

Centers of Excellence Best Practices Guide

APRIL 2005

I. Introduction

This best practices guide for developing Centers of Excellence (CoE) is designed to define the optimal levels of administration and service integration necessary for CoEs to deliver services within an integrated services model. While the purpose of existing Standards of Care is to establish minimum expectations for service delivery for Title I programs, this best practices guide for developing CoEs outlines the structural elements and integration mechanism necessary to implementing a service delivery system that is provided either by a single agency or by a multi-agency collaborative.

Federal Guidelines for Title I-Funded HIV Health Services

The Ryan White CARE Act, Title I, provides emergency assistance to Eligible Metropolitan Areas (EMA) most severely affected by the HIV/AIDS epidemic. As it applies to the San Francisco EMA, the CARE Act stipulates that Title I funds should be used to provide access to integrated health services for persons living with HIV/AIDS (PLWHA) who:

- Reside within the San Francisco EMA; **and**
- Have no third party payment source (uninsured);
- Have limited third party coverage (underinsured); **or**
- Have been denied coverage by a third party payer (uninsured or underinsured).

In addition, enrollment priorities are as follows:

- First priority: Residents of the San Francisco EMA who have low or no income and are uninsured
- Second priority: Residents of the San Francisco EMA who have low or no income and are underinsured

Finally, CARE funds will be used only for services that are not reimbursed by any other source of revenue.

II. Overview

The Centers of Excellence (CoE) Standards of Care are designed to ensure consistency among programs and programs that incorporate an integrated service model that are funded as part of the San Francisco EMA continuum of care plan for PLWHA. These standards are not intended to promote a formula approach to the support and assistance of PLWHA. Rather, these optimal acceptable standards of service delivery are established to provide guidance to integrated services programs so that they are best equipped to:

- Provide a comprehensive integrated approach to care for PLWHA that have severe need or are part of special populations.
- Provide client-centered services that respect the client's rights, values, and preferences.
- Coordinate any and all types of services and assistance to meet the client's identified needs.
- Meet the specific and varied needs of HIV-positive clients using a multidisciplinary team approach and conduct HIV risk reduction specifically for HIV-positive individuals (prevention for positives).
- Provide continuity of care for PLWHA, within an integrated system of services, throughout the course of their disease.
- Appropriately address issues of consent, confidentiality, and other client rights, for clients enrolled in services.
- Meet agreed-upon, measurable, client-centered health outcomes
- Minimize barriers to services.

For multi-agency collaborative networks, the CoE must also address the following in its program design and CoE agreement:

- Common mission and objectives that outline the collaboration's systems for effectively working and operating together
- Core values and shared philosophies that includes client-centered services

III. Description of Service

Centers of Excellence (CoE) deliver services through an integrated service model and are designed to meet the needs of PLWHA who have severe need or are part of a special population by bringing together a range of services around primary health care. Services can be provided by a single organization or by a multi-agency collaborative network. The goals of CoEs include:

- Improve health outcomes and quality of life for PLWHA that have severe needs or are from special populations.
- Provide seamless access to primary care and critical support services.
- Link to and maintain in health care PLWHA not currently in care.

Centers of Excellence encompass the following activities or services as part of a multidisciplinary care team:

- Providing primary health care to PLWHA and increasing access to primary health care for individuals not in care
- Assisting clients maintain the care and support they need
- Providing seamless access to critical support services such as case management, treatment adherence support, peer advocacy, substance use services, and mental health services

Centers of Excellence provide services to persons living with HIV/AIDS who have severe need or are part of a special population. To be in the “severe need” category, an individual must meet all of the following criteria:

- Disabled by HIV/AIDS or have a symptomatic HIV diagnosis
- Active substance abuse or mental illness
- Poverty, defined as an annual federal adjusted gross income equal to or less than 150%¹ of the federal poverty level, which for 2004 is \$13,965 for one person, or \$18,735 for two people.

“Special populations” are defined as those populations that have unique or disproportionate barriers to care, needing additional or unique services, or requiring a special level of expertise to maintain them in care. Special populations in the San Francisco EMA currently include:

- Transgender individuals
- Populations with the lowest rates of use of Highly Active Antiretroviral Therapy (HAART) including African Americans and residents of the Bayview/Hunter’s Point neighborhood in San Francisco
- Communities with linguistic or cultural barriers including undocumented individuals and monolingual Spanish speakers

¹ This is the 2004 formula and may be adjusted in subsequent years.

- Persons recently released from incarceration or individuals who have a recent criminal justice history

In July 2004, the HIV Health Services Planning Council developed the following definition of an Integrated Services Model (Centers of Excellence):

Integrated Services Model (Centers of Excellence) Definition

An integrated services model (ISM) of health and social service delivery is one where all ISM services are provided and coordinated by a multidisciplinary team. ISM services are delivered to clients in the vicinity of their primary care and can be provided by a single organization or a multi-agency collaborative network. An ISM ensures that populations with severe needs have direct access to a comprehensive spectrum of care that is delivered seamlessly, in a culturally competent manner, in accordance with the relevant San Francisco EMA Standards of Care for Client-Centered Services.

IV. Unit of Service

A Unit of Services (UOS) within a CoE collaborative may be different for each provider depending on the type of service provided. Refer to the appropriate Standards of Care for Client-Centered Services to determine UOS for a specific service.

Because of the extraordinary amount of staff time needed for multi-disciplinary and multi-agency communications and collaboration, a UOS has been developed for these coordination activities. A CoE Coordination, Planning, and Evaluation UOS is defined as the time spent by the Program Coordinator in program coordination, planning, and evaluation activities, and, for activities specifically related to the collaboration such as: face-to-face meeting time between two or more staff from different collaborating agencies for the purpose of program or fiscal coordination, planning, and/or evaluation.

For the Program Coordinator, typical coordination, planning, and evaluation activities counted as UOS include:

- Coordination of services (e.g., regular management or all-staff meetings, development of common policies and procedures, conflict resolution, etc.)
- Program planning (e.g., planning retreats)
- Program evaluation (e.g., development of CoE wide objectives, work group time in developing instruments to measure success in meeting objectives, development of joint client satisfaction survey instrument, quality assurance conducted by two or more agencies, etc.)

V. Standards of Care

A. Administration

Administrative standards ensure that each agency that is part of the CoE collaboration has a clear understanding of the scope of its responsibilities, as well the CoE's overall goal and mission. In addition, administrative standards ensure that all staff providing services within integrated services programs are properly trained and credentialed, have an understanding of the scope of their job responsibilities, and that all programs funded are adequately staffed. As part of their administrative hiring procedures, programs are encouraged to recruit and hire individuals who reflect the diversity of the patient target population.

Standard 1: Agreement for multi-agency collaboratives.

Agencies that are funded as multi-agency collaboratives will be required to develop a multi-agency agreement in order to formalize the working relationship between the collaborative agencies. The multi-agency agreement should be negotiated and signed by the executive directors of each collaborative agency. The following is not an exhaustive list. The Agreement should contain the following elements:

General Information

- Goal statement of the agreement
- Effective dates of agreement and means for changing or discontinuing agreement
- Statements acknowledging familiarity and agreement to comply with the terms of the prime contract
- Name, title, and signature of each organization's representative

Program Design

- Common mission and objectives that outline the collaboration's systems for effectively working and operating together
- Core values and shared philosophies that include client-centered services
- Agreed-upon measurable, client-centered health outcomes

Staffing

- Defined agreement regarding the hiring and roles and responsibilities of the Program Coordinator
- Defined procedure for ensuring that collaborative organizations have input into the hiring of and evaluation of staff providing services to the extent this input is compatible with labor agreements

- Process for ensuring that key staff positions within the collaborative are filled in a timely manner
- Supervision and quality assurance procedures and responsibilities

Service Delivery

- Specific services offered including location and schedule, and scope of work to be provided by each organization
- Compliance with HIPAA requirements for sharing information

Inter-agency/Inter-program Communication and Coordination

- Procedure for UOS, UDC and cost reporting
- Procedure for dispute resolution
- Reporting requirements and timelines that clearly define staff positions responsible for reporting and submitting data and timely entry of client data in the designated shared client data/registration system for San Francisco²
- Process for maintenance of client or service records
- Regular communication between collaborators and schedule of client case conferences

Measure: Completed and signed Agreements on file for each provider agency.

Standard 2: Experience/education.

Centers of Excellence provide services through a team of multidisciplinary providers (e.g., primary care providers, case manager, peer advocates, etc). Therefore, standards for experience and education for providers within the collaboration differ depending on their role and responsibilities. Standards of Care already exist for most of the service categories that CoE are required to deliver. These standards provide detailed experience and education requirements and should be referred to within each Standards of Care for Client-Centered Services.

In addition to the standards for experience and education outlined in the Standards of Care for Primary Care, the following standard is specific to medical providers working within a CoE:

- Each medical provider (MD, PA, NP) must have served a minimum of 20 HIV+ patients within the past two years. Interns must be supervised by a medical provider that meets this standard.

The following are general standards that may apply to all providers within a CoE collaboration:

² The shared client data/registration system is maintained by the San Francisco Department of Public Health HIV Health Services and is currently referred to as REGGIE.

- Strong interpersonal skills and cultural competence
- Strong knowledge of the health and social service system, especially HIV service system and providers in the EMA
- Strong communication, reading, and writing skills
- Skill and comfort working with PLWHA with severe need or who are part of a special population

Measure: **Completed paperwork, staff resumes, and credentials on file for all staff.**

Standard 3: Staffing levels.

- Each agency within a CoE collaboration will ensure that appropriate staffing levels are reached and maintained to provide contracted services.
- Each CoE will maintain one Program Coordinator position.
- The lead agency of a CoE collaboration will develop a hiring and evaluation process for the Program Coordinator that includes input from its collaborative partners.
- Positions should be filled within 10 weeks. If agency hiring freezes prevent the filling of vacant positions, coverage must be provided to ensure continuity of care by the responsible party. This action may require the redirection of contract funds.

Measure: **Full and part-time positions funded under contract are filled; OR appropriate actions are taken to fill positions.**

Standard 4: Program Coordinator.

A Program Coordinator must be funded as part of each CoE, responsible for the logistics of service coordination such as organizing case conferences, ensuring entry of client data into the shared client data/registration system, overseeing the Quality Assurance efforts of the CoE as a whole, and other responsibilities as determined by the CoE. This position should also:

- Serve as a lead administrative liaison with the San Francisco Department of Public Health, HIV Health Services (HHS);
- Monitor compliance of parties to the CoE Agreement;
- Identify and address problems and issues affecting the operation of the CoE;
- Facilitate communication among collaborating agencies; and
- Insure that agreements are kept current and signed between agencies.

Measure: Written job description on file signed by the staff/staff supervisor.

Standard 5: Lead agency.

Each CoE will have a lead agency whose responsibility will include the following activities, some of which may be assigned to the Program Coordinator:

- Development of contractual agreement with the San Francisco Department of Public Health, HIV Health Services (HHS);
- Employing the Program Coordinator (see Standard #3);
- Establishing a CoE Agreement (see Standard #1);
- Establishing sub-contracts with all providers (excluding SFDPH for fiscal contracting);
- Monitoring the CoE Agreement and sub-contracts;
- Ensuring prompt and adequate reporting (including any SFDPH section that is collaborating in the CoE) and invoicing to HHS;
- Ensuring timely and accurate client data entry into the shared client data registration system;
- Ensuring administrative coordination among collaborators, including the facilitation of CoE administrative meetings at least once a month;
- Ensuring logistical and program coordination at the CoE, including assurance that out-stationed staff are utilized and scheduled effectively;
- Organizing trainings for all staff working at the CoE;
- Ensuring quality improvements for the CoE as a whole;
- Conducting an annual provider satisfaction survey;
- Identifying and addressing problems and issues affecting the operation of the CoE; and
- Acting as the primary CoE liaison with HHS.

Measure: Completed paperwork and documentation on file including meeting minutes, program coordinator job description, and satisfaction surveys. Compliance with reporting requirements. Completed subcontracts on file.

Standard 6: Job descriptions.

Staff members will have a clear understanding of their job definition and responsibilities.

Measure: Written job descriptions on file signed by the staff/staff supervisor.

Standard 7: Policies and procedures.

Each funded agency within a CoE collaboration will have written policies and procedures manuals for personnel and for programs. The program policies and procedures manual for each agency within a COE should be a document separate from the agency personnel manual. Personnel and program policies and procedures manuals should include:

Personnel Policies and Procedures

- Annual performance reviews
- Staff training and other personnel policies (e.g., behavioral standards)

Program Policies and Procedures

- Client rights and responsibilities, including confidentiality guidelines (with particular discussion of confidentiality issues for PLWHA)
- Client grievance policies and procedures
- Client eligibility and admission requirements
- Nondiscrimination policies for clients
- Prevention with positives procedures and guidelines
- Treatment adherence procedures and guidelines
- Referral resources and procedures that ensure access to continuum of services
- All appropriate consent forms (e.g., consent to share information, treatment consent, designated shared client data/registration system consent form, HIPAA requirements)
- Data collection procedures and forms, including data reporting
- Compliance with designated shared client data/registration system requirements³
- Quality assurance/quality improvement
- Guidelines for language accessibility
- Plans for accommodating people with disabilities in addition to HIV (plans should adhere to Americans with Disabilities Act (ADA) standards to the extent possible)

In addition to the policies and procedures for individual agencies as part of a multi-site CoE, the CoE shall develop a CoE-wide shared policies and procedures manual that includes general items listed above as well as the following:

- Overview of the integrated services model including orientation information and service delivery schedule
- Role and responsibilities of the Program Coordinator
- Procedure for conflict resolution

³Applicable in San Francisco County; may not be required throughout SFEMA service areas.

- Policies and procedures for applicable service delivery standards contained in this document and CoE agreement
- Procedure for referrals between different CoEs and referrals among providers and programs within one CoE
- Procedure for referrals to other agencies and programs in the community

Measure: **Written policies and procedures manual.**

Standard 8: Staff training.

Every effort should be made for required trainings to be completed within the first year of employment. In addition, regardless of credentials, all direct service staff members must receive ongoing HIV/AIDS training as appropriate for job function. Providers in CoE should have the following training as well as additional training set forth in the Standards of Care for Client-Centered Services related to their job function:

- Orientation to the integrated services model
- For multi-agency collaboratives, basic orientation to the home agency and all agencies involved
- Harm reduction training as required by San Francisco DPH of all staff providing direct services
- Prevention with Positives interventions including assessment, counseling, referrals, and related legal issues
- In-service training on population-specific issues regarding transgender individuals, homeless individuals, individuals with disabilities, substance users, individuals with mental health disorders, and individuals recently released from incarceration
- In-service trainings on cultural competency, infection control, and legal issues related to health access
- Training on the use of designated shared client data/registration system

All clinic staff are required to maintain current licensure appropriate to job function.

Measure: **Documentation of all completed training on file.**

B. Facility Standards

Facility standards are intended to ensure program safety and accessibility for both clients and staff.

Standard 9: Standard safety requirements.

Each program administered by a CoE (whether it is a single agency or a collaboration between several agencies) is located in a physical facility that:

- Meets fire safety requirements
- Meets criteria for (ADA) compliance
- Is clean and comfortable
- Complies with Occupational Safety and Health Administration (OSHA) infection control practices
- Has emergency protocols for health- and safety-related incidents posted
- Is free from anticipated hazards

Measure: Compliance with all appropriate regulatory agencies, including ADA compliance plan; written policy describing plan for accommodating individuals with disabilities.

C. Service Delivery

These standards include both service delivery standards and standards related to the structure of the CoE. Services within Centers of Excellence are delivered to clients through a multidisciplinary team and can be provided by a single organization or a multi-agency collaborative. Standards related to service delivery for CoE define the optimum set of activities to be performed and under what parameters.

Standard 10: Required comprehensive services.

Centers of Excellence, whether a single organization or a multi-agency collaborative, bring together a range of services around primary health care, with the goal of stabilizing clients and assisting them to access and remain in care. CoE shall provide, at a minimum, the core services determined by the funder. The ISM Advisory Group recommends that the following core services are provided:

Services should follow established Standards of Care for Client-Centered Services to ensure the highest quality services.

To ensure that services provided by a CoE are accessible to clients and delivered to clients in the vicinity of their primary care, providers of support services shall:

- To the extent possible, have a visible presence at the site where primary medical care is provided to clients; and
- Have regularly scheduled office hours at the location where primary care is delivered as part of the CoE

Measure: **Services provided by a CoE (either single organization or multi-agency) are documented in the DPH contract, the multi-agency collaborative Agreement, and the partner agency subcontracts.**

Standard 11: Coordination and integration.

Assuring seamless coordinated care for clients requires that providers:

- Build a multidisciplinary team made up of representatives that provide core CoE services.
- Work closely with all members of the team in order to more effectively communicate and address client service related needs, challenges and barriers.
- Conduct multidisciplinary team case conferences every two weeks for shared clients that involves other service providers and participation of the client as appropriate and necessary.
- Ensure the development of a common treatment plan for each individual client.
- Ensure that all staff involved with client participate in the development of individualized care plan.
- Make sure that services for clients are provided in cooperation and in collaboration with other agency services and other community service providers to avoid duplication of efforts and to encourage client access to integrated health care.
- Ensure an appropriate process for client documentation and chart maintenance that is accessible to all providers within the CoE collaboration.
- Develop a mechanism for tracking referrals and ensuring clients successfully follow-up on referrals.

Measure: Detailed documentation in client charts and in shared client data/registration system.

Standard 12: Client consent for services.

All appropriate consent forms (e.g., consent to share information, treatment consent for service) should be an integral part of the CoE communication plan for linking treatment plans, obtaining legal consents, and coordinating care among agencies and staff involved in client treatment. Providers should:

- Obtain patient's signature on the appropriate consent forms, including the shared client data/registration system consent form.

Client consent for services

- Inform the client of his or her rights and responsibilities as a participant in the program.
- Obtain the client's informed consent to participate in the program.

Client consent releases

- As releases become necessary, obtain client signatures on consent to release information forms in order to facilitate communication with other service

- providers that work with the same client.
- Through these releases, a client agrees to allow information to be shared among all of the providers he/she works with within the CoE.
- Once releases have been obtained, information sharing can occur.

Measure: Detailed documentation in client charts and in shared client data/registration system.

Standard 13: Coordination outside of the CoE for essential services.

Ensuring clients have access to the recommended essential services requires providers to:

- Develop and maintain linkages with providers from other agencies to ensure that clients have access to needed services not provided within the CoE (e.g., money management, benefits counseling, and complementary therapies).
- Identify appropriate contacts at each provider agency
- Determine referral process and primary staff contacts to effectively facilitate client linkage to services

Measure: Completed Agreement on file at lead agency. Documented referral list of providers.

Standard 14: Outreach and referrals.

- Maintain appropriate referral relationships with key points of access within and outside of the HIV care system to ensure referral into care of newly diagnosed and PLWHA who are not in care. Key points of access include but are not limited to: emergency rooms, inpatient hospital settings, counseling and testing sites, substance use treatment programs, homeless shelters and SRO hotels.

Measure: Documented referral list of providers. Activities with individual providers are documented including but not limited to: list of presentations made, letters of cooperation, and in-service trainings provided to those agencies.

Standard 15: Harm reduction.

Harm reduction focuses on supporting clients in making positive changes in their lives to reduce harm caused by their substance use or sexual behaviors. The primary goal of harm reduction in the CoE is to incorporate individualized harm reduction approaches that reduce barriers for clients in realizing the goal(s) of their care/treatment plan. These strategies will include a continuum of options that support the reduction of risk behaviors related to clients' harmful substance use and sexual practices that create these barriers. This will require members of the

multidisciplinary team to engage in ongoing culturally appropriate discussions with their clients regarding their pattern of substance use and/or their current sexual practices and how it impacts their care plan in order to inform them of the array of harm reduction options. Providers should:

- Establish relationships with their clients that allow for ongoing open exploration and discussion of their clients' substance use and sexual practices.
- Non-judgmentally discuss the impact of their clients' substance use and sexual behaviors on their individualized care/treatment plan.
- Work with a client to develop an individualized harm reduction plan by providing options for their client on how to minimize harm by modifying sexual or substance using practices that will support goals within care/treatment plan.
- Establish a method to check in with the client regarding their progress and continual agreement with their plan and to continue to support their client in their behavior change(s).
- As appropriate, inform clients of prevention for positives risk reduction options.

Measure: Detailed documentation in client charts of implementation of harm reduction strategies and incorporation into the client's care/treatment plan. For SF contractors compliance with SF DPH harm reduction policy.

Standard 16: Client discharge from CoE services.

Two types of discharge exist for CoE services:

- 1) *Voluntary discharge from one or more services* –Voluntary discharge occurs when a particular service within the CoE or a specific CoE program model no longer serves the needs of the client.
- 2) *Involuntary discharge or termination from one or more services* – Involuntary discharge is appropriate to initiate when the client has exhibited threatening or dangerous behavior. Dangerous and threatening behavior must have clearly defined criteria. Involuntary discharge from one service within the CoE should not automatically result in discharge from the CoE.

The provider must ensure voluntary and involuntary discharge is not carried out in an abrupt or disruptive manner, but results from a planned and progressive process that takes into account the needs and desires of the client and his/her caregivers, family, and support network.

In case of danger, the client should be removed from the premises. The decision to discharge from service or care is not made at that moment. Agencies are encouraged to develop a policy for temporary discontinuation of services as a

consequence for inappropriate behavior. Before undertaking to discharge the provider should:

- Discuss discharge with the multi-disciplinary team in order to develop a plan for discharging the client.
- Discuss with the client and his/her caregivers (if appropriate) the decision to discharge the client from the service or program.
- Inform the client of other agencies that might better meet his/her needs for treatment and support and make arrangements to refer the client to another agency.
- Ensure client is fully informed of the grievance process.
- Document in the client's file reasons for the planned discharge.
- Set a reasonable timeline for discharge or transfer that allows sufficient time for the client or his/her caregivers to make other arrangements for care or treatment.
- Discuss and document process for reinstatement of services should that become necessary and appropriate in the future.

Measure: Documented discharge policy. Documented involuntary discharge policy and procedure that includes criteria for unacceptable behavior. Detailed documentation in client charts and in shared client data/registration system. Policy on short term discontinuation of services.

D. Cultural sensitivity and competency

Standard 17: Cultural sensitivity and competency.

- Agency/clinic must have a non-discrimination policy in place regarding hiring and client treatment that addresses issues of race/ethnicity, gender identity, sexual orientation, disability, and other relevant issues.
- Agency/clinic must show experience with the target population(s) or have a plan for developing staff sensitivity to the target population(s).
- Staff should be ethnically, culturally, and linguistically diverse or reflect the diversity of the population they serve.
- Services are provided using language and methods sensitive to the communities served.
- Services provide opportunities for clients to assist in identifying issues related to culture that may affect how they respond to services (e.g., primary language, spirituality needs, sexual orientation, community identification, family needs, immigration status, and customs).
- Service providers should have referral relationships that can address gaps in culturally competent services (e.g., if agency does not have Spanish-speaking staff, Spanish-speaking clients can be referred).
- Agency must have a cultural competency plan on file with the San Francisco Department of Public Health (for agencies in San Francisco).

Measure: Adherence to the San Francisco DPH cultural competency requirements for agencies and services in San Francisco; adherence to relevant local county/city cultural competency plan for agencies and services in San Mateo or Marin County.

E. Quality Assurance and Service Maintenance

The objectives of quality assurance and service maintenance are related to periodic evaluations of client treatment plans, service delivery, and client satisfaction with service provision, the results of which lead to service improvement.

Standard 18: Client satisfaction survey.

Providers will conduct client satisfaction surveys (or other client satisfaction activity) at least annually.

Measure: Develop an annual written summary and analysis of the program's client satisfaction activity.

Standard 19: Quality assurance.

The agency must have an active Continuous Quality Improvement (CQI) program to monitor care provided and identify means of improving care and services.

Measure: Written policies on CQI in place, including how data will be used to improve programs; one report per contract period on improvements made through CQI.

TABLE 1: Summary of Standards of Care Measures

Standard	Measure
1. Agreement for multi-agency collaboratives.	1. Completed and signed Agreements on file for each provider agency.
2. Experience/education.	2. Completed paperwork, staff resumes and credentials on file for all staff.
3. Staffing levels.	3. Full and part-time positions funded under contract are filled; OR appropriate actions being taken to fill positions.
4. Program Coordinator	4. Written job description on file signed by the staff/staff supervisor.
5. Lead agency.	5. Completed paperwork and documentation on file including meeting minutes, program coordinator job description, and satisfaction surveys. Compliance with reporting requirements. Completed subcontracts on file.
6. Job descriptions.	6. Written job description on file signed by the staff/staff supervisor.
7. Policies and procedures.	7. Written policies and procedures manual.
8. Staff training.	8. Documentation of all completed training on file.
9. Standard safety requirements.	9. Compliance with all appropriate regulatory agencies, including ADA compliance plan; written policy describing plan for accommodating individuals with disabilities.
10. Required comprehensive services.	10. Services provided by a CoE (either single organization or multi-agency) are documented in the DPH contract, the multi-agency collaborative Agreement, and the partner agency subcontracts.
11. Coordination and integration.	11. Detailed documentation in client charts and in shared client data/registration system.
12. Client consent for services.	12. Detailed documentation in client charts and in shared client data/registration system.

Standard	Measure
13. Coordination outside of the CoE for essential services.	13. Completed Agreement on file at lead agency. Documented referral list of providers.
14. Outreach and referrals.	14. Documented referral list of providers. Activities with individual providers are documented including but not limited to: list of presentations made, letters of cooperation, inservice trainings provided to those agencies.
15. Harm reduction.	15. Detailed documentation in client charts of implementation of harm reduction strategies and incorporation into the client's care/treatment plan. For SF contractors compliance with SF DPH harm reduction policy.
16. Client discharge from a CoE services.	16. Documented discharge policy. Documented involuntary discharge policy and procedure that includes criteria for unacceptable behavior. Detailed documentation in client charts and in shared client data/registration system.
17. Cultural sensitivity and competency.	17. Adherence to the San Francisco DPH cultural competency requirements for agencies and services in San Francisco; adherence to relevant local county/city cultural competency plan for agencies and services in San Mateo or Marin County.
18. Client satisfaction survey.	18. Develop an Annual written summary and analysis of the program's client satisfaction survey.
19. Quality assurance.	19. Written policies on CQI in place, including how data will be used to improve programs, one report per contract period on improvements made through CQI.