Behavioral Health Services - Adult and Older Adult

Performance Objectives FY 2025-2026

Creation Date: 2/20/25
Revised: 9/23/25

OVERVIEW - Adult and Older Adult Performance Objectives FY 25-26

Measuring client improvement and successful completion of target objectives is an important part of SFDPH contracting. The implementation of the EPIC Electronic Health Record in Fiscal Year 2023-2024 (May.22,2024) increased the ability to collect quality data on a client's presenting issues, demographics, interventions, symptom changes, and discharge status. The Performance Objectives developed for Fiscal Year 2024-25 Health Services (BHS) intends to reduce provider burden in determining objective compliance by using EPIC data to measure objectives - to the extent possible.

The Program Objectives detailed in this document have been carefully defined to measure important behavioral health processes and outcomes. All references to number of days throughout this document mean "Calendar Days" as that is how EPIC is designed to measure days. Not all objectives apply to all programs. This document is posted at: **https://www.sf.gov/resource/2024/performance-objectives**

Contractors are responsible for compliance with all items in the Performance Objectives and the Declaration of Compliance.
This document is comprised of the following 4 tabs:

- **Tab 1:** Objectives for ***Outpatient Mental Health Services and Intensive Outpatient Services***
- **Tab 2:** Objectives for ***Intensive Case Management & Full Service Partnership Programs***
- **Tab 3:** Objectives for ***SSI Advocacy and Representative Payee Programs***
- **Tab 4:** Objectives for ***Individualized Program Specific Services***

Tabs 1 through 4 provide additional detail about each performance objective. Next to each indicator are columns that describe the following:

- **Client Inclusion Criteria -** identifies which group of clients / programs are included in the measurement of the objective
- **Data Source / Compliance** - identifies the data source used to measure the objective and/or how compliance with the objective is documented and reported
- **Source of Requirement -** e.g., BHS policy, Affordable Care Act, Department of Healthcare Services, etc.

In several cases contractors are instructed to send an Annual Summary Report to the System of Care (SOC) Program Manager and the Business Office Contract Compliance (BOCC) Program Manager. Reports for BOCC should be sent by e-mail to: bocc@sfdph.org If unsure of the SOC Program Manager, contact your CDTA Program Manager for assistance.

Behavioral Health Services-Adult and Older Adult
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Indicator	Type of Objective	Client Inclusion Criteria	Data Source / Compliance	Source of Requirement	Report Availability for Providers
AOA-MH-OP-1: 80% of encounters will be signed within 3 business days	Compliance	All Providers	Epic Hyperspace / Uploaders to Provide Data	DHCS	Epic BHS Encounter Stats Reports (hyperspace users) Uploaders to Run Own Reports
AOA-MH-OP-2: 100% of clients receiving Targed Case Management (TCM) and/or Intensive Care Coordination (ICC) will have BHS Care Plan	Compliance	All clients receiving targeted case management only in FY25-26. Excludes: Outpatient services provided in residential Tx settings & first 60 days for new clients	Epic Hyperspace / Uploaders to Provide Data	BHS Policy/DHCS	DPH BHS Staff Caseload Report (hyperspace users) Uploaders to Run Own Reports
AOA-MH-OP-3: On any date 100% of clients who have been opened for more than 60 days will have a Cal AIM 7 Domain Assessment completed within the last 3 years.	Compliance	All clients with Assessment due in FY25-26. Excludes: Outpatient services provided in residential Tx settings & first 60 days for new clients and Citywide Linkage program codes (89114MH)	Epic Hyperspace / Uploaders to Provide Data	BHS Policy/DHCS	DPH BHS Staff Caseload Report (hyperspace users) Uploaders to Run Own Reports
AOA-MH-OP-4: 80% of clients will improve on at least 1 of their prioritized actionable ANSA needs items	Outcome	All Providers	Epic Hyperspace / Uploaders to Provide Data	BHS Policy	TBD Epic Report in development
AOA-MH-OP-5: 80% of clients will either maintain or develop at least 1 of their prioritized ANSA strength item	Outcome	All Providers	Epic Hyperspace / Uploaders to Provide Data	BHS Policy	TBD Epic Report in development

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Indicator	Type of Objective	Client Inclusion Criteria	Data Source / Compliance	Source of Requirement	Report Availability for Providers
AOA-ICMFSP-1: 100% of clients receiving targeted case management will have a Care Plan.	Process	All clients receiving targeted case management only in FY25-26.	Epic	BHS Policy/DHCS	DPH BHS Staff Caseload Report (hyperspace users) Uploaders to Run Own Reports
AOA-ICMFSP-2: On any date 100% of clients who have been open more than 60 days will have a CalAIM 7 domain assessment completed within the last 3 years.	Process	Excludes: Outpatient services provided within residential Tx settings & first 60 days for new clients	Epic	BHS Policy/DHCS	DPH BHS Staff Caseload Report (hyperspace users) Uploaders to Run Own Reports
AOA-ICMFSP-3: 80% of clients will improve on at least 1 of their prioritized actionable ANSA items	Outcome	All Providers	Epic Hyperspace / Uploaders to Provide Data	BHS Policy	TBD Epic Report in development
AOA-ICMFSP-4: 80% of clients will either maintain or develop at least 1 of their prioritized ANSA strength item	Outcome	All Providers	Epic Hyperspace / Uploaders to Provide Data	BHS Policy	TBD Epic Report in development

Indicator	Type of Objective	Client Inclusion Criteria	Data Source/Compliance	Source of Requirement	Report Availability for Providers
Section J: SSI Advocacy / Benefits Counseling Program Outcomes					
AOA-SSIBEN-1: 85% of the client cases in which claims for benefits have been filed and that have been fully adjudicated by program representation during the contract period will result in a favorable decision or an award for the client.	Outcome	Clients who filed claims for benefits which have been fully adjudicated by representation from the Homeless Advocacy Project or Positive Resource Center between 7/1/25 – 6/30/26	Contractor collects data, including % of claims awarded at initial, reconsideration, Admin Law Hearing, or Appeals Council levels. Decisions for clients at any level, & Continuing Disability Reviews measured by receipt of proof of award e.g., SSA Notice of Awards, other documentation received from SSA, or documented in SSA or CalMED database. Contractor prepares Annual Summary Report documenting achievement for SOC Program Manager by 9/1/25	BHS Policy	N/A
AOA-SSIBEN-2: The program must meet 75% percent of their contracted units of service.	Process	All UOS reported on invoice report for 7/1/25 - 6/30/26	Budget office invoice reports	BHS Policy	N/A

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Section K: Representative Payee Program Outcomes					
AOA-REPPAY-1: 100% of authorized rent payments will be disbursed within two business days of date benefit checks are received.	Process	All clients enrolled in Conard and HealthRight 360 Rep. Payee programs during FY25-26	Contractors collect data routinely & conduct annual internal audit; contractor prepares Annual Summary Report documenting achievement for SOC Program Manager by 9/1/25	BHS Policy	N/A
AOA-REPPAY-2: 75% of clients receiving money management services will maintain stability in housing for a period of at least six months.	Outcome	All clients enrolled for ≥ 6 months in Conard or HealthRight 360 Rep. Payee programs during FY25-26	Contractors audit client files (physical or electronic); contractor prepares Annual Summary Report documenting achievement for SOC Program Manager by 9/1/25	BHS Policy	N/A

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Indicator	Type of Objective	Client Inclusion Criteria	Data Source / Compliance	Source of Requirement	Report Availability for Providers
Civil Service - Assisted Outpatient Treatment (Chris Wright- Program Manager)					
1. 60% of clients that meet AOT criteria and that the AOT Care Team has contact with will engage in voluntary services.	Outcome	Individuals referred in FY 25-26	Epic	AOT Procedures	N/A-AOT will track and report September
2. In an effort to inform the community regarding AOT, the program will conduct a minimum of 3 presentations a year.	Process	Presentations in FY 25-26	AOT Data	AOT Procedures	N/A-AOT will track and report September
3. AOT will submit an annual report to the State Department of Mental Health in compliance with WIC 5348(d), which will be posted on the AOT website.	Process	Annual Report	DHCS Website	AOT Procedures	N/A-AOT will track and report September
NOVA/NOVA Pretrial					
1. 25% of NOVA clients closed during the fiscal year shall be referred to mental health services as measured by outcome disposition.	Outcome	Individuals referred in FY 25-26	Self Report	Contract Requirement	NA
2. Citywide NOVA will serve at least 30 clients during the FY	Process	Individuals referred in FY 25-26	Epic	Contract Requirement	NA
Civil Service - CARE Court (Charlie Newcomb - Program Manager)					
1. In an effort to inform the community regarding CARE Court, the program will conduct a minimum of 3 presentations a year.	Process	Presentations in FY 25-26	CARE Court Data	CARE Court Procedures	N/A- CARE Court will track and report to in September
2. 60% of clients that the CARE Court Team has contact with will be referred to voluntary services within 30 days of first encounter.	Outcome	Individuals referred in FY 25-26	CARE Court Data	CARE Court Procedures	N/A- CARE Court will track and report to in September
3. 60% of client in CARE Court will recive weekly engagment from CARE Court staff.	Outcome	Individuals referred in FY 25-26	Epic	CARE Court Procedures	N/A- CARE Court will track and report to in September
4. 80% of CARE Court clients will be assessed for housing needs.	Process	Individuals referred in FY 25-26	CARE Court Data	CARE Court Procedures	N/A- CARE Court will track and report to in September
Civil Service - Drug Court Treatment Center (Leon Hopkins- Program Manager)					
1. 100% of eligible clients will receive a initial assessment while in custody within 30 days of their initial referral to the Drug Court Treatment program.	Process	All clients who have an initial referral in FY. Excludes: clients who are re-referred to the program.	Court Database	BHS	Needs to be developed with the Court
2. 60% of clients will be transitioned from custody to an appropriate level of treatment, as defined in their individualized treatment plans.	Outcome	All clients who have had an initial assessment completed. Excludes: clients who are re-referred to the program.	Court Database	BHS	Needs to be developed with the Court
3. Complete progress reports will be submitted to the court for 60% of active clients at least 2 days prior to their scheduled court day.	Process	Clients opened into DCTC Outpatient Treatment Program.	Court Database	BHS	Needs to be developed with the Court
4. At least 25% of clients open in the Drug Court Treatment program will successfully graduate from the program.	Outcome	Clients discharged during FY25-26	Court Database	BHS	Needs to be developed with the Court
Civil Service - Community Justice Center (Erick Reijerse- Program Manager)					
1. 60% of clients will be enrolled to an appropriate level of treatment, as defined in their individualized treatment plans.	Outcome	All clients who have had an initial assessment completed. Excludes: clients who are re-referred to the program.	Court Database	BHS	Needs to be developed with the Court
2. At least 25% of clients open in the Drug Court Treatment program will successfully graduate from the program.	Outcome	All clients discharged in FY25-26	Court Database	BHS	Needs to be developed with the Court
3. 80% of CJC clients will be assessed for housing needs.	Process	All clients with an episode opened in FY25-26	Court Database	BHS	Needs to be developed with the Court
4. 100% of eligible clients will receive an initial assessment while in custody within 30 days of their initial referral to the Community Justice Center program.	Process	All clients who have an initial referral in FY. Excludes: clients who are re-referred to the program.	Court Database	BHS	Needs to be developed with the Court

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Felton Institute - HIV Nightline, MH Suicide Prevention and Drug Relapse Prevention- ONLY MH SUICIDE PREVENTION IS AOA					
1. Felton Institute will maintain 3 telephone crisis infrastructure lines that attend to: Mental Health/Suicide Crisis Line, Drug Line and Relapse Prevention Line and HIV/AIDS Line to be open 24 hours a day, 365 days a year.	Process	All clients with an episode opened in FY 25-26	Felton Institute will be responsible for tracking and providing information prior to site visit	BHS	Felton to provide to SOC
2. Felton Institute will receive a minimum call volume for each telephone crisis line broken down with 60% unduplicated callers.	Process	All clients with an episode opened in FY 25-26	Felton Institute will be responsible for tracking and providing information prior to site visit	BHS	Felton to provide to SOC
3. Felton Institute will maintain a volunteer hotline pool of 100 volunteers trained and mentored to provide crisis caller support and referrals across all three lines.	Process	All clients with an episode opened in FY 25-26	Felton Institute will be responsible for tracking and providing information prior to site visit	BHS	Felton to provide to SOC
4. Felton Institute will provide 12 outreach/training opportunities/digital experiences to promote and market the three hotlines to callers, recruit volunteers, provide general education to the public.	Process	All clients with an episode opened in FY 25-26	Felton Institute will be responsible for tracking and providing information prior to site visit	BHS	Felton to provide to SOC
NICOS Chinese Health - CLAS ACT (Culturally and Linguistically Appropriate Services Advocacy, Consultation and Training) Project					
1. Post-test forms completed by 50% of all attendees at NICOS CLAS ACT educational presentations.	Process	Attendees at CLAS ACT educational presentations on cultural and linguistic competence and related topics during FY25-26	"Monitored by SOC Program Manager via completed test forms on presentations; evaluated based on % of presentations with completed tests forms during FY25-26; Contractor prepares Annual Summary Report documenting achievement of objective for SOC Program Manager. Program must have program data ready at the time of site visit."	BHS	N/A
2. 75% of CLAS ACT training participants will report an increase in confidence in addressing cultural and/or linguistic barriers when working with their clients."	Outcome	Attendees at CLAS ACT educational presentations on cultural and linguistic competence and related topics during FY25-26	"Monitored by SOC Program Manager via completed test forms on presentations; evaluated based on % of presentations with completed tests forms during FY25-26; Contractor prepares Annual Summary Report documenting achievement of objective for SOC Program Manager. Program must have program data ready at the time of site visit."	BHS	N/A
NICOS Chinese Health - Chinese Community Gambling Problem Project					
1. Post- test forms completed by 50% of all attendees at NICOS educational presentations on problem gambling.	Process	Attendees at educational presentations on problem gambling in FY 25/26	"Monitored by SOC Program Manager via completed test forms on presentations; evaluate based on % of presentations with completed tests; Contractor prepares Annual Summary of achievement for AOA Program Manager. Program must have program data ready at the time of site visit."	BHS	N/A
2. At least 50% of problem gambling education participants will report a decreased intention to gamble.	Outcome	Attendees at educational presentations on problem gambling in FY 25/26	"Monitored by SOC Program Manager via completed test forms on presentations; evaluate based on % of presentations with completed tests; Contractor prepares Annual Summary of achievement for AOA Program Manager. Program must have program data ready at the time of site visit."	BHS	N/A
San Francisco Mental Health Clients' Rights Advocates					
1. SF MHCRA will resolve at least 515 cases regarding Patients' Rights issues.	Process	All BHS clients who contact the program directly, through family, or other concerned party via phone, email, fax, or in person in FY25-26	MHCRA Database, Director's monthly, quarterly, and year-end reports; contractor prepares staff report, documented in the client database Apricot Community Tech knowledge and evaluated by the AOA Program Manager. Program must have program data ready at the time of site visit.	BHS	N/A
2. SF MHCRA staff will review at least 4 behavioral health facilities for compliance with Patients' Rights issues selected by MHCRA based on complaints collected, reporting of rights data, and/or changes in the law.	Process	During FY25-26	Outreach logs, MHCRA Director's monthly, quarterly, and year-end reports; contractor prepares Annual Summary of achievement for AOA Program Manager. Program must have program data ready at the time of site visit.	BHS	N/A
3. SF MHCRA will conduct 6 Patients' Rights checklist reviews for compliance with CCR Title 9 and W & I Code 5235 and W & I Code 5331, as required by BHS.	Process	During FY25-26	Outreach logs, client database, MHCRA Director's monthly, quarterly, and year-end	BHS	N/A

Swords to Plowshares					
1. 75% of clients who are employment capable will be enrolled in employment and training services.	Process	All Clients assessed for job readiness in FY25-26	Case mgmt. contacts, client files, ETO Database and Epic assessments and Tx plans; contractor prepares Annual Summary of achievement for AOA Program Manager. Program must have program data ready at the time of site visit.	BHS	N/A
2. 80% of clients who are employment capable will engage in some form of classroom training.	Process	All Clients assessed for job readiness in FY25-26	Case mgmt. contacts, client files, ETO Database and Epic assessments and Tx plans; contractor prepares Annual Summary of achievement for AOA Program Manager. Program must have program data ready at the time of site visit..	BHS	N/A
3. 50% of clients who are employment capable will pursue and/or obtain vocational placement (i.e., volunteer, internship. stipend position, or paid job).	Outcome	All Clients assessed for job readiness in FY25-26	Case mgmt. contacts, client files, ETO Database and Epic assessments and Tx plans; contractor prepares Annual Summary of achievement for AOA Program Manager. Program must have program data ready at the time of site visit.	BHS	N/A
Swords to Plowshares COVER Program					
1. The program will have 20 veterans receiving assistance per month (includes in-custody workshops and case management).	Outcome	All clients of program in FY25-26	Program self report. Program must have program data ready at the time of site visit.	BHS	N/A
2. The program will offer two life skills workshops per month attended by 75% of veteran's in COVER pod.	Process	All clients of program in FY25-26	Program self report. Program must have program data ready at the time of site visit.	BHS	N/A
UCSF Citywide- Assisted Outpatient Treatment					
1. 50% of participants discharged from the Assisted Outpatient Treatment Program will be connected to clinically appropriate services	Outcome	All clients with an episode opened in FY 25-26	Epic	AOT Procedures	N/A
2. 100% of clients who meet the necessary requirements will have a coordinated entry assessment in the One system.	Outcome	All clients with an episode opened in FY 25-26	One System	AOT Procedures	N/A
3.Citywide AOT will have at least one engagement or documented engagement attempt within 7 days of any psychiatric hospitalization.	Outcome	All clients with an episode opened in FY 25-26	Epic	AOT Procedures	N/A
UCSF Citywide - CARE Court Treatment					
1. 50% of participants discharged from the CARE Court Treatment Program will be connected to clinically appropriate services	Outcome	All clients with an episode opened in FY 25-26	Epic	CARE Court Procedures	N/A
2. 100% of clients who meet the necessary requirements will have a coordinated entry assessment in the One system.	Outcome	All clients with an episode opened in FY 25-26	One System	CARE Court Procedures	N/A
3.Citywide CARE Court will have at least one engagement or documented engagement attempt within 7 days of any psychiatric hospitalization.	Outcome	All clients with an episode opened in FY 25-26	Epic	CARE Court Procedures	N/A
Westside Community Mental Health Center - Crisis Intervention (WSC)					
1. Less than 30% of clients seen in the Crisis Clinic will be seen at PES or hospitalized on the same day.	Process	Clients seen at Westside Crisis in FY25-26	Epic	BHS	TBD
2. 60% of Westside Crisis client episode lengths will be < 60 days.	Process	Client episodes closed in FY25-26 and clients open on 6/30/25	Epic	BHS	N/A
3. 80% of clients responding to the client satisfaction survey will report satisfaction with the overall quality of services.	Outcome	Clients seen in FY25-26	Client Satisfaction Survey	BHS	BOCC

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RAMS PAES	Type of objective	Client inclusion criteria	Data source/compliance	Source of requirement	Report Availability for Providers
1. Provide services to 300 unduplicated clients for CCS.	Process	Clients seen in FY25-26	Self Report	BHS	RAMS to send to AOA/BOCC Monitoring
2. 3,160 total hours of direct Outpatient Behavioral Health Services shall be provided	Process	Clients seen in FY25-26	Self Report	BHS	RAMS to send to AOA/BOCC Monitoring
3. 65 total units of Indirect/Outreach Services shall be provided.	Process	Clients seen in FY25-26	Self Report	BHS	RAMS to send to AOA/BOCC Monitoring
4. 90 total units of consultation and training hours to the DHS staff and management shall be provided.	Process	Clients seen in FY25-26	Self Report	BHS	RAMS to send to AOA/BOCC Monitoring
5. 80% of clients responding to the client satisfaction survey will report satisfaction with the overall quality of services.	Outcome	Clients seen in FY25-26	Client Satisfaction Survey	BHS	BOCC
6. 80% of discharged clients will have successfully completed assessment &/or linkage activities as defined in their individualized plans or will have left before completion with satisfactory progress.	Outcome	Clients seen in FY25-26	Self Report	BHS	RAMS to send to AOA/BOCC Monitoring
7. Engagement: Program will achieve an average "intake show rate" of 60%.	Outcome	Clients seen in FY25-26	Self Report	BHS	RAMS to send to AOA/BOCC Monitoring
Felton Institute - Socially Isolated Older Adults					
1. By June 30, 2026, 6 community partners will be reached by program staff to collaborate on identifying and locating isolated older adults as evidenced by an outreach report.	Process	During FY25-26	Outreach Report	BHSA	Felton to send to AOA/BHSA/BOCC Monitoring
2. By June 30, 2026, 30 socially isolated older adults will be screened for behavioral health needs using a preclinical screening tool, administered by program staff as evidenced by an assessment report	Process	Clients seen in FY25-26	Assessment Report	BHSA	Felton to send to AOABHSA//BOCC Monitoring
3. By June 30, 2026, 20% of socially isolated older adults screened and identified as having a specialty mental health need will be referred onward to more appropriate behavioral health services as evidenced by a referral tracking report	Outcome	Clients seen in FY25-26	Referral Tracking Report	BHSA	Felton to send to AOA/BHSA/BOCC Monitoring
4. By June 30, 2026, 18 socially isolated older adults with non-specialty mental health needs will join the Felton Older Adult Social Club (SIOA) as reflected in a FY 25-26 new participant report.	Process	During FY25-26	New Participant Report	BHSA	Felton to send to AOABHSA//BOCC Monitoring
5. By June 30, 2026, the program will link isolated older adults to meaningful activities rendering a participation count of 56 for the FY 25-26 as evidenced by a classes & groups report.	Outcome	Clients seen in FY25-26	Classes & Groups Report	BHSA	Felton to send to AOA/BHSA/BOCC Monitoring
6. By June 30, 2026, Felton Older Adult Social Club (SIOA) staff will offer and facilitate 2 healthy aging classes in FY 25-26 as evidenced by sign-in sheets.	Process	During FY25-26	Sign-in Sheets	BHSA	Felton to send to AOABHSA//BOCC Monitoring
7.By June 30, 2026, 50% of intakes will complete a WHO (World Health Organization) Quality of Life (QoL) Scale Questionnaire and have increased scores in two domains (excluding those who participated in 2 or less activities) at their yearly renewal.	Outcome	Clients with renewal date in FY25-26	QoL Scale Questionnaire Report	BHSA	Felton to send to AOA/BHSA/BOCC Monitoring
Curry Senior Center - Addressing the Needs of Socially Isolated Older Adults-Peer Supporting Services					
1. Outreach and Engagement: By June 30, 2026, 240 older adults who are at risk of homelessness will be reached by Peer Support Specialists	Process	Clients seen in FY25-26	Outreach client contact logs and event sign in sheets	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
2. Screening and Assessment: By June 30, 2026, 60 isolated older adults will be screened for behavioral health needs using a preclinical Behavioral Health screening tool, administered by Peer Support Specialists.	Process	Clients seen in FY25-26	Screening Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
3. Screening and Assessment: By June 30, 2026, 60% of isolated older adults screened and identified as having a behavioral health need will be referred to appropriate behavioral health services (including case management, substance use, mental health, and social support groups).	Outcome	Clients seen in FY25-26	Referral Tracking System	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
4. Screening and Assessment: By June 30, 2026, 60 isolated older adults will be screened for risk of homelessness using a validaded screening tool, administered by Peer Support Specialists.	Process	Clients seen in FY25-26	Screening Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
5. Screening and Assessment: By June 30, 2026, 90% of isolated older adults screened and identified for being at risk of homelessness will be referred to appropriate services.	Outcome	Clients seen in FY25-26	Referral Tracking System	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
6. Wellness Promotion: By June 30, 2026, 24 isolated older adults will attend 2 group activities.	Process	Clients seen in FY25-26	Group Activity Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
7.Wellness Promotion: By June 30, 2026, 60% of older adults who participate in 2 group activities will report increased levels of social connectedness.	Outcome	Clients seen in FY25-26	Client Satisfaction Survey	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
8. Service Linkage: By June 30, 2026, 60 isolated older adults will be screened for non-behavioral health needs.	Process	Clients seen in FY25-26	Client Logs	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
9. Service Linkage: By June 30, 2026, 75% of isolated older adults who indicate the need for non-behavioral health services will be referred to the appropriate service.	Outcome	Clients seen in FY25-26	Client Log Sheets	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring

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Curry Senior Center - Drop-in Center					
1. Screening and Assessment: By June 30, 2026, 180 seniors will be informally assessed for non-behavioral health services needs as evidenced by referral/linkage participating log provided and collected by the Program manager and Peer Staff.	Process	Clients seen in FY25-26	Referral/Linkage Participating Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
2. Screening and Assessment: By June 30, 2026, 50% of seniors who report non-behavioral health needs will be referred to services as evidenced by referral/linkage participating log provided and collected by the Program Manager and Peer staff.	Outcome	Clients seen in FY25-26	Referral/Linkage Participating Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
3. Screening and Assessment: By June 30, 2026, 50 limited English-speaking seniors will be informally assessed for non-behavioral health services needs as evidenced by referral/linkage participating log provided and collected by the Program Manager and Peer Staff	Process	Clients seen in FY25-26	Referral/Linkage Participating Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
4. Screening and Assessment: By June 30, 2026, 50% of limited English-speaking seniors who report non-behavioral health needs will be referred to services as evidenced by referral/linkage participating log provided and collected by the Program Manager and Peer Staff.	Outcome	Clients seen in FY25-26	Referral/Linkage Participating Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
5. Wellness Promotion: By June 30, 2026, 250 seniors will attend activities offered by Peer staff as evidenced by the Peer-staff administered participant log. Examples of activities are: game tournaments, exercise, and discussion groups.	Process	Clients seen in FY25-26	Participant Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
6. Wellness Promotion: By June 30, 2026, 50% of participants attending 3 or more activities will report an increase in socialization as measured by client participation surveys administered quarterly by the Program Manager and Peer staff and tracked by data analysts.	Outcome	Clients seen in FY25-26	Client Satisfaction Survey	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
7. Outreach & Engagement. By June 30, 2026, the Drop-In Center staff will screen 100 older adults for housing risk and other supportive service needs, as evidenced by referral/linkage participating log.	Process	Clients seen in FY25-26	Referral/Linkage Participating Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
8. Outreach & Engagement. By June 30, 2026, 50% of older adults screened for housing risk, and other supportive services, will be referred to the office of the day as evidenced by referral/linkage participating log.	Outcome	Clients seen in FY25-26	Referral/Linkage Participating Log	BHSA	Curry to send to AOA/BHSA/BOCC Monitoring
Episcopal Community Services - Socially Isolated Older Adults					
1. By June 30, 2026, 40 socially isolated older adults will be screened for behavioral health needs administered by program staff.	Process	Clients seen in FY25-26	Assessment Report	BHSA	ECS to send to AOA/BHSA/BOCC Monitoring
2. By June 30, 2026, 50% of socially isolated older adults screened and identified as having a specialty mental health need will be offered appropriate behavioral health services as evidenced by a referral tracking.	Outcome	Clients seen in FY25-26	Referral Tracking Report	BHSA	ECS to send to AOA/BHSA/BOCC Monitoring
3. By June 30, 2026, 30 socially isolated older adults with non-specialty mental health needs will join the monthly social acitivity by program staff.	Process	During FY25-26	New Participant Report	BHSA	ECS to send to AOA/BHSA/BOCC Monitoring
4. By June 30, 2026, the program will connect 80 isolated older adults to meaningful community activities.	Outcome	Clients seen in FY25-26	Classes & Groups Report	BHSA	ECS to send to AOA/BHSA/BOCC Monitoring
5. By June 30, 2026, program staff will offer and facilitate 4 healthy aging classes.	Process	During FY25-26	Sign-in Sheets	BHSA	ECS to send to AOA/BHSA/BOCC Monitoring
6. By June 30, 2026, 50% of intakes will complete a WHO (World Health Organization) Quality of Life (QoL) Scale Questionnaire and have increased scores in two domains.	Outcome	Participant Report	Participant Report	BHSA	ECS to send to AOA/BHSA/BOCC Monitoring
APIWC dba SF Community Healthcare Center - Program 1: Peer Navigation & Outreach					
1. At least 80% of clients engaged in services will receive a minimum of one peer navigation or case management encounter per month, as documented in the client or program record. Qualifying encounters include assessments, gender-affirming care navigation, outreach, referrals, care coordination, case management check-ins, and other supportive services.	Process	Clients engaged in services during fiscal year	Self Report - Tracked monthly, to reflect that clients may engage/dis-engage/graduate from care throughout the grant year (monthly tracking will start 4/1/26). Monthly engagement percentage will be averaged at year-end to speak to annual engagement.	BHS	N/A

2. By the end of the fiscal year, at least 80% of clients who are engaged in services for a minimum of 90 days will achieve at least one individualized care plan goal, as documented in the client or program record. Qualifying outcomes include: Initiation/re-initiation of gender-affirming care; completion of gender-affirming surgery; Successful linkage to other medical or behavioral health care; Successful linkage to substance use services or treatment; Placement in temporary shelter; Placement into permanent housing or stabilization of insecure housing; Enrollment in job training, educational program, and/or obtained a job; Successful linkage to legal resources; Resolution of food insecurity; Or achievement of a client-specific goal as identified and documented by the case manager or navigator.	Outcome	Clients engaged in services during fiscal year	Self Report - Tracked annually.	BHS	N/A
APIWC dba SF Community Health Center - Program 2: Short Term Behavioral Health Services					
1. At least 80% of clients engaged in services will receive a minimum of one behavioral health encounter per month, as documented in the medical or program record. Qualifying encounters include behavioral health assessments, individual or group counseling sessions, substance use treatment services, or behavioral health navigation.	Process	Clients engaged in services during fiscal year	Self Report - Tracked monthly, to reflect that clients may engage/dis-engage/graduate from care throughout the grant year (monthly tracking will start 4/1/26). Monthly engagement percentage will be averaged at year-end to speak to annual engagement.	BHS	N/A
2. By the end of the fiscal year, at least 70% of clients who are engaged in services for a minimum of 90 days will demonstrate improved behavioral health stability, as documented in the medical or program record. Qualifying outcomes include: Reduction in mental health and/or substance use symptoms as measured by standardized tools and/or clinical assessment; Completion of one or more individualized treatment plan goals; Increased engagement with the behavioral health care team, including consistent attendance and participation; effective use of a safety plan and/or therapeutic interventions to de-escalate a crisis; completion of a gender-affirming surgery assessment and/or referral; or successful linkage to a higher-level of care and/or substance use treatment.	Outcome	Clients engaged in services during fiscal year	Self Report - Tracked annually.	BHS	N/A