LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Avenue, 14th Floor, Los Angeles, CA 90020
MAIN: 213.738.2816 | EMAIL: hivcomm@lachiv.org | WEB: https://hiv.lacounty.gov

AGENDA FOR THE REGULAR MEETING OF THE STANDARDS AND BEST PRACTICES COMMITTEE

MONDAY, OCTOBER 19, 2026 | 10:00 AM—1:00 PM
EXTENDED MEETING
510 S. Vermont Ave.
Terrace Level Conference Room (9th Floor), Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles, CA 90020

As a building security protocol, attendees entering the first-floor lobby must notify security personnel that they are attending a Commission on HIV meeting.

TO JOIN THE MEETING VIRTUALLY, PLEASE REGISTER USING THE LINK BELOW:
https://bos-lacounty-gov.zoom.us/webinar/register/WN_Pk58YtVKToyJcWDLyyP3Gw

COMMITTEE CO-CHAIRS: Caitlin Dolan and Montana Volby

AGENDA POSTED: October 14, 2026

PUBLIC COMMENT: Public comment is an opportunity for members of the public to address the Commission on an agenda item or other matter within the Commission's subject matter jurisdiction. Comments may be provided in person or submitted electronically to https://forms.cloud.microsoft/g/sTQqRq5dH7

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission office at hivcomm@lachiv.org or leave a voicemail at 213.738.2816.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con la Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico a HIVComm@lachiv.org, por lo menos 72 horas antes de la junta.

SUPPORTING DOCUMENTATION: Supporting documents are available on the Commission's website https://hiv.lacounty.gov/meetings.

1. **ADMINISTRATIVE MATTERS**

- **A.** Call to Order and Roll Call — 10:00 AM—10:05 AM
- **B.** Code of Conduct and Meetings Guidelines — 10:05 AM—10:07 AM
- **C.** Approval of the Agenda **MOTION #1** — 10:07 AM—10:09 AM
- **D.** Approval of Prior Meeting Minutes **MOTION #2** — 10:09 AM—10:10 AM

2. **PUBLIC COMMENT** 10:10 AM—10:15 AM

Comments may not exceed 2 minutes per person, per agenda item.

3. **COMMITTEE NEW BUSINESS ITEMS** 10:15 AM—10:20 AM

Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

4. **REPORTS**

- **A.** Commission on HIV (COH) Staff Report — 10:20 AM—10:25 AM
  - i. Operational and Commission Updates
- **B.** Co-Chair Report — 10:25 AM—10:35 AM
  - i. 2026 SBP Workplan and Meeting Calendar Updates
  - ii. Service Standard Review Calendar Updates
- **C.** Division of HIV and STD Programs (DHSP) — 10:35 AM—10:45 AM

5. **DISCUSSION** 10:45 AM—12:50 PM

- **A.** Dejon Smith Committee-Only Application Review **MOTION #3**
- **B.** Program Year 35 Assessment of the Efficiency of the Administrative Mechanism Updates
- **C.** Universal Service Standards Review Workgroup Updates
- **D.** Oral Health Service Standard Review **MOTION #4**

6. **NEXT STEPS** 12:50 PM—12:55 PM

A. Task/Assignment Recap

B. Agenda Development for the Next Meeting

7. **ANNOUNCEMENTS** 12:55 PM—1:00 PM

Opportunity for members of the public and Commission members to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.

8. **ADJOURNMENT** **1:00PM**

PROPOSED MOTION(S)/ACTIONS(S)	
MOTION #1	Approve the agenda order, as presented or revised.
MOTION #2	Approved the prior Committee meeting minutes, as presented or revised.
MOTION #3	Recommend the applicant for Committee-only membership and forward the application to the Executive Committee for approval.
MOTION #4	Announce a public comment period for the Oral Health Services standards ending on October 30, 2026.

STANDARDS AND BEST PRACTICES COMMITTEE MEMBERSHIP		
Gerardo	Almazan	Committee-Only Member
Oscar	Arellano	Committee-Only Member
Robert	Bolan, MD	Community-Based & AIDS Service Orgs (CBO/ASO)
Mikhaela	Cielo, MD	Ryan White Part D / CYF Providers
Anthony	Corona	Committee-Only Member
Johnny	Cross	Committee-Only Member
Caitlin	Dolan	Committee-Only Member
Arlene	Frames	Committee-Only Member
Lauren	Gersh, LCSW	Committee-Only Member
Joseph	Green	Committee-Only Member
Roberto	Lara	Committee-Only Member
Eric	Mattern	Substance Use Providers
Paul	Nash, Cpsychol, AFBPsS, FHEA	HIV Academic Researcher
Byron	Patel, RN, ACRN	Health Care Providers (FQHCs)
Nolan	Ross Samé-Weil, MBA	Board of Supervisors Office #4 Representative
Emmanuel	Sanchez-Ramos, DrPH, MPH	Affected & Disproportionately Impacted Communities
Montana	Volby	Unaffiliated Representative - SPA 1
QUORUM: 9		

LOS ANGELES COUNTY
COMMISSION ON HIV

Hybrid Meeting Guidelines

(Updated 6.11.26)

- ☐ This meeting is a **Brown-Act meeting** and is being recorded.
  - Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
  - Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

- ☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

- ☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet.

- ☐ **Public Comment** can be submitted in person or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

- ☐ For individuals joining in person, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via Zoom** to mitigate any potential streaming interference for those joining virtually.

- ☐ Attendees joining online should **remain muted** unless called upon.

- ☐ Commissioners and Committee-only members invoking **SB 707 for "Just Cause"** must communicate their intentions to staff no later than one hour before the meeting. Members requesting to join pursuant to SB 707 must have their audio and video on for the entire duration of the meeting and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges.

- ☐ Members will be required to explicitly state their agency's **Ryan White Program Part A conflicts of interest** on the record. A list of conflicts can be found in the meeting packet, courtesy of staff.

If you experience challenges in logging into the virtual meeting, please contact Commission staff at hivcomm@lachiv.org for assistance. Please note that staff may have limited availability during meetings and responses may be delayed. We appreciate your patience and will follow up as soon as we're able.

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

Approved by COH 6/8/23

CODE OF CONDUCT

APPROVED BY OPERATIONS COMMITTEE ON 05/25/23; COH 06/08/23
Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19; 3/3/22, 3/23/23; 5/30/23)**

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 9/02/26

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts.***An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.***

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALMANZAN	**Gerardo**	No affiliation	No Ryan White or prevention contracts
VAZQUEZ ALVAREZ	**Leo**	LACADA	No Ryan White or prevention contracts
ARRELANO	**Oscar**	Homeless Outreach Program Integrated Care System (HOPICS)	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention
			Data to Care Services
			Medical Transportation Services
BARAJAS	**Jeronimo**	Unaffiliated Member	No Ryan White or prevention contracts
BIENEMAN	**Stevie**	AIDS Healthcare Foundation	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			Medical Transportation Services
			HIV & STD LB
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			Sexual Health Express Clinics (SHEx-C)
BLEA	**Leroy**	California Department of Public Health, Office of AIDS	Part B Grantee

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
BOLAN	**Robert**	LA LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
BROWN	**Jasmine**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Core HIV Medical Services - PSS
			HTS - Storefront
			HTS - Social and Sexual Networks
CIELO	**Mikhaela**	Los Angeles General Hospital	No Ryan White or prevention contracts
COPELAND	**Raniyah**	Equity Impact Solutions	No Ryan White or prevention contracts
CORONA	**Anthony**	Watt's Healthcare	Core HIV Medical Services - MCC & PSS
			Biomedical HIV Prevention Services
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			Medical Transportation Services
CORONA	**Ceasar**	Tarzana Treatment Center	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Care Management
			Substance Use Transitional Hsg
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			HIV Testing and Viral Hepatitis Services
CROSS	**Johnny**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Population (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
DAVIES	**Erika**	City of Pasadena	No Ryan White or prevention contracts

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DOLAN	**Caitlyn**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
GAMBOA	**Robert**	LA LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
GERSH	**Lauren**	APLA Health & Wellness	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			High Impact Prevention
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts
GRIFFEN	**TJ**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Populations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GUTIERREZ	**Joaquin**	REACH LA	HTS - Social and Sexual Networks
HARRIS	**Darryn**	St. John's Well Child and Family Center (SJW)	Core HIV Medical Services - AOM; MCC & PSS
			Oral Health
			HTS - Social and Sexual Networks
			Mental Health
			Biomedical HIV Prevention Services
			Medical Transportation Services
HUNT	**Angela**	Unaffilated Member	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JOHNSON	**LeiLani**	Unaffilited Member	No Ryan White or prevention contracts
JOHNSON	**Stephanie**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Populations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
LARA	**Roberto**	AMAAD	No Ryan White or prevention contracts
LESTER	**Rob**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
LOCKLEAR	**Preston**	LA LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
MARTINEZ	**Miguel**	No affiliation	No Ryan White or prevention contracts

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MATTERN	**Eric**	Tarzana Treatment Center	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Care Management
			Substance Use Transitional Hsg
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			HIV Testing and Viral Hepatitis Services
MCKINLEY	**Kiante**	LA LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
MENDOZA	**Vilma**	Unaffiliated representative	No Ryan White or prevention contracts
MILLER	**Jack**	Unaffiliated Member	No Ryan White or prevention contracts
MORRISON	**Donta**	UCLA CARE	No Ryan White or prevention contracts
MULLEN	**Sadie**	No affiliation	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	No Ryan White or prevention contracts
NGUYEN	**Kevin**	Saban Community Clinic	No Ryan White or prevention contracts

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
NWIZU	**Ujuonu**	Public Health Alliance	No Ryan White or prevention contracts
CERDA OROZCO	**David**	No affiliation	No Ryan White or prevention contracts
PACHECO	**Elizabeth**	Tarzana Treatment Center	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Substance Use Transitional Hsg
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			HIV Testing and Viral Hepatitis Services
PATEL	**Byron**	Los Angeles LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PLEASANTS	**Shawn**	Unaffiliated Member	No Ryan White or prevention contracts
ROJAS	**David**	LAC Consumer & Business Affairs	No Ryan White or prevention contracts

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SALAMANCA	**Ismael**	City of Long Beach	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			HTS - Social and Sexual Networks
			Medical Transportation Services
SANCHEZ-RAMOS	**Emmanuel**	APLA Health	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD - ExC
			High Impact Prevention
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
SAN AGUSTIN	**Glen**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention Services
			Data to Care Services
			Medical Transportation Services
SAME-WEIL	**Nolan Ross**	Los Angeles Centers for Alcohol & Drug Abuse (L.A. CADA)	No Ryan White or prevention contracts
SANTIAGO	**Draya**	Unaffilited Member	No Ryan White or prevention contracts
SKELTON	**Maria**	No affiliation	No Ryan White or prevention contracts
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Core HIV Medical Services - PSS
			HTS - Storefront
			HTS - Social and Sexual Networks
WEBB	**Christopher**	REACH LA	HTS - Social and Sexual Networks

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
			Core HIV Medical Services - AOM & MCC
VALENZUELA	**David**	LAC Department of Public Health	No Ryan White or prevention contracts
VOLBY	**Montana**	Unaffilited Member	No Ryan White or prevention contracts

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MINUTES FOR THE REGULAR MEETING OF THE STANDARDS AND BEST PRACTICES COMMITTEE

DATE: Monday, August 17, 2026 from 10:00 AM—12:00 PM.

LOCATION: 510 S. Vermont Ave. Terrace Level Conference Room (9th Floor), Los Angeles, CA 90020

CALL TO ORDER: COH staff called the meeting to order at 10:05am.

CO-CHAIRS: Caitlin Dolan and Montana Volby

SUPPORTING DOCUMENTATION: Supporting documents are available on the Commission's website https://hiv.lacounty.gov/standards-and-best-practices-committee/

STANDARDS AND BEST PRACTICES COMMITTEE MEMBERSHIP P = Present | A = Absent| SB707 = Remote Participation | PU = Public			
Gerardo Almazan	P	Joseph Green	P
Oscar Arellano	A	LeiLani Johnson	LOA
Robert Bolan, MD	P	Roberto Lara	P
Mikhaela Cielo, MD	P	Eric Mattern	P
Anthony Corona	P	Byron Patel, RN, ACRN	P
Johnny Cross	SB707	Emmanuel Sanchez-Ramos, DrPH, MPH	PU
Caitlin Dolan	P	Draya Santiago	LOA
Arlene Frames	SB707	Montana Volby	EA
Lauren Gersh	EA		

ADMINISTRATIVE MATTERS	**MOTION #1**: Approval of the Agenda. *Approved by consensus.* **MOTION #2**: Approval of Prior Meeting Minutes. *Approved by consensus.*
PUBLIC COMMENT	Member of the public Jeffrey Young shared he submitted public comments for the Universal Service Standards and Client Bill of Rights and Responsibilities (see meeting packet for a copy of the documents) earlier that morning. COH staff noted the comments were received and the Committee will review them during the discussion portion of the meeting.
COMMITTEE NEW BUSINESS ITEMS	There were no committee new business items.
REPORTS	**COMMISSION ON HIV (COH) STAFF REPORT** Interim-Executive Director, Dawn McClendon-Musson, welcomed Paul Nash to the SBP Committee; he transferred over from the PP&A Committee. P. Nash holds the HIV Academic/Scientist Representative seat. D. McClendon-Musson shared that the next COH meeting will be on September 10, 2026, at the CA Endowment. According to the COH workplan,

	the September 10th meeting will be the last meeting for the COH unless the Executive Committee determines an additional meeting is needed to address any new business items or urgent items that arise between now and the October 22, 2026 Executive Committee meeting. At the meeting, Commissioners will hold a vote on the Program Year (PY) 36 and 37 Priority Setting and Resource Allocations (PSRA). In order for full members to participate in the vote, they must have completed the "Needs Assessment and PSRA" training and must have submitted their conflict-of-interest form. The training is available for viewing on the COH website; full members must notify staff they have completed the training to be marked eligible to vote on the PY 36 and PY37 resource allocations. COH staff will send reminders leading to the September 10th meeting. She noted that the Commissioner Core training series is complete; COH staff are developing additional capacity building opportunities including a knowledge assessment survey to gauge how commissioners and committee-only members feel about the new COH structure and identify additional training needs. She will also conduct a call down to all members and solicit feedback on the new COH structure and areas of improvement. Also, COH staff will conduct a virtual mini-refresher towards the end of the year to keep members engaged Lastly, D. McClendon-Musson, COH co-chair Katja Nelson, and MCE Committee co-chair Ish Herrera, attended the 2026 National Ryan White Program Conference in Washington D.C. Key takeaways included learning how other planning councils implement community engagement activities, and utilizing digital tools to improve the COH's PSRA process. **CO-CHAIR REPORT** Caitlin Dolan, SBP Committee co-chair, led an overview of the Service Standards Revision tracker, and Committee workplan (see meeting packet for a copy of the documents). Based on the tracker, the Committee will review the Oral Health Service standards after approving the revised Universal Service Standards and Client Bill of Rights and Responsibilities. COH staff shared background information explaining the reasons why the Committee will conduct a review of the Oral Health Service standards in October. In January 2026, Dr. Farina Younai shared the latest, "Oral Health Guidelines for the Management of HIV Positive Patients" and encouraged the SBP Committee to review the Oral Health Services standards. Additionally, there is an upcoming DHSP solicitation for Oral Health services. Ryan White Program dental providers will participate in the October 19 Committee meeting and share additional information to inform the Oral Health service standards discussion. Additionally, the Committee added a meeting on November 2, 2026, from 10am-12pm at the Vermont corridor to close out Committee business for the remainder of 2026.

	DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT Paulina Zamudio, DHSP staff, shared presents service delivery and utilization data, and customer support issues data with the SBP Committee to identify any gaps in communities that may not be accessing services and for the committee to discuss and take into consideration when reviewing service standards. P. Zamudio reported that DHSP received HRSA funding for PY 36 (current cycle) and has awarded contracts for Benefits Specialty, Residential Services, and Nutrition Services for a 5-year term; the terms can be adjusted based on availability of funding. She added that DHSP is still waiting for a response from HRSA regarding a carry-over request for EHE funds, and a response from CDC regarding supplemental funding. DHSP staff Sona Oksuzyan reported that service utilization reports for PY35 are ready; COH staff will coordinate with DHSP staff to determine when to schedule the PY35 service utilization report presentation(s).
DISCUSSION ITEMS	**ASSESSMENT OF THE EFFICIENCY OF THE ADMINISTRATIVE MECHANISM (AEAM) UPDATES** J. Rangel-Garibay shared updates regarding the Program Year (PY) 35 AEAM, noting that key informant interviews with DHSP staff Dr. Michael Green, and Paulina Zamudio are scheduled for August 25. A draft PY35 AEAM report will be available for Committee review at the October 19 meeting. **UNIVERSAL SERVICE STANDARDS AND CLIENT BILL OF RIGHTS AND RESPONSIBILITIES REVIEW** The committee reviewed public comments received for the Universal Service Standards and the Client Bill of Rights and Responsibilities on 8/16/26 (see updated meeting packet on the COH website for a copy of the document). Given the number of public comments received, the Committee decided to establish a work group to conduct an in-depth review of and address issues described in the public comments. The Committee decided to postpone **MOTION #3** to allow the Committee more time to review public comments and revise the documents as appropriate. The following Committee members expressed interest in participating in the "Universal Service Standards Review Workgroup": Robert Bolan, Arlene Frames, Joseph Green, Eric Mattern, Paul Nash, Nolan Ross, Johnny Cross, and DHSP staff member Paulina Zamudio. COH staff will follow-up to coordinate the workgroup's meeting schedule. Additionally, the Committee decided to establish workgroups to conduct service standards reviews moving forward. The Committee also discussed coordinating with DHSP staff and the COH's Planning, Priorities, and Allocations (PP&A) Committee to determine next steps for scheduling PY 35 Ryan White Program service utilization reports.

	MOTION #3: Approve the Universal Service Standards and Client Bill of Rights and Responsibilities, as presented or revised, and elevate to the Executive Committee. *Did no hold vote; motion continued to next meeting.*
ANNOUNCEMENTS	There were no announcements.
ACTION ITEMS	
RESPONSIBLE PARTY	**ITEM**
COH STAFF	• Follow-up with committee members who volunteered to serve on the Service Standards Review Workgroup for the Universal Service Standards and the Client Bill of Rights and Responsibilities. • Invite DHSP's Clinical Quality Management (CQM) Team to share relevant findings, performance data, and quality improvement priorities, and to participate in future SBP Committee meetings as appropriate. • Send reminder to Committee members regarding the November 2, 2026 Committee meeting.
NEXT MEETING	The next Standards and Best Practices Committee meeting will be an extended meeting on Monday October 19, 2026, from 10:00am—1:00pm at the Vermont Corridor. The additional time is to accommodate the Oral Health Service Standards discussion.
ADJOURNMENT	The meeting adjourned at 11:30am.

PREPARED BY: Jose Rangel-Garibay	**APPROVAL DATE:**

JOIN US FOR THE

2026 Data Summit

Data to Decisions: Preparing for Ryan White Planning

Friday, October 30, 2026	9:00AM - 3:00PM	510 S Vermont Ave Los Angeles CA 90020	Food & raffles	RSVP Required

Join us for a full day of learning and capacity-building designed to help members and community partners better understand how data is used in Ryan White planning and priority setting and resource allocation.



COME DRESSED WITH YOUR HALLOWEEN SPIRIT!

There will be food, raffles, and prizes for those who are dressed in their Halloween best!

RSVP REQUIRED

Scan QR code or click: https://forms.cloud.microsoft/g/8bU7xCjiHy

WHAT TO EXPECT

- Data 101 & Epidemiology 101
- Data sources used in PSRA
- Ryan White Funding 101
- Understanding Utilization & Expenditure Data
- Community Voice & Lived Experience as Data
- Interactive PSRA exercises & group discussion

WHO SHOULD ATTEND?



Open to Commission members, committee-only members, community partners, providers and the public.

Come learn, ask questions, and build confidence in using data to inform Ryan White planning and decisions.

LOS ANGELES COUNTY COMMISSION ON HIV

COUNTY OF LOS ANGELES Public Health Division of HIV and STD Programs

LOS ANGELES COUNTY COMMISSION ON HIV

2026-27 STANDARDS AND BEST PRACTICES COMMITTEE MEETING CALENDAR

MONTH	KEY ACTIVITIES
April 20, 2026 **10am-12pm**	• Nominate and elect committee co-chairs • Conduct committee orientation training • Review and adopt 2026 committee workplan
May 18, 2026 **10am-12pm**	• Review Assessment of the Efficiency of the Administrative Mechanism (AEAM) assessment tool • Develop service standard development schedule
June 15, 2026 **10am-12pm**	• Launch AEAM assessment tool for PY35 • Review of Universal Service Standards and Client Bill of Rights and Responsibilities
August 17, 2026 **10am-12pm**	• Continue reviewing Universal Service Standards and Client Bill of Rights and Responsibilities • Initiate review of Oral Health Service Standards • Updates to PY35 AEAM
October 19, 2026 **10am-1pm** **Extended Meeting**	• Review Oral Health Service Standards • Review AEAM report for PY35
November 2, 2026 **10am-12pm**	• Review recommendations from the Universal Service Standards Review Workgroup Finalize review of Oral Health Service Standards • Initiate review of Legal Services standards
December 2026 ****CANCELED****	Limited Commission and Committee activity in recognition of the holiday period
February 8, 2027 **10am-12pm**	• Draft 2027-28 committee workplan and meeting calendar • Draft service standard development schedule

Revised: 10/15/26

LOS ANGELES COUNTY COMMISSION ON HIV

2026 STANDARDS AND BEST PRACTICES COMMITTEE MASTER WORKPLAN *(Revised 10/15/26)*

PURPOSE

To define the scope, priorities, and core activities of the **Standards & Best Practices (SBP) Committee** during the Ryan White Program Year (March 1, 2026 – February 28, 2027), in alignment with the revised Commission Bylaws, Ryan White HIV/AIDS Program (RWHAP) Part A legislative and program expectations, CDC/HRSA integrated planning guidance, and the Commission's restructured governance model. The SBP Committee leads the Commission's work to strengthen the quality, consistency, and effectiveness of the HIV service delivery system by supporting clinical quality management, developing and maintaining service standards, identifying best practices, assessing service effectiveness, and advancing service system improvements in coordination with DHSP and other Commission working units.

CRITERIA

Activities included in this workplan are selected based on their ability to:

- Fulfill SBP responsibilities defined in the Commission Bylaws;
- Support compliance with RWHAP Part A, HRSA expectations, CDC/HRSA integrated planning guidance, Brown Act, and County requirements;
- Strengthen quality management and performance/outcomes accountability across the HIV service continuum;
- Promote consistent, evidence-informed standards and best practices in HIV prevention and care;
- Identify service gaps and recommend feasible system improvements and directives; and
- Align with Commission and staff capacity, recognizing a bi-monthly meeting schedule.

CORE COMMITTEE RESPONSIBILITIES

The SBP Committee is responsible for:

- Supporting DHSP's Clinical Quality Management Plan and reviewing aggregate quality, utilization, and outcomes data to assess service effectiveness;
- Identifying, reviewing, and recommending service standards, best practices, and outcome measures across the HIV care continuum;
- Evaluating service effectiveness, including outcomes, cost effectiveness, capacity, access, and service models;
- Identifying service gaps, system inefficiencies, and improvement opportunities, and recommending corrective actions to DHSP and the Commission;
- Recommending service delivery improvements and implementation directives, in coordination with the Planning, Priorities & Allocations Committee;
- Conducting the Assessment of the Administrative Mechanism and overseeing implementation of adopted recommendations;
- Promoting consistency and quality in HIV services countywide through system-level review (not individual provider oversight); and
- Carrying out additional responsibilities as assigned by the Commission or Board of Supervisors.

Approved 5/18/26

2026 STANDARDS AND BEST PRACTICES COMMITTEE MASTER WORKPLAN *(Revised 8/13/26)*

ACRONYMS	
• **COH:** Commission on HIV • **DHSP:** Division on HIV and STD Programs • **BOS:** Board of Supervisors • **HRSA:** Health Resources and Services Administration • **MCE:** Membership and Community Engagement Committee • **PP&A:** Planning, Priorities, and Allocations Committee • **SBP:** Standards and Best Practices Committee	• **EO:** Executive Office • **CEO LAIR:** Chief Executive Office Legislative Affairs and Intergovernmental Relations • **OA:** California Office of AIDS • **CHIPTS:** Center for HIV Identification, Prevention, and Treatment Services.

#	OBJECTIVE	TASKS/ACTIVITIES	TIMELINE	NOTES/COMMENTS
1	Establish committee leadership.	• Hold nominations for committee co-chairs. • Elect committee co-chairs.	April	**COMPLETED**
2	Develop 2026 committee workplan.	• Review and adopt annual workplan *(subject to change).* • Establish meeting calendar *(subject to change).*	May	**COMPLETED**
3	Monitor progress on committee workplan.	• Provide monthly updates/reports to Executive Committee and COH.	Ongoing	
4	Conduct committee orientation.	• Review role, scope, and responsibilities of committee.	April	**COMPLETED**
5	Assist with development of the BOS Annual Report	• Outline SBP Committee key accomplishments and challenges • Submit accomplishments and challenges to Executive Committee for incorporation into BOS Annual Report.	Jan-Feb 2027	
6	Conduct review/revisions of service standards, as needed.	• Conduct review/revisions of service standards, as needed. • Develop schedule based on service rankings, DHSP RFP schedule, consumer/provider concern, or in response to changes in the HIV care continuum. • Review service utilization reports. • Collaborate with DHSP, COH committees and caucuses, and RWHAP Part A providers.	Ongoing	Universal Standards Review Workgroup met on 9/21/26 and 10/5/26 (see summary report) and will finalize their review on 10/27/26. Committee will discuss the Oral Health Service Standards on 10/19/26.
7	Conduct the Assessment of the Efficiency of the Administrative Mechanism.	• Review assessment tool, revise as needed. • Conduct assessment for PY 35 (Mar 1, 2025-Feb 28, 2026) • Collaborate with DHSP and RWHAP Part A providers.	May-Oct	Review survey findings on 10/19/26 and submit report to Executive Committee.

2026 STANDARDS AND BEST PRACTICES COMMITTEE MASTER WORKPLAN *(Revised 8/13/26)*

		• Analyze and report findings.		
8	Review and monitor clinical quality management activities.	• Review report(s) on clinical quality management activities led by DHSP. • Review service category evaluation report(s). • Identify strategies for addressing findings. • Collaborate with DHSP; review service category evaluation report(s).	Ongoing	COH staff will meet with CQM team on 10/20/26 to discuss possible approaches.
9	Develop and monitor program directives.	• Develop and define directives for implementation of services and service models. • Ensure priorities and implementation efforts are consistent with needs, the HIV care continuum, and service delivery. • Develop strategies to address unmet need. • Collaborate with PP&A Committee.	Ongoing	
10	Compile best practices as related to HIV care and prevention.	• Identify, collect, and disseminate best practices for reducing HIV transmission, improving health outcomes, and optimizing quality of life and self-sufficiency for all PLWH.	Ongoing	

SERVICE STANDARDS REVISION DATE TRACKER FOR PLANNING PURPOSES

Last updated: 8/13/26

KEYWORDS AND ACRONYMS	
HRSA: Health Resources and Services Administration	**COH:** Commission on HIV
RWHAP: Ryan White HIV/AIDS Program	**DHSP:** Division on HIV and STD Programs
HAB PCN 16-02: HIV/AIDS Bureau Policy Clarification Notice 16-02 RWHAP: Eligible Individuals & Allowable Uses of Funds	**SBP Committee:** Standards and Best Practices Committee
	PLWH: People Living With HIV

GENERAL

Document Name	Description	Notes
Universal Service Standards	Apply to all services and covers areas such as non-discriminatory service delivery, client confidentiality, quality care, and grievance procedures. The SBP Committee reviews this document on a bi-annual basis or as needed per community stakeholder, service provider agency, or COH member request.	**Currently under review** **Last approved by COH: 1/11/2024**
Client Bill of Rights and Responsibilities	Empowers clients to advocate for themselves and work in partnership with their service providers to achieve the best possible HIV/AIDS care and treatment. Service provider agencies are required to provide clients with a copy of this document when receiving HRSA RWHAP services.	**Currently under review** **Last approved by COH: 1/11/2024**
Prevention Services	HIV and STI prevention services are those services used alone or in combination to prevent the transmission of HIV and STIs and may include Biomedical, Non-Biomedical, and Harm Reduction services.	Prevention standards **are not** required by CDC or HRSA but are developed by the COH to support inclusive, status-neutral prevention and care planning. **Last approved by COH: 1/11/2024**

CORE SERVICES

Service and Service Category	HRSA PCN 16-02 Service Description	Notes
Service Category: AIDS Drug Resistance Program Treatments	State-administered program authorized under RHWAP Part B to provide U.S. Food and Drug Administration (FDA)- approved medications to low-income clients living with HIW who have no coverage or limited health care coverage.	ADAP contracts directly with agencies and is administered by the California Department of Public Health, Office of AIDS.

LOS ANGELES COUNTY COMMISSION ON HIV

CORE SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
Early Intervention Services (PH Clinics) *Service Category: Early Intervention Services*	EIS is a combination of services rather than a stand-alone service and must include: • Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV • Referral services to improve HIV care and treatment services at key points of entry • Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse care. • Outreach services and Health Education/Risk Reduction related to HIV diagnosis	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 5/2/2017**
Home-Based Case Management *Service Category: Home and Community-Based Health Services*	Provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include: • Appropriate mental health, developmental, and rehabilitation services • Day treatment or other partial hospitalization services • Durable medical equipment • Home health aide services and personal care services in the home	**Upcoming DHSP solicitation. Consider scheduling review in 2027.** Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 9/92022**
Service Category: Hospice Services	End-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are: • Mental health counseling • Nursing care • Palliative therapeutics • Physician services • Room and board	**Last approved by COH: 5/2/2017**
Medical Care Coordination (MCC) *Service Category: Medical Case Management, including Treatment Adherence Services*	Provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided by an interdisciplinary team that includes specialty care providers. Medical Case Management includes all types of case management encounters	Currently funded for RW PY36 (3/1/2026-2/28/27). **MCC:** Last approved by the COH on 1/11/2024

CORE SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
	(e.g. face-to-face, phone contact, and any other forms of communication). Key activities include: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Timely and coordinated access to medically appropriate levels of health and support services and continuity of care • Continuous client monitoring to assess the efficacy of the care plan • Re-evaluation of the care plan at least every 6 months with adaptations as necessary • Ongoing assessment of the client's and other key family members' needs and personal support systems • Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments • Client-specific advocacy and/or review of utilization of services May also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible.	**Treatment Education Services**: Last approved by the COH on 5/2/2017
Medical Nutrition Therapy *Service Category: Medical Nutrition Therapy*	Includes: • Nutrition assessment and screening • Dietary/nutritional evaluation • Food and/or nutritional supplements per medical provider's recommendation • Nutrition education and/or counseling These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.	**Last approved by COH: 5/2/2017**
Mental Health Services *Service Category: Mental Health Services*	Provision of outpatient psychological and psychiatric screening, 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	**Upcoming DHSP solicitation. Consider scheduling review in 2027.**

CORE SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
	mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 5/2/5017.**
Oral Health Services *Service Category: Oral Health Care*	Activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.	**Upcoming DHSP solicitation. Review scheduled for October 2026.** Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 4/13/2023**
Ambulatory Outpatient Medical (AOM) services *Service Category: Outpatient/Ambulatory Health Services*	Provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits. Allowable activities include: • Medical history taking • Physical examination • Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing • Treatment and management of physical and behavioral health conditions • Behavioral risk assessment, subsequent counseling, and referral • Preventative care and screening • Pediatric developmental assessment • Prescription and management of medication therapy • Treatment adherence • Education and counseling on health and prevention issues • Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology.	**Last approved by COH: 2/13/2025**
Service Category: Substance Abuse Outpatient Care	Provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:	**Last approved by COH: 1/13/2022**

CORE SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**

	• Screening
	• Assessment
	• Diagnosis and/or
	• Treatment of substance use disorder, including:
	  ○ Pretreatment/recovery readiness programs
	  ○ Life-saving overdose prevention and response services or supplies such as opioid reversal supplies, substance test kits, and overdose reversal and training services
	  ○ Behavioral health counseling associated with substance use disorder
	  ○ Medication assisted therapy
	  ○ Neuro-psychiatric pharmaceuticals
	  ○ Relapsed prevention	

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
Child Care Services *Service Category: Child Care Services*	Intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.	**Last approved by COH: 7/8/2021**
Emergency Rental Assistance *Service Category: Emergency Financial Assistance*	Limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by ADAP, or another HRSA RWHAP-allowable cost needed to improve health outcomes. EFA must occur as direct payment to an agency or through a voucher program.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 2/13/2025** **Updates from DHSP:** Program currently only provides rental assistance. Clients must be facing eviction to qualify, the limit is $5,000 per year, per client, and applications are through Benefits Specialists.

LOS ANGELES COUNTY COMMISSION ON HIV

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
Nutrition Support Services *Service Category: Food bank/Home Delivered meals*	Provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following: Personal hygiene products; Household cleaning supplies; Water filtration/purification systems in communities where issues of water safety exist.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 8/10/2023**
Service Category: Health Education/Risk Reduction	Provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status.	**Last approved by COH: 4/10/2025**
Housing Services: Residential Care Facility for Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF) *Service Category: Housing*	Provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services). Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy service on behalf of the eligible client, as well as fees associated with these activities.	Currently funded for RW PY36 (3/1/2026-2/28/27) with RW Part B funds. **Last approved by COH: 4/10/2025**
Legal Services **Permanency Planning** *Service Category: Other Professional Services, Legal Services*	Provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: Legal services provide to and/or on behalf of the HRSA RWHAP=eligible PLWH and involving legal matters related to or arising from their HIV disease, including: • Assistance with public benefits such as Social Security Disability Insurance (SSDI) • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP • Preparation of: ○ Healthcare power of attorney	**Upcoming DHSP solicitation. Consider scheduling review in November 2026.** Currently funded for RW PY36 (3/1/2026-2/28/27) with RW Part B funds. **Last approved by COH: 7/12/2018**

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
	○ Durable powers of attorney ○ Living wills Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: • Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney • Preparation for custody, or adoption Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.	
Language Services *Service Category: Linguistic Services*	Include interpretation and translation activities, both oral and written to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWAHP-eligible services.	**Last approved by COH: 5/2/2017**
Medical Transportation *Service Category: Medical Transportation*	Provision of nonemergency transportation that enable an eligible client to access or be retained in core medical and support services.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 2/13/2025**
Benefits Specialty Services (BSS) **Patient Support Services (PSS)** **Transitional Case Management (TCM): Justice-Involved Individuals, Youth, and Older Adults 50+** *Service Category: Non-Medical Case Management*	Provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. Non-Medical Case Management (NMCM) provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public, private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone	**BSS**: Currently funded for RW PY36 (3/1/2026-2/28/27). Last approved by COH 9/8/2022. **PSS:** Currently funded for RW PY36 (3/1/2026-2/28/27). Last approved by COH 12/11/2025 **TCM Justice-Involved, Youth, and Older Adults 50+:** Last approved by COH 10/9/2022

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
	contact, and many other forms of communication. Key activities include: Initial assessment of service needs; Development of a comprehensive, individualized care plan; Timely and coordinated access to medically appropriate levels of health and support services and continuity of care; client-specific advocacy and/or review of utilization services; continuous client monitoring to assess the efficacy of the care plan; Re-evaluation of the care plan at least every 6 months with adaptations as necessary; Ongoing assessment of the client's and other key family members' needs and personal support systems.	
Linkage and Reengagement Program *Service Category: Outreach Services*	Provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 5/2/2017**
Psychosocial Support Services *Service Category: Psychosocial Support Services*	Provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services category may include: • Bereavement counseling • Caregiver/respite support (HRSA RWHAP Part D) • Child abuse and neglect counseling • HIV support groups • Nutrition counseling provided by a non-registered dietitian • Pastoral care/counseling services	**Last approved by COH: 9/10/2020**
Referral Services *Service Category: Referral for Health Care and Support Services*	Directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans.	**Last approved by COH: 5/2/2017**
Substance Use Disorder Transitional Housing	Activities provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:	Currently funded for RW PY36 (3/1/2026-2/28/27) with RW Part B funds.

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
Service Category: Substance Abuse Services (residential)	• Pretreatment/recovery readiness programs • Behavioral health counseling associated with substance use disorder • Medication assisted therapy • Neuro-psychiatric pharmaceuticals • Relapse prevention • Detoxification, if offered in a separate licensed residential setting	**Last approved by COH: 1/13/2022**

COMMITTEE-ONLY SEAT APPLICATION SUMMARY FOR DEJON SMITH TO THE STANDARDS AND BEST PRACTICES COMMITTEE

BACKGROUND:

Dejon Smith (He/Him/His) applied for a full Commissioner seat and indicated they were also open to serving as an Alternate or in a Committee-only role if a full seat was not available. Based on their application and the current open seats on the Commission roster, he did not meet the requirements for any of the available full Commission (COH) seats. The Membership and Community Engagement (MCE) Committee forwarded the application to the SBP Committee for consideration as a Committee-only member.

APPLICATION SUMMARY:

- Age: 30-39 years old
- Gender Identity: Man
- Race/Ethnicity: Black or African American
- 12 years of Lived Experience
- 15 years of Professional Experience
- Currently employed at REACH LA
    - Ryan White Program-funded agency
    - CDC-funded agency
- Has not served on an advisory board
- Was recommended to apply by Aaron Mason, LMFT at REACH LA
- Does not use or receive HIV prevention services in Los Angeles County
- Lives/Works in Supervisorial District 2 (Holly Mitchell) and SPA 6 (South Los Angeles)
- Somewhat unprepared to serve on the COH; Familiar with the COH's work
- Interested in assuming a leadership role on the COH.
- Represents the following categories:
    - Community Based Organizations serving affected populations/AIDS Services Organizations;
    - Affected communities, including people living with HIV/AIDS, members of a federally recognized Indian Tribe as represented in the population, individuals co-infected with hepatitis B or C, and historically underserved groups and subpopulations;
    - Recipient of other federal HIV programs including but not limited to providers of HIV prevention services

Please tell us more about why you wish to serve on the Los Angeles County Commission on HIV or one of its committees.

I want to serve on the Los Angeles County Commission on HIV because I've spent most of my career on the front lines of HIV prevention and care, from working as an HIV Testing Counselor with the AIDS Healthcare Foundation in New York, where I provided testing and counseling to at risk populations and ran a mobile testing unit to reach people where they gathered, to serving as Health Promotion Associate with Gay Men of African Descent, facilitating outreach and group interventions within Black gay and same gender loving communities. That experience, along with my current work as a Caseworker and Patient Navigator at REACH LA in Los Angeles, where I project manage three community programs and see firsthand how gaps in coordination and resources affect people's access to care, has given me a grounded understanding of what communities actually need. Having worked across New York, Chicago, and Los Angeles with populations that are often underserved, including youth, people of color, and LGBTQ+ communities, I want to bring that frontline perspective into the county's decision-making process and help ensure the people most affected by HIV have a real voice in sharing its response.

Describe your community involvement. Please identify the organizations or agencies you have served and your participation or membership. Include your activities, responsibilities, accomplishments, and any boards/commissions on which you have served.

Most of my career has been rooted in direct community health work rather than formal board services. At REACH LA in Los Angeles, I serve as both a Caseworker and Patient Navigator, and I project manage three community programs, Zen Folk, Positive Practice, and Case Management (Let's Get U to U), which includes gathering community health data, identifying unmet needs in the neighborhoods we serve, running outreach for new populations, and personally getting clients to their appointments and those interested, reaching viral suppression. Earlier in my carer I work with the AIDS Healthcare Foundation in New York providing HIV counseling and testing to at risk populations, including supporting a mobile testing unit that met people where they gathered, and with Gay Men of African Descent, known as GMAD, where I screened and counseled clients for HIV testing and facilitated group interventions.

Before moving into public health work, I managed the office of Youth Pride Services in Chicago, where I coordinated events, fundraisers, and workshop for underserved youth and youth of color, and served as a facilitator for programs like Brotha2Brotha and Positive Relationships. I don't currently hold any board or commission seats, but nearly every I've held has put me directly in service of communities I'm part of.

UNIVERSAL SERVICE STANDARDS REVIEW WORKGROUP
MEETING SUMMARY FOR 9/21/26 AND 10/05/26

Description: The workgroup is tasked with conducting an in-depth review of the Commission on HIV's (COH) Universal Service Standards and Client Bill of Rights and Responsibilities (including all public comments received) and submit revisions/recommendations to the Standards and Best Practices Committee for consideration.

Meeting Attendees: Nolan Ross, Eric Mattern, Paulina Zamudio, Paul Nash, Joseph Green, Robert Bolan and Jose Rangel.

Meeting Summary: The workgroup met on September 21, 2026, and October 5, 2026, and reviewed public comments received on August 16, 2026, regarding the Universal Service Standards and Client Bill of Rights and Responsibilities documents. The workgroup examined the comments and made recommendations on how to address them including revisions to the documents and requesting regular updates from the Division on HIV and STD Programs (DHSP) Clinical Quality Management (CQM) team at future SBP Committee meetings. The workgroup also decided to redesign the documents for better readability and accessibility; COH staff will draft a redesigned version of the documents and share with the workgroup by October 23, 2026. A copy of the public comment response matrix is included in the meeting packet.

Next Steps: The next meeting will be held on **Tuesday October 27, 2026, from 2pm-3:30pm** via Zoom: https://bos-lacounty-gov.zoom.us/meeting/register/USFcu7UuRTy7kWO5yuMxVg

LOS ANGELES COUNTY COMMISSION ON HIV

SUMMARY RESPONSE TO PUBLIC COMMENTS SUBMITTED TO THE STANDARDS AND BEST PRACTICES COMMITTEE ON 8/16/26

#	Key Concern	Proposed Workgroup Response
1	Introduction, Status-Neutral Framework **Does not meet consumer needs.** This describes a goal but not an actual operating rule. HRSA Policy Clarification Notice 21-02 sets a specific, usable standard: agencies are expected to start services, including antiretroviral medication, for a newly diagnosed or re-engaging client before their paperwork is finished, and confirm eligibility afterward. The document never states this. **Missing:** A rule saying a newly diagnosed client can start treatment now and get their eligibility confirmed later, rather than waiting on paperwork first.	**REVISION:** Add language regarding "Rapid Start" program as an example to better connect the status-neutral framework to the Universal Service Standards. The Rapid Start program provides access to medication/treatment as soon as possible without waiting to verify RWHAP eligibility.
2	Section 6.0 Referrals **Does not meet consumer needs.** The CDPH Common Standards require screening for eight specific needs (medical care, case management, housing, food, mental health, substance use, transportation, benefits counseling) and require a "warm hand-off," meaning staff actually connect the client to the next provider rather than just handing over a name or number. **Missing:** the list of required screening areas, and the warm hand-off requirement, both of which reduce the chance a referral gets dropped.	**REVISION:** add "At the time of client intake into any RWHAP service, the client shall be screened for the need for other services, including but not limited to: medical care, case management, housing, food, mental health, substance us issues, transportation, and benefits counseling. Referrals should be made for any necessary services that are identified but not offered by the screening agency; referrals should be performed utilizing a warm handoff when possible. Warm handoffs can be completed in-person, by phone, or via video to ensure a seamless transition and reduce the chances of the client being lost to follow-up. Referrals must be documented wherever contractually required."

4	Section 5.0 First Appointment Timing **Does not meet consumer needs, as written.** The state's actual standard measures something different: the appointment itself must be offered with 10 calendar days of the referral. The document's "5 days to being intake" is not the same measurement, and it's unclear if agencies are even tracking the right thing. **Missing:** the correct 10-day, referral-to-appointment metric that the state actually monitors against.	No revision recommended.
5	Missing Appointments **Does not meet consumer needs.** This is a complete gap. The state requires agencies to have a process for following up on a missed appointment, ideally within 24 hours, specifically because missed appointments are linked to worse health outcomes later. **Missing:** Any standard at all addressing what happens after a client misses an appointment.	**REVISION:** Add language regarding follow-up attempts, requiring at least three different types of contact attempts before closing cases in alignment with contract language regarding minimum follow-up expectations for missed appointments. **PROPOSED LANGUAGE:** "Service provider agencies are expected to monitor client progress by maintaining regular contact, or "following-up" with the client to support their RWHAP service needs. Follow-up activities consist of face-to-face meetings, telephone conversations, or other forms of communication with the client. Follow-up must involve a conversation with the client; leaving a voicemail or message is not considered follow-up. Multiple attempts to reach a client may be necessary and use of an emergency contact may be needed if attempts to reach the client using their direct contact information does not work."
6	Section 7.0 Lost-to-Follow-up Outreach **Does not meet consumer needs, as written.** The 12-month window itself is actually better for clients than the state's 3-month minimum, giving people more time to come back before their case closes. But the document never says how many outreach attempts are required or how often. Without that, an agency could technically comply by contacting a client only once	**REVISION:** Add language regarding follow-up attempts, requiring at least three different types of contact attempts before closing cases in alignment with contract language regarding minimum follow-up expectations for missed appointments. **PROPOSED LANGUAGE:** "Service provider agencies are expected to monitor client progress by maintaining regular contact, or "following-up" with the client to support their RWHAP service

	a month for a year, which is much slower than the state's own minimum pace of three attempts per month. **Missing:** A required minimum number and pace of outreach attempts, not just a longer time window.	needs. Follow-up activities consist of face-to-face meetings, telephone conversations, or other forms of communication with the client. Follow-up must involve a conversation with the client; leaving a voicemail or message is not considered follow-up. Multiple attempts to reach a client may be necessary and use of an emergency contact may be needed if attempts to reach the client using their direct contact information does not work."
7	<u>General Eligibility Requirements, Income</u> **Does not meet consumer needs.** This number is wrong. The state raised the income limit to 600% of the Federal Poverty Line effective January 1, 2025, under CDPH HCP Management Memo 25-01. A client between 500% and 600% FPL, who actually qualifies, could be turned away based on this outdated figure. **Missing:** the correct current 600% FPL threshold.	DHSP and COH base RWHAP eligibility requirements on HRSA guidance described in PCN 16-02 not CDPH HCP Management Memo 25-01. **REVISION:** Add a statement noting that Los Angeles County has different FPL thresholds, 300% for Nutrition Support Services, and 500% for all other RWHAP services.
8	<u>Recertification of Eligibility</u> **Does not meet consumer needs**. This is complete gap. State policy requires eligibility to be re-checked once a year, on the client's birthday, replacing an older six-month check-in requirement. Without a state standard, agencies could default to the outdated, more burdensome six-month cycle, or fail to recertify clients at all. **Missing:** Any recertification standard.	**REVISION:** Add language regarding annual recertification requirements. **PROPOSED LANGUAGE:** "Following intake eligibility determination, eligibility redeterminations must be conducted and documented on an annual basis based on the client's initial eligibility determination date."
9	<u>Self-Attestation and Existing Records</u> **Does not meet consumer needs, as written:** The document only mentions one documentation shortcut, self-attestation. State policy also allows agencies to use existing records already on file with ADAP, Medi-Cal, or state tax filings to confirm eligibility, without making the client produce new paperwork. **Missing:** the option to use existing state records instead of new documentation.	The Universal Standards should reference DHSP guidelines broadly rather than listing specific documents as this would be more practical and less likely to require frequent updates. The purpose of the Universal Standards is to guide clients to connect with service providers for individualized assistance rather than provide a comprehensive list of required documents.

10	HIV status and Residency Documentation **Does not meet consumer needs, as written:** "Verifiable documentation" isn't defined. The state's actual list is specific and includes a protective rule: a single positive HIV antibody test should not delay a client's access to care, since most people with one positive test do have HIV. **Missing:** the specific list of acceptable documentations, and the single-test rule that prevents unnecessary delay for newly diagnosed clients.	**REVISION:** Add "Anyone interested in accessing HIV services through the Ryan White Program should talk with a Benefits Specialist to learn more about the services available and eligibility requirements" to the eligibility section.
11	Home and Community-Based Health Services **Does not meet consumer needs.** When this specific service is funded through the state's Medi-Cal Waiver Program, it comes with much stricter requirements: full Medi-Cal eligibility, a nursing-facility-level care certification, and a cognitive/functional score at or below 60. A client could be told they qualify for this service, then be denied later once these separate criteria are applied. **Missing:** a note explaining that this specific service has its own, stricter eligibility gate.	**REVISION:** Add clarification that the listed services are allowable under HRSA, but not all services are currently funded by DHSP. Funding priorities can change based on COH's PSRA process and/or available funding. Include link to IM+ LA website for more information about available services and benefits specialist. The public comment addresses a service under the Medical-Cal Waiver program which is different than the "Home and Community-Based Health Services" service category as defined by PCN #16-02.
12	Immigration Status **Does not meet consumer needs.** This is a complete gap, and possibly the most consequential one. Both HRSA PCN 21-02 and the state's Common Standards affirmatively state that immigration status does not affect eligibility, and that this information should not be shared with immigration enforcement. None of this appears anywhere in a document that's supposed to reassure clients about how to access care. **Missing:** a plain, written statement of this protection	**REVISION:** Add "RWHAP services are available to anyone with HIV who meets the eligibility requirements. To learn more, talk with a Benefits Specialist" to the eligibility section. DHSP and COH base RWHAP eligibility requirements on HRSA guidance described in PCN 16-02. Given the current political climate, the workgroup decided not to include language that directly references immigration status as it is understood among contracted provider agencies that immigration status is not part of the eligibility screening. The SBP Committee can revisit this topic when the political climate may be more favorable, with the understanding that any changes would be reviewed during the biannual Universal Standards review process.
13	Veterans and Indian Health Service Clients	**REVISION:** Add an explanation of "Payer of Last Resort" to the eligibility screening section.

	Does not meet consumer needs. Federal policy specifically prohibits denying services to a veteran with VA benefits, or to an eligible American Indian/Alaska Native client, just because they could also get care elsewhere. Neither protection appears in the document. **Missing:** both named protections.	**PROPOSED LANGUAGE:** "Ryan White HIV funds must always be considered the funding source of last resort, to be used only when all other possible sources have been exhausted or are not available." Additionally, mentioning Veterans and American Indian/Alaskan Native clients or other specific populations unnecessarily could create endless requirements, as the RWHAP is already the payer of last resort.
14	Insurance Screening/Payer of Last Resort **Does not meet consumer needs, as written.** Ryan White funding is only supposed to be used when no other coverage, like Medi-Cal or Covered California, can pay first. The state requires an actual insurance-status screening and documentation step to prove this. The document never turns this into an actual task for intake staff. **Missing**: real insurance-screening and documentation requirement.	**REVISION:** Add an explanation of "Payer of Last Resort" to the eligibility screening section. **PROPOSED LANGUAGE:** "Ryan White HIV funds must always be considered the funding source of last resort, to be used only when all other possible sources have been exhausted or are not available."
15	Telehealth Choice **Partially meets consumer needs.** The core right to choose is correctly stated and matches state law (Welfare and Institutions Code § 14132.725). But the state's fuller policy also says telehealth must never replace in-person care a client actually needs and must not cut a client off from their community. **Missing:** the explicit rule that telehealth is a choice, not a substitute for necessary in-person care.	**REVISION:** Add language noting that telehealth is a choice not a substitute for in-person care.
16	Confidentiality and Release of Information **Does not meet consumer needs:** The state actually requires three separate consent forms for three separate purposes, not one form covering everything. More importantly, the state has an absolute rule that mental health, substance use, and legal services information is never shared between providers, no matter what the client consents to. This document doesn't	**REVISION:** Add a statement specifying that mental health, substance use, and legal service information is not shared between providers.

	mention that protection at all. **Missing:** the three-form structure, and the absolute non-sharing rule for the most sensitive categories of information.	
17	Interpreters **Partially meets consumer needs.** Correctly bans untrained interpreters and minors. But the state adds two conditions this document skips: HIPAA-covered services must use HIPAA-compliant interpretation, and even outside of that, family or friends should only interpret as a last resort and only with the client's specific permission. **Missing:** both of those conditions.	Language used in the COH's service standards is deliberately at a 6th grade level.
18	Staff Training **Does not meet consumer needs.** No deadline, no required topics. The state requires training within 60 days of hire covering four specific areas (general HIV knowledge, navigating the local system of care, confidentiality/security, and cultural competence), plus a confidentiality agreement staff must re-sign every year. None of that is in this document. **Missing:** the 60-day deadline, the four required topics, and the annual confidentiality re-signature.	DHSP requires contracted provider staff to complete 16 Continuing Education Units annually in core HIV subject areas listed in contracts.
19	Unallowable Costs **Does not meet consumer needs.** This is a complete gap. Ryan White funds specifically cannot pay for PrEP, non-occupational PEP, cash payments to clients, and several other categories. This matters because the document's own status-neutral framework promotes connecting HIV-negative clients to PrEP, without ever saying this funding source can't pay for it. **Missing:** any list of what these funds cannot cover, and a note on where to actually get PrEP paid for instead.	**REVISION:** Add a section to the introduction related to unallowable costs for Ryan White Program funds as defined on Policy Clarification Notice #16-02
20	Workplace Safety and ADA Compliance **Meets consumer needs.** This correctly and fully requires compliance with disability access and workplace safety law	**N/A**

	without any gap that would put a client at risk. **No missing element identified here.**	
21	Progress notes/ARIES **Does not meet consumer needs, as written.** This never mentions ARIES, the state's required system that other agencies rely on to coordinate a shared client's care, or the state's two-week data-entry deadline. **Missing:** a standard connecting progress notes to timely ARIES entry.	DHSP is directly funded by HRSA for RWHAP Part A and does not use ARIES. DHSP utilizes E2LA.
22	Grievance Response Time **Partially meets consumer needs:** Fine for a pure Ryan White complaint. But a client whose issue also touches their Medi-Cal managed care plan has a shorter, 30-day appeal deadline under federal Medicaid rules, and could lose that window while still waiting on the 45-day response here. **Missing:** a note that Medi-Cal-related complaints may have a shorter, separate deadline.	**REVISION:** Add "**Client Grievance Process:** Service provider agency must establish policies and procedures for addressing and resolving client grievances at the level closest to the source within agency. Grievance data must be routinely tracked, trended, and reported to the agency's CQM Committee for discussion and resolution of quality of care or service issues identified.
23	Appendix B, Complaint Channel **Does not meet consumer needs:** CMS does not oversee the Ryan White Program and cannot actually help with a Ryan White complaint. The correct contact is HRSA's HIV/AIDS Bureau, or, for Medi-Cal Waiver-funded services specifically, a State Fair Hearing. **Missing:** the correct agency name, and the separate State Fair Hearing pathway for Waiver-funded services.	**REVISION:** Remove "external ombudsman" language (see item K on client bill of rights and responsibilities). Add "Th**e DHSP Customer Support Program** is a telephone line that is available to clients receiving services from DHSP funded agencies. The Customer Support line gives individuals an opportunity to voice their complaints or concerns regarding their HIV/AIDS care and services. Contractor must inform clients that the Customer Support Line can be utilized by calling 1(800) 260-8787, Monday through Friday from 8:00am to 5:00pm PST. All after-hour calls and calls made during County holidays are forwarded to voice mail and followed-up on within two business days. The Customer Support Line is not intended to response to emergency or crisis-related concerns.

		Customer Support Program Posters: DHSP will provide Customer Support Program posters to Contractor, which contain information about how clients may file a complaint or concern with DHSP. Contractor must ensure that the posters are located in areas of the facility used by patients and visible to clients. Contractor must ensure that staff, as well as clients/patients, are aware of the DHSP Customer Support Program."
24	Case Closure Window **Meets and exceeds consumer needs.** As noted in Stage 1 above, the 12-month window itself is more generous than the state's 3-month minimum, giving clients more time before a case can be closed. The related gap, missing attempt-frequency requirements, is addressed separately above.	**REVISION:** Add language regarding follow-up attempts, requiring at least three different types of contact attempts before closing cases in alignment with contract language regarding minimum follow-up expectations for missed appointments.
25	"Inactive" Status for Temporary Absences **Does not meet consumer needs:** The state allows a middle option, marking a file "inactive" rather than permanently closing it, specifically for situations like incarceration where a client is expected to come back. This document only has one tool: permanent closure. **Missing**: an inactive-status option, which matters most for clients returning from incarceration, exactly when they need continuity of care most.	**REVISION:** Add language explaining that cases are not permanently closed but marked as inactive with the potential for future follow-up alignment with contract requirements.
26	Section 7.0, Notice Before Disenrollment **Does not meet consumer needs, as written.** Too vague. The state requires at least 10 days' notice before a forced disenrollment, and a specific letter stating the exact date, the exact reason, and how to appeal. This document doesn't require any of those specifics. **Missing:** the 10-day minimum notice, and the required letter contents.	**REVISION:** Add "If a client is lost to follow-up or requests to discontinue RWHAP services, a formal disenrollment process should be initiated. When appropriate, the disenrollment process should include connecting the client with resources or other transitional support to promote continued success."

27	Record Retention and Destruction **Does not meet consumer needs.** This is a complete gap. The state requires closed client files to be kept for at least three years plus the current year, then destroyed securely, such as by cross-cut shredding. This document only addresses security for active files, not what happens after a case closes. **Missing:** a retention period and secure destruction standard for closed files.	Record retention and destruction requirements should be handled through contracts rather than the universal standards; DHSP contracts specify a seven-year retention period.
28	Section 2.0, Client Input **Does not meet consumer needs, as written.** States a goal without a method. The state requires this on an annual basis and names three acceptable mechanisms: a client advisory board, a locked suggestion box, or a satisfaction survey. **Missing:** the annual requirement and the specific mechanism options.	**REVISION:** Add "Service provider agencies must implement a Clinical Quality Management (CQM) program that assesses the extent to which the care and service provided are consistent with federal, State, and local standards of HIV/AIDS care and services. The CQM plan must describe the mechanism for obtaining ongoing feedback from clients regarding the accessibility and appropriateness of service and care through patient satisfaction surveys or other mechanisms. Feedback must include the degree to which the service meets client's needs and satisfaction. Patient satisfaction survey results and client feedback must be discussed by the agency's CQM committee at least annually for continuous program improvement. For additional guidance, review the "Clinical Quality Management" section of DHSP contract."
29	Transition from Medi-Cal Waiver Program **Does not meet consumer needs.** This is a complete gap. The state's own Medi-Cal Waiver Program document names Ryan White as the intended next stop for a client who is disenrolled after hitting their $33,937 annual cost cap. This document has no corresponding standard for receiving those clients quickly or coordinating the handoff. **Missing:** an expedited-intake standard	The point of entry for most clients is through a Benefits Specialist or Case Manager. Any person with HIV seeking RWHAP services should talk with a Benefits Specialist or Case Manager. For more information visit the Im+LA website.

	for clients arriving after a Medi-Cal Waiver cost-cap disenrollment.	
30	Purpose of universal standards is not clear in the introduction.	**PROPOSED LANGUAGE:** "Please note that this document is not intended to serve as a comprehensive guide to all regulations related to Ryan White HIV service delivery, nor is it a manual of all Ryan White program requirements. Instead, the Universal Service Standards are intended to serve as an outline of key requirements and characteristics of the Ryan White system that pertain to all core and support service categories. Service provider agencies are encouraged to build on this guidance based on community needs and available resources."

SERVICE STANDARDS FOR ORAL HEALTH CARE SERVICES

LOS ANGELES COUNTY
COMMISSION ON HIV

APPROVED BY THE COH ON 04/13/23

SERVICE STANDARDS: ORAL HEALTH CARE SERVICES

IMPORTANT: The service standards for Oral Health Care Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

Human Resource Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) # 16-02 *(Revised 10/22/18)*: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White-funded agencies offer to clients, however, providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV (COH) developed Oral Health Care Services standards to establish the minimum services necessary to provide oral health care services to people living with HIV. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP), members of the Los Angeles County COH Standards and Best Practices Committee (SBP), caucuses, and the public-at-large.

SERVICE DESCRIPTION

Oral health care services are an integral part of primary medical care for all people living with HIV. Most HIV infected patients can receive routine, comprehensive oral health care in the same manner as any other person. All treatment will be administered according to published research and available standards of care. In addition, the COH developed a Dental Implants addendum to provide specific service delivery guidance to Ryan White Part A-funded agencies regarding the provision of dental implants. For more information, see the Oral Health Care Service Standard Addendum.

Service shall include (but not limited to):

- Routine dental care and oral health education and counseling
- Obtaining a comprehensive medical and oral hygiene history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV status

- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV-related oral manifestations
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, prosthodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- Maintaining individual patient dental records in accordance with current standards
- Complying with infection control guidelines and procedures established by the California Occupation Safety and Health Administration (Cal-OSHA)

The following are priorities for HIV oral health treatment:

1. Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
2. Elimination of presenting symptoms
3. Elimination of infection
4. Preservation of dentition and restoration of functioning

Recurring themes in this standard include:

- Good oral health is an important factor in the overall health management of people living with HIV.
- Treatment modifications should only be used when a patient's health status demands them.
- Comprehensive evaluation is a critical component of appropriate oral health care services.
- Treatment plans should be made in conjunction with the patient.
- Collaboration with primary medical providers is necessary to provide comprehensive dental treatment.
- Prevention and early detection should be emphasized.

GENERAL CONSIDERATIONS: <u>There is no justification to deny or modify dental treatment based on the fact that a patient has tested positive for HIV</u>. Further, the magnitude of the viral load is not an indicator to withhold dental treatment for the patient. If, however, a patient's medical condition is compromised, treatment adjustments, as with any medically compromised patient, may be necessary.

<u>SERVICE/ORGANIZATIONAL LICENSURE CATEGORY</u>

HIV/AIDS oral health care services shall be provided by dental care professionals who have applicable professional degrees and current California State licenses. Dental staff can include dentists, dental assistants, dental assistants in extended functions, dental hygienists, and dental hygienists in extended practice. Clinical supervision shall be performed by a licensed dentist responsible for all clinical operations.

Dentists: A dentist must complete a four-year dental program and possess a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree. Additionally, dentists must pass a

three-part examination as well as the California jurisprudence exam and a professional ethics exam. Dentists are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Assistants (RDA): RDAs must possess a diploma or certificate in dental assisting from an educational program approved by the California Dental Board, or 18 months of satisfactory work experience as a dental assistant. RDAs are regulated by the California Dental Board (please see Dental Board of California for further information).

Unlicensed Dental Assistants (DA): Unlicensed dental assistants are not licensed by the Dental Board of California, but they are subject to certain laws governing their conduct. Section 150.1 is the statute governing the duties that unlicensed dental assistants are allowed to perform. Unless a specific duty is listed in that regulations, the dental assistant is NOT allowed to perform that duty. A dental assistant may only expose radiographs after successful completion of a board-approved radiation safety course. Dental assistants with certain experience or educational backgrounds may qualify to apply for Registered Dental Assistant (RDA) licensure.

Registered Dental Assistants in Extended Functions (RDAEF)[1]: RDAEF holds a current licensure as a Registered Dental Assistant or has completed the requirements for licensure as a RDA, completed a Board-approved course in the application of Pit & Fissure Sealants, completed a Board-approved RDAEF program, passed a written examination administered by the Board, and submitted fingerprint clearances from both the Department of Justice and the Federal Bureau of Investigation. RDAEFs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists (RDH): RDHs must have been granted a diploma or certificate in dental hygiene from an approved dental hygiene educational program. RDHs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists in Extended Functions (RDHEF)[2]: RDHEF holds a current license as a registered dental hygienist in California, completed clinical training approved by the dental hygiene board in a facility affiliated with a dental school under the direct supervision of the dental school faculty, performed satisfactorily on an examination required by the dental hygiene board, and completed an application form and paid all application fees required by the dental hygiene board. RDHEF are regulated by the California Dental Board (please see Dental Board of California for further information).

[1] Registered Dental Assistant in Extended Functions Applicants - Dental Board of California

[2] Codes Display Text (ca.gov)

SERVICE STANDARDS

All contractors must meet the Universal Standards of Care approved by the COH in addition to the following Oral Health Care Services standards. The Universal Standards of Care can be accessed at: https://hiv.lacounty.gov/service-standards

SERVICE COMPONENT	STANDARD	DOCUMENTATION
INTAKE	Intake process will begin during first contact with client.	Intake took in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
	Consent for Services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibilities and the Division on HIV and STD Programs (DHSP) Customer Support Program[3].	Signed, dated forms in client file.
EVALUATION When presenting for dental services, people living with HIV should be given a comprehensive oral evaluation. When indicated,	A comprehensive oral evaluation will be given to patients living with HIV and will include: • Documentation of patient's presenting complaint • Caries charting	Signed, dated evaluation on file in patient chart.

[3] The program aims to assist consumers of HIV and STD services who have experienced difficult accessing services from DHSP-funded providers throughout Los Angeles County.

diagnostic tests relevant to the evaluation of the patient should be performed and used in diagnosis and treatment planning. In addition, full medical status information from the patient's medical provider, including most recent lab work results, should be obtained, and considered by the dentist	• Radiographs or panoramic and bitewings and selected periapical films • Complete periodontal exam or PSR (Periodontal Screening Record) • Comprehensive head and neck exam • Complete intra-oral exam, including evaluation for HIV-associated lesions • Pain assessment	
	As indicated, diagnostic tests relevant to the evaluation will be used in diagnosis and treatment planning. Biopsies of suspicious oral lesions will be taken.	Signed, dated evaluation in patient chart to detail additional tests.
	Full medical status information will be obtained from the patient's medical provider and considered in the evaluation. The medical history and current medication list will be updated regularly to ensure all medical and treatment changes are noted.	Signed, dated evaluation in patient chart to detail medical status information.
	Obtain a thorough medical, dental, and psychosocial history to assess the patient's oral hygiene habits and periodontal stability and determine the patient's capacity to achieve dental implant success and the possibility of dental implant failure.	Client Chart/Treatment Plan/Provider Progress Notes
	Clinician, after patient assessment, will make necessary referrals to specialty programs including, but not limited to smoking cessation programs; substance use	

	treatment; medical nutritional therapy, thereby increasing patients' success rate for receiving dental implants.	
	The clinicians referring patients to specialty Oral Healthcare services will complete a referral form, educate the patient, and discuss treatment plan alternatives with patient.	
TREATMENT PLANNING In conjunction with the patient, each dental provider shall develop a comprehensive, multidisciplinary treatment plan. The patient's primary reason for the visit should be considered by the dental professional when developing the dental treatment plan. Treatment priority should be given to the management of pain, infection, traumatic injury, or other emergency conditions. Dental provider will support and reinforce patient understanding, agreement, and education in the patient's treatment plan. Ensure patient understanding that dental implants are for medical necessity (as determined by the dental provider through assessments and evaluation) and would lead to improved HIV health outcomes. Reinforce that Ryan White	A comprehensive, multidisciplinary treatment plan will be developed in conjunction with the patient.	Treatment plan dated and signed by both the provider and patient in patient file.
	Patient's primary reason for dental visit should be addressed in treatment plan.	Treatment plan dated and signed by both the provider and patient in the patient file to detail.
	Patient strengths and limitations will be considered in development of treatment plan.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment priority will be given to pain management, infection, traumatic injury, or other emergency conditions.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment plan will include consideration of the following factors: • Tooth and/or tissue supported prosthetic options • Fixed protheses, removable prostheses or combination • Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits • Restorative implications, endodontic status, tooth	Treatment plan dated and signed by both the provider and patient in file to detail.

funds cannot be used to provide dental implants for cosmetic purposes.	position and periodontal prognosis • Craniofacial, musculoskeletal relationships	
	Six-month recall schedule will be used to monitor any changes. A three-month recall schedule may be considered to limit disease progression and maintain healthy periodontal tissues in advanced cases of periodontitis or caries.	Signed, dated progress note in patient file to detail.
	Treatment plans will be updated as deemed necessary.	Signed, dated progress note in patient file to detail.
	The receiving clinician will review the referral, consider the patient's medical, dental, and psychosocial history to determine treatment plan options that offer the patient the most successful outcome based on published literature. The clinician will discuss with patient dental implant options with the goal of achieving optimal health outcomes.	Referral in Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will consider the patient's perspective in deciding which treatment plan to use.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will discuss treatment plan alternatives with the patient and collaborate with the patient to determine their treatment plan.	
	The clinician and the patient will revisit the treatment plan periodically to determine if any adjustments are necessary to achieve the treatment goal.	

	The clinician will educate patients on how to maintain dental implants and the importance of routine care.	
INFORMED CONSENT Patients will sign an informed consent document for all dental procedures. This informed consent process will be ongoing as indicated by the dental treatment plan.	As part of the informed consent process, dental professionals will provide the following before obtaining consent: • Diagnostic information • Recommended treatment • Alternative treatment • Benefits and risks of treatment • Limitations of treatment	Signed, dated progress note or informed consent in patient field to detail.
	Dental providers will describe all options for dental treatment and allow the patient to be part of the decision-making process.	Signed, dated progress note or informed consent in client file to detail.
	After the informed consent discussion, patients will sign an informed consent for all dental procedures.	Signed, dated informed consent in client file.
	This informed consent process will be ongoing as indicated by the dental treatment plan.	Ongoing signed, dated informed consents in client file (as needed).
MEDICAL CONSULTATION AND PRIMARY CARE PARTICIPATION Dentists can play an important part in reminding patients of the need for regular primary medical care and CBC, CD4, viral load tests every three to six months depending on the past history of HIV infection and level of suppression achieved and encouraging patients to adhere to their medication	Primary care physicians will be consulted when providing dental treatment.	Signed, dated progress note to detail consultations.
	Primary care physicians will be consulted when providing dental treatment depending on the medical needs of the patient. Consultation with medical providers will be: • To obtain the necessary laboratory test results • When there is any doubt about the accuracy of the information provided by the patient	Signed, dated progress note to detail consultations.

regimens. However, even the highest number of viral copies has no impact on the provision of dental care. If a patient is not under the regular care of a primary care physician, the patient should be urged to seek care and a referral to primary care will be made.	• When there is a change in the patient's general health, determine the severity of the condition and the need for treatment modifications • If after evaluating the patient's medical history and the laboratory tests, the oral health provider decides that treatment should occur in a hospital setting • New medications are indicated to ensure medication safety and prevent drug/drug interactions • Oral opportunistic infections are presents	
	Dentists will encourage consistent medical care in their patients and provide referrals as necessary. Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail referrals and discussion.
	Programs may decide to discontinue oral health services if a client has not engaged in primary medical care. Patients will be made aware of this policy at time of intake into the program.	Signed, dated progress notes to detail referrals and discussion. Policy on file at provider agency. Intake materials will also state this policy.
	Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail discussion.

PREVENTION/EARLY INTERVENTION Dental professionals will emphasize prevention and early detection of oral disease by educating patients about preventive oral health practices, including instruction in oral hygiene. In addition, dental professionals may provide counseling regarding behaviors (e.g., tobacco use, unprotected oral sex, body piercing in oral structures) and general health conditions that can compromise oral health. The impact of good nutrition on preserving good oral health should be discussed.	Dental professionals will educate patients about preventive oral health practices.	Signed, dated progress note in patient file to detail education efforts.
	Routine examinations and regular prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail schedule.
	Dental professionals will provide basic nutritional counseling to assist in oral health maintenance. Referrals to an RD and others will be made, as needed.	Signed, dated progress note to detail nutrition discussion and referrals made.
	Root planing/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
SPECIAL TREATMENT CONSIDERATIONS	As indicated, the following modifications to standard dental treatment should be considered: • Bleeding tendencies may determine whether or not to recommend full mouth scaling and root planning or multiple extractions in one visit. • In severe cases, patients may be treated more sagely in a hospital environment where blood transfusions are available. • Deep block injections should be avoided in patients with bleeding tendencies. • A pre-treatment antibacterial mouth rinse should be used for those	Signed, dated process note or treatment plan in patient file to detail treatment modifications and referrals.

	patients with periodontal disease. • Patients with salivary hypofunction should be closely monitored for caries, periodontitis, soft tissue lesions and salivary gland disease. • Fluoride supplements should be prescribed for those with increase caries and salivary hypofunction. Referral to dental professional experiences in oral mucosal and salivary gland diseases should be made in severe cases of xerostomia.	
	Routine examinations and regularly prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail scheduled.
	Root planning/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
TRIAGE, REFERRAL, COORDINATION On occasion, patients will require a higher level of oral health treatment services than a given agency is able to provide. Coordinating oral health care with primary care medical providers is vital. Regular contact with a client's primary care clinic will ensure integration of services and better client care. Train referring dental providers on how to adequately complete referral	As needed, dental providers will refer patients to full range of oral health care providers, including: • Periodontists • Endodontists • Prosthodontists • Oral surgeons • Oral pathologists • Oral medicine practitioners	Signed, dated progress note to document referrals in patient chart.
	Providers will attempt to contact a client's primary care clinic if required or as clinically indicated to coordinate and integrate care.	Documentation of contact with primary medical clinics and providers to be placed in progress notes. In

forms to allow more flexibility in treatment planning for receiving specialty dental providers.		
OUTREACH Programs providing dental care for people living with HIV will actively promote their services through known linkages and direct outreach.	Programs will promote dental services for people living with HIV through linkages or outreach.	Service promotion/outreach plan on file at provider agency.
CLIENT RETENTION	Programs shall develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact • Text messaging
STAFFING REQUIREMENTS AND QUALIFICATIONS	Provider will ensure that all staff providing oral health care services will possess applicable professional degrees and current California state licenses.	Documentation of professional degrees and licenses on file.
	Providers shall be trained and oriented before providing oral health care services both in general dentistry and HIV specific oral health services. Training will include: • Basic HIV information • Office and policy orientation • Infection control and sterilization techniques	Training documentation on file maintained in personnel record.

	• Methods of initial evaluation of the patient living with HIV disease • Health maintenance education and counseling • Recognition and treatment of common oral manifestations and complications of HIV disease • Recognition of oral signs and symptoms of advanced HIV disease	
	Oral health care providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
	Dentist in charge of dental operations shall provide clinical supervision to dental staff.	Documentation of supervision on file.
	Dental care staff will complete documentation required by program.	Periodic chart review to confirm.
	Providers will seek continuing education about HIV disease and associated oral health treatment considerations.	Documentation of trainings in employee file.

ACRONYMS

AIDS *Acquired Immune Deficiency Syndrome*
CAL-OSHA *California Occupation Safety and Health Administration*
CD4 *Cluster Designation 4*
DDS *Doctor of Dental Surgery*
DHSP *Division of HIV and STD Programs*
HBV *Hepatitis B Virus*
HIPAA *Health Insurance Portability and Accountability Act*
HIV *Human Immunodeficiency Virus*
RDA *Registered Dental Assistant*
RDAEF *Registered Dental Assistant in Extended Functions*
RDH *Registered Dental Hygienists*
RDHEF *Registered Dental Hygienist in Extended Functions*
STI *Sexually Transmitted Infection*

DEFINITIONS AND DESCRIPTIONS

Client registration and intake is the process that determines a person's eligibility for oral services.

Oral prophylaxis is a preventive dental procedure that includes the complete removal of calculus, soft deposits, plaque, and stains from the coronal portions of the tooth. This treatment enables a patient to maintain healthy hard and soft tissues.

Direct supervision is supervision of dental procedures based on instructions given by a licensed dentist who must be physically present in the treatment facility during performance of those procedures.

General supervision is the supervision of dental procedures based on instructions given by a licensed dentist, but not requiring the physical presence of the supervising dentist during the performance of those procedures.

Basic supportive dental procedures are the fundamental duties or functions which may be performed by an unlicensed dental assistant under the supervision of a licensed dentist because of their technically elementary characteristics, complete reversibility, and inability to precipitate potentially hazardous conditions for the patient being treated.

Standard precautions are an approach to infection control that integrates and expands the elements of universal precautions (human blood and certain human body fluids treated as if known to be infectious for HIV, Hepatitis B Virus (HBV) and other blood-borne pathogens). Standard precautions apply to contact with all body fluids, secretions, and excretions (except for sweat), regardless of whether they contain blood, and to contact with non-intact skin and mucous membranes.

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PRACTICE GUIDELINES FOR THE TREATMENT OF HIV PATIENTS IN GENERAL DENTISTRY

(5th Edition)

Oral Health Advisory Group of the Pacific AIDS Education and Training Center
formerly the Dental Steering Committee

Last updated: June 30, 2025

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Foreword

This document is an update to four previously published versions of guidelines and is intended to supplement the following resource related to the dental treatment of HIV-infected patients:

American Academy of Oral Medicine Clinician's Guide to
Treatment of Patients with HIV & Other Communicable Diseases
Fifth Edition - 2018
Brian C Muzyka, DMD, MS, MBA, Editor
Lauren L Patton, DDS, Editor[1]

The Oral Health Advisory Group of the Pacific AIDS Education and Training Center approved the adoption of this document as general guide for treatment of HIV-infected patients. The field of HIV therapy undergoes constant change. Therefore, the Pacific AIDS Education & Training Center has requested that the Oral Health Advisory Committee regularly update this supplement

Our knowledge of HIV manifestations, diagnosis and treatment will continue to grow and change over time. It is for this reason that dental care providers are encouraged to continually educate themselves about HIV disease and associated oral health treatment considerations.

Disclaimer

This executive summary is not intended to set out any standards of care. It is intended to serve as a helpful source of up-to-date information to assist dental practitioners in making informed decisions about the care they provide. Dentists should always exercise their own professional judgment in any given situation, with any given patient. No information contained in this document should be construed as legal advice. Dentists must consult with their own lawyers for legal advice.

[1] American Academy of Oral Medicine Clinician's Guide to
Treatment of Patients with HIV & Other Communicable Diseases
Fifth Edition - 2018
Brian C Muzyka, DMD, MS, MBA, Editor
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Oral Health Advisory Group

These recommendations for treatment were assembled and reviewed by the Pacific AIDS Education & Training Center's Oral Health Advisory Group. The members of this committee are individuals professionally involved with ensuring the best possible dental care for HIV infected patients. This group includes faculty from dental schools, Pacific AIDS Education and Training Center faculty, dental and medical clinic directors, and attorneys all involved in providing service to individuals who are HIV positive.

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With special thanks to **Roseann Mulligan, DDS, MS**, Chair, Oral Health Advisory Group of the Pacific AIDS Education and Training Center, for her help and guidance in collaborating to update all prior revisions of Practice Guidelines for the Treatment of HIV Patients in General Dentistry.

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Patient Assessment

A. Medical Assessment

In general, the medical assessment of a patient with HIV infection includes the same elements as any other patient. It is the standard of care to ask about all health conditions and to collect information about the status of each condition at baseline (first visit) and periodically thereafter, especially during annual updates. The patient's medication list should also be completed and updated as well, listing dosages and regimens that are subject to change during the course of HIV disease management.

When to Contact the Patient's Physician? The decision on when to contact the patient's physician is up to the dental care provider, based on his or her assessment of the patient's medical conditions and oral treatment needs, and whether additional information is needed from the patient's physician prior to initiating treatment. This is handled the same way as for any other medical condition. Some examples are:

- To obtain the necessary laboratory test results.

-When there is any doubt about the accuracy of the information provided by the patient (i.e., inconsistent or illogical answers to questions about medical history) and more accurate information is needed to ensure patient's safety in the course of dental treatment.

- If patient reports a change in his/her general health or signs and symptoms and considering the nature and severity of the condition and any impending medical treatments, it is necessary to determine the need for dental treatment modifications.

- The dental health provider should use the medical history and the laboratory test results to decide if treatment should occur in a hospital setting. Such a decision should be made in consultation with the patient's physician.

B. Oral Health Assessment

Oral Health Assessment of the HIV sero-positive patient is the same as any other dental patient. Every patient must undergo a baseline dental and periodontal assessment even if they do not occur on the same first visit. The dental record must clearly indicate the patient's chief complaint and its history. In addition, the patient's previous dental history, including all past treatments, complications and frequency of recall and hygiene visits, should be obtained. A full mouth series of radiographs is necessary for diagnosis and treatment planning. If the patient is edentulous or impacted teeth are noted, a panoramic radiograph should be taken. A complete head and neck and extra oral examination including the cutaneous tissues, the regional lymph nodes, all major salivary glands, the cranial nerves, the temporomandibular joints and the muscles of mastication should be performed. This should be followed with an intraoral assessment of all oral and pharyngeal mucosal tissues, gingivae and dentition. A full record of decayed and missing teeth as well as all existing restorations and prostheses and their time of placement should be documented. Periodontal charting should include examination and recording of the following: measurements of pocket depths, attachment loss, mobility, bleeding on probing and suppuration.

A comprehensive treatment plan should be formulated based on the collected information and phased in terms of priority of care (addressing pain, eliminating infections, restoration of diseased teeth, replacement of missing teeth, periodontal tissues, and oral hygiene instruction and education). The plan should be reviewed with the patient, presenting different treatment options and signed by both the doctor and the patient. The patient has the right to refuse the dental care provider's recommendations. The risks of non-treatment should be explained, and patient's refusal of any recommended treatment should be documented and signed by the patient. The patient's treatment plan should be updated on an annual basis even if care is still ongoing and the original plan has not been completed.

In the course of dental treatment, the dentist should prescribe all the necessary medications that address the patient's dental and periodontal needs. For oral conditions that require care by a specialist in a particular dental field (i.e., oral and maxillofacial surgery, periodontics, prosthodontics, endodontics, orofacial pain, oral medicine, etc.), the dental care provider should make the necessary referral and follow-up.

If at any point during the dental treatment, the dental care provider notices oral soft tissue lesions or salivary gland conditions that directly or indirectly indicate HIV disease progression, a referral should be made to the oral health specialist who can assist in diagnosing and treating the oral condition and, at the same time, the patient's physician should be notified of the referral, the reasons for the referral, the possible implications related to the HIV infection (if any), and the need for follow-up.

The dental care provider must have a contingency plan for responding to patients with emergencies that occur after office hours, on weekends, during holidays or office vacation schedules.

Diagnostic Tests in the Evaluation of the HIV Infected Patient

The CD4 cell count and the viral load measurement are the two laboratory markers that are used to monitor HIV infection. The CD4 cells are a subset of lymphocytes (synonyms are the T4 or the T-helper cells), which correlates with the patient's immune status. The normal value for adults is 750 – 1000 cells/ml. Patients with values less than 200 cells/mm^3 are considered to have advanced immunosuppression and are defined as having AIDS. Those with a value of less than 50 cells/ml are considered to be in a very advanced stage and are usually symptomatic. Patients with low CD4 cell counts (less than 200 cells/mm^3 are at risk for developing the diseases associated with AIDS (opportunistic infections and cancers.) Those with high counts (greater than 350 cells/ mm^3) usually do not manifest AIDS-related illnesses.

The viral load is a test, which measures the amount of viral RNA in a milliliter of plasma. It represents how much the virus is replicating and the magnitude of the viral burden in the body. The viral load test is also used as a prognostic indicator: the higher the value, the higher the risk of a declining CD4 count and clinical progression. With lower values, one expects slower progression of HIV disease.

Depending on the test kit used, the minimum viral load value is 20 – 50 cells/mm^3. Below this value, the test is usually reported as "undetectable." The goal of therapy with antiviral drugs is to reduce the viral load to an "undetectable" value. The significance of an "undetectable" viral load is that very little viral replication is occurring. This means that there is little risk of the virus being able to mutate which can result in drug resistance and treatment failure. Reduction of the viral load to "undetectable" levels usually results in an improvement in the immune system (the CD4 cell count rises). Many patients are unable to reduce their viral load to undetectable. For these patients, the goal is to reduce the viral load as much as possible.

In interpreting the viral load, it is important to know that patient fluctuation plus lab variation can be as much as three-fold. So, a value of 50,000 cells/mm^3 followed by a value of 70,000 cells/mm^3 may be within the lab variation. However, a value of 5,000 cells/mm^3 followed by a value of 50,000 cells/mm^3 shows a significant increase. This might indicate drug failure or that the patient has stopped taking medications.

For the dentist, the CD4 cell count indicates the immune status of the patient. The magnitude of the viral load is not an indicator to withhold dental treatment for the patient. High viral loads may be present in a patient with early asymptomatic disease, while low viral loads can be seen in very advanced patients on suppressive antiviral therapy. Knowledge of these markers can tell the dentist the general health of the patient and the risk of progression. The dentist can play an important part in reminding patients of the need for regular follow up and monitoring of these markers. Most commonly, the CD4 cell count and viral load determinations are to be performed every three to six months depending on the past history of HIV infection and level of suppression achieved.

A. Laboratory Tests to Track HIV Progression

CD4 Cell Count: Assesses the level of CD4 or T-helper cells, which help the immune system to fight infections. Decreases in this number indicate an increased risk of infection. The CD4 level can be listed as CD4 count or the number may be listed as T4 (CD3+CD4) count. In children under age 5

years, CD4 percentage is preferred for monitoring immune status because of age-related changes in absolute CD4 count in this age group; however, CD4 count can be used in older children.

Viral load (VL) or HIV-1 RNA: This represents the copies/ mm^3 of the virus in the blood plasma. The goal is to reach an undetectable level of copies. Increasing viral load levels while on antiviral therapy can indicate the development of resistance. The level of viral load does not determine dental care treatment modifications. Treatment modifications are based on HIV clinical presentation and laboratory indicators. The CD4 cell count correlates with the immune status of the patient.

Platelets: Platelets are necessary, along with other factors, for blood to clot. If thrombocytopenia occurs, the risk of bleeding may be so severe as to delay elective and even some emergency therapy until the platelets can be replaced. There is a critical value (see below) which, if not reached, places the patient at risk for severe bleeding.

Absolute neutrophils: Neutrophils may be reported as segmented cells, granulocytes, polymorphonuclear cells, polys, or PMNs. Neutrophils are a special class of white cells that are important for fighting infections. If their numbers decrease, the risk of infection increases.

B. Critical Laboratory Test Values

Critical laboratory test values are the values that necessitate a change in dental management. It is essential to monitor the lab values that have a direct impact on the ability to safely treat dental patients. All patients with HIV require monitoring of their neutrophils and platelets for invasive treatment, but comorbidities may require monitoring of other lab values such as those for liver function or diabetes.

Absolute Neutrophil Count (ANC)

Less than 500 cells/mm^3 (Normal values 1,800 – 8,000 cells/mm^3): An ANC below 500 cells/mm^3 (< about 20% neutrophils) represents a risk of infection due to severe neutropenia and necessitates prophylactic antibiotics prior to invasive procedures that will precipitate bacteremia using the AHA (American Heart Association) guidelines. Consider a therapeutic regimen of post-treatment antibiotics concurrent with invasive procedures and after consultation with the physician.

Platelets

For most oral health care, the platelet count should be above 50,000 cells/ml^3 (normal adult values: 150,000-450,000 cells/mm^3). **A low value represents thrombocytopenia - less than 50,000/mm^3 for adult patients or less than 75,000/mm3 for pediatric patients.** When an extensive and/or invasive procedure is planned with risk of bleeding, consult with the physician and recommend intervention to boost platelets prior to such procedures. The physician may elect to give a platelet infusion to increase the platelet count. **The dentist must receive laboratory confirmation of the platelet count immediately (1-2 days) before an invasive procedure.** Delay elective dental procedures until the platelet count improves.

CD4 T-Lymphocytes (Helper cells) (absolute)

Less than 50 cells/mm^3 (normal values 590-1120 cells/mm^3) **or less than 15% CD4 percentage for children under 5 years (normal value is CD4 percentage > 25%)**: Evaluate patient for severe opportunistic disease and treatment plan realistically considering degree of disease. Even patients

with severely diminished CD4 levels may tolerate definitive dental care rather than only palliative treatment; this must be individually considered for each patient with close consultation with the physician to determine stage of disease. At or below 200 cells/mm^3: the patient is considered to have AIDS due to the increased risk of opportunistic infections. Emphasize good oral care and have the patient contact you immediately if oral problems start.

Viral Load

The viral load does not have an impact on dental treatment planning. The number of viral copies is indicative of disease, but any modification of dental treatment would be based on the other laboratory test results (discussed previously) and not on the viral load. A significantly high viral load is taken as a predictor of more rapid disease progression and should be correlated with the patient's CD4 count. However, for a very high viral load (e.g., 1 million), medical consultation is warranted, and treatment may be deferred until it improves.

C. Suggested Frequency of Obtaining Lab Reports

Laboratory tests are important to monitor the patient's health. The issue of how frequently laboratory tests need to be obtained is primarily dependent upon the patient's medical stability, CD4 T-helper cell count, whether the patient is on antiretroviral therapy (ART), and the length of time of viral suppression during ART.

According to the U.S. Public Health Service (PHS) recommendations, depending on the time of ART initiation and response to therapy, CD4$^+$ T-cell levels should be monitored every 3 to 6 months and up to one year if the patient is virally suppressed for over 2 years. The frequency of viral load monitoring depends mostly on adherence to prescribed medications.[2] Because ART can affect other blood values regardless of the CD4 count, the patients who are taking this therapy require frequent monitoring: usually every six months or less, depending upon critical values that may need more follow-up. Current laboratory test results are very important for invasive dental procedures. At the same time, clinical judgment is necessary as most dental procedures need not be delayed just because the laboratory results are older than ideal.

D. Blood Tests Based on Clinical Scenario

Like any patient, the clinical scenario may direct the provider to order diagnostic blood tests. The indication and interpretation of these laboratory tests would not differ in HIV infected patients. The following are some examples of labs that may be ordered in specific situations:

- Complete blood count (CBC) including red blood cell count (RBC), white blood cell count (WBC) and differential count (Diff), platelet count (PLT), hemoglobin level (Hb) and hematocrit (Hct) in patients with history of anemia, thrombocytopenia, advanced HIV disease, and prior to surgical procedures to determine if the patient is at risk for post-operative complications such as infection or poor healing,
- Metabolic panel in patients with a history of kidney disease, Hepatitis B/C or other liver diseases should be assessed as the dentist may need to adjust the dosage of analgesics or antibiotics prescribed,

[2] https://www.ncbi.nlm.nih.gov/books/NBK513289/access 06/10/2025

- INR or prothrombin time (PT) and partial thromboplastin time (PTT) for patients with advanced liver disease, those who are taking prescription anticoagulants other than novel oral anticoagulants (NOACs), or when history or physical findings indicate a need to assess bleeding potential,
- Hemoglobin A1c for diabetic patients. These patients should be individually assessed to evaluate their risk for post-operative complications, such as infection or poor healing. Some experts will defer invasive treatment when the HbA1c is above 8%.[3]
- Assessment of tuberculosis status should occur in patients with a history of recent exposure to or symptoms of TB, which may include skin PPD testing, blood Quantiferon Assay, or chest x-ray.

It should be emphasized that, although having access to laboratory tests for HIV positive patients is helpful to the dental provider, it is not always necessary for many routine procedures.

The dentist can also be instrumental in encouraging patients to adhere to their medication regimen. The most common cause of drug failure is the patient taking his/her medications inconsistently. Missing just a few doses a month can result in the virus becoming resistant.

[3] Doucet et al. Management of Glucose-Lowering Therapy in Older Adults with Type 2 Diabetes: Challenges and Opportunities. Clin Interv Aging. 2023 Oct 9;18:1687-1703.

Antibiotic Prophylaxis

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

Prophylactic antibiotics should not be prescribed routinely for the dental visit when the HIV infection is well controlled. Routine antibiotic coverage prior to procedures may cause bleeding and bacteremia and is not recommended. Many patients at an advanced stage of HIV disease are already taking antibiotics to prevent opportunistic infections, so the dentist should not prescribe additional antibiotic medications without contacting the physician.

- Antibiotic prophylaxis is recommended for patients with a neutrophil count below 500 cells/mm3 requiring procedures likely to cause bleeding and bacteremia, if the patient is not already taking antibiotics for prophylaxis against opportunistic infections. In these cases, a therapeutic regimen of post-treatment antibiotics concurrent with invasive procedures should be considered. Therefore, it is important to check with the physician for the most current CBC with differential to determine the ANC value (see page 9 for more details).

- The regimen for prevention of bacterial endocarditis is the same in HIV patients as it is for non-infected patients. The American Heart Association guidelines for antibiotic prophylaxis should be followed as with any patient. Consult the patient's physician to determine the need for antibiotic prophylaxis for the patient with multiple co-morbidities and with prosthetic joint replacements or intravascular devices.

- Antibiotic prophylaxis is always recommended for an HIV positive patient with a prosthetic joint if CD4 counts are less than 200/dL, there is a history of a previous deep prosthetic joint infection, and diabetes with HbA1c $\geq$ 8%. For patients with CD4 counts less than 200/mm^3 and a history of a previous deep prosthetic joint infection, antibiotic coverage may be considered.[4]

- As with any patient, it is the standard of care to investigate all possible drug interactions before prescribing antibiotics or any other medications for patients with HIV infections.

[4] Cennimo DJ, AAHIVS; Shoemaker M. Prevention of Opportunistic Infections (OI) in Patients with HIV Infection January 01, 2025 https://emedicine.medscape.com/article/1529727-overview

Treatment Considerations

A. Modifications of Dental Therapy

There is no justification for modifying dental treatment based on the fact that the patient is infected with the HIV virus. However, if the patient's medical status is complex, treatment adjustments may be necessary as would be the case with any medically compromised patient. After performing a thorough assessment, the dentist should determine any treatment modifications needed. **IT IS ESSENTIAL FOR ALL PRACTITIONERS TO UNDERSTAND THAT MOST HIV PATIENTS, EVEN IF SYMPTOMATIC, CAN BE TREATED SAFELY IN A TYPICAL DENTAL OFFICE OR CLINIC.**

- Bleeding tendencies may determine whether or not to recommend full mouth scaling and root planning or multiple extractions in one visit. In conjunction with establishing a history of excessive bleeding and the appropriate laboratory tests, a tooth-by-tooth approach to assess bleeding tendencies could be used as a clinical method to evaluate the patient's risk of hemorrhage.

- In patients who are at risk of increased bleeding, deep block injections should be avoided. In these patients, intraligamentary or local infiltration may be an appropriate alternative.

- When performing dental extractions on patients who are at risk for increased bleeding, local measures such as primary closure after surgery and the use of local thrombotic agents such as gelfoam or topical thrombin are helpful in controlling the bleeding.

- In patients who are taking oral anti-platelet drugs or anticoagulants, the decision to discontinue these agents prior to dental procedures must be made in conjunction with the patient's physician and after careful consideration of the patient's risk of bleeding versus their risk for thromboembolism.

- For patients who are taking antiplatelet agents such as aspirin, clopidogrel (Plavix), ticlopidine (Ticlid), and dipyridamole/aspirin (Aggrenox), there is no need to discontinue the anticoagulant for dental and most surgical procedures. For extensive surgical procedures, consult the patient's physician to see if these agents may be discontinued prior to the planned procedure. Typically, these drugs must be withheld one week before the procedure.

- Restorative and simple tooth extractions may be performed on patients who take warfarin anticoagulant (Coumadin) with INR values of 3.5 or lower. For extensive surgical procedures or when the INR values are higher, consult with the patient's physician to see if warfarin may be discontinued. It should be noted that many patients who take warfarin are at risk for a thromboembolic event and, it may be preferable to discontinue warfarin in conjunction with heparin bridging. This is accomplished by stopping warfarin 5 days before the scheduled surgery and replacing it with low molecular weight heparin (Lovenox). In extreme cases, where the patient's risk of thromboembolism is very high, hospitalization, warfarin reversal, and heparinization may be necessary.

- For patients who are taking the increasingly popular novel anticoagulants (NOACs) such as dabigatran (Pradaxa), rivaroxiban (Xarelto), and apixaban (Eliquis), there is no need to discontinue these agents for dental procedures or routine dental prophylaxis. For extractions and surgical procedures, discontinuation of these agents 24 hours before the planned procedure is adequate to reduce the risk of bleeding.

- In severe cases of profound thrombocytopenia (platelets < 50,000/mm^3) or anemia (Hb < 10 g/dL), depending on the invasiveness and extent of treatment needed, patients may be treated more safely in a hospital environment where blood or platelet transfusions are available.

- The ability to withstand treatment for an extended amount of time should be ascertained.

- The ability to return for sequential visits should be determined when a treatment plan is prepared or when a dental procedure is being initiated.

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

- A six-month recall schedule should be instituted to monitor any oral changes. If the patient is severely immunosuppressed (i.e., CD-4 count of < 100/mm^3), a shorter recall period such as a three-month interval should be considered.

- Patients exhibiting oral lesions should be assessed in a timely manner.

- When salivary hypofunction is present, the patient should be closely monitored for caries, periodontitis, soft tissue lesions, and salivary gland disease.

- Fluoride supplements in the form of a rinse and/or toothpaste should be encouraged for those with increased caries and salivary hypofunction.

- Oral hygiene is important in a medically compromised patient, as poor hygiene may be responsible for more rapid progression of oral disease. A proactive attitude and an emphasis on prevention should be encouraged. Dental treatment should also be prioritized based on the patient's health and circumstances (e.g., ability to tolerate long appointments, ability to perform oral hygiene, etc.).

B. Nutrition Counseling

Because of certain oral conditions, the HIV patient may have difficulty consuming a balanced diet. The patient may suffer from changes in taste and decreased ability to chew and swallow because of drug-induced salivary hypofunction. Medications can also lead to GI upset and nausea, further inhibiting the intake of a balanced diet. It is the role of the dentist to recognize oral manifestations that are associated with nutritional deficiencies resulting in intraoral manifestations due to low levels of vitamin B-12, folic acid, etc. Nutritional supplements or referral to the patient's physician or a registered dietitian may be necessary. Some areas to be aware of include:

- Poor oral intake of food or fluid,

- Difficulty chewing and swallowing due to continuous mouth sores resulting from candidiasis, herpes simplex, aphthous ulcers, etc.,
- Severe dental caries,
- Changes in perception of taste or smell,
- Patient complaints of economic inability to meet caloric and nutrient needs.

C. Patient Education and Referral for Substance Use Disorder and Tobacco Use

As part of patient education about oral self-care and the importance of regular oral health maintenance visits, the dental care provider should provide information to the patient about the negative impact of smoked and smokeless tobacco, e-cigarettes, marijuana and illicit substances, such as crystal methamphetamine, on oral tissues. As needed, the patient should be provided with the appropriate referrals for recovery, counseling, and risk reduction programs.

HIV Testing

Just like the materials and processes used in dentistry have improved in the past decade, so too has the testing and treatment for HIV. In fact, the field of HIV testing has improved dramatically in recent years. Using the same premise of screening with a sensitive test and reflexing to a more specific test, the HIV tests currently recommended by the CDC are extremely sensitive and specific because these tests ascertain both antibody (IgM and IgG) and antigen (p24). This makes these tests far more accurate and allows detection of HIV earlier in the disease process. The 4th generation tests allow detection at the acute stage of infection, between 2-3 weeks, well before the former standard Western Blot test would detect infection. The 4th generation tests also have a far shorter processing time and can be run in most lab settings in 60 minutes for a preliminary result. For these reasons, the Western Blot is no longer considered a confirmatory test.

It is important to refer to the CDC's website for the most current recommendations:[5]

The current testing recommendations call for the use of a 4th generation test, reflexed if positive to HIV-1/2 antibody differentiation test and an RNA/Nucleic Acid Test (NAT).

If people test positive, it is important to ensure they are linked to medical care. Early detection of HIV infection provides many opportunities for health professionals to intervene and help prevent further transmission to others. Use of antiretroviral medications shortly after infection can reduce the viral load set point, reduce the onset of opportunistic infections, and ensure connection to medical care. Physicians who regularly care for HIV patients will also have access to community resources, including testing for partners, Pre-Exposure Prophylaxis (PrEP) for partners, and medication assistance. The Affordable Care Act has made insurance more widely available, so that more people can get tested for HIV. The US Preventive Services Task Force has given HIV testing a Grade A, which means insurance providers will reimburse it.

[5] https://www.cdc.gov/hivnexus/hcp/diagnosis-testing/index.html#:~:text=CDC%20recommends%20all%20patients%20between,foster%20earlier%20diagnosis%20and%20treatment.Access June 10th, 2025

Hepatitis B and C

Hepatitis B

Hepatitis B is a vaccine-preventable liver infection caused by HBV. The HBV is transmitted when blood, semen, or other body fluid from a person infected with the virus enters the body of someone who is uninfected. Hepatitis B infection can range from a mild, short-term, acute illness lasting a few weeks to a serious, long-term, chronic infection. For a chronically infected person with HBV, infectivity depends on the Hepatitis B e antigen (HbeAg) status. If this person is both e antigen positive and surface antigen (HbsAg) positive, he or she will have more virus in the blood and is more likely to transmit HBV. According to the CDC, about 640,000 adults in the US have chronic (long-term) hepatitis B.[6] In 2023, 48% of all acute hepatitis B cases were people ages 40–59 years. Hepatitis B vaccination is recommended for all adults between the ages of 19 to 59 and adults older than 60 with risk factors for hepatitis B. The HBV vaccine is indicated for people who have an occupational risk of exposure to blood or other blood-contaminated body fluids.

The HBV vaccine consists of three doses. The second dose is given 1-2 months after the first; and the third dose is 4-6 months after the first. A blood test to determine antibody titers should be done 30-60 days after the last dose. A person must have an antibody titer >10 mIU/mL to be immune. If a person has a titer level <10 mIU/mL after immunization, the entire series must be repeated. If the person continues to have a low titer level, they are considered primary non-responders. If this person has an exposure, counseling is advised, as the person should get an immunoglobulin injection (HBIG) to help boost immunity. All healthcare providers must be offered the Hepatitis B vaccine by their employer, free of charge, and within 10 days of potentially being exposed to body fluids (Title 8 Cal OSHA).[7] The employee has the right to refuse the Hepatitis B vaccine. A Hepatitis B declination statement must be signed and witnessed.

Hepatitis B is 100 times more infectious than HIV. Prior to the introduction of the HBV vaccine, healthcare providers had a prevalence of HBV infection approximately 10 times higher than the general population. **For an unvaccinated healthcare worker, the risk of hepatitis B virus infection from occupational needle sticks is between 6 and 30%, depending on the absence or presence of HBV e antigen in the source case blood.** After exposure to hepatitis B, the majority of acute infections are resolved spontaneously. For those who do not clear the hepatitis B infection and remain chronically infected, there currently is no cure. However, an individualized approach consisting of supportive care, interferon and antiviral agents such as *entecavir* and *tenofovir* are used to slow down the viral replication in the chronically infected.[8]

Standard Precautions, formerly known as Universal Precautions, are now the minimum infection prevention processes to be followed in the dental operatory as many patients and their healthcare providers may be unaware of their HBV status. It is important to consistently follow routine barrier precautions and safely handle needles and other sharps. Blood contains the highest HBV titer of all body fluids. It is the most important vehicle of transmission in the healthcare setting. In the dental setting, the

[6] https://www.cdc.gov/hepatitis-b/about/index.html
[7] www.dir.ca.gov/title8/5193.
[8] https://www.cdc.gov/hepatitis-b/hcp/clinical-overview/index.html#cdc_clinical_overview_overview-overview

gingival sulcus has the greatest concentration of Hepatitis B. The Hepatitis B virus is also found in other body fluids, including saliva. However, saliva is not an efficient vehicle of transmission because it contains low quantities of infectious HBV. HBV has been demonstrated to survive in dried blood on surfaces for at least one week when at room temperature.

Hepatitis C

Hepatitis C is the most commonly reported blood-borne infection in the United States. According to the CDC, the number of new hepatitis C virus (HCV) infections steadily increased from 2013–2021 (29,700 to 69,800 estimated infections, respectively) and has remained relatively stable from 2021–2023.[8] The number of estimated infections in 2023 was 69,000, well above the annual target of 35,000. Persons aged 30–39 years had the highest rates of acute hepatitis C. The rates of infection are highest among injection drug users (60% of cases), sexual exposure accounts for approximately 15% of cases, whereas an additional 5% of exposures are from a combination of hemodialysis patients, those employed as health care workers (HCW), or infants infected by their mother during birth. Co-infection with HIV and HCV is common. Approximately one-fourth of the HIV-positive individuals in the US are believed to be coinfected with both viruses (i.e., about 250,000-300,000 people). Co-infection is especially common among HIV-infected injection drug users, and people with hemophilia who received clotting factor concentrates before 1987. It is important to note that percutaneous exposure to blood through tattooing, body piercing and acupuncture can transmit HCV.

If untreated, long-term HCV infection can eventually cause chronic liver disease which can range from mild to severe, including cirrhosis and liver cancer. Direct-acting antiviral (DAA) treatment is recommended for nearly all people diagnosed with hepatitis C. An 8–12-week course of oral DAA therapy cures more than 95% of people infected with hepatitis C regardless of HCV genotype. DAAs include protease inhibitors such as *simeprevier*, polymerase inhibitors such as *sofosbuvir* and nonstructural protein 5A (NS5A) inhibitors such as *daclatasvir.* Many of these agents have antiviral activity against all genotypes and some are used in conjunction with ribavirin.[9]

HCV is spread in the dental office by percutaneous or mucosal exposures to infected blood. **For HCV, the risk of infection after a needlestick or cut is approximately 1.8%. The risk following a blood splash is unknown; however, HCV infection from such an exposure has been reported.** According to the CDC guidelines, post-exposure prophylaxis should not be used after occupational exposure to HCV. The guideline recommendations are:[10]

- Serologic testing of source patient,
- Determination of baseline values of HCV for the person exposed (anti-HCV and ALT activity),
- Follow-up testing four-six months after exposure for anti-HCV and ALT,
- Confirmation of all anti-HCV results reported as positive by enzyme immunoassay.

There are no current recommendations to restrict an individual who is infected with HCV from working. Standard Precautions and strict aseptic techniques, which include hand washing, use of personal protective barriers and proper care in the use and disposal of needles and sharps, should be employed.

[9] American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA). Recommendations for testing, management, and treating hepatitis C: HCV testing and linkage to care. https://www.hcvguidelines.org

[10] https://www.cdc.gov/hepatitis-c/

Sexually Transmitted Infections

Many patients with HIV infection may also experience another sexually transmitted infection (STI). Several STIs have manifestations in the head and neck region and can play a role in transmitting the infection to others. Syphilis has manifestations in the head and neck structures during all its clinical stages. Primary syphilis might be associated with ulcers of chancre in the oral tissues; secondary syphilis may involve mucocutaneous lesions involving oral mucosa and the associated regional lymph nodes; granulomatous lesions in tertiary syphilis may present in the oral tissues; congenital syphilis leads to distinct oral mucosal and dental abnormalities in the fetus. Another major STI, gonorrhea may lead to presentations in the oral tissues either as a primary infection or as secondary involvement with the spread of the infection. Similarly, sexual transmission of herpes may occur through the involved extra and intraoral tissues.

Dental clinicians should be familiar with the clinical findings of major STIs. When these presentations are noted, prompt referral to a medical provider for clinical management is necessary. Syphilis, at every stage of the disease, is treated with benzathine penicillin G, as intramuscular injections and for those allergic to penicillin a course of oral doxycycline or tetracycline fully treats the infection. Uncomplicated gonorrhea responds well to intramuscular injections of ceftriaxone or oral azithromycin. Herpes simplex infection, especially in HIV positive patients, is managed by oral antivirals such as acyclovir or valaciclovir that shorten the course of the disease.[11]

In addition to treatments of active infections, for patients with HIV infection, chemoprevention has been shown effective in reducing the rates of infection with STIs. Prophylaxis with oral doxycycline (Doxy-PEP) is recommended within 72 hours after a high-risk exposure to reduce the risk of infection with syphilis and gonorrhea.[12]

[11] https://www.cdc.gov/std/treatment-guidelines/default.htm
[12] https://www.cdc.gov/mmwr/volumes/73/rr/rr7302a1.htm

Antiretroviral Drugs

Knowledge of antiretroviral drugs is constantly growing, but it should be emphasized that long-term clinical data on drug interactions does not exist for many of the newer medications. An up-to-date list of these agents and their known side effects and drug interactions are provided in Appendix A. Currently, there are no known drug interactions between antiretroviral agents and local anesthetics used in general dentistry. There are, however, several drugs that are prescribed by dentists or used in the office that may be contraindicated in patients taking antiretroviral medications. It is recommended that the dental care provider consult a reference that thoroughly discusses drug side effects and interactions prior to prescribing any medications or dispensing in the dental office.

Patients taking some of these drugs are likely to suffer from salivary hypofunction. [13] Use of prescription medications such as pilocarpine, cevimeline, and bethanechol as salivary gland stimulants should be considered. Excellent oral hygiene home care, topical fluoride and frequent hygiene recall visits, as well as nutritional counseling and saliva enhancers (sugarless gum, water, saliva substitutes) will be critical for prevention of periodontal disease and dental caries. Patients should also be assessed for consumption of unexpected sources of sugar such as over-the-counter medications including products like antacids (e.g., Tums, Rolaids); cough drops; suspensions (e.g., Nystatin); and fungal troches (e.g., Mycelex). All of these may contribute to dental caries.

[13] https://www.ncbi.nlm.nih.gov/books/NBK513308/ accessed June 11, 2025

Occupational Post-Exposure Prophylaxis (oPEP)

Most occupational HIV exposures do not result in the transmission of HIV. There have been no documented reports of occupational transmission from a patient to a dentist. The risk with percutaneous injury is considered to be about 0.3% per incident and the risk with mucous membrane exposure is about 0.09%. Anti-retroviral medications used in treating the infection are also useful in preventing it, if used soon after exposure occurs as post-exposure prophylaxis (oPEP). Successful oPEP can prevent viral replication and HIV infection.

Documentation of the event and assessment of risk remain important. The person who is exposed should be referred immediately to a physician who can provide counseling, testing and appropriate medications. The interval within which PEP should be initiated for optimal efficacy is not known, however, "as soon as possible" is recommended. This exposure should be treated as a medical emergency.

For updated recommendations: see the October 2014 New York State Department AIDS Institute, www.aidsinstitute.org.

Management of Occupational Blood Exposure

- Wash wounds and skin with soap and water,
- Flush mucous membranes with water or saline,
- The incident should be reported to a supervisor if applicable and should be, documented in an injury/exposure log,
- Report to a medical provider for testing, access to post-exposure protocol and oPEP,
- New testing algorithms include the combo Antibody/Antigen test with confirmation by Multispot,

Basic Overview

Assessing Infection Risk and Source Case Testing

- Important to determining if occupational post-exposure prophylaxis (oPEP) with ART is necessary
- If source case testing is not possible, PEP is recommended for high-risk exposures

Medications

- Start oPEP as soon as possible, preferably within 2 hours of exposure and not longer than 72 hours
- Single or multiple tablet regimen for 28 days

Baseline Labs to Monitor Exposed Person for Adverse Reactions

- Pregnancy test if applicable
- Complete Blood Count with differential and platelets
- Urinalysis
- Renal Function Tests (BUN and Serum Creatinine)

- Liver Function Tests (Aspartate and Alanine Aminotransferase, Alkaline Phosphatase, Total Bilirubin)

Monitoring
- Baseline testing
- Retest at 6 and 16 weeks. (Note: fourth generation testing is generally used now)

A. Assessing Risk of Infection

In assessing the risk, consider the type of injury and review the patient's health history looking for history of HIV infection, hepatitis, sexually transmitted diseases, blood transfusions, and organ transplants. All of these can increase the risk to dental HCW. A potential exposure to HIV will involve an infectious bodily fluid and a portal of entry. In the dental office, blood is the primary agent of concern. Saliva and vomitus do not have the potential for transmitting HIV unless bloody. If source patient's health history indication of no HIV infection cannot be unconditionally accepted as negative. It is estimated that up to 15% of HIV positive persons in the U.S. are unaware of their infection due to the long latent period (up to 10 years) between initial infection and appearance of symptoms. Interview the patient and discuss these issues to get some idea of the personal characteristics of the patient involved that could affect that person's risk potential.

For substantial exposures, consider using the Oraquick Rapid HIV Testing device to determine if the patient who was the source of the exposure is HIV-positive. This is a non-invasive test which can be administered by any HCW. The test device is used to swab the person's gingiva and is then placed in a solution-containing receptacle. The results are available in 20 minutes. This simple test is extremely accurate but note that this is an antibody test and thus will not give a positive result for very recent infections. However, it does give valuable information that assists in a decision whether to start an oPEP medication regimen. A positive rapid HIV test should be preliminarily considered a true positive for the purposes of initial oPEP decision-making. A person receiving a positive result should be referred to medical care and have the result confirmed by more accurate antigen/antibody test or nucleic acid test in a laboratory setting. Most dental offices do not keep an inventory of these devices and the patient could be sent to an urgent care center or other location where HIV testing can occur. It is the responsibility of the dental office to pay for such testing. The source patient cannot be required to have such a test and must consent to it.

B. Making Decision Regarding oPEP[14]

If the source patient is HIV-positive, then post-exposure prophylaxis with antiretroviral medications is recommended. However, the decision to take or not take the medication must be made by the person who sustained the exposure. Decades of records of percutaneous exposures of dental HCW, as well as several studies specifically addressing dental workers, have not identified any dental HCW who contracted HIV infection by an occupational exposure in the United States. Most documented cases of HCWs becoming HIV-infected via occupational exposure occurred in hospital settings during earlier years of the epidemic from major exposures involving very ill patients with advanced AIDS and high viral loads in their blood. Such patients are normally not receiving dental care and dental procedures do not result in the quantity of bleeding which can occur in a hospital operating room. With that, the chance of infection is always there and the use of PEP medication must be seriously considered.

[14] *PEP Quick Guide for Occupational Exposures,* National Clinician Consultation Center, UCSF, Updated: June 18, 2021

A major reason for not using PEP medication following any exposure is the toxicity of these drugs and the length of time they should be taken (recommendation is 28 days, if they can be tolerated). HIV experts agree that 28 days is the best length of treatment to give persons the highest chance of avoiding infection while not developing the serious side effects which can develop with long-term use of the antiretroviral medications. However, ability to tolerate these drugs is a serious consideration. The most common side effects reported are nausea, fatigue, headache, vomiting, diarrhea, and myalgias. Guidelines for PEP indicate that taking PEP medications is not justified when the risk of transmission is negligible.

Taking oPEP Medications

If the exposed person decides to take oPEP medications, it should begin as soon as possible. The best time to start is within 24 hours of exposure. Starting PEP more than 72 hours after exposure is considered ineffective, so the sooner the better. There are many HIV anti-retroviral medications available, and different regimens have been approved over the years. The current recommended regimen calls for three drugs from two different drug classes: one from the Integrase Strand Transfer Inhibitor (INSTI) class and two from the Nucleoside Reverse Transcriptase Inhibitor (NRTI) class.

There are two preferred PEP regimens per current CDC recommendations for otherwise healthy persons: the combination NRTI Truvada (which includes Tenofovir and Emtricitabine) and either Raltegravir or Dolutegravir from the INSTI class. Advantages of using INSTI drugs is that they are generally well-tolerated, have fewer drug-drug interactions, and are less likely to develop resistance to HIV. Other regimens may be considered under special circumstances. Another PEP regimen that may receive CDC recommendation soon is Biktarvy, which is a three-drug regimen in one pill that is taken once a day with or without food. It contains the INSTI Bictegravir and two NRTIs. The CDC recently (May 2025) approved Biktarvy for non-occupational PEP and approval for use as occupational PEP will likely occur soon.

Side effects such as diarrhea, nausea, and headaches can occur with any of these drug regimens and can usually be managed with antimotility, antiemetic, and analgesic agents. Serious side effects are rare but can occur. These are usually associated with long-term use for an established infection, rather than short-term use as PEP to prevent an infection.

<u>Remember that the decision about whether to take the PEP medications must ultimately be made by the exposed person him/herself.</u>

The National Clinicians' Post-Exposure Prophylaxis Hotline is the PEPline. This is an excellent resource for questions regarding exposures and the need for PEP. It is open 24 hours a day, seven days a week. The phone number is (888) 488-4911.

Pre-Exposure Prophylaxis (PrEP)

PrEP (pre-exposure prophylaxis) is the use of antiretroviral medication to prevent HIV. PrEP is for people without HIV who may be exposed to HIV through sex or injection drug use.[15] When taken as prescribed, both oral and injectable PrEP reduce the risk of getting HIV from sex by about 99%. Oral PrEP has also been shown to reduce the risk of getting HIV from injection drug use by at least 74%. Clinicians are encouraged to discuss adherence to the PrEP regimen with all their patients who are at risk for exposure to HIV. PrEP is a part of a more comprehensive HIV prevention program that also consists of proper condom use and screening for other sexually transmitted infections (STIs).

Legal and Privacy Issues

Testing for HIV infection and reporting HIV test results are governed by California statute. Protection of information regarding HIV status, handling of public health records containing information about HIV or AIDS and personal identifying information, and federal and state rules governing protected health information and medical records, all limit disclosure by medical care providers. Additionally, people living with HIV ("PLWH") are entitled to a host of legal protections. Both federal and state constitutions promise a right to privacy which applies to HIV status. These laws, in addition to federal and state laws prohibiting discrimination against PLWH, are key considerations when serving this community.

Informed Consent for HIV Testing[16]
Before a medical care provider, including a dentist, may test a patient for HIV infection, the provider must inform the patient that the test is planned. Medical care providers must also provide information about the test, inform the patient that there are numerous treatment options available for a patient who tests positive for HIV and that a person who tests negative for HIV should continue to be routinely tested. The medical care provider must also inform the patient that he or she has the right to decline the test. If a patient declines the test, the medical care provider shall note that fact in the patient's medical file.

HIV Testing for Occupational Exposure[17]
In some limited instances, healthcare workers, including dentists, may be exposed to blood borne pathogens as part of their occupation. Thus, occupational exposure may give rise to HIV testing. In these cases, the law requires following strict protocols that balance the needs of the healthcare workers with the privacy interests of PLWH. Even in the context of occupational exposure, HIV testing of a patient cannot be mandated by a healthcare worker. Post-exposure prophylaxis for HIV exposure is available for occupational exposure and should be considered where appropriate.

Notification of HIV Test Results[18]
A patient who is tested for HIV infection should receive timely information and counseling from the medical care provider. An explanation of the results as well as the implications of those results to the patient's health should be explained.

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[15] https://www.cdc.gov/hivnexus/hcp/prep/index.html
[16] California Health and Safety Code § 120990.accessed June 11, 2025
[17] California Health and Safety Code § 120262.accessed June 11, 2025
[18] California Health and Safety Code § 120990(h).accessed June 11, 2025

If the patient tests positive for HIV infection, the medical care provider shall inform the patient that there are numerous treatment options available and identify follow-up testing and care that may be recommended. That information must also include contact information for medical and psychological services to ensure proper linkages to HIV care. If the patient tests negative for HIV infection and is known to be at high risk for HIV infection, the medical care provider shall advise the patient of the need for periodic retesting due to limitations of testing technology and the six month "window period" for verification of results.[19] Medical care providers may also offer prevention counseling or a referral to prevention counseling to the patient.

Electronic notification of test results for HIV infection is only permitted if requested by the patient and the medical care provider considers such notification "most appropriate."[20] Prior consent from the patient must be obtained for any electronic notification and the medical care provider must view the results prior to the patient accessing such results. Telephone communication is not considered electronic communication. Regardless of the type of notification, protocol with regard to dispensing post-test information, as described above, still applies.

HIV Reporting[21]

In 2006, California, along with a number of other states, moved from codes-based reporting to names-based reporting for HIV/AIDS. This was in response to new funding requirements of the Ryan White CARE Act, requiring federal funding allocations to states be calculated according to the number of HIV-positive individuals identified by name. Surveillance data from previously identified individuals living with HIV could not be imported to the new system and had to be re-identified and validated under the new system.

Dentists, as health care providers, after ordering an HIV test, are required to report cases of HIV infection to the local health officer using patient names on a form developed by the state Department of Public Health. Laboratories are also required to submit HIV case report forms to the local health officer. Once the local health officer is able to eliminate duplicate reports, they are submitted to the state Department of Public Health. The state, in turn, removes any personally identifying information and submits required reporting to the federal Centers for Disease Control.

Confidential Public Health Records[22]

Because HIV reporting has shifted to a names-based reporting system, there are legal protections that generally prohibit disclosure of public health records containing information regarding HIV or AIDS and personal identifying information, either developed or acquired by the local public health agency, the state, or an agent thereof. A few exceptions do apply, including written authorization of the person who is the subject of the record or a guardian or conservator of that person or use of public health records containing such information by state and local health officers in conducting research in the investigation,

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[19] *See* California Department of Public Health, *HIV Testing Information and Resources for California Clinicians*, http://www.cdph.ca.gov/programs/aids/documents/ctthivtestinfoforclinicians.pdf (last accessed June 11, 2025) (explaining "window period").

[20] California Health and Safety Code § 123148.Accessed June 11th, 2025

[21] California Health and Safety Code § 121022(a). Accessed June 11, 2025

[22] California Health and Safety Code § 121025. Accessed June 11, 2025

control and surveillance of the disease.[23] Unauthorized disclosure, ranging from negligent to willful, may result in civil penalties up to $25,000 per actionable offense.[24]

Disclosure of HIV Test Results[25]

Unauthorized disclosure of HIV test results linked to individual identifying information is generally prohibited from disclosure. Including the results of an HIV test in a patient's medical records is not considered disclosure. Written authorization is required for each separate disclosure of HIV test results and must identify to whom such disclosure can be made. Unauthorized disclosure, ranging from negligent or willful, may result in civil penalties up to $25,000 per actionable offense.

Privacy and Confidentiality of Medical Records[26]

Federal law governing protected health information under the Health Insurance Portability and Accountability Act also protects records containing information regarding HIV or AIDS and personal identifying information. Unauthorized disclosure is generally prohibited unless it falls within specific permitted use such as coordinating care and treatment of the patient, as part of administrative processes to obtain payment for care provided, for public health purposes, and in response to criminal justice processes, including specific circumstances where court orders or warrants demand disclosure. Unauthorized disclosure is subject to administrative penalties and criminal penalties for anyone who knowingly obtains or discloses individually identifiable personal health information. This law offers individuals no private right to legal action.

State law governing confidential medical information under the Confidentiality of Medical Information Act applies to any licensed or certified health care provider, which includes dentists. Medical records include charts, records, notes, laboratory results, and pharmacy and prescription histories. Unauthorized disclosure is generally prohibited unless it falls within specific exceptions such as coordinating care, treatment, payment of services for the patient, for public health purposes, and in response to legal processes, including specific circumstances where court orders or warrants demand disclosure. Unauthorized disclosure is subject to a private right of action including provisions for civil penalties (including nominal damages and actual damages) as well as administrative fines up to $250,000 per violation.

Legal Standards for Treating PLWH[27]

Federal and state constitutions protect the fundamental right to privacy. In California, that fundamental right extends to HIV status.[28] In addition to these constitutional rights, PLWH are protected by non-discrimination mandates which can be found in the federal Americans with Disabilities Act[29], Section 504 of the federal Rehabilitation Act, and California's Unruh Civil Rights Act and Disabled Person's Act.[30] These laws prohibit discrimination against all PLWH in public accommodations.

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[23] California Health and Safety Code § 121025 (a)-(b).Accessed June 11, 2025
[24] California Health and Safety Code § 121025 (e).Accessed June 11, 2025
[25] California Health and Safety Code § 120980.Accessed June 11, 2025
[26] https://law.justia.com/codes/california/code-civ/division-1/part-2-6/chapter-2/section-56-10/ Accessed June 11, 2025
[27] https://constitution.congress.gov/constitution/amendment-4/ accessed June 11, 2025
[28] CA Const. art. I, § 1.
[29] *Bragdon v. Abbott*, 524 U.S. 624 (1998) (finding that the Americans with Disabilities Act applies to all people living with HIV, regardless of their stage of infection).
[30] https://www.ada.gov/law-and-regs/ada/ Accessed June 11, 2025

Dentists, as medical care providers providing health services to the public, are required to comply with non-discrimination provisions applying to public accommodations. This means dentists must serve PLWH and any considerations when making exceptions to serving a patient living with HIV must be based on reasonable judgments informed by current medical knowledge and not based on stereotypes or irrational fears. Given that the risk of HIV infection to dental staff or other patients is remote and can be further reduced by implementing already required universal safety precautions applying to all blood borne pathogens, any argument which relies on this particular risk will be legally insufficient.[31]

The community standard of practice requires that dentists be as familiar with basic HIV medical care as they are with other common medical conditions. A referral to other general practitioners because the dentist is ignorant about basic HIV medical care is a violation of community dental practice norms. Referrals to a specialist or to a hospital setting must always be based on the clinical needs of the patient, not the ignorance or fear of the dentist, staff or other patients. The legal obligation of the dental provider is to refer patients for testing and follow-up. For example, a dentist may be held legally liable if a patient who has a lesion with unknown etiology needs a referral in order to rule out possible HIV etiology, and the referral for testing and counseling is not done.

Ethical Standards for Treating PLWH

Ethical standards of the California Dental Association, American Dental Association, and World Dental Federation also make clear that it is unethical to refuse to care for PLWH because of fear of the risk of infection.

Best Practices for Treating PLWH

Any decision to deny dental services to PLWH should be made with an abundance of caution. Typically, any policies and practices that result in differential treatment and care of HIV-positive patients, including blanket refusals to treat HIV-positive patients and blanket referrals of all HIV-positive patients to "specialists" have been found to be scientifically unwarranted, and courts have found such blanket practices and policies to constitute unlawful discrimination against PLWH.

PLWH have reported facing discrimination in accessing dental services.[32] Given this particular history, dentists must understand that some PLWH may choose not to disclose their HIV status. For this reason, any effort to help patients feel comfortable and confident in disclosing their HIV status is vital to serving this vulnerable population.

Staff must receive appropriate training on the specific protections which apply to the privacy and confidentiality of HIV status. Because patient information must be kept confidential to the extent possible, unauthorized disclosures of HIV or AIDS-related information coupled with personally identifiable information, or medical records of patients living with HIV, should be monitored. Given that unauthorized disclosures can lead to significant awards for damages, utilizing a uniform written authorization form that includes specific mention of HIV/AIDS-related information, the party with whom such information can be shared, and the patient's signed consent would help to safely facilitate any necessary exchange in information.

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[31] https://archive.ada.gov/hiv/ada_hiv_enforcement.htm accessed June 11, 2025

[32] *See* Brad Sears, Christian Cooper, Fariba S. Younai, and Tom Donohoe. HIV Discrimination in Dental Care: Results of a Discrimination Testing Study In Los Angeles County (2012), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Sears-HIV-Discrimination-Dental-Care-Dec-2011.pdf (last accessed June 11, 2025).

Selected Websites for HIV/AIDS Information for Dentists

General Sites of Particular Interest to Dentists:

- American Dental Association – legal, regulatory, ethical issues, evidence-based dentistry http://www.ada.org/

- California Dental Association – extensive resources on practice management http://www.cda.org

- HIVdent – extensive information on oral manifestations, infection control, medications, picture gallery, and other resources: http://www.hivdent.org

Federal Government-Sponsored Websites:

- Aids.gov – overview of federal resources -- http://www.aids.gov/

- Centers for Disease Control and Prevention (CDC) (www.cdc.gov):
  National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
  http://www.cdc.gov/nchstp/hiv-aids/dhap.htm
  CDC National Prevention Information Network (NPIN)-- http://cdcnpin.org

- Health Resources and Services Administration (HRSA):
  HRSA Target Center – Tools for the Ryan White Community
  http://careacttarget.org/library/guide-hivaids-clinical-care-oral health/

  AIDS Education Training Centers (AETCs) – HIV Education for Healthcare Professionals, with listing of regional AETC's resources and training opportunities -- http://aidsetc.org/

- National Institutes of Health (NIH)
  AIDS Info – Guidelines in use of antiretroviral agent -- http://aidsinfo.nih.gov
  National Institute for Dental and Craniofacial Research -- http://www.nidcr.nih.gov/

Clinical Resources for Dentists:

- HIVdent – Comprehensive site with resources for oral healthcare -- http://www.hivdent.org/

- American Academy of Oral Medicine – Publisher of Clinicians Guides Series, which includes "Clinician's Guide to Treatment of Patients with HIV & Other Communicable Diseases, 4th ed, 2013." https://maaom.memberclicks.net/clinicians-guides

- Mountain Plains AETC – publications include "Oral Health Care for the HIV-Infected Patient" http://www.mpaetc.org/Products

General Clinical Resources:

- HIV Insite (UCSF) – comprehensive up-to-date information on HIV/AIDS
  http://hivinsite.ucsf.edu/

- John Hopkins AIDS Guide – available for mobile devices and web
  http://www.hopkinsguides.com/Hopkins.up

- University of Liverpool –free drug interaction apps for HIV and Hepatitis C
  https://www.hiv-druginteractions.org/
  http://www.hep-druginteractions.org/

- Infectious Disease Society of America - HIVMA/IDSA Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus
  https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/
  accessed June 11, 2025

- DrugBank – comprehensive database with over 6,800 drug entries -- http://www.drugbank.ca/
  accessed June 11, 2025

Infection Control:

- Organization for Safety, Asepsis and Prevention (OSAP) – mission is safe and infection-free delivery of oral healthcare – http://www.osap.org accessed June 11, 2025

- American Nursing Association Safe Needles Save Lives – many resources on needlestick safety and prevention-- www.needlestick.org/ accessed June 11, 2025

Post-Exposure Prophylaxis:

- The National Clinician's Hotlines:
  Post-Exposure Prophylaxis Hotline – http://www.nccc.ucsf.edu/about_nccc/pepline/
  HIV/AIDS Care Consultation
  (800) 933-3413
  Perinatal HIV Consultation
  (888) 448-8765
  Hepatitis C Consultation
  (844) 437-4636
  Substance Use Consultation
  (855) 300-3595
  Pre-Exposure/PrEP Consultation
  (855) 448-7737
  Post-Exposure/PEP Consultation
  (888) 448-4911

- Florida Caribbean AETC – resources include printed summary guidelines for PEP and many other topics, http://fcaetc.org/treatment-guidelines.php accessed June 11, 2025

International Issues in HIV/AIDS:

- AIDS Education Global Information System (AEGIS) – information and resources for global AIDS epidemic – http://www.aegis.com/ accessed June 11, 2025

- World Dental Federation (FDI) http://www.fdiworlddental.org accessed June 11, 2025

APPENDIX A

Known Antiretroviral Drug Interactions In General Dentistry

NOTE: The information here may serve as a guideline, but it only represents some of the known drugs and the adverse drug reactions *at this time* (2025). https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/drug-interactions-overview.
New drugs and drug interactions are being discovered constantly, so dentists are encouraged to check the latest information before prescribing drugs. For more complete information about all drug interactions and contraindications, please consult information provided by the drug manufacturer or a recently published drug reference. **Some good sources include**: **American Academy of Oral Medicine 2018, and Medical Management of HIV Infection 2018. Latest updates can also be found on various websites-see Selected Websites for HIV/AIDS information as a guide. Summary information on antiretroviral drug interactions is available in a free app for Apple and Android devices from the University of Liverpool. https://www.hiv-druginteractions.org/**

The human immunodeficiency virus (HIV) must insert its genetic material into a susceptible cell to replicate and release more virions. This process involves a number of steps that present opportunities for therapeutic intervention. HIV mutates rapidly in response to single drug therapy and quickly develops resistance to individual drugs. Antiretroviral (ARV) drugs delivered in combination therapy were found to be far more effective in suppressing HIV replication. This is now the standard of care for anti-HIV drug therapy and it allows those who respond favorably to therapy to have a more normal life span. However, this comes with a price. There is direct toxicity from the drugs themselves and drug-drug interactions are frequent. These effects can have serious consequences, and can be difficult to predict. The current ARV drugs are far more effective and easier to tolerate than earlier drugs, but they are all toxic to varying degrees. Clinicians prescribing these drugs always have to weigh hoped-for benefits against potential negative consequences from adverse effects of the individual drugs and unintended interactions between all the medications a given patient is taking.

Six major classes of ARV drugs have been developed to treat HIV/AIDS, however no drugs have been developed to date that cure the HIV infection. The drugs currently available in each of these classes are discussed below. ARV drugs may be cited by an abbreviation, a pharmaceutical name, and/or a brand name, so all these names are presented. Many drugs, including a number of ARVs and other commonly prescribed drugs, interact with the Cytochrome P450 (CYP450) enzyme system in the liver and intestine that is responsible for much drug metabolism. An individual drug may be a substrate (i.e., be metabolized by) these enzymes; it may also inhibit or induce the metabolism of another drug. An individual drug may be a substrate, inhibitor, and/or inducer all at the same time depending on the individual CYP450 enzymes it interacts with and how these affect other involved drugs. This can greatly complicate the spectrum of drug-drug interactions and make them difficult to predict.

Drug interactions in dental practice are not as voluminous as they are in medical practice because most dental-related drug therapy is short-term, and the number of drug classes is small in comparison. Dentists do need to be aware of the potential for interaction between drugs they may prescribe and the ARV and other drugs that patients are taking concurrently. There may be interactions involving drugs not prescribed by the dentist that can have clinical consequences for dental practice. As an example, drugs that inhibit the metabolism of warfarin could increase bleeding tendency and dentists should have recent INR values for such patients before performing invasive procedures. The app for mobile devices from the University of Liverpool that gives information on potential ARV drug interactions with other drugs is particularly easy to access and understand. This app is a free download from the website: https://www.hiv-druginteractions.org/

Fortunately for dentists, their most commonly used drugs are local anesthetics, which have very low potential for drug-drug interactions with ARVs. Commonly used amide anesthetics are metabolized by the CYP450 system but adverse drug-drug interactions with ARVs have not been noted. Systemic toxicity from local anesthetics can occur from excessive dosage or inadvertent intravascular injections. Care should be taken when administering local anesthetics to patients with compromised liver function because toxic dose levels may be lower in such persons. Other drugs that dentists may prescribe, including some antibiotics, antifungals, anxiolytics, sedatives and topical steroids, have the potential for interactions with certain ARVs. **Please refer to the tables at the end of this appendix** for a complete list of currently-approved ARVs (with FDA approval dates), each drug has a section on contraindications with potential drug-drug interaction concerns for general dentists listed first, followed by other potential interactions that dentists should be aware of, and then a summary of adverse reactions to the drugs themselves.

1. NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)

NRTIs prevent the conversion of viral RNA into double-stranded DNA so it can insert into the genome of the cell. This was the first class of ARV medications discovered. These drugs are the backbone of antiretroviral therapy and are commonly prescribed in three-drug regimens that contain two NRTIs and a third drug chosen from one of the NNRTI, PI, or INSTI classes. NRTIs are not extensively metabolized before being eliminated by the kidneys. Therefore, significant interaction with enzymes involved in drug metabolism is unlikely. However, drug-drug interactions from other causes can occur. Adverse effects from NRTI drugs themselves are common and can be severe. These include mitochondrial toxicity, lactic acidosis, hepatic steatosis, myelosuppression with cytopenia, cardiomyopathy, and many others.

2. NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)

NNRTIs prevent the conversion of viral RNA into DNA similar to the NRTIs, but they have a different mechanism of action. These drugs have an affinity for the CYP450 enzyme system. NNRTIs may be metabolized by these enzymes as well as inhibit or induce them whether or not they are a substrate for metabolism. These properties greatly increase the potential of NNRTIs for serious drug-drug interactions. Serious adverse effects of the drugs themselves include drug hypersensitivity (including Stevens-Johnson Syndrome), lipid disorders, serious skin rash, and liver toxicity.

3. PROTEASE INHIBITORS (PI)

PIs block the enzyme necessary to produce mature virions that propagate the HIV infection. PIs have a high barrier to development of drug resistance, but also have a propensity to bad metabolic effects, including GI disturbances, dyslipidemia, insulin resistance, and changes in fat distribution in the body (lipodystrophy). Similar to NNRTIs, PIs have a strong affinity to CYP450 enzymes and consequently a strong potential for serious drug-drug interactions. All PIs inhibit the most prominent CYP enzyme. The strong inhibitory properties of ritonavir are actually exploited by combining it with other PIs so that the other PI drug can be effective when administered in smaller doses.

4. FUSION AND ENTRY INHIBITORS

Entry inhibitors interfere with the viral ability to enter the cell. The two currently available entry inhibitors are in different drug classes and have markedly different metabolic profiles as discussed below.

5. INTEGRASE STRAND TRANSFER INHIBITORS (INSTI) -

Integrase strand transfer inhibitors (INSTI) block the enzyme necessary to integrate the viral DNA into the DNA of the cell. They are generally well tolerated, although they are also prone to development of drug resistance and cause insomnia and headaches.

OTHER:

- Fixed Dose Combination with NRTI And INSTI ARVS

    - Pharmacokinetic Enhancers
      Pharmacokinetic enhancers have no activity against HIV but they enhance the activity of ARV medications that are given concurrently.

- Fixed Dose Combination with ARV Inhibitors and Drug Metabolism Inhibitor:
    - For drug-drug interaction potential and adverse reactions, see discussion of individual drugs

It is best to consult a drug reference before prescribing any medications to determine if there are any contraindications.

A NOTE ON HEPATITIS C:

Hepatitis C (HCV) is a viral infection that has many of the same risk factors as HIV. Older HCV drug regimens did not have high cure rates and did not contain direct acting antiretroviral drugs. Direct-Acting Antiviral agents (termed DAAs) for HCV were introduced in 2011 and are much more effective at curing the disease in shorter time frames. However, drug interactions in the coinfected are very complex and will become more so as more HCV drugs are released. The current hope is that the advent of DAAs for HCV will result in an effective oPEP for HCV to be developed in the near future. The University of Liverpool has also developed an app for mobile devices that identifies drug interactions with HCV drugs. It can be downloaded at http://hep-druginteractions.org/

ANNEX A

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	Common Side Effects	Contraindications/Considerations
NRTIs block reverse transcriptase, an enzyme HIV needs to make copies of itself.		
Abacavir (Ziagen; also included in Epzicom, Triumeq, Trizivir)	Nausea And Vomiting; Headache; Sleep Problems; Skin Rashes; Fever And Chills; Infection In The Nose, Throat, Or Ear; General Feeling Of Being Unwell, Tired, Or Not Having Your Usual Energy (Hypersensitivity Reaction, Increase In Cholesterol, Possible Risk Of Heart Disease)	**Dental: interactions unlikely.** General: Caution to patients with previously demonstrated hypersensitivity to abacavir or any other component of the products; Caution to patients testing positive for the presence of the HLA-B*5701 allele; Genetic testing is recommended before you starting this medication. Moderate to severe hepatic impairment is a possibility.
Emtricitabine (Emtriva; also included in Biktarvy, Complera, Descovy, Genvoya, Odefsey, Stribild, Symtuza, Truvada)	Headache, Diarrhea, Elevated Creatine Kinase, Nausea, Fatigue, Dizziness, Depression, Insomnia, Abnormal Dreams, Rash, Abdominal Pain, Asthenia, Increased Cough, And Rhinitis. The Most Common Side Effects Reported During Clinical Trials In Children Were Anemia And Skin Discoloration/Hyperpigmentation.(Rash And Skin Darkening Of Palms Or Soles)	**Dental: interactions unlikely.** General:Do not use this medicine if you or your child are also taking lamivudine, Atripla®, Combivir®, Complera®, Epivir®, Epivir-HBV®, Epzicom®, Odefsey®, Stribild®, Triumeq®, Trizivir®, or Truvada®. Tell your doctor right away if you or your child are using any of these medicines.
Lamivudine (Epivir; also included in Cimduo, Combivir, Delstrigo, Dovato, Epzicom, Triumeq, Trizivir)	Headache, Nausea, Malaise, Fatigue, Nasal Signs And Symptoms, Respiratory Tract Infections, Throat And Tonsil Discomfort, Abdominal Discomfort And Pain, Vomiting, Diarrhea, And Cough. (Skin Rash)	**Dental: interactions unlikely.** General:Do not use this medicine if you or your child is also taking zalcitabine or medicines containing emtricitabine or lamivudine (eg, Atripla®, Combivir®, Complera®, Emtriva®, Epzicom®, Stribild®, Trizivir®, Truvada®).
Tenofovir Disoproxil Fumarate, also known as TDF (Viread; also included in Atripla, Cimduo, Complera, Delstrigo, Stribild, Truvada)	Rash, Diarrhea, Headache, Pain, Depression, Asthenia, And Nausea. The Most Common Side Effects Associated With This Drug In Combination With Otherantiretrovirals Have Included Mild To Moderate Gastrointestinal Events (E.G., Nausea, Diarrhea, Vomiting, And Flatulence) Long Term Adverse Effects Include Decreases In Kidney Function And Bone Mineral Density. (Kidney And Bone Damage)	**Dental: interactions unlikely**. General: Tenofovir can harm your kidneys, especially if you also use certain medicines for infections, cancer, osteoporosis, organ transplant rejection, high blood pressure, or pain or arthritis (including Advil, Motrin, and Aleve).Do not take tenofovir together with adefovir (Hepsera), or with combination medicines that contain tenofovir (Atripla, Biktarvy, Cimduo, Complera, Descovy, Genvoya, Odefsey, Stribild, Symfi, or Truvada).Do not use if you have kidney disease.
Tenofovir Alafenamide, also known as TAF (Vemlidy; also included in Biktarvy, Descovy, Genvoya, Odefsey, Symtuza)	Increase In Ldl ("Bad") Cholesterol, Weight Gain	**Dental: interactions unlikely**. General:This medicine should not be used together with dexamethasone (Decadron®), certain seizure medicines (eg, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, Dilantin®, Tegretol®, Trileptal®), medicines for tuberculosis (eg, rifampin, rifapentine, Priftin®, Rifadin®, Rimactane®), certain stomach medicines (eg, dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, Aciphex®, Dexilant®, Nexium®, Prevacid®, Prilosec®), or St. John's wort. This medicine may cause serious types of allergic reactions, including skin reactions and drug reaction with eosinophilia and systemic symptoms (DRESS syndrome).
Zidovudine, also known as AZT (Retrovir; also included in Combivir, Trizivir)	Anemia; Nausea; Vomiting; Lactic Acidosis; Increase In Cholesterol; Fat Loss In Arms, Legs Or Face; Fatty Liver	**Dental: Fluconazole increases AZT serum levels.** General: not to be prescribed with any meds that cause bone marrow suppression. Zidovudine has serious interactions with the following drugs: cabotegravir; cidofovir; clozapine; deferiprone; ganciclovir; pretomanid; ribavirin; ropeginterferon alfa 2b; stavudine; valganciclovir. Zidovudine has severe interactions with the following drug: elvitegravir/cobicistat/emtricitabine/tenofovir DF

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)	Common Side Effects	Contraindications/Considerations
NNRTIs block reverse transcriptase, an enzyme HIV needs to make copies of itself.		
Doravirine (Pifeltro; also included in Delstrigo)	Skin Rash, Weight Gain	**Dental: interactions unlikely** Do not use this medicine together with carbamazepine (Tegretol®), enzalutamide (Xtandi®), mitotane (Lysodren®), oxcarbazepine (Trileptal®), phenobarbital (Luminal®), phenytoin (Dilantin®), rifampin (Rifadine®), rifapentine (Priftin®), or St John's wort.
Efavirenz (Sustiva; also included in Atripla)	Vivid Dreams, Anxiety, Depression, Insomnia, Skin Rash, Liver Damage, Suicidal Ideation	**Dental: Increases plasma concentrations of midazolam and triazolam. Serum levels of EFV are increased by fluconazole. EFV interacts with CYP450 enzymes, affecting the hepatic metabolism of many co-administered drugs, including antiretrovirals**. General: Do not take with voriconazole, elbasvir/grazoprevir, or St. John's wort, as these combinations can reduce the effectiveness of Atripla or lead to serious side effects. Do not use with other medications containing efavirenz, emtricitabine, or tenofovir disoproxil fumarate, unless directed by a healthcare professional.Should not be used in patients that experience depression or other mental health issues.
Etravirine (Intelence)	Skin Rash	**Dental: Antifungal agents increase ETV concentrations. ETV decreases itraconazole and ketoconazole concentrations. It increases serum levels of alprazolam, diazapam and warfarin which may in turn increase INR. Erythromycin also increases ETV concentration**. General: Serious skin reactions can occur with this medicine. This medicine may cause you to have excess body fat.
Nevirapine (Viramune)	Skin Rash, Liver Damage	**Dental: NVP induces CYP450 enzymes and affects the levels of many co-administered drugs. Drugs that inhibit CYP3A activity (ketoconazole, cimetidine and macrolide antibiotics can increase NVP levels. Risk of hepatotoxicity exists with fluconazole.** General: Serious side effects have occurred with this drug. The most serious side effects have included hepatitis, hepatic failure, Stevens-Johnson syndrome, toxic epidermal necrolysis, drug reaction with eosinophilia and systemic symptoms, and hypersensitivity reactions. Hepatitis/hepatic failure have been isolated or associated with signs of hypersensitivity which have included severe rash or rash accompanied by fever, general malaise, fatigue, muscle/joint aches, blisters, oral lesions, conjunctivitis, facial edema, eosinophilia, granulocytopenia, lymphadenopathy, or renal dysfunction.(Should not be used in people with liver problems, or in women with CD4 greater than 250 or in men with CD4 greater than 400)

Rilpivirine (Edurant; also included in Complera, Juluca, Odefsey)	Depression, Trouble Sleeping, Skin Rash, Suicidal Ideation	**Dental: Macrolide anibiotics and azole antifungals may increase RVP levels. RPV decreases serum levels of ketoconazole**. General: Do not use rilpivirine (the active ingredient contained in Edurant Ped) if you are also taking dexamethasone (Decadron®), St. John's wort, medicine to treat tuberculosis (eg, rifampin, rifapentine, Priftin®, Rifadin®, or Rimactane®), seizure medicine (eg, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, Dilantin®, Tegretol®, or Trileptal®), or certain stomach medicines (eg, esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, Aciphex®, Nexium®, Prevacid®, Prilosec®, or Protonix®).This medicine may cause serious types of allergic reactions, including anaphylaxis and drug reaction with eosinophilia and systemic symptoms (DRESS syndrome)(Take with food. Should not be used in people with CD4 less than 200 or HIV viral load greater than 100,000
Rilpivirine for intramuscular injection (combined with cabotegravir as Cabenuva)	Injection Site Reactions (Pain, Swelling)	**Dental: interactions unlikely**. General: Concomitant administration of SUNLENCA is contraindicated with strong CYP3A inducers. Do not use CABENUVA in patients receiving carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifabutin, rifampin, rifapentine, systemic dexamethasone (>1 dose), and St John’s wort. Because CABENUVA is a complete regimen, coadministration with other antiretroviral medications for the treatment of HIV-1 infection is not recommended(Should not be used in people with CD4 less than 200 or HIV viral load greater than 100,000

Protease Inhibitors (PIs)	**Common Side Effects**	**Contraindications/Considerations**
PIs block HIV protease, an enzyme HIV needs to make copies of itself.		
Atazanavir (Reyataz; also included in Evotaz)	Nausea, Vomiting, Diarrhea, Jaundice, Gall Bladder And Kidney Stones, Liver Damage, Skin Rash, Increase In Cholesterol, Changes In Heart Rhythm	**Dental: co-administration with azoles could increase ATV and also increase itraconazole and ketoconazole. Efficacy of codiene could be reduced. Serum levels of alprazolam, diazapam midzolam could be increased**. General: Some medicines can cause unwanted or dangerous effects when used with atazanavir: alfuzosin;cisapride;irinotecan;rifampin;sildenafil (Revatio, for treating pulmonary arterial hypertension);St. John's wort;antipsychotic medicine--lurasidone, pimozide;antiviral medicine--elbasvir/grazoprevir, glecaprevir/pibrentasvir, indinavir, nevirapine;ergot medicines--dihydroergotamine, ergotamine, ergonovine, methylergonovine;heart rhythm medication--amiodarone, quinidine;medicine to lower cholesterol--lomitapide, lovastatin, simvastatin;sedative medicines--triazolam, oral midazolam. May increase opioid & benzodiazepine levels by inhibiting metabolism

Darunavir (Prezista; also included in Prezcobix, Symtuza)	Nausea, Vomiting, Diarrhea, Skin Rash, Increase In Bad Cholesterol, Liver Damage	**Dental: Symtuza might increase the risk of bleeding if taken with certain blood thinners.** General: Sulfa Allergy: Darunavir contains a sulfonamide moiety. The incidence and severity of rash were similar in subjects with or without a history of sulfonamide allergy. Patients with hemophilia may develop an increase in bleeding events. May increase opioid & benzodiazepine levels by inhibiting metabolism
Lopinavir/Ritonavir (Kaletra)	Nausea, Vomiting, Diarrhea, Skin Rash, Increase In Cholesterol, Liver Damage, Xerostomia	**Dental: may increase metabolism of warfarin and therby increase INR.** General: Do not use this medicine if you or your child are also using alfuzosin (Uroxatral®), apalutamide (Erleada®), cisapride (Propulsid®), colchicine (Colcrys®), dronedarone (Multaq®), elbasvir/grazoprevir (Zepatier®), ergot medicines (eg, dihydroergotamine, ergotamine, methylergonovine, Cafergot®, Ergomar®, Methergine®, or Migranal®), lomitapide (Juxtapid®), lovastatin (Advicor®, Altoprev®, Mevacor®), lurasidone (Latuda®), oral midazolam (Versed®), pimozide (Orap®), ranolazine (Ranexa®), rifampin (Rifadin®), sildenafil (Revatio®), simvastatin (Simcor®, Vytorin®, Zocor®), or triazolam (Halcion®). Pancreatitis may occur while you are using this medicine. This medicine may increase blood sugar levels. This medicine may cause heart rhythm problems, including PR or QT prolongation. This medicine may increase the amount of cholesterol and fats in your blood. This medicine may cause you to have excess body fat. May increase opioid & benzodiazepine levels by inhibiting metabolism
Ritonavir (Norvir; also included in low doses to “boost” other PI drugs)	Nausea, Vomiting, Taste Changes, Xerostomia	**Dental: contraindicated with sedative hypnotics (alpazolam, diazapam, midazolam), meperidine, propoxyphene.Increases plama levels of clarithromycin and fluconazle. Changes levels of NSAIDS, antihistamines and antifungals.** General: Do not use this medicine if you or your child are also using alfuzosin (Uroxatral®), apalutamide (Erleada®), cisapride (Propulsid®), colchicine (Colcrys®), dronedarone (Multaq®), elbasvir/grazoprevir (Zepatier®), ergot medicines (eg, dihydroergotamine, ergotamine, methylergonovine, Cafergot®, Ergomar®, Methergine®, or Migranal®), lomitapide (Juxtapid®), lovastatin (Advicor®, Altoprev®, Mevacor®), lurasidone (Latuda®), oral midazolam (Versed®), pimozide (Orap®), ranolazine (Ranexa®), rifampin (Rifadin®), sildenafil (Revatio®), simvastatin (Simcor®, Vytorin®, Zocor®), or triazolam (Halcion®). Pancreatitis may occur while you are using this medicine. This medicine may increase blood sugar levels. This medicine may cause heart rhythm problems, including PR or QT prolongation. This medicine may increase the amount of cholesterol and fats in your blood. This medicine may cause you to have excess body fat. (Take with food. Generally doesn't cause these symptoms when used in low doses to “boost” other PI drugs. May increase opioid & benzodiazepine levels by inhibiting metabolism

Fusion Inhibitor (FI)	Common Side Effects	Contraindications/Considerations
Fusion inhibitors block HIV from entering the CD4 T lymphocytes (CD4 cells) of the immune system.		
Enfuvirtide (Fuzeon)	Local Injection Site Reactions, Diarrhea, Nausea, And Fatigue. An Increased Rate Of Bacterial Pneumonia Was Observed In Subjects Treated With Fuzeon In Clinical Trials." (Redness, Itching, Swelling, Pain, Or Hard Lumps At Injection Site)	**Dental: interactions unlikely.** Hypersensitivity to FUZEON or any of its components (Given by injection)

Entry Inhibitor	Common Side Effects	Contraindications/Considerations
CCR5 antagonists block CCR5 coreceptors on the surface of certain immune cells that HIV needs to enter the cells.		
Maraviroc (Selzentry)	Skin Rash, Hypersensitivity Reaction, Liver Damage	**Dental: concurrent azole antifungals (itraconazole and ketoconazole) and erythromycin may increase MVC serum concentrations.** General: Not recommended in patients with dual/mixed- or CXCR4-tropic HIV-1. Only indicated for patients with CCR5-tropic HIV-1 infection. St John's Wort will decrease the level or effect of maraviroc by affecting hepatic/intestinal enzyme CYP3A4 metabolism.

Integrase Inhibitors	Common Side Effects	Contraindications/Considerations
Bictegravir (included in Biktarvy)	Skin Rash, Weight Gain	**Dental: interactions unlikely.** General: If you've ever had hepatitis B, it may become active or get worse after you stop using this medicine. Biktarvy is not recommended in patients with severe renal impairment or patients with end-stage renal disease who are not receiving chronic hemodialysis, or patients with no antiretroviral treatment history and end-stage renal disease (ESRD) who are receiving chronic hemodialysis. Do not take Biktarvy if you also take a medicine that contains Dofetilide or Rifampin.
Cabotegravir (Vocabria)	Fever, Fatigue, Blisters, Muscle Or Joint Ache; Swelling In Eyes, Mouth, And Face	**Dental: interactions unlikely.** General: You should not use this medicine together with a seizure medicine (eg, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, Dilantin®, Tegretol®, Trileptal®) or medicine to treat tuberculosis (eg, rifampin, rifapentine, Priftin®, Rifadin®, Rimactane®). Using these medicines together may make cabotegravir (the active ingredient contained in Vocabria) less effective.(People with a history of hepatitis B or C virus or people who have certain liver function test changes may be more likely to develop new or worsening changes.)

Cabotegravir and Rilpivirine (Cabenuva)	Injection Site Reactions, Fever, Fatigue, Headache, Musculoskeletal Pain, Nausea, Sleep Disorders, Dizziness, Rash	**Dental: interactions unlikely.** General: Concomitant administration of SUNLENCA is contraindicated with strong CYP3A inducers. Do not use CABENUVA in patients receiving carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifabutin, rifampin, rifapentine, systemic dexamethasone (>1 dose), and St John's wort. Because CABENUVA is a complete regimen, coadministration with other antiretroviral medications for the treatment of HIV-1 infection is not recommended(Should not be used in people with CD4 less than 200 or HIV viral load greater than 100,000
Dolutegravir (Tivicay; also included in Dovato, Juluca, Triumeq)	Insomnia, Depression, Skin Rash, Suicidal Ideation, Weight Gain	**Dental: interactions unlikely**. Using this medicine while you are pregnant can harm your unborn baby. You should not use this medicine together with dofetilide (Tikosyn®). Using these medicines together may cause serious or life-threatening side effects.
Elvitegravir (Vitekta; also included in Genvoya, Stribild)	Insomnia, nausea, diarrhea, depression, skin rash, suicidal ideation, increase in cholesterol, weight gain	**Dental: Genvoya can interact with sedatives used in dental procedures, particularly those containing diazepam**. This medicine should not be used together with alfuzosin (Uroxatral®), carbamazepine (Tegretol®), lamivudine (Combivir®, Epivir®, Epivir-HBV®, Epzicom®, Triumeq®, Trizivir®), lomitapide (Juxtapid®), lovastatin (Mevacor®), lurasidone (Latuda®), midazolam (Versed®), phenobarbital (Luminal®), phenytoin (Dilantin®), pimozide (Orap®), rifampin (Rifadin®, Rimactane®), sildenafil (Revatio®), simvastatin (Zocor®), triazolam (Halcion®), St John's wort, or ergotamine medicines (eg, dihydroergotamine, ergotamine, methylergonovine, Cafergot®, Ergomar®, Wigraine®).
Raltegravir (Isentress)	The most common side effects of moderate to severe intensity were insomnia, headache, nausea, dizziness, and fatigue. The most commonly reported side effects of all intensities and regardless of causality included diarrhea, nausea, headache, nasopharyngitis, fatigue, upper respiratory tract infection, pyrexia, abdominal pain, and vomiting. (Insomnia, depression, skin rash, hypersensitivity reaction, suicidal ideation, weight gain)	**Dental: interactions unlikely**. General: Serious skin and allergic reactions (eg, Stevens-Johnson Syndrome, toxic epidermal necrosis) can occur with this medicine.

gp120 Attachment Inhibitor	Common Side Effects	Contraindications/Considerations
Attachment inhibitors bind to the gp120 protein on the outer surface of HIV, preventing HIV from entering CD4 cells		
Fostemsavir (Rukobia)	Nausea, concerns of QT prolongations and elevated liver enzymes in patients with co-existing hepatitis are also known.(nausea, diarrhea, stomach pain, headache, skin rash, fatigue)	**Dental: Changes in taste have been reported as a less common side effect of Rukobia**. General: Do not take RUKOBIA if you take certain medicines, including enzalutamide, carbamazepine, phenytoin, rifampin, mitotane, St. John's wort (Hypericum perforatum).RUKOBIA may cause a heart rhythm problem called QTc prolongation. QTc prolongation causes an irregular heartbeat. (Has not been tested in children)

Post attachment inhibitor	Common Side Effects	Contraindications/Considerations
Post-attachment inhibitors block CD4 receptors on the surface of certain immune cells that HIV needs to enter the cells.		
Ibalizumab (Trogarzo)	Diarrhea, skin rash, kidney damage	**Dental: interactions unlikely.** General: Using this medicine could harm unborn baby while you are pregnant.(Given by intravenous infusion

Capsid inhibitor	Common Side Effects	Contraindications/Considerations
Capsid inhibitors interfere with the HIV capsid, a protein shell that protects HIV's genetic material and enzymes needed for replication.		
Lenacapavir (Sunlenca)	Injection site reactions (pain, swelling)	**Dental: interactions unlikely**. General: Concomitant administration of SUNLENCA is contraindicated with strong CYP3A inducers(First given as pills as well as injection

Combination Meds	Common Side Effects	Contraindications/Considerations
Combination HIV medicines contain two or more HIV medicines from one or more drug classes.		
CABENUVA 2021 cabotegravir and rilpivirine(cabotegravir / rilpivirine, CAB / RPV, CAB plus RPV, Cabenuva kit, cabotegravir extended-release injectable suspension and rilpivirine extended-release injectable suspension)	Injection Site Reactions, Fever, Tiredness, Headache, Muscle Or Bone Pain, Nausea, Sleep Problems, Dizziness, Rash	**Dental: interactions unlikely**
DOVATO 2019 dolutegravir and lamivudine(dolutegravir sodium / lamivudine, DTG / 3TC)	Headache, Nausea, Diarrhea	**Dental: interactions unlikely**
BIKTARVY 2018 bictegravir, emtricitabine, and tenofovir alafenamide (bictegravir sodium / emtricitabine / tenofovir AF, BIC / FTC / TAF)	Diarrhea, Headache, Nausea, Dizziness, Insomnia.	**Dental: interactions unlikely**
DELSTRIGO 2018 doravirine, lamivudine, and tenofovir disoproxil fumarate(doravirine / lamivudine / tenofovir DF, DOR / 3TC / TDF)	Trouble Sleeping. Headache, Nausea, Diarrhea, Abnormal Dreams, Fatigue, Fever	**Dental: interactions unlikely**

SYMTUZA 2018 darunavir, cobicistat, emtricitabine, and tenofovir alafenamide (darunavir ethanolate / cobicistat / emtricitabine / tenofovir AF, DRV / COBI / FTC / TAF)	Diarrhea, Nausea, Stomach Pain, Gas, And Indigestion, Rash, Fatigue, Headache, Muscle Aches	**Dental:** mouth sores or ulcers
CIMDUO 2018 lamivudine and tenofovir disoproxil fumarate(lamivudine / tenofovir DF, 3TC / TDF)	Headache, Pain, Diarrhea, Rash, Depression, Changes In Body Fat Distribution	**Dental:** decreased bone density
JULUCA 2017 dolutegravir and rilpivirine(dolutegravir sodium / rilpivirine hydrochloride, DTG / RPV)	Headache, Nausea, Diarrhea	**Dental:** oral sores or lesions
ODEFSKY 2016 emtricitabine, rilpivirine, and tenofovir alafenamide (emtricitabine / rilpivirine hydrochloride / tenofovir AF, FTC / RPV / TAF)	Headache, Sleep Disturbances, Fatigue, Diarrhea, Nausea, Insomnia.	**Dental:** mouth sores, dry mouth, and changes in taste
DESCOVY 2016 emtricitabine and tenofovir alafenamide(emtricitabine / tenofovir AF, FTC / TAF)	Headaches, Nausea, Diarrhea, Sleep Issues, Weight Loss, Rash, Stomach Pain.	**Dental:** dry mouth and taste changes
EVOTAZ 2015 atazanavir and cobicistat(atazanavir sulfate / cobicistat, ATV / COBI)	Yellowing Of The Skin Or Eyes (Jaundice), Rash, Nausea, Headaches, Dizziness, Insomnia, Abnormal Dreams, Stomach Pain, Diarrhea, Fatigue, Loss Of Appetite, Increased Appetite, Indigestion, Bloating, Flatulence, And Increased Levels Of Bilirubin In The Blood.	**Dental:** mouth sores as part of a severe skin reaction
PREZCOBIX 2015 darunavir and cobicistat(darunavir ethanolate / cobicistat, DRV / COBI)	Nausea, Rash, Headache, Stomach Area (Abdominal) Pain, Vomiting, Diarrhea, Changes In Body Fat Distribution	**Dental:** mouth sores or ulcers
GENOYA 2015 elvitegravir, cobicistat, emtricitabine, and tenofovir alafenamide(elvitegravir / cobicistat / emtricitabine / tenofovir AF, EVG / COBI / FTC / TAF)	Nausea, Diarrhea, And Fatigue	**Dental:** failure of an implant to properly integrate with the jawbone (osseointegration) or becoming loose or lost over time, loose teeth, gum discoloration or recession
TRIUMEQ 2014, TRIUMEQPD 2022 abacavir, dolutegravir, and lamivudine (abacavir sulfate / dolutegravir sodium / lamivudine, ABC / DTG / 3TC)	Nausea, Diarrhea, Stomach Pain, Vomiting, Headache, Dizziness, Fatigue, Trouble Sleeping, Abnormal Dreams, Depression, Anxiety. Rash, Fever, Cough, Sore Throat	**Dental:** Mouth ulcers or sores can occur as a symptom of a hypersensitivity reaction to abacavir
STRIBILD 2012 elvitegravir, cobicistat, emtricitabine, and tenofovir disoproxil fumarate(elvitegravir / cobicistat / emtricitabine / tenofovir DF, EVG / COBI / FTC / TDF)	Fatigue (Tiredness), Headache, Abnormal Dreams	**Dental:** one loss decrease in bone mineral density (osteopenia) or more severe bone loss (osteoporosis)

COMPLERA 2011 emtricitabine, rilpivirine, and tenofovir disoproxil fumarate(emtricitabine / rilpivirine hydrochloride / tenofovir DF, FTC / RPV /	Headache, Nausea, Sleep Problems (Insomnia), Anormal Dreams	**Dental:** mouth sores, dry mouth, and changes in taste
SYMFI 2008 efavirenz, lamivudine, and tenofovir disoproxil fumarate(efavirenz / lamivudine / tenofovir DF, EFV / 3TC / TDF)	Rash, Dizziness, Trouble Sleeping, Headache, Nausea, Diarrhea, Fatigue, Cough, Depression	**Dental:** mouth sores and ulcers, bone Loss
ATRIPLA 2006 efavirenz, emtricitabine, and tenofovir disoproxil fumarate(efavirenz / emtricitabine / tenofovir DF, EFV / FTC / TDF)	Dizziness, Trouble Sleeping (Insomnia), Drowsiness, Unusual Dreams, Difficulty Concentrating, Depressed Mood, Diarrhea, Nausea, Vomiting, Stomach Pain, Rash (Often Appears As Maculopapular Skin Eruptions, Typically Mild-To-Moderate And Often Resolving Within A Month).	**Dental:** bone loss, decreased bone mineral density
TRUVADA 2004 emtricitabine and tenofovir disoproxil fumarate(emtricitabine / tenofovir DF, FTC / TDF)	Nausea, Vomiting, Diarrhea, Headache, And Dizziness.	**Dental:** decreased bone density
KALETRA 2000 lopinavir and ritonavir(ritonavir-boosted lopinavir, LPV / r, LPV / RTV)-	Diarrhea, Nausea, Vomiting, High Cholesterol Or Triglycerides	**Dental:** bad taste in the mouth
EPZICOM/004-discontinued abacavir and lamivudine (Epicom) (abacavir sulfate / lamivudine, ABC / 3TC)	Trouble Sleeping, Headache, Feeling Tired, Liver Damage, Lactic Acidosis	**Dental:** mouth sores and potentially contribute to tooth wear
TRIXIVIR-discontinued abacavir, lamivudine, and zidovudine(abacavir sulfate / lamivudine / zidovudine, ABC / 3TC / ZDV)	Nausea, Vomiting, And Diarrhea; Neurological Effects Such As Headache And Tiredness; Joint Pain; And Changes In Body Fat Distribution.	**Dental:** oral ulcerations and lesions, bleeding gums can be a sign of clotting problems
COMBIVIR-discontinued lamivudine and zidovudine(lamivudine / zidovudine, 3TC / ZDV)	Chills Feverpale Skin Sore Throat Unusual Tiredness Or Weakness	**Dental:** bleeding gums, oral mucosal pigmentation changes



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HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

The Customer Support Line can assist you with accessing HIV or STD services and addressing concerns about the quality of services you have received.

Will I be denied services for reporting a problem?

No. You will not be denied services. Your name and personal information can be kept confidential.

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

On the web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles Public Health
Division of HIV and STD Programs





Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

La Línea de Atención al Cliente puede ayudarlo a acceder a los servicios de VIH o ETS y abordar las inquietudes sobre la calidad de los servicios que ha recibido.

¿Se me negarán los servicios por informar de un problema?

No. No se le negarán los servicios. Su nombre e información personal pueden mantenerse confidenciales.

¿Puedo llamar de forma anónima?

Si.

¿Puedo ponerme en contacto con usted a través de otras formas?

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

En el sitio web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

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Public Health
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