT OF INTEREST (COI) SHEET

	Aldous, Jeannette	Bamford, Laura	Grelotti, David	Paugh, Shannon	Hernandez, Yessica	Saville, Edith	Spector, Stephen
CHS: WICYF*							
Early Intervention Services: Regional Services	Conflicted			Conflicted	Conflicted	Conflicted	
Early Intervention Services: Minority AIDS Initiative	Conflicted				Conflicted	Conflicted	
Emergency Financial Assistance	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted
Food Services: Food Bank/Home Delivered Meals							
Home-Based Health Care Coordination						Conflicted	
Medical Case Management	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted		Conflicted
Medical Nutrition Services							
Mental Health: Counseling / Therapy	Conflicted			Conflicted	Conflicted	Conflicted	
Mental Health: Psychiatric Medication Management	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted
Non-Medical Case Management	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted
Oral Health	Conflicted			Conflicted	Conflicted	Conflicted	
Outpatient Ambulatory Health Services: Medical Specialty	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted
Outpatient Ambulatory Health Services: Primary Care	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted
Outreach Services	Conflicted			Conflicted	Conflicted	Conflicted	
Peer Navigation**	Conflicted			Conflicted	Conflicted	Conflicted	
Substance Use Disorder Treatment: Outpatient							
Substance Use Disorder Treatment: Residential							
Transportation: Assisted and Unassisted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted	Conflicted

*Coordinated HIV Services for Women, Infants, Children, Youth and Families

**Referral for Healthcare and Support Services

No Conflicts

Garcia,
Rosemary

Lochner,
Mikie

Quezada-Torres,
Karla

Rodriguez,
Martha

Tilghman,
Winston

Whyte,
Fadra



Tuesday, May 12, 2026, 4:00 PM – 5:30 PM
Seville Plaza – Live Well Support Center
5469 Kearny Villa Rd, 1st Floor
Training Room D

To participate remotely via Zoom:

<https://sdcounty-ca-gov.zoom.us/j/85484754922?pwd=ZpYeGCmH8chZaEWU4CqvcvUNPBkgl.1>

Call in: 1-669-444-9171

Meeting ID: 854 8475 4922

Passcode: 285782

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 | Mikie Lochner | Edith Saville | Shannon Paugh | Dr. Stephen Spector | Dr. Winston Tilghman | Karla Quezada-Torres | Dr. Martha Rodriguez | Dr. Fadra Whyte

MEETING AGENDA ORDER OF BUSINESS

1. Call to order, introductions, comments from the chair, and a moment of silence (4-4:05)
2. Public comment (for members of the public) (4:05-4:10)
3. Sharing our concerns (for committee members) (4:10-4:15)
4. **ACTION:** Approve the consent MSEC agenda (which includes the May 12, 2026 agenda and February 10, 2025 minutes) (4:15-4:20)
5. New Business:
 - a. **Presentation:** HIV/HCV Micro Elimination Among Ryan White Outpatient Ambulatory Health Service Providers Pilot Project (4:20-4:35)
 - b. **Presentation:** Ryan White Chart Review Summary (4:35-4:45)
6. Old Business:
 - a. **Discussion:** Review and update the Mental Health Service Standards (4:45-5:05)
 - b. **Discussion:** Review and update the Psychiatric Medication Management Service Standards (5:05-5:15)
 - c. **Discussion:** Mental Health Taskforce (5:15-5:20)
7. Other Updates: (5:20-5:25)
 - a. STI and MPox Update
 - b. Committee member updates
8. Future agenda items for consideration (5:25-5:27)
9. Announcements (5:27-5:30)

10. Adjournment (5:30)

11. **Next meeting date:** September 8, 2026, from 4:00 PM – 5:30 PM

Location: To be determined AND virtually via Zoom



Tuesday, February 10, 2026, 4:00 PM – 5:30 PM
 County Operations Center
 5530 Overland Ave, San Diego, CA 92123 (Room 124)

A quorum for this meeting is seven (7).

Committee Members Present: Dr. Laura Bamford | Dr. Rosemary Garcia | Dr. David Grelotti (Chair) | Yessica Hernández | Mikie Lochner | Shannon Paugh | Karla Quezada-Torres | Edith Saville | Dr. Stephen Spector

Committee Members Absent: Dr. Jeannette Aldous (Co-Chair) | Dr. Winston Tilghman | Dr. Martha Rodriguez | Dr. Fadra Whyte

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Grelotti called the meeting to order at 4:07PM and introductions were made. A moment of silence was observed.	
2. Public Comment	None	
3. Sharing our Concerns	<ul style="list-style-type: none"> - A request that non-HPG members sign required forms for participation. - A reminder that providers should treat their patients with care and respect. 	
4. Action: Approve the consent MSEC agenda (which includes the February 10, 2026 agenda and November 04, 2025 minutes	<p>Motion: Approve the consent MSEC agenda (which includes the February 10, 2026 agenda and November 04, 2025 minutes</p> <p>Motion/Second/Count (M/S/C): Quezada-Torres/Saville/8-0</p> <p>Abstentions: Grelotti</p> <p>Motion Carries</p>	
5. Old Business:		
a. None.		
6. New Business:		
a. Mental Health Service Utilization Report i. Discuss additional data requests	<p>Dustin Walker presented the FY23-FY24 Mental Health Service (MHS) Utilization Report and the following discussion occurred.</p> <ul style="list-style-type: none"> - A question regarding why utilization had decreased while the need continued to increase. - A clarification that some of the data does not include individuals accessing services outside of the Ryan White system. 	

Agenda Item	Action	Follow-up
	<ul style="list-style-type: none"> - A clarification that individuals receiving psychiatric medications from primary care providers are not represented in the data. - A clarification that underspending is often due to staff vacancies. - A clarification that the number of contracted agencies did not change. However, information regarding staffing amongst those agencies is unknown. 	
<p>b. Discussion: Mental Health task force or working group</p>	<ul style="list-style-type: none"> - A clarification that a working group would comprise fewer than a quorum of this committee and would not need to follow the Brown Act. - A clarification that a task force would be created by the HPG and therefore would be open to other members and the public. - A reminder that the Clinical Quality Management (CQM) meetings are currently looking at mental health. - A question regarding the limitations and restrictions of a task force. - A clarification that conflict of interest requirements would still apply to a task force due to the Brown Act. - A clarification that a task force is more limited than a working group but would allow consumers receiving services to be part of the process. - A reminder that the Priority Setting and Resource Allocation Committee will be creating the questions for the needs assessment survey. - A suggestion to create a working group that could build the foundation for a task force. - A clarification that CQM meetings should be the starting point that can inform a task force. 	<p>HPG Support Staff will forward CQM meeting information to committee.</p>
<p>c. Discussion: Update the Mental Health and Psychiatric Medication</p>	<p>The committee reviewed the Mental Health Services Standards documents and the following discussion occurred. Packet Page 11 (Document Page 1)</p>	

Agenda Item	Action	Follow-up
Management Service Standards	<ul style="list-style-type: none"> - Add “partners” to be inclusive of couples. - Change psychosocial stress to mental health crisis. - Add a timeline for the intake. <p>Page 12 (Page 2)</p> <ul style="list-style-type: none"> - Add “provider will provide referrals back to primary care providers as appropriate”. - Add Medications and adherence to medication regimens. <p>Page 13 (Page 3)</p> <ul style="list-style-type: none"> - Add a timeline for treatment plans or frequency of visits. - Add a section for frequency and duration. <p>Discussion:</p> <ul style="list-style-type: none"> - A suggestion that training should be incorporated into the Service Standard documents to hold providers accountable. - A reminder that the Universal Standards incorporated language regarding training. - A clarification that timelines are highly encouraged and can be monitored on the contract side. - A question regarding incorporating whole person care language being applied to each of the Service Standards section. - A clarification that the integration has been primarily through case-management. - A reminder that wait times for mental health services should be considered when reviewing standards. 	
d. Discussion: Review meeting schedule and identify priorities for 2026 work plan	Tabled.	
7. Other Updates:		
a. STD and Mpox Update (Dr. Tilghman)	Tabled.	

Agenda Item	Action	Follow-up
b. Committee member updates	Tabled.	
8. Future agenda items for consideration	Tabled.	
9. Announcements	Tabled.	
10. Next meeting date:	Date: May 12, 2026, Time: 4:00 PM – 5:30 PM Location: TBD	
11. Adjournment	The meeting was adjourned at 5:35PM	



County of San Diego
Health and Human Services Agency
Public Health Services
HIV, STD, AND HEPATITIS BRANCH

RYAN WHITE OUTPATIENT
AMBULATORY HEALTH SERVICES

REPORT ON
COMPLIANCE WITH PRACTICE GUIDELINES
2025

STUDY DESIGN AND METHODOLOGY

United Healthcare conducted a medical chart review for the County of San Diego’s Ryan White HIV/AIDS Treatment Extension Act of 2009-funded primary medical care clinics between February 2026 and April 2026, at the request of the County of San Diego Health and Human Services Agency; Division of Public Health Services; HIV, STD, and Hepatitis Branch. The goal was to determine the quality of care provided to persons living with HIV/AIDS and contractor compliance with established Practice Guidelines, as well as to collect baseline data for future use. The review tool was slightly revised to clarify specific data points and capture additional relevant data. The County of San Diego HIV Health Services Planning Group’s Medical Standards and Evaluation Committee reviewed and approved the data elements to be collected during the review.

The entire client registration database was examined, and the eligible population was selected. Eligibility for inclusion in the review required continuous enrollment in the program from October 2024 through September 2025 with a minimum of one medical visit during the 12-month period.

The resulting list was sorted by primary care sites to determine each clinic’s patient population. Twenty-five percent of the eligible enrollees, but no fewer than ten patients, were selected as the sample for each clinic. The percentage of the clinic’s sample population ranged from 25% to 40%. There was a twenty-one percent increase in the number of patients eligible for inclusion in the review this year.

To present an equitable representation of cis-female, trans-female, and cis-male clients, gender selection was biased; charts for 100% of eligible cis-females, 29% of eligible cis-males, and 100% of eligible trans-female clients were reviewed. The resulting sample represents 33% of the eligible Ryan White clients.

The chart below illustrates the percentage of eligible clients reviewed for each site. In this report, clinic sites are lettered A through E; however, to preserve a blinded status, the letters representing each clinic do not coincide with those of the list below.

Clinic Organization	Total Eligible Clients	# of Charts Reviewed	Percent of total Eligible Clients Reviewed
UCSD-OWEN	28	10	36%
Hillcrest Family Health Centers	40	10	25%
San Ysidro Health	44	11	25%
Vista Community Clinic	25	10	40%
AIDS Healthcare Foundation	31	10	32%
Total	168	51	33%

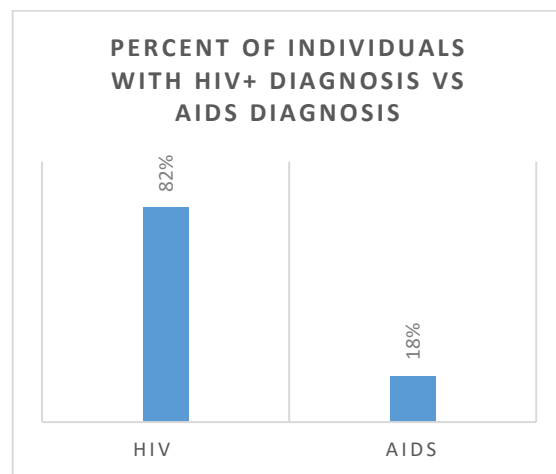
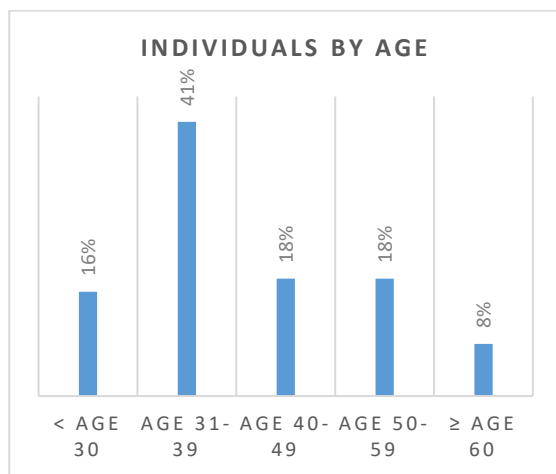
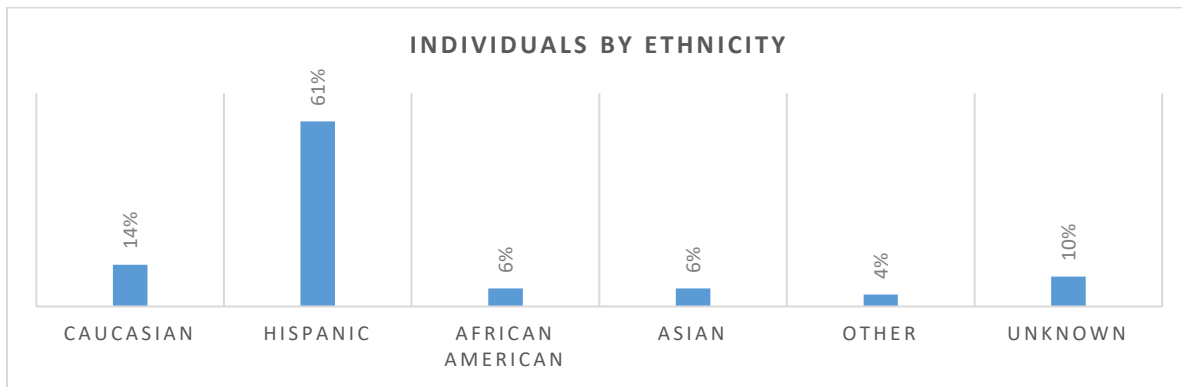
Each medical record was reviewed by a UHC licensed Registered Nurse Case Manager for all services provided from October 1, 2024 through September 30, 2025. The review included medical encounters, laboratory test results, medications, documentation of patient adherence, screening tests for sexually transmitted infections (STI) and tuberculosis (TB), Papanicolaou (PAP) smear tests for people assigned female at birth, documentation of dental referrals, hepatitis A, B, and C screening, lipid screening,

vaccinations, and mental health and substance use disorder screening. Data was entered into Microsoft Excel to ensure accurate and consistent collection.

This document reports the overall results of the medical record review. In addition, statistical tests comparing 2024 and 2025 were completed on appropriate measures. Select sections from the review tool are presented anonymously by clinic to provide the County with comparative results of compliance. Subsequent reports detailing individual clinic performance will be provided to the County, which then will review clinic-specific results with each clinic. In addition, certain sections will show benchmarks for comparisons. For further information regarding these benchmarks please visit <https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio>.

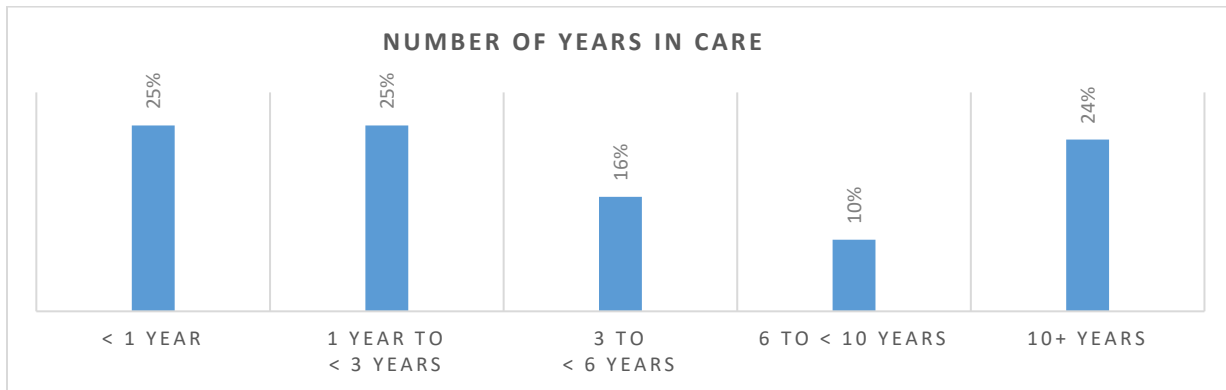
DEMOGRAPHICS

Of the 51 clients included in the sample, 41 were cis-male, 8 were cis-female, and 2 were trans-female, representing 29%, 100%, and 100% of eligible clients in each respective population. The following charts show additional demographics and data for the sample population:



Because the amount of time receiving care for HIV can greatly influence outcomes, the number of years in care (i.e., enrolled in the Ryan White Outpatient Ambulatory Health Services) for the sample population is

presented. The chart below shows that 13 (25%) of the sampled clients have been receiving care for less than one year, 13 (25%) one to three years, 8 (16%) three to less than six years, 5 (10%) six to less than 10 years, and 12 (24%) for over 10 years.



The average number of in-person visits per client documented for the 12-month period program-wide was 2, and the average number of telehealth encounters was 1. The total average number of encounters was 3 compared to 4 in 2024.

Summary of Medical Record Review Results – Comparison with the 2024 Review

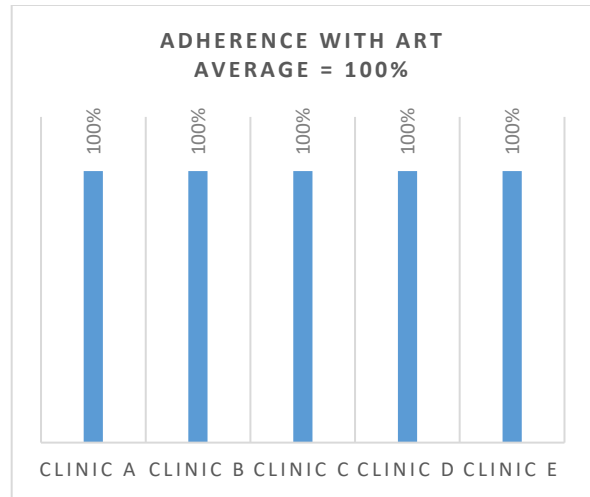
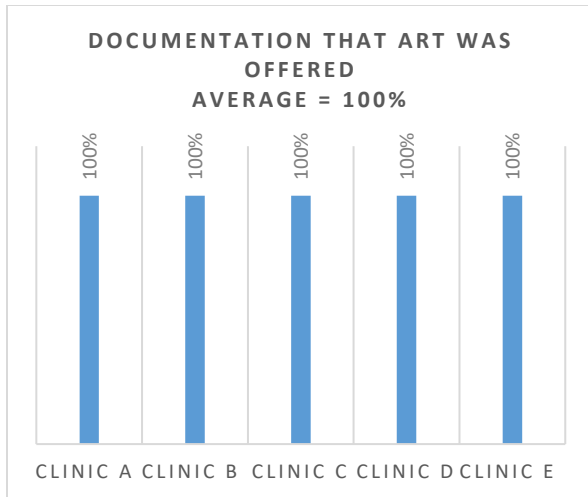
Treatment Plan Adherence

Questions were presented to determine patient adherence to the recommended treatment plan: documentation of follow-up visits scheduled, patient adherence to the schedule, and number of visits missed in excess of 30 days.

The reviewer found that 100% of the reviewed charts documented the follow-up schedule, consistent with the same results from 2024. The current review also revealed that 98% of these patients were adherent to the schedule while 2% were non-adherent (i.e., missing more than one appointment by more than 30 days), an increase of two percentage points compared to 2024.

Antiretroviral Therapy

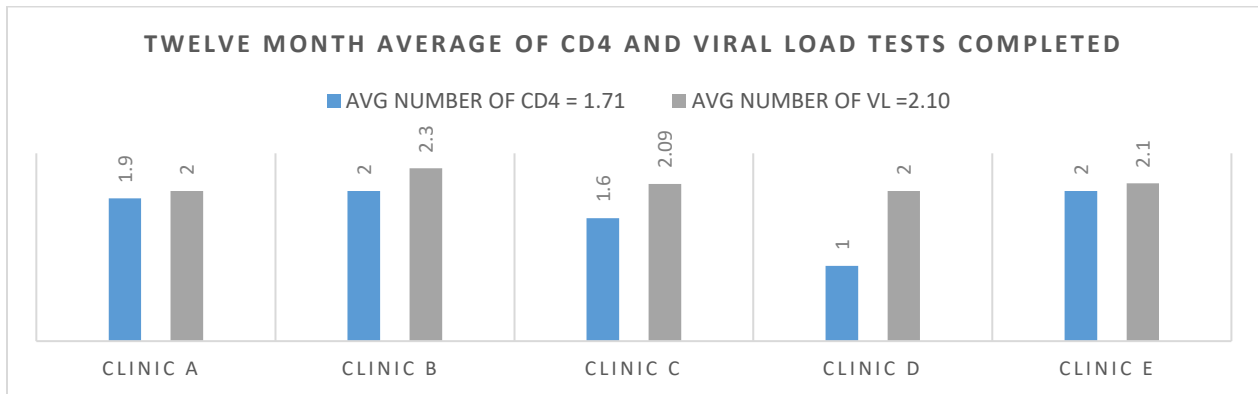
The reviewer looked for documentation confirming antiretroviral therapy (ART) was prescribed for the clients and found confirmation in 100% of the records reviewed, which is identical to the previous year. Adherence to the medication regimen (i.e., documentation that the individual missed no more than three doses over a 30-day period) was also confirmed in 100% of the records reviewed, consistent with the results from 2024. The results are shown for each clinic in the graphs below.



Frequency and Outcome of CD4 T-Cell Counts and Viral Loads

In December 2015, the San Diego County HIV Services Planning Group’s Medical Standards and Evaluation Committee implemented a recommendation to decrease the required CD4 count frequency in certain cases for clients who have sustained undetectable viral load (VL) results. For clients who have consistently undetectable VL results on ART and CD4 counts between 300 and 500 for at least two years, the CD4 count only needs to be checked once per year. For clients who have consistently undetectable VL results on ART and CD4 counts over 500 for at least 2 years, CD4 counts are considered optional. These exceptions are listed in the current practice guidelines.

Clients are eligible for up to eight VL tests per year. On average, each client received 1.71 CD4 counts and 2.10 VL tests during the twelve-month review. The CD4 count average is lower in this review period compared to the average in 2024 of 2.14. This difference is not statistically significant. The average number of viral loads test also decreased from 2.60 to 2.10. This decrease is also not statistically significant.

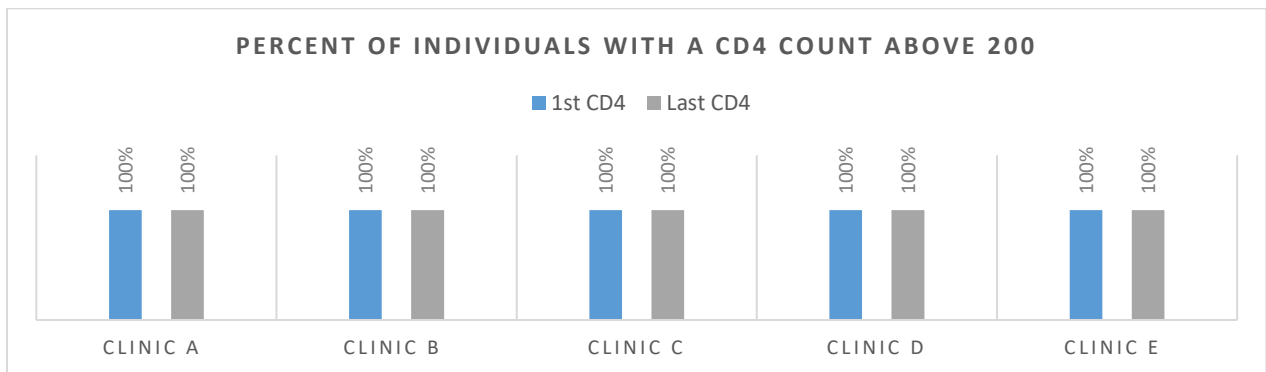


Previous reports used measures that looked at the percentage of clients with HIV infection who had two or more CD4 counts performed during the measurement year. There is currently no comparable measure to use as a benchmark, as the minimum recommended number of CD4 counts varies based on the clinical situation. The National HIVQUAL measure looks at CD4 counts every four months while the local measure, until recently, has been every three months.

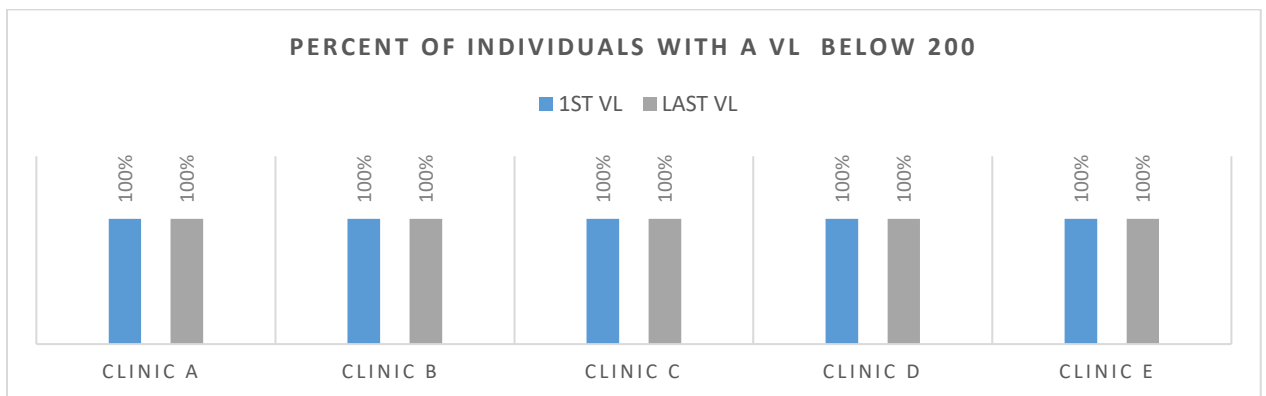
National HIVQUAL: Every 4 months: Percentage of patients for whom at least one VL test was performed in each four-month trimester of the review period at least 60 days apart. Every 6 months: Percentage of patients for whom at least one viral load test was performed in each six-month semester of the review period at least 60 days apart.

Outcomes of treatment were evaluated by collecting the values of the first and last CD4 and VL results during the twelve-month period. Parameters were set for CD4 counts greater than 200 cells/mm³ and for VLs less than 200 copies/mL.

Analysis of CD4 counts shows an increase in the percentage of clients who received at least two CD4 tests with a count above 200 remained at 100% from first to last compared with an increase from 97% to 98% in 2024



VL outcomes showed that the percentage of clients with results of <200 copies/mL remained at 100% from the first and last compared with an increase from 97% to 98% in 2024



Resistance Testing

The Practice Guidelines state that those eligible for genotype testing are patients who are: a) treatment-naïve, or b) patients with a detectable viral load greater than 1,000 copies/mL who have been on stable ART for at least one month at the time of VL testing. In addition, the US Department of Health and Human Services recommends genotypic testing as the preferred resistance testing to guide therapy in ART-naïve patients.

The chart extraction consisted of documenting those records that reported a genotype test during the 12-month period. The chart review included a screening for patients with no previous experience with ART.

There were three newly enrolled, treatment-naïve individuals reported in this sample, and all three clients received a treatment-naïve genotype. Each had a VL greater than 1,000 copies/mL; as newly enrolled and treatment-naïve, they would not be eligible for a treatment-experienced genotype. Last year's review consisted of 2 newly enrolled and neither client had a documented baseline/treatment-naïve genotype test.

Communicable Disease Screening

The Practice Guidelines specify the frequency for screening for STIs and TB:

- Sexual risk and drug use assessment should be repeated every three months (once per quarter); screening for syphilis, gonorrhea, and chlamydia should be done annually at a minimum; and
- Screening for TB (PPD or QuantiFERON) shall be completed annually unless already known to be infected/treated.

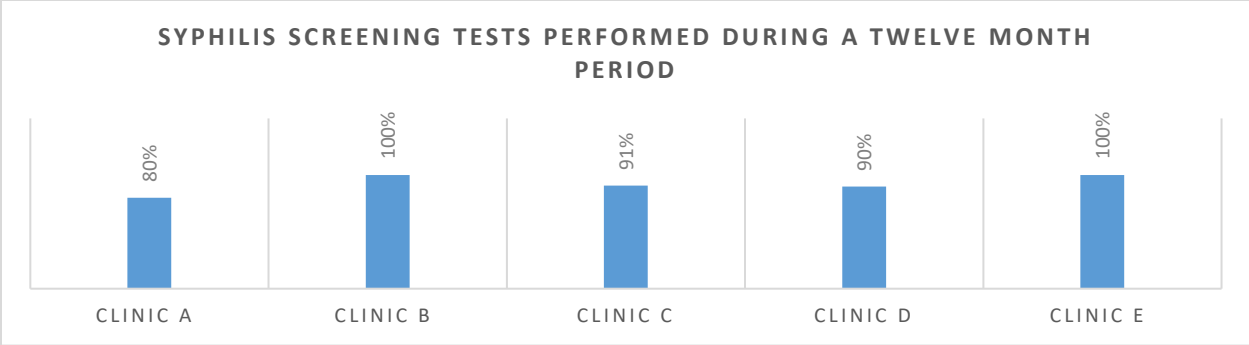
Sexually Transmitted Infections

Medical records were examined for evidence of either a notation by the practitioner or completion of the Sexual Health Risk Assessment form and laboratory results for STIs (syphilis, gonorrhea, and chlamydia).

Documentation confirming risk assessments were completed in a twelve-month period was found in 100% of charts, an increase of 5% compared to the 2024 review. This statistic could be misleading since some patients who have undetectable VLs may be seen only once or twice per year.



Laboratory testing for STIs averaged 92% for syphilis screens across all clinic sites, which is a decrease of 5% from the 2024 review.



The charts were reviewed for evidence of screening for chlamydia and gonorrhea. Screening rates were assessed for each of the following groups (not mutually exclusive):

- Patients who were newly enrolled in care
- Patients who were sexually active and
- Patients who had STI documented in the last twelve months.

All individuals who were diagnosed with an STI in the last twelve months received urogenital screening for chlamydia and gonorrhea which is consistent with the 2024 review.

Out of the 10 newly enrolled clients, 80% received urogenital screening for chlamydia and gonorrhea. In addition, the percentage of those documented as sexually active who received urogenital screening for chlamydia and gonorrhea increased from 97% to 100%, and this difference is statistically significant ($p = 0.01$)

The overall averages using these three criteria are as follows:

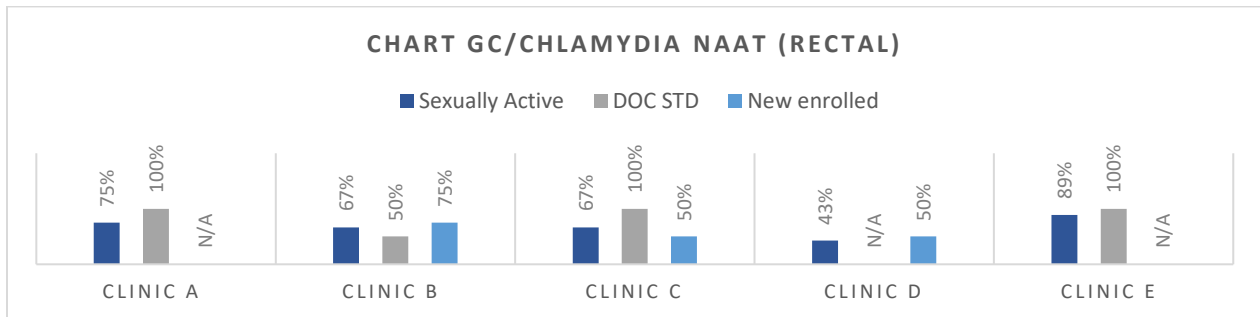
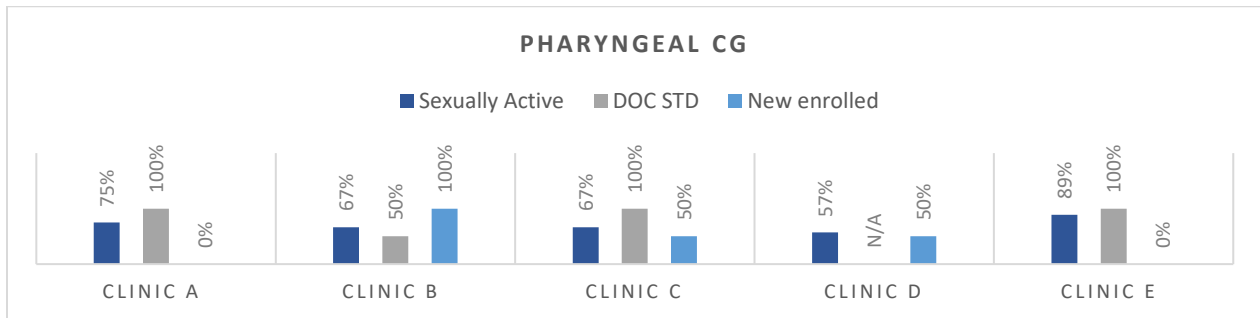
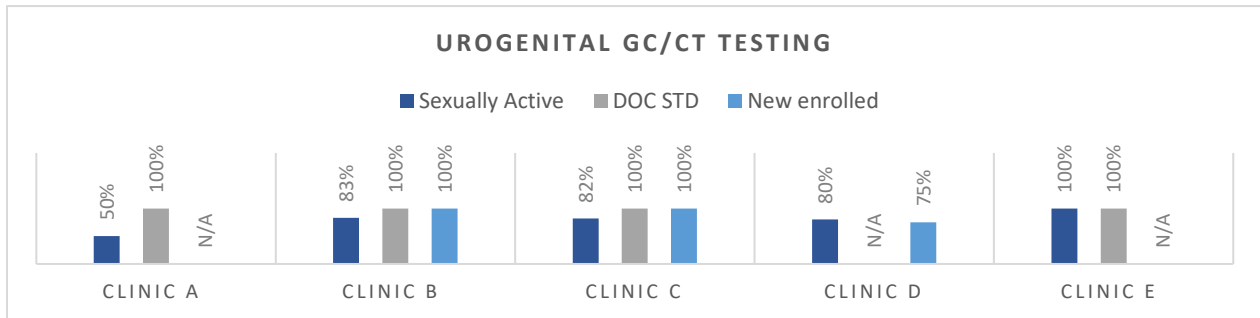
	Newly Enrolled	Sexually Active	Documented STI
Urogenital chlamydia and gonorrhea screening	80%	77%	100%

Eighty percent of clients with documented STI received pharyngeal screening for chlamydia and gonorrhea, a decrease of 20% compared to 2024. There was a decrease of 20% in clients with a documented STI who received rectal screening for gonorrhea and chlamydia from 100% to 80% which was not statistically significant.

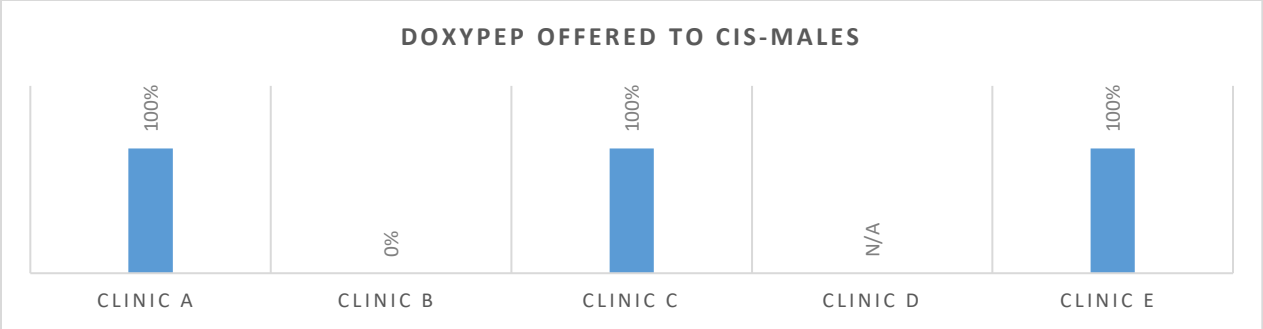
The percentage of clients who are sexually active who received pharyngeal chlamydia and gonorrhea screening increased to 71% in this year’s review from 69% in 2024, an increase which was not statistically significant. The percentage of sexually active clients who received rectal gonorrhea and chlamydia screening increased from 65% to 69%, and this increase is not statistically significant. The overall averages for extragenital screening for gonorrhea and chlamydia are presented in the chart below.

	Newly Enrolled	Sexually Active	Documented STI
Pharyngeal chlamydia and gonorrhea screening	70%	71%	80%
GC/Chlamydia Rectal	60%	69%	80%

The following graphs represent the results by clinic:



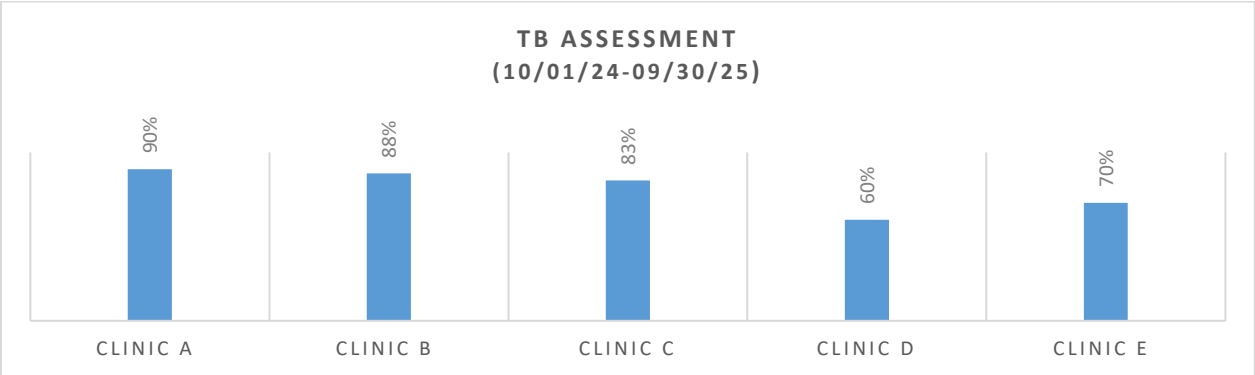
The reviewer also determined if Doxycycline STI Post-Exposure Prophylaxis (i.e., DoxyPEP) was offered to those clients who had a documented STI within the past 12 months. The results showed that 60% of cis-males were offered DoxyPEP. There was no trans-female who had a documented STI.

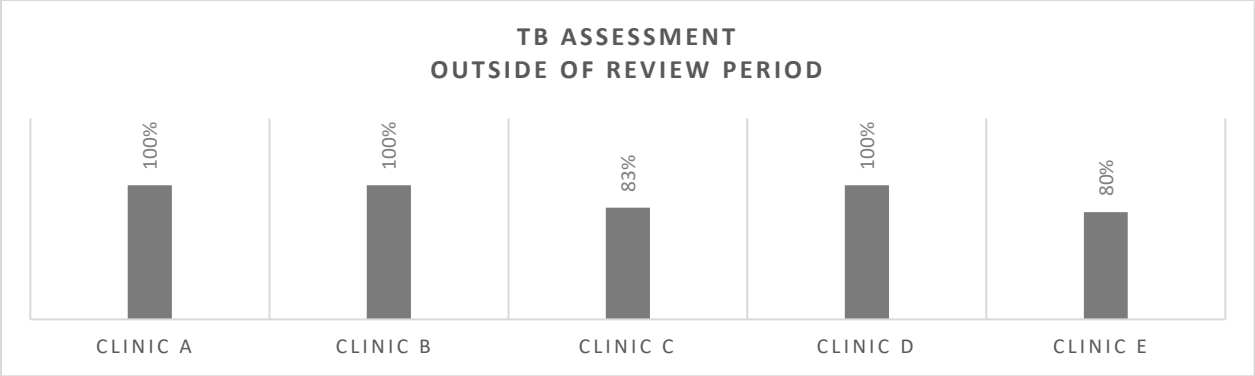


Tuberculosis Testing

To decrease the occurrence of opportunistic infections, persons living with HIV should have an annual TB skin test (PPD), chest X-ray (CXR), or QuantiFERON screening, unless there is documentation of a previous positive reaction. In addition, documentation of a baseline CXR and prophylactic therapy must be present in the medical record for all patients with a previous positive reaction. Medical records were examined for documentation of both items. The percentage of known positives and documentation of prophylactic treatment were collected.

The following charts show clinic results for the percentage of clients who received testing for TB. Seven clients who had a previous positive test were excluded from these figures. Documentation in the medical records indicates that 77% of non-exempt individuals received a TB test during the twelve-month review period, an increase of twenty-seven percentage points that is statistically significant ($p = 0.014$). When TB screenings completed outside of the review period are included, the overall screening rate increases to 93%. QuantiFERON screening was used 100% of the time. The study found that 85% of charts for those clients with a prior positive test contained documentation of a CXR or a notation that a CXR had been performed in previous years. This is an increase of 20%. This result is not statistically significant. TB risk assessments for those with prior positive results were found in 43% of the medical records reviewed, which is an increase of 28% over last year’s results and is not statistically significant.

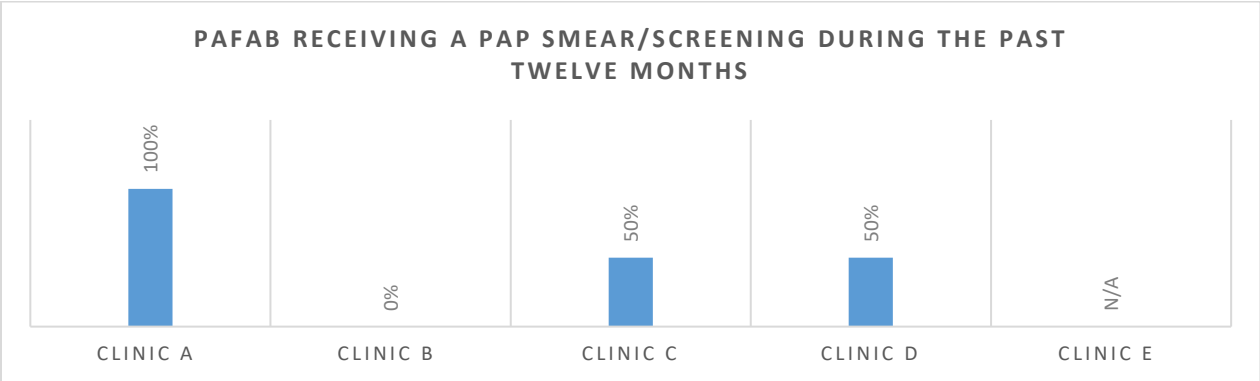




Papanicolaou (Pap) Test

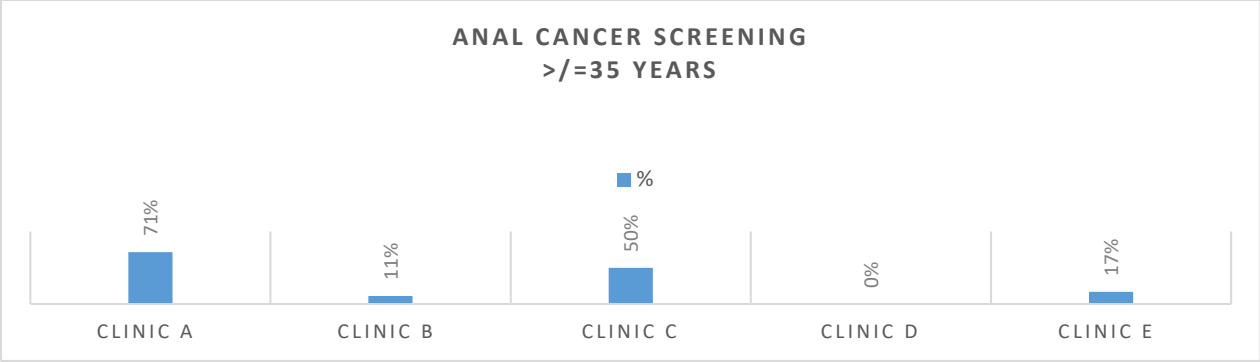
Practice Guidelines for persons assigned female at birth (PAFAB) include an initial and annual Pap smear to screen for cervical cancer unless a hysterectomy for non-dysplasia/non-malignant indications has been performed. A Pap test should be done annually for three years and if normal, can be done every three years thereafter.

The records were reviewed for an indication that the patient’s cervical cancer screening had been addressed. Overall, 63% of PAFAB had received at least one Pap test during the twelve-month period or had an indication in their chart of when the next Pap smear is due. This represents an increase of 52% from 2024 which is borderline statistically significant (p=0.050). The results by clinic are displayed in the following graph.



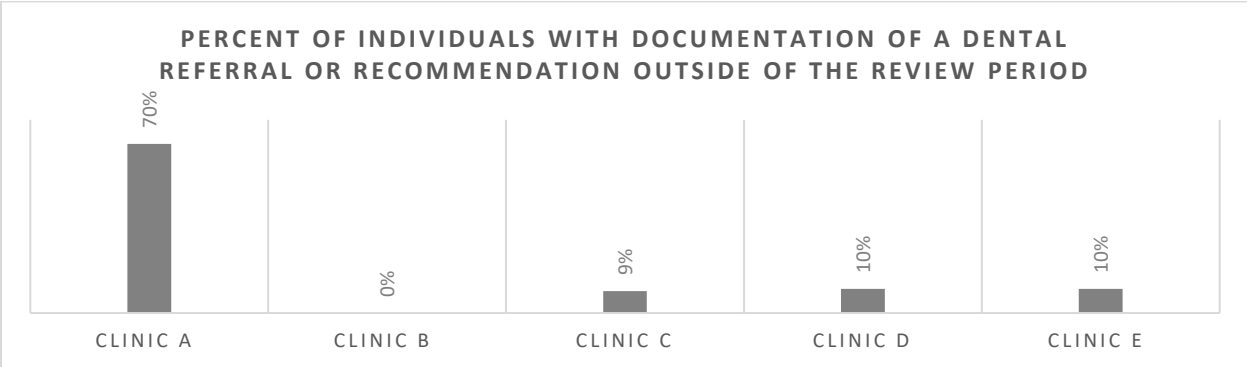
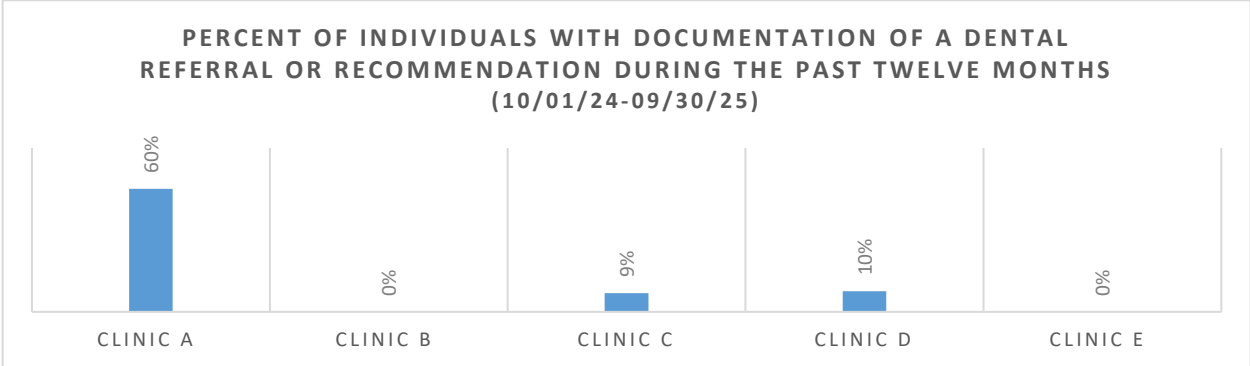
Anal Cancer Screening

The charts were also reviewed to determine if anal cancer screening was conducted for those clients aged 35 and older. The results show 31% of the clients were screened in comparison to 24% in 2024, which is not statistically significant.



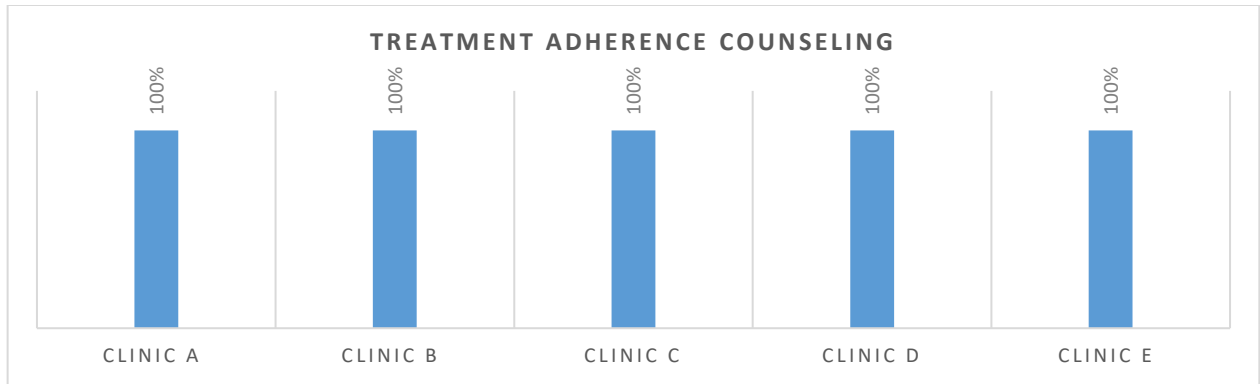
Dental Referral

The contract with the Ryan White service providers requires that the medical records contain documentation that the primary care practitioner referred to or advised the patient about annual dental care. Documentation was found in 16% of the records reviewed, representing a decrease from 17% in 2024, which is not statistically significant. When documentation of dental referrals completed outside of the review period is included, the overall referral rate increases to 20%



Treatment Adherence Counseling

The reviewer confirmed that all clients received treatment adherence counseling, an increase of 1% compared to the previous review. The following graph represents the results of each clinic:

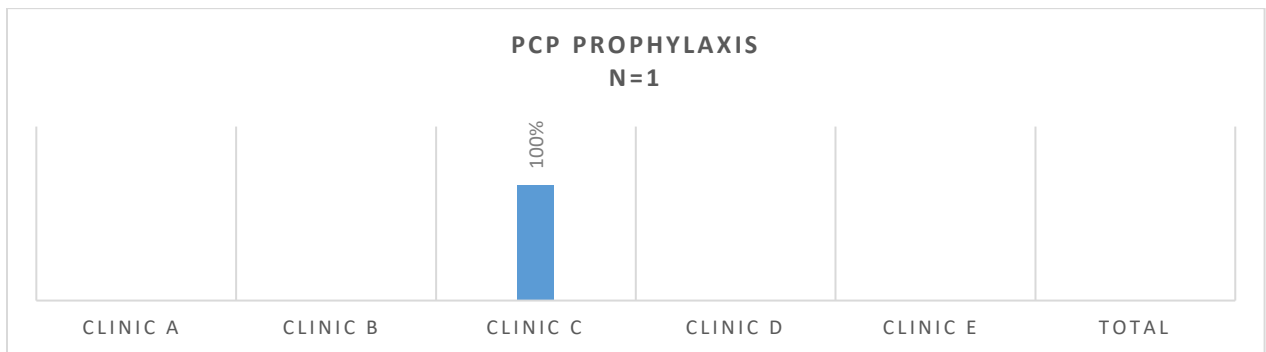


PCP (PJP) Prophylaxis

The HAB measures for the prescription of *Pneumocystis carinii* (now *jiroveci*) pneumonia (PCP/PJP) prophylaxis is based on the following criteria:

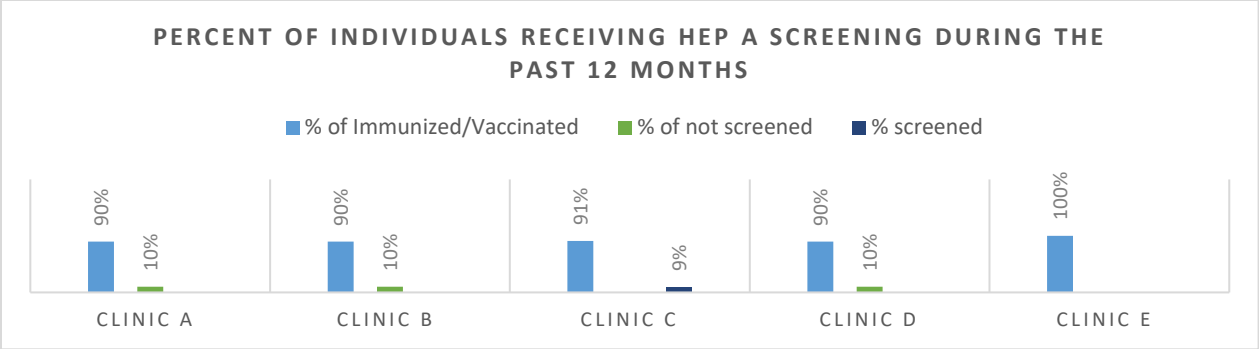
- The client is HIV +
- Is not newly enrolled, and
- Has a CD4 T-cell count <200 unless the post-test after three months rose above 200 cells/mm³

One client met the above criteria and was prescribed PCP/PJP prophylaxis, resulting in a rate of 100%. In the previous year, four clients met the above criteria, and three were prescribed PCP/PJP prophylaxis. One client qualified for PCP but was not prescribed due to drug allergy. This difference is not statistically significant.



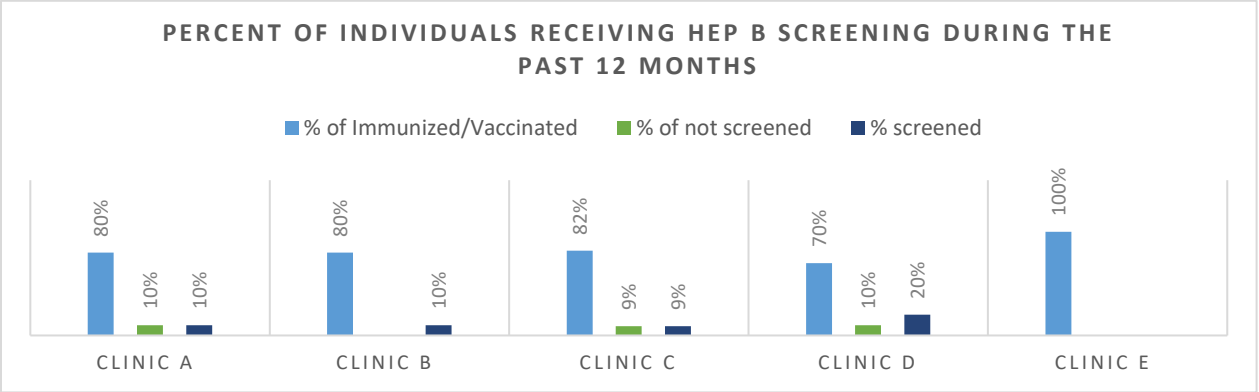
Hepatitis A Screening

Medical records were reviewed for Hepatitis A screening and vaccinations. Overall, 92% of clients were immunized/vaccinated during the review period. This is an increase of 2%, a result that is not statistically significant.



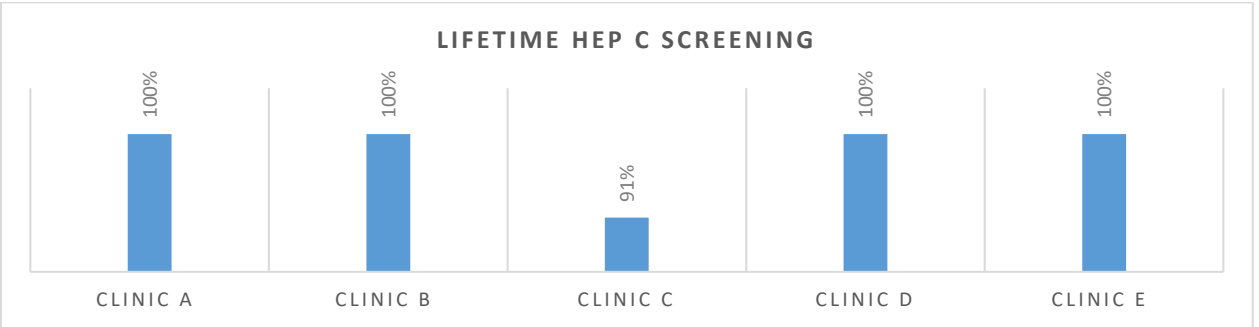
Hepatitis B Screening

Screening for Hepatitis B was also reviewed. Eighty-two percent of clients were immunized/vaccinated compared to 96% in 2024. This measure did consider previous infection and/or the vaccination status of each client. The graph below represents the results by clinic.

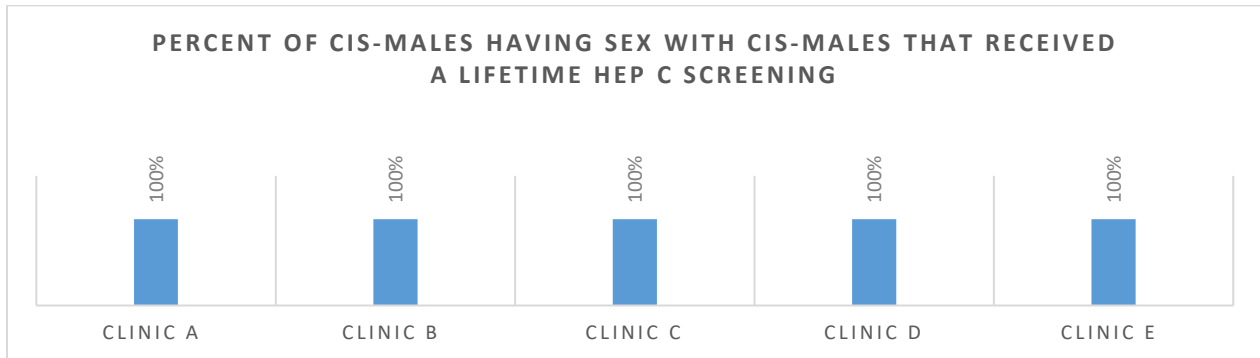


Hepatitis C Screening

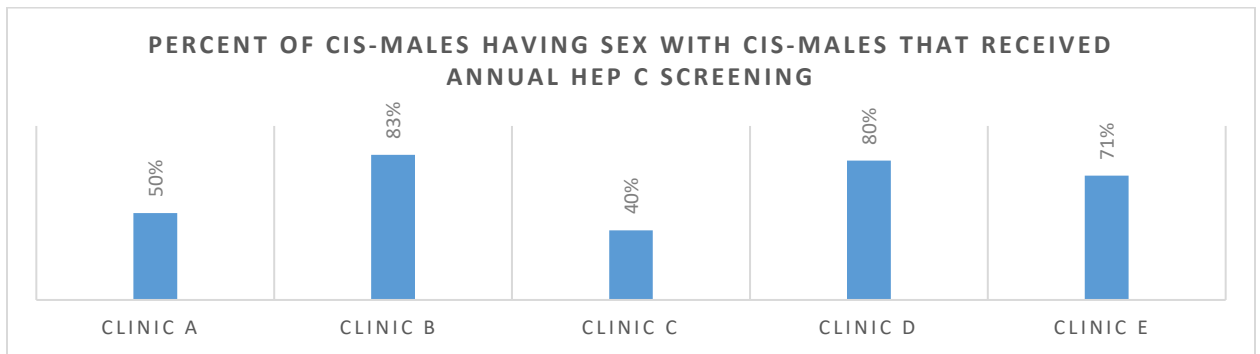
The review captured those clients who received a lifetime screening for Hepatitis C at any time. In 2025, the numbers of clients who had received a lifetime Hepatitis C Screening at any time or who were previously confirmed with Hepatitis C was 98%, which is an increase of 2% from the previous year and is not statistically significant. The following graph represents the results by clinic:



Further review of the records revealed that all cis-males who reported having sex with other cis-males, all received a lifetime Hepatitis C Screening. This is a 4% increase from the previous year that is not statistically significant. The following graph represents the results by clinic:

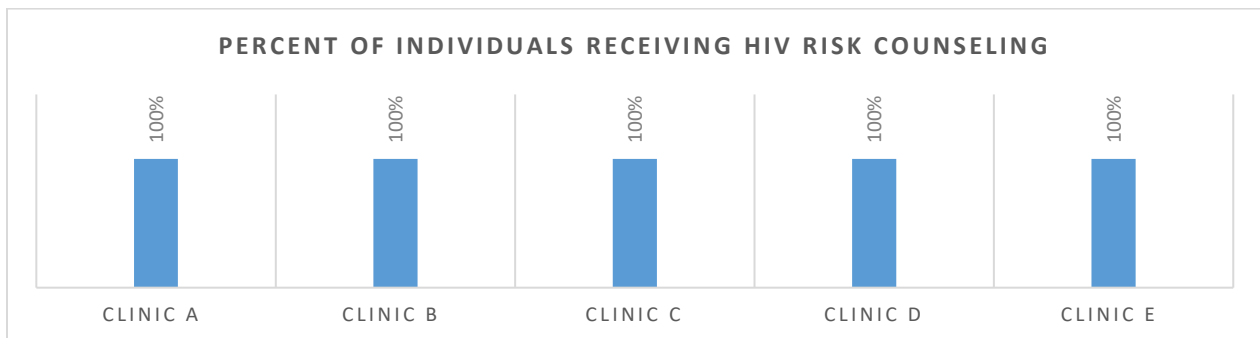


Medical records also were reviewed for documentation that annual Hepatitis C screening was done for cis-males who reported having sex with other cis-males or those with active or previous injection drug use not previously tested for Hepatitis C. It was found that 67% of those eligible for annual Hepatitis C screening based on the criteria above received the screening. This is an increase of 7% from the previous year which is not statistically significant.

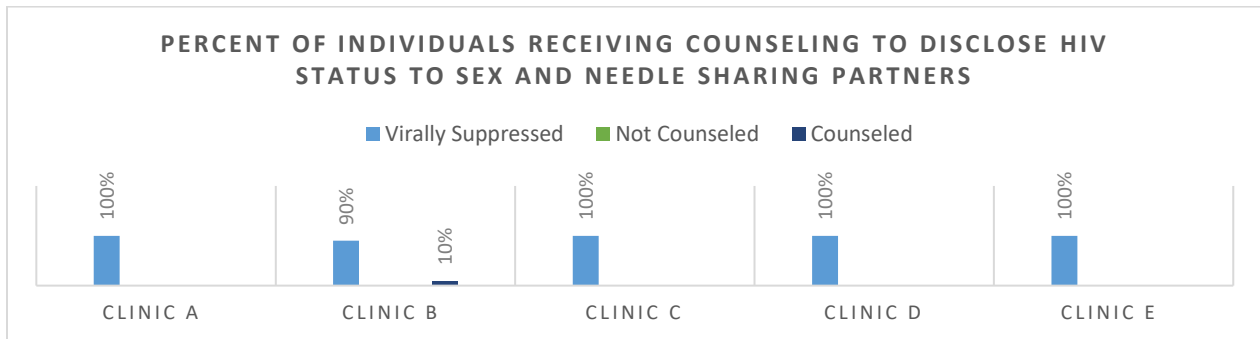


HIV Risk Counseling

Reviews of the medical records indicated that all clients received HIV risk counseling, an increase of 1% from the previous year that is not statistically significant. The graph below represents the results by clinic:

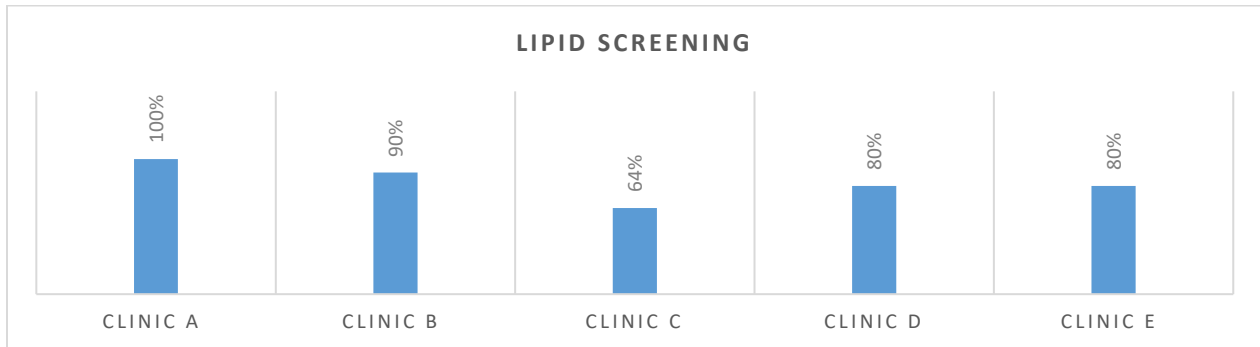


The reviewer also looked for evidence that individuals were counseled on the disclosure of HIV infection to sex and needle-sharing partners and/or were referred to HIV Partner Services if they were not virally suppressed. Ninety-eight percent of the clients were virally suppressed compared to 99% in 2024.



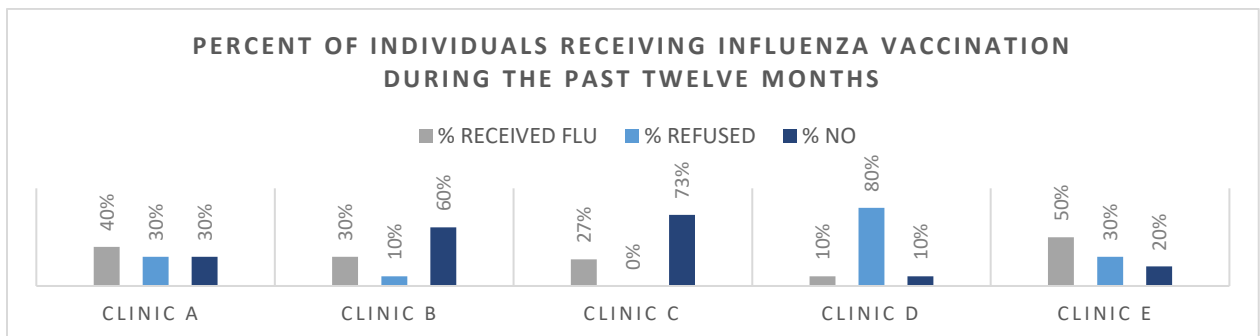
Lipid Screening

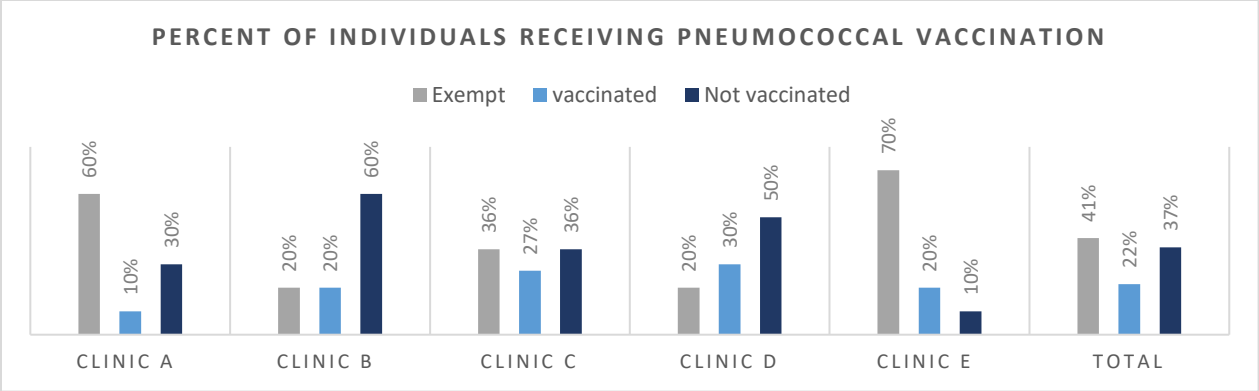
Eighty-two percent of individuals received lipid screening during this review period. This represents a 9% decrease from the previous year and is not statistically significant.



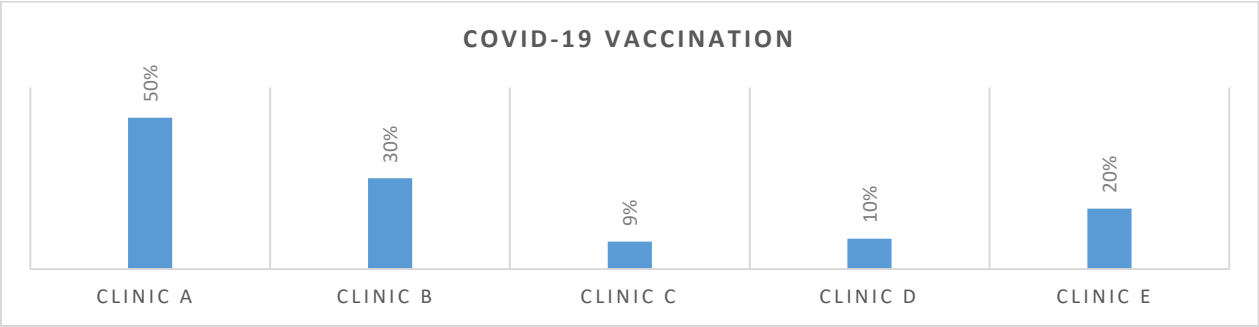
Vaccinations

A review of the medical records showed that 31% of clients received an influenza vaccination, a decrease of 45% which is statistically significant ($p < 0.001$). Documentation showed 22% of patients received a pneumococcal vaccination and 41% were exempt. The clients that were vaccinated all received Prevnar 20. The following graphs represent the results by clinic:

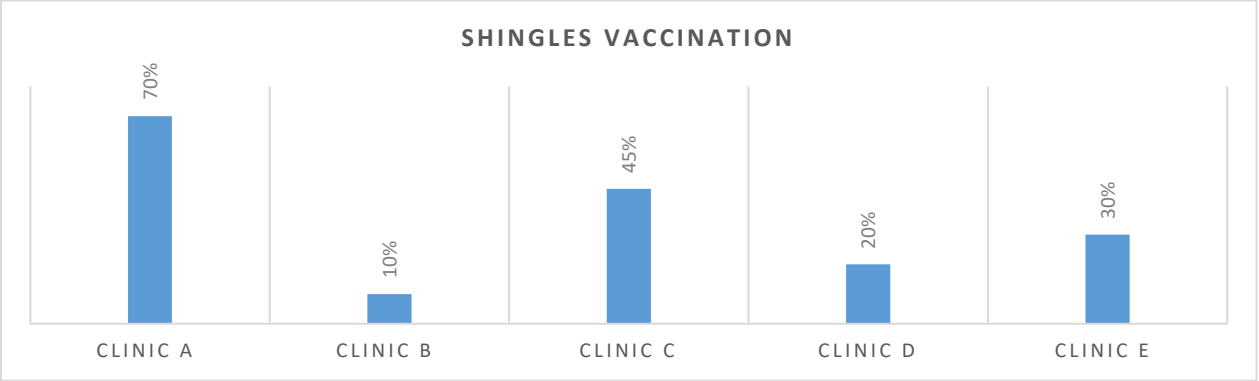


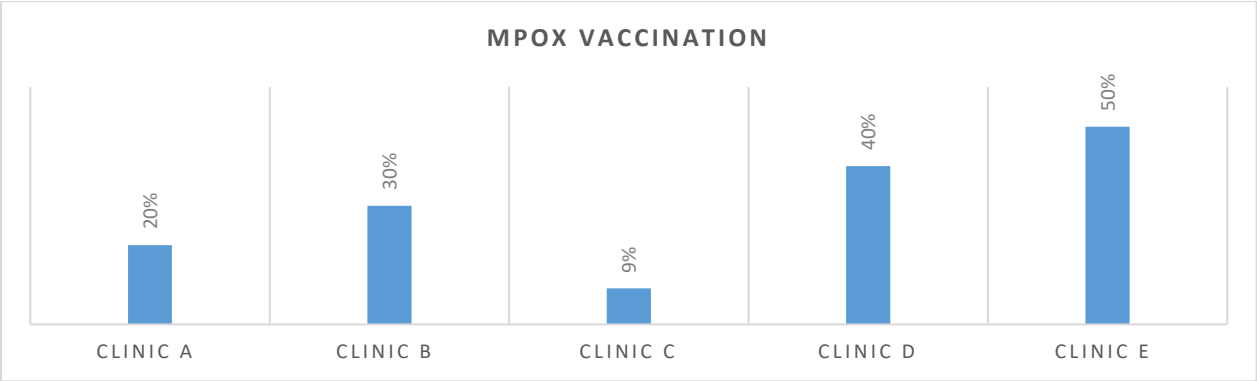
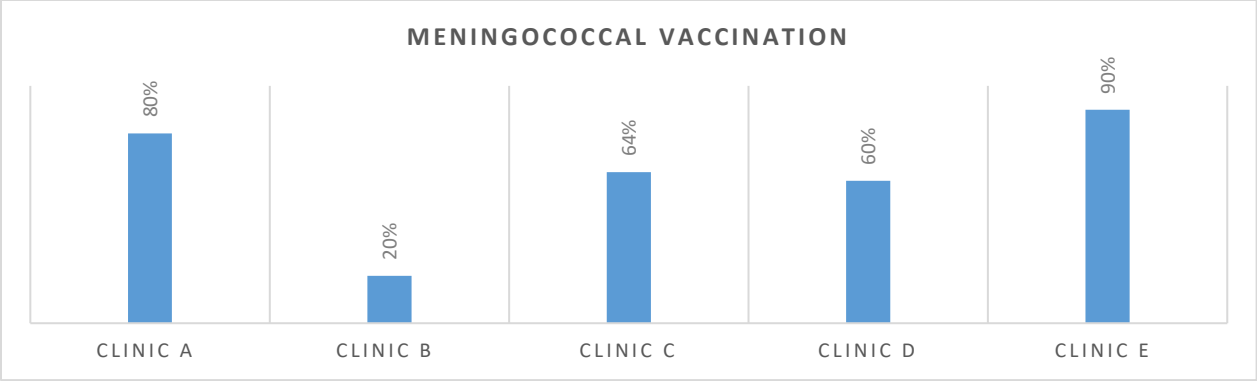


The charts were also reviewed for evidence of COVID-19 vaccination. Twenty-four percent of the clients had a documentation of COVID-19 vaccination compared to 70% from 2024. This is a decrease of 46% which is statistically significant ($P = < 0.01$)



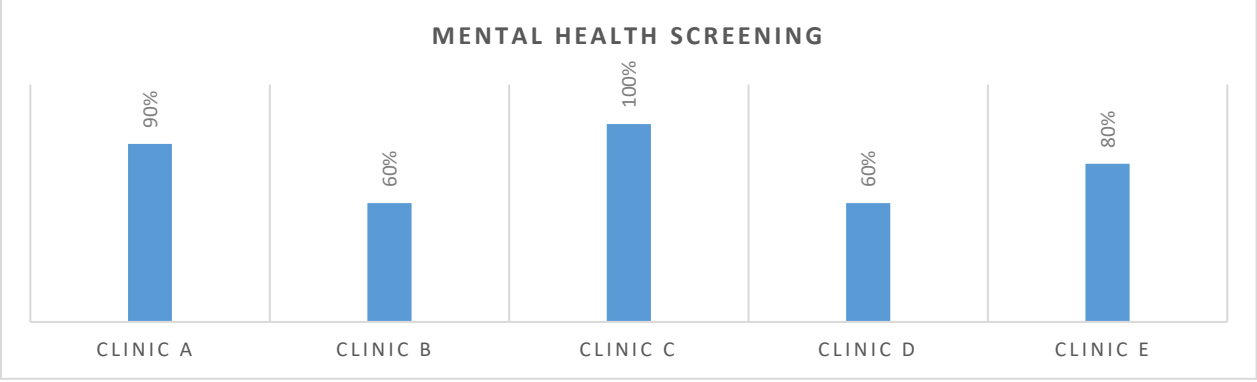
During this year’s review, the reviewer also looked for documentation of shingles vaccination for all clients and documentation of meningococcal and Mpox vaccination. The records indicated that 35% received the shingles vaccine, a decrease of 24% which is not statistically significant. Sixty-three percent of the clients received the meningococcal vaccine, a decrease of 7 percentage points in comparison to 2024. Twenty-nine percent were vaccinated for Mpox, a decrease of 14 percentage points from last year’s results. The following graphs represent the results by clinic:

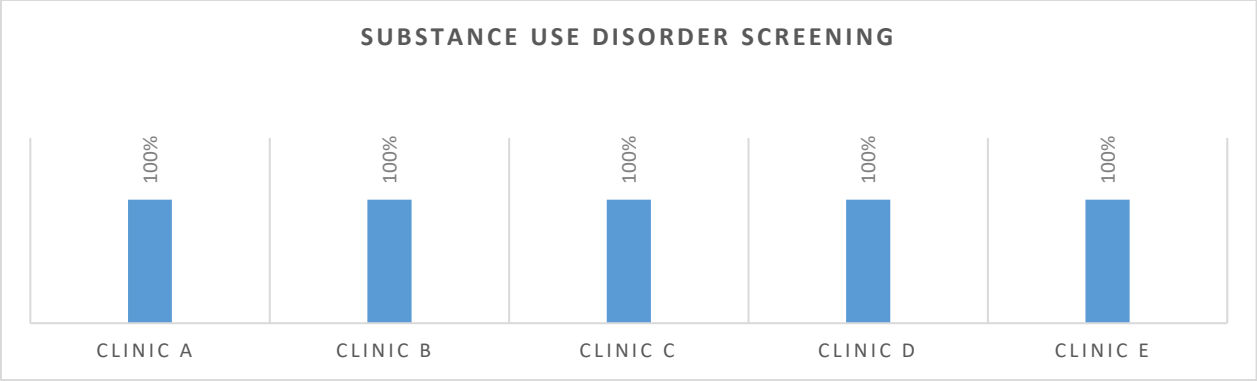




Mental Health and Substance Use Disorder Screening

In this year’s review, the reviewer checked for documentation that mental health and substance use disorder screening were conducted. The records indicated that 78% of clients had documentation of mental health screenings compared to 67% in 2024. All clients had documented substance use disorder screening compared to 89% in 2024. The following graphs represent each clinic’s results:





Conclusions

Overall, the results of the 2025 medical record review indicate that clients receiving care continue to demonstrate high levels of adherence to their medication regimen and treatment plan. The primary overall conclusions and observations from this chart review include:

- The percentage of individuals under the age of 30 increased from 6% to 16%
- The proportion of clients with less than one year in care increased from 13% to 25%
- Sexual risk assessment and syphilis screening rates continue to be high
- Screening rates for GC and CT (urogenital, pharyngeal, and rectal) were higher in those with a documented STI than in newly enrolled and sexually active clients
- TB screening and dental referrals showed an increase when data from outside the review period were taken into account
- Vaccinations decreased overall compared to the prior review period

Based on the results of the review, there is an opportunity to continue discussion around the frequency and consistency of documentation for certain preventive care and screening measures as the program moves to next review period. United Healthcare will be providing individual clinic results as well as feedback from the Nurse Case Manager to use in future discussion with each clinic.

Mental Health Services

The National HIV/AIDS Strategy for the United States 2022–2025, along with the Sexually Transmitted Infections (STIs) and Viral Hepatitis National Strategic Plans, identified the need to integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence.

~~NATIONAL STRATEGIC PLANS: ADDRESSING THE SYNDEMIC The National HIV/AIDS Strategy for the United States 2022–2025, along with the Sexually Transmitted Infections (STIs) and Viral Hepatitis National Strategic Plans identified the need to integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence. The White House, 2023. National HIV/AIDS Strategy 2023 Interim Action Report. Washington, DC.~~

Commented [GD1]: CITE: [The White House, 2023. National HIV/AIDS Strategy 2023 Interim Action Report. Washington, DC.](#)

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~~are covered in a separate service standard ([see Psychiatric Medication Management](#)).

Purpose and Goals

The goal of mental health services is to provide outpatient, assessment, diagnosis, [psychological and treatment, and/or referral for psychiatric services](#) 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. ~~Scheduling of intakes must take into consideration the urgency of the concern. Mental health services are allowable for clients with HIV 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, ~~conjoint/coup~~family, and/or group settings, and 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 clients~~ and [his/her/their partners or](#) family improve their functioning, given the complications of living with HIV. The frequency and duration are ~~based on~~based upon client needs or as outlined 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~~consist 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~~a mental health crisis. 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.

Commented [WT2]: What is the basis of this requirement? What would happen if another Ryan White eligible client is not available for the group therapy? Does funding source matter here (assuming that providers are not paid exclusively by Ryan White and provide counseling to people with different funding sources)? Is it more important for there to be at least one other person living with HIV in the group?

Commented [WT3]: Is there a particular reason why there is so much space between this and the next section?

- o **Psychiatric consultation:** Mental health service pProviders ~~will will~~ provide referrals back to primary care providers or to a psychiatric referrals service provider as appropriate.
- o Visits may be conducted in-person in person or, when appropriate, via telehealth, based on client needs and preference.
- Referral/coordination/linkages
 - o **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 (e.g., psychiatric evaluation and medication management, neuropsychological testing, day treatment programs, and in-patient hospitalization); primary care, case management, dental ~~treatment~~care, and substance use treatment.
- Development of follow-up plans if needed
- Case closure

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Standard	Measure
Staff assesses clients' eligibility and needs	Documentation of interviews and assessments <u>assessments</u> of 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 <u>Maintenance of a</u> in 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 ongoing 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, including those associated with HIV and aging
- Cultural issues-matters related to communities affected by HIV
- Mental disorders related to HIV and/or other medical conditions
- Mental ~~disorders~~health symptoms that can be induced-related toby prescription druguse
- Medications and aAdherence to medication regimes
- Diagnosis and assessment of HIV-related mental health concernsissues
- 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 and/or crisis intervention. Persons ~~receiving participating in 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 and frequency of sessions ~~and the frequency of sessions~~
- Date for reassessment
- Projected treatment end date
- ~~R~~Any recommendations for follow up
- Signature of the mental health professional rendering service

Frequency of sessions should reflect best practices in the treatment of the mental health problem. 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 clients’ 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 consistent with the treatment plan	Documentation of service provided to ensure that: <ul style="list-style-type: none"> • Services provided are allowable under Ryan White, stateState, and local guidelines • Services provided are consistent with the treatment plan

Psychiatric Medication Management Services

NATIONAL STRATEGIC PLANS: ADDRESSING THE SYNDEMIC The National HIV/AIDS Strategy for the United States 2022–2025, along with the Sexually Transmitted Infections (STIs) and Viral Hepatitis National Strategic Plans identified the need to integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence. The White House. 2023. National HIV/AIDS Strategy 2023 Interim Action Report. Washington, DC.

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 licensed mid-level/advanced practice practitioner/provider. 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.

[Does the primary care standards mention screening, and are there recommendations there to prescribe or refer?]

Key Service Components and Activities

Key activities for psychiatric medication management services include:

- Initial comprehensive assessment, including documentation of diagnosis and determination of ~~need~~ appropriateness 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 <u>transition plan</u> 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 ~~psychiatry~~ resident or an advanced practice provider (e.g., 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 and substance use. 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.

What about ECT, TMS, ketamine

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: <ul style="list-style-type: none"> • 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): <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Date, type of contact, time spent • Treatment plan including current medical and psychotropic medication and dosages • Progress toward psychiatric treatment plan goals

Standard	Measure
	<ul style="list-style-type: none"> • Interventions and client’s response to interventions • Referrals provided • Results of interventions and referrals • Documentation of provider addressing existing and newly identified goals
<p>Prior to initiating psychotropic medications, psychiatry providers will counsel clients on the risks, benefits, and common side effects of the medications.</p>	<p>Documentation in client chart indicating that the patient has been told about and understands:</p> <ul style="list-style-type: none"> • 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 completed, 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
<p>Staff will document reasons for disenrollment in the client record</p>	<p>Documentation of reason for disenrollment</p>
	<p>Documentation of “inactive status” and maintenance of records and contact information to facilitate rapid re-enrollment, as appropriate</p>

County of San Diego Monthly STD Report

Volume 18, Issue 4: Data through November 2025; Report released April 30, 2026.



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

	2024		2025	
	November	Previous 12-Month Period*	November	Previous 12-Month Period*
Chlamydia	1259	16183	1157	15305
Female age 18-25	424	5375	420	5022
Female age ≤ 17	44	565	27	604
Male rectal chlamydia	75	1235	58	836
Gonorrhea	478	6107	430	5273
Female age 18-25	43	577	32	388
Female age ≤ 17	11	83	0	37
Male rectal gonorrhea	117	1465	121	1260
Early Syphilis (adult total)	46	711	34	528
Primary	7	107	0	77
Secondary	15	186	10	140
Early latent	24	418	24	311
Congenital syphilis	4	29	1	29

* Cumulative case count of the previous 12 months.

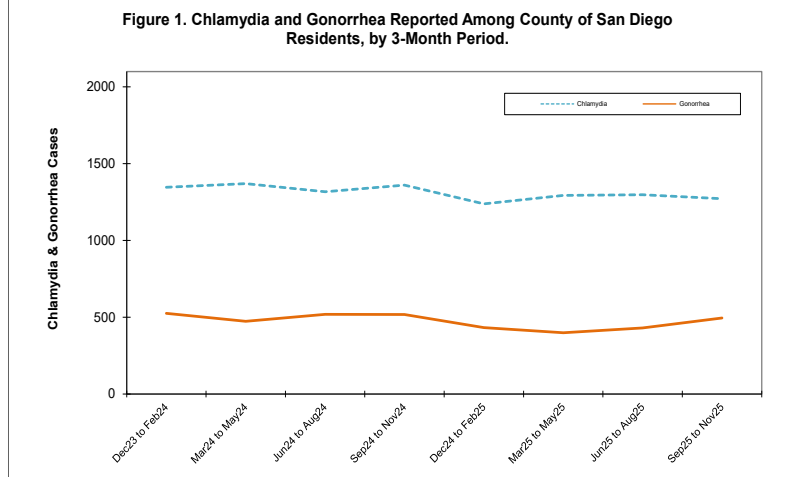
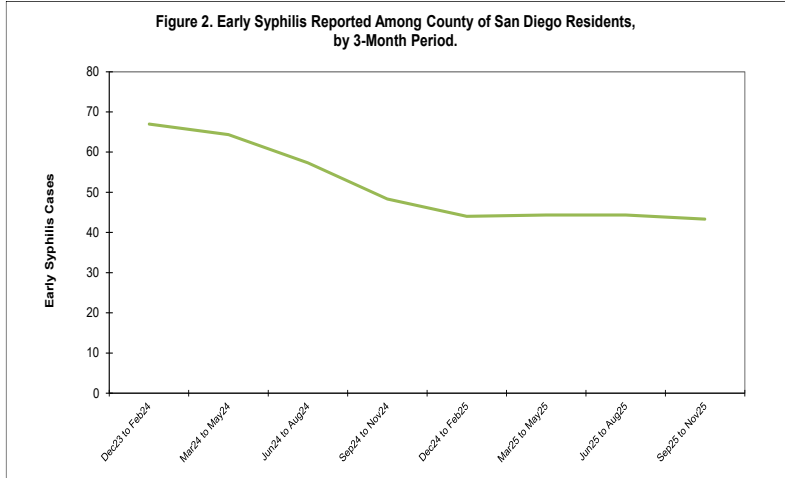


Table 2. Selected STD Cases and Annualized Rates per 100,000 Population for San Diego County by Age and Race/Ethnicity, Year-to-Date.

	All Races*		Asian/PI		Black		Hispanic		White	
	cases	rate	cases	rate	cases	rate	cases	rate	cases	rate
All ages										
Chlamydia	14181	470.2	421	110.1	587	414.6	1654	157.7	1849	141.6
Gonorrhea	4843	160.6	177	46.3	324	228.9	1052	321.2	975	74.7
Early Syphilis	482	16.0	20	5.2	55	38.8	223	21.3	122	9.3
Under 20 yrs										
Chlamydia	2395	318.6	41	51.6	99	285.3	208	63.5	305	117.0
Gonorrhea	235	31.3	9	11.3	21	60.5	42	12.8	36	13.8
Early Syphilis	10	1.3	0	0.0	3	8.6	4	1.2	2	0.8



Note: Rates are calculated using 2024 Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 09/2025.
* 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.

Editorial Note: Vaccination Recommended for High-Risk Californians as Mpox Cases Rise Statewide

On April 17, 2026, the California Department of Public Health (CDPH) issued a [news release](#) encouraging Californians at high risk for mpox to get vaccinated in the context of rising cases across the state and a recent travel-associated case of clade I mpox in San Francisco. At the time of the report, California was experiencing more than double the average weekly number of clade II mpox cases compared to the same period in previous years (14.5 weekly cases compared to 5.8 in 2024 and 3.4 in 2025). Most of these infections occurred among people who were unvaccinated [1]. In San Diego County, there have been 12 mpox cases reported in 2026 (see **Figure 3**), 10 (83%) of which occurred in unvaccinated individuals and two (17%) of which occurred in fully vaccinated individuals (unpublished data from the HIV, STD, and Hepatitis Branch, Department of Public Health Services, County of San Diego Health and Human Services Agency).

On April 14, 2026, the San Francisco Department of Public Health confirmed the first clade I mpox case in a San Francisco resident. The case occurred in an unvaccinated adult who was hospitalized and improving and reported close contact with someone who had traveled internationally to an area where clade I mpox virus is circulating [2]. This is the seventh clade I mpox case in California since November 2024 and the first in San Francisco. Clade I mpox infections can be severe, and people with weakened immune systems have the highest risk of severe disease and hospitalization. (continued on page 2)



County of San Diego Monthly STD Report

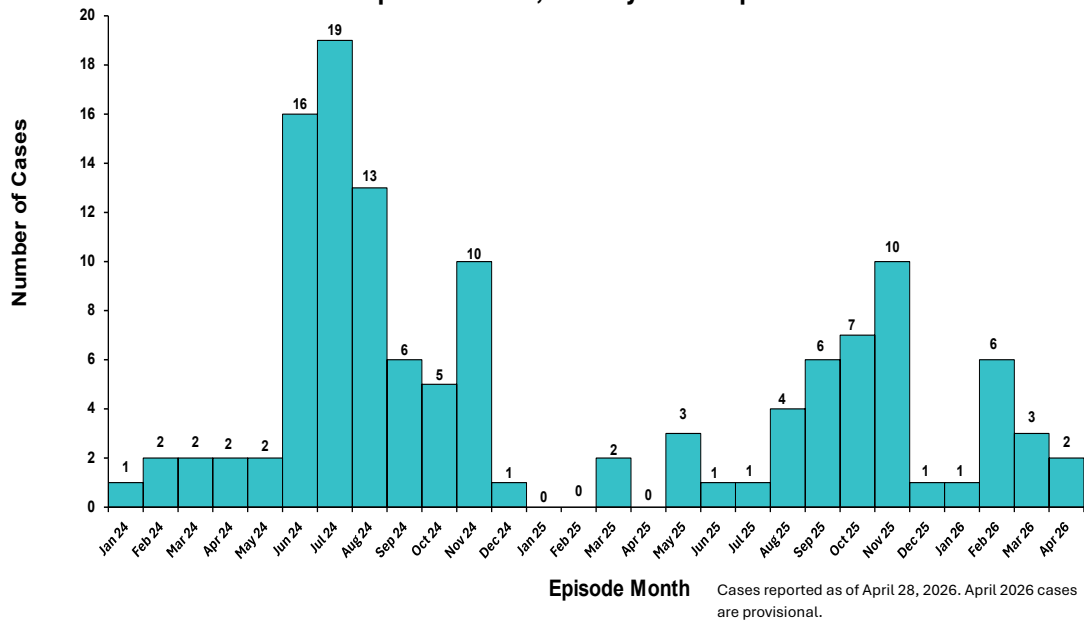
Volume 18, Issue 4: Data through November 2025; Report released April 30, 2026.



Editorial Note: Continued

The two-dose JYNNEOS vaccine is safe and effective in preventing severe mpox illness and reducing the risk of infection from clade I and clade II mpox. Maximal protection is achieved approximately two weeks after completion of the two-dose series. CDPH recommends the JYNNEOS vaccine for anyone who is vulnerable to mpox, *including persons planning to travel internationally who anticipate sexual or intimate contact while traveling*, or requests the vaccine [3]. Mpox vaccine is readily available through healthcare providers in San Diego County. For those who do not have a healthcare provider and/or experience barriers getting the vaccine, the JYNNEOS vaccine is available through the [County Sexual Health Clinics](#).

Figure 3. Mpox Cases Reported Among San Diego County Residents by Episode Month, January 2024 – April 2026



**HIV PLANNING GROUP
4-MONTH COMMITTEE TRACKING
May 2025 - Feb 2026**

Medical Standards & Evaluation Committee (MSEC)	May	Sep	Nov	Feb	#	# of JC Starting Jan 2026
Total Meetings	1	1	1	1	4	
(13) Members						
Aldous, Dr. Jeannette ^{CC}	*	*	*	1	1	
Bamford, Dr. Laura	*	*	1	*	1	
Garcia, Rosemary	*	*	*	*	0	
Grelotti, David ^C	*	*	1	*	1	
Hernandez, Yessica	*	*	1	*	1	
Lochner, Mikie	*	*	*	*	0	
Paugh, Shannon	*	*	*	*	0	
Quezada-Torres, Karla	*	*	*	*	0	
Rodriguez, Martha	*	*	1	1	2	
Saville, Edith		*	*	*	0	
Spector, Dr. Stephen	1	*	*	*	1	
Tilghman, Dr. Winston	*	*	*	1	1	
Whyte, Fadra	*	*	*	1	1	
Committee members are expected to attend all meetings. To remain in good standing and eligible to vote, the committee member may not miss more than 2 meetings within the 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

NM = No Meeting

NQ = No Quorum

If the physical attendance quorum requirement is met, SB 707 permits a member who is not physically present to request virtual attendance at the local legislative body's meeting under the "just cause" circumstance.

Qualifying Reason	Provisions to Attend Remotely	Requirements /Limitations
<p>"Just Cause"</p>	<ul style="list-style-type: none"> ▪ Childcare or caregiving need of a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner that requires them to participate remotely. ▪ A contagious illness prevents the member from attending the meeting in person. ▪ A need related to a physical or mental condition not otherwise accommodated by any reasonable accommodations provided. ▪ Travel while on official business of the legislative body or another state or local agency. ▪ An immunocompromised child, parent, grandparent, grandchild, sibling, spouse, or domestic partner of the member that requires the member to participate remotely. ▪ A physical or family medical emergency that prevents a member from attending in person. ▪ Military service obligations that result in a member being unable to attend in person because they are serving under official written orders for active duty, drill, annual training, or any other duty required as a member of the California National Guard or a United States Military Reserve organization that requires the member to be at least 50 miles outside the boundaries of the local agency. 	<p>A member is limited to two (2) virtual attendances due to "just cause" per calendar year.</p>

Note: The criteria for "emergency circumstance" from AB 2302 are now combined with the "just cause" circumstance for remote participation.

Additional Information for Members Participating Remotely

In addition to making a request for "just cause" for remote attendance, SB 707 imposes the following three (3) additional requirements on legislative body members seeking to appear remotely at public meetings:

1. The member shall notify 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.
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.

Furthermore, a member of a legislative body may request reasonable accommodation, pursuant to the applicable law, to participate in meetings remotely. Remote participation due to reasonable accommodation shall be treated as in-person attendance (counting towards quorum) and shall adhere to the following requirements:

1. The member shall request reasonable accommodation to participate remotely at the time of quorum check prior to each meeting.
2. The member shall participate through both audio and visual technology. Any member with a disability, as defined in Section 12102 of Title 42 of the United States Code, may participate only through audio technology if a physical condition related to their disability results in a need to participate off camera.
3. The member shall 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 of those individuals.