Tuesday, August 25, 2026, 3:00 PM – 4:30 PM
County Operations Center
5560 Overland Ave, San Diego, CA 92123
(Meeting Room 172)

The Charge of the Strategies & Standards Committee: To oversee the Integrated Plan and make recommendations to adjust objectives, strategies, and activities to promote the Getting to Zero (GTZ).

TABLE OF CONTENTS

Meeting Location & Directions:

Strategies & Standards Committee

Tuesday, August 25, 2026
3:00 PM - 4:30 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:

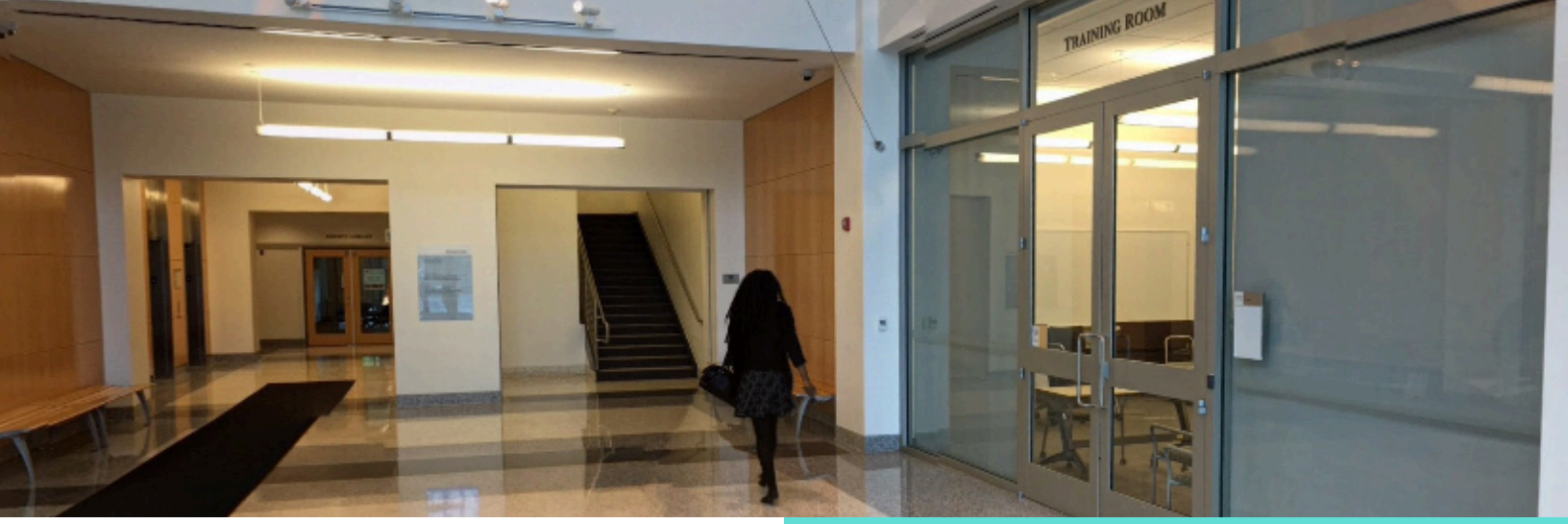
1. Take I-163 North to Exit 8 for Kearny Villa Road.
2. Keep right, follow signs for Kearny Villa Road.
3. Turn right onto Chesapeake Dr.
4. County Operations Center will be on your right.

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.

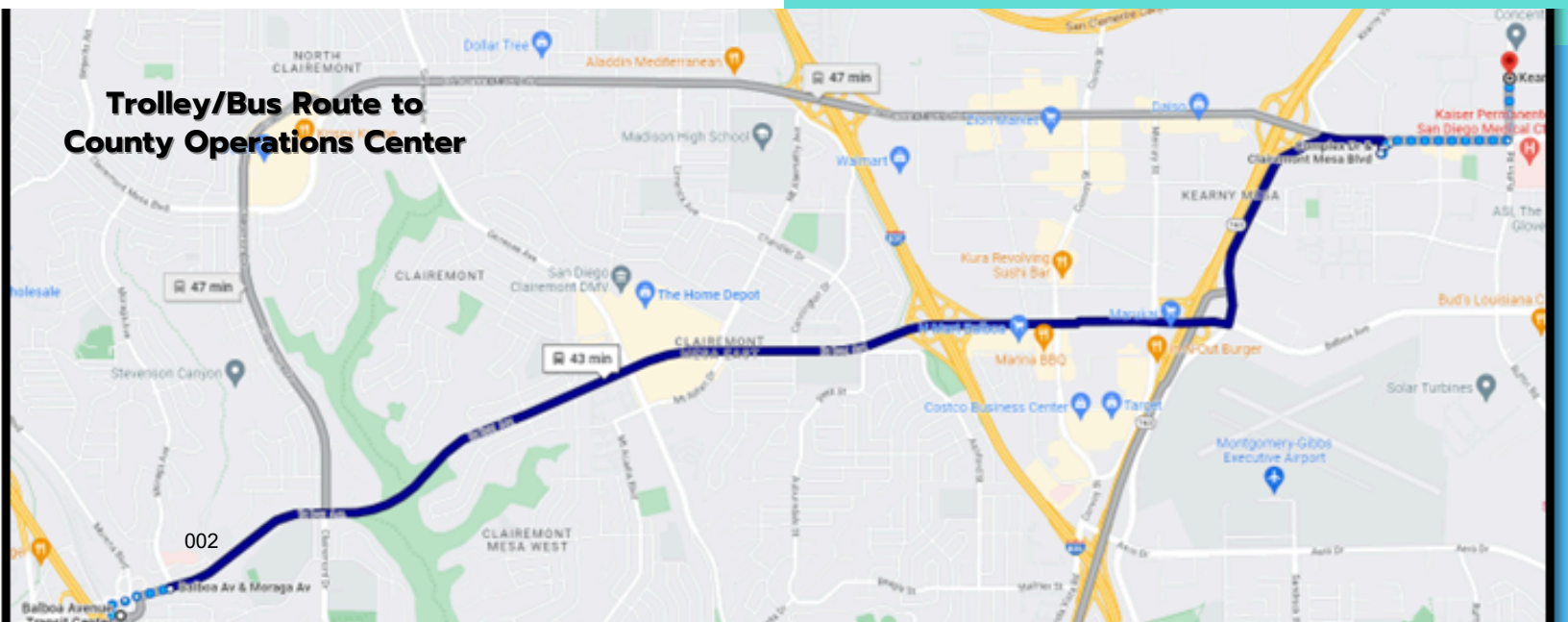
FROM BUS:

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**.



STRATEGIES & STANDARDS COMMITTEE

Tuesday, August 25, 2026, 3:00 PM – 4:30 PM
County Operations Center
5560 Overland Ave, San Diego, CA 92123
(Meeting Room 172)

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 six (6)

Committee Members: Nicole Aguilar | Roger Al-Chaikh | Amy Applebaum | Juan Conant | Beth Davenport | Michael King | Skyler Miles | Joseph Mora | Veronica Nava | Ivy Rooney | Dr. Winston Tilghman | Jeffery Weber (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 25, 2026
5. **ACTION***:* Approve the Strategies & Standards minutes for July 7, 2026
6. Review follow-up items from last meeting
7. Old Business:
    a. **ACTION**: Additional clarification on the extension requirements for the PARS enrollment *(per 5/27/26 HPG meeting recommendation)*
    b. **ACTION**: Revise and approve additional language in Food Bank/Home Delivered Meals Service Standards *(per 5/27/26 HPG meeting recommendation)*
8. New Business:
    a. **ACTION**: Approve a revision to the Attendance Policy regarding minimum attendance requirements
    b. **ACTION**: Review and approve Outreach Service Standards
    c. **ACTION**: Review and approve Service Standards for Psychosocial Support and Health Education
9. Routine Business:
    a. Review: Committee work plan
    b. Review: Committee attendance
    c. Recommendations from Priority Setting & Resource Allocation Committee
    d. Recommendations for Recipient, HIV Planning Group (HPG), and HPG committees
    e. Suggested items for the future committee agenda
10. Announcements
11. Next meeting date: October 6, 2026 at 3:00 PM – 4:30 PM
    Location: Southeastern Live Well Center, 5101 Market St, San Diego, CA, 92114 (Room C)
12. Adjournment

STRATEGIES AND STANDARDS COMMITTEE

Tuesday, July 7, 2026, 3:00 PM – 4:30 PM
County Operations Center
5530 Overland Ave, San Diego, CA 92123
Training Room 124

A quorum for this meeting is six (6)
Committee Members Present: Nicole Aguilar | Juan Conant | Beth Davenport | Michael King | Ivy Rooney | Dr. Winston Tilghman | Jeffery Weber (Chair)
Members Absent: Roger Al-Chaikh | Amy Applebaum | Skyler Miles | Joseph Mora

ORDER OF BUSINESS

Agenda Item	Discussion/Action	Follow-Up
1. Call to order, introductions, comments from the chair, and a moment of silence	Jeffery Weber called the meeting to order at 3:07 PM and noted quorum presence. 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 July 7, 2026	**Motion:** Approve the Strategies and Standards Committee agenda for July 7, 2026 **Motion/Second/Count (M/S/C):** Davenport/King/7-0 **Abstentions:** none **Motion carries**	
5. **ACTION**: Approve the Strategies and Standards Committee meeting minutes from April 7, 2026	**Motion:** Approve meeting minutes for April 7, 2026 **M/S/C:** Rooney/Aguilar/7-0 **Discussion:** none **Abstentions:** none **Motion carries**	
6. Review follow-up items from last meeting		
7. Old Business		
a. **ACTION**: Approve a new Strategies and Standards Committee co-chair	**Motion:** Approve Beth Davenport as the new Strategies and Standards Committee co-chair **M/S/C:** Tilghman/Aguilar/6-0 **Discussion:** none **Abstentions:** Davenport **Motion carries**	

Agenda Item	Discussion/Action	Follow-Up
b. **ACTION**: Additional clarification on the extension requirements for the PARS enrollment *(per 5/27/26 HPG meeting recommendation)*	Motion tabled The following discussion took place: - A request was made at the May HPG meeting to review data related to the impact of the reduced enrollment timelines and the enrollment extension requirements on the waitlist.	The Recipient's Staff has been in contact with a PARS provider and will bring data to the next meeting for discussion.
c. **ACTION**: Revise and approve additional language in Food Bank/Home Delivered Meals Service Standards *(per 5/27/26 HPG meeting recommendation)*	Motion tabled The following discussion took place: - Recommendation to specify a referral process for consumers. - Recommendation to add clarifying language about limited availability of vouchers and that clients may be asked to obtain them from another provider. While this process exists, clients have reported concerns about communication with the provider and access to alternate options.	Recipient's Office will incorporate language based on provider feedback regarding process and will present in August meeting
8. New Business		
a. **ACTION**: Revise and approve Outreach Service Standards	Motion tabled The following discussion took place: - Felipe Ruiz provided clarification on the Outreach Service Standards in their present state. - Suggestion to combine current documents to reflect prevention as part of the care continuum.	Beth Davenport will take word documents and develop a draft for review and consideration at August meeting
b. **ACTION**: Revise and approve Psychosocial Support Services Standards	Motion tabled The following discussion took place: - Felipe Ruiz provided clarification on the Psychosocial Support Services in their present state. - Suggestion to develop a new service standard using language from Psychosocial Support Service Standards,	Jeffery Weber will develop a draft on psychosocial support and health education services for review and consideration at August meeting

Agenda Item	Discussion/Action	Follow-Up
	Health Education and Risk Reduction Standards, and Referral for Healthcare and Support Services Standards.	
c. **ACTION**: Revise and approve Health Education and Risk Reduction Standards	Not applicable. See above.	
d. **ACTION**: Revise and approve Referral for Healthcare and Support Services Standards	Not applicable. See above.	
9. Routine Business		
a. **Review**: Committee work plan	- Request to change August 8th meeting to August 25th at 3 PM, pending quorum.	
b. **Review**: Committee attendance		
c. **Discussion**: Recommendations from Priority Setting & Resource Allocation Committee (PSRAC)	None	
d. Recommendations to the HIV Planning Group (HPG), HPG committees, and requests of recipient	None	
e. Suggested items for future committee agenda	None	
10. Announcements		
11. Next meeting date	**Date:** Tuesday, August 25, 2026 **Time:** 3:00 PM – 4:30 PM **Location:** County Operations Center, 5560 Overland Ave, San Diego, CA 92123 (Training Room 172) and online via Zoom	
12. Adjournment	Meeting adjourned at 4:25 PM.	

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 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 resulting from emergency financial and housing difficulties. This is done through providing financially stable living situations and environments which enable 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 is responsible for determining client's need and eligibility for emergency financial and/or housing assistance. Clients must provide valid proof of the qualifying financial and/or housing emergency. Case managers shall 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), capped at $1,000 per year.
- Food Vouchers, which use the same criteria as described in Food Bank/Home-Delivered Meals, capped at 12 weeks per calendar year
- Grocery bags, which provide up to 12 weeks per year of shelf-stable pantry staples for the eligible Ryan White client and any legally dependent minors or adults
- Medications (on the ADAP formulary), capped at $1,000 per year.

Emergencies are defined as facing potential loss of basic utilities, food or housing or temporary inability to access to needed medications. Funds provided are intended to help eligible clients through a temporary, unplanned crisis.

All other sources of funding in the community for emergency financial assistance must be used and any payment made by this service must be as the payer of last resort.

Housing:
Emergency Housing Assistance offers temporary assistance with housing needs, including:

- Short-term hotel/single room occupancy (SRO) stays of up to 30 days at establishments identified and approved by the Emergency Assistance provider, with extensions possible with prior approval from the County. Payment must be made directly to the hotel/SRO by the Emergency Assistance provider, or with prior approval, the referring case management agency, who shall be reimbursed by the Emergency Assistance provider
- Eviction Prevention, which provides payment to a landlord to prevent loss of housing for a Ryan White eligible client, capped at $2,300 per year.
- Up to two months' rental assistance for individuals establishing new housing. Assistance amount is based upon fair market value for the zip code the housing is located in.
- Partial Assistance Rent Subsidy (PARS) is a short-term, 24-month maximum, partial rental assistance program designed to transition clients to more stable housing arrangements. It provides up to 40% of the Fair Market Rate for rental housing in the client's zip code, as published by HUD.

All clients utilizing PARS are required to meet at least monthly with their case managers to develop and implement a housing plan to promote stable housing, as PARS is a temporary, short-term program. Individuals on PARS can continue past the 24-month enrollment cap, in six-month increments for up to 24 additional months, provided they are enrolled in case management, have a housing plan, attend at least 90% of scheduled appointments, and have shown progress in meeting the objectives of their housing plan.

Standard	Measure
Staff verifies 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 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.

Assessment and Service Plan

Case managers shall work with clients, in-person or virtually, to determine the need for financial and/or housing assistance. 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.

Case managers shall develop individualized housing plans for clients covering how each client

will receive short-term, transitional and emergency housing services. Each plan shall include a strategy to assist the client in obtaining stable housing. Case managers will meet with clients monthly. Clients shall be allowed to miss no more than three (3) consecutive appointments without extenuating circumstances over a period of 12 months.

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 payment 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

STRATEGIES AND STANDARDS COMMITTEE
RECIPIENT REQUEST 2 of 2
08/24/2026

PARS ACTIVE & WAITLIST DEMOGRAPHICS REPORT
AS OF AUGUST 4, 2026

Overview

This write up summarizes demographic information, participation trends, and qualitative program insights for the PARS program based on August 2026 data and additional information provided by the funded provider. The write up includes:

- Active client demographics
- Waitlist activity
- Enrollment trends
- Program operations insights
- Housing case management involvement
- Considerations for future tracking efforts

Waitlist & Enrollment Trends (2023–2026)

The dataset provided by funded provider shows historical monthly figures including new applicants on the waitlist, enrollments, applications received, and total active participants.

Key Patterns

- Waitlist counts typically fluctuate within the 60–70 new applicants range by 2025–2026, demonstrating steady demand.
- Monthly enrollments vary, often between 0–8 clients depending on the month.
- Applications from previously enrolled clients consistently increase over time, culminating in 31 returning applications in August 2026.
- Total active participation numbers generally fall between 70–100 throughout the period.

Demographics

- Race/Ethnicity: Hispanic/Latino is the most represented group (41), followed by Black (12) and White (17). Smaller groups include Asian (3) and American Indian (2).
- Gender: Majority Male (51), with Female (17) and Transgender MTF (7) also represented.
- Age: Clients aged 45+ make up the largest portion (45), followed by 31–44 (28) and 18–30 (2).

- Region: Central region accounts for the highest share (49), followed by East (12), North (8), and South (6).

Active Client Demographics (August 2026)

The active client dataset reflects a total of 86 clients with the following breakdowns.

Age Distribution

- 18–30: 1
- 31–44: 28
- 45+: 57

Regional Distribution

- Central: 63
- East County: 8
- North County: 3
- South Bay: 12

Gender

- Male: 58
- Female: 18
- Trans MTF: 10

Race/Ethnicity

- Hispanic/Latino: 55
- White: 19
- Black/African American: 8
- Asian: 2
- American Indian: 1
- Other: 1

Monthly Additions (July 2026)

- Five new participants were enrolled in July 2026, increasing total active and waitlist combined participation to 99. Among the 99 clients:
    - Gender: 68 Male, 22 Female, 9 Trans MTF
    - Race/Ethnicity: 56 Hispanic/Latino, 27 White, 15 Black/African American, 1 Asian

PARS Enrollment Duration, Suspensions, and Terminations

Participants typically remain in PARS for the full four-year term. Suspensions and terminations occur, though formal tracking is not currently in place.

Suspensions

- Temporary
- Common when participants relocate to new or more affordable housing

- May lead to termination if the participant cannot regain stable housing after displacement or eviction

Terminations occur due to:

- Completion of the four-year term
- Increased income resulting in ineligibility
- Enrollment into other subsidized housing programs (e.g., Section 8, TBRA)
- Relocation outside San Diego County

Tracking Needs

- There is currently no formal tracking of suspension/termination patterns, but this can be implemented moving forward.

Trends Among PARS Participants and Those on the Waitlist

Eligibility Rules & Requirements

- PARS eligibility rules remain stable.
- Some participants require reminder letters to maintain communication with their case manager.

Housing Cost Pressures

- Voucher payment standards continue to change due to ongoing rental increases.

Financial Literacy & Homeownership Support

- RW Housing Case Managers report successful cases where participants saved enough during their PARS term to purchase a home.
- Case managers emphasize bridging the gap between rising housing costs and financial literacy by teaching budgeting and long-term planning.

Waitlist Dynamics

- Some individuals awaiting a second or third term have been on the waitlist for years.
- Current enrollees often join the waitlist before their term ends to secure a future spot.
- Some waitlisted individuals have high needs but face long waits due to the first-come, first-served structure.
- Circumstances may change while waiting; some clients lose housing or move outside the county before a spot becomes available.

Housing Resource Tracking for Waitlisted Clients 45+

- No formal tracking exists for housing resources specific to waitlisted clients over age 45.
- PARS applicants must be enrolled in HOPWA, Section 8, and TBRA, but additional housing resource information from case managers is not routinely collected.

- RW Housing Case Management can begin targeted enrollment and resource tracking for this subgroup if needed.

RW Housing Case Management Participation

- All 87 participants enrolled in PARS are also enrolled in RW Housing Case Management, indicating complete overlap in services and strong coordinated support between programs.

Summary

As of the latest August 4, 2026 data provided by funded provider, PARS reflects a program that continues to serve a predominantly 45+, male, and Hispanic/Latino population, most of whom reside in the Central region of San Diego County. Enrollment and waitlist patterns suggest sustained and significant demand for housing support, as evidenced by consistently high waitlist numbers, recurring applicants, and a total of 99 individuals engaged with the program through active participation or waitlist placement. Participants typically remain enrolled for the full four-year term, though suspensions and terminations do occur due to changes in housing stability, income, eligibility, and relocation. Rising rental prices and the evolving landscape of voucher payment standards continue to shape client experiences, reinforcing the importance of financial literacy and long-term planning—areas where RW Housing Case Management plays a critical role. The full overlap between RW Housing Case Management and PARS enrollment underscores strong program integration and coordinated support. While PARS has established stable eligibility rules and participant expectations, opportunities remain to strengthen tracking around suspensions, terminations, and housing resources—especially for older adults on the waitlist.

Food Bank/Home Delivered Meals

Service Category Definition

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food.

Purpose and Goals

The goal of this service category is to improve and promote better health in clients living with HIV by ensuring they can obtain food items, personal hygiene products (toilet paper, tampons/pads, incontinence products), and household cleaning supplies through the use of food vouchers. For clients who are unable to prepare their own food due to documented medical reasons, this program will provide three pre-prepared meals per day, seven days per week.

Intake

Clients who meet eligibility for Ryan White Part A services can access Food Bank/Home Delivered meals through case management.

The need for food vouchers will be based upon the following:

- Client income at or below the minimum living wage for an individual living in San Diego County, adjusted for the number of people living in the household, including dependent minors, as described by the MIT Living Wage Calculator.
- Assessment of eligibility for programs and services available to client to obtain food, including SNAP and Medi-Cal. Clients who are eligible for SNAP and/or Medi-Cal can only receive Ryan White benefits for a maximum of 90 days per calendar year to provide coverage during the enrollment process. must enroll in those programs within 90 days of entering into Food Bank/Home-Delivered Meals.

Clients will be deemed eligible for food vouchers if they meet income requirements. Clients who are eligible for food benefits under any program (for example, SNAP or Medi-Cal) must enroll and use those benefits. Ryan White Food Vouchers can only supplement but not replace other benefits available to clients. Further, any monetary benefit received from other programs will be deducted from the weekly or monthly Food Voucher amount provided to clients under Ryan White.

The need for home-delivered meals will be made based upon diagnosed medical conditions that interfere with grocery shopping and preparation of food items.

Key Service Components and Activities

This service provides food items to clients, including hot meals or a voucher program to

purchase food. The service also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies

Unallowable costs include:

- Permanent water filtration systems for water entering a home
- Household appliances
- Pet foods
- Other non-essential products

The dollar value of food vouchers will be based upon published guidelines regarding cost of food for residents of San Diego County and will be adjusted annually in March. As of April 2026, the current weekly value of a food voucher is $100 per week for eligible Ryan White clients. For minors who are legal dependents of the Ryan White client, the weekly food voucher value as of April 2026 is $50 for minors under the age of 12 and $100 weekly for minors who are aged 12-17. The weekly food voucher limit will be offset by other food benefits (SNAP, Medi-Cal) received by the client.

Personnel Qualifications

For food vouchers, personnel qualifications are covered by Case Management standards. For Food Banks and providers of Home-Delivered Meals, staff will possess the appropriate licensure/certification in accordance with California regulations.

Assessment and Service Plan

Case managers will assess each client's need for services, and they will repeat that assessment at least every 12 months or when there are changes in client's income or health status. For clients enrolled in home-delivered meals, meal plans will be approved by a registered dietitian. Each client's food distribution plan will be determined at the time of the initial intake/assessment.

STRATEGIES AND STANDARDS COMMITTEE
RECIPIENT REQUEST 1 of 2
08/24/2026

DRAFT LANGUAGE FOR INCORPORATION INTO FOOD BANK/HOME DELIVERED MEALS SERVICE STANDARDS

- **Referral Process for Clients**
  - The Provider shall maintain a clear and accessible referral process for all clients seeking Food Bank or Home-Delivered Meal services.
  - When a client contacts the Provider directly or is referred by another agency, the Provider shall:
    - acknowledge the referral within a reasonable timeframe;
    - inform the client of eligibility criteria and any documentation required; and
    - provide guidance on next steps, including timelines for assessment, service initiation, or placement on a waitlist if applicable.
  - In situations where a client's needs fall outside the scope of the Provider's program or capacity, the Provider shall offer alternate referral options and assist the client in connecting with an appropriate organization.
- **Communication with Clients and Referring Agencies**
  - The Provider shall maintain timely and transparent communication with clients and referring agencies regarding service availability, required follow-up, and any changes to the client's service status.
  - If the Provider is unable to serve a client immediately, they shall inform the client and referring agency of the reason (e.g., waitlist, geographic restriction, program limits) and offer information about alternate resources when appropriate.
  - The Provider shall ensure that communication does not create barriers to access; alternative methods (phone, email, or other communication channels) shall be made available when feasible.
- **Limited Voucher Availability**
  - Food vouchers issued through the program are limited and subject to availability. The Provider shall inform clients at the time of referral or intake that vouchers may not always be in stock or immediately accessible.
  - When voucher supplies are low or unavailable, the Provider shall inform clients as promptly as possible and offer guidance on how to obtain vouchers from another authorized provider, if available.
  - The Provider shall ensure clients understand that voucher availability is not guaranteed and may vary based on funding, inventory, and distribution schedules.
- **Access to Alternate Providers and Service Options**

- The Provider shall maintain a list of authorized alternate food assistance providers, updated regularly, to support clients who need access to services not currently available through the Provider.
- When redirecting a client to another provider, the Provider shall:
  - give clear instructions on how to contact the alternate provider;
  - confirm any required documentation; and
  - advise the client about expected timelines or capacity limitations where such information is known.
- The Provider shall make reasonable efforts to ensure the client does not experience gaps in food access when transitioning between providers, to the extent feasible.

HIV Prevention Overview

HIV Prevention Services reduce the transmission of HIV by reaching and serving populations of focus vulnerable to HIV, including both people living with HIV (PLWH) and HIV negative individuals. The specific service categories are defined by those providing funding to the County of San Diego, Public Health Department – HIV, STD & Hepatitis Branch, including the Centers for Disease Control and Prevention and the State of California Department of Public Health. Currently funded services include, but are subject to change based upon guidance from funders:

- Outreach
- Condom Distribution
- Social Media
- Linkage/Navigation
- Partner Services
- HIV Testing

In addition to adhering to all guidance from funders, service providers shall involve PLWH and HIV negative individuals who are disproportionately impacted by HIV, in planning, design, and implementation of HIV prevention activities. Providers are expected to maintain the priority population's ongoing involvement in an advisory capacity.

Outreach

Service Category Definition

Outreach services promote access to and engagement in appropriate services for people vulnerable to HIV infection, people newly diagnosed or identified as living with HIV and those lost or returning to HIV medical care. Services include identification and providing information/education and referral. When appropriate, staff conducting outreach may accompany clients to initial visits to medical care, case management or navigation services. These services must align with all funder requirements.

Purpose and Goals

Outreach services identify persons who might benefit from a range of HIV services, educate prospective clients about the benefits of the services and provide linkage to services for clients who agree to participate. For those unaware of their status to make them aware of their status and link them to care or, for those that know their status, to engage or reengage them in prevention and care as appropriate. Outreach activities are focused on individuals in priority populations. Outreach contacts may be conducted one-on-one in person and online (depending on the funding source).

Initial Contact

Outreach contacts are for:

- Individuals who do not know their HIV status and need referral to HIV testing
- Individuals who are vulnerable to HIV that would benefit from Pre-Exposure Prophylaxis (PrEP) education and/or navigation services
- Individuals living with HIV that are not in care and need assistance to engage or re-engage in HIV primary medical care

Exclusions

- Outreach conducted under Ryan White Part A funds may not include online outreach activities

- Outreach conducted under Centers of Disease Control and Prevention (CDC) funds may include online outreach activities
- Outreach programs cannot pay for HIV counseling or testing services.

Standard	Measure
Individuals that are vulnerable to acquiring or transmitting HIV are contacted through outreach	Document all in person and online outreach activities with location of contact

Key Service Components and Activities

Outreach services include the provision of the following three activities:

- Identification of people who do not know their HIV status and if eligible linkage into Ryan White Outpatient/ Ambulatory Health Services or other HIV prevention, care and treatment services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status if eligible into Ryan White Outpatient/Ambulatory Health Services or other HIV prevention, care and treatment services

Outreach services are:

- Conducted at times and in places where there is a high probability that individuals vulnerable to or living with HIV infection congregate
- Designed to provide quantified program reporting of activities and outcomes to inform local evaluation of effectiveness
- Planned and delivered in coordination with local HIV continuum of prevention and care and treatment outreach programs to avoid duplication of effort and to address any gaps in services
- Focused on populations known, through local epidemiologic data or review of service utilization data or strategic planning process, to be disproportionately vulnerable to HIV infection

Standard	Measure
Contact appropriate priority and vulnerable populations for services and ensure services are effective and applicable	Document outreach services: • Are planned and delivered in coordination with all local HIV outreach programs to avoid duplication of effort and address any service gaps • Are conducted with priority populations known to be at disproportionately vulnerable to HIV infection • Are conducted with priority communities whose residents have disproportionate risk or establishments frequented by individuals vulnerable to HIV infection • Are designed so that activities and results can be quantified for program reporting and evaluation of effectiveness

Assessment and Service Plan

Outreach workers will determine each individual's knowledge of their HIV status, vulnerability to acquire or transmit HIV and direct the individual to the appropriate service or resources.

- For individuals who do not know their HIV status, refer them to HIV testing
- For individuals who know their status and are negative, refer them to the appropriate prevention resources and services

- For individuals who know their status, are positive, are not in care and need assistance help them engage or re-engage in HIV primary medical care through the appropriate service, as determined by the circumstances

Standard	Measure
Direct individuals to the appropriate services and resources	Document all individuals are directed to the appropriate services based on the HIV status and need

Condom Distribution

Service Category Definition

Venue-based distribution is an HIV and sexually transmitted disease (STD) prevention strategy that helps increase the availability and accessibility of condoms and lubricant in an effort to prevent the spread of HIV. All activities align with funder requirements and the County of San Diego San Diego Condom Distribution Partner Program protocol.

Purpose and Goals

Identify, engage, and collaborate with venues that are frequented by persons vulnerable to HIV and STD infections in communities disproportionately impacted by HIV and STDs. These communities include those marginalized by social, economic, or other structural conditions in addition to communities within the general population in areas of San Diego County with high HIV incidence. Making condoms and lubricant widely available through the program is integral to successful HIV prevention.

Venue Enrollment

Regional providers contact venues to assess readiness to participate in venue-based condom distribution program. Eligible venues, or locations that serve clients and patrons who are populations of focus vulnerable to HIV.

Standard	Measure
Assess the venue for participation in the venue-based condom distribution program	Provider and venue complete Venue Readiness Assessment (VRA)
Enroll qualifying venue for participation in the venue-based condom distribution program	Based on the VRA, qualifying venue contact and provider complete the Participating Venue Information (PVI) form
Maintain up to date records of participating venues	Regional provider forwards documentation to the local program coordinators (Provider and County)

Key Service Components and Activities

Venue-based condom and lubricant distribution is a structural intervention that provides communities with resources needed to prevent the spread of HIV. Venues are enrolled and contacted quarterly to ensure proper display and storage of condoms and lubricant.

Standard	Measure
Venue orders condoms and lubricant directly	Complete customized order form for the California AIDS Clearinghouse (CAC)
Venue receive, display and store condoms and lubricant properly	Regional provider conducts quarterly Venue Progress Checks (VPC)

Assessment and Service Plan

Maintain proper storage, ample supply, and diverse venue locations by tracking the venue sites monthly and performing venue progress checks (VPC) with each venue on a quarterly basis.

Standard	Measure
Track and update list of venues	Document number and name of location in Monthly Progress Reports (MPR)
Venue ensures proper storage and placement of condoms and lubricant	Document on VPC storage and placement of condoms and report completed VPCs in MPR

Social Media

Service Category Definition

Social media platforms and websites are utilized to provide information to communities vulnerable to or living with HIV including those marginalized by social, economic, or other structural conditions in addition to communities in the general population within San Diego County with high HIV incidence. All activities align with funder requirements and the San Diego Materials Review Panel and Site Certification protocols.

Purpose and Goals

Social media platforms and websites are utilized to engage and educate communities vulnerable to or living with HIV to reduce transmission through prevention education. This form of outreach creates access to information and how to access services. This structural intervention provides communities with resources needed to prevent the spread of HIV. Making sexual health education, testing information, and condom distribution sites widely available is integral to successful HIV prevention.

Website and Social Media Review and Certification

Regional websites are developed reviewed and maintained. Review is conducted by a local Materials Review Panel (MRP) composed of community members and public health representative to assess appropriateness based on community standards and accuracy of information.

Standard	Measure
Websites and media information are reviewed and approved as appropriate based on community standards	Materials are submitted to MRP for review and documentation is provided and retained with suggested modification and/or approval
Websites and media platforms are certified based on the kind of information on the site/platform	Certification is documented and kept on file
Social/sexual networking sites are utilized for education, promotion and resources	Social/sexual networking interactions are tracked and reported monthly

Key Service Components an Activities

The regional websites and social media platforms provide accurate and relevant information Countywide to communities vulnerable to and living with HIV. This information is designed to connect community members with education, testing, navigation and resources available within select regions of the County. These efforts are conducted with the support of a countywide technical assistance provider.

Standard	Measure
Websites and media provide information on services related to HIV prevention, testing, primary medical care and support services	Regional providers track and report web hits from regional websites and metrics from social media platforms monthly

Standard	Measure
Messaging is cross promoted, accurate and supports initiatives of the County (e.g. Getting to Zero and Undetectable=Untransmittable)	Countywide technical assistance provider reports aggregate web hits from regional websites and metrics from social media platforms monthly

Assessment and Service Plan

Regional websites and social media platform information dissemination are tracked and reported monthly. Testing is conducted with messaging to assess the most effective way to reach priority populations.

Standard	Measure
Social media activities contain current and accurate appropriate messaging	Content in regional websites is reviewed by MRP prior to posting. A/B testing informs messaging

Linkage / Navigation

Service Category Definition

Navigation services link people to necessary services: medical care, health care benefits, and social support services. The term linkage incorporates the process for getting an HIV negative individual on PrEP or an HIV positive individual on Antiretroviral Therapy (ART) as well as providing any needed support services to obtain and be retained in care. These services must align with all funder requirements.

Purpose and Goals

Navigation is a service to help a person obtain timely, essential and appropriate HIV-related medical care and social support services that will optimize their health and prevent HIV acquisition and transmission. Goals include linking HIV negatives individuals to PrEP to prevent the acquisition of HIV and HIV positives individuals to care to achieve and maintain HIV viral load suppression. This supports the scientifically proven facts that taking PrEP daily helps to prevent HIV. Those who are HIV positive and undetectable cannot transmit HIV (U=U). People with HIV who achieve an undetectable viral load cannot sexually transmit the virus.

Intake

Recruitment and initial contact with service recipients includes sharing information about navigation services, assessing eligibility for assistance programs and readiness to engage in services.

Standard	Measure
All persons who are unaware of their HIV status are referred to HIV testing	Document referrals to HIV testing (see standard on testing)
All persons who test negative are eligible and referred to PrEP navigation and other support services as appropriate	Document HIV negative services recipients who are eligible, screened and accept or reason did not accept service
All persons who test or are known to be positive are eligible and referred to ART navigation and other support services as appropriate	Document HIV positive services recipients and any barriers to initiate and/or maintain engagement in care or reason did not accept service

Key Service Components and Activities

Navigation activities include linking service recipients to the HIV prevention or care system and referral, linkage and assistance with insurance enrollment, transportation, and other supportive services. As well as efforts to dismantle barriers to timely and consistent care and treatment to prevent the acquisition and transmission of HIV as well as improve health outcomes. Navigation programs provide navigation to health care providers, health care benefits, drug assistance program and supportive services.

The training of navigators is essential to ensure staff can meet the needs of service recipients. Recommended approaches include involvement of priority populations in service delivery, safe and secure program environment, trauma-informed approach with consideration of intersectionality, sexual health education, harm reduction, health and wellness with consideration of social determinants of health, and social networks.

Standard	Measure
Identify HIV care and supportive service providers to which the clients will be referred as follows: • People vulnerable to HIV are linked to PrEP navigation • People newly diagnosed with HIV are linked to HIV care and other services • People previously diagnosed with HIV and out of care are linked to HIV care and other services	Navigators maintain referral lists with PrEP providers, HIV primary care providers and providers of supportive services
	Document and report all referrals and outcome of referrals are tracked in funder required data systems

Assessment and Service Plan

Navigation and linkage activities are conducted with specific health outcomes related to engagement in care including screening, enrollment, referral to medical provider, acquiring and filling prescription, initiating medication and following up for retention in care.

Standard	Measure
Clinic/facility establish and update protocols to allow for vulnerable and newly diagnosed persons to be engaged in care as quickly as feasible	Revise and retain protocols as appropriate
Verify client attended the medical appointment	Document release of information and attendance at medical appointment
Link services recipients as quickly as feasible	Document and report on the time from diagnosis (negative or positive) to medical appointment, acquisition of prescription and initiation of medications (PrEP or ART)
Aid to address any barriers to engagement in care	Document efforts to address barriers and delivery or referral to supportive services
Follow up with services recipient as appropriate based on resources and aid address any barriers to retention in care	Document all follow up contacts and efforts to address any barriers

Partner Services

Service Category Definition

HIV Partner Services is a service which assists HIV-positive persons in notifying their sexual and/or needle sharing partners of possible exposure to HIV. HIV Partner Services is always voluntary, client-centered and confidential for both the person living with HIV and their partner(s). HIV Partner Services is free and offered through local health departments. Many community-based organizations partner with the health department to offer HIV Partner Services for their clients and elicit partner locating and identifying information for submission to the health department for notification.

Note: Surveillance-based Partner Services are strictly a health department function and are not included in this service standard. Additionally, anonymous partner notification is a health department function that is not permitted to be performed by any other entity.

Purpose and Goals

Partner Services helps HIV positive people in notifying their sexual and/or needle sharing partners of possible exposure to HIV. Partners are offered and encouraged to test for HIV and STDs in order to ensure timely identification and linkage to care and are either linked to HIV primary care, if positive, or PrEP, if negative.

Intake / Initial Contact

Persons newly identified with HIV, as well as persons who are not virally suppressed are offered Partner Services. Staff will elicit partner locating information.

Standard	Measure
All persons newly diagnosed with HIV will be offered partner services	Documentation that client was offered Partner Services
All persons living with HIV who are not virally suppressed will be offered partner services.	Documentation that client was offered Partner Services

Key Service Components and Activities

HIV Partner Services provides three options for letting partners know they may have been exposed to HIV and/or STDs and provide linkages to testing and medical care.

- Anonymous Third Party: Specially trained local health department staff notifies partners without disclosing any information about the original client.
- Dual Disclosure: The client wants to disclose to partners themselves with the support of trained HIV Partner Services staff. Trained staff can provide immediate linkage to services once the client has told the partner of their exposure.
- Self Disclosure: The client notifies their partner(s), after working with trained Partner Services staff to develop a disclosure plan.

Standard	Measure
Increase number of HIV cases diagnosed	• # of new HIV cases identified • # of HIV positive people who undergo partner services interview • # of partners elicited
Increase number of people who participate in HIV partner services	
Increase number of partners elicited through HIV partner services	

Assessment and Service Plan

Community-based organizations are required to document provision of HIV Partner Services. This includes identifying and locating information for all partners to be notified via third party notification. Separate documentation is required for each partner requiring notification. Community-based organizations can request third party notification from the HIV, STD and Hepatitis Branch Field Services Unit by calling 619-692-8501. Community-based organizations may contact the same number if assistance is needed eliciting partner information.

Standard	Measure
Community-based organizations will provide and document referrals for HIV Partner Services	• Data for partners requiring dual or third party notification is documented on a form designated by the County of San Diego • Data must be entered into a database identified and maintained by the HIV, STD and Hepatitis Branch

Testing

Service Category Definition

Purpose and Goals

Intake / Initial Contact

Standard	Measure

Key Service Components and Activities

Standard	Measure
	•
	•
	•

Assessment and Service Plan

Standard	Measure

Medical Advocacy Services

Service Category Definition

Medical Advocacy Services are designed to help patients navigate the healthcare system, communicate with providers, and make informed decisions through education and information. Additionally, the offer the individual support regarding the emotional and psychological issues related to living with HIV especially navigating complicated medical systems and language barriers that may be present.

This can include:

- Helping with diagnoses, second opinions, hospitalizations, and care decisions
- Supporting seniors or patients with complex needs, including care planning and safety concerns
- Negotiating with connecting to insurance or payment sources, disputing denial of care, and managing medical bills
- Promoting healthy living and preventing hospitalization
- Peer mentorship, advocacy, and for support for remaining connected to medical care

Purpose and Goals

Medical advocacy services help patients navigate the healthcare system, coordinate care, manage medical bills, and ensure their voices are heard in treatment decisions. Additionally, it is meant to increase client self-efficacy and create a support system for individuals with HIV navigating medical treatment and engagement. It is also meant to promoting problem solving, increased service access and development of selfcare steps towards diseases self-management. In addition, to provide a central and dedicated support contact in order to address and minimize crisis situations and stabilize clients' psychological health status to maintain their participation in the care systems.

Key Service Components and Activities

Medical advocacy services exist to help HIV+ patients navigate the healthcare system, Ryan White funded care options, protect patient's rights, improve communication with all providers, and ensure HIV+ individuals receive safe, coordinated, and informed care. Services may include:

- Help patients understand diagnoses, test results, and treatment options.
- Receive Education and information on HIV transmission and how to reduce the risk of transmission including being virally suppressed (U=U)

- Optional individualized plans that support and sustain health behaviors to reduce, limit, and ultimately eliminate HIV related health risks.
- Organize appointments, follow-ups, and transitions between specialists
- Prevent gaps in care by ensuring all providers communicate effectively
- Link patients to financial assistance, legal support, social services, and employer accommodations
- Educate patients about their rights and how to navigate the healthcare system
- Work within the medical systems to resolve complaints and improve communication.
- Provide broader support across medical, financial, and logistical issues
- Address barriers to accessing health care and use resources to support positive health
-

Intake

Services may be accessed through referral from another Ryan White HIV care and/or support service. Individuals may also self-refer, contingent upon verification of Ryan White eligibility. If the Medical Advocacy Services provider is the client's first contact with HIV Care Program, the client must be screened for eligibility as described in the Universal Standards of Care.

Purpose and Goals

The goal of referrals for Medical Advocacy Services is to provide culturally and linguistically appropriate referrals to help HIV+ patients navigate the complex medical and service areas to maintain their health, wellbeing, and maintain connection to all needed medical and care services.

Personnel Qualifications

Medical Advocacy Services providers are *not* required to be licensed or registered in the State of California. However, providers should be trained and knowledgeable in HIV-related issues such as available services, treatment, eligibility services, etc. Services may be provided by paid staff or volunteers. Individual supervision and guidance must be available to all staff as needed. All HCP-funded staff and volunteers providing Medical Advocacy Services must complete an initial training session related to their job description and serving those with HIV.

STRATEGIES AND STANDARDS COMMITTEE

2026 WORK PLAN

MEETING DATE	OBJECTIVES

February 3, 2026	• Continue to review and update:
	  ○ Service Standards Introduction
	  ○ Case Management Standards
	• Discuss and further refine PARS enrollment criteria

April 7, 2026	• Approve:
	  ○ Approve criteria for extension requirements for PARS enrollment
	  ○ Food Bank/Home-Delivered Meals service category
	  ○ Additional Service Standards Introduction updates
	• Develop Medical Advocacy Service Standard

June 2, 2026	Meeting cancelled

July 7, 2026	• Revise additional language in Food Bank/Home Delivered Meals Service Standards *(per 5/27/26 HPG meeting recommendation)*
	• Revise criteria for extension requirements for the PARS enrollment *(per 5/27/26 HPG meeting recommendation)*
	• Revise and approve:
	  ○ Psychosocial Support Services Standards
	  ○ Health Education and Risk Reduction Standards
	  ○ Referral for Healthcare and Support Services Standards

August 25, 2026	• Revise and approve:
	  ○ Psychosocial Support Services Standards
	  ○ Health Education and Risk Reduction Standards
	  ○ Referral for Healthcare and Support Services Standards

October 6, 2026	•
December 1, 2026	*To be determined. Meeting overlaps with the annual Truax event.*

HIV PLANNING GROUP
12-MONTH COMMITTEE TRACKING
August 2025 - July 2026

Strategies and Standards Committee									
	Aug	**Oct**	**Dec**	**Feb**	**Apr**	**June**	**July**	**#**	**# of JC Starting Jan 2026**
Total Meetings	1	1	0	1	1	0	1	**5**	
(11) Members									
Aguilar, Nicole	**1**	*	NM	*	*	NM	*	**1**	
Al-Chaikh, Roger					*	NM	**1**	**1**	
Applebaum, Amy	*	*	NM	*	*	NM	**1**	**1**	
Conant, Juan	**1**	**1**	NM	*	**1**	NM	*	**3**	
Davenport, Beth [cc]	**1**	*	NM	**1**	*	NM	*	**2**	
King, Michael	*	*	NM	**1**	**JC**	NM	*	**1**	**1**
Miles, Skyler	*	**1**	NM	*	*	NM	**1**	**2**	
Mora, Joseph	*	**1**	NM	*	**1**	NM	**1**	**3**	
Rooney, Ivy	*	*	NM	*	*	NM	*	**0**	
Tilghman, Winston	*	*	NM	*	*	NM	*	**0**	
Weber, Jeffery [c]	*	*	NM	*	*	NM	*	**0**	

Committee members are expected to attend all meetings. To remain in good standing and eligible to vote, the committee member may not miss more than two (2) meetings within the 12 months.

***** = Present

1 = Absent for the month

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

JC = Just Cause

NM = No Meeting

NQ = No Quorum

SENATE BILL (SB) 707: THE USE OF JUST CAUSE (2026)

(An Amendment to AB 2302)

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

Qualifying Reason	Provisions to Attend Remotely	Requirements /Limitations
"Just Cause"	▪ Childcare or caregiving need of a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner that requires them to participate remotely. ▪ A contagious illness prevents the member from attending the meeting in person. ▪ A need related to a physical or mental condition not otherwise accommodated by any reasonable accommodations provided. ▪ Travel while on official business of the legislative body or another state or local agency. ▪ An immunocompromised child, parent, grandparent, grandchild, sibling, spouse, or domestic partner of the member that requires the member to participate remotely. ▪ A physical or family medical emergency that prevents a member from attending in person. ▪ Military service obligations that result in a member being unable to attend in person because they are serving under official written orders for active duty, drill, annual training, or any other duty required as a member of the California National Guard or a United States Military Reserve organization that requires the member to be at least 50 miles outside the boundaries of the local agency.	A member is limited to **<u>two (2)</u>** virtual attendances due to "just cause" per calendar year.

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

Additional Information for Members Participating Remotely

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

1. The member shall notify the support staff at the earliest opportunity possible, including at the start of a regular meeting, of their need to participate remotely for just cause, including a general description of the circumstances relating to their need to appear remotely at the given meeting.
2. The member shall publicly disclose at the meeting before any action is taken, whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.
3. The member shall participate through both audio and visual technology.

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

1. The member shall request reasonable accommodation to participate remotely at the time of quorum check prior to each meeting.
2. The member shall participate through both audio and visual technology. Any member with a disability, as defined in Section 12102 of Title 42 of the United States Code, may participate only through audio technology if a physical condition related to their disability results in a need to participate off camera.
3. The member shall disclose at the meeting before any action is taken, whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.