MEASURE A

Essential Health Care Services Tax Ordinance

Oversight Committee
7th Report

to the Alameda County Board of Supervisors
and the Public

Review of Expenditures in

Fiscal Year (FY) 2012/2013

July 1, 2012 – June 30, 2013

FISCAL YEAR 2012/2013

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MEASURE A OVERSIGHT COMMITTEE MEMBERS

COMMITTEE MEMBER	REPRESENTING/NOMINATED BY
Suzanne Barba	League of Women Voters*
John Becker	City Managers' Association
Olga Borjon	Supervisor Richard Valle (District 2)
Arthur Chen, M.D.	Alameda-Contra Costa Medical Association
Louis Chicoine	Supervisor Scott Haggerty (District 1)
Bradley Cleveland	Supervisor Nate Miley (District 4)
Fran David	City Managers' Association
Adam Davis	Hospital Council of Northern California
Rochelle Elias	Alameda County Mental Health Board
Doug Jones	Central Labor Council of Alameda County
Gwendolyn McClain	Alameda County Public Health Commission
Sally Morgan	League of Women Voters*
Al Murray	City of Berkeley
George Phillips	Supervisor Wilma Chan (District 3)
Ursula Rolfe, M.D.	League of Women Voters
Terry Sandoval	Central Labor Council of Alameda County
(vacant)	Supervisor Keith Carson (District 5)
(seat in abeyance)	Alameda County Taxpayers Association, Inc.

*Suzanne Barba resigned in December 2014. Sally Morgan was appointed to serve the remainder of her term.

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY STAFF

Alex Briscoe	Agency Director
Rebecca Gebhart	Finance Director
Ryan Gordon	Administrative Assistant
James Nguyen	Administrative Services Officer
Connie Soriano	Administrative Assistant

FY 12/13
EXECUTIVE SUMMARY

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

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

This report is based on a number of sources:

- Self-reported information provided by recipients of Measure A funds
- A presentation by the Alameda Health System (AHS, dba Alameda County Medical Center)
- The Alameda County Health Care Services Agency (HCSA), which monitors the contracts with recipients of Measure A funds—including negotiating scope of work and payment schedule, developing contracts, preparing letters to the Board for approval, authorizing payments, and tracking expenditures.

Measure A, the Essential Health Care Services Initiative, was passed by 71% of Alameda County voters in March 2004. It authorized the County of Alameda to raise its sales tax by one-half cent to provide additional financial support for emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low-income, and uninsured adults, children, families, seniors, and other residents of Alameda County. In June 2014, 76% of voters passed Measure AA, which extended the half-cent sales tax through 2034. These services faced sharply increasing costs with inadequate resources to meet the needs of County residents. Measure A funds substantially eased the countywide crisis in health care; however, the economic downturn and slow recovery experienced both county- and nationwide since the passage of the Measure have threatened some of the gains achieved.

The initiative generated $121,049,205 in FY 12/13. AHS received 75% of these funds, and the Board distributed the remainder of the funds to other health care providers, including the following:

- Initiatives funded by the Alameda County Public Health Department and Behavioral Health Care Services (BHCS)
- Primary care clinics
- Children's, St. Rose, ValleyCare, and Washington Hospitals
- School health centers

In addition to helping AHS stabilize its budget and expand its health care services, Measure A has helped enable serious long-term planning to meet future health care needs for County residents. For example, the Public Health Department has used Measure A funds to examine and address health inequities within the client population and to develop a strategic plan. These initiatives will continue to bear fruit over time.

MAJOR CONCLUSION

The Oversight Committee found that AHS and other recipients of the sales tax revenue spent the funds in compliance with the strictures of Measure A. In addition, the Committee found that in FY 12/13, Measure A enabled expansions in services and facilities, which reflects the stated primary goal of the measure.

HIGHLIGHTS

Even in light of recent and ongoing federal health care reform, according to American Community Survey data for 2013, an estimated 197,159 people, or 12.6% of County residents, are uninsured. Thus, Measure A revenues continue to play a critical role in helping indigent, uninsured, and low-income residents of Alameda County—who depend on the County's health care safety net—maintain access to medical services.

With regard to Measure A recipient reporting, the Committee recognizes an ongoing trend of improvement in the quality and level of detail in the reporting compared to prior years. This is due in part to the ongoing effort of the Committee to revise and refine the reporting form to solicit more specific information from fund recipients and thereby improve their oversight accountability to Alameda County taxpayers.

The sales tax revenue received through Measure A enabled the following positive developments in the delivery of health care services:

- In the face of a sluggish economic recovery, Measure A enabled a large number of providers to continue existing programs and maintain the service levels offered by these programs. For example, AHS admitted almost 15,000 patients for hospitalization and conducted more than 311,000 outpatient visits, while the Public Health Prevention Initiative served more than 77,000 Measure A clients.
- Most providers presented clear, quantified information that showed increases in the number of clients served, increases in desired outcomes, or decreases in harmful behavior as a result of Measure A-funded services. For example, the services provided by the Detoxification/Sobering Center resulted in reducing the number of individuals entering a County emergency department with a diagnosis of intoxication by 52% and decreased the length of stay for those who did enter an emergency department by four hours.
- Measure A funds increased access to health care services both geographically and through provision of a greater number and variety of services. Asian Health Services and Tiburcio Vasquez Health Center, Inc. (TVHC) used Measure A funding to support the development of new community health clinics that have expanded health services to more than 10,000 new patients in Oakland and Ashland/Cherryland.
- The California Telehealth Network used Measure A funds to equip telehealth stations (video stations at which patients can access medical services remotely) for Children's Hospital & Research Center Oakland (CHRCO), Alameda County Juvenile Justice Center, Madison School-Based Health Center, and Healthy Communities, Inc. The stations enable these providers to increase access to specialty care for pediatric patients seen in traditional and nontraditional settings.
- The Day Labor Center referred more than 900 clients for primary and episodic health care, reducing the number of emergency room visits and saving an estimated $810,000.
- CHRCO and St. Rose hospital, the Public Health Prevention Initiative, Behavioral Health and Alcohol and Other Drug Community-Based Providers, school health services, and many smaller providers used Measure A funds to qualify for over $42 million in federal, state, and private matching funds. The $1 million that CHRCO and St. Rose each received in matching funds represents a $1 match for every $2 in Measure A funds.
- AHS significantly increased its level of services and improved patient satisfaction throughout its inpatient and outpatient network. Outpatient dental surgeries increased by 47%. The patient satisfaction score at John

George jumped 20 points, from the 52nd to the 72nd percentile among psychiatric hospitals. The Fairmont Hospital campus received a 4-star overall quality rating, and a large number of staff also received awards and recognition for their quality service. Highland Hospital emergency department's Navigators program, which guides patients and families through the care process, won the 2013 California Association of Public Hospitals/Safety Net Institute Quality Leaders Award.

- AHS reduced wait times at the Highland emergency department and implemented the Patient Call Manager program to improve clinical outcomes, prevent readmissions, and improve satisfaction by calling patients post-discharge. The care transitions program for patients with complex health needs resulted in a 19% reduction in overall 90-day readmissions.
- CHRCO used its Measure A allocation to reduce patient wait times in a number of service areas—by over 50% in providing pain medication to sickle cell patients—or to provide services more quickly when compared to peer hospitals. CHRCO also used its allocation to increase emergency department staff such that it could serve the highest volume of patients (46,000 visits) of any emergency department in the Bay Area. The average time for providing sickle cell patients with proper pain medication has gone from 90 minutes to 30 minutes, which is among the top in the nation.
- The community-based primary care health centers affiliated with the Alameda Health Consortium provided comprehensive care for 40,600 individual clients, who made a total of 138,269 visits. Overall, Alameda Health Consortium member health centers provided an increased number of visits under HealthPAC compared to the previous year, up 18,000 visits from FY 11/12. The health centers also enrolled 4,600 more patients into the program, a 13% increase from the preceding fiscal year.
- Many organizations and departments, including the Public Health Department, Multicultural Institute, and Preventive Care Pathways, used Measure A funds to increase health outreach and education efforts, with a focus on prevention. Measure A also allowed for the continuation and expansion of mental health services among many providers.
- Measure A gives the County flexibility to address unmet needs and unanticipated costs. Specifically, the $150,000 each member of the Board receives as a discretionary allocation gives the supervisors the flexibility to respond to unanticipated needs in their districts. Over the period of this report, there were 16 contracts for services for youth, children, seniors, and the general population from the allocations. During this period, the Committee noted an increased focus on healthy living, wellness, and prevention initiatives.

CONCERNS

In developing this report, the Oversight Committee has identified several concerns regarding the state of health care funding both during the years of Measure A implementation (2004-2012) and in the foreseeable future. These general concerns stem from a slow, uneven economic recovery rate, health care funding cuts, and a decrease in the number of uninsured Alameda County residents.

Despite indicators that reflect a positive fiscal outlook, the path towards economic recovery still remains fragile. In addition, given the uneven impact of the recovery, many families living in disadvantaged communities have not benefited from the improved job and housing markets and continue to need access to the essential health care services that Measure A provides.

At the same time, the Committee is paying close attention to the recent and ongoing state and federal health care reform initiatives, which promise to expand coverage and increase access to care to more than 150,000 County residents who are currently uninsured. At the start of 2014, Alameda County, through HCSA, successfully transitioned more than 40,000 uninsured residents from the Low-Income Health Program to state

Medi-Cal insurance, which gives enrollees access to additional medical services from a wider network of health care providers. In addition, approximately 5,600 newly eligible residents were able to seek coverage through Covered California, the statewide health insurance exchange program. While these accomplishments represent a boost to health access for many children, adults, and families, many individuals in Alameda County remain uninsured. Moreover, funding cuts from the previous five years, Medi-Cal rate reductions, and potential state and federal funding cuts have deteriorated the County's safety net, decreased the ability of health providers to offer services to the Medi-Cal and uninsured populations, and challenged health care expansion efforts.

Realizing the full promise of these reforms presents a significant challenge as the health care delivery system remains fragmented, eligibility systems are cumbersome and difficult to negotiate, and access to care continues to be compromised by low rates and a shortage of providers—particularly in primary and preventative care. Measure A will continue to serve as an essential revenue stream to emphasize prevention 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 services delivery by addressing the root causes of poor health outcomes.

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

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

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

General Funding Concerns

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

Reporting and Review Concerns

- The Committee expresses an ongoing concern that the County Counsel's interpretation of the Measure A ordinance limits the Committee's ability to review program efficacy and cost-effectiveness. In addition, the Committee does not have the capacity to review HCSA's process of controls and review of how the money is spent—via audit or other method. The Committee recommends that the Board authorize HCSA to include evaluations of Measure A programs as part of its initiative to improve oversight and outcomes in all its programs. This includes identifying an additional resource to ensure that Measure A contracts are included in the initiative.

- Both HCSA and the Oversight Committee believe that the interpretation of the statute must be revised to expand the role of the Committee and appropriately allocate Measure A funds for administrative staff to oversee the contracts and ensure the effective use of public funds to all grantees.
- Although reporting continues to improve, the Committee expresses the ongoing concern that its review is impacted by the varying level of detail provided in fund recipient reports, as well as varying levels of responsiveness to specific questions posed by the Committee to specific recipients. This makes it difficult for the Committee to determine whether funding is being spent on the Measure A target population. For example:
  - Multiple provider reports listed objectives that are not measurable and/or stated positive outcomes without quantifying the statements. For example, Behavioral Health Care Services at Juvenile Justice Center makes assertions of "increased coping skills" and "a great benefit" from court-ordered evaluations without quantifying these statements. The Mind Body Awareness Project was unable to collect data during this period due to organizational transitions, which made it difficult for the Committee to determine program effectiveness.
  - For some reports, it is unclear whether the target population falls within one of the categories listed in the Measure A statute: "indigent, low-income, and uninsured adults, children, families, seniors, and other residents of Alameda County." For example, the information presented by providers such as Service Opportunities for Seniors and the Teleosis Institute does not track whether the population served falls within the requirements of Measure A.
  - In other reports, the provider's description of the services offered raises questions as to their relevance to the wording of the Measure A statute. For example, while the Committee recognizes the value of the California Product Stewardship Council drug disposal program, it is unclear whether these activities and their target populations fall within the wording of Measure A.

In light of some of these reporting concerns, the Committee recommends that trainings reinforce proper and accurate completion of demographic information and adherence to Measure A services. Additionally, the Committee recommends that HCSA continue to work with recipients to improve the use of results-based performance measures and ensure that the population and services supported with Measure A comply with the ordinance. The Committee recommends that the recipient reporting form include a question about service delivery in multiple languages, as language barriers can potentially impede access to services for members of the Measure A target population.

Alameda Health System

The Oversight Committee urges AHS to define specific measureable program objectives for how it spent Measure A funds, and then to align reported results with these objectives. In the absence of such objectives, it is difficult for the Oversight Committee to ascertain their performance.

Detoxification/Sobering Center

The Center's 100% reliance on Measure A funds makes it entirely dependent on this funding source.

St. Rose Hospital

Even with Measure A funds at the present level, St. Rose Hospital remains in extreme financial distress. Since it is a safety net hospital for central and southern Alameda County, the Committee notes that other solutions are needed to maintain this vital service.

Tri-City Health Center, Inc.

This provider used Measure A funds for financial stabilization. The Committee questions the use of Measure A funds to address internal management issues.

Administration/Infrastructure Support

Given the total annual expenditure of over $121 million and only 0.12% for administrative support, the Committee recommends exploring cost-effective ways to evaluate Measure A-funded programs and services and improve the accountability of Measure A investments by implementing the use of results-based performance measures.

Board of Supervisors Discretionary Allocations

- As noted in the reporting concerns above, some Board allocations are for direct services, while others are informational, preventive, or long-term focused and therefore more difficult to quantify. It would be helpful to develop a process that ensures these Board allocations are aligned with the intent of the ordinance.
- The Committee expresses the belief that a fair and equitable process should exist for providers to apply for Board discretionary funds. This ensures transparency in the process of awarding Board allocations.
- Continuing an ongoing trend, the FY 12/13 allocations included a large number of relatively small discretionary Board allocations, which require the use of additional HCSA administrative time. Instead of granting allocations that represent an insignificant percentage of a program's budget, the Committee recommends that the Board consider setting a minimum amount of $25,000 for discretionary grants so that the Measure A funds can have a significant positive impact on a provider's program and services.

FOR MORE INFORMATION

The full report of the Oversight Committee and all supporting documents are available online at www.acgov.org/health/indigent/measureA.htm. For more information about Measure A expenditures or the Committee, please contact James Nguyen at (510) 618-2016 or James.Nguyen@acgov.org.

SECTION 1

FUNDING ALLOCATION AND REVIEW PROCESS

The language of Measure A allocates funds as follows:

- The Alameda Health System (AHS, dba Alameda County Medical Center) receives a direct allocation of 75% of funds.
- The Alameda County Board of Supervisors (Board) allocates the remaining 25% of funds.

On December 14, 2004, after initial passage of the ordinance, the Board approved the first funding allocations of its 25% share of Measure A funds, which the Board has since reviewed and allocated approximately every three years. In FY 12/13, the Board approved a total of $33,195,193 in Measure A funding, which includes base allocations and one-time allocations to provide essential health care services. Some of the providers, organizations, and allocations include the following:

- Alameda Boys & Girls Club
- Alameda County Asthma Start
- Alameda County Behavioral Health Care Services (BHCS) Community-Based Organization Providers
- Alameda County Dental Health
- Alameda County Public Health Department Prevention Initiative
- Alameda County Sobering/Detoxification Center
- Behavioral Health and Medical Costs for the Juvenile Justice Center
- Board of Supervisors allocations
- Center for Early Intervention on Deafness
- Center for Elders' Independence
- City of San Leandro
- Community-Based Organization Primary Care Clinics
- Criminal Justice Screening and In-Custody Services
- Direct Medical and Support Services in Oakland
- Fire Station Health Portals
- Fremont Aging & Family Services
- Health Enrollment for Children
- Health Services for Day Laborers
- Non-County Hospitals
- School Health Centers
- School-Based Behavioral Health Initiative
- Senior Injury Prevention Program
- Youth and Family Opportunity Initiative

As a tool for reviewing funding allocations, the Measure A Citizen Oversight Committee developed a reporting form, which contains questions on specific uses of funds received, for all Measure A fund recipients to complete.

Most recently, the Committee developed a review form and revised the reporting form to solicit more specific information from fund recipients. While modifying the form to improve the quality of the responses is an ongoing effort, these revisions have improved the quality of reports.

For the FY 12/13 report, the Committee received presentations on several allocations, including the Alameda Health System, Center for Healthy Schools and Communities' School Health Centers and School-Based Behavioral Health Initiative, Day Labor Center, Multicultural Institute, and Street Level Health Project. The Committee used the report forms returned by most Measure A fund recipients, along with information from the presentations, to review all funding allocations. Also as in prior years, varying levels of detail provided in the reports as well as varying levels of responsiveness to specific questions posed by the Committee to specific recipients made it difficult for the Committee to evaluate the reports consistently and thoroughly. However, as noted, the revised form and the informational sessions conducted to help providers understand how to complete the reporting form have improved the information reported to the Oversight Committee.

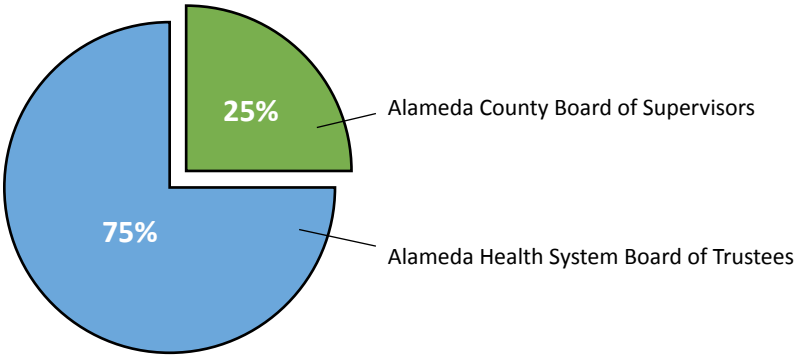
SECTION 2

HOW THE MONEY WAS SPENT

The Alameda Health System (AHS, dba Alameda County Medical Center) receives 75% of Measure A funds through a specific designation. The AHS Board of Trustees allocates these funds within AHS. The Alameda County Board of Supervisors (Board) allocates the remaining 25% of Measure A funds. The Alameda County Health Care Services Agency (HCSA) manages these funds.

Figure 1

DISTRIBUTION OF MEASURE A FUNDS



In FY 12/13, Measure A generated $121,049,206 (not including interest earned). The funds were allocated as follows:

Alameda Health System (75%)	$90,786,904
Alameda County (non-AHS) (25%)	$30,262,301
TOTAL	**$121,049,205**

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

The following sections provide more detail on the allocation and expenditure of Measure A funds.

REVIEW OF FY 12/13 EXPENDITURES:

75% of Measure A Funds Allocated to the Alameda Health System (dba Alameda County Medical Center)

FY 12/13 allocation: $90,786,904

Expended/encumbered in FY 12/13: $90,786,904

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

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

Measure A clients served: 403,365 (**Total clients**: 424,595)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

In FY 12/13, AHS adopted a three-year strategic plan. The plan rests on six pillars:

- **Growth/Access to Care** goals relate to maintaining the health of all County residents by expanding access to services. Key goals in FY 12/13 included the following:
  - Implementation of electronic health records
  - Opening of Highland Care Pavilion, including new specialty clinics and the same-day clinic
  - Operating room expansion, with additional physicians and staff in anesthesiology, gastroenterology, urology, ENT, and muscular skeletal services
  - Specialty care expansion at neighborhood-based wellness clinics and opening of the Hope Center for complex care
- **Quality Enhancement** goals align with patient safety initiatives, such as benchmarks set by the Joint Commission, a national accrediting organization for hospitals. Key goals in FY12/13 included the following:
  - Establishing an improved infrastructure for quality control
  - Increased focus on panel management
  - Increased focus on harm reduction

Measure A Helps

ALAMEDA HEALTH SYSTEM

Ms. X. is a 44-year-old woman with congestive heart failure, post-traumatic stress disorder, homelessness, and crack cocaine addiction. A HOPE Center nurse care manager enrolled her in the HOPE program and began working with her. The AHS team found short-term clean and sober housing for her, and worked to find Ms. X. long-term subsidized housing and an outpatient substance abuse treatment program. Ms. X. also began receiving primary care for the first time. After having established stable housing, the nurse care manager began to work on self-management support surrounding the potential for heart failure. Ms. X. now knows to call the HOPE Center if she is feeling short of breath rather than going to the emergency department.

- **Service Enhancement** goals move toward greater patient loyalty, a culture of customer service, and an enhanced patient experience. Key goals in FY 12/13 included the following:
  - Training staff to improve the patient experience
  - Upgrading facilities and expanding hours of service
  - Establishing new models of care designed to improve outcomes
- **Fiscal Stewardship** goals represent a commitment to financial stability, operational efficiency, and debt-reduction. AHS is working to offset declining federal funds with new patient revenues from expanded Medi-Cal, the Health Insurance Exchange under health care reform, and new contracts with commercial payers, and is working to deliver care more efficiently and cost-effectively. Key goals in FY 12/13 included the following:
  - Establishing a System Transformation Center to oversee a range of organizational improvement initiatives
  - Implementing a Cost Management initiative, aimed at decreasing use of overtime labor and improving core staff scheduling, redesigning the supply chain, improving purchased service contract pricing, implementing flex scheduling, and other initiatives
  - Expanding Lean initiatives, which optimize business processes by breaking them down into component steps that permit the identification and elimination of efforts that confer no value
  - Beginning implementation of Soarian Financials enterprise software to streamline billing with eventual integration into electronic health records
- **Workforce Development** goals seek to create a culture that encourages innovation and fosters high achievement by attracting, developing, and retaining competent and compassionate staff. Key goals in FY 12/13 included the following:
  - Designing a new physician operating model in which AHS reorganizes physician resources within the health system to improve and strengthen quality control, care coordination, billing and collections, and provider education
  - Increasing education to clinical and support staff on providing patient- and family-centered care
  - Hiring additional physician and support staff to expand service offerings
  - Working to increase employee engagement, which correlates to the quality of the patient experience
- **Community/Image Enhancement** goals address the need for community stakeholders and constituents to understand AHS's contributions to the well-being of the entire County. Key goals in FY 12/13 included the following:
  - The phased rollout of a new name and brand, Alameda Health System, to better communicate the

Measure A Helps

ALAMEDA HEALTH SYSTEM

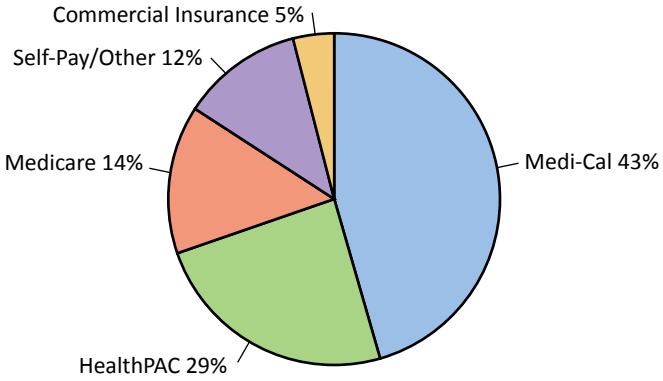
CF is a 17-year-old male who was having seizures that were not responding to medication. AHS caregivers collaborated with colleagues at Children's Hospital and Research Center Oakland and developed a plan for him to have brain surgery to eliminate the focus of his seizures. His first surgery was successful, but ultimately he required a second surgery. As a result of his continued seizures and hospitalizations, he became socially isolated and depressed. AHS established bi-weekly visits in its clinic to manage his seizure medications and provide psychological support. He has been seizure-free for six months and his mood is much improved. He is now volunteering for a local organization, working to improve the environmental conditions in his neighborhood.

operating model as a public health authority with multiple geographic locations serving patients throughout Alameda County
- Strengthening linkages with community primary care providers
- Expanding health education activities
- Better helping patients connect with community resources

AHS's expansion strategy, facilities upgrades, and rebranding are designed to attract new patients and patient revenue as well as to exceed the expectations of patients who now have a choice under health care reform. At the same time, AHS is working hard to manage costs while improving satisfaction and quality and improving the health of the populations it serves.

Figure 2

ALAMEDA HEALTH SYSTEM PAYER MIX, FY 12/13



MEASURE A FUNDING SUMMARY

Measure A is a supplemental revenue source for AHS, reducing the gap between reimbursement for services from a variety of sources and the actual cost of providing those services to underinsured and uninsured persons. AHS used Measure A funds with the express purpose of providing primary care and specialty care, and preventative and mental health services, to indigent, low-income, and uninsured children, families, and seniors of Alameda County. AHS used Measure A funds to fill in budget gaps related to providing that care. For FY 12/13, AHS made the following percentage allocations per service line:

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

Measure A therefore supports all of AHS's services, with the exception of that fraction of AHS's business for which it receives full reimbursement for the cost of services provided.

Measure A helped AHS achieve the following measurable objectives in FY 12/13:

AHS Client Results: Overview

- 311,330 outpatient visits (297,889 in FY 11/12)
- 84,355 visits to Highland emergency department (82,060 in FY 11/12)
- 14,605 overall discharges (14,839 in FY 11/12)
- 12,759 visits to John George Psychiatric Hospital emergency department (11,420 in FY 11/12)
- 2,137 patients served by trauma center (2,131 in FY 11/12)
- Interpreter services offered in 26 languages

Wellness Centers: Newark, Eastmont, Hayward, Highland

- Newark Wellness reached its goal of a 10% expansion in primary care visits.
- AHS's panel management program for preventive health, which began in December 2011, has resulted in substantial increases in patients who are candidates for various screenings actually receiving those screenings, including Pap smears, mammograms, and colorectal cancer.
- 85% of patients seen in the tele-dermatology clinic, where an offsite UCSF dermatologist consults with an AHS provider, had their cases resolved without needing in-person visits.
- More than two-thirds of children participating in AHS's Bite to Balance program for six months or more maintained or decreased their Body Mass Index (BMI) and achieved significant improvement in cholesterol and blood sugar levels as a result of receiving fresh produce and nutrition education.

John George Psychiatric Hospital

- Seclusion-restraint incidents remained below the community standard for inpatient services of five incidents per 1,000 patient days; for emergency services, the standard for seclusion restraints is approximately 100 incidents per 1,000 patient visits. In FY 12/13 John George was at six incidents per 1,000 patient visits, one of the lowest rates in the United States.

Figure 3

MEASURE A REVENUE TREND

Budget figures show Measure A funding to the Alameda Health System (dba Alameda County Medical Center) between FY 08/09 and FY 12/13.

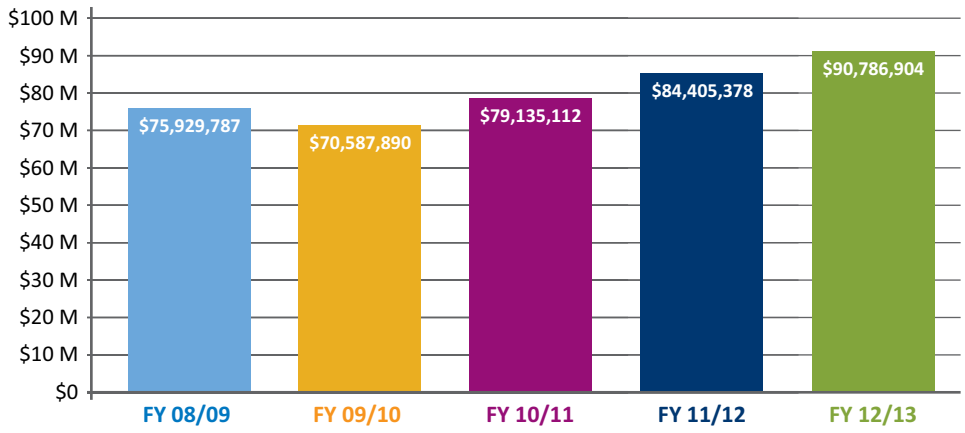
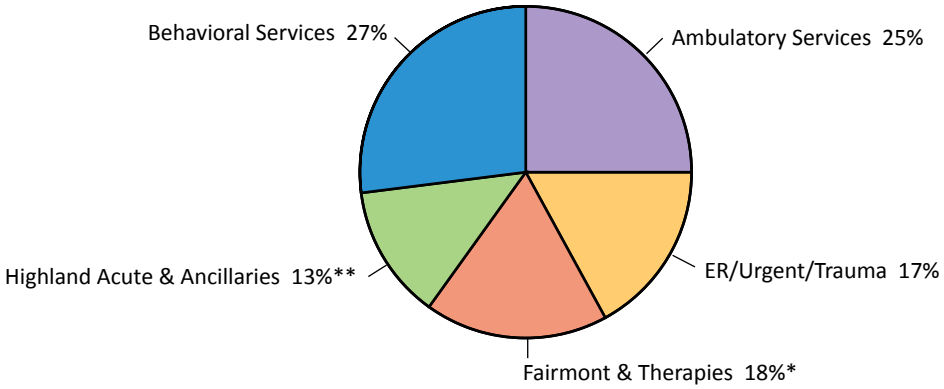


Figure 4

ALLOCATION OF ALAMEDA HEALTH SYSTEM MEASURE A FUNDS BY % IN FY 12/13



* Fairmont includes Skilled Nursing, Acute Rehab, and Therapies.

** Highland Acute & Ancillaries includes ICU, SDU, Medical/Surgical, Perioperative, Labor and Delivery, Nursery and ICN, and Ancillaries (i.e., laboratory, radiology, etc.).

HIGHLIGHTS

Working with Alameda County, AHS leveraged its Measure A funds to obtain an additional $108 million in federal support.

AHS significantly increased its level of services and improved patient satisfaction throughout its inpatient and outpatient network. Highland emergency department's Navigators program, which guides patients and families through the care process, won the 2013 California Association of Public Hospitals/Safety Net Institute Quality Leaders Award.

Highland also opened the three-story, 80,000-square-foot Highland Care Pavilion, including the 4,340-square-foot same-day clinic with 11 examination rooms and 10 specialty clinics, which increased outpatient capacity.

AHS reduced wait times at the Highland emergency department and implemented the Patient Call Manager program to improve clinical outcomes, prevent readmissions, and improve satisfaction by calling patients post-discharge. The care transitions program for patients with complex health needs resulted in a 19% reduction in overall 90-day readmissions.

Outpatient dental surgeries increased by 47%.

The John George patient satisfaction score jumped 20 points from the 52nd to the 72nd percentile.

Fairmont Hospital campus received a 4-star overall quality rating. A large number of AHS staff received awards and recognition.

CONCERNS

The Committee urges AHS to define specific measureable program objectives for how it spent Measure A funds, and then to align reported results with these objectives. In the absence of such objectives, it is difficult for the Oversight Committee to ascertain their performance.

REVIEW OF FY 12/13 EXPENDITURES:

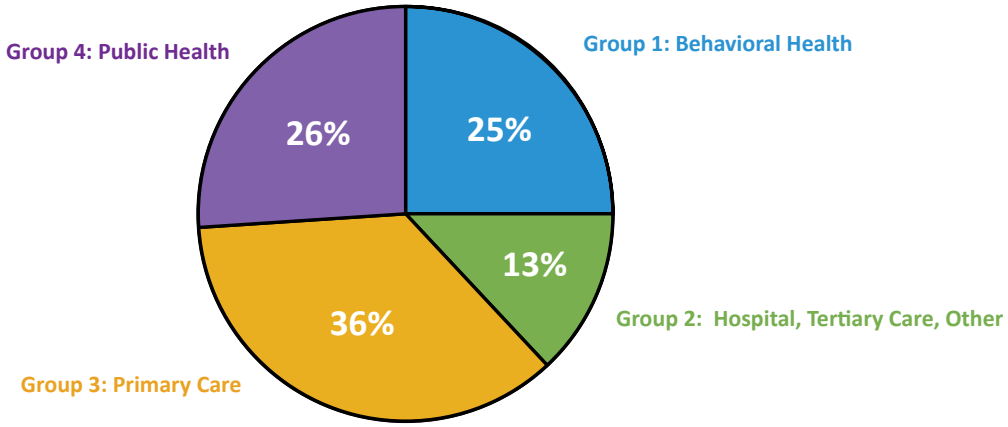
25% of Measure A Funds Allocated by The Alameda County Board Of Supervisors

In FY 12/13, the Board of Supervisors (Board) approved approximately $33.2 million in total Measure A allocations. The Board allocations are listed by group in the following chart.

NOTE: Since most of the allocations are approved by the Board before and during each fiscal year based on sales tax revenue projections, the total allocation amount may not equal the actual revenue received. For more details on Board allocations, see Appendix B: FY 12/13 Budget Information and Appendix C: FY 12/13 Measure A Fund Distribution by Provider or Program. This list may include allocations that were approved by the Board but not expended by the end of the fiscal year.

Figure 5

MEASURE A FUNDING APPROVED BY THE BOARD OF SUPERVISORS IN FY 12/13



Group 1: Behavioral Health – $8,467,000

Alameda County Behavioral Health Care Services Community-Based Providers 924,000
Building Opportunities for Self-Sufficiency (BOSS) 75,000
Center for Empowering Refugees and Immigrants 75,000
Criminal Justice Screening and In-Custody Services 4,306,000
Detoxification/Sobering Center 2,000,000
Mental Health Services for Juvenile Justice Center 360,000
School Health Services (School-Based Behavioral Health Initiative) 600,000
Board Discretionary Allocations (4 allocations) – Total $127,000

Group 2: Hospital, Tertiary Care, Other – $4,231,098

Children's Hospital & Research Center Oakland 2,000,000
St. Rose Hospital 2,000,000
Administration/Infrastructure Support 191,098
Board Discretionary Allocations (2 allocations) – Total $40,000

Group 3: Primary Care – $12,337,103

Alameda County Dental Health 150,000
Alameda Health Consortium: Electronic Health Record and Capital 1,600,000
California Telehealth Network 47,500
Capital Expansion: Asian Health Services, Axis Community Health, LifeLong Medical Care, Inc., Tiburcio Vasquez Health Center, Inc. 800,000
Center for Elders' Independence 50,000
Fire Station Health Portals 750,000
Fremont Aging & Family Services 50,000
Health Enrollment for Children 160,000
Health Insurance Eligibility & Enrollment 200,000
Health Services for Day Laborers: Community Initiatives (Day Labor Center) 75,000
Health Services for Day Laborers: Multicultural Institute 75,000
Health Services for Day Laborers: Street Level Health Project 75,000
Healthy Communities, Inc. 200,000
HillCare Foundation 26,000
Hospice: Getting the Most Out of Life Program 75,000
Medical Costs for Juvenile Justice Center 199,000
Preventive Care Pathways 400,000
Primary Care Community-Based Organizations 5,511,603
Provider Quality Improvement Project 10,000
Roots Community Health Center 30,000
School Health Centers 1,400,000
Tri-City Health Center: General Budget Stabilization 300,000
Board Discretionary Allocations (3 allocations) – Total $103,000

Group 4: Public Health – $7,763,912

AIDS Providers (AIDS Healthcare Foundation, AIDS Project of the East Bay, East Bay AIDS Center) 200,000
Alameda Boys & Girls Club, Inc. 25,000
Alameda County Asthma Start 100,000
California Prevention & Education Project 250,000
Center for Early Intervention on Deafness 50,000
Centerforce 14,992
City of San Leandro 50,000
Davis Street Family Resource Center 100,000
Deputy Sheriff's Activities League/REACH AYC 20,000
Eden Youth and Family Center 150,000
Environmental Health: Improve Field Sanitation Conditions/Nail Salons 50,000
Environmental Health: GPS Monitoring System 150,000
Federally Qualified Health Center Capacity Building 86,000
Latino Commission on Alcohol and Drug Abuse 150,000
LifeLong Medical Care: Heart 2 Heart 100,000
Office of AIDS Administration: Ryan White Providers 100,000
Public Health Prevention Initiative 2,784,000
Public Health Food Security/Food Justice Strategy 150,000
Public Health Pilot to Decrease Absenteeism in Schools 150,000
Senior Injury Prevention Program 100,000
Service Opportunity for Seniors (Meals-On-Wheels) 250,000
Youth and Family Opportunity Initiatives 2,450,000
Board Discretionary Allocations (8 allocations) – Total $283,920

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

Group 1: Behavioral Health

Behavioral Health Providers (Mental Health/Alcohol and Other Drug)

Building Opportunities for Self-Sufficiency

Center for Empowering Refugees and Immigrants

Criminal Justice Screening and In-Custody Services

Detoxification/Sobering Center

East Bay Community Recovery Project

Mental Health Services for Juvenile Justice Center

National Alliance on Mental Illness Tri-Valley

Safe Alternatives to Violent Environments

School Health Services (School-Based Behavioral Health Initiative)

Youth ALIVE!

BEHAVIORAL HEALTH PROVIDERS (MENTAL HEALTH/ALCOHOL AND OTHER DRUG)

FY 12/13 allocation: $924,000

Expended/encumbered in FY 12/13: $416,410

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $507,590

Types of services provided: Mental Health, Substance Abuse

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

Measure A clients served: 7,000 (**Total clients**: 43,000)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

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

MEASURE A FUNDING SUMMARY

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

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

HIGHLIGHTS

Despite significant reductions in County General Funds available to support behavioral health services, Measure A funds supplemented the budgets of CBOs that deliver these services, allowing these CBOs to provide a higher level of access to services for uninsured and health care safety net populations.

Specifically, compared to the preceding year, FY 12/13 saw a decline of only approximately 2% in both the total number of unique clients served (about 36,000 unique persons) across the behavioral health system, and the total number of services delivered to that population. In light of County General Fund reductions of about 10% and a Bay Area cost of living increase of about 2.4% for that same period, the Measure A supplement to providers' maintenance of effort was very effective in mitigating those declines.

In addition, the BHCS-contracted CBOs leveraged their Measure A allocations to obtain an additional $20,821 in matching funds from Medi-Cal and the Medi-Cal Administrative Activities (MAA) program.

CONCERNS

To increase accountability and transparency, the Committee recommends that in the future BHCS make allocations to fewer agencies in larger amounts, to more easily track actual expenditures.

BUILDING OPPORTUNITIES FOR SELF-SUFFICIENCY

FY 12/13 allocation: $75,000

Expended/encumbered in FY 12/13: $75,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Substance Abuse

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

Measure A clients served: NA* (**Total clients**: 800)

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

**Funding not used for direct services*

AGENCY/PROGRAM BACKGROUND

Building Opportunities for Self-Sufficiency (BOSS) helps homeless, poor, and disabled people achieve health and self-sufficiency, and fights against the root causes of poverty and homelessness. BOSS serves approximately 1,500 homeless families and individuals in Alameda County every year. Its residential capacity includes 168 beds for singles and 48 units for families, plus a variable-unit program that houses up to 29 people. BOSS also operates nonresidential programs (income advocacy, drop-in center, leadership development project, temporary jobs program). Over 40% of BOSS participants are homeless for the first time. Another 30% are chronically homeless, and the remaining 30% have experienced more than one episode of homelessness as they work to rebuild their lives.

Homeless advocates estimate it can take 37 hours a week to travel between service providers for services homeless people need. BOSS reduces this burden by housing multiple services and resources in each of its programs. These services include benefits advocacy, health care referrals, assistance in obtaining health care coverage, case management services, payee/money management services, mental health services, recovery services, housing placement services, employment services, and adult education services.

Measure A Helps

BUILDING OPPORTUNITIES FOR SELF-SUFFICIENCY (BOSS)

Because of drug and alcohol addiction, George spent 10 years living on the streets in Berkeley and Oakland, finally spending two years in jail for a violent crime. Upon release, he was referred to the BOSS Single Adult program, where he lived for six months, receiving services to support his recovery and search for employment and housing. He met all his parole requirements, completing his program and paying restitution to his crime victim. Through the BOSS transitional housing and employment programs, George obtained an apartment and job for six months before transitioning to a permanent position with a local Business Improvement District. A permanent housing subsidy enabled George to move into a one-bedroom apartment.

MEASURE A FUNDING SUMMARY

BOSS used its Measure A allocation to achieve two high-level objectives, as follows:

- Facilitate and complete its executive/leadership team transition to best address agency needs and emerging community issues, including the following tasks:
  - Create a dedicated Human Resources department with full-time staff
  - Create and fill an Operations Director position
  - Complete the transfer of computer logins, budget, and signature authority
  - Establish and implement a regular schedule of internal meetings
  - Conduct 25 one-on-one stakeholder meetings
  - Review personnel performance and mentor three staff monthly
  - Monitor performance of current projects
  - Complete strategic planning and develop monthly action Item lists
- Complete the service/site reorganization, including the following tasks:
  - Implement new program curricula and establish new program goals, focusing on housing first, critical time intervention, and trauma informed care.
  - Establish and submit an administrative policies and procedures manual
  - Submit a policies and procedures manual for programs/projects

CENTER FOR EMPOWERING REFUGEES AND IMMIGRANTS

FY 12/13 allocation: $75,000

Expended/encumbered in FY 12/13: $75,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health, Mental Health

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

Measure A clients served: 16 (**Total clients**: 32)

Service area: Berkeley, Oakland, Union City

AGENCY/PROGRAM BACKGROUND

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

MEASURE A FUNDING SUMMARY

Measure A funding supported the following CERI programs and outcomes:

- **Young women's group**. This group serves 11 young women. Two women graduated this spring and are both

enrolled in community college. At the onset of this program, three of the young woman were involved in underground sex trafficking and/or drug dealing. Currently all are free of illegal activity.

- **Boys middle school group**. This group serves six to eight boys. All of the young men are at risk of probation involvement and are failing school. Last year none of the boys were referred to probation and all of them progressed to 7th or 8th grade.
- **Latency-age after-school program**. Three youth in this program received one-on-one interventions and are enrolled in community college. One family with two young boys has been provided intensive case management services, and the boys have received much needed IEPs that have helped them to stay in school.

In addition, CERI used its Measure A allocation to meet the following objectives:

Outreach and Education

- **Community events**. Hold two community-wide events annually with outreach to at least 200 individuals.
- **Home and school visits**. Provide 196 hours of visits annually to individuals and/or families.
- **Psycho-educational workshops**. Hold 12 workshops annually (one per month).
- **Support groups, including life skills classes, art, and other nontraditional mental health prevention activities**. Hold six ongoing support groups annually (all with the participation of a marriage and family therapy intern or a psychology intern), with at least five individuals served by each.
- **Workshops for community and schools**. Hold two cultural wellness workshops annually for community groups.

Mental Health Consultation

- **Consultation and/or training for community-based organizations (CBOs)**. Hold three or more training events annually.
- **Consultation and/or training for schools, probation officers, child welfare workers, health clinics**. Provide ongoing and continuous training.

Early Intervention

- **Early intervention for individuals and families**. Provide 160 hours of short-term, low-intensity interventions to at least four individuals annually.
- **Referral and linkage to alternative programs**. Provide these services as needed.

Measure A Helps

CENTER FOR EMPOWERING REFUGEES AND IMMIGRANTS

When Vani, a 19-year-old Cambodian-American, first came to CERI, she was a teen mother on probation for stealing and dealing drugs and at risk of dropping out of high school. She felt hopeless and suicidal. Her parents, survivors of the Khmer Rouge genocide in Cambodia, are active substance abusers, and her home life was chaotic. After Vani started attending CERI, she got her grades on track and connected with many young women in the group. Through CERI, Vani committed to stop "living the life." She graduated high school and is enrolled in community college. She works part-time at CERI, providing administrative support and peer mentoring to other youth. She no longer feels depressed and hopes to become a probation officer.

HIGHLIGHTS

The CERI program has resulted in the following positive outcomes for youth clients:

- Feeling more connected to their peers and their families, better relationships with their parents, and less isolation, as reported in client surveys
- An increase in graduation from high school and enrollment in college
- A reduction of youth involved in criminal activity from three at the onset of the program to none currently involved

In addition, CERI leveraged its Measure A allocation to obtain an additional $75,000 in matching funds from the Mental Health Services Act (MHSA) and private funders.

CRIMINAL JUSTICE SCREENING AND IN-CUSTODY SERVICES

FY 12/13 allocation: $4,306,000

Expended/encumbered in FY 12/13: $4,306,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

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Types of services provided: Hospital Inpatient, Mental Health

Individuals served: Adults, Indigent, Low Income, Seniors, Uninsured, Other residents

Measure A clients served: 2,971 (**Total clients**: 4,900)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

A program of BHCS, Criminal Justice (CJ) Screening/In-Custody Services provides a full range of mental health services to approximately 1,400 County jail inmates every month. An estimated 16% of inmates have serious mental illnesses. Without jail mental health services, mentally ill inmates would go untreated.

MEASURE A FUNDING SUMMARY

BHCS used its Measure A fund allocation to maintain staff at CJ Screening/In-Custody Services who provided assessment of all inmates and improved care for adults in the jail settings with timely access to medications and reduced potential medication abuse at Santa Rita Jail. The mental health service is staffed seven days a week, for 16 hours each day, to assess inmates as they enter the jail for mental health conditions and suicide risk factors. Mental health staff also works in other areas of the jail including the inmate housing units where inmates with mental illnesses can be assessed, monitored, and provided with ongoing treatment as well as crisis intervention. The jail's suicide prevention program, a collaborative effort between mental health and other staff, has resulted in a significant decrease in inmate suicides.
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Specific services supported by Measure A include the following:

Mental Health Screening

- **Initial (Intake)**. At the time of booking, all inmates are screened for medical and psychiatric treatment needs. Inmates found to need further mental health screening are forwarded to the Criminal Justice Mental Health (CJMH) department. Within 14 days, staff conducts an additional mental health appraisal on all inmates. Inmates found to need a further mental health evaluation are referred to CJMH. The screening assessment includes an evaluation of the inmates' current psychiatric condition, psychiatric history, substance abuse (addictions) history and current use, psychiatric medication history and current need for medications, suicide history and current risk factors, and more.
- **Post-booking**. CJMH clinicians triage and screen all referred inmates for mental health service needs and recommend appropriate treatment plans based on the assessment. Onsite services allow CJMH staff to proactively deliver mental health services to mentally ill inmates who might otherwise fall through the cracks.

Crisis Intervention

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

Management of Inmate Behavioral Problems

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

Suicide Prevention

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

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

All inmates receiving mental health services are seen by CJMH clinicians who develop individualized treatment plans, with the goal of assisting the inmates to achieve mental stability, develop an awareness of their psychological and behavioral problems, and acquire coping skills while incarcerated. Clinicians develop treatment plans with short and long-term goals, identifying how these goals will be carried out.

- **Medication support services**. When appropriate, CJMH psychiatrists evaluate inmates and prescribe psychotropic medications to alleviate symptoms and allow the inmates to achieve an optimal level of functioning while incarcerated.
- **Counseling services**. Inmates referred for counseling services receive an additional post-booking assessment and are provided ongoing counseling sessions as determined by their treatment plan.

- **Misdemeanant incompetents**. Whenever possible, with regard to misdemeanant Incompetent to Stand Trial (PC 1370.01) inmates, CJMH staff collaborate with the courts to provide treatment geared to restoring competence and/or refer inmates to community programs that can address competency.
- **Court-ordered evaluations (PC 4011.6s)**. CJMH clinicians conduct court-ordered psychiatric evaluations (PC 4011.6s) to assess the need for acute inpatient psychiatric care and provide reports back to the courts.
- **Inpatient services**. CJMH staff or deputies send inmates requiring acute inpatient hospitalization to acute psychiatric inpatient hospitals. When inmates are returned to the jail, they are held in the Outpatient Housing Unit (Infirmary) until CJMH clinicians can assess them, continue their medications, and clear them for housing
- **Inmates who refuse treatment**. All treatment in the jail is voluntary. CJMH staff monitor inmates with serious mental illnesses who refuse treatment and make an ongoing attempt to engage these inmates in treatment.
- **Outreach and teamwork**. Dedicated CJMH staff (clinicians and psychiatrists) work on Special Housing Units: Ad Seg, Mental, Women's. These staff closely monitor inmates on these units. Visits occur several times a week, including cell checks for inmates who refuse to be seen or who are noncompliant with treatment.
- **Substance abuse treatment**. Inmates have access within the jail to programs that specifically address addiction problems. CJMH clinicians also address substance abuse as part of their ongoing interventions with inmates.

Measure A Helps

CRIMINAL JUSTICE SCREENING AND IN-CUSTODY SERVICES

Mr. A., assigned to a community case management team, failed to cooperate with his treatment. He didn't take his psychiatric medications, used substances, and was often homeless. Over time, he experienced hundreds of intakes to John George Psychiatric Pavilion and was ultimately arrested and incarcerated for a misdemeanor. A collaborative effort involving the Court Advocacy Project, the court, the jail mental health team, the outpatient case management team, and BHCS Bed Control developed a plan to engage Mr. A. in treatment, establish stabilization, and transition him to a rehabilitation center for longer term care. This plan, which broke Mr. A's pattern of recidivism, would not have been possible without this collaborative effort beginning with mental health services in the jail.

Mental Health On-call/Emergency Services

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

Discharge Planning/Continuity of Care

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

Training

The CJMH Director, the Senior Clinician(s), and other mental health professionals provide training to sheriff's personnel and civilian staffs in mental illnesses and suicide prevention on a regular basis. All new CJMH staff receive 40 hours of initial training before assuming independent work assignments. CJMH managers and psychiatrists provide ongoing training to CJMH line staff in topics related to the practice of jail psychiatric services. CJMH schedules regular training for CJMH staff by outside trainers on a variety of topics related to jail and community mental health matters

Administration of Psychotropic Medications to Patients in a Psychiatric Emergency

As defined in section 5008(m)* of the Welfare and Institutions code, psychiatrists can legally prescribe psychotropic medication for emergency situations. CJMH staff have access to trainings provided by BHCS. The CJMH Lead Psychiatrist attends the monthly BHCS Psychiatric Practices Committee convened by the BHCS Medical Director's office and shares information learned with other CJMH psychiatrists.

CONCERNS

The recipient has provided identical reports for the past three years, which makes it difficult to determine significant improvements and outcomes.

DETOXIFICATION/SOBERING CENTER

FY 12/13 allocation: $2,000,000

Expended/encumbered in FY 12/13: $1,936,821

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $63,179

Types of services provided: Substance Abuse

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

Measure A clients served: 9,319 (**Total clients**: 9,319)

Service area: Countywide, Homeless or transient

AGENCY/PROGRAM BACKGROUND

The Detox/Sobering Center works to maximize the recovery, resilience, and wellness of all eligible Alameda County residents who are developing or experience serious mental health, alcohol, or drug concerns.

The Detox Center is a social model nonmedical detoxification center specifically designed for individuals requiring 24-hour/7-day-a-week monitoring. It offers van transport for individuals needing transportation to and from medical/psychiatric/treatment/housing or any other ancillary service they may need. These services allow clients to fulfill all admission requirements for their next level of treatment.

The Sobering Center is designed to assist those needing immediate sobering services from alcohol/drugs. It provides a brief visit of 23 hours or less with continual monitoring for safe withdrawal, 24 hours per day, seven

days per week. Within the Sobering Center, the Health Center is staffed with nurse coordinators who monitor withdrawal and assist with medical triage/assessment to ensure safe and healthy withdrawal. The center also provides TB tests and referrals to medical/psychiatric services for all individuals as needed.

MEASURE A FUNDING SUMMARY

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

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

- Cherry Hill Sobering Center provided 4,946 services.
- The Detox Center provided 2,235 services.
- The Health Center provided 2,138 services to existing clients.
- The Sobering Center collaborated with the Alameda County-supported EMS Corp program and hired 10 of their recent EMT graduates.
- The Sobering Center now has medical triage and supported services 24 hours a day, 7 days a week.
- Law enforcement leadership and officers attend bi-monthly trainings in groups 25-30 for training, education, and orientation around the Detox/Sobering Center's programs and services.

Measure A Helps

DETOXIFICATION/SOBERING CENTER

When a male with a 20-year-history of alcohol dependence arrived at the Detox/Sobering Center as a returning client, he was angry, resistant, and not taking his bipolar disorder medication. He rarely communicated with staff, making critical comments regarding staff and other clients. After several visits, he became more receptive and willing to share his story. As staff worked with him, the client began accepting referrals to treatment, became stabilized on his medications, and worked on his treatment program. During times of struggle or relapse, he reaches out to the Center for help. He is currently clean and sober for over a year and doing well. He frequently checks in with staff, thanking them for not giving up on him.

HIGHLIGHTS

An internal research project shows that services provided by the Detox/Sobering Center reduced the number of individuals entering a County emergency department with a diagnosis of intoxication by 52%, and decreased the length of stay for those who did enter an emergency department by four hours.

The expanded outreach to include more law enforcement collaborations—providing officers with an alternative for intoxicated individuals—has resulted in more residents being offered a treatment approach to public intoxication rather than incarceration and/or hospitalization.

EAST BAY COMMUNITY RECOVERY PROJECT

Board of Supervisors discretionary allocation: District 5/Supervisor Carson

FY 12/13 allocation: $35,000

Expended/encumbered in FY 12/13: $35,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Substance Abuse

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

Measure A clients served: 53 (**Total clients**: 53)

Service area: Oakland

AGENCY/PROGRAM BACKGROUND

East Bay Community Recovery Project (EBCRP) supports self-sufficiency and wellness of individuals and families by providing comprehensive and integrated services for mental health, substance use, and related health conditions while addressing housing and employment.

Project Pride, the women's residential program of EBCRP, provided substance abuse and mental health services, including reunification services, to 33 women and 20 children in FY 12/13. Approximately 75% of the women with involvement in Child Protective Services were reunited with their children. All the women who came in pregnant gave birth to healthy infants.

MEASURE A FUNDING SUMMARY

EBCRP used its Measure A allocation to purchase a mobile modular unit that serves as a child care and activity area. This purchase enabled EBCRP to enhance services to the women in the residential program and their children.

MENTAL HEALTH SERVICES FOR JUVENILE JUSTICE CENTER

FY 12/13 allocation: $360,000

Expended/encumbered in FY 12/13: $360,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health

Individuals served: Children

Measure A clients served: 350 (**Total clients**: 1,061)

Service area: Fremont, Hayward, Oakland, San Leandro

AGENCY/PROGRAM BACKGROUND

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

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

MEASURE A FUNDING SUMMARY

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

- Help mitigate the mental health issues of youth detained, including crisis intervention and ongoing mental health support while detained.
- Maintain data on both the number of youth self-referrals, as a measure of youth reaching out for help in mitigating mental health issues associated with detention, and on the number of crisis referrals received by BHCS from probation and/or the medical unit.
- Provide court ordered mental health assessments. Approximately 300 mental health assessments are completed each year by the Guidance Clinic staff. Measure A funding covers approximately 60 of those assessments.

HIGHLIGHTS

Youth who receive Measure A-funded services are only in Juvenile Hall for an average of 28 days. As a result, long-term measurable results are not available. Thanks in part to Measure A funding, the program achieved the following short-term results:

- Increased coping skills among the target population for managing anxiety, depression, and trauma symptoms due to being detained.

- Court-ordered evaluations to help the courts determine placement options. This is a great benefit to the youth, as many of them are experiencing mental health issues that need to be taken into account by the court for disposition.
- Immediate crisis intervention for suicidal youth to avoid self-harm.

In addition, BHCS leveraged its Measure A allocation to obtain an additional $80,822 in matching funds.

NATIONAL ALLIANCE ON MENTAL ILLNESS TRI-VALLEY

Board of Supervisors discretionary allocation: District 1/Supervisor Haggerty

FY 12/13 allocation: $17,000

Expended/encumbered in FY 12/13: $17,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health

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

Measure A clients served: 650 (**Total clients**: 650)

Service area: Dublin, Livermore, Pleasanton

AGENCY/PROGRAM BACKGROUND

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

NAMI Tri-Valley not only provides peer support groups and information and referrals, but also offers advocacy for families and their loved ones, educational public meetings, and workshops. Trained family members teach the Family-to-Family Education classes.

MEASURE A FUNDING SUMMARY

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

- **Family-to-Family Education program**. NAMI Tri-Valley provided two 12-week series of classes in FY 12/13 (target: one series). Overall, 32 attended and completed the classes.
- **NAMI Tri-Valley Connection Recovery Group**. NAMI Tri-Valley conducted a weekly 90-minute peer support groups for persons with a psychiatric diagnosis. An estimated 30 people on average attended the group weekly.
- **NAMI Tri-Valley Family/Caregiver Support Groups**. NAMI Tri-Valley offered twice-monthly peer support groups for families and caregivers. The groups provide a safe place to talk, network, learn new coping skills, and gain resources in the community around a mentally ill loved one. This program is specifically directed to family members of adults with mental illness. On average, 12 to 18 people attend each meeting.

- **NAMI Tri-Valley Resource and Support Group**. NAMI Tri-Valley offered a once-monthly peer support group to support parents of children suspected of or diagnosed with a mood disorder. On average, six people attend the monthly meeting. While the support groups were held twice monthly in early FY 12/13, because of a personal situation for the facilitator, they later tapered to once a month.
- **NAMI Tri-Valley General Meetings**. NAMI Tri-Valley held a once-monthly public meeting at which invited guest speakers talked about mental health topics or issues. The speakers are experts in their field. On average, 25 to 30 people attended each meeting. This venue provided educational awareness on mental health and psychiatric disorders.
- **NAMI National Conference**. NAMI Tri-Valley sent two members to an annual national conference held in San Antonio, Texas. These members brought back and shared the latest valuable information and research on mental illness
- **NAMI Tri-Valley Disability Workshop**. NAMI Tri-Valley conducted a collaborative effort with Bay Area Legal Aid to provide information on disability benefits, such as the difference between Supplemental Security Income and Social Security Disability Insurance, eligibility factors, time frames, the application process, and navigating the Social Security system. 30 people attended the workshop.
- **Equipment and software purchases**. NAMI Tri-Valley purchased much-needed equipment and software: two computer laptops, two printers, two external drives, a projector, software, and printer supplies.

Measure A Helps

NATIONAL ALLIANCE ON MENTAL ILLNESS TRI-VALLEY

A college-age male checked himself into a psychiatric hospital as he was experiencing frightening symptoms such as hearing voices. The parents, also frightened, contacted NAMI Tri-Valley. They met with the support group facilitator to determine how to care for their son after his discharge. The mother was terrified about how her son would act and unsure how to talk with him. The facilitator invited the parents to a support group so they would not feel alone in this situation. They attended the Family-to-Family classes, which helped them gain the understanding to fully support their son through his recovery. Through the NAMI Tri-Valley support programs, the son is now back at college and the parents are cautiously optimistic about his future.

SAFE ALTERNATIVES TO VIOLENT ENVIRONMENTS

Board of Supervisors discretionary allocation: District 1/Supervisor Haggerty

FY 12/13 allocation: $50,000

Expended/encumbered in FY 12/13: $50,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health

Individuals served: Adults, Children, Families, Seniors, Indigent, Low Income, Uninsured, Other: Victims of domestic violence

Measure A clients served: 310 (**Total clients**: 3,324)

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

AGENCY/PROGRAM BACKGROUND

Safe Alternatives to Violent Environments (SAVE) promotes alternatives to domestic violence through support services, advocacy, and education and assists domestic violence victims and their families to end the cycle of violence.

All SAVE services are provided free of charge. In FY 12/13, more than 90% of the clients who received SAVE counseling services met the HUD definition of low income, with the majority falling into the "extremely low income" category. Approximately 40% of clients self-reported a disability of some kind.

Approximately 80% of clients served were from Alameda County, mainly coming from Fremont, Hayward, and Oakland. The clients from neighboring counties were largely shelter clients who had been forced to flee their home counties for safety.

Only 30% of clients had some form of health insurance. In most cases, that was Medi-Cal. Because SAVE services are provided to any victim in need, lack of adequate insurance was a nonissue for clients.

At SAVE, the only criteria for participation in counseling services is that the client has experienced or is experiencing domestic violence. Drop-in domestic violence support groups are available to victims three

Measure A Helps

SAFE ALTERNATIVES TO VIOLENT ENVIRONMENTS

Janelle came to the SAVE shelter with her three daughters. During her stay, Janelle lost custody of two of her daughters because of her inability to properly care for their medical and mental health needs. Janelle is a life-long victim of abuse. The depression and post-traumatic stress disorder (PTSD) that she suffers have made it difficult to care for her children. With twice-weekly counseling with the SAVE psychologist, Janelle began dealing with the separation from her children and addressing the issues that have contributed to her situation. With support from her shelter case manager, she has reunited with one of her daughters. She recently qualified for transitional housing and continues receiving weekly case management and attending counseling and parenting classes.

days a week. All counseling services are available to clients for as long as needed. There is no limit on the number of sessions a person can attend.

Counselors are well-versed in other SAVE services and how to access them. If a client comes to a support group and reports that it is unsafe for her to return home that night, the counselors not only provide the immediate emotional support needed but connect that person with a crisis worker who can place the client into shelter immediately and help her plan for her ongoing safety.

MEASURE A FUNDING SUMMARY

SAVE used its Measure A funds to provide group and individual counseling services (target: 200 group and 200 individual counseling sessions) to domestic violence victims and their children:

- The support groups provide a safe place for women who are experiencing or have experienced domestic violence to talk about their issues with other women and the support of a trained facilitator. The information and sense of community that they receive from support groups help them break their isolation and see that the blame lies with the abuser.
- Individual counseling services provide clients with a private setting to discuss the violence they have experienced. All counselors are licensed clinicians or supervised interns who have had specific training regarding the needs of domestic violence victims.

HIGHLIGHTS

Of the counseling participants surveyed:

- 95% reported knowing more ways to plan for their safety.
- 84% reported knowing more about community resources.
- 84% reported feeling more confident about making their own decisions.

With counseling services available:

- More than 50% of women achieved permanent housing (compared with 45% the previous year).
- 30% increased their income (compared with 15% the previous year).
- 15% obtained employment (compared with 8% the previous year).

SCHOOL HEALTH SERVICES (SCHOOL-BASED BEHAVIORAL HEALTH INITIATIVE)

FY 12/13 allocation: $600,000

Expended/encumbered in FY 12/13: $600,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Substance Abuse

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

Measure A clients served: 2,804 (**Total clients**: 2,804)

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

AGENCY/PROGRAM BACKGROUND

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

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

Co-coordinated by CHSC and the Alameda County Behavioral Health Care Services (BHCS) Agency, the Alameda County School-Based Behavioral Health Initiative strives to strengthen and expand school-based behavioral health practice, finance, evaluation, and policy in Alameda County. In partnership with school districts and service providers, and by leveraging and blending local, state, and federal resources, the Initiative invests over $24 million annually toward delivering a continuum of school-based behavioral health supports to students in schools throughout Alameda County. The Initiative has implemented school-based behavioral health supports throughout the County.

Measure A Helps

SCHOOL HEALTH SERVICES (SCHOOL-BASED BEHAVIORAL HEALTH INITIATIVE)

The Coordination of Services Team (COST) provides students facing learning and behavioral health challenges intensive case management fluidly and effectively. Michael, a 10th grader, needed a wide range of support. His brother, whom Michael lived with, was facing eviction; his mother's location was unknown; and his father struggled with substance abuse. Through COST, collaboration occurred among the primary care services team, principal and teachers, Family Resource Center coordinator, District Nurse, and community agencies. Meetings were held with Michael's father, CPS, and a potential foster family. Michael was successfully placed in a supportive home, did not miss school, and is on track with his credits towards graduation. He receives ongoing counseling and will continue with the same counselor next year.

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

- The Our Kids Our Families program, provided at 29 school sites in the Hayward and Oakland Unified School Districts, is a school-based behavioral health program that fosters social-emotional wellness in an educational environment so that children and families feel connected, safe, and supported in school. The Our Kids Our Families program supports prevention efforts at the school sites, as well as early intervention and treatment services for any student and their family that needs it. The program pairs clinical case managers from the CHSC or Hayward Youth and Family Services Bureau with nonprofit providers who access Medi-Cal funding through BHCS. The clinical case managers work with the schools to provide prevention supports and intervention services to students and their families who are not Medi-Cal eligible. The nonprofit providers provide group and individual treatment services to students who are Medi-Cal eligible.
- The School District Consultation program places behavioral health consultants (BHCs) in school districts to provide and enhance preventive social-emotional supports and mental health services for students and their families. The BHCs conducted the following activities:
  - Assessed the social-emotional service needs and infrastructure of a school district or set of schools and developed a service plan
  - Coordinated the work of all partner agencies who deliver behavioral health services in schools and districts
  - Provided and/or coordinated clinical case management, group, and individual counseling to students
  - Provided workshops, parenting groups, and mental health and other appropriate consultation to parents/caregivers; linked parents/caregivers with needed resources in the school and community; supported school and school district efforts to engage and support families in meaningful and positive ways
  - Provided crisis assessment and intervention for students, supported schools in effective crisis response, and supported school districts in developing crisis response protocols
  - Provided clinical supervision to interns and/or actively participated in intern recruitment and placement
  - Conducted planning to develop service referral and coordination systems
  - Provided behavioral health consultation to district and/or school staff to strengthen positive connections between students and adults
  - Conducted psycho-education for a wide range of audiences including district administrators, teachers, school staff, parents, students, and community partners
  - Participated in district- or school-wide efforts to create a positive climate, prevent conflicts and violence, and enhance the community setting for all of its members
  - Developed or coordinated leadership and other opportunities for children/youth that allow them to participate meaningfully in their school

MEASURE A FUNDING SUMMARY

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

Increase Access to Behavioral Health Supports for Students and Their Families in Eight School Districts in Alameda County

Prior to 2011, the vast majority of County-funded, school-based behavioral health supports were concentrated in Oakland and Hayward. Measure A funding has been instrumental in helping expand to previously underserved school districts in the county, specifically the following:

- Emery Unified

- Newark Unified
- New Haven Unified
- Dublin Unified
- Livermore Valley Joint Unified
- Pleasanton Unified
- San Leandro Unified
- Hayward Unified (strengthened support)

Address the Behaviorial Health Support Needs of Students

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

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

In addition to coordinating and providing direct services to students and their families, BHCs in Emery, Newark, New Haven, San Leandro, and Hayward Unified School Districts kicked off the first year of the Our Kids Our Families intern program. By supervising a total of 22 (an increase of 7 over 2011-2012) social work interns, the program was able to increase capacity and service access for students and their families in each of these districts.

Strengthen the Use of Evidence-Based Practices Along a Continuum of Behavioral Health Supports That Includes Prevention, Early Intervention, and Treatment

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

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

In addition, BHCs worked to strengthen the quality of early intervention and treatment programs in all school districts. Fundamental to the Initiative's evidence-based framework, BHCs provided and worked with current providers and interns to expand the use of therapeutic groups to serve students showing early signs of behavioral health struggle and students assessed to be "at risk." BHCs in all district either directly provided crisis response services or coordinated crisis response, all of which function to minimize harm and ensure appropriate support for everyone in the school environment impacted by crisis.

Implement Consistent Criteria, Procedures, and Practices for Behavioral Health Assessments, Referrals, and Linkages in the Schools

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

the following:

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

In six of the eight school districts supported under this program, considerable progress was made toward strengthening and expanding COST in FY 12/13.

HIGHLIGHTS

While the full countywide and district-specific analysis for FY 12/13 is still in progress, an initial sample of programs in Hayward and Oakland, as well as through select school-based providers, is quite promising. In aggregate, students who were assessed as struggling in any one of the presenting problem areas at intake showed significant improvements at discharge.

Behavioral health providers and BHCs also assess clients on observed strengths at intake and discharge, including eight different "Internal Factors" and three "External Factors." The initial sample indicates significant improvements in strength areas, an indication that students receiving treatment services are increasing their resilience.

In addition to these accomplishments, the School-Based Behavioral Health Initiative leveraged its Measure A allocation to obtain $6,478,582 in matching funds from the following sources:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funding: $3,225,822
- Tobacco Master Settlement Fund (TMSF)/CHSC discretionary: $1,366,331
- Medi-Cal Administrative Activity (MAA): $752,019
- Mental Health Services Act Prevention/Early Intervention Program: $494,064
- City of Oakland, Oakland Unite: $200,000
- School District funding: $82,574

YOUTH ALIVE!

Board of Supervisors discretionary allocation: District 5/Supervisor Carson

FY 12/13 allocation: $25,000

Expended/encumbered in FY 12/13: $25,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health

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

Measure A clients served: 47 (**Total clients**: 226)

Service area: Oakland

AGENCY/PROGRAM BACKGROUND

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

KWP offers families of homicide families a "ministry of presence," being present both physically and emotionally for families during their crisis. This takes the form of peer-based mental health first aid and a supportive staff presence from KWP's first response staff that delivers intense outreach for an initial period of 4-6 weeks. During this time, staff avails themselves to families for any need that may surface. Specific barriers that the program assists with include the following:

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

For families that have received threats after the homicide, KWP addresses their safety concerns and coordinates with the Oakland Police Department and community-based Street Outreach partners to monitor

Measure A Helps

YOUTH ALIVE!

An 18-year-old man was fatally shot while sitting in his car in front of his house. He was survived by his mother, father, and three young siblings, all predominantly monolingual Spanish speakers. Youth ALIVE!/KWP staff contacted the parents within 24 hours of the homicide. Over the next six days, KWP conducted daily wellness checks, accompanied the family to their VoC appointment, and supported them in selecting a funeral home. Because the family's needs exceeded the $5,000 VoC allocation, KWP secured an additional $500 from the CRSN emergency fund. KWP staff dedicated approximately four weeks working with this family to identify needs and link them to the appropriate resources, including mental health services offered through CCEB.

their loved one's services to deter more violence that would further complicate their existing trauma. KWP also conducts wellness checks with families, usually around the 6-12 month period, to reconnect and assess how their coping skills and resiliency are developing. For those that have emerging needs or resurfacing symptoms, KWP advocates to have these families linked back into mental health services to promote their healing.

MEASURE A FUNDING SUMMARY

Youth Alive!/KWP used its Measure A allocation to achieve the following measurable objectives in FY 12/13:

- Provide first responder crisis intervention services to an estimated 15–20 Spanish-speaking victim groups (families and friends of homicide victims) associated with Oakland homicides.
- Respond to and served 122 families impacted by homicides in Oakland. There were 12 homicides (10%) of Latino victims and, of these, 11 victim groups were Latino and/or Spanish-speaking families.
- Serve an additional 13 victim groups (African-American families), bringing the total to 24 victim groups given intensive support services though these funds.
- Accompany and support each impacted family through their VoC appointment, guide them through the funeral and burial arrangements, and provide a "ministry of presence."
- In addition to the VoC services offered ($5,000 for burial costs and funding for mental health visits), secure additional financial contributions for half of the families served through the Crisis Response Support Network (CRSN) emergency fund.
- Give all families information about therapeutic services and basic grief/trauma symptoms, and refer five families for immediate therapeutic intervention through Catholic Charities of the East Bay (CCEB).

Though the overall number of families served (24) exceeded the Measure A funding objective for this project by four families, the project underperformed on its goal of serving 20 Spanish-speaking victim groups (families and friends of homicide victims) associated with Oakland homicides by four families.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

Group 2: Hospital, Tertiary Care, Other

Children's Hospital & Research Center Oakland

St. Rose Hospital

ValleyCare Foundation

Washington Hospital

Administration/Infrastructure Support

NOTE: Alameda Health System (dba Alameda County Medical Center) is also part of the Hospital, Tertiary Care, Other group. See "Review of FY 12/13 Expenditures: 75% of Measure A Funds Allocated to the Alameda Health System" for a breakdown of Alameda Health System Measure A funding and expenditures.

CHILDREN'S HOSPITAL & RESEARCH CENTER OAKLAND

FY 12/13 allocation: $2,000,000

Expended/encumbered in FY 12/13: $2,000,000

Types of services provided: Emergency Medical, Hospital Outpatient, Public Health, Mental Health

Individuals served: Children, Indigent, Low Income, Uninsured

Measure A clients served: 39,226 (**Total clients**: 51,426)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

Trauma services are a subset of the ED, requiring highly specialized equipment, facilities, and highly trained staff. CHRCO's ED is one of two designated Level 1 Pediatric Trauma Centers in Northern California and the only one in the Bay Area. CHRCO's Trauma Center has 24-hour in-house staff and resources that include ED attending physicians who are pediatric specialists in emergency medicine, trauma surgery, anesthesiology, neurosurgery, orthopedics, diagnostic imaging, and critical care. CHRCO 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.

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

The ED also has a fellowship training program and hosts three fellows in pediatric emergency medicine. There are no other pediatric emergency fellow programs in Northern California.

Unfortunately, the children seen in the CHRCO ED have experienced some kind of misfortune, and nearly all had no choice but to seek emergency care. The ED's impact is immeasurable. Without the CHRCO ED, children would need to travel further and/or receive care that is not specialized to children. With little doubt, more children would die without the CHRCO ED.

MEASURE A FUNDING SUMMARY

Seventy percent of patients seen in the CHRCO ED receive Medi-Cal. This number is higher than almost any other hospital—child or adult—in California. Medi-Cal reimbursement is significantly less than from private payers. The percentage of children on Medi-Cal has been trending higher over the last decade. With a nearly 3:1 public-to-private-payer ratio, CHRCO relies on supplemental funding from Alameda County via Measure A to sustain its vital services for Alameda County's children.

Measure A Helps

CHILDREN'S HOSPITAL & RESEARCH CENTER OAKLAND

The day before Kailee turned 11 years old, she landed badly while jumping on a trampoline, heard a crack, and felt sharp pains in her left arm. At the CHRCO ED, X-rays confirmed that both bones in her forearm were broken and would require orthopedic intervention. Accustomed to calming kids of all ages, Kailee's ED nurse had a pocketful of jokes that she routinely tells patients. Soon Kailee, her sister, and her mom were laughing. Kailee sailed through her procedure with flying colors, and was all smiles as she admired her new neon green cast. Kailee's mom says, "I'm so glad we came to Children's! Thank you so much for taking such good care of us."

At CHRCO, Measure A funding supported the pediatric ED, specifically to provide 18 full-time staff for the large volume of children seen. This program is consistent with the stated intent of Measure A to "provide additional financial support for emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low-income, and uninsured adults, children, families, seniors, and other residents of Alameda County."

In FY 12/13, there were a total of 46,513 visits and 32,581 unique patients to the CHRCO ED, making it the highest volume ED in the Bay Area. Six hundred seventy-nine of these visits were trauma cases where the child faced an immediate life-threatening situation. Measure A monies allows the CHRCO ED to provide faster and more efficient care. The total average time children spent at the CHRCO ED, from arrival to discharge, shrunk to 3.1 hours. According to studies conducted by McKesson, this figure compares with 4.1 hours for CHRCO's peer group.

Measure A funding also helped the ED upgrade its space to be more kid-friendly and purchase state-of-the-art equipment, such as new monitors and imaging equipment. The CHRCO ED is the only children's ED on the West Coast that does ultrasounds, rather than higher risk CT scans.

About 10% of all children who present at the ED do not have a regular provider, and staff offer solutions through primary care clinics as well as community-based clinics.

The CHRCO ED has also gained national recognition for its treatment of sickle cell disease patients, most of whom present to the ED with severe pain.

HIGHLIGHTS

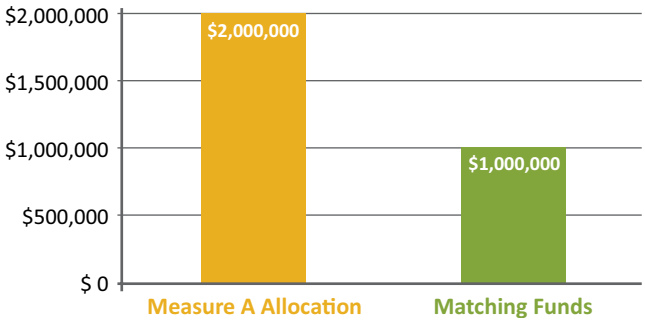
CHRCO effectively used its Measure A allocation to reduce patient wait times in a number of service areas—by over 50% in providing pain medication to sickle cell patients—or to provide services more quickly when compared to peer hospitals. CHRCO also used its allocation to increase ED staff such that it could serve the highest volume of patients (46,000 visits) of any ED in the Bay Area.

In FY 12/13, over 400 children seen in the ED were referred to and seen at CHRCO's asthma clinic for follow-up care and asthma education. The average time for providing sickle cell patients with proper pain medication has gone from 90 minutes to 30 minutes, which is among the top in the nation.

In addition, CHRCO leveraged its Measure A allocation to obtain an addition $1,000,000 in matching funds from the California Medical Assistance Commission.

Figure 6

CHILDREN'S HOSPITAL USE OF MEASURE A FUNDING TO OBTAIN MATCHING FUNDS



CONCERNS

The specific program objectives provided by CHRCO are not presented in measurable terms.

ST. ROSE HOSPITAL

FY 12/13 allocation: $2,000,000

Expended/encumbered in FY 12/13: $2,000,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

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

Measure A clients served: 5,465 (**Total clients**: 42,041)

Service area: Countywide, Homeless or transient

AGENCY/PROGRAM BACKGROUND

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

- **Critical access**. SRH serves as a critical access point form Alameda County and is the only Medi-Cal contracted facility between Oakland and Fremont. Additionally, SRH serves as a safety net hospital and provides health care access to many low-income residents that do not have adequate transportation to the Alameda County Medical Center.
- **Hospitalists programs**. The Hospitalists assume care of indigent and uninsured patients who are admitted to SRH. This alleviates the financial impact of the private physicians who request compensation for lack of reimbursement.
- **Women's services**. SRH operates the Women's Center to meet the growing demand for OB/GYN services in the community, because many OB practitioners do not accept Medi-Cal rates. The program provides immediate and emergency care for pregnant women who present to the emergency room, often with no history of prenatal care. Over 74% of patients seen in the clinic are Medi-Cal beneficiaries.
- **Cardiac care**. SRH is the only Medi-Cal contracted facility to provide elective cardiac and percutaneous coronary intervention (PCI) services in Central Alameda County. There has been a 3% increase in procedures for Medi-Cal beneficiaries in FY 2013 over 2012. SRH routinely accepts hospital transfers for emergency and elective cardiac care from non-Medi-Cal providers.

Measure A Helps

ST. ROSE HOSPITAL

A 61-year-old female with severe chest pain received a cardiac catheterization procedure at the SRH ER. Three months later she returned to have a permanent catheter inserted to treat her diabetes. Unfortunately, the patient reached her lifetime maximum benefit, and her health plan stopped paying her claims. Overnight she became "uninsured," leaving her with thousands of dollars of unpaid hospital bills. Compounding this, the patient's husband attempted to commit suicide and was hospitalized due to his injuries. The patient's daughter asked if SRH could help. SRH made the compassionate decision to waive the patients' remaining bills. Measure A support in part enables SRH to provide this level of charity care and still keep its doors open to serve the community.

MEASURE A FUNDING SUMMARY

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

- Provide emergency care for uninsured patients. The SRH ER experienced 36,272 visits in FY 12/13, including 68%, or 24,700 visits, from uninsured (11%) and underinsured (57%) patients.
- Provide financial support to hospital-based physician groups to take ER calls and provide services to uninsured patients. SRH inpatient volumes, including nursery service utilization, included 45.5% Medi-Cal patients and 6.2% uninsured patients.
- Provide referral services for follow-up/after care for uninsured patients.
- Assist in supporting SRH inpatient services to uninsured and underinsured patients. Hospital-based physicians provided over 10,750 patient encounters for uninsured patients for the year.
- Employ a financial counselor to assist in identifying uninsured patients who may qualify for other funding sources such as Medi-Cal or HealthPAC. In FY 12/13, the ER financial counselor assisted 1,809 uninsured patients, an increase of 7.2% over the preceding year.
- Add 9.0 full-time equivalent (FTE) staff.

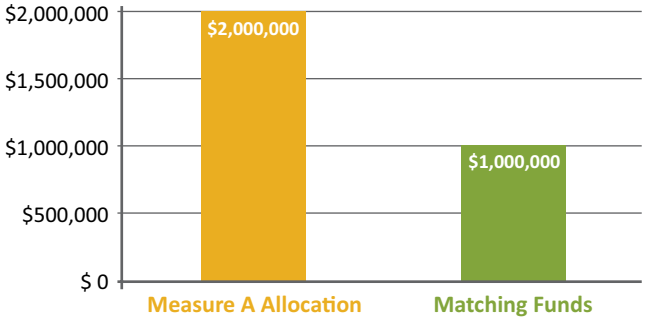
HIGHLIGHTS

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

SRH uses Measure A revenue primarily to support its emergency department, which is a vital service to residents of Hayward and surrounding communities.

Figure 7

ST. ROSE HOSPITAL USE OF MEASURE A FUNDING TO OBTAIN MATCHING FUNDS



CONCERNS

Even with Measure A funds at the present level, SRH remains in extreme financial distress. Since it is a safety net hospital for Central and South County, the Committee notes that other solutions are needed to maintain this vital service.

Program objectives should be measurable, and achievements directly related to them. Otherwise, it is difficult for the Oversight Committee to ascertain performance.

VALLEYCARE FOUNDATION

Board of Supervisors discretionary allocation: District 1/Supervisor Haggerty

FY 12/13 allocation: $20,000

Expended/encumbered in FY 12/13: $20,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient

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

Measure A clients served: NA (**Total clients**: 30,682)

Service area: Dublin, Livermore, Pleasanton

AGENCY/PROGRAM BACKGROUND

ValleyCare Foundation is a division of ValleyCare Health System, which provides state-of-the-art, top-quality health care to families, including under- and uninsured families, living in the Tri-Valley and surrounding communities. As a nonprofit health system, with facilities in Livermore, Dublin, and Pleasanton, ValleyCare Health System reinvests any profit it makes into the organization for new technology, facilities, and services. It has a total of 242 beds and a medical staff of over 300, offering a wide array of inpatient and outpatient services.

MEASURE A FUNDING SUMMARY

ValleyCare used its Measure A allocation to provide efficient treatment and progressive methods in the emergency room and Neonatal Intensive Care Unit (NICU) by purchasing the following medical equipment:

- A trauma stretcher, which greatly benefits the critically ill children and babies in transport to the emergency room, where the exact weight determination is crucial and helps reduce medication dosing errors
- A regular emergency department stretcher, to replace stretchers nearing end of life and accommodate an increased influx of patients
- A pediatric syringe pump for the NICU, which contains a drug library and has dosing capabilities to administer smaller amounts and doses of medication, greatly reducing any chance of medication dosing errors

WASHINGTON HOSPITAL

Board of Supervisors discretionary allocation: District 1/Supervisor Haggerty

FY 12/13 allocation: $20,000

Expended/encumbered in FY 12/13: $20,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient

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

Measure A clients served: 1,371 (**Total clients**: 207,678)

Service area: Fremont, Hayward, Newark, Sunol, Union City

AGENCY/PROGRAM BACKGROUND

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

MEASURE A FUNDING SUMMARY

Washington Hospital used its Measure A allocation to support two specific program objectives:

- **Purchase of two chemotherapy infusion chairs for the Sandy Amos, R.N. Outpatient Infusion Center**. In FY 12/13, the infusion center served 1,371 patients who needed IV fluids or medications. Generally, the medicine is infused over several hours, while the patient rests in a reclining chair.
- **Construction of a bi-plane cath lab**. The bi-plane cath lab opened for patients on September 25, 2013. In the bi-plane cath lab, interventional cardiologists treat cardiac patients by implanting stents and clearing blocked blood vessels.

Measure A Helps

WASHINGTON HOSPITAL

A patient at the new infusion center offered his thoughts:

"Before the center existed, I was treated for my cancer at Stanford, a trip that took over half a day and required a toll. The ride home was frequently excruciating, as I was nauseous after the chemo and sitting in traffic for an hour didn't help. Sometimes I received infusions at my doctor's office. The room was so small that you could hold hands with the stranger sitting next to you getting chemo. With the infusion center at Washington Hospital, I have privacy, natural light, and a caring staff to help me as I get my infusion. This is a resource that our community has needed for a long time."

ADMINISTRATION/INFRASTRUCTURE SUPPORT

FY 12/13 allocation: $191,098

Expended/encumbered in FY 12/13: $148,799

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $42,299

Types of services provided: NA*

Individuals served: NA*

Measure A clients served: NA* (**Total clients**: NA*)

Service area: NA*

**Recipient provides administrative services to the Oversight Committee and County*

AGENCY/PROGRAM BACKGROUND

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

The HCSA Administration/Indigent Health Department provides the following:

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

MEASURE A FUNDING SUMMARY

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

HIGHLIGHTS

Effective administrative staff support for the work of the Oversight Committee and the County helps ensure the appropriate use of funds consistent with all the requirements of Measure A.

CONCERNS

Given the total annual expenditure of over $121 million and only 0.12% for administrative support, the Committee recommends exploring cost-effective ways to evaluate Measure A programs.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

Group 3: Primary Care

Alameda County Dental Health

Alameda Health Consortium: Electronic Health Record and Capital

California Telehealth Network

Capital Expansion: Asian Health Services, Axis Community Health, LifeLong Medical Care, Inc., Tiburcio Vasquez Health Center, Inc.

Fire Station Health Portals

Fremont Aging and Family Services

Health Enrollment for Children

Health Insurance Eligibility and Enrollment

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

Health Services for Day Laborers: Multicultural Institute

Health Services for Day Laborers: Street Level Health Project

Healthy Communities, Inc.

HillCare Foundation

Hospice: Getting the Most Out of Life Program

Medical Costs for Juvenile Justice Center: Mind Body Awareness

Medical Costs for Juvenile Justice Center: Victims of Crime

Preventive Care Pathways

Primary Care Community-Based Organizations

Roots Community Health Center

School Health Services: School Health Centers

Tiburcio Vasquez Health Center, Inc.

Tri-City Health Center: General Budget Stabilization

Tri-City Health Center: Mowry Clinic

ALAMEDA COUNTY DENTAL HEALTH

FY 12/13 allocation: $150,000

Expended/encumbered in FY 12/13: $150,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

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

Measure A clients served: 1,035 (**Total clients**: 5,687)

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

AGENCY/PROGRAM BACKGROUND

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

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

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

MEASURE A FUNDING SUMMARY

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

- Provide 1,035 infants, toddlers, and young children with oral assessments and fluoride varnish applications, while giving their parents and caregivers dietary and dental health education, anticipatory guidance, and assistance in accessing dental care for their family
- Enroll at least 375 infants and toddlers into the Healthy Kids Healthy Teeth (HKHT) program of preventive dental services and access early dental care
- Ensure 78% of children/families receive care through either Medi-Cal or Healthy Families
- Provide a minimum of two English/Spanish 20-minute dental health education sessions per week
- Ensure that a minimum of 125 families and children be assisted in getting access to dental providers who are willing and able to provide early care and become a dental home
- Ensure that at least 35% of enrolled children visit a dentist at least once during the year since enrollment in HKHT
- Expand operation of WIC to a third site, Telegraph, in addition to Hayward and Eastmont

HIGHLIGHTS

A preliminary analysis of health outcomes for children participating in the WIC Oral Health program shows that they have a 42% need for restorative dental treatment compared to children who did not benefit from the program, at a cost of 52% less.

The WIC Oral Health program leveraged its Measure A allocation to obtain an addition $67,868 in matching federal funds from the Maternal, Paternal, Child & Adolescent Health program (MCPAH) and Child Health and Disability Prevention (CHDP).

ALAMEDA HEALTH CONSORTIUM: ELECTRONIC HEALTH RECORD AND CAPITAL

FY 12/13 allocation: $1,600,000

Expended/encumbered in FY 12/13: $1,600,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Hospital Outpatient, Mental Health

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

Measure A clients served: 175,037 (**Total clients**: 175,037)

Service area: Countywide, Homeless or transient

AGENCY/PROGRAM BACKGROUND

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

The Alameda Health Consortium is guided by the following principles:

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

The health centers see patients regardless of income, uninsured status, and immigration status. In addition to providing medical care, the health centers provide health education, free screenings, social service, and health coverage assistance at community events and health fairs. Over 20 different languages are spoken across the

health centers including English, Spanish, Cantonese, Mandarin, Vietnamese, Tagalog, Farsi, Mam, Mien, Lao, Thai, Korean, Japanese, Hindi, Cambodia, Mongolian, Burmese, French, Armenian, and Ilocano.

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

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

MEASURE A FUNDING SUMMARY

This was a one-time allocation to strengthen Electronic Health Record (EHR) systems and capital infrastructure at the eight Consortium health centers. Half of this Measure A allocation supported the planning and rollout of NextGen Electronic Health Record (EHR) systems at the health centers and affiliated school-based health centers. Measure A funds provided initial support for the transition from paper medical charts to electronic systems, including training staff and health care providers on the NextGen EHR technology, increasing IT staff, extracting data from thousands of paper charts and entering the data into newly created EHRs for each patient, and purchasing necessary software and hardware to connect critical patient data (e.g., labs, scheduling information) from different departments and vendors into single records.

The other half of this allocation supported health center building improvements, reconfigurations of departments and facilities to improve efficiency and capacity, and the building of entirely new clinic locations in preparation to serve more Alameda County residents under the Affordable Care Act.

Specific implementation details for each of the Consortium members are as follows.

Asian Health Services

EHR Implementation

Measure A funds supported Asian Health Services' planning throughout the year leading up to the initial launch of the EHR at its new clinic in Oakland Chinatown. Asian Health Services documented the workflow of clinicians, created electronic interfaces, and developed a training curriculum and schedules for the clinical teams to phase in the adoption of the EHR.

Capital Infrastructure

With Measure A support, Asian Health Services completed the conversion of the former Silver Dragon Restaurant in Oakland into a comprehensive health center with 20 exam rooms and a staffing model designed to provide a patient-centered health home.

Axis Community Health

EHR Implementation

Axis Community Health successfully achieved full EHR implementation at all clinical sites, affecting the care of more than 10,000 patients. Axis has continued to optimize the system, enhance interfaces, develop and refine additional templates, and provide ongoing training for staff to further optimize the use of the system.

Capital Infrastructure

Axis is currently developing additional clinical space to expand capacity to meet the urgent need for primary care services in eastern Alameda County. Renovation of a recently purchased space, estimated to be completed in late 2014, will result in 28 exam rooms, eight behavioral health rooms, a pharmacy, and administrative space.

La Clínica

EHR Implementation

La Clínica used its Measure A funding to expand its capacity to utilize EHR and its capabilities by centralizing and expanding its IT department. La Clínica hired additional IT staff to support implementation of the Electronic Practice Management (EPM), a part of the NextGen system that manages all patient appointment scheduling, tracking of patient demographic and diagnoses and visit data, and billing data. Implementing the EPM is the precursor and part of preparing for the EHR rollout. During the program year six sites went live with EHR, including five school-based health centers. La Clínica is working to train staff on EHR and ensure that all sites have EHR properly up and running by 2015.

Capital Infrastructure

In May 2013, La Clínica IT staff began relocating to the larger facility in Oakland that now houses all IT staff and consultants. The former IT area is being renovated to centralize La Clínica's billing department. The centralization of billing staff and the billing hotline will build billing's capacity and improve services.

LifeLong Medical Care

EHR Implementation

LifeLong has "gone live" with EHR systems at three major sites, which combined serve more than 11,000 patients. Two of the three sites have met federal EHR Meaningful Use requirements, with the third scheduled to meet these requirements in mid 2014.

Capital Infrastructure

The LifeLong West Berkeley capital project—rehabilitation of an existing historic structure and a 12,000-square-foot addition—is nearing completion, with occupancy scheduled for mid-August 2014. The project is being completed six weeks early and on budget. This project increases clinic capacity to provide high-quality care for current and new patients; better serves clients by improving efficiency; creates work areas designed for family-focused health care; promotes a collaborative, person-centered approach to physical and mental health; preserves the historic elements of the landmark 1927 building; and increases energy efficiency and reduces negative environmental impact.

Native American Health Center

EHR Implementation

Native American Health Center used its Measure A allocation to support EHR planning and implementation

at the 7 Directions clinic site in Oakland and to meet and achieve federal Meaningful Use standards. Funds supported the salaries and benefits of the EHR Project Assistant/Meaningful Use Coordinator and Information Database Technician. A small portion was also spent on supplies for developing EHR training materials for providers and support staff. As of June 30, 2013, all behavioral health care sites and school-based medical sites went live on EHR.

Capital Infrastructure

Native American Health Center used Measure A capital monies to beautify the Native American Health Center's International Blvd. location in Oakland, which houses the computer training room and the WIC, billing, pediatric dental, and behavioral health departments. Specific improvements include removal of an oil tank that had been left over from a previous tenant, purchasing an evaporative fan cooler for the 7 Directions clinic, and upgrading the alarm systems at both the 7 Directions clinic and the 3124 International Blvd. location.

Tiburcio Vasquez Health Center

EHR Implementation

Tiburcio Vasquez Health Center used its Measure A funds to purchase additional NextGen licenses, a MAS 90 general ledger accounts receivable interface that allows them to download revenue data from MAS 90 directly to their accounting software, a Quest orders result interface that allows them to electronically retrieve lab results faster and directly to the patient files, a phone reminder interface to automatically call patients to remind them of appointments, and an i2i referral manager interface that automatically sends referrals documented in the NextGen EHR to the i2i software to produce internal and external reports to monitor and improve access to care for patients.

Capital Infrastructure

Tiburcio Vasquez Health Center applied $51,345.98 of its grant to acquire a property in San Leandro, on which they will build a 20,000-square-foot clinic to provide primary care, women's services, pediatrics, dental care, and some specialty care. The new clinic will dramatically expand access to services for residents in the unincorporated area of Ashland as well as San Leandro. Tiburcio Vasquez spent the remaining $33,000 of the grant on computers and dental equipment purchased for the Silva Pediatric Clinic in Hayward, which Tiburcio Vasquez Health Center newly acquired from St. Rose Hospital. The organization serves more than 3,000 low-income children at this location.

Tri-City Health Center

EHR Implementation

Tri-City Health Center conducted planning with clinicians and staff in preparation for the launch of the EHR implementation in the fall of 2013. Tri-City Health Center is converting a large volume of patient records to the new EHR system. They used Measure A funds to purchase lab tracking software and to partially offset the cost of scanning and abstracting medical records. Tri-City Health Center expects all sites to fully implement the EHR system by September 2014, supporting the care of more than 20,000 patients.

Capital Infrastructure

Tri-City Health Center used its capital allocation to complete computer hardware and cabling for the EHR implementation at its Mowry Ave. and Liberty St. clinic sites. Tri-City Health Center also used a portion of its

capital allocation to increase its primary care capacity to see more patients. To do so, Tri-City Health Center contracted with Coleman and Associates to help improve workflows and enhance productivity and efficiency.

West Oakland Health Council

EHR Implementation

West Oakland Health Council implemented the NextGen EHR at all primary care sites. West Oakland Health Council used its Measure A funds to purchase an i2i interface referral tracking system, purchase a pharmacy management system, and cover other hosting, licenses, and training expenses. The new EHR system supports the care of more than 17,000 patients seen by West Oakland Health Council.

Capital Infrastructure

West Oakland Health Council used its capital funds to improve disabled access by installing three new handicap-accessible doors; improve access to cancer screening by installing mammography equipment; and conduct necessary building maintenance such as replacing flooring and repairing the roof.

CALIFORNIA TELEHEALTH NETWORK

FY 12/13 allocation: $47,500

Expended/encumbered in FY 12/13: $47,500

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Hospital Inpatient, Hospital Outpatient, Mental Health

Individuals served: Children, Indigent, Low Income, Uninsured

Measure A clients served: 33 (**Total clients**: 33)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

Care coordination for adjudicated or foster care youth confined to the Alameda County Juvenile Justice Center, a facility run by the county's Probation Department, and treated by physicians from Children's Hospital & Research Center Oakland, has been significantly improved through the California Telehealth Network (CTN), a new collaboration afforded through use of telehealth equipment. The benefit of this collaboration through care transitions can continue as patients return to their communities after being released.

One of the best opportunities for using the telehealth technology resides at Children's Hospital Oakland, with a large physician base that benefits from access to learning opportunities. More opportunities can be explored

as site partners begin to consider the wider circle of telehealth use outside of patient/doctor interactions.

With the large numbers of diverse Limited English Proficiency (LEP) populations in the County, implementing video capability for medical interpretation is becoming an imperative. The telehealth carts include videoconferencing equipment that allows for the interpreter to be "virtually" present in the room. Video allows interpreters to access important visual body language cues that enhance their ability to facilitate the most effective, sensitive, high-quality, and safe communication between patient and provider. Reducing wait times to access interpreter services and removing costs associated with travel and wait time for interpreters allows hospitals and clinics to become more efficient in serving both providers and patients.

Measure A Helps

CALIFORNIA TELEHEALTH NETWORK

A youth who was detained at JJC had serious sleep problems due to ear/nose/throat (ENT) issues. He had to sit at an almost 90-degree angle while sleeping to be able to breathe properly. Staff repeatedly tried to make follow-up appointments to take place after his release, but they never took place. Attempts to place him in a group home setting were unsuccessful, as every home refused him because of his medical condition. The JJC clinician then decided to use telemedicine to provide additional care via ENT department and outpatient surgery. Although challenges existed with CHRCO because of the youth's size and condition, the use of this technology enabled the youth to avoid extended detainment at JJC.

MEASURE A FUNDING SUMMARY

Measure A funds enabled HCSA to leverage state resources to purchase fully equipped telehealth stations for the four Model eHealth Community partners: Children's Hospital & Research Center Oakland (CHRCO), the Alameda County Juvenile Justice Center (JJC) Health Services Unit, Madison School-Based Health Center, and Healthy Communities, Inc.

As a result, 40–60 youth at Camp Sweeney now have onsite access to specialty care, which reduces the wait to see specialists as well as the stigma associated with being transported to a medical provider by law enforcement. Additionally, through the four locations in CHRCO, every pediatric patient has greater access to culturally diverse specialists, and wait times for patient referral and follow-up appointments are expected to decrease significantly over time with greater use of the equipment.

At the JJC in particular, several primary accomplishments were achieved:

- Sub-specialists were sought out at CHRCO through several departments, such as endocrinology, orthopedics, cardiology, plastic surgery, the hand clinic, and neurology.
- Besides the telehealth cart, other devices such as an EKG, otoscope, and stethoscope were added by leveraging the Measure A and CTN investments. Currently the JJC is utilizing EKG software 1–2 times per week.
- Grand Rounds with CHRCO, as well as other educational conferences and video conferences, took place.

HIGHLIGHTS

Use of telehealth equipment enabled the CTN providers to better serve children by increasing access to care, particularly specialty care for pediatric patients being seen in traditional and nontraditional settings.

In addition, HCSA leveraged its Measure A allocation to obtain $220,000 in CTN matching funds.

CAPITAL EXPANSION: ASIAN HEALTH SERVICES, AXIS COMMUNITY HEALTH, LIFELONG MEDICAL CARE, INC., TIBURCIO VASQUEZ HEALTH CENTER, INC.

ASIAN HEALTH SERVICES

FY 12/13 allocation: $200,000

Expended/encumbered in FY 12/13: $200,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

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

Measure A clients served: NA* (**Total clients**: 24,387)

Service area: NA*

AXIS COMMUNITY HEALTH

FY 12/13 allocation: $200,000

Expended/encumbered in FY 12/13: $200,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health, Substance Abuse

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

Measure A clients served: NA* (**Total clients**: 14,000)

Service area: NA*

LIFELONG MEDICAL CARE, INC.

FY 12/13 allocation: $200,000

Expended/encumbered in FY 12/13: $200,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health, Substance Abuse

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

Measure A clients served: NA* (**Total clients**: 43,563)

Service area: Berkeley

TIBURCIO VASQUEZ HEALTH CENTER, INC.

FY 12/13 allocation: $200,000

Expended/encumbered in FY 12/13: $200,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Hospital Outpatient, Mental Health, Public Health

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

Measure A clients served: NA* (**Total clients**: 15,557)

Service area: Ashland, Cherryland, Hayward, San Leandro, Union City

**Funding used for capital improvement project, not direct services*

AGENCY/PROGRAM BACKGROUND

The following providers received Measure A funding for capital expansion projects:

- **Asian Health Services**. Asian Health Services (AHS) provides access to affordable and comprehensive health care for the uninsured and underinsured, including the immigrant and refugee Asian community, working to ensure equal access to health care services regardless of income, insurance status, language, or culture. As part of its mission, AHS provides services in English and 11 Asian languages: Cantonese, Vietnamese, Mandarin, Khmer, Korean, Tagalog, Mien, Lao, Mongolian, Karen, and Karenni.
- **Axis Community Health**. Axis Community Health provides quality, affordable, accessible, and compassionate health care services that promote the well-being of all members of the community. Axis serves a patient population that is low income and ethnically and linguistically diverse. Ninety-seven percent are at or below 200% of the federal poverty line (less than $44,700 for a family of four). Forty-nine percent are of Hispanic/Latino origin, 14% Asian or Pacific Islander, 5% African American, and 32% Caucasian or other. Over 40% are best served in another language.
- **LifeLong Medical Care, Inc.** 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.
- T**iburcio Vasquez Health Center, Inc.** 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.

MEASURE A FUNDING SUMMARY

Asian Health Services

AHS used its Measure A allocation for a new clinic capital project that included a photovoltaic system and a variety of office furniture: workstations, desks, seating, tables, and file cabinets.

Axis Community Health

Axis Community Health used its Measure A allocation for a capacity-building renovation of its property

in Pleasanton. Upon completion, the new site will include 27 examination rooms, a Clinical Laboratory Improvement Amendments (CLIA) level-one laboratory, a draw station, a pharmacy, and administrative space. The clinical areas will also include eight mental health counseling rooms that will accommodate Axis's integrated behavioral health services.

Once completed, Axis will nearly double its capacity and serve a projected 20,000 patients with similar demographics to the current patient population. To meet the growing needs of the community, Axis expects to increase the number of employees at the center to 190 staff members.

LifeLong Medical Care, Inc.

LifeLong used its Measure A allocation to build a new community health center in West Berkeley. The new clinic opened on September 9, 2013.

Tiburcio Vasquez Health Center, Inc.

Due to the increasing volume of patients seen at TVHC clinics and the limited availability of services rendered in the Ashland/Cherryland area of southern Alameda County, TVHC plans to open and operate a new two-story primary care clinic. TVHC used its Measure A allocation to purchase freestanding furniture and equipment for the new clinic's clinical rooms, laboratory, waiting areas, dental operatories, conference room, and administrative offices.

HIGHLIGHTS

Asian Health Services

AHS projects that its new clinic will serve about 3,500 low-income, limited English-speaking patients by the end of its first year of operation.

LifeLong Medical Care, Inc.

LifeLong leveraged its Measure A allocation to obtain an additional $13,000,000 in matching funds from the following sources:

- New Market tax credit loan
- City of Berkeley Community Development Block Grant
- Capital campaign ($2.1M)
- Federal funding from the Health Resources and Services Administration (stimulus funds)

The amount leveraged represents a 6,500% return on the Measure A allocation.

Tiburcio Vasquez Health Center, Inc.

By contributing to the completion of the new clinic, Measure A funding has helped increase TVHC's clinical capacity by 46%—enabling services to 7,200 new patients over its existing patient population of 15,557 at its current facilities.

In addition, TVHC leveraged its Measure A allocation to obtain over $1 million in matching funds from its capital campaign.

FIRE STATION HEALTH PORTALS

FY 12/13 allocation: $750,000

Expended/encumbered in FY 12/13: $3,176

Amount carried over to FY 13/14: $746,824

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Mental Health, Public Health (anticipated)*

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

Measure A clients served: NA* (**Total clients**: NA*)

Service area: Hayward (anticipated)*

**Portal scheduled to open in spring 2015; no clients have been served up to this time*

AGENCY/PROGRAM BACKGROUND

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

The objective of the Fire Station Health Portals is to provide a new access point for comprehensive primary and preventative care to communities in critical need of health care services. In addition, the portal will provide insurance enrollment assistance, connection to a medical home, and emergency department and hospital discharge follow-up. The portal model in Hayward, the first site, will reduce wait times for patients seen at community clinics by guaranteeing primary care appointments within 72 hours and providing extended hours. During the first two years of operation, over 5,000 new patients are projected to be seen at the Hayward site, the majority of whom will consist of low-income, uninsured, and indigent residents. Ability to pay is not a factor in receipt of care.

MEASURE A FUNDING SUMMARY

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

During FY 12/13, HCSA used Blue Shield of California Foundation funding in the amount of $170,880 (leveraged from an FY 11/12 Measure A allocation) for program planning, development, communications, and marketing for the portal project. HCSA spent $3,175.85 of its FY 12/13 allocation for printing services and site assessment consulting. HCSA expects to expend a significant amount of its Measure A funding towards this effort in FY 13/14 and 14/15.

FREMONT AGING AND FAMILY SERVICES

FY 12/13 allocation: $50,000

Expended/encumbered in FY 12/13: $50,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health

Individuals served: Indigent, Low Income, Seniors, Uninsured

Measure A clients served: 247 (**Total clients**: 392)

Service area: Fremont, Hayward, Newark, Union City

AGENCY/PROGRAM BACKGROUND

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

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

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

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

Measure A Helps

FREMONT AGING AND FAMILY SERVICES

A 65-year-old client suffered from impaired vision and swollen feet due to diabetes. He gained a lot of weight from his medication and experienced several visits to the emergency room. Through the Health Promoter program, the client became more engaged about changing his behaviors. He enjoyed the support of the group environment. The Health Promoter started attending the client's doctor's appointments and helped facilitate a referral to a physical therapist. The client learned he was incorrectly taking his medication and was educated on diabetes and healthy eating. Within two years he was meeting his goals, and his diabetes was considered controlled. His vision and his ability to walk were no longer an issue.

The program provides services to Afghan elders in the following areas:

- **Falls prevention strategies**. Exercise and yoga classes; sessions on weight management, osteoporosis, vitamins, dizziness and falls prevention, pain management, and more

- **Mental health and well-being**. Collaboration with the Fremont Mobile Mental Health team, health education sessions on senior abuse, group trips to local attractions, programming that facilitates socialization among participants, education sessions on anxiety and depression
- **Physical well-being.** Diabetes education and education sessions on diabetes prevention, sessions on headaches, aging and senior health, relaxation techniques, colon cancer, and hemorrhoids
- **Literacy.** Two levels of ESL classes
- **Immigration and naturalization.** Assistance with completing the US citizenship application, study materials for the civic and history test, filing of fee waiver due to low income, assistance with Medical Waiver (N-648) for those with disabilities
- **Housing.** Information on low-income housing, applications and flyers for the Housing Authority of Alameda County wait list
- **Social Service assistance/referrals.** Assistance with applying for SSI, food stamps, and other welfare benefits

MEASURE A FUNDING SUMMARY

Measure A funding helped the Health Promoter program meet its overall program objective to improve both the physical and mental health of older adults through increasing access to health services, supporting healthy behavior changes, monitoring medications, and providing health education classes. If Measure A funds were not available or were reduced, services would be reduced drastically.

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

Service Linkage

- Provide Health Promotion services to Afghan clients (target: 100; actual: 128)
- Offer care from a primary care physician (target: 90; actual: 128)
- Provide health education and socialization from Health Promoters (target: 100; actual: 128)
- Offer home visits (target: 250 visits to 85 clients; actual: 432 visits to 128 clients)
- Conduct home safety evaluations (target: 85; actual: 15 prior to a revision of the home safety checklist)
- Refer clients to City of Fremont Case Management and/or Counseling services (target: 35; actual: 30, as only this number needed referrals)
- Provide eligibility assistance and support to access supportive services to clients (target: 85; actual: 112)
- Help clients access other community services (target: 50; actual: 69)

Wellness Plan

Ensure the following:

- Clients complete the Wellness Screen (target: 80; actual: 27 before changing model)
- Clients develop a Wellness Action Plan (target: 40; actual: 27 before changing model)
- Clients participate in their Action Plan (target: 30; actual: 26 of the 27 who completed the plan)
- Clients show improvement after six months (target: 30; actual: 16 of the 27 who completed the plan)

Medication Management

- Provide medication review, education, and counseling (target: 40; actual: 124)
- Utilize "teach back" methodology to show an increased knowledge of medication among clients (target: 40; actual: 117)
- Improve medication compliance within six months for clients identified as having deficits in medication compliance (target: 30; actual: 45)

Chronic Disease Self-Management

- Train Health Promoters to lead Chronic Disease Self-Management Program (CDSMP) classes (target: 3; actual: 3)
- Offer one 15-hour CDSMP class for Afghan participants (target: 15; actual: 23)
- Achieve participants showing an increase in their ability to manage chronic conditions (target: 12; actual: 17)
- Offer one six-week diabetes class for participants (target: 5-10; actual: 40)

HIGHLIGHTS

The Health Promoters continue to surpass target program objectives—quite substantially in areas such as medication management, where actual results exceeded targets by 50-200%.

In addition, the Health Promoters program leveraged its Measure A allocation to obtain almost $100,000 in matching funds from the Fremont General Funds.

HEALTH ENROLLMENT FOR CHILDREN

FY 12/13 allocation: $160,000

Expended/encumbered in FY 12/13: $160,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Mental Health, Public Health, Substance Abuse

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

Measure A clients served: 488 (**Total clients**: 3,055)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

MEASURE A FUNDING SUMMARY

Thanks in part to Measure A funding, the program provided benefit program application assistance to 1,896 Alameda County residents.

HIGHLIGHTS

The Health Insurance Enrollment Assistance department leveraged its Measure A allocation to obtain an additional estimated $80,000 in matching funds from Medi-Cal (based on 50% reimbursement).

HEALTH INSURANCE ELIGIBILITY AND ENROLLMENT

FY 12/13 allocation: $200,000

Expended/encumbered in FY 12/13: $200,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

Individuals served: Adults, Indigent, Low Income, Uninsured

Measure A clients served: 101 (**Total clients**: 67,030)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

A specific program of HCSA focused on increasing eligibility and enrollment into the Health Program of Alameda County (HealthPAC), a low-income health program, to ensure that clients enrolled in HealthPAC made a seamless transition to Medi-Cal in 2013 as part of the Patient Protection and Affordable Care Act (ACA).

MEASURE A FUNDING SUMMARY

Measure A funds allowed HCSA to develop the necessary data systems to administratively transfer a subset of HealthPAC enrollees to Medi-Cal. To achieve this objective, HCSA employed a consulting firm to assist in developing the appropriate business processes, policies and procedures, and data systems, which ultimately led to 40,000 Alameda County newly eligible residents enrolled in Medi-Cal on January 1, 2014.

Measure A Helps

HEALTH INSURANCE ELIGIBILITY AND ENROLLMENT

Seventy-one-year-old Betty, a retiree, had Medicare but needed supplemental insurance. Betty was denied Medi-Cal for being over the limit of allowable assets/property. The Medi-Cal worker explained that Betty had to decrease the $30,000 balance in her IRA to an allowable $3,000 to be approved for Medi-Cal. Although she needed the supplemental coverage, Betty did not want to risk spending down her IRA for fear of losing her life savings. After examining the situation, a Health Insurance Enrollment Assistance technician determined Betty was eligible for HealthPAC. Betty applied for and was accepted into the HealthPAC program, which provided supplemental coverage while not penalizing her for saving money for her retirement.

In concert with HCSA, the consultants provided the following services:

- **Database development**. Developed a database used to document and track HealthPAC enrollees who would transition to Medi-Cal on January 1, 2014.

- **Staff training**. Trained health insurance technicians and auditors on how to properly document HealthPAC enrollees that transitioned to Medi-Cal, so that this information could be regularly provided to the State Department of Health Care Services.
- **Data provided**. Worked with staff to provide detailed data to each of the HealthPAC medical homes showing which HealthPAC members were transitioning to Medi-Cal and which ones would remain in the program.
- **Coordination with Social Services**. Participated and facilitated regular meetings with HCSA and Alameda County Department of Social Services staff about the transition. The consultants also worked on ensuring that Social Services received data regularly on the people who transitioned.

HEALTH SERVICES FOR DAY LABORERS: COMMUNITY INITIATIVES (DAY LABOR CENTER)

FY 12/13 allocation: $75,000

Expended/encumbered in FY 12/13: $75,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Mental Health, Public Health, Substance Abuse

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

Measure A clients served: 350 (**Total clients**: 800)

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

AGENCY/PROGRAM BACKGROUND

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

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

The DLC provides services in the following areas:
- **Mental health**. The DLC works provides workshops and informational meetings to help educate workers about mental health needs and issues related to domestic violence.
- **Alcohol and drug**. The DLC provides workers with literature about the effects of alcohol and drug use and abuse.
- **Hospital and inpatient services**. The DLC portal services use hospital services for extreme and/or

emergency cases only, with use of lab and other specialty services as needed.

- **Public health prevention**. The DLC offers Zumba classes for women workers, develops and monitors individual health plans for weight and diabetes management and prevention, and provides HIV prevention education and screening.
- **Outpatient services**. In addition to ancillary services provided by the Davis Street Clinic and/or St. Rose Hospital sites, the County provides DLC workers with dental services three months out of the year.
- **Youth and community services**. The DLC provides services to the indigent population and youth from the surrounding neighborhood, including job skills training and community volunteer service opportunities.
- **Socialization**. The DLC maintains a community garden and has a 20-team soccer league to address the workers' ailments of depression, isolation, and loneliness due to being separated from the families in their home countries.
- **Other services**. When workers are physically attacked for their cash, DLC helps them fill out police reports and supports them to recuperate both physically and mentally. DLC also helps workers with the "U-Visa" process, which allows them to reside in the U.S. legally.

Measure A Helps

HEALTH SERVICES FOR DAY LABORERS: COMMUNITY INITIATIVES (DAY LABOR CENTER)

A 36-year-old female had a lump in her breast that had been changing in size and caused discomfort. Her husband, who participates in the DLC soccer league, referred her to the DLC health screening program. After the screening, the Health Navigator referred the woman to the "Every Woman Counts" program at Highland Hospital for free cancer screening services. Although the program normally serves woman 40 years and older, it made an exception and received her because of the advocacy and referral notes that the DLC Health Navigator and Nurse Practitioner provided. The new screening detected breast cancer, and the woman began a treatment program. She is currently cancer-free and has recently gone back to work.

MEASURE A FUNDING SUMMARY

Measure A funds provide approximately half of the support needed to sustain the DLC health program.

Measure A helped the DLC achieve the following measurable objectives:

- Offer and provide day health-related navigation/referral services to day labor workers specific to health care needs of the age of the day labor worker population (target: 300; actual: 568)
- Provide primary health care referrals for health care screenings and/or episodic care visits (target: 250; actual: 742)
- Hold regular meetings with Davis Street Clinic and St. Rose Hospital staff to review services provided to referred day labor workers (target: 6 meetings; actual: 5, in part because of administration changes at St. Rose Hospital after the sale of the hospital)
- Advocate for the day labor worker population and their health care needs—including appropriate hours of operation, types of services needed, and/or cost structures—with local health care clinics (actual: participation at several County and City of Hayward meetings, advocating for appropriate services)
- Train Peer Health Educators to help provide health education and outreach services to the day labor worker population (target: 6; actual: 8)

- Conduct external outreach to the day labor worker population (target: 400 unduplicated contacts; actual: 1,850)
- Provide community health, safety, and wellness presentations and/or trainings on topics such nutritional and healthy cooking, HIV testing and prevention, and occupational safety as to unemployed and/or underemployed day labor workers (target: 6 trainings; actual: 27)
- Conduct follow-up assessments with and offer recommendations to day labor workers referred into the health care system (actual: 196 follow-up referrals)
- Help workers receive all of their documentation, including visas, drivers' licenses, etc., to reside and work in the U.S. through the "U-Visa" program (actual: 5 workers)

HIGHLIGHTS

In almost all areas, the DLC health program surpassed target program objectives.

The DLC made more than 900 direct and follow-up referrals for primary and episodic health care for a variety of ailments. By reducing the number of emergency room visits, this results in a cost savings of $810,000.

In addition, the DLC leveraged its Measure A allocation to obtain $205,342 in matching funds from the following sources:
- California Wellness Foundation
- City of Hayward
- San Francisco Foundation
- Y and H Soda Foundation

HEALTH SERVICE FOR DAY LABORERS: MULTICULTURAL INSTITUTE

FY 12/13 allocation: $75,000

Expended/encumbered in FY 12/13: $75,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health, Substance Abuse, Other: Dental Referrals

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

Measure A clients served: 500 (**Total clients**: 669)

Service area: Berkeley, Oakland, Homeless or transient

AGENCY/PROGRAM BACKGROUND

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

MI focuses its efforts in the following areas:
- **Street conditions**. MI staff brings its services to about 40-50 day laborers seeking work in West Berkeley

every day. The program works with local officials and businesses to ensure that the area is safe, there is access to trash receptacles and bathrooms, and no harassment of workers occurs.

- **Job-matching**. MI provides no-fee job-matching services for day laborers to receive jobs at a fair minimum wage.
- **Skill-building**. MI offers different vocational trainings such as skills needed to operate a business, Spanish-language GED preparation courses, and other topics.
- **Fair working conditions**. MI staff aid workers in redressing problems (wage claims, unsafe conditions, occupational injuries) that result from jobs not obtained through the Institute.
- **Referrals and individualized follow-up for educational, health, and legal services**. MI works with various public sector and nonprofit partners that offer specialized services such as classes, medical services for low-income individuals, and legal support.
- **Community-building and healthy pastimes**. Sponsoring events like soccer matches, street cleaning, and a weekly simple shared meal helps break down isolation and leads to new ways of working together.

Measure A Helps

HEALTH SERVICE FOR DAY LABORERS: MULTICULTURAL INSTITUTE

Patricia, a recent immigrant from Guatemala, had a tooth that hurt badly but did not seek dental care because of the cost. Patricia attended a dental care event at MI's Berkeley offices. The dentist first recommended pulling her molar to avoid a root canal and crown. However, no area community clinic could provide root canal services. MI's partner, OnSite Health, brought in the root canal equipment to treat Patricia and two other patients. As it turned out, Patricia's tooth could be sufficiently reconstructed to the point of the tooth being saved. Patricia could not believe it – more than a $1,000 debt averted, the pain taken care of, and the tooth itself saved.

MEASURE A FUNDING SUMMARY

Measure A funding helped MI's day laborer program conduct regular outreach to at least 472 unduplicated day laborers to inform/give support about clinic services and other health/health education activities (target: 400).

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

- Set aside approximately 50 clinic days for the day laborer population through partnerships with the Alameda County Health Care for the Homeless Program (ACHCHP) and with West Berkeley Family Practice (WBFP)/ LifeLong Medical, offering personalized assistance with paperwork and the provision of free or low-cost services
- Conduct 737 medical/laboratory and/or case management support encounters including diabetes and high blood pressure screening, dental care services, consultations and case management around medical and health issues, and other support services
- Hold eight special health education events for a combined attendance of 277 participants, including medical screenings; workshops/screenings on diabetes, flu prevention, and HIV/STIs; a workshop on nutrition, healthy eating, and maximizing food bank resources; and more
- Co-sponsor and facilitate STI/J counseling and/or rapid HIV testing to approximately 50 individuals; provide flu and other vaccinations to approximately 60 individuals; and provide dental referrals and services to approximately 75 individuals

HIGHLIGHTS

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

HEALTH SERVICES FOR DAY LABORERS: STREET LEVEL HEALTH PROJECT

FY 12/13 allocation: $75,000

Expended/encumbered in FY 12/13: $75,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health

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

Measure A clients served: 370 (**Total clients**: 950)

Service area: Countywide, Homeless or transient

AGENCY/PROGRAM BACKGROUND

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

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

MEASURE A FUNDING SUMMARY

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

- Provide health care screening and episodic care annually to clients across multiple languages (target: 780 unduplicated clients; actual: 760)
- Offer health-related navigation/referral services (target: 600 referrals; actual: 1,115)
- Provide mental health prevention workshops/trainings (target: 10; actual: 18)
- Offer mental health consultations/referrals annually to low-income immigrant communities in Alameda County (target: 75; actual: 119 mental health consultations, 206 mental health referrals)
- Offer occupational health, violence prevention, health education, and community wellness presentations to low-income immigrants (target: 30; actual: 30)

- Distribute free healthy fruit and produce food bags to low-wage workers and their families (target: 1,500 workers/families; actual: 3,899)
- Connect individuals to resources of local grassroots, community organizations that provide legal, educational, and social services (target: 850; actual 695, because of three-month gap in hiring new volunteer coordinator to oversee this effort after previous person left position)
- Collaborate with community-based organizations, health care agencies, and/or governmental agencies to promote the health and wellness of immigrants and refugees (target: collaboration with 12 outside agencies; actual: 30 agencies, 54 collaborative events)
- Participate in meetings regarding health reform and implementation (target: 4 meetings; actual: 9)

Measure A funds also allowed Street Level Health Project to provide Mam (a Mayan language) and Mongolian interpretation to its patients and clients and provide training for the Mam-Mayan interpreter in the lay health worker skills and community resource information needed to work in the clinic.

Measure A Helps

HEALTH SERVICES FOR DAY LABORERS: STREET LEVEL HEALTH PROJECT

When Jesus, a 50-year-old Mexican immigrant, started suffering from eye problems, he came to the doctor at Street Level. Jesus was diagnosed with pterygia, an abnormal growth of the eye's mucous membranes that can impair vision. Staff referred Jesus to optometry specialists at Eastmont Wellness Center for an evaluation, assuring him he would not have to pay and helping enroll him in HealthPAC. Shortly after, Jesus's financial situation worsened and he ended up homeless, missing his optometry visit. Street Level connected him with temporary housing and helped reschedule his appointment. The optometrist recommended Jesus for surgery, and the pterygium was successfully removed. He is glad to have drastically reduced eye irritation and full vision once again.

HIGHLIGHTS

Street Level Health Project surpassed its target program objectives in most areas—quite substantially in areas such as health-related referrals and healthy food distribution, where actual results exceeded targets by over 200%.

In addition, Street Level Health Project leveraged its Measure A allocation to obtain a total of $138,000 in matching fund from the following sources:

- Episcopal Charities
- Frances K and Charles D Field Foundation
- Kaiser Permanente
- La Clínica de la Raza
- Philanthropic Ventures Foundation
- San Francisco Foundation
- The California Wellness Foundation

HEALTHY COMMUNITIES, INC.

FY 12/13 allocation: $200,000

Expended/encumbered in FY 12/13: $200,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health, Substance Abuse

Individuals served: Adults, Seniors, Indigent, Low Income, Uninsured, Other Residents: Re-entry Community

Measure A clients served: 371 (**Total clients**: 5,084)

Service area: Countywide, Homeless or transient

AGENCY/PROGRAM BACKGROUND

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

MEASURE A FUNDING SUMMARY

Measure A funding helped enable Healthy Communities to achieve the following:

- Expand into a larger facility located at 1485 8th Street, Oakland, CA 94607
- Create a communications plans to support facility expansion
- Create transitional plans to support the merger process with the West Oakland Health Council
- Work with consultants that provide expertise in the areas outlined above
- Maintain the Mobile Medical Unit, including generators, locks, doors, electrical system, and tire replacement

HIGHLIGHTS

The expansion into the larger facility provides Healthy Communities the necessary space to expand its current services and offer additional services.

HILLCARE FOUNDATION

Measure A one-time allocation, Board of Supervisors discretionary allocation: District 4/Supervisor Miley

FY 12/13 allocation: $36,000

Expended/encumbered in FY 12/13: $36,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health, Substance Abuse

Individuals served: Adults, Low Income, Indigent, Uninsured

Measure A clients served: 200 (**Total clients**: 200)

Service area: Oakland

AGENCY/PROGRAM BACKGROUND

HillCare Foundation provides health care and case management for indigent minority women.

MEASURE A FUNDING SUMMARY

Measure A funding helped HillCare Foundation provide the following for re-entry/high-risk women:

- 50 OB/GYN and primary care encounters
- 50 health education encounters
- 50 case management encounters

HIGHLIGHTS

HillCare Foundation's efforts resulted in increased infant birth weights, decreased drug use by expectant mothers, and a reduction in pregnancy-related hypertension and diabetes.

Measure A Helps

HILLCARE FOUNDATION

Ms. M., age 23, was experiencing her second pregnancy. On her first prenatal visit, she tested positive for cocaine and marijuana. After HillCare Foundation provided substance abuse intervention and case management, Ms. M. stopped using drugs by her fifth prenatal visit. At delivery, Ms. M. was free of drugs. Her baby was delivered at term with a normal birth weight and no complications. Since delivery, the mother has remained drug-free.

HOSPICE: GETTING THE MOST OUT OF LIFE PROGRAM

FY 12/13 allocation: $75,000

Expended/encumbered in FY 12/13: $70,296

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $4,704

Types of services provided: Emergency Medical, Hospital Inpatient, Mental Health, Public Health

Individuals served: Children, Families, Seniors, Indigent, Low Income

Measure A clients served: 1,827 (**Total clients**: 3,000)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

Hospice is an underutilized Medicare and Medi-Cal benefit of significant value. The Alameda County "Getting the Most Out of Life (GMOL)" program is designed to increase knowledge and utilization of the hospice benefit. The GMOL mission is to reduce suffering and improve quality of care for residents of Alameda County. Its key indicators are community members and organizations, medical providers/clinical staff and referring providers, health plans and associations, public health leadership, the terminally ill, hospice patients, and family members. GMOL addresses bereavement, loss, and grief in terms of understanding these emotions as part of the healing process and learning how to cope as individuals transition through the stages.

MEASURE A FUNDING SUMMARY

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

Measure A funding helped the GMOL program develop a systems-integrated approach to deliver advanced care planning and end-of-life services, achieving the following outcomes:

- Fill the significant gap in information and service to people with serious illnesses or who are terminally ill. GMOL made an average of three presentations per month to baby boomers and the elderly on hospice and advanced care planning. GMOL produced brochures and developed a menu of hospice providers and produced a clinical training module focused on hospice and learning when and how to make hospice referrals.
- Reduce institutional barriers to hospice utilization through presentations to physicians on issues of hospice around mental health, cultural diversity, and age. The program held a professional exchange in November 2012 that was attended by 139 people representing a number of organizations and agencies.
- Promote hospice provider collaboration and coordinate activities. Ten Alameda County hospice providers formed a Hospice Coalition for planned events that increase the public awareness of aging, advanced care planning, and hospice benefits, such as an Art of Aging/Cycles of Life Event attended by over 200 people.

Measure A funding also helped GMOL promote equitable access to advanced care planning and hospice services through the following activities:

- Increase knowledge of hospice and advanced care planning among ethnically diverse populations in Alameda County by developing over 1,000 brochures about the benefits of hospice in Spanish and presenting the benefits of advanced care and hospice to community-based audiences in Pashto, Mandarin, Spanish, and Tagalog.

- Foster an increase in willingness to advocate for end-of-life care. In partnership with Behavioral Health Care Services, GMOL made presentations to over 100 mental health consumers and developed training for medical professionals that included hospice advocacy for those conserved in locked facilities.
- Increase the willingness for seniors to complete "Physicians Order for Life Sustaining Treatment" (POLST) forms. GMOL distributed over 300 POLST forms to seniors and included an evaluation form that directly asked if individuals intended to complete the POLST form. Fewer than 2% answered no.

HIGHLIGHTS

In just its first full year, the GMOL program substantially raised awareness of hospice offerings as evidenced by its distributing over 1,000 brochures and 300 POLST forms, and holding multiple presentations/events attended by 100-200 providers or impacted community members.

In addition, GMOL leveraged its Measure A allocation to obtain an additional estimated $12,000 in matching funds from hospice provider organizations in Alameda County and other sponsors.

MEDICAL COSTS FOR JUVENILE JUSTIC CENTER: MIND BODY AWARENESS

FY 12/13 allocation: $55,000

Expended/encumbered in FY 12/13: $55,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health, Substance Abuse

Individuals served: Children, Indigent, Low Income, Uninsured, Other Residents: Transitional Age Youth

Measure A clients served: 750 (**Total clients**: 1,276)

Service area: Berkeley, Hayward, Oakland, Union City

AGENCY/PROGRAM BACKGROUND

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

MEASURE A FUNDING SUMMARY

Measure A funding helped MBA achieve the following measurable objectives:

- Provide mindfulness-based classes at the ACJJC. MBA used Measure A funds to deliver mindfulness-based stress reduction programs in several units (2, 3, and 4) of the Alameda County Juvenile Justice Center (ACJJC). Classes took place twice a week, for 1.5 hours.
- Offer at least one team-taught (co-facilitated by more than one instructor) class, with a goal of eventually team- teaching all classes. Approximately 75% of classes were team-taught (co-facilitated) in FY 12/13.
- Provide a minimum of one instructor per class. MBA met this objective for 100% of classes taught. Classes that weren't taught were results of the units being on lockdown.
- Collaborate with probation, the medical unit at ACJJC, and Alameda County Behavioral Health Care Services (BHCS) to make sure these agencies are reinforcing services outside of classes. MBA Executive Director Sam Himelstein met at various times with medical staff and guidance clinic (BHCS) staff to collaborate about reinforcing services.

HIGHLIGHTS

Measure A funding helped enable MBA to provide services to 750 transitional age youth. Research data analyzed in the past year revealed a 10-15% decrease in stress and 15-20% increase in self-regulation among the youth served.

MBA program staff worked effectively at establishing a cooperative working relationship with probation department staff.

Measure A support also enabled MBA to hire a new executive director with a comprehensive clinical vision to serve ACJJC youth after they become released. The goal of this new expanded program will be to track youth in MBA programs once released to help reduce recidivism and prevent violence.

CONCERNS

MBA was unable to collect any data in FY 12/13, due in part to data collection being halted by MBA's leadership transition. This makes it difficult to determine program effectiveness.

MEDICAL COSTS FOR JUVENILE JUSTICE CENTER: VICTIMS OF CRIME

FY 12/13 allocation: $90,000

Expended/encumbered in FY 12/13: $90,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Mental Health

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

Measure A clients served: 48 (**Total clients**: 3,505)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

The Victim Compensation program offers the following:

- Crisis support referrals and follow-up to outside agencies
- Optimum compensation assistance through the investigation and utilization of other applicable financial resources and recovery
- Support in navigating the client's immediate access to critical needs services (i.e., medical, mental health, pharmaceutical, etc.)
- Swift processing of emergency claims to alleviate client financial suffering and hardship
- Increased expansion of covered financial services and benefits and the evaluation of their effectiveness in addressing the client's needs

Measure A Helps

MEDICAL COSTS FOR JUVENILE JUSTICE CENTER: VICTIMS OF CRIME

As a result of being shot in the back multiple times, a 16-year-old remains a paraplegic with lower paralysis of his body. Through the Victim Compensation Program, the boy's mother received both a 30-day income loss benefit and an emergency relocation assistance benefit, which helped them obtain one week of temporary lodging until they were able to move into a new home. They also received an emergency food stipend during this period. When the mother had to quit her job to care for her son, the program's in-home care benefit provided them $416 per week, and the vehicle purchase benefit enabled them to buy a modified van to transport the victim to his daily destinations.

MEASURE A FUNDING SUMMARY

The Victim Compensation program used its Measure A allocation to hire staff, which enabled the program to expedite the processing of claims submitted by the Guidance Clinic originating in the Alameda County Family

Justice Center, Camp Sweeney, school-based health centers in Alameda County, and/or Crisis Service Response Teams.

HIGHLIGHTS

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

PREVENTIVE CARE PATHWAYS

FY 12/13 allocation: $400,000

Expended/encumbered in FY 12/13: $400,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical

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

Measure A clients served: 1,766 (**Total clients**: 1,800)

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

Homeless or transient

AGENCY/PROGRAM BACKGROUND

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

Preventive Care Pathways primarily serves indigent African-American clients. The clients receive wrap-around services as well as food, clothing, and shelter.

MEASURE A FUNDING SUMMARY

Preventive Care Pathways used its Measure A allocation to provide direct medical and support services, including medical exams and pharmacy and laboratory services, to adult residents in Oakland.

HIGHLIGHTS

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

Preventive Care Pathways leveraged its Measure A allocation to obtain an additional $70,200 in matching funds and in-kind contributions from the following sources:

- General Assistance funding
- Preventive Care Pathways providers
- Staff providers in-kind services
- Preventive Care network administration
- Equipment and supplies in-kind services
- Pharmacy and lab donations
- Volunteer services

PRIMARY CARE COMMUNITY-BASED ORGANIZATIONS

FY 12/13 allocation: $5,511,603

Expended/encumbered in FY 12/13: $5,472,584

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $39,019

Types of services provided: Hospital Outpatient, Mental Health

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

Measure A clients served: 40,906 (**Total clients**: 176,237)

Service area: Countywide, Homeless or transient

AGENCY/PROGRAM BACKGROUND

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

The Alameda Health Consortium is guided by the following principles:

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

The health centers see patients regardless of income, uninsured status, and immigration status. In addition to providing medical care, the health centers provide health education, free screenings, social service, and health

coverage assistance at community events and health fairs. Over 20 different languages are spoken across the health centers including English, Spanish, Cantonese, Mandarin, Vietnamese, Tagalog, Farsi, Mam, Mien, Lao, Thai, Korean, Japanese, Hindi, Cambodia, Mongolian, Burmese, French, Armenian, and Ilocano.

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

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

The Measure A allocation to the primary care community-based organizations included a ninth fund recipient, Healthy Communities, Inc., which is a not a member of the Alameda Health Consortium.

MEASURE A FUNDING SUMMARY

The eight Alameda Health Consortium member health centers and Healthy Communities, Inc. used their Measure A allocation Measure A funds to meet the objective of providing essential medical services to Health Program of Alameda County (HealthPAC) enrollees, as well as health insurance enrollment assistance for the uninsured. Health centers provided primary care, mental health, and other health visits under HealthPAC.

Measure A Helps

PRIMARY CARE COMMUNITY-BASED ORGANIZATIONS

Testimony from a low-income, uninsured patient who is enrolled in HealthPAC and receives care at Asian Health Services:

"I am a refugee from Cambodia. I saw killing right in front of my eyes. I suffered terrible nightmares and had hypertension, thyroid problems, and depression. I had no insurance or money even to buy food. I lost hope and wanted to kill myself. I was introduced to Asian Health Services, where the staff understood my hardships and helped me apply for food stamps, general assistance, and the health program. My doctor referred me to a counselor who listened to my story and helped me cope with my pain. They also have people from my country who helped me work through my traumas. I now sleep better and the pain is more tolerable. I am very grateful and feel hope."

In FY 12/13, Alameda Health Consortium member community health centers achieved the following measurable objectives:

- Served over 175,000 patients at over 70 sites across Alameda County. Of the 175,000 patients, 40,594 of these patients were enrolled in HealthPAC.
- Collectively provided over 850,000 visits in primary medical, dental, behavioral health, enabling and support, and social services.
- Successfully enrolled and provided essential health care to more than 40,000 low-income Alameda County residents.
- Through HealthPAC, experienced more than 138,000 visits from uninsured Alameda County residents.
- Provided over 13,000 visits for mental health services at the health centers.

Actual visits compared to contracted visits for each Consortium health center are as follows:

FY 12/13 PROVIDER	ACTUAL YTD VISITS	TARGET YTD VISITS	PERCENT OF TARGET
Asian Health Services	21,980	21,829	101%
Axis Community Health	14,864	12,443	119%
La Clínica	30,855	31,616	98%
LifeLong Medical Care	22,181	19,473	114%
Native American Health Center	4,836	5,076	95%
Tiburcio Vasquez Health Center	15,033	14,597	103%
Tri-City Health Center	20,355	18,325	111%
West Oakland Health Council	8,165	9,478	86%
Total	138,269	132,837	104%

In addition, Healthy Communities, Inc. finished FY 12/13 providing 59% of its target HealthPAC visits. At the end of FY 12/13, 1,399 County residents used Healthy Communities Inc., as their HealthPAC medical home.

HIGHLIGHTS

Measure A funds provided comprehensive care for 40,600 individual clients, who made a total of 138,269 visits. For five of the eight member centers, actual visits exceeded target visits. Overall, Alameda Health Consortium member health centers provided an increased number of visits under HealthPAC compared to the previous year, up 18,000 visits from FY 11/12. The health centers also enrolled 4,600 more patients into the program, a 13% increase from the previous fiscal year.

The number of mental health visits provided exceeded the expected number of contracted visits by 53% (almost 13,000 visits versus target number 8,429).

In addition, the Alameda Health Consortium leveraged its Measure A allocation to obtain matching funds from the 1115 Medicaid Waiver through HealthPAC by the Alameda County Health Care Services Agency.

ROOTS COMMUNITY HEALTH CENTER

FY 12/13 allocation: $30,000

Expended/encumbered in FY 12/13: $30,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

Individuals served: NA*

Measure A clients served: NA* (**Total clients**: NA*)

Service area: Oakland

**Allocation used to produce a report*

AGENCY/PROGRAM BACKGROUND

Roots Community Health Center works to provide high quality, culturally competent, comprehensive health care and mental health services with the goal of eliminating health disparities in East Oakland. Roots Community Center accomplishes its mission by providing state-of-the-art, top quality care while also honoring the "roots" of culture, heritage, and tradition; by providing unprecedented access to preventative, primary, and urgent care; by reducing the need for emergency services; and by establishing partnerships to ensure a more efficient continuum of care in East Oakland.

MEASURE A FUNDING SUMMARY

Roots Community Health Center used its Measure A allocation to fund a study that assessed the current state and needs of primary care practices serving Afro-American patients in East Oakland, and provided recommendations on how to preserve and expand these points of access to care. The study resulted in a 41-page report, *Realities of Medical Practices Serving African-Americans in East Oakland*. The report included three recommendations for community root providers and 10 recommendations for health policy workers.

SCHOOL HEALTH SERVICES: SCHOOL HEALTH CENTERS

FY 12/13 allocation: $1,400,000

Expended/encumbered in FY 12/13: $1,400,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health, Substance Abuse

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

Measure A clients served: 11,813 (**Total clients**: 11,813)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

A key component of the Center for Healthy Schools & Communities, the school health centers (SHCs) play a vital role in creating universal access to health services by providing a continuum of age-appropriate and integrated health and wellness services for youth in a safe, youth-friendly environment at or near schools.

The school health centers (SHCs) provide services in the following areas:

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

Measure A Helps

ELMHURST/ALLIANCE HEALTH CENTER

One 8th grade student had been coming to the SHC almost daily complaining of sore throat, headache, or being tired or hungry. Illness was rarely detected, though this student did have behavior challenges at school. The staff at the SHC established a positive relationship with him and learned that he was very lonely, with many hours home alone after school and very few friends. With support, staff have seen some positive changes, as the student has learned to become less socially awkward. Most recently, the physician's assistant detected oversized tonsils in this student and recommended immediate removal. He was scheduled to see a surgeon, and staff believe that treatment will help the student feel better and improve his speech and self-confidence tremendously.

SHC services are accessible. SHCs are open during school hours and often after school as well. SHC services are available at no cost to clients, regardless of their insurance status, thus filling a gap for students who are uninsured or underinsured. Of those clients for whom data was recorded, 27% did not have a primary care medical home and 35% did not have a regular dental

provider. SHCs offer a full scope of integrated services with easy referrals between providers.

MEASURE A FUNDING SUMMARY

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

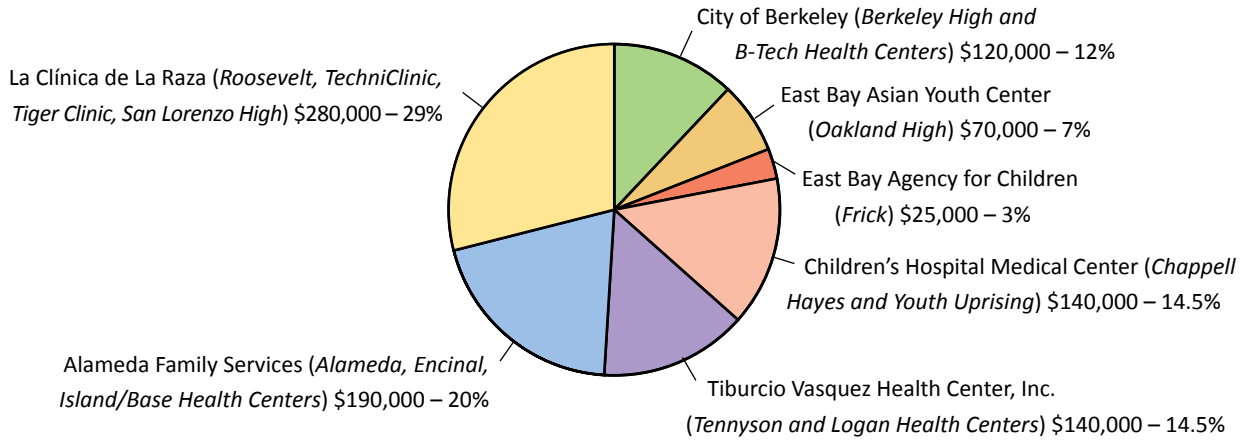
- Alameda County SHCs continue to expand, now providing programs at one elementary school, seven middle schools, 14 high schools, and one community college.
- SHCs have improved academic outcomes. Without an SHC on-site, many students might have been sent home—rather than having their health issues addressed on-site and being sent back to class.
- Clients return for multiple visits to the SHCs, demonstrating the value of integrated and youth-friendly services.
- Physical health services were provided during 40% of all SHC visits. Individual and group behavioral health services were provided during 26% of all visits to 2,036 clients.
- Sexual/reproductive health services were provided during 34% of all visits. According to clinic data, 46% of female clients reported that they "always" used contraception at baseline, compared to 55% at follow-up.
- At the five SHC sites providing dental services in FY 12/13, 23% of all visits (763 clients making 2,504 visits) had a dental service provided. These services included screening exams and cleanings, case management, and restorative treatment.

Figure 8

DISTRIBUTION OF MEASURE A FUNDS ALLOCATED TO SCHOOL HEALTH CENTERS

(Centers are italicized and listed beside the providers in parentheses)

NOTE: Of the total $1,400,000 allocated to School Health Centers in FY 12/13, $940,000 was allocated directly to School Health Centers and the remaining portion was used for evaluation.



The SHCs offered a variety of outreach activities over the school year, such as parent workshops, speakers, and other after-school events for the community. Overall, SHCs engaged 49,621 students; 3,641 family members; 2,876 school staff; and 1,074 other participants through a total of 2,522 events and activities. Additionally, the SHCs provide school support programs, such as school-wide assemblies, health fairs, classroom presentations,

and group health education. Sixteen of the SHCs have a Youth Advisory Board and/or a Peer Health Education program where students develop leadership skills and give classroom presentations on various health issues.

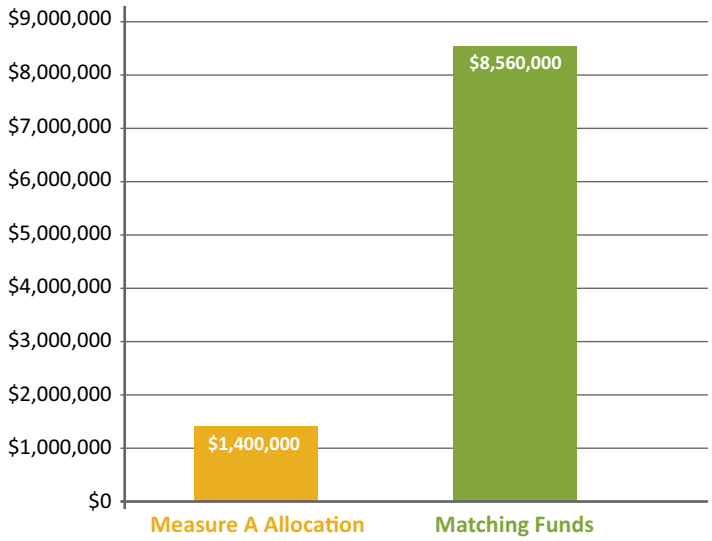
HIGHLIGHTS

The program continues to grow, in number of sites, types of services offered, and numbers of clients served—for example, dental is now offered at a handful of sites. The program is a true collaborative among County departments, school districts throughout the County, and a slew of community-based clinics and service providers. Administrative costs are kept to a minimum with funding targeted at direct services. The program takes monitoring, reporting, and data collection seriously, and has worked with UCSF and others to develop effective data systems and evaluate program effectiveness.

The SHCs leveraged their Measure A allocation to obtain an additional $8,560,000 in matching funds from local, state, federal, and private sources.

Figure 9

ALAMEDA COUNTY SCHOOL HEALTH SERVICES COALITION USE OF MEASURE A FUNDING TO OBTAIN MATCHING FUNDS



Measure A Helps

TENNYSON HEALTH CENTER

A patient came in for immunizations to enroll in school. The patient was new to the country and had no health care home to access services. After giving the student all of his required shots, the school-based medical provider discovered that the patient also had nonactive TB. The provider and school-based clinical staff worked with the patient and his family to get him the proper care and treatment. By working internally with Tiburcio Vasquez Health Center's main site, Highland Hospital, and the County Public Health Department, the Tennyson SHC was able to get the patient the proper tests and medication, establish a treatment plan, and ensure that he was successfully enrolled into school.

TIBURCIO VASQUEZ HEALTH CENTER, INC.

Board of Supervisors discretionary allocation: District 2/Supervisor Valle

FY 12/13 allocation: $60,000

Expended/encumbered in FY 12/13: $60,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health

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

Measure A clients served: 2,300 (**Total clients**: 5,200)

Service area: Ashland, Cherryland, Hayward, Union City

AGENCY/PROGRAM BACKGROUND

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

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

- **Young Men & Women's Programs**. These programs work to foster leadership and empowerment in young men and women, specifically youth from disenfranchised communities. The programs explore oppression through a social justice lens, community organizing, and personal subjects.
- **After School Youth Empowerment Programs**. The Hip-Hop Elements program is a forum for any Logan student interested in creative expression through hip-hop. The program focuses on several areas of hip-hop, including the art of being a Disc Jockey (DJ), Graffiti Art, Break Dancing, Master of Ceremony (MC)/Spoken Word, Poetry, etc.
- **Youth Advisory Program/Peer Navigator Program**. The group serves as a forum for youth to give input into health center policy and function and to actively promote health to the high school campus. They accomplish this by developing school wide "health tips" that air on the school PSA system, hosting workshops, organizing

Measure A Helps

TIBURCIO VASQUEZ HEALTH CENTER, INC.

JH and JP, participants in the Young Women's program, shared their stories: JH's parents raised her in a gang-affiliated environment. JH reports that the positive environment of the health center program helps her stay focused on her goals. She says, "I have a lot of anger inside, but talking about my problems with other girls in the program helps me with my anger." Similarly, after JP's parents' separation, she lived in a car with her mother and siblings for a time. While she still has relationship problems with her mother, over time, the relationship has improved. JP says, "Talking with other girls in the program who have similar family problems really helped me see that I was not alone."

an annual health fair, and participating in community activities that promote leadership, community involvement, and civic participation.

- **CAFÉ, Parent Engagement Program.** At CAFÉ (Club de Aprendizaje Para Una Familia Estable), parents learn about domestic violence and immigration reform policies such as Deferred Action for Childhood Arrivals (DACA). The program strongly fosters leadership development among participants.
- **Health Education/Family Planning**. The school-based health centers continued providing one-on-one health education visits to youth. Students receive individual counseling regarding family planning education, pregnancy prevention options, and STI/HIV education. Additionally, wrap-around care is provided through case management to ensure all students are provided the support and care to meet their health needs.

MEASURE A FUNDING SUMMARY

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

Measure A funding helped TVHC achieve the following measurable objectives:

- The health centers served and provided outreach to over 5,000 students to educate and promote the services provided through the health centers.
- Over 980 students received individual health care sessions.
- The centers conducted nearly 200 individual case management sessions that covered sexual health education and pregnancy options counseling while linking students to the medical services provided at the clinic.
- Youth organized and coordinated the "Breaking the Cycle of Violence" event. This youth-led and youth-driven event experienced a turnout of well over 500 students.
- The young women's program had 26 participants who focused on creating a curriculum that promoted goal-setting, positive body image, and self-awareness development while also exploring health and social justice topics such as STIs/HIV and pregnancy prevention, healthy relationships, and racism/discrimination awareness.
- A total of 53 young men and women attended groups exploring topics around personal responsibility and professional development.
- Eighty-eight Hip-Hop Elements members performed at various school and community events including the annual health fair.
- Twenty-seven Youth Advisory Board members received community service hours for their participation, including staging the annual health fair. The event was a huge success and was one of the largest and most well attended health fairs to date. Over 350 students participated in the health fair and over 35 student volunteers helped run the health fair on the day of the event.
- Nearly 250 new parents joined CAFÉ this year. As a result of CAFÉ presentations, 100% of the applicants were granted residency status. Three parents were hired as Parent Leaders and contribute to the planning and coordination of these groups.

HIGHLIGHTS

The number of students served and number of programs offered at the health centers continues to grow. Events such as the "Breaking the Cycle of Violence" event and the annual health fair involve and draw large numbers of participants and attendees.

TVHC leveraged its Measure A allocation to obtain an addition $25,000 in matching funds from the Latino Community Foundation.

TRI-CITY HEALTH CENTER

GENERAL BUDGET STABILIZATION

FY 12/13 allocation: $300,000

Expended/encumbered in FY 12/13: $300,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health

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

Measure A clients served: NA (**Total clients**: 27,910)

Service area: Fremont, Hayward, Livermore, Newark, Pleasanton, Union City

MOWRY CLINIC

Board of Supervisors discretionary allocation: District 1/Supervisor Haggerty

FY 12/13 allocation: $33,000

Expended/encumbered in FY 12/13: $33,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health

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

Measure A clients served: 7,269 (**Total clients**: 22,364)

Service area: Fremont, Hayward, Livermore, Newark, Pleasanton, Union City

AGENCY/PROGRAM BACKGROUND

Tri-City Health Center (TCHC) is committed to delivering excellent health services in a caring, nurturing, and respectful atmosphere. TCHC works to promote optimal health, eliminate preventable diseases, and improve the quality of life for every individual and family in the community. TCHC provides a wide spectrum of health education, health care, and social services to everyone, without regard to financial position, ethnicity, language, culture, sexual orientation, or any other criteria. TCHC is a fiscally responsible, independent, not-for-profit community health center and a key member of the community's vital health safety net.

Tri-City Health Center received two Measure A allocations: one for general budget stabilization, and one specifically for the Mowry clinic.

MEASURE A FUNDING SUMMARY

General Budget Stabilization

TCHC used its general $300,000 Measure A allocation to achieve financial stability so that it can continue to provide quality primary health care for those in need.

Mowry Clinic

TCHC used a separate $33,000 Measure A allocation to purchase furnishings and equipment for its Mowry clinic. Items purchased included waiting room chairs, break room chairs, exam room tracks and curtains, and blood pressure/vitals equipment.

These upgrades helped the Mowry clinic see 7,269 unduplicated patients with a total of 23,743 visits in FY 12/13, compared to 3,374 unduplicated patients with 8,346 visits in FY 11/12.

HIGHLIGHTS

Mowry Clinic

The allocation of $33,000 provided needed minor renovations, furniture, and medical equipment for this clinic, providing improved access for clients with disabilities, extra examining rooms, and a treatment room. Clients have reported that the upgrades have resulted in a more pleasant and brighter environment.

The Mowry clinic serviced 7,269 unduplicated patients and increased the number of visits by approximately 15,000 year over year, compared to its goal of increasing visits by 4,000.

CONCERNS

General Budget Stabilization

TCHC describes the purpose of its $300,000 allocation as "budget stabilization." The Committee questions the use of Measure A money to address internal management issues.

FUNDS ALLOCATED BY THE ALAMEDA COUNTY BOARD OF SUPERVISORS

Group 4: Public Health

AIDS Providers (AIDS Healthcare Foundation, AIDS Project of the East Bay, East Bay AIDS Center)

Alameda Boys & Girls Club, Inc.

Alameda County Asthma Start

California Prevention & Education Project

California Product Stewardship Council

Center for Early Intervention on Deafness

Centerforce

City of San Leandro

Davis Street Family Resource Center

Deputy Sherriffs' Activity League/REACH Ashland Youth Center

Drivers for Survivors, Inc.

East Bay Korean American Senior Services Center

Eden Youth and Family Center

Environmental Health: Improve Field Sanitation Conditions/Nail Salons

Environmental Health: GPS Monitoring System

HIV Education & Prevention Project of Alameda County

Latino Commission on Alcohol and Drug Abuse

LifeLong Medical Care (Heart 2 Heart)

Office of AIDS Administration: Ryan White Providers

Public Health Prevention Initiative

Public Health Food Security/Food Justice Strategy

Public Health Pilot to Decrease Absenteeism in Schools

Senior Injury Prevention Program

Service Opportunity for Seniors (Meals on Wheels)

Spectrum Community Services, Inc.

SSI Housing Trust

Teleosis Institute

Urban Strategies Council, Inc.

Youth and Family Opportunity Initiatives

AIDS PROVIDERS (AIDS HEALTHCARE FOUNDATION, AIDS PROJECT OF THE EAST BAY, EAST BAY AIDS CENTER)

FY 12/13 allocation: $200,000

Expended/encumbered in FY 12/13: $150,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $50,000

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health, Mental Health, Substance Abuse

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

Measure A clients served: 90 unduplicated clients served, 148 clients enrolled in the program (**Total clients**: 35,716 unduplicated clients served, 47,910 clients enrolled)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

The Alameda County Health Care Services Agency (HCSA) administers the Health program of Alameda County (HealthPAC) to provide affordable health care to uninsured low-income people living in Alameda County.

As a subset of HealthPAC, the overall goal of the HealthPAC Specialty HIV/AIDS program is to successfully transition eligible patients who were receiving primary care and prescriptions under the federal Ryan White program into the Low Income Health Program (LIHP). This program allowed Counties to receive federal funding to expand services to populations eligible for coverage under health care reform beginning in January 2014. Alameda County's LIHP was called HealthPAC MCE and HCCI.

The program also ensured that HIV/AIDS clients in the HealthPAC MCE were automatically transitioned to Medi-Cal effective January 1, 2014 and that those in HealthPAC HCCI were eligible to enroll in coverage through Covered California. Although HealthPAC provides comprehensive services, it is not health insurance, so it was crucial that these clients got transitioned to Medi-Cal or Covered CA to ensure no interruptions in care and continuous medication access.

The following medical homes participated in the program:

- AIDS Healthcare Foundation
- East Bay AIDS Center
- AIDS Project of the East Bay

MEASURE A FUNDING SUMMARY

Measure A funds allowed the three medical homes to provide comprehensive health care and public health services to uninsured County residents living with HIV/AIDS. The funds specifically helped these clinics successfully transition from the federal Ryan White program to HealthPAC.

Specifically, Measure A funding helped the HealthPAC Specialty HIV/AIDS program achieve the following objectives:

- Ensure that 95% of LIHP-eligible patients dis-enrolled by ADA were successfully enrolled in HealthPAC within 90 days of being determined eligible for LIHP.
- Ensure that 95% of patients screened by an enrollment worker and then enrolled in LIHP had an outpatient medical visit (regardless of site) within 90 days of enrollment in LIHP.
- Ensure that 95% of patients enrolled in LIHP who were on antiretrovirals (ARVs) prior to LIHP enrollment had sufficient medication dispensed to cover at least 60 days within the three months after LIHP enrollment.

The program enrolled and transitioned 148 clients from Ryan White into HealthPAC MCE and HCCI and provided services to 90 unduplicated clients.

	HEALTHPAC ENROLLMENT			NUMBER OF UNDUPLICATED PATIENTS RECEIVING CARE
	MCE	HCCI	TOTAL	
AIDS Healthcare Foundation	48	3	51	49
AIDS Project of the East Bay	2	0	2	
East Bay AIDS Center	78	17	95	41
Total	**128**	**20**	**148**	**90**

HIGHLIGHTS

All of the providers met the program objectives, as confirmed via three site visits during the contract period.

CONCERNS

The HealthPAC program does not currently survey participants to determine if they were satisfied with the services they received.

ALAMEDA BOYS & GIRLS CLUB, INC.

FY 12/13 allocation: $25,000

Expended/encumbered in FY 12/13: $25,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health, Substance Abuse

Individuals served: Children, Low Income, Uninsured

Measure A clients served: 239 (**Total clients**: 2,388)

Service area: Alameda

AGENCY/PROGRAM BACKGROUND

Founded in 1949, the Alameda Boys & Girls Club provides high-impact, affordable youth development programs and services for over 60,000 youth, ages 6 through 18. The Club strives to inspire and enable all youth, especially those who need it the most, to realize their full potential as productive, responsible, and caring citizens. The Club offers a variety of life-enhancing and life-changing programs in the areas of health and fitness, education and technology, performing and visual arts, and leadership and life skills.

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

MEASURE A FUNDING SUMMARY

Measure A funds enabled the Alameda Boys & Girls Club to implement a health and wellness program to ensure that youth grow up healthy in body, mind, and spirit—in other words, a program that meets the needs of the "whole" child.

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

- Health clinic (dental and vision) and the breathmobile (respiratory) (target: 420 total participants, 105 Measure A-funded; actual: 429 total, 107 Measure A-funded)
- Small group life skills workshops and individual and family counseling (target: 360 total participants, 90 Measure A-funded; actual: 419 total, 105 Measure A-funded)
- Nutrition and healthy snacks program (target: 250 total participants, 63 Measure A-funded; actual: 256 total, 64 Measure A-funded)
- Sustainable garden program (target: 150 total participants, 38 Measure A-funded; actual: 165 total, 42 Measure A-funded)
- Gym fitness or outdoor recreational activities (target: 1,000 total participants, 250 Measure A-funded; actual: 1,410 total, 353 Measure A-funded)

HIGHLIGHTS

Observations, pre- and post- surveys, and participant journals reveal the following:

- Club kids serviced by the Health Clinic received beneficial vision, dental, and respiratory screenings and

treatment to improve their physical well-being. The dental clinic treated three emergency cases in FY 12/13, immediately after screening, which means these kids had severe dental issues that would have gone untreated for an unimaginable period of time. This improved health has decreased school absences.

- Children participating in life skills workshops and individual and family counseling demonstrated a decrease in confrontational incidents and improvement in pursuit of healthy lifestyles, such as not smoking and avoiding drugs and alcohol.
- Student participation in health, nutrition, and fitness programs reported an increase in stamina, better weight management, and higher energy levels. They influenced their parents and families to be more healthy and fit as well. Ninety-percent are now more active, have lost weight, and have more stamina and strength.

Alameda Boys & Girls club leveraged its Measure A allocation to obtain an additional $75,000 in matching funds from the Tobacco Settlement Fund.

ALAMEDA COUNTY ASTHMA START

FY 12/13 allocation: $100,000

Expended/encumbered in FY 12/13: $100,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

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

Measure A clients served: 46 (**Total clients**: 367)

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

AGENCY/PROGRAM BACKGROUND

A program of the Alameda County Public Health Department, Asthma Start provides in-home case management to families of children/adolescents with asthma. The program provides asthma education related to disease, symptoms, medication, and its use. The program develops a care plan for the family, inspects their home for asthma triggers, and teaches the family how to remediate them; advocates with landlords; and partners with Code Enforcement as needed to take care of identified issues around healthy homes. Families are given supplies to assist in managing their child's asthma such as pillow and mattress encasings, non-bleach-based mold cleaner,

Measure A Helps

ALAMEDA COUNTY ASTHMA START

Nan's three-year-old daughter Dee had visited the emergency room 10 times in six months with severe asthma symptoms. Connecting with Asthma Start provided Nan great relief. The Asthma Coordinator made sure Nan understood Dee's medications; she had not been giving them correctly. The Asthma Coordinator also called the pharmacy to transfer the prescriptions to a much closer pharmacy. The program spoke to Dee's doctor and clarified her care as mom had misunderstood the doctor, thinking she was to take Dee to Oakland from Livermore each time she wheezed, which was a hardship because they did not have a car. The family was followed for four months and during this time, Dee has not required any emergency room or urgent care visits.

vacuums, etc. Families are linked to any needed services such as food, housing, medical home, and insurance.

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

MEASURE A FUNDING SUMMARY

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

- Increase caregivers knowledge of asthma (target: 90% of caregiver passing an asthma post-test with a score of 90% or better; actual: 98% of caregivers)
- Help children maintain or reduce asthma symptoms to the lowest level (target: 95% of children; actual: 99%)
- Help caregivers reduce at least one identified asthma trigger (target: 95% of caregivers; actual: 100%)
- Reduce the number of children requiring hospital or emergency department visits post-case management (target: 20% or less of children; actual: 3%)
- Increase caregiver confidence in managing their child's asthma (target: 95% of caregivers reporting increased confidence; actual: 100%)

Measure A Helps

ALAMEDA COUNTY ASTHMA START

Zach, 4, was referred to Asthma Start after being diagnosed with asthma with symptoms including severe coughing and shortness of breath. Zach was taking a controller and allergy medication. The Asthma Coordinator worked with Dad to get Zach's medications organized. At the home, the corner near the fireplace had mold, the fireplace had no flue, the stove fan needed a cover, and the heater contained fiberglass. Asthma Start referred the case to Healthy Homes, who put in a fan over the stove and worked with the landlord to fix the fireplace and heater. The family received dust-mite mattress and pillow covers as well as a vacuum. Zach is now doing much better and has not had any recent symptoms.

HIGHLIGHTS

Asthma Start served 367 children/adolescents in FY 12/13, 100 more than in any other year of the program. Measure A funding helped enable the program to meet or exceed all of its target objectives.

The effectiveness of this program is evident in the reduction of hospitalizations from 32% prior to case management to 3% post-case management, and emergency department visits from 56% prior to case management to 13% post.

In addition, the Asthma Start program leveraged its Measure A allocation to obtain $36,300 in matching funds from the following sources:

- Every Child Counts
- Kaiser Community Benefit
- Targeted Case Management

CALIFORNIA PREVENTION & EDUCATION PROJECT

FY 12/13 allocation: $250,000

Expended/encumbered in FY 12/13: $250,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

Individuals served: Adults, Low Income

Measure A clients served: NA* (**Total clients**: NA*)

Service area: Oakland

**Recipient provided no services during the FY 12/13 reporting period*

AGENCY/PROGRAM BACKGROUND

The California Prevention & Education Project (CAL-PEP) was founded in 1984 and is nationally recognized for its effective approaches to working with hard-to-reach, high-risk populations. CAL-PEP works in East and West Oakland, as well as other communities throughout Alameda and San Francisco Counties, to serve those who have limited access to health care. CAL-PEP has assisted in pioneering effective prevention strategies in street outreach and mobile HIV/AIDS, sexually transmitted disease (STD), and hepatitis testing. CAL-PEP provides accessible health education, disease prevention, risk reduction, and support services to people at high risk for or currently living with HIV/AIDS.

MEASURE A FUNDING SUMMARY

CAL-PEP will use its Measure A allocation to purchase a mobile clinic vehicle. Once the medical van is in use, the program will provide family planning services and STD testing and treatment to underserved areas in East and West Oakland. The clinic will also address issues of stigma many people in these areas face when seeking treatment, especially for STDs.

During the FY 12/13 reporting period, CAL-PEP identified the mobile clinic vehicle for purchase and bought some equipment and medical supplies. CAL-PEP expected to start services in August 2013.

CALIFORNIA PRODUCT STEWARDSHIP COUNCIL

Board of Supervisors discretionary allocation: District 4/Supervisor Miley

FY 12/13 allocation: $22,000

Expended/encumbered in FY 12/13: $22,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

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

Measure A clients served: NA* (**Total clients**: NA*)

Service area: Countywide

**Recipient does not provide direct services*

AGENCY/PROGRAM BACKGROUND

California Product Stewardship Council (CPSC) works to shift California's product waste management system from one focused on government-funded and ratepayer-financed waste diversion to one that relies primarily on producer responsibility to reduce public costs and drive improvements in product design that promote environmental sustainability.

MEASURE A FUNDING SUMMARY

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

- **Monitor legislation and policy relevant to pharmaceuticals, pharmaceutical take-back, and drug disposal at the state and federal level.** CPSC monitored federal, state, and local legislation and reported to County staff on what was happening in other areas regarding safe medication disposal rules.
- **Educate local hospitals on the Alameda Drug Ordinance.** CPSC organized and participated in a webinar hosted by the Center for Environmental Health for the Northern California hospital group to ensure they understood the ordinance and its benefits to public health, encouraging rollout of the program.
- **Set up and organize a national call to create a sustainable hospital group on education and understanding of the Alameda Drug Ordinance.** CPSC presented on two national webinars on the subject of medication disposal and discussed organization of a national hospital group. There is not enough activity nationally to support such a working group at this time.
- **Organize Sacramento stakeholder meetings to support the implementation of the ordinance.** A site visit is planned for fall 2014.
- **Organize a national call to engage stakeholders regarding the progress and gather support for the ordinance.** CPSC participated in two national calls and presented at the northwest conference of Hazardous Materials Managers on the Alameda medication ordinance and the need to coordinate efforts between counties considering the same.
- **Coordinate with radio and other media outlets about press coverage, including developing articles and op-eds to bring awareness of the ordinance and press release development and support.** CPSC reviewed an op-ed and made corrections to one published in June by a UC Berkeley student in the paper. CPSC was co-

lead finalizing the joint press release with King County Washington and the Product Stewardship Institute.

- **Develop outreach material messaging as requested by the County, including a fact sheet about the ordinance.** CPSC completed the fact sheet on the ordinance development and updated it to include new information about the ruling in the Ninth Circuit Court.
- **Provide assistance and support as requested by County in responding to challenges of the ordinance.** CPSC compiled data and facilitated communication efforts to respond to local challenges by the Sierra Club regarding the fact that the medications once collected are incinerated.
- **Attend and participate in the Alameda County Medical Disposal (MEDS) coalition meetings and program rollout meetings as requested by the County.** CPSC participated in all the MEDS coalition meetings either in person or via conference, presenting updates on legislation, data, and future presentations and connections.
- **Assist and provide input for the Safe Drug Disposal Conference.** CPSC participated in the planning, arranged speakers, and conducted a presentation at the conference.
- **Participate in other research, education, and outreach projects requested by the County to assist in the purposes set forth above.** CPSC responded to a variety of requests during the grant term, including contacting legislators from other states to coordinate support from the National Association of Counties for safe medication disposal across the country, posting to social media, coordinating with professors from Georgia to get funding for more research on the benefits of ordinances like Alameda's, and meeting with new product developers of medication disposal bins.

CONCERNS

CPSC used its Measure A funding to implement a County ordinance promoting the safe disposal of medications for all residents. The Committee questions whether this meets the letter or spirit of the Measure A statute. CPSC used these funds as part of a public awareness campaign that was not limited to "indigent, low-income, and uninsured adults, children, families, and seniors of Alameda County." While the Committee does not question the usefulness of the safe medication disposal ordinance, the use of Measure A funds for this purpose appears to fall outside the scope of the statute.

In addition, the provider included no specific measurements or statistics to indicate the effectiveness of the public awareness campaign.

CENTER FOR EARLY INTERVENTION ON DEAFNESS

FY 12/13 allocation: $50,000

Expended/encumbered in FY 12/13: $50,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

Individuals served: Children, Families, Indigent, Low Income

Measure A clients served: 857 (**Total clients**: 1,475)

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

AGENCY/PROGRAM BACKGROUND

The Center for Early Intervention on Deafness (CEID) provides a wide range of services and supports for families to maximize the communication potential of children, from birth through 5, who are deaf, are hard of hearing, and/or have severe speech and language delays.

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

MEASURE A FUNDING SUMMARY

Measure A funding helped enable CEID staff (two part-time audiologists, one part-time hearing screening specialist, one full-time bilingual audiology coordinator, and one part-time bilingual audiology assistant) to provide services five days per week by appointment and through referrals from medical providers.

Measure A Helps

CENTER FOR EARLY INTERVENTION ON DEAFNESS

Freddy began to lose hearing in both ears around age 2. His family did not have enough money for two hearing aids. When Freddy came to CEID for preschool, he had lost almost all hearing in both ears, and his one hearing aid was not programmed to his current level of hearing loss. When Freddy was referred to the CEID audiology clinic, the audiologist reprogrammed Freddy's one hearing aid and provided a loaner for the other ear. As an active preschooler, Freddy was rough on his hearing aid, breaking the tubing, separating the ear mold, etc. Instead of waiting days or weeks to get an appointment, he could walk across the courtyard and have it repaired the same day.

Measure A funding helped CEID provide the following services:

- Newborn hearing screenings (target: 135 patients; actual: 139)
- Audiological evaluations (target: 392 patients; actual: 265)
- Hearing aids and molds (target: 230 patients; actual: 289)
- Hearing screenings/Head Start (target: 122 patients; actual: 93)
- Training for pediatric residents (target: 78 residents; actual: 71)

HIGHLIGHTS

In areas of newborn hearing screenings and hearing aids and molds, CEID exceeded its target numbers in providing services. CEID served a large number of patients overall.

In addition, CEID leveraged its Measure A allocation to obtain an additional $25,000 in matching funds (the maximum possible) from the Medi-Cal Administrative Activities (MAA) program.

CONCERNS

CEID reports that 58% of patients were treated using Measure A funds. However, Measure A funds represent only 2.5% of the agency's total budget and only 18% of the budget allocated to performance of services. The Committee would like some clarification about this discrepancy.

CENTERFORCE

FY 12/13 allocation: $14,992

Expended/encumbered in FY 12/13: $14,992

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

Individuals served: Adults, Indigent, Low Income, Uninsured

Measure A clients served: NA* (**Total clients**: NA*)

Service area: NA*

**Recipient does not provide direct services*

AGENCY/PROGRAM BACKGROUND

Centerforce supports, educates, and advocates for individuals, families, and communities impacted by incarceration. Centerforce partners with state prisons, county jails, law enforcement, and social service and medical providers to reach over 20,000 individuals annually. Headquartered at San Quentin, Centerforce provides direct services in Santa Rita Jail and four state prisons as well as direct services to communities and families of the incarcerated in Oakland, San Francisco, the Bay Area counties, and Fresno and Madera counties.

MEASURE A FUNDING SUMMARY

Centerforce used its Measure A allocation to conduct focus groups with incarcerated and formerly incarcerated people, as well as individual interviews with hepatitis C care providers. With this funding, Centerforce was able to discover information about the Hepatitis C services available to indigent populations in Alameda County as well as awareness of these services.

Specifically, Centerforce conducted five focus groups with 52 participants total: 35 inside Santa Rita Jail (10 men and 25 women) and 17 on the outside (five men and 12 women). Centerforce also interviewed 13 community health clinicians or program directors (seven M.D.s, one nurse practitioner, one physician's assistant, four program directors) representing 14 different agencies/entities.

HIGHLIGHTS

As a result of this assessment, Centerforce was able to successfully compete for funding to provide Hepatitis C testing, treatment, and care services to men and women transitioning back to Alameda County from incarcerated settings. Centerforce leveraged its Measure A allocation to obtain $200,000 in matching funds from an Alameda County Public Health Innovations grant (Innovations in Reentry).

CONCERNS

The Committee notes that the organization does not list any accomplishments and is unsure of the connection between the purpose of Measure A and the services this organization provides. While the organization lists a $200,000 matching grant, Centerforce used Measure A funds to conduct focus groups with incarcerated and formerly incarcerated people and did not provide direct health services.

CITY OF SAN LEANDRO

FY 12/13 allocation: $50,000

Expended/encumbered in FY 12/13: $50,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

Individuals served: Seniors

Measure A clients served: 9,426 (**Total clients**: 67,806)

Service area: San Leandro, San Lorenzo

AGENCY/PROGRAM BACKGROUND

The City of San Leandro offers a wide range of activities, services, and resources for seniors. Within the city, the Recreation and Human Services Department strongly emphasizes the importance of health and wellness. Programs are designed to foster healthy independent living, educate the public about how they can achieve

improved health and wellness, enhance quality of life, and build a sense of belonging and community among older adults, caregivers, and families.

MEASURE A FUNDING SUMMARY

Measure A funding has supported the City of San Leandro in offering programs, services, and education that are aimed at prevention and improving health outcomes. The opening of the new Senior Community Center combined with the additional support of Measure A has significantly impacted the opportunities afforded to the local senior population.

Prior to opening the Senior Community Center, the Senior Services staff was significantly reduced through budget cuts. Although the Senior Community Center has been thriving since opening in April, it has been a challenge to operate the facility and grow programs with limited staff. The additional part-time staff provided by the Measure A grant have allowed Recreation and Human Services to maintain quality senior services, grow programs, and continue to offer critical health and wellness services to San Leandro seniors.

Measure A funding supports a comprehensive health and wellness framework by allowing the City of San Leandro to offer the following critical programs to seniors. The City of San Leandro set an attendance objective of 50% of Senior Community Center members participate in programs and services formulated to promote health and wellness. Specific target and actual numbers are as follows:

- Health Checks—Blood pressure checks and flu shot clinics (target: 360; actual: 576 blood pressure checks, 311 flu shot clinics)
- Mercy Brown Bag program—Grocery bag of nutritional food, twice monthly, to eligible seniors (target: 576; actual: 579)
- Pull Up a Chair exercise class (target: 720 participants; actual: 1,005)
- Fall prevention class (target: 3,600 participants; actual: 6,955)
- Health education classes (target: 6 classes; actual: 11)

HIGHLIGHTS

Participation in health services and screenings represented a 160% increase over the original objective, supporting service to 9,426 additional seniors.

DAVIS STREET FAMILY RESOURCE CENTER

FY 12/13 allocation: $100,000

Expended/encumbered in FY 12/13: $100,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Public Health

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

Measure A clients served: 12,263 (**Total clients**: 37,161)

Service area: Ashland, Castro Valley, Cherryland, Hayward, Oakland, San Leandro, San Lorenzo, Homeless or transient

AGENCY/PROGRAM BACKGROUND

The Davis Street Family Resource Center (DSFRC) helps low-income people in the Eden area and its surrounding communities improve their quality of life with short- and long-term assistance. For over 40 years, DSFRC has provided "just in time" services to working poor families, supporting single mothers and fathers to move out of poverty through safety net programs and by caring for nearly 1,200 children each day. DSFRC safety net programs include an emergency food and clothing program; information and referral; and a free and low-cost medical, dental, and mental health clinic.

MEASURE A FUNDING SUMMARY

DSFRC used its Measure A allocation to hire a clinical supervisor and part-time family advocate, providing a reliable fiscal stream to expand and strengthen its outpatient mental health program. These funds enabled DSFRC to offer the necessary supervision, training, program evaluation, and planning for eight mental health interns who were placed in five San Leandro Unified School District schools. The interns provided family and individual counseling and assessment to 130 low-income and underinsured/uninsured clients, who otherwise would not have accessed mental health services either due to long waiting lists, cost, or other barriers.

Measure A Helps

DAVIS STREET FAMILY RESOURCE CENTER

A tragedy four days before Christmas led Susan to DSFRC, after her two school-age nieces arrived home from school to find that their mother had passed. Susan appealed to Davis Street's mental health staff for toys and a holiday basket for her nieces. Although the toys and baskets had been allocated, staff was able to fulfill Susan's request and worked to integrate supportive services that included assistance in obtaining legal guardianship and mental health services. Susan's nieces began receiving services in the outpatient mental health clinic and continue to work through their grief one day at a time. Today, Susan's eldest niece actively participates in a youth development program and is an honor roll student.

Measure A funding helped DSFRC achieve the following measurable objectives:

- **Health services**. Full integration of uninsured and underinsured clients who currently access acute, primary

care, physical therapy, dental, and mental health services (target: 1,225 clients)
  - Provided access to all DSFRC services to 2,083 clients
  - Provided family, individual counseling, and assessment to Medi-Cal clients through ACCESS to 165 clients
  - Provided low-cost individual and family counseling to 130 clients
  - Provided case management to ensure access to all services to 2,083 clients
- **Family support services**. Full integration of clients who currently access the DSFRC emergency food and clothing program (target: 2,100 clients)
  - Provided access to all DSFRC services to 35,078 clients, including 24,713 receiving food and 10,365 receiving clothing items
  - Provided 2,822 grocery bags filled with fresh vegetables, canned goods, whole grains, and protein to 8,466 households, twice per month
  - Provided clothing and household items to 3,491 households once per month
  - Provide eligibility screening to seven clients and enrolled five clients into the Kaiser Child Health Plan

HIGHLIGHTS

The 2,083 uninsured and underinsured clients served in the DSFRC medical and mental health programs represent an increase of 70% over the target number. The 35,078 clients receiving food and clothing items represent an increase of 1,670% over the target goal.

DEPUTY SHERIFFS' ACTIVITY LEAGUE REACH/ASHLAND YOUTH CENTER

FY 12/13 allocation: $20,000

Expended/encumbered in FY 12/13: $20,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health

Individuals served: Children, Families, Low Income, Uninsured

Measure A clients served: 150 (**Total clients**: 1,000)

Service area: Ashland, San Lorenzo

AGENCY/PROGRAM BACKGROUND

REACH Ashland Youth Center (AYC) honors youth power and builds community resilience. REACH AYC is committed to creating a culture of safety, belonging, and possibility that cultivates equity and happiness—in families, in community, and beyond.

REACH AYC works in partnership with the Alameda County Deputy Sheriffs' Activities League (DSAL) to provide recreation programming to young people in the unincorporated Ashland and San Lorenzo areas of Alameda County.

MEASURE A FUNDING SUMMARY

The DSAL and REACH AYC used their Measure A allocation to achieve the following objectives:

- **Create a menu of fitness and recreation programs for each of the three zones: Bohannon Middle, Edendale Middle, and Washington Manor Middle.** In a four-month period, all three middle school locations had a specific recreation component designed, comprised of boxing conditioning, yoga, volleyball, strength and fitness, hip-hop dance, and talk-it-out/walk-it-out.
- **Coordinate all coaches/volunteer leaders to run each program/class.**
- **Enroll youth into the activities so that each program has participants who are most local to that particular zone.** One hundred fifty members enrolled across school sites, including 40 girls in volleyball, 50 in basketball, 30 in dance, and 45 in boxing.
- **Conduct pre-assessments with all new participants and post-program assessments.** The surveys revealed that programming improved the attitudes of 90% of participants toward fitness programs. It also enhanced the confidence of 85% of participants to try new things and take part in sports activities.
- **Maintain regular contact with participants and their families to ensure ongoing participation and satisfaction with the programming.** DSAL's community organizer checked in with youth and families on a regular basis via phone calls and emails. Approximately 10 email blasts went out to families about additional health and safety resources available to them.
- **Increase awareness of healthy food and other resources for health and safety in the community.** One hundred community members attended a spaghetti feed where food was prepared with healthy ingredients. The fair featured six community resource tables disseminating information from resources including the library, drug awareness organizations, the Hayward Area Recreation and Park District, and the food bank.

HIGHLIGHTS

The DSAL and REACH AYC leveraged their Measure A allocation to obtain $355,000 in matching funds.

DRIVERS FOR SURVIVORS, INC.

Board of Supervisors discretionary allocation: District 1/Supervisor Haggerty

FY 12/13 allocation: $15,000

Expended/encumbered in FY 12/13: $15,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Hospital Inpatient, Hospital Outpatient, Public Health

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

Measure A clients served: 1,110 (Total clients: 1,110)

Service area: Fremont, Newark, Union City

AGENCY/PROGRAM BACKGROUND

Drivers for Survivors provides free transportation service and supportive companionship for ambulatory cancer patients in Fremont, Newark, and Union City. Drivers for Survivors ensures that those in need of oncology-related appointments can access essential health and treatment services.

MEASURE A FUNDING SUMMARY

Measure A Funds enabled Drivers for Survivors to launch its program. Drivers for Survivors used its Measure A allocation to produce and distribute appropriate amounts of outreach materials that matched its size.

These materials include brochures distributed to a wide range of hospitals and medical centers throughout the Bay Area, as well as volunteer packets and client packets distributed to all new clients and volunteer drivers. Drivers for Survivors created and distributed packets to 1,250 patients at a cost of $2.00 each.

Measure A Helps

DRIVERS FOR SURVIVORS, INC.

Katherine, age 90, volunteered at the Kaiser Permanente Fremont Medical Center until a few years ago. Katherine doesn't drive, so a doctor at Kaiser recommended Drivers for Survivors as a way to get to her weekly oncology appointments. She lives three miles from the hospital and had no other viable options. "Most of my friends have passed away, and the others have canes or medical problems," she said. Since August, a Drivers for Survivors volunteer has been providing weekly transportation for Katherine. The driver waits at the hospital and then drives her home again. Katherine sums up her experience with Drivers for Survivors: "It's so wonderful. They absolutely remove the worry and concern of going to my appointments."

HIGHLIGHTS

Measure A funding helped Drivers for Survivors surpass its goal of providing 1,000 client rides over a 10-month period (actual: 1,110 rides provided). Client surveys report 100% client satisfaction and an 85% "excellent" rating for on-time arrival.

EAST BAY KOREAN AMERICAN SENIOR SERVICES CENTER

Board of Supervisors discretionary allocation: District 5/Supervisor Carson

FY 12/13 allocation: $10,000

Expended/encumbered in FY 12/13: $10,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health

Individuals served: Adults, Seniors, Low Income, Uninsured

Measure A clients served: 125 (**Total clients**: 125)

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

AGENCY/PROGRAM BACKGROUND

East Bay Korean American Senior Services Center provides a hot and nutritious ethnic lunch for seniors five days a week throughout year. The Center also offers preventive health care and education, such as physical exercise, line dance, yoga, meditation, fall prevention, and nutritional education, to support the physical and mental health of the seniors and reduce their medical expenses. Finally, the Center helps seniors obtain and manage social services including Medicare, Medi-Cal, in-home support services (IHSS), Social Security disability insurance (SSI), Cash Assistance Program for Immigrants (CAPI), general assistance, and more, and provides translation and interpretation of English documents into Korean.

The Center provides an information respite center for spouses and caregivers of dementia patients. By attending the Center together, the caregivers can enjoy a social experience while the rest of the group helps watch out and care for the dementia patient.

MEASURE A FUNDING SUMMARY

East Bay Korean American Senior Services Center used its Measure A allocation to install new flooring in its multipurpose room, social room, and office. This one-time capital improvement helped ensure that senior clients can participate in all the activities the Center offers.

Measure A Helps

EAST BAY KOREAN AMERICAN SENIOR SERVICES CENTER

As one example of the care seniors at the Center receive, the Executive Director noticed one woman's complexion was very yellow and talked to the woman about her condition. This prompted the woman to visit her doctor, who discovered that the woman had a blocked carotid artery and needed surgery right away. Now she is healthy and does lots of volunteer work in the Center kitchen. In another example, a male senior got very sick at the Center, with vomiting and diarrhea. While other seniors helped clean him up, the Executive Director called 911 for an ambulance. It turned out the man had a bad case of food poisoning, but was back rejoining the activities at the Center the next day.

HIGHLIGHTS

Before replacing the floor, Center staff had concerns that a senior might be caught by the tears in the floor and fall down. The new floor alleviates that worry and allows seniors who may otherwise not have an opportunity to socialize among their own culture to fully enjoy meals and entertainment.

CONCERNS

The Committee notes that the provider did not mention how many meals it served during the year, and that it provided services for a total of 125 clients. This seems like a low number.

EDEN YOUTH AND FAMILY CENTER

FY 12/13 allocation: $150,000

Expended/encumbered in FY 12/13: $150,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health, Mental Health, Substance Abuse

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

Measure A clients served: 393 (**Total clients**: 40,000)

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

AGENCY/PROGRAM BACKGROUND

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

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

To increase its effectiveness in serving children, youth, and families, EYFC familiarized itself with programmatic resources offered by other agencies and created partnerships within the communities it serves. EYFC partners and links with public and private community organizations to ensure public and mental health resources are available for children, youth, and families to improve the delivery of services. EYFC is currently in contact with several school districts, youth organizations, and employers on a regular basis.

EYFC partnerships include the following:

- The Children's Hospital & Research Center Oakland Center for Child Protection offers a full range of medical and mental health services to children and adolescents impacted by abuse and/or exposure to violence.
- The California Offender Program Services is a diversion program that offers classes to address offenders who are minors.
- The Community Alliance for Special Education provides individual technical assistance, consultations, representation, and training through their network of educational and legal specialists.
- The Hayward Community School provides educational opportunities for 40-50 referred students, ages 12-17 years, whose behavior prevents their success in a regular school setting.
- The Silva Pediatric Medical Clinic is a pediatric primary health care clinic serving the residents of Hayward and surrounding communities.
- The La Familia Counseling Service family advocate provides families with insurance information and application assistance for Medi-Cal through additional partner clinics.
- The Tiburcio Vasquez Health Center mental health worker provides the Hayward Community School students with mental health assessments, treatment and rehabilitation services, consultation with staff at mental health agencies, and clinical supervision of the mental health staff and its administrative services.

Measure A Helps

EDEN YOUTH AND FAMILY CENTER

When he came to EYFC, a young man was very socially withdrawn and not enthusiastic about working on digital projects or mentoring youth. He had an interest in engineering, but was not planning on attending college or volunteering. The youth's father, uncle, and brother – not to mention most of his friends – were involved in gangs. He often got into fights with people deemed as rivals. At EYFC, he slowly began to open up socially. He joined the media team and helped create a short anti-drug film. Through EYFC's youth education and employment program, he is now employed at a local college. He participated in several health-related workshops and expressed how big of a difference the program made on him.

MEASURE A FUNDING SUMMARY

EYFC used its Measure A allocation to support implementation of a youth program expansion plan and a financial sustainability plan to address the *Employment and Support Services to High-Risk Youth* and the *3-Year EYFC Business Model for Sustaining Youth Programs.*

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

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

- 104 at-risk youth completed a series of five, three-hour workshops related to career and employability competency to improve behavioral health in terms of intrinsic motivation, locus of control, and self-esteem.
- 104 youth obtained paid work experience opportunities year-round that matched their interests and aptitudes to improve connections to peers, adults, and community members.
- 90 youth obtained educational support services related to academic tutoring, GED preparation and testing,

career coaching, financial aid advice, and scholarship opportunities.
- 100 youth engaged with access to high-end video, graphic, web design, music production, and film production tools.
- 129 youth participated in four peer-support group counseling sessions, laser removal treatments, community service, education, and career planning, which resulted in youth making healthier life choices as they distanced themselves from past gang and substance use involvement.
- 60 preschool children (infants, toddlers, preschoolers) engaged in a diversified set of curriculum that strengthened the children's opportunities for success in life.

HIGHLIGHTS

EYFC leveraged its Measure A allocation to obtain $372,800 in matching funds from the following grant contracts:
- Alameda County Probation Department (Evening Reporting Center): $150,000
- Alameda County Social Services (Summer and Afterschool Youth Employment Program): $172,800
- Kaiser Permanente (New Start Tattoo Removal Program): $50,000

ENVIRONMENTAL HEALTH: IMPROVE FIELD SANITATION CONDITIONS/NAIL SALONS

FY 12/13 allocation: $50,000

Expended/encumbered in FY 12/13: $12,681*

Amount carried over to FY 13/14: $37,319

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

Individuals served: Adults, Low Income

Measure A clients served: 357 (**Total clients**: 357)

Service area: Alameda, Berkeley, Oakland, San Leandro

**This program got started late and was not expected to complete work program until 12/31/13. The budget was not fully expended at the time the recipient submitted its report.*

AGENCY/PROGRAM BACKGROUND

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

The Alameda County Environmental Health Department (ACEH) created a Healthy Nail Salon Recognition HNSR) program and technician certification with the California Healthy Nail Salon Collaborative. ACEH researched issues, program models, and industry practices; did outreach; developed standards and forms;

trained owners and workers; performed audits; and began recognizing the first salons. Healthy Nail Salons are required to use safer products and practices that help protect worker health and create a safer environment for clients and the surrounding community.

While the outreach and education associated with the HNSR program are geared toward nail salon workers and owners, the program helps prevent exposure to chemicals to the unborn via mothers' exposure in the workplace. It also helps prevent second-hand exposure to children via contaminants brought by workers from workplace to home on their work clothing.

The HNSR program achieves its goals through the following activities:

- Identifying the most problematic nail salon products and processes so that salon workers know where the highest risks are and where the highest priorities are to seek alternatives
- Identifying preferable products and practices for improved worker, client, and community safety
- Identifying reliable information sources for salon workers
- Offering a rebate to cover all or most of the cost of purchasing and installing approved air purification equipment for work stations
- Providing a tool (recognition certificate and use of logo) to salons to promote themselves as Healthy Nail Salons
- Providing a way for public/clients to identify salons with healthier products and practices
- Issuing training certificates for workers so that their new knowledge is documented and transferable to new positions

MEASURE A FUNDING SUMMARY

ACEH used its Measure A allocation to achieve the following:

- HNSR program development
  - Learn technical/toxics issues and industry sector materials and practices
  - Recruit program partners and establish local advisory work group
  - Identify program models and appropriate standards for recognition
  - Develop training curriculum for nail salon owners and workers
  - Engage culturally competent staff and outside resources
  - Set up forms and tracking mechanisms
  - Work with the California Healthy Nail Salon Collaborative and Asian Health Services to do outreach to members, direct mail, workshops, and media outreach
  - Participate in regional government work group to gain information from compliance agencies and other local HNSR programs and to share lessons learned
- Provide training for salons
  - Offer workshops for interested salon owners or managers considering applying
  - Provide onsite worker training for employees

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

- Notify over 330 Alameda County nail salons about the HNSR program by mail, and notify an additional 35 Alameda County salons that are members of the CA Healthy Nail Salon Collaborative through the Collaborative
- Provide workshop training to 22 salon owners and managers
- Receive applications from 16 salons for HNSR recognition
- Train 30 workers at salons or at owner workshops

- Replace over 75% of nail polish products at seven salons with safer formulations

HIGHLIGHTS

With a very small budget and less than half expended, the report notes that 357 clients were served.

CONCERNS

While the number of clients served given the small budget is impressive, the Committee notes that of the 357 salons contacted and invited to the workshop, only 22 salon owners and five workers actually attended the workshops—an extremely low percentage compared to the invitees.

ENVIRONMENTAL HEALTH: GPS MONITORING SYSTEM

FY 12/13 allocation: $150,000

Expended/encumbered in FY 12/13: $125,807

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $24,193

Types of services provided: Public Health

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

Measure A clients served: NA* (**Total clients**: NA*)

Service area: Countywide

**Recipient does not provide direct services*

AGENCY/PROGRAM BACKGROUND

The Alameda County Environmental Health Department (EHD) supports the health, safety, and well-being of the public through promotion of environmental quality. EHD uses enforcement authority, education, and cooperation to promote awareness of environmental protection, environmental justice, and pollution prevention.

The EHD mobile food placarding program incorporates GPS surveillance and other tools to help ensure a safer food supply for all consumers of food sold by mobile food operations in Alameda County. Identifying which trucks are operating improperly through field inspections and then posting placards encourages the mobile food operators to make the necessary changes so their food is safer. Safer food reduces the incidence of illness from food trucks.

MEASURE A FUNDING SUMMARY

EHD used its Measure A allocation to help develop a Mobile Food Facility (MFF) placarding program as an augmentation to the existing food vehicle compliance program, which is charged with monitoring and regulating mobile food vendors. Specific tasks performed include the following:

- Identify which mobile units are active and update the EHD database with this information
- Identify methods for tracking mobile units to allow for more effective surveillance of legal and illegal food trucks in the field, including gathering data from other jurisdictions that use GPS and other methods, identifying legal issues related to using GPS, and identifying possible GPS providers
- Meet and collaborate with other local jurisdictions to develop a more complete picture of the mobile food industry in the Bay Area and to monitor and permit mobile units that cross county lines
- Notify all Alameda County mobile food operators and commissaries of the placarding program and facilitate community meetings with the operators
- Institute an expanded field inspection system for the mobile food trucks so that placards are issued based on actual operational performance of the vehicle
- Develop educational outreach tools, written guidelines, and inspection forms that accommodate placarding
- Develop customized red, yellow, and green placards for mobile food facilities similar to those issued at fixed food facilities
- Conduct ongoing trainings for EHD field inspection staff on mobile food facility inspections, placarding, and uploading inspection results to the EHD database

Thanks in part to its Measure A funding, EHD achieved the following measurable results:
- Sent two mass mailing letters to 334 truck operators and 119 commissaries to advise them of the coming placarding of the food vehicles
- Inspected 170 mobile food vehicles in the field and/or at the office for structural and operational requirements
- Closed 10 mobile food trucks for noncompliance, all of which were reopened upon achieving compliance
- Provided consultation to an average of five clients per day either by phone or drop-in visit to educate the client on requirements to operate in a safe and compliant manner, and on the placarding program

CONCERNS

Neither the food truck owners nor the customers who receive their services can be clearly identified as indigent, low-income, or uninsured. The Committee expresses a concern that these services, while worthwhile, have no relation to the original intent for distribution of Measure A funds.

The Committee also notes that the amount of Measure A funding spent on salaries and administrative costs far exceeds the amount spent on actual program costs, but the agency does not give any explanation of the benefit achieved by these expenditures.

Finally, the agency does not account for the approximately $15,000 left unspent from its Measure A allocation.

Given these concerns, the Committee recommends that this agency not receive Measure A funding in the future.

HIV EDUCATION & PREVENTION PROJECT OF ALAMEDA COUNTY

Board of Supervisors discretionary allocation: District 3/Supervisor Chan, District 4/Supervisor Miley, District 5/Supervisor Carson

FY 12/13 allocation: $35,000

Expended/encumbered in FY 12/13: $35,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Emergency Medical, Public Health, Substance Abuse

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

Measure A clients served: 536 (**Total clients**: 1,284)

Service area: Alameda, Hayward, Oakland, San Leandro, Homeless or transient, Outside of Alameda County

AGENCY/PROGRAM BACKGROUND

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

HEPPAC clients can conveniently access free drop in services that are client-centered and low threshold. The HEPPAC clinical staff are highly skilled and provide safer injection trainings, conduct overdose prevention trainings, and distribute life-saving Narcan to intravenous drug user (IDU) clients receiving wound care services through the clinic. Clients have reduced the mortality and morbidity related to active substance use as a result of these services.

MEASURE A FUNDING SUMMARY

Measure A has contributed to improving the overall health results of HEPPAC's client population by providing critical wound care and clinical services to extremely low income, marginalized active injection drug users and high-risk youth and young adults engaging in unprotected sex with multiple partners who generally do not access traditional hospital and clinic settings.

Measure A Helps

HIV EDUCATION & PREVENTION PROJECT OF ALAMEDA COUNTY

Ms. M. was homeless when she first accessed HEPPAC clinic services. Through a referral to a shelter, she was able to receive housing. Ms. M. was a substance user who refused to go to a traditional medical facility because of stigma and poor treatment. She did not have a primary care physician. Through risk-reduction counseling at HEPPAC, Ms. M. reported a reduction in use. In addition, Ms. M. tested positive and was subsequently treated for chlamydia. Ms. M. was also tested and referred into primary care services for Hepatitis C (HCV). Because of Ms. M.'s resistance to medical services at traditional clinics, she would not have accessed support and would not have gotten treatment if not for HEPPAC.

Measure A-funded services conducted by HEPPAC include the following:

- Testing and treatment for sexually transmitted infections to youth and young adults primarily residing in East Oakland
- Abscess/wound care to people who inject drugs
- Overdose prevention education and Narcan distribution
- Safer injection trainings for active IDUs
- General health screenings for County residents who are homeless and at least 13 years of age

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

- Perform abscess/wound care services at the Casa Segura site (target: 200 IDU visits, 50 unduplicated IDUs; actual: 417 IDU visits, 228 unduplicated IDUs)
- Perform abscess/wound care follow-up services at HEPPAC's syringe exchange program (SEP) locations (target: 300 IDUs, including 80 at Casa Segura site; actual: 326 IDUs, 127 at Casa Segura site)
- Refer clients from HEPPAC SEPs to Casa Segura for STI, HIV, and/or HCV rapid testing, and provide treatment for those who test positive for chlamydia and/or gonorrhea at the Casa Segura drop-in center (target: 100 client referrals; actual: 119 client referrals)
- Refer IDUs and/or their sexual partners who test positive for HIV and/or HCV to primary care services as needed (actual: 140 referrals)
- Conduct Safer Injection workshops and Overdose Prevention training to all wound care patients during syringe access hours and at the Casa Segura drop-in center (actual: 56 Safer Injection workshops with 98 participants, 34 Overdose Prevention trainings with 38 participants)

LATINO COMMISSION ON ALCOHOL AND DRUG ABUSE

FY 12/13 allocation: $150,000

Expended/encumbered in FY 12/13: $150,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Substance Abuse

Individuals served: Children, Families, Indigent, Low Income

Measure A clients served: 806 (**Total clients**: 806)

Service area: Oakland

AGENCY/PROGRAM BACKGROUND

The Latino Commission on Alcohol and Drug Abuse of Alameda County provides education, prevention, intervention, and treatment of alcohol- and drug-related problems through multi-modality, culturally, and linguistically appropriate programs and services. The agency has been providing services to the population of Alameda County for almost 43 years through six major components.

Centro de Juventud is a youth center dedicated to the prevention of the use of drugs and alcohol by youth between the ages of 7–18 years. Centro de Juventud is a project of the Latino Commission on Alcohol and Drug

Abuse of Alameda County and was created to address the issues prevalent in the community, including the high incidence of drug abuse and the high mortality rates from heroin use in the Latino community. Centro de Juventud is a threefold program:

- A youth center that provides after-school activities. The program provides homework assistance, tutoring, prevention education, and social and recreational activities for youth between the ages of 6 and 18.
- A parent and families component that provides information, education, referrals and services as needed, alcohol and drug education, parenting education, and supportive services.
- On-campus support services to World and Achieve School, Manzanita School, and the Oakland Military Institute. The services provided include English literacy, individual tutoring, reading assistance, translation and interpretation services, science tutoring, and other services as requested by teachers and other school officials.

Since its inception, Centro de Juventud has continually conducted community assessments to identify and address the ever-changing needs of a community in transition. The staff of Centro de Juventud participates in yearly ongoing staff trainings to deepen their cultural competency skills. Centro serves clients from many Latin American nations (predominantly Mexico, Puerto Rico, Cuba, Guatemala, Honduras, and El Salvador), and training focuses on appreciating the differing styles and needs of sub-groups within the Latino population based on geographic regions (country of origin), socioeconomic status, and indigenous status.

Measure A Helps

LATINO COMMISSION ON ALCOHOL AND DRUG ABUSE

A Mexican family who immigrated to the U.S. has had many problems regarding their children's education. Of the four children, three have attended Centro de Juventud at one time or another, two on a regular basis. Their mother says, "I'm so grateful for Centro staff. If not for their efforts, my daughter could have lost a year in school. Staff have made every effort to speak to teachers and the principal to find out how to help my daughter succeed." The mother said that Centro has had other positive outcomes in their lives such as being able to navigate systems of care, being aware of their children's school progress, and showing their children positive activities and healthy relationships.

MEASURE A FUNDING SUMMARY

The Latino Commission on Alcohol and Drug Abuse Centro de Juventud used its Measure A allocation to achieve the following objectives:

- Provided services to 473 unduplicated children and youth at both the Centro and school sites, and family support services to over 300 family members.
- Provided mediation and school system navigation support services to parents, including translation to 76 unduplicated parents at parent/teacher conferences and assistance with school enrollment forms and the enrollment process to approximately 22 parents.
- Provided 888 hours of direct on-campus support at World and Achieve Schools, including 534 hours of English and science tutoring to 50 unduplicated youth and English literacy/skill development to 18 unduplicated youth at World and Achieve. In addition, staff provided individual tutoring and assistance to approximately 40 unduplicated students with special and behavioral problems.
- Provided 191 hours of English and science tutoring to approximately 100 students at Manzanita School. In

addition, Centro staff provided reading assistance and support to 75 youth.

- Provided 163 hours of services including translation, interpretation, and tutoring as well as alcohol and drug presentations to parents, students, and staff at Oakland Military Institute.
- Provided case management support, including intake and assessment, service planning, direct support, evaluation, and a maximum of three sessions per client, to a total of 240 youth and/or families facing multiple challenges.
- Assessed and referred 62 families to health services
- Assessed and referred 56 families with young children to immunization services.
- Assisted and referred two homeless individuals to detox services.
- Provided a total of 1,051 free summer lunches and 2,365 summer lunch program snacks to youth.
- Provided assistance to a minimum of 115 low-income residents in applying for health coverage through Medi-Cal and other available options.
- Conducted a community needs assessment to document the services available to the community.
- Conducted a forum to collect information about services available to the community.
- Developed and disseminated a community resource directory that focuses on community substance abuse, mental health, and family services.
- Provided written reports that document the number of youth and parents served each quarter.

HIGHLIGHTS

In addition to services provided, the Latino Commission on Alcohol and Drug Abuse Centro de Juventud leveraged its Measure A allocation to obtain $68,865 in matching funds from the following sources:

- Noel Gallo, City Council Office District 5: $25,000
- Cash contributions: $12,475
- In-kind donations/contributions: $31,390

LIFELONG MEDICAL CARE: HEART 2 HEART

FY 12/13 allocation: $100,000

Expended/encumbered in FY 12/13: $100,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health, Other: Community Engagement and Empowerment

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

Measure A clients served: NA* (**Total clients**: NA*)

Service area: Berkeley

**Recipient offers a place-based program, so does not record client numbers*

AGENCY/PROGRAM BACKGROUND

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

The LifeLong Heart 2 Heart (H2H) program works to achieve the following:
- Foster advocacy efforts to address community priorities
- Support community efforts to build strong networks among neighbors
- Engage residents in activities to promote healthier behaviors
- Increase the social and environmental supports for healthier behavior

MEASURE A FUNDING SUMMARY

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

Foster Advocacy Efforts to Address Community Priorities

- **Coordinate grassroots advocacy skill-building workshops.** An H2H resident planned and presented a Healthy Conductor workshop to help people become more accountable for their own health. The training included a video on African-American risks for stroke and heart attack and steps individuals and communities can adopt to reduce risk.
- **Assist in organizing community meetings to bring together city departments and/or elected officials and neighbors to share successes and priorities.** Over 75 residents mingled with city leaders, rekindled friendships, and made new friends at the Spring Block Party, a collaboration of LifeLong and the City of Berkeley Public Health Department (COB-PH). H2H and COB-PH offered glucose, HIV, and dental health screenings as well eligibility screening for food stamps and health insurance. A presentation and Q&A about the Affordable Care Act provided residents the opportunity to increase their understanding of health insurance options and identify next steps.
- **Distribute mini-grants to support advocacy efforts.** H2H awarded the following mini-grants:
  - Twinkle Little Stars program: $2,700. This program is a social etiquette program designed to improve,

enhance, and preserve the social skills of underserved young women between the ages of 6-18. The workshop served 32 youth and met for two hours per week over eight consecutive Saturdays.

- McGee Avenue Baptist Church: $2,100. This mini-grant helped the church expand its Backyard Garden Program to construct and maintain seven new Backyard Gardens for seniors and low-income residents in the H2H neighborhood. The Backyard Garden Program offers youth-led training for young parents and the elderly on organic gardening and healthy eating, as well as cooking demonstrations for heart-healthy meals.
- Collaborating Agencies Responding to Disasters (CARD): $2,700. This mini-grant enabled CARD to provide a series of classes for the H2H community to promote empowering, sustainable disaster preparedness and response. (Note: Due to staff changes at CARD, the agency did not implement the classes.)

Support Community Efforts to Build Strong Networks Among Neighbors

- **Collaborate with the fire department, schools, COB-PH, and community-based organizations (CBOs) to provide disaster preparedness education to the H2H community including parents and students.** H2H conducted disaster preparedness training at San Pablo Park in Berkeley, including valve shut-off and emergency kit preparation. H2H also held ongoing meetings at Oregon Park to develop an application for an emergency cache.
- **Support neighbor-led projects, workshops, and classes in collaboration with public health.** A group of neighbors who came together last year in conjunction with a mini-grant project have continued to meet regularly to plan neighborhood improvement efforts such as a neighborhood watch program.
- **Reconnect with the Spanish-speaking population in H2H neighborhood.** The program held one bilingual workshop in conjunction with Farm Fresh Choice, educating residents about healthy eating, smart food choices, and the CalFresh program. H2H volunteers also conducted door-to-door surveys with tenants at a housing complex in the neighborhood where the majority of the tenants are Spanish-speaking.

Engage Residents in Activities to Promote Healthier Behaviors

- **Organize produce distribution and at least two cooking classes in conjunction with local food justice and community gardening organizations.** Weekly fresh produce giveaways continue at the LifeLong West Berkeley and LifeLong Over 60 Health Center sites, adjacent to the H2H neighborhood, under the auspices of the AmeriCorps volunteers and in partnership with various local farmers' market programs. Other food justice activities include the following:
  - The six-week Cooking Matters, presented twice to a total of 20 participants, teaches families how to cook healthy, affordable meals. Participants learn to shop smarter, make healthier food choices, and cook delicious meals. Food for these series is provided through another funding source.
  - In partnership with the Ecology Center, the Fruit/Vegetable Rx Program features a medical provider who gives patients a "prescription" for fresh produce, redeemable at the local farmers market, as well as healthy cooking tips and nutrition counseling.
  - At a CalFresh food giveaway at Oregon Park Apartments, approximately 15 residents in attendance received fresh produce giveaways, provided by Farm Fresh Choice.
  - An "It's Time for Recess" event held at the Young Adult Project (YAP) in honor of National Food Day brought neighbors together to share successes and identify priorities in an informal "health fair" atmosphere.
  - The Harvest Celebration at Oregon Park provided healthy Mediterranean food to nearly 30 people joining in the celebration.
- **Offer health education workshops based on community requests, including healthy cooking, meditation, health insurance info, and other topics.** In collaboration with COB-PH, H2H offered a series

of 13 healthy eating workshops, with an average attendance of ten. H2H also held health education workshops in the community, including a blood pressure screening training workshop, and monthly informal trainings held on the City of Berkeley (COB)'s mobile van, which parks in the H2H neighborhood one Saturday per month.

Increase the Social and Environmental Supports for Healthier Behavior

- **Collaborate with other partners to establish "Health Hubs."** H2H and COB-PH staff, accompanied by volunteers, visit neighborhood barbershops a least once per month to support the barbers, provide information on hypertension and nutrition, make referrals for health and social service resources, and answer health-related questions.
- **Assist in the coordination of door-to-door neighborhood visits.** H2H conducted one door-to-door blood pressure screening event, in which every household was approached by Alameda County Health Pipeline Partnerships (ACHPP) EMS Corps, with additional support from two nurses.
- **Provide "benefit check-ups" at H2H events.** At virtually all H2H events, eligibility experts screen residents for a variety of benefits, including health insurance and CalFresh. In addition, online benefits check-ups are available for seniors. The program screened a total of 45 individuals.

CONCERNS

The Committee notes that this fund recipient spent 78% of the funds on 1.18 FTE staff and administrative overhead, and only 22% on direct services. Of the services provided, much of that was "community empowerment" and "community mobility" (including "social etiquette")—the recipient report was not clear about specific outcomes. Finally, it appears that what was spent on direct services calculates out to about $190/target household. It is unclear what impact, if any, that had or could have on the Measure A target population.

While recognizing that the expenditures on fresh food programs and improving eating habits do conform to the intent of Measure A, and while recognizing the value of disaster-preparedness and neighborhood watch programs, the Committee questions whether these latter programs meet the requirements of Measure A.

OFFICE OF AIDS ADMINISTRATION: RYAN WHITE PROVIDERS

FY 12/13 allocation: $100,000

Expended/encumbered in FY 12/13: $100,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Hospital Outpatient, Public Health, Mental Health, Substance Abuse

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

Measure A clients served: 1,898 (**Total clients**: 1,898)

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

AGENCY/PROGRAM BACKGROUND

The Alameda County Public Health Department works in partnership with the community to ensure the optimal health and well-being of all people through a dynamic and responsive process respecting the diversity of the community and providing for present and future generations. Within the Public Health Department, the Office of AIDS Administration (OAA) works to reduce the rates of new HIV infections, increase the number of County residents who know their HIV status earlier through HIV testing, and link individuals who are positive into care.

OAA released a Request for Applications (RFA) to agencies already receiving Ryan White program dollars to serve low-income clients living with HIV/AIDS. The purpose was to support quality improvement (QI) activities related to transferring clients into the Low Income Health Plan (LIHP) in preparation for health care reform. Samples QI activities include the following:

- Production and/or translation of materials for monolingual clients
- Retention of consultant services for QI-related work
- Ensuring that client data collection is accurate, complete, and up-to-date
- Development of "standing orders" for efficient delivery of health care for clients across the patient spectrum
- Development of performance measures to track outcomes of client care
- Evaluating and responding to client satisfaction
- Tracking linkage to care, client referrals, or client no-show rates

Measure A Helps

PROJECT OPEN HAND (POH)

POH organized focus groups for clients living with HIV to understand how receiving food from POH affects them. Overwhelming feedback from the focus groups indicated that improved food security and health impacts are the main impact of POH. One male client said, "You know you have food for the next day," while another client talked about how his income falls below the poverty line and he subsidizes his normal grocery shopping with POH food. A female client shared an inspiring story: Before coming to POH, she was having a problem with diabetes; now, she has gotten her diabetes under control and does not need to take medication. She attributed that change to the healthy groceries she receives from POH.

- Development of protocols for seamlessly transferring clients to other agencies

The Ryan White providers receiving funding under the OAA RFA include the following:
- AIDS Project of the East Bay
- Allen Temple Health and Social Services
- Facente Consulting
- La Clínica de la Raza
- LifeLong Medical
- Project Open Hand
- Tri-City Health Center

MEASURE A FUNDING SUMMARY

AIDS Project of the East Bay

AIDS Project of the East Bay (APEB) used its Measure A allocation to achieve the following:
- Install a server for Medisoft, the agency's electronic health record (EHR) system
- Complete the programming of the system
- Develop standing orders for primary medical care

These improvements have allowed APEB to increase patient tracking for better medical care and continuity of care, as well as decrease medical errors.

Allen Temple Health and Social Services

Allen Temple Health and Social Services used its Measure A allocation to achieve the following:
- Develop tools to improve program participation in agency programs. Allen Temple conducted an assessment of client needs that resulted in the creation of a resource card listing all of the agency's health and social services. Allen Template also developed a tracking system to more accurately count the participation in the programs offered.
- Create a Healthy Food Policy and develop a program enrollment package. Allen Temple consulted a registered dietitian to develop a food and nutrition policy and set healthy guidelines for all meals prepared onsite, and created a program packet to collect intake information for new clients.
- Conduct a satisfaction survey for clients currently receiving service (target: 50% client completion; actual: 52% completion).

Measure A funding has helped improved lives by increasing client access to additional services such as CalFresh and Medi-Cal onsite enrollments, and through the offering of expanded nutrition education services provided by peer leaders trained in the CalFresh curriculum.

Facente Consulting

Facente Consulting used its Measure A allocation to conduct a needs assessment of HIV-positive clients in the Oakland Transitional Grant Area to guide the HIV service priorities and funding allocation process for Ryan White program funds. This assessment focused on four goals:
- Mapping service locations and investigating the distance clients must travel to access HIV services
- Examining the impact of the LIHP on consumers of HIV services and consumer awareness of the health care changes resulting from the Affordable Health Care Act

- Assessing the needs of HIV-positive heterosexual men in Alameda and Contra Costa Counties, including identifying disparities in accessing services
- Exploring the incidence of intimate partner violence and its impact on HIV incidence, prevalence, and outcomes

For each focus goal, the needs assessment included recommendations based on the findings. Facente made these recommendations in hopes of increasing the quality of service, and ultimately improving outcomes, for HIV-positive individuals.

La Clínica de La Raza

La Clínica used its Measure A allocation to achieve the following:
- Enter and monitor accurate and complete patient data in the i2i Tracks HIV patient registry database (target: 5 months of data for 50 patients; actual: 6 months of data for over 50 patients)
- Develop and approve a set of HIV care and treatment standing orders for use in Family Medicine
- Complete and approve a procedure for tracking external referrals given to HIV patients

This project has increased the capacity of the panel managers in Family Medicine, as a newly established panel manager assistant is now in place to support an existing panel manager focusing on other chronic diseases. Standing orders allow medical and panel management assistants to work at the top of their licenses in coordinating care as part of a care team. Finally, documenting the referral process in writing enables staff across all sites, including but not limited to Family Medicine, to ensure that the loop is closed on referrals.

La Clínica's services contribute to improved outcomes for people living with HIV/AIDS by engaging clients, making services more comprehensive when the client is there for an appointment, and making referrals to external providers much simpler.

Via i2iTracks population management, panel managers track patients and establish individual relationships. If/when a client misses an appointment; the panel manager calls the patient to follow-up, check in on what is going on in the client's life, and re-engage the patient in care as much as possible. As a result of panel management efforts, 100% of clients are retained in care as evidenced by having had a viral load test in the past 12 months.

LifeLong Medical

LifeLong utilized Measure A funds to transition from LAB TRACKER to NextGen. For many years, the HIV health care team at LifeLong Berkeley Primary Care utilized LAB TRACKER HIV, an HIV-specific EHR. LAB TRACKER HIV was an essential tool for managing patient care, collecting and reporting Ryan White program data, and tracking progress towards program objectives. As LifeLong moved to utilizing NextGen for all patient types, the functionalities to appropriately manage and continually improve HIV care had to be transitioned into NextGen.

Specifically, LifeLong used its Measure A allocation to achieve the following:
- Monitor the impact of the LIHP transition on patient care patterns. LifeLong collected and used data to monitor various measures that identify and address adverse impacts on access, retention in care, and clinical outcomes.
- Utilize the NextGen EHR to facilitate evidence-based care and continuously improve HIV medical and case management care. LifeLong created customized templates/protocols within NextGen to ensure HIV-positive clients receiving medical care are given timely diagnostic tests and follow-up care, and that HIV-positive

clients receiving case management services are given timely diagnostic tests and follow-up care. Over the coming months, the team will finalize exactly how to track each measure within the NextGen system, enabling auto-population/integration of data from the "visit notes" and lab modules of the system to the greatest extent possible.

Through the use of health information technology, such as the former LAB TRACKER tool and now NextGen EHR, LifeLong's HIV care team can systematically monitor how well they are addressing the needs of their clients and ensure care is delivered based upon evidence-based guidelines. As a result, clients are far more likely to receive the care they need in a timely manner and therefore experience positive health outcomes and a better quality of life.

Project Open Hand

Project Open Hand (POH) used its Measure A allocation to conduct focus groups to identify seven performance measures to track health outcomes of HIV-positive consumers in the agency's nutrition program.

Tri-City Health Center

Tri-City Health Center used its Measure A allocation to achieve the following:

- Track HIV patient appointments by accurate, newly implemented standing orders (target: 50% of clients; actual: 100%)
- Contact clients who have not shown up for a scheduled appointment to reschedule their visit (target: 85%; actual: 72%)
- Provide results and follow-up appointments to patients with scheduled tests/standing orders (target: 100%; actual: 75%)

Tri-City Health Center is in the process of implementing a comprehensive patient-centered health home model of care that focuses on building care teams, coordinating care transitions both inside and outside the clinic, and implementing health IT tools to facilitate this change.

Tri-City uses daily huddles to identify patients with a high no-show rate. These daily huddles (with chart reminders) also provide a means to address outstanding health maintenance screenings, such as hepatitis and pneumococcal vaccinations; syphilis screenings; and cervical, breast, and colon cancer screenings. Coupling two proactive strategies, one aimed at bringing the no-show rate down and another targeting health maintenance, helps positively influence health outcomes for clients.

Measure A Helps

TRI-CITY HEALTH CENTER

A young transgender woman was about to fall out of care. The Tri-City Early Intervention Services Linkage Coordinator, in conjunction with the TransVision staff, contacted the client to schedule a medical appointment. During the appointment, the RN Primary Care Coordinator found active syphilis. After syphilis treatment, he discovered that the client had been noncompliant with her HIV medication and using methamphetamines. Adherence counseling and harm reduction helped her get back on medication and to break her methamphetamine addiction. Front desk and clinical staff helped keep the client in care by rescheduling follow-up appointments and contacting her after a no-show. After two appointments, the client showed a reduced viral load, gained 40 pounds, and stated she had stopped using methamphetamines.

PUBLIC HEALTH PREVENTION INITIATIVE

FY 12/13 allocation: $2,784,000

Expended/encumbered in FY 12/13: $2,783,635

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $365

Types of services provided: Emergency Medical, Hospital Outpatient, Public Health, Mental Health

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

Measure A clients served: 77,022 (**Total clients**: 124,233)

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

AGENCY/PROGRAM BACKGROUND

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

The Measure A Prevention Initiative aims to reduce health disparities via three priority areas:
- Chronic Disease & Injury Prevention
- Health Inequities & Community Capacity-Building
- Obesity Prevention & School Health

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

These priority areas encompass the following programs.

Chronic Disease & Injury Prevention

- **Asthma Start**. Provides in-home case management to families of children/adolescents with asthma, including asthma education and a care plan for the family.
- **Diabetes**. Provides self-management education to adults with type 2 diabetes, including classes, a support group, and a monthly newsletter.
- **Dental Health - MCAH**. Implements the Alameda County Strategic Plan for Oral Health 2012-2017, including increasing access to dental care for pregnant women and providing elementary school-based services.
- **Project New Start**. Provides free tattoo removal services, support service linkage, mentoring, and guidance and support to at-risk, adjudicated, or formerly gang-involved youth and young adults.
- **EMS (City of Fremont)**. Provides access to health resources and guidance to low-income, frail, primarily homebound, Afghan elders.
- **EMS (Pipeline)**. Manages pipeline projects to increase the participation of youth by catering to health career interests and needs of these student populations.

Health Inequities & Community Capacity-Building

- **FHS Help Me Grow**. Aims to make developmental screening universal for young children in pediatric sites, to ultimately improve the early identification of developmental concerns in young children.
- **FHS Reproductive Justice Campaign**. Trains Alameda County Public Health Clearinghouse staff on best practices for providing unbiased, nonjudgmental, and supportive information and referrals for women's health and pregnancy-related services.
- **CAPE (Community Assessment, Planning, Education, and Evaluation)**. Supports community capacity-building in the Hoover Historic District in West Oakland and in Sobrante Park through partnerships with community organizations focused on health, education, and violence prevention.
- **Community Nursing.** Works with the Street Level Health Project to provide healthy physical recreation, allow participants to develop support relationships with other community members and service providers, and provide food assistance service.
- **Immunization Registry**. Recruits health care providers to join the California Immunization Registry program (CAIR) in Alameda County and provides training and technical assistance on registry use
- **HIV Prevention**. Provides critical wound care and clinical services to extremely low income marginalized active users and high-risk youth and young adults engaging in unprotected sex with multiple partners.

Obesity Prevention & School Health

- **Nutrition Services**. Works to improve food access in Oakland through involvement with the East Oakland Boxing Association (EOBA), the HOPE Collaborative, and other providers and programs.
- **Community-Designed Initiatives**. Provides scholarships to enable people to become yoga instructors through the Niroga Institute; provides case management, referrals, and parent education, nutrition, and cooking classes through Lotus Bloom; and offers vegetable gardening, community garden tours, and urban "greening" education sessions through Mandela Market.

MEASURE A FUNDING SUMMARY

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

Chronic Disease & Injury Prevention

Asthma Start

- Serve 367 children/adolescents, 100 more than in any other year.
- Reduce emergency department visits and hospitalizations, decreasing medical costs by as much as 53%.
- Secure medical homes, insurance, and medications for 100% of the children/adolescents in the program.
- Reduce hospitalizations from 32% prior to case management to 3% post case management, and emergency department visits from 56% prior to case management to 13% post.
- In partnership with Oakland Code Enforcement (CE), develop mold brochures explaining what mold is, how it can affect a person's health, who is responsible for what when it comes to mold, and how to remediate it.
- Partner with the District Attorney (DA) so that the DA can refer families impacted by asthma-related truancy directly to Asthma Start.
- Increase caregiver knowledge of asthma so that 98% pass a post-test with a score of 90% or better.
- Enable 99% of children/adolescents to maintain or reduce asthma symptoms to the lowest level.
- Support 100% of caregivers to reduce at least one identified asthma trigger

Diabetes

- Reduce A1c, a test that shows how well a person is controlling his or her diabetes, in 83% of clients (target: 75%).
- Reduce blood pressure in 77% of clients (target: 50%).
- Reduce weight in 85% of clients reduced their weight (target: 75%).
- Increase physical activity among 74% of clients (target: 50%).
- Achieve 80% of clients starting to read food labels, count carbohydrates, and practice portion control (target: 80%).
- Provide 16 hours of self-management education to adults throughout the County in English, Spanish, Hindi, Punjabi, Urdu, Farsi, and Cantonese.
- Serve approximately 400 clients per year in a local support group upon completing the 8-week education program.
- Distribute a monthly newsletter to over 300 past participants per month, informing them about diabetes news, diabetes-friendly recipes, the support group schedule, and more.

Measure A Helps

DIABETES

Christina, a member of the Oakland class, says, "I almost cried when I got my first A1c test result. I knew it would not be good, but fourteen? The first meeting of the Diabetes Support Group, I wanted to run away and cry. But, I stayed. I learned how to make a meal plan, and about exercise, and how important fiber is to a diabetic. I learned diabetes can be controlled, and I didn't have to be so afraid. When I read my next A1c test result, I did cry! My A1c had dropped from 14 to 8.5! My numbers would not have changed so dramatically were it not for the caring and expert instructions of my Diabetes Coach!"

Dental Health - MCAH

- Provide comprehensive services to students at nine schools in Hayward and Oakland.
- Implement a plan to increase access to dental care for pregnant women.
- Provide services including dental screening/examinations, fluoride, and dental sealant applications to 1,350 students at 12 school-based dental programs (target: 1,300 students).
- Perform dental screenings and follow-up case management services to 213 students and fluoride and sealant applications to 72 students through the dental program at Madison Middle School Health Center (target: 50 students).
- Convene sustainability workgroups overseeing the collaborative work of La Clínica de la Raza, LifeLong, and Asian Health Services with Oakland Unified School District (OUSD) to provide school-based dental service, resulting in, for example, screenings performed for 2,009 students in total, Asian Health Services treating over 141 students at Franklin Elementary School, and La Clínica providing screenings to 1,080 students and preventive service to 1,265 students in Hayward.

Project New Start

- Partner at least 75–90 youth per year formerly involved gang youth with sponsoring agencies committed to supporting each youth's lifestyle change.
- Conduct 24 no-cost tattoo removal clinics providing 1,500–2,000 treatments for very high risk youth, of whom 75% are underinsured or uninsured.
- Achieve a 60% rate of youth returning to the program for tattoo removal treatments, completing community service hours, maintaining mentorship relationships, and either enrolling in school or a GED program or completing a job training program and finding employment.

EMS (City of Fremont)

- Conduct 432 Health Promoter home visits to 128 clients (target: 250 home visits to 85 clients).
- Providing services including health education and socialization to 128 Afghans (target: 100).
- Provide regular care from a primary care physician to 128 clients (target: 90).
- Conduct 15 home evaluations (target: 85; home safety check list underwent revision).
- Refer 30 clients to City of Fremont case management and/or counseling services (target: 35; only 30 in need of referral).
- Provide 112 clients eligibility assistance and support to access supportive services (target: 85).
- Support 69 clients to access other community services (target: 50).
- Complete Wellness Screen for 27 clients (target: 80; model was changed after 27).
- Develop a Wellness Action Plan for 27 clients (target: 40; model was changed after 27).
- Have 26 clients participate in their Action Plan (target: 30).
- Have 16 clients show improvement after six months (target: 30).
- Provide 124 medication review, education, and counseling sessions (target: 40).
- Have 177 clients show an increased knowledge of their medication (target: 40).
- Have 45 clients identified as having deficits in medication compliance improve their compliance within six months (target: 30).
- Train three Health Promoters to lead Chronic Disease Self-Management Program (CDSMP) classes (target: 3).
- Offer one 15-hour CDSMP class (target: 1).
- Have 23 Afghans participate in CDSMP class (target: 15).
- Have 17 participants show an increase in their ability to manage chronic conditions (target: 12).
- Offer two six-week diabetes classes (target: 1).
- Have 40 participants attend the diabetes class (target: 5–10).
- Conduct exercise and yoga classes; sessions on weight management, osteoporosis, vitamins, colon cancer, hemorrhoids, and more; and sessions led by a physical therapist on dizziness and falls prevention, pain management, anxiety and depression, aging and senior health, relaxation techniques, and more.
- Enroll 25 clients in partnership with the City of Fremont's Mobile Mental Health team.
- Conduct an 8-week diabetes class in Farsi.
- Conduct two levels of ESL classes.

EMS (Pipeline)

- Support approximately 800 youth into Pipeline programs.
- Based on post-survey, have 100% of Pipeline programs express that Alameda County Health Pipeline

Measure A Helps

PROJECT NEW START

When Lawrence came to the program, he was living in a halfway house for formerly incarcerated young adults battling substance abuse issues. He sought tattoo removal and a lifestyle change as a path to move away from gangs and a criminal past. Although Lawrence was filled with guilt and shame, he knew that if he was going to be successful that it was going to start with tattoo removal. Today, Lawrence, age 24, is still receiving tattoo removal, working as a substance abuse counselor in a halfway house, interning at the San Francisco General Hospital's psychiatric unit, and attending San Francisco State University full-time working toward a BA/BS in Psychology and holding a 3.9 GPA.

Partnership (ACHPP) had increased communication between them and other Pipeline programs.
- Increase the number of programs referring students to other ACHPP programs by 50% from the prior year.
- Through the ACHPP mini-grant program, provide 78 young men of color (YMOC) program participants services including paid internships, career exposure, and mentors.
- Convene eight meetings of ACHPP steering committee members, partners, and stakeholders.
- Increase six of the 10 services offered to Alameda County youth.
- Facilitate coalition meetings with an average of 12 Pipeline program directors in attendance; 16 partner meetings; over a dozen meetings with health industry, education, and policy representatives; a strategic retreat for program directors; and a stakeholder convening with over 50 participants in the health industry and education.
- Co-host the Health Industry Consultancy in April 2013 with Oakland Unified School District's College and Career Readiness Office.
- Document 48 student referrals into Pipeline programs; 20 between Model Neighborhood Program, Health Career Connections, Biotech Partners, and CHAMPS; eight into MIMS; and 20 into EMS Corps.

Measure A Helps

FHS HELP ME GROW (HMG)

Thirty-one-month-old Diego was screened in his pediatrician's office with the ASQ. Diego scored in the monitoring zone in Communication, and his mother expressed concerns about his development. The pediatrician referred Diego's family to HMG. HMG supported Diego's family through the evaluation process, where Diego was found to be 35% delayed in language development. HMG and Diego's pediatrician referred him to a private speech therapy clinic and supported Mom to get Diego's hearing checked. Mom reports that Diego is speaking more clearly and has a larger vocabulary. She is still concerned and plans to use HMG to secure an evaluation from her local school district when Diego turns three.

Health Inequities & Community Capacity-Building

FHS Help Me Grow (HMG)

- Increase the number of individual practice sites participating in the HMG Pediatric Strategies program to 37.
- Increase the number of low-income, Medi-Cal, or uninsured children screened at ages 9, 1, and 24 months using standardized screening tools; identify and refer those at risk for developmental delay.
- Identify children with special health care needs and facilitate appropriate referrals to CCS and other programs.
- Increase access to primary and specialty care for low-income, Medi-Cal, or uninsured children through education, training, and support to pediatric sites serving these children.
- Enable pediatric health care professionals and parents to act as partners in the "medical home" to coordinate all medical services and community supports necessary to achieve maximum potential for the child.
- Recruit and train new Alameda County pediatricians in early childhood mental health and developmental screening.
- Assist Child Health & Disability Prevention (CHDP) providers with developing business practices to incorporate early childhood developmental and mental health screening into well-child exam appointments.
- Distribute medical home materials designed specifically for Alameda County CHDP providers to all practice sites, distribute materials to explain health policy changes affecting children and assist providers in navigating

those changes, and produce medical home fax/email blasts to keep providers abreast of changes in service systems and community resources.

FHS Reproductive Justice Campaign

- Through Maternal Paternal Child and Adolescent Health (MPCAH), organize a social marketing campaign to encourage young women in Alameda County to call the Public Health Clearinghouse for information about where to get high-quality, low-cost, or free women's health services, including pregnancy tests and prenatal care.
- Bring about a 5% increase in calls to the Clearinghouse following the bus shelter campaign that reached over 12 million Alameda County residents.
- Distribute over 2,000 pregnancy test kits through home visiting providers, health educators, and community-based organizations.

CAPE (Community Assessment, Planning, Education, and Evaluation)

- Gather 100+ Sobrante Park community residents to gain information and present testimony to the City of Oakland Planning Commission on how they would be impacted by locating a crematorium in close proximity.
- Conduct Sobrante Park Resident Action Council (RAC)/Neighborhood Crime Prevention Council (NCPC) meetings monthly, with an average attendance of 42 residents attending each meeting.
- Put on several multicultural community events hosted by the RAC, including a Christmas La Posada and Kwanzaa Celebration attended by 225 people, a Martin Luther King, Jr. Day event attended by 80, and an Earth Day event attended by 75.
- Have Sobrante Park Time Banking (SPTB), in partnership with the Sobrante Park Leadership Council (SPLC), plan and host its 6th Annual Time Banking Health Fair, attended by an estimated 500 people who received free health screenings, health promotion, and information about community activities.
- Support an annual total of 2,258 service hour exchanges among community residents.
- Through RAC leadership, bring 17 Sobrante Park residents to the City of Oakland Responding to Disasters (CORE) program.
- Support the West Oakland Health and Safety Collaborative (WOHSC) to work with the City of Oakland to plan a six-session community-building and violence prevention program.
- Manage resident-led Hoover Elementary School Parent Teachers Council (PTC) activities including weekly meetings and an end-of-the-year Holiday Community Dinner attended by approximately 200 community residents.
- Through the PTC and WOHSC, coordinate an annual health fair with approximately 150 participants.
- Through the West Oakland Mini-Grant committee (WOMGC), award $30,000 for 22 mini-grants, ranging in size from $400-$2,000, for projects including youth sports, development, and recreation; nutrition education; cultural awareness; community history; and senior activities.
- Award mini-grants to support several large community-wide events including the Black & Brown Family Reunion and Juneteenth Festival, attended by approximately 200 people; the Safe N Sane Halloween Party & Health Festival, attended by 100; and a Martin Luther King, Jr. Day event involving 40 organizations and attended by 1,110.
- Through the Youth West Oakland Young Adult Mini-Grant Committee (YWOMC), fund one $1,500 application from the McClymond's High School Youth Organizing and Leadership Opportunities Program for the "Pass the Peace" festival.
- Support residents in recruiting their neighbors to participate in disaster preparedness training and preventing burglary workshops.
- Offer intensive trainings to encourage dialog, understanding, and appreciation of differences and the ability to

work together to solve common problems, attended by 55 residents.

Community Nursing

- Provide healthy physical recreation, food assistance services, and access to life counseling and resource support for 12–17 participants, three times per week.
- Participate in five health fairs, providing health screenings, health education, and information to about 1,500 attendees.
- Attend 48 community meetings to discuss health-related matters affecting families in the West Oakland neighborhood.
- Collaborate with Berkeley Unified School District (BUSD) to develop and implement a coordinated, multi-agency, service delivery model (universal, early prevention, intervention) that links students, families, and school staff to needed resources.
- Provide referral and case management services, including assistance in navigating the health care system and other social services, to approximately 300–700 medically uninsured immigrants.
- Provide Hepatitis B education, screening, vaccination, and chronic infection counseling to approximately 400 Asian and Latino/Hispanic individuals with limited access/no access to health care and limited English proficiency.
- Distribute flyers, newspapers, and brochures in Chinese, Vietnamese, Korean, Mongolian, Spanish, and English.
- With BUSD, conduct a total of 11 trainings at staff meetings on the topics of allergies/Epi-pen, seizure disorders, and medication administration.
- Provide over 135 health consultations to BUSD staff and families covering topics such as vision, food allergies/Epi-pen, BUSD medication policy, and resources and referrals for emotional/behavioral/mental health issues.
- Participate in 15 504/IEP/SST meetings with school staff and families.
- Conduct seven public health nurse family visits.
- Provide dental screening to 1,129 students and sealants to over 120 students.
- Conduct 33 health education classes to sixty 7th and 8th graders at West Oakland Middle School on topics such as alcohol, tobacco, and other drugs; mental health; nutrition; and more.
- Provide a total of 1,656 student encounters in the Madison Health Center for medical, dental, health education, and first aid services.
- Partner with Nutrition Services and the Madison Peer Educators to conduct one Heart Health Workshop held at Madison Middle School with 35 adults attending.

Immunization Registry

- Provide education and support contributing to 40 providers/medical groups meeting the Stage 1 Meaningful Use attestation requirement for the Medicare and Medicaid EHR Incentive program.
- Send out over 3,600 recall postcards reminding patients they are due for their immunizations.

Measure A Helps

COMMUNITY NURSING

A participant was injured in a car accident, resulting in limited mobility and muscular pain. She had been advised to get regular exercise and lose weight. After learning of the no-cost services at the Street Level Health Project, she began attending regularly. She was motivated to regain her mobility and lose weight to reduce physical strain on her body. The participant lost 80 pounds during her attendance, and regained a significant level of mobility. She was so encouraged with the services that she has been volunteering with other services provided at Street Level.

- Promote the elimination of vaccine-preventable diseases by implementing the California Immunization Registry program (CAIR) in Alameda County to eliminate both missed opportunities to immunize and unnecessary immunizations.
- Increase the number of providers who use CAIR in Alameda County to 78 organizations, and the number of Alameda County patient records in CAIR to 47,077.

HIV Prevention

- Provide critical wound care and clinical services to extremely low income marginalized active users and high-risk youth and young adults throughout the week at exchanges, during outreach, and at the drop-in clinic.
- Perform 525 HIV tests.
- Conduct three Health Communication and Information workshops to 50 high-risk individuals.
- Provide abscess/wound care to at least 200 injection drug use (IDU) clients.
- Provide abscess/wound care follow-up services at SEP locations to at least 300 IDU clients.
- Of the 300, provide abscess/wound care follow-up services to at least 80 SEP clients.
- Increase awareness of risk-reduction strategies for 57 HIV+ African-American TPA contacts.
- Provide assistance in addressing individualized prevention plans and establishing risk-reduction goals and exit plans for 80% of HIV+ African-American clients.
- Experience a total of 631 visits, of which 417 were IDU visits and 228 accounted for unduplicated clients.
- Experience a total of 429 visits at SEP locations, of which 326 were IDU follow-up visits and 308 accounted for unduplicated SEP clients.
- Experience a total of 127 visits for abscess/wound care follow-up services, including 83 unique clients.
- Refer 119 IDU clients from SEPs to Casa Segura for a total of 428 visits (214 STI visits and/or 184 HIV visits/tests and/or 30 HCV rapid testing visits), providing treatment for 42 cases who tested positive for STIs.
- Refer 140 clients that tested positive for HIV and/or HCV to primary care services.
- Conduct 56 Safer Injection workshops with 98 participants and 34 Overdose Prevention trainings with 38 participants.
- Conducts five HCPI events designed to build skills around HIV knowledge, increase risk reduction, and increase partner communication for a total 75 participants, of whom 89% increased or maintained their knowledge around HIV and risk reduction.

Measure A Helps

HIV PREVENTION

A 46-year-old, heterosexual, HIV+ female with a long history of IDU was not consistent with taking her medications or using condoms due to her drug habit, the lack of education regarding condom use, and homelessness. When the client came for services, she requested drug treatment and was linked to Cherry Hill. The case manager worked with the client to develop a prevention plan that best suited the client's needs for sexual risk reduction and her life goal to obtain housing and sober living. Over a four-month period, the client reports that she has had protected sex with one individual. Since obtaining permanent housing, the client reports consistent medication use.

Obesity Prevention & School Health

Nutrition Services

- Support the East Oakland Boxing Association (EOBA) in developing youth leaders who have learned to help plan and implement culturally appropriate cooking and gardening classes.

- Support youth leaders in developing and conducting garden and nutrition workshops for students at four neighboring elementary schools.
- Through EOBA, present five interactive parent cooking and nutrition workshops for EOBA parents as well as community members.
- Also through EOBA, provide lunch daily to over 130 youth in partnership with the Oakland Summer Lunch program.
- Provide support to the HOPE Collaborative to improve food access in Oakland; to manage contracts for Mandela MarketPlace; to the Unincorporated Area community, participating in the Food System work with Mandela MarketPlace and the Alameda County Food Policy Council; to Place Matters initiatives including Education and Land Use and Transportation.
- Expand and refine the Soda Free Summer Campaign, which has been a national model sparking similar social marketing campaigns across the state and U.S.
- Support the Oakland Food Policy Council, specifically the direct support of collaboratives working for a just, fair, and equitable food system.
- Support the epidemiologist in the CAPE unit around data collection, analysis, and report development.
- Support the CalTrans-funded Safe Routes to School Program.

Measure A Helps

COMMUNITY-DESIGNED INITIATIVE: LOTUS BLOOM

Letter from Janet (Logan):

Lotus Bloom is filling a vital role for children who need extra help, like Logan, whose premature birth put him at risk for serious developmental delays. Thanks to Lotus Bloom, we have a team of compassionate and knowledgeable professionals helping us monitor our son's progress. Through Lotus Bloom's partnerships with outstanding community organizations, Logan has received many valuable learning and social opportunities. I participated in the parent leadership training series, which provided me with tools on advocating for my child. I really appreciate the supportive, diverse community of Lotus Bloom parents. We look out for each other's children and help each other be better parents and community leaders.

Community-Designed Initiatives

- At the Niroga Institute, provide scholarships to 12–16 people annually to become certified yoga teachers.
- Support Niroga in paying for faculty for the training, teachers for the classes, program management, rental of classroom space, and books and materials for the students.
- Assist with some placement and continued tracking and support of the graduate students.
- Enable Niroga to provide a one-day training in Transformative Life Skills to 35 Alameda County Public Health Department WIC staff in December 2012.
- In collaboration with several community partners, support Lotus Bloom to administer a series of health-related nutrition programs to families and the at-large community, including two health fairs, seven Parent Leadership Training program (PLAN) trainings for 22 parents, a six-series workshop for 35 parent leaders, two series of yoga class, a dance program, and adoption of a healthy food policy.
- At Lotus Bloom, hold monthly meetings for 12–18 families, plus two meetings with legislators.
- Through Lotus Bloom, obtain three new grant resources for the San Antonio district, including funding to support the 3–5-year-old playgroup program; $10,000 to support the development of the kitchen into a fully licensed commercial kitchen; and a Rotary grant.
- At Mandela MarketPlace, complete formation of a Food Policy Team of community residents who assess the learning of the Oakland Council, determine which priorities make the most sense to integrate into their work, and determine any policy challenges that need to be addressed to fulfill the Community Healthy Market Place vision.

HIGHLIGHTS

The Committee notes that the accomplishments of the various Public Health Prevention Initiative providers are many, based on the programs they manage. Among these accomplishments, many providers met or exceeded their target goals for their programs, sometimes substantially.

One item that seems to make a significant impact in the community, especially youth, is the mentorship program that allows low-income youth to have an opportunity to experience Health Careers at an early age.

In addition, Public Health Prevention Initiative providers leveraged their Measure A allocations to obtain a total of $884,226 in matching funds from the following sources:

- **Asthma Start**: Every Child Counts, Kaiser Community Benefit, and Targeted Case Management
- **Diabetes**: Medi-Cal Administrative Activities (MAA)
- **Dental Health–MCAH**: Federal financial participation funds (FFP) from MCAH and CHDP.
- **Project New Start**: MAA and large in-kind contributions/partnerships with volunteer medical professionals whose service provision amount to well over $200,000 per year
- **Emergency Medical Services (contract with City of Fremont)**: City of Fremont General Funds
- **CAPE**: A grant from Kaiser Family Foundation for the SPTB 2013 Health Fair
- **Nutrition Services**: CalTrans (Safe Routes to Schools and CDPH Nutrition Network), and Public Health Institute for Community Transform Grant (CTG) local funds
- **Community Designed Initiative–Lotus Bloom**: Two organizations through in-kind services (Luna Kids Dance and Niroga Institute), plus a $150 gift card from Safeway
- **Community Designed Initiative–Mandela Market**: Kresge Foundation and California Endowment

PUBLIC HEALTH FOOD SECURITY/FOOD JUSTICE STRATEGY

FY 12/13 allocation: $150,000

Expended/encumbered in FY 12/13: $150,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

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

Measure A clients served: 16 (**Total clients**: 60)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

Alameda County Nutrition Services works to ensure that all people live in safe, connected neighborhoods that offer fresh, affordable foods; are choosing active, healthy lifestyles; and are engaged in their communities.

Food to Food (F2F) health centers provide pregnant women with fresh produce prescriptions that connect them with local food access points as well as healthy living classes, which include exercise, cooking, and stress-reduction components. Young adults in West Oakland manage the produce supply business at participating corner stores in their community and promote produce sales. Young adults in Ashland/Cherryland grow, produce, and distribute community-sustained agriculture food boxes. F2F also contains a mini-grant component, which funds innovative, locally defined community-based projects that align or build on the foundation of F2F. The mini-grants have helped develop curricula on subjects such as stress management and eating well on a budget, which local Federally Qualified Health Centers (FQHCs), Tiburcio Vasquez and West Oakland Health Center, have included in their classes.

MEASURE A FUNDING SUMMARY

The F2F program used its Measure A allocation to provide mini-grants of $500–$1,500 to six community organizations to improve food environments in West Oakland and Ashland/Cherryland.

These funds and grants enabled F2F to transform the food landscape in the West Oakland and Ashland/Cherryland communities.

West Oakland

- Team Fresh-West Oakland added one new market as a food access point for families in the program and the community at large. As a result, Mandela MarketPlace's Healthy Neighborhood Store Alliance now has four participating stores.
- Due to partnerships between Mandela MarketPlace (MMP) and F2F mini-grantee City Slicker Farms (CSF), CSF became an additional site for coupon redemption.
- CSF built a garden that now grows fresh fruits, vegetables, and herbs at the West Oakland Health Center (WOHC). These fresh fruits and vegetables are used in the classes the moms participate in through F2F.
- Beginning in November, the WOHC will premiere an onsite produce stand bringing the total number of food access points this year to four.

Ashland/Cherryland

- Community Development Block Grant (CDBG) funds allowed the construction of a greenhouse so Dig Deep Farms and Produce (DDFP) can grow their own plant starts, eliminating the need to buy the starts. The greenhouse raising was held on Wednesday, Oct. 24, 2012. The greenhouse will double as a farm stand with hopes to become the first fixed-site retail establishment for DDFP providing Ashland/Cherryland residents healthy and locally grown fruits and vegetables. DDFP continues to work in partnership with the Tiburcio Vasquez Health Center (TVHC) to provide healthy produce bags to 30 F2F participants.

These funds also helped achieve the following measurable objectives:

- Ashland/Cherryland enrolled 39 women, 23 of whom came back for a second visit for prenatal care and to obtain prescriptions for healthy grocery bags.
- West Oakland enrolled 86 women, 37 of whom came back for a second visit for prenatal care and to obtain prescriptions for healthy grocery bags.
- Ashland/Cherryland met its objective of 60% of participants increasing their intake of fresh produce. Of the 23 women for whom there was data, 14 (61%) showed an increase, six (26%) decreased, and three (13%) stayed the same.
- F2F leveraged the use of land for gardens at the Camp Sweeney youth detention facility to grow produce on 40 acres.

HIGHLIGHTS

The F2F program leveraged its Measure A allocation to obtain $405,000 in matching funds from the following sources:

- California Department of Transportation (CalTrans) – Safe Routes to Schools
- California Department of Public Health Nutrition Network
- Public Health Institute for Community Transformation Grant funds

CONCERNS

It is unclear how other program funds and the work by the Sheriff's Department at Camp Sweeney were associated with the program funded by Measure A. The program also does not clearly identify who was served, nor does it state any measurable outcomes

PUBLIC HEALTH PILOT TO DECREASE ABSENTEEISM IN SCHOOLS

FY 12/13 allocation: $150,000

Expended/encumbered in FY 12/13: $150,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

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

Measure A clients served: 11 (**Total clients**: 13)

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

AGENCY/PROGRAM 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.

ACPHD is part of a working partnership with the Alameda County Health Care Services Agency (HCSA), District Attorney's office, and Interagency Children's Policy Council that seeks to address the issue of chronic absenteeism and truancy as it relates to health issues countywide.

Barriers to attendance, particularly for younger students, include chronic health issues that do not get addressed. This project seeks to work with early grades to impact third-grade reading level and long-term educational achievement and prevent progression to school district Student Attendance Review Boards and to Truancy Court. Ensuring students miss less school has been strongly linked to better short-term and long-term educational outcomes. ACPHD Asthma Start has already had significant success in working with the District Attorney's office in the Alameda County Truancy Court in reducing unnecessary absences due to health issues. This project should help school districts prevent further progression of absences, keep kids in school, and help them do better academically.

Specifically, the partnership seeks to support school districts to address chronic absenteeism through the following activities:

- Coordinating services and programs across the various County agencies (HCSA, District Attorney, Interagency Children's Policy Council, Behavioral Health, ACPHD) working on truancy prevention related to health
- Increasing knowledge and outreach of the connection between chronic absenteeism, health issues, and educational outcomes by conducting literature review, creating materials, and consulting with experts
- Supporting coordination of case management services for asthma, diabetes, and other medical conditions between ACPHD, Behavioral Health, and school districts, including the San Lorenzo, Hayward, and Oakland Unified School Districts.

MEASURE A FUNDING SUMMARY

ACPHD received a one-time Measure A allocation to develop a closer relationship with a school district to track

health and absences and set up referral linkages from elementary schools addressing high chronic absenteeism.

The program used part of its allocation to establish a pilot project with the Hayward Unified School District, which seeks to develop and implement processes at the district and school level to track, plan, and intervene around excessive absenteeism through the following activities:

- Increasing district capacity to code and track attendance data related to health issues in the student information system, ZANGLE
- Working with four target elementary schools—Cherryland, Hard, Park, and Schafer Park—to examine the attendance recording and intervention processes, in particular aligning attendance promotion with school and community-based supports through school-based Coordination of Services Teams (COST)
- Implementing processes and lessons learned at the remaining elementary schools and district-wide

ACPHD also accomplished the following as part of the County agency collaboration:

- Meeting roughly bi-monthly with HCSA, the District Attorney's office, and the Interagency Children's Policy Council
- Developing health guidelines to inform parents when to keep their children home from school and when they should be sent to school
- Through the ACPHD Asthma Start and Nursing programs, meeting with the San Lorenzo Unified School District to identify students with excessive absences due to health issues at the Student Attendance Review Board (SARB) to prevent truancy and to provide case management and referral services for students identified
- Developing background information on chronic absenteeism and health
- Referring 13 families/children from truancy court to Asthma Start and 10 children to Public Health Nursing

CONCERNS

The project spent this year's allocation for program setup and system development. However, as noted in the report, the program has no reportable data yet. It remains to be seen if any service-related outcomes result. Without baseline data, there is no way to determine how the program impacts third-grade reading levels or absenteeism.

In addition, with respect to Harder Elementary specifically, the program does not indicate how it will determine the impact of Measure A funds vs. the impacts of the Hayward Promise Neighborhood program.

SENIOR INJURY PREVENTION PROGRAM

FY 12/13 allocation: $100,000

Expended/encumbered in FY 12/13: $100,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health, Mental Health, Substance Abuse

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

Measure A clients served: 2,788 (**Total clients**: 2,811)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

The Public Health Department works with Emergency Medical Services (EMS) through agreements with the following providers to deliver injury prevention services to County seniors:

- **Memorandum of Understanding (MOU) with the Alameda County Social Services Agency (SSA).** Secure and maintain maximum independence and dignity in a home environment of older and functionally impaired persons capable of self-care with appropriate supportive services.
- **Contracts with Adult Day Services Network of Alameda County, St. Mary's Center, and Senior Support of Tri Valley-Medication Safety Pilot program, and United Seniors of Oakland.** Improve the quality of life and health of older adults by assisting them in gaining knowledge about the proper use of medications, and reduce the number of illnesses, hospitalizations, emergency department visits due to mismanaged medications.

Measure A Helps

LIFE ELDER CARE SENIOR INJURY PREVENTION PROGRAM

Florence, 81, is a very active person, but she was concerned that her balance was declining. When she was tested in the fall prevention program, she could stand barely ½ second on each foot. The instructors worked with her for one hour a week, and she practiced herself on the other days. Florence was so happy to see the improvement, it motivated her to continue to practice. Her focus and commitment paid off. After 12 weeks, she was able to stand on each foot for 5 seconds. The other students helped Florence compile her different medications and vitamins into a booklet. Florence is now exercising on her own and is confident in her ability to stay active.

MEASURE A FUNDING SUMMARY

Measure A funding helped EMS, through each of the contracted agencies providing senior injury prevention

services, achieve the following objectives.

MOU with SSA

- **Fall risk screening, assessment, and education.** A health care professional or paraprofessional used a validated screening tool to screen and assess the fall risk of older adults. Appropriate education on fall-risk reduction, evidence-based physical activities, medication management, and minor home modification referrals were made to meet the client's needs (target for all providers: 443; actual: 846).
- **Minor home modifications.** Residential modifications that are necessary where risk for falls and other risk factors can be reduced or minimized by minor home adaptations (target for all providers: 57 assessments; actual: 59).
- **Physical activity sessions.** Individual and group exercises using evidenced-based models to improve strength and balance to educate fall risk (target for all providers: 508; actual: 1,203).
- **Individual medication management.** Medication management consists of education by health care professionals with seniors and/or their families and caregivers (target for all providers: 235; actual: 341).

Measure A Helps

SPECTRUM COMMUNITY SERVICES – SENIOR INJURY PREVENTION PROGRAM

Ruth, 66, suffered a stroke that left her unable to walk, speak, swallow, bathe, feed herself, dress herself, get up and down, or sit up. She has gone through several specialized facilities for rehabilitation that have enabled her to walk again using a cane and move around her home. Regular attendance at Spectrum's exercise classes helped her make further progress. She gained more strength and confidence and kept working on getting up her staircase. In February, Ruth was able to climb the entire staircase. It was the first time she had been on the second floor of her house since her stroke. She credits Spectrum's classes for giving her the strength in her legs to get to the top.

Contract with Adult Day Services Network

- Total served: 39 participants.
- Home visits: 39. At each home visit, the interviewer compiled a detailed medication inventory and interviewed the participant about medication adherence, organization, and support using a standardized interview instrument.
- Medications and medication disposal
  - 419 medications noted.
  - 120 medications discarded.
  - 25 disposal mailers given to caregivers.
  - 29 medication devices given to caregivers (mostly medi-sets, some alarm clocks and pill cutters).
- Pharmacy reports to primary care physicians (PCPs): 39 pharmacy reports prepared by licensed pharmacist and forwarded to PCPs.
- PCP responses to pharmacy reports
  - 80% of PCPs responded to pharmacy reports.
  - 59% made medication changes or had a follow-up visit with the participant to discuss the medication regimen.

Contract with St. Mary's Center

- St. Mary's Center staff, in collaboration with student nurses, called or visited each senior weekly, up to 12 weeks.
- Sixty-one seniors' medication lists were entered in www.drugs.com to determine any drug interaction risks.

- Eight medicine compliance tools, such as medi-sets, were offered and accepted, and seven gallon-size containers collected old or unused medications for disposal, using drop-off sites.
- Thirteen mail-in envelopes were provided to participants.
- Eighty-three participants completed a pre and post survey with slightly over half (58) showing a self-reported improved quality of life score.

Contract with Senior Support of Tri Valley-Medication Safety Pilot program

- Thirty-eight clients were served in the Medication Safety program.
- Seven clients actually disposed of medications. All other participants had no medications to dispose of or had already disposed of medications via their pharmacy or take-back days.
- Six clients made specific in-office or over-the-phone appointments with their doctors to discuss any questions they had about their medications.
- Of the 38 clients served, 11% had their medications adjusted, 28% stated they had become more compliant with their medication regime, and 24% reported that they felt better overall.

Contract with United Seniors of Oakland

- Four pre-trained senior volunteers offered 19 trainings in English and Spanish to seniors, covering medication safety topics (target: 20 trainings to 300 seniors; actual: 19 trainings to 202 seniors).
- A success rate of over 60% was achieved based on correctly answered questions between the scores of pre and post tests, demonstrating increased knowledge about medication safety following the trainings as compared with what they knew before the trainings.

Measure A Helps

EMS (CONTRACT WITH ADULT DAY SERVICES NETWORK)

A 76-year old Vietnamese-speaking widow lives alone in senior housing, and has no family support system. She has multiple medical problems including diabetes type II, hypertension, chronic bronchitis, degenerative joint disease in the knee, and obesity. She suffers from depression and feels isolated. During the home visit, workers discovered 12 different medications, nine of which were prescribed. She was taking a wrong dosage of one medication and did not know what several of the others were for. Interventions during the home visit helped educate the client about medication indications and dosage and resulted in the primary care physician making adjustments to the prescriptions. The client was confused with these changes at first but now feels she can adhere to them.

HIGHLIGHTS

In several cases, actual provider outcomes greatly exceeded targets. For example, through the MOU with SSA, providers offered physical activity sessions to 1,203 seniors, compared to a target of 508.

In addition, Adult Day Services Network leveraged its Measure A allocation to obtain $5,741 in matching funds from foundation dollars.

SERVICE OPPORTUNTIES FOR SENIORS (MEALS ON WHEELS)

Measure A one-time allocation, Board of Supervisors discretionary allocation: District 4/Supervisor Miley

FY 12/13 allocation: $266,000

Expended/encumbered in FY 12/13: $266,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Hospital Outpatient, Public Health

Individuals served: Seniors, Indigent, Low Income

Measure A clients served: 326/668 (**Total clients**: 1,002/1,335)

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

AGENCY/PROGRAM BACKGROUND

Service Opportunity for Seniors (SOS) Meals on Wheels offers a home-delivered nutrition program to maintain or improve the physical and social well-being of seniors with a hot meal and a daily check-in. The nutrition services include procurement, preparation, transporting, and serving meals, as well as nutrition education.

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

In addition, Meals on Wheels establishes a safety net for an at-risk population. The drivers interact with homebound seniors daily and report significant problems or changes that occur, especially for seniors living alone. The office staff is trained to deal with a wide range of situations and makes sure that the appropriate care is provided for seniors who need assistance. The combination of daily nutritious meals and wellness monitoring enables homebound seniors to retain their independence and to remain in their home for as long as they can.

Measure A Helps

SERVICE OPPORTUNTIES FOR SENIORS (MEALS ON WHEELS)

Linda, 61, is semi-retired and volunteers part-time at a homeless shelter. One morning, while getting her regiment of pills for morning pain, she slipped and fell, breaking her hip. Several weeks after the surgery, she was ready to go home from the rehab center. Her daughter, who could check on her morning and evening, was concerned about a lunchtime meal. The discharge planner contacted Meals on Wheels, and Linda was scheduled to receive her meal service the very next day. When the bell rang, Linda made her way to the door. As she opened it, Linda could not believe what she saw. Standing in front of her was that same driver that delivered meals to Linda's mother many years ago.

MEASURE A FUNDING SUMMARY

The SOS Meals on Wheels program received two Measure A allocations in FY 12/13. Meals on Wheels used the first to deliver 5,000 meals to seniors in the unincorporated Castro Valley area, and the second to deliver approximately 51,936 meals in central Alameda County and parts of Oakland. Meals on Wheels also provided 34,280 bulk meals to Bay Area Community Services (BACS) of Oakland.

In addition, Measure A funds helped Meals on Wheels move into a bigger kitchen which produced quality meals at a faster and more efficient rate. The new kitchen and equipment gave Meals on Wheels the capacity to produce 86,216 meals (including those supplied to BACS) and directly serve 1,335 seniors.

HIGHLIGHTS

Every eligible senior received a hot nutritious meal, and no waiting list occurred in FY 12/13.

In addition, SOS Meals on Wheels leveraged its second Measure A allocation to obtain $260,000 in matching funds from the Valley Foundation and Alameda County Meals on Wheels.

SPECTRUM COMMUNITY SERVICES, INC.

Board of Supervisors discretionary allocation: District 2/Supervisor Valle, District 3/Supervisor Chan, District 4/Supervisor Miley

FY 12/13 allocation: $75,000

Expended/encumbered in FY 12/13: $75,000

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health, Mental Health

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

Measure A clients served: 453 (**Total clients**: 453)

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

AGENCY/PROGRAM BACKGROUND

Spectrum Community Services assist low-income, disadvantaged, and elderly residents of Alameda County as they attempt to achieve and maintain self-sufficiency and improve the quality of their lives. Spectrum employs multiple strategies to implement this mission, offering individuals and families programs that remedy crisis, maintain and improve health and functionality, and develop skills and the capacity to help themselves.

Spectrum's Fall Risk Reduction Program (FRRP) promotes wellness and delivering preventive services to a population at high risk for falls and fall-related injuries. FRRP uses a multipronged approach to address the physical, behavioral, and environmental factors that contribute to falls. FRRP employs strategies that educate

about fall prevention; guide and refer for home safety modifications that can prevent falls; and offer training to build strength, stamina, mobility, balance, and fall prevention skills. Each program component focuses on empowering seniors to implement solutions and to become more confident of their control over their own lives.

Spectrum targets its FRRP classes at senior housing and recreation centers located in low-income neighborhoods. These sites are also where Spectrum holds its senior meal program for low-income seniors. The program also emphasizes social interaction, giving isolated seniors the opportunity to develop new friendships and improve conditions like depression. The FRRP contributes to a healthier, independent lifestyle, greatly improving the functional ability and quality of life for the fastest-growing segment of the population.

Measure A Helps

SPECTRUM COMMUNITY SERVICES, INC.

Bob, an 80-year-old Caucasian male, suffers from high blood pressure and arthritis. His initial health assessment revealed chronic lower back pain and decreased mobility. After two months of attending class, his mobility and flexibility improved to where he could get up and proceed with his morning activities with less pain. Prior to joining the class, Bob tried walking for fitness. His walks lasted about 15–20 minutes, 1–2 times per week. He can now easily walk on a treadmill for 30–40 minutes, 2–3 times per week, and has decreased his lower back pain has significantly. Bob says, "I tell everybody how much this class has helped! I feel so good I actually want to exercise more."

MEASURE A FUNDING SUMMARY

Spectrum's FRRP used its Measure A allocation to achieve the following objectives:

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

Services funded by Measure A included the following:

- Weekly fall prevention skill-building classes at seven sites in the target area
- Evaluation and reassessment of class participants to tailor exercise programs and measure progress
- Quarterly workshops at five locations that provided practical training in preventing falls

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

- Muscular endurance: 75% improved, 15% maintained, 10% declined
- Flexibility: 50% improved, 37% maintained, 13% declined
- Mobility: 70% improved, 19% maintained, 11% declined
- Strength: 65% improved, 23% maintained, 12% declined

HIGHLIGHTS

Regular FRRP clients report a positive boost in mood and decreased depression.

SSI HOUSING TRUST

FY 12/13 allocation: $1,000,000

Expended/encumbered in FY 12/13: $52,389

Amount carried over to FY 13/14: $947,611

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health, Mental Health

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

Measure A clients served: 47 (**Total clients**: 1,487)

Service area: Countywide, Homeless or transient

AGENCY/PROGRAM BACKGROUND

The Alameda County Health Services Agency (HCSA) helps poor, disabled Alameda County residents receive disability income and mitigates the negative impact of long processing times by stabilizing their health and living situations while their applications are pending.

MEASURE A FUNDING SUMMARY

HCSA used Measure A funds to establish the SSI housing trust, a revolving fund to increase housing stability for clients. When clients are approved for disability benefits, the fund is replenished from the client's retroactive benefits. This increase in housing stability improves clients' ability to access care and support from disability advocates, and helps improve their mental health as well.

Overall the program provided disability advocacy services, including care coordination, to 1,488 individuals, of whom 755 were approved for disability benefits and 533 still had claims pending at the end of the fiscal year. These awards in disability income resulted in clients receiving over $9 million in ongoing income since the date of their approvals.

Measure A Helps

SSI HOUSING TRUST

One client, a 53-year-old man with schizophrenia, had been living under a bridge for years. With the extra housing subsidy, he was able to move indoors and now lives in a studio apartment. He is visibly happier and healthier. Another client, a 59-year-old woman who has diabetes, depression, and anxiety, was on the verge of being evicted. The subsidy prevented her from becoming homeless. A 36-year-old man with depression who was living under an overpass was able to move into a single-room occupancy hotel and is now looking for permanent housing. A 53-year-old woman who has bipolar disorder and post-traumatic stress disorder used the extra income from the housing subsidy to escape an abusive relationship and secure her own housing.

HIGHLIGHTS

When clients enter the program, generally they receive a maximum of $336/month in income. Measure A funds enable clients to nearly double their income to $654/month while their disability application is pending. Upon approval for disability benefits, clients receive at least $865/month in income, almost tripling their original income.

Connecting clients to care ultimately reduces unnecessary use of emergency room services. Having a disability advocate can lead to better health outcomes for clients because there is an outside source corroborating client complaints and providing information—for example, emergency room records—from other treatment sources that would otherwise be unavailable to care providers.

In addition, the program leveraged its Measure A allocation to obtain $2,060,000 in matching funds from the following sources:

- Mental Health Service Act (MHSA)
- Medi-Cal Administrative Activities (MAA)
- Community Services Block Grant (CSBG)
- Alameda County General Fund

These leveraged funds help recover 95.4% of the Measure A funds expended and can be reinvested in the project.

TELEOSIS INSTITUTE

Board of Supervisors discretionary allocation: District 4/Supervisor Miley

FY 12/13 allocation: $11,080

Expended/encumbered in FY 12/13: $11,080

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Hospital Outpatient, Public Health, Substance Abuse

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

Measure A clients served: NA (**Total clients**: 6,000)

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

AGENCY/PROGRAM BACKGROUND

The Teleosis Institute is devoted to developing effective, sustainable health care provided by professionals who serve as environmental health stewards. The Alameda County Safe Medicine Disposal Program is one initiative of the Teleosis Institute.

MEASURE A FUNDING SUMMARY

Teleosis Institute used its Measure A allocation to develop a Safe Medication Disposal Program, which provides education and take-back locations to help achieve the following:

- Reduce unused medication from accumulating in households
- Reduce risk of accidental poisoning for seniors, youth, and children

Measure A funding helped the program achieve the following measurable results:

- Establish four new take-back sites
- Serve 6,000 County residents using the sites
- Collect 12,500 lbs. of unused pharmaceuticals
- Remove 5,000 lbs. of unwanted waste from households and streets in Alameda County

HIGHLIGHTS

A large number of residents used the take-back sites, resulting in a substantial amount of unused pharmaceuticals removed from homes and streets and reducing the risk of potential use by others.

CONCERNS

The provider describes the number of pounds of medicines collected, but does not provide details of the population that contributed to this collection.

URBAN STRATEGIES COUNCIL, INC.

Board of Supervisors discretionary allocation: District 4/Supervisor Miley

FY 12/13 allocation: $99,840

Expended/encumbered in FY 12/13: $99,840

Amount carried over to FY 13/14: $0

FY 13/14 savings transferred to reserve: $0

Types of services provided: Public Health

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

Measure A clients served: NA* (**Total clients**: NA*)

Service area: Countywide

**Recipient does not provide direct services*

AGENCY/PROGRAM BACKGROUND

Urban Strategies Council works with partners to eliminate persistent poverty by building vibrant, healthy communities. Urban Strategies Council is a social impact organization using tools of research, policy, collaboration, innovation, and advocacy to achieve equity and social justice.

The Violence Prevention Initiative Executive Committee is responsible for implementation and monitoring of the Violence Prevention Blueprint adopted by the Board of Supervisors in 2005 and is an effort to work with County agencies, cities, and community groups to identify ways in which the County can support efforts at violence prevention and intervention. Urban Strategies has worked with the Executive Committee to build the capacities of County agencies and community-based organizations to understand the causes of violence and to implement effective strategies to prevent or intervene in violence. Urban Strategies provides accurate, up-to-date data on the incidence of violence in the County and changes over time so that stakeholders understand

where inroads are being made and where additional efforts need to be made to reduce violence. Urban Strategies also provides information on evidence-based practices for preventing and reducing violence so that public agencies and community-based organization can consider them in the course of improving their strategies and program interventions related to violence.

MEASURE A FUNDING SUMMARY

Urban Strategies does provide direct services. It supports the Violence Prevention Initiative Executive Committee by providing staffing for meetings, work plan development, data and policy analysis, mapping, and resource development.

Urban Strategies used its Measure A allocation to provide program support services for the Violence Prevention Initiative and Public Health with the following specific objectives:

- **Staff the Violence Prevention Initiative Executive Committee.** Urban Strategies staffed 10 monthly meetings of the Violence Prevention Initiative Executive Committee.
- **Support work plan development.** Urban Strategies provided support to the Executive Committee and completed a work plan for the FY 12/13 program period including recommendations related to essential public health and substance abuse services to the indigent, low-income, reentry, and uninsured populations .
- **Provide data analysis and map production.** Urban Strategies produced an annual report tracking violent crime countywide and within each city in the County over the past decade, providing a source of information for local jurisdictions, County officials, and community-based organizations to determine changes in patterns of violent crime and to inform their planning and actions.
- **Communicate with Supervisors' staff on district projects.** Urban Strategies communicated with and provided advice and support to the Board of Supervisor's staff on their respective district projects and efforts and how these projects and efforts assist in providing essential public health and substance abuse services to the indigent, low-income, and uninsured populations.
- **Assist in funding applications.** Urban Strategies provided assistance to County agencies and Supervisor Miley's office to identify funding possibilities and prepare applications for district violence prevention projects and other public health and substance abuse services.

CONCERNS

While the Committee recognizes that dealing with re-entry issues benefits the entire population, it questions whether Measure A funding is appropriate for this organization, given that it provides no direct services and performs activities that are much broader in scope than public health.

YOUTH AND FAMILY OPPORTUNITY INITIATIVES

FY 12/13 allocation: $2,450,000

Expended/encumbered in FY 12/13: $2,048,371

Amount carried over to FY 13/14: $401,629

FY 13/14 savings transferred to reserve: $0

Types of services provided: Mental Health, Substance Abuse

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

Measure A clients served: 9,944 (**Total clients**: 9,944)

Service area: Countywide

AGENCY/PROGRAM BACKGROUND

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

The goal of the countywide Youth and Family Opportunity (YFO) Initiative is to strengthen the capacity of "anchor" community-based organizations (CBOs) to provide a continuum of high-quality, accessible school-linked health and wellness supports to youth and families experiencing poor health and educational outcomes.

The 10 CBOs include the following:
- Alameda Family Services
- Berkeley YMCA Youth Institute
- Berkeley Youth Alternatives (BYA)
- East Bay Asian Youth Center (EBAYC)
- Fremont Family Resource Center
- La Familia
- McClymonds Youth and Family Center Alternatives in Action (AIA)
- Newark Unified School District: New Haven Kid Zone
- REACH Ashland Youth Center
- Youth Radio

The Measure A funds for the YFO initiative financially support school-linked programs that focus on youth development, family strengthening, and mental health services. Youth projects promote healing, develop capacity and skills, and provide support for youth to lead, learn, and take action. The family strengthening programs provide parents with emotional support and tools to foster nurturing relationships with their children. They also provide other types of support, such as financial planning or work training, to encourage stability and reduce stress for families.

Youth and Community Services

The CBOs offered enrichment programs to promote health and wellness and improve the social, emotional, and physical health of youth and their families. Many of the youth and community services included family engagement.

School-Linked Fitness, Nutrition, and Physical Health Services

Some CBOs offered physical fitness activities, for example:

- At REACH Ashland Youth Center, the Alameda County Deputy Sheriffs' Activities League (ACDSAL) provided single and multi-session interventions in recreation and fitness designed for young people to achieve physical health and to develop healthy strategies to cope with life issues and stress.
- Berkeley Youth Alternatives (BYA) provided physical fitness and recreation activities through the Lady Hoops basketball program and summer dance classes.

CBOs also offered nutrition and wellness services for youth, for example:

- REACH Ashland Youth Center provided medical and dental services through the Fuente Wellness Center, wellness consultations, and a sexual health education group for adolescents.
- Fremont Family Resource Center offered family nutrition services.
- New Haven Kid Zone provided community garden organizing as well as a Latino herbal/home remedies workshop.
- BYA provided life skills workshops for middle school and high school girls in the teenage pregnancy prevention program.

School-Linked Social and Emotional Learning and Academic Services

All of the CBOs offer school-linked programs that include a variety of activities from arts and media to sports and academic tutoring, for example:

- AIA, through the McClymonds Youth and Family Center, provided direct service programming in social justice, action research, project management, and implementation.
- REACH Ashland Youth Center, through partnerships with San Lorenzo Unified School District, Alameda County Library, and the Alameda County Arts Commission, offered tutoring in core subject areas, online credit recovery, computer literacy, library exposure, arts programming, and enrichment activities to strengthen educational and social supports.
- Newark and Fremont Unified offered a Peacemakers program at Thornton Jr. High School and Newark Jr, High School.
- EBAYC offered after-school learning at Dewey Elementary School and Oakland High School.
- La Familia held school-wide anti-bullying workshops for grades K-6.
- New Haven Kid Zone held workshops in resiliency and anti-bullying, as well as student group counseling for various age groups.
- BYA provided tutoring, mentoring sessions, and case management for youth in middle school and high school, as well as music and poetry classes through its Teen Center during the summer.
- Fremont Family Resource Center held a summer youth camp and youth support group.
- Youth Radio provided academic advising and case management/counseling.

Job Training

Many of the funded CBOs provided job training and onsite employment opportunities to youth, for example:

- REACH Ashland, BYA, EBAYC, YMCA of Berkeley, and Youth Radio provided employment internships for youth at their centers.
- Youth Radio provided career advising and job training in youth in broadcast journalism, digital media, videography, graphic design, audio engineering, social media, and music production.
- Youth Radio offered career/college exploration activities and work-based placement.

Community Outreach

All 10 of the funded CBOs engaged in community outreach to their client base and encouraged families and youth to participate in their programs, for example:

- AIA completed a needs assessment with youth and adults in the community and, as a result, increased coordination among service providers.
- La Familia provided programming in civic engagement and community organizing.
- New Haven Kid Zone led a comprehensive door-to-door community survey in the Kids' Zone geographic service area.

Parent Engagement

BYA, REACH Ashland Youth Center, La Familia, New Haven Kid Zone, Fremont Family Resource Center, Fremont and Newark Unified, and AIA all provided services that encouraged parents to be more involved and active in their children's lives, for example:

- La Familia, New Haven Kid Zone, Fremont Family Resource Center, and Newark and Fremont Unified all offer parenting workshops and classes.
- BYA facilitated a parents' association to provide parenting information and a safe space for parents to seek assistance on child development.
- BYA held group parenting sessions for young fathers who desire to have healthy relationships with their children and an Urban Parenting series to train parents and guardians about healthy child development and setting good boundaries with their children.
- REACH Ashland Youth Center offered family support services, as well as a Soccer Adult Coaching Program and Soccer Advisory Board, Parent/Guardian Orientations of the youth center, and a San Lorenzo Unified School District Parent Tour.
- AIA hosted the West Oakland Parent Action Network, an active parent council that trained parent representatives from three West Oakland schools, and held various parent education workshops and events throughout the year.

Youth Development/Leadership

Many of the CBOs provided youth development services and gave youth leadership opportunities that help build confidence and skills like problem-solving and public speaking and give youth a voice in identifying community needs and making policy recommendations, for example:

- REACH Ashland Youth Center convened a youth leadership council, a Leadership & Employment Development Academy, and other programming designed with youth-relevant themes that develop life skills such as group collaboration, problem-solving, and positive decision-making.
- AIA provided youth development programming on social justice, action research, and leadership through their Culture Keepers mentoring program, Youth Organizing and Leadership Opportunity program, and youth-initiated community impact projects.
- La Familia provided youth group clients with El Joven noble character education curriculum focused on moral development, led a Community Center Youth Project, and held a college awareness workshop.
- Newark and Fremont Unified hosted the Youth Empowerment and Work Experience Academy and also provided a special group curriculum designed to target at-risk youth that provides students with a safe space to build self-esteem while learning positive life skills and self-empowerment techniques.

Financial Health Services

Some of the CBOs offered financial health services that help families to become economically self-sufficient, for example:

- The Fremont SparkPoint Family Resource Center offered financial coaching for low-income residents and a Peer Lending Circle Program to help families save money and increase their credit score, and helped families access health coverage.
- BYA referred families to housing agencies and provided work-readiness services for parents and guardians.

Mental Health Services

The funded CBOs offered a broad array of mental health services, including individual therapy, group therapy, case management, information and referral, prevention and early intervention, for example:

- Alameda Family Services provided case management, counseling, anger manager, substance abuse prevention and treatment programs for high-risk youth and their families in Alameda.
- La Familia provided low-income individuals and families with therapy and case management support and offered group counseling and social skills groups to elementary and middle school students.
- BYA provided individual counseling and had counselors facilitating group counseling to girls of color at middle schools as well as support circles for parents.
- REACH Ashland Youth Center provided individual and crisis response, case management, and many trauma-informed services.
- AIA offered individual coaching and referrals to supports and services.
- New Haven Kid Zone provided resource and referrals, case management, and individual therapy.
- Youth Radio provided group counseling.
- Newark and Fremont Unified provided therapy using trauma informed cognitive behavioral therapy (CBT), art therapy, play therapy, and motivational interviewing.
- Fremont Family Resource Center offered one-on-one case management support.

MEASURE A FUNDING SUMMARY

The 10 member community-based organizations used the (YFO) Initiative Measure A allocation to achieve the following:

Alameda Family Services

- Provide 190 individual sessions that included case management, entitlement, and program enrollment (Cal-Fresh, CalWorks and Medi-Cal) as appropriate, of which 28.5% of services went towards applying for Health Insurance, and 37.5% of services had to do with needs for housing
- Develop a program assessment, to be conducted in the first quarter of FY 13/14

Alternatives in Action

- Provide over 100 youth development programs and activities about topics such as violence prevention, restorative justice, community organizing, leadership development, professional training, and intergenerational dialog
- Engage participation of 350 youth in projects and events developed by and for youth to promote a positive and safe community and school environment
- Engage participation of 120 parents in parent education workshops and events
- Perform a program evaluation of Culture Keepers, a cascading mentorship program with high school mentors and elementary school mentees, that revealed high client satisfaction and program effectiveness

- Achieve more than 90% of program participants reporting that the program helped them set goals, take action against violence in their community, and feel more confident about going to college, and more than 98% reporting that the program helped them stay more connected and make positive changes in their schools and communities
- Achieve program participants showing an increase in SRI (scholastic reading inventory) scores and CAHSEE test scores

Berkeley Youth Alternatives

- Provide 36 mentoring sessions for youth in middle school and high school
- Provide 72 life skills workshops for more than 250 middle school and high school girls in the teenage pregnancy prevention program
- Provide 428 individual sessions of counseling, tutoring, and case management services to 32 middle school and high school youth
- Conduct a client satisfaction survey showing that over 90% of youth and parent participants were satisfied with services

East Bay Asian Youth Center

- Provide more than 100 sessions to over 220 youth at the Dewey After School Learning program
- Provide 178 sessions to 886 youth at the Oakland High School After School Learning program
- Gain participation of 43 youth in the Oakland High School internship program
- Offer a total of 42 ongoing group sessions to 39 youth who attended regularly
- Provide a total of 6,352 individual sessions to more than 120 youth in after-school programming

City of Fremont: Summer Probation Youth Program

- Conduct a survey of probation youth at the end of their summer program showing that 64% identified at least one goal for themselves for the future
- Have more than 90% say that they learned how their choices and actions have an impact now and in the future, and more than 60% say that the program helped them reduce their alcohol and drug use

City of Fremont: Family Resource Center and Our Kids Our Families

- Cut the number of students served by Youth and Family Services who are in crisis or at risk by more than a third over the course of counseling, with more than 83% of students rated stable or higher
- Provide individual family support services to more than 2,000 adults
- Provide engagement and referral or capacity-building group sessions/workshops to more than 300 youth and 600 adults
- Provide youth development sessions focused on character building, community organizing, and healthy relationships to more than 250 youth

Measure A Helps

ALTERNATIVES IN ACTION

As part of their youth campaign to promote nonviolence, Isaac and his peers from the Youth Organizing and Leadership Opportunity (YOLO) Program did a radio spot on Streets Is Talking Radio. The night before the show, Isaac's friend was murdered. Despite the pain that he was in, Isaac was able to harness his emotion and convey the importance of their campaign to the audience. Later that week, Isaac was interviewed by Channel 2 news. He was able to connect the campaign's goal to break the cycles of drugs, violence, and dysfunction with his friend's death. Through his involvement with YOLO, Isaac has received mentorship and guidance, as well as support completing his college FAFSA form and application to college.

- Conduct a satisfaction survey of the voluntary income tax assistance program showing that 98% of respondents would recommend the program to others

La Familia

- Provide over 1,500 individual youth therapy sessions to 179 students
- Offer three different group sessions for elementary and middle school students utilizing a strength-based approach to improve social skills and build confidence
- Provide parent groups and parent workshops to more than 120 parents
- Conduct client surveys that showed that, overall, parents were satisfied with the parent workshops
- Refer 164 families and youth to outside services including CalFresh, Medi-Cal, and health providers

Newark Unified School District

- Conduct bullying prevention session for 550 students in grades K–6
- Offer the El Joven Noble program, which included positive communication skills and moral development focusing on Latino culture and family roles, to 97 participants
- Offer 10 sessions of social skills groups to 56 students in grades 1–6

New Haven Unified School District: Union City Kid Zone

- Create a governance structure that provides overall leadership and promotes shared leadership among the 30+ partners who provide services in and around Union City and make up the Union City Kid Zone
- Complete community canvasing in the Decoto neighborhood and receive over 1,000 surveys in English, Spanish, Tagalog, and Vietnamese
- Secure a $150,000 grant from the S.H. Cowell Foundation to sustain ongoing fund development

REACH Ashland Youth Center

- Officially open the youth center in May 2013 and register 1,245 youth as members in the first three months
- Conduct a client feedback survey completed by 250+ members that showed youth were largely satisfied with youth programming, in particular that youth feel safe at REACH (92.6%), would recommend REACH to friends (92.1%), look forward to coming to REACH (90.8%), and plan to continue coming in the fall (90.1%)
- Achieve 28.2% of youth who responded to the survey reporting that they want to learn to do better in school and 26.2% reporting they wanted to work to improve their community

YMCA of Berkeley Teen Center

- Serve 55 at-risk youth through the YMCA PG&E Teen Center Youth Institute program
- Partner with Berkeley Unified School District (BUSD) and area community-based organizations to implement the year-round after-school Youth Institute program, with 25% of Youth Institute students enrolling in academic support services through the Teen Center
- Collaborate with other community-based organizations to provide teen peer education programming to 250 youth within BUSD, including 10 peer-led technology workshops
- Achieve the following:
  - 20 Youth Institute students participating in internships
  - 50 youth participating in community service projects
  - 50% of Youth Institute students returning for the following year
  - 90% of students showing improved technical proficiency in software
  - 90% of youth participants indicating an increase in self-confidence
  - 90% of youth increasing their community involvement

Youth Radio

- Offer students intensive training in journalism, music production, multimedia arts, and professional development, including teaching students industry-standard software programs such as Reason, ProTools, and Photoshop, and digital platforms such as Soundcloud, Facebook, Twitter, and Wordpress
- Achieve 100% of participants reporting that they could use the skills they learned at Youth Radio, in other areas of their lives
- Achieve 97% of students reporting that Youth Radio staff pay attention to what is going on in their lives, with 96% reporting that they feel respected by other participants in the program
- Help students achieve academic and career success, with 97% of Youth Radio students graduating high school, and 88% going to college

HIGHLIGHTS

Measure A funding enabled the CBOs participating in the YFO initiative to achieve a wide variety of outcomes for a large number of youth and their families.

In addition, the participating CBOs leveraged the YFO initiative Measure A allocation to obtain an additional $5,318,683 in matching funds from the following sources:

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

APPENDICES

APPENDIX A: MEASURE A REVENUE RECEIVED IN EACH FISCAL YEAR

APPENDIX B: FY 12/13 BUDGET INFORMATION

APPENDIX C: FY 12/13 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

APPENDIX D: MAPS: GEOGRAPHIC DISTRIBUTION OF PROVIDERS FUNDED BY MEASURE A IN FY 12/13

Map 1 Alameda County Public Health Programs

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

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

Map 4 School Health Centers

Map 5 HealthPAC Provider Network

APPENDIX A:
MEASURE A REVENUE RECEIVED IN EACH FISCAL YEAR

FISCAL YEAR 04/05

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/22/04	07/04	5,211,585	1,737,195	6,948,780	5,211,585	1,737,195	6,948,780
10/21/04	08/04	5,142,150	1,714,050	6,856,200	10,353,735	3,451,245	13,804,980
11/19/04	09/04	6,856,200	2,285,400	9,141,600	17,209,935	5,736,645	22,946,580
12/28/04	10/04	5,494,355	1,831,452	7,325,807	22,704,290	7,568,097	30,272,387
01/19/05	11/04	5,437,350	1,812,450	7,249,800	28,141,640	9,380,547	37,522,187
02/17/05	12/04	7,249,800	2,416,600	9,666,400	35,391,440	11,797,147	47,188,587
03/31/05	01/05	6,299,953	2,099,984	8,399,937	41,691,393	13,897,131	55,588,524
04/21/05	02/05	4,291,500	1,430,500	5,722,000	45,982,893	15,327,631	61,310,524
05/18/05	03/05	5,722,050	1,907,350	7,629,400	51,704,943	17,234,981	68,939,924
06/24/05	04/05	8,412,419	2,804,139	11,216,559	60,117,362	20,039,120	80,156,483
07/20/05	05/05	4,988,025	1,662,676	6,650,700	65,105,387	21,701,796	86,807,183
08/19/05	06/05	6,650,700	2,216,900	8,867,600	71,756,087	23,918,696	95,674,783
	INTEREST EARNED		116,927	116,927			
	TOTAL	**71,756,087**	**24,035,623**	**95,791,710**			

FISCAL YEAR 05/06

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/23/05	07/05	7,593,094	2,531,031	10,124,125	7,593,094	2,531,031	10,124,125
10/20/05	08/05	4,791,900	1,597,300	6,389,200	12,384,994	4,128,331	16,513,325
11/18/05	09/05	6,389,250	2,129,750	8,519,000	18,774,244	6,258,081	25,032,325
12/23/05	10/05	10,712,696	3,570,899	14,283,595	29,486,940	9,828,980	39,315,920
01/19/06	11/05	5,642,475	1,880,825	7,523,300	35,129,415	11,709,805	46,839,220
02/16/06	12/05	7,523,250	2,507,750	10,031,000	42,652,665	14,217,555	56,870,220
03/31/06	01/06	7,854,305	2,618,102	10,472,407	50,506,970	16,835,657	67,342,627
04/21/06	02/06	5,059,800	1,686,600	6,746,400	55,566,770	18,522,257	74,089,027
05/18/06	03/06	6,746,400	2,248,800	8,995,200	62,313,170	20,771,057	83,084,227
06/23/06	04/06	7,371,527	2,457,176	9,828,703	69,684,697	23,228,233	92,912,930
07/20/06	05/06	5,450,100	1,816,700	7,266,800	75,134,797	25,044,933	100,179,730
08/17/06	06/06	7,266,825	2,422,275	9,689,100	82,401,622	27,467,208	109,868,830
	INTEREST EARNED		380,741	380,741			
	TOTAL	**82,401,622**	**27,847,949**	**110,249,571**			

FISCAL YEAR 06/07

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/22/06	07/06	8,322,635	2,774,212	11,096,847	8,322,635	2,774,212	11,096,847
10/18/06	08/06	5,513,100	1,837,700	7,350,800	13,835,735	4,611,912	18,447,647
11/16/06	09/06	9,242,400	3,080,800	12,323,200	23,078,135	7,692,712	30,770,847
12/22/06	10/06	7,953,029	2,651,009	10,604,038	31,031,164	10,343,721	41,374,885
01/18/07	11/06	6,025,875	2,008,625	8,034,500	37,057,039	12,352,346	49,409,385
02/22/07	12/06	8,004,300	2,668,100	10,672,400	45,061,339	15,020,446	60,081,785
03/29/07	01/07	6,588,768	2,196,256	8,785,024	51,650,107	17,216,702	68,866,809
04/18/07	02/07	5,224,050	1,741,350	6,965,400	56,874,157	18,958,052	75,832,209
05/17/07	03/07	6,965,400	2,321,800	9,287,200	63,839,557	21,279,852	85,119,409
06/22/07	04/07	8,152,952	2,717,651	10,870,603	71,992,509	23,997,503	95,990,012
07/19/07	05/07	5,736,525	1,912,175	7,648,700	77,729,034	25,909,678	103,638,712
08/16/07	06/07	7,648,725	2,549,575	10,198,300	85,377,759	28,459,253	113,837,012
INTEREST EARNED			655,872	655,872			
	TOTAL	**85,377,759**	**29,115,125**	**114,492,884**			

FISCAL YEAR 07/08

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/26/07	07/07	8,530,372	2,843,457	11,373,829	8,530,372	2,843,457	11,373,829
10/18/07	08/07	6,117,375	2,039,125	8,156,500	14,647,747	4,882,582	19,530,329
11/21/07	09/07	8,156,475	2,718,825	10,875,300	22,804,222	7,601,407	30,405,629
12/28/07	10/07	7,883,441	2,627,814	10,511,255	30,687,663	10,229,221	40,916,884
01/16/08	11/07	6,205,800	2,068,600	8,274,400	36,893,463	12,297,821	49,191,284
02/21/08	12/07	8,274,375	2,758,125	11,032,500	45,167,838	15,055,946	60,223,784
03/27/08	01/08	7,183,405	2,394,468	9,577,873	52,351,243	17,450,414	69,801,657
04/17/08	02/08	5,386,200	1,795,400	7,181,600	57,737,443	19,245,814	76,983,257
05/22/08	03/08	7,181,625	2,393,875	9,575,500	64,919,068	21,639,689	86,558,757
06/24/08	04/08	8,049,440	2,683,146	10,732,586	72,968,508	24,322,835	97,291,343
07/18/08	05/08	5,966,175	1,988,725	7,954,900	78,934,683	26,311,560	105,246,243
08/21/08	06/08	7,954,875	2,651,625	10,606,500	86,889,558	28,963,185	115,852,743
INTEREST EARNED			766,401	766,401			
	TOTAL	**86,889,558**	**29,729,586**	**116,619,144**			

FISCAL YEAR 08/09

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/25/08	07/08	8,032,186	2,677,396	10,709,582	8,032,186	2,677,396	10,709,582
10/15/08	08/08	6,121,050	2,040,350	8,161,400	14,153,236	4,717,746	18,870,982
11/20/08	09/08	8,161,425	2,720,475	10,881,900	22,314,661	7,438,221	29,752,882
12/26/08	10/08	6,854,632	2,284,877	9,139,509	29,169,293	9,723,098	38,892,391
01/22/09	11/08	6,073,950	2,024,650	8,098,600	35,243,243	11,747,748	46,990,991
02/19/09	12/08	6,661,050	2,220,350	8,881,400	41,904,293	13,968,098	55,872,391
03/27/09	01/09	6,506,559	2,168,853	8,675,412	48,410,852	16,136,951	64,547,803
04/16/09	02/09	5,227,725	1,742,575	6,970,300	53,638,577	17,879,526	71,518,103
05/21/09	03/09	5,471,475	1,823,825	7,295,300	59,110,052	19,703,351	78,813,403
06/23/09	04/09	5,786,013	1,921,503	7,707,516	64,896,065	21,624,854	86,499,416
07/16/09	05/09	5,148,450	1,716,150	6,864,600	70,044,515	23,341,004	93,364,016
08/20/09	06/09	5,906,775	1,968,925	7,875,700	75,951,290	25,309,929	101,239,716
INTEREST EARNED			363,681	363,681			
	TOTAL	**75,951,290**	**25,673,610**	**101,603,397**			

FISCAL YEAR 09/10

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/29/09	07/09	6,149,831	2,049,944	8,199,775	6,149,831	2,049,944	8,199,775
10/22/09	08/09	5,255,175	1,751,725	7,006,900	11,405,006	3,801,669	15,206,675
11/12/09	09/09	5,621,400	1,873,800	7,495,200	17,026,406	5,675,469	22,701,875
12/17/09	10/09	6,841,664	2,280,555	9,122,219	23,868,070	7,956,024	31,824,094
01/14/10	11/09	5,547,675	1,849,225	7,396,900	29,415,745	9,805,249	39,220,994
02/18/10	12/09	7,083,300	2,361,100	9,444,400	36,499,045	12,166,349	48,665,394
03/22/10	01/10	5,300,019	1,766,673	7,066,692	41,799,064	13,933,022	55,732,086
04/16/10	02/10	4,565,100	1,521,700	6,086,800	46,364,164	15,454,722	61,818,886
05/19/10	03/10	6,271,650	2,090,550	8,362,200	52,635,814	17,545,272	70,181,086
06/17/10	04/10	6,715,126	2,238,375	8,953,502	59,350,940	19,783,647	79,134,587
07/06/10	05/10	4,990,200	1,663,400	6,653,600	64,341,140	21,447,047	85,788,187
08/19/10	06/10	6,246,750	2,082,250	8,329,000	70,587,890	23,529,297	94,117,187
INTEREST EARNED			89,426	89,426			
	TOTAL	**70,587,890**	**23,618,724**	**94,206,613**			

FISCAL YEAR 10/11

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/06/10	07/10	7,621,466	2,540,489	10,161,954	7,621,466	2,540,489	10,161,954
10/05/10	08/10	5,148,675	1,716,225	6,864,900	14,486,366	4,256,714	17,026,854
11/19/10	09/10	6,414,900	2,138,300	8,553,200	23,039,566	6,395,014	25,580,054
12/16/10	10/10	7,979,212	2,659,737	10,638,949	33,678,514	9,054,751	36,219,003
01/05/10	11/10	5,770,575	1,923,525	7,694,100	41,372,614	10,978,276	43,913,103
02/14/11	12/10	7,202,100	2,400,700	9,602,800	40,136,927	13,378,976	53,515,903
03/18/11	01/11	6,419,660	2,139,887	8,559,546	46,556,587	15,518,862	62,075,449
04/06/11	02/11	5,011,275	1,670,425	6,681,700	51,567,862	17,189,287	68,757,149
05/18/11	03/11	6,808,575	2,269,525	9,078,100	58,376,437	19,458,812	77,835,249
06/17/11	04/11	7,606,900	2,535,633	10,142,533	65,983,337	21,994,446	87,977,782
07/06/11	05/11	5,865,000	1,955,000	7,820,000	71,848,337	23,949,446	95,797,782
08/17/11	06/11	7,286,775	2,428,925	9,715,700	79,135,112	26,378,371	105,513,482
INTEREST EARNED			51,101	51,101			
	TOTAL	**79,135,112**	**26,429,471**	**105,564,583**			

FISCAL YEAR 11/12

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/16/11	07/11	6,851,714	2,283,905	9,135,619	6,851,714	2,283,905	9,135,619
10/13/11	08/11	5,564,625	1,854,875	7,419,500	12,416,339	4,138,780	16,555,119
11/23/11	09/11	6,840,450	2,280,150	9,120,600	19,256,789	6,418,930	25,675,719
12/23/11	10/11	9,250,127	3,083,376	12,333,502	28,506,916	9,502,305	38,009,221
01/17/12	11/11	6,181,350	2,060,450	8,241,800	34,688,266	11,562,755	46,251,021
02/14/12	12/11	7,774,725	2,591,575	10,366,300	42,462,991	14,154,330	56,617,321
03/16/12	01/12	7,386,032	2,462,011	9,848,043	49,849,023	16,616,341	66,465,364
04/02/12	02/12	5,637,150	1,879,050	7,516,200	55,486,173	18,495,391	73,981,564
05/24/12	03/12	7,006,050	2,335,350	9,341,400	62,492,223	20,830,741	83,322,964
06/14/12	04/12	8,143,605	2,714,535	10,858,140	70,635,828	23,545,276	94,181,104
07/10/12	05/12	6,139,200	2,046,400	8,185,600	76,775,028	25,591,676	102,366,704
08/15/12	06/12	7,630,350	2,543,450	10,173,800	84,405,378	28,135,126	112,540,504
INTEREST EARNED			54,248	54,248			
	TOTAL	**84,405,378**	**28,189,374**	**112,594,752**			

FISCAL YEAR 12/13

DATE RECEIVED	MONTH EARNED	ALAMEDA HEALTH SYSTEM	COUNTY	TOTAL	ALAMEDA HEALTH SYSTEM CUMULATIVE TOTAL	COUNTY CUMULATIVE TOTAL	CUMULATIVE TOTAL
09/20/12	07/12	8,629,696	2,876,565	11,506,262	8,629,696	2,876,565	11,506,262
10/2/12	08/12	6,461,925	2,153,975	8,615,900	15,091,621	5,030,540	20,122,162
11/14/12	09/12	8,058,525	2,686,175	10,744,700	23,150,146	7,716,715	30,866,862
12/17/12	10/12	8,133,215	2,711,072	10,844,287	31,283,362	10,427,787	41,711,149
12/27/12	11/12	6,197,775	2,065,925	8,263,700	37,481,137	12,493,712	49,974,849
02/12/13	12/12	8,346,525	2,782,175	11,128,700	45,827,662	15,275,887	61,103,549
03/18/13	01/13	8,019,683	2,673,228	10,692,910	53,847,345	17,949,115	71,796,459
03/29/13	02/13	6,209,550	2,069,850	8,279,400	60,056,895	20,018,965	80,075,859
05/14/13	03/13	7,568,775	2,522,925	10,091,700	67,625,670	22,541,890	90,167,559
06/19/13	04/13	7,881,560	2,627,187	10,508,746	75,507,229	25,169,076	100,676,306
07/01/13	05/13	6,827,475	2,275,825	9,103,300	82,334,704	27,444,901	109,779,606
08/12/13	06/13	8,452,200	2,817,400	11,269,600	90,786,904	30,262,301	121,049,206
INTEREST EARNED			45,124	45,124			
	TOTAL	**90,786,904**	**30,307,425**	**121,094,329**			

APPENDIX B: FY 12/13 BUDGET INFORMATION

	APPROVED BASE ALLOCATION	BUDGET ADJUSTMENTS	TOTAL ALLOCATION	CARRYOVER FROM PREVIOUS FISCAL YEAR[1]	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR[1]	TOTAL	SAVINGS[2]
Group 1: Behavioral Health									
Alameda County Behavioral Health Care Services (BHCS) Community-Based Organizations (CBOs)	724,000	200,000	924,000	0	924,000	416,410	0	416,410	507,590
Building Opportunities for Self-Sufficiency (BOSS)	0	75,000	75,000	0	75,000	75,000	0	75,000	0
Center for Empowering Refugees and Immigrants	0	75,000	75,000	0	75,000	75,000	0	75,000	0
Cherry Hill Sobering and Detoxification Center	2,000,000	0	2,000,000	2,064,342	4,064,342	1,936,821	2,064,342	4,001,163	63,179
Criminal Justice Screening and In-Custody Services	4,056,000	250,000	4,306,000	0	4,306,000	4,306,000	0	4,306,000	0
Mental Health Services for Juvenile Justice Center	360,000	0	360,000	0	360,000	360,000	0	360,000	0
School Health Services (School-Based Behavioral Health Initiative)	600,000	0	600,000	0	600,000	600,000	0	600,000	0
Group 2: Hospital, Tertiary Care, Other									
Children's Hospital & Research Center Oakland	2,000,000	0	2,000,000	0	2,000,000	2,000,000	0	2,000,000	0
St. Rose Hospital	2,000,000	0	2,000,000	0	2,000,000	2,000,000	0	2,000,000	0
Administration/Infrastructure Support	191,098	0	191,098	0	191,098	148,799	0	148,799	42,299
Group 3: Primary Care									
Alameda County Dental Health	150,000	0	150,000	0	150,000	150,000	0	150,000	0
Alameda Health Consortium: Electronic Health Record and Capital	0	1,600,000	1,600,000	0	1,600,000	1,600,000	0	1,600,000	0
California Telehealth Network	0	47,500	47,500	0	47,500	47,500	0	47,500	0
Capital Expansion	0	800,000	800,000	0	800,000	800,000	0	800,000	0
Center for Elders' Independence[3]	50,000	0	50,000	0	50,000	0	0	0	50,000
Fire Station Health Portals	750,000	0	750,000	677,950	1,427,950	3,176	1,424,774	1,427,950	0
Fremont Aging and Family Services	50,000	0	50,000	0	50,000	50,000	0	50,000	0
Health Enrollment for Children	160,000	0	160,000	0	160,000	160,000	0	160,000	0
Health Insurance Eligibility and Enrollment	0	200,000	200,000	0	200,000	200,000	0	200,000	0
Health Services for Day Laborers	150,000	75,000	225,000	0	225,000	225,000	0	225,000	0
Healthy Communities, Inc.	0	200,000	200,000	0	200,000	200,000	0	200,000	0
HillCare Foundation	0	26,000	26,000	0	26,000	26,000	0	26,000	0
Hospice: Getting The Most Out of Life Program	0	75,000	75,000	0	75,000	70,296	0	75,000	4,704
Medical Costs for Juvenile Justice Center	199,000	0	199,000	0	199,000	145,000	0	199,000	54,000
Preventive Care Pathways	100,000	300,000	400,000	0	400,000	400,000	0	400,000	0

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APPENDIX B: FY 12/13 BUDGET INFORMATION (CONTINUED)

	APPROVED BASE ALLOCATION	BUDGET ADJUSTMENTS	TOTAL ALLOCATION	CARRYOVER FROM PREVIOUS FISCAL YEAR[1]	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR[1]	TOTAL	SAVINGS[2]
Group 3: Primary Care (Continued)									
Primary Care Community-Based Organizations[3]	5,511,603	0	5,511,603	0	5,511,603	5,472,584	0	5,472,584	39,019
Provider Quality Improvement Project	0	10,000	10,000	0	0	0	0	0	10,000
Roots Community Health Center	0	30,000	30,000	0	30,000	30,000	0	30,000	0
School Health Centers	1,400,000	0	1,400,000	0	1,400,000	1,400,000	0	1,400,000	0
Tri-City Health Center: General Budget Stabilization	0	300,000	300,000	0	300,000	300,000	0	300,000	0
Group 4: Public Health									
AIDS Providers	0	200,000	200,000	0	200,000	150,000	0	150,000	50,000
Alameda Boys & Girls Club, Inc.	25,000	0	25,000	0	25,000	25,000	0	25,000	0
Alameda County Asthma Start	100,000	0	100,000	0	100,000	100,000	0	100,000	0
California Prevention & Education Project (CAL-PEP)	0	250,000	250,000	0	250,000	250,000	0	250,000	0
Center for Early Intervention on Deafness	50,000	0	50,000	0	50,000	50,000	0	50,000	0
Centerforce	0	14,992	14,992	0	14,992	14,992	0	14,992	0
City of San Leandro	50,000	0	50,000	0	50,000	50,000	0	50,000	0
Davis Street Family Resource Center	0	100,000	100,000	0	100,000	100,000	0	100,000	0
Deputy Sheriff's Activities League/REACH AYC	0	20,000	20,000	0	20,000	20,000	0	20,000	0
Eden Youth and Family Center	0	150,000	150,000	0	150,000	150,000	0	150,000	0
Environmental Health: Improve Field Sanitation Conditions/Nail Salons[1]	0	50,000	50,000	0	50,000	12,681	12,319	25,000	25,000
Environmental Health: GPS Monitoring System[1]	0	150,000	150,000	0	150,000	125,807	24,193	150,000	0
Federally Qualified Health Center Capacity Building	0	86,000	86,000	0	86,000	0	0	0	86,000
Latino Commission on Alcohol and Drug Abuse	0	150,000	150,000	0	150,000	150,000	0	150,000	0
LifeLong Medical Care: Heart 2 Heart	0	100,000	100,000	0	100,000	100,000	0	100,000	0
Office of AIDS Administration: Ryan White Providers	0	100,000	100,000	0	100,000	100,000	0	100,000	0
Public Health Prevention Initiative	2,784,000	0	2,784,000	0	2,784,000	2,783,635	0	2,783,635	365
Public Health Food Security/Food Justice Strategy	0	150,000	150,000	0	150,000	150,000	0	150,000	0
Public Health Pilot to Decrease Absenteeism in Schools	0	150,000	150,000	0	150,000	150,000	0	150,000	0
Senior Injury Prevention Program	100,000	0	100,000	0	100,000	100,000	0	100,000	0
Service Opportunity for Seniors (Meals on Wheels)	0	250,000	250,000	0	250,000	250,000	0	250,000	0
SSI Housing Trust[1,4]	0	0	0	1,000,000	1,000,000	52,389	947,611	1,000,000	0
Youth and Family Opportunity Initiatives[1]	2,450,000	0	2,450,000	107,057	2,557,057	2,048,371	508,686	2,557,057	0

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APPENDIX B: FY 12/13 BUDGET INFORMATION (CONTINUED)

	APPROVED BASE ALLOCATION	BUDGET ADJUSTMENTS	TOTAL ALLOCATION	CARRYOVER FROM PREVIOUS FISCAL YEAR[1]	TOTAL AVAILABLE FUNDS	EXPENDED AND/OR ENCUMBERED	CARRYOVER TO NEXT FISCAL YEAR[1]	TOTAL	SAVINGS[2]
Reserve	250,000	0	250,000	0	250,000	0	0	0	250,000
Board of Supervisors	750,000	0	750,000	981,041	1,731,041	632,909	1,098,132	1,731,041	0
TOTAL FY 12/13	**27,010,701**	**6,184,492**	**33,195,193**	**4,830,390**	**38,025,583**	**30,763,370**	**6,080,057**	**36,843,427**	**1,182,156**

1. The Board of Supervisors approved certain allocations to carry over unexpended funds to the next fiscal year. The carryover funds must be used for the same purpose for which the Board approved the original allocation.

2. Savings are unexpended funds that will revert to the general Measure A account for reallocation in future fiscal years.

3. The contract associated with this allocaiton encumbered funds that included Measure A allocations for both FY 11/12 and FY 12/13.

4. On June 5, 2012, the Board of Supervisors approved the reallocation of $1,000,000 from the Sobering and Detoxification Center to Supplemental Security Income (SSI) Housing Trust augmentation for General Assistance clients.

APPENDIX C:
FY 12/13 MEASURE A FUND DISTRIBUTION BY PROVIDER OR PROGRAM

	MEASURE A ALLOCATION FY 12/13	EXPENDED/ ENCUMBERED FY 12/13
GROUP 1: BEHAVIORAL HEALTH		
Alameda County Behavioral Health Care Services Community-Based Providers	**924,000**	**416,410**
Mental Health Providers		
Alameda County Mental Health Association	31,634	31,634
Alameda Family Services	3,960	3,960
Asian Community Mental Health Services	8,076	8,076
Axis Community Health, Inc.	8,213	6,063
Bay Area Legal Aid	75,000	33,095
Berkeley Addiction Treatment Services, Inc.	4,511	4,511
Bi-Bett Corporation	1,616	1,616
Bonita House, Inc.	48,277	48,277
Building Opportunities for Self Sufficiency (BOSS)	13,355	13,355
Carnales Unidos Reformando Adictos	19,701	19,701
Center for Independent Living	2,069	2,069
Community Health for Asian Americans	2,113	2,113
Crisis Support	27,936	27,936
East Bay Community Recovery Project	30,152	30,152
Filipino Advocates for Justice	2,026	2,026
Horizon Services, Inc.	29,241	-
Humanistic Alternatives to Addiction	2,091	2,091
Latino Commission on Alcohol and Drug Abuse of Alameda County	47,963	17,842
Magnolia Women's Recovery Programs, Inc.	3,599	3,599
Native American Health Center, Inc.	2,726	2,726
Native American Health Center, Inc.	1,786	1,786
New Bridge Foundation, Inc.	40,055	40,055
Second Chance, Inc.	43,507	43,507
Solid Foundation, Inc.	3,575	-
Southern Alameda County Committee for Raza Mental Health	43,248	43,248
St. Mary's Center	3,513	3,513
Thunder Road-Adolescent Treatment	8,588	8,588
West Oakland Health Council, Inc.	21,199	14,871
Unallocated	194,270	-
Total Allocation	**724,000**	**416,410**
Building Opportunities for Self-Sufficiency (BOSS)	**75,000**	**75,000**
Center for Empowering Refugees and Immigrants	**75,000**	**75,000**
Criminal Justice Screening and In-Custody Services	**4,306,000**	**4,306,000**
Detoxification/Sobering Center	**2,000,000**	**1,936,821**

	MEASURE A ALLOCATION FY 12/13	EXPENDED/ ENCUMBERED FY 12/13
GROUP 1: BEHAVIORAL HEALTH (CONTINUED)		
East Bay Community Recovery Project (BOS D5)	**35,000**	**35,000**
Mental Health Services for Juvenile Justice Center	**360,000**	**360,000**
National Alliance on Mental Illness Tri-Valley (BOS D1)	**17,000**	**17,000**
Safe Alternatives to Violent Environments (SAVE) (BOS D1)	**50,000**	**50,000**
School Health Services (School-Based Behavioral Health Initiative)	**600,000**	**600,000**
Youth ALIVE! (BOS D5)	**25,000**	**25,000**

	MEASURE A ALLOCATION FY 12/13	EXPENDED/ ENCUMBERED FY 12/13
GROUP 2: HOSPITAL, TERTIARY CARE, OTHER		
Children's Hospital & Research Center Oakland	**2,000,000**	**2,000,000**
St. Rose Hospital	**2,000,000**	**2,000,000**
ValleyCare Foundation (BOS D1)	**20,000**	**20,000**
Washington Hospital (BOS D1)	**20,000**	**20,000**
Administration/Infrastructure Support	**191,098**	**148,799**

	MEASURE A ALLOCATION FY 12/13	EXPENDED/ ENCUMBERED FY 12/13
GROUP 3: PRIMARY CARE		
Alameda County Dental Health	**150,000**	**150,000**
Alameda Health Consortium: Electronic Health Record and Capital	**1,600,000**	**1,600,000**
California Telehealth Network	**47,500**	**47,500**
Capital Expansion		
Asian Health Services	200,000	200,000
Axis Community Health	200,000	200,000
LifeLong Medical Care, Inc.	200,000	200,000
Tiburcio Vasquez Health Center, Inc.	200,000	200,000
Total Allocation	**800,000**	**800,000**
Center for Elders' Independence	**50,000**	**0**
Fire Station Health Portals	**750,000**	**3,176**
Fremont Aging and Family Services	**50,000**	**50,000**
Health Enrollment for Children	**160,000**	**160,000**
Health Insurance Eligibility and Enrollment	**200,000**	**200,000**
Health Services for Day Laborers: Community Initiatives (Day Labor Center)	**75,000**	**75,000**
Health Services for Day Laborers: Multicultural Institute	**75,000**	**75,000**

	MEASURE A ALLOCATION FY 12/13	EXPENDED/ ENCUMBERED FY 12/13
GROUP 3: PRIMARY CARE (CONTINUED)		
Health Services for Day Laborers: Street Level Health Project	**75,000**	**75,000**
Healthy Communities, Inc.	**200,000**	**200,000**
HillCare Foundation (One-time funding and BOS D4)	**36,000**	**36,000**
Hospice: Getting the Most Out of Life Program	**75,000**	**68,031**
Medical Costs for Juvenile Justice Center: Mind Body Awareness	**55,000**	**55,000**
Medical Costs for Juvenile Justice Center: Victims of Crime	**90,000**	**90,000**
Preventive Care Pathways	**400,000**	**400,000**
Primary Care Community-Based Organizations		
Alameda Health Consortium	12,736	12,736
Asian Health Services	712,774	712,774
AXIS Community Health Center	454,215	454,215
Healthy Communities	270,994	270,994
La Clínica de la Raza	1,143,863	1,143,863
LifeLong Medical Center	661,152	661,152
Native American Health Center	337,144	337,144
Tiburcio Vasquez Health Center	618,594	618,594
Tri-City Health Center	465,900	465,900
West Oakland Health Council	795,206	795,206
Unallocated	39,019	0
Total Allocation	**5,511,603**	**5,472,584**
Roots Community Health Center	**30,000**	**30,000**
School Health Services (School Health Centers)		
Alameda Family Services (Alameda, Encinal, and Island/Base Health Centers)	190,000	190,000
Children's Hospital Medical Center (Chappell Hayes and Youth Uprising)	140,000	140,000
City of Berkeley (Berkeley High and B-Tech Health Centers)	120,000	120,000
East Bay Agency for Children (Frick)	25,000	25,000
East Bay Asian Youth Center (Oakland High)	70,000	70,000
La Clínica de La Raza (Roosevelt, TechniClinic, Tiger Clinic, and San Lorenzo High)	280,000	280,000
Tiburcio Vasquez Health Center (Tennyson and Logan Health Centers)	140,000	140,000
Evaluation	435,000	435,000
Total Allocation	**1,400,000**	**1,400,000**
Tiburcio Vasquez Health Center, Inc. (BOS D2)	**60,000**	**60,000**
Tri-City Health Center: General Budget Stabilization	**300,000**	**300,000**
Tri-City Health Center: Mowry Clinic (BOS D1)	**33,000**	**33,000**

	MEASURE A ALLOCATION FY 12/13	EXPENDED/ ENCUMBERED FY 12/13
GROUP 4: PUBLIC HEALTH		
AIDS Providers		
AIDS Healthcare Foundation	50,000	50,000
AIDS Project of the East Bay	50,000	50,000
Bay Area Consortium for Quality Health Care	50,000	0
East Bay AIDS Center	50,000	50,000
Total Allocation	**200,000**	**150,000**
Alameda Boys & Girls Club, Inc.	**25,000**	**25,000**
Alameda County Asthma Start	**100,000**	**100,000**
California Prevention & Education Project (CAL-PEP)	**250,000**	**250,000**
California Product Stewardship Council (BOS D4)	**22,000**	**22,000**
Center for Early Intervention on Deafness	**50,000**	**50,000**
Centerforce	**14,992**	**14,992**
City of San Leandro	**50,000**	**50,000**
Davis Street Family Resource Center	**100,000**	**100,000**
Deputy Sheriffs' Activities League/REACH AYC	**20,000**	**20,000**
Drivers for Survivors, Inc. (BOS D1)	**15,000**	**15,000**
East Bay Korean American Senior Services Center (BOS D5)	**10,000**	**10,000**
Eden Youth and Family Center	**150,000**	**150,000**
Environmental Health: Improve Field Sanitation Conditions/Nail Salons	**50,000**	**12,681**
Environmental Health: GPS Monitoring System	**150,000**	**125,807**
HIV Education & Prevention Project of Alameda County (HEPPAC) (BOS D3, D4, D5)	**35,000**	**35,000**
Latino Commission on Alcohol and Drug Abuse of Alameda County	**150,000**	**150,000**
LifeLong Medical Care: Heart 2 Heart	**100,000**	**100,000**
Office of AIDS Administration: Ryan White Providers		
AIDS Project of the East Bay	15,000	15,000
Allen Temple Health and Social Services	15,000	15,000
La Clínica de la Raza	14,948	14,948
LifeLong Medical	15,000	15,000
Project Open Hand	14,300	14,300
Tri-City Health Center	15,000	15,000
Total Allocation	**100,000**	**100,000**
Public Health Prevention Initiative		
Chronic Disease & Injury Prevention		
Asthma	203,967	201,092
Community-Designed Initiative	80,013	80,013
Diabetes	262,097	255,901
EMS	175,000	175,000
Healthy Kids Healthy Teeth	144,626	156,511
Project New Start	17,479	20,049
Total	**883,182**	**888,566**

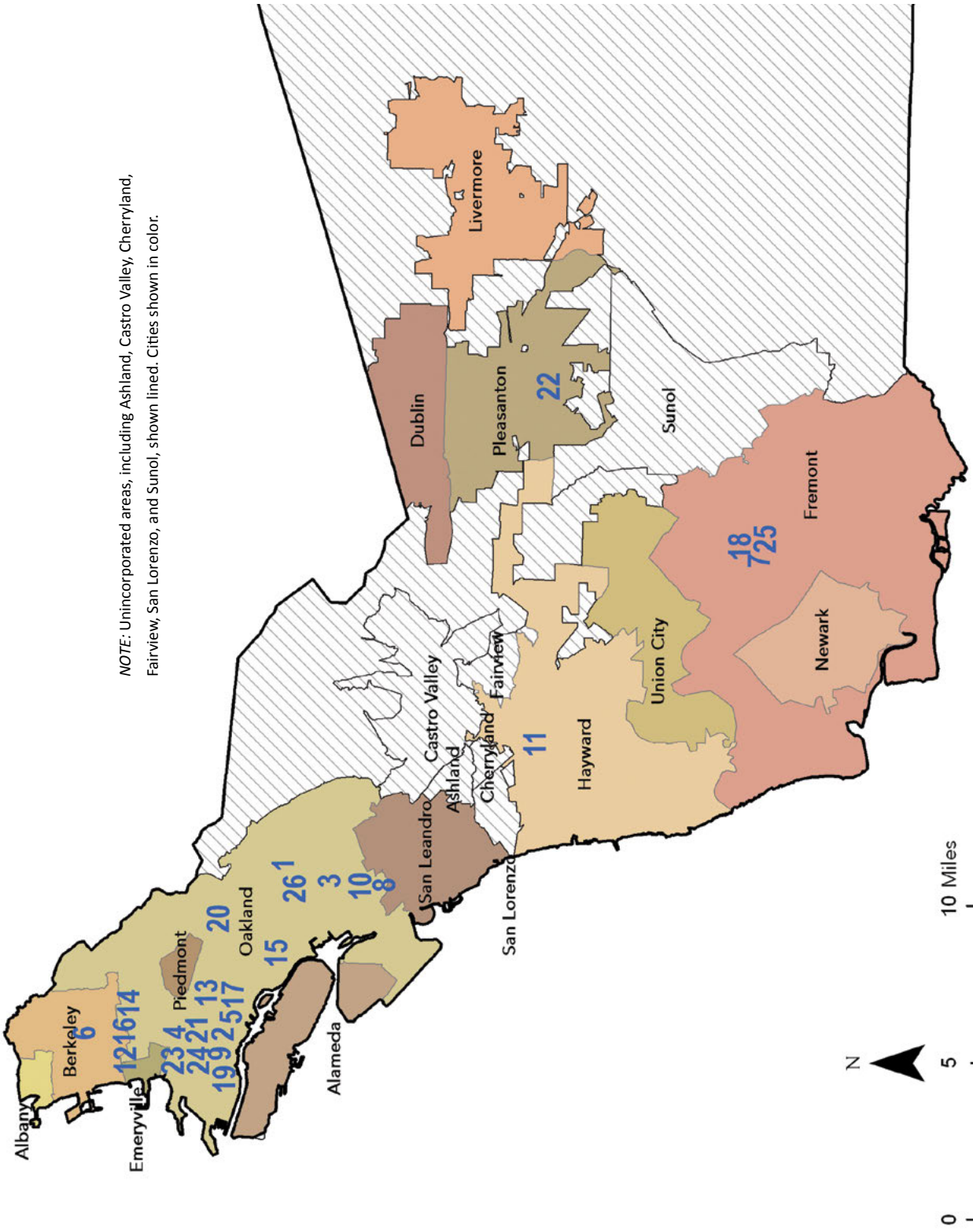
	MEASURE A ALLOCATION FY 12/13	EXPENDED/ ENCUMBERED FY 12/13
GROUP 4: PUBLIC HEALTH (CONTINUED)		
Health Inequities & Community Capacity-Building		
Community Nursing	95,037	103,923
Community-Designed Initiative	108,021	117,656
FHS - Healthy Passage System of Care	77,664	90,558
HIV Prevention	96,522	96,522
Immunization Registry	196,378	218,765
Office of Director/CAPE	499,491	505,829
Total	**1,073,113**	**1,133,253**
Obesity Prevention & School Health		
Community-Designed Initiative	354,589	355,921
Nutrition Services	296,302	296,302
Public Health Nursing	176,814	169,431
Total	**827,705**	**821,654**
Total Allocation	**2,784,000**	**2,783,635**
Public Health Food Security/Food Justice Strategy	**150,000**	**150,000**
Public Health Pilot to Decrease Absenteeism in Schools	**150,000**	**150,000**
Senior Injury Prevention Program	**100,000**	**100,000**
Service Opportunity for Seniors (Meals on Wheels) (One-time funding and BOS D4)	**266,000**	**266,000**
Spectrum Community Services, Inc. (BOS D2, D3, D4)	**75,000**	**75,000**
SSI Housing Trust	**1,000,000**	**52,389**
Teleosis Institute (BOS D4)	**11,080**	**11,080**
Urban Strategies Council, Inc. (BOS D4)	**99,840**	**99,840**
Youth and Family Opportunity Initiatives		
Alameda Family Services	100,000	100,000
Berkeley YMCA	100,000	100,000
Berkeley Youth Alternatives (BYA)	100,000	100,000
East Bay Asian Youth Center (EBAYC)	100,000	100,000
City of Fremont	295,909	295,909
La Familia Counseling Service	150,000	150,000
McClymonds Youth and Family Center Alternatives in Action (AIA)	250,000	250,000
Newark Unified School District	79,091	79,091
New Haven Unified School District	175,000	175,000
REACH Ashland Youth Center	598,372	598,372
Youth Radio	100,000	100,000
Total Allocation	**2,450,000**	**2,048,371**

MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS FUNDED BY MEASURE A IN FY 12/13

#	PROVIDER	CITY
1	Adult Day Services Network of Alameda County	Oakland
2	AIDS Project of The East Bay	Oakland
3	Allen Temple Health & Social Services	Oakland
4	Attitudinal Healing Connection, Inc	Oakland
5	California Prevention and Education	Oakland
6	City of Berkeley	Berkeley
7	City of Fremont	Fremont
8	Community Reformed Church	Oakland
9	Dental Health Foundation	Oakland
10	East Oakland Boxing Association	Oakland
11	Hayward Unified School District	Hayward
12	Higher Ground Neighborhood Development	Oakland
13	HIV Education and Prevention Project of Alameda County	Oakland

#	PROVIDER	CITY
14	Institute For Food and Development	Oakland
15	La Clinica De La Raza, Inc.	Oakland
16	LifeLong Medical Care Inc.	Oakland
17	Lotus Bloom	Oakland
18	Lucile Packard Children's Hospital Stanford	Fremont
19	Mandela MarketPlace	Oakland
20	Niroga Institute, Inc.	Oakland
21	Project Open Hand	Oakland
22	Senior Support of the Tri-Valley	Pleasanton
23	St. Mary’s Center	Oakland
24	Tides Center	Oakland
25	Tri-City Health Center	Fremont
26	United Seniors of Oakland and Alameda	Oakland

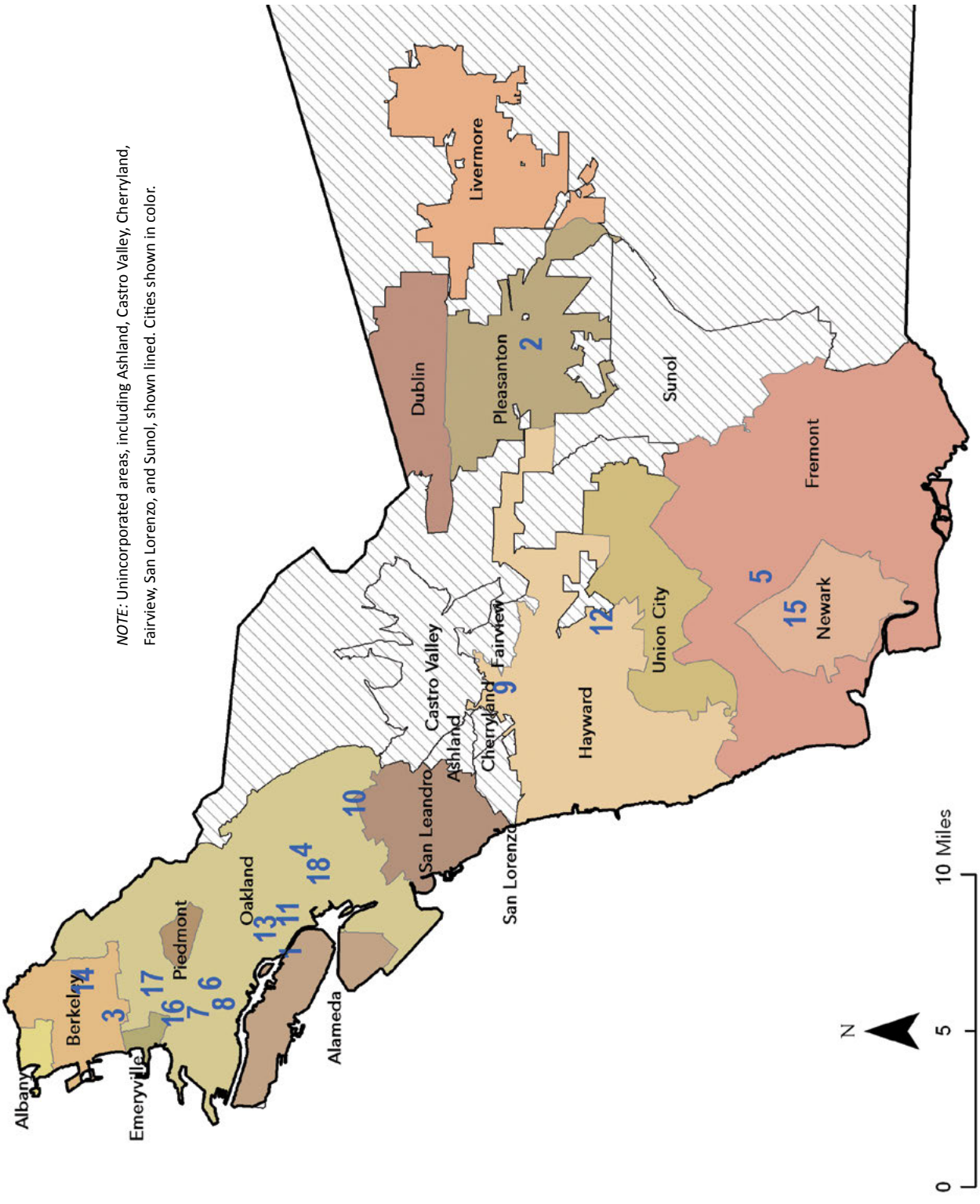
MAP 1
ALAMEDA COUNTY PUBLIC HEALTH PROGRAMS
FUNDED BY MEASURE A IN FY 12/13



MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES ALCOHOL AND OTHER DRUG PROVIDERS FUNDED BY MEASURE A IN FY 12/13

#	PROVIDER	CITY
1	Alameda Family Services	Alameda
2	Axis Community Health, Inc.	Pleasanton
3	Berkeley Addiction Treatment Services, Inc.	Berkeley
4	Bi-Bett Corporation	Oakland
5	Carnales Unidos Reformando Adictos	Fremont
6	Community Health for Asian Americans	Oakland
7	East Bay Community Recovery Project	Oakland
8	Filipino Advocates for Justice	Oakland
9	Horizon Services, Inc.	Hayward
10	Humanistic Alternatives to Addiction	Oakland
11	Latino Commission on Alcohol and Drug Abuse of Alameda County	Oakland
12	Magnolia Women's Recovery Programs, Inc.	Hayward
13	Native American Health Center, Inc.	Oakland
14	New Bridge Foundation, Inc.	Berkeley
15	Second Chance, Inc.	Newark
16	St. Mary's Center	Oakland
17	Thunder Road Adolescent Treatment Centers, Inc.	Oakland
18	West Oakland Health Council, Inc.	Oakland

MAP 2
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
ALCOHOL AND OTHER DRUG PROVIDERS
FUNDED BY MEASURE A IN FY 12/13

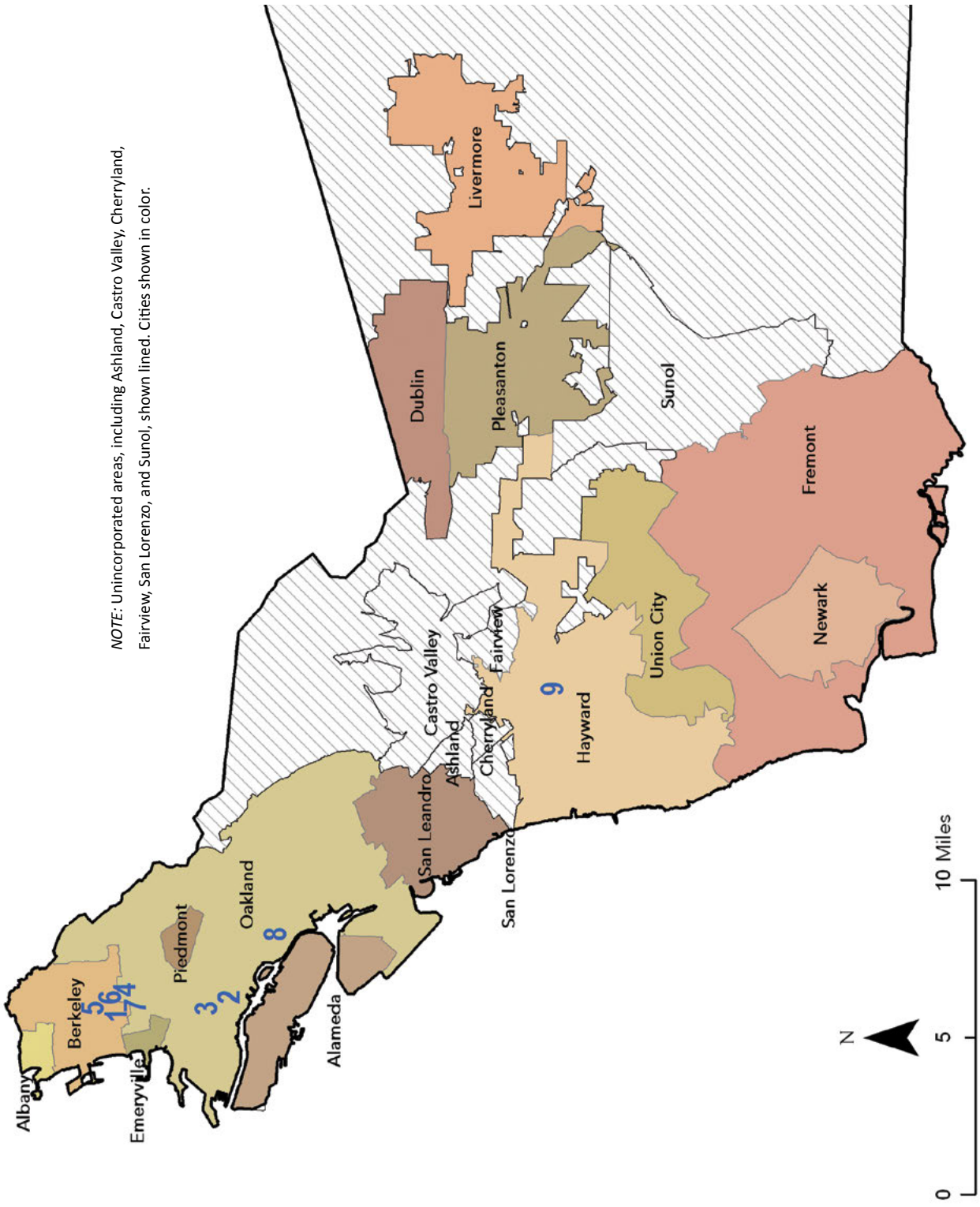


NOTE: Unincorporated areas, including Ashland, Castro Valley, Cherryland, Fairview, San Lorenzo, and Sunol, shown lined. Cities shown in color.

MAP 3
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
MENTAL HEALTH COMMUNITY-BASED ORGANIZATION PROVIDERS
FUNDED BY MEASURE A IN FY 12/13

#	PROVIDER	CITY
1	Alameda County Mental Health Association	Berkeley
2	Asian Community Mental Health Services	Oakland
3	Bay Area Legal Aid	Oakland
4	Bonita House, Inc.	Oakland
5	Building Opportunities for Self-Sufficiency (BOSS)	Berkeley
6	Center for Independent Living	Berkeley
7	Crisis Suppport Services of Alameda County	Oakland
8	Native American Health Center	Oakland
9	Southern Alameda County Commitee for Raza Mental Health (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 12/13



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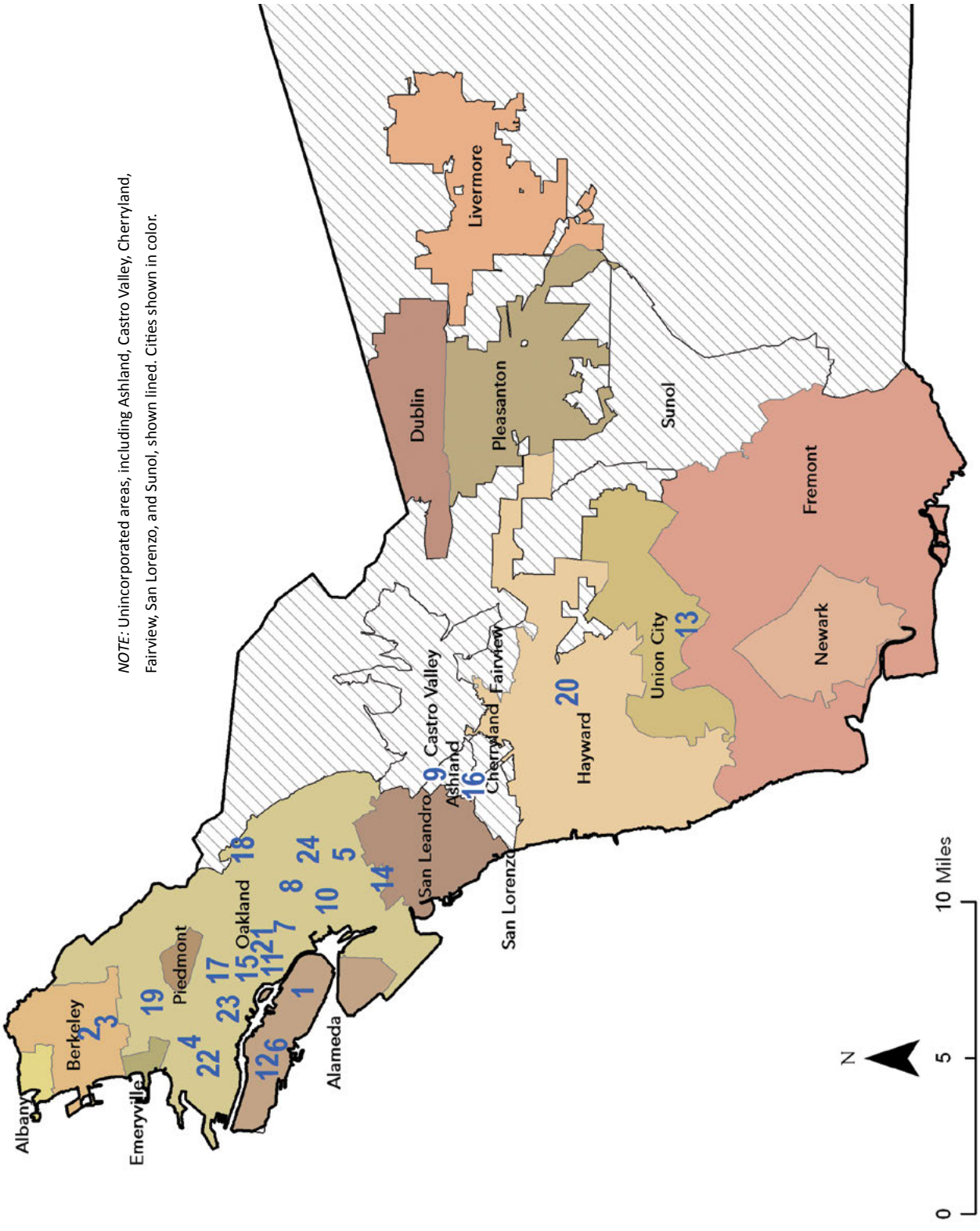
MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 12/13

NOTE: In FY 12/13, Measure A helped leverage funding to increase the number of School Health Centers from 12 to 21.

#	PROVIDER	CITY
1	Alameda High School-Based Health Center	Alameda
2	Berkeley High School Health Center	Berkeley
3	B-Tech Health Center	Berkeley
4	Chappell Hayes Health Center	Oakland
5	Elmhurst/Alliance Wellness Center	Oakland
6	Encinal High School-Based Health Center	Alameda
7	Fremont Tiger Clinic	Oakland
8	Frick Middle School-Based Health Center	Oakland
9	Fuente Wellness Center (REACH Ashland Youth Center)	San Leandro
10	Havenscourt Campus Health Center	Oakland
11	Hawthorne Health Center	Oakland
12	Island/BASE High School-Based Health Center	Alameda
13	Logan Health Center	Union City
14	Madison Health Center	Oakland
15	Roosevelt Health Center	Oakland
16	San Lorenzo High Health Center	San Lorenzo
17	Shop 55 Wellness Center	Oakland
18	Skyline High School Health Center	Oakland
19	TechniClinic	Oakland
20	Tennyson Health Center	Hayward
21	United for Success/Life Academy Health Center	Oakland
22	West Oakland Middle School Health Center	Oakland
23	Youth Heart Health Center (La Escuelita Education Complex)	Oakland
24	Youth Uprising/Castlemont Health Center	Oakland

MAP 4
SCHOOL HEALTH CENTERS FUNDED BY MEASURE A IN FY 12/13

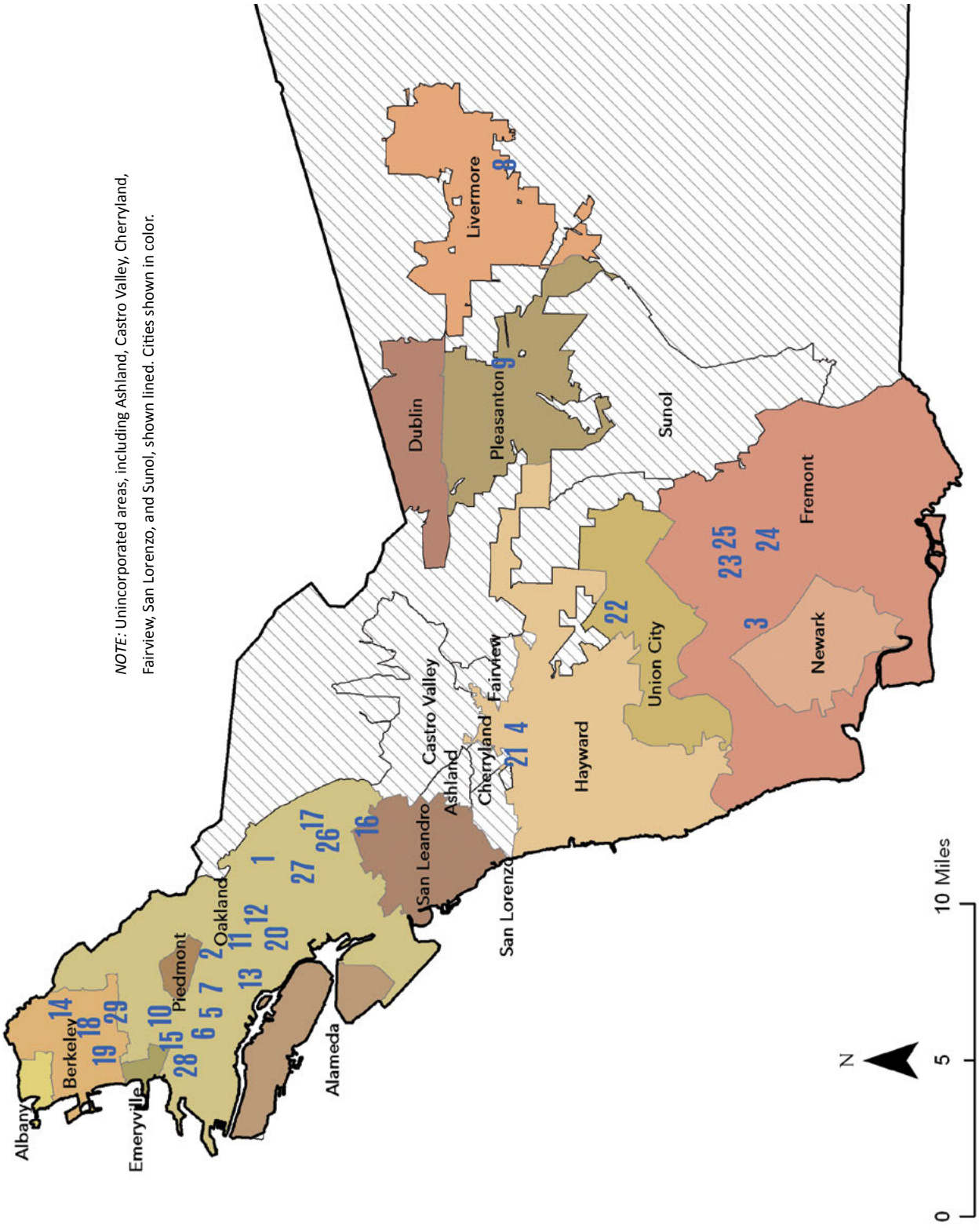


MAP 5
HEALTHPAC PROVIDER NETWORK FUNDED BY MEASURE A IN FY 12/13*

#	PROVIDER	CITY
ALAMEDA HEALTH SYSTEM		
1	Eastmont Wellness Center	Oakland
2	Highland Hospital	Oakland
3	Newark Health Center	Newark
4	Winton Wellness Center	Hayward
ASIAN HEALTH SERVICES		
5	Adult Medical Services	Oakland
6	Asian Health Services	Oakland
7	Frank Kiang Medical Center	Oakland
AXIS COMMUNITY HEALTH		
8	Axis Community Health - Livermore	Livermore
9	Axis Community Health - Pleasanton	Pleasanton
HEALTHY COMMUNITIES		
10	Save-a-Life Wellness Center	Oakland
LA CLÍNICA DE LA RAZA		
11	Clinica Alta Vista	Oakland
12	La Clinica de la Raza	Oakland
13	San Antonio Neighborhood	Oakland
LIFELONG MEDICAL CENTER		
14	Berkeley Primary Care	Berkeley
15	Downtown Oakland Clinic	Oakland
16	Howard Daniel Clinic	Oakland
17	LifeLong Medical Care - East Oakland	Oakland
18	Over 60 Health Center	Berkeley
19	West Berkeley Family Practice	Berkeley
NATIVE AMERICAN HEALTH CENTER		
20	Native American Health Center	Oakland
TIBURCIO VASQUEZ HEALTH CENTER, INC.		
21	Tiburcio Vasquez - Hayward	Hayward
22	Tiburcio Vasquez - Union City	Union City
TRI-CITY HEALTH CENTER		
23	Tri-City Health Center - Liberty	Fremont
24	Tri-City Health Center - Mowry	Fremont
25	Tri-City Health Center - State	Fremont
WEST OAKLAND HEALTH COUNCIL		
26	Albert J. Thomas Medical Clinic	Oakland
27	East Oakland Health Center	Oakland
28	West Oakland Health Center	Oakland
29	William Byron Rumford Medical Center	Berkeley

* The Health Program of Alameda County, also known as HealthPAC (and formerly known as CMSP or ACE) is a County program that provides affordable health care to uninsured people living in Alameda County. Services are provided through one of the nine community-based clinics that are part of the network or through the Alameda Health System (dba Alameda County Medical Center).

MAP 5
HEALTHPAC PROVIDER NETWORK
FUNDED BY MEASURE A IN FY 12/13



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