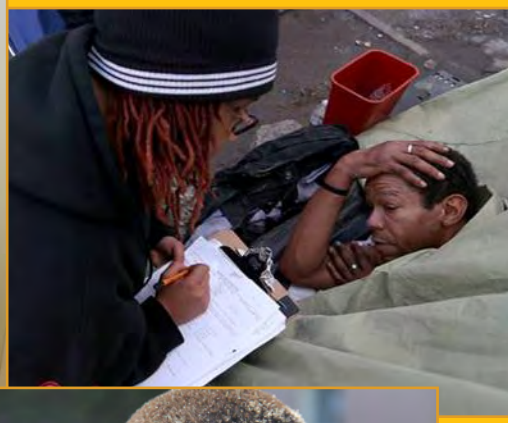
Fiscal Year
2016/2017



MEASURE A

Essential Health Care Services Tax Ordinance

MEASURE A CITIZEN OVERSIGHT COMMITTEE
11TH REPORT TO THE ALAMEDA COUNTY
BOARD OF SUPERVISORS AND THE PUBLIC

Review of Expenditures July 1, 2016 – June 30, 2017

MEASURE A

Essential Health Care Services Tax Ordinance

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11TH REPORT

TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS

AND THE PUBLIC

REVIEW OF EXPENDITURES IN

Fiscal Year (FY) 2016/2017

July 1, 2016 – June 30, 2017

PHOTO CREDITS

Cover photos (L to R): City of San Leandro Senior Services, Alameda Boys & Girls Club, Inc., Axis Community Health, Alameda County Community Food Bank, HIV Education and Prevention Project of Alameda County

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MEASURE A CITIZEN OVERSIGHT COMMITTEE MEMBERS

The Measure A ordinance established a Citizen Oversight Committee, which consists of 17 members appointed by the Alameda County Board of Supervisors (Board) to annually review the expenditures for the prior year and report to the Board on the conformity of the expenditures to the ordinance. The Committee develops, publishes, and presents a final report to the Board, based on individual reports submitted by fund recipients at the end of each year. Each nominating agency is responsible for appointing a new member to any current vacancy. For more information regarding the Measure A Oversight Committee, please contact the Alameda County Health Care Services Agency at 510-618-3452.

SEAT	COMMITTEE MEMBER	REPRESENTING/NOMINATED BY
Seat 1	Ursula Rolfe, M.D.	League of Women Voters
Seat 2	Susan Hauser	League of Women Voters
Seat 3	(seat in abeyance)	Alameda County Taxpayers Association, Inc.
Seat 4	Jaseon Outlaw, Ph.D.	Alameda County Mental Health Board
Seat 5	(vacant)	Alameda County Public Health Commission
Seat 6	Kuwaza Imara	Central Labor Council of Alameda County
Seat 7	Rachel Richman	Central Labor Council of Alameda County
Seat 8	(vacant)	Hospital Council of Northern California
Seat 9	Arthur Chen, M.D.	Alameda-Contra Costa Medical Association
Seat 10	Al Murray	City of Berkeley
Seat 11	John Becker	City Managers' Association
Seat 12	Kelly McAdoo	City Managers' Association
Seat 13	(vacant)	District 1 Supervisor Scott Haggerty
Seat 14	Zachariah Oquenda	District 2 Supervisor Richard Valle
Seat 15	Charles Go, Ph.D.	District 3 Supervisor Wilma Chan
Seat 16	(vacant)	District 4 Supervisor Nate Miley
Seat 17	Dru Howard	District 5 Supervisor Keith Carson

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY STAFF

Colleen Chawla, *Agency Director*

Rebecca Gebhart, *Finance Director*

James Nguyen, *Administrative & Financial Services Manager*

Connie Soriano, *Administrative Specialist II*

Anna Gee, *Secretary*

½% History of the Measure

Passed by **71% of Alameda County voters** in March 2004

Extended through 2034 (as Measure AA) by 76% of voters in June 2014

Raises County sales tax by one-half cent for health care services: Emergency medical, hospital inpatient/outpatient, public health, mental health, substance abuse

Target populations: Indigent, low income, and uninsured adults, children and families, seniors, and other residents of Alameda County

FY 2016/2017 Measure A Executive Summary

(July 1, 2016 – June 30, 2017)

About the Measure A Citizen Oversight Committee

One of the provisions of Measure A required the establishment of a Citizen Oversight Committee. 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."

With ongoing support from the Alameda County Health Care Services Agency (HCSA), 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 annual report. Report forms that are based on the Results-Based Accountability methodology, along with in-person presentations from several providers, were used to review all funding allocations.

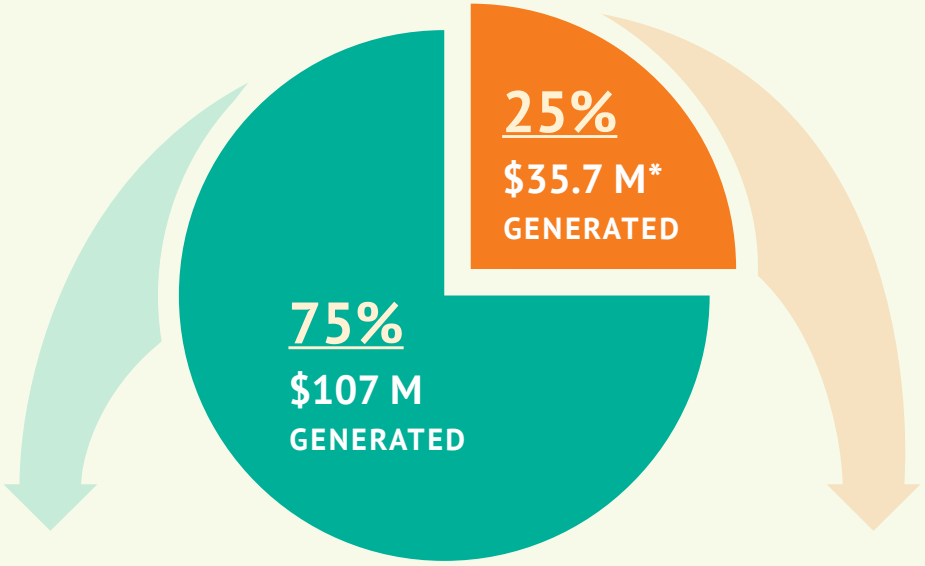
Overall Conclusion

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.

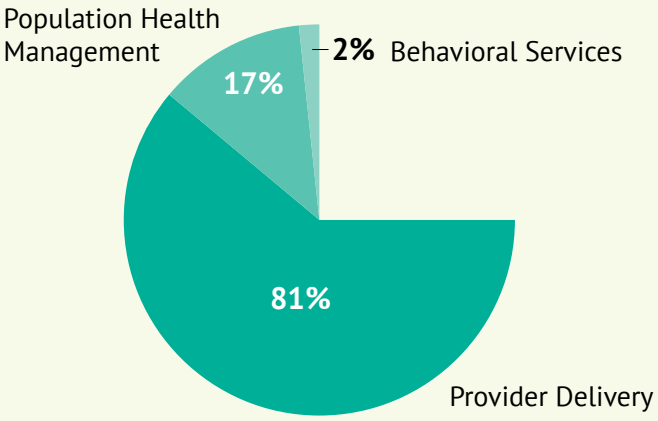
Measure A generated $142,643,720* in FY 16/17.

Of the $142,643,720 that Measure A generated in FY 16/17, 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.

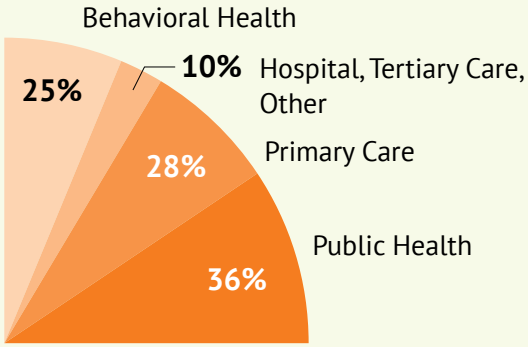
DISTRIBUTION OF MEASURE A FUNDS



$107 M Allocation of Measure A Funds to Alameda Health System



$32 M Allocation of Measure A funds approved by the Board of Supervisors**



* 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 in increasing the number of individuals who have health insurance, an estimated 80,391 individuals or 4.9% of County residents, remain uninsured according to the American Community Survey estimates for 2017. 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 providing ongoing technical assistance training to providers.

Alameda County Community Food Bank

Everybody Benefits

In a continuing trend, Measure A funds in FY 16/17 supported the health and well-being of large numbers of County residents. Providers serving large populations included AHS (122,636 County residents through Measure A) and the Alameda County Public Health Department Public Health Prevention Initiative (64,959). Patient numbers accessing care for certain diagnoses at Primary Care Community-Based Organizations included 40,514 patients with hypertension; 23,415 patients with diabetes; 8,822 patients with asthma; 6,713 prenatal patients; 30,153 with a mental health diagnosis; and 1,714 with HIV.

Measure A's reach extended throughout the County. Recipient providers stretched from Berkeley in the north to Fremont in the south to Livermore in the east.

AHS served **122,636** County residents through Measure A in FY 16/17, while the Alameda County Public Health Department Public Health Prevention Initiative served **64,959**.

Measure A Leverages Additional Funding

Many Measure A recipients leveraged their allocations to receive additional funds from other sources. For the 25% of Measure A funds allocated by the Board, recipients leveraged their allocations to obtain a total of $26,756,099 in matching funds. Thus, every $1 in Measure A funds to these recipients returned $0.78 in matching funds.

For some recipients, the matching funds represented a return greater than 1 to 1. Tiburcio Vasquez Health Center, Inc. obtained over $210,000

Axis Community Health

93%

Reduction in percentage of clients who had been to the ER after receiving Asthma Start's case management services.

in matching funds on its $60,000 Measure A allocation. Eden Youth and Family Center obtained over $200,000 in matching funds on its $75,000 Measure A allocation. Most notably, the School-Based Behavioral Health Initiative obtained over $6,000,000 in matching funds on its $622,000 Measure A allocation—a ratio of almost 10 to 1.

Health Outcomes Improve

In addition to financial benefit, physical and mental health services funded by Measure A resulted in measurable positive outcomes for recipients. For example, for patients who attended a health class at Davis Street Community Center, Inc., 63% with a BMI score greater than or equal to 30 saw a drop in score of at least 0.10 points, 50% of hypertensive patients saw a drop in their blood pressure reading to less than 140/90, and 67% of diabetic patients had a post-class Hemoglobin A1C reading that was less than 7.0, a significant indication of controlled diabetes.

In addition, due to case management, there was a 93% reduction in the percentage of clients who had been to the emergency room after receiving Asthma Start's case management services.

Clients Are Satisfied

Recipient surveys reveal a high level of satisfaction with Measure A-funded services. For example, 95% of Senior Support Program of Tri-Valley clients would recommend the program to someone they know. 87% of UCSF Benioff Children's Hospital Oakland patients reported they were satisfied or very satisfied with the services they received. Axis Community Health received an overall 95% satisfaction rating, and 100% of families of newborn patients reported that they were satisfied with the services they received at the Center for Early Intervention on Deafness.

Providers Exceed Expectations

In another example of Measure A funding providing notable bang for the buck, many providers exceeded their targets in services provided, thus improving their service-to-dollar ratio. For example, the City of Fremont Aging and Family Services Health Promoters program assisted 113 older adult clients in accessing and receiving mental health, health, and medically related services, compared to a target of 50. The Senior Injury Prevention Program Enhance Fitness program served 84 participants compared to a target of 11—an increase of 764%—while the Ger-Fit program served 109 participants compared to a target of 13—an increase of 817%. And the LifeLong Medical Center Heart2Heart

program participated in 203 community engagement activities and events compared to a target of 30, and provided health education and services to 644 community members compared to a target of 100.

Youth Receive Special Attention

Youth populations continue to be a special focus for many Measure A providers, with positive results. The Child and Adolescent Needs and Strengths (CANS) assessment administered to students receiving services through the School-Based Behavioral Health Initiative showed significant improvements in life functioning, behavioral/emotional needs, school success, and child strengths. Among students who received individual or group clinical services, the proportion who experienced depression decreased from 30% at intake to 10% at discharge.

Eighty-three percent of youth participating in the Mind Body Awareness program at the Juvenile Justice Center reported a decrease in stress, and 81% reported that they learned positive tools and skills to manage emotions. At Alameda Boys & Girls Club, 725 unduplicated youths participated in Healthy Habits programming. In FY 16/17, the graduation rate for participants in the Spanish Speaking Unity Council of Alameda County, Inc. Latino Men and Boys Program was 95%, compared to the Oakland Unified School District's graduation rate of 45% for Latino boys.

Alameda Boys & Girls Club

General Concerns and Recommendations

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 (2004-2017) 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. According to the EveryOne Counts! 2017 Homeless Count and Survey data submitted to the U.S. Department of Housing and Urban Development (HUD), an estimated 5,629 County residents experiencing homelessness were counted. 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

San Leandro Senior Services

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.

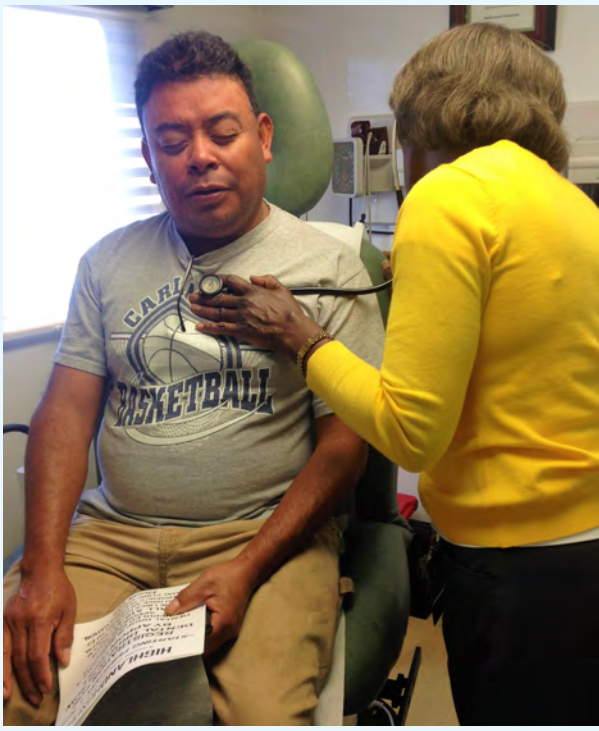
Regarding Measure A funding, the Committee raises the following concerns.

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.

- 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.



Multicultural Institute

RECOMMENDATION: HCSA should receive funding to provide training to Measure A recipients to increase their capacity to effectively collect and report demographic data on the clients that they serve and their results-based effort, quality, and impact measures. The Committee further advocates that HCSA be sufficiently staffed to successfully implement such a process.

RECOMMENDATION: Organizations that do not provide adequate information 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 selected programs.

RECOMMENDATION: Up to 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: To sustain base funding, adequate Measure A reserves should be maintained to address projected decreases in revenue.

Center for Early Intervention on Deafness

Specific Concerns

Alameda Health System

In response to questions from the Measure A Oversight Committee, Nancy Kaatz, Interim CFO, and Mr. Terry Lightfoot, Director of Public Affairs and Community Engagement, described Alameda Health System's accounting decision to integrate Measure A dollars ($106,757,190) into their "overall revenue" ($969,974,000). Therefore, the Committee 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 their entire agency staff of 4,148.

RECOMMENDATION: Alameda Health System should undergo a full and comprehensive audit to track Measure A fund allocations during the FY16/17 period to ensure public accountability for how the $107 million in tax funds were utilized. If this is not possible, then the auditor should recommend the appropriate accounting and reporting systems that would enable satisfactory tracing of Measure A dollars.

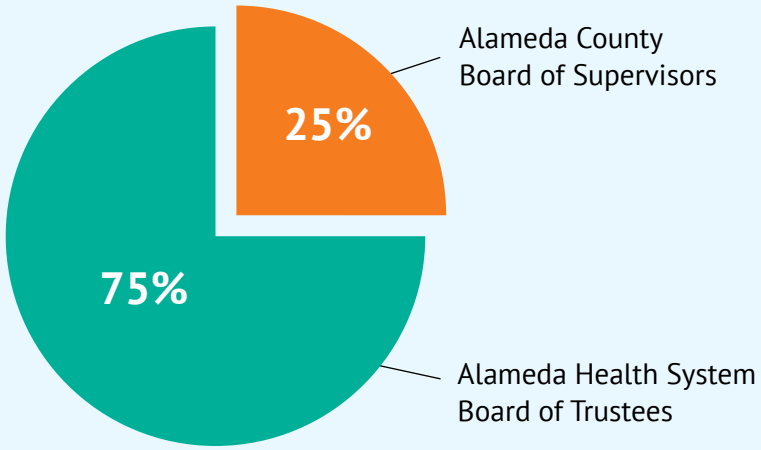
Genesis Worship Center

This provider did not supply any Measure A funding information for FY 16/17, despite repeated calls from Health Care Services Agency staff to obtain this information. 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.

DISTRIBUTION OF MEASURE A ALLOCATIONS



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.

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 16/17, Measure A generated $142,643,720 (not including interest earned). The funds were allocated as follows:

Alameda Health System (75%): $106,982,790

Alameda County (non-AHS) (25%): $35,660,930

TOTAL: $142,643,720

In FY 16/17, the Alameda County approved budget totaled $2.971 billion. The Alameda County Health Care Services Agency approved budget totaled $728 million, or 24.5% of the total County budget. Measure A revenues not specifically designated for AHS accounted for 1.2%.

The following sections in the report provide more detail on how AHS and the Board spent Measure A funds in FY 16/17, which includes revenue generated in the reporting year as well as unspent funds earned in previous years.

FY 16/17: 75% Of Measure A Funds Allocated to Alameda Health System

alamedahealthsystem.org

FY 16/17 Allocation: **$106,982,790** | **Expended/Encumbered:** **$106,982,790**

Individuals served by Measure A: 122,636 (Total individuals served: 122,636)

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, 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- to five-year strategic plan, which is built on the following pillars:

- Access: Increase total clinic visits from 297,289 to 350,152
- Quality: Eliminate preventable harm
- Service: Improve the patient experience
- Sustainability: Achieve an Earnings Before Interest, Depreciation, and Amortization (EBIDA) margin of 6.8%
- Workforce Development: Reduce the number of managers receiving low employee engagement scores

The AHS Complex Care Program is a multidisciplinary team of registered nurse care managers, social workers, and community health workers that serve AHS patients with multiple chronic conditions who frequently use the emergency department (ED) as their source of primary care. The program's goal is to help patients gain the confidence and skill they need to succeed, to make sure their care is well coordinated, and that they have tools for success. Program services include social support and tangible needs, coordination of and access to services, self-management and mental health, and medical status and health trajectory. These categories include assistance in placing patients in temporary or permanent housing, monitoring their nutrition, and ensuring delivery of fresh food.

Matching Funds

$23.8 M

AHS leveraged its Measure A allocation to obtain **$23,835,950** in matching federal funds.

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 except for the small share of services for which AHS receives full reimbursement.

In FY 16/17, Measure A helped AHS achieve the following:

- Increased total clinic visits by 7% from 297,289 (FY 15/16) to 318,365
- Improved patient experience scores and preventable harm standardized (Agency for Healthcare Research and Quality) scores

Access

- Increased clinic visits from 297,289 to 318,365
- Improved clinic workflow and processes
- Improved patient follow-up procedures

Sustainability

- Achieved an EBIDA margin of 4.8%
- Established performance benchmarks and operating expense controls
- Improved operational and finance reporting capabilities
- Assessed service line/business profitability
- Completed reimbursement analytics

Quality

- Reduced Agency for Healthcare Research and Quality Patient Safety Indicator (AHRQ PSI) 90 score from 1.01 to 0.185
- Implemented cross-functional harm reduction teams to review root causes and employ proven best practices
- Implemented BETA Heart/Just Culture initiative systemwide

Service

- Improved the top box score (patients rating the hospital 9 or 10) to 71.5% systemwide
- Implemented nurse hourly rounding on patients
- Developed a medication management tool for patients

Workforce Development

- Reduced the number of Tier 3 (low Action Plan Readiness, or APR) managers from 44 to 31
- Ensured management understands the importance of engagement
- Provided coaching, counseling, and training to improve management skills
- Developed a leadership academy curriculum for systemwide training

Concerns

In response to questions from the Measure A Oversight Committee, Nancy Kaatz, Interim CFO, and Mr. Terry Lightfoot, Director of Public Affairs and Community Engagement, described Alameda Health System's accounting decision to integrate Measure A dollars ($106,757,190) into their "overall revenue" ($969,974,000). Therefore, the Committee was unable to:

- Determine what portion of Measure A funds were allocated to personnel, subcontracted services, non-personnel program and/or

Success Story

After experiencing an on-the-job injury, Mr. S., 57, lost his job, home, and health insurance. He first visited the Highland Hospital ED due to unbearable pain from swollen legs and the inability to walk. Doctors diagnosed Mr. S. with multiple medical issues, including heart failure, cirrhosis, COPD, and gout. Mr. S.'s physician enrolled him in the AHS Complex Care Program. The Complex Care team found Mr. S. housing, scheduled automatic prescription and daily meal deliveries to his residence, arranged transportation for his medical appointments, and ordered him a walker. Mr. S. also received a handicap-accessible scooter, allowing him to ride to the drugstore for minor supplies.

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 4,148.

RECOMMENDATION: Alameda Health System should undergo a full and comprehensive audit to track Measure A fund allocations during the FY16/17 period to ensure public accountability for how the $107 million in tax funds were utilized. If this is not possible, then the auditor should recommend the appropriate accounting and reporting systems that would enable satisfactory tracing of Measure A dollars.

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

FY 16/17 Allocation: **$775,848** | **Expended/Encumbered:** **$505,760**

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: Berkeley

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.

Matching Funds

$25,003

from the **Medi- Cal and the Medi-Cal Administrative Activities (MAA) programs.**

Measure A Funding Summary

Measure A funds were used to support seven mental health and 19 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 contracts.

The use of Measure A funds to mitigate budget cuts allowed providers to serve approximately the same number of County residents in substance user disorder programs as prior years, 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.

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

achealthyschools.org

FY 16/17 Allocation: **$622,356** | **Expended/Encumbered:** **$622,356**

Individuals served by Measure A: 4,563 (Total individuals served: 4,563)

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

Services provided: Mental Health, Substance Abuse

Service area: Ashland, Castro Valley, 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 a core program of the Alameda County School-Based Behavioral Health Initiative: the Our Kids Our Families Program, District Behavioral Health Consultation program. The main objective of the initiative is to implement and strengthen this program 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

Matching Funds

$6,016,022

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**

educational environment so that children and families feel connected, safe, and supported in school. The program 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 included 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 Our Kids Our Families Program, District Behavioral Health Consultation program.

Prevention Activities

BHCs in all eight school districts were responsible for planning and/or implementing evidence-based prevention programs that promote social/emotional learning (SEL) among students and SEL application among adults, including the following:

- Positive Behavioral Interventions and Supports (PBIS)
- Restorative justice
- Mental health consultations with teachers, staff, parents, and students
- Classroom-based SEL curriculum and instruction

BHCs also 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:

- Youth groups (5,246 youth seved)
- Teacher consultations (3,601 teachers served)
- Staff presentations (1,456 staff served)
- Individual mentorship/drop-ins with youth (1,299 youth served)
- Family groups/workshops (115 families served)

Highlights

100%

In surveys of youth receiving behavioral health services in the School-Based Behavioral Health Initiative, **100% reported improvements in their access to an individual who can help them in a crisis.**

99%

In surveys of parents whose students had received services, **99% who participated in parent/family engagement workshops reported that the information addressed their needs and will help them as parents.**

↓20%

Among students who received individual or group clinical services, **the proportion who experienced depression decreased from 30% at intake to 10% at discharge**.

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 16/17, BHCs provided crisis assessment services to 265 youth.
- 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 18 social work and MFT interns. During FY 16/17, 4,563 students were provided with 152,433 hours of clinical services through the program.
- In FY 16/17, BHCs coordinated SEL initiatives at all eight school districts supported by Measure A funds. Emery, Newark, and Hayward school districts received funding to implement a 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 also supported 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. During FY 16/17, BHCs supported the implementation of COST in 204 schools in 13 school districts. COSTs at these schools received over 8,861 student referrals during the year. Approximately 69% of all students (or 6,098) referred to COST were connected to critical behavioral health services.

Success Story

A student was referred to prevention and early intervention services due to concerns around his arguing with teachers, anger outbursts, and peer conflicts. The COST team, teachers, and staff developed a plan to support this student inside and outside of the classroom. The school also collaborated with the student's parents. The student was not willing to engage in services/ treatment outside of school, but showed more interest in services provided at the school. Prevention and early intervention services included building a rapport with the student and developing emotional awareness and coping skills. Eventually, the student demonstrated a more positive outlook toward counseling and was linked to an outside provider for treatment.

Criminal Justice Screening and In-Custody Services

FY 16/17 Allocation: **$4,306,000** | **Expended/Encumbered:** **$4,306,000**

Individuals served by Measure A: 4,515 (Total individuals served: 4,515)

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.

The Adult Forensic Unit (FU) of BHCS uses Measure A funding to amplify the mental health system coverage in the Adult Forensic Behavioral Health (AFBH) area of Alameda County Jail.

AFBH staff provided 12,689 unduplicated services to 4,515 consumers.

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 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
- Link clients to appropriate community services

In FY 16/17, staff provided 12,689 unduplicated services to 4,515 consumers, including the following:

- 1,018 collateral services
- 5,954 assessments/initial screenings
- 5,473 individual therapy sessions
- 7,857 face-to-face medication interviews
- 4,822 non-face-to-face medication interventions
- 1,430 crisis interventions
- 978 brokerage services
- 4,910 plan development services

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 conduct an additional mental health appraisal. Inmates found to need a further mental health evaluation are referred to ABFH mental health professionals. 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. ABFH clinicians triage and screen all referred inmates for mental health service needs and recommend appropriate treatment plans based on the assessment. ABFH provides services onsite in select special housing units. These onsite services allow ABFH staff to proactively deliver mental health services to mentally ill inmates who might otherwise fall through the cracks.

Crisis Intervention

- Onsite. ABFH 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, an ABFH clinician is on call and can be reached by pager to assist with urgent mental health matters.

Management of Inmate Behavioral Problems

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

Suicide Prevention

ABFH 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, ABFH 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. ABFH staff work with inmates who demonstrate a risk for suicide and address risk factors, develop relapse prevention strategies, and discuss coping strategies. ABFH takes preventive action on all inmates expressing suicidal thoughts and/or demonstrating self-injurious behaviors.

Success Story

Ms. X, a 62-year-old Chinese immigrant, was arrested and charged with a violent crime against a family member. Ms. X became extremely distraught with her situation, resulting in a suicide attempt that resulted in multiple serious injuries. AFBH staff provided weekly support to ensure that Ms. X would stabilize and remain safe while in custody, as well as take psychiatric medications to address certain symptoms. Staff linked Ms. X with a clinician in the community who spoke her native language and other community supports. A discharge plan was devised and she was successfully and safely discharged back into the community and linked with housing and ongoing treatment.

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

All inmates receiving mental health services are seen by ABFH 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, ABFH 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, ABFH 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. ABFH clinicians conduct court-ordered psychiatric evaluations to assess the need for acute inpatient psychiatric care and provide reports back to the courts.
- Inpatient services. ABFH 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 ABFH clinicians can assess them, continue their medications, and clear them for housing.
- Inmates who refuse treatment. All treatment is voluntary. ABFH staff monitor inmates with serious mental illnesses who refuse treatment and make an ongoing attempt to engage these inmates in treatment.
- Outreach and teamwork. ABFH 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. ABFH clinicians also address substance abuse as part of their ongoing interventions with inmates.

Emergency mental health services are available 24 hours a day.

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. An ABFH psychiatrist is on call to accommodate the continuity of psychotropic medications.

Discharge Planning/Continuity of Care

When ABFH staff have advance notice of an inmate's date of release, staff make a referral for follow-up outpatient treatment. ABFH staff work 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 ABFH 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 ABFH staff receive 40 hours of initial training. ABFH managers and psychiatrists provide ongoing training to ABFH line staff in topics related to the practice of jail psychiatric services. The ABFH Lead Psychiatrist attends the monthly BHCS Psychiatric Practices Committee and shares information learned with other ABFH psychiatrists.

All new ABFH staff receive 40 hours of initial training.

Detoxification/Sobering Center

FY 16/17 Allocation: **$2,143,224** | **Expended/Encumbered:** **$2,122,733**

Individuals served by Measure A: 7,658 (Total individuals served: 7,658)

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

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

Service area: Countywide, Homeless or transient

Background

The Detox/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 onsite include residential sobering services, residential detoxification and withdrawal management services, basic health services, referral services, and substance use crisis stabilization. Cherry Hill provides services to the vast majority of persons identified in the Alameda County Behavioral Health Care Services (BHCS) substance use system.

Measure A Funding Summary

With its Measure A funding, the Detox/Sobering Center achieved the following:

- Cherry Hill Detoxification Center provided 8,973 units of service, with a total of 2,643 admissions.
- Cherry Hill Sobering Center provided 5,015 units of service, with a total of 5,015 admissions.
- The Health Center provided a total of 1,058 health services.

Success Story

A middle-aged woman referred to Cherry Hill had a severe co-occurring mental and substance use disorder. She was homeless and in immediate need of detoxification services. After a brief stay at Cherry Hill, the client was able to stabilize on her medication and to eat and sleep on a consistent basis. She was supported and encouraged throughout her stay at Cherry Hill and successfully transitioned to residential treatment. The client contacted Cherry Hill after graduating from treatment to thank staff for admitting her when they did. She stated that the "one time" she was ready for help they were available.

Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services

lafamiliacounseling.org

FY 16/17 Allocation: $164,902 | **Expended/Encumbered: $164,902**

Individuals served by Measure A: 2,565 (Total individuals served: 7,774)

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

Services provided: Mental Health

Service area: Cherryland, Fremont, Hayward, Newark, Union City

Background

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

La Familia's work with unaccompanied immigrant youth (UIY) reaches out to youth and families who might otherwise be overlooked in service provision given barriers to service including limited English-language fluency, few and inadequate social supports, lack of knowledge of available services due to recent immigration, and the psychological impact of trauma.

Highlights

95%

In direct client surveys **95% of youth agreed that they are doing better in school after receiving support**.

Measure A Funding Summary

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

- Make a total of 2,643 personal contacts (not unique individuals), including 84 personal contacts with youth, with a focus on engaging caregivers, school staff, and partners in other community-based organizations
- Provide a total of 24 trainings for and 354 consultations with leaders and professionals
- Provide three parent reunification workshops
- Refer 100 individuals for medical services and insurance enrollment
- Of the six individual cases opened to Preventative Counseling, close two cases and transfer two to UIY clinicians

La Familia Counseling Services

lafamiliacounseling.org

FY 16/17 Allocation: $50,000* | **Expended/Encumbered: $50,000**

Individuals served by Measure A: 1,377 (Total individuals served: 1,377)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Ashland, Cherryland, Hayward, Oakland, San Leandro, Union City, Homeless or transient

Includes Board of Supervisors discretionary allocation from **District 2/Supervisor Valle*

Background

La Familia Counseling Services 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 and referral in areas of housing, job referrals, nutrition, translations, health referrals, immigration, legal and general orientation, and health education workshops to low income residents (target: 300 residents; actual: 395)
- Conduct outreach to community members (target: 600 members; actual: 542)
- Provide intense case management individual/family interventions, including intake and assessment, service planning, direct support, and evaluation, for an average period of 90 days (target: 20 interventions; actual: 25)
- Conduct parent/family support, psychoeducation, health, and wellness workshops (target: 12 workshops attended by 100 community members; actual: 12 workshops attended by 172 community members)
- Assist low income Hayward residents in connecting to health care coverage through Medi-Cal and other social services (target: 130 residents; actual: 143)

La Familia also used its Measure A funding to support community-based engagement and participation via school presentations, church events, tabling events within the community, domestic violence shelters for short-term interventions, and referrals to the La Familia Family Resource Center (FRC) site. At the FRC site, clients can participate in monthly immigration consultations, Zumba classes, yoga and meditation, and other events related to culture and wellness.

Highlights

97%

In participant surveys **97% of participants feel they now have a place to go for health and wellness.**

Matching Funds

$50,000

from the **Alameda County Health Care Services Agency.**

Mental Health Services for Juvenile Justice Center

FY 16/17 Allocation: **$360,000** | **Expended/Encumbered:** **$360,000**

Individuals served by Measure A: 105 (Total individuals served: 686)

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

Services provided: Mental Health, Substance Abuse

Service area: Countywide

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. Mental health support services range from ongoing therapy to mental health assessments to crisis interventions.

Mental health assessments, in addition to helping the court and probation determine appropriate placement options, also provide recommendations to essential service linkages in the community that are suitable for youth after their discharge. For youth in Juvenile Hall experiencing mental distress, crisis interventions are provided as soon as possible onsite to help prevent escalation of mental health symptoms that could lead to their hospitalization.

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. 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.

Highlights

8

As a result of immediate crisis intervention, **only eight clients were hospitalized** in FY 16/17.

Matching Funds

$39,386

from **Medi-Cal**.

Measure A Funding Summary

BHCS used its Measure A allocation to achieve the following:

- Provide ongoing therapy, mental health assessments, and crisis interventions to 105 youth detained at Juvenile Hall.
- Provide court-ordered mental health assessments. Guidance Clinic staff completed approximately 181 mental health assessments in FY 16/17. Measure A funding covered approximately 30 of those assessments.
- Offer immediate crisis intervention for suicidal youth to avoid self-harm and/or hospitalization. The Guidance Clinic performed 186 crisis interventions, of which Measure A funded 40.

Mental Health Services for Newcomers and Immigrants (CERI)

cerieastbay.org

FY 16/17 Allocation: $80,371 | **Expended/Encumbered: $80,371**

Individuals served by Measure A: 56 (Total individuals served: 225)

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

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, Cambodia, and Vietnam. Presently, the majority of its 200 clients are Cambodian refugees living in Oakland. Over 75% of staff are Cambodian and speak the Khmer language.

Matching Funds

$76,556

from the **Mental Health Services Act (MHSA), MAA, and other foundations.**

Measure A Funding Summary

CERI used its Measure A allocation to achieve the following:

- Conduct outreach and psychoeducation/prevention visits including large community events and presentations; one-on-one outreach; psychoeducation groups; ongoing support groups; and print, radio, and television media (target: 124 visits; actual: over 320, including 10 large community events, 160 support and psychoeducation groups, and 150 one-on-one sessions)
- Provide mental health consultation services including family consultation, training for community groups, distribution of print media, professional leadership consultation, and prevention visits (target: 120 services; actual: over 200, including 60 youth leadership groups, 100 prevention visits, and 40 trainings with MFT/MSW interns)
- Provide mental health early intervention individual needs assessments and low intensity and brief counseling (target: 40 clients; actual: 56)
- Provide Medi-Cal Administrative Activities (MAA) and Medi-Cal assistance, informing community members regarding mental health services and making referrals (target: 300 hours; actual: 500)
- Complete contacts with youth and adults

Safe Alternatives to Violent Environments (SAVE)

save-dv.org

FY 16/17 Allocation: **$25,000*** | **Expended/Encumbered:** **$25,000**

Individuals served by Measure A: 3,949 (Total individuals served: 7,896)

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

Services provided: Public Health, Mental Health

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

Includes Board of Supervisors discretionary allocation from **District 1/Supervisor Haggerty*

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.

SAVE's Community Oriented Prevention Services (COPS) program provides resources and support for domestic violence victims. COPS Advocates are available at the Fremont, Hayward, Newark, San Leandro, and Union City Police Departments.

The SAVE Teen Dating Violence Prevention (TDVP) program offers young people the space to safely explore the topic of dating and intimate partnerships in a judgment-free setting. The curriculum helps them recognize the spectrum of relationships by identifying healthy, unhealthy, and violent characteristics. The program also covers warning signs, community resources, sexting, consent, gender stereotypes, digital dating violence, and media literacy.

The SAVE clinical program offers nonjudgmental, compassionate support; food and clothing; referrals for help with legal, financial, housing, and other matters; classes and workshops; individual counseling; and ongoing case management services.

Measure A Funding Summary

SAVE used its Measure A allocation to achieve the following:

- COPS program: Serve 75 clients, 14 of whom had multiple contacts with their COPS Advocate, and assist 46 clients in creating a safety plan
- TDVP program: Conduct 114 presentations in which 3,796 students participated
- Clinical program: Provide 531 sessions serving 78 participants

Highlights

100%

100% of clients reported increased knowledge about **how to access community resources or what community resource to access** if needed.

Matching Funds

$243,125

from the following sources:

- **California Governor's Office of Emergency Services**
- **Office on Violence Against Women Blue Shield**
- **Cities of Fremont, Hayward, and San Leandro**

Senior Support Program of Tri-Valley

ssptv.org

FY 16/17 Allocation: **$20,000*** | **Expended/Encumbered:** **$20,000**

Individuals served by Measure A: 20 (Total individuals served: 20)

Populations served: Seniors

Services provided: Mental Health

Service area: Dublin, Livermore, Pleasanton, Sunol

Includes Board of Supervisors discretionary allocation from **District 4/Supervisor Miley*

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. In addition to assessments, counselors provide crisis intervention, resources, and referrals, as needed.

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.

Highlights

85%

85% indicated improvements in mental health (target: 80%).

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 (target: 20)
- Conduct program pre-evaluation with 34 clients to assess mental health status (target: 20)
- Enroll 59% (20 of 34) of screened clients in the In-Home Counseling Program (target: 75%)

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 2: HOSPITAL, TERTIARY CARE, OTHER

St. Rose Hospital

strosehospital.org

FY 16/17 Allocation: **$1,500,000** | **Expended/Encumbered:** **$1,500,000**

Individuals served by Measure A: 21,759 (Total individuals served: 28,975)

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 provides quality health care to the community with respect, compassion, and professionalism. SRH works in partnership with physicians and employees to heal and comfort all those it serves.

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 subsidizes 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.
- Tele-Psychiatry. SRH started a Tele-Psychiatry program for patients presenting to the emergency department (ED) with mental health issues. Prior to this program, SRH physicians were not able to write or release 5150s and had to call the Hayward Police Department (HPD) to write the hold or release. Because of HPD's workload and call

Highlights

↓21.5%

Since implementing the Tele-Psychiatry program, SRH has transferred an average of 32.4 patients per month to John George Psychiatric Hospital. This represents a **21.5% reduction in referrals prior to the implementation of the program**.

Matching Funds

$1.5 M

from the **intergovernmental transfer program through the Medi-Cal program**.

priority, there were times SRH physicians and staff would wait several hours before HPD would arrive. Since SRH physicians are now able to write or release 5150s as part of this program, they no longer need to take HPD away from their primary duties.

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 3,770 patient encounters and provide over $3.2 million in cost of care to uninsured/indigent patients
- For both traditional and Managed Care Medi-Cal programs, conduct over 25,200 patient encounters and incur over $30.4 million of costs in excess of amounts
- Experience 31,448 ER visits, including 69%, or 21,759 visits, from uninsured and underinsured patients (target: 23,500)
- Provide financial support to hospital-based physicians to take ER call and provide services to 11,217 uninsured/underinsured patients (target: 12,100)
- Support SRH inpatient services to 2,860 uninsured and underinsured patients (target: 3,000)

Success Story

After a 29-year-old Hispanic male had surgery at SRH for acute appendicitis, his wife wrote:

"Our family is so [grateful] for the opportunity for my husband to be treated at St. Rose Hospital. We were uninsured and thought that we would be sent away from St. Rose Hospital. We are living with my husband's family. We do not have any other place to live … and we have to pay our rent so that the four of us do not have to become homeless. My husband's family relies on us to pay our rent so that they can buy food for the household. We are so grateful for St. Rose."

UCSF Benioff Children's Hospital Oakland

childrenshospitaloakland.org

FY 16/17 Allocation: **$2,000,000** | **Expended/Encumbered:** **$2,000,000**

Individuals served by Measure A: 28,882 (Total individuals served: 21,882)

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), which treats children who experience abuse and other types of trauma
- Two school-based clinics in Oakland

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 16/17, to CHO's ED was the highest volume ED in the San Francisco Bay Area.

Trauma services are a subset of the ED, requiring highly specialized equipment, facilities, and highly trained staff. 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.

Highlights

96%

96% of patients reported that they agree or strongly agree that the **school clinics helped them with their problem** (target: >80%).

Matching Funds

$1 Million

from the **California Department of Health Care Services**.

The ED also functions as the gateway to ongoing medical care for many children in Alameda County. 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 600 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. Clinical case management assists families with navigating the criminal justice system, arranging necessary medical follow-up, and assisting with community resource referrals. Comprehensive evidenced-based mental health services are provided to children, adolescents, and their families. 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

Highlights

87%

87% of patients reported they were **satisfied or very satisfied with the services they received** (target: >80%).

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.

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.

In FY 16/17, there were a total of 46,380 visits to the ED.

Measure A Funding Summary

CHO used its Measure A allocation to achieve the following:

Emergency Department

- In FY 16/17, there were a total of 46,380 visits to the ED.
- 451 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 2.91 hours, compared to 3.1 hours three years previously (target: <3 hours).

Center for Child Protection

- In FY 16/17, the CCP provided forensic medical and/or mental health services for more than 600 children and their families (target: 600).
- All children and youth presenting through the ED and/or Child Abuse Management clinic for forensic medical care received crisis intervention and a corresponding needs assessment.
- 90% of children referred internally for psychotherapy services began service engagement within one week of the referral.
- 124 children participated in individual therapy.
- 32 children participated in group therapy.
- 85% of children participating in therapy demonstrated enhanced intrapersonal and interpersonal functioning.
- 100% of children who received Trauma-Focused Cognitive Behavioral Therapy demonstrated clinical progress (target: 100%).

School-Based Clinics

- In FY 16/17, the two clinics run by CHO had a total of 6,735 encounters and saw 947 unique patients.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 3: PRIMARY CARE

Alameda County Dental Health

www.acphd.org/dental-administration.aspx

FY 16/17 Allocation: $257,580 | **Expended/Encumbered: $227,580**

Individuals served by Measure A: 3,053 (Total individuals served: 6,052)

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

Services provided: Public Health

Service area: Alameda, Ashland, Berkeley, Castro Valley, Cherryland, Fairview, 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.

The Alameda County Office of Dental Health 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 centers (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, defining and gaining acceptance for home care behaviors, and promoting the oral health of prenatal women and their newborns.

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.

Matching Funds

$257,580

from the **Maternal, Child and Adolescent Health Program (MCAH) and Child Health and Disability Prevention (CHDP)**.

Measure A Funding Summary

Measure A funding helped the Office of Dental Health achieve the following:

- Provide oral health education to 922 parents/guardians through WIC Dental Days (target: at least 1,000)
- Provide oral health assessments to 856 infants/children 0-5 years old through WIC Dental Days (target: at least 900)
- Screen 1,205 students at the school-based program (target: 1,050)
- Provide fluoride varnish to 74% of eligible infants/children through WIC Dental Days (target: 100%)
- Provide 80% of parents whose children received a dental assessment and need a dental provider with care coordination and assistance towards making an appointment with a dental provider (target: 100%)
- Enroll 84% of infants and children receiving an oral health assessment into the Healthy Kids Healthy Teeth (HKHT) program and link them to a dental home (target: at least 75%)

Success Story

At a WIC Dental Day, a Laotian mother informed the Community Health Outreach Worker (CHOW) and Registered Dental Assistant (RDA) that her four-year-old daughter had been complaining of tooth pain but did not have dental insurance. The RDA performed a dental screening and determined that the child was suffering from a severe gum infection. The CHOW scheduled a next-day dental appointment and referred the family to the Alameda County Health Care Services Agency to enroll in Medi-Cal. The child was enrolled in Medi-Cal and obtained the proper dental services to treat her infection. The family now has a dental home and has begun receiving routine preventive dental services.

Axis Community Health

www.axishealth.org

FY 16/17 Allocation: **$98,300*** | **Expended/Encumbered:** **$98,300**

Individuals served by Measure A: 756 (Total individuals served: 12,872)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Castro Valley, Dublin, Livermore, Pleasanton

Includes Board of Supervisors discretionary allocations from **District 1/Supervisor Haggerty and **District 4/Supervisor Miley***

Background

Axis Community Health works to provide quality, affordable, accessible, and compassionate health care services that promote the well-being of all members of the community.

The opening of a new clinic site in Pleasanton increases access to primary care and mental health services for low income residents by doubling the capacity of Axis Community Health to serve the target area.

Measure A Funding Summary

Axis Community Health used its Measure A allocation to provide primary care medical services in eastern Alameda County, including pediatrics, internal medicine, OB/Gyn, and family planning medical services, as well as mental health counseling and integrated behavioral health services at the new Axis clinic site.

The new site provided 7,000 patient visits to roughly 1,200 patients, including 756 Measure A patients.

Highlights

95%

Axis Community Health received an overall **95% satisfaction rating**.

Center for Elders' Independence

cei.elders.org

FY 16/17 Allocation: $53,581 | **Expended/Encumbered: $53,581**

Individuals served by Measure A: 660 (Total individuals served: 750)

Populations served: Low Income Adults, Families, Seniors

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

Service area: Countywide, 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.

CEI's Caring for the Caregiver program enhances comprehensive care coordination for participants by providing information, skills training, and support for family and other unpaid caregivers. It provides participants' families and friends much-needed relief from caregiving's ongoing emotional and physical demands. Caregivers hear from others who are dealing with the same challenges and receive advice and instructions from members of CEI's medical team.

Measure A Funding Summary

CEI used its Measure A allocation to conduct four Caring for the Caregiver series with a total of 26 classes to 54 family caregivers of low income seniors (target: four series to 40 caregivers).

Highlights

94%

Based on a survey of family caregivers who participated in the Caring for the Caregiver series, 94% reported **improvements in physical and emotional health**.

98%

98% reported **improvements in confidence and effectiveness in managing the care of their senior**.

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

achealthyschools.org

FY 16/17 Allocation: $1,957,784 | **Expended/Encumbered: $1,957,784**

Individuals served by Measure A: 15,976 (Total individuals served: 15,976)

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

The SHCs also focused on integrated systems and access to and utilization of care.

In FY 16/17, there were 28 SHCs, with some serving multiple schools. During the same period, the number of clients increased to 15,976 (a 141% increase over a decade), and the number of annual client visits increased to 65,691 (a 143% 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. Twelve percent of clients reported having no insurance.

Highlights

100%

SHC evaluation data shows nearly 100% reported **high levels of satisfaction with the people who work at the SHC**.

Matching Funds

$12.2 M

from **Medi-Cal Administrative Activities (MAA) and Targeted Case Management (TCM)**.

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

Medical/Health Education Services

Physical health services provided during SHC visits included general health counseling, nutrition counseling, and injury treatment. In addition, the SHCs provided 2,748 non-HPV immunization visits.

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 1,477 HPV immunization visits.

Outside of clinical visits, the SHCs provided the following services:

- Health fairs/outreach reaching 23,274 youth and 10,632 adults
- First aid supplies given to 14,488 youth and 33 adults
- Reproductive health education reaching 6,390 youth and 1,503 adults
- Dental screenings provided to 3,564 youth and 10 adults
- Physical activity, recreation, dance, and yoga provided to 1,155 youth and one adult
- Tobacco and alcohol/drug use education reaching 621 youth and seven adults
- Nutrition education including gardening and cooking reaching 509 youth and 10 adults
- Other health screenings such as flu clinics and immunizations reaching 245 youth and 58 adults

Behavioral Health Services

Individual behavioral health services included individual therapy, assessment and intake, psychosocial screening, academics/college/life skills counseling, individual contacts/meetings, and case management. Behavioral health group counseling was also provided.

SHCs behavioral health services included the following:

- School safety/climate presentations and activities reaching 10,861 youth and 1,203 adults
- Screening for trauma provided to 703 youth and 41 adults
- Self-esteem/image/empowerment sessions reaching 276 youth and 54 adults
- Parent/family support groups, workshops, and trainings reaching 186 youth and 2,473 adults

Highlights

96%

Evaluation data indicates that SHCs helped students **feel like they had an adult they could turn to if they needed help or support.**

- Social skills/communication/anger management/conflict resolution sessions reaching 142 youth
- Crisis intervention/grief support sessions reaching 658 youth and 110 adults
- Restorative justice/circle activities involving 344 youth and 20 adults

Oral Health Services

At the 12 SHC sites providing dental services, 1,747 clients had a dental service provided for screening exams and cleanings, and also for case management and restorative treatment. In addition, 3,564 students were provided dental screenings during schoolwide screenings in eight SHCs.

Youth Enrichment and School Community Supports

The SHCs provided a variety of youth enrichment activities and community supports, including the following:

- Schoolwide assemblies or special events reaching 5,837 youth and 2,678 adults
- Classroom presentations and interventions reaching 3,797 youth and 607 adults
- Youth advisory board, leadership, research, and advocacy groups serving 1,631 youth
- Peer health education groups, peer counseling, and mentoring serving 1,583 youth and 13 adults
- Academic support for 1,351 youth
- Job training and career exploration for 521 youth
- Acculturation support for newcomers and unaccompanied youth reaching 502 youth and 19 adults
- School staff workshops, training, and orientations reaching 1,365 adults

Insurance Enrollment

The SHCs conducted outreach and education activities to educate and enroll families in health coverage and other benefits programs. These SHCs provided the following:

- 7,008 families with information about health insurance and benefits eligibility
- 410 families with onsite application assistance to enroll in CalFresh, CalWORKs, or other public benefits
- 133 families with application assistance to enroll in Medi-Cal, HealthPAC, or Covered California coverage

The SHCs also conducted insurance screening and enrollment with 308 youth.

Success Story

AB is a 16-year-old Latino student struggling with multiple substance use, major depression, and PTSD from community violence exposure. He often showed up at school intoxicated, attended class sporadically, and had confrontations with several teachers over his behavior. He refused counseling and medical services arranged by his parents with an outside provider. Initially, he was guarded in engaging with the SHC. Through the SHC staff's caring, nonjudgmental stance and counseling interventions using a harm reduction model, AB has become comfortable at the clinic and comes to appointments regularly and frequently. He still struggles with school but attends more often than previously. Recently, he has started reducing his substance use.

Integrated Systems

Twenty-five SHC sites reported strong school partnerships and collaborations around student health in FY 16/17. Examples included jointly planning school health events, a mobile van to parents and families, restorative justice circles, and trauma-informed classrooms and supports.

Other integrated systems results included the following:

- 18 of the sites reported having a signed Letter of Agreement (LOA) between their SHC and the school administration, clarifying roles and responsibilities and fostering regular communication.
- 26 sites reported successes in regularly participating in their school's Coordination of Service Team (COST) programs to discuss at-risk students and develop plans to support them.
- Eight sites reported successes in coordination with County and local community agency partners to improve access to services, including behavioral health, a college readiness program, and food donations to provide fresh fruit in classrooms and disburse bags of food to food-insecure students and their families.

Highlights

91%

91% of students who participated in group programs reported that the SHC helped them **have goals and plans for the future**.

Connecting Kids to Coverage (CKC) Initiative

www.whhs.com

FY 16/17 Allocation: $188,386 | Expended/Encumbered: $188,386

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 at 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

Highlights

98%

In a consumer satisfaction survey, 98% of respondents said that they would **recommend the center to other parents**.

Matching Funds

$61,330

from the **Alameda County Center for Healthy Schools and Communities (CHSC) General Fund**.

students about health insurance eligibility guidelines and enrollment assistance resources at the CKC Family Resource Centers.
- 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 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.

Highlights

72%

In a consumer satisfaction survey, 72% of respondents said they would **rate the centers "excellent" or "very good."**

- 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 support of the CKC centers. Fifty-four percent 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. Sixty percent of these CalFresh applications were for children.
- 28 individuals were assisted with CalWorks applications.

Highlights

70%

70% of people who received health insurance enrollment assistance also received **assistance with applying for other public benefits or getting other family support**.

Davis Street Community Center, Inc.

davisstreet.org

FY 16/17 Allocation: $80,000* | **Expended/Encumbered: $80,000**

Individuals served by Measure A: 27 (Total individuals served: 66)

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

Services provided: Public Health

Service area: Alameda, Castro Valley, Hayward, Oakland, San Leandro, San Lorenzo, Outside of Alameda County, Homeless or transient

Includes Board of Supervisors discretionary allocation from **District 3/Supervisor Chan*

Background

Davis Street Community Center works to improve health, address poverty, and increase the overall quality of life of residents in Alameda County.

To improve health outcomes, Davis Street conducts hands-on cooking classes to increase education regarding healthy eating choices, promote healthier eating practices, increase physical activity, increase capacity to make healthier meals using foods available, and lower BMI levels. Each class is conducted in English and Spanish. All participants leave with a bag of food ingredients from the food warehouse. In addition, a wellness coaching session is available to all class participants.

Highlights

67%

For patients who attended the class, 67% of diabetic patients had a **post-class Hemoglobin A1C reading that was less than 7.0**, a significant indication of controlled diabetes.

Measure A Funding Summary

Davis Street used its Measure A allocation to achieve the following:

- Notify 800 local individuals and families of the need for periodic blood pressure and weight checks. Davis Street contacted families through health fairs, local events, mailings, and placement of an outreach worker at the clinic and food distribution center.
- Develop and offer hands-on cooking classes for 66 participants, 27 of whom were diagnosed with at least one of the following conditions: hypertension, obesity, or type 2 diabetes.
- Refer 13% of patients with high HgbA1C levels to health education services for diabetes management classes (target: 50%).
- Provide effective treatment for 12% of patients whose blood pressure was above 140/90 (target: 50%).
- Refer 38% of patients between ages 2-7 who were overweight to weight management classes (target: 50%).
- Have 20% of adult patients with diabetes complete the cooking classes and increase their knowledge of preparing healthy food at home (target: 30%).
- Have 36% of 20 adult patients with elevated blood pressure increase their knowledge of healthy cooking (target: 36%).

Health Aging and Family Services

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

FY 16/17 Allocation: **$53,581** | **Expended/Encumbered:** **$53,581**

Individuals served by Measure A: 48 (Total individuals served: 161)

Populations served: Indigent, Low Income, Uninsured Seniors

Services provided: Public Health, Mental Health

Service area: Fremont, 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. In the Home Meds program, nursing students as well as health promoters collect medication information and enter it into a database

Highlights

100%

100% of clients received services from health promoters who s**poke their language and understood their culture** (target: 100%).

Matching Funds

$127,790

from the **City of Fremont General Fund and the Alameda County Public Health Department**.

that analyzes the list for possible negative effects and/or interactions. If the program identifies a potential problem, the program alerts Alameda County's pharmacist, who reviews the medication list and tries to contact the client's doctor if a problem is confirmed.

- 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 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 four health education groups. The first is the Stanford Chronic Disease Self-Management Program. The second is the Diabetes Education Group. One health promoter has been trained to lead this group. The third is the Matter of Balance (MOB) group, an evidence-based class that promotes fall prevention. Four health promoters and two volunteers have been trained as leaders. Fourth, one health promoter was trained to be a certified instructor for Tai Chi for falls prevention.

Measure A Funding Summary

Measure A helped the Health Promoter Program achieve the following:

- Provide health promotion services to 161 older refugee, immigrant, and low income residents over 60 years of age (target: 135)
- Provide assistance and referrals for 132 clients (target: 110)
- Ensure that 157 clients have a primary care physician (target: 110)
- Assist 113 older adult clients in accessing and receiving mental health, health, and medically related services, including making referrals and applying for services; assistance completing forms for Medi-Cal, Medicare, and other health insurance; obtaining medical supplies; providing or arranging transportation to mental health or medical appointments; and providing translations services (target: 50)
- Conduct fall, home safety, mental health, and health screenings for 60 older adults and refer clients to appropriate services as needed (target: 50)
- Assess or reassess 47 clients regarding their ability to self-manage their chronic conditions using the Partners-In-Health Scale (target: 45)
- Develop 45 Wellness Plans (target: 45)
- Collaborate with 45 clients to monitor the successful completion of their Wellness Plans (target: 40)
- Provide health education to 58 clients to improve chronic condition self-management (target: 50)
- Provide medication review and/or assistance and education to 84 clients (target: 50)

Highlights

97%

97% of all Health Promoter clients **have a primary physician** (target: 95%).

Success Story

When Latifa went for a checkup for a lump on her breast, she was advised that the lump was harmless and didn't require any further testing. She remained worried and reached out to her health promoter. They developed a wellness action plan in which Latifa would seek a second opinion. The second doctor ordered a referral for a mammogram, whose results confirmed that Latifa had breast cancer. After much research, the health promoter found a clinic that would accept Latifa as a Medi-Cal patient. The health promoter scheduled and escorted Latifa to the consultation. Latifa was scheduled for surgery followed by chemotherapy, and has been cancer-free for two years.

Health Enrollment for Children

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

FY 16/17 Allocation: **$300,000** | **Expended/Encumbered:** **$300,000**

Individuals served by Measure A: 1,737 (Total individuals served: 6,949)

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 competent 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.

Matching Funds

$150,000

from **Medi-Cal Administrative Activities (MAA)**.

Measure A Funding Summary

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

- 1,737 Alameda County residents received application assistance.
- The Health Insurance Technician (HIT) assistance toll-free line received 2,637 calls.

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

FY 16/17 Allocation: **$107,301*** | **Expended/Encumbered:** **$43,340**

Individuals served by Measure A: 204 (Total individuals served: 292)

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, Oakland, San Lorenzo

Includes Board of Supervisors discretionary allocation from **District 2/Supervisor Valle*

Background

The Day Labor Center (DLC) works to enable low income, predominantly migrant clients in the East Bay Area, including at-risk youth and re-entry clients, to reach self-sufficiency through employment and community integration programs.

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.
- Public health prevention. The DLC offers Zumba classes for women.
- 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.
- 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.

Note: In January 2017, the DLC no longer had enough committed funding to continue their work and made the decision to close the project.

Highlights

83%

83% of clients **received the follow-up care needed** (target: 30%).

56%

56% of clients who **needed three or more medical treatment visits, sessions, and/or referrals received them** (target: 50%).

Measure A Funding Summary

Measure A funding helped the DLC achieve the following:

- Distribute over 350 outreach flyers to inform workers about health care services to over 99 clients (target: 100 health outreach activities to at least 50 clients)

- Make 187 referrals; 99 health and/or dental assessments, referrals, and/or follow-up; and over 36 follow-up referrals (target: 400 health and/or dental assessments and /or referrals and at least 150 follow-up referrals to a minimum of 100 clients)
- Identify and refer 41 uninsured clients to a health insurance eligibility worker (target: 100)
- Identify, conduct community-based health outreach to, and/or refer a minimum of six uninsured immigrant youth (UIY) and/or their sponsor family members to health and/or dental services (target: 15)
- Host two quarterly meetings with appropriate staff from the DLC and partner agencies to review and evaluate the monitoring system for chronic conditions (target: four)

Highlights

23%

23% of clients who were contacted through a health outreach encounter **came into the DLC for health and/or dental assessments and/or referrals** (target: 10%).

Health Services for Day Laborers: Multicultural Institute

mionline.org

FY 16/17 Allocation: **$89,301** | **Expended/Encumbered:** **$89,301**

Individuals served by Measure A: 817 (Total individuals served: 942)

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

Services provided: Hospital Outpatient, Public Health

Service area: Berkeley, Oakland, Homeless or transient

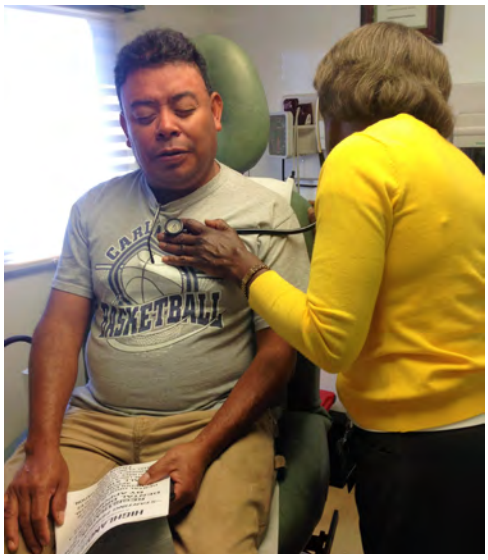
Background

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 low income youth and adults lacking access to critical services. Its programs are focused on historically disadvantaged groups in neighborhoods in Alameda and other counties.

The Life Skills/Day Laborer Program offers comprehensive wraparound services focused on improving the economic and social lives of Alameda County day laborers and other low income families. In addition, MI contributes to health awareness and prevention by offering health education, referrals, screenings and health services.

In addition to health referrals, services, and educational workshops, participants also benefit from the following:

- Culturally and linguistically appropriate street outreach. In MI's on-the-street model, staff accompanies day laborers every morning while they look for work in West Berkeley. This approach allows for services to trickle down to those that otherwise would not seek out these services. Referrals and job placements often occur at the street corners. This program also works with local officials and area businesses to ensure that the area is safe, that workers have access to trash receptacles and portable bathrooms, and that there is no harassment of workers.
- Workforce development and job placement assistance. This program offers day laborers job matching services at no cost. They are connected to employers for short-term, long-term, and permanent jobs at a minimum of $20/hour. MI also aids workers in addressing employment problems related to wage claims, unsafe conditions, and occupational injuries.
- Referrals and follow-up services. This program's health activities help individuals navigate the health system by providing language-



Highlights

93%

93% of individuals served reported that their **health care needs were met** with MI's assistance.

appropriate resources, information, case management, and referrals. The focus is on health education and outreach. Even though MI does not have doctors and nurses on staff, it provides free health services through its partnerships with other health organizations or clinics. MI also provides immigration resources and legal information thanks to the help of volunteer and private lawyers that partner with MI.

- Vocational skill development. Various educational and vocational courses offered through this program include a Spanish-language GED preparation course, a computer skills development course, and a business entrepreneurship course that includes yearlong coaching to assist self-employed immigrants and immigrant small business owners.
- Community-building. MI helps break down isolation and builds a sense of community by hosting Thanksgiving and Christmas holiday events every year and distributing holiday baskets to the homeless and community members that need it the most. Once a month, MI outreach staff and day laborers work together to clean the street. MI distributes bags of groceries and healthy food baskets.

Measure A Funding Summary

Measure A funding helped MI achieve the following:

- Provide outreach to 817 unduplicated clients and 103 one-on-one health-related consultations (target: outreach to 700 clients and 100 consultations)
- Host or co-sponsor nine health care trainings or workshops attended by 132 participants, as well as 10 street-based health education sessions on attended by 131 participants (target: eight trainings and eight education sessions attended by 120 participants each)
- Arrange five health care screening events attended by 85 individuals (target: four events attended by 100 individuals)

Success Story

Lorenzo, a 40-year-old Guatemalan day laborer, commented to staff that he had been experiencing blurry vision. He didn't think it was that serious and had been ignoring it for months. Staff insisted that he get checked and encouraged him to visit the mobile van. After his initial checkup, he was referred to Highland Hospital, where he had two surgeries: one for cataracts and the other on his retina. Thanks to him enrolling in HealthPAC and his referral from the mobile van, he paid nothing to receive these services. His vision is better and currently there is no risk of him losing his eyesight.

Health Services for Day Laborers: Street Level Health Project

streetlevelhealth.org

FY 16/17 Allocation: **$89,301** | **Expended/Encumbered:** **$89,301**

Individuals served by Measure A: 673 (Total individuals served: 742)

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

Services provided: Public Health, Mental Health

Service area: Countywide

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.

Twenty-two percent of Street Level Health's new patients had not seen a doctor in over five years, and 61% of patients were uninsured. The Street Level Health Access Program is a critical entry point to the health care and social service system for a vulnerable population excluded in Alameda County. Many of the community members that access Street Level Health 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.

Street Level Health's Whole Person Care Model strives to combat these barriers by prioritizing Mam language interpretation as part of its free, twice-weekly health screenings, drop-in health navigation, and onsite health enrollment. In response to the issues related to food access and malnutrition in the community, the Health Access Program provides a nutritious, twice-weekly lunch service.

Mental health awareness has been an area of focus this year due to heightened immigration enforcement in the community. Street Level's Mental Health team initiated a five-week seminar series to provide guidance on how to reduce stress and establish internal peace. Participants found the sessions to be a safe place to share personal stories and learn the ways of reducing stress, such as meditation and breathing exercises.

Highlights

2,292

Street Level Health met or exceeded its targets in all areas—for example, **distributing 2,292 free bags of fruits and vegetables to 456 low income households**, compared to a target of 2,000 bags to 400 households.

Measure A Funding Summary

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

- Provide 1,130 health care screening and episodic care visits to 676 clients across multiple languages (target: 1,200 screenings/visits to 750 clients)
- Offer 2,785 health-related navigation and referral services across 76 local health care agencies (target: 2,100)
- Provide 347 mental health consultations to 181 low income clients (target: 125 consultations)
- Provide 247 nutritionist/herbalist consultations to 180 clients (target: 100 consultations)
- Distribute 2,292 free healthy fruit and vegetable food bags to 456 low income households (target: 2,000 bags to 400 households)
- Recruit and train 26 prospective and current health care providers to provide them with experience working with uninsured low income communities (target: 25)
- Provide medical service in the same day to 96% of clients who checked in to the clinic (target: 95%)
- Refer 80% of clients who had no health care coverage to the enrollment worker (target: 75%)
- Provide information on how to access services to 90% of clients who screened positively for unmet mental health needs (target: 80%)
- Provide a glucose screening at first visit to 84% of clients who reported a family history of diabetes (target: 60%)

Success Story

Yolanda came to Street Level Health to address issues that were not being taken seriously by her current primary care provider. During her visit, Yolanda received a health screening, a nutritionist/herbalist consultation, and a mental health consultation. The mental health consultation revealed that Yolanda was undergoing extreme anxiety and difficulty managing her stress after her son was murdered two months prior. The fear and pain from this tragic event were in addition to her medical issues. Yolanda was immediately referred to Casa del Sol for further evaluation and treatment. She was also set up with a care plan at Highland Hospital and Street Level Health for continuous medical treatment.

Increase Hospice Utilization

gettingthemostoutoflife.org

FY 16/17 Allocation: $50,000 | **Expended/Encumbered: $50,000**

Individuals served by Measure A: 45 (Total individuals served: 2,000)

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

Services provided: Hospital Inpatient, Hospital Outpatient

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. GMOL provides education and resources in advance care planning and increased utilization of hospice services, and helped with the creation of the In-Home Support Services Care Partners Palliative Program.

For the No One Dies Alone (NODA) program, GMOL contracts with Comfort Homesake, a nonprofit organization, to train culturally and linguistically diverse residents in multiple topics such as empathy, conversation starters, end-of-life services, and a three-part series that covers advance care planning, advance directives, and physician orders for life-sustaining treatment. The NODA Touching Souls pilot is designed to develop interpersonal communication skills and create a resource in the families of the formerly incarcerated.

Volunteers provided dispatch, visits, and other services at Highland Hospital and the Alameda County Social Services Agency Care Partners palliative program.

Measure A Funding Summary

GMOL and Comfort Homesake used their Measure A allocation to develop a process and outreach material to provide NODA services to the terminally ill, unhoused, and re-entry populations. Specifically, Measure A funding enabled GMOL and Comfort Homesake to achieve the following:

- Develop a training module on NODA for lay persons and clinical staff at the Alameda County Health Care Services Agency homeless clinic
- Train over 30 NODA volunteers and maintain a team of at least eight volunteers who provide dispatch, visits, and other services at Highland Hospital and the Alameda County Social Services Agency Care Partners palliative program
- Develop electronic and hard-copy manual NODA referral processes
- Develop a Touching Souls logo and written program outline for formerly incarcerated persons to be involved in their own health care or the care of a seriously or terminally ill family member
- Prepare a brochure for the Santa Rita Jail transition center
- Execute 46 and hand out over 130 Advance Health Care Directives

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

FY 16/17 Allocation: **$261,000** | **Expended/Encumbered:** **$261,000**

Individuals served by Measure A: 1,497 (Total individuals served: 1,497)

Populations served: Low Income, Uninsured Adults, Children

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.

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

Measure A Funding Summary

Measure A funds the position of the JJ Health Services Director, who acts as an interagency liaison between BHCS, the Alameda County Health Care Services Agency, the Probation and Public Health Departments, and community providers. The JJ Health Services Director works to align all of the partners to ensure youth involved in the juvenile justice system have access to comprehensive health services inside the JJC as well as in the community.

Examples of the JJ Health Services Director's work include the following:

- Improved communication. The JJ Health Services Director has re-established regular meetings between interagency partners to update protocols and procedures related to delivery of primary and mental health care services.
- Quality improvement: The JJ Health Services Director has strengthened the quality improvement process between health care partners and Probation, including more frequent interagency case reviews with a focus on improving quality of care and coordination of services. Youth needing intensive services are referred to two agencies that operate four programs: Project Permanence, Multidimensional Family Therapy, Intensive Case Management, and Multisystem Therapy.

Success Story

A 17-year-old African American man with severe developmental delays and mental health needs was detained at JJC for a minor crime. He was released and assigned a probation officer. The probation officer had a difficult time connecting the young man to services and reached out to the JJ Health Services Director for support. The JJ Health Services Director helped the probation officer connect the youth with a program that had culturally appropriate staff and immediate availability. After two weeks working with the program clinician, the young man returned to school. He continued to make progress in school attendance and with his therapist and has since been dismissed from probation.

- Connecting JJC youth to mental health/youth development supports. The JJ Health Services Director ensures that youth—particularly those in need of intensive services—transitioning from the JJC to Probation get connected to mental health and other support services.
- Opportunities for care redesign. The JJC Health Services Director has initiated a process to explore the redesign of comprehensive health services for juvenile justice-involved youth.

Medical Costs for Juvenile Justice Center: Mind Body Awareness

mbaproject.org

FY 16/17 Allocation: **$58,939** | **Expended/Encumbered:** **$58,939**

Individuals served by Measure A: 221 (Total individuals served: 221)

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.

Highlights

87%

Based on evaluation surveys and focus groups, 87% of youth reported **that groups were a safe space to share**.

Measure A Funding Summary

MBA used its Measure A funds to teach mindfulness-based stress reduction classes in several units of the Alameda County Juvenile Justice Center (ACJJC), as well as at Camp Sweeney. Classes took place once a week, for 1.5 hours. Specifically, Measure A funding helped MBA achieve the following:

- Serve 221 unique youth through a 10-week mindfulness-based group model (target: 270)
- Lead 247 groups run by meditation instructors trained in a trauma-informed mindfulness-based curriculum (target: 240)
- Distribute mindfulness-based tools including books, posters illustrating key principles, and postcards illustrating mindfulness tools to 75% of youth at ACJJC (target: 60%)

Matching Funds

$64,000

from the following sources:

- **Quest Foundation**
- **Fenwick Foundation**
- **Kalliopeia**
- **APS Foundation**
- **Angell Foundation**

Medical Costs for Juvenile Justice Center: Niroga Institute

niroga.org

FY 16/17 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:

- 504 classes for youth
- 2,850 youth service encounters
- 108 classes for staff
- Three all-day retreats for youth

Highlights

88%

88% of participating youth reported that the program was **helpful for managing emotions and stress**.

Medical Costs for Juvenile Justice Center: Victims of Crime

alcoda.org/victim_witness/california_victim_compensation_program

FY 16/17 Allocation: **$90,000** | **Expended/Encumbered:** **$76,384**

Individuals served by Measure A: 2,733 (Total individuals served: 2,733)

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

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

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

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 as they reclaim their sense of safety, well-being, and dignity.

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
- 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 economic services and resources

Measure A Funding Summary

The Victim Compensation Program used its Measure A allocation to expedite the processing of claims submitted by the Guidance Clinic originating in the Alameda County Family Justice Center, Camp Sweeney,

Success Story

An application was filed on behalf of a minor sexual assault victim, Jane. The adult applicant who filed for Jane did not utilize available benefits to help Jane overcome emotional trauma. Therefore, the application was approved and issued a zero payment award. When Jane reached adult status, she followed up on her claim. Staff explained all available services and benefits and helped Jane secure psychotherapy. Because Jane desired to move from the city where she was victimized, staff also performed property searches, made housing program inquiries, and helped Jane fill out rental applications. Staff also provided emergency reimbursement of Jane's out-of-pocket hotel costs and other temporary lodging expenses.

school-based health centers in Alameda County, and/or Crisis Service Response Teams.

Staff identified and followed up to contact qualifying claimants who were approved but did not access or use funds for covered medical, mental health, relocation, wage loss, or other services.

Specifically, program staff funded by Measure A processed applications for 2,733 victims of crime during FY 16/17. Of these, 57%, or 1,555 victims, submitted bills for approved benefits that were processed by staff. The remaining 43%, or 1,178 victims, did not submit bills for benefits. However, staff followed up to confirm that the victims were aware they had an approved application and to find out what prevented them from submitting a bill. Staff documented the reasons and provided assistance to victims who requested help finding resources for their approved benefits. Staff also documented reasons why victims chose not to seek assistance for approved benefits or submit bills for approved benefits.

1,555 victims submitted bills for approved benefits that were processed by staff.

Native American Health Center

www.nativehealth.org

FY 16/17 Allocation: **$35,000** | **Expended/Encumbered:** **$35,000**

Individuals served by Measure A: 387 (Total individuals served: 3,971)

Populations served: Low Income, Uninsured Children, Families

Services provided: Public Health, Mental Health

Service area: Oakland, San Leandro

Background

Native American Health Center (NAHC) provides comprehensive services to improve the health and well-being of American Indians, Alaska Natives, and residents of the surrounding communities.

The NAHC School-Based Health Center Department provides health services in collaboration with the Oakland, San Leandro, and Alameda Unified school districts. NAHC School-Based Health Centers (SBHCs) offer integrated comprehensive services including medical, behavioral health, dental, and youth development. Family and community engagement are essential elements in every health center.

Measure A Funding Summary

NAHC received a one-time Measure A allocation to support the opening of its San Leandro site through the purchase of supplies, equipment, and furniture. This funding allowed the site to open for services immediately.

Measure A funding helped the NACH SBHCs achieve the following:

- Provide comprehensive medical services to 27% of the students at Madison Park Academy, San Leandro High School, United for Success/ Life Academy, and Skyline High School SBHCs (target: 25-50%)
- Provide dental services to 30% of students at the four SBHCs (target: 20-50%)
- Provide dental screenings for 1,450 students and additional dental visits for cleaning, exams, and treatments for 1,074 students at the Madison, San Leandro, and UFSA/Life Academy SBHCs
- Provide appointments for behavioral health services to 512 students
- Provide health education/promotion and youth development services to 20% of the student body at the four SBHCs (target: 20-40%)
- Have each of the four NAHC SBHCs participate in at least one family or community health event that promoted health services and educated the community about services offered at the SBHCs
- Implement health career internship/leadership programs at all SBHCs

Highlights

↓10%

UFSA/Life Academy SBHC **reduced its no-show rate** to less than 10%.

15%

Madison SBHC **increased the number of students receiving clinical services** by 15% compared to the previous year.

Preventive Care Pathways

healthcare.gov/coverage/preventive-care-benefits

FY 16/17 Allocation: $214,322 | Expended/Encumbered: $214,322

Individuals served by Measure A: 1,978 (Total individuals served: 4,600)

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

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

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

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, providing health care services for individuals re-entering the community from the prison system, and conducting health fairs and community education presentations at schools, churches, and other community sites.

Measure A Funding Summary

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

- Provide 4,093 medical service visits to 3,300 unduplicated low income residents (target: 1,500 visits to 250 patients)
- Screen 333 patients for Hepatitis C (target: 30)
- Provide treatment to 47 patients who tested positive for Hepatitis C
- Coordinate four health fairs and/or workshops attended by 510 participants (target: four fairs/workshops with 50 participants)
- Provide Covered California or Medi-Cal application assistance to 484 residents (target: 30)
- Attend three Covered California CEE Alameda County Partnership Meetings (target: two)

Matching Funds

$210,000

from the following sources:

- **Alameda County Social Services Agency General Assistance funding**
- **Alameda County Foster Families**
- **Alameda County Probation (AB109)**
- **Alameda County Health Care Services Agency Hepatitis C Screening and Treatment**
- **Environmental Analysis for TLS Project**

ALAMEDA HEALTH CONSORTIUM

Primary Care Community-Based Organizations

FY 16/17 Allocation: **$5,370,494** | **Expended/Encumbered:** **$5,370,494**

Individuals served by Measure A: 18,660 (Total individuals served: 194,299)

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

Services provided: Hospital Inpatient, Hospital Outpatient, 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 provide a wide range of support services to improve the lives of patients served. More than 20 different languages are spoken across the health centers.

Highlights

40,514

Patients number accessing care for certain diagnoses increased, sometimes dramatically, over the previous year:

- 40,514 patients with hypertension
- 23,415 patients with diabetes
- 8,822 patients with asthma
- 6,713 prenatal patients
- 30,153 with mental health as diagnosis
- 1,714 with HIV

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

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

- 16,634 low income Alameda County residents made a total of 63,159 service visits to access quality services through HealthPAC.
- 18,660 low income residents were enrolled in HealthPAC at one of the health centers.
- Across three health centers, 39,465 patient screenings for HIV and 12,183 for Hepatitis C were conducted.
- Twelve Community Health Workers were added across the health centers, increasing their capacity to support more than 800 medically complex patients.
- LifeLong Medical Care opened a primary care health center site in Pinole, increasing patient access to services.
- Two cohorts totaling 18 primary care professionals from across the consortium completed the UC Davis Primary Care Psychiatry Fellows program to better manage behavioral health patients with complex needs.
- Three primary care professionals participated in the UC Davis Pain Management Fellows Program to increase provider capacity in the area of pain management and opioid addiction.
- The Training and Technical Assistance program for behavioral health clinicians continued to grow to support primary care and behavioral health integration at all health centers.
- Data sharing between specialty mental health providers and primary care providers was improved to work towards a whole-person care approach when caring for behavioral health patients.

Success Story

A young female patient came to America from Mexico alone in search of a better life. With no family support, she was at a loss when she became pregnant. Through community members, she learned about LifeLong Medical Care. At LifeLong, she gained access to prenatal care and learned how to manage a healthy pregnancy. Her providers at the clinic invited her to join one of LifeLong's Centering Pregnancy Groups. In this group, she met other Spanish-speaking women who provided her with the support she was lacking from being far away from home. At LifeLong, this patient received necessary medical care and support from fellow community members all in one place.

Actual Visits for Each Consortium Health Center

	Total Patients	Primary Care, Specialty Visits	Dental Visits	Mental Health Visits	Total Visits
Asian Health Services	332	992	-	42	1,034
Axis Community Health	1,642	6,255	-	129	6,384
La Clinica de la Raza	5,335	15,869	165	1,322	17,356
LifeLong Medical Care	1,147	3,750	467	304	4,521
Native American Health Center	608	1,517	1,088	127	2,732
Tiburcio Vasquez Health Center	4,737	13,551	3,111	709	17,371
Tri City Health Center	2,282	8,481	3,035	377	11,893
West Oakland Health Center	551	1,121	733	14	1,868
Total	**16,634**	**51,536**	**8,599**	**3,024**	**63,159**

Roots Community Health Center

FY 16/17 Allocation: **$100,000** | **Expended/Encumbered:** **$100,000**

Individuals served by Measure A: 173 (Total individuals served: 173)

Populations served: Indigent, Low Income Adults

Services provided: Public Health, Mental Health

Service area: Oakland

Background

Roots Community Health Center works to eliminate health disparities in Oakland by providing culturally competent, comprehensive health care, mental health, and wraparound services, and by emphasizing self-sufficiency and community empowerment. Roots Community Health Center accomplishes its mission by providing top quality health care; conducting community-based participatory research; and offering opportunities for rehabilitation, education, training, and employment to reduce poverty and dependency in the community. They prioritize services for African American men, the formerly incarcerated, homeless residents, and those with substance use and mental health issues.

The Healthy Measures program expands access to health care services to formerly incarcerated populations via a Transition Navigator at Santa Rita Jail who bridges them post-release to a Roots Health Navigator, who facilitates their engagement in clinical and wraparound services at Roots Community Health Center. Roots Health Navigators facilitate improved health care access through patient advocacy and care coordination and successfully link reentry patients—many of whom have never engaged in primary care—to Roots as their medical home, thereby improving chronic disease management and health outcomes.

Healthy Measures not only diagnoses and treats medical conditions, but addresses barriers such as housing and food security that exacerbate chronic illness and ultimately lead to increased recidivism and inappropriate utilization of costly and overburdened systems such as emergency and psych emergency departments.

Matching Funds

$63,396

from **Medi-Cal Administrative Activities (MAA)** and **Targeted Case Management (TCM)**.

Measure A Funding Summary

Roots Community Health Center used its Measure A allocation to achieve the following:

- Health navigation services:
  - Enroll 173 individuals into Healthy Measures

- Conduct 390 post-release navigation and case management visits to 173 individuals
- Connect 21 new clients to Medi-Cal enrollments and complete 27 CalFresh applications

- Medical services: Serve 93 unduplicated patients with a total of 151 patient visits
- Behavioral health services: Conduct 43 visits for 17 clients

Success Story

Rosita was referred to the Healthy Measures program by her parole officer when she was nearing the end of her housing stipend and on the brink of becoming homeless. She was seen frequently by Roots' primary health care provider and a Health Navigator, who provided wraparound care and management services, including helping Rosita find housing, scheduling her doctor visits, and taking her to job interviews. Thanks to this support, Rosita has experienced healthy outcomes including treatment of chronic conditions, smoking cessation, stable affordable housing, and a well-paying job.

Tiburcio Vasquez Health Center, Inc.

tvhc.org

FY 16/17 Allocation: $60,000* | **Expended/Encumbered: $60,000**

Individuals served by Measure A: 350 (Total individuals served: 2,502)

Populations served: Low Income, Uninsured Children, Families

Services provided: Public Health, Mental Health

Service area: Hayward, Union City

Includes Board of Supervisors discretionary allocation from **District 2/Supervisor Valle*

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 and 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

95%

In evaluation surveys, 95% of respondents expressed that health center staff helped them **get services they wouldn't otherwise get**.

Matching Funds

$210,965

from **private grants, the school district, federal funding,** and **organization funding.**

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 (target: 10-15%)
- Provide oral health screenings to the student body at each school health center site
- Pilot oral health screenings for at least one additional school campus served by a school health center
- Provide the following medical coverage: 40 hours per week at Logan High School, 16 hours per week at Tennyson High School, and 24 hours per week at Hayward High School
- Provide 40 hours per week of behavioral health-related services, referrals, and linkages at Logan and Tennyson High Schools
- Provide an average of 16–35 hours per week of health education, health promotion, and youth development services at each site
- Engage with family and/or community members through at least one health-related events and/or activitiy at each school health center

Success Story

A teen who was very far along in her pregnancy was referred to the health center. Staff learned that the teen had no prenatal care and no primary care provider. She also didn't know her due date. Staff contacted the prenatal coordinator at the main school health center site and was able to book an appointment to start the teen with prenatal care in less than a week. Staff also called the family support service team who work with pregnant or parenting teens. The teen left very happy to know of all the services she was going to be receiving in such a short period of time.

Washington Hospital

www.whhs.com

FY 16/17 Allocation: **$33,000*** | **Expended/Encumbered:** **$33,000**

Individuals served by Measure A: 51 (Total individuals served: 51)

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

Services provided: Hospital Outpatient, Public Health

Service area: Countywide, Homeless or transient

Includes Board of Supervisors discretionary allocation from **District 1/Supervisor Haggerty*

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.

Patients referred to the Community Mammography Program at Washington Hospital benefit from prompt screening and evaluation at no cost. Timely access to preventative mammography screenings can catch abnormalities early in the disease process, especially with aggressive cancers. With the access this program provides and with timely screening/mammogram appointments, patients stand the best chance of quick medical follow-up for abnormal findings.

Washington Hospital provided free mammography screenings to 51 indigent, low income, and uninsured patients.

Measure A Funding Summary

Washington Hospital used its Measure A allocation to provide free mammography screenings to 51 indigent, low income, and uninsured patients referred to Washington Hospital by local partner health centers. Forty percent, or 20 of these mammograms, showed suspicious findings requiring follow-up. Seventeen of the 20 patients were called back for additional evaluation, and three required a six-month follow-up screening.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 4: PUBLIC HEALTH

Alameda Boys & Girls Club, Inc.

alamedabgc.org

FY 16/17 Allocation: **$107,161** | **Expended/Encumbered:** **$107,161**

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

Populations served: Indigent, 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 (ABGC) 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, caring, and responsible 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. Approximately 70% of youth attending ABGC are living in poverty.

Daily programming at ABGC focuses on education and career development; character and leadership; health and life skills; Science, Technology, Engineering, and Mathematics (STEM); fine and performing arts; and sports, fitness, and recreation. ABGC also provides onsite vision, dental, and respiratory clinics as well as small group counseling sessions for all youth.

Measure A Funding Summary

Measure A funding helped ABCG serve Alameda youth and teens with a comprehensive culinary, nutrition, and health education program integrated with physical fitness, recreational, and environmental programming.

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

- Increase access to medical and mental health services to low income youth
  - 405 youth received 38 vision and/or respiratory screenings and referrals to follow-up care (target: 12 screenings/referrals for 270 youth).

Highlights

100%

100% of members who received a vision and/or respiratory screening with a detected issue were **referred to needed follow-up services**.

- Four health education events and/or workshops were conducted with 425 youth attending (target: four events/workshops with 320 youth attending).
- 299 youth were served through 12 mental counseling sessions (target: eight sessions serving 50 youth).
- 40 mental health visits were provided (target: 30).

- Increase access to culturally competent public health and mental health services to low income youth through Life Skills workshops for middle and high school students and daily programming for all youth designed to guide youth towards choices and lifestyles that support health, responsibility, and morality
  - Four Passport to Manhood workshops were conducted serving 50 middle school male students (target: four workshops serving 50 students).
  - Nine SmartGirls workshops were conducted serving 42 female members (target: six workshops serving 75 members).
  - 725 members participated in 40 Healthy Habits workshops (target: 40 workshops for 240 members).
- Increase access to culturally competent public health services to youth through a comprehensive culinary, nutrition, and health education program
  - 264 unduplicated members participated in culinary and nutrition education programming (target: 250).
  - Three culinary, nutrition, and health workshops education workshops/events were provided to all Club youth (target: one).
- Increase access to culturally competent public health services to youth through a dynamic, garden-based nutrition and ecology education program
  - 428 unduplicated members participated in nutrition and ecology education programming (target: 250).
  - One garden-based nutrition and ecology education event/ workshop was conducted for all Club youth (target: one).
- Increase access to culturally competent public health services to youth through a low and high impact recreation and sports program
  - 2,450 unduplicated youths participated in low and high impact recreation and sports (target: 1,000).
  - Four low and high impact sports and recreation workshops/events were conducted for all Club youth (target: one).

Highlights

90%

90% of youth **learned a new skill for handling the transition from childhood to adulthood**.

Asthma Start

acphd.org/asthma.aspx

FY 16/17 Allocation: $100,000 | **Expended/Encumbered: $100,000**

Individuals served by Measure A: 39 (Total individuals served: 41)

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

Services provided: Public Health

Service area: Alameda, Hayward, Oakland, 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 and provide environmental cleaning in the home. 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.

Ninety-five percent of the children served were insured by Medi-Cal and from low income families. Asthma Start is the only program in the County that provides this type of service to families.

Measure A Funding Summary

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

- Open 356 cases in a 12-month period and close 54 cases, of which 41 were closed successfully (target: open 250 cases)
- Increase knowledge of asthma in 100% of caregivers (target: 95%)
- Help 98% of children maintain or reduce asthma symptoms to the lowest level (target: 95%)

Highlights

↓34%

Prior to case management, 34% of the clients had been hospitalized and 76% had been to the emergency room. Post case management, **0% had been hospitalized and 5% had been to the emergency room**.

Matching Funds

$50,000

from **Targeted Case Management (TCM)**.

- Help 100% of caregivers reduce at least one identified asthma trigger (target: 95%)
- Reduce instances of children requiring hospitalization to 0% and emergency department visits to 5% post-case management (target: 20% or less)
- Increase confidence in managing their child's asthma in 100% of caregivers (target: 95%)
- Ensure 100% of children have a medical home and insurance before discharge (target: 100%)

Center for Early Intervention on Deafness

ceid.org

FY 16/17 Allocation: **$53,581** | **Expended/Encumbered:** **$53,581**

Individuals served by Measure A: 877 (Total individuals served: 1,361)

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

Services provided: Public Health

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

Background

The Center for Early Intervention on Deafness (CEID) works to maximize communication potential through early education, family support, and community audiology services. CEID provides essential hearing health services for infants, children, and adults. Their diverse staff provides clients with a safe and comfortable experience through their appointment and testing. Staff are able to connect patients and parents with important resources and support them as they navigate service systems. CEID is one of the few clinics that provides services to seniors whose hearing has deteriorated over time.

Measure A Funding Summary

CEID used its Measure A allocation to hire staff that is bilingual in Spanish and English. In addition, Measure A funding enable CEID to offer onsite pediatric resident training. Residents learned how to understand and explain 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 108 newborn hearing screenings (target: 150)
- Perform 718 audiological evaluations for children, youth, and adults (target: 300)
- Dispense hearing aids and ear molds to 175 residents (target: 125)
- Train 42 pediatric residents (target: 75)

Highlights

100%

100% of patients reported that their **quality of life (access to sound in environments and communication) had improve**d (target: 85%).

City of Alameda: Community Paramedicine Services

alamedaca.gov/fire/community-paramedic-program-0

FY 16/17 Allocation: **$246,048** | **Expended/Encumbered:** **$246,048**

Individuals served by Measure A: 94 (Total individuals served: 331)

Populations served: Indigent, Low Income Adults, Seniors

Services provided: Emergency Medical, Substance Abuse

Service area: Alameda, Homeless or transient

Background

The Alameda Fire Department's Community Paramedic (CP) program helps guide clients towards improved health and well-being, connect clients with appropriate services, and intervene at critical junctures when clients are most at risk and unable to maintain an active participation in the management of their health care.

Specific services provided by the CP program include in-home medication reconciliation, collaboration with family and significant others for client care plan, phone visits, facilitation of residential detox enrollment with transportation, immediate advanced life support assessment and care with transport coordination, home safety assessments with appropriate referrals, and smoke detector inspections with battery replacement.

The CP Program is comprehensive in order to identify the diverse range of client needs that often fall into separated domains of health and medical care, mental and behavioral health care, substance abuse, and social support. CP services are available regardless of an individual's medical insurance, socioeconomic status, or health status.

Highlights

↓34%

The estimated **cost to Alameda Hospital resulting from readmissions was reduced by 34%**.

↓25%

Non-urgent utilization of 911 and emergency services was **reduced by 25%.**

Measure A Funding Summary

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

- Enroll 90 clients in the program
- Continue services for four frequent utilizer clients who were enrolled prior to FY 16/17
- Provide 187 home visits and 570 phone visits to clients
- Perform 200 physical assessments, 766 bio-psych-social assessments, and 90 home safety assessments
- Make one to two referrals per month to the Alameda Senior Fall Prevention Program as a result of home safety assessments
- Perform 90 medication reconciliations and identify and address five medication errors

City of San Leandro

sanleandro.org

FY 16/17 Allocation: **$53,581** | **Expended/Encumbered:** **$53,581**

Individuals served by Measure A: 8,535 (Total individuals served: 64,918)

Populations served: Seniors

Services provided: Public Health

Service area: Castro Valley, 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 supported the City of San Leandro in offering programs, services, and education aimed at prevention and improving health and wellness outcomes.

The Recreation and Human Services Department used its Measure A funds to increase the participation of San Leandro seniors and older adults in opportunities and experiences designed to enhance health and wellness. The department set a goal of participation by 50% of the senior population in its health and wellness programs and services.

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 685 seniors (target: 360)
- Through the Mercy Brown Bag program, distribute 925 grocery bags of nutritional food to 990 eligible seniors (target: 720)
- Provide 25 health education classes attended by 304 seniors (target: 12 classes)
- Conduct 33 Pull Up a Chair exercise classes attended by 535 seniors (target: 36 classes)
- Hold 234 fall prevention exercise and balance classes attended by 228 seniors (target: 208 classes)

Highlights

↑100%

Recreation and Human Services exceeded almost all of its targets for senior services, sometimes dramatically. For example, **the Senior Community Center conducted 685 health checks**—an increase of over 100% compared to the previous year.

Countywide Plan for Seniors: Getting the Most Out of Life

gettingthemostoutoflife.org

FY 16/17 Allocation: **$250,000** | **Expended/Encumbered:** **$183,579**

Individuals served by Measure A: 838 (Total individuals served: 22,000)

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

Services provided: Hospital Outpatient, Public Health

Service area: Countywide

Background

The Alameda County Getting the Most Out of Life (GMOL) program strives 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.

Advance health care planning is the foundation of the GMOL program, while hospice utilization supports people when they are at end of life. GMOL's newly developed palliative service is a bridge for individuals to receive curative care and have their stress, worry, and anxiety addressed in a way that builds trust.

No One Dies Alone (NODA) services in a patient's home or at the hospital allow the patient to feel supported by the presence of someone trained in the art of comfort and deep listening. In addition, the Touching Souls program is designed to develop interpersonal communication skills and create a resource in the families of the formerly incarcerated.

Highlights

37%

37% of training participants reported **executing an advanced directive**.

Measure A Funding Summary

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

- Increase knowledge of palliative care planning through 23 advanced health care trainings on aspects of advanced health care planning and a NODA volunteer program to 34 individuals
- Complete over 150 advanced care directives
- Provide advanced care planning and hospice resources at various community events/fairs such as the Healthy Living Festival, San Quentin Health Fair, Bonita House, Center for Elder Independence, and other senior centers
- Offers a National Health Decision that supported 13 people with

advanced care planning conversations and notarized advanced directives in three locations throughout Alameda County
- Maintain monthly Hospice Providers Coalition meeting agendas and notes
- Establish a handbook for the Alameda County Health Care Services Agency/Social Services Agency In-Home Support Services (HCSA/SSA IHSS) Care Partners program as the County's first palliative care program
- Increase outreach and generate 478 self-referrals that are now the Care Partners client base
- Through its Care Partners program, collect data of hospice referrals resulting in an increase in hospice utilization in Alameda County

Highlights

92%

92% of training participants reported **they would recommend the training to others**.

Countywide Plan for Seniors: Home-Based Nursing Case Management

www.acphd.org/public-health-nursing.aspx

FY 16/17 Allocation: **$500,000** | **Expended/Encumbered:** **$332,663**

Individuals served by Measure A: 40 (Total individuals served: 1,450)

Populations served: Adults, Seniors

Services provided: Public Health, Mental Health

Service area: Castro Valley, Emeryville, 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 respecting the diversity of the community and providing for present and future generations.

Alameda County Public Health Nursing (PHN) works with clients 55+ years old to confront the psychosocial challenges that prevent clients from maintaining or improving their health status. PHN case managers perform comprehensive, multidomain assessments and advocate, refer, and link clients to necessary services

PHN nurses provide assistance with health care system navigation, interpretation of medical care plans, and assistance to caregivers, clients, and health care teams on follow-through. Nurses play a key role in care transitions out of emergency room or hospital settings back into the community. Nurses are also able to identify risk factors and make referrals for screening and early intervention to prevent disease and injury as well as promote clients' health and well-being.

Measure A Funding Summary

PHN used its Measure A allocation to achieve the following:

- Facilitate case management and care coordination focused on chronic medical disease self-management for older adults
- Hire a PHN/program manager to plan and develop a dedicated program model that began implementation in the fall of 2017
- Provide training to PHN Field Nursing units on the assessment of complex, vulnerable adults

Success Story

A 67-year-old marginally housed male with kidney disease, type II diabetes, hypertension, obesity, chronic back pain, and mental health issues was referred to PHN. PHN completed an assessment that included physical health, behavioral symptoms, medications, psychosocial supports, cognition, and other risk factors. PHN set up a nephrology appointment, follow-up nutrition consultation, urology appointments, immunizations, and an eye check for the client, and provided education regarding the client's diseases. The client has attended all appointments and is working on integrating exercise into his routine. PHN is helping him apply for food stamps and has supplied him farmers market vouchers.

Countywide Plan for Seniors: Injury Prevention, Meals, Nutrition

www.alamedasocialservices.org/public/services/elders_and_disabled_adults/area_agency_on_aging.cfm

FY 16/17 Allocation: **$750,000** | **Expended/Encumbered:** **$702,369**

Individuals served by Measure A: 3,982 (Total individuals served: 3,982)

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 goal is to enhance the health, safety, and well-being of older adults by offering coordinated services that promote health and wellness, with an emphasis on prevention and early access to behavioral health services. AAA partners with community-based organizations to provide evidence-based Health Promotion Programs via delivery of services in community clinic settings such as senior centers, community centers, and senior housing communities.

AAA's programs include the following:

- Senior Nutrition Program. This home-delivered meals program is designed to provide meals for consumers 50-60 years old while eliminating or minimizing the wait list.
- Brown Bag Nutrition Program. This senior nutrition program regularly provides bags of food to older adult citizens living on limited incomes. Services are provided throughout the entirety of Alameda County with a special emphasis on low income minority seniors.
- SNAP-Ed Community Gardens Program. This program works to build out four community gardens and provide nutrition education at senior housing sites.

Highlights

↑710%

In several areas, AAA greatly exceeded its targets. For example, **the Senior Nutrition program served 809 participants compared to a target of 114**—an increase of 710%.

Matching Funds

$49,579

from **federal, state, and local funding sources administered by the Area Agency on Aging as well as federal SNAP-Ed dollars to support additional community gardens at low income senior housing**.

Measure A Funding Summary

AAA used its Measure A allocation to provide the following:

- Serve 58,340 meals to 809 seniors in Oakland through Service Opportunities for Seniors (SOS) Meals on Wheels, with no Priority A seniors on a waiting list anywhere in Alameda County (target: 59,523 meals to 114 seniors)
- Provide a 20-pound bag of groceries two times per month to 500 older adults through the Mercy Brown Bag Program (target: 500)
- Offer nutrition and physical activity classes to 82 people through the senior community garden project
- Complete six garden projects in Oakland, Hayward, and Newark (target: four)

Success Story

Mr. M. was a firefighter in Oakland for most of his life. He is now homebound and mostly bedbound, and has several chronic health conditions. His pension is not enough to support full-time paid assistance, and he has no other resources to pay for help. He has a part-time caretaker assist him in the mornings and spends the rest of his day alone, with his television. He depends on someone from SOS Meals on Wheels coming by daily to give him lunch. He feels blessed to have someone who comes daily to check on him.

Eden Youth and Family Center

eyfconline.org

FY 16/17 Allocation: **$75,000*** | **Expended/Encumbered:** **$75,000**

Individuals served by Measure A: 110 (Total individuals served: 408)

Populations served: Indigent, 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

Includes Board of Supervisors discretionary allocation from **District 2/Supervisor Valle*

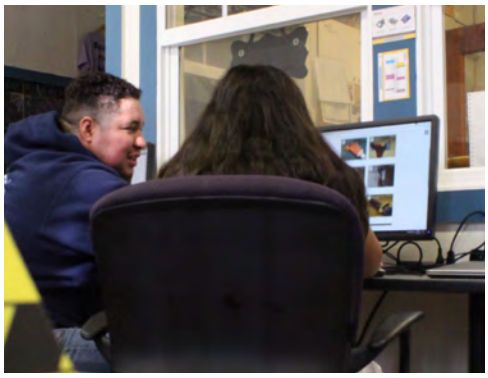
Background

Eden Youth and Family Center (EYFC) provides and supports a comprehensive array of services and advocacy for children, youth, and families in 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. The EYFC team provides youth with tutoring, academic skills, GED preparation, college readiness, career coaching, and completion of college and scholarship applications.

EYFC programs include the following:

- New Start Tattoo Removal helps young people remove the stigmatized markings of their past and increases their likelihood of success in the future. Through mentorship and case management, the New Start Tattoo Removal team works with participants to assist in rebuilding their self-esteem and their lives.
- The Step Forward program offers wraparound case management services to all of EYFC program participants. This program teaches soft skills including communication and listening skills, anger management skills, and empathy for others.
- The Computer Clubhouse provides creative, safe, and free out-of-school learning environments where youth can work with peer mentors to express ideas, develop skills, and build self-confidence through learning new technologies.
- Community Connection Peer Navigation provides culturally tailored information and personal mentorship to high risk youth and their



Matching Funds

$206,000

from **Substance Abuse and Mental Health Services Administration (SAMHSA) Drug-Free Communities, the Kaiser Permanente Tattoo Removal Program, and the Best Buy Foundation**.

families to facilitate access to services, encourage better self-care, and promote treatment success to improve long-term healthy behaviors and outcomes.
- The Hayward Coalition for Healthy Youth aims to strengthen collaboration among Hayward's residents, nonprofit and government agencies, schools, and law enforcement to prevent and reduce substance abuse.

Measure A Funding Summary

Note: Program outcomes were affected by a 47% loss in total program budget in FY 16/17.

EYFC used its Measure A allocation to achieve the following:
- Provide 50 life skills training sessions to 171 youth and young adults. The trainings covered health, wellness, drug prevention, and nutrition information, as well as communication and life skills, financial literacy, job readiness, resume building, and technology skills (target: 75).
- Coordinate Youth Advisory Councils (YACs) to provide Alcohol, Tobacco, and Other Drugs (ATOD) awareness education and prevention to over 261 youth and families at a community event, and present to parent groups (target: 75).
- Organize, coordinate, and sponsor the first annual "Reach for a Better Community" event designed to promote healthy/positive activities for youth in parks, nutritional and physical health, and community health. The event was attended by 150 youth and families.
- Provide case management to 24 youth and young adults with ATOD-focused workshops and one-on-one sessions, and refer youth with substance abuse and other health concerns for services to improve their overall health and wellness (target: 75).
- Provide 53 at-risk youth and young adults with wraparound case management support via the Step Forward and Computer Clubhouse programs, and link them to community resources to support their overall health and well-being.
- Refer 459 youth and families to onsite service providers for health screenings, pediatric health care, behavioral health needs, and early childhood education and child care (target: 100).

Highlights

82%

82% percent of program evaluation survey respondents reported they are **able to get along better with friends and others** after taking part in EYFC's programs.

90%

90% reported they are **better able to cope when things go wrong**.

100%

100% of YAC members agreed or strongly agreed that **participating in the YAC helped them stay away from negative activity**.

Emergency Medical Services (EMS) Corp

acphd.org/ems-corps.aspx

FY 16/17 Allocation: **$604,942** | **Expended/Encumbered:** **$604,942**

Individuals served by Measure A: 30 (Total individuals served: 30)

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 through youth development, mentoring, and job training.

The EMS Corps targets young men of color from low income and underserved communities. This program is designed to interrupt a pattern of behavior that leads to violence and an unhealthy lifestyle. By guiding them through life coaching, transformative mentoring, and health and wellness training, the program supports young men in making personal transformation and giving back to their community. Participants volunteer at middle and high schools, teach CPR, and conduct blood pressure screenings at churches, health fairs, and job fairs.

Measure A Funding Summary

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

- Receive 200 applications for the EMS Corps (target: 200)
- Operate two cohorts (target: two)
- Interview 60 potential candidates (target: 80)
- Select 40 participants for the program
- Train 30 EMTs (target: 35)
- Employ 70% of graduates (target: 60%)
- Conduct 10 volunteer community service events (target: five)

Highlights

85%

85% of program graduates were **offered employment** (target: 70%).

90%

90% of graduates **found the program impacted their lives in a positive way**.

Emergency Medical Services (EMS) Injury Prevention

acgov.org/ems

FY 16/17 Allocation: **$210,112** | **Expended/Encumbered:** **$210,112**

Individuals served by Measure A: 721 (Total individuals served: 721)

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

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

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 providers, and the services they offer, include the following:

- City of Fremont. The Afghan Elderly Association's Health Promotion Program connects seniors to health services in the community and provides emotional support. The program includes the Linkages Program, which provides information, referrals, and assistance to participants; medication assistance and counseling; the Happy, Healthy Me Program, a chronic condition self-management program; and health education groups. The program also offers chronic disease self-management training to help clients identify goals and an action plan to lessen the impact of chronic disease.
- DayBreak Adult Care Centers. In the Medication Safety program, a nurse or social worker visits the elderly in their home to assist with their day-to-day management of medications. DayBreak also provides medication management education to In-Home Support Services (IHSS) caregivers to review the basics of medication management.
- St. Mary's Center. St. Mary's offers a medication safety program, as well as programs for nutrition and fall-risk prevention and consumer education regarding how to access basic needs.
- United Seniors of Oakland and Alameda County (USOAC). For physical activity and nutrition, USOAC makes presentations to participants on healthy living and USOAC Walk Clubs throughout Alameda County. They outreach to older adults to participate in the USOAC Annual Healthy Living Festival to have seniors come and participate in healthy activities, receive resources provided by exhibitors, and properly dispose of unwanted medications at this event.

Highlights

↑200%

City of Fremont Health Promotion **exceeded its target for assisting clients in accessing and receiving mental health, health, and medically related services** by over 200%.

↑2000%

USOAC **exceeded its target for senior outreach** by 2,000%.

- Senior Support Program of the Tri-Valley. The medication safety program assists clients to have the tools and knowledge necessary to safely take their medications, serves as a double-check for medical systems to ensure medications are being taken safely, and provides seniors in the Tri-Valley with a free resource to reduce fall risks related to medication errors.

Measure A Funding Summary

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

- City of Fremont Health Promoter Program
  - Provide Health Promoter services to 161 refugee, immigrant, and low income residents over 60 years of age (target: 135)
  - Provide assistance and/or referrals for 132 clients (target: 110)
  - Ensure that 156 clients have a primary physician (target: 110)
  - Assist 113 older adult clients in accessing and receiving an array of mental health, health, and medically related services (target: 50)
  - Conduct falls, home safety, mental health, and health screenings for 60 older adults and refer clients to appropriate services as needed (target: 50)
  - Assess or reassess 47 clients regarding their ability to self-manage their chronic conditions (target: 45)
  - Develop 45 Wellness Plans and collaborate with clients to monitor the successful completion of their Wellness Plans (target: 45)
  - Provide health education to 58 clients through four evidence-based group trainings to improve chronic condition self-management (target: three groups to 50 clients)
  - Provide medication review and/or assistance and education to 84 clients (target: 50)
- DayBreak Adult Day Centers
  - Complete medication safety assessments to 34 participants (target: 40)
- Senior Support Services of the Tri-Valley
  - Provide medication safety services to 38 low income residents 60 or older living in the Tri-Valley (target: 38)
- St. Mary's Center
  - Facilitate a 12-week medication safety program for 60 older adults (target: 47)
  - Provide health screenings to 43 participants in the medication safety program (target: 37)
  - Provide 31 medication interaction reports to participants' primary care physician or pharmacist for further assessment (target: 31)
  - Complete 1,804 weekly medication safety compliance calls (target: 1,128)
  - Conduct 1,240 face-to-face medication safety conversations with participants (target: 564)
  - Conduct a 12-week review with 41 participants enrolled in the program (target: 24).

Success Story

St. Mary's Center

Brenda, 62, has multiple chronic health conditions. She enjoys cooking and spending time with friends, but because of her chronic conditions and all of the medication she is taking, she often doesn't feel well enough to socialize. St. Mary's staff evaluated Brenda's medication for possible interactions. The interaction indicated four medications Brenda was taking that interacted with one another and her food. As a result of the medication review assessment, Brenda's primary care physician was able to change one of her medications to reduce the dry-mouth she had been experiencing. Brenda feels very grateful to the collaboration among partners to make a change that is helping her feel better.

- Give information and guidance to 47 participants regarding disposal of expired, misused, or unused medication (target: 28)
- Give nutrition education and exercise encouragement to 36 participants (target: 37)
- Give medication management assistance devices to 26 participants (target: 24)

• United Seniors Oakland Alameda County (USOAC) Medication Education
- Provide medication safety training to 296 seniors through one-on-one and/or group sessions (target: 150)
- Outreach to 5,000 seniors through community sites (target: 250)

Highlights

↑76%

76% more Senior Support Program of the Tri-Valley clients **disposed of unused/expired medications** compared to program inception (target: 40%).

Food as Medicine: Alameda County Community Food Bank

www.accfb.org

FY 16/17 Allocation: **$15,479*** | **Expended/Encumbered:** **$15,479**

Individuals served by Measure A: 60 (Total individuals served: 180)

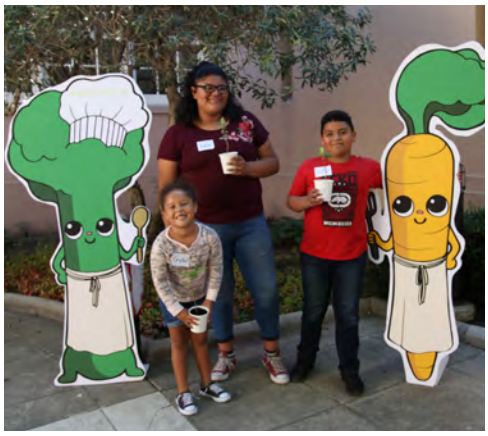
Populations served: Low Income, Uninsured Adults, Children, Families

Services provided: Public Health

Service area: Hayward, Oakland

Includes Board of Supervisors discretionary allocation from **District 3/Supervisor Chan*

Background



Alameda County Community Food Bank (ACCFB) pursues a hunger-free community where children, adults, and seniors of Alameda County do not worry about where their next meal is coming from.

Through the Food as Medicine program, ACCFB worked in partnership with the Alameda County Deputy Sheriffs Activities League, Dig Deep Farms, UCSF Benioff/Children's Hospital Oakland, and the Alameda County Public Health Department to provide food deliveries to 60 youth program participants and their families (344 total household members) as part of a study to determine the effects of these activities on participant health. The study is targeted towards children, but the parents/caregivers are included in the activities as well.

Fifty-four percent of the families included in the study were food insecure, including 20% who were food insecure with hunger. About a quarter of families reported that someone in the household had used emergency food or a food bank in the past 12 months.

Measure A Funding Summary

ACCFB used its Measure A allocation to achieve the following:

- Provide 492 food packages across the life of the program, delivered by Dig Deep Farms (target: 400). Participants received nonperishable food packages from the Food Bank twice monthly that emphasized whole grains and high fiber foods.
- Ensure that 100% of food packages meet the nutritional requirements set by the Food as Medicine initiative.

Food as Medicine: Alameda County Deputy Sheriffs Activities League

www.acdsal.org

FY 16/17 Allocation: **$84,693** | **Expended/Encumbered:** **$84,693**

Individuals served by Measure A: 328 (Total individuals served: 328)

Populations served: Low Income Adults, Children, Families

Services provided: Hospital Outpatient, Public Health

Service area: Ashland, Berkeley, Cherryland, Emeryville, Oakland, San Leandro

Background

The Alameda County Deputy Sheriffs' Activities League (DSAL) unites Sheriff's Office personnel, citizens, and youth in Alameda County to pursue and implement initiatives that reduce crime, better the lives of area residents, and enhance the community through action and collaboration with its partners.

Through a program in partnership with Dig Deep Farms, UCSF Benioff/ Children's Hospital Oakland, and the Alameda County Public Health Department, DSAL provided food deliveries, nutrition education and cooking classes, educational events, home visits, and special events to 60 families as part of a study to determine the effects of these activities on participant health. The study is targeted towards children, but the parents/caregivers are included in the activities as well.

Measure A Funding Summary

DSAL/Dig Deep Farms used its Measure A allocation to achieve the following:

- Employ and create internship opportunities for local residents who have been involved in the criminal justice or social services system to grow pesticide-free produce on local parcels of land.
- Package and deliver up to 60 bags of produce per week to patients prescribed through the Food as Medicine program out of Children's Hospital. Approximately 940 total deliveries were made during the project period.
- Pick up prepackaged boxes of dry goods from the Alameda County Community Food Bank to deliver alongside the produce bags to ensure a wholesome variety of grains and vegetables.

Highlights

100%

100% of families responding to a survey by Children's Hospital indicated that they were **eating the majority of the foods in their deliveries**.

80%

80% of the families who utilized the food prescriptions to eat healthier showed **improvements in the children's/youth's health status**.

Food as Medicine: Alameda County Public Health Department

www.acphd.org/nutrition-services

FY 16/17 Allocation: **$6,000*** | **Expended/Encumbered:** **$6,000**

Individuals served by Measure A: 8,000 (Total individuals served: 40,000)

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

Services provided: Public Health

Service area: Countywide

Includes Board of Supervisors discretionary allocation from **District 3/Supervisor Chan*

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 provides for present and future generations.

Through the Food as Medicine program, the Public Health Department Nutrition Services Program worked in partnership with the Alameda County Community Food Bank, Alameda County Deputy Sheriffs Activities League, Dig Deep Farms, and UCSF Benioff/Children's Hospital Oakland to conduct nutrition education classes, along with hands-on cooking practice, to 60 youth program participants and their families (344 total household members) as part of a study to determine the effects of these activities on participant health. The study is targeted towards children, but the parents/caregivers are included in the activities as well.

Class offerings included child care, translation, all food, ingredients, lesson handouts, cooking equipment, and a small incentive or reinforcement item. All classes were held at accessible sites located in specific ZIP codes targeted by the Food as Medicine Pilot Initiative.

Highlights

100%

100% of the study participants reported **preparing a healthy recipe provided by Nutrition Services Program**.

Measure A Funding Summary

The Nutrition Services Program used its Measure A allocation to achieve the following:

- Conduct seven nutrition education class series
- Provide hands-on cooking practice of three healthy recipes featuring whole grains provided under the ALL IN Food as Medicine Pilot Initiative

Measure A funds were used primarily to obtain cooking equipment and pay for the time of the staff nutrition educator.

Food as Medicine: UCSF Benioff Children's Hospital Oakland

www.childrenshospitaloakland.org

FY 16/17 Allocation: $27,966* | **Expended/Encumbered: $27,966**

Individuals served by Measure A: 328 (Total individuals served: 328)

Populations served: Hospital Outpatient

Services provided: Low Income Adults, Children, Families, Seniors

Service area: Hayward, Oakland, San Leandro, San Lorenzo

Includes Board of Supervisors discretionary allocation from **District 3/Supervisor Chan*

Background

The mission of UCSF Benioff Children's Hospital Oakland is to protect and advance the health and well-being of children through clinical care, teaching, and research.

Through the Food as Medicine program, Children's Hospital worked in partnership with the Alameda County Community Food Bank, Alameda County Deputy Sheriffs Activities League, Dig Deep Farms, and the Alameda County Public Health Department to provide food deliveries, nutrition education and cooking classes, educational events, home visits, and special events to 60 youth program participants and their families (344 total household members) as part of a study to determine the effects of these activities on participant health. The study is targeted towards children, but the parents/caregivers are included in the activities as well.

Measure A Funding Summary

Children's Hospital used its Measure A allocation to achieve the following in the Food as Medicine program:

- Enroll 60 children with or at high risk for prediabetes
- Conduct 108 office visits
- Coordinate 941 food deliveries
- Offer cooking classes to four participant families
- Assess 60 participating families for household food security
- Make three presentations to community health clinics and pediatric providers to promote food as medicine

Highlights

100%

100% of enrolled families that received food deliveries reported that the program **helped them maintain their diabetes diet plan**.

Genesis Worship Center

genesiswc.com

FY 16/17 Allocation: **$5,000*** | **Expended/Encumbered:** **$5,000**

Individuals served by Measure A: Unknown

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

Services provided: Public Health

Service area: Oakland

Includes Board of Supervisors discretionary allocation from **District 4/Supervisor Miley*

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.

Concern

This provider did not supply any Measure A funding information for FY 16/17, despite repeated calls from Health Care Services Agency staff to obtain this information. Therefore, the Committee cannot evaluate whether funds were spent in accordance with the strictures of Measure A.

Healthy Homes Department Fixing to Stay and Group Living Facilities Project

www.achhd.org

FY 16/17 Allocation: **$229,337** | **Expended/Encumbered:** **$229,201**

Individuals served by Measure A: 219 (Total individuals served: 443)

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

Services provided: Public Health

Service area: Albany, Ashland, Castro Valley, Cherryland, Dublin, Newark, Oakland, Piedmont, San Lorenzo, Union City

Background

The Alameda County Healthy Homes Department promotes an integrated approach for safe and healthy housing through collaborative community initiatives, applied research, and policy development to improve the lives of vulnerable populations.

One of the main goals of the Healthy Homes Department Fixing to Stay program is to ensure that clients can stay in their homes as long as possible in a way that contributes to their well-being. The program offers home repairs and modifications as well as a health and risk assessment of their home which includes client education on how to prevent housing-based hazards that could make their home unhealthful.

The Healthy Homes Department also works with group living facility operators to improve housing conditions ranging from overcrowding to unsanitary conditions. Many of these hazards can lead to respiratory issues, unintentional injuries, and other health problems.

Matching Funds

$101,398

from the **Minor Home Repair Program of the Healthy Homes Department**.

Measure A Funding Summary

The Healthy Homes Department leveraged its Measure A allocation to achieve the following:

- Fixing to Stay:
  - Conduct outreach to 188 older adults (target: 150)
  - Complete 143 assessments (target: 100)
  - Complete 70 home modifications (target: 80)
  - Provide additional assistance and referrals to 44 clients
- Group Living Facilities project:
  - Hold three working group meetings (target: four)
  - Complete 31 health and safety risk assessments (target: 30)
  - Conduct nine cooperative compliance efforts (target: eight)
  - Have seven facility operators make at least one improvement
  - Have three operators resolve all the deficiencies found

Health Services for Persons Who Inject Drugs HIV Education and Prevention Project of Alameda County (HEPPAC)

www.casasegura.org

FY 16/17 Allocation: **$150,000** | **Expended/Encumbered:** **$150,000**

Individuals served by Measure A: 2,124 (Total individuals served: 4,051)

Populations served: Low Income, Uninsured Adults, Seniors, Other residents: Undocumented immigrants

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

Service area: Oakland

Background

The HIV Education and Prevention Project of Alameda County (HEPPAC) works to stop the further spread of preventable diseases among people who use drugs in the community. HEPPAC's primary population of active substance users are marginally housed or chronically homeless. HEPPAC is the only program in Oakland that addresses their increased risk for HIV and HCV due to their active substance use.

HEPPAC's average participant is an African American male, 45 years of age and homeless, with an average of 30 years of substance use.

Harm reduction services include syringe access, distribution of sterile drug-using materials, and naloxone distribution. Drug consumption spaces, also known as supervised injection facilities, decrease overdose deaths, the volume of littered syringes in public spaces, and the volume of public drug use. Syringe exchange participants receive information on available services including wound care, antibody screening, crisis counseling services, educational workshops, hygiene kits, and referral services for substance use treatment services and other basic needs services. Mobile harm reduction services occur in communities that don't surround HEPPAC's fixed exchange sites.

Wound care services include primary medical and holistic health services and are offered during HEPPAC's fixed exchange sites. Basic wound care services range from lancing, packing and cleaning, and some antibiotic medication dispensary services. HEPPAC's herbal/acupuncture services includes auricular acupuncture services and distribution of tinctures for pain management, stress management, and skin infections.

Among people who inject drugs who are aware of their positive HIV and/or HCV status, HEPPAC works to improve access to primary care

Highlights

90%

Of the 294 syringe exchange and clinic participants who completed an unstructured workshop, **90% self-reported to have increased knowledge of at least one protective behavior**.

and specialty services for treatment. The Roots Clinic assists this effort by providing primary care services for participants who make the decision to assign the clinic as their medical home. In addition, antibody screening and phlebotomy for viral load testing is available across HEPPAC's service delivery. Mobile harm reduction services capture participants who rove the community.

Measure A Funding Summary

HEPPAC used its Measure A allocation to achieve the following:

- Exchange 51,326 sterile syringes (target: 50,000)
- Provide an average of 23 weekly hours of syringe exchange services in Northern Alameda County (target: 25)
- Collect 121,015 used syringes during non-fixed exchange site service hours (target: 100,000)
- Link 41 participants to medical assisted treatment programs
- Through its street team medicine team, provide care to address soft tissue infections to 214 people who inject drugs at fixed exchange locations and during non-exchange hours (target: 150)
- Through its Community Health Promoters, refer 241 people who inject drugs to HEPPAC's onsite medical team at the Roots Clinic for emergency triage care (target: 150)
- Provide herbal/acupuncture services to 1,304 syringe exchange participants
- Facilitate unstructured workshops to 294 syringe exchange and clinic visitors (target: 300)
- Administer pre and post tests to measure participants' knowledge of identifying at least one risk reduction practice
- Offer HIV and HCV counseling and testing services to workshop participants, including antibody screening to 204 syringe exchange participants

Success Story

Raul was referred to HEPPAC's site by a peer who informed him he could get free food and medical care. Raul is a meth user and his wife is an injection opioid user. She was diagnosed with HCV last year and Raul was never tested. After receiving food during his first visit, Raul and his wife returned and utilized HEPPAC's syringe access services. After one month of utilization, Raul tested for HIV and HCV. He was positive for HCV and was linked with the Roots Clinic, where he receives treatment. Raul also created a social network of other participants and does day labor work at least twice per week.

HIV Education and Prevention Project of Alameda County OPEND Program

www.casasegura.org

FY 16/17 Allocation: **$150,000** | **Expended/Encumbered:** **$150,000**

Individuals served by Measure A: 513 (Total individuals served: 513)

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

Services provided: Public Health, Substance Abuse

Service area: Countywide, Homeless or transient

Background

The HIV Education and Prevention Project of Alameda County (HEPPAC) works to stop the further spread of HIV/AIDS and Hepatitis C among injection drug users in Alameda County. Through prevention, education, care, and treatment, HEPPAC helps reduce the harm caused by injection drug use in the community.

The HEPPAC Overdose Prevention Education and Naloxone Distribution (OPEND) project trains individuals to recognize and respond to an opioid overdose. The trainings provide individuals who are at risk for overdose with increased awareness about their risk and dialogue within their community regarding how to prevent overdose and overdose death. Staff distribute opioid overdose rescue kits including naloxone, the drug that can reverse a potentially fatal overdose, to each individual who is trained.

To increase access to services and community awareness of the project, OPEND provides staff trainings at agencies within the County including substance use treatment and mental health programs, organizations focused on homelessness, re-entry and HIV/AIDS organizations, and harm reduction agencies. OPEND also presents at conferences and events and held an Overdose Awareness Day event to raise awareness about the opioid overdose public health crisis for the general public.

Highlights

100%

100% of service providers trained would **recommend the training to other providers** in Alameda County (target: 90%).

Measure A Funding Summary

HEPPAC used its Measure A allocation to achieve the following:

- Conduct outreach to 25 social service programs to propose becoming OPEND sites (target: 15)
- Administer one-on-one trainings to 513 clients who access services at an OPEND site (target: 200)
- Distribute 781 naloxone kits to OPEND clients and service providers (target: 200)

- Provide five OPEND "train the trainer" trainings to 50 service providers to establish five new OPEND sites (target: five trainings to 20 providers to establish five new sites)
- Provide 19 OPEND trainings to 361 staff from 34 community-based organizations in Alameda County to increase opioid overdose capacity (target: 20 trainings to 80 staff from 20 organizations)
- Make 10 presentations on current trends of opioid use, activities and accomplishments, and challenges for the OPEND project to 150 key community stakeholders including Alameda County Board of Supervisor members, funders, collaborators, and those who support and/or access services (target: four presentations to 50 stakeholders)

Success Story

Tim was with his wife when she began overdosing on opioids, but he didn't know what to do or how to intervene. He called 911, but she died before they arrived. When he told staff at the HEPPAC syringe exchange site about his wife, they informed him about naloxone and how to reverse an overdose. He got trained and began carrying his kit with him everywhere. When one person, Darryl, was using heroin a few houses down from where Tim lived and started to overdose, Darryl's friends called to Tim across the backyards. Tim was able to administer naloxone, and within three minutes, Darryl was breathing.

Home Visiting Services

www.tvhc.org/ | www.acphd.org/mpcah.aspx

FY 16/17 Allocation: $1,250,000 | Expended/Encumbered: $878,568

Individuals served by Measure A: 316 (Total individuals served: 316)

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

Services provided: Public Health, Mental Health

Service area: Ashland, Castro Valley, Cherryland, Dublin, Fremont, Hayward, Livermore, Newark, Pleasanton, San Leandro, San Lorenzo, Sunol, Union City, Homeless or transient

Background

Measure A funds were used to support two components of the Early Childhood Home Visiting and Family Support System of Care: the hiring of a Home Visiting Integration Manager into the MPCAH unit and the provision of home visiting and family support services to pregnant and parenting teens and other families with young children by Tiburcio Vasquez Health Center.

MPCAH

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 provides for present and future generations. Within the Public Health Department MPCAH program, the Home Visiting Integration (HVI) manager provides oversight of continuous quality improvement (CQI) activities; integration of numerous home visiting programs into a system of care with common outcomes and standards; professional development; and opportunities for community feedback and engagement, implementation of change, and overall improved service delivery with a goal of addressing health inequities.

The addition of the HVI manager position allows the MPCAH unit to further its mission to better serve multistressed, low income pregnant women, mothers, fathers, and families in Alameda County through well-coordinated, culturally responsive, and client-centered services.

Tiburcio Vasquez

Tiburcio Vasquez Health Center (TVHC) promotes the health and well-being of the community by providing accessible, high quality care. TVHC is committed to ensuring this human right through quality service, advocacy, and community empowerment. Family Support Services (FSS)

Highlights

85%

85% of screened TVHC clients were able to follow through on referrals and **obtain a permanent medical home**.

Matching Funds

$131,973

from **Targeted Case Management (TCM).**

is a program of TVHC that provides comprehensive case management services to pregnant and parenting teens and adults in the community. Services provided range from health education and parenting skills to financial and housing assistance. FSS case managers also link clients to TVHC and enroll them as new patients.

Measure A Funding Summary

MPCAH

MPCAH used its Measure A allocation to fund the HVI manager position. Due to delays in the hiring process, the HVI manager did not come on board until near the end of the FY 16/17 fiscal year. During this time frame, the HVI manager achieved the following:

- Worked with staff to operationalize evaluation metrics and quality improvement measures for the home visiting system of care and lay the groundwork for the development of a Family Advisory Committee (FAC)
- Supported MPCAH home visiting programs in preparing for the submission of reports that monitor service delivery and outcomes
- Met with MPCAH program managers to learn about the client population, service delivery successes and challenges, and outreach strategies and needs
- Attended or committed to attend trainings in the next fiscal year that support professional development, quality improvements, and service delivery

TVHC

TVHC used its Measure A allocation to achieve the following:

- Assess 356 clients to determine if they had a medical home and refer them to local medical providers
- Screen 67 children for developmental concerns, identify concerns in 21 children, and refer them to the Regional Center of the East Bay and/or their local school district for additional assessment and services
- Screen 263 parents for parental depression, identify 24 parents with a high risk for parental depression, and refer 10 clients for additional mental health supports and/or treatment

Success Story

TVHC

A 29-year-old mother and her two children, originally from Honduras, have been living in the United States for eight years. Their TVHC case manager has supported the family in accessing mental health, legal, and immigration services, as well as navigating social services benefits. When assessed for mental health safety, the mother shared that she was a victim of sexual abuse by a family member, which caused her to fall into deep depression and attempt suicide. The case manager linked the mother to mental health services. The mother was able to work through her trauma and make peace with her experience, and her most recent assessment showed a significant improvement.

La Clinica de La Raza: Dental Clinic Expansion Project

www.laclinica.org

FY 16/17 Allocation: **$1,000,000** | **Expended/Encumbered:** **$1,000,000**

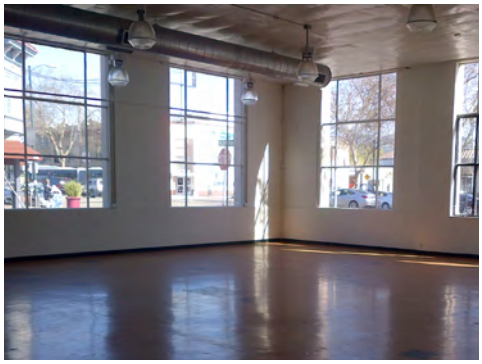
Individuals served by Measure A: NA (Total individuals served: NA)

Populations served: Low Income, Uninsured Children

Services provided: Public Health

Service area: Countywide

Background



La Clínica de La Raza works to improve the quality of life of the diverse communities it serves by providing culturally appropriate, high quality and accessible health care for all.

The relocation and renovation of the La Clínica Dental at Children's Hospital Oakland clinic is intended to provide necessary pediatric dental services to a larger number of patients. La Clínica is one of the few pediatric dental health centers in Northern California to offer dental care to children with special needs including medical issues, developmental challenges, and more. The priority is to treat patients who cannot be treated elsewhere and to provide routine care to children from the local community.

The relocation/renovation will increase La Clínica's dental operatories from six to thirteen. By increasing service capacity, La Clínica will improve access for 25% of the current pediatric outpatient clinic population with an unmet oral health need upon entering school.

La Clínica CHO currently serves 5,778 patients a year, and proposes to serve 8,819 total patients per year by 2017 as a result of the proposed services expansion project.

Measure A Funding Summary

Because commencement of renovation of the building at 4881 Telegraph Ave. in Oakland was delayed, construction did not begin until after FY 16/17. No Measure A funds were spent during this fiscal year.

LifeLong Medical Care Heart2Heart

lifelongmedical.org

FY 16/17 Allocation: **$100,000** | **Expended/Encumbered:** **$100,000**

Individuals served by Measure A: 1,776 (Total individuals served: 1,776)

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 build relationships and strengthen social cohesion between community members by linking residents with needed resources and services to reduce the rates of hypertension, heart disease, and stroke occurrence in the H2H neighborhood in South Berkeley.

Measure A Funding Summary

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

- Organize 11 community outreach events, in partnership with community organizations, to increase visibility and promote healthy behaviors (target: three). 443 individuals participated in outreach events.
- Provide 14 Neighborhood Health Advocate (NHA) community health education training sessions to 33 residents (target: 20 residents).
- Coordinate with 32 NHAs to participate in 203 community engagement activities to educate and link 617 community members to medical resources (target: 30 events to 100 community members).
- Administer mini-grants totaling $10,500 to six individuals/groups who implement a variety of health and wellness programs (target: four individuals/groups). 96 individuals attended activities funded by mini-grants.
- Provide health education and services including hypertension education, screenings, linkage to resources, and information on health-related topics to 644 community members through 109 community health events (target: 100 community members at 50 events).

Matching Funds

$72,349

from the **Community Development Block Grant** awarded by the **City of Berkeley.**

Mandela MarketPlace

mandelamarketplace.org

FY 16/17 Allocation: **$10,000*** | **Expended/Encumbered:** **$10,000**

Individuals served by Measure A: 1,520 (Total individuals served: 1,520)

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

Services provided: Public Health

Service area: Ashland, Cherryland

Includes Board of Supervisors discretionary allocation from **District 4/Supervisor Miley*

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 Eden Area Food Alliance (EAFA), which receives fiscal sponsorship from Mandela MarketPlace, Inc., provides public health services to residents by increasing healthy food access and expanding the presence of urban agriculture and community gardens in the Eden Area: the unincorporated Alameda County communities of Ashland, Castro Valley, Cherryland, Fairview, and San Lorenzo.

Members of the EAFA engage groups of Eden Area residents in healthy eating and active living initiatives through building and sustaining a local network of community gardens to increase healthy food access and strengthen community food security, while also teaching residents the skills necessary to garden and grow their own food. EAFA members also have developed curricula for and lead workshops for Eden Area residents to learn how to grow fresh produce, glean local produce, and care for chickens and bees.

Measure A Funding Summary

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

- Coordinate installation and restoration of two garden sites in the Eden Area to educate 20 low income youth about growing fresh produce.
- Install one community garden located at an affordable housing site in the Eden Area.
- Provide training to 20 low income residents, especially youth, at the affordable housing site with a focus on increasing skills to grow fresh produce.

Highlights

50%

50% of Eden Area youth and residents trained in the program reported an **increase in knowledge and skills to grow fresh produce**.

Matching Funds

$13,868

from the **Alameda County Public Health Department.**

- Plan and host two trainings or informational workshops for 30 Eden Area residents to build awareness of policies that could support increased opportunities to grow healthy food locally.
- Plan and host two trainings or informational workshops for 30 Eden Area residents on Alameda County chicken and bee ordinances as a strategy to increase community food security.
- Plan and host one training for 30 Eden Area residents to learn how to glean local produce as a strategy to increase healthy food access.
- Conduct community outreach to 600 Eden Area residents to increase awareness and participation in EAFA, the Eden Area Livability Initiative (EALI), and other local food and urban agriculture initiatives.
- Schedule bi-annual meetings with the Alameda County District 4 Supervisor to provide updates on community food access challenges and recommend programs/policies to improve health for Eden Area residents.

Highlights

50%

50% of Eden Area residents served reported **increased access to fresh produce, healthy eating, and social cohesion**.

Needle Exchange Emergency Distribution (NEED)

www.berkeleyneed.org

FY 16/17 Allocation: **$25,000*** | **Expended/Encumbered:** **$25,000**

Individuals served by Measure A: 350 (Total individuals served: 2,380)

Populations served: Indigent, Low Income, Uninsured Adults

Services provided: Public Health, Substance Abuse

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

Includes Board of Supervisors discretionary allocation from **District 5/Supervisor Carson*

Background

Needle Exchange Emergency Distribution (NEED) is a collectively run needle distribution and exchange program dedicated to reducing drug-related harm among people who use drugs, including preventing the transmission of HIV/AIDS, Hepatitis C, and other blood-borne diseases. NEED offers free, anonymous services that are participant-driven and views supporting and improving the physical and social health of drug users, and communities affected by drug-related harm, as crucial public health work.

NEED's harm reduction services include syringe exchange, syringe disposal, and referrals to other health services. Services are provided three times per week at three locations in the Berkeley.

Measure A Funding Summary

NEED used its Measure A allocation to achieve the following:

- Provide 2,380 service contacts (target: 1,750)
- Distribute 914,691 syringes (target: 350,000)
- Dispose of 356,156 syringes through a licensed medical waste disposal company (target: 200,000)
- In 127 service contacts, refer participants to other services provided by community partners including HIV/HCV/STI testing, medical care, drug treatment, and wound care
- Ensure that 77% of weekly sites were adequately stocked with syringes and other supplies (target: 80%)
- Have 71% of participants report using the services for more than one year (target: 75%)

Highlights

96%

96% of participants who needed syringes **received the syringes they requested** (target: 70%).

76%

76% of participants reported that they would **not know where else to go to get sterile syringes** (target: 70%).

Nutrition Services in West Oakland: City Slickers Farm

www.acphd.org/nutrition-services

FY 16/17 Allocation: $50,000* | **Expended/Encumbered: $50,000**

Individuals served by Measure A: 8,000 (Total individuals served: 40,000)

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

Services provided: Public Health

Service area: Countywide

Includes Board of Supervisors discretionary allocation from **District 5/Supervisor Carson*

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 provides for present and future generations.

A program of the Public Health Department's Community Health Services Division, Alameda County Nutrition Services promotes and supports healthy eating and physical activity through committed partnership with communities to reduce chronic disease and improve long-term health.

Measure A Funding Summary

Using its Measure A allocation, Nutrition Services subcontracted with City Slicker Farms to achieve the following:

- Build eight school-based garden beds at four sites in West Oakland
- Conduct garden-based nutrition education reaching 800 students
- Build eight raised garden beds at senior housing sites throughout Alameda County
- Conduct quarterly technical assistance visits

Highlights

100%

100% of participants demonstrated an **increase in knowledge of garden-based nutrition education** (target: 80%).

100%

100% of participants reported **eating produce grown from the garden beds** (target: 50%).

Public Health Prevention Initiative

FY 16/17 Allocation: **$5,230,000** | **Expended/Encumbered:** **$5,230,000**

Individuals served by Measure A: 64,959 (Total individuals served: 144,093)

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 in 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 "Asthma Start" entry on page 80)
- 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
- Home Visiting and Family Support
- Immunization
- Lotus Bloom
- Mandela MarketPlace
- Niroga Institute

Matching Funds

$1.16 M

from the following sources:

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

- Nutrition Services
- Office of Dental Health (see the separate "Alameda County Dental Health" entry on page 38)
- 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 Program

- Hold monthly meetings of the Berkeley Healthy Schools Collaborative attended by Public Health Department staff, Berkeley Unified School District (BUSD) representatives, community-based organizations, and 2020 Vision representatives.
- Provide over 10 programmatic consultations to fellow Public Health programs working with BUSD.
- Provide over 15 school-linked referrals to and case consultations with public health nurses.
- For BUSD's Attendance Awareness Month, distribute over 500 health and attendance flyers; hand out over 5,000 stickers; and send letter/materials to all Berkeley Child Health and Disability Prevention (CHDP) providers.
- Provide over 45 health consultations to the family engagement coordinators for students with chronic absenteeism.
- Attend 12 SART/SARB meetings.
- Support 11 elementary school-based oral health screenings for second and fifth graders, in partnership with Alameda County Public Health and BUSD, at which over 1,200 students were screened and over 500 received dental sealants.
- Provide over 100 health consultations covering topics such as vision, food allergies, medications, nutrition and obesity, health insurance, and health conditions including asthma, head lice, ADHD, diabetes, ring worm, and more.
- Provide over 40 consultations regarding SB 277/school immunizations.
- Participate in five 504/IEP/SST meetings with school staff and families.
- Conduct 10 public health nurse family visits .
- Conduct three health trainings at staff meetings on the topics of cystic fibrosis, immunizations, and asthma.
- Assist BUSD in planning and implementation of the Northern California Breathmobile® at three school sites.

Highlights

100%

CAL-PEP

In post-tests, 100% of CLEAR clients maintained or achieved a **perfect score regarding learning new risk reduction techniques**, while 81% of HIV-positive clients maintained or achieved a perfect score regarding awareness of viral suppression.

CAL-PEP

- Provide HIV testing and education services to those at highest risk for HIV infection and their sexual partners
- Enroll six individuals with HIV-positive status in need of extra support services into CLEAR case management for one-on-one support with behavior change support.
- Provide education workshops to promote healthy choices and sexual wellness with positives and their sexual partners.
- Provide some basic resources to clients as needed.
- Increase the risk reduction skills of nine CLEAR clients (target: eight).
- Screen and enroll 10 unduplicated HIV-positive African Americans in CLEAR.
- Have 80% of clients make a commitment to reduce at least one high risk practice to reduce the spread of HIV.
- Ensure that four newly diagnosed or out-of-care clients are retained in primary care services for a minimum of six months (target: five).
- Increase the awareness of partner services in 67 HIV-positive clients (target: 50).
- Increase the awareness of viral suppression in 59 HIV-positive clients (target: 50).
- Conduct five HCPI events designed to increase knowledge of HIV disease, medication adherence, and viral suppression among African American HIV-positive individuals and their sexual partners.
- Increase knowledge of HIV status for 50 HIV high risk partners of HIV-positive clients (target: 50).
- Provide HIV testing to 50 sexual and/or drug-using social network partners of HIV-positive individuals.
- Conduct outreach 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 outreach contacts.
- Refer high risk social network partners of HIV-positive individuals to CAL-PEP's HIV testing program.
- Refer high risk negative partners to other social services.

Child Health & Disability Prevention Program (CHDP)

- Offer onsite training to 21 CHDP provider offices to implement developmental screening or add a screening interval in their practice.
- Screen 11,266 children were using the ASQ and MCHAT in pediatric sites or clinics.
- Increase screenings by 51% in the first six months of 2017, compared to the previous year.
- Add a screening interval at 35% of sites.
- Refer 2,955 of children who scored of concern to community and health care services for follow-up, with an additional 1,976 referred to the Help Me Grow (HMG) phone line for follow-up.

Highlights

CCNI

100%

100% of CCNI RACs have found a fiscal sponsor and have **established protocols to access and manage their money**.

80%

80% of SP resident leaders **completed the transition planning and leadership development training sessions**.

75%

75% of participating youth **attended all youth leadership development sessions** and have continued to **participate in other civic engagement activities**.

City and County Neighborhood Initiative (CCNI)

- Engage 20 Sobrante Park (SP) resident leaders in co-designing a self-sustainability plan (target: 15).
- Hold three SP transition planning meetings (target: six).
- Provide 10 Leadership Development trainings sessions in SP (target: 11).
- Provide 25 technical assistance hours per month apiece to SP and West Oakland (WO) Resident Action Council (RAC) leaders (target: 25 apiece).
- Elect five leaders to the WO RAC executive body.
- Provide six leadership development trainings for WO RAC leaders and community members (target: six).
- Secure fiscal sponsors for WO and SP RACs.
- Have four youth participate in youth leadership development activities (target: 10).
- Identify and engage one new resident leader to provide adult support to the future RAC youth leadership development and civic engagement program.

Community Assessment, Planning, and Evaluation (CAPE) Unit

- Complete approximately 112 data requests.

Diabetes

- Provide 16 hours of self-management education to adults with type 2 diabetes and pre-diabetes.
- Hold 18 classes attended by 145 clients.
- Serve approximately 1,000 clients in monthly or bimonthly support groups.
- Produce a monthly newsletter that is sent to over 400 past participants.
- Train six peer educators to work with the program.
- Achieve the following outcomes among program participants:
  - 83% implemented a positive nutrition lifestyle changes at the end of the course (target: 75%).
  - 88% lost weight (target: 50%).
  - 78% decreased their blood pressure (target: 50%).
  - 84% became more physically active (target: 50%).
  - 83% had an A1c < 7% or were lower than their original A1c measurement (target: 75%).

East Oakland Boxing Association (EOBA)

- Provide organic gardening, access to healthy food and fresh vegetables, nutrition and cooking classes, and daily physical activities.
- Have 34 high school gym participants participate in the community service program (target: 30).
- Have 21 Youth Leadership Interns and aspiring interns participate in garden, cooking, and gym programs (target: 20).
- Have 200 youth participate in daily physical activity and maintain awareness of the importance of being active to improve their health.

Highlights

EOBA

100%

100% of youth participated in **daily physical activity** and maintained **awareness of the importance of being active to improve their health**.

95%

95% of high school gym members completed the community service program and reached their community service hour goals. **The gym members contributed a total of 720 hours of community service.**

100%

100 % of Youth Leadership Interns **remained in the program at the end of the year**.

- Provide over 23,000 hours of tutoring to children ages 5-20.
- Have youth from the fitness program and cook club help to distribute over 25,000 pounds of fresh produce and over 100,000 pounds of food to the low income Oakland community.
- Take youth on 45 field trips, including hiking, camping, rafting, youth fitness events, and health fairs.

Healthy Retail Program

- Refine and expand the activities by developing tools to outline and track the work progress in each store, as well as reporting templates.
- Create Levels of Engagement (LOE), a programmatic tool to outline the program activities for each store.
- Remove most alcohol and tobacco ads inside and outside the stores, reorganize stores to highlight healthier items, and add fresh produce sections.
- Enroll four new corner stores into the program, expanding the number of stores from six to ten (target: four).
- Reach 2,301 community members during nutritional education outreach events (target: 2,500).
- Create a learning community comprised of county staff, CBO members, and contractors to meet and discuss the program development and improvement strategies, share resources, and learn from each other every month.

Home Visiting and Family Support

- Increase the percentage of interpreters who are present with home visiting case managers during home visits and who accompany clients to health care provider visits.
- Serve 425 non-English speaking families.
- Have interpreters make 213 face-to-face contacts with home visiting clients.
- Have interpreters accompany home visitors to clients or accompany clients to visits with health care providers 100% of the time they were requested.

Immunization

- Ensure that 90 % of previous providers continued participating in the California Immunization Registry (CAIR).
- Facilitate the transition and training for approximately 200 front-end users to the new CAIR2 software.
- Verify that Community Health Care Network providers and major providers such as Kaiser and Sutter continued data exchange with CAIR.
- Perform monthly data quality reviews to correct duplicates and errors.
- Help ensure that new immunization records were entered properly into the CAIR system.
- Analyze information about how to enhance programs and make improvements in over 8,000 students and staff that were vaccinated against the flu at 101 Oakland schools.

Success Story

Home Visiting and Family Support

A two-year-old girl was diagnosed at birth with Down syndrome and congenital heart disease. She has been followed a case manager from the home visiting program since discharge from the hospital. The parents speak Vietnamese only. The case manager has worked with the same interpreter from the very beginning. Having this consistent interpreter has made a positive impact on the family, as they have developed a relationship with the interpreter and feel comfortable sharing their fears and concerns with the case manager, who can respond in a culturally sensitive manner. The case manager has also coordinated the interpreter's time with the child's physical therapy visits.

- Work with the State of California to ensure that over 200 laboratories reported test lab results of Alameda residents through the California Reportable Disease Information Exchange (CalREDIE).
- Receive and process 21,373 patients with at least one disease incident.
- Establish a system to run CalREDIE daily data extracts.
- Help users of CalREDIE software resolve issues.

Lotus Bloom

- Recruit seven parent leaders who participated in meetings and wellness activities (target: six).
- Hold nine parent leader meetings attended by 171 parents (target: 40 parents).
- Uphold the Physical Movement and Healthy Food Policy at four sites (target: four).
- Have four partner organizations adopt and implement the policy (target: three).
- Train 20 Lotus Bloom staff to present and reinforce the policy (target: 20).
- Conduct workshops at UCSF Benioff/Children's Hospital Oakland for 94 residents.
- Host dental screenings at the Uptown/West Oakland location.
- Lead parent/child dance and movement classes, as well as Tae Kwon Do classes for elementary-aged students.
- Hold 11 community playtime events attended by 731 children and 434 adults (target: eight events).

Mandela MarketPlace

- Complete an Ashland Cherryland Food Policy Council (ACFPC) vacant land survey to identify parcels that are eligible for agriculture use under AB 551.
- Connect ACFPC members to resources and trainings to increase food and health policy advocacy skills.
- Build relationships with local and regional nonprofit, community, and County partners.
- Engage at regional and state levels with legislators, other food policy councils, and other partners to develop equitable food and agriculture policies.
- Work with ACFPC, the Alameda County Health Care Services Agency (HCSA), and the District 4 Supervisor's office to negotiate and execute a contract to provide $10,000 to ACFPC.
- With the Hayward Food Access Committee, engage service providers and community, nonprofit, and city/County partners to increase membership and build awareness of the Food Access Committee, and establish a Food Access Committee leadership structure.
- Support the Food Access Committee's grant writing to expand community cooking classes to other facilities.

Highlights

Lotus Bloom

100%

100% of parent leaders **attended monthly meetings**.

100%

100% of the **wellness ideas and activities created were implemented**

100%

100% of partner organizations **adopted and implemented the Healthy Food Policy**.

- Provide technical assistance to Hayward City Council members to sustain and inform the direction of the Task Force and Food Access Committee.
- Assist a Hayward City Council member with research and writing of the first Hayward Homeless Count, which addressed service gaps for the hungry and homeless community in Hayward.
- Translate client needs into projects that address expressed food access gaps, including establishment of a community garden and community-led cooking classes at South Hayward Parish.
- Develop a grid listing all food access service providers in the Hayward area.
- Begin engagement to develop a food recovery program.
- With the Tri City Food Coalition, support brokering of relationships among partners to participate in local food access-related projects, including a mobile food pantry program.
- Engage and collect data and surveys on food access gaps and challenges among food pantry service providers, nonprofits, farmers, food waste service providers, and city/County partners.
- Connect local food entrepreneurs with trainings to build business capacity, and provide support in entering markets.
- In Livermore, engage community, nonprofit and city/County partners to conduct research and collect data on food access gaps in Livermore.
- Develop a proposal for Mandela to provide technical assistance and capacity-building support to train special needs youth to grow food and launch a weekly produce stand in partnership with the city.
- Share the results of the community needs assessment shared with County and city staff.

Niroga Institute

- Accept seven students into the Integral Health Fellows (IHF) Transformative Life Skills training program, all of whom graduated.
- Have IHF graduates provided 766 hours of service (766 classes) at approximately 33 sites.
- Have six of the nine graduates complete all 100 hours of their service within the year.
- Teach yoga and stress-reduction classes to 11 Alameda County Public Health Department (ACPHD) Chronic Disease Program sessions.
- Provide a yoga session and hand out yoga protocols to attendees at ACPHD's Diabetes and Wellness Day in San Leandro.
- Conduct weekly classes held at Tiburcio Vasquez Clinic with between 10 and 20 participants.
- Provide yoga therapy modules to four yoga teachers.
- Present a conference on youth and stress resilience with 150 attending.

Highlights

Niroga Institute

100%

100% of IHF program students **finished the course**.

78%

78% of students **completed their 100 hours of service** within one year.

90%

90% of students report they have **gained knowledge and skills to enhance their own health and well-being**.

Nutrition Services

- Staff an epidemiologist in the CAPE unit.
- Fund subcontractors East Oakland Boxing Association and Lotus Bloom (see individual entries for specific accomplishments).
- Support a Program Specialist in Nutrition Services who receives all requests coming from the community and organizational partners and identifies the appropriate staff to promote nutrition, water, and physical activity in Alameda County.
- Enable Nutrition Services to attend 40 community events/fairs to reach over 5,000 Alameda County residents.

Project New Start

- Conduct 23 no-cost tattoo removal clinics.
- Provide 1,850-2,200 treatments for 51-62 high risk youth, of whom 75% are underinsured or uninsured.
- Rent lasers and purchase medical supplies and clinic-supplied food and beverages.
- Provide support service linkage, care coaching, and guidance for personal and professional development.

Public Health Nursing

- Draft a cross-departmental plan to place Community Health Outreach Workers in county WIC sites to provide basic services including enrolling eligible families in medical insurance programs and linking them to primary care homes.

Public Health Nursing Healthy Living Project

- Conduct four training sessions consisting of a total of 43 classes.
- Enroll 54 students who set health-related goals and attended the classes.

Success Story

Healthy Living Project

One of the students in the program belonged to a low income family and lived with a parent who was diabetic. The student didn't understand how nutrition and physical activity could play a role in diabetes, never paid attention to what she ate, and only exercised during PE because it was mandatory. During the course she gained interest in nutrition value and food labels. She began to make healthier choices and went from drinking two sodas a day to half a cup each day, while increasing her water intake. She signed up for the soccer team and enjoyed playing for the season.

Public Health Services for Homeless Residents: Abode Services

www.abodeservices.org

FY 16/17 Allocation: **$100,000** | **Expended/Encumbered:** **$100,000**

Individuals served by Measure A: Information not submitted by provider (Total individuals served: 49)

Populations served: Information not submitted by provider

Services provided: Information not submitted by provider

Service area: Fremont, Newark, Union City, Homeless or transient

Background

Abode Services works to end homelessness by assisting low income, unhoused people, including those with special needs, to secure stable, supportive housing and by advocating for the removal of the causes of homelessness.

Part of the Abode Services HOPE Project, the Tri-City Housing Navigation program works with homeless clients who frequently come from traumatized backgrounds and unstable family/social environments, with anxiety and depression impacting their ability to positively relate to the world. They also frequently have feelings of isolation, paranoia, and frustration around traditional social services. Housing Navigators work with clients to develop a sense of self-empowerment and strength, boost self-esteem, and build up their resiliency to face the extreme stresses that the homeless face.

Housing Navigators often act as a brokering or mediating party in the referral process to other services for individuals who may not have been able to navigate services on their own. Navigators work with clients on developing coping skills to enable them to engage with staff at other agencies.

After someone is housed, Housing Navigation staff continue to check on participants, first focusing on their basic survival needs and then moving into assisting them in finding deeper forms of fulfillment and support in their new community.

Highlights

86%

14 clients completed exits from Housing Navigation services in South County, of which 12, or 86%, **obtained permanent supportive housing** (target: 80%).

Measure A Funding Summary

The HOPE Project Tri-City Housing Navigation program used its Measure A allocation to fund one Housing Navigator position. The Housing Navigator provided the following services:

- Manage a caseload of 25 chronically homeless individuals from the

Tri-City area at any one time (target: 40-50)

- Serve 49 total individuals over the course of the fiscal year (target: 60)
- Have 14 individuals submit Homestretch documentation, with eight completing all housing match documentation by the end of the fiscal year (target: 50)
- Provide a total of 410 contacts that resulted in service provisioning for enrolled participants (target: 3,120)

Success Story

When a chronically homeless deaf couple and their developmentally disabled son received a Section 8 voucher, the Tri-City Housing Navigator assisted them in the housing search. He utilized a wide variety of techniques to keep them engaged during this process despite frequent disappointments in the difficult housing market. When a unit was identified, the Housing Navigator assisted the family throughout the move-in process, including working with movers to get their belongings, assisting with shopping for their new furniture, and applying for subsidized utility programs. He continued to work with them for several months after they were housed, including mediating conflicts with the landlord and teaching basic good tenancy skills.

Senior Injury Prevention Program

acphd.org/ipp/sipp.aspx

FY 16/17 Allocation: **$115,000** | **Expended/Encumbered:** **$115,000**

Individuals served by Measure A: 409 (Total individuals served: 409)

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) includes the following components:

- Minor home modifications. SIPP provides residential modifications of homes that are necessary to facilitate the ability of older individuals to remain at home and that are not available under other programs.
- Home Meds. Home Meds is a medication management program designed to address medication-related problems and errors that endanger the lives and well-being of community-dwelling elders. A contact includes individualized in-home screening, an assessment and alert process to identify medication problems, and computerized screening and pharmacist review based on protocols to help prevent falls, dizziness, confusion, and other medication-related problems for elders living at home.
- Tai Chi: Moving for Better Balance. This physical activity program is designed to improve balance, strength, and physical performance for older adults to reduce fall frequency.
- A Matter of Balance. This physical activity program is designed to reduce fall risk, reduce fear of falling, improve falls self-management, improve falls self-efficacy, and promote physical activity. Activities include group discussion, problem-solving, skill building, assertiveness training, videos, sharing practical solutions, and exercise training.
- Lifestyle-integrated Functional Exercise (LiFE). This physical activity program is designed to improve the overall functional fitness and well-being of older adults.

Highlights

↑817%

The **Enhance Fitness program served 84 participants** compared to a target of 11—an increase of 764%—while the **Ger-Fit program served 109 participants** compared to a target of 13—an increase of 817%.

- Geri-Fit®. This is a progressive resistance strength program designed to the increase strength, flexibility, range of motion, mobility, gait, and balance of older adults.
- Enhance Fitness. This program is designed to improve the overall functional fitness and well-being of older adults.

Measure A Funding Summary

SIPP used its Measure A allocation to provide the following:

- Minor home modifications to 37 consumers (target: 30)
- Home Meds medication management to 29 consumers (target: 35)
- 782 Tai Chi: Moving for Better Balance classes to 116 participants (target: 1,175 classes to 41 participants)
- 103 Matter of Balance classes to 13 participants (target: 366 classes to 42 participants)
- LiFE sessions for 21 participants (target: 87)
- 869 Geri-Fit sessions to 109 participants (target: 638 sessions to 13 participants)
- 674 Enhance Fitness sessions to 84 participants (target: 487 sessions to 11 participants)

Success Story

Client V. suffers from osteoarthritis and had hip replacement surgery about one year ago. She feels quite unsteady on her feet and utilizes a wheelchair to move from place to place. Determined to improve her balance, Client V. registered for the Tai Chi: Moving for Better Balance program and faithfully attended every class. In the beginning, she completed the movements seated, but, eventually, she started completing more of the movements standing. Through physical assessments, she improved in every single category tested. Client V. constantly expresses gratitude for the program and now feels she is strong enough to transition to a group exercise class, where she can continue progressing.

Service Opportunities for Seniors (Meals on Wheels)

sosmow.org

FY 16/17 Allocation: **$16,000*** | **Expended/Encumbered:** **$16,000**

Individuals served by Measure A: 52 (Total individuals served: 1,958)

Populations served: Indigent, Low Income, Uninsured Seniors

Services provided: Hospital Inpatient, Hospital Outpatient, Public Health

Service area: Castro Valley

Includes Board of Supervisors discretionary allocation from **District 4/Supervisor Miley*

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 8,471 meals and provide wellness checks to 52 unduplicated seniors in Castro Valley (target: 5,000 meals to 20 seniors).

Highlights

89%

89% said that receiving a daily meal and wellness check i**mproved their health and overall living situation**.

Spanish Speaking Unity Council of Alameda County, Inc. DBA The Unity Council

unitycouncil.org/program/lmb/

FY 16/17 Allocation: **$400,000** | **Expended/Encumbered:** **$400,000**

Individuals served by Measure A: 240 (Total individuals served: 240)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Oakland, San Leandro

Background

The Unity Council helps families and individuals build wealth and assets through comprehensive programs of sustainable economic, social, and neighborhood development.

The Unity Council Latino Men and Boys (LMB) program works to increase high school graduation rates and access to health services for its target youth. Its model focuses on health, well-being, and cultural healing.

LMB mentors provide comprehensive support to students, teachers/administrators, and health staff, including counseling and mentoring for youth. In addition, mentors provide coordinated and individualized culturally relevant services and opportunities for youth and their families to connect them to formal and informal supports, providers, and community to support achievement of positive health and life outcomes. Care coordination services include facilitation of and/or participation in Coordination of Services Teams (COST); orientation, assessment, and tracking; translation and interpretation; service coordination meetings with principals, teachers, health providers, probation, and/or family members; and referrals.

Matching Funds

$495,443

from the following sources:

- **The California Endowment**
- **Oakland Unified School District (OUSD)**
- **Comcast**
- **OUSD Schools**
- **Corporations**

Measure A Funding Summary

The Unity Council LMB program used its Measure A allocation to achieve the following:

- Serve 240 total participants (target: 275)
- Provide nine mentors who mentored 113 middle school youth
- Place four male participants in peer health group trainings
- Offer four health workshops at school health centers (SHCs) on topics including manhood development, sex and healthy relationships, mental health, the effects of drugs and alcohol, and the importance of a nutritious diet and active lifestyle

- Ensure that 168 workshop participants had an annual well visit at the SHC
- Conduct meetings and planning sessions with school and school health center staff to recruit and coordinate care for participants
- Participate in COST and individual meetings
- Deliver values-based curriculum facilitated by mentors, AmeriCorps, and SHC health educators at 10 school sites
- Host four parent engagement meetings for over 100 parents facilitated by LMB mentors on topics including neglect, drug and alcohol use and abuse, cultural differences, and understanding ways children are exposed to trauma
- Work with SHC staff at 10 sites to build their capacity to engage Latino young men and boys in health care access and services

Highlights

95%

In FY 16/17, the **graduation rate for LMB participants was 95%**, compared to OUSD's graduation rates of 45% for Latino boys.

100%

100% of participants have **access or have obtained information to receive health services at SHC or outside providers**.

Spectrum Community Services, Inc.

spectrumcs.org

FY 16/17 Allocation: **$76,128** | **Expended/Encumbered:** **$76,128**

Individuals served by Measure A: 465 (Total individuals served: 4,614)

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

Services provided: Public Health

Service area: Ashland, Castro Valley, Cherryland, Fairview, Fremont, Hayward, Newark, Oakland, San Leandro, San Lorenzo, Union City, Outside of Alameda County, Homeless or transient

**Includes Board of Supervisors discretionary allocations from*
District 2/Supervisor Valle**, **District 3/Supervisor Chan**, and **District 4/Supervisor Miley

Background

Spectrum Community Services improve 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) classes and workshops help seniors to avoid falls by working on cardiovascular endurance, upper-body and lower-body strengthening, balance, and flexibility. The program includes the Enhanced Fitness exercise class, which includes fall prevention tips, and the I Have Fallen and I Can Get Up workshop covering topics including home safety, medication management, how to get up from a fall, ways to ask for help, using adaptive devices, accountability partners, exercises, and resources in Alameda County. The classes and workshops are offered free to participants, 44% of whom are extremely low income.

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.

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.

Highlights

75-90%

Between 75 and 90% of participants **maintained or improved arm strength, leg strength, and dynamic balance and agility** from the beginning of the classes (target: 80%).

88%

88% of participants **reported being fall-free** during the most recent quarterly reporting period (target: 75%).

Measure A Funding Summary

Spectrum Community Services used its Measure A allocation to help achieve the following:

- FRRP:
  - Provide fall prevention class sessions to 317 seniors through 11 one-hour sessions each week (target: 400)
  - Conduct 294 Enhanced Fitness assessments (target: 180)
  - Provide Enhanced Fitness classes to 311 participants
  - Offer 49 fall prevention tips in these classes (target: 48)
  - Provide nine fall prevention workshops to 98 participants (target: four workshops)
- Nutrition Program:
  - Provide 1,960 meals to 43 participants (target: 1,920 meals)
  - Provide 170 quarterly nutrition education materials

Success Story

Joanne found Spectrum's FRRP when her doctor diagnosed her with a compressed fracture in her back. The doctor gave her a list of vitamins to help with the osteoporosis but listed her health condition as irreversible. When she started attending classes, Joanne was hunched over, and staff saw her hair but never her face. After two years of classes, she is walking more upright. Instructors have noticed her smile and how she is walking with more confidence. Joanne comments on her improvement: "I feel great. Everything in class—from the balance, to the aerobics, to the strength training, to the stretches—is helping me on a daily basis."

Youth and Family Opportunity Initiatives

achealthyschools.org/youth-development.html

FY 16/17 Allocation: **$2,597,818** | **Expended/Encumbered:** **$2,597,818**

Individuals served by Measure A: 14,083 (Total individuals served: 14,083)

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

Services provided: Public Heath, Mental Health, Substance Abuse

Service area: Countywide

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.

The countywide Youth and Family Opportunity (YFO) initiative provides 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.

YFO partners are situated in the County's areas of highest need per social determinants of health and work to address those needs in order to interrupt cycles of inequity and create schools and communities that support all young people to thrive.

The organizations involved in the YFO initiative include the following:

- Alameda Family Services (AFS)
- 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 (NUSD)
- REACH Ashland Youth Center
- Tri-Valley Health Initiative
- Union City Kid Zone (UCKZ)
- Youth Radio

Highlights

90%

In YFO surveys of youth and families, 90% of respondents agreed or strongly agreed they **now had a place to go for health and wellness services**.

Matching Funds

$2M

from the following sources:

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

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.

- AFS 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 critical care coordination, and health and wellness, youth development, and family support services to address the needs of its student and family population.
- BYA provides culturally competent case management, behavioral health, and youth development services to low income children and youth ages 6–18 and their families.
- EBAYC provides school-day and after-school holistic supports, including care coordination, individual case management and referrals, mentoring, and youth development activities.
- Fremont Family Resource Center provides case management and referrals to a wide array of health, wellness, and basic needs supports to families, including behavioral health services for individuals and groups, food and emergency housing, and family financial stability.
- La Familia serves low income, underserved, primarily Spanish-speaking communities in Hayward with health access and family support services through a partnership with the Hayward Unified School District (HUSD), including outreach, case management, health and wellness workshops, and referrals to HUSD youth and their families.
- Newark Unified School District provides family support, health education, and support services to NUSD youth and families.
- 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.
- UCKZ offers a range of onsite supports and referrals to children and families in the New Haven Unified School District, specifically in the Decoto neighborhood of Union City.
- Youth Radio provides wraparound health and wellness support to youth enrolled in their media arts education and internship placement program, with services including assessment, case management, behavioral health services, healthy food, and individual mentoring.

Measure A Funding Summary

YFO used its Measure A allocation to achieve the following client results across a variety of service areas:

- Health access

Success Story

Youth Radio

The Case Manager worked closely with a young woman, Molly, to help her access critical medical care. Though fully covered with health insurance through Kaiser, Molly had difficulties advocating for herself and scheduling appointments. This difficulty was exacerbated by her homeless status, and the fact that Molly did not have a cellphone. The Case Manager sat with Molly for hours, helping her navigate Kaiser's system and getting appointments for the consultation and procedure. After the procedure, the Case Manager met with Molly to make sure everything went smoothly, and they are still meeting on an as-needed basis for 1-on-1 check-ins.

- 738 families received onsite application assistance to enroll in Medi-Cal, HealthPAC, or Covered California coverage.
- 698 families received onsite application assistance to enroll in CalFresh, CalWORKs, or other public benefits.
- Over 3,000 families were provided information about health insurance and benefits eligibility or referred to an offsite location for application assistance.

- Youth-focused individual and group counseling, case management, and behavioral health services
  - 566 youth were served through Coordination of Services Teams (COST) coordinated and/or or attended by YFO grantees.
  - 370 youth received case management.
  - 307 youth received individual services.
  - 45 youth were seen in groups.
  - 158 youth received crisis intervention support.
- Family-focused individual and group counseling, case management, and behavioral health services
  - 1,800 parents/caregivers received case management.
  - 776 parents/caregivers received crisis intervention, including basic needs support.
  - 138 parents/caregivers received home visits.
  - 12 parents/caregivers received one-on-one services.
  - 31 families participated in family counseling.
  - 81 parents/caregivers participated in family support groups.
- Health and wellness, leadership, and life skills
  - 1,239 youth participated in health and wellness workshops focused on health education and healthy lifestyle choices.
  - 733 parents/caregivers participated in health and wellness workshops focused on health education and healthy lifestyle choices.
  - 317 youth participated in leadership development activities that increase resiliency by focusing on personal growth, health and wellness, leadership, and life skills.
  - 578 parents/caregivers participated in leadership development activities that increase resiliency and ability to support their children's healthy development and success.
  - 419 youth participated in additional life skills activities, such as the Fremont Youth Empowerment Academy, mentoring programs, El Joven Noble, and a Tier 1 friendship room.
- Referrals made for additional health and wellness services
  - 370 youth received case management.
  - 1,800 families received case management.
  - 776 families were served with crisis intervention, including basic needs referrals.
- Community events focused on raising awareness of free and affordable health care services
  - 87 community events were held.
  - 14,683 contacts were made at the events.

Highlights

91%

91% of families agreed or strongly agreed that the YFO program helped them **understand how to get resources for themselves and their family, and learn information or skills they can use with their family**.

77%

77% of youth reported that they **eat healthier foods and/or exercise more** because of their YFO program.

- 534 children and families in Livermore, Dublin, and Pleasanton were provided with health information and services through the Tri-Valley community health fairs.
- 105 physicals, including sports physicals, were given.
- 27 immunizations, including DTaP, MMR, VZ, IPV, and Hep B, were given.
- 140 dental screenings, 159 vision screenings, and 66 hearing screenings were provided.

Specifically, the YFO Initiative member organizations used their Measure A allocation to achieve the following.

Fremont Family Resource Center

- Run the Youth Empowerment Academy, a seven-week program for youth on probation that included instruction in health, self-advocacy for health, education and basic needs services, substance use education and referrals, and healthy communication and decision-making skills

La Familia

- Train 45 parent ambassadors in topics ranging from facilitating a meeting to health analysis and advocacy, plus HUSD topics such as COST, full-service community schools, and child welfare and attendance
- Conduct outreach and engagement to HUSD families on services and opportunities available at La Familia and other health and wellness organizations to over 5,000 people

NUSD

- Offer the Newark Parents Program, which provided health access and family support services, including home visits, health and benefits enrollment referrals, other health and basic needs referrals, and regular workshops on topics including positive parenting and nutrition

REACH AYC

- Provide more than 1,200 clients with more than 5,300 clinic visits at the Fuente health clinic

Tri-Valley Health Initiative

- Through health fairs, provide 534 children, youth, and families with health screenings, referrals, and direct services

UCKZ

- Provide case management and referrals to almost 1,200 families at their hub and at New Haven Unified School District school sites
- Provide health and wellness workshops on topics such as nutrition, positive behavioral interventions, depression, and loss and grief

Success Story

Fremont Family Resource Center

Samantha, a 38-year-old East Indian woman with daughters aged 12 and 8, divorced her husband due to domestic violence. Samantha came to the Fremont Family Resource Center because her time at the shelter where she was living had expired. She wanted to get resources for mental health, food/clothing, physical health, employment, and child care. The Case Manager linked Samantha to Alameda County Social Services, helped her apply for CalWORKs and CalFresh, and assisted with choosing a managed care provider. The Case Manager also worked to secure transportation and mental health services for both daughters. She helped Samantha rent a room and linked her to a psychiatrist to stabilize her depression.

Youth UpRising

youthuprising.org

FY 16/17 Allocation: **$71,535** | **Expended/Encumbered:** **$71,535**

Individuals served by Measure A: 1,765 (Total individuals served: 14,480 service hours provided)

Populations served: Low Income Adults, Children, Families

Services provided: Mental Health

Service area: Countywide

Background

Youth UpRising (YU) 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.

In partnership with Castlemont Community Transformation Schools (CCTS), First 5, Jewish Family Children Services, Kidango Preschool, and Alameda County Behavioral Health Care Services, YU coordinated a continuum of early childhood services in CCTS for the 2016/17 school year. YU was responsible for implementing the necessary partnerships, teacher consultations, and professional development to successfully address the mental health and wellness needs of students attending CCTS. The behavioral interventionist coordinated and provided school-based behavioral support, early intervention groups, student mental health consultation to teachers, staff development, parent engagement, and 0-8 Early Childhood Hub Stakeholder collaboration.

Measure A Funding Summary

YU used its Measure A allocation to achieve the following at CCTS:

- Provide mental health consultation as an integrated, consistent component of instructional staff professional development
- Provide a coordinated service referral and monitoring system
- Provide behavioral health interventions to reduce students' mental health barriers to attendance, engagement, and learning
- Facilitate parents' ability to engage in school-based mental supports for their child and family

Success Story

When a kindergarten student demonstrated behavioral challenges including hitting, biting, and hiding from adults, the YU behavioral health consultant worked with the child's caregiver and family, teacher, school administrators, and district services to have the child evaluated. The child was offered a placement in a setting that could provide individualized attention and support. The following summer, the child attended summer school at Parker Elementary School. Classes in a different environment made a significant impact. The child had more language skills, which resulted in less behavior problems and more friendships. The child was reunited with peers from the first kindergarten class and was able to experience mutually satisfying interactions and relationships.

APPENDICES

APPENDIX A: Measure A Revenue Received

APPENDIX B: FY 16/17 Budget Information

APPENDIX C: FY 16/17 Measure A Fund Distribution by Provider or Program

APPENDIX D: Maps: Geographic Distribution of Providers Funded by Measure A in FY 16/17

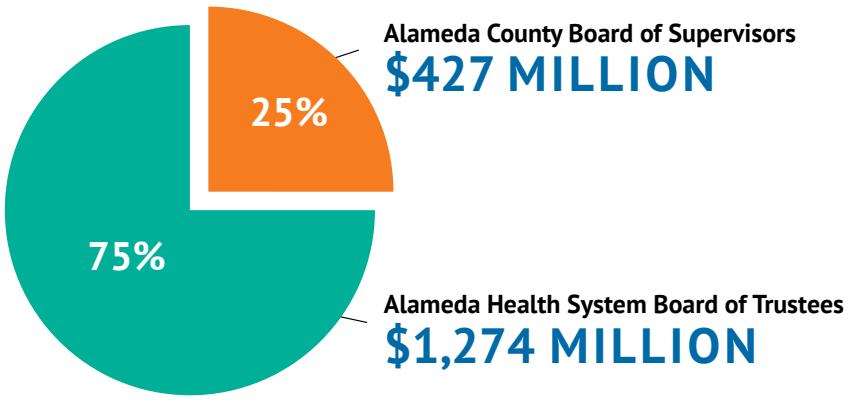
- **Map 1** Alameda County Public Health Programs
- **Map 2** Alameda County Behavioral Health Care Services Alcohol and Other Drug Providers
- **Map 3** Alameda County Behavioral Health Care Services Mental Health Community-Based Organization Providers
- **Map 4** School Health Centers
- **Map 5** HealthPAC Provider Network

APPENDIX A

Measure A Revenue Received

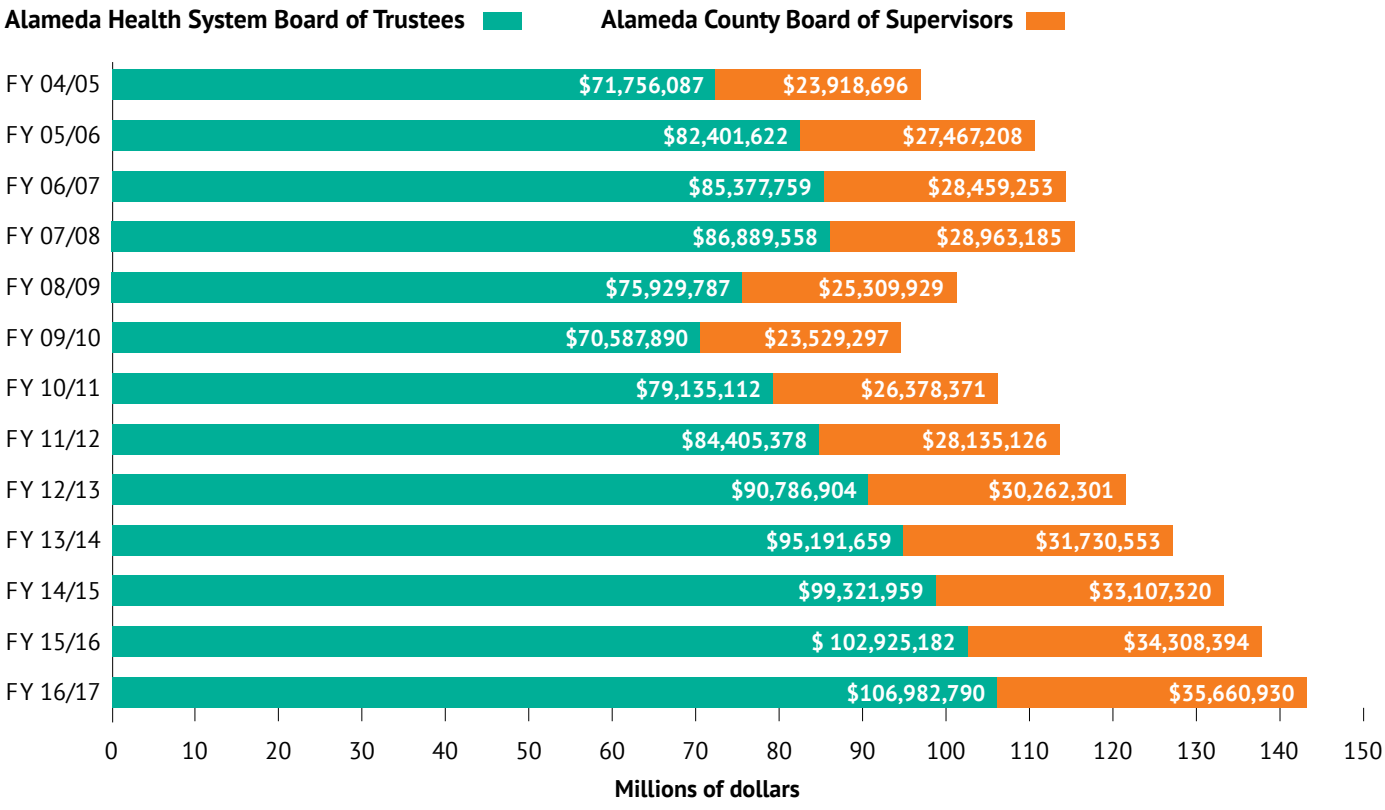
FY 04/05 through FY 16/17

TOTAL REVENUE EARNED (FY 04/05 THROUGH FY 16/17)



$1.7 BILLION

REVENUE EARNED EACH FISCAL YEAR (FY 04/05 THROUGH FY 16/17)



APPENDIX B: FY 16/17 BUDGET INFORMATION

	TOTAL ALLOCATION[3]	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	505,760	0	505,760	270,088
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[4]	2,143,224	512,134	2,655,358	2,122,733	532,625	2,655,358	0
Criminal Justice Screening and In-Custody Services	4,306,000	0	2,143,224	4,306,000	0	4,306,000	-2,162,776
Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services	164,902	0	164,902	164,902	0	164,902	0
La Familia Counseling Services (Glad Tidings)	20,000	0	20,000	20,000	0	20,000	0
Mental Health Services for Juvenile Justice Center	360,000	0	2,143,224	360,000	0	360,000	1,783,224
Mental Health Services for Newcomers and Immigrants: Center for Empowering Refugees and Immigrants (CERI)	80,371	0	80,371	80,371	0	80,371	0
Group 2: Hospital, Tertiary Care, Other							
St. Rose Hospital	1,500,000	0	1,500,000	1,500,000	0	1,500,000	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	257,580	0	257,580	227,580	0	227,580	30,000
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
Connecting Kids to Coverage (CKC) Initiative	188,386	0	188,386	188,386	0	188,386	0
Direct Medical and Support Services (Oakland): Preventive Care Pathways	214,322	0	214,322	214,322	0	214,322	0
Fremont Aging & 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	203,942	0	203,942	63,961
Increase Hospice Utilization: Getting the Most Out of Life Program	50,000	0	50,000	50,000	0	50,000	0
Medical Costs for Juvenile Justice Center	505,963	0	505,963	479,997	0	479,997	25,966
Native American Health Center	35,000	0	35,000	35,000	0	35,000	0
Primary Care Community-Based Organizations	5,370,494	0	5,370,494	5,370,494	0	5,370,494	0
Roots Community Health Center	100,000	0	100,000	100,000	0	100,000	0

Continued on next page

	TOTAL ALLOCATION[3]	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 Alameda (Community Paramedicine)	246,048	0	246,048	246,048	0	246,048	0
City of San Leandro	53,581	0	53,581	53,581	0	53,581	0
Countywide Plan for Seniors (Home-Based Nursing Care Management)	500,000	0	500,000	323,663	0	323,663	176,337
Countywide Plan for Seniors (Injury Prevention, Meals, and Nutrition)	750,000	0	750,000	702,369	0	702,369	47,631
Countywide Plan for Seniors (Getting the Most Out of Life)	250,000	0	250,000	183,579	0	183,579	66,421
Eden Youth and Family Center	50,000		50,000	50,000		50,000	0
EMS Corps	604,942	0	604,942	604,942	0	604,942	0
Food As Medicine: Alameda County Deputy Sheriffs' Activities League	84,693	0	84,693	84,693	0	84,693	0
Healthy Homes Department	229,337	0	229,337	229,201	0	229,201	136
Health Services for Persons Who Inject Drugs: HIV Education and Prevention Project of Alameda County	150,000	0	150,000	150,000	0	150,000	0
HIV Education and Prevention Project of Alameda County: OPEND Project	150,000	0	150,000	150,000	0	150,000	0
Home Visiting Services[1]	1,250,000	0	1,250,000	878,568	371,432	1,250,000	0
La Clinica de La Raza, Inc. (Dental Clinic Expansion Project)	1,000,000	0	1,000,000	1,000,000	0	1,000,000	0
LifeLong Medical Care: Heart 2 Heart	100,000	0	100,000	100,000	0	100,000	0
Nutrition Services in West Oakland: City Slickers Farm	25,000	0	25,000	25,000	0	25,000	0
Public Health Prevention Initiative	2,973,896	0	2,973,896	2,910,414	0	2,910,414	63,482
Public Health Prevention Initiative (EMS Injury Prevention)	210,112	0	210,112	210,112	0	210,112	0
Public Health Services for Homeless Residents: Abode Services	100,000	0	100,000	100,000	0	100,000	0
Senior Injury Prevention Program	115,000	0	115,000	115,000	0	115,000	0
Spanish Speaking Unity Council of Alameda County, Inc. DBA The Unity Council	400,000	0	400,000	400,000	0	400,000	0
Youth and Family Opportunity Initiatives[1]	2,597,818	17,080	2,614,898	2,597,818	17,080	2,614,898	0
Youth UpRising	71,535	0	71,535	71,535	0	71,535	0
Board of Supervisors[1]	750,000	432,770	1,182,770	595,873	586,897	1,182,770	0
TOTAL FY 16/17[3]	**34,249,999**	**961,984**	**35,211,983**	**32,959,927**	**1,508,034**	**34,467,961**	**744,022**

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 16/17.
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 16/17 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

GROUP 1: BEHAVIORAL HEALTH	MEASURE A ALLOCATION FY 16/17	EXPENDED/ ENCUMBERED FY 16/17
Alameda County Behavioral Health Care Services (BHCS) Community-Based Organizations (CBOs)		
Mental Health Providers		
Alameda County Mental Health Association	37,503	18,300
Alameda Family Services	7,377	0
Asian Health Services, Inc.	9,576	0
Axis Community Health, Inc.	4,990	0
Berkeley Addiction Treatment Services, Inc.	5,132	0
Bi-Bett Corporation	2,421	0
Bonita House, Inc.	57,234	45,701
Building Opportunities for Self-Sufficiency (BOSS)	31,665	31,665
Carnales Unidos Reformando Adictos, Inc.	36,694	36,694
Center for Independent Living	2,452	2,452
Community Health for Asian Americans	2,378	2,378
Crisis Support Services of Alameda County	33,119	1,578
East Bay Community Recovery Project	34,083	1,590
Filipino Advocates for Justice	15,359	15,359
Horizon Services, Inc.	7,560	0
Humanistic Alternatives to Addiction	2,328	0
Institute for the Advanced Study of Black Family Life and Culture	70,736	36,456
Magnolia Women's Recovery Programs, Inc.	11,027	359
Native American Health Center, Inc.	24,575	21,937
New Bridge Foundation, Inc.	33,937	29,218
Second Chance, Inc.	81,034	76,265
Senior Support Program of the Tri Valley	32,664	32,664
Southern Alameda County Committee for Raza	51,272	47,233
Southern Alameda County Committee for Raza	42,955	37,930
St. Mary's Center	37,262	37,262
Thunder Road-Adolescent Treatment	8,627	-
Uplift Family Services	30,719	30,719
West Oakland Health Council, Inc.	20,269	0
Unallocated	40,900	0
Total Allocation	**775,848**	**505,760**
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
Other Program Expenses	450,898	450,898
Total Allocation	**622,356**	**622,356**

GROUP 1: BEHAVIORAL HEALTH	MEASURE A ALLOCATION FY 16/17	EXPENDED/ ENCUMBERED FY 16/17
Cherry Hill Sobering and Detoxification Center	**2,143,224**	**2,122,733**
Criminal Justice Screening and In-Custody Services	**4,306,000**	**4,306,000**
Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services	**164,902**	**164,902**
La Familia Counseling Services	**50,000**	**50,000**
Mental Health Services for Juvenile Justice Center	**360,000**	**360,000**
Safe Alternatives to Violent Environments (SAVE)	**25,000**	**25,000**
Senior Support Program of Tri-Valley	**20,000**	**20,000**

GROUP 2: HOSPITAL, TERTIARY CARE, OTHER	MEASURE A ALLOCATION FY 16/17	EXPENDED/ ENCUMBERED FY 16/17
St. Rose Hospital	**1,500,000**	**1,500,000**
UCSF Benioff Children's Hospital Oakland	**2,000,000**	**2,000,000**

GROUP 3: PRIMARY CARE	MEASURE A ALLOCATION FY 16/17	EXPENDED/ ENCUMBERED FY 16/17
Alameda County Dental Health	**257,580**	**227,580**
Axis Community Health	**98,300**	**98,300**
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	170,250	170,250
East Bay Agency for Children	49,434	49,434
East Bay Asian Youth Center	51,834	51,834
Hayward Youth & Family Services	8,900	8,900
La Clinica de La Raza, Inc.	277,811	277,811
LifeLong Medical Center	113,500	113,500
Seneca Family of Agencies	48,223	48,223
Tiburcio Vasquez Health Center	219,681	219,681
UCSF Benioff Children's Hospital Oakland	103,668	103,668
Other Program Expenses	710,876	710,876
Total Allocation	**1,957,784**	**1,957,784**
Community Initiatives	**18,000**	**18,000**
Connecting Kids to Coverage (CKC) Initiative	**188,386**	**188,386**
Davis Street Community Center, Inc.	**80,000**	**80,000**
Direct Medical and Support Services (Oakland): Preventive Care Pathways	**214,322**	**214,322**
Fremont Aging & Family Services	**53,581**	**53,581**
Health Enrollment for Children	**300,000**	**300,000**

GROUP 3: PRIMARY CARE	MEASURE A ALLOCATION FY 16/17	EXPENDED/ ENCUMBERED FY 16/17
Health Services for Day Laborers		
Health Services for Day Laborers: Community Initiatives (Day Labor Center)	89,301	25,340
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**	**203,942**
Increase Hospice Utilization: Getting the Most Out of Life Program	**50,000**	**50,000**
Medical Costs for Juvenile Justice Services		
Medical Costs for Juvenile Justice Center: Direct Service Planning & 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	90,000	76,834
Unallocated	12,800	0
Total Allocation	**505,963**	**479,997**
Native American Health Center	**35,000**	**35,000**
Primary Care Community-Based Organizations		
Alameda Health Consortium:		
Asian Health Services	580,741	580,741
Axis Community Health Center	607,166	607,166
La Clínica de La Raza	1,708,699	1,708,699
LifeLong Medical Center	660,149	660,149
Native American Health Center	256,088	256,088
Tiburcio Vasquez Health Center	827,442	827,442
Tri-City Health Center	562,651	562,651
West Oakland Health Council	167,558	167,558
Total Allocation	**5,370,494**	**5,370,494**
Roots Community Health Center	**100,000**	**100,000**
Tiburcio Vasquez	**60,000**	**60,000**
Washington Hospital	**33,000**	**33,000**

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 16/17	EXPENDED/ ENCUMBERED FY 16/17
Alameda Boys & Girls Club, Inc.	**107,161**	**107,161**
Alameda County Asthma Start	**100,000**	**100,000**
Center for Early Intervention on Deafness	**53,581**	**53,581**
City of Alameda (Community Paramedicine Services)	**246,048**	**246,048**
City of San Leandro Senior Services	**53,581**	**53,581**
Countywide Plan for Seniors (Home-Based Nursing Case Management)	**500,000**	**323,663**
Countywide Plan for Seniors (Injury Prevention, Meals, and Nutrition)	**750,000**	**702,369**
Countywide Plan for Seniors (Getting the Most Out of Life)	**250,000**	**183,579**
Eden Youth and Family Center	**75,000**	**75,000**

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 16/17	EXPENDED/ ENCUMBERED FY 16/17
EMS Corps		
Berkeley Youth Alternatives (BYA)	40,000	40,000
Other Program Expenses	564,942	564,942
Total Allocation	**604,942**	**604,942**
Food As Medicine: Alameda County Community Food Bank	**15,479**	**15,479**
Food As Medicine: Alameda County Deputy Sheriffs' Activities League	**84,693**	**84,693**
Food As Medicine: Alameda County Public Health Department	**6,000**	**6,000**
Food As Medicine: UCSF Benioff Children's Hospital Oakland	**27,966**	**27,966**
Genesis Worship Center	**5,000**	**5,000**
Healthy Homes Department: Fixing to Stay and Group Living Facilities Project	**229,337**	**229,201**
HIV Education and Prevention Project of Alameda County (HEPPAC): Syringe Exchange Program	**150,000**	**150,000**
HIV Education and Prevention Project of Alameda County (HEPPAC): OPEND Project	**150,000**	**150,000**
Home Visiting Services	**1,250,000**	**878,568**
La Clínica de La Raza, Inc. (Dental Clinic Expansion Project)	**1,000,000**	**1,000,000**
LifeLong Medical Care: Heart 2 Heart	**100,000**	**100,000**
Mandela MarketPlace, Inc.	**10,000**	**10,000**
Needle Exchange Emergency Distribution	**25,000**	**25,000**
Nutrition Services in West Oakland: City Slickers Farm	**50,000**	**50,000**
Public Health Prevention Initiative		
CAL-PEP Inc.	48,566	48,566
Center for Oral Health	180,000	180,000
City of Berkeley	180,835	180,835
City Slicker Farms	70,000	70,000
East Oakland Boxing Association	52,530	52,530
HIV Education and Prevention Project of Alameda County	194,150	194,150
International Contact Inc.	47,162	38,717
Lotus Bloom	34,145	34,145
Mandela MarketPlace	122,024	122,024
Native American Health Center	153,151	153,151
Niroga Institute, Inc.	51,771	51,771
The Mentoring Center	51,425	51,425
Tiburcio Vasquez Health Center	590,000	589,382
Tides Center (Hope Collaborative)	80,000	80,000
Subtotal Program Expenses	1,855,759	1,846,696
Other Program Expenses	1,118,137	1,063,718
Total Allocation	**2,973,896**	**2,910,414**
Public Health Prevention Initiative: EMS Injury Prevention	**210,112**	**210,112**
Public Health Services for Homeless Residents: Abode Services	**100,000**	**100,000**
Senior Injury Prevention Program	**115,000**	**115,000**
Service Opportunity for Seniors (Meals on Wheels)	**16,000**	**16,000**
Spanish Speaking Unity Council of Alameda County, Inc. DBA The Unity Council (Latino Men and Boys Program)	**400,000**	**400,000**
Spectrum Community Services, Inc.	**76,128**	**76,128**

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 16/17	EXPENDED/ ENCUMBERED FY 16/17
Youth and Family Opportunity Initiatives		
Alameda Family Services	107,161	107,161
Alternatives in Action (AIA)	267,903	267,903
Berkeley Youth Alternatives (BYA)	107,161	107,161
City of Fremont	160,742	160,742
Dublin Unified School District	17,860	17,860
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
Livermore Unified School District	3,563	17,860
Newark Unified School District	107,161	107,161
New Haven Unified School District	107,161	107,161
Pleasanton Unified School District	17,860	17,860
Southern Alameda County Committee for Raza dba La Familia Counseling Services	160,742	160,742
Spanish Speaking Unity Council (LMB)	64,297	50,000
Youth Radio	107,161	107,161
Other Program Expenses	1,042,205	1,042,205
Total Allocation	**2,597,818**	**2,597,818**
Youth UpRising	**71,535**	**71,535**

APPENDIX D

MAPS: GEOGRAPHIC DISTRIBUTION OF PROVIDERS FUNDED BY MEASURE A IN FY 16/17

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

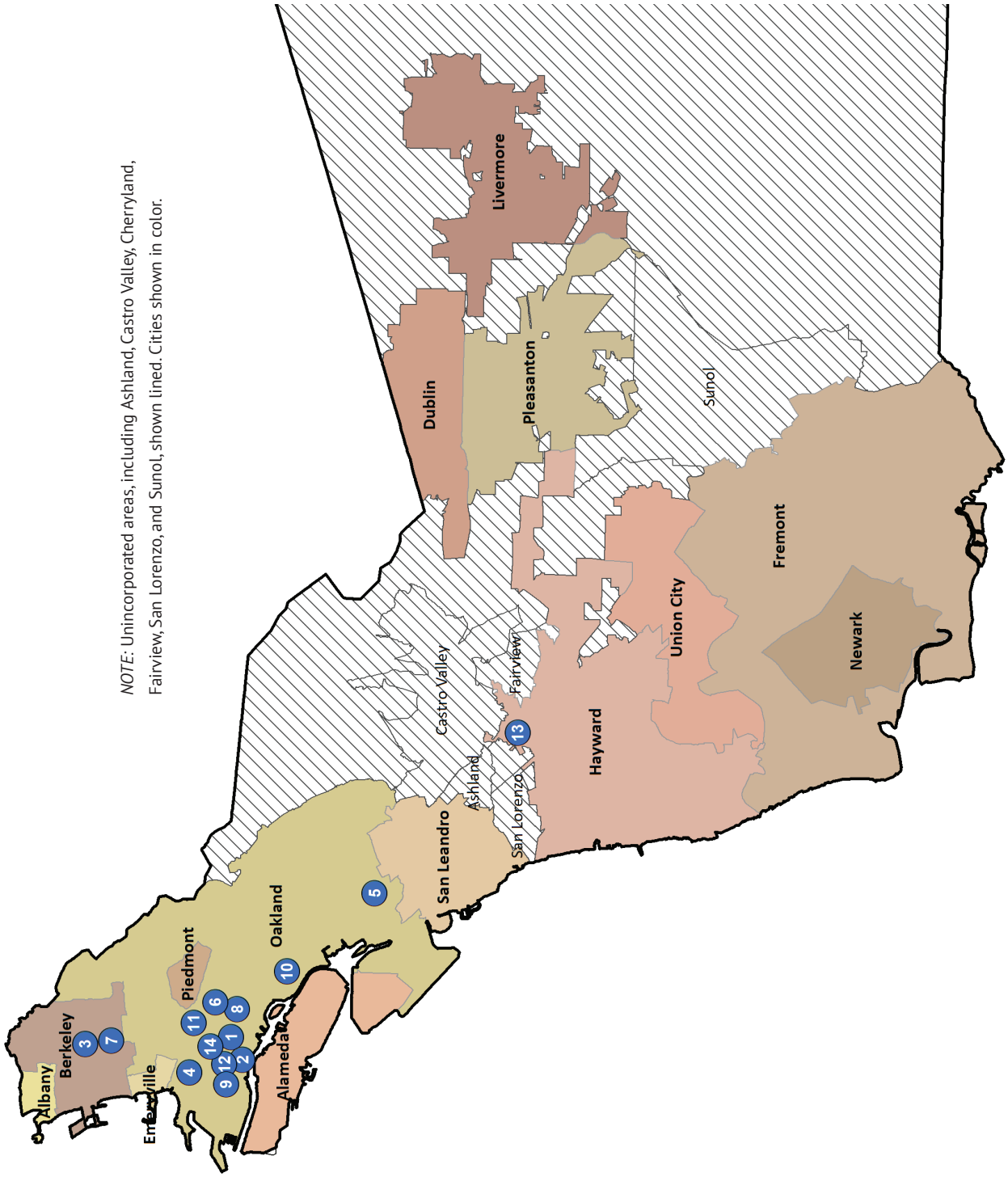
Map 4 School Health Centers

Map 5 HealthPAC Provider Network

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS FUNDED BY MEASURE A IN FY 16/17

#	PROVIDER	CITY
1	California Prevention and Education	Oakland
2	Center for Oral Health	Oakland
3	City of Berkeley	Berkeley
4	City Slicker Farms	Oakland
5	East Oakland Boxing Association	Oakland
6	HIV Education and Prevention Project of Alameda County (HEPPAC)	Oakland
7	International Contact	Berkeley
8	Lotus Bloom	Oakland
9	Mandela MarketPlace	Oakland
10	Native American Health Center	Oakland
11	Niroga Institute	Oakland
12	The Mentoring Center	Oakland
13	Tiburcio Vasquez Health Center	Hayward
14	Tides Center (HOPE Collaborative)	Oakland

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS
FUNDED BY MEASURE A IN FY 16/17

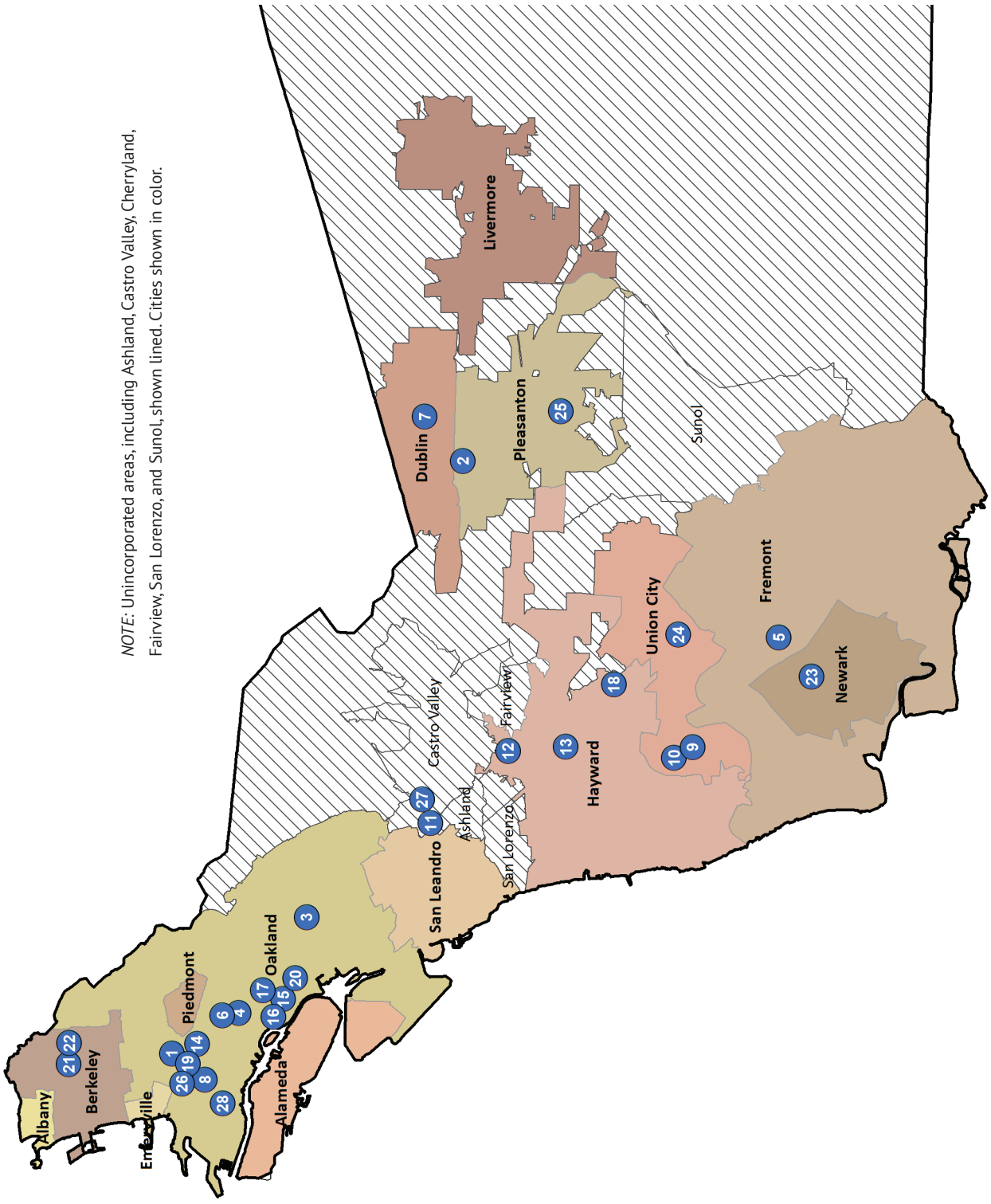


NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES ALCOHOL AND OTHER DRUG PROVIDERS FUNDED BY MEASURE A IN FY 16/17

#	PROVIDER	CITY
1	Adolescent Treatment Centers	Oakland
2	Axis Community Health	Pleasanton
3	Bi-Bett Corporation	Oakland
4	Bi-Bett Corporation	Oakland
5	Carnales Unidos Reformando Adictos	Fremont
6	Community Health for Asian Americans	Oakland
7	East Bay Community Recovery Project	Dublin
8	East Bay Community Recovery Project	Oakland
9	EMQ FamiliesFirst	Union City
10	Filipino Advocates for Justice	Union City
11	Horizon Services, Inc.	San Leandro
12	Horizon Services, Inc.	Hayward
13	La Familia	Hayward
14	La Familia	Oakland
15	La Familia	Oakland
16	La Familia	Oakland
17	La Familia	Oakland
18	Magnolia Women's Recovery	Hayward
19	Magnolia Women's Recovery	Oakland
20	Native American Health Center, Inc.	Oakland
21	New Bridge Foundation, Inc.	Berkeley
22	New Bridge Foundation, Inc.	Berkeley
23	Second Chance, Inc.	Newark
24	Senior Support Program of the Tri-Valley	Union City
25	Senior Support Program of the Tri-Valley	Pleasanton
26	St. Mary's Center	Oakland
27	The Institute for Black Family Life and Culture	San Leandro
28	The West Oakland Health Council, Inc.	Oakland

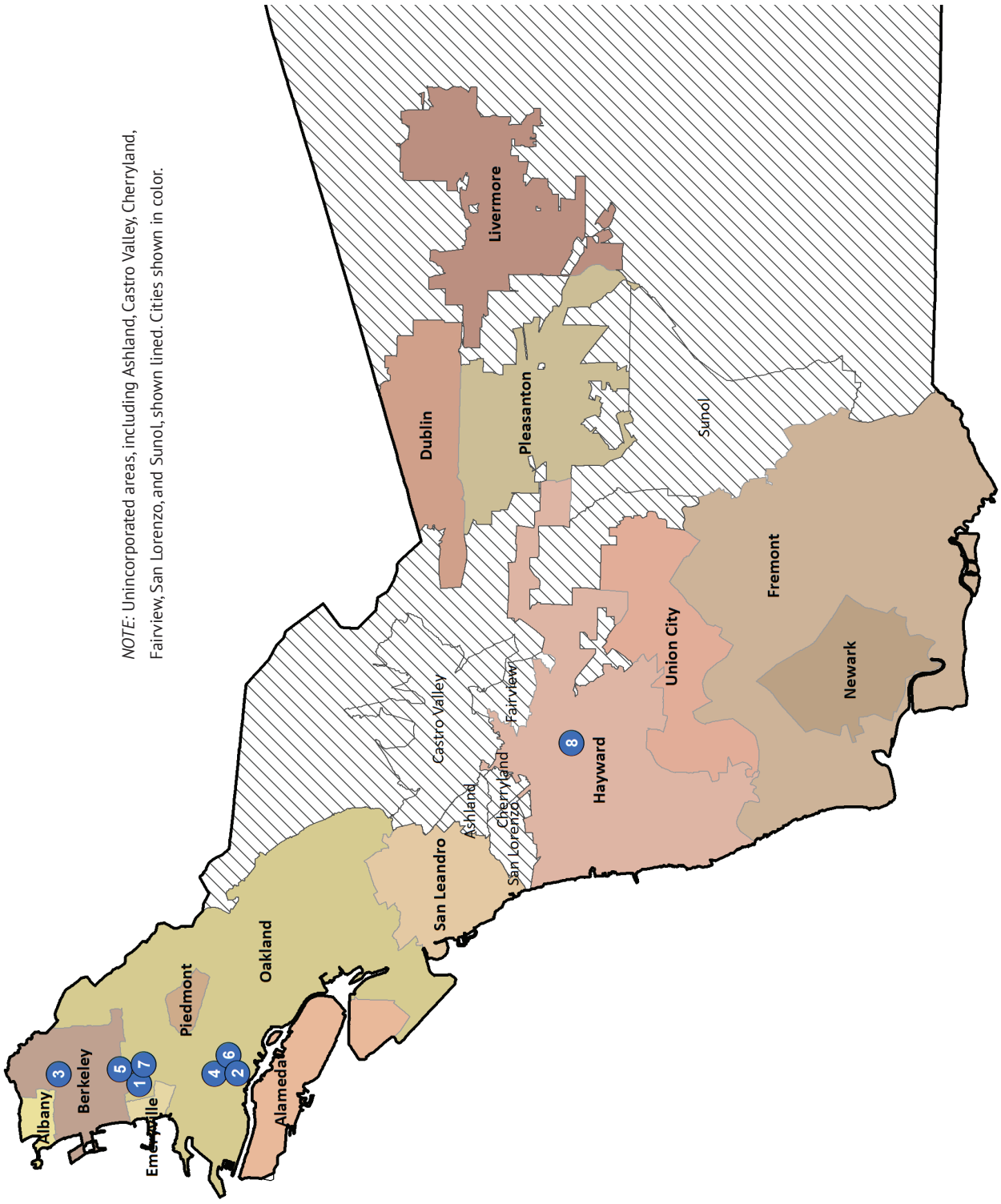
MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
ALCOHOL AND OTHER DRUG PROVIDERS
FUNDED BY MEASURE A IN FY 16/17



MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 16/17

#	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 Committee for Raza (La Familia Counseling Services)	Hayward

MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 16/17



NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

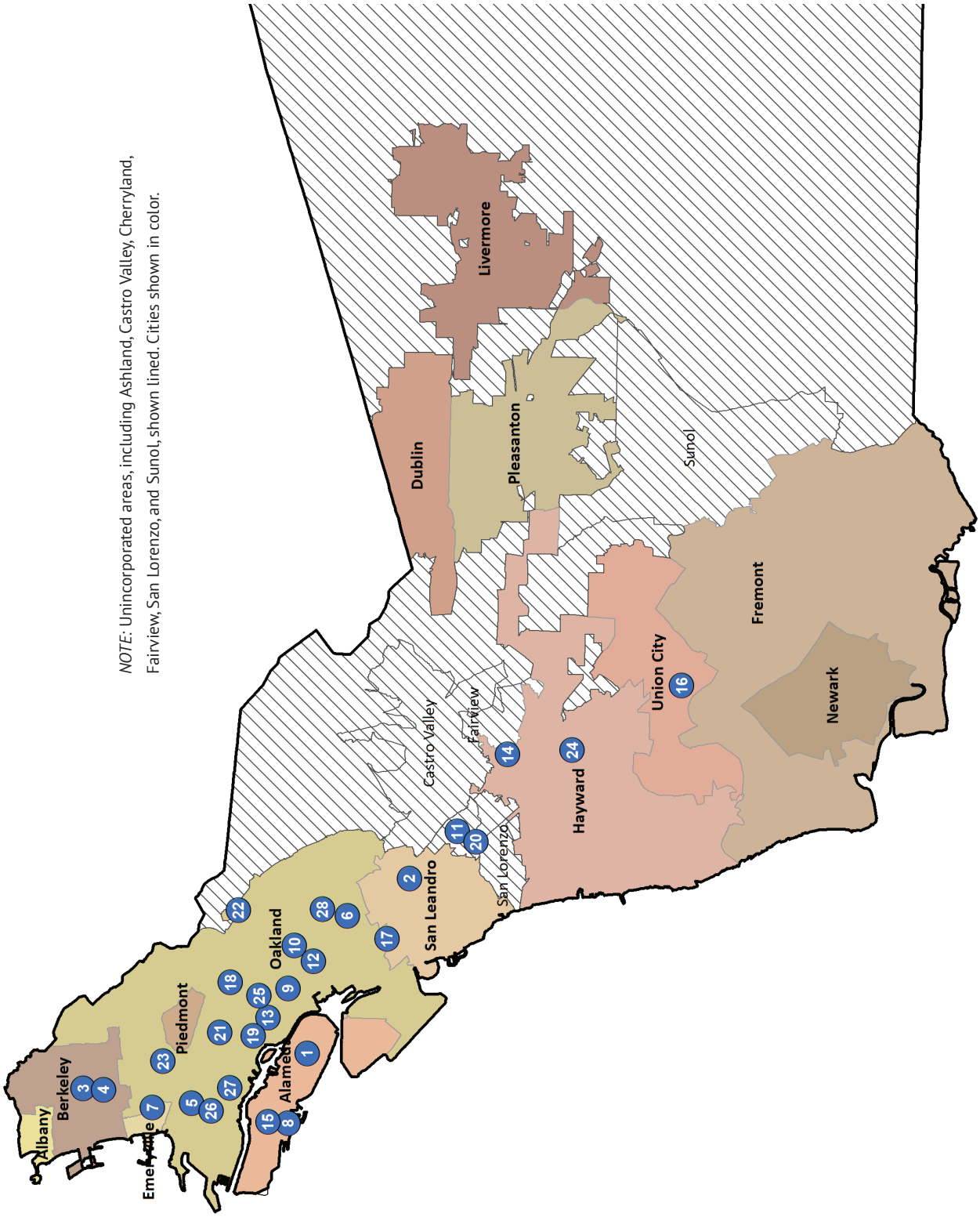
MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 16/17

#	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	Emeryville Health Center	Emeryville
8	Encinal High School-Based Health Center	Alameda
9	Fremont Tiger Clinic	Oakland
10	Frick Middle School-Based Health Center	Oakland
11	Fuente Wellness Center (REACH Ashland Youth Center)	San Leandro
12	Havenscourt Health Center	Oakland
13	Hawthorne Health Center	Oakland
14	Hayward High School Mobile Health Van	Hayward

#	PROVIDER	CITY
15	Island/BASE High School-Based Health Center	Alameda
16	Logan Health Center	Union City
17	Madison Health Center	Oakland
18	Rising Harte Wellness Center	Oakland
19	Roosevelt Health Center	Oakland
20	San Lorenzo High Health Center	San Lorenzo
21	Shop 55 Wellness Center	Oakland
22	Seven Generations SBHC (Skyline High School)	Oakland
23	TechniClinic	Oakland
24	Tennyson Health Center	Hayward
25	Seven Generations SBHC (United for Success/Life Academy)	Oakland
26	West Oakland Middle School Health Center	Oakland
27	Youth Heart Health Center (La Escuelita Education Complex)	Oakland
28	Youth Uprising/Castlemont Health Center	Oakland

MAP 4

SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 16/17



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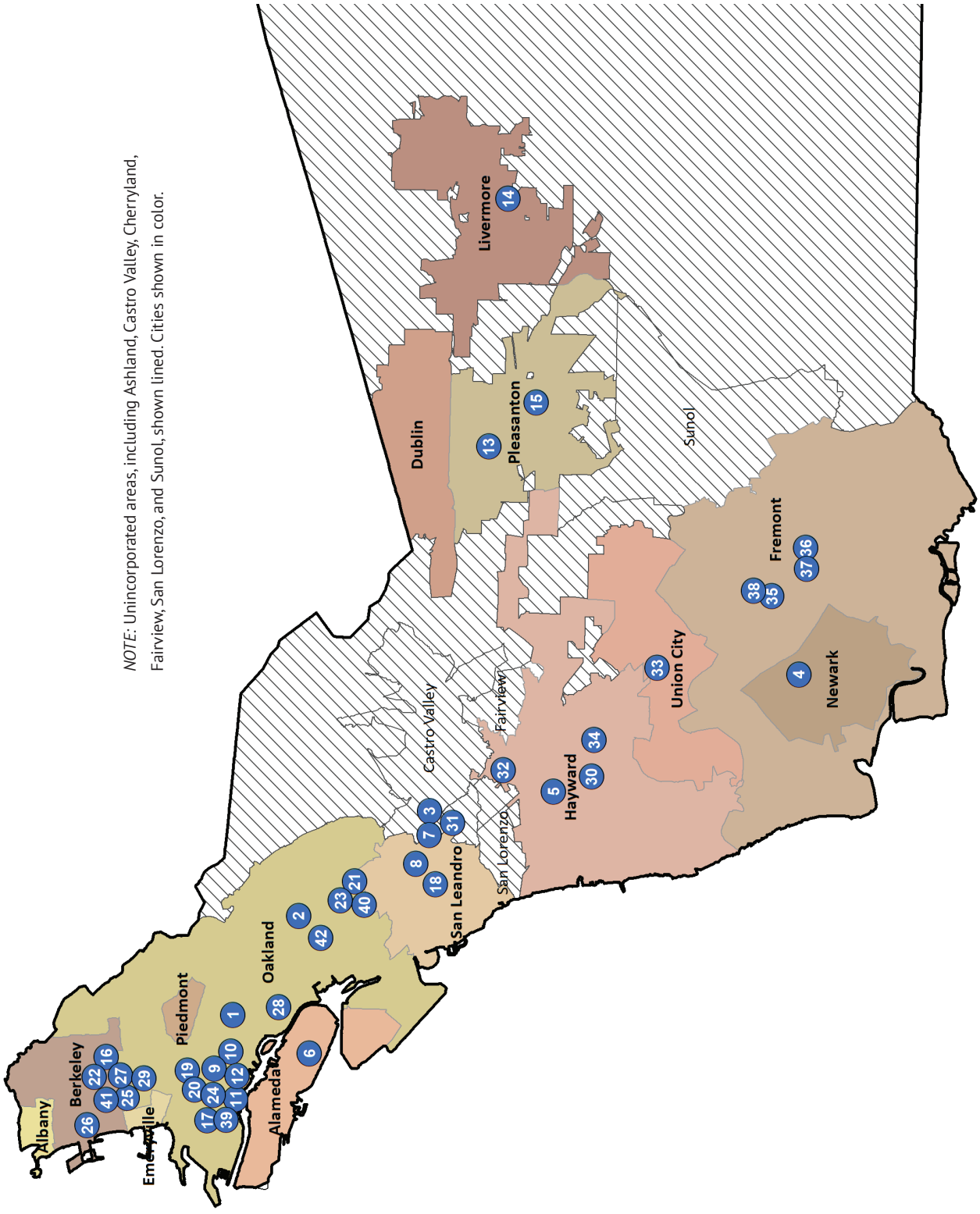
MAP 5
HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 16/17

#	PROVIDER	CITY
Alameda Health System		
1	Highland Hospital	Oakland
2	Eastmont Wellness	Oakland
3	Fairmont Hospital	San Leandro
4	Newark Wellness	Newark
5	Hayward Wellness	Hayward
6	Alameda Hospital	Alameda
7	John George Psychiatric Pavilion	San Leandro
8	San Leandro Hospital	San Leandro
Asian Health Services		
9	Oakland Hotel	Oakland
10	Frank Kiang Medical Center	Oakland
11	Asian Health Services	Oakland
12	Rolland & Kathryn Lowe Medical Center	Oakland
Axis Community Health		
13	Axis Community Health - Hacienda	Pleasanton
14	Axis Community Health - Livermore	Livermore
15	Axis Community Health - Pleasanton	Pleasanton
Bay Area Consortium for Quality Health Care, Inc.		
16	Berkeley Health Center	Berkeley
17	AHMI Clinic	Oakland
18	**Davis Street Community Center Inc.**	San Leandro
19	**East Bay AIDS Center**	Oakland
20	**Healthy Communities, Inc.**	Oakland
21	**Integrated Medical Associates**	Oakland

#	PROVIDER	CITY
LifeLong Medical Care		
22	Berkeley Primary Care	Berkeley
23	Howard Daniel Clinic	Oakland
24	Downtown Oakland Clinic	Oakland
25	Over 60 Health Center	Berkeley
26	West Berkeley Family Practice	Berkeley
27	Ashby Health Center	Berkeley
28	Native American Health Center	Oakland
29	**Prevention Care Pathways**	Oakland
30	**St. Rose Hospital**	Hayward
Tiburcio Vasquez Health Center		
31	Tiburcio Vasquez San Leandro	San Leandro
32	Tiburcio Vasquez Hayward	Hayward
33	Tiburcio Vasquez Union City	Union City
34	Tiburcio Vasquez Silva Clinic	Hayward
Tri-City Health Center		
35	Tri City Health Center - State	Fremont
36	Tri City Health Center - Main Street	Fremont
37	Tri-City Health Center - Irvington	Fremont
38	Tri City Health Center - Mowry II	Fremont
West Oakland Health Center		
39	West Oakland Health Center	Oakland
40	Albert J. Thomas Medical Clinic	Oakland
41	William Byron Rumford Medical Center	Berkeley
42	East Oakland Health Center	Oakland

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 16/17



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