

Measure A

Essential Health Care Services Tax Ordinance



**MEASURE A CITIZEN OVERSIGHT COMMITTEE
14TH REPORT TO THE ALAMEDA COUNTY
BOARD OF SUPERVISORS AND THE PUBLIC**

Review of Expenditures

July 1, 2019 – June 30, 2020

Measure A — Health Care for All

MEASURE A

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Fiscal Year (FY) 2019/2020
July 1, 2019 – June 30, 2020**

PHOTO CREDITS

Clockwise from top left: LIFE ElderCare; Health Services for Day Laborers: Multicultural Institute; Alameda Boys & Girls Club, Inc.; Health Services for Day Laborers: Street Level Health Project; HERS Breast Cancer Foundation; Alameda Boys & Girls Club, Inc.

Page 7 (L to R): Family Paths; Tiburcio Vasquez Health Center, Inc.; Drivers for Survivors; Health Services for Day Laborers: Street Level Health Project; Alameda Boys & Girls Club, Inc.

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MEASURE A CITIZEN OVERSIGHT COMMITTEE MEMBERS

The Measure A ordinance established a Citizen Oversight Committee, which consists of 17 members appointed by the Alameda County Board of Supervisors (Board), to annually review the expenditures for the prior year and report to the Board on the conformity of the expenditures to the ordinance. The Committee develops, publishes, and presents a final report, based on individual reports submitted by fund recipients at the end of each year, to the Board. Each nominating agency is responsible for appointing a new member to any current vacancy. For more information about the Measure A Citizen Oversight Committee, please contact the Alameda County Health Care Services Agency at MeasureA@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	Ann E. Maris, PhD	Alameda County Taxpayers Association, Inc.
Seat 4	(vacant)	Alameda County Mental Health Board
Seat 5	Nestor Castillo	Alameda County Public Health Commission
Seat 6	(vacant)	Alameda Central Labor Council
Seat 7	Rachel Richman	Alameda Central Labor Council
Seat 8	Rebecca Rozen	Hospital Council of Northern & Central California
Seat 9	Frank Staggers Jr., M.D.	Alameda-Contra Costa Medical Association
Seat 10	Colin Arnold	City of Berkeley
Seat 11	Christine Martin	City Managers' Association
Seat 12	Kelly McAdoo	City Managers' Association
Seat 13	Michael McCorriston	District 1 Supervisor David Haubert
Seat 14	(vacant)	District 2 Supervisor Richard Valle
Seat 15	Charles Go, Ph.D.	District 3 Supervisor Dave Brown
Seat 16	Linda Tangren	District 4 Supervisor Nate Miley
Seat 17	(vacant)	District 5 Supervisor Keith Carson

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY STAFF

Colleen Chawla, *Agency Director*

Kristel Acacio, *Finance Director*

James Nguyen, *Administrative & Financial Services Manager*

Tamara Lawson, *Program Financial Specialist*

Justine Eclipse, *Secretary*



FY 2019/2020 Measure A Executive Summary

(July 1, 2019 – June 30, 2020)

History of Measure A

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

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.



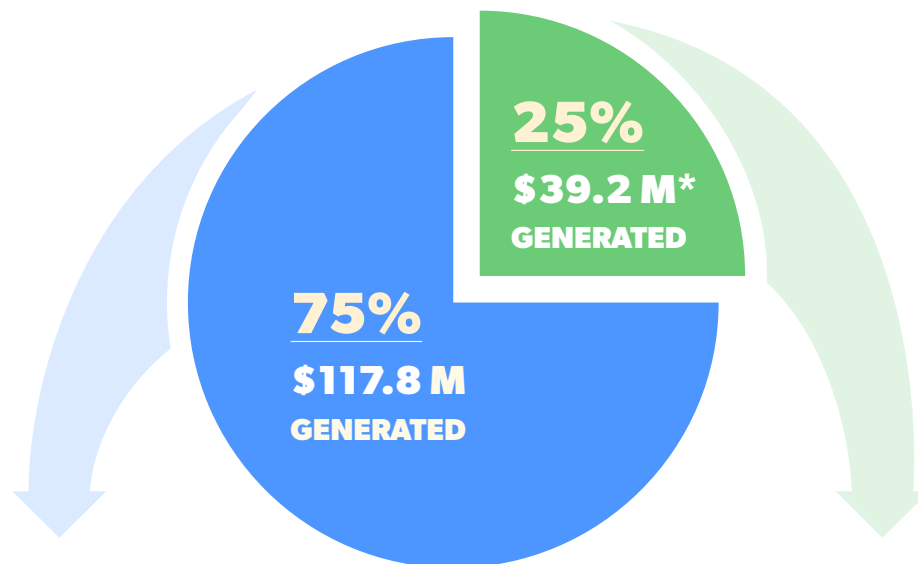
Overall Conclusion

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.

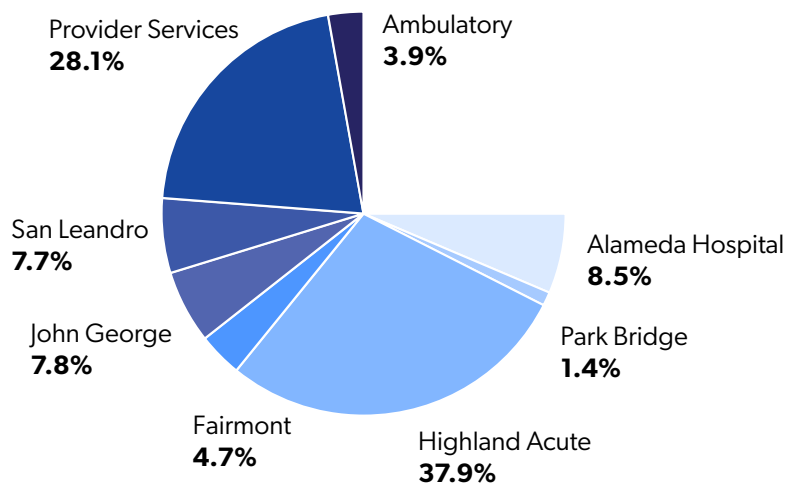
Revenue & Expenditures: At a Glance

Of the \$157,068,735* that Measure A generated in FY 19/20, 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.

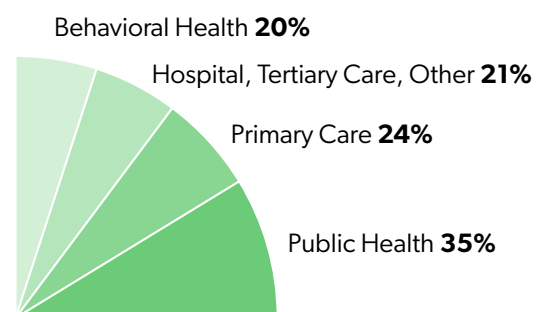
DISTRIBUTION OF MEASURE A FUNDS



\$117.8 M Allocation of Measure A Funds to Alameda Health System



\$39.2 M Allocation of Measure A Funds Approved by the Board of Supervisors**



* Does not include interest earned.

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

Highlights

Since the full implementation of the Affordable Care Act in 2014, more than 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 80,779 individuals, or 4.9% of County residents, remain uninsured, according to the American Community Survey estimates for 2020. (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.

Moreover, the novel coronavirus (COVID-19) pandemic, which began in December 2019, has disproportionately impacted vulnerable populations in Alameda County, including older adults and seniors, persons experiencing homelessness, and communities of color. Collectively, many of the community-based organizations, health care providers, County agencies, and school and city partners funded by Measure A responded to the pandemic to expand COVID-19 testing and contact tracing; support shelter-in-place, isolation, quarantine, and protective measures, especially for high risk groups; and participate in other countywide responses to address the needs of marginalized communities most impacted by the pandemic.

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.

Touching the Lives of Many...

Even in the face of COVID-19, many Measure A providers continued to serve large numbers of County residents. For example, the 75% of Measure A tax revenues that supports AHS enabled them to provide services to 119,276 patients in FY 19/20. Providers under the Public Health Prevention Initiative served a cumulative total of 36,916 County residents through Measure A, while the member agencies of the Primary Care Community-Based Organizations served 15,082 residents.



AHS served over **119,276**
County residents through
Measure A in FY 19/20,
while the Alameda County
Public Health Department
Public Health Prevention
Initiative served over
36,916.



Alameda Boys & Girls Club



Home Visiting Services



...And Covering the Wide Variety of County Residents

The extent of Measure A's reach is reflected in more than numbers alone. Measure A funding supports providers throughout the County, in every Supervisory district stretching from Berkeley to Fremont to Livermore. Some funding recipients offer services to the general population, while others focus on resident subgroups, including seniors, youth, the unhoused, the incarcerated, and those struggling with substance use. And an increasing number of providers offer services in the County's wide array of languages—beyond English and Spanish, these include Cantonese, Farsi, Mandarin, Punjabi, Tagalog, and Vietnamese, among many others.



Achieving and Exceeding Goals

Measure A funding recipients typically met, and often exceeded, their targets for service delivery. For example, La Familia provided free food to 1,624 low income families during 150 distribution events, compared to a target of 150 families at 20 events. Similarly, the Healthy Food Healthy Families: Alameda County Deputy Sheriffs' Activities League had 5,547 "food prescriptions" redeemed at their Food as Rx Clinic, compared to a target of 1,500. And the LifeLong Medical Care Heart 2 Heart (H2H) program served 2,899 community members at community health events, compared to a target of 100—an increase of almost 2,900%.



Pivoting to Meet COVID-19 Challenges

In response to the unprecedented challenges presented by the COVID-19 pandemic, Measure A recipients showed an impressive ability to adapt so as to continue serving the community. Providers who typically offer in-person physical and mental health services quickly shifted to telehealth, including phone- and video-based contacts. Among these providers were UCSF Benioff Children's Hospital Oakland, Tiburcio Vasquez Health Center, and the Countywide Plan for Seniors: Getting the Most Out of Life advance care directive program. The Unity Council: Latino Men and Boys Program offered virtual job readiness training. In-person classes such as those offered for fall prevention by the Senior Injury Prevention Program partners or mindfulness by Niroga Institute were made available online. Some programs such as La Familia Counseling Services began conducting at-home and outdoor visits. The City of San Leandro and Spectrum Community Services, Inc., shifted their onsite meal programs to pickup and delivery, among many other providers who added or increased the capacity of their meal services. Many providers also added distribution of PPE, hand sanitizer, and related supplies to their service delivery. Through two allocations, the Alameda County Office of Homeless Care and Coordination (OHCC), in coordination with HCSA, supported housing of displaced persons due to the pandemic.



Health Services for Day Laborers
Street Level Health



Addressing the Whole Person

Beyond physical health, many Measure A recipients focused on mental and behavioral health issues with programs that support improved outcomes in personal and social development for clients ranging from youth to seniors. Through the Center for Healthy Schools and Communities (CHSC) School-Based Behavioral Health Initiative, 92% of clients agreed or strongly agreed that the school-based health center helped them deal with stress and anxiety better, while 85% of Mental Health Services for Newcomers and Immigrants (CERI) clients who received a referral to mental health treatment services were successfully connected to services.



Making a Measurable Impact

Recipient surveys reveal a high level of satisfaction with Measure A-funded services. At St. Rose Hospital (SRH), the patient satisfaction score for the overall hospital rating increased 6.4 points from the preceding year to 74.8. At Roots Community Health Center, 100% of clients reported high satisfaction with the program, improved health status, and improved management of their health conditions.



Increasing Knowledge to Support Better Outcomes

More than just addressing existing health issues, many Measure A providers focus on knowledge and education as a way to prevent health and life crises before they occur. Eden Youth and Family Center provided youth with individual or group life skills training that covered health, wellness, drug prevention, and nutrition information to increase their knowledge of maintaining a healthy lifestyle. At Safe Alternatives to Violent Environments (SAVE), 100% of clients reported increased knowledge of community resources. And 82% of HIV Education and Prevention Project of Alameda County (HEPPAC) wound care services participants increased their knowledge of vein rotation and safer injection techniques.

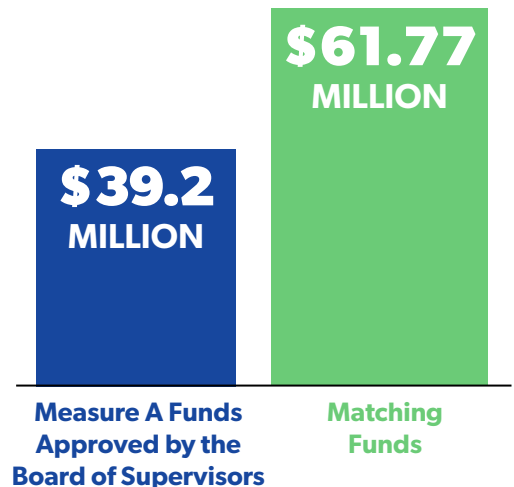


Generating Additional Funds

Many Measure A recipients leveraged their allocations to receive additional funds from other sources. Over 40% of recipients leveraged their Measure A allocation to obtain matching funds from government programs, private and public foundations, and individuals. These matching funds often represented a more-than-50% return on the allocation, and sometimes exceeded 100%. The CHSC School-Based Behavioral Health Initiative received a return of over 300% in matching funds, Healthy Food Healthy Families: Alameda County Deputy Sheriffs' Activities League nearly 750%, and the Center for Healthy Schools and Communities (School Health Centers) over 900%.



Medical Costs for Juvenile Justice Center
Niroga Institute





Center for Healthy Schools and Communities



Seeding Innovative Programs and Services

In addition to the COVID-specific pivots mentioned above, Measure A funds continued to provide a foundation for innovation in health care among County providers. These ranged from the Countywide Plan for Seniors Injury Prevention & Nutrition Services' community gardening program in low income senior housing to a peer-to-peer mentoring program implemented on a middle and high school campus through the CHCS School-Based Behavioral Health Initiative. In addition, CHSC began rollout of new data collection tools to better capture results-based metrics of both the direct services and systems support work that the organization provides, while through Alameda County Behavioral Health Care Services, the Center Point Substance Use Disorder Helpline initiated new procedures to manage its pending services list for residential treatment and started a three-way call appointment-setting procedure with providers and callers.

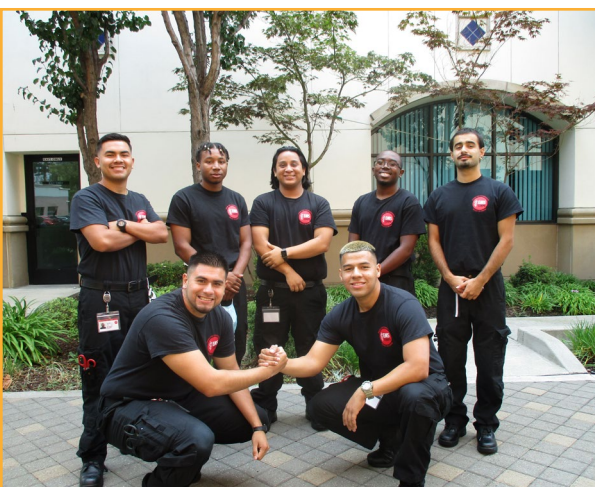
General Concerns and Recommendations

In developing this report, the Oversight Committee identified several concerns regarding the state of health care funding both during the years of Measure A implementation (2004-2019) 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



Emergency Medical Services (EMS) Corp

in primary and preventive care. In addition, the public health system, which has experienced long-term underfunding, requires additional resources to build a strong and qualified workforce and modern data and information systems to deliver essential public health services. 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.

The COVID-19 pandemic has had a profound negative impact on the mental health and well-being of people, with increasing numbers of people experiencing anxiety, depression, loneliness, and other mental health concerns. Furthermore, the increased isolation as a result of the shelter-in-place and social distancing measures highlighted the critical ways natural, social, and built environments affect mental health and the need for more clean and healthy outdoor spaces, particularly in urban Alameda County.

Note: The Committee believes it is important to present any concerns it noticed while reviewing Measure A recipient reports. At the same time, the Committee wants to make clear that raising a concern does not necessarily mean that a problem exists with a recipient's use of Measure A funds. For example, the concern might arise because of incomplete or inaccurate reporting, not because of any inappropriate use of funds.

Insufficient Reporting

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 questions posed by the Committee to 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 were not measurable, and many stated positive outcomes that were not supported with quantifiable data.

RECOMMENDATIONS

- HCSA should receive continued 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.
- Organizations that do not provide adequate information may not be considered for future funding.



Public Health Prevention Initiative



LifeLong Medical Care (Heart 2 Heart)



Health Services for Day Laborer
Multicultural Institute

Economic Impacts from COVID-19

While the U.S. economy has had more than eight years of growth following the Great Recession, the COVID-19 pandemic could continue to affect the global and local economy as a result of production and supply chain slowdowns and financial market disruptions, 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.

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.

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 19/20, Measure A generated \$157,068,735 (not including interest earned). The funds were allocated as follows:

Alameda Health System (75%): \$117,801,551

Alameda County (non-AHS) (25%): \$39,267,184

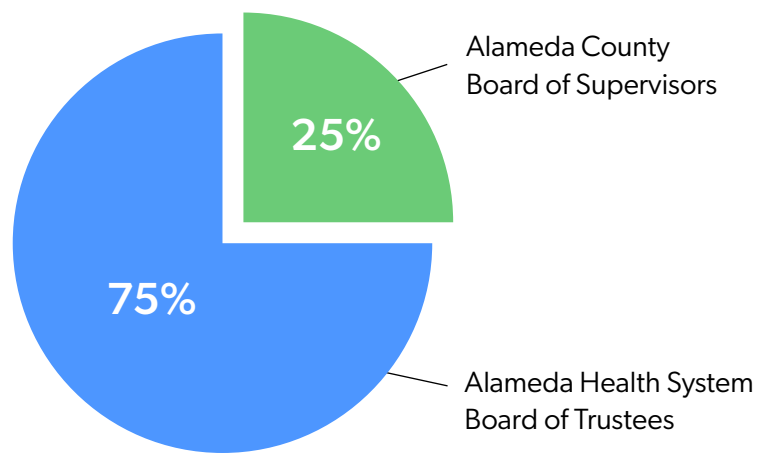
TOTAL: \$157,068,735

In FY 19/20, the Alameda County approved budget totaled \$3.5 billion. The Alameda County Health Care Services Agency* approved budget totaled \$927 million, or 26.2% of the total County budget. Measure A revenues not specifically designated for AHS accounted for \$38,004,832, 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 19/20, which includes revenue generated in the reporting year as well as unspent funds earned in previous years.

DISTRIBUTION OF MEASURE A ALLOCATIONS





FY 19/20: 75% of Measure A Funds Allocated to Alameda Health System

alamedahealthsystem.org



FY 19/20 Allocation: \$118,001,551 | Expended/Encumbered: \$118,001,551



Individuals served by Measure A: 119,276 (Total individuals served: 119,276)



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 the median time from decision to admit to inpatient bed at the Highland Hospital Emergency Department (ED). This not only reduces congestion in the ED but also improves quality of care and patient satisfaction, can decrease the number of patients leaving without being seen, and minimizes exposures to COVID-19 and other infectious diseases in waiting areas.
- **Quality:** Decrease hospital-acquired infections and harms. This 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. This partnership ensures helps ensure that patients reach prior levels of function with effective home health care.



Matching Funds

\$30 M

through an **Intergovernmental Transfer**.

- **Workforce Development:** Reduce workplace injury. The ability to provide a safe environment for staff and volunteers is not only a priority for the health of employees but also essential to providing high quality patient care.

In response to COVID-19, AHS successfully implemented telemedicine and other patient-focused technology. In a just a few weeks, AHS doubled the number of remote visits. Telephone and video visits led to an improved patient experience that included ambulatory telephone visits, ambulatory video, behavioral health visits, and resident-to-visitor skilled nursing home visits. To further leverage technology and to ensure equity, teams also built an online classroom to prepare and share best practices with patients and clinicians.

AHS also erected fully operational COVID-19 triage tents in their hospital parking lots to minimize COVID-19 exposure on campuses and utilized technology to help keep patients and their families connected by use of iPads at the bedside.

Other actions AHS took in response to COVID-19 included eliminating elective surgeries to reduce risk of exposure to COVID-19 and allow for an increased census due to the COVID-19 patient surge; expediting COVID-19 lab testing for staff, patients, community members, and health care workers; providing enhanced benefits and support to the essential workforce, including child and family care, family medical leave, and isolation housing; and waiving or reducing out-of-pocket costs for employees associated with testing and treatment for COVID-19.

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 Achievements

AHS does not have programs specifically or separately supported by Measure A funds. As a result, the results below are for AHS as a whole. Its overall 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 19/20, Measure A helped AHS achieve the following across its strategic pillars.

Access

AHS decreased the time from decision to admit to inpatient bed at the Highland Hospital ED to five hours, 25 minutes (target: eight hours).

Success Story

Mr. T was hit by a car while riding a motorized skateboard. He spent ten days in the hospital and suffered multiple internal injuries that included surgery to remove his spleen. In addition, he broke several bones in his legs and had to learn to walk again with the support of many physical therapists. Mr. T credits his recovery to the trauma physicians, surgeons, nurses, physical therapists, and staff. Everyone on his care team continually checked on him and made themselves available to answer his questions. Mr. T showed his appreciation by creating and posting a video called “Thank You Highland Hospital” on his YouTube channel.

Highlights

Access

AHS exceeded its target time from decision to inpatient bed by almost three hours.

It continued multidisciplinary rounds with all medicine and surgical teams daily, added a new physician shift to increase the capacity for admission and transfer from Highland Hospital to Alameda Hospital, and efficiently responded to hospital surges.

Quality

AHS reduced the hospital-acquired infections (HAI) index to 3.20 and the number of hospital-acquired harms (HAH) per 1,000 discharges to 1.45 (targets: 6.29 and 2.22).

It continued monitoring and daily collaboration with unit staff, increased scrutiny on hand hygiene during the COVID pandemic, and conducted routine peer review of confirmed harms to share learnings across departments and divisions and improve safe patient care and the adoption of best practices.

Experience

AHS increased its HCAHPS scores for hospital ratings, with 70.1% giving a 9 or 10 rating (target: 69.2%; state average: 70%). It also increased its CGCAHPS scores for provider ratings, with 74.9% giving a 9 or 10 rating (74.29%; state average: 77%).

AHS implemented Highland Hospital's Care Champion Committees, with the goal of engaging staff, reviewing data, and improving care; Alameda Hospital's Patient Experience Committee to address service and service recovery; and No Pass Zones, an intervention that empowers all staff to respond to call lights and decrease patient waits.

It also established Greet-Introduce-For-Thank you (GIFT), a communication tool designed to help drive a culture of human connections and pivoted to virtual Ambulatory Care visits during COVID-19.

Network

AHS decreased the rehospitalization rate for home health patients within 30 days to 7.94% (target: 14.4%).

The Care Management and Social Services teams continued facilitating patient transfers to home health and conducted monthly joint operations meetings to review metrics and performance issues. They also proactively monitored patients to predict potential declines in health and ensure interventions were put in place immediately to prevent a readmit.

Workforce Development

AHS reduced the number of workplace injuries occurring during the year to 234 (target: 252), with 6.4 work-related injuries and illnesses for every 100 full-time employees (national average: 6.8).

Highlights

Quality

The HAI index decreased by over 54% and HAH by nearly 35%.

It revised its Injury Illness and Prevention Plan (IIPP) to focus on management, leadership, employee protection, hazard identification and assessment, hazard prevention and control, education and training, and program evaluation/improvement. AHS also held monthly meetings with departments exhibiting high claim rates to review claims and discuss potential workplace safety measures, had ergonomic vendors complete over 300 preventative ergonomic evaluations, and established a Workplace Violence Prevention program covering risk assessment, reporting/recording obligations, incident response and investigation, and training.

Highlights

Network

AHS exceeded its target rate for rehospitalizations by almost 50%.

Workforce Development

Since FY 14/15, the AHS injury rate per 100 full-time employees has dropped from 9.7 to 6.2.

BEHAVIORAL HEALTH

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Behavioral Health and Alcohol and Other Drug Community-Based Providers

www.acbhcs.org



FY 19/20 Allocation: \$150,000 | Expended/Encumbered: \$150,000



Individuals served by Measure A: 26,361 (Total individuals served: 26,361)



Populations served: Indigent Adults, Families, Seniors



Services provided: Mental Health, Substance Abuse



Service area: Countywide

Background

Alameda County Behavioral Health Care Services (BHCS) works to maximize the recovery, resilience, and wellness of all eligible Alameda County residents who are developing or experience serious mental health, alcohol, or drug concerns. Community-based organizations (CBOs) provide mental health services under contract with BHCS to meet the diverse cultural and language needs of County resident populations.

In response to the COVID-19 pandemic, all teams secured PPE for their staff and consumers as well as provided information around safety during the health crisis. In addition, the County moved many meetings and collaborations to virtual, enabling quick sharing of information and health orders updates.

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

Measure A Funding Achievements

Measure A funding helped BHCS providers achieve the following:

- La Familia Adult Service Team provided 3,560 service hours and 802 medication support hours to 119 unique clients, with an average monthly caseload of 85 clients (target: 5,320 service hours and 875 medication support hours to 150 clients, with an average monthly caseload of 112 clients).
- Mental Health Association of Alameda County (MHAAC) Family Caregiver provided 849 service hours and responded to 973 questions from family caregivers and consumers (target: 1,026 service hours and 3,600 questions).



Matching Funds

\$150,000

from Medi-Cal.



Highlights

57%

57% of ABODE HOPE clients received at least **one non-cash benefit such as WIC, CalFresh, CalWORKs, child care, or transportation** (target: 30%).

- MHAAC Certification Hearing Representation Program provided 10,570 service hours; interviewed 5,624 certified patients; and attended 4,772 certification review hearings (target: 5,465 service hours; 2,000–4,000 interviews; and 2,000–4,000 hearings).
- Patient’s Right Advocacy Program provided 3,919 service hours and responded to 10,270 calls (target: 2,722 service hours and 900–1,200 calls).
- ABODE Homeless Outreach for People Empowerment (HOPE) provided 4,207 service hours to 2,606 outreach contacts (target: 5,594 service hours to 3,600 contacts).

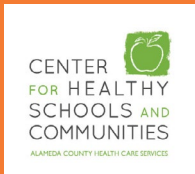
★ Highlights

89.5%

89.5% of ABODE HOPE clients

accessed health insurance

(target: 70%).



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

achealthyschools.org

-  **FY 19/20 Allocation: \$1,333,336 | Expended/Encumbered: \$1,333,336**
-  **Individuals served by Measure A:** 17,585 (Total individuals served: 17,585)
-  **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 care 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 support 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 a 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 in 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. In response to the global COVID-19



Matching Funds

\$4.2 M

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

pandemic and countywide shelter-in-place mandate, DHWCs and SBCCs quickly pivoted to support Alameda County families.

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 Achievements

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

- Refer 5,189 students to Early Intervention Behavioral Health services, of whom 71% were connected to services
- Refer 5,748 students to Treatment services, of whom 65% were connected to services
- Provide 20,647 hours of treatment services
- Implement the Coordination of Service Team (COST) program at 268 schools in 14 school districts (target: 250 schools in 14 districts)
- Refer 17,585 students to COST services
- Have DHWCs provide:
 - 431 hours of capacity-building trainings and consultations to school districts and staff and 66 hours to parents and caregivers to support the behavioral, social, and emotional health of young people
 - 2,453 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
 - 2,559 hours of coaching and consultation
- Through the SBCCs, develop and implement a peer-to-peer mentoring program on a middle/high school campus focused on promoting behavioral, academic, and community engagement skills and training and teaching 55 high school mentors who served 86 middle school students and offered activities twice a week for the entire middle school of 400 students



Success Story

After his father died in China, a senior student was living in a small studio with his mother. When she passed away due to cancer, the student was fending for himself. The student's teacher referred him to COST, and the team immediately went into action to get him food, gift cards, telehealth support, and connection with an older sibling in the Bay Area. The COST team checked in with the student regularly and met him at his diploma pick-up to make sure he received a graduation picture and felt celebrated. His guidance counselor also connected him with the Student Health Center at the university he began attending in the fall.

Cherry Hill Detox and Sobering Station

 **FY 19/20 Allocation: \$2,295,875 | Expended/Encumbered: \$2,295,875**

 **Individuals served by Measure A:** 7,934 (Total individuals served: 7,934)

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

 **Services provided:** Substance Abuse

 **Service area:** Countywide, Homeless or Transient, Outside of Alameda County

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.

Measure A funds allow Cherry Hill to provide medical triage to address clients' physical health as well as their sobering and detox needs. In response to the COVID-19 pandemic, medical staff offered the option of telehealth appointments to meet client health and medication needs. Medical staff were also trained by the Alameda County Public Health Department to provide COVID-19 testing onsite at the Sobering Center.

The Detoxification and Sobering Centers provide a safe place for addicted and alcoholic individuals to come and receive life-saving services such as health stabilization, medication-assisted therapy, and withdrawal management. Cherry Hill offers services in English, Spanish, and Tagalog and partners with Alameda County Behavioral Health Care Services for additional interpreter services.



Matching Funds

\$1.78 M

from **Whole Person Care, Drug Medi-Cal (DMC)**, and the **Substance Abuse Prevention and Treatment Block Grant (SABG)** program.



Highlights

100%

100% of discharged clients were **referred to residential treatment, outpatient, or community support services** (target: 90%).

Measure A Funding Achievements

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

- Provide detoxification services to 2,129 individuals (target: 2,094)
- Maintain a daily occupancy of 22.79 residents at the Detoxification Center (target: 27)
- Provide a total annual bed day service capacity of 8,911 (target: 8,377)
- Admit 20.38 clients each day for sobering services (target: 20)

★ Highlights

92%

92% 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 19/20 Allocation: \$4,307,599 | Expended/Encumbered: \$4,307,599**

 **Individuals served by Measure A:** 3,925 (Total individuals served: 3,925)

 **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 develop or are experiencing 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. Providing supportive mental health services helps decrease the risk for mental health/psychiatric decompensation, including suicide and self-harm, as well as dangerous behavior towards others. AFBH assesses clients for emergency psychiatric holds, refers clients to John George Psychiatric Hospital for treatment when needed, and helps connect clients to treatment in the community when they are released from jail.

AFBH provided a full range of mental health services to incarcerated clients at Santa Rita Jail, despite significant challenges presented by COVID-19, including a mass release of inmates at the beginning of the pandemic. AFBH coordinated discharge planning efforts to ensure that mental health clients being released would be offered specialized services and resources to help prevent homelessness and other high risk outcomes.

AFBH ensured its staff had a full spectrum of PPE, met with staff regularly to address their questions around safety, coordinated onsite COVID testing, and added telehealth as an alternative to in-person visits. AFBH also developed educational materials about COVID for a wide range of learning abilities and languages.

In FY 19/20, AFBH also began a relationship with the Safe Landing Center, who provide reentry support services from a trailer in the Santa Rita Jail parking lot. AFBH staff worked closely with Safe Landing staff to ensure collaboration around discharge planning and referrals, and trained staff

Success Story

After a stay at Napa State Hospital, Mr. D was transported to Santa Rita Jail to await a court hearing. AFBH staff connected him to a forensic Full Service Partnership (FSP), which provides intensive outpatient care to people in the criminal justice system. AFBH staff requested Mr. D's bloodwork and records from Napa, completed the paperwork recommending conservatorship, and worked with community partners to ensure Mr. D would be connected to services after his hearing. When Mr. D was released, the forensic FSP helped him find temporary housing. Currently, Mr. D lives in supportive aggregate housing, is no longer conserved, and receives services to support his mental health recovery.

how to determine whether a client was exposed to COVID on their housing unit at the jail.

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

Measure A Funding Achievements

AFBH used its Measure A allocation to achieve the following:

- Provide 24-hour, seven-day-per-week in-person clinical staffing at the jail
- Each month, provide an average of:
 - 1,696 hours of mental health services to 959 individuals (target: 1,500 hours)
 - 144 hours of crisis intervention services (target: 100)
- Be available to Sheriff's Department and medical staff either on call or in person 24 hours daily, seven days per week 100% of the time for consult regarding mental health needs, crises, and services in the jail (target: 100%)
- Each month, complete an average of:
 - 301 new mental health and substance abuse disorder assessments (target: 275)
 - 579 face-to-face medication evaluations (target: 550)
 - 270 non-face-to-face medication supportive services (target: 250)

★ Highlights

100%

100% of individuals in crisis **received follow-up treatment**, including **referral for acute psychiatric hospital services** for those who met 5150 criteria (target: 100%).



La Familia Counseling Services (Glad Tidings)

lafamiliacounseling.org

\$ FY 19/20 Allocation: \$272,391* | Expended/Encumbered: \$272,391

Individuals served by Measure A: 914 (Total individuals served: 914)

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

Services provided: Public Health, Mental Health, Substance Abuse

Service area: Castro Valley, 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.

In response to the COVID-19 pandemic, La Familia transitioned to virtual services and performing outreach to and connecting with clients via teletherapy. In addition, they provided warm meals once a week in conjunction with Mandela Market and another community business.

Services are provided to clients in English and Spanish.



Measure A Funding Achievements

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

- Provide one-on-one and family behavioral health services to 21 individuals and families (target: 29)
- Conduct four one-on-one intensive case management services, excluding behavioral health services (target: seven)
- Conduct 12 psycho-education workshops and/or support groups in relation to wellness (target: 12)
- Conduct outreach, information, and referrals to basic needs and services to 225 participants (target: 250)
- Refer:
 - 111 workshop/support group participants to the Family Resource Center (target: 248)
 - 131 participants to the Glad Tidings site (target: 248)
 - 149 participants to other community-based organizations (target: 248)

★ Highlights

93%

93% of participants reported **improved life skills, social/emotional well-being, and community and school connectedness** (target: 80%).

Mental Health Services for Juvenile Justice Center

 **FY 19/20 Allocation: \$360,000 | Expended/Encumbered: \$360,000**

 **Individuals served by Measure A:** 66 (Total individuals served: 491)

 **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 are experiencing serious mental health, alcohol, or drug concerns.

In FY 19/20, the JJC Guidance Clinic successfully implemented several major improvements to mental health services for youth detained at the JJC:

- Enhanced screening. The Guidance Clinic partnered with the JJC medical clinic to implement a screening tool to be administered to all youth upon being booked into the JJC. The screening tool assess youth risk for depression, self-harm, and suicide. Youths determined to be at-risk receive a more thorough mental health assessment and a treatment or safety plan as needed.
- Improved care planning: Guidance Clinic clinicians, psychiatrists, and manager now participate in weekly JJC care coordination meetings to cross-share information with Probation staff to better serve and support youth with ongoing mental health needs. This process also provides important information to the Guidance Clinic staff member who works in the JJC Transition Center (JJC TC) and conducts referrals upon release/reentry.
- Increased supports. Youth who require ongoing mental health supports have increased and documented treatment/support plans that are shared with JJC partners. These plans identify a youth's needs, triggers, coping mechanisms, and recommended supports and are used to avoid unnecessary confrontations, crises, or hospitalizations.

The Guidance Clinic and JJC Medical clinic also implemented the Patient Health Questionnaire to improve the identification and referral process for youth in crisis. This provides JJC a process for early identification of youth who are at risk for harming themselves, which triggers a referral to a behavioral health clinician. In addition, the Guidance Clinic offers an



Success Story

A youth was detained at the JJC because of a domestic violence situation with their mom. Upon the youth's release, a Guidance Clinic staff member made a referral to Eden Counseling Services. The staff member also provided the youth with their contact information in case the youth needed to speak to someone. While waiting to be connected to a therapist in the community, the youth had several disputes with their parents and reached out to the staff person for support. The staff member continued to support the youth until they were established with a community therapist. The youth was also referred to a BHCS-contracted provider who serves youth on probation.

adolescent sex-offender treatment program and conducts court-ordered psychological evaluations.

Services are available in Cantonese, Spanish, and Vietnamese.

Measure A Funding Achievements

BHCS used its Measure A allocation to achieve the following:

- 83% of youth booked into the JJC were seen by a mental health clinician (target: 80%).
- 97% of youth referred for crisis counseling services were seen by a mental health clinician (target: 90%).
- 100% of youth/families who requested a referral to a community mental health provider received a referral upon discharge from the JJC (target: 90%).
- 60% of youth referred for community mental health services upon discharge completed a visit with a community mental health provider (target: 70%).

Mental Health Services for Newcomers and Immigrants (CERI)

lafamiliacounseling.org

-  **FY 19/20 Allocation: \$86,096 | Expended/Encumbered: \$86,096**
-  **Individuals served by Measure A:** 47 (Total individuals served: 425)
-  **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 clients are Cambodian refugees living in Oakland. Through a grant from Alameda County's Underserved Ethnic and Language Populations program, CERI has started serving other Southeast refugees and asylees countywide.

The CERI Youth Program serves youth from a variety of backgrounds, including those who identify as Cambodian American, Vietnamese American, African American, Latinx, and multiracial. The Youth Leadership Program offers a safe space for teens and Transition-Age Youth who live in low income neighborhoods and are at risk for gang involvement, school dropout, substance abuse, and sex trafficking. Youth develop community organizing skills, explore mental health and personal wellness issues, and set education and career goals. CERI also operates Wellness in Action (WIA), a workforce development program that recruits individuals from underserved refugee and immigrant communities to work as community wellness outreach workers within their communities.

Throughout the COVID-19 pandemic, CERI staff stayed in touch with clients and offered counseling sessions by phone and Zoom and provided laptops to several families so that the children could participate in distance learning and clients could participate in CERI activities. CERI now holds weekly town hall meetings by Zoom attended by more than 60 people. CERI leveraged



Matching Funds

\$671,546

from the **Mental Health Services Act (MHSA)**, **Medi-Cal Administrative Activities (MAA)**, **City of Oakland funding**, and **private grants**.



Highlights

97%

97% of clients receiving mental health services agreed or strongly agreed that they **feel more connected to their culture and community** (target: 90%).

its Measure A funding to obtain several COVID-19 emergency grants to help very low income clients with basics such as food, rent, and utilities during the pandemic, including meal delivery.

CERI clients also work with local Asian community groups to fight ICE raids and deportation orders devastating the Cambodian community. This anti-deportation work is part of a larger effort within CERI to provide civic education, information, and advocacy training for its clients. In response to cutbacks in food stamps, for example, CERI helped SSI recipient clients register with CalFresh. CERI also helps clients register to vote, understand the ballot, and educate themselves about their rights in American society.

Services are offered in Burmese, Khmer, Mien, and Vietnamese.

Measure A Funding Achievements

CERI used its Measure A allocation to achieve the following:

- Hold 23 community events (target: five)
- Hold 26 monthly psycho-education workshops to community groups (target: 24)
- Conduct nine support groups (target: six)
- Host 31 culturally based education workshops (target: three)
- Make 24 mental health consultations with community-based organizations, community leaders, health care providers, and/or community groups (target: eight)
- Engage 33 clients in preventive counseling (target: 40)
- Provide 10 referrals to Alameda County Behavioral Health Care Services mental health treatment (target: six)



Success Story

After receiving a letter from ICE that he was being deported to Cambodia, Rouen reached out to CERI for assistance. CERI, in collaboration with Asian Law Caucus and Asian Prisoners Support Committee, organized a rally at the ICE building in San Francisco. After Rouen was detained by ICE, CERI provided therapy and care management for his wife and children. The family received support with schooling, financial support for food and basic needs, and case management. Rouen's wife even took a job at CERI as a care manager and outreach worker. Over time, the Alameda County District Attorney office vacated Rouen's conviction and dismissed his record, enabling him to return home.

Mental Health Services for Unaccompanied Immigrant Youth

achealthyschools.org

 **FY 19/20 Allocation: \$350,000 | Expended/Encumbered: \$350,000**

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

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

 **Services provided:** Public Health, Mental Health

 **Service area:** Cherryland, Fremont, Hayward, Newark, 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.

CHSC's Unaccompanied Immigrant Youth (UIY) program provides school-based, school-linked, and community-based services to UIY youth and families/caregivers so that they can access resources and services to improve their physical, mental, and socio-emotional health and well-being and meet basic needs. The program also builds the capacity of school systems to better identify and link UIY and their caregivers to services and supports.

In FY 19/20, the program funded and partnered with La Familia and Eden Church (the UIY Care Team) to provide direct and capacity-building services through case managers located at school and community sites in the Fremont, Hayward, Newark, and New Haven school districts.

In response to the COVID-19 pandemic, the UIY Care Team pivoted to virtual/teleservice provision and case management and focused on responding and meeting the immediate and basic needs of UIY students and families who were greatly impacted by the pandemic. The team provided daily hot meals, groceries, basic supplies, and PPE to UIY students and their families and assisted families in receiving public benefits and philanthropic grants to support their food security, economic, and housing stability. The team also supported UIY families and students with virtual case management, workshops, and community-based services to meet their basic needs and protect their well-being and economic security.



Matching Funds

\$242,502

from **Alameda County Behavioral Health Care Services (BHCS)**, **Medi-Cal Administrative Activities (MAA)**, and the **Mental Health Services Act (MHSA)**.



Highlights

87%

87% of UIY clients agreed that because of the services they have a **place to go when they need health and wellness services** (target: 80%).

CHSC also developed a new evaluation framework to better capture results-based metrics of both direct services and system support throughout the center's programs, including the UIY Care Team.

Services are provided primarily in Spanish. All direct staff are bilingual in Spanish and English. Presentations and workshops for school educators and community partners are conducted in English.

Measure A Funding Achievements

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

- Provide 1,163 hours of high quality, culturally competent, language-specific direct services to 596 UIY students and 484 families/caregivers
- Conduct 14 outreach activities for identifying and connecting with UIY in schools and the community (target: 20)
- Distribute 497 information materials related to UIY services and programs (target: 600)
- Link 105 UIY students to health insurance and health and wellness services such as applications for Medi-Cal insurance enrollment, specialty mental health services, and primary care visits (target: 115)
- Identify and open 71 preventative counseling cases with UIY student clients (target: 85)
- Hold 15 workshops for UIY and families/caregivers to increase access to health and wellness services (target: 14)
- Conduct 126 home visits to address health and wellness issues and resources and support to UIY and families/caregivers (target: 15)
- Provide:
 - 255 consultation sessions with school district teachers, staff, and providers to develop their capacity to support UIY students and their families
 - 13 consultation sessions with school administrators to develop their capacity to support UIY students and their families



Success Story

A 17-year-old male who left family in Honduras had been living with his cousin for one year and was given 48 hours to move out. The UIY Care Team Case Manager connected the student to a family who hosted and supported him to continue his education. The student was also connected to an attorney who took his case at no cost and helped him obtain his work permit. The student graduated high school and is attending adult school for one year. He plans to transfer to a community college as he works to save for college. He continues living with his host family and receiving support from the community.

Substance Use Disorder Services

www.acbhcs.org

 **FY 19/20 Allocation: \$450,000 | Expended/Encumbered: \$450,000**

 **Individuals served by Measure A:** 464 (Total individuals served: 1,498)

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

 **Services provided:** Substance Abuse

 **Service area:** Countywide

Background

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

Measure A funds were used to fund a portion of the Center Point Substance Use Disorder (SUD) Helpline to provide SUD screening and referrals, care navigation, and connection to treatment and recovery programs for residents seeking help for a substance addiction.

In FY 19/20, the SUD Helpline initiated new procedures to manage its pending services list for residential treatment. It also started a three-way-call appointment-setting procedure with SUD providers and callers. This has enabled SUD Helpline counselors and care navigators to provide more timely access to treatment for beneficiaries and helped maximize available residential bed capacity.

All SUD services are available to clients with the use of a language translation line and/or counselors who speak their language.

Measure A Funding Achievements

The Center Point SUD Helpline used its Measure A allocation to achieve:

- Receive and respond to 1,444 calls for SUD-related information or screening and referral for SUD services (target: 940)
- Connect 693 unique individuals to substance treatment
- Answer 100% of phone calls in less than 30 seconds during normal business operating hours (target: 95%)
- Provide callers with a wait time of 12 seconds (target: less than five minutes)
- Drop or miss only four percent of calls (target: five percent)
- Provide care navigation service to 34% of residential-referred callers



Success Story

A male client was hospitalized numerous times due to drinking and using and ended up in the ICU after suffering two seizures. The doctors informed him that he would die if he continued on his current path. When a friend gave him the SUD Helpline phone number he phoned from his hospital room, knowing that if he went home alone, he would relapse. He reached an SUD Helpline care navigator and was connected to Diablo Valley Ranch (DVR) via a three-way call. He arrived at DVR the next morning. The client is still in the program and is looking into studying addiction at a local university.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

HOSPITAL, TERTIARY CARE, OTHER

St. Rose Hospital 38

UCSF Benioff Children’s Hospital Oakland.....40



St. Rose Hospital
strosehospital.org

- FY 19/20 Allocation: \$7,504,000 | Expended/Encumbered: \$7,504,000**
- Individuals served by Measure A:** 16,110 (Total individuals served: 21,469)
- 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 hospital outpatient services for indigent, low income, underinsured populations in Central and Southern Alameda County.

Over 75% of SRH's inpatient admissions are generated through the emergency department (ED). With the Measure A supplemental funding, SRH 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 in diagnosing patients quickly provides better patient care and enhanced quality of service.

SRH offers 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. Since SRH physicians are now able to write or release 5150s as part of this program, they no longer need to take HPD away from their primary duties.

In addition, SRH operates as a Center for Excellence in Cardiac Care and is designated as a 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.



Matching Funds

\$8.5M

from an **intergovernmental transfer**
through Medi-Cal.



Highlights

74.8

The **patient satisfaction score** for the overall hospital rating increased 6.4 points from the preceding year to 74.8 (target: 79.3).

In 2019, SRH implemented Meditech Expanse as the hospital's new medical record platform. With minimal additional vendor costs, SRH used departmental managers and staff to design and implement the information technology system to mirror current workflows and documentation processes.

COVID-19 caused the redirection of organizational resources to focus on the pandemic. Process/time measures were impacted due to the time constraints that were directly related to the increased time needed for processing COVID-19 patients, testing, ensuring infection prevention protocols were always in place, and consistent ED documentation and time-stamping. Despite COVID-19, SRH was able to start the optimization of the Meditech system, quickly collect and respond to government agencies with requests for data, and maintain process and impact measure quality as compared to prior years.

In addition to Meditech, SRH was able to implement a buprenorphine pilot study and a hand hygiene program, focus on medication reconciliation and bar-coding improvements, and initiate a midline program.

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

Measure A Funding Achievements

SRH used its Measure A allocation to achieve the following:

- Achieve zero patients with elective C-sections prior to 39 weeks
- Achieve a 112-minute wait time from the decision to admit to the time the patient is admitted and leaves the ED (national average: 84 minutes)
- For over 200 myocardial infarction patients who received percutaneous cardiac intervention, limit the average time from entering the emergency room door to the time of receiving their procedure to 69 minutes, with 88.24% of patients receiving their procedure within 90 minutes (target: average of 70 minutes, 85% of patients within 90 minutes)
- Meet the Sepsis Core Measure Bundle treatment and time frames 65% of the time (national average: 65%)
- Achieve zero patient safety occurrences for:
 - Deaths in low mortality diagnosis-related groups
 - Falls with hip injury
 - Accidental puncture or laceration
 - Postoperative sepsis
 - Pressure ulcers
 - Postoperative acute kidney injury requiring dialysis
 - Iatrogenic pneumothorax
 - Postoperative hemorrhage/hematoma
 - Deaths among surgical patients with serious treatable conditions
- Maintain a success rate of 16.88% for NTSV C-sections, thus maintaining SRH's status as a referral center for high risk pregnancies (target: less than 23.9%)



Success Story

A patient presented to the SRH ED and was admitted for a small bowel obstruction. They write:

"When I entered the emergency department, I had no medical insurance. I was admitted for several days and, because of the charity program offered at St. Rose, I received assistance during these hard times. I am the sole provider for my family and was in desperate need for financial assistance. If this charity program wasn't available, I'd still be paying the medical bills to this day. I am very grateful for this amazing program for all the great help."

-  **FY 19/20 Allocation: \$2,000,000 | Expended/Encumbered: \$2,000,000**
-  **Individuals served by Measure A:** 1,396 (Total individuals served: 28,438)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families
-  **Services provided:** Emergency Medical, Hospital Outpatient, Public Health, Mental Health, Substance Abuse
-  **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 supports three programs/activities:

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

Trauma Services

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.



Matching Funds

\$1M

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

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.

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.

CCP

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.

The COVID-19 pandemic and extended shelter-in-place order led to a sharp increase in child maltreatment and family violence at the same time that many agencies charged with supporting children and families significantly reduced services or closed altogether. CCP remained fully operational during FY 19/20, delivering medical services in compliance with all state, County, and hospital regulatory guidelines and transitioning psychotherapy services to telehealth formats. CCP medical and administrative staff participated in numerous events including webinars



Success Story

An adolescent female from Namibia moved to Oakland with her father. When she went to the Chappell Hayes Health Center at McClymonds High School for a medical visit, she had been in the area for over two months but not enrolled in school. She had a positive tuberculosis blood test and required latent tuberculosis treatment. Over the next few weeks, Chappell Hayes staff saw the young woman several times, offering medical follow-up and case management. They provided her with the vaccines required for school enrollment, helped with enrollment, and linked the family to economic resources. They also connected the family to culturally sensitive community resources to help build social connections.



Highlights

.6%

The **percentage of trauma cases that ended in fatality** was 0.6%, compared to a national benchmark of 2.5%.

to make sure all stakeholders understood strategies for promoting child safety during the pandemic as well as avenues for safely accessing services.

CCP restructured the department's mental health services in an effort to both ensure children are receiving the most effective and efficient services and prepare for the anticipated increase in child abuse case post-pandemic.

School-Based Health Services

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 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.

The two school-based health centers rapidly pivoted to providing virtual telehealth services during the COVID-19 shelter-in-place order. They provided training for school staff on trauma-informed teaching during the pandemic and ongoing consultation to school staff for student mental health support. They also launched a school-based health education team that provided virtual comprehensive sex education to students, virtual classroom presentations directly connecting students to medical and behavioral health care at the health centers, and case management.

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

Highlights

100%

100% of patients agreed that health center staff **made them feel welcome** and **taught them things that were useful to staying healthy** (target: 90%).

100% of sexually active patients strongly agreed or agreed that the school health center **helped them to use protection more often** (target: 100%).

Measure A Funding Achievements

BCHO used its Measure A allocation to achieve the following:

ED and CCP

- Provide specialized treatment quickly for 987 children who have acute physical trauma (target: 1,000)
- Serve 315 unique patients at CCP (target: 600)
- Assess 114 children in the ED for maltreatment (target: 100)
- Provide individual or group psychotherapy to 89 unique children (target: 200)
- Perform 59 non-inpatient forensic or medical examinations related to sexual or physical abuse (target: 125)
- For the most severe trauma-related injuries, reduce the average time between admission and:
 - When a patient received a CT scan to 38 minutes (target: under 60 minutes)
 - The decision to admit to 43 minutes (target: under 60 minutes)
- Reduce the average length of stay in the ED to 92 minutes (target: under 120 minutes)
- Contact and schedule 90% of referrals from law enforcement for non-acute forensic examinations within five days (target: 100%)
- Contact 89% 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)

School-Based Clinics

- At McClymonds High School Chappell Hayes and Youth Uprising Health Centers, provide:
 - 2,294 in-person and remote health encounters (target: 1,500)
 - 664 in-person and remote behavioral health encounters (target: 1,000)
 - 341 health education encounters (target: 300)

★ Highlights

100%

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

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Alameda County Dental Health

dental.acphd.org



FY 19/20 Allocation: \$257,580 | Expended/Encumbered: \$257,580



Individuals served by Measure A: 7,679 (Total individuals served: 19,480)



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



Services provided: Public Health



Service area: Countywide, Homeless or Transient

Background

The Alameda County Office of Dental Health supports efforts to improve the oral health of Alameda County residents by partnering with the community to assess oral health status and resources and to ensure access to community-based services and oral health education. We actively engage in policy development that incorporates evidence-based dental disease prevention and promotes oral health equity.

The Office of Dental Health provides an accessible early entry point for oral health assessment and preventive dental services for high risk families and children ages 0–5 years at Women, Infants, and Children centers (WIC), as well as continuity and referral for regular follow-up dental care in the community. At WIC Dental Days:

- Families learn about 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.
- 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 visiting the dentist during their pregnancy.



Matching Funds

\$736,832

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



Highlights

100%

100% of health care professionals receiving oral health training reported having **increased their knowledge** (target: 75%).

Dental Health collaborated with other Community Health Services Division programs, including Tobacco, Chronic Disease, Project New Start, Alcohol and Other Drug Prevention, Nutrition Services, and WIC, to participate in existing community events and/or to host an outreach event. This ensured that community residents received more comprehensive health information in a one-stop shop.

COVID-19 impacted Dental Health's ability to provide in-person dental services, due to the fact that WIC clinics were closed to in-person appointments. In response, WIC moved to providing services via the phone. COVID-19 also impacted Dental Health's ability to conduct in-person outreach and collaborate with community partners to host events. Dental Health focused on providing dental hygiene kits to community partners that serve families through drive-by food and diaper giveaways.

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 Achievements

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

- At WIC Dental Days:
 - Provide oral health education to 471 parents/guardians of infants and children ages 0–5 years (target: 775)
 - Have 451 infants and children ages 0–5 years attend (target: 750)
 - Provide an oral health assessment to 446 infants and children (target: 750)
 - Give a fluoride varnish application to 415 children, representing 93% of those who received an oral assessment (target: 675 children, representing 90% of those receiving an assessment)
 - Refer 58% of infants and children in attendance for long-term care coordination with a dentist (target 65%)
- Provide oral health training to 37 health care professionals working with underserved populations through public health organizations, community-based organizations, and community health clinics (target: 100)
- Participate in 18 community events and/or presentations (target: 25)
- At community events, conduct outreach to 3,289 community members (target: 1,500)
- At Axis Community Health:
 - Participate in six community events (target: four)
 - Provide 3,368 dental patient visits to community members (target: 5,000)
 - Ensure that 65% of children and youth who received care coordination were provided dental care (target: 50%)

★ Highlights

3,289

The Office of Dental Health more than doubled their outreach goal of 1,500 by **reaching 3,289 community members through community events.**

-  **FY 19/20 Allocation: \$57,397 | Expended/Encumbered: \$57,397**
-  **Individuals served by Measure A:** 56 (Total individuals served: 56)
-  **Populations served:** Low Income Adults, Families, Seniors
-  **Services provided:** Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse
-  **Service area:** Alameda, Albany, Ashland, Berkeley, Castro Valley, Cherryland, Dublin, Emeryville, Fairview, Hayward, Livermore, Oakland, Piedmont, Pleasanton, San Leandro, San Lorenzo

Background

The Center for Elders' Independence (CEI) provides high quality, affordable, integrated health care services to the elderly that 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.

After Caring for the Caregiver classes were suspended due to the COVID-19 shelter-in-place, CEI offered phone support to caregivers who were formerly or presently enrolled. In addition to reassurance calls, caregivers were able to attend a bi-weekly Zoom check.

Services are provided in English, Spanish, and Cantonese.

Measure A Funding Achievements

CEI used its Measure A allocation to achieve the following:

- Enroll 56 caregivers in the Caring for the Caregiver program (target: 40)
- Complete one Caring for the Caregiver series with eight classes (target: four series with 28 classes)

Success Story

Fred Chavez is caregiving for his 98-year-old mom, who suffers from dementia. He joined the Caring for the Caregiver series and describes this experience as life-transforming. He learned about his mom's condition and was able to improve his communication with her and respond to her behaviors in a more constructive way. He felt much less frustrated and was even able to enjoy their time together. During the COVID-19 shelter-in-place order, Fred joined the bi-weekly Zoom check-in forum, where he continued to benefit from the peer support, guidance, and camaraderie of other caregivers dealing with challenges similar to the ones he is experiencing.



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

achealthyschools.org



FY 19/20 Allocation: \$1,350,000 | Expended/Encumbered: 1,350,000



Individuals served by Measure A: 13,274 (Total individuals served: 13,274)



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



Services provided: Public Health, Mental Health, Substance Abuse



Service area: Alameda, Ashland, Berkeley, Cherryland, Emeryville, Hayward, Oakland, San Leandro, San Lorenzo, Sunol, 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.

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
- Physical health
- Behavioral health
- Oral health
- Youth development and academic outcomes
- Integration of health and wellness support services

The COVID-19 pandemic led to many of the SBHC sites closing in March 2020, greatly impacting staffing and services offered to clients. Despite these challenges, the SBHCs quickly pivoted and modified their services to meet student and family needs. This included telephone and email outreach to students and families to assess needs and educate them about telehealth options and services available at the lead agencies. The SBHCs also distributed community resource guides, assisted with food distribution and public benefits enrollment, and provided referrals for critical basic needs. Some sites continued to provide urgent medical and dental care; most converted in-person medical appointments to telephone/video appointments where possible. They also provided



Matching Funds

\$12.3M

from:

- **Medi-Cal and other third-party billing**
- **Tobacco Master Settlement Agreement funding**
- **Kaiser Foundation**
- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT)**
- **Funding from the County, cities, school districts, and state and federal governments**
- **Private grants**

individual and group behavioral health services via telehealth, and youth development through the provision of virtual after-school activities. Throughout all of these efforts, maintaining the health and safety of their staff was a major priority, through the provision of masks and proper PPE.

Many school-based staff were reassigned within their organizations from closed SBHC locations to ones that remained or were later approved to reopen. As County partners, the SBHCs developed the Health Education Collaborative for health educators and site supervisors to engage with students and young people more effectively through virtual platforms.

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

Measure A Funding Achievements

CHCS used its Measure A funding to achieve the following:

Increased Access to Care

- Maintain 28 SBHC sites (target: 28)
- Offer SBHC access to 36,703 students countywide (target: 38,000)
- Register 13,274 students as clients (target: 15,000)
- Conduct 42,463 visits with registered clients (target: 60,000)

Physical Health

- Provide 20 medical service hours per week at 27 sites (target: 20 hours)
- Conduct:
 - 22,649 medical visits (target: 26,000)
 - 7,303 first aid visits (target: 7,200)
 - 1,268 health education clinical visits (target: 3,600)
- For youth ages 0–18, make:
 - 12,769 non-clinical health fair/outreach contacts (target: 20,000)
 - 15,979 non-clinical first aid supplies contacts (target: 15,000)
 - 861 non-clinical health education for nutrition contacts (target: 3,000)
 - 3,761 non-clinical health education for reproductive health contacts (target: 6,000)
 - 801 non-clinical screening and other contacts (target: 3,000)
 - 573 non-clinical health education for tobacco and alcohol/drug use contacts (target: 500)
 - 277 non-clinical physical activity contacts (target: 300)
 - 1,030 non-clinical vision screening contacts (target: 500)
- For adults over age 18, make 409 non-clinical first aid supplies contacts (target: 300)

Behavioral Health

- Conduct 10,473 behavioral health service visits (target: 16,000)
- Provide 26 hours of behavioral health service per week at 25 sites (target: 25 hours)

★ Highlights

96%

96% of clients agreed or strongly agreed that the SBHC helped them feel like they **had an adult they could turn to if they needed help** (target: 90%).

♥ Success Story

A parent brought in a recently immigrated student who needed immunizations for school entry. The student did not have active health insurance, although the parent was planning to enroll them under the parent's Medi-Cal. SBHC staff was able to enroll the student into Gateway for temporary coverage and provide the needed immunizations. After learning about the SBHC services offered, the family also obtained dental appointments and are now up-to-date with routine cleanings.

- Discuss 352 youth in non-clinical school staff consultations involving 607 staff and 5,523 youth in Coordination of Services Team (COST) consultations involving 1,940 staff (target: 5,000 students and 2,500 staff)
- For youth ages 0–18, make:
 - 429 non-clinical crisis intervention/grief contacts for individuals and groups (target: 500)
 - 455 non-clinical restorative justice/circle contacts conducted by SBHC staff and other groups (target: 200)
 - 19,044 non-clinical school safety/climate presentation/activity contacts (target: 10,000)
 - 719 non-clinical self-esteem/social skills groups contacts (target: 500)
 - 385 non-clinical trauma screening contacts (target: 750)

Oral Health

- Provide 13 hours of dental service per week at 12 sites (target: 12 hours at 12 sites)
- Conduct 3,195 visits with dental services (5,000)
- Provide dental services to 1,318 clients (target: 1,750)
- Make 3,720 non-clinical dental screening contacts to youth ages 0–18 (target: 3,000)

Youth Development and Academic Outcomes

- For youth ages 0–18, make:
 - 1,890 non-clinical youth development contacts, such as advisory board, leadership, advocacy, etc. (target: 1,500)
 - 4,789 non-clinical peer health education group contacts (target: 1,000)
 - 337 non-clinical job training/career exploration contacts, such as applying, internships, and shadowing (target: 750)
 - 507 non-clinical acculturation support contacts for newcomers and unaccompanied youth (target: 500)
 - 892 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 22 sites (target: 21)
- For adults over age 18, make:
 - 5,760 non-clinical health fair/outreach contacts (target: 3,500)
 - 2,530 non-clinical parent/family support contacts (target: 2,000)
 - 2,780 non-clinical school safety/climate presentation/activity contacts (target: 1,000)
 - 749 staff workshop/training contacts (target: 1,000)
- For youth ages 0–18, make 1,447 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 COST programs at 22 sites (target: 28)



Success Story

After a school community lost a student to suicide, the school reached out to the SBHC to plan how to best support the students, teachers, and community as a whole. SBHC staff collaborated with school personnel to check-in with students and had behavioral health providers from other parts of the program stationed at the SBHC to check in with any students dropping in, as well as reaching out to any at-risk students who had come through the SBHC that year. The SBHC also program offered no-cost groups, one for the parents and one for the teens.



Highlights

96%

96% of clients were **sent back to class after a medical visit** rather than going home, which helped them to avoid missing valuable classroom instruction time (target: 90%).



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

drwatsonwellness.com

 **FY 19/20 Allocation: \$229,587 | Expended/Encumbered: \$229,587**

 **Individuals served by Measure A:** 4,618 (Total individuals served: 4,618)

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

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

 **Service area:** Countywide, Homeless or Transient

Background

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

In response to the COVID-19 pandemic, Preventive Care Pathways increased their hours to provide testing and vaccines to the community and set up mobile services to reach those who were not able to come into their facilities. By collaborating with other community organizations, Preventive Care Pathways was able to provide more resources to the community that included free testing, masks, hand sanitizers, and other supplies, as well as access to free food and housing. They also used the media to present education related to screening and testing.

Services are provided in English, Spanish, and Ara.

Measure A Funding Achievements

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

- Conduct 4,618 medical visits to 734 unduplicated low income patients with Alameda Alliance or Anthem Blue Cross Medi-Cal (target: 2,500 visits to 500 patients)
- Screen 498 patients for Hepatitis C as a part of a basic health screening (target: 400)
- Provide treatment for 56 patients who tested positive for Hepatitis C, of whom 71% received or completed treatment (target: 80%)
- Coordinate one health fair/workshop attended by 100 participants



Matching Funds

\$137,800

from **Alameda County Social Services Agency and General Assistance funding, Medi-Cal Administrative Activities (MAA),** and **in-kind funding.**



Highlights

100%

100% of patients who tested positive for diabetes, Hepatitis C, and/or prostate screenings at an event **received follow-up care** (target: 80%).

(target: six health fairs/workshops with 50 participants)

- At the health fair/workshop, provide 85 Hepatitis C and/or prostate cancer screenings, representing 85% of attendees (target: 25%)
- Provide Covered California or Medi-Cal application assistance to 282 uninsured residents, of whom 100% submitted an application (target: 200 residents, with 50% submitting an application)
- Have 79 applications that received assistance and were approved for Medi-Cal select the Preventive Care Pathways James A. Watson Wellness Center as their primary care provider, representing 67% of such applications (target: 50%)
- Attend 25% of Covered California CEE Alameda County partnership meetings that were held (target: 50%)

★ Highlights

82%

82% of patients reported that they **would not know where else to go**, would go to the emergency room, or wouldn't do anything to address their health care needs if they didn't know about the Preventive Care Pathways James A. Watson Wellness Center (target: 50%).



Direct Medical and Support Services: Roots Community Health Center

www.rootsclinic.org

-  **FY 19/20 Allocation: \$250,000 | Expended/Encumbered: \$250,000**
-  **Individuals served by Measure A:** 195 (Total individuals served: 10,287)
-  **Populations served:** Indigent, Low Income Adults, Children, Families, Seniors
-  **Services provided:** Public Health, Mental Health
-  **Service area:** Hayward, Oakland, San Leandro, Homeless or Transient

Background

Roots Community Health Center works to uplift those impacted by systemic inequities and poverty. They accomplish this through medical and behavioral health care, health navigation, workforce enterprises, housing, outreach, and advocacy.

Roots utilized Measure A funding to build out an entire behavioral health suite in deep East Oakland, where these services are sorely needed. This provides a conducive space for support groups and workshops for community members with mild, moderate, and severe mental illness. The build-out of the behavioral health suite allowed Roots to better position themselves to obtain ongoing behavioral health funding that they otherwise would not have been able to obtain due to inadequate facilities.

The COVID-19 pandemic necessitated a shift in how Roots provided many of their services, and the renovated behavioral suite has proven to be a tremendous asset in this shift. Clinicians have had ample space to physically distance from one another, and each office is suitable to conduct telehealth visits. Clinicians are able to remain onsite each day for in-person support to those who present in crisis, and navigators and eligibility/enrollment specialists are always available for in-person and telephonic support.

Measure A Funding Achievements

Roots used its Measure A allocation to achieve the following:

- Build or renovate seven rooms at the Roots Community Health Center to provide behavioral health and eligibility/enrollment services (target: seven)
- Provide onsite behavioral health services to 1,073 unduplicated patients because of the new space



Success Story

Mr. A sought mental health therapy after moving out of a residential religious community. He was experiencing homelessness but was able to secure a bed in a shelter. He was raised by his single mother and older brother. He had a history of gang association, selling and using illegal substances, and incarceration. After engaging in behavioral health services, Mr. A opened a small business and stated that he felt more confident with managing his finances, enough to move into a permanent residence. He worked to shift his interpersonal relationships, got engaged to be married, and became closer to his father and extended family members.

- Hire three staff (target: three)
- Submit:
 - 262 renewal Medi-Cal applications
 - 301 CalFresh applications, of which 108 were approved
- Hire one clinical navigator to assist patients that are not eligible for navigation services under other programs (target: one)
- Make 105 navigation visits serving 45 clients

★ Highlights

95%

95% of clients in the clinic and 100% of clients in the navigation program self-reported **improvement in their health status.**

Health Insurance Enrollment

www.acgov.org/health/indigent/hiea.htm



FY 19/20 Allocation: \$300,000 | Expended/Encumbered: \$300,00



Individuals served by Measure A: 1,410 (Total individuals served: 7,836)



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

The Alameda County Health Care Services Agency Health Insurance Enrollment Assistance department prescreens County residents on the phone and provides information and referrals for application assistance for the following health and social service programs: Medi-Cal, CalFresh, Cash Aid, and HealthPAC. Health Insurance Technicians (HITs) can schedule enrollment assistance appointments to complete applications.

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

In FY 19/20, benefits assistance was provided to clients according to the following percentages by program:

- Medi-Cal: 61%
- HealthPAC: 19%
- CalFresh: 13%
- Covered California: 6%
- CalWORKs: 1%

Services are provided in English, Spanish, and Cantonese.

Measure A Funding Achievements

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 7,836 low income County residents (target: 7,800)
- Receive 4,683 calls on the HIT assistance toll-free line (target: 3,000)



Success Story

During the pandemic, many community members found themselves needing health insurance due to contracting the coronavirus. One such family reached out to Health Insurance Enrollment Assistance after being referred by the hospital. This family of five had all contracted coronavirus and were without health insurance. They had been afraid of applying for insurance since they were undocumented and were worried they would have to pay thousands of dollars in medical bills. The HIT helped them apply for Medi-Cal with retroactive coverage for the entire family, as well as helping the parents apply for HealthPAC so they could seek medical care in the future. The entire family ultimately received coverage.



Health Services for Day Laborers: Multicultural Institute

mionline.org

-  **FY 19/20 Allocation: \$95,662 | Expended/Encumbered: \$95,662**
-  **Individuals served by Measure A:** 692 (Total individuals served: 738)
-  **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 offers ongoing free health activities and services to low income, monolingual Spanish-speaking, and uninsured individuals. MI is a trusted organization that brings the health services to the community members where they are and to the street corners where day laborers regularly congregate. The majority of the community served by MI does not easily access medical, dental, vision, health coverage, and enrollment services. They have even less access to regular preventive doctor visits. All this results in individuals less likely getting proper treatment for health conditions that could be prevented with the proper care.

MI staff provides health case management support and offers assistance in navigating the health system. Through this help, individuals are able to solve their immediate health needs, enroll in health coverage, and register with a primary care doctor. MI often offers free services that individuals typically do not have access to.

In FY 19/20, MI successfully enhanced and increased access to health services, activities, and support through its cultural- and linguistic-appropriate model. Additionally, MI continued to invest resources and time to cultivate and strengthen partnerships that increase individuals' access to these services. Highlights include the following:

- Blood pressure workshops/screenings. MI continued to partner with LifeLong Medical Center to cohost diabetes and blood pressure workshops and provide medical screenings during street outreach.
- Optometry. Through a partnership with the UC Berkeley School of Optometry, a total of 30 uninsured individuals received free eye exams and an updated eye prescription. They were treated with care and each received free eyewear.



★ Highlights

98%

98% of individuals served felt
prepared for the referred service
(target: 90%).

- **Flu shot.** Before the COVID-19 outbreak, MI partnered with Walgreens to host a one-time flu shot event for day laborers to receive the shot for free on the street corners.
- **Community-building.** As a way to build community among the day laborers, MI hosted monthly street clean-ups for day laborers to help keep the neighborhood clean. For Thanksgiving, MI distributed 125 healthy food baskets to day laborers and other low income individuals. MI was able to host its yearly Christmas Day Laborer Event in December, where day laborers received a hot meal, Christmas gifts, and raffle items and participated in a healthy eating workshop.
- **Social worker/therapist.** MI continued to offer its monthly Alameda Health System mobile health van visits and monthly social worker sessions through the Alameda County Health Care for the Homeless program. In addition, a therapist was assigned to MI monthly.
- **Client study.** MI partnered with the University of California Berkeley Public Health Department and the California Initiative for Health Equity & Action (Cal-IHEA) and organized interviews with the day laborer community served by MI to gauge their insight and opinions about social and economic factors that affect their health and well-being. Through this study, MI and Cal-IHEA identified and analyzed the mental and physical health needs of day laborers, the risks and abuses day laborers encounter when looking for work, and their day-to-day interactions in the community where they seek employment.

The COVID-19 pandemic caused MI to pause the majority of its in-person activities. MI staff shifted its service model of daily street outreach to a remote and virtual program delivery method. MI has also been sharing COVID-19-related preventive measures and information in Spanish and English to the community through texts, individual phone calls, WhatsApp chats, video calls, and its Facebook page. In addition, MI has offered COVID-19 direct services and resources including COVID-19 updates, preventive measures, and resources; distribution of food essentials and PPE; advocacy and application support by helping constituents complete relief, rental, and financial assistance applications; and direct service and health support/referrals.

Services are provided primarily in Spanish and, when needed, in English.

Measure A Funding Achievements

Measure A funding helped MI achieve the following:

- Provide outreach to 692 unduplicated day laborer and other low income clients (target: 700)
- Contact 100% of day laborers on the street during daily street outreach (target: 80%)
- Register 94% of outreached day laborers with MI (target: 80%)
- Perform 118 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)



Success Story

Jorge, a 65-year-old Mexican, has been a day laborer for over 10 years. Jorge was skeptical about COVID-19 and dismissed MI's COVID-19 information, PPE, and resources. He believed that COVID-19 was a fake illness created by the government. He was one of the few day laborers that would not wear a mask while seeking work on street corners, and he would not socially distance. Jorge tested positive for COVID but questioned the results because he was asymptomatic. The second time he tested positive, he was severely symptomatic and stayed in quarantine for more than two weeks. Staff provided him PPE, COVID-19 information and resources, and essential food items.

- Host and/or co-sponsor 10 health care trainings or workshops for 186 participants on topics that included occupational health and safety, sexual health, oral health, and substance abuse (target: eight trainings/workshops with 120 participants)
- Arrange eight health screening events serving 131 unduplicated individuals (target: four events serving 100 individuals)





Health Services for Day Laborers: Street Level Health Project

streetlevelhealthproject.org

-  **FY 19/20 Allocation: \$95,662 | Expended/Encumbered: \$95,662**
-  **Individuals served by Measure A:** 374 (Total individuals served: 275)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Families, Seniors
-  **Services provided:** Public Health, Mental Health
-  **Service area:** Countywide, Homeless or Transient

Background

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

In response to the COVID-19 pandemic, SLHP successfully pivoted all in-person services to over-the-phone consultations via the SLHP hotline. Patients could call the hotline Monday-Friday from 9am-5pm and be referred to services including health insurance enrollment or phone consults with a medical provider, herbalist and nutritionist, and mental health educator. The nutritionist and herbalist provided herb and tincture drop-offs to patient homes once every two weeks. Clients also received support about wage theft, the COVID -19 monetary fund, and Oakland Worker's Collective employment support.

Due to the increase in need for mental health services in the uninsured immigrant community, SLHP increased service hours by over 25%, and the number of mental health visits provided monthly doubled since the beginning of the pandemic. Mental health educators focused on individual telephone counseling sessions to help clients develop various coping strategies for the hardships that negatively impacted their life. In addition, SLHP made COVID -19 prevention and education workshops a regular part of their monthly outreach and established a partnership with La Clinica to schedule COVID testing appointments directly for uninsured community members in need of a diagnostic test.

Services are provided in Spanish, English, and Mam.



★ Highlights

98%

98% of clients who checked into the clinic **received medical care that same day** (target: 95%).

Measure A Funding Achievements

SLHP used its Measure A allocation to achieve the following:

- Make 588 health care screening and episodic care visits to 460 unduplicated clients across multiple languages (target: 700 clients)
- Provide 2,509 health-related navigation/referral services to 1,506 clients across a network of 60 local health care agencies (target: 2,000 services)
- Conduct 386 mental health consultations with 190 unduplicated clients from low income communities in Alameda County (target: 200 consultations)
- Provide 150 nutritionist/herbalist consultations to 165 clients (target: 195 consultations)
- Distribute 3,519 free food bags to low income individuals (target: 2,500)
- Recruit and train 19 prospective and current health care providers, providing them with experience working with uninsured low income communities (target: 20)



Health Services for Unaccompanied Immigrant Youth

achealthyschools.org

 **FY 19/20 Allocation: \$350,000 | Expended/Encumbered: \$350,000**

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

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

 **Services provided:** Public Health, Mental Health

 **Service area:** Cherryland, Fremont, Hayward, Newark, 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.

CHSC's Unaccompanied Immigrant Youth (UIY) program provides school-based, school-linked, and community-based services to UIY youth and families/caregivers so that they can access resources and services to improve their physical, mental, and socio-emotional health and well-being and meet basic needs. The program also builds the capacity of school systems to better identify and link UIY and their caregivers to services and supports.

In FY 19/20, the program funded and partnered with La Familia and Eden Church (the UIY Care Team) to provide direct and capacity-building services through case managers located at school and community sites in the Fremont, Hayward, Newark, and New Haven school districts.

In response to the COVID-19 pandemic, the UIY Care Team pivoted to virtual/teleservice provision and case management and focused on responding and meeting the immediate and basic needs of UIY students and families who were greatly impacted by the pandemic. The team provided daily hot meals, groceries, basic supplies, and PPE to UIY students and their families and assisted families in receiving public benefits and philanthropic grants to support their food security, economic, and housing stability. The team also supported UIY families and students with virtual case management, workshops, and community-based services to meet their basic needs and protect their well-being and economic security.

CHSC also developed a new evaluation framework to better capture results-based metrics of both direct services and system support throughout the center's programs, including the UIY Care Team.



Matching Funds

\$242,502

from **Alameda County Behavioral Health Care Services (BHCS)**, **Medi-Cal Administrative Activities (MAA)**, and the **Mental Health Services Act (MHSA)**.



Highlights

100%

100% of UIY clients agreed that the services helped them **meet with a doctor or nurse** (target: 80%).

Services are provided primarily in Spanish. All direct staff are bilingual in Spanish and English. Presentations and workshops for school educators and community partners are conducted in English.

Measure A Funding Achievements

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

- Provide 1,163 hours of high quality, culturally competent, language-specific direct services to 596 UIY students and 484 families/caregivers
- Conduct 14 outreach activities for identifying and connecting with UIY in schools and the community (target: 20)
- Distribute 497 information materials related to UIY services and programs (target: 600)
- Link 105 UIY students to health insurance and health and wellness services such as applications for Medi-Cal insurance enrollment, specialty mental health services, and primary care visits (target: 115)
- Identify and open 71 preventative counseling cases with UIY student clients (target: 85)
- Hold 15 workshops for UIY and families/caregivers to increase access to health and wellness services (target: 14)
- Conduct 126 home visits to address health and wellness issues and resources and support to UIY and families/caregivers (target: 15)
- Provide:
 - 255 consultation sessions with school district teachers, staff, and providers to develop their capacity to support UIY students and their families
 - 13 consultation sessions with school administrators to develop their capacity to support UIY students and their families



Success Story

A 17-year-old male who left family in Honduras had been living with his cousin for one year and was given 48 hours to move out. The UIY Care Team Case Manager connected the student to a family who hosted and supported him to continue his education. The student was also connected to an attorney who took his case at no cost and helped him obtain his work permit. The student graduated high school and is attending adult school for one year. He plans to transfer to a community college as he works to save for college. He continues living with his host family and receiving support from the community.

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

acbhcs.org



FY 19/20 Allocation: \$221,069 | Expended/Encumbered: \$221,069



Individuals served by Measure A: 73 (Total individuals served: 584)



Populations served: Low Income, Uninsured Adults, Children



Services provided: Emergency Medical, Hospital Outpatient, Public 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 oversees certain programs that provide medical services at the Alameda County Juvenile Justice Center (JJC). In FY 19/20, Alameda County's Juvenile Justice Health Services (JJHS) achieved significant successes and improvements to better serve youth detained at the JJC:

- **JJC Health Policy Manual.** The JJC Health Team (Medical Clinic, Guidance Clinic, and JJHS Director) completed the first JJC Health Policy Manual. The manual is a thorough documentation of the comprehensive health services available to detained youth, outlining all physical, dental, and mental health policies and procedures for the JJC.
- **Patient Health Questionnaire (PHQ-9).** To improve screening for risk of depression or self-harm upon a youth's detention, the JJC Medical Clinic implemented the PHQ-9 to be administered upon booking of youth into the JJC.
- **Increased access to care.** Every youth receives a medical assessment prior to being booked into detention. Once detained, the majority of youth receive a physical examination and dental screening, and those who need dental treatment are treated at the JJC Medical Clinic.
- **Improving health outcomes.** The JJC Medical Clinic ensures youth get care and treatment that meets medical quality standards. Two important standards prioritized by the JJC Medical Clinic are ensuring all youth have up-to-date/age-appropriate immunizations and that every youth with a sexually transmitted infection (STI) is treated.
- **COVID-19 protocol.** The JJC Medical Clinic, JJHS Director, and Probation partners worked quickly to prevent any possible COVID-19 outbreak within the JJC, developing protocols that informed screening and testing



Success Story

A father and his son, who had an extensive history in the juvenile justice system and multiple psychiatric hospitalizations, were connected to a school-based clinic staffed by the same medical doctor who served the youth in the JJC. The doctor worked with the youth to stay on his medication and stay focused on his treatment goals. The doctor also played a critical role in de-escalating conflicts between the youth and his father. With this support, the youth was able to remain at his father's home with no further contact with the police or need for psychiatric hospitalization and to eventually move into supportive housing for transitional-aged youth.

procedures for every youth booked into the JJC, implementing a clear quarantine/isolation process for youth who tested positive for COVID-19, and creating guidelines for use of PPE for everyone entering the JJC.

The JJHS Director plays an important role in ensuring continuity of care for justice-involved youth and families. For example, the JJHS director assisted with ensuring that three youth had continued access to psychiatric medication upon release from detention, a process that involved navigating Alameda County Social Services for Medi-Cal authorization, BHCS for pharmacy approval, and multiple medical providers. Additionally, the JJHS Director helped youth and families access medical care outside of the JJC, such as working with Social Services to have a released youth's Medi-Cal re-activated so that he could get required follow-up care for an ankle injury.

Services are provided in Cantonese, English, and Spanish.

Measure A Funding Achievements

BHCS used its Measure A allocation to achieve the following at the JJC:

- Provide a comprehensive physical exam and dental screening to 65% of youths booked into the JJC (target: 70%)
- Screen 100% of youths for self-harm at intake (target: 95%)
- Bring immunizations up to date for 327 youths
- Provide dental treatment to 76 youths



Medical Costs for Juvenile Justice Center: Niroga Institute

niroga.org

-  **FY 19/20 Allocation: \$89,152 | Expended/Encumbered: \$89,152**
-  **Individuals served by Measure A:** 1,326 encounters (Total individuals served: 1,678 encounters)
-  **Populations served:** Low Income, Uninsured Children
-  **Services provided:** Mental Health
-  **Service area:** Countywide

Background

Niroga Institute strives to foster the health and well-being of children, youth, families, and communities through the practice of dynamic mindfulness, an evidence-based, trauma-informed, transformative life skills program that strengthens stress resilience and social-emotional learning.

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 emotional 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 youth class participants reported that the class was helpful for **managing emotions and stress** (target: 60%).

As a result of the COVID-19 shelter-in-place and social distancing, Niroga was not able to provide services onsite in person and moved to online services. To start, Niroga offered weekly recorded sessions for viewing collectively or individually with accompanying documentation, so that the youth could practice inside their rooms. JJC staff also had access to videos, which were shared with staff working inside other County jails.

Measure A Funding Achievements

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

- 385 TLS classes for youth, including a total of 1,678 youth encounters (target: 400 classes and 1,500 encounters)
- One daylong TLS immersion for four youth (target: three immersions for 15 youth)
- 106 TLS classes for staff, with an average of 4.5 staff per class (target: 90 classes averaging five staff per class)



Success Story

A female participant in the yoga and mindfulness class had a history of physical abuse and was in foster care. One day she reported to the JJC clinical psychologist that she had been very irritable and angry at the staff earlier in the day. She hadn't slept well the night before because of a nightmare about her mother. After she took the Niroga class, she reported that she felt much better, much calmer, and more positive, with more self-control. She attributed her improved sense of self to the practice of yoga and mindfulness and hoped she could continue these practices on the "outs."



Medical Costs for Juvenile Justice Center: Victims of Crime

alcoda.org

- \$ FY 19/20 Allocation: \$90,000 | Expended/Encumbered: \$90,000**
- Individuals served by Measure A:** 797 (Total individuals served: 1,749)
- 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:** 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.

Under the guidelines of the California Victim Compensation and Government Claims Board (CalVCB), Alameda County Victim Services staff are committed to promptly assist with financial services to all impacted victims of crime. Ensuring that all victims of crime receive vital and essential financial services first requires that they are aware of the CalVCB program's existence. This has been a significant area of concern, with active outreach throughout Alameda County. However, a CalVCB study identified that many approved victim of crime claimants do not access program financial services and remain financially unserved. Therefore, staff has conducted more thorough research to discover the barriers that prevent crime victims from seeking program services, including establishing a full-time employee solely focused on this in-depth research; empower and educate claimants about the CalVCB program and all its available financial services; and guide claimants in accessing approved funding.

COVID-19 impacted the organization's ability to provide CalVCB services, as many claimants were afraid to come to the office in person to drop off bills and request specific services or even to visit a document assistance center to have their bills faxed to the Victim Services Center. To assist claimants, staff provided postage-paid return envelopes to enable



★ Highlights

100%

CalVCB reviewed 100% of approved applications to **identify victims of crime who might need additional assistance from staff to access and utilize approved CalVCB funds** (target: 100%).

approved claimants to submit their unpaid bills, expense requests, and supporting documentation through the mail. Staff also arranged that claimants could send and receive courtesy faxes at their nearest document service provider and offered telephone assistance to help complete certain forms.

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

Measure A Funding Achievements

CalVCB used its Measure A allocation to achieve the following:

- Of the 1,749 claimants with approved CalVCB funds, identify 797 who did not use their funds (target: 797 of 1,749)
- Successfully contact 273 of the 797 claimants with unused funds (target: 797)
- In a survey of the 273 contacted claimants with unused funds, identify that:
 - 273 were not aware of the approved funds
 - 220 needed information and assistance to access the funds
 - 53 declined the use of the funds
- Ensure that, of the 273 contacted claimants, 50 claimants received over \$500,000 in financial assistance after being contacted (target: 100 claimants and \$1,000,000 in assistance)



Success Story

Staff contacted a claimant to determine why bills and expenses had not been submitted for payment on her CalVCB claim. The claimant badly needed CalVCB's financial assistance, as her victim of crime incident resulted in a pregnancy. Having no health insurance, the claimant was panicking about how she would pay for a medical pregnancy exam, prenatal care, X-rays, laboratory tests, and birth, delivery, and hospital expenses. After staff educated the claimant about CalVCB's covered financial services, she made an appointment for further pregnancy testing and related obstetrics care. The claimant expressed relief knowing she can submit her expenses to CalVCB for payment and instead focus on her pregnancy and well-being.



ALAMEDA HEALTH
CONSORTIUM

Primary Care Community-Based Organizations

www.alamedahealthconsortium.org



FY 19/20 Allocation: \$5,753,009 | Expended/Encumbered: \$5,753,009



Individuals served by Measure A: 15,082 (Total individuals served: 30,762)



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
- Bay Area Community Health Center
- La Clínica
- LifeLong Medical Care
- Native American Health Center
- Tiburcio Vasquez Health Center
- West Oakland Health



Matching Funds

\$5.75M

as part of **Care Connect** activities.



Highlights

↑ 55%

The number of **patients receiving buprenorphine for opioid use disorder** increased by 55% during the fiscal year (target: 55%).

In FY 19/20, the eight Consortium health centers completed implementation of electronic health records on a single platform to enhance patient care and coordination. The enhanced ability for collaboration better supports continuity of care, whole person care, and integrating care across clinics, hospitals, and doctors. When the COVID-19 pandemic hit, the centers pivoted to providing health care through video, phone, text, and chat so that patients could continue to get the care they need. The centers also began offering COVID-19 diagnostic testing to patients and the community at large, making up 43% of the community testing sites in Alameda County. In addition, the health centers partnered with the Alameda County Public Health Department to provide contact tracing and case investigation for COVID-19-positive patients. Health center workers also tracked down and vetted resources for patients, verified insurance, helped patients apply for housing, and partnered with the County on vaccinations.

Health centers worked to redirect patients from opiate treatment for pain management to alternative modalities of pain management, such as acupuncture, chiropractic services, and behavioral health services. This effort minimizes patients' risk of opiate addiction. The centers also helped link patients from emergency rooms back to their primary care homes, ensuring a seamless transition from medication-assisted treatment (MAT) induction to MAT maintenance. Patients struggling with addiction can now get their MAT and behavioral health care within the primary care setting in an integrated and holistic manner.

For hepatitis C treatment, health centers partnered with both the Alameda Alliance for Health and Diplomat Pharmacy to ensure all forms and related documentation could be submitted 100% virtually with no need for wet signatures. This ensured treatment approvals were not delayed and optimized safety during the pandemic. Successful treatment for hepatitis C is directly correlated with regression of cirrhosis (chronic liver damage leading to scarring and liver failure), reduction in risk for hepatocellular carcinoma (liver cancer), and reduction of extrahepatic manifestations such as cryoglobulinemia, dermatologic disorders, and diabetes. Additionally, cured patients can no longer transmit HCV to sexual partners, children, or needle-sharing partners, thereby reducing the spread of hepatitis C in the community.

The Health Program of Alameda County, also known as HealthPAC, is a County program that provides affordable health care to uninsured people living in Alameda County. HealthPAC is not insurance and does not provide everything that insurance does. HealthPAC and the Consortium work in partnership with the eight member health centers to research, develop, analyze, and report on appropriate measures for system improvement deliverables.

Services are available in English, Spanish, Cantonese, Mandarin, Vietnamese, Tagalog, Farsi, Mam, Mien, Lao, Thai, Korean, Japanese, Hindi, Cambodian, Mongolian, Burmese, French, Armenian, and Ilocano.



Success Story

A LifeLong Medical Care patient in her 70s, with comorbid medical and mental health disorders, had been on opiates for pain relief for many years. After taking the training on pain management, this patient's primary care provider referred the patient to the pain management clinic, which initiated lumbar steroid injections for the patient and, together with the primary care provider, managed to decrease the patient's opiate intake. The patient was also referred to behavioral health services within her primary care health home.



Highlights

79%

79% of patients born between 1945 and 1965 were **screened for hepatitis C** (target: 79%).

Measure A Funding Achievements

The Consortium health centers used their Measure A allocation to achieve the following:

- Conduct two Continuing Medical Education (CME) trainings on tapering and managing opioid prescriptions in the primary care setting (target: two)
- Sign five new contracts with interdisciplinary and non-clinical pain management providers (target: five)
- Conduct three CME sessions on hepatitis C management and treatment for 25 providers (target: two sessions for 25 providers)
- To increase the number of patients receiving recommended perinatal care for better maternal and infant outcomes, have one representative on the Alameda County Perinatal Equity Initiative Steering Committee (target: one)
- Offer 772 father-centered services encounters (target: 500)
- Provide food pharmacy, food prescription, and/or food distribution services at eight health centers (target: eight)
- To increase health care coverage and access, conduct 12 On-Site Medical Eligibility (OSME) workshops with eight health centers represented (target: 12 workshops and eight health centers)
- Enroll patients in CalFresh at six health centers (target: six)
- Enroll 38 enrollees in health center centering programs, a provider-led group prenatal care model that results in healthier babies and reduced racial disparities in preterm birth (target: 30)
- Fully implement an electronic health record system in eight health centers (target: eight)
- Enroll 30,762 patients in HealthPAC (target: 30,762)
- Offer provider recruitment and retention programs at eight health centers (target: eight)

★ Highlights

↑ 18%

The number of patients accessing **non-clinical pain management services** such as chiropractic services, acupuncture, and interdisciplinary pain management increased 18% during the fiscal year (target: 18%).



Roots Community Health Center

www.rootsclinic.org

 **FY 19/20 Allocation: \$200,000 | Expended/Encumbered: \$200,000**

 **Individuals served by Measure A:** 208 (Total individuals served: 416)

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

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

 **Service area:** Oakland, Homeless or Transient

Background

Roots Community Health Center works to uplift those impacted by systemic inequities and poverty through medical and behavioral health care, health navigation, workforce enterprises, housing, outreach, and advocacy.

The Roots Healthy Measures program expands access to health care services to formerly incarcerated populations via a Transition Navigator at Santa Rita jail who forms relationships with community members pre-release and bridges them to a Roots Health Navigator post-release, who then facilitates their engagement in clinical and wraparound services at Roots Community Health Center. Roots Health Navigators facilitate improved health care access through patient advocacy and care coordination, while supporting clients to build their own skills of self-advocacy.

Healthy Measures services include individualized case management, primary medical care, behavioral health, barrier removal services, and linkage to social services. These services are imperative to this population given that they are often the most overlooked, complex, and medically vulnerable. The program not only diagnoses and treats medical conditions but also addresses barriers such as housing and food security, which exacerbate chronic illness and ultimately lead to increased recidivism and inappropriate utilization of costly and overburdened systems such as emergency and psychiatric emergency departments.

Measure A Funding Achievements

Roots used its Measure A allocation to achieve the following:

- Through Health Navigation workers, conduct comprehensive enrollment of 416 eligible clients for case management at post-release

Success Story

Rob's life had been going in a downward spiral since a shoulder injury left him temporarily disabled. Before the injury, Rob was a unionized sprinkler fitter making upward of \$60 an hour. After his injury, he could only afford to move from hotel to hotel, eventually living in his sister's backyard. After meeting with Rob, Roots provided him with items from the food pantry and men's clothing pantry, a bus pass, and an ID voucher. Roots also provided funds to get Rob reinstated into the union and helped find him temporary housing. Rob was eventually reinstated into the union and obtained the tools, equipment, and clothes needed for his work.

- Make 575 Navigator visits to 390 clients
- Provide onsite counseling services to 29 unduplicated clients
- Submit 63 Medi-Cal applications for post-release clients, of whom 26 were enrolled in Medi-Cal
- Complete 75 behavioral health sessions

★ Highlights

100%

100% of clients with a specified chronic condition **received medical care.**



Tiburcio Vasquez Health Center, Inc.

tvhc.org

- FY 19/20 Allocation: \$40,000* | Expended/Encumbered: \$40,000**
- Individuals served by Measure A:** 668 (Total individuals served: 668)
- Populations served:** Low Income, Uninsured Children
- Services provided:** Public Health
- Service area:** Ashland, Castro Valley, Cherryland, Hayward, San Leandro, Union City

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

Background

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

TVHC's school-based health centers serve as a safety net option for students to take control of their own health. School health centers increase public health and safety by increasing reproductive health education, reducing unplanned pregnancies, and providing referrals to community clinics that provide primary, dental, vision, behavioral health, and ancillary services for both students and their families.

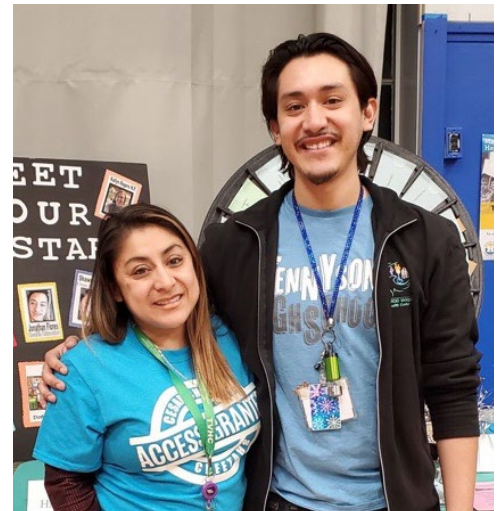
COVID-19 and the closure of schools impacted hours of operation and decreased the number of student patients seen. In response, TVHC implemented telehealth services so that patients could access the health centers to seek information about primary care or reproductive health.

Services are provided in English and Spanish.

Measure A Funding Achievements

Measure A funding helped TVHC achieve the following:

- At the school-based health centers, provide an average of:
 - 13 hours of medical-related services per week to 22% of the student body (target: 16–40 hours to 30–50% of the student body)
 - 38 hours per week of health education, health promotion, and youth development services to 17% of the student body (target: 20–35 hours to 20–40% of the student body)



★ Highlights

88%

88% of Tennyson clients and 66% of Hayward clients were **screened for body mass index (BMI)** at least once during the school year.

- Provide first aid supplies to 729 youth at Tennyson and 220 youth at Hayward
- Offer health education on:
 - Nutrition to 52 youth at Tennyson and 53 youth at Hayward
 - Reproductive health to 488 youth at Tennyson and 53 youth at Hayward
 - Tobacco, alcohol, and other drug use to 27 youth at Tennyson and 53 youth at Hayward
 - Dental health to 486 youth at Tennyson
 - Reproductive health and dental health to 25 adults over age 18 at Tennyson
- Hold health fairs and outreach for:
 - 483 youth at Tennyson and 880 youth at Hayward
 - 338 adults at Tennyson and 201 adults at Hayward
- Coordinate and/or participate in one family and/or community member health-related event and/or activity each at each school-based health center (target: two each)
- Provide 313 follow-up referrals to a primary care provider and/or home clinic
- Through groups at the school-based health centers, make:
 - 41 self-esteem and social skills contacts to youth ages 0–18 and six contacts to adults over age 18
 - Nine crisis intervention/grief support contacts to youth ages 0–18
- Discuss 106 youth ages 0–18 in Coordination of Services Team (COST) consultations and nine youth in non-COST consultations
- Hold COST consultations regarding adults over age 18 involving 51 staff and non-COST consultations regarding adults involving six staff

★ Highlights

100%

Staff attended 100% of Alameda

County Health Care Services

Agency meetings to **support**

the development, design,

sustainability, and efficacy of the

school-based health centers and

respond to any follow-up requests in a

timely manner (target: 80%).



Washington Hospital
Healthcare Foundation

Washington Hospital Healthcare Foundation

whhs.com



FY 19/20 Allocation: \$25,000* | Expended/Encumbered: \$25,000



Individuals served by Measure A: 51,526 (Total individuals served: 139,992)



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



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



Service area: Countywide, Homeless or Transient

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 district residents through medical services, education, and research.

The Morris Hyman Critical Care Pavilion, opened in FY 18/19, is more than four times larger than the previous emergency department, containing 40 examination rooms. This expansion has drastically increased the hospital's ability to provide quality patient care, especially during the pandemic. With the addition of six new defibrillators, the facility is now equipped with additional life-saving technology to offer the most advanced opportunities for care to all populations.

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 Achievements

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

- Purchase and install six Zoll defibrillators for use in the emergency department (target: six)
- Stabilize and treat 51,526 patients in the emergency department (target: 50,000)
- Train 155 emergency room, intensive care, and rapid response personnel in the use of the new defibrillators for emergency resuscitation situations (target: 120)

West Oakland Health Center

westoaklandhealth.org

 **FY 19/20 Allocation: \$1,500,000 | Expended/Encumbered: \$1,500,000**

 **Individuals served by Measure A:** 7,801 (Total individuals served: 7,801)

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

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

 **Service area:** Countywide

Background

West Oakland Health Center (WOHC) works to improve the health and socioeconomic status of the community by providing high quality preventive care for its diverse neighbors throughout the East Bay. WOHC strives to be a hub of health, well-being, connection, and inspiration.

During the COVID-19 pandemic, WOHC offered expanded telehealth services in addition to onsite services including vaccinations, testing, and COVID-19 information.

Services are provided in Spanish, Chinese, Farsi, French, Arabic, Laotian, Portuguese, Punjabi, Russian, ASL, Tagalog, Vietnamese, Nepali, and English.

Measure A Funding Achievements

The one-time Measure A funds received by WOHC helped sustain the organization during the period of unknowns presented by the COVID-19 pandemic. The funds were loaned and were not used by WOHC. Instead, they remained in the WOHC bank accounts, allowing WOHC to maintain a reserve and operate with less financial stress. These funds are being paid back as per the loan agreement.

This cash reserve helped WOHC remain in operation and provide the following:

- 25,451 onsite and virtual medical visits
- 2,947 onsite and virtual dental visits
- 5,526 onsite and virtual mental health visits
- 2,855 onsite substance use visits
- 1,213 onsite and virtual vision visits
- 1,408 case management visits
- 40 childhood immunization status visits (target: 82)
- 1,284 cervical cancer screenings (target: 2,426)

Highlights

25,451

Measure A funds helped WOHC provide 25,451 **onsite and virtual medical visits**.

2,947

Measure A funds helped WOHC provide 2,947 **onsite and virtual dental visits**.

- 280 breast cancer screenings (target: 1,061)
- 1,590 body mass index (BMI) screenings and follow-up plans (target: 3,467)
- 2,982 tobacco use screenings and cessation plans (target: 3,816)
- 3,355 HIV screenings (target: 4,700)
- 776 asthma screenings (target: 1,581)
- 986 diabetes mellitus screenings (target: 3,793)
- 1,890 hypertension screenings (target: 5,629)
- 870 overweight and obesity screenings (target: 1,505)
- 325 HIV tests (target: 333)
- 118 hepatitis B tests (target: 122)
- 720 seasonal flu vaccines (target: 839)

★ Highlights

325

Measure A funds helped WOHc provide 325 **HIV tests** (target: 122).

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Alameda Boys & Girls Club, Inc.

alamedabgc.org

- FY 19/20 Allocation: \$114,794 | Expended/Encumbered: \$114,794**
- Individuals served by Measure A:** ~1,500 (Total individuals served: 2,190)
- 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. ABGC programs address child health concerns such as obesity, heart disease, and depression, as well as tackling unequal access to medical care, mental health services, physical activity, and fresh foods.

The Get Growing gardening and Get Cooking culinary programs teach participants about personal responsibility, commitment, and caring for the environment. The physical activity component helps members with peer-group identification, teamwork, and good sportsmanship. The comprehensive program meets multiple needs among youth and organizational goals through multidimensional and creative methods.

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.

Measure A Funding Achievements

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 255 unduplicated low income youth (target: 12 screenings to 270 youth)



★ Highlights

90%

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

90% of Smart Girls participants learned **something new about** developing positive relationships.

- Provide four health education events and/or workshops to 320 youth (target: four events/workshops to 320 youth)
- Provide four mental health workshops on topics including coping mechanisms for anger, bullying, technology safety, and stress management to 168 youth (target: four workshops to 200 youth)
- Provide three six-session Club Knights workshops discussing how to make good decisions, avoid harmful substances, and act responsibly to 60 middle school male students (target: four workshops to 50 students)
- Provide five 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 77 female students (target: six workshops to 75 students)
- Provide three Healthy Habits workshops to 445 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 445 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)
- Provide dynamic, garden-based nutrition and ecology education to 216 youth (target: 250)
- Provide four low- and high-impact recreation and sports events to help 1,125 youth develop and/or maintain an active and physically fit lifestyle (target: 1,000)



Success Story

This year's awards night was successfully catered by the Seed to Table culinary program. It was fitting that the meal made to celebrate ABGC participants was cooked by Get Cooking participants and featured produce grown by the Get Growing program. The menu included made-from-scratch ragu, béchamel sauce, and salad dressing. Vegetables to create the featured lasagna included onion, broccoli, bell peppers, and Swiss chard. The dinner was a huge success and showcased to participants' parents, who enjoyed the meal, what their children were learning and accomplishing.

Alameda County Pharmacist Association

 **FY 19/20 Allocation: \$4,150* | Expended/Encumbered: \$4,150**

 **Individuals served by Measure A:** 268 (Total individuals served: 268)

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

 **Services provided:** Substance Abuse

 **Service area:** Fremont, Hayward, Oakland, San Leandro

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

Background

Alameda County Pharmacist Association works to advance the practice of pharmacy to promote healthy equity and wellness in Alameda County. The Association makes presentations to seniors to give them a better understanding of how their medications work, the importance of properly disposing unwanted or outdated medications, and how to talk with their doctor and pharmacist about medications. Presentations are also offered to seniors, parents, children, and health care workers on topics such as how drugs affect and harm the brain and how to use Naloxone to reverse the effects of opioid drugs. In response to COVID-19, the Association utilized Zoom to reach and educate health care professionals that interact with seniors and youth.

Presentation information is translated into Spanish.

Measure A Funding Achievements

Alameda County Pharmacist Association leveraged its Measure A allocation to achieve the following:

- Provide 11 health education presentations by pharmacist/instructor (target: four)
- Provide health education presentations on prescription medicine and drug interactions between opioids, nicotine, and/or cannabis to 268 participants (target: 40)

Highlights

100%

100% of health care professionals felt more **knowledgeable about interactions between prescription medications and drugs**

(target: 80%).

Area Agency on Aging Meals on Wheels Program

alamedacountysocialservices.org

 **FY 19/20 Allocation: \$501,000 | Expended/Encumbered: \$501,000**

 **Individuals served by Measure A:** 1,937 (Total individuals served: 10,689)

 **Populations served:** Seniors

 **Services provided:** Public Health

 **Service area:** Countywide

Background

Alameda County Area Agency on Aging (AAA) is the primary agent for change that ensures and sustains a life free from need and isolation for all older Alameda County residents. This community-based system of care provides services that support independence, protects the quality of life of older Californians and persons with functional impairments, and promotes older adult and family involvement in the planning and delivery of services.

Measure A funding provided supplemental funds that allowed SOS Meals on Wheels (MOW) and Spectrum Community Services to avoid putting high risk people on waiting lists. Meal delivery services were impacted greatly because of COVID-19, and each of AAA's programs saw an approximate 50% increase in meals needed, as well as the grocery bag delivery program increasing by about 60%.

Grocery bag inserts are often translated into Chinese and Spanish, and nutrition education materials are translated into Chinese, Vietnamese, Farsi, Japanese, and Spanish as needed.

Measure A Funding Achievements

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

- Provide 57,926 meals and 6,000 grocery brown bags to 250 clients each
- Maintain two gardens in senior housing
- Offer 7,608 service units of the Senior Injury Prevention Program to 1,437 clients



Matching Funds

\$141,831

from state **SNAP Ed funding**.



Success Story

An 81-year-old MOW client has chronic pain from arthritis and back problems. She is not able to stand for any length of time and is no longer able to leave the house without assistance. While family could grocery shop and visit occasionally, they did not live close enough to help on a daily basis. MOW has been providing her with a daily friendly visit and nutritious meal since then.

Asthma Start

acphd.org/asthma.aspx

 **FY 19/20 Allocation: \$100,000 | Expended/Encumbered: \$100,000**

 **Individuals served by Measure A:** 66 (Total individuals served: 70)

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

 **Services provided:** Public Health

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

Background

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

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

- Asthma Start was designated as an Essential Service II during the COVID-19 pandemic, which necessitated a quick redesign in order to provide services to clients by phone and video. Asthma supplies were made available through doorstep drop-offs, which were coordinated and confirmed with clients. The redesign was so effective that the program was invited to share its strategies through two webinars for other asthma programs in California. Adding to the challenge was a backlog of 268 referrals received just before the shelter-in-place.
- COVID-19 safety protocols were implemented to keep clients and providers safe through dropping off of supplies, technology-assisted contact, and obtaining needed signatures via safe measures.
- By ensuring access to a medical home, medical insurance, asthma supplies, and medications, emergency department visits and hospitalizations as well as missed school days and parental work-loss time/wages are reduced. Parents also have access to education to improve their knowledge on how to manage asthma/chronic disease.
- 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.
- Asthma Start addresses Social Determinants of Health by assisting with housing, food, employment, and smoking cessation, and refers and links clients to any other needed services.



Matching Funds

\$405,000

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



Highlights

92%

92% of clients who successfully completed the program **reduced their number of emergency room visits at discharge** (target: 80%).

- The program advocates 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.
- Partnering with Alameda Alliance for Health, the program has increased the number children who have access to asthma case management. Alliance works with Valley Care and UCSF Benioff Children's Hospitals and receives weekly reports on children who 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.

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

Measure A Funding Achievements

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

- Enroll 70 clients in the program (target: 50)
- Successfully discharge 53 clients from the program (target: 40)



Success Story

During a call with an Asthma Start coordinator, a mother advised she thought mold might be causing her child's asthma. Due to shelter-in-place, the coordinator couldn't go into the home but was able to observe a possible cause of the mold at the apartment where they lived. The coordinator made several recommendations for treating the mold accumulation as well as changing bedrooms. The coordinator provided the mother with some cleaning supplies to abate the problem. After a four-week follow-up, the mother said the child had no asthma symptoms and showed a photo that indicated the mold was 95% gone. The coordinator was able to provide alternative methods for assistance.



Center for Early Intervention on Deafness

ceid.org

-  **FY 19/20 Allocation: \$57,397 | Expended/Encumbered: \$57,397**
-  **Individuals served by Measure A:** 114 (Total individuals served: 1,040)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Public Health
-  **Service area:** Alameda, Albany, Berkeley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Pleasanton, San Leandro, San Lorenzo, Union City, Homeless or Transient

Background

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

CEID provides 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 that accept patients with Medi-Cal. CEID's rapid response to continue providing services during the COVID-19 shelter-in-place meant outreach via phone and video, as well as providing resources and referrals, which allowed patients to continue getting quality and timely care.

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-six 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.



★ Highlights

100%

100% of newborn babies who needed a screening were **scheduled within one week of receiving a referral** (target: 95%).

Measure A Funding Achievements

CEID used its Measure A allocation to achieve the following:

- Conduct 16 newborn hearing screenings based on referrals from community clinics, Alta Bates Medical Center, and UCSF Benioff Children's Hospital Oakland (target: 75)
- Perform 481 hearing evaluations for children, youth, and adults based on referrals from community clinics (target: 450)
- Dispense hearing aids and ear molds to 185 patients based on referrals from UCSF Benioff Children's Hospital Oakland, Kaiser, California Children's Services (CCS), and community clinics (target: 175)
- Train 32 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)

★ Highlights

96%

96% of patients reported that their **quality of life, in terms of access to sound in environments and communication, improved** (target: 85%).



Countywide Plan for Seniors: Getting the Most Out of Life

gettingthemostoutoflife.org

-  **FY 19/20 Allocation: \$250,000 | Expended/Encumbered: \$217,666**
-  **Individuals served by Measure A:** 653 (Total individuals served: 5,874)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Families, Seniors
-  **Services provided:** Public Health
-  **Service area:** Alameda, Berkeley, Dublin, Fremont, Oakland, San Leandro

Background

“Getting the Most Out of Life” (GMOL) is an institutionalized, community-based palliative care program in Alameda County. GMOL supports underserved sick, frail, and terminally ill elders and their care providers through deep listening and goals of care conversations by supporting them to complete Advance Directives (ADs) expressing their health care decisions.

During the shelter-in-place, GMOL implemented telehealth virtual home visits, established the National Healthcare Decisions Day (NHDD) Train-the-Trainer education curriculum, set up case management support, and continued to develop diverse community partnerships. Clients were connected to social resources in order to remain safe and comfortable in their homes. Though the program was stymied by COVID-19, the team did COVID screenings and were available to clients for questions and concerns. GMOL also provided information about Advance Care Planning (ACP) online, collaborating remotely with over 25 community partners as well as a group of Alameda County Health Care Services Agency (HCSA) staff in a Train-the-Trainers Education Initiative.

In order to serve all languages, GMOL uses the language line along with UC Berkeley student volunteer translators, bilingual In-Home Supportive Services (IHSS) care providers, bilingual staff, and community and faith-based organization partners.

Measure A Funding Achievements

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

- Provide ACP and related services to 190 new IHSS clients (target: 190)
- Make follow-up visits with 125 clients (target: 36)
- Perform 171 ACP home visits with clients to assist with completing ACP forms (target: 180)



Matching Funds

\$438,018

from the **Alameda County Social Services Agency, In-Home Supportive Services/Public Authority (IHSS/PA), and Medi-Cal Administrative Activities (MAA).**

- Complete:
 - 140 ADs (target: 120)
 - 132 Physician Orders for Life-Sustaining Treatment (POLST) forms (target: 120)
 - 150 intake questionnaires (target: 120)
- Receive 146 post-home visit evaluations (target: 120)
- Connect 159 clients connected to other resources (target: 150)
- Coordinate care for 120 IHSS recipient clients by sharing copies of their AD/health care risks with their primary care providers
- Send 123 ADs and letters to clients' primary care providers (target: 120)
- Make eight home health and hospice information visits and referrals/admissions (target: 24)
- Train 5,246 IHSS care providers and 23 Alameda County IHSS professionals on ACP-related topics (target: 5,400 providers and 60 professionals)
- Provide 19 NHDD Train-the-Trainer trainings to 628 new trainers (target: 12 trainings to 600 trainers)
- Enable 1,256 participants to receive NHDD training from newly trained NHDD trainers (target: 1,200)



Success Story

After receiving a call from the son of an elderly woman, Care Partners assessed the woman using various tools and techniques to determine that the client needed additional IHSS hours, contact with her social worker, education for her and her son regarding monitoring her condition, and tools for care. A list of issues was created for the client and son to discuss with her physician, and they completed ACP education and AD and POLST forms training. These measures helped the client remain safely at home with an improved quality of life.

Countywide Plan for Seniors: Home-Based Nursing Case Management

acphd.org/older-adults.aspx

 **FY 19/20 Allocation: \$500,000 | Expended/Encumbered: \$500,000**

 **Individuals served by Measure A:** 217 (Total individuals served: 217)

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

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

 **Service area:** Alameda, Albany, Castro Valley, Fremont, Hayward, Livermore, Newark, Oakland, San Leandro, Union City

Background

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

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

OA/HR nurse case managers provide home- and community-based case management services to medically complex, very vulnerable older adults whose psychosocial challenges create significant barriers to health and well-being. Case managers work closely with clients, their caregivers, family members, and others to identify and make progress toward achievable goals.

During the height of the pandemic, all public health nurses were needed for the COVID-19 response. Because OA/HR is operated by nurse case managers, the program was suspended while case managers were deployed to COVID outbreak investigations and management. Nurse case managers attempted to stay in touch with their clients by phone during the shelter-in-place and make appropriate referrals to ensure stability before closing the cases.

Client service languages include English, Spanish, Dari, Cantonese, and Vietnamese.



Matching Funds

\$53,492

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



Highlights

91%

91% of clients received a **comprehensive nursing assessment** within two weeks of enrollment, and 89% had an **ICP completed and approved** in the two weeks following.

Measure A Funding Achievements

The OA/HR program used its Measure A allocation to achieve the following:

- Refer 45 clients to and enroll 30 clients in the program (target: enroll 45 clients)
- Conduct 1,270 intensive public health nurse case management encounters, including 333 face-to-face encounters, to medically complex and vulnerable clients 60+ years old with psychosocial challenges
- Develop 38 individualized care plans (ICPs) for high risk clients to specifically address and improve their quality of life
- Ensure that 40 clients received a home-based Comprehensive Nursing Assessment



Success Story

BA was a 79-year-old female with a history of severe hypertension, COPD, anxiety, physical frailty, substance misuse, and frequent emergency room visits. BA was referred to OA/HR by a social worker. The case manager completed an assessment and worked with BA's primary care provider to help him to sort out her medication regimen and implement a pain contract with a stable monthly prescription. BA also got in-home mental health services. By the time the pandemic hit, BA was in a much more stable situation. Thanks largely to BA's nurse, BA found a measure of peace and security at the end of her life.

Countywide Plan for Seniors: Senior Injury Prevention Program

alamedacountysocialservices.org

-  **FY 19/20 Allocation: \$797,808 | Expended/Encumbered: \$797,808**
-  **Individuals served by Measure A:** 250 Meals on Wheels; 250 grocery brown bag; 1,437 SIPP (Total individuals served: 3,575 Meals on Wheels; 5,500 grocery brown bag; 1,614 SIPP)
-  **Populations served:** 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 runs four programs funded by Measure A: Meals on Wheels meal delivery, Mercy Brown Bag grocery delivery, a gardening program at low income senior housing, and the Senior Injury Prevention Program.

COVID had a major impact on the meal delivery services because of increased demand (50-60% more), a change in the delivery model, and a struggle to find younger volunteers to replace older adult volunteers. The gardening program also suffered as a result of the shelter-in-place orders.

Grocery bag inserts are often translated into Chinese and Spanish, and nutrition education materials are translated into Chinese, Vietnamese, Farsi, Japanese, and Spanish as needed.



Matching Funds

\$141,831

from state **SNAP Ed funding**.

Measure A Funding Achievements

AAA used its Measure A allocation to achieve the following:

- Provide 57,926 meals to 250 Meals on Wheels clients
- Distribute 6,000 grocery brown bags to 250 Mercy Brown Bag clients
- Establish two gardens in senior housing
- Provide 7,608 service units to 1,437 clients in the Senior Injury Prevention Program

COVID-19 Crisis Response Services

acgov.org/health (HCSA) / homelessness.acgov.org (OHCC)



FY 19/20 Allocation: \$54,332 | Expended/Encumbered: \$44,172



Individuals served by Measure A: 1,276 (Total individuals served: 1,278)



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



Services provided: Public Health



Service area: Countywide, Homeless or Transient

Background

The Alameda County Health Care Services Agency (HCSA) and Alameda County Office of Homeless Care and Coordination (OHCC) work in partnership to achieve health equity by providing high quality services, fostering safe and healthy communities, and promoting fair and inclusive opportunities for all residents. In response to COVID-19, OHCC received one-time Measure A funds to provide critical, immediate, and ongoing services through Project Roomkey, an initiative that secured hotel rooms to house homeless people during the pandemic. OHCC activities included providing support to Project Roomkey program operators and stakeholders during the initial phase of program operations. These services played critical roles in the establishment of 13 Project Roomkey hotel and trailer projects, which safely accommodated 1,276 individuals by the end of FY 19/20 and continued to operate throughout the COVID-19 crisis.

Every Project Roomkey guest is linked to a case manager who provides connections to needed services such as mental health, health care, entitlement benefits, and other safety net resources. In addition, every guest receives an individualized housing plan. To date, 405 guests have successfully exited to housing.

Measure A Funding Achievements

OHCC used its Measure A allocation to attend three Project Roomkey program workflow and procedure meetings (target: three).



Success Story

A 52-year-old woman, who had been in and out of jail and struggling with addiction and trauma, had left a treatment program with no place to go. She was living on the streets when she got a call from a treatment program saying there was an open hotel room for her as part of Project Roomkey. Now she says, "I feel good every day... got my strength back on. I look good. My mind is set! It feels good to have a roof over your head, take a hot shower every day, and have something in your stomach."

Dana Burrell (Glass Door Communications)

glasshousepr.com

\$ FY 19/20 Allocation: \$46,500* | Expended/Encumbered: \$0

Includes Board of Supervisors discretionary allocation from **District 1/Supervisor Haubert and **District 2/Supervisor Valle***

Background

Glass House Communications is a public relations and event planning organization serving the nonprofit and public-facing sectors.

Measure A Funding Achievements

Glass House Communications planned to use its Measure A allocation to hold a Mental Health Summit. The event was canceled due to COVID-19, and no funds were spent.



Drivers for Survivors

- \$ FY 19/20 Allocation: \$10,000* | Expended/Encumbered: \$10,000**
- Individuals served by Measure A: 7** (Total individuals served: 109)
- Populations served:** Low Income Adults, Seniors
- Services provided:** Emergency Medical, Hospital Outpatient
- Service area:** Ashland, Castro Valley, Cherryland, Dublin, Fremont, Hayward, Livermore, Newark, Pleasanton, San Leandro, San Lorenzo, Union City

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

Background

Drivers for Survivors provides free transportation service and supportive companionship for ambulatory cancer patients from suspicious findings through completion of treatments.

Throughout the COVID-19 pandemic, Drivers for Survivors ride requests were significantly decreased in all service areas because nonessential medical appointments were cancelled. The signature fundraiser for this organization, Black & White Ball, was postponed as well. As of February 29, 2021, Drivers for Survivors was officially closed.

Services were provided in English, Spanish, and Chinese.



Measure A Funding Achievements

Drivers for Survivors used its Measure A allocation to achieve the following:

- Provide 82 rides for East Alameda County clients (target: 400)
- Serve seven unduplicated clients (target: 20)

★ Highlights

90%

90% of clients reported that the program **helped them meet their treatment plans** (target: 90%).



Eden United Church of Christ (Padres Unidos)

facebook.com/PUdeCherryland

\$ FY 19/20 Allocation: \$25,000* | Expended/Encumbered: \$25,000

Individuals served by Measure A: 200 (Total individuals served: 400)

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

Services provided: Public Health, Mental Health

Service area: Ashland, Cherryland, Hayward

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

Background

Padres Unidos de Cherryland (PUC) works to promote healthy initiatives in unincorporated Cherryland. This parent-led group advocates for safe school routes for Cherryland Elementary School. The group collaborates with County officials, the Safe Routes to School program, the Hayward Unified School District, Public Works, and the office of Alameda County Supervisor Miley to keep children and families safe.

Other activities include workshops on mental health resources, domestic violence, positive parenting skills, sexual abuse prevention, and community health. The group provides information to increase awareness around chronic illnesses and promote health in a culturally appropriate way.

In response to COVID-19, PUC committed to virtual meetings and continuing its mission to keep community members healthy, engaged, and organized to respond to community needs.

Services are offered in Spanish and English.

Measure A Funding Achievements

PUC used its Measure A allocation to achieve the following:

- Provide three behavioral health trainings to 65 community members (target: three trainings to 60 members)
- Distribute brochures about diabetes prevention and available health care services in Spanish and English to 400 residents (target: 400)
- Ensure that 42 community leaders participated in the Safe Routes to School training (target: 25)
- Offer the Safe Routes to School presentation to 42 participants (target: 30)
- Conduct three Safe Routes to School training workshops (target: three)



Success Story

A new member of the Cherryland community began attending the PUC community meetings. She was concerned about safe pathways to her children's school. Being trained in the Safe Routes to School model, she volunteered to help make a difference. She got training and support of community leaders, the Alameda County Sheriff, and District 4 staff. She connected with Public Works officials to identify solutions for the lack of sidewalks. This woman also learned about access to mental health resources and support and connected with a therapist who speaks her language. She became an active member and leader in her community who could be counted on by her peers.

Eden Youth and Family Center

eyfconline.org



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



Individuals served by Measure A: 234 (Total individuals served: 615)



Populations served: Low Income Adults, Children, Families



Services provided: Public Health, Mental Health, Substance Abuse



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

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

Background

Eden Youth and Family Center (EYFC) promotes equitable access to coordinated services, strategic partnerships, policy, and advocacy, contributing to the overall health and well-being of youth and families in historically under-resourced communities.

In FY 19/20, youth received extensive training on tobacco/marijuana prevention and effects on the brain through the Youth Advisory Council (YAC). The YAC advocated to the Hayward Economic Development Committee and Community Commission for the ban of flavored tobacco, e-cigarettes, and vaping products in Hayward. They also met with Hayward City Council members and the mayor. Ultimately, the Hayward City Council passed a ban on flavored tobacco, vaping products, and e-cigarettes.

In response to the COVID-19 shelter-in-place order, EYFC quickly transitioned to online/virtual services and expanded resource deliveries to meet the need for social and emotional support for their youth and families. They provided bilingual messaging through their website and social media to help parents access the equipment and internet services required to keep their children engaged in school assignments. For families without home printers or other necessary supplies, including food or housing, EYFC located solutions. The youth team expanded virtual check-ins, movie nights, and Zoom hangouts, and designed weekly “We Care Packages” stocked with games and art supplies. In addition, EYFC’s Computer Clubhouse staff supported youth by providing technology support to gain access to virtual school platforms and stay connected to their academics.

Services are provided in English and Spanish, and additional translation services are available.



Matching Funds

\$17,635

from **Hayward Promise
Neighborhood for Substance
Use Education and Prevention,
Case Management, Technology
Support, and Workforce
Development.**

Measure A Funding Achievements

EYFC used its Measure A allocation to achieve the following:

- Provide 22 at-risk youth with case management to improve their overall health and well-being (target: 30)
- Make three referrals for behavioral health services for crisis intervention
- Provide 615 youth with individual or group life skills training that covered health, wellness, drug prevention, and nutrition information to increase their knowledge of maintaining a healthy lifestyle (target: 30)
- Coordinate YAC to provide leadership development, training, and awareness campaigns focusing on tobacco, marijuana, and opioid use for 20 youth participants (target: 10)

★ Highlights

83%

83% of youth **increased their social-emotional wellness, specifically their social and coping skills** when things go wrong (target: 80%).



Emergency Medical Services Corps

ems.acgov.org/CommtyResources/EMSCorps

\$ FY 19/20 Allocation: \$607,791 | Expended/Encumbered: \$607,791

Individuals served by Measure A: 613 (Total individuals served: 613)

Populations served: Low Income, Uninsured Adults

Services provided: Emergency Medical, Substance Abuse

Service area: Countywide

Background

The Emergency Medical Services (EMS) Corps works to increase the number of underrepresented Emergency Medical Technicians (EMTs). Through its life coaching, community service, mentorship, and health and wellness programs, EMS Corps helps give participants the tools to be successful in their personal and professional lives.

Over 30 Alameda County Health Care Services Agency (HCSA), Behavioral Health Care Services (BHCS), and Public Health Department (PHD) staff, as well as external ambulance companies, collaborated to provide health career exposure to youth.

Services are provided in English and Spanish.



Measure A Funding Achievements

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

- Provide nine workforce development activities to 95 youth and young adults (target: five schools involved with a goal of 90 attendees)
- Conduct two five-month-long cohorts for a total of 130 young men of color (target: 160 participants)
- Recruit and interview 65 potential candidates for EMS Corps (target: 80)
- Select 34 participants for the EMS Corps program (target: 40)
- Implement five workforce development projects/activities to serve youth and young adults (target: three)
- Work with ten partners in the implementation of projects/activities (target: five)
- Hold seven meetings with partners and employers to provide technical assistance for recruitment and retention of boys and men of color for EMS Corps and other related youth programs (target: five)
- Share six communications to support assistance for recruitment (target: three)

★ Highlights

100%

100% of participants **learned EMT training skills** (target: 100%).

Ernestine C. Reems Community Services

 **FY 19/20 Allocation: \$100,000* | Expended/Encumbered: \$100,000**

 **Individuals served by Measure A:** 125 (Total individuals served: 325)

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

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

 **Service area:** Alameda, Oakland

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

Background

Ernestine C. Reems Community Services advocates and provides for community members' educational needs. The program refers many of its participants to housing services, job training and education, and mental health services.

Due to COVID-19, services were conducted virtually and through the use of mobile phones.

Measure A Funding Achievements

Ernestine C. Reems Community Services used its Measure A allocation to achieve the following:

- Provide case management services to 128 adults (target: 125)
- Make health and social services referrals for 88 adults (target: 85)
- Offer 52 hours of counseling services (target: 65)
- Provide 32 one-on-one mentoring services (target: 40)

Highlights

69%

69% of reentry clients reported they were **able to take action to improve their circumstances** (target: 40%).



Family Paths

familypaths.org

-  **FY 19/20 Allocation: \$5,000* | Expended/Encumbered: \$5,000**
 -  **Individuals served by Measure A:** 279 calls (Total individuals served: 1,159 calls)
 -  **Populations served:** Indigent, Low Income, Uninsured Adults, Families
 -  **Services provided:** Mental Health
 -  **Service area:** Ashland, Cherryland, Hayward
- *Includes Board of Supervisors discretionary allocation from **District 2/Supervisor Valle***

Background

Family Paths provides mental health and supportive services with respect, integrity, compassion, and hope to strengthen family relationships. Intervention and support services are provided to help families who are in immediate crisis, including risks from COVID-19, child abuse, domestic violence, exposure to violence, social isolation, effects from immigration and acculturation, parenting stress, and family mental health issues. Community needs are addressed through a 24-hour Parenting Stress Helpline, as well as preventative and supportive services through parenting classes and mental health treatment. Helpline counselors attend to the emotional needs of parents and caregivers and build their resilience through active listening and validation and by sharing tools that will help them stay in or return to a grounded and calm state. Helpline counselors also provide community resources and information to parents and caregivers, facilitate referrals to the mental health and parent education services offered at Family Paths, and engage parents and caregivers in the process of looking at concerns or behavioral challenges and coming up with ideas for the parent or caregiver to try.

During the COVID-19 shelter-in-place, Family Paths parent education classes and mental health programs were offered virtually and/or through telehealth. Family Paths also created and launched a Parent Advisory Group (PAG) that met monthly to consider ways to improve Family Path services and maximize the impact of Measure A funding.

Helpline staff provide services in Spanish and English, and access to the County language line is available for other languages.



Success Story

A mother of a six-year-old child called the Parenting Stress Helpline and stated that she was in crisis because she was unable to regulate herself or her overactive child. The Helpline counselor worked with her to shift her negative self-talk to more kind and compassionate thoughts. The mother was also encouraged to practice self-compassion and regulation tools to be with the feelings and sensations instead of fighting against them. The caller made a connection between how she was feeling about herself and how she felt about her child. By the call's end, she was more grounded and positive. She also continued speaking with the counselor weekly.

Measure A Funding Achievements

Family Paths used its Measure A allocation to achieve the following:

- Field 1,159 calls to the Parenting Stress Helpline, including 279 calls from Alameda County Supervisorial District 2 residents (target: 2,000 calls and 250 from District 2 residents)
- Provide immediate phone support to 857 Helpline callers, and/or screen and direct them to additional resources at Family Paths (target: 869)





Health Services for Persons Who Inject Drugs: HIV Education and Prevention Project of Alameda County | heppac.org

-  **FY 19/20 Allocation: \$310,684 | Expended/Encumbered: \$310,684**
-  **Individuals served by Measure A:** 3,433 (Total individuals served: 5,002)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Seniors
-  **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 only program in Oakland that addresses persons who inject drugs (PWIDs) and their increased risk for HIV and Hepatitis C due to their drug use. HEPPAC's primary population of active drug users includes unhoused residents of Oakland and Black, Indigenous, and Persons of Color (BIPOC). HEPPAC's fixed and mobile integrated services spanning North, West, Central East, and Deep East Oakland enable more unhoused and homeless individuals to access harm-reduction supplies. In response to COVID-19, HEPPAC also provided PPE, including N95 and daily masks, hand sanitizer, and gloves, to participants.

In the OPEND program, HEPPAC provides both mobile services to PWIDs and marginalized populations, as well as services at three fixed Syringe Service Program (SSP) locations in in West, Central East Fruitvale, and Deep East Oakland.

In response to the COVID -19 pandemic, HEPPAC worked with the City of Oakland and outside agencies to coordinate integrating harm-reduction services into the larger spectrum of mobile outreach services throughout Oakland, including providing ready-to-eat meals and adding hand-washing stations at mobile and fixed sites.

HEPPAC's mobile team also continued to educate participants about and refer them to internal wound care services. HEPPAC worked with partner agencies providing abscess wound care to create a referral plan and new ways of providing services during the pandemic, such as setting up outdoor medical rooms and providing education on safer injection practices to prevent abscesses in an open setting to support social distancing.



Success Story

Tina, a 61-year-old African American female, began injecting drugs at the age of 30. HEPPAC's mobile team provided services to the encampment where Tina lived, including a hand-washing station, supplies for hygiene and wound care, PPE, syringes and other harm-reduction supplies, and a hot meal. Since Tina had tested positive for Hepatitis C the previous year, HEPPAC referred her to COVID-19 testing and a doctor to follow up regarding her Hepatitis C status. Testing showed that she was in need of aggressive treatment for her Hepatitis C and had COVID-19. HEPPAC worked to successfully get Tina into stable housing and start and maintain Hepatitis C treatment.

Holistic nonwestern medicine is one of HEPPAC's most utilized services. Clients use the services for ailments such as decreasing smoking sensation, increasing liver function, joint pain, skin repair, and detoxification. During the pandemic, acupuncture services were halted, and consults, tinctures, and other non-injectable herbalist supplies were distributed for ailments and other medical issues that acupuncture and/or herbs assist.

During mobile and fixed SSPs, HEPPAC offers Medication Assistance Treatment (MAT) by providing PWIDs with pamphlets and individual interventions to address their interest in decreasing and/or abstaining from using their drug of choice. HEPPAC also distributes fentanyl test strips at SSPs and encourages participants to test their supply in bulk.

Services are offered in Spanish.

Measure A Funding Achievements

HEPPAC used its Measure A allocation to achieve the following:

- Provide 30 hours per week of syringe access services in Oakland (target: 30)
- Exchange 34,690 sterile syringes and 27,352 used/littered syringes (target: 50,000 and 100,000)
- Treat 79 PWIDs for soft tissue infection (target: 150)
- Refer 85 PWIDs to the onsite medical team (target: 150)
- Provide herbal/acupuncture services to 1,535 PWIDs (target: 2,000)



★ Highlights

76%

76% of syringe access participants learned about safer injection techniques and methods for proper disposal of used/littered syringes (target: 65%).



Healthy Food Healthy Families:

Alameda County Community Food Bank

accfb.org

-  **FY 19/20 Allocation: \$47,500* | Expended/Encumbered: \$47,500**
-  **Individuals served by Measure A:** 12,093 (Total individuals served: 350,000)
-  **Populations served:** Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Public Health
-  **Service area:** Ashland, Cherryland, Oakland

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 helped La Clínica de la Raza, Native American Health Center, Roots Community Health Center, and West Oakland Health Center to provide healthy food to their patients, half of which consisted of fresh fruits and vegetables.

The Food Bank and pantries also work to collaborate in ways that can support improved food security and improved community health outcomes, including collaboration with health systems that can help clients/patients and their families access a healthy diet to support prevention and management of diet-sensitive chronic illness. Food distributions at health care sites help the Food Bank to meet clients where they are and helps health systems provide access to services when patients screen as being at risk of or experiencing food insecurity.

Services are provided in English and Spanish

Measure A Funding Achievements

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

- Support four clinic partners by conducting 89 food distributions (target: 48 distributions)
- Supply 82,125 pounds of food for 54,750 meals to patients/clients at four partner sites (target: 96,000 pounds and 122,400 meals)

Highlights

100%

100% of distributions included **at least two fresh vegetables** (target: 100%).

27.9 LBS.

An average of 27.9 **pounds of food were provided** per client household (target: 25 pounds).



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

acdsal.org

- \$ FY 19/20 Allocation: \$168,910* | Expended/Encumbered: \$168,910**
- Individuals served by Measure A: 23,354** (Total individuals served: 23,354)
- Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
- Services provided:** Public Health
- Service area:** Alameda, Ashland, Castro Valley, Cherryland, Fairview, Fremont, Hayward, Newark, Oakland, Piedmont, San Leandro, San Lorenzo, Union City, Homeless or Transient

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

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.

To ensure the availability of fresh produce to Alameda County communities with high levels of food insecurity, DSAL built the Dig Deep Farms Food Hub. The Food Hub benefits community health, particularly the health of low income residents, by:

- Aggregating, cleaning, processing, packaging, and distributing recovered produce and food items to nutrition programs and affordable housing complexes for low income children, adults, and seniors, or other places where fresh, nutritious food is needed.
- Aggregating and distributing produce from local and regional growers to institutional purchasers throughout Alameda County, such as hospitals, schools, and other institutions.
- Scaling up "Food as Medicine" pilot projects to provide at-risk youth and families with "prescriptions" for fresh produce at a farm stand or through delivery, thus making produce accessible to low income consumers and raising awareness of how and why to cook and consume a variety of fruits and vegetables.
- Building a pipeline of living-wage food systems jobs in small business opportunities based around the Food Hub. The pipeline includes entrepreneurship development, business incubation, and career pathway education and support for Food Hub employees to move up the ladder in restaurant work, transportation, distribution and logistics, food processing, and/or supervision and management.



Matching Funds

\$1.24M

from the following sources:

- CalRecycle
- StopWaste
- Stupski Foundation
- Alameda County Social Services
- Alameda Alliance
- Kaiser Permanente
- USDA Community Food Project

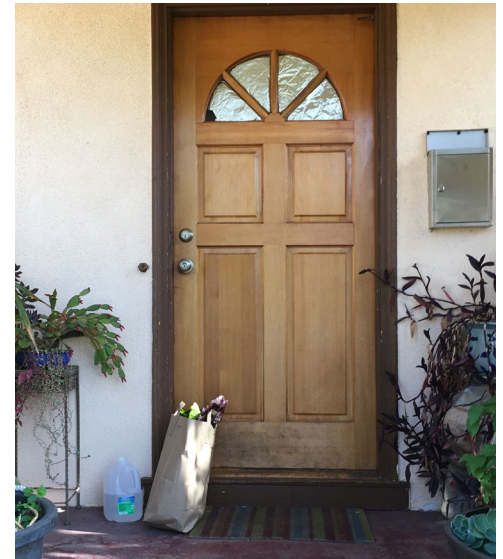
Though COVID-19 caused delays with the Food as Medicine program, the program developed other means of distributing prescriptions, such as transitioning to home delivery instead of in-clinic pick up. This involved establishing a system to route deliveries and creating dispatch lists for each vehicle and partnering with East Bay Paratransit to employ drivers who would otherwise have been furloughed/unemployed due to the shutdown to transport bags of fresh produce, boxes of fresh produce from Bay Cities Produce, food bank food, and the meals prepared by partner restaurants and caterers. In addition, DSAL launched an Emergency Food Distribution Grant program, which awarded \$15,000 to local food vendors who would otherwise have been shuttered to prepare meals for distribution.

DSAL provides services in English and Spanish.

Measure A Funding Achievements

DSAL used its Measure A allocation to achieve the following:

- Prescribe 2,373 produce prescriptions (target: 2,700)
- Redeem 1,651 produce prescriptions at Hayward Wellness Center's food Farmacy, operated by Dig Deep Farm's stand (target: 2,000)
- Distribute 113,168 servings of produce through produce prescriptions at Dig Deep Farm's stand (target: 9,450)
- Provide 629 culturally relevant recipes, including ingredients, by Dig Deep Farms (target: 500)
- Hire and train one staff at Dig Deep Farms to operate the Food Farmacy (target: one)
- Have 1,135 produce prescriptions redeemed at the Food Farmacy operated by Dig Deep Farms (target: 3,600)
- Have 5,547 prescriptions redeemed at the second Food as Rx Clinic (target: 1,500)
- Recover and transfer 357,537 pounds of food to 60,907 individuals at affordable housing complexes for consumption by residents (target: 350,000 pounds of food to 500 individuals)
- Allow 31 entrepreneurs to use the Food Hub commercial kitchen space for their food production (target: 2–4)
- In response to the COVID-19 shelter-in-place:
 - Serve 32,768 families, including an estimated 6,600 unduplicated families, through food delivery and pick-up models
 - Deliver or have picked up 114,471 bags of food
 - Have 62,984 meals prepared by vendors in need of work or income, 30 of whom would have otherwise been out of work



★ Highlights

95%

95% of patients who redeemed produce prescriptions reported **improvement in their eating habits** (target: 50%).



Healthy Food Healthy Families: La Clinica De La Raza

laclinica.org



FY 19/20 Allocation: \$15,000* | Expended/Encumbered: \$15,000



Individuals served by Measure A: 4,007 (Total individuals served: 4,007)



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



Services provided: Public Health



Service area: Oakland

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

Background

La Clinica de La Raza improves the quality of life for diverse communities by providing culturally appropriate, high quality, accessible health care for all. La Clinica's Food Farmacy program provides families with whole grains, lean protein, and large quantities of fresh produce from the Alameda County Community Food Bank and Dig Deep Farms.

Due to COVID-19, clinic visits decreased and fewer patients received referrals to the Food Farmacy. In response, La Clinica offered its Food Farmacy as a food bag pick-up. This enabled La Clinica to serve an increased number of clients due to a greater need for food during the pandemic.

Services are provided in English, Spanish, and Cantonese.

Measure A Funding Achievements

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

- Serve 4,007 individuals via Food Farmacy distributions (target: 500)
- Provide CalFresh information to 221 participants (target: 300)
- Provide food vouchers or prescriptions to 167 patients (target: 300)



Highlights

88%

88% of participants said the food distributions **improved their food security** (target: 75%).

83%

83% of participants reported that the vouchers/prescriptions allowed them to **receive foods they would otherwise not have access to** (target: 75%).



Healthy Food Healthy Families: Native American Health Center

nativehealth.org

- FY 19/20 Allocation: \$15,000* | Expended/Encumbered: \$15,000**
- Individuals served by Measure A:** 612 (Total individuals served: 612)
- Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
- Services provided:** Public Health
- Service area:** Oakland

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

Background

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

Groups and community events were cancelled or postponed due to the COVID-19 pandemic, but services were quickly adapted to provide food through drive-through and no-contact delivery for families and elders, instead of the previous model of the walk-in Food Farmacy. Collaboration with the Alameda County Community Food Bank, Dig Deep Farms, and Mandela Marketplace made this shift possible. Much-needed resources were provided during the pandemic to community elders, those in quarantine, those fearful of leaving their homes, people who lost jobs, and those who were unable to safely access grocery stores.

Services are provided in English and Spanish

Measure A Funding Achievements

NAHC used its Measure A allocation to achieve the following:

- Serve 612 individuals/patients via Food Farmacy distributions (target: 500)
- Provide CalFresh information to 612 participants (target: 300)
- Distribute 800 food prescriptions/vouchers (target: 300)
- Hold 20 one-on-one interviews with Food Farmacy participants (target: 20)



Success Story

Julia (Creek Nation of Oklahoma) said, “What I liked best about the program is that it teaches you to eat healthy, and gives you ideas about how to drink more water, and use local/traditional foods and recipes to get the correct nutrients. I also learned how to read nutrition labels to understand that I should look at the information—serving size, ingredients, etc. I have heart disease in my family, so I had to change for the better, and encourage my daughter to eat healthy, too. Now she loves fruit!”



Healthy Food Healthy Families: Roots Community Health Center

rootsclinic.org

-  **FY 19/20 Allocation: \$15,000* | Expended/Encumbered: \$15,000**
-  **Individuals served by Measure A:** 541 (Total individuals served: 541)
-  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families, Seniors
-  **Services provided:** Public Health, Mental Health
-  **Service area:** Oakland

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

Background

Roots Community Health Center works to uplift those impacted by systemic inequities and poverty through medical and behavioral health care, health navigation, workforce enterprises, housing, outreach, and advocacy.

Being located in the “food desert” of East Oakland, Roots provides fresh locally sourced produce to the community. Clients who receive food from these distributions greatly increase their fruit and vegetable intake, tackle food insecurity in their household, increase their overall healthy eating habits, and combat negative health conditions through food.

Roots also partners with other internal programs and external organizations to hold food distributions that offered tabling opportunities for other clinical, behavioral, and place-based programming. In response to COVID-19, Roots quickly pivoted to a delivery service for all clients in need of food access and education.

Services are provided in Spanish and English.

Measure A Funding Achievements

Roots used its Measure A allocation to achieve the following:

- Distribute food to 541 individuals, including 132 seniors, 313 adults, and 96 children (target: 500)
- Provide CalFresh programming and enrollment information to 541 individuals (target: 300)
- Provided a food voucher or prescription to 424 individuals (target: 300)
- Conduct 24 one-on-one interviews or focus groups with participants of the food distribution program (target: 20)

★ Highlights

100%

100% of participants reported being **satisfied or very satisfied with the quality of foods received** (target: 75%).

95%

95% of participants reported that the distributions **improved food security** in their household (target: 75%).

Healthy Food Healthy Families:

UCSF Benioff Children's Hospital Oakland

childrenshospitaloakland.org

 **FY 19/20 Allocation: \$39,857* | Expended/Encumbered: \$39,857**

 **Individuals served by Measure A:** 365 (Total individuals served: 365)

 **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, healing, teaching, and research.

Families enrolled in the BCHO Food as Medicine program receive deliveries of fresh vegetables and whole grains. This leads to both improved food security, resulting from an increased connection to food resources and increased knowledge of cooking through receipt of novel foods and texted recipes, as well as better diet, through increased consumption of vegetables.

Throughout the COVID-19 pandemic, the Food as Medicine program continued to deliver food to families. Despite some people having difficulty shopping as a result of shelter-in-place orders, farmers markets were deemed essential services and home deliveries of nutritious food took place. During this time, BCHO expanded the program to include families of adolescents who have type 2 diabetes. Without the benefit of in-person clinic visits to evaluate long-term health impacts, BCHO was able to continue to gather data from participants through online surveys and telephone conversations.

Services are provided in English and Spanish.

Measure A Funding Achievements

Through the Food as Medicine program, BCHO used its Measure A allocation to supply 846 community-supported agriculture (CSA) vegetable deliveries weekly to 75 food-insecure families, totaling 365 individuals, for three months (target: 900 deliveries to 75 families).

Highlights

88%

88% of participants **received all 12 scheduled deliveries** (target: 90%).

75%

75% of caregivers increased the frequency with which they **served brown rice, instead of white rice**, at home meals (target: 80%).

Healthy Food Healthy Families: West Oakland Health Council, Inc.

westoaklandhealth.org



FY 19/20 Allocation: \$15,000* | Expended/Encumbered: \$15,000



Individuals served by Measure A: 550 (Total individuals served: 550)



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



Services provided: Public Health, Mental Health



Service area: Alameda, Oakland, Homeless or Transient

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

Background

West Oakland Health Council (WOHC) works to improve the health and socioeconomic status of the community by providing high quality preventative care and treatment throughout the East Bay. WOHC strives to be a hub of health, well-being, connection, and inspiration.

The WOHC Food Farmacy distribution program helps households who might run out of money, food stamps, and other resources. Participation in the food distribution program helps ensure families have extra food to last throughout the month and access to educational material such as healthy nutritional recipes. WOHC also provides CalFresh enrollment services to participants who are not aware of this program.

Due to COVID-19, WOHC had to pause its food distribution for two months while they evaluated and implemented clinic safety and social distancing protocols. WOHC then shifted food distribution outdoors in a dedicated area located by each clinic entrance, and pre-bagged food for pick-up.

Services are provided in Spanish and Urdu.

Measure A Funding Achievements

In collaboration with the Alameda County Community Food Bank and Dig Deep Farms, WOHC used its Measure A allocation to achieve the following:

- Provide fresh produce and dry goods via eight Food Farmacy distributions to a total of 550 patients/individuals (target: 500)
- Provide information about CalFresh programming and enrollment to 150 individuals/patients (target: 100)
- Distribute food vouchers or prescriptions to 350 individuals (target: 300)



Highlights

100%

100% of Food Farmacy participants **increased their knowledge of health and/or food-related behaviors** such as recipes, cooking, food prep/food storage, and gardening (target: 75%).



Healthy Homes Department

Fixing to Stay & Group Living Facilities Project

achhd.org

- FY 19/20 Allocation: \$311,511 | Expended/Encumbered: \$311,511**
- Individuals served by Measure A:** 98 (Total individuals served: 213)
- Populations served:** Low Income, Uninsured Adults, Seniors
- Services provided:** Public Health
- Service area:** Albany, Castro Valley, Cherryland, Dublin, Emeryville, Newark, Oakland, San Lorenzo, Union City

Background

The Alameda County Healthy Homes Department (ACHHD) 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 railings, 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 with a healthy housing environment that is advantageous to their recovery and quality of life. This year the program was able to ensure that more of the independent living homes met minimal health and safety standards by successfully meeting the standards of the Independent Living Association. Enrolling homes in the Independent Living Association means more homes are making a commitment to improve the housing conditions for vulnerable disabled low income adults.

Since the COVID-19 shelter-in-place started, some services could not be delivered to clients, and many clients were anxious about admitting



Matching Funds

\$158,933

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



Highlights

83%

83% of older adults received
intervention to remain in housing
(target: 80%).

someone to their homes. This reduced ACHHD's normal service levels and limited the agency in being able to address interior housing conditions.

Clients receive some services in Spanish.

Measure A Funding Achievements

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

- Conduct outreach to 77 older adults and their families (target: 75)
- Complete 55 health and safety risk assessments (target: 50)
- Attend 14 meetings of the Independent Living Association and Group Living Facilities Work Team (target: 16)
- Conduct 74 site visits and healthy home assessments (target: 85)
- Respond to 10 complaints/grievances related to independent living homes (target: six)
- Track and report four updated maps to stakeholders quarterly (target: four).
- Update and publish a list of known independent living homes and share it with key County partners four times (target: four)
- Provide clean and habitable housing conditions to 64 independent living residents (target: 50)



Success Story

Mr. and Mrs. V are an Oakland couple over 65 years of age. Mrs. V suffers from health conditions that make it difficult to use the bathroom comfortably. During a Health and Safety Risk assessment, Healthy Homes staff determined the toilet's shut-off valve was deteriorated and leaking. Healthy Homes worked with an approved contractor to replace the valves and replaced the toilet with one that is energy efficient as well as higher for better comfort. The installation has greatly improved the couple's quality of life.



HERS Breast Cancer Foundation

hersbreastcancerfoundation.org



FY 19/20 Allocation: \$15,000* | Expended/Encumbered: \$15,000



Individuals served by Measure A: 90 (Total individuals served: 256)



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 products regardless of financial status.

Through the WE Support, YOU Survive program, 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.

Due to COVID-19, program locations in San Leandro and Pleasanton were temporarily closed. During this time, patients were able to be seen at the Fremont location, which remained open with reduced hours.

Staff members speak English, Malaysian and Indonesian dialect Bahasa, Malaysian dialect Dayak, Mandarin, Portuguese, Tagalog, Ilocano, Italian, and Cantonese.

Measure A Funding Achievements

HERS Breast Cancer Foundation used its Measure A allocation to provide 90 patients with prosthetic and other post-surgical fitting services via the WE Support, YOU Survive assistance program (target: 92).



★ Highlights

100%

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



Home Visiting Services

acphd.org/mpcah

- \$ FY 19/20 Allocation: \$1,850,170 | Expended/Encumbered: \$1,739,386**
- Individuals served by Measure A:** 974 (Total individuals served: 2,775)
- Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families
- Services provided:** Public Health, Mental Health, Substance Abuse
- Service area:** Countywide

Background

The Family Health Services (FHS) division, under the auspices of the Alameda County Public Health Department (ACPHD), works to ensure the optimal 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, mothers, 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 unit's Starting Out Strong Home Visiting System of Care is composed of 14 programs, of which Measure A funded five in FY 19/20: Native American Health Center: Strong Families, UCSF Benioff Children's Hospital Oakland (BCHO) Special Start Program, Tiburcio Vasquez Health Center (TVHC) Family Support Services Program, Brighter Beginnings, and ACPHD Special Start Program.

In response to COVID-19, MPCAH successfully developed and implemented telehealth strategies to maintain service continuity to target populations, including medically fragile children and their families.

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



Matching Funds

\$566,419

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

Measure A Funding Achievements

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

- Serve 502 parents, of whom 98% of eligible parents were screened for depression (target: 452 and 90%)
- Serve 459 children, of whom 82% of eligible children received early

developmental screening (target: 413 and 85%)

- Ensure that 82 children ages 6–11 months were breastfed or fed breast milk, of whom 54% were fed in this way for at least six months (target: 74 and 60%)
- Of 431 parents eligible for a Reproductive Life Plan, ensure that 81% had a documented plan (target: 388 and 75%)



Success Story

Anita, a single mother of three children, was laid off from her job due to COVID-19 and was collecting unemployment. Her one-year-old son had been born premature and has some developmental complications requiring monthly medical appointments at Children's Hospital Oakland. The TVHC case manager assisted with establishing dental care for the children and referring Anita to mental health services for depression and anxiety. The case manager also organized a schedule to help Anita supervise her older children during distance learning and coordinated a holiday gift drop-off when Anita did not have money to buy her children Christmas gifts.



FY 19/20 Allocation: \$500,000 | Expended/Encumbered: \$500,000



Individuals served by Measure A: 19 (Total individuals served: 1,295)



Populations served: Indigent, Low Income Adults



Services provided: Public Health



Service area: Countywide, Homeless or Transient

Background

The Alameda County Office of Homeless Care and Coordination (OHCC), in coordination with the Alameda County Health Care Services Agency (HCSA), strives to achieve health equity by working in partnership to provide high quality services, foster safe and healthy communities, and promote fair and inclusive opportunities for all residents.

The partners' "respite exits to housing" program helps secure permanent housing and supports for residents exiting hospitals, skilled nursing facilities, or medical respite facilities. Although classified as a Rapid Rehousing program, which provides temporary rental assistance, the policy of this program is to transition clients to mainstream affordable housing, supportive housing, or another financially sustainable ongoing housing resource within five years.

The COVID-19 pandemic required the agency and contractors to be flexible and adaptive to this unprecedented crisis. In the short term, contractor agency East Bay Innovations (EBI) was unable to meet the original scope and received permission to assist disabled guests in non-congregate shelters established to provide homeless, at-risk residents a safe place to shelter and quarantine during the pandemic. Over the longer term, EBI was able to help two disabled homeless County residents secure stable housing, while contractor agency Adobe Services was able to house 16 clients.

Measure A Funding Achievements

Through EBI and Abode Services, OHCC and HCSA used their Measure A allocation to provide housing services to 18 homeless individuals (target: 20).



Success Story

EBI served a client with complex medical needs who was in a nursing facility. EBI learned that the client had a temporary subsidy that was expiring and that he would become homeless if he did not obtain another subsidy source. EBI applied this client to their mainstreaming list, but he still had months to wait before he'd be issued a voucher. EBI was able to use the Measure A-funded program to temporarily subsidize the client's place so that he was able to keep his housing. He was discharged safely home, and EBI is now working to transition him to the mainstream subsidy.



La Familia Counseling Service: Youth Resiliency

lafamiliacounseling.org

-  **FY 19/20 Allocation: \$200,000 | Expended/Encumbered: \$200,000**
-  **Individuals served by Measure A:** 52 (Total individuals served: 52)
-  **Populations served:** Indigent, Low Income, Uninsured Children, Families
-  **Services provided:** Public Health, Mental Health, Substance Abuse
-  **Service area:** Livermore, Union City

Background

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

La Familia's ROOTS youth resilience program helps youth and families stay connected and engaged and provides critical mental health, social-emotional, and basic needs support. In response to the COVID-19 shelter-in-place order, when in-person services were unavailable, La Familia staff transitioned to telehealth and virtual services. Check-ins and case management were provided via phone, text messages, and video/virtual platforms. When participation dropped off, staff made home visits to the most at-risk youth. In addition, information and resource links were provided to families needing mental health, financial, health screening, and legal services, as well as COVID-related testing and information.

La Familia staff are bilingual in Spanish and English.

Measure A Funding Achievements

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

- Enroll 90% of participants in the ROOTS program through their Coordination of Services Team (COST) and/or school administrator (target: at least 50% of participants)
- Enroll 29 girls and 23 boys in the program (target: 20–25 participants each)
- Engage 52 youth in the mentoring group, covering topics such as mental health, substance abuse, sexually transmitted infections, birth control, college and career, communication, and suicide and COVID-19 prevention (target: 40–50)
- Provide individual mentoring and case management to 51 youth (target: 40–50 youth for mentoring, 20–25 for case management)



Matching Funds

\$153,040

from **various foundations and grants.**



Highlights

91%

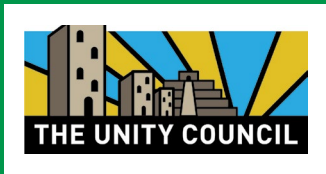
91% of youths reported that ROOTS helped them **learn how to cope when things go wrong** (target: 75%).

- Assess all participants for health insurance status
- Refer three youth and their families for health insurance and benefits application assistance
- Refer 22 youth/families for basic needs, e.g., food and behavioral services
- Provide four workshops for families related to mental health and wellness, stress, and COVID-19

★ Highlights

90%

90% of youths said ROOTS helped them **get along better with friends or others their age** (target: 75%).



Latino Men and Boys Program

unitycouncil.org

\$ FY 19/20 Allocation: \$200,000 | Expended/Encumbered: \$200,000

Individuals served by Measure A: 230 (Total individuals served: 230)

Populations served: Low Income Children

Services provided: Public Health, Mental Health

Service area: Oakland

Background

The Unity Council promotes social equity and improves quality of life by building vibrant communities where everyone can work, learn, and thrive. 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.

During FY 19/20, LMB strengthened its relationship and data-sharing arrangement with the Oakland Unified School District (OUSD). A four-year agreement allocates consistent funding from OUSD to the program each year and systematizes communication and data-sharing responsibilities on the part of the OUSD and each school site. The program also receives class set data rosters in full at the district level, which provide a detailed picture of each of student in the program, including attendance, GPA, newcomer status, and English Language Learner status. LMB staff also participate in school site Coordination of Service Team (COST) meetings and the OUSD Office of Equity's Latino Student Achievement (LSA) Task Force meetings.

LMB also introduced more systematic implementation meetings with school partners and worked to strengthen its partnerships with School-Based Health Centers (SHCs). The program introduced Urban, an online curriculum designed for middle school-aged youth on topics including nutrition, leadership development, character development, social-emotional learning, budget banking, conflict resolution, team building, personal relationships, self-discovery, and self-awareness.

At the outset of the COVID-19 pandemic, LMB mentors prioritized helping students process the fear, uncertainty, and trauma of the shelter-in-place order. Wellness checks were done via phone calls, text messages, and



Matching Funds

\$491,000

The Unity Council LMB program leveraged its Measure A allocation to obtain \$491,000 in **matching funds**.

email at least once a week. Mentors also enrolled families into emergency response resources, such as emergency cash assistance and food distribution programs provided by The Unity Council, and advised them of free, bilingual testing sites in Fruitvale and East Oakland. Due to internship sites being shut down, LMB transitioned to virtual job readiness training.

Services are offered in English and Spanish.

Measure A Funding Achievements

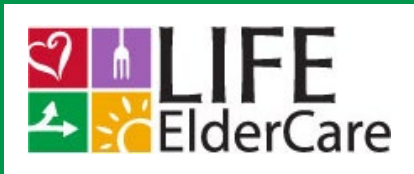
The Unity Council LMB program used its Measure A allocation to achieve the following:

- Conduct meetings and planning sessions with school and SHC staff to recruit and coordinate care for 60 participants
- Deliver the Joven Noble beginning and advanced curriculum of health presentations to 180 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 50 participants, as well as three housing/financial assistance referrals
- Develop one Program Profile document for school-based best practices leadership
- Engage with eight SHC staff to build their capacity to engage Latino young men and boys



Success Story

Luis joined LMB while at the United for Success Academy and was supported by his mentor, Mr. G. When the pandemic hit, Luis couldn't attend class in person, and his father lost his job. After most of Luis's family tested positive for COVID-19, they received cash assistance and bagged groceries each week from The Unity Council, which helped keep the family fed. In May 2020, Luis graduated in excellent standing from middle school and continued his journey with The Unity Council through the Summer Summit program. Mr. G is still making a positive impact in Luis's life, and Luis dreams of working in a lab someday.



LIFE ElderCare
lifeeldercare.org

\$ FY 19/20 Allocation: \$15,000 | Expended/Encumbered: \$15,000

Individuals served by Measure A: 20 (Total individuals served: 376)

Populations served: Low Income 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 at highest risk for harmful falls. Tactics to prevent falls include physical movement, understanding and correcting usage of prescribed and over-the-counter medications and supplements, increasing client knowledge of behaviors proven to reduce fall risk, and establishing a safe home environment.

When COVID-19 prevented in-person and in-home visits, interventions and assessments were completed over GrandPads, devices similar to iPads with built-in Internet, or via phone. Clients were matched with volunteers who provided help by doing simple errands or were added to the food bank delivery program. By engaging students at three local colleges, LIFE ElderCare provided job training while serving additional clients.

The Fall Prevention program kinesiologist speaks Vietnamese and English. All other languages are accommodated via the language line.

Measure A Funding Achievements

LIFE ElderCare used its Measure A allocation to provide comprehensive fall prevention assessments and educational sessions to 376 eligible adults aged 60 and over (target: 100).



★ Highlights

100%

100% of clients who received fall prevention assessments were **informed about specific risk levels and beneficial interventions** (target: 95%).



LifeLong Medical Care Heart 2 Heart

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

-  **FY 19/20 Allocation: \$100,000 | Expended/Encumbered: \$100,000**
-  **Individuals served by Measure A:** 3,353 (Total individuals served: 3,353)
-  **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 to provide members with information about hypertension education, screenings, resource links, and health-related topics. 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. Finally, H2H administers mini-grants to individuals or groups to support implementation of a variety of health and wellness programs. Recipients in FY 19/20 included Healing Our Hearts - Freedom Community Clinic, Healthy Heart Program - Women's Daytime Drop-in Center, Spring Stress Cleanse Series, Real Love Project - The Master Seal Worship Center Outreach Ministry, and Planting Wellness - Ashby Community Garden.

In response to COVID-19, in-person outreach, screenings, and education shifted to phone and email contact. Staff trainings were also shifted to virtual environments, which opened up new possibilities for community engagement activities. Community events were offered virtually for a community learning series and a health education series, offering topics such as emergency preparedness, mental health tips, healthy eating during the holidays, and guided meditations.



Matching Funds

\$35,000

from the **Sutter Health Foundation**.

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

Measure A Funding Achievements

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

- Organize 14 community outreach events attended by 180 participants (target: three events)
- Provide eight community health education training sessions to 12 residents (target: 20 residents)
- Coordinate with 12 NHAs to participate in 17 community engagement activities to educate and link 257 community members to medical resources (target: 30 activities and 100 community members)
- Administer five mini-grants to five individuals who implemented a variety of health and wellness programs (target: four grants to four individuals)
- Serve 2,899 community members at 199 community health events (target: 100 members at 50 events)

★ Highlights

86%

86% of enrolled community members reported that the community health education training made them **feel more connected to the community** (target: 50%).



Love Never Fails

loveneverfailsus.com

-  **FY 19/20 Allocation: \$994,542 | Expended/Encumbered: \$994,542**
 -  **Individuals served by Measure A:** 16 (Total individuals served: 37)
 -  **Populations served:** Indigent, Low Income, Uninsured Adults, Children, Families
 -  **Services provided:** Mental Health, Substance Abuse
 -  **Service area:** Countywide, Outside of Alameda County, Homeless or Transient
- *Includes Board of Supervisors discretionary allocation from **District 4/Supervisor Miley***

Background

Love Never Fails helps empower all people to express and experience their best sense of humanity by restoring, educating, and protecting survivors of human trafficking. Love Never Fails supports the physical and mental health of survivors of human trafficking through talk and art therapy, healthy diet, exercise, and relationships. Wraparound services meet clients where they are and bring them closer to a stable and safe life, where they can be positive, active members of society. The Healthy Relationship classes provide insight on red flags, as well as how to set healthy boundaries and ways to exit if the client feels unsafe in the relationship. These steps help clients stop the cycle of violence and exploitation in their lives.

Though COVID-19 and the shelter-in-place decreased the number of in-person and mental health assessments, clients were still able to receive assessment via remote and telehealth appointments.

Measure A Funding Achievements

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

- Provide clinical case management, mental health, and substance abuse services to 37 human trafficking survivors and/or their children (target: 40)
- Receive 345 medical visits and 801 mental health/substance abuse visits from clients (target: 200 medical and 350 mental health/substance abuse)



Success Story

Having been sexually, physically, and emotionally abused most of her life, Laura found her way to Love Never Fails, where she received 18 months of safe housing and restorative services, as well as classes in parenting, recovery, boundaries, safety, and more. Laura worked with a Life Coach, who helped her realize her dreams, and attained a job she loves. Her children received therapy, consistently stayed in school, and have been able to begin their healing as well. Laura has learned to be sober, and has grown both emotionally and spiritually.

Nutrition Services in West Oakland: City Slicker Farms

acphd.org/nutrition-services | cityslickerfarms.org



FY 19/20 Allocation: \$30,000* | Expended/Encumbered: \$30,000



Individuals served by Measure A: 200 (Total individuals served: Not available)



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



Services provided: Public Health



Service area: Hayward, Oakland

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

Background

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

City Slicker Farms reinforces self-sustaining access to food and builds community through urban farming, education, and recreation. City Slicker Farms contracts with Nutrition Services to install raised bed gardens in locations throughout Alameda County, including low income senior housing sites and community sites. Garden program participants report increased physical and mental well-being, increased consumption of vegetables, lowered stress and improved mental health, and enhanced connections with neighbors outdoors.

In addition to garden beds, City Slickers 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 Slickers staff build relationships with site staff, residents, and/or students to ensure enthusiasm for the gardens as well as maximum produce harvests.

Coordination of garden support during COVID-19 was successful to help gardens flourish and provide increased access to fresh fruits and vegetables. Instead of conducting in-person classes, plants, seedlings and garden materials were dropped off at sites or picked up from City Slicker Farms. Although in-person community engagement was reduced,



Highlights

100%

100% of the garden beds were
**actively used by residents of the
low income senior housing** sites
(target: 80%).

residents were able to continue to work in their gardens, harvest produce, spend time outside, and engage with others.

Services are provided in English and Spanish.

Measure A Funding Achievements

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

- Build two garden beds at two low income senior housing sites (target: two beds)
- Make 16 mentor and technical assistance visits and/or provide plant starts/seedlings at senior sites where gardens had previously been installed (target: 16)

★ Highlights

80%

80% of garden participants reported **harvesting produce from the garden beds** (target: 80%).

Public Health Prevention Initiative

acphd.org



FY 19/20 Allocation: \$3,027,743 | Expended/Encumbered: \$2,828,553



Individuals served by Measure A: 36,916 (Total individuals served: 107,717)



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*
- 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
- International Contract for Interpreter Services
- Lotus Bloom
- Mandela MarketPlace
- Niroga Institute
- Nutrition Services
- Office of Dental Health—Berkeley Schools*
- Public Health Nursing (PHN) Healthy Living Project

*This provider also received standalone Measure A funding. For details, see the entry under the provider's name elsewhere in this report.



Matching Funds

\$792,228

from the following sources:

- Targeted Case Management (TCM)
- Title XIX federal funds through the Maternal, Child, and Adolescent Health (MCAH) program
- Medi-Cal Administrative Activities (MAA)
- Merck Foundation
- City of Berkeley grant

In conjunction with the Measure A-funded services listed below, the ACPHD providers modified their offerings in response to COVID-19. Many pivoted to phone and video telehealth service delivery, video and online classes, and email and physical mail communications as appropriate. Others set up delivery and drop-off/pick-up systems for supplies and food as relevant or established outdoor service sites where social distancing could be maintained.

Services are provided in a wide variety of languages, which vary by provider.

Measure A Funding Achievements

Measure A funds were 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.

Asthma Start

- Enroll 205 clients in the program (target: 250)
- Successfully discharge 165 clients from the program (target: 200)

CAL-PEP

- Conduct five health communications/public information (HCPI) events for 73 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 69 HCPI participants (target: 30)
- Refer 10 partners of HIV-positive clients to HIV testing services (target: 10)
- Refer five high risk negative individuals to PrEP services, of whom two were linked to services (target: five)

CHDP Developmental Screening—Help Me Grow

- Develop 60 developmental screening goals (target: 60)
- Provide monthly site visits to reinforce screening practices and offer technical assistance to clinic staff at 57 sites (target: 56)
- Track and evaluate screening data from 60 sites (target: 56)

City of Berkeley—School-Linked Health Services Program

- Provide 70 health consultations and community resources to school staff (target: 50)
- Hold five meetings with Berkeley Unified School District (BUSD) staff regarding COVID-19 testing (target: five)
- Conduct 100 encounters with school staff regarding immunization compliance and promotion of infection prevention, including COVID-19 resources and guidance on reducing the risk of transmission (target: 50)
- Provide communication to six school-related organizations (target: five)
- Make 30 in-person and virtual outreach activities (target: 10)
- Produce 10 COVID-19 flyers or materials (target: 10)



Success Story

CAL-PEP

A 65-year-old, HIV-positive, African American female was unstably housed, had a heavy addiction to crack, and had been living in an encampment for the past 10 years. CAL-PEP connected her to in-house retention, navigation, and case management services. Attending program workshops helped the client prioritize her HIV care needs and strengthen her support circle. She was referred and linked to a trailer housing program, where she received additional case management that focused on mental health and substance use recovery. She was able to refrain from using substances and took her medication daily as recommended.



Highlights

89%

Asthma Start

89% of clients **reduced their number of emergency room visits** (target: 80%).

- Provide 14 health guidance manual updates (target: 14)
- Provide five COVID-19 guidance updates (target: two)
- Conduct three medication reviews (target: 14)
- Hold one medication policy training (target: two)
- Hold 36 collaboration meetings with BUSD administrators (target: 25)
- Make four contacts between Breathmobile host site school staff and Breathmobile staff (target: 15)
- Establish two COVID-19 testing sites and three mobile testing sites (target: two each)
- Conduct 1,026 COVID-19 tests (target: 1,000)

CAPE Unit

- Receive 40 and complete 33 data requests from stakeholders within two weeks of receipt (target: 75)

Diabetes

- Enroll 71 clients into diabetes self-management education (DSME) classes (target: 120)
- Ensure that 37 clients successfully completed DSME (target: 100)
- Lower the baseline A1c or maintain a goal of lower than 7% in 32 clients
- Lower the baseline blood pressure or maintain it at lower than 140/90 in 27 clients

EOBA

- Ensure that 178 youth participated in cooking, gardening, and/or physical activity programs (target: 150)
- Ensure that 46 EOBA youth participated in the Youth Leadership program (target: 40)
- Ensure that 63 EOBA youth boxers participated in the Boxing Leadership program (target: 40)
- Reach 3,581 households through the food distribution program (target: 1,350)
- Distribute 89,443 pounds of fresh produce and pantry items and 8,094 prepared meals

Health Equity Planning & Policy—CCNI

- Hold 25 technical assistance (TA) consultations with COR and FAJ community leaders and organizational staff to support their capacity to utilize health data and analysis in leading community-based solutions (target: 20)
- Hold 12 monthly meetings with the partner collaborative to plan project activities (target: 12)
- Hold three community power mapping sessions (target: two)
- Train and support 15 community residents to serve as survey canvassers (target: 20)
- Hold three community outreach events to disseminate Know Your Rights information and housing resources (target: five)
- Ensure that 30 residents received information about housing and health programs and services (target: 50)



Success Story

Health Equity Planning & Policy

In 2019, ACPHD staff and community partners went door to door to talk with Union City residents in rental apartments. One tenant, Manuel, was trying to get his landlord to get rid of mold in his apartment, which was causing his children to have respiratory problems. Partners helped Manuel in getting his landlord to respond, get rid of the mold, and make upgrades to the apartment. After Manuel expressed concerns about his carbon monoxide detector and using gas in the apartment, given that his children have asthma, staff connected Manuel to ACPHD's Asthma program, where they received home visits and case management.



Highlights

100%

EOBA

100% of youth reported satisfaction with the **cooking, gardening, and physical activity programming** (target: 85%).

- Provide orientation and information on County programs to seven resident leaders (target: 10)
- Survey 400 Union City households on how rental housing issues affect their health and well-being (target: 200)

Healthy Retail Program

- Host outreach events at 10 stores for 9,317 community participants (1,439 in-person and 7,878 online) (target: 10 stores for 2,500 participants)

HEPPAC

- Distribute 558 informational brochures about local health care coverage to 220 residents during syringe access services (target: 300 flyers to 150 residents)
- Inform 380 residents about HEPPAC's public syringe drop boxes in the community (target: 250)
- Make 171 HEPPAC participants aware of available HIV and HCV services (target: 156)

Immunization Section

- Create 144 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)

International Contract for Interpreter Services

- Provide 220 medical interpretation service encounters to clients, including 174 in-person and 46 phone encounters (target: 275)
- Translate two English materials, including brochures and flyers, into multiple languages (target: five)

Lotus Bloom

- Recruit 57 parents to attend 21 meetings to generate ideas and activities for wellness in their community (target: 40 parents and six meetings)
- Train 109 parents and staff in the Physical Movement and Health Food Policy for playgroups and events (target: 100)
- Conduct two Community Playtime events attended by 229 community members to encourage physical activity and healthy eating for children and their families (target: six events with 300 attendees)
- Implement two Family Engagement night programs attended by 436 community members offering physical activity for children and their families (target: three events with 300 attendees)
- Conduct six nutrition and/or gardening classes (target: two)

Mandela Partners

- Provide nutrition education and outreach activities at two stores reaching 4,230 community members (target: two stores and 500 community members)



Success Story

International Contract for Interpreter Services

A Tamil interpreter accompanied a nurse case manager during all home and telephonic visits with a pregnant client who had left her family behind and knew no one in this country. The interpreter provided language interpretation and educated the nurse case manager about the client's cultural norms and understanding of information provided. The interpreter also provided the cultural context within which the client experienced the services she was receiving and helped the client complete important documents related to her immigration status and needs. When the client was outside the US, with the interpreter's support, the nurse case manager was still able to provide her with guidance and support via telehealth.



Highlights

80%

Immunization Section

80% of program staff reported an **increase in efficiency in identifying intended clients** (target: 80%).

Niroga Institute

- Provide semester-long twice-weekly Dynamic Mindfulness (DMind) stress resilience and social-emotional learning sessions to 745 students (target: 700)
- Provide daylong DMind training with an accompanying video curriculum and follow-up coaching to 25 teachers at each school (target: 25)
- Ensure that 15 teachers led DMind for their students (target: 15)

Nutrition Services

- Provide technical assistance to 50 community-based organizations to create events that provided and encouraged healthy eating and drinking water (target: 30)

Office of Dental Health—Berkeley Schools

- Provide oral health education to 591 third grade students in participating Berkeley schools via group presentations (target: 471)
- Provide dental screening to 503 third grade students in participating Berkeley schools (target: 483)
- Offer preventive services to 216 students who received a dental screening (target: 290)

PHN Healthy Living Project

- Conduct 26 health education workshops to 30 participants (target: 40 workshops and 45 participants)
- Have 30 students set health-related goals (target: 40)
- Provide 27 training sessions (target: 34)



★ Highlights

98%

Office of Dental Health—Berkeley Schools

98% of the student third grade student population **received oral health education** (target: 78%).

Public Health Prevention Initiative: EMS Injury Prevention

ems.acgov.org

 **FY 19/20 Allocation: \$225,007 | Expended/Encumbered: \$225,007**

 **Individuals served by Measure A:** 767 (Total individuals served: 769)

 **Populations served:** Low Income Seniors

 **Services provided:** Hospital Outpatient, Public Health, Mental Health

 **Service area:** Countywide

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 EMS Senior Injury Prevention Program (SIPP) 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. As a result of the COVID-19 shelter-in-place, nurses switched to collecting medication information from participants over the



Success Story

DayBreak Adult Care Centers

An 81-year-old gentleman who receives some assistance from his family was assessed by a nurse for medication safety. She found that this individual was using more than one pharmacy, was cutting pills by hand, had 100 tabs that were expired and discontinued, and did not know how to dispose of these old medications. Because of this intervention, and with the help of his family who received instruction from this nurse, these concerns have been addressed. At a follow-up assessment, the nurse noted that no medication doses were being missed and that the patient's blood pressure and blood sugar were stable.

phone. After review by a pharmacist, the nurses used the information to assist these individuals, with family support to improve compliance and avoid adverse interactions.

- **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. However, because of COVID-19, the community center was closed and the Community Nursing partnership was put on hold, as the team pivoted to telephone-based services to stay in contact with participants. 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. In response to the COVID-19 shelter-in-place, staff pivoted to continue to provide medication safety education and review to clients, primarily through frequent phone contact and direct mail follow-up contact with clients.
- **United Seniors of Oakland and Alameda County (USOAC).** USOAC offers a medication safety training program and conducts outreach to seniors through community sites. The program educates older adults on the proper way to communicate with their doctors and having their medication review more often, which result in better medication management. Due to the COVID-19 pandemic, USOAC pivoted to one-on-one training over the phone. Services are provided in English and Spanish.

Measure A Funding Achievements

Measure A helped EMS achieve the following:

City of Fremont

- Provide services to 360 refugee, immigrant, and low income seniors over 50 years of age (target: 135)
- Assist 168 clients in accessing medical services (target: 120)
- Provide health and medication education and assistance to 123 clients (target: 50)
- Complete health and safety assessments for 64 clients (target: 50)
- Provide referrals and/or assistance to 121 clients to access entitlement, community, and supportive service programs (target: 110)

★ Highlights

100%

City of Fremont

100% of clients indicated their **health improved** as a result of the physical health, mental health, and medication education and support they received (target: 50%).

DayBreak Adult Day Care Centers

100% of participants **improved compliance with their prescribed medication regimens** (target: 20%).

St. Mary's Center

100% of participants reported **better management of medication disposal** (target: 60%).

DayBreak Adult Day Care Centers

- Complete medication safety assessments for six participants (target: 40)

St. Mary's Center

- Enroll 32 participants in the 12-week medication safety program for older adults (target: 47)
- Provide health screenings to nine enrolled participants (target: 37)
- Send six medication interaction reports to the participant's primary care provider or pharmacist for assessment (target: 24)
- Complete 1,577 weekly medication safety compliance calls (target: 1,128)
- Conduct 292 face-to-face medication safety conversations (target: 564)
- Provide a 12-week review to 12 enrolled participants (target: 24)
- Give information and guidance to 32 participants regarding the disposal of expired, misused, or unused medication (target: 28)
- Give recommended nutrition education and exercise encouragement to 32 participants (target: 37)

Senior Support Program of the Tri-Valley

- Enroll 33 low income residents aged 60 or older living in the Tri-Valley in the Medication Safety services program (target: 38)

USOAC

- Provide medication safety training to 198 seniors through 80 one-on-one and eight group sessions (target: 200 seniors, 10 one-on-one sessions, 10 group sessions)
- Outreach to 5,896 seniors through nine community sites such as health fairs and senior centers (target: 300 seniors and 10 sites)

Highlights

76%

Senior Support Program of the Tri-Valley

76% of clients reported that their **compliance level for properly taking medications increased** because of the program (target: 50%).

95%

United Seniors of Oakland and Alameda County

95% of training participants felt the trainer **explained the information very well and/or well** (target: 75%).

Public Health Services for Homeless Residents: Abode Services

abodeservices.org



FY 19/20 Allocation: \$107,123 | Expended/Encumbered: \$107,123



Individuals served by Measure A: 184 (Total individuals served: 418)



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 work to build rapport with unsheltered participants and are transitioning into a more active role of supporting clients to obtain housing documentation. Outreach staff also work to link individuals into the new Alameda County Coordinated Entry System, which includes Home Stretch, a countywide program matching homeless people with disabilities to permanent supportive housing and related resources. In response to the pandemic, the outreach team supported COVID-19 response efforts to include linkage to emergency hotels, PPE, scattered site hotels, and testing.

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 Achievements

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

- Provide 561 hours of housing outreach (target: 1,040)
- Provide outreach and engagement services to and enroll 184 individuals in the outreach program (target: 150)
- Enroll 126 unduplicated individuals in the outreach program (target: 150)
- Perform 421 hours of referral and case management services (target: 312)



Success Story

Abode's outreach team began working with a participant despite her resistance to entering shelter. Being vulnerable on the streets, as well as needing consistent medical attention, Abode's outreach team continued to work with her and other agencies and finally got her into Safer Ground, where she was assigned a Housing Navigator from Abode. Subsequently, her health stabilized and she became very engaged with staff. She moved into permanent supportive housing in January 2021.

- Make 1,560 outreach contacts to enrolled clients (target: 1,350)
- Distribute 2,550 hygiene and other supply kits to homeless unsheltered individuals (target: 150)
- Make eight complete referrals to Home Stretch-eligible clients (target: 60)
- Help eight enrolled clients collect and submit all needed documents for a Home Stretch permanent supportive housing referral (target: 50)

Safe Alternatives to Violent Environments

save-dv.org



FY 19/20 Allocation: \$15,000* | Expended/Encumbered: \$15,000



Individuals served by Measure A: 18 (Total individuals served: 159)



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



Services provided: Mental Health



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

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

Background

Safe Alternatives to Violent Environments (SAVE) works to strengthen every individual and family they serve with the knowledge and support needed to break the cycle of domestic violence and build healthier lives. Counseling services at SAVE help clients plan for their safety and learn more about community resources.

Being able to provide top-notch therapeutic services at no cost to the consumer is critical because the individuals served by SAVE, who have experienced the complex trauma often associated with domestic violence, also face significant financial burdens. Clinicians are trained in Eye Movement Desensitization and Reprocessing (EMDR), which is the gold standard of treatment for people who have experienced trauma.

In response to COVID-19, SAVE began offering teletherapy so work with clients could continue.

Clients are served in Spanish, ASL, and English. Other languages can be provided through Alameda County's language line.

Measure A Funding Achievements

SAVE used its Measure A allocation to achieve the following:

- Provide 988 free outpatient community mental health service sessions to 159 participants (target: 95 sessions to 28 participants)
- Provide trauma-informed mental health interventions for 18 adult victims of domestic violence through the collaborative development of 14 safety plans and provision of relevant community-based resource packets to 16 clients (target: 14 completed safety plans, 14 tailored safety plans completed, and 14 clients receiving a community-based resource packet)



Success Story

After suffering anxiety, depression, and self-doubt from being in an abusive relationship, Shaina sought help at SAVE, where she learned about community resources available to support her and her child. Shaina secured an apprenticeship in the trades, which afforded her a salary, excellent benefits, and a child care subsidy. With the help of SAVE, she filed a restraining order against her abuser and gained full custody of her child.

Senior Injury Prevention Program

alamedacountysocialservices.org

 **FY 19/20 Allocation: \$237,985 | Expended/Encumbered: \$237,985**

 **Individuals served by Measure A:** 2,053 (Total individuals served: 34,710)

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

 **Services provided:** Hospital Outpatient, Public Health, Mental Health

 **Service area:** Countywide

Background

Measure A funding supported the Senior Injury Prevention Program (SIPP) offered by three entities: the City of Fremont, the City of San Leandro, and Alameda County Emergency Medical Services (EMS).

City of Fremont

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 works to improve the physical and mental health of older adults in the community, with a focus on older immigrants and refugees, through increasing access to health and mental health services and community services, supporting healthy behavior changes, monitoring medications, and providing health education classes. The use of peer health promoters enhances the ability to deepen positive health behaviors and sustain long-term relationships. Since the older Afghan community is primarily monolingual and often illiterate, the use of trained, culturally sensitive peers is crucial.

In response to COVID-19, HSD leadership had to adjust all services to continue care provision under shelter-in-place directives. Staff quickly contacted and routinely checked-in with all clients, either by phone or through video. Service changes included providing individualized



Matching Funds

\$136,892

from the **City of Fremont's Human Services Department.**

emergency preparedness plans, assisting with access to nutritional food in a safe manner, increasing knowledge around safety precautions, monitoring health, and supporting emotional well-being while being isolated.

Services are offered in Dari and Pashtu.

City of San Leandro

The San Leandro Recreation and Human Services Department (SLRHS) works to provide services that enhance residents' quality of life and inspire pride in their community. 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 programs and services.** Staff program a wide array of services, 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 tax preparation help, health insurance counseling, and blood pressure checks 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 food bag distributions twice monthly.
- **Special events.** Several special occasions are celebrated throughout the year, including Martin Luther King, Jr.'s Birthday, Lunar New Year, Día de Los Muertos, and more. The annual Senior Thanksgiving Luncheon serves a delicious traditional Thanksgiving meal to approximately 500 seniors.

In response to the COVID-19 pandemic, facilities were closed and most programs were suspended. Senior Services staff were reassigned to provide essential services such as grocery and meal distributions and conference and wellness calls. The Senior Meal program was converted to a drive-up model with Senior Services providing daily staffing support, filling roles that were previously volunteer functions. The number of lunches distributed increased 86% from pre-pandemic levels. Staff prepared fun brain games and printed resource information handouts to distribute with lunches.

Staff worked with partner organizations and program instructors to develop a list of vulnerable seniors and made periodic check-in calls to offer them resource information as well as engaging in social contact. Staff

Success Story

City of San Leandro

Prior to the Senior Community Center closing due to COVID-19, Daprosa Carino, 75, attended multiple classes on an ongoing basis. A diabetic, Daprosa found the Diabetes Self-Management class and Diabetes Support Group very helpful in controlling her blood sugar. After the Center's closure, Daprosa signed up to receive a bag of nutritious groceries twice a month. She liked the convenience and safety of staying in her car while staff placed the grocery bag in her trunk. She was also grateful that the Fall Prevention class instructors called frequently, mailed her an illustrated booklet of exercises, and even delivered weights to her house to keep up with her exercise program.

Highlights

90%

City of San Leandro

90% of seniors obtained **three or more blood pressure screenings** in a year (target: 80%).

also facilitated weekly conference calls to permit class and social program attendees the opportunity to connect with each other and created a new web page as an adjunct to the main Senior Services information page, displaying content around themes such as “Stay Fit” and “Stay Nourished.”

For the Fall Prevention Enhance Fitness class, a partner agency mailed out instructional guides to participants to support their exercise programs at home and coordinated with Senior Services staff to retrieve their weights from onsite facilities to distribute for home use.

EMS

Alameda County EMS provides quality emergency medical services and prevention programs to improve the health and safety of residents in Alameda County. The EMS Senior Injury Prevention Program (SIPP) 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. As a result of the COVID-19 shelter-in-place, nurses switched to collecting medication information from participants over the phone. After review by a pharmacist, the nurses used the information to assist these individuals, with family support to improve compliance and avoid adverse interactions.
- **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



★ Highlights

100%

EMS: City of Fremont

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

EMS: DayBreak Adult Day Care Centers

100% of participants or caregivers **improved their medication management** (target: 40%).

EMS: St. Mary’s Center

100% of participants attributed their medication regimen compliance to **program communication follow-up practices** (target: 80%).

services when needed. However, because of COVID-19, the community center was closed and the Community Nursing partnership was put on hold, as the team pivoted to telephone-based services to stay in contact with participants. 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. In response to the COVID-19 shelter-in-place, staff pivoted to continue to provide medication safety education and review to clients, primarily through frequent phone contact and direct mail follow-up contact with clients.
- United Seniors of Oakland and Alameda County (USOAC). USOAC offers a medication safety training program and conducts outreach to seniors through community sites. The program educates older adults on the proper way to communicate with their doctors and having their medication review more often, which result in better medication management. Due to the COVID-19 pandemic, USOAC pivoted to one-on-one training over the phone. Services are provided in English and Spanish.

Measure A Funding Achievements

Measure A helped the SIPP providers achieve the following:

City of Fremont

- Provide services to 360 refugee, immigrant, and low income seniors over 50 years of age (target: 135)
- Assist 168 clients in accessing medical services (target: 120)
- Provide health and medication education and assistance to 123 clients (target: 50)
- Complete health and safety assessments for 64 clients (target: 50)
- Provide referrals and/or assistance to 121 clients to access entitlement, community, and supportive service programs (target: 110)

City of San Leandro

- Provide 283 free drop-in blood pressure screenings to 217 unduplicated seniors (target: 360 screenings)
- Distribute a bag of nutritional food to 88 low income seniors twice a month (target: 50)
- Provide nine health education class sessions led by health professionals to 187 unduplicated seniors (target: 12 sessions)
- Conduct four Pull Up a Chair exercise sessions attended by 120 unduplicated seniors (target: 240 seniors)



Success Story

City of Fremont

Mr. Mohammed, a 67-year-old Afghan gentleman, was living in a shed behind a business and had a major urological problem that required medical intervention. His Health Promoter helped him apply and qualify for Medi-Cal, found a primary care provider and specialist, accompanied him to medical appointments, and worked on applying for housing waitlists. After Mr. Mohammed eventually found a room to rent, his Health Promoter continued to spend many hours providing translation support, reading his documents due to his poor vision, and helping him access medical care by calling providers, setting up appointments, being present when translation support was needed, and giving him emotional support.



Highlights

100%

City of Fremont

100% of clients indicated their **lives improved** as a result of their Health Promoter's support (target: 75%).

- Hold 12 Fall Prevention Enhance Fitness class sessions attended by 86 unduplicated seniors (target: 150 unduplicated seniors)
- Hold an Annual Senior Resource Fair offering health resources, information, flu shots, and free health checks attended by 228 seniors (target: 200)

EMS

- City of Fremont
 - Provide services to 360 refugee, immigrant, and low income seniors over 50 years of age (target: 135)
 - Assist 168 clients in accessing medical services (target: 120)
 - Provide health and medication education and assistance to 123 clients (target: 50)
 - Complete health and safety assessments for 64 clients (target: 50)
 - Provide referrals and/or assistance to 121 clients to access entitlement, community, and supportive service programs (target: 110)
- DayBreak Adult Day Care Centers
 - Complete medication safety assessments for six participants (target: 40)
- St. Mary's Center
 - Enroll 32 participants in the 12-week medication safety program for older adults (target: 47)
 - Provide health screenings to nine enrolled participants (target: 37)
 - Send six medication interaction reports to the participant's primary care provider or pharmacist for assessment (target: 24)
 - Complete 1,577 weekly medication safety compliance calls (target: 1,128)
 - Conduct 292 face-to-face medication safety conversations (target: 564)
 - Provide a 12-week review to 12 enrolled participants (target: 24)
 - Give information and guidance to 32 participants regarding the disposal of expired, misused, or unused medication (target: 28)
 - Give recommended nutrition education and exercise encouragement to 32 participants (target: 37)
- Senior Support Program of the Tri-Valley
 - Enroll 33 low income residents aged 60 or older living in the Tri-Valley in the Medication Safety services program (target: 38)
- USOAC
 - Provide medication safety training to 198 seniors through 80 one-on-one and eight group sessions (target: 200 seniors, 10 one-on-one sessions, 10 group sessions)
 - Outreach to 5,896 seniors through nine community sites such as health fairs and senior centers (target: 300 seniors and 10 sites)

★ Highlights

97%

EMS: Senior Support Program of the Tri-Valley

97% of clients **received a compliance call within one week** of their Medication Services consult (target: 80%).

Senior Support Program of the Tri-Valley

cityservecares.org/seniors



FY 19/20 Allocation: \$25,000* | Expended/Encumbered: \$25,000



Individuals served by Measure A: 27 (Total individuals served: 36)



Populations served: Low Income Seniors



Services provided: Mental Health, Substance Abuse



Service area: Dublin, Livermore, Pleasanton, Sunol

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

Background

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

The In-Home Counseling Program makes a difference in the lives of Tri-Valley seniors by providing counseling services in seniors' homes. Staff members receive referrals from case managers, family members, caregivers, local community-based organizations, police and fire departments, and other concerned members of the community. In addition to assessments, counselors provide crisis intervention, resources, and referrals, as needed.

Due to COVID-19, in-home counselors began calling seniors to schedule in-home or virtual appointments. Initial visits allow counselors to observe the senior's environment to gain a better understanding of the individual. The weekly, bi-weekly, or monthly sessions also allow counselors to assess psychosocial, physical, mental health status, and personal history.

By making this service free of charge, many older adults get the benefit of much-needed support with their most challenging end-of-life issues. In many cases, the counselor is the only contact the client has.

Measure A Funding Achievements

Senior Support Program of the Tri-Valley used its Measure A allocation to achieve the following:

- Provide In-Home Counseling services to 36 seniors with mental health issues (target: 35)
- Conduct program pre-evaluation with 36 clients to assess mental health status (target: 35)
- Enroll 31 screened clients in the In-Home Counseling Program (target: 26)



Success Story

After losing her sister, Mrs. Smith was evaluated for mental health issues by a marriage and family therapist and was enrolled in the mental health counseling program. While grieving the loss of her sister, Mrs. Smith had become isolated and found it difficult to do daily tasks. After receiving treatment for depression, bereavement, and social isolation, Mrs. Smith reported a newfound sense of hope and became more social by reconnecting with friends, leaving the house to shop, and attending virtual group meetings.



Service Opportunities for Seniors (Meals on Wheels)

sosmow.org

\$ FY 19/20 Allocation: \$32,970 * | Expended/Encumbered: \$32,970

Individuals served by Measure A: 213 (Total individuals served: 2,774)

Populations served: Low Income, Uninsured Seniors

Services provided: Public Health

Service area: Countywide

Includes Board of Supervisors discretionary allocation from **District 3/Supervisor Chan and **District 4/Supervisor Miley***

Background

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

The onset of COVID-19 greatly increased the demand for Meals on Wheels, requiring logistical and operational innovations. SOS Meals on Wheels' response measures included stopgaps, enabling hundreds more seniors to enroll in the program, and creating new policies and procedures to maintain a healthy and safe operation.

Due to the older age of many of the volunteers, new volunteers were recruited to deliver meals. Training videos and outdoor training were implemented to get the new volunteers up to speed. Spectrum Community Services' Senior Meals Program, a partner program, moved into SOS Meal on Wheels' kitchen, which allowed cooks to work alongside each other and scale production. A delivery program was instituted to ensure that staff, volunteers, and clients were protected and physically distanced at all times.

Services to clients are offered in Chinese, Spanish, and English.

Measure A Funding Achievements

SOS Meals on Wheels used its Measure A allocation to deliver 28,731 daily meals and wellness checks to 212 unduplicated homebound seniors in San Lorenzo and Castro Valley (target: 10,000 meals to 60 seniors).



Matching Funds

\$26,500

from the following sources:

- **Eden Area Foundation**
- **Eden Township Health District**
- **Castro Valley Rotary Club**
- **San Leandro Rotary Club**

Southern Alameda County Comite de la Raza Mental Health DBA La Familia Counseling Services

LiveLaFamilia.org



FY 19/20 Allocation: \$20,000 | Expended/Encumbered: \$20,000



Individuals served by Measure A: 1,624 (Total individuals served: 1,624)



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



Services provided: Public Health, Mental Health



Service area: Livermore

Background

La Familia Counseling Services provides underserved multicultural communities with the tools and support necessary to build resilience, wellness, and economic power. Through the food pantry program, La Familia leverages trusted messengers to distribute aid and support from a community hub such as an elementary school. This program leverages school relationships to help families meet their basic needs and therefore encourage more learning-ready students.

During the COVID-19 pandemic, La Familia was able to serve many families by providing food donated from community stores and picked up by volunteers.

Services are provided in Spanish.

Measure A Funding Achievements

La Familia used its Measure A allocation to provide a variety of free food to 1,624 low income families who attend Marilyn Avenue School during 150 distribution events (target: 150 families and 20 events).



Highlights

100%

100% of usable donations **were distributed to eligible families** (target: 95%).



Spectrum Community Services, Inc.: Fall Prevention Program and Meals

spectrumcs.org

- FY 19/20 Allocation: \$90,000* | Expended/Encumbered: \$90,000**
- Individuals served by Measure A:** 3,411 (Total individuals served: 3,826)
- Populations served:** Indigent, Low Income, Uninsured Seniors
- Services provided:** Public Health
- Service area:** Alameda, Ashland, Castro Valley, Fremont, Hayward, Oakland, San Leandro, San Lorenzo, Union City

Includes Board of Supervisors discretionary allocation from **District 2/Supervisor Valle and **District 3/Supervisor Chan***

Background

Spectrum Community Services assists low income individuals, families, and seniors in their efforts to live independently. In partnership with local service organizations, Spectrum offers a wide variety of community programs and services.

Spectrum's Senior Meal Program provides critically needed nutritious meals to seniors to maintain their health and independence. The program's services fight social isolation through dining sites that provide a welcoming place for seniors to have a meal together. More than just a meal, the program also provides nutritional education every month and distributes materials for other valuable resources.

Due to COVID-19, Spectrum closed its kitchen and moved its staff to work in the SOS/Meals on Wheels kitchen to produce chilled meals in individual serving trays that better met seniors' needs under the new conditions. Many partner sites switched from being dining sites to become distribution sites. Because no population is at higher risk from COVID-19 than the vulnerable seniors who depend on Spectrum to deliver meals and services, the agency maintained a contactless protocol that allowed staff to have safely distanced conversations with each senior as they picked up their meal. They also distributed face coverings to help seniors comply with local health mandates.

The Spectrum Fall Prevention exercise classes alleviate isolation and loneliness by creating an atmosphere that makes it easy for people to make friends. The people that attend classes frequently plan other activities

Highlights

72%

72% of Fall Prevention class participants reported that their **level of confidence, ease of performing daily activities, and/or level of fall prevention knowledge increased** (target: 70%).

together and often assist one another in getting to medical appointments. The classes also provide information about important issues, give participants a chance to discuss what is happening in their communities, and alert seniors about scams and how to avoid them, items that could prove to be hazardous to older adults, and other topics of interest.

In response to the COVID-19 pandemic and subsequent lockdown, in-person classes were suspended. During the initial weeks of the shelter-in-place, the program created and distributed exercise booklets to participants that described in detail, and with visual representations, the exercises done in class. The program spent hundreds of hours on the telephone with clients doing wellness checks and making referrals and began meeting online with participants who had the ability to participate in online classes. The program also produced videos that replicated the live instruction offered, which could be accessed by registered participants 24/7 on YouTube.

In late 2020, Spectrum Fall Prevention began to offer an evidence-based program called EnhanceWellness, a personalized one-on-one program where clients are guided by certified wellness coaches to make changes that promote healthy habits. Coaches help clients address concerns regarding diet, exercise, sleep, and more, and sessions include exercise instruction and discussions about general wellness. The duration of the program is six months, and coaching sessions are about an hour, once or twice a week. Three staff members attended virtual training and became certified wellness coaches.

Verbal assistance for Senior Meals participants is available in Spanish, Mandarin, Cantonese, and English. Select Fall Prevention Classes are available in these languages as well.

Measure A Funding Achievements

Spectrum used its Measure A allocation to achieve the following:

- Deliver 90,182 meals to 3,366 County seniors (target: 65,000 meals to 3,000 seniors)
- Provide 624 group exercise class sessions to 456 seniors in south and central Alameda County (target: 900 classes to 135 seniors)



-  **FY 19/20 Allocation: \$49,440 | Expended/Encumbered: \$49,440**
-  **Individuals served by Measure A:** 916 (Total individuals served: 916)
-  **Populations served:** Indigent, Low Income Adults, Children, Families
-  **Services provided:** Hospital Outpatient, Public Health, Mental Health
-  **Service area:** Countywide, Outside of Alameda County, Homeless or Transient

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. Measure A funding supported BCHO's implementation of FINDconnect™, an innovative digital platform that empowers patients, care teams, and community organizations to collaboratively address the social determinants of health. This offers an efficient and lower cost model to combat disparities and ensure all children have equitable access to their optimal health and development.

Patient Navigators work alongside providers to refer patients and families to community-based resources. Navigators can see data such as the total number of active visits, new visits in the past two weeks, closed visits, total number of resources referred, and total number of active Navigators.

This funding helped further the development of FINDconnect to support screening for basic unmet needs. During COVID-19, the development team provided services in person and virtually to make referrals, the vast majority of which were referrals to the Alameda Food Bank for families experiencing food insecurity. The funding also allowed the team to further refine FINDconnect's reporting capabilities.

Services are provided in over 50 languages through the use of in-person, video-based, and phone-based interpreters.

Measure A Funding Achievements

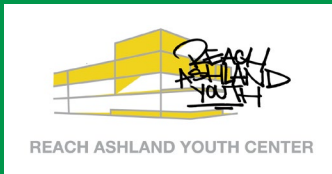
CHO used its Measure A allocation to achieve the following:

- Provide FIND navigation services to screen 916 patients for basic unmet needs and offer them resources (target: 600)
- Provide 1,669 individualized resource referrals (target: 916)



Success Story

A family who was referred to FINDconnect by a primary care provider had lost their mother to COVID-19. The father expressed concerns about his daughter's emotional health and about financial difficulties he was facing. The program provided him with summer camp resources for grief, local food pantry information, rent assistance programs, and utility assistance information. His daughter attended a summer grieving camp, and the father went to food pantries, received rent assistance, and obtained a \$400 credit for his utilities. All communication between the Navigator and the care provider was entered and monitored in the FINDconnect platform.



Youth and Family Opportunity Initiatives

achealthyschools.org

-  **FY 19/20 Allocation: \$2,724,654 | Expended/Encumbered: \$2,724,654**
-  **Individuals served by Measure A:** 29,615 (Total individuals served: 29,615)
-  **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 leads 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.

The COVID-19 pandemic had a huge impact on the YFO organizations because all of them are place-based service providers, utilizing schools and community-based sites to engage and support clients. Though COVID-19 caused the providers to close down facilities, they developed alternative ways of reaching their clients through phone calls, texts, and Internet-based outreach to check on youth and families and connect them to services and resources. These included applying for grants for cash relief; developing delivery/pick-up systems for food, supplies, and wellness and learning packets; identifying and sharing resources; and shifting to virtual classes and gatherings.

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.



Matching Funds

\$5.86M

from the following sources:

- **Medi-Cal Administrative Activities (MAA)**
- **Alameda County funding: Board of Supervisors**
- **Alameda County Probation Office**
- **Alameda County Social Services**
- **First 5**
- **Local and national foundations**
- **Federal grants**
- **City and school district funding**
- **Individual donors**

The organizations involved in the YFO initiative include the following:

- Alameda Family Services (AFS) provides an array of health and wellness services to families, primarily in the city of Alameda, through their Family Support Services Center, Senior Connections program, and partnerships with the school district and other community-based organizations.
- 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.
- East Bay Agency for Children (EBAC) operates Family Resource Centers (FRCs) that provide health and wellness supports such as language classes; parenting workshops, groups, and presentations; crisis support including referral to case management; housing referrals; immigration-related legal referrals; food pantry; referrals to dental care coordination; and the enrollment of eligible children and families in health coverage and other public benefits programs.
- 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.
- 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.
- Fremont Unified School District offers supports across the three tiers of prevention, early intervention, and treatment; has a family liaison who supports students and their families with accessing health-related and other needed resources; and partners with Bay Area Community Health’s Outreach & Eligibility Workers to promote health coverage and public benefits enrollment services.
- Health Initiatives for Youth (HIFY) took over operations of the McClymonds Youth and Family Center in FY 19/20. They worked closely with the school administration; Children’s Hospital Oakland, who runs the onsite health center; students; families; and other community partners to integrate into the McClymonds community and tailor the programming to meet the needs of youth and families.
- La Familia Counseling Service 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.
- Lincoln was chosen in FY 19/20 to provide school-linked health and wellness services to students and their families in West Oakland. Lincoln worked with the administration and staff of West Oakland Middle School and McClymonds High School to introduce their school-based program, which provides intensive case management service and group wellness sessions to youth and their families at each site.
- 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.

- 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. UCFC has also launched a food distribution program, which is one of the largest food distribution sites in Alameda County.
- YR Media provides wraparound health and wellness support to youth enrolled in their media arts education and internship programs. 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 Achievements

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

- Hold 100 community events focused on raising awareness of free and affordable health care services, at which 34,648 contacts were made (target: 60–70 events and 20,000 contacts)
- At the events, provide the following:
 - Application assistance to enroll in Medi-Cal, HealthPAC, or Covered California to 4,488 families (target: 350–400 families)
 - Application assistance to enroll in CalFresh, CalWORKs, or other public benefits to 2,460 families (target: 350–400)



Success Story

When David, a transitional aged youth, came to the FFRC, he was homeless, had been in foster care for years, and had a long history of mental health conditions and a heart condition. The Family Support Services (FSS) Coordinator helped get him into temporary housing and purchased basic move-in supplies. She assisted David with applying for CalFresh benefits and linked him to mental health services, where he was able to start seeing a therapist and a psychiatrist. The FSS coordinator continued to connect David to resources and helped him complete low income housing applications and obtain required documentation such as a Social Security card and birth certificate.

- Information about health insurance and benefits eligibility and/or referrals to an offsite location for application assistance to 6,687 families (target: 3,000)
- Serve over 150 children and families at one health fair and three smaller health events in the Tri-Valley (target: 250 children and families)
- Through the New Haven Unified School District's Union City Family Center food bank, provide healthy snacks to 5,235 youth and 14,678 adults/families (target: 3,500)
- Serve 787 clients at the REACH Ashland Youth Center onsite Health Center (target: 1,000)
- Serve 1,939 youth through care coordination, case management, and referrals (target: 1,000)
- Serve 358 youth through individual and group counseling (target: 150)
- Engage 740 youth and mentor 27 youth in health and wellness workshops focused on health education and healthy lifestyle choices, and place 25 youth in health-related internships (target: 1,000)
- Enable 63 youth to participate in small wellness groups, including mentoring and affinity-based support groups (target: 50)
- Enable 83 youth to participate in leadership development activities that increase resiliency by focusing on personal growth, health and wellness, and leadership (target: 20–30)
- Enable 451 youth to participate in arts and enrichment activities that increase resiliency and social-emotional and well-being (target: 300)
- Provide college and career support to 318 youth
- Provide support with chronic attendance issues to 189 youth
- Enable 328 youth to participate in college and career-readiness activities
- Provide case management to 3,423 parents/caregivers (target: 2,500)
- Make home visits with resource referrals to 706 parents/caregivers
- Provide crisis intervention, including basic needs support, to 2,828 parents/caregivers, of whom 85 received individual and family counseling and 92 participated in family support groups (target: 150)
- Ensure that 1,361 parents/caregivers participated in health and wellness workshops focused on health education and healthy lifestyle choices (target: 300)
- Enable 264 parents/caregivers to participate in career readiness and/or financial literacy classes
- Enable 7,152 families to participate in school-based engagement efforts

APPENDICES

Appendix A: Measure A Auditor-Controller Report FY 04/05 through FY 19/20

Appendix B: FY 19/20 Budget Information

Appendix C: FY 19/20 Measure A Fund Distribution by Provider or Program

Appendix D: Maps: Geographic Distribution of Providers Funded by Measure A in FY 19/20

Map 1 Alameda County Public Health Programs Funded by Measure A in FY 19/20

Map 2 Alameda County Behavioral Health Care Services Alcohol and Other Drug Providers Funded by Measure A in FY 19/20

Map 3 Alameda County Behavioral Health Care Services Mental Health Community-Based Organization Providers Funded by Measure A in FY 19/20

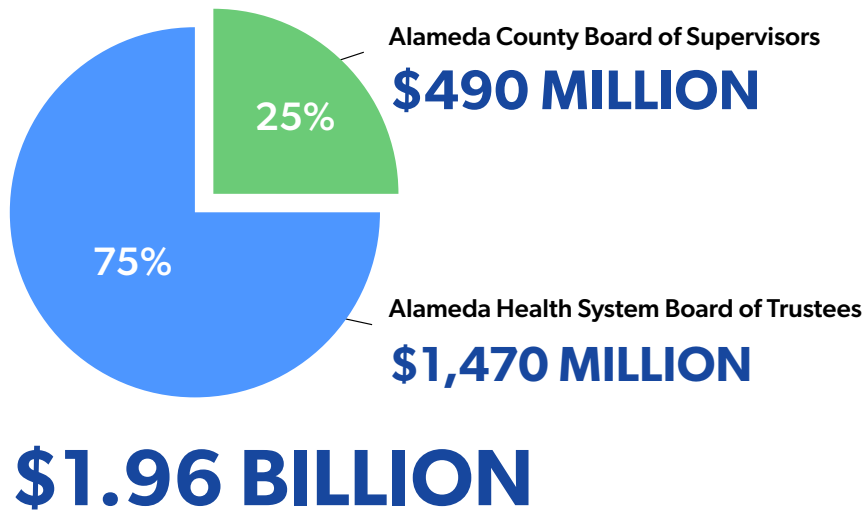
Map 4 School Health Centers Funded by Measure A in FY 19/20

Map 5 HealthPAC Provider Network Funded by Measure A in FY 19/20

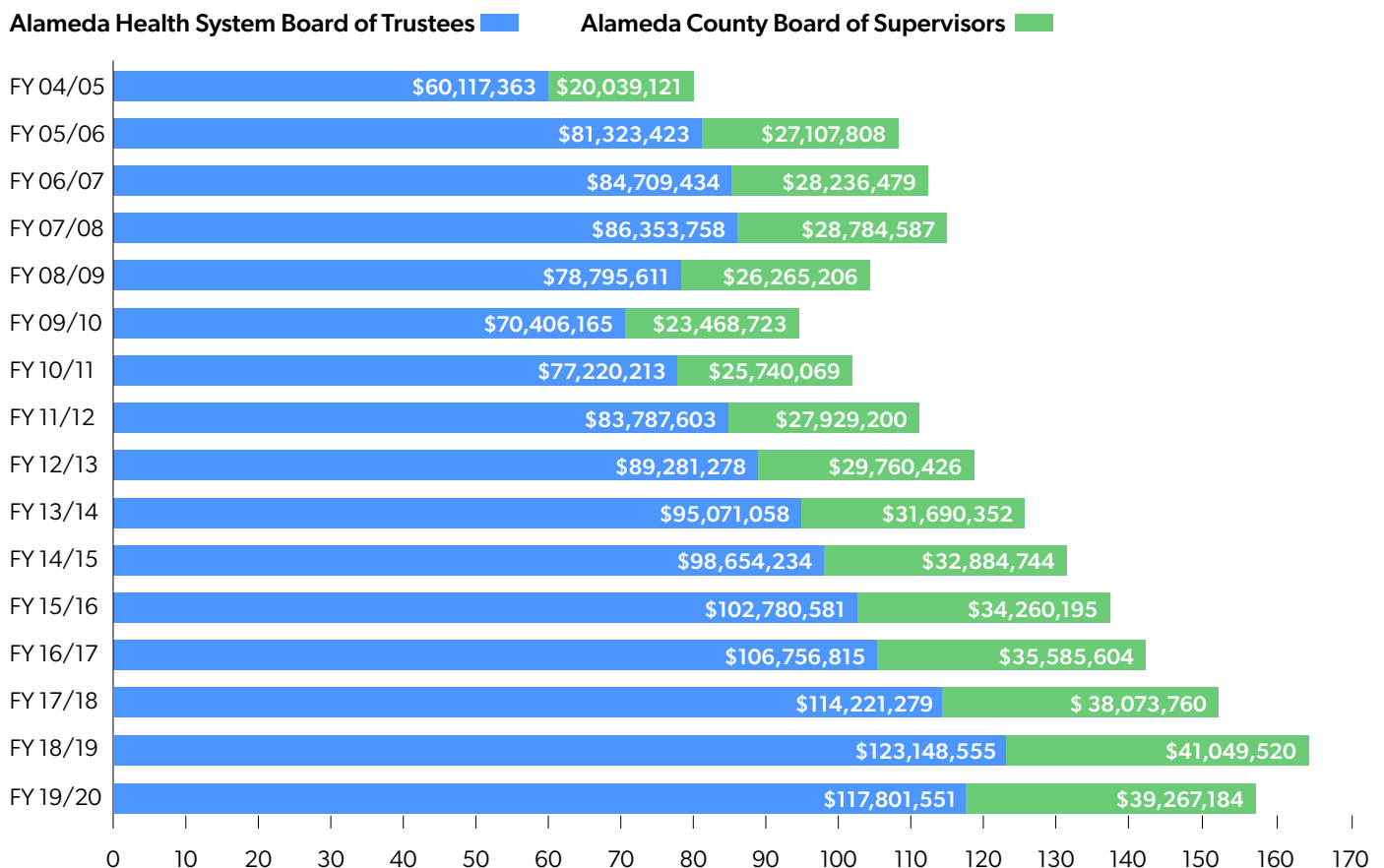
APPENDIX A: MEASURE A AUDITOR-CONTROLLER REPORT FY 04/05 THROUGH FY 19/20

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 19/20)



REVENUE RECEIVED EACH FISCAL YEAR (FY 04/05 THROUGH FY 19/20)



APPENDIX B: FY 19/20 BUDGET INFORMATION

	TOTAL ALLOCATION ¹	CARRYOVER FROM PREVIOUS FISCAL YEAR ²	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR ²	TOTAL	SAVINGS ⁴
Behavioral Health							
Behavioral Health Services	150,000	0	150,000	94,517	55,483	150,000	0
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)	1,333,336	0	1,333,336	1,333,336	0	1,333,336	0
Cherry Hill Detoxification and Sobering Center ¹	2,295,875	559,884	2,855,759	2,115,539	740,220	2,855,759	0
Criminal Justice Screening and In-Custody Services	4,306,000	0	4,306,000	4,306,000	0	4,306,000	0
Mental Health for Juvenile Justice Center	360,000	0	360,000	360,000	0	360,000	0
Mental Health Services for Newcomers and Immigrants: Center for Empowering Refugees and Immigrants (CERI)	86,096	0	86,096	86,096	0	86,096	0
Health Services for Unaccompanied Immigrant Youth	350,000	0	350,000	349,998	0	349,998	2
La Familia Youth Resiliency (Gender-Based Mentoring)	200,000	0	200,000	200,000	0	200,000	0
Substance Use Disorder Services	450,000	0	450,000	265,551	184,449	450,000	0
Public Health Services for Homeless Residents	107,123	0	107,123	91,968	15,155	107,123	0
Hospital, Tertiary Care, Other							
St. Rose Hospital ²	2,049,440	1,000,000	3,049,440	2,000,000	1,049,440	3,049,440	0
UCSF Benioff Children's Hospital Oakland ²	7,750,000	8,500,000	16,250,000	2,254,000	13,996,000	16,250,000	0
Primary Care							
Alameda County Dental Health ³	257,580	-56,657	200,923	200,923	0	200,923	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)	1,350,000	0	1,350,000	1,349,990	0	1,349,990	10
Direct Medical and Support Services (Oakland): Preventive Care Pathways	229,587	0	229,587	229,587	0	229,587	0
Direct Medical and Support Services: Roots Community Health Center	250,000	0	250,000	250,000	0	250,000	0
Health Enrollment for Children	300,000	0	300,000	300,000	0	300,000	0
Health Services for Day Laborers	244,289	0	244,289	244,289	0	244,289	0
Medical Costs for Juvenile Justice Health Services	511,891	0	511,891	369,851	0	369,851	142,040
Primary Care Community-Based Organizations	5,753,009	0	5,753,009	5,753,009	0	5,753,009	0
Roots Community Health Center	200,000	0	200,000	200,000	0	200,000	0

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
Public Health							
Alameda Boys & Girls Club, Inc.	114,794	0	114,794	114,794	0	114,794	0
Area Agency on Aging (Meals on Wheels Program)	245,000	0	245,000	245,000	0	245,000	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
Countywide Plan for Seniors: Home-Based Nursing Case Management	500,000	0	500,000	500,000	0	500,000	0
Countywide Plan for Seniors: Hospice & Advance Life Planning	250,000	252,332	502,332	217,666	0	217,666	284,666
Countywide Plan for Seniors: Injury Prevention & Nutrition Services	797,808	17,579	815,387	786,471	0	786,471	28,916
COVID-19 Crisis Response Services	3,000,000	0	3,000,000	54,332	2,945,668	3,000,000	0
EMS Ambulance Providers to Serve 5150 Indigent Population	0	1,915,000	1,915,000	1,244,994	670,006	1,915,000	0
Emergency Medical Services (EMS) Corp	607,791	0	607,791	607,791	0	607,791	0
Emergency Preparedness, Mitigation, Response, and Recovery	0	137,534	137,534	73,464	64,070	137,534	0
Health Services for Persons Who Inject Drugs: HIV Education and Prevention Project of Alameda County (HEPPAC)	310,684	0	310,684	310,684	0	310,684	0
Healthy Homes Department: Fixing to Stay & Group Living Facilities Project	311,511	0	311,511	197,589	0	197,589	113,922
Home Visiting Services	1,850,170	3,465,432	5,315,602	1,648,781	3,535,643	5,184,424	131,178
Homelessness 3-Year Action Plan	500,000	0	500,000	500,000	0	500,000	0
Latino Men and Boys Program: Spanish Speaking Unity Council of Alameda County, Inc. DBA The Unity Council	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 Livermore: La Familia Counseling Service	20,000	0	20,000			0	20,000
Nutrition Services in West Oakland (City Slicker Frams)	25,000	0	25,000	5,000	20,000	25,000	0
Public Health Prevention Initiative	3,027,743	0	3,027,743	2,772,281	0	2,772,281	255,462
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	107,123	0	107,123	0
Senior Injury Prevention Program	123,191	0	123,191	123,191	0	123,191	0
Senior Injury Prevention Program: City of San Leandro Senior Services	57,397	0	57,397	57,397	0	57,397	0
Senior Injury Prevention Program: Fremont Aging & Family Services	57,397	0	57,397	57,397	0	57,397	0
West Oakland Health Center	1,500,000	0	1,500,000	1,500,000	0	1,500,000	0
Youth and Family Opportunity Initiatives	2,724,654	-24,733	2,699,921	2,724,654	0	2,724,654	-24,733
Board of Supervisors²	750,000	990,424	1,740,424	996,120	744,304	1,740,424	0
TOTAL FY 19/20⁵	46,154,360	16,756,795	62,911,155	37,939,254	24,020,438	61,959,692	951,463

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 19/20.

APPENDIX C:

FY 19/20 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

GROUP 1: BEHAVIORAL HEALTH	MEASURE A ALLOCATION FY 19/20	EXPENDED/ ENCUMBERED FY 19/20
Behavioral Health and Alcohol and Other Drug (AOD) Community-Based Providers		
Alameda County Mental Health Association	31,139	16,549
Bonita House Inc.	61,310	20,437
Center for Independent Living	2,627	2,607
Southern Alameda County Comite for Raza	54,924	54,924
Total Allocation	150,000	94,517
Center for Empowering Refugees and Immigrants (CERI)	86,096	86,096
Center for Healthy Schools and Communities (School-Based Behavioral Health Initiative)		
City of Hayward	220,000	220,000
Portia Bell Hume Center	143,492	143,492
Emeryville Unified School District	40,178	40,178
Hayward Unified School District	50,000	50,000
Other Program Expenses	879,666	879,666
Total Allocation	1,333,336	1,333,336
Cherry Hill Detoxification and Sobering Center (Horizon Services, Inc.)	2,295,875	2,115,539
Criminal Justice Screening and In-Custody Services	4,306,000	4,306,000
Health Services for Unaccompanied Immigrant Youth		
La Familia Unaccompanied Immigrant Youth	176,646	176,646
Eden United Church of Christ	60,000	60,000
Other Program Expenses	113,354	113,354
Total Allocation	350,000	350,000
La Familia Counseling Service (Glad Tidings)	30,000	30,000
Mental Health Services for Juvenile Justice Center	360,000	360,000
Public Health Services for Homeless Residents (Abode Services)	107,123	91,968
Substance Use Disorder Services		
Axis Community Health, Inc.	1,429	1,341
Center Point	193,693	193,693
Filipino Advocates for Justice	19,259	19,129
Horizon Services, Inc.	5,017	-
Native American Health Center	30,815	-
New Bridge	84,230	-
Senior Support Program of the Tri-Valley	38,518	13,476
St. Mary's Center	38,519	37,913
Uplift Family Services	38,520	-
Total Allocation	450,000	265,552

GROUP 2: HOSPITAL, TERTIARY CARE, OTHER	MEASURE A ALLOCATION FY 19/20	EXPENDED/ ENCUMBERED FY 19/20
St. Rose Hospital	7,750,000	2,540,000
UCSF Benioff Children's Hospital Oakland	2,000,000	2,000,000

GROUP 3: PRIMARY CARE	MEASURE A ALLOCATION FY 19/20	EXPENDED/ ENCUMBERED FY 19/20
Alameda County Dental Health (Axis Community Health)	257,580	257,580
Center for Elders' Independence	57,397	57,397
Center for Healthy Schools and Communities (School Health Centers)		
Alameda Family Services	125,000	125,000
City of Berkeley	75,000	75,000
East Bay Agency for Children	50,000	50,000
East Bay Asian Youth Center	50,000	50,000
Fred Finch	50,000	50,000
La Clinica de La Raza, Inc., Inc.	400,000	400,000
LifeLong Medical Center	150,000	150,000
Native American Health Center	200,000	200,000
Tiburcio Vasquez Health Center	125,000	125,000
Sunol Glen Unified School District	25,000	25,000
UCSF Benioff Children's Hospital Oakland	100,000	100,000
Total Allocation	1,350,000	1,350,000
Direct Medical and Support Services (Oakland)		-
Preventive Care Pathways	229,587	229,587
Roots Community Health Center	250,000	250,000
Total Allocation	479,587	479,587
Health Enrollment for Children	300,000	300,000
Health Services for Day Laborers		-
Multicultural Institute	95,662	-
Street Level Health Project	148,627	-
Total Allocation	244,289	-
Medical Costs for Juvenile Justice Services		-
Niroga Institute	89,152	89,152
Victims of Crime	90,000	59,630
Unallocated	332,739	-
Total Allocation	511,891	369,851
Primary Care Community-Based Organizations		
Alameda Health Consortium:		
Asian Health Services	610,521	610,521
Axis Community Health	638,300	638,300
Davis Street Family Resource Center	107,123	107,123
La Clínica de La Raza	1,796,317	1,796,317
LifeLong Medical Center	694,001	694,001

GROUP 3: PRIMARY CARE	MEASURE A ALLOCATION FY 19/20	EXPENDED/ ENCUMBERED FY 19/20
Native American Health Center	269,219	269,219
Tiburcio Vasquez Health Center	869,872	869,872
Tri-City Health Center	591,504	591,504
West Oakland Health Council	176,152	176,152
Total Allocation	5,753,009	5,753,009
Roots Community Health Center	200,000	200,000
Tiburcio Vasquez Health Center	40,000	40,000
Washington Hospital Healthcare Foundation	25,000	25,000
West Oakland Health Center	1,500,000	1,500,000

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 19/20	EXPENDED/ ENCUMBERED FY 19/20
Alameda Boys & Girls Club, Inc.	114,794	114,794
Alameda County Pharmacist Association	4,150	4,150
Asthma Start	100,000	100,000
Area Agency on Aging (Meals on Wheels Program)	245,000	245,000
Center for Early Intervention on Deafness	57,397	57,397
Countywide Plan for Seniors (Getting the Most Out of Life)	250,000	217,666
Countywide Plan for Seniors (Home-Based Nursing Case Management) ¹	500,000	520,512
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
Service Opportunity for Seniors: Meals on Wheels	399,376	399,376
Spectrum Community Services	85,249	85,249
St. Mary's Center	30,490	30,490
Unallocated	50,700	50,700
Total Allocation	797,808	786,471
COVID-19 Crisis Response Services	3,000,000	54,332
Dana Burrell (Glass House Communications)	46,500	46,500
Drivers for Survivors	10,000	10,000
Eden United Church of Christ (Padres Unidos)	25,000	25,000
Eden Youth and Family Center	20,000	20,000
EMS Ambulance Providers to Serve 5150 Indigent Population	-	1,244,994

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 19/20	EXPENDED/ ENCUMBERED FY 19/20
EMS Corps		
Berkeley Youth Alternatives	78,742	-
Other Program Expenses	529,049	-
Total Allocation	607,791	607,791
Ernestine C. Reems Community Services	100,000	100,000
Family Paths	5,000	5,000
HIV Education and Prevention Project of Alameda County (HEPPAC) OPEND	310,684	310,684
Healthy Food Healthy Families		
Alameda County Community Food Bank	47,500	47,500
Alameda County Deputy Sheriffs' Activities League, Inc.	270,000	270,000
La Clinica de La Raza, Inc.	15,000	15,000
Native American Health Center	15,000	15,000
Roots Community Health Center	15,000	15,000
UCSF Benioff Children's Hospital Oakland	40,000	40,000
West Oakland Health Council, Inc. DBA West Oakland Health Center	15,000	-
Total Allocation	417,500	402,500
Healthy Homes Department (Fixing to Stay & Group Living Facilities Project)	311,511	197,589
HERS Breast Cancer Foundation	15,000	15,000
Homelessness 3-Year Action Plan		-
Abode Services	250,000	250,000
East Bay Innovations	250,000	250,000
Total Allocation	500,000	500,000
Home Visiting Services		
Brighter Beginnings	461,239	402,746
Native American Health Center, Inc.	122,520	117,021
Tiburcio Vasquez Health Center	590,000	590,000
UCSF Benioff Children's Hospital Oakland & Research Center	676,411	629,619
Total Allocation	1,850,170	1,739,386
La Familia Counseling Service (Youth Resiliency)	200,000	200,000
Latino Men and Boys Program (Spanish Speaking Unity Council of Alameda County, Inc. DBA The Unity Council)	200,000	200,000
Life ElderCare	15,000	15,000
LifeLong Medical Care: Heart 2 Heart	100,000	100,000
Love Never Fails	50,000	50,000
Meals on Wheels of Alameda County	5,000	5,000
Nutrition Services in Livermore (La Familia Counseling Service)	\$20,000	20,000
Nutrition Services in West Oakland (City Slickers Farm)	30,000	30,000
Public Health Prevention Initiative		
California Prostitutes Education Project (CAL-PEP, Inc.)	52,025	52,025
Center for Oral Health	152,114	152,114
City of Berkeley	193,715	193,715
East Oakland Boxing Association	69,865	69,865

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 19/20	EXPENDED/ ENCUMBERED FY 19/20
HIV Education and Prevention Project of Alameda County	47,294	47,294
Lotus Bloom	36,577	36,577
Mandela Partners	130,715	130,715
Niroga Institute, Inc.	55,458	55,458
Tides Center	85,698	85,698
Unallocated	2,204,283	2,005,092
Total Allocation	3,027,744	2,828,553
Public Health Prevention Initiative: EMS Injury Prevention		-
Adult Day Services Network of Alameda County	26,018	26,018
City of Fremont	136,892	136,892
Senior Support Program of the Tri-Valley	26,018	26,018
St. Mary's Center	26,024	26,024
United Seniors of Oakland and Alameda County	10,125	10,125
Total Allocation	225,077	225,077
Public Health Services for Homeless Residents: Abode Services	107,123	91,968
Safe Alternatives to Violent Environments	15,000	15,000
Senior Injury Prevention Program		-
City of San Leandro Senior Services	57,397	57,397
City of Fremont: Aging & Family Services	57,397	57,397
Senior Injury Prevention Program (SSA)	123,191	123,191
Total Allocation	237,985	237,985
Senior Support Program of the Tri-Valley	25,000	\$25,000
Service Opportunity for Seniors (Meals on Wheels)	32,970	-
Southern Alameda County Comite de la Raza Mental Health DBA La Familia Counseling Services	20,000	20,000
Spectrum Community Services, Inc. (Fall Prevention Program and Meals)	90,000	90,000
UCSF Benioff Children's Hospital Oakland (FIND Desk services)	49,440	49,440
Youth and Family Opportunity Initiatives		
Alameda Family Services	114,794	114,794
Berkeley Youth Alternatives	114,794	114,794
Health Initiatives for Youth	114,794	114,794
East Bay Asian Youth Center	114,794	114,794
Youth Radio	114,794	114,794
La Familia Counseling Service	192,191	192,191
Eden Youth and Family Center	0	-
City of Fremont - Family Resource Center	172,191	172,191
Fremont Unified School District	114,794	114,794
New Haven Unified School District	114,794	114,794
Newark Unified School District	114,794	114,794
Livermore Unified School Distirct	19,131	19,131
Dublin Unified School District	19,131	19,131
Pleasanton Unified School Distirct	19,131	19,131

GROUP 4: PUBLIC HEALTH	MEASURE A ALLOCATION FY 19/20	EXPENDED/ ENCUMBERED FY 19/20
La Clinica de La Raza, Inc.	50,000	50,000
East Bay Agency for Children	103,500	103,500
Lincoln	125,419	125,419
Other Program Expenses	1,105,608	1,105,466
Total Allocation	2,724,654	2,724,512

MAP 1

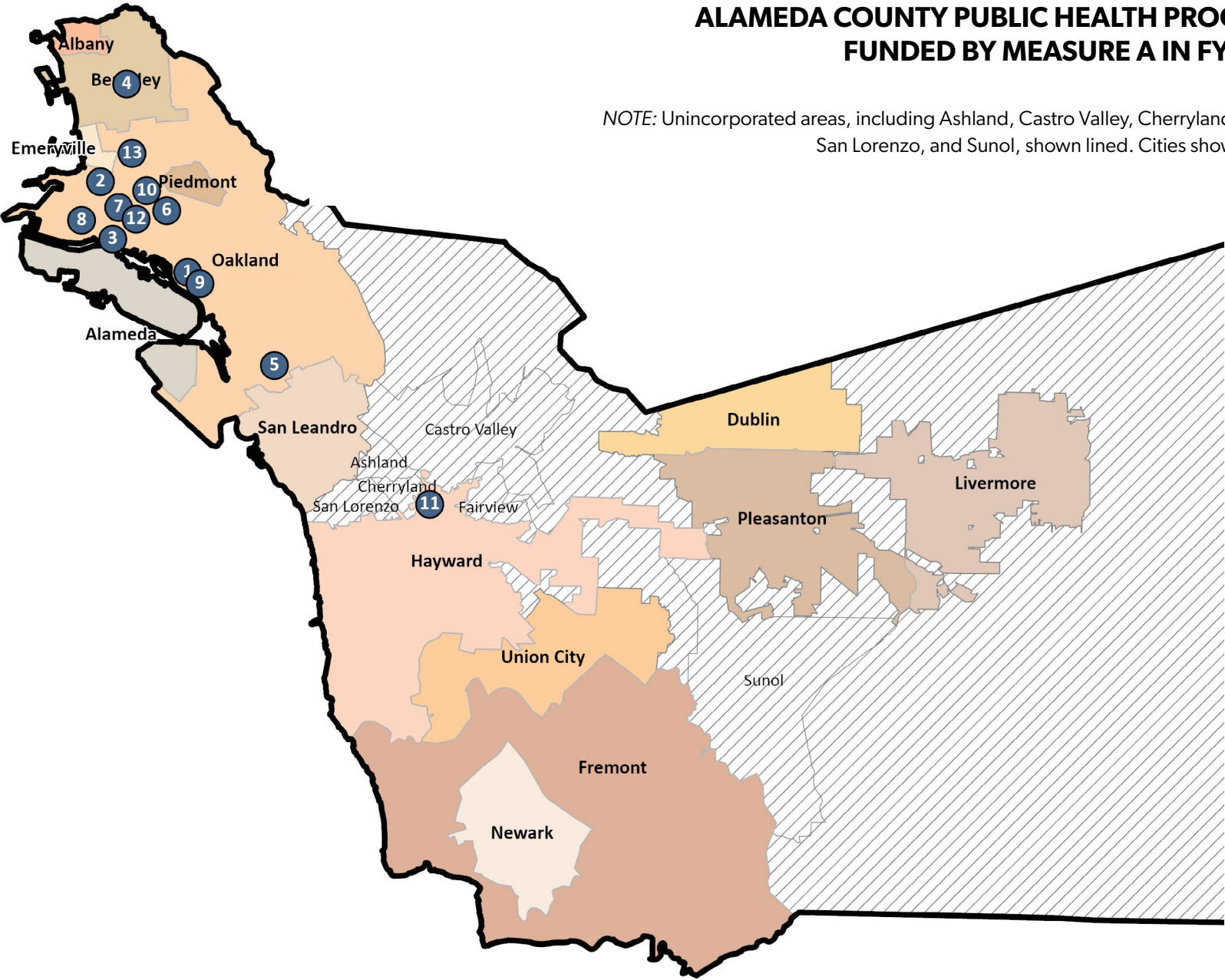
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS FUNDED BY MEASURE A IN FY 19/20

#	PROVIDER	CITY
1	Brighter Beginnings	Oakland
2	California Prostitutes Education Project	Oakland
3	Center for Oral Health	Oakland
4	City of Berkeley	Berkeley
5	East Oakland Boxing Association	Oakland
6	HIV Education and Prevention Project of Alameda County	Oakland
7	Lotus Bloom	Oakland

#	PROVIDER	CITY
8	Mandela Partners	Oakland
9	Native American Health Center, Inc.	Oakland
10	Niroga Institute	Oakland
11	Tiburcio Vasquez Health Center	Hayward
12	Tides Center (Hope Collaborative)	Oakland
13	UCSF Benioff Children's Hospital Oakland	Oakland

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS
FUNDED BY MEASURE A IN FY 19/20

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



MAP 2

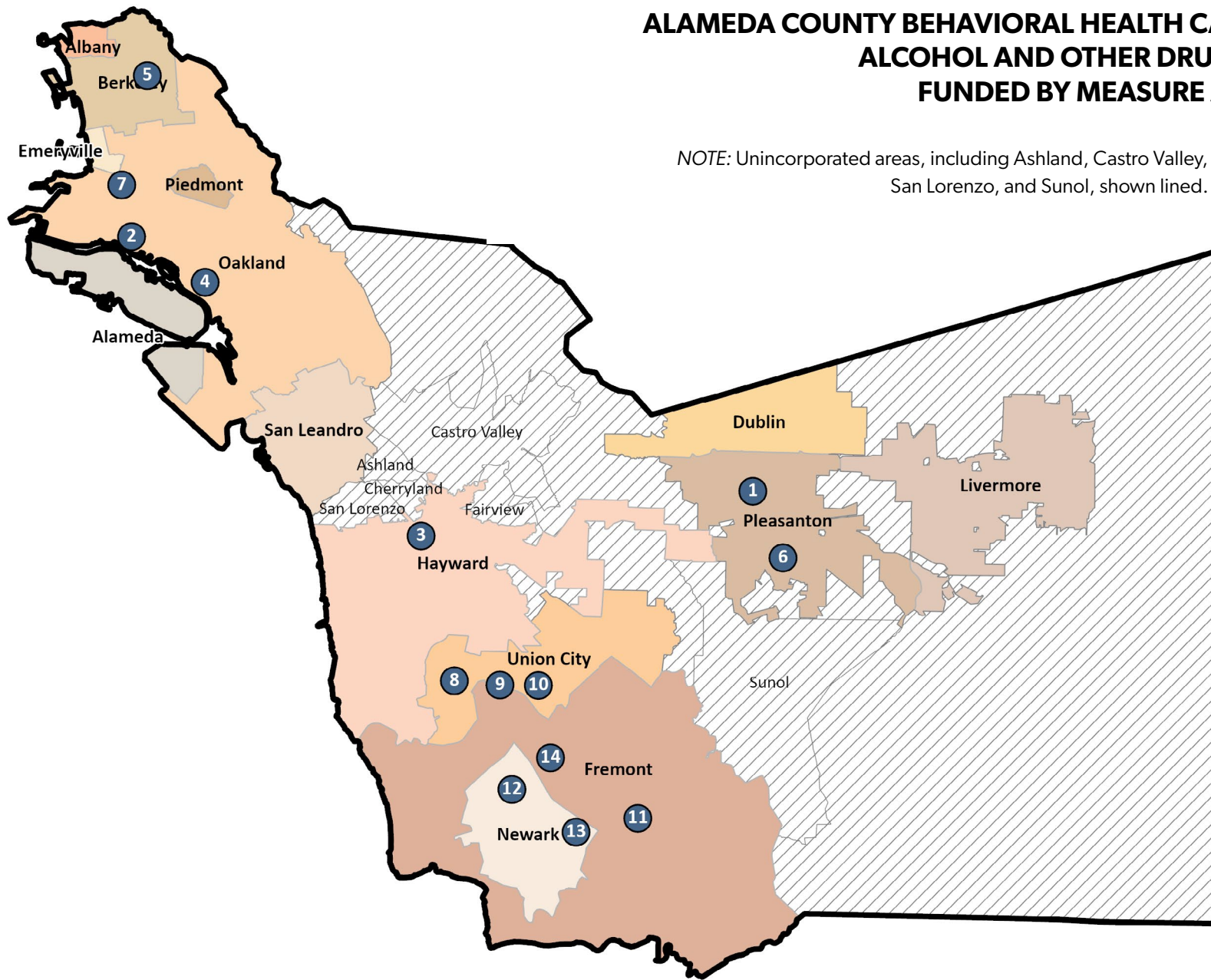
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES ALCOHOL AND OTHER DRUG PROVIDERS FUNDED BY MEASURE A IN FY 19/20

#	PROVIDER	CITY
1	Axis Community Health, Inc.	Pleasanton
2	Filipino Advocates for Justice	Oakland
3	Horizon Services, Inc.	Hayward
4	Native American Health Center, Inc.	Oakland
5	New Bridge Foundation, Inc.	Berkeley
6	Senior Support Program of the Tri-Valley	Pleasanton
7	St. Mary's Center	Oakland

#	PROVIDER	CITY
	Uplift Family Services (formerly EMQ Families First) - Administrative Services Office Uplift Family Services School Sites:	Campbell
8	Itliong Veracruz Middle School	Union City
9	Cesar Chavez Middle School	Union City
10	James Logan High School	Union City
11	Horner Jr. High School	Fremont
12	Newark Jr. High School	Newark
13	Newark Memorial High School	Newark
14	Thornton Jr. High School	Fremont

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
ALCOHOL AND OTHER DRUG PROVIDERS
FUNDED BY MEASURE A IN FY 19/20

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



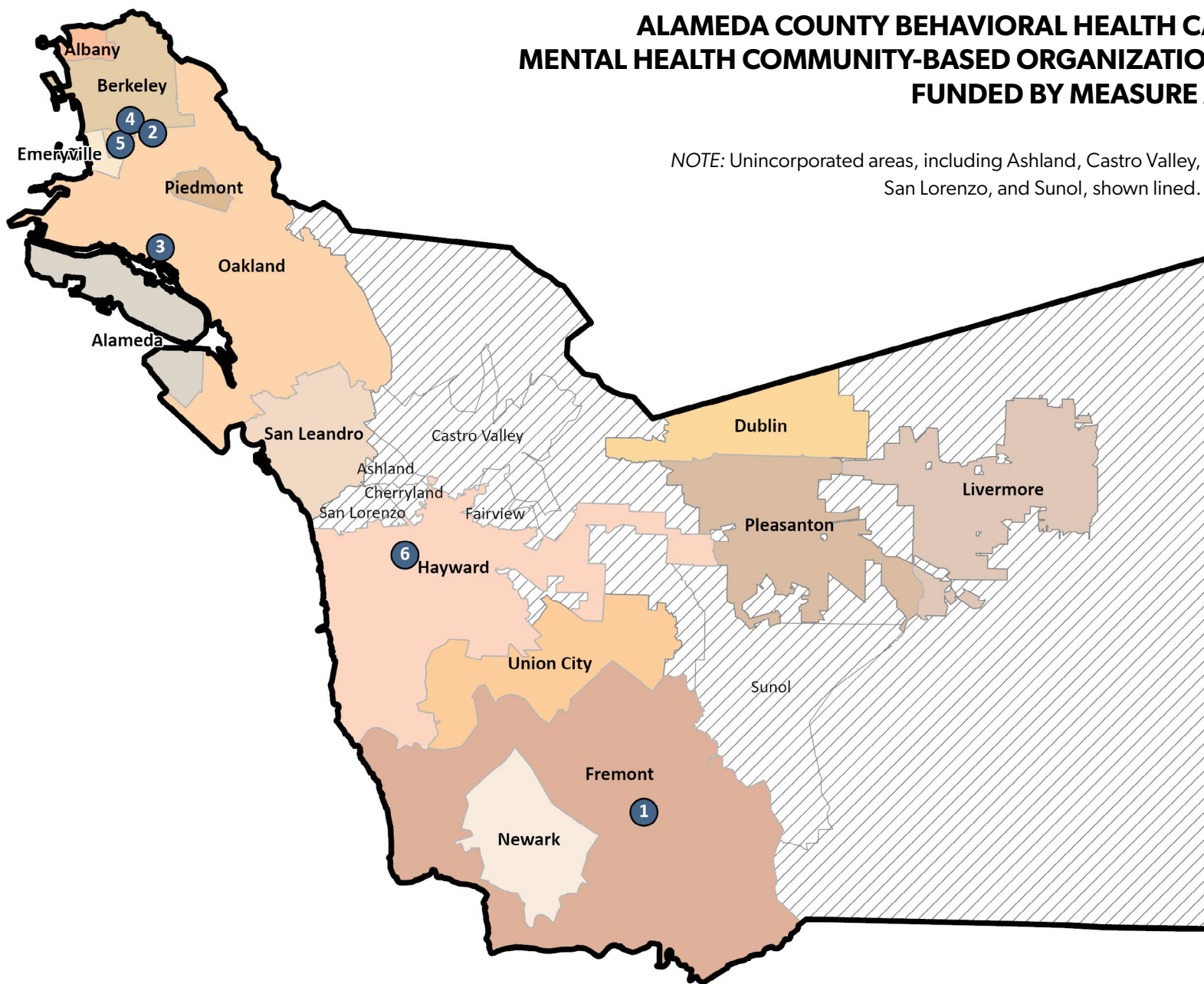
MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 19/20

#	PROVIDER	CITY
1	Abode Services, Inc.	Fremont
2	Bonita House, Inc.	Oakland
3	Center for Empowering Refugees and Immigrants	Oakland
4	Center for Independent Living	Berkeley
5	Mental Health Association of Alameda County	Oakland
6	The Alliance for Community Wellness (La Familia Counseling Service)	Hayward

MAP 3

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS FUNDED BY MEASURE A IN FY 19/20

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 19/20

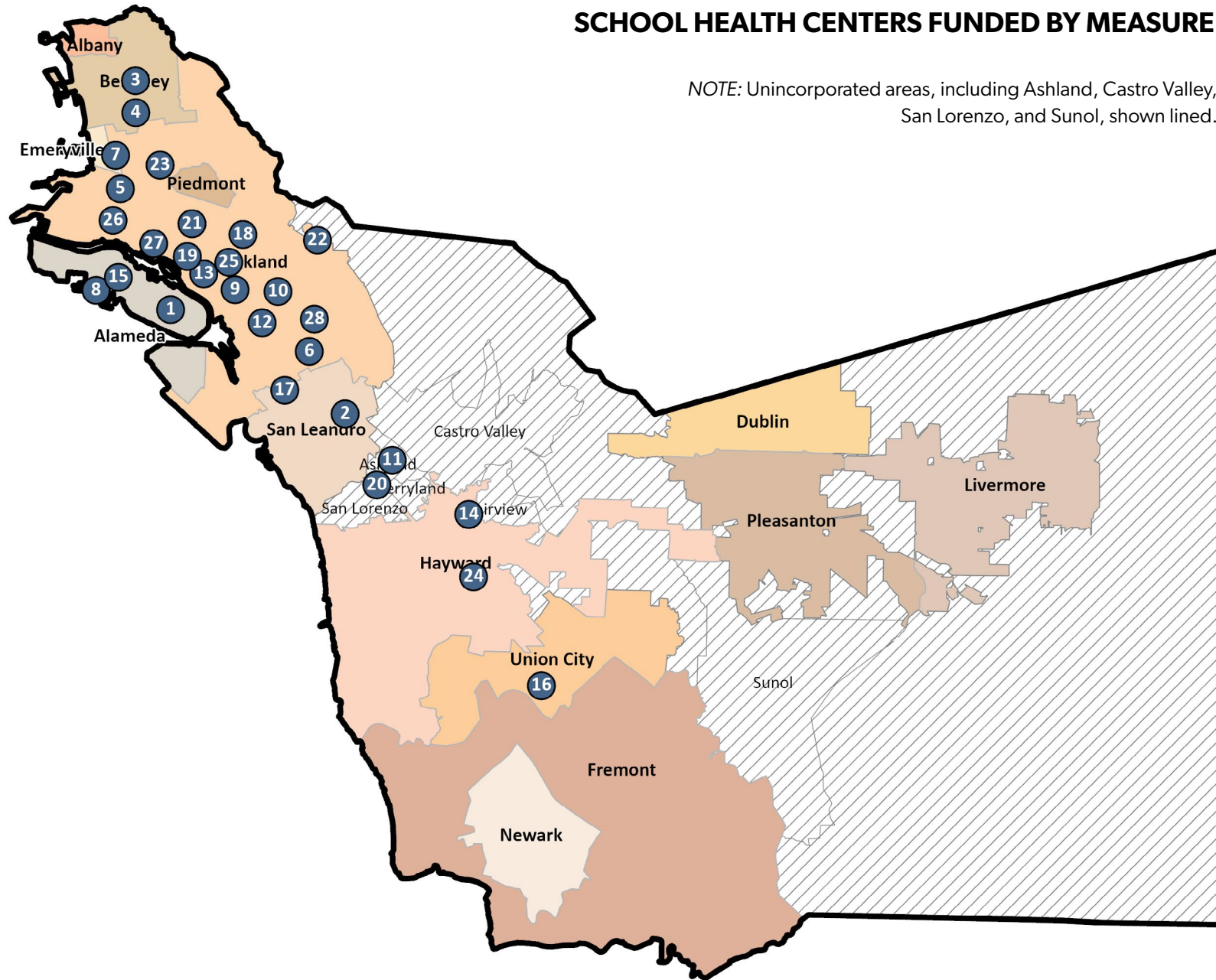
#	PROVIDER	CITY
1	Alameda High School-Based Health Center	Alameda
2	Barbara Lee Health & Wellness Center	San Leandro
3	Berkeley High School Health Center	Berkeley
4	Berkeley Technology Academy Health Center	Berkeley
5	Chappell Hayes Health Center	Oakland
6	Elmhurst/Alliance Wellness Center	Oakland
7	Emeryville Health Center	Emeryville
8	Encinal High School-Based Health Center	Alameda
9	Fremont Tiger Clinic	Oakland
10	Frick Health and Wellness Center	Oakland
11	Fuente Wellness Center (REACH Ashland Youth Center)	San Leandro
12	Havenscourt Health Center	Oakland
13	Hawthorne Health Center	Oakland
14	Hayward High Health Center	Hayward

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

MAP 4

SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 19/20

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



HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 19/20

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 41 sites, which are operated by one of the 11 HealthPAC providers that include Alameda Health System (dba Alameda County Medical Center).

MAP 5

HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 19/20

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

