Fiscal Year
2013/2014





MEASURE A

Essential Health Care Services Tax Ordinance

OVERSIGHT COMMITTEE
8TH REPORT TO THE ALAMEDA COUNTY
BOARD OF SUPERVISORS AND THE PUBLIC

Review of Expenditures July 1, 2013 – June 30, 2014

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REVIEW OF EXPENDITURES IN

Fiscal Year (FY) 2013/2014

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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)
Bradley Cleveland	Supervisor Nate Miley (District 4)
Fran David	City Managers' Association
Adam Davis	Hospital Council of Northern California
Kuwaza Imara	Central Labor Council of Alameda County
Gwendolyn McClain	Alameda County Public Health Commission
Sally Morgan	League of Women Voters
Al Murray	City of Berkeley
George Phillips	Supervisor Wilma Chan (District 3)
Rachel Richman	Central Labor Council of Alameda County
Ursula Rolfe, M.D.	League of Women Voters
(vacant)	Alameda County Mental Health Board
(vacant)	Supervisor Keith Carson (District 5)
(seat in abeyance)	Alameda County Taxpayers Association, Inc.

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY STAFF

Rebecca Gebhart, Interim Agency Director

James Nguyen, Administrative Services Officer

Connie Soriano, Administrative Specialist II

FY 2013/14 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 strictures 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.

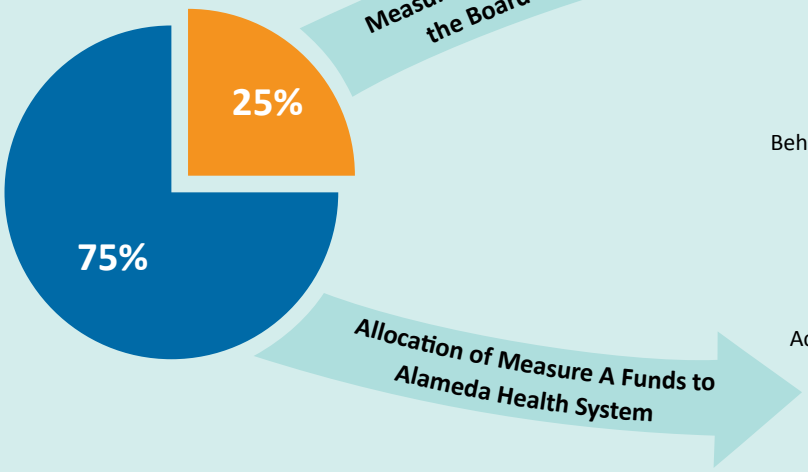
A→AA
History of the Measure

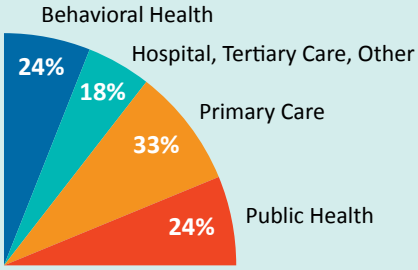
Measure A, the Essential Health Care Services Initiative, was passed by 71% of Alameda County voters in March 2004. In June 2014, 76% of voters passed Measure AA, which extended the initiative through 2034. Both measures authorize the County of Alameda to raise its sales tax by one-half cent to provide 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 $126,761,410 in FY 13/14.

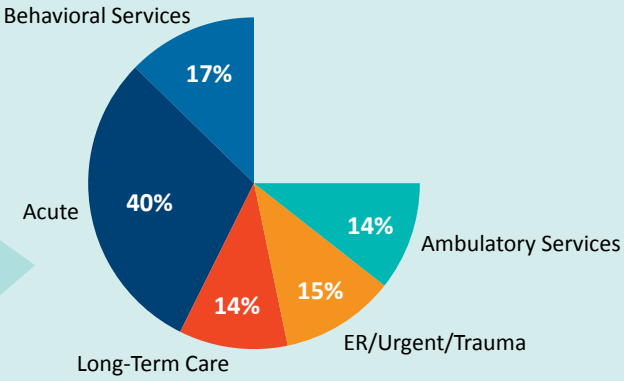
Of the $126,761,410 that Measure A generated in FY 13/14, AHS received 75% and the remainder of the funds were distributed by the Board to many health care providers to provide essential health care services.

DISTRIBUTION OF MEASURE A FUNDS





Total generated: $31.7 million
Total allocated: $33.6 million*



Total $95.1 million

**Note:* 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

Even in light of recent and ongoing federal health care reform, according to American Community Survey data for 2014, an estimated 182,223 people, or 11.8% of County residents, are uninsured. 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 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.

Highlights (continued)

Large Numbers Served

Measure A enabled a large number of providers to continue existing programs and maintain the service levels offered by these programs. For example, AHS saw more than 100,000 patients in its emergency departments systemwide and conducted more than 320,000 outpatient visits, while the Public Health Prevention Initiative served more than 100,000 Measure A clients.

Similarly, the community-based primary care health centers affiliated with the Alameda Health Consortium provided comprehensive care for more than 39,000 Measure A clients, who made a total of 111,686 visits.

Increased Access to Care

Measure A funds increased access to health care services both through new/expanded facilities and through the provision of a greater number and variety of services. At AHS alone, orthopedic visits to Highland Hospital increased 81% over the baseline year FY 10/11, while cardiology visits increased 47%.

Highland also expanded lactation services to seven days per week, established a new Sunday high risk newborn clinic, opened a Same Day Clinic (SDC) for patients with serious but non-life-threatening conditions, and doubled enrollment in the Complex Care Program from 214 to 427 patients.

Among the Wellness Centers, Newark Wellness expanded specialty care services to include psychiatry, mammography, early oral preventive pediatric care services, and prenatal centering program; Hayward Wellness relocated to Southland Mall to accommodate 36 new exam rooms covering over 23,000 square feet; and Eastmont Wellness expanded specialty care services to 16 exam rooms and 6,600 square feet.

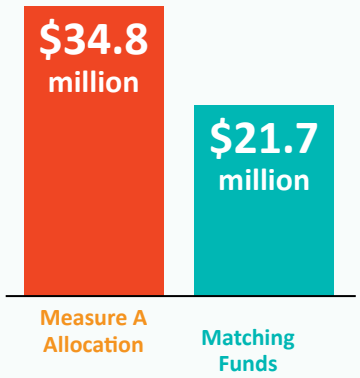
Improved Outcomes

Most providers presented clear, quantified information that showed increases in the number of clients served, increases in desired outcomes, or decreases in harmful behavior as a result of Measure A-funded services.

For example, children participating in the Alameda County Dental Health WIC "Dental Days" had 42% fewer restorative dental treatment needs compared to children who did not benefit from the program, while San Leandro Hospital showed significant reductions in patients leaving without being seen (-77%), emergency department (ED) arrival-to-discharge times (-32%), operating room (OR) turnover times (-75%), and ED arrival-to-provider times (-61%).

42% ↓

Children participating in the Alameda County Dental Health WIC "Dental Days" had 42% fewer restorative dental treatment needs compared to children who did not benefit from the program.



The recipients of the 25% of Measure A funds allocated by the Board obtained $21,746,090 in matching funds from public and private sources.

Client surveys revealed more qualitative outcomes also. At Safe Alternatives to Violent Environments (SAVE), 88% of clients surveyed reported that they felt safer and more equipped to make their own decisions. Research data for the Mind Body Awareness program revealed significant decreases (19.6%) in perceived stress, increases (23.7%) in healthy self-regulation, and increases in self-esteem (14.1%) from pre- to post-testing among youth participants in the Alameda County Juvenile Justice Center.

Service Stabilization

Compared to the preceding year, FY 13/14 saw a decline of only 2% in both the number of clients served and number of services delivered by the Behavioral Health and Alcohol and Other Drug (AOD) Community. Given County General Fund reductions of 10% and a cost of living increase of 2.4% for that period, Measure A support was very effective in stabilizing services.

Hospitalization Reduction

As a result of immediate crisis intervention offered by Mental Health Services at the Juvenile Justice Center, only two clients were hospitalized in FY 13/14. In addition, thanks in part to Measure A funding, Preventive Care Pathways clients experienced a reduction in emergency room visits to AHS and outside emergency rooms.

Geographic Reach

Measure A funds increased access to health care services both geographically and through the provision of a greater number and variety of services. For example, Eden Youth and Family Center serves a community of high need in South Hayward, and has developed a long-term strategic plan to help area youth and families. The program works collaboratively with its network of partnerships, which increases the effectiveness of all the organizations.

Matching Funds

The recipients of the 25% of Measure A funds allocated by the Board received a total of $33.6 million in allocations. This same group of providers obtained $21.7 million in matching funds from public and private sources. These matching funds represent a $.63 match for every $1 in Measure A funds.

AHS alone obtained $104 million in matching funds on its $95.2 million Measure A allocation, thus obtaining better than a 1:1 return.

Flexible Response

Measure A gives the County flexibility to address unmet needs and unanticipated costs. Specifically, the $150,000 each member of the Board receives as a discretionary allocation gives the supervisors the flexibility to respond to unanticipated needs in their districts. Over the period of this report, there were 16 contracts for services for youth, children, seniors, and the general population from the allocations. During this period, the Committee noted an increased focus on healthy living, wellness, and prevention initiatives.

Award-Winning Service

AHS programs and staff received numerous awards and accolades. As just some examples: Fairmont Hospital received a 4-Star quality rating from the Center for Medicare & Medicaid Services (CMS), while Alameda Hospital received a Gold Plus Award from the American Heart Association and American Stroke Association for excellence in the treatment of heart disease, heart failure, and stroke.

Highland Hospital's Cardiac Catheterization Laboratory Technicians earned elite designation as a Registered Cardiovascular Invasive Specialist (RCIS) from Cardiovascular Credentialing International (CCI).

John George Psychiatric Hospital (JGPH) Director of Nursing, Judy Linn, was honored with the Annual Leadership Award from the American Psychiatric Nurses Association, while the Occupational Therapy Department at JGPH was honored with the Outstanding Collaboration & Support Award from the Alameda County Network of Mental Health Clients.

The Board discretionary allocations enabled the supervisors to respond to unanticipated needs in their districts and focus on healthy living, wellness, and prevention initiatives..

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 (2004-2013) 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. In addition, per capita sales tax has declined and continues to trend downward, which will impact the revenues raised by the measure.

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.

At the same time, the Committee is paying close attention to the recent and ongoing state and federal health care reform initiatives, which have resulted in the expansion of health coverage to more than 200,000 previously uninsured County residents after 2014. While this accomplishment represented a boost to health access for many children, adults, and families, more than 33,000 individuals in Alameda County continue to remain uninsured. Moreover, funding cuts from the previous five years, Medi-Cal rate reductions, and potential state and federal funding cuts have deteriorated the County's safety net, decreased the ability of health providers to offer services to the Medi-Cal and uninsured populations, and challenged health care expansion efforts.

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 rates and a shortage of providers—particularly in primary and preventative 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.

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.

General Funding Concerns

The Committee recommends that HCSA 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.

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 money is spent—via audit or other method. The Committee recommends that the Board 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 an additional resource to ensure that Measure A contracts are included in the initiative.
- 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 example, Behavioral Health Care Services at Juvenile Justice Center makes assertions of "increased coping skills" and "a great benefit" from court-ordered evaluations without quantifying these statements. The Mind Body Awareness Project was unable to collect data during this period due to organizational transitions, which made it difficult for the Committee to determine program effectiveness.
  - 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." For example, the information presented by providers such as Service Opportunities for Seniors and the Teleosis Institute does not track whether the population served falls within the requirements of Measure A.
  - 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. For example, while the Committee recognizes the value of the California Product Stewardship Council drug disposal program, it is unclear whether these activities and their target populations fall within the wording of Measure A.

In light of some of these reporting concerns, the Committee recommends that trainings reinforce proper and accurate completion of demographic information and adherence to Measure A services. Additionally, the Committee recommends that HCSA 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. The Committee recommends that the recipient reporting form include a question about service delivery in multiple languages, as language barriers can potentially impede access to services for members of the Measure A target population.

Alameda Health System

In describing its program accomplishments, AHS often does not provide measurable objectives, making it difficult to get a sense of progress from the prior year. The Committee notes that this feedback has been offered for several years to AHS/Alameda County Medical Center.

UCSF Benioff Children's Hospital Oakland

The Committee notes that UCSF Benioff Children's Hospital Oakland does not list measurable objectives, a concern that has been raised in the last several years. ED encounters can vary due to the severity of flu seasons and other unexpected health trends. Therefore, it is understandable that total ED encounters may change from year to year. However, measurable objectives should still be set and performance measured. This also applies to the Center for Child Protection (CCP) and school clinics.

Also, two-thirds of the hospital's $2.5 million allocation helps offset undercompensated costs of ED visits from patients with Medi-Cal. However, the hospital administration states that it is "not reasonable nor possible to tie the Measure A funding to a specific number of patient encounters." The Committee asserts that this can and should be done to ensure accountability for use of public tax dollars.

San Leandro Hospital

The provider report states that the hospital folded Measure A funding into their general operating budget: "As described in previous presentations and reports, we don't specifically allocate these funds to individual programs; rather, all of our operations are combined and we endeavor to track the profitability for each of our programs." The Committee asks the provider to show an awareness of the purpose of this public money and to address its requirements in the specific manner defined in the measure.

Indigent Health Stabilization

Healthy Communities

The provider report indicates that logistical and other problems interfered with completion of tasks funded by Measure A. There is no indication of when these tasks will be completed.

West Oakland Health Council

No report was submitted. Therefore, there is no evidence of any compliance. The Oversight Committee cannot assume that the funds were used in compliance with Measure A. Until this situation is resolved, the Oversight Committee recommends that this organization should not receive any further Measure A funding.

Primary Care Community-Based Organizations

Healthy Communities

In addition to the eight clinics that are members of the Alameda Health Consortium, a ninth provider, Healthy Communities (not a member of the consortium) received an allocation of $163,114. No information was provided regarding the use of Measure A funds by Healthy Communities, and no additional report was submitted.

City of San Leandro

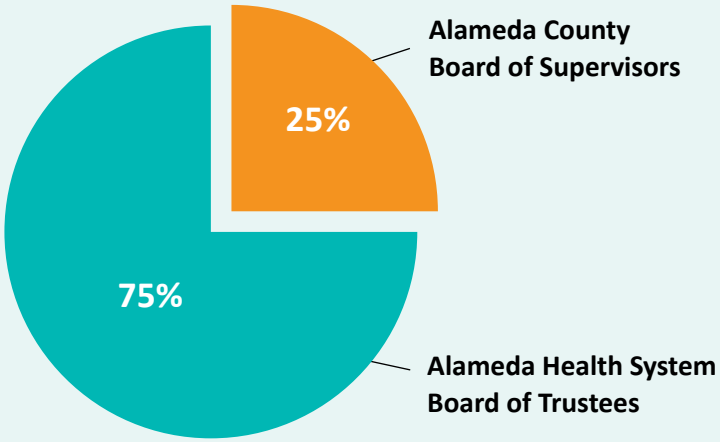
From the information provided, it is not clear whether the City of San Leandro prioritized and/or ended up serving underserved populations.

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 13/14, Measure A generated $126,761,410 (not including interest earned). The funds were allocated as follows:

Alameda Health System (75%): $95,071,058
Alameda County (non-AHS) (25%): $31,690,352
TOTAL: $126,761,410

In FY 12/13, the Alameda County approved budget totaled $2,622,397,815. The HCSA approved budget totaled $664,880,978, or 25.4% of the total County budget. Measure A revenues not specifically designated for AHS accounted for 4.6% of the HCSA budget.

The following sections in the report provide more detail on how AHS and the Board spent Measure A funds in FY 13/14, which includes revenue generated in the reporting year as well as unspent funds earned in previous years.

FY 13/14: 75% OF MEASURE A FUNDS ALLOCATED TO Alameda Health System

alamedahealthsystem.org

Allocation: **$95,071,058** | Expended/Encumbered: **$95,071,058**

Individuals served by Measure A: **434,778** (Total individuals served: **457,661**)

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

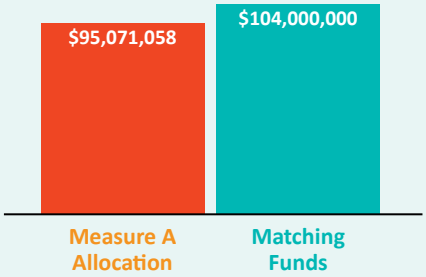
BACKGROUND

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:

- Growth/Access to Care goals relate to providing care to all County residents by expanding access to services. Key goals in FY 13/14 included the following:
  - Acquisition of San Leandro Hospital and affiliation with Alameda Hospital
  - Relocation of Hayward Wellness to Southland Mall
  - Expanding specialty care at Eastmont, Newark, and Hayward Wellness clinics
  - Increasing Cardiology, Dermatology, Optometry, and Orthopedic service lines
  - Expanding Complex Care Program for high risk, high cost, complex care patients
  - Increasing medical home assignments for emergency department (ED) and specialty clinic patients
  - Increasing utilization rate of 24-hour nurse advice line
  - Reducing overall EDs length-of-stay
- Quality Enhancement goals in FY 13/14 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 13/14 included the following:
  - Continued focus on panel management, including increasing preventive health screenings at outpatient facilities
  - Incorporation of Alameda Health Partners, a physician organization developed to streamlining clinical priorities and coordinating and supporting physicians in delivering high quality, efficient, value-

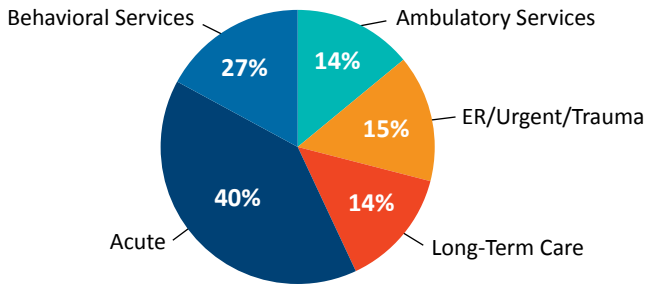
Matching Funds



AHS leveraged its Measure A allocation to obtain **$104 million in matching funds** through a number of different IGTs provided by Alameda County, including the following:

- Medicaid Waiver: $30 million
- Seniors and Persons with Disabilities: $21 million
- Rate Range: $20 million
- DSRIP: $33 million

ALLOCATION OF ALAMEDA HEALTH SYSTEM MEASURE A FUNDS IN FY 13/14



based care to patients and communities
  - 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 move toward greater patient loyalty, a culture of customer service, and an enhanced patient experience. Key goals in FY 13/14 included the following:
  - Completing the first phase of MyAlamedaHealth.org, an online patient portal designed to allow patients 24-hour secure access to medical information and the ability to communicate with doctors
  - 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 transition from inpatient services to long term care, rehabilitation, or the home
  - Improving "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
- Fiscal Stewardship 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 13/14 included the following:
  - Expanding Kaizen rapid improvement events (Kaizen is a management practice inspired by Japanese lean manufacturing, which optimizes business processes by eliminating wasted efforts)
  - Improving charge capture, billing, and revenue cycle management processes across the organization
  - Implementing an ongoing cost management initiative aimed at

Measure A Helps

COPD patient Mr. T. was discharged to a residential drug treatment facility because of his abuse of alcohol. With staff support, he stopped drinking and has maintained his sobriety for nine months. He regularly attends the COPD group clinic, where he learned more about his disease and how to care for himself. Eventually, he asked for nicotine patches and subsequently quit smoking. Now his health is stabilized, he lives independently in transitional housing, and he continues to encourage other patients in the COPD group clinic to cut back on or stop drinking alcohol, using drugs, and smoking.

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 13/14 included the following:
  - Establishing Alameda Health Partners (AHP), 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
- Community/Image Enhancement goals address the need for community stakeholders and constituents to understand AHS's contributions to the well-being of the entire County. Key goals in FY 13/14 included the following:
  - Finalizing brand strategy, logos, informational materials, and websites for San Leandro Hospital and AHS Wellness Centers
  - Increasing awareness of AHS as Covered California certified sites
  - Launching phase two of the AHS advertising campaign to improve AHS brand awareness, challenge the stigma of public health systems, and increase knowledge of the services provided by AHS
  - Promoting AHS physicians as thought leaders with national expertise and AHS as a teaching organization with coveted residency programs
  - Establishing a school-based clinic in San Leandro to support children and families with high quality primary, specialty, and acute care
  - Creating relationships with non-health care stakeholders such as local senior centers to provide health education, resources, and support to the community

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. AHS used Measure A funds to fill in budget gaps related to

Highlights

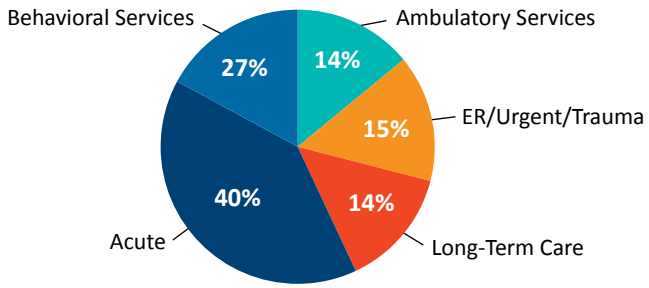
At JGPH, **patient satisfaction improved** from the 72nd percentile in FY 12/13 to the 81st percentile in FY 13/14.

Fairmont Hospital received a **4-Star quality rating** from the Center for Medicare & Medicaid Services (CMS).

Alameda Hospital received a **Gold Plus Award** from the American Heart Association and American Stroke Association for **excellence in the treatment of heart disease, heart failure, and stroke**.

Alameda Hospital's inpatient wound and skin care program received the **Sharon Baronoski Founder's Award**, a national award recognizing **excellence in the prevention and reduction of pressure wounds** with significant improvement in patient outcomes.

ALLOCATION OF ALAMEDA HEALTH SYSTEM MEASURE A FUNDS IN FY 13/14



providing primary care and specialty care, and preventative and mental health services, to indigent, low income and uninsured children, families, and seniors in Alameda County.

For FY 13/14, AHS made the following percentage allocations per service line:

- 27% Behavioral Services
- 25% Ambulatory Services
- 18% Fairmont and Therapies
- 17% ED/Urgent Care/Trauma Services
- 13% Highland Acute Care and Ancillary Services

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 13/14:

AHS Client Results: Overview

- 321,128 outpatient visits
- 133,176 total inpatient days
- 101,670 visits to AHS medical EDs
- 16,483 system discharges
- 13,268 visits to JGPH ED
- 6,830 inpatient and outpatient surgeries performed
- 2,077 patients served by Trauma Center
- 1,131 babies delivered
- Interpreter services offered in 26 languages

Highland Hospital

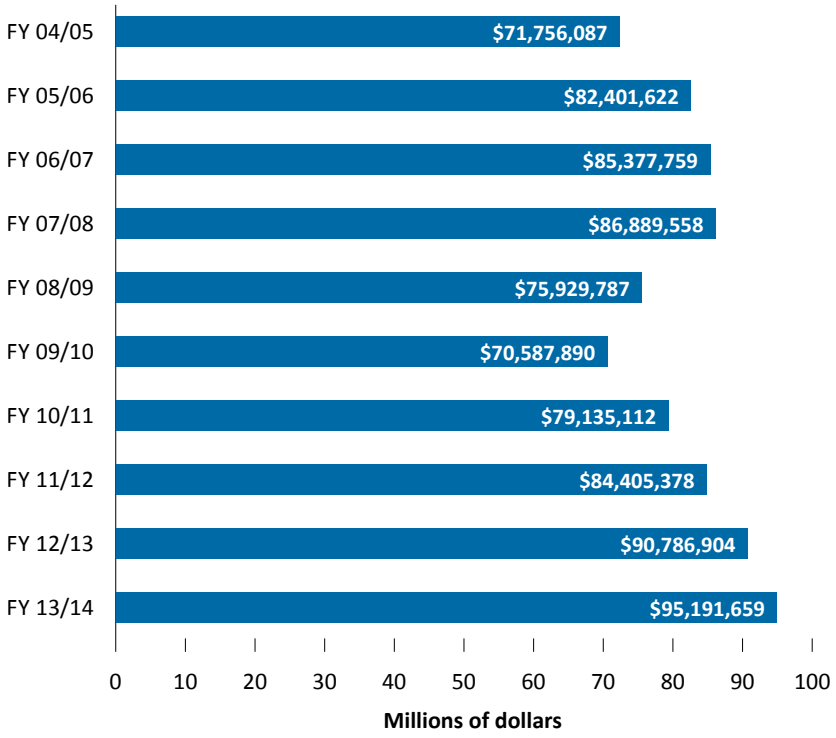
- Increased Orthopedic visits 81% since FY 10/11, for a total of 15,502
- Increased Cardiology visits 47% over FY 10/11 baseline, for a total of 4,831
- Reduced backlog of Cardiology patients waiting for a first appointment by 80% over two years, from 401 to 81 patients as of October 2013

Highlights

Many staff and programs received local, regional, and national recognition during the FY 13/14:

- JGPH Director of Nursing, Judy Linn, was honored with the **Annual Leadership Award from American Psychiatric Nurses Association**
- JGPH Administrator, Guy Qvistgaard, was appointed to the **Board of National Alliance of Mental Illness**
- The Occupational Therapy Department at JGPH was honored with the **Outstanding Collaboration & Support Award** from Alameda County Network of Mental Health Clients
- Alameda Hospital was featured in the U.S. News and World Report, **"2015 Best Hospitals"** edition
- Highland Hospital's Cardiac Catheterization Laboratory Technicians earned elite designation as **Registered Cardiovascular Invasive Specialist (RCIS)** from Cardiovascular Credentialing International (CCI).

REVENUE EARNED EACH FISCAL YEAR (FY 04/05 THROUGH FY 13/14)



- Increased Optometry visits 94% over the FY 10/11 baseline, for a total of 5,617
- Increased Dermatology visits 167% over the FY 10/11 baseline, for a total of 2,902
- Increased preventive screenings for breast cancer by 12% since FY 12/13 through a mammogram improvement project
- Developed "pod-care" entry to prenatal care—a "one-stop-shop" model that centralizes prenatal care to provide easier access to services and ensure no aspect of care is overlooked
  - Expanded lactation services to seven days per week, including evening shifts
  - Established new Sunday high risk newborn clinic to see infants post-discharge on Sundays when primary care clinics are closed
  - Incorporated early pregnancy detection dating ultrasounds during new OB physical exams using new GE ultrasound machines
- Answered a total of 3,686 Nurse Advice Line calls, an average of 369 calls per month, with a 66% increase during the last quarter of the year
- Piloted the Art of Caring Program, customer service training for over 90 nurses and nurse leaders, including feedback, coaching, and skills application to improve patient experience
- Through the ED Navigator program, connected over 310 high risk patients to a medical home and received the Kaiser Permanente Clinical Systems Development Award for "Improving the Patient Experience/ Improving the Health of Populations"
- Increased compliance with sepsis bundle to 69%, a 68% improvement over prior year

Highlights

Many staff and programs received local, regional, and national recognition during the FY 13/14:

- Highland Hospital earned **Echocardiography Accreditation (ICAEL)** from the Inter-societal Accreditation Commission.
- Highland Hospital Earned **Prestigious Level II Trauma Center Verification** from the American College of Surgeons.
- The Medical Director of the Hope Center served as **advisor to a statewide collaborative for complex care management**, presenting at Institute for Healthcare Improvement conference.
- Hope Center received the **2013 Quality Leaders Award—Honorable Mention** from the California Association of Public Hospitals.

- Reinstated 19 licensed beds, added nine licensed beds, hired 10 inpatient nurses, and opened new 10-bed observation unit for low acuity patients to keep beds for higher acuity admissions
- Improved patient flow by reducing ED median length-of-stay by 56% for low acuity patients and 21% for high acuity patients over FY 10/11 baseline

Same Day Clinic and Highland Care Pavilion

- Opened 4,340-square foot Same Day Clinic (SDC), designed for patients with serious but non-life threatening conditions, and cared for 11,669 patient visits
- Expanded SDC service hours to include Saturdays and opened Urgent Dermatology Clinic to relieve stress on the ED
- Opened new 14-station Infusion Center in Highland Care Pavilion

COMPLEX CARE PROGRAM

The Complex Care Program involves close collaboration among the Hope Center, which coordinates care for high cost, high risk patients suffering multiple chronic conditions; the Pain Clinic; the Healthy Hearts Clinic; and the Care Transitions Program to manage patient care, reduce readmissions, and improve outcomes.

- Doubled enrollment in Complex Care Program from 214 to 427 patients
- Implemented the Hospital Admissions Risk Multiplier Screen (HARMS-8), an evidenced-based tool to identify critical patient intervention areas at intake
- Assigned a medical home to 78.5% of all patients falling into the high risk criteria, compared to 73% the previous year
- Reduced 30-day readmissions for high risk patients who received full complement of services by 44% over baseline, 90-day readmissions by 56%, and over-90-day readmissions by 24%
- Reduced 30-day readmissions at the COPD clinic by 21%
- Provided follow-up care from care managers at the AHS-sponsored respite home to 27 patients
- Established training program for volunteer health coaches at the Healthy Hearts Clinic
- Conducted 439 admission consults with medication reconciliation; 68 discharge clinic consults (correcting 10 patient safety problems); 1,031 post-discharge interventions, including 391 home/shelter visits; 164 patient education interventions; 175 refill authorizations; and resolution of 82 insurance issues from program pharmacists

Wellness Centers: Newark, Eastmont, Hayward, Highland

- Expanded specialty care services at Newark Wellness, including psychiatry, mammography, early oral preventive pediatric care services, and prenatal centering program
- Relocated Hayward Wellness to Southland Mall to accommodate 36

Measure A Helps

Mr. G., 50, had heart failure. He was managing stress with substance abuse and cigarette smoking, and had not seen a doctor in years. The Care Transitions Program provided smoking cessation counseling, nicotine patches, assistance finding a doctor, health education, and help applying for entitlements. He received motivational counseling to help make lifestyle changes. At discharge, Mr. G had quit smoking and was committed to his health. He wrote to his social worker: "Your help has seemed so relentless and dedicated that you remind me of a locomotive steaming down the track and shoving every negative obstacle out of the way."

new exam rooms; over 23,000 square feet; and an expected 50,000 annual visits for specialties such as optometry, podiatry, nephrology, cardiology, psychiatry, acupuncture, nutrition, and health education classes
- Expanded specialty care services at Eastmont Wellness to accommodate 16 exam rooms; 6,600 square feet; and up to 40,000 additional expected annual visits, and expand services to offer a multi-use clinic, orthopedic cast room, podiatry, urology, endocrinology, ophthalmology, optometry, and rheumatology specialties
- Increased adult medicine, women, and pediatric patient encounters at Oakland-based clinics (Highland and Eastmont) by 13% over the FY 10/11 baseline, for a total of 133,914 encounters
- Expanded "Centering Pregnancy" program to three Wellness Centers
- Established a "Baby-Friendly" Community Clinic at Eastmont Wellness, including new remote equipment that enables tele-lactation support
- Trained 85% of adult medicine staff, providers, and residents in population health management, including preventive screening for breast cancer, diabetes, and other diseases
- Enrolled 102 children and 77 families in AHS's childhood obesity prevention program, Bite to Balance
- Upgraded the Electronic Health Record (EHR) system at Hayward, Newark, and Eastmont Wellness to a new version with features to improve the efficiency and quality of care

John George Psychiatric Hospital

- Achieved an employee engagement response rate of 91%
- Maintained seclusion-restraint incidents for inpatient services below the community standard of 5 or fewer per 1,000 patient days, with 4.0 incidents per 1,000 patient days
- Maintained seclusion-restraint incidents for emergency services at 5.3 incidents per 1,000 patient visits, one of the lowest rates in the United States compared to approximately 145 incidents per 1,000 patient visits shown at other psychiatric hospitals
- Implemented Alternative Interventions Champions, a multi-disciplinary group of staff experts who developed a half-day education program and competency, and delivered it to entire JGPH staff resulting in a 40% decrease in 1:1's (sitters)
- Sustained best practice at 18 minutes for the amount of time in which an ambulance can complete the patient drop-off and return to the field
- Sustained an average length of stay within the industry best practice benchmark of 7.5-8.5 days

Fairmont Hospital

- Provided acute inpatient rehabilitation services to 20 patients per day, while the skilled nursing facility had an average daily census of 101 patients
- Began design of the Rehab Healing Garden
- Provided a robotics exoskeleton unit at the physical therapy gym to

Measure A Helps

Mr. B., 27, had AIDS, hepatitis B, tuberculosis, and secondary syphilis. The RN Care Manager told Mr. B's mother to bring him immediately to the Highland Hospital ED. The RN followed the man throughout his hospitalization, introducing him to HIV services and other needed clinics such as the Chest Clinic. Mr. B has not been re-hospitalized in an eight-month period. He is now employed, adheres to his medication regimen, and regularly attends his medical appointments. The RN Care Manager believes this success story is the result of inpatient teaching, navigating the patient through the system for his multiple health care needs, and engaging him in the importance of self-care.

enable stroke patients and those with lower limb disabilities, including paraplegia as a result of spinal cord injury (SCI), to perform self-initiated standing, walking, and turning
- Made an additional seven beds available for the Neuro-Respiratory Unit

San Leandro Hospital
- Projected $6.3 million in additional net revenue as a result of increased volume
- Achieved a 19% increase in average weekly operating room surgical volume
- Improved the average daily ED census by 18%
- Reduced the number of patients left without being seen by 77%
- Reduced the patient arrival-to-discharge times in the ED by 32%
- Reduced operating room turnover times by 75%
- Reduced arrival-to-provider time in the ED by 61%
- Established "daily/weekly operating report" with key performance indicators
- Collected and collated regional market data to provide a comprehensive understanding of how San Leandro is serving the needs of the market and what needs the hospital is not filling
- Established benchmarks to identify appropriate staffing levels to help increase patient satisfaction during high volume hours
- Established performance reviews at the department and executive levels
- Executed monthly/weekly compliance audits

Alameda Hospital
- Affiliated with AHS on May 1, 2014, adding 281 beds (acute, sub-acute, skilled nursing), 200 physicians, and 100 volunteers serving a greater community of 100,000 people
- Gradually increased Emergency Care Center volume and maintained door-to-doctor times at 30 minutes, well below the national average
- Treated approximately 1,800 patients at the Kate Creedon Center for Advanced Wound Care since its opening in July 2012, with a nearly 90% complete healing rate for chronic wounds

San Leandro Hospital achieved a 19% increase in average weekly operating room surgical volume and improved the average daily ED census by 18%.

CONCERNS

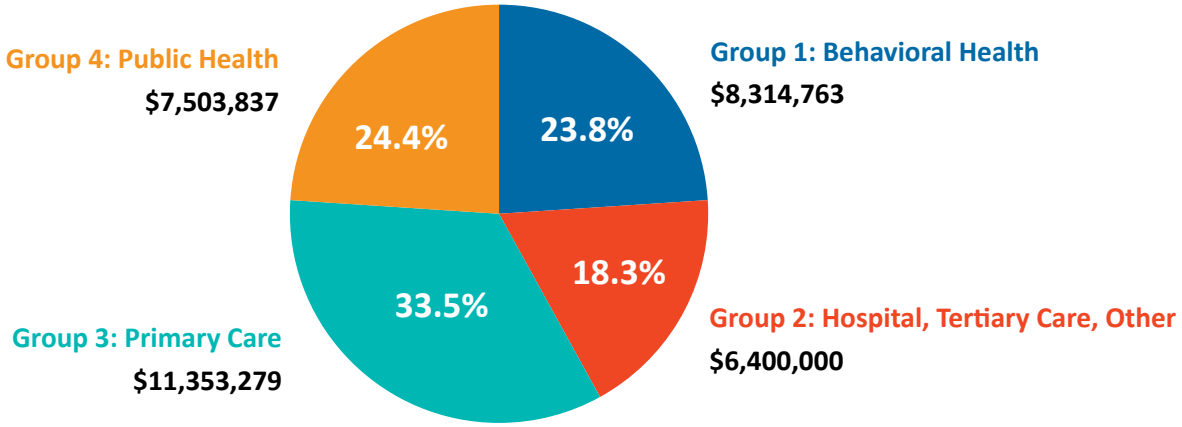
In describing its program accomplishments, AHS often does not provide measurable objectives, making it difficult to get a sense of progress from the prior year. The Committee notes that this feedback has been offered for several years to AHS/Alameda County Medical Center.

FY 13/14: **25% OF MEASURE A FUNDS** ALLOCATED BY The Alameda County Board of Supervisors

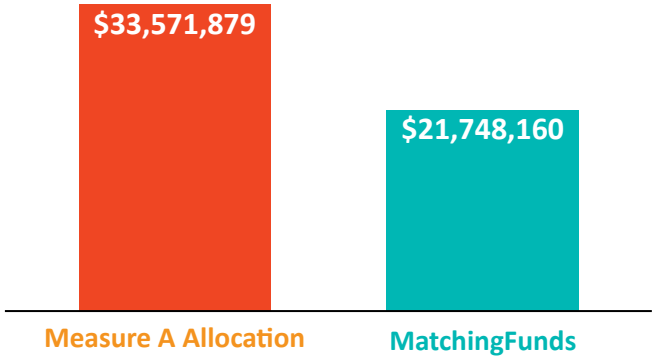
In FY 13/14, the Board of Supervisors (Board) approved approximately $33.6 million in total Measure A allocations. The Board allocations are listed by group in the following chart.

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 13/14 Budget Information and Appendix C: FY 13/14 Measure A Fund Distribution by Provider or Program. This list 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 13/14



TOTAL MATCHING FUNDS OBTAINED BY LEVERAGING MEASURE A ALLOCATIONS



FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 1: BEHAVIORAL HEALTH

Asian Health Services (Bantreay Srei)

www.asianhealthservices.org

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

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

Populations served: Low Income Children, Seniors

Services provided: Public Health, Mental Health

Service area: Oakland

BACKGROUND

Banteay Srei is a youth development, asset-building organization that is nonjudgmental of young Southeast Asian women who are at risk of or engaged in the underground sex trade. Banteay Srei seeks to provide the resources that support women's healthy development through self-empowerment and self-determination.

Banteay Srei believes in providing young women at risk of or currently impacted by sexual exploitation with holistic services. Banteay Srei's youth development/after-school programs provide young Southeast Asian and Asian American women with the safe spaces that promote sex-positive education, community-building activities, leadership development, and peer and intergenerational support. The culturally relevant programs foster cultural pride, a stronger support system, and self-determination. Banteay Srei also serves as a gateway to health.

MEASURE A FUNDING SUMMARY

With the support of Measure A funds, Banteay Srei has achieved the following during FY 13/14:

- Conducted 39 weekly peer health educational workshops for 28 Southeast Asian young women to promote leadership development, establish peer support networks, and enhance family support.
- Led three community workshops to engage the larger community/neighborhood in developing positive alternatives for young women and young people at risk.
- Provided 43 leadership trainings for five Southeast Asian youth leaders. The youth leaders conducted the 39 peer health workshops mentioned above.
- Delivered 10 presentations/trainings on topics of CSEC health screening, awareness of CSEC patterns or recruitment, and recommendations of supporting at-risk or sexually exploited young women. Banteay Srei has presented to over 400 local community members and both local and national service providers and health advocates.

Measure A Helps

A committed participant of Banteay Srei became sexually exploited after meeting a man she first encountered on social media. She was able to get herself out of the situation and back home safely. She declined mental health services from a therapist and instead sought out Banteay Srei for peer and intergenerational group support, where she felt safe and gained knowledge of women's health and empowerment. Through Banteay Srei, the young woman accessed Asian Health Services Youth Program's Teen Clinic for reproductive health. With the support of Banteay Srei, the woman graduated high school and started community college.

- Supported 15 young Southeast Asian women to access academic support, housing, mental/medical health, and career development services.

These efforts helped lead to the following outcomes:

- All 33 young women served by the program reported that:
  - They have built their self-confidence, learned more about caring for their bodies, are proud of their culture, and believe they can make a difference.
  - Banteay Srei has provided them with tools to make healthy decisions, build healthy relationships, and speak up more about issues that impact them.
  - They are aware of where to go to access medical and mental health services.
- In addition, all 33 signed up for FPACT/Minor Consent.
- 13 young women accessed services with Asian Health Services' Teen Clinic and/or with mental health services partners.
- Four were re-enrolled in school or a GED program.
- Four have graduated high school and are college tracked.
- Six young women found jobs.

Highlights

All Banteay Srei participants reported **improvement in a wide variety of areas related to self-esteem and self-confidence**.

Banteay Srei used Measure A funds to support their annual Claws for a Cause Fundraiser, which **raised $3,600**.

Behavioral Health and Alcohol and Other Drug (AOD) Community

www.acbhcs.org

Allocation: **$738,480** | Expended/Encumbered: **$738,480**

Individuals served by Measure A: **7,500** (Total individuals served: **44,000**)

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

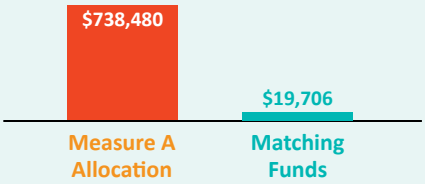
The BHCS-contracted CBOs used Measure A funds to provide a broad array of mental health and substance use disorder services, ranging from outreach to intensive programs, in multiple geographic areas across the county. Measure A funds have helped mitigate budget cuts and the lack of cost-of-living adjustments (COLAs), which would have resulted in program cuts. Measure A funds have also helped offset the impact of reductions in funding, thereby contributing to system stability.

The use of Measure A funds to mitigate budget cuts allowed providers to serve approximately the same number of County residents in alcohol and other drug (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.

Highlights

Compared to the preceding year, FY 13/14 saw a **decline of only 2% in both the number of clients served and number of services delivered**. Given County General Fund reductions of 10% and a cost of living increase of 2.4% for that period, Measure A support was very effective in stabilizing services.

Matching Funds



BHCS-contracted CBOs leveraged their Measure A allocations to obtain **$19,706 in matching funds** from Medi-Cal and the Medi-Cal Administrative Activities (MAA) program.

Center for Empowering Refugees and Immigrants

cerieastbay.org

Allocation: **$76,500** | Expended/Encumbered: **$76,500**

Individuals served by Measure A: **24** (Total individuals served: **48**)

Populations served: Low Income, Uninsured Children, Families

Service provided: Mental Health

Service area: Oakland, 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. CERI works to improve the social, economic, and psychological health of refugees and their families affected by war, torture, or other forms of extreme trauma.

MEASURE A FUNDING SUMMARY

With its Measure A funding, CERI offered four to six groups per week to youth of various ages. The groups provided social and emotional support and introduced the youth to a variety of activities to enhance self-esteem and improve family and social relationships. CERI also provided tutoring, case management, nonviolent communication mentoring, and sponsorship of fun activities in the community.

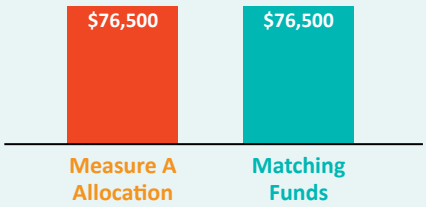
Specifically, CERI used its Measure A allocation to achieve the following:

- Community-wide events with outreach to at least 50 individuals (target: 8 events; actual: 10 monthly potlucks plus a community event with over 100 attending)
- Support groups, including life skills classes, art, and other nontraditional mental health prevention activities (target: 4 ongoing groups serving 5–12 children and youth at each group; actual: 3 ongoing groups serving 5–10 participants at each group, plus 3 short-term groups)
- Consultation and/or training for community-based organizations (CBOs) (target: 2 trainings; actual 2 trainings)
- Early intervention for individuals and families including short-term, low-intensity interventions (target: 40 hours to at least 4 individuals; actual: no youth enrolled in the early intervention program; 8 individuals did receive 50 hours of one-on-one interventions)

Measure A Helps

A homeless young woman who was involved in a violent domestic relationship was shot last year. CERI connected her to a program that helps homeless adults in Oakland find emergency and permanent housing. At the time of this report, the woman is connected to permanent housing, has ended the violent domestic relationship, and is working.

Matching Funds



CERI leveraged its Measure A allocation to obtain **$76,500 in matching funds** from the Mental Health Services Act (MHSA).

Center for Healthy Schools & Communities

(School-Based Behavioral Health Initiative)

achealthyschools.org

Allocation: **$603,100** | Expended/Encumbered: **$603,100**

Individuals served by Measure A: **3,064** (Total individuals served: **3,064**)

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

A 17-year-old student was referred for services for being angry, yelling, and hitting school property. The student planned to join the military, which would require him to return to and graduate from his comprehensive high school. The student and consultant discussed the behavior he would need to show to return to the school. Together they determined what triggered his anger and set up a plan for either avoiding these triggers or addressing his anger if he is triggered. The student was able to use the plan effectively and return to the comprehensive high school. He is expecting to graduate and then begin his military career.

- 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; 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.

Middle school students who had received behavioral health services reported that those services were extremely helpful in **improving their ability to handle daily life, get along better with friends and family members, and succeed in school**.

A district-specific assessment of the six CFE domains found that **Hayward students demonstrated significant improvement in each of the six domains of the CFE** when comparing intake to discharge, while **Oakland students demonstrated significant improvement in five** of the six domains.

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 helping 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 assess 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

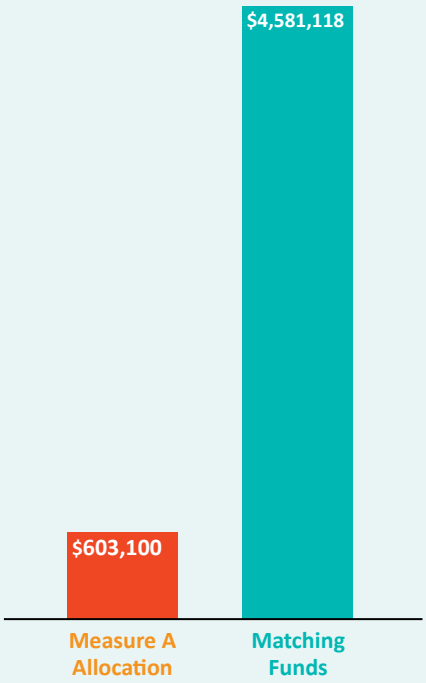
The Our Kids Our Families Intern Program supervised a total of nine social work and MFT interns. The intern programs enabled Our Famlies Our Kids to increase service capacity and service access for students and their families.

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:

- Positive behavioral interventions and supports

Matching Funds



The School-Based Behavioral Health Initiative leveraged its Measure A allocation to obtain **$4,581,118 in matching funds** from the following sources:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funding: $503,100
- Tobacco Master Settlement Fund (TMSF)/CHSC discretionary : $1,513,112
- Medi-Cal Administrative Activity (MAA): $850,000
- Mental Health Services Act Prevention/Early Intervention Program: $1,167,332
- City of Oakland, Oakland Unite: $200,000
- School District funding: $347,574

- 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 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 works 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

In six of the eight school districts supported under this program, considerable progress was made toward strengthening and expanding COST in FY 13/14.

BHCs support the implementation of Coordination of Services Teams in the schools.

Chabot/Las Positas Community College

clpccd.org

Allocation: **$20,000** | Expended/Encumbered: **$19,396**

Individuals served by Measure A: **111** (Total individuals served: **11,899**)

Populations served: Indigent, Low Income, Uninsured Adults

Services provided: Mental Health

Service area: Countywide

BACKGROUND

Chabot/Las Positas Community College works to strengthen student learning, retention, and success. They accomplish this by supporting the physical, emotional, and social well-being of students through accessible, high quality health services and activities.

A licensed marriage and family therapist (MFT) and a marriage family therapy intern are contracted to provide services through the Las Positas College Student Health and Wellness Center.

MEASURE A FUNDING SUMMARY

Chabot/Las Positas Community College used its Measure A allocation to achieve the following:

- Provide immediate interventions to eight students in emotional crisis following the Las Positas College Mental Health Emergency guidelines with the mental health crisis response team
- Provide 20–28 hours of marriage and family therapy per week to 61 clients, for a total of 457 visits
- Provide 42 mental health community referrals
- Provide psychiatric referrals as needed for medication evaluation, treatment, and management

Measure A Helps

K.L. is a 29-year-old Korean student attending Las Positas College. She came to the Health and Wellness Center and told the nurse that she was depressed and had suicidal thoughts. Staff recommended K.L. be seen by a psychiatrist to provide a medication evaluation and possible medication. She agreed to visit a free walk-in psychiatric clinic where should could be assessed by a psychiatrist and prescribed medication the same day. Staff also explained how she could seek help herself in the future by going to any hospital with an emergency room, calling Alameda County's 24-hour crisis line by dialing 911, or coming to the health center.

Criminal Justice Screening and In-Custody Services

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

Individuals served by Measure A: approximately 2,971 (Total individuals served: 4,872)

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

Services provided: Hospital Inpatient, 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 approximately 1,200 County jail inmates every month. An estimated 16% of inmates have serious mental illnesses. Without jail mental health services, mentally ill inmates would go untreated.

Highlights

The jail's suicide prevention program, a collaborative effort between mental health and other staffs, has resulted in a **significant decrease in inmate suicides**.

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. 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 include the following.

Mental Health Screening

- Initial (Intake). At the time of booking, all inmates are screened for medical and psychiatric treatment needs. Within 14 days, staff conducts an additional mental health appraisal. Inmates found to need a further mental health evaluation are referred to 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. Criminal Justice Mental Health (CJMH clinicians triage and screen all referred inmates for mental health service needs and recommend appropriate treatment plans based on the assessment.

At the time of booking, all inmates are screened for medical and psychiatric treatment needs.

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.

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.
- 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

Measure A Helps

Mr. M., a 51-year-old homeless veteran, was arrested on misdemeanor charges and found incompetent to stand trial due to serious mental illness. Mr. M. had not been participating in community treatment and had been kicked out of his board and care home. He initially refused all mental health services in the jail, but with engagement efforts made by jail mental health, Mr. M. gradually agreed to take his psychiatric medications. The psychiatrist was able to adjust Mr. M's medications over time, and he became much more stable. Mr. M. was transferred to Villa Fairmont, where he is doing well and will likely be discharged when he completes the program.

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 several times a week, 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 in topics related to the practice of jail psychiatric services.

Administration of Psychotropic Medications to Patients in a Psychiatric Emergency

Psychiatrists can legally prescribe psychotropic medication for emergency situations. The CJMH Lead Psychiatrist attends the monthly BHCS Psychiatric Practices Committee and shares information learned with other CJMH psychiatrists.

CJMH staff work with inmates who demonstrate a risk for suicide and address risk factors, develop relapse prevention strategies, and discuss coping strategies.

Inmates have access within the jail to programs that specifically address addiction problems.

Detoxification/Sobering Center

Allocation: **$2,040,000** | Expended/Encumbered: **$2,040,000**

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, Outside of Alameda County

BACKGROUND

The Detox/Sobering Center 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 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. These services allow clients to fulfill all admission requirements for their next level of treatment.

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 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 4,679 units of service.
- The Detox Center provided 2,194 units of service.
- The Health Center provided 720 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 40-year-old male client has a 25-year history of multiple substance abuse. He also has a history of trauma, having witnessed his uncle's suicide at age 10. The client did not want to come to Cherry Hill; however, he was forced by his family. The client gradually became less resistant to treatment, and agreed to have a mental health assessment regarding his childhood trauma. As the days passed, the client became willing to go to residential treatment for one year. His father stated, "I don't know what magic you do here at Cherry Hill, but this is the first time I've spoken to my son in 10 years."

G.O.A.L.S. for Women, Inc.

goalsforwomen.com

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

Individuals served by Measure A: **55** (Total individuals served: **147**)

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

Services provided: Mental Health

Service area: Berkeley, Hayward, Oakland

BACKGROUND

G.O.A.L.S. for Women works to ensure that no and very low income women, children, and families (including men and boys) who identify with the African American experience have access to free, culturally competent, and responsive peer and clinical mental health counseling, case management, and support services in their local neighborhoods, at the right time and in the right dose/intensity/duration to reduce/eliminate suffering, prevent conditions from worsening, and support wellness and recovery.

Users of G.O.A.L.S. services are primarily disadvantaged and trauma-surviving African American women (mostly single women, some pregnant and parenting or of child-bearing age). Another moderate percentage of participants are older adults and grandparents raising grand-children. Services are provided both in the G.O.A.L.S. South Berkeley neighborhood-based outpatient clinic and at various locations throughout the County through targeted outreach at special events. Services are specifically focused on reducing psychological distress, building stress management and coping skills, reducing prolonged suffering/isolation, and building social connections while reducing the stigma and mistrust of seeking mental health-related care.

Many participants do not have a usual source of primary care (although most have Medi-Cal) or have not previously experienced the benefits of obtaining culturally appropriate mental health services and supports. Some participants have serious physical health conditions and require advocacy to access primary care or SSI.

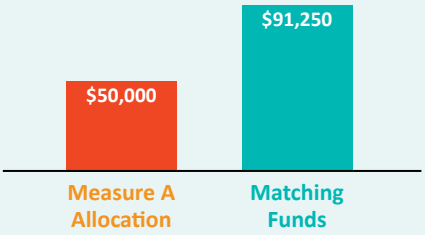
MEASURE A FUNDING SUMMARY

Measure A funds enabled G.O.A.L.S. for Women to provide ethnically appropriate mental health outpatient assessment, counseling , case management, supportive peer group services (Kitchen Table Talks), mental health and wellness education, referrals to other services including insurance coverage, mentoring, coaching, and suicide prevention.

Highlights

Across service areas, 100% of clients receiving services report **improvements in self-esteem, reduction in stigma, and other positive changes**.

Matching Funds



G.O.A.L.S. for Women leveraged its Measure A allocation to obtain **$91,250 in matching funds** from a private foundation.

The G.O.A.L.S. clinic is not authorized to bill Medi-Cal, so they would not have been able to serve and support clients without Measure A funding.

G.O.A.L.S. for Women used its Measure A allocation to achieve the following:

- Provide culturally appropriate mental health and Medi-Cal enrollment outreach, education, and consultation and reduce risk for onset of mental illnesses, prolonged suffering , and stigma and discrimination. G.O.A.L.S. facilitated drop-in, telephone, and text message requests for mental health support and offered appointments during the day, evenings, and weekends (target: 35 unduplicated community members; actual: 56).
- Provide culturally appropriate mental health screenings (target: 20 community members; actual: 28).
- Provide culturally appropriate mental health assessments and engagement, which includes screening utilizing an African-American-sensitive general anxiety checklist and cultural idiom of distress common in African-American populations meeting medical necessity for mental health intervention (target: 10 community members; actual: 11).
- Provide free individual and/or clinical group counseling (target: 8 community members; actual: 11).
- Provide referrals to other needed health, housing, or other social services on an as-needed basis (actual: 8 referrals).
- Provide culturally appropriate drop-in Kitchen Table Talks, which are peer/cultural support groups (target: 10 community members; actual: 22).

Measure A Helps

In a letter to Alameda County Supervisors and Health Care Services Agency staff, a G.O.A.L.S. client writes:

I have been a G.O.A.L.S. client for 2 ½ years. I had been searching for an African-American support system that would make me feel at ease with the issues I was addressing. I have been carrying a load of stress all alone for so long, and this organization came into my life at a very critical point. I feel that G.O.A.L.S. for Women is critical to the well-being of African American women and our families. Being a college student studying to become a social worker and give back, G.O.A.L.S. has been a foundation for me to make that dream a reality.

La Familia Counseling Services

lafamiliacounseling.org

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

Individuals served by Measure A: **3,174** (Total individuals served: **3,174**)

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

Services provided: Public Health

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

BACKGROUND

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

MEASURE A FUNDING SUMMARY

La Familia used its Measure A allocation to conduct mental health-related workshops. The workshops were based on the National Alliance on Mental Illness (NAMI) Mental Health Curriculum and Healthy Relationships of California. Topics included working and communicating with family members who have mental health issues.

Mental Health Services for Juvenile Justice Center

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

Individuals served by Measure A: **136** (Total individuals served: **1,002**)

Populations served: Low Income Children, Families

Services provided: Mental Health

Service area: Countywide

BACKGROUND

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

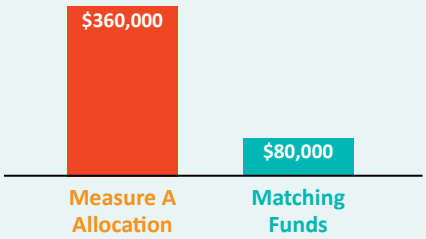
- Mitigate the mental health issues of detained youth by offering crisis intervention and ongoing mental health support while detained.
- Provide court-ordered mental health assessments. Guidance Clinic staff completed approximately 246 mental health assessments in FY 13/14. Measure A funding covered approximately 66 of those assessments.
- Offer immediate crisis intervention for suicidal youth to avoid self-harm. The Guidance Clinic performed 238 crisis interventions to avoid self-harm and/or hospitalization, of which Measure A funded 127.

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 two clients were hospitalized in FY 13/14**.

Matching Funds



BHCS leveraged its Measure A allocation to obtain **$80,822 in matching funds**.

National Alliance on Mental Illness (NAMI) Tri-Valley

nami-trivalley.org

Allocation: **$3,683** | Expended/Encumbered: **$2,915**

Individuals served by Measure A: **453** (Total individuals served: **453**)

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

Services provided: Mental Health

Service area: Castro Valley, Dublin, Hayward, Livermore, Pleasanton, San Leandro, San Lorenzo, Sunol, Outside of Alameda County

BACKGROUND

National Alliance on Mental Illness (NAMI) Tri-Valley, in collaboration with other community agencies and organizations, is dedicated to improving the quality of life for those whose lives are affected by mental illness by providing support, resource information, education programs, and advocacy.

NAMI Tri-Valley not only provides peer support groups and information and referrals, but also offers advocacy for families and their loved ones, educational public meetings, and workshops, including the following:

- Family-to-Family Education Program. Family-to-Family is an evidence-based national program that teaches family/caregivers all aspects around mental illness and recovery.
- NAMI Tri-Valley Family/Caregiver Support Groups. The Family/Caregiver support groups are a safe place for tired, stressed-out caregivers to gain knowledge and support from their peers. The groups are facilitated by volunteer-experienced family members and mental health professionals. By encouraging peers to network with, they can provide each other continual support between support groups.
- NAMI Tri-Valley Parent Resource and Support Group. This monthly group helps parents of children who are suspected of or are diagnosed with an emotional or psychiatric disorder. The group provides information, resources, and support for parents needing coping tools and strategies in caring for their child or children.
- NAMI Tri-Valley General Meetings. NAMI's general meetings are open to the public and offer a venue to provide valuable information and connections as guest speakers talk about their particular areas of expertise. These meetings help many find resources and support, regardless whether they are a consumer, a family member, or an interested member of the public.

Measure A Helps

One mother whose young adult son was diagnosed with schizophrenia decided the best support that she could give to her son was to learn all that she could about his illness. She first attended the Family/Caregiver support groups on a regular basis, then took the Family-to-Family Education course. During this time, when her son's mental health deteriorated, she was able to advocate for and maintain a close relationship with her son because of all she learned at NAMI. This greatly helped in her son's recovery, from hospitalization to a group home setting and on to an apartment, living independently.

MEASURE A FUNDING SUMMARY

NAMI Tri-Valley used its Measure A allocation to support the following programs:

- Family-to-Family Education Program. NAMI Tri-Valley provided two 12-week series of classes in FY 13/14 (target: one series). Overall, 30 attended and completed the classes.
- NAMI Tri-Valley Family/Caregiver Support Groups. NAMI Tri-Valley offered twice-monthly peer support group for families and caregivers. The groups provide a safe place to talk, network, learn new coping skills, and gain resources in the community around their mentally ill loved one. On average, 12–18 people attended each meeting, with a total attendance of 245 in FY 13/14.
- NAMI Tri-Valley Parent Resource and Support Group. NAMI Tri-Valley offered a once-monthly peer support group to support parents, grandparents, and guardians of children suspected of or diagnosed with a mood disorder. On average, six people attended the monthly meeting, with a total attendance of 48 in FY 13/14.
- NAMI Tri-Valley General Meetings. NAMI Tri-Valley held a once-monthly public meeting at which invited guest speakers talked about mental health topics or issues. On average, 25–30 people attended each meeting, with a total attendance of 130 in FY 13/14.

Highlights

Based on end-of-class surveys, 100% of those who took the 12-week Family-to-Family course learned considerable to vast amounts of information that have **improved their lives and gave them the ability to better support their loved one with serious and persistent mental illness**.

Safe Alternatives to Violent Environments (SAVE)

save-dv.org

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

Individuals served by Measure A: **263** (Total individuals served: **3,241**)

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

Services provided: Mental Health

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

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 abuse 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 funds are a key source of funds for SAVE counseling services. SAVE used its Measure A funds to provide 40 domestic violence support group sessions and 80 sessions of individual counseling for domestic violence victims.

Measure A Helps

Lisa, 30, came to the SAVE shelter with one of her children and no familial support system. Shortly after her arrival, Lisa had a seizure that landed her in the hospital. Her daughter was taken into CPS custody. After being released from the hospital, Lisa expressed suicidal thoughts. With the support of a psychologist and case management staff, Lisa began to look at her issues and made the hard decision to enter a residential treatment program, where she is doing well.

Highlights

Of the counseling participants surveyed, 88% of clients reported that they felt **safer and more equipped to make their own decisions**.

Senior Support Program of Tri-Valley

ssptv.org

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

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

Populations served: Low Income, Uninsured Families, 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. The program received 24 new referrals in the last quarter of FY 13/14 alone.

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

Diana, 78, lives alone in a senior housing complex. Due to consistent paranoia, she has alienated her family and people in her community. When Diana was referred to In-Home Counseling, she didn't have any friends in her complex and was becoming more and more isolated. The counselor helped Diana increase her social skills by practicing assertive communication. The counselor also suggested ways to improve listening skills and encouraged her to accept differences of opinions. Within a few months, Diana started attending more functions at the senior housing facility. She reported making two friends she feels comfortable with and no longer reports being left out of activities.

Tri-Valley Haven for Women

trivalleyhaven.org

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

Individuals served by Measure A: **37** (Total individuals served: **128**)

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

Services provided: Mental Health

Service area: Castro Valley, Livermore, Pleasanton

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 Tri-Valley Haven 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

Funding through Measure A provided increased availability of counseling staff and increased access to counseling sessions.

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: 205 sessions to 37 clients)
- Based on staff assessment, have clients show improved mental health (target: 60% of clients served; actual: 75%)

Measure A Helps

Rachel, 26, came to TVH to process memories of childhood sexual abuse. Rachel had self-harmed her whole life and had been involved in a number of abusive relationships. As treatment progressed, Rachel became committed to her healing and explored not only the trauma itself but also the wider dysfunction in her family of origin, which included parental neglect. Rachel has been able to navigate conflicts with family members, develop a healthy relationship with a partner, and identify and pursue her professional goals. Rachel has also become an increasingly strong advocate for survivors of childhood sexual abuse and sexual assault.

Youth Alive!

youthalive.org

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

Individuals served by Measure A: **47 families, 118 individuals** (Total individuals served: **87 families, 234 individuals**)

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

Services provided: Mental Health

Service area: Oakland

BACKGROUND

Youth ALIVE! works to prevent violence and develop youth leadership. The Youth ALIVE!/Khadafy Washington Project (KWP) provides first responder crisis intervention, intensive support, emotional "first aid," and linkage to ongoing mental health services to the families of Oakland homicide victims.

KWP offers families of homicide families a "ministry of presence." This takes the form of peer-based mental health first aid and a supportive staff presence from KWP's first response staff that delivers intense outreach for an initial period of 4–6 weeks. Specific barriers that the program assists with include the following:

- Navigation of funeral/burial process
- Support/advocacy with funeral homes
- Access to Victim of Crime (VoC) services, including financial support for mental health services
- Relocation (due to violent incidence)
- Providing immediate/basic needs such as food in home, gift cards, and transportation for appointments

For families that have received threats after a homicide, KWP addresses their safety concerns and coordinates with Oakland Police Department and community-based Street Outreach partners to monitor their loved one's services to deter more violence that would further complicate their existing trauma. KWP also conducts wellness checks with families to assess how their coping skills and resiliency are developing. For those that have emerging needs or resurfacing symptoms, KWP advocates to have these families linked back into mental health services to promote their healing.

Measure A Helps

An 18-year-old Latino man was shot and killed in front of his home. Youth ALIVE!/KWP staff contacted the family within 24 hours, and found that their landlord had sent them an eviction notice due to delinquent rent. KWP negotiated to allow the family to stay in the home until the end of the month. KWP then helped link the famly to mental health services through CCEB, enroll the younger siblings in school, secure employment for the oldest son, and arrange assistance with U-Visa application and grief support. The victim's mother shared that she and her children were "feeling a sense of hope" for the first time.

MEASURE A FUNDING SUMMARY

Youth Alive!/KWP used its Measure A allocation to achieve the following measurable objectives in FY 13/14:

- Provide first responder crisis intervention services to an estimated 15–

20 Spanish-speaking victim groups (families and friends of homicide victims) associated with Oakland homicides.

- Respond to and serve 87 families impacted by homicides in Oakland. There were 15 homicides (17%) of Latino victims and, of these, 15 victim groups were Latino and/or Spanish-speaking families.
- Serve an additional 32 victim groups (African-American families), bringing the total to 47 victim groups given intensive support services though these funds.
- Accompany and support each impacted family through their VoC appointment, guide them through the funeral and burial arrangements, and provide a "ministry of presence."
- In addition to the VoC services offered ($5,000 for burial costs and funding for mental health visits), secure additional financial contributions for half of the families served through the Crisis Response Support Network (CRSN) emergency fund.
- Give all families information about therapeutic services and basic grief/trauma symptoms, and refer five families for immediate therapeutic intervention through Catholic Charities of the East Bay (CCEB).

Youth Alive!/KWP used its Measure A allocation to provide first responder crisis intervention services to an estimated 15–20 Spanish-speaking victim groups associated with Oakland homicides.

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: **$249,979**

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 provides the following:

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

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

MEASURE A FUNDING SUMMARY

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

HCSA provided contract and administrative support for 60 Measure A allocations in FY 13/14. There were two RBA 101 trainings in April 2014, with a total of 14 organizations and 39 participants attending one of the trainings.

San Leandro Hospital

sanleandroahs.org

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

Individuals served by Measure A: **4,935** (Total individuals served: **22,033**)

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

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

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

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.

Program objectives have been aligned with the AHS three-year strategic plan. Within the plan, specific objectives for San Leandro Hospital include the following:

- Standardize and install management control systems across ED and operating room (OR)
- Design and install metrics management tools
- Develop a recurring operating report to highlight performance
- Improve rounding intervals to focus on standard work times
- Optimize patient visits by reducing length-of-stay and arrival-to-provider times
- Implement a governance model to create a continuous improvement culture
- Provide adequate resources for the ED and OR based on census demand
- Create better delegation and clarity of roles and responsibilities among staff
- Standardize the referral management and review process
- Increase performance of practices allowing for better capacity utilization and increased patient throughput
- Improve productivity as a result of data-driven management practices to reduce operational costs

Measure A funds are critical to San Leandro Hospital's ability to reduce 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 FUNDING SUMMARY

Measure A is a supplemental revenue source that supports all San Leandro Hospital services with the exception of a small share of services for which AHS receives full reimbursement. Measure A funds are

critical to San Leandro Hospital's ability to reduce the gap between reimbursement for services from a variety of sources and the actual cost of providing those services to underinsured and uninsured persons.

With the help of Measure A funding, San Leandro Hospital was able to provide the following services in FY 13/14:

- 7,615 total inpatient days
- 19,897 visits to to the medical ED
- 1,686 discharges
- 901 inpatient and outpatient surgeries performed

Measure A funding also helped San Leandro Hospital achieve the following:

- Projected $6.3 million in additional net revenue due to increased patient volume
- 19% increase in average weekly OR surgical volume
- 18% improvement in average daily ED census
- 77% reduction in patients leaving without being seen
- 32% reduction in patient arrival-to-discharge times in the ED
- 75% reduction in OR turnover times
- 61% reduction in arrival-to-provider time in the ED
- Establishment of "daily/weekly operating report" containing key performance indicators for enhancing patient satisfaction
- Development of capacity plan to identify minimum/maximum constraints based on forecasted volume for the ED, OR, and floor
- Collection of regional market data to provide a comprehensive understanding of how San Leandro is and is not serving the needs of the market
- Establishment of benchmarks to identify appropriate staffing levels
- Establishment of performance reviews at the department and executive levels
- Holding of weekly meetings the surgical services, ED, and strategic planning management action teams
- Execution of monthly/weekly compliance audits

CONCERNS

The provider report states that the hospital folded Measure A funding into their general operating budget: "As described in previous presentations and reports, we don't specifically allocate these funds to individual programs; rather, all of our operations are combined and we endeavor to track the profitability for each of our programs." The Committee asks the provider to show an awareness of the purpose of this public money and to address its requirements in the specific manner defined in the measure.

Highlights

San Leandro Hospital **improved patient care metrics in a number of key areas**, including significant reductions in patients leaving without being seen (-77%), ED arrival-to-discharge times (-32%), OR turnover times (-75%), and ED arrival-to-provider times (-61%).

Measure A funding helped San Leandro Hospital achieve a projected $6.3 million in additional net revenue due to increased patient volume.

St. Rose Hospital

strosehospital.org

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

Individuals served by Measure A: **11,156** (Total individuals served: **40,805**)

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

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

Service area: Countywide

BACKGROUND

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

- Critical access. SRH serves as a critical access point for Alameda County and is the only Medi-Cal-contracted facility between Oakland and Fremont. Additionally, SRH serves as a safety-net hospital and provides health care access to many low income residents that do not have adequate transportation to the Alameda County Medical Center.
- Hospitalists programs. The Hospitalists assume care of indigent and uninsured patients who are admitted to SRH. This alleviates the financial impact of the 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 2014 over 2013. SRH routinely accepts hospital transfers for emergency and elective cardiac care from non-Medi-Cal providers.

Measure A Helps

A 42-year-old female with abdominal pain sought treatment at the SRH ER. A CT scan revealed acute appendicitis. The patient underwent a successful emergency laparoscopic appendectomy. This patient was uninsured. After receiving her bill from the hospital, she was devastated, worried that she and her husband might lose their home. She asked the hospital if there was a program that could help them with the bill. SRH made the decision to waive the hospital bill due to the family's circumstances. Measure A made it possible for the hospital to help with the family's bill and their financial hardship.

MEASURE A FUNDING SUMMARY

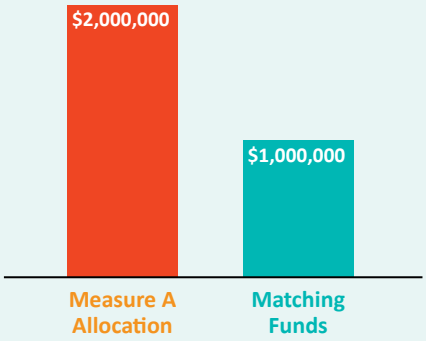
SRH used its Measure A allocation to help achieve the following objectives:

- Provide emergency care for uninsured patients. The SRH ER experienced 35,163 visits in FY 13/14, including 73%, or 25,549 visits, from uninsured and underinsured patients.
- Provide financial support to hospital-based physician groups to take

ER calls and provide services to uninsured patients. SRH inpatient volumes, including nursery service utilization, included 45.5% Medi-Cal patients and 6.2% uninsured patients.

- Provide referral services for follow-up/after care for uninsured patients.
- Assist in supporting SRH inpatient services to uninsured and underinsured patients. Hospital-based physicians provided over 12,093 patient encounters for uninsured patients for the year.
- Employ a financial counselor to assist in identifying uninsured patients who may qualify for other funding sources such as Medi-Cal or HealthPAC. In FY 13/14 the ER financial counselor assisted 1,809 uninsured patients, an increase of 7.2% over the preceding year.

Matching Funds



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

UCSF Benioff Children's Hospital Oakland

childrenshospitaloakland.org

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

Individuals served by Measure A: **31,365** (Total individuals served: **39,592**)

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 the 2013-2014 year, to CHO's ED was the highest volume ED in the San Francisco Bay Area.

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

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

Nadia, 9, was brought to the CHO ED from her school, where she had been attacked by a mentally ill person wielding a claw hammer. Medical and CCP staff completed a forensic evaluation and psychosocial crisis assessment, as well as a medical evaluation and treatment. The CCP clinical social worker provided crisis support to parents. When Nadia was discharged from the hospital, CCP arranged for outpatient psychotherapy and followed up with her in the outpatient clinic. When Nadia was returning to school, CCP staff conducted advocacy for an interdistrict transfer, and Nadia's mother was able to transition both Nadia and three younger children to a new school.

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

Center for Child Protection

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

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

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

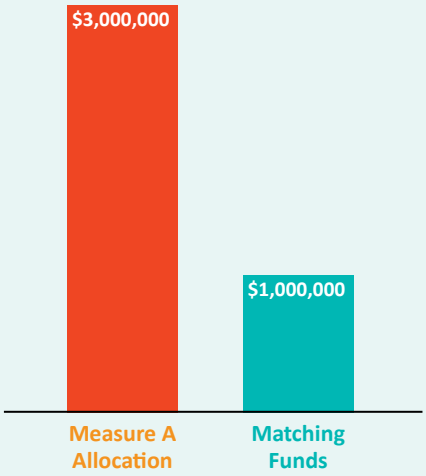
Clinical case management is provided to children and adolescents who present to the ED and/or child abuse management clinic following diagnosis or disclosure of abuse. Comprehensive evidenced-based mental health services are provided to children, adolescents, and their families who have been exposed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

School-Based Clinics

CHO runs two school-based health centers: one at Castlemont High School and one at McClymonds High School. 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 **$1,000,000 in matching funds** through an Intergovernmental Transfer (IGT) 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 13/14, 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 spend at the ED has shrunk to 3.1 hours. This figure compares with 4.1 hours for CHO's peer group according to studies conducted by McKesson.
- Measure A funding has also helped the ED to upgrade its space to be more kid-friendly and to 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 has gone 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 13/14, 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 13/14, 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 in the last several years. ED encounters can vary due to the severity of flu seasons and other unexpected health trends. Therefore, it is understandable that total ED encounters may change from year to year. However, measurable objectives should still be set and performance measured. This also applies to the CCP and school clinics.

Also, two-thirds of the hospital's $2.5 million allocation helps offset undercompensated costs of ED visits from patients with Medi-Cal. However, the hospital administration states that it is "not reasonable nor possible to tie the Measure A funding to a specific number of patient encounters." The Committee asserts that this can and should be done to ensure accountability for use of public tax dollars.

The average time for providing sickle cell patients with proper pain medication has gone 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: **$151,213** | Expended/Encumbered: **$151,213**

Individuals served by Measure A: **2,285** (Total individuals served: **4,833**)

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

Services provided: Outpatient, Public Health

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

BACKGROUND

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

A program of the Public Health Department, the WIC Oral Health Collaborative program 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.

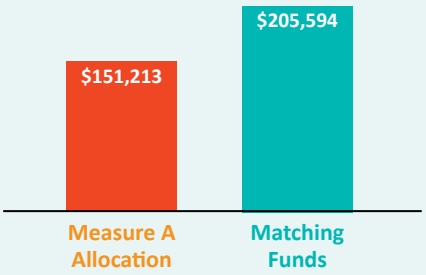
For children who need follow-up care beyond the services provided at the WIC site, the outreach/case manager collaborates with the family to assess insurance coverage, obtain a dental appointment with a provider, and assist with making the initial dental appointment. For families lacking insurance coverage, the case manager 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 914 children with oral assessments and fluoride varnish applications
- Provide 1,371 parents and caregivers dietary and dental health education, anticipatory guidance, and assistance in accessing dental care

Matching Funds



The WIC Oral Health Program leveraged its Measure A allocation to obtain an addition **$205,594 in matching federal funds** from the Maternal, Paternal, Child & Adolescent Health Program (MCPAH) and Child Health and Disability Prevention (CHDP).

- Ensure that 78% of children/families receive care through Medi-Cal
- Increase the parent/caregiver's oral health knowledge and preventive oral health behaviors through the provision of at least six English and Spanish dental health education sessions per month
- Ensure that a minimum of 150 families and children be assisted in getting access to dental providers who are willing and able to provide early care and become a dental home
- Ensure that at least 75% of children enrolled in HKHT visit 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

Highlights

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

Center for Elder's Independence

cei.elders.org

Allocation: **$51,000** | Expended/Encumbered: **$51,000**

Individuals served by Measure A: **123** (Total individuals served: **699**)

Populations served: Indigent, Low Income Adults, Seniors

Services provided: Public Health

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

BACKGROUND

The Center for Elders' Independence (CEI) provides high quality, affordable, integrated health care services to the elderly, which promote autonomy, quality of life, and the ability of individuals to live in their communities.

CEI also supports and educates family caregivers of frail senior participants so they can help keep seniors healthy and safe.

MEASURE A FUNDING SUMMARY

CEI used its Measure A allocation to increase access to medical services for seniors by efficiently assessing and enrolling seniors into the PACE plan. PACE is considered the gold standard of care for frail older adults with multiple, chronic, and complex health care needs—a truly integrated, comprehensive, coordinated, interdisciplinary team-based approach. Specifically, CEI hired and trained an assessment nurse (RN) who worked with Alameda Alliance to develop a risk assessment tool and referral process.

This effort resulted in the following:

- The RN assessed 123 seniors.
- 13 non-PACE eligible referrals were made.
- 70 applications were submitted to the CA Department of Health Care Services (DHCS).
- 66 applicants were certified eligible by DHCS and enrolled in PACE.
- CEI completed care plans for all new enrollees within 60 days of enrollment.

With this funding, CEI has also been able to streamline assessment procedures to be more efficient going forward, and be better prepared for increased referrals when the CCI/Cal MediConnect launches.

Measure A Helps

Mr. G. began to develop multiple health problems that forced him to retire and seek medical help. CEI assessed and enrolled Mr. G., who feels he has found the ideal health care situation for his medical needs, with a team of professionals and aides who work together to help him with every other aspect of his life. And he's met a community of friends with whom he can socialize and share his memories at the PACE center. In addition, Measure A-funded presentations like the one Mr. G. attended let seniors, caregivers, and other community service providers/physicians know about PACE and lead to many CEI enrollments.

Center for Healthy Schools and Communities (School Health Centers)

achealthyschools.org/school-health-centers.html

Allocation: **$1,887,000** | Expended/Encumbered: **$1,887,000**

Individuals served by Measure A: **13,017** (Total individuals served: **13,017**)

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

Services provided: Public Health, Mental Health, Substance Abus

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.

A key component of the Center for Healthy Schools and Communities, the 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.

The SHCs provide services in the following areas:

- Comprehensive school health services in a safe, accessible environment on or near the school campus during convenient hours
- Referrals to necessary health and wellness services
- First aid, medical, and health education services
- Behavioral health services
- Dental health services
- Nonclinical services such as youth development and school climate services

SHC services are accessible. SHCs are open during school hours and often after school as well. 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. Of those clients with data recorded, 28% did not have a primary care medical home, and 33% did not have a regular dental provider.

The SHCs offered a variety of outreach activities over the school year, such as parent workshops, speakers, and other after-school events for the community.

Measure A Helps

A 13-year-old patient was overweight and had high cholesterol, specifically high triglycerides. He was motivated through appointments with the SHC Nurse Practitioner and the RD at Preventative Medicine to make many lifestyle changes. These included increasing his exercise at school during recess, after school, and on weekends with his family. He stopped buying chips and saved that money for other things, drank more water, ate more slowly, and talked more to family during meals instead of automatically getting seconds. His cholesterol is now normal, with a significant decrease in the triglycerides from 200 to 75.

MEASURE A FUNDING SUMMARY

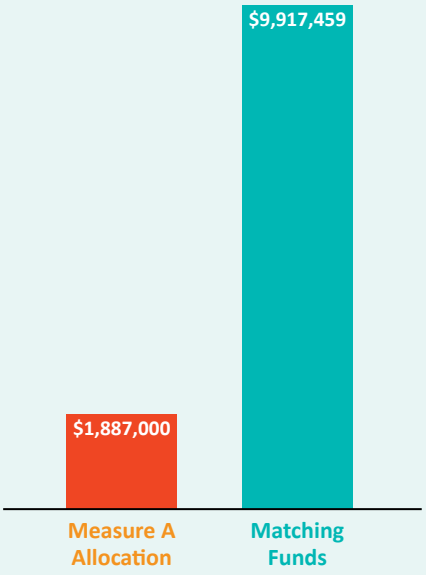
Measure A funds supported 15 of the 25 SHCs. The SHCs achieved the following measurable outcomes in the target service areas:

- Alameda County SHCs continue to expand, now providing programs at one elementary school, seven middle schools, 14 high schools, and one community college.
- SHCs have improved academic outcomes. Without an SHC onsite, many students might have been sent home, rather than having their health issues addressed onsite and being sent back to class.
- Clients return for multiple visits to the SHCs, demonstrating the value of integrated and youth-friendly services.
- Physical health services were provided during 43% of all SHC visits. Individual and group behavioral health services were provided during 28% of all visits to 2,655 clients.
- Sexual/reproductive health services were provided during 32% of all visits. According to clinic data, 46% of female clients reported that they "always" used contraception at baseline, compared to 55% at follow-up.
- At the six SHC sites providing dental services in FY 13/14, 21% of all visits (766 clients) had a dental service provided. These services included screening exams and cleanings, case management, and restorative treatment.

Measure A funds also allowed the SHCs to offer nonbillable services such as youth development. SHC provided leadership development and mentoring through peer health education programs and youth advisory boards, as well as a variety of programming including sports, tutoring, dance, arts, media, and gardening during lunch or after school.

This year, Measure A funds were also used to support a specific equity-focused SHC project: the Latino Men and Boys (LMB) program. This program provides youth development for males of color in five Oakland schools with SHCs. The program collaborates with school administrators, counselors, and the SHC to identify Latino youth that are at risk of dropping out and provides them with intensive mentoring, academic tutoring, and health-related supplemental programs that improve educational outcomes and physical and emotional wellness. In 2014, LMB program participants had over 250 visits at SHCs.

Matching Funds



The SHCs leveraged their Measure A allocation to obtain $9,917,459 in matching funds from local, state, federal, and private sources.

Fire Station Health Portals

Allocation: **$750,000** | Expended/Encumbered: **$268,099**

Individuals served by Measure A: Portal scheduled to open in spring 2015; no clients have been served up to this time

Populations served: Indigent, Low Income, Uninsured Adults, Children, Families, Seniors (*anticipated*)

Services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Mental Health, Public Health (*anticipated*)

Service area: Hayward (*anticipated*)

BACKGROUND

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 ensure optimal health and well-being and respect the diversity of all residents.

The objective of the Firehouse Clinic is to provide a new access point for comprehensive primary and preventative care to communities in critical need of health care services. In addition, the Firehouse Clinic will provide insurance enrollment assistance, connection to a medical home, and emergency department and hospital discharge follow-up. The clinic model in South Hayward, the first site, will reduce wait times for patients seen at community clinics by guaranteeing primary care appointments within 72 hours and providing extended hours. During the first two years of operation, over 5,000 new patients are projected to be seen at the Hayward site, the majority of whom will consist of low income, uninsured, and indigent residents. The intention is to provide services to populations that historically may have been excluded from mainstream health care.

The Firehouse Clinic will accept public insurance, such as Medi-Cal, Medi-Care, and County-sponsored insurance coverage; some forms of private insurance; or a flat-fee payment for particular services. Ability to pay is not a factor in receipt of care.

The clinic model in South Hayward, the first site, will reduce wait times for patients seen at community clinics by guaranteeing primary care appointments within 72 hours and providing extended hours.

MEASURE A FUNDING SUMMARY

Rollout of the first clinic site in Hayward is anticipated in spring 2015. Thus, no clients have been served at the clinic at this time.

Measure A funding for this initiative has been approved by the Alameda County Board of Supervisors for rollover until buildout of the Firehouse Clinic is complete and clinical operations can begin. During FY 14/15 and FY 15/16, Measure A funding will be expended towards this effort: $1.2 million in capital funding to the City of Hayward for construction of the building and $970,000 for the provision of clinical services.

Fremont Aging and Family Services

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

Allocation: **$51,000** | Expended/Encumbered: **$51,000**

Individuals served by Measure A: **123** (Total individuals served: **173**)

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:

- Happy, Healthy Me (HHM). HHM is a chronic condition self-management program that helps elders identify healthy goals through problem-solving and goal-setting. The program assesses 12 areas related to successful self-management behavior and utilizes problem-solving techniques, motivational interviewing, and goal-setting techniques to help the elder establish obtainable goals.
- Medication assistance and counseling. Elders are able to consult with AFS's public health nurse at the weekly Healthy Aging Program. The nurse and nursing students review the elder's medications, check to make sure each person understands one's medications, provide teach-

Measure A Helps

Mr. M., a 69-year-old man from Afghanistan, was living in Hayward but lost his housing. A friend in Fremont offered his storage unit as a place to live and referred Mr. M to the Afghan Health Promoters. When Mr. M. first met with his Health Promoter, he had no income or medical coverage, had high blood pressure and arthritis, and was depressed. The Health Promoter applied for Medi-Cal, food stamps, and general assistance, all of which Mr. M. is now receiving. The Health Promoter is also assisting Mr. M. as he applies for housing and CAPI funds to help afford the housing, as well as helping Mr. M. with his citizenship.

back methods, and if necessary call the person's doctor to request more information on questionable medications or side effects.
- Linkages. The Linkages program provides information, referral, and assistance to Afghan elderly, linking them to a variety of community programs; social services; housing; and other federal, state, and local entitlement programs. The Health Promoters provide translation, transportation, completing forms, and other services as necessary to improve the health and well-being of each person being served.
- Health education groups. In addition to the Healthy Aging Program's weekly presentations on health issues such as nutrition, heart disease, and exercise, the Health Promoter Program also offers extended, evidenced-based groups. Past groups have included a Diabetes group and the Stanford Chronic Disease Self-Management program.

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.

Service Linkage
- Provide health promotion services to Afghan clients (target: 100; actual: 173)
- Offer care from a primary care physician (target: 90; actual: 159 obtaining a primary care physician and/or a health plan)
- Provide health education and socialization from Health Promoters (target: 100; actual: 135)
- Offer home visits (target: 85 clients; actual: 118)
- Conduct home safety evaluations (target: 40; actual: 35)
- Refer clients to City of Fremont case management and/or counseling services (target: 25; actual: 62)
- Provide eligibility assistance and support to access supportive services to clients (target: 100; actual: 103)
- Help clients access other community services (target: 50; actual: 71)

Wellness Plan

Ensure the following:
- Clients complete the Wellness Screen (target: 80; actual: 69)
- Clients develop a Wellness Action Plan (target: 40; actual: 39)
- Clients participate in their Action Plan (target: 30; actual: 32 of the 39 who completed the plan)
- Clients show improvement after six months (target: 30; actual: 17 of the 17 who completed the plan)

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.

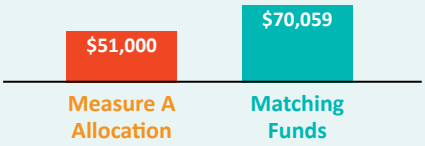
Medication Management

- Provide medication review, education, and counseling (target: 50; actual: 69)
- Utilize "teach back" methodology to show an increased knowledge of medication among clients (target: 50; actual: 69)
- Improve medication compliance within six months for clients identified as having deficits in medication compliance (target: 30; actual: 48)

Chronic Disease Self-Management

- Offer one 15-hour CDSMP class for Afghan participants (target: 18 participants; actual: class not held)
- Achieve participants showing an increase in their ability to manage chronic conditions (target: 12; actual: NA, as class was not held)
- Offer one six-week diabetes class for participants (target: 20 participants; actual: 12)

Matching Funds



The Health Promoters program leveraged its Measure A allocation to obtain **$70,059 in matching funds** from the Fremont General Funds.

Health Enrollment for Children

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

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

Individuals served by Measure A: **520** (Total individuals served: **2,167**)

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

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

Service area: Countywide

BACKGROUND

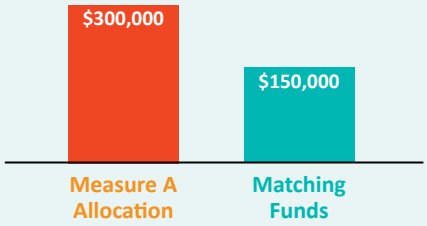
The Alameda County Health Care Services Agency Health Insurance Enrollment Assistance department provides underinsured and uninsured Alameda County residents information, referrals, and application assistance for the following health care and benefit programs: Medi-Cal, CalFresh, Cash Aid, Healthy Families, and Kaiser Child Health Plan.

In 2013, the Health Insurance Enrollment Assistance department began a partnership with the Oakland 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 2,167 Alameda County residents.

Matching Funds



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

Health Insurance Eligibility and Enrollment

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

Individuals served by Measure A: **20,368** (Total individuals served: **277,510**)

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

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

A specific program of HCSA focused on maximizing client access to health services funded by Medi-Cal, through the elimination of system errors created during the Healthy Families Transition and implementation of the Affordable Care Act.

The MEDS error elimination services increase access to care for low income Medi-Cal clients. When the MEDS system blocks a MEDS case, clients seeking nonemergency care are often denied access to care or service providers are not reimbursed for the care they provide.

Staff corrected errors that were generated by the MEDS system and updated information that to ensure correct benefits were applied to the case. These efforts give clients access to affordable, high quality health care provided in the County.

MEASURE A FUNDING SUMMARY

In 2013, a total of 277,510 clients received Medi-Cal Benefits in Alameda County. Data discrepancies cause eligible clients to have an inactive status appear on their record, causing interruptions of care. Measure A funding allowed a team of eligibility workers to dedicate themselves to resolving these types of data/system conflicts, resulting in Medi-Cal records that are active and ensuring continued access to medical care. In FY 12/13, a total of 20,368 discrepant records were corrected by this team.

Measure A Helps

Individuals discontinued from SSI/SSP due to the annual COLA are placed in Craig v. Bonta aid codes 1E aged, 2E blind, and 6E disabled. These individuals remain as "Exception Eligibles" until an SSA eligibility worker completes an eligibility determination. One example: Ms. Smith, a 33-year-old Berkeley resident, suffers from multiple health issues including lupus. She has frequent medical appointments and pharmaceutical needs. Ms. Smith contacted the MEDS EE team in desperate need of assistance. Her eligibility status showed as inactive, and she was unsuccessful in getting assistance from Social Security. The team member resolved the issue, and Ms. Smith was granted access to her doctor and medications.

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

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

Allocation: **$120,131** | Expended/Encumbered: **$120,131**

Individuals served by Measure A: **350** (Total individuals served: **660**)

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

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

Service area: Ashland, Cherryland, 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, unemployed, and underemployed individuals, including at-risk youth, re-entry clients, and migrant workers, reach self-sufficiency through employment and community integration programs.

Through the services of partners St. Rose Hospital in Hayward, Davis Street Health Clinic in San Leandro, California State East Bay's Initiative for Community Wellness in Hayward, and Samuel Merritt University in Oakland, the DLC Healthcare Portal Project provides primary health care services to hundreds of under- and unemployed, mostly migrant workers in Southern Alameda County. The DLC continues to develop culturally competent material for its clientele and to train Peer Health Educators to provide outreach and information services to this population.

The DLC provides services in the following areas:

- Mental health. The DLC provides workshops and informational meetings to help workers' mental health needs and issues related to domestic violence.
- Alcohol and drug. The DLC provides workers with literature about the effects of 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 provides services to the

Measure A Helps

Pedro, 54, came to the DLC to get checked for his stomach and arm pains. Staff checked his height, weight, temperature, and blood pressure, and sent him to give a blood sample to test his blood sugar levels. When he returned to get the test results, staff recommended more tests because of suspected diabetes. After this second test, DLC staff confirmed Pedro's diabetes. They counseled him about his diet and medication, encouraged him to attend nutrition classes, and set up regular blood sugar checks. Pedro's condition has improved greatly, and DLC staff and health partners continue to monitor him regularly.

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.

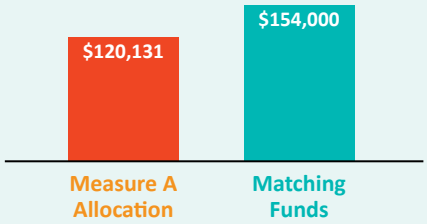
MEASURE A FUNDING SUMMARY

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

Measure A funding helped the DLC achieve the following measurable objectives:

- Offer health-related navigation and referral services specific to the health care needs of the 640 workers within the working-age day labor population at the DLC
- Provide over 900 primary health care referrals for health care screenings and/or episodic care visits
- Conduct 210 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 five 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 several County and City of Hayward meetings
- Train and work with four 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 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 community health, safety, and wellness presentations and/or trainings to unemployed and/or underemployed day labor workers

Matching Funds



The DLC leveraged its Measure A allocation to obtain **$154,000 in matching funds** from foundation sources.

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

Health Services for Day Laborers: Multicultural Institute

mionline.org/

Allocation: **$85,000** | Expended/Encumbered: **$85,000**

Individuals served by Measure A: **1,023** (Total individuals served: **1,023**)

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

Services provided: Hospital Outpatient, Public Health

Service area: Berkeley, Oakland

BACKGROUND

The Multicultural Institute (MI) accompanies immigrants in their transition from poverty and isolation to prosperity and participation.

MI focuses its efforts in the following areas:

- 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.
- Street conditions. MI staff brings its services to about 40–50 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-matching. MI provides no-fee job-matching services for day laborers to receive jobs at a fair minimum wage.
- Skill-building. MI offers different vocational trainings such as skills needed to operate a business, Spanish-language GED preparation courses, and other topics.
- Fair working conditions. MI staff aid workers in redressing problems (wage claims, unsafe conditions, occupational injuries) that result from jobs not obtained through the Institute.
- Community-building and healthy pastimes. Sponsoring events like soccer matches, street cleaning, and a weekly simple shared meal helps break down isolation and leads to new ways of working together.

Measure A Helps

A day laborer came for dental help who had two front teeth that were so rotten, they were ready to fall out. The program assisted him at the onsite dental van. He thought that that was all the care he would need, but he had extractions done along with a deep cleaning. His teeth were so decayed that after the onsite appointments, he was referred to the LifeLong Medical dental clinic for further help. In the end, he received a full set of dentures.

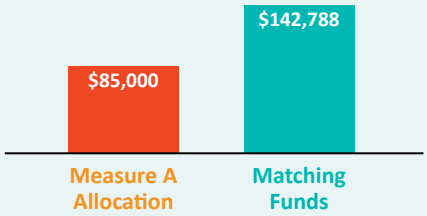
MEASURE A FUNDING SUMMARY

Measure A funding helped MI's Day Laborer program conduct regular outreach to day laborers to inform/give support about clinic services and other health/health education activities (target: 600 unduplicated day laborers; actual: 923).

More specifically, Measure A funding helped MI offer the following in Alameda County:

- Provide health care services onsite or close by (target: 2,800 encounters; actual: 2,726)
- Offer case management and/or referral in conjunction with health services (target: 300 encounters; actual: 508)
- Have clients participate in training or workshops on various topics such as occupational health/safety, sexual health, oral health, substance abuse, nutrition, diabetes and high blood pressure, and health care resources and program enrollment (target: 250 clients; actual: 252)
- Have clients participate in health screenings, receiving referrals as needed (target: 100 clients; actual: 100)
- Provide health care (including dental and mental health) treatment and services via contracted services (target: 700 health care visits/ encounters; actual: 501)
- Provide weekly distribution of Alameda County Food Bank groceries for qualifying low income households (target: 2,000 beneficiaries in 500 unduplicated households; actual: 1,306 beneficiaries in 413 households)
- Develop new partnerships within the County to streamline client integration in new and existing health care services for which they are eligible (actual: 3 partnerships)
- Aid individuals with health insurance coverage requirements and enrollment (actual: 29 individuals)
- Partner with UC Berkeley's School of Social Welfare on project to implement survey to day laborers to gather quantitative data capturing environmental stressors and individual health indicators, resulting in an aggregate data report on depression, anxiety, alcohol use, and sexual behavior (target: 70 day laborers surveyed; actual: 83)

Matching Funds



MI leveraged its Measure A allocation to obtain **two years of matching funds** from the City of Berkeley in the amount of **$71,394 each year**.

Health Services for Day Laborers: Street Level Health Project

streetlevelhealth.org

Allocation: **$85,000** | Expended/Encumbered: **$85,000**

Individuals served by Measure A: **408** (Total individuals served: **1,700**)

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

Services provided: Public Health, Mental Health

Service area: Countywide

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 provides a safe space for people from 33 different countries that speak 34 different languages to receive vital services, information, and referrals. On an average program day participants see a doctor, access mental health services, get vaccinated, receive free medication, eat a hot meal, receive a bag of free healthy food, and enroll in health care coverage, all within the same day and space.

MEASURE A FUNDING SUMMARY

Measure A funds allowed Street Level to develop and implement a new patient screening questionnaire, which involved research and planning, testing out the questionnaire, gathering feedback from community members and health workers, making revisions, and training volunteers. The questionnaire has allowed Street Level to both improve the quality of clinical care and make significantly more tailored referrals to mental health services, recovery resources, gynecology/reproductive services, STI testing, and health care coverage.

Measure A funds also allowed Street Level to deepen the integration of health education into its clinic visits. During FY 13/14, the Street Level nutritionist collaborated with a volunteer to develop nutrition health education materials that volunteers can review with patients as part of the clinic visit.

Measure A Helps

Odsaikhan, 40, came to Street Level Health Project seeking health care. He had chronic thyroid issues and had lost 20 pounds in the last 11 months, with symptoms of sweating, tremors, palpitations, hair loss, appetite changes, and shoulder pain. After Odsaikhan's physical exam, staff diagnosed him with Graves' Disease and hepatitis. Staff referred Odsaikhan to Highland Hospital and connected him to free hepatitis B testing and HealthPAC enrollment, both offered onsite at Street Level. Odsaikhan returned a month later for follow-up care, feeling pleased at his improved health since beginning treatment. Street Level will now support Odsaikhan in transitioning his primary care to a community clinic that meets his needs.

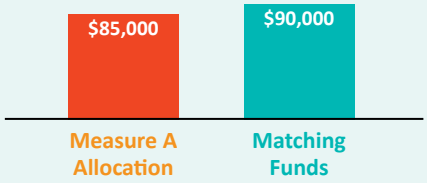
Measure A funds also allowed Street Level to provide Mam (a Mayan language) and Mongolian interpretation to patients and clients. Interpretation was provided within the clinic and during street outreach with day laborers.

Measure A funds helped Street Level to strengthen its health navigation and referral program by hiring a staff member to directly support health navigation volunteers and build the program's infrastructure.

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

- Provide health care screening and episodic care annually to clients across multiple languages (target: 930 unduplicated clients; actual: 817)
- Offer health-related navigation/referral services (target: 800 referrals; actual: 1,438)
- Provide mental health prevention workshops/trainings (target: 10; actual 11)
- Offer mental health consultations/referrals annually to low income immigrant communities in Alameda County (target: 125; actual: 144)
- Provide nutritionist/herbalist consultations (target: 150; actual: 134)
- Offer occupational health, violence prevention, health education, and community wellness presentations to low income immigrants (target: 30 workshops; actual: 31)
- Distribute free healthy fruit and produce food bags to low wage workers and their families (target: 4,000 bags to 400 workers/families; actual: 6,944 bags to 701 workers/families)
- Connect individuals to resources of local grassroots community organizations that provide legal, educational, and social services (target: 850 referrals; actual: 981)
- Provide presentations related to the Affordable Care Act to low wage workers and other community-based organizations (target: 5 presentations; actual: 5)
- 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: 20 collaborative events)
- Participate in meetings regarding health reform and implementation (target: 4 meetings; actual: 5)
- Leverage financial support from private foundations by submitting grant applications for the Health Access Program (target: 4 applications; actual: 8)
- 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: 59)

Matching Funds



Street Level Health Project leveraged its Measure A allocation to obtain a total of **$90,000 in matching funds** from the following sources:

- California Endowment
- Frances K. and Charles D. Field Foundation
- Latino Community Foundation
- San Francisco Foundation
- Thomas J. Long Foundation

Measure A funds also allowed Street Level to deepen the integration of health education into its clinic visits.

Increase Hospice Utilization

gettingthemostoutoflife.org/about-variant-2

Allocation: **$200,000** | Expended/Encumbered: **$182,140**

Individuals served by Measure A: **600** (Total individuals served: **1,000**)

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

Alameda County Health Care Services Agency (HCSA) Human Resources works to ensure that the agency and its operating departments achieve organizational goals through a dynamic, comprehensive, and high quality human resource service delivery.

Hospice is an underutilized Medicare and Medi-Cal benefit of significant value. The Alameda County "Getting the Most Out of Life" (GMOL) program is designed to reduce suffering and improve quality of care for residents of Alameda County through advance health care planning and hospice utilization.

GMOL seeks to accomplish the following:

- Change attitudes about end-of-life planning and hospice
- Increase willingness to advocate for end-of-life and hospice planning for/by Measure A beneficiaries
- Increase knowledge about advance health care planning and hospice
- Increase willingness to refer eligible patients to hospice services
- Increase knowledge of how to improve hospice services
- Increase knowledge of and completion rate of CA Advance Health Directives and the Physician's Order for Life Sustaining Treatment (POLST)
- Determine what percentage of Alameda County deaths are hospice deaths and what percentage of eligible patients receive the hospice option
- Answer the question: Have we increased hospice utilization?

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

MEASURE A FUNDING SUMMARY

Measure A provides 100% of the funding for the GMOL program.

In the area of hospice utilization and data collection, GMOL and HCSA staff used Measure A funding to design an In-Home Support Services (IHSS) pilot. While it is well established that hospice utilization reduces costs, the proposal is to integrate health care and social services into a

system of care for the terminally ill. The innovation is the potential to begin with a robust data collection plan to demonstrate the potential for increasing hospice utilization.

In the area of collaborative stakeholder engagement, Measure A funding helped the GMOL program achieve the following objectives:

- A coalition of hospice provider organizations, donors, and volunteers presented The Art of Aging/Cycles of Life at the Oakland Museum. This free event was attended by 200 people, including a large number of low income and ethnically diverse community members.
- GMOL and the Alameda County Hospice Providers Coalition launched its Conversation Campaign, encouraging people to have a conversation about advance health care wishes and planning before a medical crisis occurs. Results from the Campaign include the following:
  - 253 people trained in Alameda County from 11 ethnic groups.
  - 119 documentation cards returned by participants who made a commitment to have conversation with family or loved ones and return the cards to GMOL.
- Sponsorship of the Death Café in Fremont (South County) and a National Healthcare Decisions Day (NHDD) Expo and Program at the Kaiser Center in Oakland. The Kaiser Center Expo called The Life of Stories attracted 182 attendees, 45 volunteers, and 29 end-of-life care vendors, and resulted in 11 advance directives completed.

Measure A provides 100% of the funding for the GMOL program.

Indigent Health Stabilization

Allocation: **$1,150,000** | Expended/Encumbered: **$1,150,000**

Individuals served by Measure A: **4,284** (Total individuals served: **7,765**) *Total numbers for the four providers who submitted reports and completed work in FY 13/14 as explained in "Background," below.*

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

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

Service area: Countywide

BACKGROUND

The Measure A grant for indigent health stabilization was awarded to six organizations:

- Preventive Care Pathways: $200,000
- Davis Street Family Resource Center: $200,000 (expended: $177,968)
- Healthy Communities: $200,000
- Integrated Medical Associates of Alameda County: $200,000
- Roots Community Health: $150,000
- West Oakland Health Council: $200,000

Preventive Care Pathways

Preventive Care Pathways serves the needs of all that seek pathways towards overall wellness. It offers "Pathways to Wellness" to the general population by providing medical services for at-risk and indigent patients, production and presentation of educational videos and literature, and health care services for individuals re-entering the community from the prison system.

Patients are African-American and other minority patients who are indigent and homeless. Many patients are re-entry patients who typically cannot receive services. Patients receive wraparound services and food, clothing, and shelter, as well as laboratory services and medications.

Davis Street Family Resource Center

Davis Street Family Resource Center (DSFRC) helps people with low incomes in the Eden area and its surrounding communities, which includes the cities and unincorporated areas of San Leandro, San Lorenzo, Castro Valley, Hayward, and Union City, improve their quality of life through short- and long-term assistance.

The full-service primary health care clinic provides critical medical services, as well as dental care, substance abuse treatment, domestic violence prevention, and mental health care. DSFRC serves low income,

Measure A Helps

Preventive Care Pathways

An African male with diabetes, hypertension, neuropathy, and pain had lost his job and was not able to seek care. He had lost 40 pounds due to the neuropathy. Through HealthPac's transition to Medicaid (Alameda Alliance), he was able to be seen at the Preventive Care Pathways clinic and initiate insulin and medication for neuropathy and pain. He has gained 25 pounds and has his diabetes under control. His quality of life has improved significantly as a result of his chronic/acute disease management.

undocumented, and uninsured clients between the ages of 0 and 80+ years.

Healthy Communities

Healthy Communities works to decrease violence and health inequities in people of color in every community in which it offers services. To accomplish this, Healthy Communities collaborates with other community-conscious organizations, churches, businesses, and individuals. Healthy Communities also engages community and political leadership to foster lasting relationships and activities that build a stronger and safer community.

Integrated Medical Associates of Alameda County

Integrated Medical Associates of Alameda County Inc. (IMAAC) provides medical services to low income or no income, transient, homeless, and working poor; unemployed individuals; uninsured adults; individuals recently released from incarceration; immigrant populations; seniors; and other residents of Alameda County in the medically underserved/Health Professional Shortage Area (HPSA).

The IMAAC clinic provides ongoing continuity of care for patients. The majority are African-American and other minority patients who are indigent, unemployed, and homeless. Many of these patients are re-entry patients who typically receive medical services from the emergency department (ED) when they are sick. Patients receive quality medical care, continuity care, referrals to specialists, and follow-up visits, as well as laboratory and imaging referral services.

Roots Community Health

The Roots Community Health funding period was for 18 months, from January 2014 to June 2015. However, the contract was executed in June 2014, so work accomplished will be reported for FY 14/15.

West Oakland Health Council

As of the publication of this report, West Oakland Health Council had not submitted a provider report.

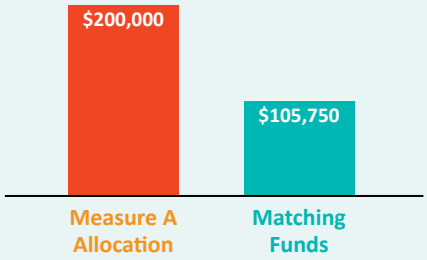
MEASURE A FUNDING SUMMARY

The indigent health stabilization providers used their Measure A allocations to achieve the following:

Preventive Care Pathways

- Become a Covered California Certified Enrollment Entity (CEE). The application was submitted in November 2014.

Matching Funds



Preventive Care Pathways leveraged its Measure A allocation to obtain **$105,750 in matching funds** from the following sources:

- General Assistance funding
- Preventive Care Pathways providers
- Staff providers in-kind services
- Preventive Care Network administration
- Equipment and supplies in-kind services
- Pharmacy and lab donations
- Volunteer services
- Funding generated from uninsured HealthPac patients transitioning to Medi-Cal and other covered services/programs

- Have staff approved and trained as Covered California Enrollment Counselors. Four staff members were identified, and applications were submitted on their behalf in November 2014.
- Designate one staff person to participate in the Covered CA CEE Alameda Partnership meetings. Designated staff has attended two meetings so far.
- Strategize on how to best coordinate enrollment efforts as Alameda County works toward building a "No Wrong Door" approach to enrollment.
- Recruit 1 FTE of each: nurse practitioner, medical assistant, and administrative assistant.
- Provide direct medical service visits to 175 low income County residents on average per month.
- Provide a total of 1,750 patient office visits to HealthPac/transitioning HealthPac patients, who received quality medical care and follow-up care.

Davis Street Family Resource Center

- See a total of 515 patients in the new primary care center. All of these patients were sliding-scale fee-payers and, thus, would not have had access to quality medical care without the existence of the new clinic.
- Pay consultant fees necessary for the development of a federal application for a new federally qualified health center.
- Purchase new clinical equipment including five examination tables, clinician rolling stools, diagnostic equipment, and licenses to electronic health records and a patient management and electronic billing system.

Healthy Communities

- Provide health care coverage and public health services application assistance and/or appropriate referrals for assistance for the re-entry population in Alameda County.
- Increase access to culturally competent support services for West Oakland Health Council (WOHC) re-entry patients through participation in Healthy Communities Health Education, Violence Prevention, and Community Outreach services.
- Make personal contact with Save a Life Wellness Center (SALWC) patients and coordinate with the Alameda Health Enrollment with a new medical home (target: 1,850 total, 1,300 new Medi-Cal/former HealthPac, 150 HealthPac, 400 Medi-Cal; actual: 260 total, 238 former HealthPac, three HealthPAC, 19 Medi-Cal).
- Enroll 33 former SALWC patients with a new primary care provider.
- Become a Covered CA Certified Entity (CEE). HCI became a CEE on 11/02/2013.
- Have staff approved and trained as Certified Enrollment Counselors (CEC). Staff currently includes five CECs, with more going through the certification process.
- Designate at least one staff person to participate in the Covered CA CEE Alameda County Partnership meetings. One staff member has been designated.

Measure A Helps

Davis Street Family Resource Center

The Chin family initially came to DSFRC for the holiday bike give-away and food basket. During the give-away, Davis Street staff did a preliminary screening of family needs. Staff learned that the family had one disabled parent, and the other was severely underemployed. This family was experiencing severe food shortages, two of the children required dental care, and the father needed medical care and management of a chronic condition that was not being monitored. Staff developed a relationship with this family and over the past year witnessed improvement in their medical and social condition. The father is now fully employed, and the children have qualified for medical insurance.

Preventive Care Pathways provided direct medical service visits to 175 low income County residents on average per month.

- Complete development of a mechanism to track benefits program application submission to ensure application approval.
- Conduct five planning meetings with WOHC staff to design referral system enhancements.
- Contract with consultants to provide assistance in the transformation of Healthy Communities. This included the creation of a transformation plan, an initial viability and feasibility assessment report, a nondisclosure agreement, process mapping, a press release, and other documents and instruments.
- Improve the forms used to process clients during intake and initial assessment to help streamline the process and allow for better tracking of outcomes resulting from assistance to clients.

Integrated Medical Associates of Alameda County

- Become a Covered California Certified Enrollment Entity (CEE)—completed .
- Have staff approved and trained as Covered California Enrollment Counselors. One staff members was identified, and an application was submitted on his behalf in November 2014.
- Designate one staff person to participate in the Covered CA CEE Alameda Partnership meetings. Designated staff has attended two meetings so far.
- Strategize on how to best coordinate enrollment efforts as Alameda County works toward building a "No Wrong Door" approach to enrollment.
- Provide application assistance and/or appropriate referrals to patients that are eligible for CalFresh and CalWorks.
- Provide a total of 1,500 direct medical service visits and assistance to low income Alameda County residents. Patients received referrals to laboratories, NorCal imaging, and specialists for preventive services.
- Increase access to health care and public health services for low income residents of Alameda County by providing health insurance and public health services application assistance and/or appropriate referrals for assistance.
- Offer diabetic education for pre-diabetic and diabetic patients.

Measure A helped Healthy Communities to provide health care coverage and public health services application assistance and/or appropriate referrals for assistance for the re-entry population in Alameda County.

CONCERNS

Healthy Communities

The provider report indicates that logistical and other problems interfered with completion of tasks funded by Measure A. There is no indication of when these tasks will be completed.

West Oakland Health Council

No report was submitted. Therefore, there is no evidence of any compliance. The Oversight Committee cannot assume that the funds were used in compliance with Measure A. Until this situation is resolved, the Oversight Committee recommends that this organization should not receive any further Measure A funding.

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**)

Populations served: Children

Services provided: Mental Health

Service area: Countywide

BACKGROUND

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

HCSA oversees certain programs that provide services at the Alameda County Juvenile Justice Center (JJC). Included in these programs are services provided by the JJC Health Services Director. The JJC Health Services Director is responsible for 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 in the community
- 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 and regulations
- Increase collaboration with Probation to enable better access to BHCS services to youth on probation

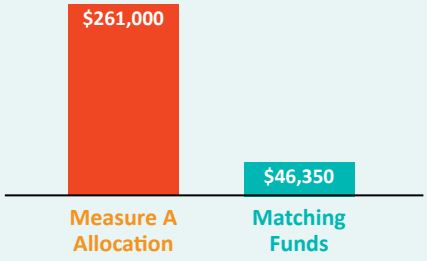
MEASURE A FUNDING SUMMARY

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

The services provided by the JJC Health Services Director contributed to improving the lives of the youth in JJC in the following manner:

- Develop a blended funding model that covers the costs of youth mental health services with no Medi-Cal. This model increased services to 10 youth at any given time a year.

Matching Funds



The JJC Health Services Director leveraged its Measure A allocation to obtain **$46,350 in matching funds** from Maternal Child Health (MCH).

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

- Develop a report on the needs of girls in probation to guide future program development.
- Redesign mental health services to allow for increased staffing in units. This enabled more than one unit to have two clinicians onsite.
- Develop a program model for expansion of $1,000,000 of Medi-Cal billable services to be implemented in FY 14-15.
- Develop a database for tracking psychotropic medications for youth in JJC and Camp Sweeney.
- Develop a process to train probation and BHCS staff working in JJC and Camp Sweeney on trauma-informed care.

Measure A helped the JJC to redesign mental health services to allow for increased staffing in units.

Medical Costs for Juvenile Justice Center: Mind Body Awareness

mbaproject.org

Allocation: **$56,100** | Expended/Encumbered: **$56,100**

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.

MEASURE A FUNDING SUMMARY

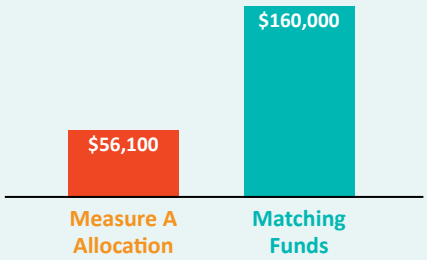
Measure A funding helped MBA achieve the following measurable objectives:

- Provide mindfulness-based classes at the ACJJC. MBA used Measure A funds to deliver mindfulness-based stress reduction programs in several units (1, 2, 3, and 4) of the Alameda County Juvenile Justice Center (ACJJC) as well as Camp Sweeney. Classes took place once per week, for 1.5 hours.
- Offer at least one team-taught (co-facilitated by more than one instructor) class, with a goal of eventually team-teaching all classes. Approximately 55% of classes were team-taught in FY 13/14.
- Provide a minimum of one instructor per class. MBA met this objective for 100% of classes taught. Classes that weren't taught were results of the units being on lockdown, instructor illness, or instructor scheduling issues.
- Collaborate with probation, the medical unit at ACJJC, and Alameda County Behavioral Health Care Services (BHCS) to make sure these agencies are reinforcing services outside of classes. The prior and

Highlights

Research data analyzed in the past year revealed **a significant decrease (19.6%) in perceived stress, a significant increase (23.7%) in healthy self-regulation, and a significant increase in self-esteem (14.1%) from pre- to post-testing**.

Matching Funds



MBA leveraged its Measure A allocation to obtain over **$160,000 in matching funds.**

current MBA Executive Directors met at various times with guidance clinic (BHCS) and probation leadership to collaborate about reinforcing services.

- Complete an evaluation of services. This evaluation included measuring stress and self-regulation quantitatively, and interviewing both ACJJC line staff and youth about the impact of the MBA program. MBA collected data and published some academic journal articles on the efficacy of its work in FY 13/14. The best-quality data was collected from Camp Sweeney.

Measure A Helps

During the time Jerome, an MBA participant, was working through the program, another youth in the unit was egging him on and verbally abusing him. While Jerome wanted to curse at or physically assault the youth, he knew that choice would lead to a new charge. Instead, in his own words: "I just remembered mindfulness and meditation. I took about three or four breaths, and I made a solid decision to walk back to my room and not get in trouble."

Medical Costs for Juvenile Justice Center: Niroga Institute

niroga.org

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

Individuals served by Measure A: **132** (Total individuals served: **315**)

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

Services provided: Mental Health

Service area: Countywide

BACKGROUND

Niroga Institute fosters health and well-being 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 provide the following at the Alameda County Juvenile Justice Center (JJC):

- 13 TLS classes per week serving an average of eight youth each
- Three all-day immersions/retreats serving an average of eight youth each
- Three intersessions with 10 classes per week, serving an average of 12 youth each
- One staff class per week serving an average of five staff each

Highlights

In evaluation surveys, the vast majority of participants expressed positive outcomes such as an increase in self-control, decrease in stress, and healthy habits from Niroga Institute activities: over 80% from weekly youth TLS sessions, 100% from daylong immersions, and 100% from staff classes.

Medical Costs for Juvenile Justice Center: Victims of Crime

alcoda.org/victim_witness/california_victim_compensation_program

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

Individuals served by Measure A: **35** (Total individuals served: **3,125**)

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

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

Service area: Countywide

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

Highlights

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.

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: **$204,000** | Expended/Encumbered: **$204,000**

Individuals served by Measure A: **2,098** (Total individuals served: **3,050**)

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

Services provided: Emergency Medical, Mental Health

Service area: Alameda, Albany, Berkeley, Castro Valley, Emeryville, Hayward, Oakland, Piedmont, Pleasanton, San Leandro, San Lorenzo

BACKGROUND

Preventive Care Pathways offers "Pathways to Wellness" to the general population by providing medical 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.

Preventive Care Pathways primarily serves African-American and other minority patients who are indigent and homeless. The clients receive wraparound services as well as food, clothing, and shelter.

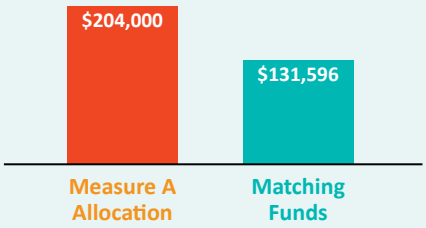
MEASURE A FUNDING SUMMARY

Preventive Care Pathways used its Measure A allocation to provide direct medical and support services, including medical exams and pharmacy and laboratory services, to 645 indigent patients enrolled in the Health Program of Alameda County (HealthPAC).

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 **$131,596 in matching funds and in-kind contributions**.

Primary Care Community-Based Organizations

Allocation: **$5,611,835** | Expended/Encumbered: **$5,611,835**

Individuals served by Measure A: **38,918** (Total individuals served: **175,000**)

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

Services provided: Outpatient, Mental Health

Service area: Countywide

BACKGROUND

The Alameda Health Consortium is a regional association of eight community-based primary care 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. Over 20 different languages are spoken across the health centers.

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

- Asian Health Services
- Axis Community Health
- La Clinica
- LifeLong Medical Care
- Native American Health Center
- Tiburcio Vasquez Health Center
- Tri-City Health Center
- West Oakland Health Council

Highlights

Alameda Health consortium Centers **exceeded the "Healthy People 2020" goals for prenatal care**, both in regards of percentage of patients starting prenatal care in the first trimester and notably in reducing low birth weight deliveries (4.4% vs goal of <7.9%).

MEASURE A FUNDING SUMMARY

The eight Alameda Health Consortium member health centers used their Measure A allocation to provide essential health services—primary care medical, behavioral health, dental—to uninsured, low income (<200% FPL) Alameda County residents.

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

- 39,000 Alameda County residents accessed quality services such as primary care, dental care, and mental health services, as well a prescription medicines at very low costs through HealthPAC.
- Patients made over 111,686 visits collectively to the health centers.
- For dental services alone, patients made over 7,000 visits that included cleanings, examinations, and fluoride treatments.
- In terms of mental health, Measure A funds supported 7,000 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

CONCERNS

Healthy Communities

In addition to the eight clinics that are members of the Alameda Health Consortium, a ninth provider, Healthy Communities (not a member of the consortium) received an allocation of $163,114. No information was provided regarding the use of Measure A funds by Healthy Communities, and no additional report was submitted.

Measure A Helps

From an interview with the son of an undocumented patient at Asian Health Services:

"In Korea, there were only hospitals and no community health clinics. In the United States, with the health insurance and its complicated system, community health clinics play a very important and absolutely humanitarian role to treat the low income population and immigrants. To be honest, we have never been to the hospital in a long time. So, the problem is we don't know what kind of problems we have. My mom was recently able to enroll in HealthPAC at Asian Health Services clinic and saw her doctor a few times already. I know she is almost 60, so we need to watch out for her health especially her diet. Because our family has history of diabetes, she shows some signs of pre-diabetes. "

Actual Visits for Each Consortium Health Center

	Total Patients	Primary Care, Specialty Visits	Dental Visits	Mental Health Visits	Total Visits
Asian Health Services	6,046	14,276	253	459	14,988
Axis Community Health	4,144	11,160	-	2,040	13,200
La Clinica de la Raza	10,041	27,288	2,487	272	30,047
LifeLong Medical Care	4,978	12,995	295	2,505	15,795
Native American Health Center	1,131	2,317	807	122	3,246
Tiburcio Vasquez Health Center	5,399	12,261	1,641	905	14,807
Tri-City Health Center	5,509	13,142	1,259	438	14,839
West Oakland Health Council	1,670	4,157	475	132	4,764
Total	38,918	97,596	7,217	6,873	111,686

Tiburcio Vasquez Health Center, Inc.

tvhc.org

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

Individuals served by Measure A: **2,350** (Total individuals served: **5,500**)

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

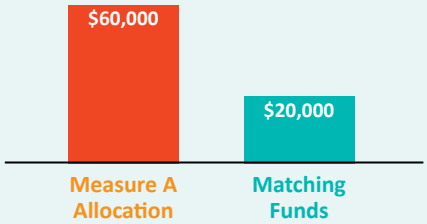
BACKGROUND

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 youth and parent leadership development programs. Providing health education and youth leadership development services helps to ensure that youth receive comprehensive intervention and support. These programs include the following:

- Young Men's & Women's Programs. These programs work to foster leadership and empowerment in young men and women, specifically youth from disenfranchised communities. The programs explore oppression through a social justice lens, community organizing, and personal subjects.
- After School Youth Empowerment Programs. 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.
- Youth Advisory Program/Peer Navigator Program. 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, organizing an annual health fair, and participating in community activities that promote leadership, community involvement, and civic participation.
- CAFÉ Parent Engagement Program. At CAFÉ (Club de Aprendizaje Para Una Familia Estable), parents learn about domestic violence and immigration reform policies such as Deferred Action for Childhood

Matching Funds



TVHC leveraged its Measure A allocation to obtain an addition **$20,000 in matching funds** from the Latino Community Foundation.

Providing health education and youth leadership development services helps to ensure that youth receive comprehensive intervention and support.

Arrivals (DACA). The program strongly fosters leadership development among participants.

- Health Education/Family Planning. The school-based health centers provide one-on-one health education visits to youth. Students receive individual counseling regarding family planning education, pregnancy prevention options, and STI/HIV education. Additionally, wraparound care is provided by case management to ensure all students are provided support and care to meet their health needs.

MEASURE A FUNDING SUMMARY

Measure A funding helps make it possible for TVHC to continue to provide school-based youth outreach, health education, case management services, and parent engagement to high school students and their parents through the Tennyson and Logan health centers.

Measure A funding helped TVHC achieve the following measurable objectives:

- The Health Educator(s) and Youth Leaders coordinated a multi-racial young women and young men's empowerment program that met weekly, reaching a total of 30 youth.
- The health centers served and provided outreach to over 5,000 students to educate and promote the health center services.
- The centers conducted 868 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, attracted approximately 90 parents to weekly workshops. Since August 2013, a total of 34 workshops have been organized, on topics including natural health nutrition, how to navigate the education system, immigration laws, health care reform, college readiness, and more. CAFÉ also graduated 90 parents.
- Teams of Health Educators and Peer Health Educators provided presentations about the health center and a range of health topics to roughly 1,000 students.
- Health Educators conducted 1:1 health education counseling sessions with a total of 200 students.
- 50 students received training to become Peer Educators. Students were introduced to a variety of topics to share with their peers.
- Students have used the outreach and health promotion strategies learned in their weekly workshops to promote pregnancy prevention on their respective campuses. Their presentations have led to over 300 students registering as new patients at Tiburcio Vasquez Health Center.
- The Hip-Hop Elements program hosted a hip-hop freestyle dance event that attracted over 200 youth and community members.
- TVHC helped train and develop 15 YAB members.
- For the annual health fair, 20+ community organizations and local agencies participated. The event reached over 200 students.

Measure A Helps

A Latina client came into the health center having suicidal thoughts. During her meeting with the Health Educator, it became clear that the client's anxiety was high and that she was having thoughts of self-harm. The health center contacted her parents and informed them of what was occurring, reassuring them that the client was safe, and then the client was taken to a psychiatric hospital for evaluation. A week later, the client returned and has been checking in regularly ever since. She is receiving outpatient therapy, continues to be involved in the Young Women's Empowerment group, and is planning to participate in the Summer Health Justice Leadership Academy.

The health centers served and provided outreach to over 5,000 students to educate and promote the health center services.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 4: PUBLIC HEALTH

Alameda Boys & Girls Club, Inc.

alamedabgc.org

Allocation: **$102,000** | Expended/Encumbered: **$102,000**

Individuals served by Measure A: **2,000** (Total individuals served: **5,175**)

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 these 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.
  - 424 youth participated.
  - Four informational events/workshops were held.
  - 278 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.
  - 1,462 youth participated.
  - 94 workshops were held.
  - 324 clients participated in daily programming, with 91.5% showing improvement.
- Get Cooking nutrition and healthy cooking program. Students participating in health, nutrition, and fitness programs reported an

Measure A Helps

One of five children, club member Lavell was raised by his single mother, who died from an illness when he was 13. He and his siblings moved in with their aunt, who also died from an illness. At the Boys & Girls Club, Lavell assisted in Get Growing and Get Cooking. He became interested in transforming vegetables, fruits, and herbs into delicious, nutritional food. While Lavell was working as a Program Assistant at the Club he was also taking college courses, drumming with the Drum Corps, and teaching poetry workshops to Club teens. Lavell won the 2014 Youth of the Year award and received the $2,000 Sally Rudloff Scholarship.

increase in stamina, better weight management, and higher energy levels. They influenced their parents and families to be more healthy and fit as well.

- 413 youth participated.
- Two informational events/workshops were held.
- 93% of youth showed improvement.

- Get Growing sustainable garden.
  - 306 youth participated.
  - Two informational events/workshops were held.
  - 90% of youth showed improvement.
- Physical recreation.
  - 1,923 youth participated in gym fitness or outdoor recreational activities.
  - Five informational events/workshops were held.
  - 100% of youth showed improvement.

Participants demonstrated a decrease in confrontational incidents and improvement in pursuit of healthy lifestyles, such as not smoking and avoiding drugs and alcohol.

Alameda County Asthma Start

acphd.org/asthma.aspx

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

Individuals served by Measure A: **46** (Total individuals served: **367**)

Populations served: Children

Services provided: Public Health

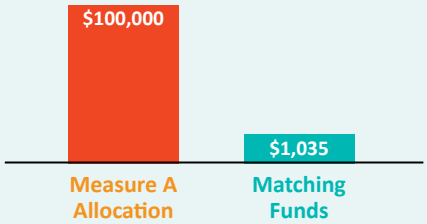
Service area: Countywide, Homeless or transient, Outside of Alameda County

BACKGROUND

A program of the Alameda County Public Health Department, 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 identified issues around healthy homes. Families are given supplies to assist in 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.

Seventy-four percent of the children/adolescents seen last year were covered by a Medi-Cal program and from low income families. Asthma Start is the only program in the County doing in-home asthma case management. Physicians do not see their patient's home, so medication can be given but control may not be obtained.

Matching Funds



The Asthma Start program leveraged its Measure A allocation to obtain **$1,035 in matching funds** from Targeted Case Management (TCM) and Medi-Cal Administrative Activities (MAA).

MEASURE A FUNDING SUMMARY

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: 99%)
- Help children maintain or reduce asthma symptoms to the lowest level (target: 95% of children; actual: 98%)
- 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: 12% needing hospitalization, 16% 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%)

Berkeley Food & Housing Project

bfhp.org

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

Individuals served by Measure A: **6** (Total individuals served: **275**)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Berkeley

BACKGROUND

Berkeley Food & Housing Project provides emergency food and shelter, transitional housing, permanent housing, and housing placement with support services to homeless individuals and families.

Berkeley Food & Housing Project's North County Women's Center serves homeless or formerly homeless women and children, many of whom are domestic violence survivors. About 80% of the women served are from disadvantaged populations, minorities, and of extremely low socioeconomic status.

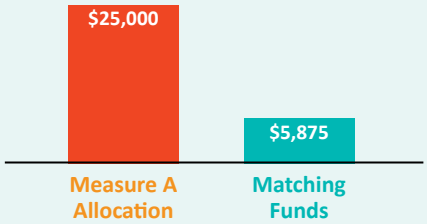
MEASURE A FUNDING SUMMARY

Berkeley Food & Housing Project used its Measure A allocation to increase access to medical, mental health, and public health services to women and children. To meet this objective, Berkeley Food & Housing Project offered the following:

- Health screenings and workshops. All of the clients were presented with the opportunity to attend two health fairs, weekly onsite clinics, and women's health workshops.
- Cooking and nutritional instruction. Eight clients in the transitional housing program graduated from a six-week cooking instruction course designed to help them gain vital life skills that would allow them to be self-sufficient once they moved into their permanent housing. The cooking course also helped the women prepare affordable meals while maintaining a healthy and nutritious balance of ingredients.
- Exercise and recreational activities. Zumba exercise dance was introduced.
- The program served 275 women and children at its North County Women's Center in FY 13/14.

Berkeley Food & Housing Project also provided clients linkages, referrals, and access to health care and behavioral health care services through the U.C. Berkeley Suitcase clinic, LifeLong Medical clinic, and Berkeley Mental Health to 75% of the clients served. This has positively reduced one of greatest barriers this population faces: access to health care services.

Matching Funds



Berkeley Food & Housing Project leveraged its Measure A allocation to obtain **$5,875 in matching funds** from Medi-Cal Administrative Activities (MAA).

Center for Early Intervention on Deafness

ceid.org

Allocation: **$51,000** | Expended/Encumbered: **$51,000**

Individuals served by Measure A: **790** (Total individuals served: **1,210**)

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, Union City

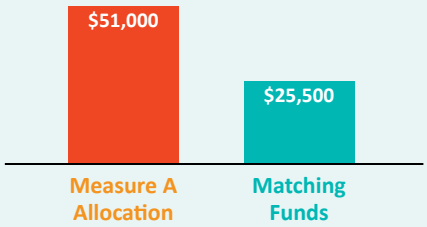
BACKGROUND

The Center for Early Intervention on Deafness (CEID) works to maximize the communication potential of young children (0–5 years old) who are deaf, are hard of hearing, or have severe speech and language delays by providing exemplary early start educational services. CEID strives to create a diverse, inclusive, and educationally rich environment to empower students and their families with the academic and social tools needed to reach their full potential.

As one of the few audiology providers in the area that accepts Medi-Cal patients, CEID provides a critical service to an underserved population. Its waiting times are significantly shorter than other clinics, and it provides services in the language of the patient (two staff members are bilingual Spanish/English). 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.

CEID provides audiological services, including hearing evaluations and dispensing of hearing devices, to Alameda County children, many from low income, ethnically diverse families. Without the availability of CEID's audiological services, many of these children would be undiagnosed and would not have proper hearing devices. In addition, CEID provides regular trainings to pediatric residents from Alameda County hospitals in the early identification of hearing loss and the resources available to them and their patients.

Matching Funds



CEID leveraged its Measure A allocation to obtain **$25,500 in matching funds** from Medi-Cal Administrative Activities (MAA).

MEASURE A FUNDING SUMMARY

Measure A funding helped CEID provide the following services:

- Newborn hearing screenings (target: 120 patients; actual: 155)
- Audiological evaluations (target: 250 patients; actual: 269)
- Hearing aids and molds (target: 275 patients; actual: 225)
- Hearing screenings/Head Start (target: 100 patients; actual: 108)
- Training for pediatric residents (target: 70 residents; actual: 74)

City of San Leandro

sanleandro.org

Allocation: **$51,000** | Expended/Encumbered: **$51,000**

Individuals served by Measure A: **70,008** (Total individuals served: **189,141**)

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

Specific target and actual numbers are as follows:

- Blood pressure/weight checks (target: 360, actual: 579)
- Mercy Brown Bag program—Grocery bag of nutritional food monthly to eligible seniors (target: 576; actual: 593)
- Health education classes (target: 6 classes; actual: 12)
- Pull Up a Chair exercise class (target: 720 participants; actual: 891)
- Fall prevention class (target: 3,600 participants; actual: 6,675)
- Referral to additional health and wellness programs and services (target: 30% of participants; actual: 40%)

CONCERNS

From the information provided, it is not clear whether the City of San Leandro prioritized and/or ended up serving underserved populations.

Measure A Helps

Melody, in her 70s, lives by herself and has no family in the area. She is faced with many health challenges, among them chronic obstructive pulmonary disease and leukemia. Her Social Security check is her sole income, and often she doesn't have enough funds to meet her basic needs. Through City of San Leandro programs, each month Melody receives a free blood pressure check, and twice monthly she picks up a nutritious bag of groceries from the Mercy Brown Bag program. When her health permits, she volunteers at the Senior Community Center, where she also attends multiple drop-in social programs, a handicrafts class, and many community education programs.

Eden Youth and Family Center

eyfconline.org

Allocation: **$160,000** | Expended/Encumbered: **$160,000**

Individuals served by Measure A: **440** (Total individuals served: **42,000**)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Ashland, Castro Valley, Cherryland, Fremont, Hayward, San Leandro, San Lorenzo, Union City, Homeless or transient

BACKGROUND

Eden Youth and Family Center (EYFC) provides and supports a comprehensive array of public health, mental health, outpatient, substance abuse, and other services and advocacy for children, youth, and families in South Hayward and throughout Alameda County. The vision is to create a multiservice agency that serves as a hub to draw critical services to enhance the economic, social, educational, and health needs of community members.

EYFC staff use early intervention strategies for youth that are at risk of lapsing into self-destructive behaviors, such as gang membership, violence, alcohol and drug problems, personal and family crisis, and physical and mental health issues. EYFC teaches them the importance of nutrition, peer support groups, leadership skills, adult/peer mentoring, organizational skills, critical thinking, community involvement, education, training, life skills, career preparation, and employment and job retention.

EYFC partners and links with public and private community organizations to ensure public and mental health resources are available for children, youth, and families to improve the delivery of services. EYFC is currently in contact with several school districts, youth organizations, and employers on a regular basis.

EYFC partnerships include the following:

- The Children's Hospital & Research Center Oakland Center for Child Protection offers a full range of medical and mental health services to children and adolescents impacted by abuse and/or exposure to violence.
- The California Offender Program Services is a diversion program that offers classes to address offenders who are minors.
- The Community Alliance for Special Education provides individual technical assistance, consultations, representation, and training through their network of educational and legal specialists.
- The Hayward Community School provides educational opportunities for 40-50 referred students, ages 12–17, whose behavior prevents their

Measure A Helps

A female youth at EYFC has addictions to marijuana, tobacco, and alcohol. She remains wary and sensitive about discussing these topics. Two high schools have expelled her, and she has been arrested multiple times. EYFC staff had a difficult time getting this youth involved in multimedia projects, but slowly she began to open up. She has begun to learn graphic design and has spent time in the music studio. She has improved her language and opens up about her personal conflicts. She now completes multimedia projects and is starting to think about a career. Dependent on getting a work permit, she will receive an internship in EYFC's sister program.

success in a regular school setting.

- The Silva Pediatric Medical Clinic is a pediatric primary health care clinic serving the residents of Hayward and surrounding communities.
- The La Familia Counseling Service family advocate provides families with insurance information and application assistance for Medi-Cal through additional partner clinics.
- The Tiburcio Vasquez Health Center mental health worker provides Hayward Community School students with mental health assessments, treatment and rehabilitation services, and consultation with staff at mental health agencies, and conducts clinical supervision of the mental health staff and its administrative services.

MEASURE A FUNDING SUMMARY

EYFC used its Measure A allocation to support implementation of a youth program expansion plan and a financial sustainability plan.

Specifically, EYFC created a system (through its own programs and collaborative partners) that blends academic education, occupational training, career/life skills training, work-based learning, and multidimensional wraparound public and mental health support services to create a rich, holistic, client-centric learning environment.

Through these program enhancements, Measure A funding helped EYFC achieve the following objectives:

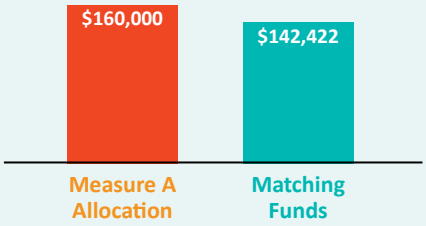
- Provide youth paid career and employability competency workshops to improve behavioral health in terms of intrinsic motivation, locus of control, and self-esteem (target: 100 youth; actual: 245)
- Provide youth with paid work experience opportunities that match their interest and aptitudes to improve connections to peers, adults, and community members (target: 100 youth; actual: 198)
- Provide youth with educational support services related to academic tutoring, GED preparation and testing, career coaching, financial aid advice, and scholarship opportunities to improve behavioral health in terms of attendance and engagement in classroom (target: 75 youth; actual: 540)
- Provide youth access to high end video, graphic, web design, music production, and film production tools (target: 75 youth; actual: 337)
- Provide youth with gang tattoo removal treatments to make positive behavioral changes by removing symbols of past behaviors associated with gang and drug activities (target: 75 youth; actual: 195)
- Through EYFC service provider La Familia Counseling Service, provide families with insurance information and application assistance for Healthy Families and/or Medi-Cal through additional partner clinics (target: 50 families; actual: 50)
- Through La Familia Counseling Service, match families and youth with community resources (target: 50 families; actual: 50)

Highlights

The program serves a community of high need in South Hayward, and has developed a **long-term strategic plan** to help area youth and families.

The program works collaboratively with its network of partnerships, which **increases the effectiveness of all the organizations**.

Matching Funds



EYFC leveraged its Measure A allocation to obtain **$142,422 in matching funds** from the following grant contracts:

- Alameda County Probation Department Evening Reporting Center: $33,280
- Alameda County Social Services Summer and Afterschool Youth Employment Program: $45,500
- Kaiser Permanente (New Start Tattoo Removal Program): $9,600
- EYFC Administration: $54,042

Emergency Medical Services (EMS) Corp

acphd.org/ems-corps.aspx

Allocation: **$602,800** | Expended/Encumbered: **$598,544**

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 through youth development, mentoring, and job training.

The EMS Corps recruits young men of color from low income/ underserved communities. Some EMS Corps participants are from the Camp Sweeney First Responder Program, a 10-week curriculum-based program offered in partnership with the Alameda County Probation Department. The EMS Corps also accepts referrals from the Alameda County Pipeline Partnership and various community-based organizations.

EMS Corps program recipients perform community service and receive a monthly stipend. The EMS Corps graduates enter the EMS workforce as EMTs, Health Coaches, and Health Technicians. Some graduates enroll in college and take advantage of the EMS Corps Fire Academy. EMS Corps students are reaching a younger generation of boys and young men of color by volunteering their time at middle and high schools, teaching life-saving skills to other students.

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 attending an EMT training course, consisting of 136 hours of instruction and 24 hours of supervised clinical experience
- Mental health services for 40 EMS Corps youth including weekly Healing Circles and 90 hours of individual psychotherapy sessions, self-care reform, and health and wellness
- Mentorship, case management, life coaching, and academic tutoring

Program results include the following:

- 35 EMS Corps youth are certified EMTs.
- 30 are employed.
- 20 youth participated in the Camp Sweeney First Responder program.

Measure A Helps

EMS Corps graduate Dexter Harris was once incarcerated at Camp Sweeney. He attended and graduated from the First Responder program at the Camp. Once he was released, he enrolled and graduated from the EMS Corps. Currently, he works for Paramedics Plus as an Emergency Medical Technician. Dexter also graduated from the BAY EMT Fire Fighter academy through a partnership with Merritt College. Dexter wanted to give back to the young men at Camp Sweeney, so he became a Lead Instructor, teaching the First Responder program to Camp Sweeney youth. Dexter was featured in the PBS News hour story on the EMS Corps as well The Robert Wood Johnson Foundation "Promise Story" on the program.

Environmental Health: Improve Field Sanitation Conditions/Nail Salons

.acgov.org/aceh/healthynail/index.htm

Allocation: **$0** | Expended/Encumbered: **$12,319** (This provider received its allocaton in FY 12/13 but expended it in FY 13/14.)

Individuals served by Measure A: **383** (Total individuals served: **383**)

Populations served: Low Income Adults

Services provided: Public Health

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

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 HNSR program achieves its goals through the following activities:

- Identifying highest risk nail salon products and practices and assisting salon owners and workers 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

Measure A Helps

Vicky's Nails in Alameda is the largest salon to become certified in Alameda County so far. Owner Xuan Huynh has actively sought to create a healthy work space as well as a safer space for clients. Because most workers eat lunch at the salon, Mr. Huynh moved all volatile chemicals to a location at least 15 feet away from the break area. With these storage practices, installation of new air purification equipment, and increased use of gloves and other protective equipment, Vicky's Nails has become a healthier place for workers and clients. Xuan Huynh actively promotes his salon's Healthy Nail Salon status with signage and information on his website.

MEASURE A FUNDING SUMMARY

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

- Notify over 330 Alameda County nail salons about the HNSR Program by mail
- Through the CA Healthy Nail Salon Collaborative, notify an additional 35 Alameda County salons that are members of the Collaborative
- Provide workshop training to 21 salon owners and workers
- Receive applications from 17 salons for HNSR recognition
- Replace between 25% and 50% of nail polish products at eight salons with safer formulations
- Install approved air purification units at seven salons
- Recognize eight salons as Healthy Nail Salons

Highlights

The program leveraged its Measure A allocation by teaming with Asian Health Services for an **in-kind match of donated staff hours valued at $9,00**0 and by collaborating with Supervisor Wilma Chan for recognition of participating salons.

HIV Education and Prevention Project of Alameda County (HEPPAC)

casasegura.org

Allocation: **$31,000** | Expended/Encumbered: **$31,000**

Individuals served by Measure A: **592** (Total individuals served: **1,492**)

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

Services provided: Public Health, Substance Abuse

Service area: Countywide

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.

HEPPACs wound care services are available throughout the week at exchanges, during outreach, during syringe exchange services hours, and at HEPPAC's Casa Segura location. Clients have reduced the mortality and morbidity related to active substance use as a result of HEPPAC services.

MEASURE A FUNDING SUMMARY

Measure A has contributed to improving the overall health results of 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 who generally do not access traditional hospital and clinic settings.

HEPPAC used its Measure A allocation to achieve the following measurable objectives:

- Administer care for soft tissue damage due to injection drug use, and dispense prescriptions of antibiotics by a qualified medical professional at the Casa Segura clinic and syringe exchange locations (target: 600 wound care visits, 50 unduplicated clients; actual: 305 visits, 100 unduplicated clients)
- Provide wound care follow-up services to intravenous drug users (IDUs) at both the Casa Segura clinic and syringe exchange program (target: 100 visits; actual: 46)
- Provide wound care and general health care referral services to various local health care agencies, including Highland Hospital (target: referrals

Measure A Helps

Client O., 48, has utilized HEPPACs Tuesday Fruitvale syringe exchange site for the past five years. He has completed at least nine substance use treatment programs, almost lost his left leg due to an untreated abscess, and has lost communication with his family. O. receives wound care services and education on vein rotation during his exchange visits. He has established a small network of peers who also utilize HEPPACs syringe exchange services, and they congregate over food each week during their exchange visits. Through HEPPACs transportation assistance service, O. is able to visit the Casa Segura site, where he showers, washes clothes, and volunteers his time while staying off the streets.

for 20 unduplicated clients; actual: 65)

- Provide patient and health education and trainings during wound care visits with IDUs on topics such as safer injection and overdose prevention (target: 100 visits/trainings; actual: 120)
- Provide STI screening and/or HIV/HCV rapid testing at the Casa Segura clinic, and then provide treatment for those who test positive for chlamydia and/or gonorrhea at HEPPACs Casa Segura Drop-in Center (target: 100% of clients who test positive for HIV/HCV; actual: 100%)
- Refer IDUs and/or their sexual partners who test positive for HIV and/or HCV to primary care services as needed (target: 100 referrals to 50 unduplicated clients; actual: 171 referrals to 52 unduplicated clients)
- Provide risk-reduction education and awareness to at-risk youth, young adults, and IDUs and/or their injecting and sexual partners (target: 100% of youth who access STI testing services; actual: 100%)
- Install and maintain the syringe drop box by collecting on a weekly basis any used and dirty syringes placed in the box; in addition, survey the drop box location and collect any loose syringes in the immediate area (target: collect 5,000 syringes; actual: 3,483)
- 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 to properly dispose of used syringes and reduce the risk of HIV and HCV (target: 100 IDU clients; actual: 132)

Measure A helped HEPPAC to administer care for soft tissue damage due to injection drug use, and dispense prescriptions of antibiotics by a qualified medical professional at the Casa Segura clinic and syringe exchange locations.

LIFE ElderCare

lifeeldercare.org

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

Individuals served by Measure A: **38** (Total individuals served: 42**0**)

Populations served: Low Income Seniors

Services provided: Public Health

Service area: Fremont, Hayward, Newark, Union City

BACKGROUND

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

LIFE Elder Care programs include fall prevention, 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 public health services for seniors living in Fremont, Newark, and Union City through fall prevention programs to reduce the number of falls among seniors and risk of falling for at-risk seniors. The programs achieved the following:

- 80% of seniors participating in the programs 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.
- 76% of enrollees express reduced fear of falling post-program.
- 78% of enrollees had improved times on the Single Leg Stand test post-program vs. pre-program
- 65% of enrollees had improved scores on the Berg & Tinetti Balance Tests post-program vs. pre-program.
- 67% of enrollees had improved scores on the Timed Up & Go test post-program vs. pre program.

80% of seniors in the programs demonstrated fewer falls in the three months after they enrolled than in the three months prior to enrollment.

LifeLong Medical Care: Heart 2 Heart

lifelongmedical.org/services/heart-2-heart.html

Allocation: **$200,000** | Expended/Encumbered: **$200,000** (2-year contract, $100,000 per year)

Individuals served by Measure A: **1,230** (Total individuals served: **1,230**)

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

Services provided: Public Health

Service area: Berkeley

BACKGROUND

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

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

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

MEASURE A FUNDING SUMMARY

Measure A was the major funder for H2H services in FY 13/14.

The LifeLong H2H program used its Measure A allocation to achieve the following measurable objectives in its four target areas.

Increase access to public health services to residents in South Berkeley by working collaboratively with existing neighborhood groups (such as neighborhood watch or charge-related groups) to address common priorities.

- Provide health education to neighborhood groups, such as the health ministry of a local faith congregation, to equip and familiarize their members with information so that they can help others find health and social services they need. Outreach included 12 Health Hubs, 10 Mobile Van events, two farmers market events, and 16 Health Advocate workshops.
- Distribute mini-grants to support stronger networks among neighbors, foster leadership, and build capacity opportunities for healthy behaviors. H2H awarded the following mini-grants:
  - McGee Avenue Baptist Church. Partnering with the Youth Advocacy Initiative, McGee conducted trainings on gardening and nutrition to

Measure A Helps

Mr. Davis, a diabetic, lives in the H2H neighborhood. During a barbershop Health Hub event, a team member noticed Mr. Davis was limping. The team member found out that Mr. Davis's toe had turned black and that he was in severe pain. The team member made a doctor's appointment for Mr. Davis's foot to be looked at the next day. Later that month, Mr. Davis explained his toe was badly infected and needed to be amputated, and that the same leg had multiple ulcers. He thanked the team member for encouraging him to see his doctor and was very grateful to have seen H2H that day.

teach youth how to become leaders and advocates by exploring the benefits of a healthy diet. Along with the youth trainings McGee also engaged adults by hosting trainings on how to choose healthy foods.
  - Lunch Love Community Documentary Project. This project held two events focused on concerns regarding health, nutrition, and food justice. Both events provided participants with a healthy meal, food justice films which were shot locally, and a discussion panel.
  - Farm Fresh Choice/ Ecology Center. Farm Fresh Choice provides healthy, organic, locally grown produce to South Berkeley residences. They used their grant to hire a youth outreach worker to run their stand.
- Assist in the coordination of door-to-door neighborhood visits twice a year, in coordination with the Alta Bates Summit Ethnic Health Institute and Alameda County Health Pipeline Partnership, to promote healthy behaviors. H2H held two door-to-door outreach events.

Increase access to public health services to residents in South Berkeley by supporting individuals to make healthy choices

- Provide monthly information and referral services through the mobile van. Each monthly mobile van has a theme to provide opportunities and resources for the community.
- Train and support staff at local barbershop Health Hubs to provide heart health information to costumers.
- Offer fresh produce at all H2H events.

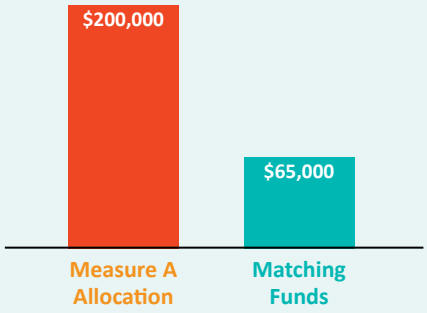
Increase access to public health services to residences in South Berkeley by engaging residents in activities to promote healthier behaviors

- Recruit seven neighborhood residents to attend Health Promoters Program. Health Promoters are trained to conduct a health analysis to prioritize health concerns and the root causes in their community; disseminate information and education about LifeLong; provide health education; and support the implementation of the Affordable Care Act.
- Train and certify seven Health Promoter residents on topic including health leadership, team development and effectiveness, and health-specific issues.
- Mentor and coordinate activates of Health Promoters to lead community-building efforts, provide health promotion messages to individuals and community groups, and link residents to health services and health insurance as appropriate. Each certified Health Advocate attended and/or performed outreach at least two events.

Increase access to public health services to residents in South Berkeley by evaluating the effectiveness of the H2H project.

- Evaluate the effectiveness of the H2H project in achieving its intermediate goals of creating a community in which prepared providers and community partners work with informed patients with hypertension. Focus groups have been completed and initial analysis will be reviewed.

Matching Funds



LifeLong H2H leveraged its Measure A allocation to obtain **$65,000 in matching funds** from the City of Berkeley.

Partnering with the Youth Advocacy Initiative, McGee conducted trainings on gardening and nutrition to teach youth how to become leaders and advocates by exploring the benefits of a healthy diet.

Public Health Prevention Initiative

Allocation: **$3,135,037** | Expended/Encumbered: **$2,278,231**

Individuals served by Measure A: **108,802** (Total individuals served: **148,751**)

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

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

Service area: Countywide, Outside of Alameda County

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.

Chronic Disease & Injury Prevention

- Asthma Start. Provides in-home case management to families of children/adolescents with asthma, including asthma education and a care plan for the family. For information on this program, see the separate "Asthma Start" entry on page 94.
- Diabetes. Provides self-management education to adults with type 2 diabetes, including classes, a support group, and a monthly newsletter.
- Healthy Kids Healthy Teeth. 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. For information on this program, see the separate "Alameda County Dental Health" entry on page 57.
- Project New Start. Provides services to build on youth assets and positive development, focus on environmental change, promote protective factors while preventing risk factors, and collaborate consistently and holistically.

Measure A Helps

PROJECT NEW START

From program participant Tony: "After high school, I had no direction. I didn't even know how to get into college. Having nothing to do caused me to do stupid things, such as getting tattoos. After I got a tattoo on my hand, I realized I made the wrong decision. I enrolled in Project New Start, which changed my life. Project New Start has a very good way of requiring us to seek help from a mentor. My mentor Mike has helped me succeed in school, work, and socializing. Eventually I was able to get the job that I've always wanted, and I am working for EVA airways at SFO."

- Dating Matters/Teen Violence. Exposes 11- to 14-year-olds to healthy relationship competencies and promotes pro-social relationship norms to support the development of healthy relationships and prevention of adolescent dating abuse.
- Senior Services: Day Break Adult Day. Assists seniors in gaining knowledge about the proper use of medications and reduces the number of illnesses, hospitalizations, and emergency department visits due to mismanaged medications.
- Senior Services: St. Mary's. Assists older adults in getting knowledge about the proper use of medications and reduces the number of illnesses.
- Senior Services: City of Fremont Health Promoter Project. Provides access to health resources and guidance to low income, frail, primarily homebound, Afghan elders. For information on this program, see the separate "Fremont Aging and Family Services" entry on page 63.
- Senior Services: Senior Injury Prevention. Maximizes independence of older persons by removing individual and social barriers and providing needed services. For information on this program, see the separate "Senior Injury Prevention Program" entry on page 122.
- Senior Services: Senior Support of Tri Valley. Assists seniors in gaining knowledge about the proper use of medications and reduces the number of illnesses, hospitalizations, and emergency department visits due to mismanaged medications.
- Senior Support Services: United Seniors of Oakland & Alameda County. Assists seniors in gaining knowledge about the proper use of medications and reduces the number of illnesses, hospitalizations, and emergency department visits due to mismanaged medications.

Health Inequities & Community Capacity-Building

- School Health and Community Nursing: Berkeley School-Linked Health Services (SLHS) Program. Collaborates with Berkeley Unified School District (BUSD) and other agencies to develop and implement a coordinated service delivery model that links students, families, and school staff to needed resources, with a special focus on attendance and truancy.
- School Health and Community Nursing: City and County Neighborhood Initiative. Provides vital medical, health education, and community-building services to West Oakland residents.
- School Health and Community Nursing: Healthy Living Program at Madison Park Business and Art Academy. Offers middle school-aged students the nine-lesson Madison Health Living curriculum, which includes nutrition basis, web-based diet analysis, information about energy and calories, label reading, exercise, fast food, breakfast, and media influence.
- School Health and Community Nursing: Higher Ground Youth Leadership Program. Develops leadership skills, provides academic support, and supports health behavior adoption through educational sessions and workshops, tutoring and mentoring, and family engagement events.

Matching Funds

Many Public Health Prevention Initiative providers leveraged their Measure A allocations to obtain matching funds:

- The Medication Safety project used Measure A funds to leverage **foundation grants**.
- Lotus Bloom leveraged funding from two organizations through **in-kind services and assisted a parent in applying for a Best Babies Zone grant in the amount of $1,500 for nutrition and cooking activities** within the playgroup program at Castlemont.
- Niroga used Measure A fund to **supplement funds** from other grant funding sources.
- Project New Start used Measure A funds to leverage funds from Medi-Cal Administrative Activities (MAA) and large in-kind contributions/ partnerships from volunteer medical professionals whose service provision amounts to **well over $200,000 per year**.
- East Oakland Boxing Association used Measure A funds as a match for OFCY funds to **support the SmartMoves program**, which includes health and wellness programs.
- Mandela Marketplace used Measure A funds were to leverage **Kresge Foundation and California Endowment grants**.

- Immunization. Recruits health care providers to join the California Immunization Registry program (CAIR) in Alameda County and provides training and technical assistance on registry use.
- HIV Prevention: HEPPAC. Increases awareness of harm reduction-based health, specifically abscess wound care, OPEND, and vein rotation practices, and provides access to services to increased-risk populations.
- HIV Prevention: CALPEP. Provides services including HIV testing, partner services, CLEAR case management, group education, and referrals.
- Lotus Bloom. Administers a series of health-related nutrition programs to serve families as well as the at-large community.
- Niroga. Empowers low income young adults with a training in yoga and Transformative Life Skills (TLS) to bring into their communities
- Mandela Marketplace. Through the Food Policy Council, advises and advocates for residents of Ashland/Cherryland on agricultural and food policy issues.
- Family Planning: CALPEP. Provides street outreach in high risk communities including homeless encampments, drug treatment programs, prostitute strolls, drug houses, and schools and school-based programs.
- Perinatal Services. Provides outreach and education to marginalized, often linguistically and/or culturally isolated Pacific Islander women of child-bearing age and their families.
- Child Services: Child Health Disability Prevention Program. Provides children aged 0–5 years in Alameda County with developmental and behavioral screening and support with service linkage.
- Child Services: Family Health Services Home Visiting. Provides culturally competent care through interpreter services to pregnant women and families with young children.
- City/County Neighborhood Initiative. Addresses an array of barriers, including child and family cultural/linguistic barriers, the need for increased services for vulnerable populations, and lack of knowledge of available services.
- Health Pipeline Program. Utilizes best practices to increase the participation of youth by streamlining their operations and leveraging current and new partnerships with stakeholders in the health workforce.

Obesity Prevention & School Health

- Nutrition Services. Conducts community interventions and programming as well as social marketing/education on the health effects of obesity.
- East Oakland Boxing Association. Provides holistic wellness programming to youth through nutrition, gardening, and physical fitness programs.

Lotus Bloom administers a series of health-related nutrition programs to serve families as well as the at-large community.

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

- Reduce A1c, a test that shows how well a person is controlling his or her diabetes, in 84% of clients (target: 75%).
- Reduce blood pressure in 53% of clients (target: 50%).
- Reduce weight in 50% of clients (target: 75%).
- Increase physical activity among 67% of clients (target: 50%).
- Achieve 84% 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.
- Conduct 24 no-cost tattoo removal clinics providing 1,500–2,000 treatments for very high risk youth, of whom 75% are underinsured or uninsured and formerly adjudicated or gang/drug-involved.
- Provide support service linkage, self-care coaching, and guidance for personal and professional development.
- Require youth to get involved in positive activities such as employment, educational attainment, vocational training, mentoring, and community service.
- Achieve 60% of youth consistently returning for tattoo removal treatments, completing community service hours, maintaining mentorship relationships, and either enrolling in school or a GED program or completing a job training program and getting employment.

Dating Matters/Teen Violence

- Deliver the Dating Matters curricula (six 50–minute sessions) to 456 sixth grade students at five Oakland middle schools.
- Deliver the Dating Matters curricula (seven 50–minute sessions) to 441 seventh grade students at five Oakland middle schools.
- Deliver the Safe Dates curricula (10 50–minute sessions) to 845 eighth grade students at 10 Oakland middle schools.

Senior Services: Day Break Adult Day

- Achieve the following:
  - 20% of program participants improving medication compliance
  - 50% disposing of inactive medications
  - 70% of staff forwarding updated medication inventories and pharmacy reports to the participants primary care physicians
  - 50% of physicians responding to medication safety reports forwarded to them

Measure A Helps

SENIOR SERVICES: ST. MARY'S

Nancy, 87, suffers from arthritis, hypertension, and heart disease, and experiences bouts of depression and fatigue. At St. Mary's Center she would sit by herself, eat her lunch quickly, then leave. Through patience and a little TLC, her Senior Advocate helped coax Nancy out of her shell. Though Nancy has limited mobility and is often in pain, she has joined her building's exercise class, which makes her feel very proud and increases her energy. When she comes to the center for hot lunch, she sits at the same table with her new friends. Her Senior Advocate continues to works with her on nutrition and her medication regimen.

- 30% of physicians making a change in medication regimen or requesting a follow-up appointment with their patient or the caregiver

Senior Services: St. Mary's

- Serve 73 clients in this program (target: 47).
- Have 40 clients submit medication interaction reports to their health provider for review (target: 24).
- Conduct 1,041 phone calls to discuss medication compliance with the 73 clients served.
- Provide 373 face-to-face conversations with the 73 clients served.
- Achieve 69 clients participating in a "Be Well, Be Happy" nutritional workshop.
- Provide medi-sets to 37 clients to keep their medication in one place.

St. Mary's conducted 1,041 phone calls and 373 face-to-face conversations to discuss medication compliance with the 73 clients served.

Senior Services: Senior Support of Tri Valley

- Serve 42 clients in the Medication Safety program, educating them on topics regarding medication disposal.
- Have nine clients dispose of medications through this program. All other participants had no medications to dispose of or had already disposed of medications via their pharmacy or take back days.
- Of the 42 clients served:
  - 2% had their medications adjusted.
  - 66% stated they had become more compliant with their medication regime
  - 100% reported that they felt better overall.
- Of the 33 interaction reports completed, there were a total of:
  - 230 major drug interaction alerts
  - 299 moderate drug interaction alerts
  - 73 minor drug interaction alerts
  - 14 major drug/food interaction alerts
  - 60 moderate drug/food interaction alerts
  - 13 minor drug/food interaction alerts

Senior Support Services: United Seniors of Oakland & Alameda County

- Train 270 seniors on proper use of their medications determined by pre- and post-test results gathered in 12 provider trainings (target: 300 seniors in 20 trainings).
- Increase the number of Spanish-speaking participants.
- Utilize pretrained senior volunteers who had complete the program with the previous year's Measure A funding.
- Achieve a 60% success rate showing knowledge of medication safety based on result differences in correctly answered questions between the scores of pre and post tests (target: 60%).

Health Inequities & Community Capacity-Building

School Health and Community Nursing: Berkeley School-Linked

Health Services (SLHS) Program

- In partnership with the City of Berkeley's Immunization Coordinator, improve BUSD kindergarten vaccination rates by 10%.
- Hold monthly meetings of the "Berkeley Healthy Schools Collaborative" on topics including housing, resources, family engagement providers, mental health crisis services, and school mindfulness programs.
- Make presentations on "Chronic Absenteeism & Health: What Is Your Role?", attended by over 20 participants, and on "Early Prevention and Treatment of Asthma: The Case for Preventing Chronic Absenteeism", attended by over 15 participants.
- Provide over 20 school-linked referrals/case consultations from the SLHS public health nurse.
- Participate in 12 SARB and 5 SART elementary meetings.
- Establish biweekly meetings with the BUSD Office of Family Engagement and Equity.
- Assist BUSD in planning and implementation of the Northern California Breathmobile at two elementary schools and one preschool.
- Provide Breathmobile services to over 55 BUSD students.
- Provide oral health screenings to over 1,100 second and fifth graders in 11 elementary schools, and provide sealants to over 145 students.
- Provide over 130 health consultations covering topics such as vision, food allergies/Epi-pen, medications, nutrition/obesity, health Insurance/ACA, and more.
- Partner in 13 504s/IEPs/SST meetings with school staff and families.
- Conduct 10 public health nurse family visits.
- Conduct five health trainings at staff meetings on the topics of allergies/Epi-pen, seizure disorders, and medication administration.

School Health and Community Nursing: City and County Neighborhood Initiative

- Provide health screening in various venues with referrals to health care providers and/or local clinics as well as Covered California.
- Connect clients with needed health care services.
- Succeed in getting clients to return to school to obtain their high school diplomas.

School Health and Community Nursing: Healthy Living Program at Madison Park Business and Art Academy

- Have 22 middle school-aged youth participate in the healthy living program.
- Achieve 100% of students reporting making at least one improvement in eating choices or physical activity
- Achieve 50% of students making at least one lasting eating choice and working on more.

School Health and Community Nursing: Higher Ground Youth Leadership Program

- Achieve the following:

Measure A Helps

LOTUS BLOOM

Aroni, 3, has been attending playgroups for about one year with grandpa Cesario. Aroni's mom works 40+ hours to provide for their household. Aroni's dad has been in and out of Aroni's life. He tends to have tantrums during transitions. Aroni also has had episodes of biting, hitting, and throwing objects. Lotus Bloom staff has provided his family with resources for additional services as the family waits for Medi-Cal services. In the meantime, Aroni attends the playgroups on a weekly basis, enjoys the BBZ nutrition workshops by parent leader Laura, and makes the best of his experience. Grandpa also participates in monthly workshops.

- 77% of parents reporting they are more involved in their children's school life and activities
- 100% of students completing the program
- 50% reporting that student-led workshops were useful
- 50% completing at least two life goals
- 100% being promoted to the next grade
- 90% ranking their presentation skills as good or better

Immunization

- Provide education and support contributing 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.
- Promote the elimination of vaccine-preventable diseases by implementing the California Immunization Registry program (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.

HIV Prevention: HEPPAC

- Provide abscess/wound care services for soft tissue damage due to injection drug use to 388 people who inject drugs (PWID) patients (592 total visits from 235 unduplicated clients) at the Casa Segura Clinic (target: 300 PWID patients).
- Provide abscess/wound care follow-up services to 313 PWIDs (301 unique clients) at HEPPACs SEP locations (target: 300 PWIDs).
- Provide abscess/wound care follow-up services to 92 unique clients (124 visits) at the Casa Segura site (target: 156 clients).
- Refer 105 clients from HEPPACs SEPs to Casa Segura for a total of 402 visits (177 STI visits and/or 225 HIV visits/tests and/or 120 HCV rapid testing visits) for STI and/or HIV and/or HCV rapid testing and provide treatment for those testing positive for STIs (target: 156 clients).
- Refer 151 clients who tested positive for HCV and/or HIV to primary care services.
- Conduct 61 Safer Injection workshops with 135 participants and 37 Overdose Prevention trainings with 65 participants at the Casa Segura Drop-in Center (target: 300 participants).

HIV Prevention: CALPEP

- Conduct Targeted Prevention Activities (TPAs) at many venues including testing sites, community events, HIV-positive venues, homeless shelters, primary care sites, and other community-based organizations.
- Provide all TPA contacts with risk-reduction materials and/or

HEPPAC provided abscess/wound care services for soft tissue damage due to injection drug use to 388 people who inject drugs (PWID) patients.

information, including condoms, lube, safer sex literature, and/or needle hygiene kits.
- Refer 100% of the clients to at least one resource including primary care services, housing assistance/shelter, CAL-PEP's medical services, legal assistance, food pantry, and partner services.
- Enroll eight clients in the CLEAR program.
- Have four HIV-positive individuals complete a minimum of eight sessions with their case manager.
- Achieve 88% of clients improving and/or maintaining greater risk behavior understanding by their discharge date.

Lotus Bloom
- Create a healthy cookbook that captures recipes from participants in the playgroup program, and distribute the cookbook to 40 parents.
- Offer a seven-week PLAN training to 25 parent participants, with 100% of participants reporting that they learned new skills on parents' rights, how to advocate for their own child, choosing and enrolling in school, and speaking in public.
- Administer 16 sessions of dance and movement by an average of 35 parent/child dyads attended, a Yoga for Strength series attended by 12 people, and parent/child yoga sessions attended by 18 participants.
- Achieve 100% of the 65 participants of the dance and yoga series reporting that they now include exercise activities at least one day per week for at least 20 minutes.
- Achieve 100% of participants (210 people) in the playgroup program participating in weekly physical movement at least twice per week.
- Create an organizational healthy food policy listing foods that are welcomed in the centers and foods to refrain from, and have 100% of participants honor the policy.

Niroga
- Provide classes in yoga and Transformative Life Skills (TLS) to over 15 youth agencies and organizations.
- Achieve the following after a daylong retreat at the Alameda County Juvenile Justice Center:
  - 83% of the youth reported learning techniques to manage stress and difficult emotions.
  - 83% reported learning healthy habits.
  - 100% reported that they felt they had a sense of community and understanding with their peers.
- Offer a total of 767 classes in the Public Health department and underserved communities over the past year, serving 772 unduplicated children and adults.
- Save the medical care system at least $1,512,000 for one year through avoidance of emergency room visits.
- Accept and provide scholarships to 12–16 low income young people to become certified yoga teachers, with 12 students graduating.
- Require graduates of the program to give back 100 hours of community

Measure A Helps

NIROGA

When Brishana was two years old, her mom was murdered near their home. Her father passed away when she was nine. After she turned 18, she experienced periods of depression, paranoia, and anxiety attacks. She was working a full-time job, living and providing on her own. Through Niroga's Breathe Campaign, Brishana for the first time visited the street where her mother was murdered. After continuing with Niroga's yoga program, Brishana is now, at age 21, a Niroga Integral Health Fellow (IHF). She says, "The biggest impact Niroga has had on me is being a part of a community and feeling like I'm home. I think that's what I've been wanting."

service providing TLS
- Provide TLS training for approximately 35 Alameda County Public Health Department–WIC staff to incorporate strategies and techniques with clients.
- In a feedback form surveying the effectiveness of the training, achieve the following:
  - 82% of students were satisfied/very satisfied with Niroga's support in helping them develop and maintain a consistent yoga practice.
  - 100% were satisfied/very satisfied with Niroga's support in helping them incorporate the concepts of yoga philosophy into their life.
  - 91% were satisfied to very satisfied with Niroga's help in preparing them to safely and effectively teach yoga to others.

Mandela Marketplace
- Hire a Food Policy Council Coordinator.

Perinatal Services
- Translate a one-page English language pregnancy resource guide into Tongan and Samoan, two of the largest Pacific Islander subpopulations in Alameda County.
- Tailor the materials in a culturally sensitive design and print them.
- Distribute the guides at the 2nd Annual Asian and Pacific Islander Women's Health Summit and in the community.

Child Services: Child Health Disability Prevention Program
- Screen 5,872 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 1,228 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.

Child Services: Family Health Services Home Visiting
- Provide in-home, in-person interpretation in 149 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 32 residents.

Niroga saved the medical care system at least $1,512,000 for one year through avoidance of emergency room visits.

Family Health Services Home Visiting provided in-home, in-person interpretation in 149 languages by pairing interpreters with home visitors who visit pregnant women and families with young children on a weekly or semi-monthly basis.

- Hold annual events such as the Sobrante Park Time Banking Health Fair, which served 500 residents this year with over 40 vendors offering health education workshops, and the La Posada/Kwanzaa celebration, involving 250 residents.
- Conduct three meetings of the Sobrante Park Leadership Council (SPLC), which brings together leaders of 14 community institutions.
- Partner with Alameda County to provide a career and college-readiness program for 31 Sobrante Park youth of different races and cultural backgrounds.
- Link 31 families with culturally appropriate mental health services to help them cope with a traumatic event that happened in the neighborhood.

City/County Neighborhood Initiative (CCNI): West Oakland

- Conduct program and strategic planning for a new West Oakland Youth Center.
- Through the West Oakland Mini-Grant Collaborative, distribute $20,000 to 14 distinctive resident grant applicants.
- Through the West Oakland Young Adult Mini-Grant Collaborative, distribute $5,000 to four grant applicants.
- Establish a summer enrichment program for 10 Hoover Elementary School students and Spanish language classes for parents at Hoover Elementary and McClymond's High School.
- Host a series of community dinners to discuss community responsibility, strengthen West Oakland, and reduce violence, with approximately 80-100 youth attending these events.
- Offer a six-week series of summer family engagement activities called Friday Night Live, attended by over 500 residents.
- Raise more than $12,000 for the Juneteenth celebration, attended by over 1,000 participants.
- Conduct the West Oakland Job Fair, which attracted about 600 job-seekers.
- Place 25 youth in paying jobs.
- Offer a construction job orientation for re-entry individuals, which was attended by 30 residents.

Health Pipeline Program (HPP)

- Support the position of the Alameda County HPP (ACHPP) coordinator, who is instrumental in administrating the ACHPP steering committee and cross collaboration.
- Support 1,440 youth into Pipeline programs.
- Create a mini-grant program that awarded three organizations that developed innovative strategies to engage young men of color (YMOC) a total of $44,502.
- Enable 14 YMOC to participate in Mentoring in Medicine and Science's Clinical Exposure and Mentoring Summer Internship.
- Enable 34 YMOC to become involved in the ROPE initiative, including attending a three-day retreat to improve levels of self-confidence and

Measure A Helps

CHILD HEALTH: FAMILY HEALTH SERVICES HOME VISITING

A home visiting nurse worked with a Hindi-speaking interpreter, case managing a medically fragile baby born to a recent immigrant mother from India. When the nurse screened the mom for postpartum depression, the mom described how badly treated she felt in the home, as her in-laws threatened to send her back to India without her baby if she didn't comply with their orders. With the interpreter serving as both linguistic and cultural broker, the nurse implemented a care plan for the baby and helped the mom to deal with her in-laws, helped her understand her rights living in the US, and provided her with tools to learn basic English.

self-understanding, making college trips, and receiving individual and group tutoring.
- Provide summer internships for eight YMOC with supplemental workshops on college/career preparation, professionalism development, and exposure to YMOC college students as program facilitators.
- Host 48 ACHPP high school and college students to participate in an anatomy lab workshop and campus tour at Samuel Merritt University.
- Host eight 8 ACHPP high school and college students for an exclusive tour at Santa Clara Kaiser Medical Center.
- Sponsor 70 student rafting trips where students were matched with college and post-baccalaureate students for mentorship.
- Recruit 20 ACHPP youth to volunteer at the 2013 We Connect Health Fair in Oakland.

Health Pipeline Program created a mini-grant program that awarded three organizations that developed innovative strategies to engage young men of color a total of $44,502.

Obesity Prevention & School Health

Nutrition Services
- Through a subcontract with the Oakland Food Policy Council (OFPC), provide advocacy that led the Oakland Planning Department to develop zoning and other regulations that would provide residents the ability to grow food on their land.
- 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 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 gardening classes three days per week for 200 East Oakland youth focused on healthy eating.
- Host a six-week culturally based cooking and nutrition workshop each quarter for at least 50 families.
- Create three YouTube videos through the EOBA Urban Fresh Gardeners program.
- Have all youth participate in daily physical activity and maintain awareness of the importance of being active to improve their health, with 75% of EOBA youth reporting exercising four or more times per week.

East Oakland Boxing Association offered cooking classes two days per week and gardening classes three days per week for 200 East Oakland youth focused on healthy eating.

- Participate in four workshops at local schools or community organizations.
- Provide lunch to over 130 youth every day for seven weeks through the Oakland Summer Lunch Program.
- Provide over 900 hours of tutoring to children ages 5–20.
- Assist 10 youth on their journey from high school to beginning their first year at college.
- Distribute 20,406 pounds of fresh produce and 8,851 pounds of food to the low income Oakland community.
- Take youth on 15 field trips including hiking, camping, kayaking, and visits to the aquarium and zoo.

Measure A Helps

SCHOOL HEALTH & COMMUNITY NURSING: CITY AND COUNTY NEIGHBORHOOD INITIATIVE

A woman who had a history of hypertension and complained of dizziness received a health screening at a Health Fair. The client had not seen a doctor in over two years and stopped taking her high blood pressure medication over a year ago. The screener advised the women's friend to take her to the emergency room right away. Three weeks later, the client called the screener, stating that the screener had saved her life. She said, "I went to the emergency room like you told me. They told me if I would have waited any longer, I could have had a stroke."

School of Imagination

schoolofimagination.org

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

Individuals served by Measure A: **253** (Total individuals served: **325**)

Populations served: Low Income, Uninsured Children

Services provided: Public Health

Service area: Alameda, Castro Valley, Fremont, Livermore, Pleasanton

BACKGROUND

The School of Imagination brings out the extraordinary in every child by providing groundbreaking, collaborative, and individualized educational, therapeutic, and family support services in a nurturing and positive environment through the highest quality inclusion program that supports all children, encouraging them to become positive influences on society.

School of Imagination serves over 300 children each week. Its program has contributed to improving the lives of the children it serves by providing children with autism and developmental delays and disabilities with the most effective, research-based therapeutic techniques.

Children on the autism spectrum often have skills that develop unevenly due to the lack of development in some of the areas of their brain. Using the cutting-edge Early Start Denver Model (ESDM)—a highly effective treatment methodology for children with autism—clinicians and educators can clearly define the level of development in a functional way is extremely helpful in planning treatment that is most effective. Treatment can occur within the classroom, in the therapy room, or at home, which allows for much greater progress in a shorter period of time due to the consistency and clarity of treatment protocols.

The ESDM also has a strong parent training component. This methodology allows School of Imagination the opportunity to provide a multidisciplinary approach (educators and clinicians) that is consistent across disciplines and in the home. Children are making progress across all areas of development (cognitive, language, motor skills, and self-care) due to the implementation of this therapy protocol and methodology, which improves their prognosis for catching up to their same-age peers by the time that they are in kindergarten and no longer needing special education services, which cost school districts millions of dollars each year.

Measure A Helps

Letter from the parents of IDP toddler Brandon:
When we came to speech therapy, Brandon was demonstrating significant receptive and expressive language delay, testing in the lower 10th percentile. Brandon has been universally described as exceptionally strong willed (aka stubborn), and we thought it was unlikely that he would take to a speech therapy class. Ms. Leslie took the time to learn Brandon's likes and dislikes and catered to his pace and personality. In the past six months, Brandon's speech and behavior have improved exponentially, with another breakthrough session just this past week. Ms. Leslie's tremendous dedication, patience, and love towards Brandon has deeply impacted his life and our family.

MEASURE A FUNDING SUMMARY

Measure A funds provided training to School of Imagination's clinical and educational team on the ESDM treatment methodology for children with autism. The teachers and clinicians who received this training implemented protocols in the classrooms and therapy sessions, specifically in the Infant Development Program (IDP) and individual therapy sessions. Both the therapy and infant development programs are provided to children ages 2–3 years old with developmental delays and autism. The earlier that these children receive help, the greater their chance is to develop age-appropriate skills.

This training immediately impacted over 250 children who attend School of Imagination's program by providing them with the most effective treatment methodologies. This training allowed the treatment team to impact the families in the community by continuing to disseminate the ESDM to all children and families that need help. Parent training has also commenced, which allows families to work directly with providers using the ESDM model. The consistency between parents and providers is greatly enhanced and has yielded even greater improvements in the development of the children.

All of School of Imagination's 29 teachers and 13 therapists completed the training and passed the assessment measures established by the UC Davis MIND Institute.

Highlights

The results of the ESDM training have been fantastic. **Children are making faster progress and parents know what to do to best help their child** due to the new training methodology.

Senior Injury Prevention Program

acphd.org/ipp/sipp.aspx

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

Individuals served by Measure A: **2,788** (Total individuals served: **2,811**)

Populations served: Low Income, Uninsured 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 that respects the diversity of the community and provides for present and future generations.

The Public Health Department'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:

- ADSNAC/DayBreak
- Rebuilding Together Oakland
- Senior Support Program of the Tri-Valley
- St. Mary's Center
- Spectrum
- LIFE ElderCare

Measure A Helps

A 70-year-old male had a stroke and was experiencing extreme left-side weakness, putting him at very high risk of falls. Staff at LIFE ElderCare designed a unique set of exercises for him. The student nurse guided the man extra slowly and performed the exercises directly in front of him. After four weeks, the client had learned the routine and was able to stand for five seconds on each leg. By the seventh week, his single leg stand was at 15 seconds. By the end of the 10-week program, he could walk to a nearby park and back without feeling weak afterwards.

MEASURE A FUNDING SUMMARY

SIPP providers served 1,773 new clients in FY 13/14, compared to a target of 820 new clients.

Measure A funding helped SIPP achieve the following objectives:

- 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: 443; actual: 846).

- 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: 57 assessments/modifications; actual: 59).
- 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: 508; actual: 1,203).
- Individual/group medication management. The program educated individual groups of older persons, in addition to their families, friends, caregivers, and community individuals, on the safe disposal of and other health measures for managing their medication properly (target for all providers: 235; actual: 341).

SIPP providers served 1,773 new clients in FY 13/14, compared to a target of 820 new clients.

Service Opportunties for Seniors (Meals on Wheels)

sosmow.org

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

Individuals served by Measure A: **348** (Total individuals served: **1,292**)

Populations served: Indigent, Low Income Seniors

Services provided: Hospital Outpatient, Public Health

Service area: Castro Valley

BACKGROUND

Meals on Wheels targets low income seniors who are age 60 and older, homebound, alone, recently discharged from the hospital, or having a physical or mental impairment. Ninety-five percent of Meals on Wheels clients receive SSI or Medicare income, while the other 5% have insufficient income to meet all their monthly expenses.

MEASURE A FUNDING SUMMARY

Meals on Wheels used its Measure A allocation to deliver 5,000 meals to seniors in the unincorporated Castro Valley area.

Highlights

Every eligible senior received a **hot nutritious meal, and no waiting list** occurred in FY 13/14.

Measure A Helps

One day, when Meals on Wheels recipient Eddie's driver went to deliver his meal, there was no answer at the door. The driver tried to call Eddie and also got no answer. The driver immediately called his supervisor, who ultimately contacted the police to request a wellness check on Eddie. The police reported that Eddie was being transferred to the hospital due to a fall that left him incapacitated. The Meals on Wheels team might literally have saved Eddie's life.

Spectrum Community Services, Inc.

spectrumcs.org

Allocation: **$90,000/$250,000** | Expended/Encumbered: **$90,000/$250,000**

Individuals served by Measure A: **500/*** (Total individuals served: **500/2,935**) *Kitchen renovation was completed at the beginning of FY 14/15, so Measure A clients served can be tracked from that point forward. Total clients served by the kitchen program is 2,935.*

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.

Over four decades, Spectrum has developed programs that address seniors' most critical issues, including the Senior Nutrition Program and the Fall Risk Reduction Program (FRRP).

In FY 13/14, Spectrum received two Measure A allocations: One for the FRRP, and one for renovation of the kitchen used in the Senior Nutrition Program.

FRRP

Spectrum's FRRP promotes wellness and delivers preventive services to a population at high risk for falls and fall-related injuries. FRRP employs strategies that educate about fall prevention; guide and refer for home safety modifications that can prevent falls; and offer training 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.

Classes are provided at no cost to area seniors who are living on very low fixed incomes. Spectrum targets its FRRP classes at senior housing and recreation centers located in low income neighborhoods. The program emphasizes social interaction, giving isolated seniors the opportunity to develop new friendships and improve conditions like depression.

Senior Nutrition Program Kitchen Renovation

The renovated commercial kitchen at Josephine Lum Lodge is used 248 serving days each year to prepare and cook fresh, nutritious senior meals

Measure A Helps

FRRP

Anne H., 60, is a regular participant of Spectrum's Fall Prevention Exercise Program. Having at one time weighed 350 lbs., Anne now weighs 200 lbs. Anne has been diagnosed with Functional Movement Disorder. When she joined the program, she was having extreme difficulties walking, even while using a walker, due to severe leg weakness, tremors, and poor trunk coordination. Anne has made significant progress in mobility, strength, and coordination. She has stopped using the walker and is now able to walk using a cane for balance. Anne has regained much of her core control and is able to perform daily tasks with far more ease.

in compliance with the Title III Older Americans Act. The meals are distributed that day to 28 partner serving sites, plated, and served to the seniors who eat together in a congregate style getting the benefits not only of the nutritious food, but also the socialization to fight isolation.

MEASURE A FUNDING SUMMARY

FRRP

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:

- Offer fall prevention education and regular exercise classes designed to build strength, mobility, and balance to elders who are at risk for falls
- Reduce the incidence of falls among program participants
- Improve participating seniors' strength, mobility, and ability to walk with confidence
- Offer seniors and caregivers throughout the target area fall risk prevention workshops at which participants can obtain practical information about how to minimize fall risk

Services funded by Measure A included the following:

- Weekly fall prevention skill-building classes at seven sites in the target area
- Evaluation and reassessment of class participants to measure individual progress and identify changes needed to the program curriculum
- Quarterly workshops at five locations to provide practical training in preventing falls

FRRP conducts senior fitness tests every six months to chart the impact of the program and the progress in the participants. Recently conducted tests show the following results:

- Muscular endurance: 40% improved, 47% maintained, 13% declined
- Flexibility: 49% improved, 41% maintained, 10% declined
- Mobility: 43% improved, 48% maintained, 9% declined
- Strength: 40% improved, 52% maintained, 8% declined

Senior Nutrition Program Kitchen Renovation

Spectrum received a one-time Measure A allocation to renovate its commercial kitchen at Josephine Lum Lodge with increased capacity to prepare senior meals. This renovation has allowed an increase in capacity to serve senior meals in Alameda County, as noted by the following:

- In conjunction with the Alameda County Area Agency on Aging, Spectrum increased its meal service area to include 11 partner sites in Oakland and Alameda, as well as the ongoing areas of all Central and South County. Spectrum is actively pursuing more partner sites to make meals available to more seniors.
- Average daily meals served have increased from 300 to 400.

Measure A Helps

SENIOR NUTRITION PROGRAM KITCHEN RENOVATION

Senior Meals participant Felicia began her journey with Spectrum as a volunteer over 20 years ago. No longer able to volunteer herself, now she gets served by others. With the assistance of her walker, Felicia walks every day to join her friends for a nutritious lunch. Felicia has a difficult time sitting or standing for a long period of time, which makes it nearly impossible for her to cook at home. With the help of Spectrum, Felicia is able to get a fresh meal and needed social interaction each day, including a special birthday celebration each year with a Spectrum lunch.

SSI Housing Trust

Allocation: **$0** | Expended/Encumbered: **$346,292** (This provider received its allocation in FY 12/13 but expended it in FY 13/14.)

Individuals served by Measure A: **300** (Total individuals served: **2,135**)

Populations served: Indigent, Low Income, Uninsured Adults, Other residents: Disabled and Chronically Homeless

Services provided: Public Health, Mental Health

Service area: Countywide

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.

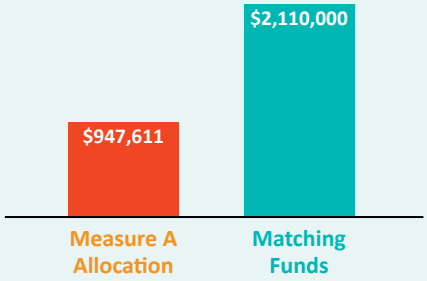
MEASURE A FUNDING SUMMARY

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 2,135 individuals, of whom 1,006 were approved for disability benefits and 779 still had claims pending at the end of the fiscal year. These awards in disability income resulted in clients receiving over $15 million in ongoing income since the date of their approvals.

Calendar year 2013 was 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 **$2,110,000 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**.

Teleosis Institute

teleosis.org

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

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

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

Services provided: Hospital Outpatient, Public Health, Substance Abuse

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

BACKGROUND

The Teleosis Institute is developing develop a Safe Medication Disposal Program with the goal of reducing unused medication from accumulating in households and reducing risk or accidental poisoning for seniors, youth, and children through education and take-back locations.

MEASURE A FUNDING SUMMARY

The Teleosis Institute used its Measure A funding to develop new take-back sites, to coordinate the effort throughout the County, and to support the development of the Safe Medication Disposal Ordinance.

Measure A funding helped the program achieve the following:

- Increase access to public health and/or substance abuse services to seniors, adults, families, at-risk youths, and/or other residents by assessing existing program results.
- Collect 12,564 lbs. of unused pharmaceuticals from four sites.
- Conduct educational outreach through a survey and follow-up calls.
- Prepare a final summary assessment that provides information about program effectiveness, participation, and educational guidelines for others to develop similar programs. The summary assessment document contained the following recommendations:
  - Establishing one agency to oversee a Countywide program would minimize operational overlap and improve collection efficiency.
  - Establishing sites in larger medical institutions such as hospitals would provide the most efficient and effective results; pharmacy take-back sites collection would also improve collection rates.
  - Educational outreach for health executives and health professionals in primary care and end-of-life care is essential for improved program outcomes.

The Teleosis Institute used its Measure A funding to develop new take-back sites, to coordinate the effort throughout the County, and to support the development of the Safe Medication Disposal Ordinance.

Viola Blythe Community Services

violablythe.org

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

Individuals served by Measure A: **7,470** (Total individuals served: **9,860**)

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

Services provided: Public Health

Service area: Fremont, Newark, Union City

BACKGROUND

The Viola Blythe Center is a nonprofit, nonsectarian corporation organized to promote, support, and advocate for social and human services to any person who is in immediate need. This mission is accomplished by a variety of programs, including emergency food and clothing distribution, referrals to other agencies, and special programs at Thanksgiving and Christmas.

MEASURE A FUNDING SUMMARY

The Viola Blythe Center used its Measure A allocation to increase access to public health for families through food and clothing programs. Specifically, Measure A funding helped the Viola Blythe Center achieve the following:

- 2,471 families with a total of 7,470 clients received more nutritional food items such as fresh meat, milk, eggs, rice, and beans.
- 3,916 clients received clothing including warm coats and back-to-school clothing for children.

Measure A Helps

The Viola Blythe Center received an emergency phone call on a Sunday afternoon. A grandmother was crying and in a panic mode because two of her grandson's children, ages six months and two years, were left in her care with nothing but the clothes on their back. The grandson is incarcerated and the mother has problems with drug abuse. Within a few hours the Viola Blythe Center was able to help her out with food, baby food, formula, blankets, diapers, car seats, new clothing, and some other necessities. Measure A funds helped this client out in a time of immediate need.

Youth and Family Opportunity Initiatives

achealthyschools.org/youth-development.html

Allocation: **$2,499,000** | Expended/Encumbered: **$2,791,517**

Individuals served by Measure A: **15,508** (Total individuals served: **15,508**)

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

Services provided: Mental Health, Substance Abuse

Service area: Countywide

BACKGROUND

The Center for Healthy Schools & 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
- Fremont Unified School District
- La Familia
- New Haven Kid Zone
- 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 therapy, group therapy, case management, information and referral, prevention, and early intervention. For example:

- Alameda Family Services provides an array of mental health services to youth and families, including case management for youth, parenting

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**.

The funded CBOs offer a broad array of mental health services, including individual therapy, group therapy, case management, information and referral, prevention, and early intervention.

skills classes, teacher consultations, and more.

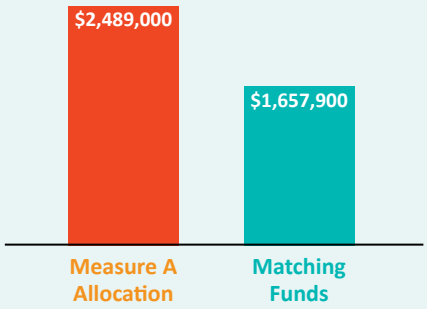
- AIA provides critical wraparound services and supports to address students' holistic needs. Services include empowerment groups on topics such as violence prevention, restorative justice and conflict resolution techniques, relationship building, trauma recovery, anti-oppressive education, and social 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. It also offers one-on-one case management support.
- New Haven Kid Zone provides resource and referrals, case management, and individual therapy.
- Newark Unified School District uses both a school-wide anti-bullying curriculum and individual counseling to create a safe and positive environment for children to flourish academically and emotionally.
- Newark and Fremont Unified School Districts provide therapy using trauma-informed cognitive behavioral therapy (CBT), art therapy, play therapy, and motivational interviewing.
- 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. Youth Radio also provides group counseling.

Youth and Community Services

The CBOs offer enrichment programs to promote health and wellness and improve the social, emotional, and physical health of youth and their families. Many of the youth and community services include family engagement. For example:

- BYA uses curriculum such as Alive & Free Violence Prevention Curriculum, G.R.O.W. Workshops, and Youth Council and Mentoring. BYA also hosted 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-

Matching Funds



The participating CBOs leveraged the YFO initiative Measure A allocation to obtain an addition **$1,657,900 in matching funds** from the following sources:

- Medi-Cal Administrative Activities
- Targeted Case Management
- Early and Periodic Screening Diagnosis and Treatment (EPSDT)
- Federal Funding (for example, 21st Century Grants)
- Foundations (for example, Kaiser Community Benefits)
- City of Berkeley and City of Oakland funding
- Additional Alameda County funding: Probation Department, Social Services Administration, General Fund

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 offered a diabetes series in partnership with the Alameda County Diabetes Program.
- 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 offered 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 the 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 Individual Education Plan (IEP) meetings on behalf of youth and parents. BYA offers a monthly food program, in conjunction with the Alameda County Food Bank, which provides a family of four with groceries that can last three weeks.
- EBAYC staff provides individual advising, home visits, teacher/

Measure A Helps

FREMONT FAMILY RESOURCE CENTER

Jorge, a fourth grader, was referred to the Fremont Family Resource Center. Jorge's grades had dropped, and he had been suspended from school after shoving a classmate to the ground. The Family Support Specialist discovered that Jorge's father was extremely stressed due to financial concerns and that his wife had recently passed away. Staff linked Jorge's father to financial literacy education, as well as help applying for health insurance and CalFresh food benefits. Jorge received counseling to build self-expression and stress management skills. In a few weeks Jorge reported being happier at school, had improved his grades, and was proud to report that he had received no suspensions or detentions.

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.
- 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/SNAP clinics for new/renewal community members.
- Newark Unified School District staff facilitate teacher/parent consultations and meet regularly with parents and administrators.
- REACH Ashland Youth Center 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.

In addition to working directly with youth and parents, staff advocate on their clients' behalf with probation, schools, and other public services to ensure the clients have completely accessed all the services available to them.

MEASURE A FUNDING SUMMARY

Through the Measure A YFO initiative grant, 15,508 clients were served during FY 13/14.

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
  - 1,146 youth were seen in groups.
  - 1,877 youth received individual services.
- Family-focused individual and group counseling, case management, mental health services, alcohol and drug assessment, and referrals
  - 3,384 families were served in groups.
  - 1,102 families received services one-on-one.
- Youth leadership development and enrichment activities on improving personal growth, health and wellness, academic achievement, and creating career opportunities.
  - 7,690 youth benefitted from these services.

- Family engagement in schools focusing on health and wellness, work readiness, and life skills
  - 11,354 families benefitted from these services.
- Community events focus on raising awareness of free and affordable health care services
  - 314 community events .
  - 8,451 contacts were made at the events.

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

Alameda Family Services

- Alameda Family Services is improving integration of health supports through implementation of an Effort to Outcome Database as part of their YFO grant. Currently, four out of five programs at Alameda Family Services use this database.
- The Family Support Center conducts a telephone survey twice a year for clients currently enrolled in their program at the time of the survey. In FY 13/14, 80% of survey participants reported that staff treat them well, and 60% reported that services greatly improved their stability and/or life skills.
- From previous feedback and research, Alameda Family Services learned that their clients wanted the program to be open more hours with more opportunities to contact case managers. AFS now has more case managers directly engaged with the Family Support Center and are therefore able to offer in-person services 3-4 days per week for at least four hours per day. They also have more ongoing phone coverage by case managers.

Alternatives in Action

- The behaviors/conditions that have improved include the following:
  - Students have "graduated" from mental health (case management and therapy) services.
  - Students have completed probation, school attendance has increased, grades have improved, and family engagement has increased.
  - Chronic absences dropped by more than 15%.
  - Seniors have 100% FAFSA completion and 100% OUSD Cal Grant Application completion.
- AIA also administered a student survey with the following results:
  - 96% of students felt like they belonged in the program.
  - 100% of students felt safe in this program.
  - 97% said this program helps them to feel more confident about what they can do.
  - 99% said this program helps them believe they can finish high school.
  - 93% of students said that since coming to this program, they are better at something that they used to think was hard.

Measure A Helps

YOUTH RADIO

Youth Radio met K. through its MATCH program, which provides media and tech education, wraparound support services, and paid employment to formerly incarcerated youth. K. left the program and faced frequent bouts of homelessness and other struggles. This past year, K. came back to Youth Radio needing help and an income. Through Youth Radio's Workforce Development Pathway program, K. received mental health support services, college credit, a job at an international hospitality company, and a stable place to stay. He has since obtained an opportunity through a fellowship at Yosemite National Park, where he is earning a wage and work experience and participating in many activities including hiking, cliff jumping, and fishing.

- 94% said since coming to this program, they are better at setting goals for themselves.
- 93% said this program helps them to feel like a part of their community.
- 100% said this program helps them to make positive changes in their schools or communities.

Berkeley Youth Alternatives

- Youth demonstrated an overall increase in resilience based on a pre- and post-program 14-point resilience scale.

City of Fremont: Human Services Agency

Results from three of the primary service areas the City of Fremont/ Human Services Agency offers are summarized below.

Youth Counseling

- 13 out of 25 youth who responded to a client satisfaction survey reported that their ability to talk about feelings had improved a lot and they worry a lot less.
- The Family Development Matrix administered and the data aggregated from this evaluation tool indicated 112 of the 145 clients achieved a higher social-emotional health assessment score and increased stability by the end of their participation in the program.

Parent Counseling

- 60% of parents surveyed indicated that counseling services were very helpful.
- 30% indicated services were mostly helpful.
- 5 out of 11 parents stated that classroom behavior improved a lot.
- 4 out of 9 parents stated that school attendance for their children improved a lot.

Financial Stability

- 92% of Volunteer Income Tax Assistance (VITA) customer respondents reported that the quality of the tax preparation was excellent.
- 99% reported that they would recommend this free tax preparation service to others.

East Bay Asian Youth Center

- Chronic absenteeism at Garfield Elementary School and Roosevelt Middle School has been reduced 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 have 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.

112 of the 145 clients achieved a higher social-emotional health assessment score and increased stability by the end of their participation in the program.

- Eden began a new tattoo removal program in partnership with Kaiser Permanente. The program utilized qualified volunteer doctors, nursing, and medical staff in the tattoo removal process. Youth ages 13–25 must complete 50 hours of community service in lieu of payment for treatment; be employed, enrolled in school, or enrolled in a job-training program; and attend monthly group support sessions.

La Familia

- La Familia conducted a post survey with a sample group of 18 youth who participated in their youth development workshops. The most common theme in post-feedback was that youth felt "safe" coming to the center onsite. They also reported they could trust staff and the group.

Newark Unified School District

- Administrators report that student attendance has improved.
- Parents report feeling more confident when communicating needs to school.
- Families report that their child is doing better in school and that family communication has improved.

REACH Ashland Youth Center

Based on a youth survey administered in February 2014:

- 90-93% respondents stated that REACH AYC is fun, they would recommend REACH AYC to a friend, they feel safe at REACH AYC, and staff treat them with kindness and respect.
- 34% of respondents shared they talked with a staff person about a personal challenge they were facing, and 89% said it was either helpful or very helpful.
- 77% agreed that participating in REACH AYC helps improve their grades.
- 74% agreed that participating in REACH AYC helps them work harder in school.

Youth Radio

- According to Youth Radio's evaluation, their programs and services have helped 97% of participants graduate high school, and 88% percent go to college. Education is a strong predictor of health and is associated with practicing more health-promoting behaviors.
- Youth Radio's workforce development program provided participants with post-secondary education, intensive professional development, and industry placement with employer partners across many sectors. Upon admission to the fellowship program, participants concurrently earned college credit as students in Berkeley Community College's Multimedia Arts Certificate program–a first college experience for many participants. 100% of young people in the first cohort were placed in externships with employer partners.

According to Youth Radio's evaluation, their programs and services have helped 97% of participants graduate high school, and 88% percent go to college.

APPENDICES

APPENDIX A: MEASURE A REVENUE RECEIVED

APPENDIX B: FY 13/14 BUDGET INFORMATION

APPENDIX C: FY 13/14 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

APPENDIX D: MAPS: GEOGRAPHIC DISTRIBUTION OF PROVIDERS FUNDED BY MEASURE A IN FY 13/14

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

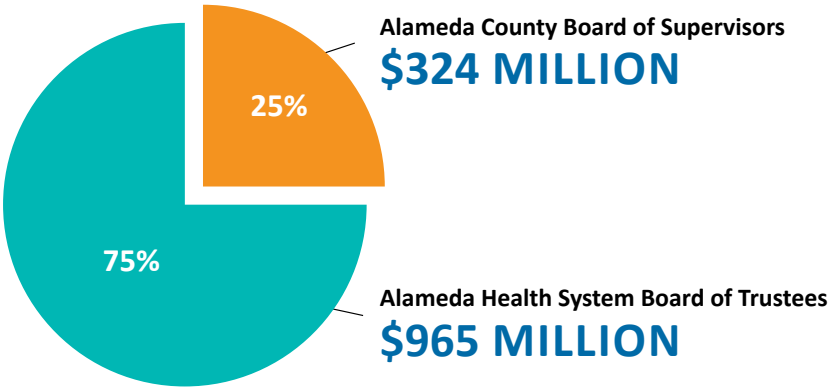
Map 5 HealthPAC Provider Network

APPENDIX A

MEASURE A REVENUE RECEIVED

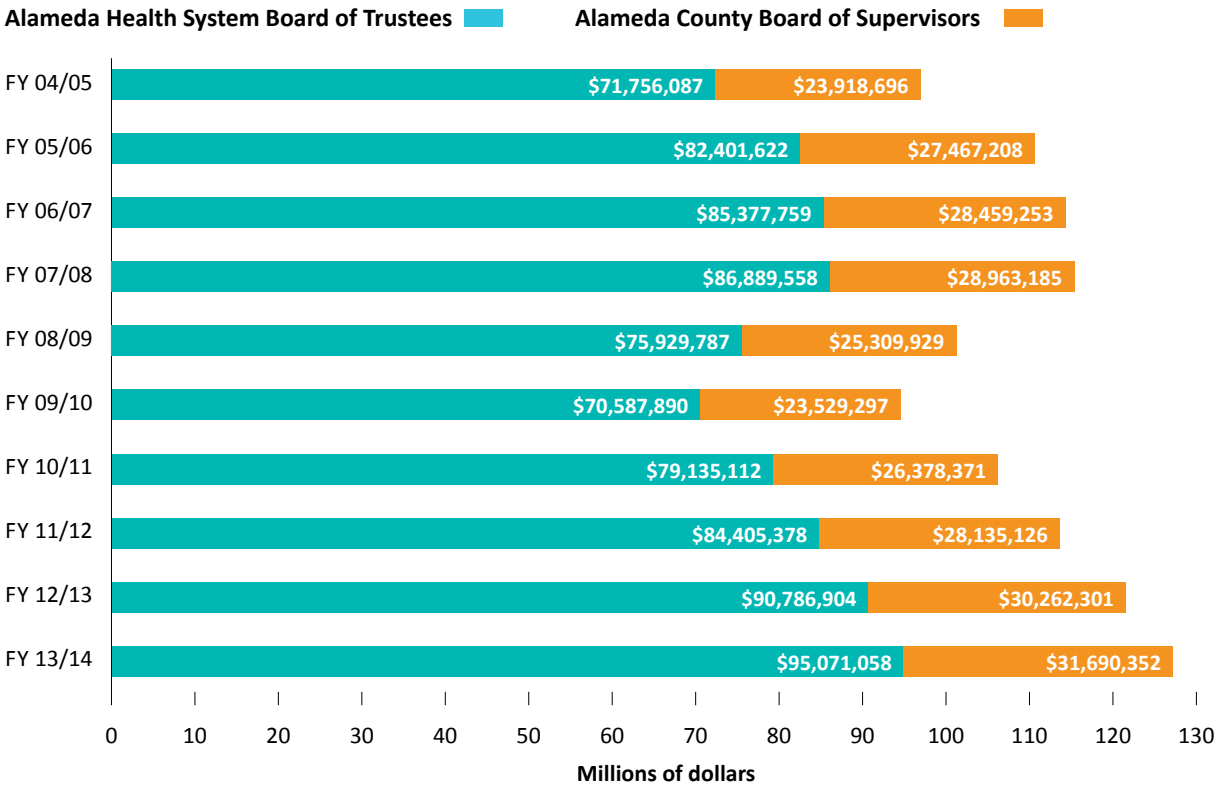
FY 04/05 through FY 13/14

TOTAL REVENUE EARNED (FY 04/05 THROUGH FY 13/14)



$1.28 BILLION

REVENUE EARNED EACH FISCAL YEAR (FY 04/05 THROUGH FY 13/14)



APPENDIX B: FY 13/14 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							
Asian Health Services (Banteay Srei)	25,000	0	25,000	25,000	0	25,000	0
Alameda County Behavioral Health Care Services Community-Based Organizations	738,480	0	738,480	394,112	0	394,112	344,368
Center for Empowering Refugees and Immigrants	76,500	0	76,500	76,500	0	76,500	0
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	603,100	0	603,100	603,100	0	603,100	0
Chabot-Las Positas Community College	20,000	0	20,000	19,396	0	19,396	604
Cherry Hill Sobering and Detoxification Center	2,040,000	2,064,342	4,104,342	2,040,000	2,064,342	4,104,342	0
Criminal Justice Screening and In-Custody Services	4,306,000	0	4,306,000	4,306,000	0	4,306,000	0
G.O.A.L.S for Women, Inc.	50,000	0	50,000	50,000	0	50,000	0
La Familia Counseling Service	12,000	0	12,000	12,000	0	12,000	0
Mental Health Services for Juvenile Justice Center	360,000	0	360,000	360,000	0	360,000	0
National Alliance on Mental Illness (NAMI) Tri-Valley	3,683	0	3,683	3,683	0	3,683	0
Safe Alternatives to Violent Environments (SAVE)	10,000	0	10,000	10,000	0	10,000	0
Senior Support Program of Tri-Valley	20,000	0	20,000	20,000	0	20,000	0
Tri-Valley Haven for Women	25,000	0	25,000	25,000	0	25,000	0
Youth Alive!	25,000	0	25,000	25,000	0	25,000	0
Group 2: Hospital, Tertiary Care, Other							
Direct Service Planning & Administration	400,000	0	400,000	249,979	0	249,979	154,502
San Leandro Hospital	1,000,000	0	1,000,000	1,000,000	0	1,000,000	
St. Rose Hospital	2,000,000	0	2,000,000	1,500,000	0	1,500,000	500,000
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	151,213	0	151,213	151,213	0	151,213	0
Center for Elders' Independence	51,000	0	51,000	51,000	0	51,000	0
Center for Healthy Schools & Communities (School Health Centers)	1,887,000	0	1,887,000	1,887,000	0	1,887,000	0
Fire Station Health Portals	750,000	1,424,774	2,174,774	262,099	1,912,675	2,174,774	0
Fremont Aging & Family Services	51,000	0	51,000	51,000	0	51,000	0
Health Enrollment for Children	300,000	0	300,000	300,000	0	300,000	0
Health Insurance Eligibility & Enrollment	200,000	0	200,000	200,000	0	200,000	0
Health Services for Day Laborers[3]	290,131	0	290,131	255,000	35,131	290,131	0
Increase Hospice Utilization	200,000	0	200,000	182,140	0	182,140	17,860
Indigent Care Stabilization	1,150,000	0	1,150,000	1,150,000	0	1,150,000	0

Continued on next page

APPENDIX B: FY 13/14 BUDGET INFORMATION (CONTINUED)

	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 3: Primary Care (continued)							
Medical Costs for Juvenile Justice Services	447,100	0	447,100	447,100	0	447,100	0
Preventive Care Pathways	204,000	0	204,000	204,000	0	204,000	0
Primary Care Community-Based Organizations	5,611,835	0	5,611,835	5,611,835	0	5,611,835	0
Tiburcio Vasquez Health Center	60,000	0	60,000	60,000	0	60,000	0
Group 4: Public Health							
Alameda Boys & Girls Club, Inc.	102,000	0	102,000	102,000	0	102,000	0
Alameda County Asthma Start	100,000	0	100,000	100,000	0	100,000	0
Berkely Food & Housing Project	25,000	0	25,000	25,000	0	25,000	0
Center for Early Intervention on Deafness	51,000	0	51,000	51,000	0	51,000	0
City of San Leandro Senior Services	51,000	0	51,000	51,000		51,000	0
Eden Youth and Family Center	160,000	0	160,000	160,000	0	160,000	0
EMS Corps	602,800	0	602,800	598,544	0	598,544	4,256
Healthy Nail Salon Program	0	12,319	12,319	12,319	0	12,319	0
HIV Education & Prevention Project of Alameda County	31,000	0	31,000	31,000	0	31,000	0
LIFE ElderCare	10,000	0	10,000	10,000	0	10,000	0
LifeLong Medical Care: Heart 2 Heart	200,000	0	200,000	200,000	0	200,000	0
Public Health Prevention Initiative	3,135,037	0	3,135,037	3,135,037	0	3,135,037	0
School of Imagination	50,000	0	50,000	50,000	0	50,000	0
Senior Injury Prevention Program	100,000	0	100,000	100,000	0	100,000	0
Service Opportunity for Seniors (Meals-On-Wheels)	16,000	0	16,000	16,000	0	16,000	0
Spectrum Community Services, Inc.	250,000	0	250,000	250,000	0	250,000	0
Spectrum Community Services, Inc.	90,000	0	90,000	90,000	0	90,000	0
SSI Housing Trust (GA Clients)	0	947,611	947,611	346,292	601,319	947,611	0
Teleosis Institute	21,000	0	21,000	21,000	0	21,000	0
Viola Blyte Community Services	10,000	0	10,000	10,000	0	10,000	0
Youth and Family Opportunity Initiatives	2,499,000	508,685	3,007,685	2,791,517	216,168	3,007,685	0
Board of Supervisors	750,000	TBD	750,000	482,255	267,745	750,000	0
TOTAL FY 13-14	**34,321,879**	**4,957,731**	**39,279,610**	**32,343,446**	**5,062,248**	**37,405,694**	**1,878,396**

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, and these amounts may not represent Measure A fund distributions in FY 13/14.
2. Savings are unexpended funds that will revert to the general Measure A account for reallocation in future fiscal years.
3. This allocation included funding for the Day Labor Center.

APPENDIX C:
FY 13/14 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

	MEASURE A ALLOCATION FY 13/14	EXPENDED/ ENCUMBERED FY 13/14
GROUP 1: BEHAVIORAL HEALTH		
Asian Health Services (Banteay Srei)	**25,000**	**25,000**
Alameda County Behavioral Health Care Services Community-Based Organizations		
Mental Health Providers		
Adolescent Treatment Centers, Inc.	8,760	8,760
Alameda County Mental Health Association	32,267	31,149
Alameda Family Services	2,020	2,018
Alameda Family Services	2,020	2,018
Asian Community Mental Health Board	8,238	0
Axis Community Health, Inc.	3,120	2,809
Axis Community Health, Inc.	2,193	1,455
Axis Community Health, Inc.	3,064	2,052
Berkeley Addiction Treatment Services, Inc.	4,601	3,840
Bi-Bett Corporation	1,648	955
Bonita House, Inc.	49,243	49,243
Building Opportunities for Self-Sufficiency (BOSS)	13,622	13,622
Carnales Unidos Reformando Adictos, Inc.	20,095	19,972
Center For Independent Living	2,110	2,110
Community Health for Asian-Americans	2,155	0
Crisis Support Services of Alameda County	28,495	28,495
East Bay Community Recovery Project	30,755	23,012
Filipino Advocates for Justice	2,067	2,047
Horizon Services, Inc.	18,027	17,953
Horizon Services, Inc.	11,799	0
Humanistic Alternatives To Addiction, Research, and Treatment, Inc.	2,133	1,656
Latino Commission on Alcohol and Drug Abuse of Alameda County	13,017	11,468
Latino Commission on Alcohol and Drug Abuse of Alameda County	5,723	5,723
Latino Commission on Alcohol and Drug Abuse of Alameda County	2,730	2,454
Latino Commission on Alcohol and Drug Abuse of Alameda County	2,453	2,213
Latino Commission on Alcohol and Drug Abuse of Alameda County	25,000	21,234
Magnolia Women'S Recovery Programs, Inc.	3,671	4,280
Native American Health Center, Inc.	4,603	1,721
New Bridge Foundation, Inc.	35,180	31,962
New Bridge Foundation, Inc.	5,678	5,664
Second Chance, Inc.	44,377	44,377
Southern Alameda County Comitee for Raza	44,113	31,688
St. Mary's Center	3,583	3,583

	MEASURE A ALLOCATION FY 13/14	EXPENDED/ ENCUMBERED FY 13/14
GROUP 1: BEHAVIORAL HEALTH (CONTINUED)		
West Oakland Health Council, Inc.	21,623	14,580
Unallocated	278,298	0
Total Allocation	**738,480**	**394,112**
Center for Empowering Refugees and Immigrants (CERI)	**76,500**	**76,500**
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	**603,100**	**603,100**
Chabot-Las Positas Community College	**20,000**	**19,396**
Criminal Justice Screening and In-Custody Services	**4,306,000**	**4,306,000**
Detoxification/Sobering Center	**2,040,000**	**2,040,000**
G.O.A.L.S for Women, Inc.	**50,000**	**50,000**
La Familia Counseling Service	**12,000**	**12,000**
Mental Health Services for Juvenile Justice Center	**360,000**	**360,000**
National Alliance on Mental Illness (NAMI) Tri-Valley	**3,683**	**3,683**
Safe Alternatives to Violent Environments (SAVE)	**10,000**	**10,000**
Senior Support Program of Tri-Valley	**20,000**	**20,000**
Tri-Valley Haven for Women	**25,000**	**25,000**
Youth Alive!	**25,000**	**25,000**

	MEASURE A ALLOCATION FY 13/14	EXPENDED/ ENCUMBERED FY 13/14
GROUP 2: HOSPITAL, TERTIARY CARE, OTHER		
Direct Service Planning & Administration	**400,000**	**249,979**
San Leandro Hosptial	**1,000,000**	**1,000,000**
St. Rose Hospital	**2,000,000**	**1,500,000**
UCSF Benioff Children's Hospital Oakland	**3,000,000**	**3,000,000**

	MEASURE A ALLOCATION FY 13/14	EXPENDED/ ENCUMBERED FY 13/14
GROUP 3: PRIMARY CARE		
Alameda County Dental Health	**151,213**	**151,213**
Center for Elders' Independence	**51,000**	**51,000**
Center for Healthy Schools & Communities (School Health Centers)		
Alameda County Medical Center	105,000	105,000
Alameda Family Services	190,000	190,000
CHRCO	140,000	140,000
City of Berkeley	120,000	120,000
East Bay Asian Youth Center	70,000	70,000
La Clinica de La Raza, Inc.	280,000	280,000
Tiburcio Vasquez Health Center	140,000	140,000

	MEASURE A ALLOCATION FY 13/14	EXPENDED/ ENCUMBERED FY 13/14
GROUP 3: PRIMARY CARE (CONTINUED)		
Unity Council Boys and Men of Color	110,100	110,100
University of California, San Francisco	314,000	314,000
Evaluation	417,900	417,900
Total Allocation	**1,887,000**	**1,887,000**
Fire Station Health Portals	**750,000**	**262,099**
Fremont Aging & Family Services	**51,000**	**51,000**
Health Enrollment for Children	**300,000**	**300,000**
Health Insurance Eligibility & Enrollment	**200,000**	**200,000**
Health Services for Day Laborers		
Health Services for Day Laborers: Community Initiatives (Day Labor Center)	120,131	120,130
Health Services for Day Laborers: Multicultural Institute	85,000	85,000
Health Services for Day Laborers: Street Level Health Project	85,000	85,000
Total Allocation	**290,131**	**290,130**
Hospice: Getting The Most Out of Life Program	**200,000**	**182,140**
Indigent Care Stabilization (6 Providers)		
Preventive Care Pathways	200,000	200,000
Healthy Communities, Inc.	200,000	200,000
Roots Community Center	150,000	150,000
Integrated Medical Assoicates of Alameda County	200,000	200,000
Davis Street Family Resource Center	200,000	200,000
West Oakland Health Council	200,000	200,000
Total Allocation	**1,150,000**	**1,150,000**
Medical Costs for Juvenile Justice Services	**447,100**	**447,100**
Medical Costs for Juvenile Justice Center: Direct Service Planning & Administration	261,000	261,000.0
Medical Costs for Juvenile Justice Center: Mind Body Awareness Project	56,100	56,100
Medical Costs for Juvenile Justice Center: Niroga Institute	40,000	40,000
Medical Costs for Juvenile Justice Center: Victims of Crime	144,000	90,000
Total Allocation	**447,100**	**447,100**
Preventive Care Pathways	**204,000**	**204,000**
Primary Care Community-Based Organizations		
Alameda Health Consortium		
Asian Health Services	724,975	710,760
AXIS Community Health Center	528,636	518,271
Healthy Communities	166,376	163,114
La Clínica de La Raza	1,381,636	1,354,546
LifeLong Medical Center	651,820	639,039
Native American Health Center	303,600	297,647
Tiburcio Vasquez Health Center	702,507	688,733
Tri-City Health Center	589,508	577,949
West Oakland Health Council	539,882	529,323
Unallocated	22,895	
Total Allocation	**5,611,835**	**5,611,835**
Tiburcio Vasquez Health Center	**60,000**	**60,000**

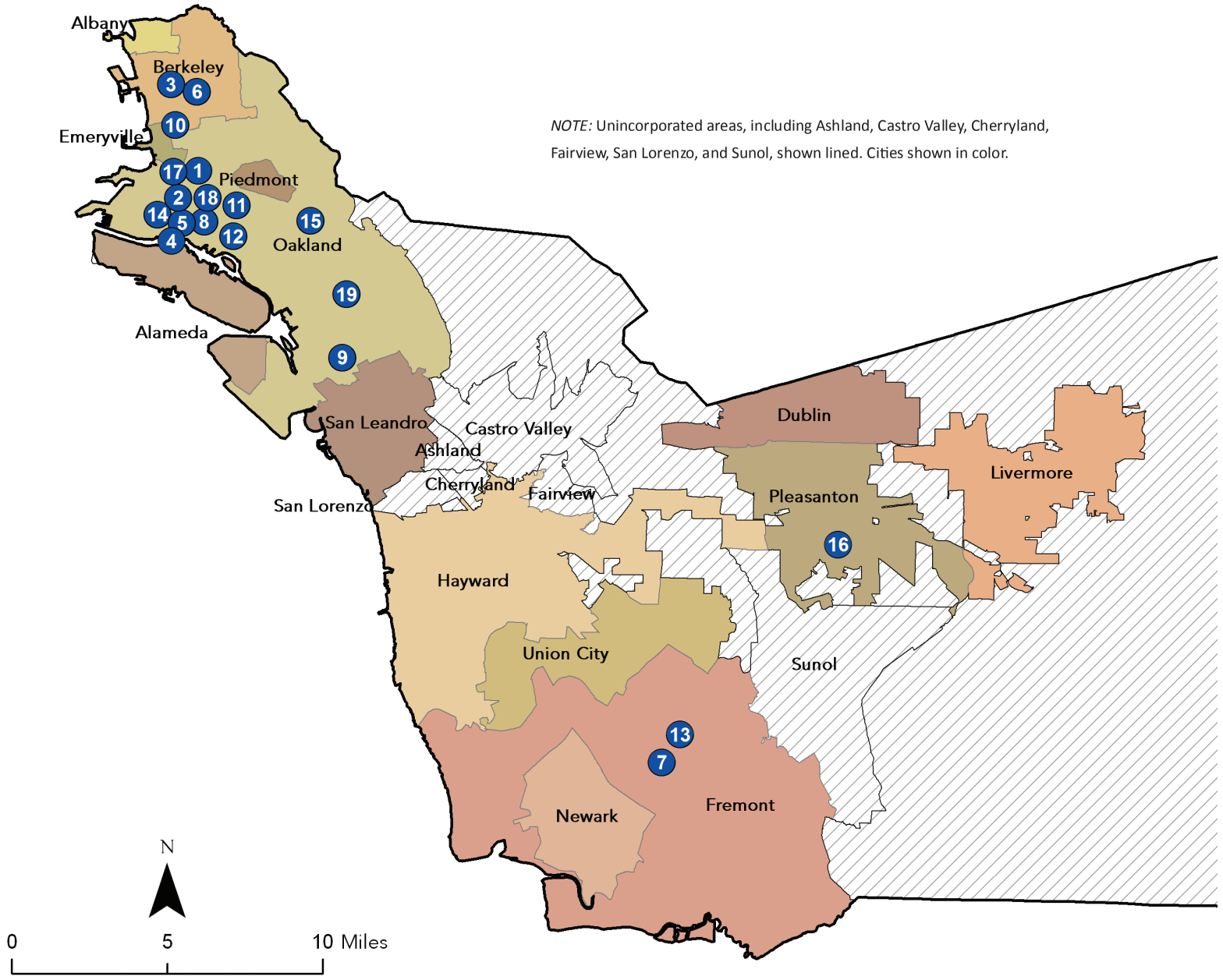
	MEASURE A ALLOCATION FY 13/14	EXPENDED/ ENCUMBERED FY 13/14
GROUP 4: PUBLIC HEALTH		
Alameda Boys & Girls Club, Inc.	**102,000**	**102,000**
Alameda County Asthma Start	**100,000**	**100,000**
Berkely Food & Housing Project	**25,000**	**25,000**
Center for Early Intervention on Deafness	**51,000**	**51,000**
City of San Leandro Senior Services	**51,000**	**51,000**
Eden Youth and Family Center	**160,000**	**160,000**
EMS Corps	**602,800**	**598,544**
HIV Education & Prevention Project of Alameda County (HEPPAC)	**31,000**	**31,000**
Improve Field Sanitation Conditions/Nail Salons	**0**	**12,319**
LIFE ElderCare	**10,000**	**10,000**
LifeLong Medical Care: Heart 2 Heart	**200,000**	**200,000**
Public Health Prevention Initiative		
Chronic Disease and Injury Prevention		
Asthma	303,967	322,015
Community-Designed Initiative	81,513	70,389
Diabetes	262,097	239,650
EMS	300,135	155,762
Healthy Kids Healthy Teeth	295,839	259,080
Project New Start	17,479	4,661
Total	**1,261,030**	**1,051,557**
Health Inequities & Community Capacity Building		
Community Nursing	95,037	246,500
Community-Designed Initiative	110,917	50,200
FHS-Healthy Passage System of Care	78,441	35,858
HIV Prevention	98,202	(7,772)
Immunization Registry	196,378	189,036
Office of Director / CAPE	481,465	438,541
Total	**1,060,440**	**952,363**
Obesity Prevention and School Health		
Community-Designed Initiative	360,464	121,791
Nutrition Services	296,302	282,007
Public Health Nursing	176,814	198,566
Total	**833,580**	**602,365**
Total Allocation	**3,135,037**	**2,278,231**
School of Imagination	**50,000**	**50,000**
Senior Injury Prevention Program	**100,000**	**100,000**
Service Opportunity for Seniors (Meals-On-Wheels)	**16,000**	**16,000**
Spectrum Community Services, Inc.	**90,000**	**90,000**
Spectrum Community Services, Inc.	**250,000**	**250,000**
SSI Housing Trust (GA Clients)	**0**	**346,292**
Teleosis Institute	**21,000**	**21,000**
Viola Blyte Community Services	**10,000**	**10,000**

	MEASURE A ALLOCATION FY 13/14	EXPENDED/ ENCUMBERED FY 13/14
GROUP 4: PUBLIC HEALTH (CONTINUED)		
Youth and Family Opportunity Initiatives		
Alameda Family Services	100,000	100,000
Alternatives in Action (AIA)	250,000	250,000
Berkeley Youth Alternatives (BYA)	100,000	100,000
City of Fremont	150,000	150,000
East Bay Asian Youth Center (EBAYC)	100,000	100,000
Eden Youth and Family Center	100,000	100,000
Fremont Unified School District	100,000	100,000
La Familia	150,000	150,000
Newark Unified School District	100,000	100,000
New Haven Unified School District	100,000	100,000
REACH Ashland Youth Center	1,041,000	1,149,000
Westcoast	90,000	90,000
Youth Radio	100,000	100,000
Total Allocation	**2,499,000**	**2,791,517**

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS FUNDED BY MEASURE A IN FY 13/14

#	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	Daybreak Adult Care Centers	Oakland
9	East Oakland Boxing Association	Oakland
10	Higher Ground Neighborhood Development	Oakland

#	PROVIDER	CITY
11	HIV Education and Prevention Project of Alameda County	Oakland
12	Lotus Bloom	Oakland
13	Lucile Packard Children's Hospital Stanford	Fremont
14	Mandela Market Place	Oakland
15	Niroga Institute, Inc.	Oakland
16	Senior Support of the Tri-Valley	Pleasanton
17	St. Mary Center	Oakland
18	Tides Center	Oakland
19	United Seniors of Oakland and Alameda	Oakland



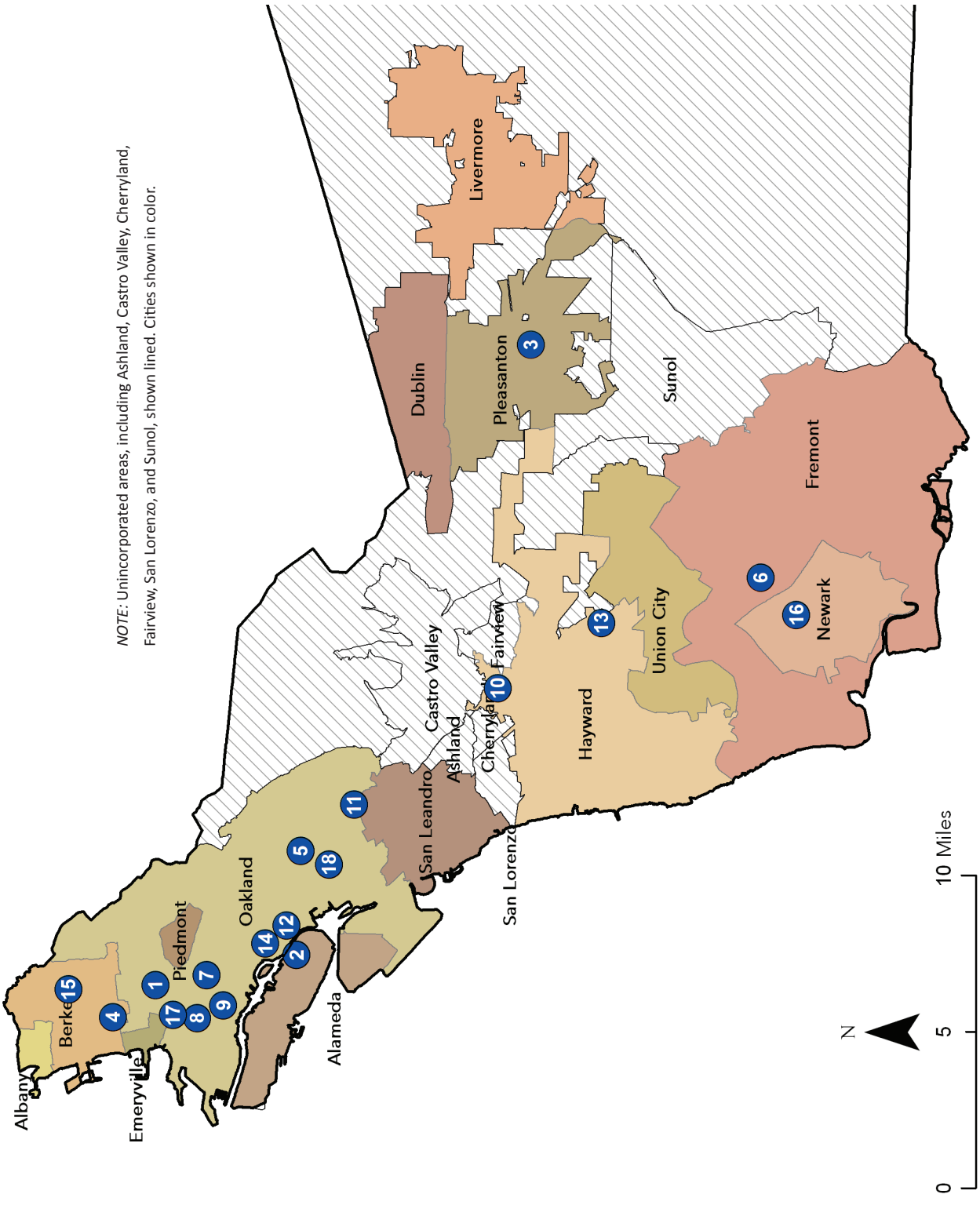
NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS
FUNDED BY MEASURE A IN FY 13/14

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES ALCOHOL AND OTHER DRUG PROVIDERS FUNDED BY MEASURE A IN FY 13/14

#	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.	Hayward
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

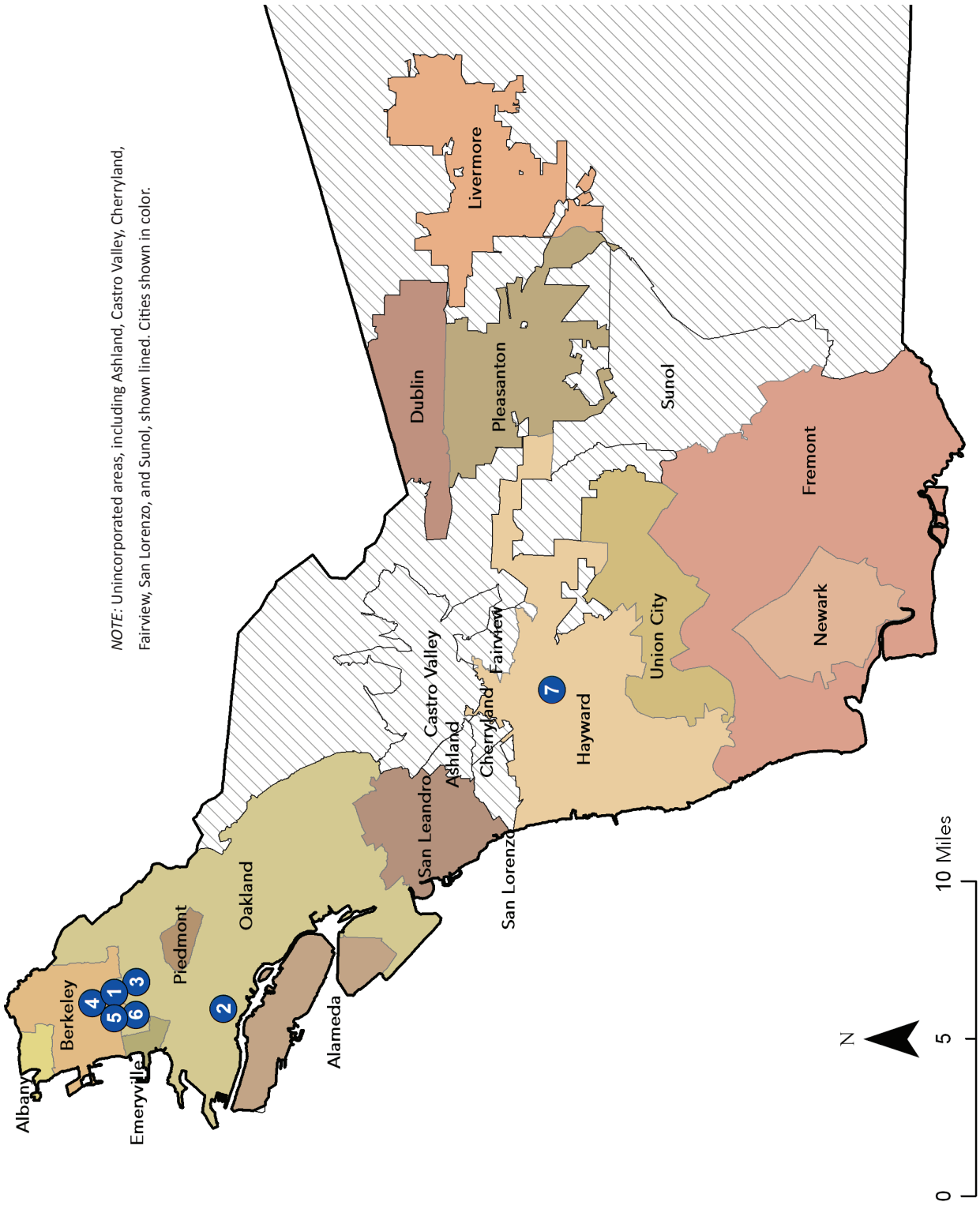
MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
ALCOHOL AND OTHER DRUG PROVIDERS
FUNDED BY MEASURE A IN FY 13/14



MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 13/14

#	PROVIDER	CITY
1	Alameda County Mental Health Association	Berkeley
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 13/14

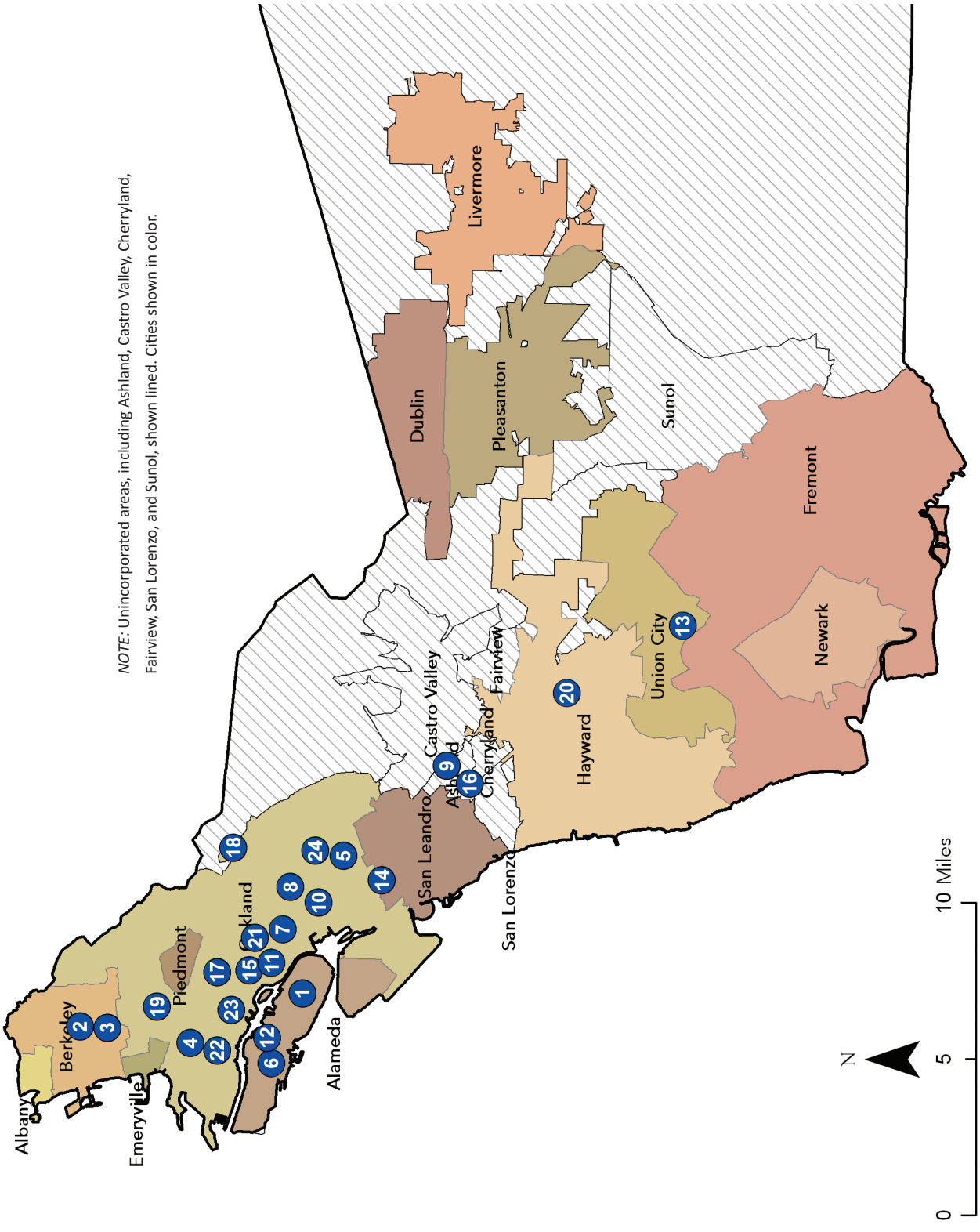


MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 13/14

#	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	Island/BASE High School-Based Health Center	Alameda

#	PROVIDER	CITY
13	Logan Health Center	Union City
14	Madison Health Center	Oakland
15	Roosevelt Health Center	Oakland
16	San Lorenzo High Health Center	San Lorenzo
17	Shop 55 Wellness Center	Oakland
18	Skyline High School Health Center	Oakland
19	TechniClinic	Oakland
20	Tennyson Health Center	Hayward
21	United for Success/Life Academy Health Center	Oakland
22	West Oakland Middle School Health Center	Oakland
23	Youth Heart Health Center (La Escuelita Education Complex)	Oakland
24	Youth Uprising / Castlemont Health Center	Oakland

MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 13/14

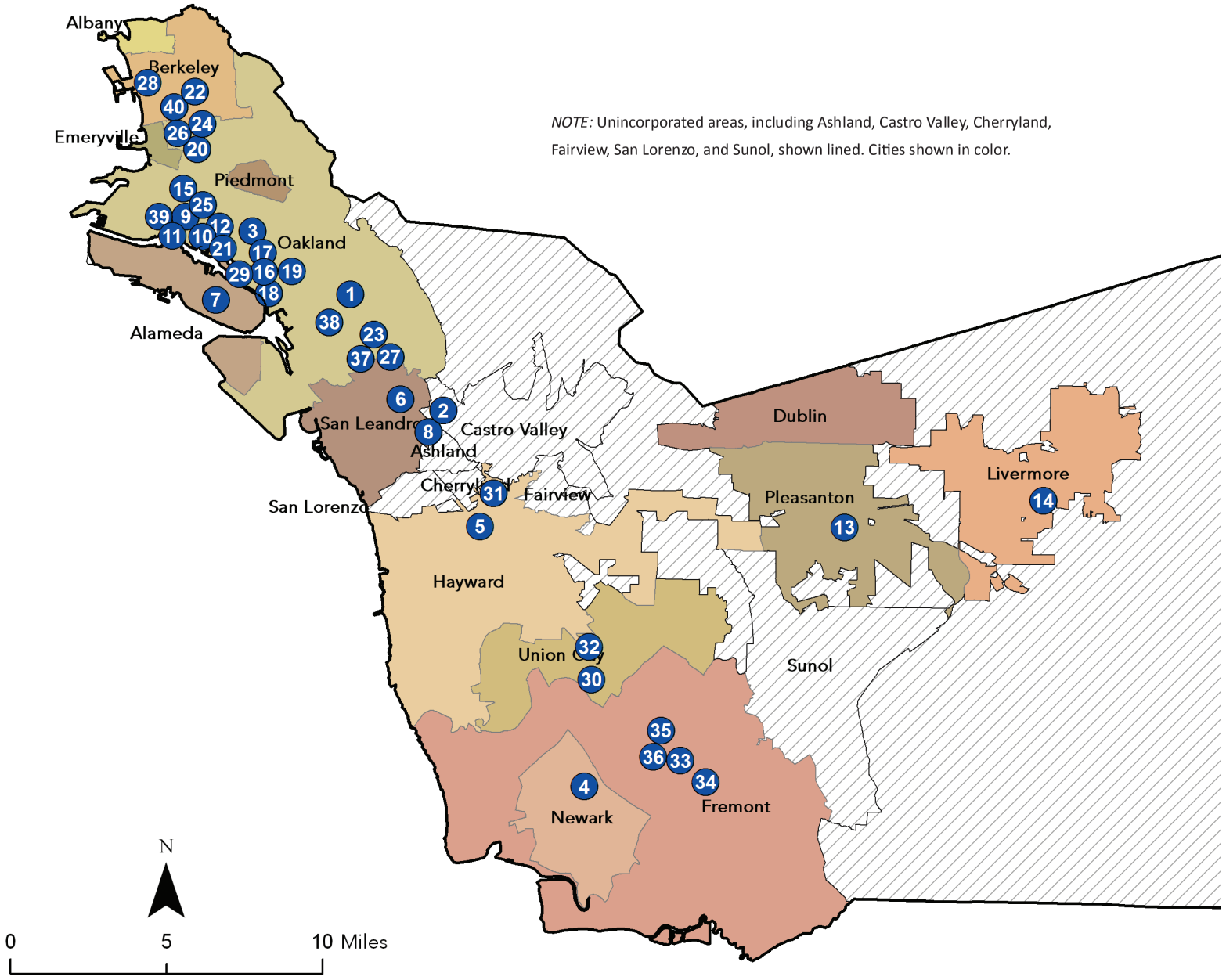


MAP 5
HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 13/14

#	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	Asian Health 835 Clinic	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
HEALTHY COMMUNITIES		
15	Save-a-Life Wellness Center	Oakland
LA CLÍNICA DE LA RAZA		
16	Casa del Sol	Oakland
17	Clinica Alta Vista	Oakland
18	La Clinica de la Raza	Oakland
19	La Clinica Dental	Oakland
20	La Clinica Dental/Children's	Oakland
21	San Antonio Neighborhood	Oakland

#	PROVIDER	CITY
LIFELONG MEDICAL CENTER		
22	Berkeley Primary Care Access	Berkeley
23	Howard Daniel Clinic	Oakland
24	LifeLong Dental Care	Berkeley
25	LifeLong Medical Care DOC	Oakland
26	Over 60 Health Center	Berkeley
27	East Oakland	Oakland
28	West Berkeley Family Practice	Berkeley
NATIVE AMERICAN HEALTH CENTER		
29	Native American Health Center	Oakland
TIBURCIO VASQUEZ HEALTH CENTER, INC.		
30	Tiburcio Vasquez, Logan Health	Union City
31	Tiburcio Vasquez, Hayward	Hayward
32	Tiburcio Vasquez, Union City	Union City
TRI-CITY HEALTH CENTER		
33	Tri-City Health Center - Liberty	Fremont
34	Tri-City Health Center - Main	Fremont
35	Tri-City Health Center - Mowry	Fremont
36	Tri-City Health Center - State	Fremont
WEST OAKLAND HEALTH COUNCIL		
37	Albert J. Thomas Medical Clinic	Oakland
38	East Oakland Health Center	Oakland
39	West Oakland Health Center	Oakland
40	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 13/14