Tuesday, June 11, 2024, 4:00 PM – 5:30 PM
County Operations Center
5560 Overland Ave, San Diego, CA 92123
(Room 172)

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).

TABLE OF CONTENTS
Meeting Packet

Document	Page Number(s)
Meeting Directions for 06/11/2024 meeting	001 – 002
06/11/2024 MSEC Agenda	003 – 004
02/27/2024 MSEC Meeting Minutes	005 – 008
Ryan White Primary Care Program – Report on Compliance with Practice Guidelines (Presentation)	009 – 030
Ryan White Outpatient Ambulatory Health Services – Compliance with Practice Guidelines 2023 (Executive Report)	031 – 050
Outpatient/Ambulatory Medical Care Services Standards – Draft (last approved in 2020)	051 – 057
Oral Health Care Services and Dental Practice Guidelines QR Codes	058
STI/Mpox Updates	059-066
STD Monthly Report Vol 16 Issue 5 (Released June 11, 2024)	067
Provided for Informational Purposes:	
MSEC Attendance Summary	068
2024 HIV Needs Assessment Survey Flyer	069
Assembly Bill 2449 Reminders: (Just Cause, Emergency Circumstances)	070 – 072

Meeting Location & Directions:

Medical Standards & Evaluations Committee

Tuesday, June 11, 2024

4:00 PM - 5:30 PM

County Operations Center
5560 Overland Ave
San Diego, CA 92123
(Training Room 172)

Parking is **free**. 3-hour visitor parking is available in the parking lot and parking structure. For County business exceeding 3 hours, please park in the numbered spaces in the parking structure.

FROM I-163 SOUTH:

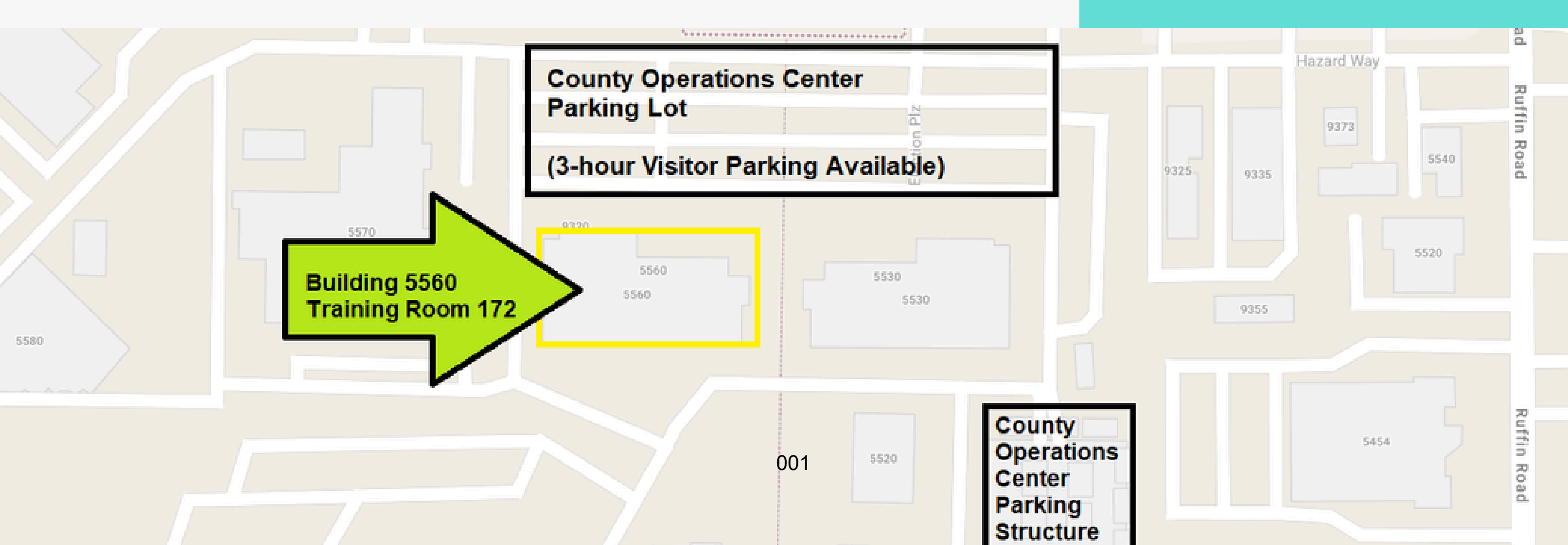
1. Take I-163 North to Exit 8 for Kearny Villa Road.
2. Keep right, follow signs for Kearny Villa Road.
3. Turn right onto Chesapeake Dr.
4. County Operations Center will be on your right.

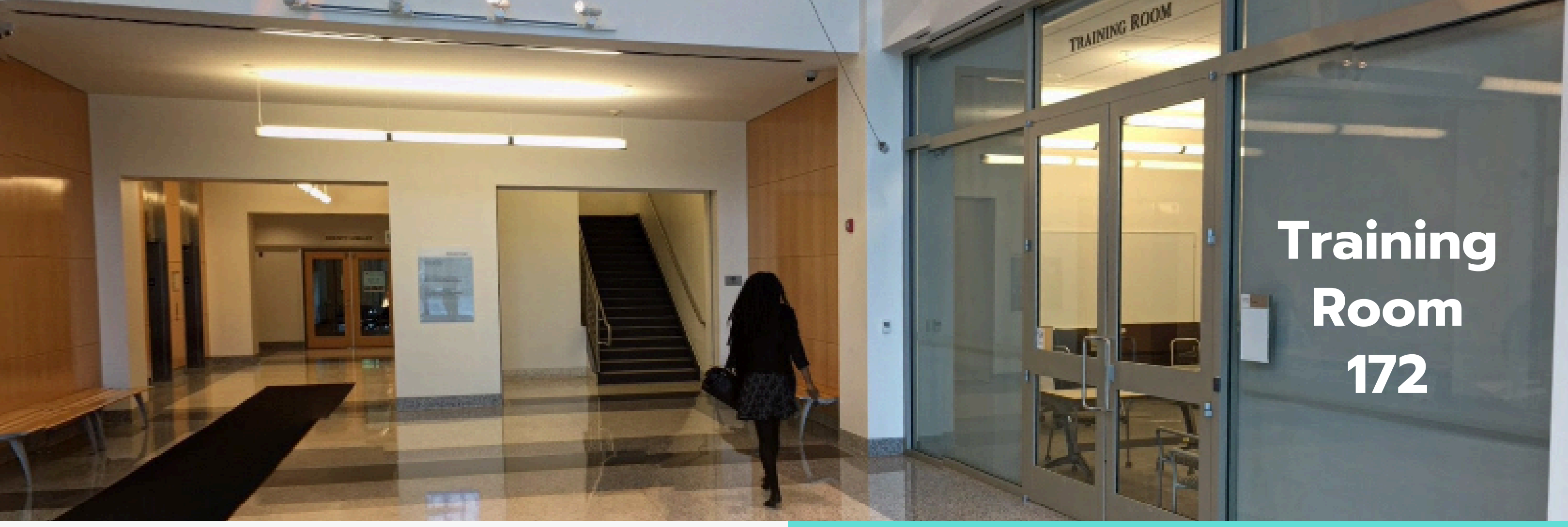
FROM I-15 SOUTH:

1. Take I-15 North to Exit 10 for Clairemont Mesa Blvd.
2. Turn left onto Clairemont Mesa Blvd.
3. Turn right onto Overland Ave.
4. Continue straight to stay on Overland Ave.

PUBLIC TRANSPORTATION

MTS Bus Routes:
25, 235, 928





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 right on Clairemont Mesa Blvd (after U.S. Bank Branch on the right).
6. Cross the street and turn left onto Overland Ave. and head north.
7. Enter east through County Operations Center entrance/black gate. **Building 5560** will be on your left.

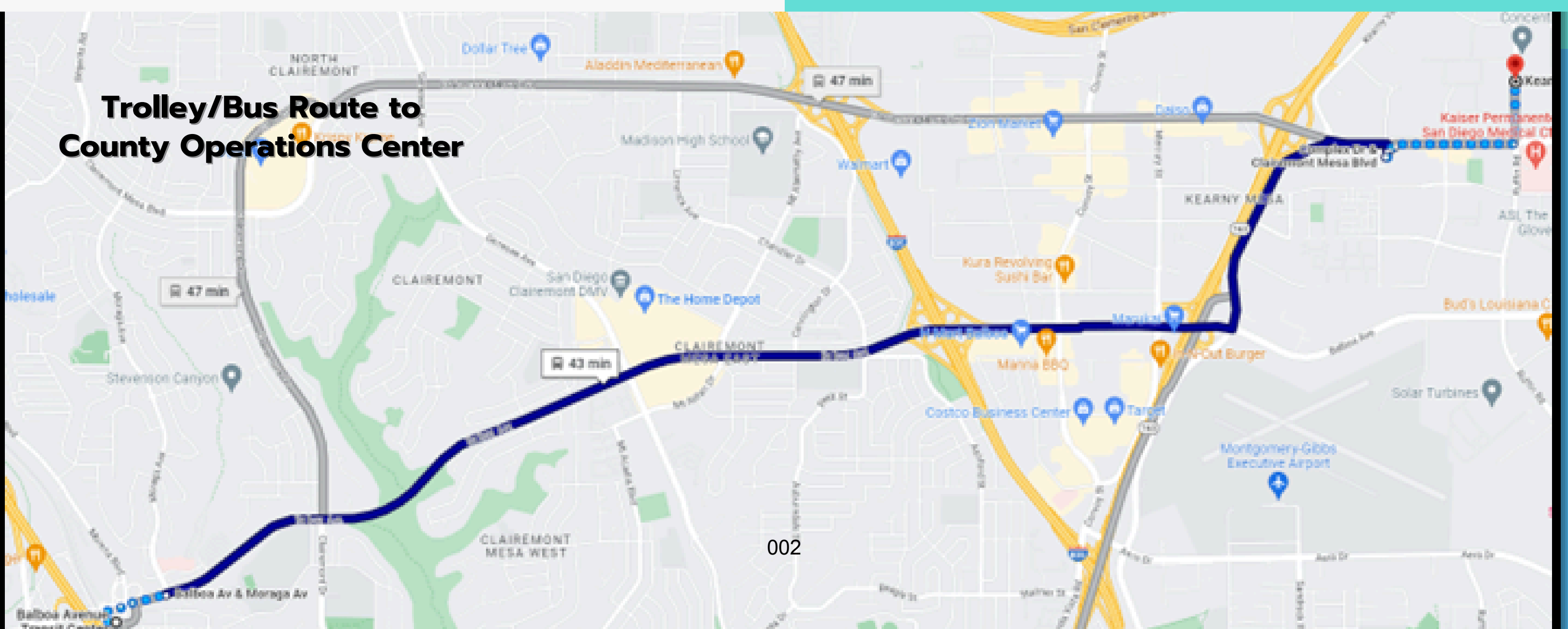
FROM BUS:

From Ruffin Road:

1. Walk north towards Ruffin Road.
2. Turn left on Hazard Way.
3. Enter through County Operations Center entrance/black gate and head further west. Access to County Operations Center buildings will be on your **left**.

From Overland Ave.:

1. Walk north on Overland Ave.
2. Enter east through County Operations Center entrance/black gate.
3. Turn left on pedestrian walkway. **Building 5560** will be on your **left**.



MEDICAL STANDARDS AND EVALUATION COMMITTEE

Tuesday, June 11, 2024,4:00 PM – 5:30 PM
County Operations Center
5560 Overland Ave, San Diego, CA 92123
(Room 172)

To participate remotely via Zoom:
https://us06web.zoom.us/j/84265220872?pwd=TGRydGxvcm40dEVIQUhmd0lsWUlZUT09
Call in: 1-669-444-9171
Meeting ID: 842 6522 0872 **Passcode:** 428631

Language translation services are available upon request at least 96 hours prior to the meeting.
Please contact HPG Support Staff via e-mail at hpg.hhsa@sdcounty.ca.gov.

A quorum for this meeting is five (5).
Committee Members: Dr. Jeannette Aldous (Co-Chair) | Dr. Laura Bamford | Dr. David Grelotti | Yessica Hernández | Bob Lewis | Karla Quezada-Torres | Dr. Stephen Spector | Lisa Stangl | Dr. Winston Tilghman (Chair)

MEETING AGENDA
ORDER OF BUSINESS

1. Call to order, roll call, comments from the chair and a moment of silence
2. Public comment (for members of the public)
3. Sharing our concerns (for committee members)
4. **Action:** Approve the MSEC agenda for June 11, 2024
5. **Action:** Approve the MSEC minutes from February 27, 2024
6. New Business:
    a. **Presentation:** Ryan White Primary Care Program – Report on Compliance with Practice Guidelines (Jeanette Johnson)
    b. **Action:** Approve Outpatient/Ambulatory Health Service Standards
    c. **Discussion:** Develop plan for updating Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services
7. Old Business:
    a. **Discussion:** Continue the discussion on MSEC leadership succession planning
8. Other Updates:
    a. STI and MPox Update (Dr. Tilghman)
    b. Committee member updates
9. Future agenda items for consideration

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

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

WORK PLAN
<u>February 27, 2024</u> • Finalize 2024 work plan and priorities • Review Outpatient/Ambulatory Health Service Standards and identify needed revisions • Discuss succession planning
<u>June 11, 2024</u> *(from May 14)* • Review Executive Report of Ryan White Quality Assurance Chart Review • Finalize and approve Outpatient/Ambulatory Health Service Standards • Develop plan for updating Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services
<u>September 10, 2024</u> • Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services
<u>November 12, 2024</u> • Update Dental Practice Guidelines, Oral Health Service Standards, and List of Allowable Dental Services (if not completed in September 2024) • Review Ryan White Quality Assurance Chart Review tool • Identify priorities and develop work plan for 2025

MEDICAL STANDARDS AND EVALUATION COMMITTEE (MSEC)

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

A quorum for this meeting is six (6).
Committee Members present: Dr. David Grelotti | Bob Lewis | Mikie Lochner | Ivy Rooney | Dr. Stephen Spector | Lisa Stangl | Dr. Winston Tilghman (Chair) | Karla Quezada-Torres
Committee Members absent: Dr. Jeannette Aldous (Co-Chair) | Yessica Hernández
Committee Members joining virtually: Dr. Laura Bamford (Just Cause)

Meeting Minutes

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Tilghman called the meeting to order at 4:18 PM and noted the presence of an in-person quorum. A moment of silence was observed. - Due to the frequency of this committee's meetings, its attendance policy will be if a member misses two consecutive meetings their voting is suspended until the attendance is back in compliance. - Finalized Practice Guidelines were sent to all committee members via email along with the meeting reminder.	
2. Public comment	None	
3. Sharing our concerns	A committee member shared their concern about access to medical services for the aging population.	
4. **Action:** Review and approve the February 27, 2024 meeting agenda	**Motion:** Approve the February 27, 2024 meeting agenda as presented. **Motion/Second/Count (M/S/C):** Lochner/Lewis/6-0 **Abstentions:** Tilghman **Motion carries**	
5. **Action:** Review and approve the November 14, 2023 meeting minutes	**Motion:** Approve the November 14, 2023 meeting minutes as presented. **M/S/C:** Stangl/Quezada-Torres/5-0 **Abstentions:** Lochner, Tilghman **Motion carries**	

Agenda Item	Action	Follow-up
6. Old Business:		
a. Discussion: Getting to Zero (GTZ) Community Engagement – Next Steps	Dr. Tilghman discussed the GTZ Community Engagement Plan and noted no specific tasks for the MSEC, but the committee will continue to review the goals and objectives to determine if any might apply to the committee.	
b. Discussion: MSEC committee meeting logistics	The committee held a discussion about the time of day, the frequency, and the day of the week that this committee meets and noted the following: - Consider holding these meetings at the County Operations Center as a better option. Providers traveling from Hillcrest and La Jolla area experience heavy traffic. - Start the meetings at 4:30 PM. - If MSEC chooses to become a working group independent of the HIV Planning Group (HPG), there may be more flexibility. - Requested that the Southeastern Live Well Center not be used for future meetings. Patrick Loose, the Recipient, noted that it is more complicated for the staff to use non-County approved facilities. The committee decided to continue meeting 4:00 PM – 5:30 PM.	HPG Support Staff (HPG SS) will schedule the May/June committee meeting and all future MSEC meetings at the location other than the Southeastern Live Well Center.
7. New Business:		
a. Action: Approve 2024 work plan	**Motion:** Approve the 2024 work plan, pending the May date change. **M/S/C:** Quezada-Torres/Grelotti/8-0 **Discussion:** Dr. Tilghman reviewed the work plan and clarified that medical specialty service standards are part of the Outpatient/Ambulatory Health Service (OAHS) Standards. **Abstentions:** Tilghman **Motion carries**	
b. Discussion: Review Outpatient/Ambulatory Health Service	Dr. Tilghman reviewed the OAHS Standards.	MSEC members to review the Standards

Agenda Item	Action	Follow-up
(OAHS) Standards and identify needed revisions	The committee made the following comments: - Recommendation to add the GTZ app under referrals/linkage on page 6. - The Ryan White legislation requires that a certain percentage be spent on core medical services. The AIDS Regional Information & Evaluation System (ARIES) will be replaced by HIV Care Connect, which will go live in May 2024. There will be a two-month overlap with ARIES, which is scheduled to sunset at the end of June 2024. The committee was asked to review the OAHS Standards and provide feedback to HPG SS prior to the next meeting.	before the next meeting and send any feedback to HPG SS. HPG SS to send a word version to the committee.
c. Discussion: MSEC leadership succession planning	Dr. Tilghman provided an update regarding several HPG seats that will be terming out in 2024, including his own seat. He will not be able to continue serving as Chair but will remain on the committee. The new MSEC Chair will be required to serve also on the Steering Committee which meets on the third Tuesday of every month. He encouraged committee members to consider becoming the MSEC Chair. The committee will have a discussion and will make recommendations if possible. Presently, Dr. Grelotti and Dr. Spector are eligible as current HPG members to become MSEC Chair.	
8. Other Updates:		
a. STI and Mpox Update (Dr. Tilghman)	Dr. Tilghman reviewed the County of San Diego Monthly Sexually Transmitted Infection (STI) Report, which was included in the meeting materials packet.	
b. Committee member updates	None	

Agenda Item	Action	Follow-up
9. Future agenda items for consideration	None	
10. Announcements	The 2024 Needs Assessment Survey of HIV Impact is available. Please encourage clients to take the survey.	
11. Next meeting date:	**Date:** May or June TBD, 2024 **Time:** 4:00 PM **Location:** TBD The committee recommended May 7, 2024 or June 11, 2024.	HPG SS to finalize the next committee meeting date.
12. Adjournment	The meeting was adjourned at 5:29 PM.	

RYAN WHITE PRIMARY CARE PROGRAM

Report on Compliance with Practice Guidelines 2023

Study Design

- Eligibility for the inclusion required continuous enrollment in the program from October 2022 through September 2023

- The clinics listed below are lettered from A-E, however, to preserve a blinded status, the letters representing each clinic do not coincide with the order of the list below
  - Family Health Center: Hillcrest
  - San Ysidro Health Center
  - UCSD – Owen Clinic
  - Vista Community Clinic
  - AIDS Healthcare Foundation

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Population

- Decrease of 65 patients sampled compared to 2022 (126 to 61)
- 100% of eligible cis-females
- 21% of eligible cis-males
- 100% of eligible trans-females

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Individuals by Ethnicity

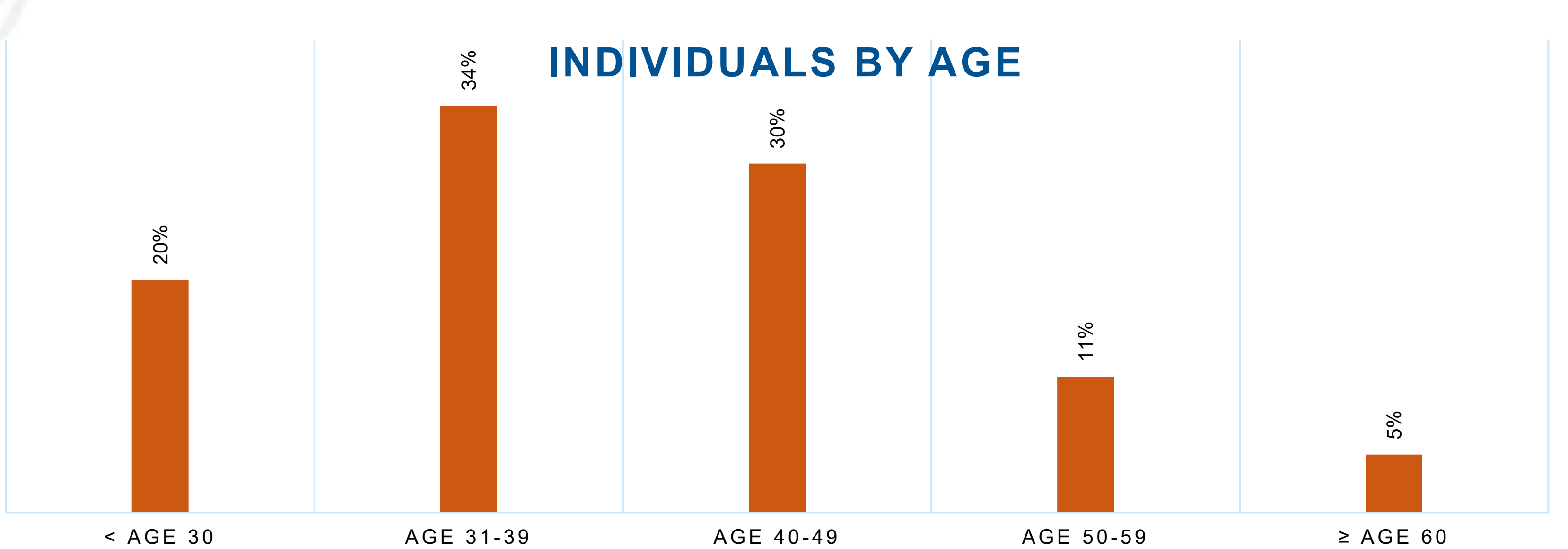
INDIVIDUALS BY ETHNICITY

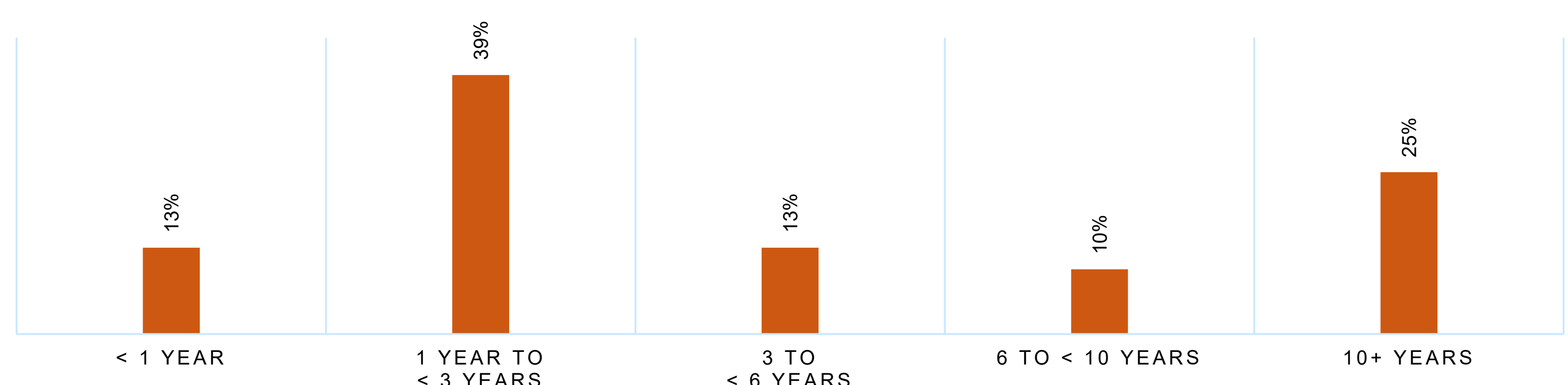
	CAUCASIAN	HISPANIC	AFRICAN AMERICAN	ASIAN	OTHER
	5%	57%	7%	0%	31%

012

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Age Category/Number of Years in Care





Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Visits

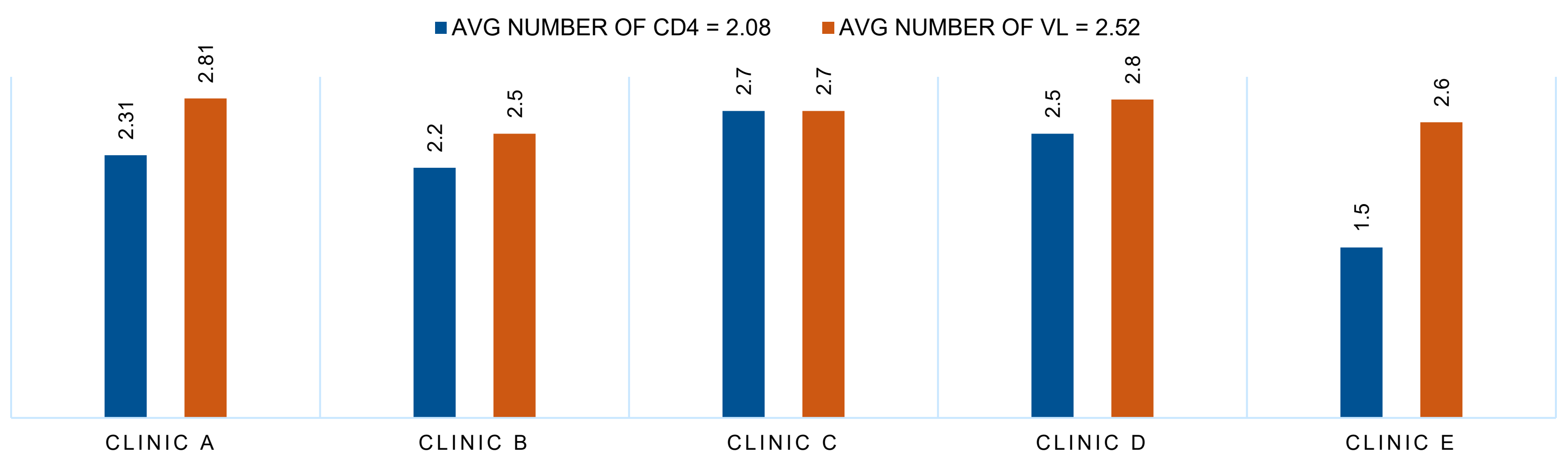
- Average number of visits = 4
- Number of face-to-face = 260
- Number of telehealth = 47

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Frequency and outcome of CD4 and VL

- Documentation showed 100% of clients were offered ART
- Average of 84% were adherent with ART

- 12-month average of CD4 and VL test completed

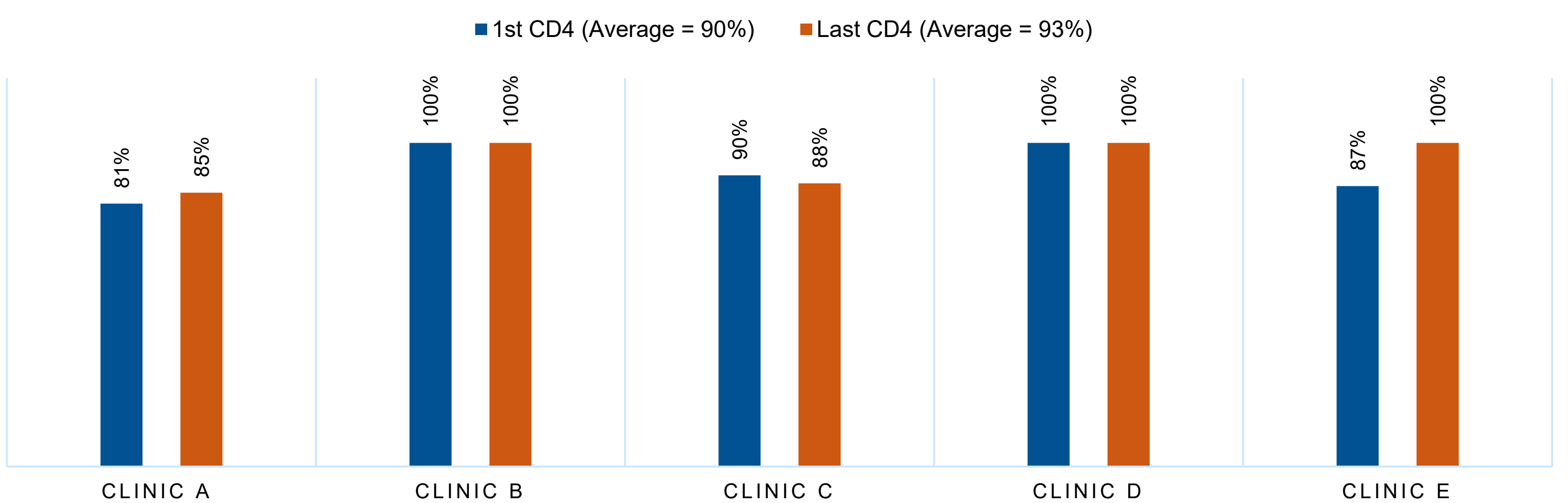


015

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

CD4 Counts

- Individuals who received at least two CD4 tests with a count above 200 from the first to the last test (90% to 93%)

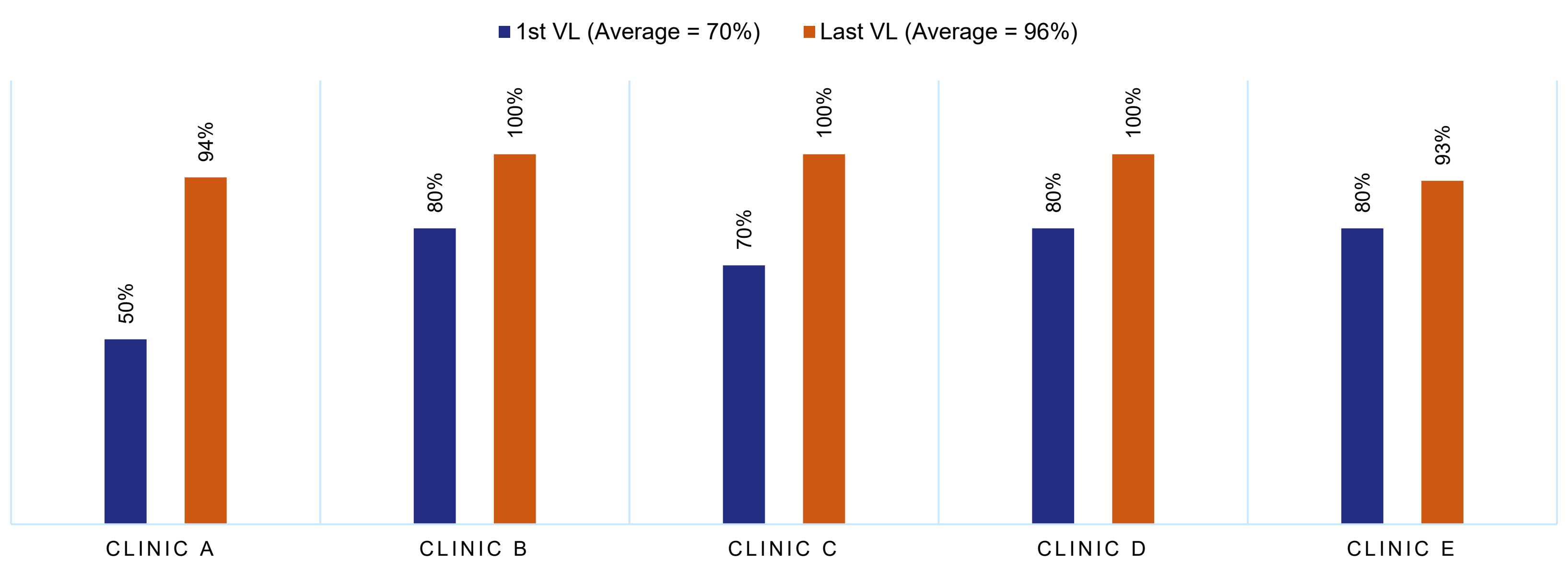


016

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Viral Load Counts

- VL outcomes showed a change in the number of clients below 200 copies from the first to the last test (70% to 96%)



Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Resistance Testing

- In 2023 there were 6 newly-enrolled and treatment-naïve individuals that had a documented baseline/treatment-naïve genotype.
- 33% of individuals had a VL greater than 1,000, an increase of 27 percentage points compared to 2022. This difference is statistically significant
- Two (10%) of those clients with VL > 1,000 were on a stable ART regimen for at least one month prior to the VL test. Neither client had a documented treatment-experienced genotype test

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

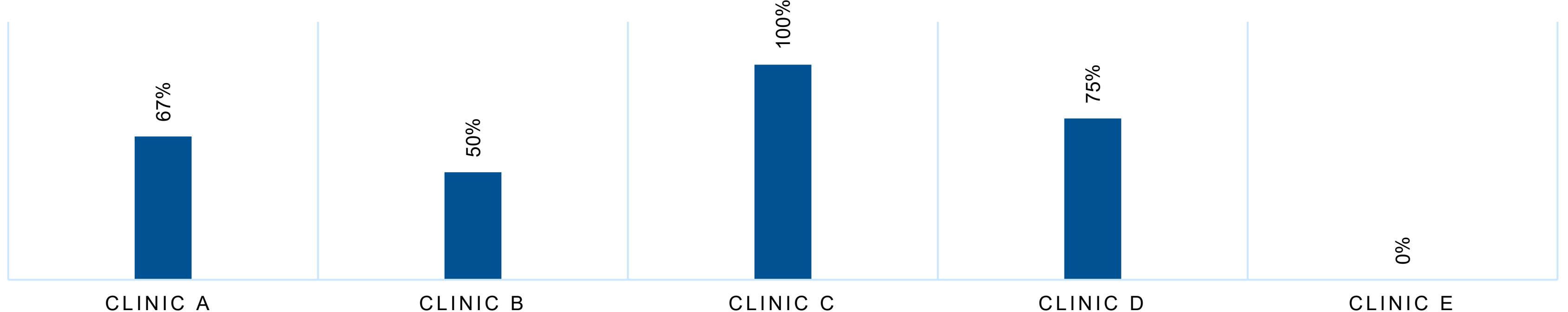
STI testing

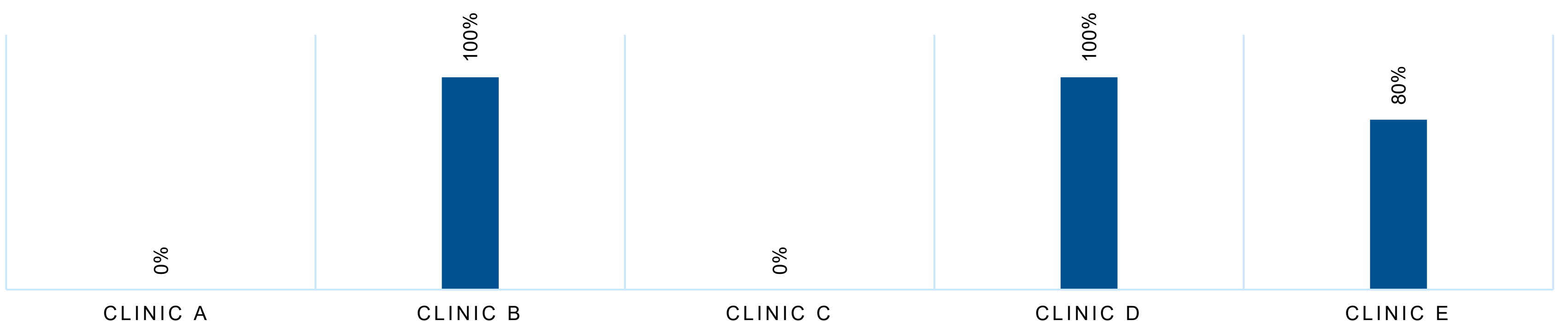
- Increase in syphilis testing by 3% compared to 2022 (87% to 97%).
- Decrease in sexual health risk assessment for all reviewed charts by 2% compared to 2022 (97% to 95%)
- Clients with a documented STI
  - Decrease in urogenital screening for chlamydia and gonorrhea from 100% to 91%
  - Increase in pharyngeal chlamydia and gonorrhea screening from 67% to 100%
  - GC/Chlamydia rectal screening - 100%, same as the previous year

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

DoxyPEP

- New measure for 2023
- DoxyPEP was offered to 62% of cis-males and 85% of trans-females





Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

TB Assessment

- TB testing during the 12-month period increased to 78% from 59% in 2022
- QuantiFERON performed 100%
- TB risk assessments for those with prior positive results were found in 43% of the medical records, compared to 63% from 2022
- 14% of clients with a prior positive test contained documentation or notation that a CXR was performed in previous years

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Papanicolaou (Pap) Test

- 81% of PAFAB had at least one Pap test during the 12-month period or had an indication in their chart of when the next Pap test is due.

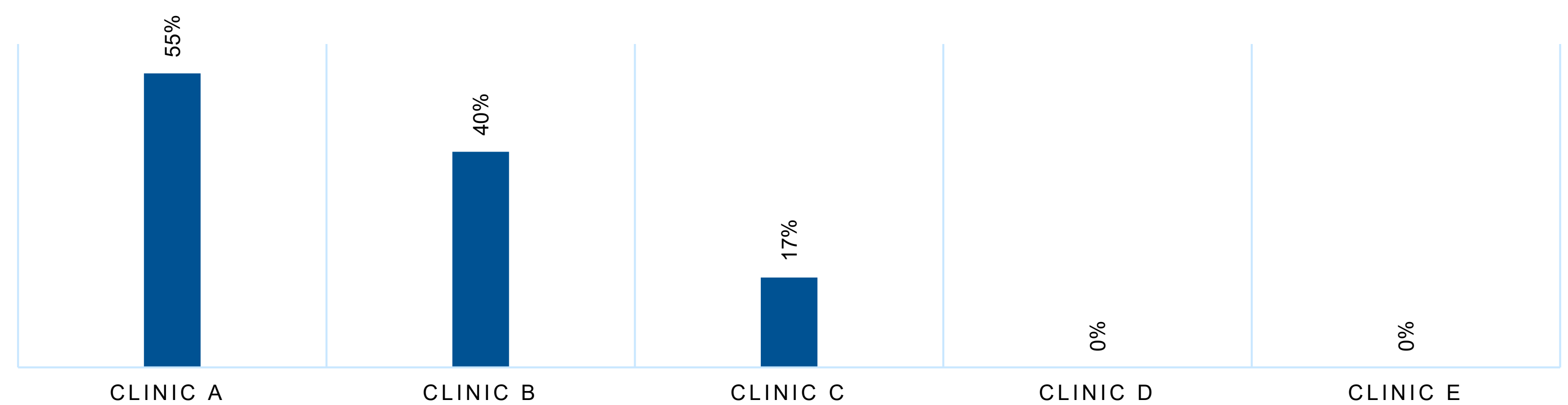
PAFAB RECEIVING A PAP SMEAR/SCREENING DURING THE PAST TWELVE MONTHS

Clinic	Percentage
CLINIC A	0%
CLINIC B	80%
CLINIC C	67%
CLINIC D	N/A
CLINIC E	100%

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Anal Cancer Screening

- New measure for 2023
- 25% of clients aged 35 and older were screened for anal cancer

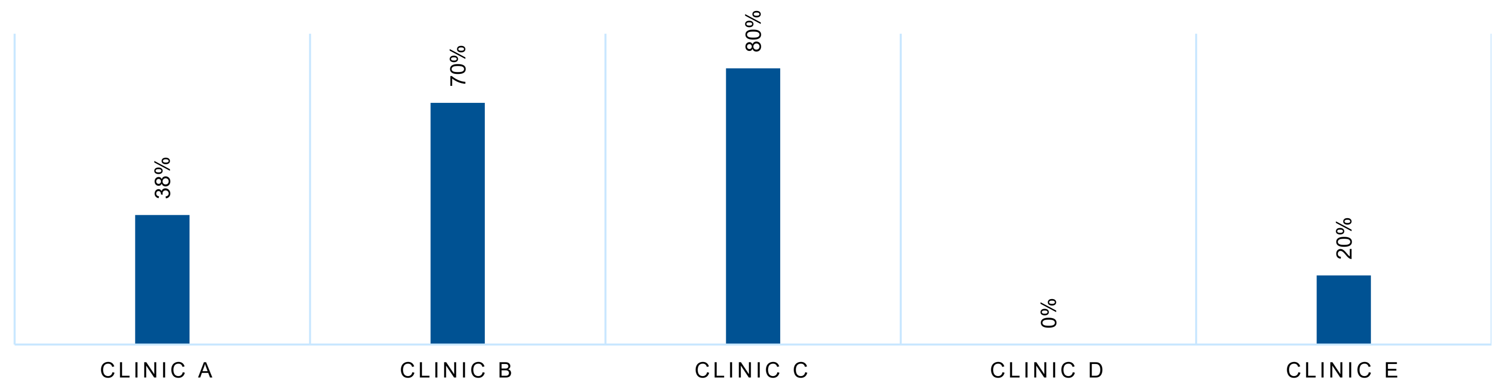


023

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Dental Referral

- Decrease in dental referral by 5% (44% to 39%)

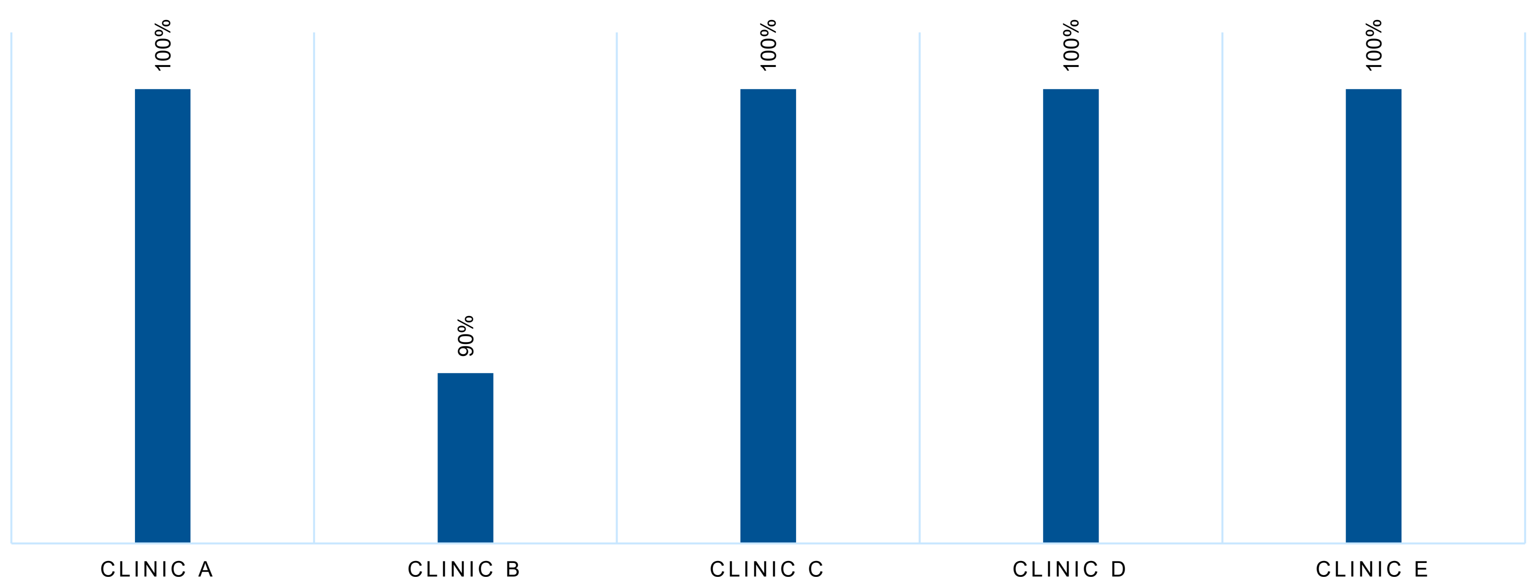


024

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Treatment Adherence Counseling

- Decrease in documentation in treatment adherence counseling by 1% (99% to 98%)



Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Hepatitis Screening

- Hepatitis A screening – 84% of clients were immunized/vaccinated compared to 93% in 2022
- 85% of cis-males having sex with cis-males received an annual Hepatitis C screening. Increase of 27% compared to the previous year
- Lifetime Hepatitis C screening – 98% of clients received a screening compared to 99% in 2022
  - 100% of cis-males having sex with cis-males received a lifetime Hepatitis C screening

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

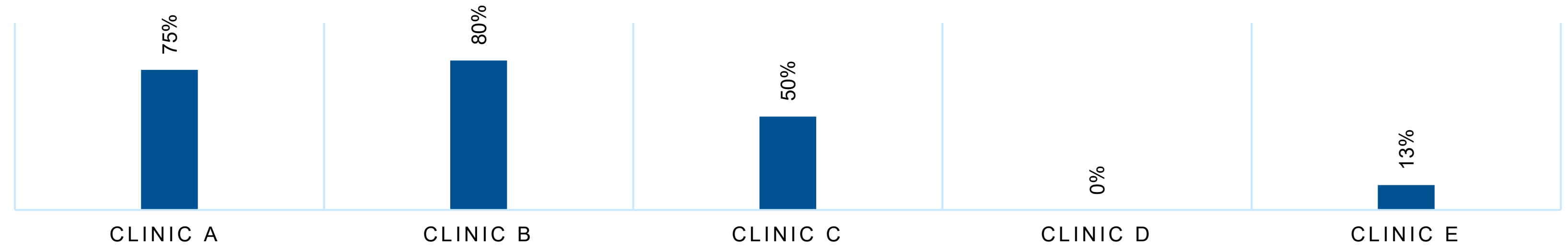
Vaccinations

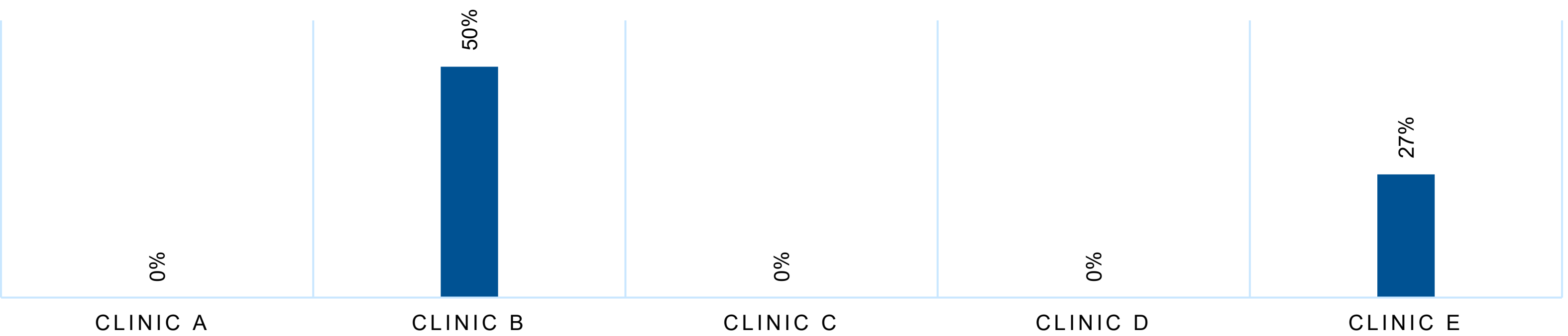
- Decrease in Influenza vaccinations from 70% to 54%
- 30% of clients received a pneumococcal vaccination and 18% were exempt. The remaining 52% of clients received no vaccine.
- Of those clients receiving pneumococcal vaccination - 67% received Prevnar 20, 17% received Pneumovax, and 17% received Prevnar 13
- Decrease in COVID-19 vaccination from 97% to 82%
- 28% of all clients received the shingles vaccine
- Decrease in meningococcal vaccine from 73% to 66%
- Increase in Mpox vaccine from 32% to 34%

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Mental Health and Substance Use Disorder Screening

- New measure for 2023
- 44% of all clients received a mental health screening
- 15% of all clients received a substance use disorder screening





Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Summary

- Decrease of 65 clients in comparison to the 2022 chart review
- Increase of 27 percentage points for clients who had a VL of 1,000 which is statistically significant
- Decrease in the number of TB screening (63% to 43%) and CRX (43% to 14%) for those with a known positive test
- Increase of 33% of those who met the criteria for PCP/PJP Prophylaxis were prescribed. A result that is statistically significant
- New measures for 2023
  - DoxyPEP – 62% of cis-males and 85% of trans-females
  - Anal Cancer Screening – 25% of clients aged 35 and older
  - Shingles vaccine for all clients = 28%
  - Mental health screening – 44%
  - Substance abuse screening – 15%

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Summary (cont.)

Overall, based on the results of the review, clients continued to adhere to their medication regimen and treatment plan.

Proprietary Information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

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

2023

STUDY DESIGN AND METHOLDOGY

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 December 29, 2023, and January 25, 2024, 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 2022 through September 2023 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 percent of the clinic's sample population ranged from 25% to 56%. There was a forty-eight percent decrease in the number of patients eligible for inclusion in the review this year.

In order to present an equitable representation of cis-female, trans-female, and trans-male clients, gender selection was biased; charts for 100% of eligible cis-females, 21% of eligible cis-males, and 100% of eligible trans-female clients were reviewed. The resulting sample represents 31% 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
San Ysidro Health	62	16	26%
UCSD -Owen	30	10	33%
AIDS Healthcare Foundation	28	10	36%
Vista Community Clinic	18	10	56%
Hillcrest Family Health Centers	59	15	25%
Total	197	61	31%

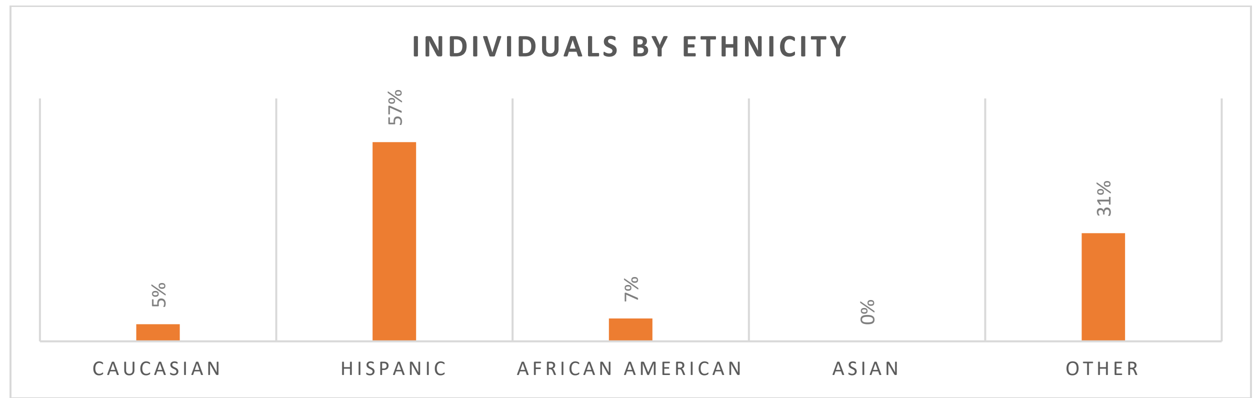
Each medical record was reviewed by a UHC licensed Registered Nurse Case Manager for all services provided from October 1, 2022, through September 30, 2023. The review included medical encounters, laboratory test results, medications, documentation of patient adherence, screening tests for sexually transmitted 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,

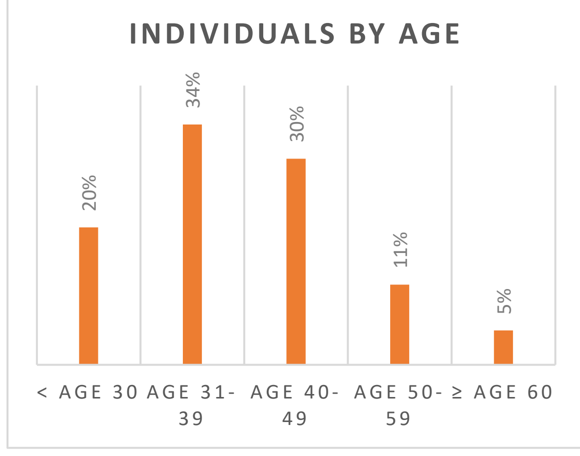
vaccinations, and mental health and substance use disorder screening. Data was entered into Microsoft Excel to ensure accurate and consistent collection.

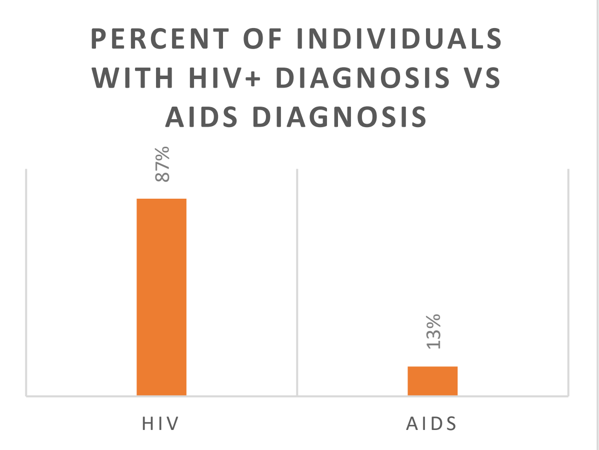
This document reports the overall results of the medical record review. In addition, statistical tests comparing 2022 and 2023 were completed on appropriate measures. Select sections from the review tool are presented anonymously by clinic to provide the County with comparative results of compliance. 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 61 clients included in the sample, 37 were cis-male, 16 were cis-female, and 8 were trans-female, representing 21%, 100%, and 100% of eligible clients in each respective population. The following charts show additional demographics and data for the sample population:

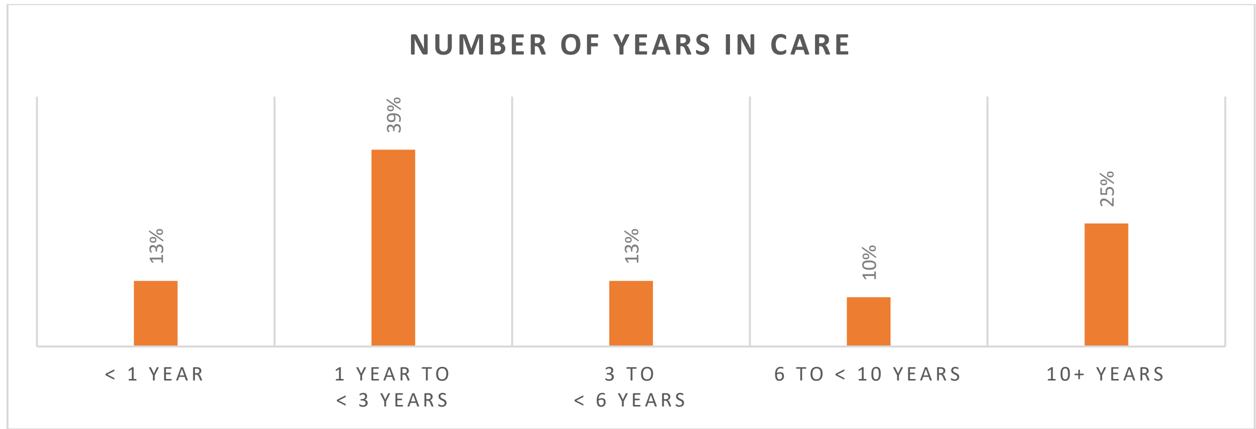






Because the amount of time receiving care for HIV disease can greatly influence outcomes, the number of years in care (i.e., enrolled in the Ryan White Outpatient Ambulatory Health Services) for the sample

population is presented. The chart below shows that 8 (13%) of the sampled clients have been receiving care for less than one year, 24 (39%) one to three years, 8 (13%) three to less than six years, 6 (10%) six to less than 10 years, and 15 (25%) for over 10 years or more.



The average number of in-person visits per client documented for the 12-month period program-wide was 4, and the average number of telehealth encounters was 1. The total average number of encounters was 5 compared to 3 in 2022.

Summary of Medical Record Review Results – Comparison with the 2022 Review

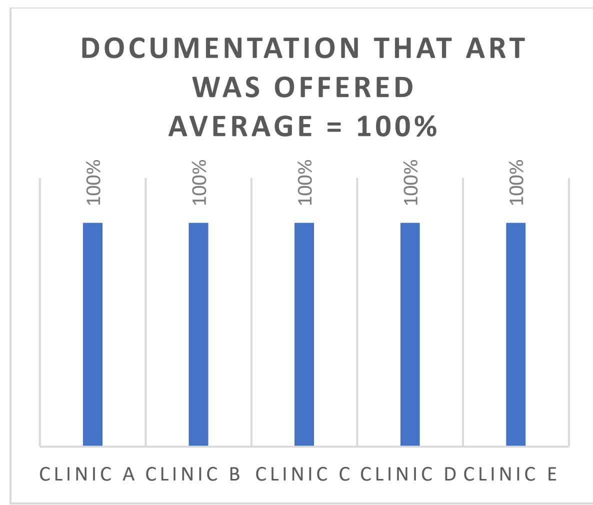
Treatment Plan Adherence

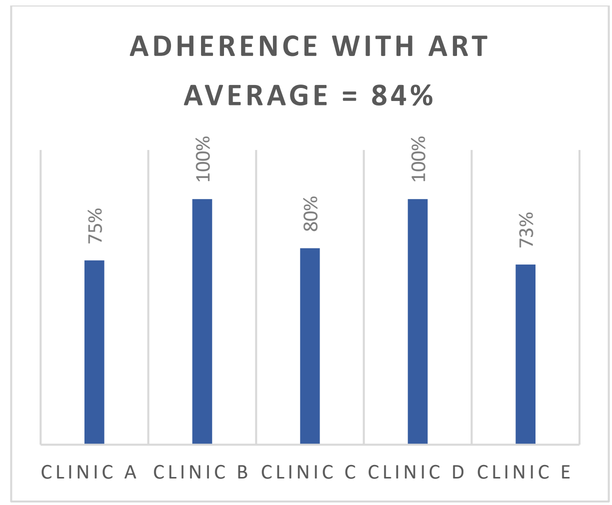
Questions were presented to determine patient adherence to the recommended treatment plan: documentation of follow-up visits scheduled, patient adherence to the schedule, and number of visits missed in excess of 30 days.

The reviewer found that 100% of the reviewed charts documented the follow-up schedule. This is an increase of two percentage points from 2022. The current review also revealed that 79% of these patients were adherent to the schedule while 21% were non-adherent (i.e., missing more than one appointment by more than 30 days), a difference of one percentage point compared to 2022.

Antiretroviral Therapy

The reviewer looked for documentation that 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 confirmed in 84% of the records compared to 92% in 2022. The results are shown for each clinic in the graphs below.

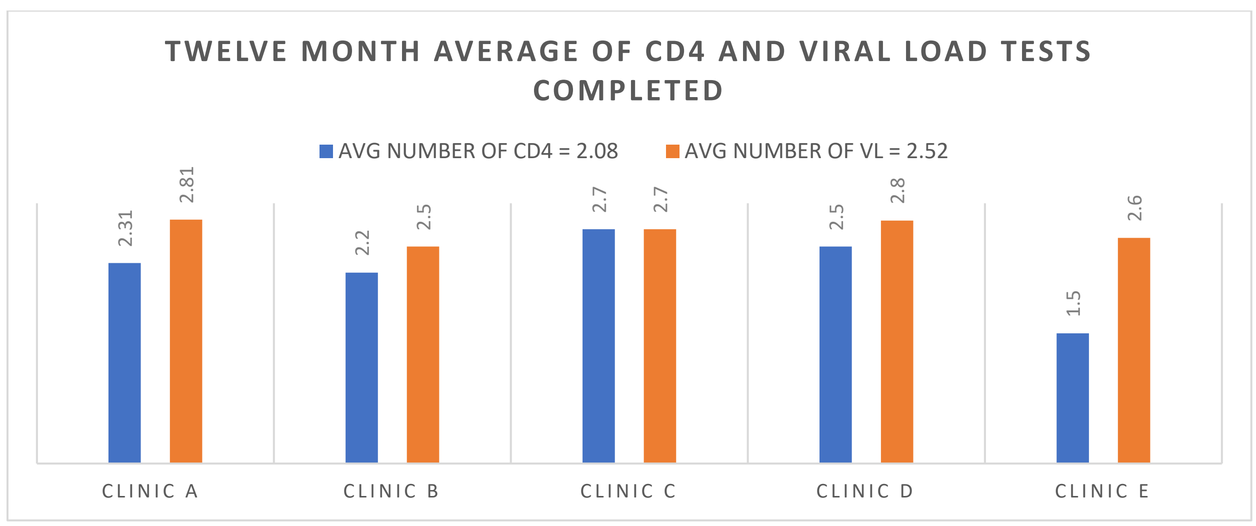




Frequency and Outcome of CD4 T-Cell Counts and Viral Loads

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 test per year. On average, each client received 2.08 CD4 counts and 2.52 VL tests during the twelve-month review. The CD4 count average is higher in this review period compared to the average in 2022 of 2.02. This increase is *not* statistically significant. The average number of viral loads also increased from 2.50 to 2.58. This increase is also *not* statistically significant.

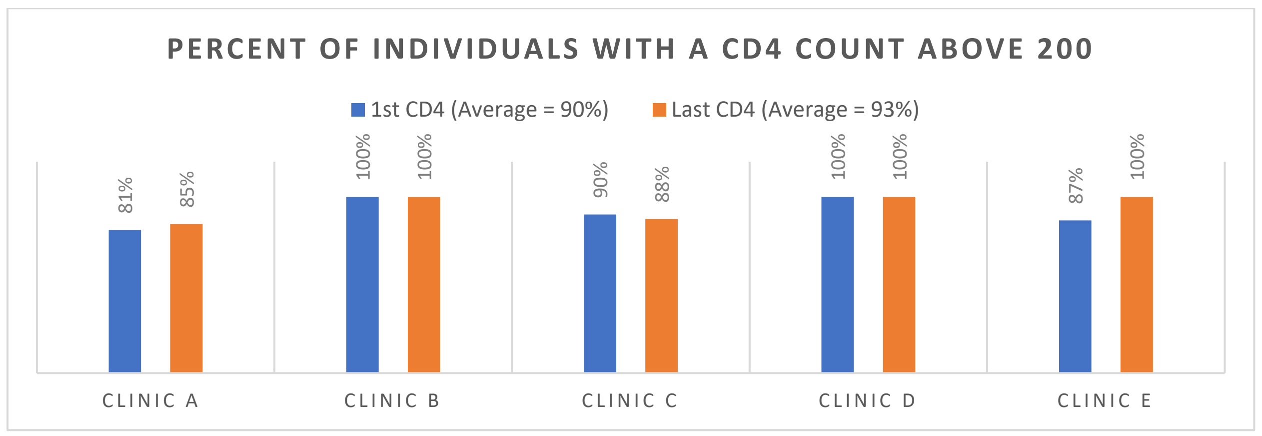


Previous reports used measures that looked at the percentage of clients with HIV infection who had two or more CD4 counts performed during the measurement year. There is currently no comparable measure to use as a benchmark, as the minimum recommended number of CD4 counts varies based on the clinical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

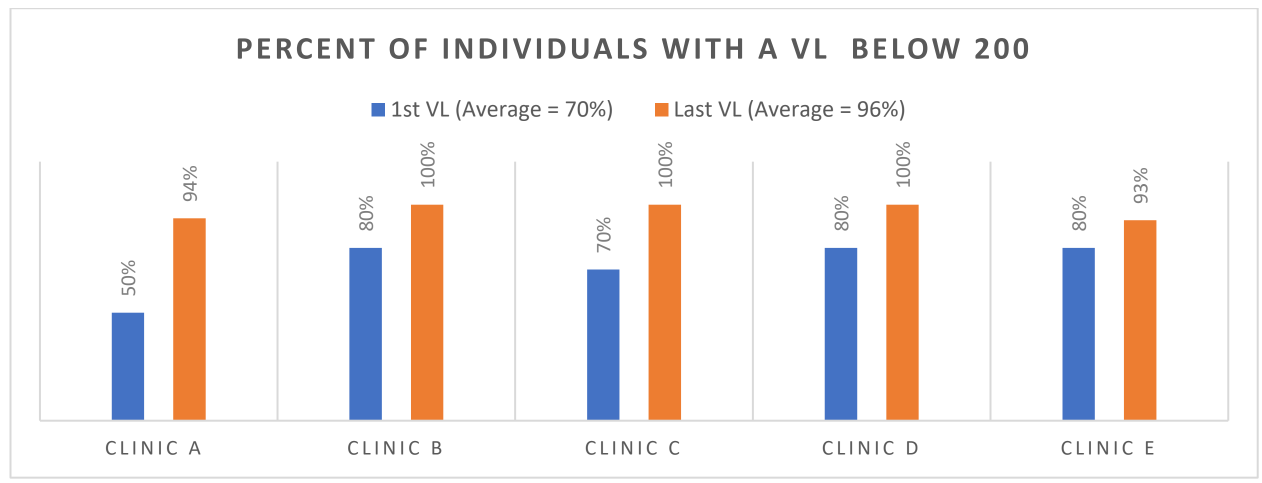
National HIVQUAL: Every 4 months: Percentage of patients for whom at least one VL test was performed in each four-month trimester of the review period at least 60 days apart. Every 6 months: Percentage of patients for whom at least one viral load test was performed in each six-month semester of the review 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/mm^3 and for VLs less than 200 copies/mL.

Analysis of CD4 counts shows a decrease in the percentage of clients who received at least two CD4 tests with a count above 200 from first to last (90% to 93%) compared to 2022 (95% to 97%).



VL outcomes showed a decrease in the percentage of clients with results of <200 copies/mL from the first and last testing (70% to 96%) compared to 2022 (95% to 98%).



Resistance Testing

The Practice Guidelines state that those eligible for genotype testing are patients who are: a) treatment-naive, 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 6 newly enrolled and treatment-naïve individuals reported in this sample, and all received a treatment-naïve genotype. Last year's review consisted of no newly enrolled and treatment-naïve clients who had a documented baseline/treatment-naïve genotype test.

In this year's review, 33% of individuals had a VL greater than 1,000, an increase of 27 percentage points compared to 2022. This result *is* statistically significant (z=4.2901). Two out of the twenty clients were on a stable ART regimen for at least one month prior to the date of the VL test and neither of the clients had a documented treatment-experienced genotype test. During the 2022 review, 6% of individuals were found to have a VL higher than 1,000 and one client was on a stable ART regimen for at least one month prior to the VL test and had a documented treatment-experienced genotype test.

Communicable Disease Screening

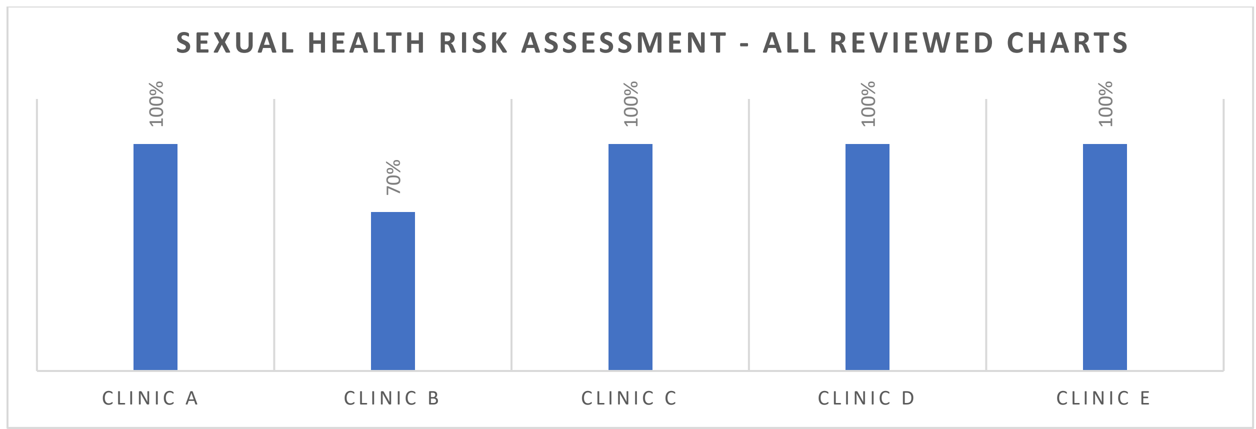
The Practice Guidelines specify the frequency for screening for STIs and TB:

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

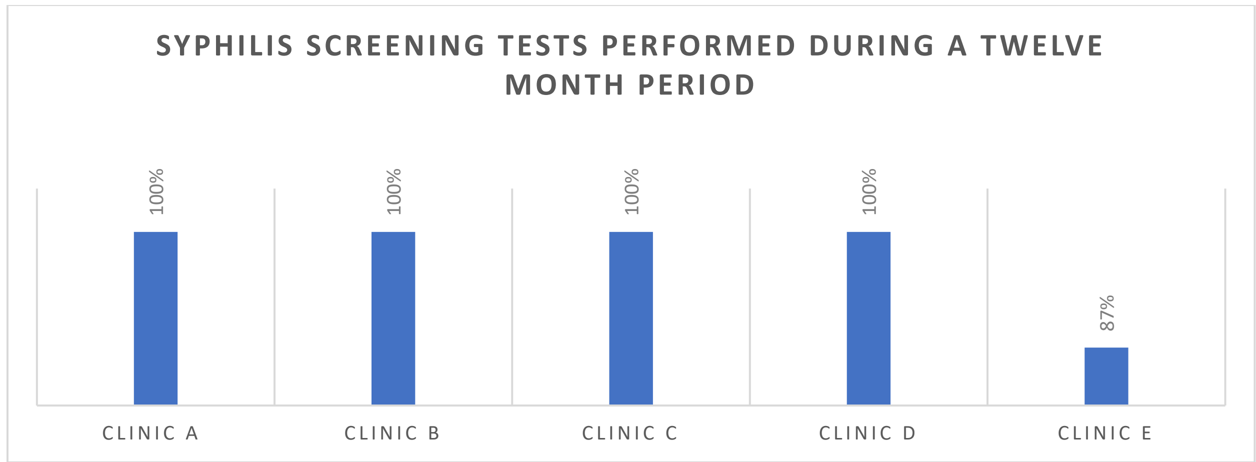
Sexually Transmitted Infections

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 that risk assessment was completed in a twelve-month period was found in 95% of the clients reviewed compared to 97% in 2022. 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 97% for syphilis screen across all clinic sites, which is an increase of 3%. This increase is *not* statistically significant.



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 an STI documented in the last twelve months.

Ninety-one percent of all individuals who were diagnosed with an STI in the last twelve months received urogenital screening for chlamydia and gonorrhea. This is a decrease of 9% from last year's results which is *not* statistically significant.

Out of the 30 newly enrolled clients in 2023, 93% 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 decreased from 97% to 94%, and this difference *not* statistically significant.

The overall averages using these three criteria are as follows:

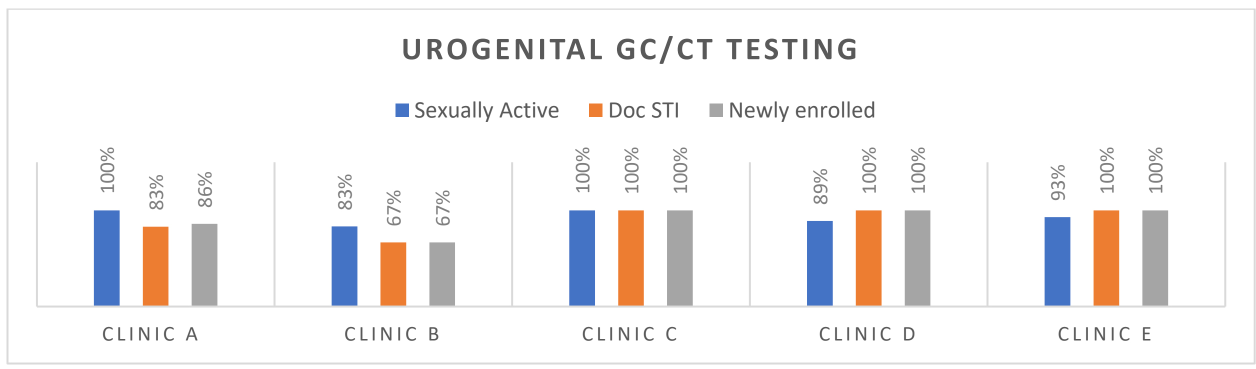
	Newly Enrolled	Sexually Active	Documented STI
Urogenital chlamydia and gonorrhea screening	93%	94%	91%

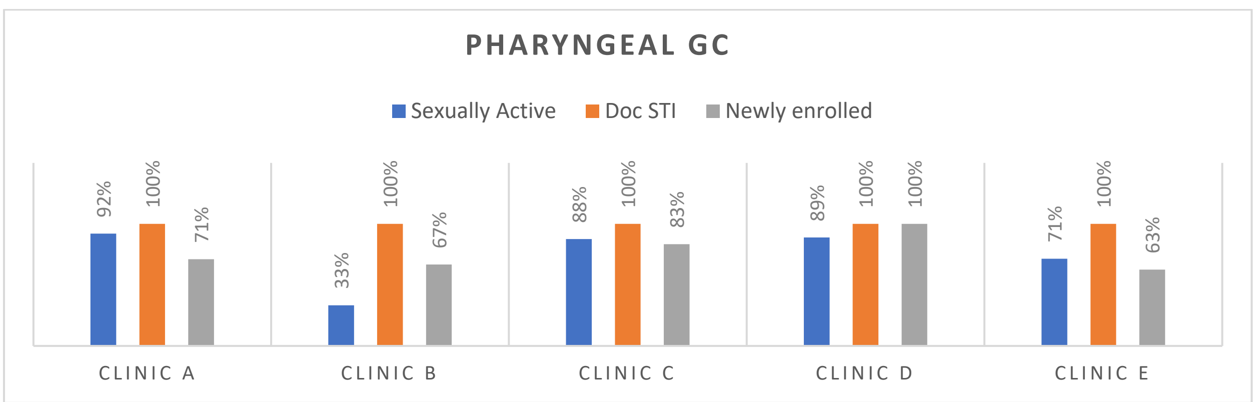
All clients with a documented STI received pharyngeal screening for chlamydia and gonorrhea compared to 67% in 2022, a result that is statistically significant (p=0.0072, z=2.4495). There was an increase of 61% in clients with a documented STI who received rectal screening for gonorrhea and chlamydia from 39% to 100% which was *not* statistically significant.

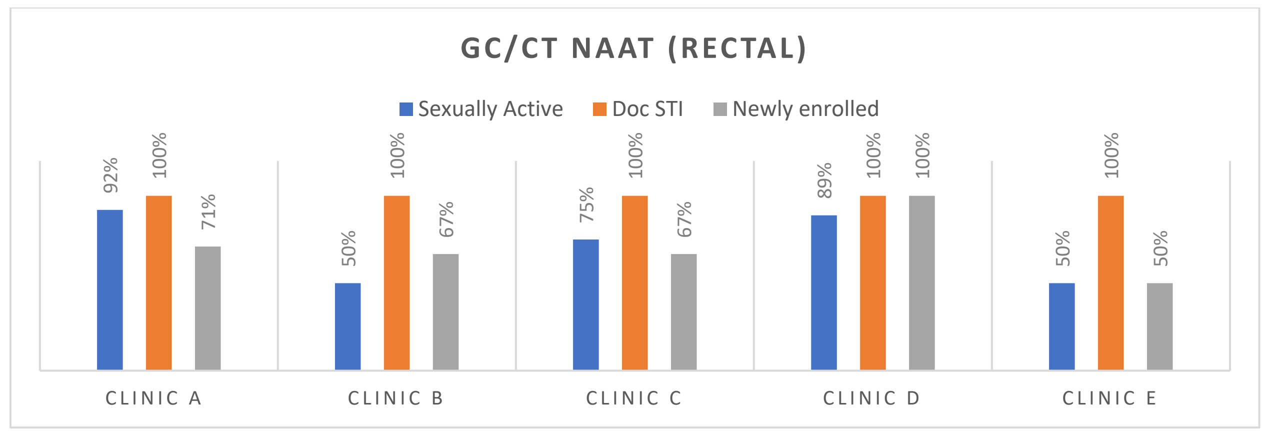
The percentage of clients who are sexually active who received pharyngeal chlamydia and gonorrhea screening decreased from 79% in 2022 to 78% in 2023, a difference which is *not* statistically significant. The percentage of sexually active clients who received rectal gonorrhea and chlamydia screening increased from 67% to 72%, and this difference 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	77%	78%	100%
GC/Chlamydia Rectal	100%	72%	100%

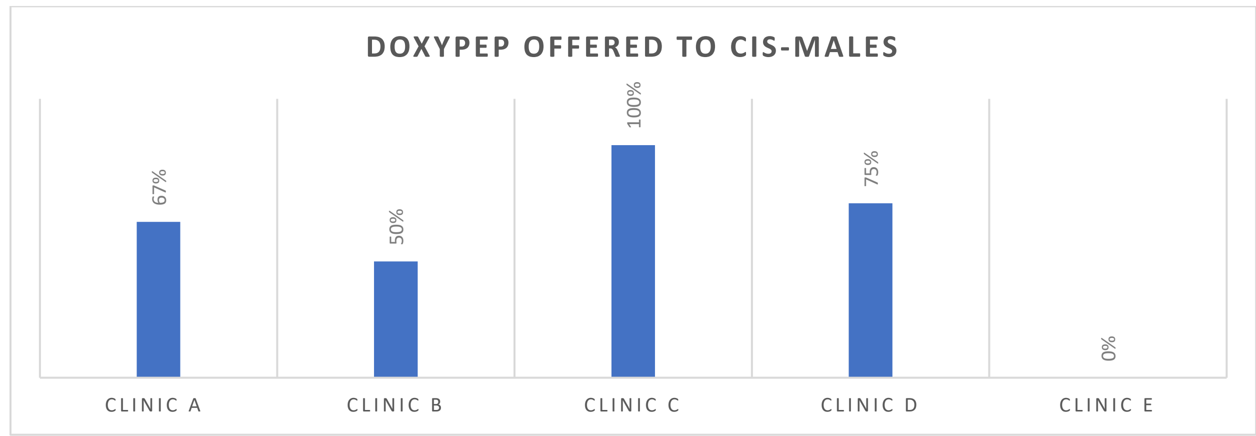
The following graphs represent the results by clinic:

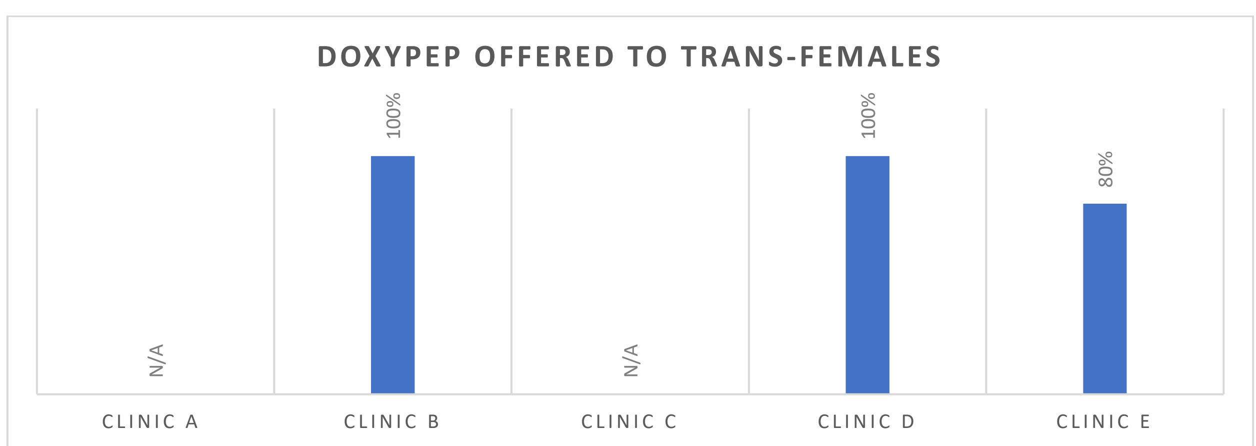






The reviewer also determined if Doxycycline STI Post-Exposure Prophylaxis (i.e., DoxyPEP) was offered to those clients who had a documented STI within the past 12 months. The results showed that 62% of cis-males and 85% of trans-females were offered DoxyPEP.

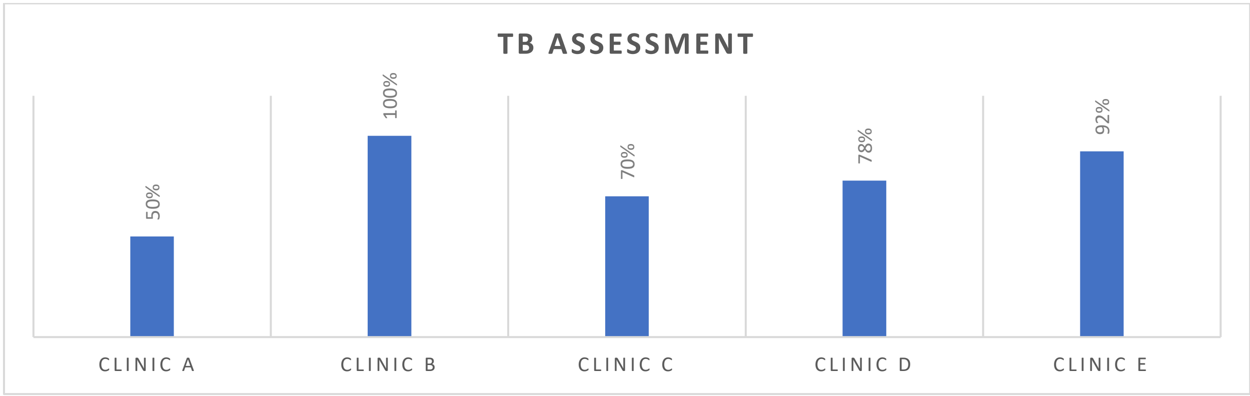




Tuberculosis Testing

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.

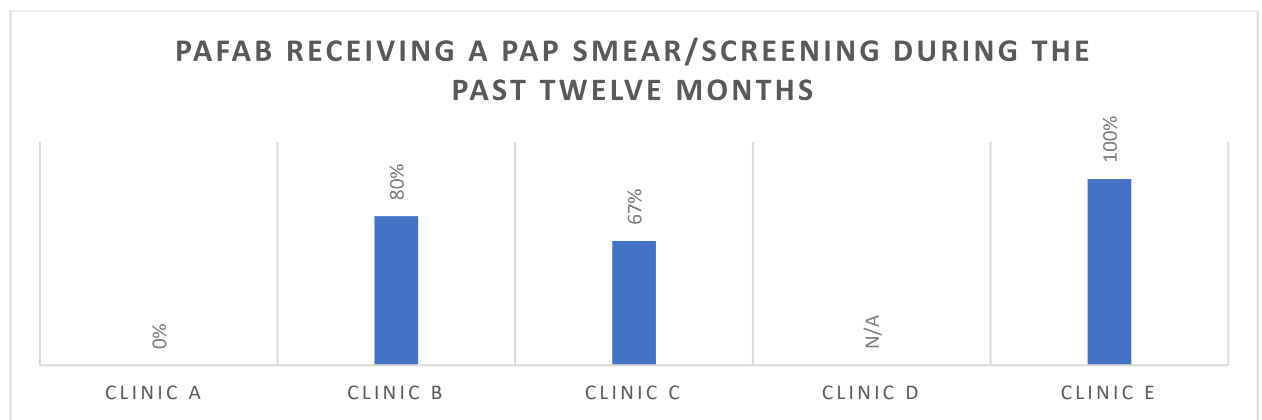
The following chart shows clinic results for the percentage of clients who received testing for TB. Seven clients who had a previous positive test were excluded from these figures. Documentation in the medical records indicate that 78% of non-exempt individuals received a TB test during the twelve-month period, an increase of nineteen percentage points. QuantiFERON screening was used 100% of the time. The study found that 14% 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 a decrease of 60%. This result is *not* statistically significant. TB risk assessment for those with prior positive results were found in 43% of the medical records reviewed, which is a decrease of 20% over last year's results and *not* statistically significant.



Papanicolaou (Pap) Test

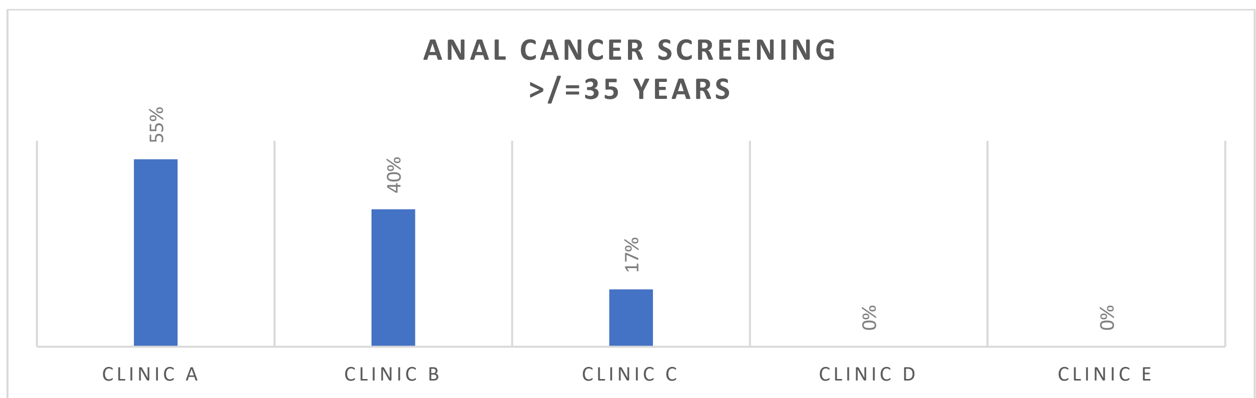
Practice Guidelines for persons assigned female at birth (PAFAB) include an initial and annual Pap smear to screen for cervical cancer unless a hysterectomy for non-dysplasia/non-malignant indications has been performed. A Pap test should be done annually for three years and if normal, can be done every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

The records were reviewed for an indication that the patient's cervical cancer screening had been addressed. Overall, 81% 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 9% from 2022 which is *not* statistically significant. The results by clinic are displayed in the following graph.



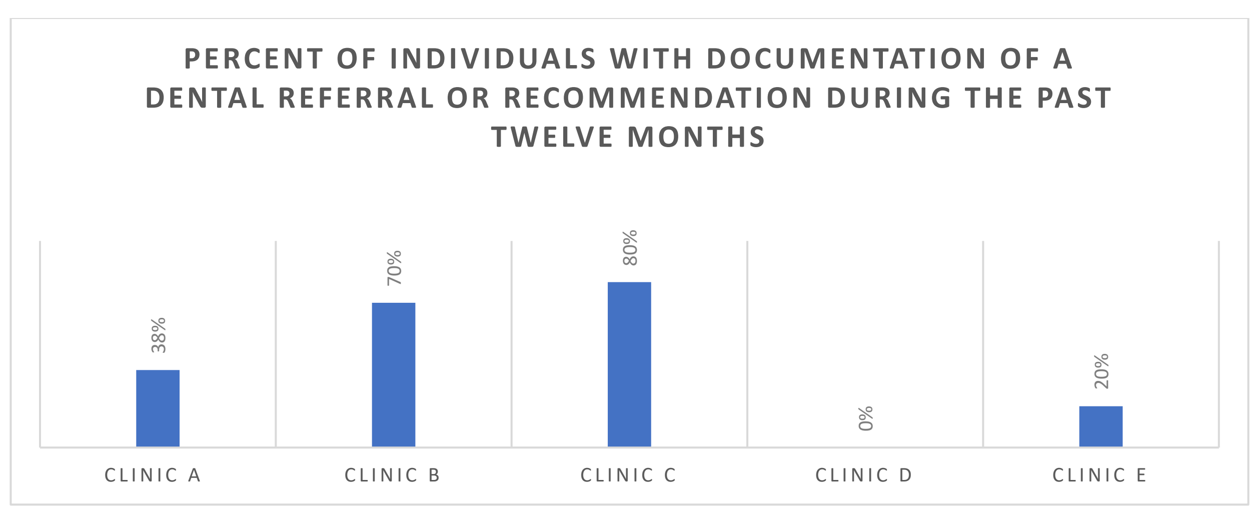
Anal Cancer Screening

The charts were also reviewed to determine if anal cancer screening was conducted for those clients aged 35 and older. The results show 25% of the clients were screened and the results by clinic are listed below.



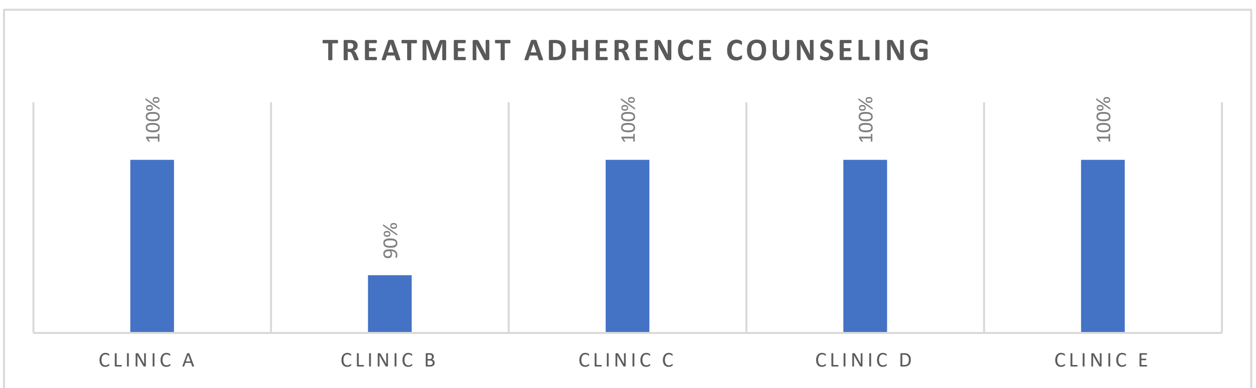
Dental Referral

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 39% of the records reviewed, a 5% decrease compared to 44% in 2022.



Treatment Adherence Counseling

The overall average for documenting treatment adherence counseling was 98%, a decrease of 1% compared to the previous review. The following graph represents the results by clinic:

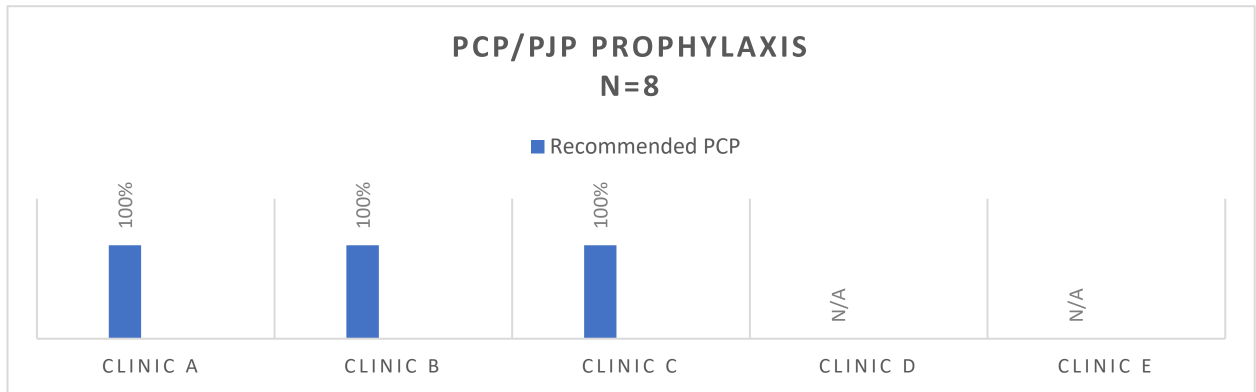


PCP (PJP) Prophylaxis

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

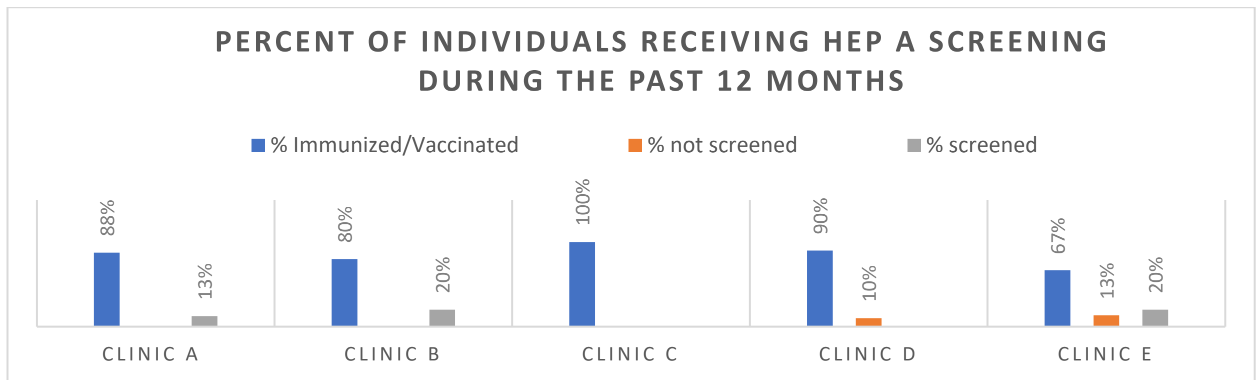
- The client is HIV +
- Is not newly enrolled, and
- Has a CD4 T-cell count <200 unless the post-test after three months rose above 200 cells/mm^3

Eight clients met the above criteria and all 8 were prescribed PCP/PJP prophylaxis, constituting a rate of 100%. In the previous year, nine clients met the above criteria and only three were prescribed PCP/PJP prophylaxis. This difference *is* statistically significant (p=0.0169. z =2.1213)



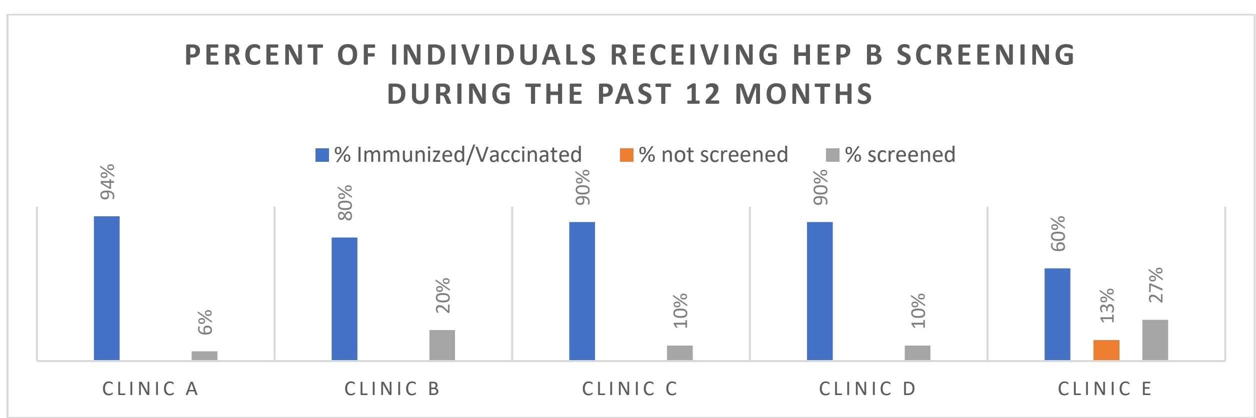
Hepatitis A Screening

Medical records were reviewed for Hepatitis A screening and vaccinations. Overall, 84% of clients were immunized/vaccinated during the review period. This is a decrease of 9%, a result that is *not* statistically significant.



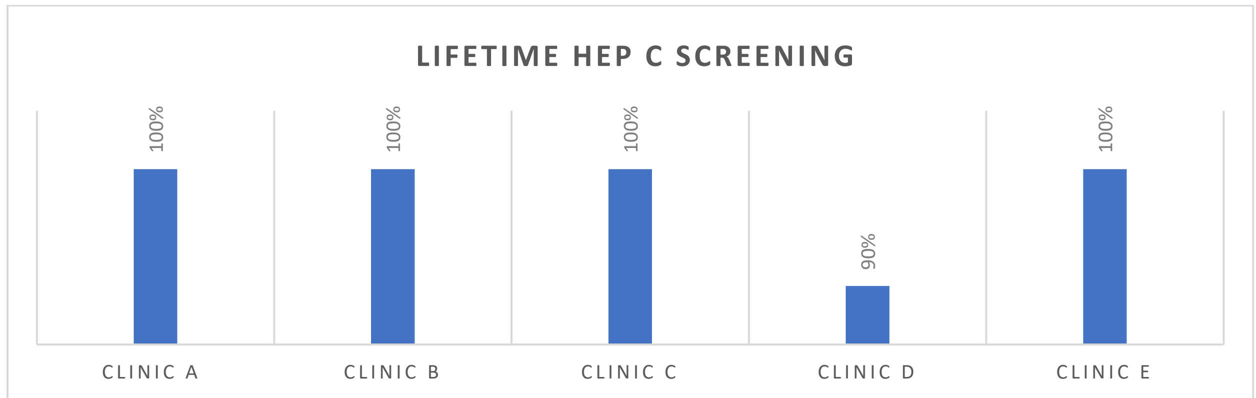
Hepatitis B Screening

Screening for Hepatitis B was also reviewed. Eighty-two percent of clients were immunized/vaccinated compared to 93% in 2022. This measure did consider previous infection and/or the vaccination status of each client. The graph below represents the results by clinic.

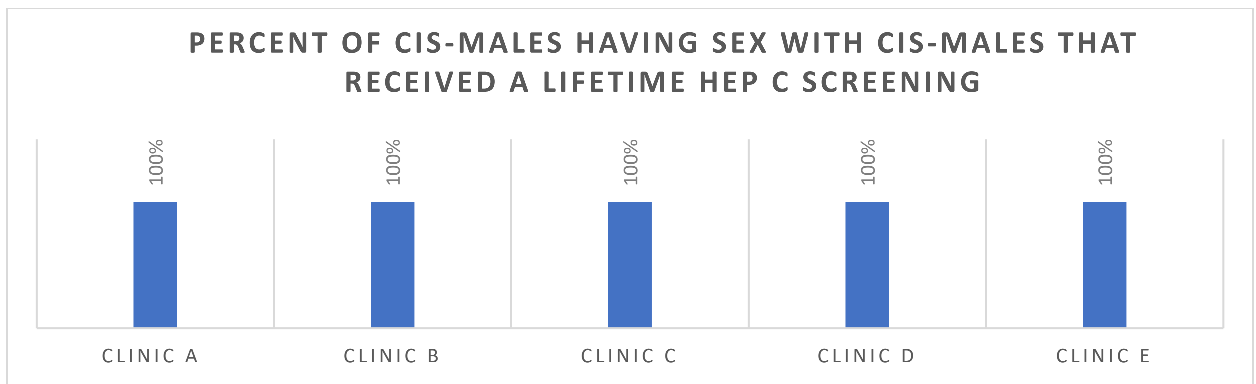


Hepatitis C Screening

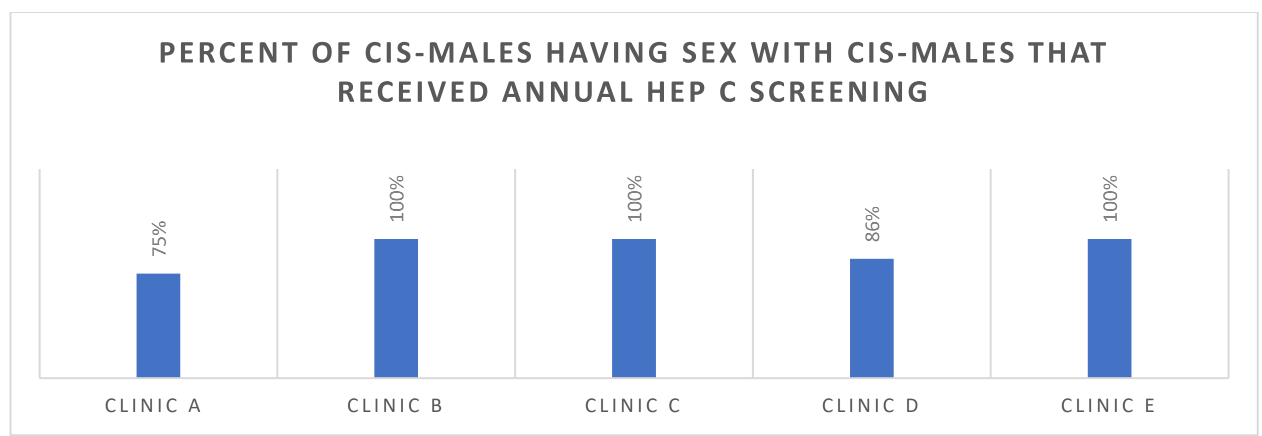
The review captured those clients who received a lifetime screening for Hepatitis C at any time. In 2023, the numbers of clients who had received a lifetime Hepatitis C Screening at any time or who were previously confirmed with Hepatitis C was 98%, which is a decrease of 1% from the previous year. The following graph represents the results by clinic:



Further review of the records revealed that, of the 27 cis-males who reported having sex with other cis-males, all received a lifetime Hepatitis C Screening. This is an increase of 3% from the previous year. The following graph represents the results by clinic:

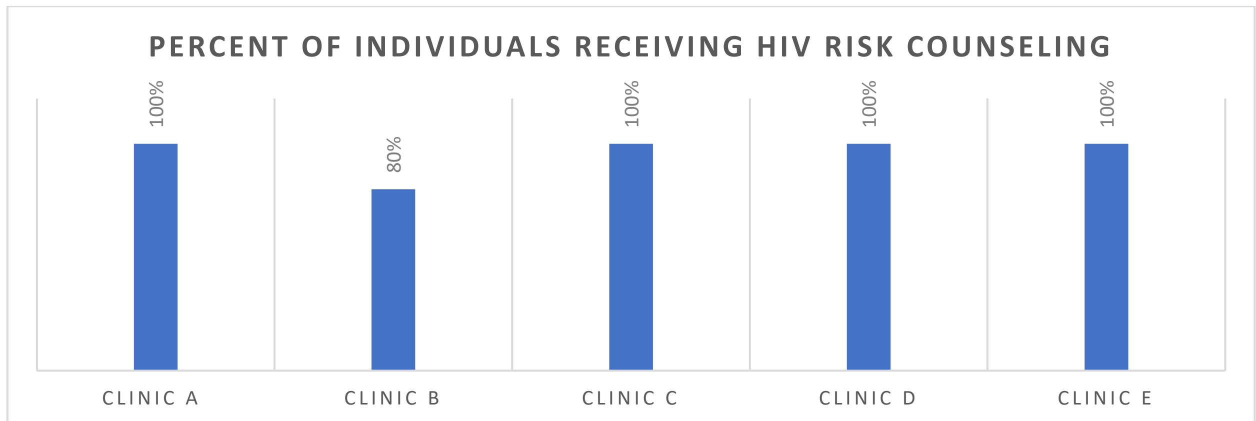


Medical records also were reviewed for documentation that annual Hepatitis C screening was done for cis-males who reported having sex with other cis-males or those with active or previous injection drug use not previously tested for Hepatitis C. It was found that 85% of those eligible for annual Hepatitis C screening based on the criteria above received the screening. This is an increase of 27% from the previous year which *is* statistically significant (p=0.0008, z=3.1435).

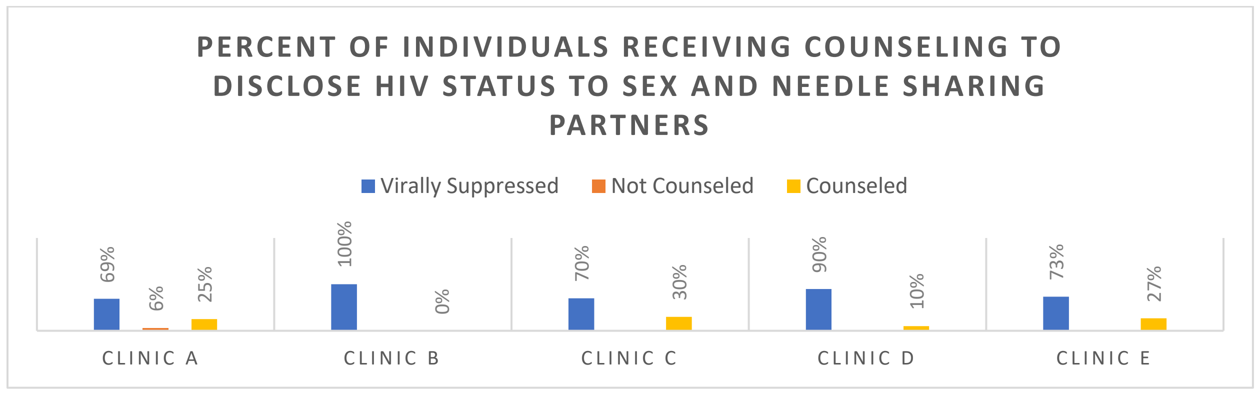


HIV Risk Counseling

Review of the medical records indicated that 97% of the clients received HIV risk counseling, a decrease of 2% from the previous year. The graph below represents the results by clinic:

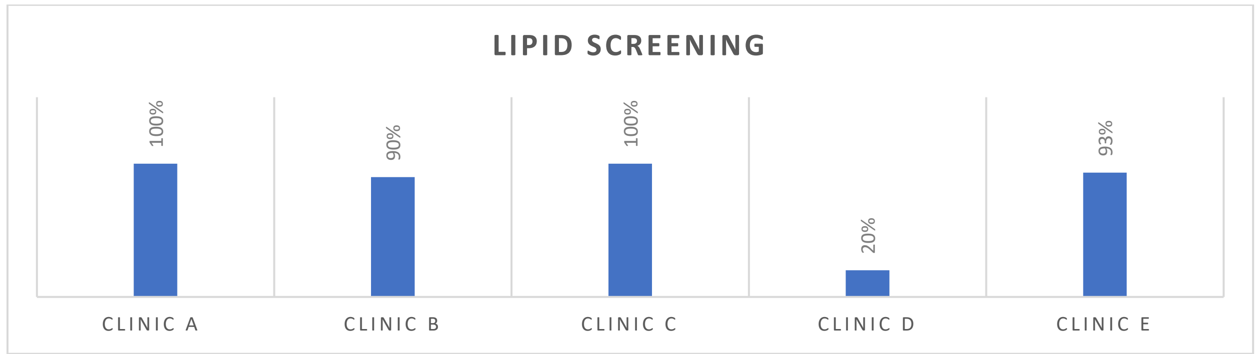


The reviewer also looked for evidence that individuals were counseled on the disclosure of HIV infection to sex and needle-sharing partners and/or were referred to HIV Partner Services if they were not virally suppressed. Seventy-nine percent of the clients were virally suppressed compared to 89% in 2022.



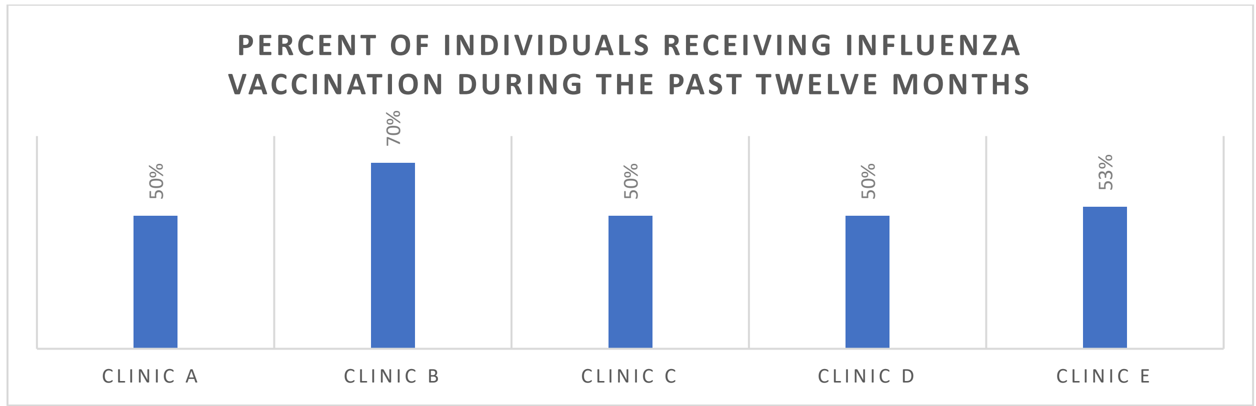
Lipid Screening

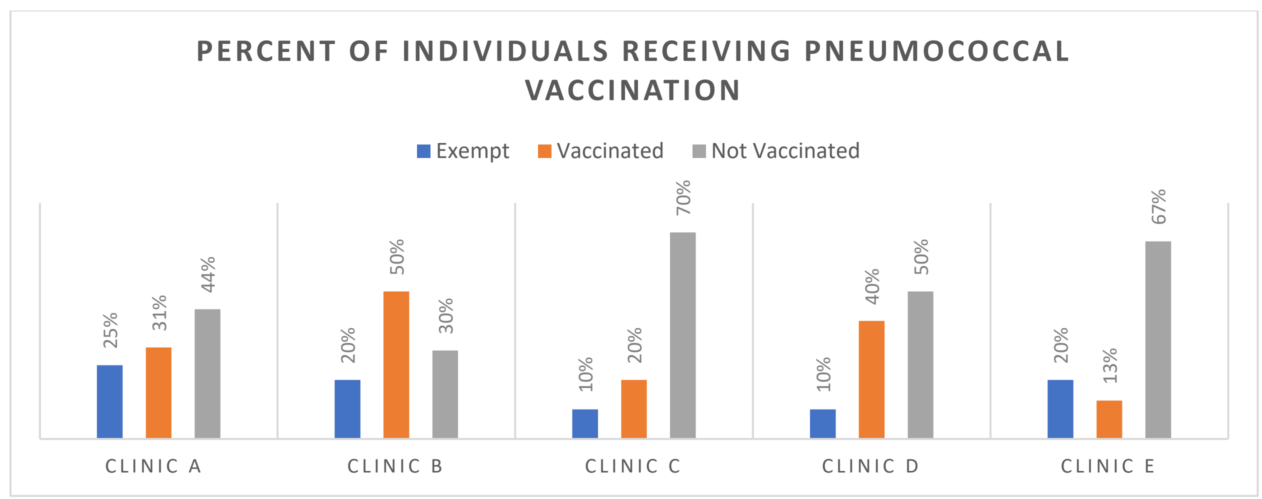
Eighty-four percent of individuals received lipid screening during the 2023 review period. This represents a 7% decrease from the previous year.



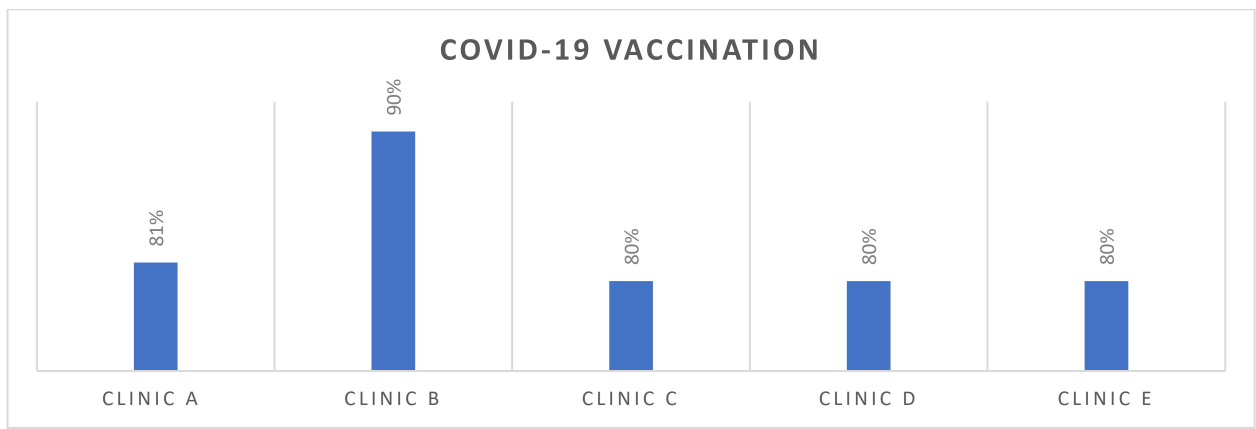
Vaccinations

A review of the medical records showed that 54% of clients received an influenza vaccination, a decrease of 16% which is *not* statistically significant. Documentation showed 30% of patients received a pneumococcal vaccination and 18% were exempt. Of the eighteen clients that were vaccinated during the review period, 67% received Prevnar 20, 17% received Pneumovax, and 17% received Prevnar 13 The following graphs represent the results by clinic:

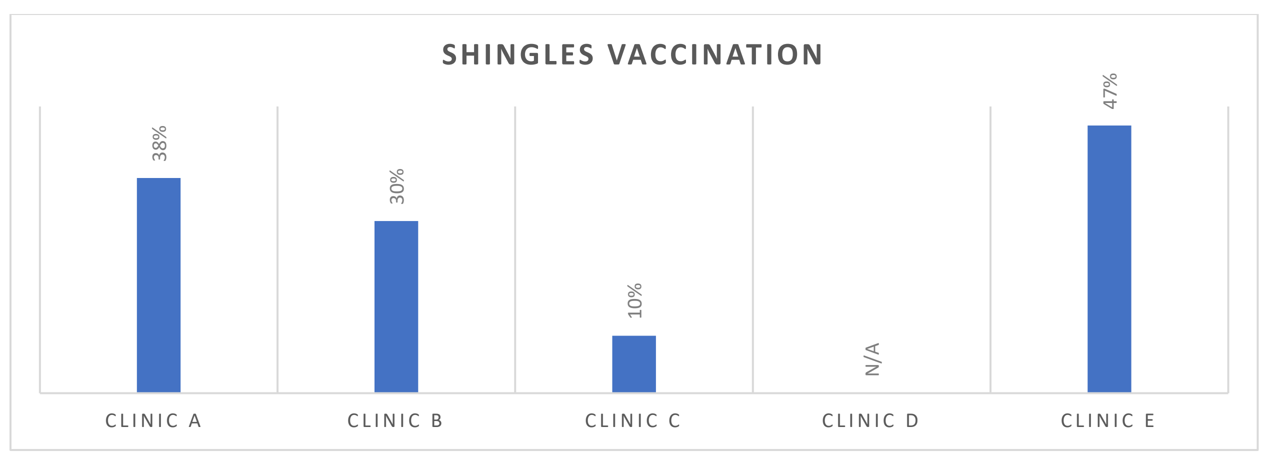


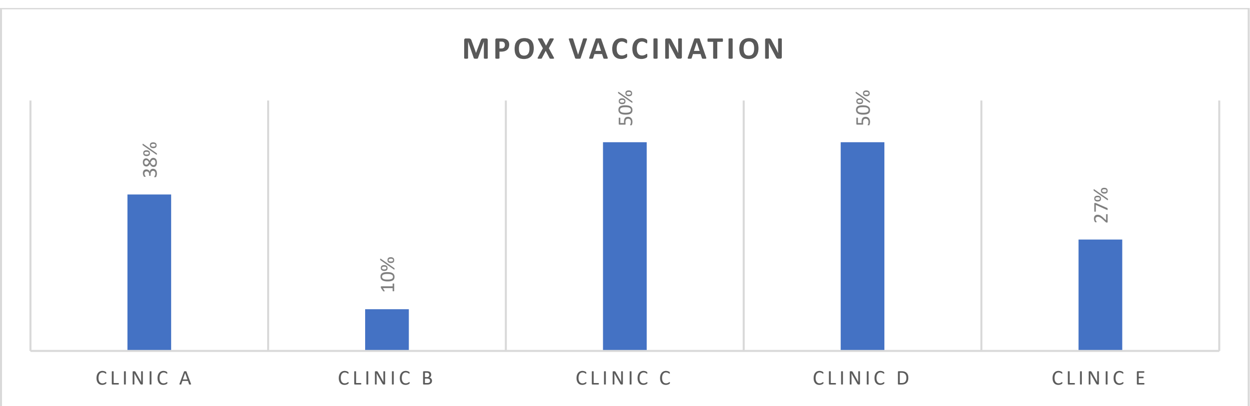


The charts were also reviewed for evidence of COVID-19 vaccination. Eighty-two percent of the clients had a documentation of COVID-19 vaccination compared to 97% from 2022. This is a decrease of 15% which is *not* statistically significant.



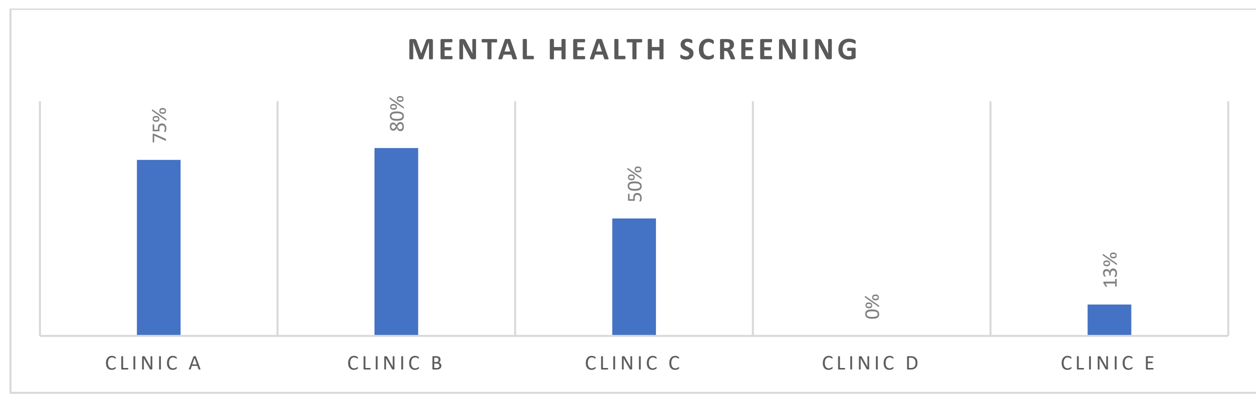
During this year's review, the reviewer also looked for documentation of shingles vaccination for all clients and documentation of meningococcal and Mpox vaccination. The records indicated that 28% received the shingles vaccine. Sixty-six percent of the clients received the meningococcal vaccine a decrease of 7 percentage points in comparison to 2022. Thirty-four percent were vaccinated for Mpox, an increase of 2 percentage points from last year's results. The following graphs represent the results by clinic:

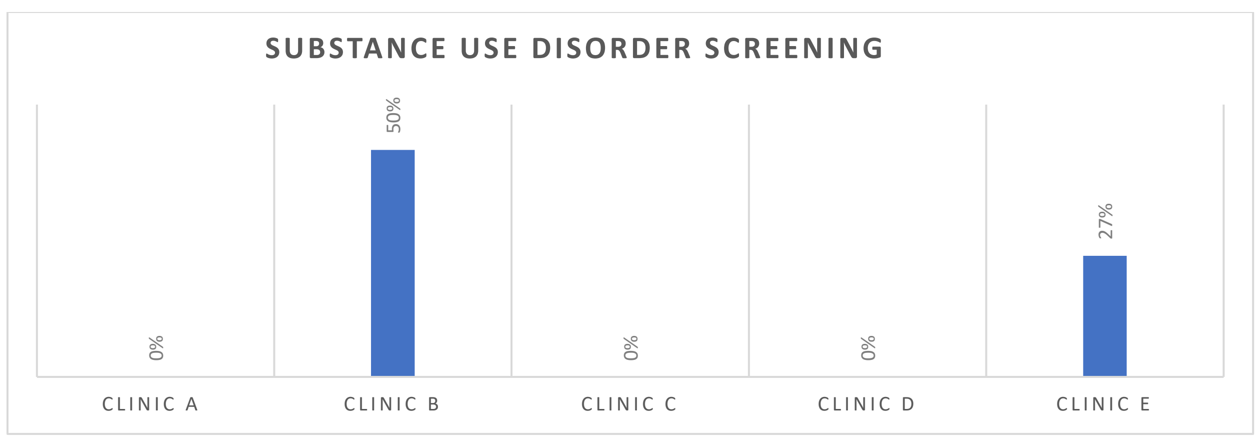




Mental Health and Substance Use Disorder Screening

In this year's review, the reviewer also looked for documentation if mental health and substance use disorder screening were conducted. The following graphs represent each clinic's results:





Conclusions

In this review period clients continued to be adherent to their medication regimen and treatment plan. There were also new measures that were reviewed: DoxyPep offering, anal cancer screening, shingles vaccination regardless of age, mental and substance use disorder screening. The primary overall conclusions and observations from this chart review include:

- Decrease of sixty-five clients from 2022 chart review.
- Increase in overall visits, including telehealth, to an average of 5 visits compared to 3 in 2022.
- Increase of 27 percentage points for clients who had a VL of 1,000 which is statistically significant.
- 70% of overall clients who had a documented STI within the past 12-month were offered DoxyPEP.
- Decrease in TB screening (63% to 43%) and chest x-rays (43% to 14%) for those with a known positive test.
- 25% of clients aged 35 and older received anal cancer screening.
- Increase of 33% of clients that met the criteria for PCP/PJP Prophylaxis were prescribed it, a result that is statistically significant.
- Increase of 27% of those who met the criteria received the annual Hepatitis C screening which is statistically significant.
- Shingles vaccination for all age groups: 28% received the vaccine.
- 52% of clients should have received pneumococcal vaccination but did not receive the vaccine.
- 44% of clients received a mental health screening while 15% were screened for substance use disorder.

Based on the results of the review, there is opportunity to discuss the frequency and level of documentation for certain measures as we move toward the 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.

Outpatient/Ambulatory Medical Care Services

Service Category Definition

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

Primary activities for OAHS include:

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

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

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

Purpose and Goals

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

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

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

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

Intake

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

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

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

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

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

Key Service Components and Activities

Key service components and activities include the following:

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

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

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

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

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

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

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

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

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

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments for all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients in the medical record
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for clients who are deemed ineligible for the Ryan White Primary Care Program or deemed ready to be transitioned out of certain services

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

Personnel Qualifications

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

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

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

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

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

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

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

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

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

Standard	Measure
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Initial Assessment:

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

Treatment Plan:

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

Treatment Provision:

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

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

Transition and Discharge

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

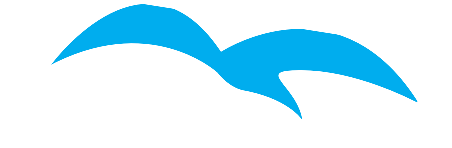
- Client has died.
- Client requests to be disenrolled.
- Client enrolls in another primary care program.
- Client cannot be located within 120 days after repeated efforts, including attempted written, oral and personal contact.
- Client relocates outside of San Diego County.
- Client demonstrates repeated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

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

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

Scan this QR code to access the HIV Service Standards report and go to page 54 for Oral Health Care Services.

Scan this QR code to access the San Diego County Dental Practice Guidelines approved in 2020.



STI/Mpox Updates

M. Winston Tilghman, MD

HPG Medical Standards and Evaluation Committee Meeting

June 11, 2024

Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 73 / No. 2
June 6, 2024

CDC Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection Prevention, United States, 2024

BOX 1. CDC recommendations for use of doxycycline as postexposure prophylaxis for bacterial sexually transmitted infections prevention

Recommendation*	Strength of recommendation and quality of evidence†
• Providers should counsel all gay, bisexual, and other men who have sex with men (MSM) and transgender women (TGW) with a history of at least one bacterial sexually transmitted infection (STI) (specifically, syphilis, chlamydia or gonorrhea) during the past 12 months about the benefits and harms of using doxycycline (any formulation) 200 mg once within 72 hours (not to exceed 200 mg per 24 hours) of oral, vaginal, or anal sex and should offer doxycycline postexposure prophylaxis (doxy PEP) through shared decision-making. Ongoing need for doxy PEP should be assessed every 3–6 months.	AI High-quality evidence supports this strong recommendation to counsel MSM and TGW and offer doxy PEP.
• No recommendation can be given at this time on the use of doxy PEP for cisgender women, cisgender heterosexual men, transgender men, and other queer and nonbinary persons.	Evidence is insufficient to assess the balance of benefits and harms of the use of doxy PEP

* Although not directly assessed in the trials included in these guidelines, doxy PEP could be discussed with MSM and TGW who have not had a bacterial STI diagnosed during the previous year but will be participating in sexual activities that are known to increase likelihood of exposure to STIs.
† See Table.

Clinical Guidelines (CDPH vs CDC) on Doxy PEP for Bacterial STI Prevention

Doxycycline postexposure prophylaxis (doxy PEP): individual self-administration of 200mg doxycycline (any formulation) by mouth within 72 hours of condomless oral, vaginal, or anal sex, with a max dose of 200mg/24 hrs.

CDPH **Recommendations** (4/28/2023)	CDC **Recommendations** (6/4/2024)
- **Recommend** doxy-PEP to men who have sex with men (MSM) or transgender women (TGW) who have had ≥1 bacterial STI in the past 12 months.	- **Providers should counsel** GBMSM and TGW w/a hx of ≥ 1 bacterial STI during the past 12 months about benefits/harms of using doxy PEP **and should offer doxy PEP through shared decision-making**. - Doxy PEP could be discussed with MSM & TGW who have not had a bacterial STI diagnosed in past 12 months but will be participating in sexual activities known to increase exposure to STIs.
- **Offer** doxy-PEP using shared decision-making to all **non-pregnant individuals** at increased risk for bacterial STIs and to those requesting doxy-PEP, even if these individuals have not been previously diagnosed with an STI or have not disclosed their risk status.	- **No recommendation** can be given on the use of doxy PEP for **cisgender women, cisgender heterosexual men, transgender men**, and **other queer and nonbinary persons** d/t insufficient evidence in these populations; - Pharmacokinetic data suggests doxy PEP should be effective in other populations, but clinical data is limited - Providers should use their clinical judgement & shared decision-making to inform use of doxy PEP w/populations not part of CDC recommendations.

CDPH Doxy-PEP Recommendations for Prevention of STIs (ca.gov)

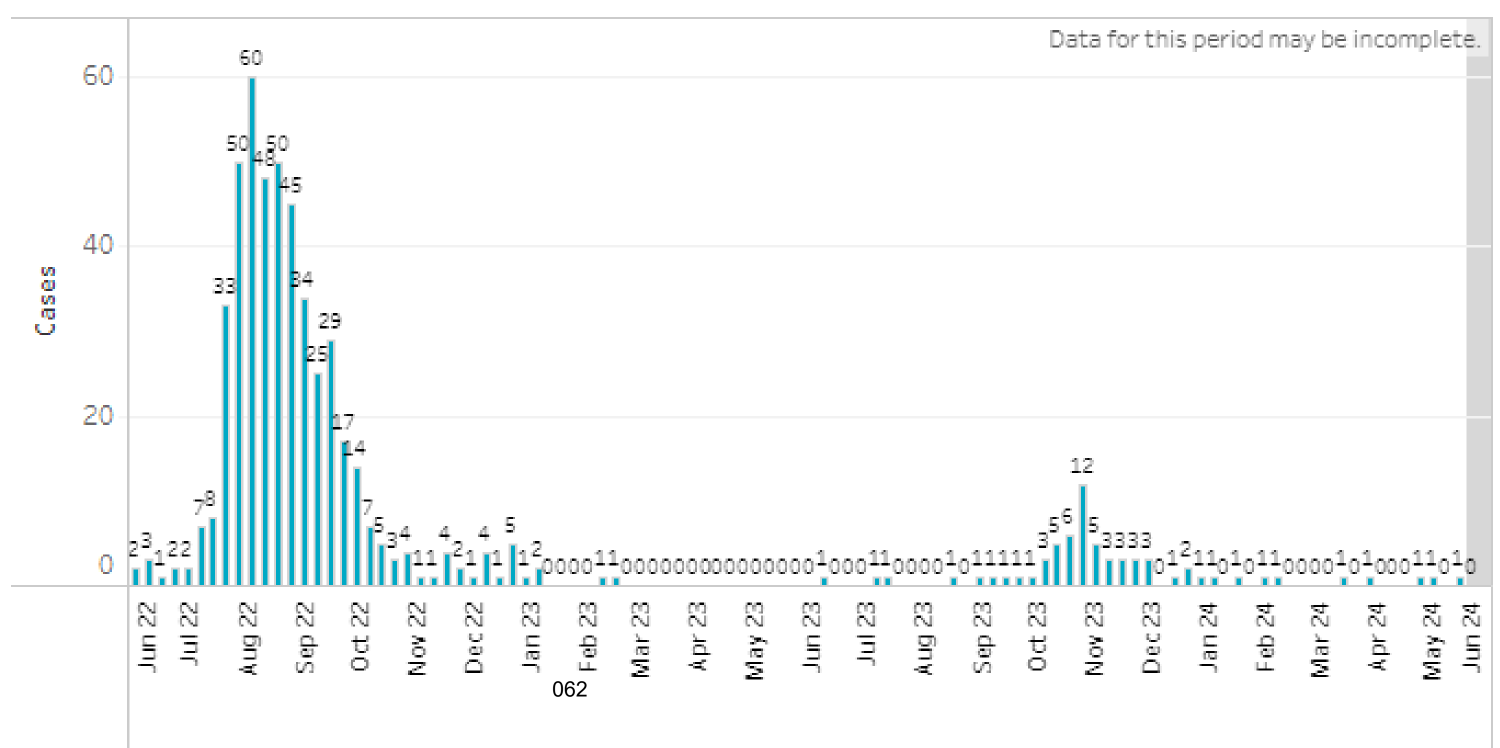
CDC Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection Prevention, United States, 2024 | MMWR

Slide Credit: California Dept of Public Health

Mpox Cases – San Diego County (through 6/1/24, updated 6/4/24)

Cumulative Cases*	Cases Since Last Report	Cumulative Hospitalizations	Cumulative Deaths
538	1	20	1

MPOX Confirmed and Probable Cases* by Episode Date,^ San Diego County



Ongoing Clade I Mpox Outbreak in DRC

State of California—Health and Human Services Agency
California Department of Public Health
Health Advisory
TO: Healthcare Providers
Clade I Mpox Virus with Geographic Spread in the Democratic Republic of the Congo: Recommendations for California Health Care Providers
12/11/2023

- In 2023: >14,000 cases, CFR 4.5%; in 2024 to date: >5000 cases; CFR 6.5%
  - Approximately 70% in children under age 15; many cases also occurring among women
- Most cases are suspected cases based on clinical diagnosis (not laboratory confirmed)
  - May lead to overestimate of cases from conditions with similar symptoms (e.g., chickenpox, concurrent measles outbreak)
  - CFR only 1.4% among 216 hospitalized patients with confirmed MPXV infection in DRC from 2007-2011
- Transmission in DRC
  - Zoonotic spillover (animal to people) in some provinces
  - Household transmission (close, prolonged & direct contact) likely contributory
  - Sexual transmission; recent outbreak in South Kivu with 29% cases identify as sex workers; documented cluster of clade I among MSM in 2023
- Mpox vaccination not generally available in DRC

Pittman PR, PLoS Negl Trop Dis, 2023; Kibungu EM, EID 2024; Rapid Risk Assessment: Risk Posed to US by Clade I Mpox Outbreak in DRC (cdc.gov)

Slide courtesy of Eric Tang, MD, MPH (CDPH

Risk/Potential Impact of Clade I Importation to US

- CDC/CDPH conducting enhanced Clade I surveillance testing of positive non-variola orthopoxvirus (NVO) specimens
- Currently no cases in US or outside endemic areas in Africa
- No direct commercial flights from DRC or neighboring countries to the US
- CDC assessment of risk very low for general population & low-to-moderate for MSM
  - Availability of high-quality supportive care and access to medical counter measures
  - Documented sexual transmission of Clade I, including among MSM, and Clade IIb outbreak impacting MSM could lead to increased risk in population; however, population immunity among MSM likely to reduce severity of the infection
  - CFR would likely be much lower in US if Clade I imported

Rapid Risk Assessment: Risk Posed to US by Clade I Mpox Outbreak in DRC (cdc.gov)

Slide courtesy of Eric Tang, MD, MPH (CDPH

Clade I Mpox Preparedness

- **Vaccination**
  - In CA estimate only ~40% of eligible people 2-dose vaccinated → vaccinate at-risk populations
- **Surveillance/Testing**
  - NVO+/Clade II PCR neg = possible Clade I → obtain clade-specific testing
  - Seeing a potential Clade I case? (i.e., symptoms + personal/close contact history of travel to DRC)
    - Providers instructed to report immediately to LHD; CDPH also requests notification (stdcb@cdph.ca.gov or mpoxadmin@cdph.ca.gov)
    - Send lab specimens to CDPH VRDL for Clade-specific testing (or local PHL if Clade-specific testing is available)
    - VRDL mpox testing guidance available at Mpox test order; VRDL contact info - (510) 307-8585 or VRDL.Submittal@cdph.ca.gov.
- **Isolation & Contact Tracing**
  - Recommend being more aggressive for initial/early cases for containment to limit onward spread

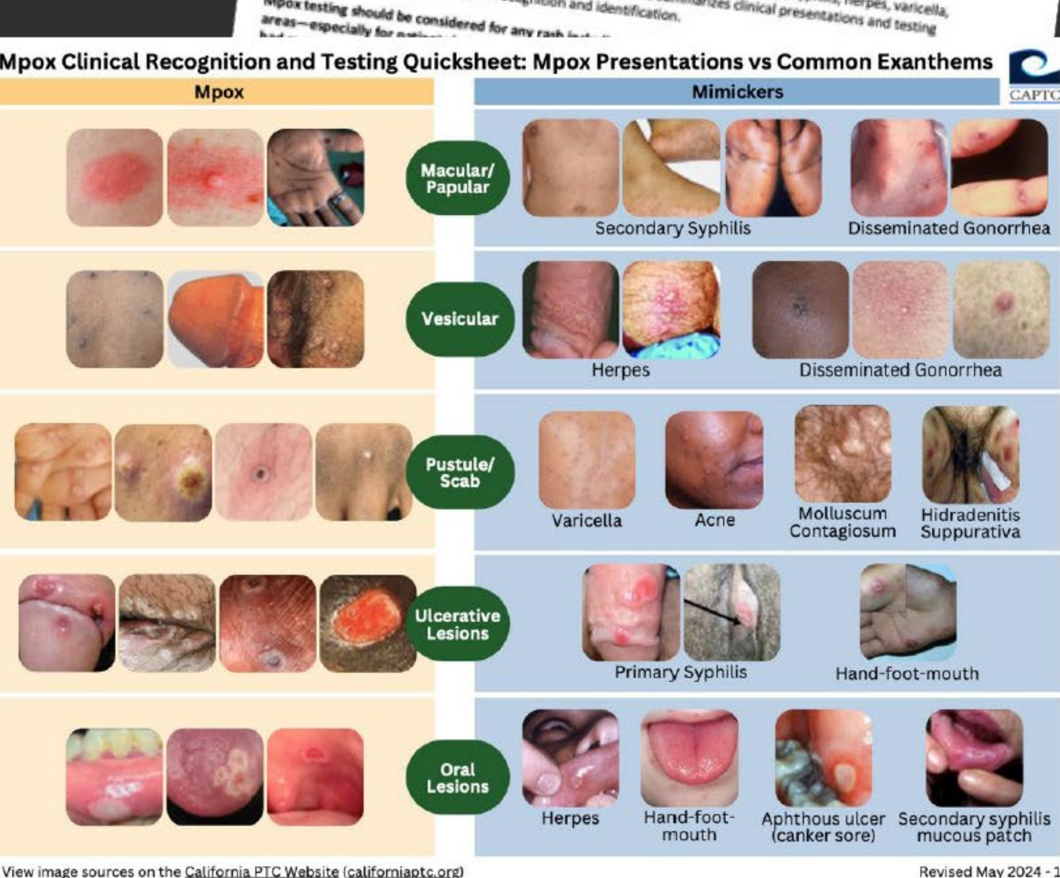
CDPH CAHAN 12.11.2023

Slide courtesy of Eric Tang, MD, MPH (CDPH

CAPTC: Mpox Clinical Recognition and Testing Job Aids

- Tools for mpox clinical recognition and to bring mpox to the differential
  - Identification of mpox rashes
  - Differential diagnosis for rashes similar to mpox
  - Explanation of evaluating rashes with mpox on the differential
  - Details on mpox testing
- Shorter job aid: printed resource to help facilitation clinical recognition of mpox
- Longer job aid: electronic resource with helpful links to mpox-related resources

https://californiaptc.com/resources/mpox-job-aids/



Slide courtesy of Eric Tang, MD, MPH (CDPH

County of San Diego Monthly STD Report

Volume 16, Issue 5: Data through December 2023; Report released June 11, 2024.

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

	2022		2023	
	Dec	*Previous 12-Month Period**	Dec	*Previous 12-Month Period**
Chlamydia	1331	18141	1215	17509
Female age 18-25	450	6271	409	5664
Female age ≤ 17	35	531	47	634
Male rectal chlamydia	137	1683	115	1692
Gonorrhea	604	7792	507	6427
Female age 18-25	74	1113	37	709
Female age ≤ 17	11	100	8	89
Male rectal gonorrhea	130	1594	137	1510
Early Syphilis (adult total)	81	1098	58	1020
Primary	16	191	8	155
Secondary	14	325	11	304
Early latent	51	582	39	561
Congenital syphilis	4	33	1	35

* 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	17509	532.6	521	121.4	537	374.7	1733	154.4	2246	160.7
Gonorrhea	6427	195.5	229	53.4	357	249.1	1072	95.5	1164	83.3
Early Syphilis	1024	31.2	43	10.0	104	72.6	448	39.9	299	21.4
Under 20 yrs										
Chlamydia	2361	286.0	38	44.5	98	274.5	229	63.6	301	111.5
Gonorrhea	417	50.5	8	9.4	38	106.5	85	23.6	33	12.2
Early Syphilis	18	2.2	1	1.2	3	8.4	13	3.6	0	0.0

Note: Rates are calculated using 2022 Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 10/2023.
* Includes cases designated as "other," "unknown," or missing race/ethnicity.

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

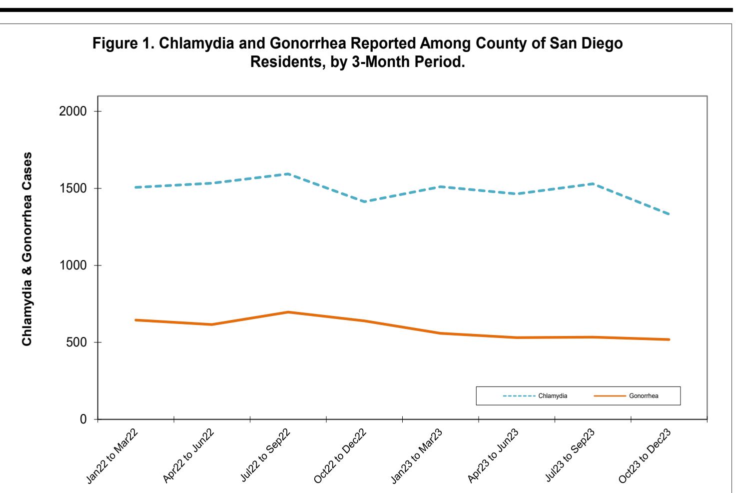


Figure 1. Chlamydia and Gonorrhea Reported Among County of San Diego Residents, by 3-Month Period.

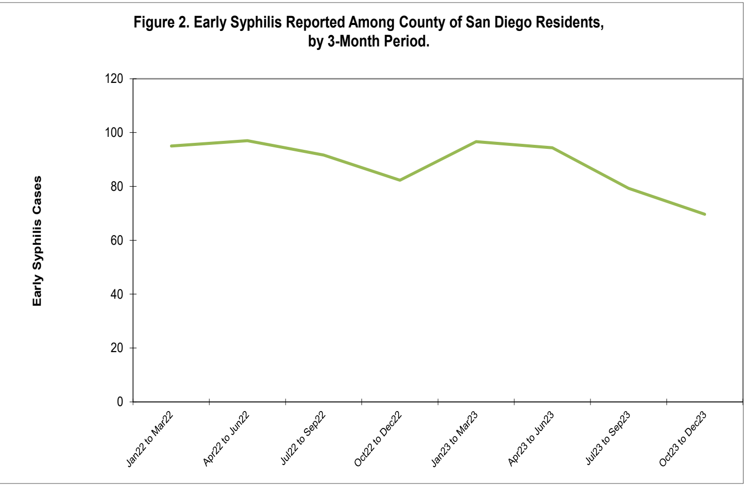


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.

Editorial Note: CDC Confirms JYNNEOS Vaccine Effectiveness Against Mpox Virus Infection

According to a recent report from the Centers for Disease Control and Prevention (CDC), mpox virus infection after receipt of two JYNNEOS vaccine doses is estimated to have occurred in <1% of fully vaccinated persons and comprises a small proportion of national cases (271 of 32,819 cases reported during May 11, 2022-May 1, 2024). The odds of having systemic illness and prevalence of hospitalization were lower among fully vaccinated mpox cases than among unvaccinated cases ($p<0.05$), and no deaths were reported among fully vaccinated mpox cases. This report corroborated other published findings that mpox virus infection in fully vaccinated persons in the United States (U.S.) is rare and less severe regardless of the route of vaccination (i.e., subcutaneous, intradermal, and heterologous) [1].

Despite public perception of an increase in mpox cases among fully vaccinated persons in 2024 and studies indicating that vaccine antibody titers decrease a few months after vaccination, CDC has confirmed that, to date, persistent vaccine-derived immunologic response among persons who received the two-dose vaccine series exists [1][2]. This was based on disparate time intervals from vaccination to infection among fully vaccinated persons, which suggest that immunity is not waning. The clinical significance of waning antibody levels is uncertain, as the level of circulating antibody titers is likely not the only marker of protection conferred by mpox vaccinations. Breakthrough infections have not comprised a significant proportion of mpox infections, including in 2024. Currently, booster doses are not recommended for persons at risk of mpox exposure during the ongoing outbreak [1].

Since October 2023, the Advisory Committee on Immunization Practices (ACIP) recommends routine vaccination with the 2-dose JYNNEOS vaccine series for people aged 18 years and older at risk for mpox [3]. With only one in four eligible U.S. persons fully vaccinated, efforts should be made to increase vaccine coverage and integrate mpox vaccination into routine healthcare of persons who are vulnerable to mpox and at higher risk of complicated or life-threatening mpox illness. Persons who received the first dose >28 days ago should receive their second vaccination as soon as possible to complete the series [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
May 2023 - Feb 2024

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

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

* = Present

1 = Absent for the month

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

JC = Just Cause

EC = Emergency Circumstance

NM = No Meeting

NQ = No Quorum

LIVE WELL
SAN DIEGO

YOUR VOICE MATTERS!

2024 COUNTY OF SAN DIEGO HIV NEEDS ASSESSMENT SURVEY

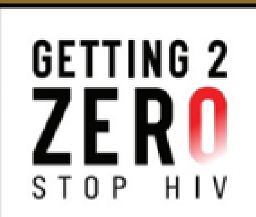
TELL US ABOUT:

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

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

TAKE THE SURVEY ONLINE!

CHECK OUT OUR NEW APP FOR COUNTY'S HIV RESOURCES



hpg.hhsa@sdcounty.ca.gov

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

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

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

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

ADDITIONAL REQUIREMENTS FOR A MEMBER PARTICIPATING REMOTELY:

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

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

AB 2449 Checklist
(Applicable January 1, 2023 to December 31, 2025)

Procedures for Public Participation

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

Procedures for Member to Teleconference from a Remote Location

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

Procedures for the Board/Commission/Committee/Group

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

TELECONFERENCING RULES UNDER THE BROWN ACT

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