SAN FRANCISCO EMA RYAN WHITE HIV 2024 STANDARDS OF CARE UPDATE PROJECT

CENTERS OF EXCELLENCE STANDARDS OF CARE

NOTE: The draft standards below describe only service elements specific to Ryan White-funded services provided in the context of the San Francisco EMA's Centers of Excellence model. Overarching standards common to all programs - such as standards related to client eligibility, insurance and benefits screening, facility standards, staff qualifications, evaluation, and use of Ryan White funds as the payor of last resort - will be included in a separate Common Standards document. This document will also be fully formatted in a future version.

OVERVIEW AND PURPOSE OF CENTERS OF EXCELLENCE SERVICES STANDARDS

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Centers of Excellence Standards of Care is to ensure consistency, service equity, and a high degree of quality among services provided as part of our region's Ryan White HIV continuum of care for persons living with HIV on low incomes. These standards are not intended to promote a formula approach to the support and assistance of persons living with HIV through the Centers of Excellence (CoE) model. 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 low-income persons with HIV who have severe needs 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 each client's identified needs;
- Meet the specific and complex needs of clients through a multidisciplinary, team-based approach to care;
- Provide continuity of care for PLWHA within an integrated system of services throughout the course of their infection; and
- Continually minimize client barriers to services.

DESCRIPTION OF CENTERS OF EXCELLENCE SERVICES

CENTERS OF EXCELLENCE INTEGRATED SERVICES MODEL DEFINITION

The San Francisco EMA Centers of Excellence program is an integrated services model (ISM) of health and social service delivery in which all needed client services are provided and coordinated by a multidisciplinary team whose composition is tailored to the needs of specific HIV subpopulations. Centers of Excellence ensure that populations with severe needs have direct access to a comprehensive spectrum of care that is delivered seamlessly, in a culturally competent manner, and in accordance with all relevant care standards.

The goals of Centers of Excellence services include:

- Improving health outcomes and quality of life for persons with HIV who have severe needs or are from special populations;
- Providing seamless access to all needed primary care and critical support services; and
- Linking and maintaining in health care persons with HIV who are not currently in care or are at high risk of falling out of care.

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

- Providing primary health care to persons with HIV who have severe needs or are from special populations;
- Providing treatment adherence and retention services for persons at high risk of falling out of care;
- Assisting clients in maintaining the care and support they need to preserve a health and wellness; and
- Providing seamless access to a range of critical support services including as case management, treatment adherence support, peer advocacy, substance use services, and mental health services

At the time of this writing, clients with **severe need** are defined by the San Francisco HIV Community Planning Council as persons with HIV who meet **all** of the following criteria:

- Disabled with HIV or with symptomatic HIV diagnosis;
- Active substance user or person living with a diagnosed mental illness; and
- Person living in poverty, defined as having an annual federal adjusted grow income or less than **150%** of Federal Poverty Level for the current calendar year.

The Planning Council has identified the following groups as **special populations** who face unique or disproportionate barriers to care:

- Populations with the lowest rates of viral suppression and who experience health disparities;
- Communities with linguistic or cultural barriers to care;
- Persons who are being released from incarceration in jails or prisons, or who have a recent criminal justice history; and
- Persons living with HIV age 60 or older.

UNITS OF SERVICE:

A unit of service within the Centers of Excellence model is based on the specific unit of service for each sub-service delivered through the multidisciplinary program. Please Refer to the

appropriate Standards of Care to determine the specific unit of service for each service category delivered through a given CoE.

CENTERS OF EXCELLENCE REQUIREMENTS:

All Centers of Excellence programs and provider must provide the key activities listed below:

- **Establishment and Maintenance of Collaborations:**

Each agency that is part of a given Centers of Excellence collaboration must have a clear understanding of the scope of its responsibilities, as well as of the CoE's overall goal and mission. In addition, all staff providing services within integrated services programs must be properly trained and credentialed, have an understanding of the scope of their job responsibilities, and have adequate staff funding to provide specific CoE services. Agencies that are funded as multi-agency collaboratives are required to develop a **Multi-Agency Agreement** in order to formalize the working relationship between collaborating 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 the Agreement and the methods for changing or discontinuing the Agreement;
- ✓ Statements acknowledging familiarity and agreement to comply with the terms of the prime contract; and
- ✓ 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 a commitment to client-centered services; and
- ✓ Agreed-upon measurable, client-centered health outcomes and data collection and reporting methodologies.

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; and
- ✓ Supervision and quality assurance procedures and responsibilities.

Service Delivery:

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

Inter-Agency / Inter-Program Communication and Coordination:

- ✓ Procedure for units of service, unduplicated clients, and cost reporting;
- ✓ Procedure for dispute resolution;
- ✓ Reporting requirements and timelines that clearly define staff responsible for reporting and submitting data and timely entry of client data;
- ✓ Process for maintenance of client or service records; and
- ✓ Procedures for ongoing communication between collaborators along with a schedule of client case conferences.

- **Program Coordinator:**

A Program Coordinator must be funded as part of each Center of Excellence program. The Program Coordinator is 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 specific Center. This position should also:

- Serves as lead administrative liaison with the San Francisco Department of Public Health, HIV Health Services (HHS);
- Monitors compliance of parties to the CoE Agreement;
- Identifies and addresses problems and issues affecting the operation of the CoE;
- Facilitates communication among collaborating agencies; and
- Ensures that agreements are kept current and signed between agencies.

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.

- **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);
- Identifying, hiring, training, and supervising the Program Coordinator;
- Establishing the Center of Excellence Agreement;
- Establishing subcontracts with all providers;
- Continually monitoring the CoE Agreement and subcontracts;
- 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.

- **Policies and Procedures Manual:**

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

- **Required Comprehensive Services:**

Centers of Excellence 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. Services should follow

established Standards of Care for Ryan White 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.

- **Coordination and Integration:**

Ensuring 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 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 involve 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 a given client participate in the development of the individualized care plan;
- Promote attendance CoE staff at key updating, skills building, and service planning meetings within the San Francisco EMA, including quarterly HIV Quality Improvement meetings;
- Ensure that services for clients are provided in cooperation and in collaboration with other agency services and other community service providers to avoid duplication of effort 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; and
- Develop a mechanism for tracking referrals and ensuring clients successfully follow-up on referrals.

- **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; and
- Determine referral process and primary staff contacts to effectively facilitate client linkage to services.