SAN DIEGO HIV PLANNING GROUP

Tuesday, August 5, 2025, 3:00 PM – 4:30 PM
County Operations Center
5530 Overland Ave, San Diego, CA 92123
(Training Room 124)

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

TABLE OF CONTENTS

Meeting Location & Directions:

Strategies and Standards Committee

Tuesday, August 5, 2025

3:00 PM - 4:30 PM

County Operations Center

5530 Overland Ave

San Diego, CA 92123

(Training Room 124)

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.

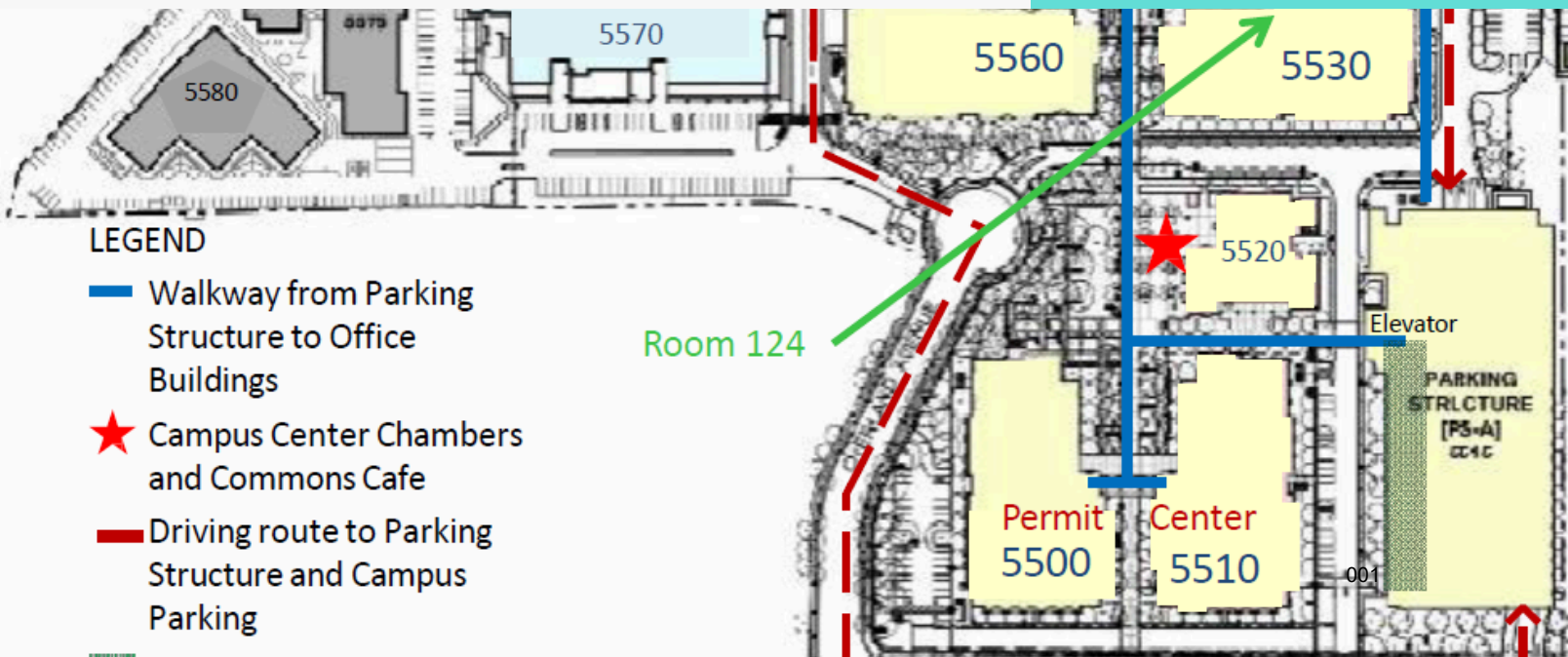
FROM I-15 SOUTH:

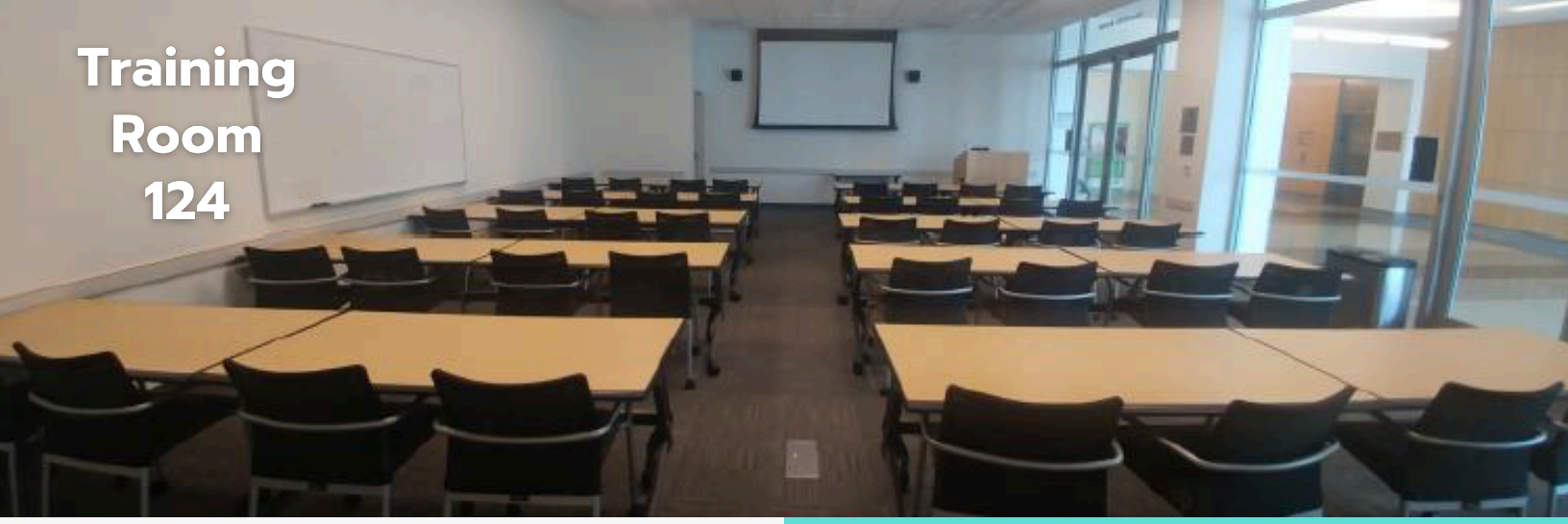
1. Take I-15 North to Exit 10 for Clairemont Mesa Blvd.
2. Turn left onto Clairemont Mesa Blvd.
3. Turn right onto Overland Ave.
4. Continue straight to stay on Overland Ave.

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 5530** will be on your left.

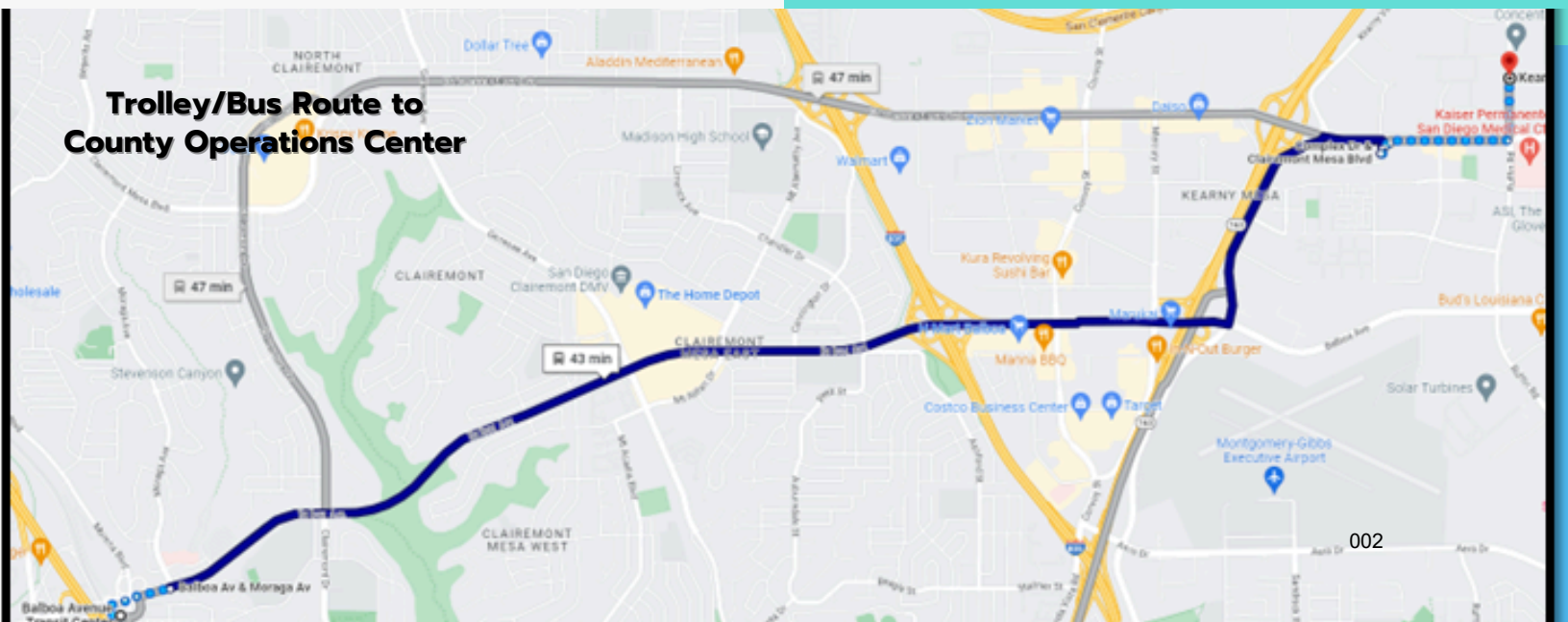
FROM BUS:

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 5530** will be on your **left**.



STRATEGIES & STANDARDS COMMITTEE

Tuesday, August 5, 2025, 3:00 PM – 4:30 PM
County Operations Center
5530 Overland Ave, San Diego, CA 92123
(Training Room 124)

To participate remotely via Zoom:

https://us06web.zoom.us/j/85772860296?pwd=Ym1jWit6cWhnL05BOTlyR25LbWhqQT09

Call in: +1 (669) 444-9171

Meeting ID (access code): 857 7286 0296 **Password:** 630634

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

A quorum for this meeting is seven (7)

Committee Members: Nicole Aguilar | Amy Applebaum | Juan Conant | Beth Davenport | Michael King | Skyler Miles | Joseph Mora | Veronica Nava | Ivy Rooney | Dr. Winston Tilghman | Jeffery Weber | Michael Wimpie (Chair)

ORDER OF BUSINESS

1. Call to order, introductions, comments from the chair, and a moment of silence
2. Public comment (for members of the public)
3. Sharing our concerns (for committee members)
4. **ACTION**: Approve the Strategies & Standards Committee agenda for August 5, 2025
5. **ACTION***:* Approve the Strategies & Standards minutes for June 3, 2025
6. Review follow-up items from last meeting
7. New Business:
    a. **ACTION**: Review and approve Clarification Regarding the Partial Assistance Rental Subsidy (PARS) Waiting List Priorities and Enrollment
    b. **ACTION**: Review and approve the combined Medical/Non-Medical Case Management Standards
    c. **ACTION**: Review and approve the committee meeting attendance policy
8. Old Business:
    a. **ACTION**: Review and approve Service Standards Introduction
    b. **ACTION**: Review and approve Emergency Financial Assistance and Housing Standards
    c. **ACTION**: Review and approve Universal Standards
    d. **ACTION**: Review and approve Trauma-Informed Care guidelines
9. Routine Business:
    a. Recommendations from Priority Setting & Resource Allocation Committee
    b. Recommendations to the HIV Planning Group, HIV Planning Group committees, and requests of recipient
    c. Review: Committee Attendance
    d. Suggested items for the future committee agenda
10. Announcements
11. Next meeting date: October 7, 2025 at 3:00 PM – 4:30 PM
    Location: to be determined and online via Zoom.
12. Adjournment

STRATEGIES AND STANDARDS COMMITTEE

Tuesday, June 3, 2025, 3:00 PM – 4:30 PM
Southeastern Live Well center
5101 Market St, San Diego, CA 92114
Tubman Chavez Room A

A quorum for this meeting is seven (7)
Committee Members: Nicole Aguilar | Amy Applebaum | Beth Davenport | Michael King | Skyler Miles | Joseph Mora | Veronica Nava | Dr. Winston Tilghman | Jeffery Weber | Michael Wimpie (Chair)
Members Absent: Juan Conant | Ivy Rooney

ORDER OF BUSINESS

Agenda Item	Discussion/Action	Follow-Up
1. Call to order, introductions, comments from the chair, and a moment of silence	Michael Wimpie called the meeting to order at 3:00 PM. Introductions were had. A moment of silence was observed.	
2. Public comment (for members of the public)	None	
3. Sharing our concerns (for committee members)	None	
4. **ACTION**: Approve the Strategies and Standards Committee agenda for June 3, 2025	**Motion:** Approve the Strategies and Standards Committee agenda for June 3, 2025 **Motion/Second/Count (M/S/C):** Davenport/Tilghman/9-0 **Abstentions:** none **Motion carries**	
5. **ACTION**: Approve the Strategies and Standards Committee meeting minutes from February 4, 2025	**Motion:** Approve meeting minutes for February 4, 2025 **M/S/C:** Weber/Nava/7-0 **Discussion:** **Abstentions:** King, Tilghman **Motion carries**	
6. Review follow-up items from last meeting	• HPG Support Staff (HPG SS) will forward the Transportation Standards to the HPG for approval. **Completed** • HPG SS will send the word document of the Universal Standards to the committee for additional input and bring back the document for review and	

Agenda Item	Discussion/Action	Follow-Up
	approval at the next meeting. **Completed** • HPG SS will forward the Anti-Racism statement to the Steering Committee for approval. **Completed** • HPG SS will bring back the Emergency Financial Assistance and Housing Service Standards to the committee for further review and the next meeting. **Completed**	
7. New Business		
a. **ACTION**: Approve Service Standards Introduction	Motion tabled The following discussion took place: - ERT in the first paragraph should be ART (Antiretroviral Therapy). - The language is confusing and seems to be missing some components.	HPG Support Staff (HPG SS) to clarify the language and bring the introduction back for discussion.
b. **ACTION**: Approve Non-Medical Case Management Standards	Motion tabled The following discussion took place: - Recommendation to - Clarify what it means to be vulnerable. - Recommendation to add language on the criteria for service eligibility. - Recommendation to replace the word “standardized” with “comprehensive” in the Intake section as different assessment tools are used. - Recommendation to combine medical and non-medical case management components. - Recommendation to remove the word “timely” under the Key Service Components section. - Recommendation to change “non-adherence” to “non-engagement”. - There may be a need for a separate working group.	HPG SS to work with the Recipients’ Office to revise and bring back for review. HPG SS to work with the HPG Chair to approve an ad hoc working group with Joseph Mora, Michael King, Veronica Nava, Amy Applebaum, and Michael Wimpie.

Agenda Item	Discussion/Action	Follow-Up
8. Old Business		
a. **ACTION**: Approve Universal Standards	Motion tabled The following discussion took place: - Add trauma-informed language as the opening section of the Universal Standards - Termination of services: replace second and third dot points with "client exhibits behavior that is not aligned with the safe and welcoming environment" - At the beginning of the document, define what safe and welcoming environment is	HPG SS to look into an additional meeting in July. HPG SS will incorporate discussed suggestions and bring back to the committee for approval.
b. **ACTION**: Approve Trauma-Informed Care Language	Language discussed in 8a and incorporated into the Universal Standards.	
c. **ACTION**: Approve Emergency Financial Assistance and Housing Standards	Tabled	
9. Routine Business		
a. **Discussion**: Recommendations from Priority Setting & Resource Allocation Committee (PSRAC)	Tabled	
b. **Review**: Committee Attendance	Tabled	
c. Recommendations to the HIV Planning Group (HPG), HPG committees, and requests of recipient	Tabled	
d. Suggested items for future committee agenda	Tabled	
10. Announcements	Tabled	
11. Next meeting date	**Date:** Tuesday, August 5, 2025 **Time:** 3:00 PM – 4:30 PM **Location:** TBD	
12. Adjournment	Meeting adjourned at 4:31 PM.	

ACTION ITEM INFORMATION SHEET

RECOMMENDATION FOR CLARIFICATION OF WAITING LIST PRIORITIES FOR NEW CLIENTS FOR PARTIAL ASSISTANCE RENTAL SUBSIDY (PARS)

DATE: August 5, 2025

ITEM: Approve clarification regarding PARS waiting list priorities and enrollment

BACKGROUND:
PARS provides up to 48 months of rental assistance to eligible Ryan White clients. The amount of the subsidy is calculated at 40% of the Fair Market Rent (FMR), published and updated annually by the Department of Housing and Urban Development (HUD).

PARS is a program to promote housing stability, as housing stability is a predictor of success in medical treatment and sustained viral suppression. Under Ryan White legislation, all support for housing must be temporary; ongoing or indefinite support is not allowed. The current recommendation for the duration of housing programs is 24 months, and PARS, while temporary, exceeds what is recommended and reflects the challenges of finding affordable housing in the region.

PARS has two primary purposes. The first is to provide short-term financial support to Ryan White clients to stabilize housing during an unexpected but short-term financial emergency, such as the loss of a roommate or an unexpected car repair. The expectation is that once the short-term emergency has been addressed, the client will be able to transition off PARS and maintain housing stability. The second purpose of PARS is to provide housing stability to clients who can no longer afford their current housing situation while they find more affordable housing. Again, the expectation is that during the 48-month period of the program, clients will find more affordable housing and transition into that housing once the subsidy ends.

Housing support has been ranked as a high need in previous needs assessments of persons living with HIV in San Diego County. To respond to this need, the HIV Planning Group (HPG) has taken several actions. In addition to providing more funding for housing through PARS and Emergency Housing, these actions include the creation and funding of Housing Case Management, a form of non-medical case management focused on clients in the PARS program who require assistance in locating and moving to more affordable housing. The hope is to reduce the waiting list for PARS by helping clients locate more affordable housing.

One concern that has been expressed by members of the public and members of the HPG is the ability of clients who have previously completed a 48-month enrollment in PARS to re-enroll in PARS. While members of the HPG and members of the public support the ability of clients to re-enroll, they have also emphasized providing priority to clients who have not previously enrolled in the program.

RECOMMENDATION:
Following these discussions, the recommendation of this Action Item Information Sheet is to clarify the waiting list policy and adopt the clarifications for the PARS program as described below:

1. Establish two waiting lists. The first waiting list will be for clients requesting PARS who have never been enrolled in PARS. The second waiting list will be for clients who have previously received PARS. When enrollment opportunities in PARS occur, clients will be enrolled first from the waiting list of clients who have not received PARS before. Once clients on that list have been enrolled, declined enrollment, or cannot be contacted for 90 days, clients from the second waiting list will be offered enrollment opportunities.
2. For each waiting list, the position on the waiting list will be based on a first-come, first-qualified basis.

~~Medical~~ Case Management

Service Category Definition

Case management, both medical and non-medical, helps clients navigate and manage needs, including medical and mental health care, benefits programs, housing and rental assistance, food assistance, and emergency financial assistance. Medical and non-medical case management differ only in their goals. Medical case management focuses on helping clients achieve optimal health outcomes related to HIV, including engagement in medical care, treatment adherence, and achievement of viral suppression. Non-medical case management is for clients who require coordination, guidance and assistance in improving access to and retention in needed medical and support services, including support in eliminating barriers.

~~Medical Case Management is the provision of a range of client-centered activities focused on~~ Care managers often work with ~~improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided by~~ an interdisciplinary team that includes ~~other~~ medical providers, specialty care providers, mental health providers, substance use treatment providers, and medical advocates. Case management services include one-on-one meetings between the case manager and the client, and these meetings can take place in-person or via virtual platforms or phone calls. Services also include significant activities outside of these meetings, such as efforts of the case manager to identify services for their clients or participate in treatment team meetings regarding their clients. ~~Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact and any other forms of communication). Case managers function as a part of the interdisciplinary team. Services specifically link clients with health care, psychosocial and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services, and continuity of care through ongoing assessment of the needs and personal support systems of the client.~~

~~The objective of Medical Case Management Services is improving health care outcomes, whereas Non-Medical Case Management Services provide guidance and assistance in improving access to needed services.~~

Purpose and Goals

The goal of ~~medical case management~~case management services is to provide clients

with support to sustain or improve their abilities to live and function optimally. ~~improve overall health outcomes for clients in support of the HIV care continuum by linking to and maintaining them in appropriate care and treatment services while increasing self-sufficiency.~~

Intake

~~Medical case management staff operate as part of the clinical care team.~~ Clients may be referred to ~~medical case managers~~case management by primary care providers, mental health providers or any other provider of services. Clients are also able to self-refer. ~~or other clinical staff. Medical case managers~~Case managers ~~shall assess~~ determine eligibility for services~~each client's need for the service~~ based ~~on a standardized~~upon an initial, documented ~~assessment~~ of immediate needs ~~tool~~. Clients whose needs might be better met by other services, such as Peer Navigation, will be referred to those services. When clients are denied services for any reason other than what is described below under "Exclusions," the provider must document the reasons for the denial of service, document attempts to link the client to other service providers, and notify the County of the number of clients denied services and the reasons why in their monthly progress reports. ~~Clients must demonstrate that they are unable to access or remain in HIV medical care as determined by medical care managers based on whether or not:~~

- ~~Client is currently enrolled in outpatient/ambulatory health services~~
- ~~Client is following their medical plan~~
- ~~Client is keeping medical appointments~~
- ~~Client is taking medication as prescribed~~

Exclusions

Clients who ~~receive HIV medical case management~~can access case management or care coordination services through Medi-Cal or other public or private payers (other than VA or HIS) ~~from any other funding source are~~ are not eligible for this service. ~~Clients without need for the services based on their initial assessment may be referred to non-medical case management services. Likewise, clients who are enrolled in care and in compliance with their treatment plans may be directed to non-medical case management if they require assistance or guidance in obtaining access to certain medical, social, community, financial and other needed services.~~

Key Service Components and Activities

~~These~~ Case management~~services~~ ensure~~s~~ timely and coordinated access to ~~medically appropriate levels of~~ health and support services~~, as well as continuity of care,~~ through ongoing assessment of the needs and personal support systems of the client. ~~Medical c~~Case management can include~~s~~ the provision of treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS treatments.

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client monitoring to assess the efficacy of the plan
- Periodic reevaluation and adaptation of the plan, at least every 6 months
- On~~-~~going assessment of client needs and personal support systems
- Coordination and follow up of medical treatments
- Treatment adherence counseling to ensure readiness for and adherence to ART, nPEP and PrEP~~. complex HIV treatments~~
- Client-specific advocacy and/or review of utilization of services
- Coordination and linkage to services required to implement the plan such as:
    - Health care
    - Psychosocial services
    - Benefits/entitlement counseling and other services
- Referrals assisting clients to access other public and private programs for which they may be eligible (e.g., Medi-Cal, Medicare~~Medi-Cal Part D~~, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local healthcare and supportive services)

~~This includes all types of case management, including face-to-face meetings,~~

~~telephone calls, and any other forms of communication.~~

Personnel Qualifications

~~Medical c~~Case management services are provided by ~~a medical case manager~~staff who meet~~s~~ one or more of the following requirements:

- Master's in Social Work or related field or a registered nurse with a minimum of one-year experience working in the field of HIV/AIDS, or a medical setting, or related field; or
- Bachelor's degree in social work or related field~~, or a registered nurse,~~ and a minimum of two years of experience working in the field of HIV/AIDS; and/or~~, a medical setting or other related field.~~
- ~~Three years of full-time work of direct consumer service experience under the supervision of a health or human service professional.~~
- Work~~, or~~ volunteer experience or lived experience in the field of HIV~~/AIDS~~ that demonstrates competency to provide case management to persons living with or vulnerable to HIV~~/AIDS~~.

Commented [LC1]: Previous dot has or, unclear to me if this one should be the same

Assessment and Service Plan

At the initiation of ~~medical~~ case management services, providers must conduct a comprehensive assessment of each client~~, including factors that affect access to and retention in medical care, such as~~, including:

- Health status
- Medical care and providers
- Activities of daily living
- Mental health status
- Substance ~~abuse~~ use assessment/screening
- Income, benefits and health insurance status
- Employability and/or employment status
- Family/social support system

- ~~Living situation/environment~~Current housing status, quality of housing, and housing needs
- Partner services needs and options
- Disability
- Other factors affecting ability of client to access health and social services

During the initial assessment, providers must also ensure that they assess both income supports and health care supports for clients:

- **Income Supports:** An evaluation for income support benefits that includes consideration of all public, private and community resources, such as the following:
    - Wages
    - Monetary support from family, partner or spouse, or friends
    - General Relief
    - CalFresh (Food stamps)
    - Unemployment
    - State Disability Insurance
    - Supplemental Security Income
    - Social Security Disability Income
    - Private short-term disability insurance
    - Private Long-Term Disability insurance
    - Housing

The Income Support assessment includes reviewing the impact of employment on benefits. ~~Medical c~~Case managers refer clients to state vocational rehabilitation and other employment readiness programs as appropriate.

- **Health Care Supports:** An evaluation for health care benefits includes but is not limited to the following:
    - Medi-Cal

- ~~Medi-Cal Part B~~Medicare
- Private medical insurance, including but not limited to HMOs, PPOs, etc.
- OA HIPP (Health Insurance Premium Payment Program)
- ~~Medi-Cal HIPP (Medi-Cal funded Health Insurance Premium Payment Program)~~
- AIDS Drug Assistance Program (ADAP)
- Covered California
- ~~Health Care Funding~~

~~Non-Medical Case Management~~

~~Service Category Definition~~

~~Non-medical case management services provide guidance and assistance in accessing medical, social, community, legal, financial and other services needed by people living with or vulnerable to acquiring HIV. Non-medical case management services may also include assisting eligible clients to obtain access to other public and private programs and resources for which they may be eligible, such as health insurance marketplace plans, Medi-Cal, Medi-Cal Part D, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services. This category does not include treatment adherence.~~

~~The objective of non-medical case management services is to provide guidance and assistance in improving access to needed services, whereas the objective of medical case management services is to improve health care outcomes.~~

~~Purpose and Goals~~

~~The goal of non-medical case management services is to improve access to medical, social, community, legal, financial and other needed services for clients while increasing self-sufficiency.~~

~~Intake~~

~~Case managers shall assess client need for the service based on a standardized assessment tool. Client must demonstrate that they are able to access or remain in HIV medical care to qualify for non-medical case management services.~~

Exclusions

Clients who receive HIV non-medical case management from any other funding source are not eligible for this service. Clients with no need for the services based on their assessment may be referred to other services.

Key Service Components and Activities

These services include several methods of communication, including face-to-face, phone contact and any other forms of communication deemed appropriate by the Ryan White Program recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six months with adaptations as necessary
- Ongoing assessment of the client's needs and personal support systems
- Timely and coordinated access to appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services

Commented [SY2]: Suggest adding for consistency with HAB PCN 16-02.

Personnel Qualifications

Non-medical case management services are to be provided by individuals trained in or experienced with the local HIV service delivery system who have at least a high school diploma or GED equivalency, with a minimum of two years related professional or volunteer experience.

Assessment and Service Plan

An individual care plan serves as the guiding document for case management activities and is based upon the results of the initial assessment. The individual care plan must be monitored regularly during client visits and should be updated at least every six months during client enrollment.

An individual care plan is based on the completed comprehensive assessment, and

~~includes the following:~~

- ~~Clear description of priority areas for needed services~~
- ~~Measurable objectives and specific action steps to be taken by the client and the case manager, with timelines~~
- ~~Expected outcomes and goals~~
- ~~Regularly updated progress notes~~
- ~~Documentation of phone or face-to-face contact with client at least once every 30 days to discuss changes and progress toward meeting goals of client Individual Care Plan~~
- ~~Updates after reassessment at least once every six months, more frequently as needed~~
- ~~Documentation of all meetings with client via phone or in-person, to be held at least once every 30 days to discuss changes and progress toward meeting goals~~

~~The case manager is to provide regular follow-up procedures to encourage and help maintain a client in medical care. Documentation of all attempts to contact the client shall be in the progress notes. Follow-up may include telephone calls, written correspondence and direct contact.~~

~~Wherever possible, continuity of care shall be maintained by minimizing changes to the individual case manager assigned to work with the client. When a change of individual case manager is necessary, providers shall work to ensure the transition of care is as smooth as possible.~~

Emergency Financial Assistance and Housing

Service Category Definition

Emergency financial assistance:
Emergency financial assistance provides limited one-time or short-term payments to assist the Ryan White HIV/AIDS Program client with an emergent need for paying for essential utilities, limited supplemental rental assistance, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Housing:
Housing services provide limited short-term assistance to support emergency, temporary or transitional housing to enable clients or families to gain or maintain outpatient/ambulatory health services. Housing- related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Purpose and Goals

Housing and emergency financial services are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. The goal of these services is to prevent negative client outcomes as a result of emergency financial and housing difficulties by providing financially stable living situations and environments which enables clients to access or maintain medical and other necessary care and treatment services and improve compliance with medical regimens that improve health outcomes.

Intake

Any Case management program may refer and are responsible for determining clients' need and eligibility for emergency financial assistance and housing assistance. Clients must provide valid proof of the qualifying financial and/or housing emergency. Case managers will coordinate client application intake and initiation of financial assistance services. Case managers may also provide information on other relevant services during the intake process. A new application must be completed for each subsequent emergency. For housing emergencies clients must access other subsidized housing, either tenant or project based prior to accessing Ryan White services.

Key Service Components and Activities

Emergency financial assistance:
Emergency financial assistance provides fiscal support for essential services through either one-time or short-term payments to agencies or the establishment of voucher programs. Services include payments for:

- Utilities (water, electricity, and gas)
- Food (including groceries and food vouchers)
- Medications (on the ADAP formulary)

Emergencies are defined as facing potential loss of basic utilities resulting from past due payments, access to needed medications, food, or housing. Funds provided are intended to help client through a temporary, unplanned crisis.

It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any payment made by this service will be as the payer of last resort

Housing:

Housing assistance is provided in the form of:

- **Emergency housing assistance** offers temporary assistance with housing needs, including:
- Short-term hotel/single room occupancy (SRO) stays of up to 2 weeks at establishments identified and approved of by the Emergency Assistance provider, with extensions possible with prior approval from the County. Payment for stay must be made directly to the hotel/SRO by the Emergency Assistance provider, or with prior approval, the referring case management agency who will be reimbursed by the Emergency Assistance provider; and/or
- Up to 2 months' rent assistance for individuals establishing new housing or facing eviction from current housing. Assistance amount is based upon Fair Market Value for the zip code the housing is located in.
- **Partial Assistance Rent Subsidy (PARS) program** is a short-term, forty-eight (48) month maximum partial rental assistance program designed to transition clients to more stable housing arrangements.

All clients are required to work with their case managers to develop a care plan with the goal of eventual self-sufficiency. Individuals on PARS can continue past the 48-month enrollment cap providing adherence to their individual care plan can be demonstrated. There is no lifetime cap per client.

Standard	Measure
Staff verifies clients' eligibility clients' eligibility and needs based upon applications submitted by case manager.	Retention of the Emergency Assistance Request Form and EARP Budget Worksheet in clients' chart as verification of eligibility.
Staff monitors utilization of services and release funds.	Documentation of services provided/offered to clients with the dates of the services and proof of payment.

Exclusions

Housing services may not:

- Be used for mortgage payments
- Be in the form of direct cash payments to clients
- Be used for rental or security deposits. Such deposits are typically returned to clients as cash which would violate the prohibition on providing cash payments to clients.

Assessment and Service Plan

Case managers will determine the need for financial and housing assistance. Clients will need to submit proof of the need (i.e., past due electrical bill, shut-off notice, eviction warning notices). Emergency financial assistance and housing assistance funds can only be used as a last resort for payment of services and items, and complete or partial assistance with housing payments.

Housing plan: Case managers will develop individualized housing plans for clients covering how each client will receive short term, transitional and emergency housing services. Each plan will include a strategy to assist the client in obtaining stable housing.

Standard	Measure
Staff will ensure that all services provided are accessed appropriately and for a period of time defined by each financial or housing assistance type.	Documentation of services and payments to verify that: • All services provided to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the grantee • Assistance is provided only for the following essential services: utilities, housing, food (including groceries, food vouchers, and food stamps), or medications • Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients • Emergency funds are allocated, tracked, and reported by type of assistance • Ryan White is the payer of last resort • All service providers are for short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care • Type of housing-related services provided including housing assessment, search, placement, advocacy, and the fees associated with them • Mechanisms are in place to allow newly identified clients access to housing services

Universal Standards

Trauma-Informed Services

The County of San Diego Health and Human Services Agency (HHSA) requires all funded and contracted programs be part of a Trauma-Informed System, which includes providing trauma-informed services and maintaining a trauma-informed workforce. It is an approach for engaging individuals—staff, clients, partners, and the community—and recognizing that trauma and chronic stress influence coping strategies and behavior. Trauma-informed systems and services minimize the risk of re-traumatizing individuals and/or families, and promote safety, self-care, and resiliency.

A safe and welcoming environment is a physical and emotional space where all clients and staff, regardless of race, ethnicity, sexual orientation, gender identity, immigration status, income level, religion, or substance use history, feel respected, affirmed, and free from judgment or harm. This environment supports trust, engagement, and retention in care, which are essential for achieving optimal health outcomes for people living with HIV (PLWH).

HHSA has adopted the following Trauma-Informed Principles:

- Understanding trauma and its impact to individuals.
- Promoting safety.
- Awareness of cultural, historical, disability, and gender issues, and ensuring competence and responsiveness.
- Supporting consumer empowerment, control, choice, and independence.
- Sharing power and governance (e.g., including clients and staff at all levels in the development and review of policies and procedures).
- Demonstrating trustworthiness and transparency.
- Integrating services along the continuum of care.
- Believing that establishing safe, authentic, and positive relationships can be healing.
- Understanding that everyone experiences trauma in different ways and recognition that trauma can affect people's physical, mental, emotional, and spiritual well-being.
- Trauma-informed practices are interwoven through the system and are present in ongoing trainings, supervision, and daily operations.
- Understanding that wellness is possible for everyone.

All providers will ensure that all staff shall receive at least annual training regarding trauma-informed systems of care. This training shall include some or all of the following:

- Principles of trauma-informed care
- Working with clients who have or might have a history of trauma, particularly trauma experienced within medical and service delivery systems, with a focus on developing trusting and caring relationships
- Identifying and intervening when clients or staff might be activated
- Tools to de-escalate encounters with clients who are experiencing trauma response
- Developing policies and process that support consumer choice, agency and empowerment

Standard	**Measure**
Agency policies address trauma-informed care	Documentation in policies regarding trauma-informed principles
Staff receive annual training on trauma-informed services	Documentation of all staff trainings on trauma-informed care

	Copies of the curriculum, handouts, etc. kept on file

Intake Requirements

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

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

Once a client has established eligibility, they will be enrolled in the Ryan White program. Clients maintain their enrollment by completing an annual re-enrollment at 12 months. For mid-year recertifications, clients do not need to provide additional documentation unless there has been a change in residency, income, or insurance status. Documentation of residency, income and insurance status is required for all annual re-enrollments.

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

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

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

Also, at the time of intake, providers are required to assess needs of client and their ability to meet these needs through Ryan White services or offer appropriate referrals. To the degree that telehealth appointments are appropriate for, continue to be allowable by third party payors and are provided to clients, information regarding the potential availability of telehealth services as well as the availability of assistance with the provision of necessary equipment and some limited internet access will be provided.

Within 90 days of intake or recertification, providers also assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, and service location. Service information and assessment is also provided regarding temporary housing services, food services, emergency financial assistance, mental health services and substance use treatments, and available transportation. Such information will be provided to clients and documented in ~~ARIES~~ CERS at least once a year thereafter.

[Measure: ~~ARIES~~ CERS note indicating date service information/referrals were provided.]

Additionally, providers are required to review client rights and responsibilities, complaint and

grievance policies and confidentiality and sharing of protected health information.

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

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

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

Client Rights and Responsibilities

Clients have the right to receive services that address their needs, as well as refuse services. Clients may actively engage in decision making. Clients also have the right to involve their family members and/or other identified support persons in support of their care if they wish. Consent will be required in order for any information to be shared directly by providers with such persons. All providers must have written policies and procedures regarding client rights and responsibilities. Clients are informed of these rights and responsibilities during intake and a written copy is made available.

Clients are informed of service expectations in a clear and supportive manner at the time of engagement. If these expectations are not being met, providers will engage the client in a respectful, collaborative conversation to discuss any needed changes and explore supportive options. In some cases, a mutual service agreement may be developed to help clarify goals and ensure continued access to care. The purpose of such agreements is to support the clients' success in the program. If further support is needed, additional steps may be taken in partnership with the clients. No client will be denied services based solely on current or past substance use.~~Clients are informed of expectations when accessing services. If a client does not meet these expectations, the provider is responsible for informing the client of needed changes and a contract may be implemented in order for client to continue receiving services. Failure to comply with a contract may require additional corrective action. Clients will not be denied service due to knowledge of current or prior substance use.~~

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

Standard	Measure

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

Complaint and Grievance Process

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

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

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

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

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

The following is the Goldenrod process:

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

Standard	Measure
Clients' rights are protected, and clients have access to complaint and grievance processes and are made aware of such processes and the outcomes.	Documentation of a complaint and grievance policies and client orientation of processes.

Clients can file a complaint and grievance without being subject to retaliation.	Verification of confidential Client Service Evaluation "Goldenrod" (available in English and Spanish) and mechanism to mail form in an observable location at sites where services are provided.

Case Closure

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

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

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

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

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

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

Termination of Services

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

- Client is deceased
- Client demonstrates repeated non-engagement
- Client exhibits repeated behavior that is not aligned with the safe and welcoming environment ~~demonstrates repeated non-adherence~~
- ~~Client exhibits inappropriate behavior in violation of specific written policies of the provider~~
- Client violates confidentiality of other client(s)

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

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

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

Cultural and Linguistic Competency

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

This competency includes ensuring that eligible, RW-certified transgender people with HIV have access to care, treatment and support services that improve their health and decrease risk of morbidity and mortality related to HIV. All providers will help to ensure eligible, RW certified transgender clients living with HIV are provided with access to gender-affirming services including but not limited to hormone therapy, gender-affirming mental health services and STD testing and treatment.

All providers must have policies and procedures that address cultural competency, diversity, and inclusiveness. Provider's intake procedures will assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, and service location. Staff

working directly with clients must receive a minimum of four hours of cultural competency training each year.

Providers will identify staff and volunteers who can provide bilingual/bicultural services to individuals who need or prefer to communicate in other languages. If there are no staff members or volunteers who can perform this function, the provider will develop alternate methods to ensure language appropriate services are available.

Providers will employ proactive strategies such as partnering with other local organizations to develop a diverse workforce.

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

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

Privacy and Confidentiality

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

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

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

The form must contain:

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

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

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

Universal Standards

Trauma-Informed Services

The County of San Diego Health and Human Services Agency (HHSA) requires all funded and contracted programs be part of a Trauma-Informed System, which includes providing trauma-informed services and maintaining a trauma-informed workforce. It is an approach for engaging individuals—staff, clients, partners, and the community—and recognizing that trauma and chronic stress influence coping strategies and behavior. Trauma-informed systems and services minimize the risk of re-traumatizing individuals and/or families, and promote safety, self-care, and resiliency.

A safe and welcoming environment is a physical and emotional space where all clients and staff, regardless of race, ethnicity, sexual orientation, gender identity, immigration status, income level, religion, or substance use history, feel respected, affirmed, and free from judgment or harm**.** This environment supports trust, engagement, and retention in care**,** which are essential for achieving optimal health outcomes for people living with HIV (PLWH).

HHSA has adopted the following Trauma-Informed Principles:

- Understanding trauma and its impact to individuals.
- Promoting safety.
- Awareness of cultural, historical, disability, and gender issues, and ensuring competence and responsiveness.
- Supporting consumer empowerment, control, choice, and independence.
- Sharing power and governance (e.g., including clients and staff at all levels in the development and review of policies and procedures).
- Demonstrating trustworthiness and transparency.
- Integrating services along the continuum of care.
- Believing that establishing safe, authentic, and positive relationships can be healing.
- Understanding that everyone experiences trauma in different ways and recognition that trauma can affect people's physical, mental, emotional, and spiritual well-being.
- Trauma-informed practices are interwoven through the system and are present in ongoing trainings, supervision, and daily operations.
- Understanding that wellness is possible for everyone.

All providers will ensure that all staff shall receive at least annual training regarding trauma-informed systems of care. This training shall include some or all of the following:

- Principles of trauma-informed care
- Working with clients who have or might have a history of trauma, particularly trauma experienced within medical and service delivery systems, with a focus on developing trusting and caring relationships
- Identifying and intervening when clients or staff might be activated
- Tools to de-escalate encounters with clients who are experiencing trauma response
- Developing policies and process that support consumer choice, agency and empowerment

Standard	**Measure**
Agency policies address trauma-informed care	Documentation in policies regarding trauma-informed principles
Staff receive annual training on trauma-informed services	Documentation of all staff trainings on trauma-informed care

	Copies of the curriculum, handouts, etc. kept on file

Intake Requirements

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

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

Once a client has established eligibility, they will be enrolled in the Ryan White program. Clients maintain their enrollment by completing an annual re-enrollment at 12 months. For mid-year recertifications, clients do not need to provide additional documentation unless there has been a change in residency, income, or insurance status. Documentation of residency, income and insurance status is required for all annual re-enrollments.

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

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

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

Also, at the time of intake, providers are required to assess needs of client and their ability to meet these needs through Ryan White services or offer appropriate referrals. To the degree that telehealth appointments are appropriate for, continue to be allowable by third party payors and are provided to clients, information regarding the potential availability of telehealth services as well as the availability of assistance with the provision of necessary equipment and some limited internet access will be provided.

Within 90 days of intake or recertification, providers also assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, and service location. Service information and assessment is also provided regarding temporary housing services, food services, emergency financial assistance, mental health services and substance use treatments, and available transportation. Such information will be provided to clients and documented in CERS at least once a year thereafter.

[Measure: CERS note indicating date service information/referrals were provided.]

Additionally, providers are required to review client rights and responsibilities, complaint and grievance policies and confidentiality and sharing of protected health information.

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

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

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

Client Rights and Responsibilities

Clients have the right to receive services that address their needs, as well as refuse services. Clients may actively engage in decision making. Clients also have the right to involve their family members and/or other identified support persons in support of their care if they wish. Consent will be required in order for any information to be shared directly by providers with such persons. All providers must have written policies and procedures regarding client rights and responsibilities. Clients are informed of these rights and responsibilities during intake and a written copy is made available.

Clients are informed of service expectations in a clear and supportive manner at the time of engagement. If these expectations are not being met, providers will engage the client in a respectful, collaborative conversation to discuss any needed changes and explore supportive options. In some cases, a mutual service agreement may be developed to help clarify goals and ensure continued access to care. The purpose of such agreements is to support the clients' success in the program. If further support is needed, additional steps may be taken in partnership with the clients. No client will be denied services based solely on current or past substance use.

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

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

Complaint and Grievance Process

In the event clients feel that they are not being heard or services are not being delivered in a

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

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

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

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

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

The following is the Goldenrod process:

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

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

Case Closure

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

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

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

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

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

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

Termination of Services

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

- Client is deceased
- Client demonstrates repeated non-engagement
- Client exhibits repeated behavior that is not aligned with the safe and welcoming

environment
- Client violates confidentiality of other client(s)

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

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

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

Cultural and Linguistic Competency

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

This competency includes ensuring that eligible, RW-certified transgender people with HIV have access to care, treatment and support services that improve their health and decrease risk of morbidity and mortality related to HIV. All providers will help to ensure eligible, RW certified transgender clients living with HIV are provided with access to gender-affirming services including but not limited to hormone therapy, gender-affirming mental health services and STD testing and treatment.

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

Providers will identify staff and volunteers who can provide bilingual/bicultural services to individuals who need or prefer to communicate in other languages. If there are no staff members or volunteers who can perform this function, the provider will develop alternate methods to ensure language appropriate services are available.

Providers will employ proactive strategies such as partnering with other local

organizations to develop a diverse workforce.

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

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

Privacy and Confidentiality

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

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

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

The form must contain:

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

- Client's signature or legal representative's signature

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

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

STRATEGIES AND STANDARDS COMMITTEE

2025 TRAINING/WORK PLAN

MEETING DATE	OBJECTIVES

February 4, 2025	• Review and update:
	  ○ Emergency Financial Assistance and Housing Standards
	• Continue to review and update:
	  ○ Universal Standards
	  ○ Trauma-Informed Care
	  ○ Transportation Standards

April 1, 2025	No meeting

June 3, 2025	• Review and update:
	  ○ Service Standards Introduction
	  ○ Non-Medical Case Management Standards
	  ○ Prevention-Outreach Standards
	• Continue to review and update:
	  ○ Universal Standards
	  ○ Trauma-Informed Care
	  ○ Emergency Financial Assistance and Housing Standards

August 5, 2025	• Review and approve:
	  ○ Changes to the Partial Assistance Rental Subsidy (PARS) waiting list priorities and enrollment
	  ○ Universal Standards
	  ○ Emergency Financial Assistance and Housing Standards
	• Review:
	  ○ Case Management Standards
	• Discussion:
	  ○ Committee meeting attendance policy

October 7, 2025	• Review and approve:
	  ○ Case Management Standards
	  ○ Service Standards Introduction
	• Review data on newly funded service categories

December 7, 2025	• Prevention-Outreach Standards • Develop Standards for Medical Advocacy

HIV PLANNING GROUP
6-MONTH COMMITTEE TRACKING
July 2024 - June 2025

STRATEGIES	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	#
Total meetings		1		1		1		1		0	0	1	5
(12) Members													
Aguilar, Nicole								*		NM	NM	*	**0**
Applebaum, Amy		*		*		*		*		NM	NM	*	**0**
Conant, Juan								*		NM	NM	**1**	**1**
Davenport, Beth		*		*		*		**1**		NM	NM	*	**1**
King, Michael												*	**0**
Miles, Skyler												*	**0**
Mora, Joseph		*		**1**		**1**		*		NM	NM	*	**2**
Nava, Veronica												*	**0**
Rooney, Ivy		*		*		*		*		NM	NM	**1**	**1**
Tilghman, Winston		*		*		*		**1**		NM	NM	*	**1**
Weber, Jeffery		*		*		*		*		NM	NM	*	**0**
Wimpie, Michael [c]		*		*		*		*		NM	NM	*	**0**

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

***** = Present

1 = Absent for the month

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

JC = Just Cause

EC = Emergency Circumstance

NM = No Meeting

NQ = No Quorum

ASSEMBLY BILL (AB) 2302: THE USE OF JUST CAUSE AND EMERGENCY CIRCUMSTANCES (2025)

(An Amendment to AB 2449)

If the physical attendance quorum requirement is met, AB 2302 permits a member who is not physically present to request virtual attendance at the local legislative body's meeting under two circumstances: ***(1) for "just cause"*** *and* ***(2) due to "emergency circumstances"****.*

Qualifying Reason	Provisions to Attend Remotely	Requirements/Limitations
"Just Cause"	▪ There is a childcare or caregiving need (*for a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner*) that requires the member to participate remotely. ▪ A contagious illness prevents the member from attending the meeting in person. ▪ There is a need related to a defined physical or mental disability that is not otherwise accommodated for. ▪ Traveling while on official business of the legislative body or another state or local agency.	A member is limited to **<u>two (2)</u>** virtual attendances due to "just cause" per calendar year.
"Emergency Circumstances"	**"*A physical or family medical emergency that prevents a member from attending the meeting in person*."** A member is ***<u>not</u>*** required to disclose any medical diagnosis or disability, or any personal medical information that is already exempt from existing law.	**A member of the legislative body must:** 1. Make a request to the body to allow the member to meet remotely due to an emergency circumstance; and 2. Provide a general description of no more than 20 words of the circumstance justifying such attendance. A request from a member to attend remotely requires that the legislative body take action and <u>approve</u> the remote attendance at the start of the meeting for the member to be allowed to participate remotely for that meeting[1].

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

Additional Requirements for a Member Participating Remotely

In addition to making a request either for "just cause" or due to an "emergency circumstance" for remote appearance, AB 2302 imposes the following three (3) additional requirements on legislative body members seeking to appear remotely at public meetings:

1. The member:
   - Notifies the legislative body at the earliest opportunity possible, including at the start of a regular meeting, of their need to participate remotely for just cause, including a general description of the circumstances relating to their need to appear remotely at the given meeting. **OR**
   - Requests the legislative body to allow them to participate in the meeting remotely due to emergency circumstances and the legislative body takes action to approve the request. *(See "requirements/limitations" for the use of emergency circumstances.)*
2. The member shall publicly disclose at the meeting before any action is taken, whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.
3. The member shall participate through both audio and visual technology.