

Making the Connection:

Standards of Care for Client-Centered Services

Case Management Supplement

San Francisco EMA

Includes San Francisco City and County,
San Mateo County, and Marin County

February 2004

Prepared for

San Francisco Department of Public Health,
HIV Health Services, and the
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Dedication

The Case Management Supplement Standards of Care are dedicated to the clients of the HIV Health Services System, to case managers who devote themselves to providing services to others, and to individuals who are both client and case manager in the San Francisco EMA.

Acknowledgments

Sincere gratitude goes out to all who contributed to the process of developing the Case Management Supplement Standards of Care. Special thanks go to the Case Management Working Group members and to the consumer focus group participants, who contributed their knowledge and experience to make these standards practical and worthwhile.

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CASE MANAGEMENT SUPPLEMENT

Standards of Care

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I. Introduction

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.

In addition to these federal guidelines, the San Francisco EMA has developed standards of care for all Title I-funded HIV health services in the San Francisco EMA. These standards, outlined here, are designed to define the minimally acceptable levels of service delivery and provide suggested measures to determine whether service standards are being met.

In 1996, sponsored by the HIV Health Services Division of the San Francisco Department of Public Health and the HIV Health Services Planning Council, a San Francisco EMA Case Management Task Force developed a comprehensive case management manual entitled, "*Making the Connection: Standards of Practice for Client-Centered HIV Case Management*." This manual was designed to create consistency within the practice of case management throughout the San Francisco EMA. The core activities defined by the manual were used to develop the Case Management Supplement Standards of Care. "*Standards of Practice for Client-Centered HIV Case Management*" will continue to serve as a comprehensive guide to establishing and operating a case management program and will continue to be used as the training curriculum for case management

programs and case manager training. The manual will be updated simultaneous to the development of these standards. These standards will serve as a supplement to that document.¹

II. Overview

Case Management Supplement Standards of Care are designed to ensure consistency among the Title I case management services provided as part of the San Francisco EMA continuum of care plan for PLWHA. The development of these Standards was guided by the philosophy of client-centered care and that clients are full partners in their care management. These Standards encourage, and in many instances require, that the client be involved in all decisions affecting his or her choice of provider and the level or intensity of the services he or she receives. The case manager has interconnected roles as counselor and advocate for the client while assisting the client in navigating the service systems with the appropriate supports to help the client maintain his or her independence, and in achieving a comfortable, safe, and secure living situation. Participation in case management is voluntary and the client can decline to participate in any or all parts of the program at any time.

Case management is provided through a diversity of service delivery models, therefore these standards are not intended to promote a formula approach to the support and assistance of PLWHA. Rather, these minimally acceptable standards of service delivery are established to provide guidance to case management programs so that they are best equipped to:

- 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 as appropriate, conduct HIV risk reduction specifically for HIV-positive individuals (prevention for positives).
- Provide continuity of care for people with HIV, within a comprehensive system of services, throughout the course of their disease.
- Appropriately address issues of consent, confidentiality, and other client rights, for clients enrolled in services.

¹ "Making the Connection: Standards of Practice for Client-Centered HIV Case Management," San Francisco Department of Public Health SFEMA Case Management Task Force, HIV Health Services Planning Council, April 1996.

III. Description of Service

Case management for PLWHA is a service that links and coordinates assistance from multiple agencies and caregivers who provide psychosocial, medical, and practical support. The purpose of case management is to assist clients in obtaining the highest level of independence and quality of life consistent with their functional capacity and preferences for care.

Case management encompasses the following activities or services as part of a multidisciplinary care team:

- Conducting an initial interview and intake which includes determination of whether case management is an appropriate service for the client and collecting basic eligibility information
- Conducting a comprehensive assessment of client's psychosocial, medical/nursing, and practical support needs
- Developing and coordinating an individual Care Plan with the client based on the results of the assessment and input from the multidisciplinary team which outlines client's goals, objectives, and activities to meet the client's needs and preferences for services and support
- Implementing the Care Plan which involves the step-by-step accomplishment of the goals and objectives laid out in the plan by the client and the case manager
- Coordinating the services that the client receives from various service providers, ensuring that the client receives the most appropriate combination of services and avoids unnecessary and expensive duplication
- Following-up and monitoring the client's Care Plan involving members of the multidisciplinary team as appropriate
- Conducting a reassessment of client needs, as necessary to determine whether the Care Plan and services continue to be of high quality and are appropriate for the client's condition, and that care among care providers continues to be coordinated
- Advocating for the client as appropriate
- Transferring or discharging clients when appropriate

IV. Unit of Service

A Unit of Service (UOS) is one-hour contact between a client and a case manager or one-hour contact on behalf of the client.

V. Standards of Care

A. Administration

Administrative standards ensure all staff providing case management services 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: Experience/education.

- Masters degree in social work, counseling, nursing, or other appropriate field, including clinical training; OR a Bachelors degree plus appropriate experience in human services; OR a high school degree or GED plus three years experience in human services which may include work as an intern or volunteer
- 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 men who have sex with men (regardless of their sexual orientation), women, transgender, people of color, substance users, homeless and/or individuals with mental illness
- Strong analytical skills and knowledge base necessary for carrying out complex tasks (e.g., intake, preliminary assessment, and giving immediate referrals) involved in provision of effective case management services

Agencies may wish to hire a person who does not meet the above standards but who has a combination of skills and experience that in the judgment of the hiring committee prepares the individual for the tasks and responsibilities of case management work. In this situation, an individual training plan must be developed and implemented at the time of hiring.

While case management is provided through a diversity of service models, agencies must provide case managers with a level of clinical supervision appropriate to performing comprehensive psychosocial services, including assessments. Clinical supervision must be provided either directly through a clinical supervisor, through a member of the interdisciplinary team, or through consultation.

Measure: Completed paperwork on file for all staff.

Standard 2: Staffing levels.

Agencies will ensure appropriate staffing levels are reached and maintained to provide contracted services.

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

Standard 3: 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 4: Policies and procedures.

Each funded agency will have written policies and procedures manuals for personnel and for programs. The program policies and procedures manual for case management 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
- Referral resources and procedures that ensure access to continuum of services
- All appropriate consent forms (e.g., consent to share information, treatment consent, shared client data/registration)

system² consent form for San Francisco only, HIPAA requirements)

- Data collection procedures and forms, including data reporting
- Compliance with 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)

Measure: Written policies and procedures manual.

Standard 5: 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 ongoing⁴ HIV/AIDS training as appropriate for employee job function. Case managers should have the following trainings:

- Harm reduction training as required by San Francisco DPH of all staff providing direct services
- CPR and First Aid certification preferred within the first year of employment and kept current thereafter

Some suggested topics for ongoing case management training include:

- Performing comprehensive psychosocial assessments and care planning
- Crisis intervention
- Benefits eligibility
- Counseling
- Workplace entry/re-entry and employment services
- Prevention for Positives interventions including assessment, counseling, and referral

Measure: Documentation of all completed trainings on file.

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.

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

⁴ Case management programs are required to provide at least 24 hours per year of on-the-job or community training for their case management staff.

B. Facility Standards

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

Standard 6: Standard safety requirements.

The program 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; written policy describing plan for accommodating individuals with disabilities.

C. Service Delivery

Standards related to service delivery define the minimum set of activities to be performed and under what parameters.

Standard 7: Initial interview and intake.

The initial interview and intake are the first encounters that the client will have with the case management program. They provide an opportunity to inform the client about the scope of services available through case management and of the full spectrum of services available within the HIV health services system. A first step is to determine if a client is registered in the shared client data/registration system in order to minimize duplication with information-sharing for the client⁵. During the initial interview and intake, providers should:

- Determine whether the client is in a crisis situation and requires immediate service referral and assistance.
- Determine the immediate needs of the client and connect the client to appropriate resources.
- Determine whether the client's needs for social and practical support can be well served by the particular agency and consider whether the case management program is culturally and otherwise appropriately matched to the client.
- Inform the client of the scope of services offered by the case management program, including the program's benefits and limitations.
- 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.
- Gather appropriate client information, including verification of client's HIV status and county address, and determine program eligibility.⁶
- With the client, mutually agree on a decision to go forward with the client's enrollment in the case management program.

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

⁵ 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.

⁶ "Making the Connection: Standards of Practice for Client-Centered HIV Case Management," pg. 23, Practice Hints, SFDPH, 1996. The client may not have a letter of HIV diagnosis or proof of local residency. If this is the case, the case manager should document the reasons that eligibility cannot be confirmed at the time of Intake and initiate the process to obtain the required documents. Lack of documentation should not become a barrier to acquisition of service. Necessary referral should be made on the basis of presumptive eligibility.

Standard 8: Client assessment.

The information collected during the client assessment is important for establishing a baseline profile for each client. This information is used to develop a Care Plan for the client and to make initial service referrals. Comparing this baseline profile with information collected during follow-up and reassessment visits will allow case managers to assess the client's continuing need for services and support. During the client assessment, providers should work with the client to:

- Encourage clients to identify their primary and secondary needs. A complete assessment includes determination of the client's need for services such as housing, food, primary care, clothing, money management, benefits, visiting nurse and home health care, hospice, legal services including immigration, employment/work entry and re-entry, and other services offering practical support for daily living.
- Determine the extent and nature of the client's service needs.
- Assess the client support network.
- Determine the extent to which other service agencies, including the client's primary medical provider, other social service providers, and other case management programs, are involved in the client's treatment and support.
- Assist the client to determine health education and/or other support needs in order to reduce HIV transmission risk.
- Work with the client to develop a written Care Plan that prioritizes the client's identified service and support needs, as well as the frequency of face-to-face contacts.

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

Standard 9: Development of the Care Plan.

The Care Plan reflects the needs that have been identified by the client and the case manager during the client assessment. The development of the care plan is an interactive process that encourages the client to actively participate in the decision-making process related to his/her care, support, and treatment. The purpose of the Care Plan is to:

- Document and organize/plan for comprehensive support services and to promote continuity of care at a level that is desirable to the client.
- Demonstrate a relationship between actions and the wants,

needs, strengths, and limitations of the client as documented in the client assessment.

- Ensure that the Care Plan is a realistic reflection of what the client and the case manager can accomplish together for the benefit of the client.

The Care Plan, which should be modified as necessary, depending on the client's current condition and or need for services, includes:

- Prioritized, long and short term goals as identified by the client and the case manager;
- Identification of all services currently needed by the client as well as resources readily available to assist the client;
- Identification of agencies that have the capacity to provide needed services to the client and a plan for how these services will be accessed and coordinated;
- A clear definition of the role of the case manager in implementing the plan; and
- An estimate of the time frame for accomplishment of goals, objectives, and activities/tasks of the Care Plan with the client and his/her caregivers.

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

Standard 10: Implementation of the Care Plan.

Implementation of the Care Plan, like all other aspects of HIV case management, requires the case manager and the client, in coordination with the multidisciplinary team, to work closely together to achieve the goals and objectives of the Care Plan. Providing encouragement to the client is as much a part of implementing the Care Plan as the actual brokerage and coordination of services. In implementing the Care Plan effectively, providers should:

- Take steps to minimize barriers to obtaining needed services, (e.g., contact other providers to make arrangements for client referral; arrange transportation for client; contact client to determine whether referral appointments have taken place; make arrangements directly with service programs to provide services to client; escort clients to appointments if necessary; and guide client to be a better advocate for him/herself).
- Support and encourage the client to take action on his/her own behalf.
- Monitor the progress of the Care Plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation.

- Advocate for the client when necessary (e.g., advocating for the client with a service agency or a benefits program to assist the client in receiving necessary services).
- Monitor changes in client's physical, mental health, social, and economic status, and level of functionality.
- Communicate periodically with the client, either in person or by telephone, to assess whether an appropriate and desired level of service is being rendered.

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

Standard 11: Follow-up and monitoring.

Regular follow-up and monitoring of the client by the case manager helps to determine whether the goals and objectives of the Care Plan are being met. In addition, by regularly following-up with the client, the case manager can reassess any changes in the client's situation and revise the Care Plan appropriately. When following-up with and monitoring a client, providers should:

- Review the Care Plan with the client to determine its relevance, adequacy and timeliness.
- Make sure treatment and support is being coordinated to avoid duplication or any gaps in services.
- Record in progress notes any changes that have occurred in any of the following areas: 1) basic needs (e.g., food, housing, transportation, clothing, income, and social and practical support systems); 2) physical health and health care (e.g., change in HIV disease status [e.g. stabilization, progression, improvements], other health care or medical problems, contact with primary medical provider); 3) mental health (e.g., change in mental health status, adequacy of mental health care); and 4) substance abuse (e.g., status of any new or ongoing substance use problems, adequacy of current treatment or need for new treatment).
- Address, as appropriate, any changes that have emerged in the client's condition or circumstances in order to avoid crisis situations; or conversely, address any changes that create opportunities for transition toward autonomy and independence.
- Maintain client contact on a regular basis in order to build communication, trust, and rapport with the client⁷.

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

⁷ Refer to Core Activity #5 in "*Making the Connection: Standards of Practice for Client-Centered HIV Case Management*," for further guidelines regarding follow-up and monitoring.

Standard 12: Reassessment.

A comprehensive reassessment of the client's medical, psychosocial, and financial condition and service needs should be conducted at least once every six months. Such regularly scheduled, periodic reassessments of the Care Plan with the client are necessary to determine whether the appropriate level of care is being delivered as a client's situation changes over time. Reassessment is an important opportunity to work with the client to reevaluate his/her conditions and to make appropriate adjustments to the level and intensity of services being delivered. When conducting a reassessment, providers should:

- Record any changes that have occurred in the client's physical, mental, and psychosocial status since the last formal assessment was conducted.
- Review with the client the adequacy of client's social support network, including adequacy of caregiver support, ability of caregivers to provide needed psychosocial and practical support in light of any changes in client's condition.
- Assess changes in client's financial status or benefits that may affect the client's ability to meet his or her expenses.
- Discuss with client any legal and financial arrangements such as durable power of attorney, living will, and guardianship of children/dependents if applicable.
- Determine client's need for services listed in Standard 8.
- Determine to what extent the goals of the Care Plan have been achieved since the previous assessment was conducted, including any barriers or obstacles that were encountered.
- Assess the satisfaction of the client with the level of care and services that he/she has been receiving.
- Assess whether client requires an increase or decrease in the intensity of case management services the client receives.
- Assess client's capacity to begin or continue transition toward greater autonomy and independence through vocational rehabilitation, job training and/or employment services.

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

Standard 13: Transfer and discharge.

Transfer or discharge from case management programs occur when the case management program no longer serves the needs of the client (e.g., when client has progressed to a more advanced stage of disease and needs more intensive case management; when client's health status has improved such that they might be capable of greater self-efficacy; when client moves out of the area, transfers case management responsibility to another service program, refuses further participation in the program, or is no longer eligible for the program). It is appropriate for the case manager to initiate discharge when the client has exhibited threatening or dangerous behavior.

It is important to ensure that transfer and discharge are not carried out in an abrupt or disruptive manner, but result 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. Before undertaking to transfer or discharge a client from case management services, providers should take the following steps:

- If the case manager assesses that the agency is no longer able to meet the client's needs, consult with the supervisor and other members of the multidisciplinary care team in order to develop a plan for discharging or transferring the client.
- Discuss with the client and his/her caregivers the decision to discharge the client from the case management 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.
- Document in the client's file reasons for the planned transfer or discharge and document in progress notes discussion with the client about planned transfer or 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: Detailed documentation in client charts and in shared client data/registration system.

Standard 14: Assistance with vocational rehabilitation and employment services.

In order to best serve clients who are considering employment, providers should be prepared to discuss the impact of employment on the services provided at that agency, and to make referrals necessary to determine the impact of employment on the spectrum of health and human services currently utilized by the client. In addition, providers should offer clients information about the wide array of services which are available to support their efforts, including benefits counseling, short-term psychotherapy, career counseling, vocational rehabilitation and workforce development programs. Providers should be prepared to make referrals that:

- Assist clients in identifying services for which they might be eligible, including but not limited to HIV/AIDS-specific programs.
- Facilitate access to programs of the State Department of Vocational Rehabilitation, the State Employment Development Department, One-Stop workforce development centers, Community College, and community-based job training and employment development programs.
- Provide support to clients as appropriate, and as they pursue training and employment goals.

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

Standard 15: Harm reduction.

In conjunction with the multidisciplinary team, providers should offer support and education to clients by employing harm reduction strategies, which includes both abstinence-based and non-abstinence-based options, around issues such as substance abuse and sexual behavior. The goal of harm reduction is to work with the client to agree on a plan for reduced risk and to incorporate alternative approaches towards reducing risk into the Care Plan. Providers should:

- Discuss with client their pattern of use and/or sexual behavior practices using harm reduction strategies.
- Explore with the client whether other aspects of clients' lives influence their use or practices.
- Work with client to develop an individualized plan to reduce risk and harm which will be incorporated into the Care Plan.

Measure: Detailed documentation in client charts of implementation of harm reduction strategies and incorporation into the Care Plan.

Standard 16: Coordination with a multidisciplinary team.

Building a multidisciplinary team approach into case management and care coordination for clients requires that providers:

- Work closely with clients' health care providers and other members of the care team in order to more effectively communicate and address client service related needs, challenges and barriers.
- Facilitate participation of other service team members in the development of individualized care plan.
- Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate.
- Make sure that services for clients will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and to encourage client access to integrated health care.⁸
- Report referral and coordination updates to the multidisciplinary team.

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

⁸ *“Making the Connection: Standards of Practice for Client-Centered HIV Case Management,”* It is strongly urged that clients who enroll in HIV case management programs choose a single agency and a single case manager to be their primary care coordinator at the time of enrollment. When other programs or agencies remain involved in coordinating a client's care, the case manager should work with the client and other providers to designate a primary case manager. Case conferences should be called to share information and to avoid duplication 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: 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. Experience/education.	1. Completed paperwork on file for all staff.
2. Staffing levels.	2. Full and part-time positions funded under contract are filled; OR appropriate actions being taken to fill positions.
3. Job descriptions.	3. Written job description on file signed by the staff/staff supervisor.
4. Policies and procedures.	4. Written policies and procedures manual.
5. Staff training.	5. Documentation of all completed trainings on file.
6. Standard safety requirements.	6. Compliance with all appropriate regulatory agencies, including ADA compliance; written policy describing plan for accommodating individuals with disabilities.
7. Initial interview and intake.	7. Detailed documentation in client charts and in shared client data/registration system.
8. Client assessment.	8. Detailed documentation in client charts and in shared client data/registration system.
9. Development of the Care Plan.	9. Detailed documentation in client charts and in shared client data/registration system.
10. Implementation of the Care Plan.	10. Detailed documentation in client charts and in shared client data/registration system.
11. Follow-up and monitoring.	11. Detailed documentation in client charts and in shared client data/registration system.
12. Reassessment.	12. Detailed documentation in client charts and in shared client data/registration system.
13. Transfer and discharge.	13. Detailed documentation in client charts and in shared client data/registration system.

Standard	Measure
14. Vocational rehabilitation and employment assistance.	14. Detailed documentation in client charts and in shared client data/registration system.
15. Harm reduction.	15. Detailed documentation in client charts of implementation of harm reduction strategies and incorporation into the Care Plan.
16. Coordination with a multidisciplinary team.	16. 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.	19. Annual written summary and analysis of the program's client satisfaction activity.
19. Quality assurance.	20. 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.