Tuesday, November 10, 2026, 4:00 PM – 5:30 PM
County Operations Center
5560 Overland Ave., San Diego, CA 92123
Training Room 171

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

TABLE OF CONTENTS

Meeting Packet Documents	Page Number(s)
Meeting Directions for 11/10/2026 meeting	001 – 002
11/10/2026 MSEC Agenda	003 – 004
09/08/2026 MSEC Meeting Minutes	005 – 009
Ryan White Char Review Tool	010 – 013
Psychiatric Medication Management Service Standards Draft	024 – 021
Monthly STD Report Volume 18 Issue 4	022
Provided for Informational Purposes:	
MSEC Attendance Summary	023
Senate Bill (SB) 707: The Use of Just Cause	024

Meeting Location & Directions:

Medical Standards & Evaluation Committee (MSEC)

Tuesday, November 10, 2026
4:00 PM - 5:30 PM

County Operations Center
5560 Overland Ave
San Diego, CA 92123
(Training Room 171)



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

FROM I-163 SOUTH:

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

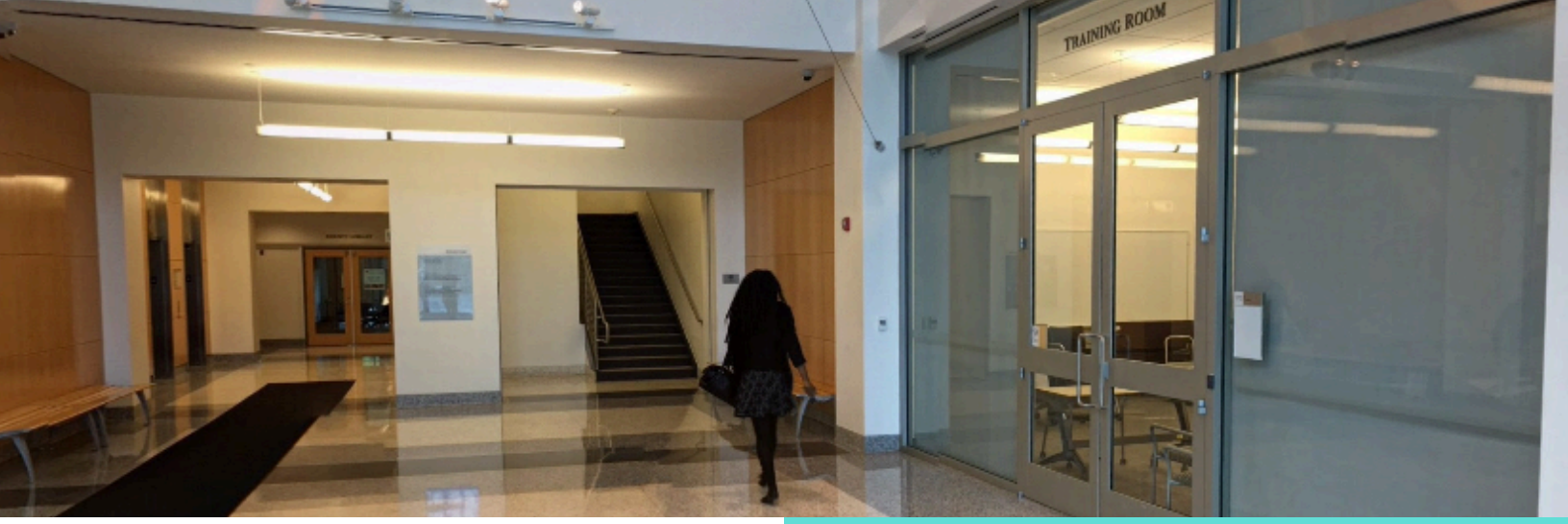
FROM I-15 SOUTH:

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

PUBLIC TRANSPORTATION

MTS Bus Routes:
25, 235, 928





FROM TROLLEY & BUS:

1. Take the Blue Trolley Line to the Balboa Avenue Transit Center.
2. Walk to Balboa Ave & Moraga Ave bus stop (about 7-minute walk, 0.3 miles).
3. Take Route 27 bus from Balboa Ave & Moraga Ave to Complex Dr & Clairemont Mesa Blvd.
4. Head north on Complex Dr.
5. Cross the street and turn right on Clairemont Mesa Blvd (after U.S. Bank Branch on the right).
6. Cross the street and turn left onto Overland Ave. and head north.
7. Enter east through County Operations Center entrance/black gate. **Building 5560** will be on your left.

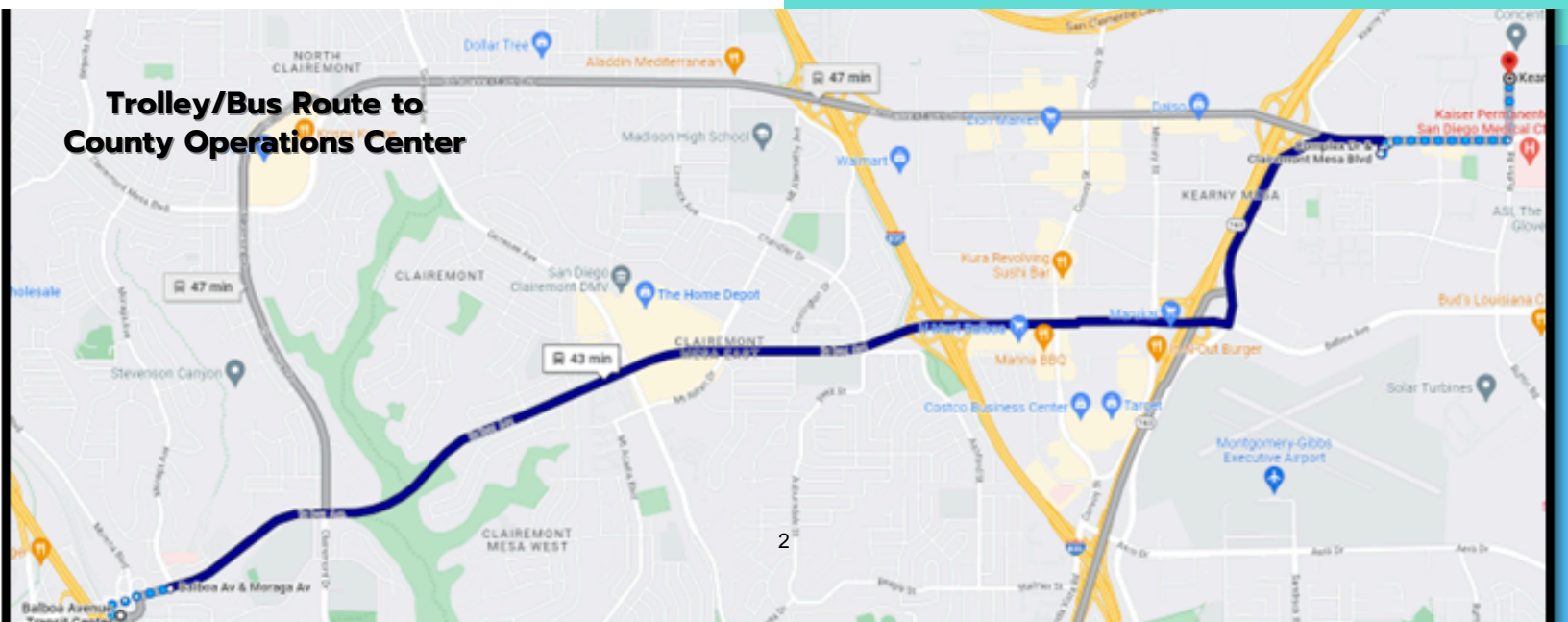
FROM BUS:

From Ruffin Road:

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

From Overland Ave.:

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



MEDICAL STANDARDS AND EVALUATION COMMITTEE

Tuesday, November 10, 2026, 4:00 PM – 5:30 PM
County Operations Center
5560 Overland Ave. San Diego, Ca, 92123
Training Room 171

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 eight (8).

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

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 10, 2026 agenda and September 8, 2026 minutes) *(4:15-4:20)*
5. New Business:
    a. **Discussion**: Review Ryan White Quality Assurance Chart Review tool *(4:20-5:00)*
    b. **ACTION**: Review and update the Psychiatric Medication Management Service Standards *(5:00-5:20)*
6. Old Business:
    a. None
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 9, 2026, from 4:00 PM – 5:30 PM
    Location: To be determined AND virtually via Zoom

MEDICAL STANDARDS AND EVALUATION COMMITTEE (MSEC)

Tuesday, September 8, 2026, 4:00 PM – 5:30 PM
County Operations Center
5560 Overland Ave. San Diego, Ca, 92123
Training Room 172

A quorum for this meeting is seven (7).

Committee Members Present: Dr. Rosemary Garcia | Dr. David Grelotti (Chair) | Edith Saville | Shannon Paugh | Dr. Winston Tilghman | Karla Quezada-Torres | Dr. Martha Rodriguez | Dr. Fadra Whyte

Committee Members Absent: Marco Aguirre Mendoza | Dr. Jeannette Aldous (Co-Chair) | Dr. Laura Bamford | Yessica Hernández | Dr. Stephen Spector

Agenda Item	Action	Follow-up
1. Welcome and moment of silence, comments from the Chair	Dr. Grelotti called the meeting to order at 4:09 PM and introductions were done. A moment of silence was observed.	
2. Public Comment	- A comment about medication management and mental health timeliness.	
3. Sharing our Concerns	None	
4. Action: Approve the consent MSEC agenda (which includes the September 8, 2026 agenda and May 12, 2026 minutes	**Motion:** Approve the consent MSEC agenda (which includes the September 8, 2026 agenda and May 12, 2026 minutes **Motion/Second/Count (M/S/C):** Quezada-Torres/Edith Saville/ 6-0 **Abstentions:** Dr. Grelotti **Motion Carries**	
5. New Business:		
a. **Discussion**: Review and update Mental Health Questions in the Needs Assessment Survey	- A clarification about the overall purpose of the needs assessment survey and whether the committee's role is to create new mental health questions, refine the existing ones, or provide feedback. Members emphasized that this is an opportunity to improve questions that were not well-received in the 2022 assessment. - HPG Staff outlined the upcoming timeline: the working group will meet through September and	

Agenda Item	Action	Follow-up
	October to shorten the 87-question survey, incorporate mental health content, and develop a draft for HPG review. The survey is expected to launch in early January with a two-month response window. - A question about whether standardized or validated mental health screening tools should be used instead of creating new items. Using established measures could make results easier to interpret and compare. - A comment about response options in the current survey that frame barriers as patient-level issues rather than system-level obstacles (e.g., limited access, long wait times, not being able to reach providers). They stressed the importance of capturing quality of care and user experience, not only service utilization. - An observation that mental health questions are currently directed only to respondents aged 50+, through the needs spans all ages. - Other observations included: o No distinction between types of PrEP (oral vs. injectable) or dosing intervals. o Missing questions about HIV testing pathways, including the Take-Me-Home test kit program. o Limited focus on STI prevention and self-collect testing kits. o Lack of questions that reflect real experiences navigating services. - A comment on whether qualitative approaches, such as group focus	

Agenda Item	Action	Follow-up
	groups, could provide deeper insights. Historically, participation has been low, but incentives planned for this cycle may improve engagement. - A suggestion was made to review every question by asking: "Why are we asking this?" and "How will this information be used?" Items without a clear purpose may be appropriate for removal. - HPG staff to share the draft survey and the committee will share the survey with their teams for additional feedback.	
b. **ACTION**: Review and update the Mental Health Service Standards	**Motion:** Update the mental health service standards **(M/S/C):** Quezada-Torres/ Whyte/ 7-0 **Abstentions:** Dr. Grelotti **Motion Carries** **Discussion:** - A clarification was shared that HRSA confirmed COI rules apply only to financial decisions, not to service standards discussions. - A comment was made that mental health providers should have clearer expectations for communicating with members of the client's care team. - A concern was raised that the existing measure ("documentation of all services provided/offered") is too vague and should be more specific. - Members agreed that providers should identify and document a client's care team, including: o HIV provider and/or primary care provider o Psychiatrist, if applicable o Case manager (medical or non-medical), if applicable - Providers should obtain releases of information (ROIs) for relevant	

Agenda Item	Action	Follow-up
	care-team members when the client consents, and document when consent is declined. - Members acknowledged challenges with cross-system communication but agreed that providers must still document outreach attempts, even if two-way communication does not occur. - A comment emphasized support for a “no wrong door to care” approach, meaning providers should help connect clients to appropriate services when needs arise. - Members agreed that therapists do not need to document referrals made by other providers, but should document referrals and recommendations they make themselves. - Documentation should include: o Recommendations made o Referrals placed o Follow-up noted when appropriate - Members noted that therapists may not be able to confirm whether clients complete outside referrals, but documenting the referral and any effort made is sufficient. - There was general agreement to keep the standard as written (“staff ensures clients are connected to appropriate services when needed”) and update the measures beneath it. **Suggested Changes to the Document:** - Document when a provider “identified a need” and “made a referral to a provider,” including the name, phone number, and communication details.	

Agenda Item	Action	Follow-up
	- Add that documentation must include written referrals. - Add that documentation may also include ROIs. - Add that providers should maintain copies of written reports. - Acknowledge that mental health providers may "reach out to the primary care doctor to put that person on notice about a need for a referral." - Add detailed documentation requirements, including: o Documentation of services provided, offered, recommended, or referred o Documentation of the client's clinic/HIV provider and/or PCP o Documentation of psychiatrist involvement, if applicable o Documentation of case manager (medical or non-medical), if applicable o Documentation of ROIs obtained or declined o Documentation of outreach attempts to inform care-team members that the client is starting mental health services o Retention of written referrals and documentation of follow-up when appropriate o Requirement to obtain ROIs with the treatment team - Requirement to reach out to members of the treatment team to notify them when a client begins mental health services - Documentation must reflect services provided, offered, and recommended to clients.	

Agenda Item	Action	Follow-up
	- Document when a therapist advises a client to seek care, as "I wrote it down, and I told someone" is necessary for coordination and liability. - Clarify that documentation may include "referred and/or recommended." - Confirm that the document should contain the measure: documentation of services provided, offered, and recommended to clients. - Add that documentation should show that a care team exists, as "there's that care team that is responsible for X, Y, and Z needs."	
c. **ACTION**: Review and update the Psychiatric Medication Management Service Standards	**Motion Tabled**	
6. Old Business:		
a. None		
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	- Upcoming binational conference "Pride Without Fear" presented by VIDA	
10. Next meeting date:	**Date:** November 10, 2026 **Time:** 4:00 PM – 5:30 PM **Location:** County Operations Center, 5560 Overland Ave, San Diego, CA 92123 Training Room 171	
11. Adjournment	The meeting was adjourned at 5:44 PM	

RYAN WHITE PRIMARY CARE PROGRAM
6Practice Guidelines Compliance Chart Review: 10/1/25 – 9/30/26

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 >200 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
6Practice Guidelines Compliance Chart Review: 10/1/25 – 9/30/26

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

RYAN WHITE PRIMARY CARE PROGRAM
6Practice Guidelines Compliance Chart Review: 10/1/25 – 9/30/26

Case ID: _____ Reviewer: _____ Date: _____

Psychiatric Medication Management Services

NATIONAL STRATEGIC PLANS: ADDRESSING THE SYNDEMIC The National HIV/AIDS Strategy for the United States 2022–2025, along with the Sexually Transmitted Infections (STIs) and Viral Hepatitis National Strategic Plans identified the need to integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence. The White House. 2023. National HIV/AIDS Strategy 2023 Interim Action Report. Washington, DC.

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 licensed ~~mid-level~~advanced practice ~~practitioner~~provider. 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.

[Does the primary care standards mention screening, and are there recommendations there to prescribe or refer?]

Key Service Components and Activities

Key activities for psychiatric medication management services include:

- Initial comprehensive assessment, including documentation of diagnosis and determination of ~~need~~ appropriateness 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~~a 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 psychiatry~~ic~~ resident or an advanced practice provider (e.g., ~~,~~ 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 and substance use. 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.

[What about ECT, TMS, ketamine]

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 18, Issue 9: Data through April 2026; Report released September 25, 2026.

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

	2025		2026	
	April	*Previous 12-Month Period**	*April*	*Previous 12-Month Period**
Chlamydia	1342	15754	1298	14945
Female age 18-25	425	5112	451	5103
Female age ≤ 17	45	587	38	570
Male rectal chlamydia	72	1030	59	750
Gonorrhea	389	5651	441	5546
Female age 18-25	30	492	45	430
Female age ≤ 17	2	81	1	24
Male rectal gonorrhea	80	1369	105	1360
Early Syphilis (adult total)	37	616	31	517
Primary	5	101	7	73
Secondary	11	172	9	127
Early latent	21	343	15	320
Congenital syphilis	1	29	2	24

* 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	4853	442.5	139	99.9	186	361.3	516	135.3	561	118.2
Gonorrhea	1921	175.1	71	51.0	99	192.3	381	319.9	456	96.1
Early Syphilis	149	13.6	3	2.2	22	42.7	64	16.8	34	7.2
Under 20 yrs										
Chlamydia	885	323.8	11	38.1	37	293.3	74	62.1	107	112.9
Gonorrhea	100	36.6	6	20.8	2	15.9	11	9.2	15	15.8
Early Syphilis	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

Note: Rates are calculated using 2024 Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 09/2025.

* 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.

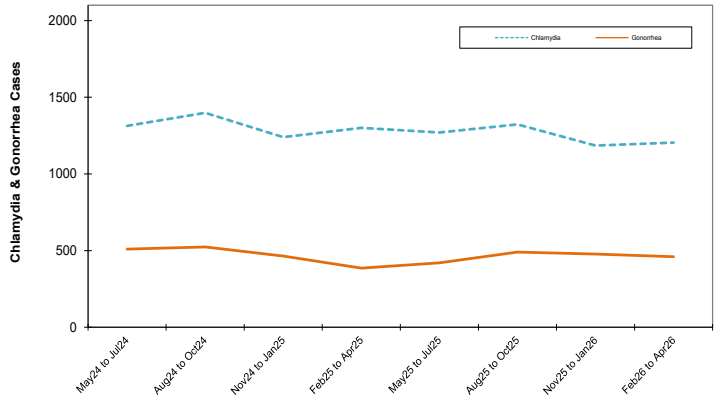
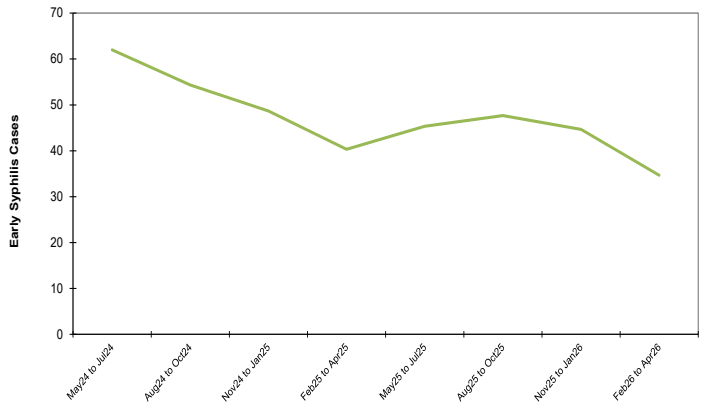


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.

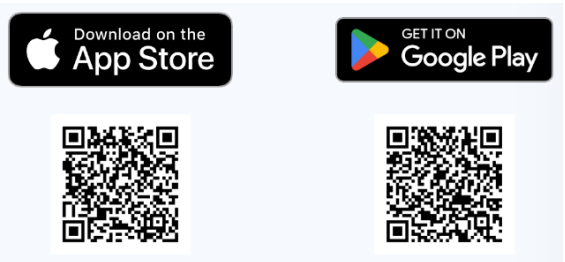


Editorial Note: New Syphilis Tools App Is Now Available

The Syphilis Tools app, developed by the University of Washington and the National STD Curriculum in partnership with the Centers for Disease Control and Prevention (CDC), is now available for health professionals. Syphilis Tools is a no-cost, point-of-care mobile/web-based app for health care professionals to obtain detailed information and evidence-based CDC recommendations on syphilis screening, staging, serologic testing, treatment, monitoring, and sex partner management. Other features of the app include access to county-based syphilis rates to aid in risk stratification, a syphilis nontreponemal serology (RPR/VDRL) tool for monitoring and interpretation of RPR/VDRL titers, and medical images. Protected health information is not collected by the Syphilis Tools app.

The app is available for download on the Apple App Store or Google Play, and the progressive web app is available at https://std.uw.edu.





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 2025 - Sep 2026

Medical Standards & Evaluation Committee (MSEC)	Nov	Feb	May	Sep	#	# of JC Starting Jan 2026
Total Meetings	1	1	1	1	**4**	
(13) Members						
Aguirre Mendoza, Marco				**1**	**1**	
Aldous, Dr. Jeannette [CC]	*	**1**	*	**1**	**2**	
Bamford, Dr. Laura	**1**	*	*	**1**	**2**	
Garcia, Rosemary	*	*	**1**	*	**1**	
Grelotti, David [C]	**1**	*	*	*	**1**	
Hernandez, Yessica	**1**	*	*	**1**	**2**	
Paugh, Shannon	*	*	*	*	**0**	
Quezada-Torres, Karla	*	*	*	*	**0**	
Rodriguez, Martha	**1**	**1**	*	*	**2**	
Saville, Edith	*	*	*	*	**0**	
Spector, Dr. Stephen	*	*	*	**1**	**1**	
Tilghman, Dr. Winston	*	**1**	*	*	**1**	
Whyte, Fadra	*	**1**	*	*	**1**	

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.

* = Present

1 = Absent for the month

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

JC = Just Cause

NM = No Meeting

NQ = No Quorum

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

(An Amendment to AB 2302)

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

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

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

Additional Information for Members Participating Remotely

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

1. The member shall notify the 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.
2. The member shall publicly disclose at the meeting before any action is taken, whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.
3. The member shall participate through both audio and visual technology.

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

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

SB 707: Open meetings: meeting and teleconference requirements. (2026) – in effect until January 1, 2030