Fiscal Year
2014/2015





MEASURE A

Essential Health Care Services Tax Ordinance

OVERSIGHT COMMITTEE
9TH REPORT TO THE ALAMEDA COUNTY
BOARD OF SUPERVISORS AND THE PUBLIC

Review of Expenditures July 1, 2014 – June 30, 2015

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REVIEW OF EXPENDITURES IN

Fiscal Year (FY) 2014/2015

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MEASURE A
OVERSIGHT COMMITTEE MEMBERS

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

* Gwendolyn McClain resigned in July 2016. Keith Davies was appointed to serve the remainder of her term.

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY STAFF

Rebecca Gebhart, Interim Agency Director

James Nguyen, Interim Finance and Administration Director

Connie Soriano, Administrative Specialist II

FY 2014/15 Measure A Executive Summary

ABOUT THE MEASURE A OVERSIGHT COMMITTEE

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

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

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

OVERALL CONCLUSION

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

A→AA

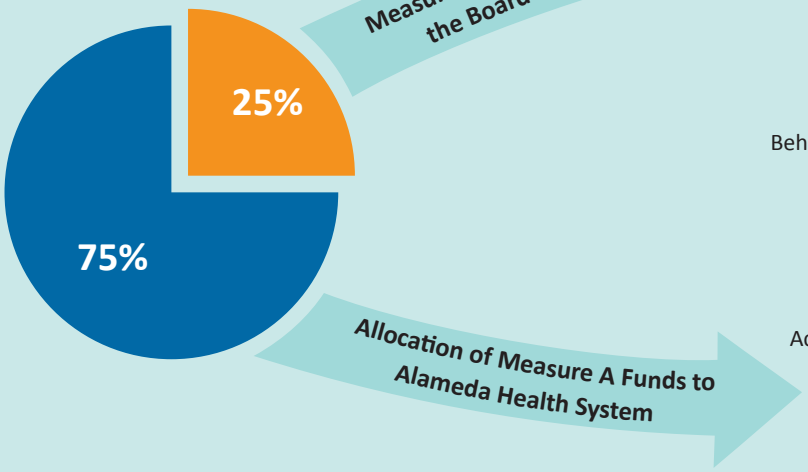
History of the Measure

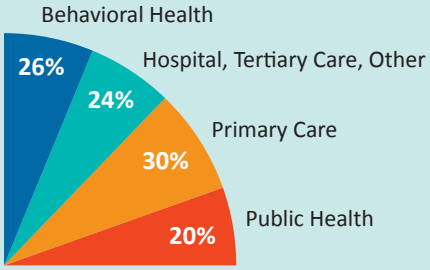
Measure A, the Essential Health Care Services Initiative, was passed by 71% of Alameda County voters in March 2004. In June 2014, 76% of voters passed Measure AA, which extended the initiative through 2034. Both measures authorize the County of Alameda to raise its sales tax by one-half cent to provide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

Measure A generated $132,429,279* in FY 14/15.

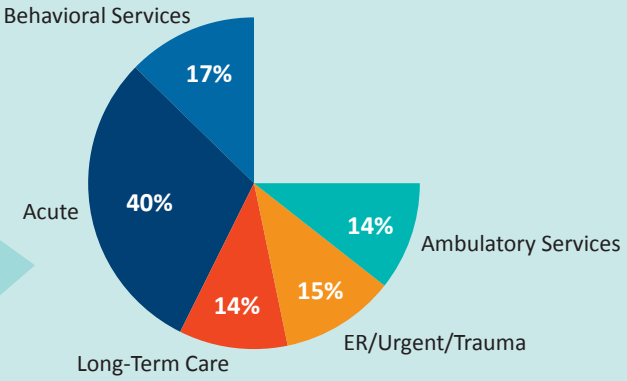
Of the $132,429,279 that Measure A generated in FY 14/15, AHS received 75% and the remainder of the funds was distributed by the Board to many health care providers who provide essential health care services.

DISTRIBUTION OF MEASURE A FUNDS





Total generated: $33.1 million
Total allocated: $35.1 million**



Total $99.3 million

* Does not include interest earned.

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

Highlights

Since the full implementation of the Affordable Care Act in 2014, more than 40,000 newly eligible County residents have been enrolled into the state's Medi-Cal program, and more than 64,000 residents have been enrolled in Covered California. Despite these achievements to increase the number of individuals who have health insurance, an estimated 158,734 individuals, or 10.1% of County residents, remain uninsured, according to the American Community Survey data for 2015. Thus, Measure A revenues continue to play a critical role in helping indigent, uninsured, and low income residents of Alameda County—who depend on the County's health care safety net—maintain access to essential health services.

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

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

Large Numbers Served, Wide Geographic Reach

Measure A funds continue to support the health and well-being of large numbers of County residents. AHS alone served 156,330 County residents through Measure A in FY 14/15, while the Alameda County Public Health Department Public Health Prevention Initiative served over 200,000.

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

Mental Health/Behavioral Health Services

More than just physical health, a great number of Measure A providers used their allocation to achieve positive mental and behavioral health outcomes for the target population. For example, everyone in the Abode Services Greater HOPE program has been connected with mental health services and housing support services, with over 75% of clients reporting decreased psychiatric hospital stays and/or criminal justice involvement. At the new Schreiber Center, clients receiving therapy and psychiatric services have shown an overall decrease in symptoms of depression, reduced side effects of medications, improved communication with family, increased access to mental health services, and improved care with current providers following the recommendations of a psychiatrist.

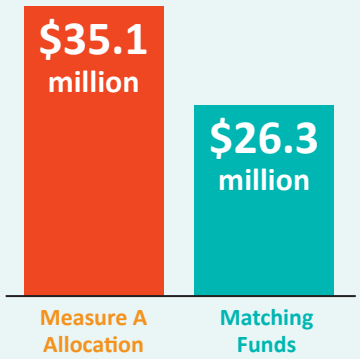
Youth Outcomes

A number of providers reported on improved mental and behavioral health outcomes for youth. The Center for Healthy Schools and Communities School-Based Behavioral Health Initiative reported that students who received group or individual services presented statistically significant improvements in life functioning (43%), behavioral/emotional needs (24%), and school success (34%) from intake to discharge. Youth participating in the Mind Body Awareness program at the Juvenile Justice Center revealed a significant decrease (20.4%) in perceived stress, a significant increase in healthy self-regulation (19.6%), and a significant increase in self-esteem (14.1%) from pre to post testing. A behavioral health assessment used by half of the community-based organizations in the Youth and Family Opportunity initiative revealed significant improvement in client behavioral/emotional needs (34.4%), life functioning (40.5%), school (39.9%), and child strengths (27.6%).

Program Stabilization

Measure A funds contribute to stabilization of health care service delivery in the face of cuts from other funding sources. For example, despite

AHS alone served 156,330 County residents through Measure A in FY 14/15, while the Alameda County Public Health Department Public Health Prevention Initiative served over 200,000.



The recipients of the 25% of Measure A funds allocated by the Board obtained $26,347,012 in matching funds from public and private sources.

significant reductions in County General Funds available to support behavioral health services, Measure A funds helped Behavioral Health and Alcohol and Other Drug (AOD) Community organizations maintain a higher level of access to services for uninsured and health care safety net populations. Specifically, only a minimal change occurred when comparing the total number of unique clients served during this year across the behavioral health system with the number of clients served last year across providers receiving Measure A funds.

Leveraged Funding

A large number of Measure A recipients leveraged their allocations to receive matching funds from other sources. For the 25% of Measure A funds allocated by the Board, recipients leveraged their allocations to obtain a total of $26.3 million in matching funds. Thus, every $1 in Measure A funds to these recipients returned $0.75 in matching funds. For some recipients, the matching funds represented a return greater than 1:1. Safe Alternatives to Violent Environments (SAVE) obtained over $80,000 in matching funds on its $30,000 Measure A allocation. Fremont Aging and Family Services obtained almost $200,000 in matching funds on its $52,000 Measure A allocation. Most dramatically, the School-Based Behavioral Health Initiative obtained $6,216,000 in matching funds on its $617,000 Measure A allocation, while the School Health Centers obtained over $10,000,000 in matching funds on an allocation of just under $2,000,000.

Agency Collaboration

Measure A funding encouraged provider collaboration with other agencies to improve health care outcomes. The Detoxification/Sobering Center expanded its collaboration with mental health providers, including John George Psychiatric Hospital, crisis services, Highland Hospital, local medical clinics, and law enforcement. These partnerships had a significant positive impact on the clients and families served, allowing for increased referral capability, increased collaborative consultation and training, and a warm hand-off for clients to and from multiple levels of the health care system.

Exceeding Targets

Many Measure A recipients exceeded their target numbers for clients served, sometimes dramatically. Serving a larger number of clients with a given allocation translates to a lower per-client cost. For example, La Familia greatly exceeded its targets for providing information to low income residents (2,697 actual vs. 1,200 target, an increase of over 100%) and providing health care application assistance (723 actual vs. 133 target, an increase of over 500%). Safe Alternatives to Violence (SAVE), having set a target of providing 160 individual counseling sessions, actually provided 377—an increase of over 100%. Fremont Aging and Family Services

conducted 563 home visits to 140 clients, compared to a target of 350 home visits to 85 clients. And the City of San Leandro Senior Community Center conducted 740 blood pressure/weight checks, compared to a target of 360—an increase of almost 100%.

Preventive Care

In addition to providing emergency care and treatment, many Measure A providers used their funding to offer cost-effective preventive care. An analysis of health outcomes for children participating in the Alameda County Dental Health WIC "Dental Days" showed that they had 42% fewer restorative dental treatment needs compared to children who did not benefit from the program. Preventive Care Pathways clients experienced a reduction in emergency room visits to AHS and outside emergency rooms, as well as improvement in clinical findings related to diabetes, hypertension, and congestive heart failure. With the timely diagnostic care offered at Washington Hospital, abnormal findings were detected and treated earlier, which translated to better patient outcomes.

Service Growth

Many Measure A recipient providers experienced noticeable growth in service delivery in FY 14/15. For example, as a result of its Measure A-funded expansion efforts, Roots Community Health Center experienced an 87% increase in patient visits and a 300% increase in laboratory visits compared to the same time period pre-expansion. The Senior Support Program of Tri-Valley In-Home Counseling Program had more referrals in FY 14/15 than in any other year.

Crisis Services

Measure A goes beyond standard health care delivery to offer services to those in emergency or crisis situations. Through the Victims of Crime program, Measure A funding helped enable clients who would normally have been ignored because of lack of information of available resources, or limited resources to pay for treatment services, to receive necessary services on an ongoing basis at no cost to the client or to Alameda County. In a survey, Mercy Brown Bag Program recipients indicated that 37% didn't have enough money to buy food or other necessary items to last the entire month, 34% had to skip meals, and 76% thought their health would be negatively affected without this program. Thus, the program helped fill an important gap in maintaining the health and well-being of the older adult population.

As a result of its Measure A-funded expansion efforts, Roots Community Health Center experienced an 87% increase in patient visits and a 300% increase in laboratory visits.

Concerns

In developing this report, the Oversight Committee identified several concerns regarding the state of health care funding both during the years of Measure A implementation (2004-2015) and in the foreseeable future.

While Measure A tax revenues have gradually increased each year since their lowest levels in 2010, economic indicators reveal that the annual rate of change from the prior year started to decrease in 2012.

Furthermore, many families living in disadvantaged communities have not benefited from the improved job and housing markets during the economic recovery over the past few years and continue to need access to the essential health care services that Measure A provides.

The Committee urges Alameda County to continue to pay close attention to policy changes proposed by the 2016 presidential administration that may have significant impacts on health care access or the County's safety net. Moreover, Medi-Cal rate reductions and other funding cuts over the past several years have continued to decrease the ability of health providers to offer services to the expanded Medi-Cal and uninsured populations in the County.

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

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

Outside the area of health care funding, the Committee recognizes that the composition of the Committee has improved in reflecting the diverse make-up of the population served by Measure A. The Committee notes that this should be an area of ongoing focus as Committee member selections are made moving forward.

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

NOTE: The Committee believes it is important to present any concerns it noticed while reviewing Measure A recipient reports. At the same time, the

Committee wants to make clear that raising a concern does not necessarily mean that a problem exists with a recipient's use of Measure A funds. For example, the concern may arise because of incomplete or inaccurate reporting, not because of any inappropriate use of funds.

Reporting and Review Concerns

- 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.
- 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.
- 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. In addition, the Committee does not have the capacity to review HCSA's process of controls and review of how the funding is spent—via audit or other method.
- Although reporting continues to improve, the Committee expresses the ongoing concern that its review is impacted by the varying level of detail provided in fund recipient reports, as well as varying levels of responsiveness to specific questions posed by the Committee to specific recipients. This makes it difficult for the Committee to determine whether funding is being spent on the Measure A target population. For example:
  - Multiple provider reports listed objectives that are not measurable and/or stated positive outcomes without quantifying the statements.
  - For some reports, it is unclear whether the target population falls within one of the categories listed in the Measure A statute: "indigent, low income, and uninsured adults, children, families, seniors, and other residents of Alameda County."
  - In other reports, the provider's description of the services offered raises questions as to their relevance to the wording of the Measure A statute.

RECOMMENDATION: *HCSA should receive funding to create a process for Measure A recipients to verify that they are using Measure A funds to provide their described programs to the populations listed in the measure. This process can include HCSA staff providing training to Measure A recipients on how to effectively collect demographic data to report on the diverse populations of indigent, uninsured, and low income clients they serve by race, ethnicity, geography, and language. The Committee further advocates that HCSA be sufficiently staffed to successfully implement such a process.*

RECOMMENDATION: *The Board should authorize HCSA to include evaluations of Measure A programs as part of its initiative to improve*

oversight and outcomes in all its programs. This includes identifying additional funding to ensure that Measure A contracts are included in the initiative.

RECOMMENDATION: *HCSA should hold trainings to reinforce proper and accurate completion of demographic information and adherence to Measure A services.*

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

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

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

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

Alameda Health System

The Committee notes the following concerns:

- AHS provides well-stated goals, but objectives are not quantified. References are made to "True North" metrics without measurable objectives provided. AHS did not revise its report to include measurable objectives.
- Several results are described, however very few are quantified other than a generalization—for example, "improving patient transition from inpatient services to long-term care, rehabilitation, or the home."
- The Measure A funding expenditures reported by AHS exceeded the total Meaure A allocation of $99,321,959. The four reported categories of expenditures should add up to but not exceed this figure. AHS did not revise these figures.
- AHS reported that Measure A funds covered 3,484 FTEs, which seems excessive to reviewers. AHS did not respond to a request for clarification.
- Measure A accounts for 12.9% of the AHS budget. The number of individuals served by this funding should be less than the total number of individuals served by the agency. The provider report suggests that 94% of 156,330 individuals seen are uninsured and that 100% are qualified for entitlement benefit programs. This does not correspond with information provided in presentations from AHS executive staff. AHS should clarify and correct this information.

Although AHS has made some progress, the Committee notes that these concerns have been raised for at least the last five years.

RECOMMENDATION: *A formal audit should be conducted to more accurately gain an understanding of expenditure of Measure A funds.*

Abode Services

Greater HOPE

Based on the provider report, it is unclear how the Measure A funds increased access to services for vulnerable populations.

HOPE Crisis Outreach Program

The Committee questions the use of Measure A funds to help people obtain survival gear for living on the streets: tents, sleeping bags, etc. The Committee wonders whether this money would be better used to fund housing or efforts to put clients into housing.

Administration/Infrastructure Support

The Direct Service Planning and Administration group does not have enough resources allocated to carry out a Measure A program evaluation that would adequately ensure accountability to Alameda County taxpayers for this annual expenditure of over $120 million. As a first step, appropriate levels of staffing and expenditures would allow staff to conduct mandatory audits and subsequent training for at least 10% of funding recipient programs.

San Leandro Hospital

The provider's report contains an impressive list of services and achievements. However, there is no alignment between these achievements and the clearly stated and quantifiable objectives in the provider report. In addition, the goals and objectives listed were not specific to San Leandro Hospital but instead were an exact reprint of the entire AHS goals and objectives. This causes difficulty in determining the intent and actual impact of Measure A funds.

For example, the provider reports that all 24,627 individuals served were served by Measure A, but elsewhere reports that only 54% of individuals served qualified for Measure A benefits. The budget numbers reported are for the entire hospital budget and are not specific to the Measure A grant.

The omitted information in the Measure A Funding Summary section has been requested several times without response.

RECOMMENDATION: *A full audit should be performed to determine accounting for Measure A expenditures.*

St. Rose Hospital

The objectives included in the provider report are not quantifiably stated and should be revised. While the provider included excellent quantified results achieved in serving uninsured and underinsured patients, these should be revised to match the categories of patients described in the goals and objectives.

UCSF Benioff Children's Hospital

The Committee notes that CHO does not list measurable objectives, which has been raised *repeatedly* in the last several years. Additionally, many of the achievements do not give a specific time frame for achievement—it is unclear what improvement, if any, took place from FY 13/14 to FY 14/15.

All the numbers listed under the Measure A Funding Summary are identical to the numbers listed in the FY13/14 Measure A report.

RECOMMENDATION: *A full audit should be performed to determine accounting for Measure A expenditures.*

Collaboration Agencies Responding to Disasters (CARD)

It is unclear if the Measure A allocation to CARD complies with the ordinance requirement that funds go to provide "emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low income, and uninsured adults, children, families and seniors, and other residents of Alameda County."

The project was not completed, with no services deliverables report. The provider reports that only the "planning phase" was completed before the agency went out of business. Only $7,500 of the $25,000 was paid out to CARD, and these Measure A funds went to planning for services that were never provided.

West Oakland Youth Center (WOYC)

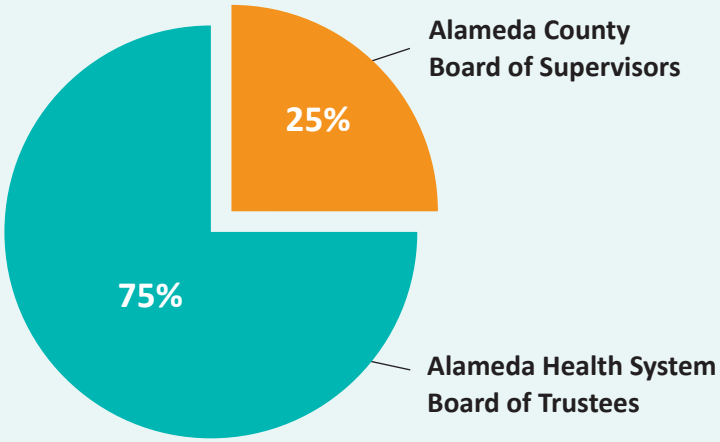
One staff assigned to the WOYC project resigned mid-year. The supervisor took on the project responsibilities but wasn't able to bill against Measure A funding. Therefore, the actual expenditure was $44,244 out of WOYC's $70,000 allocation.

HOW THE MONEY WAS SPENT

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

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

DISTRIBUTION OF MEASURE A FUNDS



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

In FY 14/15, Measure A generated $132,429,279 (not including interest earned). The funds were allocated as follows:

Alameda Health System (75%): $99,321,959
Alameda County (non-AHS) (25%): $33,107,320
TOTAL: $132,429,279

In FY 14/15, the Alameda County approved budget totaled $2.786 billion. The Alameda County Health Care Services Agency approved budget totaled $614.8 million, or 22.1% of the total County budget. Measure A revenues not specifically designated for AHS accounted for 5.4%.

The following sections in the report provide more detail on how AHS and the Board spent Measure A funds in FY 14/15, which includes revenue generated in the reporting year as well as unspent funds earned in previous years.

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

alamedahealthsystem.org

Allocation: **$99,321,959** | Expended/Encumbered: **$99,321,959**

Individuals served by Measure A: **156,330** (Total individuals served: **156,330**)

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

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

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

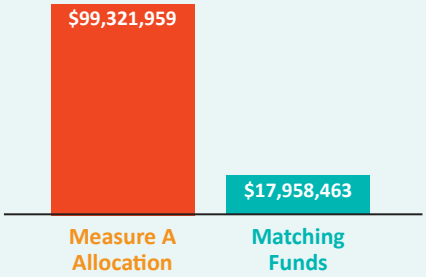
BACKGROUND

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

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

- Access goals relate to providing care to all County residents by expanding access to services. Key goals in FY 14/15 included the following:
  - Increasing coordination and referral of specialty care with the Community Health Clinic Network (CHCN)
  - Further integration of San Leandro and Alameda Hospitals into the system
  - Increasing Cardiology, Dermatology, Optometry, and Orthopedic service lines
  - Expanding the Complex Care Program for high risk, high cost, complex care patients
  - Increasing medical home assignments for emergency department (ED) and specialty clinic patients
  - Increasing the utilization rate of the 24-hour nurse advice line
  - Reducing the overall length of stay in the various EDs
- Quality Enhancement goals in FY 14/15 further aligned AHS with patient safety initiatives, such as benchmarks set by the Joint Commission, Center for Medicare and Medicaid Services (CMS), and U.S. Centers for Disease Control (CDC). Key goals in FY 14/15 included the following:
  - Continued focus on panel management, including increasing preventive health screenings at outpatient facilities
  - Incorporation of Alameda Health Partners, a physician organization dedicated to streamlining clinical priorities and coordinating and supporting physicians in delivering high quality, efficient, value-based care to patients and communities

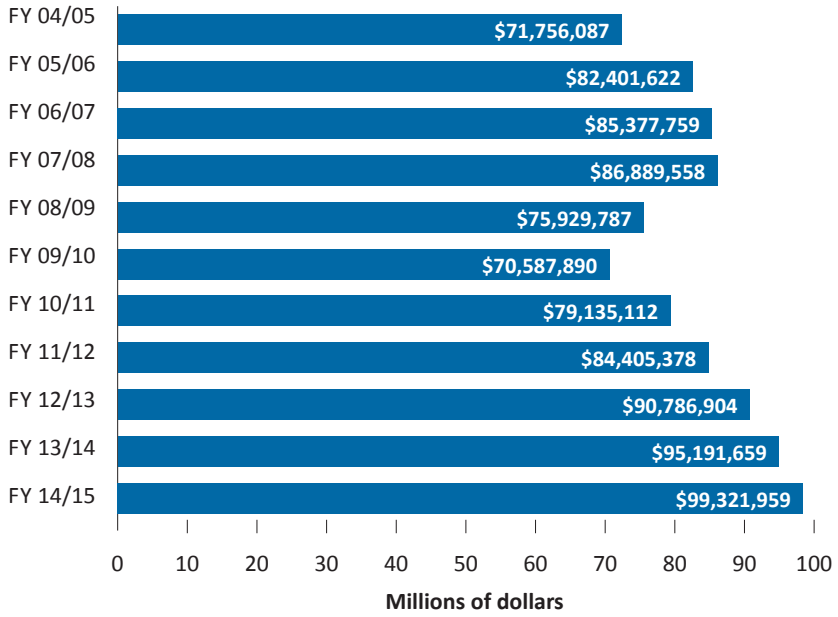
Matching Funds



AHS leveraged its Measure A allocation to obtain **$17,958,463 in matching funds** through a number of different intergovernmental transfers provided by Alameda County, including the following:

- Medicaid Waiver
- Seniors and Persons with Disabilities
- Rate Range
- DSRIP

REVENUE EARNED EACH FISCAL YEAR (FY 04/05 THROUGH FY 14/15)



Service Enhancement goals included improving patient transitions from inpatient services to long-term care, rehabilitation, or the home.

  - Continued focus on harm reduction, including reducing sepsis infection and pressure ulcers at inpatient facilities
  - Establishing a new care coordination infrastructure, multidisciplinary teams, and processes to improve patient flow, documentation, and avoidable readmissions
- Service Enhancement goals promote an improved patient experience. Key goals in FY 14/15 included the following:
  - Developing processes and implementing best practices designed to reduce the response time to patient call buttons
  - Increasing inclusion of patient preference in his or her treatment
  - Conducting patient experience surveys in cooperation with the U.S. Agency for Healthcare Research and Quality (AHRQ) and Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Sharing data, best practices, and findings with the Safety Net Institute (SNI) to foster shared learning and benchmarking across California's public hospitals
  - Improving patient transitions from inpatient services to long-term care, rehabilitation, or the home
  - Improving the "fast track" door to discharge process for lower acuity patients at John George Psychiatric Hospital (JGPH) and Highland Hospital, for better patient flow and utilization of provider resources
- Sustainability goals represent a commitment to financial stability, operational efficiency, and debt reduction. Under the Affordable Care Act, AHS seeks to offset declining federal funds with new patient revenues from expanded Medi-Cal, the Health Insurance Exchange, and new contracts with commercial payers. Key goals in FY 14/15 included the following:
  - Developing processes such as Budget Variance and FTE committees to maintain budget discipline

- Establishing a Revenue Cycle Improvement Project to develop standardized reporting
- Implementing forecasting software to model service line projections through 2020
- Developing reconciliation processes and standards to correct material accounting errors and inaccuracies and ensure financial integrity
- Improving charge capture, billing, and revenue cycle management processes across the organization
- Implementing an ongoing cost management initiative aimed at reducing unnecessary costs and improving efficiency by decreasing usage of overtime labor and improving core staff scheduling, redesigning the supply chain, improving purchased service contract pricing, and implementing flex scheduling
- Developing a managed care contracting department to expand access to commercially insured patients so patients who want to stay with AHS can do so without service interruption
- Improving end-to-end revenue cycle functioning

• Workforce Development goals promote a culture of customer service, innovation, and achievement by attracting, developing, and retaining competent and compassionate staff. Key goals in FY 14/15 included the following:
  - Establishing Alameda Health Partners, a physician organization dedicated to coordinating and supporting physicians and streamlining clinical priorities
  - Increasing staff training in population health management
  - Evaluating and providing training in communication skills competencies and customer service for permanent inpatient nurses and staff members
  - Hiring additional physician and support staff to meet patient demand and expand service offerings
  - Working to increase employee engagement and commitment to organizational goals and patient experience

MEASURE A FUNDING SUMMARY

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

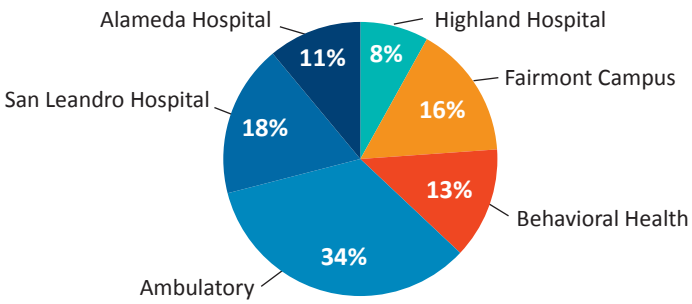
Measure A helped AHS achieve the following measurable objectives in FY 14/15:

• Access: Decrease length of stay for admitted patients to 6.9 hours (target: 7.8 hours)
• Sustainability: Attain a -8.0% operating margin in fiscal 2015, and 3.3% in budget 2016 (target: 3.0%)

Measure A Helps

In 2014, Mr. H. came to the Highland ED 18 times. Primarily homeless, he had cirrhosis, congestive heart failure, hepatitis B, kidney disease, and pain. The complex care management team twice discharged Mr. H. to skilled nursing facilities (SNFs), which he left against medical advice. The team continued to see him when he was in the hospital. Over time he seemed more comfortable talking and building trust. However, after yet another discharge and return hospital stay, the team came up with the idea of hospice. In the hospice SNF, the team ran interference between Mr. H. and staff. Shortly after, Mr. H. asked for help contacting friends and relatives, and the team has been helping him fill out applications for independent housing.

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



Measure A helped AHS experience a decline in preventable harm of 11% systemwide and 40% over the past five years.

- Quality: Experience a decline in preventable harm of 11% systemwide and 40% over the past five years
- Service: In hospital surveys, obtain approximately a 12% improvement in patient responses compared to the prior year
- Workforce Development: In surveys, obtain a 3.88 employee engagement score and a 3.68 physician engagement score (target score: 4)

CONCERNS

The Committee notes the following concerns:

- AHS provides well-stated goals, but objectives are not quantified. References are made to "True North" metrics without measurable objectives provided. AHS did not revise its report to include measurable objectives.
- Several results are described, however very few are quantified other than a generalization—for example, "improving patient transition from inpatient services to long-term care, rehabilitation, or the home."
- The Measure A funding expenditures reported by AHS exceeded the total Meaure A allocation of $99,321,959. The four reported categories of expenditures should add up to but not exceed this figure. AHS did not revise these figures.
- AHS reported that Measure A funds covered 3,484 FTEs, which seems excessive to reviewers. AHS did not respond to a request for clarification.
- Measure A accounts for 12.9% of the AHS budget. The number of individuals served by this funding should be less than the total number of individuals served by the agency. The provider report suggests that 94% of 156,330 individuals seen are uninsured and that 100% are qualified for entitlement benefit programs. This does not correspond with information provided in presentations from AHS executive staff. AHS should clarify and correct this information.

Although AHS has made some progress, the Committee notes that these concerns have been raised for at least the last five years.

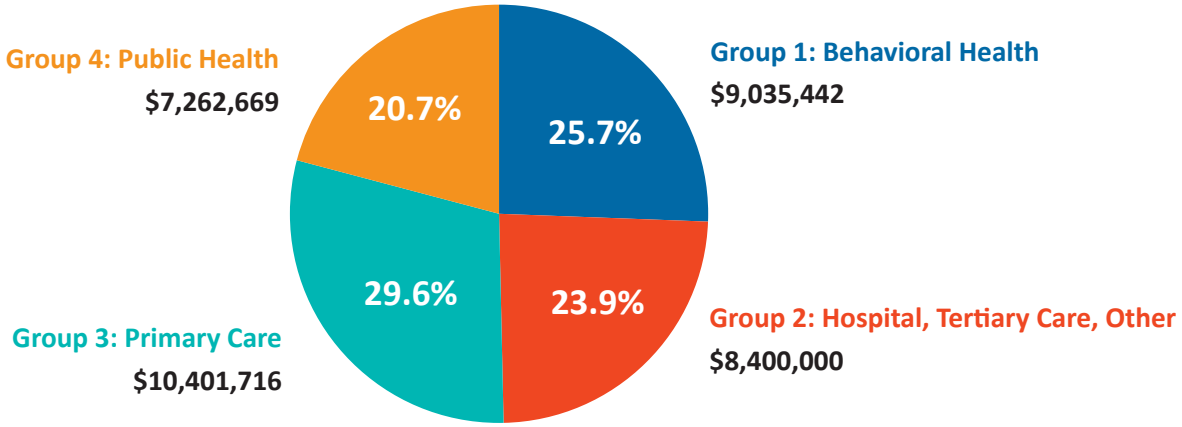
RECOMMENDATION: *A formal audit should be conducted to more accurately gain an understanding of expenditure of Measure A funds.*

FY 14/15: **25% OF MEASURE A FUNDS** ALLOCATED BY The Alameda County Board of Supervisors

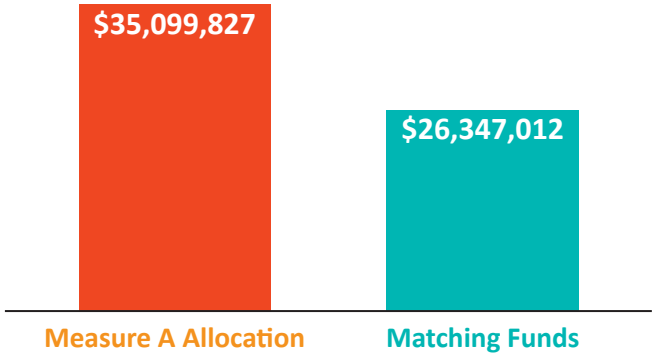
In FY 14/15, the Board of Supervisors (Board) approved approximately $35.1 million in total Measure A allocations. The Board allocations are listed by group in the following chart.

NOTE: Since most of the allocations are approved by the Board before and during each fiscal year based on sales tax revenue projections, the total allocation amount may not equal the actual revenue received. For more details on Board allocations, see Appendix B: FY 14/15 Budget Information and Appendix C: FY 14/15 Measure A Fund Distribution by Provider or Program. The appendices may include allocations that were approved by the Board but not expended by the end of the fiscal year.

MEASURE A FUNDING APPROVED BY THE BOARD OF SUPERVISORS IN FY 14/15



TOTAL MATCHING FUNDS OBTAINED BY LEVERAGING MEASURE A ALLOCATIONS



FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 1: BEHAVIORAL HEALTH

Abode Services

www.abodeservices.org

Allocation: **$50,000/$90,000** | Expended/Encumbered: **$50,000/$64,975**

Individuals served by Measure A: **50/122** (Total individuals served: **50/612**)

Populations served: Indigent, Low Income, Uninsured Adults

Services provided: Mental Health, Substance Abuse

Service area: Castro Valley, Fremont, Hayward, Livermore, Newark, Oakland, Union City, Homeless or transient

BACKGROUND

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

Abode Service received two Measure A allocations: one for its Greater HOPE program, and one for its HOPE Crisis Outreach Program.

Greater HOPE

Greater HOPE provides wraparound clinical services and housing to adults with severe mental illness, long histories of homelessness, and other barriers such as chronic health conditions.

HOPE Crisis Outreach Program

The HOPE program provides outreach and engagement services to homeless people in Livermore, mid County, and Fremont. The program assesses people's needs and helps connect them to resources including income, shelter, medical services, mental health and drug and alcohol services, employment, etc. The team also helps link people to basic resources like survival gear for living on the streets, IDs, Social Security cards, food, cell phones, transportation, etc.

Through its street outreach, the HOPE program reaches those with the most barriers, which often include severe mental health challenges, drug and alcohol addiction, and/or chronic health conditions. The goal is to provide services and linkage to referrals and housing that will improve health and housing outcomes for these clients.

Measure A Helps

HOPE Crisis Outreach Program

The HOPE team encountered a 55-year-old homeless man with severe alcohol addiction and a physical disability. This man had almost daily interaction with police, fire, and paramedics due to drinking heavily, passing out, or falling out of his wheelchair. The HOPE team helped the client get an ID, Social Security card, and income, as well as complete his application for housing. The client moved into his own apartment after nine months. He has stopped drinking and smoking. He has established a primary care provider and stabilized his health needs. Since becoming housed, this client has not had a single encounter with law enforcement or emergency services.

MEASURE A FUNDING SUMMARY

Greater HOPE

Measure A funds were used to improve the delivery of services and documentation and billing of services. Through Measure A funding, the

team received IPS training, hired an employment specialist, and launched an employment program utilizing the IPS model. Five people are currently enrolled in the employment program.

Specifically, Abode Services Greater HOPE used its Measure A allocation to achieve the following:

- Create and implement a Quality Assurance manual
- Train nine staff on Quality Assurance standards (target: 7)
- Review and update 65 clinical files to ensure accuracy (target: 50)
- Develop and implement a tool to track staff productivity
- Develop and implement performance improvement plans for clinicians with productivity of less than 45%
- Train 11 staff in Assertive Community Treatment
- Hire an Employment Specialist and develop a vocational program

HOPE Crisis Outreach Program

Measure A funds were used to fund the HOPE program's street outreach efforts in mid County.

Specifically, the Abode Services HOPE Crisis Outreach Program used its Measure A allocation to achieve the following:

- Provide 100% of direct services in locations outside clinic offices (target: 75%)
- Link 83% of clients to a primary care provider (PCP) and have them make at least one visit to a PCP within six months of enrollment (target: 100%)
- House 58% of clients in temporary shelter or transitional housing at program exit (target: 50%)
- Help 42% of clients obtain permanent housing at program exit, with 2% of those obtaining permanent housing within six months (target: 25% of clients obtaining housing, with 50% obtaining housing within six months)
- Help 67% of clients exit the program to a known destination (target: 60%)
- Have 92% of clients who enter the program without health insurance coverage exit with health insurance coverage (target: 100%)
- Have 67% of clients experience an increase in monthly income from program intake to program exit (target: 25%)

CONCERNS

Greater HOPE

Based on the provider report, it is unclear how the Measure A funds increased access to services for vulnerable populations.

HOPE Crisis Outreach Program

The Committee questions the use of Measure A funds to help people obtain survival gear for living on the streets: tents, sleeping bags, etc. The Committee wonders whether this money would be better used to fund housing or efforts to put clients into housing.

Highlights

Greater HOPE

The program served 50 people during this period and maintained 85% housing stability. Everyone in the program was connected with mental health services and housing support services. 55% of clients without SSI benefits were connected to benefit advocacy services. Over 75% of clients decreased psychiatric hospital stays and/or criminal justice involvement.

Matching Funds

Abode Services Greater HOPE leveraged its Measure A allocation to obtain matching funds from Medi-Cal Billing. The HOPE Crisis Outreach Program obtained matching funds from Medi-Cal Administrative Activities (MAA).

Behavioral Health and Alcohol and Other Drug (AOD) Community

www.acbhcs.org

Allocation: **$753,250** | Expended/Encumbered: **$383,219**

Individuals served by Measure A: **9,556** (Total individuals served: **35,393**)

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

Services provided: Mental Health, Substance Abuse

Service area: Countywide

BACKGROUND

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

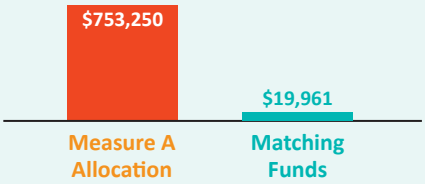
Community-based organizations (CBOs) provide mental health and substance use disorder services under contract with BHCS to meet the diverse cultural and language needs of County resident populations.

MEASURE A FUNDING SUMMARY

Measure A funds were used to support 26 mental health and substance use disorder programs. Funds were roughly evenly distributed between mental health and AOD programs. Providers used Measure A funds to support expansion in service operations and administrative needs, and to address cost increases not sufficiently covered by standard cost-of-living adjustments (COLAs) provided by their contracts.

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

Matching Funds



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

Center for Healthy Schools and Communities

(School-Based Behavioral Health Initiative)

achealthyschools.org

Allocation: **$617,362** | Expended/Encumbered: **$617,362**

Individuals served by Measure A: **3,840** (Total individuals served: **3,840**)

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

Services provided: Mental Health, Substance Abuse

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

BACKGROUND

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

- Children are physically, socially, and emotionally healthy.
- Children succeed academically.
- Environments are safe, supportive, and stable.
- Families are supported and supportive.
- Systems are integrated and care is coordinated and equitable.

Co-coordinated by CHSC and the Alameda County Behavioral Health Care Services (BHCS) Agency, the Alameda County School-Based Behavioral Health Initiative strives to strengthen and expand school-based behavioral health practice, finance, evaluation, and policy in Alameda County. In partnership with school districts and service providers, the Initiative works to deliver a continuum of school-based behavioral health supports to students in schools throughout Alameda County.

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 Our Kids Our Families 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.

Measure A Helps

An 8th grade student in New Haven Unified was having difficulty self-regulating his emotion and relating to his peers, and often sought attention through negative behaviors. He attended a support group created by the COST team to give students from Mexico and Central America the opportunity to address their thoughts and feelings regarding their transition to the United States. Throughout the group, students were allowed to address their issues of grief, loss, and trauma. As the group progressed, the student was able to build positive relationships with group members, increased his sense of empathy, and became very engaged in conversations regarding group topics.

- The School District Consultation program places behavioral health consultants (BHCs) in school districts to provide and enhance preventive social-emotional supports and mental health services for students and their families. The BHCs conducted the following activities:
  - Assessed the social-emotional service needs and infrastructure of a school district or set of schools and developed a service plan
  - Coordinated the work of all partner agencies who deliver behavioral health services in schools and districts
  - Provided and/or coordinated clinical case management, group, and individual counseling to students
  - Provided workshops, parenting groups, and mental health and other appropriate consultation to parents/caregivers; linked parents/caregivers with needed resources in the school and community; and supported school and school district efforts to engage and support families in meaningful and positive ways
  - Provided crisis assessment and intervention for students, supported schools in effective crisis response, and supported school districts in developing crisis response protocols
  - Provided clinical supervision to interns and/or actively participated in intern recruitment and placement
  - Conducted planning to develop service referral and coordination systems
  - Provided behavioral health consultation to district/school staff to strengthen connections between students and adults
  - Conducted psycho-education for administrators, teachers, school staff, parents, students, and community partners
  - Participated in district- or school-wide efforts to create a positive climate, prevent conflicts and violence, and enhance the community setting for all members
  - Developed or coordinated leadership and other opportunities for children/youth that allow them to participate meaningfully in their school
  - Expanded partnerships with County, city, and/or community-based organizations to fill service gaps
  - Worked to become more integrated into the school district's operational systems

Highlights

Parent surveys reported a high level of satisfaction. Parents saw improvements in their children's **ability to handle school and daily life, resolve problems, and interact positively with peers and adults**. Parents also reported having a support network to assist them in dealing with their child's behavioral problems.

The majority of parents reported that the parent/family engagement events were **useful and informative, addressed their needs, and increased their knowledge and parenting skills**.

In six of the eight school districts supported under this program, considerable progress was made toward **strengthening and expanding COST** in FY 14/15. Three of the districts now have COST at every site, and five districts have made considerable progress in their implementation and expansion efforts. This is a substantial increase since the 2009-2010 school year, where only one of the eight districts was making a systemwide effort at implementing COST.

MEASURE A FUNDING SUMMARY

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

Increase access to behavioral health supports for students and their families in eight school districts in Alameda County

Measure A funding has been instrumental in continuing to expand to previously underserved school districts in the County, specifically the following:

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

Address the behavioral health support needs of students

As measured by the Community Functioning Evaluation (CFE) administered to all students receiving early intervention and treatment services under the School-Based Behavioral Health Initiative, services delivered and/or coordinated by BHCs yielded positive results. At intake and discharge, school-based providers and BHCs assessed their clients on six common problem areas:

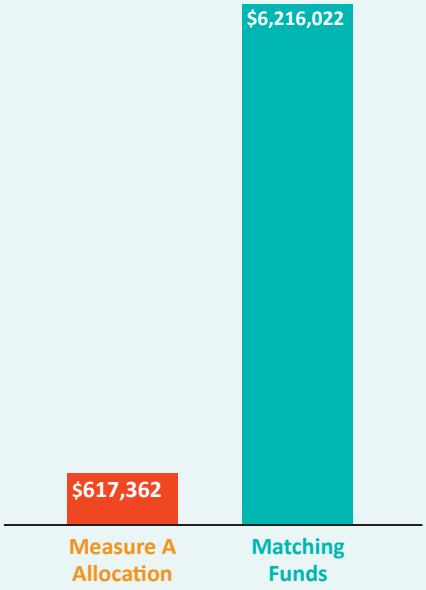
- Academic functioning
- Social relationships
- Exposure to violence/challenging environments
- Emotional and behavioral functioning
- Health/basic needs
- Living arrangements and basic functioning

The Our Kids Our Families Intern Program supervised a total of 16 social work and MFT interns. The intern programs enabled Our Families Our Kids to increase service capacity and service access for students and their families.

Strengthen the use of evidence-based practices along a continuum of behavioral health supports that includes prevention, early intervention, and treatment

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

Matching Funds



The School-Based Behavioral Health Initiative leveraged its Measure A allocation to obtain **$6,216,022 in matching funds** from the following sources:

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

- Positive behavioral interventions and supports
- Restorative justice
- Mental health consultation with teachers, staff, parents, and students

In addition, BHCs worked to strengthen the quality of early intervention and treatment programs in all school districts. BHCs provided and worked with current providers and interns to expand the use of therapeutic groups to serve students showing early signs of behavioral health struggle and students assessed to be "at risk." BHCs in all districts either directly provided crisis response services or coordinated crisis response.

Implement consistent criteria, procedures, and practices for behavioral health assessments, referrals, and linkages in the schools

BHCs support the implementation of Coordination of Services Teams (COST) in the schools. COST is an evidence-based model for coordinating care at a school site. The multidisciplinary COST work together to do the following:

- Use referrals and data-driven screenings to identify students who are struggling
- Deliberate strengths and challenges
- Assess supports needed
- Help implement interventions
- Monitor progress and provide appropriate follow-up
- Identify the broader learning support resource needs of the school
- Make recommendations about resource allocation

Highlights

An analysis of students across all grade levels showed **improvement in relationships with teachers, peers, and family**. Additionally, students who received group or individual services presented **statistically significant improvements in life functioning (43%), behavioral/emotional needs (24%), and school success (34%)** from intake to discharge.

In a survey conducted among middle and high school students who had received behavioral health services, 87% of respondents found those services to be **extremely helpful in improving their ability to handle daily life, get along better with friends and family members, and succeed in school**.

Criminal Justice Screening and In-Custody Services

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

Individuals served by Measure A: approximately 4,232 (Total individuals served: 4,318)

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

Services provided: Mental Health

Service area: Countywide

BACKGROUND

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

A program of BHCS, Criminal Justice (CJ) Screening/In-Custody Services provides a full range of mental health services to County jail inmates every month. Without jail mental health services, mentally ill inmates would go untreated.

MEASURE A FUNDING SUMMARY

BHCS used its Measure A fund allocation to maintain staff at CJ Screening/In-Custody Services who provided assessment of all inmates and improved care by ensuring timely access to medications and reduced potential medication abuse at Santa Rita Jail. The demand for jail mental health services continues to remain steady, even though the number of overall inmates in the jail has decreased. To deliver mental health services effectively, mental health staff were assigned to various areas of the jail: intake (booking), inmate housing units, and the clinic. Staff worked in the intake section of the jail seven days a week, two shifts per day.

Specific services supported by Measure A included the following.

Mental Health Screening

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

Highlights

Prior to Measure A funding, there were too few mental health staff working in the jail to accommodate the high volume of inmates needing mental health assessments, services, and medications. Many had to wait a long time (two months) to be seen, if at all. CJMH now has **mental health teams assigned to all the high risk housing units**. They have also begun providing **weekly groups for inmates** in the special population male housing unit and at Glen Dyer Detention Facility (GDDF) in Oakland. They have **expanded services** at GDDF. Previously, inmates who wanted mental health services had to be transported to Santa Rita Jail in Dublin and would often wait in holding cells for most of the day. Now those needing mental health services are seen by CJMH clinical staff on site at GDDF weekly.

special housing units 1, 2, 8, 9, and 24. These onsite services allow CJMH staff to proactively deliver mental health services to mentally ill inmates who might otherwise fall through the cracks.

Crisis Intervention

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

Management of Inmate Behavioral Problems

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

Suicide Prevention

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

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

All inmates receiving mental health services are seen by CJMH clinicians, who develop individualized treatment plans to help inmates achieve mental stability, develop an awareness of their psychological and behavioral problems, and acquire coping skills while incarcerated.

- Medication support services. When appropriate, CJMH psychiatrists evaluate inmates and prescribe psychotropic medications to alleviate symptoms and allow the inmates to achieve an optimal level of functioning while incarcerated.
- Counseling services. Inmates referred for counseling services receive an additional post-booking assessment and are provided ongoing counseling sessions as determined by their treatment plan.
- Misdemeanant incompetents. With regard to misdemeanant Incompetent to Stand Trial (PC 1370.01) inmates, CJMH staff collaborate with the courts to provide treatment geared to restoring competence and/or refer inmates to community programs that can address competency.

Measure A Helps

A 19-year-old African American youth ended up in jail due to an incident in which his behavior escalated and his parents were fearful someone would be hurt. In jail, the youth was housed in administrative segregation due to his violence when psychotic and off his medications. The CJMH clinician was able to support both the youth and his family while he was in custody. This collaboration went on for the year while the youth was in custody. The clinician was able to help the youth regarding the loss around his college scholarship, being diagnosed with a serious mental illness, his adjustment to jail, and hope for the future.

- Court-ordered evaluations. CJMH clinicians conduct court-ordered psychiatric evaluations (PC 4011.6s) to assess the need for acute inpatient psychiatric care and provide reports back to the courts.
- Inpatient services. CJMH staff or deputies send inmates requiring acute inpatient hospitalization to acute psychiatric inpatient hospitals. When inmates are returned to the jail, they are held in the Outpatient Housing Unit (Infirmary) until CJMH clinicians can assess them, continue their medications, and clear them for housing.
- Inmates who refuse treatment. All treatment is voluntary. CJMH staff monitor inmates with serious mental illnesses who refuse treatment and make an ongoing attempt to engage these inmates in treatment.
- Outreach and teamwork. CJMH clinicians and psychiatrists closely monitor inmates in Special Housing Units: Ad Seg, Mental, Women's. Visits occur weekly, including cell checks for inmates who refuse to be seen or who are noncompliant with treatment.
- Substance abuse treatment. Inmates have access to programs that specifically address addiction problems. CJMH clinicians also address substance abuse as part of their ongoing interventions with inmates.

Mental Health On-Call/Emergency Services

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

Discharge Planning/Continuity of Care

When CJMH staff have advance notice of an inmate's date of release, staff make a referral for follow-up outpatient treatment. CJMH staff work closely with court mental health advocates the Court Advocacy Project (CAP), the Forensic Assertive Community Treatment (FACT) team, the Behavioral Health Court (BHC), and community service providers in coordinating treatment plans and release plans for persons in custody with serious mental illnesses.

Training

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

Administration of Psychotropic Medications to Patients in a Psychiatric Emergency

Psychiatrists can legally prescribe psychotropic medication for emergency situations.

Emergency mental health services are available 24 hours a day by onsite staff or by mental health professionals who work on call.

Detoxification/Sobering Center

Allocation: **$2,080,800** | Expended/Encumbered: **$1,948,778**

Individuals served by Measure A: **6,873** (Total individuals served: **6,873**)

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

Services provided: Substance Abuse

Service area: Countywide, Homeless or transient

BACKGROUND

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

The Detox Center is a social model nonmedical detoxification center specifically designed for individuals requiring 24-hour/7-day-a-week monitoring. It offers van transport for individuals needing transportation to and from medical, psychiatric, treatment, housing, or any other ancillary service.

The Sobering Center is designed to assist those needing immediate sobering services from alcohol/drugs. It provides a brief visit of 23 hours or less with continual monitoring for safe withdrawal, 24 hours per day, seven days per week. Within the Sobering Center, the Health Center is staffed with nurse coordinators and health technicians who monitor withdrawal and assist with medical triage/assessment to ensure safe and healthy withdrawal. The center also provides TB tests and referrals to medical/psychiatric services for all individuals as needed.

MEASURE A FUNDING SUMMARY

Measure A provides 100% of the funding to Cherry Hill Detoxification Services Program/Horizon Services, Inc., the sole provider of the Detox/Sobering Center.

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

- Cherry Hill Sobering Center provided 5,198 units of service.
- The Detox Center provided 2,229 units of service.
- The Health Center provided 985 services to existing clients.
- Law enforcement leadership and officers attended bi-monthly trainings in groups of 25-30 for training, education, and orientation around the Detox/Sobering Center's programs and services.

Measure A Helps

A 45-year-old uninsured, homeless Latino male arrived at Cherry Hill for sobering and detox services. He had been using alcohol and methamphetamine for 10 years without treatment and had not taken his medication for several months. Based on the Nurse Coordinator's recommendation of medical intervention, Cherry Hill transported the client to Highland Hospital. After stabilizing, the client transferred to the Detox Center, where he began to open up about his life, including loss and multiple traumas. After four days at the Detox Center, the client expressed interest in ongoing care. He was successfully transferred to La Familia, a residential alcohol and drug treatment center in Oakland.

La Familia Counseling Services

lafamiliacounseling.org

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

Individuals served by Measure A: **2,697** (Total individuals served: **2,697**)

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

Services provided: Mental Health, Substance Abuse

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

BACKGROUND

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

MEASURE A FUNDING SUMMARY

Measure A provided 100% of the funding for the targeted La Familia services. La Familia used its Measure A allocation to achieve the following:

- Provide individual and family basic needs information and referral in the areas of housing, job referrals, nutrition, translations, health referrals, immigration, legal and general orientation, and health education workshops to low income residents, to help them attain increased psychosocial and economic stability (target: 1,200 residents; actual: 2,697)
- Provide case management support—including intake and assessment, service planning, direct support, and evaluation—for an average of 90 days to families facing multiple challenges (target: 159 families; actual: 79)
- Provide assistance in applying for health coverage through Medi-Cal and other available options to low income Hayward residents (target: 133 residents; actual: 723)
- Provide workshops/support groups for adults/caregivers on topics to improve access to medical and mental health resources, nutrition, parenting, coping skills, academic engagement, and advocacy (target: 105 workshops/support groups; actual 105)
- Provide workshops/support groups to youths to foster healthier relationships, discuss maladaptive behaviors and risk factors, and explore personal and social responsibility (target: 40 workshops/support groups; actual: 56)

Highlights

La Familia met or exceeded its targets for almost all of its program objectives. In two areas, it greatly exceeded its targets: **providing information to low income residents** (2,697 actual vs. 1,200 target, an increase of over 100%), and **providing health care application assistance** (723 actual vs. 133 target, an increase of over 500%).

Mental Health Services for Juvenile Justice Center

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

Individuals served by Measure A: **149** (Total individuals served: **1,097**)

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

Services provided: Mental Health, Substance Abuse

Service area: Countywide, Outside of Alameda County

BACKGROUND

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

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

MEASURE A FUNDING SUMMARY

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

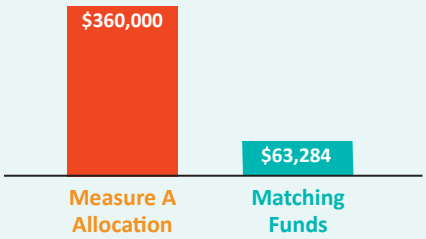
- Mitigate the mental health issues of detained youth by offering crisis intervention and ongoing mental health support while detained.
- Provide court-ordered mental health assessments. Guidance Clinic staff completed approximately 244 mental health assessments in FY 14/15. Measure A funding covered approximately 33 of those assessments.
- Offer immediate crisis intervention for suicidal youth to avoid self-harm. The Guidance Clinic performed 156 crisis interventions to avoid self-harm and/or hospitalization, of which Measure A funded 21.

Highlights

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

- The program resulted in **increased coping skills** among the target population for managing anxiety, depression, and trauma symptoms due to being detained.
- As a result of immediate crisis intervention, **only four clients were hospitalized** in FY 14/15.

Matching Funds



BHCS leveraged its Measure A allocation to obtain **$63,284 in matching funds** from Medi-Cal.

Mental Health Services for Newcomers and Immigrants (CERI)

cerieastbay.org

Allocation: **$78,030** | Expended/Encumbered: **$72,359**

Individuals served by Measure A: **25** (Total individuals served: **50**)

Populations served: Low Income, Uninsured Children, Families

Services provided: Mental Health

Service area: Alameda, Albany, Oakland, San Leandro, Union City

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.

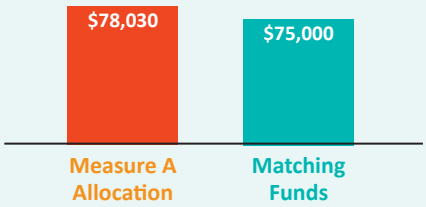
The agency's focus is on Cambodian survivors of the Khmer Rouge genocide and their families, although they have expanded services to other refuge and immigrant populations.

MEASURE A FUNDING SUMMARY

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

- Community events (target: 8 events attended by 50 individuals; actual: monthly events attended by 45 individuals)
- Home and school visits (target: 196 hours; actual: 200)
- Psycho-educational workshops (target: 1 per month; actual: 1 per month)
- Support groups, including life skills classes, art, and other nontraditional mental health prevention activities (target: 4 ongoing groups; actual: 5)
- Cultural workshops for the community and schools (target: 2 workshops; actual: 1)
- Consultation and/or training for community-based organizations (CBOs) (target: 3 trainings; actual: 3)
- Consultation and/or training for schools, probation officers, child welfare workers, and health care workers
- Early intervention for individuals and families including short-term, low intensity interventions (target: 160 hours to at least 4 individuals; actual: 4 individuals)

Matching Funds



CERI leveraged its Measure A allocation to obtain **$75,000 in matching funds** from the Mental Health Services Act (MHSA), including Medi-Cal Administrative Activities (MAA).

Oakland Police Department

www.acbchs.com

Allocation: **$250,000** | Expended/Encumbered: **$250,000**

Individuals served by Measure A: **410** (Total individuals served: **410**)

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

Services provided: Mental Health, Substance Abuse

Service area: Oakland, Homeless or transient

BACKGROUND

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

The Oakland Police Department Mobile Evaluation Team (M.E.T.) provides mobile assessment and evaluation services to those in crisis living in East Oakland. East Oakland was identified by the Oakland Police Department as having the second-largest percent of crisis calls after the downtown area, where BHCS already has a mobile crisis team.

M.E.T. strives to avoid the use of involuntary psychiatric hospitalization when appropriate by providing alternative treatment resources, which may include consultation, crisis intervention, and referral to brief treatment and/or diversion to other voluntary crisis services as available.

MEASURE A FUNDING SUMMARY

M.E.T. used its Measure A allocation to achieve the following objectives:

- Respond to six crisis calls per day, which increased to eight calls per day as the program became established. The Oakland Police Department responds to 20–25 mental health-related calls a day on average, so M.E.T. picked up, on average, one-quarter to one-third of the calls.
- Reduce the amount of time a cover officer has to be on the scene of the 5150 crisis call after the M.E.T. arrives. The cover unit was needed on scene for an average of 15 minutes, with a maximum of 30 minutes and a minimum of five minutes for some calls.
- Provide alternative resources to individuals in crisis. The result of the call was recorded on 320 of the 410 calls that M.E.T. responded to. Of the 320 calls, 58% of individuals were not put on an involuntary hold (5150) and were instead given resource materials, de-escalated, had a physical health/medical issue addressed, or refused to accept services. None of the calls that M.E.T. responded to resulted in an arrest.

Highlights

Having M.E.T. respond to 5150 calls **frees up patrol units** to attend to other types of public safety calls.

M.E.T. **takes the pressure off officers having to make complex mental health decisions** as the clinical mental health staff are able to assist with their expertise, knowledge of the system, and access to the mental health history of patients.

M.E.T. has the ability to **respond faster to 5150 MH crisis calls** because the information is available on the patrol car's computer and the M.E.T. officers can proactively dispatch themselves to the call.

M.E.T. provides **options to de-escalate most situations** by allowing the individual to make the choice to speak with either a clinician or an officer.

Options Recovery Services

optionsrecovery.org

Allocation: **$25,000** | Expended/Encumbered: **$20,000**

Individuals served by Measure A: **6** (Total individuals served: **100**)

Populations served: Indigent, Low Income, Uninsured Adults

Services provided: Substance Abuse

Service area: Berkeley, Oakland

BACKGROUND

Options Recovery Services works to break the cycle of addiction that causes crime, homelessness, and broken families.

MEASURE A FUNDING SUMMARY

Options Recovery Services used its Measure A allocation to achieve the following:

- Complete renovations to the interior of the Berkeley City Hall Annex building, including painting, floor repair, new carpet installation, and new lighting
- Provide ADA accessibility to the building including an exterior wheelchair ramp and modifications to the front door and restrooms
- Bring the facility into compliance with state Medi-Cal regulations
- Ensure efficient communication and accurate and secure information management by installing a new phone system, computers, copier, fax, and Internet access

Options Recovery Services used its Measure A allocation to provide ADA accessibility to the building, including an exterior wheelchair ramp.

Safe Alternatives to Violent Environments (SAVE)

save-dv.org

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

Individuals served by Measure A: **59** (Total individuals served: **112**)

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

Services provided: Mental Health

Service area: Fremont

BACKGROUND

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

All SAVE services are provided free of charge. At SAVE, the only criteria for participation in counseling services is that the client has experienced or is experiencing domestic violence. The drop-in domestic violence support groups held at SAVE's community office are open to any woman struggling with the effects of domestic violence in her life. Any woman can come to group whenever she needs it. There is no registration process, and there are no limitations on how often she can come.

Support groups provide a safe place for women to talk about their issues with each other and the support of a trained facilitator. The information and sense of community they receive from the group helps to reduce isolation and see that the blame lies with the abuser.

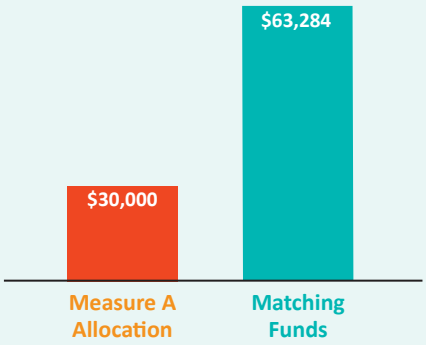
Counseling staff are all trained in domestic violence and have expertise in the effects of that particular kind of trauma. They also understand the types of additional challenges clients who are low income or disabled or struggling with substance abuse or mental health issues might face. They work to ensure that they provide a trauma-informed, culturally appropriate, safe environment in which no client will ever feel judged or blamed for her choices.

MEASURE A FUNDING SUMMARY

Measure A support is a key source of funds for SAVE counseling services. SAVE used its Measure A allocation to meet the following objectives:

- Provide individual counseling sessions to participants, with at least 50% of clients participating in more than one session (target: 160 sessions to 45 participants; actual: 377 sessions to 59 participants, with 92% participating in more than one session)
- Develop safety plans in collaboration with clinicians and clients, with

Matching Funds



SAVE leveraged its Measure A allocation to obtain **$86,000 in matching clinical program funding** from the California Office of Emergency Services as well as private foundation funding.

Highlights

All SAVE programs supported by Measure A **exceeded their targets**, sometimes dramatically. For example, having set a target of providing 160 individual counseling sessions, SAVE actually provided 377—an increase of over 100%.

65% of clients reporting an increased feeling of safety (target: 20 safety plans; actual 28, with 100% of clients reporting an increased feeling of safety)

- Provide a packet of information containing relevant community-based resources to clients, with 65% of clients reporting increased knowledge of how to access community resources (target: 20 packets; actual 28, with 100% of clients reporting increased knowledge of how to access community resources)

Measure A Helps

A transgender Latina client – born as male and identifying as female – with physical disabilities came to SAVE for counseling. The client did not feel safe in her environment and had few financial resources. She had been expelled from her family and had no supportive relationships. The therapist assisted the client with food and hygiene needs and with calling shelters. The next morning, the client moved into the SAVE domestic violence shelter, where she continued to receive therapeutic support. The client was eventually able to find a sense of purpose and focus in her recovery. She moved to Washington state and has become an active member of the transgender community.

Senior Support Program of Tri-Valley

ssptv.org

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

Individuals served by Measure A: **46** (Total individuals served: **46**)

Populations served: Seniors

Services provided: Mental Health

Service area: Dublin, Livermore, Pleasanton, Sunol

BACKGROUND

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

The In-Home Counseling Program makes a difference in the lives of Tri-Valley seniors by providing counseling services in seniors' homes. Staff members receive referrals from case managers, family members, caregivers, and other concerned members of the community. Counseling occurs on an individual basis. During sessions, counselors conduct assessments, including psychosocial, physical, mental health status, and personal history. Counselors also 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.

MEASURE A FUNDING SUMMARY

Senior Support Program of Tri-Valley depends on Measure A funding to support its In-Home Counseling program. Measure A funding supported the following objectives:

- Provide In-Home Counseling services to at least 20 seniors with mental health issues who are referred from community, staff, family, etc.
- Conduct progress evaluations of clients every six weeks until discharge
- Train and supervise interns to assist with counseling
- Evaluate and adjust the program throughout the year by giving evaluation surveys to clients at the end of each client's program

Measure A Helps

After a fall four years ago, Mr. J., 76, did not feel fully recovered and continued to have bouts of depression, forgetfulness, foggy thinking, and inertia. In sessions at the In-Home Counseling Program, the counselor assessed that Mr. J. needed more interactions with family, friends, and community, and discussed ways he could reach out more. Mr. J. received resources for managing his depression, finding a primary care doctor, and locating activities in the community. With each session, Mr. J opened up more about himself and what he wanted to create in his life. Mr. J. has become more outgoing and has started to reach out to others in the community.

Highlights

In FY 14/15, the In-Home Counseling Program had **more referrals than in any other year**.

The Schreiber Center

acbhcs.org

Allocation: **$250,000** | Expended/Encumbered: **$250,000**

Individuals served by Measure A: **15** (Total individuals served: **15**)

Populations served: Low Income Adults

Services provided: Mental Health

Service area: Countywide

Note: In addition to its individual allocation, the Schreiber Center also received Measure A money through the Public Health Prevention Initiative allocation (see page 107). The funding summary information described here is for the total of both allocations.

BACKGROUND

The Developmental Disabilities Council advocates for the rights of people with developmental disabilities to be assisted in the fullest development of their mental, physical, and spiritual potentials, and the right to community living in the least restrictive environment.

MEASURE A FUNDING SUMMARY

The Developmental Disabilities Council used its Measure A allocation to develop a specialty mental health clinic, the Schreiber Center, for adults with developmental disabilities.

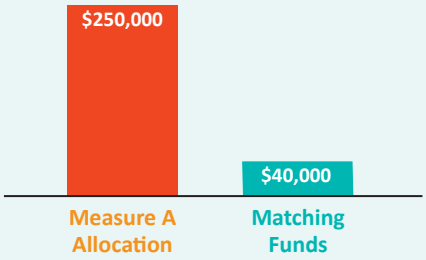
The Schreiber Center, staffed by a full-time clinician and part-time psychiatrist, is now open, located in the Gail Steele Wellness Center in Hayward. A referral process was developed in collaboration with the Regional Center of the East Bay, and extensive outreach and training is ongoing. Services include assessment for specialty mental health, case consultation, psychotherapy, and medication support.

Since the Schreiber Center's opening, the program has received over 50 referrals. Of those 50 referrals, 16 have been opened to the Center and 12 are currently receiving therapy and psychiatric services. Nine are pending assessment.

Highlights

Clients have improved in the following ways: **decreased symptoms of depression, reduced side effects of medications, improved communication with family, increased access to mental health services, and improved care** with current providers following the recommendations of a psychiatrist.

Matching Funds



The Schreiber Center leveraged its Measure A allocation to obtain approximately **$40,000 in matching funds** from Medi-Cal and Mental Health Services Act (MHSA) funds.

Tri-Valley Haven for Women

trivalleyhaven.org

Allocation: **$25,000** | Expended/Encumbered: **$25,000**

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

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

Services provided: Mental Health

Service area: Castro Valley, Dublin, Livermore, Oakland

BACKGROUND

Tri-Valley Haven for Women (TVH) creates homes safe from abuse and contributes to a more peaceful society. TVH strives to build a world without violence.

The majority of clients at TVH have experienced domestic violence, sexual abuse, molestation, or assault at some time in their lives. TVH professional counseling staff provide intake and assessment and ongoing counseling services.

Counseling involves validating client experiences, providing education on domestic violence and sexual abuse, helping clients realize they are not alone, and providing support in many clinical ways. Clients leave with a desire to take care of themselves, many for the first time in their adult lives, and with a positive feeling about their future.

All of these factors help clients live fuller lives and have a positive sense of self and community rather than living in a state of shame and fear where they feel alone, hopeless, and worthless.

MEASURE A FUNDING SUMMARY

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

- Provide professional counseling sessions to adult and children clients (target: 200 sessions to 25 unduplicated clients; actual: 224 sessions to 56 clients)
- Based on staff assessment, have clients show improved mental health (target: 60% of clients served; actual: 91%)

Measure A Helps

When 12-year-old Ana's mom took her to the hospital for stomach pain, tests revealed that Ana was pregnant. She'd been raped by her stepfather. During counseling at TVH, Ana learned that the rape and sexual abuse were not her fault in any way. Ana began to open up to her therapist and process the trauma in a safe environment. When the stepfather went to trial, TVH worked with the district attorney's office to ensure Ana would be protected. TVH's Linkages Program helped the family maintain safe, stable housing. Ana was able to stay at her middle school, where she is now getting As in her classes and loves to play basketball.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 2: HOSPITAL, TERTIARY CARE, OTHER

Administration/Infrastructure Support

acgov.org/health

Allocation: **$400,000** | Expended/Encumbered: **$228,437**

Note: Recipient does not provide direct services

BACKGROUND

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

The HCSA Administration/Indigent Health department serves to provide the following:

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

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

MEASURE A FUNDING SUMMARY

The HCSA Administration/Indigent Health department used its Measure A allocation to provide administrative support for the management of Measure A including, but not limited to, contract development and monitoring, management of special projects, budget oversight and preparation of the annual reports, and staffing of the Measure A Oversight Committee.

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

- HCSA provided contract and administrative support for 65 Measure A allocations. Of the 65 contracts, Administration and Indigent Health

staff was involved in the contract development of 33 of the executed contracts. Of the 33 contracts that were developed by Administration and Indigent Health staff, 90.9% were fully executed within 2.5 months (which is the average turnaround time to develop a contract, receive Board approval, and encumber funds).

- Administration and Indigent Health staff provided one Results-Based Accountability (RBA) training in April 2015 to organizations that received Measure A base funding. A total of 10 organizations were trained in RBA, with 25 participants attending.
- Administration and Indigent Health staff monitored 33 Measure A contracts. The Measure A contract providers had contracts with either monthly or quarterly reimbursement schedules. Of the 156 invoices processed, 90.9% were processed within 30 days of receiving the invoice and progress report.
- Administration and Indigent Health staffed and convened 10 Measure A Oversight Committee meetings. Of the 10 meetings that were scheduled, 100% were convened.
- Administration and Indigent Health staff completed the production and distribution of the FY 13/14 Measure A Final Report.

Of the 33 contracts that were developed by Administration and Indigent Health staff, 90.9% were fully executed within 2.5 months.

CONCERNS

The Direct Service Planning and Administration group does not have enough resources allocated to carry out a Measure A program evaluation that would adequately ensure accountability to Alameda County taxpayers for this annual expenditure of over $120 million. As a first step, appropriate levels of staffing and expenditures would allow staff to conduct mandatory audits and subsequent training for at least 10% of funding recipient programs.

San Leandro Hospital

sanleandroahs.org

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

Individuals served by Measure A: **24,627** (Total individuals served: **24,627**)

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

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

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

BACKGROUND

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

MEASURE A FUNDING SUMMARY

This provider did not supply any Measure A funding summary information for FY 14/15.

CONCERNS

The provider's report contains an impressive list of services and achievements. However, there is no alignment between these achievements and the clearly stated and quantifiable objectives in the provider report. In addition, the goals and objectives listed were not specific to San Leandro Hospital but instead were an exact reprint of the entire AHS goals and objectives. This causes difficulty in determining the intent and actual impact of Measure A funds.

For example, the provider reports that all 24,627 individuals served were served by Measure A, but elsewhere reports that only 54% of individuals served qualified for Measure A benefits. The budget numbers reported are for the entire hospital budget and are not specific to the Measure A grant.

The omitted information in the Measure A Funding Summary section above has been requested several times without response.

Because of these concerns, the Committee recommends a full audit to determine accounting for Measure A expenditures.

St. Rose Hospital

strosehospital.org

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

Individuals served by Measure A: **11,132** (Total individuals served: **40,805**)

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

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient

Service area: Countywide, Homeless or transient

BACKGROUND

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

- Critical access. SRH serves as a critical access point for Alameda County and is the only Medi-Cal-contracted facility between Oakland and Fremont. Additionally, SRH serves as a safety-net hospital and provides health care access to many low income residents who do not have adequate transportation to the Alameda County Medical Center.
- Hospitalists programs. The Hospitalists assume care of indigent and uninsured patients who are admitted to SRH. This alleviates the financial impact of private physicians who request compensation for lack of reimbursement.
- Women's services. SRH operates the Women's Center to meet the growing demand for OB/GYN services in the community, because many OB practitioners do not accept Medi-Cal rates. The program provides immediate and emergency care for pregnant women who present to the emergency room (ER), often with no history of prenatal care.
- Cardiac care. SRH is the only Medi-Cal-contracted facility to provide elective cardiac and percutaneous coronary intervention (PCI) services in central Alameda County. There has been a 3% increase in procedures for Medi-Cal beneficiaries in fiscal year 2015 over 2014. SRH routinely accepts hospital transfers for emergency and elective cardiac care from non-Medi-Cal providers.

SRH serves approximately 12% of Alameda County's indigent population.

MEASURE A FUNDING SUMMARY

SRH used its Measure A funds to subsidize the cost of providing care to the following groups of patients:

- Patients who qualify for charity care
- Uninsured and/or indigent patients

Measure A Helps

A 61-year-old homeless male was brought into the emergency department due to loss of consciousness with acute gastrointestinal bleeding. He was undocumented and uninsured. After being admitted, the patient wanted to leave the hospital because of his inability to pay. After discussion with the physician, he decided to stay. An upper gastrointestinal endoscopy revealed gastritis, duodenitis, and an duodenal ulcer. A blood transfusion was given. The patient was stabilized and discharged six days later. Since the patient did not qualify for insurance, the hospital made the decision to waive the hospital bill. The patient has often returned to St. Rose Hospital to thank the staff for their kindness.

- Traditional Medi-Cal beneficiaries
- Medi-Cal Managed Care enrollees, including Alameda Alliance members
- HealthPAC members

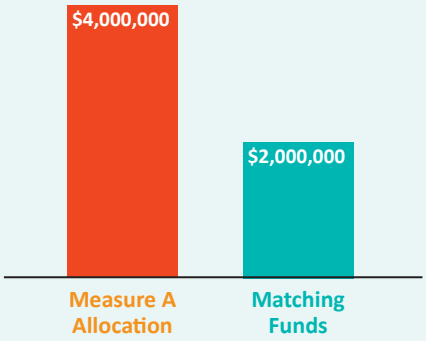
SRH used its Measure A allocation to help achieve the following:

- Provide emergency care for uninsured and underinsured patients. The SRH ER experienced 33,263 visits in FY 14/15, including 73%, or 24,224 visits, from uninsured and underinsured patients.
- Provide hospital admissions for 3,381 uninsured or underinsured patients, representing 57% of total inpatient admissions.
- Assist in supporting SRH inpatient services to uninsured and underinsured patients. Hospital-based physicians provided over 11,500 patient encounters for uninsured patients for the year.

CONCERNS

The objectives included in the provider report are not quantifiably stated and should be revised. While the provider included excellent quantified results achieved in serving uninsured and underinsured patients, these should be revised to match the categories of patients described in the goals and objectives.

Matching Funds



SRH leveraged its Measure A allocation to obtain **$2,000,000 in matching funds** from the intergovernmental transfer program through the Medi-Cal program.

UCSF Benioff Children's Hospital Oakland

childrenshospitaloakland.org

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

Individuals served by Measure A: **33,676** (Total individuals served: **43,118**)

Populations served: Indigent, Low Income, Uninsured Children

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

Service area: Countywide

BACKGROUND

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

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

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

Emergency Department

CHO provides highly specialized pediatric emergency services for the children of Alameda County, 24 hours a day, seven days a week. CHO's ED sees a broad array of pediatric disease and injury from the basic to the most complex. CHO is the leading provider for Alameda County children in need of acute care. Children with Medi-Cal rely nearly exclusively on CHO for emergency services since the public hospitals in the area do not provide specialized pediatric care and do not have any beds for children in the event a child needs to stay overnight. In FY 14/15, CHO's ED was the highest volume ED in the San Francisco Bay Area.

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

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

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

Measure A Helps

A school clinic patient who is now 25 years old was a bright and vibrant student at Castlemont High School and won a scholarship for track in Idaho. She was hesitant to pursue this opportunity, as she had significant family pressure to stay in Oakland. However, with encouragement from her therapist she was able to leave. Over her breaks from college she often came to the clinic for ongoing care and would discuss the "culture shock" of living in Idaho coming from East Oakland. With continued support and encouragement she completed college, has completed her Masters of Science in Criminal Justice, and is living in Louisiana.

California. Without the CHO ED, children would need to travel farther and/or receive care that is not specialized to children. With little doubt, more children would die without the CHO ED.

Center for Child Protection

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

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

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

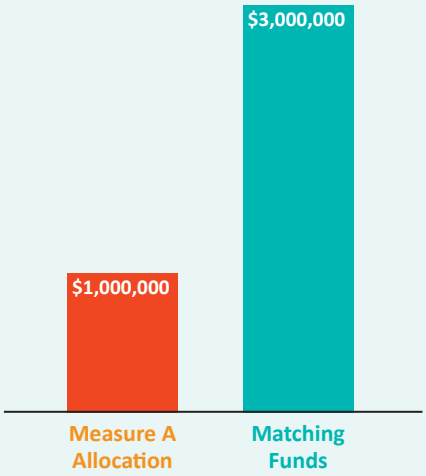
Clinical case management is provided to children and adolescents who present to the ED and/or child abuse management clinic following diagnosis or disclosure of abuse. Comprehensive evidenced-based mental health services are provided to children, adolescents, and their families who have been exposed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

School-Based Clinics

CHO runs two school-based health centers: one at Castlemont High School and one at McClymonds High School. The school health centers provide a safe and convenient place for students to receive integrated, comprehensive medical and mental health services. The Youth Uprising/Castlemont Health Clinic sees students from Castlemont High School as well as members of the community ages 11–24. The Chappell Hayes Health Clinic sees students from McClymonds High School as well as members of the community ages 11–21.

The Castlemont site is now the highest volume school-connected mental health site in Alameda County. The sites' School-Based Mental Health Program has become a national model for the integration of medical and mental health care, and it has been cited for success at addressing underlying social stressors related to mental health. The program has

Matching Funds



CHO leveraged its Measure A allocation to obtain **$3,000,000 in matching funds** through an intergovernmental transfer using supplemental funds from the California Department of Health Care Services.

developed a training and consultation program for school professionals and mental health providers who work with schools, and it has contracts to conduct trainings throughout Alameda County and California.

MEASURE A FUNDING SUMMARY

CHO used its Measure A allocation to achieve the following:

Emergency Department

- In FY 14/15, there were a total of 44,508 unique patients to the ED.
- 665 of these visits were trauma cases where the child faced an immediate life-threatening situation.
- The total average time children spent at the ED shrunk to 3.1 hours. This compares with 4.1 hours for CHO's peer group according to studies conducted by McKesson.
- Measure A funding helped the ED upgrade its space to be more kid-friendly and purchase state-of-the-art equipment, such as new monitors and imaging equipment.
- The average time for providing sickle cell patients with proper pain medication decreased from 90 minutes to 30 minutes, which is among the top in the nation.
- Over 400 children seen in the ED were referred to and seen at CHO's asthma clinic for follow-up care and asthma education.

Center for Child Protection

- In FY 14/15, the CCP served more than 1,000 children.
- The CCP conducted 104 forensic evidentiary examinations, 55 outpatient medical consultations, and 57 inpatient medical consultations, and provided clinical and psychotherapy services to 556 children.

School-Based Clinics

- In FY 14/15, the two clinics run by CHO had a total of 2,458 encounters and saw 823 children/adolescents.

CONCERNS

The Committee notes that CHO does not list measurable objectives, which has been raised *repeatedly* in the last several years. Additionally, many of the achievements do not give a specific time frame for achievement—it is unclear what improvement, if any, took place from FY 13/14 to FY 14/15.

All the numbers listed under the Measure A Funding Summary are identical to the numbers listed in the FY13/14 Measure A report.

Because of these concerns, the Committee recommends a full audit.

The average time for providing sickle cell patients with proper pain medication decreased from 90 minutes to 30 minutes, which is among the top in the nation.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 3: PRIMARY CARE

Alameda County Dental Health

www.acphd.org/dental-administration.aspx

Allocation: **$153,662** | Expended/Encumbered: **$153,662**

Individuals served by Measure A: **2,088** (Total individuals served: **4,833**)

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

Services provided: Public Health

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

Note: In addition to its individual allocation, Alameda County Dental Health also received Measure A money through the Public Health Prevention Initiative allocation (see page 107). The funding summary information described here is for the total of both allocations.

BACKGROUND

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

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

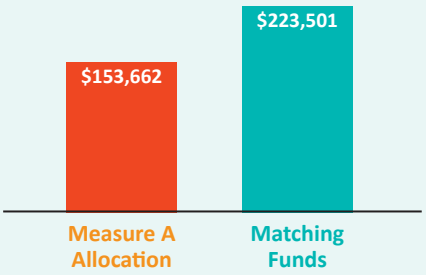
For children who need follow-up care beyond the services provided at the WIC site, the outreach worker collaborates with the family to assess insurance coverage, obtain a dental appointment with a provider, and assist with making the initial dental appointment. For families lacking insurance coverage, the outreach worker arranges insurance assistance through the Healthy Smiles Dental Treatment program.

MEASURE A FUNDING SUMMARY

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

- Enroll at least 400 infants and toddlers into the Healthy Kids Healthy Teeth (HKHT) program of preventive dental services and access to early dental care
- Provide 710 of these children with oral assessments and fluoride varnish applications

Matching Funds



The WIC Oral Health Program leveraged its Measure A allocation to obtain **$223,501 in matching federal funds** from the Maternal, Child & Adolescent Health Program (MCAH) and Child Health and Disability Prevention (CHDP).

Highlights

An analysis of health outcomes for children participating in the WIC "Dental Days" showed that they had **42% fewer restorative dental treatment needs** compared to children who did not benefit from the program.

- Ensure that 78% of the families received care through Medi-Cal
- Ensure that a minimum of 150 families and children be assisted in getting access to dental providers who were willing and able to provide early care and become a dental home
- Ensure that at least 75% of children enrolled in HKHT visited a dentist at least once during the year to begin accessing supplemental fluoride varnish and additional oral health family education services
- Expand operation of WIC "Dental Days" to a fourth site (Fremont) in addition to Hayward, Eastmont, and Telegraph
- Provide prenatal oral health education to WIC staff who conducted prenatal classes for 455 prenatal women, and establish an incentive for women to attend the classes

Measure A Helps

A five-year-old child had severe tooth decay and needed immediate dental treatment. The family was hesitant to accept public health services while they were experiencing financial hardship and language barriers. The outreach worker referred the family to the Healthy Smiles program and ensured them that translation services would be available. The child had his dental appointment and was scheduled for follow-up treatment. The outreach worker kept in close contact with the family and was able to enroll other siblings into the Healthy Smiles program. The child is no longer suffering from dental pain and infection, and has a dental home that provides preventive and restorative dental services.

Berkeley Community Health Project (Berkeley Free Clinic)

berkeleyfreeclinic.org

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

Individuals served by Measure A: **653** (Total individuals served: **8,207**)

Populations served: Indigent, Low Income, Uninsured Adults

Services provided: Public Health, Mental Health

Service area: Countywide, Homeless or transient

BACKGROUND

The Berkeley Free Clinic (BFC) works to empower individuals and communities by providing accessible, client-centered health services and information. All services at BFC are provided completely free of charge. BFC also provides extensive education and referrals to every client.

Every client is screened for health insurance needs and, when applicable, referred to BFC's Certified Enrollment Counselors for help exploring options for health insurance. Providers also work with clients to determine what social services, like food, housing, and long-term primary care, might be beneficial to the client. BFC's Information Resource Collective provides in-person and over-the-phone referrals for requests ranging from legal counsel to crisis hotlines to transportation resources and more.

MEASURE A FUNDING SUMMARY

Every year, the BFC provides thousands of same-day appointments for acute medical care, STI screens, TB tests, dental care, and peer counseling. Measure A funding enabled BFC to provide fully comprehensive care to individuals requiring more significant help than what BFC is typically able to afford.

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

- Provide acute medical care for certain respiratory infections, dermatological concerns, urinary tract infections, and minor wounds/burns to 101 clients.
  - 94% of clients indicated that they were satisfied or highly satisfied with the services they received.
  - 64% indicated they knew more about how to treat or prevent their health concern after the visit than they did before.
  - 35% reported that if they had not come to BFC, they would have needed to rely on the emergency room to address their concerns.

Measure A Helps

After her boyfriend cheated on her, ZD came to BFC for an STD screen. She received information about symptoms, treatment, and how long it would take before an STD showed up on a test. The BFC counselor who called ZD with the test results took extra time to talk with ZD about how she was doing emotionally. ZD was uninsured, so the counselor also talked with her about health insurance. A BFC Certified Enrollment Counselor helped ZD navigate the Covered CA system and sign up for health insurance. She has a primary care doctor now and feels much more secure and in control of her health.

- Provide confidential STI/HIV testing and counseling to 150 clients and provide referrals to other organizations for STI and HIV management as needed.
  - 100% of clients with a reactive result on a rapid HIV test received a confirmatory test the same day and a confirmed result within two weeks.
  - 68% indicated that they knew more about their sexual health after the visit than they did before.
  - 100% presenting GC or NSU received treatment the night of their visit.
- Provide Hepatitis A, B, and C testing and counseling to 72 clients and provide referrals to other organizations for long-term Hepatitis B or C management
  - 95% of clients indicated that they were satisfied or highly satisfied with the services they received.
  - 76% who were unvaccinated and at high risk for Hepatitis B were vaccinated.
  - 73% indicated that they knew more about how to treat or prevent their health concern after the visit than they did before.
- Provide Tuberculosis (TB) testing and counseling to 100 clients and provide referrals to other organizations for long-term TB management.
- Provide 150 free peer counseling sessions and provide referrals to crisis lines and other resources as needed.
  - 94% of clients indicated that they were satisfied or highly satisfied with the services they received.
- Provide dental screening, cleanings, and/or fillings.
  - 41 clients were provided with dental exams and cleanings.
  - 40 clients received fillings.
  - 98% of clients indicated that they were satisfied or highly satisfied with the services they received.

100% of clients with a reactive result on a rapid HIV test received a confirmatory test the same day and a confirmed result within two weeks.

Center for Elders' Independence

cei.elders.org

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

Individuals served by Measure A: **N/A** (Total individuals served: **675**) *FY 14/15 Measure A funds were spent on program development; no direct services were offered as a result of this year's funding.*

Populations served: Indigent, Low Income Adults, Seniors

Services provided: Hospital Inpatient

Service area: Alameda, Albany, Ashland, Berkeley, Castro Valley, Cherryland, Emeryville, Hayward, Oakland, San Leandro, San Lorenzo

BACKGROUND

The Center for Elders' Independence (CEI) provides 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 Program of All-inclusive Care for the Elderly (PACE) is a comprehensive, community-based long-term care health plan that serves frail adults age 55 and over with complex medical needs. All enrollees are Medi-Cal beneficiaries, and most also have Medicare coverage.

MEASURE A FUNDING SUMMARY

CEI used its Measure A allocation to achieve the following objectives:

- Develop an in-house End-of-Life (EOL) and advance care planning program that incorporates industry best practices and materials using internal and external resources and personnel
- Develop and/or acquire advance care planning and EOL training materials and train staff to implement advance care planning and end-of-life care
- Research the cost of hiring a chaplain to provide emotional and spiritual support to participants and families in the EOL program, and offer chaplain services
- Develop a plan for implementing the EOL program, including chaplain services, for applicable participants
- Develop a plan for collecting data on EOL participation and administer a survey to participants on their advance care planning/advance directive (AD) experience

Program services began in FY 15/16.

CEI used its Measure A allocation to develop an in-house EOL and advance care planning program that incorporates industry best practices and materials.

Center for Healthy Schools and Communities (School Health Centers)

achealthyschools.org

Allocation: **$1,924,740** | Expended/Encumbered: **$1,924,740**

Individuals served by Measure A: **14,446** (Total individuals served: **14,446**)

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 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 Center focuses its programs on five specific result areas:

- Children are physically, socially, and emotionally healthy.
- Children succeed academically.
- Environments are safe, supportive, and stable.
- Families are supported and supportive.
- Systems are integrated and care is coordinated and equitable.

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

Mental Health and Substance Abuse Services

The SHCs offer school-based counseling on alcohol and drugs including individual counseling, prevention and early intervention, substance abuse assessments, and relapse prevention. Behavioral health group counseling is offered at the SHCs for prevention and early intervention, including some groups that focus on conflict resolution and/or restorative justice. The SHCs also offer crisis intervention, family therapy, and referrals as needed. Other services included case management, individual contact/meetings, plan development, and collateral with family members and school staff.

Public Health Prevention and Outpatient Services

The SHCs provide public health prevention and outpatient services

Measure A Helps

A 17-year-old female was brought to the SHC because she was crying in class. She told the therapist that she had had an upsetting sexual experience the day before. While undergoing STI testing, the youth revealed that she had met a man on the Internet and had been raped. Police and CPS reports were filed, and her mother was brought into the clinic. Staff revealed to the mother what had happened, because the student was afraid to tell her. The mother was extremely supportive and planned to connect the young woman to Kaiser for care. She thanked SHC staff profusely for the support provided to her and her daughter.

through medical visits with providers and health education/outreach activities. Medical visits include sports physicals, disease screening, chronic disease management, medicine management, and other primary care services. The SHCs also treat injuries, headaches, abdominal pain, cold/flu symptoms, and other first aid needs.

The SHCs also provide sexual/reproductive health services, including contraceptive maintenance, contraceptive counseling/family planning advice, and sexually transmitted infection (STI) counseling.

Finally, dental services are offered at eight SHCs. Most visits are for screening, assessment, and examinations, and the rest are for preventive services. Referrals and follow-up care are provided as needed.

Youth and Community Services

The SHCs offer education and outreach activities ranging from health fairs and other schoolwide events to workshops on parenting or healthy relationships, The SHC also offer a wide range of nutrition and physical education activities. SHCs provide leadership development and mentoring through peer health education programs and youth advisory boards. They also provide a variety of programming including sports, tutoring, dance, arts, media, and gardening during lunch or after school.

MEASURE A FUNDING SUMMARY

Measure A funds supported 15 of the 27 SHCs. 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.

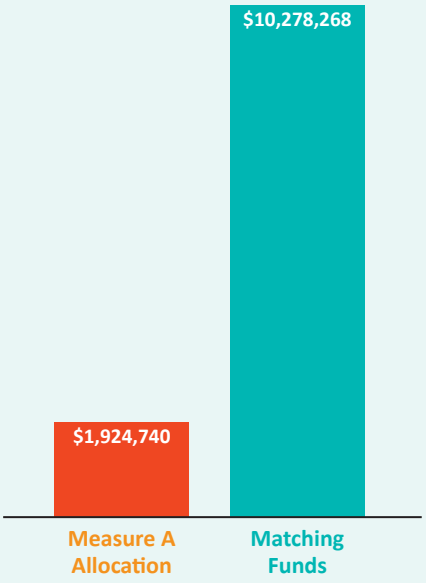
The SHCs used their Measure A allocation to achieve the following objectives.

Provide comprehensive school health services in a safe, accessible environment on or near the school campus during convenient hours

SHCs continue to expand. In FY 14/15, the SHCs served three elementary, 10 middle, and 18 high schools. During the same period, the number of clients increased from 5,010 to 14,446 (a 188% increase), and the number of annual client visits increased from 18,818 to 60,780 visits (a 223% increase). The SHCs also served more than 1,000 clients from the broader community, including high school graduates, college students, siblings, and community members.

SHCs are open during school hours and often after school as well. Nearly one-quarter of visits were drop-in, demonstrating the flexibility of the

Matching Funds



The School-Based Behavioral Health Initiative leveraged its Measure A allocation to obtain **$10,278,268 in matching funds** from Medi-Cal and other third-party billing; the Tobacco Master Settlement Fund (TMSF); and other funding from the County, cities, school districts, the state, the federal government, and private grants.

services. In addition, SHC services are available at no cost to clients, regardless of their insurance status, thus filling a gap for students who are uninsured or underinsured. Nearly one in five clients were reported to have no insurance.

Of those clients with data recorded, 26% did not have a primary care medical home and 28% did not have a regular dental provider.

Without an SHC onsite, many students might have been sent home—leading them to miss a portion of the school day—rather than having their health issues addressed on site and being sent back to class.

Provide SHC clients with referrals to necessary health and wellness services

SHCs offer a full scope of integrated services with easy referrals among providers. Clients return for multiple visits to the SHCs, demonstrating the value of integrated and youth-friendly services.

Provide first aid, medical, and health education services

SHCs help clients with a variety of medical concerns. The SHCs provide vital care for health problems that could interfere with students' ability to attend and succeed in school.

SHCs provide education and interventions to encourage healthy behaviors, such as delayed sexual initiation and contraceptive use. According to clinic data, female contraceptive use improved significantly over time.

Provide behavioral health services

Individual and group behavioral health services were provided during 21% of all visits to 3,015 clients. A sample of clients were tracked over time and improvements were reported in clients' presenting problems and observed strengths.

Provide dental health services

SHCs are increasingly providing vital dental services to their clients. At the eight sites providing services in FY 14/15, 22% of all visits (1,045 clients) had a dental service provided. Many of the visits resulted in identification of suspicious areas of decay or urgent needs.

Provide additional nonclinical services such as youth development and school climate services

SHCs integrate health and education through broader student and community educational programs. Overall, SHCs had 18,650 contacts

Highlights

Comprehensive health services were provided at or near Alameda County schools to an increasing number of students compared to previous years. Care provided included **primary medical care, first aid, health education, behavioral health services, and dental care** at eight school sites, as well as referrals to additional sources of care when needed.

SHC evaluation data showed that SHCs are **providing safe places for youth to get needed care**:

- 61% of clients returned for more than one visit, indicating high patient satisfaction and that patients feel welcomed and safe in the clinics.
- Compared to non-users, significantly more clients reported "always" receiving counseling (31% users vs. 24% non-users) , and reproductive health services (39% vs. 25%).
- 87% said, "The SHC helped me get services I wouldn't otherwise get."
- 87% said, "The SHC helped get help sooner than I normally would."
- 95% said, "The people who work there helped me work through my problem."

with adult participants such as family members, school staff, and other school community members through these events and activities. Eight of the SHCs have a Youth Advisory Board and 10 have a Peer Health Education or Peer Mentoring program, where students develop leadership skills and learn to give classroom presentations on various health issues.

CONCERNS

The provider reported program results, including statistics, for the 27 schools served by SHCs—not for the 15 SHCs specifically funded by Measure A. The results for these 15 schools might differ considerably from the average of the 27 SHCs.

Given the sizable allocation of almost $2 million, the provider should report more precise information to the Oversight Committee.

Highlights

Survey data indicated that SHCs are **helping youth with overall health and healthy behaviors**. Clients who completed the survey said that the health center helped them to:

- Exercise more: 71%
- Eat healthier foods: 73%
- Avoid getting into fights: 63%
- Deal with stress/anxiety better: 76%
- Feel like I had an adult I could turn to if I needed help or support: 89%
- Feel more confident: 88%
- Stop using or use less tobacco, alcohol, or drugs: 53%

Fire Station Health Portals

Allocation: **$750,000** | Expended/Encumbered: **$187,050**

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

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

Services provided: Emergency Medical

Service area: Alameda, Homeless or transient

BACKGROUND

The Alameda Fire Department's Community Paramedic (CP) program guides clients towards health and well-being, connects clients with appropriate services, and intervenes when clients are unable to take an active role in the management of their health care.

The CP program primarily provides case management, with some medical evaluation. These efforts include assisting with house cleaning, locating family members with whom clients had lost contact, and connecting clients with programs and activities in the community. CPs spend a lot of time with each client's family members to educate them on the client's chronic conditions and to aid in reaching out for other services.

CP program objectives include the following:

- Enroll post-hospital discharge patients who were admitted for congestive heart failure, chronic obstructive pulmonary disease, heart attack, sepsis, and pneumonia, as well as frequent utilizers of emergency services, into the program
- Assess enrollees' needs for additional medical, mental health, and social services
- Help clients secure primary care physicians
- Connect clients with specialists: cardiologists, neurologists, pulmonologists, etc.
- Secure in-home support services or facilitate an increase in hours previously allotted to clients
- Assist with establishing physical or occupational therapy services for clients in their homes
- Connect clients with local resources and outreach programs, such as the Alameda Food Bank, Meals on Wheels, Alameda Friendly Visitors, Alameda Point Collaborative, and Mastick Senior Center
- Obtain medical equipment for clients, such as wheelchairs, walkers, canes, commodes, bedside rails, etc.
- Assist clients with their prescription medications, including medication education, picking up prescriptions from the pharmacy, and disposing of medications that had expired or were no longer prescribed
- Perform home safety evaluations for clients, ensuring that smoke/

Measure A Helps

A 79-year-old woman with special needs due to her medical condition was referred to the CP program. She had MS, chronic back pain, and limited use of her hands. Because her neurologist was in San Francisco, she had not had an appointment in years. She received County-provided caregiver support during weekdays, but on weekends she was alone and struggled with activities such as preparing food. Thanks to the CPs, her caregiver hours were increased to include weekends. A neurologist was found whose office is ten minutes from her house. A medical alert system was set up, so the client can call for help if she falls when she is alone.

carbon monoxide detectors were functioning properly and eliminating any potential trip or fall hazards
- Refer clients to the Alameda Fire Department Senior Fall Prevention Program, which provided many clients with grab rails and smoke detectors—with no cost to the client in some cases

MEASURE A FUNDING SUMMARY

The CP program used its Measure A allocation to work on establishing pathways for referrals and case management through meetings and phone calls with various medical and social service providers within the County. CPs worked with discharge planners and physicians from Alameda Hospital to receive referred post-discharge and frequent utilizer patients, and to clarify discharge instructions, medications, and follow-up plans.

The CP program used its Measure A allocation to work on establishing pathways for referrals and case management with medical and social service providers within the County.

Using its Measure A funding, the CP program achieved the following:
- Enrolled five clients into the post-discharge program.
- Enrolled 11 clients into the frequent utilizers program.
- Provided 15 total combination referral/assistance efforts. CPs not only referred clients to other health and social services in the County, they also helped clients develop a plan for returning to employment, reconnect with family members, and rekindle the desire to resume past healthy hobbies.
- Provided 49 total combination face-to-face visits and assessments. CPs visited clients in their homes, in the emergency department, and at a local clinic. CPs performed medical, bio-psych-social, and home safety assessments. CPs also performed medication reconciliation for each client.

Fremont Aging and Family Services

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

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

Individuals served by Measure A: **31** (Total individuals served: **31**)

Populations served: Indigent, Low Income, Uninsured Seniors

Services provided: Public Health, Mental Health

Service area: Fremont, Hayward, Newark, Union City

BACKGROUND

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

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

The AFS Health Promoter Program improves both the physical and mental health of older adults by increasing access to health services, supporting healthy behavior changes, monitoring medications, and providing health education classes. The program offers these services at home and at community congregate sites to older adults in Southern Alameda County, with a focus on low income, Afghan refugee women over the age of 50 years.

Within the Health Promoter Program, Afghan Health Promoters develop relationships with Afghan seniors, provide emotional support, offer health education, and coordinate referrals for health and social services.

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

- Linkages. The Linkages program provides information, referral, and assistance to participants. Health Promoters assist participants access an array of services and entitlement programs. Additionally, they help 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' medications, 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

Measure A Helps

Rahima, an 81-year-old Afghan woman, suffers from hypertension and heart and vascular problems, and has been diagnosed with serious mental illness (SMI). She takes multiple medications including psychotropic medication. She was referred to the Happy, Healthy Me program as she was isolated and not getting out of the house. Her initial goal was to attend AEA's Healthy Aging Program at least once a month, which she quickly exceeded by going two to three times a month. While at the program, her depression lifted and her SMI symptoms decreased. When her SMI symptoms increase, the health promoter and Rahima's doctor monitor her to get her back on track.

assist with translation and how to use medication.

- 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.
- Health education groups. The program offers two health education groups. The first is the Stanford Chronic Disease Self-Management Program. Three health promoters have been trained as leaders, and the group is offered at least once a year. The second is the Diabetes Education Group. One health promoter has been trained by the Alameda County Public Health Department to lead the group. Other health promoters assist.

MEASURE A FUNDING SUMMARY

Measure A funding helped the Health Promoter Project meet its overall program objective to improve both the physical and mental health of older adults through increasing access to health services, supporting healthy behavior changes, monitoring medications, and providing health education classes.

Measure A helped the Health Promoter Project achieve the following measurable objectives.

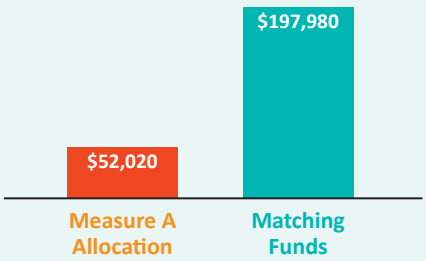
General

- Provide health promotion services to Afghan clients (target: 100; actual: 152)
- Ensure clients receive care from a primary care physician (target: 90; actual: 151)
- Provide socialization from Health Promoters (target: 100; actual: 152)
- Have clients complete a wellness screen (target: 60; actual: 89)
- Conduct home safety evaluations (target: 40; actual: 89)

Service Linkage

- Conduct home visits to clients (target: 350 home visits to 85 clients; actual: 563 home visits to 140 clients)
- Provide health education from Health Promoters (target: 100; actual: 152)
- Refer clients to City of Fremont case management and/or counseling services (target: 25; actual: 36)
- Provide eligibility assistance and support to access supportive services to clients (target: 100; actual: 111)
- Help clients access other community services (target: 50; actual: 72)

Matching Funds



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

Medication Management

- Provide medication review, education, and counseling (target: 50; actual: 51)
- Utilize the "teach back" methodology to show an increased knowledge of medication among clients (target: 50; actual: 51)
- Improve medication compliance within six months for clients identified as having deficits in medication compliance (target: 30; actual: 41)

Happy, Healthy Me

Ensure the following:

- Clients develop a Wellness Action Plan (target: 40; actual: 36)
- Clients participate in their Action Plan (target: 30; actual: 34)
- Clients show improvement after six months (target: 30; actual: 34)

Health Education Groups

- Offer one 15-hour Chronic Disease Self-Management Program class for Afghan participants (target: 15 participants; actual: 16)
- Achieve participants showing an increase in their ability to manage chronic conditions (target: 12; actual: 16)
- Offer one six-week diabetes class for participants (target: 12 participants; actual: 18)

Highlights

In almost all areas, the Health Promoters program exceeded its targets, sometimes dramatically. For example, the program conducted **563 home visits to 140 clients**, compared to a target of 350 home visits to 85 clients.

Health Enrollment for Children

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

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

Individuals served by Measure A: **1,260** (Total individuals served: **1,260**)

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.

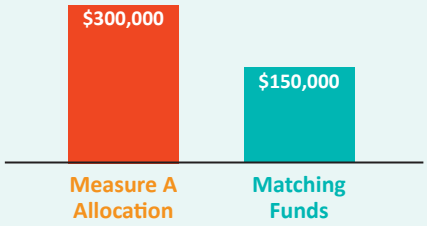
The Health Insurance Enrollment Assistance department is a critical resource for some of the hardest-to-reach and most vulnerable populations in Alameda County. The department provides a client-centric and culturally competent approach to help residents enroll into health care and benefit programs and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

In 2014, the Health Insurance Enrollment Assistance program expanded services in the San Leandro Unified School District. The goal was to offer health insurance assistance in a familiar setting to families served by the district, who otherwise would not follow through with applying for or renewing their County benefits. The school district gave the department space to come in weekly to support families.

MEASURE A FUNDING SUMMARY

Thanks in part to Measure A funding, the program provided benefit program application assistance to approximately 6,000 Alameda County residents.

Matching Funds



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

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

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

Allocation: **$86,700** | Expended/Encumbered: **$86,700**

Individuals served by Measure A: **350** (Total individuals served: **500**)

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

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

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

BACKGROUND

The Health Service for Day Laborers Community Initiatives/Day Labor Center (DLC) program works to enable low income migrant clients in the East Bay, including at-risk youth and re-entry clients, reach self-sufficiency through employment and community integration programs.

Through partners Samuel Merritt University in Oakland, California State East Bay's Initiative for Community Wellness in Hayward, Davis Street Clinic in San Leandro, and the Alameda County Healthcare for the Homeless Van, the DLC Healthcare Portal Project provides referrals for safety net health care services to hundreds of under- and unemployed, mostly migrant clients in Southern Alameda County. The DLC develops culturally competent material for its clientele and trains Peer Health Educators to provide outreach and information services to this population.

The DLC provides services in the following areas:

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

Measure A Helps

Hugo, 18, came from Guatemala without his parents. His situation in Guatemala was dangerous, and his family thought he would be safer in America. Hugo came to Hayward with an uncle who took him in and brought him to the DLC. DLC staff helped Hugo with his paperwork and made an appointment for him to talk to a lawyer about his immigration situation. The lawyer was able to help Hugo stay in America for now. Hugo attends Tennyson High School, where the DLC director coaches the soccer team. Hugo hopes to graduate this year, and the DLC is going to help him go to Chabot College.

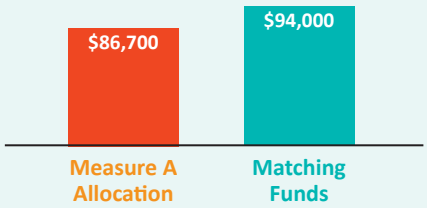
minors in Alameda County and coordinates needed services to this clientele. The DLC provides services to the indigent population and youth from the surrounding neighborhood, including job skills training and community volunteer service opportunities.
- Socialization. The DLC maintains a community garden and has an 18-team soccer league to address the workers' ailments of depression, isolation, and loneliness due to being separated from their families in their home countries.

MEASURE A FUNDING SUMMARY

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

Measure A funding helped the DLC achieve the following objectives:
- Offer health-related navigation and referral services specific to the health care needs of approximately 500 workers within the working-age day labor population at the DLC, including 71 new clients
- Provide over 1,000 primary health care referrals for health care screenings and/or episodic care visits for issues including eye irritations, blurry vision, urination pain, toothaches, swollen joints, high blood sugar, GERD, hearing problems, persistent cough, allergies, gastritis, flu-like symptoms, high cholesterol, mental health concerns, and abdominal pains
- Conduct 400 follow-up assessments with and offer recommendations to clients referred into the health care system
- Communicate the information and issues obtained in client follow-up assessments to allied community-based organizations, policy makers, and governmental agencies to assist in improving health care services for the day labor population
- Hold six semi-annual meetings with appropriate staff from both the clinic and Center to review and evaluate the services provided
- Advocate for the day labor population and their health care needs—including hours of operation, types of services needed, and/or cost structures—with local clinics by participating in Supervisor Valle's Tennyson Corridor Initiative, which proposes to construct a new family community center at the current DLC site
- Train and work with six Peer Health Educators to provide health education and outreach services to the day labor population
- Conduct external outreach to the working-age day labor population at five locations, and maintain a partnership between local clinics and the Center to ensure day labor workers become integrated as part of the local health care system
- Provide ongoing monthly community health, safety, and wellness presentations and/or trainings to unemployed and/or underemployed day labor workers
- Identify and register almost 100 individuals who may be eligible for health coverage, including Medi-Cal and Alameda County's HealthPac

Matching Funds



The DLC leveraged its Measure A allocation to obtain **$94,000 in matching funds** from foundation sources.

Health Services for Day Laborers: Multicultural Institute

mionline.org/

Allocation: **$86,700** | Expended/Encumbered: **$86,700**

Individuals served by Measure A: **1,603** (Total individuals served: **1,814**)

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

Services provided: Public Health, Mental Health

Service area: Berkeley, Oakland, Homeless or transient

BACKGROUND

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

MI focuses its efforts in the following areas:

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

Measure A Helps

Guapo, 34, approached MI staff after working on a tree service job. He had gauze over his left eye, which was red. He explained that a tree branch had poked and severely scraped his eye. He had not gone to the hospital or to a clinic because he had no health insurance or money. MI staff immediately referred Guapo to the Alameda County Health Care for the Homeless (ACHCH) mobile van. ACHCH staff quickly assessed his medical situation and sent him to San Leandro Kaiser. Guapo received free same-day services and follow-ups. Doctors said if he would have waited any longer he was at high risk of losing his eyesight.

MEASURE A FUNDING SUMMARY

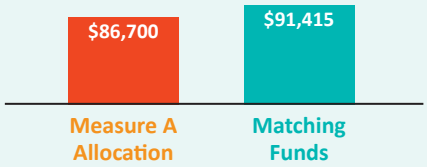
Measure A funding helped MI achieve the following objectives:

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

- Target: Provide outreach to 700 unduplicated clients and 70 one-on-one consultations, with 90% of contacts reporting that their health care needs were met
- Actual: Outreach to 1,332 clients, 297 consultations held, and 93% of contacts reporting that their health care needs were met

- Provide health education and public health promotion on various topics
  - Target: Host or co-sponsor eight health care trainings or workshops attended by 150 participants, with 70% indicating an increase in knowledge about the topics
  - Actual: 11 trainings/workshops held attended by 240 participants, with 70% indicating an increase in knowledge
- Provide health care treatment and services through partnerships with providers and/or contracted services
  - Target: 400 screenings or visits, with 70% of contacts indicating that they would not have had access to such services if it weren't for MI and its partners
  - Actual: 248 screenings/visits provided, with 85% of contacts indicating that they would not have had access to services otherwise
- Offer a food distribution program
  - Target: Provide weekly distribution of Alameda County Food Bank groceries for 900 unduplicated clients, representing about 320 unduplicated households, with 60% of households reporting that without MI they would not have had access to food
  - Actual: Groceries distributed to 804 clients representing 320 households, with 87% indicating that they would not have had food otherwise

Matching Funds



MI leveraged its Measure A allocation to obtain **$71,394 in matching funds** from the City of Berkeley and **$20,021** from the Metropolitan Transportation Commission (MTC).

Health Services for Day Laborers: Street Level Health Project

streetlevelhealth.org

Allocation: **$86,700** | Expended/Encumbered: **$86,700**

Individuals served by Measure A: **500** (Total individuals served: **1,600**)

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

Services provided: Public Health, Mental Health

Service area: Countywide, Homeless or transient

BACKGROUND

Street Level Health Project is an Oakland-based grassroots organization dedicated to improving the health and well-being of underserved urban immigrant communities in the Bay Area. The Street Level community center is an entry point to the health care and social service system for those most often overlooked and neglected, namely the uninsured, underinsured, and recently arrived. Street Level develops trusting relationships with isolated immigrants, offers them a place to build a healthy and vibrant community, and empowers them to advocate for the well-being of themselves and their families.

Street Level Health Project offers accessible health care services to low income immigrant workers who would often otherwise delay or avoid seeking care due to barriers such as cost, immigration status, language, lack of insurance, or discrimination. Services are free and are provided on a drop-in basis, with no appointment required.

In FY 14/15, 87% of Street Level patients lacked insurance coverage. Ninety-two percent were immigrants, 93% spoke a language other than English, and 61% reported speaking no English.

MEASURE A FUNDING SUMMARY

Measure A funds allowed Street Level to offer a free, thrice-weekly drop-in health screening clinic to low income immigrant workers, as well as to offer drop-in mental health consultations and referrals in Spanish during health screening clinic hours.

Measure A funds also allowed Street Level to provide Mam (a Mayan language) and Mongolian interpretation to patients and clients. Interpretation was provided within the clinic and during street outreach with day laborers.

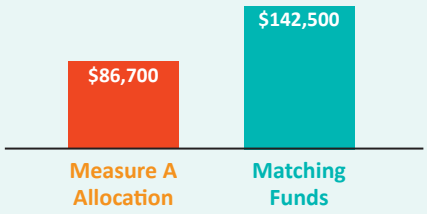
Measure A Helps

Feliciano, a 39-year-old Mam-speaking Guatemalan day laborer, had high risk of heart failure. He went to the hospital for a pacemaker, but was hesitant about the operation and left the hospital against medical advice. Over the following month, Street Level staff had eight case management encounters with Feliciano to review questions, fears, and doubts. When his symptoms began to worsen, Feliciano decided he was ready for the operation. The surgery was completed without complication, and Feliciano was able to resolve his bills and enroll in regular coverage with assistance from Street Level's onsite staff. He also was able to recover over $1,000 at Street Level's wage theft clinic.

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

- Provide health care screening and episodic care to clients across multiple languages (target: 750 clients, with 95% receiving same-day services; actual: 738 clients, with 98% receiving same-day services)
- Offer health care referrals (target: 1,000 referrals; actual: 1,354)
- Provide mental health prevention workshops/trainings (target: 10; actual 10)
- Offer mental health consultations/referrals annually to low income communities in Alameda County (target: 125; actual: 213)
- Provide nutritionist/herbalist consultations (target: 100; actual: 157)
- Distribute free healthy fruit and produce food bags to low income households (target: 5,000 bags to 400 workers/families; actual: 7,896 bags to 701 families)
- Provide referrals to local grassroots community organizations that provide legal, educational, and social services (target: 850 referrals; actual: 895)
- Collaborate with community-based organizations, health care agencies, and/or governmental agencies to promote the health and wellness of immigrants and refugees (target: collaboration with 12 outside agencies; actual: 22)
- Leverage financial support from private foundations by submitting grant applications for the Wellness and Prevention or Health Access Program (target: 4 applications, with 50% being approved; actual: 11 applications, with 80% being approved)
- Collaborate with students enrolled in the health field and health care-related schools to train future multilingual health care providers, providing them with experience working with uninsured low income communities (target: 20 students; actual: 44)

Matching Funds



Street Level Health Project leveraged its Measure A allocation to obtain a total of **$142,500 in matching funds** from the following sources:

- San Francisco Foundation
- Frances K. and Charles D. Field Foundation
- Kaiser Permanente
- California Endowment
- Latino Community Foundation

Hope Hospice

hopehospice.com

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

Individuals served by Measure A: **11** (Total individuals served: **45**)

Populations served: Low Income Adults, Families, Seniors

Services provided: Public Health

Service area: Castro Valley, Dublin, Hayward, Livermore, Pleasanton, San Leandro

BACKGROUND

Hope Hospice is dedicated to helping patients and clients live each day to the fullest with dignity, hope, and courage. Every end-of-life experience is patient-centered; based on individual choice; and lightened by hope, comfort, and dignity.

MEASURE A FUNDING SUMMARY

Measure A funding helped Hope Hospice increase access to mental health and public health services to senior adults with life-limiting illnesses. Services were offered to seniors who were formerly in hospice care yet no longer eligible to receive hospice, or who did not meet the Centers for Medicare and Medicaid services (CMS) criteria for admission to hospice.

Specifically, Hope Hospice used it Measure A allocation to achieve the following:

- Make outreach calls to all discharged and ineligible hospice patients, with the exception of patients who moved out of Alameda County (target: 30 patients; actual: 55).
- Provide outreach services for up to six months to discharged and/or ineligible hospice patients who elected to enroll in the Transitions Program. Outreach services performed during this period totaled 354. For the Transitions cohort admitted within the six-month period, outreach services totaled 140.
- Have patients and/or caregivers indicate that they were satisfied with the service. Satisfaction surveys reflected a 100% satisfaction level.
- Have patients experience fewer falls and returns to the hospital. In the same surveys, patients reported zero falls, and 6% were admitted to the hospital.

Other services provided through the Measure A funds included management of volunteer workers who were sent to the residents' homes providing a variety of services. Volunteer services included haircuts, respite care, minor home repairs, errand running, cooking and cleaning, therapeutic massage, art and music services, and pet therapy.

Measure A Helps

Mrs. Smith, who had dementia, had been a hospice patient at Hope Hospice. Her health had improved and she was discharged to the Transitions program. After her spouse died in hospice, Mrs. Smith continued to receive Transitions care, including weekly companionship visits from a volunteer. Mrs. Smith did not remember her volunteer from week to week but always enjoyed pleasant conversations with her. She received haircuts provided by Hope Hospice volunteers and a visit from a volunteer harpist. Her family received education packets sent each month providing tips on keeping their loved one safe and maintaining a positive approach to her daily living.

Increase Hospice Utilization

gettingthemostoutoflife.org/about-variant-2

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

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

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

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

Service area: Countywide

BACKGROUND

The Alameda County "Getting the Most out of Life" (GMOL) program is designed to reduce suffering and improve quality of care for terminally ill residents of Alameda County through advance health care planning and hospice utilization.

GMOL services go beyond education of end-of-life care and resources. The program aims to demonstrate social change, collect data, motivate behavior change, and create general public awareness around end of life.

GMOL seeks to accomplish the following:

- Increase knowledge of end-of-life planning resources in disadvantaged and multilingual communities
- Increase hospice awareness by tracking an increase in hospice utilization in Alameda County
- Train care providers, social workers, and public health workers to increase hospice utilization of their clients
- Track the number of completed advance care health directives through trainings and/or outreach efforts

Measure A funding helped GMOL train 110 IHSS staff to have meaningful end-of-life conversations with IHSS consumers.

MEASURE A FUNDING SUMMARY

Each of the GMOL affiliate programs—Comfort Homesake, Hospice Providers Coalition, Care Partners, and the Clinical Partnership—used Measure A funds to work toward GMOL's overall program goals by offering specific services that further its mission.

Measure A funding helped the GMOL program achieve the following:

- Complete over 31 outreach and radio media events educating more than 2,800 County residents from disadvantaged and multilingual communities about available end-of-life resources
- Track 14 major hospice organizations to show increases in hospice admissions and patient deaths in hospice care
- Train 110 In-Home Support Service (IHSS) staff to have meaningful end-of-life conversations with IHSS consumers
- Assist County residents in completing 65 advance health care directives

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

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

Individuals served by Measure A: **0** (Total individuals served: **0**) *The position funded by this allocation does not provide any direct services.*

Populations served: Children

Services provided: Mental Health

Service area: Countywide

BACKGROUND

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

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

- Plan, organize, direct, and evaluate the operations of all health services programs for minors in the Alameda County juvenile justice system, including the Guidance Clinic, Children's Hospital contract, HCSA-contracted services for youth in JJC and Camp Sweeney, and Behavioral Health Care Services (BHCS)-contracted services for youth
- Serve as the primary liaison to the Juvenile Court and Probation Department for juvenile health services operations, collaborations, and re-entry planning
- Coordinate service systems to ensure compliance with legislative mandates and minimum standards as well as state and federal rules
- Increase collaboration with Probation to enable better access to BHCS services to youth on probation

JJC's Measure A allocation covered the cost of the JJC Health Services Director.

MEASURE A FUNDING SUMMARY

This Measure A allocation covered the cost of the JJC Health Services Director. The position was vacant as of October 2015 as a result of the then-Director taking a new position within BHCS. In the first three months of FY 14/15, this Director continued some of the initiatives from the previous fiscal year while preparing to move to the new position. The measurable results for the first three months of the fiscal year included:

- Begin work on a request for proposals (RFP) for new services to Probation youth for a program called Parenting With Love and Limits
- Continue development of a database for tracking psychotropic medications for youth in JJC and Camp Sweeney

Medical Costs for Juvenile Justice Center: Mind Body Awareness

mbaproject.org

Allocation: **$57,222** | Expended/Encumbered: **$57,222**

Individuals served by Measure A: **160** (Total individuals served: **277**)

Populations served: Indigent, Low Income, Uninsured Children

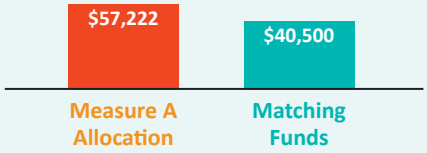
Services provided: Public Health, Mental Health, Substance Abuse

Service area: Countywide

BACKGROUND

Founded in 2000 by a group of formerly incarcerated youth, Mind Body Awareness (MBA) delivers mindfulness-based mental health programming to at-risk, gang-involved, and incarcerated youth in three Bay Area counties. MBA's mission is to help youth transform harmful behavior and live meaningful lives through the practices of mindfulness meditation and emotional awareness. MBA also engages in customized curriculum development and training for service providers working with at-risk youth regionally and nationally. The heart of MBA's work is to provide the most at-risk youth in the most difficult environments—probation detention facilities, youth detention camps, and at-risk schools—with concrete tools to reduce stress, impulsivity, and violent behavior and increase self-esteem, self-regulation, and overall well-being.

Matching Funds



MBA leveraged its Measure A allocation to obtain over **$40,500 in matching funds.**

MEASURE A FUNDING SUMMARY

Measure A funding helped MBA achieve the following:

- Provide mindfulness classes across four units at the Alameda County Juvenile Justice Center (ACJJC) as well as Camp Sweeney. Classes took place once or twice per week, for 1.5 hours, for 48 weeks. A total of 307 classes were scheduled, with 238 held. Each class served an average of 4.2 youth.
- Offer at least one team-taught (co-facilitated by more than one instructor) class, with a goal of eventually team-teaching all classes. Approximately 48% of classes were team-taught in FY 14/15.
- Provide a minimum of one paid instructor per class. MBA met this objective for 100% of classes taught.
- Meet with the guidance clinic director from Alameda County Behavioral Health Care Services (BHCS), Probation leadership, and ACJJC mental health staff to collaborate about reinforcing services.
- Complete an evaluation of services that included statistically validated pre and post self-report survey measures to evaluate stress and self-regulation and a shorter weekly program evaluation form.

Medical Costs for Juvenile Justice Center: Niroga Institute

niroga.org

Allocation: **$80,800** | Expended/Encumbered: **$80,800**

Individuals served by Measure A: **310** (Total individuals served: **310**)

Populations served: Indigent, Low Income, Uninsured Children, Adults (ages 16–24)

Services provided: Mental Health

Service area: Countywide

BACKGROUND

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

MEASURE A FUNDING SUMMARY

Niroga Institute used its Measure A allocation to achieve the following:

- 13 TLS classes per week year-round, serving nine youth per class and more than 115 youth per week
- Three all-day immersion retreats in three units, serving an average of eight youth each
- 10 classes per week during intersession, four times per year, serving an average of 10 youth each
- One staff class per week, serving an average of seven staff each

Highlights

In evaluation surveys, the vast majority of participants expressed positive outcomes such as an i**ncrease in self-control, decrease in stress, and healthy habits** from Niroga Institute activities: over 80% from weekly youth TLS sessions and daylong immersions, and 75% from staff classes.

Medical Costs for Juvenile Justice Center: Victims of Crime

alcoda.org/victim_witness/california_victim_compensation_program

Allocation: **$144,000** | Expended/Encumbered: **$90,000**

Individuals served by Measure A: **2,457** (Total individuals served: **3,354**)

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

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

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

BACKGROUND

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

The Victim Compensation Program offers the following:

- 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

Highlights

Measure A funding helped enable clients who would normally have been ignored because of lack of information about available resources, or limited resources to pay for treatment services, to receive **necessary services on an ongoing basis** at no cost to the client or to Alameda County.

MEASURE A FUNDING SUMMARY

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

Preventive Care Pathways

healthcare.gov/coverage/preventive-care-benefits

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

Individuals served by Measure A: **3,424** (Total individuals served: **3,700**)

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

Services provided: Emergency Medical, Mental Health

Service area: Countywide, Homeless or transient

BACKGROUND

Preventive Care Pathways offers "Pathways to Wellness" to the general population by providing medical and health care services for at-risk and indigent patients as well as individuals re-entering the community from the prison system. Preventive Care Pathways also produces and presents educational videos and literature.

The Preventive Care Pathways clinic is easily accessible and conveniently located in North Oakland. It provides same-day and urgent appointments and referrals to specialty clinics. A pharmacy, chiropractic care, and imaging services are onsite, which is a convenience for most patients who may have transportation issues or limited funds. This accessibility to services results in reduced emergency room visits and early detection of chronic disease, cardiovascular disease, Hepatitis C , and cancer.

MEASURE A FUNDING SUMMARY

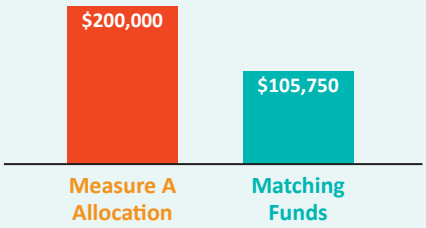
Preventive Care Pathways used its Measure A allocation to achieve the following objectives:

- Become a Covered California Certified Enrollment Entity (CEE). The CEE application was completed in November 2015.
- Have staff approved and trained as Covered California Enrollment Counselors
- Designate one staff person to participate in the Covered CA CEE Alameda Partnership Meetings. Designated staff has attended all meetings in FY 14/15.
- Strategize how best to coordinate enrollment efforts as Alameda County works toward building a No Wrong Door approach to enrollment.
- Recruit one full-time equivalent (FTE) of each: nurse practitioner, medical assistant, and administrative assistant. One FTE medical assistant was hired in January 2015.
- Provide direct medical service visits to low income County residents. Services were provided to 3,424 residents, an average of 428 per month. The target was 150–350 services per month.

Highlights

Thanks in part to Measure A funding, Preventive Care Pathways clients experienced a **reduction in emergency room visits** to Alameda Health System and outside emergency rooms, as well as **improvement in clinical findings related to diabetes, hypertension, and congestive heart failure**.

Matching Funds



Preventive Care Pathways leveraged its Measure A allocation to obtain **$105,750 in matching funds**.

Primary Care Community-Based Organizations

Allocation: **$5,734,272** | Expended/Encumbered: **$5,734,272**

Individuals served by Measure A: **22,449** (Total individuals served: **184,024**)

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

Services provided: Hospital Inpatient, Mental Health

Service area: Countywide

BACKGROUND

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

The Alameda Health Consortium is guided by the following principles:

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

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

The Consortium is made up of eight member health centers:

- Asian Health Services
- Axis Community Health
- La Clinica
- LifeLong Medical Care
- Native American Health Center

Measure A Helps

When Salvador lost his job, he also lost his employer-sponsored coverage through Kaiser. One year earlier, Salvador had been diagnosed as pre-diabetic. When Salvadro went to pick up his wife's medication for the last time at Kaiser, the pharmacist told him that he and his wife could receive care at LifeLong Medical Care and might be eligible to enroll in a special program that would cover the cost of their medications. Salvador now regularly goes to the LifeLong clinic for eye exams and other tests. Twice a year he consults with nutritionists there. They've told him he must continue to eat healthy and exercise to avoid full-scale diabetes.

- Tiburcio Vasquez Health Center
- Tri-City Health Center
- West Oakland Health Center

MEASURE A FUNDING SUMMARY

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

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

- 22,449 low income Alameda County residents received access to quality services at very low cost through HealthPAC.
- Over 19,000 patients received some type of medical service visit.
- For dental services alone, patients made over 9,000 visits that included cleanings, examinations, and fluoride treatments.
- In terms of mental health, Measure A funds supported over 2,000 mental health visits.
- Over 185,000 laboratory tests were given to patients during visits.
- Measure A funds supported the transition of 20,000 HealthPAC patients now eligible for Medi-Cal under the Affordable Care Act.

Measure A funding helped Consortium member community health centers ensure that 22,449 low income Alameda County residents received access to quality services at very low cost.

Actual Visits for Each Consortium Health Center

	Total Patients	Primary Care, Specialty Visits	Dental Visits	Mental Health Visits	Total Visits
Asian Health Services	336	936	-	20	956
Axis Community Health	1,877	5,026	-	181	5,207
La Clinica de la Raza	7,374	19,672	1,967	744	22,383
LifeLong Medical Care	1,361	3,765	584	257	4,606
Native American Health Center	604	1,011	1,388	161	2,560
Tiburcio Vasquez Health Center	4,455	11,165	2,316	854	14,335
Tri-City Health Center	2,387	7,649	1,941	146	9,736
West Oakland Health Center	620	1,567	928	-	2,495
Total	**19,014**	**50,791**	**9,124**	**2,363**	**62,278**

Roots Community Health Center

rootsclinic.org

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

Individuals served by Measure A: **367** (Total individuals served: **9,180**)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Alameda, Oakland, San Leandro, Homeless or transient

BACKGROUND

Roots Community Health Center works to provide culturally competent, comprehensive health care, mental health, and wraparound services with the goal of eliminating health disparities in Oakland. Roots Community Center accomplishes its mission by providing top quality care; conducting community-based participatory research; and offering opportunities for rehabilitation, education, training, and employment to reduce poverty and dependency in the community.

Roots implements its programs and services while honoring the "roots" of culture, heritage, and tradition by providing access to preventive, primary, and urgent care; remaining community-aware and community-responsive; and establishing partnerships to ensure a more efficient continuum of care in Oakland.

Highlights

As a result of its Measure A-funded expansion efforts, Roots Community Health Center experienced an **87% increase in patient visits and a 300% increase in laboratory visits** compared to the same time period pre-expansion.

MEASURE A FUNDING SUMMARY

Roots Community Health Center used its Measure A funds to support increased capacity and expand access to medical outpatient services for indigent, low income, and uninsured adults, children, families, and seniors, including the reentry population, those with unstable housing, and those with limited English proficiency throughout Alameda County.

Roots increased access to medical services in two ways:

- Increased clinic capacity through the construction and renovation of three new examination rooms and the expansion of administrative offices at Roots Community Health Center. Patient visits included routine, episodic/urgent, and preventive care. The expansion also facilitated the movement of patients from illness-based episodic care to ongoing primary and preventive care.
- Increased the capacity of Roots Community Health Alliance to provide primary and specialty care services by developing new agreements and partnerships with 18 community partners, and by providing Roots Alliance members assistance with various stages of electronic health records adoption, implementation, and meaningful use.

Tiburcio Vasquez Health Center, Inc.

tvhc.org

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

Individuals served by Measure A: **1,349** (Total individuals served: **6,749**)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Ashland, Cherryland, Hayward, Union City

BACKGROUND

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

Through its Logan and Tennyson school health centers, TVHC offers health education, case management, and parent engagement programs. Providing health education and youth leadership development services helps to ensure that youth receive comprehensive intervention and support. These programs include the following:

- Youth empowerment programs build leadership and advocacy skills—two competencies often linked to an increase in school attendance and performance, meaningful relationships with caring adults, and overall improvements in health.
- The Hip-Hop Elements program is a forum for any Logan student interested in creative expression through hip-hop. The program focuses on several areas of hip-hop, including the art of being a Disc Jockey (DJ), Graffiti Art, Break Dancing, Master of Ceremony (MC)/Spoken Word, Poetry, etc.
- The Youth Advisory Board (YAB) provides a platform for youth to give input into health center policy and function. YAB members accomplish this by providing feedback to health center staff and serve as an important evaluation tool for the center's services. YAB also serves as a means for youth to actively promote health to the high school campus. They accomplish this by developing school-wide "health tips" that air on the school PSA system, hosting workshops, and organizing an annual health fair.
- At the CAFÉ (Club de Aprendizaje Para Una Familia Estable) Parent Engagement Program, parents learn about health care reform. Participants also receive free dental screenings.
- The school-based Health Educators provide one-on-one health education counseling sessions. Reducing barriers to access shifts culture and behavior, thereby improving the overall health of young people.

Measure A Helps

A student at Tennyson High School was a newcomer to the U.S. The student needed access to health care and behavioral health care. The student's caregiver did not have any verifiable documents that would allow for a consent to treatment for the youth. The TVHC site manager contacted an eligibility specialist at TVHC's main site in Hayward. The specialist directed the site manager to the proper forms that would cover liability and allow the youth to receive necessary services. The youth was seen later in the week, and the caregiver expressed thanks to TVHC staff for finding a way to get the necessary paperwork completed and on file.

MEASURE A FUNDING SUMMARY

TVHC's Measure A funding supports a continuum of care model that incorporates health education, case management services, and youth and parent leadership development programs that operate out of health centers at Logan and Tennyson High Schools and the mobile health clinic at Hayward High.

Measure A funding helped TVHC achieve the following objectives:

- The Health Educator(s) and Youth Leaders coordinated a multiracial young women and young men's empowerment program that met weekly, reaching a total of 30 youth.
- Health Educators assisted with individualized family planning education, pregnancy testing, and counseling for approximately 60 students.
- The program impacted over 5,000 students by addressing three critical health issues most prevalent on the campuses it serves: teen violence, substance abuse, and sexual health.
- The centers conducted 900 individual case management sessions covering sexual health education and pregnancy options counseling and linking students to the medical services provided at the clinic.
- CAFÉ, the Spanish-speaking parent empowerment group, reached approximately 60 Spanish-speaking parents through weekly structured parent education and empowerment classes. 90 parents graduated from the program.
- Teams of Health Educators and Peer Health Educators provided presentations about the health center and a range of health topics to roughly 1,500 students.
- 60 students received training to become Peer Educators. Students were introduced to a variety of topics to share with their peers.
- Students used the outreach and health promotion strategies learned in their weekly workshops to promote pregnancy prevention on their respective campuses. Their presentations led to over 300 students registering as new patients at TVHC.
- TVHC helped train and develop 15 YAB members.

The program impacted over 5,000 students by addressing three critical health issues most prevalent on the campuses it serves: teen violence, substance abuse, and sexual health.

Washington Hospital

www.whhs.com

Allocation: **$34,000** | Expended/Encumbered: **$25,070**

Individuals served by Measure A: **82** (Total individuals served: **88,537**)

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

Services provided: Emergency Medical, Hospital Outpatient, Public Health

Service area: Ashland, Cherryland, Fremont, Hayward, Newark, Sunol, Union City, Homeless or transient

BACKGROUND

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

MEASURE A FUNDING SUMMARY

Washington Hospital used its Measure A allocation to increase access to hospital outpatient services for adults, seniors, and other residents of Alameda County by providing free mammography screening examinations to indigent, low income, and uninsured patients referred to Washington Hospital by local health centers. The service included the mammogram procedure, interpretation of results by the radiology group, consultation with the patient, and arrangements for follow-up care as needed.

Washington Hospital provided mammograms to 82 patients, of whom 18 had abnormal findings detected.

Highlights

With the timely diagnostic care that this program offers, abnormal findings were detected and treated earlier, which should translate to a better outcome for the patient.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 4: PUBLIC HEALTH

100 Black Men of the Bay Area

100blackmenba.org

Allocation: **$25,000** | Expended/Encumbered: **$25,000**

Individuals served by Measure A: **273** (Total individuals served: **750**)

Populations served: Low Income Children

Services provided: Public Health, Mental Health

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

BACKGROUND

100 Black Men works to develop programs designed to improve the quality of life for African Americans and other people of color. The Bay Area chapter was established in 1988, and represents one of 116 chapters located in the United States, England, and the Caribbean.

All 100 Black Men chapter activities are guided by the organization's "Four for the Future" plan, which focuses on four areas that are critical to ensuring the future of the Black community: 1) mentoring across a lifetime and leadership development, 2) education, 3) health and wellness, and 4) economic empowerment. 100 Black Men of the Bay Area places an emphasis on nurturing the Bay Area's marginalized youth.

The 100's Youth Movement program strives to improve the overall health and well-being of marginalized children through structured physical fitness training, wholesome food choices, character development, and mentoring. Through these activities, Youth Movement helps children improve their health, develop long-term goals, and overcome obstacles to lifetime success and achievement. Youth Movement builds confidence and resiliency skills and reinforces the values of commitment and hard work, upon which youth can draw for achievement in academics and other areas throughout their lives. Youth Movement services low income children and families who may be at risk for developing serious chronic conditions, and who may face challenges accessing the health care system.

A large cadre of volunteers is needed to make the Youth Movement program a success. Athletic training clinics are held on Saturdays each year from January through May. The day begins with a healthy breakfast followed by a half-hour Life Skills workshop that addresses topics such as nutrition/eating habits, conflict resolution, and "how to say no."

Measure A Helps

Testimony from a volunteer parent:

"I am a single mom of an eight-year-old girl and a 14-year-old boy. I did not expect the Youth Movement track and field program to contribute to their overall well-being in the ways that it has. My son has been able to benefit from the program's mentoring, which has helped him learn self-discipline and character development. Youth Movement has helped him build confidence, which shows up every day in big and small activities. My daughter also enjoys the friendships she makes and the hands-on opportunities the program provides. I believe the program's biggest impact has been healthier physical and mental health for my family."

MEASURE A FUNDING SUMMARY

Measure A funding supported the 100 Black Men of the Bay Area's Youth Movement Program to provide public health services, including nutritious

meals and health and physical fitness programs to low income children and youth, ages 4 to 18 years old, who live in Oakland, Alameda, San Leandro, Hayward, and Berkeley. Measure A funding enabled 100 Black Men of the Bay Area to improve the quality of its nutrition curriculum and to provide stipends to its hard-working volunteers.

Specifically, 100 Black Men of the Bay Area used its Measure A allocation to achieve the following:

- Assess 273 youth for fitness measures including aerobic capacity and upper-body strength (target: 250)
- Have 91% of girls and 94% of boys with poor baseline aerobic capacity levels achieve appropriate fitness levels within six months (target: 90%)
- Engage 500 youth in the Saturday clinics and 750 in the annual Tommie Smith Youth Track Meet (target: 500)
- Offer after-school athletic training four days per week (target: four)
- Offer three clinics and eight track meets (target: 20 total)
- Have an estimated 88% of youth stay in the program throughout the year (target: 80%)
- Recruit and train 22 volunteer coaches throughout Alameda County, and provide first aid/CPR to seven volunteers
- Recruit Youth Movement participants through the Oakland Unified School District's African American Male Achievement program and Martin Luther King, Jr. Elementary School in Berkeley
- Secure training facilities through joint-use agreements from Alameda County schools and Park & Rec Departments
- Maintain the existing three track and field clubs and work to organize a new club
- Host and sponsor two youth cross-country meets in Alameda County (target: three)
- Host and sponsor eight youth track and field meets (target: four)

Highlights

In almost all areas, 100 Black Men of the Bay Area **met or exceeded its target outcomes** for the Youth Movement program.

Alameda Boys & Girls Club, Inc.

alamedabgc.org

Allocation: **$104,040** | Expended/Encumbered: **$104,040**

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

Populations served: Low Income, Uninsured Children

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Alameda, Oakland

BACKGROUND

Founded in 1949, the Alameda Boys & Girls Club provides high impact, affordable youth development programs and services for over 65,000 youth, ages 6–18. The Club strives to inspire and enable all youth, especially those who need it the most, to realize their full potential as productive, responsible, and caring citizens. The Club offers a variety of life-enhancing and life-changing programs in the areas of health and fitness, education and technology, performing and visual arts, and leadership and life skills.

Seventy-eight percent of youth attending the Alameda Boys & Girls Club come from families that live at or below the poverty line.

MEASURE A FUNDING SUMMARY

Alameda Boys & Girls Club used its Measure A allocation to serve youth in the following programs:

- Health Clinic services. Club youth serviced by the Health Clinic received beneficial vision, dental, and respiratory screenings and treatment to improve their physical well-being. This improved health decreased their school absences.
  - 387 youth were served.
  - Four informational events/workshops were held with 470 youth in attendance.
  - 182 youth were screened, representing 70% of overall club youth.
- Mental health services. Services offered included individual and family counseling, as well as small group Life Skills workshops. Participants demonstrated a decrease in confrontational incidents and improvement in pursuit of healthy lifestyles, such as not smoking and avoiding drugs and alcohol.
  - 173 youth were served in individual counseling.
  - 695 youth participated in 17 six-week Life Skills workshops.
  - 715 youth participated in daily programming, with 77.5% developing a healthy eating habit and 90% demonstrating responsible decision-making.

Measure A Helps

Ja'Nylah, 16, faced the common peer pressure to participate in dangerous and illegal activities such as sex, alcohol, and drugs. She was able to combat these pressures and stand up for her own beliefs through the self-confidence and healthy habits she learned in the Life Skills SmartGirls workshops. Being in a supportive environment with female peers, she learned how to become the person she wanted to be, not who others thought she should be. Ja'Nylah states, "Becoming president of our girls group taught me to understand that there are people that want me to succeed, and demonstrate important skills needed in everyday life."

- Get Cooking nutrition and healthy cooking program. Students participating in health, nutrition, and fitness programs reported an increase in stamina, better weight management, and higher energy levels. They influenced their parents and families to be more healthy and fit as well.
  - 258 youth participated.
  - Four informational events/workshops were held.
  - 85.5% of youth showed improvement in eating.
- Get Growing sustainable garden.
  - 301 youth participated.
  - Four informational events/workshops were held.
  - 84% of youth showed improvement in learning a new gardening skill.
- Physical fitness and recreation.
  - 1,630 youth participated in gym fitness or outdoor recreational activities.
  - Four informational events/workshops were held.
  - 87.5% of youth showed improvement in physical fitness scores.

Students participating in health, nutrition, and fitness programs reported an increase in stamina, better weight management, and higher energy levels. They influenced their parents and families to be more healthy and fit as well.

Alameda County Asthma Start

acphd.org/asthma.aspx

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

Individuals served by Measure A: **31** (Total individuals served: **36**)

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

Services provided: Public Health

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

Note: In addition to its individual allocation, Asthma Start also received Measure A money through the Public Health Prevention Initiative allocation (see page 107). The funding summary information described here is for the total of both allocations.

BACKGROUND

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

Asthma Start provides in-home case management to families of children and adolescents with asthma. The program provides asthma education related to disease, symptoms, medication, and its use. The program develops a care plan for the family, inspects their home for asthma triggers, and teaches the family how to remediate them; advocates with landlords; and partners with Code Enforcement as needed to take care of issues managing their child's asthma such as pillow and mattress encasings, non-bleach-based mold cleaner, vacuums, etc. 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 and the District Attorney for those that are truant due to asthma.

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

MEASURE A FUNDING SUMMARY

Measure A funds one-third of the Asthma Start budget.

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

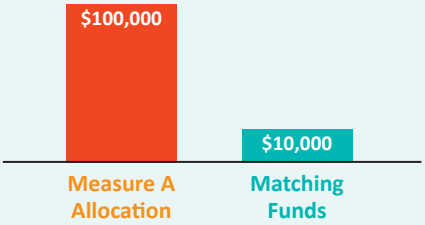
- Increase caregiver knowledge of asthma (target: 90% of caregivers passing an asthma post test with a score of 90% or better; actual: 95%)
- Help children maintain or reduce asthma symptoms to the lowest level (target: 95% of children; actual: 99%)

Measure A Helps

An 11-year-old girl was referred to Asthma Start after she had gone into the clinic for three urgent care appointments related to her asthma. Asthma Start connected the family to Healthy Homes, who helped with installing a handrail, painting the bathroom, installing double-paned windows and a threshold, removing carpet and replacing it with laminate flooring in the child's bedroom, and adding tile in the bathroom. After these changes to the home, the mother reported that her daughter was doing very well with her asthma. She had not had any recent symptoms or need for Albuterol, and she had not needed to go to the emergency room, hospital, or urgent care.

- Help caregivers reduce at least one identified asthma trigger (target: 95% of caregivers; actual: 100%)
- Reduce instances of children requiring hospitalization or emergency department visits post-case management (target: 20% or less of children; actual: 3% needing hospitalization, 15% needing emergency department visits)
- Increase caregiver confidence in managing their child's asthma (target: 95% of caregivers reporting increased confidence; actual: 100%)
- Ensure children have a medical home and insurance before discharge (target: 100% of children; actual: 100%)

Matching Funds



Asthma Start leveraged its Measure A allocation to obtain **$10,000 in matching funds** from Targeted Case Management (TCM) and Medi-Cal Administrative Activities (MAA).

CAL-PEP

calpep.org

Allocation: **$258,621** | Expended/Encumbered: **$258,621**

Individuals served by Measure A: **226** (Total individuals served: **226**)

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

Services provided: Substance Abuse

Service area: Countywide, Homeless or transient

BACKGROUND

CAL-PEP provides accessible health education, disease prevention, risk reduction, and support services to people at high risk for or currently living with HIV/AIDS.

MEASURE A FUNDING SUMMARY

Measure A funding helped CAL-PEP meet some of the basic needs of their clients. Basic needs include transportation, food bags, and gift cards.

In addition, CAL-PEP used its Measure A allocation to achieve the following:

- Increase awareness of CAL-PEP partner services among HIV-positive African American clients (target: 50 clients: actual: 66)
- Conduct Targeted Prevention Activities (TPAs) in high risk venues where African American positive and high risk negative individuals congregate
- Distribute partner services information and safer sex materials to all TPA contacts
- Refer high risk negative partners to HIV testing, primary care substance abuse treatment, and other services as needed
- Have CLEAR clients increase risk-reduction skills (target: 8 clients; actual: 9)
- Screen and enroll HIV-positive African American clients into CLEAR (target: 10 clients; actual: 10)
- Have CLEAR participants complete a pre- and post-test assessment to measure their risk behavior at intake and discharge
- Have HIV high risk partners or social networks of HIV-positive clients increase their knowledge of their HIV status (target: 50 partners/social networks; actual: 49)
- Conduct events to increase knowledge of HIV status, risk-reduction skills, and communication among HIV-positive African Americans and their negative sexual partners (target: 5 events; actual: 5)

Measure A Helps

A 49-year-old African American bisexual male was enrolled into CAL-PEP's CLEAR program. He was recently released from jail and had stopped taking his HIV medication. He lives in a homeless encampment, smokes crack, drinks alcohol, and has sex with women and men when under the influence. In the CLEAR program, the client was linked to primary care and onsite mental counseling services. Additionally, the client participated in the onsite PWP groups. With the support of CLEAR services, the client's confidence and outlook improved. He is currently on medications, is housed at the EOCP Crossroads shelter, recently stopped using crack, and reports that he always uses condoms with his HIV-negative partner.

Center for Early Intervention on Deafness

ceid.org

Allocation: **$57,020** | Expended/Encumbered: **$57,020**

Individuals served by Measure A: **438** (Total individuals served: **756**)

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

Services provided: Public Health

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

BACKGROUND

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

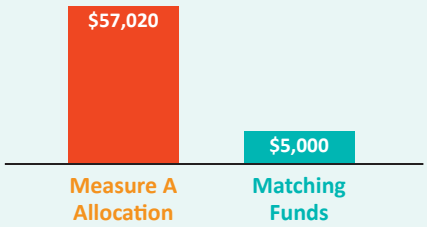
As one of the few audiology providers in the area that accepts Medi-Cal patients, CEID provides a critical service to an underserved population. It provides Spanish translation and coordinates translation services for patients who speak other languages. Patients receive the service as well as the follow-up information necessary to continue to monitor their or their child's hearing health care needs.

MEASURE A FUNDING SUMMARY

Measure A funding helped CEID provide the following services:

- Newborn hearing screenings (target: 120 patients)
- Audiological evaluations for children and adults (target: 300 patients)
- Hearing aids and accessory dispensing for children and adults (target: 150 patients)
- Community hearing screenings (target: 100 community members)
- Training for pediatric residents (target: 75 residents)

Matching Funds



CEID leveraged its Measure A allocation to obtain **$5,000 in matching funds** from Alameda County District 2 Supervisor Valle.

City of San Leandro

sanleandro.org

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

Individuals served by Measure A: **10,548** (Total individuals served: **69,429**)

Populations served: Seniors

Services provided: Public Health

Service area: San Leandro, San Lorenzo

BACKGROUND

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

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

MEASURE A FUNDING SUMMARY

The part-time staff provided by Measure A allowed Recreation and Human Services to maintain quality senior services, grow programs, and continue to offer critical health and wellness services to San Leandro seniors.

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

Specific target and actual numbers are as follows:

- Blood pressure/weight checks (target: 360, actual: 740)
- Mercy Brown Bag program—Grocery bag of nutritional food monthly to eligible seniors (target: 576; actual: 611)
- Health education classes (target: 6 classes; actual: 15)
- Pull Up a Chair exercise class (target: 120 participants; actual: 128)
- Fall prevention class (target: 6,750 participants; actual: 6,888)
- Referral to additional health and wellness programs and services (target: 395 seniors accessing other programs; actual: 1,667)

Highlights

Recreation and Human Services exceeded all of its targets for senior services, sometimes dramatically. For example, the Senior Community Center **conducted 740 blood pressure/weight checks**, compared to a target of 360—an increase of almost 100%. The program experienced a 96% success rate at **delivering a bag of nutritional food to 48 seniors twice per month**, and **increased awareness of high blood pressure and weight level risk factors** in 100% of clients. Over 300 seniors attended fall prevention classes every month.

Collaboration Agencies Responding to Disasters (CARD)

CARDcanhelp.org

Allocation: **$25,000** | Expended/Encumbered: **$7,500**

Individuals served by Measure A: N/A (Total individuals served: **14,862**)

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

Services provided: Other (Emergency Preparedness)

Service area: Countywide

BACKGROUND

In partnership with traditional disaster relief agencies, CARD prepares local community groups to participate in coordinated response and recovery efforts for vulnerable and underserved populations in Alameda County. CARD services are for everyone and anyone, particularly for individuals with Access and Functional Needs (AFN).

MEASURE A FUNDING SUMMARY

As a result of Measure A funding, CARD engaged in planning activities that fully included the preparedness and planning needs of vulnerable communities with the partnership of the agencies that serve them.

Specifically, CARD used its Measure A funds to conduct the following activities: Preplanning for three community-based events, research, social media planning, curriculum selection, and partnership planning.

While CARD successfully completed the planning portion of this contract, CARD's Board voted to cease operations. CARD is in the process of decommissioning as a nonprofit corporation.

As a result of Measure A funding, CARD was able to engage in planning activities that fully included the unique preparedness and planning needs of vulnerable communities with the partnership of the agencies that serve them.

CONCERNS

It is unclear if the Measure A allocation to CARD complies with the ordinance requirement that funds go to provide "emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low income, and uninsured adults, children, families and seniors, and other residents of Alameda County."

The project was not completed, with no services deliverables report. The provider reports that only the "planning phase" was completed before the agency went out of business. Only $7,500 of the $25,000 was paid out to CARD, and these Measure A funds went to planning for services that were never provided.

Community Health and Wellness Element

acgov.org/cda

Allocation: **$17,697** | Expended/Encumbered: **$17,697**

Individuals served by Measure A: **38,604** (Total individuals served: **38,604**)

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

Services provided: Public Health

Service area: Ashland, Cherryland

BACKGROUND

The Alameda County Community Development Agency works to enhance the quality of life of County residents and plan for the future well-being of the County's diverse communities; to balance the physical, economic, and social needs of County residents through land use planning, environmental management, neighborhood improvement, and community development; and to promote and protect agriculture, the environment, economic vitality, and human health.

The purpose of the Element is to develop the foresight and the regulatory authority necessary to ensure that County land use and other policies are not incompatible with health, but rather that they support healthy, equitable, and ecological community development. It summarizes all of those actions that the County has or will take in support of the community vision, thereby providing an opportunity for improved collaboration and coordination of efforts taking place in Ashland and Cherryland.

The following objectives were identified as part of this project and are aligned with the Element's vision and purpose:

- Residents invested in a vision for their community
- A shift in focus to the environment in which projects are developed
- A healthy community image
- A planning model that could be replicated in other unincorporated communities or cities within Alameda County

The Ashland and Cherryland Community Health and Wellness Element was approved by the Alameda County Board of Supervisors in December 2015.

MEASURE A FUNDING SUMMARY

Thanks in part to Measure A funding, the Ashland and Cherryland Community Health and Wellness Element was approved by the Alameda County Board of Supervisors in December 2015.

Emergency Medical Services (EMS) Corps

acphd.org/ems-corps.aspx

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

Individuals served by Measure A: **80** (Total individuals served: **80**)

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

Services provided: Emergency Medical, Public Health, Mental Health

Service area: Countywide

BACKGROUND

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

The EMS Corps targets young men of color from underserved communities. A majority of the youth that are selected to participate in the EMS Corps are recruited from a variety of community-based organizations.

The EMS Corps is part of a national network of programs and organizations that serves boys and men of color. The EMS Corps provides opportunities for young men of color to pursue a career in EMS and creates pathways for careers in health care. The program's wraparound support services prepare young men of color for careers by providing them with professional development and exposure to health care professionals through a group mentoring model.

MEASURE A FUNDING SUMMARY

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

- Two annual five-month-long cohorts of approximately 80 youth from low income communities
- An EMT training course consisting of 136 hours of instruction, 24 hours of supervised clinical experience, and 10 documented patient contacts
- EMT instructors, equipment, and training materials
- CPR training
- Mental health services that included 90 hours of individual psychotherapy sessions and weekly group counseling
- Health and wellness and self-care reform
- Life coaching, mentorship, case management, life coaching, tutoring, community service, and a stipend for 40 EMS Corps students

Measure A Helps

When he first came into the EMS Corps, John was a high school dropout and had spent time in the Juvenile Justice System. Once he realized that he would get out what he put into the program, John excelled. He graduated from the EMS Corps and passed the National Registry exam. John now works for Cherry Hill detox center as a health care technician. He also coordinates community outreach events for the EMS Corps, serves as a peer coach in the Life Coaching class, and tutors and mentors incoming students. John was recently accepted into the Merritt College Fire Academy. He credits his success in life to the EMS Corps.

Program results included the following:

- 36 of the 40 EMS Corps students are employed, 28 as EMTs.
- 18 are pursuing higher education.
- 12 EMS Corps graduates enrolled in the Fire Academy.
- Eight graduates are enrolled in the Health Coach program through the Alameda Health Pipeline Partnership.
- Seven EMS Corps alumni volunteer in the EMS Corps as mentors, tutors, and skills instructors.

36 of the 40 EMS Corps students are employed, 28 as EMTs.

Environmental Health: Improve Field Sanitation Conditions/Nail Salons

acgov.org/aceh/healthynail/index.htm

Allocation: **$25,000** | Expended/Encumbered: **$12,547**

Individuals served by Measure A: **325 salons** (Total individuals served: **325 salons**)

Populations served: Low Income Adults, Children

Services provided: Public Health

Service area: Countywide, Outside of Alameda County

BACKGROUND

Alameda County Environmental Health Services (EHS) promotes the health, safety, and well-being of the public through promotion of environmental quality. EHS uses enforcement authority, education, and cooperation to promote awareness of environmental protection, environmental justice, and pollution prevention. EHS carries out this mission in partnership with a wide variety of other government, nonprofit, and for-profit organizations.

The Alameda County Environmental Health Department (ACEH) created a Healthy Nail Salon Recognition (HNSR) program and technician certification with the California Healthy Nail Salon Collaborative. The program serves businesses in seven cities: Alameda, Albany, Berkeley, Fremont, Hayward, Oakland, and Pleasanton.

The HNSR program achieves its goals through the following activities:

- Assisting salon owners and workers in identifying the highest risk nail salon products and practices and in selecting preferable products, practices, and protective equipment to improve worker, client, and community safety
- Identifying or creating reliable information sources for salon workers/owners
- Offering a rebate to cover all or most of the cost of purchasing and installing appropriate air purification equipment
- Providing recognition (certificate and use of logo) to salons to promote themselves as Healthy Nail Salons
- Providing online and branding tools for customers/clients to find and patronize Healthy Nail Salons
- Providing training and training certificates to empower workers with better information and a way to demonstrate to prospective employers that they know Healthy Nail Salon criteria

The HNSR program assists salon owners and workers in identifying the highest risk nail salon products and practices and selecting preferable alternatives.

MEASURE A FUNDING SUMMARY

Measure A funding helped the ACEH/HNSR program achieve the following:

- Hold one formal workshop for salon owners, with 24 attendees representing 12 salons
- Send mailers to 325 salons in Alameda County
- Respond to three media requests
- Participate in six stakeholder meetings
- Review 18 applications
- Perform 14 site audits with technical assistance
- Conduct 10 onsite trainings for workers at nine salons, with 31 attendees
- Provide six recognitions and four equipment reimbursements
- Offer translation services at the owner workshop and at three salons
- Respond to one complaint by phone
- Contact 13 salons to participate in an outcomes survey organized and carried out on behalf of the California Healthy Nail Salon Collaborative

Measure A funding helped the ACEH/HNSR program send mailers to 325 salons in Alameda County.

Genesis Worship Center

genesiswc.com

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

Individuals served by Measure A: **1,170** (Total individuals served: **7,700**)

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

Services provided: Public Health

Service area: Oakland

BACKGROUND

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

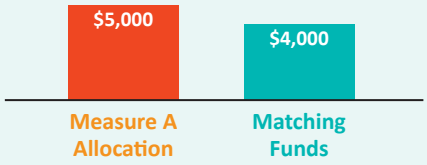
MEASURE A FUNDING SUMMARY

Genesis Worship Center used its Measure A allocation to provide meals to 548 clients in December 2014 and 622 clients in January 2015. The target was 100 clients per week.

Highlights

Genesis Worship Center **exceeded its target of feeding 100 clients per week** in both months for which it used its Measure A allocation.

Matching Funds



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

HIV Education and Prevention Project of Alameda County (HEPPAC)

casasegura.org

Allocation: **$26,000** | Expended/Encumbered: **$26,000**

Individuals served by Measure A: **646** (Total individuals served: **1,615**)

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

Services provided: Public Health, Substance Abuse

Service area: Alameda, Berkeley

Note: In addition to its individual allocation, HEPPAC also received Measure A money through the Public Health Prevention Initiative allocation (see page 107). The funding summary information described here is for the total of both allocations.

BACKGROUND

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

Many HEPPAC clients would go untreated because their only options are emergency departments, where there are long wait times and the fear of being stigmatized for their substance use and/or chronic homeless status.

MEASURE A FUNDING SUMMARY

Measure A supported HEPPAC's client population by providing critical wound care and clinical services to extremely low income, marginalized active injection drug users and high risk youth and young adults engaging in unprotected sex with multiple partners.

HEPPAC used its Measure A allocation to achieve the following:

- Administer care for soft tissue damage due to injection drug use by a qualified medical professional at the Casa Segura clinic and syringe exchange locations (target: 100 wound care visits, 50 unduplicated clients; actual: 142 visits, 73 unduplicated clients)
- Provide wound care follow-up services to intravenous drug users (IDUs) at both the Casa Segura clinic and syringe exchange program (target: 12 visits; actual: 13)
- Maintain two syringe drop box locations by collecting used syringes in the box weekly and collecting any loose syringes in the immediate area (target: collect 5,000 syringes; actual: 3,041 at drop box, 2,015 loose syringes collected)
- Conduct outreach to the IDUs accessing the drop box location to make them aware of the drop box and provide them with information on how

Measure A Helps

T., a 37-year-old African American homeless male, accesses HEPPACs mobile outreach services at least every other week. T. was informed of his positive HCV status over 13 years ago and never followed up or sought further care. He was enrolled into Medicare, but his assigned medical home was in Fremont. Because he is based in Oakland, he never accessed the home. HEPPAC provided confirmatory HCV screening services and connected him with a health benefits enrollment specialist to change his assigned medical home to LifeLong Medical services. At LifeLong, they are addressing T.'s chief medical concerns and preparing him for possible HCV treatment services.

to properly dispose of used syringes and reduce the risk of HIV and HCV (target: 100 IDU clients; actual: 146)

- Encourage PWIDs receiving abscess/wound care services to participate in at least one of the following: HIV or HCV testing and counseling services (target: 100 PWIDs, with 52% participating in at least one service)
- Demonstrate increased knowledge among PWIDs of their HIV and/or HCV status (target: 156 PWIDs)
- Refer all PWIDs and/or their sexual and/or needle-sharing partners who test positive for HIV and/or HCV and/or an STI to primary care services as needed

HEPPAC used its Measure A allocation to demonstrate increased knowledge among PWIDs of their HIV and/or HCV status.

Hospital Committee for Livermore-Pleasanton Area dba ValleyCare Health System

valleycare.com

Allocation: **$15,000** | Expended/Encumbered: **$4,536**

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

Populations served: Low Income Children

Services provided: Public Health

Service area: Livermore

Note: The provider submitted its report late for Committee review. Therefore, this summary may reflect incomplete information.

BACKGROUND

ValleyCare Health System works to care, to educate, and to discover.

MEASURE A FUNDING SUMMARY

ValleyCare used its Measure A allocation to provide quality, nutritious meals to low income children ages 18 months to six years living in Livermore. Meals were provided through ValleyCare's nonprofit, hospital-based food service establishment.

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

- Conduct four trainings monthly to instruct staff on the nutritional benefits and proper preparation of fresh fruits and vegetables, with 100% of staff completing at least one training
- Use 90% of purchased food to prepare healthy meals
- Have 50% of Head Start program participants complete the food education curriculum

ValleyCare used its Measure A allocation to provide quality, nutritious meals to low income children ages 18 months to six years living in Livermore.

LIFE ElderCare

lifeeldercare.org

Allocation: **$12,400** | Expended/Encumbered: **$12,400**

Individuals served by Measure A: **26** (Total individuals served: **202**)

Populations served: Low Income Seniors

Services provided: Public Health

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

BACKGROUND

LIFE ElderCare empowers seniors to live with independence and interdependence by nourishing mind, body, and spirit. LIFE ElderCare's fall prevention program includes individualized exercise programs, medication screening and education, and environmental assessments and minor home modifications.

MEASURE A FUNDING SUMMARY

LIFE ElderCare used its Measure A funds to increase access to home-based public health services for low income, at-risk seniors in Central and Southern Alameda County through a person-centered, multifaceted fall prevention program. The program achieved the following objectives:

- 87 seniors (age 60+) enrolled in the program.
- 77% of seniors participating in the program demonstrated fewer (or if 0, no more than 0) falls in the three months after they enrolled than in the three months prior to enrollment.
- 100% of enrollees received an initial strength and balance assessment by a certified fitness instructor.
- 100% of enrollees had an individualized exercise plan designed for and taught to them by trained, screened nursing students.
- 100% of enrollees received medication screening and education on medication management.
- 100% of enrollees received a home hazard assessment and education and assistance in reducing clutter and fall hazards.
- 100% of those enrollees who needed minor home modifications received them.
- 72% of enrollees expressed more confidence about not falling after participating in the program.
- 58% of enrollees had improved times on the Single Leg Stand test post-program vs. pre-program.
- 53% of enrollees had improved scores on the Berg & Tinetti Balance Tests post-program vs. pre-program.
- 53% of enrollees had improved scores on the Timed Up & Go test post-program vs. pre-program.

Measure A Helps

After Mrs. Q., 83, fell and was hospitalized, she was very interested in giving the fall prevention program a try. At the beginning, her scores rated her at very high risk of another fall. Student nurses taught Mrs. Q. the recommended exercises, which she faithfully did every day. Mrs. Q's furniture arrangement also posed a hazard. The students helped her move some items out of high traffic areas, and the program paid for Mrs. Q to have grab bars professionally installed in her shower. Mrs. Q.'s follow-up assessments have rated her as low risk of future falls. She is even back to taking her daily outside walk.

Mercy Retirement Center

eldercarealliance.org/mercy-retirement-care-center

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

Individuals served by Measure A: **5,427** (Total individuals served: **5,427**)

Populations served: Low Income Seniors

Services provided: Public Health

Service area: Countywide

BACKGROUND

The Mercy Brown Bag Program coordinates the distribution of over a million pounds of free nutritious groceries to low income older adults in Alameda County to improve the quality of their lives by combating the negative effects of hunger, malnutrition, isolation, and a sense of uselessness.

Seniors who come to central locations to get their food are given information about other essential services and volunteer opportunities in their area, while having an environment in which to exercise and socialize.

MEASURE A FUNDING SUMMARY

The Mercy Brown Bag Program used its Measure A allocation to distribute two nutritiously balanced bags of groceries each month to a minimum of 3,000 senior households, representing a minimum of 5,500 grocery bags to 4,000 individual seniors.

Highlights

In a survey, Mercy Brown Bag Program recipients indicated the following:

- 37% didn't have enough money to buy food or other necessary items to last the entire month.
- 34% had to skip meals.
- 76% thought their health would be negatively affected either somewhat (22%) or a great deal (54%) without this program.

Thus, the program **helped fill an important gap in maintaining the health and well-being of the older adult population**.

Public Health Prevention Initiative

Allocation: $**3,151,570** | Expended/Encumbered: **$3,151,570**

Individuals served by Measure A: **202,475** (Total individuals served: **236,257**)

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

Services provided: Public Health

Service area: Countywide

BACKGROUND

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

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

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

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

These priority areas encompass the following programs and organizations.

Chronic Disease & Injury Prevention

- Diabetes
- Project New Start
- Asthma Start (see the separate "Asthma Start" entry on page 90)
- Healthy Kids Healthy Teeth (see the separate "Alameda County Dental Health" entry on page 51)

Health Inequities & Community Capacity-Building

- Immunization
- HIV Prevention: HEPPAC (see the separate "HIV Education and Prevention Project of Alameda County (HEPPAC)" entry on page 102)
- HIV Prevention: CAL-PEP
- Lotus Bloom
- Niroga
- Healthy Retail Project
- HOPE Collaborative—A Project of the Tides Center
- Mandela Marketplace
- Developmental Disabilities Council—Older Adult System of Care (see the separate "Schreiber Center" entry on page 39)

Measure A Helps

HOPE COLLABORATIVE

From client Abdu Abdulalim: "After leaving Eritrea as a war refugee and moving to California, ten years ago I bought this food market, Three Amigos. Recently I met the HOPE Collaborative, which transforms corner stores into healthy markets. Since then, I have increased the store's healthy food offerings by carrying fresh produce. HOPE volunteers have come to the store for work days, replacing tobacco and alcohol signs with colorful posters promoting healthy foods. They are designing a mural promoting healthy foods and beverages for the outside of the store. HOPE taught me which alcohol and tobacco products are most harmful and helped me understand why I should sell less of these products."

- Child Health Disability Prevention Program
- Home Visiting and Family Support
- City and County Neighborhood Initiative (CCNI): Sobrante Park and West Oakland

Obesity Prevention & School Health
- Healthy Living Program for Children at Madison Park Business and Art Academy
- Berkeley School-Linked Health Services Program
- Nutrition Services
- East Oakland Boxing Association

MEASURE A FUNDING SUMMARY

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

Chronic Disease & Injury Prevention

Diabetes
- Provide 16 hours of self-management education to adults with type 2 diabetes in a variety of languages.
- Offer local support groups serving 996 clients per year.
- Send out a monthly newsletter to 350 past participants per month.
- Reduce A1c, a test that shows how well a person is controlling his or her diabetes, in 71% of clients (target: 75%).
- Reduce blood pressure in 53% of clients (target: 50%).
- Reduce weight in 64% of clients (target: 75%).
- Increase physical activity in 82% of clients (target: 50%).
- Achieve 92% of clients starting to read food labels, count carbohydrates, and practice portion control (target: 75%).

Project New Start
- Partner at least 75–90 formerly involved gang youth with sponsoring agencies committed to supporting each youth's lifestyle change through tattoo removal.
- Remove visible gang-related and/or drug-related tattoos from the face, neck, forearms, hands, and, when appropriate, below the knee areas of participants to improve employment, social, and educational possibilities for youth.
- Participate in collaborations to reduce youth violence in Alameda County.

Health Inequities & Community Capacity-Building

Immunization
- Promote the elimination of vaccine-preventable diseases by implementing the California Immunization Registry program (CAIR) in Alameda County.

Measure A Helps

DIABETES

The California Thoroughbred Horsemen's Foundation asked the diabetes program to provide diabetes education for the workers at Berkeley's Golden Gate Fields. The foundation has a small onsite clinic with a medical provider two mornings a week. Since the program's usual eight-week diabetes course would not fit the workers' schedules, the program suggested a monthly diabetes class and support group. In addition, the clinic's minimal services limited access to care and did not offer a continuity of diabetes care that is critical in preventing complications. What's more, many of the workers were uninsured and were not aware of HealthPAC. CCNI set up onsite enrollment for Medicaid, HealthPAC, and Covered California.

- Support medical providers who strive to improve their immunization rates and prevent diseases for their patients.
- Through CAIR, ensure that a child who has received immunization from multiple sites has one source of immunization coverage truth.
- Also through CAIR, ensure that users have rapid access to complete and up-to-date immunization records, helping eliminate missed opportunities to immunize and minimize unnecessary immunizations.
- Allow staff to focus not only on recruiting and retaining providers that serve underinsured children in the County, but also to increase the numbers of records in the Immunization Registry and use the Immunization Registry for specific reminder and recall projects.
- Recruit health care providers to join the registry.
- Provide training and technical assistance on registry use for medical office staff.
- Set up data exchanges with medical providers' Electronic Health Record systems.
- Build and support a network of immunization providers and support vaccination efforts in needed areas.
- Identify populations who would benefit from immunization-related projects to prevent communicable diseases.

HIV Prevention: CAL-PEP

- Conduct Targeted Prevention Activities (TPAs) in high risk communities and other venues where African American positive and high risk negative individuals congregate.
- Distribute partner services information and safer sex materials to all TPA contacts.
- Enroll 10 clients in the CLEAR program.
- Have 80% of participants take a pre and post test to measure their risk behavior at intake and discharge.
- Conduct five HCPI events designed to increase knowledge of current HIV status, risk reduction skills, and partner communication among African American HIV-positive participants and their negative sexual partners.
- Provide HIV testing to drug using and sexual partners of HIV-positive individuals.

Lotus Bloom

- Build parent/resident leadership in two neighborhoods, Castlemont and San Antonio, to further expand health, nutrition, and wellness

Immunization

- Provide education and support to over 40 providers/medical groups meeting the Stage 1 Meaningful Use attestation requirement for the Medicare and Medicaid EHR Incentive Program.
- Send out over 4,000 recall postcards reminding patients they are due for their immunizations.

Measure A Helps

HIV PREVENTION: HEPPAC

Client A., 49, accessed HEPPAC during mobile outreach providing syringe exchange and harm reduction supply distribution at a homeless encampment in East Oakland. HEPPAC staff referred A. for follow-up risk reduction counseling services. A. accessed the syringe exchange three more times after his initial visit and received HIV/HCV testing. When A. tested positive for HCV, HEPPAC referred him to ACA enrollment, HCV treatment, housing, and mental health and substance use treatment services for methadone. A. successfully enrolled in ACA and obtained linkages to specialty care for his HCV and a medical home that addresses his overall health needs. He is now stably housed, medically insured, and maintaining methadone substance treatment.

- Promote the elimination of vaccine-preventable diseases by implementing CAIR in Alameda County to eliminate both missed opportunities to immunize and unnecessary immunizations.
- Increase the number of providers who use CAIR in Alameda County to 120 organizations, and the number of Alameda County patient records in CAIR to 49,430.

Niroga

- Select, train, and place IHF graduates in the community where they are needed the most; extend evaluation to organizational and community impacts; complete data analysis and reporting; and formalize policy recommendations.
- Provide a one-day Transformative Life Skills training for approximately 25 Alameda County Public Health Department – Community Health Services staff to incorporate strategies and techniques with clients.
- Provide 25 hours of healing yoga/meditation/stress reduction classes and preparation of materials to the diabetes prevention and management classes, diabetes prevention and management supports groups, and hypertension prevention and management classes.
- Provide healing yoga therapy/stress reduction/meditation sessions to the Ethnic Health Institute Health Ministry Program's hypertension and prevention management clients.
- Create a healing yoga therapy educational tool for asthma prevention and management.

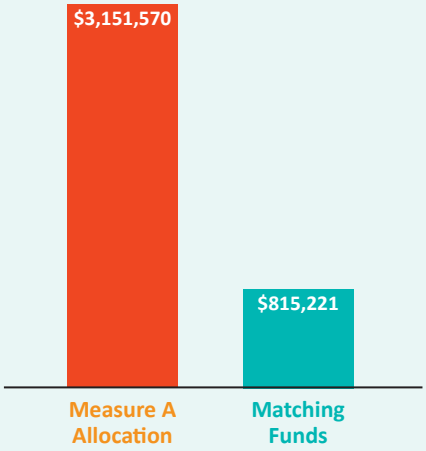
Mandela Marketplace

- Expand regional food interests in the Ashland, Cherryland, Livermore, Tri Cities, and Hayward areas.
- Deliver 15+ fruits and vegetables twice a week on consignment, ensuring that the store has a mix of produce items that are always fresh.
- Develop a healthy retail intervention model, including store selection, recruitment, and enrollment process; store and store owner assessment; technical assistance to store owner on healthy retail; community engagement; product guidelines; sales tracking and inventory management systems; store owner and staff training; healthy foods procurement; and marketing.

Child Health Disability Prevention Program (CHDP)

- Screen 6,964 children using the Ages and Stages Questionnaire (ASQ) and Modified Checklist for Autism in Toddlers (MCHAT) in Help Me Grow pediatric sites and clinics.
- Refer 1,396 children who scored of concern to the Help Me Grow phone line for follow-up, which could include referral to entitlement services such as the Regional Center of the East Bay or Alameda County Behavioral Health; referral for family navigation services; referrals to play groups or community-based programs; and provision of child development guidance and resources.
- Institutionalize universal developmental screening as indicated by an

Matching Funds



Public Health Prevention Initiative providers leveraged their Measure A allocations to obtain **$815,221 in matching funds** from the following sources:

- Medi-Cal Administrative Activities (MAA)
- Targeted Case Management (TCM)
- Children's Health and Disability Prevention (CHDP)
- Maternal, Child, and Adolescent Health (MCAH)
- The Centers for Disease Control (CDC)
- The U.S. Department of Agriculture (USDA)
- Cal Endowment

increase in the number of CHDP providers who employ a standardized tool for developmental and mental health screening.
- Provide resources to parents that focus on how to access needed services for children who are identified with any developmental concerns.
- Increase the number of low income, Medi-Cal or uninsured children screened at nine, 18, and 24 months of age. Identify and refer those at risk for developmental delay.
- Identify children with special health care needs and facilitate appropriate referrals to California Children's Services (CCS) and other programs.
- Increase access to primary and specialty care for low income, Medi-Cal, or uninsured children through education, training, and support to pediatric sites serving these children.
- Enable pediatric health care professionals and parents to act as partners in the "medical home" to coordinate all medical services and community supports necessary to achieve maximum potential for the child.
- Recruit and train new Alameda County pediatricians in early childhood mental health and developmental screening.
- Assist CHDP providers with developing business practices to incorporate early childhood developmental and mental health screening into well-child exam appointments.

Home Visiting and Family Support
- Provide 424 in-home, in-person interpretation sessions in 16 languages by pairing interpreters with home visitors who visit pregnant women and families with young children on a weekly or semi-monthly basis.
- Assign interpreters to certain cases wherever possible to strengthen the relationship between the interpreter and the client.
- Arrange for interpreters to accompany clients to health care provider visits when possible.

City/County Neighborhood Initiative (CCNI): Sobrante Park
- Conduct monthly meetings of the Sobrante Park Resident Action Council (RAC) and the Neighborhood Crime Prevention Council (NCPC), attended by an average of 33 residents.
- Successfully lobby the Board of Supervisors (BOS) to select Sobrante Park as one of six Violence Prevention Initiative (VPI) sites. As a VPI site, Sobrante Park will receive additional attention and resources from the BOS to coordinate existing violence prevention efforts in the neighborhood, align and leverage resources, and communicate about violence prevention to the wider community.
- Hold annual events such as the Sobrante Park Time Banking Health Fair, which served 300 residents this year with over 40 vendors offering health education workshops.
- Conduct three meetings of the Sobrante Park Leadership Council (SPLC), which brings together leaders of 14 community institutions.

CHDP screened 6,964 children and referred 1,396 children of concern to the Help Me Grow phone line for follow-up.

- Collaborate with partners including mental health specialists, community health educators/promoters, traditional healers, and community capacity-builders to create a cross-ethnic approach named "Healing Violence with Culture, Traditional Medicine, and Meaningful Engagement."
- Connect participants to hands-on community improvement and violence prevention projects.

City/County Neighborhood Initiative (CCNI): West Oakland

- Conduct a door-to-door survey to reassess community priorities for action. 53 residents responded to the survey.
- Relaunch the West Oakland RAC, which held monthly meeting to discuss community priorities for action.
- Through the West Oakland Mini-Grant Committee, distribute $18,625 to 11 distinctive resident grant applicants.
- Train youth at McClymonds High School's Alternatives in Action program to co-facilitate focus groups with local youth to assess their opinions about community issues and priorities for action.
- Through the West Oakland Youth Mini-Grant Committee, distribute $6,000 to six grant applicants.
- Provide logistic and programmatic support for the West Oakland Youth Center, which began offering youth activities and mentoring at the site. Approximately 400 residents attended the six-week "Friday Night Live" program, participating in activities such as sports activities, cooking workshops, connections to community resources, giveaways, and games.

Obesity Prevention & School Health

Healthy Living Program for Children at Madison Park Business and Art Academy

- Work to ensure children do the following:
  - Increase consumption of fruits and vegetables for snacks.
  - Drink water between meals and during physical activity.
  - Discover fun ways to be physically active.
  - Set goals for eating healthier snacks and being physically active.
- Provide a healthy snack once a week, along with a workbook.

Berkeley School-Linked Health Services (SLHS) Program

- Support stronger linkages between Ph.D. programs to build more productive inter- and intra-agency collaborations, with a focus on those that address educational attainment.
- Collaborate with the Berkeley Unified School District (BUSD) and other agencies to develop and implement a coordinated, multiagency service delivery model that links students, families, and school staff to needed resources, with a special focus on attendance and truancy.
- Serve as a consultant, specifically in the areas of physical health, to school administration and elementary school staff and families.

Measure A Helps

CCNI: SOBRANTE PARK

In FY 14/15, residents worked together to increase safety and reduce blight at the Edes Avenue throughway. This throughway had become a neglected and dangerous dumpsite, earning the nickname "Death Alley." Thirteen residents formed a core group to tackle the Edes throughway, mobilizing 145 additional residents in clean-up and beautification activities. CCNI staff and the residents obtained $4,000 in in-kind donations and $500 in cash donations to support their work. As a result of their efforts, Edes is no longer "Death Alley." The dumping has essentially stopped, and it is safe to walk on the street. Edes Avenue has new trees, plants, and vegetation.

- Facilitate data sharing to analyze health-related absenteeism.
- Distribute messaging campaign flyers, banners, and articles, including 700 attendance teacher toolkits and 3,000 stickers.
- Conduct attendance surveys at all 11 district elementary schools.
- Successfully advocate for a BUSD RN position and an increase in nursing services within BUSD.
- Support oral health screenings at the 11 elementary schools for second and fifth graders. 1,065 children were screened, and over 290 children received dental sealants.
- Conduct 16 Public Health family visits at their homes.
- Participate in eight 504/IEP/SST meetings with school staff and families.
- Participate in eight SARB and five SART elementary meetings.
- Provide over 15 school-linked referrals/case consultations with fellow PHNs.

Nutrition Services

- Engage in environmental change and policy advocacy for nutrition/food access, obesity prevention, and physical activity promotion activities currently unallowable by USDA funds and expansion to geographic areas and sites outside of USDA-allowed service areas.
- Provide subcontracts to community-based organizations (CBOs) working on food access issues.
- Support the Oakland Food Policy Council, specifically the direct support of collaboratives working for a just, fair, and equitable food system.
- Support an epidemiologist in the CAPE unit for data collection, analysis, and report development.
- Support the CHS Health Care Program Administrator working on County collaborations and overseeing the Food 2 Families program, as well as the Ashland Cherryland Food Policy Council and Mandela Marketplace.
- Support the Soda Free Summer campaign including social media, video contests, and collateral materials.
- Support of Safe Routes to School Program funded by CalTrans.
- Participate in East Oakland Building Healthy Communities, Outcome 4 Access to Healthy Foods.
- Participate in food systems/food Policy Collaboratives including HOPE, Oakland Food Policy Council, Berkeley Food Policy Council, and Place Matters Land Use and Transportation workgroup.
- Monitor contracts of CBOs conducting nutrition and physical activity promotion efforts under Measure A.

East Oakland Boxing Association (EOBA)

- Offer cooking classes two days per week and sports nutrition classes once per month for 200 East Oakland youth .
- Facilitate two health and nutrition presentations for at least 50 EOBA youth and parents.

EOBA offered cooking classes two days per week and sports nutrition classes once per month for 200 East Oakland youth.

- Have all youth participate in daily physical activity and maintain awareness of the importance of being active to improve their health.
- Provide gardening classes three days per week for East Oakland youth focused on access to fresh organic vegetables and fruits, environmental stewardship, physical activity, stress reduction, life/work skills, and leadership.
- Create three educational YouTube videos through the EOBA Urban Fresh Gardeners program.
- Participate in a minimum of two offsite community events and three workshops at EOBA promoting healthy eating, gardening, and/or physical activity.
- Increase the amount of free fresh produce available to EOBA youth, their families, and the community to help improve the overall health and well-being of the community.

Measure A Helps

EOBA

Twins Monica and Sofia are fifth graders at Encompass Academy. They have attended EOBA for over a year. When the twins started at EOBA, their in-school behavior was out of control. They would have temper tantrums in class, sometimes lashing out physically against their peers and even teachers. This behavior was not without reason – both girls had lived through traumatic experiences at home. At EOBA, staff drew upon various methods of mitigating Monica and Sofia's behaviors. The girls learned that they had adults who cared about their progress, and whom they could trust. Their teachers report drastically fewer behavioral issues at school, and more positive attitudes from both twins.

Ryan White Provider RFP: Community Health for Asian Americans (Office of AIDS)

chaaweb.org

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

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

Populations served: Low Income Adults, Families

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Oakland

BACKGROUND

Community Health for Asian Americans (CHAA) is committed to improving the quality of life for marginalized communities, with special focus on Asian and Pacific Islander (API) communities in the Bay Area.

The CHAA Burmacare program helps Burmese clients access HIV and other services. Due to language and cultural issues, these clients were previously not in care for their HIV and other needs. Their community speaks an indigenous dialect that is not well known even to translation services. This adds to cultural issues that isolate the clients due to beliefs and stigma around HIV and AIDS, along with underlying substance use that is also stigmatized and therefore hidden within the community.

Through this program, clients are able to engage with providers about their medical care and access services like mental health and substance abuse. Clients are also able to access dental care as well as apply for medical and financial benefits.

CHAA used its Measure A allocation to ensure that 25 HIV-positive immigrant and refugee clients are covered by and maintain their Medi-Cal benefits and additional social benefits.

MEASURE A FUNDING SUMMARY

CHAA used its Measure A allocation to achieve the following:

- Ensure that 25 HIV-positive immigrant and refugee clients are covered by and maintain their Medi-Cal benefits and additional social benefits such as housing, immigration, financial assistance, and so on
- Provide clinical case management supervision to the community health outreach worker and health navigator for their work with HIV-positive clients enrolled in Burmacare
- Hire a Licensed Behavioral Clinician to work with the case manager to ensure appropriate care, especially for alcohol and drug treatment and tobacco cessation

Senior Injury Prevention Program

acphd.org/ipp/sipp.aspx

Allocation: **$115,000** | Expended/Encumbered: **$115,000**

Individuals served by Measure A: **2,606** (Total individuals served: **2,606**)

Populations served: Low Income Adults, Seniors

Services provided: Public Health

Service area: Countywide

BACKGROUND

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

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

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

The SIPP providers include the following:

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

Measure A Helps

LIFE ELDERCARE

Samir, 76, enjoys the exercises LIFE ElderCare helps with in his home each week. LIFE ElderCare's Unitek College nursing students have given him specific tips on how to make his home safer, helped to compile his meds into a foldable he can take to his doctors, and told him about the role good hydration and nutrition play in avoiding falls. Thanks to his exercise, on evidence-based assessments, Samir has progressed to a 10 on some of the exercises a 7 on others. He no longer has to rely on his walker to get about his house the way he did prior to enrolling.

MEASURE A FUNDING SUMMARY

SIPP providers served 1,399 new seniors in FY 14/15, compared to a target of 1,010 new seniors.

Measure A funding helped SIPP provide the following:

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

screen and assess the fall risk of older adults. Appropriate education on fall-risk reduction, evidence-based physical activities, medication management, and minor home modification referrals was made to meet the client's needs (target for all providers: 602; actual: 730).

- Minor home modifications. The program made residential modifications that were necessary where risk for falls and other risk factors could be reduced or minimized by minor home adaptations (target for all providers: 58 assessments/modifications; actual: 80).
- Physical activity sessions. The program used individual and group exercises using evidenced-based models to improve strength and balance to reduce fall risk (target for all providers: 50; actual: 108).
- Individual/group medication management. The program educated individual groups of older persons, in addition to their families, friends, caregivers, and community individuals, on the safe disposal of medications and other health measures for managing their medication properly (target for all providers: 196; actual: 289).

Highlights

In all areas, the **SIPP providers exceeded their targets**, in some cases dramatically. For example, the target for individual and group physical activity sessions was 50, while the actual number of sessions was 108—an increase of over 100%.

Service Opportunties for Seniors (Meals on Wheels)

sosmow.org

Allocation: **$116,000** | Expended/Encumbered: **$116,000**

Individuals served by Measure A: **703** (Total individuals served: **1,953**)

Populations served: Indigent, Low Income, Uninsured Seniors

Services provided: Hospital Outpatient, Public Health

Service area: Castro Valley, Oakland

BACKGROUND

Service Opportunity for Seniors (SOS) Meals on Wheels assists homebound seniors who are in need of supplemental balanced nutrition through a daily home-delivered meal service to prevent early institutionalization.

Meals on Wheels delivers meals to seniors who are released from the hospital to recuperate at home and to homebound seniors with no capability to purchase or cook their food. The nutrition services include procurement, preparation, serving, and transporting meals; a wellness check; and nutrition education.

MEASURE A FUNDING SUMMARY

Meals on Wheels used its Measure A allocation to deliver 70,000 meals and provide wellness checks to 700 homebound seniors in Castro Valley and Oakland.

Highlights

90% of homebound seniors rated their delivered meals as good, very good, or excellent. 90% also reported that **receiving meals from Meals on Wheels improved their health**.

South Hayward Parish

southhaywardparish.org

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

Individuals served by Measure A: **6,499** (Total individuals served: **27,476**)

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

Services provided: Public Health

Service area: Castro Valley, Hayward, Union City

BACKGROUND

South Hayward Parish works to engage people of faith in the endeavor and partnership of building and maintaining a just and nurturing community.

South Hayward Parish provides two days' worth of food assistance to low income families in an area that is considered a food desert by distributing food donated and purchased through the Alameda County Community Food Bank. Two-thirds of the food distributed is fresh produce. In many cases, the food provided by the service is the only fresh produce that the clients receive. In addition, South Hayward Parish provides nutrition workshops for promoting healthier eating habits and cooking methods. It also promotes any available services that can assist clients in need.

MEASURE A FUNDING SUMMARY

South Hayward Parish used its Measure A allocation to provide a total of 38,994 meals to 6,499 unduplicated clients over a 63-day period.

Measure A Helps

One nutrition workshop focused on introducing children to the kitchen. The children participating in this workshop were taught how to make a simple healthy breakfast for the family. The children were also taught basic food safety procedures such as the importance of personal hygiene when handling food. The workshop provided a fun learning opportunity for children, helped introduce them to the importance of food and the necessary safety precautions required, and supported an improved family diet. The workshop was beneficial to the families and gave the children incentive to go home and prepare a healthy meal for their families.

Spectrum Community Services, Inc.

spectrumcs.org

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

Individuals served by Measure A: **567** (Total individuals served: **567**)

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

Services provided: Public Health, Mental Health

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

BACKGROUND

Spectrum Community Services assists low income, disadvantaged, and elderly residents of Alameda County as they attempt to achieve and maintain self-sufficiency and improve the quality of their lives. Spectrum employs multiple strategies to implement this mission, offering individuals and families programs that remedy crisis, maintain and improve health and functionality, and develop skills and the capacity to help themselves.

Spectrum's Fall Risk Reduction Program (FRRP) uses a multipronged approach to address the physical, behavioral, and environmental factors that contribute to falls. FRRP employs strategies that educate about fall prevention; offers guidance regarding home safety modifications and environmental changes that can prevent falls; and offers exercise classes to build strength, stamina, mobility, balance, and fall prevention skills. Each program component focuses on empowering seniors to implement solutions and to become more confident of their control over their own lives.

The program emphasizes social interaction, giving isolated seniors the opportunity to develop new friendships and improve conditions like depression.

MEASURE A FUNDING SUMMARY

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

- Provide sessions focused on fall prevention education and strength/mobility/balance-building exercises at seven locations (target: 15 seniors per location each week; actual: 33 seniors per location)
- Conduct an evaluation of participants every six months to collect information regarding whether they fell, the cause of any falls, and their confidence on a number of fall-related topics (target: 50 participants; actual: 325)
- Evaluate participants on improvement in strength and mobility every six months, with the following results:

Measure A Helps

After experiencing a stroke, John, 86, went through rehabilitation and recovered many of his motor skills. However, John's health insurance only covered 12 weeks of physical therapy, after which he did not participate in any kind of exercise program. Because of this inactivity, John was lacking in lower body strength and suffered from poor balance and low mobility. During 2014, John had four falls. John joined the FRRP program and attends class 1-2 times per week. He has gained enough lower body strength to lift himself out of a chair without an assistive device. In 2015, John had one fall, which is a 75% reduction from the previous year.

- Flexibility: 45% improved, 46% maintained
- Endurance: 44% improved, 43% maintained
- Strength: 56% improved, 41% maintained
- Mobility: 29% improved, 56% maintained

- Conduct one-on-one consultations with 26 participants who experienced a fall to identify possible causes and recommend home modifications and home exercises to prevent future falls
- Conduct outreach demonstrations and presentations of the Fall Prevention Program at health fairs and workshops (target: 2 health fairs and 3 workshops; actual: 5 health fairs and 4 workshops)

Highlights

Spectrum's FRRP **met or exceeded its targets in all areas**, sometimes dramatically. For example, while targeting 15 seniors per location at their exercise sessions, actual attendance was 33 seniors per location—more than a 100% increase.

SSI Housing Trust

Allocation: **$0** | Expended/Encumbered: **$601,319**)

Individuals served by Measure A: **647** (Total individuals served: **2,081**)

Populations served: Indigent, Low Income, Uninsured Adults, Other residents: Disabled and Chronically Homeless

Services provided: Public Health, Mental Health

Service area: Countywide

Note: This provider received its allocation in FY 12/13 but expended it in FY 14/15.

BACKGROUND

The Alameda County Health Services Agency (HCSA) helps poor, disabled Alameda County residents receive disability income and mitigates the negative impact of long processing times by stabilizing their health and living situations while their applications are pending.

The HCSA SSI housing trust seeks to achieve the following:

- Connect clients to outpatient mental health and primary care
- Obtain health insurance benefits for clients
- Obtain disability income for clients
- Improve housing stability for clients

This increase in housing stability improves clients' ability to access care, enables them to work with disability advocates, and helps improve their mental health.

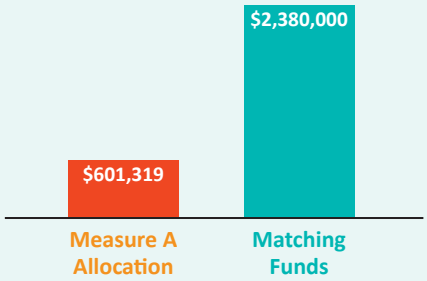
MEASURE A FUNDING SUMMARY

Measure A funds were used to establish a revolving fund to increase housing stability for clients. When clients are approved for disability benefits, the fund is replenished from the client's retroactive benefits.

Overall the program provided disability advocacy services, including care coordination, to 2,081 individuals, of whom 1,214 were approved for disability benefits and 867 still had claims pending at the end of the fiscal year. These awards in disability income resulted in clients receiving almost $25 million in ongoing income since the date of their approvals.

Calendar year 2013 was the pilot year to prove the concept. The project began to transition to full scale in January of 2014. The leftover funds from FY 12/13 and FY 13/14 were rolled over to FY 14/15.

Matching Funds



The SSI trust program leveraged its Measure A allocation to obtain **$2,380,000 in matching funds** from public funding sources.

Highlights

Clients entering the program receive a maximum of $336/month in income. Through this fund, while their disability application is pending, **client income nearly doubles to $654/month. Upon approval for disability benefits, client income nearly triples to $865/month**.

Viola Blythe Community Services

violablythe.org

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

Individuals served by Measure A: **2,023** (Total individuals served: **2,052**)

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

Services provided: Public Health

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

BACKGROUND

The Viola Blythe Community Service Center works to support and advocate for social and human services to any person in immediate need.

MEASURE A FUNDING SUMMARY

Viola Blythe used its Measure A allocation to increase access to quality nutritional food and provide clothing to low income families. Specifically, Measure A funding helped the Viola Blythe Center achieve the following:

- Distribute 6,511 pounds of food including fresh meat, dairy, and produce
- Provide 133 children with new clothing for back to school

Viola Blythe used its Measure A allocation to distribute 6,511 pounds of food to low income families.

West Oakland Youth Center

westoaklandyouthcenter.org

Allocation: **$70,000** | Expended/Encumbered: **$70,000**

Individuals served by Measure A: **800** (Total individuals served: **1,000**)

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

Services provided: Public Health, Mental Health

Service area: Oakland

BACKGROUND

The Alameda County Public Health Department (ACPHD) and the City of Oakland joined together in 2003 to fight growing poverty, violence, and chronic disease in Oakland through the City/County Neighborhood Initiative (CCNI). They chose to focus activities on two Oakland neighborhoods that were experiencing high crime rates, but that also had identified resources such as strong neighborhood associations and institutions.

One of these neighborhoods is the Hoover Historic District in West Oakland, where the West Oakland Youth Center (WOYC) is located.

CCNI partners include resident groups, community-based organizations, and the Oakland Unified School District. It is funded by the ACPHD, Alameda County Measure A/AA and City of Oakland Measure Y/Z.

MEASURE A FUNDING SUMMARY

Along with ACPHD and City of Oakland Measure Y, Measure A provides funding to the CCNI. The most significant outcome of these funding efforts was the opening of the West Oakland Youth Center (WOYC) in a building that had sat vacant for many years. The WOYC provides physical space and youth-focused programs and has become a major resource for West Oakland youth and the community.

Within the framework of the scope of services funded by Measure A, related outcomes fall into the following five categories:

- Strategic planning
- Partnership development
- Community and youth engagement
- Planning for youth programs and services, including piloting potential programs
- Operations-related functioning

Highlights

With support of Measure A, through the work of the CCNI and WOYC, youth and adults in the West Oakland Hoover District have a physical building that provides **safe spaces and resources that can benefit their health and well-being**.

During the summer of 2014, the CCNI collaborated with the WOYC on a series of **summer family engagement activities** called Friday Night Live. Approximately 500 residents attended the six-week program, participating in activities such as **sports activities, cooking workshops, connections to community resources, giveaways, and games**.

Strategic Planning

Activities supported by Measure A included the following:

- Participate in 12 planning sessions with partners including ACPHD staff, YMCA, St. Mary's Senior Center, McClymonds High School, Oakland Unified School District, City of Oakland, Alternatives in Action, Attitudinal Healing Connection-Oakland, People's Grocery, and Supervisor Carson's office
- Create and implement a strategic plan

Partnership Development

The goal was to establish a cooperative network of agencies, community-based organizations. and local neighborhood groups that would work together for improving the health of youth. Partners included YMCA, St. Mary's Senior Center, East Bay Asian Local Development Corporation, Hoover Elementary School, One West, McClymonds High School, Attitudinal Healing Connection, West Oakland Youth MiniGrant Committee, and West Oakland MiniGrant Committee.

Activities supported by Measure A included the following:

- Hold three working sessions to create a neighborhood assets map that includes churches, local community organizations, and small neighborhood groups chosen for outreach and relationship-building so that they could contribute their resources to creating youth-focused programs at the WOYC
- Create a plan for WOYC Steering Committee membership roles and responsibilities
- Have partners meet to choose their level of participation

Community and Youth Engagement

The WOYC building has its main entrance located in a high traffic area near Hoover Elementary School where groups of youth congregate. Neighboring residents have reported possible criminal activities in the building's vicinity. These factors required thoughtful and respectful approaches to community dialogues on a regular, consistent basis. Youth who frequented the area were invited to participate in discussions, both formally held and in ongoing dialogues in their "territories."

Related actions included forming a Youth Action Board (YAB) in partnership with Alternatives in Action. The youth met weekly for three months to plan youth-friendly and relevant programs and services. The West Oakland MiniGrant Committee also served as a vehicle for developing youth leaders who have interests in civic participation.

Young people in the West Oakland Hoover District neighborhood had several opportunities to engage in the WOYC. They helped plan and implement six Friday Night Live events, which included use of the WOYC

Highlights

In June 2014, over 1,000 residents took part in Juneteenth activities. Forty vendors provided activities and/or resources, and over 100 participants received **diabetes, blood glucose, blood pressure, and HIV/AIDS health screenings, as well as free clothing**.

building and facilities. Several community events cosponsored with CCNI, including Juneteenth and Health Fair, brought approximately 400 participants to these gatherings.

Youth Program and Services Development and Pilots

Activities supported by Measure A included the following:

- Hold over 40 planning sessions related to designing the types of programs that are relevant and most important to youth in the community
- Create a preliminary program and service schedule with offerings in employment skill building, information on educational opportunities, and life mentoring
- Partner with the Laney College Culinary program to establish a satellite facility at WOYC
- Explore partnerships with Alternatives in Action and the Robinson Baker YMCA for mentoring and tutoring

Operations-Related Functions

CCNI staff spent approximately 16 hours per week over a five-month period on operations, including working with City of Oakland staff to complete the furnishings and obtaining media and culinary equipment, computers, and other objects that would allow for services and programs. These tasks required navigating City of Oakland's bureaucracy and building cooperative relationships with staff to complete the transactions.

CONCERNS

One staff assigned to the WOYC project resigned mid-year. The supervisor took on the project responsibilities but wasn't able to bill against Measure A funding. Therefore, the actual expenditure was $44,244 out of WOYC's $70,000 allocation.

Highlights

Youth were engaged in **civic actions and helped influence policy makers** regarding funds for community resources and public policies that influence their health. Youth also had **greater access to information about the governmental, social, and public health services** available to them.

In addition, community residents joined together in neighborhood associations to address crime and **improve their physical environments**.

Youth and Family Opportunity Initiatives

achealthyschools.org/youth-development.html

Allocation: **$2,548,980** | Expended/Encumbered: **$2,548,980**

Individuals served by Measure A: **12,817** (Total individuals served: **12,817**)

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

Services provided: Mental Health, Substance Abuse

Service area: Countywide

BACKGROUND

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

The goal of the countywide Youth and Family Opportunity (YFO) initiative is to strengthen the capacity of "anchor" community-based organizations (CBOs) to provide a continuum of high quality, accessible school-linked health and wellness supports to youth and families experiencing poor health and educational outcomes.

The CBOs involved in the YFO initiative include the following:

- Alameda Family Services
- Alternatives in Action (AIA)
- Berkeley Youth Alternatives (BYA)
- City of Fremont: Human Services Agency
- East Bay Asian Youth Center (EBAYC)
- Eden Youth and Family Center
- Fremont Family Resource Center
- La Familia
- Newark Unified School District
- REACH Ashland Youth Center
- Union City Kid Zone
- Youth Radio

Mental Health Services

The funded CBOs offer a broad array of mental health services, including individual and group counseling, case management, mental health, alcohol and drug assessment, and referrals. For example:

- Alameda Family Services provides an array of mental health services to youth and families, including case management for youth, parenting skills classes, teacher consultations, and more.
- AIA provides critical wraparound services and supports to address

Highlights

Measure A funding enabled the CBOs participating in the YFO initiative to achieve a wide variety of outcomes for a large number of youth and their families. A behavioral health assessment used by half of the CBOs revealed that clients indicated **significant improvement in the following areas**:

- Behavioral/emotional needs: 34.4%
- Life functioning: 40.5%
- School: 39.9%
- Child strengths: 27.6%

students' holistic needs. Services include empowerment groups on topics such as violence prevention, restorative justice and conflict resolution techniques, relationship-building, trauma recovery, anti-oppressive education, and social justice principles.

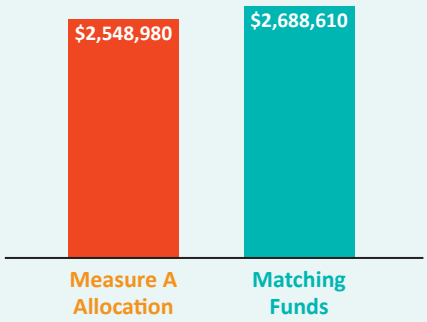
- BYA provides culturally competent psychosocial, mental, and emotional health services to low income and poverty-level children and youth ages 6–18. Participants are underinsured, undernourished, and underdiagnosed, and live in families where there is a parent who is either underemployed or unemployed.
- EBAYC provides case management, after-school learning, parent engagement, intake sessions, individual advising, home visits, teacher/administrator consultations, and more.
- Fremont Family Resource Center provides counseling and behavioral health services for individuals and groups.
- Newark Unified School District uses both a schoolwide anti-bullying curriculum and individual counseling to create a safe and positive environment for children to flourish academically and emotionally.
- Youth Radio offers intensive individual case management services to all youth participants. Case managers work with youth to navigate a wide range of challenges and opportunities, including health care system navigation, family reunification, and school enrollment.

Community Youth and Family Services

The CBOs offer programs including after-school services, arts/culture/media, case management, community outreach, insurance enrollment, information and referrals, gang prevention, and leadership development. For example:

- BYA uses curriculum such as the Alive & Free Violence Prevention Curriculum, G.R.O.W. Workshops, and Youth Council and Mentoring. BYA also hosts job fairs/job sessions with Oakland Unified School District, Security Guard Training, OSHA 10 Training, Goodwill Industries, and East Bay Innovations.
- Eden Youth and Family Center provides youth with paid career and employability competency workshops to improve behavioral health in terms of intrinsic motivation, locus of control, and self-esteem.
- Fremont Family Resource Center offers services in family financial stability including an integrated program to support low income individuals/families to build assets and become financially self-sufficient.
- La Familia offers workshops and services that address needs such as immigration, conversational English, and chronic disease education. La Familia also addresses youth health and wellness needs through a variety of services such as case management, youth support groups, interactive workshops for youth, and summer camps. La Familia also offers a diabetes series in partnership with the Alameda County Diabetes Program.

Matching Funds



The participating CBOs leveraged the YFO initiative Measure A allocation to obtain an additional **$2,688,610 in matching funds** from the following sources:

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

- Newark Unified School District works to support family wellness by hosting workshops directed at families most often underserved, including Latino Literacy communication skills workshops, culturally responsive parenting classes, and educational engagement workshops.
- REACH Ashland Youth Center offers a variety of programs for youth directed at increasing a sense of connection and belonging as well as widening their access to health access. Through its partners, REACH Ashland Youth Center also offers career and employment workshops, as well as recreation and fitness programming.
- Union City Kids Zone facilitates behavioral health prevention groups and workshops including Psycho Education and Social Skills, Acculturation Group for new immigrants, Girls Empowerment, and Mindfulness. Union City Kids Zone also offers a variety of youth development activities.

Wraparound Services

In addition to the formal services offered to youth and families described above, CBOs also offer wraparound services and may serve as the safety net for a family who is just short of extreme crisis. Wraparound services are a way for staff to support young people to increase their self-esteem, set goals, and have an accountability structure outside the formal counseling setting. In addition to working directly with youth and parents, staff advocate on their clients' behalf with probation, schools, and other public services to ensure that clients have completely accessed all the services available to them.

- AIA wraparound services include home visits; coordinating meetings with principals, teachers, and health service providers; meeting with probation and families; attending school/legal/mental health/medical consultations; and/or attending appointments.
- Alameda Family Services staff facilitate teacher consultation/IEPs and participate in Mental Health Service Teams for Transitional Aged Youth.
- BYA provides home and office visits to check in with parents and guardians. Staff regularly meet with school officials and Alameda County Probation staff and participate in IEP meetings on behalf of youth and parents. BYA hosts outreach events within the community to educate youth and families of color about health coverage and opportunities to engage in wellness activities. BYA staff meet with probation staff to coordinate referrals and set meetings with youth, probation, and counselors. BYA staff provide home visits and office visits when indicated to allow for discussions with parents and guardians.
- EBAYC staff provide individual advising, home visits, teacher/administrator consultations, IEP meetings, school attendance review team meetings, coordination of services team meetings, and more.
- Eden Family Youth Center partners on a number of collaboratives and pilot programs to provide seamless wraparound services to youth.

Measure A Helps

REACH AYC

A patient at AYC's clinic experienced behavioral issues that compromised her safety. She was illiterate and had previously experienced homelessness and psychosis. Clinic staff made sure the client received comprehensive medical care and behavioral health care services. Staff collaborated with other providers to discuss how best to proceed. The team scheduled a neuropsychological assessment to better understand her needs and how to move forward. She is now on waiting lists for ongoing therapy to address attachment issues and multiple traumas. She has also connected with REACH AYC's literacy program to improve her reading skills and Soulciety, an employment program, which helped her create her first resume.

- Fremont Family Resource Center provides support to families during IEP meetings, School Attendance Review Board (SARB) meetings, and teacher/principal consults. The program provides school-based behavioral health services to students and case management services to their families.
- La Familia offers monthly Medi-Cal enrollment and Cal-Fresh clinics.
- Newark Unified School District staff facilitate teacher/parent consultations and meet regularly with parents and administrators. Staff have hosted workshops on parent empowerment, community organizing, community health advocacy, adolescent development, communicating with school officials, positive communication, and the importance of eating healthy and exercise.
- REACH AYC partners with schools and community providers to provide recreation and fitness, arts and creativity, and career and employment services; community-based behavioral health and case management; and medical/dental services.
- Union City Kids Zone offers support for families with hardships by connecting them with partnered service providers and referrals to local resources. They also offer home visits, connections to therapists, workshops to students and parents, translations for parents, information on college readiness, college scholarship application assistance, and teacher/student consultations.
- Youth Radio's Direct Service staff provide comprehensive wraparound services to young people, including healthy food service and academic and career advising. Youth Radio staff also provide support at court hearings, broker communication with probation officers and court officers, write letters of support, and engage with teachers and guidance counselors.

Union City Kids Zone offers support for families with hardships by connecting them with partnered service providers and referrals to local resources.

MEASURE A FUNDING SUMMARY

Through the Measure A YFO initiative grant, 2,817 clients were served during FY 14/15.

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

- Youth-focused individual and group counseling, case management, mental health, alcohol and drug assessment, and referrals
  - 9,534 youth were seen in groups.
  - 2,631 youth received individual services.
- Family-focused individual and group counseling, case management, mental health services, alcohol and drug assessment, and referrals
  - 3,389 families were served in groups.
  - 1,425 families received services one on one.
- Youth leadership development and enrichment activities for improving personal growth, health and wellness, academic achievement, and creating career opportunities.
  - 2,253 youth benefited from these services.

- Family engagement in schools focusing on health and wellness, work readiness, and life skills
  - 4,796 families benefited from these services.
- Community events focusing on raising awareness of free and affordable health care services
  - 347 community events were held.
  - 25,473 contacts were made at the events.

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

Alameda Family Services

- In a survey administered to 65 adult clients, 97% of survey participants reported that staff treated them well, and 80% reported that services greatly improved their stability and/or life skills.

Alternatives in Action

- Students in the program completed probation, school attendance increased, grades improved, and family engagement increased.
- AIA administered a student survey that revealed the following results:
  - 98% said being in the program made them feel good about themselves.
  - 98% of students felt like they belonged in the program and felt safe in the program.
  - 98% said the program helped them feel more confident about what they can do.
  - 98% said the program helped them believe they can finish high school.
  - 97% said the program helped them learn how to be healthy.
  - 97% said they are better at saying "no" to things they know are wrong.
  - 98% said they are more of a leader.

Berkeley Youth Alternatives

- Youth demonstrated an overall increase in resilience based on a pre- and post-program 14-point resilience scale.
- 56% of youth achieved academic improvement, and 88% remained in school.

City of Fremont: Human Services Agency

- 68% of school-based students improved in functioning.
- Post-evaluation ratings showed 146% improvement in thriving and/or self-sufficiency.
- In a survey of more than 100 teachers, administrators, counselors, and other school staff, the majority of respondents were most satisfied with consultation services, stabilization of youth on campus, positive impact of crisis management on campus, and engagement of parents.

Measure A Helps

AIA

A student at McClymonds was struggling with issues around peer pressure and popularity. Her academics suffered, she started using marijuana and was staying out all hours of the night, and she attended her own Community Impact Project panel under the influence of marijuana. AIA program staff referred her to needed resources and also used a restorative approach to connect her back to her peers and the community. With the care management structure put in place by AIA, staff consistently addressed behavior, built relationships with this student to guide her through this time, and developed opportunities for her to give back to her community.

East Bay Asian Youth Center

- Chronic absenteeism at Garfield Elementary School and Roosevelt Middle School decreased by over 50% since the establishment of an EBAYC/school-coordinated attendance promotion partnership.

Eden Youth and Family Center

- Through participation in monthly support groups and volunteer commitments, participants found peer support, exposure to healthy life alternatives, increased self-esteem, positive outcomes in career and social development, and safe separation from their past lives.
- Participants in the youth employment program began receiving an income, which helped them pay bills and buy clothing and improved their attitudes.
- Many of the youth participants increased their attendance and grades.

La Familia

- Pre and post evaluations showed a statistically significant increase in self-esteem.
- Counseling clients also showed improvements in school academics based on GPA and school attendance.

Newark Unified School District

- Administrators reported that student attendance improved.
- Parents reported feeling more confident when communicating needs to the school.
- Families reported that their child was doing better in school and that family communication improved.

REACH Ashland Youth Center

Based on a youth survey administered in June 2015:

- 91-95% respondents stated that REACH AYC is fun, they would recommend REACH AYC to a friend, they felt safe at REACH AYC, and staff treated them with kindness and respect.
- 54% of respondents talked with a staff person about a personal challenge they were facing, and 80% said it was either helpful or very helpful.
- 87% agreed that participating in REACH AYC helped improve their grades.
- 91% agreed that participating in REACH AYC helped them work harder in school.
- 81% said that participating in REACH AYC helped them have better school attendance.

Youth Radio

- 100% of participants agreed that they can use the skills they learned at Youth Radio in their lives.
- 98% agreed that they can do well on many different professional tasks.
- 94% of Media Ed students reported increased skills producing their own media content.

54% of Reach AYC survey respondents talked with a staff person about a personal challenge they were facing, and 80% said it was either helpful or very helpful.

- 97% of participants rated their experience at Youth Radio as good or excellent.
- 72% reported increased confidence in critical thinking about the media, time management, writing, presenting to groups, and taking a leadership role on a community issue.
- 80% reported increased frequency in thinking positively about themselves throughout the day.
- Over 80% of participants are on track to graduate high school.
- Over 70% of college-age participants are on track to enroll in college.
- 307 jobs were created.

Over 80% of Youth Radio participants are on track to graduate high school. Over 70% of college-age participants are on track to enroll in college.

APPENDICES

APPENDIX A: MEASURE A REVENUE RECEIVED

APPENDIX B: FY 14/15 BUDGET INFORMATION

APPENDIX C: FY 14/15 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

APPENDIX D: MAPS: GEOGRAPHIC DISTRIBUTION OF PROVIDERS FUNDED BY MEASURE A IN FY 14/15

Map 1 Alameda County Public Health Programs

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

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

Map 4 School Health Centers

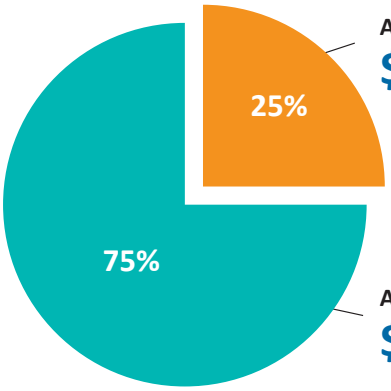
Map 5 HealthPAC Provider Network

APPENDIX A

MEASURE A REVENUE RECEIVED

FY 04/05 through FY 14/15

TOTAL REVENUE EARNED (FY 04/05 THROUGH FY 14/15)

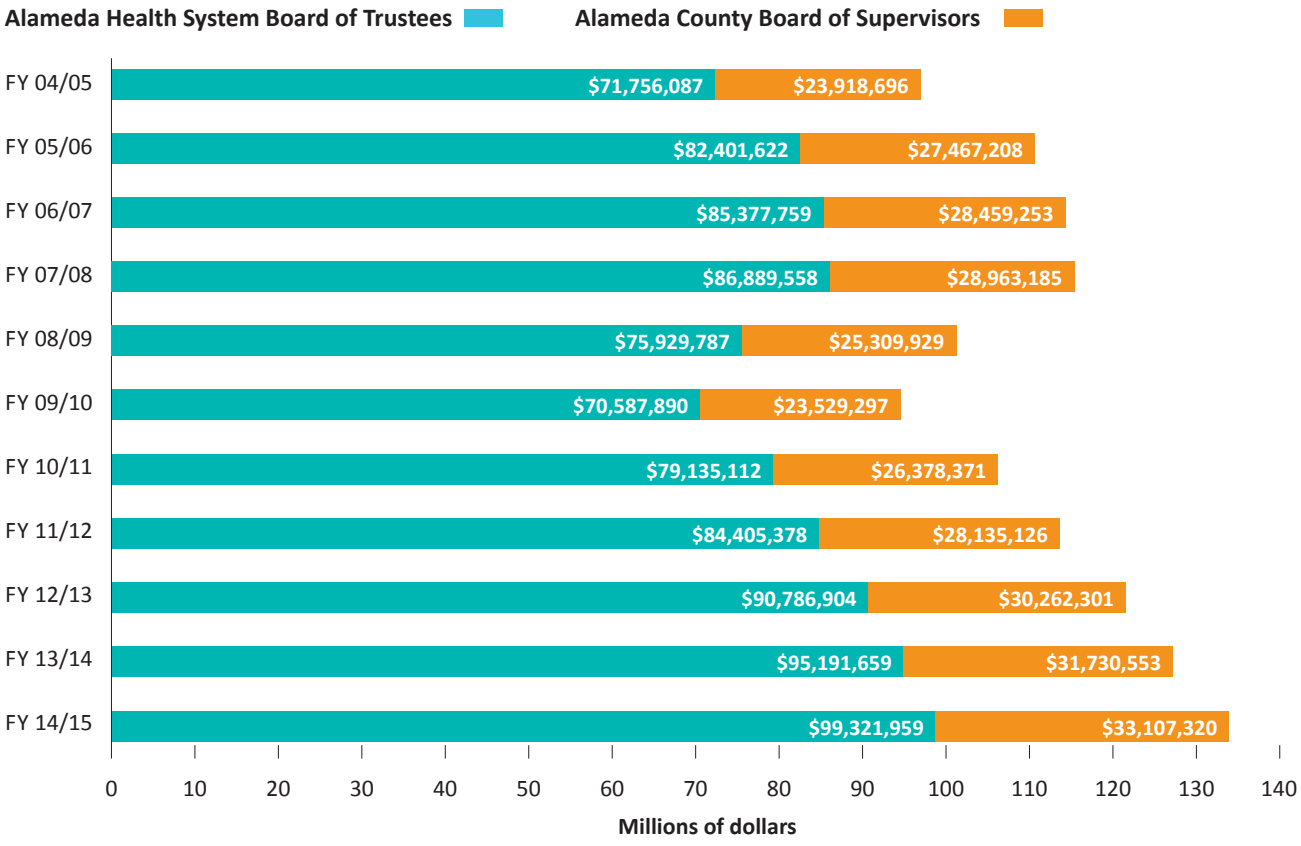


Alameda County Board of Supervisors
$357 MILLION

Alameda Health System Board of Trustees
$1,064 MILLION

$1.42 BILLION

REVENUE EARNED EACH FISCAL YEAR (FY 04/05 THROUGH FY 14/15)



APPENDIX B: FY 14/15 BUDGET INFORMATION

	TOTAL ALLOCATION	CARRYOVER FROM PREVIOUS FISCAL YEAR[1]	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR[1]	TOTAL	SAVINGS[2]
Group 1: Behavioral Health							
Abode Services	90,000	0	90,000	64,975	0	64,975	25,025
Alameda County Behavioral Health Care Services (BHCS) Community-Based Organizations (CBOs)	753,250	0	753,250	383,219	0	383,219	370,031
Center for Empowering Refugees and Immigrants	78,030	0	78,030	72,359	0	72,359	5,671
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	617,362	0	617,362	617,362	0	617,362	0
Cherry Hill Sobering and Detoxification Center[3]	2,080,800	2,064,342	4,145,142	1,948,778	64,342	2,013,120	132,022
Criminal Justice Screening and In-Custody Services	4,306,000	0	4,306,000	4,306,000	0	4,306,000	0
La Familia Counseling Service	88,000	0	88,000	88,000	0	88,000	0
Mental Health Services for Juvenile Justice Center	360,000	0	360,000	360,000	0	360,000	0
Oakland Police Department[1,4]	250,000	0	250,000	89,875	160,125	250,000	0
The Schreiber Center	250,000	0	250,000	250,000	0	250,000	0
Senior Support Services of the Tri-Valley	10,000	0	10,000	10,000	0	10,000	0
Group 2: Hospital, Tertiary Care, Other							
Administration/Infrastructure Support	400,000	0	400,000	228,437	0	228,437	171,563
San Leandro Hospital	1,000,000	0	1,000,000	1,000,000	0	1,000,000	0
St. Rose Hospital	4,000,000	0	4,000,000	4,000,000	0	4,000,000	0
UCSF Benioff Children's Hospital Oakland	3,000,000	0	3,000,000	3,000,000	0	3,000,000	0
Group 3: Primary Care							
Alameda County Dental Health	153,662	0	153,662	153,662	0	153,662	0
Center for Elders' Independence	52,020	0	52,020	52,020	0	52,020	0
Center for Healthy Schools and Communities (School Health Centers)	1,924,740	0	1,924,740	1,924,740	0	1,924,740	0
Fire Station Health Portals[1]	750,000	1,912,675	2,662,675	2,084,883	577,792	2,662,675	0
Fremont Aging and Family Services	52,020	0	52,020	52,020	0	52,020	0
Health Enrollment for Children	300,000	0	300,000	300,000	0	300,000	0
Health Services for Day Laborers	260,100	0	260,100	260,100	0	260,100	0
Increase Hospice Utilization: Getting the Most out of Life Program	200,000	0	200,000	151,187	0	151,187	48,813
Medical Costs for Juvenile Justice Center	503,022	0	503,022	262,136	0	262,136	240,886
Preventive Care Pathways	312,080	0	312,080	312,080	0	312,080	0
Primary Care Community-Based Organizations	5,734,272	0	5,734,272	5,734,272	0	5,734,272	0
Roots Community Center	50,000	0	50,000	50,000	0	50,000	0

Continued on next page

	TOTAL ALLOCATION	CARRYOVER FROM PREVIOUS FISCAL YEAR[1]	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR[1]	TOTAL	SAVINGS[2]
Group 4: Public Health							
Alameda Boys & Girls Club, Inc.	104,040	0	104,040	104,040	0	104,040	0
Alameda County Asthma Start	100,000	0	100,000	100,000	0	100,000	0
California Prevention and Education Project (CAL-PEP)	27,000	0	27,000	27,000	0	27,000	0
Center for Early Intervention on Deafness	52,020	0	52,020	52,020	0	52,020	0
City of San Leandro	52,020	0	52,020	52,020	0	52,020	0
EMS Corps	604,942	0	604,942	604,242	0	604,242	700
Healthy Nail Salon Project[1,5]	25,000	0	25,000	12,547	12,453	25,000	0
Mercy Retirement and Care Center	40,000	0	40,000	40,000	0	40,000	0
Public Health Prevention Initiative	3,151,570	0	3,151,570	3,151,570	0	3,151,570	0
Ryan White Provider: Community Health for Asian Americans	50,000	0	50,000	50,000	0	50,000	0
Senior Injury Prevention Program	115,000	0	115,000	115,000	0	115,000	0
SSI Housing Trust[1]	0	601,319	601,319	601,319	0	601,319	0
Youth and Family Opportunity Initiatives[1]	2,538,780	743,439	3,282,219	3,075,994	206,225	3,282,219	0
Board of Supervisors[1]	750,000	267,745	1,017,745	647,144	370,601	1,017,745	0
TOTAL FY 14/15[6]	**35,185,730**	**5,589,520**	**40,775,250**	**36,389,001**	**1,391,538**	**37,780,539**	**994,711**

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 revert to the general Measure A account for reallocation in future fiscal years.
3. On July 8, 2014, the Board of Supervisors approved the reallocation of $2,000,000 from the Sobering and Detoxification Center to St. Rose Hospital.
4. Oakland Police Department Funds not used in FY 14/15 will be carried over to FY 15/16 (Board Letter approved on 6/2/15).
5. Healthy Nail Salon one-time funds not used in FY 14/15 will be carried over to FY 15/16. (Board Letter approved on 4/21/15)
6. The total allocation includes Measure A Base and Measure A One-Time Allocations approved by the Board of Supervisors for FY 14/15.

APPENDIX C:
FY 14/15 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

	MEASURE A ALLOCATION FY 14/15	EXPENDED/ ENCUMBERED FY 14/15
GROUP 1: BEHAVIORAL HEALTH		
Abode Services	**140,000**	**114,975**
Alameda County Behavioral Health Care Services Community-Based Organizations		
Adolescent Treatment Centers, Inc.	9,885	0
Alameda County Mental Health Association	36,411	26,668
Alameda Family Services	4,559	0
Asian Community Mental Health Board	9,296	9,296
Axis Community Health, Inc.	6,978	6,742
Berkeley Addiction Treatment Services, Inc.	5,192	5,171
Bi-Bett Corporation	2,774	0
Bonita House, Inc.	55,567	55,567
Building Opportunities for Self-Sufficiency (BOSS)	30,743	5,526
Carnales Unidos Reformando Adictos, Inc.	22,676	25,007
Center for Independent Living	2,381	2,381
Community Health for Asian Americans	2,432	2,343
Crisis Support Services of Alameda County	32,155	32,155
East Bay Community Recovery Project	31,547	30,697
East Bay Community Recovery Project	4,072	3,912
Haart	2,407	0
Horizon Services, Inc.	13,314	10,076
La Familia Counseling Service	7,344	6,132
La Familia Counseling Service	3,229	2,527
La Familia Counseling Service	1,384	480
La Familia Counseling Service	1,540	1,156
La Familia Counseling Service	14,105	14,105
Latino Commission on Alcohol and Drug Abuse of Alameda County	7,345	7,345
Latino Commission on Alcohol and Drug Abuse of Alameda County	3,229	3,229
Latino Commission on Alcohol and Drug Abuse of Alameda County	14,105	0
Latino Commission on Alcohol and Drug Abuse of Alameda County	1,383	0
Latino Commission on Alcohol and Drug Abuse of Alameda County	1,540	1,540
Magnolia Women's Recovery Programs, Inc.	4,142	4,485
Magnolia Women's Recovery Programs, Inc.	2,287	1,914
Native American Health Center, Inc.	3,138	3,138
New Bridge Foundation, Inc.	46,107	-
Second Chance, Inc.	50,076	50,076
Southern Alameda County Committee for Raza	49,778	49,778
St. Mary's Center	4,043	-

	MEASURE A ALLOCATION FY 14/15	EXPENDED/ ENCUMBERED FY 14/15
GROUP 1: BEHAVIORAL HEALTH (CONTINUED)		
West Oakland Health Council, Inc.	24,400	21,774
Unallocated	241,686	-
Total Allocation	**753,250**	**383,219**
Center for Empowering Refugees and Immigrants (CERI)	**78,030**	**72,359**
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	**617,362**	**617,362**
Cherry Hill Sobering and Detoxification Center	**2,080,800**	**1,948,778**
Criminal Justice Screening and In-Custody Services	**4,306,000**	**4,306,000**
La Familia Counseling Service	**100,000**	**100,000**
Mental Health Services for Juvenile Justice Center	**360,000**	**360,000**
Oakland Police Department	**250,000**	**89,875**
Options Recovery Services	**25,000**	**20,000**
Safe Alternatives to Violent Environments (SAVE)	**30,000**	**30,000**
The Schreiber Center	**250,000**	**250,000**
Senior Support Program of Tri-Valley	**20,000**	**20,000**
Tri-Valley Haven for Women	**25,000**	**25,000**

	MEASURE A ALLOCATION FY 14/15	EXPENDED/ ENCUMBERED FY 14/15
GROUP 2: HOSPITAL, TERTIARY CARE, OTHER		
Direct Service Planning and Administration	**400,000**	**228,437**
San Leandro Hosptial	**1,000,000**	**1,000,000**
St. Rose Hospital	**4,000,000**	**4,000,000**
UCSF Benioff Children's Hospital Oakland	**3,000,000**	**3,000,000**

	MEASURE A ALLOCATION FY 14/15	EXPENDED/ ENCUMBERED FY 14/15
GROUP 3: PRIMARY CARE		
Alameda County Dental Health	**153,662**	**153,662**
Berkeley Community Health Project (Berkeley Free Clinic)	**50,000**	**50,000**
Center for Elders' Independence	**52,020**	**52,020**
Center for Healthy Schools and Communities (School Health Centers)		
Alameda Family Services	200,656	200,656
City of Berkeley	127,828	127,828
City of Fremont	32,278	32,278
East Bay Asian Youth Center	72,828	72,828
La Clinica de La Raza, Inc.	291,312	291,312
LifeLong Medical Center	109,242	109,242
Native American Health Center	109,242	109,242

	MEASURE A ALLOCATION FY 14/15	EXPENDED/ ENCUMBERED FY 14/15
GROUP 3: PRIMARY CARE (CONTINUED)		
Tiburcio Vasquez Health Center	208,080	208,080
UCSF Benioff Children's Hospital Oakland	145,656	145,656
University of California, San Francisco	159,800	159,800
Evaluation and Other Expenses	467,818	467,818
Total Allocation	**1,924,740**	**1,924,740**
Fire Station Health Portals	**750,000**	**2,084,883**
Fremont Aging and Family Services	**52,020**	**52,020**
Health Enrollment for Children	**300,000**	**300,000**
Health Services for Day Laborers		
Health Services for Day Laborers: Community Initiatives (Day Labor Center)	86,700	86,700
Health Services for Day Laborers: Multicultural Institute	86,700	86,700
Health Services for Day Laborers: Street Level Health Project	86,700	86,700
Total Allocation	**260,100**	**260,100**
Hope Hospice	**10,000**	**10,000**
Hospice: Getting the Most out of Life Program	**200,000**	**151,187**
Medical Costs for Juvenile Justice Services	**447,100**	**447,100**
Medical Costs for Juvenile Justice Center: Direct Service Planning and Administration	261,000	74,114
Medical Costs for Juvenile Justice Center: Mind Body Awareness Project	57,222	57,222
Medical Costs for Juvenile Justice Center: Niroga Institute	40,800	40,800
Medical Costs for Juvenile Justice Center: Victims of Crime	144,000	90,000
Total Allocation	**503,022**	**262,136**
Preventive Care Pathways	**312,080**	**312,080**
Primary Care Community-Based Organizations		
Alameda Health Consortium		
Asian Health Services	620,078	620,078
AXIS Community Health Center	648,293	648,293
La Clínica de La Raza	1,824,440	1,824,440
LifeLong Medical Center	704,866	704,866
Native American Health Center	273,434	273,434
Tiburcio Vasquez Health Center	883,490	883,490
Tri-City Health Center	600,763	600,763
West Oakland Health Council	178,908	178,908
Total Allocation	**5,734,272**	**5,734,272**
Roots Community Center	**50,000**	**50,000**
Tiburcio Vasquez	**60,000**	**60,000**
Washington Hospital	**34,000**	**34,000**

	MEASURE A ALLOCATION FY 14/15	EXPENDED/ ENCUMBERED FY 14/15
GROUP 4: PUBLIC HEALTH		
100 Black Men of the Bay Area	**25,000**	**25,000**
Alameda Boys & Girls Club, Inc.	**104,040**	**104,040**
Alameda County Asthma Start	**100,000**	**100,000**
California Prevention & Education Project (CAL-PEP)	**27,000**	**27,000**
Center for Early Intervention on Deafness	**57,020**	**57,020**
City of San Leandro Senior Services	**52,020**	**52,020**
Collaboration Agencies Responding to Disasters (CARD)	**25,000**	**7,500**
Community Health and Wellness Element	**25,000**	**25,000**
EMS Corps		
Bay Area Youth EMT Program	100,000	92,927
Berkeley Youth Alternatives	50,000	50,000
Other Program Expenses	454,942	461,315
Total Allocation	**604,942**	**604,242**
Environmental Health: Improve Field Sanitation Conditions/Nail Salons	**25,000**	**12,547**
Genesis Worship Center	**5,000**	**5,000**
HIV Education and Prevention Project of Alameda County (HEPPAC)	**26,000**	**26,000**
Hospital Committee for Livermore-Pleasanton Area dba ValleyCare Health System	**15,000**	**15,000**
LIFE ElderCare	**12,400**	**12,400**
Mercy Retirement and Care Center	**40,000**	**40,000**
Public Health Prevention Initiative		
Community-Designed Initiative:		
Mandela Market Place	40,800	40,000
Niroga Institute, Inc.	35,700	38,200
Tides Center (HOPE Collaborative)	-	21,000
Other Program Costs	-	-
Dental Health:		
Center for Oral Health	133,055	130,606
Emergency Medical Services:		
Daybreak Adult Care Centers	23,581	23,581
Senior Support Program of the Tri-Valley	23,581	23,581
St. Mary's Center	23,586	23,586
United Seniors of Oakland & Alameda	7,283	7,283
City of Fremont	176,088	176,088
Total	**463,673**	**483,924**
Health Inequities and Community Capacity-Building		
Health Inequities and Community Capacity-Building-Office of Director/CAPE:		
Attitudinal Healing Connection, Inc.	69,360	69,360
FHS- Healthy Passage System of Care:		
Lucile Packard Children's Hospital Stanford	40,401	-!
HIV Prevention:		
California Prevention and Education	45,778	45,778
Community Health for Asian Americans	50,000	50,000
HIV Education and Prevention Project of Alameda County	41,616	41,616

	MEASURE A ALLOCATION FY 14/15	EXPENDED/ ENCUMBERED FY 14/15
GROUP 4: PUBLIC HEALTH (CONTINUED)		
Office of Director/CAPE	99,960	99,960
Total	**347,114**	**306,713!**
Obesity Prevention and School Health		
Community-Designed Initiative:		
City of Berkeley	175,568	69,360
East Oakland Boxing Association	51,000	-
Lotus Bloom	33,150	45,778
Nutrition Services:		
Earth Island	10,200	50,000
Total	**269,918**	**165,138**
Alcohol and Other Drugs Primary Prevention		
CHS: Eden Youth and Family Center	20,000	20,000
Total	**20,000**	**20,000**
Subtotal Program Expenses	2,050,865	2,175,794
Other Program Expenses	1,100,705	975,776
Total Allocation	**3,135,037**	**2,278,231**
Ryan White Provider: Community Health for Asian Americans	**50,000**	**50,000**
Senior Injury Prevention Program	**115,000**	**115,000**
Service Opportunity for Seniors (Meals on Wheels)	**116,000**	**116,000**
South Hayward Parish	**10,000**	**10,000**
Spectrum Community Services, Inc.	**50,000**	**50,000**
SSI Housing Trust (GA Clients)	**-**	**601,319**
Viola Blythe Community Services	**5,000**	**5,000**
West Oakland Youth Center	**70,000**	**44,244**
Youth and Family Opportunity Initiatives		
Alameda Family Services	178,384	178,384
Alternatives in Action (AIA)	260,100	260,100
Berkeley Youth Alternatives (BYA)	104,040	104,040
City of Fremont	429,100	429,100
Dublin Unified School District	16,666	16,666
East Bay Asian Youth Center (EBAYC)	104,040	104,040
La Clinica de la Raza	191,040	191,040
La Familia	156,060	156,060
Livermore Unified School District	16,666	16,666
Newark Unified School District	104,040	104,040
New Haven Unified School District	104,040	104,040
Pleasanton Unified School District	16,666	16,666
REACH Ashland Youth Center	744,003	744,003
Seneca Family of Agencies	40,000	40,000
Unity Council	142,424	142,424
Westcoast	77,100	77,100
Youth Radio	104,040	104,040
Professional and specialized services		287,585
Total Allocation	**2,538,780**	**3,075,994**

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS FUNDED BY MEASURE A IN FY 14/15

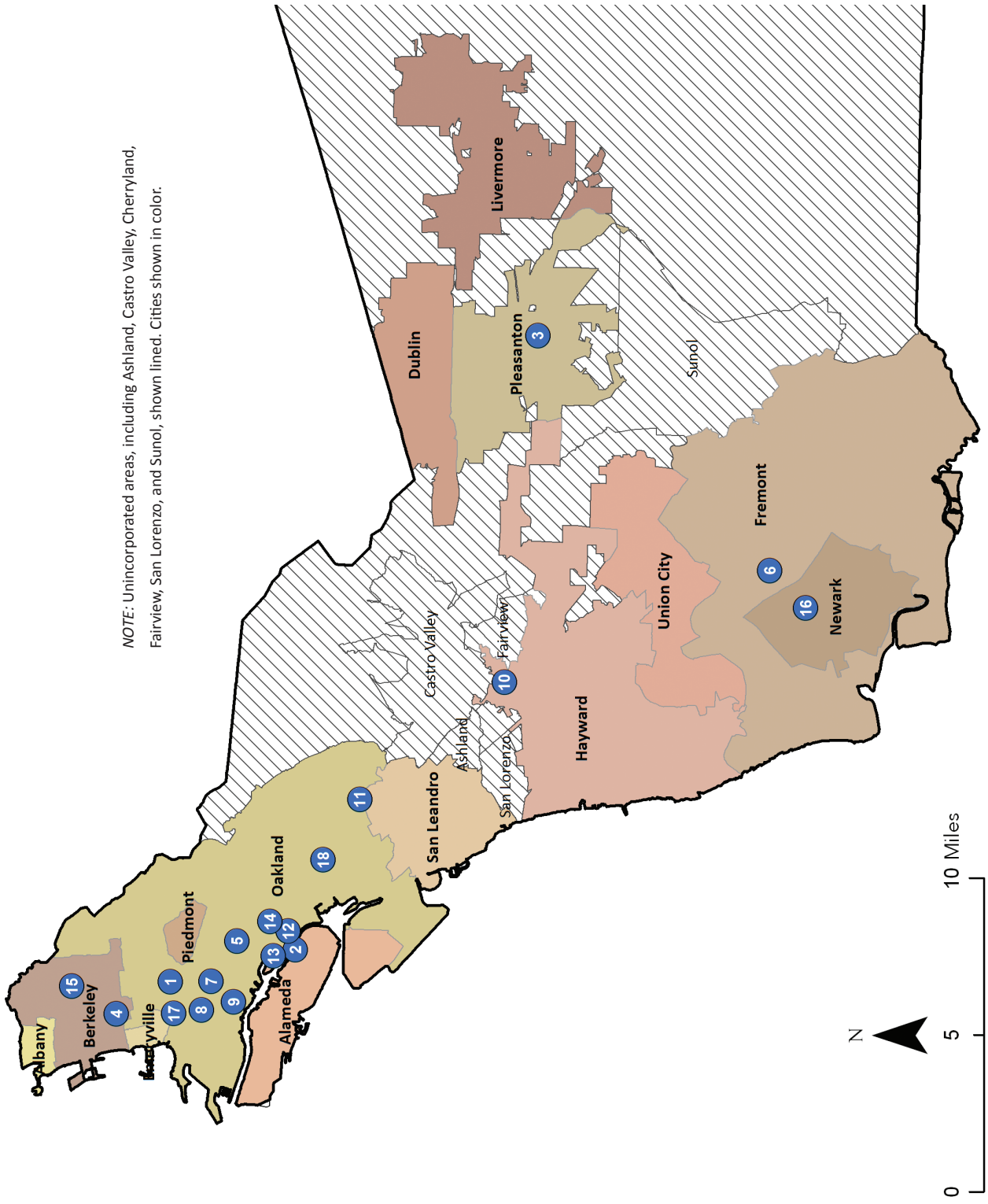
#	PROVIDER	CITY
1	Attitudinal Healing Connection, Inc.	Oakland
2	Bay Area Youth EMT Program	Oakland
3	Berkeley Youth Alternatives	Berkeley
4	Center for Oral Health	Oakland
5	California Prevention and Education	Oakland
6	City of Berkeley	Berkeley
7	City of Fremont	Fremont
8	Community Health for Asian Americans	Oakland
9	Daybreak Adult Care Centers	Oakland
10	Earth Island	Berkeley
11	East Oakland Boxing Association	Oakland
12	Eden Youth and Family Center	Hayward
13	Higher Ground Neighborhood Development	Oakland
14	HIV Education and Prevention Project of Alameda County	Oakland
15	Lotus Bloom	Oakland
16	Lucile Packard Children's Hospital Stanford	Fremont
17	Mandela MarketPlace	Oakland
18	Niroga Institute, Inc.	Oakland
19	Senior Support of the Tri-Valley	Pleasanton
20	St. Mary’s Center	Oakland
21	Tides Center	Oakland
22	United Seniors of Oakland and Alameda	Oakland

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS
FUNDED BY MEASURE A IN FY 14/15

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES ALCOHOL AND OTHER DRUG PROVIDERS FUNDED BY MEASURE A IN FY 14/15

#	PROVIDER	CITY
1	Adolescent Treatment Centers, Inc.	Oakland
2	Alameda Family Services	Alameda
3	Axis Community Health, Inc.	Pleasanton
4	Berkeley Addiction Treatment Services, Inc.	Berkeley
5	Bi-Bett Corporation	Oakland
6	Carnales Unidos Reformando Adictos	Fremont
7	Community Health for Asian Americans	Oakland
8	East Bay Community Recovery Project	Oakland
9	Filipino Advocates for Justice	Oakland
10	Horizon Services, Inc.	Hayward
11	Humanistic Alternatives to Addiction	Oakland
12	Latino Commission on Alcohol and Drug	Oakland
13	Magnolia Women's Recovery Programs, Inc.	Oakland
14	Native American Health Center, Inc.	Oakland
15	New Bridge Foundation, Inc.	Berkeley
16	Second Chance, Inc.	Newark
17	St. Mary's Center	Oakland
18	West Oakland Health Council, Inc.	Oakland

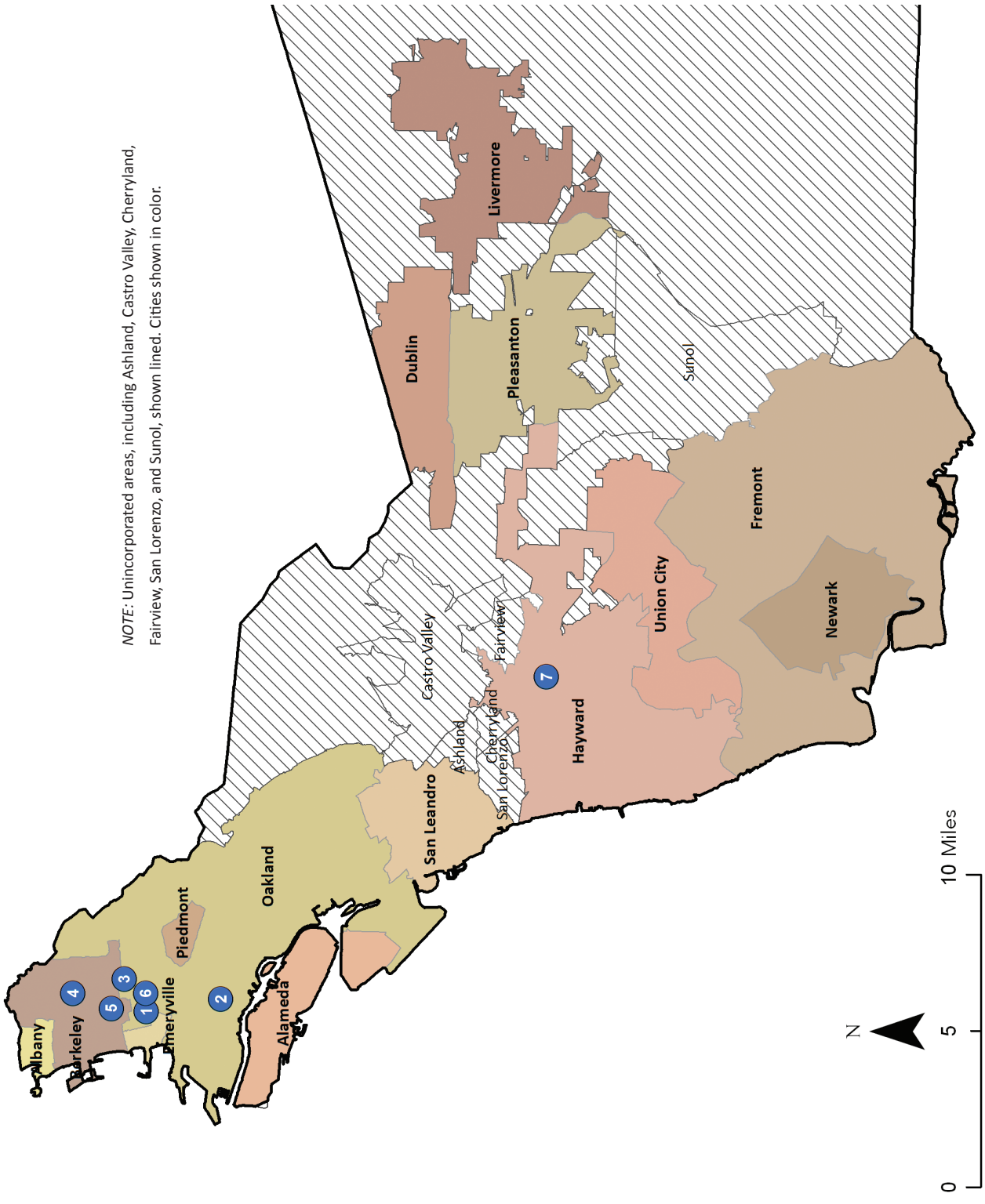
MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
ALCOHOL AND OTHER DRUG PROVIDERS
FUNDED BY MEASURE A IN FY 14/15



MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 14/15

#	PROVIDER	CITY
1	Alameda County Mental Health Association	Oakland
2	Asian Community Mental Health Services	Oakland
3	Bonita House, Inc.	Oakland
4	Building Opportunities for Self-Sufficiency	Berkeley
5	Center for Independent Living	Berkeley
6	Crisis Suppport Services of Alameda County	Oakland
7	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 14/15

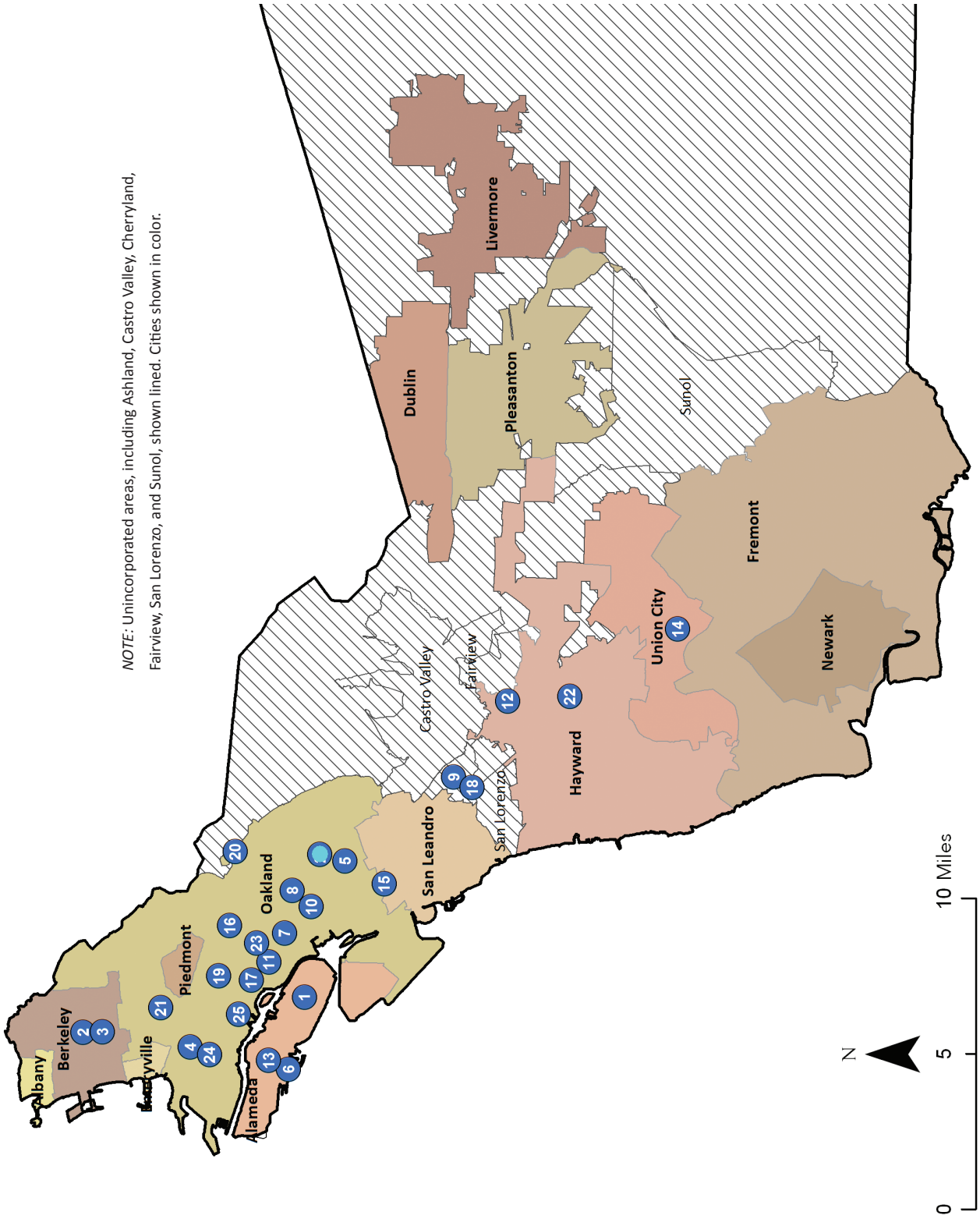


MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 14/15

#	PROVIDER	CITY
1	Alameda High School-Based Health Center	Alameda
2	Berkeley High School Health Center	Berkeley
3	B-Tech Health Center	Berkeley
4	Chappell Hayes Health Center	Oakland
5	Elmhurst/Alliance Wellness Center	Oakland
6	Encinal High School-Based Health Center	Alameda
7	Fremont Tiger Clinic	Oakland
8	Frick Middle School-Based Health Center	Oakland
9	Fuente Wellness Center (REACH Ashland Youth Center)	San Leandro
10	Havenscourt Campus Health Center	Oakland
11	Hawthorne Health Center	Oakland
12	Hayward High School Mobile Health Van	Hayward
13	Island/BASE High School-Based Health Center	Alameda
14	Logan Health Center	Union City
15	Madison Health Center	Oakland
16	Rising Harte Wellness Center	Oakland
17	Roosevelt Health Center	Oakland
18	San Lorenzo High Health Center	San Lorenzo
19	Shop 55 Wellness Center	Oakland
20	Skyline High School Health Center	Oakland
21	TechniClinic	Oakland
22	Tennyson Health Center	Hayward
23	United for Success/Life Academy Health Center	Oakland
24	West Oakland Middle School Health Center	Oakland
25	Youth Heart Health Center (La Escuelita Education Complex)	Oakland
26	Youth Uprising / Castlemont Health Center	Oakland

MAP 4

SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 14/15



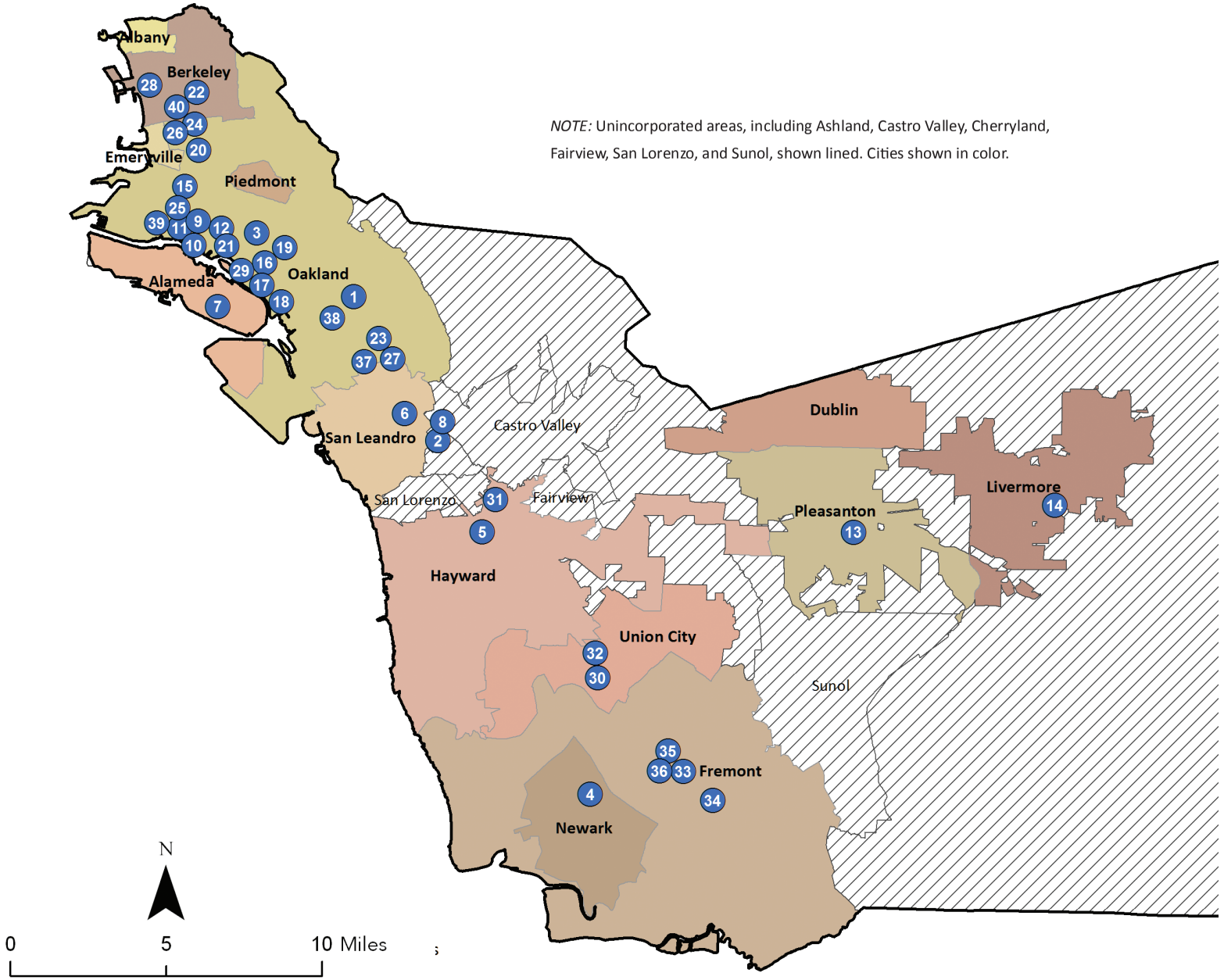
NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 5
HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 14/15

#	PROVIDER	CITY
ALAMEDA HEALTH SYSTEM		
1	Eastmont Wellness Center	Oakland
2	Fairmont Hospital	San Leandro
3	Highland Hospital	Oakland
4	Newark Wellness	Newark
5	Hayward Wellness	Hayward
6	San Leandro Hospital	San Leandro
7	Alameda Hospital	Alameda
8	John George Pavilion	San Lorenzo
ASIAN HEALTH SERVICES		
9	Roland and Kathryn Lowe Medical Center	Oakland
10	Asian Health Dental Clinic	Oakland
11	Asian Health Services	Oakland
12	Frank Kiang Medical Center	Oakland
AXIS COMMUNITY HEALTH		
13	Axis Community Health - Pleasanton	Pleasanton
14	Axis Community Health - Livermore	Livermore
LA CLÍNICA DE LA RAZA		
15	Casa del Sol	Oakland
16	Clinica Alta Vista	Oakland
17	La Clinica de la Raza	Oakland
18	La Clinica Dental	Oakland
19	La Clinica Dental/Children's	Oakland
20	San Antonio Neighborhood	Oakland

#	PROVIDER	CITY
LIFELONG MEDICAL CENTER		
21	Berkeley Primary Care Access	Berkeley
22	Howard Daniel Clinic	Oakland
23	LifeLong Dental Care	Berkeley
24	LifeLong Medical Care DOC	Oakland
25	Over 60 Health Center	Berkeley
26	East Oakland	Oakland
27	West Berkeley Family Practice	Berkeley
NATIVE AMERICAN HEALTH CENTER		
28	Native American Health Center	Oakland
ST. ROSE HOSPITAL		
29	St. Rose Hospital	Hayward
TIBURCIO VASQUEZ HEALTH CENTER, INC.		
30	Tiburcio Vasquez, Logan Health	Union City
31	Tiburcio Vasquez, Hayward	Hayward
32	Tiburcio Vasquez, Union City	Union City
33	Tiburcio Vasquez, San Leandro	San Leandro
TRI-CITY HEALTH CENTER		
34	Tri-City Health Center - Liberty	Fremont
35	Tri-City Health Center - Main	Fremont
36	Tri-City Health Center - Mowry	Fremont
37	Tri-City Health Center - State	Fremont
WEST OAKLAND HEALTH COUNCIL		
38	Albert J. Thomas Medical Clinic	Oakland
39	East Oakland Health Center	Oakland
40	West Oakland Health Center	Oakland
41	William Byron Rumford Medical	Berkeley

* The Health Program of Alameda County, also known as HealthPAC (and formerly known as CMSP or ACE), is a County program that provides affordable health care to uninsured people living in Alameda County. Services are provided through one of the nine community-based clinics that are part of the network or through the Alameda Health System (dba Alameda County Medical Center).



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

MAP 5
HEALTHPAC PROVIDER NETWORK
FUNDED BY MEASURE A IN FY 14/15