

Fiscal Year
2018/2019



MEASURE A

Essential Health Care Services Tax Ordinance

MEASURE A CITIZEN OVERSIGHT COMMITTEE
13TH REPORT TO THE ALAMEDA COUNTY
BOARD OF SUPERVISORS AND THE PUBLIC

Review of Expenditures July 1, 2018 – June 30, 2019

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AND THE PUBLIC**

REVIEW OF EXPENDITURES IN

Fiscal Year (FY) 2018/2019

July 1, 2018 – June 30, 2019

PHOTO CREDITS

Cover photos (L to R): Alameda Boys & Girls Club, Center for Early Intervention on Deafness, City of San Leandro Senior Services, Center for Early Intervention on Deafness, Health Services for Day Laborers: Multicultural Institute

Page 2 (L to R): Spectrum Community Services, Inc. (Meals on Wheels), George Mark Children's House, ACCMA Community Health Foundation/East Bay Conversation Project, Alameda Boys & Girls Club

Page 4: Latino Men and Boys Program

Page 5: Fremont Aging and Family Services

Page 6: LifeLong Medical Care (Heart 2 Heart)

Page 7: Countywide Plan for Seniors (Injury Prevention, Meals, Nutrition)

Page 8: Youth and Family Opportunity Initiatives

Page 9: Direct Medical and Support Services (Oakland): Preventive Care Pathways

Page 19: Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)

Page 23: Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services

Page 25: La Familia Counseling Services

Page 28: Mental Health Services for Newcomers and Immigrants (CERI)

Page 38: Alameda County Dental Health

Page 41: Center for Healthy Schools and Communities (School Health Centers)

Page 44: Fremont Aging and Family Services

Page 47: Health Services for Day Laborers: Multicultural Institute

Page 49: Health Services for Day Laborers: Street Level Health Project

Page 55: Medical Costs for Juvenile Justice Center: Victims of Crime

Page 57: Preventive Care Pathways

Page 61: Tiburcio Vasquez Health Center, Inc.

Page 63: Washington Hospital Healthcare Foundation

Page 66: ACCMA Community Health Foundation/East Bay Conversation Project

Page 68: Alameda Boys & Girls Club, Inc.

Page 70: Asthma Start

Page 72: Center for Early Intervention on Deafness

Page 74: City of San Leandro Senior Services

Page 76: Countywide Plan for Seniors: Getting the Most Out of Life

Page 80: Countywide Plan for Seniors: Injury Prevention, Meals, Nutrition

Page 82: Eden Youth and Family Center

Page 86: Emergency Preparedness, Mitigation, Response, & Recovery

Page 88: George Mark Children's House

Page 92: Healthy Food Healthy Families: Alameda County Community Food Bank

Page 93: Healthy Food Healthy Families: Alameda County Deputy Sheriffs' Activities League

Page 95: Healthy Homes Department Fixing to Stay & Group Living Facilities Project

Page 97: HERS Breast Cancer Foundation

Page 103: La Familia Counseling Services: Youth Resiliency

Page 105: Latino Men and Boys Program

Page 107: Lend A Hand Foundation

Page 110: LifeLong Medical Care Heart 2 Heart

Page 113: Nutrition Services in West Oakland: City Slicker Farms

Page 117: Public Health Prevention Initiative

Page 127: Sandra Wing Healing Therapies Foundation

Page 130: Spectrum Community Services, Inc. (Fall Prevention Program)

CONTENTS

MEASURE A CITIZEN OVERSIGHT COMMITTEE MEMBERS	1
EXECUTIVE SUMMARY	2
HOW THE MONEY WAS SPENT	10
FY 18/19: 75% OF MEASURE A FUNDS ALLOCATED TO Alameda Health System	11
REVIEW OF FY 18/19 EXPENDITURES: 25% OF MEASURE A FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS	
GROUP 1: BEHAVIORAL HEALTH	
Behavioral Health and Alcohol and Other Drug (AOD) Community-Based Providers	15
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	18
Cherry Hill Detoxification and Sobering Centers	20
Criminal Justice Screening and In-Custody Services	21
Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services	23
La Familia Counseling Services	25
Mental Health Services for Juvenile Justice Center	26
Mental Health Services for Newcomers and Immigrants (CERI)	28
GROUP 2: HOSPITAL, TERTIARY CARE, OTHER	
St. Rose Hospital	31
UCSF Benioff Children's Hospital Oakland	33
GROUP 3: PRIMARY CARE	
Alameda County Dental Health	38
Center for Elders' Independence	40
Center for Healthy Schools and Communities (School Health Centers)	41
Fremont Aging and Family Services	44
Health Enrollment for Children	46
Health Services for Day Laborers: Multicultural Institute	47
Health Services for Day Laborers: Street Level Health Project	49
Medical Costs for Juvenile Justice Center: Direct Service Planning and Administration	51
Medical Costs for Juvenile Justice Center: Niroga Institute	53
Medical Costs for Juvenile Justice Center: Victims of Crime	55
Preventive Care Pathways	57
Primary Care Community-Based Organizations	58
Tiburcio Vasquez Health Center, Inc.	61
Washington Hospital Healthcare Foundation	63
GROUP 4: PUBLIC HEALTH	
ACCMA Community Health Foundation/East Bay Conversation Project	66
Alameda Boys & Girls Club, Inc.	68
Asthma Start	70
Center for Early Intervention on Deafness	72
City of San Leandro Senior Services	74
Countywide Plan for Seniors: Getting the Most Out of Life	76
Countywide Plan for Seniors: Home-Based Nursing Case Management	78
Countywide Plan for Seniors: Injury Prevention, Meals, Nutrition	80

Eden Youth and Family Center	82
Emergency Medical Services (EMS) Corps	84
Emergency Preparedness, Mitigation, Response, & Recovery	86
George Mark Children’s House	88
Health Services for Persons Who Inject Drugs HIV Education and Prevention Project of Alameda County (HEPPAC)	90
Healthy Food Healthy Families: Alameda County Community Food Bank	92
Healthy Food Healthy Families: Alameda County Deputy Sheriffs’ Activities League	93
Healthy Food Healthy Families: UCSF Benioff Children’s Hospital Oakland	94
Healthy Homes Department Fixing to Stay & Group Living Facilities Project	95
HERS Breast Cancer Foundation	97
HIV Education and Prevention Project of Alameda County (HEPPAC) OPEND Program	98
Home Visiting Services	100
La Familia Counseling Services: Youth Resiliency	103
Latino Men and Boys Program	105
Lend A Hand Foundation	107
LIFE ElderCare	108
Lifelong Medical Care Heart 2 Heart	110
Needle Exchange Emergency Distribution	112
Nutrition Services in West Oakland: City Slicker Farms	113
Oakland Unified School District: Behavioral Health Stipends	115
Oakland Unified School District: Water Hydration Stations	116
Public Health Prevention Initiative	117
Public Health Prevention Initiative: Emergency Medical Services (EMS) Injury Prevention	122
Public Health Services for Homeless Residents: Abode Services	125
Sandra Wing Healing Therapies Foundation	126
Senior Injury Prevention Program	127
Social Good Fund, Inc. (The East Oakland Collective)	129
Spectrum Community Services, Inc.: Fall Prevention Program	130
Spectrum Community Services, Inc.: Meals on Wheels	132
Women’s Cancer Resource Center	133
Youth and Family Opportunity Initiatives	134

APPENDICES

APPENDIX A: MEASURE A AUDITOR-CONTROLLER REPORT	139
APPENDIX B: FY 18/19 BUDGET INFORMATION	140
APPENDIX C: FY 18/19 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM	142
APPENDIX D: MAPS: GEOGRAPHIC DISTRIBUTION OF PROVIDERS FUNDED BY MEASURE A IN FY 18/19	147

MEASURE A CITIZEN OVERSIGHT COMMITTEE MEMBERS

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

For more information regarding the Measure A Oversight Committee, please contact Alameda County Health Care Services Agency Administrative & Financial Services Manager James Nguyen at James.Nguyen@acgov.org.

SEAT	COMMITTEE MEMBER	REPRESENTING/NOMINATED BY
Seat 1	(vacant)	League of Women Voters
Seat 2	Susan Hauser	League of Women Voters
Seat 3	(seat in abeyance)	Alameda County Taxpayers Association, Inc.
Seat 4	(vacant)	Alameda County Mental Health Board
Seat 5	Zhonnet Harper	Alameda County Public Health Commission
Seat 6	Kuwaza Imara	Central Labor Council of Alameda County
Seat 7	Rachel Richman	Central Labor Council of Alameda County
Seat 8	Rebecca Rozen	Hospital Council of Northern California
Seat 9	Frank Staggers, M.D. (previously Art Chen, M.D.)	Alameda-Contra Costa Medical Association
Seat 10	Colin Arnold	City of Berkeley
Seat 11	Christine Martin	City Managers' Association
Seat 12	Kelly McAadoo	City Managers' Association
Seat 13	Michael McCorriston	District 1 Supervisor Scott Haggerty
Seat 14	(vacant)	District 2 Supervisor Richard Valle
Seat 15	Charles Go, Ph.D.	District 3 Supervisor Wilma Chan
Seat 16	Linda Tangren	District 4 Supervisor Nate Miley
Seat 17	(vacant)	District 5 Supervisor Keith Carson

Note: The members above were involved in the development of the FY 18/19 Measure A Oversight Committee Report.

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY STAFF

Colleen Chawla, *Agency Director*

Kristel Acacio, *Financial Services Director*

James Nguyen, *Administrative & Financial Services Manager*

Tamara Lawson, *Administrative Specialist II*

Justine Eclipse, *Secretary II*

Kin Leung, *Specialist Clerk I*



1/2 % History of the Measure

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

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

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

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

FY 2018/2019 Measure A Executive Summary

(July 1, 2018 – June 30, 2019)

About the Measure A

Citizen Oversight Committee

One of the provisions of Measure A required the establishment of a Citizen Oversight Committee. The Measure states: “The citizen oversight committee shall annually review the expenditure of the essential health care services tax fund for the prior year and shall report to the Board of Supervisors on the conformity of such expenditures.”

With ongoing support from the Alameda County Health Care Services Agency (HCSA), the Oversight Committee spent several months reviewing allocation reports, highlighting accomplishments while deliberating and communicating concerns to providers, and reviewing and editing the Measure A annual report. Report forms that are based on the Results-Based Accountability methodology, along with in-person presentations from several providers, were used to review all funding allocations.



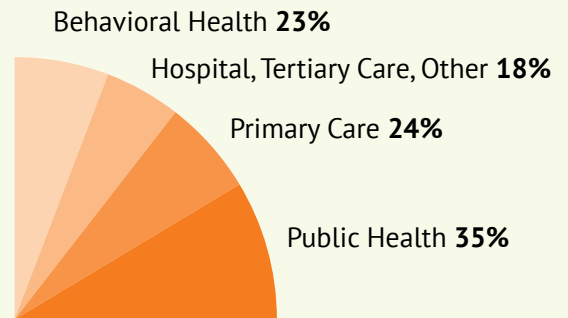
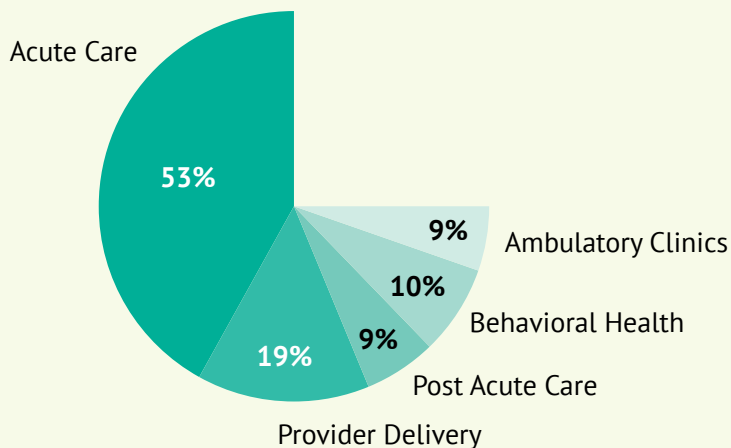
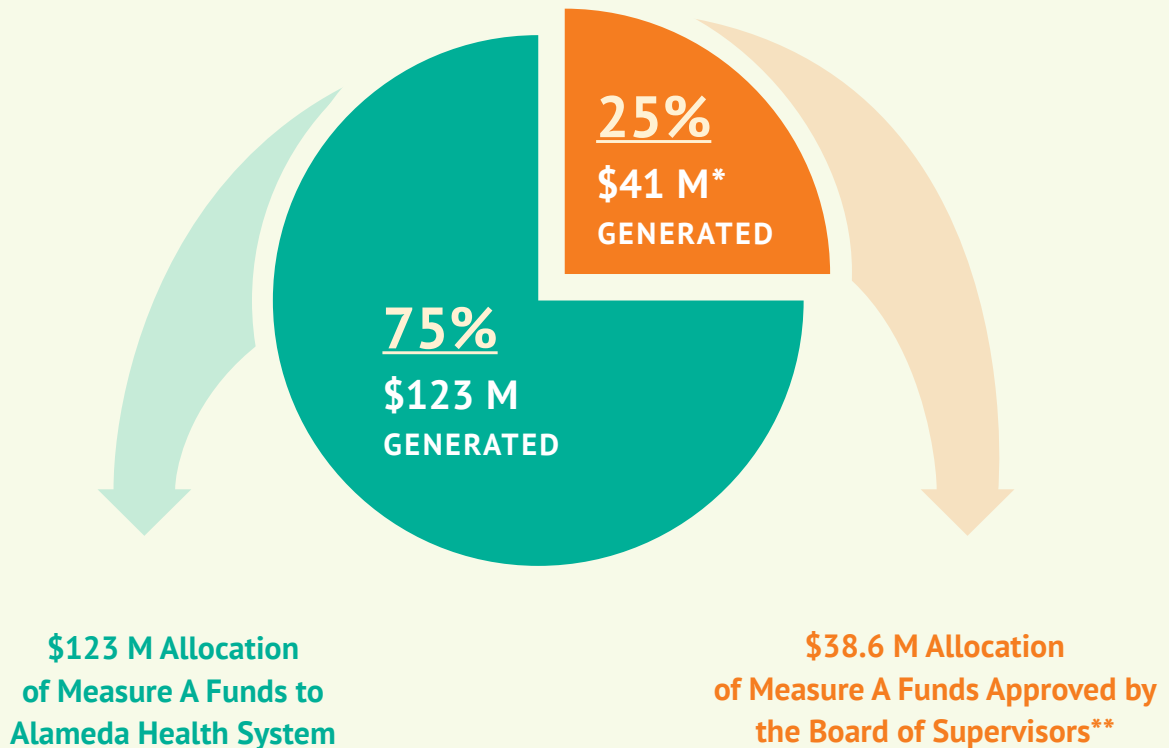
Overall Conclusion

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

Measure A generated **\$164,198,071*** in FY 18/19.

Of the \$164,198,071 that Measure A generated in FY 18/19, AHS received 75%, and the remainder of the funds was distributed by the Alameda County Board of Supervisors (Board) to many health care providers who provide essential health care services.

DISTRIBUTION OF MEASURE A FUNDS



* Does not include interest earned.

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

Highlights

Since the full implementation of the Affordable Care Act in 2014, more than 16,000 newly eligible Alameda County residents have been enrolled in the state's Medi-Cal program, and more than 57,000 County residents have been enrolled in Covered California. Despite these achievements in increasing the number of individuals who have health insurance, an estimated 72,422 individuals, or 5.1% of County residents, remain uninsured, according to the American Community Survey estimates for 2019. (Source: U.S. Census Bureau, Small Area Health Insurance Estimates)

However, during this time period under the Trump administration, serious efforts were taken to dismantle the Affordable Care Act, which may erode public health coverage. Thus, Measure A revenues continue to play a critical role in helping indigent, uninsured, and low income residents of the County—who depend on the County's health care safety net—maintain access to essential health services.

With regard to Measure A recipient reporting, the Committee recognizes an ongoing trend of improvement in the quality and level of detail in the reporting process compared to prior years. This is due in part to the ongoing effort of the Committee and HCSA to improve the accountability of Measure A recipients by providing ongoing technical assistance training to providers.

Service to a Large—and Growing—Number of County Residents

Service providers receiving Measure A funding continue to serve a large portion of County residents. For example, AHS, which receives 75% of Measure A tax revenues, provided services to 166,057 patients in FY 18/19, while the providers under the Public Health Prevention Initiative served a cumulative total of 39,010 County residents through Measure A. Even among smaller providers, numbers continue to grow. The Tiburcio Vasquez Health Center, Inc. health center at Tennyson High School served roughly four times more clients than the preceding year, while the center at Hayward High School served 8% more clients. At LIFE ElderCare, the number of older adults served increased 121% from the previous year.

Health Care Across All Segments

As in prior years, Measure A service providers continue to reach all of the County's residents, across geography, demographics, and even language. South and East County residents are represented by La Familia Counseling Services and Spectrum Community Services, Inc. (Meals on Wheels), among others, while multiple providers are located in the



Latino Men and Boys Program



AHS served over **166,000** County residents through Measure A in FY 18/19, while the Alameda County Public Health Department Public Health Prevention Initiative served over **39,000**.



Fremont Aging and Family Services

population centers of Oakland and Berkeley. Several funding recipients focus on resident subgroups, including seniors, youth, the unhoused, the incarcerated, and those struggling with substance use. And service offerings reflect the County's wide array of languages—beyond English and Spanish, various providers offer their services in Cantonese, Farsi, Mandarin, Punjabi, Tagalog, and Vietnamese, among many others.

Goals Met and Exceeded

In most cases, Measure A recipient providers met all or nearly all of their performance goals. And the providers often exceeded these goals, sometimes greatly. One of the County's Behavioral Health and Alcohol and Other Drug (AOD) Community-Based Providers, Mental Health Association of Alameda County (MHAAC), exceeded their goals for responding to phone calls by nearly 300%. At Healthy Food Healthy Families: Alameda County Community Food Bank, the total number of meals served (28,978) exceeded the target (21,428) by 135%. The LifeLong Medical Care Heart 2 Heart (H2H) program exceeded all target goals, including an increase of community members served through engagement activities of almost 2,000%—from a target of 100 to an actual number of 1,929.

Focus on Mental and Behavioral Health

Measure A recipients provide services across the whole-person health spectrum, with many focused on mental and behavioral health issues. These programs support improved outcomes in personal and social development for clients ranging from youth to seniors. For example, 95% of Niroga Institute youth class participants reported that the class was helpful for managing emotions and stress, while 85% of Sandra Wing Healing Therapies Foundation clients indicated that their Care Team Member helped them cope with the physical and emotional difficulties they were experiencing.

Quantifiable Impact

Satisfaction surveys reveal that recipients are using their Measure A funding to effectively address the needs and concerns of their patients and clients. At St. Rose Hospital (SRH), the patient satisfaction score for communication with nurses increased four points from the preceding year to 84.6, exceeding the target of 83.9. Through Medical Costs for Juvenile Justice Center: Direct Service Planning and Administration, 88% of youth who received medical services were satisfied with them.

Access Where It Counts

Measure A funding recipients utilize community-based and mobile locations to make services accessible to populations that have less mobility, lack transportation to or trust in traditional medical settings, or are otherwise hard to reach—populations that often have a great need for services. Through the Health Services for Day Laborers allocation, 100% of individuals served by Multicultural Institute’s (MI’s) mobile health services reported that they would not have had access to services if it weren’t for MI or its partners, and 94% of clients accessing the Street Level Health Project food pantry reported that they would not have received healthy food if they did not get it through the pantry.

Knowledge = Prevention

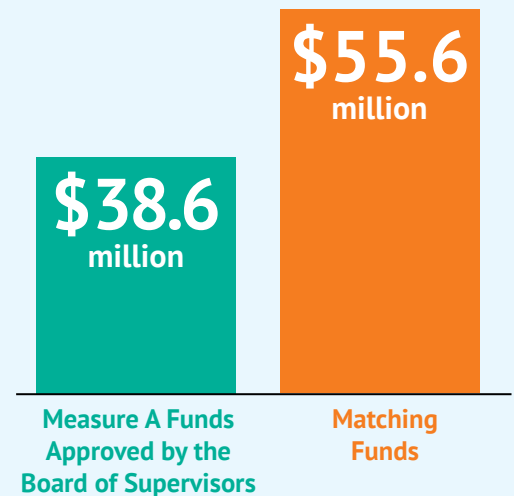
Measure A funding recipients wisely direct some of their efforts to improving caregiver and client knowledge, thus helping prevent health and life crises before they occur. At Criminal Justice Screening and In-Custody Services, 100% of Adult Forensic Behavioral Health (AFBH) leadership staff reported that, as a result of participation in suicide prevention meetings, they felt more prepared to assess and treat inmates with high risk for suicide. Ninety-five percent of individuals contacted through the ACCMA Community Health Foundation/East Bay Conversation Project were more likely to engage in advance care planning following the outreach. And 98% of HIV Education and Prevention Project of Alameda County (HEPPAC) workshop participants reported increased knowledge of at least one protective behavior such as safer injection practices or HIV/HCV and overdose prevention.

Return on Investment

While health care outcomes are the most important indicator of Measure A’s value, the funding also shows its worth in strictly financial terms. Over 25% of recipients leveraged their Measure A allocation to obtain matching funds from government programs, private and public foundations, and individuals. These matching funds often represent a more-than-50% return on the allocation, and sometimes exceed 100%. The Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative) received a nearly 250% return in matching funds, Alameda County Dental Health and Fremont Aging and Family Services nearly 300%, Healthy Food Healthy Families: Alameda County Deputy Sheriffs’ Activities League over 400%, and the Center for Healthy Schools and Communities (School Health Centers) almost 1,400%.



LifeLong Medical Care Heart 2 Heart



General Concerns and Recommendations



Countywide Plan for Seniors
Injury Prevention, Meals & Nutrition

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 (2004-2019) and in the foreseeable future.

Many families, especially those living in disadvantaged communities, have not benefited from the economic recovery in recent years and face rising housing and living costs, which significantly impact the health of County residents. According to EveryOne Counts! 2018 Homeless Count and Survey data submitted to the U.S. Department of Housing and Urban Development (HUD), an estimated 8,022 County residents experiencing homelessness were counted. As the housing and homelessness crisis continues to grow in Alameda County, Measure A continues to play a vital role in providing essential health services to many vulnerable residents, including low income families and seniors.

The Committee urges Alameda County to pay close attention to public health policy changes that relate to homelessness and housing affordability that may have significant impacts on health care access or the County's safety net. In addition, Alameda County should continue to closely monitor efforts that threaten entitlement programs, change the definition of Public Charge, or dismantle the Affordable Care Act.

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

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

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

RECOMMENDATION: Recruitment of Oversight Committee membership should place an ongoing focus on representing the diverse make-up of the population served by Measure A as part of the Committee's continuous quality improvement efforts.

CONCERN: The Committee expresses an ongoing concern that the County Counsel's interpretation of the Measure A ordinance limits the Committee's ability to review program efficacy and cost-effectiveness.

The Oversight Committee believes that the interpretation of the statute must be revised to expand the role of the Committee and appropriately allocate Measure A funds for administrative staff to expand the oversight of contracts, including programmatic and financial audits or other methods to ensure the effective use of public funds to all grantees.

As part of its role in providing fiscal oversight, the Committee recognizes a need for providers and HCSA to work together to evaluate the long-term impact of Measure A investments in Alameda County.

RECOMMENDATION: The Board should authorize and fund HCSA to include evaluations of Measure A programs as part of its initiative to improve oversight and outcomes in selected programs.

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

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

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



Youth and Family Opportunity Initiatives



Direct Medical and Support Services (Oakland)
Preventive Care Pathways

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

RECOMMENDATION: Organizations that do not provide adequate information may not be considered for future funding.

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

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

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

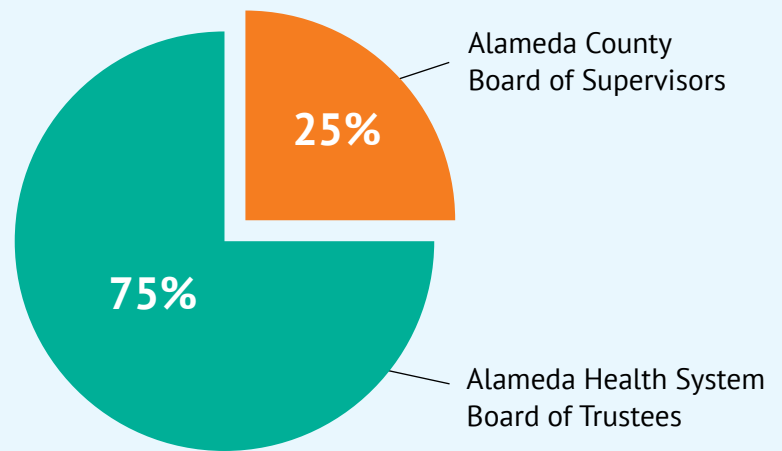
RECOMMENDATION: Ascertain awardees who consistently do not use their full allocated funds, and reduce their allocated funding as appropriate.

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 ALLOCATIONS



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

In FY 18/19, Measure A generated \$164,198,071 (not including interest earned). The funds were allocated as follows:

Alameda Health System (75%): \$123,148,555

Alameda County (non-AHS) (25%): \$41,049,520

TOTAL: \$164,198,071

In FY 18/19, the Alameda County approved budget totaled \$3.4 billion. The Alameda County Health Care Services Agency* approved budget totaled \$856 million, or 25.1% of the total County budget. Measure A revenues not specifically designated for AHS accounted for \$32,618,942, or 1%.

* Excludes Emergency Medical Services and Vector Control

The following sections in the report provide more detail on how AHS and the Board spent Measure A funds in FY 18/19, which includes revenue generated in the reporting year as well as unspent funds earned in previous years.

FY 18/19: 75% of Measure A Funds Allocated to Alameda Health System

alamedahealthsystem.org



FY 18/19 Allocation: \$125,492,615 | Expended/Encumbered: \$125,492,615



Individuals served by Measure A: 166,057 (Total individuals served: 166,057)



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

Background

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

AHS services are based on the following pillars:

- **Access.** Decrease check-in-to-discharge time for ambulatory appointments. This results in additional appointments made and more patients seen in the clinics.
- **Quality.** Decrease hospital-acquired infections and harms. Reducing hospital-acquired infections and harms improves the health of patients and decreases the length of stay, which can lead to improved outcomes and decreased utilization.
- **Experience.** Improve Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) scores. The HCAHPS and CGCAHPS surveys reflect the voices of patients and provide AHS with information about their experience. AHS uses the data and patients' comments to determine what key drivers impact the overall scores.
- **Network.** Decrease rehospitalization during the first 30 days of home health. AHS has partnered with Golden Pacific Home Health to provide home health services to eligible uninsured patients within five days of inpatient hospital discharge. Services include assisting with managing the symptoms of chronic conditions, assessing and treating wounds, instructing the patient in medication management, physical therapy, occupational therapy, speech therapy, diet counseling, and personal care support.
- **Workforce Development.** Reduce workplace injury. Training and education is key to providing a safe environment for staff and volunteers.



Matching Funds

\$29.8M

AHS leveraged its Measure A allocation to obtain \$29,845,294 in matching funds through an **Intergovernmental Transfer.**

AHS provides services in over 25 languages in person, by teleconference, or by videoconference. An additional 10 languages are offered through contracted phone interpretation.

Measure A Funding Summary

AHS does not have programs specifically or separately supported by Measure A funds. As a result, the results below are for AHS overall. AHS's programs, goals and strategies are aligned to ensure its ability to meet the purpose of the voter-approved Essential Health Care Services Initiative, providing additional support for emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low income, and uninsured adults, children, families, seniors, and other residents of Alameda County.

In FY 18/19, Measure A helped AHS achieve the following across its strategic pillars.

Access

Performance measure:

- Reducing the time from when the patient checks in at the front desk to the time when the patient checks out from the clinic

Improvement efforts:

- Monitoring of overall results and times for each process step
- Clinic-specific process improvement plans to address the root causes of delays in throughput time and decrease patient wait times

Results:

- Primary care: 71 minutes (target: 69; baseline: 75)
- Specialty care: 79 minutes (target: 86; baseline: 94)

Quality

Performance measures:

- Reducing the hospital-acquired infections (HAI) index
- Reducing the number of hospital-acquired harms (HAH) per 1,000 discharges

Improvement efforts:

- Infection preventionist participation in daily rounds
- Auditing of device and equipment maintenance
- Real-time feedback to staff

Results:

- HAI index: 6.17 (target: 9.72)
- HAH per 1,000 discharges: 2.22 (target: 2.76)

Success Story

A community health outreach worker recently helped Mr. P., who was suffering from diabetes, high cholesterol, high blood pressure, and cirrhosis. He was constantly forgetting things and falling from lack of balance and had trouble walking because his legs were so swollen, and he didn't remember to take his medications. Mr. P.'s primary care physician connected him to the complex care team at Highland Hospital. Mr. P. got his medication adherence under control but still needed a new liver. He was referred to the gastroenterology team at Highland, then to UCSF for a liver transplant. He received a transplant within two weeks of his initial evaluation at UCSF.

Highlights

7 min.

Access

AHS **exceeded the goal in specialty care** by seven minutes, and the time from check-in to discharge in primary care decreased by four minutes.

Experience

Performance measures:

- Increasing HCAHPS scores for hospital ratings
- Increasing CGCAHPS scores for provider ratings

Improvement efforts:

- Implementing No Pass Zones, an intervention that empowers all staff including non-nursing personnel to respond to call lights and decrease patient waits
- Reviewing patient comments monthly
- Establishing Greet-Introduce-For-Thank you (GIFT), a communication tool designed to help drive a culture of human connections
- Reviewing performance and sharing best practices at ambulatory leadership meetings

Results:

- HCAHPS: 67.7% giving a 9 or 10 rating (target: 72.79%; state average: 70%)
- CGCAHPS: 72.8% giving a 9 or 10 rating (76.78%; state average: 77%)

Network

Performance measure:

- Rate of rehospitalization for home health patients within 30 days

Improvement efforts:

- Care Management and Social Services teams' continued facilitation of patient transfers to home health
- Streamlined communication with monthly joint operations meetings to review metrics and performance issues among Case Management, Social Services, Rehabilitation, and Golden Pacific Home Health
- Proactive monitoring of patients utilizing clinical pathways to predict potential declines in health and ensure interventions are put in place immediately to prevent a readmit

Results:

- 6.5% rehospitalization rate (target: 14.4%; statewide average: 14.6%)

Workforce Development

Performance measure:

- Number of workplace injuries occurring during the year

Improvement efforts:

- Training and education of staff and volunteers

Results:

- 257 injuries (target: 288)
- 6.4 work-related injuries and illnesses for every 100 full-time employees (national average: 6.8)

Highlights

↓ 40%

Quality

The HAI index **decreased by over 40%** and HAH by nearly 30%, both of which exceeded the target.

Highlights

↓ 3.3 per 100

Workforce Development

Since FY 14/15, the **AHS injury rate per 100 full-time employees has dropped from 9.7 to 6.4.**

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 1: BEHAVIORAL HEALTH

Behavioral Health and Alcohol and Other Drug (AOD) Community-Based Providers	15
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	18
Cherry Hill Detoxification and Sobering Centers	20
Criminal Justice Screening and In-Custody Services	21
Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services	23
La Familia Counseling Services	25
Mental Health Services for Juvenile Justice Center	26
Mental Health Services for Newcomers and Immigrants (CERI)	28

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

www.acbhcs.org



FY 18/19 Allocation: \$829,513 | Expended/Encumbered: \$829,513



Individuals served by Measure A: 407 (Total individuals served: 28,684)



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



Services provided: Mental Health, Substance Abuse



Service area: Countywide, Outside of Alameda County

Background

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

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

For mental health services, the programs receiving Measure A funds provide the following services:

- Access to services in the threshold languages
- Representation and advocacy for capacity hearings
- Mental health support for family members of individuals with a mental illness
- Education to consumers around the pros and cons of working as it relates to their current benefits

Services are provided in Spanish, Vietnamese, Cantonese, and Mandarin.

For SUD, Measure A funds are utilized across 22 programs within the Alameda County SUD treatment system. The programs provides adolescent and adult early intervention; adolescent, perinatal, and adult outpatient and residential treatment; and sobering and detoxification services.

Early intervention programs help “catch” clients who demonstrate a need for SUD treatment before their SUD addiction becomes severe. Outpatient treatment services are the primary source of treatment for clients in Alameda County, while residential treatment is in high demand in Alameda County.



Matching Funds

\$9,107

from **Medi-Cal**.

Highlights

300%

The MHAAC Patient's Rights Advocacy program **exceeded their goals for responding to phone calls by nearly 300%**.

Alameda County's SUD treatment system underwent a major transition in 2018 to become a Drug Medi-Cal Organized Delivery System (DMC-ODS), which required many providers to hire and onboard more staff to meet the standards set forth by the DMC-ODS.

Measure A Funding Summary

Mental Health

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

- La Familia Adult Service Team provided 4,335 service hours and 793 medication support hours to 128 unique clients (target: 4,529 service hours and 908 medication support hours to 150 clients).
- Asian Health Services Adult Level 1 Service Team provided 7,947 service hours and 928 medication support hours to 270 unique clients (target: 10,347 service hours and 984 medication support hours to 286 clients).
- Mental Health Association of Alameda County (MHAAC) Family Caregiver provided 1,140 service hours and responded to 1,411 questions from family caregivers and consumers (target: 1,026 service hours and 3,600 questions).
- MHAAC Certification Hearing Representation Program provided 1,979 service hours; interviewed 5,230 certified patients; and attended 4,550 certification review hearings (target: 5,465 service hours; 2,000–4,000 interviews; and 2,000–3,000 hearings).
- Patient's Right Advocacy Program provided 3,515 service hours and responded to 7,714 calls (target: 2,722 service hours and 900–1,200 calls).
- ABODE Homeless Outreach for People Empowerment (HOPE) provided 15,833 service hours; engaged 380 clients; and served 341 unduplicated households (target: 6,000 service hours; 350 engaged clients; and 400 unduplicated households).
- 75% of Asian Health Services Adult Level 1 Service Team clients received two or more visits within 30 days of their episode opening date (target: 84%).
- 100% of ABODE HOPE clients with entry/exit information were entered into the Homeless Management Information System (HMIS) (target: 80%).
- 65% of ABODE HOPE clients completed the Coordinated Entry Standardized Housing Assessment Tool (target: 60%).
- 48% of ABODE HOPE clients received at least one non-cash benefit such as WIC, CalFresh, CalWORKs, child care, or transportation (target: 30%).
- 85% of duplicated crisis line callers with a risk level of 3–5 were stabilized without law enforcement or hospital intervention (target: 80%).

Highlights

51%

The Certification Hearing Representation Program **exceeded their interview and certification hearing goals by 30% and 51%.**

SUD

In FY 18/19, Measure A funds were used to augment the following types of SUD treatment:






- Early intervention. Measure A funds were used to augment an early intervention program at Santa Rita Jail, identifying inmates who would need SUD treatment services when they are released and connecting them to appropriate SUD treatment resources prior to their release.
- Outpatient treatment. Measure A funds helped support additional capacity to serve more clients in the outpatient sites.
- Residential treatment. Measure A funds helped support additional capacity to serve clients in residential sites.
- Sobering and detoxification. Sobering and detoxification services received half of their annual allocation via Measure A funds. Cherry Hill, a program of Horizon Services and the sole sobering and detoxification service in Alameda County, used the Measure A funds to expand not only their capacity to do sobering and detox services but also to become a screening and referral portal to the continuum of SUD treatment services for all clients being released from detox.

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

- Number of unduplicated clients receiving services:
 - La Familia's El Chante: 88 (target: 56)
 - CURA: 251 (target: 170)
 - East Bay Community Recovery Project's Project Pride: 58 (target: 48)
 - New Bridge Foundation: 54 (target: 49)
 - La Familia Primavera Outpatient Adolescent Program: 98 (target: 150)
- Percentage of clients receiving at least one treatment service in the previous 45 day:
 - El Chante: 89% (target: 95%)
 - CURA: 99% (target: 95%)
 - Project Pride: 100% (target: 95%)
 - New Bridge Foundation: 87% (target: 95%)
 - La Familia Primavera Outpatient Adolescent Program: 77% (target: 95%)
- Percentage of clients admitted into treatment who were rated as successfully completing treatment at discharge:
 - El Chante: 52%
 - CURA: 42%
 - Project Pride: 34%
 - New Bridge Foundation: 59%
 - La Familia Primavera Outpatient Adolescent Program: 29%

Success Story

A 49-year-old Caucasian homeless male bounced back and forth with multiple sobering and detoxification episodes over the course of one year. During each episode in the Detoxification Center, the client would participate in Alcoholic Anonymous meetings, read literature related to drug and alcohol addiction and recovery, and discuss his continued use with staff. After many stays at Cherry Hill, the client was referred to a Residential Treatment Facility in January of 2019. This client made a commitment to achieve his goal of arriving at the program and was able to do so directly with transportation assistance from Cherry Hill.

-  **FY 18/19 Allocation: \$1,391,656 | Expended/Encumbered: \$1,391,656**
-  **Individuals served by Measure A:** 4,956 (Total individuals served: 15,833)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Mental Health, Substance Abuse
-  **Service area:** Countywide, Homeless or Transient

Background

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

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

The Initiative deploys District Health and Wellness Consultants (DHWCs) and School-Based Clinical Consultants (SBCCs) to oversee and strengthen the delivery of prevention services, such as youth groups, teacher consultations, staff presentations, individual mentorship/drop-ins with youth, and family groups/workshops. DHWCs and SBCCs also are responsible for planning and implementing evidence-based prevention programs that promote positive school climate, such as Positive Behavioral Interventions and Supports (PBIS); restorative justice; mental health consultations with teachers, staff, parents, and students; and social and emotional learning (SEL) curriculum and instruction.

While DHWCs are placed at the district level, SBCCs are placed at the school level and are currently deployed at schools within the Oakland and Hayward Unified School Districts. Similar to DHWCs, SBCCs support school-based health and wellness efforts by providing skill-building trainings and consultations with teachers and staff, developing relationships with community partners, connecting families to internal and external health services, and performing case management for students with mental health service needs.

Matching Funds

\$3,051,156

from the **Tobacco Master Settlement Fund (TMSF), Medi-Cal Administrative Activity (MAA), and Prevention and Early Intervention (PEI).**

Highlights

92%

92% of clients were **connected to a Tier 2: Early Intervention service** within one month (target: 90%).

93%

93% of clients were **connected to a Tier 3: Treatment service** within one month (target: 90%).

Providers funded via Measure A have the capacity to serve clients in multiple languages, with a particular focus on Spanish, and have access to the County's interpretation and translation services that expand the capacity to serve students and families who speak other languages.

Measure A Funding Summary

Through the School-Based Behavioral Health Initiative, CHSC-supported sites used their Measure A allocations to achieve the following:






- Refer 4,023 students to Tier 2: Early Intervention Behavioral Health services, of whom 75% were connected to services
- Refer 4,780 students to Tier 3: Treatment services, of whom 64% were connected to services
- Provide 23,422 hours of treatment services
- Implement the Coordination of Service Team (COST) program at 253 schools in 14 school districts (target: 250 schools in 14 districts)
- Refer 15,833 students to COST services
- Refer 8,850 students to behavioral health services, of whom 70% were connected to services
- Connect 92% of these students within one month of their original referral
- Spend 15,975 hours providing capacity-building support within schools
- Have DHWCs spend 239 hours providing capacity-building trainings and consultations across school districts to develop school staff and parent/caregiver capacity to support the behavioral, social, and emotional health of young people
- Have DHWCs provide 4,144 hours of mental health consultation, including supervision of mental health providers and interns; consultations with teachers, staff, and parents; referrals to services; and crisis response
- Through SBCCs, have over 5,000 students participate in positive youth development small groups and/or individual support check-ins



Success Story

Brian was referred to COST due to concerns about his academics and classroom behavior. The COST team discovered that Brian was a transfer student who had recently been placed in the custody of a relative and had been out of school for two years. Classroom observations revealed that Brian frequently became mentally fatigued by the middle of the day. A plan was made in partnership with Brian's guardian to get Brian's academics up to grade level. As changes were implemented, Brian's focus and energy improved. Through the COST process, early on in Brian's attendance at his new school, resources were provided and utilized to help him progress.

Cherry Hill Detoxification and Sobering Centers

-  **FY 18/19 Allocation: \$2,295,875 | Expended/Encumbered: \$2,295,875**
-  **Individuals served by Measure A:** 9,400 (Total individuals served: 9,537)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Seniors
-  **Services provided:** Substance Use Prevention, Treatment, and Recovery
-  **Service area:** Countywide, Outside of Alameda County, Homeless or Transient

Background

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

The Cherry Hill Detoxification Center emphasizes the importance of a non-judgmental approach, one that inspires and motivates people who are very sick and frustrated to enter into treatment or continue their recovery from addictive substances.

The Cherry Hill Sobering Center is the only facility in Alameda County that provides transportation, health assessments, and brief interventions within the first 24 hours of intake for intoxicated individuals. Its services are an alternative solution for law enforcement in lieu of incarceration, and it is a resource for hospital emergency departments throughout the County.

The Sobering Center also identifies individuals in need of Medication Assisted Treatment and provides a direct referral and transportation to Highland Hospital's Suboxone Clinic, which then often motivates individuals to transfer to the Detoxification Center to further their recovery journey.

Cherry Hill offers services in English, Spanish, and Tagalog and partners with Alameda County Behavioral Health Care Services for additional interpreter services.

Measure A Funding Summary

Cherry Hill Detoxification and Sobering Centers used its Measure A allocation to achieve the following:

- Provide detoxification services to 2,367 individuals (target: 2,025)
- Maintain a daily occupancy of 26 residents at the Detoxification Center (target: 25)
- Provide a total annual bed day service capacity of 9,334 (target: 9,125)
- Admit nearly 20 clients each day for sobering services (target: 20)

Matching Funds

\$622,122


from **Whole Person Care.**


Highlights


93%


93% of intoxicated clients were **engaged in services for a minimum of six hours per episode** (target: 50%).

Criminal Justice Screening and In-Custody Services

 **FY 18/19 Allocation: \$4,306,000 | Expended/Encumbered: \$4,306,000**

 **Individuals served by Measure A:** 4,388 (Total individuals served: 4,388)

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

 **Services provided:** Mental Health

 **Service area:** Countywide

Background

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

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

Because the jail population has a higher risk for suicide than the general community, AFBH staff provide support and evaluations to address and decrease suicides in the jail. Individuals placed on suicide watch are assessed by AFBH staff, who see them face to face daily for up to three days to monitor risk. AFBH services also help ensure continuity of psychiatric medications, which reduces the risk of psychiatric decompensation while in custody.

During FY 18/19, AFBH filled a number of vacant positions, thus increasing its ability to provide services to clients. AFBH also developed a more comprehensive training program for new clinicians working in a forensic setting. Additionally, they developed more inclusive, interdisciplinary teams of leadership and line staff to focus on new staff training.

AFBH staff at Santa Rita Jail speak the following languages: Spanish, Mandarin, Vietnamese, Tagalog, Hindi, Punjabi, Japanese, and Russian.

Measure A Funding Summary

AFBH staff used their Measure A fund allocation to achieve the following:

- Provide mental health services to 4,388 unique individuals
- Provide an average of 1,884 hours of mental health services each month (target: 1,500)

Highlights

100%

100% of AFBH leadership staff reported that the **discussions at suicide prevention meetings were productive and led to coordination of services** to high risk clients (target: 100%).

100%

100% of AFBH leadership staff reported that, as a result of participation in suicide prevention meetings, they felt **more prepared to assess and treat inmates with high risk for suicide** (target: 90%).

- Conduct an average of 614 face-to-face medication evaluations each month
- Offer mental health services to nearly 1,100 individuals each month
- Complete an average of 312 new mental health assessments each month
- Conduct 82% of mental health services with clients in the jail face to face (target: 80%)
- Provide an average of 105 hours of crisis intervention services each month (target: 100)
- Be available to Sheriff's Department and medical staff either on call or in person 24 hours daily, 7 days per week 100% of the time for consult regarding mental health needs, crises, and services in the jail (target: 100%)
- Attend 12 suicide prevention meetings with the Sheriff's Department and Santa Rita Jail medical provider (target: 10)

Success Story

A 43-year-old transgendered male-to-female client had a significant mental health treatment history, including multiple in-custody psychiatric holds and two suicide attempts by hanging. The AFBH treatment team provided twice-weekly counseling sessions and weekly psychiatric appointments to come up with a plan and set treatment goals. The client came to the insight that she constantly places herself in dangerous situations to “push the boundaries.” She expressed wanting to break this cycle as well as her cycle of substance use. After a time, the client moved to a lower-level housing unit with more independence and privileges. She was able to remain safely in jail with no additional suicide attempts until her release.



Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services

lafamiliacounseling.org



FY 18/19 Allocation: \$176,648 | Expended/Encumbered: \$176,648



Individuals served by Measure A: 2,575 (Total individuals served: 7,805)



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



Services provided: Mental Health



Service area: Fremont, Hayward, Newark, Union City

Background

La Familia Counseling Services provides underserved multicultural communities with the tools and support necessary to build resilience, wellness, and economic power.

As recent immigrants, the individuals that La Familia serves face numerous barriers to accessing services due to limited English proficiency, limited social support networks, and lack of awareness or knowledge about how to access the various services that are available to them.

The unaccompanied immigrant youth (UIY) Care Team utilizes a variety of strategies to support the unique needs of this population. These include using treatment modalities that are trauma-informed, addressing spirituality and/or folk traditions, addressing language barriers when indigenous languages are predominantly spoken at home, utilizing cultural humility principles to promote inclusion and acceptance, and empowerment techniques to improve the clients' sense of agency and belonging while coping with acculturation and/or reunification challenges.

The majority of services are delivered to individuals who are primarily or exclusively Spanish-speaking. All direct service staff are bilingual in Spanish and English.

Measure A Funding Summary

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

- Spend 976 hours connecting UIY to health coverage and a medical home
- Conduct 36 workshops/trainings to UIY and their caregivers on topics including college readiness (25 participants) and coping skills (224 participants) (target: 30)



Highlights

89%

89% of youth receiving services reported **relating better to friends and other people.**

- Through outreach in school districts and the community, identify and open sessions with 70 preventative counseling UIY clients, who each received eight sessions (target: 70)
- Develop and distribute informational materials related to UIY services and programs to 575 different individuals and/or families (target: 300)
- Connect 70 UIY and families to health and wellness services such as applications for Medi-Cal insurance enrollment, specialty mental health services, and primary care visits (target: 100)
- Conduct 22 home visits, where a range of services was provided (target: 20)
- Provide short-term counseling and brokerage support to 70 individuals and families

Success Story

After experiencing sexual violence in her homeland starting at age 12, a 15-year-old Guatemalan high school student and her mother migrated to the US to reunify with the student's father. When her father died, the student was referred to the UIY Care Team for support. The student's mother wanted the student to withdraw from school and work to help with funeral and other costs. The case manager was able to keep the student in school, connect her to the school-based clinician for emotional support, and connect the family to helpful community resources. The student was able to manage her grief, depression, and trauma and finish the school year.



La Familia Counseling Services

lafamiliacounseling.org

- \$ FY 18/19 Allocation: \$272,391* | Expended/Encumbered: \$272,391**
- 👤 Individuals served by Measure A:** 1,082 (Total individuals served: 1,082)
- 👥 Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
- ⊕ Services provided:** Public Health, Mental Health, Substance Abuse
- 📍 Service area:** Ashland, Cherryland, Hayward, Oakland, San Leandro, San Lorenzo, Union City, Homeless or Transient

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

Background

La Familia Counseling Services provides underserved multicultural communities with the tools and support necessary to build resilience, wellness, and economic power.

Services are offered at the Family Resource Center and the Glad Tidings site, among other locations, and are provided to clients in both English and Spanish.

Measure A Funding Summary

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

- Provide one-on-one and family behavioral health services to 25 individuals and four families (target: 60 total)
- Conduct seven one-on-one intensive case management services, excluding behavioral health services (target: seven)
- Conduct 26 psycho-education workshops and/or support groups in relation to wellness (target: 12)
- Conduct outreach, information, and referrals to basic needs and services to 496 participants (target: 250)
- Refer 220 workshop/support group participants to the Family Resource Center (target: 248)
- Refer 561 participants to the Glad Tidings site (target: 248)
- Refer 285 participants to other community-based organizations (target: 248)




Highlights


100%


100% of the 12 workshops/support groups **continued throughout the fiscal year to give new participants an opportunity to participate** (target: 50%).

Mental Health Services for Juvenile Justice Center

 **FY 18/19 Allocation: \$360,000 | Expended/Encumbered: \$360,000**

 **Individuals served by Measure A:** 82 (Total individuals served: 590)

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

 **Services provided:** Mental Health, Substance Abuse

 **Service area:** Countywide

Background

Alameda County Behavioral Health Care Services (BHCS) offers mental health services to youth at the Alameda County Juvenile Justice Center (JJC) in an effort to maximize the recovery, resilience, and wellness of those who develop or experience serious mental health, alcohol, or drug concerns.

Many of the youth detailed in the JJC deal with trauma on a daily basis and are living with toxic stress. Clinicians help youth manage their trauma and deal with the stress of detention by providing direct therapy. Clinicians also help youth and their families begin the healing process while detained, and staff in the Transition Center help connect families to services once they leave the JJC. Working with system partners, Transition Center staff help ensure that the majority of youth and families who request mental health services upon release are referred to a community health provider.

Guidance Clinic staff also help Probation staff understand that behavioral challenges that youth exhibit can be tied to mental health needs. Clinicians use this information to help advocate for the least restrictive setting for youth to get needed treatment or support. Clinicians regularly help youth avoid placement in a group home or a higher level of detention or incarceration.

Services are available in Cantonese, Spanish, and Vietnamese.

Measure A Funding Summary

BHCS used its Measure A allocation to achieve the following:

- 81% of youth booked into the JJC were seen by a mental health clinician (target: 80%).
- 59% of youth referred for crisis counseling services were seen by a mental health clinician (target: 90%).
- 50% of youth referred due to a safety concern were seen by a mental health clinician within 30 minutes (target: 80%).

Success Story

A young man, BT, was detained at the JJC for the first time. BT disclosed to the crisis clinician that he had attempted suicide several times in the past. BT met with the clinician for therapy several times a week and started medication to address his depression and suicidal thoughts. Before BT's release, Transition Center staff created a discharge plan with BT's father, including referral to services in the community. Upon release, BT was given a prescription for medication, and an appointment was made with a mental health provider in the community. BT has been maintaining safely in the community for several months.

- 92% of youth/families who requested a referral to a community mental health provider received a referral upon discharge from the JJC (target: 90%).
- 33% of youth referred for community mental health services upon discharge completed a visit with a community mental health provider (target: 70%).
- 44% of youth discharged from the JJC who needed to see a psychiatrist for medication completed a visit with a psychiatrist in the community (target: 70%).

Highlights

92%

92% of youth/families who requested a referral to a community mental health provider **received a referral upon discharge** from the JJC.

Mental Health Services for Newcomers and Immigrants (CERI)

cerieastbay.org

- 💰 **FY 18/19 Allocation: \$86,096 | Expended/Encumbered: \$86,096**
- 👤 **Individuals served by Measure A:** 45 (Total individuals served: 400)
- 👥 **Populations served:** Low Income, Uninsured Adults, Children, Families, Seniors
- ⊕ **Services provided:** Mental Health
- 📍 **Service area:** Alameda, Berkeley, Fremont, Hayward, Oakland, Pleasanton, San Leandro

Background

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

The agency's focus is on refugees and immigrants from Afghanistan, Cambodia, and Vietnam. Presently, the majority of its 400 clients are Cambodian refugees living in Oakland.

In FY 18/19, CERI expanded its services for at-risk youth and young adults in three ways. First, it launched a Co-Ed Support Group that focuses on leadership and advocacy skills and emotional support. The participants in this group also created a youth-led Youth Development Team, which meets regularly with the City of Oakland's Equity and Race Initiative team. Finally, CERI now provides a drama therapy group with a social justice focus, as well as individual therapy as needed, for up to 20 Southeast Asian LGBTQ young adults. The group has been instrumental in providing support in combating stigma, homelessness, prevention of major mental illness, and even suicidal ideation among this vulnerable population of young people as they explore their sexual identity in the context of their own culture and society at large.

CERI also provides clinical services, support groups, care management, and community activities for its adults and older adults, who were most directly impacted by the Khmer Rouge genocide. Over the last year, it has continued its drama therapy group for adult survivors, which has helped empower them to tell their story and achieve a new level of healing. CERI also hired a new Cambodian American interpreter and care manager, who helped revive the women's groups.



💰 Matching Funds

\$86,095

from the **Mental Health Services Act (MHSA), Medi-Cal Administrative Activities (MAA), City of Oakland Fund for children and youth, and funding from grants/individual donors.**

Measure A Funding Summary

CERI used its Measure A allocation to achieve the following:






- Hold 11 psycho- education workshops
- Make 337 one-on-one outreach/home visits
- Conduct 94 support groups
- Hold 24 large community events
- Perform 57 other outreach and engagement events
- Conduct 19 consultations with family members/prevention visits
- Conduct 77 consultations with professional leaders
- Hold two trainings for professional leaders
- Provide preventative counseling to 24 clients
- Make two mental health referrals
- Screen and assist 15 applicants for mental health services with the application for Medi-Cal benefits
- Inform three Medi-Cal recipients or potential clients about Medi-Cal services
- Educate 244 at-risk Medi-Cal recipients or potential clients to understand the need for mental health services
- Encourage 60 Medi-Cal recipients or potential clients to accept needed health services
- Gather information about 47 individuals' mental health needs and Medi-Cal eligibility
- Assist 65 individuals in accessing Medi-Cal physical and mental health services by providing referrals and follow-up and arranging transportation for mental health care

Success Story

V., a 59-year-old female who had been sexually abused and sold into prostitution, was suicidal with plans. When she came to CERI, she had severe post-traumatic stress disorder, major depression, and flashbacks about what happened to her and her family during the Cambodian genocide. She received individual therapy and psychiatric treatment and, over time, started to come to support groups and participate in community activities. She also became a leader in the community garden program. Recently, V. spoke at a public event about her experience as a refugee. She has been interviewed by a writer and her story is going to be a chapter in a book about refugees.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS GROUP 2: HOSPITAL, TERTIARY CARE, OTHER

St. Rose Hospital	31
UCSF Benioff Children’s Hospital Oakland	33

-  **FY 18/19 Allocation: \$5,000,000 | Expended/Encumbered: \$5,000,000**
-  **Individuals served by Measure A:** 20,378 (Total individuals served: 26,465)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Emergency Medical, Hospital Inpatient, Hospital Outpatient
-  **Service area:** Countywide, Homeless or Transient

Background

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

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

- **Emergency department.** Over 75% of St. Rose’s inpatient admissions are generated through the emergency department (ED). With the Measure A supplemental funding, St. Rose is able to provide the community with an ED staffed with licensed physicians 24 hours a day, seven days a week. The efficiency of the ED diagnosing patients quickly provides better patient care and enhanced quality of service.
- **Tele-Psychiatry.** SRH started a Tele-Psychiatry program for patients presenting to the ED with mental health issues. Prior to this program, SRH physicians were not able to write or release 5150s and had to call the Hayward Police Department (HPD) to write the hold or release. Because of HPD’s workload and call priority, there were times SRH physicians and staff would wait several hours before HPD would arrive.

In addition, SRH operates as a Center for Excellence in Cardiac Care and is designated as an ST-segment elevation myocardial infarction (STEMI) receiving center. SRH is also an active participant in the Alameda County Care Connect Problem Solving Learning Community, which works to eliminate barriers and share information in care coordination of community members.

SRH serves approximately 11% of Alameda County’s indigent population. Services are provided to clients in multiple languages, including English, Spanish, Mandarin, Farsi, Tongan, Vietnamese, Dari/Pashto, Hindi, Cantonese, Punjabi, Tagalog, and Nepali.

Highlights

84.6

The patient satisfaction score for communication with nurses **increased four points from the preceding year to 84.6** (target: 83.9).

Matching Funds

\$5M

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






Measure A Funding Summary

SRH used its Measure A allocation to achieve the following:

- Reduce the time from the decision to admit to the time the patient is admitted and leaves the ED by 15 minutes from the preceding year to 95 minutes (national average: 84 minutes)
- For over 200 myocardial infarction patients who received percutaneous cardiac intervention, limit the time from entering the emergency room door to the time of receiving their procedure to 90 minutes 88% of the time, an 8% improvement from the preceding year
- Meet the Sepsis Core Measure Bundle treatment and time frames 78% of the time, placing SRH in the 90th percentile nationally (national average: 65%)
- Achieve zero patient safety occurrences for falls with injury, postoperative sepsis, pressure ulcers, and postoperative acute kidney injury requiring dialysis
- Achieve zero patients with elective C-sections prior to 39 weeks
- Maintain a success rate of 13% for Nulliparous, Term, Singleton, Vertex (NTSV) C-sections, thus maintaining SRH's status as a referral center for high risk pregnancies (target: less than 23.9%)

Success Story

A 28-year-old female presented to the emergency room and was subsequently admitted. She writes: "I want to thank Saint Rose Hospital for putting me on a charity fund that covered my \$61,241.40 bill that I got for my admission at the hospital. Without this charity fund, it would have been a hardship for me and my family. I am a single mother of two kids. My husband passed away on Christmas Eve 2016, so paying that amount was going to be nearly impossible. I want to thank Saint Rose Hospital again for everything that they did to help me out."

-  **FY 18/19 Allocation:** \$2,000,000 | **Expended/Encumbered:** \$2,000,000
-  **Individuals served by Measure A:** 1,290 (Total individuals served: 28,157)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families
-  **Services provided:** Emergency Medical, Hospital Outpatient, Public Health, Mental Health
-  **Service area:** Countywide

Background

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

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

- The pediatric Emergency Department (ED), specifically to provide adequate staffing for the large volume of children seen at the ED
- The Center for Child Protection (CCP), which treats children who experience abuse and other types of trauma
- Two school-based clinics in Oakland

Emergency Department

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

Trauma services are a subset of the ED, requiring fast action, highly specialized equipment, facilities, and a specially trained multidisciplinary team. BCHO'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.

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

Highlights

1%

The percentage of **trauma cases that ended in fatality** was 1%, compared to a national benchmark of 2.5%.

Matching Funds

\$1M

through an intergovernmental transfer using supplemental funds from the **California Department of Health Care Services**.

Approximately 70% of patients seen in the BCHO ED receive Medi-Cal. This number is higher than almost any other hospital—child or adult—in California. The percentage of children on Medi-Cal has been trending higher over the last decade.

Center for Child Protection

CCP is a comprehensive child abuse program within BCHO. It is the designated site for forensic medical services in Alameda County for social services, the courts, and the police and is the only provider in Alameda County that has the capacity to offer many of its services. It 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. CCP employs one of only three board-certified child abuse pediatricians in Northern California.

In addition to physical forensic examinations, comprehensive evidence-based mental health services are provided to children, adolescents, and their families. These services address the short- and long-term psychological impacts on children and families of trauma and witnessing violence. Therapy includes individualized cognitive behavioral therapy, group therapy, and dyad therapy.

Clinical case management is provided to children and adolescents who present to the ED and/or child abuse management clinic following diagnosis or disclosure of abuse. Clinical case management assists families with navigating the criminal justice system, arranging necessary medical follow-up, and assisting with community resource referrals. Medical staff also provide telephone and in-person case consultation to child welfare, law enforcement, and the District Attorney's Office for medical forensic cases.

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

School-Based Clinics

BCHO runs two school-based health centers: one at Castlemont High School and one at McClymonds High School. The specially trained teams at the centers look at all aspects of an adolescent's life to help address the many medical and mental health issues they could be facing. Both sites are integrated into full-service youth and/or family centers that promote youth development and serve as national models for adolescent health care.

The Castlemont Clinic—which operates a full-time comprehensive team of six therapists and a psychiatrist, as well as comprehensive medical

Success Story

R left Guatemala at the age of 14, escaping gang violence, sexual abuse, and political retaliation. At Castlemont High School, she couldn't focus in class, had difficulty establishing healthy relationships, and engaged in self-harm, fights, and suicidal ideation. When R starting therapy at the Castlemont Clinic, the therapist diagnosed her with PTSD and major depression. R participated in group and individual therapy and received psychiatry support at BCHO's Outpatient Center. She was able to reflect on her decisions and chose to transfer to a different school. She began seeing positive changes in her new environment and became more motivated. R was able to graduate from high school and begin working.

services—is a hub for teachers, parents, and students to coordinate therapy, care, support, and help. The Castlemont site is now the highest volume school-connected mental health site in Alameda County.

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

Services are provided to patients who speak over 50 languages. BCHO has on-site Spanish interpreters, and phone-based interpreters are provided for other languages.

Measure A Funding Summary

BCHO used its Measure A allocation to achieve the following:

ED and CCP

- Provide specialized treatment quickly for 1,112 children who have acute physical trauma (target: 1,000)
- Serve 621 unique patients at CCP (target: 700)
- Assess 141 children in the ED for maltreatment (target: 100)
- Provide individual or group psychotherapy to 194 unique children (target: 200)
- Perform 125 non-inpatient forensic or medical examinations related to sexual or physical abuse (target: 120)
- For the most severe trauma-related injuries, reduce the time between admission and when a patient received a CT scan to 46 minutes (target: under 60 minutes)
- For the most severe trauma-related injuries, reduce the time between admission and the decision to admit to 42 minutes (target: under 60 minutes)
- Reduce the average length of stay in the ED to 111 minutes (target: under 120 minutes)
- Contact and schedule 80% of referrals from law enforcement for non-acute forensic examinations within five days (target: 100%)
- Contact 90% of psychotherapy referrals within five days (target: 100%)
- Among 100% of psychotherapy referrals that are contacted and get care, conduct a culturally focused screening assessment to address barriers to treatment (target: 100%)
- Obtain an “under triage rate,” where patients get the correct resources for their level of trauma severity, of 1% (national benchmark: 5%; lower is better)

Highlights

100%

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

School-Based Clinics

- At McClymonds High School Chappell Hayes Health Center, provide 1,679 service encounters to 291 unique patients (target: 1,500 encounters to 300 patients)
- At Castlemont Youth Uprising Health Center, provide 4,274 service encounters to 704 unique patients (target: 4,000 encounters to 700 patients)

Highlights

91%

91% of patients strongly agreed or agreed that the health centers helped them **eat better or exercise more** (target: 100%).






FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 3: PRIMARY CARE

Alameda County Dental Health	38
Center for Elders' Independence	40
Center for Healthy Schools and Communities (School Health Centers)	41
Fremont Aging and Family Services	44
Health Enrollment for Children	46
Health Services for Day Laborers: Multicultural Institute	47
Health Services for Day Laborers: Street Level Health Project	49
Medical Costs for Juvenile Justice Center: Direct Service Planning and Administration	51
Medical Costs for Juvenile Justice Center: Niroga Institute	53
Medical Costs for Juvenile Justice Center: Victims of Crime	55
Preventive Care Pathways	57
Primary Care Community-Based Organizations	58
Tiburcio Vasquez Health Center, Inc.	61
Washington Hospital Healthcare Foundation	63

Alameda County Dental Health

dental.acphd.org

-  **FY 18/19 Allocation: \$257,580 | Expended/Encumbered: \$257,580**
-  **Individuals served by Measure A:** 6,515 (Total individuals served: 25,103)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Public Health
-  **Service area:** Alameda, Ashland, Castro Valley, Cherryland, Fairview, Fremont, Hayward, Livermore, Newark, Oakland, Pleasanton, San Leandro, San Lorenzo, Union City

Background

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

The Alameda County Office of Dental Health provides an accessible early entry point for oral health assessment and preventive dental services for high risk families and children ages 0 to 5 years at Women, Infants, and Children centers (WIC), as well as continuity and referral for regular follow-up dental care in the community. The focus of the service is to families of children ages 9 to 15 months who participate in Dental Days at WIC sites. Since siblings often accompany the caregiver at the Dental Days, all services are offered to them as well.

At WIC Dental Days:

- Families have the opportunity to learn about critical dietary and brushing practices that reduce the risk of tooth decay and periodontal (gum) disease.
- Families learn the skills of positioning and assessing their child's oral health and tooth brushing routines to maintain good overall health.
- Parents and caregivers learn the benefits of fluoride in toothpaste and tap water in reducing or preventing tooth decay.
- Each child receives a fluoride varnish application, which reduces the risk of cavities by 50%.
- Parents and caregivers have the opportunity to set goals for sustaining the oral health of their child and their family as a whole.
- Parents and caregivers receive the opportunity to have case management assistance to access a dentist in the community to become the ongoing dental home for that child. The intervention and access to care at an early age provides a powerful means to prevent or mitigate the risk of dental disease in this highly vulnerable population.



Matching Funds

\$736,833

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

- Prenatal women can learn about how to maintain their own oral health and the health of their future newborn by attending a prenatal class at WIC that incorporates oral health information and emphasizes the importance of visit the dentist during their pregnancy.

WIC Dental Day services are offered to clients in multiple languages, primarily Spanish, Chinese, and Vietnamese. Phone translation services for other languages are used as needed.

Dental Health also delivers services through Axis Community Health. Axis front desk staff are bilingual in English and Spanish, and the medical providers speak the following languages: Bengali, Burmese, Dari, Farsi, French, German, Hindi, Italian, Kannada, Marathi, Nepali, Punjabi, Spanish, Tagalog, Telugu, and Urdu.

Measure A Funding Summary

The Office of Dental Health used its Measure A allocation to achieve the following:

- At WIC Dental Days:
 - Provide oral health education to 817 parents/guardians of infants and children ages 0–5 years (target: 775)
 - Have 782 infants and children ages 0–5 years attend (target: 750)
 - Provide an oral health assessment to 765 infants and children (target: 750)
 - Give a fluoride varnish application to 681 children, representing 89% of children receiving an assessment (target: 675 children representing 90% of assessed children)
 - Refer 63% of infants and children in attendance for long-term care coordination with a dentist (target: 65%)
- Provide oral health training to 250 health care professionals working with underserved populations through public health organizations, community-based organizations, and community health clinics (target: 100)
- Participate in 76 community events and/or presentations (target: 50)
- At community events:
 - Conduct outreach to 2,915 community members (target: 1,500)
 - Offer clinical services to 225 community members (target: 300)
 - Give a fluoride varnish treatment to 91 community members, representing 40% of those offered clinical services (target: 270 community members, representing 90% of those offered services)
- At Axis Community Health:
 - Conduct outreach to 661 community members (target: 750)
 - Provide 991 dental patient visits to community members (target: 1,250)
 - Ensure that 80% of children and youth who received care coordination were provided dental care (target: 75%)

Success Story

A school nurse contacted the Office of Dental Health because a nine-year-old child was not able to attend school due to severe mouth pain. The child's family, recent immigrants to the U.S., did not have health or dental insurance. The Dental Health Family Service Care Coordinator (FSCC) helped the family find a dentist, who asked that the child first have a physical exam by a pediatrician. With the help of FSCC, the child was able to get his physical the following day. Soon after, the child was treated by the dentist. Within a week, the child was free from pain and able to return to school.

Highlights

2,915

The Office of Dental Health nearly **doubled their outreach goal** of 1,500 by reaching 2,915 community members through community events.



FY 18/19 Allocation: \$57,397 | Expended/Encumbered: \$57,397



Individuals served by Measure A: 53 (Total individuals served: 53)



Populations served: Adults, Families, Seniors



Services provided: Public Health



Service area: Countywide

Background

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

CEI's Caring for the Caregiver program enhances comprehensive care coordination for participants by providing information, skills training, and support for family and other unpaid caregivers. Supporting and educating caregivers of high risk older adults helps prevent caregiver burnout and provides them an opportunity to learn from one another and build a personal network of other caregivers and resources.

In FY 18/19, CEI began working with DayBreak Adult Services to facilitate, promote, and organize the program cohorts. Having a dedicated resource delivering the program increased the number of enrolled caregivers and enabled CEI to offer a consistent schedule of series. CEI also began using a virtual reality software program that replicates conditions common to older adults, such as macular degeneration and dementia. This tool enables caregivers to experience first-hand how their seniors are perceiving them and how caregivers, in turn, are interpreting the responses and behaviors of their loved ones.

Services are provided in Mandarin, Spanish, and English.

Measure A Funding Summary

CEI used its Measure A allocation to conduct five Caring for the Caregiver series to 53 caregivers, completing 24 classes (target: four series to 40 caregivers).

Highlights

90%

90% of caregivers reported **improvement in their physical and emotional health** (target: 75%).

92%

92% of caregivers increased their knowledge about **how to help manage frail seniors' chronic health issues** (target: 75%).



\$ FY 18/19 Allocation: \$1,291,680 | Expended/Encumbered: \$1,291,680

👤 Individuals served by Measure A: 14,500 (Total individuals served: 14,500)

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

+ Services provided: Public Health, Mental Health, Substance Abuse

📍 Service area: Countywide

Background

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

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

SBHCs services are focused in the following areas:

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

Many SBHC staff are bilingual in Spanish, Mam, Cantonese, or Vietnamese. Other languages are accommodated through translation services where needed.

Measure A Funding Summary

CHCS used its Measure A funding to achieve the following:

Increased Access to Care

- Maintain 28 SBHC sites (target: 28)
- Offer SBHC access to 36,666 students countywide (target: 38,000)



\$ Matching Funds

\$14 M

from the following:

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

- Register 14,500 students as clients, representing 26% of students (target: 15,000, representing 30% of students)

Medical/Health Education Services

- Conduct 56,762 client visits (target: 60,000)
- Provide 22 medical service hours per week (target: 20)
- Conduct:
 - 24,862 medical visits (target: 26,000)
 - 5,594 first aid visits (target: 7,200)
 - 2,039 health education clinical visits (target: 3,600)
- For youth ages 0–18, make:
 - 21,311 non-clinical health fair/outreach contacts (target: 20,000)
 - 20,376 non-clinical first aid supplies contacts (target: 15,000)
 - 3,196 non-clinical health education for nutrition contacts (target: 3,000)
 - 9,346 non-clinical health education for reproductive health contacts (target: 6,000)
 - 1,172 non-clinical screening and other contacts (target: 3,000)
 - 168 non-clinical health education for tobacco and alcohol/drug use contacts (target: 500)
 - 346 non-clinical physical activity contacts (target: 300)
 - 1,051 non-clinical vision contacts (target: 500)
- For adults over age 18, make 347 non-clinical first aid supplies contacts (target: 300)

Behavioral Health Services

- Conduct 16,552 behavioral health service visits (target: 16,000)
- Provide 30 hours of behavioral health service per week (target: 25)
- Discuss 5,002 youth in non-clinical school staff consultations involving 2,629 staff (target: 5,000 students and 2,500 staff)
- For youth ages 0–18, make:
 - 305 non-clinical crisis intervention/grief contacts for individuals and groups (target: 500)
 - 269 non-clinical restorative justice/circle contacts conducted by SBHC staff and other groups (target: 200)
 - 22,248 non-clinical school safety/climate presentation/activity contacts (target: 10,000)
 - 1,441 non-clinical self-esteem/social skills groups contacts (target: 500)
 - 904 non-clinical trauma screening contacts (target: 750)

Oral Health Services

- Provide 15 hours of dental services per week at 12 sites (target: 12 hours at 12 sites)
- Conduct 5,302 visits with dental services (5,000)
- Provide dental services to 1,861 clients (target: 1,750)

Highlights

98%

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

99%

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

- Make 4,530 non-clinical dental screening contacts to youth ages 0–18 (target: 3,000)

Youth Development and Academic Outcomes






- For youth ages 0–18, make:
 - 1,970 non-clinical youth development contacts, such as advisory board, leadership, advocacy, etc. (target: 1,500)
 - 3,203 non-clinical peer health education group contacts (target: 1,000)
 - 407 non-clinical job training/career exploration contacts, such as applying, internships, and shadowing (target: 750)
 - 564 non-clinical acculturation support contacts for newcomers and unaccompanied youth (target: 500)
 - 754 non-clinical academic support contacts (target: 500)

Integration of Health and Wellness Support Services

- Offer information on health insurance and benefits eligibility or referral either onsite and/or to an offsite location for application assistance at 27 sites (target: 21)
- For adults over age 18, make:
 - 2,833 non-clinical health fair/outreach contacts (target: 3,500)
 - 4,570 non-clinical parent/family support contacts (target: 2,000)
 - 4,132 non-clinical school safety/climate presentation/activity contacts (target: 1,000)
 - 1,404 staff workshop/training contacts (target: 1,000)
- For youth ages 0–18, make 1,205 non-clinical parent/family support contacts (target: 1,000)
- Have updated Letters of Agreement with the school administration at 22 sites (target: 28)
- Regularly participate in Coordination of Services Team (COST) programs at 23 sites (target: 28)

Success Story

A student was hospitalized for an organ failure. The SBHC team assisted in transitioning the student home and providing much of the follow-up care, including medical, mental health, and social work services. This patient received coordinated school-based and interdisciplinary care and critical transportation assistance and is now recovering well from home and at school. The student is looking forward to graduating in a few months and is excited about finding a job, as the student adjusts to illness with resilience and determination.

-  **FY 18/19 Allocation: \$55,456 | Expended/Encumbered: \$55,456**
-  **Individuals served by Measure A: 114** (Total individuals served: 114)
-  **Populations served:** Seniors
-  **Services provided:** Public Health, Mental Health
-  **Service area:** Fremont, Newark, Union City

Background

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

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

Within AFS, the Afghan Elderly Health Promotion Program consists of four components that are interrelated and utilized in the home and at the Afghan Elderly Association (AEA) offices, the Healthy Aging Program (HAP), and the Afghan Health Promoter Program. The AEA has trained part-time Health Promoters who connect seniors to health services in the community and provide emotional support. The program is offered in Dari and Pashto.

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

- **Linkages.** The Linkages program provides information, referral, and assistance to participants. Health Promoters help participants access an array of services and entitlement programs. Additionally, they assist with translation, completing forms, transportation, housing, and other community services as needed.
- **Medication assistance and counseling.** The City of Fremont’s Public Nurse reviews participants’ medication, evaluates their knowledge and usage of their medications, and provides training and feedback as needed. When necessary, the nurse calls participants’ doctors and pharmacists for clarification or to express concerns. Health promoters conduct in-home reviews of medications, evaluating knowledge of



Matching Funds

\$150,000

from the **City of Fremont General Fund, Medical Administrative Activity (MAA) funds, and in-kind support from the City of Fremont’s Human Services Department.**

medications and use. They provide medication assistance as needed. In the Home Meds program, nursing students as well as Health Promoters collect medication information and enter it into a database that analyzes the list for possible negative effects and/or interactions. If the program identifies a potential problem, the program alerts Alameda County's pharmacist, who reviews the medication list and tries to contact the client's doctor if a problem is confirmed.

- Happy, Healthy Me (HHM). HHM is a chronic condition self-management program that helps participants identify problems and healthy goals. The program utilizes a mix of cognitive behavior techniques, motivational interviewing, and problem-solving techniques. Problems and mid-range goals are established, and a health plan is developed utilizing short-term action steps.
- Health education groups. Health Promoters are certified leaders in the Diabetes Education and Matter of Balance groups. Outside trainers are brought in to educate clients as needed.

Measure A Funding Summary

Measure A helped the Health Promoter Program achieve the following:

- Provide services to 112 refugee, immigrant, and low income seniors over 60 years of age (target: 12)
- Ensure that 114 clients have a primary physician (target: 36)
- Help 17 clients access a specialty physician or service (target: five)
- Help 52 clients access, use, and benefit from medical services (target: 15)
- Provide medication review, assistance, and education to 24 clients (target: 15)
- Provide health information and education to 86 clients (target: 11)
- Have 22 clients complete an assessment of their ability to self-manage chronic conditions (target: 11)
- Have 10 clients improve and/or complete at least one self-management goal (target: eight)
- Complete 20 fall and home safety assessments (target: 15)
- Complete 25 PHQ-4 mental health screens (target: 15)
- Provide emotional support to 106 clients (target: 15)
- Provide referrals and/or assistance to 48 clients to access entitlement, community, and supportive service programs (target: 33)

Highlights

100%

100% of clients were **assisted by Health Promoters who spoke their language and understood their culture** (target: 100%).

Success Story

Ms. Noori had experienced trauma while in Afghanistan and became depressed and anxious. She developed insulin-dependent diabetes mellitus (IDDM) and experienced minor strokes and falls. Ms. Noori's Health Promoter helped her learn how to manage her IDDM and properly inject insulin, attended and translated at medical appointments, and made sure her medications were monitored by the Healthy Aging Program nurse. The Health Promoter referred Ms. Noori to the City of Fremont Mobile Mental Health team, and Ms. Noori also attended the Matter of Balance class. Ms. Noori has been more consistent in managing her IDDM, not sustained any falls, and developed a more positive outlook about her life and future.

Health Enrollment for Children

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



FY 18/19 Allocation: \$300,000 | Expended/Encumbered: \$300,000



Individuals served by Measure A: 7,856 (Total individuals served: 7,856)



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



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



Service area: Countywide

Background

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

The Health Insurance Enrollment Assistance department is a critical resource for some of the hardest-to-reach and most vulnerable populations in Alameda County. The department provides a client-centric and culturally competent approach to help residents enroll into health care and benefit programs and has the unique ability to serve the whole family regardless of what program they are eligible for.

Services are provided in English, Spanish, and Cantonese.

In FY 18/19, benefits assistance was provided to clients according to the following percentages by program:

- Medi-Cal: 69%
- HealthPAC: 14%
- CalFresh: 12%
- Covered California: 4%
- CalWORKs: 1%

Measure A Funding Summary

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

- Provide benefit application assistance by phone and in person to 7,856 low income County residents (target: 7,504)
- Receive 3,132 calls on the Health Insurance Technician (HIT) assistance toll-free line (target: 2,702)

Highlights

83%

83% of benefit applications submitted **resulted in clients receiving benefits** (target: 81%).



Health Services for Day Laborers: Multicultural Institute

mionline.org

- \$** FY 18/19 Allocation: \$95,662 | Expended/Encumbered: \$95,662
- 👤** Individuals served by Measure A: 706 (Total individuals served: 774)
- 👥** Populations served: Indigent, Low Income, Uninsured Adults, Families, Seniors
- +** Services provided: Hospital Outpatient, Public Health
- 📍** Service area: Berkeley, Oakland, Homeless or Transient

Background

The Multicultural Institute (MI) accompanies immigrants in their transition from poverty and isolation to workforce participation and prosperity. MI's health activities bring resources, preventive measures, new information, and referrals to the street corners where day laborers are located, making services more accessible on a regular basis. Staff help individuals navigate the health system and solve their immediate health needs and also work with larger provider networks to advocate for the needs of the day laborer and immigrant community.

In FY 18/19, staff partnered with the City of Berkeley Public Health Division to organize focus groups among the individuals that MI serves. The results were ideas, statistics, and demographics that helped shape a 2018 City of Berkeley Health Division Report. Staff are also part of the Oral Health Strategy Planning Committee in the City of Berkeley. These meetings and discussions help gauge the oral health needs and concerns of the underrepresented Berkeley community. The result is Oral Health Vision 2028, a plan aiming to help Berkeley residents through prevention, education, and organized community efforts.

In addition, MI partnered with Onsite Dental to hold a five-day dental event over the course of five weeks. MI also continues to partner with LifeLong Medical Center to provide medical screenings during street outreach, as well as diabetes and blood pressure screenings and prevention workshops. Finally, MI continues its partnership with the Alameda County Health Care for the Homeless (ACHCH) mobile van by hosting them at its Berkeley office and providing sign-up and referral assistance.

The majority of the people served are not insured. Staff realize that even though partner organizations offer HealthPAC enrollment support, some day laborers prefer to ask MI staff for help because of the level



Highlights

100%

100% of individuals served reported that they would **not have had access to services if it weren't for MI or its partners** (target: 70%).

87%

87% of unduplicated day laborers outreached **learned about a resource or opportunity that they did not know about before** (target: 80%).

of trust they have with them. Due to individuals coming to staff with enrollment questions and assistance requests, program staff decided to receive HealthPAC enrollment training from Alameda County's Health Care Services Agency and since then have had the capacity to enroll individuals.

In addition to the health-related services, the Life Skills/Day Laborer program offers wraparound services through a holistic approach based on daily street outreach. Services are offered in a culturally and linguistically appropriate way. Day laborers are connected to short-term, long-term, and permanent jobs; individuals are offered various educational and vocational courses; and immigration and legal support is provided. All these services positively address and solve social and personal issues that affect the mental health and overall well-being of the community. The program also hosts gatherings like the annual Thanksgiving and Christmas event, so that day laborers and other low income individuals can come together and build connections.

Even when day laborers are in regular need of health consultations and services, they rarely seek assistance. Some of this is attributable to the fact that other urgent needs, such as securing a job, become the main priority. Additionally, difficult living and working conditions may result in health concerns, including stress and substance abuse. Language, cost, and knowledge barriers contribute as well. Having a reliable nonprofit like MI bringing health services out in the community where day laborers congregate is invaluable.

Measure A Funding Summary

Measure A funding helped MI achieve the following:

- Provide outreach to 706 unduplicated day laborer and other low income clients (target: 700)
- Contact 98.5% of day laborers on the street during daily street outreach (target: 80%)
- Register 100% of outreached day laborers with MI (target: 80%)
- Perform 246 one-on-one consultations regarding health-related navigation and/or guidance about health care insurance and coverage options and referral services across various local health care agencies (target: 100)
- Host and/or co-sponsor 11 health care trainings or workshops for 175 participants on topics that included occupational health and safety, sexual health, oral health, and substance abuse (target: eight trainings/workshops with 120 participants)
- Host and/or co-sponsor 12 street-based health education sessions for 185 participants on nutrition topics including wise grocery shopping, healthy eating, exercise, and sugary-drink education (target: eight sessions with 120 participants)
- Arrange six health screening events serving 127 unduplicated individuals (target: four events serving 100 individuals)

Success Story

Ramon, 37, suffers from drug and alcohol addiction. MI staff had tried to refer him to facilities that could provide medical support, but he refused. One day when the ACHCH mobile van was onsite, Ramon came asking for help, saying he wanted to come clean. Nancy, the ACHCH social worker, got him into a program at Fairmont Hospital in San Leandro. Ramon was concerned that if he went to the hospital and shared his information, they would call ICE and he would be deported. After a long conversation reassuring him that ICE would not be involved, staff took Ramon him to the hospital, making sure that he arrived there safely.



Health Services for Day Laborers: Street Level Health Project

streetlevelhealth.org



FY 18/19 Allocation: \$95,662 | Expended/Encumbered: \$95,662



Individuals served by Measure A: 537 (Total individuals served: 626)



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



Services provided: Public Health, Mental Health



Service area: Alameda, Albany, Berkeley, Castro Valley, Emeryville, Hayward, Newark, Oakland, San Leandro, San Lorenzo, Union City, Homeless or Transient

Background

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

SLHP's whole person care model takes into account the social aspects that impact the community's ability to access health care in a culturally sensitive manner. This model allows many community members to access medical, mental health, and nutrition services all in one location, often on the same day.

Free services provided by SLHP include the following:

- Consultations with a nutritionist, who provides personal health education, lifestyle, and diet advice, taking into account foods that are culturally familiar to patients. The nutritionist works closely with other medical providers to form a well-rounded health plan incorporating both traditional western medicine and more gentle natural approaches. This approach especially benefits patients with diabetes, hypertension, gout, and high cholesterol.
- Food bags to community members.
- Healthy, balanced meals twice per week.
- Consultations with a mental health counselor. The counselor also hosts somatic stress reduction workshops to help community members gain the tools to cope with stress and anxiety in their daily lives.

Services are provided in Spanish, English, Mam, and Nepali.

SLHP clinic staff, medical providers, and community health worker volunteers also join the Street Outreach Team to conduct free basic health screenings at sites where many day laborers look for employment. Community health workers follow up with patients and



Highlights

94%

94% of clients accessing the food pantry reported that they **would not have received healthy food if they did not get it through the pantry** (target: 75%)

invite them to visit the office for a more comprehensive medical exam. One outreach event was conducted at a Mam church, where the team conducted a needs assessment survey in conjunction with health screenings.

Measure A Funding Summary


SLHP used its Measure A allocation to achieve the following:

- Make 1,109 health care screening and episodic care visits to 897 unduplicated clients across multiple languages (target: 700 clients)
- Provide 3,396 health-related navigation/referral services to 1,793 clients across a network of 96 local health care agencies (target: 2,000 services)
- Conduct 272 mental health consultations with 124 unduplicated clients from low income communities in Alameda County (target: 200 consultations)
- Provide 268 nutritionist/herbalist consultations to 163 clients (target: 150 consultations)
- Distribute 3,373 free food bags to low income individuals (target: 2,500)
- Recruit and train 25 prospective and current health care providers, providing them with experience working with uninsured low income communities (target: 20)


Success Story

Camila, a 20-year-old Mam speaker, was pregnant and came to SLHP for counseling due to lack of resources to sustain another child. The Health Access Program manager helped Camila make an appointment at a nearby clinic, where she was enrolled in Medi-Cal and received a therapeutic abortion. Two days later, Camila returned to SLHP complaining of abdominal cramping. The Health Access Program manager accompanied Camila back to the clinic, where she explained that Camila spoke Mam, not Spanish. Mistaking Mam for Spanish is common, and a delay in patient care could have led to severe health implications. Camila received an appointment the same day and is now doing well.

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

 **FY 18/19 Allocation: \$261,160 | Expended/Encumbered: \$261,160**

 **Individuals served by Measure A: 108** (Total individuals served: 731)

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

 **Services provided:** Hospital Outpatient

 **Service area:** Countywide

Background

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

BHCS oversees certain programs that provide medical services at the Alameda County Juvenile Justice Center (JJC). These services are provided under the coordination of the JJC Health Services Director. The Health Services Director is a critical position that uniquely coordinates among health care services provided by UCSF Benioff Children's Hospital, the Alameda County Probation Department, and BHCS. As part of this coordination, the Director helps families and partners navigate often-challenging systems.

Services are provided in Cantonese, English, Persian, Punjabi, and Spanish.

Measure A Funding Summary

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

In FY 18/19, the Measure A-funded Director achieved the following specific accomplishments:

- Establish a set of health policies for the JJC. These policies bring the County in compliance with state mandates and establish and specify the types of medical and mental health care services youth receive while detained in the facility.

Success Story

A youth in the JJC had serious health issues from a past gunshot wound. The medical clinic helped manage the youth's pain, identified options for improving his health, and eventually recommended surgery. The youth's Medi-Cal insurance had been deactivated, and the family was concerned about paying for his surgery and follow-up care. The JJC Health Services Director worked with the mental health clinician and family to get the youth's insurance reactivated. The Director also coordinated with the local hospital to ensure the family would not need to pay and to expedite the surgery. The surgery went smoothly, the medical clinic provided excellent follow-up care, and the youth is healing well.

- Establish weekly meetings among members of a Health Team to better support youth while they are in detention. The Health Team initially started with medical and mental health managers, but soon expanded to include Probation managers, public health nurses, JJC psychiatrists, and the Behavioral Health staff person from the Transition Center. The Health Teams allow partner agencies to create care plans for youth while they are in detention, better coordinate services for youth, and begin transition planning before youth leave the JJC.

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

- 66% of youth booked into the JJC received a comprehensive physical exam (target: 80%).
- 39% of youth booked into the JJC received a dental health screening (target: 75%).

Highlights

88%

88% of youth who received medical services were **satisfied with the services** (target: 80%).



Medical Costs for Juvenile Justice Center: Niroga Institute

niroga.org



FY 18/19 Allocation: \$89,152 | Expended/Encumbered: \$89,152



Individuals served by Measure A: 1,820 encounters (Total individuals served: 2,300 encounters)



Populations served: Indigent Children, Transition-Aged Youth



Services provided: Mental Health



Service area: Countywide, Outside of Alameda County

Background

Niroga Institute strives to foster the health and well-being of children, youth, families, and communities through the practice of trauma-informed dynamic mindfulness.

Niroga Institute provides twice-weekly or weekly Transformative Life Skills (TLS) sessions for at-risk and incarcerated youth at the Alameda County Juvenile Justice Center (JJC). Each lesson includes mindful action, breathing, and centering, with time for discussion about real-life applications of the skills being taught. The lessons support the following objectives:

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

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

Hour-long dynamic mindfulness sessions are also provided for JJC staff. The sessions focus on the applications of TLS that promote relaxation and increase self-awareness. The staff classes incorporate the action, breathing, and centering necessary for stress reduction and increased well-being. The instructor teaches specific techniques that can be used during the workday for self-care and applied to the staff's work with clients.

Highlights

100%

100% of staff class participants were **satisfied with the class content, the teacher's effectiveness, and the overall quality of the class** (target: 70%).

95%

95% of youth class participants reported that the class was **helpful for managing emotions and stress** (target: 40%).

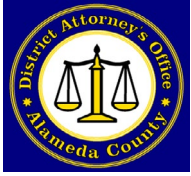
Measure A Funding Summary

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

- 507 TLS classes for youth, including a total of 1,783 youth encounters (target: 400 classes and 1,500 encounters)
- Three day-long TLS immersions for 15 youth (target: three immersions for 15 youth)
- 102 TLS classes for staff, with an average of five staff per class (target: 90 classes averaging five staff per class)

Success Story

When a new student came to the TLS class, he expressed that his hands hurt because he had been punching the walls in his cell. He said he had anger issues and was currently feeling very upset. After the yoga and mindfulness practice, the student stated that he felt calm and relaxed. Additionally, the student told the instructor that he had ADHD and couldn't focus. He would continually look outside of the room and get distracted by movements and sound. After several weeks in the class, the student never reported feeling angry, and he was able to hold his attention longer by focusing on his breathing.



Medical Costs for Juvenile Justice Center: Victims of Crime

alcoda.org/victim_witness/california_victim_compensation_program

- \$** **FY 18/19 Allocation: \$90,000 | Expended/Encumbered: \$79,118**
- 👤** **Individuals served by Measure A:** 2,936 (Total individuals served: 2,936)
- 👥** **Populations served:** Indigent, Low Income, Uninsured Adult, Children, Families, Seniors
- +** **Services provided:** Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse
- 📍** **Service area:** Alameda, Albany, Berkeley, Castro Valley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Piedmont, Pleasanton, San Leandro, San Lorenzo, Union City, Outside of Alameda County, Homeless or Transient

Background

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

The Victim Compensation Program serves to improve the lives of and provide economic support to clients experiencing the trauma aftermath of crime. Through the program, the California Victim Compensation Board (CalVCB) offers the following:

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

Services are primarily provided in Spanish, Chinese, and Mandarin.



Highlights

↑ **75%**

The average CalVCB claims **processing time improved by 75%** compared to the statewide average.

↑ **100%**

CalVCB application filings increased **by 100%**.

Measure A Funding Summary

CalVCB used its Measure A allocation to target 36% of clients served who were previously unaware of or uninformed about the CalVCB filing process. The program made direct contact with these clients to provide program information, address questions, explain the eligibility process, invite them to submit a loss request or bills, and offer helpful resources and referrals.

Success Story

A CalVCB application was filed by a minor female trauma crime victim of human trafficking and sexual assault. The applicant received immediate filing assistance through her assigned Victim/Witness Advocate. The Advocate identified the crisis needs of the applicant for which financial assistance could be requested through the CalVCB program, which is the payer of last resort towards covered expenses. In this case, the program was able to assist with payment of the applicant's out-of-pocket mental health counseling, in-patient hospitalization, and medical expenses. Additionally, relocation assistance was provided out of the CalVCB emergency revolving fund as a direct payment of move-in costs to the landlord.



Preventive Care Pathways

Preventive Care Pathways

[healthcare.gov/coverage/preventive-care-benefits](https://www.healthcare.gov/coverage/preventive-care-benefits)



FY 18/19 Allocation: \$229,587 | Expended/Encumbered: \$229,587



Individuals served by Measure A: 3,078 (Total individuals served: 5,400)



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



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



Service area: Countywide, Homeless or Transient

Background

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

Services are provided in English, Spanish, Chinese, and Arabic.

Measure A Funding Summary

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

- Conduct 5,400 medical visits to 634 unduplicated low income patients with Alameda Alliance or Anthem Blue Cross Medi-Cal (target: 2,500 visits to 500 patients)
- Screen 942 patients for Hepatitis C as a part of a basic health screening (target: 400)
- Provide treatment for 117 patients who tested positive for Hepatitis C, of whom 95% received or completed treatment (target: 80%)
- Coordinate two health fairs and workshops attended by 130 participants (target: six health fairs/workshops with 50 participants)
- At the health fairs/workshops, provide 75 Hepatitis C and/or prostate cancer screenings, representing 61% of attendees (target: 25%)
- Provide Covered California or Medi-Cal application assistance to 341 uninsured residents, of whom 43% submitted an application (target: 200 residents, with 50% submitting an application)
- Have 137 applications who received assistance and were approved for Medi-Cal select the Preventive Care Pathways James A. Watson Wellness Center as their primary care provider, representing 38% of such applications (target: 50%)
- Attend two Covered California CEE Alameda County partnership meetings, representing 50% of meetings held (target: two, representing 50% of meetings)



Matching Funds

\$137,800






from the following sources:

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



ALAMEDA HEALTH
CONSORTIUM

Primary Care Community-Based Organizations

-  **FY 18/19 Allocation: \$5,753,0091 | Expended/Encumbered: \$5,753,009**
-  **Individuals served by Measure A:** 18,826 (Total individuals served: 271,958)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Public Health, Mental Health, Substance Abuse
-  **Service area:** Countywide

Background

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

The 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 communities.
- Racial and ethnic health disparities must be eliminated to have healthy communities.

The Consortium’s outpatient services are provided at eight community health center locations throughout Alameda County:

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

Highlights

7 of 8

Seven of the eight health centers met their goal for **improving performance on the Colorectal Cancer Screening HEDIS measure**, and all eight centers **met their goal on the Controlling High Blood Pressure HEDIS measure**.

More than 20 languages are spoken across the health centers.

The Consortium health centers continuously work to improve access to care for all patients. In FY 18/19, the clinics served 8,874 more patients than the previous year. The centers also implement Healthy Teeth Healthy Communities (HTHC), a four-year dental pilot program to help increase the utilization of preventive dental services for children and youth ages 0–20 years. In addition, the Consortium partners with Alameda County Behavioral Health on Integrated Behavioral Health (IBH) initiatives, such as the UC Davis Primary Care Psychiatry and Primary Care Pain Fellowships, the work of Integrated Behavioral Health Care Coordinators (IBHCCs), and supporting the community health centers in behavioral health integration efforts. It also partners with the East Bay Naturalization Collaborative to offer naturalization services to health center patients.

Measure A Funding Summary

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

- Hold 12 On-Site Medi-Cal Eligibility (OSME) health center and social services agency leadership staff workshops for all eight community health centers (target: 12 workshops for eight centers)
- Promote food security within the clinic setting by hosting food distribution at five health centers for patients and community members (target: five)
- Provide a “Food Farmacy,” or food-as-medicine, model for patients to access food right after seeing a provider at five health centers (target: five)
- Educate patients on nutrition and making healthy food choices at four health centers (target: four)
- Have five health centers complete the Father Corps Self-Assessment Tool (target: five)
- Have staff from four health centers attend a “Father-Friendly Principles” training (target: four)
- Participate in two technical site visits each at three health centers (target: three centers)
- Provide culturally appropriate handouts and resources in the clinic at seven health centers (target: seven)
- Enroll 18,826 low income Alameda County residents in HealthPAC, of whom 17,247 accessed services
- Provide the following number of patient visits:
 - Primary care: 77,298
 - Specialty care: 2,293
 - Dental: 11,592
 - Optometry: 1,862
 - Podiatry: 91
 - Mental health: 2,410

Success Story

A homeless woman who lives out of her vehicle was referred by her provider for a colonoscopy. The Consortium connected her with a Community Health Worker (CHW), who got the patient a voucher for a night’s stay in a hotel to complete her prep for the procedure and programmed reminders in the patient’s phone so she would know when to do each step. When the patient’s driver bowed out of taking her to the procedure, the CHW secured a transportation voucher and worked with the patient on finding another trusted individual to see her through the procedure. Through this coordination of care, the patient successfully completed her colonoscopy.

- Utilize loan repayment programs to attract and retain providers at three health centers (target: three)
- Provide opportunities for professional development, including covering Continuing Medical Education expenses, at five health centers (target: five)
- Offer provider compensation in the form of bonuses, salary increases, and retirement plan contributions at all eight health centers (target: eight)
- Provide 68% of patients on a chronically high dose of opioids with buprenorphine, or ensure that they have evidence of an alternative harm reduction plan (target: 55%)
- Attain a 77% Hepatitis C screening rate for active patients born between 1945 and 1965 (target: 75%)
- Prescribe treatment for 70% of patients with chronic Hepatitis C (target: 62%)
- Attain a sustained virologic response (SVR12/ “cure”) rate of 96% for patients who have completed Hepatitis C treatment and follow-up labs (target: 96%)



\$ FY 18/19 Allocation: \$40,000* | Expended/Encumbered: \$40,000

Individuals served by Measure A: 610 (Total individuals served: 610)

Populations served: Low Income, Uninsured Children, Families

Services provided: Public Health, Mental Health

Service area: Hayward

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

Background

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

TVHC’s school-based health centers are a safe and convenient place for students to receive the medical and mental health support they need to succeed in school and become productive members of the community. A student who is tired, sick, suffering from asthma, stressed, depressed, or scared often experiences academic performance issues and an increased risk of dropping out of school. The school health centers advocate holistic health care, paying careful attention to the dynamic relationship among mind, body, and spirit. Their primary objective is to make important health and wellness information more readily accessible to youth and provide an effective tool for youth to take control of their own well-being.

Health center staff also work with teachers, providing ongoing support for individual students to ensure they are on track with their learning requirements. In addition, they work with school staff and the community to offer continuing support, crisis intervention, and promotion of school and community-based events.

Services are provided in English and Spanish.



Highlights

↑ 472

Tennyson served **472 more clients than the preceding year**, while Hayward served **138 more clients**.

Measure A Funding Summary

Measure A funding helped TVHC achieve the following:






- Provide an average of 16 medical hours per week each at Tennyson High School and Hayward High School (target: 16 each)
- Conduct 902 medical visits at Tennyson and 307 at Hayward (target: 427 at Tennyson, 491 at Hayward)

- Make 25 oral health referrals at Tennyson and two at Hayward (target: 12 each)
- Provide oral health services to 90 students at Tennyson and nine at Hayward (target: 50 each)
- Provide an average of 27 hours per week of health education, health promotion, and youth development services at Tennyson and 24 hours per week at Hayward (target: 16 each)
- Make 12 classroom and other group presentations at Tennyson and seven at Hayward (target: eight each)
- Through the presentations, serve 1,254 students at Tennyson and 302 students at Hayward, (target: 285 at Tennyson, 327 at Hayward)
- Hold 36 family and/or community member health-related events and/or activities each at Tennyson and Hayward (target: two each)
- Screen and enroll 100 clients in health coverage and other health and social programs at Tennyson and 50 clients at Hayward (target: 24 each)
- Participate in 36 Coordination of Services Team (COST) meetings at Tennyson and 18 at Hayward (target: 12 each)

Highlights

100%

100% of clients reported that the health center **helped them deal better with stress and anxiety** (target: 100%).

-  **Allocation: \$50,000*** | **Expended/Encumbered: \$50,000**
-  **Individuals served by Measure A:** 51,722 (Total individuals served: 51,722)
-  **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

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

Background

The Washington Hospital Healthcare Foundation enhances the work of the Washington Hospital Healthcare System by increasing public awareness and providing financial support. The Washington Hospital Healthcare System addresses the health care needs of community residents through medical services, education, and research.

The most notable highlight of FY 18/19 was the opening of the Morris Hyman Critical Care Pavilion. This 224,800-square-foot building contains a state-of-the-art critical care unit with 48 beds, a medical surgical unit with 68 single-occupancy patient rooms, and an emergency department that is four times the size of the previous facility. The emergency department contains two fully functioning resuscitation rooms that can accommodate patients suffering from traumatic injuries. In the emergency department, a medically certified translator is provided by phone. Languages offered include Spanish, Tagalog, Farsi, Hindi, Arabic, Mandarin, Cantonese, and Vietnamese.



Measure A Funding Summary

The Washington Hospital Healthcare Foundation used its Measure A allocation to achieve the following:

- Purchase and install ceiling-mounted booms and operating lights in two resuscitation rooms in the emergency department of the new Critical Care Pavilion (target: two)
- Train 165 personnel in the new facility for several months before the Pavilion was opened to accept patients (target: 165)
- Ensure that 100% of the infrastructure was in place to equip the resuscitation rooms and provide trauma care to patients when the facility began operations (target: 100%)

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

GROUP 4: PUBLIC HEALTH

ACCMA Community Health Foundation/East Bay Conversation Project	66
Alameda Boys & Girls Club, Inc.	68
Asthma Start	70
Center for Early Intervention on Deafness	72
City of San Leandro Senior Services	74
Countywide Plan for Seniors: Getting the Most Out of Life	76
Countywide Plan for Seniors: Home-Based Nursing Case Management	78
Countywide Plan for Seniors: Injury Prevention, Meals, Nutrition	80
Eden Youth and Family Center	82
Emergency Medical Services (EMS) Corps	84
Emergency Preparedness, Mitigation, Response, & Recovery	86
George Mark Children’s House	88
Health Services for Persons Who Inject Drugs HIV Education and Prevention Project of Alameda County (HEPPAC)	90
Healthy Food Healthy Families: Alameda County Community Food Bank	92
Healthy Food Healthy Families: Alameda County Deputy Sheriffs’ Activities League	93
Healthy Food Healthy Families: UCSF Benioff Children’s Hospital Oakland	94
Healthy Homes Department Fixing to Stay & Group Living Facilities Project	95
HERS Breast Cancer Foundation	97
HIV Education and Prevention Project of Alameda County (HEPPAC) OPEND Program	98
Home Visiting Services	100
La Familia Counseling Services: Youth Resiliency	103
Latino Men and Boys Program	105
Lend A Hand Foundation	107

LIFE ElderCare	108
LifeLong Medical Care Heart 2 Heart	110
Needle Exchange Emergency Distribution	112
Nutrition Services in West Oakland: City Slicker Farms	113
Oakland Unified School District: Behavioral Health Stipends	115
Oakland Unified School District: Water Hydration Stations	116
Public Health Prevention Initiative	117
Public Health Prevention Initiative: Emergency Medical Services (EMS) Injury Prevention	122
Public Health Services for Homeless Residents: Abode Services	125
Sandra Wing Healing Therapies Foundation	126
Senior Injury Prevention Program	127
Social Good Fund, Inc. (The East Oakland Collective)	129
Spectrum Community Services, Inc. : Fall Prevention Program	130
Spectrum Community Services, Inc.: Meals on Wheels	132
Women’s Cancer Resource Center	133
Youth and Family Opportunity Initiatives	134

- \$ **FY 18/19 Allocation: \$38,909.72*** | **Expended/Encumbered: \$20,000**
- 👤 **Individuals served by Measure A:** 1,281 (Total individuals served: 1,281)
- 👥 **Populations served:** Low Income, Uninsured Adults, Families, Seniors
- + **Services provided:** Public Health
- 📍 **Service area:** Countywide

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

Background

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

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

- Formed steering committees in Alameda and Contra Costa Counties with a broad range of community organizations and individuals—including businesses, faith-based organizations, senior advocates, elected officials, health care organizations, health care professionals, estate attorneys, fiduciaries, hospices, and others—to promote advance care planning
- Trained hundreds of champions/coaches to promote advance care planning in the East Bay through ongoing trainings that are offered free of charge on a quarterly basis
- Sponsored or participated in dozens of events, presentations, and programs to introduce the concepts and benefits of advance care planning and end-of-life care to thousands of East Bay residents
- Organized daylong summits with notable advance care planning speakers to teach health care professionals and the public how to have better advance care planning conversations

Services are provided in English, Chinese, and Spanish. EBCP also offers free up-to-date resources through its website, providing a focal point of information and guidance on advance care planning for the target



Highlights

100%

100% of coalition meeting participants **found the meetings engaging and informative** (target: 80%).

audience and a resource to help advance care planning advocates engage in outreach activities.

Measure A Funding Summary

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

- Increase the size of its coalition to 96 community organizations (target: 105)
- Hold quarterly steering committee meetings attended by 68 individuals (target: 60)
- Conduct outreach for and provide 63 activities that promoted advance care planning (target: 60)
- Ensure that 129 advocates completed the quarterly training (target: 100)
- Add 26 advance care planning resources to the program website (target: 20)

Highlights

95%

95% of individuals were more likely to **engage in advance care planning following the outreach** (target: 85%).

- \$ **FY 18/19 Allocation: \$114,794 | Expended/Encumbered: \$114,794**
- 👤 **Individuals served by Measure A:** 1,750 (Total individuals served: 2,445)
- 👥 **Populations served:** Indigent, Low Income, Uninsured Children
- + **Services provided:** Public Health, Mental Health, Substance Abuse
- 📍 **Service area:** Alameda, Oakland

Background

The Alameda Boys & Girls Club (ABGC) serves thousands of Alameda youth and teens each year with a comprehensive culinary, nutrition, and health education program integrated with physical fitness, recreational, and environmental programming. Members learn essential lessons about personal health and fitness and how their food choices affect the environment.

The gardening and cooking programs teach participating members about personal responsibility, commitment, and caring for the environment. In Seed-to-Table, interns and students from neighboring schools help maintain an edible garden and work with youth in ABCG's kitchen. Family Freshies is a farmers market-style activity where members harvest produce from the garden and display it for youth and their families to take home free of charge once a month to promote healthy eating.

The physical activity component of the program helps members with peer-group identification, teamwork, and good sportsmanship. In addition, medical and mental health services help those who are low income receive necessary and beneficial medical check-ups and referrals to follow-up care such as counseling and dental and vision work. Mental health services help members think critically about the concepts of "normal" or "typical" versus "abnormal" behaviors, provide them with knowledgeable solutions to the feelings they face, and promote their ability to create a healthy and stable life for themselves.



Highlights

100%

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

Measure A Funding Summary

ABGC used its Measure A allocation to achieve the following:

- Provide 12 dental, vision, and/or respiratory screenings and referrals to follow-up care to 391 unduplicated low income youth (target: 12 screenings to 270 youth)

- Provide four health education events and/or workshops to 400 youth (target: four events/workshops to 320 youth)
- Provide five mental health workshops on topics including coping mechanisms for anger, bullying, technology safety, and stress management to 260 youth (target: four workshops to 200 youth)
- Provide four six-session Passport to Manhood workshops discussing how to make good decisions, avoid harmful substances, and act responsibly to 81 middle school male students (target: four workshops to 50 students)
- Provide nine six-session Smart Girls workshops to discuss how to avoid dating violence, harassment, and sexually transmitted diseases, as well as sexual myths and regular gynecological care, to 52 female students (target: five workshops to 14 students)
- Provide four Healthy Habits workshops to 600 members to encourage a commitment to healthy eating and physical activity (target: four workshops to 240 members)
- Provide a comprehensive culinary, nutrition, and health education program to 206 youth that teaches the value of healthy cooking and eating by combining hands-on cooking activities, field trips, and a teaching curriculum (target: 250 youth)
- Offer one hands-on/informational event/workshop for all youth per year (target: one)
- Provide a dynamic, garden-based nutrition and ecology education to 255 youth (target: 250)
- Provide low and high impact recreation and sports to help 1,275 youth develop and/or maintain an active and physically fit lifestyle (target: 1,000)

Success Story

Na'Ziyah, 14, started coming to ABGC when she was seven years old. Her older sister was a member and her younger brother would eventually join as well. Na'Ziyah has always appreciated ABGC for giving her the ability to be herself, connect with friends without cliques, and have a community. Today, her favorite activity is cooking in the kitchen because she gets to try foods that she cooks herself, knows what ingredients are in them, and can sell them in the café. Mentorships are a big factor in her success, because they have helped her work through personal health struggles by understanding and learning how to positively tackle them.



Asthma Start

acphd.org/asthma.aspx

- \$** **FY 18/19 Allocation:** \$100,000 | **Expended/Encumbered:** \$100,000
- 👤** **Individuals served by Measure A:** 82 (Total individuals served: 82)
- 👥** **Populations served:** Indigent, Low Income, Uninsured Children, Families
- +** **Services provided:** Public Health
- 📍** **Service area:** Alameda, Hayward, Oakland, San Leandro, San Lorenzo

Background

Asthma Start works with families of children and adolescents diagnosed with asthma to provide them with the tools needed to manage their asthma, avoid the emergency department and hospital, ensure that they have healthy homes, and live a healthy life avoiding the long-term complications of asthma. The program addresses social determinants of health by assisting with housing, food, employment, and smoking cessation, and refers and links clients to any other needed services.

Asthma Start’s services encompass the following programs and activities:

- Addressing the environmental aspect of asthma by visually inspecting the client’s home and educating the parents on how to address issues. The program also provides information such as what each medication does, whether the meds are expired, and how are they administered. The program assists other cultures in understanding the medical and prescription refill system so they don’t go without services or medication. The program is sensitive to cultural differences with regard to their beliefs and practices about their child’s disease.
- Advocating with property owners when additional safety and environmental issues are identified in the client’s home. The program also supplies every family with mattress and pillow encasings and other asthma supplies as needed to assist them in caring for their child.
- Working with the District Attorney (DA) regarding truancy due to asthma. The family goes through the Asthma Start case management program as a part of their contract with truancy court, and Asthma Start reports to the court on their progress.
- With Public Health Nursing, attending School Attendance Review Board (SARB) meetings to try and assist students that are chronically absent due to illness before they become truant. If asthma is cited as the reason for the absences, the family is referred to the Asthma Start program.



\$ Matching Funds

\$200,000

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

- Partnering with Alameda Alliance for Health to increase the number of children that have access to asthma case management. Alliance works with Valley Care and UCSF Benioff Children’s Hospitals and receives weekly reports on children that were seen in the emergency department for asthma. Those children are then referred to Asthma Start for contact and follow-up to provide case management.

The program received an Achievement Award in the 2019 National Association of Counties for addressing asthma education and social determinants of health, partnering with a Medi-Cal Managed Care Health Plan, and reducing emergency room visits and hospitalizations.

Staff can provide services in English, Spanish, Amharic, Tigrinya, and Swahili. If a client requires other languages, the program uses interpreters from an outside service.

Measure A Funding Summary

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

- Enroll 82 clients in the program (target: 50)
- Successfully discharge 70 clients from the program (target: 40)

Success Story

A child had been to the emergency room six times in the past twelve months due to asthma. According to the child’s mother, the child often returned coughing and wheezing from his weekend visits with his father, and she suspected the father was smoking in his apartment. The Asthma Coordinator (AC) provided the family with asthma education, dust mite-proof mattress and pillow covers, an air purifier, and a moisture absorber to reduce the humidity in the apartment. The mother and grandmother improved their consistency with giving the child his medication and vacuuming and washing the bedsheets. Through this collaborative effort, the child’s emergency room visits were reduced to zero.

- \$ **FY 18/19 Allocation: \$57,397 | Expended/Encumbered: \$57,397**
- 👤 **Individuals served by Measure A:** 125 (Total individuals served: 1,036)
- 👥 **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
- + **Services provided:** Public Health
- 📍 **Service area:** Alameda, Berkeley, Castro Valley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Piedmont, San Leandro, San Lorenzo, Union City

Background

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

CEID provides community audiology services to Alameda County families and individuals through two clinics in Berkeley and Oakland. Patients are primarily low income and Medi-Cal-insured, making CEID one of the few audiology providers who accept patients with Medi-Cal.

CEID is an acknowledged expert in pediatric audiology and reaches out to community clinics and their doctors, birthing centers, and private pediatricians. Referred patients are able to receive timely, professional hearing evaluations and are provided and fitted with hearing devices for a diagnosed hearing loss.

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

CEID has multilingual staff who speak Spanish, Tagalog, English, and ASL and secures interpreters for patients whose primary languages include Amharic, Arabic, Cambodian, Cantonese, Darci, Farsi, Hungarian, Lao, Mandarin, Punjabi, Russian, Tigrigna, Tongan, and Vietnamese.

Measure A Funding Summary

CEID used its Measure A allocation to achieve the following:

- Conduct 28 newborn hearing screenings based on referrals from community clinics, Alta Bates Medical Center, and UCSF Benioff Children's Hospital Oakland (target: 75)



Highlights

100%

100% of CCS and/or Medi-Cal patients who requested a hearing aid and/or ear mold received one (target: 95%).

- Perform 816 hearing evaluations for children, youth, and adults based on referrals from community clinics (target: 450)
- Dispense hearing aids and ear molds to 376 patients based on referrals from UCSF Benioff Children’s Hospital Oakland, Kaiser, California Children’s Services (CCS), and community clinics (target: 175)
- Train 69 pediatric residents on pediatric hearing loss, how to read audiograms and audiological reports, types of hearing testing, amplification options, and the role of the pediatric provider in hearing loss care and management (target: 50)

Success Story

A man with significant hearing loss came to CEID for a new ear mold. While working with CEID’s audiologist at the Berkeley Clinic, the patient discussed barriers to being able to conduct basic daily activities that require making phone calls. With the help of CEID staff, the patient got a caption call phone. In a handwritten note sent to the clinic, he shared, “I ♥ my new Caption Call Phone! Thank you for getting it for me. It really changed my life. Now I don’t have to depend on other people to make phone calls for me anymore! I feel like a more independent person!”



City of San Leandro Senior Services

sanleandro.org

- \$** **FY 18/19 Allocation: \$57,397 | Expended/Encumbered: \$57,397**
- 👤** **Individuals served by Measure A:** 12,386 (Total individuals served: 46,615)
- 👥** **Populations served:** Low Income Adults, Families, Seniors
- +** **Services provided:** Public Health
- 📍** **Service area:** Ashland, Castro Valley, San Leandro, San Lorenzo

Background

The San Leandro Recreation and Human Services (SLRHS) Department offers a wide range of activities, services, and resources for seniors, their families, and caregivers. Staff design senior programs to support healthy life choices, improve quality of life, and create a sense of community and inclusion. These activities include the following:

- **Classes.** Classes promote good physical, mental, and emotional health. Participants have the opportunity to exercise safely; explore visual and performing arts, crafts, and creative writing; dance a wide variety of styles; improve driving skills; learn to use smartphones; and more.
- **Social programs.** Participants get together to share games, food, friendship, and fun. Participants gather for positive social interactions with their peers while enjoying these activities.
- **Community Education Program (CEP).** CEP consists of services, workshops, consultations, and presentations on topics relevant to older adults, their families, and caregivers. These programs and services are offered in partnership with various nonprofit organizations, other city departments, and outside agencies. Participants can receive flu shots, tax preparation help, and health insurance counseling and participate in support groups such as the Diabetes Support Group, Peer Support for Seniors, and Rainbow Seniors. Nutritional offerings include a meal service on weekdays and a monthly food bag distribution.
- **Special events.** Several special occasions are celebrated throughout the year, including Martin Luther King, Jr.'s Birthday; Lunar New Year; Older Americans Month; and Día de Los Muertos. The annual Senior Thanksgiving Luncheon serves a delicious traditional Thanksgiving meal to approximately 500 seniors.



Highlights

83%

83% of seniors obtained **three or more blood pressure screenings** in a year (target: 80%).

Measure A Funding Summary

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

- Provide 11 free, drop-in blood pressure screenings to a total of 491 unduplicated seniors (target: 12 screenings to 360 seniors)
- Distribute a bag of nutritional food to 65 seniors twice a month through the Mercy Brown Bag program, a total of 1,215 seniors (target: 50 seniors twice per month, a total of 1,200 seniors)
- Provide 11 health education class sessions through the CEP attended by 240 unduplicated seniors (target: 12 sessions attended by 234 seniors)
- Conduct 37 Pull Up a Chair exercise sessions attended by 177 unduplicated seniors (target: 36 sessions attended by 240 seniors)
- Hold 372 Fall Prevention Enhance Fitness class sessions attended by 2,207 unduplicated seniors (target: 108 sessions attended by 1,800 unduplicated seniors)
- Hold a Senior Resource Fair offering health resources, information, and free health checks attended by 240 seniors (target: 300)

Success Story

Martha Torres, 75, started attending programs after her husband passed away, to help with her loneliness. Her first contact was the meal program, where she made friends with some of her lunch companions and staff. Eventually Martha enrolled in the Enhance Fitness class, which she attends once or twice per week and which helps her feel good and walk better. She sometimes also attends Pull Up a Chair classes, where she especially likes the gentle stretching. About a year ago Martha also signed up for the Mercy Brown Bag program, which she indicated helps her prepare more meals at home.



Countywide Plan for Seniors: Getting the Most Out of Life

gettingthemostoutoflife.org

💰 **FY 18/19 Allocation: \$250,000 | Expended/Encumbered: \$152,455.83**

👤 **Individuals served by Measure A:** 211 (Total individuals served: 211)

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

⊕ **Services provided:** Public Health

📍 **Service area:** Countywide

Background

Alameda County In-Home Support Services (IHSS) Care Partners offers Getting the Most Out of Life, a unique, culturally relevant palliative care program that helps low income clients who have a serious or terminal illness or are frail elders and high utilizers of acute care services to remain at home safely, comfortably, and with support to improve the quality of their lives. The program supports clients through home visits during which clients are engaged in advance care planning (ACP), goals of care conversations, and care coordination. Through ACP clients document their health care decisions and share their wishes with their loved ones, caregivers, and health care providers.

The program educates and trains Alameda County health care professionals to meet a growing need as the older population grows exponentially. These professionals become allies in initiating conversations that increase advance health care planning activities and hospice utilization among terminally ill clients. Clients learn about end-of-life (EOL) planning, complete their advance directives (ADs), identify their needs through evidence-based assessment tools, and get support to access a range of a palliative care and hospice services when indicated.

The program is designed to address racial and cultural disparities in access to EOL planning and care among the County's low income older adult population. The program offers increased access to culturally affirmative ACP education and training along with AD form completion workshops and presentations at community outreach and engagement table events, faith-based organizations, senior centers, residential care facilities for the elderly, and federally qualified health care centers.

The program partners with Comfort Homesake, a nonprofit that offers trainings and direct services related to EOL issues and ACP. Comfort Homesake administers the No One Dies Alone (NODA) program, which



Highlights

100%

100% of IHSS clients were likely or very likely to **contact Care Partners again for support with advance care planning**, as well as **make referrals to their friends and family** (target: 75%).

provides services in a patient's home or at the hospital to allow the patient to feel supported by the presence of someone trained in the art of comfort and deep listening.

The Care Partners program won a 2018 Challenge Award, given to the most innovative programs in California counties. The program serves a very racially diverse group of adults and seniors, including 34% African American, 32% Asian, 12% Latino, 10% Caucasian, 5% Native Hawaiian and other Pacific Islander, and 7% other.

Measure A Funding Summary

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

- Assist in the completion of 140 AD and 119 Physician Orders for Life Sustaining Treatment (POLST) forms (target: 120 each)
- Share 125 AD forms with clients' primary care physicians (target: 120)
- Train 5,645 IHSS and 63 Alameda County staff on advance care planning-related topics (target: 5,400 and 60)
- Provide ACP and related services to 177 new IHSS clients, both care recipients and their care providers (target: 180)
- Ensure that 34 established IHSS clients received follow-up visits (target: 36)
- Receive self-referrals from 64 IHSS clients (target: 60)
- Receive 141 referrals from IHSS staff and community providers and partners (target: 120)
- Perform 211 ACP home visits with IHSS clients to assist them with completing ACP forms (target: 180)
- Connect 175 clients to other resources, such as safety, food, transportation, and legal resources (target: 180)
- Through Comfort Homesake, provide three ACP trainings and assist with the completion of 117 AD forms
- Train two on-call volunteers for 24/7 NODA referral calls
- Provide NODA services from a trained volunteer to 19 terminally ill patients (target: 20)

Highlights

100%






100% of persons referred to NODA **received services from a trained, culturally sensitive NODA volunteer** (target: 25–50%).

80%

80% of new IHSS clients **completed an AD form**, and 67% completed a POLST form, during the home visit (target: 67%).

Countywide Plan for Seniors: Home-Based Nursing Case Management

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

-  **Allocation: \$500,000 | Expended/Encumbered: \$500,000**
-  **Individuals served by Measure A:** 118 (Total individuals served: 118)
-  **Populations served:** Indigent, Low Income Adults, Seniors
-  **Services provided:** Hospital Outpatient, Public Health, Mental Health
-  **Service area:** Countywide

Background

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

Older Adults, Healthy Results (OAHR) is an ACPHN long-term home visiting nurse case management program for older adults who have trouble managing complex health conditions due to psychosocial challenges.

OAHR's population has complex, chronic medical conditions; functional impairments; and psychosocial stressors that impede their ability to manage health conditions, increasing the risk of health decline. OAHR aims to improve chronic care management, stabilize health decline, meet functional needs, and ultimately improve quality of life (QOL). To help clients achieve these goals, the program:

- Helps clients identify and set achievable goals. The public health nurse (PHN) works with each client/caregiver to develop an Individualized Care Plan (ICP) that enumerates priority goals. This care plan is updated every six months with the input of clients and caregivers.
- Facilitates communication with the health care team. Many clients are prescribed very complicated treatment regimens or are asked to pursue extensive medical workups, coordinating multiple appointments over weeks and months. Without the right support and expertise, these clients are not able to navigate the system effectively.
- Helps mitigate the deficiencies of the health care delivery system. The most vulnerable patients often have difficulty accessing services. OAHR works to coordinate care and facilitate access to treatment and services.

Highlights

95%

95% of clients who screened positive on the Comprehensive Assessment **received an intervention to reduce risk for falls and injuries** (target: 80%).

- Supports health care providers by being the “eyes and ears” in the home and community. OAHR expands the reach of providers so that they have a fuller picture of the home environment, adequacy of support/caregiving systems, cognitive capacity, functional limitations, and more.
- Helps clients who have terminal or end-stage conditions to have a dignified death. PHNs assist clients with end-of-life decision-making, advocate with health care providers to address goals of care and support clients’ treatment choices, and help clients connect with family members before death.

Services are provided in English, Spanish, Farsi, Tagalog, Punjabi, Mandarin, Cantonese, and Mien.

Measure A Funding Summary

ACPHN used its Measure A allocation to achieve the following:






- Refer 70 clients to and enroll 44 clients in OAHR
- Complete 646 face-to-face home- and community-based nurse case management encounters with vulnerable older adults
- Develop 221 ICPs based on ACPHN’s Comprehensive Assessment that prioritize the client’s safety, values, and hierarchy of needs
- Help ensure that 181 ICP goals were met or partially met (target: 177)
- Develop 46 QOL goals to help positively impact clients’ quality of life
- Help ensure that 41 QOL goals were met or partially met (target: 37)
- Partially complete the OAHR Case Management Manual, a comprehensive guide with program protocols for nursing care of vulnerable older adults in a home visit setting
- Provide education and advocacy regarding the needs of the older adult population in Alameda County, specifically the rising rate of older adult poverty and effects on morbidity
- Participate in countywide planning efforts for building a dementia-capable system of care
- Perform 30 community outreach activities
- Provide consultation and support for 33 community members and health care/social services providers
- Create 50 ICPs based on home-based multi-domain Comprehensive Assessments (target: 50)
- Approve 39 ICPs within two weeks of the Comprehensive Assessment (target: 50)
- Screen 43 clients for fall risk on the Comprehensive Assessment
- Provide an intervention to reduce risk for falls and injuries for 41 clients who screened positive on the Comprehensive Assessment

Success Story

C is a 63-year-old African-American male with chronic pain, anxiety, COPD, and opioid-induced constipation. His OAHR Comprehensive Assessment revealed that C was at high risk for opioid overdose and death. Over the next nine months, C was tapered off all narcotic analgesics but continued to seek pain control. He denied any behavioral health concerns despite fluctuating mood, anxiety, distractibility, agitation, and insomnia. C needed long-term support to manage his medications and attend medical appointments. Over the course of one year and 37 home visits, the PHN supported C as he tapered off all opioid medications. C’s risk for opioid-related morbidity and mortality decreased.

Countywide Plan for Seniors: Injury Prevention, Meals, Nutrition

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

-  **FY 18/19 Allocation: \$809,125 | Expended/Encumbered: \$809,125**
-  **Individuals served by Measure A:** 9,486 (Total individuals served: 9,486)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Seniors
-  **Services provided:** Public Health
-  **Service area:** Countywide

Background

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

AAA's programs funded by Measure A include the Senior Injury Prevention Program (SIPP), Meals on Wheels, the Mercy Brown Bag Nutrition Program, and the SNAP-Ed Community Gardens Program.

SIPP includes the following components:

- Enhance Fitness. This program is designed to improve the overall functional fitness and well-being of older adults.
- Geri-Fit®. This is a progressive resistance strength program designed to increase strength, flexibility, range of motion, mobility, gait, and balance in older adults.
- Home Meds. This medication management program is designed to address medication-related problems and errors that endanger the lives and well-being of community-dwelling elders. A contact includes individualized in-home screening, an assessment and alert process to identify medication problems, and computerized screening and pharmacist review based on protocols to help prevent falls, dizziness, confusion, and other medication-related problems for elders living at home.
- Lifestyle-integrated Functional Exercise (LiFE). This physical activity program is designed to improve the overall functional fitness and well-being of older adults.
- A Matter of Balance. This physical activity program is designed to reduce fall risk, reduce fear of falling, improve falls self-management and self-efficacy, and promote physical activity. Activities include



Matching Funds

\$83,528

from federal **Supplemental Nutrition Assistance Program Education (SNAP-Ed)** dollars to support additional community gardens at low income senior housing.

group discussion, problem-solving, skill building, assertiveness training, videos, sharing practical solutions, and exercise training.

- Minor home modifications. SIPP provides residential modifications of homes that are necessary to facilitate the ability of older individuals to remain at home and that are not available under other programs.
- Tai Chi: Moving for Better Balance. This physical activity program is designed to improve balance, strength, and physical performance for older adults to reduce fall frequency.

Meals on Wheels is a home-delivered meals program designed to provide meals for older adult consumers while eliminating or minimizing the wait list. The Mercy Brown Bag Nutrition Program regularly provides bags of food to older adult citizens living on limited incomes. The SNAP-Ed Community Gardens Program works to build out community gardens and provide nutrition education at senior housing sites.

Measure A Funding Summary

AAA used its Measure A allocation to achieve the following:

- Provide the following:
 - 12,655 Enhance Fitness classes to 226 unduplicated consumers (target: 10,747 classes to 226 consumers)
 - 1,599 Geri-Fit classes to 517 unduplicated consumers (target: 1,053 classes to 517 consumers)
 - Home Meds management to 699 unduplicated consumers (target: 502)
 - LiFE sessions to 101 unduplicated consumers (target: 90)
 - 357 Matter of Balance classes to 82 unduplicated consumers (target: 352 classes to 82 consumers)
 - Minor home modifications to 254 unduplicated consumers (target: 163)
 - 3,449 Tai Chi: Moving for Better Balance classes to 506 unduplicated consumers (target: 5,165 classes to 506 consumers)
- Deliver 64,446 meals to 348 unduplicated consumers, with zero consumers on the waiting list for meals (target: 59,125 meals to 216 consumers, with zero on the waiting list)
- Provide 6,560 grocery bags to 535 unduplicated consumers, of whom 79 were homebound (target: 5,000 bags to 500 consumers, of whom 75 are homebound)
- Create six community gardens in low income older adult housing in Alameda County (target: two)

Success Story

SIPP

Client M recently underwent a left hip replacement surgery, resulting in loss of lower body strength, balance, and overall functionality. Prior to the surgery M was highly independent and active, but this soon changed after being discharged from the hospital. Concerned about his balance and further lower body strength deterioration, M began attending the LiFE program. Within a few weeks, M had an increase in stamina and improved body mechanics. He felt an increase in independence and confidence and a decrease in fear of falling. These changes motivated M to enroll in a local gym for additional exercise.

- \$** **FY 18/19 Allocation: \$15,000*** | **Expended/Encumbered: \$15,000**
- 👤** **Individuals served by Measure A:** 135 (Total individuals served: 788)
- 👥** **Populations served:** Low Income, Uninsured Adults, Children, Families
- +** **Services provided:** Public Health, Mental Health, Substance Abuse (referrals)
- 📍** **Service area:** Ashland, Cherryland, Fremont, Hayward, Newark, Oakland, San Leandro, San Lorenzo, Union City

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

Background

Eden Youth and Family Center (EYFC) provides and supports a comprehensive array of services and advocacy for children, youth, and families in South Hayward and surrounding communities. They accomplish their mission through numerous programs focused on safety, education, and advocacy.

EYFC programs include the following:

- New Start Tattoo Removal helps young people remove the stigmatized markings of their past and increases their likelihood of success in the future. Through mentorship and case management, the New Start Tattoo Removal team works with participants to assist in rebuilding their self-esteem and their lives. Participants are required to make community reparations for past activities by completing 50 hours of community service during the time they are in the program. Participants are also required to be employed, seeking employment, or enrolled in school and/or vocational training.
- Wraparound case management services are offered to all EYFC program participants. Through group workshops and one-on-one sessions, participants learn soft skills including communication and listening skills, anger management skills, and empathy for others.
- The Hayward Coalition for Healthy Youth aims to strengthen collaboration among Hayward's residents, nonprofit and government agencies, schools, and law enforcement to prevent and reduce substance abuse.
- The Youth Advisory Council (YAC) empowers youth to become leaders and resources for the community. YAC members develop skills in public speaking, project management, research, and social media advocacy campaigns. YAC members attend weekly youth council meetings to plan and implement youth service projects. They also prepare presentations for city and County policy makers, community-



\$ Matching Funds

\$14,783

from **Hayward Promise**
Neighborhood Case Management.

based organizations, and youth-serving groups and engage in legislative efforts advocating for policies that positively impact youth.

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

Services are provided in English and Spanish.

Measure A Funding Summary

EYFC used its Measure A allocation to achieve the following:

- Provide 53 at-risk youth with case management to improve their overall health and well-being (target: 25)
- Make five referrals for behavioral health services for crisis intervention
- Provide 57 youth with individual or group life skills training that covered health, wellness, drug prevention, and nutrition information, as well as tutoring, mentoring support, and one-on-one peer-to-peer coaching (target: 25)
- Coordinate YAC to provide leadership development, training, and awareness campaigns focusing on tobacco, marijuana, and opioid use for 25 youth participants (target: 10)
- Through YAC, organize and host the third annual Reach for a Better Community Wellness event, attended by over 150 youth and families, to build awareness of healthy alternatives to alcohol, tobacco, and other drugs by encouraging positive coping mechanisms and improving wellness
- Through YAC, work with the Hayward Unified School District on a proposal to implement a morning nutrition break at Mt. Eden High School






Success Story

Youth member RI recently made the decision to transition from male to female. Although his mother was supportive, his aunt and younger brother would discourage and insult him. RI also wanted to change how he looked through healthy diet and exercise. EYFC staff spoke with RI about developing boundaries and valuing his own needs. The youth group offered emotional support and discussed healthy food options in the area and favorite ways to exercise. Eventually, RI's situation with his family began to improve. EYFC's support made it easier for RI to maintain his confidence and self-esteem. RI also began buying healthier foods and working out or walking every day.



Emergency Medical Services (EMS) Corps

ems.acgov.org

-  **FY 18/19 Allocation: \$85,000 | Expended/Encumbered: \$85,000**
-  **Individuals served by Measure A:** 914 (Total individuals served: 914)
-  **Populations served:** Low Income Adults, Children
-  **Services provided:** Public Health
-  **Service area:** Countywide

Background

The Emergency Medical Services (EMS) Corps works to provide an ethnically diverse group of Alameda County youth with a supportive network of academic, social, and professional development to build a successful career in all areas of the health industry.

Through a grant from Atlantic Philanthropies, the Oakland Unified School District (OUSD), Alameda County Health Care Services Agency (HCSA), and Alameda Health System (AHS) formed the Oakland Health Pathways Partnership (HPP) to strengthen OUSD health pathways and increase the number and quality of health care internships and other work-based learning experiences for OUSD students. Upon the completion of the award, leadership and staff of many departments within HCSA came together as the Healthcare Agency Pathway Partnership for Youth (HAPPY) Committee. The Committee's top priority was to expose ethnically diverse youth to career opportunities within HCSA and its partners through the HCSA Summer Internship, a paid, five-week, project-based work experience. The HCSA Summer Internship provides youth participants exposure to non-clinical health careers and public service; delivers knowledge of social determinants of health to build awareness of health disparities; provides quality mentorships with and access to professionals in health careers; conducts trainings on civic engagement, job search, CPR and triage, mental health, and first aid; and supports the growth and development of leadership and professional skills.

Interns experience improved academic lives. As students are involved in health pathways at their schools, this experience provides them with the experience needed to do well in their classes. Students in the 12th grade use the intern experience as the capstone project needed to obtain their high school diploma. The program has a 100% high school graduation rate.

Services are provided in English and Spanish.

Highlights

90%

90% of HPP participants were **involved in the joint workforce development projects/activities** (target: 50%).

Matching Funds

\$30,000

from **Kaiser**.

Measure A Funding Summary

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

- Implement five joint workforce development projects and activities coordinated by 75 partners to serve youth and young adults (target: five projects/activities coordinated by 40 partners)
- Provide workforce development activities involving 14 local school districts and colleges/universities attended by 211 youth and young adults (target: 12 school districts/colleges/universities and 200 youth/young adults)
- Provide one workforce development opportunity for at-risk youth ages 13–28 for EMS Corps (target: one)
- Share five communications to support the recruitment and retention of boys and men of color for EMS Corps and other related youth programs (target: five)
- Hold five meetings with African-American Male Achievement (AAMA), Hidden Genius, and other affinity groups and community-based organizations (target: three)
- Host HPP meetings and events for 10 participants (target: eight)
- Through 15 HPP programs, serve 914 youth and young adults (target: 1,000)
- Host the first Allied Health Expo for high school students and adults, where 165 participants including 30 adults interviewed for employment at AHS, LifeLong Medical, La Clinica, and Senior Helpers

Success Story

Upon entering the HPP program, Kyle shared his passion to pursue a career in mental health. He was also interested in learning about County careers. The HPP team matched him with Tiffany Lynch, a Behavioral Health Care Services staff member. Tiffany provided Kyle mentorship and work experience that allowed him to feel part of the team. After the completion of the internship, HPP staff supported Kyle in the college application and scholarship process. In Fall 2019, Kyle became a pre-Public Health major at UC Berkeley, having received a full-tuition scholarship from the Cal Alumni Association. The following summer, Kyle assisted the HPP team as an HCSA college intern.



Emergency Preparedness, Mitigation, Response, & Recovery

acphd.org/phep.aspx

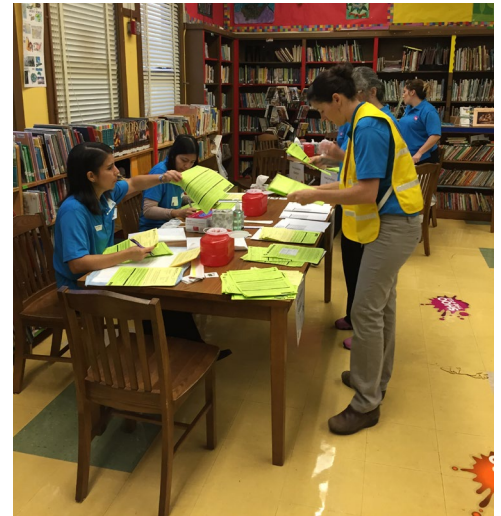
- \$** **FY 18/19 Allocation: \$250,000 | Expended/Encumbered: \$ 112,466**
- 👤** **Individuals served by Measure A:** 250 (Total individuals served: 250)
- 👥** **Populations served:** Adults, Seniors
- +** **Services provided:** Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health
- 📍** **Service area:** Countywide

Background

The Alameda County Public Health Department Public Health Emergency Preparedness program works to build resilient communities in partnership through education, preparedness, response, and recovery from public health emergencies, including infectious disease outbreaks, natural disasters, and terrorism.

Incident Command System (ICS) trainings teach public employees their roles and responsibilities during a disaster and how to work effectively under a disaster response framework and foster a culture of preparedness and response beyond the agency. The program has trained over 600 staff, who are now capable of effectively operating during an actual event. These staff also influence their own programs and departments and their community to be more disaster-resilient.

AC Alert, Alameda County’s 24/7 notification system, communicates critical information quickly to residents across the County about serious events such as earthquakes, fires, severe weather, unexpected road closures, missing persons, and evacuations of buildings and neighborhoods. The alerts reach over 1,192 internal contacts, representing local, state, and regional planning and response partners, as well as over 30,000 external contacts that have opted to receive AC Alert messages. The Alameda County Health Care Services Agency (HCSA) reaches out and encourages the community’s most vulnerable populations and their providers, such as the unsheltered, schools, the medically fragile, seniors, and individuals with limited access and functional needs, to be added to AC Alert. Recent events that have shown the importance of AC Alert and affect multiple areas across the County include power shutoffs, extreme heat waves, and poor air quality due to wildfire smoke.



Highlights

100%

100% of HCSA Group Managers passed the Group Manager exam in AC Alert (target: 90%).

Measure A Funding Summary

The Alameda County Public Health Emergency Preparedness program used its Measure A allocation to achieve the following:

- Provide six ICS training classes to 225 participants (target: seven classes to 280 participants)
- Expand ICS trainings to HCSA departments such as Behavioral Health Care Services, Environmental Health, and the Office of the Director
- Conduct four ICS functional exercise sessions to 61 participants (target: four sessions to 80 participants)
- Conduct two enrollment periods for 904 HCSA staff to register on AC Alert (target: two enrollment periods for 1,400 staff)
- Certify eight HCSA staff as Group Managers to perform critical functions in AC Alert (target: 12)
- Fund personnel to enroll staff and develop and train administrators to support and sustain critical functions in AC Alert for the broader community

Highlights

97%

97% of ICS training participants indicated that the training **fulfilled or exceeded their expectations** (target: 90%).



George Mark Children's House

George Mark Children's House
georgemark.org

THE CENTER OF EXCELLENCE IN PEDIATRIC PALLIATIVE CARE

- \$ Allocation: \$50,000*** | **Expended/Encumbered: \$ 50,000**
- Individuals served by Measure A:** 7 (Total individuals served: 85)
- Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families
- Services provided:** Public Health
- Service area:** Castro Valley, Hayward, Oakland

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

Background

George Mark Children's House (GMCH) offers comprehensive, compassionate, life-affirming care to children facing a life-limiting diagnosis. GMCH aims to provide the highest quality of care and to minimize discomfort by addressing the physical, emotional, spiritual, and psychosocial needs of the entire family.

GMCH's respite care program serves children who have medical conditions that make survival to adulthood unlikely. Young adults up to age 25 are also considered on a case-by-case basis. Patients have a range of complex health issues, including cancer that is unresponsive to treatment, brain injury, genetic diseases with relentless deterioration with age, and birth anomalies incompatible with life. The majority of these children also have developmental delays.

These children often live isolated lives, with few chances to socialize, experience pleasurable interactions with people outside of family members, meet pets, or engage in other playful child-like fun. Children also typically live with some degree of physical discomfort, such as respiratory problems, stiff and painful muscles, reoccurring infections, and seizures.

Through the GMCH respite program, with its qualified staff and trained volunteers, children are provided what one parent describes as a "magical" stay, including gentle, supportive activities. GMCH nurses and physicians can observe the children and offer guidance to parents about how to alter their daily protocols to enhance their child's wellness. For these parents and guardians, a temporary break is enhanced by their knowledge that their child is in medically safe hands. These families do not have in-home health care providers or access to caregivers they can trust to care for their child so that they can attend siblings'



\$ Matching Funds

\$45,000

from the **Santa Clara County Board of Supervisors**.

school or extracurricular activities or engage in even the most basic self-care activities such as getting sufficient sleep or attending medical appointments.

Staff includes a licensed medical interpreter and Certified Nursing Assistant who is bicultural and bilingual in English and Spanish. Translation in languages other than Spanish is provided through a third-party service when needed.

Measure A Funding Summary

GMCH used its Measure A allocation to provide 38 days of respite care, representing 10 admissions, to 39 low income pediatric patients and their families in Alameda County (target: 49 days, 15 admissions, and 45 family members).

Note that the actual numbers reflect the first six months of the contract period, while the target numbers reflect the full-year contract period.

Success Story

Diagnosed with congenital quadriplegia, severe cognitive delays, and uncontrolled epilepsy at birth, Jacob has been coming to GMCH for respite care since he was 10 years old. Now 16, Jacob enjoys visits to GMCH and the attention he receives from staff and volunteers who talk and sing to him, hold his hand, and involve him in activities. Equally important, his mother Anna can rely on the respite care to care for herself and her family—which includes Jacob's three siblings, one of whom is also developmentally disabled. Further helping the family, the GMCH social worker located a donor who provided Jacob's family a van equipped for a wheelchair.



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

www.casasegura.org

- \$** **FY 18/19 Allocation: \$160,684 | Expended/Encumbered: \$160,684**
- 👤** **Individuals served by Measure A:** 741 (Total individuals served: 2,829)
- 👥** **Populations served:** Indigent, Low Income, Uninsured Adults, Seniors, Other Residents
- +** **Services provided:** Emergency Medical, Hospital Outpatient, Public Health, Substance Abuse
- 📍** **Service area:** Berkeley, Emeryville, Oakland

Background

The HIV Education and Prevention Project of Alameda County (HEPPAC) works to stop the further spread of preventable diseases among people who use drugs in the community. HEPPAC is the longest-running harm-reduction-based program in Oakland serving persons who inject drugs (PWID) and addressing their increased risk for HIV, hepatitis, and overdose death.

HEPPAC's fixed syringe exchange sites act as a point of access for risk-reducing supplies and medical treatment for PWID. HEPPAC continues to collaborate with two major street-based health clinics, with coordinated services present at all three fixed sites throughout Oakland. Roots Community Clinic attends HEPPAC's Fruitvale and Deep East Oakland sites, while Trust Clinic attends the West Oakland site. This increases access to needed harm-reduction services, supplies, and medical care to populations of PWID and other drug users that traditionally don't access a medical home. This also leads to a reduction in clients accessing County emergency departments due to the availability of medical care at fixed sites.

HEPPAC's fixed and mobile integrated services span North, West, Central East, and Deep East Oakland. This reach increases homeless individuals' access to hygiene equity, harm-reduction supplies, sterile syringes, biohazard containers, medical attention, and education that supports them staying healthy, alive, and able to thrive so they can make healthier choices in efforts to display impactful change in their lives.

HEPPAC's basic needs services, including food, clothing, and hygiene kits, are impactful in the ever-growing population of homeless and unhoused individuals and groups in Oakland and the larger Bay Area.

Highlights

96%

96% of syringe access participants **decreased their needle-sharing practices** (target: 50%).

HEPPAC enhances its harm-reduction efforts by educating residents on how to properly dispose of used/littered syringes and increasing the distribution of biohazard containers at encampments, local businesses, and community programs. This equates to fewer littered syringes in public areas. HEPPAC continues to collect used/littered syringes in the Oakland community during syringe access services.

The Oakland drug-using community is assuming Fentanyl is present in all drugs. Some have mastered safe usage to decrease overdose risk, which is causing a trend in users seeking Fentanyl-laced drugs due to the more intense and sometimes longer effects. HEPPAC distributes Fentanyl test strips to participants who use drugs and has added the proper use of Fentanyl test strips, as well as methods to decrease overdose risk due to Fentanyl, as an education category.

Measure A Funding Summary

HEPPAC used its Measure A allocation to achieve the following:

- Provide 28 hours per week of syringe access services in Oakland (target: 30)
- Exchange 75,338 sterile syringes and 185,061 used/littered syringes (target: 50,000 and 100,000)
- Treat 204 PWID for soft tissue infection (target: 150)
- Refer 161 PWID to the onsite medical team (target: 150)
- Provide herbal/acupuncture services to 2,139 PWID (target: 2,000)

Success Story

Lisa, a 47-year-old African American female, moved in with a man twice her age who started her on injecting heroin and later became her pimp. She became a sex worker at age 18, sold drugs, and began recycling to financially support herself and her partner. After her partner died, Lisa stayed with a female friend who lived in an RV. HEPPAC provided mobile services at the RV encampment, where Lisa accessed harm-reduction supplies and HIV/HCV testing. Lisa tested positive for HCV and received harm-reduction supplies, Medication-Assisted Treatment (MAT) services, and HCV treatment. She cleared her HCV, continues to utilize MAT, and is now a syringe exchanger for her encampment.



Healthy Food Healthy Families: Alameda County Community Food Bank

accfb.org

- Allocation: \$15,000*** | **Expended/Encumbered: \$15,000**
- Individuals served by Measure A:** 9,590 (Total individuals served: 332,600)
- Populations served:** Low Income, Uninsured Adults, Children, Families, Seniors
- Services provided:** Public Health
- Service area:** Ashland, Cherryland

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

Background

Alameda County Community Food Bank works to create a hunger-free community by improving food security and, by extension, community health outcomes. The Food Bank participates in meetings with ALL IN Alameda County, a countywide effort focused on addressing the issues of poverty through collaboration and innovation, and helped to organize the countywide Healthcare Convening. The Food Bank continues to test models of collaboration with health systems that are efficient for each partner and can help clients/patients and their families access a healthy diet to support prevention and management of diet-sensitive chronic illness.

Volunteers and clinic-based staff communicate with clients in English and Spanish.



Measure A Funding Summary

The Food Bank used its Measure A allocation to achieve the following:

- Supply 43,467 pounds of food for 28,978 meals to patients/clients at Native American Health Center and La Clínica de la Raza (target: 21,428 meals)
- Serve 2,179 households representing 9,590 individuals with these meals, of whom 47% were adults, 46.5% children, and 6.5% seniors

Highlights






135%

The **total number of meals served** (28,978) exceeded the target (21,428) by 135%.



Healthy Food Healthy Families: Alameda County Deputy Sheriffs' Activities League

acdsal.org

-  **Allocation: \$50,000*** | **Expended/Encumbered: \$50,000**
-  **Individuals served by Measure A:** 526 (Total individuals served: 2,045)
-  **Populations served:** Low Income Adults, Children, Families, Seniors
-  **Services provided:** Public Health
-  **Service area:** Countywide

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

Background

The Alameda County Deputy Sheriffs' Activities League (DSAL) implements the Community Capitals Policing model, which builds on existing community capitals (natural, human, social, economic, built, political, and cultural) to create safer, healthier, more vibrant communities with authentic opportunities for all.

Over 12% of Alameda County's population is food insecure, and over 39% of this population earns too much to qualify for government benefits such as CalFresh. To help counter this reality, DSAL works with ALL IN Alameda County, a countywide effort focused on addressing the issues of poverty through collaboration and innovation.

In FY 18/19, construction was completed on the Dig Deep Farms Food Hub, a certified community commercial kitchen and distribution center. As the home base for DSAL's Food as Medicine and Food Recovery programs, the Food Hub is where fresh produce is aggregated, processed, and then distributed to farm stands, Food as Medicine Pharmacies, and low income housing residents.

DSAL provides services in English and Spanish.

Measure A Funding Summary

DSAL used its Measure A allocation to achieve the following:

- Make 8,873 pounds of nutritious food available at no cost to lower income residents, approximately 17 pounds per person
- Complete construction of the Food Hub
- Recruit three staff members to begin operations at the Food Hub (target: three)








Matching Funds

\$2,138,20

from the following sources:

- **Community Development Block Grants**
- **Community Vision**
- **Aramark**
- **CalRecycle**

-  **Allocation: \$20,000*** | **Expended/Encumbered: \$15,911**
-  **Individuals served by Measure A:** 170 (Total individuals served: 230)
-  **Populations served:** Low Income Adults, Children, Families
-  **Services provided:** Public Health
-  **Service area:** Oakland

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

Background

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

Through the Food as Medicine program, BCHO surveyed 180 caregivers of children ages 9–11 years who were attending La Clinica for a physical or follow-up visit. Sixty-three respondents, or 35%, screened positive for food insecurity. Thirty of those families were enrolled in the program to receive deliveries of fresh vegetables and whole grains. All enrolled families received a booklet of community food resources to help ensure continued greater food security. For example, participants learned that they could access food from locations in Alameda County through the Alameda County Community Food Bank Emergency Hotline anonymously without needing to give any identifying information.

Measure A Funding Summary

Through the Food as Medicine program, BCHO used its Measure A allocation to achieve the following:

- Supply 394 community-supported agriculture (CSA) vegetable deliveries to 30 food-insecure families weekly for three months (target: 50 families)
- Provide weekly delivery of whole grains to 30 food-insecure families program for three months (target: 25 families)
- Ensure that the grain deliveries included 10 different whole grain products to help increase exposure (target: five)

Success Story

When Monica's husband left the family, the household lost their only source of income, and their level of food insecurity was very severe. The Food as Medicine program delivered foods like kale, quinoa, and brown rice that were new to Monica's family but that they liked and continued to buy on their own. Monica's dedication to feed her family led her to experiment with foods she had never seen before. When the family received information about food resources such as WIC, CalFresh, and food banks, Monica immediately started making phone calls. She was able to re-establish her CalFresh benefits and get food from the food bank.



Healthy Homes Department Fixing to Stay & Group Living Facilities Project

www.achhd.org



FY 18/19 Allocation: \$208,000 | Expended/Encumbered: \$208,000



Individuals served by Measure A: 96 (Total individuals served: 235)



Populations served: Low Income, Uninsured Adults, Seniors



Services provided: Public Health



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

Background

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

The Healthy Homes Department Fixing to Stay program provides interventions to help older adult clients stay in their homes as long as possible in housing conditions that contribute to their well-being. The interventions include essential items such as grab bars, functioning water heaters, and electrical work, as well as minor repairs such as fixing a lock on a back door or replacing a broken ceiling fan. This work enables clients to enjoy their homes safely.

Independent living homes are group living housing environments for disenfranchised residents who face multiple obstacles including being formerly incarcerated, elderly, or mentally ill or having other disabilities. While many are formerly homeless and unsheltered, the Department's interventions ensure that these residents have good quality affordable housing. Bringing these homes into compliance provides residents a healthy housing environment that is advantageous to their recovery and quality of life.

Measure A Funding Summary

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

- Conduct outreach to 114 older adults and their families (target: 99)
- Complete 105 health and risk assessments for older adults (target: 75)
- Add 40 homes to the list of independent living homes

BEFORE



AFTER



Matching Funds

\$317,866

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

- Share an updated list of independent living homes in Alameda County with key partners three times (target: four)
- Track a city and map report to demonstrate trends and report it to key partners three times (target: four)
- Conduct 60 site visits and related technical support activities (target: 60)
- Respond to 10 complaints/grievances related to independent living homes, of which 70% were resolved (target: four)

Highlights






88%

88% of older adults were **linked with health, housing, or human services** as a result of outreach efforts (target: 75%).



HERS Breast Cancer Foundation

hersbreastcancerfoundation.org

-  **Allocation: \$10,000*** | **Expended/Encumbered: \$10,000**
-  **Individuals served by Measure A:** 79 (Total individuals served: 219)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Seniors
-  **Services provided:** Public Health
-  **Service area:** Countywide

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

Background

The HERS Breast Cancer Foundation supports all individuals healing from breast cancer by providing post-surgical consultation, fitting services, and products regardless of financial status.

HERS is unique in the Bay Area in that it does not turn away patients who lack insurance, whose insurance doesn't cover the services and products they need, and/or who self-identify as being low income. Through the WE Support, YOU Survive program, these individuals receive consultation and fitting services that they would otherwise go without, as well as post-surgical products that help their physical and emotional healing process.

In FY 18/19, HERS opened a third Program Store location in San Leandro, joining the existing stores in Pleasanton and Fremont. The location makes services more accessible to residents of communities in the immediate area such as Hayward, San Lorenzo, and Oakland.

Staff members speak English, Spanish, Malay, Mandarin, Portuguese, Tagalog, Italian, Cantonese, and Hindi.

Measure A Funding Summary

HERS Breast Cancer Foundation used its Measure A allocation to provide 79 patients with prosthetic and other post-surgical fitting services via the WE Support, YOU Survive assistance program (target: 63).



Highlights

100%

100% of breast cancer survivors served indicated that their **appointment experience was very good to excellent** (target: 100%).



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

www.casasegura.org

- \$** **FY 18/19 Allocation: \$150,000 | Expended/Encumbered: \$150,000**
- 👤** **Individuals served by Measure A:** 733 (Total individuals served: 1,948)
- 👥** **Populations served:** Indigent, Low Income, Uninsured Adults, Seniors, Undocumented Immigrants
- +** **Services provided:** Emergency Medical, Hospital Outpatient, Public Health, Substance Abuse
- 📍** **Service area:** Oakland

Background

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

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

Injection-related abscess and general wound care services are offered during fixed exchange sites. These services include safer injection practices, vein care and rotation education, lancing, incision and drainage (IND) packing, and cleaning wounds. Some antibiotic medication dispensary services are available. In addition, HEPPAC provides herbal and acupuncture services for stress management, pain management, skin infections, and detoxification.

HEPPAC links active opioid users to Medication-Assisted Treatment (MAT) services. Utilization of MAT can result in active users prioritizing their physical and mental health needs, which helps increase protective behaviors and decrease HIV and HCV risk, overdose death, and substance use.

Measure A Funding Summary

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

Highlights

98%

98% of workshop participants reported **increased knowledge of at least one protective behavior** such as safer injection practices or HIV/HCV and overdose prevention.






- Exchange 1,086,550 sterile syringes (target: 50,000)
- Provide an average of 25 weekly hours of syringe exchange services in Oakland (target: 25)
- Exchange 31,890 used or littered syringes (target: 100,000)
- Provide medical treatment to address soft tissue infections to 305 people who inject drugs (target: 150)
- Refer 78 people who inject drugs to HEPPAC's onsite medical team at the Roots Clinic (target: 150)
- Facilitate unstructured workshops to 305 syringe exchange and clinic visitors (target: 300)
- Administer pre- and post-tests to 311 syringe exchange and clinic participants to measure their knowledge of identifying at least one risk-reduction practice
- Offer counseling and testing services, including 229 HIV and 166 HCV antibody screenings, to workshop participants
- Link 38 participants to MAT programs
- Provide herbal/acupuncture services to 1,304 syringe exchange participants

Success Story

An active opioid injector, Patricia was diagnosed with HCV a few years ago but never treated for it. When she and her partner came to HEPPAC's syringe exchange program, they were given harm-reduction supplies, food, and screening services—including HCV testing for her partner—as well as referrals to other fixed sites. Patricia received abscess wound care, and both she and her partner started treatment for HCV. Patricia and her partner continue to access harm-reduction supplies, food, and resources and engage with their peers. They have informed their social network about how HEPPAC assisted them and have referred others to HEPPAC's services.

Home Visiting Services

www.acphd.org/mpcah.aspx

-  **FY 18/19 Allocation: \$2,950,000 | Expended/Encumbered: \$1,350,000**
-  **Individuals served by Measure A:** 969 (Total individuals served: 1,844)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families
-  **Services provided:** Public Health, Mental Health
-  **Service area:** Countywide, Homeless or Transient

Background

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

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

The MPCAH Early Childhood Home Visiting System of Care provides comprehensive home-based, family-centered, early intervention services to high risk families with children ages 0–5 years. Some of these families include medically fragile infants, and all face multiple challenges. For example, a growing number of families are being displaced due to gentrification and are now housing insecure or homeless. This system of care helps improve birth outcomes, eliminate health disparities, inspire families to succeed, and guide them along their desired path for health and wellness.

Family support service (FSS) providers spend time with families in their homes and in their communities. FSS providers are case managers, nurses, advocates, and allies to the families they serve. They often collaborate with other service providers, clinical and non-clinical. These collaborations across the Early Childhood Home Visiting System of Care include inter-and intra-agency referrals that ultimately help to reduce the barriers in accessing developmental, educational, medical, and mental health services, as well as other community resources.

Matching Funds

\$1,589,873

from **Targeted Case Management (TCM)** (Tiburcio Vasquez Health Center and UCSF Benioff Children's Hospital Oakland) and **Medi-Cal Administrative Activities (MAA)** (Brighter Beginnings).

The Early Childhood Home Visiting System of Care is composed of 12 programs, of which three were funded through Measure A:

- Brighter Beginnings focuses on serving North County’s parenting teens and young adult families with small children. Case managers encourage and support their clients to complete their education while providing parenting support through the Parents as Teachers (PAT) curriculum during individual visits and monthly groups. Parents as Teachers promotes the optimal early development, learning, and health of children by supporting and engaging their parents and caregivers.
- Tiburcio Vasquez Health Center (TVHC) provides services in the community and within a health clinic setting to pregnant and parenting teens and young adults in South County. Collaborations with TVHC clinic medical providers help address health-related concerns in a timely manner for pregnant and parenting caregivers and their children. Clients also have access to dental care providers and SSA eligibility workers for help with health insurance and other public benefit needs.
- UCSF Benioff Children’s Hospital Oakland’s Special Start program works with children who are medically fragile and at high risk for developmental delay. The program has the ability to link 100% of their clients with developmental screening and works to ensure that children who screen at risk for developmental concerns receive appropriate services. The program provides families with options to see a physical therapist and infant developmental specialists directly in the home as a stopgap measure when community partners are unable to provide services. Case managers recognize that parents are more at risk for post-partum depression given the traumatic experiences associated with neonatal intensive care unit (NICU) hospitalizations, and they emphasize the importance of assessing parents for depression and prioritizing mental health support for the families they serve. Their clients can access a mental health support team in the home if they are unable to reach services within the community.

Services are provided primarily in English and Spanish, but there are bicultural and bilingual staff also providing services in Cantonese. Additional languages are accessed through interpretation services.

Measure A Funding Summary

FHS/MPCAH used its Measure A allocation to achieve the following:

- Serve 969 patients, of whom 92% were screened for depression (target: 85%)
- Serve 527 children, of whom 95% received early developmental screening (target: 85%)
- Ensure that 104 children ages 6–11 months were breastfed or fed breast milk, of whom 37% were fed in this way for at least six months (target: 60%)

Success Story

Tiburcio Vasquez Health Center

A 16-year-old mother of a 42-month-old autistic son was depressed, had a learning disability, and needed financial assistance, food stamps, and medical insurance, as well as child development and parenting assistance. Her case manager supported her in getting accommodations at school as well as a referral for therapy. The case manager also administered a developmental screen on the son, which eventually led to a diagnosis of autism. The child was linked to speech and language therapy, as well as physical and occupational therapy. Because of the mom’s hard work, she was able to graduate high school. This family continues to be enrolled in the program, where they receive ongoing support.

- Of 546 parents eligible for a Reproductive Life Plan, ensure that 71% had a documented plan (target: 75%)
- Ensure that for 72% of children ages 0–6 months, their parent/ caregiver reported engaging in safe sleep behaviors (target: 80%)
- Refer 53% of parents who screened positive for parental depression to mental health supports or treatment, of whom 75% received services (target: 100% and 75%)
- Refer 68% of children who screened of concern to developmental services, of whom 75% received services (target: 100% and 85%)
- Ensure that 68% of women consistently used contraception/birth control if they did not want to get pregnant in the next year (target: 75%)

Success Story

UCSF Benioff Children's Hospital Oakland Special Start Program

A child who was receiving case management services had been born at 27 weeks; weighed 1,020 grams; had Bronchopulmonary Dysplasia (BPD); was gastrostomy tube-fed; and had hypertonia. On one home visit, the case manager noted that the child had lost weight and was breathing abnormally. The parents reported that the child had a pediatric appointment in three days. The case manager contacted the pediatrician right away and arranged for transportation to an immediate appointment. The child was directly admitted back to the NICU that day. If the case manager had not intervened at that moment, the child might have continued to deteriorate, resulting in a life-threatening emergency.



La Familia Counseling Services: Youth Resiliency

Ahealthyschools.org

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

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

Populations served: Low Income, Uninsured Children, Families

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Livermore, Union City

Background

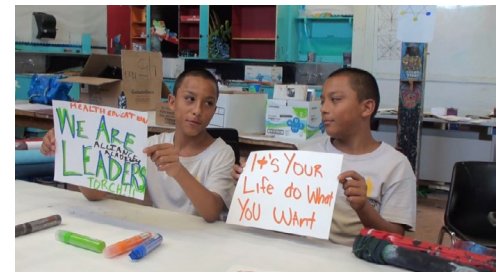
The Center for Healthy Schools and Communities (CHSC) works to foster the academic success, health, and well-being of Alameda County youth by building universal access to high quality supports and opportunities in schools and neighborhoods.

The Youth Resiliency Program offered through La Familia Counseling Services is based on evidence that a critical link exists between children's healthy development and educational attainment, ultimately impacting long-term health outcomes. Youth who are surrounded by supports and opportunities such as those provided by this program strengthen their protective factors, encounter less risk, and ultimately show evidence of higher rates of successful transitions into adulthood, including healthier behaviors and increased success in school and employment, which leads to improved health outcomes throughout life.

Youth in the program benefit from being in a gender-specific environment within their school setting that supports their development, self-esteem, social skills, and healthy decision-making. Program mentors not only provide individual and group support to the youth, but connect with the school staff to improve the students' connection to school and caring adults and their ability to develop and excel in their classes.

La Familia also offers expanded health and wellness resources at their Fuller Family Resource Center in Hayward, including health care and benefits eligibility and enrollment, chronic disease education, nutrition and fitness classes, immigration supports, and the Cultura y Bienestar program.

La Familia staff are bilingual in Spanish and English.



Matching Funds

\$77,240

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

Measure A Funding Summary

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

- Hire and train two qualified, bilingual mentors
- Enroll 23 girls and 27 boys in the gender-based mentoring program (target: 20–25 participants each)
- Engage these 50 youth in the mentoring group, covering topics such as mental health, substance abuse, sexually transmitted infections, birth control, college and career, communication, and suicide prevention (target: 40–50)
- Offer individual mentoring to these 50 youth (target: 40–50)
- Provide case management to 35 youth (target: 20–25)
- Provide crisis intervention support (suicide assessment and suspected abuse) to two youth
- Assess all participants for health insurance status
- Refer one student and their family for health insurance and benefits application assistance

Success Story

Lilian was referred to the program in part because she told a staff that she was having out-of-body experiences. The mentor enrolled Lilian in the group and began case management, including connecting her to a doctor for evaluation. Lilian had some tests done that came back abnormal. She had health insurance, but the coverage was not sufficient to cover the costs of her appointments and tests. The mentor connected Lilian to the Kaiser Medical Financial Assistance program to help cover the costs for the family so that Lilian could get the appropriate health care she needed.



Latino Men and Boys Program

unitycouncil.org/program/youth-achievement-programs/

- \$ Allocation: \$200,000 | Expended/Encumbered: \$200,000**
- 👤 Individuals served by Measure A: 217** (Total individuals served: 217)
- 👥 Populations served:** Indigent, Low Income, Uninsured Children, Families
- ✚ Services provided:** Public Health, Mental Health
- 📍 Service area:** Oakland, Homeless or Transient

Background

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

The Unity Council Latino Men and Boys (LMB) program helps retain students who would otherwise disengage from formal schooling. The service extends beyond the students who formally enroll in the LMB course to reach the most vulnerable populations of Latino and immigrant youth at participating school sites. Care coordination services include facilitation of and/or participation in Coordination of Services Teams (COST) meetings.

During FY 18/19, at Castlemont and Oakland High Schools, The Unity Council provided a week-long job readiness training for 30 young adults. The youth engaged in workshops that covered a range of topics that included Know Your Rights training, legal and health services, and protective factors for youth working in high risk, low wage sectors such as construction and food service.

Services are offered in English and Spanish. When possible, translation is offered in Mam.



Matching Funds

\$405,000

from **The California Endowment, Kaiser, and the Obama Foundation.**

Measure A Funding Summary

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

- Conduct meetings and planning sessions with school and school health center (SHC) staff to recruit and coordinate care for 60 participants
- Deliver the Joven Noble beginning and advanced curriculum of health presentations to 217 participants

- Provide physical and behavioral health services at SHCs and federally qualified health centers (FQHCs) to 150 participants
- Provide three parent workshops facilitated by LMB mentors to 75 participants
- Engage SHC staff at nine school sites in COST meetings to build their capacity to engage Latino young men and boys in health care access and services
- Develop and produce one mentor best practice handbook, one program profile document for school-based leadership, and one Coro Fellow sustainability report to share with school health providers across Alameda County

Success Story

As a seventh grader, Emilio was referred to LMB because of truancy concerns, a low grade point average, negative self-esteem, and overall disruptive behavior. The program provided tutoring, hosted student-led conferences and parent meetings, supported Emilio with individualized mentoring, sat in classes that he struggled with, and held him accountable to his word. In eighth grade, Emilio began the first marking period with a 4.0 GPA and was able to maintain honor roll status throughout the semester. He has no referrals or suspensions and is proactive in assuming leadership roles on and off campus when presented with the opportunity. Emilio is a prime example of how this program supports young men in addressing barriers that limit their wellness as well as their educational and professional aspirations.



Lend A Hand Foundation

lendahandfoundation.org

- 💰 **Allocation: \$10,000*** | **Expended/Encumbered: \$10,000**
- 👤 **Individuals served by Measure A:** 760 (Total individuals served: 5,000)
- 👥 **Populations served:** Low Income Children
- ⊕ **Services provided:** Public Health
- 📍 **Service area:** Cherryland, Hayward, San Lorenzo

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

Background

The Lend A Hand Foundation works to enhance the quality of life of impoverished children, youth, and families by offering educational, cultural, and sporting activities, as well as supplies to meet basic needs. One of the foundation's key activities in FY 18/19 was the distribution of hygiene kits containing toothbrushes, toothpaste, dental floss, deodorant, wipes, and tissues to students at the Cherryland School October School Health Fair. Students also received age-appropriate written materials covering various health issues, as well as backpacks to hold all of their supplies. The backpacks also contained information for parents on child-related health issues.



Measure A Funding Summary

The Lend A Hand Foundation used its Measure A allocation to distribute hygiene kits and backpacks to 760 students (target: 760).

\$ FY 18/19 Allocation: \$15,000* | Expended/Encumbered: \$15,000

👤 Individuals served by Measure A: 23 (Total individuals served: 389)

👥 Populations served: Seniors

+ Services provided: Public Health

📍 Service area: Countywide

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

Background

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

LIFE ElderCare provides at-home fall prevention services to seniors who cannot use the fall prevention programs offered out in the community. This includes the many older adults who have chronic conditions, disabilities, insufficient support, and/or frailty that presents barriers to attending an outside program. This demographic, typically ages 70–90, is actually at highest risk for harmful falls. All of these clients have at least one limitation to their ability to manage the activities of daily living.

The program looks at the whole person based on the understanding that bad falls almost never happen due to a single factor. For example, because someone is depressed, they don't eat breakfast. Because of that, they forget to take a medication. And because of that, they feel dizzy and when they shower, they start to wobble and fall.

Program engagement last from three to seven weeks. During this time, the program does the following:

- Teaches exercise from the National Institutes of Health proven to reduce falls and injuries from falls. If clients need more, the kinesiologist works with them over four to five additional weeks to incorporate personalized strength and balance exercises into their daily routine using the Lifestyle Integrated Functional Exercise (LiFE) program.
- Conducts home safety assessments, starting with a collaborative walk-through with the client in their home. If minor modifications are needed, the program ensures that they are completed either at that time or soon after.
- Completes a full medication review. Medication-related problems endanger the lives of a high percentage of elders living at home,

Highlights

↑ 121%

The **number of older adults served by the program**, 389, was an increase of 121% from the previous year and exceeded the target of 60 by over 600%.

leaving them at risk for falls, dizziness, cardiac symptoms, confusion, and other side effects that frequently result in emergency room visits and hospitalization. If potential problems are identified, the program arranges for a pharmacist to review and respond.

- Provides education discussing simple behavioral changes clients can make to significantly reduce their risk of falls and injuries. These include things like wearing sturdy slippers, staying hydrated and well nourished, and getting eyeglass prescriptions checked more frequently.

LIFE ElderCare is able able to serve large numbers of individuals in part because of close partnerships with multiple nursing student cohorts, including those from Ohlone College, Samuel Merritt College, and Cal State East Bay. Students are trained, assigned in pairs to clients, and monitored by their Clinical Supervisors. Students have the opportunity to spend quality time with older adults and learn to view these adults through a different lens than a hospital or doctor's office setting.

Also, in an effort to provide the benefits of the program to a larger base of clients, LIFE ElderCare has begun providing interventions to their Meals on Wheels clients as part of the meal delivery program itself.

The current Fall Prevention Coordinator speaks Vietnamese, and all outreach materials are translated into Chinese and Spanish. As needed, the program uses other services and tools for translation into other languages. Additionally, many of the nursing students speak second languages, which allows LIFE ElderCare to better serve its culturally diverse population.

Measure A Funding Summary

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

Success Story

During her assessment, Ting, an 84-year-old, low income, Mandarin-speaking woman, described how she had to crawl over the side of the bathtub to prevent falling and held on to a drawer handle to get up from the toilet. LIFE ElderCare provided Ting a raised toilet seat with handrails, a grab bar on the side of the shower stall, and a transfer bench to make it easier to get in and out. The program also provided a medication review, personalized exercises, and health education and matched Ting with a Mandarin-speaking Friendly Visitor. This has helped Ting avoid loneliness and depression, which can actually make a person more prone to falls.

- \$** **FY 18/19 Allocation: \$100,000 | Expended/Encumbered: \$100,000**
- 👤** **Individuals served by Measure A:** 6,969 (Total individuals served: 6,969)
- 👥** **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
- +** **Services provided:** Public Health
- 📍** **Service area:** Berkeley, Oakland

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 hosts community outreach events targeting social cohesion within the community to reduce health inequalities, specifically cardiovascular disease. These events promote healthy behaviors and make H2H more visible and accessible to the community.

H2H also provides health education at community health events where hypertension screenings are offered as a drop-in service. At these events, community members receive hypertension education, linkages to resources, and information on health-related topics.

In addition, H2H trains community members to become Neighborhood Health Advocates (NHAs) and empowers them with tools to improve the health and well-being of their community. H2H coordinates with the NHAs to participate in community engagement activities, which include small group presentations, community fairs, vegetable giveaways, table talks, health screenings, and other outreach events.

Finally, H2H administers mini-grants to individuals or groups to support implementation of a variety of health and wellness programs. Grants awarded in FY 18/19 ranged from a demonstration to older adults on how to prepare healthy home-cooked meals to cultivating a garden at the South Berkeley Senior Center to offering free community fitness classes twice per week at the Center, among others.

Services and written materials are provided in English and Spanish, with translation services for other languages as needed.



Matching Funds

\$65,000

from the **Sutter Health Foundation.**

Measure A Funding Summary

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

- Organize 12 community outreach events attended by 308 participants (target: three events)
- Provide 16 community health education training sessions to 22 residents (target: 20 residents)
- Coordinate with 29 NHAs to participate in 93 community engagement activities to educate and link 1,929 community members to medical resources (target: 29 activities and 100 community members)
- Administer five mini-grants to five individuals, who implemented a variety of health and wellness programs with 185 attendees (target: four grants to four individuals)

Highlights

2,000%

The H2H program exceeded all target goals during the project year, including an **increase of community members served through engagement activities** of almost 2,000%, from a target of 100 to an actual number of 1,929.

Needle Exchange Emergency Distribution

berkeleyneed.org



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



Individuals served by Measure A: 281 (Total individuals served: 2,421)



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



Services provided: Public Health, Substance Abuse



Service area: Outside of Alameda County, Homeless or Transient

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

Background

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

NEED is the only harm-reduction services organization in Berkeley and one of only four in Alameda County. It offers syringe access and disposal to hundreds of people who use drugs in the East Bay for free, year-round. NEED also offers the opioid overdose reversal drug naloxone.

Measure A Funding Summary

NEED used its Measure A allocation to achieve the following:

- Make 2,421 service contacts (target: 1,750)
- Distribute 1,040,979 syringes through all sites (target: 500,000)
- Safely dispose of 403,485 used syringes by a licensed medical waste disposal company (target: 200,000)
- Ensure that 98% of weekly sites were adequately stocked with syringes and other supplies (target: 100%)
- Distribute more than 2,000 doses of naloxone



Success Story

A Latin American woman in her sixties requested some syringes for herself and several friends who use methamphetamine. She explained that the supplies NEED offered made it easier for her to help her friends use their drugs safely. She recalled how difficult it was to obtain syringes in the days before services like NEED were available. She remembered people resharpening used syringes with matchbooks or pleading with pharmacists to purchase a new package. The woman also took a naloxone kit in case anyone she knew took opioids occasionally or by accident. She expressed her appreciation that NEED workers are friendly and nonjudgmental.



Nutrition Services in West Oakland: City Slicker Farms

www.acphd.org/nutrition-services

- \$** FY 18/19 Allocation: \$50,000* | Expended/Encumbered: \$50,000
- 👤** Individuals served by Measure A: 800 (Total individuals served: 40,000)
- 👥** Populations served: Low Income, Uninsured Adults, Children, Families, Seniors
- +** Services provided: Public Health
- 📍** Service area: Countywide

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

Background

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

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

City Slicker Farms contracts with Nutrition Services to install raised bed gardens in locations throughout Alameda County, including senior housing sites, public housing sites, one senior center, one Head Start school site, one Oakland Unified School District continuation high school, and one school with special needs students.

In addition to garden beds, City Slicker provides soil, plants, and garden and nutrition education to residents. They also provide follow-up garden education mentorship visits with seasonal crops for planting and pest management for gardens installed in prior years. The mentorship educational classes help City Slicker staff build relationships with site staff, residents, and/or students to ensure enthusiasm for the gardens as well as maximum produce harvests.

Gardens installed increase access to fresh fruits and vegetables for community members living within Alameda County's disadvantaged communities. Additionally, City Slicker Farms' services contribute to improving community members' lives by increasing physical activity



Highlights

100%

100% of garden beds were in **good condition, including being weeded, having amended soil, and having no pest infestation, to yield produce to seniors** (target: 100%).

through gardening and increasing social connectedness among those who garden.

Services are provided in English, Spanish, and Chinese.

Measure A Funding Summary

Nutrition Services used its Measure A allocation to contract with City Slicker Farms to achieve the following:

- Build 20 garden beds total at nine low income community sites (target: 20 beds at 10 sites)
- Make 16 mentor and technical assistance visits at senior sites where gardens had previously been installed (target: 16)

Highlights

80%

80% of participants demonstrated **increased gardening knowledge** after a mentor visit (target: 80%).



- Allocation: \$15,000*** | **Expended/Encumbered: \$15,000**
- Individuals served by Measure A:** 886 (Total individuals served: 5,357)
- Populations served:** Low Income Children
- Services provided:** Mental Health
- Service area:** Oakland

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

Background

The Oakland Unified School District (OUSD) works to build a full-service community district focused on high academic achievement while serving the whole child, eliminating inequity, and providing each child with excellent teachers, every day.

The Surgeon General's Report indicates that 10% of students will need a mental health service during their K–12 education. In Oakland, where students are exposed to high rates of poverty and community violence, this number is higher. Providing early mental health services to children that are free of charge, culturally competent, child-centered, and easily accessible at school serves to remove barriers to learning that if unchecked could result in long-term negative outcomes including generational poverty, unemployment, and homelessness.

School-based mental health services are expensive to procure, and most schools lack resources to purchase a licensed therapist or social worker. For OUSD, mental health interns represent a viable solution to fill gaps in services at a fraction of the cost. Interns receive a stipend for their year-long internship, which covers transportation costs and child therapy-related supplies or expenses. In return, schools receive a half-time clinician who can see any students and provide a range of services, many of which are not covered by insurance, including Medi-Cal.

Services are provided in English, Spanish, and Cantonese.

Measure A Funding Summary






OUSD used its Measure A allocation to achieve the following:

- Recruit and place 30 mental health interns in 15 schools (target: 30 interns in 15 schools)
- Provide school-based mental health services to 886 referred students

Success Story

A fifth grade student with a high number of discipline referrals and suspensions was facing expulsion. After meeting with the mental health intern, who shared her ethnic and cultural background, the student's mother agreed to try counseling for her son. Through therapy, the student eventually shared that he and his mother had been homeless for several months, following her break-up with his father because of domestic violence. The intern connected the mother with a program that helped her secure a job and move into a transitional shelter for domestic violence victims. At the termination of his counseling, the student had had no fights in two months and was improving academically.



-  **Allocation: \$100,000 | Expended/Encumbered: \$100,000**
-  **Individuals served by Measure A:** 11,585 (Total individuals served: 11,585)
-  **Populations served:** Adults, Children
-  **Services provided:** Public Health
-  **Service area:** Oakland

Background

For this project, Oakland Unified School District (OUSD) set out to provide clean drinking water for all OUSD students and staff. This helps reduce consumption of sugary drinks and promotes better health.

Measure A Funding Summary

OUSD used its Measure A allocation to install 27 hydration stations in district schools (target: 27).

Highlights

100%

100% of students and staff reported **great satisfaction in knowing they have clean drinking water** (target: 100%).



Public Health Prevention Initiative

- \$** **FY 18/19 Allocation: \$3,027,743 | Expended/Encumbered: \$2,914,911**
- 👤** **Individuals served by Measure A:** 39,010 (Total individuals served: 115,200)
- 👥** **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
- +** **Services provided:** Emergency Medical, Hospital Outpatient, Public Health, Mental Health, Substance Abuse
- 📍** **Service area:** Countywide, Homeless or Transient

Background

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

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

- Asthma Start (see the separate “Asthma Start” entry on page 70)
- California Prostitutes Education Project (CAL-PEP)
- Child Health & Disability Prevention (CHDP) Developmental Screening—Help Me Grow
- City of Berkeley—School-Linked Health Services Program
- Community Assessment, Planning, and Evaluation (CAPE) Unit
- Diabetes
- East Oakland Boxing Association (EOBA)
- Health Equity Policy & Planning—City/County Neighborhood Initiative (CCNI)
- Healthy Retail Program
- HIV Education and Prevention Project of Alameda County (HEPPAC)
- Immunization Section
- Language Services for Starting Out Strong Home Visiting Programs
- Lotus Bloom
- Mandela MarketPlace
- Niroga Institute
- Nutrition Services
- Office of Dental Health (see the separate “Alameda County Dental Health” entry on page 38)
- Project New Start
- Public Health Nursing (PHN) Healthy Living Project



\$ Matching Funds

\$985,697

from the following sources:

- **Title XIX federal funds through the Maternal, Child, and Adolescent Health (MCAH) program**
- **OFCY funds**
- **Medi-Cal Administrative Activities (MAA)**
- **Merck Foundation**
- **City of Berkeley grant**
- **Oakland Literacy Coalition**

Measure A Funding Summary

Measure A funds are used for a broad array of services that benefit the residents of Alameda County. The Public Health Prevention Initiative programs used Measure A funding to help achieve the following.

CAL-PEP

- Conduct five health communications/public information (HCPI) events for 66 HIV-positive clients designed to increase knowledge of HIV disease, medication adherence, and viral suppression among African American HIV-positive individuals and their sexual partners (target: five events for 30 clients)
- Administer a pre- and post-test quiz to 36 HCPI participants (target: 30)
- Refer 10 partners of HIV-positive clients to HIV testing services, of whom all 10 received services (target: 10)
- Refer and link five high risk negative individuals to PrEP services (target: five)
- Verify 14 PrEP referrals by a unique identifying HIV testing number and notes (target: five)

CHDP Developmental Screening—Help Me Grow

- Develop developmental screening goals and promote the use of a standardized screening tool at 58 pediatric sites (target: 60)
- Provide monthly site visits to reinforce screening practices and offer technical assistance to clinic staff at 57 sites (target: 60)
- Collect screens from 56 sites monthly, enter results, and track screening data (target: 60)

City of Berkeley—School-Linked Health Services Program

- Provide 73 health consultations and community resources to school staff (target: 50)
- Conduct 74 encounters with school staff regarding immunization compliance (target: 50)
- Make 31 Health Education and Attendance for Life (HEAL) case contacts (target: 25)
- Attend 14 Student Attendance Review Board (SARB) and School Attendance Review Team (SART) meetings (target: 15)
- Publicize the Breathmobile asthma mobile clinic through 15 outreach encounters with school staff (target: 15)
- Make 31 contacts between Breathmobile host site school staff and Breathmobile staff (target: 15)

CAPE Unit

- Receive 61 and complete 50 data requests from stakeholders within two weeks of receipt (target: 75)

Highlights

97%

CAL-PEP

97% of participants **increased or maintained their knowledge and awareness of HIV, its treatment, and viral suppression** (target: 85%).

Success Story

CHDP Developmental Screening—Help Me Grow

Linda, age two-and-a-half, was referred to Help Me Grow by her pediatrician based on fine motor concerns and concerns about her social-emotional development. Linda's parents reported that she did not show interest in playing with toys, seemed disengaged, and would often just wander around the house seeming lost. The parents were provided with different strategies to support her behavior and fine motor skills at home. Linda was also connected to a playgroup that was specifically designed for children with developmental and behavioral concerns. After a few months in the playgroup, Linda's mother reported that Linda was more engaged in activities, was getting along with other kids, and seemed happier overall.

Diabetes

- Enroll 160 clients into diabetes self-management education (DSME) classes (target: 120)
- Ensure that 128 clients successfully completed DSME (target: 100)
- Lower the baseline A1c or maintain a goal of lower than 7% in 118 clients
- Lower the baseline blood pressure or maintain it at lower than 140/90 in 115 clients

EOBA

- Ensure that 158 youth participated in cooking, gardening, and/or physical activity programs (target: 150)
- Ensure that 50 EOBA youth participated in the Youth Leadership program (target: 40)
- Ensure that 94 EOBA youth boxers participated in the Boxing Leadership program (target: 40)
- Reach 1,611 households through the food distribution program (target: 1,350)

Health Equity Planning & Policy—CCNI

- Ensure that five West Oakland (WO) residents took formal elected leadership roles (target: seven)
- Host 10 monthly Resident Action Council (RAC) membership meetings hosted by RAC leaders (target: 10)
- Conduct two development training sessions with WO RAC elected leaders (target: two)
- Ensure that three RAC elected leaders participated in technical assistance consultations (target: four)
- Provide 24 technical assistance consultations for three WO RAC elected leaders (target: 12 sessions for four leaders)
- Enact two contracts with organizations to provide long-term leadership development and community-building and engagement opportunities (target: two)
- Host two meetings between the WO RAC and Congress of Neighborhoods (CoN) at large community efforts (target: two)
- Host two transition planning meetings between CCNI staff and WO RAC leaders (target: two)
- Ensure that 15 WO youth participated in a youth leadership development and civic engagement training program (target: 10)
- Provide 10 technical assistance consultations for two Sobrante Park (SP) RAC leaders (target: 12 sessions for four leaders)
- Host seven monthly meetings where SP elected leaders came together to plan RAC activities (target: 10)
- Facilitate one meeting between Roots Community Clinic (fiscal sponsor) and the leaders of the SP RAC (target: two)
- Enact a contract with one organization, CoN, to provide long-term leadership development and community building and engagement opportunities (target: one)
- Host two meetings between SP RAC leaders and CoN (target: two)

Highlights

100%

EOBA

100% of youth reported that the **cooking, gardening, and physical activity programming contributed to their health** (target: 85%).

Success Story

Health Equity Policy & Planning—CCNI

The chairperson of the WO RAC, Annette, proposed a partnership with the City of Oakland called Friday Night Live (FNL), a program designed to curb violence and build community by offering a safe space for youth and families on Friday nights. The RAC recruited 13 West Oakland high risk youth ages 15 to 22 to help organize and carry out the five-week program, which over 1,200 youth and families attended. Activities included a backpack giveaway for 100 students, blood pressure screenings, football games, rock climbing, diabetes information, art-making, dental check-ups and referrals, live music, DJ, food, dance and hula hoop contests, open-air movies, and lots of safe fun.

Healthy Retail Program

- Host outreach events at 10 stores for 1,863 community participants (target: 10 stores for 2,500 participants)

HEPPAC

- Distribute 350 information brochures about local health care coverage to 221 residents during syringe access services (target: 300 flyers to 150 residents)
- Inform 308 residents about HEPPAC's public/littered syringe pick-up services in the community (target: 250)
- Make 400 HEPPAC participants aware of available HIV and HCV services (target: 156)

Immunization Section

- Create 173 perinatal Hepatitis B case reports to identify women of child-bearing age infected with hepatitis B disease (target: 180)
- Create 44 STD reports to identify new primary cases of syphilis (target: 44)

Language Services for Starting Out Strong Home Visiting Programs

- Provide 275 medical interpretation services to clients (target: 275)
- Translate three English materials, including brochures and flyers, into multiple languages (target: five)

Lotus Bloom

- Recruit 40 parents to attend 18 meetings to generate ideas and activities for wellness in their community (target: 40 parents and six meetings)
- Implement four family engagement night programs integrating physical activity for 358 participants (target: four programs)
- Train 163 parents and staff in the Physical Movement and Health Food Policy (target: three)
- Conduct six Community Playtime events attended by 1,175 community members to encourage physical activity for children and their families (target: six events)
- Conduct nutrition and gardening classes for 18 participants (target: two)

Mandela Partners

- Identify and engage one store in the Ashland area to participate in the program (target: two)
- Provide outreach activities including recipe and food tasting demos and nutrition education to 67 total community members (target: 500)

Niroga Institute

- Provide semester-long twice-weekly Dynamic Mindfulness (DMind) stress resilience and social-emotional learning sessions to 714 students (students: 700)

Highlights

100%

Immunization Section

100% of ACPHD-administered vaccines were **entered into the California Immunization Registry (CAIR)** (target: 100%).

Success Story

Niroga Institute

In one mindfulness session, students were practicing noticing sounds in their environment and how the sounds affect their feelings. A girl in the classroom began to cry as she was listening to the instructions. When asked what was wrong, she responded that she was sad because she missed her mother. The instructor asked if other students ever got sad because they missed their mom, and they all agreed. Then a little girl next to her gave her a hug, and then two other students came to give her a hug. Soon she was laughing and happy thanks to her compassionate classmates.

- Provide daylong DMind training with an accompanying video curriculum and follow-up coaching to 30 teachers at each school (target: 25)
- Ensure that 17 teachers led DMind for their students (target: 15)

Nutrition Services

- Through Cooking for Health Academy, provide 12 class series to assist 193 class participants in learning ways to provide healthful meals for their families (target: eight series to 160 participants)
- Through the Nutrition Services Retail Program, provide 13 grocery store tours and 91 cooking demonstrations to give 3,933 participants tools and resources to make healthier food choices (target: 80 demonstrations and 24 tours)
- Provide technical assistance to 50 community-based organizations to create events that provided and encouraged healthy eating and beverages (target: 30)

Project New Start

- Conduct 11 tattoo removal clinics for 65 high risk youth (target: 12 clinics for 60 youth)
- Perform 1,600 tattoo removal treatments (target: 1,440)

PHN Healthy Living Project

- Provide four courses of nine lessons each for 54 students who set personal goals, learned about healthy eating habits and exercise, and considered how to make lifestyle changes that promote health and fitness (target: four courses for 40 students)

 **Success Story**






Project New Start

Suzy hated looking at herself in the mirror because she had tattoos on her face, neck, and arms. She has three children and was homeless for several years. She decided to live with her grandparents and get her life in order. She had several outstanding parking tickets she could not pay, which kept her from getting her driver’s license. She explained: “Project New Starts means everything to me, because you wrote a letter on my behalf for court indicating that I was in the program, and I got all the tickets dismissed.” Suzy is now enrolled in community college, completing her AA degree as a medical assistant.



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

acgov.org/ems

-  **FY 18/19 Allocation: \$225,077 | Expended/Encumbered: \$225,077**
-  **Individuals served by Measure A:** 687 (Total individuals served: 688)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Seniors
-  **Services provided:** Hospital Outpatient, Public Health, Mental Health, Substance Abuse
-  **Service area:** Alameda, Ashland, Berkeley, Castro Valley, Cherryland, Fremont, Hayward, Livermore, Newark, Oakland, Pleasanton, San Leandro, San Lorenzo, Sunol, Union City

Background

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

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

- City of Fremont. The Afghan Elderly Association’s Health Promotion Program consists of four interrelated components that are utilized in the home and at the Afghan Elderly Association (AEA) offices, the Healthy Aging Program (HAP), and the Afghan Health Promoter Program. The AEA has trained Health Promoters who connect seniors to health services in the community and provide emotional support. The program includes the Linkages Program, which provides information, referrals, and assistance to participants, including translation, completing forms, transportation, housing, and other community services; medication assistance and counseling, in which medication reviews take place both at the weekly HAP program and in the participants’ homes, and medication information is entered into a database that analyzes it for possible negative effects and/or interactions; the Happy, Healthy Me Program, a chronic condition self-management program in which participants identify problems and healthy goals; and health education groups, including diabetes education and the Matter of Balance fall prevention class. The program is offered in Dari and Pashtu.
- DayBreak Adult Care Centers. In the Medication Safety program, a nurse or social worker visits the elderly in their home to assist with their day-to-day management of medications. Program nurses are bilingual in English and Chinese.

Matching Funds

\$150,000

The City of Fremont and Afghan Elderly Association Health Promoter Program leveraged its Measure A allocation to obtain \$150,000 in matching funds from **City of Fremont general funds and Medi-Cal Administrative Activities (MAA) funds.**

- St. Mary's Center. St. Mary's offers a medication safety program to help participants gain a better understanding of the medications they are taking and learn how to implement healthier lifestyles. Through the Cal-State University East Bay (CSUEB) Community Nursing program, nursing students from CSUEB provide linkages to program participants to stay in compliance with their medication regimen and receive further medical services when needed. The student nurses support the program's wellness coordinators and participants by accompanying participants to primary care appointments when major interactions on medication or other interventions are needed. Services are provided in English, Spanish, Tagalog, Cantonese, and Mandarin.
- Senior Support Program of the Tri-Valley. The medication safety program assists clients to have the tools and knowledge necessary to safely take their medications, serves as a double-check for medical systems to ensure medications are being taken safely, and provides older adults with a free resource to reduce fall risks related to medication errors. The program helps older adults who are trying to manage complex medication conditions on top of navigating the health system within the confines of various insurance plans as well as multiple doctors and pharmacies, which do not always communicate.
- United Seniors of Oakland and Alameda County (USOAC). USOAC offers a medication safety training program and conducts outreach to seniors through community sites.

Measure A Funding Summary

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

- City of Fremont and Afghan Elderly Association Health Promoter Program
 - Provide Health Promoter services to 262 refugee, immigrant, and low income seniors over 60 years of age (target: 28)
 - Ensure that 265 clients have a primary physician (target: 84)
 - Assist 41 clients with obtaining access to specialty physicians or services (target: 11)
 - Assist 120 clients with obtaining services that help them access, use, and benefit from medical services (target: 35)
 - Provide medication review, assistance, and education to 35 clients (target: 35)
 - Provide health information and education to 201 clients (target: 25)
 - Ensure that 52 clients complete an assessment of their ability to self-manage chronic conditions (target: 25)
 - Help 22 clients improve and/or complete at least one self-management goal (target: 18)
 - Complete 46 fall and home safety assessments (target: 35)
 - Complete 58 mental health screens (target: 35)
 - Offer emotional support to 247 clients (target: 35)
 - Refer 113 clients to and/or assist them in accessing entitlement, community, and supportive service programs (target: 77)

Success Story

City of Fremont and Afghan Elderly Association Health Promoter Program

Widowed in her 40s, Ms. Noori, now in her 50s, was depressed and anxious. She had developed insulin-dependent diabetes mellitus (IDDM), experienced a few minor strokes, and had some falls. The Health Promoter helped educate Ms. Noori on how to manage her diabetes and properly inject insulin. She attended and translated at Ms. Noori's medical appointments and made sure Ms. Noori's medications were properly monitored. The Health Promoter also referred Ms. Noori to mental health services and a fall prevention class. With this support, Ms. Noori has been more consistent in managing her diabetes, not sustained any falls, and developed a more positive outlook about her life and future.

- DayBreak Adult Day Centers
 - Complete medication safety assessments for 40 participants (target: 40)
- St. Mary's Center
 - Enroll 58 participants in the 12-week medication safety program for older adults (target: 47)
 - Provide health screenings to 44 enrolled participants (target: 37)
 - Send 17 medication interaction reports to the participant's primary care provider or pharmacist for assessment (target: 24)
 - Complete 1,282 weekly medication safety compliance calls (target: 1,128)
 - Conduct 1,152 face-to-face medication safety conversations (target: 564)
 - Provide a 12-week review to 45 enrolled participants (target: 24)
 - Give information and guidance to 62 participants regarding the disposal of expired, misused, or unused medication (target: 28)
 - Give recommended nutrition education and exercise encouragement to 64 participants (target: 37)
 - Provide medication management assistance devices to 22 participants (target: 24)
- Senior Support Program of the Tri-Valley
 - Enroll 39 low income residents age 60 or older living in the Tri-Valley in the medication safety services program (target: 38)
- United Seniors of Oakland and Alameda County
 - Provide medication safety training to 286 seniors through one-on-one and/or group sessions (target: 150)
 - Conduct outreach to 7,400 seniors through community sites (target: 250)






Success Story

St. Mary's Center

Betty, a 79-year-old African American, engaged in a 12-week workshop at her residence building where a wellness coordinator facilitated weekly classes to discuss medication safety. Betty learned about the safe disposal of unused, unwanted, or expired medications. With the support of the program, Betty was informed that she was taking three medications that had major interactions, and those reports were sent to her provider. With the support of the program, Betty was able to inform her provider of the findings, and together they made corrections on the medication prescribed. She has fewer side-effect symptoms now that her medication has been revised.

Public Health Services for Homeless Residents: Abode Services

www.abodeservices.org

-  **FY 18/19 Allocation: \$107,123 | Expended/Encumbered: \$107,123**
-  **Individuals served by Measure A:** 192 (Total individuals served: 815)
-  **Populations served:** Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Public Health, Mental Health, Substance Abuse
-  **Service area:** Fremont, Newark, Union City

Background

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

The Abode Services HOPE Project links homeless individuals to street medicine, mobile clinic services, and primary care providers in traditional clinic settings to ensure that these individuals receive health care. Outreach staff also work to link individuals to the new Alameda County Coordinated Entry System, with the goal of securing housing for them.

HOPE Project staff speak Spanish and English, and interpretation and translation services are used to provide services in other languages as needed.

Measure A Funding Summary






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

- Provide 1,198 hours of housing outreach (target: 1,040)
- Provide outreach and engagement services to and enroll 192 individuals in the outreach program (target: 150)
- Perform 1,198 hours of referral and case management services (target: 312)
- Make 1,018 outreach contacts to enrolled clients (target: 1,350)
- Distribute 1,419 hygiene and other supply kits to homeless unsheltered individuals (target: 150)
- Make 15 complete housing referrals for eligible clients (target: 60)
- Help 15 enrolled clients collect and submit all needed documents for a permanent supportive housing referral (target: 50)

Highlights

950%

Abode Services **exceeded its target for referral and case management services by almost 400%, and for the number of hygiene and other supply kits distributed by almost 950%.**

-  **Allocation: \$10,000*** | **Expended/Encumbered: \$5,000** for first six months of funding cycle
-  **Individuals served by Measure A:** 28 (Total individuals served: 154)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Public Health
-  **Service area:** Dublin, Livermore, Pleasanton

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

Background

The Sandra Wing Healing Therapies Foundation provides public health services for low income adults, families, and seniors with cancer in the Tri-Valley area.

Measure A Funding Summary

During the first six months of its funding cycle, the Sandra Wing Healing Therapies Foundation used its Measure A allocation to achieve the following. Note that the target numbers are for the full 12-month cycle:


- Receive 37 applications and provide services to 75 cancer patients (target: 108 patients)
- Assign 139 clients to care team members
- Increase the number of practitioners to 32 (target: 33)
- Ensure that 82.5% of care team members had a patient list of fewer than 10 patients (target: 90%)
- Distribute 873 informational brochures to 56.5% of the target chemotherapy and radiation centers and hospitals (target: 1,000 brochures to 50% of target sites)




Highlights

85%

85% of clients indicated that their Care Team Member **helped them cope with the physical and emotional difficulties** they were experiencing (target: 70%).

 **FY 18/19 Allocation: \$123,191 | Expended/Encumbered: \$123,191**

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

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

 **Services provided:** Public Health

 **Service area:** Countywide

Background

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

AAA's Senior Injury Prevention Program (SIPP) includes the following components:

- **Enhance Fitness.** This program is designed to improve the overall functional fitness and well-being of older adults.
- **Geri-Fit®.** This is a progressive resistance strength program designed to increase strength, flexibility, range of motion, mobility, gait, and balance in older adults.
- **Home Meds.** This is a medication management program designed to address medication-related problems and errors that endanger the lives and well-being of community-dwelling elders.
- **Lifestyle-integrated Functional Exercise (LiFE).** This physical activity program is designed to improve the overall functional fitness and well-being of older adults.
- **A Matter of Balance.** This physical activity program is designed to reduce fall risk, reduce fear of falling, improve falls self-management, improve falls self-efficacy, and promote physical activity.
- **Minor home modifications.** SIPP provides residential modifications of homes that are necessary to facilitate the ability of older individuals to remain at home and that are not available under other programs.
- **Tai Chi: Moving for Better Balance.** This physical activity program is designed to improve balance, strength, and physical performance for older adults to reduce fall frequency.

Services are offered in English and Spanish.

Highlights

98%

98% of class participants were **satisfied with the amount of individual attention and level of challenge in the exercises** (target: 90%).

Measure A Funding Summary

SIPP used its Measure A allocation to provide the following:






- 1,891 Enhance Fitness sessions to 34 unduplicated participants (target: 1,606 sessions to 34 participants)
- 239 Geri-Fit sessions to 77 unduplicated participants (target: 157 sessions to 77 participants)
- Home Meds medication management to 105 unduplicated consumers (target: 75)
- LiFE sessions to 15 unduplicated participants (target: 14)
- 53 Matter of Balance classes to 12 unduplicated participants (target: 53 classes to 12 participants)
- Minor home modifications to 38 unduplicated consumers (target: 24)
- 515 Tai Chi: Moving for Better Balance classes to 76 unduplicated participants (target: 772 classes to 76 participants)

Success Story

Sharon, a 61-year-old African American female, is a participant in the Enhance Fitness program. When she began experiencing multiple symptoms from the medication she was taking, she decided to contact the Home Meds program to get her medication reviewed. Upon review, Sharon realized that several of her medications interacted with some of the foods she was consuming. She worked with her Health & Fitness Coordinator to make changes in her nutrition habits to remove the foods that were causing interaction and make healthier choices when shopping. Sharon shared her experience with other women in her residence building and was able to recruit other members to the program.

Social Good Fund, Inc. (The East Oakland Collective)

eastoaklandcollective.com

-  **Allocation: \$15,000*** | **Expended/Encumbered: \$15,000**
-  **Individuals served by Measure A:** 5,464 (Total individuals served: 14,010)
-  **Populations served:** Low Income, Uninsured Adults, Families, Seniors
-  **Services provided:** Public Health
-  **Service area:** Oakland, Homeless or Transient

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

Background

The East Oakland Collective (EOC) is a member-based community organizing group serving the communities of deep East Oakland by working towards racial and economic equity. With programming in civic engagement and leadership, economic empowerment, neighborhood and transportation planning, and homeless services and solutions, EOC helps amplify underserved communities from the ground up.

Distributing nutritious food and essential supplies to transient, unhoused, low income, and uninsured populations not only helps address some of the basic needs for this population but also provides a conduit to gain trust and allows for the dissemination of information and referrals. This population often lacks the knowledge of resources and/or struggles with connecting with agency and government assistance. EOC acts as the middle person to connect the served population to housing and shelter referrals, while also advocating for more resources to encampments.

Measure A Funding Summary






EOC used its Measure A allocation to distribute the following to individuals who are no to low income or who are unsheltered and living in homeless encampments across Oakland:

- 19,400 nutritious meals to 9,085 unduplicated individuals (target: 15,000 meals to 2,500 individuals)
- 4,006 hygiene and medical supply packages to 4,006 unduplicated individuals (target: 15,000 packages to 2,500 individuals)

Highlights

53.75%

53.75% of meal recipients reported that they **would not have received a nutritious meal that day otherwise** (target: 50%).

-  **Allocation: \$55,000 | Expended/Encumbered: \$55,000**
-  **Individuals served by Measure A:** 245 (Total individuals served: 1,062)
-  **Populations served:** Indigent, Low Income, Uninsured Seniors
-  **Services provided:** Public Health
-  **Service area:** Castro Valley, Fremont, Hayward, Newark, Oakland, Pleasanton, San Leandro, San Lorenzo, Union City

Includes Board of Supervisors discretionary allocation from **District 2/Supervisor Valle and **District 4/Supervisor Miley***

Background

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

Spectrum’s Fall Prevention classes and workshops help seniors to avoid falls by working on cardiovascular endurance, upper-body and lower-body strengthening, balance, and flexibility. The program includes the Enhance Fitness exercise class, which includes fall prevention tips. Classes are offered free to participants. Select classes are taught bilingually in Chinese and Spanish.

The classes also help community members become part of a group of individuals that have common concerns regarding aging. They alleviate isolation and loneliness by creating an atmosphere that makes it easy for people to make friends. They also provide a forum for sharing information about important issues and discussing what is happening in participants’ communities.

Measure A Funding Summary

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

- Provide 452 weekly one-hour Enhance Fitness exercise classes to 1,340 seniors, representing 172 unique participants per week, at locations in Castro Valley, Oakland, and San Leandro (target: 450 classes to 800 seniors, representing 60 unique participants per week)
- Provide 234 weekly one-hour Enhance Fitness exercise classes to 192 seniors, representing 73 unique participants per week, at locations in Fremont and Hayward (target: 650 seniors, representing 50 unique participants per week)



Success Story

A year after joining the Spectrum Fall Prevention exercise class, Dianne, 72, had hip replacement surgery. Six weeks later, Dianne returned to the class—compared to a typical hip replacement patient, who does not return to class for two to three months. A few weeks after her return, Dianne was on her feet and exclaimed, “This is the first time I have done this without pain!”

- Conduct 362 fitness assessments at locations in Castro Valley, Oakland, and San Leandro (target: 240)
- Conduct 105 fitness assessments at locations in Fremont and Hayward (target: 50)
- Provide 46 weekly fall prevention tips at locations in Castro Valley, Oakland, and San Leandro, and 46 at locations in Fremont and Hayward (target: 44 each)

💰 **Allocation: \$150,000*** | **Expended/Encumbered: \$75,000** for first six months of funding cycle

👤 **Individuals served by Measure A:** 97 (Total individuals served: 488)

👥 **Populations served:** Indigent, Low Income Seniors

⊕ **Services provided:** Public Health

📍 **Service area:** Dublin, Livermore, Pleasanton, Sunol

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

Background

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






Through the Meals on Wheels program, healthy meals are available for seniors ages 60 years and older who are unable to prepare their own food and have difficulty with mobility. Fresh, nutritious meals are distributed during the week, and chilled or frozen meals can be preordered for weekends and holidays. These nutritious meals are essential to the senior recipients' health.

The daily wellness and safety check from the Meals on Wheels volunteers who visit with each older adult breaks the cycle of isolation and helps prevent depression. In addition, many of the seniors the program serves are not connected to other community-based services. Through a thorough assessment process, the program often identifies additional resources to help these older adults.

Measure A Funding Summary

The Spectrum Meals on Wheels program used its Measure A allocation to deliver 15,819 meals to 132 homebound seniors in Dublin, Livermore, Pleasanton, and Sunol (target: 18,692 meals to 64 seniors).



-  **Allocation: \$20,000*** | **Expended/Encumbered: \$20,000**
-  **Individuals served by Measure A:** 981 (Total individuals served: 1,330)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Families, Seniors
-  **Services provided:** Public Health, Mental Health
-  **Service area:** Countywide

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

Background

Women's Cancer Resource Center (WCRC) creates opportunities for women with cancer to improve their quality of life through education, supportive services, and practical assistance.

WCRC allows for multiple points of entry to its services. As clients receive support, they are introduced to other WCRC programs that may support their global wellness. Additionally, they may be connected to programs outside of WCRC. For example, if a client reaches out to WCRC expressing a need to be connected to other people as a way to manage her sadness, the WCRC volunteer works to address the client's self-stated need for a support group. Next, the volunteer explores other WCRC offerings that might help the client connect to others so she feels less isolated. WCRC's Wellness Workshops provide opportunities for connectedness and support.

Services are provided in English and Spanish.

Measure A Funding Summary

WCRC used its Measure A allocation to achieve the following:

- Have 17 staff and volunteers provide information on cancer-related resources and referrals to an average of 267 individuals per quarter, through 1,381 hours of support to callers and walk-in clients (target: 12 staff/volunteers supporting 260 individuals per quarter by offering 1,560 hours of support)
- Offer 232 affinity-based support groups for women with cancer led by an average of 7.7 staff and consultants (target: 276 groups led by 10 staff/consultants)
- Offer free psychotherapy services from 29 therapists to 39 low income women with cancer (target: 35 therapists and 70 women)
- Provide 11 case consultation sessions led by licensed staff (target: 10)
- Provide three professional development in-service sessions for volunteer therapists (target: three)

Success Story

Cleo engaged with WCRC after she received a metastatic breast cancer diagnosis and needed someone to talk to about her shock, sadness, and frustration. As her cancer progressed, Cleo felt that it would be useful to access WCRC's Free Therapy Program (FTP) to receive 12 free psychotherapy sessions, removing a cost barrier for her. WCRC paired Cleo with a licensed volunteer therapist who met with Cleo to process her worry, fear, and anger about having to live with metastatic cancer in her 40s. Cleo felt the FTP played an important role in supporting her mental health.



REACH ASHLAND YOUTH CENTER

Youth and Family Opportunity Initiatives

achealthyschools.org

- \$** **FY 18/19 Allocation: \$2,704,654 | Expended/Encumbered: \$2,704,654**
- 👤** **Individuals served by Measure A:** 19,610 (Total individuals served: 19,610)
- 👥** **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
- +** **Services provided:** Public Health, Mental Health, Substance Abuse
- 📍** **Service area:** Countywide, Homeless or Transient

Background

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

The countywide Youth and Family Opportunity (YFO) initiative provides a variety of supports and opportunities to youth to strengthen their protective factors, encounter less risk, and ultimately show evidence of higher rates of successful transitions into adulthood, which lead to improved health outcomes throughout life. YFO partners are situated in the County’s areas of highest need based on social determinants of health and work to address those needs to interrupt cycles of inequity and create schools and communities that support all young people to thrive.

In addition to the formal health and wellness services offered to youth and families, YFO organizations also offer family support and youth development services as part of their holistic programming and may serve as the safety net for a young person or family who is just short of extreme crisis.

The organizations involved in the YFO initiative include the following:

- Alameda Family Services (AFS) provides an array of health and wellness services to families, including outreach, information and referrals, health and benefit enrollment assistance, case management, and workshops on topics such as on parenting education, talking to parents about sexual abuse prevention, and healthy eating. AFS facilitates access to health-related services for youth, families, and seniors through their collaboration with 31 partner organizations.
- Alternatives in Action (AIA) provides a full continuum of cultural-responsive health and wellness supports through a myriad of partnerships. AIA’s health and wellness and youth development



\$ Matching Funds

\$2.5M

from the following sources:

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

activities include gardening and healthy living, violence prevention, self-esteem, gender-based empowerment, identity development, healthy relationships, and social justice.

- Berkeley Youth Alternatives (BYA) provides culturally competent case management, behavioral health, and youth development services to low income children and youth ages 6–18 and their families. Activities and supports include the SPARK Health Program, nutrition and gardening programs, health screenings, one-on-one counseling, mentoring, physical fitness activities, and health clinic services with community partners.
- East Bay Asian Youth Center (EBAYC) provides school-day and after-school holistic supports, including care coordination, individual case management and referrals, mentoring, and youth development activities. EBAYC coordinates the Coordination of Services Team (COST) and participates in the Culture and Climate Team at Oakland High School, including training school staff and partners.
- Fremont Family Resource Center (FFRC) is a collaboration of 24 state, County, City of Fremont, and nonprofit organizations working together to serve families living in the Tri-Cities. As a “one stop” resource center, they provide case management and referrals to a wide array of health, wellness, and basic needs supports, including Medi-Cal and benefits enrollment, internal and external referrals to health and behavioral health services, and family financial stability through SparkPoint.
- Fremont Unified School District offers supports across the three tiers of prevention, early intervention, and treatment; behavioral health coordination and infrastructure; and linkages to primary care services and other health-related resources in the community. The Program Managers support the district and partners in expanding the multi-tiered system of supports and in implementing effective COST, which are the core of the system of identification, referral, and service delivery for students. The district also supports truant students and families and works to engage and support families via Parent Cafes.
- La Familia Counseling Services serves low income, underserved, primarily Spanish-speaking communities in Hayward with health access and family support services through a partnership with the Hayward Unified School District (HUSD). La Familia runs a Parent Ambassador Program to conduct outreach and provides case management and referrals to HUSD youth and their families. La Familia also offers health and wellness resources at HUSD sites and at their Fuller Family Resource Center, including health care and benefits eligibility and enrollment, chronic disease education, nutrition and fitness classes, and immigration support.
- Newark Unified School District’s (NUSD) Newark Parent Partner Program provides health access and family support services, primarily through workshops and referrals to partner organizations. Partnerships with over 30 organizations enable families to access health and benefits enrollment and health care, basic needs support, legal aid, and mental health supports. Workshops focus on positive parenting, adapting to a new culture and parenting, and nutrition.

Success Story

BYA

As a seventh grader, Jessica was failing all her classes, shutting down verbally and emotionally, and being disrespectful at home. BYA staff suggested counseling and participation in the BYA after-school program to help with Jessica’s social skills and academics. In the beginning, Jessica was unapproachable and very angry. She stayed with BYA in the eighth grade and really started to change. She was smiling more, and staff noticed her a few times laughing and playing games with other kids. Jessica told staff that she wanted to prepare for high school, and that year, with tutoring, she was able to increase her math, reading, and writing skills.

- REACH Ashland Youth Center offers a variety of programs for youth that increase their healing, sense of connection, and belonging, as well as increasing their access to health care. REACH clinical case managers and community health outreach workers specifically focus on youth health and wellness. REACH partners with community providers to provide onsite behavioral, physical, and dental health services; health education and internships; youth leaderships; recreation and fitness; arts and creativity; education; and career and employment supports.
- The Tri-Valley Health Initiative is a collaboration between the school districts; the cities of Pleasanton, Dublin, and Livermore; County Board of Supervisor Districts 1 and 4; the Alameda County Health Care Services Agency; Kaiser Permanente; and Stanford Valley Care Health. The Initiative supports Community Health and Wellness Events in all three cities to provide immunizations; physical, dental, vision, and other health screening and referrals; health education; and health care enrollment to youth and families.
- Union City Family Center (UCFC) offers a range of onsite supports and referrals to a vast partnership collaborative for children and families in the New Haven Unified School District, specifically in the Decoto neighborhood of Union City. For parents, UCFC staff and partners provide health and wellness workshops that include wellness, mindfulness, and health eating. They also provide fathers and mothers groups and parent affinity groups (Filipino, Chinese, Asian-Indian, and Latino). UCFC has also launched a food distribution program, which is one of the largest food distribution sites in Alameda County.
- Youth Radio provides wraparound health and wellness support to youth enrolled in their media arts education and internship programs. Services include a self-assessment of needs and interests and a bio-psycho-social assessment (SIGECAPS), case management, behavioral health services, and healthy food. Case managers work with youth to navigate a wide range of challenges and opportunities and refer youth for basic needs and counseling services through their collaboration with community-based organizations.

YFO organizations employ bilingual, bicultural staff, many of whom are bilingual in at least one other language.

Measure A Funding Summary

YFO Initiative providers used their Measure A allocation to achieve the following:

- Hold 101 community events focused on raising awareness of free and affordable health care services, at which 25,479 contacts were made (target: 60–70 events and 20,000 contacts)
- At the events, provide the following:
 - Application assistance to enroll in CalFresh, CalWORKs, or other public benefits to 481 families (target: 350–400)

Highlights

98%

98% of youth agreed their program helped them get **services or opportunities they wouldn't otherwise have** (target: 85%).

96%

96% of youth and families agreed or strongly agreed they now had **places to go for health and wellness services** (target: 85%).

- Information about health insurance and benefits eligibility and/or referrals to an offsite location for application assistance to 3,967 families (target: 3,000)
- Serve over 200 children and families at one health fair and three smaller health events in the Tri-Valley (target: 250 children and families)
- Through the UCFC food bank, provide healthy snacks to more than 5,000 youth and 3,000 adults (target: 3,500)
- Serve 1,003 youth at the REACH Ashland Youth Center onsite Health Center (target: 1,000)
- Serve 2,338 youth through care coordination, case management, and referrals (target: 1,000)
- Serve 403 youth through individual and group counseling (target: 150)
- Engage 654 youth in health and wellness workshops focused on health education and healthy lifestyle choices (target: 1,000)
- Enable 25 youth to participate in leadership development activities that increase resiliency by focusing on personal growth, health and wellness, and leadership (target: 20–30)
- Enable 300 youth to participate in arts and enrichment activities that increase resiliency and social-emotional well-being (target: 272)
- Provided college and career support to 125 youth
- Provide support with chronic attendance issues to 335 youth
- Enable 156 youth to participate in college and career readiness activities
- Enable 594 youth to participate in digital media training and internships
- Provide case management to 4,692 parents/caregivers (target: 2,500)
- Make home visits with resource referrals to 331 parents/caregivers
- Provide individual counseling and support groups to 150 parents/caregivers
- Provide crisis intervention, including basic needs support, to 655 parents/caregivers
- Ensure that 326 parents/caregivers participated in health and wellness workshops focused on health education and healthy lifestyle choices (target: 300)
- Ensure that 102 parents/caregivers participated in leadership development activities that increase resiliency and ability to support their children’s healthy development and success (target: 100)
- Enable 78 parents/caregivers to participate in career readiness classes
- Enable 385 parents/caregivers to participate in financial literacy
- Enable 2,699 parents/caregivers to participate in school-based engagement efforts

Success Story

La Familia

The Parent Ambassador Supervisor was contacted about mental health services for a student at one of the middle schools who had recently lost her mother. The Supervisor told the girl’s father about the services La Familia’s Cultura and Bienestar program offers, along with other supports. The Supervisor worked to ensure the consent forms were filled out and the referral was smooth, especially given how overwhelmed the father was with the loss. The program was able to successfully connect the student to grief counseling and continued to follow up with home visits until both the student and father felt there was no longer a need.

APPENDICES

APPENDIX A: Measure A Auditor-Controller Report

APPENDIX B: FY 18/19 Budget Information

APPENDIX C: FY 18/19 Measure A Fund Distribution by Provider or Program

APPENDIX D: Maps: Geographic Distribution of Providers Funded by Measure A in FY 18/19

Map 1 Alameda County Public Health Programs

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

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

Map 4 School-Based Health Centers

Map 5 HealthPAC Provider Network

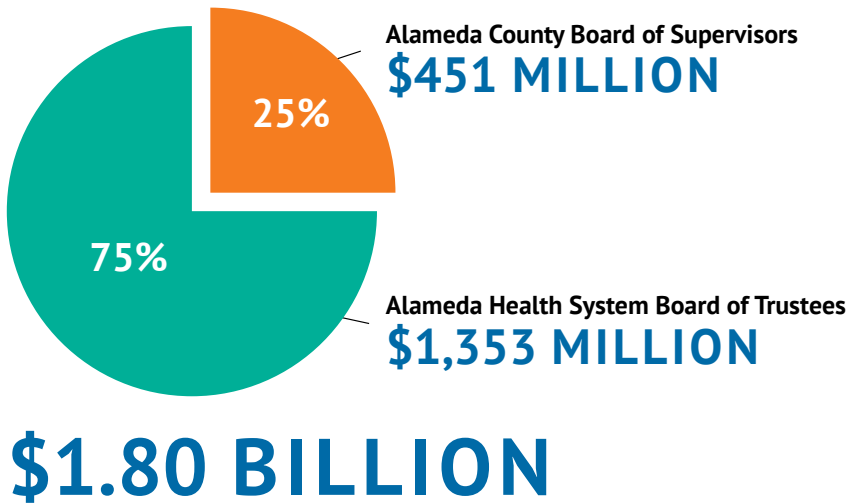
APPENDIX A

Measure A Auditor-Controller Report

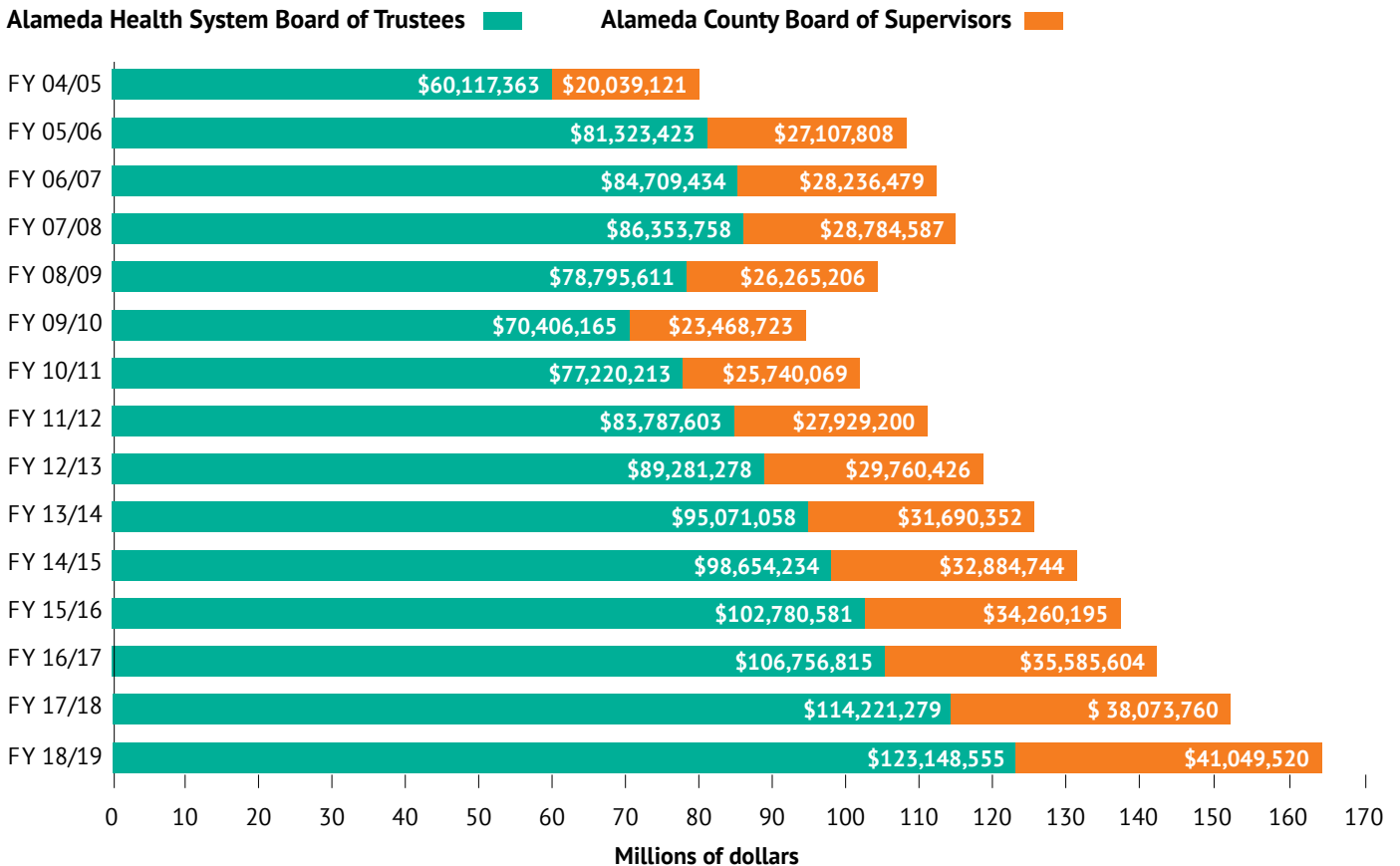
FY 04/05 through FY 18/19

Measure A Funds received from the state and the distribution of the funds according to the provisions of Measure A:

TOTAL REVENUE RECEIVED (FY 04/05 THROUGH FY 18/19)



REVENUE RECEIVED EACH FISCAL YEAR (FY 04/05 THROUGH FY 18/19)



APPENDIX B: FY 18/19 BUDGET INFORMATION

	TOTAL ALLOCATION ¹	CARRYOVER		TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR ²	TOTAL	SAVINGS ⁴
		FROM PREVIOUS FISCAL YEAR ³						
Group 1: Behavioral Health								
Behavioral Health and Alcohol and Other Drug (AOD) Community-Based Providers	829,513	0	829,513	255,582	0	255,582	573,931	
Center for Empowering Refugees and Immigrants (CERI)	86,096	0	86,096	86,095	0	86,095	1	
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	636,256	0	636,256	636,256	0	636,256	0	
Cherry Hill Detoxification and Sobering Center ¹	2,295,875	246,027	2,541,902	1,982,018	559,884	2,541,902	0	
Criminal Justice Screening and In-Custody Services	4,306,000	0	4,306,000	4,306,000	0	4,306,000	0	
Health Services for Unaccompanied Immigrant Youth: La Familia Counseling Services	176,648	0	176,648	176,648	0	176,648	0	
La Familia Counseling Services (Glad Tidings)	20,000	0	20,000	20,000	0	20,000	0	
Mental Health Services for Juvenile Justice Center	360,000	0	360,000	360,000	0	360,000	0	
Group 2: Hospital, Tertiary Care, Other								
St. Rose Hospital ²	1,500,000	7,000,000	8,500,000	0	8,500,000	8,500,000	0	
UCSF Benioff Children's Hospital Oakland ²	2,000,000	500,000	2,500,000	1,500,000	1,000,000	2,500,000	0	
Group 3: Primary Care								
Alameda County Dental Health ³	257,580	130,000	387,580	444,237	-56,657	387,580	0	
Center for Elders' Independence	57,397	0	57,397	57,397	0	57,397	0	
Center for Healthy Schools and Communities (School Health Centers)	2,047,080	0	2,047,080	2,597,241	0	2,597,241	-550,161	
Direct Medical and Support Services (Oakland): Preventive Care Pathways	229,587	0	229,587	229,587	0	229,587	0	
Fremont Aging and Family Services	57,397	0	57,397	57,397	0	57,397	0	
Health Enrollment for Children	300,000	0	300,000	300,000	0	300,000	0	
Health Services for Day Laborers	280,624	0	280,624	191,324	0	191,324	89,300	
Medical Costs for Juvenile Justice Services	511,891	0	511,891	423,473	0	423,473	88,418	
Primary Care Community-Based Organizations	5,753,009	0	5,753,009	5,753,007	0	5,753,007	2	

Continued on next page

	TOTAL ALLOCATION ⁵	CARRYOVER FROM PREVIOUS FISCAL YEAR ²	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR ²	TOTAL	SAVINGS ⁴
Group 4: Public Health							
Alameda Boys & Girls Club, Inc.	114,794	0	114,794	114,794	0	114,794	0
Asthma Start	100,000	0	100,000	100,000	0	100,000	0
Center for Early Intervention on Deafness	57,397	0	57,397	57,397	0	57,397	0
City of San Leandro Senior Services	57,397	0	57,397	57,397	0	57,397	0
Countywide Plan for Seniors (Getting the Most Out of Life)	250,000	154,788	404,788	152,456	252,332	404,788	0
Countywide Plan for Seniors (Home-Based Nursing Care Management) ³	500,000	0	500,000	500,114	0	500,114	-114
Countywide Plan for Seniors (Injury Prevention, Meals, Nutrition)	797,808	68,896	866,704	849,125	17,579	866,704	0
EMS Ambulance Providers to Serve 5150 Indigent Population	0	2,730,000	2,730,000	815,000	1,915,000	2,730,000	0
Emergency Medical Services (EMS) Corp	607,791	0	607,791	607,791	0	607,791	0
Emergency Preparedness, Mitigation, Response, & Recovery	250,000	0	250,000	112,466	137,534	250,000	0
Health Services for Persons Who Inject Drugs: HIV Education & Prevention Project of Alameda County (HEPPAC)	160,684	0	160,684	160,684	0	160,684	0
Healthy Homes Department: Fixing to Stay & Group Living Facilities Project	208,000	81,071	289,071	253,760	0	253,760	35,311
HIV Education & Prevention Project of Alameda County (HEPPAC) OPEND	85,000	0	85,000	85,000	0	85,000	0
Home Visiting Services ³	2,950,170	2,272,899	5,223,069	1,757,638	3,465,431	5,223,069	0
La Familia Counseling Services (Youth Resiliency)	200,000	0	200,000	200,000	0	200,000	0
LifeLong Medical Care (Heart 2 Heart)	100,000	0	100,000	100,000	0	100,000	0
Nutrition Services in West Oakland: City Slicker Farms	50,000	0	50,000	50,000	0	50,000	0
Public Health Services for Pacific Islanders	0	244,115	244,115	78,354	0	78,354	165,761
Public Health Prevention Initiative	3,027,743	0	3,027,743	2,914,911	0	2,914,911	112,832
Public Health Prevention Initiative: EMS Injury Prevention	225,077	0	225,077	225,077	0	225,077	0
Public Health Services for Homeless Residents: Abode Services	107,123	0	107,123	71,853	0	71,853	35,270
Senior Injury Prevention Program	123,191	0	123,191	123,191	0	123,191	0
Youth and Family Opportunity Initiatives ³	2,704,654	17,080	2,721,734	2,746,467	-24,733	2,721,734	0
Board of Supervisors²	750,000	905,424	1,655,424	665,000	990,424	1,655,424	0
TOTAL FY 18/19⁵	35,246,782	11,376,185	46,622,967	30,821,222	14,841,794	45,663,016	959,951

1. Cherry Hill Detoxification and Sobering Center's carryover balance includes carryover of unexpended funds from the Board-approved original allocation and any unspent funds from subsequent Board-approved allocations.
2. The Board 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.
3. Actuals that exceed the budget will be offset by reduced expenditures in the next fiscal year.
4. Savings are unexpended funds that will revert to the general Measure A account for reallocation in future fiscal years.
5. The total allocation includes Measure A Base and Measure A One-Time Allocations approved by the Board for FY 18/19.

APPENDIX C: FY 18/19 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

	MEASURE A ALLOCATION FY 18/19	EXPENDED/ ENCUMBERED FY 18/19
GROUP 1: BEHAVIORAL HEALTH		
Behavioral Health and Alcohol and Other Drug (AOD) Community-Based Providers		
Alameda County Mental Health Association	40,175	20,811
Alameda Family Services	9,176	-
Asian Health Services, Inc.	10,257	-
Axis Community Health, Inc.	6,710	-
Berkeley Addiction Treatment Services, Inc.	5,498	-
Bi-Bett Corporation	2,594	-
Bonita House, Inc.	61,311	-
Building Opportunities for Self-Sufficiency (BOSS)	33,921	33,920
Center for Independent Living	2,627	2,627
Crisis Support Services of Alameda County	35,478	35,478
CURA	39,307	-
Filipinos Advocates for Justice	19,259	19,205
Horizon Services, Inc.	13,116	13,116
Humanistic Alternatives to Addiction	2,493	-
Institute for the Advanced Study of Black Family Life & Culture	80,596	-
LifeLong (EBCRP)	36,511	-
Magnolia Women's Recovery Programs, Inc.	11,812	9,581
Native American Health Center, Inc.	30,815	-
New Bridge Foundation, Inc.	41,371	4,469
Second Chance, Inc.	86,805	-
Senior Support Program of the Tri-Valley	40,602	27,969
Southern Alameda County Comite for Raza	122,556	24,186
St. Mary's Center	45,528	43,793
Thunder Road-Adolescent Treatment	9,242	-
Uplift Family Services	38,520	20,427
Unallocated	3,233	-
Total Allocation	829,513	255,582
Center for Empowering Refugees and Immigrants (CERI)	86,096	86,096
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)		
Emery Unified School District	40,178	40,178
Hume Center	143,492	143,492
Unallocated	452,586	452,586
Total Allocation	636,256	636,256
Cherry Hill Detoxification and Sobering Center (Horizon Services, Inc.)	2,295,875	1,982,018
Criminal Justice Screening and In-Custody Services	4,306,000	4,306,000

GROUP 1: BEHAVIORAL HEALTH	MEASURE A ALLOCATION FY 18/19	EXPENDED/ ENCUMBERED FY 18/19
Health Services for Unaccompanied Immigrant Youth		
La Familia Counseling Services	172,191	172,191
Unallocated	4,457	4,457
Total Allocation	176,648	176,648
La Familia Counseling Services (Glad Tidings)	20,000	20,000
Mental Health Services for Juvenile Justice Center	360,000	360,000

GROUP 2: HOSPITAL, TERTIARY CARE, OTHER	MEASURE A ALLOCATION FY 18/19	EXPENDED/ ENCUMBERED FY 18/19
St. Rose Hospital	1,500,000	1,500,000
UCSF Benioff Children's Hospital Oakland	2,000,000	-

GROUP 3: PRIMARY CARE	MEASURE A ALLOCATION FY 18/19	EXPENDED/ ENCUMBERED FY 18/19
Alameda County Dental Health		
Axis Community Health	257,580	300,000
Unallocated	-	144,237
Total Allocation	257,580	444,237
Center for Elders' Independence	57,397	57,397
Center for Healthy Schools and Communities (School Health Centers)		
Alameda Family Services	124,200	124,200
Children's Hospital & Research Center	99,360	99,360
City of Berkeley	74,520	74,520
East Bay Agency for Children	49,680	49,680
East Bay Asian Youth Center	49,680	49,680
La Clinica de La Raza, Inc.	397,440	397,440
LifeLong Medical Center	149,040	149,040
Native American Health Center	198,720	198,720
Tiburcio Vasquez Health Center	149,040	149,040
Unallocated	755,400	755,400
Total Allocation	2,047,080	2,047,080
Direct Medical and Support Services (Oakland): Preventive Care Pathways	229,587	229,587
Fremont Aging and Family Services	57,397	57,397
Health Enrollment for Children	300,000	300,000
Health Services for Day Laborers		
Multicultural Institute	95,662	95,662
Street Level Health Project	95,662	95,662
Unallocated	89,300	-
Total Allocation	280,624	191,324

GROUP 3: PRIMARY CARE	MEASURE A ALLOCATION FY 18/19	EXPENDED/ ENCUMBERED FY 18/19
Medical Costs for Juvenile Justice Services		
Niroga Institute	89,152	89,152
Victims of Crime	90,000	79,118
Unallocated	332,739	343,621
Total Allocation	511,891	511,891
Primary Care Community-Based Organizations		
Alameda Health Consortium:		
Asian Health Services	610,520	610,520
Axis Community Health	638,300	638,300
Davis Street Family Resource Center	107,123	107,123
La Clínica de La Raza	1,796,318	1,796,318
LifeLong Medical Center	694,001	694,001
Native American Health Center	269,219	269,219
Tiburcio Vasquez Health Center	869,872	869,872
Tri-City Health Center	591,503	591,503
West Oakland Health Council	176,151	176,151
Unallocated	2	2
Total Allocation	5,753,009	5,753,009
Tiburcio Vasquez Health Center	40,000	40,000

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 18/19	EXPENDED/ ENCUMBERED FY 18/19
ACCMA (Alameda-Contra Costa Medical Assoc.) Community Health Foundation	20,000	20,000
Alameda Boys & Girls Club, Inc.	114,794	114,794
Alameda County Asthma Start	100,000	100,000
Alameda County Community Food Bank	15,000	15,000
Center for Early Intervention on Deafness	57,397	57,397
City of San Leandro Senior Services	57,397	57,397
Countywide Plan for Seniors (Getting the Most Out of Life)	250,000	152,456
Countywide Plan for Seniors (Home-Based Nursing Case Management)¹	500,000	500,114
Countywide Plan for Seniors (Injury Prevention, Meals, Nutrition)		
Afghan Elderly Association	30,402	30,402
Daybreak Adult Care Centers	52,174	52,174
Life ElderCare, Inc.	37,938	37,938
LifeLong Medical Care	36,850	36,850
Mercy Brown Bag	51,750	51,750
Rebuilding Together Oakland	6,105	6,105
Senior Support Program of the Tri-Valley	16,774	16,774
SOS/Meals on Wheels-North	382,950	382,950
SOS/Meals on Wheels-North	16,426	10,248
Spectrum Community Services	85,249	85,249
St. Mary's Center	30,490	30,490

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 18/19	EXPENDED/ ENCUMBERED FY 18/19
Countywide Plan for Seniors (Injury Prevention, Meals, Nutrition) (Continued)		
Unallocated	50,700	56,878
Total Allocation	797,808	797,808
Eden Youth and Family Center	15,000	15,000
Emergency Preparedness, Mitigation, Response, & Recovery	250,000	112,466
EMS Ambulance Providers to Serve 5150 Indigent Population	-	815,000
EMS Corps		
Berkeley Youth Alternatives (BYA)	78,742	78,742
Other Program Expenses	529,049	529,049
Total Allocation	607,791	607,791
George Mark Children's House	50,000	50,000
Health Services for Persons Who Inject Drugs: HIV Education & Prevention Project of Alameda County (HEPPAC) OPEND	160,684	160,684
Healthy Food Healthy Families (AC Deputy Sheriff's Activities League, Inc.)	50,000	50,000
Healthy Homes Department: Fixing to Stay & Group Living Facilities Project	208,000	208,000
HERS Breast Cancer Foundation	10,000	10,000
HIV Education & Prevention Project of Alameda County (HEPPAC) OPEND	85,000	85,000
Home Visiting Services		
Brighter Beginnings	350,000	350,000
Native American Health Center/Undetermined	190,224	-
Tiburcio Vasquez Health Center	590,000	590,000
UCSF Benioff Children's Hospital Oakland	693,681	693,681
Unallocated	(473,735)	(283,511)
Total Allocation	1,350,170	1,350,170
La Familia Counseling Services (Youth Resiliency)	200,000	200,000
La Familia Counseling Services	30,000	30,000
Lend A Hand Foundation, Inc. of Northern California	10,000	10,000
Life ElderCare	15,000	15,000
LifeLong Medical Care: Heart 2 Heart	100,000	100,000
Nutrition Services in West Oakland: City Slicker Farms	75,000	75,000
Oakland Unified School District	115,000	115,000
Public Health Services for Pacific Islanders	-	78,354
Public Health Prevention Initiative		
California Prostitutes Education Project	52,025	52,025
Center for Oral Health	152,114	152,114
City of Berkeley	193,715	193,715
East Oakland Boxing Association	56,272	56,272
HIV Education and Prevention Project of Alameda County	47,294	47,294
Lotus Bloom	36,577	36,577
Mandela Partners (previously Mandela MarketPlace)	130,715	130,715
Niroga Institute	55,458	55,458
Tides (Hope Collaborative)	85,698	85,698
Unallocated	2,217,875	2,105,043
Total Allocation	3,027,743	2,914,911

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 18/19	EXPENDED/ ENCUMBERED FY 18/19
Public Health Prevention Initiative: EMS Injury Prevention	225,077	225,077
Public Health Services for Homeless Residents: Abode Services	107,123	71,853
Sandra J Wing Healing Therapies Foundation	10,000	10,000
Senior Injury Prevention Program	123,191	123,191
Social Good Fund, Inc. (The East Oakland Collective)	15,000	15,000
Spectrum Community Services, Inc.	55,000	55,000
Spectrum Community Services, Inc.: Meals on Wheels Program	75,000	75,000
UCSF Benioff Children's Hospital Oakland	20,000	20,000
Washington Hospital (Capital)	50,000	50,000
Women's Cancer Resource Center	20,000	20,000
Youth and Family Opportunity Initiatives		
Alameda Family Services	114,794	114,794
Alternatives in Action (AIA)	286,985	286,985
Berkeley Youth Alternatives (BYA)	114,794	114,794
City of Fremont	172,191	172,191
Dublin Unified School District	19,131	19,131
East Bay Asian Youth Center (EBAYC)	114,794	114,794
Fremont Unified School District	114,794	114,794
Livermore Unified School District	19,132	19,132
New Haven Unified School District	114,794	114,794
Newark Unified School District	114,794	114,794
Pleasanton Unified School District	19,131	19,131
Other Program Expenses	1,499,320	1,541,133
Total Allocation	2,704,654	2,746,467

Note:

1. Actuals that exceed the budget will be offset by reduced expenditures in the next fiscal year.

APPENDIX D
MAPS: GEOGRAPHIC DISTRIBUTION OF
PROVIDERS FUNDED BY MEASURE A IN FY 18/19

Map 1 Alameda County Public Health Programs

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

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

Map 4 School-Based Health Centers

Map 5 HealthPAC Provider Network

MAP 1

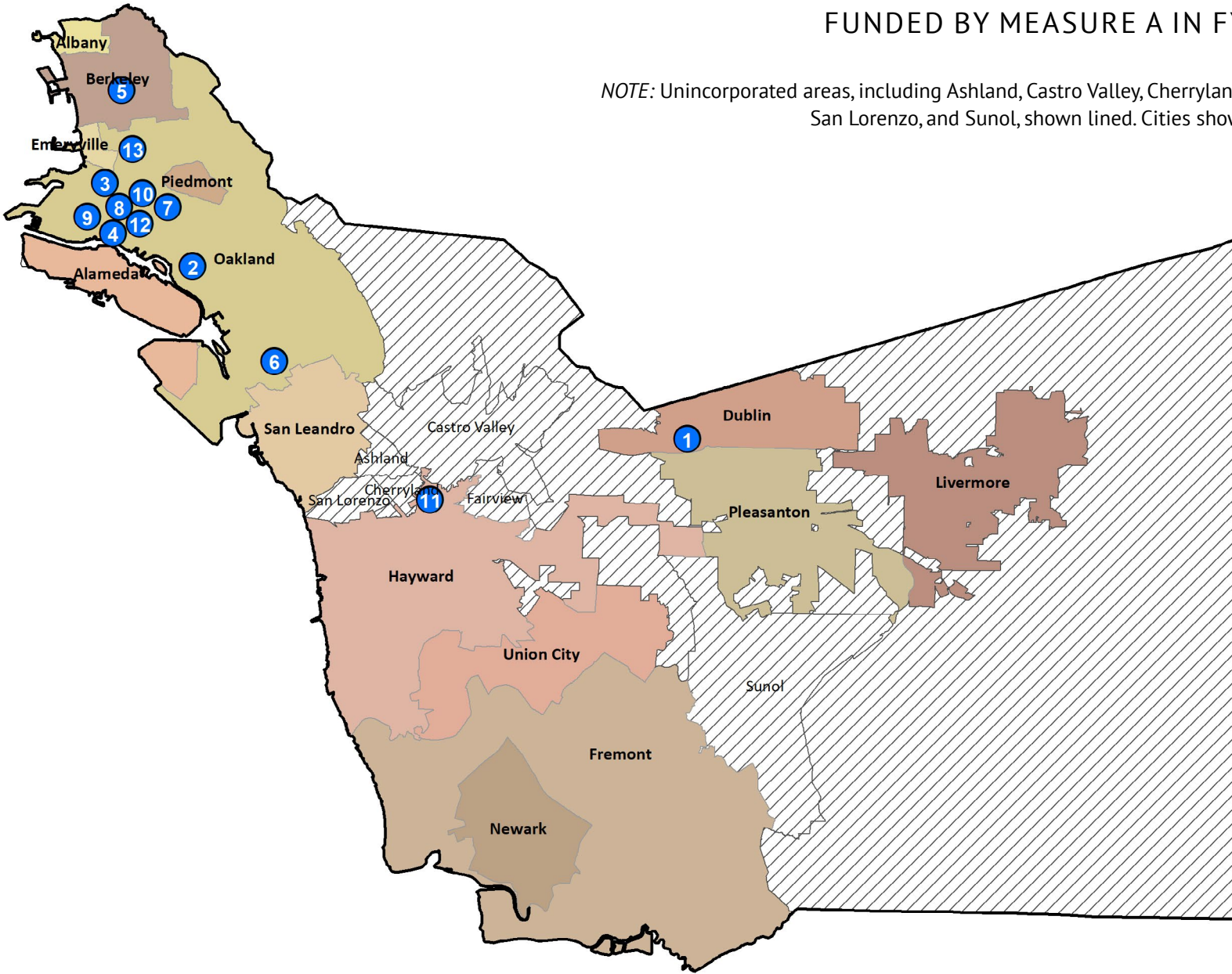
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS FUNDED BY MEASURE A IN FY 18/19

#	PROVIDER	CITY
1	Axis Community Health	Dublin
2	Brighter Beginnings	Oakland
3	California Prostitutes Education Project	Oakland
4	Center for Oral Health	Oakland
5	City of Berkeley	Berkeley
6	East Oakland Boxing Association	Oakland
7	HIV Education and Prevention Project of Alameda County	Oakland

#	PROVIDER	CITY
8	Lotus Bloom	Oakland
9	Mandela Partners (previously Mandela MarketPlace)	Oakland
10	Niroga Institute	Oakland
11	Tiburcio Vasquez Health Center	Hayward
12	Tides (Hope Collaborative)	Oakland
13	UCSF Benioff Children's Hospital Oakland	Oakland

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS
FUNDED BY MEASURE A IN FY 18/19

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



MAP 2

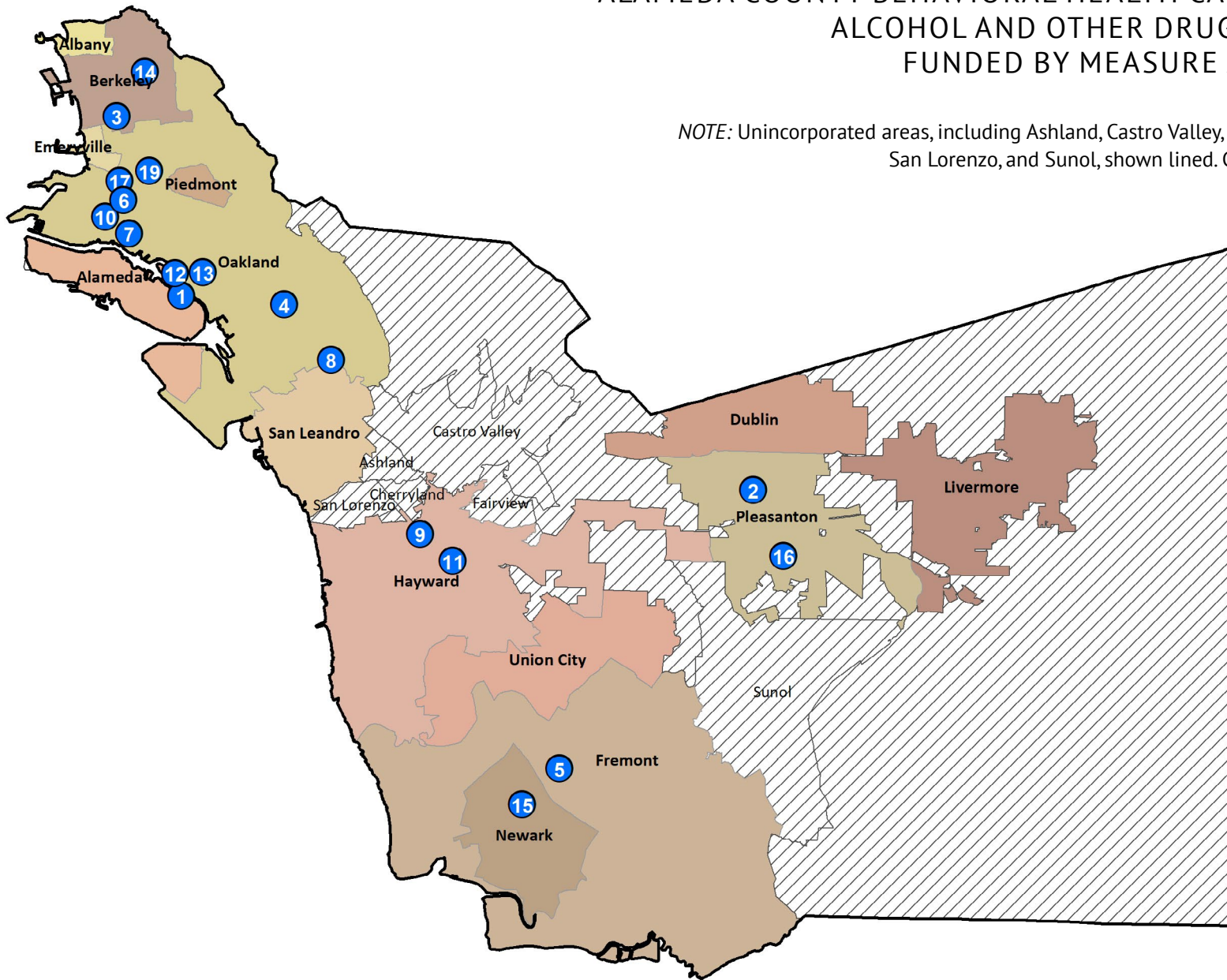
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES ALCOHOL AND OTHER DRUG PROVIDERS FUNDED BY MEASURE A IN FY 18/19

#	PROVIDER	CITY
1	Alameda Family Services	Alameda
2	Axis Community Health, Inc.	Pleasanton
3	Berkeley Addiction Treatment Services, Inc.	Berkeley
4	Bi-Bett Corporation	Oakland
5	Carnales Unidos Reformando Adictos	Fremont
6	East Bay Community Recovery Project (LifeLong)	Oakland
7	Filipino Advocates for Justice	Oakland
8	Humanistic Alternatives to Addiction, Research, and Treatment	Oakland
9	Horizon Services, Inc.	Hayward
10	Institute For the Advanced Study of Black Family Life & Culture, Inc.	Oakland

#	PROVIDER	CITY
11	La Familia Counseling Services	Hayward
12	Magnolia Women's Recovery Programs, Inc.	Oakland
13	Native American Health Center, Inc.	Oakland
14	New Bridge Foundation, Inc.	Berkeley
15	Second Chance, Inc.	Newark
16	Senior Support Program of the Tri-Valley	Pleasanton
17	St. Mary's Center	Oakland
18	Uplift Family Services (formerly EMQ Families First)	Campbell
19	Thunder Road (Bay Area Community Services)	Oakland

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
ALCOHOL AND OTHER DRUG PROVIDERS
FUNDED BY MEASURE A IN FY 18/19

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

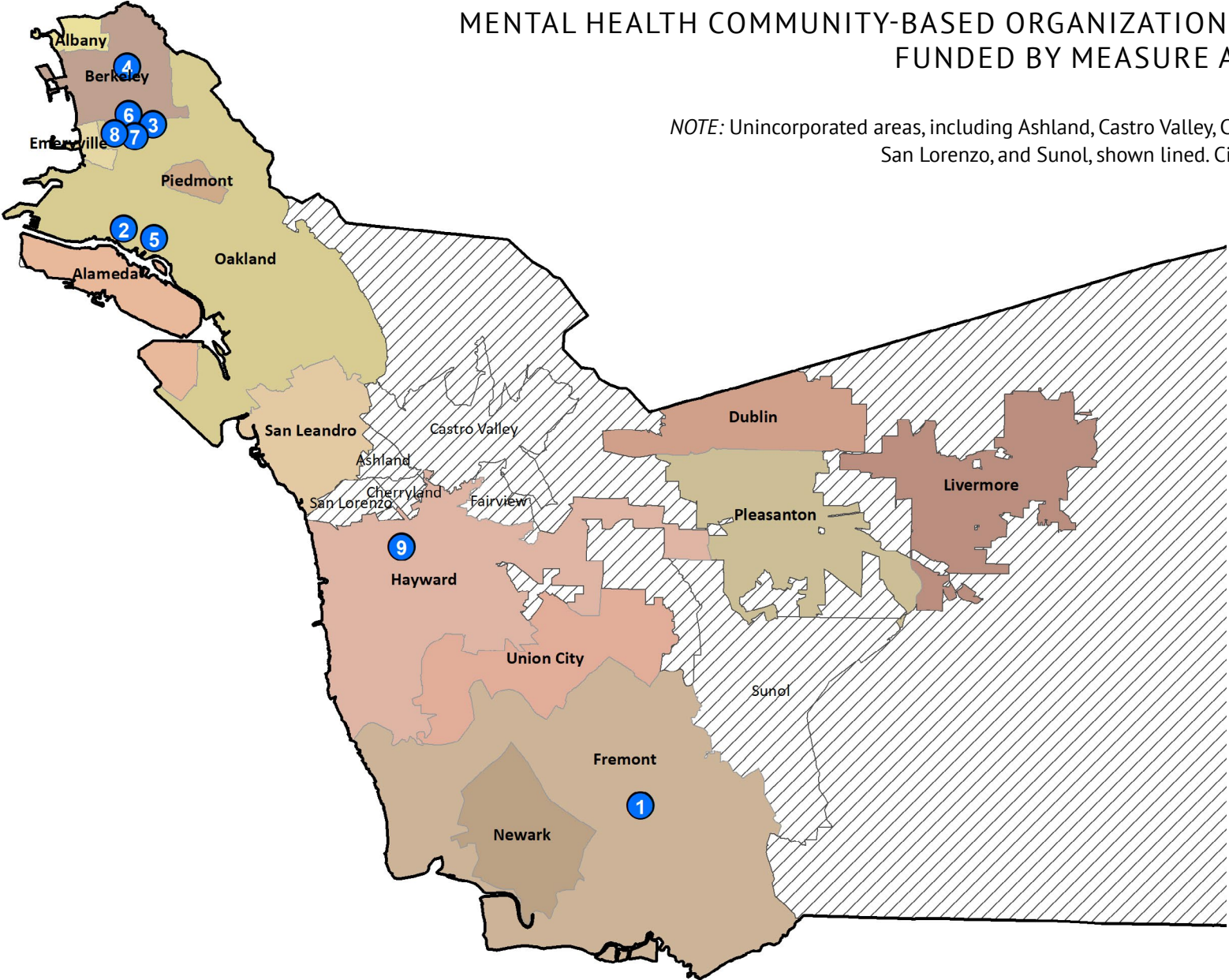


MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 18/19

#	PROVIDER	CITY
1	Abode Services, Inc.	Fremont
2	Asian Health Services	Oakland
3	Bonita House, Inc.	Oakland
4	Building Opportunities for Self Sufficiency	Berkeley
5	Center for Empowering Refugees and Immigrants	Oakland
6	Center for Independent Living	Berkeley
7	Crisis Support Services of Alameda County	Oakland
8	Mental Health Association of Alameda County	Oakland
9	Southern Alameda County Committee for Raza (La Familia Counseling Services)	Hayward

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS FUNDED BY MEASURE A IN FY 18/19

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



MAP 4

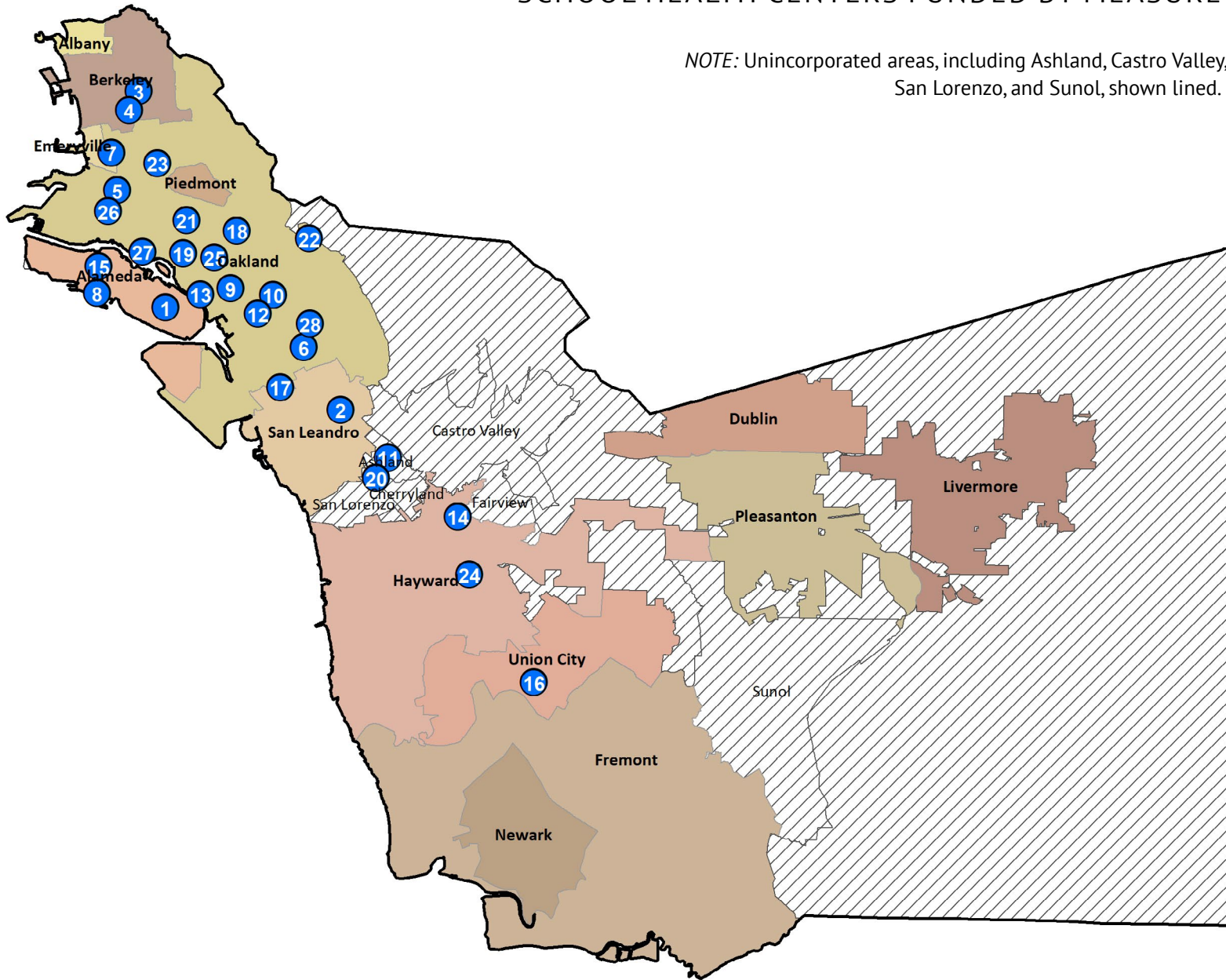
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 18/19

#	PROVIDER	CITY
1	Alameda High SHC	Alameda
2	San Leandro High	San Leandro
3	Berkeley High SHC	Berkeley
4	BTA Health Center	Berkeley
5	Chappell Hayes–McClymonds High	Oakland
6	Elmhurst/Alliance SHC	Oakland
7	Emery SHC	Emeryville
8	Encinal High SHC	Alameda
9	Fremont Tiger Clinic	Oakland
10	Frick Health Center	Oakland
11	Fuente–REACH AYC	San Leandro
12	Havenscourt	Oakland
13	Hawthorne	Oakland
14	Hayward High	Hayward

#	PROVIDER	CITY
15	Island Health & Wellness Center	Alameda
16	Logan High SHC	Union City
17	Madison SHC	Oakland
18	Rising Harte	Oakland
19	Roosevelt Middle	Oakland
20	San Lorenzo SHC	San Lorenzo
21	Shop 55 Oakland High	Oakland
22	Skyline High SHC	Oakland
23	TechniClinic	Oakland
24	Tennyson SHC	Hayward
25	United for Success/Life Academy	Oakland
26	West Oakland Middle SHC	Oakland
27	Youth Heart	Oakland
28	Youth Uprising	Oakland

SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 18/19

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 18/19

#	CITY	#	CITY
Alameda Health System <i>(site locations listed below)</i>			
1	Alameda Hospital	Alameda	
2	Eastmont Wellness	Oakland	
3	Fairmont Hospital	San Leandro	
4	Hayward Wellness	Hayward	
5	Highland Hospital	Oakland	
6	John George Psychiatric Pavilion	San Leandro	
7	Newark Wellness	Newark	
8	San Leandro Hospital	San Leandro	
Asian Health Services <i>(site locations listed below)</i>			
9	Asian Medical Center	Oakland	
10	Frank Kiang Medical Center	Oakland	
12	Rolland & Kathryn Lowe Medical Center	Oakland	
Axis Community Health <i>(site locations listed below)</i>			
12	Axis Community Health - Hacienda	Pleasanton	
13	Axis Community Health - Livermore	Livermore	
14	Axis Community Health - Pleasanton	Pleasanton	
Davis Street Community Center Inc			
15	Davis Street Family Resource Center	San Leandro	
La Clinica de la Raza <i>(site locations listed below)</i>			
16	Clinica Alta Vista	Oakland	
17	San Antonio Neighborhood Health Center	Oakland	
18	Transit Village	Oakland	
LifeLong Medical Care <i>(site locations listed below)</i>			
19	Ashby Health Center	Berkeley	
20	Downtown Oakland Clinic	Oakland	
21	Howard Daniel Clinic	Oakland	
22	LifeLong Medical Care-East Oakland	Oakland	
23	Over 60 Health Center	Berkeley	
24	West Berkeley Family Practice	Berkeley	
Native American Health Center			
25	Seven Directions	Oakland	
St. Rose Hospital			
26	St. Rose Hospital (ER/IP)	Hayward	
Tiburcio Vasquez Health Center <i>(site locations listed below)</i>			
27	Tiburcio Vasquez Firehouse Clinic	Hayward	
28	Tiburcio Vasquez Hayward	Hayward	
29	Tiburcio Vasquez San Leandro	San Leandro	
30	Tiburcio Vasquez Silva Clinic	Hayward	
31	Tiburcio Vasquez Union City	Union City	
Tri-City Health Center <i>(site locations listed below)</i>			
32	Tri-City Health Center - Irvington	Fremont	
33	Tri City Health Center - Liberty	Fremont	
34	Tri City Health Center - Main Street	Fremont	
35	Tri City Health Center - Mowry I	Fremont	
36	Tri City Health Center - Mowry II	Fremont	
37	Tri City Health Center - State	Fremont	
West Oakland Health Center <i>(site locations listed below)</i>			
38	Albert J. Thomas Medical Clinic	Oakland	
39	East Oakland Health Center	Oakland	
40	West Oakland Health Center	Oakland	
41	William Byron Rumford Medical Center	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).

HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 18/19

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