San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Community Health Equity & Promotion
Performance Objectives FY 2022-2023

Revised: 9/22/23

FY22-23 CHEP HPS Objectives

CID #	Agency	Program & Objectives
1000024733	**IFR: Instituto Familiar de la Raza, Inc.**	**Health Access Point for Latinx**
	Objective #1	By June 30th, 2023, agency will provide detailed executive summary report of completed start-up activities and strategic implementation plan.
	Objective #2	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective #3	By June 30th, 2023, agency will have identified lead data manager, responsible for quarterly client level data submissions and quarterly HAP prog narrative submissions.
	Objective #4	By June 30th, 2023, agency will provide documentation of onsite overdose response policy (policy language and guidance provided to agency by
1000024732	**Rafiki Coalition for Health and Wellness**	**Capacity Building Health Access Point for Black African American Community**
	Objective #1	By June 30th, 2023, agency will provide detailed Executive Summary Report of completed Capacity Building needs assessment, Health Access plan, detailed program implementation plan and time-line for FY23-24 along with comprehensive curriculum for workforce development and traini sub-contractor PRC.
	Objective #2	By June 30th, 2023, agency will have identified Health Access Point sub-contractors and completed executed sub-contractor MOU agreements f FY23-24.
	Objective #3	By June 30th, 2023, agency will have identified lead data manager, responsible for quarterly data submissions.
	Objective # 4	By June 30th, 2023, agency will have identified designated staff to attend HAP Required monthly meetings.
	Objective # 5	By June 30th, 2023, agency will provide documentation of onsite overdose response policy.
1000024732	**San Francisco Community Health Center (SFCHC)**	**Health Access Point for Transwomen: STAHR (San Francisco Transgender Alliance for Health Resources)**
	Objective #1	By June 30th, 2023, agency will provide detailed executive summary report of completed HAP Start-Up Activities, and strategic implementation p
	Objective #2	By June 30th, 2023, agency will provide detailed executive summary of completed ***Capacity Building Activities*** and strategic plan.
	Objective #3	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective # 4	By June 30th, 2023, agency will have identified lead data manager, responsible for quarterly client level data submissions and quarterly HAP prog narrative submissions.

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CID #	Agency	Program & Objectives
	Objective # 5	By June 30th, 2023, agency will provide documentation of onsite overdose response policy (policy language and guidance provided to agency by
1000024737	**Alliance Health Project (AHP)**	**Health Access point for API & API Transgender Women**
	Objective #1	By June 30th, 2023, agency will provide detailed executive summary report of completed start-up activities and strategic implementation plan (inc to program follow-up items).
	Objective #2	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective #3	By June 30th, 2023, agency will have identified lead data manager, responsible for quarterly client level data submissions and quarterly HAP prog narrative submissions.
	Objective #4	By June 30th, 2023, agency will provide documentation of onsite overdose response policy (policy language and guidance provided to agency by
1000024735	**LYRIC**	**Youth Health Access Point**
	Objective #1	By June 30th, 2023, agency will provide detailed executive summary report of completed start-up activities and strategic implementation plan.
	Objective #2	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective #3	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective # 4	By June 30th, 2023, agency will provide documentation of onsite overdose response policy (policy language and guidance provided to agency by
1000024736	**Ward86**	**Health Access Point for People Who Use Drugs (PRO-TEST)**
	Objective #1	By June 30th, 2023, agency will provide detailed executive summary report of completed start-up activities and strategic implementation plan.
	Objective #2	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective #3	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective # 4	By June 30th, 2023, agency will provide documentation of onsite overdose response policy (policy language and guidance provided to agency by

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CID #	Agency	Program & Objectives
1000024734	**SFAF**	**Health Access Point for Gay MSM Community (A5)**
Appendix A-5	Objective #1	By June 30th, 2023, agency will provide detailed executive summary report of completed start-up activities and strategic implementati
	Objective #2	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective #3	By June 30th, 2023, agency will have identified designated staff to attend Health Access Point (HAP) Required monthly network meetings.
	Objective # 4	By June 30th, 2023, agency will provide documentation of onsite overdose response policy (policy language and guidance provided to agency by
Appendix A-4	**SFAF**	**HAP Network Capacity Building: Integration of HIV/STI/HCV Testing (A4)**
	Objective # 5	By June 30th, 2023, agency will provide detailed executive summary report of completed start-up planning activities and strategic implementation supported agency.
Appendix A-3	**SFAF**	**The Black Health Clinical Assistant Program: Rafiki Capacity Building (A3)**
	Objective # 6	By June 30th, 2023, agency will provide detailed executive summary report of completed Rafiki capacity building activities, planning activities, ass strategic implementation plan for FY23-24 as applicable, challenges, and success.
Appendix A-1	**SFAF**	**Training Academy & Clinical Assistant Program (A1)**
	Objective # 7	By June 30th, 2023, 30 unduplicated participants will engage in CHW-TA training, and complete 270 hours of training.
	Objective # 8	By June 30th, 2023, measured via participant surveys and observation, participants will demonstrate increased knowledge of best practices relate health program implementation and engagement.
	Objective # 9	By June 30th, 2023, five organizations within the HAP network will participate in Community Health Worker Training Academy by sending at leas employees to available trainings.
	Objective # 10	By June 30th, 2023 20 individuals will complete the HIV test counselor certification process through 2 trainings.
	Objective # 11	By June 30th, 2023, Graduates will report increased knowledge of sexual health and basic competencies around conducting test counseling sess
	Objective # 12	By June 30th, 2023 the program will hire and onboard 5 clinical interns.

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	Objective # 13	By June 30th, 2023, three of the five clinical interns will enter paid community health opportunities within 6 months of completing the program.
1-21927	**Aguilas**	**Special Project Latino MSM- El Ambiente (Contract Ended 6/30/23)**
	Objective # 1	By the end of the fiscal year, 90% of Latino men who have sex with men clients of AGUILAS will be offered at least one HIV test annually as mea documented by client consent for service form.
	Objective # 2	By the end of the fiscal year, 80% of HIV-negative/unknown status Latino men who have sex with men clients of AGUILAS will report having had the prior 6 months, as measured or documented by self-report, EvaluationWeb and/or client surveys and electronic charts.
1-21928	**SFCHC**	**Special Project - Trans Women - Transform Collaborative (Contract Ended as of 12/31/2022)**
		By the end of each fiscal year, Transform Collaborative will distribute at least 6, 000 condoms as documented in the condom inventory.
		By the end of each fiscal year, 90% of HIV/HCV-negative clients will be referred to HIV/HCV testing services as documented on the client intake
1-2679	**SFCHC**	**HERR for API MSM (Contract Ended as of 12/31/2022)**
	Objective # 1	90% of HIV/HCV-negative/unknown status clients will be offered an HIV/HCV test at intake.
	Objective # 2	80% of HIV/HCV-negative/unknown status clients engaged in services for the first 6 months of the FY will be offered an additional HIV/HCV test mark.
	Objective # 3	90% of HIV-positive clients who have not seen an HIV primary care provider will be offered linkage to care at intake.
	Objective # 4	The Connection will distribute at least 6,000 condoms annually.
	SFCHC	**PrEP for Trans Latina Women (Community Engagement)**
	Objective # 1	By the end of each fiscal year, 20 new participants from the target community will report having initiated PrEP (i.e. took the first dose of medicatic documented by client files, surveys or medication logs.
	Objective # 2	By the end of each fiscal year, 70% of clients who initiated PrEP and for whom follow-up data is available will report still being on PrEP after 6 mo documented by client files, surveys or medication logs.
	Objective # 3	By the end of each fiscal year, 70% of new participants who initiate PrEP will report having taken the first dose within three months of decision as by client files, surveys or medication logs

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1-2610	**SFCHC**	**PrEP Navigation Program (Contract ended as of 12/31/2022)**
	Objective # 1	By the end of each fiscal year, 35 new participants from the target community will report having initiated PrEP (i.e. took the first dose of medicatic documented by client files, surveys or medication logs.
	Objective # 2	By the end of each fiscal year, 70% of new participants who initiate PrEP will report having taken the first dose within three months of decision as by client files, surveys or medication logs.
	Objective # 3	By the end of each fiscal year, 70% of clients who initiated PrEP and for whom follow-up data is available will report still being on PrEP after 6 mo documented by client files, surveys or medication logs.
1-9622	**BAART**	**HIV Testing in a Sub Use Tx Setting (Contract Ended 6/30/23)**
	Objective # 1	By the end of each fiscal year, the program will have an HIV/HCV test planned and/or performed on all HIV/HCV negative/unknown status clients
	Objective # 2	By the end of each fiscal year, the program will offer appropriate linkage to care and partner services to all clients testing positive.
1-9849	**BVHP**	**HIV/HCV Testing in Methadone Program (Contract Ended 6/30/23)**
	Objective # 1	By the end of each fiscal year, 100% of HIV/HVC negative/unknown status program clients will have an HIV/HCV test planned and/or performed, in client records
	Objective # 2	By the end of each fiscal year, 100% of program clients who test positive, will be offered appropriate linkage to care and partner services, as doc client records.
1-8933	**Facente**	**Consulting Programs**
	Objective # 1	At the end of each year on December 31, between 2019 and 2023, Shelley Facente of Facente Consulting will prepare a final report summarizing activities and accomplishments, as measured by submission of the final report.
1-2608	**Glide Foundation**	**OPT-IN HIV/HCV Linkage to care (Program Ended 12/31/2022, i.e. including Row 79, 80, 81).**
	Objective # 1	By the end of each fiscal year, 50 Percent of people identified as HCV Positive will have initiated HCV treatment.
	Objective # 2	By December 31 of each contract year, 50 Percent of people identified as HIV Positive who are "out of care" will be linked to care within 30 days.
	Objective # 3	By December 31 or each contract year, 50 Percent of people expressing that they would like to be initiated on PrEP will be connected to a PrEP

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CID #	Agency	Program & Objectives
		HIV/HCV Linkage to care & Harm Reduction Programs
	Objective # 1	By June 30, 156 clients living with HCV will have completed the Glide Prep-C screen and a Patient Navigation Assessment and Care Plan, finally Glide's HCV Active Linkage services.
	Objective # 2	By June 30, 17 clients with HCV who are already in primary care but who have been denied access to HCV treatment as a result of their drug us linked to a supportive provider, as measured by SFDPH data collection forms.
	Objective # 3	By June 30, 43 clients previously untreated for HCV will receive treatment as a result of participation in Glide's HCV Active Linkage program, as SFDPH data collection forms.
	Objective # 4	By June 30, 85 clients not already engaged in primary medical care will have been linked to primary care to receive HCV-related care, as measu data collection forms.
	Objective # 5	By June 30, 575 individuals at high risk for HCV will have been screened for HCV, as measured by the SFDPH HCV Screening Forms submitted each month
1-13476	**Harm Reduction Coalition (contract continuing through 6/30/24 FYI)**	**DOPE/SRO Overdose Prevention Program (Program Ended as of 6/30/23)**
	Objective # 1	By the end of each fiscal year, the DOPE Project will collect overdose incident data on 80% of clients who report at time of refill that they used th
	Objective # 2	By the end of each fiscal year, the DOPE Project will conduct 2 Train the Trainer sessions to support naloxone training, which encompasses trair deliver overdose prevention training to other providers and clients.
		DOPE Project | Training Institute
	Objective # 1	Monitor Completed UOS per contract
		Tenant Overdose Response Organizers (TORO) at SROs (Program ended as of 1/31/22)
	Objective # 1	Monitor Completed UOS per contract
1-2612	**HR360**	**HCV Linkage to care**
	Objective # 1	By the end of each fiscal year, 100 unduplicated clients will have been enrolled in the HCV Linkage Program as measured by the client assessm forms.
	Objective # 2	By the end of each fiscal year, 75 unduplicated clients who have been enrolled in the HCV Linkage Program will have initiated primary care as m client activity logs and case notes.

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	Objective # 3	By the end of each fiscal year, 75 unduplicated clients who have been enrolled in the HCV Linkage Program will have received a full medical eva measure by client activity logs and case notes.
1-9851	**HR360**	**HIV Testing in a Sub Use Tx Setting (Contract Ended 12/31/22)**
	Objective # 1	By the end of the fiscal year, 90% of participants testing HTV-positive will be offered partner services as documented by a referral to appropriate provider.
	Objective # 2	By the end of the fiscal year, 80% of participants testing HIV-positive will be offered linkage to care as documented by development of a care pla electronic health record system.
	Objective # 3	By the end of the fiscal year, 60% of participants previously testing HIV-positive who have been out of care will be offered linkage to care as docu assessment resulting in either a referral to appropriate services or the development of a care plan.
	Objective # 4	By the end of the fiscal year or as requested by San Francisco Department of Public Health, HR360 CHEP will provide data on HIV positivity rate
1-21930	**IFR**	**HERR For Drivers Among MSM (Contract Ended 12/31/2022)**
	Objective # 1	By the end of the fiscal year, 90% of Latino males who have sex with males clients of Instituto Familiar de la Raza will be offered at least one HIV as measured/or documented by assessment or intake forms.
	Objective # 2	By the end of the fiscal year, 60% of HIV-negative/unknown status Latino males who have sex with males clients of Instituto Familiar de la Raza having had an HIV test in the prior 6 months, as measured or documented by self-report, EvaluationWeb.
	Objective # 3	By the end of the fiscal year, 90% of HIV-positive clients in Instituto Familiar de la Raza testing positive or who have not seen an HIV primary car prior 6 months will be offered linkage to care as measured or documented by client treatment plans
	Objective # 4	By the end of the fiscal year, 90% of people testing HIV-positive at Instituto Familiar de la Raza will be offered partner services as measured by E
	Objective # 5	By the end of the fiscal year, Instituto Familiar de la Raza will distribute at least 10,000 of condoms annually as measured by invoices and progra
	IFR	**Special Projects for Latino MSM (Contract Ended 12/31/2022)**
	Objective # 1	By the end of the fiscal year, Instituto Familiar de la Raza will conduct a total of 850 HIV tests for Latino males who have sex with males as meas EvaluationWeb.
	Objective # 2	By the end of the fiscal year, 60% of HIV-negative/unknown status Latino males who have sex with males clients of Instituto Familiar de la Raza having had an HIV test in the prior 6 months, as measured or documented by self-report, EvaluationWeb
	Objective # 3	By the end of the fiscal year, 90% of Latino males who have sex with males clients of Instituto Familiar de la Raza will be offered at least one HIV as measured/or documented by assessment intake form.

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CID #	Agency	Program & Objectives
	Objective # 4	By the end of the fiscal year, 90% of people testing HIV-positive at Instituto Familiar de la Raza will be offered partner services as measured by E
	Objective # 5	By the end of the fiscal year, 90% of HIV-positive clients in Instituto Familiar de la Raza testing positive or who have not seen an HIV primary car prior 6 months will be offered linkage to care as measured or documented by client treatment plans
	Objective # 6	By the end of the fiscal year, Instituto Familiar de la Raza will distribute at least 10,000 of condoms annually as measured by invoices and progra
1-2680	**IFR**	**PrEP Services for Latino MSM (Contract Ended 12/31/2022)**
	Objective # 1	By the end of each fiscal year, 50 new participants will report having initiated PrEP (i.e., took the first dose of medication).
	Objective # 2	By the end of each fiscal year, 40 (80%) of new participants who initiate PrEP will report having taken the first dose within three months of decisi
	Objective # 3	At six-month follow-up 70% of clients who initiated PrEP and for whom follow-up data is available will report still being on PrEP
1-2681	**LYRIC**	**PrEP Services for Youth (Contract Ended 12/31/2022)**
	Objective # 1	By the end of contract fiscal term, 135 new participants will have been asked about their interest in PrEP and, if interested, will be offered PrEP n support by the end of the term. Assessments to be documented in agency's participant database.
	Objective # 2	By the end of fiscal year, 10 new participants will report having initiated PrEP (i.e. took the first dose of medication) by the end of the term, as me report and/or staff observation and documented in their partisan profiles.
	Objective # 3	By the end of contract fiscal year, at the 3-months follow-up, 50% of participants who initiated PrEP, and for whom follow-up data is available, wil PrEP as measured by self-report and/or staff observation and documented in their participant files.
1-2553	**MNHC**	**PWP in the COE (Contract Ended 12/31/22).**
	Objective # 1	90% of PWP participants will receive at least one session focused on addressing barriers to adherence as identified in their assessment, and me program records.
	Objective # 2	At least 50% of clients identified as out-of-care or tenuously in-care and enrolled in the PWP program will be engaged in care as measured by att (2) or more HIV Primary Care Evaluation visits at least three months apart during the contract period.
	Objective # 3	Within 1 year of enrollment in PWP, 35% of clients will have undetectable viral loads (<40 copies/ml) as measured by laboratory results.
1-17931	**NAHC**	**Hozhoni Project**

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	Objective # 1	By the end of the fiscal year, Hozhoni will conduct a total of 60 targeted HIV rapid tests to MSM, MSM-IDU, and TFSM clients of NAHC.
	Objective # 2	By the end of the fiscal year, 65% of HIV-negative/unknown status MSM, MSM-IDU, and TFSM attendees of Hozhoni groups will report having h in the prior 6 months, as measured by self-report and data on linkage to testing.
	Objective # 3	At six-month follow-up 70% of clients who initiated PrEP and for whom follow-up data is available will report still being on Prep By the end of the
	Objective # 4	By the end of the fiscal year, 90% of HIV-positive Hozhoni clients who have completed case management intake and who have not seen an HIV physician will be offered linkage to care by their prevention case manager, within six months of intake/ onset of case management.
	Objective # 5	By the end of the funding term, 0% of people testing HIV-positive at NAHC will be offered partner services, as documented by their LINCS case r Their partners will also be offered NAHC services
	Objective # 6	During the contract term, Hozhoni will distribute 4000 condoms (male/female) annually.
1-17985	**SFAF**	**HIV Testing (Contract Ended 12/31/2022)**
	Objective # 1	By the end of the fiscal year, SFAF (and its subcontractors) will report an 85% linkage to care rates for newly diagnosed clients in all programs, li being defined as attending first medical appointment within 3 months of diagnoses.
	Objective # 2	By the end of the fiscal year, SFAF will report the number of unduplicated clients who are on PrEP and testing in this program.
	Objective # 3	By the end of the fiscal year, 80% of clients testing at SFAF programs will report having had an HIV test within the last 6 months.
	SFAF	**HERR Drivers for MSM (The Stonewall Project)**
	Objective # 1	By the end of the fiscal year, SFAF (and its subcontractors) will report a 70% linkage to care rates for newly diagnosed substance users, linkage defined as attending first medical appointment within three months of diagnoses
	Objective # 2	By the end of the fiscal year, SFAF will report an 80% retention rate among HIV positive substances users, retention defined by having had a doc appointment, prescription refill or lab work per treatment plan with the past six months.
	SFAF	**Special Project for AAMSM**
	Objective # 1	By the end of the fiscal year, SFAF will report on the percentage of tests among AAMSM.
	Objective # 2	By the end of the fiscal year, SFAF will report on linkage to care rates among newly diagnosed AAMSM as defined by attending first medical app 3 months of diagnoses.

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CID #	Agency	Program & Objectives
	Objective # 3	By the end of the fiscal year, SFAF will report an 80% retention rate among HIV-positive AAMSM, retention as defined by having had a doctor's a prescription refill or lab work per treatment plan within the past six months.
	SFAF	**MSM SP (Stonewall Castro/LIFE Program)**
	Objective # 1	By the end of the fiscal year, SFAF will report on the percentage of tests among MSM.
	Objective # 2	By the end of the fiscal year, SFAF will report on linkage to care rates among newly diagnosed MSM as defined by attending first medical appoin months of diagnoses.
	Objective # 3	By the end of the fiscal year, SFAF will report an 80% retention rate among HIV-positive MSM, retention as defined by having had a doctor's app prescription refill or lab work per treatment plan within the past six months
1-21929	**SFAF**	**Stonewall PWP in CoE (Contract Ended 12/31/2022)**
	Objective # 1	N/A: Monitored by Deliverables/UOS listed in contract
		Street Intercept
	Objective # 1	Monitored on deliverables only: SFAF should complete 600 surveys by the end of contract term
1-2600	**SFAF**	**PrEP Navigation Program (Contract ended as of 12/31/2022)**
	Objective # 1	By the end of each fiscal year, 350 new participants will report having initiated PrEP (i.e., took the first dose of medication).
1-2611	**SFAF**	**HIV/HCV OPT-IN (Program Ended 12/31/2022)** ***Programs beginning on Row 162 - 168 are all continuing through 6/30/25 in th***
	Objective # 1	By the end of each fiscal year, 41 clients will have been enrolled in the HCV Linkage Program as measured by the client assessment and intake
	Objective # 2	By the end of each fiscal year, 39 clients who have been enrolled in the HCV Linkage Program will have initiated primary care as measured by cl and case notes.
	Objective # 3	By the end of each fiscal year, 35 clients who have been enrolled in the HCV Linkage Program will have received a full medical evaluation as me activity logs and case notes.
		HCV Informed HCV Screening and Linkage to Care

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	Objective # 1	By the end of each fiscal year, 41 clients will have been enrolled in the HCV Linkage Program as measured by the client assessment and intake
	Objective # 2	By the end of each fiscal year, 39 clients who have been enrolled in the HCV Linkage Program will have initiated primary care as measured by cl and case notes.
	Objective # 3	By the end of each fiscal year, 35 clients who have been enrolled in the HCV Linkage Program will have received a full medical evaluation as me activity logs and case notes.
	Objective # 4	By the end of each fiscal year, 27 clients will initiate HCV treatment.
		Mobile Low Threshold HCV Services
	Objective # 1	N/A: Monitored by Deliverables/UOS listed in contract
		SFDPH-Harm Reduction for Providers (Monitored by Deliverables/UOS listed in the contract
	Objective # 1	N/A: Monitored by Deliverables/UOS listed in contract
1-2609	**SFAF**	**SSIP/CHEERS Queer Program (Contract Ended 12/31/22)**
	Objective # 1	By the end of each fiscal year, at least 648 PLWARH will have been screened with the SIP screener app or via a paper screener if needed, eithe street/venue-based outreach or by presenting for services at Strut, as measured by recorded app metrics or manual calculations of paper screen applicable.
	Objective # 2	By the end of each fiscal year, at least 170 PLWARH with AUDIT-C scores S4 will have completed a SIP counseling session, as measured by th tools developed in collaboration with SFDPH.
	Objective # 3	By the end of each fiscal year, at least 110 participants will self-report positive change in binge drinking and/or sexual HIV risk when participating follow up, as measured by SIP data collection tools.
1-2634	**SFAF**	**Syringe access and Disposal Services (Effective 7/1/23 this Contract is transferring from CHEP to BHS Oversight)**
	Objective # 1	By the end of each fiscal year, Syringe Access Collaborative/San Francisco AIDS Foundation will report on the percentage of HIV tests among p drugs.
	Objective # 2	By the end of each fiscal year, Syringe Access Collaborative/San Francisco AIDS Foundation will report on linkage to care rates among newly di who inject drugs, as defined by attending first medical appointment within three months of diagnosis.
	Objective # 3	By the end of each fiscal year, Syringe Access Collaborative/San Francisco AIDS Foundation will report on linkage to care rates among newly di who inject drugs, as defined by attending first medical appointment within three months of diagnosis.

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	SFAF	**Syringe Access and Disposal Services - HYA Wraparound**
	Objective # 1	N/A: Monitored by Deliverables/UOS listed in contract
	SFAF	**Syringe access and Disposal Services -6th Street Harm Reduction Center**
	Objective # 1	By the end of each fiscal year, Syringe Access Collaborative/San Francisco AIDS Foundation will report on the percentage of HIV tests among p drugs.
	Objective # 2	By the end of each fiscal year, Syringe Access Collaborative/San Francisco AIDS Foundation will report on linkage to care rates among newly dia who inject drugs, as defined by attending first medical appointment within three months of diagnosis.
	Objective # 3	By the end of each fiscal year, Syringe Access Collaborative/San Francisco AIDS Foundation will report a 70% retention rate among HIV-positive inject drugs, retention defined as having had a doctor's appointment, prescription refill, and/or lab work per treatment plan within the past six mor
	SFAF	**Syringe access and Disposal Services-Syringe Sweeps War Memorial**
	Objective # 1	N/A: Monitored by Deliverables/UOS listed in contract
	SFAF	**HIV Syringe access and Disposal Services, Drug testing Support**
	Objective # 1	N/A: Monitored by Deliverables/UOS listed in contract
1-2673	**SFAF**	**PrEP Services for AAMSM (contract ended 12/31/2022)**
	Objective # 1	By the end of the fiscal year, SFAF will have hired and/or trained 5 peer leaders from the prioritized population (e.g. ambassadors. Popular Opin This can be removed; a Year 1 objective.
	Objective # 2	By the end of the fiscal year, 40 new participants will report having initiated PrEP (i.e., took the first dose of medication).
	Objective # 3	By the end of the fiscal year, at the six-month follow-up, 70% of clients who initiated PrEP and for whom follow-up data is available will report stil PrEP.
1-9852	**SFAF**	**HIV Testing In Sub Use Tx Setting (Contract Ended 12/31/22)**
	Objective # 1	By the end of the fiscal year, SFAF will report on the percentage of tests among people who inject drugs.

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	Objective # 2	By the end of the fiscal year, SFAF will report on linkage to care rates among newly diagnosed people who inject drugs as defined by attending fi appointment within 3 months of diagnoses.
	Objective # 3	By the end of the fiscal year, SFAF will report a 70% retention rate among HIV-positive among people who inject drugs, retention as defined by h doctor's appointment, prescription refill or lab work per treatment plan within the past six months.
1-20773	**SFAF**	**Mobile Contingency Management for Homeless clients & Fentanyl Treatment Street Outreach**
	Objective # 1	At least 70% of clients who completed at least 8 weeks of the program agreed that they learned new skills to address their substance use goals a by the client satisfaction survey data
	Objective # 2	At least 60% of clients who completed at least 8 weeks of the program agreed that they either stopped or reduced their use of stimulants.
	Objective # 3	At least 70% of clients who completed at least 8 weeks of the program agreed that they achieved their harm reduction use management goals as by the client satisfaction survey data
1-21907	**UCSF-AHP**	**HIV Testing (contract Ended 12/31/2022)**
	Objective # 1	By the end of the fiscal year, 60% of HIV-negative/unknown status MSM, IDU, and TFSM clients of UCSF Alliance Health Project HIV Counselin Program will report having had an HIV test in the prior 6 months, as measured or documented by self-report or EvaluationWeb.
	Objective # 2	By the end of the fiscal year, 60% of HIV-negative/unknown status MSM, IDU, and TFSM clients of UCSF Alliance Health Project HIV Counselin Program will report having had an HIV test in the prior 6 months, as measured or documented by self-report or EvaluationWeb.
	Objective # 3	
	Objective # 4	By the end of the fiscal year, 90% of people testing HIV-positive at Alliance Health Project HCAT will be offered partner services as measured by EvaluationWeb.
	Objective # 5	By the end of the fiscal year, Alliance Health project HPCAT will distribute 6,500 condoms annually as measured by invoices.
1-2606	**UCSF-AHP**	**PrEP Navigation Program (Contract Ended 12/31/2022)**
	Objective # 1	By the end of the fiscal year, 60 new participants from the target community will report having initiated PrEP (i.e. took the first dose); as documen files, surveys, or medication logs.
	Objective # 2	By the end of the fiscal year, 80% of new participants who initiate PrEP (i.e. took the first dose) will report having taken the first dose within three decision; as documented by client files, surveys, or medication logs.
	Objective # 3	At 6-month fiscal year, 70% of clients who initiated PrEP (i.e. took the first dose) and for whom follow-up data are available will report still on PrE documented by client files, surveys, or medication logs.

FY22-23 CHEP HPS Objectives

CID #	Agency	Program & Objectives
1-9855	**UCSF DSAAM Ward 93**	**HIV/HCV Testing & Treatment Support**
	Objective # 1	By the end of the fiscal year, 95% of HIV-infected patients with detectable HIV viral load will receive at least one treatment adherence interventio or nursing provider within a month from the time that the detectable viral load is discovered.
	Objective # 2	By the end of the fiscal year, 90% of HIV-infected patients entering methadone maintenance who have not seen an HIV primary care provider in months will be offered linkage or re-linkage to care.
	Objective # 3	By the end of the fiscal year, 100% of patients who have new positive HIV test results are offered linkage to HIV care at the time of test results di patient.
	Objective # 4	By the end of the fiscal year, 95% of patients of negative or unknown status in treatment will be offered an HIV test.
1-2662	**UCSF Ward 86**	**UCSF/Positive Health Program-STD Services FY 22-23**
	Objective # 1	By the end of the fiscal year, 90% of patients who had at least one primary care clinic visit will be screened for STIs once every 12 months.
	Objective # 2	Identify EPIC workflow for documentation of patients who opt-out of STI testing in a primary care clinic visit once every 12 months.
	Objective # 3	By the end of the fiscal year, 90% of people experiencing homelessness who had at least one clinic visit with the drop-in service for unhoused pa UP) will be tested for syphilis with an RPR at least once every 12 months.
MOU # 36	**Ward86**	**EtHE Clinical Champion (Effective 7/1/23, this MOU will become a contract, CID#28373. However, the MOU#36 continued thr to align to CDC funding ending on 7/31/23)**
	Objective # 1	Complete a gap analysis of campus clinics and needs assessment with campus clinic providers and nurses to identify barriers to screening, orde processing, and treating STIs at ZSFG among multidisciplinary care teams, completed by Ward 86 clinic RNs. The team aims to complete a gap needs assessment with 1M and Adult Urgent Care this contract year.
	Objective # 2	Develop and implement process for improved STI screening of ED and admitted patients at ZSFG by February 2023.
	Objective # 3	Finalize proposed countermeasures with implementation plan (A3 components 5&6) by September 2022.
	Objective # 4	Implement countermeasures and run PDSA cycles October 2022 – February 2023
	Objective # 5	Perform data analysis on post-intervention data to assess changes in STI testing/error rates by May 2023.
	Objective # 6	Analyze data, compose manuscript, and disseminate data at institutional, local and national level by June 2023.

FY22-23 CHEP HPS Objectives

CID #	Agency	Program & Objectives
MOU # 36	**Ward86**	**PrEP Coordinators (Effective 7/1/23, this MOU will become a contract, CID#28373. However, the MOU#36 continued through align to CDC funding ending on 7/31/23)**
	Objective # 1	Ward 86 will conduct at least two (2) in-person trainings for clinical staff, two (2) in the outpatient setting and two (2) in the inpatient setting on the campus. Trainings will be comprised of a power point presentation reviewing prevention basics, Ward 86 prevention team contacts and service d
	Objective # 2	Complete at least three (3) PrEP consultations with unduplicated outpatient Providers using the EPIC clinical referral pathway. Successful compl comprised of triage of initial EPIC referral, contact with referring Provider, completion of PrEP initiation and assignment of PrEP navigator for follo
	Objective # 3	Complete at least fifteen (15) unduplicated PrEP initiations using the inpatient EPIC referral pathway. Successful completion is comprised of initia receipt, initiation of PrEP by Ward 86 PrEP team Provider, completion of PrEP initiation labs, and assignment to PrEP coordination.
	Objective # 4	Complete at least twenty (20) LA-CAB PrEP initiations with unduplicated patients by the end of the fiscal year.
	Objective # 5	For all outpatient clinics working with PrEP coordinators: Provide at least one (1) site visit by Prevention RN to attend staff huddle and provide en support to outpatient sites.
	Objective # 3	Increase ZSFG/SFHN patients who are on PrEP by 10%, measured by referral list data.
1-9850	**Westside**	**HIV Testing in Community Health Center**
	Objective # 1	All HIV-negative/unknown status clients will be offered an HIV test.
	Objective # 2	At least 70% of HIV negative/unknown status clients of supported programs will report having had an HIV test in the prior 6 months, as measured and data on linkage to testing.
MOU # 9	**South East Health Center**	**Prevention with Positives**
	Objective # 1	Monitor Based on Contract UOS Deliverables
MOU # 12	**SFDPH Jail Health**	**Jail Health Services HIVIS Testing**
	Objective # 1	Monitor Based on Contract UOS Deliverables
MOU # 13	**SFDPH Jail Health**	**Jail Health Services HIVIS Testing**
	Objective # 1	Monitor Based on Contract UOS Deliverables

FY22-23 CHEP HPS Objectives

CID #	Agency	Program & Objectives
MOU # 21	**SFDPH STD Prevention & Control**	**HIV Testing, Partner Services, and Linkages to Care-STD Program**
	Objective # 1	Monitor Based on Contract UOS Deliverables
MOU # 33	**SFDPH Microbiology Lab**	**Laboratory Testing Services : No Objectives**
	Objective # 1	N/A
MOU # 35	**WPIC**	**Low-Threshold HCV Treatment**
	Objective # 1	By June 30th, 2023, 30 clients will have been enrolled in hepatitis C (HCV) treatment services
	Objective # 2	By June 30th, 2023, 10 clients with a positive HCV RNA test result will have initiated HCV treatment
	Objective # 3	By June 30th, 2023, 5 clients who initiated HCV treatment will have completed the HCV treatment course
	Objective # 4	By June 30th, 2023, 1 client who completed HCV treatment will have achieved SVR12
MOU # 35	**WPIC**	**CHEP EtHE Street Medicine**
	Objective # 1	Monitor Based on Contract UOS Deliverables
MOU # 35	**WPIC**	**HHS ETE Street Medicine -HHS Funding-these objectives will be listed under the HHS Objectives list**

FY22-23 CHEP WELL Objectives

FY 22-23

CID #	Agency	Program & Objectives
1000017771	**SDDT - Central American Resource Center CARECEN of Northern California**	**Health Promotion Program - Cuerpo Sano**
	Objective #1	By June 30, 2023, 50 families will be engaged in enhanced service connection and assessed to inform future PSE strategies.
	Objective #2	By June 30th, 2023, 8 community leaders will engage in Sugar Sweetened Beverage (SSB) focused leadership training
	Objective #3	By June 30th, 2023, the Health Promotion Program Policy Coordinator will plan and lead PSE advocacy activities including 4 public meetings, 4 policy stakeholder meetings, and 2 non-meeting advocacy related strategies (phone banking or letter writing).
	Objective #4	By June 30th, 2023, the Communications and Media Associate will lead a media strategy to support PSE advocacy via social media and other media outlets relevant to Latinx community.
1000018155	**SDDT - Marin City Health & Wellness Center DBA Bayview City**	**Contract Ended 6/30/23**
	Objective #1	By 6/30/2023, Bayview clinic successfully implements work plan and distributes a final satisfaction survey to 100 patients.
	Objective #2	By 6/30/23, a total of 20 new priority population patients enroll in the Bayview Clinic's PCMH-accredited case management services. The Case Manager enrolls priority population patients into case management services.
	Objective #3	By June 30, 2023, as a result of its Patient Centered Medical Home program the Bayview Clinic improves its patient satisfaction Net Impact Score by 15% of baseline data, as measured by the net impact scoring system and documented in Survey Monkey. The Quality Improvement and Risk Manager develops surveys based on key informant input and administers to patients receiving care coordination services at the Bayview Clinic. Data is collected quarterly in Survey Monkey and analyzed at CQI meetings to strategize improvement efforts.
	Objective #4	By 6/30/23, the Bayview Clinic will improve Controlling High Blood Pressure and Diabetes Management health measures by 15% of baseline biometric data as documented in the patient record. The Director of Care Management ensures wrap around, case management services are being implemented by the Case Manager through evaluation of care plan and health outcome data on patients enrolled. This data is pulled out of the EHR and evaluated quarterly by the patient's Care Team to monitor health improvements, address barriers to care, and identify additional linkages needed.
1000018430	**SDDT - Tenderloin Neighborhood Development Corporation (TNDC)**	**Promoting Health Equity Program**
	Objective #1	By June 30, 2023, 10% of Kain Na participants will be referred and participate in the Food Justice Leadership Academy, which will result in cross-collaboration between Kain Na and HCSC work as measured by tracking enrollment and documented in the client records.
	Objective #2	By June 30, 2023, ensure that 50% of Food Justice Leadership Academy graduates are active participants in the work of Healthy Retail SF and the Food Policy Council.
	Objective #3	By June 30, 2022, engage 105 Healthy Corner Store shoppers (35 per year) in focus group discussions to understand benefits to having healthy corner stores in their neighborhood and challenges that still exist in achieving food security and health equity.
1000017769	**SDDT - 18 Reasons**	**Towards Health Equity & Liberation**
	Objective #1	By June 30, 2023, 18 Reasons will have successfully implemented the PSE strategy work plan by delivering a report outlining the process and resolution of PSE work.

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CID #	Agency	Program & Objectives
	Objective #2	by June 30, 2023, 18 Reasons will have advocated for pregnant patients to be a priority audience for CalAIM Medically Supported Nutrition
	Objective #3	By June 30, 2023, at least 60% of graduates from group sessions will report eating more fruits and vegetables as a result of the program.
	Objective #4	By June 30, 2023, at least 60% of graduates from group sessions will report drinking fewer sugar-sweetened beverages as a result of the program, among those who report drinking sugary drinks.
1000018303	**SDDT - Southeast Asian Development Center (S**	**Southeast Asian Health Ambassadors (Contract Ended 6/30/23)**
	Objective #1	By June 30, 2023, the SEADC Health Educator and SEAHAs will have at least 150 Community members and stakeholders pledging to support the SEAHAs call to action measured by pledges signed by various community members provided to the Department of Public Health.
	Objective #2	By June 30, 2023, 70% of 150 community members who participated in our community health gatherings will have increased their knowledge of the benefits of healthy food consumption.
	Objective #3	By February 30, 2023, SEAHAs will receive endorsements for their proposed systems change from at least 75% of stakeholders participating in their community presentations.
1000002656	**Livable City**	**Sunday Streets Program**
	Objective #1	By June 30, 2023, Livable City will plan and implement Sunday Streets events in the Bayview, Excelsior, Mission, Tenderloin, and Western Addition neighborhoods.
	Objective #2	By June 30, 2023, Livable City will organize 4 street openings (distinct from Sunday Streets) with an attendance of 500 to 2000 individuals.
	Objective #3	By June 30, 2023, Livable City will provide ongoing community convening and planning efforts.
1000008932	**Public Health Enterprises, Heluna Health**	**Newcomers Health Program/Refugee Health**
	Objective #1	By June 30, 2023, and for the end of each contract term, Heluna Health will provide financial management, pay personnel and operational expenses, and ensure timely and accurate invoices.
	Objective #2	By June 20, 2023, Heluna Health will provide monthly reports on itemized budget expenditures to the Population Health Division's Program Administrator for approval. Heluna will attach monthly-itemized expenses and submits a monthly invoice for payment. (No fees shall be due for invoiced items that lack an appropriate level of detail or are otherwise not in line with DPH expectations. Heluna shall work with DPH to provide any needed information to substantiate invoices before approval for payment).
	Objective #3	By June 30, 2023, and at the end of each contract term, Heluna Health will provide closeout reports to the DPH Population Health Division, Director of Operations, Finance, and Grants Management.
	Objective #4	By June 20, 2023, Heluna Health will submit an annual reconciliation comparing revenues received to actual costs incurred. (This reconciliation is due with the final invoice, 45 calendar days after the end of the services reported must be returned to the Department of Public Health. Reconciliation detail is by Service Mode, not by contract appendix total. If the contractor must return funds to the Department, a check must be made payable to the Department of Public Health, along with FFS reconciliation and final invoice).
10000016941	**San Francisco Public Health Foundation**	**Program Administration, Community Health Engagement**
10000013401	**San Francisco Public Health Foundation**	**Program Administration, Sugary Drink Distributor Tax Project**
10000013727	**San Francisco Public Health Foundation**	**Program Administration, SF Tobacco Free Project**
	Objective #1	By January 15, 2023, SFPHF program staff will provide summary progress reports for SFDPH staff, including work completed and in progress from July 1, 2022, through December 31, 2022.
	Objective #2	By June 30, 2023, SFPHF program staff will complete subcontract management for subcontractors starting from July 1, 2022, to June 30, 2023.
	Objective #3	By June 30, 2023, SFPHF program staff will complete program administration tasks starting from July 1, 2022, to June 30, 2023.

FY22-23 CHEP WELL Objectives

CID #	Agency	Program & Objectives
	Objective #4	By June 30, 2023, SFPHF program staff will complete capacity building/program support from July 1, 2022, to June 30, 2023.
	Objective #5	By August 31, 2023, SFPHF program staff will provide summary progress reports for SFDPH staff, including work completed and in progress from January 1, 2023, through June 30, 2023.