SAN DIEGO HIV PLANNING GROUP (HPG)

Wednesday, October 22, 2025, 3:00 PM – 5:00 PM
Southeastern Live Well Center
5101 Market Street, San Diego, CA 92114
Tubman Chavez Room A

The Charge of the HIV Planning Group: The HIV Planning Group Committee Charge is to set priorities & allocate funds to provide services for people living with HIV/AIDS.

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Meeting Location & Directions:

HIV Planning Group (HPG)
October 22, 2025
3:00 PM – 5:00 PM

Southeastern Live Well Center
5101 Market Street
San Diego, CA 92114
Tubman Chavez Room A

Visitor/Employee parking available in parking structure. Main entrance can be accessed by exiting the parking structure on the 2nd floor and walking down the sidewalk to the left.

FROM I-805 SOUTH:

1. Head northwest on I-805 North.
2. Take exit 12B for Market St.
3. Turn right onto Market St.
4. The destination will be on your right.

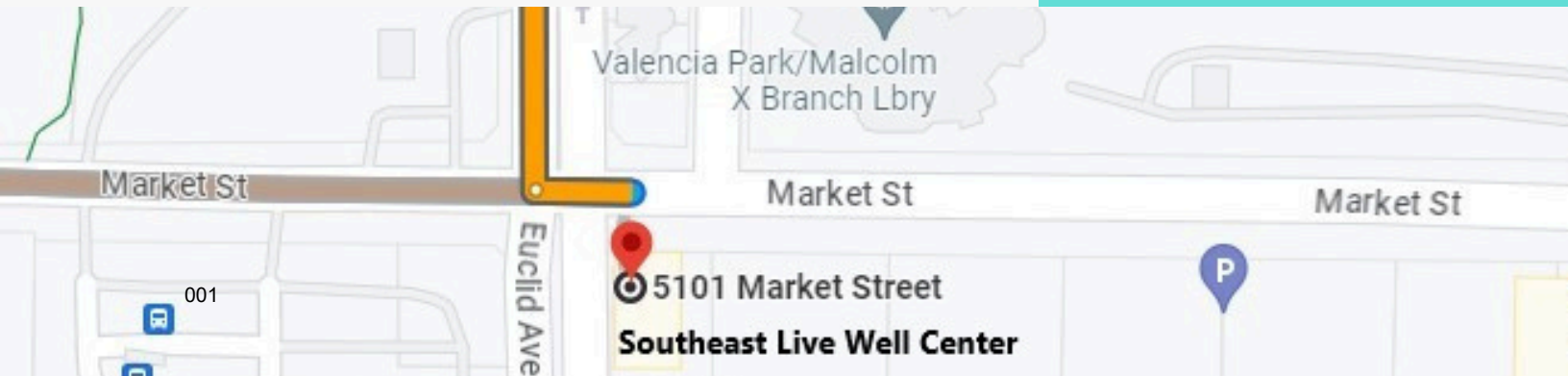
FROM I-805 NORTH:

1. Head southeast on I-805 South.
2. Take exit 13A for CA-94-E/M L King Jr. Fwy.
3. Merge onto CA-94 E.
4. Take exit 4A for Euclid Ave.
5. Turn left onto Euclid Ave.
6. Use the left 2 lanes to turn left onto Market St.
7. The destination will be on your right.

PUBLIC TRANSPORTATION

MTS Trolley:
Orange Line

MTS Bus Routes:
3, 4, 5, 13, 60, 916, 917 and 955



Procedure of HPG Public Requests During HPG Meetings

During public comment periods of HPG meetings, public members sometimes request a variety of things directly or indirectly in their comments (e.g., information/clarification, data, investigation of a circumstance, etc. or may assert circumstances that require clarification to address either in 1:1 communication or in a subsequent meetings).
The process/procedure for responding is as follows.

During each HPG meeting (including the one in which the direct or indirect request is made), the chair or vice-chair will:

Explain the process for a response and indicate that:

1. HPG Support Staff has placed their email and phone number in the chat so that the speaker can contact the staff to discuss and clarify the request. The staff will obtain contact information for any needed follow-up (name, email address, phone number, and preference for communication).

2. When the speaker contacts HPG Support, staff will respond within one business day via email or phone call to obtain contact information and the basic details of the request.

3. The day following the HPG meeting, an internal debrief meeting will be held which includes the review of follow-up items. Follow-up items are discussed and assigned to appropriate personnel to respond further to obtain the required information/clarification. The requestor will be contacted the same business day as the meeting is held. *Items that involve or require provider contract information are assigned to Recipient staff.*

4. If the situation requires further research or data gathering, Support Staff will inform the requestor and provide a good faith estimate of the time required for the research and when the requestor may expect a fuller response from the staff.

5. Every attempt will be made to obtain and communicate the requested information within a 10-day period.

6. When a full response is provided, the follow-up item will be recorded as completed.

HPG CONFLICT OF INTEREST (COI) SHEET

	Conant, Juan	Davenport, Beth	Garcia Bigley, Felipe	Grelotti, David J.	Ignalino, Ben	King, Michael	Matthews, Eva	Nava, Veronica	Paugh, Shannon	Spector, Stephen A.	Van Brocklin, Rhea
CHS: WICYF*											
Early Intervention Services: Regional Services											
Early Intervention Services: Minority AIDS Initiative											
Emergency Financial Assistance											
Food Services: Food Bank/Home Delivered Meals											
Home-Based Health Care Coordination											
Medical Case Management											
Medical Nutrition Services											
Mental Health: Counseling / Therapy											
Mental Health: Psychiatric Medication Management											
Non-Medical Case Management											
Oral Health											
Outpatient Ambulatory Health Services: Medical Specialty											
Outpatient Ambulatory Health Services: Primary Care											
Outreach Services											
Peer Navigation**											
Subtance Use Disorder Treatment: Outpatient											
Subtance Use Disorder Treatment: Residential											
Transportation: Assisted and Unassisted											

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

**Referral for Healthcare and Support Services

No Conflicts

Aguilar, Nicole
Aguirre Mendoza, Marco
Donovan, Michael
Garcia, Rosemary

Fleming, Tyra
Jones, Lori
Kubricky, Cinnamen

Lochner, Michael
Lothridge, Jen
Miles, Skyler
Rooney, Ivy

Weber, Jeffery
Wimpie, Michael
Yancey, Adrienne

Revised 9/18/25

SAN DIEGO HIV PLANNING GROUP (HPG)

Wednesday, October 22, 2025, 3:00 PM – 5:00 PM
Southeastern Live Well Center
5101 Market Street, San Diego, CA 92114
Tubman Chavez Room A

To participate remotely via Zoom:
https://us06web.zoom.us/j/85368987291?pwd=KnO1bBlgoyR53sVY04E8ymyNo6OUq4.1
Call in: +1 (669) 444-9171
Meeting ID (access code): 853 6898 7291 **Password:** SDHPG
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 thirteen (13)
HPG Members: Nicole Aguilar | Marco Aguirre Mendoza | Juan Conant | Beth Davenport | Michael Donovan | Tyra Fleming | Rosemary Garcia | Felipe Garcia-Bigley | David Grelotti | Ben Ignalino | Lori Jones | Michael King | Cinnamen Kubricky *(Vice-Chair)* | Michael Lochner *(Chair)* | Jen Lothridge | Eva Matthews | Skyler Miles | Veronica Nava | Shannon Paugh | Ivy Rooney | Stephen Spector | Rhea Van Brocklin | Jeffery Weber | Michael Wimpie | Adrienne Yancey

ORDER OF BUSINESS

1. Call to order and roll call *(3-3:05)*
2. Welcome, moment of silence, matters from the Chair *(3:05-3:15)*
3. Public comment (for members of the public) – concerns/questions/suggestions for future training topics/agenda items *(3:15-3:25)*
4. HPG Member Open Forum – concerns/questions/suggestions for future training topics/agenda items *(3:25-3:35)*
5. **ACTION:** Approve the HPG agenda for October 22, 2025 *(3:35-3:40)*
6. HIV, STD, and Hepatitis Branch (HSHB) Report *(3:40-3:55)*
7. Routine Business: *(3:55-4:10)*
    a. **ACTION:** Approval of consent agenda for October 22, 2025 which includes:
        i. Approval of HPG minutes from September 24, 2025
        ii. Acceptance of the following committee minutes:

Steering Committee	None
Membership Committee	None
Priority Setting and Resource Allocation Committee	None
Medical Standards and Evaluation Committee	None
Community Engagement Group	September 10, 2025
Strategies and Standards Committee	August 5, 2025

(The following is for HPG information, not for acceptance):

CARE Partnership	*None*

iii. *(Membership Committee)*: HPG appointments/reappointments – none

b. Report Outs:

i. State Office of AIDS (OA) and AIDS Drug Assistance Program (ADAP) – Leroy Blea

ii. Housing Committee – Nicole Aguilar or committee representative

iii. California HIV Planning Group (CHPG) – Mikie Lochner

8. Old Business: *(4:10-4:30)*

a. **ACTION** *(Strategies and Standards Committee)*: Approve changing the PARS enrollment period from 48 months to 24 months, with extension periods allowed in 6-month increments for up to 48 months while clients are actively working on a housing plan

b. **ACTION** *(Strategies and Standards Committee)*: Approve Universal Standards

c. **ACTION** *(Medical Standards and Evaluation Committee)*: Approve Dental Practice Guidelines

9. New Business: *(4:30-4:50)*

a. **ACTION** *(Strategies and Standards Committee)*: Approve Service Standards Introduction

b. **ACTION** *(Strategies and Standards Committee)*: Approve Case Management Standards

c. **ACTION** *(Strategies and Standards Committee)*: Approve Emergency Financial Assistance and Housing Standards

10. HPG Support Staff Updates *(4:50-4:55)*

11. Announcements *(4:55-5:00)*

12. Adjournment *(5:00)*

Next Meeting Date: *one week early* **Wednesday, November 19, 2025,** at **3:00 PM – 5:00 PM**
Location: Southeastern Live Well Center, 5101 Market Street, San Diego, CA 92114 (Tubman Chavez Room C) and via Zoom

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES AND STANDARDS COMMITTEE

ACTION ITEM INFORMATION SHEET
RECOMMENDATION TO APPROVE CHANGE IN PARTIAL ASSISTANCE RENTAL SUBSIDY (PARS) ENROLLMENT PERIOD

DATE: August 5, 2025

ITEM: Approve change in PARS enrollment period

BACKGROUND:
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.

Under Ryan White legislation, all support for housing must be temporary; ongoing or indefinite support is not allowed. The Health Resources and Services Administration's (HRSA) current recommendation for the duration of housing programs is 24 months, and PARS, while temporary, exceeds what is recommended. It currently provides up to 48 months of rental assistance to eligible Ryan White clients. During a discussion at the Strategies and Standards Committee on August 5, 2025, the members discussed the value in aligning PARS with federal guidance and reducing the amount of time clients might be on the waiting list.

Based upon these discussions, the Strategies and Standards Committee recommended modifying PARS enrollment to a period of 24 months and allowing clients to extend their enrollment if they are taking steps to find more affordable housing but have been unable to find affordable housing. Clients would be able to extend their enrollment in six-month increments up to four (4) times as long as they are otherwise actively working with their case manager to find more affordable housing.

RECOMMENDATION:

1. Change the enrollment period for PARS to 24 months, allowing up to four (4) optional extension periods of six (6) months each for clients who are actively working with their case manager to find more affordable housing.

This recommendation comes to the HPG as a seconded motion, open for discussion.

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES AND STANDARDS COMMITTEE

ACTION ITEM INFORMATION SHEET
RECOMMENDATION TO APPROVE UNIVERSAL STANDARDS

DATE: October 22, 2025

ITEM: Approve the revised *Universal Standards*, as recommended by the Strategies and Standards Committee.

BACKGROUND:
The Universal Standards are revised every several years to ensure that all Ryan White-funded providers offer the same fundamental components across service areas. Universal standards further ensure that all services are equitable and accessible to all clients living with HIV/AIDS.
The Strategies and Standards Committee reviewed and recommended the following updates to the *Universal Standards* at its August 5, 2025 meeting:

- Added Trauma-Informed Services Guidelines to the beginning of the document.
- Included additional language to the Client Rights and Responsibilities section on respectful and collaborative conversation expectations.
- Added the following dot point to the Termination of Services section:
    - Client demonstrates repeated non-engagement.
- Updated the Termination of Services section with the following language:
    - Client exhibits repeated behavior that is not aligned with the safe and welcoming environment.

RECOMMENDATION:
Approve the revised *Universal Standards*.

This recommendation comes to the HPG as a seconded motion, open for discussion.

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).

SAN DIEGO HIV PLANNING GROUP (HPG)
MEDICAL STANDARDS AND EVALUATION COMMITTEE (MSEC)

ACTION ITEM INFORMATION SHEET
RECOMMENDATION TO APPROVE DENTAL PRACTICE GUIDELINES

DATE: October 22, 2025

ITEM: Approve the revised *Dental Practice Guidelines*, as recommended by MSEC.

BACKGROUND:
The Dental Practice Guidelines are crucial for improving oral health outcomes among people living with HIV/AIDS. The previously approved guidelines were significantly outdated, and MSEC partnered with the County of San Diego's Chief Dental Officer to provide subject matter expertise in reviewing and revising the document. The Los Angeles County Commission on HIV Health Services was the resource used to develop the new guidelines.
MSEC reviewed and recommended the *Dental Practice Guidelines* at its September 9, 2025 meeting.

RECOMMENDATION:
Approve the revised *Dental Practice Guidelines*.

This recommendation comes to the HPG as a seconded motion, open for discussion.

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

County of San Diego

Original Source:
Los Angeles County
Commission on HIV Health Services

Revised by:
San Diego County Standards of Care Dental Working Group, 9/4/08 and 4/7/11
San Diego County HIV Planning Group Dental Working Group 5/26/20 and 6/22/20
San Diego County Medical Standards & Evaluation Committee 9/9/2025

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

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

San Diego County HIV Planning Group 10/22/2025

Contents

Initial and Periodic Exam

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

Medical Assessment

Annual Health History with updated review at each visit
Review of labs (see laboratory values)

When to Contact the Patient's Primary Care Physician

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

Dental History

History of last dental visit
Oral hygiene routine
Review of diet

Extra-Oral Examination

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

Intra-Oral Examination

Periodontal Examination

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

Soft Tissue Examination (including oral cancer screening)

Many different oral mucosal lesions have been associated with HIV infection including:

- candidiasis
- cryptococcosis, cryptosporidiosis, and histoplasmosis.
- human papillomavirus may lead to condylomata, warts, or cancer.

30-80% of HIV-infected adults will present with abnormal HIV-related intra-oral findings.

- Epstein-Barr virus can lead to oral hairy leukoplakia
- human herpesvirus (HHV-8) may develop into Kaposi's sarcoma
- herpes simplex virus (HSV)
- cytomegalovirus may lead to cytomegalovirus oral ulcers.

Hard Tissue Examination

Xerostomia occurs in up to 40% of HIV positive patients, due to the side effects of some antiretroviral (ARV) medications. The combination of periodontal disease, reduced salivary flow and antibodies increases the likelihood of caries.

Radiographs

As indicated after intra-oral and extra-oral exam is completed but may include full mouth series and/or panorex, bitewings, periapicals.

Laboratory Values (normal ranges for an adult living with HIV)

- At the initial exam a Complete Blood Count (CBC) with differential, CD4 Count, and Viral Load should be reviewed.
- Frequency of labs is based on individual patients and their treatment needs. If CD4 count is greater than or equal to 200 cells/mm^3, a CD4 count is generally checked every six months or as ordered by physician. If CD4 is less than 200 cells/mm^3, a CD4 count is generally checked every 3 months or as ordered by the physician.
- Thrombocytopenia, anemia, and hepatobiliary diseases may occur in the course of HIV disease progression and with opportunistic infections.
- Evaluate each patient on a case-by-case basis. Use the above recommendations as general guidelines and not as an absolute, especially when urgent or emergency care is needed.

CD 4 Count

- The normal value for adults is 500 – 1000 cells/mm^3.
- Patients with values less than 200 cells/mm^3 are considered to have immunocompromise.
- CD4 less than 50 cells/mm^3 – Evaluate patient for opportunistic disease. Usually there is no contraindication with routine dental care. If white count is expected to increase, then you may consider delaying elective dental procedures until white count improves. Emphasize good oral care and have them contact you immediately if oral problems start.

CD4 count is not a reason to not do dental treatment, but instead indicates the immune status of the patient and the risk for certain oral conditions that can affect oral and overall health.

- CD4 monitoring may be done less often for stable patients.

Viral Load

- While the viral load does not indicate the immune status of the patient, it reflects the viral burden in the body and the risk of clinical progression and immunosuppression

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

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

- The viral load itself does not directly influence dental treatment, but a detectable viral load may indicate to the dentist that the patient is not on an optimized ARV regimen and may benefit from timely follow-up with the primary care provider

Platelet Count

- Normal Value (Normal values: 150,000-450,000 cells/mm^3
- Less than 60,000-80,000 consider intervention depending of risk of bleeding

White Blood Cells (total)

- Normal Value 4,000-10,000 cells/mm^3
- Less than 2,000 may want to consider delay of elective procedures and/or use of antibiotic prophylaxis in consultation with physician.

Absolute Neutrophil Counts

- Normal Value
- Less than 500 cells/mm^3 may want to consider delay of elective procedures and/or use of antibiotic prophylaxis in consultation with physician.

Hematocrit (%) (HCT)

- Normal values: female 37-47%, male 42-52%
- Less than 10% consult with physician -consider red cell transfusion for invasive procedures.

Hemoglobin (HGB)

- Normal values: female 12-16q/dL, male 14-18q/dL
- Less than 10 consult with physician -consider red cell transfusion for invasive procedures

Red Blood Cell (RBC)

- Normal values: female 4-5 million/mm^3, male 4-6 million/mm^3.

- Less than 1.0 million/mm^3. Consult with physician - consider red cell transfusion for invasive procedures

Modifications to dental treatment

Antibiotic Prophylaxis

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

Following invasive dental procedures (that involve manipulation of the gingival tissue, manipulation of the periapical region of teeth, or perforation of the oral mucosa) patients with a compromised immune system may be at risk for complications of bacteremia and distant site infection. The American Dental Association states when "white-blood-cell neutrophil counts less than 500 cells/mL, may require antibiotic prophylaxis.[28] However, antibiotic use may predispose patients to adverse drug reactions, superinfection and drug-resistant microorganisms, so antibiotics should be used judiciously, not routinely.[28, 34]" Consultation with the patient's physician is recommended for management of patients with a compromised immune system.

Medications in HIV

Medications may interfere with dental treatment and cause adverse effects, such as decreased salivary flow, altered liver function, and bone marrow suppression, resulting in anemia, thrombocytopenia, and neutropenia. HIV Medicine is a dynamic field and knowledge of ARV medications is constantly evolving. It should be emphasized that long-term clinical data on drug interactions does not exist for many of the newer medications. It is recommended that the dental care provider consult a reference that thoroughly discusses drug side effects and interactions prior to prescribing any medications or consult with the patient's primary care provider.

For more information on specific ARV medications is available at:

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

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

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

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

Other Considerations

A pre-treatment antibacterial mouth rinse will reduce intraoral bacterial load, especially for those patients with periodontal disease.

A six-month recall schedule should be instituted to monitor any oral changes. If the patient has a CD4 count of less than 200 cells/mm^3, a shorter recall period such as a three-month interval should be considered.

Oral hygiene and the use of silver diamine fluoride (SDF) are important in a medically compromised patient. A proactive attitude and an emphasis on prevention should be encouraged. Dental treatment should also be prioritized based on the patient's health and circumstances (e.g. patients without the ability to tolerate long appointments, ability to perform oral hygiene, etc. should be treated with SDF to arrest existing caries and restored with a glass ionomer material when necessary until more definitive treatment can be comfortably and appropriately provided).

Infectious diseases, such as Hepatitis B, Hepatitis C, or Tuberculosis, should be ascertained and preventative protocols followed.

Oral Health Education: Caries Prevention and Smoking

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

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

Nutritional Counseling

Because of certain oral conditions, people living with HIV may have difficulty consuming a balanced diet. The patient may suffer from changes in taste and decreased ability to chew and swallow because of drug-induced xerostomia. This can lead to gastrointestinal upset and nausea, further inhibiting the intake of a balanced diet. It is the role of the dentist to recognize oral manifestations, which are associated with nutritional deficiencies that can cause intraoral manifestations such as vitamin B12, folic acid, etc. Nutritional supplements or referral to the patient's physician or a registered dietitian may be necessary. Some areas to be aware of include:

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

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

Annual Updated Treatment Plan

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

Covered Services

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

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

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

Additional clarification is available on pages 13-15 of the HAB HIV Oral Health Performance

Measures document: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/oralhealthmeasures.pdf.

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

Post-Exposure Prophylaxis (PEP)

Most occupational HIV exposures do not result in the transmission of HIV. There have been no documented reports of transmission from a dentist to a patient. Documentation of the event and assessment of risk remain important. The person who is exposed should be referred immediately to a physician who can provide counseling, testing, and appropriate medications.

Discrimination and Legal Issues

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

Warmline: 800-933-3413

PEPline: 888-448-4911

Perinatal HIV Hotline: 888-448-8765

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

Privacy

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

- Dentists **must** establish an atmosphere in which patients feel comfortable in disclosing their status by indicating on the medical intake form that patients are not discriminated against on the basis of disability, and that all medical information disclosed is confidential.
- Dentists are responsible for training staff to ensure that all patient information is kept confidential and is in accordance with all state laws and the Health Insurance Portability and Accountability Act (HIPAA).
- A thorough discussion of HIV privacy law, including practice tips for protecting the privacy of dental records, can be found in the Schulman article in the Journal of the California Dental Association: https://pubmed.ncbi.nlm.nih.gov/7508498/
- HIPAA guidelines are found at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/index.html. Accessed October 3, 2025.
- Dentists should also refer to information available from the California Department of

Health Services,Office of AIDS at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx. Accessed October 3, 2025.

- In the state of California, written consent of the patient is not required for exchange of treatment-related information between health care providers, as long as that information is obtained for the patient's benefit. However, many medical and dental offices are reluctant to provide lab data over the phone because of the especially sensitive nature of the information. You can more easily obtain medical information related to patient treatment if you offer to fax or mail a consent form.

Selected Bibliography

American Dental Association. Human Immunodeficiency Virus (HIV) Updated August 29, 2023. Accessed October 5, 2025. https://www.ada.org/resources/ada-library/oral-health-topics/hiv

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

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

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

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

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

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

Selected Websites for HIV/AIDS Information

Sites of Particular Interest to Dentists

American Dental Association
https://www.ada.org/en Accessed October 5, 2025
HIVdent
http://www.hivdent.org/ Accessed October 5, 2025
National Institute of Dental & Craniofacial Research
http://www.nidcr.nih.gov/ Accessed October 5, 2025
Pacific AIDS Education and Training Center
http://paetc.org/ Accessed October 5, 2025

American Nursing Association Safe Needles Save Lives
https://www.nursingworld.org/practice-policy/work-environment/health-safety/safe-needles/safe-needles-law/ Accessed October 5, 2025

Other Helpful Links

Morbidity and Mortality Weekly Report (CDC)
http://www.cdc.gov/mmwr/ Accessed October 5, 2025
The Body - A Multimedia AIDS & HIV Information Resource
http://www.thebody.com/index.shtml Accessed October 5, 2025
National HIV/AIDS Clinicians' Consultation Center (Warmline and PEP line)
http://www.nccc.ucsf.edu/ Accessed October 5, 2025
L.A. Public Health Organization: AIDS Info
http://publichealth.lacounty.gov/dhsp/ Accessed October 5, 2025
American Medical Association
http://www.ama-assn.org/ Accessed October 5, 2025
County of San Diego HIV/AIDS Reporting
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/hiv_aids_epidemiology_unit/reporting.html Accessed October 5, 2025

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES AND STANDARDS COMMITTEE

ACTION ITEM INFORMATION SHEET
RECOMMENDATION TO APPROVE SERVICE STANDARDS INTRODUCTION

DATE: October 22, 2025

ITEM: Approve the revised *Service Standards Introduction*, as recommended by the Strategies and Standards Committee.

BACKGROUND:

The Service Standards Introduction is an important component of the service standards. It establishes the foundational context and purpose of the document, ensuring everyone understands why the standards exist and what they are intended to achieve.
The Strategies and Standards Committee reviewed and recommended the *Service Standards Introduction* at its October 7, 2025 meeting.

RECOMMENDATION:

Approve the revised *Service Standards Introduction*.

This recommendation comes to the HPG as a seconded motion, open for discussion.

Service Standards Introduction

The purpose of The Ryan White HIV/AIDS Program (Ryan White) is to find people with Human Immunodeficiency Virus (HIV) who are not receiving primary care, link them to primary care and services, and keep them linked over time. Two primary benefits result. The first is the personal health benefit. Those adherent to the antiretroviral therapy (ART) can achieve viral suppression, at which point the virus can no longer do additional damage to their immune system. The second is a public health benefit. Those who are virally suppressed cannot transmit HIV sexually to others.

The Ryan White Service Standards are minimum expectations for the quality, accessibility, and core components of services provided to people with HIV, ensuring clients receive consistent, high-quality care, regardless of their location. The Standards cover aspects like intake, client confidentiality, trauma-informed system of care, cultural humility, and continuity of care. By setting clear expectations, the Service Standards help improve health outcomes, such as sustained viral suppression, and reduce the spread of HIV.

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES AND STANDARDS COMMITTEE

ACTION ITEM INFORMATION SHEET
RECOMMENDATION TO APPROVE CASE MANAGEMENT STANDARDS

DATE: October 22, 2025

ITEM: Approve the revised *Case Management Standards*, as recommended by the Strategies and Standards Committee.

BACKGROUND:

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. The previously approved Medical Case Management Standards and Non-Medical Case Management Standards were combined into one document in effort to better define the framework, clarify the purpose of case management services, and ultimately help clients better overcome barriers and improve health outcomes.

The Strategies and Standards Committee reviewed and recommended the revised *Case Management Standards* at its October 7, 2025 meeting.

RECOMMENDATION:

Approve the revised *Case Management Standards*.

This recommendation comes to the HPG as a seconded motion, open for discussion.

Case Management Service Standards

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.

Care managers often work with an interdisciplinary team that includes 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.

Purpose and Goals

The goal of case management services is to provide clients with support to sustain or improve their abilities to live and function optimally.

Intake

Clients may be referred to case management by primary care providers, mental health providers or any other provider of services. Clients are also able to self-refer. Case managers shall determine eligibility for services based upon an initial, documented assessment of immediate needs. 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.

Exclusions

Clients who can access case management or care coordination services through Medi-Cal or other public or private payers (other than VA or HIS) are not eligible for this service.

Key Service Components and Activities

Case management ensures timely and coordinated access to health and support services through ongoing assessment of the needs and personal support systems of the client. Case management can include 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
- Ongoing 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
- 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, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services)

Personnel Qualifications

Case management services are provided by staff who meet 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 and a minimum of two years of experience working in the field of HIV/AIDS; and/or
- Work, volunteer experience or lived experience in the field of HIV that demonstrates competency to provide case management to persons living with or vulnerable to HIV.

Assessment and Service Plan

At the initiation of case management services, providers must conduct a comprehensive assessment of each client, including:

- Health status
- Medical care and providers
- Activities of daily living
- Mental health status
- Substance use assessment/screening
- Income, benefits and health insurance status
- Employability and/or employment status
- Family/social support system
- 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 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. 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
  - Medicare
  - Private medical insurance, including but not limited to HMOs, PPOs, etc.
  - OA HIPP (Health Insurance Premium Payment Program)
  - AIDS Drug Assistance Program (ADAP)
  - Covered California

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES AND STANDARDS COMMITTEE

ACTION ITEM INFORMATION SHEET
RECOMMENDATION TO APPROVE EMERGENCY FINANCIAL ASSISTANCE AND HOUSING STANDARDS

DATE: October 22, 2025

ITEM: Approve the revised *Emergency Financial Assistance and Housing Standards*, as recommended by the Strategies and Standards Committee.

BACKGROUND:

The Emergency Financial Assistance and Housing Standards are revised every several years to ensure clients living with HIV/AIDS continue to have access to housing, utilities, and basic needs during emergencies.

The Strategies and Standards Committee reviewed and recommended the following update to the *Emergency Financial Assistance and Housing Standards* at its October 7, 2025 meeting:

- Changes in the Partial Assistance Rent Subsidy (PARS) enrollment period based on the recently approved changes to PARS enrollment period from 48 months to 24 months.

RECOMMENDATION:

Approve the revised *Emergency Financial Assistance and Housing Standards*.

This recommendation comes to the HPG as a seconded motion, open for discussion.

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)
- 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.

All other sources of funding in the community for emergency financial assistance must be effectively 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 two weeks 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; and/or
- Up to two 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) is a short-term, 24-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 24-month enrollment cap, in six-month increments for up to 24 additional months, provided they are actively working on a 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.
- 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 shall determine the need for financial and housing assistance. Clients must 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.

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.

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

RW 2025-26 PART A AWARD INFORMATION	
Funding Source	Total RW 2025-26 Award
Part A	11,941,254.00
Part A MAI	812,482.00
TOTAL AWARD AMOUNT	**12,753,736.00**

RW 2025-26

YEAR TO DATE EXPENDITURE AND SAVINGS BREAK-DOWN

Through August 2025

FY25-26 ALLOCATION BREAK DOWN								
Funding Source	Admin. $	Admin. %	CQM $	CQM %	RW 2025-26 Service dollars	Total	CORE Medical Services	Support Services
Part A	1,149,330	10%	335,660	3%	10,456,264	11,941,254	46.05%	53.95%
Part A MAI	81,248	10%	34,092	4%	697,142	812,482		
TOTAL	**1,230,577.80**		**369,752.07**		**11,153,406.13**	**12,753,736.00**	**49%**	**51%**

Ryan White Part A Allocations — **% Elapsed** **50%**

Service Categories	HRSA Ranking	Priority Ranking	RW 2025-26 HPG Initial Allocation	%	HPG & Recipient Approved Actions +/-	RW 2025-26 HPG Adjusted Allocation	%	RW 2025-26 Year to Date Expenditure	RW 2025-26 Year-to-Date - % Expenditure/Budget)	RW 2025-26 Balance	Comments
Outpatient Ambulatory Health Services: Primary Care	1l	1	1,102,630.00	11%	718,407.00	1,821,037.00	17%	706,238.47	39%	1,114,798.53	
Outpatient Ambulatory Health Services: Medical Specialty	1l	2	195,000.00	2%	-	195,000.00	2%	97,327.03	50%	97,672.97	
Psychiatric Medication Management	1j	12	6,000.00	0%	7,500.00	13,500.00	0%	3,805.93	28%	9,694.07	
Oral Health	1k	3	160,940.00	2%	97,847.00	258,787.00	2%	116,971.46	45%	141,815.54	
Medical Case Management	1h	4	1,151,853.00	12%	(122,000.00)	1,029,853.00	10%	483,896.68	47%	545,956.32	
Non-Medical Case Management for Housing		6	200,000.00	2%	-	200,000.00		7,459.93	4%	-	
Housing: Emergency Housing	2e	9	1,183,515.00	12%	203,717.00	1,387,232.00	13%	549,722.25	40%	837,509.75	
Housing: Location, Placement and Advocacy Services		8	100,000.00	1%	(100,000.00)	-		-	0%	-	
Housing: Partial Assistance Rental Subsidy (PARS)	2e	7	850,507.00	9%	104,000.00	954,507.00	9%	415,036.95	43%	539,470.05	
Non-Medical Case Management	2h	5	392,021.00	4%	(85,000.00)	307,021.00	3%	155,456.09	51%	151,564.91	
Coordinated HIV Services for Women, Infants, Children, Youth, and Families (WICYF)	1c	13	993,157.00	10%	70,000.00	1,063,157.00	10%	492,604.91	46%	570,552.09	
Childcare Services	2a		-	0%	-	-	0%	-	0%	-	
Early Intervention Services: Regional Services	1c	14	790,000.00	8%	(42,000.00)	748,000.00	7%	355,435.67	48%	392,564.33	
Health Education & Risk Reduction	2d	14a	-	0%	-	-	0%	-	0%	-	
Outreach Services	2j	14b	-	0%	-	-	0%	-	0%	-	
Referral Services	2l	14c	-	0%	-	-	0%	-	0%	-	
Referral to Health and Supportive Services (Peer Navigation)		16	260,000.00	3%	(61,148.00)	198,852.00	2%	82,779.57	42%	116,072.43	

Ryan White Part A Allocations								% Elapsed	50%		
Service Categories	HRSA Ranking	Priority Ranking	RW 2025-26 HPG Initial Allocation	%	HPG & Recipient Approved Actions +/-	RW 2025-26 HPG Adjusted Allocation	%	RW 2025-26 Year to Date Expenditure	RW 2025-26 Year-to-Date - % Expenditure/Budget)	RW 2025-26 Balance	Comments
Mental Health: Counseling/Therapy	1j	10	810,000.00	8%	(230,000.00)	580,000.00	6%	275,960.74	48%	304,039.26	
Psychosocial Support Services		17	46,744.00	0%	-	46,744.00	0%	-	0%	-	
Substance Use Services: Outpatient	1m	11	313,127.00	3%	41,010.00	354,137.00	3%	159,299.85	45%	194,837.15	
Substance Abuse Services: Residential	2o	18	-	0%	-	-	0%	-	0%	-	
Home-based Health Care Coordination	1e	19	228,500.00	2%	(15,000.00)	213,500.00	2%	93,898.51	44%	119,601.49	
Transportation: Assisted and Unassisted	2g	20	151,830.00	2%	(60,000.00)	91,830.00	1%	42,539.93	46%	49,290.07	
Food Services: Food Bank/Home-Delivered Meals	2c	21	536,073.00	5%	97,090.00	633,163.00	6%	204,919.65	32%	428,243.35	
Medical Nutrition Therapy	1i	22	35,542.00	0%	-	35,542.00	0%	18,656.86	52%	16,885.14	
Legal Services	2i	23	285,265.00	3%	-	285,265.00	3%	149,784.39	53%	135,480.61	
Emergency Financial Assistance	2b	24	61,856.00	1%	-	61,856.00	1%	23,170.07	37%	38,685.93	
Home Health Care	1f	25	-	0%		-	0%	-	0%	-	
Early Intervention Services: HIV Counseling and Testing	1c	26	-	0%		-	0%	-	0%	-	
Cost-Sharing Assistance	1d	27	-	0%		-	0%	-	0%	-	
Hospice	1g	28	-	0%		-	0%	-	0%	-	
Subtotal			9,854,560.00	100%	624,423.00	10,478,983.00	98%	4,434,964.94	42%	6,044,018.06	

Ryan White Part A Minority AIDS Initiative (MAI)			RW 2025-26 HPG Initial Allocation		HPG & Recipient Approved Actions +/-	RW 2025-26 HPG Adjusted Allocation	%	RW 2025-26 Year to Date Expenditure	RW 2025-26 Year-to-Date - % Expenditure/Budget)	RW 2025-26 Balance	Comments
Multi-Disciplinary Team			593,182.00		-	593,182.00	86%	231,031.30	39%	362,150.70	
Housing: Emergency Housing			100,000.00		-	100,000.00	14%	22,308.59	22%	77,691.41	
		Subtotal	693,182.00		-	693,182.00	100%	253,339.89	37%	439,842.11	
		TOTAL	10,547,742.00		624,423.00	11,172,165.00		4,688,304.83	42%	6,483,860.17	

CORE and Support Sevices Allocation Breakdown						
	Total Allocation	% Allocated	Total Expenditure	% Spent	Total Balance	% Balance
CORE Medical Services	4,825,976.50	46.1%	1,986,263.28	41.2%	2,839,713.22	58.8%
Support Services	5,653,005.00	53.9%	2,230,351.43	39.5%	3,422,653.57	60.5%
TOTAL	10,478,981.50		4,216,614.71		6,262,366.79	

Ryan White Utilization Report

Summary of Services for FY 25

(March 1, 2025 - February 28, 2026)

HIV, STD and Hepatitis Branch

Wednesday, September 24, 2025, 3:00 PM – 5:00 PM
County Operations Center
5530 Overland Ave, San Diego, CA 92123
Training Room 124

A quorum for this meeting is thirteen (13)

HPG Members Joining in Person (22): Nicole Aguilar | Marco Aguirre Mendoza | Juan Conant | Michael Donovan | Tyra Fleming | Rosemary Garcia | Felipe Garcia-Bigley | David Grelotti | Ben Ignalino | Lori Jones | Michael King | Cinnamen Kubricky *(Vice-Chair)* | Michael Lochner *(Chair)* | Jen Lothridge | Eva Matthews | Veronica Nava | Shannon Paugh | Ivy Rooney | Stephen Spector | Rhea Van Brocklin | Jeffery Weber | Michael Wimpie

HPG Members Absent (2): Beth Davenport | Skyler Miles | Adrienne Yancey

ORDER OF BUSINESS

Agenda Item	Discussion/Action	Follow-Up
1. Call to order and roll call	Mikie Lochner called the meeting to order at 3:03 PM and noted the presence of an in-person quorum.	
2. Welcome, moment of silence, matters from the Chair	A moment of silence was observed. The Chair made the following announcements: - A reminder that the Planning Body is here for consumers and to support those living with HIV in San Diego County.	
3. Public comment	The following comments were made: - A concern about access to HIV specialty services. - A request to make available what HPG seats are currently vacant. - A concern about rising expenses. - A concern about the safety of undocumented people.	
4. HPG Member Open Forum	The following comments were made: - A reminder that people living with HIV are dealing with a lot more than just HIV like having to navigate government assistance, family emergencies, and childcare. We are all in this together and need to support each other with hope. - A concern about continuous access to mental health counseling services beyond an intake call. - A reminder to stay consistent with the message and the narrative, given the	

Agenda Item	Discussion/Action	Follow-Up
	current political climate and the amount of misinformation in the media. - A request from the Pacific AIDS Education & Training Center (AETC) representative to present at a future HPG meeting.	
5. Member Recognition and Acknowledgements	The Chair mentioned attending the CASA meeting where they requested a training on how to use their voices to advocate for their community. They also requested having more meeting in the south region.	
6. **ACTION**: Approve the HPG agenda for September 24, 2025	**Motion:** Approve the HPG agenda for September 24, 2025 with an acknowledgement that 10a has been tabled. **Motion/Second/Count (M/S/C):** Donovan/Matthews/21-0 **Discussion:** none **Abstentions:** Lochner **Motion carries**	
7. HIV, STD, and Hepatitis Branch (HSHB) Report	Patrick Loose went over the HSHB report. The following comments were made: - What is the reason PARS is considered emergency assistance if there is a waiting list to get in. - What is the process for deploying allocations approved at HPG.	
8. Routine Business		
a. **ACTION**: Approve the consent agenda for September 24, 2025 which includes: i. HPG minutes (7/23/25, 8/6/25, 8/13/25) ii. Steering Committee minutes (7/11/25); Membership Committee minutes (5/14/25; 7/9/25); Medical Standards and Evaluation Committee minutes (5/13/25); Community Engagement Group minutes (7/16/25); Strategies and Standards Committee minutes (6/3/25); CARE Partnership minutes for information only (7/21/25) iii. Membership Committee: HPG appointments / reappointments	**Motion:** Approve the consent agenda for September 24, 2025 **M/S/C:** Lothridge/Grelotti/20-0 **Discussion:** none **Abstentions:** Kubricky, Lochner **Motion carries**	

Agenda Item	Discussion/Action	Follow-Up
9. Old Business		
a. None		
10. New Business		
a. **Presentation**: Conflicts of Interest – County Counsel	Tabled	
b. **Report**: Assessment of the Administrative Mechanism – Dasha Dahdouh	Dasha Dahdouh presented on the FY24 Assessment of the Administrative Mechanism. The following comments were made: - Appreciation for clear content. - Inquiry into the reason a procurement took over a year. Per the Recipient, there was an active investigation into the protest which was ultimately found to be found merit. All existing contracts that experienced delays were extended to ensure that the provision of services continues and there are no interruptions. - Are data being collected on the timeline between the service delivery and the invoice. Per the Recipient, according to the contract terms, the invoices are due on the 10th of the month for the previous month. Invoices always lag behind the delivery of services.	
c. **ACTION**: Approve MAI funding allocations for FY 25 (March 1, 2025 – February 28, 2026)	**Motion:** Approve MAI funding allocations for FY25. **M/S/C:** Lothridge/Donovan/17-0 **Public Comment:** - A concern that the transgender community is not getting the help they need. **Discussion:** - A concern that MAI is being increased when the funds are being underutilized. **Abstentions:** Garcia-Bigley, King, Lochner, Van Brocklin **Motion carries**	
d. **ACTION***:* Approve FY25 reallocations (March 1, 2025 – February 28, 2026)	**Motion:** Approve a decrease in Oral Health by $77,912 from $336,699 to $258,787. **M/S/C:** Ignalino/Jones/14-0 **Abstentions:** Conant, Garcia-Bigley, King, Kubricky, Lochner, Paugh, Van Brocklin **Motion carries**	

Agenda Item	Discussion/Action	Follow-Up
	Motion: Approve a decrease in Housing: Emergency Housing by $50,000 from $1,009,274 to $959,274 (a former Recipient action). **M/S/C:** Donovan/Weber/20-0 **Abstentions:** Lochner, Van Brocklin **Motion carries** **Motion:** Approve a decrease in Medical Case Management by $50,000 from $1,079,853 to $1,029,853; a decrease in Non-Medical Case Management by $45,000 from $392,021 to $347,021; and a decrease in Early Intervention Services by $25,000 from $773,000 to $748,000. **M/S/C:** Kubricky/Nava/13-0 **Abstentions:** Aguirre Mendoza, Garcia-Bigley, Grelotti, Ignalino, King, Lochner, Paugh, Spector, Van Brocklin **Motion carries** **Motion:** Approve a decrease in Referral to Health and Supportive Services (Peer Navigation) by $70,000 from $268,852 to $198,852. **M/S/C:** Rooney/Lothridge/14-1 **Discussion:** A concern that peer navigation is an important service. Per the Recipient, the amount was added as part of the award that will likely not be spent. **Abstentions:** Garcia-Bigley, Grelotti, King, Kubricky, Lochner, Paugh, Van Brocklin **Motion carries** **Motion:** Approve a decrease in Home-Based Health Care Coordination by $15,000 from $228,500 to $213,500. **M/S/C:** Lochner/Weber/17-0 **Discussion:** A concern was shared about the aging population. **Abstentions:** Conant, Garcia-Bigley, King, Van Brocklin **Motion carries**	

Agenda Item	Discussion/Action	Follow-Up
	Motion: Approve a decrease in Transportation: Assisted and Unassisted by $10,000 from $101,830 to $91,830. **M/S/C:** Lochner/Lothridge/14-0 **Discussion:** **Abstentions:** Conant, Garcia-Bigley, Grelotti, Ignalino, King, Paugh, Spector, Van Brocklin **Motion carries** **Motion:** Approve an increase in Coordinated HIV Services for Women, Infants, Children, Youth and Families (WICYF) by $70,000 from $993,157 to $1,063,157. **M/S/C:** Lochner/Donovan/19-0 **Discussion:** A concern that women may be getting left out of case management. **Abstentions:** Nava, Spector, Van Brocklin **Motion carries** **Motion:** Approve an increase in Partial Assistance Rental Subsidy (PARS) by $104,000 from $160,940 to $264,940; an increase in Food Bank/Home-Delivered Meals by $70,090 from $563,073 to $633,163; and an increase in Substance Use Services: Outpatient by $41,010 from $313,127 to $354,137. **M/S/C:** Lochner/Nava/17-1 **Public Comment:** A concern was shared about the length of the waiting list. **Abstentions:** Fleming, Kubricky, Matthews, Van Brocklin **Motion carries**	
e. **ACTION** *(Steering Committee):* Approve Ryan White Part A carryover funds from FY25 to FY26 in the amount of $427,958 towards Housing: Emergency Housing	**Motion:** Approve Ryan White Part A carryover funds from FY25 to FY26 in the amount of $427,958 towards Housing: Emergency Housing **M/S/C:** Steering Committee/22-0 **Discussion:** none **Abstentions:** none **Motion carries**	
f. **ACTION** *(Strategies and Standards Committee)*: Approve Universal Standards	Tabled	
g. **ACTION** *(Strategies and Standards Committee)*: Approve changing the PARS	Tabled	

Agenda Item	Discussion/Action	Follow-Up
enrollment period from 48 months to 24 months, with extension periods allowed in 6-month increments for up to 48 months while clients are actively working on a housing plan		
11. HPG Support Staff Updates	None	
12. Announcements	- A call for 2025 Dr. A. Brad Truax Award nominations. - North Region Planning Meeting (Town Hall) on Friday, October 10, 2025 at the North Inland Live Well Center at 11:00 AM – 1:00 PM.	
13. Adjournment	The meeting was adjourned at 5:03 PM.	
Next meeting date	Date: Wednesday, October 22, 2025 Time: 3:00 PM – 5:00 PM Location: Southeastern Live Well Center, 5101 Market Street, San Diego, CA 92114 (Tubman Chavez Room A) and via Zoom	

COMMUNITY ENGAGEMENT GROUP

Wednesday, September 10, 2025, from 3:00 PM – 5:00 PM
Southeastern Live Well Center
5101 Market St, San Diego, CA 92114
(Tubman Chavez Room A)

A quorum for this meeting is three (3).
Committee Members Present: Michael Donovan (Chair) | Jen Lothridge (Co-Chair) | Veronica Nava
Committee Members Absent: Hector Garcia

MEETING MINUTES

Agenda Item	Discussion/Action	Follow-Up
1. Call to order, roll call, comments from the chair, and a moment of silence	The chair called the meeting to order at 3:03PM and noted the presence of an in-person quorum.	
2. Review Background, Mission Statement, Goals, and Agreement of Meeting Decorum	Committee members read the Mission Statement and the Community Engagement Group (CEG) Charge. Donovan, Lothridge, and Nava reviewed the meeting decorum.	
3. Introductions (Name, Role with HPG/Consumer, Pronouns), Icebreaker	Members and participants introduced themselves.	
4. Public comment (for members of the public)	A member of the public stated that housing is a problem, and that the PARS program waiting list should be expanded.	
5. Sharing our concerns (for committee members)	None.	
6. **ACTION:** Approve the consent CEG agenda (which includes the September 10, 2025 agenda and the July 16, 2025, minutes)	**Motion:** Approve the consent CEG agenda (which includes the September 10, 2025 agenda and the July 16, 2025, minutes) **Motion/Second/Count (M/S/C):** Nava/Lothridge/2-0 **Abstention(s)**: Donovan **Motion carries**	
Follow-Up Items from minutes:	None.	
7a. Committee Updates		
I. HIV Planning Group (HPG)	The committee has not met since August 13 where they approved all allocations for fiscal year 2026. The next time they are meeting is September 24, and there is a long list of items including reallocations, several documents that are coming from other committee meetings, and a presentation on the Assessment of the Administrative Mechanism.	

Agenda Item	Discussion/Action	Follow-Up
II. Strategies and Standards Committee	The committee is going to meet at the beginning of October. They meet every other month, and in August they approved the Universal Standards and changed the PARS enrollment.	
III. Steering Committee	The committee is going to review and approve the Assessment of the Administrative Mechanism before it goes to the HPG.	
IV. Membership Committee	Currently, the HPG has 25 active members. We've recently appointed 2 new members, and we have several vacancies. There are openings for general member seats, as well as a few designated seats. We've received a handful of applications in the past couple of months, and are in the process of reviewing them, conducting interviews, and inviting potential members to upcoming meetings.	
V. Priority Settings and Resource Allocation Committee (PSRAC)	The committee meeting tomorrow is cancelled. They will try to reschedule for October.	
VI. Medical Standards and Evaluation Committee (MSEC)	The committee reviewed and approved the Dental Practice Guidelines document. They will now be tackling Mental Health Service Standards for the remainder of the year.	
7b. Community Updates		
I. CARE Partnership	CARE Partnership will be meeting this month. They will have a presentation on Sharia's Closet and the IVY study.	
II. HIV Housing Committee/Housing Opportunities for Persons with AIDS (HOPWA)	The member who provided HOPWA updates has stepped down from the committee. The chair and support staff are determining next steps to provide updates during this meeting.	
8. New Business		

a. Presentation: Aging and Independence Services	Matthew Parcasio presented on Aging & Independence Services (AIS) and the following topics were covered:
	- Older Adult Population Projections (60+ Years)
	- AIS Call Center
	- Adult Protective Services
	- Long-Term Care Support
	- Public Guardian & Public Administrator
	- Case Management
	- In-Home Supportive Services
	- Caregiver Support
	- Living Safely
	- Nutrition Programs
	  o Congregate Meal Sites
	  o CalFresh Expansion Program
	- Health & Fitness	

Agenda Item	Discussion/Action	Follow-Up
	- Outreach & Education - Aging Roadmap - AIS Newsletter	
9. Old Business		
a. Committee Attendance	None.	
b. Discussion: Review 2025 CEG workplan	The committee reviewed the 2025 CEG workplan and the following was discussed: - A community member suggested holding a meeting at the downtown library.	
10. Announcements	- San Diego LGBT Center will be hosting Thanksgiving dinner. Stay tuned for more information. - Truax Award call for nominations are due October 5th. - Malcom X Library Gift Day Fundraiser on September 20th.	
11. Next meeting date	**Next Meeting:** Wednesday, October 15, 2025, at 3:00 PM – 5:00 PM **Location**: County Operations Center, 5530 Overland Ave, San Diego, CA 92123, Room 124	
12. Adjournment	Meeting was adjourned at 4:26PM.	

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

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

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 3:03 PM. Introductions were had. A moment of silence was observed. The chair had no comments/updates.	
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 August 5, 2025	**Motion:** Approve the Strategies and Standards Committee agenda for August 5, 2025 **Motion/Second/Count (M/S/C):** Rooney/Weber/7-0 **Abstentions:** none **Motion carries**	
5. **ACTION**: Approve the Strategies and Standards Committee meeting minutes from June 3, 2025	**Motion:** Approve meeting minutes for June 3, 2025 **M/S/C:** King/Tilghman/7-0 **Abstentions:** none **Motion carries**	
6. Review follow-up items from last meeting	• HPG Support Staff (HPG SS) to clarify the Service Standards Introduction language and bring the document back for discussion. **In Progress** • HPG SS to work on the Case Management Standards with the Recipients' Office to revise	

Agenda Item	Discussion/Action	Follow-Up
	and bring back for review. **In Progress** • 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. **In Progress** • HPG SS will incorporate discussion suggestions in the Universal Standards and bring back to the committee for approval. **Completed**	
7. New Business		
a. **ACTION**: Review and approve Clarification Regarding the Partial Assistance Rental Subsidy (PARS) Waiting List Priorities and Enrollment	**Motion:** Approve changing the PARS enrollment period from 48 months to 24 months, with extension periods allowed in 6-month increments for up to 48 months while clients are actively working on a housing plan. **M/S/C:** Miles/Weber/8-0 **Discussion:** The following discussion took place: - The goal of PARS is to provide stable housing while people look for affordable, permanent housing. - Having two lists might create more barriers to reapplying, thus increasing homelessness. - This service is specifically for temporary housing assistance. - Consider decreasing the time on PARS to 24 months (from 48) with a 6-month extension at a time for up to 48 hours. **Abstentions:** none **Motion carries**	HPG SS will bring the revised Action Item to the September HPG meeting
b. **ACTION**: Review and approve combined Medical/Non-Medical Case Management Standards	Motion tabled. The document is still being reviewed and finalized by the HSHB staff.	HPG SS will follow up with the final revisions for the October meeting

Agenda Item	Discussion/Action	Follow-Up
c. **ACTION**: Review and approve the committee meeting attendance policy	The committee has been tasked with developing an attendance policy because they meet every other month. The motion has been tabled until October.	
8. Old Business		
a. **ACTION**: Review and approve Service Standards Introduction	Tabled	
b. **ACTION**: Review and approve Emergency Financial Assistance and Housing Standards	Tabled	
c. **ACTION**: Review and approve Universal Standards	**Motion:** Approve Universal Standards **M/S/C:** Wimpie/Rooney/7-0 **Discussion:** The following discussion took place: - Trauma-Informed Care Guidelines have been incorporated into the Universal Standards. - All suggestions from the previous meeting were addressed in the tracked changes for the committee's reference. **Abstentions:** none **Motion carries**	
d. **ACTION**: Review and approve Trauma-Informed Care guidelines	The document has been incorporated into the Universal Standards.	
9. Routine Business		
a. **Discussion**: Recommendations from Priority Setting & Resource Allocation Committee (PSRAC)	None	
b. Recommendations to the HIV Planning Group (HPG), HPG committees, and requests of recipient	None	

Agenda Item	Discussion/Action	Follow-Up
c. **Review**: Committee Attendance	The attendance summary was reviewed as part of agenda items 7c.	
d. Suggested items for future committee agenda	None	
10. Announcements	None	
11. Next meeting date	**Date:** Tuesday, October 7, 2025 **Time:** 3:00 PM – 4:30 PM **Location:** to be determined and via Zoom.	
12. Adjournment	Meeting adjourned at 4:30 PM.	

Office of AIDS and AIDS Drug Assistance Program
Updates

- **ADAP Client and EW Satisfaction Survey:** The ADAP Client and Enrollment Workers Satisfaction Survey will gather feedback from selected ADAP clients and EWs across California. Approximately 30 randomly selected ADAP enrollment sites will invite up to 10 clients per site to participate in a short, confidential survey. This survey reflects the services and support provided by the Office of AIDS (OA), not the performance of the selected sites and EWs. The surveys will help OA improve access and satisfaction with ADAP services. More information will be available in the coming weeks.

- **ADAP and PrEP-AP Income Policy Exemption:** A management memo (MM) was sent to EWs on August 8th outlining the income exemption policy for clients who are above the income limits due to variable income (e.g., tips, commissions, bonuses), but still within 5% of the income threshold.

- **Addition of Doxycycline Post-Exposure Prophylaxis (DoxyPEP)** to the PrEP-AP Immediate Access Formulary: A MM was sent to EWs on August 14th which informs PrEP-AP EWs & Clinical Providers that effective July 25, 2025, doxycycline has been added to the PrEP-AP Immediate Access formulary including for use as DoxyPEP to prevent sexually treated infections (STIs). Individuals may enroll in PrEP-AP Immediate Access to rapidly access 30 days of either Pre-Exposure Prophylaxis (PrEP) or Post-Exposure Prophylaxis (PEP) medications for the prevention of HIV.

- **PrEP-AP Updates Allowable Services:** A management memo was sent on September 4th, notifying PrEP-AP Clinical providers of additions to PrEP-AP's Allowable PrEP Related Medical Services.

- **Covered California Open Enrollment Dates:** Covered California's open-enrollment period for 2026 begins on November 1, 2025, and runs through January 31, 2026. During this time, consumers can sign up for new health coverage. In addition, renewal for Covered California begins on October 15, 2025. At that time, consumers can review their current plan, make changes for 2026, or opt back into their existing coverage.

- **ADAP Enrollment Worker Advisory Committee (AEWAC):** AEWAC met on October 9, 2025, and discussed upcoming Medi-Cal policy changes, suggestions for improving the ADAP Enrollment System, and ways to streamline documentation requirements for clients.

- **Employer Based - Health Insurance Premium Payment (EB-HIPP) Program Expansion to Non-ADAP Primary Insured:** A management memo was sent to Enrollment Workers informing them that effective July 1, 2025, the EB-HIPP program expanded benefits to include paying the premiums for an ADAP client who is enrolled as a spouse or dependent on their spouse's, registered domestic partner's (RDP), or parent's employer-based health insurance plan.

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.