Tuesday, November 4, 2025, from 4:00 PM – 5:30 PM
County Operations Center, 5530 Overland Ave, San Diego, CA 92123, Training Room 124

The Charge of the Medical Standards & Evaluation Committee: Ensure that HIV Primary Care services provided through local Ryan White-funded clinics meet or exceed established HIV clinical practice standards and Public Health Services (PHS) guidelines, assuring availability and access to state-of-the-art medical care for all eligible persons living with HIV (PLWH).

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Meeting Packet

Meeting Location & Directions:

Medical Standards & Evaluation Committee

Tuesday, November 04, 2025
4:00 PM - 5:30 PM

County Operations Center
5530 Overland Ave
San Diego, CA 92123
(Training Room 124)

FROM I-163 SOUTH:

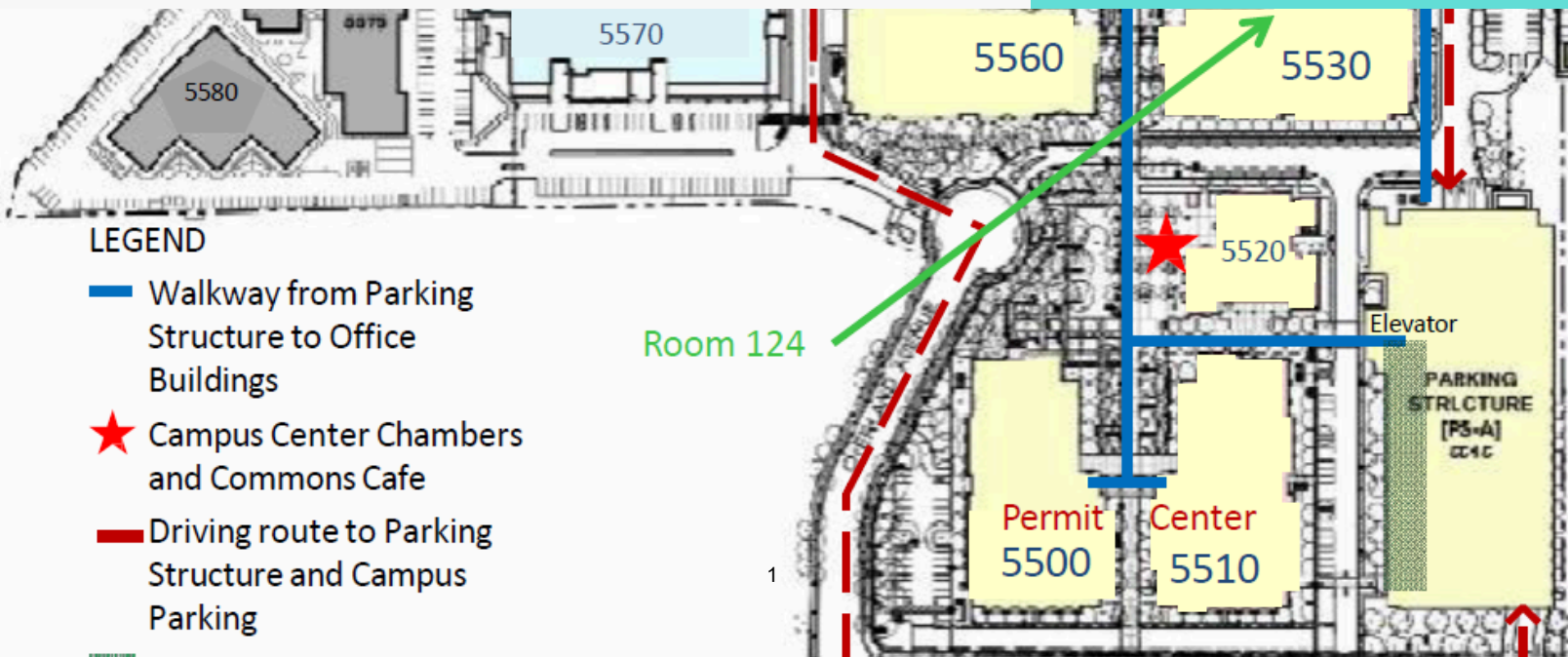
1. Take I-163 North to Exit 8 for Kearny Villa Road.
2. Keep right, follow signs for Kearny Villa Road.
3. Turn right onto Chesapeake Dr.
4. County Operations Center will be on your right.

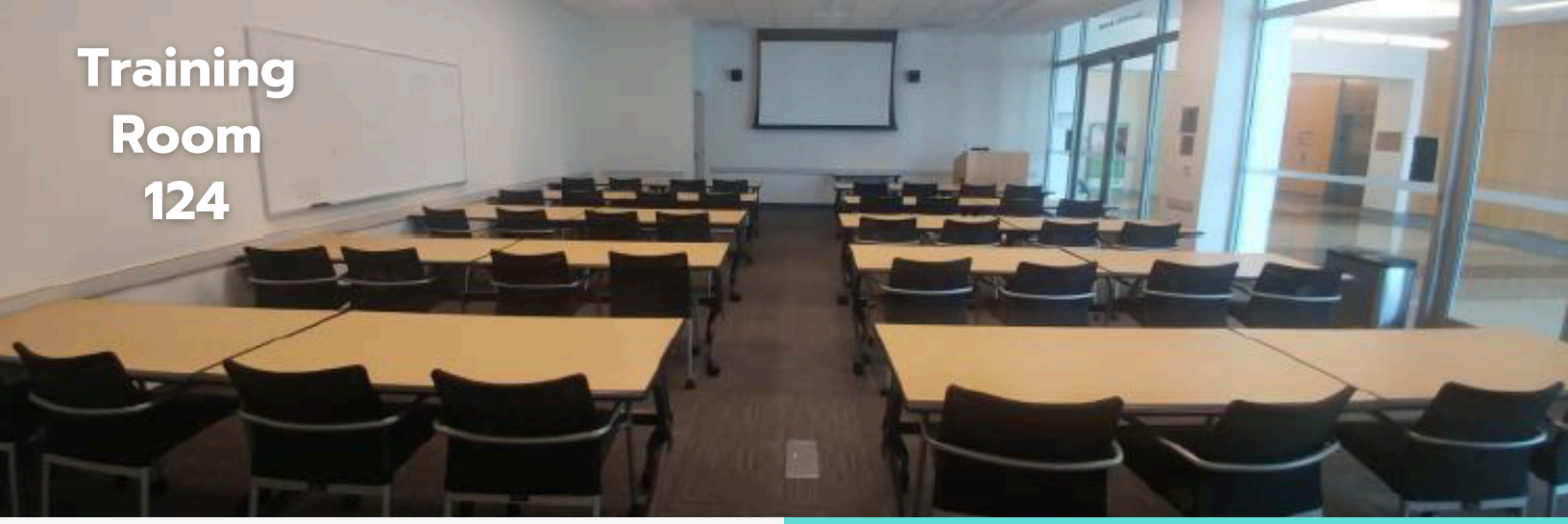
FROM I-15 SOUTH:

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

PUBLIC TRANSPORTATION

MTS Bus Routes:
25, 235, 928





FROM TROLLEY & BUS:

1. Take the Blue Trolley Line to the Balboa Avenue Transit Center.
2. Walk to Balboa Ave & Moraga Ave bus stop (about 7-minute walk, 0.3 miles).
3. Take Route 27 bus from Balboa Ave & Moraga Ave to Complex Dr & Clairemont Mesa Blvd.
4. Head north on Complex Dr.
5. Cross the street and turn right on Clairemont Mesa Blvd (after U.S. Bank Branch on the right).
6. Cross the street and turn left onto Overland Ave. and head north.
7. Enter east through County Operations Center entrance/black gate. **Building 5530** will be on your left.

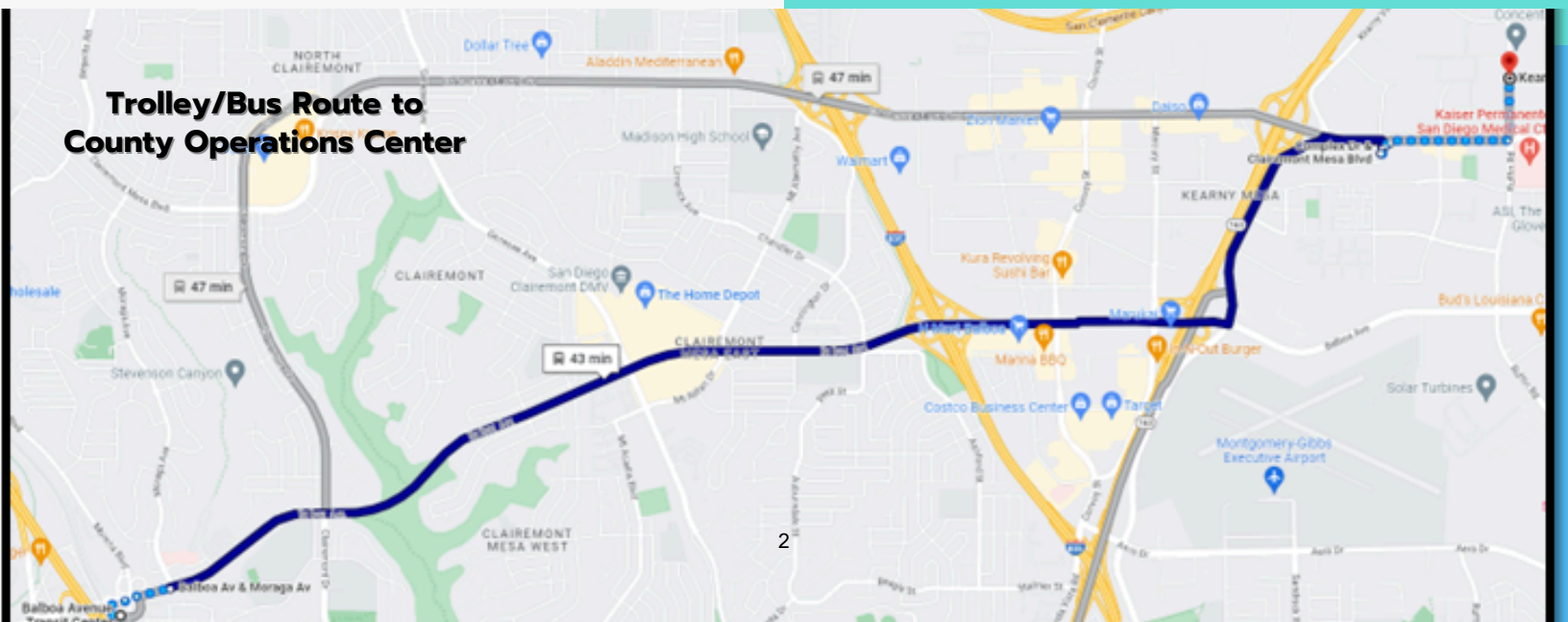
FROM BUS:

From Ruffin Road:

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

From Overland Ave.:

1. Walk north on Overland Ave.
2. Enter east through County Operations Center entrance/black gate.
3. Turn left on pedestrian walkway. **Building 5530** will be on your **left**.



Tuesday, November 04, 2025, 4:00 PM – 5:30 PM
County Operations Center
5530 Overland Ave, San Diego, CA 92123 (Room 124)

To participate remotely via Zoom:
https://sdcounty-ca-gov.zoom.us/j/85484754922?pwd=ZpYeGCmH8chZaEWU4CqvcmUNPBkgIn.1
Call in: 1-669-444-9171
Meeting ID: 854 8475 4922 **Passcode:** 285782

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

A quorum for this meeting is seven (7).

Committee Members: Dr. Jeannette Aldous (Co-Chair) | Dr. Laura Bamford| Dr. Fadra Whyte | Dr. Rosemary Garcia | Dr. David Grelotti (Chair) | Yessica Hernández | Mikie Lochner | Shannon Paugh | Karla Quezada-Torres | Dr. Martha Rodriguez | Edith Saville | Dr. Stephen Spector | Dr. Winston Tilghman

MEETING AGENDA
ORDER OF BUSINESS

1. Call to order, introductions, comments from the chair, and a moment of silence *(4-4:05)*
2. Public comment (for members of the public) *(4:05-4:10)*
3. Sharing our concerns (for committee members) *(4:10-4:15)*
4. **Action**: Approve the consent MSEC agenda (which includes the November 04, 2025 agenda and the September 09, 2025 minutes) *(4:15-4:20)*
5. Old Business:
    a. None.
6. New Business:
    a. **Discussion**: Review Ryan White Quality Assurance Chart Review tool *(4:20-4:30)*
    b. **Discussion**: Ryan White Part A Mental Health and Psychiatric Medication Management Services *(4:30-5:20)*
        i. Mental Health Service Utilization Report
        ii. Mental Health and Psychiatric Medication Management Service Standards
        iii. Establish plan to review current service landscape and identify data, stakeholders, and subject matter experts to inform service standard revisions
7. Other Updates: *(5:20-5:25)*
    a. STI and MPox Update
    b. Committee member updates
8. Future agenda items for consideration *(5:25-5:27)*

9. Announcements *(5:27-5:30)*
10. Adjournment *(5:30)*
11. **Next meeting date:** February 10, 2026, from 4:00 PM – 5:30 PM

    Location: To be determined AND virtually via Zoom

WORK PLAN
February 11, 2025 • Update Dental Practice Guidelines and Oral Health Service Standards • Finalize 2025 work plan and priorities
April 8, 2025 • Finalize and Approve Dental Practice Guidelines and Oral Health Service Standards • Finalize 2025 work plan and priorities • Review Mental Health Services and Psychiatric Medication Management
May 13, 2025 • Finalize and Approve Dental Practice Guidelines and Oral Health Service Standards • Ryan White Chart Review Summary – Jeanette Johnson
September 9, 2025 • Finalize and Approve Dental Practice Guidelines • Review 2024 Needs Assessment findings and identify priorities
November 4, 2025 • Review Ryan White Quality Assurance Chart Review tool • Review RWPA Mental Health and Psychiatric Medication Management Services
February 10, 2026 • Update Mental Health Services and Psychiatric Medication Management • Review work plan for 2026

Tuesday, September 09, 2025, 4:00 PM – 5:30 PM
County Operations Center
5530 Overland Ave, San Diego, CA 92123 (Room 124)

To participate remotely via Zoom:
https://sdcounty-ca-gov.zoom.us/j/87211982598?pwd=aB4GoyqB1wuPNNGWDbbPluqEjjsltt.1
Call in: 1-669-444-9171
Meeting ID: 872 1198 2598 **Passcode:** 444062

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

A quorum for this meeting is seven (7).
Committee Members Present: Dr. Jeannette Aldous (Co-Chair) | Dr. Laura Bamford | Dr. Fadra Whyte | Dr. Rosemary Garcia | Dr. David Grelotti (Chair) | Yessica Hernández | Mikie Lochner | Shannon Paugh | Karla Quezada-Torres | Dr. Martha Rodriguez | Edith Saville | Dr. Stephen Spector | Dr. Winston Tilghman

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Grelotti called the meeting to order at 4:06PM and introductions were done. A moment of silence was observed. The chair expressed concern about upcoming changes to the funding and medical landscape that are likely to impact both patients and health systems. They emphasized the importance of staying united as a team.	
2. Public Comment	The following public comments were made: - A concern about the County's Request for Proposals process and impact on continued access to patient-centered services.	
3. Sharing our Concerns	The following committee comments were made: - A reminder that Medicare open enrollment runs from October 15 to December 7, and clients should refer to their pharmacy for help with plan changes.	HPG SS will follow up regarding bringing staff from the contracting

Agenda Item	Action	Follow-up
	- A clarification that MSEC helps set medical service standards but is not involved in contracting decisions, and that concerns may be better addressed through a County forum. - A County staff member shared that there is an online forum available to submit comments. - A concern about a disconnect between what is approved by this Committee and HPG and what is implemented through contracting, with a request to invite someone from contracting to the next HPG meeting. - A concern about a gap between field realities and survey expectations, with a call for more open dialogue across committees to address service and funding challenges.	team to an HPG meeting.
4. Action: Approve the consent MSEC agenda (which includes the September 09, 2025 agenda and the May 13, 2025 minutes)	**Motion:** Approve the consent MSEC agenda with the amendment of moving 6a. above 5a. **Motion/Second/Count (M/S/C):** Lochner/Aldous/12-0 **Discussion:** **Abstentions: Dr. Grelotti** **Motion Carries**	
5. Old Business:		
a. Action: Update and approve Dental Practice Guidelines	**Motion:** Approve the Dental Practice Guidelines with the recommended changes. **M/S/C:** Aldous/Lochner/12-0 **Discussion:** Recommended changes in packet: **Page 24 – 25** - Update the Table of Contents **Page 27** - Under oral mucosal lesions section change to human herpes virus (HHV-8)	

Agenda Item	Action	Follow-up
	- Under lab values 2nd dot point add the sentence "CD4 monitoring may be done less often for stable patients". - When discussing normal ranges, clarify if it is an adult living with or without HIV. **Page 28** - Second dot point change "no problem" to "no contraindication". **Page 30** - Change CD4 of < 200/mm3. **Page 31** - Do not edit treatment plan as it is not purview of the committee. **Page 35 – 36** - Add "Last accessed [date]" or direct to American Dental Association search if links are inactive. **Abstentions: Dr. Grelotti** **Motion Carries**	
6. New Business:		

a. Discussion: Review 2024 Needs Assessment findings and identify priorities	Dasha presented on the Needs Assessment and the following topics:
	- Total Questions & Responses
	- HIV & Ryan White Status
	- Demographics
	  o Gender orientation
	  o Sexual orientation
	  o Age
	  o Race/Ethnicity
	  o Zip code
	- Common Themes
	  o Housing
	  o English/Spanish differences
	  o Social support
	  o Substance use
	  o Trouble accessing services
	- Top Unmet Needs
	  o Rent
	  o Transportation	

Agenda Item	Action	Follow-up
	○ Dental ○ Legal services ○ Referrals ○ Peer Navigation ○ Food ○ Case Management - What Matters Most for 50+	
b. Action: Review and approval of the committee meeting attendance policy	**Motion:** Approve the MSEC attendance policy "Committee members are expected to attend all meetings. To remain in good standing and eligible to vote, the committee member may not miss more than 2 meetings within the 12 months." **M/S/C:** Hernandez/Aldous/10/1 **Discussion:** Possibly change to a percentage. **Abstentions:** Dr. Grelotti & Spector **Motion Carries**	HPG SS will update the attendance policy. And forward to the Membership Committee.
7. Other Updates:		
a. STD and Mpox Update (Dr. Tilghman)	Tabled.	
b. Committee member updates	Tabled.	
8. Future agenda items for consideration	Tabled.	
9. Announcements	- November 4th is election day; therefore, individuals might be late for the meeting.	
10. Next meeting date:	**Date:** November 04, 2025, **Time:** 4:00 PM – 5:30 PM **Location:** County Operations Center 5530 Overland Ave, San Diego, CA 92123 (Room 124)	
11. Adjournment	The meeting was adjourned at 5:42PM	

RYAN WHITE PRIMARY CARE PROGRAM
Practice Guidelines Compliance Chart Review: 10/1/24 – 9/30/25

Case ID: _____ Reviewer: _____ Date: _____

HIV + □ AIDS DX □

Question 1 - Appointments -

Number of in-person visits in review period: _____ Number of telehealth visits in review period: _____
Follow-Up Appointments Documented: □ Yes □ No
Number of appointments (in-person or telehealth) missed by > 30 days: _____

Patient compliant: did not miss more than one appointment (in-person or telehealth by 30 days): □ Yes □ No

Question 2 – Documentation that Antiretroviral Therapy was Prescribed.

Was antiretroviral therapy prescribed: □ Yes □ No
Outcome: ❑ Prescribed ❑ Refused

Question 3 – Resistance Testing

Previous treatment with antiretroviral therapy: □ Yes □ No

Section 3A
VL >1000 copies □ Yes □ No

Stable ART for at least 1 month prior to the VL >1000 copies/mL? □ Yes □ No

Treatment Experienced Genotype: □ Yes □ No □ Not applicable
Section 3B
Date first diagnosis _____
Treatment Naïve Genotype: □ Yes □ No □ Not applicable

Question 4 – CD4 and VL Tests

Is client suppressed: □ Yes □ No
Is CD4 >500 (Consistently after 2 years) □ Yes □ No

Number of CD4 tests: _____ Number of VL tests: _____

Date: 1st test _____	Value _____	Date: 1st test _____	Value _____
Date: 2nd test _____	Value _____	Date: 2nd test _____	Value _____
Date: 3rd test _____	Value _____	Date: 3rd test _____	Value _____
Date: 4th test _____	Value _____	Date: 4th test _____	Value _____

Question 4A – PCP Prophylaxis

PCP Prophylaxis: ❑ Yes ❑ No ❑ Refused/declined □ Not applicable

Question 5 - Sexually Transmitted Infections

Documentation of Sexual Risk Assessment: □ Yes □ No
❑ MSM ❑ Transgender woman ❑ Sexually Active ❑ Documented Not Sexually Active

RYAN WHITE PRIMARY CARE PROGRAM
Practice Guidelines Compliance Chart Review: 10/1/24 – 9/30/25

Case ID: _____ Reviewer: _____ Date: _____

❑ Newly enrolled in care
Documented STI within last 12 months ❑Yes ❑ No
If yes, was STI treated ❑Yes ❑ No
If yes, was DoxyPep offered ❑Yes ❑ No

Urogenital GC/CT**:** ❑ Yes ❑ No ❑ Refused/declined ☐ Not applicable
Date of last test_____

GC/NAAT (Throat): ❑ Yes ❑ No ❑ Refused/declined ☐ Not applicable
Date of last test_____

GC/Chlamydia NAAT (Rectal): ❑ Yes ❑ No ❑ Refused/declined ☐ Not applicable
Date of last test_____

Syphilis testing: ☐ Yes ☐ No ❑ Refused/declined
Date of last test_____

Question 6 – Cervical Cancer Screening

Was cervical cancer screening status addressed? ❑ Yes ❑ No TAH ❑
Date of last Pap smear _____

Anal cancer screening addressed (35 years and older) ❑ Yes ❑ No ❑ Refused/declined

Question 7 – Hepatitis A and B

Hep A screening? ❑ Yes _____ _____ _____
❑ No ❑ Immune/Vaccinated ❑ Refused/declined

Hep B screening? ❑ Yes _____ _____ _____
❑ No ❑ Immune/Vaccinated ❑ Refused/declined ❑ Active infection

Question 8 – Hepatitis C

Annual Hep C Screening during audit period? ❑ Yes ❑ No ❑ Refused/declined ❑ Active infection ❑Not applicable

Lifetime Hep C Screening? ❑ Yes ❑ No
❑ Prior confirmed Hep C ❑ Refused/declined

Is there ongoing risk of Hepatitis? ❑ Yes ❑ No. If Yes list risks
1. _____
2._____

Injection drug use (active or previous history, but not tested)? ❑ Yes ❑ No
Sexually active MSM? ❑ Yes ❑ No

Case ID: _____ Reviewer: _____ Date: _____

Question 9 – Lipid screening

Lipid screening? ❑ Yes ❑ No ❑ Refused/declined

Question 10 – Tuberculosis Assessment

Screening test (PPD or QuantiFERON) ordered during audit year? ❑ Yes ❑ No ❑ Prior positive ❑ Refused/declined

Type of test: ❑ PPD ❑ QuantiFERON
Documentation that PPD was placed? ❑ Yes ❑ No
Documentation that PPD was read? ❑ Yes ❑ No

Annual risk assessment done? ❑ Yes ❑ No (check if only prior positive)

10A –If positive, documentation of CXR or notation that CXR was done previously? ❑ Yes ❑ No (check if only TB positive)

Question 11 –Vaccination

Influenza vaccine? ❑ Yes ❑ No ❑ Refused/declined

Pneumococcal vaccine? ❑ Yes ❑ Pneumovax ❑ Prevnar
❑ No ❑ Refused/declined ❑ Exempt

Meningococcal vaccine ❑ Yes ❑ No ❑ Refused/declined ❑ Exempt

COVID-19 vaccine ❑ Yes/addressed ❑ No/not addressed ❑ Refused/declined

Mpox vaccine ❑ Yes/addressed ❑ No/not addressed ❑ Refused/declined
❑ 1st dose ❑ 2nd dose

Shingles ❑ Yes/addressed ❑ No/not addressed ❑ Refused/declined

Question 12 – Treatment Adherence and HIV Risk Counseling

Treatment adherence counseling? ❑ Yes ❑ No ❑ N/A (not on treatment) ❑ Refused/declined
HIV Risk Counseling? ❑ Yes ❑ No ❑ Refused/decline

Counseling regarding disclosure to sex and needle sharing partners and/or referral to HIV Partner Services? ❑ Yes ❑ No ❑ Refused/declined
❑ N/A (Patient is virally suppressed)

Question 13 – Dental

Documentation of Dental Referral/Recommendation/Dental Care addressed: ❑ Yes ❑ No If yes, date(s)_____
If outside of the review period, list last known date(s)_____

Question 14 – Mental health and substance use screening.

Documentation of mental health screening ❑ Yes ❑ No
Documentation of substance use screening ❑ Yes ❑ No

Mental Health Services

Service Category Definition

Mental health services are the provision of outpatient psychological, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Psychiatric services related to medication is covered in a separate service standard.

Purpose and Goals

The goal of mental health services is to provide outpatient, assessment, diagnosis, and treatment to persons living with HIV.

Intake

Providers will conduct a comprehensive client intake process. This process determines a client's need for mental health services and the extent of services that need to be provided. A client intake will be completed for all clients who request or are referred to mental health services. The intake process also acquaints the client with the range of services offered and determines the client's interest in such services. Mental health services are allowable for HIV-infected clients only.

Key Service Components and Activities

Key activities for mental health services include:

- Initial comprehensive assessment including documentation of diagnosis and determination of needs
- Development of individual treatment plans
- Treatment provision in individual, family, and/or group settings, crisis intervention and psychiatric consultation.
    - **Individual Counseling/Psychotherapy**: Frequency and duration of individual counseling or psychotherapy is determined based upon client need or as outlined in the Treatment Plan.
    - **Family and Conjoint Counseling/Psychotherapy:** The overall goal of family and conjoint counseling/psychotherapy is to help the client and his/her family improve their functioning, given the complications of living with HIV. The frequency and duration are based on upon client needs or as outline in the Treatment Plan.
    - **Group Treatment:** Group treatment can provide opportunities for increased social support vital to those isolated by HIV. Provider will assure an appropriate clinician facilitates the groups and limit the groups to a maximum of 12 persons per group (unless it is a couples-specific group).
        - Group counseling sessions consists of face-to-face contact between one or more therapists and a group of no fewer than two Ryan White eligible clients.
    - **Crisis Intervention:** This is an unplanned service provided to an individual, couple or family experiencing psychosocial stress. Crisis interventions are provided in order to prevent deterioration of functioning or to assist in the client's return to baseline functioning. Client safety will be assessed and addressed. This service may occur as often as necessary to ensure client safety and maintenance of baseline functioning.

- **Psychiatric consultation:** Providers will provide psychiatric referrals as appropriate.

- Referral/coordination/linkages
  - **Referral/Coordination:** Providers will establish linkages and collaborative relationships with other providers for client referral to ensure integration of services and better client care, including, but not limited to, additional mental health services (psychiatric evaluation and medication management, neuropsychological testing, day treatment programs and in-patient hospitalization); primary care, case management, dental treatment, and substance use treatment.
- Development of follow-up plans if needed
- Case closure

Standard	Measure
Staff assesses clients' eligibility and needs	Documentation of interviews and assessments all potential clients and their respective needs
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients
	Maintain a single mental health record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients

Personnel Qualifications

All mental health practitioners will have training and experience with HIV related issues and concerns. It is recommended that practitioners participate in continuing education and training on issues related to HIV and mental health. At a minimum, practitioners providing mental health services to people living with HIV will possess knowledge about the following:

- HIV disease process and current medical treatments
- Psychosocial issues related to HIV
- Cultural issues related to communities affected by HIV
- Mental disorders related to HIV and/or other medical conditions
- Mental disorders that can be induced by prescription drug use
- Adherence to medication regimes
- Diagnosis and assessment of HIV-related mental health issues
- HIV legal and ethical issues
- Knowledge of human sexuality, gender, and sexual orientation issues
- Substance use theory, treatment, and practice

In accordance with State licensing and practice rules and regulations, all direct services will be provided by culturally sensitive, linguistically appropriate, and competent licensed counselors or duly supervised interns.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State of California
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Comprehensive **Assessment:** This is an assessment completed during a face-to-face interview in which the client's history and current presentation are evaluated to determine diagnosis and treatment plan. This assessment will be provided to all persons receiving individual, family/conjoint, and/or group psychotherapy. Persons receiving crisis intervention or drop-in psychotherapy groups only do not require this assessment. The assessment will be based on clinical standards appropriate to the modality chosen with knowledge of HIV risk and harm reduction.

Reassessments: A reassessment is ongoing and driven by client need, such as when there is significant change in the client's status. The reassessment will be documented in the client chart.

Treatment Plans: Treatment plan is developed with the client and is required for persons receiving individual, family/conjoint, and/or group psychotherapy. The provider will continue to address and document existing and newly identified treatment plan goals. The Treatment Plan will include at minimum:

- Diagnosed mental illness or condition
- Treatment modality (group or individual)
- Date for mental health services
- Recommended number of sessions
- Date for reassessment
- Projected treatment end date
- Any recommendations for follow up
- Signature of the mental health professional rendering service

Regular follow-up procedures are provided to encourage and help maintain a client in treatment. The documentation of attempts to contact the client will be in the progress notes. The follow-up may include telephone calls, written correspondence, and direct contact.

Standard	Measure
Staff will assess client's condition and needs	Documentation of comprehensive assessment
Staff will develop a treatment plan. Staff will also monitor and continuously reassess clients' needs	Documentation of the existence of a detailed treatment plan.
Staff will ensure that services meet Ryan White and local guidelines and are consist with the treatment plan	Documentation of service provided to ensure that: • Services provided are allowable under Ryan White, state, and local guidelines • Services provided are consistent with the treatment plan

Psychiatric Medication Management Services

Service Category Definition

Psychiatric medication management services are the provision of outpatient psychiatric screening, assessment, diagnosis, and treatment services offered to clients living with HIV. Specifically, these include psychiatric medication assessment, prescription, and monitoring by a licensed psychiatrist or supervised resident or mid-level practitioner. Although they form a separate service category, psychiatric medication management services are part of the comprehensive array of mental and behavioral healthcare services that also may include individual, family, and group counseling and psychotherapy and crisis intervention. These other services are described in the **Mental Health Services Service Standards**.

Purpose and Goals

The goal of psychiatric medication management services is to provide medication assessment, prescription, and monitoring services to people living with HIV in order to alleviate or decrease psychiatric symptoms, stabilize mental health conditions, and improve and sustain quality of life. All services and interventions must be based on proven and evidence-based clinical methods and in accordance with legal and ethical standards. The services delivered shall reflect a philosophy that affirms a patient's right to privacy, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

Intake

Patient intake is required for all patients who request or are referred for psychiatric medication management services and shall be initiated at the time a patient presents for services. Intake is a time to gather registration information and provide basic information about psychiatric medication management services and other HIV services, as appropriate. It is also a pivotal moment for establishment of trust and confidence in the care system. In most cases, a client who receives psychiatric medication management services will already be receiving HIV primary care and enrolled in a medical care coordination program.

Providers will conduct a comprehensive client intake process that determines a client's need for psychiatric medications and other mental health services and the extent of services that need to be provided. Practitioners shall provide an appropriate level of information that is helpful and responsive to patient need. Staff shall conduct the patient intake with respect and compassion.

Key Service Components and Activities

Key activities for psychiatric medication management services include:

- Initial comprehensive assessment, including documentation of diagnosis and determination of need for psychiatric medications
- Development of individual treatment plans
- Referral to and/or coordination with other providers to ensure that the client has access to the full array of services that are required for optimal mental and physical health outcomes and coordination of pharmacologic and non-pharmacologic interventions
- Development of follow-up plans, if needed
- Case closure, when a client's condition is stabilized and/or the client can be referred back to the primary care provider for ongoing management

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments for all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake, and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients

Standard	Measure
	Completion of the Client Transition Plan for clients deemed ineligible for psychiatric medication management or deemed ready to be transitioned out of these services

Personnel Qualifications

Psychiatric medication management services are provided by medical doctors who are board-eligible in psychiatry. A psychiatrist may collaborate with a psychiatric resident, registered nurse/nurse practitioner (RN/NP), or physician's assistant (PA) under the supervision of a medical doctor who is board-eligible in psychiatry. Intake may be conducted by other licensed mental health professionals (e.g., psychologists, licensed clinical social workers). All prescriptions shall be prescribed solely by physicians licensed by the state of California or by NPs or PAs who are practicing under their supervision.

All psychiatric medication management practitioners will have training and experience with HIV-related issues and concerns. It is recommended that practitioners participate in continuing education and training on issues related to HIV and mental health. At a minimum, practitioners providing psychiatric medication management services to people living with HIV will possess knowledge about the following:

- HIV disease process and current medical treatments
- Psychosocial issues related to HIV
- Cultural issues related to communities affected by HIV
- Mental health conditions related to HIV and/or other medical conditions
- Mental health conditions that can be induced by prescription drug use
- Adherence to medication regimens
- Diagnosis and assessment of HIV-related mental health issues
- HIV legal and ethical issues
- Knowledge of human sexuality, gender identity, and sexual orientation issues
- Substance use theory, treatment, and practice

In accordance with State licensing and practice rules and regulations, all direct services will be provided by culturally sensitive, linguistically appropriate, and competent providers.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees and board eligibility or certification in psychiatry
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff

Assessment and Service Plan

Psychiatric Assessment and Treatment Plans: Psychiatric assessments and treatment plans are core components of a psychiatry visit and should be clearly outlined in the medical record, typically using the "SOAP" format (i.e., Subjective, Objective, Assessment, Plan). Treatment plans should be developed collaboratively with the client. Assessment and treatment plans completed by unlicensed psychiatric providers must be cosigned by a medical doctor board-eligible in psychiatry.

Components of the assessment and plan generally include:

- A statement of the problems, symptoms, or behaviors to be addressed in treatment.
- Goals (desired outcomes) and objectives (measurable change in symptoms or behaviors)
- Interventions proposed (including pharmacologic and non-pharmacologic interventions)
- Appropriate modalities to address the identified problems
- Frequency and expected duration of services

- Service referrals (e.g., day treatment programs, substance use treatment, etc.)

Treatment Provision: All modalities and intervention in mental health treatment, including psychiatric medication management, will be guided by the needs expressed in the assessment and treatment plan. Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their client's presenting problems. Treatment shall conform to the standards of care recognized within the general community and supported by clinically published research for the client's condition. Psychiatric service providers shall adopt and follow performance standards as set forth in the latest HIV mental health guidelines. Programs providing psychiatric services shall be responsible for obtaining and maintaining staff, facility, and referral systems in compliance with American Medical Association standard guidelines.

Ongoing Psychiatric Sessions: Mental health treatment should include counseling regarding knowledge of modes of transmission, prevention, risk and harm reduction strategies (as well as root causes and underlying issues related to practices that may facilitate HIV transmission). Substance use, treatment adherence, development of social support systems and community resources as indicated by the client's circumstance are important areas to be explored. Focus should also be placed on maximizing social and adaptive functioning. When present in a client's life, the role of spirituality and religion should be understood and utilized as a strength when present. If clients begin to deteriorate physically, emotional distress can be relieved by helping them prepare for disability and even death. For the client whose health has improved, exploration of future goals, including returning to school or work, is indicated. When a signed release has been completed, sources of support and care can be recommended to significant others and family members. Many of these issues may also be addressed by other mental health professionals who are involved in the client's care and perform non-pharmacologic interventions based on the **Mental Health Services Service Standards**.

Psychiatric Evaluations, Medication Monitoring, and Follow-up: Psychiatrists shall use clinical presentation, evidence-based practice guidelines, and specific treatment goals to guide the evaluation, prescription, and monitoring of appropriate medication.

For medication monitoring and follow-up, visit frequency should be based on the acuity of the client's condition and the level of need.

Visits may be conducted in-person or via telehealth (telepsychiatry), based on client needs and preference.

For those patients on psychotropic medication, side effects of these agents shall be assessed at each visit, along with the provision of education regarding their medications. In addition, these patients should be regularly counseled about the importance of adherence to psychotropic medications.

The American Psychiatric Association (2001) suggests the following general pharmacologic treatment guidelines, especially for those patients with symptomatic HIV disease:

- Use lower starting doses and titrate more slowly.
- Provide the least complicated dosing schedules possible to achieve the desired outcome.
- Concentrate on drug side effect profiles as a means to avoid unnecessary adverse effects.
- Be aware of drug metabolism/clearance pathways to minimize drug-drug interactions and possible organ damage.

In general, refills shall not be written beyond three months of the last psychiatric visit. However, exception can be made in special circumstances or when the stability of the client warrants less frequent monitoring. Such exceptions shall be documented in the client progress notes.

Psychiatrists must coordinate the provision of psychiatric care with primary medical clinics and other related providers. Regular contact with a patient's primary care clinic and related providers will ensure integration of services and maintain care continuity.

Documentation: Treatment provision should be documented through progress notes and include the date and signature of the psychiatrist. For unlicensed psychiatric providers, progress notes will be cosigned by a medical doctor board-eligible in psychiatry.

Progress notes for evaluations, medication monitoring, and follow-up will include:

- Date, type of contact, time spent

- Treatment plan including current medical and psychotropic medications and dosages
- Progress toward psychiatric treatment plan goals
- Interventions and patient's response to interventions
- Referrals provided (e.g., psychotherapy, neuropsychological assessment, case management, medical services, etc.)
- Results of interventions and referrals
- Documentation that the provider has addressed existing and newly identified goals

Informed Consent: Informed consent is required of every patient receiving psychotropic medications.

When starting a new psychotropic medication, providers should ensure that the client understands:

- Medication benefits
- Risks
- Common side effects
- Side effect management
- Timetable for expected benefit

Informed consent for new psychotropic medications should be documented in the client medical record.

Standard	Measure
Psychiatric assessments and treatment plans are developed concurrently and collaboratively with the client and include interventions and modalities to address mental health conditions.	Assessment and treatment plan in client chart to include: • Statement of problem • Goals and objectives • Interventions and modalities • Frequency of service • Referrals
Assessments, reassessments, progress notes, and documentation of informed consent for new psychotropic medications completed by unlicensed psychiatric providers will be cosigned by a medical doctor board-eligible in psychiatry.	Co-signature in client record
Practitioners will use outcome research and published standards of care, as appropriate and available, to guide their treatment.	Progress note signed and dated by psychiatrist detailing interventions in the client file
Treatment, as appropriate, will include counseling about (at minimum): • Prevention and practices that may facilitate transmission, including root causes and underlying issues related to practices that may facilitate HIV transmission • Substance use • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life • Disability, death, and dying • Exploration of future goals	Progress note signed and dated by psychiatrist detailing counseling sessions in client file
Progress notes for psychiatric services will document progress through treatment provision.	Signed and dated note to be placed in the client file including: • Date, type of contact, time spent • Treatment plan including current medical and psychotropic medication and dosages • Progress toward psychiatric treatment plan goals

Standard	Measure
	• Interventions and client's response to interventions • Referrals provided • Results of interventions and referrals • Documentation of provider addressing existing and newly identified goals
Prior to initiating psychotropic medications, psychiatry providers will counsel clients on the risks, benefits, and common side effects of the medications.	Documentation in client chart indicating that the patient has been told about and understands: • Medication benefits • Risks • Common side effects • Side effect management • Timetable for expected benefit

Transition

Clients will be disenrolled from psychiatric medication management services when all action items on the individual care plan are competed, medical care is stabilized, the issue(s) for which the client requested or was referred for psychiatric medication management services are resolved or can be managed on an ongoing basis by the client's primary care provider, and the client meets all of the following criteria:

- Enrolled in HIV medical care
- Following her/his/their medical plan since the previous assessment
    - The medical plan may include other health-related issues (for example, mental health, substance use, smoking, hypertension, gynecological, etc.)
- Keeping medical appointments
- Taking medication as prescribed

Standard	Measure
Staff will document reasons for disenrollment in the client record	Documentation of reason for disenrollment
	Documentation of "inactive status" and maintenance of records and contact information to facilitate rapid re-enrollment, as appropriate

County of San Diego Monthly STD Report

Volume 17, Issue 9: Data through April 2025; Report released September 26, 2025.

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

	2024		2025	
	April	*Previous 12-Month Period**	*April*	*Previous 12-Month Period**
Chlamydia	1420	17189	1345	15768
Female age 18-25	475	5564	425	5118
Female age ≤ 17	50	618	47	589
Male rectal chlamydia	120	1592	72	1030
Gonorrhea	501	6304	393	5677
Female age 18-25	55	616	30	495
Female age ≤ 17	3	83	4	83
Male rectal gonorrhea	121	1503	80	1369
Early Syphilis (adult total)	54	893	27	593
Primary	5	122	2	96
Secondary	8	252	8	168
Early latent	41	519	17	329
Congenital syphilis	2	30	2	30

* Cumulative case count of the previous 12 months.

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

	All Races*		Asian/PI		Black		Hispanic		White	
	cases	*rate*	*cases*	*rate*	*cases*	*rate*	*cases*	*rate*	*cases*	*rate*
All ages										
Chlamydia	5252	478.8	158	113.6	224	435.1	584	153.2	686	144.5
Gonorrhea	1668	152.1	60	43.1	116	225.3	368	309.0	311	65.5
Early Syphilis	152	13.9	5	3.6	22	42.7	65	17.0	39	8.2
Under 20 yrs										
Chlamydia	826	302.2	13	45.0	38	301.2	64	53.7	110	116.1
Gonorrhea	75	27.4	3	10.4	10	79.3	13	10.9	5	5.3
Early Syphilis	4	1.5	0	0.0	2	15.9	1	0.8	1	1.1

Note: Rates are calculated using 2023 Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 01/2025.

* Includes cases designated as "other," "unknown," or missing race/ethnicity.

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

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

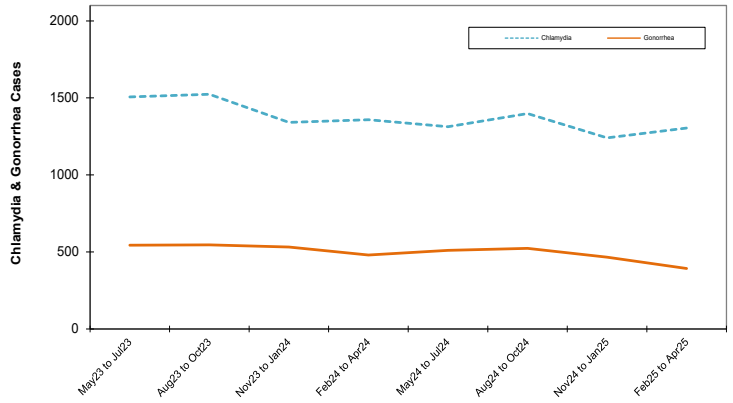
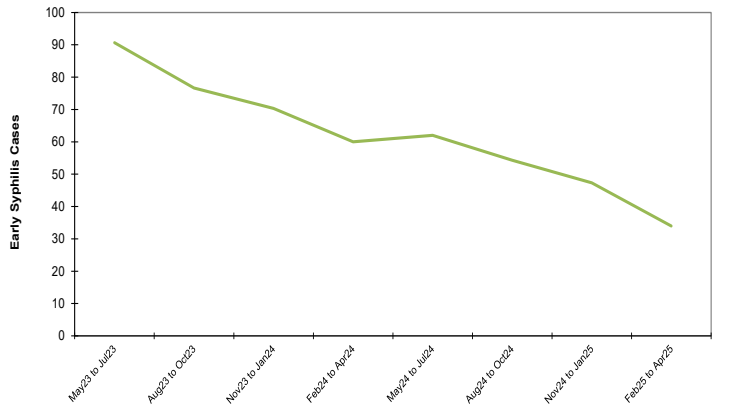


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Editorial Note: Brief STI and HIV Updates

- The Centers for Disease Control and Prevention (CDC) released **provisional 2024 national sexually transmitted infection (STI) surveillance data** on September 24, 2025. Over 2.2 million cases of chlamydia, gonorrhea, and syphilis were reported in 2024, representing a 9% decline in overall STI morbidity compared to 2023 and three consecutive years of decrease. Cases of chlamydia, gonorrhea, and primary and secondary syphilis decreased by 8%, 10%, and 22%, respectively, since 2023. Despite these encouraging trends, CDC emphasized that there is still more work to do, since congenital syphilis cases increased by 2% since 2023, with over 4,000 cases reported in 2024, and the overall STI case burden in the United States remains 13% higher than it was a decade ago.
- A recently published randomized, controlled, open-label, noninferiority trial demonstrated that **treatment of early (i.e., primary, secondary, and early latent) syphilis with one dose of 2.4 million units of benzathine penicillin G was noninferior to treatment with three weekly 2.4-million-unit doses in achieving a serologic response six months after treatment.** When stratified by HIV infection status, there was no apparent difference in the percentage of participants in each arm with serologic response to treatment. This trial, which excluded pregnant persons and persons with neurosyphilis and enrolled a low number of women, supports current CDC early syphilis treatment recommendations.
- **CDC published new clinical recommendations for twice-a-year injectable lenacapavir as an additional option for HIV pre-exposure prophylaxis.**
- **The Food and Drug Administration (FDA) has accepted priority review of two oral agents for treatment of uncomplicated gonorrhea.** Planned action dates for gepotidacin and zoliflodacin are December 11, 2025 and December 15, 2025, respectively. These agents were described previously in Volume 16, Issue 4 of this report.

County of San Diego STD Clinics: www.STDSanDiego.org
Phone: (619) 692-8550 **Fax:** (619) 692-8543
STD Clinical Consultation Line: (619) 609-3245 (8am-5pm, M–F)

Provider STD Reporting: (619) 692-8520; fax (619) 692-8541
Sign up to receive Monthly STD Reports, email STD@sdcounty.ca.gov

HIV PLANNING GROUP
4-MONTH COMMITTEE TRACKING
Nov 2024 - Sep 2025

Medical Standards & Evaluation Committee						
MSEC	**Nov**	**Feb**	**Apr**	**May**	**Sep**	**#**
Total Meetings	1	1	1	1	1	**5**
(13) Members						
Tilghman, Dr. Winston	**JC**	*	*	*	*	**0**
Aldous, Dr. Jeannette [CC]	*	**JC**	*	*	*	**0**
Bamford, Dr. Laura	**1**	*	*	*	*	**1**
Grelotti, David [C]	*	*	*	*	*	**0**
Hernandez, Yessica	*	*	*	*	*	**0**
Spector, Dr. Stephen	**1**	*	*	**1**	*	**2**
Quezada-Torres, Karla	*	**1**	*	*	*	**1**
Rodriguez, Martha	*	*	*	*	*	**0**
Paugh, Shannon		*	**1**	*	*	**1**
Garcia, Rosemary			*	*	*	**0**
Whyte, Fadra			*	*	*	**0**
Lochner, Mikie				*	*	**0**
Saville , Edith					*	**0**

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

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

JC = Just Cause
EC = Emergency Circumstance
NM = No Meeting
NQ = No Quorum

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.