A. Table of Contents

I. Introduction

II. University Policies
   A. UCSF Non-Discrimination Policy
   B. Universal Precautions
   C. UCSF Policy on Substance Abuse

III. Agency Policies
   A. Code of Conduct
   B. Sexual Harassment
   C. Art in the Workplace
   D. Quality Improvement
   E. Supervision
   F. Tuberculosis Testing
   G. Safety Training
   H. Dress Code
   I. Oath of Confidentiality
   J. Research at AHP
   K. Media Inquiries
   L. Client Grievance Procedure
   M. Working with Clients Requiring Reasonable Accommodation
   N. Working with Hearing-Impaired Clients
   O. Working with Visually-Impaired Clients
   P. Assessing Staff Language Proficiency
   Q. Working with Non English Speaking Clients
   R. Policy on Commitment to Cultural Competency
   S. Policy on After-hours Services
   T. Policy on Vacation and Leave Coverage
   U. Policy on Staff Orientation
   V. AHP Computer Use Policy and Guidelines
   W. Email & ePHI Policy
   X. Scents and Fragrances
   Y. Conflicts of Interest Among AHP Staff
   Z. Tobacco Use
   AA. Staff Licenses/Certification
   BB. Ebola Policy
IV. Services Center Program Descriptions
   A. Behavioral Health Services
   B. HIV Counseling and Testing

V. Program Specific Policies and Procedures
   A. Alcohol and Other Drug Program Operations Manual
   B. Mental Health Medi-Cal Operations Manual

VI. Services Center Clinical Policies
   A. Confidentiality and HIPAA Guidelines
   B. Client Rights and Responsibilities
   C. Policy on Documentation
   D. Clients Demonstrating Inappropriate Behaviors
   E. Clients Demonstrating Intoxicated Behaviors
   F. Policy on Weapons
   G. Standards for Scheduled Appointments
   H. Policy on Officer of the Day (OD) Standards
   I. Standards for Home Visits and Transportation
   J. Policy on Service Animals
   K. Policy on TB Surveillance
   L. Determining Eligibility for CARE Funded Services
   M. Determination of Payer of Last Resort
   N. Serosorting and Superinfection Risk Reduction Counseling
   O. Working with Persons with Mental Health, Substance Abuse or Co-occurring Disorders
   P. Policy on Disclosure
   Q. Policy on Harm Reduction
   R. Policy on Compliance with CBHS Staff Credentialing, Training and ANSA Certification
   S. Policy on Unusual Occurrences

VII. Services Center Operations Policies
   A. Safety
      1) Officer of the Day
      2) Non-OD Staff
      3) Dialing 9-911 for Emergencies
      4) Telephone Emergency Button
      5) UC Police Silent Alarm
      6) Bio-Hazard Waste
   B. Officer of the Day (OD) Role and Responsibilities
   C. Services Center Reception Desk
      1) Reception
      2) Reception Desk Backup
VII. Services Center Operations Policies

C. Services Center Reception Desk (continued)
   3) Client Flow
   4) OD Role
   5) Client in Crisis Situation
   6) Triage
   7) Soliciting/Sales Drop Ins
   8) Client Drop Off for Clinician/Accepting Packages
   9) Literature/Promotional Material
  10) Fax Information
  11) Signing In and Out

D. Medical Records
   1) General
   2) Filing
   3) Shredding

E. Environmental/Facilities
   1) Building Maintenance
   2) Parking/Transportation
   3) UCSF Shuttle Service
   4) Public Transportation to the Services Center
   5) Bicycle Storage
   6) Janitorial/Waste Removal
   7) Hazardous Waste
   8) Building Access
   6) Mail
   7) Staff Lounge and Vending Area
   8) Heating and Air Conditioning
   9) Smoking

F. Physical Security
   1) Keys
   2) Access Codes
   3) Alarm Panel

G. Opening/Closing
   1) Opening Procedures
   2) Closing Procedures

H. Emergency Evacuation Plan

I. Room Scheduling

J. Computer Systems
I.
INTRODUCTION
INTRODUCTION

The Alliance Health Project, formerly the AIDS Health Project, has been proudly providing HIV-related mental health services in San Francisco since 1984, when it helped to establish the San Francisco Model of Care—a system of care credited with helping many people with HIV and AIDS live longer and have healthier, fuller lives.

In 2010, the Alliance Health Project (AHP) received funding from the city and county to provide mental health services to the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. This new funding brings AHP’s professional, client-centered care not only to those living with HIV, but also to the LGBTQ community.

To reflect these changes and fulfill a long-term interest to serve the uninsured and underinsured LGBTQ community with their mental health needs, AHP has become the Alliance Health Project. Our mission is to support the mental health and wellness of the LGBTQ and HIV-affected communities in constructing healthy and meaningful lives.

AHP continues its full range of HIV-related services to both HIV-positive and HIV-negative people at risk in San Francisco, as well as education to providers working with HIV. Our mental health services for the LGBTQ community provide support and psychotherapy groups as well as individual psychotherapy services and ongoing psychiatric clinical care, including medication evaluation and monitoring, are offered at our AHP Services Center.

AHP has provided HIV prevention, education, counseling and psychiatric services to tens of thousands HIV-infected men, women, youth, and their providers. AHP has counseled and provided HIV-test results to more than 200,000 individuals and has trained more than 80,000 health care professionals, educators, and students. AHP currently provides direct services to nearly 7,000 clients annually, many of whom struggle with chronic mental illness, homelessness and substance abuse.
II. UCSF POLICIES
UCSF NON-DISCRIMINATION POLICY

The University of California, San Francisco, in compliance with Titles VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and the Civil Rights Act of 1991, does not discriminate on the basis of race, color, national origin, religion, sex, physical or mental disability, or age in any of its policies, procedures, or practices; nor does the University, in compliance with Section 402 of the Vietnam Era Veterans Readjustment Act of 1974, and Section 12940 of the State of California Government Code, discriminate against any employees or applicants for employment because they are disabled veterans or veterans of the Vietnam era, or because of their medical condition (as defined in Section 12926 of the California Government Code), their ancestry, or their marital status; nor does the University discriminate on the basis of citizenship, within the limits imposed by law or University policy; nor does the University discriminate on the basis of sexual orientation or gender identity; nor does the University discriminate against vendors seeking business with the University. This nondiscrimination policy covers admission, access, and treatment in University programs and activities, and application for and treatment in University employment. It is against the law and University policy to retaliate against a person for pursuing his/her rights under these laws and/or for participating in an investigatory proceeding. In conformance with University policy of 1973, and Section 402 of the Vietnam Era Veterans Readjustment Act of 1974, the University of California, San Francisco is an affirmative action/equal opportunity employer.

Inquiries regarding UCSF’s equal opportunity policies may be directed to:

Director Cristina Pérez-Abelson
Office of Affirmative Action, Equal Opportunity & Americans with Disability Act
3333 California Street, Room S16
San Francisco, California 94143
(415) 476-4753

Director Pérez-Abelson is also the 504 coordinator for the UCSF campus.

Note: To the extent that your grievance alleges discrimination in violation of applicable University policy, civil law remedies may also be available, including injunctions and restraining or other orders (AB 2350).
THE OFFICE OF ENVIRONMENTAL HEALTH AND SAFETY

OEH&S Biosafety Manual Chapter 13

A. SPILL RESPONSE

In any spill scenario, the priority of actions is determined by the "PEP" rule - People, Environment, Property. The highest priority is to provide aid to injured personnel and prevent spill area access to others.

IMMEDIATELY REPORT ALL SPILLS AND INJURIES.

ALL UCSF LOCATIONS EXCEPT SAN FRANCISCO GENERAL HOSPITAL (SFGH): 9-911

AT SFGH: 206-8522

Next, action should be taken to prevent environmental damage if it can be done without endangering personnel. An example would be to prevent a radioactive biomaterial or a potent toxin from entering a sanitary drain by placing an absorbent in the flow path. Finally, action to prevent property damage should be taken if it can be done safely.

The basic rules for responding to a spill are:

1. **Tend the injured** - ensure receipt of immediate medical care; do not attempt to move the injured individual(s) unless ambient conditions become life-threatening. Persons splashed, sprayed with or otherwise exposed to human blood or other body fluids or tissues during a spill should immediately call the Exposure Hotline at pager 719-3898.

2. **Isolate the spill** - evacuate the immediate spill area or the entire room in the case of an aerosolizing (splashing or spraying) spill or a spill of volatile material; prevent others from entering the spill area with barricades or, if necessary, a sentry.

3. **Contain the spill** - place absorbent material around, on or in the flow path of the spilled material only if it can be done safely.

4. **Await assistance or proceed with cleanup** - unless laboratory personnel are trained and properly supplied with personal protective equipment, DO NOT attempt to clean up the spill; immediately call 9-911 from any campus location except SFGH (from SFGH, call 206-8522), provide the information requested and await arrival of the Emergency Responder.

5. **Clean up** - if and only if laboratory personnel are trained, properly supplied with personal protective equipment and otherwise able to clean up and disinfect the spill safely, they should proceed in accordance with the **UCSF Biological Spill Emergency Procedures**; a copy should be in every red **Biological Safety Logbook**. Detailed procedures for biohazard spill cleanup are in Chapter 12 (Recommended Work Practices), Section L of this Manual.

Contrary to intuition, the volume of a spill is not necessarily a valid measure of the risks involved. For example, dropping a glass vial containing 1.0 ml of lyophilized anthrax spores poses much greater risk to laboratory staff than dropping a 10 liter glass bottle of Escherichia coli K12 culture. Factors other than volume that must be considered in spill risk assessment include:

- **Location** - e.g., biohazard cabinet, countertop, floor, equipment
Within 24 hours of any biohazard spill cleanup, a written report must be provided to the Biosafety Officer (BSO) at Box 0942. The report must include the date, time and location of the spill, the identity and quantity of the material spilled, details of the cleanup process used, names of individuals involved in the spill and cleanup, and the nature and extent of any injuries or property damage.

One-time-use spill kits are available from several safety supply sources. These kits contain everything needed for cleaning up and disposing of biohazard spills, with the exception of respiratory protection which is rarely needed. Laboratories should consider obtaining a supply of kits and training laboratory staff to use them.

**B. DECONTAMINATION**

Decontamination of a spill site is an integral part of the spill cleanup procedure. Residual biohazardous material must be removed from the spill area to prevent further risk of injury or exposure to personnel working in the area. Further discussion of decontamination methods may be found in Chapter 12 (Recommended Work Practices), Section M.

The standard surface decontaminant in use at the University of California, San Francisco (UCSF) is a 1:10 dilution of regular household bleach (e.g., Clorox). This provides the ideal concentration of sodium hypochlorite (0.5%) for general disinfection of surfaces; using bleach routinely at greater concentration is not advised because of its corrosive properties. However, for liquid disinfection, dilution of the bleach by the volume of the liquid being disinfected must be considered; 10% is again the target bleach concentration. Thus, 900 ml of infectious liquid may be disinfected by adding 100 ml of undiluted bleach. The disinfecting properties of diluted bleach degrade with time; diluted bleach solutions should be used within seven days of their preparation. Also, bleach is available in industrial strength, approximately twice that of household bleach; if used, industrial bleach should be diluted 1:20 for routine surface use. Bleach solution requires a very short contact time (typically less than 5 minutes), is rapidly inactivated by contact with organic materials, and should never be used for handwashing because of its corrosiveness.

The alternatives to 1:10 bleach at UCSF are Wescodyne, a common iodophor, and 70% ethanol or isopropanol. Of the two, Wescodyne has a broader antimicrobial spectrum than alcohol but is less convenient to use. Ethanol is very commonly used for routine disinfection of biological safety cabinets and benchtop work surfaces; unlike Wescodyne, it dries quickly and leaves little residue. Other disinfectants commonly used include phenolics (e.g., Amphyl, Lysol), quaternary ammonium compounds (e.g., Roccal, Cavicide), formaldehyde and glutaraldehyde. The choice of disinfectant depends on the antimicrobial spectrum required, the surfaces or materials to be treated, and the presence of antagonistic agents. Additional information is available in Appendix D (Sterilization and Disinfection).

**C. BLOODBORNE PATHOGEN EXPOSURES AND NEEDLESTICKS**

Many laboratories at UCSF handle and work with human blood, blood products, body fluids, unfixed tissues and cell cultures of human origin. All individuals handling any of these materials are subject to the Bloodborne Pathogens Standard. One of the health surveillance requirements of this standard is the provision of no-cost post-exposure treatment and follow-up for all exposed individuals. The way to access this provision
is through the Needlestick, or Blood and Body Substance Exposure, Hotline.

It is very important that an individual who has been exposed to any of these substances, or to any bloodborne pathogen under laboratory conditions (e.g., laboratory cultures or isolates of HIV, cytomegalovirus or other bloodborne agent), call the Hotline immediately.

**BLOOD AND BODY SUBSTANCE EXPOSURE HOTLINE**

**ALL UCSF LOCATIONS EXCEPT SFGH**: 719-3898 (24-HR PAGER)

**AT SFGH**: 469-4411

D. OTHER EMERGENCIES

Responses to other emergencies, such as fire, explosion, and earthquake, are covered in detail in departmental Emergency Action Plans. A reference pamphlet that summarizes proper actions for most common emergencies is available from the Office of Environmental Health and Safety (EH&S).

|| Table of Contents || Chapter 12 || Appendix Introduction ||
University of California Policy on Substance Abuse

The University of California recognizes dependency on alcohol and other drugs as a treatable condition and offers programs and services for University employees and students with substance dependency problems. Employees (including student employees) and students are encouraged to seek assistance, as appropriate, from employee support programs, health centers, and counseling or psychological services available at University locations or through referral. Information obtained regarding an employee or student during participation in such programs or services will be treated as confidential, in accordance with Federal and State laws.

The University strives to maintain campus communities and worksites free from the illegal use, possession, or distribution of alcohol or of controlled substances, as defined in schedules I through V of the Controlled Substances Act, 21 United States Code §812, and by regulation at 21 Code of Federal Regulations §1308. Unlawful manufacture, distribution, dispensing, possession, use, or sale of alcohol or of controlled substances by University employees and students in the workplace, on University premises, at official University functions, or on University business is prohibited. In addition, employees and students shall not use illegal substances or abuse legal substances in a manner that impairs work performance, scholarly activities or student life.

Employees found to be in violation of this Policy, including student employees if the circumstances warrant, may be subject to corrective action, up to and including dismissal, under applicable University policies and labor contracts, or maybe required, at the discretion of the University, to participate satisfactorily in an employee support program.

Students found to be in violation of this Policy may be subject to corrective action, up to and including dismissal, as set forth in the University of California Policies Applying to Campus Activities, Organizations, and Students (Part A) and in campus regulations, or may be required, at the discretion of the University, to participate satisfactorily in a treatment program.

--University of California Office of the President, November 1, 1990
III. AGENCY POLICIES
1. Staff shall not use any non-prescription psychoactive substances while on duty at the Alliance Health Project (AHP).

2. Relationships between Staff and clients shall remain purely professional in nature. No money should ever be exchanged. Contact with clients outside the agency should be avoided unless considered a therapeutic intervention such as a home visit. Most specifically, contact that leads to an exchange of goods and services shall be prohibited as this can confuse the therapeutic relationship and be easily misunderstood.

3. No staff shall (1) make any comments to a client, (2) engage in physical contact with a client, or (3) engage in any conduct before a client, that could be interpreted as physically threatening or sexual in intent.

4. Staff shall adhere to the UCSF Policy on Sexual Harassment. According to the Policy issued in September 1994, sexual harassment in any form will not be tolerated. Supervisors are expected to represent the university’s policy by creating a harassment-free environment, and by responding appropriately to complaints.

5. Staff shall adhere to the UCSF Non-Discrimination Policy that states, in part, that it is the policy of the University not to engage in discrimination against or harassment of any person employed by or seeking employment with the University of California on the basis of race, color, national origin, religion, sex, gender, gender expression, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), genetic information (including family medical history), ancestry, marital status, age, sexual orientation, citizenship, or service in the uniformed services. This policy is intended to be consistent with the provisions of applicable state and federal laws and University policies.

6. Staff shall not enter into agreements that constitute a conflict of interest. This includes, but is not limited to, referrals of AHP clients to AHP staff in private practice, private practice training or consultation contracts if the original contact was made through AHP, and granting of agency contracts, such as consulting agreements or paid employment, to any individual who in accepting such offers personally benefits the grantor.

7. Shall adhere to the Oath of Confidentiality which stipulates that the undersigned, hereby agrees not to divulge any information or records concerning any client/patient without proper authorization in accordance with California Welfare and Institutions Code, Section 5328, et seq.
8. Staff are expected to be knowledgeable of child/elder/spouse and domestic partner abuse reporting laws and agree to follow appropriate reporting procedures.

I have read and understand the above AHP Code of Conduct and agree to its provisions. I also understand that failure to comply with these standards constitutes serious misconduct and may result in dismissal from AHP.

_____________________________________
Staff Name

_____________________________________
Staff Signature

_____________________________________
Date

_____________________________________
Witness Name

_____________________________________
Witness Signature

_____________________________________
Date
Policy on Sexual Harassment

Date: 1/16/07

Purpose:
To provide counsel about implementation of the university’s sexual harassment policy, whose purpose is to protect all employees from any form of sexual harassment.

Policy:
UCSF’s position on sexual harassment is very clear. According to the Policy on Sexual Harassment issued in September 1994, sexual harassment in any form will not be tolerated. Supervisors are expected to represent the university’s policy by creating a harassment-free environment, and by responding appropriately to complaints.

Understanding what constitutes sexual harassment and knowing how to handle a complaint, however, are not as clear. This memo will underline the practical applications of UC’s sexual harassment policy and will address the specific procedures that supervisors at the Alliance Health Project should follow in order to maintain a workplace free of sexual harassment.

Procedure:
1. Recognizing Sexual Harassment:
Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature are sexual harassment, and illegal when an employee’s response to this conduct becomes a deciding factor in employment decisions (quid pro quo) or when such actions create a hostile environment. The term “hostile environment” refers to a workplace where an employee does not feel that he or she can get work done because of the offensive or intimidating behavior of others.

Two criteria are crucial to the definition of sexual harassment. Behavior that is sexual harassing will be both sexual in nature and unwelcome, as perceived by the recipient. Behavior that may seem to be sexual in nature, but is invited by the recipient, such as a backrub by a co-worker, may be deemed inappropriate, but it is not necessarily illegal.

Sexual harassment may take a visual form, as in derogatory posters, cartoons, or explicit drawings. In the case of the Alliance Health Project, where sexually explicit materials may seem consistent with the objectives of the agency, special consideration should be given to artwork and decorations to see that they are not offensive as defined by those who will view them. (For more information, see the Report from the AHP "Art in the Workplace"/Sexual Harassment Subcommittee.)

The recipient of sexual harassment could be a third party, who is not technically the instigator or recipient of a specific behavior, but who observes it happening and for whom it is
unwelcome. In addition, harassment in the workplace may be perpetrated not only by employees, but also by any agents outside of the workplace over which the university should have some control.

2. Creating a Harassment-Free Environment
It is the supervisor’s responsibility to create a harassment-free environment. This means explaining the policy of the university to all employees, expressing strong disapproval for sexual harassment of any type, setting an example by not participating in sexual harassment, and being consistent and immediate in response to complaints. Supervisors should take action when they receive a complaint from an employee, observe sexual harassment, or hear that sexual harassment may be taking place. Every complaint, even if it is suspect, must be taken seriously.

Part of the supervisor’s responsibility is to ascertain whether an employee feels comfortable talking to the supervisor about an incident, to make it clear to employees that they have other resources should they feel uncomfortable, and to define these resources so that employees can access them without going to the supervisor.

When a supervisor learns about an alleged incident of sexual harrassment, he or she must notify AHP’s Director about the incident and any complaint that stems from it.

3. Lodging a Complaint
Ideally, a complaint of sexual harassment will be handled in the most informal fashion possible. The idea behind this is that the recipient of sexual harassment is usually not out for vengeance, but simply wants the behavior to stop.

Encourage employees, if they feel comfortable doing so, to talk to the person instigating the behavior. The recipient should state in the simplest, most specific, and most direct fashion what it is that bothers him or her and ask the instigator to stop the behavior. At the same time, the recipient should document what was said and when, date the document, and record the instigator’s response. The instigator is likely to be defensive about their behavior. Encourage the employee to be firm and not to seem apologetic about what happened. It is also possible that the instigator will not be defensive, but instead will be concerned about having hurt the recipient, stating that it was not his or her intention to harass.

If the recipient does not feel comfortable broaching the subject with the instigator, or after confronting, the behavior continues, the recipient can make an informal complaint to his or her supervisor, unit manager, or another AHP supervisor with whom he or she feels comfortable. The supervisor to whom the recipient complains has the responsibility to follow-up on the case until it is resolved, even if the recipient does not report to the supervisor.

The recipient may also make an informal complaint to an advisor at the UCSF Office of Sexual Harassment whose job it is to respond to specific complaints. At the informal complaint level, the Office of Sexual Harassment cannot guarantee confidentiality and anonymity, although the file pertaining to the incident will be confidential and available only to university officials.
with a legal responsibility to know. Once the recipient identifies him or herself to a supervisor or to a Sexual Harassment Advisor, the university is legally obligated to investigate, even without the recipient’s consent. While the recipient’s desire to keep the matter confidential will be considered, such wishes must be weighed against the university’s responsibility to investigate and take action, and the rights of the alleged instigator to know the name of the complainant and the alleged complaint. If employees desire anonymity, they may call a Sexual Harassment Advisor and ask questions without disclosing identifying information about themselves or the other party.

4. Investigating a Complaint
When notified by the recipient, an AHP supervisor should first find out as much about the allegations as possible, including whether the incident is isolated and if there were any witnesses. The supervisor should then present the complaint to the instigator. In what is called a "pregrievance procedure," the supervisor should describe to the instigator the specific behavior that must stop, and express AHP’s disapproval of the behavior. Even if the instigator disagrees with the recipient’s specific allegations, the supervisor should seek to settle the matter by extracting a verbal agreement that the instigator will cease the general behavior. If the identity of the recipient is known to the instigator, the instigator should be informed that retaliation—for example, talking against the complainant to others—is prohibited. The supervisor should document all the steps he or she follows, and follow-up with the recipient to ensure that the behavior stops. During this stage, the supervisor may wish to consult with a Sexual Harassment Advisor as well.

If the pregrievance procedure is unsuccessful, the supervisor should contact the Sexual Harassment Prevention and Resolution Coordinator. An informal complaint resolution process will ensue, involving a preliminary investigation and a mediation within 10 calendar days of the request. Mediation—handled by the coordinator—should result in an agreement. The supervisor will also be kept informed throughout the mediation process, although, in keeping with confidentiality requirements, no other departments or witnesses should be informed. If, however, the behavior is particularly egregious or if it persists after mediation, other campus authorities may be informed. It is the department manager’s responsibility, with the assistance of the Coordinator, to ensure that the parties comply with the agreement. Managers should report breaches of compliance directly to the Coordinator.

If the informal complaint resolution process is unsatisfactory to the parties involved, either party may initiate a formal grievance procedure through the Coordinator.

5. Discipline
Disciplinary decisions are contingent upon circumstances of the event, especially context and degree of behavior. For example, harassment occurring between employees of different levels, a supervisor and his or her employee, will be considered more serious than that between people at the same power level. Also, the intensity and seriousness of the behavior is a factor in determining how the instigator will be disciplined. However, all complaints will be taken seriously regardless of their context and degree. Disciplinary options range from a verbal warning to termination of employment.
Referrals:
Lori Thoemmes is a source of information about AHP's implementation of the Sexual Harassment Policy. If an employee feels uncomfortable approaching one of these sources for information, he or she may contact any AHP supervisor with whom he or she feels comfortable or the UCSF Office of Sexual Harassment.

For further information on this policy or the topic covered by this policy, contact:

Lori Thoemmes: 476-3951
Sexual Harassment Prevention & Resolution Coordinator: 476-4284
The Office of Sexual Harassment Prevention & Resolution: 476-5186
Office of Affirmative Action/Equal Opportunity: 476-4752
The UCSF Center for Gender Equity: 476-5222
Employee/Labor Relations: 476-3905
California Department of Fair Employment and Housing: 800-884-1684
Policy on Art in the Workplace

Date: 7/12/96

Purpose:
To create an environment free of all forms of harassment, exploitation, and intimidation.

Policy:
The University of California San Francisco (UCSF) is committed to creating and maintaining a community in which students, faculty, and administrative and academic staff can work together in an atmosphere free of all forms of harassment, exploitation, or intimidation, including sexual. Specifically, every member of the campus community should be aware that UCSF is strongly opposed to sexual harassment and that such behavior is prohibited by both law and University policy. It is the intention of UCSF to take whatever action may be needed to prevent, correct, and, as necessary, discipline behavior which violates this policy.

Procedure:
1. Upon receipt of a complaint regarding workplace art or any other matter that might be construed as sexual harassment, the Unit Manager should first ensure that the staff person involved is aware of his/her rights under University Policy. In addition, the staff person should be made aware of the usual procedure used within AHP to manage such claims.

2. The artwork in question should be taken down while discussion of the issue is underway.

5. The staff person should be informed that the complaint can be handled informally, first through a discussion with the unit and/or the matter can be immediately referred to the AHP Ad Hoc Committee for investigation. (Note that these two avenues are not mutually exclusive, and that the purpose of a unit discussion is to educate the staff generally to the issue of a potentially hostile work environment). Also, please note that the staff person who brings the complaint should not be identified in the course of the unit discussion unless he or she wishes to come forward. Furthermore, the purpose of the unit discussion is not to dissuade the complainant from his or her complaint, and that the final disposition of any complaint is not a matter of unit consensus or majority rule; rather, it is intended only as a matter of raising sensitivity in the workplace at large. The staff person bringing the complaint is in control of the process at all times.

4. Staff or managers can secure the involvement of the Ad Hoc Committee as below.
Art in the Workplace Ad Hoc Committee

1. A standing Art in the Workplace Ad Hoc Committee will be identified. Membership will include, at a minimum, members from the Program Advisory Committee representing a mix of staff, including direct service and administrative staff, gender, sexual orientation, and cultural diversity.

2. The Chairperson of the Committee may be contacted by a manager or staff person to investigate concerns regarding art in the workplace. Staff will be notified of their right to anonymously contact the Ad Hoc Art in the Workplace Committee.

3. Once contacted, the Chairperson should notify the Project Director that a concern has been raised. Then, the Unit Manager should be contacted by the Chair who will discuss the issue and agree to a process. For example, the Unit manager may decide to take down the artwork, poster, etc at that time and end the process. Or, he/she may ask the committee to give advice on whether the piece should come down, etc., and make a presentation about the issue to the committee. The person responsible for the artwork as well as the person who brought the complaint should also be given an opportunity to present before the committee. This could be done either in person, or in writing to protect the anonymity of the complainant.

In general, while it is possible to have a nuisance complaint (a disgruntled co-worker who wants to “get” his/her colleague could bring a complaint not so much because the art in question is offensive, but because of a personal vendetta of some kind) the assumption is that all complaints will be taken seriously.

4. The committee should review the case, and make a recommendation to the Unit Manager with a copy to the Project Director. The committee should attempt to reach consensus, but ultimately will operate on a simple majority basis. All members must vote and votes will be anonymous. The Chairperson is charged with communicating the committee’s findings to the parties involved.

5. Decisions of the committee will be reviewed by the Project Director who has final responsibility for worksite policies and procedures.

Referrals:
For further information on this policy or the topic covered by this policy, contact:

Lori Thoemmes
Director
UCSF Alliance Health Project
Box 0884
Phone 476-3951
Fax: 502-7271
Overview
The UCSF Alliance Health Project (AHP) has a commitment to Continuous Quality Improvement (CQI) to ensure the effectiveness, accessibility and efficiency of agency services. The AHP Quality Improvement Plan has been developed by the Director with the input of the Management Team, staff, clients, the Community Advisory Board (CAB), and the San Francisco Department of Public Health, Community Behavioral Health Services (CBHS). The AHP Director is the CQI coordinator for the agency.

The plan is implemented on an ongoing basis through the efforts of the Management Team serving as the overall agency CQI team and reporting to the Executive Team consisting of the Executive Director and Director. Information is gathered with input from employees, clients, CAB members, stakeholders and community partners.

The philosophies and direction of the CQI Plan and the Management Team are to:
- Promote service excellence and continuous quality improvement;
- Address agency performance issues, quality of service, program results and client outcomes;
- Utilize a broad-based approach in respect to program measurements and inclusion of staff, client and stakeholder input;
- Support the short and long-term priorities of AHP;
- Examine current processes and identify potential changes to improve client services and increase efficiency;
- Review standards of performance, establish performance targets and record and evaluate results.

The Management Team meets every Monday, excepting the third of each month, to carry out the above mentioned philosophies as well as to enhance communication between teams and to address ongoing agency “housekeeping” issues. The Management Team is composed of the following staff members:
- Executive Director
- Director
- Manager, Fiscal and Administrative Operations
- Manager, HIV Counseling and Testing
- Manager, Behavioral Health Services (BHS)
- Manager, Training and Publications

CQI responsibilities include the examination of data, assessment, planning and implementation of service delivery adjustments and staff training when necessary, to promote continual improvement. Information is utilized from a wide variety of sources, and occurs and involves participation at many levels from inside and outside of the agency.

Stakeholder involvement in the CQI process occurs through the following mechanisms:
- Client feedback through customer satisfaction surveys and outcome measurements;
- Employee feedback through recommendations and input at supervision, monthly All Staff Meetings, monthly Clinical Staff Meetings and strategic planning;
• Volunteer CAB members mirroring the clients AHP serves review agency results and provide feedback;
• Program managers/supervisory staff review results, monitoring data, receiving feedback from employees and examining processes for quality, efficiency and effectiveness and implementing useful changes and trainings throughout the agency;
• Community partners providing input and opinions to AHP staff and the CAB.

Participation on CQI teams is based on knowledge, expertise and perspective regarding the area of agency operation. The current AHP CQI teams are:
• Management Team;
• Clinical Team;
• Program Utilization Review and Quality Committee;
• Psychiatry Team;

All changes and communication are reported to staff through their supervisor. Major changes that require Management Team approval are communicated back to the staff after Management Team approval and are addressed at monthly Clinical Staff Meetings or All Staff Meetings.

The annual Client Satisfaction Survey results are reviewed by program managers and supervisory staff prior to reporting to the Director with any accompanying comments or recommendations. The results of the survey are also shared with the staff and specific questions and suggestions are discussed with the staff at weekly meetings. Client Satisfaction Survey results are reported to Community Behavioral Health Services as part of annual program monitoring reports.

Record Review
AHP’s Program Utilization Review and Quality Committee (PURQC) consisting of the Medical Director and two supervisory staff, meets once a week. The BHS manager/supervisory staff are responsible for reviewing all records regarding the status of treatment prior to reauthorization. The PURQC committee uses an internal database to review the status of all active CBHS clients for reauthorization of ongoing care.

The BHS manager/supervisory staff review the Triage Team response to request for services from all new AHP clients regarding eligibility for services and appropriateness of referrals.

The agency complies with CBHS policies and procedures for collecting and maintaining timely, complete and accurate unduplicated client and service information in AVATAR. New client registration data is entered within 48 hours or two working days after data is collected. Service data for the preceding month, including units of service, will be entered by the 15th working day of each month.

A monthly clinical staff meeting allows for discussion of issues related to AVATAR data input/management and documentation requirements.
For patients receiving medication evaluation and monitoring, a sample of charts (two charts per MD/NP) are reviewed annually in a peer review process as per the San Francisco General Hospital Department of Psychiatry Guidelines. Completed QA forms are reviewed by the Medical Director and submitted to the Department of Psychiatry.

**Measures and Outcomes**
The contract for each AHP program details the goals and objectives related to that service, the population to be served, and the number of service hours to be delivered. Monthly Units of Service reports are prepared by program managers/supervisory staff and reviewed by the Director to assure that units are being met. Areas of deficiency are noted, and the program staff members develop an action plan to address identified problems. In consultation with the Program Manager and the Director, client services are modified as appropriate. A report of these activities and any actions taken will be reported to the funder during annual contract monitoring.

**In-Service Training and Continuing Education of Staff**
Staff routinely attend in-services and outside trainings with specific attention given to up-to-date information on interventions targeting current client population. Staff are encouraged to attend outside trainings by program managers. Staff submit training forms to the research unit for entering into a database that can issue reports on overall staff training activities.

The clinical staff of all AHP programs meet on a monthly basis to assess and evaluate shared clinical issues such as, care management basics, client entry into care, and clinical assessments standards and identify areas where greater training is needed. This meeting also serves as a forum for the active participation of all clinical staff members, with leadership from staff with extensive experience in psychotherapy, counseling, and neuropsychological assessment, in program development activities.

AHP staff in-service suggestions are requested from staff twice a year and reviewed by the AHP Management Team. Following discussion of topics and trainer options, AHP schedules monthly in-service trainings on clinically relevant topics. The in-service trainings address cultural and/or gender issues on a quarterly basis. Past trainings have focused on enhancing sensitivity in working with specific populations including African Americans, Latino/a Issues, Women and HIV, Transgender Issues, Men Who Have Sex With Men, Substance Users (including injection drug use). An evaluation form is distributed to staff following each training and their responses are considered when scheduling future in-services.

A monthly peer case conference is held to provide clinical staff with the opportunity to discuss and reflect on the presenting problem, course of treatment, cultural considerations, and quality of therapeutic relationship in individual cases while ensuring the client’s rights to privacy are respected.

**Staff Supervision and Evaluation**
Clinical staff receives at least one hour of individual supervision per week. Non-licensed staff may receive additional individual or group supervision as mandated by state licensure and/or
academic requirements. Clinical interns receive weekly individual and group supervision. They also receive a weekly didactic training on topics relating to clinical practice.

Clinical staff review ongoing CBHS clients with supervisors as a part of weekly supervision. This review includes discussion of plan of care, how treatment goals are identified, established and monitored, and appropriateness of discharge planning.

Staff evaluations are completed on an annual basis.

Agency policies and procedures are reviewed regularly at the monthly All Staff Meeting.

Affirmative Action
AHP follows University of California affirmative action guidelines in all hiring and other personnel actions. Employment is offered and services are provided in compliance with UCSF affirmative action guidelines.

Tuberculosis Screening/Monitoring
The Occupational Health Program (OHP) at UCSF provides required TB screening for all staff, interns, and volunteers. Administration of TB screening is monitored by AHP. OHP reports test results to the individual staff member. When a positive test result occurs, OHP confers with the individual about needed follow up care and provides this information to AHP's Director. Results of the initial TB test and all annual TB testing or related medical evaluation results are placed in the individual staff member’s file at AHP.

Client Satisfaction
AHP administers its own Client Satisfaction Surveys on a regular basis. The range of service types offered at AHP requires a variety of approaches for administering Client Satisfaction Surveys. For services that are time-limited by design, such as, psychotherapy and time-limited support groups, surveys are distributed to individual clients at the end of the services provision. For most other services, the AHP Client Satisfaction Survey is administered during a two-week period annually. Clients are asked to rate the effectiveness of a service, how helpful the service was in responding to the problems the client identified when he or she first came for services, the responsiveness of agency staff, whether clients would refer friends to AHP, and whether they feel the services were worthwhile. Measures include: sensitivity to cultural needs, comfort level with environment and services offered, improved ability to deal more effectively with psychosocial issues and improvement in client identified problem areas. The survey will also measure the level of client satisfaction and challenges for each type of service provided. Services will be modified as appropriate subsequent to an analysis of the survey data. This information is entered into a database capable of providing status reports. These reports are reviewed regularly by the Program Managers and the Director and results are used to improve AHP services.

Cultural Competency
AHP submits an annual Cultural Competency Report to CBHS. AHP is in compliance with UCSF Cultural Competency policies, which are consistent with SF DPH Policy 24.
requirements. AHP’s commitment to cultural competence is demonstrated by its quarterly in-service trainings on cultural and/or gender issues, which are required for all clinical staff. Past trainings have focused on enhancing sensitivity in working with specific populations including African Americans, Latino/a Issues, Women and HIV, Transgender Issues, Men Who Have Sex With Men, Substance Users (including injection drug use).

**Client Confidentiality Protection**

Information about client rights, and confidentiality is provided to all new clients, in compliance with HIPAA regulations. UCSF policies are consistent with SF DPH policies in this regard. Grievance procedures and HIPAA information are posted in the reception area of each program site. Copies of each are also made available to clients upon request. Clients are encouraged to utilize the grievance process should they feel services are not adequately being provided. All records and documents related to clients are maintained in locked and secured locations. Newly hired staff are trained in agency and University mandated client confidentiality as well as HIPAA compliance related to client confidentiality and recording keeping. Staff are required to sign oaths of confidentiality to protect the privacy of client information at all times. All clients are provided a statement of rights and responsibilities at intake as well as a separate booklet regarding agency compliance with all HIPAA regulations. A notation is placed in the client record indicating that privacy materials have been received by client. A summary of the SF DPH Privacy Notice (in both English and Spanish) is posted at the AHP Services Center in full view of the clients as well as distributed as part of the registration packet.

All disclosures of client information are documented and in the clients record, and consents are obtained and filed in the client record for all disclosures not related to billing, payment, treatment or operations. A consent to release information is obtained form the client any time mental health, substance abuse and or HIV information is shared with a provider.
Policy on Supervision
Date: 8/1/97

Purpose:
To define the goals and procedures of supervision at the UCSF Alliance Health Project.

Policy:
In order to further the mission of AHP in an atmosphere of mutual trust and respect, supervision is provided to staff to ensure that work meets agency standards for quality, quantity, and timeliness, and to promote the well-being and professional development of staff within the agency.

Procedure:
1. Each staff person has and can identify a primary supervisor (the supervisor who does performance evaluations and time sheets) and, when appropriate, secondary supervisors.

2. Supervision is a regularly scheduled meeting that has a predetermined length and is uninterrupted: generally, 30 minutes to one hour in length and once a week.

3. Supervision is held in private to facilitate discussion of sensitive topics. However, supervisors may disclose details of supervision to others, as needed (most commonly to the supervisor’s supervisor). Supervisors will also, as often as possible, communicate to the subordinate, in advance, their intention to discuss specific items outside of supervision, particularly when those items involve sensitive topics.

6. Both supervisor and subordinate are expected to bring issues to discuss. Issues raised in supervision should be documented by the supervisor. Supervision should include an initial check-in to define priority items and a recap at the end to acknowledge which items have been covered and which have not, and to confirm action steps.

7. The supervisor should define the goals, purposes, and structure of each supervisory relationship and clearly express them to each supervisee, noting when appropriate decisions about differences in supervisory procedures among staff.

8. Supervision needs may change over time. Both parties may evaluate the structure, including the timing and frequency, as needed.

9. Both parties are expected to express mutual respect, to act professionally, and to be sensitive to cultural issues and perspectives.
10. In the case of an employee who is subordinate to more than one supervisor, all of the employee’s supervisors are expected to maintain appropriate and ongoing communication with each other and with the supervisee regarding work assignments, time commitments, evaluation, and other matters. Further, supervisors are expected to clearly define their roles for the subordinate.

11. If there is a problem in the supervisory relationship, the employee may wish to appeal to their supervisor’s supervisor, AHP’s Director or Executive Director, the union or bargaining unit to which they belong, or to UCSF Labor Relations. While employees may contact any of these parties, they are encouraged to use the approach that is likely to lead to the most expeditious and satisfactory result: moving up the chain of command from supervisor to supervisor’s supervisor, etc.

12. Supervisors are expected to implement the skills taught in Performance management Training. Supervisory performance should be considered as part of that employee’s annual performance review.

What is discussed in supervision?

1. Acknowledgement and recognition for routine tasks as well as for extraordinary tasks.

2. Past, present, and future work tasks, including how to undertake and accomplish tasks, and improve the quality of work. When appropriate, recognition that tasks may be inherently unclear and that part of the task is working around that lack of clarity.

3. Interpersonal issues related to other staff, clients, collaborators, and others.


5. Pertinent information about the unit, the Program Advisory Committee and other AHP committees, the agency, and the university, including agency and university policies relating to probation, evaluation, termination, grievance, and employee service.

6. The subordinate’s professional development and career goals, how this affects unit needs, ways to improve supervisee’s skill set, allocation of tasks based on these skills.

Referrals:

For further information on this policy or the topic covered by this policy, contact:

Lori Thoemmes
Box 0884
476-3951
Purpose
To insure the safety of Alliance Health Project (AHP) staff, interns, volunteers, and clients, the agency requires all staff, interns and volunteers to be tested for Tuberculosis upon beginning work at AHP.

Policy
All AHP staff, interns and volunteers are required to take a TB test when beginning work at AHP. The initial test must be taken prior to the first day of work and/or volunteer involvement. Any staff or interns out of compliance will be asked not to participate in AHP work until test results are received by the Programs Coordinator.

Procedure
1. TB testing for AHP staff, interns and volunteers is provided through the Occupational Health Program at UCSF. New staff, interns or volunteers may arrange for this baseline screening and assessment by calling the Occupational Health Program (OHP) at 885-7580.

2. Each staff member, volunteer or intern is responsible for making his or her own appointment to take the TB test prior to the first day of work and/or volunteer involvement. Costs of testing done at OHP are borne by AHP.

3. Results of the initial TB test and all annual TB testing or related medical evaluation results will be placed in the individual staff member’s file.

4. Should a positive test be given to a staff member, intern or a volunteer, OHP will confer with the individual about needed follow up care and will also provide this information to AHP’s Director, Lori Thoemmes, 476-3951, who will notify the individual’s Unit Manager and the Programs Coordinator.

5. Annual Surveillance for TB testing is required based on a hierarchy of risk. All AHP staff and volunteers with direct client contact are required to have an annual TB test. AHP staff and volunteers with no client contact are not required to have annual testing.

6. It is the responsibility of each staff member, volunteer, or intern to monitor their re-testing. AHP medical staff will follow up with staff members and volunteers to remind them of the annual TB testing schedule for those with direct client contact.

7. Those that require annual surveillance can meet this requirement by attending one of the outreach testing clinics held by OHP every June at Parnassus, Mt. Zion, Mission Bay, and China Basin campuses. In addition, OHP offers year round drop-in clinics. The schedule is
available at the OHP website, http://occupationalhealthprogram.ucsf.edu. As an additional resource, AHP will endeavor to provide testing for our personnel once a year as allowed by OHP.

7. Staff or volunteers who have tested positive in the past for TB will be counseled when they meet with OPH for pre-work testing. Staff and volunteers who test positive are able to work as long as they are not symptomatic—fever, chills, night sweats or a dry hacking cough. Symptomatic individuals will be asked to leave work and return when asymptomatic and they have had a chest x-ray and a note from their medical provider.

**Referrals**
For further information on this policy or the topic covered by this policy, contact:

Lori Thoemmes, Director
UCSF Alliance Health Project
Box 0884
Phone: 476-3951
Fax: 502-7271
Email: lori.thoemmes@ucsf.edu
Policy on Safety Training
Date: 6/1/00

Purpose: Comply with SFDPH and UCSF requirements
To insure the safety of AHP staff, interns, volunteers, and clients, the Alliance Health Project requires all staff and interns to take an annual safety training.

Policy: Mandatory Safety Training
All AHP career staff and administrative interns will take an annual safety training. This is to be completed within 60 days of the start date of a career position or an administrative internship.

Procedure:
1. Once per year a safety training will be part of the AHP monthly staff meeting. This will satisfy the requirement for most on-going staff. Those in attendance must be sure they have signed all applicable registration sheets in order for their attendance to meet the requirement.

2. New staff/interns are required to attend the morning session of a safety training at San Francisco General Hospital within 60 days of their start date. The documentation received from the Trainer must be turned in to the AHP Staffing Coordinator for the training to be counted as meeting the requirement.

3. It is the responsibility of each staff member, volunteer, or intern to monitor their training. Supervisors of staff and interns will receive monthly reports on compliance.

Referrals:
For further information on this policy or the topic covered by this policy, contact:

Lori Thoemmes, Director
UCSF Alliance Health Project
Box 0884
Phone: 476-3951
Fax: 502-7271
Email: lori.thoemmes@ucsf.edu
AHP Dress Code Policy
Date: 8/8/11

Purpose:
The purpose of this policy is to establish written guidelines governing standards of dress for all AHP employees.

Policy:
All AHP employees shall dress and groom appropriately to project a professional image to the public we serve, within the context of the primary work environment for each employee.

Minimal dress code standards prohibit the wearing of:

1. Beach attire, including swim shorts and beach-type sandals.
2. Strapless or backless shirts
3. Tank tops, halter tops or cropped shirts
4. Casual athletic wear/exercise garments; including sweat pants and baseball caps
5. Torn or frayed garments
6. Walking shorts/Bermuda shorts*  

* Please note the one exception to item #6 is that shorts may be worn by HCAT staff during street fair-type mobile testing events.
I, the undersigned, hereby agree not to divulge any information or records concerning any client/patient without proper authorization in accordance with California Welfare and Institutions Code, Section 5328, et seq.

I recognize that unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code and Title 9, California Administrative Code as follows:

W & I Code, Section 5330: Any person may bring an action against an individual who has willfully and knowingly released confidential information or records concerning the person in violation of the provisions of this chapter, for the greater of the following amounts:

1. Five hundred dollars ($500.00)
2. Three times the amount of actual damages, if any sustained by the plaintiff.

Any person may, in accordance with the provisions of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, bring an action to enjoin the release of confidential information or records in violation of the provisions of this chapter, and may in the same action seek damages as provided in the section.

It is not a prerequisite to an action under this section that the plaintiff suffer or be threatened with actual damages.

Title 9, California Administrative Code, Section 942, Oath of Confidentiality: All officers and employees of the department collecting, maintaining, and utilizing any patient data information in the course of their duties with the department shall sign an oath of confidentiality.

“As a condition of performing my duties as an officer, employee or volunteer of the Department of Health, I agree not to divulge to any unauthorized person any client/patient data obtained from any facility by the Department. I recognize that the unauthorized release of confidential information may make me subject to a civil action under the provisions of the Welfare and Institutions Code, and may result in the termination of any office of employment.”

(please print)

Name: __________________________________________________________

Current address: ___________________________________________________

Permanent address: _____________________________________________

_______________________________________________________________

Signature: ___________________________ Date: ______________________
Policy on Research at AHP
Date: 3/11/96

**Purpose:**
The purpose of this policy is to establish written guidelines governing the review of staff/intern generated research proposals.

**Policy:**
All AHP staff shall follow the following steps when reviewing research proposals.

When a research proposal(s) is submitted to program directors or supervisors they shall, with any member of their program they deem useful, first review the proposal with the following principles in mind.

a. Is the research proposed of good quality and would it generate information that would improve our understanding of services or is it likely to have a significant impact on our program’s future plans?

b. Is the research going to require active involvement of AHP staff (e.g., will staff need to be involved in data collection, distribute forms, etc?)

c. Is the research being proposed by AHP staff/interns or from non-AHP researchers?

d. Is other research currently going on that makes the climate unfavorable for additional activity at this time?

Upon completing their review, Program Directors should discuss the proposal with the Director and then forward to the Executive Director for review. Proposals should come with the Program Director’s opinion as to the worthiness of the proposal. (The above criteria should guide worthiness rating.)

The Executive Director will then review and discuss the research proposal with the Program Director. Final decisions will be communicated to the proposal’s author by the Program Director. Appeal of research decisions will be directed to the Executive Director.
Policy on Media Inquiries
Date: 4/15/13

Purpose:
The purpose of this policy is to establish written guidelines governing the response to media (print, radio, internet, and television) inquiries for all AHP employees.

Policy:
All AHP employees shall direct media (print, radio, internet, and television) inquiries appropriately so as to project a professional image to the public we serve, within the context of the mass media environment.

All media inquiries (print, radio, internet, and television) are to be directed to DK Haas, LGBT Community Liaison. She can be reached at 476-6394 or the inquiry can be referred to Lori Thoemmes or Rob Marks.
Client Grievance Procedure

1. The client should try to resolve any disagreement - including dissatisfaction with any decision, any service or information provided, or allegation of discrimination or mistreatment - directly with the staff member or volunteer. This should be arranged immediately if at all possible. If follow-up is necessary by phone or by an appointment, such follow-up will be done within 14 days.

2. If that does not resolve the situation, the client should ask to speak with the staff member’s or volunteer’s immediate supervisor. This should be arranged immediately if at all possible. If follow-up is necessary by phone or by an appointment, such follow-up will be done within 14 days. Clients should be encouraged to submit a grievance in writing. However, a client may file a formal grievance orally. If filed orally, the agency should summarize the grievance in writing and, if possible, obtain the client’s signature. A copy should be made for the client. The agency will maintain written records of all grievances including the final resolution of each complaint.

3. If this fails to resolve the situation, the client should schedule an appointment with the Alliance Health Project’s program manager, depending on the grievance, for resolution. All appointments will be scheduled within 14 days of a request for a meeting.

4. If this fails to resolve the situation, the client may make an appointment with the Director or Executive Director of Alliance Health Project for a final resolution of the grievance. All appointments will be scheduled within 14 days of a request for a meeting.

5. The resolution of the grievance will be noted in the client’s chart. A client will be provided with copies of documents relevant to his or her grievance to the extent that the documents are not confidential and/or legally protected from disclosure. Clients may be required to pay a reproduction charge for this service but this charge will be waived if financial hardship can be demonstrated and if the quantity to be reproduced is reasonable. Resolutions will be completed within reasonable time frames but no longer than 30 days from the date of receiving a grievance unless there are documented reasons by either the agency or the client.

6. Copies of all grievance communications will be sent to the Executive Director for review. Summary reports of all grievances will be submitted to the appropriate funding agency. Any trends in client dissatisfaction will be noted and tracked as part of quality improvement.

7. Clients who file a grievance will not be denied a service or be retaliated against solely due to their filing.

8. Use of the grievance procedure does not replace any existing avenues of review or redress provided by law.
9. Clients have a right to a representative of their choice, if they wish to have one, at any time during the grievance process to act as an advocate and observer. A representative might be a friend, other client, support person, family member, or formal advocate. An agency staff member may represent a client, if the client chooses, in a grievance process.

10. The identity of the grievant will be kept confidential to the extent possible while enabling the agency to investigate the grievance.

11. Grievances may be filed outside the Alliance Health Project by the client at the following agencies:

   - San Francisco Dept. of Public Health
   - AIDS Office
   - 25 Van Ness Avenue, Suite 500
   - San Francisco, CA 94102
   - (415) 554-9000

   - HIV Consumer Rights Advocate
   - 1540 Market Street, Suite 301
   - San Francisco, CA 94102
   - (415) 863-8131
   - (415) 863-0831 Fax

   - San Francisco Human Rights Commission
   - 25 Van Ness Avenue, Suite 800
   - San Francisco, CA 94102
   - (415) 252-2500

   - HIV Consumer Rights Advocate
   - 1540 Market Street, Suite 301
   - San Francisco, CA 94102
   - (415) 863-8131
   - (415) 863-0831 Fax

   - Patients Rights Advocacy Services
   - 1095 Market St., #618
   - San Francisco, CA 94103
   - (415) 552-8100

   - Office of Civil Rights
   - Health & Human Services
   - 50 UN Plaza, Room 322
   - San Francisco, CA 94102
   - (415) 437-8310
Policy on Working with Clients Requiring Reasonable Accommodation

Date: 6/28/01

**Purpose:**
To assure that all clients receive appropriate services.

**Policy:**
AHP will make necessary accommodations to assure that clients with special needs can receive appropriate services.

**Procedure:**
1. When a client contacts AHP for services, and identifies a special need, he or she will be offered appropriate assistance.

2. AHP Intake staff will assure that the client has appropriate assistance in accessing services. Types of assistance might include: large print materials, audio devices, interpreter assistance.

3. If after intake it is determined that the client needs and would be appropriate for AHP services, the Clinical Coordinator will work with the client to develop an individualized plan for assistance in accessing these services if needed.
Policy on Working with Hearing-Impaired Clients
Date: 5/16/01

Purpose:
To assure that all clients receive appropriate services.

Policy:
AHP will make necessary accommodations to assure that clients with hearing impairments can receive appropriate services.

Procedure:
1. When a hearing-impaired client calls AHP via the California Relay Service to request services, AHP front desk staff will work with the Relay Service to schedule an appointment for the client.

2. When a hearing-impaired client calls AHP via the TTY device to request services, AHP front desk staff will interact with the clients to schedule an appointment for the client.

3. When AHP staff need to call a hearing-impaired client, AHP staff will contact the California Relay Service at 1-800-735-2922 to assist communication during the phone call or if the client has access to a TTY device AHP staff will utilize the client’s TTY number.

4. AHP staff will contact Bay Area Communication at 356-0405 for assistance in scheduling an American Sign Language Interpreter to be present during an appointment with a hearing-impaired client. An AHP purchase order will need to be completed to arrange reimbursement.

5. If after intake it is determined that the client needs and would be appropriate for AHP service, the Clinical Coordinator will develop a plan whereby an American Sign Language interpreter will be present for all subsequent individual or group sessions.
Policy on Working with Visually-Impaired Clients
Date: 6/28/01

Purpose:
To assure that all clients receive appropriate services.

Policy:
AHP will make necessary accommodations to assure that clients with visual impairments can receive appropriate services.

Procedure:
1. When a visually impaired client contacts AHP for services, he or she will be offered appropriate forms and descriptions of services in large print or on audiotape.

2. AHP Intake staff will assure that the client has appropriate assistance in completing necessary paperwork.

3. If after intake it is determined that the client needs and would be appropriate for AHP services, the Clinical Coordinator will work with the client to develop an individualized plan for assistance in accessing these services if needed.
Policy on Assessing Staff Language Proficiency
Date: 1/17/07

**Purpose:**
To assure that all clients receive appropriate services.

**Policy:**
AHP will assess the language proficiency of applicants for reception/greeting level assignments as well as clinical services to assure that clients with language needs can receive appropriate services.

**Procedure:**
1. When an applicant reports language fluency, he/she is required to meet with an AHP staff person who is fluent in that language to assess the applicant’s language proficiency.

2. If there is no AHP staff person who is fluent in that language, the Program Manager will locate another UCSF employee to meet with the applicant for language proficiency assessment.
Policy on Working with Non English Speaking Clients

Date: 6/28/01, Rev. 9/07

Purpose:
To assure that all clients receive appropriate services.

Policy:
AHP will make necessary accommodations to assure that clients with language or speech needs can receive appropriate services.

Procedure:
1. When a non-English speaking client contacts AHP for services, he or she will be offered services in a language of the client’s choice.

2. AHP Intake staff will assure that the client has appropriate assistance in completing necessary paperwork. AHP staff will arrange for interpreter services by a mental health professional or certified interpreter.

3. Clients will be advised that AHP does not permit family members to serve as translators except in emergencies.

4. If after intake it is determined that the client needs and would be appropriate for AHP services, the Clinical Coordinator will work with the client to develop an individualized plan for assistance in accessing these services on an ongoing basis.
Policy on Commitment to Promoting Cultural Competency

Date: 9/07

Purpose:
To ensure that all clients of AHP receive services provided in the most culturally competent manner possible.

Policy:
Considerations of cultural competence will be taken into account at all levels of organizational structure and function. AHP will strive to recruit, retain and promote at all levels a diverse staff and leadership that are representative of the demographic characteristics of the clients we serve. Furthermore, AHP commits to providing ongoing training to continually improve staff and management skills in these areas.

Procedure:
1. AHP will provide annually at least three culturally oriented in-services to staff in all HIV/AIDS mental health contracted programs

2. When job openings occur, specific outreach will be made to recruit diverse staff. As staff are retained, efforts to promote diverse staff into leadership will be identified as one of a range of issues to consider when promoting from within.

3. Discussion of cultural issues will be woven into clinical discussion of clients, supervision of staff and everyday professional life at AHP.
Policy on After Hours Services
Date: 3/1/96

Purpose:
To ensure professional standards and continuity of services for clients of UCSF Alliance Health Project

Policy:
Clinical staff will adhere to agency policy regarding services after hours.

Procedure:
In the event of an emergency in the building after regular business hours, the BOD system will be utilized. When the Services Center phone system has been shut off, the outgoing message on the main telephone line will advise callers on alternate emergency services.

AHP Services Center has fire/intrusion/life safety alarms which are monitored 24 hours a day by UC Police. The system is directly connected to the UCPD dispatch center. AHP Staff emergency contact numbers are maintained at the front desk in an envelope marked "emergency contact numbers".
Policy on Vacation and Leave Coverage

Date: 7/24/95

**Purpose:**
To ensure professional standards and continuity of services for clients of UCSF Alliance Health Project.

**Policy:**
Clinical staff will follow agency policy in informing the front desk and immediate supervisor regarding sick days and vacation time.

**Procedure:**
1. Staff are expected to plan according to clinical needs for scheduled time away.

2. If a staff member is ill or has an unplanned absence, front desk staff and supervisors will attempt to contact any scheduled appointments to inform them of the cancellation.

3. If staff are unable to contact a client prior to arrival for an appointment, the BOD will determine client need and either refer client to the crisis team or facilitate re-scheduling the appointment with the absent staff member.
Policy on Staff Orientation
Date: 1/12/05

Purpose:
To ensure all staff have a thorough and clear understanding of AHP Policies and Procedures.

Policy:
All AHP employees will be provided an orientation to AHP Policies and Procedures upon signing in as an employee with the AHP Staffing Coordinator. Policy and Procedures changes or revisions will be communicated to all staff via staff meeting discussions and electronically via e-mail. The Policy and Procedures manual is accessible to all staff via a shared folder maintained by the building manager on an organizational server.

Procedure:
1. All new hires will meet with the staff coordinator on their first day of employment to sign in. Sign-in includes reviewing and signing the following forms and policies:

   - UC Photo ID
   - Affirmative Action Data
   - I-9
   - Withholding Form (W-4)
   - Pay Disposition
   - Resume Supplement
   - State Oath of Allegiance
   - Workers Comp Physician Designation
   - AHP Code of Conduct
   - AHP Oath of Confidentiality
   - AHP Dress Code
   - AHP Telephone Use Policy
   - Languages Spoken
   - Benefits Designation Form
   - Job description Card
   - LPPI Personal Information & Confidentiality
   - LPPI Child/Dependent Adult Abuse Reporting
   - LPPI Property Loss
   - LPPI Electronic and Software Policy Statement
   - LPPI Substance Abuse Policy

   Review of the following AHP & UCSF Polices:
   - TB Policy and handout
   - Benefits packet
   - Time sheet & leave request
   - UCSF Substance Abuse Policy
   - AHP & UCSF Policies on Sexual Harassment
   - AHP Scent/Fragrance Policy
   - UCSF New Hire Orientation and Benefits Schedule

2. All staff will attend monthly staff meetings and all clinical staff will attend monthly in-service training.

3. New policies will be reviewed with all staff at monthly All Staff Meeting and made available in online Policy and Procedure manual.
AHP Computer Use Policy and Guidelines
Date: 6/05, Rev. 3/11

These are the procedures and guidelines governing the use of computers and the network that links them at the UCSF Alliance Health Project (AHP). They are based on:

- Federal law:
  Health Information Portability Accountability Act of 1996 (HIPAA)
  Digital Millennium Copyright Act
- State law:
  SB1386
- University of California, Office of the President Policy IS-3

The intent of these guidelines is to maintain network security, ensure privacy of electronic Protected Health Information (ePHI), enhance the stability of the network, and maximize the performance and longevity of our workstations. Each of these aspects is crucial to our work: our clients need to know that their information is protected in order to entrust us with their disclosures and, in this time of dwindling resources, AHP needs to do everything possible to minimize disruptions that would require MIS staff time to remedy.

Our work involves private client health information, private staff and volunteer information, and confidential agency knowledge. Each of us is responsible for maintaining the security of this information and securing his or her workstation.

Federal and state laws dictate severe penalties for failure to follow these procedures. Potential consequences include fines up to $250,000; imprisonment for a term of up to 10 years; and UCSF corrective and disciplinary action up to and including dismissal.

GUIDELINE:

The first point, and a very significant one, is that computer equipment belongs to AHP. Computers have become one of our most important tools at work and it is easy to begin thinking of your AHP computer as your own. However, all computer equipment is the property of AHP and any material stored on that equipment becomes the property of AHP (this includes email messages, documents, and internet downloads) and the University.

Your office workstation is a resource intended for appropriate work-related usage. It is not intended for personal use or entertainment. If you believe you need to add non-AHP provided software or hardware to your computer in order to perform your job, please contact MIS staff.
AHP staff who work from home, must take the same steps to protect ePHI as would be taken at the office. Virus protection software must be installed on your home computer if used for AHP work. MIS staff will provide that virus software. AHP staff working at home must also:

• Keep virus software up to date.
• Run Sophos virus sweep weekly
• Report any suspicious virus or web-related incident to MIS staff.

PROCEDURE:

The following items are designed to protect and secure AHP data.

Network Login/Passwords

• Information access is limited to those who have a valid password.
• Passwords must be 8 characters or more and use a combination of numbers and letters.
• DO NOT use a word in the English dictionary, a name, a place, a birthday, a phone number or a social security number as a password. Examples of good passwords:
  - BYOB#222  (abbreviations are good)
  - 2+2=four  (numbers and symbols are good)
  - U2Rsisters
  - LuvU4ever
  - 2charle$  (instead of using the name charles only)

• DO NOT share passwords.
• DO NOT sign on to multiple computer stations. Sign out of computer stations as you leave them.
• Contact your Manager, Information Services (MIS) immediately if you suspect a password has been compromised (an unauthorized person knows your password and may be using your account & password to access the network, internet, or email).
• Passwords expire at regular intervals, such as every six or every three months depending on the system or application. Users will be notified by MIS staff when passwords are due to expire.
• Mac users will change their passwords at least once a year unless otherwise instructed by MIS staff.

Audits & Monitoring of Network Login

Data security requires that sign-in identity and computer user be the same. DO NOT allow anyone to use a computer under your sign-in identity. HIPAA and UCOP both forbid the sharing of user accounts.

AHP staff has access to various types of electronic protected health information (ePHI) based on their job requirements. To ensure that only authorized staff is accessing specific data resources, **AHP MIS staff will monitor and audit Windows user account log in patterns.**
Internet Downloads

Software may not be downloaded onto your computer from the internet or from any other source (CD, discs, etc.) UNDER ANY CIRCUMSTANCES. This includes but is not limited to: games, screensavers, programs, demo software, video clips, animation, etc. If you believe you need a non-AHP provided software to perform work-related tasks, contact MIS staff. There are several reasons for this rule:

- Computer viruses are often contained in internet downloads.
- Computer viruses can lead to data loss.
- Downloads may contain Spyware that collects information about the user, the workstation and the network. This is a violation of AHP network security. It also slows down your computer and the entire AHP network.
- Limited storage space on both workstations and the server.

Computer Viruses

There is a tremendous risk of AHP computer virus infection (which will then spread to the entire UCSF system) through internet downloads and email attachments. AHP takes the following steps to prevent computer virus infections:

- SOPHOS Anti-Virus Software: Each computer needs to be scanned once a week. Each Windows User is responsible for setting the appropriate SOPHOS configuration and running it on their assigned computer. Macintosh anti-virus scans are done weekly by appointed MIS Work Group (MISWG) staff members.
- SPYBOT Anti-Spyware Software for PCs: PC users need to scan their computer once a week with this anti-spyware software.
- SYGATE Firewall for PCs: Personal firewall software is installed on each PC.

PC users must take extreme caution before downloading e-mail attachments. Permitted attachments are doc, xls, pdf and jpg files; others file extensions often indicate viruses and MIS staff should be consulted prior to downloading. Email from unknown sources should be deleted immediately without opening.

Email

Limit of Email to Non-Personal Use

Email sent from AHP uses the UCSF Exchange Server using a variety of programs: Entourage, Outlook and UCSF Webmail. Accessing non-UCSF email services puts AHP hardware at risk. Please do not access your personal email without your supervisor’s approval.

Email Maintenance

Detailed email maintenance requirements and instruction are contained in the PC and Macintosh User Instructions that MIS staff will distribute to each user as appropriate. Failure to follow these instructions will result in your email system locking up and may cause data loss.

Email and ePHI

Please see AHP’s Email & ePHI policy for information on sending Protected Health Information via email.
External Media

- Do not plug USB, iPods or other devices into an AHP computer unless approved by your AHP supervisor.
- Use of floppies or ZIP disks to transfer information to AHP computers is discouraged due to the potential for virus infection. If this is the only data transfer option then staff is required to scan the floppy in the a: drive prior to transferring data onto their AHP computer.
- CDROM: No CDs or DVDs are allowed. Exceptions are work-related CDs that have been cleared by MIS staff in advance (such as UCSF Ergonomics CD) and commercially produced CDs.
- Personal Desktop Assistants (PDA): PDA use needs to be approved in advance by AHP Management and MIS Staff. All PDA software must be installed by MIS staff onto AHP computers. Only PDAs interfaced exclusively to AHP computers are permitted. The PDAs must have their wireless networking functionality (if available) disabled. This guards against viruses and hacking methods designed for PDAs that can infiltrate the AHP network.

Please remember that the intent of these guidelines is to maintain network security, ensure privacy of ePHI, enhance the stability of the network, and maximize the performance and longevity of our workstations. Each of these aspects is crucial to our work: our clients need to know that their information is protected in order to entrust us with their disclosures and, in this time of dwindling resources, AHP needs to do everything possible to minimize disruptions that would require MIS staff time to remedy.
Email and ePHI Policy

Date: 3/1/11, Rev. 9/24/14

Purpose:
To ensure the privacy of electronic Protected Health Information (ePHI) transmitted via electronic mail (e-mail).

Definitions:
Protected Health Information (PHI): An individual’s health information protected under the Federal Health Insurance Privacy and Accountability Act (HIPAA). This includes medical, mental health and substance information with identifiers that could possibly link an individual to that medical information. Examples of the identifiers include name, address, age, date of birth, phone numbers, email addresses, social security numbers, account numbers, medical record numbers, driver’s license numbers, or voice or image records.

Background:
Because of the dual relationship that UCSF Alliance Health Project (AHP) has with University of California San Francisco (UCSF) and the San Francisco Department of Public Health (SFDPH), privacy issues are complicated. UCSF provides AHP with infrastructure including email and email safety. In turn, AHP is a contract agency of SFDPH and is required to uphold the privacy guidelines put forth by SFDPH. Therefore, AHP is required to protect the privacy and security of PHI under University policies and SFDPH policies as well as State and Federal law.

UCSF has established a way to ensure that email containing ePHI is protected. Emails sent from one UCSF email address to another UCSF email address are transmitted in a protected environment and are not encrypted.

Policy:
1. Communication of PHI via email will conform to UCSF and SFDPH privacy policies and AHP notice of HIPAA privacy practices.
2. Emails containing PHI sent from a UCSF email address to an email address outside of the UCSF email system other than the client must be sent securely.
3. Emails from a UCSF email address to a client must be sent securely unless the client requests that they be sent unencrypted. If the client wants unencrypted email communication, please discuss this with the Medical Director.

Procedure:
1. Do not share your email user ID and password with anyone.
2. Do not use personal email systems (e.g., Gmail, Yahoo) to transmit PHI.
3. Ensure that a valid release of information is on record for the intended recipients other than the client themselves. If the recipient is the client, ensure that the client agrees to
communication via secure email. If a client requests unencrypted email communication, discuss these situations with the Medical Director.

4. Limit the release of PHI to the minimum necessary for the intended purpose.

5. Begin the subject line with any of the following trigger words, followed by a colon: “Secure:”, “ePHI:”, or “PHI:”. The trigger words are not case sensitive and a space following the colon is optional. Refer to UCSF’s Secure Email Tutorial for additional information: http://it.ucsf.edu/services/secure-email/tutorial/how-secure-email-works.

6. Do not include PHI in the subject line

7. Include a confidentiality message footer such as:

**CONFIDENTIALITY NOTICE** This e-mail communication and any attachments are for the sole use of the intended recipient and may contain information that is confidential and privileged under state and federal privacy laws. If you received this e-mail in error, be aware that any unauthorized use, disclosure, copying, or distribution is strictly prohibited. If you received this e-mail in error, please contact the sender immediately and destroy/delete all copies of this message.

Other Considerations

1. SFDPH email addresses end in “dph.org” and are external to the UCSF email system. Therefore emails containing PHI sent from UCSF to SFDPH must be sent securely.

2. When replying to emails with PHI make sure to change the Subject Line to begin with a trigger word.

3. Best practice is to secure all emails containing PHI regardless of recipient (e.g., UCSF or non-UCSF)

What to Expect as a Sender

1. You will receive an email notification confirming that your message has been sent securely. It will include the following details:
   a. Recipient Addressee(s);
   b. Subject line text excluding the trigger word;
   c. Attachments (if any);
   d. Sent date and time

2. Once your recipient has retrieved the email on UCSF Secure Messenger, you will receive an email notification indicating the time and date that the message was retrieved along with the details listed above.

3. You will also be able to track the activity of your secure message in an account that has been automatically created for you on UCSF Secure Messenger.
   a. Follow the URL contained in the notification
   b. Sign in specifying your own email address and current Network (Active Directory) password
   c. Select ‘Sent Items’ under MESSAGES to review status of your sent mail.

4. If you inadvertently send the message to an external recipient via secure email, you can recall the message via UCSF Secure Messenger.
Policy on Scents and Fragrances
Date: 5/3/01

Purpose:
The provision of an atmosphere free of sources of irritation to staff and clients with allergy or immune system difficulties is of the highest priority to the Alliance Health Project.

Policy:
AHP staff are required, and clients are encouraged to avoid the use or wearing of scents, perfumes, fragrances and similar substances while they are within AHP premises.

Procedure:
1. All AHP staff are to be made familiar with AHP policies upon initial hiring. In addition, these policies will be discussed from time to time at staff meetings and other similar occasions.

2. Signs describing this policy, and asking for client cooperation in adhering to this policy will be posted in all meeting rooms at AHP Services Center.

Referrals:
Lori Thoemmes is the primary source for information about AHP’s implementation of the Scent and Fragrance Policy. If an employee feels uncomfortable approaching her for information, he or she may contact any AHP supervisor with whom he or she feels comfortable.

For further information on this policy or the topic covered by this policy, contact:

Lori Thoemmes: 476-3951
Policy on Conflicts of Interest
Among AHP Staff
Date: 6/9/08

Purpose:
To prevent actual and perceived inappropriate relationships among staff.

Policy:
AHP staff shall not engage in relationships when they pose actual or perceived conflicts of interest.

Procedure:
1. AHP managers and supervisors shall strive to preserve their impartial and professional evaluation of supervisees.

2. While AHP supports the development of friendly social relationships among co-workers, managers and supervisors, all staff shall strive to avoid actions or decisions that could allow for the development of actual or perceived conflicts of interest.

3. AHP managers and supervisors shall not ask staff or interns to perform non-agency related tasks whether or not financial remuneration is involved or mutual agreement among parties is present. Dual relationships (including outside consults, partnerships, nepotism, etc.) with supervisees that might impair the supervisor’s objectivity and professional judgment shall be avoided.

4. Existing or potential conflicts of interest or questions about a potential conflict of interest shall be communicated to immediate supervisors or the Director.

5. Action will be taken when there is an actual conflict of interest or when there may be a reasonable perception of a conflict. These actions will be open, accountable and properly documented at the Management Team level while respecting the confidentiality of the information disclosed.

6. This policy has been developed in line with and to supplement existing UCSF guidelines, state law, federal regulation, and UC policies.
Policy on Tobacco Use
Date: 3/31/09

Purpose:
The University of California, San Francisco AHP has adopted a smoke-free environment policy in order to minimize health risk, improve the quality of air, and enhance the work place environment.

Further, as tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit and given that effective treatments do exist, AHP clients who use tobacco should be offered assistance to help them quit.

Policy:
To provide a smoke-free environment for its staff, clients, and visitors, AHP shall be a smoke-free facility. Smoking is prohibited inside of AHP and within 20 feet of all entrances. This policy applies to all staff, clients and visitors to AHP.

Additionally, it shall be the policy of AHP to identify and provide all clients who use tobacco with the opportunity to receive information regarding the adverse health consequences of smoking and to receive counseling and support to help them quit.

Procedures:
1. All staff, students, patients and visitors must observe this smoke-free policy. Supervisors are responsible for enforcing this policy in their respective areas, and for addressing problems through the existing administrative structure.

2. "No smoking" signs will be posted and maintained in public areas by the AHP services center facilities manager or designee.

3. Clinicians will consistently identify and document tobacco use upon initial intake/assessment for all clients presenting for clinical services at AHP. Additionally clients receiving clinical services at AHP will be asked as part of ongoing assessment regarding tobacco usage.

4. Clients reporting tobacco use will be assessed for readiness to change with respect to reducing or stopping tobacco use and will be offered information/referral and/or support to help them make and maintain their desired changes.
Policy on Staff Licenses/Certification

Date: 6/15/14

Purpose:
The purpose of this policy is to establish written guidelines to describe AHP’s procedures for monitoring staff licenses/certification to ensure professional client services.

Policy:
All licensed clinical staff are responsible for ensuring that their license/certification is current according to the regulations of the appropriate governing agency.

Procedure:
1. Clinical staff required to be licensed or to have specific certification shall be responsible for the following:
   a) Providing a copy of the current California license or certificate to the Operations Coordinator and front desk staff following each renewal.
   b) Acquiring and providing the professional licensing or certifying agency the necessary continuing education credits for license or certification maintenance.
   c) The immediate notification of their supervisor in the event of license revocation or restriction.

2. Twice a year, the AHP Director will verify that staff required to be licensed or to have specific certification are in compliance with this policy.

3. In addition, AHP shall ensure the following:
   a) No professional clinical employee is performing duties requiring unrestricted licensure or certification during periods of non-licensure, suspension, restriction, or awaiting certification.
   b) Evidence of professional license status is maintained either in confidential personnel files or is available for review when necessary.
   c) Written notice is provided to employees who do not provide proof of license renewal/re-certification by the time it is due, that failure to renew on time may result in not meeting conditions of continued employment.

4. If employees have not received their new license by the expiration date of their current license, one of the following must be presented to their supervisor:
   a) Copy of the Cashier’s Check or Certified Check made payable to appropriate licensing authority with a registered return mail receipt from the licensing board.
   b) Evidence of license renewal/re-certification application receipt from appropriate licensing authority.
c) Employees who do not have a valid license or verification of renewal by the expiration date will be considered to be out of compliance with the UCSF staff position to which they were hired.

5. Enforcement:

It is the responsibility of the employee's supervisor to notify the Behavioral Health Services (BHS) Manager when it appears that an employee will not be able to produce evidence of a valid license by the first of the next month following the expiration date. The supervisor shall take the employee off clinical client care duties upon knowledge of license expiration. The BHS Manager will report the employee to the AHP Director and UCSF Human Resources for further action as described in their hiring agreement.

Where the employee is a member of medical staff, the appropriate procedures for suspension of privileges and possible termination of appointment in accordance with due process under Title 22, CCR and California law shall be followed. Reporting of such actions shall be made to the Medical Board of California according to the Business and Professions Code, Section 805.
Purpose:
Ebola is a type of Viral Hemorrhagic Fever causing viral illness symptoms progressing to multisystem failure and death in >70% of cases. The most recent outbreak has originated in West Africa and efforts now are being made to contain the spread of this illness.

Policy:
Everyone at the AHP Services Center will be screened for Ebola. Individuals that may have Ebola will be isolated and emergency services will be activated to manage the situation.

Procedure:

Ask – Mask – Isolate – Communicate

Self-screening flyers for Ebola will be posted in the lobby and at the front desk of the Services Center. These flyers screen for people having symptoms of Ebola and a risk for exposure to someone with Ebola. This flyer will direct affected individuals to identify themselves to staff.

Staff will not have physical contact with an individual who identifies as having screened-in for Ebola. Staff will attempt to maintain a three feet distance from the identified individual.

For individuals who self screen-in and notify staff in the lobby of their possible infection, staff will direct that person to a Crisis room and close the door. The person will be told to open the desk drawer and don a mask for the protection of others.

For individuals who self screen-in and notify staff in a treatment room of their possible infection, staff will leave the treatment room and close the door. The OD and Medical Director will be notified immediately.

All staff and clients present in the building at the time will be asked to cooperate with collection of contact information. Staff will collect the names, addresses, phone numbers and approximate distance from the affected individual of all staff and clients and then they will be asked to leave the building. No one will be allowed to enter the Services Center except as directed by the OD or Medical Director.

Senior staff with assistance of others will call 9-911 to initiate emergency services for assistance in managing the situation including arranging for care for the affected individual and decontamination of the building. Staff will not clean any possibly contaminated items. A specialized team will address the decontamination of the building at a later date.
IV.
SERVICES CENTER
PROGRAM
DESCRIPTIONS
The UCSF Alliance Health Project’s Behavioral Health Services (BHS) provide integrated outpatient mental health and substance use counseling for the LGBTQ and HIV-affected communities in San Francisco. These LGBTQ-affirming services include:

- Weekly and bi-weekly individual psychotherapy and couples counseling.
- Ongoing and time-limited therapy groups for persons living with HIV and LGBTQ-identified persons living with serious mental illness.
- Weekly peer-facilitated support groups for persons living with HIV.
- The only HIV-related mental health crisis program in San Francisco.
- Triage and assessment services for new and returning clients.
- Psychiatric evaluation, treatment and medication monitoring.
- Neuropsychological testing and other services for clients with HIV-related cognitive concerns.
- A wide range of substance use counseling services for LGBTQ persons and those living with HIV/AIDS or struggling to avoid infection.
- Case management services for patients at SFGH Ward 86.
- Two substance use support groups in the community. Both groups address the importance of a Harm Reduction approach to service access.
- A clinical training program for graduate students in psychology or social work who receive comprehensive clinical training in a community mental health clinic setting.

AHP’s Behavioral Health Services Program has integrated several innovative approaches into its individual counseling programs. These innovations include brief psychotherapy and a groundbreaking model for training therapists to offer this approach and, through our Considering Work Program, individual and group counseling to persons living with HIV or a disabling mental illness who are interested in returning to work, school, or other gainful activity.

With funding from two federal grants, BHS has addressed the impact of substance use on HIV risk among African American and Latino men who have sex with men. Both programs were developed to include mental health and HIV prevention services in the provision of substance use counseling and case management.

Our support groups for the LGBTQ and HIV-affected communities include Strong & Proud, Queer Women’s Disability & Chronic Illness Group, a Transgender Support Group, and a New Positives Support Group.
The HIV Counseling and Testing (HCAT) team provides confidential HIV screening, results, and linkage in San Francisco. HCAT also provides sexually transmitted infection (STI) screening and treatment for oral and rectal chlamydia and gonorrhea, detecting a significant number of asymptomatic cases. This STI screening and treatment service was the first of its kind in California and helps to reduce the overall burden of STIs in our community while significantly reducing the risk of HIV transmission among these clients.

AHP developed the first HIV counseling and testing program in the country and for more than 25 years, HCAT has collaborated with the San Francisco Department of Public Health HIV Prevention Section to conduct various HIV/STD related studies. Through this research partnership, HCAT is currently providing RNA screening and the use of multi-rapid HIV test screening.

HCAT provides HIV testing at our AHP Services Center (1930 Market Street) and at various locations throughout San Francisco. These Mobile Sites are at community events, street fairs, health fairs and at selected locations that are social ‘hubs’ for the community.

HCAT provides short-term follow up services to clients given an HIV-positive test result to assure they successfully access appropriate medical and psychosocial care. Linkage staff ensure that these clients are connected to the medical, social and psychological support they need. Linkage staff also assist these clients in identifying and notifying any current and past partners of their risk for HIV as well.
V.
PROGRAM SPECIFIC POLICIES & PROCEDURES
a. Program Mission and Philosophy Statement(s)

This document describes the policies and procedures for the University of California, San Francisco (UCSF) Alliance Health Project (AHP) Alcohol and Other Drug Program (AOD) at 1930 Market Street in San Francisco. These AOD program policies and procedures have been developed to comply with the Standards for Drug Treatment Programs (Drug Standards); DMC Certification Standards for Substance Abuse Clinics; and Title 22, California Code of Regulations (CCR), Section 51341.1; as well as other applicable laws and regulations and complement the policies contained in the UCSF Alliance Health Project Policies and Procedures Manual.

Founded in 1984 as the AIDS Health Project, AHP is the leading provider of HIV-related behavioral health care in San Francisco. In this capacity, AHP has pioneered many of the mental health interventions used to serve people with HIV and those seeking to remain uninfected. AHP is also a leading developer of HIV-related publications and training programs for people working with HIV.

In 2010, consistent with AHP’s strategic plan and a request from the San Francisco Department of Public Health (SFDPH), AHP assumed responsibility for much of the city’s outpatient mental health care for lesbian, gay, bisexual, transgender, queer (LGBTQ) clients. To reflect this change, and fulfill a long-term interest to assist the uninsured and underinsured LGBTQ community with their behavioral health needs, the AIDS Health Project became the Alliance Health Project.

AHP’s mission is to support the behavioral health and wellness of the LGBTQ and HIV-affected community in constructing healthy and meaningful lives.

AHP’s AOD program activities are guided by the following agency values:

- **Client-centered.** We focus on the individual needs of each person seeking our services
- **Strength-based.** We help individuals maximize their existing capacities to undertake the challenges they identify
- **Health and wellness enhancing.** We work toward an individual’s vision of a healthy and meaningful life
- **Culturally competent.** We constantly develop our capacities to match the growing diversity of the populations we serve; and we recognize that individuals, as the experts in their own lives, have much to teach us about their cultures.

b. Program Description

The AHP AOD program is an outpatient service that provides a supportive environment for people seeking to address the impact of substance use on their ability to create meaningful and constructive lives. AHP’s AOD program offers group and individual counseling services.
c. Program Objectives

The goal of the AHP AOD Program is to provide outpatient services that support program participants in achieving an alcohol and drug free lifestyle, thus reducing the negative consequences associated with alcohol and drug abuse on their lives.

1. **By the end of the fiscal year, 50% of clients will decrease substance use and HIV-related risk behaviors (needle sharing and unsafe sexual practices) by 25% within three months of enrollment, as documented by client self-report in a survey instrument.**

   **Evaluation**

   This outcome will be accomplished by (1) establishing a sound clinical treatment plan between the Case Manager and the client: and (2) Developing and administering a risk behavior survey tool. The client file will be reviewed quarterly by the Case Manager and the AOD Program Coordinator. The client data will be reviewed and analyzed by the Program Manager and the to incorporate results into the program design. A report summarizing the results will be prepared by the Program Manager.

2. **By the end of the fiscal year, 33% of clients enrolled in the program for at least three months will be linked to services as agreed upon in the treatment plan including, but not limited to: appropriate mental health services, substance abuse treatment, housing services, medical care, etc.**

   **Evaluation**

   Linkage to psychiatric intervention/treatment will be facilitated by the Case Manager and documented in the client record subsequent to the client beginning treatment. This will be reviewed quarterly by the Case Manager and the AOD Program Coordinator.

3. **By the end of fiscal year, no more than 15% of unduplicated clients will be lost to follow-up. A client lost to follow-up is defined as one who the provider has been unable to contact or locate after several attempts. This definition does not include clients who decline services in favor of others, relocate outside of the service area, or are deceased.**

   **Evaluation**

   Active outreach is an integral part of the AOD Program. The case manager, in consultation with the Clinical Supervisor, will document all missed appointments, subsequent contacts and attempts to locate the client.

d. Program Evaluation Plan

1. **Analysis of data:** Client data is entered into the CalOMS database and the AVATAR electronic record and billing system maintained by SFDPH. Each quarter, quality
assurance will be conducted by the AOD Program Manager. Client charts are reviewed using a standard protocol to evaluate data related to treatment, such as, TPOC, service type, length of treatment, referrals, progress in treatment up to discharge, drug screening incidents and results, continuing recovery, and treatment exit plans.

2. Relationship between objectives and evaluation techniques: Successful completion of objectives will be measured by service data – units of service (UOS) and unduplicated clients (UDC) are recorded in the client database and presented on monthly invoices. Client Satisfaction Survey forms are used to measure levels of client satisfaction.

3. Techniques utilized to measure activities. Weekly individual staff supervision, monthly staff meeting, and case conferences are utilized in addressing overall concerns regarding delivery of services to clients or for exploring challenging clinical issues in working with clients. An outcome evaluation tool will document that AOD Program clients have been successfully treated.

4. Responsible staff: All clinical staff provide ongoing feedback on the strengths and weaknesses of each service modality and help develop plans for program enhancement as needed.
1. Admission and Readmission

AHP’s AOD Program will provide outpatient drug free treatment services directed at stabilizing and rehabilitating persons (beneficiaries) with substance abuse diagnoses. Acceptable diagnoses are all of the diagnoses listed in the substance abuse section of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV).

The primary beneficiaries of treatment services will be individuals who are actively involved in alcohol and drug abuse and who are experiencing the negative consequences associated with alcohol and drug abuse. Significant Others of beneficiaries may be involved in the treatment process through collateral services. Any non-collateral service that is provided to individuals without a DSM IV diagnosis will not be billed through DMC. During the intake process, an assessment will be conducted to determine eligibility for admission to services.

a) The primary criterion for admission to the program shall be involvement with alcohol and/or drugs, or problems related to alcohol and/or drug use, including family members or significant others of individuals who are abusing chemicals.

b) Drugs of abuse may include substances such as alcohol, methamphetamine, marijuana, prescription medication, cocaine, crack, heroin, PCP, and any unlawful use of sedatives, stimulants, and inhalants.

c) Statement of Nondiscrimination: Admission shall not be denied on the basis of race, color, religion, sex, sexual orientation, gender, age, national origin, inability to pay, or disability. The above shall not preclude services for special programs or funding for specific populations such as the Treatment Access Program (TAP), Behavioral Health Court and the Community Justice Center (CJC).

d) All participants shall be deemed by the assessing clinician and the physician to be physically and mentally capable of assuming full responsibility for their own decisions and actions in relation to recovery from alcohol and/or drug misuse.

e) Client referrals are accepted from individuals, family, friends, community agencies and professionals, including physicians, therapists, courts, schools, probation officers, or CPS workers. Referrals for individuals under the age of eighteen (18) years of age will be referred to San Francisco Community Behavioral Health Services (CBHS) for connection to treatment by the Children, Family and Youth Services Division.

f) Participation in the program shall be voluntary. Beneficiaries must be willing to participate in all aspects of the program and abide by all rules and regulations.

g) Readmission: If an individual seeks readmission within six months of an initial admission a brief intake questionnaire may be utilized; beyond six months, the new admission intake procedure shall be followed. An exception to this would be if there were unusual
circumstances surrounding the person's prior treatment episode discharge, e.g. an involuntary discharge due to dangerous or threatening behavior while in treatment or discharged due to need for a more intensive treatment program (i.e. residential treatment or inpatient hospitalization).

h) All individuals who are deemed not eligible for services will receive referrals to agencies or programs that may better meet their needs. Individuals in need of detoxification or residential services will be referred to the CBHS Treatment Access Program (TAP).

2. Intake and Assessment

a) An initial interview will be scheduled to determine if an individual meets criteria for admission. Persons not meeting criteria for admission will be referred to the most appropriate agency or program.

b) Prescription and over-the-counter drugs are permitted when taken in standard dosage and/or according to a physician’s prescription. Clients taking prescription medication must report this information as part of the intake process. A release of information form will be obtained from the client so that staff may communicate with the prescribing MD and document the prescription medication in the client’s medical records chart.

c) Upon determination of eligibility for services, the assessing clinician will complete a full client assessment and intake packet including all applicable consents and other administrative paperwork, and provide the individual with a general orientation to treatment. The intake and orientation process includes, but is not limited to, completing forms including personal, financial, educational, vocational, and medical information. The intake also will require the completion of the Substance Abuse Treatment Standards Intake/Assessment of Need (SRD01) which includes a detailed substance abuse history of the individual applying for services. The Addiction Severity Index (ASI) screening tool will be used to help in diagnosing the individual and determining treatment needs. Appropriate releases of information or requests for information will be completed at intake and necessary signatures will be obtained. The individual will be informed of client rights (fair hearings), confidentiality and privacy practices, program rules and regulations, available treatment modalities, and the expected length of treatment. The individual will sign a consent for treatment form and all intake documents will be placed in a medical records chart with the individual's name and unique client identification number on the outside of the chart. Additionally, client data will be entered into the CalOMS database and the AVATAR electronic record and billing system maintained by CBHS.

d) All client paper records will be kept in the locked medical records room which meets HIPAA standards.

e) At a minimum, the following information will be gathered at intake:
Social, economic and family background;
Education
Vocational achievements;
Criminal history, legal status;
Medical history;
Drug history;
Previous Treatment episodes;
Information gathered to determine if participant is appropriate for admission;
Date and type of admission (e.g., new, readmission, etc.);
Referral source and reason for referral
Admission agreement;
Health questionnaire;
Authorization to release information;
Permission to Follow Up and
Participant rights document.

f) Upon completion of this process and the signing of the consent form, the client shall be admitted to treatment.

g) Intake times may vary based on clinical staff availability. Appointments may be on a walk-in basis or by scheduled appointment time. If scheduled appointments are required, these will be handled by front desk staff.

h) The clinical coordinator will review and make case assignments based on intake materials.

3. Treatment Care of Plan

Each client will have an individually written Treatment Plan of Care (TPOC) within the first 30 days of their access to services based upon the information that the AOD counselor obtains during the intake and assessment processes. The TPOC will be in writing completed in the electronic database with a paper copy in the hard chart, and will be reviewed by the clinical coordinator to assure that plan of care is reflected in a measurable, quantifiable and time specific manner. Treatment plans will identify targeted behavioral changes and will include clinical interventions, service access model and contingency plans to address difficulties with treatment adherence. Treatment plans will also be reviewed to assess the need for updates, revisions, or, as a way to establish a discharge plan. All staff has weekly clinical supervision, team meetings and clinical rounds. Treatment plans will be specifically reviewed during weekly clinical supervision at the time of client assignment, 30 days from clients’ access to services and on a quarterly basis. Supervisors will document the review of all treatment plans in the client’s file and document any follow-up needed.

A signed TPOC will become part of the client’s hard copy client file. A copy of the TPOC will also be given to the client. At a minimum, the treatment plan will include the following:
• Statement of problems to be addressed in treatment;
• Statement of measurable goals to be reached which address those problems;
• Action steps which will be taken by program and/or client to accomplish goals; and
• Target dates for accomplishment of action steps, goals, and when possible, resolution of problems.
• A copy of the Program Admission Agreement including the Follow Up Agreement: Consent for follow-up is reviewed with clients at time of referral and consent is included in the program agreement.

The following policy and procedure will be followed by all AOD counselors when developing a treatment plan:

POLICY
A clear, understandable and mutually agreed upon plan of care is an important part of assuring that clients are successful in attaining their treatment goals. All assigned clients will have an individualized written Treatment Plan of Care (TPOC) within the first 30 days of their access to services, which will be developed based upon the information obtained in the intake and assessment process.

PURPOSE
To provide the counselor and client with a mutually agreed upon plan of care that identifies targeted behavioral changes and which will include clinical interventions, service access model and contingency plans to address treatment adherence difficulties.

PROCEDURE
The initial treatment plan will include:
• A statement of problems to be addressed,
• Goals to be reached which address each problem,
• Action steps which will be taken by the counselor/client to accomplish identified goals,
• Target dates for the accomplishment of action steps and goals,
• A description of the services, including modalities, to be provided and the frequency thereof; and
• The assignment of a primary counselor.
• The counselor will ensure that the initial treatment plan meets the following requirements:
  1. The counselor will complete and sign the treatment plan within thirty (30) calendar days of the admission to treatment date.
  2. The physician will review for medical necessity, approve, and sign the treatment plan within fifteen (15) calendar days of the signature by the counselor
  3. The client's signature is obtained, signifying that the client participated in the treatment planning process and was agreeable to the goals and action steps set forth.
  4. The counselor will ensure that the treatment plan is reviewed and updated as described below:
     • The counselor will review and sign the updated treatment plan no later than ninety (90) calendar days after signing the initial treatment plan, and no later than every
ninety (90) calendar days thereafter, or when a change in problem identification or focus of treatment occurs, whichever comes first.

- Within fifteen (15) calendar days of signature by the counselor/client, the physician will review for medical necessity, approve, and sign all updated treatment plans. (If the physician has not prescribed medication, a licensed psychologist can review, approve and sign all updated treatment plans in lieu of a physician signature.)
- The AHP AOD physician will determine the medical necessity of continued treatment at AHP every six months by reviewing treatment plans completed every 90 days after the first treatment plan, including reassessment and justification included in treatment plans every 180 days.

4. Discharge

Any changes in the status of a client’s participation in the program is reviewed by the clinical coordinator and a plan of care will be clearly articulated and documented in the client’s file.

a) Discharge protocol: Length of access to services is established early in the treatment planning stages of engagement and will be revised at 30 days, 90 days and yearly of date of initial acceptance to the program.

b) Voluntary discharge is defined as mutually agreed upon termination from services. Voluntary discharge will occur when agreed upon treatment goals have been reached. Clients may also decide to terminate services without consulting with staff.

c) Transfers and referrals: Any client who is discharged as a result of relocation to another county or referral to another treatment facility for continuing AOD treatment.

d) A discharge summary will be documented in client’s file by program staff within one week of discharge from the program. At a minimum, the AHP AOD discharge summary will include:

1. description of treatment episode;
2. current drug usage;
3. vocational/educational achievements
4. reason for discharge;
5. clients' discharge plan; and
6. any referrals made while client was in the program

e) Involuntary discharge is defined as termination from services that has not been mutually agreed upon by program staff and client and before treatment plan goals have been reached.

1. Involuntary discharge may occur when a client does not follow-up with program staff as agreed. This may include not keeping initial or regularly scheduled appointments or not attending initial counseling session.
2. If client no shows for two consecutive weeks and has not contacted staff regarding same, a call will be placed advising client of next available appointment.

3. If client no shows for that appointment, client will be discharged.

4. A letter will be sent documenting discharge plan and process for re-engaging in services.

5. Staff will consult with the Clinical Coordinator as needed.

4. Individual and Group Sessions

AHP’s AOD Program will provide outpatient drug free treatment services directed at stabilizing and rehabilitating persons with substance abuse diagnoses. Individuals in need of day treatment, detoxification, or residential care are referred to other community providers.

Individual and group sessions shall be directed toward concepts of withdrawal, recovery, an alcohol and drug free lifestyle, relapse prevention and familiarization with related community recovery resources. Emphasis shall be placed on the recovery continuum appropriate to participants' needs.

Individual sessions shall provide face-to-face discussion between a participant and a counselor/program specialist on issues identified in the participant's recovery or treatment plan.

Group sessions shall provide face-to-face contact in which one or more counselors/program specialists provide discussion with two or more participants, focusing on the needs of participants served.

The counselor/program specialist documents sessions, by signing their name and putting the date and the following information of participant’s attendance at individual and group sessions. This documentation is then placed in the participant's file:

a) Date of each session attended;
b) Type of session (i.e., individual or group);
c) Progress toward achieving the participant’s recovery or treatment plan goals for each individual or group session attended.
d) The progress notes shall include one or more of the following:
   1. Participant’s progress towards one or more goals in the participant’s recovery or treatment plan;
   2. New issues or problems that affect the participant’s recovery or treatment plan; or
   3. Types of support provided by the program or other appropriate health care providers.

Each client receiving outpatient services will be seen weekly or more often, depending on his/her need and treatment plan. At a minimum, all clients shall receive two counseling sessions (group or individual) per 30-day period or be subject to discharge.
Exceptions to the above frequency of services may be made for individual clients where it is determined by program staff that fewer contacts are clinically appropriate and that progress toward treatment goals is being maintained. Such exceptions shall be noted in the case file.

a) Type of Services

The need for the following minimum services shall be assessed and, when needed, shall be provided directly or by referral to an ancillary service. These services include, but are not limited to:

1. Education opportunity;
2. Vocational counseling and training;
3. Job referral and placement;
4. Legal services;
5. Medical services, dental services;
6. Social/recreational services; and
7. Individual and group sessions for participants, spouses, parents and other significant people.

To the maximum extent possible, programs shall provide and utilize community resources and document referrals in participant files.

5. Alumni involvement

The AHP AOD program does not include activities for alumni.

6. Use of Volunteers

AHP expands its ability to provide AOD program services with a Clinical Traineeship Program. Each year, AHP selects 14 trainees for an internship with a weekly commitment of 20 to 22 hours, for a term of 11 months from mid-August to the middle of the following July. The application procedures are posted annually on our website for all interested parties to apply. The traineeship is open to PsyD, PhD, MFT and MSW applicants. Clinical trainees are accepted from a variety of schools and disciplines and are selected by the PsyD and LMFT clinicians who coordinate the program through a formal job interview process.

The AHP Clinical Traineeship Program started nearly 20 years ago and consists of components such as Orientation, Client Caseload, Group Supervision, Didactic Trainings by a cadre of mental health professionals, including UCSF faculty psychiatrists, psychologists, LCSWs, and MFTs, many of whom are members of the LGBTQ community.

The Traineeship Program Orientation takes place in August from 9:00 AM to 3:00 PM every Tuesday and Thursday over the course of three weeks. Trainees start the 20- to 22-hour per week traineeship program the week of September 1. Orientation includes elements such as, agency
overview, HIV and LGBTQ-related psychosocial issues, documentation requirements, cultural humility, time-limited dynamic psychotherapy, substance abuse treatment, harm reduction, care management of severe mental illness.

In September, trainees receive therapy client assignments, begin conducting intakes, and meet with their individual supervisors. Most trainees carry a caseload of six to eight clients and some will have the opportunity to co-facilitate a group.

Trainees are required to attend two hours per week of group supervision and one hour per week of individual supervision from an AHP licensed mental health professional. Trainees follow all UCSF employee procedures, as well as city, federal and state laws. Clinical trainees complete an employment application, as well as read and sign the State Oath of Allegiance, AHP Code of Conduct and Oath of Confidentiality; and review AHP, AHP AOD, and UCSF policies on performance evaluation, substance abuse, tuberculosis, sexual harassment, computer use, and protection of ePHI and HIPAA compliance.

AHP follows universal precautions to protect clients and staff from the spread of infectious disease. All staff and volunteers must complete an annual health and safety training. There is signage and policy in place regarding hand washing and using a mask if coughing/sneezing.

All staff and volunteers receive annual TB testing and results are placed in personnel files. Providers are trained in the spread of tuberculosis and other infectious diseases and follow the tuberculosis and other infectious disease protocols established by the SFDPH and UCSF.

7. Recreational Activities

N/A

8. Detoxification Services, if applicable

N/A

9. Program Administration

The Alliance Health Project (AHP) is a program of the University of California, San Francisco, Department of Psychiatry at San Francisco General Hospital (SFGH) and is governed by the policies and procedures of the University of California, San Francisco (UCSF). The governing board of UCSF is the Board of Regents of the University of California. Their bylaws, member information, contact information, meeting schedule (once per month or more) and minutes are available to the public at: http://regents.universityofcalifornia.edu/about/.

AHP currently has contracts with the SFDPH to provide mental health and substance abuse services to residents of the City and County of San Francisco. As such, AHP and its programs follow all applicable UCSF, SFDPH and State of California policies and procedures. UCSF
policies can be found at http://httpppolicies.ucsf.edu/. SFDPH policies for mental health and substance abuse providers are at: http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSmnuPolyProc.asp

The Executive Director of AHP is James W. Dilley, MD, a Clinical Professor of Psychiatry at UCSF and the Vice-Chair and Chief of the UCSF Department of Psychiatry at SFGH. Dr. Dilley has been AHP’s executive director since 1984. Dr. Dilley has ultimate responsibility for overall agency operations. However, final determination of what AHP can and cannot do remains with the University.

The AHP Executive Committee is the final decision-making body of the agency and is comprised of the Executive Director and the Director. Their decision making is informed by weekly meetings with the Management Team, comprised of the managers of the five units that constitute AHP: AIDS and Substance Abuse Program (ASAP) Counseling and Case Management Services; HIV Counseling and Testing Services; Fiscal and Administrative Services; Publications and Training; Psychiatry, Assessment, Crisis and Triage Services; and Psychosocial Support and Prevention Services. Further information about the Management Team can be found at: http://www.ucsf-ahp.org/about_ahp/who_we_are/.

Founded in 1984 as the AIDS Health Project, AHP is one of the primary providers of HIV-related behavioral health care in San Francisco. In this capacity, AHP has pioneered many of the mental health interventions used to serve people with HIV and those seeking to remain uninfected. AHP is also a leading developer of HIV-related publications and training programs for people working with HIV. In 2010, consistent with AHP’s strategic plan and a request from the San Francisco Department of Public Health (SFDPH), AHP assumed responsibility for much of the city’s outpatient mental health care for LGBTQ clients. To reflect this change, and fulfill a long-term interest to serve the uninsured and underinsured LGBTQ community with their mental health needs, the AIDS Health Project became the Alliance Health Project.

The mission of AHP is to support the mental health and wellness of the LGBTQ and HIV-affected communities in constructing healthy and meaningful lives. AHP began providing substance abuse treatment services in 1984 when clinicians first recognized the relationship between substance abuse and HIV transmission.

The Community Advisory Board (CAB) was established in 1986 to help AHP achieve its mission. Board members assist in that goal by increasing the recognition of the accomplishments and mission of AHP in the LGBTQ and HIV-affected care-giving and receiving communities; raising funds in support of the activities of AHP; and as representatives of the community, advising AHP as to the growth, development and implementation of substance abuse and mental health programs. The CAB consists of 10 to 15 members from various backgrounds and professions that are reflective of the communities of substance abuse and mental health providers, agency clients and donors that AHP serves. The CAB meets the second Thursday of even months and the public is invited to attend and participate. Further information about individual CAB members is at www.ucsf-ahp.org/about_ahp/who_we_are/.
Information, data or recommendations emanating from the CAB, AHP ad-hoc committees, clients, family and public feedback shall be provided to and be used by the Management Team for the purpose of reviewing, improving and recommending change in the delivery of AOD program services.

10. Personnel Practices

UCSF Human Resources provides AHP’s recruitment, employer-employee relations, salary administration, employee classification, and processing of employee status changes in coordination with the agency Director and the Manager, Fiscal and Administrative Services. The UCSF payroll office serves as the office of record for hiring documents and is charged with monitoring and enforcing compliance with applicable local, federal and state laws. UCSF Human Resources policies are at: http://ucsfhr.ucsf.edu/index.php/policies/cat/site/Campus%20Policies/

AHP maintains personnel files on all AOD program volunteers and employees. Among other elements, these personnel files contain:

a) Application for employment and resume;
b) Employment confirmation statement;
c) Job description;
d) Salary schedule and salary adjustment information;
e) Employee evaluations;
f) Health records including a health screening report or health questionnaire, and tuberculosis test results as required; and
g) Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries).

The AHP AOD program maintains and revises, as needed, job descriptions for each employee and volunteer. The Director approves the job descriptions ad revisions. Among other elements, the job descriptions include:

a) Position title and classification;
b) Duties and responsibilities;
c) Lines of supervision; and
d) Education, training, work experience and other qualifications for the position.

11. Participant Grievances/Complaints

A statement of Grievance Procedures; (See Policy Below)
POLICY

Each client of AHP’s AOD programs has the right to file a grievance. The original signed grievance form will be placed in the client's chart and the client will be given a copy of the procedure.

The AHP Grievance Procedure is as follows:

a. Work with your current counselor to resolve issues/concerns. If no resolution, go to “b”.
b. The counselor will arrange a meeting with the supervisor of the client’s AOD counselor. If no resolution, go to “c”.
c. The counselor or client will arrange a meeting with the manager of the AOD program. If no resolution, go to “d”.
d. The manager will arrange a meeting with the AHP Director. If no resolution, go to “e”.
e. The client may contact the California Department of Social Services, Public Inquiry and Response at 1-800-952-5253.

The grievance procedure is available in English and Spanish.

12. Fiscal Practices

The AHP Fiscal and Administrative Services Unit is responsible for direction and supervision of administrative and financial aspects of contracts and grants compliance, as well as purchasing, accounts payable and accounts receivable functions for the agency. AHP’s Fiscal and Administrative Services Unit interfaces with the SFGH Department of Psychiatry, Division of Administration and Finance to ensure compliance with all UCSF procedures, as well as federal, state and local regulations.

UCSF campus administrative policies at http://policies.ucsf.edu/, 300 series, Fiscal Policies, govern all financial activities, including cash, billing, ledger, cost allocation, accounts receivable, purchasing authority, reimbursement. The 350 Series, Audit, includes policies for internal controls and external audits.

A copy of AHP’s statement regarding client fees is given to each client admitted to the AHP AOD program and it is also posted in the lobby of the AHP Services Center.

AHP Statement Regarding Client Fees: If you are on Medi-Cal, your services are paid in full every month. We can bill your insurance company if you bring in claim forms. Others will be charged a fee for services based on ability to pay.

As a contractor with the SFDPH, AHP is required to follow all policies found at: www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSmnuPolyProc.asp, including 2.03-10, 12/13/11, Fee Policy for Substance Abuse Treatment.
13. Continuous Quality Management

The following policy has been established for continuous quality management of the AHP AOD program.

AHP’s Alcohol and Other Drug (AOD) Programs will follow the policies and procedures set forth for Utilization Review, Program Evaluation, and Quality Assurance. At a minimum, AHP’s AOD program will ensure that the following occurs:

1. Continuity of Care
   a. A treatment plan is developed at the earliest practical time after admission, not to exceed 30 days. This activity is monitored by the counselor, supervisor/manager and the Program Utilization Review and Quality Committee (PURQC) that meets every two weeks for chart review. Program Assistants (PA) utilize a chart check-off list in which they monitor and check each time an item or form for the chart has been completed.
   b. The services required are provided and documented in the client record. This activity is monitored by the counselor, supervisor/manager, and the PURQC that meets weekly for chart review. PAs utilize a chart check-off list in which they monitor and check each time an item or form for the chart has been completed.
   c. Failure of the client to keep scheduled appointments is discussed with the client and other action taken as appropriate. The PURQC monitors progress notes in their weekly meeting to assure that the counselor is following up with each client appropriately. Program Assistant prints out a monthly report which reflects client no shows per individual counselor and clients who have not had any contact in 30 days. Counselors are required to make contact with clients who no show on the same day of the missed appointment to engage them in the treatment process.
   d. Client progress in achieving the goals and objectives identified in the treatment plan is assessed and documented on a continuous basis. All treatment plans are reviewed and signed by the Medical Director, Client, Supervisor, and the Counselor. At the time of signing the treatment plan, the Supervisor reviews the progress notes to assure that treatment is geared toward the goals and objectives identified in the TCOP. Counselors will be asked to rewrite any treatment plan that appears to be inaccurate for the problems identified by the client.
   e. AHP’s AOD program has a reminder system for each TPOC due date (90 days from the initial treatment plan date). Counselors are provided with a printout of all TPOC due dates at least two weeks prior to the expiration of the due date.
   f. Continuing services are based on the physician's determination of medical necessity, no sooner than five (5) months and no later than six (6) months from the clients' admission or the date of completion of the most recent justification for continuing services.
g. The client's record contains all required documents (correspondence, authorization to release information, and consent for treatment). Inclusion of these documents will be monitored by the counselor, supervisor/manager and the PURQC at weekly chart review meetings.

h. All AOD clients are followed up by the AOD program within 30 days after discharge. AOD clients sign an agreement at the time of admission stating how they wish to be contacted for appointments, cancellations, or discharge follow up. If the client is agreeable, a standard letter is sent out that inquires how they are doing and encourages them to contact AHP. Clients who state they would prefer telephone contact will be called by program staff.

14. Participant rights

Client Rights

1. At the time of intake, all clients are provided with a document which includes the following:
   a. A statement of nondiscrimination;
   b. A statement of Client Rights;
   c. A statement of Grievance Procedures;
   d. A statement of the Appeal Process for Discharge;
   e. A statement of the AHP AOD Program Rules and Regulations;
   f. A statement regarding Client Fees;
   g. A statement of Access to Treatment Files in accordance with Executive Order #B-22/76. This document will be explained to each client admitted to the AHP AOD program and it shall also be posted in a prominent place which is accessible and visible to clients in the lobby of the AHP Services Center. (See Client Rights & Program Rules/Expectations below).
   h. Confidentiality: See Client Rights & Program Rules/Expectations below.
   i. Consent to Treatment: See Client Rights & Program Rules/Expectations below.

CLIENT RIGHTS

AHP approaches each AOD services participant with a commitment to support and protect each individual's fundamental human, civil, constitutional and statutory rights. In order to insure that these rights are protected and that the dignity of each individual is recognized and respected, AHP staff exercise the following procedures.

I. Procedure

During the Intake Assessment Counselors will:
A. Assess each participant's fee for services according to the Client Fee Determination Statement and the AHP Alcohol and Drug Services Participant Fee Schedule

B. Describe the program activities which will be required for program completion.

C. Describe the participant's statutory rights to confidentiality; and

D. Review Client rights that include the Grievance Procedure. Participant rights in either English or Spanish, depending upon the individual's preference, are given to the client by the staff upon admission to the program. The client reads the rights and is asked if he/she understands them. If necessary, the staff member explains each right until the client responds positively and then documents in the intake record that the client understands his/her rights. The client retains a copy. A copy is posted in the lobby of our offices.

**CLIENT RIGHTS AND RESPONSIBILITIES**

As a client of the UCSF Alliance Health Project, you have the right to:

- Confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2
- Be treated with respect and dignity by all staff and volunteers.
- A safe, healthful and comfortable accommodations to meet your needs
- To be free from verbal, emotional, physical abuse and/or sexual behavior
- Know in advance that all services are provided free of charge, with the exception of some social events.
- Be advised in advance of the nature of the services with which you will be provided.
- Receive quality care without discrimination as to race, color, age, gender, sexual orientation, disability status, homelessness, religion, national origin, or economic status.
- Refuse or terminate services.
- Be informed within a reasonable time of anticipated termination of services.
- Expect that all information related to your care will be treated confidentially.
- Voice grievances without being subject to discrimination or reprisal.

**CLIENT RESPONSIBILITIES**

As a client of the UCSF Alliance Health Project, you have the responsibility to:

- Provide the agency with demographic and other important information about yourself necessary to begin services, including required consents for services and residency statements.
- Cooperate with agency staff and volunteers in the delivery of your services.
- Treat agency staff, volunteers, and other clients with respect and consideration.
• Notify the agency when you are unable to keep appointments by calling your counselor directly or the AHP Services Center main number at (415) 476-3902.

_______________________________
Client Name

_______________________________
Client Signature

______________________
Date

A copy of the client rights and responsibilities shall be provided to the client at admission. The original signed client rights and responsibilities document will be placed in the client file.

15. Non-Discrimination in Provision of Employment and Services

POLICY

As a division of the University of California, San Francisco, AHP, in compliance with Titles VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and the Civil Rights Act of 1991, does not discriminate on the basis of race, color, national origin, religion, sex, ability to pay, physical or mental disability, or age in any of its policies, procedures, or practices; nor does the University, in compliance with Section 402 of the Vietnam Era Veterans Readjustment Act of 1974, and Section 12940 of the State of California Government Code, discriminate against any employees or applicants for employment because they are disabled veterans or veterans of the Vietnam era, or because of their medical condition (as defined in Section 12926 of the California Government Code), their ancestry, or their marital status; nor does the University discriminate on the basis of citizenship, within the limits imposed by law or University policy; nor does the University discriminate on the basis of sexual orientation or gender identity; nor does the University discriminate against vendors seeking business with the University. This nondiscrimination policy covers admission, access, and treatment in University programs and activities, and application for and treatment in University employment.

PURPOSE

To ensure that AHP services do not discriminate on the basis of race, color, creed, national origin, sex, age, sexual orientation, gender, ability to pay, or physical or mental disability. AHP will not deny an otherwise eligible individual any service or provide a benefit, which is different or provided in a different manner or at a different time, from that provided to others under its AOD contract. AHP will not subject any individual to segregation or separate treatment in any matter related to the receipt of any service; restrict an otherwise eligible individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit;
and/or treating any individual differently from others in determining whether such individual satisfied any admission, enrollment, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service or benefit.

**PROCEDURE**

At any time, California State Department of Health Care Services staff may access and monitor AHP's AOD programs and facilities to ensure that clients and intended beneficiaries are provided services without regard to race, color, creed, national origin, sex, ability to pay, sexual orientation, or age and also to monitor that services are provided without regard to physical or mental disability. AHP will ensure that all clients and intended beneficiaries of service are informed of their rights including their right to file a complaint alleging discrimination or a violation of their civil rights. AHP will ensure that AOD program participants are provided a copy of their rights which include the right of appeal and the right to be free from sexual harassment and sexual contact by members of the treatment, recovery, advisory, or consultant staff. Additionally, these rights and the right of appeal will be posted in the AHP Services Center lobby.

**16 Confidentiality**

I, the undersigned, hereby agree not to divulge any information or records concerning any client/patient without proper authorization in accordance with Title 42, Code of Federal Regulations, Part 2 and California Health and Safety Code, Sections 11812(c) and 11977.

I recognize that unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code and Title 9, California Administrative Code as follows:

W & I Code, Section 5330: Any person may bring an action against an individual who has willfully and knowingly released confidential information or records concerning the person in violation of the provisions of this chapter, for the greater of the following amounts:

(1) Five hundred dollars ($500.00)
(2) Three times the amount of actual damages, if any sustained by the plaintiff.

Any person may, in accordance with the provisions of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, bring an action to enjoin the release of confidential information or records in violation of the provisions of this chapter, and may in the same action seek damages as provided in the section.

It is not a prerequisite to an action under this section that the plaintiff suffer or be threatened with actual damages.
Title 9, California Administrative Code, Section 942, Oath of Confidentiality: All officers and employees of the department collecting, maintaining, and utilizing any patient data information in the course of their duties with the department shall sign an oath of confidentiality.

“As a condition of performing my duties as an officer, employee or volunteer of the Department of Health, I agree not to divulge to any unauthorized person any client/patient data obtained from any facility by the Department. I recognize that the unauthorized release of confidential information may make me subject to a civil action under the provisions of the Welfare and Institutions Code, and may result in the termination of any office of employment.”

(please print)

Name: ______________________________________________________________________

Current address: ______________________________________________________________________

Permanent address: ______________________________________________________________________

Signature: ___________________ Date: __________

17. Community relations

A written description of AHP’s AOD services and admission criteria and procedures is provided to program applicants, to the general public, and to cooperating referral sources. These referral sources include emergency room personnel, law enforcement agencies, and self-help groups such as Alcoholics Anonymous. Continuing efforts are made to guarantee coordination and cooperation with other service providers and enhance relations with neighbors through a good neighbor policy.

Because of its reputation for providing excellent behavioral health services and its 30 years of service, AHP is well known in the behavioral health service communities. As such, client word of mouth and provider referral are two important community outreach methods. AHP maintains and enhances referrals through coordination with providers and offering drop in services. We also promote our services through a quarterly publication distributed to over 2,500 clients and behavioral health community providers. AHP also conduct outreach through visits and trainings to community providers.

AHP staff routinely maintain consultative relationships with providers such as Peter Claver, Catholic Charities, Health at Home, Maitri, and Coming Home/VNH. During consultation, clinicians may advise program staff on behavioral interventions focused on maintaining clients in their current setting. AHP staff can recommend appropriate mental health and substance abuse services and can facilitate appointments with other AHP programs. Other sources of referral are providers working within the county jails and behavioral health courts, as well as population-specific treatment programs, including the Latino Commission, Instituto Familiar de la Raza and UCSF Men of Color Program.
In addition, AHP regularly refers clients to such programs as: Ward 86, Visiting Nurses and Hospice, Peter Claver Community, and a variety of substance abuse treatment programs. Relationships with these agencies and programs have already been established by way of memorandums of understanding that are frequently used for client service referrals.

18. Maintenance of Program in a Clean, Safe and Sanitary Physical Environment

The AHP Services Center will be under the management of the Community Health Program Coordinator/Operations. To ensure that the AHP Services Center complies with all applicable local, state and federal laws and regulations:

• The AHP Services Center will be cleaned and sanitized daily by the Vanguard Cleaning Services five nights a week (Monday-Friday).
• The Community Health Program Coordinator/Operations will be responsible for checking the client bulletin board in the waiting room to ensure that all required notices are posted and up to date. The Community Health Program Coordinator/Operations is also required to contact the Fire Department and obtain annual fire clearances.
• As an SFDPH contractor, the AHP Services Center has a Bloodborne Pathogen (BBP) Exposure Control plan as defined in the California Code of Regulations, Title 8, Sect. 5193, Bloodborne Pathogens (http://www.dir.ca.gov/title8/5193.html), and must demonstrate compliance with all requirements including, but not limited to, exposure determination, training, immunization, use of personal protective equipment and safe needle devices, maintenance of a sharps injury log, post-exposure medical evaluations, and record keeping.
• As an SFDPH contractor, AHP is responsible for correcting all known site hazards, the proper use of equipment located at the site, the health and safety of employees and all other persons who work at or visit the job site as per local and/or state regulations.
• The AHP Management Team meets on a weekly basis (with no meeting in the third week of the month) to review, assess, and correct overall agency matters and safety issues at the AHP Services Center.
• All employees are required to sign a Code of Conduct which prohibits the use of any non-prescription psychoactive substances while on duty at the Alliance Health Project.
• AHP site specific policies and procedures are developed, implemented, revised as needed, and reviewed annually by the AHP Director and with input from the Management Team and the Community Health Program Coordinator/Operations. These policies are developed in compliance with all applicable UCSF, SFGH, city/county and state guidelines.
• Clients and staff at the AHP Services Center are required to follow AHP’s policies on Clients Demonstrating Inappropriate Behaviors, Clients Demonstrating Intoxicated Behavior, and Policy on Weapons. The purpose of those policies is to maintain the safety of all staff and clients.
19. Use of Prescribed Medications by Participants

**Policy Statement**
Prescription drug use is permitted when taken according to a prescribing provider’s prescription. Clients will report their prescription medication as part of the intake process. Prescription medication information will be documented in the client’s medical records chart. If necessary, a release of information form will be obtained from the client so that staff may communicate with the prescribing provider.

20. Maintenance and Disposal of Participant Files

1. Establishment, Control and Location of Records
   a. A case file (client record) is opened for each client admitted to AHP’s AOD program.
   b. All active medical records are stored in the medical records room under the “rule of three,” meaning that each medical record can only be accessed if one has keys to three different locks (front door, medical record room door, and file cabinet lock). Inactive charts are also stored according to the rule of three, though due to space limitations all are not necessarily in the medical records room. The medical records room is kept locked at all times; AHP staff have access to the Medical Records area during regular business hours. Chart cabinets remain unlocked during business hours and keys to these are maintained by the Community Health Program Coordinator/Operations and the Program Managers.
   c. Information released from records will only be released in accordance with 42 CFR, Part 2 regulations.

2. Contents of Records
   At a minimum, all client records will contain the following:
   a. Demographic and Identifying Data:
      • Client identifier (name, number, etc.)
      • Date of birth,
      • sex,
      • race/ethnic background,
      • address,
      • telephone number,
      • next of kin, or emergency contact number
      • consent to treatment;
      • referral source and reason for referral,
      • date of admission; and
      • type of admission (i.e., new, etc.)
b. Intake Data

All data gathered during intake shall be placed in the client's record:

- Social, economic and family background,
- Education and vocational achievements,
- Criminal history, legal status,
- Medical history,
- Drug history; and
- Previous treatment episodes.

Other Information Required:

i. All client services (individual, collateral, crisis, group, intake, assessment, treatment and discharge planning) should be documented in the client chart in the progress note section. Progress notes should follow the PIRP (Presenting Problem, Intervention/Assessment, Response and Plan) and should correspond to one or more of the goals/problem areas noted on the treatment plan. Progress notes must be dated and signed by the AOD counselor. All client related contacts such as telephone contacts, referrals, home visits, correspondence, and no shows will be documented in the client chart.

ii. All chart documentation will be subject to quality assurance procedures to ensure that services occur within appropriate time frames and that all required documentation is contained in the record.

iii. When a client has left, completed, or dropped out of treatment, a discharge summary must be completed which reflects the client's progress in treatment up to the date of discharge. For clients completing treatment, an exit plan should be part of the discharge plan which reflects the client's individual plan to assist him/her in remaining clean and sober.

iv. All progress notes contained in the client record should clearly state the client’s progress toward reaching goals.

Other requirements:

i. Progress notes are maintained within the AVATAR and ARIES systems.

ii. All entries will be signed and dated.

iii. All significant information pertaining to a client will be included in the client's electronic record. AOD counselors will follow the standard format established for electronic chart entries. Counselors can access their client charts by following medical records procedures for checking out charts.

The following policy and procedure has been established for client/chart confidentiality and counselor requirements for checking out a chart:
POLICY

All information and records obtained in the course of providing client services shall be confidential. (California Welfare & Institutions Code Section 5328) All client records are kept under separate lock and key with limited access, according to confidentiality guidelines found in the W & I Code. (California Welfare & Institutions Code Section 5328). Clients have a right to confidentiality as provided for in Title 42, Sections 2.1 through 2.67-1, Code of Federal Regulations.

PROCEDURE

All staff will be conscious of client privacy and will not discuss any client related business when in the common areas of the clinic (hallway, copier room, medical records, and reception area).

AHP Alcohol and other Drug Programs:

A. All active medical records are stored in the medical records room under the “rule of three,” meaning that each medical record can only be accessed if one has keys to three different locks (front door, medical records room door, and file cabinet lock). No unauthorized person will be allowed to enter the Medical Records room.

1. The medical records room is kept locked at all times; AHP staff have access to the Medical Records area during regular business hours. Chart cabinets are locked during hours when the facility is closed and keys to these are maintained by the Community Health Program Coordinator/Operations and the Program Managers.

2. Charts are pulled for clients who will be seen by AHP psychiatrists and nurses. First, a photocopy is made of the next day’s appointments from the following books: CPSAS, Case Management, Psychiatrist, and NPs; then, the books are returned to CPSAS as soon as possible. After all charts have been pulled, the photocopied appointment sheets are stored in the CPSAS appointment book at the front desk for the next day.

3. The evening backup Program Assistant (PA) pulls charts for the following work day’s appointments. The daytime backup PA re-files the charts that were pulled the day before and does so as early in the day as possible.

4. Charts pulled for the following day’s appointment are secured in a locked cabinet located in the Medical Records room overnight. The following day, the morning PA brings these to the front desk for the psychiatrist and nurses to pick up.

5. “Out” cards located in the medical records room are used as placeholders for the charts pulled for the following day’s appointments. PAs indicate on the card both the client’s and the provider’s name, as well as the date the chart was pulled.

6. Each night, the PA returns any charts from the front desk to the medical records room to be re-filed. These are secured in a locked cabinet pending re-filing by the backup PA of the day the following morning.
Disposal and Maintenance of Record:

- AHP will store AOD closed client records under triple lock for a period of not less than four years from the date they were officially closed.

21. Drug Screening

When drug screening by urinalysis is deemed appropriate and necessary by the Manager/Supervisor, or Medical Director, the following policy and procedure will be followed:

Policy
Drug testing at AHP will be used as a therapeutic adjunct to existing outpatient treatment and services.

Purpose
Drug testing is not viewed as treatment, but rather as a treatment process to help individuals in their efforts to maintain a drug-free lifestyle. Staff will ensure that clients and other agencies understand that drug testing is one of several tools used in treatment and that the testing procedure and the results (positive or negative) do not meet the established standards for any type of legal or punitive action.

Procedure
The following will be the protocol for therapeutic drug testing of clients served by the AOD Program at AHP.

Protocol
Prior to drug testing, staff will establish whether the client is currently taking prescribed or over-the-counter medication. If the client is taking prescribed medication, a release of information will be obtained from the client at intake so that staff may communicate with the prescribing MD and document any prescription medication in the client's medical records chart.

Testing will be done on a random basis when:
- There is therapeutic justification for doing so
- When staff is concerned about compliance to program requirements
- To assist in breaking through denial
- At any other time that staff feel is necessary to enhance treatment.

Procedures:
- Test kits will be kept in a locked filing cabinet and be requested from office staff when needed.
- Tests will be self-administered and un-observed. This is an issue of trust and is considered part of the therapeutic process
- Gloves will be available if the client requests them.
The client will be asked to go into the single use restroom on the ground floor of the AHP Services Center and provide a urine sample.
When the urine sample has been provided, the client will place the sample on the bathroom counter and notify staff that they are ready to test.
Staff will accompany the client into the bathroom where the client will perform the test by dipping the stick into the sample.
The counselor will document the results in the progress note.
When the test is complete, the client will empty the remaining sample into the toilet and throw the container and test strip into the garbage can.
The counselor will document test results in the client's chart. If the test was positive, the client will work with staff on relapse prevention issues.

Please note the method of testing may change based on the type of test kit the program orders, e.g. it could be saliva test strips which would change the testing protocol.


CODE OF CONDUCT

1. Staff shall not use any non-prescription psychoactive substances while on duty at the Alliance Health Project (AHP).

2. Relationships between Staff and clients shall remain purely professional in nature. No money should ever be exchanged. Contact with clients outside the agency should be avoided unless considered a therapeutic intervention such as a home visit. Most specifically, contact that leads to an exchange of goods and services shall be prohibited as this can confuse the therapeutic relationship and be easily misunderstood.

3. No staff shall (1) make any comments to a client, (2) engage in physical contact with a client, or (3) engage in any conduct before a client, that could be interpreted as physically threatening or sexual in intent.

4. Staff shall adhere to the UCSF Policy on Sexual Harassment. According to the Policy issued in September 1994, sexual harassment in any form will not be tolerated. Supervisors are expected to represent the university's policy by creating a harassment-free environment, and by responding appropriately to complaints.

5. Staff shall adhere to the UCSF Non-Discrimination Policy that states, in part, that it is the policy of the University not to engage in discrimination against or harassment of any person employed by or seeking employment with the University of California on the basis of race, color, national origin, religion, sex, gender, gender expression, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), genetic information (including family medical history), ancestry, marital status, age, sexual orientation, citizenship, or service in the uniformed services. This policy is intended to be consistent with the provisions of applicable state and federal laws and University policies.

6. Staff shall not enter into agreements that constitute a conflict of interest. This includes, but is
not limited to, referrals of AHP clients to AHP staff in private practice, private practice training or consultation contracts if the original contact was made through AHP, and granting of agency contracts, such as consulting agreements or paid employment, to any individual who in accepting such offers personally benefits the grantor.

7. Shall adhere to the Oath of Confidentiality which stipulates that the undersigned, hereby agrees not to divulge any information or records concerning any client/patient without proper authorization in accordance with California Welfare and Institutions Code, Section 5328, et seq.

8. Staff are expected to be knowledgeable of child/elder/spouse and domestic partner abuse reporting laws and agree to follow appropriate reporting procedures.

I have read and understand the above AHP Code of Conduct and agree to its provisions. I also understand that failure to comply with these standards constitutes serious misconduct and may result in dismissal from AHP.

_______________________________  _______________________________
Staff Name                               Witness Name

_______________________________  _______________________________
Staff Signature                        Witness Signature

_______________________________  _______________________________
Date                                  Date
UCSF Alliance Health Project
Mental Health Medi-Cal
Operations Manual
Program Mission and Philosophy Statement(s)

This document describes the policies and procedures for the University of California, San Francisco (UCSF) Alliance Health Project (AHP) Mental Health Medi-Cal services at 1930 Market Street in San Francisco.

Founded in 1984 as the AIDS Health Project, AHP has been a leading provider of HIV-related behavioral health care in San Francisco. In this capacity, AHP pioneered many of the mental health interventions used to serve people with HIV and those seeking to remain uninfected. AHP is also a leading developer of HIV-related publications and training programs for people working with HIV.

In 2010, consistent with AHP’s strategic plan and a request from the San Francisco Department of Public Health (SFDPH), AHP assumed responsibility for much of the city’s outpatient mental health care for lesbian, gay, bisexual, transgender, queer (LGBTQ) clients. To reflect this change, and fulfill a long-term interest to assist the uninsured and underinsured LGBTQ community with their behavioral health needs, the AIDS Health Project became the Alliance Health Project.

AHP’s mission is to support the behavioral health and wellness of the LGBTQ and HIV-affected community in constructing healthy and meaningful lives.

AHP’s services are guided by the following agency values:

- **Client-centered.** We focus on the individual needs of each person seeking our services.
- **Strength-based.** We help individuals maximize their existing capacities to undertake the challenges they identify.
- **Health and wellness enhancing.** We work toward an individual’s vision of a healthy and meaningful life.
- **Culturally competent.** We constantly develop our capacities to match the growing diversity of the populations we serve; and we recognize that individuals, as the experts in their own lives, have much to teach us about their cultures.

Program Description

The goal of AHP’s Integrated Full-Service Outpatient mental health program is twofold: first, to prevent the need for acute hospitalization and psychiatric emergency services (PES) by providing comprehensive psychosocial and psychiatric services at the AHP and, second, to improve patients' quality of life by appropriately diagnosing and treating the psychiatric disorders and meeting the behavioral health needs of LGBT and HIV+ clients seeking services.
The program has a history of providing specialized and culturally sensitive behavioral health treatment to HIV/AIDS clients resulting in a reduction of acute hospitalization and decreased usage of psychiatric emergency services groups.

Target Population

AHP’s IFSO mental health program serves people who identify as LGBT and/or persons with AIDS/HIV disease or disabling HIV disease who reside in the city of San Francisco, have Medi-Cal, and are low-income. Adult LGBT and HIV/AIDS patients who have been identified and referred by the San Francisco Mental Health Plan (SFMHP) or access AHP’s Behavioral Health Services based on the SFMHP admission criteria will be served by AHP’s Behavioral Health Services program. These patients have been determined and authorized by the SFMHP Access System to be able to benefit from intakes/assessment, neuropsychological testing, case management/brokerage, individual counseling/psychotherapy, psychiatric assessment/consultation, and/or medication monitoring.

Program Objectives

All objectives, and descriptions of how objectives will be measured, are contained in the CBHS document entitled CBHS Performance Objectives FY 14-15.

1. Methodologies:
   A. Program Outreach, Recruitment, Promotion, and Referrals

       Because of its reputation for providing excellent behavioral health services and its longevity in the community, AHP is well known in the HIV service and behavioral health service communities. As such, client word of mouth and provider referral are two important client outreach methods. AHP maintains and enhances referrals through coordination with providers and offering drop in services. We also promote our services through a quarterly publication distributed to over 2,500 clients and conduct outreach through visits/trainings to community providers.

       AHP staff routinely maintains consultative relationships with providers such as Peter Claver, Catholic Charities, Health at Home, Maitri, and Coming Home/VNH. During consultation, clinicians may advise program staff on behavioral interventions focused on maintaining clients in their current setting. AHP staff can recommend appropriate mental health and substance abuse services and can facilitate appointments with other AHP programs. Finally, the AHP clinician can provide expert information about the medical and psychiatric interface of HIV care.

       In addition, AHP regularly refers clients to such programs as: Ward 86, Visiting Nurses and Hospice, Peter Claver Community, and a variety of substance abuse treatment programs. Relationships with these agencies and programs have already been established by way of MOU and are frequently used for referral.
B. Admission, Enrollment and Intake

Adult LGBT and HIV/AIDS patients who have been identified and referred by the San Francisco Mental Health Plan (SFMHP) or access AHP's Behavioral Health Services based on the SFMHP admission criteria will be served by the AHP's Behavioral Health Services program. These patients have been determined and authorized by the SFDPH Behavioral Health Access Center (BHAC) to be able to benefit from intakes/assessment, neuropsychological testing, individual counseling/psychotherapy, psychiatric assessment/consultation, and/or medication monitoring. In addition, AHP is a referral for Community Behavioral Health Services to provide services for clients with substance abuse concerns.

Priority for services will be given to patients who are low-income, uninsured and/or underinsured and those individuals on the program waiting list. Secondary consideration will be given to all others outside of the above priorities. Services will be available to English and Spanish-speaking clients.

Clients may self-refer for group or individual therapy, while only AIDS/MH service providers may refer for neuropsychological testing. Providers may also refer for individual or group therapy or psychiatric assessment/consultation. Clients will access services via an intake and assessment provided. These comprehensive intake and assessments will also identify other service needs and appropriate referrals to other providers as needed.

Wellness and Recovery

AHP includes the Wellness & Recovery perspective in our programs in a variety of ways. In a very general sense, most clinical staff are relationally oriented in their work with clients. This stance demands that the client and the clinician both must actively participate and agree to the treatment plan. This collaborative process helps empower clients to play a primary role in their own well being. AHP also has a program specifically for clients considering returning to work. Part of the work staff help clients grapple with relates to the physical impact of HIV, but many clients also have pre-existing mental health and substance concerns that also impact work issues.

Our Considering Work Program uses a “stages of change model” to help clients uncover their place in the process and make well informed decisions about returning to a job, getting additional training, conducting a trial work period, volunteering or deciding not to attempt employment.

Our HIV support groups program, which has been in place for over 20 years, uses a peer model for facilitation. This model trains community members who are also often clients of the agency, to facilitate support groups. Although the focus of these groups is HIV support, issues related to mental health, social isolation, physical health, spirituality and many other topics are a large part of the fabric of the groups concerns. It provides a place for peers to share coping skills and get support from one another.
AHP clients help organize and conduct periodic social events including such activities as video nights, potluck dinners, and trips to museums. These events provide an opportunity for social connections for our sometimes isolated clients.

Since we have a large number of dually- and triply-diagnosed clients we also provide a range of substance abuse related services, from a harm-reduction informed counseling program to 12-step groups held on sight to recovery support groups that require a period of abstinence from drugs and alcohol. Our belief is that we can provide the clients seeking services the appropriate treatment based on their stage of change.

AHP also provides clients many volunteer opportunities within the agency. Clients are informed about events through our quarterly newsletter to clients and flyers posted in the clinic. We have a Community Advisory Board that includes clients with the important role of helping the agency create services that are most needed in the community. Clients also volunteer to facilitate weekly support groups.

C. Service Delivery

Services are provided at the AHP Client Services Center located at 1930 Market Street. The Behavioral Health Services Program will accept clients from 9 a.m. to 5 p.m., Monday through Friday.

Because of limited and shrinking mental health resources, coupled with the need to serve many new acute clients coming in the front door, the program consistently applies utilization review and discharge/exit criteria to alleviate increasing caseload pressure, and to prioritize services to those most in need. Clinicians will consider such factors as: risk of harm, functional status, psychiatric stability and risk of decompensation, medication compliance, progress and status of Care Plan Objectives, and the clients' overall environment, to determine which clients can be discharged from MHS/CMB services into medication-only or to PPN/Primary Care. The program also utilizes more of time-efficient brief therapy and group interventions to maximize the number of clients that can be helped.

AHP has a long history of providing client centered services with no demand for abstinence as a requirement for services. AHP provides "pre-treatment" and harm reduction services to clients who are not yet willing to enter substance abuse treatment by first letting the client determine whether substance abuse is an issue that they wish to resolve. If a client decides that substance use treatment is not a goal for him or her, staff respect that decision, and continue to work with the client on other issues for which he or she requests assistance. This decision on AHP's part is a crucial piece of its harm reduction model, and helps ensure that staff can continue to provide the client with stabilization assistance even if they are actively using non-prescribed drugs.
Depending on the needs of the client some constellation of the following services will be offered.

The primary modes of service are:
1. Intakes/Assessments
2. Behavioral Health Services
3. Group Therapy
4. Medication Management/Monitoring
5. Crisis Intervention
6. Case Management/Brokerage
7. Neuropsychological testing
8. Transgender Medication Service

Definition of modalities/interventions:
- **Intakes/Assessments**: “Assessment” means a service activity which includes the presenting problem, relevant conditions, mental health history, medical history, medications, substance use, client strengths, risks, mental status examination, a complete five-axis diagnosis from the most current DSM. Depending on the type of service, assessments must be completed within a particular amount of time.

- **Behavioral Health Services**: “Behavioral Health Services” means those individual therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral, and substance use services. Individual therapy will serve each client for up to 20 weeks. If at the end of 20 weeks it is determined between the client and the therapist that additional therapy is required, the client will be referred to an alternative treatment source.

- **Group Therapy**: See above, though service is provided in a group setting

- **Medication Support Services**: “Medication Support Services” means those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

- **Crisis Intervention**: “Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy.
Case Management: “Targeted Case Management” means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; and plan development. The focus of the case management services may vary depending on the primary concern for the client at the time of services. The focus could be related primarily to mental health or substance use depending on the situation the client wants to address.

Neuropsychological Testing: “Neuropsychological Testing” is the provision of specialized tests to determine the presence or absence of HIV-associated dementia or minor cognitive motor disorder. Review of results with patient and referring provider will address any needed accommodation, medication and support.

Transgender Medication Services: For transgender clients receiving primary care services at Castro Mission Health Center, Psychiatric Medication Support Services will be provided.

D. Intakes/Assessments

1. The following areas are included as appropriate as a part of AHP client records.
   a. Relevant physical health conditions reported by the client are identified and updated as appropriate.
   b. Presenting problems and relevant conditions affecting the client’s physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.
   c. Documentation will describe client strengths in achieving client plan goals.
   d. Special status situations that present a risk to client or others will be documented and updated as appropriate.
   e. Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
   f. Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.
   g. A mental health history will be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
   h. Documentation will include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs.
   i. A relevant mental status examination shall be documented.
   j. A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.
2. Timeliness/Frequency Standard for Assessment
   Depending on the type of service, assessments must be completed within a particular amount of time.

E. Client Plans
   1. Client Plans developed by AHP clinical staff will:
      a. Have specific observable and/or specific quantifiable goals/treatment objectives related to the client’s mental health needs and functional impairments;
      b. Identify the proposed type(s) of intervention/modality and descriptions of the interventions to be provided;
      c. Have a proposed frequency and duration of intervention(s) that focus on the impairments;
      d. Have consistency with the qualifying diagnosis;
      e. Be signed (or electronic equivalent) by the person providing the service(s), the LPHA, and the client.

2. Timeliness/Frequency of Client Plan
   a. AHP client plans will be updated at least annually.

F. Progress Notes
   Progress notes within AHP client records will describe how services reduced impairment, restored functioning or prevented deterioration in an area outlined in the plan and shall include documentation of medical necessity, encounters, interventions applied and beneficiary response to interventions and locations of interventions, date of services, documentation of referrals, documentation of follow-up, amount of time to provide services, signature of the person providing the service and their licensure.

G. Discharge Planning, Exit Criteria and Process
   Clients may become inactive at AHP when they have completed their time-limited service or when their treatment goals are met. Often, clients and therapists agree that clients could benefit from additional services, and the client transitions from one service to start another. For our time-limited services, such as psychotherapy and some short-term groups, clients can request re-admission to service a year from the end of treatment. Clients can always request a meeting to assess their current needs.

   In addition, admission and eligibility criteria will also include the patient's and physician's agreement for ambulatory or home care psychiatric services, and residency in San Francisco. Discharge criteria will be based on patient outcomes and the patient's willingness to continue to accept the services.
2. Continuous Quality Improvement:

A. Achievement of contract performance objectives and productivity: AHP complies with CBHS policies and procedures for collecting and maintaining timely, complete and accurate unduplicated client and service information in AVATAR. New client registration data is entered within 48 hours or two working days after data is collected. Service data for the preceding month, including units of service, will be entered by the 15th working day of each month. Successful completion of objectives will be measured by service data (UOS/UDC) recorded in Avatar and presented on monthly invoices. Program statistics are reviewed on an ongoing basis by the Program Manager and discussed in quarterly meetings with the Director and Medical Director to ensure that each program is meeting its objectives. Areas of deficiency are noted by the manager who, in collaboration with program staff members, develops an action plan to address identified problems. In consultation with the Director and the Medical Director, client services are modified as appropriate.

B. Quality of documentation, including a description of the frequency and scope of internal chart audits: Clinical staff review ongoing CBHS clients with supervisors as a part of weekly supervision. This review includes discussion of plan of care, how treatment goals are identified, established and monitored, and appropriateness of discharge planning. A monthly clinical staff meeting allows for discussion of issues related to AVATAR data input/management and documentation requirements. AHP’s three person Program Utilization Review and Quality Committee (PURQC), led by the Medical Director, meets every two weeks. The Program Manager, Behavioral Health Services and the Supervisor, Behavioral Health Services are responsible for reviewing all records regarding the status of treatment prior to reauthorization. The PURQC committee uses an internal database to review the status of all active CBHS clients for reauthorization of ongoing care. For patients receiving medication evaluation and monitoring, a sample of charts (five charts per MD/NP) are reviewed annually in a peer review process as per the SFGH Department of Psychiatry Guidelines. Completed QA forms are reviewed by the Medical Director and submitted to the Department of Psychiatry.

C. Cultural competency of staff and services: As a primary mental health organization, AHP employs professional mental health providers who are taught early in their careers the values of diversity and respect for individual differences. In addition, AHP actively promotes these ideas as an integral part of the agency’s standard of care and fosters an environment in which these values are promoted. AHP’s commitment to cultural competence is demonstrated by regular staff trainings and our history of working with a diverse population of clients. This is illustrated by our quarterly inservice trainings on cultural and/or gender issues, required for all clinical staff. Past trainings have focused on working with specific populations including, Asian and Pacific Islanders, African Americans, mental health services for transgender people, Latino/a Issues and Women and HIV. Staff also attend outside trainings that include
topics related to cultural competent services. A monthly peer case conference is held to provide clinical staff with the opportunity to discuss and reflect on client presenting problem, course of treatment, cultural considerations, and quality of therapeutic relationship in individual cases while ensuring the client’s rights to privacy are respected. Clients give feedback on the effectiveness of these efforts and the sensitivity of our staff through the Client Satisfaction Survey.

We will continue to use any staff openings as an opportunity to recruit staff/volunteers who reflect the diverse clients with whom we work. We offer interventions, including psychological testing and psychotherapy, in English and Spanish, and can accommodate other languages through the use of interpreters. Our staff reflects our target populations in ethnicity, gender, age, life experience and sexual orientation.

D. Satisfaction with services: Client Satisfaction Survey forms will be used to measure levels of client satisfaction. AHP has developed a standard Client Satisfaction Survey that can be administered across all programs. AHP’s survey is administered in addition to the Client Satisfaction Query required by CBHS. The survey includes two HIV prevention-related questions and asks the same questions for all clients, regardless of the service provided to allow for the possibility of data review across service type. We continue to have the ability to assess data in a service-specific way that allows for comparisons between programs and interventions. The survey is tailored to include specific questions related to satisfaction. Measures include: sensitivity to cultural needs, comfort level with environment and services offered, improved ability to deal more effectively with psychosocial issues and improvement in client identified problem areas. The survey also measures the level of client satisfaction and challenges for each type of service provided. Services are modified as appropriate subsequent to an analysis of the survey data program managers and the agency director.

E. Timely completion and use of outcome data, including CANS and/or ANSA data Mental Health Program: AHP CBHS compliance staff audit charts on a quarterly basis to ensure that ANSAs are completed in a timely manner. The compliance staff also send out reminders to staff to ensure that clinicians complying with CBHS standards, for example, “Openings --- Please remember to complete the ANSA and mark “Final”. Do not leave in Draft status.” Staff is also encouraged to compare ANSA ratings from year to year when they are completing re-authorization paperwork to identify areas where clients have made improvements and where they continue to have significant impairments. Annually, we review our ANSA ratings in a clinical staff meeting to ensure that staff understands how the ANSA ratings can be helpful in terms of the agency performance and individual progress.
VI.
SERVICES CENTER
CLINICAL POLICIES
Policy on Confidentiality and HIPAA Guidelines

Date: 1/26/99, Rev. 4/14/03

**Purpose:**
Each client’s confidentiality must be protected in accordance with state and federal guidelines governing mental health, HIV disease, and substance abuse.

**Policy:**
1. All records and documents related to clients are maintained according to the policies and procedures of the Department of Psychiatry at San Francisco General Hospital and AHP. These policies and procedures require all client records to be kept in locked and secured locations. AHP staff with access to these locations have signed 1) a Code of Conduct; and 2) an Oath of Confidentiality. No written or oral information will be given out by an AHP staff person without a Release of Confidential Information form signed by the client, unless legally mandated.

**Procedure:**
1. Each AHP client, at time of intake, is given the “Notice of Privacy Practices” (HIPAA) booklet. A “Notice of Privacy Practices Acknowledgement of Receipt” form is given to the client to sign, and a copy is filed in the Client Record.
2. Each AHP staff person is required to sign a Code of Conduct and an Oath of Confidentiality at the time of employment.
3. Each AHP staff person will receive training and orientation related to the issues concerning confidentiality.
4. No written or oral information will be given out by an AHP staff person without a Release of Confidential Information form signed by the client.
5. Legally mandated exceptions to maintaining client confidentiality are as follows:
   - Responding to acute crises requiring 5150 involuntary hospitalizations as defined by law: If an AHP staff determines a client meets criteria for danger to self or others or grave disability, the treatment plan will include involuntary evaluation at PES.
   - California Reporting Law: Under the California Reporting Law, AHP staff are legally mandated to report suspected incidents of child abuse and/or elder abuse immediately by telephone, and send a written report to the appropriate agency within 36 hours.
   - Tarasoff Decision: Duty to Warn: Under the Tarasoff Decision, AHP staff are legally mandated to warn potential victims of violence, and to notify the police.
6. An AHP staff person must always notify his/her supervisor of any legally mandated exception to client confidentiality.
7. Client files are located in locked file cabinets and available only to AHP personnel.
Policy on Clients Rights and Responsibilities
Date: 1/28/98

Purpose:
Each client’s rights and responsibilities must be protected in accordance with state and federal guidelines governing mental health, HIV Disease, and substance abuse.

Policy:
1. All clients will be informed of their rights and responsibilities at initial AHP intake. Clients will sign a document confirming the same.

Procedure:
1. At intake clients will be given a Rights and Responsibilities form to review and sign. Each AHP staff person will receive training and orientation related to the issues concerning client’s rights and responsibilities.
2. Clients who enter AHP through crisis and are not able to understand or review these forms will be given the information at a follow-up visits when appropriate.
3. This document will be updated at client’s re-authorization or after a break in treatment services.
Purpose:
To ensure service delivery to clients meets professional standards.

Policy:
All significant client interactions need to be appropriately documented in that individual client’s record in a timely manner.

Procedure:
1. All documentation must be clearly written, legible, dated and signed.

2. All documentation must follow specific AHP program formats.

3. Documentation must clearly substantiate all interventions and/or dispositions.
Policy on Clients Demonstrating Inappropriate Behaviors
Date: 1/26/99

Purpose:
1. To maintain the safety of staff and clients.
2. To maintain a professional and comfortable atmosphere at the AHP Services Center.
3. To demonstrate a clear and consistent message regarding inappropriate behavior in a professional setting.

Policy:
It is expected that clients will conduct themselves in an appropriate manner at AHP Services Center. Behavior considered inappropriate includes the following:

• Threatening or violent behavior
• Yelling in public areas
• Using profanity in public areas
• Crying in public areas
• Sleeping
• Sexually inappropriate behavior
• Leaving food or other belongings in the building
• Bringing an animal (other than a service animal) into the Services Center.
• Self injurious behavior

Procedure:
1. If a client in the reception area displays inappropriate behavior, staff will respond as follows:

   A) If the behavior is so severe as to seriously disturb others in the reception area, or if there is an immediate threat of danger, front desk staff will notify the Crisis team. If the Crisis team is closed, front desk staff will notify the OD via pager. Responding staff will make a clinical determination as to how to proceed, alerting other staff and/or SFPD/UCPD as appropriate. The decision should be based on the clinical presentation of the client involved, taking into account the safety of the client and others immediately near him/her.

   B) If the behavior is not as severe as described in above, front desk staff will notify the OD to address the behavior.
2. If a client in a counseling room or group room is behaving inappropriately, staff are to respond as follows:

A) If there is an immediate threat to safety, the staff member concerned should leave the room and seek assistance. Staff or designee should notify the Crisis team, or alternately, the OD.

B) Crisis team or the OD will make an clinical judgment as to how to proceed, alerting other staff, SFPD/UCPD as appropriate. The decision should be based on the clinical presentation of the client involved, taking into account the safety of the client and others immediately near him/her.

C) If the client is well known to the clinician, (e.g., case management or psychotherapy) and the behavior poses no immediate threat to safety, the clinician can choose to address the behavior as appropriate, based on the client’s presentation and treatment plan.
Policy on Clients Demonstrating Intoxicated Behavior

Date: 1/26/99

Purpose:
1. To maintain the safety of staff and clients.
2. To maintain a professional and comfortable atmosphere at the AHP Services Center.
3. To demonstrate a clear and consistent message regarding inappropriate behavior in a professional setting.

Policy:
It is expected that clients not come to the Services center when they are intoxicated. In general, with some specific exceptions, staff will not engage with intoxicated clients, other than to ask them to leave and return on another day when they are sober.

Procedure:
1. If an active client arrives at the Services Center for an appointment, and presents with intoxicated behavior, the staff person scheduled to see that client will ask the client to leave and return at a later date when sober. Exceptions are as follows:
   A) If an active ASAP client is requesting detox, ASAP can be contacted to facilitate the request. ASAP staff will determine, based on the client’s history, behavior, and presentation, whether to provide direct assistance to facilitate detox. ASAP staff will consult with supervisory staff as needed in this process. If ASAP is closed, the OD will provide the client with a list of detox referrals kept at the front desk.
   B) If the client states that he/she is suicidal and or homicidal, the client should be immediately referred to the Crisis team for further evaluation. If the Crisis team is not open, 911 should be called.

2. If an active client drops into AHP without an appointment and presents with intoxicated behavior, the OD will be contacted and will proceed as in paragraph 1 above.

3. If a non-client arrives at the Services center and demonstrates intoxicated behavior, the OD should ask that person to leave and return at a later date when sober. Exceptions as in paragraph 1 above.

4. If a client calls AHP and is intoxicated, staff can give detox information over the phone if requested. If the client states he/she is suicidal and or homicidal, the client should be immediately referred to the Crisis team for evaluation. If Crisis team is unavailable, 911 should be called.
Policy on Weapons

Date: 2/6/98

Purpose:
To maintain safety of staff and clients.

Policy:
No weapons are allowed at sites where AHP staff, volunteers or interns provide services to clients.

Procedure:
1. A weapon is defined as any object or substance that is perceived and/or intended to be used to cause harm.

2. If during an interaction with a client who is NOT threatening to self or others, it comes to a staff person’s attention that the client has a weapon, the staff person will:
   
   A) Alert another staff person, preferably an OD or supervisor;
   
   B) Ask the client to leave;
   
   C) Inform the client that he/she can return without the weapon.

3. If during an interaction with a client who IS a threat to self or others, and a weapon is present, the staff person will:
   
   A) Alert another staff person, preferably an OD or supervisor;
   
   B) Ask the client to leave the building;
   
   C) Contact police to advise them of situation;
   
   D) Contact AHP Crisis Team to advise them of situation;
   
   E) File incident report and inform management at AHP.
Purpose:
To ensure service delivery to clients meets professional standards.

Policy:
In general, schedules appointments will start and end on time.

Procedure:
1. In general, psychotherapy sessions last 50 minutes. If the client is late, the session will still end on time, unless there are exceptional clinical circumstances.

2. If a client is more than 20 minutes late to a scheduled intake or assessment appointment, he/she will not be rescheduled for another appointment, unless clinical judgment dictates otherwise.
Policy on Officer of the Day Standards
Date: 5/2/13, Rev. 10/16/14

Purpose:
The Officer of the Day (OD) assesses triages, manages and/or resolves out of the ordinary situations at the AHP Services Center. Additionally, the OD assumes management and control of AHP Services Center in emergency situations.

Policy:
The Officer of the Day (OD) provides clinical support and back up to staff, clients and visitors to the AHP Services Center at 1930 Market Street. The OD is available to staff and clients during hours of operations. Priority is given to issues related to need for immediate crisis assessment, disruptive behavior, and time-sensitive matters related to clinical care of clients. Questions about service access, information and referrals, and unscheduled visits to the clinic will be triaged by the OD by redirecting to voice mail message, call back or directing clinic staff to address issues.

Procedure:
1. Officer of the Day responsibilities are shared by all clinical staff at the AHP Services Center. The OD schedule is included in the weekly Services Center Schedule and is drafted by the Behavioral Health Services (BHS) Manager and the Community Health Program Coordinator/Operations.

2. In the event of an unscheduled absence that effects the OD schedule, the BHS Manager will be responsible for securing appropriate coverage. In the event that the BHS Manager is unavailable, OD coverage will be coordinated by the AHP Services Center Medical Director.

3. For clients of the HIV Counseling and Testing (HCAT) unit, initial support and clinical back up will be provided by HCAT staff.

4. AHP staff will contact the OD for assistance under the following circumstances:
   • A client or visitor displays or demonstrates disruptive behavior within, directly in front of, or in the rear parking lot of the AHP Services Center.
   • A client presents in a crisis situation.
   • A medical or safety emergency in the immediate vicinity of AHP Services Center.
   • Any situation which potentially could disrupt the provision of services to clients.
   • Questions related to service access, queries about agency information or referrals, or clients appearing for an unscheduled visit should be referred to the OD to triage or resolve, as appropriate.
5. In the event of an emergency such as a fire, earthquake, gas leak, etc., the OD will immediately take charge of the facility and direct other staff in protecting clients, staff and the facility from harm, injury, or damage. The OD will also contact/coordinate with emergency services (police, fire, PG&E) as appropriate. The OD will continue to supervise the emergency response until specifically relieved by a senior manager, or by police or fire personnel.

6. The Crisis Team should be contacted, in addition to the OD, when an immediate response is required due to urgency and/or potential for violence.
Standards for Home Visits Policy
Date: 2/11/98

**Purpose:**
To ensure professional standards and safety during home visits.

**Policy:**
All home visits will be conducted in a safe and professional manner.

**Procedure:**
1. The first time a client is visited at home, staff will conduct the visit in a team of two.
   Exceptions can occur when it is clinically established that the home visit will be safe, i.e., if the client is well known to the agency and/or based on collateral information.

2. At no time will staff transport clients in their cars.

3. See Crisis Team policy on home visits.
Policy on Service Animals

Date: 3/11/96, Rev. 2/10/05

**Purpose:**
To assure AHP Services center follows the standards under the Americans with Disabilities Act (ADA), and to assure that clients with service animals are treated with respect and courtesy.

**Policy:**
AHP will make necessary accommodations to assure that clients with service animals can receive appropriate services. The ADA defines a service animal as any guide dog, signal dog or other animal trained to provide assistance to an individual with a disability.

**Procedure:**
1. A service animal at AHP is expected to be well behaved. Service animals must be leashed or appropriately restrained while at AHP. If the behavior of a service animal causes property damage, physical danger, or makes an area uncomfortable or unwelcoming for other clients, the owner will be advised that he/she may return for services, but not with the animal in question. Clinical staff will meet with the client as necessary to develop an appropriate plan. If additional action is required, a Program Manager will mediate the situation. Note: As per ADA guidelines, “a public accommodation may exclude any service animal that is out of control”.

2. If a client presents to HCAT with a service animal and needs to have a specimen collected, staff will collect the specimen in a counseling room, rather than the phlebotomy area.

3. Pets that are not service animals are not allowed at AHP Services Center.
Purpose:
To assure quality service delivery in an environment with reduced risk of transmission of TB.

Policy:
Persons with suspected or confirmed TB infection and those exposed to them will participate in surveillance to ensure individual safety and decrease the risk of further transmission.

Procedure:
1. Clients identified as having suspected TB exposure or active TB infection will be contacted by medical staff at AHP Services Center

2. Clients will be asked if they are willing to participate with the TB surveillance program by allowing AHP to share their name and their provider’s name with the TB office at San Francisco General Hospital.

3. If a client elects to participate, the information will be communicated by the medical staff in a timely manner. The TB office will provide appropriate follow up for the known infection or possible exposure.

4. If the client refuses to participate, the clients will be asked to comply with the steps the TB office recommends for appropriate follow up through the client’s primary provider. The client will allow our medical staff to work directly with the client’s primary provider to assure proper follow up occurs. If the client refuses both steps 3 and 4, the client will be barred from services until they are determined not to be a risk to others according to the standards of the TB office.

5. Clients whose TB ineffective status is questionable will be barred from service until either proper surveillance or adequate treatment has been determined.
Policy on Determining Eligibility for CARE Funded Services
Date: March 2012

Purpose:
The University of California, San Francisco Alliance Health recognizes that Ryan White Comprehensive AIDS Resource Emergency (CARE) Act funds are the payor of last resort for mental health services and are intended for the provision of care to low-income, un- and under-insured San Francisco residents living with HIV.

Policy:
To provide procedures for ensuring that all clients are screened for eligibility to receive services and for alternative sources of payments (for example private insurance, MediCal or Medicare) so as to ensure that CARE dollars are the payor of last resort for AHP mental health services.

Procedure:
1. All new and returning Clients requesting CARE funded services will be assessed for eligibility based on residency, income and insurance status at time of triage and again at intake/assessment. Clients will be asked to provide current residence, amounts and source of income and insurance coverage, if any.

2. Clients who report having private insurance or access to other available funding for mental health services will be assisted in accessing appropriate services with non-CARE funded providers.

3. Clients who are not currently receiving health or financial benefits for which they may be eligible will be referred to an Eligibility Worker or Benefits Counselor for a more in-depth assessment.

4. AHP clients who have active San Francisco MediCal and who meet medical necessity will be opened under AHP’s Community Behavioral Health Services (CBHS) program and all eligible MediCal funded services will be billed under CBHS.

5. AHP clients receiving CARE funded mental health services who become eligible for MediCal during course of treatment and who meet medical necessity will be enrolled in AHP’s CBHS program.

6. All clients will be administered the “Twice Yearly Client Update Questionnaire” in April and October to verify continued eligibility based on residency, income and insurance status. Clients who have had changes in residency, income or insurance status making them ineligible for CARE funded services will be assisted in accessing services using alternative funding sources or from other non-CARE funded providers.
Policy on Determination of Payer of Last Resort

Purpose:
To assure that a determination of payer of last resort is made for all clients who receive services.

Policy:
AHP will screen all individuals who request services to determine income level and payer of last resort.

Procedure:
1. All clients are screened for eligibility for services by AHP intake staff.
2. When a client requests services at AHP, he/she is first asked the following: (a) “Are you HIV positive?” and (b) “Do you reside or intend to reside in San Francisco?” If a client answers yes to these questions, then the client is advised that our CARE-funded services are for individuals who are low-income and uninsured or underinsured.
3. Clients who meet the above criteria are advised that he/she will need to present an original letter of diagnosis from a Bay Area county confirming HIV status, or have a primary provider fax a letter of diagnosis, before services can be provided. For crisis services, this letter needs to be provided within 3 months.
4. The client is then asked if he/she has MediCal, and this is verified by the Program Assistant via the State of California MediCal Website. If the client has MediCal, he/she is informed that all MediCal-eligible services will be billed to MediCal rather than to CARE.
5. Residency, income and insurance status, including MediCal eligibility, are checked during twice yearly updates by the staff person who is working with the client.
6. Third party payer status is noted both in the electronic medical record system and in the client’s record.
7. AHP intake staff screening determination is reviewed by the intake coordinator.
Policy on Serosorting and Superinfection Risk Reduction Counseling

Date: 1/28/08

Purpose:
To provide all clients, regardless of serostatus, with the most up-to-date information needed to minimize their risk of acquiring and/or transmitting sexually transmitted diseases (STD’s) including HIV and all types of infectious hepatitis (A, B, and C). This information should include, when appropriate, a discussion of the specific risks associated with serosorting and HIV super-infection. The goal of AHP’s prevention counseling is not only to reduce the risk of new infections but also to help clients have the best and most worry-free sexual lives possible.

Policy:
AHP staff and volunteers who provide counseling should assess the HIV and STD prevention needs of all clients regardless of serostatus and should specifically address the risks associated with sero-sorting. For HIV positive clients, staff and volunteers should also discuss the issue of HIV super-infection.

Procedure:
1. HIV and STD prevention counseling begins with an assessment and understanding of the client’s sexual activity and his or her relationships. This includes an understanding of whether and with whom the client is engaging in sexual activity, and the specific nature and frequency of the sexual behavior including whether and when condoms are used. A discussion of the potential risks of serosorting and HIV super-infection must be based on this understanding.

2. Clients who report engaging in un-protected anal intercourse based on sero-sorting, regardless of serostatus, should be provided with information regarding the risks and limitations of this approach as a prevention strategy. (See information from the San Francisco Department of Public Health City Clinic following this policy.)

3. HIV-negative clients should be reminded that unprotected anal intercourse poses a potential risk of infection with HIV, as well as other STD’s, including all types of infectious hepatitis. Further, having unprotected sex with HIV- positive persons who have been treated for HIV, may result in becoming infected with strains of HIV that have become resistant to available treatments.

4. HIV-positive clients should be asked to discuss how having HIV has affected their sexual lives and their sexual decision making. Staff should seek to include a discussion of serosorting and the potential risks of HIV super-infection. Clients should be told that
serosorting is not fail-safe and does not necessarily protect against other STD’s including all types of infectious hepatitis. They should also be told that while superinfection is likely a rare event, recent research makes it clear that it can happen—even among men who have been living with HIV for many years. While the clinical implications of such an event are not fully known, it is possible that stronger and more resistant strains of HIV can be transmitted.

Superinfection of HIV

*Developed by San Francisco City Clinic - 2/28/2005*

Superinfection with HIV happens when a person already infected with one strain of HIV becomes infected with another strain of HIV.

**How does Superinfection Occur?**
Increased risk for Superinfection has been shown to occur within the first year of getting HIV infected.

**What occurs with Superinfection**
Superinfection may increase viral load and decrease CD4 counts. The new second strain (Superinfecting strain) may be stronger than the first or it may be resistant to one or more anti-HIV drugs. Superinfection may speed the course of HIV disease.

**How Common is Superinfection?**
It is not known how common Superinfection is. Research suggests it does occur, but not very often. Given how often HIV positive persons have unprotected sex with other HIV positive persons, Superinfection appears to be difficult, but possible.

Unprotected intercourse puts you at risk for not only STDs, but HIV Superinfection as well.

**For more STD info**
http://www.noah-health.org/
http://www.sfsi.org/
http://www.ashastd.org/
http://www.cdc.gov/std/
http://www.sfcityclinic/

**Gay Men’s Health info**
http://www.healthypenis.org/
http://inspot.org/
http://www.gmhc.org
Policy on Working with Persons with Mental Health, Substance Abuse or Co-occurring Disorders
Date: June 28, 2008

Purpose:
To welcome all potential clients and members of their support network who request assistance with issues related to mental health and/or substance abuse and/or co-occurring disorders and to ensure the provision of integrated, quality mental health and substance abuse services and support. All individuals who request assistance, or anyone referring an individual for services, should be welcomed regardless of their presentation. Every door is the right door to be screened and gain access to the most appropriate services. The Alliance Health Project (AHP) provides comprehensive mental health and substance abuse services to San Francisco residents living with or at risk for contracting HIV/AIDS.

Philosophy:
AHP has made a commitment to develop a welcoming, accessible, integrated, culturally competent, recovery oriented, continuous, and comprehensive system of care. We are committed to increasing the capability of ALL programs and ALL staff to be welcoming and engaging towards ALL individuals in empathic, hopeful relationships that facilitate appropriate identification of needs, access to appropriate assessment, and properly matched services. The San Francisco Department of Public Health’s Community Behavioral Health Services (CBHS) has chosen the Comprehensive, Continuous, Integrated System of Care (CCISC) framework for the development of an integrated service system. A consensus document has been developed by CBHS to guide this process.

Within the CCISC framework, it is particularly important to welcome and engage those individuals who might ordinarily have difficulty gaining access to services, such as those who have co-occurring mental health and substance use disorders, who are from diverse cultural groups, or who have associated chronic medical conditions, all of whom are at risk for poorer outcomes if not successfully welcomed into care. Consequently CBHS has prioritized the development of welcoming procedures as one of the most important and fundamental starting places for CBHS system transformation and integration.

The AHP recognizes that all individuals and all service settings are not the same. Consequently there is no single correct welcoming intervention for all individuals. Each program at the AHP must have the capacity to develop welcoming engagement strategies and interventions that are appropriately matched to individuals who may be
coming to our door and that are designed to have those individuals experience that “Every door is the right door” whether they will be provided with continuing services in that setting or not.

**Procedure:**

1. Welcoming is the first step in engagement. Engaging individuals with any type of difficulty in a culturally appropriate manner is one of the most important contributors to success in any setting. It involves a pro-active stance that conveys empathy and hope to actively reach out to individuals. It starts with basic courtesy over the telephone and in person, regardless of the service being sought. The AHP will make every attempt to recruit employees with the capacity to communicate with clients in their preferred language. In the event that this is not possible, AHP has contracted with translation services and while this is not optimal it can assist with meeting the immediate needs of clients while making a determination about a more appropriate course of action.

2. Welcoming is a practice that is independent of resource availability or program eligibility. Welcoming messages will be conveyed in the attitudes and behaviors of all staff, clinical and administrative. It is especially important to be welcoming to an individual who will not be provided with ongoing services in the program door they first enter. Welcoming these individuals communicates a sincere desire to engage the person in care as soon as possible, to welcome the person into the system of care as a whole, and to pro-actively assist the person with making the connection with a provider who will assume responsibility to continue the welcoming empathic relationship and provide the services needed. After a referral is made, the service provider with whom initial contact was made will make every reasonable effort to ensure that the individual is given access to the services they need.

3. An essential component of welcoming practice is the elimination of barriers to access. No program should have arbitrary requirements that automatically exclude an individual from access or assessment based on for example substance use level, length of sobriety, type of medication or mental health diagnosis. Again, welcoming means “every door is the right door” whether individuals will be provided continuing services in that setting or not.

4. The welcoming response includes the necessity for programs to provide screening to determine the presence of mental health and or substance abuse disorders at whichever program the individual first enters for services. Information on referral resources shall be available at all programs to assist staff members with identifying the most appropriate resources for clients.

5. Welcoming includes the recognition that simultaneous treatment of co-occurring disorders, when they exist, results in the most successful and desirable treatment outcomes. Service providers should convey a belief in the possibility of recovery and
openness to harm reduction approaches and a willingness to “start where the individual is at” and provide services accordingly.

6. The AHP will develop staff competencies that reflect the knowledge and skills necessary for success in an agency that serves individuals with co-occurring disorders. Advanced staff competencies will be developed for supervisory staff. These staff members are leaders in the organization and as such they will be expected to lead the agency in its progress toward the development of a Continuous, Comprehensive, and Integrated System of Care.

7. The AHP’s staff training program will be modified to assist staff members in developing skills and competencies that improve their ability to work effectively with persons with mental health, substance abuse or co-occurring disorders.

8. Agency program brochures and or posters, orientation handout materials, website information, etc., shall be visible, accessible, culturally and linguistically relevant and customer friendly.

9. The AHP will become stronger by working collaboratively with other programs in the system. Each program approach has its strengths and limitations. By honest acknowledgement of these, and through knowledge of the assets of other approaches, programs can more effectively serve the needs of clients. Comprehensive services may be achieved by expanding service options within existing programs, through collaboration with other service agencies, or by creating new services to address specific needs.
Purpose:
While the University of California, San Francisco Alliance Health Project (AHP) recognizes that it is both a personal responsibility and a public health issue for persons living with HIV to inform previous sexual partners of potential exposure to HIV, AHP also recognizes the complex array of psycho-social issues that make HIV disclosure difficult.

Policy:
It will be the policy of AHP clinicians to offer all HIV positive Clients who report recent high risk sex with assistance and support in notifying all previous partners of possible exposure including the option of accessing Third Party Partner Notification Services.

Procedures:
1. All HIV+ AHP Clients who report recent high risk behavior will be offered assistance in notifying partners of potential exposure to HIV.

2. Disclosure assistance is always voluntary and the decision to utilize disclosure assistance services, or how, when, or if to notify an exposed partner, is always the Client’s decision.

3. The confidentiality of the Client will always be protected and the Client’s name or other identifying information will never be revealed to partners.

4. All components of disclosure assistance and partner services will be conducted in a client-centered and culturally relevant manner and will respect the needs of the Client.

5. Disclosure assistance should be available at any time during the continuum of care and should be offered to all Clients who desire assistance in talking with others about their HIV status regardless of HIV status.

Referrals:

Resources:
Partner Services, San Francisco Department of Public Health (415) 487-5516.
Policy on Harm Reduction
Date: February 2011

Purpose:
To promote methods and treatment that are free of judgment or blame and directly involve the client in setting treatment goals so as to reduce the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals and their community.

Philosophy:
AHP recognizes that clients are responsive to culturally competent, non-judgmental services, delivered in a manner that demonstrates respect for individual dignity, personal strength, and self-determination. As a service provider, AHP is responsible to the wider community for delivering interventions which attempt to reduce the economic, social and physical consequences of drug- and alcohol-related harm and harms associated with other behaviors or practices that put individuals at risk.

Policy:
1. AHP services shall be consistent with the harm reduction philosophy.

2. Access to AHP services shall not be denied to clients who are unable or unwilling to abstain from unsafe practices.

3. Prior to a client’s discharge, AHP staff shall make a reasonable attempt to find additional or alternative treatment.

4. Clients shall not be denied access to, restricted from participation in, or terminated from, AHP services on the basis of their use of prescribed medication.

Procedure:
1. AHP staff and program language shall not reflect bias toward personal behaviors, experiences, ethnicity, sexual orientation, or personal choices.

2. AHP staff and programs shall convey a willingness to “start where the individual is at” and provide services from a client-centered perspective in order to assist clients in making choices that lead toward better health.

3. AHP staff and programs shall convey a belief in the possibility of recovery and openness to harm reduction approaches.
4. AHP staff and programs shall build on the fact that people change in incremental ways and must be offered a range of treatment outcomes in a continuum of care from reducing unsafe practices to abstaining from dangerous behavior.

5. Treatment success shall be measured comprehensively to include incremental improvement in housing, physical and mental health, finance, employment and family and social support system.

6. AHP shall expand service options within existing programs, through collaboration with other service agencies or by creating new services to address specific needs.

7. AHP staff shall attempt, within the context of their programs, to follow-up with clients who demonstrate an inability or unwillingness to participate in treatment.

8. AHP staff and programs shall promote strategies that reduce harm for those clients who are unable or unwilling to modify their unsafe behavior.

9. Use episodes or periods of return to unsafe health practices are understood by AHP staff and programs to be part of the recovery process and will not be equated with or conceptualized as “failure of treatment.”
Policy on Compliance with CBHS Staff Credentialing, Training and ANSA Certification
Date: February 2011

Purpose:
To ensure program compliance with all CBHS requirements regarding staff credentialing and training.

Policy:
1. It is the policy of the UCSF Alliance Health Project as a provider under the San Francisco CBHS System of Care to comply with all CBHS requirements regarding staff credentialing, training and ANSA certification.

2. Supervisors and/or clinical training coordinators are responsible for ensuring that all new staff and interns are in compliance with all staff credentialing, training and ANSA certification requirements before billable clinical services are provided to Clients under our CBHS program.

Procedure:
1. Supervisors and/or clinical training coordinators will provide all new AHP staff clinicians and clinical interns with all required CBHS staff verification and credentialing documentation and AVATAR and ANSA registration and training information. Supervisor and/or clinical training coordinator also to provide new clinical staff with instructions on obtaining or updating National Provider Identification number (NPI).

2. All new AHP clinical staff and interns will complete all required CBHS paperwork and return to their supervisors or training coordinator along with a copy of current BBS license or internship registration. Supervisors or training coordinator to review all paperwork to ensure proper completion and forward to AHP Program Manager/CBHS coordinator for submission.

3. Supervisors and/or clinical training coordinators to ensure that all paperwork is submitted to CBHS for processing. Supervisor and/or clinical training coordinator to ensure that all subsequent CBHS AVATAR computer systems and ANSA certification trainings are completed.

4. All licensed and licensed eligible AHP clinical staff are to provide Program Manager/CBHS coordinator with copy of license or internship registration upon renewal.

5. The current designated AHP ANSA liaisons are Stephan Ouellette and Mary Beth Reticker.
Purpose:
The purpose of this policy is to define unusual occurrences and give staff direction for reporting and investigating such incidents in order to:

- identify events or conditions which have or may have an adverse effect on the health or safety of clients, family members, staff and/or members of the general public.
- develop and implement appropriate corrective actions that address the immediate well-being and safety of clients and prevent similar future occurrences.
- identify patterns and analyze findings to identify possible areas for quality improvements.

Definition:
An unusual occurrence is any event or condition that has or may have an adverse affect on the health or safety of clients, family members, staff, and/or members of the general public while at the AHP Services Center.

Policy:
Unusual occurrences will be reported, investigated, and followed up according to the following procedures. This policy is based on the CBHS Quality of Care (QOC) and Unusual Occurrence (UO) Incident Reporting instructions and the Adults and Older Adults QOC form for reporting and investigating quality of care/sentinel events.

Procedure:
1. The Officer of the Day (OD) will be the first responder for building and client safety issues. The OD will assess a situation and determine what type of support they may need. Additionally, the OD assumes management and control of the AHP Services Center in emergency situations.

2. The primary focus of the OD is to assist clients, family members, staff, and/or members of the general public who may be at risk, and to take action to assure safety issues are promptly addressed and mitigated.

3. The OD should always use a second staff member as backup so that additional staff or emergency personnel can be contacted if required. Dial 9-911 for all emergencies. Calls are answered at UC Police dispatch, and they will coordinate any response required (police, fire, ambulance).

4. Each staff member directly involved in or having knowledge of an unusual occurrence shall immediately inform the OD and their supervisor/manager of the incident.
5. The supervisor/manager shall immediately notify the Behavioral Health Services (BHS) Manager and Medical Director. Supervisor/manager shall assist in further risk containment actions as follows:
   a) preserving any documents necessary to assure an effective analysis and record of the occurrence;
   b) interviewing clients and other witnesses, and;
   c) securing medical records.

6. The BHS Manager and Medical Director will notify the AHP Director as soon as possible and ensure that the CBHS program manager is verbally notified as soon as possible and no later than 24 hours after the incident has occurred.

7. The BHS Manager or designee shall complete the QOC reporting form as soon as risk containment measures are completed and there is no longer an immediate danger to clients, family members or staff.

8. All client deaths, fires and police actions involving CBHS clients that involve weapons or use of force must be reported immediately. All other incidents must be submitted within five calendar days of the occurrence.

9. AHP will notify CBHS of any unusual occurrences that require medical treatment. The QOC form can be faxed to 415-252-3001 or mailed to the CBHS Quality Management Office.

10. The Management Team and the Program Utilization Review and Quality Committee (PURQC) will review unusual occurrences to develop recommendations to improve the health or safety of clients, family members, staff, and/or members of the general public while at the AHP Services Center.

For further information on this policy or the topic covered by this policy, please refer to:

- AHP Policy on Officer of the Day Standards
- AHP Policy on Clients Demonstrating Inappropriate Behaviors
- AHP Policy on Clients Demonstrating Intoxicated Behavior
- AHP Policy on Weapons
- AHP Services Center Operations Policies
- Quality of Care and Unusual Occurrence Incident Reporting, CBHS Provider’s Manual
Quality of Care (QOC) and Unusual Occurrence (UO) Incident Reporting

Overview

The Quality of Care (QOC) and Unusual Occurrence Incident Reporting is CBHS’s systematic approach to review care concerns, negative outcomes of care, and sentinel events. Quality of care concerns and unusual occurrences are events that have or may have an adverse affect on health or safety and that involve program clients, guests, staff, and/or facilities within CBHS. Events are reviewed to assess the quality of patient care and - when issues are identified - to develop and implement appropriate corrective action. Some incidents may require a Critical Incident Review (CIR).

The reporting of negative outcomes to CBHS is required and may be in addition to reporting to State Licensing or other regulatory agencies. Reports are maintained as confidential and protected by Evidence Code 1157.6.

Purpose of Incident Reporting

- To track and monitor trends from incidents occurring in our system of care.
- To problem solve when necessary.

Requirements and Procedures

All CBHS funded programs are required to report and use the specified Quality of Care Reporting Form. It is submitted according to the directions on the age-specific QOC reporting form. Please see policy 1.04-4 for detailed guidelines and specific timeframes for reporting.

- Any incident can be reported, but we are primarily interested in client-related events.
- Regardless of the situations surrounding it, a client’s death must be reported.
- All suicide attempts must be reported.
- Reports can be submitted for an incident at your own agency or for an incident at another agency.
- All CBHS providers must submit reports–no one is exempt.
- Any staff member may submit a report to CBHS administration. Staff members should feel free to report an incident and should not be subject to discrimination or any other penalty for having done so.
- This report, and any references to it, contain privileged and confidential information and should not be documented in the client’s chart or in the staff member’s personnel file.
- Please write clearly, limit abbreviations, use both sides, and fill in the client’s full name and BIS#.
- Events must be described by stating the facts. The date, printed name, and signature of the reporter must be documented on the QOC report. Printed name and signature of the program director/immediate supervisor are also required.

Procedures at Critical Incident Review (CIR) meetings

- CBHS QM staff will review all reports and will determine if a CIR is needed. A CIR will be called for all suicides.
- CBHS providers involved in the incident will be asked to participate.
- The purpose of the CIR is to identify opportunities for quality improvement and not to place blame.
- Agency staff will have adequate time to be fully up-to-date on the client’s chart before the CIR. A staff member (usually the client’s primary clinician) should be prepared to discuss in-depth the various aspects of the client’s care (including history and treatment course) and the circumstances of the incident.
- As with the report itself, the CIR is considered confidential and privileged. This means the details discussed cannot be subpoenaed to a court of law.
- After the CIR, CBHS QM staff will review the CIR and the client’s chart.
- Further review may be needed. In most cases, a letter will be sent to the provider(s) detailing the findings and the suggestions for improvement. Once again, this information cannot be placed in a client’s chart or staff member’s personnel file.
Incident and Quality of Care Report

Print Client’s Full Name _________________________________________ BIS#

Names of others involved in incident ______________________________________

Date of incident ___________________ Location of incident ______________________

Name of Agency/Program where client has a care manager: ___________________________________________ ____(if applicable)  ____(PRINT, no Initials)

Name and Title of person reporting incident ________________________________________________

Name of reporting agency _____________________________________________ Date of reporting ______

(PRINT, no Initials)

□ Incident resulted in a referral for medical attention.
□ Incident resulted in a 5150.  } If either of these, describe on back.

Then, please check one category that best describes the incident and describe on back.

Violent Behavior

❑ Verbally or physically threatening behavior on part of a client (includes Tarasoff)
❑ Assault or physical altercation between clients
❑ Assault by a client on a staff member
❑ Damage to property as a result of client behavior
❑ Alleged homicide
❑ Other violent behavior

❑ Client Injury, Accident, or Acute Medical Problem

❑ Alleged unprofessional/unethical conduct on the part of a provider (i.e., inappropriate verbal, physical, sexual, social, business contact)

❑ Client’s Suicide Attempt

Client Death

❑ Unexpected - resulting from medical problems
❑ Expected - resulting from medical problems (client had a known life-threatening illness)
❑ Result of complications of substance abuse
❑ Accidental death/fatal injury
❑ Suicide
❑ Alleged homicide
❑ Unknown cause

CBHS 102-AOA (12-2011)  Privileged and Confidential (cf. EC § 1157.6 WIC § § 4070, 4071, 5328)
A copy of this report should not be included in the client’s clinical/medical record
Medication Issue

- Client was allegedly administered wrong medicine
- Client was allegedly administered wrong dose
- There was an alleged issue with the timeliness of obtaining or the administration of a client’s medication
- Other

Alleged Abuse, client was the □ perpetrator □ victim □ neither

- Child abuse
- Elder abuse
- Dependent abuse

- AWOL
- Alleged Inappropriate Treatment, Delay in Treatment, Documentation, and/or Discharge
- Other Incident

Description of incident, including all who have been called/contacted (attach if more room is needed):

Program’s Own Follow-Up and/or Corrective Actions:

☐ We are requesting a CBHS Critical Incident Review (CIR) of this incident.

Signature of staff member completing this form: _____________________________ Phone: _____________________________

Program Director Signature: _____________________________ Date: _____________________________

Please report incident by fax: 415-252-3001 (which is secured and protected), OR by mail to CBHS, Quality Management Office, 1380 Howard St. 2nd Floor, San Francisco 94103.

□ Reviewed and Filed

CBHS 102-AOA (12-2011) Privileged and Confidential (cf. EC § 1157.6 WIC § 4070, 4071, 5328) A copy of this report should not be included in the client’s clinical/medical record
VII.
SERVICES CENTER
OPERATIONS
POLICIES
A. SAFETY

Officer of the Day
The Officer of the Day (OD) will be the first responder for building and client safety issues. ODs will assess a situation and determine what type of support they may need. ODs should always use a second staff member as backup so that additional staff or emergency personnel can be contacted if required.

The primary focus of the OD is to assist a client or staff member who may be at risk, and to take action to assure safety issues are promptly addressed and mitigated.

When handling a situation outside the front door or outside the back door, always look through the glass or open the door to look (but stay in the building while doing so). This will allow for a safe visual assessment. If you are concerned for your own safety or the safety of another person, call 9-911. If there is a safety issue outside, ask the reception staff to immediately lock the doors, and remain inside the building. Prevent others from exiting the building until the safety issue is resolved.

Non-OD Staff
Anyone who is aware of unsafe behavior or who perceives anything that may cause an unsafe environment at the AHP Services Center should inform the OD as soon as possible. If staff are able to resolve a situation (e.g. object which presents a tripping hazard, liquid spill on a floor, etc.) they are encouraged to do so. The OD should be notified in all instances, whether the situation is corrected or not.

Dialing 9-911 for Emergencies
Dial 9-911 for all emergencies. Calls are answered at UC Police dispatch, and they will coordinate any response required (police, fire, ambulance).

Telephone Emergency Button
A red-labeled “Emergency” button is located at the top right on each phone in the building. Staff should use these buttons to summon immediate assistance inside the building, for example, a medical emergency, or when someone is displaying aggressive behavior. When pressed, the button generates a loud alarm which can be heard throughout the building. All staff in the building will respond to these alarms by immediately assembling at the front desk. The OD and/or a designee should do a quick sweep of the floor they are on before proceeding to the front desk. There is a response button at the front desk which displays the intercom number of the phone and allows front desk staff to hear via speakerphone what is going on in the room where the alarm originated. A list of intercom numbers and corresponding rooms is
kept at the front desk so that staff may locate the emergency. An alarm pressed by mistake can be cancelled by hitting the “Emergency” button a second time. If the alarm is accidentally triggered, please notify the front desk immediately.

**UC Police Silent Alarm**
There are two silent alarm buttons (one located under the front desk and one located under the Crisis admin desk) which can be used to alert the UC police in case of emergency. These are intended for use in dire situations such as weapon is displayed, threatening behavior is observed, or violence has occurred and it is impractical to call the police. When these buttons are pushed, the UC police will dispatch an officer and call the front desk to determine the nature of the emergency. These buttons can only be reset with a key, so staff at these desks should make sure they know where they are and be careful not to set them off accidentally. Keys to reset these buttons are held by the Operations Coordinator, and by UCPD personnel.

**Bio-Hazard Waste**
All body fluids are a bio-hazard and may contain blood-borne pathogens. The safest way to handle these fluids is to make sure Personal Protective Equipment (PPE) is used. AHP has provided PPE for all staff who may be handling bio-hazard waste.

The following PPE items are available in room 112 on the first floor:
- Latex gloves
- Thick rubber gloves
- Heavy work gloves
- Face masks
- Eye goggle/shields
- Shoe covers/booties
- Lab coats
- Disposable coveralls
- Garbage can with biohazard bag
- Mops, brooms, dustpans
- Sharps containers
- Large biohazard garbage (Stericycle)
- Yellow caution tape

**Cleaning Materials**
- Bleach
- Isopropyl Alcohol (bottle and swabs)
- Comet
- LpH (Vestal) Germicidal detergent
- Pyrethrine spray
- CalTech biohazard spill kits
- Cat litter
- Window cleaner
An OD encountering any hazard should notify the Operations Coordinator for support and/or assistance.

In the event that a hazard is beyond the capability of AHP staff to handle:

1. Contact UCSF Environmental Health and Safety (EH&S) at: (415) 476-1300.

2. Notify the dispatcher of the scope of the problem, provide the location, and request the emergency response team.

3. Operations Coordinator/OD should secure the area while waiting for the emergency response team to arrive. If the Operations Coordinator is not present, please call coordinator’s cell phone and notify or leave a message.

4. If the Emergency Response Team requires paperwork to be completed, please do so, and retain a copy for the Operations Coordinator.
B. Officer of the Day (OD) Role and Responsibilities

The OD at 1930 Market Street Services Center is available to staff and clients during regularly scheduled work hours in the event there is a need for assistance with issues impacting client services and to direct Services Center staff in responding to an emergency. The OD can be contacted by either administrative or clinical staff. Issues related to the physical plant at 1930 Market Street should first be directed to Christopher Hall, Community Health Program Coordinator/Operations. In his absence, the OD will resolve to the best of ability any issues related to the physical plant.

The OD will be available on site via pager whenever the building is open for Behavioral Health Services clients. The OD is scheduled on a rotating basis. If HCAT Services are operating when BHS services are not being offered, the HCAT site supervisor is responsible for securing the building at the end of the day.

The following outlines the role and responsibilities of the OD:

1. Be available via pager and on site during business hours, Monday through Friday. When not in use, the OD pager is stored at the front desk.

2. Assure that front desk staff is on site and that opening procedures are underway:
   - Assure that front of the building is clear, clean, and welcoming to clients, staff and providers. This may include asking individuals to leave the property, cleaning up debris and checking in with Christopher Hall as needed.
   - Assist front desk staff with all other opening procedures (lights on, medical records cabinets and room doors unlocked as needed). Assure that front doors are unlocked at 8:45 am.

3. Review voicemail and follow up as appropriate. Staff calling in sick or unexpectedly delayed should leave their names and the times of their appointments. It is the OD’s responsibility to call all clients and leave a message indicating that their appointment has been cancelled due to staff illness/unexpectedly out. Client can be instructed to come back next week at usual time if seen weekly, otherwise, client should expect call from staff to confirm next appointment. Forward the message to the staff person’s supervisor.

4. OD will write a progress note indicating client called and inform staff person’s supervisor that their staff is out and clients have been notified. Clinician will be advised either by voice mail or email that their clients were called along with any other pertinent information. If OD is unable to reach clients to cancel and client presents for appointment, OD will be notified when the client arrives, and OD will then coordinate with client.

5. In the event of an emergency, OD will direct staff in responding to the emergency, or in evacuating the building when warranted. OD will continue to manage the situation until relieved by another manager, emergency personnel, or when the situation is resolved.
C. SERVICES CENTER RECEPTION DESK

Reception Desk
Reception Desk coverage is provided from 8:30 am - 9 pm Monday through Thursday, and 8:30 am - 5:30 pm on Friday. The Reception staff is supervised by the Services Center Operations Coordinator. When there is no other administrative staff available, the OD will determine who is available to assure the reception desk is staffed.

The main telephone number for AHP is (415) 476-3902. There are four rollover lines which allow for multiple calls. The last number, (415) 502-7232, is not forwarded so that staff can call to speak to someone at the front desk after hours.

Primary duties of reception staff:
• Make eye contact and provide an immediate, professional, and friendly greeting to everyone entering the front door, determine the needs of each person, and notify appropriate staff of client’s arrival.
• Use telephone emergency button and/or hard-wire silent alarm to notify staff or UC police of any immediate security concerns.
• Continually monitor the lobby to assure a safe environment, immediately notify the MOD/BOD or Crisis team when inappropriate behavior is noted.
  o Inappropriate behavior includes sleeping in the lobby, bringing bicycles or large objects/garbage bags into the lobby, loud or argumentative behavior, and disruptive pets. This is NOT an exhaustive list, when in doubt, contact the OD.
• Upon request, reception staff assures that clients complete any necessary paperwork.
• Answer and appropriately direct all incoming telephone calls.
• Maintain client confidentiality at all times.
• Provide limited general information and refer more specific questions to Triage or OD.
• Complete administrative tasks as directed.
• Route incoming faxes, notify appropriate staff of deliveries.
• Maintain front lobby area.

Reception Desk Backup
Backup reception desk coverage is based on a daily rotation among Services Center administrative staff and interns for both evening and daytime shifts. The designated backup for each shift carries a pager that is handed off at the changing of the shift or if s/he will be unavailable for a period of time during the shift.

Primary duties of the Reception Backup (Daytime):
• Assist with morning opening procedures.
• Provide backup coverage to the reception desk primary. Backup staff members are expected to arrive on time and be prepared to cover if the reception desk primary is late or ill.
• Provide additional reception desk coverage during designated periods when additional staff is needed at front desk (Thursday ASAP drop-in group, Dr. Harrison’s drop in clinic, etc.).
Primary duties of the Reception Backup (Evening):

- Provide backup coverage of the reception desk during scheduled shift. Backup staff members are expected to cover the entire shift if the reception primary evening front desk PA is unavailable. Coordinate relief/breaks with OD.
- Assist evening OD and reception desk primary with closing of building (sweeping the building, securing confidential material, etc.)

**Client Flow**

Reception desk staff welcomes all staff, visitors, and clients in a warm and professional manner. Clients and visitors enter through the front door and reception staff should determine who the client/visitor needs to see. If the client has an appointment, the client’s first name is to be recorded in the client log, along with the clinician’s name, time of initial contact, time and means the clinician was notified, and time the client was seen. Clients here for HIV testing should be asked for their initials only, and HCAT staff will be promptly notified at I/C 237. The client’s initials and the time they arrive should be recorded on the log, along with “HCAT” named as the Clinician/Provider. In each case, ask the client to have a seat in the lobby area. The front desk staff person then notifies the provider via intercom that the client has arrived. If a clinician cannot be reached via intercom, contact will be attempted by pager (using the code number “123”). When notified by a provider that a client needs to complete paperwork, reception staff provides the paperwork to the client to complete while waiting for the provider. The provider comes to the lobby to escort the client to a counseling room. Providers also escort clients back to the lobby area when the appointment is finished.

Drop-in clients requesting services are triaged to on-call triage staff. If client drops in outside of triage hours, he or she should be asked to call or return during triage hours. The OD should be contacted if the client refuses to accept this instruction.

**OD Role**

The OD is a manager or clinical staff person designated to assist with daily client or building issues as they arise. The OD is scheduled in shifts throughout the day and handles non-crisis client issues, general building issues, or clients who have detailed questions about AHP services. To contact the OD, dial the OD pager and enter the code “123” for a routine issue, or “789” if the situation is urgent (security issues, etc.).

**Client in Crisis Situation**

When clients call or present in a crisis situation (either stating they are in crisis, talking about harming themselves or others, saying things like “I’m a wreck, I need help” or crying), reception staff should immediately contact the Crisis Team, or the OD if Crisis team is closed. Note: If Crisis is closed, non-urgent calls go to the Crisis Voicemail. Urgent callers are advised to contact the Mobile Crisis Team at 970-4000.

**Triage**

Triage is staffed Mon, Wed, and Fri from 9AM to 11AM by staff according to a rotating schedule. Callers with triage related questions during those hours should be soft-transferred (announced) to the designated Triage staff. At other times, callers with triage questions should be encouraged to leave a voicemail, and Triage staff will follow up with the client on the next business day.
Soliciting/Sales Drop Ins
We are unable to accommodate salespeople attempting to generate leads by walking in to our building without an appointment. All purchasing for UCSF is done through centralized accounts with the UCSF Accounting Department. If a salesperson appears in the lobby, inform them that they can leave a business card or promotional material, and that you will direct the material to a manager. Contact the OD for assistance in asking the sales person to leave, if necessary.

Client Drop Off For Clinician/Accepting Packages
If a client indicates they have something they would like to leave for a clinician, please contact the clinician to meet the client in the lobby. Do not accept anything directly from the client. Contact the OD if the clinician is unavailable. Explain to the individual that this is our policy and that all items delivered must be received by a clinical staff person.

Literature/Promotional Material
We generally post non-sales oriented material in our lobby that promotes events or services that are beneficial to the well-being of our clients. If someone wishes to post something on the board, please forward the material for review to the Operations Coordinator. We also provide limited space for newspapers and magazines which are directed towards our clients.

If someone from another agency asks to speak to someone at AHP regarding services their organization provides, contact the OD for assistance.

Fax Information
There are three fax machines at the Services Center:

- **Main Fax (located in Room 134) - (415) 476-3655**
  This is the primary business fax for the Services Center. Front desk staff members check the fax machine at the opening of the business day, at 12:30PM, and again at the close of the day. Faxes are distributed to the appropriate staff mail box.

- **Confidential Fax (located in the Medical Records room) - (415) 502-4768**
  This machine is used to receive any documents that include client names and any other client information. It is kept behind locked doors with the medical records. It is checked regularly by Administrative Staff on the same schedule as the main fax.

- **Crisis Fax (located near the Crisis office) - (415) 502-7240**
  This machine is used for outgoing and incoming faxes by the Crisis Team. It is checked by Crisis staff.

Signing In and Out
All Services Center staff and interns will sign-in using the In & Out Board upon arrival to the Services Center, and will sign out upon departure. For planned absences, staff/interns will note this in the remarks column of the In & Out Board and provide a return date, when possible. For unplanned absences or delays, staff/interns will call the front desk, who will, in turn, indicate the absence in the remarks column of the In & Out Board, providing a return date when possible.
D. MEDICAL RECORDS

General
All active medical records are stored in the medical records room under the “rule of three,” meaning that each medical record can only be accessed if one has keys to three different locks (front door, medical record room door, and file cabinet lock). Inactive charts are also stored according to the rule of three, though due to space limitations all are not necessarily in the medical records room. The medical records room is kept locked at all times; AHP staff have access to the Medical Records area during regular business hours. Chart cabinets remain unlocked and keys to these are maintained by the Operations Coordinator and the Program Managers.

Filing
Charts for certain appointments are pulled and re-filed by Administrative Interns, or Administrative Staff. It is the responsibility of the reception staff to pull and re-file other charts that may be needed throughout the day.

Charts for the following work day’s appointments are pulled on a rotating schedule by administrative interns, with admin staff members filling in when interns are absent. A copy should be made of the next day’s appointments from the following appointment books: Psychiatrists, NPs and CRISIS team; then, the books are returned to CRISIS as soon as possible; and finally, when all charts are pulled, the photocopied appointment sheets are stored in the CRISIS appointment book at the front desk. The morning backup re-files the charts that were pulled the day before and should do so as early in the day as possible (this includes charts in medical records, and any in the basket in Dr. Harrison’s office).

“Out” cards located in the medical records room are used as placeholders for the charts pulled for the following day’s appointments. Interns and admin staff indicate on the card both the client’s and the provider’s name, as well as the date the chart was pulled.

Charts are left in the rolling cart located in the Medical Records room overnight. The following day, the morning PA brings these to the front desk for the providers to pick up.

Shredding
AHP has contracted with a commercial shredding service to perform shredding of sensitive material. Anything with confidential client information is placed in one of three bins (one in the Medical Records room, one in the Crisis room, and in the 2nd floor supply room).
E. ENVIRONMENTAL/FACILITIES

Building Maintenance
The Operations Coordinator is the contact for all questions related to building maintenance or repairs. A monthly walkthrough of the entire facility is conducted to inspect for unsafe conditions, assure the proper functioning of safety equipment (e.g. fire extinguishers), and identify items in need of repair.

The building is ADA compliant and several of the restrooms accommodate wheelchairs. Clients with mobility impairments who have used the handicapped parking space may request access to the rear of the building via an intercom that connects to the front desk.

All chemicals or cleaning supplies are kept in a locked area accessible only to authorized staff. Cleaning supplies are kept in the janitorial closet next to the 2nd floor restrooms, and in the operations closet. Other chemicals are stored in locked cabinets in the lab.

Emergency evacuations are conducted annually. The fire alarm system is maintained by UC Fire and Security. Annual safety checks are conducted by the UC Fire Marshall. Documentation for the evacuation drills and Fire Marshall inspections are maintained by the Operations Coordinator.

Parking/Transportation
There is one handicapped parking space behind the building on Hermann Street. This handicapped parking space is intended for use by clients or other visitors with a handicapped parking permit.

All staff members without an assigned parking space and visitors to the Services Center need to make their own parking arrangements. Be aware of street cleaning times; neighborhood permit parking, meter rates and times.

Staff paid parking at the Services Center is managed similar to the parking procedures in the UC system. Parking is assigned based on position and seniority within position groups.

There are thirteen parking spaces located in the rear of the building, not including the handicapped space. One space is allotted to the Crisis team for home visits. The monthly fee must be submitted by the 15th of each month, by check, to AHP. Parking spots are allotted first to the Executive Director, the Director, Program Managers and the Medical Director. Remaining parking spaces are offered on a first come basis ranked by length of service at AHP.

Staff members who wish to pay for parking should sign up with AHP Operations Coordinator, identify their car (or cars) and obtain a permit to display on the dashboard (driver’s side). This permit must be displayed every time the car is parked in the assigned space.

There is no visitor parking, however, staff who have paid parking may allow someone else to park in their paid spot. Unauthorized vehicles in the parking lot will be cited and/or towed.
UCSF Shuttle Service
The UCSF shuttle stops in front of the Mint Building on Hermann Street (going towards MCB or SFGH) and in front of the Buchanan Dental Clinic (going towards Parnassus). You should flag the shuttle down to get on at either stop. When you board the shuttle at another location for a return trip, you must ask the driver to let you off at Buchanan Dental Clinic. The shuttle schedule is posted at the Hermann Street door.

Public Transportation to the Services Center
Above Ground: The “F” Market; bus Lines: 71 and 7 (on Haight Street). Muni Metro: Van Ness Station, Church Street Station or the “N” Judah at Church Street. UC Shuttle Service: From UC Parnassus Campus and/or SFGH use the UC Buchanan Dental Clinic shuttle stop @ 100 Buchanan Street.

Bicycle Storage
Staff may store a bicycle in one of the two designated areas on a first-come, first-served basis. If the two areas are full, bicycles should be stored outside, at the owner’s risk. Clients may not bring bicycles inside Services Center.

Janitorial/Waste Removal
Vanguard Cleaning Systems (Crista Pounders (650) 287-2410) provides janitorial services five days per week. The janitors put out trash and recycling bins the night before they are to be picked up.

There are two paper/can/bottle recycling bins kept in the staff lounge. Recycling is picked up on Tuesday and Thursday mornings in the rear parking lot by Sunset Scavenger.

Compost bins are located in the vending area and the staff lounge. These are emptied nightly by janitorial staff. The main compost bin is locked at the rear of the building (keys at the front desk). Janitorial staff moves the bin to the curb for collection on Monday evening for pick-up Tuesday morning.

The garbage dumpster is located in the parking lot, and the key is the same which opens the compost bin. (The key is located at the front desk). Janitors place garbage in it each time they clean, Sunset Scavenger picks the garbage up early Tuesday morning.

Hazardous Waste
Hazardous waste is picked up by Stericycle {(800) 355-8773, reference our account # 6070230-001}, on a bi-weekly basis. The hazardous waste container is kept in the lab (Room 123). Expired medications and other hazardous waste must be kept in designated container.

Building Access
• Front Lobby Door (at Market Street) is the main staff and client entrance/exit. This entrance shall remain unlocked during business hours unless otherwise directed
• Police Door (Crisis Area) – Used by Crisis Team for private exit (locked for entrance).
• Back Door – Always locked: Staff entrance/exit. Clients may only use if entering the building from the handicapped parking space (use the intercom for access).
Handicap Access - There is one handicapped parking space in the rear parking lot. It may be used on a first-come, first-served basis by staff or clients with a handicap placard. Staff members who wish to use the parking spot will have a front/back door key issued. Clients who wish to use the spot must make prior arrangements for back door access (to be let in by staff).

Mail
Campus mail delivers and picks up once daily. US Postal Service delivers once a day. All Services Center staff has a mailbox in the main copy/supply room on the first floor. Trays for incoming and outgoing mail are located on top of the staff mailboxes. Business related mail may be placed in the outgoing mailbox, and should have our campus Box number (1312) to assure that postage is applied. Incoming mail is distributed as it arrives by admin staff/interns.

Staff Lounge and Vending Area
The lounge is to be used by staff or volunteers only, and it is NOT to be used for meeting space. Please be considerate and keep it clean, safe, and comfortable for your fellow co-workers. The vending area is available for use by visitors.

Heating and Air Conditioning
There are six thermostats controlling heat, air conditioning and ventilation, divided into six zones within the building. The covered and locked thermostats are set within a range of balance and will kick-on for heat and air conditioning when needed. They are not adjustable by on-site staff. The fans run twenty-four hours a day for ventilation. Carson Mechanical provides maintenance of our HVAC system.

Smoking
UCSF is a tobacco-free campus and provides a tobacco-free environment for its faculty, staff, students, patients, and visitors.

San Francisco Municipal Code forbids smoking within 15 feet of doors, vents, or operable windows.
F. PHYSICAL SECURITY

**Keys**
The Operations Coordinator maintains building keys, and a log of assigned keys and codes, and informing the security company regarding changes in access codes. Supervisors must submit via email key requests for their staff. The Services Center Operations Coordinator maintains a log documenting key issues, and keeps all Services Center Keys in a locked box.

Keys will NOT be given to anyone who is not staff, other than contracted and bonded service vendors, such as the janitorial services, or UCPD or UC Facilities Management.

**Front/Back Door Key**
Only staff involved in the opening and closing of the Services Center has the front/back door key. These staff members also have an access code. Front/Back Door Keys and Access Codes should NOT be shared or lent.

**Master Keys**
Master keys are held by the Operations Coordinator, BHS Program Manager, Medical Director, and there is a master key held at the front desk. Off premises, master keys are held by the Executive Director, the Director, and the Admin and Fiscal Services Manager.

**Keys Kept at the Front Desk**
- Master key
- Common key
- Telephone Room key
- Key for Jim and Lori’s Office 224
- Compost and garbage bin key

**Access Codes**
All staff having access to the building must obtain prior approval from their supervisor to enter the building during off hours.

The Operations Coordinator is responsible for obtaining alarm codes and informing the security office regarding changes in access codes. Supervisors must submit via email alarm code requests for their staff.

Keys or access codes will NOT be given to anyone who is not staff, other than contracted and bonded service vendors, such as the janitorial services, or UCPD or UC Facilities Management.

**Alarm Panel**
The Services Center will be alarmed between the hours of 9:30 pm and 8:30 am. All staff issued keys to the premises will also receive a unique alarm code. The alarm is activated by the last staff person leaving in the evening and de-activated by the first staff person arriving in the morning.
UCPD monitors the alarm systems. They are located on campus at 502-6328. If the alarm goes off, UC Police will respond and notify appropriate staff from the notification list submitted and updated periodically by the Operations Coordinator.

There are security contacts on all three exit doors (front, back and crisis police door) and motion detectors throughout the building. Key pads are located just inside the front and back doors to arm or disarm the system.
G. OPENING AND CLOSING

AHP Services Center is open between the hours of 8:45 am - 8:30 pm, Monday through Thursday, and 8:30 am to 6 pm on Fridays.

The person(s) scheduled to be the morning Front Desk primary Officer of the Day (OD) and/or front desk backup is expected to arrive on time and open the building.

The person(s) scheduled to be the evening OD and/or Front desk Backup is expected to close the building, working in conjunction with the evening Front Desk PA.

A checklist of what needs to be done is included below, and will be posted in appropriate locations.

Opening Procedures
The OD is the main person responsible for opening the Service Center in the morning. There are certain tasks that are also done by the Front Desk Primary or Backup. The following is to be used as a guideline by opening staff.

Disarm the Building Alarm
- The first person to enter the building should disarm the alarm system. This person should indicate his/her name, the date, and time on the dry erase boards next to both the front and rear entrance alarm panels. In addition, all staff should use the in/out board when they arrive or depart.
- Alarm panels are located on the wall by the front reception desk and by the back door upstairs. Instructions are posted above the alarm panels.
- If alarm system is armed, the panel reads “Disarm Now”. If alarm system has already been disarmed, the panel will read “Area Ready.”
- To disarm, type in your code and press “Enter”.
- Any problems with the alarm should be reported to UC Police at 476-1414, and the Operations Coordinator.

Unlock the Front Door
- Either the OD or the front desk PA (or backup PA) should unlock the door by 8:45AM.
- Use the switches at the front desk to unlock the front doors, and to activate the handicapped button. Verify that the handicapped button is working by going outside and checking.

Open Common & Group Rooms, Turn on Lights
- Front desk primary or backup should walk through the building and open the doors for all group rooms. Additionally, turn the lights on and turn the circuit breakers on which control emergency lighting (panels in room 130A and 214).
Front Desk
- Front desk primary and back up are responsible for retrieving appointment books, files, and any other confidential information that has been stored overnight in the medical records room.
- The front desk primary should also unlock all filing cabinets in the medical records room, using the set of keys kept at the front desk.
- The front desk primary un-forwards the phones from voicemail.
- The front desk primary/backup is also responsible for checking the main client line voicemail (476-3902) and retrieving all messages that were left.
- The front desk PA should also log in to the computer so that clients can be logged in and room reservations scheduled.

Closing Procedures
After the Crisis unit closes (at 5 pm Monday – Friday), the evening front desk primary forwards the main phone line to voicemail. The "staff only" line (502-7232) is not forwarded and should continue to be answered.

Locking Door
The evening front desk PA, or HCAT clerk, will lock the front door at 7 pm (Tue, Wed, Thu,) and at 5 pm (Monday and Friday), using the switch at the front desk. Verify that the handicap button has also been switched off by going outside and checking. Group members may take a break after the doors are locked, and should be readmitted after their break.

Securing Client Information
Prior to the end of the workday, the front desk primary puts all front desk appointment books, logs, client charts and anything else containing confidential client information into the Medical Records room to be locked up for the evening. The front desk primary then locks all file cabinets in the Medical Records room, using the set of keys kept at the front desk.

Sweeping the Building
Prior to 9 pm (Monday – Thursday) and 5:30 pm (Friday), the OD and front desk primary or backup begin to secure the building. All rooms should be verified as unoccupied and secured. It is recommended that the OD and the PA check in with each other at the start and end of this process for safety.

Check all office doors to make sure they are locked (even though staff members are responsible for closing and locking their own office doors). There is a master key at the front desk.

Check and lock all unoccupied group, counseling/intake, copy/supply and conference rooms and the staff lounge (even if they are already locked) to make sure that:
- no one is inside
- all windows are closed and locked (windows located in office 202, conference room 203, classroom 204, room 219, group room 221, staff lounge)
- overhead lights are turned off
- all doors are closed and locked (staff lounge and room 130 should remain unlocked)
The following areas should all be secured:
- Offices
- Back door
- Copy/Supply rooms
- Counseling/intake rooms
- Group Rooms
- Conference Rooms
- Closets
- The medical records room (after all client information from the front desk has been locked up). File cabinets should be closed and locked – there are keys up at the front desk for this purpose.

Shut off all lights (located on elevator shaft on second floor and near reception desk on first floor. Hallway and lobby lights will stay on until automatic shut-off at 11:30PM, but others should be shut off by exiting staff).

Once everyone except closing staff have exited the building and all rooms have been verified as secured, closing staff can set the alarm and exit the building.

Alarm Instructions
- Closing staff need to decide to exit either through the front door or back door, but all must exit together.
- Instructions for setting the alarm are posted above the alarm panels. To arm building, alarm screen must say, “Ready to arm.”
- Punch in code and press Enter.
- All staff must exit the building within 60 seconds.
- Any problems with the alarm should be reported to UC Police at 476-1414, and the Operations Coordinator.
H. EMERGENCY EVACUATION PLAN

In the event of an evacuation, the Evacuation Response Monitors (ERM) will take charge of ensuring a complete evacuation of the building. For easy recognition, they will wear an orange vest and hard hat. These items will be kept at the Front Desk in a clearly marked box and in a clearly marked cabinet in the 2nd floor copy room. The ERM or the Senior Staff person in the assembly area will serve or appoint a designee to serve as the contact person with SFFD and/or SFPD.

ERM for 1st Floor:
Front desk primary is responsible for evacuation of 1st Floor. Prior to exiting the building, bring the “emergency bag” (located in the cabinet near the front desk) to the assembly area.

ERM for 2nd Floor:
Manager of the Day/Building Officer of the Day is responsible for evacuation of 2nd Floor.

Each Evacuation Response Monitor (ERM) will carry out the following tasks for their area of responsibility:

1. Instruct and/or ensure co-workers, clients, and volunteers on the floor for which he/she is responsible are performing their emergency roles.

2. Designate a fellow employee to assist in the search of all rooms, including the lobby area to confirm that everyone heard the Emergency Notification Alarm (e.g. fire alarm, overhead announcement).

3. Designate a fellow employee to stand guard at the elevator to ensure that it is not used during the evacuation.

4. Assure that the entire floor that he/she is responsible for has been evacuated; searching all areas; closing all doors to indicate that the area/room has been searched and is empty.

5. Ensure that all disabled persons are escorted to safety.

6. Inform staff and clients that it is safe to re-enter the building, upon approval of SFFD.

Responsibilities of Staff, Clinical Interns, Group Facilitators, Volunteers and Trainers include the following:

- Know the physical layout of the Services Center
- Know the location of the nearest exit, alternate exit and the direct route to each
- When alerted to an emergency, staff will assist clients and visitors, in exiting the building and leading them to the assembly site.
- At the assembly site, each staff, facilitator, intern, trainer, or volunteer must immediately report to the ERM in the orange vest and/or the Senior Staff in their assembly area that they and their clients are accounted for, or not.
• Services Center managers will assist the First or Second Floor ERMs with the evacuation. If necessary, a manager may undertake the role of the ERM.
• Crisis Team Senior Staff or Staff Supervisor will ensure the safe exit of all clients, guests, etc. waiting in the lobby area and escort them to the assembly area.

Emergency Exits

The building has three (3) exits:

First Floor
On the first floor, there are the main doors in the lobby area and a “police” door in the Crisis area. Both of these exits lead to Market Street. Those exiting on to Market Street should turn left out of the building and proceed to the northwest corner of Hermann and Laguna.

Second Floor
On the second floor, there is a door on the backside of the building, which leads to Hermann Street. Those exiting on to Hermann Street should turn right and proceed to the northwest corner of Hermann and Laguna.

The assembly area is the sidewalk area that faces Orbit Room’s side window at Hermann and Laguna.

All staff, volunteers and interns MUST familiarize themselves with the locations of the exit, fire pull stations and fire extinguishers in the building. Building maps indicating exit locations are posted throughout the building.

During an emergency evacuation drill, a Services Center manager will instruct a designated staff member to announce the need to evacuate on the overhead paging system.

During an emergency evacuation, elevators should NOT be used.

After leaving the building, staff, volunteers, interns, clients and visitors should assemble in the designated area and remain there until an ERM or Senior Staff gives you additional instructions.

Once evacuated, no one may return to the building until “all clear” has been given by the Fire Department or senior AHP manager.

Once at the assembly area, make sure that you and your group are away from any danger, e.g. power lines, crumbling buildings, etc.
I. ROOM SCHEDULING

The Services Center Operations Coordinator, or designee, has oversight of room scheduling.

Client Appointments
Staff and Interns will be instructed in setting up Outlook to access the room schedules. The Operations Coordinator will provide instructions in making reservations. Reservations may also be made with staff at the front desk.

Conference Rooms and Classroom Scheduling
There are two conference rooms in the facility and one classroom. Reservations can be requested directly if your computer has been set up to do this on Outlook. Otherwise, please send an email to the Operations Coordinator with details of your room request.

Non-AHP Use
Outside organizations are generally not permitted to use our facility, however, exceptions are made when the outside organizations goals mesh with those of AHP, and other requirements for use are met. Contact the Operations Coordinator for specific guidelines. Arrangements with outside agencies must be reviewed by the AHP Director prior to any approval for use.
**J. COMPUTER SYSTEMS**

**Computer Systems**

AHP operates on a cross-platform system with both PCs and Macs. Computer problems should be reported to the ITFS Helpdesk at 514-4100, or via email to ahp.it@ucsf.edu.

All computers are the property of AHP; computers are intended for work, not for entertainment. Anyone granted login credentials is expected to comply with all computer guidelines and procedures.