Fiscal Year
2017/2018

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, 2017 – June 30, 2018

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Essential Health Care Services Tax Ordinance

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TO THE ALAMEDA COUNTY BOARD OF SUPERVISORS

AND THE PUBLIC

REVIEW OF EXPENDITURES IN

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July 1, 2017 – June 30, 2018

PHOTO CREDITS

Cover photos (L to R): Center for Healthy Schools and Communities, Spectrum Community Services, Inc., LifeLong Medical Care Heart 2 Heart, Emergency Medical Services Corps, Center for Healthy Schools and Communities

Page 3 (L to R): LIFE ElderCare, Health Services for Day Laborers: Multicultural Institute, Emergency Medical Services Corps, Public Health Services for Pacific Islanders, Center for Healthy Schools and Communities

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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, based on individual reports submitted by fund recipients, at the end of each year to the Board. 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	(vacant)	Alameda County Mental Health Board
Seat 5	Zhonnet Harper	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	(vacant)	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	Linda Tangren	District 4 Supervisor Nate Miley
Seat 17	(vacant)	District 5 Supervisor Keith Carson

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY STAFF

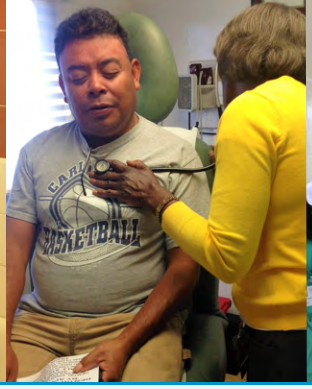
Colleen Chawla, *Agency Director*

Rebecca Gebhart, *Finance Director*

James Nguyen, *Administrative & Financial Services Manager*

Connie Soriano, *Administrative Specialist II*

Anna Erickson, *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, and substance abuse

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

FY 2017/2018 Measure A Executive Summary

(July 1, 2017 – June 30, 2018)

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.

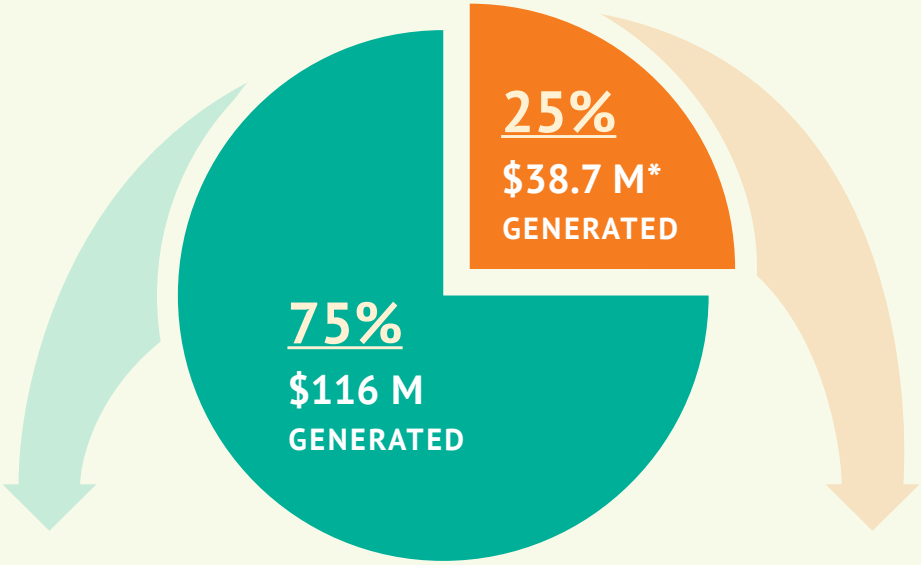
Overall Conclusion

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.

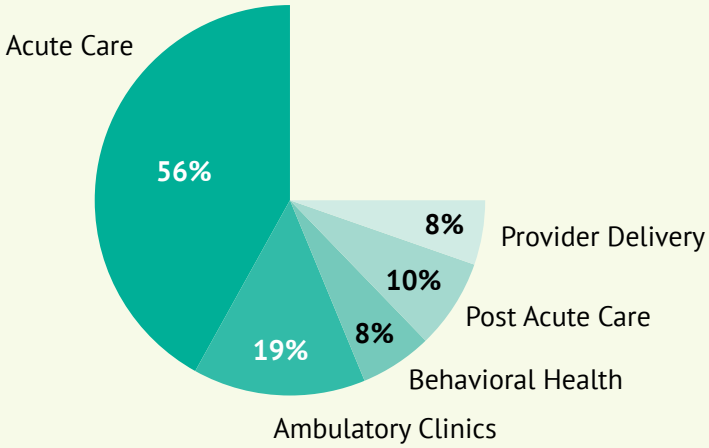
Measure A generated $154,786,579* in FY 17/18.

Of the $154,786,579 that Measure A generated in FY 17/18, AHS received 75%, and the remainder of the funds was distributed by the Alameda County Board of Supervisors (Board) to many health care providers who provide essential health care services.

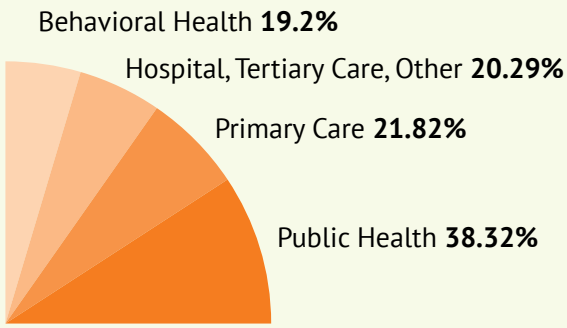
DISTRIBUTION OF MEASURE A FUNDS



$116 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. However, the current federal administration has taken serious efforts to dismantle the Affordable Care Act, which may erode public health coverage. 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 HCSA to improve the accountability of Measure A recipients by providing ongoing technical assistance training to providers.

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

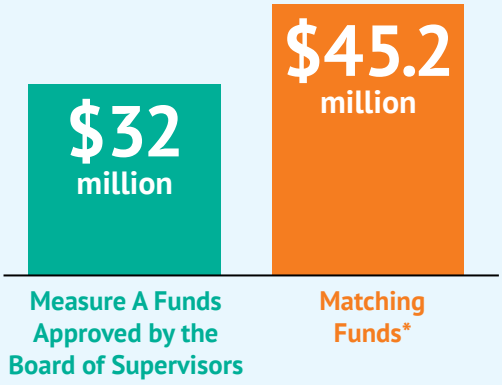
Our Measure A Tax Dollars at Work

One metric for the effectiveness of a tax measure is how broadly it enhances the community that voted it into effect. As in years past, in FY 17/18, Measure A has proven to provide Countywide benefits in a variety of ways:

- By the numbers: Measure A providers serve a large number of Alameda County's 1.5 million residents. AHS and the Alameda County Public Health Department Health Prevention Initiative providers alone served over 155,000 and 60,000 residents, respectively.
- By location: From the City of Berkeley School Linked Health Services Program to the north; to Abode Services in Fremont to the south; to the Youth and Family Initiatives Tri-Valley Health Initiative, serving Dublin, Pleasanton, and Livermore to the east; Measure A service providers are located in every geographic section of the County.
- By target groups: While most Measure A providers serve all segments of the population, several target certain demographic groups, ensuring that all segments of the County receive benefits. Programs exist that are specific to seniors (Spectrum Community Services, Inc., Service Opportunities for Seniors Meals on Wheels) and youth (UCSF Benioff Children's Hospital Oakland, Alameda Boys & Girls Club), as well as underserved nationalities such as the County's Afghan (Fremont Aging and Family Services) and Pacific Islander/Tongan (Public Health Services for Pacific Islander) communities.

AHS served over **155,000** County residents through Measure A in FY 17/18, while the Alameda County Public Health Department Public Health Prevention Initiative served over **60,000**.

Health Services for Day Laborers: Street Level Health Project



- By language: By offering services in multiple languages, Measure A recipient providers address the reality that much of the County does not speak English as a first language, if at all. Many providers offer services in Spanish, while others extend into languages such as Cantonese, Mandarin, Korean, Lao, Mam, Tagalog, Urdu, Vietnamese, and others.

Generating Additional Funds

Measure A continues to serve as leverage for its recipient providers to use to obtain matching funds. Thus, every tax dollar raised generates additional funding for needed health care services. Some notable examples in FY 17/18 include St. Rose Hospital, who raised $4,500,000 in matching funds on a $4,500,000 allocation—a one-to-one match—and Asthma Start, who raised $200,000 in matching funds on a $100,000 allocation—a two-to-one match.

Increasing Access to Services

In addition to geographic reach, many Measure A providers used their funding to conduct outreach and offer services in nontraditional, nonclinical settings. This helped remove barriers to access that exist when services are offered only in traditional environments. For example, the Countywide Plan for Seniors: Injury Prevention, Meals, Nutrition delivered services in senior centers, community centers, and senior housing communities, while the Maternal, Paternal, Child, and Adolescent Health Unit offered telephone-based interpreter services. Multiple providers also offered street-level outreach and service delivery, as well as home-based service provision.

Achieving More, Offering Greater Satisfaction

Measure A funding recipients typically met, and often exceeded, their targets for service delivery. For example, Safe Alternatives to Violent Environments provided 759 free, outpatient, community mental health service sessions to 101 participants, compared to a target of 95 sessions to 28 participants, while the Senior Injury Prevention Program offered 1,428 Tai Chi: Moving for Better Balance classes, compared to a target of 476. In addition, client surveys commonly indicated high satisfaction with services. Overall satisfaction scores of 100% were received by the Center for Early Intervention on Deafness, City of Alameda: Community Paramedicine Services, and ACCMA Community Health Foundation/East Bay Conversation Project, among others.

Responding to Emerging Health Crises

In FY 17/18, several Measure A recipients used their funding to address some of the most prevalent and growing health concerns of our time. For example, the HIV Education and Prevention Project of Alameda County OPEND Program provided treatment and education for the epidemic of opiod abuse, Preventive Care Pathways and Primary Care Community-Based Organizations screened for and treated Hepatitis C, and Abode Services worked to help remediate the County's homelessness crisis.

LIFE ElderCare

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 benefited from the economic recovery in recent years and face rising housing and living costs, which significantly impact the health of County residents. According to 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. In addition, Alameda County should continue to closely monitor the efforts by the federal administration to cut entitlement programs, change the definition of Public Charge, and dismantle the Affordable Care Act. Moreover, Medi-Cal rate reductions and other funding cuts over the past several years have continued to decrease the ability of health care 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,

Emergency Medical Services Corps

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.

CONCERN: The Committee recognizes that many organizations apply for Measure A funding to supplement their funds to provide services to the residents of Alameda County. The Committee's concern is that, because some organizations have more familiarity with the funding cycle and the process for applying for Measure A funds, this may have the unintended effect where the selection process appears to favor organizations that are more familiar with the process, to the possible exclusion of newer, more innovative organizations that may be addressing emerging health care needs of the Measure A target populations.

RECOMMENDATION: The Committee suggests that, to improve public awareness about Measure A and access to the funding process, the Board should make public announcements about the availability of Measure A funds at least nine months before the application process for the next funding cycle. The announcements should include information about Measure A, the person or persons to contact regarding applications, and a brief statement about the purpose of Measure A funds.

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 might arise because of incomplete or inaccurate reporting, not because of any inappropriate use of funds.

CONCERN: 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.

RECOMMENDATION: The Board should authorize and fund 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.

CONCERN: Although reporting continues to improve, the Committee expresses the ongoing concern that its review is impacted by the varying level of detail provided in fund recipient reports, as well as varying levels of responsiveness to specific questions posed by the Committee to specific recipients. This makes it difficult for the Committee to determine whether funding is being spent on the Measure A target population. For example:

- Multiple provider reports listed objectives that are not measurable and/or stated positive outcomes without quantifying the statements.
- For some reports, it is unclear whether the target population falls within one of the categories listed in the Measure A statute: "indigent, low income, and uninsured adults, children, families, seniors, and other residents of Alameda County."
- In other reports, the provider's description of the services offered raises questions as to their relevance to the wording of the Measure A statute.

RECOMMENDATION: HCSA should receive funding to 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.

CONCERN: While the U.S. economy has had more than eight years of growth following the Great Recession, some indicators forecast a potential economic slowdown in the next few years, which would have a negative impact on many of the providers and programs that receive Measure A funding.

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

CONCERN: In reviewing Measure A fund recipients, committee members noted that several awardees have consistently not used their full allocated funds. This is a concern as these unused funds could have been awarded to other organizations rather than sitting as rollover funds.

Public Health Services for Pacific Islanders

LifeLong Medical Care Heart 2 Heart

RECOMMENDATION: Ascertain awardees who consistently do not use their full allocated funds, and reduce their allocated funding as appropriate.

Specific Concerns

Alameda Health System

From the time the Committee voiced its initial concern in the FY 06/07 Annual Report, AHS's accounting decision has continued to integrate Measure A dollars (FY 17/18: $111,416,142) into their overall revenue (FY 17/18: $1,027,011,000). Therefore, the Committee is 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 4,409.
- Determine what portion of Measure A funds were allocated to an actual number of individuals served, separate from those served (156,790) by their entire agency.

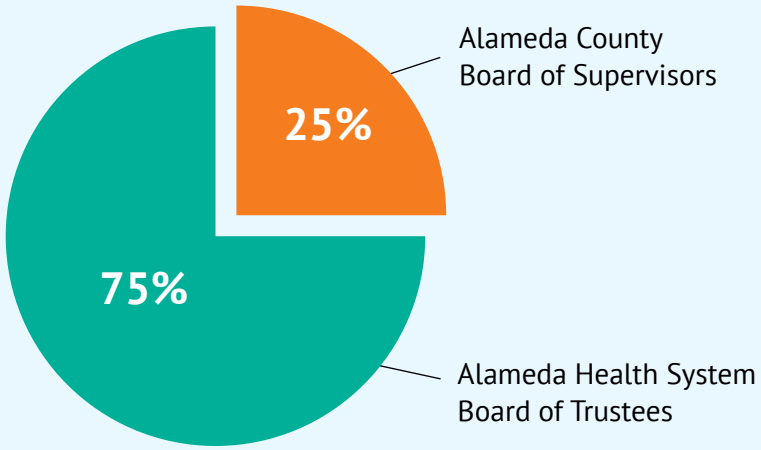
In light of the above collective concerns that have been repeated in annual Oversight Committee reports since the FY 06/07 Annual Report, it is recommended that AHS undergo a full and comprehensive audit to track Measure A fund allocations during the FY 17/18 period to ensure public accountability for how the tax funds were utilized.

NOTE: This recommendation will be changed if AHS provides a response that addresses the above concerns.

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 17/18, Measure A generated $154,786,579 (not including interest earned). The funds were allocated as follows:

Alameda Health System (75%): $116,089,934

Alameda County (non-AHS) (25%): $38,696,645

TOTAL: $154,786,579

In FY 17/18, the Alameda County approved budget totaled $3.173 billion. The Alameda County Health Care Services Agency approved budget totaled $836 million, or 26.3% of the total County budget. Measure A revenues not specifically designated for AHS accounted for 1%.

The following sections in the report provide more detail on how AHS and the Board spent Measure A funds in FY 17/18, which includes revenue generated in the reporting year as well as unspent funds earned in previous years.

FY 17/18: 75% of Measure A Funds Allocated to Alameda Health System

alamedahealthsystem.org

FY 17/18 Allocation: **$116,089,934** | **Expended/Encumbered:** **$116,089,934**

Individuals served by Measure A: 156,790 (Total individuals served: 156,790)

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) works for the caring, healing, teaching, and serving of all. It provides a patient- and family-centered system of care that promotes wellness, eliminates disparities, and optimizes the health of its diverse communities.

AHS leadership continues its third year of transition towards becoming a Population Health organization characterized by its commitment to meeting the needs of the communities that it serves. AHS is enhancing its key competencies in specific areas of care delivery—ambulatory clinics, acute care, behavioral health, and post-acute care—and supplementing the continuum of care through contractual relationships with other providers. The system will be supported with a state-of-the-art integrated technology platform, consolidated financial systems, and human resource systems characterized by a culture of accountability, providing AHS with the nimbleness to respond rapidly to opportunities and a changing environment.

The framework for these activities is built on the following pillars:

- Access. Be a leader in access to quality affordable care.
- Quality. Promote and maintain patient health and wellness while doing no harm.
- Experience. Be the best place to stay well, heal, and receive care.
- Sustainability. Be an organization that operates profitably and generates funding to support its mission.
- Network. Ensure integrated health care delivery across the continuum to optimize directly provided or contracted services.
- Workforce Development. Be the best place to learn and work.

AHS integrates access to non-clinical services to complement health care delivery and support healthy outcomes for those it serves. A key

Matching Funds

$32.9 M

AHS leveraged its Measure A allocation to obtain $32,894,622 in matching funds through an **Intergovernmental Transfer with Alameda County and the federal Center for Medicare and Medicaid Services**.

component of this program is AHS's Health Advocates program, which is a volunteer-powered, client-centered program under AHS's Care Management department. Volunteers and staff work together to assist AHS consumers with basic resource information and navigation. The goal of Health Advocates is to address the social determinants of health and to empower consumers towards improved health and quality of life.

AHS serves an extremely diverse patient population when stratified by race and ethnicity:

- African American/Black: 27%.
- American Indian and/or Alaskan Native: 2%.
- Asian: 12%.
- Hispanic/Latino: 32%.
- Native Hawaiian and/or other Pacific Islander: 4%.
- White/Caucasian: 16%.
- Other: 7%.

Measure A Funding Summary

AHS does not have programs specifically or separately supported by Measure A funds. Measure A is a supplemental funding source that supports all AHS services, with the exception of a small share of services for which AHS receives full reimbursement. Measure A funds are critical to helping AHS reduce the gap between reimbursement for services from a variety of sources and the actual cost of providing those services to underinsured and uninsured patients.

Because of this, the results listed below are for AHS's overall programs. Its goals and strategies are aligned to ensure its ability to meet the purpose of the voter-approved Essential Health Care Services Initiative, providing additional support for emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low income, and uninsured adults, children, families, seniors, and other residents of Alameda County.

In FY 17/18, Measure A helped AHS achieve the following across its strategic pillars.

Access

Improve access by increasing the number of non-traditional ambulatory encounters. Non-traditional encounters are exchanges between primary care providers and their patients via telephone and e-consults (electronic communications) between primary care and specialty care providers.

- 4,050 phone visits (target: 1,478).
- 958 e-consults (target: 660).

Success Story

Mr. M, 20, is on the autism spectrum. His unpredictable behavioral issues make it difficult for him to receive any type of medical exam, including dental. Most dentists will not examine a patient who can't sit still, can't communicate what's wrong, or is prone to sudden outbursts. The Alameda Health System-Highland Hospital Dental Clinic is one of the only locations in Northern California that offers dentistry to patients who require special assistance. They do an initial exam with every patient. For those who cannot sit still, anesthesiologists are brought in to sedate them. As Mr. M's grandmother recalls, "The care my grandson received from the Highland Dental Clinic was incredible."

Quality

Reduce patient falls in acute medical/surgical inpatient unit, skilled nursing facilities, and behavioral health locations. Quality managers, nurse managers, and executive leaders help decrease the percentage of falls by rounding at sites to reinforce and support best practices, including timely falls reconciliation, fall risk assessment, fall prevention risk identification, staff awareness, medication management, and use of bed alarms.

Falls per 1,000 patient days:
- Inpatient acute medical/surgical: 2.81 (target: 2.10).
- Skilled nursing: 1.50 (target: 1.68).
- Behavioral health: 3.10 (target: 3.14)

Experience

Improve Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Consumer Assessment of Healthcare Providers and Systems Consumer & Group Survey (CG-CAHPS) scores. These surveys reflect the voice of patients and provide information about their experience.
- HCAHPS: 72.1% (target: 74.3%).
- CG-CAHPS: 73.6% (target: 71.48%).

Network

Achieve a rehospitalization rate of less than 15% during the first 30 days in the Home Health pilot group. AHS's goal was to reduce readmissions within 30 days for patients with chronic conditions through effective case management, increased communications, and monitoring of rehabilitation services.
- Rehospitalization rate: 13.64% (target: <15%).

Workforce Development

Reduce time to hire by reducing the number of recruitment days from job posting to start date.
- Recruitment days: 66 (target: 70).

AHS exceeded its targets in the areas of Access, Network, and Workforce Development, and exceed two of three targets in the area of Quality.

Concerns

From the time the Committee voiced its initial concern in the FY 06/07 Annual Report, AHS's accounting decision has continued to integrate Measure A dollars (FY 17/18: $111,416,142) into their overall revenue (FY 17/18: $1,027,011,000). Therefore, the Committee is 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 4,409.
- Determine what portion of Measure A funds were allocated to an actual number of individuals served, separate from those served (156,790) by their entire agency.

In light of the above collective concerns that have been repeated in annual Oversight Committee reports since the FY 06/07 Annual Report, it is recommended that AHS undergo a full and comprehensive audit to track Measure A fund allocations during the FY 17/18 period to ensure public accountability for how the tax funds were utilized.

NOTE: This recommendation will be changed if AHS provides a response that addresses the above concerns.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

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Behavioral Health and Alcohol and Other Drug (AOD) Community-Based Providers

www.acbhcs.org

FY 17/18 Allocation: **$801,571** | **Expended/Encumbered:** **$713,870**

Individuals served by Measure A: 62,536 service encounters (Total individuals served: 37,931)

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

Services provided: Mental Health, Substance Abuse

Service area: Countywide, Outside of Alameda County

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 (SUD) services under contract with BHCS to meet the diverse cultural and language needs of County resident populations.

For mental health services, each program receiving Measure A funds has experience in serving the unique needs of their clients: persons at imminent risk for suicide, persons with mental health conditions who are also homeless, older adults including those who may be home-bound, family members of a loved one with a mental health condition, and those with limited English proficiency. Measure A funds help ensure continued operation of these programs as well as program efforts to better serve the community.

For SUD, two primary types of services are offered:

- Residential treatment facilities. Residential services are often the first step that many clients take to help become and remain sober. Residential services are accessed by clients throughout the County.
- Primary prevention activities. These activities serve youth and their families as well as older adults in school, community-based, senior housing, and senior center environments.

SUD services are tailored to these two systems of care and also feature culturally congruent, evidence-based programming and services for non-English speakers.

Matching Funds

$35,693

from **Medi- Cal.**

Highlights

173

CURA's SUD Residential Treatment Program **served 173 unduplicated clients**, far surpassing their goal of 80. What's more, nearly half of those clients completed their desired treatment goals upon discharge.

Measure A Funding Summary

Mental Health

Measure A funding helped BHCS mental health providers achieve the following:

- Center for Independent Living provided individual benefits counseling and/or financial literacy support services to 157 unique clients (target: 120).
- Center for Independent Living provided 14 group presentations to providers and/or clients on how working impacts Social Security benefits (target: 20).
- Asian Health Services Adult Level 1 Service Team provided 7,204 service hours and 775 medication support hours to 251 unique clients (target: 11,315 service hours and 815 medication support hours to 268 clients).
- Bonita House Inc. Dual Diagnosis residential treatment program provided 3,367 bed days to 33 unique clients (target: 2,992 bed days to 32 clients).
- Crisis Support Services 24-hour crisis line served 57,551 clients, of whom 1,096 had a high risk (level 3-5) of suicide (target: 48,000 clients, with 1,000 at a risk level of 3-5).
- Mental Health Association Family Education Resource Center responded to 1,219 new Warm Line contacts (target: 900).
- La Familia Mocine Adult Service Team provided 4,522 service hours and 655 medication support hours to 131 unique clients (target: 5,072 service hours and 838 medication support hours to 131 clients).
- 91% of Center for Independent Living clients reported being satisfied with services (target: 67%).
- 96% of Asian Health Services Adult Level 1 Service Team clients received two or more visits within 30 days of their episode opening date (target: 84%).
- 38% of BOSS Adult Level 1 Service Team clients received two or more visits within 30 days of their episode opening date (target: 84%).
- 100% of La Familia Mocine Adult Service Team clients received two or more visits within 30 days of their episode opening date (target: 90%).
- 88% of Crisis Support Services 24-hour crisis line callers with risk level 3-5 were stabilized by the end of the call without law enforcement or hospital intervention (target: 80%).
- 86% of Center for Independent Living clients surveyed reported they will use the information provided to inform their decision-making around benefits and employment (target: 67%).

SUD

Measure A funds were used to expand staffing, service hours, and physical improvements for residential services to allow for a greater number of clients, better screening, and improved patient supervision, leading to a greater chance of long-term sobriety. Measure A funds

Highlights

57,551

Crisis Support Services 24-hour crisis line served 57,551 clients, of whom 1,096 had a high risk (level 3-5) of suicide (target: 48,000 clients, with 1,000 at a risk level of 3-5)

88%

88% of Crisis Support Services 24-hour crisis line callers with risk level 3-5 were **stabilized by the end of the call without law enforcement or hospital intervention** (target: 80%).

also supported the Senior Support Program of the Tri-Valley wellness services to older adults combined with substance use disorder resources, messages, and other information.

Specifically, Measure A funding helped SUD residential treatment programs achieve the following:

- Number of unduplicated clients receiving services:
  - La Familia's El Chante: 66 (target: 50).
  - CURA: 173 (target: 80).
  - East Bay Community Recovery Project's Project Pride: 61 (target: 25).
  - New Bridge Foundation's Bridge One: 125 (target: 80).
  - Second Chance's Women's Phoenix Center: 119 (target: 160).
- Percentage of clients receiving at least two treatment sessions or treatment days within 30 days of admission:
  - El Chante: 98%.
  - CURA: 98.4%.
  - Project Pride: 100%.
  - Bridge One: 94.6%.
  - Phoenix Center: 85.6%.
- Percentage of clients admitted into treatment who were rated as successfully completing treatment at discharge:
  - El Chante: 33.3%.
  - CURA: 45.3%.
  - Project Pride: 11.9%.
  - Bridge One: 30.1%.
  - Phoenix Center: 93.8%.

Success Story

Juan, 25, was in outpatient treatment but unable to abstain from his substance use, so his counselor recommended La Familia El Chante residential treatment. At El Chante, Juan learned to communicate and accept the impact of his addiction. El Chante provided a structured environment where Juan was encouraged to take time to himself, think about his life, and be responsible to himself and others. Doing basic house chores led him to become the residential kitchen coordinator and eventually the house coordinator. He finished treatment after four months and started outpatient treatment. He has reunified with his family and understands how his addiction has impacted those around him.

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

achealthyschools.org

FY 17/18 Allocation: **$1,352,086** | **Expended/Encumbered:** **$630,045**

Individuals served by Measure A: 13,879 (Total individuals served: 13,879)

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

Services provided: 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.

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

CHSC and BHCS used their Measure A allocation to enhance two core programs of the Alameda County School-Based Behavioral Health Initiative: The Our Kids Our Families Program and the School-District Consultation program.

The Our Kids Our Families program, provided at 29 school sites in the Hayward and Oakland Unified School Districts, is a school-based behavioral health program that fosters social-emotional wellness in an educational environment so that children and families feel connected, safe, and supported in school. The 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 District Health and Wellness Consultants (DHWCs) in 14 school districts in Alameda County to provide and enhance preventive social-emotional supports and mental health services for students and their families. The services provided by DHWCs included the following:

- Assess the social-emotional service needs and infrastructure of a school district or set of schools and develop a service plan

Matching Funds

$7,428,096

from the following sources:

- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funding:**
  - **Hayward: $2,164,816**
  - **Oakland: $1,683,429**
  - **San Leandro: $336,127**
  - **New Haven: $645,882**
- **Tobacco Master Settlement Fund (TMSF)/CHSC discretionary : $1,434,525**
- **Medi-Cal Administrative Activity (MAA): $500,000**
- **Mental Health Services Act Prevention/Early Intervention Program: $478,317**

- Coordinate the work of all partner agencies who deliver behavioral health services in schools and districts
- Provide mental and behavioral health consultations in the form of trainings, workshops, and one-on-ones to school staff, parents, and district staff
- Provide and/or coordinate direct services to youth, including clinical case management, group and individual counseling, and crisis response
- Plan and establish service referral and coordination systems
- Help schools establish and/or strengthen coordinated systems of support (COST) for students experiencing behavioral health challenges

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 and School District Consultation programs:

- Conduct 235 capacity-building trainings, totaling 642 training hours, across school districts to develop school staff and parents/caregivers' capacity to support the behavioral, social, and emotional health of young people (target: 200 trainings, 600 hours).
- Have districts implement:
  - Positive Behavioral Interventions and Supports (actual: nine; target: nine).
  - Restorative practices (actual: six; target: six).
  - Social-emotional curriculum (actual: six; target: six).
- Have 235 schools across all 14 districts implement COST, with 13,879 student referrals (target: 200 schools).
- Provide 97,000 hours of early intervention/treatment services to 2,929 students (target: 90,000 hours to 2,000 students).

Highlights

94%

In surveys of youth receiving behavioral health services in the School-Based Behavioral Health Initiative, **94% know they have someone they can go to for help and support in a crisis** (target: 94%).

Cherry Hill Detox and Sobering Station

FY 17/18 Allocation: **$2,218,237** | **Expended/Encumbered:** **$2,004,835**

Individuals served by Measure A: 9,516 (Total individuals served: 9,516)

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

Services provided: Substance Abuse

Service area: Countywide, Homeless or transient

Background

The Cherry Hill Detox and Sobering Station works to cultivate or restore a sense of hope, self-confidence, and community to people impacted by substance use and mental health challenges by providing effective, trauma-informed prevention, treatment, and recovery services.

Measure A funding allows Cherry Hill to provide services to Alameda County residents at no cost to them. This allows for same-day service to be provided in a timely manner. Cherry Hill provides daily transportation services to and from health care providers, hospitals, and police departments to best respond to clients' needs.

Cherry Hill has also worked to expand its capabilities beyond withdrawal management services to also provide referral services to ongoing care. They offer monthly crisis intervention training to police officers located throughout the County to provide alternatives to incarceration.

Matching Funds

$1,519,887

from a **Whole Person Care grant** in the following amounts:

- **Detoxification Center: $897,768**
- **Sobering Center: $622,119**

Measure A Funding Summary

With its Measure A funding, Cherry Hill achieved the following.

Detoxification Center

- Provided detoxification services to 2,581 clients (target: 2,025).
- Maintained a daily occupancy of 27 residents (target: 25).
- Provided a total annual bed day service capacity of 9,740 (target: 9,125).
- Engaged 80% of clients admitted for services for a minimum of three days (target: 60%).
- Referred 93% of clients to residential, outpatient, intensive outpatient, or community support services upon discharge (target: 90%).
- Ensured 42% of referrals to ongoing care services enrolled in such services upon discharge (target: 40%).

Sobering Center

- Provided 18 admissions daily for clients in need of sobering services (target: 17).
- Engaged 60% of intoxicated clients for a minimum of six hours per episode to safely decrease intoxication levels (target: 50%).
- Referred 96% of all client episodes to residential detox, outpatient, intensive outpatient, or continuing care services (target: 90%).
- Enrolled 37% of all referrals to the Detoxification Center to safely begin the withdrawal monitoring process (target: 50%).

Success Story

Detoxification Center

A 59-year-old African American homeless male entered the Detox Center to begin the withdrawal process from illicit substances including methamphetamines and crack cocaine. The client is illiterate and challenged with a severe mental health disorder, coupled with his addiction. He frequently loudly uses profanity towards staff and others. On his twenty-fourth stay, this client reported feeling accepted by Cherry Hill. He mentioned one person in particular, a staff member who spends daily time with the client to meet his basic needs of obtaining an identification card and his medications. After two weeks at Cherry Hill, this client accepted a referral to ongoing care for residential treatment, a first for him.

Criminal Justice Screening and In-Custody Services

FY 17/18 Allocation: **$4,306,000** | **Expended/Encumbered:** **$4,306,000**

Individuals served by Measure A: 4,997 (Total individuals served: 4,997)

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.

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

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 at Santa Rita Jail (SRJ) and the Glen Dyer Detention Facility (GDDF). Measure A funds enabled having staff onsite two shifts per day, seven days per week. This increased timely initial screening, identification of treatment challenges, and crisis intervention.

Specific services supported by Measure A include the following.

Mental Health Screening

- Initial (Intake). At the time of booking, all inmates are screened for medical and psychiatric treatment needs. Within 14 days, staff conducts an additional mental health appraisal. Inmates found to need a further mental health evaluation are referred to AFBH 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. AFBH clinicians triage and screen all referred inmates for mental health service needs and recommend appropriate treatment plans based on the assessment. AFBH provides services onsite in select special housing units. These onsite services allow

Highlights

95%

95% of health education workshop participants reported that they would **recommend the workshop to a friend** (target: 90%).

AFBH staff to proactively deliver mental health services to mentally ill inmates who might otherwise fall through the cracks.

Crisis Intervention

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

Management of Inmate Behavioral Problems

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

Suicide Prevention

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

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

All inmates receiving mental health services are seen by AFBH 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, AFBH 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, AFBH staff collaborate with the

Success Story

Ms. A, 22, was incarcerated for an assault on a cashier. AFBH services became involved when deputies reported Ms. A had a hard time getting along with others on the unit, was behaving oddly, and seemed to be awake much of the time. After an initial assessment, Ms. A was diagnosed with a serious mental illness and prescribed medications. The deputies reported a big improvement, and she was no longer getting in fights with her peers. While in jail, Ms. A continued seeing AFBH staff on a regular basis. She was referred to a re-entry service program to continue services after she was released from custody.

courts to provide treatment geared to restoring competence and/or refer inmates to community programs that can address competency.
- Court-ordered evaluations. AFBH clinicians conduct court-ordered psychiatric evaluations to assess the need for acute inpatient psychiatric care and provide reports back to the courts.
- Inpatient services. AFBH 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 AFBH clinicians can assess them, continue their medications, and clear them for housing.
- Inmates who refuse treatment. All treatment is voluntary. AFBH staff monitor inmates with serious mental illnesses who refuse treatment and make an ongoing attempt to engage these inmates in treatment.
- Outreach and teamwork. AFBH 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. AFBH clinicians also address substance abuse as part of their ongoing interventions with inmates.

Mental Health On-Call/Emergency Services

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

Discharge Planning/Continuity of Care

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

Highlights

40

All new AFBH staff receive **40 hours of initial training.**

Specifically, Measure A funding helped BHCS achieve the following:

- Provide mental health staff in booking daily 100% of the time, including weekends and holidays (target: 100%).
- Hold 12 monthly meetings with the Sheriff's Department and medical providers to address suicide prevention in the jail setting (target: 12).
- Provide education on suicide prevention at 22 mandatory civilian trainings (target: 22).
- Provide an average of 2,500 monthly mental health services to consumers in Alameda County jail/detention facilities.
- Have staff available to Sheriff's Department and medical staff either on call or in person 24/7 for consult regarding mental health needs, crisis, and services in the jail (target: 24/7).
- Provide an average of 141 mental health crisis services each month.
- Provide 80% of mental health services face-to-face with consumers in the jail, with 100% of consumers having face-to-face contact with mental health staff (targets: 70% and 100%).
- Review the log daily to identify individuals place on a suicide watch 100% of the time (target: 100%).
- Meet with anyone in jail placed on a suicide watched and continue to see them face-to-face for the duration at least weekly 100% of the time (target: 100%).
- Refer over 200 individuals to a transition program to help connect them to community services to assist in decreasing recidivism.
- Each month, provide:
  - Over 500 medication evaluations.
  - Mental health services to over 1,100 individuals.
  - Over 400 new mental health assessments.
  - Over 100 crisis intervention services.

Highlights

2,500

An average of **2,500 monthly mental health services were provided** to consumers in Alameda County jail/detention facilities.

Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services

lafamiliacounseling.org

FY 17/18 Allocation: **$170,674** | **Expended/Encumbered:** **$170,674**

Individuals served by Measure A: 2,495 (Total individuals served: 7,485)

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 Service 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.

Services are delivered to individuals who are primarily or exclusively Spanish-speaking. All direct service staff are bilingual in Spanish.

Measure A Funding Summary

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

- Link 49 UIY and families to coverage and a medical home.
- Through outreach in school districts and the community, identify and open 72 preventative counseling UIY clients (target: 70).
- Develop and provide 52 trainings for community partners on how to identify UIY, understand the needs of UIY, and develop strategies to support UIY (target: 30).
- Develop and distribute informational materials related to UIY services and programs to 864 individuals and/or families (target: 300).
- Connect 89 UIY and families to health and wellness services including applications for Medi-Cal insurance enrollment, specialty mental health services, and primary care visits.
- Conduct 20 home visits.
- Provide short-term counseling and brokerage support to 72 individuals and families.

Highlights

99%

A sample of youth who received services indicated high satisfaction rates, including:

- **Overall satisfaction: 99%**
- **Experienced sensitivity to cultural/ethnic background: 99%**
- **Received the help they needed: 98%)**
- **Now know who to look to for support: 95%**

La Familia Counseling Services

lafamiliacounseling.org

FY 17/18 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 Service is an inclusive, Latino community-based, multicultural organization committed to strengthening the emotional wellness of individuals and the preservation of families.

At the Family Resource Center site, participants can take part in monthly immigration consultations, Zumba classes, yoga and meditation, and other events related to culture and wellness.

Measure A Funding Summary

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

- Provide one-on-one and family behavioral health services to 30 individuals and 30 families (target: 60).
- Conduct one-on-one intensive case management, aside from behavioral health services, with 21 individuals (target: 21).
- Conduct 36 psycho-educational workshops and/or support groups in relation to wellness (target: 12).
- Conduct outreach, information, and referrals to basic needs and services to 464 participants (target: 250).
- Transition six individuals from family into individual counseling (target: three).
- Ensure that 100% of workshops and support groups continued throughout the fiscal year to allow new participants to participate (target: 50%).
- Refer 454 participants to the Family Resource Center site for onsite clinics, programming, and services (target: 125).

Highlights

100%

100% of one-to-one intensive case management participants **received information and referrals covering entitlement benefits encompassing wellness services** (target: 100%).

Mental Health Services for Juvenile Justice Center

FY 17/18 Allocation: **$360,000** | **Expended/Encumbered:** **$360,000**

Individuals served by Measure A: *Information not provided* (Total individuals served: 633)

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.

Services provided to youth in Juvenile Hall include individual therapy, case management, court-ordered evaluations, crisis intervention, and consultation with Juvenile Hall staff, probation officers, school staff, and the juvenile courts.

Mental health staff work with youth to monitor their behavior and intervene when it impacts their ability to function in the institution. As a result of these services, youth can better cope with their anxiety, depression, and post- traumatic stress symptoms while in detention. These services greatly reduce self-harm, harm to others, and hospitalization.

Measure A Funding Summary

BHCS used its Measure A allocation to achieve the following:

- Have 74% of youth booked into the Juvenile Justice Center seen by a mental health clinician (target: 80%).
- Have 91% of youth referred for crisis counseling services seen by a mental health clinician (target: 90%).
- Have 55% of youth referred due to a safety concern seen by a mental health clinician within 30 minutes (target: 80%).
- Provide a referral to a community mental health provider upon discharge to 93% of youth/families who request one (target: 90%).
- Have 64% of youth referred for community mental health services upon discharge complete a visit with a community mental health provider (target: 70%).
- Ensure that 61% of youth discharged from the Juvenile Justice Center who need to see a psychiatrist for medication complete a visit with a psychiatrist in the community (target: 70%).

Success Story

A 15-year-old client has been in and out of Juvenile Hall since he was 12. During the client's most recent detention, which came after termination from a group home placement, the clinician explored the client's history of trauma, which included his father's incarceration and mother's substance abuse. The clinician worked with the client on setting short- and longer-term goals and on taking meds for his mood dysregulation. With these interventions, the client was able to have more positive interactions with staff and peers in Juvenile Hall. The clinician located a suitable group home for the client, where the client could engage in family therapy more readily with his mother.

Mental Health Services for Newcomers and Immigrants (CERI)

cerieastbay.org

FY 17/18 Allocation: $83,184 | **Expended/Encumbered: $83,184**

Individuals served by Measure A: 28 (Total individuals served: 250)

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

Services provided: Mental Health

Service area: Alameda, Berkeley, Fremont, Hayward, Oakland, Pleasanton, San Leandro

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

$83,184

from the **Mental Health Services Act (MHSA), Medi-Cal Administrative Activities (MAA), and other foundations.**

Measure A Funding Summary

CERI used its Measure A allocation to achieve the following:

- Through the youth and adult/older adult programs, outreach to and actively engage 5,563 community contacts (target: 804).
- Conduct 492 outreach/engagement, psycho-education, and prevention events, including large community events and presentations, one-on-one outreach, support groups, home visitation, and website blogging (target: 60).
- Provide 163 mental health consultation services, including to families, community leaders, and professionals (target: 98).
- Serve 20 unique clients in preventive counseling, including individual needs assessments and counseling sessions as needed (target: 15).
- Provide 521 hours of Medi-Cal Administrative Activities (MAA), including screening, application assistance, education, and crisis intervention (target: 200).

Highlights

98%

98% of event participants agreed or strongly agreed that "**staff helped me obtain the information I needed so that I could take care of managing my problems**" (target: 90%).

Safe Alternatives to Violent Environments (SAVE)

save-dv.org

FY 17/18 Allocation: **$20,000*** | **Expended/Encumbered:** **$20,000**

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 break the cycle of domestic violence and build healthier lives.

Being able to provide therapeutic services at no cost to the consumer is critical because the individuals served by SAVE, who have experienced the complex trauma often associated with domestic violence, also face significant financial burdens. Additionally, domestic violence has a community impact with a wide reach, from intergenerational experiences of domestic violence to emergency room costs to loss of wages for businesses. Thus, helping individuals who have experienced domestic violence in their healing improves community safety and well-being.

Measure A Funding Summary

SAVE used its Measure A allocation to achieve the following:

- Provide 759 free, outpatient, community mental health service sessions to 101 participants (target: 95 sessions to 28 participants).
- Provide trauma-informed therapeutic interventions through the collaborative development of 37 safety plans and provision of relevant community-based resources to an equal number of clients, representing 64% of clients (target: 14 plans and clients, representing 50%).
- Ensure that 77% of clients participated in more than one counseling session (target: 70%).

Highlights

100%

100% of clients report that by participating in counseling at SAVE, they **know more ways to plan for their safety**.

Senior Support Program of Tri-Valley

ssptv.org

FY 17/18 Allocation: **$45,000*** | **Expended/Encumbered:** **$45,000**

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

Populations served: Low Income Seniors

Services provided: Mental Health, Substance Abuse

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, local community-based organizations, police and fire departments, 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

83%

83% of clients 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 34 seniors with mental health issues (target: 35).
- Conduct program pre-evaluation with 98% of clients to assess mental health status (target: 100%).
- Enroll 84% 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 35
UCSF Benioff Children's Hospital Oakland 37

St. Rose Hospital

strosehospital.org

FY 17/18 Allocation: **$4,500,000** | **Expended/Encumbered:** **$4,500,000**

Individuals served by Measure A: 21,067 (Total individuals served: 27,354)

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

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient

Service area: Countywide, Homeless or transient

Background

St. Rose Hospital (SRH) 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.
- 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 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. SRH serves a racially diverse population, with no majority population:

- African American: 14.4%.
- American Indian and/or Alaskan Native: 0.2%.
- Asian: 16.5%.

Highlights

20 minutes

ED patients experienced an **average wait time of less than 20 minutes.**

Matching Funds

$4.5 M

from the **intergovernmental transfer program through the Medi-Cal program**. This represents a $1 match for every $1 in Measure A funds.

- Hispanic/Latino: 35.7%.
- Native Hawaiian and/or other Pacific Islander: 4.5%.
- White/Caucasian 22%.
- Other: 6.7%

SRH provides services to clients in multiple languages, including English, Spanish, Mandarin, Farsi, Tongan, Vietnamese, Dari/Pashto, Hindi, Cantonese, Punjabi, Tagalog, and Nepali.

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:

- Provide ED care visits and hospital-based physician encounters for 21,067 and 10,943 uninsured and underinsured patients, respectively (target: 21,100 and 11,200).
- Provide inpatient care for 2,909 indigent patient admissions (target: 2,860).
- Provide 141 tele-psychiatry service encounters to improve patient mental health evaluation and disposition for patients presenting in the ED (target: 120).
- Achieve an ED patient satisfaction score of 73.2 (target: 75.0).
- Achieve a patient rating of the ED for clinical quality of 75.5 (target: 75.0).
- Achieve an inpatient satisfaction score of 74.4 (target: 79.1).
- Avoid 22% of 5150s using tele-psychiatry encounters (target: 12%).
- Transfer 26% of ED patients with a mental health-related diagnosis for a higher level of care (target: 25.9%).

Highlights

↑ 74.4

The **overall inpatient satisfaction score increased to 74.4** from 68.4 the year before.

↓ 19.8%

The tele-psychiatry program enabled a **reduction in monthly transfers to John George Psychiatric Hospital** from 32.4 to 26 patients per month, a 19.8% reduction.

UCSF Benioff Children's Hospital Oakland

childrenshospitaloakland.org

FY 17/18 Allocation: **$2,000,000** | **Expended/Encumbered:** **$2,000,000**

Individuals served by Measure A: 1,173 (Total individuals served: 31,611)

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

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.

Trauma services are a subset of the ED, requiring highly specialized equipment and 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. CHO'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

80%

80% of children treated at CCP demonstrated a **10+ point improvement on the global assessment of functioning scale** by end of treatment (target: 75%).

Matching Funds

$1 Million

through an intergovernmental transfer using supplemental funds 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

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. 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.

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.

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.

School-Based Clinics

CHO runs two school-based health centers: one at Castlemont High School and one at McClymonds High School. The specially trained teams at the two school-based clinics look at all aspects of an adolescent's life to help address the many medical and mental health issues they could be facing. 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.

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

The sites' School-Based Mental Health Program has become a national

Highlights

98%

98% of school-based clinic patients felt that health center staff made them **feel safe talking about their problems** (target: 90%).

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

Measure A Funding Summary

CHO used its Measure A allocation to achieve the following.

Emergency Department

- Provide specialized treatment for 1,112 children who have acute physical trauma (target: 1,000).
- For the most severe trauma injuries, reduce the time between admission and when a patient gets a CT scan to 46 minutes (target: <60 minutes).
- For the most severe trauma injuries, reduce the time between admission and the decision to admit to 42 minutes (target: <60 minutes).
- Reduce the average length of stay in the ED to 111 minutes (target: <120 minutes).
- Experience a 1% rate of trauma cases that end in fatality (national benchmark: 2.5%).
- Experience a 1% "under triage rate" of getting the patients the correct resources for their level of trauma severity (national benchmark: <5%).

Center for Child Protection

- Provide specialized medical and behavioral care for 706 child victims of abuse and exploitation (target: 750).
- Conduct 2,180 psychotherapy visits (target: 2,000).
- Provide 151 forensic medical examinations (target: 125).
- Follow up with and contact 95% of psychotherapy referrals (target: 100%).
- Provide a culturally focused screening assessment to address barriers to treatment to 100% of psychotherapy referrals that are contacted and get care (target: 100%).

School-Based Clinics

- Conduct 1,525 encounters with 291 unique patients at the McClymonds Chappell Hayes Health Center (target: 1,500 encounters with 300 patients).
- Conduct 3,998 encounters with 704 unique patients at the Castlemont Youth Uprising Health Center (target: 4,000 encounters with 700 patients).

Highlights

100%

100% of school-based clinic patients felt that **health center staff cared about them** (target: 90%).

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 3: PRIMARY CARE

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Alameda County Dental Health

dental.acphd.org

FY 17/18 Allocation: $257,580 | **Expended/Encumbered: $157,580**

Individuals served by Measure A: 3,735 (Total individuals served: 7,735)

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

Services provided: Public Health

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 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 (WIC) centers, 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 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 to the Dental Days, all services are offered to them as well.

Matching Funds

$157,580

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 683 parents/guardians through WIC Dental Days (target: 950).

- Provide oral health assessments to 673 infants/children 0-5 years old through WIC Dental Days (target: 875).
- Provide fluoride varnish treatment to 547 infants/children through WIC Dental Days (target: 750).
- Refer 541 children to a dental provider (target: 640).
- Schedule an appointment with a dentist for 506 children seen through WIC Dental Days (target: 500).
- Provide oral health education to 1,179 community members (target: 2,000).
- Provide screening and fluoride varnish treatment to 157 community members at community events (target: 100).
- Provide oral health education through group presentations to 1,153 students (target: 1,200).
- Provide dental screenings to 1,153 second- and fifth-grade students (target: 1,100).
- Provide preventive dental services including cleaning, fluoride varnish, and/or sealants to 522 students (target: 576).

Success Story

A five-year-old had extensive dental problems and mouth pain. Her family had immigrated from China and did not have legal citizenship. The Community Health Outreach Worker (CHOW) at the Office of Dental Health assured the mother that her daughter could get dental help through Healthy Smiles, a program for children with no insurance. The CHOW emailed a partnering Federally Qualified Health Care Center (FQHC) explaining the situation. The mother met with an FQHC intake specialist who spoke Mandarin, the family's native language, and helped the mother apply for Medi-Cal through the Child Health and Disability Program. Her daughter was then able to receive medical and dental care in one location.

Alameda Health Consortium Health Worker Fellowship Program

www.dhti.org

Allocation: **$182,871** | **Expended/Encumbered:** **$175,000**

Individuals served by Measure A: 11 (Total individuals served: 104)

Populations served: Indigent, Low Income, Uninsured Adults

Services provided: Public Health, Mental Health

Service area: Alameda, Albany, Fremont, Oakland, Outside of Alameda County

Background

The Diversity in Health Training Institute (DHTI) works to expand and diversify the health care workforce by connecting immigrants to health care career pathways in the U.S. DHTI provides workforce development training, coaching, and social supports for foreign-trained health professionals from immigrant and refugee communities with a desire to build their careers in the health sector and the knowledge, skills, and competencies to serve unserved and underserved communities in multiple languages and with culturally relevant services.

DHTI's Community Health Worker (CHW) Fellow program combines 70 hours of in-class instruction with 40 hours of hands-on experience over the course of 20 weeks.

Highlights

100%

100% of participants who completed work literacy reported a **desire to work as a CHW** (target: 70%).

Measure A Funding Summary

Measure A funding helped DHTI achieve the following:

- Provide 60 hours of CHW instruction and six professional skills workshops to a group of 11 participants (target: 60 hours and six workshops to 12 participants).
- Provide 60 hours of individual coaching to 11 participants (target: 60 hours to 12 participants).
- Provide 283 hours of work-based learning to nine participants, for an average of 38 hours per participants (target: 480 hours to 10 participants, for an average of 40 hours per participant).
- Retain 91% of participants during the didactic portion of the instruction (target: 70%).
- Have 60% of participants who completed the didactic portion move on to complete 40 hours of work-based learning (target: 70%).
- Have 61% of participants who completed health and community literacy training increase their knowledge, as measured by pre and post tests (target: 70%).

Center for Elders' Independence

cei.elders.org

FY 17/18 Allocation: $55,456 | **Expended/Encumbered: $55,456**

Individuals served by Measure A: 24 (Total individuals served: 66)

Populations served: Low Income Adults, Seniors

Services provided: Public Health, Mental Health

Service area: Alameda, Oakland

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 to 24 family caregivers of low income seniors (target: four series to 40 caregivers). The series was successfully taught to Mandarin-speaking caregivers through use of an interpreter.

Highlights

100%

100% of caregivers reported improvements in **confidence and effectiveness in managing the care of their senior** (target: 75%).

Matching Funds

$33,000

from private grant funding from **the Archstone Foundation**.

Center for Healthy Schools and Communities (School Health Centers)

achealthyschools.org

FY 17/18 Allocation: **$1,352,086** | **Expended/Encumbered:** **$1,352,086**

Individuals served by Measure A: 15,758 (Total individuals served: 15,758)

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

Services provided: Public Health, 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.

A program of CHCS, School-Based Health Centers (SBHCs) 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.

SBHC services are focused in the following areas:

- Increased access to care
- Medical/health education
- Behavioral health
- Oral health
- Youth development and academic outcomes
- Integration of health and wellness support services

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.

Increased Access to Care

- Maintain 28 SBHC sites.
- Register 15,758 students as clients, representing 32% of the student

Highlights

96%

96% of students feel that they **have an adult they can turn to if they need help** (target: 90%).

Matching Funds

$13.4 M

from the following:

- **Medi-Cal and other third-party billing**
- **Tobacco Master Settlement Agreement funding**
- **Funding from the County, cities, school districts, and the state and federal governments**
- **Private grants**

population (target: 15,000 students representing 30% of the population).
- Offer SBHC access to 38,795 students countywide (target: 38,000).
- Conduct 60,653 client visits (target: 60,000).
- Have 63% of clients return for at least one subsequent visit (target: 60%).

Medical/Health Education Services

- Provide 22 medical service hours weekly (target: 20).
- Conduct:
  - 27,640 medical visits (target: 26,000).
  - 7,200 first aid clinical visits (target: 6,810).
  - 3,729 health education clinical visits (target: 3,600).
- Make 25,879 nonclinical health fair/outreach contacts to youth ages 0-18 (target: 20,000).
- Provide first aid supplies to 20,029 nonclinical contacts (target: 15,000).
- Make 7,106 nonclinical contacts regarding health education for reproductive health to youth ages 0-18 (target: 6,000).
- Conduct 3,298 nonclinical screenings for immunizations, STDs, etc. (target: 3,000).
- Make 741 nonclinical contacts regarding health education for tobacco and alcohol/drug use to youth ages 0-18 (target: 500).

Behavioral Health Services

- Provide 27 behavioral health service hours per week (target: 25).
- Conduct 16,400 visits with individual behavioral health services (target: 16,000).
- Make 15,340 nonclinical contacts regarding school safety, climate presentations, and other activities to youth ages 0-18 (target: 10,000).
- Discuss 5,951 youth (ages 0-18) cases in nonclinical school staff consultations (target: 5,000).
- Discuss 2,995 adult (over age 18) cases in nonclinical school staff consultations (target: 2,500).
- Make 1,953 nonclinical contacts for trauma screening to youth ages 0-18 (target: 750).
- Make 1,021 nonclinical contacts for self-esteem social skills groups for youth ages 0-18 (target: 500).
- Make 621 nonclinical contacts for crisis intervention/grief for individuals and groups for youth ages 0-18 (target: 500).
- Make 223 nonclinical contacts for restorative justice circles for youth ages 0-18 (target: 200).

Oral Health Services

- Provide 14 dental service hours weekly at 12 SBHC sites (target: 12 hours weekly at 12 sites).

Highlights

98%

98% of students say that staff helped them learn **how to take better care of their health** (target: 90%).

99%

99% feel that the **SBHC is a safe place to go if they have a problem** (target: 90%).

- Conduct 5,710 visits with dental services (target: 5,000).
- Make 5,727 nonclinical dental screening contacts with youth ages 0-18 (target: 3,000).
- Provide dental services to 2,033 clients (target: 1,750).

Youth Development and Academic Outcomes

- Make 1,571 nonclinical youth development contacts—advisory board, leadership, advocacy, etc.—to youth ages 0-18 (target: 1,500).
- Make 1,240 nonclinical peer health education contacts to youth ages 0-18 (target: 1,000).
- Make 1,287 contacts for nonclinical job training/career exploration to youth ages 0-18 (target: 750).
- Make 656 nonclinical acculturation support contacts for newcomers and unaccompanied youth ages 0-18 (target: 500).

Integration of Health and Wellness Support Services

- Provide families with information about health insurance and benefits eligibility or refer to an off-site location for application assistance at 23 SBHC sites (target: 21).
- Make 3,747 nonclinical adult contacts at health fairs/outreach events (target: 3,500).
- Make 2,784 nonclinical parent/family support contacts (target: 2,000).
- Make 1,816 nonclinical adult contacts at school safety, climate presentation, and other activities (target: 1,000).
- Conduct 1,579 staff workshops/trainings (target: 1,000).
- Have 23 sites report success in regularly participating in their school's Coordination of Service Team (COST) programs to discuss at-risk students and develop plans to support them (target: 28).
- Have 25 sites report positive and strong working relationships with their principal and other school administrators (target: 28).
- Have 21 sites report that they can provide services to students from other schools or are in negotiation to do so (target: 28).

Success Story

An SBHC behavioral health provider worked closely with a sixth grade student who had Post Traumatic Stress Disorder (PTSD) symptoms from witnessing violence against her family members. The student worked with the SBHC licensed social worker to create a safety plan and learn strategies to manage her PTSD. The therapist involved the parents in her care and safety planning. For the summer break, the therapist and student put together a "safety box" filled with items to help her manage, such as a stress ball, picture of her family, coloring book, and mindfulness prompt. The student, now in seventh grade, is no longer experiencing PTSD symptoms.

CENTER FOR HEALTHY SCHOOLS AND COMMUNITIES

Connecting Kids to Coverage (CKC) Initiative

FY 17/18 Allocation: **$209,613** | **Expended/Encumbered:** **$209,613**

Individuals served by Measure A: 3,400 (Total individuals served: 3,400)

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 (CKC) Schools 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 primary services provided by CKC are health insurance and public benefits enrollment support for uninsured and underinsured families in Alameda County.

The CKC initiative serves several populations that face multiple barriers to enrolling in coverage, including individuals with limited English proficiency, the long-term uninsured, and recent immigrants. Some of the barriers preventing these families from accessing coverage include complex eligibility requirements, enrollment procedures, and renewal processes for public programs such as Medi-Cal; limited language support for non-English speakers; and mistrust of public systems.

The CKC "one-stop shop" model is particularly important for the working poor, whose 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. In addition, the CKC staff's linguistic diversity and cultural humility make affordable coverage more accessible for families in need.

CKC's engagement efforts have proven highly effective for Spanish-speaking families, who comprised 80% of clients served in FY 17/18. It is also worth noting that 92% of clients served in FY 17/18 speak a primary language other than English.

Matching Funds

$75,000

from **school district funds**.

Measure A Funding Summary

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

- Make 1,509 phone calls to parents advertising the initiative.
- Conduct 30 trainings or presentations for school site staff, community-based partners, or other school-based resources to increase the number of people on school sites who are referring families to the CKC Family Resource Centers (FRCs) for health benefit enrollment assistance (target: 24).
- Host 105 outreach events at school sites to educate parents and students about health insurance eligibility guidelines and enrollment assistance resources at the FRCs (target: 75).
- Have 2,651 families schedule an appointment at an FRC (target: 2,500).
- Of the health insurance applications submitted, ensure that 1,567 (61%) were intake/new applications (target: 1,400).
- Of the CalFresh applications submitted, ensure that 835 (65%) were intake/new applications (target: 1,462).
- Of the CalWORKs applications submitted, ensure that 94 (91%) were intake/new applications (target: 165).
- Of the health insurance applications submitted, ensure that 1,002 (39%) were renewal applications (target: 900).
- Of the CalFresh applications submitted, ensure that 449 (35%) were renewal applications (target: 424).
- Ensure that 3,452 families attended scheduled appointments (target: 3,200).
- Ensure that 1,253 (80%) of the health insurance applications submitted were approved (target: 2,000).

Additionally, Measure A funds were used for capacity-building and evaluation of the CKC Initiative. The hired evaluator worked to further improve data strategy, including collection, management, and analysis. In addition, all stakeholders came together to identify future areas of growth for service delivery.

Success Story

A client, Mr. Vera, applied for Medi-Cal health insurance for his son. Six months later, he had not heard whether the application was denied or approved. When Mr. Vera came to the Hayward FRC to get support, the CKC coordinator called Medi-Cal. Mr. Vera did not speak English, and having a bilingual coordinator advocate for him made a huge difference. The coordinator secured a paper verifying Mr. Vera's son's coverage, and then connected Mr. Vera to a Community Dental Care Coordinator to schedule his son for a dental appointment. The coordinator also assisted Mr. Vera in applying for his own health insurance through the Health Program of Alameda County (HealthPAC).

Fremont Aging and Family Services

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

FY 17/18 Allocation: $53,581 | **Expended/Encumbered: $55,456***

Individuals served by Measure A: 39 (Total individuals served: 138)

Populations served: Indigent, Low Income, Uninsured Seniors

Services provided: Public Health, Mental Health

Service area: Fremont, Newark, Union City

** Includes carryover funds from previous year*

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.

Fremont 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 help 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

Highlights

100%

100% of clients referred to services following a fall risk, home safety risk, mental health, or health screen **received those services** (target: 75%).

Matching Funds

$134,138

from the **City of Fremont General Fund and the Alameda County Health Care Services Agency.**

promoters collect medication information and enter it into a database 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 Project achieve the following:

- Provide health promotion services to 138 older refugee, immigrant, and low income residents over 60 years of age (target: 135).
- Provide assistance and referrals to entitlement and supportive services for 155 clients (target: 110).
- Ensure that 138 clients have a primary care physician (target: 110).
- Assist 92 older adult clients in accessing and receiving mental health, health, and medically related services (target: 50).
- Conduct fall, home safety, mental health, and health screenings for 67 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 57 Wellness Plans (target: 45).
- Collaborate with 57 clients to monitor the successful completion of their Wellness Plans (target: 40).
- Provide health education to 86 clients to improve chronic conditions self-management (target: 50).
- Provide medication review and/or assistance and education to 70 clients (target: 50).

Highlights

100%

100% of clients reported that their health promoter **helped them to improve their lives** (target: 75%).

Success Story

Sultan, 67, came to the AEA offices and revealed that his applications for Cash Assistance Program for Immigrants (CAPI) and Supplemental Security Income (SSI) were recently rejected. Sultan was unemployed, had a history of mental health concerns, and was currently depressed about his current situation. The health promoter reapplied for CAPI and SSI services and made a referral to the City of Fremont's Mobile Mental Health Services to help Sultan deal with his anger and depression. The health promoter also contacted a security company, who provided Sultan employment. With this assistance, Sultan received both CAPI and SSI services. With the job and mental health support, Sultan's mood and health quickly improved.

Health Enrollment for Children

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

FY 17/18 Allocation: **$300,000** | **Expended/Encumbered:** **$300,000**

Individuals served by Measure A: 1,276 (Total individuals served: 7,504)

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.

In FY 17/18, benefits assistance was provided to clients according to the following percentage by program:

- Medi-Cal: 66%.
- CalFresh: 15%.
- HealthPAC: 13%.
- Covered California: 4%.
- CalWORKs: 1%.

Measure A Funding Summary

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

- Conduct nine health education workshops to 100 participants (target: 10 workshops to 120 participants).
- Provide benefit application assistance by phone and in-person to 7,504 County residents (target: 6,949).
- Receive 2,702 calls on the Health Insurance Technician (HIT) assistance toll-free line (target: 2,637).

Highlights

95%

95% of health education workshop participants reported that they would **recommend the workshop to a friend** (target: 90%).

Matching Funds

$150,000

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

Health Services for Day Laborers: Multicultural Institute

mionline.org

FY 17/18 Allocation: **$92,427** | **Expended/Encumbered:** **$92,427**

Individuals served by Measure A: 728 (Total individuals served: 857)

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.

MI's health activities help individuals navigate the health system by providing language-appropriate resources, information, case management, and referrals. These services not only provide individuals with preventive measures and new information but also help bring services to those that otherwise would not seek such help.

In addition to the health-related services, 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. Services provided include the following:

- Street outreach. This outreach is conducted in a culturally and linguistically appropriate way every weekday morning where day laborers seek work in West Berkeley. This allows for trust and community relationships to be built.
- Economic development. At no cost, day laborers are provided with job-matching services connecting them to employers for short-term, long-term, and permanent jobs at a minimum of $20/hour.
- Vocational skill development. Various educational and vocational courses are offered, including GED preparation, computer skills development, and business entrepreneurship.
- Immigration and legal support. MI provides updated information and resources through workshops, referrals, free clinics, and community events. MI also aids workers in addressing legal employment problems related to wage theft, wage claims, and unsafe conditions.

Highlights

85%

85% of individuals served reported that their **health care needs were met with MI's assistance** (target: 80%).

78%

78% of individuals served reported that they **would not have had access to services if it weren't for MI or its partners** (target: 70%).

- Community building. MI breaks down isolation and helps build community by hosting Thanksgiving and Christmas holiday events every year. Staff also hosts street cleanups every month, which provide a sense of collaboration.

Additional direct services are offered to the community thanks to the support from MI's partners. These include free vision screenings, eye exams, and eyeglasses provided through the UC Berkeley School of Optometry and a partnership with the Alameda County Health Care for the Homeless mobile van, which visits the MI site every month.

Measure A Funding Summary

Measure A funding helped MI achieve the following:

- Provide outreach to 728 unduplicated clients and 110 one-on-one health-related consultations to increase access to medical services and provide patient navigation support (target: outreach to 700 clients and 100 consultations).
- Contact 96% of day laborers during daily street outreach (target: 80%).
- Register 100% of outreached workers with MI (target: 80%).
- Host or co-sponsor eight health care trainings or workshops on topics including health/safety, sexual health, oral health, and substance abuse attended by 119 participants, as well as 10 street-based health education sessions attended by 175 participants (target: eight trainings and eight education sessions attended by 120 participants each).
- Arrange five health care screening events attended by 117 individuals (target: four events attended by 100 individuals).

Success Story

Marco, a 55-year-old day laborer from Guatemala, has suffered from diabetes for many years. He came to MI's office one morning because he had run out of his diabetes medication and couldn't afford to buy more. Luckily, it was a day that the Alameda County Health Care for the Homeless mobile van was scheduled to visit. Marco was registered and referred. Once on the mobile van, it was determined that he needed an insulin shot immediately, and Marco received all the needed medication.

Health Services for Day Laborers: Street Level Health Project

streetlevelhealth.org

FY 17/18 Allocation: **$92,427** | **Expended/Encumbered:** **$92,427**

Individuals served by Measure A: 702 (Total individuals served: 780)

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

Services provided: Public Health, Mental Health

Service area: Alameda, Albany, Emeryville, Hayward, Newark, Oakland, San Leandro, San Lorenzo, Union City, Homeless or transient, Outside of Alameda County

Background

Street Level Health Project (SLHP) is an Oakland-based health center dedicated to improving the health and well-being of underinsured, uninsured, and recently arrived immigrants in Alameda County.

SLHP's Whole Person Care Model aims to provide culturally responsive care by providing services in each client's language by a person who shares their culture. SLHP provides Mam language interpretation as part of its health navigation, health insurance enrollment, and consultations with medical providers, the nutritionist/herbalist, and the mental health counselor.

Free services provided by SLHP include the following:

- Consultations with a nutritionist, who works with clients to make lifestyle and diet changes tailored to their specific health needs.
- Food bags to community members, with most recipients returning every week.
- Nutritious lunch twice per week while community members wait for other services, a drop-in lunch service that is open to everyone in the community.
- Consultations with a mental health counselor.
- Workshops for Spanish-speaking community members that include somatic therapy tactics to reduce stress and anxiety.

SLHP also trains and provides leadership development to community health workers to help provide services to day laborers and other marginalized individuals. SLHP exposes these workers to the social reality of underserved communities and allows them to learn culturally competent ways of providing health care services that address a person as a whole.

Highlights

96%

96% of clients **seeking drop-in health navigation assistance and referral to on-site services** received services (target: 60%).

Measure A Funding Summary

Measure A funding helped SLHP achieve the following:

- Provide 1,184 health care screening and episodic care visits to 702 unduplicated clients across multiple languages (target: 1,200 screenings/visits to 700 clients).
- Offer 3,179 health-related navigation and referral services across 124 local health care agencies to 1,717 clients (target: 1,500 referral services).
- Provide 334 mental health consultations to 187 low income clients (target: 200 consultations).
- Provide 268 nutritionist/herbalist consultations to 219 clients (target: 150 consultations).
- Distribute 2,798 free healthy fruit and vegetable food bags to 1,070 low income households (target: 2,000 bags to 400 households).
- Recruit and train 25 prospective and current health care providers to provide them with experience working with uninsured low income communities (target: 20).

Success Story

Jorge, undocumented and homeless, has uncontrolled diabetes, high blood pressure, and chronic pain. When Jorge came to SLHP, his blood glucose was dangerously high, and he was referred to Highland Hospital. When Jorge returned to SLHP, the nutritionist gave him protein powder to mix with water to take with his diabetes medication. During a mental health consultation, the counselor worked with Jorge on his stress and depression. SLHP's health navigation services helped Jorge find a bed at a shelter and connected him with dental services. Jorge comes to SLHP regularly to eat lunch, speak with the nutritionist and medical providers, and check his blood glucose level, which has improved considerably.

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

FY 17/18 Allocation: **$261,000** | **Expended/Encumbered:** **$239,665**

Individuals served by Measure A: 851 (Total individuals served: 851)

Populations served: Low Income, Uninsured Adults, Children

Services provided: Emergency Medical, Hospital Outpatient

Service area: Ashland, Cherryland, Hayward, Oakland

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 medical services at the Alameda County Juvenile Justice Center (JJC). Many of the youth have gone years without seeing a primary care provider and have untreated sexually transmitted infections or undiagnosed chronic conditions, or are missing important vaccinations. Other times, the medical services can help youth address issues that are impacting their self-esteem. The medical services also include access to critical dental procedures, and the medical clinic fills psychotropic medications for youth, which are prescribed by BHCS psychiatrists.

These services are provided under the coordination of the JJC Health Services Director.

Measure A Funding Summary

BHCS used its Measure A allocation to cover the costs associated with coordination of medical services while youth are detained in the JJC. The allocation does not cover the costs of the services themselves. Instead, it is used to fund the JJC Health Services Director position, who has oversight of the contract for the medical services provider.

Director responsibilities include the following:

- Ensure that the medical provider is meeting contract deliverables, achieving identified objectives, and working in coordination with the partners in the Probation Department and BHCS.
- Work with the medical provider to implement new programs or services.

Success Story

A youth in detention was transferred to Willow Rock adolescent psychiatric hospital due to being a danger to himself and others. He made significant progress and was able to return to the JJC. The Health Services Director used information obtained from the medical clinic, Willow Rock, and Probation to create a comprehensive support plan for the youth. When the youth was discharged from the JJC, his Medi-Cal coverage had lapsed. The Director arranged a meeting with an HCSA health insurance technician to reactivate the youth's Medi-Cal. The Director also worked with Probation to ensure the youth was referred to a community mental health provider and a primary care medical home.

- Help coordinate care for individual youth when challenges arise among different systems.
- Issue a request for proposals for a new medical provider for the JJC.
- Work with the Alameda County Health Care Services Agency (HCSA) Director to plan for a transition of medical providers in the JJC.

In FY 17/18, Measure A funds were also used to pay for training for staff to identify ways to better integrate primary and mental health care services. Staff mapped out clinic flows to determine what types of health screening should occur and at which points of entry to the JJC. They also identified referral points from medical to mental health providers.

Based on these efforts, Measure A funding contributed to the following achievements at JJC:

- 90% of youth booked into JJC received a comprehensive physical exam (target: 80%).
- 95% of youth received a dental health screening (target: 75%).
- 550 dental procedures were completed.
- 94% of 951 youth missing vaccinations received all age-appropriate vaccinations (target: 80%).
- Over 2,800 vaccinations were provided to youth.
- 76% of youth who tested positive for a sexually transmitted infection (STI) were treated while in detention (target: 80%).
- Psychotropic medications were filled for 302 youth.

Highlights

94%

94% of 951 youth missing vaccinations **received all age-appropriate vaccinations** (target: 80%).

Medical Costs for Juvenile Justice Center: Niroga Institute

niroga.org

FY 17/18 Allocation: $86,137 | **Expended/Encumbered: $86,137**

Individuals served by Measure A: 3,000 (Total individuals served: 3,000)

Populations served: Indigent Adults, 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), a dynamic mindfulness program, to at-risk and underserved individuals, families, and communities. TLS develops social-emotional learning and stress resilience through mindful movement, breathing techniques, and meditation.

Niroga Institute provides twice-weekly or weekly TLS sessions for at-risk and incarcerated youth at the Alameda County Juvenile Justice Center (JJC). The lessons support the following objectives:

- Emotional development. Good emotion self-regulation skills, coping, and conflict resolution skills.
- Social development. Healthy relationships and a sense of connectedness to larger social networks.
- Intellectual development. Essential life skills, school success, and good decision-making skills.
- Physical development. Good health habits and health risk management skills.

In addition to weekly classes, select youth at the JJC participate in daylong immersions. The program reinforces the topics discussed in the weekly sessions, allows youth to deepen their understanding of the applications of TLS, and gives them goals to work towards.

Hour-long dynamic mindfulness sessions are also provided for JJC staff. The sessions focus on the applications of TLS that promote relaxation and increase self-awareness. The instructor teaches specific techniques that can be used during the workday for self-care and applied to the staff's work with clients.

Highlights

100%

100% of youth reported that the day-long immersion was **valuable and effective in impacting their behavior** (target: 60%).

100%

100% of youth reported that they built **skills for empathy and understanding with their peers** at the day-long retreat (target: 60%).

Measure A Funding Summary

Niroga Institute used its Measure A allocation to provide the following at the JJC:

- 528 classes, including a total of 2,362 youth encounters (target: 400 classes with 1,500 encounters).
- 99 classes for JJC staff members, with 6.6 staff attending per class (target: 90 classes with five staff attending).
- Three day-long immersion retreats attended by 19 unduplicated youth (target: three retreats attended by 15 youth).

Success Story

One student who was at JJS for about a year took the TLS class once or twice a week and completed a daylong retreat. He was transferred to Santa Rita County Jail, where he continued to practice on his own, and is now at San Quentin. Through ongoing correspondence with Niroga, he reports that he not only practices yoga and mindfulness in his cell, which helps with his back pain and getting to sleep, but has started teaching yoga to his cellmate. He has been cultivating his self-awareness and emotional intelligence. He is better able to express himself and is working towards a more peaceful existence within himself.

Medical Costs for Juvenile Justice Center: Victims of Crime

alcoda.org/victim_witness/california_victim_compensation_program

FY 17/18 Allocation: **$90,000** | **Expended/Encumbered:** **$82,125**

Individuals served by Measure A: 3,393 (Total individuals served: 3,393)

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

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

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.

After an eligibility determination is made, clients from targeted agencies who are victims of crime receive ongoing medical, dental, and psychiatric/psychological treatment at no cost to the client. In addition, the California Victim Compensation Board (CalVCB) offers the following:

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

Highlights

↑80%

Through active community outreach and education, **application filing increased by 80%**.

Measure A Funding Summary

CalVCB used its Measure A allocation to designate Claims Unit Staff to process 3,393 applications and follow up with 1,310 victims who were approved but did not submit bills for the assistance they applied for.

Sixty-one percent of the 3,393 applications were approved for benefits.

Success Story

An application was filed by an adult female crime victim of sexual assault and stalking. She received immediate filing assistance from staff at a hospital in the Alameda Health System, who referred her to CalVCB. Because the victim didn't have resources to meet her immediate need to relocate to a place of safety, staff provided critical relocation expense payments directly to the landlord when the victim secured housing that met her safety needs. The victim was also eligible to receive payment for therapy counseling through the mental health benefit on her claim. Staff informed her of other services available for recovery of lost income and payment of medical-related expenses.

Preventive Care Pathways

healthcare.gov/coverage/preventive-care-benefits

FY 17/18 Allocation: $229,587 | Expended/Encumbered: $221,823

Individuals served by Measure A: 2,038 (Total individuals served: 5,200)

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

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

Service area: Countywide, Homeless or Transient

Background

Preventive Care Pathways offers "Pathways to Wellness" to the general population by providing medical services for at-risk and indigent patients, producing and presenting educational videos and literature for health education, 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 4,992 medical service visits to 435 unduplicated low income residents (target: 1,500 visits to 500 patients).
- Screen 640 patients for Hepatitis C (target: 200).
- Provide treatment to four patients who tested positive for Hepatitis C.
- Coordinate eight health fairs and/or workshops attended by 575 participants (target: four fairs/workshops with 50 participants).
- At the health fairs/workshops, perform 250 screenings for diabetes, Hepatitis C, and/or prostate cancer (target: 250).
- Provide Covered California or Medi-Cal application assistance to 278 residents (target: 200).
- Have 141 applicants select Preventive Care Pathways/James A. Watson Wellness Center as their primary care provider.
- Attend one Covered California CEE Alameda County Partnership Meetings (target: two).

Highlights

100%

100% of patients who tested positive for Hepatitis C **received education, follow-up, tests, and treatment referrals within one month, and completed treatment** (target: 80%).

Matching Funds

$263,048

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**

ALAMEDA HEALTH CONSORTIUM

Primary Care Community-Based Organizations

FY 17/18 Allocation: **$5,558,461** | **Expended/Encumbered:** **$5,543,556**

Individuals served by Measure A: 18,732 (Total individuals served: 263,084)

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

Services provided: Public Health, Mental Health, Substance Abuse

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 and provide culturally and linguistically competent medical, dental, and behavioral health care. More than 20 languages are spoken across the health centers.

Highlights

96%

96% of patients who have completed hepatitis C treatment and follow-up labs **show sustained virologic response** (SVR12/"cure").

Measure A Funding Summary

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

- Provide consistency in the application of eligibility standards by having representatives from eight health centers attend 12 annual On-Site Medi-Cal Eligibility (OSME) health center and social services agency leadership staff workshops (target: 12 workshops attended by representatives of eight health centers).
- Ensure an adequate number of physicians to treat the population through:
  - Utilization of loan repayment programs to retain 50% of participating providers at four health center (target: four centers).
  - Offering professional development perks to retain 50% of providers at three health centers (target: three centers).
  - Offering some form of provider compensation to retain 50% of providers at five health centers (target: five centers).
  - Utilization of recruitment bonuses to recruit at least one provider at three health centers (target: three centers).
- Participate in the timely adoption of Alameda County Care Connect (AC3) by sending at least one staff member from each of the eight health centers to attend 75% of the community meetings (target: one staff member from each health center).
- Enroll 18,732 low income Alameda County residents in HealthPAC (target: 18,732).
- Ensure that 16,776 HealthPAC patients access services for a total of 73,128 visits (target: 16,776 patients making 73,128 visits).
- Provide multiple appointment offerings, in addition to primary care visits, to HealthPAC patients, including the following:
  - 1,232 specialty care visits.
  - 10,878 dental visits.
  - 1,612 optometry visits.
  - 56 podiatry visits.
  - 2,784 mental health visits.
- Provide 55% of patients who are on a chronically high dose of opioids with buprenorphine, or ensure they evidence of an alternative harm reduction plan.
- Screen 75% of patients born between 1945 and 1965 for hepatitis C.
- Prescribe treatment for 62% of patients with chronic hepatitis C (target: 45%).
- Through the Medicare Access and Children's Health Insurance Program (CHIP) Authorization Act, enroll 1,307 new children and 1,126 parents, and renew 4,780 children and 3,937 parents.
- Through the CalFresh outreach program, obtain 473 annual renewals, 1,633 new enrollments, and 222 semi-annual renewals.
- Through the HIV Access network, have 90% of clients newly diagnosed with HIV linked to HIV medical care within 30 days of diagnosis, 88% of clients have their HIV well-controlled by medication, and 98% of

Highlights

95%

95% of health education workshop participants would **recommend the workshop to a friend** (target: 90%).

primary care clients prescribed antiretroviral therapy.
- Link patients to behavioral health therapy and community resources, and help coordinate care between primary care and County specialty mental health providers.
- Open new sites including LifeLong Trust Health Center, La Clínica Julian R. Davis Pediatrics, LifeLong Lenoir Health Center, and Asian Health Services San Leandro Pediatrics.

In addition to the traditional primary care services health centers provide to uninsured Alameda County residents, Measure A funds also allowed health centers to provide services supporting the Social Determinants of Health that impact patients, such as following:
- Nutrition programs coordinated with the All-In Alameda County initiative and the Alameda County Community Food Bank.
- Programs coordinated with the Alameda County Father Corps to promote and support fathers and father-figures to be meaningfully engaged with their children and families, and to advocate for family service providers to provide father-friendly services and to assist fathers in strengthening their parenting skills.
- A collaboration with East Bay Naturalization Collaborative (EBNatz) to host naturalization workshops for 200 patients, provide recipients with $500 of legal assistance through the assigned EBNatz agency, and have over 20% of participants complete their naturalization applications.

Highlights

89%

89% of participants reported that they **learned a new skill to maintain their physical health** (target: 89%).

Tiburcio Vasquez Health Center, Inc.

tvhc.org

FY 17/18 Allocation: **$60,000*** | **Expended/Encumbered:** **$60,000**

Individuals served by Measure A: 121 (Total individuals served: 1,734)

Populations served: Low Income, Uninsured Children, Families

Services provided: Public Health, Mental Health

Service area: Hayward

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. Their programs specifically cater to students with high needs, promoting learning and ensuring school success.

Health Educators and Peer Health Educators provide presentations about the center and on a wide range of health topics to students at Tennyson and Hayward High Schools. Topics include 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. Students are given information on the benefits of delayed sexual activity, the importance of using condoms and/or birth control to prevent teen pregnancy, how to access the health center for sexually transmitted infection testing and treatment, and additional free and confidential family planning services. In addition, through the case management services, every student referred is screened and provided with a needs assessment to identify wraparound services and care.

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, diabetes prevention, and strategies for discussing sex and sexual health with teenagers.

Success Story

A student came into the health center because her blood pressure was very low. After performing an examination, staff could not find her blood pressure. She was taken by ambulance to the hospital, but staff stayed after center hours with her and her parents until the ambulance came. The student remained in the hospital for months, and staff continued to track her journey. It turns out that the student has Kawasaki Disease, which is extremely rare. The staff saved that student's life because they noticed something wasn't right and insisted that she go to the hospital, staying after hours to ensure she was taken and following the case closely afterwards.

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 two school health center sites at Tennyson and Hayward High schools.

Measure A funding helped TVHC achieve the following:

- Provide an average of 16 hours of medical services per week to students, including 695 visits at Tennyson and 183 visits at Hayward.
- Provide 40 hours per week of behavioral health-related services, including 157 visits at Tennyson.
- Provide health education, health promotion, and youth development services at each site:
  - Tennyson: 24 hours of health education per week, five events, and 30 class presentations reaching 2,000 youth.
  - Hayward: 40 hours of health education per week, three events, and 45 class presentations reaching 1,600 youth.
- Engage with 400 family and/or community members at Tennyson and 670 at Hayward through health-related events and/or activities.
- Collaborate with schools to refer youth and families to needed services by attending 20 service coordination meetings at Tennyson and 40 at Hayward, while making 40 specialty referrals at Tennyson.

Highlights

16

TVHC provided and average of **16 hours of medical services per week to students.**

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

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ACCMA Community Health Foundation/ East Bay Conversation Project

www.accma.org | www.eastbayacp.org

FY 17/18 Allocation: **$20,000*** | **Expended/Encumbered:** **$20,000**

Individuals served by Measure A: 467 (Total individuals served: 933)

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

Services provided: Public Health

Service area: Countywide, Outside of Alameda County

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

Background

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

The East Bay Conversation Project (EBCP) is a community-wide coalition of organizations and individuals dedicated to promoting understanding and engagement in advance care planning. It is dedicated to helping individuals determine their wishes for end-of-life care and make a plan to ensure those wishes are honored.

The EBCP, which is funded by the ACCMA Community Health Foundation using Measure A grant funds, involves a variety of community organizations, including hospitals, physicians, hospice agencies, nursing homes, county health care agencies, faith-based organization, senior advocacy organizations, fiduciaries, attorneys, business organizations, and other interested individuals committed to promoting advance care planning in the East Bay. The project offers free trainings, video presentations, group discussions, and more to any of these types of organizations, as well as others interested in learning more about advance care planning.

Through one form of educational outreach, the EBCP organized "Conversation Corners," or educational booths, at multiple East Bay hospitals and health care centers in celebration of National Healthcare Decisions Day. The booths were set up in lobbies and other high-traffic areas, where individuals could stop and engage in "the Conversation" about end-of-life wishes and preparing advance care directives. The "Conversation Corners" were staffed by EBCP volunteers.

Highlights

100%

100% of advocates reported that their **knowledge and confidence to introduce the concepts and value of advance care training increased** after training (target: 80%).

The project also offers free up-to-date resources through its website. The site is a focal point of information and guidance on advance care planning for the target audience and serves as a resource to help advance care planning advocates engage in outreach activities.

Measure A Funding Summary

ACCMA Community Health Foundation/EBCP used its Measure A allocation to achieve the following:

- Increase the size of its coalition to 95 community organizations (target: 105).
- Hold quarterly steering committee meetings attended by 74 individuals that represent community, business, faith-based, health care, public health, and patient advocacy organizations and individuals (target: 60 attendees).
- Conduct advance care planning outreach and provide 30 activities that promote advance care planning (target: 60 activities).
- Ensure that 66 advocates shall complete quarterly training on the concepts and value of advance care planning (target: 100).
- Add 18 advance care planning resources to the website (target: 20).

Highlights

94%

94% of individuals outreached reported that they were more likely to **engage in advance care planning** following the outreach (target: 85%).

Alameda Boys & Girls Club, Inc.

alamedabgc.org

FY 17/18 Allocation: **$110,912** | **Expended/Encumbered:** **$110,912**

Individuals served by Measure A: 1,500 (Total individuals served: 2,050)

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 the ABGC are living in poverty.

ABGC serves thousands of Alameda youth and teens each year with a comprehensive culinary, nutrition, and health education program integrated with physical fitness, recreational, and environmental programming.

Highlights

100%

100% of screened members eligible for pro bono care until the age of 18 were **signed up for the vision and/or respiratory screening** (target: 100%).

Measure A Funding Summary

ABGC used its Measure A allocation to achieve the following:

- Provide 100 dental, vision, and respiratory screening visits to 289 youth (target: 12 visits to 270 youth).
- Hold four health education events and/or workshops attended by 575 youth (target: four events/workshops attended by 320 youth).
- Provide six mental health workshops for 203 youth members on topics including coping mechanisms for anger, bullying, technology safety, and stress management (target: four workshops attended by 200 youth).
- Conduct four Passport to Manhood workshops serving 84 middle school male students to learn to make good decisions, avoid harmful substances, and act responsibly in their personal lives (target: four workshops serving 50 students).

- Conduct nine SmartGirls workshops serving 32 female students to promote self-esteem and healthy lifestyles through teaching how to avoid dating violence, harassment, and sexually transmitted diseases; discussing sexual myths; and emphasizing regular gynecological care (target: six workshops serving 14 members).
- Provide four Healthy Habits workshops to 665 members to encourage healthy eating and physical activity through daily programming (target: four workshops for 240 members).
- Provide a comprehensive culinary, nutrition, and health education program to 252 youths (target: 250).
- Offer one hands-on culinary, nutrition, and health workshop to all Club youth (target: one).
- Provide dynamic, garden-based nutrition and ecology education to 257 Club youth (target: 250).
- Provide low and high impact recreation and sports to help 1,580 youth develop and/or maintain an active and physically fit lifestyle (target: 1,000).

Highlights

100%

100% of participating youth **learned something new about developing positive relationships** (target: 90%).

ALL IN – Healthy Food, Healthy Families

www.alamedacountysheriff.org/mission.php

FY 17/18 Allocation: **$100,000*** | **Expended/Encumbered:** **$88,182.26**

Individuals served by Measure A: 553 (Total individuals served: 553)

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

Services provided: Public Health

Service area: Ashland, Castro Valley, Cherryland, Fairview, Hayward, Oakland, San Lorenzo

**Includes Board of Supervisors discretionary allocations from*
District 3/Supervisor Chan, District 4/Supervisor Miley, and District 5/Supervisor Carson

Background

The Alameda County Sheriff's Office strives to demonstrate an ability to enforce the law fairly and without bias, a commitment to professionalism, service to the community with integrity and trust, and obligation to duty with honor and pride.

ALL IN Alameda County collaborates with community members and leaders, County agencies, industry and sectors, and community-based organizations on issues such as food insecurity, community engagement and empowerment, workforce and economic development, school readiness, and ensuring children, youth, and families have adequate supports for equitable and sustained health and well-being.

Through the Alameda County Deputy Sheriffs' Activities League, the General Services Administration supported the purchase of two refrigerated vehicles to distribute fresh produce and other food for the Food as Medicine model at the Hayward Wellness Center. This model employs local people to grow, harvest, and distribute organically grown produce to patients at the clinic. The patients are given prescriptions for diet-related conditions, which can be redeemed for produce at the farm stand within the clinic.

Measure A Funding Summary

The ALL IN – Healthy Food, Healthy Families program used its Measure A allocation to achieve the following:

- Purchase two refrigerated vans to transport healthy food.
- Develop three partnerships that support food recovery efforts throughout the County.
- Provide 4,466 produce prescriptions to 553 unique patients.

Highlights

Due to the food prescriptions through the food as medicine model, patients have seen **decreases in their A1C levels** to the point where many patients who came in as pre-diabetic were no longer on the spectrum after four sessions. There have also been **dramatic reductions in systolic blood pressure, visits to the emergency department, and more**.

Matching Funds

$350,000

from **CalRecycle**.

Asthma Start

acphd.org/asthma.aspx

FY 17/18 Allocation: $100,000 | Expended/Encumbered: $100,000

Individuals served by Measure A: 295 (Total individuals served: 317)

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

Services provided: Public Health

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

Background

Asthma Start provides families of children and adolescents diagnosed with asthma with tools to manage their asthma, avoid the emergency department (ED) 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. The program develops a care plan for the family, looks at their home for asthma triggers, works with the property owners to remediate substandard housing, and partners with Code Enforcement to advocate with landlords to remediate triggers or safety issues. Families are given supplies to assist in managing their child's asthma such as pillow and mattress encasings, non-bleach-based mold cleaner, a vacuum, air purifiers, and so on. Families are 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-three percent of the children served are 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.

Highlights

99%

99% of clients **reduced their number of emergency room visits** (target: 80%).

Matching Funds

$200,000

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

Measure A Funding Summary

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

- Enroll 317 clients into the program (target: 400), of whom:
  - 162 had been to the emergency room prior to case management.
  - 52 had been hospitalized prior to case management.
- Successfully discharge 207 clients (target: 300).
- Reduce instances of children requiring hospitalization from 25% to 7% and ED visits from 78% to 1% post-case management.

Center for Early Intervention on Deafness

ceid.org

FY 17/18 Allocation: **$55,456** | **Expended/Encumbered:** **$55,456**

Individuals served by Measure A: 130 (Total individuals served: 1,526)

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

Services provided: Hospital Outpatient, Public Health

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

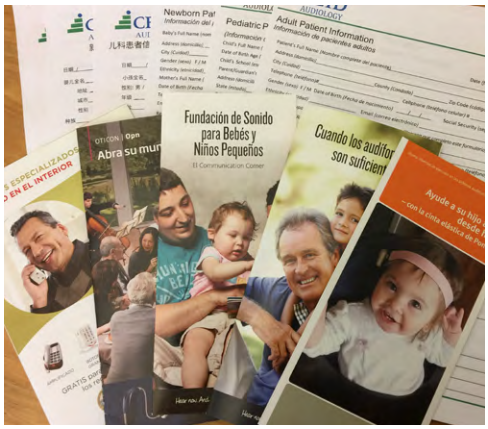
Background

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

CEID provides services to Alameda County residents through two clinics in Berkeley and Oakland. Outpatient services are provided to all ages, from newborns through seniors, who are low income and qualify for and utilize Medi-Cal insurance, making CEDI one of the few audiology providers who accept Medi-Cal patients.

CEID reaches out to community clinics and their doctors, birthing centers, and private pediatricians. Referred patients receive timely, professional hearing evaluations and are provided with hearing devices.

Significant features of CEID's services include rapid response, ability to accept Medi-Cal insurance, multilingual staff, high expertise of professional and support staff, and extraordinary follow-up. Ninety-eight percent of Alameda County audiology patients receiving CEID's services report significant improvement to their quality of life.



Highlights

99%

99% of newborn babies who needed a screening were **scheduled within a week** of receiving a referral (target: 95%).

Measure A Funding Summary

CEID used its Measure A allocation to achieve the following:

- Conduct 67 newborn hearing screenings (target: 150).
- Perform 932 hearing evaluations for children, youth, and adults based on referrals from community clinics (target: 300).
- Dispense hearing aids and ear molds to 291 patients based on referrals from UCSF Benioff Children's Hospital Oakland, Kaiser, California Children's Services, and community clinics (target: 125).
- Train 44 pediatric residents on pediatric hearing loss, how to read audiograms and audiological reports, types of hearing testing, amplification options, and hearing loss care and management (target: 75).

City of Alameda: Community Paramedicine Services

ems.acgov.org

FY 17/18 Allocation: $416,000 | **Expended/Encumbered: $185,000**

Individuals served by Measure A: 70 (Total individuals served: 70)

Populations served: Indigent, Uninsured Adults, Seniors

Services provided: Emergency Medical, Substance Abuse

Service area: Alameda

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.

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

Most CP clients receive instructions and/or referrals for services upon hospital discharge. CPs help clients and their families understand the referrals, navigate the various local systems, and make connections to access care. CPs also encourage and educate clients to be active in self-care and as independent as possible, even if this includes accepting additional assistance with in-home care.

CP services are available regardless of an individual's medical insurance, socio-economic status, or health status.

Measure A Funding Summary

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

- Make 192 referrals to and enroll 65 clients in the program.
- Perform 99 total home visits, physical assessments, bio-psych-social assessments, home safety assessments, and medication reconciliation assessments per month (target: 60).
- Make three referrals per month to community partners offering social, health care, and other support services (target: 25).

Highlights

↓100%

Thirty-day hospital readmissions were reduced by 100% compared to baseline (target: 50%).

↓83%

Utilization of 911 was reduced by 83% compared to baseline (target: 50%).

City of San Leandro Senior Services

sanleandro.org

FY 17/18 Allocation: **$55,456** | **Expended/Encumbered:** **$55,456**

Individuals served by Measure A: 12,136 (Total individuals served: 41,832)

Populations served: Low Income Adults, Families, Seniors

Services provided: Public Health

Service area: Ashland, Castro Valley, San Leandro, San Lorenzo

Background

The San Leandro Recreation and Human Services (SLRHS) Department offers a wide range of activities, services, and resources for seniors and older adults. These programs are designed to foster healthy independent living, enhance the quality of life, and build a sense of belonging and community among older adults, caregivers, and families. These activities include the following:

- Classes. Classes are designed to help participants stay fit, healthy, and active in both mind and body. Participants learn how to improve strength and balance, express creativity, laugh and relax, and have fun through exercise, dance, arts and crafts, and writing.
- Social programs. Participants get together to share food, laughter, games, dance, and more. These activities help strengthen and enhance mobility and memory skills and provide social interaction with other older adults.
- Special events. The annual Senior Thanksgiving Luncheon and other events bring older adults together to celebrate special occasions with friends and other seniors in the community.
- Community Education Program (CEP). CEP consists of services, workshops, consultations, and presentations on topics relevant to older adults, their families, and/or caregivers. These programs and services are offered in partnership with various nonprofit organizations, and other city departments, and a hot lunch program is offered five days a week. Examples include flu shot clinics, blood pressure checks, diabetes self-management, tax assistance, health insurance counseling, and many more.

Highlights

100%

100% reported that they are **as active or more active at home** or other times outside of the classroom (target: 80%).

72%

72% of grocery recipients reported that the program **provided their only stable and consistent source of groceries** (target: 60%).

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.

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

- Provide 12 free, drop-in blood pressure screenings to 46 seniors each month (target: 12 screenings to 30 seniors per month).
- Distribute a bag of nutritional food to 76 seniors twice a month through the Mercy Brown Bag program (target: 50).
- Provide 14 health education classes through the CEP attended by 19 unduplicated seniors (target: 12 classes attended by 18 unduplicated seniors).
- Conduct five Pull Up a Chair exercise classes attended by 52 unduplicated seniors (target: five classes attended by 20 unduplicated seniors).
- Hold nine fall prevention classes attended by 206 unduplicated seniors (target: nine classes attended by 150 unduplicated seniors).

Highlights

100%

100% of class participants reported that they **utilize chair exercises at home** or other times outside of the classroom (target: 80%).

Countywide Plan for Seniors: Getting the Most Out of Life

gettingthemostoutoflife.org

FY 17/18 Allocation: $250,000 | **Expended/Encumbered: $191,633.48**

Individuals served by Measure A: 207 (Total individuals served: 207)

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

Services provided: Public Health

Service area: Countywide

Background

The Alameda County Health Care Services Agency (HCSA) Getting the Most Out of Life (GMOL) program serves low income, seriously and terminally ill frail elders and utilizers of acute care services in Alameda County. Culturally sensitive, community-based advance care planning and palliative care services aim to educate and train clients about advance directives, document their health care choices, and coordinate care with family, primary care physicians, and their HCSA electronic clinic record to ensure wishes are known and honored.

The program provides clients with needed access to more support and education about respite, hospice, and other available care options, as well as information about how to access resources they believe will help them get the most out of life. Caregivers are educated and trained to better navigate complex health care systems to avoid preventable crises that lead to increased acute care utilization and access primary care to avoid delays in care issues.

GMOL is designed to address racial and cultural disparities in access to end-of-life planning and care among the County's low income older adult population. The program has partnered with San Quentin, Santa Rita Jail, and Roots Community Health Center to provide end-of-life care options for seriously and terminally ill clients, frail elders, and high utilizers of acute care services who face mental health and/or substance abuse issues and are also low income and/or uninsured adults.

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.

Highlights

100%

100% of training participants reported that they **gained additional clinical skills** (target: 30%).

Measure A Funding Summary

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

- Conduct two trainings for eight staff and navigators at St. Mary's Center to support their ability to help seniors complete advance care planning documentation.
- Provide three advance care planning trainings for 30 organizations serving homeless and reentry populations, with a total of 517 attendees.
- Have 114 out of 294 advance directives completed by inmates and/or non-English-speaking Alameda County residents.
- Ensure that 60% of in-home visits resulted in referrals to the NODA program (target: 20%).

Highlights

76%

76% of program participants reported that they received services that **reduced stress and supported the patient and family** (target: 60%).

Countywide Plan for Seniors: Home-Based Nursing Case Management

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

Allocation: **$500,000** | **Expended/Encumbered:** **$498,738**

Individuals served by Measure A: 57 (Total individuals served: 951)

Populations served: Indigent, Low Income Adults, Seniors

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Countywide

Background

Alameda County Public Health Nursing (ACPHN) provides public health nursing care, community outreach, home visits, care coordination, and advocacy to address individual and community health needs, promote healthy practices, improve health outcomes, eliminate health disparities, and ensure optimal quality of life for all Alameda County residents.

Older Adults, Healthy Results (OA/HR) is an ACPHN program that provides public health nurse case management to low income Alameda County adults 60 years of age or older with the aim of promoting wellness, maximizing function, and supporting clients to live safely in their homes and communities.

OA/HR clients struggle with an array of functional limitations, inadequate caregiving resources, and psychosocial challenges that interfere with their ability to manage complex medical conditions and put them at high risk for institutionalization. Nurse case managers provide psychosocial and medical care coordination for clients who lack the support, functional capacity, and resources to be able to perform these activities themselves. Case managers also implement sustainable support structures that allow client/caregiver units to function more independently, safely, and healthfully.

Anecdotally, the program has observed a decrease in emergency department (ED) visits and hospitalizations in approximately 50% of clients starting at about one to two months after enrollment. Other benefits provided to clients include improving access to care, reducing social isolation, obtaining and/or improving caregiving, and cultural competency. Specific services provided include the following:

- Comprehensive, multidomain, in-home nursing assessment.
- Referrals to available community resources.
- Client advocacy.
- Care coordination.

Matching Funds

$155,720

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

- Linkage to long-term services and supports and community-based resources.
- Medication review and monitoring.
- Assistance with obtaining and maintaining health benefits.
- Accompaniment to medical visits.
- Strategies to promote healthy behaviors, reduce risk, and prevent disease.
- Health education to support self-management of chronic health conditions.
- Assistance navigating the health care delivery system.
- Family and caregiver support and education.

By taking the time to build trust and a therapeutic alliance, the nurses work to mitigate some of the difficult challenges inherent in the safety net system and to model a different experience of health care and communication.

Measure A Funding Summary

ACPHN used its Measure A allocation to achieve the following:

- Refer 79 clients to and enroll 44 clients in OA/HR.
- Complete a comprehensive nursing assessment within three home visits for 100% of clients (target: 100%).
- Complete and approve an Individualized Care Plan that identified problems, goals, and interventions for 94% of clients within three weeks of their comprehensive nursing assessment (target: 80%).

Success Story

During a case management assessment, a nurse identified that SL, 68, was severely undernourished, was experiencing severe anxiety and depression, and had been on a prolonged dose of what should have been a short-term medication. After creating a care plan, the nurse made primary care appointments for SL and helped him transfer into managed care Medi-Cal. She coordinated with the primary care provider and pharmacy to make sure that medications were appropriate and delivered. She connected SL to a home visiting program specializing in older adult behavioral health care and linked him to a mental health provider. She also linked him to home-delivered meal services and made multiple home visits.

Countywide Plan for Seniors: Injury Prevention, Meals, Nutrition

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

FY 17/18 Allocation: **$773,100** | **Expended/Encumbered:** **$751,835**

Individuals served by Measure A: 3,482 (Total individuals served: 9,733)

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 funded by Measure A include the following:

- SOS Meals on Wheels. This home-delivered meals program is designed to provide meals for consumers 50-60 years old while eliminating or minimizing the wait list.
- Mercy Brown Bag Nutrition Program. This 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.

Additional AAA programs include the following:

- Minor home modifications. This program provides residential modifications of homes that are necessary to facilitate the ability of older individuals to remain at home.

Highlights

97%

97% of Meals on Wheels clients stated that having the meals **supports them staying in the home**, and 99% reported that the **meals make them feel better** (target: 90%).

Matching Funds

$45,084

from **federal SNAP-Ed dollars to support additional community gardens at low income senior housing**.

- Home Meds. This medication management program addresses medication-related problems and errors that endanger the lives and well-being of community-dwelling elders.
- 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.
- Lifestyle-integrated Functional Exercise (LiFE). This physical activity program is designed to improve the overall functional fitness and well-being of older adults.
- Geri-Fit®. This is a progressive resistance strength program designed to increase strength, flexibility, range of motion, mobility, gait, and balance in older adults.
- Enhance Fitness. This program is designed to improve the overall functional fitness and well-being of older adults.

Measure A Funding Summary

AAA used its Measure A allocation to achieve the following:

- Deliver 52,361 meals to 252 older adults in Alameda County (target: 52,000 meals to 180 adults).
- Eliminate the Priority A waiting list for Meals on Wheels in Alameda County.
- Provide 6,400 bags of food to 511 low income participants of the Mercy Brown Bag program, including 75 homebound clients (target: 5,000 bags to 500 clients, including 75 homebound clients).
- In partnership with Public Health Nutrition and City Slicker Farms, create six community gardens in low income older adult housing in Alameda County (target: four).

Highlights

90%

90% of Meals on Wheels clients **rated the food as good to excellent**, and 99% **rated the driver as good to excellent** (target: 80%).

Eden Youth and Family Center

eyfconline.org

FY 17/18 Allocation: **$20,000*** | **Expended/Encumbered:** **$20,000**

Individuals served by Measure A: 102 (Total individuals served: 371)

Populations served: Low Income Adults, Children, Families

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Ashland, 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 health-related well-being of the community.

The EYFC youth team serves over 400 culturally and ethnically rich and diverse students and their families per year. The services provided are designed and administered to address the needs of youth and young adults and their life's challenges. Most of all they are designed to address and circumvent negative experiences that youth and young adults encounter, such as school system inequalities, unemployment, high levels of violence, and incarceration.

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.
- Wraparound case management services are offered to all 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

Highlights

100%

100% of youth reported that they **eat healthier foods and/or exercise more** because of EYFC (target: 75%).

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.
- EYFC provides facility management for critical Hayward service providers such as Tiburcio Vasquez Health Center/Silva Pediatric Clinic, Hayward Community School, and Kidango Early Learning Program. This enables parents to work while having access to affordable child care, health care, and preschool.

Measure A Funding Summary

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

100%

100% of youth felt that EYFC helped **improve their social-emotional wellness, specifically their social skills and coping skills** when things go wrong (target: 80%).

81%

81% of youth felt that EYFC helped **build their resiliency factors**, specifically the presence of a caring adult and opportunity for meaningful participation (target: 80%).

Emergency Medical Services (EMS) Corps

ems.acgov.org

FY 17/18 Allocation: **$692,791** | **Expended/Encumbered:** **$606,342**

Individuals served by Measure A: 898 (Total individuals served: 898)

Populations served: Low Income Adults, Children

Services provided: Emergency Medical, Public Health, Mental Health

Service area: Countywide, Outside of Alameda County

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 program targets young men who come from the most underserved communities that have been impacted by drugs and violence.

The EMS Corps improves provides young men of color with an opportunity to transform their attitude and behavior towards life through life coaching, health and wellness, mentorship, and community service. The program also provides participants access to employment, creating a career pathway into health and public safety.

EMS Corps students participate in health and job fairs, volunteer at community events, and teach basic life-saving skills to middle and high school students and members of community-based organizations.

The EMS Corps Health Pipeline Partnership (HPP) strives to provide an ethnically diverse group of Alameda County youth with a supportive network of academic, social, and professional development to build a successful career in all areas of the health industry.

HPP is a consortium of pathway programs and organizations that aim to increase the diversity of the health care workforce by providing mentorship, academic enrichment, leadership development, and career exposure to disadvantaged and minority youth. HPP works to build coalitions and regional expansion of health career pathway systems for youth of color from grade seven through the senior year of college by leveraging existing funding, programs, employers, and other key stakeholders. In FY 17/18, over 40 staff from the Alameda County Health Care Services Agency (ACHCSA), Behavioral Health Care Services (BHCS), and Public Health Department (PHD) assisted in providing health career exposure for youth.

Matching Funds

$9.8M

from the **Mental Health Services Oversight and Accountability Commission**.

The project's purpose is twofold: to expand school-based, career-oriented academies and increase OUSD student exposure to work-based learning experiences. Among the activities of the grant was a pilot summer program designed to expose OUSD high school-aged youth to the diverse and inspiring public health functions served by ACHCSA.

Measure A Funding Summary

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

- Recruit 161 applicants for two EMS cohorts (target: 200).
- Interview 93 potential candidates (target: 90).
- Select 40 participants for the program (target: 40).
- Graduate 37 EMTs (target: 40).
- Provide employment for 33 graduates (target: 40).
- Volunteer at 17 community service events (target: 10).
- Through the HPP program, implement five joint workforce development projects/activities to serve youth and young adults (target: 30).
- Involve 75 partners (County staff, employers, mentors, presenters, community-based organizations) in the implementation of these projects/activities (target: 40).
- Provide workforce development activities to 275 youth and young adults at eight schools and colleges/universities (target: 200 youth and adults at five schools).
- Execute two contracts to provide technical assistance to the EMS Corps for workforce development opportunities for at-risk youth ages 13-28 (target: two).
- Share 12 communications for the recruitment and retention of boys and men of color for the EMS Corps and other related youth programs (target: 12).
- Hold three meetings with affinity organizations (target: three).
- Host HPP meetings and events for 12 participants (target: 10).
- Have 12 HPP participants adopt the HPP online database (target: 10).

Highlights

100%

100% of HPP participants reported they will **continue to work together to serve youth and young adults** (target: 100%).

90%

90% of youth and young adults in each program planned to **pursue a career in health after the activity** (target: 80%).

Emergency Medical Services (EMS) Ambulance Providers Serving the 5150 Indigent Population

ems.acgov.org

FY 17/18 Allocation: **$3,000,000** | **Expended/Encumbered:** **$270,000**

Individuals served by Measure A: 1,527 (Total individuals served: 1,527)

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

Services provided: Emergency Medical

Service area: Alameda, Albany, Berkeley

Background

Alameda County Emergency Medical Services (EMS) is a patient-centered local emergency medical services agency. They understand that the practice of medicine is dynamic and are committed to adapting the service they provide to a continually changing community. EMS considers input from field providers and the public they serve as essential in developing and improving this service.

Measure A Funding Summary

The EMS agency used its Measure A allocation to transport 1,527 patients on an involuntary psychiatric (5150) hold to an appropriate facility.

Those with medical needs were sent to a community emergency department, and those with psychiatric complaints were taken to John George Psychiatric Hospital.

Matching Funds

$9.8M

from the **Mental Health Services Oversight and Accountability Commission**.

Healthy Homes Department Fixing to Stay & Group Living Facilities Project

www.achhd.org

FY 17/18 Allocation: **$311,511** | **Expended/Encumbered:** **$230,440**

Individuals served by Measure A: 197 (Total individuals served: 402)

Populations served: Low Income, Uninsured Adults, Seniors

Services provided: Public Health

Service area: Albany, Ashland, Castro Valley, Cherryland, Dublin, Emeryville, Newark, Oakland, 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.

The Healthy Homes Department Fixing to Stay program works 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 the home, which includes client education on how to prevent housing-based hazards that can lead to respiratory issues, unintentional injuries, and other health problems.

Independent living homes are largely unregulated yet provide refuge to disenfranchised residents, many of whom are disabled and have challenges finding affordable housing. The Healthy Homes Independent Living Homes program helps residents achieve improved housing conditions by working with group living facility operators and owners to address housing conditions in the facility.

Matching Funds

$354,721

from **Alameda County Cares Connect funds and Minor Home Repair funds**.

Measure A Funding Summary

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

- Conduct outreach to 165 older adults (target: 175).
- Enroll 42% of outreached adults in Fixing to Stay (target: 60%).
- Complete 140 health and risk assessments (target: 130).
- Complete 22 health and risk assessments for independent living (target: 130).
- Complete 112 home modifications such as grab bars or hot water.
- Provide additional assistance and referrals to 78 clients.

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

www.casasegura.org

FY 17/18 Allocation: **$155,250** | **Expended/Encumbered:** **$152,092**

Individuals served by Measure A: 617 (Total individuals served: 2,506)

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

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

Service area: Berkeley, 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 drug users are unhoused residents of Oakland. HEPPAC is the only program in Oakland that addresses their increased risk for HIV and hepatitis C due to their drug use for those who use.

Harm reduction services include syringe access, distribution of sterile drug-using materials, and naloxone distribution. Mobile harm reduction services occur in communities that don't surround HEPPAC's thee fixed exchange sites.

Wound care services include primary medical and holistic health services and are offered during HEPPAC's fixed exchange sites. Among people who inject drugs who are aware of their positive HIV and/or HCV status, HEPPAC works to improve access primary care and specialty services for treatment.

HEPPAC links active opioid users to medicine assisted treatment (MAT) services. Utilization of MAT can result in active users prioritizing their physical and mental health needs, which helps increase protective behaviors and decrease HIV and hepatitis C risk, overdose death, and drug use.

Highlights

72%

72% of syringe access participants reported that they **learned about safer injection techniques and methods for proper disposal of used/ littered syringes** (target: 65%).

Measure A Funding Summary

HEPPAC used its Measure A allocation to expand its existing syringe access services, including three fixed outdoor locations and mobile harm reduction services. Specifically, HEPPAC's Measure A allocation allowed it to achieve the following:

- Provide an average of 28 weekly hours of syringe exchange services in Oakland (target: 30).
- Exchange 62,547 sterile syringes (target: 50,000).
- Exchange 147,233 used or littered syringes (target: 100,000).
- Provide medical treatment to address soft tissue infections to 213 people who inject drugs (target: 150).
- Refer 112 people who inject drugs to HEPPAC's onsite medical team at the Roots Clinic (target: 150).
- Provide herbal/acupuncture services to 2,304 people who inject drugs (target: 2,000).
- Enroll 54 people in MAT programs.

Highlights

81%

81% of wound care service participants reported **increased knowledge of vein rotation and safer injection techniques** (target: 70%).

HIV Education and Prevention Project of Alameda County (HEPPAC) OPEND Program

www.casasegura.org

FY 17/18 Allocation: **$150,000** | **Expended/Encumbered:** **$150,000**

Individuals served by Measure A: 560 (Total individuals served: 2,506)

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

Services provided: Public Health, Substance Abuse

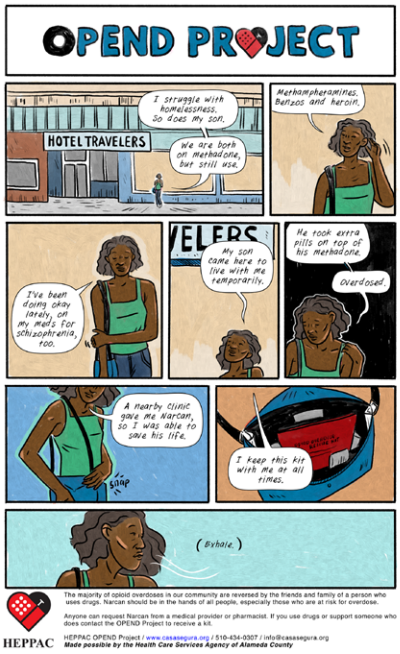
Service area: Oakland

Background

The HIV Education and Prevention Project of Alameda County (HEPPAC) works to stop the further spread of HIV/AIDS and Hepatitis C among injection drug users in Alameda County. HEPPAC is the only program in Oakland that addresses their increased risk for HIV and hepatitis C due to their drug use for those who use.

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.

HEPPAC links active opioid users to medicine assisted treatment (MAT) services. Utilization of MAT can result in active users prioritizing their physical and mental health needs, which helps increase protective behaviors and decrease HIV and hepatitis C risk, overdose death, and drug use.



Measure A Funding Summary

HEPPAC used its Measure A allocation to achieve the following:

- Provide services to 393 individuals at an OPEND site (target: 400).
- Provide eight OPEND "train the trainer" trainings to 30 service providers (target: five trainings to 20 providers).
- Provide refresher/follow-up trainings to 32 staff from five community-based organizations (target: 20 staff from five organizations).
- Provide staff trainings to 43 staff from 11 community-based organizations that have never had a training (target: 40 staff from 10 organizations).
- Conduct several staff trainings at Santa Rita Jail, with the goal of Narcan distribution upon release for those who request it.
- Increase public awareness by distributing 100 posters in Alameda County (target: 100).

Highlights

90%

90% of individuals trained reported the training **increased their ability to respond to an overdose** (target: 90%).

Home Visiting Services

www.acphd.org/mpcah.aspx

FY 17/18 Allocation: $3,282,466 | **Expended/Encumbered: $1,380,998**

Individuals served by Measure A: 920 (Total individuals served: 2,508)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Countywide, Homeless or transient

Background

The Alameda County Public Health Department (ACPHD) 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.

The mission of ACPHD's Family Health Services (FHS) is to ensure the health and well-being of diverse families with compassionate, comprehensive, and collaborative services. Within FHS, the staff of the Maternal, Paternal, Child, and Adolescent Health (MPCAH) Unit work to ensure that women, children, youth, fathers, and families achieve optimal health and well-being through the delivery of client-centered, culturally responsive, high quality, strength-based services that are merged with community transformation efforts to improve neighborhood conditions.

FHS/MPCAH provides quality services to young families in Alameda County who are facing multiple medical and social challenges. The Early Childhood Home Visiting System of Care is composed of 12 programs, of which three—Native American Health Center—Strong Families, UCSF Benioff Children's Hospital Special Start Program, Tiburcio Vasquez Health Center Family Support Services Program—and one Home Visiting Integration Manager (HVI) position were funded through Measure A.

Native American Health Center – Strong Families

Measure A funding allowed for the expansion of the Native American Health Care—Strong Families case management component. With the hiring of a new case manager, there were 379 interactions with clients directly through case management services. Also, the case manager generated 161 referrals to various community partnerships including Temporary Assistance for Needy Families (TANF), the Alameda County Food Bank, and the Bay Area Community Services.

Matching Funds

$546,878

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

UCSF Benioff Children's Hospital Special Start Program

Special Start provides comprehensive home-based, family-centered, early intervention services to high risk families with medically fragile infants that were discharged from a Neonatal Intensive Care Unit (NICU) in Alameda County. These babies and their families are followed in an intensive long-term relationship-based program that provides long-term support and education to the families as well as developmental screening of infants and depression screening for parents. Special Start facilitates connections to needed services such as infant development services, physical therapy, occupational therapy, and Regional Centers of the East Bay. Because the program works intensively and over a long period of times with the families, the Special Start case managers are adept at identifying and troubleshooting both medical and social concerns that can reduce the need for higher level, more expensive interventions such as emergency department visits and hospitalizations.

Tiburcio Vasquez Health Center Family Support Services Program

Home visiting programs are an important strategy in the FHS/MPCAH Unit's efforts to improve the lives of its client population. Tiburcio Vasquez Health Center (TVHC) Family Support Services is housed within its community health clinic, which allows case managers the ability to refer and link clients to TVHC and enroll them as new patients. Also, case managers can support clients with making appointments with a Social Services eligibility worker to apply for Medi-Cal services. Furthermore, the case managers work collaboratively with program managers to develop appropriate interventions, strategies, goals, and safety plans for each client.

Home Visiting Integration Manager

The HVI Manager position plays a pivotal role in ensuring oversight of the continuous quality improvement activities throughout the unit, development and management of the Family Advisory Committee, and facilitation of the Referral and Triage Committee for the Home Visiting System of Care, which also includes outreach strategy development. The HVI Manager collaborates with leadership and staff to ensure that the continuous quality improvement activities are relevant and sustainable and that they support accountability and best practice standards. The HVI Manager also co-facilitates the Family Advisory Committee for the Early Childhood Home Visiting System of Care, which is now called Starting Out Strong. This committee has been a platform for families to provide feedback about program planning, advocate for themselves and other families in the system of care, and partner with leadership in decision-making regarding community and agency collaborations.

Highlights

85%

85% of clients who screened positive for parental depression were **referred to mental health supports or treatment** (target: 60%).

Success Story

Tiburcio Vasquez Health Center

A Family Support Services case manager has been working with a young woman, her husband, and their two young children. The husband's work visa expired, and he has been facing deportation. The family have been living in their car at a local park. The Family Support Services case manager referred the family to the 2-1-1 national information and referral search hotline, through which the family was connected to family shelters and transitional housing. Currently the family is awaiting a placement with FESCO, an agency that helps homeless families find permanent housing. Also, the case manager is connecting the family to legal services to address the husband's expired work visa.

Measure A Funding Summary

FHS/MPCAH used its Measure A allocation for both direct services and infrastructure support for the ACPHD Early Childhood Home Visiting System of Care program. Specifically, Measure A fund helped FHS/MPCAH achieve the following:

- Ensure that parents of 49% of infants in the Special Start program reported breastfeeding or feeding their infants breast milk for at least six months (target: 65%).
- Provide 93% of enrolled children ages 0-36 months with early developmental screening (target: 85%).
- Refer 53% of screened children of concern to developmental services (target: 90%).
- Screen 92% of enrolled parents for perinatal depression (target: 85%).
- Refer 60% of clients who screened positive for parental depression to mental health supports or treatment (target: 60%).
- Ensure that 84% of clients have a primary medical provider/medical home (target: 90%).
- Conduct 50 trainings by the HVI Unit (target: 12).
- Conduct seven quality improvement activities for programs and/or committees (target: 12).
- Hold nine Home Visiting Family Advisory Committee meetings (target: 11).

Success Story

UCSF Benioff Children's Hospital Oakland Special Start Program

An 18-month girl was born with Down's Syndrome, congenital heart disease, anal atresia, hyopothyroidism, hypotonia, tethered cord, gastroesophageal reflux, and aspiration. She had undergone numerous surgical procedures and is the only child of Tagalog-speaking parents who recently immigrated to the United States. The case manager accompanied the family to medical appointments in the 10 specialty clinics overseeing the girl's care. The case manager also assisted the family with navigating programs such as In-Home Supportive Services and Supplemental Security Income (SSI). Additionally, the case manager was able to connect the family with the East Bay Community Law Center, which helped the family with their appeal for SSI and overturned the denial.

LIFE ElderCare

lifeeldercare.org

FY 17/18 Allocation: $20,000* | **Expended/Encumbered: $20,000**

Individuals served by Measure A: 176 (Total individuals served: 176)

Populations served: Seniors

Services provided: Public Health

Service area: Countywide

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

Background

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

LIFE ElderCare offers an in-home, four-visit Lifestyle Integrated Functional Exercise (LiFE) fall prevention program compromised of education on simple behavioral changes to reduce fall risk, a collaborative environmental assessment and plan, a medication review and plan, and an exercise assessment and plan. Clinical results of the program nationwide show a reduction of 31% in the rate of falls for LiFE program participants compared with controls. Avoidance of falls also results in a decrease of use of Emergency Medical Services transport and hospitalizations, resulting in significant cost savings.

In addition to fall prevention, LIFE ElderCare offers software-based medication management and care coordination including education on safe footwear, avoiding postural hypotension, keeping eyeglass prescriptions current, and having modifications such as grab bars and raised toilet seats professionally installed.

Measure A Funding Summary

LIFE ElderCare used its Measure A allocation to provide comprehensive fall prevention assessments and recommendations for interventions to 176 eligible adults in Alameda County age 60+ (target: 60).

Highlights

80%

80% of assessed clients **increased their knowledge of fall risk reduction factors**, and 100% were **informed about their own level of risk of falls** (target: 80% and 100%).

LifeLong Medical Care Heart 2 Heart

lifelongmedical.org

FY 17/18 Allocation: **$100,000** | **Expended/Encumbered:** **$100,000**

Individuals served by Measure A: 4,643 (Total individuals served: 4,643)

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, 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 combines health screenings and education with activities that promote social cohesion. Each year, H2H trains a cohort of Neighborhood Health Advocates (NHAs) to serve as peer educators for their neighbors, improving their social capital and encouraging residents to connect with each other around the health issues facing their communities. H2H also provides mini-grants to empower community members to create their own programs.

Measure A Funding Summary

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

- Organize five community outreach events, in partnership with community organizations, to increase visibility and promote healthy behaviors (target: three). 227 individuals participated in outreach events.
- Provide 24 NHA community health education training sessions to 21 residents (target: 20 residents).
- Coordinate with 32 NHAs to participate in 31 community engagement activities, including small group presentations, community fairs, H2H-sponsored events/activities, street outreach, and in-home presentations, to educate and link 1,801 community members to medical resources (target: 30 events to 100 community members).
- Administer mini-grants totaling $10,500 to five individuals/groups who implement a variety of health and wellness programs (target: four individuals/groups). 245 individuals attended activities funded by mini-grants.

Matching Funds

$65,000

from the **Sutter Health Foundation.**

- Provide health education and services including hypertension education, screenings, linkage to resources, and information on health-related topics to 4,643 community members at 265 community health events, including door-to-door blood pressure checks, mobile health van visits, drop-in clinics, and barber shop health hubs (target: 100 community members at 50 events).

Highlights

96%

96% of attendees at the hypertension clinic reported feeling **confident in taking the next steps in managing their own health** (target: 25%).

Love Never Fails

www.loveneverfailsus.com

FY 17/18 Allocation: **$20,000*** | **Expended/Encumbered:** **$20,000**

Individuals served by Measure A: 18 (Total individuals served: 18)

Populations served: Low Income, Uninsured Adults, Children, Families, Other residents: Survivors of human trafficking

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Alameda

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

Background

Love Never Fails is dedicated to the restoration, education, and protection of those involved or at risk of becoming involved in domestic human trafficking. Love Never Fails supports the physical and mental health of survivors of human trafficking in Alameda County with access to medical services, mental health services, and substance abuse treatment.

Survivors of human trafficking and their children have a safe place to live for up to 18 months with case management support and access to recovery resources. Clients who stay long-term in the program leave stabilized and healthy, are in school or working, have their own housing, have custody of their children, and have hope for their futures.

Measure A Funding Summary

Love Never Fails used its Measure A allocation to achieve the following:

- Provide clinical case management, mental health, and substance abuse services to 18 human trafficking survivors and other low income members of the community (target: 26).
- Receive 102 medical visits and 475 mental health/substance abuse visits from clients (target: 100 each).

Highlights

88%

88% of clients in the safe housing program **completed a medical visit in the first 30 days of residency** (target: 75%).

Nutrition Services in West Oakland: City Slickers Farm

www.acphd.org/nutrition-services

FY 17/18 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: Ashland, Oakland, San Leandro

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 partnerships 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 build eight school-based garden beds at four sites (target: eight beds at four sites).

Highlights

71%

71% of participants reported **eating produce grown from the garden beds** (target: 50%).

Public Health Services for Pacific Islanders

www.acphd.org/HAPI

FY 17/18 Allocation: **$250,000** | **Expended/Encumbered:** **$5,885**

Individuals served by Measure A: 13 (Total individuals served: 33)

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

Services provided: Public Health

Service area: Hayward, Oakland

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 Health Advancement for Pacific Islanders (HAPI) program cares for Pacific Islander pregnant women and teens, at no cost. The program serves both women and fathers. It offers support at prenatal care and WIC visits; gifts such as clothing, swaddles, car seats, and pack n' play; links to child care, food, housing, and dental resources in Alameda County; bus vouchers if needed; and help with enrollment in health insurance.

The program supports clients to attend their prenatal appointments, with the goal of attending more than five if they enter care late and more than 10 if they enter care early, with no preterm births. Clients are also supported to attend other appointments for ultrasounds and high risk prenatal care and with nutritionists, dentists, and other specialty providers.

The program also connects clients with the Women, Infants, and Children (WIC) program and helps troubleshoot Medi-Cal issues or assistance as clients transition from one form of health insurance to another, whether because they aged out of their parents' coverage or because they changed employers.

To increase awareness of the program and generate referrals, the HAPI program conducts outreach at Merritt College, Pacific Islander Heritage Day at Skyline College, Cal State University East Bay College Day for Pacific Islanders, and the Oakland Unified School District Honor Roll for Pacific Islanders.

Highlights

90%

90% of individuals were **successfully enrolled in health insurance** (target: 80%).

Measure A Funding Summary

The HAPI program used its Measure A funds to host two community baby showers where Pacific Islander families learned about the importance of prenatal care, the HAPI program, and health insurance for the whole family, as well as received essential baby items.

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

- Initiate support services for and enroll five women into early prenatal care (target: six).
- Enroll eight individuals into health insurance (target: 25).

Success Story

A teen client was referred to the program during her second trimester. She was expecting her first child and was not aware of the importance of prenatal care. The HAPI Health Consultant provided culturally appropriate education on the importance of prenatal care. The client ultimately attended 10 prenatal care appointments and successfully delivered a healthy baby. This client needed a car seat but was unable to purchase one and did not know how to install it correctly. The HAPI program provided her with the car seat and safety education. Measure A funds also provided the client with diapers, baby clothes, receiving blankets, health insurance enrollment, and other resources.

Public Health Prevention Initiative

FY 17/18 Allocation: **$5,300,000** | **Expended/Encumbered:** **$2,988,697**

Individuals served by Measure A: 60,277 (Total individuals served: 132,554)

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 (ACPHD) 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 programs and organizations receiving Measure A funding under the Public Health Prevention Initiative funding include the following:

- Asthma Start (see the separate "Asthma Start" entry on page 76).
- CAL-PEP/PWP.
- Child Health and Disability Prevention Program (CHDP).
- City of Berkeley.
- Community Assessment, Planning, and Evaluation (CAPE) Unit.
- Diabetes.
- East Oakland Boxing Association (EOBA).
- Health Equity Planning and Policy.
- Healthy Retail Project.
- Immunization Assessment.
- Lotus Bloom.
- Mandela MarketPlace.
- Maternal, Paternal, Child, and Adolescent Health (MPCAH).
- MPCAH Interpreter Services.
- Niroga.
- Nutrition Services.
- Office of Dental Health (see the separate "Alameda County Dental Health" entry on page 41).
- Project New Start.
- Public Health Nursing (PHN) Healthy Living Project.

Matching Funds

$476,245

from the following sources:

- **Title XIX federal funds through the Maternal, Child, and Adolescent Health (MCAH) program**
- **Child 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**
- **Kaiser Permanente**

Measure A Funding Summary

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

CAL-PEP/PWP

- Make 50 contacts with HIV-positive African Americans in high risk communities (target: 50).
- Enroll 10 CLEAR clients into case management services (target: 10).
- Link five newly diagnosed or out-of-care clients to primary care services (target: five).
- Conduct five events to increase knowledge of HIV disease, medication adherence, and viral suppression among African American HIV-positive individuals and their sexual partners.
- Provide HIV testing to 50 sexual and/or social network partners of HIV-positive individuals (target: 50).

CHDP

- Develop developmental screening goals and promote the use of a standardized screening tool at 55 pediatric sites (target: 55).
- Conduct training on the standardized developmental screening tool and practice implementation at 12 sites (target: 12).
- Provide monthly site visits to reinforce screening practices and offer technical assistance to clinic staff at 52 sites (target: 55).
- Collect screens from all 55 sites monthly, enter results, and track screening data (target: 55).
- Complete 14,508 screens.

City of Berkeley

- Hold seven meetings for the Berkeley Healthy Schools Collaborative (BHSC) (target: 12).
- Make presentations on trauma-informed systems of care, emergency preparedness, the Healthy Berkeley program, tobacco prevention, and mindfulness (target: 10).
- Distribute six Health Resource Newsletters to all Berkeley Unified School District (BUSD) preschool, elementary school, and middle school secretaries; family engagement specialists; and specific community partners (target six).
- Create comprehensive immunization resource packets and distribute them to 14 schools (target: 11).
- Create resource packets for asthma, vision, insurance, and dental care and distribute them to eight family engagement specialists (target: eight).
- Host 1,000 students who participated in activities in BUSD's September Attendance Awareness Month (target: 500).
- Distribute 540 Health Educations for Life (HEAL) flyers as part of positive messaging to the BUSD student population during September Attendance Awareness Month (target: 500).
- Provide 23 health consultations to the family engagement coordinators for students with health-related school absences (target: 20).

Highlights

85%

CAL-PEP

85% of clients testing for HIV reported increased desires to **maintain their current HIV-negative status either through condom use, abstinence, or accessing Prep/PEP services** (target: 85%).

88%

CHDP

88% of providers surveyed said that technical assistance was **helpful to their screening practices** (target: 80%).

- Make 16 referrals for emotional/behavioral/physical health issues (target: 20).
- Provide 32 immunization consultations to school secretaries (target: 25).
- Provide two in-service trainings to school secretaries on SB277/ school immunizations (target: one).
- Make 30 case management contacts for two ongoing HEAL cases (target: 12).
- Conduct medication audits and trainings for managing medications at 12 school sites (target: 12).
- Hold three planning and implementation meetings with BUSD staff and the Breathmobile partner to share and analyze school-specific utilization data (target: three).
- Distribute over 100 oral health supplies and health informational and promotional handouts at a twice-per-month grocery distribution event for BUSD students.

CAPE Unit

- Ensure that epidemiology staff respond to all data requests in a timely manner, under two weeks, 100% of the time (target: 100%).

Diabetes

- Enroll 127 clients into diabetes self-management education (DSME) classes (target: 115).
- Ensure that 121 clients successfully complete DSME (target: 115).
- Lower the baseline A1c or maintain a goal of lower than 7% in 87 clients.
- Lower the baseline blood pressure or maintain it at lower than 140/90 in 78 clients.

EOBA

- Ensure that 275 youth participate in cooking, gardening, physical activity, and Youth Leadership programs (target: 200).
- Ensure that 40 EOBA youth boxers participate in the Boxing Leadership program (target: 40).
- Reach 1,008 households through the food distribution program (target: 1,000).

Health Equity Planning and Policy

- Ensure that four West Oakland (WO) residents take formal elected leadership roles (target: seven).
- Host 10 monthly meetings where WO leaders meet to plan Resident Action Council (RAC) monthly meetings (target: 12).
- Conduct four training sessions with WO RAC elected leaders (target: six).
- Provide 29 hours per month of technical assistance/coaching for WO RAC elected leaders (target: 25).
- Hold one RAC election for RAC leader positions (target: one).
- Facilitate six meetings between The Mentoring Center (fiscal sponsor)

Success Story

City of Berkeley

The School-Linked Health Services Program (SLHSP) completed a home visit with a mom living in transitional housing with her two daughters, both suffering from poor attendance. All three family members have asthma. Based on the home visit, SLHSP initiated a referral to the Alameda County Asthma Start Program, as well as a call to the girls' primary care provider. Since this home visit, both girls have seen a provider at their primary care office, case management has started with the Asthma Start program, and attendance has increased for both girls. Both now have up-to-date asthma care plans and asthma medications at school.

and the elected leaders of the WO RAC (target: two).
- Enact a contract with one organization, Congress of Neighborhoods (CoN), to provide long-term leadership development and community building and engagement opportunities (target: one).
- Ensure that five WO residents attend at least one CoN meeting (target: four).
- Ensure that six WO residents participate in CoN community organizing campaigns (target: four).
- Host five meetings between the WO RAC and CoN (target: two).
- Host four transition planning meetings with WO RAC leaders (target: two).
- Ensure that nine WO leaders attend at least one CoN meeting (target: two).
- Ensure that four Sobrante Park (SP) residents take formal leadership roles (target: five).
- Conduct four leadership training sessions with SP RAC leaders (target: two).
- Provide 15 hours per month of technical assistance for SP RAC leaders (target: 10).
- Host 21 monthly meetings where SP elected leaders come together to plan RAC activities (target: 21).
- Facilitate four meetings between Roots Community Clinic (fiscal sponsor) and the leaders of the SP RAC (target: two).
- Host four meetings between SP RAC leaders and CoN (target: two).
- Host four transition planning meetings with SP RAC leaders (target: three).
- Provide technical assistance to seven SP RAC leaders (target: three).
- Ensure that four SP residents attend at least one CoN meeting (target: four).
- Ensure that eight SP residents participate in CoN community organizing campaigns (target: three).

Healthy Retail Project
- Host outreach events at eight stores for 1,076 community participants (target: 10 events for 2,500 participants).
- Recruit two additional corner stores to join the program.
- Identify and initiate work with a local organization, Oakland Leaf, to supply program stores with local produce.

Immunization Assessment
- Facilitate ACPHD user access to the California Reportable Disease Information Exchange (CalREDIE) information system as needed.
- Ensure that the information flow from labs to ACPHD disease investigators or disease control staff is smooth and accurate.
- Receive data from the CalREDIE system and put it through filters to create specific daily reports.
- Conduct deduplication activities daily and send reports to ACPHD weekly.

Highlights

Healthy Retail Project

90%

100% of Youth Leaders reported that EOBA's Youth Leadership program has made a **positive impact in their lives** (target: 80%).

- Input immunization data from weekly clinics, seasonal activities, and disease response activities at least weekly.
- Validate syphilis and viral hepatitis data daily to ensure that disease investigators receive accurate and timely information about cases and populations to stop and/or prevent disease transmission.
- Give feedback whenever data quality issues are identified to prevent future inefficiencies or potential errors.

Lotus Bloom

- Recruit 56 parents to attend the monthly meetings to generate ideas and activities for Community Playtime and wellness classes to promote health in their community (target: 40).
- Train three partner organizations in the Physical Movement and Health Food Policy (target: three).
- Train 150 staff and parents to reinforce the Healthy Food Policy to families at four Lotus Bloom sites (target: 100).
- Conduct 12 Zumba, tumbling, exercise/dance, and/or swimming classes to 65 parents and children at Room to Bloom and Lotus Bloom sites (target: 12 classes to 60 parents and children).
- Conduct 12 nutrition classes to 60 parents and children (target: 60).
- Administer seven Saturday Community Playtime events attended by 450 community members to encourage physical activity for children and their families (target: eight events attended by 300 community members).

Mandela MarketPlace

- Distribute outreach materials for Ashland MarketPlace and produce stands to 845 low income Ashland/Cherryland residents (target: 1,000).
- Provide nutrition education at Ashland MarketPlace and produce stands for 170 low income Ashland/Cherryland residents (target: 250).
- Provide 23 hours of technical assistance to the Eden Area Food Alliance on fundraising, leadership development, and program management (target: 25).
- Provide eight hours of technical assistance to the Hayward Task Force to End Hunger & Homelessness on fundraising, leadership development, and program management (target: 25).

MPCAH

- Provide early developmental screening to 99% of enrolled children aged 0–36 months (target: 90%).
- Provide parental depression screens to 99% of pregnant and parenting clients (target: 100%).
- Ensure that 84% of clients served have established a medical home (target: 100%).
- Conduct 50 trainings by the Home Visiting Integration Unit (target: 12).
- Conduct seven quality improvement activities for programs and/or committees (target: 12).

Success Story

Healthy Retail Project

Wah Fay Liquors has been a family-owned business for two decades, currently under the ownership of Kiet Nhan Hoang, aka Mike. It is located in an area many residential neighbors and very few retail businesses. When Mike took over ownership in the late 90s it was a high-crime neighborhood. When the store joined the Healthy Retail project, there wasn't any fresh produce being sold. Currently, they sell more than 900 pieces and $300 worth of produce monthly. The Fresh Cred program allows customers to purchase qualified fruit and vegetables products at a 50% discount. The Healthy Retail nutrition educator runs monthly food demos showcasing recipes.

- Develop, manage, and cofacilitate nine Home Visiting Family Advisory Committee meetings for the Early Childhood Home Visiting/Family Support System of Care (target: 11).

MPCAH Interpreter Services

- Provide 278 onsite interpreter services (target: 275).
- Provide 29 telephonic interpreter services (target: 28).
- Translate seven English materials (brochures, flyers, etc.) into various languages (target: five).

Niroga

- Accept 12 applicants and enroll eight in the Integral Health Fellows (IHF) Teacher Training Program (target: 12 applicants and eight enrollees).
- Conduct yoga and mindfulness classes in the community attended by eight students (target 12).
- Partner with 25 organizations to host IHF classes (target: 25).
- Provide four weekly healing yoga therapy/stress reduction/ meditation classes to four residents of Ashland Place (target: four classes to four residents).
- Host a summer daylong conference on trauma's effects on learning to 108 attendees (target: 100).

Nutrition Services

- Provide nutrition education training and technical assistance to Lotus Bloom staff to promote healthy eating and increase physical activity among 450 preschool age children, their families, and community members (target: 300).
- Provide nutrition education training and technical assistance to EOBA staff to promote healthy eating and increase physical activity among 200 participant youth and their families (target: 200).
- Provide nutrition education and technical assistance to 45 community-based organizations who create community events to provide and encourage healthy eating and beverages for their participant families (target: 35).
- Ensure that 5,250 community members receive nutrition education from Nutrition Services participation in community events (target: 400).
- Provide technical assistance to EOBA to increase access to healthy food to at 1,008 households (target: 1,000).

Project New Start

- Conduct 12 tattoo removal clinics for 66 high risk youth (target: 12 clinics for 60 youth).

Public Health Nursing Healthy Living Project

- Challenge 46 middle school students to improve their food and fitness choices by setting health-related goals and attending classes to learn how to achieve them (target: 40).

Highlights

Niroga Institute

88%

88% of IHF students reported they have **gained knowledge and learned skills to enhance their health and well-being** (target: 70%).

Nutrition Services

90%

90% of Lotus Bloom and EOBA staff who received nutrition education training and technical assistance reported **confidence to make nutrition and wellness improvements at their facility** (target: 90%).

Public Health Prevention Initiative: Emergency Medical Services (EMS) Injury Prevention

ems.acgov.org

FY 17/18 Allocation: **$217,466** | **Expended/Encumbered:** **$217,466**

Individuals served by Measure A: 413 (Total individuals served: 517)

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 falls prevention classes and 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.
- 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.
- 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.

Highlights

City of Fremont Afghan Elderly Association Health Promoter Program

80%

80% of clients whose requests and applications for mental health, health, and medically related services and supplies were submitted **received the requested services and/or supplies** (target: 50%).

- 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. Information is provided to participants on holistic medicine.

Measure A Funding Summary

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

- City of Fremont Afghan Elderly Association Health Promoter Program
  - Provide Health Promoter services to 138 refugee, immigrant, and low income residents over 60 years of age (target: 135).
  - Provide assistance and/or referrals for 155 clients (target: 110).
  - Ensure that 140 clients have a primary physician (target: 110).
  - Assist 92 older adult clients in accessing and receiving an array of mental health, health, and medically related services, including making referrals and applying for services; provided 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 translation services (target: 50).
  - Conduct falls, home safety, mental health, and health screenings for 67 older adults and refer clients to appropriate services as needed (target: 50).
  - Assess or reassess 48 clients regarding their ability to self-manage their chronic conditions (target: 45).
  - Develop 65 Wellness Plans and collaborate with clients to monitor the successful completion of their Wellness Plans (target: 45).
  - Provide health education and chronic condition self-management to 86 clients (target: 50).
  - Provide medication review and/or assistance and education to 70 clients (target: 50).
- DayBreak Adult Day Centers
  - Complete medication safety assessments to 20 participants (target: 40).
- Senior Support Program of the Tri-Valley
  - Provide medication safety services to 40 low income residents 60 or older living in Tri-Valley (target: 38).
- St. Mary's Center
  - Facilitate a 12-week medication safety program for 49 older adults (target: 47).
  - Provide health screenings to 42 participants in the medication safety program (target: 37).
  - Provide 24 medication interaction reports to participants' primary care physicians or pharmacists for further assessment (target: 24).
  - Complete 1,788 weekly medication safety compliance calls (target:

Highlights

Senior Support Program of the Tri-Valley

↑ 76%

76% more clients **disposed of unused/expired medications** compared to program inception (target: 40%).

1,128).
  - Conduct 815 face-to-face medication safety conversations with participants (target: 564).
  - Conduct a 12-week review with 31 participants enrolled in the program (target: 24).
  - Give information and guidance to 42 participants regarding disposal of expired, misused, or unused medication (target: 28).
  - Give nutrition education and exercise encouragement to 50 participants (target: 37).
  - Give medication management assistance devices to 12 participants (target: 24).
- USOAC Medication Education
  - Provide medication safety training to 265 seniors through one-on-one and/or group sessions (target: 150).
  - Outreach to 500 seniors through community sites (target: 250).

Highlights

St. Mary's Center

100%

100% of participants enrolled in the medication safety program reported they used the information they received to **better their medication regimen** (target: 90%).

Public Health Services for Homeless Residents: Abode Services

www.abodeservices.org

FY 17/18 Allocation: $103,500 | Expended/Encumbered: $103,500

Individuals served by Measure A: 353 (Total individuals served: 617)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Fremont, Newark, Union City

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 mediating party in the referral process to other services for individuals who may not be able to navigate services on their own. Navigators work with clients on developing coping skills to enable to them to engage with staff at other agencies.

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

Measure A Funding Summary

Abode Services used its Measure A allocation to achieve the following:

- Provide 294 hours of housing outreach and 477 hours of housing navigation services (target: 1,040 hours of each).
- Provide outreach and engagement services to 364 unduplicated individuals (target: 150).
- Enroll 364 unduplicated individuals in the outreach program (target:

Success Story

A homeless individual presented multiple mental health, physical health, and substance abuse diagnoses, as well as behavioral challenges. Previous attempts to house this individual had been unsuccessful due to these concerns. When the individual spent several months in the ICU due to complications with his health issues, the HOPE Project began building rapport in this stable, secure environment. Upon the individual's discharge, the Housing Navigator navigated him to a skilled nursing facility, then to a board and care, where he continues his recovery and has been working on permanent support housing applications. The Housing Navigator has also provided counseling around basic life skills, as well as coping and harm-reduction skills.

150).

- Performed 294 hours of referral and case management services (target: 312).
- Make 996 outreach contacts with enrolled clients (target: 1,350).
- Distribute 839 hygiene and other supply kits to homeless unsheltered individuals (target: 150).
- Make 3,120 housing navigation contacts with enrolled clients (target: 385).
- Provide housing navigation services for 44 clients from Fremont, Union City, or Newark (target: 20).
- Provide housing navigation services to 31 chronically homeless and high need individuals from Fremont, Union City, or Newark (target: 20).
- Help 22 enrolled clients collect and submit all needed documents for a Home Stretch permanent supportive housing referral (target: 50).
- Make 21 complete referrals to Home Stretch for eligible clients (target: 60).

Highlights

839

The program **distributed 839 hygiene and other supply kits** to homeless unsheltered individuals (target: 150).

Senior Injury Prevention Program

alamedasocialservices.org/staff/departments/adult_and_aging

FY 17/18 Allocation: $119,025 | **Expended/Encumbered: $115,000**

Individuals served by Measure A: 367 (Total individuals served: 367)

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:

- Enhance Fitness. This program is designed to improve the overall functional fitness and well-being of older adults.
- Geri-Fit®. This is a progressive resistance strength program designed to increase strength, flexibility, range of motion, mobility, gait, and balance in older adults.
- Home Meds. This 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.
- Lifestyle-integrated Functional Exercise (LiFE). This physical activity program is designed to improve the overall functional fitness and well-being of older adults.
- 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.

Highlights

1,428

In several areas, the SIPP greatly exceeded its targets. For example, the Tai Chi: Moving for Better Balance program offered **1,428 classes, compared to a target of 476.**

- 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.
- 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.

Measure A Funding Summary

SIPP used its Measure A allocation to provide the following:

- 973 Enhance Fitness sessions to 27 unduplicated participants (target: 1,098 sessions to 28 participants).
- 594 Geri-Fit sessions to 172 unduplicated participants (target: 624 sessions to 13 participants).
- Home Meds medication management to 33 unduplicated consumers (target: 36).
- 18 LiFE sessions to 12 unduplicated participants (target: 15 sessions to 12 participants).
- 122 Matter of Balance classes to 27 unduplicated participants (target: 72 classes to one participant).
- Minor home modifications to 33 unduplicated consumers (target: 25).
- 1,428 Tai Chi: Moving for Better Balance classes to 63 unduplicated participants (target: 476 classes to 38 participants).

Success Story

Doris, a SIPP program participant, recently had hip replacement surgery and previously had knee surgery. Three months after the hip surgery, Doris began coming back to her falls prevention classes at the center. Doris continues to progress in lower and upper body strength, has improved her ability to drive, and has increased her cardiovascular endurance. Doris even picks up a friend with similar health conditions and brings her to and from the classes.

Service Opportunities for Seniors (Meals on Wheels)

sosmow.org

FY 17/18 Allocation: $51,573* | **Expended/Encumbered: $51,573**

Individuals served by Measure A: 471 (Total individuals served: 1,918)

Populations served: Indigent, Low Income, Uninsured Seniors

Services provided: Public Health

Service area: Castro Valley, Oakland, San Lorenzo

**Includes Board of Supervisors discretionary allocations from*
District 3/Supervisor Chan, District 4/Supervisor Miley, and District 5/Supervisor Carson

Background

Service Opportunity for Seniors (SOS) Meals on Wheels promotes nutritional health, decreases the possibility of premature institutionalization, and fosters the independence and dignity of homebound seniors in Central Alameda County and the City of Oakland.

SOS Meals on Wheels targets low income seniors who are age 60 and older, homebound, alone, or recently discharged from the hospital, or who have a physical or mental impairment. The program enables seniors to afford living in their home on a fixed monthly income while getting nutrition and a daily check from the driver who delivers their meal. SOS Meals on Wheels provides the senior with a sense of independence to live in their home for as long as they can.

Measure A Funding Summary

SOS Meals on Wheels used its Measure A allocation to deliver 25,261 meals to 471 unduplicated seniors (target: 21,000 meals to 40 seniors).

Highlights

94%

94% of seniors said that receiving the Meals on Wheels service **improved their health and overall living situation** (target: 75%).

Spectrum Community Services, Inc.

spectrumcs.org

FY 17/18 Allocation: **$20,000*** | **Expended/Encumbered:** **$20,000**

Individuals served by Measure A: 127 (Total individuals served: 885)

Populations served: Indigent, Low Income Seniors

Services provided: Hospital Outpatient, Public Health

Service area: Fremont, Hayward, Union City

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

Background

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

Spectrum's Fall Prevention 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 Enhance Fitness exercise class, which included 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.

Measure A Funding Summary

The Spectrum Fall Prevention program used its Measure A allocation to achieve the following:

- Provide 45 Enhance Fitness classes (target: 45).
- Conduct 90 fitness assessments (target: 180).
- Provide 28 weekly fall prevention education tips (target: 48).
- Conduct four fall prevention workshops (target: four).

Highlights

82-87%

82-87% of participants **maintained or improved arm strength, leg strength, and dynamic balance and agility** from the beginning of the classes (target: 80%).

UCSF Benioff Children's Hospital Oakland Brilliant Baby Program

www.findconnect.org

FY 17/18 Allocation: **$180,000** | **Expended/Encumbered:** **$180,000**

Individuals served by Measure A: 266 (Total individuals served: 532)

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

Services provided: Hospital Outpatient, Public Health, Mental Health

Service area: Berkeley, Oakland

Background

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

Health outcomes are determined 10% by access to care, 10% by quality of care, and 80% by other social and environmental factors that are not typically addressed, including basic needs and adverse events. Research shows that severe, chronic stress can become toxic to developing brains and biological systems when a person suffers significant adverse childhood experiences, such as poverty, abuse, neglect, neighborhood violence, or the substance abuse or mental illness of a caregiver. The cumulative effect of this stress response increases the likelihood of developmental delays, learning disabilities, and behavior problems, in addition to diabetes, heart disease, depression, drug abuse, alcoholism, and other major health problems later in life.

To address this, Measure A funding supported two closely connected BHCO programs:

- The Family Information and Navigation Desk, or FIND, helps identify and resolve social determinants of health for its patients. About 95% of the patients have Medi-Cal, and many of them have basic social, economic, and environmental needs that are impacting their health. Examples include lack of food or shelter, exposure to drugs or violence, lack of a safe place to spend outdoors, landlord and housing issues, and more. These social determinants of health have a major influence on one's health but are not traditionally addressed in clinical care due to lack of time, training, reimbursement, and resources. FIND is a tool that makes it feasible to address these social determinants by automating screening for basic needs and adverse events, identifying the top three priorities for families, automatically pulling up relevant resources from a comprehensive database of services in their area, and automating the creation of an action plan.

Matching Funds

$54,000

from **the Oakland Ed Fund.**

Highlights

100%

100% of families in FIND received **one or more referrals to specific resources to address their needs** (target: 90%).

Of all families, 44% screened positive for needing outdoor activities, 19% for food insecurity, 14% in need of diapers, 13% with housing instability, 9% for child development concerns, 5% for utility support, and 1% for legal services.

- One of the top referral destinations of FIND is to the Brilliant Baby program, which works to improve the healthy development and educational trajectory of babies born into economically distressed families. The program establishes college savings accounts for babies born in Oakland into families living in poverty and offers financial coaching to parents and guardians. The financial services help parents improve their family's material financial well-being, reduce toxic financial stressors, and increase bandwidth for parenting. By focusing parents of new babies on their child's future academic success, college savings accounts from infancy change expectations about college and help break the generational poverty cycle.

Measure A Funding Summary

The FIND and Brilliant Baby programs used their Measure A allocation to achieve the following:

- Refer 58 families per month to FIND (target: 50).
- Enroll 44 families per month families in FIND (target: 40).
- Assess/screen 44 families per month (target: 40).
- Provide one or more referrals to 43 families per month (target: 36).
- Refer seven families per month from FIND to Brilliant Baby (target: 15).
- Have seven referred families per month enroll in Brilliant Baby (target: 15).
- Provide financial coaching to two families per month who enrolled in Brilliant Baby (target: three).

Success Story

Yabnely Lara and her husband have a daughter in elementary school and a toddler son. When her son was an infant, the family was screened for basic needs at BHCO and referred to FIND. The health navigator helped the family identify their top needs and appropriate resources, which included a medical-legal partnership and Brilliant Baby. Yabnely attended Brilliant Baby workshops in financial literacy and parent leadership. She also completed six one-on-one financial coaching sessions. She has saved money and feels assured about her son's education. Knowing that he has $500 to begin his college experience motivates her to save additional funds for his education.

West Oakland Health Council Optometry Clinic

FY 17/18 Allocation: **$500,000** | **Expended/Encumbered:** **$500,000**

Individuals served by Measure A: 1,172 (Total individuals served: 1,172)

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

Services provided: Public Health

Service area: Oakland, Homeless or transient

Background

The West Oakland Health Council (WOHC) works to improve the health and socio-economic status of the community by providing the highest quality preventive care and treatment for diverse neighbors throughout the East Bay. Services provided include primary care; medical and dental; behavioral health; Women, Infants, and Children (WIC); substance abuse services; and community outreach and case management.

Many of the low income residents in the WOHC service area have diabetes and no way to get the retinopathy screenings that they need. Additionally, many of the homeless persons living in the encampments around Oakland have had their eyeglasses broken or stolen. For them, having medical eye exams available along with access to low cost glasses is a giant step forward that allows them to read and see as they strive to put their lives back together and move toward getting a job.

Measure A Funding Summary

WOHC used its Measure A funds to create an entirely new Optometry department with state-of-the-art diagnostic equipment. The new Optometry department includes three exam rooms and the ability to screen diabetics with medical eye exams for retinopathy.

Youth and Family Opportunity Initiatives

achealthyschools.org

FY 17/18 Allocation: **$2,646,576** | **Expended/Encumbered:** **$2,646,576**

Individuals served by Measure A: 17,853 (Total individuals served: 17,853)

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

Services provided: Public Heath, 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.

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

The YFO organizations provide services focusing on mental health, public health, alcohol and drugs, and youth and community. Additional areas of emphasis for YFO organizations in FY 17/18 included the following:

- Staff wellness. Staff wellness and secondary trauma are significant issues for the YFOs. CHSC provided a workshop on building cultures of healing and care that looked at both individual self-care and how organizations can build staff wellness practices into their policies and practices.
- Expanding father-friendly and father-specific services. The Fatherhood Initiative and Fathers Corps led a presentation and dialogue that led to more father-friendly spaces and materials, and to partnerships that brought Café Dad and other father-specific workshops to South County. It also led to three of the YFOs joining the Fatherhood Partnership expansion cohort.
- Exploring data collection and usage to improve services. CHSC introduced the YFOs to a resource for choosing and designing databases and provided a demonstration of a data visualization tool that can be used for case management and improving access to resources.

The organizations involved in the YFO initiative include the following:

- Alameda Family Services (AFS).
- Alternatives in Action (AIA).

Highlights

93%

93% of youth and families felt they now **have places to go for health and wellness services** (target: 85%).

Matching Funds

$2.6M

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**
- **City funding**
- **Individual donors**

- 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 (AYC).
- Tri-Valley Health Initiative.
- Union City Kid Zone (UCKZ).
- Youth Radio.

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

- 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 a full continuum of cultural-responsive health and wellness supports through a myriad of partnerships.
- 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, and referrals to HUSD youth and their families.
- NUSD provides health access and family support services, primarily through workshops and referrals to partner organizations.
- REACH AYC 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 immunizations and physical, dental, and vision health screenings 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

Success Story

Youth Radio

A young person who identifies as gender nonbinary approached one of the case managers for guidance about whether to begin hormone therapy and for help with getting their family 's support. The case manager supported them in making healthy choices and establishing a long-term goal related to their identity. As a result, this young person began working with a gender therapist and obtained support from their family, including consent to begin hormone blockers. The student has been on hormones for about three months and feels very positively about that choice. They still meet with the case manager, who continues to support them in advocating for themselves and making healthy choices.

management, behavioral health services, healthy food, and individual mentoring.

Measure A Funding Summary

YFO used its Measure A allocation to achieve the following:

- Hold 81 community events focused on raising awareness of free and affordable health care services. Events ranged from outreach and information sharing at fairs and tabling, to large events such as holiday food giveaways or shootouts for non-violence, to smaller events such as one-time workshops or parent cafés (target: 60-70 events).
- Make 25,779 contacts at these events (target: 20,000).
- Provide application assistance onsite to enroll in Medi-Cal, HealthPAC, or Covered California coverage to 410 families (target: 350-400 families).
- Ensure that 481 families receiving application assistance onsite enroll in CalFresh, CalWORKs, or other public benefits (target: 350-400 families).
- Provide information about health insurance and benefits eligibility and/or referrals directly to an offsite location for application assistance to 3,600 families (target: 3,000).
- Host three Tri-Valley community health fairs in Livermore, Dublin, and Pleasanton involving 30 organizations and serving 500 children and families (target: 450).
- At the community health fairs, provide the following services:
  - 74 physicals.
  - 11 immunizations: DTaP, MMR, VZ, IPV, Hep B.
  - 196 dental screenings.
  - 179 vision screenings.
  - 64 hearing screenings.
  - 12 concussion baseline screenings.
  - 136 adult blood pressure and sugar screenings.
  - Health education on breast cancer and diabetes to 150 participants.
- Provide medical, dental, health education, and behavioral health services for 1,177 youth at the REACH AYC onsite health center (target; 1,100).
- Provide care coordination, individual and group counseling, case management, and behavioral health services to 689 through Coordination of Service Teams (target: 500).
- Offer health and wellness workshops focused on health education and healthy lifestyle choices, with topics including alcohol and other drug prevention, gender-based identity development, pregnancy and STI prevention, social skills, and nutrition to 2,430 youth (target: 2,000).

Highlights

88%

88% of youth felt 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** (target: 85%).

93%

93% of families felt that the YFO program helped **build their resiliency factors, specifically connectedness with the school and/or a stronger network of support** (target: 85%).

- Provide leadership development activities that increase resiliency by focusing on personal growth, health and wellness, leadership, and life skills to 433 youth.
- Offers arts and enrichment activities that increase resiliency and social-emotional well-being to 783 youth.
- Provide college and career supports to 283 youth.
- Offer support with chronic attendance issues, primarily through home visits and referrals, to 254 youth.
- Provide college and career readiness activities to 483 youth.
- Provide digital media training to 905 youth.
- Obtain paid internships for 318 youth.
- Provide a range of health and wellness services to families in school-based and community-based, school-linked settings, including the following:
  - Case management to 2,539 parents/caregivers.
  - Crisis intervention, including basic needs support, to 752 parents/ caregivers.
  - Individual counseling to 72 parents/caregivers.
  - Family support groups to 196 participants.
  - Home visits with resource referrals to 116 families.
- Offer health and wellness workshops focused on health education and healthy lifestyle choices, with topics including nutrition, mental health and child/youth development, and positive parenting to 265 parents/ caregivers.
- Offer leadership development activities that increase resiliency and ability to support their children's healthy development and success to 299 parents/ caregivers.
- Offer career readiness classes to 200 participants.
- Offer school-based engagement efforts to 154 participants.

Success Story

AIA

A 16-year-old student lived with his father, who had sole parental custody. The mother came onto the school campus to add her name and contact to the student 's emergency card, which was considered a breach in trust between the student 's parents. As a result, the father took visitation away from the mother, and the young man ran away. The AIA Family Coordinator had a strong relationship with the student and knew both of the parents. She checked in with the student and provided support, including meeting with the student and his father to assist with family mediation. The student returned home and began attending counseling with the father.

Youth UpRising

youthuprising.org

FY 17/18 Allocation: **$50,000** | **Expended/Encumbered:** **$50,000**

Individuals served by Measure A: 83 (Total individuals served: 4,253)

Populations served: : Children

Services provided: Mental Health

Service area: Oakland

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.

YU provides support to students who have behavioral challenges in the classroom setting by teaching coping skills and self-regulation as well as providing skills to the teachers to better manage the youth. Students benefit from fewer long-term classroom disruptions due to having a space to receive support and skills rather than detention or suspension.

Measure A Funding Summary

YU used its Measure A allocation to achieve the following:

- Provide 35 behavioral health consultation meetings to teachers/ instructional staff as an integrated, consistent component of instructional staff professional development (target: nine).
- Collect 42 professional development evaluations from teachers/ instructional staff (target: 35).
- Provide 14 hours of Direct Behavioral Therapy (DBT) trainings for teachers/instructional staff and clinicians (target: 14).
- Make 36 referrals to needed services (target: 25).
- Provide 567 individual behavioral health interventions totaling 703 hours designed to reduce the time students spend out of class to 83 students (target: 350 interventions totaling 400 hours to 45 students).
- Send 141 information sheets home to the parents of 74% of students (target: 25 sheets to parents of 65% of students).

Highlights

100%

100% of participants reported they are able to use DBT skills learned in the training to **support students and young clients and teach the emotional regulation methods outlined in the model** (target: 70%).

↑ 96%

Student time in class increased by 96%, as reported by school leaders and teachers (target: 50%).

APPENDICES

APPENDIX A: Measure A Revenue Received

APPENDIX B: FY 17/18 Budget Information

APPENDIX C: FY 17/18 Measure A Fund Distribution by Provider or Program

APPENDIX D: Maps: Geographic Distribution of Providers Funded by Measure A in FY 17/18

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-Based Health Centers

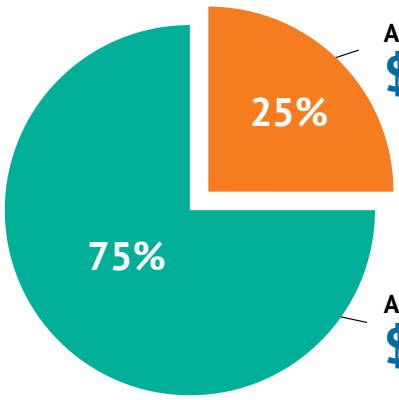
Map 5 HealthPAC Provider Network

APPENDIX A

Measure A Revenue Received

FY 04/05 through FY 17/18

TOTAL REVENUE EARNED (FY 04/05 THROUGH FY 17/18)

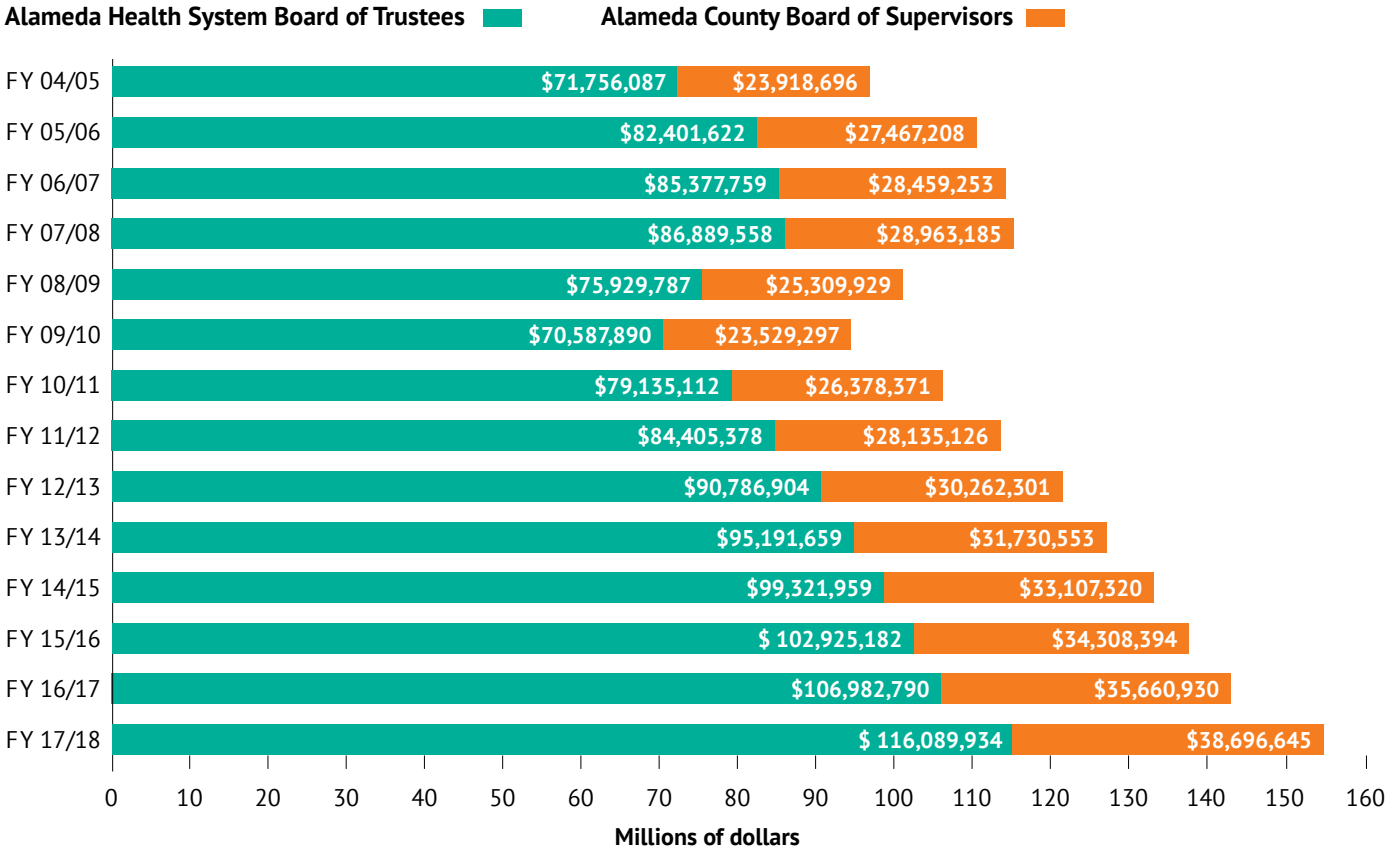


Alameda County Board of Supervisors
$466 MILLION

Alameda Health System Board of Trustees
$1,390 MILLION

$1.85 BILLION

REVENUE EARNED EACH FISCAL YEAR (FY 04/05 THROUGH FY 17/18)



APPENDIX B: FY 17/18 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)	801,571	0	801,571	614,017	0	614,017	187,554
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	630,045	0	630,045	630,045	0	630,045	0
Cherry Hill Detoxification and Sobering Center[4]	2,218,237	32,625	2,250,862	2,004,835	246,027	2,250,862	0
Criminal Justice Screening and In-Custody Services	4,306,000	0	4,306,000	4,306,000	0	4,306,000	0
Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services	170,674	0	170,674	170,674	0	170,674	0
La Familia Counseling Service (Glad Tidings)	20,000	0	20,000	20,000	0	20,000	0
Mental Health Services for Juvenile Justice Center	360,000	0	360,000	360,000	0	360,000	0
Mental Health Services for Newcomers and Immigrants: Center for Empowering Refugees and Immigrants (CERI)	83,184	0	83,184	83,184	0	83,184	0
Group 2: Hospital, Tertiary Care, Other							
St. Rose Hospital[1,5]	7,000,000	0	7,000,000	4,000,000	3,000,000	7,000,000	0
UCSF Benioff Children's Hospital Oakland	2,000,000	0	2,000,000	1,500,000	500,000	2,000,000	0
Group 3: Primary Care							
Alameda County Dental Health	257,580	30,000	287,580	157,580	130,000	287,580	0
Alameda Health Consortium Community Health Worker Fellowship Program	175,000	0	175,000	175,000	0	175,000	0
Center for Elders' Independence	55,456	0	55,456	55,456	0	55,456	0
Center for Healthy Schools and Communities (School Health Centers)	2,003,400	0	2,003,400	2,003,398	0	2,003,398	2
Connecting Kids to Coverage (CKC) Initiative	209,613	0	209,613	209,613	0	209,613	0
Direct Medical and Support Services (Oakland): Preventive Care Pathways	221,823	0	221,823	221,823	0	221,823	0
Fremont Aging & Family Services	55,456	0	55,456	55,456	0	55,456	0
Health Enrollment for Children	300,000	0	300,000	300,000	0	300,000	0
Health Services for Day Laborers	274,154	0	274,154	184,854	0	184,854	89,300
Medical Costs for Juvenile Justice Center	508,876	0	508,876	407,927	0	407,927	100,949
Primary Care Community-Based Organizations	5,558,461	0	5,558,461	5,543,556	0	5,543,556	14,905

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.	110,912	0	110,912	110,912	0	110,912	0
Alameda County Asthma Start	100,000	0	100,000	100,000	0	100,000	0
Center for Early Intervention on Deafness	55,456	0	55,456	55,456	0	55,456	0
City of Alameda (Community Paramedicine)	185,000	0	185,000	185,000	0	185,000	0
City of San Leandro	55,456	0	55,456	55,456	0	55,456	0
Countywide Plan for Seniors (Getting the Most Out of Life)	250,000	96,421	346,421	191,633	154,788	346,421	0
Countywide Plan for Seniors (Home-Based Nursing Care Management)	500,000	0	500,000	498,738	0	498,738	1,262
Countywide Plan for Seniors (Injury Prevention, Meals, Nutrition)	773,100	47,631	820,731	751,835	68,896	820,731	0
EMS Corps	606,342	0	606,342	606,342	0	606,342	0
EMS Ambulance Providers to Serve 5150 indigent population	3,000,000	0	3,000,000	270,000	2,730,000	3,000,000	0
Healthy Homes Department: Fixing to Stay & Group Living Facilities Project	311,511	0	311,511	230,440	81,071	311,511	0
Health Services for Persons Who Inject Drugs: HIV Education & Prevention Project of Alameda County	155,250	0	155,250	152,092	0	152,092	3,158
HIV Education & Prevention Project of Alameda County: OPEND Project	150,000	0	150,000	150,000	0	150,000	0
Home Visiting Services[1]	3,282,466	371,432	3,653,898	1,380,998	2,272,900	3,653,898	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 Services for Pacific Islanders	250,000	0	250,000	5,885	244,115	250,000	0
Public Health Prevention Initiative	3,000,357	0	3,000,357	2,988,697	0	2,988,697	11,660
Public Health Prevention Initiative (EMS Injury Prevention)	217,466	0	217,466	217,466	0	217,466	0
Public Health Services for Homeless Residents: Abode Services	103,500	0	103,500	103,500	0	103,500	0
Senior Injury Prevention Program	119,025	0	119,025	115,000	0	115,000	4,025
UCSF Benioff Children's Hospital Oakland Brilliant Baby Program	180,000	0	180,000	130,560	0	130,560	49,440
West Oakland Health Council's Optometry Clinic	500,000	0	500,000	500,000	0	500,000	0
Youth and Family Opportunity Initiatives[1]	2,646,576	17,080	2,663,656	2,646,576	17,080	2,663,656	0
Youth UpRising	50,000	0	50,000	50,000	0	50,000	0
Board of Supervisors[1]	750,000	586,997	1,336,997	419,755	905,424	1,325,179	11,818
TOTAL FY 17/18[3]	**44,686,948**	**1,182,186**	**45,869,134**	**35,044,759**	**10,350,301**	**45,395,060**	**474,074**

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 17/18.
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.
5. St. Rose Hospital's allocation partially includes a Board-approved reallocation of $500,000 from the Cherry Hill Detoxification and Sobering Center's unspent roll-forward balance.

APPENDIX C:
FY 17/18 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

GROUP 1: BEHAVIORAL HEALTH	MEASURE A ALLOCATION FY 17/18	EXPENDED/ ENCUMBERED FY 17/18
Alameda County Behavioral Health Care Services (BHCS) Community-Based Organizations (CBOs)		
Alameda County Mental Health Association	38,816	11,099
Alameda Family Services	8,866	8,866
Asian Health Services, Inc.	9,911	0
Axis Community Health, Inc.	6,483	6,483
Berkeley Addiction Treatment Services, Inc.	5,312	0
Bi-Bett Corporation	2,506	826
Bonita House, Inc.	59,237	59,237
Building Opportunities for Self-Sufficiency (BOSS)	32,773	22,978
Carnales Unidos Reformando Adictos, Inc.	37,978	37,978
Center for Independent Living	2,539	2,538
Crisis Support Services of Alameda County	34,278	0
East Bay Community Recovery Project	35,276	35,276
Filipino Advocates for Justice	18,608	18,608
Horizon Services, Inc.	12,672	1,787
Humanistic Alternatives to Addiction	2,409	12,672
Institute for the Advanced Study of Black Family Life & Culture	77,871	52,032
Magnolia Women's Recovery Programs, Inc.	11,413	11,413
Native American Health Center, Inc.	29,773	20,464
New Bridge Foundation, Inc.	39,973	39,973
Second Chance, Inc.	83,870	83,870
Senior Support Program of the Tri-Valley	39,229	39,229
Southern Alameda County Comite for Raza	53,067	8,080
Southern Alameda County Comite for Raza	65,346	65,346
St Mary's Center	43,988	40,584
Thunder Road Adolescent Treatment	8,929	0
Uplift Family Services	37,217	34,677
Unallocated	3,231	0
Total Allocation	**801,571**	**614,017**
Center for Empowering Refugees and Immigrants (CERI)	**83,184**	**83,184**
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)		
Emery Unified School District	38,819	38,819
Hume Center	138,640	138,640
Other Program Expenses	452,586	452,586
Total Allocation	**630,045**	**630,045**
Cherry Hill Detoxification and Sobering Center	**2,218,237**	**768,596**
Criminal Justice Screening and In-Custody Services	**4,306,000**	**4,306,000**
Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services	**170,674**	**170,674**
La Familia Counseling Service	**50,000**	**50,000**

GROUP 1: BEHAVIORAL HEALTH	MEASURE A ALLOCATION FY 17/18	EXPENDED/ ENCUMBERED FY 17/18
Mental Health Services for Juvenile Justice Center	**360,000**	**360,000**
Safe Alternatives to Violent Environments (SAVE)	**20,000**	**20,000**
Senior Support Program of Tri-Valley	**45,000**	**45,000**

GROUP 2: HOSPITAL, TERTIARY CARE, OTHER	MEASURE A ALLOCATION FY 17/18	EXPENDED/ ENCUMBERED FY 17/18
St. Rose Hospital	**7,000,000**	**4,000,000**
UCSF Benioff Children's Hospital Oakland	**2,000,000**	**1,500,000**

GROUP 3: PRIMARY CARE	MEASURE A ALLOCATION FY 17/18	EXPENDED/ ENCUMBERED FY 17/18
Alameda County Dental Health	**257,580**	**157,580**
Alameda Health Consortium Community Health Worker Fellowship Program	**175,000**	**175,000**
Center for Elders' Independence	**55,456**	**55,456**
Center for Healthy Schools and Communities (School Health Centers)		
Alameda Family Services	210,732	210,732
City of Berkeley	173,746	173,746
East Bay Agency for Children	53,648	53,648
East Bay Asian Youth Center	53,648	53,648
La Clinica de La Raza, Inc.	287,595	287,595
LifeLong Medical Center	117,473	117,473
Seneca Family of Agencies	49,910	49,910
Tiburcio Vasquez Health Center	227,369	227,369
UCSF Benioff Children's Hospital Oakland	107,296	107,296
Other Program Expenses	721,983	721,981
Total Allocation	**2,003,400**	**2,003,398**
Connecting Kids to Coverage (CKC) Initiative	**209,613**	**209,613**
Direct Medical and Support Services (Oakland): Preventive Care Pathways	**221,823**	**221,823**
Fremont Aging & Family Services	**55,456**	**55,456**
Health Enrollment for Children	**300,000**	**300,000**
Health Services for Day Laborers		
Health Services for Day Laborers: Multicultural Institute	92,427	92,427
Health Services for Day Laborers: Street Level Health Project	92,427	92,427
Unallocated	89,300	0
Total Allocation	**274,154**	**184,854**
Medical Costs for Juvenile Justice Services		
Medical Costs for Juvenile Justice Center: Direct Service Planning and Administration	261,000	215,411
Medical Costs for Juvenile Justice Center: Niroga Institute	86,137	86,137
Medical Costs for Juvenile Justice Center: Victims of Crime	90,000	82,125
Unallocated	71,739	0
Total Allocation	**508,876**	**383,673**

GROUP 3: PRIMARY CARE	MEASURE A ALLOCATION FY 17/18	EXPENDED/ ENCUMBERED FY 17/18
Primary Care Community-Based Organizations		
Alameda Health Consortium:		
Asian Health Services	589,874	589,874
AXIS Community Health Center	616,715	616,715
Davis Street Family Resource Center	103,500	0
La Clínica de La Raza	1,735,573	1,735,573
LifeLong Medical Center	670,532	670,532
Native American Health Center	260,115	260,115
Tiburcio Vasquez Health Center	840,456	840,456
Tri-City Health Center	571,501	571,501
West Oakland Health Council	170,193	170,193
Unallocated	2	0
Total Allocation	**5,558,461**	**5,454,959**
Tiburcio Vasquez	**60,000**	**60,000**

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 17/18	EXPENDED/ ENCUMBERED FY 17/18
ACCMA (Alameda Contra Costa Medical Association) Community Foundation	**20,000**	**20,000**
Alameda Boys & Girls Club, Inc.	**110,912**	**110,912**
ALL IN- Healthy Food, Healthy Families	**100,000**	**88,182**
Alameda County Asthma Start	**100,000**	**100,000**
Center for Early Intervention on Deafness	**55,456**	**55,456**
City of Alameda (Community Paramedicine Services)	**185,000**	**185,000**
City of San Leandro Senior Services	**55,456**	**55,456**
Countywide Plan for Seniors (Getting the Most Out of Life)	**250,000**	**191,633**
Countywide Plan for Seniors (Home-Based Nursing Case Management)	**500,000**	**498,738**
Countywide Plan for Seniors (Injury Prevention, Meals, Nutrition)	**773,100**	**751,835**
Eden Youth and Family Center	**20,000**	**20,000**
EMS Corps		
Berkeley Youth Alternatives (BYA)	41,400	41,400
Other Program Expenses	564,942	564,942
Total Allocation	**606,342**	**606,342**
EMS Ambulance Providers to Serve 5150 Indigent Population	**3,000,000**	**270,000**
Healthy Homes Department: Fixing to Stay & Group Living Facilities Project	**311,511**	**230,440**
Health Services for Persons Who Inject Drugs: HIV Education and Prevention Project of Alameda County	**155,250**	**152,092**
HIV Education and Prevention Project of Alameda County: OPEND Project	**150,000**	**150,000**
Home Visiting Services	**3,282,466**	**1,380,998**
Life ElderCare	**20,000**	**20,000**
LifeLong Medical Care: Heart 2 Heart	**100,000**	**100,000**
Love Never Fails	**20,000**	**20,000**

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 17/18	EXPENDED/ ENCUMBERED FY 17/18
Nutrition Services in West Oakland: City Slickers Farm	**50,000**	**50,000**
Public Health Services for Pacific Islanders	**250,000**	**5,885**
Public Health Prevention Initiative		
CAL-PEP Inc.	50,266	50,266
Center for Oral Health	146,970	151,970
City of Berkeley	187,164	187,164
East Oakland Boxing Association	54,369	54,369
HIV Education and Prevention Project of Alameda County	45,695	45,695
Lotus Bloom	35,340	35,340
Mandela Partners	43,495	43,495
Mandela Partners	82,800	82,800
Native American Health Center	153,150	0
Niroga Institute, Inc.	53,583	53,583
Tides Center (Hope Collaborative)	82,800	82,800
Subtotal Program Expenses	935,632	787,482
Other Program Expenses	2,064,725	2,201,215
Total Allocation	**3,000,357**	**2,988,697**
Public Health Prevention Initiative: EMS Injury Prevention	**217,466**	**217,466**
Public Health Services for Homeless Residents: Abode Services	**103,500**	**103,500**
Senior Injury Prevention Program	**119,025**	**115,000**
Service Opportunity for Seniors (Meals on Wheels)	**51,573**	**51,573**
Spectrum Community Services, Inc.	**20,000**	**20,000**
UCSF Benioff Children's Hospital Oakland Brilliant Baby Program	**180,000**	**130,560**
West Oakland Health Council's Optometry Clinic	**500,000**	**500,000**
Youth and Family Opportunity Initiatives		
Alameda Family Services	110,912	110,912
Alternatives in Action (AIA)	277,280	277,280
Berkeley Youth Alternatives (BYA)	110,912	110,912
City of Fremont	166,368	166,368
East Bay Agency for Children for CKC	82,800	82,800
East Bay Asian Youth Center (EBAYC)	110,912	110,912
Fremont Unified School District	110,912	110,912
La Clinica de la Raza	117,473	117,473
Livermore Unified School District	18,485	18,485
Newark Unified School District	110,912	110,912
New Haven Unified School District	110,912	110,912
Pleasanton Unified School District	18,485	18,485
Southern Alameda County Comite for Raza dba La Familia Counseling Services	166,368	166,368
Youth Radio	110,912	110,912
Other Program Expenses	1,022,933	1,022,933
Total Allocation	**2,646,576**	**2,646,576**
Youth UpRising	**50,000**	**50,000**

APPENDIX D

MAPS: GEOGRAPHIC DISTRIBUTION OF PROVIDERS FUNDED BY MEASURE A IN FY 17/18

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-Based Health Centers

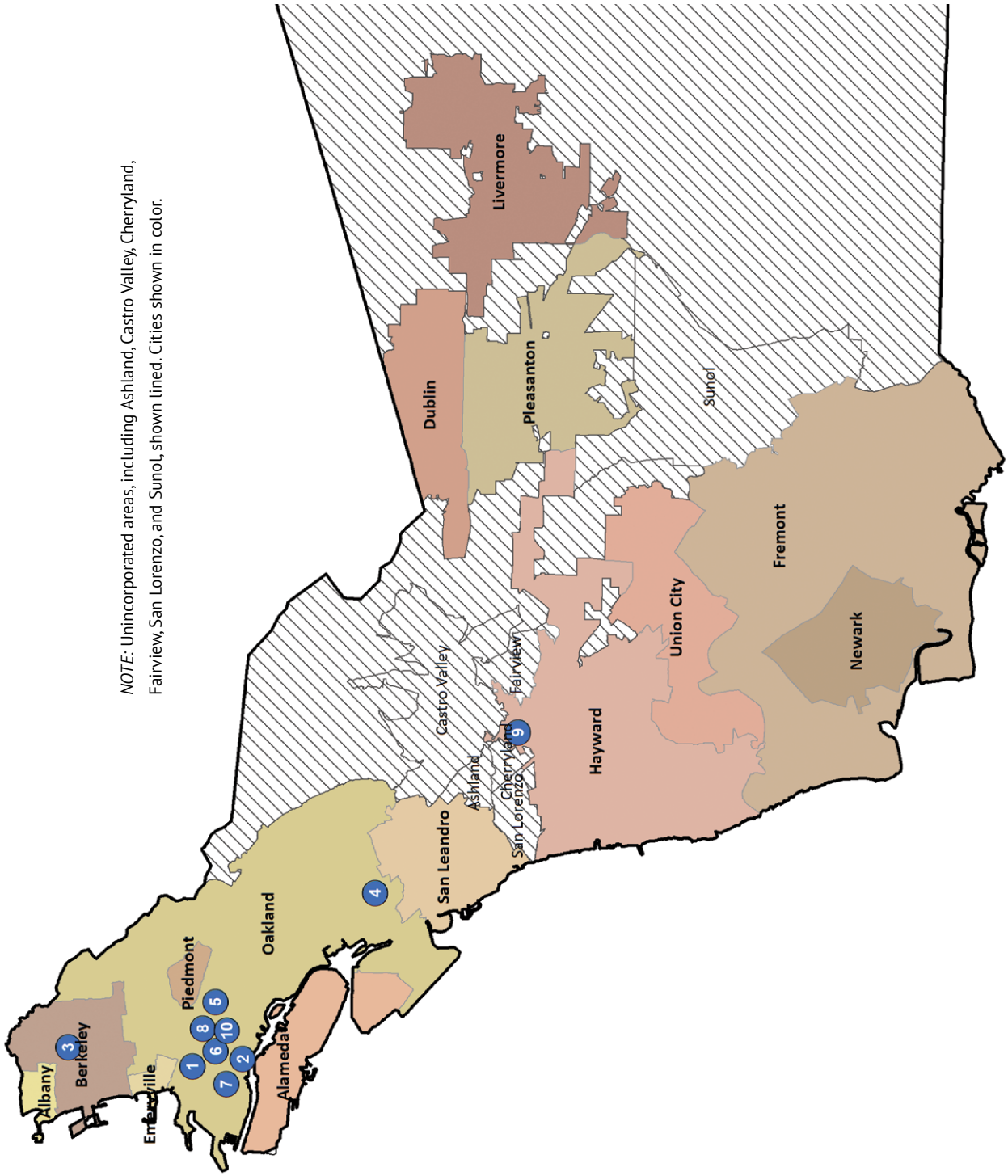
Map 5 HealthPAC Provider Network

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS FUNDED BY MEASURE A IN FY 17/18

#	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	Oakland
7	International Contact	Berkeley

#	PROVIDER	CITY
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 17/18

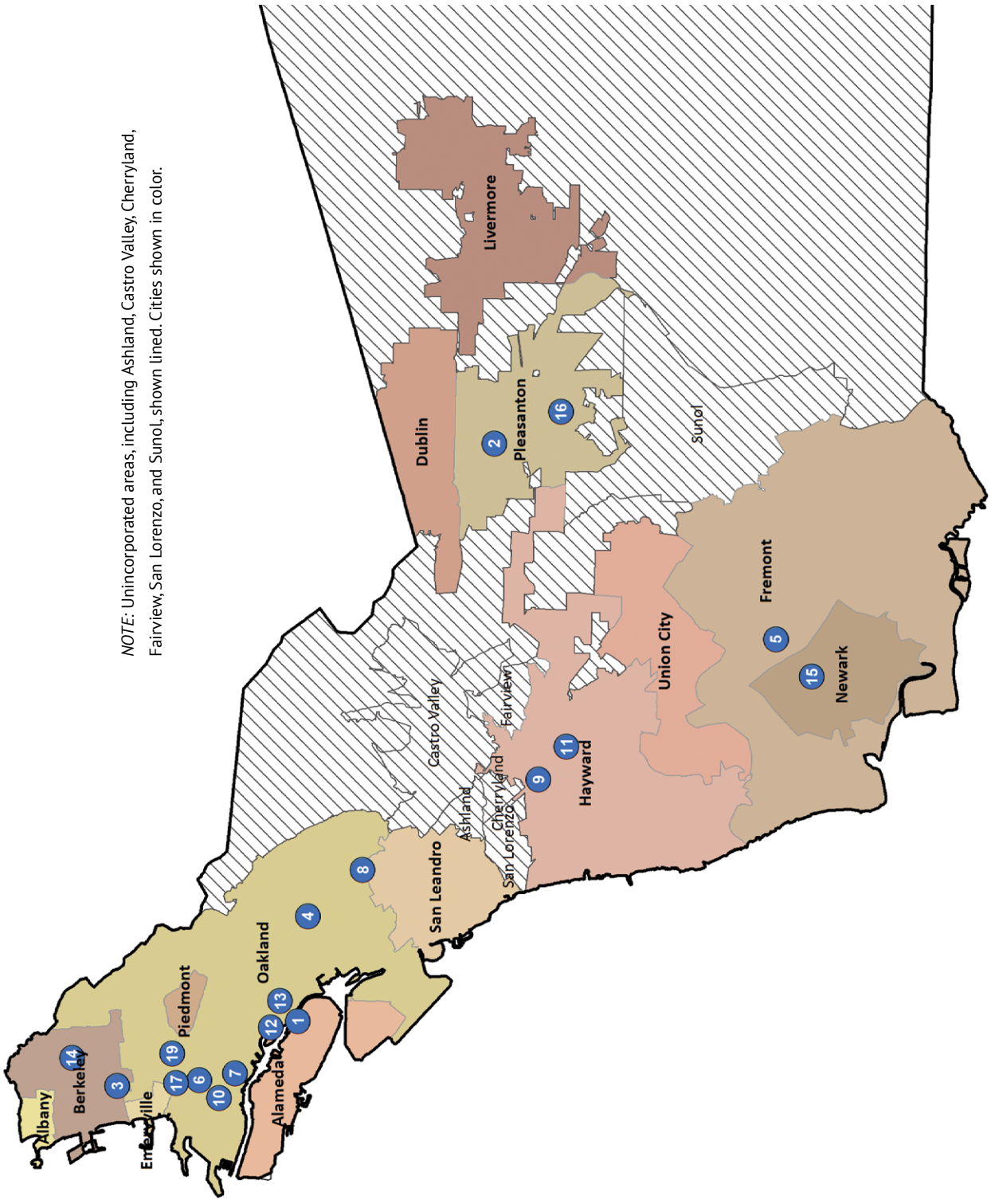


NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES ALCOHOL AND OTHER DRUG PROVIDERS FUNDED BY MEASURE A IN FY 17/18

#	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 & 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 17/18

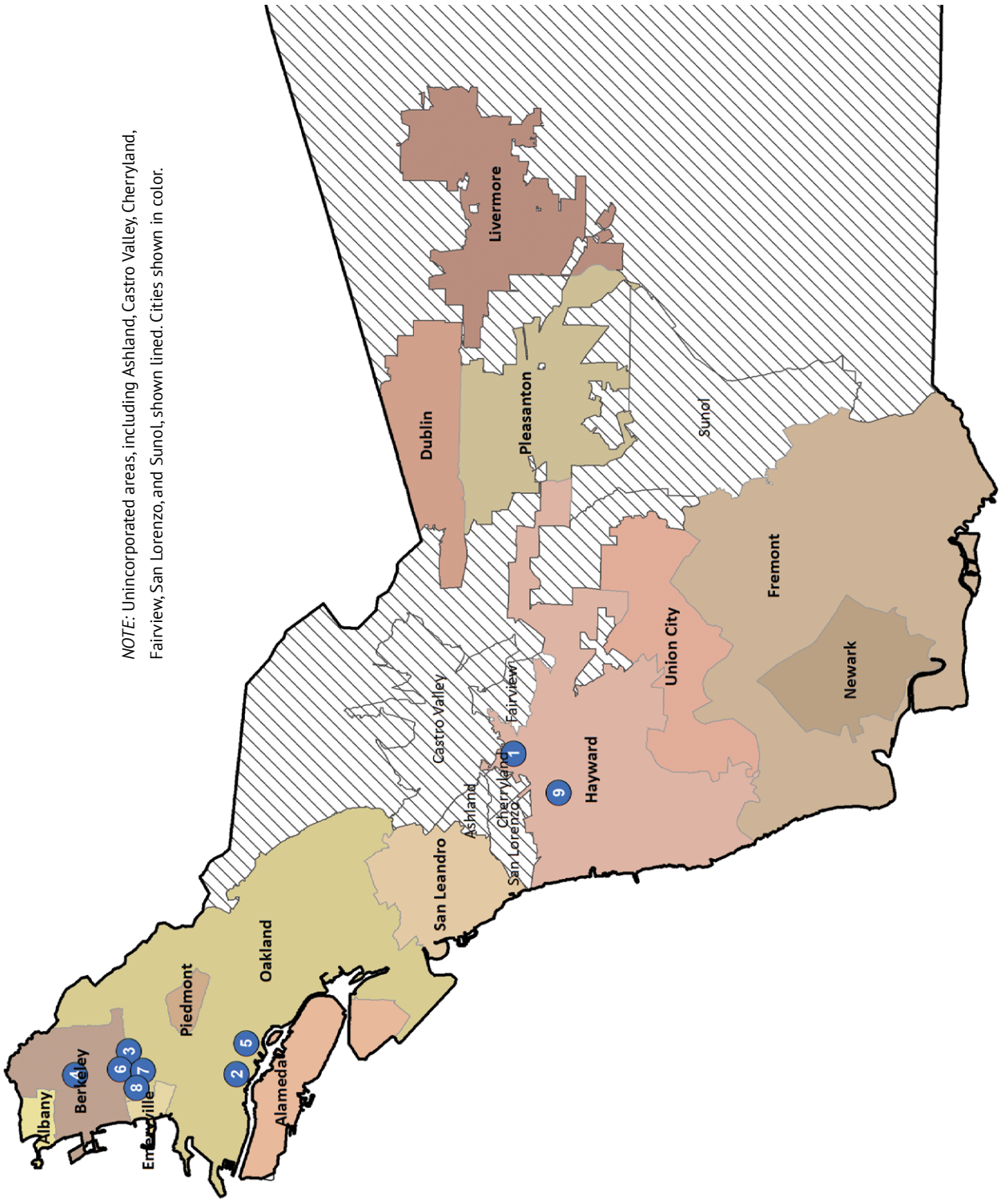


NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 17/18

#	PROVIDER	CITY
1	Alameda County Mental Health Association	Oakland
2	Asian Community Mental Health Services	Oakland
3	Bonita House, Inc.	Berkeley
4	Building Opportunities for Self-Sufficiency	Oakland
5	Center for Independent Living	Berkeley
6	Center for Independent Living	Oakland
7	Crisis Suppport Services of Alameda County	Oakland
8	Southern Alameda County Commitee for Raza (La Familia Counseling Service)	Hayward

MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 17/18



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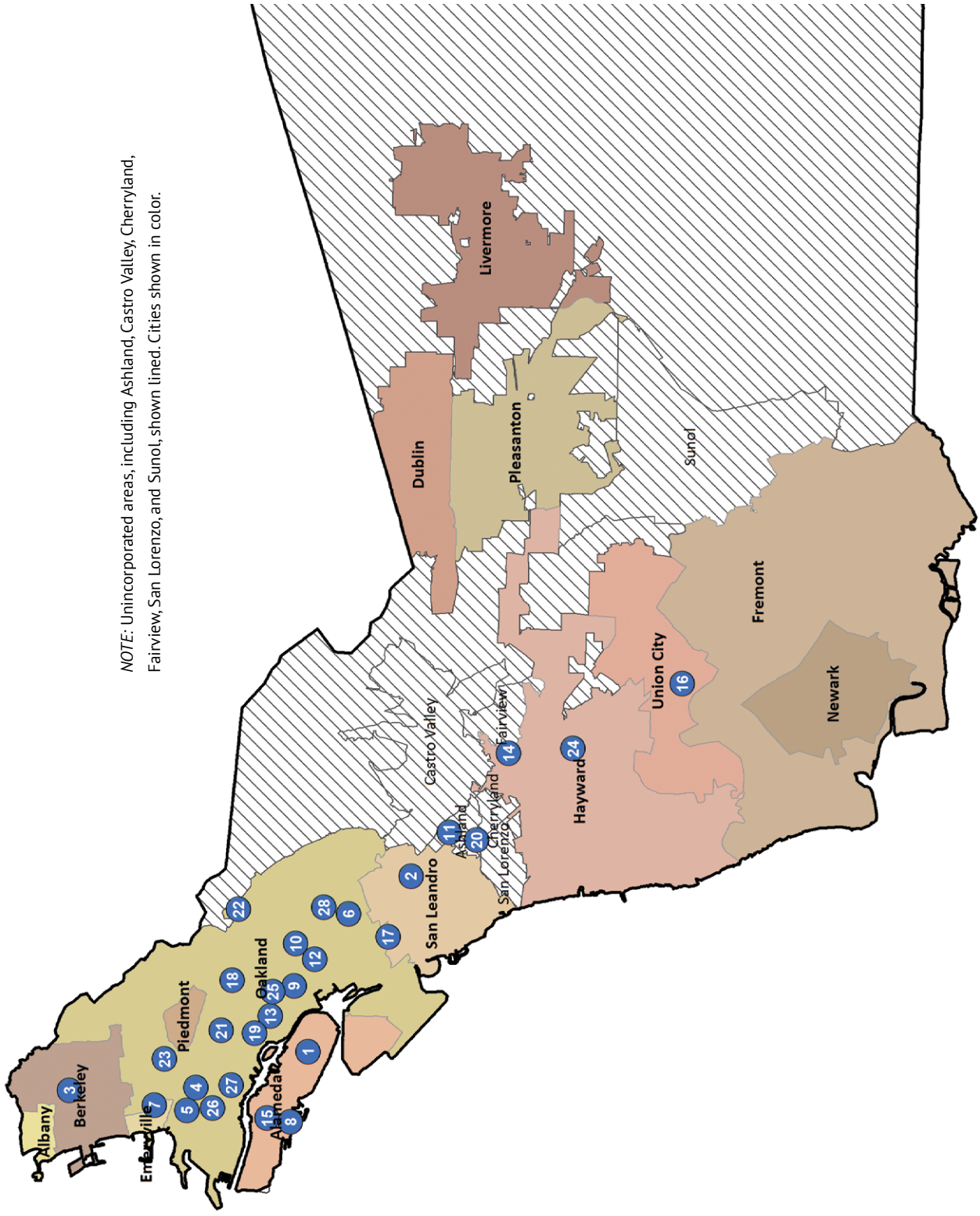
MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 17/18

#	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
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 17/18



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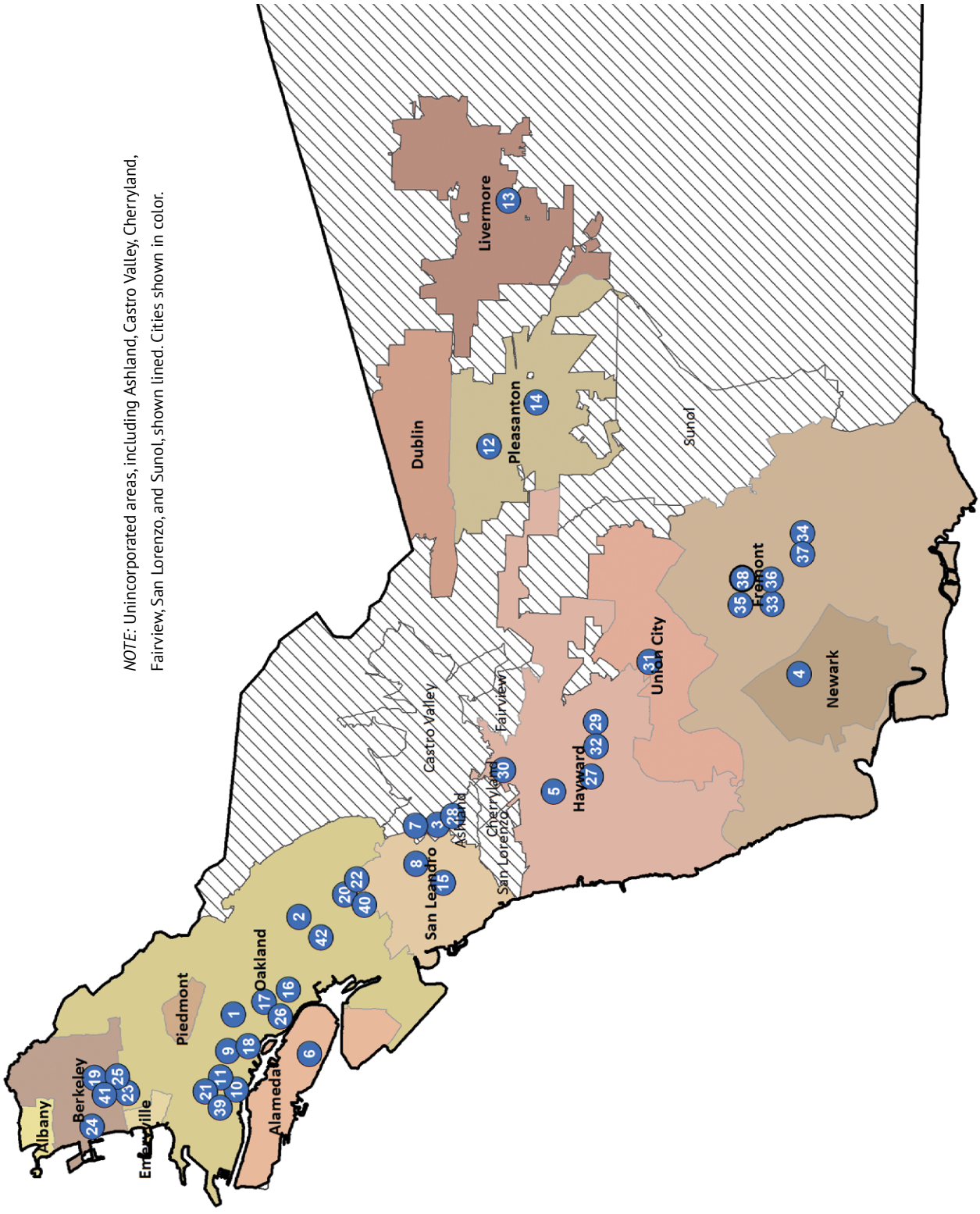
MAP 5
HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 17/18

#		CITY
Alameda Health System *(site locations listed below)*		
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 *(site locations listed below)*		
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 *(site locations listed below)*		
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. *(site locations listed below)*		
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

#		CITY
LifeLong Medical Care *(site locations listed below)*		
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**	
30	**St. Rose Hospital**	
Tiburcio Vasquez Health Center *(site locations listed below)*		
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 *(site locations listed below)*		
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 *(site locations listed below)*		
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 17/18



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