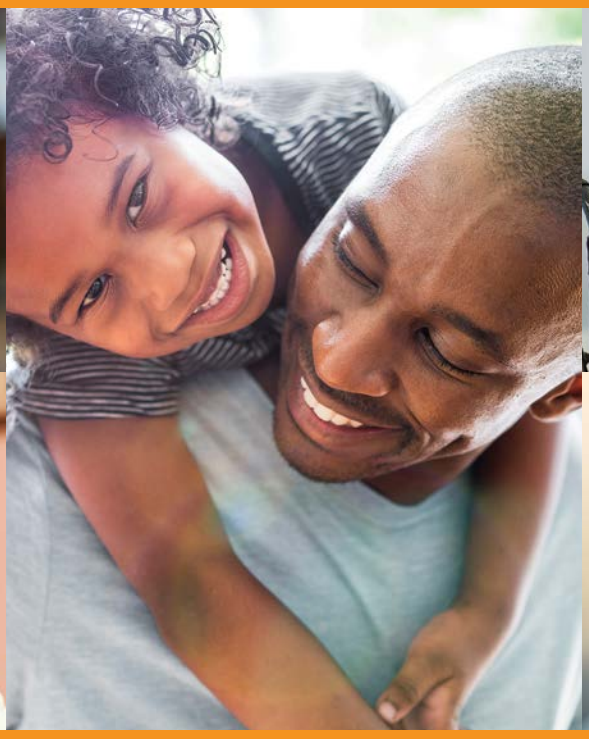
Fiscal Year
2015/2016


MEASURE A

Essential Health Care Services Tax Ordinance

OVERSIGHT COMMITTEE
10TH REPORT TO THE ALAMEDA COUNTY
BOARD OF SUPERVISORS AND THE PUBLIC

Review of Expenditures July 1, 2015 – June 30, 2016

MEASURE A

Essential Health Care Services Tax Ordinance

OVERSIGHT COMMITTEE

10TH REPORT

TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS

AND THE PUBLIC

REVIEW OF EXPENDITURES IN

Fiscal Year (FY) 2015/2016

July 1, 2015 – June 30, 2016

CONTENTS

MEASURE A
OVERSIGHT COMMITTEE MEMBERS

COMMITTEE MEMBER	REPRESENTING/NOMINATED BY
John Becker	City Managers' Association
Olga Borjon*	Supervisor Richard Valle (District 2)
Arthur Chen, M.D.	Alameda-Contra Costa Medical Association
Louis Chicoine	Supervisor Scott Haggerty (District 1)
Keith Davies	Alameda County Public Health Commission
Adam Davis	Hospital Council of Northern California
Charles Go	Supervisor Wilma Chan (District 3)
Dru Howard	Supervisor Keith Carson (District 5)
Kuwaza Imara	Central Labor Council of Alameda County
Sally Morgan	League of Women Voters
Al Murray	City of Berkeley
Zachariah Oquenda	Supervisor Richard Valle (District 2)
Jaseon Outlaw, Ph.D.	Alameda County Mental Health Board
Rachel Richman	Central Labor Council of Alameda County
Ursula Rolfe, M.D.	League of Women Voters
(seat in abeyance)	Alameda County Taxpayers Association, Inc.
(vacant)	City Managers' Association
(vacant)	Supervisor Nate Miley (District 4)

* Olga Borjon resigned in September 2017. Zachariah Oquenda was appointed to serve the remainder of her term.

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY STAFF

Colleen Chawla	Agency Director
Rebecca Gebhart	Finance Director
James Nguyen	Administrative Services Officer
Connie Soriano	Administrative Specialist II

FY 2015/2016 Measure A Executive Summary

(July 1, 2015 – June 30, 2016)

ABOUT THE MEASURE A OVERSIGHT COMMITTEE

One of the provisions of Measure A required the establishment of a Citizen Oversight Committee. The Committee's role is to annually review Measure A expenditures for each fiscal year and report to the Alameda County Board of Supervisors (Board) on whether such expenditures conform to the purposes set forth in the measure.

The Measure states: "The citizen oversight committee shall annually review the expenditure of the essential health care services tax fund for the prior year and shall report to the board of supervisors on the conformity of such expenditures."

The Oversight Committee spent several months reviewing allocation reports, highlighting accomplishments while deliberating and communicating concerns to providers, and reviewing and editing the Measure A report. The Committee used the report forms returned by most Measure A fund recipients, along with information from several provider presentations, to review all funding allocations.

OVERALL CONCLUSION

The Oversight Committee found that Alameda Health System (AHS) and other recipients of the sales tax revenue spent the funds in compliance with the provisions of Measure A. The Oversight Committee did have concerns for a small number of allocations. These concerns are noted in this Executive Summary and in the individual report summaries for the relevant providers.

A→AA

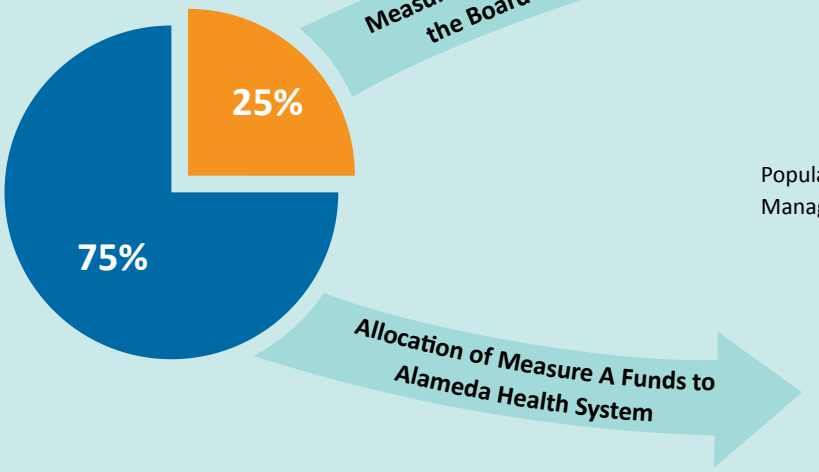
History of the Measure

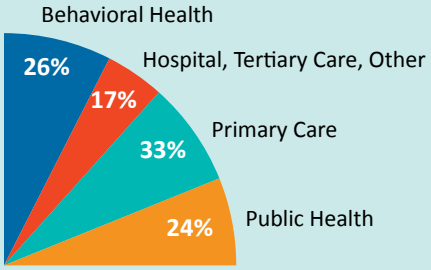
Measure A, the Essential Health Care Services Initiative, was passed by 71% of Alameda County voters in March 2004. In June 2014, 76% of voters passed Measure AA, which extended the initiative through 2034. Both measures authorize the County of Alameda to raise its sales tax by one-half cent to provide additional financial support for **emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low income, and uninsured adults, children, families, seniors, and other residents of Alameda County**.

Measure A generated $137,233,576* in FY 15/16.

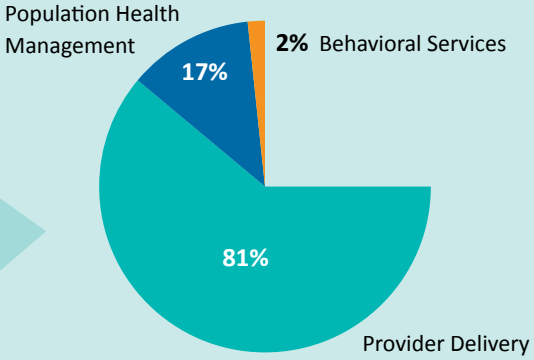
Of the $137,233,576 that Measure A generated in FY 15/16, AHS received 75%, and the remainder of the funds was distributed by the Board to many health care providers who provide essential health care services.

DISTRIBUTION OF MEASURE A FUNDS





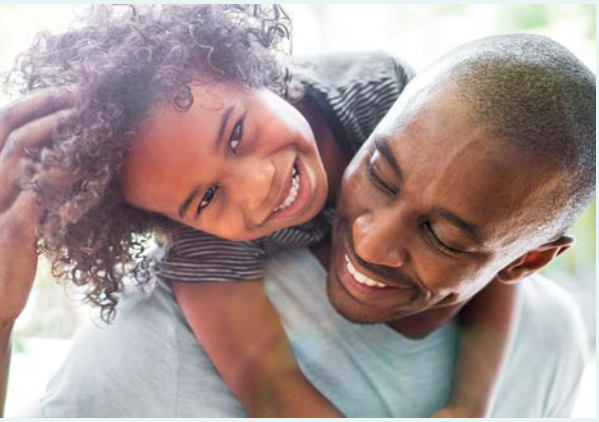
Total generated: $34.3 million
Total allocated: $32.5 million**



Total: $102.9 million

* Does not include interest earned.

** Board allocations are made in advance of a given fiscal year. Therefore, the amount generated by Measure A for that year does not equal the amount allocated by the Board.



Highlights

Since the full implementation of the Affordable Care Act in 2014, more than 40,000 newly eligible County residents have been enrolled into the state's Medi-Cal program, and more than 64,000 residents have been enrolled in Covered California. Despite these achievements to increase the number of individuals who have health insurance, an estimated 133,234 individuals, or 8.3% of County residents, remain uninsured according to the American Community Survey estimates for 2016. Thus, Measure A revenues continue to play a critical role in helping indigent, uninsured, and low income residents of Alameda County—who depend on the County's health care safety net—maintain access to essential health services.

With regard to Measure A recipient reporting, the Committee recognizes an ongoing trend of improvement in the quality and level of detail in the reporting process compared to prior years. This is due in part to the ongoing effort of the Committee and the Health Care Services Agency (HCSA) to improve the accountability of Measure A recipients by

implementing a Results-Based Accountability framework to help providers report measurable performance data that describes the effort, quality, and impact of their programs and services.

Countywide Benefits

Measure A funds continue to support the health and well-being of large numbers of County residents. AHS alone served 129,805 County residents through Measure A in FY 15/16, while the Alameda County Public Health Department Public Health Prevention Initiative served 129,388.

In addition, Measure A contributes to positive outcomes for residents throughout the County, with recipient providers located in every Supervisory District in cities from Fremont to Livermore to Berkeley.

Substantial Return on Investment

A large number of Measure A recipients leveraged their allocations to receive matching funds from other sources. For the 25% of Measure A funds allocated by the Board, recipients leveraged their allocations to obtain a total of $13.3 million in matching funds. Thus, every $1 in Measure A funds to these recipients returned $0.40 in matching funds.

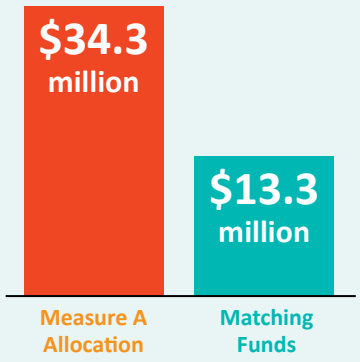
For some recipients, the matching funds represented a return greater than 1:1. Safe Alternatives to Violent Environments (SAVE) obtained almost $85,000 in matching funds on its $40,000 Measure A allocation. Fremont Aging and Family Services obtained almost $200,000 in matching funds on its $52,000 Measure A allocation. Most notably, the School-Based Behavioral Health Initiative obtained over $6,000,000 in matching funds on its $617,000 Measure A allocation, while the School Health Centers obtained almost $12,000,000 in matching funds on an allocation of roughly $1,250,000.

Exceeding Expectations

Many Measure A recipients exceeded their target numbers for clients served, sometimes dramatically. Serving a larger number of clients with a given allocation translates to a lower per-client cost. For example, La Familia greatly exceeded its targets for providing information to low income residents (4,822 actual vs. 1,200 target, an increase of over 400%) and providing health care application assistance (933 actual vs. 133 target, an increase of over 700%). HIV Education and Prevention Project of Alameda County exceeded its target for one-on-one Overdose Prevention Education and Naloxone Distribution trainings by 158%.

Fremont Aging and Family Services conducted 729 home visits to 122 clients, compared to a target of 350 home visits to 85 clients. And LifeLong Heart2Heart reached 865 residents through mobile outreach compared to a target of 200, and provided 1,696 visits to the hypertension clinic compared to a target of 500.

AHS alone served 129,805 County residents through Measure A in FY 15/16, while the Alameda County Public Health Department Public Health Prevention Initiative served 129,388.



The recipients of the 25% of Measure A funds allocated by the Board obtained $13.3 million in matching funds from public and private sources.

Client Satisfaction

In surveys, recipients of Measure A-funded services revealed high levels of satisfaction with their provider and care received. For youth receiving behavioral health services through the Center for Healthy Schools and Communities School-Based Behavioral Health Initiative, 96% stated that they were satisfied with the service they received, and 91% reported that they got the help they wanted. At Preventive Care Pathways, 100% of residents rated the medical care they received as good or very good. And at Tiburcio Vasquez Health Center, Inc., 100% of respondents expressed that health center staff helped them get services they wouldn't otherwise get.

Measurable Success

Provider recipient reporting continues to improve in providing metrics for client outcomes. Among the measurable results provided, Highland Hospital's Outpatient Pharmacy reported that average wait times have decreased from three to four hours to no more than 30 minutes. At UCSF Benioff Children's Hospital Oakland, 100% of children who received Trauma-Focused Cognitive Behavioral Therapy demonstrated clinical progress. And at the Health Services for Day Laborers: Community Initiatives Day Labor Center, 100% of clients who required follow-up care received the care they needed, and 100% of uninsured clients were signed up for health coverage.

Innovative Services

Measure A funding supports a wide variety of services that support the health and well-being of the target population. In addition to traditional medical and mental/behavioral health service providers, Measure A recipients in FY 15/16 included the Connecting Kids to Coverage Initiative, which provides health insurance application assistance; the Alameda-Contra Costa Medical Association Community Health Foundation/East Bay Conversation Project and the National Health Care Decisions Day, which promote understanding and engagement in advance care planning; and the Alameda County Breastfeeding Coalition Childcare Taskforce, which promotes and supports breastfeeding through education, collaboration, and partnership.

Youth Outcomes

A number of providers reported on improved mental and behavioral health outcomes for youth. The Center for Healthy Schools and Communities School-Based Behavioral Health Initiative reported that students who received group or individual services presented statistically significant improvements in life functioning (38%), behavioral/emotional needs (51%), and school success (37%) from intake to discharge. Youth participating in the Mind Body Awareness program at the Juvenile Justice Center revealed a decrease in stress (87%) and an increase in self-control (83%).

Concerns

In developing this report, the Oversight Committee identified several concerns regarding the state of health care funding both during the years of Measure A implementation (2004-2016) and in the foreseeable future.

Furthermore, many families, especially those living in disadvantaged communities, have not benefitted from the economic recovery in recent years and face rising housing and living costs, which significantly impact the health of County residents. In 2015, an estimated 18,000 to 23,000 County residents experienced homelessness, according to the Health Care for the Homeless Needs Assessment. As the housing and homelessness crisis continues to grow in Alameda County, Measure A continues to play a vital role in providing essential health services to many vulnerable residents, including low income families and seniors.

The Committee urges Alameda County to pay close attention to public health policy changes that relate to homelessness and housing affordability that may have significant impacts on health care access or the County's safety net. Moreover, Medi-Cal rate reductions and other funding cuts over the past several years have continued to decrease the ability of health providers to offer services to the expanded Medi-Cal and uninsured populations in the County.

Realizing the full promise of these reforms presents a significant challenge as the health care delivery system remains fragmented, eligibility systems are cumbersome and difficult to negotiate, and access to care continues to be compromised by low reimbursement rates and a shortage of providers—particularly in primary and preventive care. Measure A will continue to serve as an essential revenue stream in developing creative and innovative ways to improve access to care, lower the cost of care, and improve the patient experience. This in turn helps promote equity in health care service delivery by addressing the root causes of poor health outcomes.

RECOMMENDATION: The Board should make a public announcement that Measure A funding is open to all organizations so that eligible organizations become aware of this funding opportunity and learn how to apply.

Outside the area of health care funding, the Committee recognizes that the composition of the Committee has improved in reflecting the diverse make-up of the population served by Measure A.

RECOMMENDATION: Recruitment of Oversight Committee membership should place an ongoing focus on representing the diverse make-up of the population served by Measure A.

Regarding Measure A funding, the Committee raises the following concerns.

NOTE: The Committee believes it is important to present any concerns it noticed while reviewing Measure A recipient reports. At the same time, the Committee wants to make clear that raising a concern does not necessarily mean that a problem exists with a recipient's use of Measure A funds. For example, the concern may arise because of incomplete or inaccurate reporting, not because of any inappropriate use of funds.

Reporting and Review Concerns

- The Committee expresses an ongoing concern that the County Counsel's interpretation of the Measure A ordinance limits the Committee's ability to review program efficacy and cost-effectiveness. The Oversight Committee believes that the interpretation of the statute must be revised to expand the role of the Committee and appropriately allocate Measure A funds for administrative staff to oversee the contracts and ensure the effective use of public funds to all grantees—via audit or other method.
- As part of its role in providing fiscal oversight, the Committee recognizes a need for providers and HCSA to work together to evaluate the long-term impact of Measure A investments in Alameda County.
- Although reporting continues to improve, the Committee expresses the ongoing concern that its review is impacted by the varying level of detail provided in fund recipient reports, as well as varying levels of responsiveness to specific questions posed by the Committee to specific recipients. This makes it difficult for the Committee to determine whether funding is being spent on the Measure A target population. For example:
  - Multiple provider reports listed objectives that are not measurable and/or stated positive outcomes without quantifying the statements.
  - For some reports, it is unclear whether the target population falls within one of the categories listed in the Measure A statute: "indigent, low income, and uninsured adults, children, families, seniors, and other residents of Alameda County."
  - In other reports, the provider's description of the services offered raises questions as to their relevance to the wording of the Measure A statute.

RECOMMENDATION: HCSA should receive funding to create a process for Measure A recipients to verify that they are using Measure A funds to provide their described programs to the populations listed in the measure. This process can include HCSA staff providing training to Measure A recipients on how to effectively collect demographic data to report on the diverse population of indigent, uninsured, and low income clients they serve by race, ethnicity, geography, and language. The Oversight Committee notes that many Measure A recipients do not understand the difference between quality and impact objectives and outcomes. Many

Measure A recipients also could not provide the specific composition of the demographics that they serve. The Committee further advocates that HCSA be sufficiently staffed to successfully implement such a process.

RECOMMENDATION: Organizations that do not provide adequate information in response to HCSA and Oversight Committee requests may not be considered for future funding.

RECOMMENDATION: The Board should authorize HCSA to include evaluations of Measure A programs as part of its initiative to improve oversight and outcomes in all its programs. This includes identifying additional funding to ensure that Measure A contracts are included in the initiative.

RECOMMENDATION: HCSA should put a process in place to improve the measurable objectives and outcomes reported by providers.

RECOMMENDATION: 10% of Measure A recipients should undergo a formal audit each year to track whether money is being spent in accordance with the wording and intent of the measure.

RECOMMENDATION: HCSA should continue to hold trainings to reinforce proper and accurate completion of demographic information and adherence to Measure A services. Measure A recipients who fail to complete the reporting form adequately will be required to attend mandatory training.

RECOMMENDATION: HCSA should continue to work with recipients to improve the use of Results-Based Accountability performance measures and ensure that the population and services supported with Measure A comply with the ordinance.

RECOMMENDATION: HCSA should refine the recipient reporting form to include a question about service delivery in multiple languages, as language barriers can potentially impede access to services for members of the Measure A target population.

Alameda Health System

In response to questions from the Measure A Oversight Committee, neither Mr. David Cox, CFO, nor Mr. Terry Lightfoot, Director of Public Affairs and Community Engagement, were able to:

- Determine what portion of Measure A funds were allocated to personnel, subcontracted services, non-personnel program and/or operating expenses, or administrative overhead, separate from their overall agency budget for these categories.
- Determine what portion of Measure A funds were allocated to the actual number of staff supported, separate from their entire agency staff of 3,415.

- Determine what portion of Measure A funds were allocated to the actual number of individuals served, separate from the agency total of 43,039 individual patients.
- Explain why in their Measure A allocation report they identified 17% of their patients as being "uninsured," whereas in their presentation of September 2016 monthly metrics to the Oversight Committee only 5.5% were uninsured.

In light of the above collective concerns, it is recommended that Alameda Health System undergo a full and comprehensive audit to track Measure A fund allocations during the FY 15/16 period to clarify public accountability for how the funds were utilized.

San Leandro Hospital

As San Leandro Hospital is part of Alameda Health System, several of the concerns listed for AHS on page 9 apply to San Leandro Hospital as well. Specifically, AHS was unable to:

- Determine what portion of Measure A funds were allocated to personnel, subcontracted services, non-personnel program and/or operating expenses, or administrative overhead, separate from their overall agency budget for these categories.
- Determine what portion of Measure A funds were allocated to the actual number of staff supported, separate from San Leandro's staff of 333.

As mentioned previously, it is recommended that Alameda Health System undergo a full and comprehensive audit to track Measure A fund allocations during the FY 15/16 period to clarify public accountability for how the funds were utilized.

Timelist Group Inc.

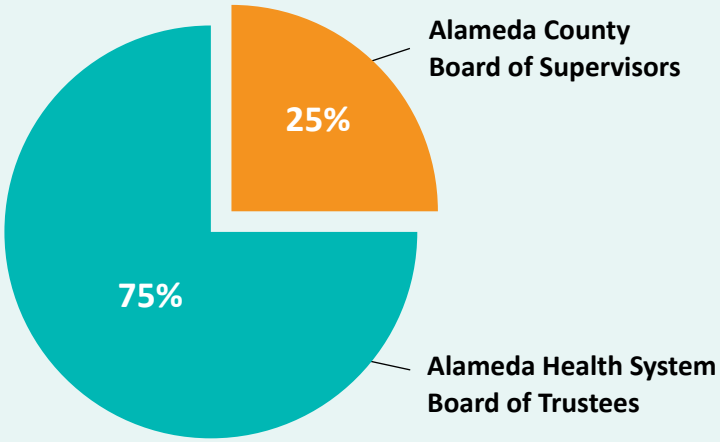
This provider did not supply any Measure A funding information for FY 15/16. Therefore, the Committee cannot evaluate whether funds were spent in accordance with the strictures of Measure A.

HOW THE MONEY WAS SPENT

Measure A tax revenue is used to provide emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low income, and uninsured adults, children and families, seniors, and other residents of Alameda County.

Each year, the Alameda Health System (AHS) receives 75% of Measure A funds, which is allocated by their Board of Trustees to provide primary and specialty care, preventative, and mental health services to patients served at AHS's multiple facilities, including Highland Hospital, John George Psychiatric Hospital, Fairmont Hospital, San Leandro Hospital, and Alameda Hospital.

DISTRIBUTION OF MEASURE A FUNDS



The remaining 25% of the Measure A funds received is allocated by the Alameda County Board of Supervisors (Board) to provide critical medical services offered by community-based health care providers, emergency care, and public health, mental health, and substance abuse services to address the many health needs of communities throughout the County.

In FY 15/16, Measure A generated $137,233,576 (not including interest earned). The funds were allocated as follows:

Alameda Health System (75%): $102,925,182
Alameda County (non-AHS) (25%): $34,308,394
TOTAL: $137,233,576

In FY 15/16, the Alameda County approved budget totaled $2.744 billion. The Alameda County Health Care Services Agency approved budget totaled $646 million, or 23.5% of the total County budget. Measure A revenues not specifically designated for AHS accounted for 5.3%.

The following sections in the report provide more detail on how AHS and the Board spent Measure A funds in FY 15/16, which includes revenue generated in the reporting year as well as unspent funds earned in previous years.

FY 14/15: 75% OF MEASURE A FUNDS ALLOCATED TO Alameda Health System

alamedahealthsystem.org

Allocation: **$102,925,182** | Expended/Encumbered: **$102,925,182**

Individuals served by Measure A: **129,805** (Total individuals served: **129,805**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

Service area: Countywide, Outside of Alameda County, Homeless or transient

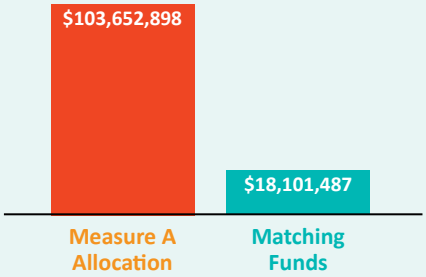
BACKGROUND

Alameda Health System (AHS) is a patient- and family-centered system of care that promotes wellness, eliminates disparities, and optimizes the health of its diverse communities.

AHS program objectives are guided by a three-year strategic plan, which is built on the following pillars:

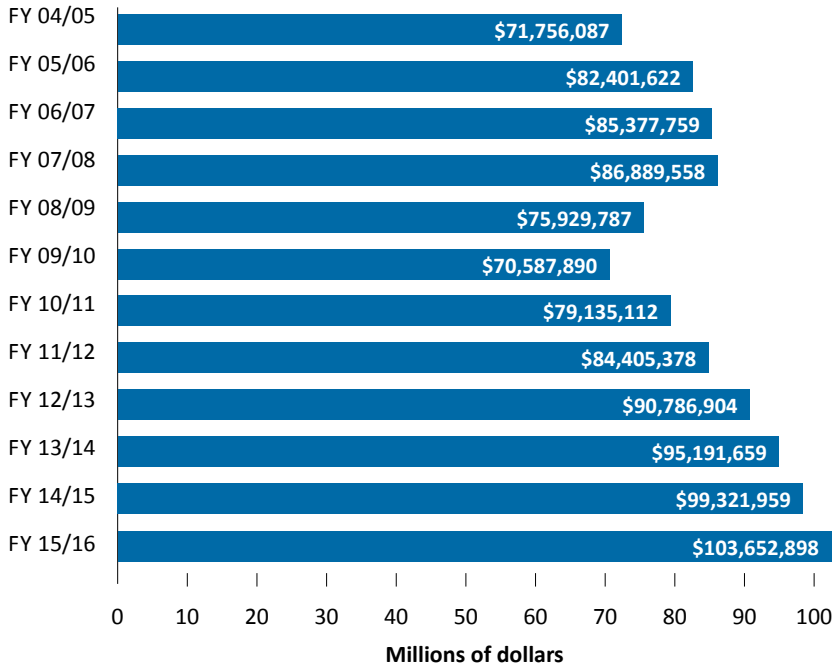
- Access goals:
  - Hiring additional providers in primary care
  - Adding convenient appointments in primary care
  - Building a model of team-based care in primary care
  - Assessing operational efficiency and streamlining processes
  - Offering e-consults in specialty care
- Sustainability goals:
  - Establishing performance benchmarks and operating expense controls
  - Improving operational and finance reporting capabilities
  - Assessing service line/business profitability
  - Completing reimbursement analytics
- Quality goals:
  - Developing harm reduction teams to review root causes and implement proven best practices
  - Conducting routine physician peer review, where applicable, for practice improvement
- Service goals:
  - Setting standards for response times to patient call buttons
  - Increasing staff efforts to include the patient in decisions about his or her treatment
- Workforce Development goals:
  - Sharing results and ensuring that staff understand what they mean
  - Providing instruction and training on how to enlist the support of team members to improve engagement

Matching Funds



AHS leveraged its Measure A allocation to obtain **$18,101,487 in matching funds** through the Seniors and Persons with Disabilities and Rate Range intergovernmental transfers provided by Alameda County.

REVENUE EARNED EACH FISCAL YEAR (FY 04/05 THROUGH FY 15/16)



MEASURE A FUNDING SUMMARY

Measure A is a supplemental revenue source for AHS, reducing the gap between reimbursement for services from a variety of sources and the actual cost of providing those services to underinsured and uninsured persons. Measure A supports all of AHS's services, with the exception of that fraction of AHS's business for which it receives full reimbursement for the cost of services provided.

In FY 15/16, Measure A helped AHS achieve the following:

- Access (number of days to the third-next-available appointment)
  - Primary care: Highland, 31; Eastmont, 41; Hayward, 80; Newark, 50.
  - Specialty care: Highland, 43; Eastmont, 53.
- Sustainability
  - Operating margin for FY 15/16 was 3.3%, compared to -8% in FY 14/15.
- Quality
  - Total harm reduction improved 55.35% from FY 10/11 to FY 15/16 and 23.77% from FY 14/15 to FY 15/16.
- Service
  - Patients who reported getting help as soon as they wanted after pressing the call button improved 6.42% over the prior year.
  - Patients who reported that staff took their and their families/ caregivers' preferences into account in deciding their health care needs after discharge improved 4.15% over the prior year.
- Workforce Development
  - Systemwide scores for employee engagement were 3.95 (2015) and 3.6 (2016), and for physician engagement were 3.68 (2015) and 3.3 (2016).

Highlights

Highland Hospital's Outpatient Pharmacy has made many significant improvements in patient care:

- Average **wait times have decreased** from three to four hours to no more than 30 minutes.
- Patients are **alerted via text message or phone call** when their prescriptions are ready.
- A free, **same-day delivery service** was launched for eligible patients.
- Pharmacy **profits have grown significantly** from approximately $400k in 2014 to a projected $2.8 million for 2016.

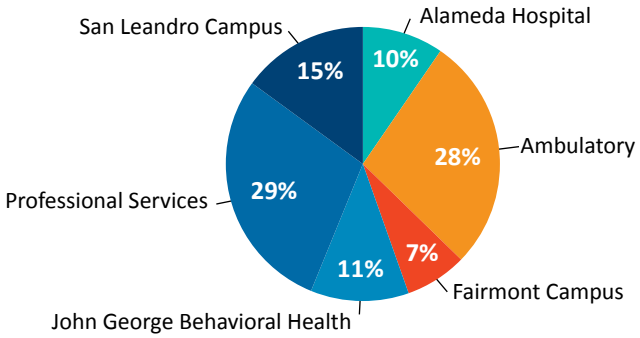
CONCERNS

In response to questions from the Measure A Oversight Committee, neither Mr. David Cox, CFO, nor Mr. Terry Lightfoot, Director of Public Affairs and Community Engagement, were able to:

- Determine what portion of Measure A funds were allocated to personnel, subcontracted services, non-personnel program and/or operating expenses, or administrative overhead, separate from their overall agency budget for these categories.
- Determine what portion of Measure A funds were allocated to the actual number of staff supported, separate from their entire agency staff of 3,415.
- Determine what portion of Measure A funds were allocated to the actual number of individuals served, separate from the agency total of 43,039 individual patients.
- Explain why in their Measure A allocation report they identified 17% of their patients as being "uninsured," whereas in their presentation of September 2016 monthly metrics to the Oversight Committee only 5.5% were uninsured.

In light of the above collective concerns, it is recommended that Alameda Health System undergo a full and comprehensive audit to track Measure A fund allocations during the FY 15/16 period to clarify public accountability for how the funds were utilized.

ALLOCATION OF ALAMEDA HEALTH SYSTEM MEASURE A FUNDS IN FY 14/15



Measure A Helps

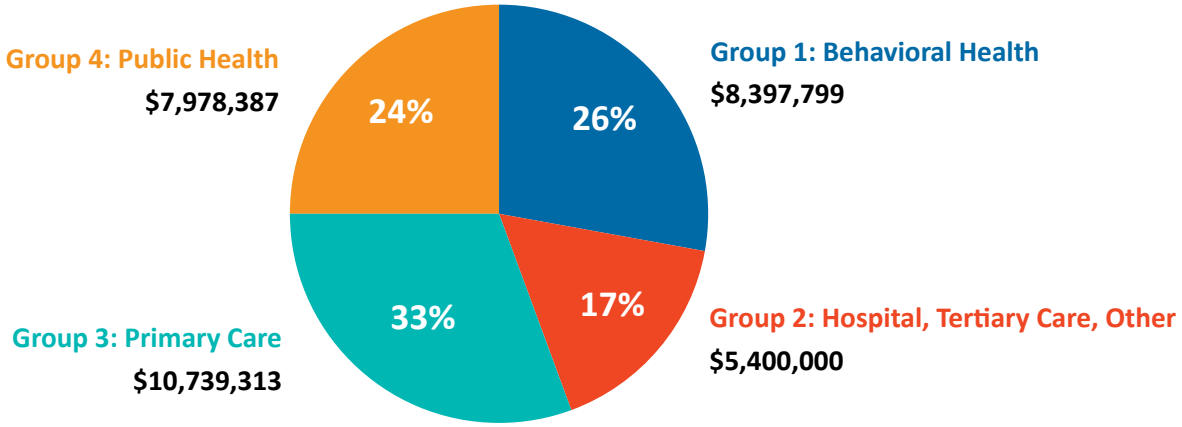
Ms. M, a homeless patient at Highland Hospital, was diagnosed with Clostridium Difficile Infection (C. Diff), AIDS and Disseminated MAC, symptoms of diarrhea, weight loss, and fever. She also reported using crack cocaine frequently. The Homeless Coordination Team, Licensed Clinical Social Worker (LCSW), and AHS Director of Social Services worked together to get Ms. M a housing voucher, assess her goals and needs, and ultimately provide a referral to the Cherry Hill Detoxification Center. The LCSW continued to engage with Ms. M and discuss other treatment options. Ms. M was able to secure a bed at Chrysalis Residential Treatment Program and was expected to graduate in January of 2017.

FY 15/16: **25% OF MEASURE A FUNDS** ALLOCATED BY
The Alameda County Board of Supervisors

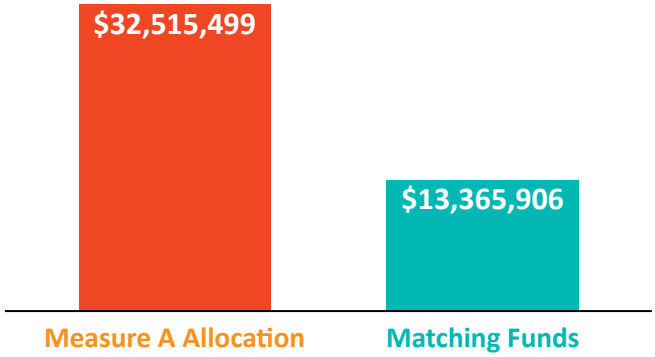
In FY 15/16, the Board of Supervisors (Board) approved approximately $34.3 million in total Measure A allocations. The Board allocations are listed by group in the following chart.

NOTE: Since most of the allocations are approved by the Board before and during each fiscal year based on sales tax revenue projections, the total allocation amount may not equal the actual revenue received. For more details on Board allocations, see Appendix B: FY 15/16 Budget Information and Appendix C: FY 15/16 Measure A Fund Distribution by Provider or Program. The appendices may include allocations that were approved by the Board but not expended by the end of the fiscal year.

MEASURE A FUNDING APPROVED BY THE BOARD OF SUPERVISORS IN FY 15/16



TOTAL MATCHING FUNDS OBTAINED BY LEVERAGING MEASURE A ALLOCATIONS



FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 1: BEHAVIORAL HEALTH

Behavioral Health and Alcohol and Other Drug (AOD) Community

www.acbhcs.org

Allocation: **$775,848** | Expended/Encumbered: **$775,848**

Individuals served by Measure A: **10,000** (Total individuals served: **36,000**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Mental Health, Substance Abuse

Service area: Countywide

BACKGROUND

Alameda County Behavioral Health Care Services (BHCS) works to maximize the recovery, resilience, and wellness of all eligible Alameda County residents who are developing or experience serious mental health, alcohol, or drug concerns.

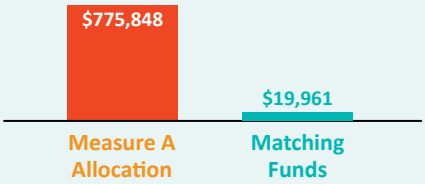
Community-based organizations (CBOs) provide mental health and substance use disorder services under contract with BHCS to meet the diverse cultural and language needs of County resident populations.

MEASURE A FUNDING SUMMARY

Measure A funds were used to support several mental health and substance use disorder programs. Funds were roughly evenly distributed between mental health and alcohol and other drug (AOD) programs. Providers used Measure A funds to support expansion in service operations and administrative needs, and to address cost increases not sufficiently covered by standard cost-of-living adjustments (COLAs) provided by their contract.

The use of Measure A funds to mitigate budget cuts allowed providers to serve approximately the same number of County residents in AOD programs, despite unavoidable cost increases for insurance, utilities, and other non-service-related operational expenses. These additional funds contributed to significant client-level outcomes, such as service continuity, outreach effectiveness, and client engagement in treatment objectives that would be put at risk by cutbacks in provider service capacity.

Matching Funds



BHCS-contracted CBOs leveraged their Measure A allocations to obtain **$19,961 in matching funds** from Medi-Cal and the Medi-Cal Administrative Activities (MAA) program.

Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)

achealthyschools.org

Allocation: **$622,356** | Expended/Encumbered: **$622,356**

Individuals served by Measure A: **2,913** (Total individuals served: **2,913**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families

Services provided: Mental Health, Substance Abuse

Service area: Ashland, Cherryland, Dublin, Emeryville, Hayward, Livermore, Newark, Oakland, Pleasanton, San Leandro, San Lorenzo, Union City, Homeless or transient

BACKGROUND

The Center for Healthy Schools and Communities (CHSC) works to foster the academic success, health, and well-being of Alameda County youth by building universal access to high quality supports and opportunities in schools and neighborhoods.

Co-coordinated by CHSC and the Alameda County Behavioral Health Care Services (BHCS) Agency, the Alameda County School-Based Behavioral Health Initiative strengthens the use of evidence-based practices along a continuum of behavioral health supports that includes prevention, early intervention, and treatment strategies.

CHSC and BHCS used their Measure A allocation to enhance two core programs of the Alameda County School-Based Behavioral Health Initiative: the Our Kids Our Families Program, and the School District Consultation program. The main objective of the initiative is to implement and strengthen these programs in the following school districts:

- Emery Unified
- Newark Unified
- New Haven Unified
- Dublin Unified
- Livermore Valley Joint Unified
- Oakland Unified
- Pleasanton Unified
- San Leandro Unified
- Hayward Unified

The Our Kids Our Families program, provided at 29 school sites in the Hayward and Oakland Unified School Districts, is a school-based behavioral health program that fosters social-emotional wellness in an educational environment so that children and families feel connected, safe, and supported in school. The Our Kids Our Families program

Measure A Helps

Jake, a 17-year-old high school senior, has experienced multiple traumas. He was placed in foster care after his parents were incarcerated but left the foster home due to abuse, leading to homelessness and substance abuse. At school, Jake was arrested for carrying a pocket knife on campus. After his arrest, Jake was referred to COST. The COST helped Jack get a job, accessed funds for transportation to and from school, and provided academic support. The COST continues to connect Jake to services available for transition-age youth and is working on a permanent housing solution. Thanks in large part to the COST support, in June 2016, Jake graduated from high school.

supports prevention efforts at the school sites, as well as early intervention and treatment services for any student and their family that needs it.

The School District Consultation program places behavioral health consultants (BHCs) in school districts to provide and enhance preventive social-emotional supports and mental health services for students and their families. The services provided by BHCs include the following:

- Assess the social-emotional service needs and infrastructure of a school district or set of schools and develop a service plan
- Coordinate the work of all partner agencies who deliver behavioral health services in schools and districts
- Provide and/or coordinate clinical case management, group and individual counseling, and crisis assessment and intervention to students
- Provide workshops, parenting groups, mental health and other appropriate consultation, and linkages to needed school and community resources to parents/caregivers

MEASURE A FUNDING SUMMARY

The School-Based Behavioral Health Initiative used its Measure A allocation to support the following activities through the District Behavioral Health Consultation program.

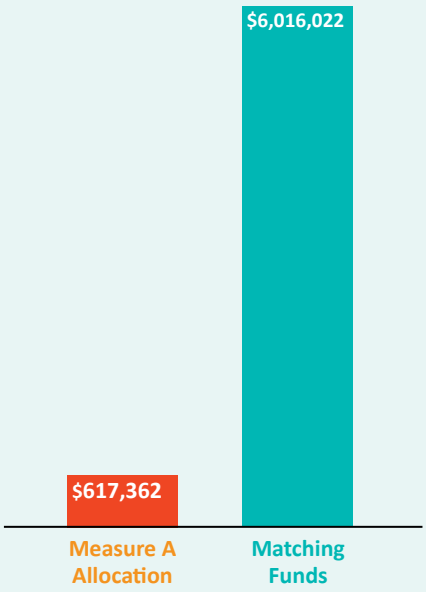
Prevention Activities

BHCs provided a variety of non-clinical preventative services to students, families, and teachers and other staff at schools and schools districts. These services included the following:

- Individual mentorship/drop-ins with youth
- Youth groups
- Individual mentorship/drop-ins with families
- Family groups/workshops
- Teacher/provider consultations
- School/district staff presentations

As a result of Measure A funding, the School-Based Behavioral Health Initiative also supported the unique needs of the population of unaccompanied immigrant youth (UIY) in schools through the development of the UIY Care Team. The UIY Care Team deployed culturally competent clinicians and case managers to schools and districts to connect UIY and their caregivers to mental health supports and other resources. BHCs supported the UIY in their schools/districts by identifying youth who might be unaccompanied immigrants and alerting the UIY team so that they could respond appropriately to their health, mental health, and academic needs. In FY 15/16, BHCs reported serving or brokering non-clinical support for 118 UIY.

Matching Funds



The School-Based Behavioral Health Initiative leveraged its Measure A allocation to obtain **$6,016,022 in matching funds** from the following sources:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funding, Hayward: $1,345,957
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funding, Oakland: $2,133,989
- Tobacco Master Settlement Fund (TMSF)/CHSC discretionary : $1,513,112
- Medi-Cal Administrative Activity (MAA): $500,000
- Mental Health Services Act Prevention/Early Intervention Program: $412,866
- City of Oakland, Oakland Unite: $200,000
- School District funding: $110,098

Early Intervention and Treatment Strategies

BHCs performed several roles and responsibilities to strengthen the quality of early intervention and treatment programs in all school districts:

- In all districts, BHCs served as key point persons for responding to behavioral health crises at school sites. BHCs either directly provided crisis response services or coordinated crisis response. In FY 15/16, BHCs provided crisis assessment services to 471 youth, with a total of 420 hours reported on this work.
- In addition to overseeing Clinical Case Managers in Oakland and Hayward, BHCs provided direct supervision and/or coordination of graduate-level social work and MFT interns in the Emery, Newark, New Haven, San Leandro, and Hayward Unified School Districts. The Our Kids Our Families Intern Program supervised a total of 16 social work and MFT interns. During FY 15/16, 4,073 students were provided with 146,318 hours of clinical services through the program. The program also provided 6,565 hours of support to the families of students receiving clinical services.
- BHCs also worked to expand the use of therapeutic groups for students who showed early signs of behavioral health struggles. In FY 15/16, 8,876 hours of group services were provided to these at-risk students. In addition, BHCs coordinated clinical staff to work with teachers and other staff to help them support students who were receiving treatment. As a result, 6,241 hours of support were provided to these teachers and staff.
- In FY 15/16, BHCs coordinated social and emotional learning (SEL) initiatives at all eight school districts supported by Measure A funds. The Emery, Newark, and Hayward school districts received funding to implement a Positive Behavioral Interventions & Supports (PBIS) framework in every school. As a result of this work, PBIS was implemented in 18 of 21 schools in Hayward and four of 13 schools in Newark. BHCs are also supporting quality improvements of San Leandro's PBIS initiative, which was implemented in every school in the district.
- BHCs also supported other SEL and restorative justice resources in school districts, such as implementing restorative justice coordinators at all secondary schools in Hayward and developing Parent Ambassador and Student Ambassador programs to support engagement in district planning efforts. BHCs also supported the adoption of SEL curriculums in the Emery, San Leandro, and Dublin school districts.
- BHCs implemented Coordination of Services Teams (COST) and other referral mechanisms for behavioral health supports. COST is an evidence-based model for coordinating care at a school site. The multidisciplinary COST worked together to identify students who are struggling through referrals and data-driven screenings; deliberate strengths and challenges and assess supports needed for each student who is struggling; support the implementation of interventions that will

Highlights

In surveys of youth receiving behavioral health services in the School-Based Behavioral Health Initiative:

- 96% stated that they were **satisfied with the service** they received.
- 91% reported that they **got the help they wanted**.
- 94% reported **improvements in their access** to an individual who can help them in a crisis.
- 85% reported i**mproved ability to cope** when things go wrong.
- 85% indicated **improved relationships** with friends and other people.
- 84% reported **improvements in school and/or work**.

In surveys of parents whose students had received services:

- 91% reported a **high level of satisfaction** with the services that their child received.
- 76% and 82% saw **improvements in their children's ability to handle school and daily life**, respectively.
- 97% who participated in parent/family engagement workshops reported that the events were **useful and informative, addressed their needs, and increased their knowledge and parenting skills**.

support the student; monitor progress and provide appropriate follow-up; identify the broader learning support resource needs of the school; and make recommendations about resource allocation.

- During FY 15/16, BHCs supported the implementation of COST in 157 schools in 13 school districts, or 56% of all schools in these districts. COSTs at these schools received over 7,228 student referrals during the year. Approximately 72% of all students (or 5,170) referred to COST were connected to critical behavioral health services.

Highlights

The Child and Adolescent Needs and Strengths (CANS) assessment administered to students receiving services showed significant improvements in:

- **Life functioning** (38%)
- **Behavioral/emotional needs** (51%)
- **School success** (37%)
- **Child strengths** (44%)

Among students who received individual or group clinical services, the proportion who experienced **depression decreased** from 35% at intake to 21% at discharge.

Criminal Justice Screening and In-Custody Services

Allocation: **$4,306,000** | Expended/Encumbered: **$4,306,000**

Individuals served by Measure A: Approximately **4,728** (Total individuals served: **4,728**)

Populations served: Indigent, Low Income, Uninsured Adults, Families, Seniors

Services provided: Mental Health

Service area: Countywide

BACKGROUND

Alameda County Behavioral Health Care Services (BHCS) works to maximize the recovery, resilience, and wellness of all eligible Alameda County residents who are developing or experience serious mental health, alcohol, or drug concerns.

A program of BHCS, Criminal Justice Mental Health (CJMH) provides a full range of mental health services to County jail inmates every month. Without jail mental health services, mentally ill inmates would go untreated.

MEASURE A FUNDING SUMMARY

BHCS used its Measure A fund allocation to maintain staff at criminal justice screening and to provide ongoing services and assessments on the housing units at Santa Rita Jail (SRJ) and Glen Dyer Detention Facility (GDDF). Goals included the following:

- Provide onsite clinical coverage in the Intake, Transfer, and Release (ITR) area of SRJ seven days a week, two shifts per day
- Provide on-call access to clinicians during times staff is not onsite
- Respond to all mental health crises within the jail in a timely manner
- Assess all inmates placed on suicide watch while in custody
- Provide assessment and monitoring of seriously mentally ill inmates housed in SRJ and GDDF
- Refer clients to appropriate community services

In FY 15/16, CJMH staff completed the following:

- 5,543 assessments/initial evaluations
- 7,249 individual therapy sessions
- 961 crisis interventions
- 7,986 face-to-face medication interviews
- 4,641 non-face-to-face medication interventions

Measure A Helps

Ms. X, 34, has a long history of mental health treatment, often from CJMH while in jail. Through repeated interventions, CJMH staff were able to develop a trusting relationship with Ms. X and encourage her to engage in treatment. During a recent incarceration, CJMH staff referred Ms. X to a re-entry program for inmates who are not connected to community mental health services. Although Ms. X continues to struggle with addiction, she has been engaged with treatment and has not returned to custody. Ms. X was stabilized by CJMH staff so she was in a much better position to take advantage of the discharge plans and referrals provided by CJMH.

Specific services supported by Measure A included the following.

Mental Health Screening

- Initial (Intake). At the time of booking, all inmates are screened for medical and psychiatric treatment needs. Within 14 days, staff conducts an additional mental health appraisal. Inmates found to need a further mental health evaluation are referred to CJMH. The screening assessment includes an evaluation of the inmate's current psychiatric condition, psychiatric history, substance abuse (addictions) history and current use, psychiatric medication history and current need for medications, suicide history and current risk factors, and more.
- Post-booking. CJMH clinicians triage and screen all referred inmates for mental health service needs and recommend appropriate treatment plans based on the assessment. CJMH provides services onsite in select special housing units. These onsite services allow CJMH staff to proactively deliver mental health services to mentally ill inmates who might otherwise fall through the cracks.

Crisis Intervention

- Onsite. CJMH clinicians respond to urgent calls regarding seriously distressed inmates and provide crisis counseling, make recommendations for interventions, initiate interim placements, and/or make arrangements for psychiatric hospitalization.
- On-call. When there are no mental health staff onsite, a CJMH clinician is on call and can be reached by pager to assist with urgent mental health matters.

Management of Inmate Behavioral Problems

CJMH clinicians collaborate with and provide consultation to deputies and staff to develop and implement plans for appropriate management of inmate behavioral problems.

Suicide Prevention

CJMH participates with sheriff's personnel and medical staff in training, oversight, and procedures designed to prevent inmate suicides. At the time of booking, all inmates are assessed for suicide risk. In addition, CJMH conducts a suicide risk assessment on all inmates called to their attention as a result of inmates expressing suicidal thoughts or demonstrating self-injurious behaviors. CJMH staff work with inmates who demonstrate a risk for suicide and address risk factors, develop relapse prevention strategies, and discuss coping strategies. CJMH takes preventive action on all inmates expressing suicidal thoughts and/or demonstrating self-injurious behaviors.

CJMH clinicians respond to urgent calls regarding seriously distressed inmates and provide crisis counseling, make recommendations for interventions, initiate interim placements, and/or make arrangements for psychiatric hospitalization.

Ongoing Treatment Services, Treatment Planning, Stabilization of Mental Disorders, and Other Services

- All inmates receiving mental health services are seen by CJMH clinicians, who develop individualized treatment plans to help inmates achieve mental stability, develop an awareness of their psychological and behavioral problems, and acquire coping skills while incarcerated.
- Medication support services. When appropriate, CJMH psychiatrists evaluate inmates and prescribe psychotropic medications to alleviate symptoms and allow the inmates to achieve an optimal level of functioning while incarcerated.
- Counseling services. Inmates referred for counseling services receive an additional post-booking assessment and are provided ongoing counseling sessions as determined by their treatment plan.
- Misdemeanant incompetents. With regard to misdemeanant Incompetent to Stand Trial inmates, CJMH staff collaborate with the courts to provide treatment geared to restoring competence and/or refer inmates to community programs that can address competency.
- Court-ordered evaluations. CJMH clinicians conduct court-ordered psychiatric evaluations to assess the need for acute inpatient psychiatric care and provide reports back to the courts.
- Inpatient services. CJMH staff or deputies send inmates requiring acute inpatient hospitalization to acute psychiatric inpatient hospitals. When inmates are returned to the jail, they are held in the Outpatient Housing Unit (Infirmary) until CJMH clinicians can assess them, continue their medications, and clear them for housing.
- Inmates who refuse treatment. All treatment is voluntary. CJMH staff monitor inmates with serious mental illnesses who refuse treatment and make an ongoing attempt to engage these inmates in treatment.
- Outreach and teamwork. CJMH clinicians and psychiatrists closely monitor inmates in Special Housing Units—Ad Seg, Mental, Women's. Visits occur weekly, including cell checks for inmates who refuse to be seen or who are noncompliant with treatment.
- Substance abuse treatment. Inmates have access to programs that specifically address addiction problems. CJMH clinicians also address substance abuse as part of their ongoing interventions with inmates.

Mental Health On-Call/Emergency Services

Emergency mental health services are available 24 hours a day by onsite staff or by mental health professionals who work on call. Access to 24-hour acute psychiatric hospitalization is available. A CJMH psychiatrist is on call to accommodate the continuity of psychotropic medications.

Discharge Planning/Continuity of Care

When CJMH staff have advance notice of an inmate's date of release, staff make a referral for follow-up outpatient treatment. CJMH staff work

Emergency mental health services are available 24 hours a day by onsite staff or by mental health professionals who work on call. Access to 24-hour acute psychiatric hospitalization is available.

closely with court mental health advocates the Court Advocacy Project (CAP), the Forensic Assertive Community Treatment (FACT) team, the Behavioral Health Court (BHC), and community service providers in coordinating treatment plans and release plans for persons in custody with serious mental illnesses.

Training

The CJMH Director, the Senior Clinician(s), and other mental health professionals provide training to sheriff's personnel and civilian staffs in mental illnesses and suicide prevention. All new CJMH staff receive 40 hours of initial training. CJMH managers and psychiatrists provide ongoing training to CJMH line staff in topics related to the practice of jail psychiatric services. The CJMH Lead Psychiatrist attends the monthly BHCS Psychiatric Practices Committee and shares information learned with other CJMH psychiatrists.

All new CJMH staff receive 40 hours of initial training.

Detoxification/Sobering Center

Allocation: **$2,143,224** | Expended/Encumbered: **$1,996,448**

Individuals served by Measure A: **7,068** (Total individuals served: **7,068**)

Populations served: Indigent, Low Income, Uninsured Adults, Seniors

Services provided: Substance Abuse

Service area: Countywide, Homeless or transient

BACKGROUND

The Detoxification/Sobering Center works to improve the quality of life for individuals, families, and the community affected by drug abuse and mental health issues by providing compassionate, effective prevention, treatment, and recovery services.

Services provided include the following:

- Residential sobering services including a stay of less than 24 hours at the Sobering Center for withdrawal management from alcohol and other drugs of abuse. The Sobering Center serves as a receiving and substance use crisis center for local law enforcement, hospitals, families, clinics, and communities. The Sobering Center is accessible to the community 24 hours per day, every day, including holidays.
- Residential detoxification services including a 3–5 day stay at the Detoxification Center focused on withdrawal management, client engagement, and referral to ongoing care. Ongoing care might include residential substance use treatment, shelters, mental health treatment, sober living, transitional living, and other community resources. The Detoxification Center is accessible to the community 24 hours per day, every day, including holidays.
- Health Center services including tuberculosis skin testing; wound care; medication management; medical assessment; blood pressure, heart rate, and pulse check; and crisis medical response.
- Transportation services for clients to and from hospitals, clinics, and treatment centers. Transportation services are also available for law enforcement, crisis response teams, and any other community provider who has a person who is in need of detoxification or sobering services.
- Recovery services including substance use prevention, relapse prevention, case management, and referral services.
- 12-step meetings including Alcoholics Anonymous and Narcotics Anonymous. These meetings are closed to the public and are offered five evenings per week, every week, including holidays.

Measure A Helps

A transgendered client (male who identifies as female) arrived at Cherry Hill with a co-occurring mental illness and substance use disorder. Despite numerous staff attempts at engagement, the client left the Sobering Center untreated. Approximately a month later, the client returned to Cherry Hill from a local hospital. Staff were able to accommodate her needs and make attempts to engage her during the detoxification process. Despite many challenging days, the client was able to safely detoxify from heroin, stabilize on her psychiatric medication, and be referred to residential co-occurring disorder treatment. Staff received a letter from the client thanking them for being accommodating and sensitive to her needs.

MEASURE A FUNDING SUMMARY

Measure A provides over 98% of the funding to Cherry Hill Detoxification Services Program/Horizon Services, Inc., the sole provider of the Detox/Sobering Center.

With this funding, the Detox/Sobering Center achieved the following:

- Cherry Hill Sobering Center provided 5,014 units of service, with a total of 5,014 admissions.
- The Detox Center provided 8,775 units of service, with a total of 2,054 admissions.
- The Health Center provided 955 health services.

Cherry Hill Sobering Center provided 5,014 units of service. The Detox Center provided 8,775 units of service.

La Familia Counseling Services

lafamiliacounseling.org

Allocation: **$50,000** | Expended/Encumbered: **$50,000**

Individuals served by Measure A: **4,822** (Total individuals served: **4,822**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Mental Health, Substance Abuse

Service area: Ashland, Cherryland, Hayward, San Leandro, San Lorenzo

BACKGROUND

La Familia Counseling Service is an inclusive, Latino community-based, multicultural organization committed to strengthening the emotional wellness of individuals and the preservation of families.

MEASURE A FUNDING SUMMARY

La Familia used its Measure A allocation to achieve the following:

- Provide individual and family basic needs information, housing referrals, job referrals, nutrition, translations, health referrals, immigration, legal and general orientation, and health education workshops to low income residents, to help them attain increased psycho-social and economic stability (target: 1,200 residents; actual: 4,822).
- Provide case management support—including intake and assessment, service planning, direct support, and evaluation—for an average of 90 days to families facing multiple challenges (target: 159 families; actual: 39).
- Provide assistance in applying for health coverage through Medi-Cal and other available options to residents who do not have health insurance (target: 133 residents; actual: 990).
- Provide workshops/support groups for adults/caregivers on topics to improve access to medical and mental health resources, nutrition, parenting, coping skills, academic engagement, and advocacy (target: 105 workshops/support groups; actual: 139).
- Provide workshops/support groups to youths to foster healthier relationships, support community building, and explore personal and social responsibility (target: 40 workshops/support groups; actual: 48).

La Familia also used its Measure A funding to provide monthly immigration consultations, Zumba, yoga and meditation, special events and activities in relation to culture and wellness, and self-enrichment classes such as ESL.

Highlights

La Familia met or exceeded its targets for almost all of its program objectives. In two areas, it greatly exceeded its targets—**providing information to low income residents** (4,822 actual vs. 1,200 target, an increase of over 400%), and **providing health care application assistance** (990 actual vs. 133 target, and increase of over 700%). Numbers also increased substantially in many areas compared to FY 14/15—for example, information and referrals increased by 56%, while health insurance referrals increased by 31% compared to the previous year.

Mental Health Services for Juvenile Justice Center

Allocation: **$360,000** | Expended/Encumbered: **$360,000**

Individuals served by Measure A: **79** (Total individuals served: **847**)

Populations served: Indigent, Low Income, Uninsured Children, Families

Services provided: Mental Health, Substance Abuse

Service area: Countywide, Outside of Alameda County

BACKGROUND

Alameda County Behavioral Health Care Services (BHCS) offers mental health services to youth at the Alameda County Juvenile Hall in an effort to maximize the recovery, resilience, and wellness of those who develop or experience serious mental health, alcohol, or drug concerns. The services provided consist of individual therapy, case management, court-ordered evaluations, crisis intervention, and consultation to Juvenile Hall staff, probation officers, school staff, and the Juvenile Court.

Youth who are detained in Juvenile Hall, by nature of being in a locked facility away from family and friends, experience anxiety, agitation, and depression in regards to their situation. This is in addition to any pre-existing mental health conditions that the youth struggle with prior to being admitted into Juvenile Hall. The goal of BHCS is to mitigate as much as possible the negative emotional impact of detention.

MEASURE A FUNDING SUMMARY

BHCS used its Measure A allocation to provide mental health services to youth detained in the Juvenile Hall facility. The funding helped BHCS attain the following objectives:

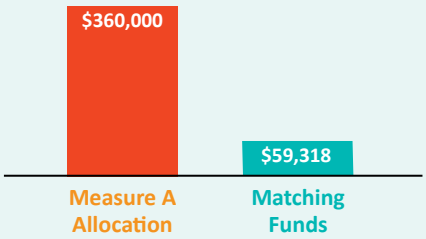
- Mitigate the mental health issues of detained youth by offering crisis intervention and ongoing mental health support while detained.
- Provide court-ordered mental health assessments. Guidance Clinic staff completed approximately 149 mental health assessments in FY 15/16. Measure A funding covered approximately 14 of those assessments.
- Offer immediate crisis intervention for suicidal youth to avoid self-harm. The Guidance Clinic performed 167 crisis interventions to avoid self-harm and/or hospitalization, of which Measure A funded 16.

Highlights

Thanks in part to Measure A funding, the program achieved the following:

- The program resulted in **increased coping skills** among the target population for managing anxiety, depression, and trauma symptoms due to being detained.
- As a result of immediate crisis intervention, **only eight clients were hospitalized** in FY 15/16.

Matching Funds



BHCS leveraged its Measure A allocation to obtain **$59,318 in matching funds** from Medi-Cal.

Mental Health Services for Newcomers and Immigrants (CERI)

cerieastbay.org

Allocation: **$80,371** | Expended/Encumbered: **$80,371**

Individuals served by Measure A: **150** (Total individuals served: **180**)

Populations served: Low Income, Uninsured Children, Families

Services provided: Mental Health

Service area: Oakland

BACKGROUND

The Center for Empowering Refugees and Immigrants (CERI) is a grassroots, nonprofit organization dedicated to providing culturally competent mental health and other social services to refugee and immigrant families with multiple layers of complex needs, exposure to violence and trauma both in their current environment and in their native countries, and weakening intergenerational relationships.

The agency's focus is on refugees and immigrants from Afghanistan, Bosnia, Cambodia, and Iran. Presently, the majority of its 200 clients are Cambodian refugees living in Oakland, about two-thirds are children, and nearly all are low income.

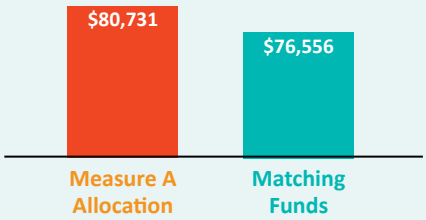
Over 50% of staff are Cambodian American and speak the Khmer language. All staff are trained in issues around trauma, refugee, and immigrant needs for those living in poverty and facing discrimination.

MEASURE A FUNDING SUMMARY

CERI used its Measure A allocation to conduct the following activities:

- Community events (target: 16 events providing outreach to 125 individuals; actual: monthly events attended by 55 individuals)
- Home and school visits (target: 392 hours; actual: 400)
- Psycho-educational workshops (target: 16 workshops)
- Support groups, including life skills classes, art, and other nontraditional mental health prevention activities (target: 10 groups)
- Cultural workshops (target: 6 workshops; actual: 6)
- Mental health trainings to increase understanding around mental health and mental health resources (target: 6 trainings; actual: 6)
- Consultation and/or training for schools, probation officers, child welfare workers, and health care workers
- Mental health early intervention for individuals and families including referral and linkage to alternative programs as needed (target: 320 hours to at least 10 individuals; actual: 500 hours to 15 individuals)

Matching Funds



CERI leveraged its Measure A allocation to obtain **$76,556 in matching funds** from the Mental Health Services Act (MHSA).

Highlights

- 100% of CERI's school-aged youth are **attending some sort of school**.
- **16% of adolescents** reported being involved in drug use, gang involvement, or sexual exploitation, compared to 40% the previous year.
- CERI made **two CPS reports**, compared to five the preceding year.
- **No youth were arrested**, compared to two the preceding year.

Safe Alternatives to Violent Environments (SAVE)

save-dv.org

Allocation: **$40,000** | Expended/Encumbered: **$40,000**

Individuals served by Measure A: **5,090** (Total individuals served: **8,688**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Public Health

Service area: Fremont, Hayward, Newark, Pleasanton, San Lorenzo, Union City

BACKGROUND

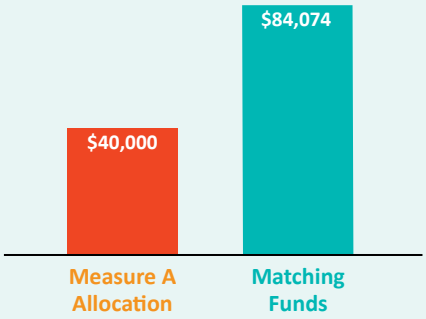
Safe Alternatives to Violent Environments (SAVE) works to strengthen every individual and family they serve with the knowledge and support needed to end the cycle of violence and build healthier lives.

The SAVE Teen Dating Violence Prevention (TDVP) program provides an opportunity for youth to discuss and learn topics that can improve their long-term wellness outcomes. It also helps educators and youth services providers have a better understanding of how the young people with whom they work know about healthy relationships, boundaries, digital safety, warning signs of dating violence, and how/where to access resources. Given the high risk youth face for being involved in violent intimate relationships, offering access to this education (which is often limited to privileged communities) improves overall community outcomes. The program is designed for and delivered in high school classrooms.

MEASURE A FUNDING SUMMARY

SAVE used its Measure A allocation to conduct 98 TDVP presentations to a total of 5,040 students.

Matching Funds



SAVE leveraged its Measure A allocation to obtain **$84,074 in matching funds**.

Highlights

In a teacher survey, 100% of teachers indicated they **liked the presentation and would recommend it to another educator**, compared to a goal of 65%.

In a student survey of questions regarding teen dating violence, **75% of students scored at least 80% correct**.

Senior Support Program of Tri-Valley

ssptv.org

Allocation: **$20,000** | Expended/Encumbered: **$20,000**

Individuals served by Measure A: **25** (Total individuals served: **25**)

Populations served: Seniors

Services provided: Mental Health

Service area: Dublin, Livermore, Pleasanton, Sunol

BACKGROUND

Senior Support Program of Tri-Valley provides services and assistance to seniors to foster independence, promote safety and well-being, preserve dignity, and improve quality of life.

The In-Home Counseling Program makes a difference in the lives of Tri-Valley seniors by providing counseling services in seniors' homes. Staff members receive referrals from case managers, family members, caregivers, and other concerned members of the community.

By making this service free of charge, many older adults get the benefit of much-needed support with their most challenging end-of-life issues. In many cases, the counselor is the only contact the client has.

MEASURE A FUNDING SUMMARY

Senior Support Program of Tri-Valley used its Measure A allocation to achieve the following:

- Provide In-Home Counseling services to at least 20 seniors with mental health issues who are referred from community, staff, family, etc. 100% of clients reported experiencing improvements in mental health (compared to a target of 80%). 100% also reported improvements in at least one of the following categories: self-care, isolation, accessing their support system, and/or experiences with anger/guilt (target: 90%). 92% of clients would refer a friend to the program.
- Conduct program pre-evaluation with each client to assess mental health status. Twenty-five evaluations were completed, each of the 25 clients received a customized plan, and 96% of screened clients enrolled in services.
- Distribute program post-evaluation survey to clients at the end of each client's program, summarize survey findings, identify recommended program changes, and implement program changes. 100% of clients reported leaving their homes within 48 hours of counseling (compared to a target of 50%), 76% reported experiencing three or more personal contacts per week (target: 60%), and 68% reported feeling engaged in

Measure A Helps

Mrs. O, 68, has struggled with lung cancer for the last five years. She recently ended a long-term relationship and had become very depressed. The In-Home Counselor referred Mrs. O to Senior Support Program of the Tri-Valley's case management team, who assisted her with shopping, Medicare, and Social Security. The counselor also addressed Mrs. O's depression and medical needs. Mrs. O discussed her guilt and grief and clarified where she wanted to live for the time she had left. Within the next month, Mrs. O was told that she had six months to live and decided to move to Southern California to be with her daughter.

one or more enjoyable activities/hobbies weekly (target: 60%).

- Recruit, train, and supervise three interns to assist with counseling. 100% of interns completed orientation and training before meeting clients. Each intern received over 50 hours of training and supervision. In addition, 100% of interns received one-on-one and group supervision weekly and bi-monthly trainings. After completing their internship, two of the three interns became Licensed Marriage and Family Therapists, and two became Senior Support Program of the Tri-Valley staff.

Highlights

In several key areas, evaluations revealed that clients exceeded program targets. For example:

- 100% indicated i**mprovements in mental health,** compared to a target of 80%.
- 100% reported **leaving the home within 48 hours of counseling,** compared to a target of 50%.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 2: HOSPITAL, TERTIARY CARE, OTHER

Administration/Infrastructure Support

acgov.org/health

Allocation: **$400,000** | Expended/Encumbered: **$252,987**

Note: Recipient does not provide direct services

BACKGROUND

The Alameda County Health Care Services Agency (HCSA) works to provide fully integrated health care services through a comprehensive network of public and private partnerships that ensures optimal health and well-being and respects the diversity of all residents.

The HCSA Administration/Indigent Health department provides the following:

- Integrated health care services to the residents of Alameda County within the context of managed care and a private/public partnership structure
- Direct oversight, administrative, and fiscal support for the County's Medically Indigent Services Plan and its provider network and all cross-departmental and cross-jurisdictional services, with an emphasis on children's services
- General oversight, administrative, and fiscal support for the Public Health, Environmental Health, and Behavioral Health Care Services Departments
- Leadership for implementation of countywide or agency-wide health care initiatives
- Leadership and assistance to private and publicly operated health care delivery systems, including implementation of programs that expand accessibility of needed medical services in the most appropriate and cost-effective settings, development of insurance alternatives for previously uninsured County residents, and implementation of programs that expand accessibility of needed medical services targeting children

The HCSA Administration/ Indigent Health department used its Measure A allocation to provide administrative support for the management of Measure A.

MEASURE A FUNDING SUMMARY

The HCSA Administration/Indigent Health department used its Measure A allocation to provide administrative support for the management of Measure A, including, but not limited to, contract development and monitoring, management of special projects, budget oversight and preparation of the annual report, staffing of the Measure A Oversight Committee, and development of the next three-year Measure A funding cycle allocations to community-based organizations and programs that provide essential health care services.

HCSA used its Measure A allocation to meet the following objectives:

- HCSA provided contract and administrative support for 65 Measure A allocations (target: at least 10). Of the 65 contracts, Administration and Indigent Health staff was involved in the contract development of 45 of the executed contracts. Of the 45 contracts that were developed by Administration and Indigent Health staff, 89% were fully executed within 2.5 months (target: at least 90%).
- Administration and Indigent Health staff provided Results-Based Accountability (RBA) and Results Scorecard training in April 2016 to 10 organizations that received Measure A base funding (target: at least 10 trainings to at least 90% of organizations receiving Measure A funding).
- Administration and Indigent Health staff monitored 45 Measure A contracts (target: at least 30). The Measure A contract providers had contracts with either monthly or quarterly reimbursement schedules. Of the 220 invoices processed, 87% were processed within 30 days from receiving the invoice and progress report (target: at least 90%).
- Staff coordinated 10 planning meetings to prepare for scheduled Measure A Citizen Oversight Committee meetings (target: at least 10). Of the 10 meetings that were scheduled, 100% were convened (target: at least 90%).
- Administration and Indigent Health staffed and convened 10 Measure A Oversight Committee meetings (target: at least 10). Of the 10 meetings that were scheduled, 100% were convened (target: at least 90%).
- Staff oversaw the production of the FY 13/14 Measure A final report and supported the Citizen Oversight Committee in the development of the FY 13/14 and FY 14/15 reports.
- Staff developed recommendations for the three-year Measure A base funding cycle starting in FY 16/17 and ending FY 18/19, and presented it to the Board of Supervisors for approval.

Highlights

Through the work of the HCSA Administration/Indigent Health department, the **total annual Measure A base allocation to provide essential health care services increased** 12.9%, compared to a target of 5%.

San Leandro Hospital

sanleandroahs.org

Allocation: **$1,000,000** | Expended/Encumbered: **$1,000,000**

Individuals served by Measure A: **43,029** (Total individuals served: **43,029**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

Service area: Countywide, Outside of Alameda County, Homeless or transient

BACKGROUND

San Leandro Hospital is a 93-bed community-based hospital that was acquired by Alameda Health System (AHS) in 2013. It provides inpatient and outpatient services including medical, surgical, and intensive care, as well as 24-hour emergency services in its 13-bed, Level II Emergency Department (ED). The hospital serves central Alameda County, a community of 265,000 people.

MEASURE A FUNDING SUMMARY

For details on San Leandro Hospital's expenditures of Measure A funds, see the AHS entry on page 12.

CONCERNS

As San Leandro Hospital is part of AHS, several of the concerns listed for AHS on page 12 apply to San Leandro Hospital as well. Specifically, AHS was unable to:

- Determine what portion of Measure A funds were allocated to personnel, subcontracted services, non-personnel program and/or operating expenses, or administrative overhead, separate from their overall agency budget for these categories.
- Determine what portion of Measure A funds were allocated to the actual number of staff supported, separate from San Leandro's staff of 333.

As mentioned previously, it is recommended that AHS undergo a full and comprehensive audit to track Measure A fund allocations during the FY 15/16 period to clarify public accountability for how funds were utilized.

St. Rose Hospital

strosehospital.org

Allocation: **$2,000,000** | Expended/Encumbered: **$2,000,000**

Individuals served by Measure A: **3,208** (Total individuals served: **32,136**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient

Service area: Countywide, Homeless or transient

BACKGROUND

St. Rose Hospital (SRH) is a safety-net, independent, nonprofit hospital that provides critical access to emergency medical, hospital inpatient, and outpatient services for indigent, low income, underinsured populations in Central and Southern Alameda County. These services include the following:

- Critical access. SRH serves as a critical access point for Alameda County and is the only Medi-Cal-contracted facility between Oakland and Fremont. Additionally, SRH serves as a safety-net hospital and provides health care access to many low income residents that do not have adequate transportation to the Alameda County Medical Center.
- Hospitalists programs. The Hospitalists assume care of indigent and uninsured patients who are admitted to SRH. This alleviates the financial impact of private physicians who request compensation for lack of reimbursement.
- Women's services. SRH operates the Women's Center to meet the growing demand for OB/GYN services in the community, because many OB practitioners do not accept Medi-Cal rates. The program provides immediate and emergency care for pregnant women who present to the emergency room (ER), often with no history of prenatal care.
- Cardiac care. SRH is the only Medi-Cal-contracted facility to provide elective cardiac and percutaneous coronary intervention (PCI) services in Central Alameda County. SRH routinely accepts hospital transfers for emergency and elective cardiac care from non-Medi-Cal providers.

SRH serves approximately 11% of Alameda County's indigent population.

MEASURE A FUNDING SUMMARY

SRH used its Measure A funds to subsidize the cost of providing care to uninsured and/or indigent patients. Specifically, SRH used its Measure A allocation to help achieve the following:

- Conduct over 4,100 patient encounters and provide over $3.5 million in cost of care to uninsured/indigent patients
- For both traditional and Managed Care Medi-Cal programs, conduct

Measure A Helps

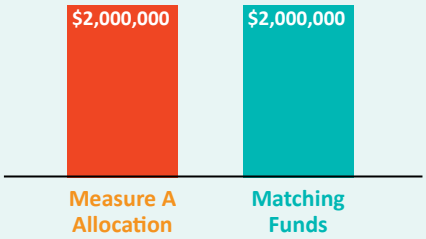
Letter from a patient who had surgery to address abdominal pain:

"I appreciate all of the assistance that you have given to me. I have a family of four. I got sick and was unable to work. I lost my job as a result of me being sick. I am unemployed and still not able to pay for health insurance. I did not meet the criteria for any other assistance. I am barely able to feed my family or take care of any of my living expenses. I am so thankful for St. Rose helping me out. St. Rose Hospital is a life saver to this community."

over 27,900 patient encounters and incur over $31 million of costs in excess of amounts

- Experience 32,234 ER visits, including 73%, or 23,496 visits, from uninsured and underinsured patients (target: 26,000)
- Provide financial support to hospital-based physicians to take ER calls and provide services to 12,476 uninsured/underinsured patients (target: 12,800)
- Support SRH inpatient services to 3,181 uninsured and underinsured patients (target: 3,000)

Matching Funds



SRH leveraged its Measure A allocation to obtain **$2,000,000 in matching funds** from the intergovernmental transfer program through the Medi-Cal program. This represents a $1 match for every $1 in Measure A funds.

UCSF Benioff Children's Hospital Oakland

childrenshospitaloakland.org

Allocation: **$2,000,000** | Expended/Encumbered: **$2,000,000**

Individuals served by Measure A: **29,262** (Total individuals served: **22,109**)

Populations served: Indigent, Low Income, Uninsured Children

Services provided: Emergency Medical, Hospital Outpatient, Public Health, Mental Health

Service area: Countywide

BACKGROUND

UCSF Benioff Children's Hospital Oakland (CHO) works to protect and advance the health and well-being of children through clinical care, teaching, and research.

At CHO, Measure A funding supported three programs/activities:

- The pediatric Emergency Department (ED), specifically to provide adequate staffing for the large volume of children seen at the ED
- The Center for Child Protection (CCP)
- School-based clinics

Emergency Department

CHO provides highly specialized pediatric emergency services for the children of Alameda County, 24 hours a day, seven days a week. CHO's ED sees a broad array of pediatric disease and injury from the basic to the most complex. CHO is the leading provider for Alameda County children in need of acute care. Children with Medi-Cal rely nearly exclusively on CHO for emergency services since the public hospitals in the area do not provide specialized pediatric care and do not have any beds for children in the event a child needs to stay overnight. In FY 15/16, to CHO's ED was the highest volume ED in the San Francisco Bay Area.

CHO's ED is one of two designated Level 1 Pediatric Trauma Centers in Northern California and the only one in the Bay Area. Children's Trauma Center has 24-hour in-house staff including pediatric specialists in emergency medicine, trauma surgery, anesthesiology, neurosurgery, orthopedics, diagnostic imaging, and critical care.

CHO maintains an extensive in-house and outpatient rehabilitation department for pediatric trauma patients. The Trauma Center also supports an injury prevention program for the hospital and the community.

For many children, the ED also functions as the gateway to a regular medical home, specialty care, or other community programs.

Measure A Helps

Issis, 14, came to the CHO ED with vaginal pain and discharge following a sexual assault. Issis's mother told the CHO social worker that she had observed changes in Issis such as resistance toward attending church and increased emotional responses, as well as missing allergy and depression medication. She also reported that Issis had attempted suicide on two occasions. The social worker provided information about the criminal justice process and victim rights as well as ongoing clinical case management to ensure that a police report was generated, a forensic interview was conducted, and a forensic medical exam was authorized. CCP therapists were contacted and immediately begin providing therapeutic services.

Approximately 70% of patients seen in the CHO ED receive Medi-Cal. This number is higher than almost any other hospital—child or adult—in California. Without the CHO ED, children would need to travel further and/or receive care that is not specialized to children. With little doubt, more children would die without the CHO ED.

Center for Child Protection

CHO and Alameda County recognize that they share a responsibility to provide immediate and comprehensive care for this population of children, yet there are many challenges to maintaining this responsibility. CCP serves more than 1,000 clients per year. CCP is a comprehensive child abuse program within CHO. CCP is the only provider in Alameda County that has the capacity to offer many of its services.

Because many CCP services are funded by external sources such as Measure A, there is no charge for eligible clients. This feature is very important because if CCP needed to charge insurance for these services, there would be a record of services provided, and many families would not step forward to divulge such sensitive information.

CCP maintains staffing 24 hours per day to respond to acute forensic examinations for children under 14 years old when the alleged sexual abuse occurred within 72 hours. Non-acute forensic examinations for children under age 18 and second opinion medical consults are performed in the CCP outpatient clinic through appointment only.

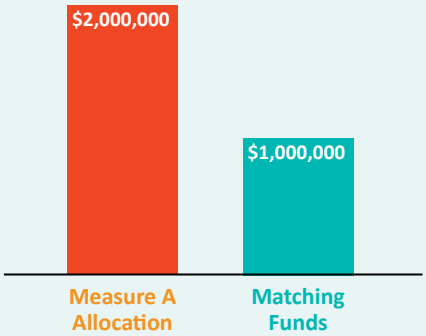
Clinical case management is provided to children and adolescents who present to the ED and/or child abuse management clinic following diagnosis or disclosure of abuse. Comprehensive evidenced-based mental health services are provided to children, adolescents, and their families who have been exposed to childhood trauma, including child abuse and/or witness to violence. For most of these families, there are no alternatives in Alameda County for many of the services provided by CCP.

School-Based Clinics

CHO runs two school-based health centers: one at Castlemont High School and one at McClymonds High School. Both sites are integrated into full-service youth and/or family centers that promote youth development and serve as national models for adolescent health care.

Youth Uprising/Castlemont Clinic—which operates a full-time comprehensive team of six therapists and a psychiatrist, as well as comprehensive medical services—is the hub for teachers, parents, and students to coordinate therapy, care, support, and help. The Castlemont site is now the highest volume school-connected mental health site in Alameda County.

Matching Funds



CHO leveraged its Measure A allocation to obtain **$1,000,000 in matching funds** through an intergovernmental transfer using supplemental funds from the California Department of Health Care Services.

The sites' School-Based Mental Health Program has become a national model for the integration of medical and mental health care, and it has been cited for success at addressing underlying social stressors related to mental health. The program has developed a training and consultation program for school professionals and mental health providers who work with schools, and it has contracts to conduct trainings throughout Alameda County and California.

MEASURE A FUNDING SUMMARY

CHO used its Measure A allocation to achieve the following:

Emergency Department

- In FY 15/16, there were a total of 47,107 visits to the ED.
- 534 of these visits were trauma cases where the child faced an immediate life-threatening situation.
- The average length of stay for patients discharged from the ED was reduced to 2.87 hours, compared to 3.1 hours the previous year (target: <3 hours).

Center for Child Protection

- In FY 15/16, the CCP served more than 2,000 children and their families.
- 452 of these children and families received intensive behavioral health services.
- The CCP conducted 97 forensic evidentiary examinations, 55 outpatient medical consultations, and 60 inpatient medical consultations, and provided clinical and psychotherapy services to 205 children.
- 35 children participated in Camp CCP, where children receive intensive group psychotherapy services integrated with socialization experiences.
- At least 90% of the individual psychotherapy clients successfully engaged in treatment after the initial assessment/onset of treatment (target: >90%).
- 35 children were referred for group psychotherapy.
- 100% had successful engagement in and completion of the group psychotherapy program.
- 100% of children who received Trauma-Focused Cognitive Behavioral Therapy demonstrated clinical progress (target: 100%).

School-Based Clinics

- In FY 15/16, the two clinics run by CHO had a total of 6,735 encounters and saw 947 unique patients.
- 83% of patients reported they were satisfied or very satisfied with the services they received (target: >80%).
- 83% of patients reported that they agree or strongly agree that the school clinics helped them with their problem (target: >80%).

Highlights

CHO met or exceeded its targets in all areas. **100% of children who received Trauma-Focused Cognitive Behavioral Therapy demonstrated clinical progress**, and 83% of school clinic patients agreed or strongly agreed that the clinics helped them with their problem.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 3: PRIMARY CARE

Alameda County Dental Health

www.acphd.org/dental-administration.aspx

Allocation: **$157,580** | Expended/Encumbered: **$157,580**

Individuals served by Measure A: **2,206** (Total individuals served: **4,680**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families

Services provided: Public Health

Service area: Alameda, Castro Valley, Fremont, Hayward, Newark, Oakland, San Leandro, San Lorenzo, Union City

BACKGROUND

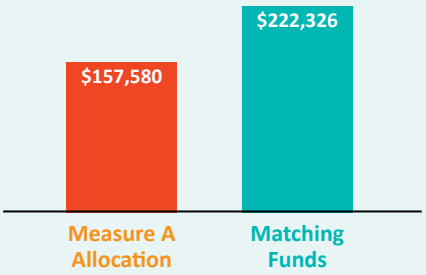
The Alameda County Public Health Department works in partnership with the community to ensure the optimal health and well-being of all people through a dynamic and responsive process that respects the diversity of the community and works to provide for present and future generations.

A program of the Public Health Department, the WIC Oral Health Collaborative provides an accessible early entry point for oral health assessment and preventive dental services for high risk families and children ages 0–5 years at Women, Infants, and Children (WIC), as well as continuity and referral for regular follow-up dental care in the community. The services provided at WIC include dental history interviews to identify risk factors and oral home care practices, brushing the child's teeth and applying fluoride, assessing the child's mouth, and setting goals for home care behaviors.

For children who need follow-up care beyond the services provided at the WIC site, the outreach worker collaborates with the family to assess insurance coverage, obtain a dental appointment with a provider, and assist with making the initial dental appointment. For families lacking insurance coverage, the outreach worker arranges insurance assistance through the Healthy Smiles Dental Treatment program. The focus of the service is to families of children (ages 9 to 15 months) who participate in Dental Days at WIC at the Eastmont, Telegraph, Hayward, and Fremont sites. Since siblings often accompany the caregiver at the Dental Days, all services are offered to them as well.

In addition, the County Public Health Department collaborates with the City of Berkeley Public Health Department to screen and provide preventive dental services including cleaning, sealants, fluoride varnish, and one-on-one oral health instruction to students at 11 schools.

Matching Funds



The WIC Oral Health Program leveraged its Measure A allocation to obtain **$222,326 in matching federal funds** from the Maternal, Child, and Adolescent Health Program (MCAH) and Child Health and Disability Prevention (CHDP).

Highlights

The program met or e**xceeded all of its targets** for both the WIC Dental Days and the school-based program.

MEASURE A FUNDING SUMMARY

Measure A funding helped the WIC Oral Health Collaborative program achieve the following:

- Provide dental education to 1,022 parents/guardians through WIC Dental Days (target: at least 1,000)
- Provide oral health assessments to 1,014 infants/children through WIC Dental Days (target: at least 900)
- Provide fluoride varnish to 832 infants/children through WIC Dental Days (target: at least 800)
- Screen 1,204 students at the school-based program (target: at least 1,050)
- Provide sealants to 100% of eligible students screened at the school-based program (target: 100%)
- Provide preventive dental services and referral to a dental home to 100% of children and students at WIC Dental Days and the school-based program (target: 100% at each)
- Enroll 79% of assessed children into the Healthy Kids Healthy Teeth (HKHT) program and link them to dental providers (target: at least 75%)

Measure A Helps

At a WIC Dental Day, a Community Health Outreach Worker (CHOW) met a four-year-old boy who was newly enrolled in Medi-Cal. The father stated that his son had been complaining of toothaches. The CHOW referred the child to the Registered Dental Hygienist (RDH), who completed a dental screening and detected severe tooth decay. The CHOW enrolled the child into the HKHT program and scheduled a next-day appointment with an HKHT provider. The efficient and effective outreach and care coordination efforts by the CHOW and RDH helped ensure that the boy received the needed dental treatment services to obtain and maintain good oral health.

Center for Elders' Independence

cei.elders.org

Allocation: **$53,581** | Expended/Encumbered: **$53,581**

Individuals served by Measure A: **649** (Total individuals served: 649)

Populations served: Indigent, Low Income Adults, Seniors

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient

Service area: Alameda, Albany, Ashland, Berkeley, Castro Valley, Cherryland, Emeryville, Fairview, Hayward, Oakland, Piedmont, San Leandro, San Lorenzo, Outside of Alameda County

BACKGROUND

The Center for Elders' Independence (CEI) provides high quality, affordable, integrated health care services to the elderly, which promote autonomy, quality of life, and the ability of individuals to live in their communities. All of CEI's participants are frail, low income adults over age 55 who qualify for Medi-Cal. Most are also Medicare beneficiaries.

CEI's Life Care Planning program enables seniors to live with dignity through the end of their lives. The program ensures that seniors' wishes are carried out and that costly and unnecessary medical treatments, hospitalizations, and emergency room services are reduced or avoided.

MEASURE A FUNDING SUMMARY

CEI used its Measure A allocation to achieve the following:

- Convene a Life Care Plan Committee and hold 18 meetings
- Hire a chaplain
- Train 12 nurses, six social workers, and six doctors on having end-of-life conversations with participants
- Develop a process for tracking conversations in CEI's electronic health record system

As a result of these efforts:

- 93% of participants had a Life Care Plan conversation with their provider.
- 12.3% of participants completed Advance Care Directives that outline each participant's preferences for health care interventions should their capacity to decide become compromised.
- 58 participants received chaplaincy services.
- 85% of participants who completed a Life Care Plan had their wishes met at the time of their death or change in condition.

Measure A Helps

A CEI chaplain recalls a senior who was vacillating about continuing dialysis and getting sicker. The senior explained that he was miserable and was ready to be done. The CEI team called his family together to honor his wishes. The senior went on to hospice in skilled nursing and quickly passed peacefully. The chaplain states that the senior had intellectual rigor and an eclectic set of beliefs. His family was very grateful for the spiritual support he received at the end of his life.

Center for Healthy Schools and Communities (School Health Centers)

achealthyschools.org

Allocation: **$1,256,750** | Expended/Encumbered: **$1,256,750**

Individuals served by Measure A: **14,790** (Total individuals served: **14,790**)

Populations served: Indigent, Low Income, Uninsured Adults, Children

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Countywide, Homeless or transient

BACKGROUND

The Center for Healthy Schools and Communities (CHSC) works to foster the academic success, health, and well-being of Alameda County youth by building universal access to high quality supports and opportunities in schools and neighborhoods.

A program of CHCS, School Health Centers (SHCs) play a vital role in creating universal access to health services by providing a continuum of age-appropriate and integrated health and wellness services for youth in a safe, youth-friendly environment at or near schools.

SHCs provide services in the following areas:

- Medical/health education
- Behavioral health
- Oral health
- Youth enrichment and school community support
- Insurance enrollment

In FY 15/16, the number of SHCs increased to 28, with some serving multiple schools. During the same period, the number of clients increased to 14,790 (a 140% increase over a decade), and the number of annual client visits increased to 63,345 (a 146% increase). The SHCs also served more than 3,000 clients from the broader community, including high school graduates, college students, siblings, and community members.

SHC services are available at no cost to clients, regardless of their insurance status, thus filling a gap for students who are uninsured or underinsured. Sixteen percent of clients reported having no insurance.

MEASURE A FUNDING SUMMARY

Measure A provides a unique, long-term funding stream to the CHSC to offer school-based health supports for children and youth in Alameda

Measure A Helps

Jonathan, 16, arrived in the U.S. this past year. During a visit to his school's SHC, Jonathan reported pain in his right knee from an injury he suffered a few years ago. The Nurse Practitioner noticed significant inflammation and limited movement and referred Jonathan to Children's Hospital for an MRI. Initially, Children's Hospital denied services because of questions about the referral and Jonathan's insurance coverage. SHC staff provided many hours of medical case management to show medical necessity, get pre-approved service authorization, and schedule the appointment. Ultimately, Jonathan received the MRI. Staff also intervened to have a $3,000 charge removed after proving that Jonathan's insurance covered the procedure.

County. Very few other funding sources exist to provide ongoing, stable, and substantial funding to finance the growing network of and investment in school health services.

Medical/Health Education Services

Physical health services provided during SHC visits included general health counseling, nutrition counseling, injury treatment, and physical activity counseling. In addition, the SHCs provided 2,109 non-HPV immunization visits and 3,385 other health screening contacts with youth in non-clinical settings.

Reproductive health services included contraceptive counseling/ family planning advice and maintenance as well as HIV, chlamydia, and other STI screening/counseling. The SHCs also provided 1,033 HPV immunization visits.

The SHCs also provided the following services to youth outside of clinical visits:

- Health fairs/outreach: 214 sessions reaching 26,196 youth
- Reproductive health education: 1,055 sessions reaching 17,665 youth
- Nutrition education (e.g., gardening/cooking): 129 sessions reaching 2,175 youth
- Tobacco and alcohol/drug use education: 43 sessions reaching 963 youth
- Other classroom presentations/interventions: 357 sessions reaching 9,463 youth
- First aid supply distribution: 415 sessions reaching 5,416 youth
- Peer health education group/peer counseling/mentoring: 238 sessions reaching 2,442 youth

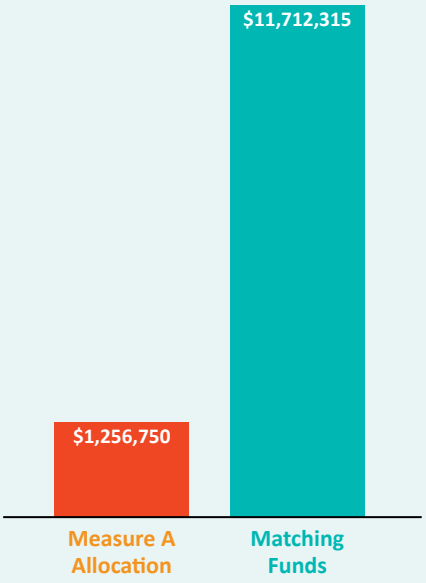
Behavioral Health Services

Individual behavioral health services included individual therapy, assessment and intake, psychosocial screening, individual contact/ meetings, plan development, collateral with family members and school staff, and case management. Behavioral health group counseling was also provided.

SHCs made 5,304 contacts with youth, including the following:

- Screening for trauma, ninth and other grades: 45 sessions reaching 1,753 youth
- School safety/climate: 33 sessions reaching 1,710 youth
- Social skills/communication/anger management/conflict resolution: 115 sessions reaching 1,175 youth
- Self-esteem/image/empowerment: 44 sessions reaching 666 youth
- Restorative justice: 128 sessions reaching 2,901 youth
- Crisis intervention/grief support: 118 sessions reaching 228 youth

Matching Funds



The School-Based Behavioral Health Initiative leveraged its Measure A allocation to obtain **$11,712,315 in matching funds** from Medi-Cal and other third-party billing; the Tobacco Master Settlement Fund (TMSF); and other funding from the County, cities, school districts, the state, the federal government, and private grants.

Oral Health Services

At the 10 SHC sites providing dental services, 1,341 clients had a dental service provided for screening exams and cleanings, and also for case management and restorative treatment. In addition, 2,489 students were provided dental screenings during school-wide screenings in eight SHCs.

Youth Enrichment and School Community Supports

The SHCs provided a variety of youth enrichment activities and community supports. For example, eight SHCs made 2,801 contacts for job training/career exploration and 2,663 contacts for youth advisory boards, leadership, research, and advocacy groups.

The SHCs also provided the following services:

- Physical activity/recreation/dance/yoga: 148 sessions reaching 1,877 youth
- School-wide assemblies or special events: 34 sessions reaching 5,222 youth
- Acculturation support for newcomers, unaccompanied youth, etc.: 116 sessions reaching 1,376 youth

Insurance Enrollment

During FY 15/16, 24 SHCs conducted application assistance to educate and enroll families in health coverage and other benefits programs. These SHCs provided the following:

- 6,341 families with information about health insurance and benefits eligibility or referral to an offsite location for application assistance
- 532 families with onsite application assistance to enroll in Medi-Cal, HealthPAC, or Covered California coverage
- 229 families with onsite application assistance to enroll in CalFresh, CalWORKs, or other public benefits

The SHCs also conducted insurance screening/enrollment with 401 youth. Of those clients with data recorded, 26% did not have a primary care medical home and 28% did not have a regular dental provider.

Highlights

SHC evaluation data shows that SHC provide safe places for youth to get needed care:

- 99% of students reported that the people who work at the SHC made it **feel like a safe place.**
- 98% reported that the people who work at the SHC were **easy to talk to and helped them work through their problem.**
- 97% indicated that the SHC helped them **get care sooner** than they normally would.
- 96% indicated that they **received care** from the SHC that they normally wouldn't have received otherwise.
- 62% of clients **returned for more than one visit**, indicating high patient satisfaction.

Evaluation data indicates that SHCs helped students:

- **Eat healthier foods and/or exercise more**: 89%
- **Deal with stress/anxiety better**: 94%
- Feel like they had **an adult they could turn to** if they needed help or support: 97%
- Feel **less irritable or have fewer angry outbursts**: 91%
- **Stop using or use less tobacco, alcohol, or drugs**: 91%

Connecting Kids to Coverage (CKC) Initiative

www.whhs.com

Allocation: **$316,435** | Expended/Encumbered: **$316,435**

Individuals served by Measure A: **2,710** (Total individuals served: **2,710**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families

Services provided: Public Health

Service area: Hayward, Oakland, San Leandro

BACKGROUND

Since 2013, the Center for Healthy Schools and Communities (CHSC) has administered Alameda County's Connecting Kids to Coverage Schools (CKC) Initiative. Implemented in the Oakland, Hayward, and San Leandro school districts, the initiative aims to eliminate common barriers to health insurance enrollment and retention by leveraging school districts as channels for reaching uninsured families.

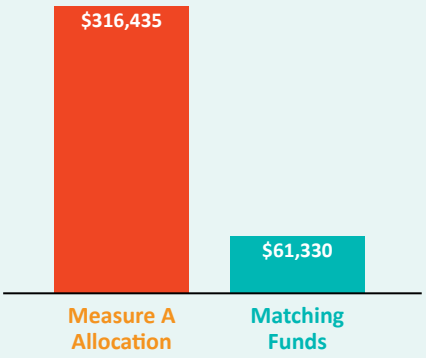
The CKC Initiative centralizes enrollment assistance in school district-based Central Family Resource Centers so that families can apply for and renew their health care coverage and public benefits in a "one-stop shop," minimizing visits to multiple County offices. The initiative is a collaboration among the Alameda County Social Services Agency, the Alameda County Health Care Services Agency (HCSA), three of the County's largest school districts, and two community-based organizations.

A majority of consumers accessing assistance are Latino and Spanish-speaking and reside in Oakland, the largest school district participating in the initiative. Most families have qualified for two or more affordable coverage programs, indicating that the "one-stop shop" model is of particular value for these families. The CKC "one-stop shop" model is particularly important for the working poor, whose demanding and inflexible work schedules and difficulty accessing reliable or efficient transportation can prevent them from making or attending appointments at different public agency locations for each family member.

The CKC Initiative utilizes three primary strategies to reach its target populations:

- Trainings or presentations for school site staff, community-based partners, or other school-based resources to increase the number of people on school sites who are referring families in need to the CKC Family Resource Centers for health benefit enrollment assistance.
- Outreach events hosted at school sites to educate parents and students about health insurance eligibility guidelines and enrollment assistance resources at the CKC Family Resource Centers.

Matching Funds



The CKC Initiative leveraged its Measure A allocation to obtain **$61,330 in matching funds** from the Alameda County Center for Healthy Schools and Communities (CHSC) General Fund.

- Targeted outreach calls to families whose Medi-Cal applications are up for renewal or have already fallen off. Center staff conducts outreach calls to these families to schedule enrollment assistance appointments at the school district site.

MEASURE A FUNDING SUMMARY

The CKC Initiative used its Measure A funding to achieve the following.

Trainings or Presentations

- 17 trainings or presentations were provided to school staff, partners, or other groups around health coverage and health and wellness resources at schools in Oakland. Approximately 350 people attended these trainings.
- Seven trainings or presentations were provided in San Leandro, with 122 people in attendance.
- East Bay Agency for Children recruited and trained six parents from the school districts to become Family Health Advocates in the Oakland Unified School District. The role of the Family Health Advocates was to conduct peer outreach to parents in their schools and to host enrollment events to provide information about health insurance eligibility and enrollment opportunities in the County.
- Family Health Advocates organized and led six enrollment events, where 79 parents received information and scheduled appointments for assistance.
- In San Leandro, Parent Facilitators led 14 enrollment events, with 309 people attending these trainings.

School Site Outreach Events

- In Oakland, there were 11 school site outreach events, with 208 people attending these events at their schools.
- In San Leandro, there were 34 school site outreach events, with 2,167 attending the outreach events.

Targeted Outreach

- Approximately 13,589 outreach calls were made to families to inform them of their Medi-Cal eligibility status and to schedule enrollment assistance appointments at CKC Family Resource Centers. Approximately 60% of these calls were to families in Oakland, 35% were to families in Hayward, and 5% were to families in San Leandro. Outreach workers administered phone calls in English, Spanish, Mandarin, and Cantonese.
- Approximately 1,907 families made appointments at the CKC Family Resource Centers to receive application assistance as a result of the outreach events, trainings, and targeted phone calls. The average family size was 3.1 individuals per family.
- Outreach efforts reached over 6,000 individuals in the County.
- Of the families who had appointments, 36% completed and submitted their applications for health insurance or other benefits with the

Highlights

- In a consumer satisfaction survey, 72% of respondents said they would **rate the centers "excellent" or "very good**."
- 98% of respondents said that they would **recommend the center to other parents**.
- 60% of respondents said that multiple members of their family were **assisted with health insurance applications** by CKC—and one in three said that their family members qualified for different programs.
- 70% of people who received health insurance enrollment assistance also received **assistance with applying to other public benefits or getting other family support**.

support of the CKC centers. Fifty-four percent (54%) of families still had active cases with the CKC centers.

Health Insurance

- 2,710 Alameda County residents were assisted with applications and enrollment in Covered California, Medi-Cal, HealthPac, or other health insurance benefits programs. Fifty percent of the individuals assisted were children under the age of 18.

Other Public Benefits

- 1,199 Alameda County residents were assisted with applications and enrollment in CalFresh. 60% of these CalFresh applications were for children.
- 28 individuals were assisted with CalWorks applications.

2,710 Alameda County residents were assisted with applications and enrollment in Covered California, Medi-Cal, HealthPac, or other health insurance benefits programs.

Fire Station Health Portals

Allocation: **$1,201,271** | Expended/Encumbered: **$1,201,271**

Individuals served by Measure A: **530** (Total individuals served: **1,255**)

Populations served: Indigent, Low Income, Uninsured Adults, Seniors

Services provided: Public Health

Service area: Alameda, Berkeley, Castro Valley, Dublin, Fremont, Hayward, Livermore, Newark, Oakland, San Leandro, San Lorenzo, Union City, Outside of Alameda County

BACKGROUND

The Alameda County Health Care Services Agency (HCSA) works to provide fully integrated health care services through a comprehensive network of public and private partnerships that ensures optimal health and well-being and respects the diversity of all residents.

A program of HCSA, the Firehouse Clinic provides a new access point for comprehensive primary and preventative care to communities in critical need of health care services, including behavioral health care services. In addition, the Firehouse Clinic provides insurance enrollment assistance, connection to a medical home, referrals, and emergency department and hospital discharge follow-up. The clinic also provides health education and outreach services to the community.

The clinic model in South Hayward, the first site, aims to reduce wait times for patients seen at community clinics by guaranteeing primary care appointments within 72 hours and providing extended hours. It is anticipated that during the first two years of operation, over 5,000 new patients will be seen at the Hayward site, the majority of whom will consist of low income, uninsured, and indigent residents.

MEASURE A FUNDING SUMMARY

The Firehouse Clinic used its Measure A allocation to achieve the following:

- Provide full-service primary and preventative medical care and public health services each week to a minimum of 1,255 clients through 1,346 visits
- Provide 291 medical case management and referrals for specialty care to clients
- Provide counseling services onsite for 83 patients experiencing mild to moderate conditions
- Develop and implement a process to screen and enroll 55 eligible uninsured clients for appropriate health coverage

Measure A Helps

A 33-year-old Hispanic male came to the clinic for anxiety and depression. He reported lethargy, fatigue, difficulty sleeping, and difficulty performing daily tasks including work. He was skeptical of psychiatric medications and concerned about side effects. Through an honest dialog of available options, the patient decided to try a course of SSRI oral medications daily as well as Behavioral Health (BH) counseling through the clinic. The patient was followed up with regularly and reported a significant difference in symptoms after a few weeks of treatment. The patient is currently continuing his medication and BH counseling and is asymptomatic for anxiety and depression. He has stated, "I can actually smile again."

Fremont Aging and Family Services

www.fremont.gov/217/Aging-Family-Services

Allocation: **$52,020** | Expended/Encumbered: **$52,020**

Individuals served by Measure A: **27** (Total individuals served: **163**)

Populations served: Indigent, Low Income, Uninsured Seniors

Services provided: Public Health, Mental Health

Service area: Fremont, Hayward, Newark, Union City

BACKGROUND

The City of Fremont's Human Services Department (HSD) supports a vibrant community through services that empower individuals, strengthen families, encourage self-sufficiency, enhance neighborhoods, and foster a high quality of life for all residents.

Aging and Family Services (AFS), a division of the HSD, provides both a Multi-Service Senior Center and a Senior Support Services team of caring professionals from diverse backgrounds—social work, nursing, gerontology, psychology, and public health—who serve seniors and their families with dignity and respect.

The AFS Afghan Health Promoter Program predominately serves frail Afghan seniors and their families living in central and southern Alameda County. It is a program of the Afghan Elderly Association (AEA), which has been caring for the health and welfare of Afghan elders in the Bay Area since 1995.

The Health Promoter Program is made up of four program areas:

- Linkages. The Linkages program provides information, referral, and assistance to participants. Health Promoters assist participants access an array of services and entitlement programs. Additionally, they assist with translation, completing forms, transportation, housing, and other community services as needed.
- Medication assistance and counseling. The City of Fremont's Public Nurse reviews participants' medication, evaluates their knowledge and usage of their medications, and provides training and feedback as needed. When necessary, the nurse calls participants' doctors and pharmacists for clarification or to express concerns. Health promoters conduct in-home reviews of medications, evaluating knowledge of medications and use. They provide medication assistance as needed.
- Happy, Healthy Me (HHM). HHM is a chronic condition self-management program that helps participants identify problems and healthy goals. The program utilizes a mix of cognitive behavior techniques, motivational interviewing, and problem-solving

Measure A Helps

Ahmad had to stop working due to health problems such as diabetes, prostrate, hypertension, stress, anxiety, and depression. With no income, he was having a difficult time finding a place to live. At another organization, he applied for the Cash Assistance Program for Immigrants (CAPI) but was denied. An AEA Health Promoter assessed Ahmad's application and felt they had reason to appeal. After completing and submitting the required paperwork, Ahmad was given a court date. At the hearing, Ahmad was granted 1.5 years of back pay. Once Ahmad received an initial payment, the Health Promoter was able to work with him on securing housing and other needed services.

techniques. Problems and mid-range goals are established and a health plan is developed utilizing short-term action steps.

- Health education groups. The program offers three health education groups. The first is the Stanford Chronic Disease Self-Management Program. Three health promoters have been trained as leaders, and the group is offered at least once a year. The second is the Diabetes Education Group. The third is the Matter of Balance (MOB) group, an evidence-based class that promotes fall prevention. Four health promoters have been trained as leaders.

MEASURE A FUNDING SUMMARY

Measure A helped the Health Promoter Project achieve the following.

General

- Provide health promotion services to Afghan clients (target: 125; actual: 163)
- Ensure clients receive care from a primary care physician (target: 100; actual: 161)
- Provide socialization from Health Promoters (target: 100; actual: 162)
- Have clients complete a wellness screen (target: 60; actual: 69)
- Conduct home safety evaluations (target: 40; actual: 75)

Service Linkage

- Conduct home visits to clients (target: 350 home visits to 85 clients; actual: 729 home visits to 122 clients)
- Provide health education from Health Promoters (target: 50; actual: 80)
- Refer clients to City of Fremont case management and/or counseling services (target: 25; actual: 28)
- Provide eligibility assistance and support to access supportive services to clients (target: 100; actual: 112)
- Help clients access other community services (target: 50; actual: 65)

Medication Management

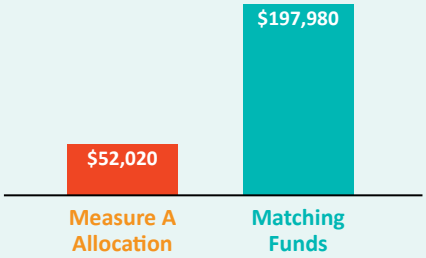
- Provide medication review, education, and counseling (target: 50; actual: 91)
- Utilize "teach back" methodology to show an increased knowledge of medication among clients (target: 50; actual: 80)
- Improve medication compliance within six months for clients identified as having deficits in medication compliance (target: 30; actual: 74)

Happy, Healthy Me

Ensure the following:

- Clients complete a Partners-in-Health (PIH) screen (target: 45; actual: 46)
- Clients complete a six-month PIH reassessment (target: 45; actual 36)
- Clients participate in their Action Plan (target: 30; actual: 35)

Matching Funds



Fremont Family and Aging Services leveraged its Measure A allocation to obtain **$197,980 in matching funds** from the City of Fremont General Fund and the Alameda County Public Health Department.

- Clients show improvement after nine months (target: 30; actual: 32)
- Clients show improved blood pressure, pulse rate, or blood sugar scores after nine months (target: 15; actual: 13)

Health Education Groups

- Offer one 16-hour MOB class for Afghan participants (target: 10 participants; actual: 16)
- Achieve participants showing an increase in their knowledge regarding falls and fall prevention (target: 10; actual: 10)
- Offer one six-week diabetes class for participants (target: 12 participants; actual: 6)

Highlights

In almost all areas, the Health Promoters program exceeded its targets, sometimes dramatically. For example, the program conducted **729 home visits to 122 clients**, compared to a target of 350 home visits to 85 clients.

Health Enrollment for Children

achealthcare.org/about/project-updates/childrens-health-insurance-enrollment

Allocation: **$300,000** | Expended/Encumbered: **$300,000**

Individuals served by Measure A: **5,851** (Total individuals served: **5,851**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

Service area: Countywide

BACKGROUND

The Alameda County Health Care Services Agency Health Insurance Enrollment Assistance department provides information, referrals, and application assistance to low income County residents and families who are eligible for the following benefit programs: Medi-Cal, Covered CA, Kaiser Child Health Plan, Health PAC, CalFresh, and CalWorks.

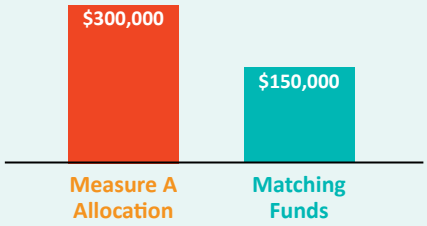
The Health Insurance Enrollment Assistance department is a critical resource for some of the hardest-to-reach and most vulnerable populations in Alameda County. The department provides a client-centric and culturally component approach to help residents enroll into health care and benefit programs and has the unique ability to serve the whole family regardless of what program they are eligible for. This assistance is particularly important with the new requirements associated with the implementation of the Affordable Care Act in January 2014.

MEASURE A FUNDING SUMMARY

The Health Insurance Enrollment Assistance department used its Measure A allocation to achieve the following:

- 5,989 Alameda County residents received application assistance.
- The Health Insurance Technician (HIT) assistance toll-free line received 2,008 calls.

Matching Funds



The Health Insurance Enrollment Assistance department leveraged its Measure A allocation to obtain **$150,000 in matching funds** from Medi-Cal Administrative Activities (MAA).

Health Services for Day Laborers: Community Initiatives (Day Labor Center)

http://www.alameda.networkofcare.org/mh/services/agency.aspx?pid=HaywardDayLaborCenter_344_2_0

Allocation: **$149,301** | Expended/Encumbered: **$149,301**

Individuals served by Measure A: **175** (Total individuals served: **300**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

Service area: Ashland, Cherryland, Fairview, Fremont, Hayward, Oakland, San Leandro, San Lorenzo, Union City

BACKGROUND

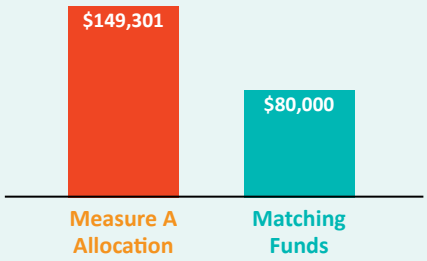
The Day Labor Center (DLC) works to empower low income individuals and families and their children, including immigrants and refugees, through economic and leadership development, community education, policy and advocacy, and immigration services, to attain their basic rights and protections, essential services, and access to full participation in society.

Through the services of partners Samuel Merritt University in Oakland, California State East Bay's Initiative for Community Wellness in Hayward, and the Alameda County Healthcare for the Homeless Van, the DLC Healthcare Portal Project provides referrals for safety net health care services, including episodic visits and emergency care when needed, to hundreds of under- and unemployed, mostly migrant clients in southern Alameda County. The DLC continues to develop culturally competent material for its clientele and to train Peer Health Educators to provide outreach and information services to this population.

The DLC provides services in the following areas:

- Mental health. The DLC provides meetings to help workers' mental health needs and issues related to domestic violence and sexual assault.
- Alcohol and drug. The DLC provides workers with weekly meetings to address alcohol and drug use and abuse.
- Hospital and inpatient services. The DLC portal services use hospital services for extreme and/or emergency cases only, including lab and other specialty services as needed.
- Public health prevention. The DLC offers Zumba classes for women, develops and monitors individual health plans for weight and diabetes management and prevention, and provides HIV prevention education and screening.
- Outpatient services. In addition to ancillary services provided by the Davis Street Clinic and/or St. Rose Hospital sites, the County provides DLC workers with dental services three months out of the year.

Matching Funds



The DLC leveraged its Measure A allocation to obtain **$80,000 in matching funds** from foundation sources.

- Youth and community services. The DLC was one of the founding organizations of the South County Unaccompanied Minor and Migrant Family Collaboration, which highlights the needs of unaccompanied minors in Alameda County and coordinates needed services to this clientele. The DLC provides services to the indigent population and youth from the surrounding neighborhood, including job skills training and community volunteer service opportunities.
- Socialization. The DLC maintains a community garden to address the workers' ailments of depression, isolation, and loneliness due to being separated from their families in their home countries.

Highlights

100% of clients, including UIY, who required follow-up care **received the care they needed**, and 100% of uninsured clients were **signed up for health coverage**.

MEASURE A FUNDING SUMMARY

Measure A funds provide approximately three-quarters of the support needed to sustain the DLC Healthcare Portal Project.

Measure A funding helped the DLC achieve the following:

- Distribute over 1,450 flyers about the health care services offered by the DLC at sites where workers congregate, and follow up with text messages and phone calls
- Register 45 new individuals as clients at the DLC
- Provide 580 health services to over 150 clients
- Train six clients to become Peer Health Educators (target: 6), including 46 hours of training
- Perform 554 health and/or dental assessments and complete 219 follow-up assessments (target: 750 assessments and 125 follow-up assessments)
- Identity 115 clients as having no health insurance and set up appointments with an eligibility worker for all identified clients
- Hold eight meetings of DLC staff and partner agencies to review and evaluate the monitoring system for chronic conditions, attended by an average of seven participants at each meeting (target: 4 meetings)
- Hold six meetings with staff from various school districts in southern Alameda County to identify undocumented immigrant youth (UIY) and inform them of/refer them to health care and other support services
- Refer seven UIY for health or dental services
- Identify seven UIY as having no insurance and refer them to an eligibility worker

Health Services for Day Laborers: Multicultural Institute

mionline.org/

Allocation: **$89,301** | Expended/Encumbered: **$89,271**

Individuals served by Measure A: **650** (Total individuals served: **906**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Hospital Outpatient, Public Health

Service area: Berkeley, Oakland, Homeless or transient

BACKGROUND

The Multicultural Institute (MI) accompanies immigrants in their transition from poverty and isolation to prosperity and participation. MI's core constituencies are Latino immigrant families and other youth and adults lacking access to critical services. Its programs are focused on historically disadvantaged groups in neighborhoods in Alameda and other counties.

MI focuses its efforts in the following areas:

- Street conditions. MI staff brings its services to day laborers seeking work in West Berkeley. The program works with local officials and businesses to ensure that the area is safe, there is access to trash receptacles and bathrooms, and no harassment of workers occurs.
- Job placement assistance. MI provides no-fee job-matching services for day laborers to receive jobs at a fair minimum wage.
- Referrals and follow-up for educational, health, and legal services. The community MI serves encounters various issues when accessing medical and legal services. MI's case management and referral system assists individuals in overcoming language barriers. MI provides navigation in the health system and is a place where individuals can obtain information on services needed.
- Skill-building. MI offers different vocational trainings such as business entrepreneurship, Spanish-language GED preparation courses, and computer skills.
- Community-building and healthy pastimes. Sponsoring events like street cleaning and shared meals helps break down isolation and leads to new ways of working together.

Measure A Helps

One morning, day laborer Jose approached MI program staff looking very sick. He is diabetic and needs to take medication regularly to keep it controlled. Staff determined that Jose hadn't taken his medication in months and referred him to the Alameda County mobile health van. The examining nurse made an appointment at Highland Hospital, because Jose needed immediate assistance. Due to extremely high sugar levels, Jose couldn't go himself. He was weak, couldn't walk straight, felt disoriented, and had blurred vision, so MI staff drove him to the hospital. MI and mobile clinic staff keep monitoring Jose's case, have connected him to a nutritionist, and gave him a free glucometer.

MEASURE A FUNDING SUMMARY

Measure A funding helped MI achieve the following:

- Provide health care referrals and patient navigation support to day laborer and other low income clients

- Target: Provide outreach to 700 unduplicated clients and 100 one-on-one consultations, with 90% of contacts reporting that the health, public health, and/or referral services were well performed and that their health care needs were met, and 80% reporting that they would not know where to access health services without MI's assistance.
- Actual: Outreach to 650 clients and 143 consultations held. 100% of contacts reported that the health, public health, and/or referral services were well performed, 90% reported that their health care needs were met, and 97% reported that they would not know where to access health services without MI's assistance.

- Provide health education and public health promotion on various topics
  - Target: Host or co-sponsor a minimum of eight health care trainings or workshops attended by 150 participants, as well as eight street-based health education sessions attended by 150 participants, with 70% reporting that the workshops were well facilitated, they liked the workshop, and/or they found it interesting or informative, and 70% also indicating an increase in knowledge.
  - Actual: 14 health care trainings/workshops held attended by 192 participants, and 12 street-based health education sessions attended by 137 participants. 95% and 99% reported that the health care workshops and street-level sessions, respectively, were well facilitated, they liked the workshop, and/or they found it interesting or informative. 95% and 89%, respectively, indicated an increase in knowledge.
- Provide health care treatment and services through partnerships with providers and/or contracted services
  - Target: Arrange a minimum of 250 screenings or treatments to a minimum of 100 individuals, with 70% of contacts indicating that the services delivered were well done, they would not have had access to such services if it weren't for MI and its partners, and the health care needs that originally brought them to MI were addressed.
  - Actual: 223 screenings/visits provided to 103 individuals. 99% indicated that the services delivered were well done, 93% indicated they would not have had access to such services if it weren't for MI and its partners, and 98% reported that the health care needs that originally brought them to MI were addressed.

93% of individuals receiving health care treatment and services indicated they would not have had access to such services if it weren't for MI and its partners.

Health Services for Day Laborers: Street Level Health Project

streetlevelhealth.org

Allocation: **$89,301** | Expended/Encumbered: **$89,301**

Individuals served by Measure A: **2,110** (Total individuals served: **2,357**)

Populations served: Indigent, Low Income, Uninsured Adults, Seniors

Services provided: Public Health

Service area: Countywide, Homeless or transient

BACKGROUND

Street Level Health Project is an Oakland-based health center dedicated to improving the health and well-being of underserved urban immigrant communities in the Bay Area. The Street Level Health Access Program is a critical entry point to the health care and social service system for a marginalized population that may be excluded from the Affordable Care Act. Many of the community members that access Street Level face a multitude of barriers that include issues related to language and literacy skills, legal status, unemployment, and lost work opportunities due to long wait times at Federally Qualified Health Centers.

MEASURE A FUNDING SUMMARY

Measure A funding helped Street Level Health Project achieve the following:

- Provide health care screening and episodic care to 810 clients across multiple languages (target: 750 clients)
- Offer 1,478 health-related navigation and referral services across 55 local health care agencies (target: 1,300 referrals)
- Distribute 4,678 free healthy fruit and produce food bags to 909 low income households (target: 5,000 bags to 400 workers/families)
- Provide 575 referrals to local grassroots community organizations that provide social services (target: 850 referrals)
- Recruit and train 57 prospective and current health care providers to provide them with experience working with uninsured low income communities (target: 25)
- Provide medical service on the same day to 99% of clients who check in to the clinic (target: 95%)
- Provide information on how to access services to 93% of clients who screen positively for unmet mental health needs (target: 80%)
- Refer 80% of clients who have no health care coverage to the enrollment worker (target: 75%)

Measure A Helps

Danny suffers from substance use, mental health needs, and income barriers. He contacted Street Level Health after being detained during a DMV visit for outstanding tickets. He was taken into custody and placed on house arrest with an ankle monitor. Danny reported feeling depressed and informed staff of past PTSD and mental health treatment, and he received both a health screening and a mental health evaluation. Based on the evaluation, Danny was referred and provided transportation to Sausal Creek Outpatient Clinic, where he received a month's supply of medication. In addition, Danny was set up with a care plan that health navigators will pursue once he is stabilized.

Increase Hospice Utilization

gettingthemostoutoflife.org/about-variant-2

Allocation: **$200,000** | Expended/Encumbered: **$151,187**

Individuals served by Measure A: **500** (Total individuals served: **2,000**)

Populations served: Indigent, Low Income, Uninsured Adults, Families, Seniors

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health

Service area: Countywide

BACKGROUND

The Alameda County "Getting the Most Out of Life" (GMOL) program is designed to reduce suffering and improve quality of care for terminally ill residents of Alameda County through increased education about and utilization of advanced health care planning, palliative care, and hospice services.

GMOL offers services that go beyond general education of advanced care planning and hospice services. The program aims to demonstrate a social change, collect data, motivate behavior change, and create general public awareness around end of life.

MEASURE A FUNDING SUMMARY

Each of the GMOL affiliate programs—Comfort Homesake, Hospice Providers Coalition, Care Partners, and the Clinical Partnership—used Measure A funds to help support and contribute to GMOL's overall mission by providing their program services.

Measure A funding helped the GMOL program achieve the following:

- Provide a minimum of two trainings per month, complete over 131 Advance Care Directives, and provide advance care planning and hospice resources at various community events/fairs
- Organize National Health Decision Day April 2016 that reached over 160 participants
- Provide outreach to over 20,000 IHSS recipients and provide over 24 trainings to two Adult Protective Services staff, six Public Health Nurses, the Office of the Public Guardian, 83 social workers, and 66 chore providers, resulting in 22 hospice referrals
- Conduct monthly meetings that brought together over 25 service providers that provide services to residents in/outside of Alameda County

Highlights

The number of advance care documents completed rose from **31 in FY 14/15 to 131 in FY 15/16.**

In an evaluation, 90% of respondents said that they felt **more comfortable starting a conversation about advance health care planning** after completing the program.

Medical Costs for Juvenile Justice Center: Direct Service Planning and Administration

Allocation: **$261,000** | Expended/Encumbered: **$261,000**

Individuals served by Measure A: **79** (Total individuals served: **847**)

Populations served: Children

Services provided: Mental Health

Service area: Countywide

BACKGROUND

The Alameda County Health Care Services Agency (HCSA) works to provide fully integrated health care services through a comprehensive network of public and private partnerships that ensures optimal health and well-being and respects the diversity of all residents.

HCSA oversees certain programs that provide services at the Alameda County Juvenile Justice Center (JJC). Included in these programs are services provided by the JJC Health Services Director.

MEASURE A FUNDING SUMMARY

This Measure A allocation is meant to cover the cost of the JJC Health Services Director. During FY 15/16, the position was unfilled.

Medical Costs for Juvenile Justice Center: Mind Body Awareness

mbaproject.org

Allocation: **$58,939** | Expended/Encumbered: **$58,939**

Individuals served by Measure A: **194** (Total individuals served: **242**)

Populations served: Indigent, Low Income, Uninsured Children

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Countywide

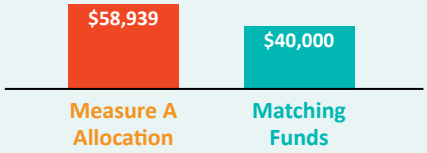
BACKGROUND

Mind Body Awareness (MBA) delivers mindfulness-based mental health programming to at-risk, gang-involved, and incarcerated youth in three Bay Area counties. MBA's mission is to help youth transform harmful behavior and live meaningful lives through the practices of mindfulness meditation and emotional awareness. MBA also engages in customized curriculum development and training for service providers working with at-risk youth regionally and nationally. The heart of MBA's work is to provide the most at-risk youth in the most difficult environments—probation detention facilities, youth detention camps, and at-risk schools—with concrete tools to reduce stress, impulsivity, and violent behavior and increase self-esteem, self-regulation, and overall well-being.

MEASURE A FUNDING SUMMARY

Measure A funding helped MBA provide 1,059 youth encounters on mindfulness-based group programs to 245 youth in five units at the Alameda County Juvenile Justice Center (ACJJC) as well as Camp Sweeney. Classes took place once or twice per week, for 1.5 hours per class.

Matching Funds



MBA leveraged its Measure A allocation to obtain **$40,000 in matching funds.**

Highlights

- 95% of participants reported that they felt the class was **a safe place to share**.
- 95% reported that they felt **connected with their instructors**.
- 93% reported that they **would recommend MBA classes** to a friend.
- 90% reported **improvement in stress and the ability to regulate their emotions**.
- 87% reported **improvement in positive coping skills**.

Medical Costs for Juvenile Justice Center: Niroga Institute

niroga.org

Allocation: **$ 83,224** | Expended/Encumbered: **$83,224**

Individuals served by Measure A: **4,023** (Total individuals served: **4,023**)

Populations served: Indigent, Low Income, Uninsured Children

Services provided: Mental Health

Service area: Countywide

BACKGROUND

Niroga Institute fosters health, well-being, and social and emotional learning by bringing Transformative Life Skills (TLS) or dynamic mindfulness to at-risk and underserved individuals, families, and communities. TLS develops social emotion learning and stress resilience through mindful movement, breathing techniques, and meditation.

MEASURE A FUNDING SUMMARY

Niroga Institute used its Measure A allocation to provide the following at the Alameda County Juvenile Justice Center (JJC):

- 12–13 TLS classes per week year-round, serving an average of seven youth per class and 90 youth per week
- Three all-day immersion retreats in three units, serving an average of eight youth each
- Two staff classes per week, serving an average of seven staff each

Highlights

- 100% of youth who responded to an evaluation survey reported that the **teachers were effective in delivering the curriculum and impacting their behavior**.
- In the weekly classes, 50%–87% of youth who responded reported **shifts from stressed to relaxed, from anxious to calm, and from distracted to focused**.
- 87% reported a **decrease in stress**.
- 83% reported an **increase in self-control**.
- For the all-day immersion, 100% of youth who responded reported **shifts from stressed to relaxed, from anxious to calm, and from distracted to focused**.
- For staff participating in the staff class, 83% of staff reported a **decrease in stress and increase in well-being**.

Medical Costs for Juvenile Justice Center: Victims of Crime

alcoda.org/victim_witness/california_victim_compensation_program

Allocation: **$90,000** | Expended/Encumbered: **$90,000**

Individuals served by Measure A: **2,760** (Total individuals served: **2,760**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health

Service area: Alameda, Berkeley, Castro Valley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Piedmont, Pleasanton, San Leandro, San Lorenzo, Union City, Outside of Alameda County

BACKGROUND

The Victim/Witness Assistance Division of the Alameda County District Attorney's Office supports and empowers crime victims and their families by promoting their rights within the criminal justice system and providing services to aid in their recovery from the emotional, psychological, social, and economic impact of crime.

The Victim Compensation Program offers the following:

- Contacts to individuals whose compensation claim was "zero awarded" (no expenses paid) for a determination as to why the client did not submit a loss request or bill for payment consideration
- Crisis support referrals and follow-up to outside agencies
- Optimum compensation assistance through the investigation and utilization of other applicable financial resources and recovery
- Support in navigating the client's immediate access to critical needs services: medical, mental health, pharmaceutical, etc.
- Swift processing of emergency claims to alleviate client financial suffering and hardship
- Increased expansion of covered financial services and benefits, and evaluation of their effectiveness in addressing the client's needs
- Increased community outreach to help educate clients about the existence of the program and its available services and resources

Highlights

Of the total 1,186 "zero awarded" claimants, **staff successfully contacted 72% to determine why a loss request or bills were never submitted** for payment and to provide information to those who were unaware that they were approved for payment of benefits.

MEASURE A FUNDING SUMMARY

The Victim Compensation Program used its Measure A allocation to hire staff, which enabled the program to expedite the processing of claims submitted by the Guidance Clinic originating in the Alameda County Family Justice Center, Camp Sweeney, school-based health centers in Alameda County, and/or Crisis Service Response Teams.

Staff contacted claimants who were approved but did not use funds for covered medical, mental health, relocation, wage loss, or other services.

Preventive Care Pathways

healthcare.gov/coverage/preventive-care-benefits

Allocation: **$214,322** | Expended/Encumbered: **$214,322**

Individuals served by Measure A: **2,598** (Total individuals served: **2,598**)

Populations served: Indigent, Low Income, Uninsured Adults, Seniors

Services provided: Emergency Medical, Public Health, Mental Health

Service area: Countywide, Homeless or transient

BACKGROUND

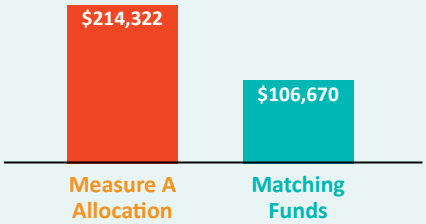
Preventive Care Pathways offers "Pathways to Wellness" to the general population by providing medical services for at-risk and indigent patients, producing and presenting educational videos and literature for health education, and providing health care services for individuals re-entering the community from the prison system.

MEASURE A FUNDING SUMMARY

Preventive Care Pathways used its Measure A allocation to achieve the following:

- Provide 2,318 medical service visits to low income residents (target: 1,500)
- Screen 320 patients for Hepatitis C (target: 30)
- Provide treatment to 36 patients who tested positive for Hepatitis C
- Coordinate four health fairs and/or workshops attended by 280 participants
- Provide Covered California or Medi-Cal application assistance to 522 residents (target: 30)
- Attend two Covered California CEE Alameda County Partnership Meetings (target: 2)

Matching Funds



Preventive Care Pathways leveraged its Measure A allocation to obtain **$106,670 in matching funds**.

Highlights

- In an evaluation survey, 100% of residents rated the medical care they received as **good or very good**.
- 75% said they would **recommend Preventive Care Pathways/James A. Watson Wellness Center** to someone they know.
- 80% of residents received application assistance and were **approved for Medi-Cal**.

Primary Care Community-Based Organizations

Allocation: **$5,870,494** | Expended/Encumbered: **$5,870,494**

Individuals served by Measure A: **21,216** (Total individuals served: **190,152**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Hospital Inpatient, Mental Health

Service area: Countywide

BACKGROUND

The Alameda Health Consortium is a regional association of community health centers that work together and support the involvement of their communities in achieving comprehensive, accessible health care and improved outcomes for everyone in Alameda County.

The Alameda Health Consortium is guided by the following principles:

- All people have the right to accessible and affordable high quality health care that prevents illness, promotes wellness, and is sensitive to the unique needs of particular communities and cultures.
- The barriers that prevent people from seeking care must be eliminated.
- Individuals and families must be empowered to participate in their own health care.
- Low income and underserved people play an important role in the formation of health policy at the local, state, and national level.
- Building consensus and coalitions around important health issues leads to innovative solutions.
- Providing quality health care improves the well-being of our communities.
- Racial and ethnic health disparities must be eliminated in order to have healthy communities.

The Consortium's outpatient services are provided at community health center locations throughout Alameda County and are not hospital-based. The health centers see patients regardless of income, insurance, or immigration status. In addition to providing medical, dental, and behavioral health care, the health centers provided a wide range of support services to improve the lives of patients served. More than 20 different languages are spoken across the health centers

The Alameda Health Consortium's eight member health centers are the following:

- Asian Health Services
- Axis Community Health
- La Clinica
- LifeLong Medical Care

Measure A Helps

A 50-year-old patient, out of work, uninsured, and undocumented, was experiencing stress, severe migraines, and blurriness of vision. He went to emergency rooms for health care, and one referred him to Tri-City Health Center. He subsequently met with a diabetes case manager and a registered dietician. The patient says, "I take 30-40 minute walks every morning. Now my diabetes is in control. I went from Hb-1Ac of 12.5 to 8 in four months. I really appreciate Tri-City Health Center. They changed my life. I like the model of community clinics and we need to make sure they are around."

- Native American Health Center
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- West Oakland Health Council

MEASURE A FUNDING SUMMARY

The eight Alameda Health Consortium member health centers used their Measure A allocation to ensure that low income uninsured Alameda County residents have access to affordable health care at community health centers under the Health Program of Alameda County (HealthPAC). The funds enable the health centers to provide essential medical services to HealthPAC enrollees, as well as health insurance enrollment assistance for the uninsured.

Specifically, Measure A funding helped Consortium member community health centers achieve the following:

- 18,266 low income Alameda County residents made a total of 60,585 service visits at very low cost through HealthPAC.
- An additional 5,525 appointment offerings were provided to HealthPAC enrollees.
- 21,216 low income residents were enrolled in HealthPAC at one of the health centers.
- Providers saw 27,629 more patients across the system compared to the prior fiscal year.
- Additional sites opened in Pleasanton, Oakland, Berkeley, Hayward, and Fremont, improving access to care.
- Communication channels improved between hospitals and the primary care clinics as part of the Care Transition Program.
- Integrated Behavioral Health Care coordinators were trained and deployed across the eight health centers.

18,266 low income Alameda County residents made a total of 60,585 service visits at very low cost through HealthPAC.

Actual Visits for Each Consortium Health Center

	Total Patients	Primary Care, Specialty Visits	Dental Visits	Mental Health Visits	Total Visits
Asian Health Services	331	966	-	18	1,031
Axis Community Health	1,778	5,055	-	154	5,209
La Clinica de la Raza	6,440	13,882	1,874	1,586	18,503
LifeLong Medical Care	1,292	3,548	596	259	4,439
Native American Health Center	654	1,128	1,560	80	2,769
Tiburcio Vasquez Health Center	4,798	11,918	3,043	602	15,563
Tri-City Health Center	2,377	8,085	2,505	203	11,389
West Oakland Health Center	596	974	702	2	1,682
Total	**18,266**	**45,556**	**10,280**	**2,904**	**60,585**

Tiburcio Vasquez Health Center, Inc.

tvhc.org

Allocation: **$60,000** | Expended/Encumbered: **$60,000**

Individuals served by Measure A: **175** (Total individuals served: **2,354**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families

Services provided: Public Health, Mental Health

Service area: Hayward, Union City

BACKGROUND

Tiburcio Vasquez Health Center, Inc. (TVHC) is dedicated to promoting the health and well-being of the community by providing accessible high quality care. TVHC's individual and organizational commitment is to ensure this human right through quality service, advocacy, and community empowerment.

TVHC has over 40 years of history providing youth-based programs and nearly 20 years of experience running school-based health centers. These programs include the following:

- The teen pregnancy prevention program has contributed to reducing teen pregnancy rates in the New Haven Unified School District. Students receive individual counseling regarding family planning education, pregnancy prevention options, and STI/HIV education.
- Through the Health Educators and Peer Health Educators programs, students provide presentations about the health center on a wide range of health topics to their fellow students at Logan and Tennyson High Schools. These presentations provide information on a range of topics including pregnancy prevention, substance abuse, and healthy relationships. Peer Health Educators also conduct classroom presentations that meet requirements for sexual health education as part of the school's science/life skills classes.
- Café, the Spanish-speaking parent empowerment group, maintains a group of over 90 parents at weekly workshops at Harder Elementary and Tennyson and Hayward High Schools. Topics include natural health nutrition, how to navigate the education system, immigration laws, health care reform, college readiness, financial education, effective communication, Internet 101, LGBTQ awareness, and diabetes prevention.

Highlights

- 100% of evaluation survey respondents expressed that health center staff helped them **get services they wouldn't otherwise get**.
- 100% strongly agreed or agreed that staff helped them **get help sooner than they normally would**.
- 97% replied that they were **satisfied or very satisfied with the school health center**.
- 100% agreed or strongly agreed that health center **staff is easy to talk to; listen carefully to what they have to say; care about what they have been through; make the health center feel like a safe place; and help them work through their problem**.

MEASURE A FUNDING SUMMARY

TVHC's Measure A funding helps support a continuum of care model that incorporates health education, case management, youth and parent leadership development programs, medical care, and behavioral health at

three school health center sites including Tennyson, Logan, and Hayward High Schools.

Measure A funding helped TVHC achieve the following:

- Provide medical services to 34% of the student body at each school health center site
- Provide oral health screenings to the student body at each school health center site
- Provide behavioral health-related services, referrals, and linkages at all campuses served by a school health center
- Provide an average of 16–35 hours per week of health education, health promotion, and youth development services at each site
- Coordinate and/or participate in at least one family or community health-related event or activity at each school health center
- Train over 60 students to become Peer Educators
- At Logan High School:
  - Register 600 new patients (target: 1,000)
  - Engage 3,000 students in health education and outreach activities (target: 1,000)
  - Reduce the client no-show rate from 30% to 13% (target: 10%)
- At Tennyson High School:
  - Have 325 ninth graders participate in peer health education (target: 150)
  - Provide family planning sessions to 312 youth (target: 300)
  - Provide a weekly multiracial empowerment program for at-risk youth attended by 40 youth (target: 30)
  - Maintain the client no-show rate at 27% (target: 10%)

Highlights

- 97% reported that the health center helped them **do better at school, get better grades, or get into fewer trouble situations**.
- 99% expressed the health center **helped them stay in school**.
- 97% responded that being part of the group program **helped them be more confident**.
- 100% agreed or strongly agreed that groups **helped them learn skills that will help them in their future**.

Washington Hospital

www.whhs.com

Allocation: **$33,000** | Expended/Encumbered: **$21,205**

Individuals served by Measure A: **52** (Total individuals served: **52**)

Populations served: Indigent, Low Income, Uninsured Adults

Services provided: Hospital Outpatient, Public Health

Service area: Countywide, Homeless or transient

BACKGROUND

The Washington Hospital Healthcare Foundation works to enhance the Washington Hospital Healthcare System by increasing public awareness and providing financial support. The Washington Hospital Healthcare System strives to meet the health care needs of district residents through medical services, education, and research.

MEASURE A FUNDING SUMMARY

Washington Hospital used its Measure A allocation to provide free mammography screening examinations to indigent, low income, and uninsured patients referred to Washington Hospital by local partner health centers.

The service included the mammography procedure, interpretation of results by the radiology group, and consultation with the patient and referral to Highland Hospital for further evaluation when needed.

Washington Hospital provided mammograms to 52 patients, of whom 15 had abnormal findings detected. Of this number, seven were called back for additional evaluation and eight required a six-month follow up to evaluate necessary next steps.

Measure A Helps

A 38-year-old woman was referred to Washington Hospital for a mammography screening exam after a community health center nurse practitioner discovered that the patient was not conducting breast self-examinations at home. The mammogram revealed three masses requiring additional screening and a biopsy. Washington Hospital referred the patient to Highland Hospital in Oakland for further treatment. This patient gained access to the health care system and was quickly and appropriately cared for by medical professionals. By coordinating care between three different health care entities, the mammography program provided potentially life-saving diagnostic care and treatment.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 4: PUBLIC HEALTH

ACCMA Community Health Foundation/ East Bay Conversation Project

www.accma.org / www.eastbayacp.org

Allocation: **$37,840** | Expended/Encumbered: **$14,624**

Individuals served by Measure A: **215** (Total individuals served: **5,536**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Public Health

Service area: Countywide, Outside of Alameda County

BACKGROUND

The ACCMA Community Health Foundation, a 501(c)3 charitable subsidiary of the Alameda-Contra Costa Medical Association (ACCMA), works with the ACCMA to promote quality of and access to health care through medical student scholarships and community health programs in Alameda and Contra Costa Counties.

The East Bay Conversation Project (EBCP) is a community-wide coalition of hospitals, physicians, hospice agencies, nursing homes, county health care agencies, faith-based organization, senior advocacy organizations, fiduciaries, attorneys, business organizations, and other interested individuals dedicated to promoting understanding of and engagement in advance care planning.

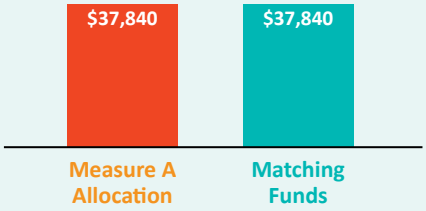
MEASURE A FUNDING SUMMARY

EBCP used its Measure A allocation to increase access to appropriate inpatient and outpatient medical services for low income and uninsured County residents by educating them about advance care planning.

Specifically, Measure A funding helped EBCP achieve the following:

- Support and enhance a diverse coalition that represents community, business, faith-based, health care, public health, and patient advocacy organizations and individuals committed to promoting advance care planning in Alameda County. Ten coalition meetings were held attended by 140 members, and the number of community organizations that participated in the meetings rose to 91 by the end of FY 15/16.
- Participate in or support 37 outreach activities to educate and engage the community in advance care planning. These activities included video presentations, interactive discussions led by EBCP volunteers, educational forums specifically targeted to faith-based leaders, and other community events. These activities reached a total of 1,580 community members.

Matching Funds



ACCMA Community Health Foundation and EBCP leveraged their Measure A allocation to obtain **$37,840 in matching funds** from community foundations.

- Conduct free quarterly training programs for 60 individual champions desiring to get detailed training on the value of advance care planning, how to engage in it, and how to encourage others to engage in it.
- Receive over 4,000 unique visits to the EBCP website, which serves as a focal point of information and guidance on advance care planning for the target audience, as well as a resource to help advance care planning advocates engaged in outreach activities.

Highlights

- 100% of coalition participants reported that coalition meetings were **engaging and informative**.
- 100% of advocates responded that their **knowledge of and ability to discuss advance care planning had increased** after training.
- 92% of residents contacted via outreach responded that they were **more likely to engage in advance care planning**.

Alameda Boys & Girls Club, Inc.

alamedabgc.org

Allocation: **$107,161** | Expended/Encumbered: **$107,161**

Individuals served by Measure A: **3,812** (Total individuals served: **3,812**)

Populations served: Low Income, Uninsured Children

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Alameda, Oakland

BACKGROUND

Founded in 1949, the Alameda Boys & Girls Club provides high impact, affordable youth development programs and services for youth ages 6–18. The Club strives to inspire and enable all youth, especially those who need it the most, to realize their full potential as productive, responsible, and caring citizens.

The Club is open to all youth from all schools and backgrounds, every day and evening after school and during school vacations. It specifically targets low income and at-risk youth to provide them with equality of opportunity and prepare them for a great future. Seventy-two percent of youth attending the Alameda Boys & Girls Club are living in poverty.

MEASURE A FUNDING SUMMARY

Measure A helps support the Alameda Boys & Girls Club Live Healthy program. Live Healthy is a year-round program serving over 500 youth and teen members that incorporates healthy cooking and gardening programs with physical fitness and recreation programming.

Specifically, Alameda Boys & Girls Club used its Measure A allocation to achieve the following:

- Increase access to medical and mental health services to low income youth
  - 422 youth received dental, vision, and/or respiratory screenings (target: 270).
  - 450 dental, vision, and respiratory screening visits were conducted (target: 360).
  - 4 health education events and/or workshops were conducted with 484 youth attending (target: 4 events/workshops with 320 youth attending).
  - 317 unduplicated youths were served through mental counseling sessions (target: 300).
  - 40 mental health visits were provided (target: 30).

Highlights

- In most areas, Alameda Boys & Girls Club **exceeded its targets, sometimes dramatically.** For example, 450 dental, vision, and respiratory screening visits were conducted compared to a target of 360, while 905 unduplicated youths participated in Healthy Habits programming compared to a target of 240.
- 100% of youth completing a satisfaction survey reported that **they liked the health education workshop.**
- 79% of youth would **recommend the workshop** to a friend.
- 97% of Passport to Manhood workshop participants would **recommend the workshop** to a friend.

- Increase access to culturally competent public health and mental health services to low income youth through Life Skills workshops
  - 4 Passport to Manhood workshops were conducted serving 46 boys (target: 4 workshops serving 40 boys).
  - 10 SmartGirls workshops were conducted serving 178 girls (target: 8 workshops serving 80 girls).
  - 905 unduplicated youths participated in Healthy Habits programming (target: 240).
- Increase access to culturally competent public health services to youth through a comprehensive culinary, nutrition, and health education program
  - 241 unduplicated clients participated in cooking programming (target: 250).
  - 1 hands-on/informational cooking event/workshop was conducted for all Club youth (target: 1).
- Increase access to culturally competent public health services to youth through a dynamic, garden-based nutrition and ecology education program
  - 291 unduplicated clients participated in gardening programming (target: 250).
  - 1 hands-on/informational gardening event/workshop was conducted for all Club youth (target: 1).
- Increase access to culturally competent public health services to youth through a low and high impact recreation and sports program
  - 1,675 unduplicated youths participated in physical fitness and recreation programming (target: 1,000).
  - 4 hands-on/informational sports and recreation events were conducted for all Club youth (target: 1).

Highlights

- 91% of SmartGirls workshop participants would **recommend the workshop** to a friend.
- 86% of youth would **recommend the Alameda Boys & Girls Club** to a friend.
- 100% of youth learned a new skill for **maintaining their physical health.**
- 90% of youth learned a skill for **maintaining their mental health.**
- 98% of youth learned something new about **developing positive relationships.**

Alameda County Asthma Start

acphd.org/asthma.aspx

Allocation: **$100,000** | Expended/Encumbered: **$100,000**

Individuals served by Measure A: **54** (Total individuals served: **64**)

Populations served: Indigent, Low Income, Uninsured Children

Services provided: Public Health

Service area: Alameda, Ashland, San Leandro, San Lorenzo

BACKGROUND

Asthma Start works with families of children and adolescents diagnosed with asthma to provide them with the tools needed to manage their asthma, avoid the emergency department and hospital, ensure that they have healthy homes, and live a healthy life avoiding the long-term complications of asthma.

Asthma Start provides in-home case management to families of children and adolescents with asthma. The program provides asthma education related to the disease, symptoms, and medication and its use. The program develops a care plan for the family, looks at their home for asthma triggers, and partners with Healthy Homes and Code Enforcement as needed to advocate with landlords to remediate triggers or safety issues. Families are given supplies to assist in managing their child's asthma such as pillow and mattress encasings, non-bleach-based mold cleaner, a vacuum, etc. Families are also linked to any needed services such as food, housing, medical home, and insurance. The program also partners with schools to case manage children that are missing school due to asthma, participates in School Attendance Review Boards, and works with the District Attorney when a child is truant due to asthma.

Eighty-nine percent of the children served are insured by Medi-Cal and from low income families. Asthma Start is the only program in the County doing in-home asthma case management.

MEASURE A FUNDING SUMMARY

Asthma Start used its Measure A allocation to achieve the following:

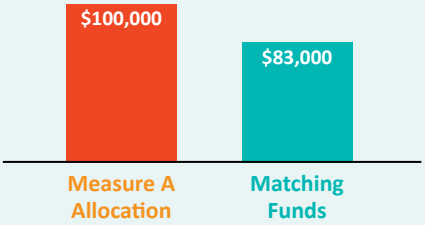
- Open 290 cases in a 12-month period and close 295 cases, of which 231 were closed successfully (target: open 250 cases)
- Increase caregiver knowledge of asthma (target: 95% of caregivers passing an asthma post test with a score of 80% or better; actual: 100%)
- Help children maintain or reduce asthma symptoms to the lowest level (target: 95% of children; actual: 99%)

Measure A Helps

Asthma Start worked with a single mother who has two children with asthma. The Asthma Coordinator discovered that their unit had bedbugs and worked with Environmental Health to exterminate them. Asthma Start gave the mother mattress and pillow encasings to assist with dust mite allergies. The water heater in the kitchen was not enclosed, so the children could get into it. The program worked with the property owner to enclose the water heater. The property owner also fixed a leak and cleaned up mold caused by the leak. Since that time, the children have not missed school due to asthma and the mother feels less anxious about managing their asthma.

- Help caregivers reduce at least one identified asthma trigger (target: 95% of caregivers; actual: 99%)
- Reduce instances of children requiring hospitalization or emergency department visits post case management (target: 20% or less of children; actual: 5% needing hospitalization, 13% needing emergency department visits)
- Increase caregiver confidence in managing their child's asthma (target: 95% of caregivers reporting increased confidence; actual: 100%)
- Ensure children have a medical home and insurance before discharge (target: 100% of children; actual: 100%)

Matching Funds



Asthma Start leveraged its Measure A allocation to obtain **$83,000 in matching funds** from Targeted Case Management (TCM) and a Kaiser Community Benefit grant.

Alameda County Breastfeeding Coalition Childcare Taskforce

californiabreastfeeding.org/coalition-information/communitycoalitions/members/alameda/

Allocation: **$6,900** | Expended/Encumbered: **$6,781**

Individuals served by Measure A: **2,200** (Total individuals served: **2,200**)

Populations served: Low Income Children, Families

Services provided: Public Health

Service area: Countywide, Outside of Alameda County

BACKGROUND

Alameda County Breastfeeding Coalition (ACBC) includes breastfeeding experts and advocates from public health, WIC, hospitals, clinics, child care organizations, health plans, community groups, and mothers and fathers interested in redefining breastfeeding as the norm for infant feeding; creating an environment that promotes and supports breastfeeding through education, collaboration, and partnership; and promoting breastfeeding integration throughout the health care system by bridging resources and services for families in Alameda County.

MEASURE A FUNDING SUMMARY

Measure A funding helped ACBC meet its objective of ensuring ongoing the quality and safety of child care center feeding practices by developing and promoting excellent reference materials and reproducible media in partnership with national, state, and local experts.

Specifically, ACBC used its Measure A allocation to achieve the following:

- Develop and broadcast a one-hour training webinar featuring experts in promotion of breastfeeding and management of breast milk in child care settings. Over 30 child care providers participated in the webinar and hundreds more are estimated to have accessed the recording posted on the ACBC website.
- Develop and distribute a Breastfeeding Friendly Childcare Toolkit with easy-to-read guidelines, handouts, and magnets for child care and early childhood education providers. 950 copies of the toolkit in English, Spanish, and Chinese were distributed throughout Alameda County child care centers, Head Start programs, and other child care sites. In addition, the toolkit was shared with communities across the state working to support breastfeeding-friendly child care centers.
- Launch the initiative with a promotion event August 5, 2015 during World Breastfeeding Week. 30 child care providers and community members attended the event.

Highlights

- Since posting the webinar and toolkit on the coalition website, over **1,500 visits (1,132 unique visits)** have accessed the materials.
- 100% of child care providers who engaged in the training resources stated they would **implement breast milk storage and feeding guidelines.**
- The Breastfeeding Friendly Childcare Toolkit and training webinar were recognized by the California Breastfeeding Coalition as a **Gold Nugget Award program** supporting Employment and Child Care.
- Los Angeles County requested permission to replicate the Toolkit with the addition of their local resources for a **campaign across Los Angeles County.**

Center for Early Intervention on Deafness

ceid.org

Allocation: **$53,581** | Expended/Encumbered: **$53,581**

Individuals served by Measure A: **783** (Total individuals served: **1,168**)

Populations served: Indigent, Low Income Adults, Children, Families, Seniors

Services provided: Public Health

Service area: Alameda, Albany, Berkeley, Castro Valley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Pleasanton, San Leandro, San Lorenzo, Homeless or transient

BACKGROUND

The Center for Early Intervention on Deafness (CEID) works to maximize the communication potential of young children through early education, family support, and community audiology services.

MEASURE A FUNDING SUMMARY

The funding that CEID received through Measure A helped CEID to hire staff that is bilingual in Spanish and English. CEID also recently hired a new part-time audiologist that is fluent in Cantonese and Mandarin.

Additionally, Measure A funding provided CEID the opportunity to offer onsite pediatric resident training. Residents learn how to properly read an audiogram, speak with parents about their child's hearing, and observe CEID teachers and therapists working with students. This training is not available elsewhere and has a definite positive impact on the ability of physicians to support their patients with appropriate diagnoses, timely referrals, meaningful explanations and information, and effective treatments.

Specifically, Measure A funding helped CEID achieve the following:

- Conduct 124 newborn hearing screenings (target: 150)
- Perform 408 audiological evaluations for children, youth, and adults (target: 300)
- Dispense hearing aids and ear molds to 170 residents (target: 150)
- Hold three community hearing screenings
- Train 69 pediatric residents (target: 75)

Highlights

- 98% of families of newborn patients reported that they were **satisfied with the services** they received.
- 97% of families reported **increased knowledge about auditory development and hearing health** following their visit to CEID.
- 100% of parents/guardians of newborns who were identified for follow-up care were **referred for evaluation and diagnostic services.**
- 97% of patients and/or guardians who completed a survey reported **increased knowledge about their hearing level** and related services following their visit to CEID.
- 98% of patients who received a referral for hearing aids **received hearing aids.**
- 97% of patients reported that their **quality of life (access to sound in environments and communication) improved.**

City of San Leandro

sanleandro.org

Allocation: **$53,581** | Expended/Encumbered: **$53,581**

Individuals served by Measure A: **4,963** (Total individuals served: **60,295**)

Populations served: Seniors

Services provided: Public Health

Service area: San Leandro, San Lorenzo

BACKGROUND

The San Leandro Recreation and Human Services Department strongly emphasizes the importance of health and wellness. The department strives to educate the public about how they can achieve improved health and wellness and continually provides or partners in programs that support health and wellness in the community.

The department has developed program guidelines and expectations regarding healthy eating and physical activity.

MEASURE A FUNDING SUMMARY

Measure A funding supports a comprehensive health and wellness framework by allowing the City of San Leandro to offer the following critical programs to seniors. The City of San Leandro set an attendance objective of 50% of Senior Community Center members participating in programs and services formulated to promote health and wellness.

Specifically, the City of San Leandro used its Measure A allocation to achieve the following:

- Hold 13 health checks, including blood pressure and weight checks, serving 741 seniors (target: 360)
- Through the Mercy Brown Bag program, distribute 553 grocery bags of nutritional food to 650 eligible seniors (target: 576)
- Provide 16 health education classes attended by 530 seniors (target: 12 classes)
- Conduct 37 Pull Up a Chair exercise classes in which 550 seniors were enrolled (target: 36 classes)
- Hold 424 fall prevention classes attended by 554 seniors (target: 208 classes)
- Conduct 1,938 other health and wellness classes

Measure A Helps

Sharon, 67, and her father Bill, 92, are regular participants at the San Leandro Senior Community Center. Sharon has cholesterol and blood pressure issues, while Bill has heart disease with a pacemaker to address low pulse. Sharon says: "It keeps my dad active and mobile at 92 years of age. If he didn't take the classes, I don't believe he would have maintained his level of mobility. It's helped me, too; it keeps me fit and strong. I feel strongly if you do not exercise and move around that your health would decline. It's a caring community where people follow up on each other if a familiar face is missing."

Drivers for Survivors, Inc.

Driversforsurvivors.org

Allocation: **$10,000** | Expended/Encumbered: **$10,000**

Individuals served by Measure A: **8** (Total individuals served: **197**)

Populations served: Low Income Adults, Seniors

Services provided: Emergency Medical, Hospital Outpatient

Service area: Fremont, Newark, Union City

BACKGROUND

Drivers for Survivors provides free transportation service and supportive companionship, from suspicious findings through treatments, for ambulatory cancer patients that live in Fremont, Newark, and Union City.

MEASURE A FUNDING SUMMARY

Drivers for Survivors used its Measure A allocation to provide an average of 253 rides per month and recruit 66 new clients.

Highlights

100% of clients **rated the service as good or excellent**.

East Oakland Community Project

eocp.net

Allocation: **$30,000** | Expended/Encumbered: **$30,000**

Individuals served by Measure A: **558** (Total individuals served: **558**)

Populations served: Indigent, Low Income, Uninsured Adults, Families

Services provided: Mental Health

Service area: Oakland

BACKGROUND

The East Oakland Community Project (EOCP) empowers homeless individuals and families in Alameda County to regain a life of self-reliance. EOCP provides dignified emergency housing and compassionate comprehensive support services that prepare homeless people to successfully transition to permanent affordable housing, increased financial stability, and well-being.

MEASURE A FUNDING SUMMARY

EOCP used its Measure A allocation to achieve the following:

- Create six office spaces through the design, purchase, and installation of furnishings to provide office space in which case managers and housing specialists meet with clients to provide case management services
- Provide case management and wraparound services to more than 150 homeless individuals and families
- Serve 558 persons in the shelter, of whom 28% obtained permanent housing

Measure A Helps

Mr. Hall, 83, came to EOCP from Highland Hospital. He had been living in Sacramento but became ill and lost his housing when he was transferred from a Sacramento hospital to Alta Bates and finally to Highland. EOCP helped Mr. Hall improve his health and find housing in a group living arrangement. He was not paying his rent and seemed to be unable to manage his SSI benefits. EOCP provided him with money management and representative payee services. Mr. Hall is now looking for a better living situation while he remains housed because his major bills are paid on time. EOCP is also connecting him with other community-based senior services.

Eden Youth and Family Center

eyfconline.org

Allocation: **$75,000** | Expended/Encumbered: **$75,000**

Individuals served by Measure A: **100** (Total individuals served: **100**)

Populations served: Low Income, Uninsured Adults, Children, Families

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Ashland, Castro Valley, Cherryland, Fremont, Hayward, Newark, Oakland, San Leandro, San Lorenzo, Union City

BACKGROUND

Eden Youth and Family Center (EYFC) provides and supports a comprehensive array of services and advocacy for children, youth, and families of the City of Hayward and the unincorporated Eden area of Alameda County, enhancing the economic, social, educational, and healthy well-being of the community.

The EYFC youth team serves over 400 culturally and ethnically rich and diverse students and families per year. Services are designed to address and circumvent negative experiences students encounter, such as school system inequalities, unemployment, high levels of violence, and incarceration. Many students are or have been involved in the foster care system or juvenile justice system, or are pregnant or parenting.

The EYFC team provides youth with tutoring, academic skills, GED preparation, college readiness, career coaching, and completion of college and scholarship applications. EYFC also offers an after-school and summer program to help transition-age youth improve their education and employment goals and skills, become more autonomous and less reliant on government programs and aid, and improve self-sufficiency and physical and mental well-being. EYFC also partners with other agencies to reduce substance abuse among youth and adults.

MEASURE A FUNDING SUMMARY

EYFC used its Measure A allocation to achieve the following:

- Provide 50 life skills training sessions to 400 youth and young adults. The trainings covered health, wellness, drug prevention, and nutrition information.
- Coordinate youth advisory councils on tobacco and alcohol use to provide leadership development, training, and awareness campaigns. Youth advisory council members participated in 50 weekly council meetings to focus on creating an implementation plan around healthy lifestyle choices for youth and young adults.

Measure A Helps

Renee, a 19-year-old former foster care youth, was homeless and came to EYFC after being robbed. EYFC provided intensive case management and connected her with mental health services, medical support, housing, and food. EYFC also connected her to the South Hayward Parish to obtain healthy food, a shower, and other resources. EYFC's case manager helped Renee obtain temporary housing and complete the forms needed to apply for permanent housing. The case manager also helped Renee secure an internship at the EYFC Computer Clubhouse. Renee maintains regular work attendance, is no longer homeless, is stable on her medication, and is able to perform daily life skills with minimal stress.

- Plan and coordinate community presentations on marijuana and the teenage brain. The presentations reached 687 members of the community (652 youth and 35 adults) over four days.
- Provide Alcohol, Tobacco, and Other Drugs (ATOD) awareness workshops to 85 Summer and After-School Youth Employment Program participants. Fifteen youth participated in an interactive speakers series presented by those who had struggled with sobriety. Forty program participants and clients were referred to local adolescent education, prevention, and treatment programs.
- Provide case management to 102 at-risk youth and young adults with wraparound case management support, and link these youth to valuable community resources to support their individual needs.
- Refer over 150 youth and families to onsite service providers for health screenings, pediatric health care, behavioral health needs, and early childhood education and child care.

EYFC used its Measure A allocation to provide case management to 102 at-risk youth and young adults with wraparound case management support.

Emergency Medical Services (EMS) Corps

acphd.org/ems-corps.aspx

Allocation: **$604,942** | Expended/Encumbered: **$604,242**

Individuals served by Measure A: **50** (Total individuals served: **50**)

Populations served: Indigent, Low Income Adults, Children, Families

Services provided: Emergency Medical, Public Health, Mental Health, Substance Abuse

Service area: Countywide, Outside of Alameda County, Homeless or transient

BACKGROUND

The Emergency Medical Services (EMS) Corps works to increase the number of underrepresented Emergency Medical Technicians (EMTs) through youth development, mentoring, and job training.

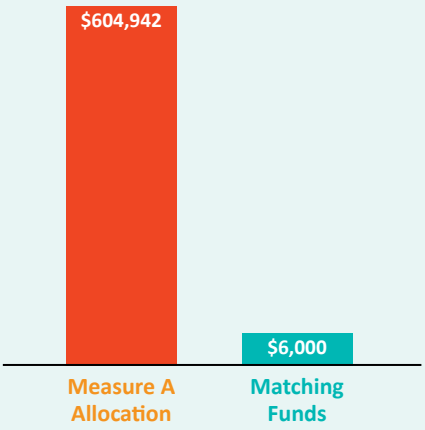
The EMS Corps targets young men of color from underserved communities. This program is designed to interrupt a pattern of behavior that leads to violence and an unhealthy lifestyle. By guiding them through a transformative mentoring process, and linking them with an entry level career opportunity, the program improves the overall quality of each individual's physical and mental health.

MEASURE A FUNDING SUMMARY

The EMS Corps used its Measure A allocation to achieve the following:

- Receive 230 applications for the EMS Corps (target: 200)
- Operate 2 cohorts (target: 2)
- Interview 80 potential candidates (target: 80)
- Select 50 participants for the program
- Train 37 EMTs (target: 35)
- Employ 80% of graduates (target: 50%)
- Conduct 15 volunteer community service events (target: 10)

Matching Funds



EMS Corps leveraged its Measure A allocation to obtain **$6,000 in matching funds** from a community grant.

Emergency Medical Services (EMS) Health Coach Program

acgov.org/ems

Allocation: $**236,000** | Expended/Encumbered: **$236,000**

Individuals served by Measure A: **1,500** (Total individuals served: **1,500**)

Populations served: Low Income Uninsured Adults, Seniors

Services provided: Hospital Outpatient, Public Health, Mental Health, Substance Abuse

Service area: Ashland, Cherryland, Fremont, Hayward, Oakland, San Leandro, San Lorenzo

BACKGROUND

The Alameda County Emergency Medical Services (EMS) Health Coach program works to improve the community's health by pairing members with culturally sensitive health coaches trained on disease management.

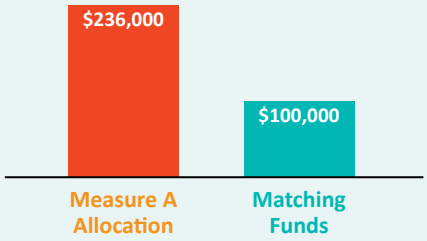
Health Coaches provide linkages to primary care physicians, nutritional services, mental health services, medication adherence support, pharmacies, and community-based resources. They help in the facilitation of medical appointments, insurance-related concerns, and accessing social/legal services.

MEASURE A FUNDING SUMMARY

The EMS Health Coach program used its Measure A allocation to achieve the following:

- Educate 1,580 community members on hypertension and diabetes (target: 1,000)
- Coach 138 members over six months on compliance with medication, decreasing emergency department visits, establishing a health home, and increasing patient knowledge of disease (target: 100)
- Connect those members to a primary care physician and enroll them in a health insurance plan
- Provide 1,500 patients with materials and resources on healthy eating from nutritional services

Matching Funds



The Health Coach program leveraged its Measure A allocation to obtain **$100,000 in matching funds**.

Emergency Medical Services (EMS) Injury Prevention

acgov.org/ems

Allocation: $**210,112** | Expended/Encumbered: **$210,112**

Individuals served by Measure A: **702** (Total individuals served: **702**)

Populations served: Low Income Adults, Seniors

Services provided: Public Health, Mental Health

Service area: Countywide

BACKGROUND

Alameda County Emergency Medical Services (EMS) provides quality emergency medical services and prevention programs to improve health and safety for residents in Alameda County. The Senior Injury Prevention Program (SIPP), an EMS program, works to prevent unintentional injuries or accidents among older adults and to raise awareness of the need for injury prevention programs for older adults.

SIPP includes the following components:

- Home visits. Using health care professionals and paraprofessionals, participants are visited in the home. Typically, these individuals are frail. Home visits provide an opportunity to evaluate the home environment and provide referrals, review of and education on medication management, falls risk reduction, physical activities, nutrition education, home safety, etc.
- Medication tools. In addition to providing education on medication management and disposal, disposal events are held in the community. Additionally, medication management devices such as medi-sets are distributed to participants.
- Physical activity and nutrition. Participants are provided information on and encouraged to participate in appropriate physical activity programs/routines and nutrition classes.
- Evidence-based programs (EBPs). EBPs are based upon rigorous study of the effects or outcomes of specific interventions or models. They include HomeMeds, a computerized system that analyzes participants' medications and identifies interactions; Flinders Chronic Disease Self-Management Program, which assists in identifying self-management skills necessary to successfully manage chronic diseases.; and Matter of Balance, a falls prevention program.
- Physician visits. Health care professionals and/or paraprofessionals accompany participants to visits with their physicians and help them prepare questions for their physician.

Measure A Helps

CITY OF FREMONT

In Afghanistan, Fawzia was hit with shrapnel when a bomb exploded nearby. This resulted in neurological damage and post-traumatic stress. After coming to the U.S., Fawzia was unable to work and needed significant help from her family. At the Healthy, Happy Me Program (HHM), Fawzia reported that she would easily get dizzy and at times fall, and that she knew she was crazy. Staff helped Fawzia obtain a walker and developed questions for her primary physician to explore. Fawzia's physician discovered that she had a significant issue with her heart. Fawzia began treatment and the program will continue to work on both her physical condition and her post-traumatic stress.

- Socialization. Regularly scheduled group activities such as health education sessions, exercise classes, nutrition classes, etc. provide participants an opportunity to socialize.

MEASURE A FUNDING SUMMARY

SIPP providers used their Measure A allocation to achieve the following:

- DayBreak Adult Day Centers: Medication Management
  - Serve 39 unduplicated seniors (target: 40)
  - Dispose of 35 expired medications (target: 20)
- City of Fremont Health Promotion
  - Serve 163 unduplicated Afghan seniors (target: 125)
  - Ensure 161 seniors receive regular care from a primary care physician (target: 100)
  - Complete 69 wellness screens (target: 60)
  - Conduct 75 home safety evaluations (target: 40)
  - Provide 161 socialization services (target: 100)
- City of Fremont Service Linkage
  - Conduct 729 home visits to 122 clients (target: 350 visits to 85 clients)
  - Refer 28 clients to case management/counseling services (target: 25)
  - Provide assistance in eligibility and access to supportive services to 112 seniors (target: 100)
  - Provide 80 health education services (target: 50)
- City of Fremont Happy, Healthy Me (Chronic Condition Management)
  - Have 46 seniors complete the Partners in Health screening (target: 45)
  - Perform a six-month PIH reassessment on 36 seniors (target: 45)
- City of Fremont Medication Assistance
  - Provide medication review, education, and counseling to 91 seniors (target: 50)
- City of Fremont Chronic Disease Self-Management/Health Education & Support Group
  - Provide 16 hours of Matter of Balance (MOB) fall prevention class (target: 16)
  - Have 10 Afghan seniors participate in MOB class (target: 10)
  - Offer one six-week Diabetes class (target: 1)
  - Have six clients attend Diabetes class (target: 12)
- Senior Support Services of the Tri-Valley
  - Serve 38 unduplicated seniors (target: 38)
  - Dispose of 20 expired medications (target: 20)
- St. Mary's Center Medication Management
  - Serve 64 unduplicated seniors (target: 47)
  - Complete 64 medication compliance reports (target: 47)
  - Dispose of 64 expired medications (target: 24)
- United Seniors Oakland Alameda County (USOAC) Medication Education
  - Serve 334 unduplicated seniors (target: 225)
  - Host one medication disposal event (target: 1)

Highlights

In many areas, SIPP providers exceeded their targets, sometimes dramatically. For example, City of Fremont Health Promotion exceeded its target for home safety evaluations by 88%, while City of Fremont Service Linkages exceeded its target for home visits by over 100%.

- Nine DayBreak Adult Centers seniors receiving medication management **significantly improved medication compliance.**
- 30 seniors in the City of Fremont Happy, Healthy me program showed improved PIH scores after nine months, and 13 showed **improved blood pressure, pulse rate, or blood sugar scores.**
- 50 seniors receiving City of Fremont medication assistance showed **increased knowledge of their medication,** and 45 improved deficits in medication compliance.
- 10 Afghan seniors in the City of Fremont MOB class showed an **increase in knowledge of falls** and fall prevention.
- 47 seniors receiving medication management from St. Mary's Center showed **improved medication compliance,** while 135 seniors at USOAC showed improved understanding of medication compliance and safety.

Genesis Worship Center

genesiswc.com

Allocation: **$5,000** | Expended/Encumbered: **$5,000**

Individuals served by Measure A: **882** (Total individuals served: **4,170**)

Populations served: Low Income Adults, Children, Families, Seniors

Services provided: Public Health

Service area: Oakland

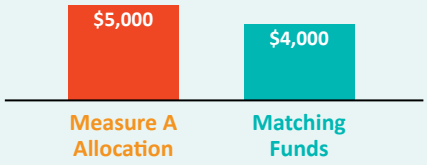
BACKGROUND

The Genesis Worship Center feeding program provides food to those in need once per week, four times per month.

MEASURE A FUNDING SUMMARY

Genesis Worship Center used its Measure A allocation to provide emergency food assistance to an average of 100 children, adults, and seniors weekly. The program served a total of 882 clients.

Matching Funds



Genesis Worship Center leveraged its Measure A allocation to obtain **$4,000 in matching funds** from the church and community members.

HIV Education and Prevention Project of Alameda County OPEND Program

casasegura.org

Allocation: **$150,000** | Expended/Encumbered: **$150,000**

Individuals served by Measure A: **385** (Total individuals served: **1,955**)

Populations served: Adults, Families, Seniors

Services provided: Emergency Medical, Public Health, Substance Abusee

Service area: Countywide, Homeless or transient

BACKGROUND

The HIV Education and Prevention Project of Alameda County (HEPPAC) works to stop the spread of preventable diseases among increased-risk communities. HEPPAC strives to reduce the impact of health-related harm in the community by addressing health disparities and external barriers and increasing access to basic needs services.

HEPPAC provides ancillary services throughout Oakland and Alameda County including the Casa Segura daytime drop-in center to access basic needs: shower, laundry, referrals, access to food, and Overdose Prevention Education and Naloxone Distribution (OPEND) services. HEPPAC's mobile outreach provides HIV/HCV counseling, testing, linkage to primary/specialty care, distribution of harm reduction supplies, access to food, OPEND syringe exchange services, and referrals.

OPEND services occur at three offsite syringe exchange sites in West to East Oakland, through street and community outreach, and by appointment at the drop-in center. Thanks to HEPPAC's OPEND program, Alameda County now has an integrated overdose prevention and free naloxone distribution program to reduce accidental overdose deaths by opioids.

Measure A Helps

A training participant came to HEPPAC to get Narcan for his girlfriend, a 31-year-old woman, who had overdosed the night before. He said they had both used heroin and cocaine and she had an extreme reaction to the drugs, while he didn't. She began foaming at the mouth and was less and less responsive over time. He said in the dark and in a panic it was difficult to draw the dose up, but after giving it, his girlfriend came back within a few minutes. He reported that she was the thirty-first person he had saved.

MEASURE A FUNDING SUMMARY

HEPPAC used its Measure A allocation to achieve the following:

- Design and develop the Alameda County OPEND program. HEPPAC hired its OPEND Coordinator and completed the development of policies and procedures, program instructional materials signage, standing order, surveys, and a data collection methodology.
- Administer 258 one-on-one OPEND trainings to active opioid users who access syringe exchange services for themselves and multiple drug-using peers and/or active opioid users recently released from incarceration at fixed syringe exchange locations in Oakland (target:

100). Trainings were conducted in HEPPAC's three Oakland syringe exchange locations, homeless encampments, street corners, and other places the target population convenes. Training participants received education on how to identify an opioid overdose, current state and federal laws for assisting during a medical emergency, and how to administer Narcan via nasal and/or auto-injection.

- Provide 25 OPEND trainings to 10 Alameda County community-based providers who work with active and former opioid users. The training provided education on the opioid epidemic in Alameda County, how to recognize an opioid overdose, how to administer Narcan, and strategies to engage opioid users on their overdose risk. Each agency began to incorporate OPEND into their preexisting programs as standard.
- Provide a minimum of four presentations on current trends of opioid use, OPEND activities and accomplishments, and challenges of the OPEND project to key community stakeholders, including board members, funders, collaborators, and those who support and/or access services.

Highlights

- HEPPAC **exceeded its target** for one-on-one OPEND trainings by 158%.
- 100% of OPEND training participants self-reported an increase in their ability to **recognize, administer, and reverse an overdose.**
- 100% of training participants **increased their opioid overdose knowledge,** found the training useful, would recommend the training to a peer, and were satisfied with the training.
- 100% of community-based organizations who received the training reported an increase in knowledge and stated they were **more comfortable identifying and responding to an accidental opiate overdose.**
- 100% of organizations reported that they **found the training informative, realistic, and easy to administer,** and that they would recommend this training to other services providers in Alameda County.

HIV Education and Prevention Project of Alameda County Syringe Program

casasegura.org

Allocation: **$150,000** | Expended/Encumbered: **$150,000**

Individuals served by Measure A: **1,009** (Total individuals served: **3,015**)

Populations served: Indigent, Low Income, Uninsured Adults, Seniors

Services provided: Emergency Medical, Public Health, Substance Abusee

Service area: Countywide, Homeless or transient

BACKGROUND

The HIV Education and Prevention Project of Alameda County (HEPPAC) works to stop the spread of preventable diseases among increased-risk communities. HEPPAC strives to reduce the impact of health-related harm in the community by addressing health disparities and external barriers and increasing access to basic needs services.

HEPPAC is responsible for the operation of Oakland's harm reduction services for active substance users. Specific harm reduction-based services include syringe exchange, pickup of littered syringes in public locations, HIV and HCV antibody screening services, individual-level risk-reduction counseling/education, Narcan distribution, and distribution of harm reduction supplies to homeless encampments. Herbal/acupuncture and crisis counseling services are also offered during exchange service hours.

HEPPACs integrated service model includes HIV/HCV counseling, testing, referral, and linkage (CTRL) health education and prevention in non-clinical settings.

MEASURE A FUNDING SUMMARY

HEPPAC used its Measure A allocation to achieve the following:

- Increase access to sterile syringes for people who inject drugs (PWIDs), at least 18 years of age residing in northern Alameda County, by conducting syringe exchange services in areas where PWIDs reside and/or frequent. A total of 2,453 contacts were made during mobile services and fixed exchange hours. Of the 2,453 contacts, 84% self-reported to have engaged in intravenous drug use within the past 10 days.
  - Exchange at least 50,000 sterile syringes for used ones during two two-hour outdoor syringe exchange sites and one two-hour indoor site. Food, hygiene kits, and other harm reduction supplies were also provided.

Measure A Helps

B, a 46-year-old Latina, is the only female staying in a non-operative mobile trailer shared with three men. She approached HEPPAC's female outreach worker for an HIV/HCV screening, crisis counseling, overdose prevention, housing referrals, and supplies including feminine hygiene products. At the screening, B tested reactive for Hepatitis C. She was given safer injection information and practiced her condom negotiation skills by conducting role plays with staff. B stated she learned a lot from HEPPAC outreach staff and within one week was attending the Thursday syringe exchange consistently. She was referred to Alameda Health System and is receiving medication to cure her Hepatitis C.

- Distribute 327,600 syringes and collect 307,944 used syringes during fixed and mobile exchange service hours. A total of 113 IDUs were new to HEPPAC's exchange services. This is an increase of 9% when compared to this time last year.
- Conduct 23 hours of mobile exchange services per week in northern Alameda County, primarily within the city of Oakland.
- Collect 89,580 used syringes from PWIDs and exchange them for sterile syringes during non-fixed exchange site service hours.

- Provide PWIDs with increased access to primary medical and holistic health services. HEPPAC provides acupuncture services at two of the three syringe exchanges. A partnership with the Roots Community Clinic has continued to provide primary medical care services during syringe exchange hours.
  - 60% of new clients (113) accessing the syringe exchange for the first time were referred through previous contact with an outreach worker during HEPPAC's street outreach program.
  - Provide medical care to 89 PWIDs during syringe exchange services. Of the 89 unduplicated clients, 81 were treated for soft tissue infections.
  - Provide 89 PWIDs with safer injection education.
  - Inform and refer at least 104 PWIDs to health care enrollment services.
- Ensure that 154 PWIDs reached through unstructured workshops and one-to-one encounters were able to identify at least one risk-reduction practice. A total of 125 (81%) who accessed an unstructured group also accessed HIV/HCV rapid antibody testing, were made aware of their current HIV/HCV status, and were offered linkage services.
  - 100% of clients attending were able to identify at least one risk-reduction practice.
  - 81% of clients that participated in an unstructured workshop accessed HIV and HCV screening services within one month.

154 PWIDs reached through unstructured workshops and one-to-one encounters were able to identify at least one risk-reduction practice.

LIFE ElderCare

lifeeldercare.org

Allocation: **$32,698** | Expended/Encumbered: **$32,698**

Individuals served by Measure A: **60** (Total individuals served: **202**)

Populations served: Seniors

Services provided: Public Health

Service area: Ashland, Castro Valley, Cherryland, Fremont, Hayward, Newark, San Leandro, San Lorenzo, Union City

BACKGROUND

LIFE ElderCare empowers seniors to live with independence and interdependence by nourishing mind, body, and spirit.

MEASURE A FUNDING SUMMARY

LIFE ElderCare used its Measure A funds to increase access to home-based public health services for low income, at-risk seniors through the HomeLIFE fall prevention program. The program achieved the following:

- 143 eligible seniors received comprehensive fall prevention assessments, education, and supports (target: 60).
- 572 interventions in the areas of exercise, medication management, environmental assessment, and general well-being were recommended to HomeLIFE seniors.
- 100% of very frail HomeLIFE seniors received an additional fall risk assessment by the program Occupational Therapist (target: 100%).
- 53% of clients improved their score on one or both of the fall risk assessments: the 4-Step Balance test or the 30-Second Chair test (target: 50%).

Measure A Helps

NG, 85, has heart disease, hypertension, CHF/angina, arthritis, leg and back problems, and "emotional problems." During her initial fall prevention assessment, her apartment was cluttered and smelled of urine. NG had over 20 bottles of medication, some expired, and said that most of the time she forgot to take them. In subsequent visits, the HomeLIFE worker disposed of and rearranged NG's medications, taught her chair exercises, went with her for walks, and signed NG up for Meals on Wheels. The program also got her a free transfer bench so she could use her shower.

LifeLong Medical Care Emery School Health Center

lifelongmedical.org

Allocation: **$98,000** | Expended/Encumbered: **$98,000**

Individuals served by Measure A: N/A (Total individuals served: N/A) *Note: Funds were used for equipment purchase, not direct services*

Populations served: Low Income, Uninsured Adults, Children

Services provided: Public Health

Service area: Emeryville

BACKGROUND

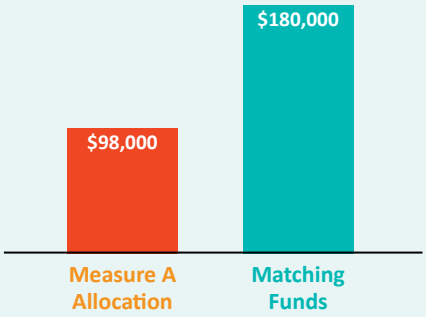
LifeLong Medical Care provides high quality health and social services to underserved people of all ages; creates models of care for the elderly, people with disabilities, and families; and advocates for continuous improvements in the health of its communities.

The Emeryville Center for Community Living brings schools, a library, and recreation and health services together in a single campus, providing an opportunity for collaboration and revitalization in Emeryville.

MEASURE A FUNDING SUMMARY

LifeLong Medical Care used its Measure A allocation to purchase equipment to equip the new LifeLong Emeryville Health Center, located within the Emeryville Center for Community Life.

Matching Funds



LifeLong leveraged its Measure A allocation to obtain **$180,000 in matching funds** from the HEDCO foundation and the U.S. Health Resources Services & Administration Oral Health Expansion.

LifeLong Medical Care Heart2Heart

lifelongmedical.org

Allocation: **$100,000** | Expended/Encumbered: **$100,000**

Individuals served by Measure A: **1,604** (Total individuals served: **1,604**)

Populations served: Low Income, Uninsured Adults, Seniors

Services provided: Public Health

Service area: Berkeley

BACKGROUND

LifeLong Medical Care provides high quality health and social services to underserved people of all ages; creates models of care for the elderly, people with disabilities, and families; and advocates for continuous improvements in the health of its communities.

The LifeLong Heart 2 Heart (H2H) program works to achieve the following:

- Foster advocacy efforts to address community priorities
- Support community efforts to build strong networks among neighbors
- Engage residents in activities to promote healthier behaviors
- Increase the social and environmental supports for healthier behavior

MEASURE A FUNDING SUMMARY

The LifeLong H2H program used its Measure A allocation to achieve the following:

- Train and certify 20 residents as Neighborhood Health Advocates (NHAs) using curriculum adapted from other successful health promoters programs, of which 100% graduated (target: 15 residents, 70% graduates). Topics included leadership, team development and effectiveness, how to navigate through the health care system, and health-specific issues.
- Engage with community members through 130 public events and/or small presentations (target: 50). Activities provided health education and linkages to community resources.
- Implement mini-grant programs and award five mini-grants to programs such as community gardens that encourage healthy behaviors, helping to create a positive change in the South Berkeley community by improving the health and well-being of residents (target: 3–4).
- Provide information on health-related topics and services to 865 residents through 33 mobile health van events stationed within the neighborhood and at other events (target: 200 residents at 10 events).

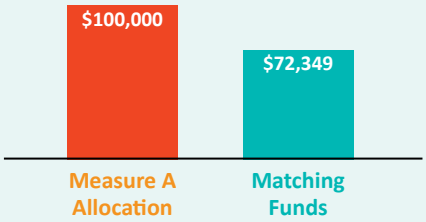
Highlights

In several areas, LifeLong H2H greatly exceeded its targets. For example, it provided 130 public events compared to a target of 50, reached 865 residents through mobile outreach compared to a target of 200, and provided 1,696 visits to the HTN clinic compared to a target of 500.

- 97% of NHA graduates reported an **increase in confidence as a leader and connecting community members to resources**.
- 92% of community event attendees reported an **increased ability to connect with community resources.**
- 90% of HTN event attendees reported an **increase in confidence in managing their health**.

- Provide heart health information to 136 residents through 10 Health Hubs events in local barbershops (target: 75 residents at 10 events).
- Contact 216 residents through 2 door-to-door outreach events to promote healthy behaviors (target: 100 residents at 2 events).
- Organize 95 drop-in Hypertension (HTN) clinics to provide 1,696 visits to residents for blood pressure screenings and health education to increase their knowledge and awareness of cardiovascular health and support healthy behaviors (target: 80 clinics providing 500 visits). 248 residents benefited from free blood pressure screenings and received important information about cardiovascular health.

Matching Funds



LifeLong H2H leveraged its Measure A allocation to obtain **$72,349 in matching funds** from the Community Development Block Grant awarded by the City of Berkeley.

Love Never Fails

loveneverfailsus.com

Allocation: **$10,000** | Expended/Encumbered: **$10,000**

Individuals served by Measure A: **22** (Total individuals served: **22**)

Populations served: Low Income, Uninsured Adults, Children, Seniors

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Hayward

BACKGROUND

Love Never Fails is dedicated to the restoration, education, and protection of those involved or at risk of becoming involved in domestic sex trafficking. The program provides trauma-informed safe housing, medical case management, and mental health and substance abuse services.

MEASURE A FUNDING SUMMARY

Love Never Fails used its Measure A allocation to serve 22 clients. This resulted in 53 completed medical visits and 229 mental health/substance abuse meetings.

Measure A Helps

A client who came to Love Never Fails was homeless, was formerly addicted to drugs, did not have custody of her child, had multiple health problems, and was traumatized from the experience of being exploited. After 18 months in the safe housing program, the client was able to gain full custody of her daughter back, get her own apartment, reinstate her driver's license, get a car, study for and pass the real estate license exam, get a job at a real estate company, and maintain a healthy, sober lifestyle.

Mandela MarketPlace

mandelamarketplace.org

Allocation: **$10,000** | Expended/Encumbered: **$10,000**

Individuals served by Measure A: **936** (Total individuals served: **936**)

Populations served: Low Income Adults, Children, Families, Seniors

Services provided: Public Health

Service area: Ashland, Cherryland

BACKGROUND

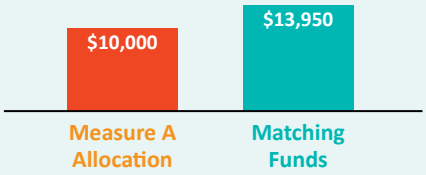
Mandela MarketPlace, Inc. works in partnership with local residents, family farmers, and community-based businesses to improve health, create wealth, and build assets through cooperative food enterprises in low income communities. The Ashland Cherryland Food Policy Council (ACFPC) is a project of Mandela MarketPlace, Inc. The resident-led ACFPC advises local government on policy to establish an equitable and secure food system for residents of the low income, unincorporated Alameda County communities of Ashland and Cherryland.

MEASURE A FUNDING SUMMARY

Mandela MarketPlace used its Measure A allocation to achieve the following:

- Conduct community outreach with 559 Ashland and Cherryland residents to increase participation in the ACFPC, the Eden Area Livability Initiative, and other local community initiatives to increase sustained community engagement in local self-governance initiatives related to urban agriculture and environmental and food-centered economic development policy (target: 300).
- Present data from the ACFPC's Vacant Land Survey at 10 community meetings, and conduct education and outreach regarding implementation of an Assembly bill related to urban agriculture incentive zones, to 311 residents (target: 300).
- Construct one community garden in a low income housing complex in Ashland to increase healthy food access for an underserved population.
- Engage 10 apartment residents in growing fruits and vegetables in the community garden, and engage 60 additional apartment residents through three gardening workshops, three food justice movie nights, and one healthy cooking class (target: 50).
- Conduct one training and/or conference on leadership or skill development attended by six ACFPC members to build their leadership capacity and technical skills to advocate for healthy food access.
- Schedule four quarterly meetings with the District 4 County Supervisor to provide policy and constituent updates.

Matching Funds



Mandela MarketPlace, Inc. leveraged its Measure A allocation to obtain **$13,950 in matching funds** from the Alameda County Public Health Department.

National Health Care Decisions Day

gettingthemostoutoflife.org

Allocation: **$1,500** | Expended/Encumbered: **$1,500**

Individuals served by Measure A: **190** (Total individuals served: **190**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Emergency Medical, Hospital Outpatient, Public Health, Mental Health

Service area: Countywide, Homeless or transient

BACKGROUND

The Alameda County "Getting the Most Out of Life" (GMOL) program is designed to reduce suffering and improve quality of care for older adults and the terminally ill through increased education about and utilization of advance care planning, palliative, and hospice services in Alameda County.

MEASURE A FUNDING SUMMARY

Measure A funding helped the GMOL program plan a public event for 160 residents of Alameda County to increase education and utilization of advance care planning and hospice services (target: 150).

Services were provided by 30 volunteers and vendors including nonprofits, social services agencies, and hospice providers.

The event resulted in five notarized Advance Health Care Directives being completed.

Highlights

86% of residents who completed a survey indicated that they felt **more comfortable talking about health care or end-of-life choices** after attending the event.

Public Health Prevention Initiative

Allocation: **$3,230,000** | Expended/Encumbered: **$3,230,000**

Individuals served by Measure A: **129,388** (Total individuals served: **181,363**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Emergency Medical, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

Service area: Countywide, Homeless or transient

BACKGROUND

The Alameda County Public Health Department works in partnership with the community to ensure the optimal health and well-being of all people through a dynamic and responsive process respecting the diversity of the community and providing for present and future generations.

The Measure A Prevention Initiative aims to reduce health disparities via three priority areas:

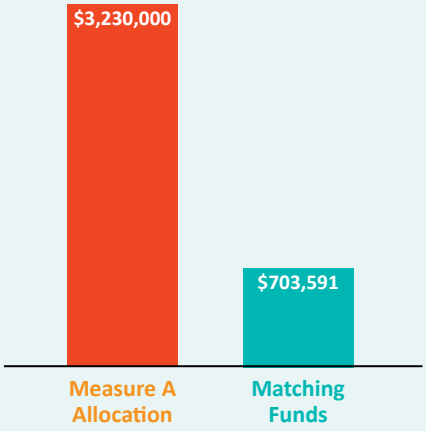
- Chronic Disease & Injury Prevention
- Health Inequities & Community Capacity-Building
- Obesity Prevention & School Health

The programs that make up these three priority areas are not designed to operate as standalone efforts but rather are complementary to other departmental programs and strategies.

The programs and organizations receiving Initiative funding include the following:

- Asthma Start (see the separate "Alameda County Asthma Start" entry on page 82)
- Berkeley School-Linked Health Services Program
- CAL-PEP
- Child Health Disability Prevention Program
- City and County Neighborhood Initiative
- Community Assessment, Planning, and Evaluation Unit
- Diabetes
- East Oakland Boxing Association
- Healthy Retail Project
- HIV Education and Prevention Project of Alameda County
- Home Visiting and Family Support
- HOPE Collaborative—A Project of the Tides Center
- Immunization
- Lotus Bloom
- Mandela MarketPlace
- Niroga Institute
- Nutrition Services

Matching Funds



Public Health Prevention Initiative providers leveraged their Measure A allocations to obtain **$703,591 in matching funds** from the following sources:

- Medi-Cal Administrative Activities
- Targeted Case Management (TCM)
- Children's Health and Disability Prevention (CHDP)
- Maternal, Child, and Adolescent Health (MCAH)
- OFCY funds
- In-kind contributions from volunteer medical professionals
- Kaiser Permanente
- Kaiser Community Benefit Grant

- Office of Dental Health (see the separate "Alameda County Dental Health" entry on page 46)
- Project New Start
- Public Health Nursing
- Public Health Nursing Healthy Living Project

MEASURE A FUNDING SUMMARY

The Public Health Prevention Initiative programs used Measure A funding to help achieve the following.

Berkeley School-Linked Health Services (SLHS) Program

- Provide support at the school level as well to as individual students and families.
- Provide over 120 consultations to school administration, elementary school staff, and families on topics including vision, food allergies, medications, immunizations, nutrition and obesity, tobacco prevention, health insurance, and more.
- Conduct 15 public health family visits at their homes.
- Provide resources and referrals for emotional/behavioral/mental health issues and housing.
- Participate in five 504/IEP/SST meetings with school staff and families.
- Support stronger linkages among programs to build more productive inter- and intra-agency collaborations, with a focus on those that address educational attainment.
- Collaborate with Berkeley Unified School District (BUSD) and other agencies to develop and implement a coordinated, multi-agency service delivery model that links students, families, and school staff to needed resources, with a special focus on attendance and truancy.
- Serve as a consultant, specifically in the area of physical health, to school administration and elementary school staff and families.
- Hold monthly meetings of the Berkeley Healthy Schools Collaborative (BHSC), attended by public health staff doing work in BUSD, BUSD representatives, youth, children, and City of Berkeley (COB) Youth Services/2020 Vision representatives as partners.
- Participate in community events including the Heart 2 Heart Block Party and Juneteenth, and coordinate public health participation in the K to College Event, Attendance Awareness Month in September, and BUSD Special Education Community event.
- Participate in two planning meetings with BUSD and UCSF Benioff Children's Hospital regarding the integration of the Family Navigation & Information Desk program and the Office of Family Engagement and Equity (OFEE).
- Provide over 30 health consultations to family engagement coordinators for students with chronic absenteeism.
- Attend eight School Attendance Review Team/School Attendance Review Board (SART/SARB) meetings.

The Berkeley SLHS program conducted 15 public health family visits at their homes.

- Convene planning and school implementation meetings with BUSD staff and the Prescott-Joseph Center for Community Excellence regarding Breathmobile services in BUSD.
- Organize a Multigenerational Family Night at Malcolm X elementary.
- Support 11 elementary school-based oral screenings for second and fifth graders. Over 1,200 students were screened, and over 300 students received dental sealants.
- Conduct outreach to students/families in severe need and track those referrals, especially those who did not have a dental home or dental insurance, to ensure that they were able to access care.
- Conduct five health trainings at staff meetings on the topics of seizure disorders, cystic fibrosis, immunizations, Epi-Pen administration, and medication administration.
- Consult with BUSD administration on the BUSD Parent Manual and BUSD health webpage updates.

CAL-PEP

- Provide HIV testing and education services to those at highest risk for HIV infection and their sexual partners.
- Enroll individuals with HIV-positive status found in need of extra support services into Choosing Life: Empowerment! Action! Results! (CLEAR) case management for one-on-one support with behavior change support.
- Conduct education workshops promoting healthy choices and sexual wellness with HIV-positive individuals and their sexual partners.
- Conduct Targeted Prevention Activities (TPAs) to 67 contacts in high risk communities and other venues where African American positive and high risk negative individuals congregate.
- Distribute partner services information and safer sex materials to all TPA contacts.
- Enroll 10 clients in the CLEAR program.
- Conduct five health communication/public information (HCPI) events designed to increase knowledge of current HIV status, risk-reduction skills, and partner communication among African American HIV-positive individuals and their negative sexual partners.
- Inform 58 partners of HIV positives or people in their social network of their HIV status.

Child Health Disability Prevention (CHDP) Program

- Conduct universal developmental screening at CHDP pediatric sites to identify children at risk for developmental delay between birth and age three.
- Provide onsite training at 21 CHDP provider offices to implement developmental screening or add a screening interval in their practice.
- Screen 8,191 children using the Ages & Stages Questionnaires (ASQ) and Modified Checklist for Autism in Toddlers (M-CHAT) in pediatric sites/clinics.

Measure A Helps

CAL-PEP

CAL-PEP encountered an HIV-positive male living in a homeless encampment. He engaged in sex work and was a heavy substance user. His focus was supporting his drug use and finding shelter at night. CAL-PEP enrolled him into CLEAR for one-on-one support and case management (CM) services for management of his HIV infection. He received an STD screen and was found to be also infected with syphilis. He was treated that day and a future appointment was made for him to come back for follow-up treatments and lab work.

- Refer 1,596 of these children who scored of concern to the Help Me Grow (HMG) phone line for follow-up, including referral to entitlement services at Regional Center of the East Bay (RCEB) or Alameda County Behavioral Health; family navigation services to assist families in reaching needed services; referrals to play groups or community-based programs; and provision of child development guidance and resources.
- Help ensure that 1,363 children needing follow-up received services.
- Increase the number of low income Medi-Cal or uninsured children screened at nine, 18, and 24 months of age.
- Increase access to primary and specialty care for low income Medi-Cal or uninsured children through education, training, and support to pediatric sites serving these children.
- Recruit and train new Alameda County pediatricians in early childhood mental health and developmental screening.

City and County Neighborhood Initiative (CCNI)

- Develop a leadership training plan and select trainers and curriculum to help expand the program beyond Sobrante Park and West Oakland.
- Partner with residents in select neighborhoods to increase their shared social and political power to enact the change in their neighborhoods that they'd like to see. Residents were provided technical assistance, seed funding, and training.
- Develop resident leadership, community priority setting, and community cohesion. Staff met weekly with leaders in each neighborhood providing training, coaching, and technical support to the infrastructure development of their Resident Action Councils (RACs). Staff also participated in the design and implementation of monthly RAC meetings in each neighborhood, as well as in various community-designed projects. Additionally, staff worked with youth residents in West Oakland to help build their leadership capacity and to eventually integrate them to the larger work of that neighborhood's RAC.
- Engage 12 Sobrante Park resident leaders and six West Oakland leaders in ongoing coaching and technical assistance sessions.
- Have Sobrante Park resident leaders organize 11 community improvement projects and two town hall meetings to help develop cohesion to address the main priorities in Sobrante Park. Across the 11 community projects, 1,108 people participated.
- In West Oakland, have 100% of residents that participated in the coaching sessions use a new skill to organize three projects and activities and hold town hall meetings to select priorities for the RAC participants. 776 community members participated.
- In West Oakland, hold a Juneteenth celebration and resource fair attended by 750 participants. 60 local vendors provided activities and /or resources, and 75 resident participants received blood pressure, diabetes, and glucose health screening. 100% of those with a positive screening result received onsite education and referral to care.

In West Oakland, a Juneteenth celebration and resource fair was attended by 750 participants. 75 resident participants received blood pressure, diabetes, and glucose health screening.

Community Assessment, Planning, and Evaluation (CAPE) Unit

- Complete approximately 190 data requests.
- Have 92% of survey respondents indicate that they were very satisfied with their overall experience with CAPE.
- Have 96% indicate that they were very satisfied or satisfied with the length of time it took to get the data/services from CAPE.

Diabetes

- Provide 16 hours of self-management education to approximately 890 adults with type 2 diabetes and pre-diabetes.
- Produce a monthly newsletter sent to over 375 past participants to keep them informed on diabetes news, provide diabetes-friendly recipes, and present other interesting stories.
- Hold 19 classes attended by 139 people.
- Achieve the following:
  - 97% of clients in the diabetes self-management program implemented positive nutrition lifestyle changes.
  - 82% of clients lost weight.
  - 90% of clients decreased their blood pressure.
  - 98% of clients became more physically active.
  - 89% of clients were at 7% or lower on the blood glucose measurement (A1c) or lower than their original A1c measurement.

97% of clients in the diabetes self-management program implemented positive nutrition lifestyle changes.

East Oakland Boxing Association (EOBA)

- Provide holistic wellness programming for at-risk youth through health and wellness programs including nutrition education, cooking, gardening, and physical education.
- Hold produce distributions once a week, distributing healthy food to 50 EOBA families.
- Offer cooking classes two days per week and sports nutrition classes once per month for 285 East Oakland youth.
- Facilitate two health and nutrition presentations for at least 50 EOBA youth and parents.
- Have all youth participate in daily physical activity and maintain awareness of the importance of being active to improve their health.
- Provide gardening classes three days per week for East Oakland youth focused on access to fresh organic vegetables and fruits, environmental stewardship, physical activity, stress reduction, life/work skills, and leadership.
- Create three educational YouTube videos through the EOBA Urban Fresh Gardeners program.
- Participate in a minimum of two offsite community events and three workshops at EOBA promoting healthy eating, gardening, and/or physical activity.
- Have 21 high school gym participants participate in the community service program, with 75% completing the program. The participants completed a total of 572 community service hours.
- Have 15 youth interns participate in the youth leadership program, with

93% of youth interns retained at the end of the year.

Healthy Retail Project

- Develop an intervention model including store selection, recruitment, and enrollment; store and store owner assessment; technical assistance to store owners on healthy retail; community engagement; product guidelines (alcohol, tobacco, and healthy foods); sales tracking and inventory management systems; store owner and staff training; healthy foods procurement; and marketing.
- Develop and refine the Healthy Retail demonstration project by working with six small corner stores.
- Work with each store to increase healthy food options, reorganize the store to highlight healthier products, and reduce the availability of and advertising for unhealthy products such as tobacco and alcohol products.
- Continue contracting with two local community-based organizations to further develop the program.
- Collect store and customer survey data for evaluation and analysis.

HIV Education and Prevention Project of Alameda County (HEPPAC)

- Have 171 people who inject drugs (PWIDs) increase knowledge of their STI and/or HIV and/or HCV status.
- Provide 200 PWIDs with increased access to primary medical care and holistic health services.
- Have 300 PWIDs increase their knowledge of and/or adopt/identify at least one HIV/HCV risk-reduction strategy.
- Reach 150 PWIDs and link them to HEPPAC abscess/wound care and clinic services. At least 40 PWIDs were unduplicated.
- Provide abscess/wound care services for soft tissue damage due to injection drug use to 126 PWID patients.
- Provide abscess/wound care follow-up services to 84 PWIDs.
- Reinstall and maintain the syringe drop box by collecting on a weekly basis any used and dirty syringes placed in the box. 7,433 used syringes were collected from the box.
- Conduct outreach to 322 PWIDs accessing the drop box location to make them aware of the drop box and provide them with information on how to properly dispose of used syringes and reduce the risk of HIV and Hepatitis C (HCV).
- Provide 104 PWIDs who congregate near the drop box location information on how to properly dispose of used syringes and how to reduce the transmission of HIV, HCV, and other blood-borne pathogens.
- Encourage 306 PWIDs receiving abscess/wound care services to participate in at least one of the following: HIV or HCV testing and counseling services, with 100% participating in at least one service.
- Refer all PWIDs and/or their sexual and/or needle-sharing partners who test positive for HIV and/or HCV and/or an STI to primary care services as needed.

HEPPAC provided 200 PWIDs with increased access to primary medical care and holistic health services and 126 PWIDs with abscess/wound care services for soft tissue damage due to injection drug use.

- Exchange 62,590 sterile syringes for used ones during two, two-hour outdoor syringe exchange sites and one two-hour indoor site. Food, hygiene kits, and other harm-reduction supplies were also provided.
- Conduct at least 25 weekly hours of syringe exchange services.
- Have PWIDs return 148,325 used syringes for sterile syringes during non-fixed exchange site service hours.
- Provide care for 190 PWIDs from HEPPAC's street medicine team at HEPPAC's fixed exchange locations and during non-exchange hours.
- Provide 322 PWIDs with safer injection education, including methods to assist in vein rotation to decrease the number of skin infections and abscesses, with 75% of wound care visitors successfully identifying at least one safer injection technique.
- Have 306 syringe exchange and clinic visitors participate in at least one unstructured workshop. Topics included information on HIV myths and misconceptions. HIV/STI, Hepatitis B and C risk factors and reduction, referrals to Casa Segura, and other social services.
- Have 100% of the unstructured workshop participants identify at least one risk-reduction practice.
- Offer 100% of the unstructured workshop participants HIV and HCV counseling and testing services.
- Reach 161 IDUs during targeted outreach/exchange and inform them of HEPPACs integrated services model. 126 were unduplicated clients.
- Inform and refer 190 PWIDs to health care enrollment services.

Home Visiting and Family Support

- Increase the percentage of in-home, in-person interpretation through pairing of interpreters with home visitors who visit pregnant women and families with young children on a weekly or semi-monthly basis.
- Offer interpreter services in 16 languages.
- Provide 20,123 face-to-face visits to 1,343 families, of whom 347 spoke a language other than English. 630 of these visits used an interpreter.

HOPE Collaborative: A Project of Tides Center

- Develop a healthy retail intervention model and implement it at three stores.
- Provide 150 hours of technical assistance per store.
- Engage a total of 110 residents through surveys and 1,075 through events, workdays, and taste-testing activities.
- Increase the inventory of healthy foods and healthy food sales, and decrease alcohol and tobacco advertising, in all three stores.
- Decrease flavored tobacco products and alcohol products that target youth in two of the three stores.

Immunization

- Work with over 200 health care organizations and immunization providers to ensure data integrity in the California Immunization Registry (CAIR), and help track immunization records for Alameda County children and adults.

Measure A Helps

HOPE COLLABORATIVE/HEALTHY RETAIL

HOPE Collaborative has been partnering with One Stop Liquor's owners to improve the store and increase its provision of fresh and prepared healthy foods. HOPE collaborated with the owners to promote fresh fruit and cereal in the front of the store. The owner recently repaired his refrigerated deli case and now provides fresh eggs, dairy products, and deli meats instead of filling the case with alcohol and junk food. He plans to add a dedicated produce rack and an upright freezer to sell frozen fruit, vegetables, and healthy meals. He is repainting the store's exterior to minimize "liquor" and emphasize "market" or "groceries" in the store's signage.

- Facilitate sending out 3,918 multilingual post cards and placing almost 2,973 phone calls on behalf of doctor offices to remind their patients who were behind on immunizations that it was time to come in and be brought up-to-date.
- Conduct data analysis from the CAIR system to determine participation and success of school-based flu vaccine campaigns.
- Add 104,512 immunization records to CAIR. Recruit new non-health care providers (e.g., schools, child care centers) to join the registry.
- Increase the completion rates for the HPV vaccine series from 57% to 64%, resulting in a completion rate at four health care sites that is much higher than the state and national average.
- Provide training and technical assistance on registry use for medical and non-medical office staff.
- Assist with reminder notices for immunizations due or recall notices for overdue clients.
- Troubleshoot potential issues between data exchanges with medical providers' electronic health record systems.
- Maintain data quality and produce reports for providers.
- Build and support a network of immunization providers and support vaccination efforts in needed areas.
- Identify populations who would benefit from immunization-related projects to prevent communicable diseases.

Lotus Bloom

- Build parent/resident leadership in two neighborhoods, Castlemont and Uptown/West Oakland, to expand health, nutrition, and wellness.
- Host 10 monthly Parent Leader Meetings attended by a total of 59 parents/caregivers, and generate five new ideas and activities for wellness activities at each.
- Implement two wellness activities at program sites.
- Recruit 20 parents at each site to attend the monthly meetings.
- Have 15 participants attend each of the wellness activities, for 90 participants total.
- Train a minimum of three parent leaders on applying for grants, budgeting, program development, evaluation, and reporting.
- Administer eight Saturday Playtimes serving 416 children and 221 parents.
- Support five partner organizations to adopt a healthy food policy.

Mandela MarketPlace

- Develop an intervention model including store selection, recruitment, and enrollment; store and store owner assessment; technical assistance to store owners on healthy retail; community engagement; product guidelines (alcohol, tobacco, and healthy foods); sales tracking and inventory management systems; store owner and staff training; healthy foods procurement; and marketing.
- Develop and refine the Healthy Retail demonstration project by working with three stores.

Measure A Helps

MANDELA MARKETPLACE/HEALTHY RETAIL

Mike and his family have owned Wah Fay Market for over 30 years. The store is busy and well-run, and the owner and staff had a vision for offering more healthy items. The program began by delivering 15 varieties of fruits and vegetables to the store bi-weekly. It also developed and installed a series of marketing materials, including price tags, floor decals, a sandwich board, and a façade banner, removing existing alcohol and tobacco ads. The program introduced Fresh Creds, which offers EBT customer 50% off fresh, canned, dried, and frozen fruits and vegetables. Sales in those categories have increased since the start of Fresh Creds.

- Work with each store to increase healthy food options and reduce the availability of and advertising for unhealthy products such as tobacco and alcohol products.

Niroga Institute

- Provide scholarships to Niroga-trained yoga teachers to participate in weekend module sessions for a period of one year.
- Provide 16 sessions of healing yoga therapy/meditation/stress reduction classes, diabetes prevention and management support groups, and hypertension prevention and management classes to the Alameda County Public Health Department (ACPHD) – Chronic Disease Program's diabetes prevention and management classes.
- Provide yoga therapy/meditation/stress reduction sessions and resources to the San Leandro Senior Center's Diabetes and Wellness Day participants.
- Provide healing yoga therapy/stress reduction/meditation sessions to the Ethnic Health Institute (EHI) – Health Ministry Program's hypertension and prevention management clients.
- Recruit and train up to 12 young adults for a year-long certificated Transformative Life Skills (TLS) Training Program.
- Place graduates in the community with greatest need in primary prevention.
- Monitor the utilization of the 100-hour volunteering commitment of each Integral Health Fellowship (IHF) graduate.
- Recruit four Niroga-trained yoga teachers to participate in weekend module sessions for a period of one year.
- Collaborate with the ACPHD to conduct yoga therapy sessions to at least 200 participants at the Diabetes and Wellness Day in October 2015.
- Develop and distribute short (5-minute) and long (15-minute) yoga therapy protocols for hypertension prevention and management.
- Distribute yoga therapy protocols as follow-up support to at least 10 faith-based organizations in Alameda County.

Nutrition Services

- Staff an epidemiologist in the CAPE unit with a focus on data collection, data analysis, and report development.
- Coordinate with East Oakland Boxing Association and Lotus Bloom on their activities.

Project New Start

- Serve 75–90 youth.
- Rent lasers and purchase medical supplies, food, and beverages.
- Conduct 24 no-cost tattoo removal clinics providing over 1,500–2,000 treatments for very high risk youth, of whom 75% were underinsured or uninsured and formerly adjudicated or gang/drug-involved.
- Provide support service linkage, care-coaching, and guidance for personal and professional development.

Project New Start conducted 24 no-cost tattoo removal clinics providing over 1,500–2,000 treatments for very high risk youth.

- Help 92% of the youth who desired employment acquire and maintain their employment goal by working.
- Help 67% of the youth who desired educational gains progress through their educational goals and work toward certificates or degrees.
- Have 86% of Project New Start youth who received laser tattoo removal treatments report an increase in the quality of life based on their individual goals and overall wellness.

Public Health Nursing

- Provide 326 instances of social services to 495 low income residents of Alameda County including housing assistance, access to public benefits, establishing primary care homes, access to employment, child care, and disability services.
- Help 49% of clients served gain access to services such as cash aid, food, and primary care for the first time.

Public Health Nursing Healthy Living Program

- Conduct four training sessions consisting of nine weeks in length for a total of 43 classes.
- Enroll 34 students who set health-related goals and attended classes.
- Provide students with a healthy snack once a week and a workbook to guide their learning.
- Obtain 100% retention and graduation rates.

Measure A Helps

PUBLIC HEALTH NURSING

An unemployed single mother of four children under the age of 10, who was receiving Cal Fresh and cash aid, was suddenly denied benefits. After several attempts to reach her eligibility worker, she contacted the Public Health Nursing outreach worker. The worker placed a call to a supervisor explaining that the mother was unable to provide food and other necessities for her children. The program manager contacted the eligibility worker and determined that a miscalculation of the mother's income had led to an erroneous denial of benefits. Immediate steps were taken to reinstate the mother's benefits, which she received the following day.

Senior Injury Prevention Program

acphd.org/ipp/sipp.aspx

Allocation: **$103,000** | Expended/Encumbered: **$103,000**

Individuals served by Measure A: **1,649** (Total individuals served: **1,649**)

Populations served: Indigent, Low Income, Uninsured Adults, Seniors

Services provided: Public Health

Service area: Countywide

BACKGROUND

The Alameda County Area Agency on Aging (AAA) works to ensure and sustain a life free from need and isolation for all older Alameda County residents. Through leadership and collaboration, AAA's community-based system of care provides services that support independence, protect the quality of life of older Californians and persons with functional impairments, and promote senior and family involvement in the planning and delivery of services.

AAA's Senior Injury Prevention Program (SIPP) has the following goals:

- Secure and maintain maximum independence and dignity in a home environment of older and functionally impaired persons capable of self-care with appropriate supportive services
- Remove individual and social barriers to economic and personal independence for older persons
- Provide a range of services designed to meet the needs of all consumers who need services, including those who are independent, semi-dependent, and very dependent

The SIPP providers include the following:

- Daybreak Adult Care Centers
- Rebuilding Together Oakland
- Senior Support Program of the Tri-Valley
- St. Mary's Center
- Spectrum
- LIFE ElderCare

Highlights

In all areas, the SIPP providers exceeded their targets, in some cases dramatically. For example, **the target for minor home modifications was 58, while the actual number was 90**—an increase of over 55%.

MEASURE A FUNDING SUMMARY

SIPP providers served 1,649 new seniors in FY 15/16, compared to a target of 1,050 new seniors.

Measure A funding helped SIPP achieve the following:

- Fall risk screening, assessment, and education. A health care professional or paraprofessional used a validated screening tool to

screen and assess the fall risk of older adults. Appropriate education on fall risk reduction, evidence-based physical activities, medication management, and minor home modification referrals was made to meet the client's needs (target for all providers: 602; actual: 840).

- Minor home modifications. The program made residential modifications that were necessary where risk for falls and other risk factors could be reduced or minimized by minor home adaptations (target for all providers: 58 assessments/modifications; actual: 90).
- Physical activity sessions. The program used individual and group exercises using evidenced-based models to improve strength and balance to reduce fall risk (target for all providers: 50; actual: 75).
- Individual/group medication management. The program educated individual groups of older persons, in addition to their families, friends, caregivers, and community individuals, on the safe disposal of and other health measures for managing their medication properly (target for all providers: 196; actual: 246).

The program made 90 residential modifications that were necessary where risk for falls and other risk factors could be reduced or minimized by minor home adaptations.

Service Opportunities for Seniors (Meals on Wheels)

sosmow.org

Allocation: **$16,000** | Expended/Encumbered: **$16,000**

Individuals served by Measure A: **60** (Total individuals served: **1,783**)

Populations served: Indigent, Low Income, Uninsured Seniors

Services provided: Hospital Outpatient, Public Health

Service area: Castro Valley

BACKGROUND

Service Opportunity for Seniors (SOS) Meals on Wheels assists homebound seniors who are in need of supplemental balanced nutrition and a wellness check through a daily home-delivered meal service to prevent early institutionalization and to allow clients to remain safely at home for as long as they can.

Meals on Wheels targets low income seniors who are age 60 and older, homebound, alone, recently discharged from the hospital, or with a physical or mental impairment.

MEASURE A FUNDING SUMMARY

Meals on Wheels used its Measure A allocation to deliver 6,349 meals and provide wellness checks to 60 unduplicated seniors in Castro Valley.

Highlights

- 91% of seniors rated their delivered meals as **good, very good, or excellent**.
- 98% said that the **service they received from their meal delivery driver was excellent**.
- 88% said that receiving a daily meal and wellness check **improved their health and overall living situation**.

Social and Environmental Entrepreneurs, Inc. (Acta Non Verba)

www.saveourplanet.org

Allocation: **$80,000** | Expended/Encumbered: **$80,000**

Individuals served by Measure A: **1,476** (Total individuals served: **2,467**)

Populations served: Low Income Children

Services provided: Public Health

Service area: Emeryville, Oakland

BACKGROUND

Social and Environmental Entrepreneurs (SEE) works to empower, encourage, and catalyze projects to collaborate and facilitate progressive change in areas of social and environmental justice.

MEASURE A FUNDING SUMMARY

SEE used its Measure A allocation to design, develop, and maintain, in collaboration with multiple stakeholders, seven edible gardens in Oakland and Emeryville. The project included development and implementation of tailored Edible Garden Project curriculum that includes nutrition programs for each site.

SEE used its Measure A allocation to design, develop, and maintain seven edible gardens in Oakland and Emeryville.

Spectrum Community Services, Inc. Fall Prevention

spectrumcs.org

Allocation: **$107,289** | Expended/Encumbered: **$107,289**

Individuals served by Measure A: **568** (Total individuals served: **568**)

Populations served: Indigent, Low Income, Uninsured Adults, Families, Seniors

Services provided: Public Health, Mental Health

Service area: Castro Valley, Fremont, Hayward, Newark, Oakland, San Leandro, San Lorenzo, Union City

BACKGROUND

Spectrum Community Services improves the health and safety of seniors and low income residents in Alameda County by enhancing their quality of life and helping them age at home with dignity.

Spectrum's Fall Risk Reduction Program (FRRP) uses a multi-pronged approach to address the physical, behavioral, and environmental factors that contribute to falls. The physical aspect focuses on balance, strength, and flexibility. The behavior aspect educates participants about medication management, primary care physician visits, vision and hearing checks, and healthier eating habits. The environmental aspect educates participants about ways to make the home safer or tips outside of the home to prevent from falling and going to hospitals.

MEASURE A FUNDING SUMMARY

Measure A funding sustains Spectrum's FRRP, enabling it to provide services to seniors at no cost. The program used its Measure A allocation to achieve the following:

- Provide 715 fall prevention class sessions to 568 seniors through one-hour sessions each week at eight County locations (target: 400 seniors).
- Have 64% of seniors attend 40 or more classes with a focus on balance, upper- and lower-body strength, and flexibility. By attending these classes, seniors gained useful knowledge about daily living skills, eating healthier, and making good choices to avoid falls.
- Conduct a one-on-one consultation with seniors who experience a fall within 48 hours of notification to identify factors that caused the incident and recommend home modifications and home exercises to prevent future falls.
- Conduct seven fall prevention workshops for 368 senior participants (target: four workshops).
- Evaluate participants on improvement in strength, mobility, and balance, with the following results:
  - Strength: 59% improved, 30% maintained
  - Mobility: 45% improved, 39% maintained
  - Balance: 54% improved, 34% maintained

Measure A Helps

Anne, 74, has difficulty with tremors and balance. Her doctors haven't been able to come up with a diagnosis. She has been going to the fall prevention program for three years and says, "I don't know what I would do without this program." Anne struggles some days, while other she stays balanced and says, "I did it." When the instructor first met Anne, her posture was very poor and she did not have the confidence to go out many places. Anne has more confidence to go out in public now as she is taking classes at the local community college. Anne's quality of life has grown because of this program.

Spectrum Community Services, Inc. Senior Nutrition Program

spectrumcs.org

Allocation: **$12,004** | Expended/Encumbered: **$12,004**

Individuals served by Measure A: **59** (Total individuals served: **4,322**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors

Services provided: Public Health

Service area: Fremont, Hayward, Newark, Union City, Outside of Alameda County, Homeless or transient

BACKGROUND

Spectrum Community Services improves the health and safety of seniors and low income residents in Alameda County by enhancing their quality of life and helping them age at home with dignity.

The Spectrum Senior Nutrition Program offers weekly evening meals that include whole grains, fruits, vegetables, and dairy, thus helping to supplement clients' nutrient intake. The program also provides socialization to participants.

MEASURE A FUNDING SUMMARY

The Spectrum Senior Nutrition Program used its Measure A allocation to serve 2,035 meals to 59 unduplicated clients. 100% of the meals provided met the Title IIIC nutrition guidelines for servings of fruits and vegetables at each meal.

Highlights

94% of clients surveyed would **recommend the meals program** to someone they know.

Timelist Group Inc.

Allocation: **$5,000** | Expended/Encumbered: **Unknown**

Individuals served by Measure A: **Unknown**

Populations served: Low Income Adults, Children, Families

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Fremont, Hayward, Newark, Union City

BACKGROUND

Timeless Group, Inc. focuses on rehabilitation, education, skills development, and job placement for pre- and post-release prisoners, including juveniles and low income families. Timelist Group aims to end the cycle of violence, crime, poverty, and recidivism through community services, resources, and educational programs.

MEASURE A FUNDING SUMMARY

Timelist Group planned to use its Measure A funding to provide probation-based services to incarcerated juveniles, unemployed youth, and adult parolees and probationers as well as low income households residing in Union City, Fremont, Newark, and South Hayward. These re-entry and reintegration services are limited to medical, mental health, and/or substance abuse treatment referral services.

CONCERN

This provider did not supply any Measure A funding information for FY 15/16. Therefore, the Committee cannot evaluate whether funds were spent in accordance with the strictures of Measure A.

Youth and Family Opportunity Initiatives

achealthyschools.org/youth-development.html

Allocation: **$2,597,818** | Expended/Encumbered: **$2,597,818**

Individuals served by Measure A: **16,588** (Total individuals served: **16,588**)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families

Services provided: Mental Health, Substance Abuse

Service area: Countywide

BACKGROUND

The Center for Healthy Schools and Communities works to foster the academic success, health, and well-being of Alameda County youth by building universal access to high quality supports and opportunities in schools and neighborhoods.

The goal of the countywide Youth and Family Opportunity (YFO) initiative is to provide coordination of care, referrals, mental health services, and other types of health supports to underserved youth and families across the County.

The YFO organizations provide services focusing on mental health, public health, alcohol and drugs, and youth and community. In addition, YFO organizations provide a continuum of integrated and high quality programs and services through effective care coordination. Care coordination ensures that youth and families are connected to formal and informal supports, providers, and community across their lives to support achievement of positive health and life outcomes.

The organizations involved in the YFO initiative include the following:

- Alameda Family Services
- Alternatives in Action (AIA)
- Berkeley Youth Alternatives (BYA)
- East Bay Asian Youth Center (EBAYC)
- Fremont Family Resource Center
- La Familia Counseling Service
- Newark Unified School District
- REACH Ashland Youth Center
- Tri-Valley Health Initiative
- Union City Kid Zone
- Youth Radio

The YFO organizations offer family support and youth development services as part of their holistic programming, and may serve as the safety net for a young person or family who is just short of extreme crisis.

Highlights

Measure A funding enabled the CBOs participating in the YFO initiative to achieve a **wide variety of outcomes for a large number of youth and their families.**

Satisfaction rates for YFO programs averaged **95% for youth and 97% for families**.

- Alameda Family Services provides an array of health and wellness services to families, including information and referrals, health and benefit enrollment assistance, case management, and workshops.
- AIA provides behavioral health services, youth development activities, and gender-based empowerment groups with topics includeing healthy living, violence prevention, restorative justice and conflict resolution techniques, relationship-building, trauma recovery, anti-oppressive education, and social justice.
- BYA provides culturally competent psycho-social, mental, and emotional health services to low income and poverty-level children and youth ages 6–18 and their families.
- EBAYC provides school-day and after-school holistic supports, including individual case management, mental health, health education, and youth development activities.
- Fremont Family Resource Center provides a wide array of health, wellness, and basic needs supports to families, including counseling and behavioral health services for individuals and groups.
- La Familia offers individual, family, and group mental health services, crisis support, onsite Medi-Cal and Cal Fresh clinics, and family support referrals to children, youth, and families.
- Newark Unified School District provides health and dental health services, health education, and health enrollment and benefit referrals.
- REACH Ashland Youth Center offers a variety of programs for youth that increase their healing, sense of connection, and belonging as well as increasing their access to health care.
- The Tri-Valley Health Initiative supports Community Health and Wellness Events in Pleasanton, Dublin, and Livermore to provide physical, dental, and vision health screening and referrals, as well as health care enrollment to youth and families.
- Union City Kids Zone offers behavioral health prevention groups and workshops, acculturation groups for new immigrants, girls' empowerment, mindfulness groups, and an array of youth development activities.
- Youth Radio provides wraparound health and wellness support to youth enrolled in their media arts education and internship placement program, with services including assessment, behavioral health services, healthy food, and individual advising.

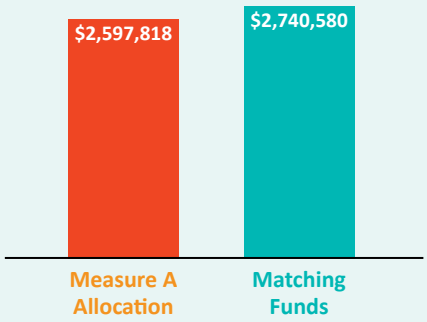
MEASURE A FUNDING SUMMARY

Through the Measure A YFO initiative grant, 16,588 clients were served during FY 15/16.

Client results were obtained across a variety of service areas, including:

- Youth-focused individual and group counseling, case management, mental health, alcohol and drug assessment, and referrals
  - 2,214 youth were seen in groups.
  - 3,194 youth received individual services.

Matching Funds



The participating CBOs leveraged the YFO initiative Measure A allocation to obtain **$2,740,580 in matching funds** from the following sources:

- Medi-Cal Administrative Activities (MAA)
- Alameda County funding: Probation Department, Social Services Administration
- Local and national foundations
- Federal grants
- Cities

- Family-focused individual and group counseling, case management, mental health services, alcohol and drug assessment, and referrals
  - 284 families were served in groups.
  - 3,771 families received services one-on-one.
- Youth leadership development and enrichment activities on improving personal growth, health and wellness, academic achievement, and creating career opportunities
  - 5,592 youth benefited from these services.
- Family engagement in schools focusing on health and wellness, work readiness, and life skills
  - 6,425 families benefited from these services.
- Referrals made for additional health and wellness services
  - 3,324 youth and adults were referred to outside services.
- Community events focus on raising awareness of free and affordable health care services
  - 304 community events were held.
  - 12,495 contacts were made at the events.
- Community health fairs providing children and families in Livermore, Dublin, and Pleasanton with health information and service
  - Three health fairs were held, attended by 600 residents.
  - 47 organizations collaborated.
  - 103 physicals, including sports physicals, were conducted.
  - 35 immunizations were provided.
  - 135 dental screenings, 138 vision screenings, and 83 hearing screenings were provided.

90% of East Bay Asian Youth Center after-school program participants said the program helped them believe they can finish high school.

The member CBOs used their YFO Initiative Measure A allocation to achieve the following.

Alternatives in Action

- At the McClymonds Youth and Family Center, 89% of students reported an increase in self-esteem.

Berkeley Youth Alternatives

- Youth demonstrated an overall increase in resilience, and better understanding of themselves and others.
- Participants showed improvement in reductions in marijuana use, improved attendance in school, and improved perspective on the importance of finishing high school and going to college.

East Bay Asian Youth Center

- 94% of after-school program participants reported that the program helped them to feel more confident about what they can do.
- 90% said the program helped them believe they can finish high school.
- 71% said that the program helped them learn how to be healthy.

Fremont Family Resource Center

- 74% of clients reported social-emotional stability at discharge, a 35% positive change.

- 72% of clients reported stability of family relationship at discharge, a positive change of 18%.
- 75% of families served reported being in stable housing at discharge, a positive change of 45%.
- 88% of families reported being stable related to food/clothing at discharge, a 36% positive change.
- 72% of clients reported stability of employment at discharge, a positive change of 30%.
- 66% of clients reported having stable finances at discharge, a 36% positive change.
- Youth clients demonstrated improved school attendance and reduced disciplinary incidents at school.

Newark Unified School District

- Administrators saw increased parent participation in their children's education, increased advocacy, and improved ability to seek health, wellness, and basic needs resources.
- Children of families served showed increased social-emotional intelligence and awareness.

REACH Ashland Youth Center

- The Fuente health clinic provided more than 1,000 clients with more than 4,750 clinic visits.
- 86% of those surveyed said that the clinic helped them get help sooner than they normally would.
- 85% said the clinic helped them get services they would not otherwise get.
- Clients reported making better decisions regarding practicing safer sex and/or using birth control (83%), exercising more (75%), and using less tobacco, alcohol, and/or drugs (49%).
- Youth surveyed said that REACH AYC program/activity they engaged in helped them feel happier (79%), feel more confident (79%), and deal better when stressed (64%).
- 84% indicated that they had learned specific skills or increased their knowledge in the program area.
- 85% reported that they learned skills that will help them in their future.
- 79% agreed that participating in REACH programming helped with their future planning.

Union City Kids Zone

- The percentage of children served who met 75% of their social-emotional indicators by the end of trimester 1 increased from 30% to 48%.
- The number of students who were on track to college- and career-readiness increased by 26%, based on the number of students passing Algebra by the end of ninth grade.

Measure A Helps

FREMONT FAMILY RESOURCE CENTER

David, a third-grader, came to live with his grandparents in Fremont due to abuse and neglect from his biological parent. David began to see a counselor at school, who linked David and his family to the Fremont Family Resource Center for assistance with food and health care benefits. The Center also connected the family to the Shop with a Cop program, which provided the entire family with holiday gifts as well as a positive interaction with Fremont Police. Due to the coordinated support, David was able to settle into his new home, school, and community, and feel safe.

Youth Radio

- 95% of Youth Radio participants indicated that social-emotional intelligence increased over the course of the session, including communication and self-management.
- Over 80% agreed with the statement, "My leadership skills have increased over the course of the session."
- 95% of seniors graduated high school.
- 90% of students were admitted and expected to matriculate into college.

95% of Youth Radio participants indicated that social-emotional intelligence increased over the course of the session.

Youth UpRising

youthuprising.org

Allocation: **$28,465** | Expended/Encumbered: **$28,465**

Individuals served by Measure A: N/A (Total individuals served: N/A)

Populations served: N/A

Services provided: N/A

Service area: N/A

Note: Provider did not provide direct services through its Measure A allocation in FY 15/16.

BACKGROUND

Youth UpRising works to transform East Oakland into a healthy and economically robust community by developing the leadership of youth and young adults and improving the systems that impact them. Youth UpRising's primary focus is building a systems change and community economic development platform that supports and strengthens personal transformation work.

MEASURE A FUNDING SUMMARY

During FY 15/16, Youth UpRising used its Measure A allocation to develop direct services that will be provided in FY 16/17. Targeted services include mental health consultation, staff development, parent wellness awareness groups, and behavioral interventions for students.

Youth UpRising used its Measure A allocation to develop direct services that will be provided in FY 16/17.

APPENDICES

APPENDIX A: MEASURE A REVENUE RECEIVED

APPENDIX B: FY 15/16 BUDGET INFORMATION

APPENDIX C: FY 15/16 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

APPENDIX D: MAPS: GEOGRAPHIC DISTRIBUTION OF PROVIDERS FUNDED BY MEASURE A IN FY 15/16

Map 1 Alameda County Public Health Programs

Map 2 Alameda County Behavioral Health Care Services
Alcohol and Other Drug Providers

Map 3 Alameda County Behavioral Health Care Services
Mental Health Community-Based Organization Providers

Map 4 School Health Centers

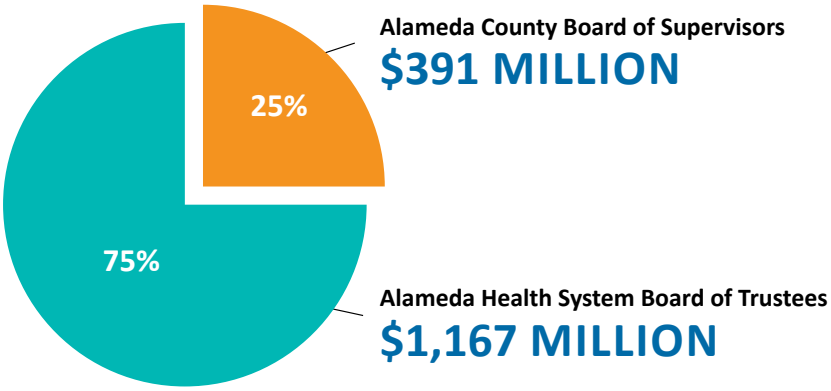
Map 5 HealthPAC Provider Network

APPENDIX A

MEASURE A REVENUE RECEIVED

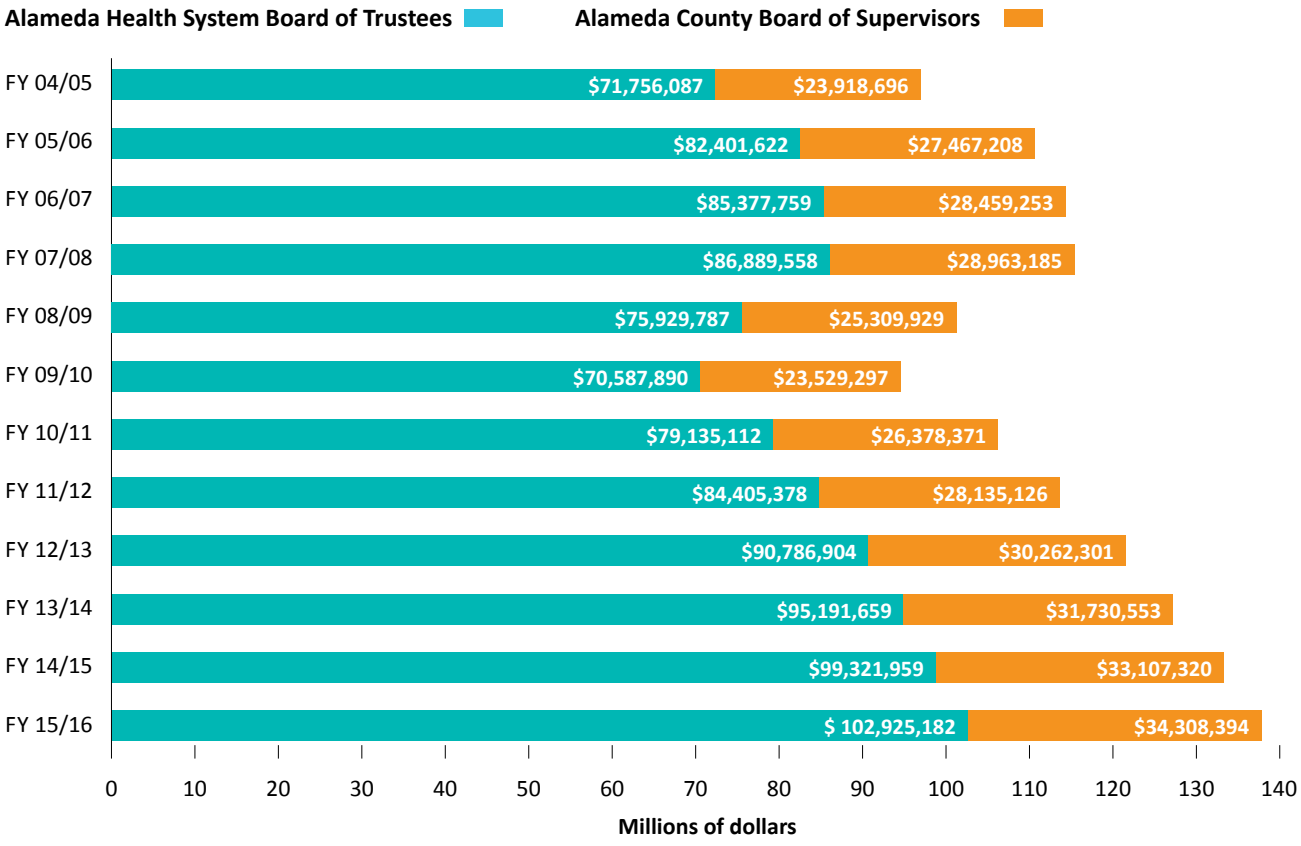
FY 04/05 through FY 15/16

TOTAL REVENUE EARNED (FY 04/05 THROUGH FY 15/16)



$1.56 BILLION

REVENUE EARNED EACH FISCAL YEAR (FY 04/05 THROUGH FY 15/16)



APPENDIX B: FY 15/16 BUDGET INFORMATION

	TOTAL ALLOCATION	CARRYOVER FROM PREVIOUS FISCAL YEAR[1]	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR[1]	TOTAL	SAVINGS[2]
Group 1: Behavioral Health							
Alameda County Behavioral Health Care Services (BHCS) Community-Based Organizations (CBOs)	775,848	0	775,848	521,742	0	521,742	254,106
Center for Empowering Refugees and Immigrants (CERI)	80,371	0	80,371	80,371	0	80,371	0
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	622,356	0	622,356	622,356	0	622,356	0
Cherry Hill Detoxification and Sobering Center	2,143,224	365,358	2,508,582	1,996,448	512,134	2,508,582	0
Criminal Justice Screening and In-Custody Services	4,306,000	0	4,306,000	4,306,000	0	4,306,000	0
Mental Health Services for Juvenile Justice Center	360,000	0	360,000	360,000	0	360,000	0
Group 2: Hospital, Tertiary Care, Other							
Administration/Infrastructure Support	400,000	0	400,000	252,987	0	252,987	147,013
San Leandro Hospital	1,000,000	0	1,000,000	1,000,000	0	1,000,000	0
St. Rose Hospital	2,000,000	0	2,000,000	2,000,000	0	2,000,000	0
UCSF Benioff Children's Hospital Oakland	2,000,000	0	2,000,000	2,000,000	0	2,000,000	0
Group 3: Primary Care							
Alameda County Dental Health	157,580	0	157,580	157,580	0	157,580	0
Center for Elders' Independence	53,581	0	53,581	53,581	0	53,581	0
Center for Healthy Schools and Communities (School Health Centers)	1,957,784	0	1,957,784	1,957,784	0	1,957,784	0
Community Initiatives (Day Labor Center)	60,000	0	60,000	60,000	0	60,000	0
Connecting Kids to Coverage (CKC) Initiative	255,105	0	255,105	255,105	0	255,105	0
Direct Medical and Support Services (Oakland): Preventive Care Pathways	214,332	0	214,332	214,332	0	214,332	0
Fire Station Health Portals[1]	750,000	577,792	1,327,792	1,120,286	207,506	1,327,792	0
Fremont Aging and Family Services	53,581	0	53,581	53,581	0	53,581	0
Health Enrollment for Children	300,000	0	300,000	300,000	0	300,000	0
Health Services for Day Laborers	267,903	0	267,903	267,903	0	267,903	0
Increase Hospice Utilization: Getting the Most Out of Life Program	200,000	0	200,000	179,042	0	179,042	20,958
Medical Costs for Juvenile Justice Center	505,963	0	505,963	493,163	0	493,163	12,800
Primary Care Community-Based Organizations	**5,870,494**	**0**	**5,870,494**	**5,870,494**	**0**	**5,870,494**	**0**

Continued on next page

	TOTAL ALLOCATION	CARRYOVER FROM PREVIOUS FISCAL YEAR[1]	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR[1]	TOTAL	SAVINGS[2]
Group 4: Public Health							
Alameda Boys & Girls Club, Inc.	107,161	0	107,161	107,161	0	107,161	0
Alameda County Asthma Start	100,000	0	100,000	100,000	0	100,000	0
Center for Early Intervention on Deafness	53,581	0	53,581	53,581	0	53,581	0
City of San Leandro	53,581	0	53,581	53,581	0	53,581	0
Eden Youth and Family Center	50,000	0	50,000	50,000	0	50,000	0
Emergency Medical Services Corps	604,942	0	604,942	604,942	0	604,942	0
Emergency Medical Services Health Coach Program	236,000	0	236,000	178,266	0	178,266	57,734
HIV Education & Prevention Project of Alameda County: OPEND Project	150,000	0	150,000	150,000	0	150,000	0
HIV Education & Prevention Project of Alameda County: Syringe Exchange Program	150,000	0	150,000	150,000	0	150,000	0
LifeLong Medical Care: Emery School Health Center	98,000	0	98,000	98,000	0	98,000	0
LifeLong Medical Care: Heart 2 Heart	100,000	0	100,000	100,000	0	100,000	0
Public Health Prevention Initiative	3,081,008	0	3,081,008	3,081,008	0	3,081,008	0
Senior Injury Prevention Program	103,000	0	103,000	103,000	0	103,000	0
Youth and Family Opportunity Initiatives[1]	2,597,818	206,225	2,804,043	2,786,963	17,080	2,804,043	0
Youth UpRising	28,465	0	28,465	28,465	0	28,465	0
Board of Supervisors[1]	750,000	370,601	1,120,601	687,831	432,770	1,120,601	0
TOTAL FY 15/16[3]	**32,197,725**	**1,519,976**	**33,717,701**	**32,491,251**	**1,169,490**	**33,660,741**	**56,960**

1. The Board of Supervisors approved certain allocations to carry over unexpended funds to the next fiscal year. The carryover funds must be used for the same purpose for which the Board approved the original allocation.

2. Savings are unexpended funds that will revert to the general Measure A account for reallocation in future fiscal years.

3. The total allocation includes Measure A Base and Measure A One-Time Allocations approved by the Board of Supervisors for FY 15/16.

4. Cherry Hill Detoxification and Sobering Center's carryover balance includes carryover of unexpended funds from the Board-approved original allocation and any unspent funds from subsequent Board-approved allocations.

APPENDIX C:
FY 15/16 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

	MEASURE A ALLOCATION FY 15/16	EXPENDED/ ENCUMBERED FY 15/16
GROUP 1: BEHAVIORAL HEALTH		
Alameda County Behavioral Health Care Services Community-Based Organizations		
Alameda County Mental Health Association	37,503	31,701
Alameda Family Services	4,696	1,830
Asian Community Mental Health Board	9,575	0
Axis Community Health, Inc.	7,187	2,929
Berkeley Addiction Treatment Services, Inc.	5,349	2,245
Bi-Bett Corporation	2,857	2,125
Bonita House, Inc.	57,234	6,941
Building Opportunities for Self-Sufficiency (BOSS)	31,665	27,831
Carnales Unidos Reformando Adictos, Inc.	23,356	23,356
Center for Independent Living	2,452	2,452
Community Health for Asian Americans	2,505	2,293
Crisis Support Services of Alameda County	33,119	33,119
East Bay Community Recovery Project	36,687	32,494
FamiliesFirst Inc.	30,719	30,719
Filipinos Advocates for Justice	15,359	15,359
Horizon Services, Inc.	13,713	10,628
Humanistic Alternatives to Addiction	2,479	1,198
Magnolia Women's Recovery Programs, Inc.	6,622	5,883
Native American Health Center, Inc.	27,807	20,993
New Bridge Foundation, Inc.	47,487	40,586
Second Chance, Inc.	51,578	51,368
Senior Support Program of the Tri Valley	32,836	32,836
Southern Alameda County Committee for Raza	108,132	105,082
St. Mary's Center	34,883	34,883
Thunder Road-Adolescent Treatment	10,182	842
West Oakland Health Council, Inc.	25,132	2,049
Unallocated	114,732	-
Total Allocation	**775,848**	**521,742**
Center for Empowering Refugees and Immigrants (CERI)	**80,371**	**80,371**
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)		
Emery Unified School District	37,506	37,506
Hume Center	133,952	133,952
West Coast Childrens Clinic	51,900	51,900
Other Program Expenses	398,998	398,998
Total Allocation	**622,356**	**622,356**
Cherry Hill Sobering and Detoxification Center	**2,143,224**	**1,996,448**

	MEASURE A ALLOCATION FY 15/16	EXPENDED/ ENCUMBERED FY 15/16
GROUP 1: BEHAVIORAL HEALTH (CONTINUED)		
Criminal Justice Screening and In-Custody Services	**4,306,000**	**4,306,000**
La Familia Counseling Service	**50,000**	**50,000**
Mental Health Services for Juvenile Justice Center	**360,000**	**360,000**
Safe Alternatives to Violent Environments (SAVE)	**40,000**	**40,000**
Senior Support Program of Tri-Valley	**20,000**	**20,000**

	MEASURE A ALLOCATION FY 15/16	EXPENDED/ ENCUMBERED FY 15/16
GROUP 2: HOSPITAL, TERTIARY CARE, OTHER		
Direct Service Planning and Administration	**400,000**	**252,987**
San Leandro Hosptial	**1,000,000**	**1,000,000**
St. Rose Hospital	**2,000,000**	**2,000,000**
UCSF Benioff Children's Hospital Oakland	**2,000,000**	**2,000,000**

	MEASURE A ALLOCATION FY 15/16	EXPENDED/ ENCUMBERED FY 15/16
GROUP 3: PRIMARY CARE		
Alameda County Dental Health	**157,580**	**157,580**
Center for Elders' Independence	**53,581**	**53,581**
Center for Healthy Schools and Communities (School Health Centers)		
Alameda Family Services	203,607	203,607
City of Berkeley	128,594	128,594
East Bay Agency for Children	4,964	4,964
East Bay Asian Youth Center	49,187	49,187
La Clinica de La Raza, Inc.	202,574	202,574
LifeLong Medical Center	61,000	61,000
Native American Health Center	113,500	113,500
Seneca Family of Agencies	40,000	40,000
Tiburcio Vasquez Health Center	219,681	219,681
UCSF Benioff Children's Hospital Oakland	98,374	98,374
University of California, San Francisco	135,269	135,269
Other Program Expenses	701,034	701,034
Total Allocation	**1,957,784**	**1,957,784**
Community Initiatives	**60,000**	**60,000**
Connecting Kids to Coverage (CKC) Initiative	**255,105**	**255,105**
Direct Medical and Support Services (Oakland): Preventive Care Pathways	**214,322**	**214,322**
Fire Station Health Portals	**750,000**	**1,120,286**
Fremont Aging and Family Services	**53,581**	**53,581**
Health Enrollment for Children	**300,000**	**300,000**

	MEASURE A ALLOCATION FY 15/16	EXPENDED/ ENCUMBERED FY 15/16
GROUP 3: PRIMARY CARE (CONTINUED)		
Health Services for Day Laborers		
Health Services for Day Laborers: Community Initiatives (Day Labor Center)	89,301	89,301
Health Services for Day Laborers: Multicultural Institute	89,301	89,301
Health Services for Day Laborers: Street Level Health Project	89,301	89,301
Total Allocation	**267,903**	**267,903**
Hospice: Getting the Most Out of Life Program	**200,000**	**179,042**
Medical Costs for Juvenile Justice Services		
Medical Costs for Juvenile Justice Center: Direct Service Planning and Administration	261,000	261,000
Medical Costs for Juvenile Justice Center: Mind Body Awareness Project	58,939	58,939
Medical Costs for Juvenile Justice Center: Niroga Institute	83,224	83,224
Medical Costs for Juvenile Justice Center: Victims of Crime	102,800	90,000
Total Allocation	**505,963**	**493,163**
Primary Care Community-Based Organizations		
Alameda Health Consortium		
Asian Health Services	634,808	634,808
AXIS Community Health Center	663,694	663,694
La Clínica de La Raza	1,867,781	1,867,781
LifeLong Medical Center	721,610	721,610
Native American Health Center	279,930	279,930
Tiburcio Vasquez Health Center	904,478	904,478
Tri-City Health Center	615,035	615,035
West Oakland Health Council	183,158	183,158
Total Allocation	**5,870,494**	**5,870,494**
Tiburcio Vasquez	**60,000**	**60,000**
Washington Hospital	**33,000**	**33,000**

	MEASURE A ALLOCATION FY 15/16	EXPENDED/ ENCUMBERED FY 15/16
GROUP 4: PUBLIC HEALTH		
ACCMA Community Health Foundation	**37,840**	**37,840**
Alameda Boys & Girls Club, Inc.	**107,161**	**107,161**
Alameda County Asthma Start	**100,000**	**100,000**
Alameda County Breastfeeding Coalition Childcare Taskforce	**6,900**	**6,900**
Center for Early Intervention on Deafness	**53,581**	**53,581**
City of San Leandro Senior Services	**53,581**	**53,581**
Drivers for Survivors, Inc.	**10,000**	**10,000**
East Oakland Community Project	**30,000**	**30,000**
Eden Youth and Family Center	**75,000**	**75,000**
Emergency Medical Services Corps		
Snowy River EMS Productions, Inc.	56,100	56,100
Other Program Expenses	548,842	548,842
Total Allocation	**604,942**	**604,242**

	MEASURE A ALLOCATION FY 15/16	EXPENDED/ ENCUMBERED FY 15/16
GROUP 4: PUBLIC HEALTH (CONTINUED)		
Emergency Medical Services Health Coach Program	**236,000**	**236,000**
Genesis Worship Center	**5,000**	**5,000**
HIV Education and Prevention Project of Alameda County (HEPPAC): OPEND Project	**150,000**	**150,000**
HIV Education and Prevention Project of Alameda County (HEPPAC): Syringe Exchange Program	**150,000**	**150,000**
LIFE ElderCare	**32,698**	**32,698**
LifeLong Medical Care: Emery School Health Center	**98,000**	**98,000**
LifeLong Medical Care: Heart 2 Heart	**100,000**	**100,000**
Love Never Fails	**10,000**	**10,000**
Mandela MarketPlace, Inc.	**10,000**	**10,000**
National Health Care Decisions Day	**1,500**	**1,500**
Public Health Prevention Initiative		
CAL-PEP Inc.	48,566	48,566
Center for Oral Health	67,262	134,524
City of Berkeley	180,835	180,835
East Oakland Boxing Association	52,530	52,530
Earth Island Institute	10,300	10,300
Emergency Medical Services Injury Prevention	210,112	210,112
Higher Ground Neighborhood Development	56,587	174,400
HIV Education and Prevention Project of Alameda County	194,150	44,150
Lotus Bloom	34,145	34,145
Lucile Packard Children's Hospital Stanford	41,613	41,613
Mandela MarketPlace	182,024	110,622
Niroga Institute, Inc.	56,771	36,771
Tides Center	140,000	68,598
Subtotal Program Expenses	1,264,595	1,147,166
Other Program Expenses	1,816,413	1,839,692
Total Allocation	**3,081,008**	**2,986,858**
Senior Injury Prevention Program	**103,000**	**103,000**
Service Opportunity for Seniors (Meals on Wheels)	**16,000**	**16,000**
Social and Environmental Entrepreneurs, Inc. (Acta Non Verba)	**155,600**	**155,600**
Spectrum Community Servies, Inc.: Fall Prevention Program	**107,289**	**107,289**
Spectrum Community Servies, Inc.: Senior Meals	**12,004**	**12,004**
Timelist Group, Inc.	**5,000**	**5,000**
Youth and Family Opportunity Initiatives		
Alameda Family Services	107,161	107,161
Alternatives in Action (AIA)	278,211	278,211
Berkeley Youth Alternatives (BYA)	107,161	107,161
City of Fremont	163,863	163,863
Dublin Unified School District	17,860	17,860
East Bay Agency for Children for CKC	17,330	17,330
East Bay Asian Youth Center (EBAYC)	107,161	107,161
Fremont Unified School District	107,161	107,161
La Clinica de La Raza	112,519	112,519

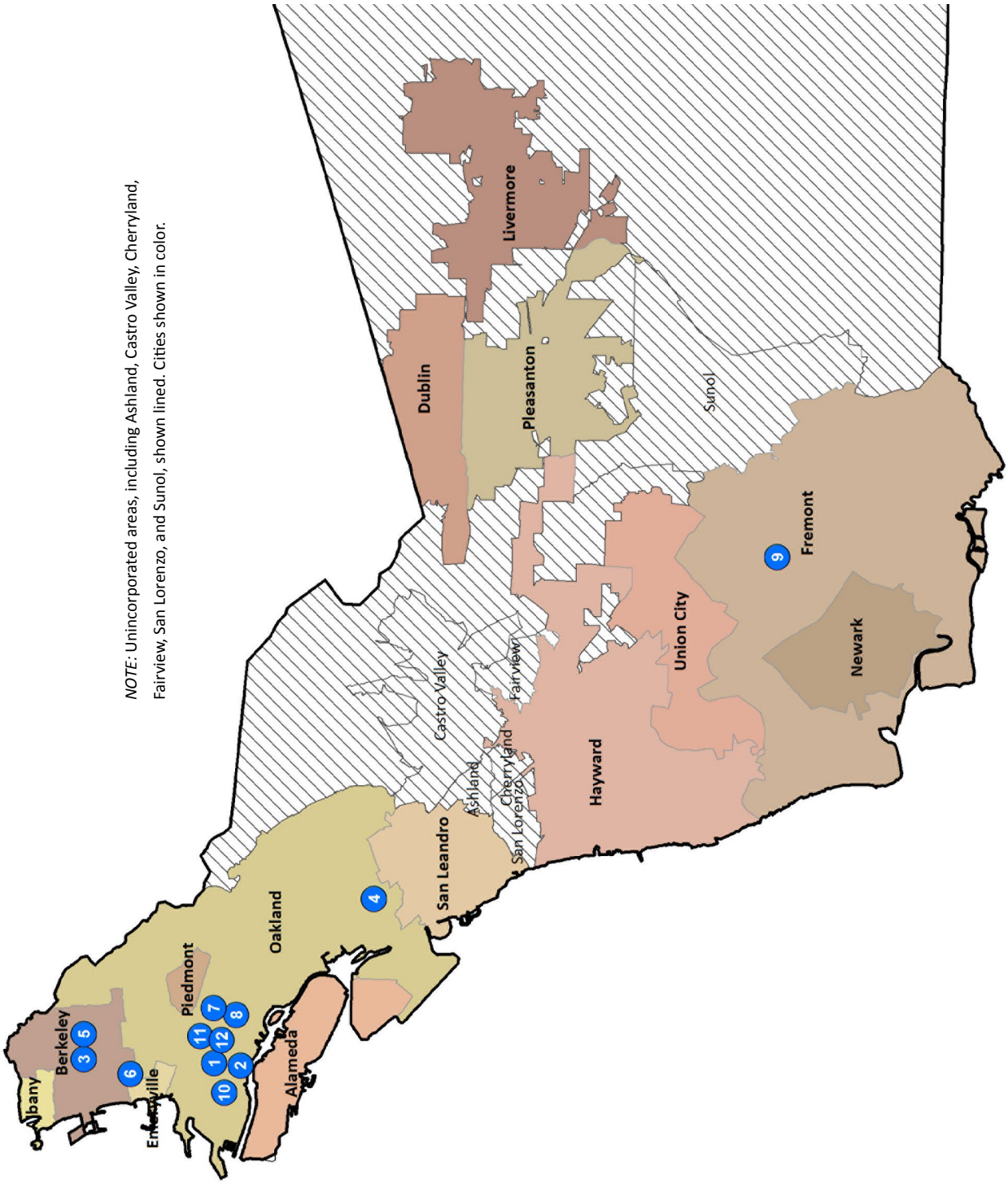
	MEASURE A ALLOCATION FY 15/16	EXPENDED/ ENCUMBERED FY 15/16
GROUP 4: PUBLIC HEALTH (CONTINUED)		
Youth and Family Opportunity Initiatives (Continued)		
Livermore Unified School District	17,860	17,860
Newark Unified School District	111,201	111,201
New Haven Unified School District	107,161	107,161
Pleasanton Unified School District	17,860	17,860
Spanish Speaking Unity Council (LMB)	64,297	64,297
Southern Alameda County Committee for Raza	160,742	160,742
Youth Radio	107,161	107,161
Other Program Expenses	993,109	993,109
Total Allocation	**2,597,818**	**2,597,818**
Youth UpRising	**28,465**	**28,465**

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS FUNDED BY MEASURE A IN FY 15/16

#	PROVIDER	CITY
1	California Prevention and Education	Oakland
2	Center for Oral Health	Oakland
3	City Of Berkeley	Berkeley
4	East Oakland Boxing Association	Oakland
5	Earth Island Institute	Berkeley
6	Higher Ground Neighborhood Development	Oakland

#	PROVIDER	CITY
7	HIV Education and Prevention Project of Alameda County	Oakland
8	Lotus Bloom	Oakland
9	Lucile Packard Children's Hospital Stanford	Fremont
10	Mandela Market Place	Oakland
11	Niroga Institute, Inc	Oakland
12	Tides Center (Hope Collaborative)	Oakland

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS
FUNDED BY MEASURE A IN FY 15/16



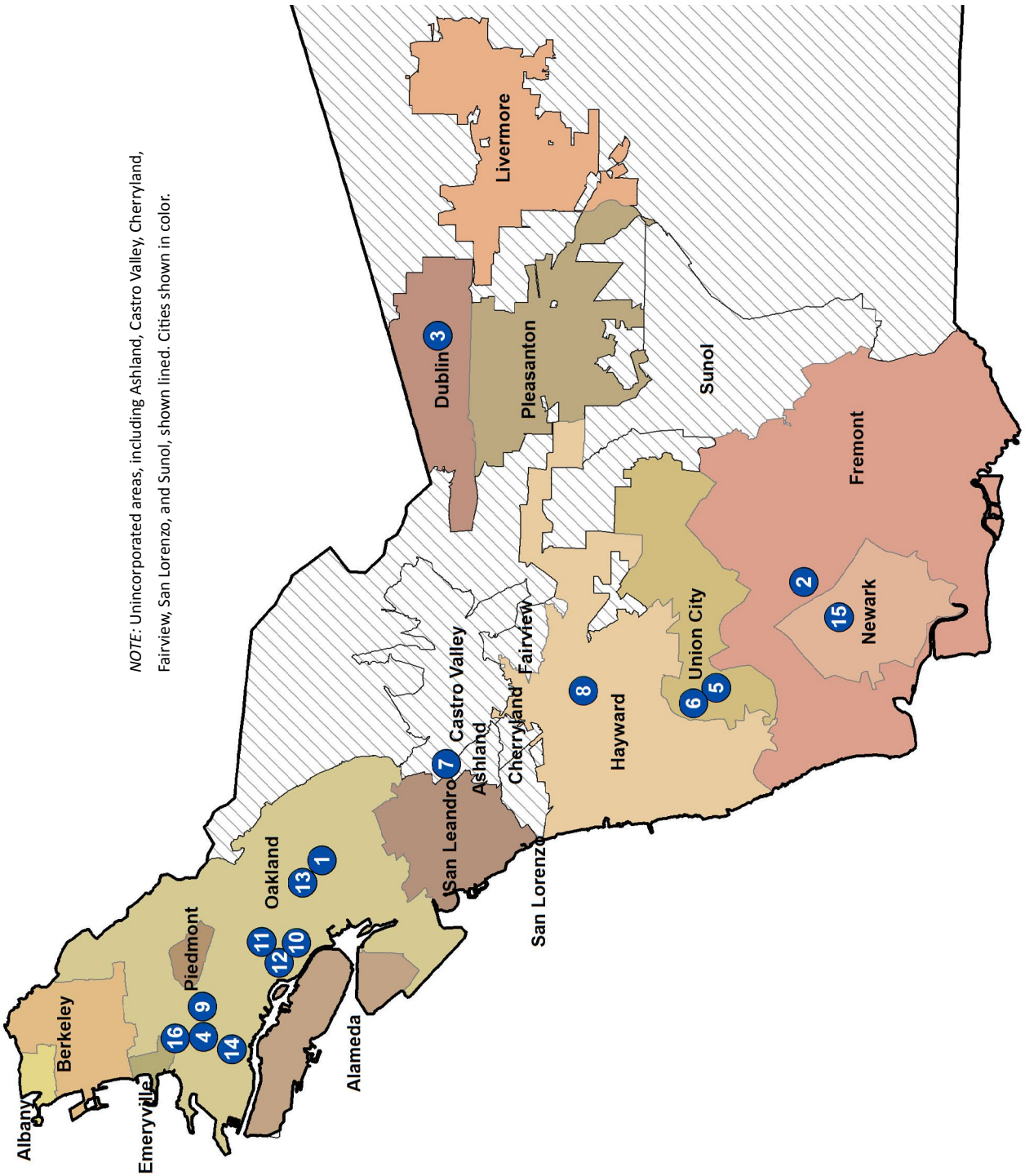
NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES ALCOHOL AND OTHER DRUG PROVIDERS FUNDED BY MEASURE A IN FY 15/16

#	PROVIDER	CITY
1	Bi-Bett Corporation	Oakland
2	Carnales Unidos Reformando Adictos	Fremont
3	East Bay Community Recovery Project	Dublin
4	East Bay Community Recovery Project	Oakland
5	EMQ FamiliesFirst	Union City
6	Filipino Advocates for Justice	Union City
7	Horizon Services, Inc.	San Leandro
8	La Familia	Hayward

#	PROVIDER	CITY
9	La Familia	Oakland
10	La Familia	Oakland
11	La Familia	Oakland
12	Native American Health Center, Inc.	Oakland
13	New Bridge Foundation, Inc.	Oakland
14	New Bridge Foundation, Inc.	Oakland
15	Second Chance, Inc.	Newark
16	St. Mary's Center	Oakland

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
ALCOHOL AND OTHER DRUG PROVIDERS
FUNDED BY MEASURE A IN FY 15/16

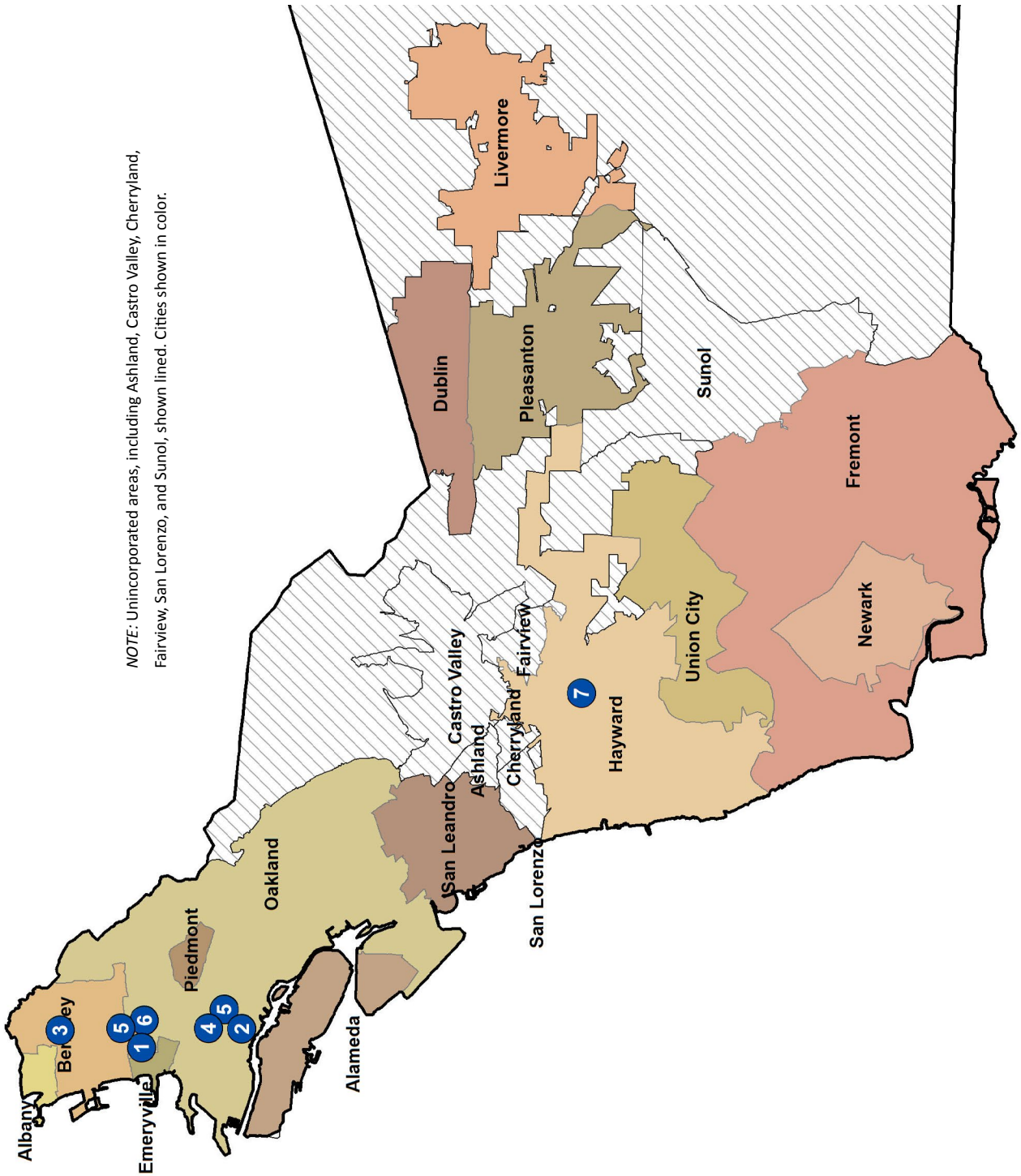


NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 15/16

#	PROVIDER	CITY
1	Alameda County Mental Health Association	Oakland
2	Asian Community Mental Health Services	Oakland
3	Bonita House, Inc.	Berkeley
4	Building Opportunities for Self-Sufficiency	Oakland
5	Center for Independent Living	Berkeley
6	Center for Independent Living	Oakland
7	Crisis Suppport Services of Alameda County	Oakland
8	Southern Alameda County Commitee for Raza (La Familia Counseling Service)	Hayward

MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 15/16

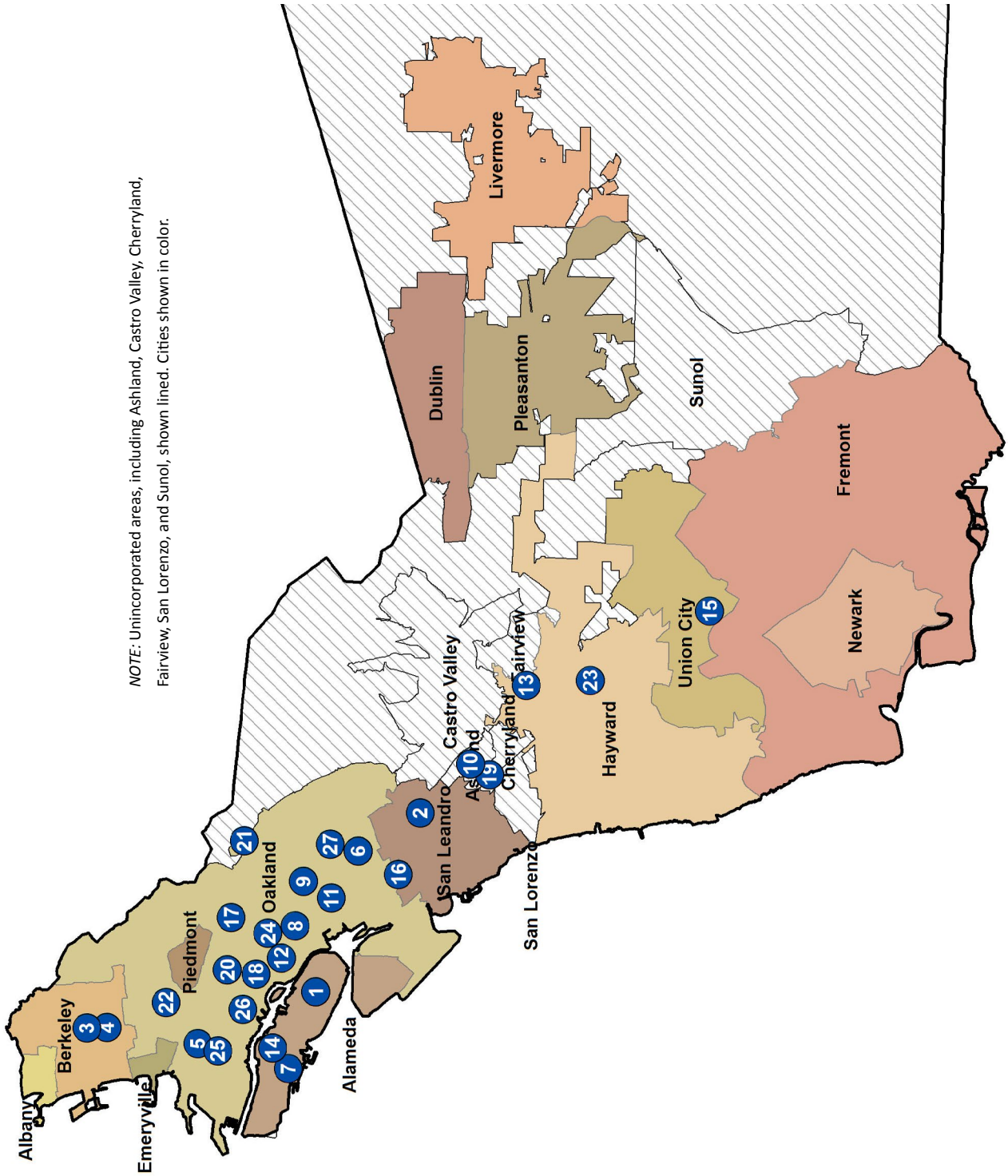


NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 15/16

#	PROVIDER	CITY
1	Alameda High School-Based Health Center	Alameda
2	Barbara Lee Health & Wellness Center	San Leandro
3	Berkeley High School Health Center	Berkeley
4	B-Tech Academy Health Center	Berkeley
5	Chappell Hayes Health Center	Oakland
6	Elmhurst/Alliance Wellness Center	Oakland
7	Encinal High School-Based Health Center	Alameda
8	Fremont Tiger Clinic	Oakland
9	Frick Middle School-Based Health Center	Oakland
10	Fuente Wellness Center (REACH Ashland Youth Center)	San Leandro
11	Havenscourt Health Center	Oakland
12	Hawthorne Health Center	Oakland
13	Hayward High School Mobile Health Van	Hayward
14	Island/BASE High School-Based Health Center	Alameda
15	Logan Health Center	Union City
16	Madison Health Center	Oakland
17	Rising Harte Wellness Center	Oakland
18	Roosevelt Health Center	Oakland
19	San Lorenzo High Health Center	San Lorenzo
20	Shop 55 Wellness Center	Oakland
21	Skyline High School: Seven Generations School-Based Health Center	Oakland
22	TechniClinic	Oakland
23	Tennyson Health Center	Hayward
24	United for Success/Life Academy: Seven Generations School-Based Health Center	Oakland
25	West Oakland Middle School Health Center	Oakland
26	Youth Heart Health Center (La Escuelita Education Complex)	Oakland
27	Youth Uprising/Castlemont Health Center	Oakland

MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 15/16



NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 5
HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 15/16

#	PROVIDER	CITY
ALAMEDA HEALTH SYSTEM		
1	Eastmont Wellness Center	Oakland
2	Fairmont Hospital	San Leandro
3	Highland Hospital	Oakland
4	Newark Wellness	Newark
5	Hayward Wellness	Hayward
6	San Leandro Hospital	San Leandro
7	Alameda Hospital	Alameda
8	John George Pavilion	San Lorenzo
ASIAN HEALTH SERVICES		
9	Roland and Kathryn Lowe Medical Center	Oakland
10	Asian Health Dental Clinic	Oakland
11	Asian Health Services	Oakland
12	Frank Kiang Medical Center	Oakland
AXIS COMMUNITY HEALTH		
13	Axis Community Health - Pleasanton	Pleasanton
14	Axis Community Health - Livermore	Livermore
LA CLÍNICA DE LA RAZA		
15	Casa del Sol	Oakland
16	Clinica Alta Vista	Oakland
17	La Clinica de La Raza	Oakland
18	La Clinica Dental	Oakland
19	La Clinica Dental/Children's	Oakland
20	San Antonio Neighborhood	Oakland

#	PROVIDER	CITY
LIFELONG MEDICAL CENTER		
21	Berkeley Primary Care Access	Berkeley
22	Howard Daniel Clinic	Oakland
23	LifeLong Dental Care	Berkeley
24	LifeLong Medical Care DOC	Oakland
25	Over 60 Health Center	Berkeley
26	East Oakland	Oakland
27	West Berkeley Family Practice	Berkeley
NATIVE AMERICAN HEALTH CENTER		
28	Native American Health Center	Oakland
ST. ROSE HOSPITAL		
29	St. Rose Hospital	Hayward
TIBURCIO VASQUEZ HEALTH CENTER, INC.		
30	Tiburcio Vasquez, Logan Health	Union City
31	Tiburcio Vasquez, Hayward	Hayward
32	Tiburcio Vasquez, Union City	Union City
33	Tiburcio Vasquez, San Leandro	San Leandro
TRI-CITY HEALTH CENTER		
34	Tri-City Health Center - Liberty	Fremont
35	Tri-City Health Center - Main	Fremont
36	Tri-City Health Center - Mowry	Fremont
37	Tri-City Health Center - State	Fremont
WEST OAKLAND HEALTH COUNCIL		
38	Albert J. Thomas Medical Clinic	Oakland
39	East Oakland Health Center	Oakland
40	West Oakland Health Center	Oakland
41	William Byron Rumford Medical	Berkeley

* The Health Program of Alameda County, also known as HealthPAC (and formerly known as CMSP or ACE), is a County program that provides affordable health care to uninsured people living in Alameda County. Services are provided through one of the nine community-based clinics that are part of the network or through the Alameda Health System (dba Alameda County Medical Center).

MAP 5
HEALTHPAC PROVIDER NETWORK
FUNDED BY MEASURE A IN FY 15/16